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Edited by Ritik Kashwani

E-mail: docritikkashwani@yahoo.com

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Mental health crisis and family bonding among the geriatric population in an urban Indian community

Arockia Vinolia Amalraj¹, Shankar Shanmugam Rajendran^{2,*}, Gomathy Priya Vekatachalam¹, Vanitha Narayanasamy Naidu¹, Karthika Devandiran¹, Premalatha Venkatesan¹, & Sumathi Murugaiyan¹

¹Department of Community Health Nursing, College of Nursing, Madras Medical College, The TN Dr MGR Medical University, Chennai, Tamil Nadu, India; ²Department of Nursing Research, College of Nursing, Madras Medical College, The TN Dr MGR Medical University, Chennai, Tamil Nadu, India; Corresponding author

Affiliation URL:

<https://www.tnmgrmu.ac.in/>

Author contact:

Arockia Vinolia Amalraj - E-mail: vinolixavier86@gmail.com
Shankar Shanmugam Rajendran - E-mail: shankarshaki@yahoo.com
Gomathy Priya Vekatachalam - E-mail: kgksavan@gmail.com
Vanitha Narayanasamy Naidu - E-mail: nvanitha967@gmail.com
Karthika Devandiran - E-mail: karthika.d38@gmail.com
Premalatha Venkatesan - E-mail: prems00005@gmail.com
Sumathi Murugaiyan - E-mail: sumathimary81@gmail.com

Abstract:

Old age in India is associated with increasing mental health concerns and changing family relationships among older adults. Therefore, it is of interest to assess the mental health crisis and family bonding among 60 elderly individuals aged ≥ 60 years in Choolai, Chennai. Mental health crisis was low in 60.00%, moderate in 23.33% and high in 16.67%, while family bonding was low in 43.33%, moderate in 35.00% and high in 21.67%. A significant negative correlation was found between mental health crisis and family bonding ($r = -0.36$, $p = 0.01$), with selected socio-demographic factors significantly associated with both variables. Thus, data shows that geriatric nursing practice highlights family bonding as a potential target for strengthening mental well-being among older adults.

Keywords: Aged, mental health, family relations, depression, geriatric assessment, nursing assessment

Background:

Ageing in India is unfolding so rapidly that families, communities and the healthcare system are struggling to keep pace. The country is moving from a youthful nation toward one with nearly one in five citizens aged 60 years or above by 2050. Among the most pressing but least visible consequences of this shift is the silent burden of late-life mental distress and the slow erosion of intergenerational family ties. The global dementia burden alone is projected to nearly triple from about 57 million cases in 2019 to 153 million by 2050 [1]. Such projections demand a re-examination of how families and nurses can protect the emotional well-being of elders. Older adults are doubly burdened by chronic non-communicable diseases and the social factors of poor health. National-level evidence shows that nearly 21% of the elderly suffer from one chronic condition, with 17% in rural and 29% in urban areas affected and hypertension and diabetes alone accounting for about 68% of all such conditions [2]. The co-existence of hypertension and diabetes, which is now recognised as a key driver of cardiovascular and renal complications [3]. Further compromises functional independence. Oral health problems, frequently overlooked, also reduce nutrition, communication and quality of life in the elderly [4]. This dense web of physical morbidity creates fertile ground for psychological distress. The mental health crisis among older people is steadily growing. A global meta-analysis estimated the prevalence of depression, anxiety and stress among the elderly at 19.2%, 16.5% and 13.9 %, respectively [5]. In India, a community-based meta-analysis reported a combined prevalence of depression of 34.4% among individuals aged 60 years and above [6], indicating that more than one in three Indian elders may be silently struggling with depressive symptoms. Such conditions remain grossly under-diagnosed and under-treated, in part because they are dismissed as a "normal" part of ageing. Family relationships have traditionally been the strongest protective shield for Indian elders, but this shield is becoming thinner. Longitudinal evidence from India shows that joint family households have declined while the

proportion of older adults living with the spouse or alone has risen and family structure remains a significant determinant of self-rated health [7]. Older adults living with both a spouse and children consistently report higher life satisfaction than those living alone [8], whereas dissatisfaction with living arrangements has been linked with a markedly higher risk of major depressive disorder [9]. Qualitative work from India highlights that ageing in place, when supported by family, sustains autonomy and dignity, but these benefits weaken when intergenerational bonds loosen [10]. Elder mistreatment, including emotional neglect, is reported by up to three-quarters of community-dwelling elders in some settings, with lack of family support being a leading risk factor [11]. Therefore, it is of interest to report the level of mental health crisis and family bonding among geriatric people residing in a selected urban area, to correlate these two variables and to explore their association with selected socio-demographic characteristics.

