Predictive Factors of Psychological Well-Being Among Older Adults with Noncommunicable Diseases: A Cross-Sectional Study

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Abstract: Psychological well-being is an influential factor for healthy aging, and noncommunicable diseases usually accompany aging. Therefore, understanding factors predicting psychological well-being is essential to designing interventions to promote good mental health among this population. This cross-sectional study examined the factors predicting psychological well-being among older adults with noncommunicable diseases. The participants included 110 older adults aged 60 years and older with noncommunicable diseases who were receiving services in the outpatient department of medicine of a university hospital in Bangkok. Thailand. Instruments for data collection were a Demographic Questionnaire, the Barthel Activities of Daily Living Index, the Self-Esteem Questionnaire, the Social Support Questionnaire, the Thai Geriatric Depression Scale (TGDS-15), and the Psychological Well-Being Questionnaire. The data was analyzed using multiple regression analysis, Spearman's rank correlation coefficients, and descriptive statistics.

The results showed that the participants had high scores on psychological well-being. Activities of daily living, self-esteem, social support, and depressive symptoms collectively predicted 61.2% of the variance in psychological well-being. Social support had the highest predictive power, followed by activities of daily living, depressive symptoms, and self-esteem, but the duration of the disease could not predict psychological well-being. The results of this study are beneficial for gerontological nurse practitioners and others to screen for factors affecting the psychological well-being of older adults with noncommunicable diseases. They can also use the findings to design and test the effectiveness of the intervention program's emphasis on increasing social support, activities of daily living and self-esteem, and decreasing depressive symptoms among older adults with noncommunicable diseases.

Keywords: Activities of daily living, Depressive symptoms, Older adults, Psychological well-being, Self-esteem, Social support

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Introduction

In 2022, there were 12.11 million people in Thailand aged 60 or older, accounting for 18.3% of the country's total population, marking an aging trend as birth rates decline. This shift suggests a full transition to an aged society within the next two decades.[1] Older adults face physiological decline and high rates of noncommunicable diseases (NCDs), such as diabetes and hypertension,[2] which often cause disabilities, affect physical appearance, and lead to stress, depression, and social isolation.[3] The COVID-19 pandemic exacerbated health challenges for older adults, impacting physical and psychological well-being (PWB) and underscoring the need to enhance psychological health for better quality of life.[4]

The prevalence of NCDs is steadily rising among older adults globally, significantly impacting mortality rates. In Thailand, NCDs, primarily cardiovascular disease, cancer, chronic obstructive pulmonary disease, and diabetes, largely stem from lifestyle factors, such as poor diet, smoking, and inactivity.[5] These days, 81% of Thai people die of NCDs, accounting for more than 400,000 deaths per year or over 1,000 deaths per day. In 2019, the estimated economic burden of NCDs in Thailand reached 1.6 trillion baht, accounting for 10% of the country's total economic value, which was spent on expenses related to NCDs[6] but also affects PWB, leading to dependence, depression, and cognitive decline.

Psychological well-being, a vital factor in healthy aging, predicts lower mortality risk and includes self-acceptance, autonomy, environmental mastery, positive relations with others, purpose in life, and personal growth.[7,8] Studies indicate moderate levels of PWB among Thai older adults with NCDs.[9] Previous studies have found that older adults with NCDs not only experience physical limitations but also face psychological impacts such as mood changes, anxiety, and fear of being a burden, which often intensify with the severity and number of diseases.[10]

In Thailand, the National Health Development Plan and the 20-Year National Strategy (2017-2036) aim to improve older adults' health, security, and self-sufficiency, including guidelines for psychological well-being care in older adults.[11] These guidelines focus on the development of screening, monitoring, and tracking high-risk groups who may have psychological health issues. The plan also includes providing psychological well-being services, supporting family social support systems,[11] and establishing the National Mental Health Strategy, which provides a psychological health hotline 1323. Community hospitals must offer social and psychological support services and counseling for all age groups while developing a district health network and improving the community's psychological health system.[12] Previous research has studied factors influencing the psychological well-being of older adults, including the development of learning programs to promote psychological well-being. These programs focus on stress relief and involve family participation in supporting the psychological well-being of older adults alongside physical health care.[13] Additionally, activities have been developed to promote the well-being of elderly groups, such as seniors' clubs, to identify activities that better address the psychological health needs of older adults.[14] This highlights the urgent need for addressing the PWB of older adults with NCDs, as it significantly affects their quality of life.

