

**MENTAL HEALTH PROBLEMS OF THE ELDERLY:  
A STUDY OF THE URBAN AND RURAL CENTRAL  
PUNJAB (PAKISTAN)**



**By**

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## ABSTRACT

This study examined the frequency of mental health problems in a sample of 624 community dwelling individuals in the age group of 60 and above residing in Central Punjab, Pakistan. The aim of current study was three fold, to estimate the prevalence of mental health problems gender and community wise, to determine the risk factors associated with mental health problems and to analyze the coping mechanism of elderly people when they encounter problematic situation. Moreover, it also focused on the family attitude towards elderly. An interview schedule was developed to collect the primary data. In addition, SRQ-20 and GDS-15 were also used to determine the prevalence rate of mental health problems. Multistage sampling technique was applied. Results indicated a pervasive prevalence of mental health problems among elderly in Central Punjab. The gender wise percentage of mental health problems indicated variance i.e. mental health problems were more prevalent among female elderly as compared to their male counterparts. While a slight difference of prevalence of mental health problems between rural and urban community was also observed. Logistic regression analysis reported that financial support to family, educational status of family, undesirable events of life, undermining the sense of control, elderly abuse, feelings of discomfort at home, family behavior, age and sex of elderly were significantly linked with mental health problems of Pakistani elderly population. These significantly associated variables were found as the major risk factors of mental health problems. The results also indicated that the respondents who were economically dependent and did not have

any source to support their families were two times more likely to report a mental health problem than those who have finances to support their families. It means that the financial dependency predominated other variables. Moreover, in case of problematic situation, elderly manifested three types of coping i.e. internalized negative assessment, inclination to withdraw and autonomic. Majority of elders were involved in emotional coping (internalized negative assessment, inclination to withdraw) rather than problem solving coping (autonomic). This study suggested estimates of elderly mental health problems in Pakistan are on the rise. It also highlighted the major risk factors and coping mechanism among elderly that pointed out the necessity of planning, legislating and establishing services network to meet elder persons' mental health needs.

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# Chapter 1

## Mental Health

### 1.1 Introduction

The concept of mental health encompasses the physical, emotional and social facet of life. It focuses on the feeling of one person about himself/herself, what's the others feel about himself, and how an individual deal with to assemble the demands of life.

It is very important to define mental health in order to understand its concept. In the beginning the concept of mental health was firmly attached with physical health but with the passage of time when the researchers and mental health practitioners started to view the concept of mental health in sociological and cultural context. This has broadened its spectrum, as follows.

"A state of complete physical, mental, and social well being and not merely the absence of disease or infirmity" (WHO, 2001b, p.1).

"The dictionary meaning of mental health is the absence of mental illness, referring to an individual's personal and social well being, meaning both inner experiences and outer behaviour" (Thomas, M. and Pierson, J. , 1999).

"According to Corsini (1999) mental health is defined as a state of mind characterized by emotional wellbeing, relative freedom from anxiety and disabling systems and a capacity to establish constructive relationships and cope with the ordinary demands and stress of life"

"A state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and fruitfully, and is able to make a contribution to his or her community" (WHO, 2001d, p.1).

In this sense, mental health encompasses the wellbeing, affective functioning for the individuals of community. Physical, mental and social functioning is mutually dependent and neither physical nor mental exist separately. They are equally exclusive and we cannot define health in a restricted way as the nonexistence of disease (Sartorius, 1990). Mental health is a recognizable balance between a people's self, others, and his/her environment, especially in the preview of existing culture.

In mental health a sense of well being is considered to be key value according to the World Health organization which is described it as; "The capacity of the individuals to form harmonious relationships with others and to participate in, or contribute constructively to, changes in his social or physical environment" (World Health Organization, 1951, p. 4).

