THEORETICAL AND METHODOLOGICAL INTERPRETATION OF THE CONCEPT OF MENTAL HEALTH IN OLD AGE

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Abstract. The article examines how the notion of mental health has been conceptualised within gerontology and the psychology of ageing from the middle of the twentieth century to the present. Three interpretive traditions are distinguished: the deficit-oriented (clinical) tradition, which equates late-life mental health with the absence of psychopathology; the eudaimonic tradition, which defines it through positive functioning; and the adaptive-resource tradition, which treats it as a dynamic balance between declining reserves and the regulatory strategies a person employs. Drawing on the works of Jahoda (1958), Erikson (1950, 1982), Antonovsky (1979), Baltes and Baltes (1990), Ryff (1989), Rowe and Kahn (1997), Keyes (2002) and Huber et al. (2011), the study argues that no single model is sufficient for old age and proposes an integrative, multi-level methodological framework in which biological, psychological and socio-cultural indicators are interpreted jointly rather than additively.

Keywords: mental health, old age, gerontopsychology, successful ageing, selective optimisation with compensation, salutogenesis, psychological well-being, methodology.

KEKSALIK DAVRIDA RUHIY SALOMATLIK TUSHUNCHASINING NAZARIY VA METODOLOGIK TALQINI

Annotatsiya. Maqolada XX asr o‘rtalaridan hozirgi davrgacha gerontologiya va qarish psixologiyasi doirasida ruhiy salomatlik tushunchasining shakllanishi va konseptual talqini o‘rganiladi. Unda uchta asosiy talqin an’anasi ajratib ko‘rsatiladi: keksalik davridagi ruhiy salomatlikni psixopatologik buzilishlarning mavjud emasligi bilan izohlaydigan defitsitga yo‘naltirilgan (klinik) yondashuv; uni ijobiy psixologik faoliyat va farovonlik orqali tavsiflaydigan evdemonik yondashuv; shuningdek, uni insonning kamayib borayotgan hayotiy resurslari va qo‘llaydigan tartibga solish strategiyalari o‘rtasidagi dinamik muvozanat sifatida talqin qiladigan adaptiv-resursli yondashuv. Jahoda (1958), Erikson (1950, 1982), Antonovskiy (1979), Baltes va Baltes (1990), Ryff (1989), Rowe va Kahn (1997), Keyes (2002) hamda Huber va boshqalarning (2011) ilmiy ishlariga tayangan holda, tadqiqotda keksalik davrida birorta alohida modelning o‘zi yetarli emasligi asoslanadi. Shu munosabat bilan biologik, psixologik va ijtimoiy-madaniy ko‘rsatkichlarni alohida-alohida qo‘shish orqali emas, balki o‘zaro yaxlit bog‘liqlikda talqin qilishga asoslangan integrativ, ko‘p darajali metodologik yondashuv taklif etiladi.

Kalit so'zlar: ruhiy salomatlik, keksalik davri, gerontopsixologiya, muvaffaqiyatli qarish, kompensatsiya orqali tanlab optimallashtirish, salutogenez, psixologik farovonlik, metodologiya.

ТЕОРЕТИКО-МЕТОДОЛОГИЧЕСКАЯ ИНТЕРПРЕТАЦИЯ ПОНЯТИЯ ПСИХИЧЕСКОГО ЗДОРОВЬЯ В ПОЖИЛОМ ВОЗРАСТЕ

Аннотация. В статье рассматривается процесс концептуального осмысления понятия психического здоровья в геронтологии и психологии старения с середины XX века до настоящего времени. Выделяются три основные интерпретационные традиции: дефицитарно-ориентированная (клиническая), отождествляющая психическое здоровье в пожилом возрасте с отсутствием психопатологических расстройств; эвдемоническая, определяющая его через позитивное психологическое функционирование; и адаптивно-ресурсная, рассматривающая его как динамическое равновесие между сокращающимися жизненными ресурсами и регуляторными стратегиями, используемыми человеком. Опираясь на научные труды Jahoda (1958), Erikson (1950, 1982), Antonovsky (1979), Baltes и Baltes (1990), Ryff (1989), Rowe и Kahn (1997), Keyes (2002), а также Huber и соавторов (2011), автор обосновывает, что ни одна отдельная модель не является достаточной для объяснения психического здоровья в пожилом возрасте. В связи с этим предлагается интегративная многоуровневая методологическая концепция, в рамках которой биологические, психологические и социокультурные показатели рассматриваются во взаимосвязи и целостном единстве, а не как простая совокупность отдельных компонентов.

Ключевые слова: психическое здоровье, пожилой возраст,

геронтопсихология, успешное старение, селективная оптимизация с компенсацией, салютогенез, психологическое благополучие, методология.