Prior studies reported that many factors such as duration of disease,[15] activities of daily living,[2] self-esteem,[16,17] social support,[18,19] and depressive symptoms[20-22] were associated with PWB but in separate studies and without theoretical foundations. Thus, the comprehensive design of the intervention and scientific explanation is limited. Thus, our study was grounded in the theoretical model of PWB proposed by Ryff and Keyes,[8] and those strong associated factors from the literature were included.

Literature Review and Conceptual Framework

Ryff and Keyes[8] defined PWB as an individual's satisfaction with their achievements throughout life, assessed by considering all life events and encompassing six key components: self-acceptance (having a positive outlook on oneself and being happy with one's past), positive relations with others (maintaining trustful and caring relationships), autonomy (independence in thought and action), environmental mastery (the ability to manage and create suitable environments), purpose in life (having direction and goals that are meaningful), and personal growth (continuous expansion of one's potential).[8] PWB is especially important for older adults, as it enables them to cope with illnesses, manage stress, and feel fulfilled. Those with high PWB can care for themselves, support their families, and actively participate in society, reducing the feeling of being a burden.

The social situation of older adults is increasingly impacted by the growing older population and the rise in NCDs, leading to prolonged illness, disabilities, greater dependency, and higher caregiving and healthcare costs. These health challenges affect both physical and PWB, contributing to sadness, despair, and depression. Maintaining good PWB is essential, as it helps older adults better adapt to physical decline and illness, benefiting themselves and society. Factors such as disease duration, activities of daily living, self-esteem, social support, and depressive symptoms play a key role in psychological health.[2,15-22]

Activities of daily living (ADLs) are everyday tasks, including bathing, dressing, eating, toileting, mobility, and household chores. These tasks are essential for self-care, and assessing an individual's ability to perform them is crucial, especially for older adults and those with NCDs.[23] In older adults, the ability to carry out ADLs often declines, which can significantly affect their PWB.[2] Struggles with basic tasks such as eating and bathing can lead to feelings of dependence, isolation, and distress, particularly for those without a support system.[24]

Self-esteem is the belief in one's value, encompassing cognitive and evaluative aspects. The cognitive self involves understanding one's identity based on family, society, and work roles, while the evaluative self is about comparing oneself to others or external standards to determine worth.[25] Erikson's theory of psychological development highlights the importance of integrity versus despair in older adults, where successfully navigating this stage leads to a sense of life's meaning and self-worth.[26] Studies have shown that self-esteem is strongly linked to psychological health and happiness in older adults, especially those with chronic diseases.[16] Self-esteem encourages self-care and adaptation, which can improve overall well-being. Studies have found that higher self-esteem leads to better psychological health, with factors such as self-reliance, positive family influences, and social respect enhancing self-esteem in older adults.[17]

Depressive symptoms in older adults are often misunderstood as part of aging. Still, they are influenced by physical changes, stress, anxiety, and social role shifts such as retirement and loss of loved ones.[27] Depression in this group is a significant public health concern, affecting functioning and increasing healthcare costs. Older adults with multiple chronic diseases, including diabetes, are at higher risk for depression, which worsens their ability to manage their health. Studies have shown that depression negatively impacts PWB.[20,21]

Social support is the assistance individuals receive that helps them feel cared for, respected, and valued, fostering a sense of belonging.[28] It includes emotional support, esteem support, social support, informational support, and tangible support.[29] Social support sources include family and peers, religious organizations, health professionals, and organized service groups. Research indicates that social support positively impacts the PWB of older adults, especially those with NCDs. Studies have shown that higher social

support correlates with better psychological health and life satisfaction.[18,19]