This idea of wellbeing has been built overtime and passes through various attempts in order to portray mental health positively by psychoanalysts and social psychologist (Kubie, 1954; Jahoda, 1958). The latter reviewers describe the term mental health being 'vague and ambiguous'. Existential Psychologists such as Maslow (1968) presented the ideas of 'Self actualization', acceding to which every person fulfilling their human potentials. According to the Mental Health Promotion by WHO, (2005) a system of norms prevailing in a society also focused in order to explain the conception of mental health as one thing that is conforms in one society

may not be conforms in next society. One intermittent difficulty to define positive mental health is that it is difficult to draw a line of demarcation amid normal and abnormal statements. It is only the prevailing set of norms and values that undermine in such attempts. Thus the definition of psychological normality varies over time in the same society and varies from one society to another society. For instance is the homosexuality a mental health problem? Is the hallucinated indicative of a spiritual one or mental illness? In order to solve these problems we have to draw a dividing line between health and mental abnormality.

## **1.2 Quality of Life- Positive Mental Health**

The notion of quality of life and social well being was used by the psychologists and philosophers in 1960s, 1970s, prior to mental health practitioners (Katschnig, 1997). The traditional practitioners were used to apply birth and death rate, life expectancy, and survival period as accepted indices of health but with the passage of time the need to use social and economic well being as accepted indices become inevitable.

In order to describe the issues relevant to the quality of life, such as housing, income, liberty and social support have been eliminated. After the attempts of WHO, it presented the definition of quality of life that may covered the territory of social indicators, happiness and health status, that is as follows;

“An individual’s perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns” (WHOQOL Group, 1995).

“The positive mental health refers to the individual having a positive sense of well-being, resources such as self-esteem, optimism, sense of mastery and coherence, satisfying personal relationships and resilience or the ability to cope with adversities. These qualities enhance the person’s capacity to make a meaningful contribution to their family, community and society” (Lavikainen, Lahtinen & Lehtinen, 2000).

The quality of life for older adults is greatly influenced by their previous life style, culture, education, health care beliefs, education, family strengths and integration into the community. Quality of life for older adults is greatly enhanced by their involvement in planning, sponsoring, and evaluating programs and services in institutional, outpatient, and community settings.

According to the Karen, (1988) the guidelines for quality of life of elderly includes;

- Environment
- Activities
- Privacy
- Choice and informed decision making
- Interactions
- Personal social and spiritual life
- Security

### **1.3 What Constitute Mental Health**

It is difficult to define mental health. The concept is used in different fields and every field of study explains it in its own context. However, most of the psychologists, social workers, carers and medical practitioner attempt to define it around three elements. (Tilbury, D 2002 pp 1-3 and p10)

- i. The idea of mature self- the people who are satisfied, enjoying their lives, having positive self image, and have awareness of their limitations may be categorized within the group of mentally healthy individuals. Their self-identity will be attached with the prevailing systems of values which forms the basis for their integrity and their internalized standard for behavior. They will have productive thinking, capacity to learn and develop and have ability to cope with the changing circumstances of life.
- ii. Self management in social relations- the intimacy of relationship is very essential in the self management and social relationships. The number and nature of such relationships may not be specified, but the implication is that the close relations with ones parents, ones children and at least one friend are very important. The ability to make and sustain intimate relationships is the notion of the ability to retain one's autonomy: the one flesh, separate persons' concept of Skeyner (1976). In spite of this intimacy, the partner is not essential for survival. This idea of autonomy is linked with the self-control in any condition. A mentally healthy person does not depend on the others wholly solely, but they can resist emotional

demands, pressures and manipulate the situation. They may post-pone their anger and tolerate frustration as necessary. Moreover, when they are not dealing with intimate relationships and dealing with casual routine matter of life, they must keep in mind the prone and consequences and effects of these matters in routine matters.

