

CHAPTER I

INTRODUCTION

1.1 Background and Significance

Mental health serves as a significant indicator of successful aging. It is associated with increasing years of health, happiness, spirituality and social well-being among older adults (Rowe & Kahn, 1998; Strawbridge, Cohen, Shema, & Kaplan, 1996). The World Health Organization [WHO] (2001, b.) stated, “Mental health is defined as a state of well-being in which the individual realizes his or her own abilities, copes with the normal stress of life, works productively and fruitfully, and is able to make a contribution to his or her community.” Successful aging is a complex process of adaptive physical, psychological, and social change across the life-span, especially the ability to cope, respond to challenges, and continue to be a vital part of society (Compton, 2005; Ebersole, Hess, & Luggen, 2004; WHO, 2001b).

Older adults have faced physical functional impairment and personal loss (Ding, 2004; Weaver, Huang, Albert, Harris, Rowe & Seeman, 2002), including socioeconomic dimension changes such as retirement, relocation, insufficient income, and social isolation (Ding, 2004; Elisha, Castle & Hocking, 2006). These changes can lead to mental distress (William, Wilkinson, Stott & Menkens, 2008). Furthermore, chronic diseases among the elderly have become the leading causes of suicide in older adults (William, Wilkinson, Stott & Menkens, 2008). Previous reports have identified depression accounts for 50% the Disability Adjusted Life Years [DALYs] in female older adults, and 10% of DALYs with male older adults (WHO, 2009). In addition, chronic diseases have become the leading causes of suicide in older adults leading to 5.0 % in male older adults and 4% in female older adults of Years Lived with Disability [YLLs] (WHO, 2003).

Before the 21st century, mental health focused on the presence of selected symptoms such as characteristics in thinking, mood, and behaviors, personal distress and/or impairment functioning (American Psychiatry Association [APA], 1994; Vaillant, 2003). Presently, mental health is based on the concept of good life and good mental health, well-being and fulfillment in life throughout older age (Compton, 2005; WHO, 1997). In terms of successful aging, older adults enjoy health, happiness, sufficient economy, and participation with others and in society; these people even face stressful situations in their life (Antonucci & Akiyama, 1995; Baltes & Carstensen, 1996; Cornwell, 2002; Cornwell, Laumann, & Schumm, 2008). Successful aging will partly decrease morbidity and increase the age of mortality (Bryant, Corbett, & Kuther, 2001; Ford, Haug, & Stange, 2000), reducing cost of care in mental disorders (Chou & Chi, 2004; Lee, 2006), increasing the immunology such as the positive effects from the presence of endorphins that reduce activity in the Autonomous Nervous System [ANS] and in the endocrine system (McCarthy, Wetzel, Slkier, Eisenstein, & Rogers, 2001), thereby reducing stress (Fredrickson, 2009; Pressman & Cohen, 2005).

The concept of mental health is even broader worldwide. The construct of mental health is a comprise of two major perspectives, i.e., the hedonic and the eudaimonic perspectives (Deci & Ryan, 2008). *The hedonic perspective* consists of positive-negative effects, affective balance and life satisfaction referring to the maximum experiences of happiness and unhappiness, presence of positive mood and the absence of negative mood, and all judgments about the good and bad elements of life (Diener, Suh, Lucas, & Smith, 1999; Kubboy, 1999; Rayan & Deci, 2001; Ryff, 1998).

The eudaimonic perspective focuses on mental capacity measured by deep values and full engagement in people's life activities and expression such as thinking, interpersonal relationships, and problem solving (Deci & Ryan, 2008; Rowe & Kahn, 1998). Based on the eudaimonic view, Ryff identified the components of psychological well-being as self-acceptance, positive relations with others, environment mastery, autonomy, purpose of life, and personal growth (Ryff, 1989a, 1989b). More individuals may become mental distressed because only the self acting

alone is insufficient to make mental health better. However, society can also effectively promote mental health (Keyes, 2005).