The disease duration refers to the period from the onset of NCDs in older adults diagnosed by a physician.[22] While older adults initially experience distress, they may adapt over time to maintain well-being. However, if they struggle to adjust or have poor self-care, the illness duration can negatively impact emotions. A longer disease duration can lead to fatigue, emotional distress, and uncertainty about the future, reducing motivation for self-care. A previous study in Germany, which conducted a longitudinal follow-up on the psychological well-being of individuals with noncommunicable diseases, found that the duration of the illness was negatively correlated with psychological well-being.[15]

In conclusion, the duration of disease, activities of daily living, self-esteem, social support, and depressive symptoms were associated with PWB or psychological health. However, the predictability of each factor in one model was not known. Knowing the power of predictability of each factor would be beneficial for focusing on critical factors that should be emphasized in the design of the intervention. Therefore, this study aimed to determine whether all these factors together could jointly predict PWB among older adults with noncommunicable diseases and which one is the strongest.

Methods

Study Design: This study used a descriptive, cross-sectional design. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) standards were used to guide this report.

Sample and Setting: The study population included older adults aged 60 and above with NCDs attending a university hospital's outpatient department of medicine in Bangkok, Thailand. Systematic random sampling was used to select participants meeting the following inclusion criteria: aged 60 or older, diagnosed by a physician with one or more of the specified NCDs (heart disease, hypertension, cancer, COPD, or diabetes) with a duration of at least six months, scoring three or higher on the Mini-Cog assessment tool, and able to communicate in Thai language both in speaking and writing. They were systematically selected based on hospital ID numbers ending in odd digits. Exclusion criteria included acute illness (e.g., severe hypoglycemia, myocardial infarction, respiratory distress) and diagnosed psychiatric disorders (e.g., bipolar disorder, schizophrenia).

Sample Size: Using the G*Power software, we performed power analysis to calculate the sample size. The statistical test chosen was linear multiple regression, with an effect size set at medium (Cohen's $f^2 = 0.15$), derived from a literature review on predictive factors of PWB among older adults with NCDs in rural areas.[2] The confidence level was set at $\alpha = 0.05$, and the power of the test was set at $1 - \beta = 0.80$. The study utilized five predictor variables. Based on these parameters, the initial sample size was 92 participants. An additional 20% was added to the sample size to account for potential data variability. Therefore, the final sample size for this study is 110 participants.

Ethical Considerations: The study received approval No. COA. MURA2023/513 from the Institutional Review Board on Research Involving Human Subjects of the Faculty of Medicine Ramathibodi Hospital, Mahidol University. After approval was granted, the primary investigator (PI) secured permission from the hospital director and coordinated with the head nurse of the outpatient department to identify eligible participants. After receiving approval, the PI collected data, ensuring that the information gathered from the interviews was kept confidential and reported as group data, with no information that could identify the study participants. Participant rights were protected throughout the study and those who wanted to decline or withdraw from the study at any time could do so without being affected their medical care.

Research Instruments: Seven instruments were used in this study, including the screening tool and six questionnaires for data collection. Permission to use all instruments was granted.

Screening Instrument

The Mini-Cog Assessment, developed by Borson et al. and translated into Thai by Trongsakul et al.,[30] was used for cognitive screening. This 3-minute test combines a three-item recall with a clock drawing test (CDT). The scoring is based on word recall (1 point per word) and the accuracy of the clock drawing (up to 2 points). Scores range from 0 to 5. A score of 3 or above was required for inclusion in the study.

Data Collection Instruments

A Demographic Questionnaire, developed by the PI, collected information from older adults on gender, age, education level, marital status, religious participation, occupation, sources of income, financial status, number of family members in the household, cohabitants, primary caregiver, chronic illnesses, duration of illness, blood sugar level, blood pressure, and membership in an older adult club.