- iii. The discharge of social roles – in the discharge of social roles, either within family, kinship, neighbourhood groups, working organizational set up or recreational interests, he or she must be firmly attached with the understanding of what general social expectations accrue around that particular role. Mentally healthy person will be able to evaluate and judge social and personal consequences of conformity. Most societies and groups will tolerate, in varying degree, some are flexible in the way roles are executed, but there can be a times when individuals are faced with painful, even dangerous choices. This discharge of social role will also demand for qualities such as sense of responsibility and a reasonable self reliance, but will also require the associated technical and social skills. In this modern world, living is making increased demands in technical terms (domestic appliances, computers, car and so on) and in social sphere (negotiating with bankers, holidaying abroad, meeting neighbor from different ethnic groups and so on). All these things deal with routine demands but the literature goes on to suggest that a healthy person will also be able to cope with emergencies. If any person do not has mature

self, lacking self management and problems in discharge of roles, then he will drift towards the threshold of mental health problems.

#### **1.4 Mental Health as a Prefix to ‘Problem’**

Just like the mental health services the term *‘mental health problem’* has a euphemistic value for those responsible for them. By adding ‘problem’, to invert the idea of ‘mental health’, a less damaging and stigmatizing state can be denoted.

However the professional conversation about the diagnosis of depression and schizophrenia is stigmatizing. Indeed some of psychiatrist simply does not communicate diagnosis such as these to their patients because of their negative connotation. In this context the term "Mental health problems’ may be less offensive to many parties. However, this might simply be a diversionary euphemism and it may not be pervasive as a tactic to avoid stigma for those with the label" (Pilgrim, 2010, p. 4).

During the nineteen century, all patients were certified under the lunacy laws and only the state was responsible to take control of madness. The single profession of psychiatry was preoccupied with segregation and management of lunatics or madness. Then with the passage of time the psychiatry extended its jurisdictions from madness to the version of nervousness provoked by the stress, trauma, and alcohol and drug abuse.

Another aspect of the term ‘mental health problems’ is that some people, critical of psychiatric terminology, object on scientific or logical grounds to notions like

‘mental illness’ or ‘mental disorders’. An acceptable alternative for these critics is ‘mental health problem’, though another currently favoured alternative is ‘mental distress. Thus the use of term ‘mental health problems’ side steps the potential offence created by psychiatric diagnoses, given that the latter do not have scientific legitimacy for everyone (Pilgrim, 2010, p. 5).

## **1.5 Mental Health Problems**

The World Health Organization pointed out, twenty five percent of the world’s population suffered from mental health problems while 450 million individuals are reported to be currently enduring from mental illness and these added to twelve percent of the global burden of the disease (WHO, 2001 cited in National Plan Action-NCDS-Pakistan, 2004). According to the national survey conducted by planning commission in 1987 indicated that ten million people were identified as mildly ill whereas one million were severely ill in Pakistan (National Plan Action-Pakistan, 2004).

The range of mental health problems may varies from the routine life worries to severe long-standing conditions. Many people who face mental health problems may overcome or learn how to deal with them, particularly if they get help in the early stages. Its spectrum is broad, as it encompasses all the mild psychological and emotional problems that lead towards the severe mental conditions. It ranges from everyday life worries to severe mental health problems i-e depression, anxiety and panic (What are mental health problems, 2011).

The terms mental health problems, mental illness and mental disorders are used synonymously by professionals in day to day practice and in the literature. Although all these terms describe difficulties that need to be attended by mental health professionals. The classification and definition of mental health problems is essential to facilitate the professionals to refer populace for proper treatment and care. But few diagnoses are contentious and these are directly concerned with the mental health field that individuals are too often treated according to or portrayed by their label. It has a deep impact on the quality of elderly life.

In this case, traditionally mental health symptoms have been divided into two categories i.e. neuroses and psychoses. As neurosis, deals with the serious forms of 'normal' emotional experiences i.e. depression, anxiety and the conditions referred to as 'neuroses' are now more normally called common mental health problems. The psychotic symptoms are more severe and thwart with the individual's perception of reality and included hallucinations as well. The mental health problems affect person's way of thinking, feeling and behavior.

