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<th><strong>Title</strong></th>
<th>The psychological well-being of elderly persons living in old urban areas of Hong Kong: A social perspective</th>
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<td><strong>Author(s)</strong></td>
<td>Lam, CW; Boey, KW</td>
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Using the Geriatric Depression Scale-15 (GDS-15) and the short form of the General Health Questionnaire-12 (GHQ-12), this study found that the Chinese elderly who live in old urban areas of Hong Kong are at risk of suffering from poor mental health because of their relatively deprived social conditions. It was also found that the respondent’s scores in the GDS-15 correlated with their social conditions, including type of housing, availability of helpers, financial status and family support. However, Chinese elderly people often avoid seeking help because of the fear of being stigmatised. There is a need for more research in the future to study their needs and problems so that social work practitioners can be well informed and culturally competent to help this disadvantaged group.

Introduction

A significant number of the elderly live in old urban areas of Hong Kong. Where the social support network has disintegrated, resulting from the migration of industries to China after the 1980s and the recent economic decline, these old urban areas have degenerated and neither better-off residents nor private developers are interested in moving to or redeveloping these regions. The government has also invested little to improve the community facilities of these areas, which are characterized by broken neighbourhoods, cramped tenements, and poor living conditions. A study has found that the older persons in these areas are of low education and do not have sufficient resources after retirement because they used to work as manual labourers, such as porters or workers in the catering and manufacturing industries, and so received meagre incomes (Mok, 1999). Since the living conditions in these areas are so undesirable, it is anticipated that those older persons living there may suffer from poor mental health.

In Hong Kong, one study found that 15% of the respondents showed signs of depression, a rate appreciably higher than the prevalence rate in the USA (Chou, Chi & Boey, 1999). Other local studies have established that depressive symptoms are negatively associated with psychological features of the elderly, such as life satisfaction (e.g., Chi & Boey, 1999).
1994) or self-rated health (e.g., Chan & Leung, 1995). Some researchers have also found that the depressive symptoms of the elderly correlate significantly with their social support (Chou & Chi, 2001a); financial strains (Chou & Chi, 2001b); and the condition of living alone (Chou et al., 1999). Yet, in most of the research on the elderly, the problems and needs of those who live in old urban areas have not received specific attention.

The research goal of this study, therefore, was to adopt a social perspective to understand the psychological well-being of those older persons who live in old urban areas. We hypothesize that, because of their relatively deprived social conditions, the elderly living in old urban areas would exhibit evident depressive symptoms that are related to the social factors including the family network, the availability of helpers, housing conditions, and financial status. To explore whether their mental health problems were more serious because of their relatively deprived social conditions, we compared the results with those of two other groups of elderly respondents in similar studies that used the same measurements—one in Hong Kong and one in Beijing.

Method

Sampling

The data collection procedure was conducted in two old urban areas in Hong Kong. However, there was no comprehensive information on the distribution of the elderly in these two areas, and they tended to be less educated, less sociable, and more difficult to contact. Hence, purposive sampling was adopted and interviewers were asked to visit those elderly people \( (n = 200) \) who were the clients of two NGOs located in these areas. In addition, with the recommendations of social workers who worked in the two districts, the interviewers interviewed 266 respondents in 10 ‘hot spots’ where elderly people in the districts usually gathered (e.g., parks, open areas near temples, etc.). Fifteen senior-year social work students conducted the individual face-to-face interviews.

Measures

The Geriatric Depression Scale-15 (GDS-15) was developed by Sheikh and Yesavage (1986) from the GDS (Brink et al., 1982) to assess an elderly person’s depressive symptoms. It was translated into Chinese and validated in Hong Kong with satisfactory reliability and validity (Lee et al., 1993; Boey & Chiu, 1998). It has to be noted that Chinese elderly tend to over-report on depressive symptoms (see Woo et al., 1994). In order to avoid a misleadingly high prevalence rate that would be recorded if the criterion of five or above was used, and also in keeping with the criterion adopted by local studies (Boey, 2000; Boey & Chiu, 1998), a cut-off point of eight was adopted in this research.

The General Health Questionnaire (GHQ) was developed by Goldberg (1972) for detecting non-psychotic mental health problems in the general population. The reliability and validity of the Chinese version of the GHQ have been established (Chan & Chan, 1983), and a ‘yes-no’ response format of the GHQ-12 was adopted for use with the elderly (Chi & Boey, 1992). The recommended cut-off scores for the GHQ-12 is seven points or above (Boey & Chiu, 1998).

The respondents were asked about their family network and whether they were living with their relatives under the same roof, or alone by themselves, and whether they had relatives living in Hong Kong. They were asked about the availability of helpers, including relatives, neighbours, or friends who could offer assistance to them when they were in trouble or faced with an emergency. They were asked about their housing e.g., private housing with independent tenancy, private housing with shared tenancy (e.g., cubicles), or public housing. The respondents were asked whether their major source of income was from their families, from their own employment or savings, or from the government’s CSSA scheme. The respondents were also asked to rate their own health on a four-point scale covering their general health status, hearing, eyesight, and mobility.