Introduction. Demographic ageing has turned late-life mental health from a marginal clinical topic into one of the central problems of contemporary social science. The proportion of persons aged sixty and over is expected to double between 2015 and 2050, and the absolute number of older adults living with a mental or neurological disorder is rising even faster than the population itself. Yet the growth of empirical research has not been matched by conceptual clarity: studies published under the common heading of "mental health in old age" frequently measure incompatible phenomena - depressive symptomatology in one case, life satisfaction in another, cognitive reserve in a third - and then compare their results as though a single construct had been assessed.

The source of this confusion is methodological rather than empirical. Behind every operational definition stands a theoretical assumption about what constitutes health in the final phase of the life course, and these assumptions differ sharply. If old age is understood primarily as a period of loss, mental health will inevitably be defined negatively, as the successful avoidance of decline. If it is understood as a distinct developmental stage with its own tasks, the same term acquires a positive and qualitatively different meaning. The interpretation of the concept therefore precedes and shapes its measurement, and any attempt to synthesise findings across studies must begin by reconstructing the theoretical frameworks that generated them.

The aim of the present article is to provide such a reconstruction. Three tasks are pursued: first, to trace the historical genesis of the mental-health construct and its extension to later life; second, to compare the principal gerontological models along their ontological and methodological commitments; third, to formulate an integrative framework capable of accommodating the specific features of ageing - heterogeneity of trajectories, the paradoxical coexistence of physical decline with emotional stability, and the cultural embeddedness of what counts as a good old age.

1. The Historical Genesis of the Mental-Health Construct

The modern career of the term begins with the Constitution of the World Health Organization (1948), which defined health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Although the formula has been criticised for setting an unattainable standard, its significance for gerontology lies in the explicit separation of health from pathology: for the first time an older person suffering from chronic somatic illness could, in principle, be described as mentally healthy.

The first systematic psychological elaboration was offered by Marie Jahoda (1958), who identified six criteria of positive mental health - self-acceptance, growth, integration of personality, autonomy, accurate perception of reality and environmental mastery. Jahoda's scheme was age-neutral by design, and its later application to old age exposed a difficulty that has never been fully resolved: several of her criteria, particularly environmental mastery and growth, presuppose expanding rather than contracting opportunity structures.

Erik Erikson (1950), in his epigenetic account of the eight ages of man, supplied the missing developmental dimension. The final crisis of ego integrity versus despair reframed late-life mental health as the achievement of a specific psychosocial task - the acceptance of one's life as necessary and meaningful - rather than as the retention of youthful capacities. In the revised formulation prepared with Joan Erikson (1982, 1997), wisdom appears as the corresponding virtue, and the accent shifts further towards the reconciliation of finitude.

A parallel line of thought developed within medical sociology. Aaron Antonovsky (1979, 1987) proposed the salutogenic model and its central construct, the sense of coherence, arguing that health should be studied along a continuum and explained by generalised resistance resources rather than by risk factors alone. Because such resources accumulate biographically, the model is intrinsically favourable to the study of ageing, and empirical work has repeatedly shown the sense of coherence to be a stronger predictor of late-life emotional well-being than objective health status.

The specifically gerontological turn came with Robert Havighurst's early formulation of successful ageing (1961) and, three decades later, with the influential programme of John Rowe and Robert Kahn (1987, 1997), who distinguished usual from successful ageing and defined the latter through three components: low probability of disease and disability, high cognitive and physical functioning, and active engagement with life. The model gave gerontology an operational vocabulary, but it also drew sustained criticism for excluding, by definition, the frail and the disabled - that is, precisely the population whose mental health is most at risk.

2. Principal Theoretical Models of Mental Health in Later Life

The most productive alternative to the successful-ageing paradigm was formulated by Paul and Margret Baltes (1990) in the model of selective optimisation with compensation. Here mental health is not a level of functioning but a process of adaptive self-regulation: as biological reserves contract, the individual narrows the range of pursued goals (selection), invests remaining resources more intensively in those retained (optimisation) and substitutes new means for lost ones (compensation). The related theory of socio-emotional selectivity advanced by Laura Carstensen (1992, 1999) explains why emotional experience often improves with age: the perception of a limited time horizon reorients motivation from information acquisition towards affect regulation, producing what has been termed the paradox of well-being.

Within positive psychology, Carol Ryff (1989, 1995) operationalised eudaimonic functioning through six dimensions - autonomy, environmental mastery, personal growth, positive relations, purpose in life and self-acceptance - and demonstrated that their age gradients diverge: environmental mastery and autonomy tend to rise into middle and later adulthood, whereas purpose in life and personal growth decline. This finding is methodologically decisive, because it shows that a composite index of well-being can remain stable while its internal structure is transformed. Corey Keyes

(2002, 2005) extended the argument with the dual-continuum model, in which mental health and mental illness constitute two correlated but distinct axes, and introduced the categories of flourishing and languishing.