The major mental health problems are depression and anxiety from the perspective of the community and primary care. The reflection of this phenomenon in the Global Burden of Disease study was visible, funded by the World Bank in which depression was reported as a second major cause of disability by the year 2020. Although the burden of care for depression and anxiety is given primary importance yet the policy of UK concentrated on the management of serious mental illness in secondary care increasingly leaving primary care to provide the lead on treatment for

CMD. There are few options for general practitioners for the management of CMD. This led to the dramatic increase in the prescriptions for antidepressants in England. It has elevated from 10m in 1990 to 25m prescriptions in 1998. (Murray, C.J., 1997, Goldberg, D. 1992, Regier, D.A., 1978)

Almost one in ten people have become victims of depression and anxiety and these are most common prevailing mental health problems. These two problems may affect adversely the life of individuals in case of severity and increased intensity of anxiety and depression. It is concluded that about 450 million people have mental health problems throughout the world (World Health Organization, 2001). According to the national statistics of UK in 18 months almost half of the people become affected by the mental health problems but the effectiveness is more prevalent among poor, long term sick and unemployed ones among the general populace (National Statistics UK, 2003). Almost 9 % people were diagnosed mixed anxiety and depression mental disorder in UK and about 8 to 12 % Populace experiencing depression in any year (The Office for National Statistics Psychiatric Morbidity report, 2001).

### **1.5.1 Definitions of Mental Health Problems**

The term *mental health problems* is used to describe an extensive range of emotional and/or behavioral complexities which may cause unease or distress. They commonly occur and include mental disorders, which are more adverse and or constant (NHS Health Advisory Services, 1995).

The Department of Health (DoH) (2000) suggested that 'mental health problems' in children and young people are broadly defined as disorders of emotions, behaviour or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child, or distress or disturbance in the family or community (DoH, 2000, p.25).

Mental health problems are real. They affect one's thoughts, body, feelings and behavior. Mental health problems are not just a passing phase. They can be reverse, seriously interfere with a person life and even cause a person to become disable. Mental health problems include depression, bipolar disorder (manic depressive illness), attention deficit (hyper activity disorder), anxiety disorder, eating disorders, schizophrenia, dementia, alzheimer and conduct disorders. Mental disorder is another term used for mental health problems (Chopra, 2005, p. 159).

Psychoses are seen to be caused by an underlying biological disturbance and include categories such as schizophrenia and manic depression, now more commonly referred to as bipolar disorder. Neuroses, often described as 'common mental health problems', include conditions such as depression and anxiety that may cause distress and impact on day to day life but do not usually affect insight or involve perceptual problems such as hallucination or hearing voices. Sometime understood as problems of living (karban, 2011, p. 38).

"The mental health problems denote emotional and psychological difficulties, which cause distress and interfere with how people go about their everyday lives" (European Commission Report, 2008)

In line with the National Service Framework for Children and Young People (DH, 2004), mental health problems are defined here as difficulties in personal relationships, psychological development, the experience of distress and maladaptive behaviour. Mental health disorders are classed as persistent and severe problems that fulfill diagnostic criteria whereas mental or psychiatric illness describes very severe cases such as psychotic disorders. The present review focuses on mental health problems and disorders, which affect the largest group of young adults (DH, 2004).

"Feelings of depression, anxiety or confusion are normal responses to the ups and downs of modern life. A person is described as experiencing mental health problems when such feelings are so extreme and he/she has difficulty carrying on everyday life" (UK, National Institute of Mental Health, 2005).

The Concept of mental health problems within mental health social work is as; mental health social work is a specialism encompassing work with people affected by mental health problems and a practice, carried out in any setting, which promotes the mental health of individuals and families. As a practice, it is rooted in awareness that problem of poverty, injustice, disadvantage, ill health or loss of esteemed roles may have serious inferences for mental health; and, conversely, that mental health problems such a depression and anxiety or substance abuse are pervasive, often unorganized, and can cause or exacerbate difficulties in coping with relationships and the external environment (Davis, 2000, p. 213).