One social criterion proposes that people evaluate their functions and community (Keyes, 2005). Social well-being consists of social acceptance, social actualization, social contribution, social coherence, and social integration (Keyes, 2002; 2005). However, social well-being studies are connected to cultural values (Oyserman, Coon, & Kemmelmeier, 2002; Pender, Murdaugh, & Parsons, 2010; Rayan & Deci, 2001).

Western and Asian cultures have differed different perspectives regarding the definition of well-being. According to the *Western view*, mental wellness emphasizes the self, and contributes to autonomy and differentiation from others (Ingersoll, 1975; Mann, Hosman, Schaalma, & DeVries, 2004; Markus & Kitayama, 1998). The *Asian view* does not regard the self; in a similar manner, it focuses on interdependent people in a community (Ingersoll-Dayton, Sangtienchai, Kespichayawattana, & Aunguroch, 2001; Neff, 2008). Furthermore, some studies have reported psychological well-being among older people that depends on a religion is the strongest factor (McFadden, 1996; Moody, 2001).

Religion is not only a cultural universal concerned with behaviors involving supernatural being(s), powers, and forces (Wallance, 1966) but is also an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to a sacred or transcendent being (God, higher power or ultimate truth/reality) (Koenig, McCullough, & Larson, 2001). Thus, religion has obvious psychological functions, psychological attachment, and a powerful emotional relationship to needs, either the need to fight depression, or the need to deny mortality and explains why people perform religious activities or seek healthy tones of hope, joy, resignation under calamities, and perseverance in the face of difficulties (Hinde 1999; Kirkpatrick, 2005).

Most Thais believe in Buddhism followed by Islam and Christians, mainly Catholic. The proportions of the three major religions comprise 93.6 percent Buddhist, 5.4 percent Muslim, 0.9 percent, Catholic (Foreign Office, Thailand, 2009).

Buddhism has had an influence on Thai thoughts, words and actions, including mental health perceptions. Buddhism comprises both affective states and mental capacity. Affective states are the direct experience of pleasurable stimuli (sensory and intellectual) and *sukha* arises from the attention, emotion, and cognition balanced in the mind. (Sheldon, Rayn, Deci, & Kasser, 2004) Focusing on mental capacity, three fundamental mental aspects exist, i.e., craving, hatred and state of dynamic flux (Ekman, Davidson, Richard, & Wallace, 2005). Mindfulness practice is a cognitive set that enables individuals to adapt successfully to stressful life events and relates to positive reappraisal (Brown, & Kasser, 2005; Gerland, Gayload, & Park, 2009). However, previous studies about religion have not yet clearly documented elements related to mental health as well as aspects regarding successful aging. Thus, a mental health instrument involving promotion and public health perspectives is required to employ in evaluating older adults.

The Thai government has identified the elderly group as a population with special needs and placed a high priority in the National Social and Economic Plan for enhancing their quality of life (Office of National Social and Economic Development Board, 1995).

Existing instruments of mental health are based on two perspectives, i.e., hedonic and eudaimonic perspectives. These instruments are more focused on the hedonic or emotional component than the eudaimonic perspective or mental capacity component (Ranzijn, & Luszcz, 2000; Ryff & Singer, 1998; Waterman, 1993). One specific instrument used to assess this component is Ryff's Scales of Psychological well-being) (Ryff, 1989a, 1989b). The hedonic perspective also appeared in assessment tools such as Life Satisfaction Scales (Neugarten, Havighurst, & Tobin, 1961), The Philadelphia Geriatric Center [PGC] Morale Scale (Lawton, 1975), the Index of Well-being, and the Index of General Affect (Campbell, Coverse, & Roders, 1976).

Only 19 research publications have reported about mental health promotion programs; most of these papers have objectives to reduce depression, loneliness and to increase self-esteem for older people in hospitals. Two papers developed the process of mental health promotion using Pender's health promotion and promoting community participation in community (Sutthilet, 2008). In addition,

the measurement provided by mental health tools for Thai older adults, reported by older people, is limited.

Currently, existing instruments of mental health measure for Thais, have only five measurements: four instruments are perspectives about mental health illness but only instrument by Mongkol and colleagues (2001) covered all perspectives of mental health.