The Barthel Activities of Daily Living Index (BAI), developed by Mahoney and Barthel, was used to measure the variable of activities of daily living. It was adapted to Thai by Jitapunkul et al.[23] It is composed of ten items: feeding, moving from a wheelchair to bed and return, transferring to and from a toilet, bathing, grooming, walking on a level surface, going up and down stairs, dressing, continence of bowels and bladder. The item responses are coded on the scales ranging from unable (scored 0) to independent (scored 1, 2, and 3), with two items (scored 0 and 1), six items (scored 0, 1, and 2); and two items (scored 0, 1, 2, and 3). For example, item 1, "Feeding," is rated as 0 = unable to feed self, 1 = needs partial assistance, and 2 = fully independent. The total score ranges from 0-20, with the higher score reflected more independently. The cut points are 0-4 = dependence, 5-11 = partially dependent, and 12-20 = independent. The reliability for this study was $\alpha = 0.86$.

The Self-Esteem Questionnaire, adapted from the Rosenberg Self-Esteem Scale by Kanchai,[31] consists of ten items. The responses are based on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). An example item is "On the whole, I am satisfied with myself." A higher score indicates higher self-esteem. The reliability for this study was $\alpha = 0.89$.

The Social Support Questionnaire was developed by Schaefer et al.[32] to measure perceived social support. It was translated and adapted to Thai older adults by Wichitsiri et al.[33] It consists of 15 items. The responses are based on a 4-point Likert scale ranging from 1 (definitely false) to 4 (definitely true). An example item is "Your children encourage you when you feel discouraged." A higher score indicates higher perceived social support. The reliability coefficient in this study was $\alpha = 0.94$.

The Thai Geriatric Depression Scale (TGDS-15) was developed by Wongpakaran et al.[34] It consists of 15 items: five positive statements where a response of No = 1 and Yes = 0, and ten negative statements where a response of Yes = 1 and No score = 0. An example item is, "Feel that most people are better off than me." The total score ranges from 0-15, with higher scores representing more depressive symptoms. The cut-off points are 0-5 = no depression, 6-10 = suggestive, and 11-15 = depression. The reliability for this study was KR-20 = 0.86.

The Psychological Well-being Questionnaire was developed by Ryff[8] and is used to assess the psychological well-being of older adults. It was translated into Thai by Wichitsiri et al.,[33] comprising 18 items. The responses are based on a 4-point Likert-like scale ranging from 1 (strongly disagree) to 4 (strongly agree). An example item is, "In many aspects of life, you still feel that you have not achieved success." The total score ranges from 18-72, with higher scores representing higher PWB. The cut-off points are 18-36 = low level of PWB, 37-54 = moderate level of PWB, and 55-72 = high level of PWB. The reliability for this study was $\alpha = 0.75$.

Data Collection: Data were collected from September 2023 to January 2024 after the IRB committee approval. A total of 110 eligible participants with NCD diagnoses of at least six months were systematically selected based on hospital ID numbers ending in odd digits. The PI personally invited screened participants to a private area, provided study information, and obtained their consent. Interviews were conducted using six assessment tools covering demographics, daily activities, self-esteem, social support, depression, and PWB. Each session lasted approximately 30 minutes, ensuring participant rights, confidentiality, and voluntary participation. The PI personally collected and verified data for completeness and accuracy before analysis.

Data Analysis: The data were analyzed using SPSS (version 29). The overall significance level was set at an alpha (α) of 0.05. Descriptive statistics were used to analyze the demographic data and selected factors related to PWB. Multiple regression with the Enter method was used to examine the factors predicting PWB among participants. The assumptions of multicollinearity and autocorrelation were tested, and they met acceptable criteria.

Results

As shown in **Table 1**, out of 110 participants, most were female (68.2%), aged between 60 and 86 years (Mean = 71.11, SD = 7.19). Most participants had an educational level of a bachelor's degree or higher, were married (59.1%), and were not employed, with the most common reason being retirement. The sample had the highest percentage of hypertension at 75.5%, followed by hyperlipidemia at 54.5%, diabetes at 40%, cerebrovascular disease at 20.9%, and others. The average duration of the disease was 10.68 years.