Materials and Methods:

A quantitative, non-experimental, descriptive cross-sectional design was employed. The study was conducted at Choolai, Chennai, Tamil Nadu, India, over four weeks. The population comprised all geriatric individuals aged 60 years and above residing at Choolai. A total of 60 participants were recruited through non-probability convenience sampling. The sample size was estimated using the formula $N = Z^2 p (1-p) / (p \times e^2)$ with $Z = 1.96$, an anticipated proportion of 0.30 derived from a previous Indian study and a relative precision of 55%, yielding a calculated minimum of 57 and a final sample of 60. Both male and female elders aged 60 years or above, residing at Choolai, able to comprehend Tamil or English and willing to provide informed consent was included, irrespective of comorbidities. Individuals with documented cognitive or learning impairment, a history of major mental illness, severe acute physical illness at the time of data collection, those residing in nursing homes or hospitals and those participating in any other ongoing study were excluded. Three instruments were used such as structured

sociodemographic proforma, the GDS-SF, the Family Belonging Scale (FBS). Content validity was obtained from the panel of nursing experts. After Institutional Ethics Committee approval and written permission from the Block Medical Officer, eligible elders were approached individually. The purpose, voluntary nature and confidentiality safeguards were explained and written informed consent was obtained. Each interview, conducted in Tamil or English as preferred, lasted 20-25 minutes. A pilot study on 10% of the sample preceded the main study; pilot participants were excluded from the final analysis. Data were coded in Microsoft Excel and analysed in IBM SPSS Statistics. A p-value <0.05 was considered statistically significant.

Results:

Of the 60 participants, the majority (40.00%) were aged 60-64 years; 53.33% were male and 93.33% were married. Informal education was reported by 33.33%, while 23.33% were graduates. Old-age pension was the primary income source for 35.00% and 50.00% earned less than ₹10,000 per month. Most (76.66%) lived with their children, 63.34% identified as Hindu

and 59.32% had two children. The mean GDS-SF score was 7.67 ± 4.06 out of 15. The majority of elders (60.00%, n = 36) had a low level of mental health crisis, while 23.33% (n = 14) had a moderate and 16.67% (n = 10) a high level (Figure 1). The mean FBS score was 38.07 ± 18.00 out of 68. Low family bonding was reported by 43.33% (n = 26), moderate by 35.00% (n = 21) and high by only 21.67% (n = 13) of participants (Figure 2). Karl Pearson's correlation revealed a statistically significant negative fair correlation between the mental health crisis and family bonding scores (r = -0.36, p = 0.01), indicating that as family bonding strengthened, the level of mental health crisis decreased. Educational level ($\chi^2 = 21.29$, p = 0.01 for mental health; $\chi^2 = 11.22$, p = 0.01 for family bonding), employment status ($\chi^2 = 13.55$ and 12.20 respectively, p = 0.01), living arrangement ($\chi^2 = 8.70$, p = 0.01 for mental health) and number of children ($\chi^2 = 8.64$, p = 0.01 for family bonding) were significantly associated with the study variables. Other variables such as age, gender, marital status, monthly income and religion did not show statistically significant associations (Table 1).

Table 1: Association between the level of mental health crisis and family bonding with selected socio-demographic variables (n = 60)

Demographic variable	Category	n	Mental Health Crisis χ^2 (p)	Family Bonding χ^2 (p)
Educational level	Informal	20	21.29 (0.01)*	11.22 (0.01)*
	Primary	13		
	Secondary	13		
	Graduate	14		
Employment status	Unemployed	17	13.55 (0.01)*	12.20 (0.01)*
	Retired	7		
	Employed	15		
Living arrangement	Old-age pension	21	8.70 (0.01)*	2.78 (0.24) NS
	Living alone	7		
	With spouse	7		
	With children	46		
Number of children	No children	12	1.24 (0.74) NS	8.64 (0.01)*
	One	4		
	Two	35		
	>Two	8		