The first instrument was developed by Namdej (1996) to screen mental health in Thai older adults. The development of this instrument is based on a concept of psychological well-being: life-satisfaction and interpersonal relationship and psychological distress. The target population was 248 older adults, 62 suffering from mental distress diagnosed by psychiatrists and 186 were mentally healthy. This instrument is self-administered with 42 items (0 to 4 scale); and the whole development, including cut-off points, takes only four months. The results found the internal consistency estimated by coefficient alpha for psychological distress scale was 0.93, for psychological well-being, 0.85, and for all, 0.94. It took only five minutes to complete the instrument. The evidence showed construct and concurrent validity of a Mental Health Screening test. The cut-off point of total scale at score 18 was appropriate to carry sensitivity, specificity, positive predictive value, negative predictive value, and false positive rate more efficiently (sensitivity = 85.5%, specificity = 83.3 %, positive predictive value = 63.1%, negative predictive value = 94.0%, false positive rate = 16.7%). No information about criterion-related validity was reported; there were an insufficient number of participants, and amount of time. This instrument is used for individuals not for society and the psychological well-being concept referred to some positive mental health. Moreover, this instrument is used by professionals.

The second instrument to be developed was by Ingersoll, Saengtienchai, Kespichayawattana, and Aunguroch (2004). The development of this instrument was based on the concept of psychological well-being by Ryff. The sample comprised 460 older adults from Bangkok and perimeters. The instrument assessed five dimensions of psychological well-being: harmony, interdependence, acceptance, respect, and enjoyment and included an interview questionnaire, 16 items, for which Cronbach's

alpha revealed an adequate internal consistency for the interpersonal well-being index (0.82), and the intrapersonal well-being index (0.69). Further, the three-week test-retest reliability was acceptable for the intrapersonal well-being scale (0.68) but somewhat lower for the interpersonal well-being scale (0.59). Based on Ryff's concept, this instrument emphasized mental functioning.

The third instrument to be developed was by Phattharayuttawat, Ngamthipwattana and Sukhatungkha (1999). The Thai Mental Health Questionnaire to assess domains of functioning followed the criteria on the DSM-IV, i.e., five domains consisting of somatization, depression, anxiety, psychotic state, and social function. The sample subjects comprised 700 people from two groups: 350 normal individuals and 350 psychiatric patients, aged between 15 to 60 years. Results found reliability coefficients for the Alpha ranged from 0.80, and the reliability coefficients for the Split-half ranged from 0.90. The instrument had an adequate reliability. The construct of the scale was in Thai, so the literacy level is rarely a problem. This instrument was tested the same as other symptom scales, i.e., screening or diagnosis scales such as PSE (Present State Examination), GHQ (General Health Questionnaire), and SCL-90 (Symptom Distress Check-List). It normally takes about 15 to 20 minutes to complete the TMHQ's scale. In all, the assessment tool included 62 items.

The fourth instrument was developed by Otrakul, Cheroenkul, Smithtikrat, Tantipiwatanaskul and Krabwong (1997) as a mental health indicator for Thais. The study was conducted in two phases: in the first phase, the meaning of mental health was defined by literature reviews and the second phase identified the psychometric properties. The sample size was 1,800 adults in nine provinces from Thailand. The meaning of mental health was composed of three domains: a) thinking perception, emotional expression and performance reaction toward self, b) thinking perception, emotional expression and performance reaction towards others or surroundings, and c) thinking perception, emotional expression and performance reaction towards society. In total item the assessment tool included 36 items. Cronbach's alpha revealed adequate internal consistency (0.9377), and discriminant analysis was used to check for the validity of the scale.

The last instrument to be developed was by Mongkol and colleagues (2001). This is the only instrument that measured cover perspectives of mental health:

mental status, mental capacity, mental quality, and supporting factors. The purpose was to find the normal value of the indicators reported by separating people in community. The sample size was 1,429 people, aged 15 to 60 years living in metropolitan government, city government and district government levels (Or-bor-tor level 1 to level 5) of northeastern Thailand. The brief Thai mental health indicator was also developed. In all the assessment tool included 15 questions; the whole reliability of this brief indicator was 0.70. The concurrent validity between this indicator and Amphorn Otrakul's Mental Health Questionnaire was found to have medium correlation.