Table 1. Demographic characteristics of the sample (N = 110)

Demographic characteristics	N (%)
Gender	
Female	75 (68.2)
Male	35 (31.8)
Age (years)	
60-69	49 (44.5)
70-79	43 (39.1)
≥ 80	18 (16.4)
(Mean = 71.11, SD = 7.19, Min-Max = 60-86)	
Marital Status	
Married	65 (59.1)
Widowed	21 (19.1)
Single	18 (16.4)
Divorced	6 (5.5)
Duration of chronic illness to date (years)**	
0.5-1	5 (4.5)
2-5	29 (26.4)
6-10	28 (25.5)
11-15	27 (24.5)
16-20	14 (12.7)
> 20	7 (6.4)
(Mean = 10.68, SD = 6.87, Min-Max = 1-30)	

Demographic characteristics	N (%)
Type of disease/disorder*	
Hypertension	83 (75.5)
Dyslipidemia	60 (54.5)
Diabetes	44 (40.0)
Cerebrovascular disease	23 (20.9)
Kidney disease	20 (18.2)
Ischemic heart disease	17 (15.5)
Cancer	16 (14.5)
Skeletal and joint system	13 (11.8)
Respiratory and pulmonary disease	12 (10.9)
Thyroid disease	8 (7.3)
Gout	6 (5.5)
Liver disease	6 (5.5)
Benign prostatic hyperplasia	5 (4.5)
Immunology and rheumatology	6 (5.5)
Neurology disorder	3 (2.7)
Others	8 (7.3)
Current living arrangement	
Living with children	62 (56.4)
Living with spouse	57 (51.8)
Living with relatives	47 (42.7)
Living alone	7 (6.4)

Table 1. Demographic characteristics of the sample (N = 110) (Cont.)

Demographic characteristics	N (%)	Demographic characteristics	N (%)
Employment status			
Not working	80 (72.7)	Currently working	30 (27.3)
Retired	50 (45.5)	Trading/Private businesses	16 (14.5)
Health issues	19 (17.3)	Housekeeper	5 (4.5)
Children/Grandchildren do not allow working	7 (6.4)	Farmer	5 (4.5)
		Employed	3 (2.7)
Unemployed	4 (3.6)	Actress	1 (0.9)

Note. *A single participant may respond with more than one answer.
** Duration of disease refers to the first diagnosed disease until now.

The PWB of older adults with NCDs was high, with a mean score of 67.73 (SD = 5.97). Analysis of specific dimensions revealed that all aspects of psychological well-being among the sample group were rated high. Similarly, the participants demonstrated high levels of self-esteem, with a mean score of 48.65 (SD = 4.66). Social support among these individuals ranged from 15 to 60 points, with a mean score of 57.80 (SD = 6.89), indicating strong social support. Furthermore, most participants were independent and did not exhibit symptoms of depression. **Table 2** shows detailed information. The study showed that 99.1% of participants were independent. Additionally, 95.5% showed no signs of depression, 2.7% had mild symptoms, and 1.8% were depressed. The detailed information is in **Table 3.**

Table 2. Range, mean and standard deviation of activities of daily living, self-esteem, social support, depressive symptoms, and psychological well-being (N = 110)

Variable	Possible Score	Actual Score	Mean ± SD	Interpretation
Activities of daily living	0-20	8-20	19.76 ± 1.25	independent
Self-esteem	10-50	19-50	48.65 ± 4.66	High
Social support	15-60	15-60	57.80 ± 6.89	High
Emotional support	3-12	3-12	11.48 ± 1.96	High
Esteem support	3-12	3-12	11.72 ± 1.48	High
Socially Support	3-12	3-12	11.10 ± 2.44	High
Information support	3-12	3-12	11.75 ± 1.25	High
Tangible support	3-12	3-12	11.75 ± 1.47	High
Depressive symptoms	0-15	0-14	1.41 ± 2.26	Low
Psychological well-being	18-72	27-72	67.73 ± 5.97	High
Self-acceptance	3-12	3-12	11.61 ± 1.38	High
Positive relations with others	3-12	6-12	11.45 ± 1.40	High
Autonomy	3-12	3-12	11.11 ± 2.60	High
Environmental mastery	3-12	5-12	11.33 ± 1.57	High
Purpose in life	3-12	6-12	10.33 ± 1.79	High
Personal growth	3-12	3-12	11.72 ± 1.42	High