In the current study, keeping in view the discussion and definitions of mental health problems, it is concluded that mental health problems have a broader spectrum. These MHPs have impact on body, thinking and feelings of individuals. They cover all the emotional and psychological difficulties that start from everyday life worries to those distressed conditions that do not usually affect insight or involvement of perceptual problems i.e. hallucination or hearing voices. These are considered as problems of daily life. Oftenly 'Neuroses' are categorized as 'Mental Health Problems' including depression and anxiety.

### **1.5.2 Definitions of Various Terms used in the literature of Mental Health Problems**

*The term disorder* implies the existence of a clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference in personal functioning. Social deviance or conflicts alone, without personal dysfunction, should not be included in mental disorders (WHO, 1992; NHS Health Advisory Service, 1995).

"Mental disorders means any disturbance of emotional equilibrium as manifested in maladaptive behaviour and impaired functioning, caused by genetic, physical, chemical, biological, psychological, or social and cultural factors. Also called emotional illness, mental illness, psychiatric disorder" (Mosby's Dental Dictionary, 2008).

"Mental illness means 'Any of various psychiatric conditions, usually characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by physiological or psychosocial factors. Also called mental disease, mental disorder" (The American Heritage Medical Dictionary, 2007).

"Psychological distress has been defined as a response to aversive internal and external stimuli that may include anxiety, fear, and psychosomatic responses such as headaches, illness and physical pain" (Ambuel et al., 1992).

*Mental illness* encompasses clinically diagnosable conditions such as personality disorders, dementia, extreme mood swings (bipolar disorders), alcoholism, depression or schizophrenia. These conditions are referred to as mental disorders that can cause distress and impair functioning (US Department of Health and Human Services 2001).

According to the mental disorder in the mental health act 1983.

In this act, mental disorder, means mental illness, arrested or incomplete development of mind, psychopathic disorders or any other disorder or disability of mind and mentally disorders shall be constructed accordingly.

*Mental illness* is variously interpreted:

- As a physical state evident from specific signs and symptoms.
- As a scientific construct subject to test of its validity, such as its usefulness in making predictions.

- As a social construction or label used to regulate societal definition of normality and abnormality (Davis, 2000, p. 215).

### **1.5.3 Concept of Mental Health Problems in Previous Studies**

Mental health problems exhibited during the adolescent years may represent a perseverance of problems that provoke in childhood or the commencement of new illness. In general sense, mental health problems encompass interpersonal sensitivity, loneliness, depression, anxiety, hostility, and in some cases suicide may be included as well (Jensen, 1991; water, 1191).

Some researcher used the term ‘severe mental health problems’ for psychotic, bipolar, major depression and schizophrenic patient (H.L. Graham et el 2001). The dementia and depression are without doubt the major mental health problems encountered in old age. The patients of dementia become visible to have sharp proneness toward aggression (Burns, Jacoby, & Levy, 1990; Hope, Keene, Fairburn, McShane, & Jacoby, 1997; Webster & Grossberg, 1996; Robert, 2002).

The major proportion of older adults resides at home and roughly speaking 20 % of them are suffering from mental health problems. They require additional assistance. In the next few decades it is estimated that about one-third of elderly people will be afflicted with mental illness and they needed interventions. The concept of mental health problems refers to the psychological distress and mental disorders (depression, Anxiety, schizophrenia etc. (Nour, & Hebert, 2010)

## **1.6 Major Mental Health Problems among Elderly**

The major mental health problems of older persons reported by provider and researchers Mildred, O. H (1995), Liptzin (1988), Ouslender (1982), Harper (1987), Gurland (1982), and Matterson and McConnel (1988) include the following.