Results

Excluding subjects with incomplete questionnaires and those who did not live in the local old urban areas, the effective sample consisted of 397 subjects (212 males and 185 females). The respondents’ ages ranged from 60–89, with a mean age of 73.3. The internal consistency of the GDS-15 (Alpha = 0.83, item total correlations ranging from 0.25 to 0.77, \( M = 0.55 \)) and the GHQ-12 (Alpha = 0.82, item total correlations ranging from 0.37 to 0.76, \( M = 0.58 \)) were both satisfactory. Using the recommended cut-off scores for the GHQ-12 (seven or above) and the GDS-15 (eight or above), it was found that 24.7% of the respondents might be considered to have mental health problems on the GHQ and 29.7% of them might be considered to have problems of depression.

The GHQ-12 did not show any significant relationship with the social variables in this study. This is similar to the results of other studies (e.g., Boey and Chiu, 1998) finding that the GDS-15 is a more sensitive measure and accounts for greater variance than the GHQ-12 in the relationships with social support, financial status, and physical health conditions. Hence, the following discussion is mainly based on the findings of the GDS-15.
Family network

It was found that those who lived alone but had relatives in Hong Kong (n = 107; M = 5.66; SD = 4.04) had significantly higher depression scores than those who lived with their families (n = 160; M = 4.60; SD = 3.78) (t = 2.16; df = 217; p < 0.05). It suggested that the respondents who lived alone exhibited more depressive symptoms than those who lived with their relatives.

Availability of helpers

Table I shows that for those respondents who sought help from their families, their GDS scores ranged from 3.89 to 4.52—significantly lower than the scores of those who did not seek help from anybody and of those who sought help from their friends.

Housing

The respondents living in private housing with independent tenancy, who had a better living environment, had significantly lower GDS-15 scores (n = 99; M = 4.35; SD = 3.56) than those who lived in private housing with shared tenancy (n = 144; M = 5.85; SD = 3.90), (F = 4.35; df = 2, 385; p < 0.05).

Financial status

It was found that those respondents who relied on CSSA as their major income source (n = 151; M = 6.03; SD = 4.07) had a significantly higher GDS-15 score than those who relied on their families (n = 126; M = 4.58; SD = 3.56) and those who relied on their own employment or savings (n = 99; M = 4.54; SD = 3.85)(F = 5.11; df = 3, 386; p < 0.05).

Self-rated health

The scores on the GDS-15 correlated significantly with the status of self-rated health problems with eyesight, hearing, and mobility (r = -0.30, -0.21, -0.17, and -0.27 respectively) at the 0.01 level.

Multiple regression analysis

A significant relationship between the GDS-15 and social factors was identified by the multiple regression analysis, with R² = 0.23. It is worth mentioning that, in addition to self-rated health factors, housing type, the availability of helpers, and income sources also accounted for the variation in the GDS-15 scores (Table II).

Discussion

Compared with similar studies that also adopted the GDS-15, it was found that our respondents had higher mean scores than their counterparts who lived in a new town in Hong Kong (mean score = 5.23 versus 3.33, t-value = 8.60, p < 0.001; Boey & Chiu, 1998), and older people living in an urban district in Beijing (mean score = 5.23 versus 3.9, t-value = 5.64, p < 0.001; Boey, 2000). The comparison implies that the mental health of older persons living in urban areas may be worse than that of their counterparts living in new towns with better

Table I. The GDS-15 scores and the availability of helpers.

<table>
<thead>
<tr>
<th>Help availability</th>
<th>Nobody (M, SD)</th>
<th>Family or relatives (M, SD)</th>
<th>Friends or others (M, SD)</th>
<th>Overall (M, SD)</th>
<th>F value (df = 2, 394)</th>
</tr>
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<tr>
<td>To help in troubles</td>
<td>5.83 (4.01)</td>
<td>4.49 (3.62)</td>
<td>5.72 (4.12)</td>
<td>5.23 (3.91)</td>
<td>5.46</td>
</tr>
<tr>
<td>To help in an emergency</td>
<td>5.95 (2.36)</td>
<td>4.52 (3.72)</td>
<td>5.72 (4.33)</td>
<td>5.23 (3.91)</td>
<td>6.02</td>
</tr>
<tr>
<td>To help with in-depth</td>
<td>5.32 (3.83)</td>
<td>3.89 (3.57)</td>
<td>5.09 (3.93)</td>
<td>5.23 (3.91)</td>
<td>12.00</td>
</tr>
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*Tukey HSD post hoc at < 0.05 level.

Table II. Multivariate analysis of factors related to GDS-15.