Table 3. Level of dependency and depression of the sample (N = 110)

Level	N (%)
Dependency	
Independent (12-20 points)	109 (99.1)
Partially dependent (5-11 points)	1 (0.9)
Depressive symptoms	
No depression (0-5 points)	105 (95.5)
Indicating depression (6-10 points)	3 (2.7)
Depressed (11-15 points)	2 (1.8)

Table 4 shows a correlation matrix between the study variables. Four variables (activities of daily living, self-esteem, social support, and depressive symptoms) were significantly associated with PWB. The duration of disease was not significantly related to PWB.

Table 4. Spearman's rank correlation coefficients between studied variables (N = 110)

Variables	1	2	3	4	5	6
1. Duration of disease	1					
2. Activities of daily living	-0.190*	1				
3. Self-esteem	-0.021	0.300**	1			
4. Social support	-0.013	0.146	0.234*	1		
5. Depressive symptom	0.129	-0.377**	-0.275**	-0.119	1	
6. Psychological well-being	0.187	0.246*	0.328**	0.209*	-0.219*	1

Note. * $p < 0.05$, ** $p < 0.01$

The multiple regression analysis used the Enter method, which considered disease duration, daily living activities, self-esteem, social support, and depressive symptoms as predictors of PWB. The results indicated that four variables, including activities of daily living, self-esteem, social support, and depressive symptoms, collectively predicted 61.2% of the PWB among older adults with NCDs ($R^2 = .612$, $F = 32.854$, $p < 0.001$). Among these, social support had the most potent predictive power (Beta = .309, $p < 0.001$), followed by activities of daily living (Beta = 0.280, $p < 0.001$), depressive symptoms (Beta = -0.265, $p = 0.010$), and self-esteem (Beta = 0.185, $p = 0.044$). The analysis showed that the duration of the disease alone could not predict the PWB among older adults with NCDs, as indicated in **Table 5.**

Table 5. Multiple regression analysis with the Enter method of factors predicting psychological well-being (N = 110)

Variables	b	SE_b	Beta	t	R^2	R^2 change	p-value
Duration of disease	0.001	0.053	0.002	0.026	0.001	0.001	0.979
Activities of daily living	1.338	0.309	0.280	4.332	0.213	0.212	< 0.001
Self-esteem	0.236	0.116	0.185	2.040	0.469	0.256	0.044
Social support	0.267	0.068	0.309	3.905	0.587	0.118	< 0.001
Depressive symptoms	-0.699	0.267	-0.265	-2.617	0.612	0.026	0.010
constant	15.289	9.060		1.687			0.095
	$R = 0.783$; $R^2 = 0.612$; $R_a^2 = 0.594$; $SE_b = 3.804$; Overall $F = 32.854$; $p < 0.001$						

Note. b = unstandardized coefficient, SE_b = standard error for the unstandardized coefficient, t = t-test statistic, R^2 = proportion of variance in the dependent variable explained by the independent variable

Discussion

This study found that the activities of daily living, self-esteem, social support, and depressive symptoms were associated and could jointly explain 61.2% of the PWB variance among older adults with NCD. Social support was the highest positive predictor. A possible reason for this is that most participants in this study had sufficient income and savings, along with primary caregivers who assisted them with transportation to hospital appointments or emergencies. This represents tangible support in terms of goods and services. In addition, older adults received emotional support from their families, who encouraged them to adapt to living with NCDs. They also received adequate information about healthcare and self-care behaviors from healthcare professionals. As a result, social support scores were high. These findings are consistent with previous studies that have indicated that social support can predict PWB.[18] Although older adults with NCDs may experience anxiety and loss of self-confidence, receiving adequate social support from family, community, and health services affects both their physical and psychological health. This support also helps them adapt more effectively.[35] Therefore, the high PWB scores of the participants in this study were probably due to the high level of social support they received.