- Delirium
- Dementia
- Depression
- Agitation
- Emotional problems associated with poor health
- Crying spells
- Irritability
- Pacing
- Wandering
- Assaultiveness
- Expressions of feelings of unworthiness, hopelessness
- Diminished memory, orientation and judgment
- Apathy
- Withdrawal
- Suicidal impulses and / or attempts
- Loneliness
- Paranoid delusions
- Demanding behaviour

- Anxiety disorders
- Alcohol abuse
- Impaired concentration
- Short attention span
- Tendencies to hoard personal items, including feces
- Stress incontinence
- Disorientation

### **1.7 Mental Health and Elderly**

The proportion of elderly people has been growing day by day with an alarming number and becoming a challenge for the developed as well as developing countries. At the same time the attitude of family members and the social and moral values are undergoing transitions. The results of aging are increasingly recognized due to illness, deprivation, externally and internally abuse. Dementia and depression are much more prevalent mental health problems among elderly throughout the world (Copeland, 2003).

The physical and mental health is interconnected and has intensive relation. In case of distress, a person's physical health undergo deterioration along with the mental health which has a greater impact on his or her relations and work abilities. Research studies regarding the care services and mental health among elderly reported that the vulnerability towards mental and physical health is more as compared to the youngsters. With the growing age, a person needed more facilitation. They have to pass through the loss of roles and status and faced retirement.

According to the WHO in 1992, 15 % of elderly were having depression. Dependency is the major cause that leads aged persons towards threshold of vulnerability.

The lack of decision making, social contacts, loss of roles and status, low income, retirement, widowhood, dependency, unmet social and emotional needs, disability, sickness, age norms, launching of children and institutionalization are those social forces that may cause the disturbance of mental health of older adults. This state of affairs lessens their hope for life and they become the sufferers of various mental health problems such as depression, anxiety, stress, and dementia (Atchley, 1988).

With the onset of aging process, multifarious changes occur in physiological and psychological aspects of life. Due to these changes, an automatic behavioral change arouse among elderly. This changing behavior of older persons is linked with physical and mental disease or social disadvantages in addition to the aging process. They have to contend with real issues of lack of finance, social support, and isolation in routine life. Another misconception about the elderly exists, that people consider depression is natural among aged ones and intellectual decline is a normal feature of aging. In actual this feature is not valid. Dementia has also confused with aging (Copeland, 2003). Contrary to this we should not present the elderly as a passive entity of society rather than functional and active. We should encourage them to make their own decisions about their life style rather than others decide for them. This effort to maximize their options, improvement in physical health, supportive environment, social support by family and other opportunities for personal growth would be healthy step in reducing the percentage of mental health problems.

The mental health among elderly is based upon stereotypical views about the process of mental health changes. These myths include assumptions that old age is attached with decline in mental health that is irreversible and associated with 'senility' that little can be done about it, and that there is no point in early detection since there is no treatment. The stigma of deteriorating mental health, however, is a powerful restriction to seek out and accepting help with mental health problems, particularly when fears of being labeled mad or committed to institutional care are also present.

There are two major categories of mental illness among the elderly i.e. organic mental illness, in which definite changes in cerebral functioning occur and functional mental disorders, where no specific physical cause found. According to an estimate from six to ten percent of all elderly have some degree of identifiable organic brain disturbance, called as dementia. (Joseph, 1986). But according to the current figures the percentage of dementia in the developed countries has been increased to alarming percentage.

The degree of organic brain deterioration increased to an extent that impaired their ability to move normally in the routine life and they become static element of society. Functional illness, comprises the disturbance of mood, such as depression, affects about a quarter of the elderly population. The majority of elder persons who become the affecter of depression in later life, attributes such as death of significant persons, removal from home, or some other exogenous cause, are indicated (Gearing and Slater, 1988, p. 27). However, the current estimation revealed that almost 450 million

people suffering from mental health problem (World Health Organization, 2001). Although a bulk of mental health problems among elderly are due to sensory losses, poorly health and the physical outcomes of medicines yet an overwhelming majority of elders faces mental health problems due to problems in the life style events. When a person become old and faces the economic dependency due to retirement or disengagement in business faces changes in housing, loss of peers and relatives, and general disturbances of normal life style are all factors that could influence an individual to an extent that mental health problems may ensure. Finally older persons in retired life can develop an altered image of themselves. In addition to physical and biological changes, their worth, values, status, society's expectation how they behave, serves to change the way in which they perceive themselves and their role and functions in society (Palmore, 1985).