<table>
<thead>
<tr>
<th>Factor</th>
<th>β</th>
<th>SE β</th>
<th>Beta</th>
<th>t-value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-rated health status</td>
<td>-1.71</td>
<td>0.39</td>
<td>-0.22</td>
<td>-4.35</td>
<td>0.000</td>
</tr>
<tr>
<td>House types</td>
<td>1.26</td>
<td>0.38</td>
<td>0.16</td>
<td>3.36</td>
<td>0.001</td>
</tr>
<tr>
<td>Had people to talk in-depth</td>
<td>-0.70</td>
<td>0.22</td>
<td>-0.15</td>
<td>-3.18</td>
<td>0.01</td>
</tr>
<tr>
<td>Self-rated movement</td>
<td>-1.15</td>
<td>0.42</td>
<td>-0.14</td>
<td>-2.74</td>
<td>0.01</td>
</tr>
<tr>
<td>Income sources²</td>
<td>0.60</td>
<td>0.22</td>
<td>0.13</td>
<td>2.79</td>
<td>0.01</td>
</tr>
<tr>
<td>Self-rated eyesight</td>
<td>-0.97</td>
<td>0.39</td>
<td>-0.12</td>
<td>-2.47</td>
<td>0.01</td>
</tr>
<tr>
<td>Self-rated hearing</td>
<td>-1.06</td>
<td>0.43</td>
<td>-0.12</td>
<td>-2.47</td>
<td>0.01</td>
</tr>
<tr>
<td>To help in troubles</td>
<td>-0.27</td>
<td>0.30</td>
<td>-0.05</td>
<td>-0.89</td>
<td>0.37</td>
</tr>
<tr>
<td>To help in emergency</td>
<td>-0.14</td>
<td>0.30</td>
<td>-0.03</td>
<td>-0.46</td>
<td>0.65</td>
</tr>
<tr>
<td>Alone-Relatives (4 groups)</td>
<td>-0.01</td>
<td>0.01</td>
<td>-0.04</td>
<td>-0.76</td>
<td>0.45</td>
</tr>
</tbody>
</table>

*R² = 0.23; F = 9.71; df = 11, 368; p < 0.0001. ¹House types: independent household, shared tenancy. ²Income sources: having own employment or savings, from family, dependent on CSSA.
community facilities, and in China, where the traditional support from family members remains intact.

The findings of this study indicate that older persons living in old urban areas are at risk of suffering from poor mental health because of their relatively deprived social conditions. It is also confirmed that the respondents’ scores on the GDS-15, apart from that relating to their health conditions, correlated with their social conditions, including type of housing, availability of helpers, and family support.

With regard to the mental health problems, it has to be noted that Chinese relied greatly on their family and friends for assistance (Cheung, 1987). Moreover, the elderly people are not vocal in expressing their needs and often avoid seeking help from mental health professionals because of the fear of being stigmatized (Casado & Leung, 2001; Tseng, Lu & Yin, 1995). Hence, it is a very worrying situation that family and community networks in old urban areas are disappearing, and it would not be realistic to expect older persons living in these areas to secure sufficient social support through their own efforts.

Limitations of the study

The convenience sampling approach was adopted in this study because the elderly living in old urban areas of Hong Kong are less sociable and more difficult to contact. Since it was not a stratified random sample, the conclusions drawn from this research need to be interpreted with caution and are in need of further studies for substantiation. Moreover, we were not able to determine the sensitivity and specificity of the GDS-15 by independent psychiatric diagnosis because of limited resources.

The policy implications for elderly services at this juncture are that, in addition to redeveloping the physical environment of old urban areas, the Hong Kong government should consider ways of enhancing the social network of older persons living in these areas so that the goal of ‘care in the community’ can be realized. It is noteworthy that those respondents who relied on the CSSA had higher scores on the GDS-15. This finding poses the question of how to make the social welfare system more effective to alleviate poverty among disadvantaged groups in the material aspect while at the same time helping their psychological well-being. The issue has become more urgent in recent years because the Hong Kong government has been trying to adopt a more strict welfare policy in order to return to a balanced budget (Chow, 2003). At the intervention level, there is no doubt that professionals can play an important role by adopting the social network approach. Central to this approach is to have adequate assessment of the elderly clients’ support networks so as to understand the realities of weak support networks as well as robust ones.

Equipped with this knowledge, social workers can strengthen the older people’s existing networks or to create new ones which will be beneficial to their well-being (Biegel, 1985; Wenger, 1991; 1994; Andersson, 1998). In fact, little effort has been invested to understand the older persons who live alone in old urban areas. There is a need for more research in the future to study their needs, their problems and the types of network that they have, so that social worker practitioners can be well informed and culturally competent to help this disadvantaged group.

References

Chi, I., & Boey, K. W. (1994). A mental health and social support study of the old-old in Hong Kong. Hong Kong: The University of Hong Kong.


## AUTHOR QUERIES

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