The activities of daily living (ADLs) positively correlate with the predictive ability for PWB. The older adults were independent at a rate of 99.1%. Although these older adults had multiple NCDs, most of them had conditions that did not significantly limit their ADLs. In addition to performing ADLs independently, they were able to manage medication, exercise, engage in hobbies, and some even continued to work. These findings align with previous studies, which indicated that older adults who can perform ADLs without relying on others feel empowered, are not a burden to their families, and remain integrated into society.[3] Furthermore, studies among older adults in China have shown that those with ADL limitations are more likely to experience negative emotions due to their inability to fulfill social roles.[36] Therefore, ADLs directly impact PWB.

Depressive symptoms are negatively correlated with, and could statistically predict, PWB in older adults. This study found that most older adults did not exhibit depressive symptoms despite having NCDs. This can be explained by the fact that the sample remained independent, had sufficient income for daily living, and had caregivers, which helped reduce stress, anxiety, and worry, contributing to good psychological well-being. These findings align with a study in Sweden, which found that depressive symptoms could predict PWB in older adults with heart failure.[22] Furthermore, it was found that individuals with higher PWB had a lower risk of developing depressive symptoms compared to those with lower PWB.[37]

Self-esteem is positively correlated with and can statistically predict PWB in older adults. The participants in this study reported high self-esteem, which may stem from satisfaction with their past lives, receiving respect from family members, and being able to care for themselves and assist others. These findings align with previous research, which indicates that older adults with high self-esteem tend to have a positive attitude toward themselves, accept their lives, feel that they are a source of support for their children, and recognize their dignity, all of which contribute to their PWB.[38] Consistent with prior research indicating that self-esteem is associated with the psychological well-being of older adults in Taiwan, engaging in volunteer activities five days a week fosters a sense of belonging within the community.[39,40]

The duration of the disease was not correlated with, nor could it predict, PWB. This contradicts a previous study conducted in Germany,[15] which found a negative correlation between disease duration and PWB. This discrepancy may be because the older adults in this study had strong social support and access to healthcare services, which facilitated their adaptation to illness.

Limitations

The study was conducted at only one university hospital, which may limit the generalizability of the findings to other populations. The results were based on self-reported answers from participants, which could be influenced by social desirability bias. During the data collection process through interviews with older adults, it was observed that answering many questions caused participants to lose focus in the latter half of the interview, potentially affecting the precision of their responses.

Conclusions and Implications for Nursing Practice and Future Research

This study demonstrates the factors influencing the PWB of older adults with NCDs based on a theoretical model of PWB developed by Ryff and Keyes, along with a literature review. It identifies the factors affecting PWB at the individual level. This highlights the importance of providing holistic nursing care that addresses the individual's physical, psychological, and social aspects. Nurses caring for older adults with NCDs should assess their PWB, social support, activities of daily living, depressive symptoms, and self-esteem to identify risks and plan interventions to promote PWB. It is essential to promote the full potential of daily activities for older adults, screen for depression in older adults, and listen to their needs to provide comprehensive healthcare support.

Social support was found to be the most influential factor, so nurses should organize training sessions to provide self-care guidance and encourage families to support older adults in maintaining good PWB. Future research should focus on comparing PWB among older adults from urban and rural areas and those who are partially or wholly dependent to understand their needs better. Additionally, the results of this study are beneficial for gerontological nurse practitioners to screen for factors affecting the psychological well-being of older adults with noncommunicable diseases. They can also use the findings to design and test the effectiveness of the intervention program with an emphasis on increasing social support, activities of daily living and self-esteem and decreasing depressive symptoms among older adults with noncommunicable diseases.