The eudaimonic perspective used a content analysis of clinicians and theoreticians based on lifespan theory of human flourishing (e.g., Erikson, 1959; Jung, 1933; Maslow, 1968; Neugarten, 1968; Roger, 1961) to develop the psychological well-being measurement. Although some psychologists tried to measure psychological well-being, the scope of positive psychological functioning, including social well-being, is limited (Keyes, 2005; Ryan & Deci, 2001).

The understanding that mental well-being is a significant aspect of successful aging in Thai culture is limited (Ingersoll, Saengtienchai, Kespichayawattana, & Aunguroch, 2004). In addition, the measurement of mental health tools for Thai older adults collected for their own elderly life is limited. The previous instrument conducted by expert views. Moreover, these instruments did not cover the aspects of culture and religion.

Furthermore, the demand of mental health is increasingly indicated in the field of public health. Public mental health practitioners need to conduct mental health tools. Presently, the area of care has changed from hospital care to community care. Evaluating and monitoring mental health promotion is significantly required at the present (Herrman, & Jane-Lopis, 2005). The negative mental health aspect cannot be employed to evaluate mental health promotion (Bryunt, Beck, & Fairclough, 2000; McClure, Turner, Peel, Spinks, Eakin, & Hughes, 2005) including viewpoints that should be changed.

The field of public health needs a conceptualization of well-being to measure mental health among older adults including one based on the constructs of

affective status, psychological functioning, spirituality, and social support. In addition, the instrument should establish either collected data among older adults or health practitioners (Pachnee & Wibonpolprasert, 2006). The assessment tool should appropriately measure elderly people in community areas and be used by self-administration (WHO, 2001). Thus, development of mental well-being assessment tool is needed in this field.

Therefore, the mental health assessment tool for older adults was conducted for older people, aged 60 years and over in the northern, northeastern, central and southern regions and the Bangkok Metropolitan Area in Thailand. Qualitative methods were used to identifying domains of mental health for Thai older adults, while quantitative methods were used to develop and test the quality of the instrument. Finally, the results from this study could identify normal older people in the community.

1.2 Research Question

1.2.1. What is a mental health assessment tool for Thai older adults?

1.2.2. How valid and reliable is the developed mental health assessment tool for Thai older adults?

1.3 Research Objectives

1.3.1 General objective

To develop and test the quality of the mental health assessment tool for Thai older adults

1.3.2 Specific Objectives

1.3.2.1 To identify domains of mental health for Thai older adults

1.3.2.2 To develop a tool for assessing mental health of Thai older adults

1.3.2.3 To test psychometric properties in terms of validity and reliability of the mental health assessment tool for Thai older adults.

1.4 Scope of Study

This study aimed to develop and test the quality of the assessment of mental health status for Thai older adults. The participants are aged more than 60 years old. They are Buddhist, Muslim, and Catholic. The study was conducted using data generated on older people, rural and urban area in the northern, northeastern, central and southern regions, municipality and non-municipality area in the Bangkok Metropolitan Area in Thailand from 2009 to 2010.

1.5 Conception Framework

The conceptual framework of this study is derived by using the instrument development procedure. The research conceptual framework of the study is as follows (Figure 1-1)