Two further contributions complete the picture. George Vaillant (2002), reporting the Harvard longitudinal studies, established that mature defence mechanisms and the quality of relationships at midlife predict late-life adaptation more strongly than income or ancestral longevity. Colin Depp and Dilip Jeste (2006), in a systematic review of twenty-eight studies, found twenty-nine distinct operational definitions of successful ageing, with disability-free status appearing in the great majority and subjective criteria in fewer than a third - empirical confirmation that the field's conceptual pluralism is not merely theoretical.

Table 1.

Comparative characteristics of the principal theoretical interpretations of mental health in old age

Model / author (year)	Ontological status of health	Core criteria	Dominant method	Principal limitation in old age
WHO definition (1948)	Complete well-being; normative ideal	Physical, mental, social well-being	Declarative; policy indicators	Unattainable standard; excludes chronic illness
Positive mental health, Jahoda (1958)	Set of personality attributes	Autonomy, growth, integration, mastery	Trait-based assessment	Assumes expanding opportunity structures
Ego integrity, Erikson (1950, 1982)	Outcome of a developmental crisis	Integrity vs. despair; wisdom	Biographical, qualitative	Low operationalisability; weak falsifiability
Salutogenesis, Antonovsky (1979, 1987)	Position on a health continuum	Sense of coherence; resistance resources	SOC-29 / SOC-13 scales	Under-specifies cognitive decline
Successful ageing, Rowe & Kahn (1987, 1997)	Achieved functional state	Absence of disease, high function, engagement	Objective functional indicators	Excludes the frail and disabled by definition
SOC model, Baltes & Baltes (1990)	Process of adaptive regulation	Selection, optimisation, compensation	Longitudinal, process-oriented	Difficult to measure cross-sectionally
Psychological well-being, Ryff (1989, 1995)	Multidimensional eudaimonic functioning	Six dimensions of positive functioning	PWB scales (18/54/84 items)	Dimensions diverge in age gradient
Dual continuum, Keyes (2002, 2005)	Two independent axes	Flourishing / languishing; symptom load	MHC-SF; two-factor models	Cultural bias of flourishing thresholds

3. Methodological Problems and an Integrative Framework

The comparison summarised in Table 1 reveals three recurrent methodological tensions. The first concerns the choice between objective and subjective criteria. Functional indicators are reliable and comparable across populations but systematically misclassify older adults who report high satisfaction despite substantial impairment; self-report measures capture this discrepancy yet are vulnerable to adaptation effects, response shift and the downward revision of internal standards. Neither class of indicator can validate the other, and their joint use requires an explicit rule for interpreting divergence rather than a mechanical averaging of scores.

The second tension is that between normative and idiographic reference points. Cross-sectional norms compare an individual with age peers and thereby import whatever level of morbidity happens to prevail in the cohort; intra-individual comparison, by contrast, treats deviation from a personal baseline as the unit of analysis and is far better suited to a population whose heterogeneity increases with age. The methodological consequence is a clear priority for longitudinal and, where feasible, measurement-burst designs over single-occasion surveys.

The third tension is cultural. The dimensions of autonomy, personal growth and active engagement that dominate Western instruments presuppose an individualistic model of the person; in collectivist and family-centred settings, interdependence, the fulfilment of intergenerational obligations and religious integration may constitute the substance rather than the context of late-life mental health. Instruments transferred without conceptual adaptation therefore risk measuring cultural distance rather than health, and the establishment of construct equivalence must precede any cross-national comparison.

On this basis an integrative framework may be proposed in which late-life mental health is defined as the dynamic correspondence between a person's regulatory resources and the demands of the ageing process, assessed simultaneously on four levels: the neurobiological (cognitive reserve, sensory and somatic status), the psychological (affect regulation, defence maturity, sense of coherence), the biographical (integrity, narrative continuity, meaning) and the socio-cultural (network density, role availability, culturally sanctioned models of old age). The levels are not interchangeable indicators of one latent variable but distinct explanatory strata, and the analytic task is to specify their interaction - how, for instance, a strong sense of coherence compensates for a shrinking social network - rather than to collapse them into a single index.

Conclusion. The historical trajectory of the concept moves from the negative and clinical towards the positive, processual and contextual. The WHO definition of 1948 opened the conceptual space; Jahoda and Erikson populated it with psychological content; Antonovsky reoriented enquiry from risk to resource; Rowe and Kahn gave it operational form at the cost of excluding the most vulnerable; Baltes and Baltes replaced states with regulatory processes; Ryff and Keyes demonstrated its multidimensionality and the relative independence of health from illness. Each step corrected a defect of its predecessor while introducing a new one, and the accumulated result is not a settled definition but a repertoire of complementary interpretations.

The practical implication for research design is that the theoretical model must be declared before instruments are

selected, and that findings should be reported as model-relative rather than as statements about mental health in general. For gerontological practice the implication is comparable: intervention aimed at restoring lost function rests on a different anthropology from intervention aimed at supporting adaptive reorganisation, and in advanced old age the second is frequently the only realistic objective. Further work is required above all on the cultural validation of instruments in non-Western and family-centred societies, where the empirical base remains thin and the conceptual base largely borrowed.

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