The involvement of the 'ideal self concept' is also a causative factor towards the mental distress. Self concept and ideal self concept, in which an individual tires to match up to the expectation of others, have been said to create problems when their expectations cannot be met. This leads towards the loss of self esteem and loss of control and paves the way to become the victims of mental health problems. So mental health in old age is made up of a complex set of biological, psychological and social interactions (Darby, et al., 1999, p. 4).

The biological, physical and social factors are more influencing factors in the health of elderly. The social scientist mostly focused on these social factors that lead towards the impairment of the social functioning of aged persons.

## **Chapter-II**

### **Elderly Situation in Pakistan**

The age group which a person should be categorized as the elderly/old has two dimensions i.e. a person 60 and has more than 60 and second having 65 and over (Clarke, 1970). But this categorization of elderly varies from 60 to 65 years age group in the developing and developed countries. In Pakistan the people aged 60 and above are considered as the elderly and the official retirement age is the same. The range of age in the older populace is regularly dictomized into 'young old' (60-74) and 'old old' (74 and above) (Clarke, 1984). Moreover in the developed countries are further classified into three groups i.e. young old (65-74), middle old (75-84), and the oldest old (85 and above) (Nizamuddin, 2010).The United Nations has also defined elderly or aged, using the two criteria of 60 and 65 years on the basis of superannuation prescribed by the national governments (Talat, 2005).

#### **2.1 Aging population in Developed and Developing World**

In developed and developing countries, the aging population is going to increase due to decrease in fertility and improvement in life expectancy that acquired special attention of government. This increase in number of elderly population will go to raise to a bulk percentage that will become 2000 million by 2050. The aging population in developing countries comprised of 8 percent that will increase to 28 percent by 2050 (Nizamuddin, Ahmed, n.d.). Weill emphasize that aging is

particularly high in developed countries with the median age probable to increase up to 45 by 2050 (Weill, 2006).

With the changing demographic scenario, the population of elderly, comprised ten percent of the world's six billion inhabitant in 2000. This percentage will go to increase to 22 percent by the year 2050 and this massive increase in elderly population would be mostly contributed by the developing countries (UN, 2002). The demographic transitions that will take more than one century to complete in the developed world, which it has occurred in several developing countries within a few decades (Ali & Kiani, 2003). Similarly Hashmi also highlighted that more than three quarter of the world's net gain of older population occurred in developing countries during the period from 1999-2000.

The growth of elderly population has been increasing twice in developing countries in comparison with developed countries. As the Asia and the Pacific region, comprised approximately 600 million older people, which is the most rapidly growing aging region. The same situation lies within the South Asian countries. The number of elderly in south Asia will quadruple to about 408 million in 2000 and currently 54 % elderly population lived in Asia (Nizamuddin and Javed, 2004). Theses historical facts revealed that the demographic transitions occurred at slow rate in developed countries as a result reported slow population aging during the 2<sup>nd</sup> half of the 20<sup>th</sup> century (Longino and Wilmoth, 2007, P.68).

The table shows a bulk of elderly population (81 million) in the region lives in India and their number will quadruple by 2050. The second largest number of elderly

population is categorized in Pakistan which is estimated to increase up to 43 million, comprising fivefold increased by the year 2050. This massive increase in aged population at national level, which has started since 1990s, indicated clear and horrible picture of serious developmental challenges in future.

Table 2.1 Number of Persons Aged (60 years and above) in SAARC Region in 2002 and 2050 (excluding Afghanistan)

SAARC Countries	No. Of Aged in Thousands	
	2002	2050
Bangladesh	7,210	42,547
Bhutan	144	678
India	81,089	324,316
Maldives	16	105
Nepal	1,438	6,516
Pakistan	8,611	42,840
Sri-lanka	1,857	6,370

Source: (Nizamudin and Javed 2004, P.6), Rapid Growth of Elderly: Policies and Practices of Care and Support of the Elderly

## 2.2 Population Aging in Pakistan

Population aging means the increase in the number and percentage of the elderly in a society. This population aging is caused due to increase in life expectancy and improvement in social environment i.e. better sanitation, hygiene, nutrition, education, and healthy physical activities (Afzal, 1994; Nizamuddin and Maqsood.