*Statistically significant at p < 0.05; NS = Not significant

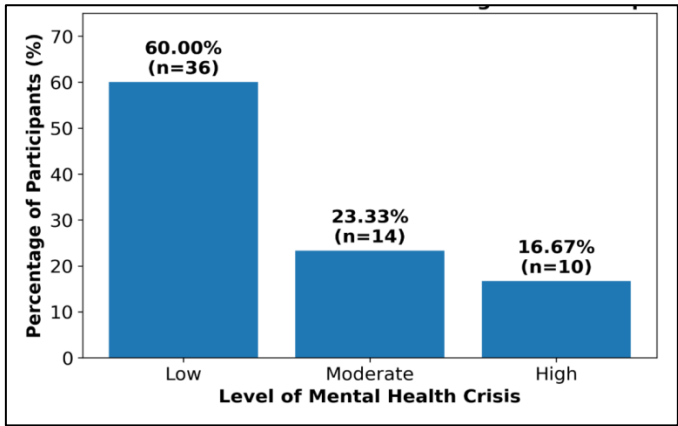


Figure 1: Distribution of mental health crisis levels among the geriatric population (n = 60)

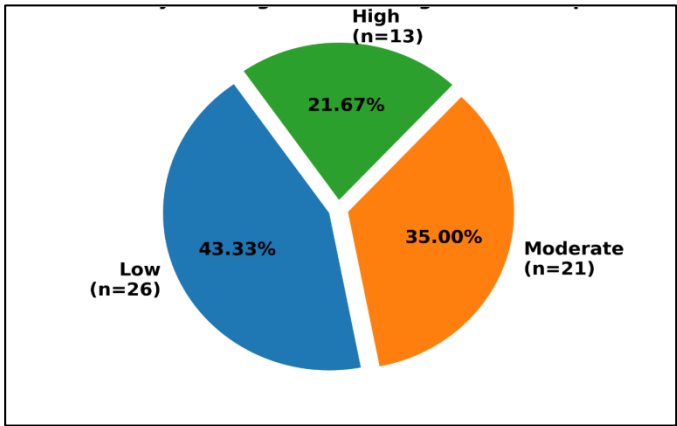


Figure 2: Distribution of family bonding levels among the geriatric population (n = 60)

Discussion:

The present study showed 60.00% of elders reported a low level of mental health crisis, 43.33% experienced low family bonding, suggesting that emotional connectedness within Indian families is weaker than the surface mental health profile suggests. This aligns with the broader scoping review evidence that social connectedness, including family ties, is among the most consistent longitudinal protective factors against depressive and anxiety symptoms in adults [12]. When connectedness frays, even physically healthy elders become emotionally vulnerable. A statistically significant negative fair correlation between mental health crisis and family bonding ($r = -0.36$, $p = 0.01$). Comparable inverse relationships have been reported in community surveys of older adults, where stronger family cohesion is linked with lower psychological distress and better life satisfaction [13]. A national-level Indian analysis confirmed that older adults co-residing with spouse or family members reported significantly higher life satisfaction, with the protective effect amplified when active social participation was preserved [14, 15]. The present results from urban Chennai add to this evidence by showing the link is not unique to rural or institutional settings. Significant associations of educational level, employment status, living arrangement and number of children with both outcomes ($p = 0.01$). Graduates and primary-educated participants showed lower mental health crisis (100% and 76.92% respectively in the low category), while retirees (100%) and pension recipients (71.43%) demonstrated stronger bonding. Higher educational attainment and stable economic status have been consistently identified as predictors of better mental health among older adults. Crucially, those living alone in this sample had the highest proportion of moderate-to-high mental health crisis (85.71%), echoing LASI-based evidence that solo living is one of the strongest demographic predictors of low life satisfaction in Indian elderly [16, 17]. Together, these findings reinforce that the family is not merely a social unit but a therapeutic resource. Nurses in urban communities should screen elders for depressive symptoms and family belonging and design interventions, structured family communication sessions, intergenerational engagement and community support groups that strengthen bonding alongside conventional mental health care. Limitations include a small, single-locality convenience sample, self-reported measures and a cross-sectional design that precludes causal inference; larger longitudinal multi-centre studies are warranted.

Conclusion:

Nurses, as frontline caregivers, must integrate routine mental health screening with family-centred counselling and community outreach. Policies that nurture intergenerational living, financial security and social engagement are urgently needed to ensure that India's rapidly ageing population grows old not in silence and isolation, but in dignity, connection and emotional well-being.

Ethical approval:

Approval was obtained from the Institutional Ethics Committee and written informed consent was obtained from all participants.

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