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ปัจจัยทำนายสุขภาวะด้านจิตใจของผู้สูงอายุที่เป็นโรคไม่ติดต่อเรื้อรัง : การศึกษาแบบตัดขวาง

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บทคัดย่อ: สุขภาวะด้านจิตใจเป็นปัจจัยที่สำคัญต่อการสูงวัยอย่างมีสุขภาพดี และโรคไม่ติดต่อเรื้อรังมักพบในวัยสูงอายุ ดังนั้น การเข้าใจปัจจัยทำนายสุขภาวะด้านจิตใจ เป็นสิ่งจำเป็นเพื่อส่งเสริมสุขภาวะทางใจของผู้สูงอายุในกลุ่มนี้ การศึกษาแบบตัดขวางนี้มีวัตถุประสงค์เพื่อศึกษาปัจจัยที่ทำนายภาวะสุขภาวะด้านจิตใจของผู้สูงอายุโรคไม่ติดต่อเรื้อรัง ผู้วิจัยใช้การสุ่มอย่างเป็นระบบในการคัดเลือกผู้สูงอายุจำนวน 110 คนที่มีอายุ 60 ปีขึ้นไปและเป็นโรคไม่ติดต่อเรื้อรังที่ได้รับบริการที่หน่วยตรวจผู้ป่วยนอกอายุรกรรม โรงพยาบาลมหาวิทยาลัยแห่งหนึ่งในกรุงเทพมหานคร เก็บข้อมูลโดยใช้แบบสอบถาม ได้แก่ แบบสัมภาษณ์ข้อมูลทั่วไป แบบประเมินดัชนีบาร์เธลเอดีแอล แบบสัมภาษณ์ความรู้สึกมีคุณค่าในตนเองของผู้สูงอายุ แบบสัมภาษณ์การสนับสนุนทางสังคม แบบประเมินภาวะซึมเศร้าในผู้สูงอายุ และแบบสัมภาษณ์สุขภาวะด้านจิตใจ วิเคราะห์โดยใช้สถิติบรรยาย วิเคราะห์ความสัมพันธ์โดยหาค่าสัมประสิทธิ์สหสัมพันธ์ของสเปียร์แมน และวิเคราะห์อำนาจการทำนายด้วยการวิเคราะห์ถดถอยพหุคูณ

ผลการศึกษาพบว่ากลุ่มตัวอย่างมีคะแนนสุขภาวะด้านจิตใจอยู่ในระดับสูง ปัจจัยความสามารถในการปฏิบัติกิจวัตรประจำวัน ความรู้สึกมีคุณค่าในตนเอง แรงสนับสนุนทางสังคมและภาวะซึมเศร้าสามารถร่วมกันทำนายสุขภาวะด้านจิตใจของผู้สูงอายุโรคไม่ติดต่อเรื้อรังได้ร้อยละ 61.2 แรงสนับสนุนทางสังคมมีอำนาจในการทำนายสูงสุด รองลงมาคือความสามารถในการปฏิบัติกิจวัตรประจำวัน ภาวะซึมเศร้า และความรู้สึกมีคุณค่าในตนเองตามลำดับ และพบว่าระยะเวลาการเป็นโรค ไม่สามารถทำนายสุขภาวะด้านจิตใจของผู้สูงอายุโรคไม่ติดต่อเรื้อรังได้ ผลของการศึกษาครั้งนี้จะเป็นประโยชน์ต่อพยาบาลเวชปฏิบัติผู้สูงอายุเพื่อใช้ในการประเมินปัจจัยที่มีอิทธิพลต่อสุขภาวะด้านจิตใจของผู้สูงอายุโรคไม่ติดต่อเรื้อรัง และนำผลการวิจัยใช้ออกแบบและทดสอบประสิทธิภาพของโปรแกรมสนับสนุนทางสังคม การส่งเสริมการปฏิบัติกิจวัตรประจำวัน และความรู้สึกมีคุณค่าในตนเอง รวมถึงลดภาวะซึมเศร้าในผู้สูงอายุที่มีโรคไม่ติดต่อเรื้อรัง

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คำสำคัญ : ความสามารถในการปฏิบัติกิจวัตรประจำวัน ภาวะซึมเศร้า ผู้สูงอายุ สุขภาวะด้านจิตใจ ความรู้สึกมีคุณค่าในตนเอง แรงสนับสนุนทางสังคม

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