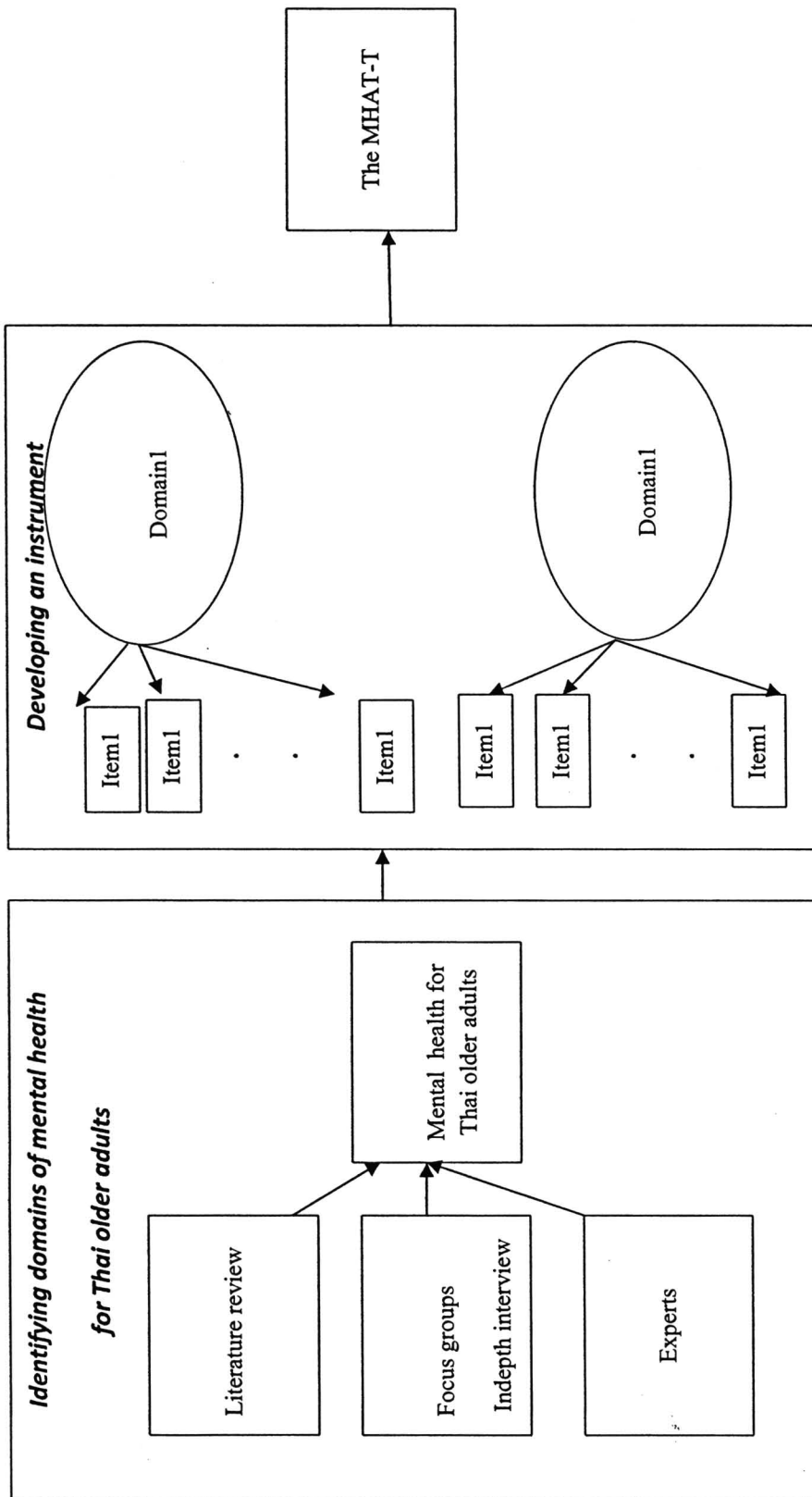


Figure 1-1 Conceptual Framework

1.6. Operational Definitions

Mental health is defined as a state of well-being in which the individual realize his or her own abilities, perceiving one's mental status, developing internal mental capacity in individuals to maintain human life (e.g., competency of coping and adaptation with the normal stress of life, fact accepting, sympathy in hedonism), having moral or mental quality (e.g., kindness, faith, and patience), family attachment and social well-being. Mental health for Thai older adults can be measured by their scores on a scale of the mental health assessment tool developed by the investigator.

Thai older Adults are defined by chronological age, classified into three groups: young elderly (60-74 years), middle elderly (75-84 years), and oldest elderly (85 years and over) (WHO, 1988). In this study, the term older adults refer to Thai older people, both male and female, divided into three groups: young elderly (60-74 years), middle elderly (75-84 years) and oldest elderly (85 years and over), residing in the target setting.

Successful aging is defined in current study as being healthy and happy in older life, the ability to cope and adapt to change, and to ensure that older adults can achieve a sense of meaning in life.