2010). Similarly Hafeez (2004) also confirmed that population of elderly going to massive in response to decrease in fertility and continuing enhancement in longevity of age. In the economic survey of Pakistan (2004-05) the life expectancy was reported 64.10 for men and 63.80 for women (Economic Survey of Pakistan, 2004-05, p. 159).

The increase in the aged populace in Pakistan was 1.921 millions in 1951 and it raised to 7.338 million (male 3.990 and female 3.348) in 1998 (Govt. of Pakistan, Population Census Bureau, 1998). The results of 1998 census showed that the estimated populace becomes 143 million in 2002, which comprised eight millions elderly population. According to this, the elderly population of male was high than female but with the passage of time due to increase in life expectancy of female aged population go to vary and it going to increase in comparison with elderly male (Khalid, 2003).

The population of Pakistan is growing rapidly to the alarming figure, which is currently estimated to be 185 million by UN. The population aging also going to increase day by day and according to the population census of 1981 counted 5.7 million elderly having age 60 and above. But in the census of 1998, it reaches to 7.2 million with 26 % increase as compared to the previous census. According to the UN estimates, the aging population i.e. 60 and above touches the figure of 11.5 million (1.1 million are aged 80 years and above) in Pakistan. These number will proceed to sixteen million and fifty million by 2020 and by 2050 respectively. Recently the elderly population of country consists of 6 percent and this percentage will raises to 16 percent in future years i.e. up to 2050. Moreover, the support ratio (the number of

populace aged between 15 and 64 divided by number of people 65 and above), which is calculated to be 15 at present but to be expected to decrease 7 by 2050 (UNDESA, 2009).

UN estimation indicated that recently aging populace comprises of 11.5 million of the total population (185 million) which will go to raise to 50 million by 2050 and this ratio comprises of six percent of the whole population of Pakistan (UN Department of Economics and Social Affairs, 2009).

A remarkable feature of the size of aged population in Punjab province stands much above of the old population percentage of the country. Percentage of elderly at national level is 5.54 while percentage of Punjab province is 6.12, which is 67 % high than national level (Nizamuddin and Maqsood. 2010).

### **2.3 Elderly Research Studies in Pakistan**

Due to the lack of funding and financial constraints only a few researchers have been conducted to highlight the needs and problems of elderly. In Pakistan, the aging populace faces various problems due to changing family structure, values and urbanization. These studies only focused the elderly socio-economic conditions and daily life activities but no comprehensive research work has been conducted on their mental health status.

The research work on elderly situation started by Afzal in 1994, who did a case study on the consequences on aging and found that many of the aged persons in Pakistan had to work for survival. In another qualitative study on elderly, it was estimated that majority of older men in Pakistan desired to continue their economic

activity as they felt that they were losing their status in family and society. This insufficient income was the recognized as a major problem (Afzal, 1999a). He also indicated that family was a key cause of support for elderly but due to multifarious problems and socioeconomic transformation within the family structure, the family could not perform their duties regarding the care of elderly in proper way. Most of the caregivers in rural areas were middle aged or older ones but in urban areas the caregivers were relatively younger ones. This study also represented that majority of elders have some chronic diseases (Afzal, 1999b).

While discussing the issues regarding the livelihood conditions and quality of life among elderly, it was found that it's compulsory to provide them a pleasure able environment at micro level (family) and at macro level (society) for their better adjustment. On 15<sup>th</sup> October, 2001, the celebration of international Day of Elderly the President of Pakistan, laid special emphasize on the reinforcement of family structure and improvement of family relations that will establish a strong social support network (United Nation Population Fund, 1999).

According to the Dar (1996), it was estimated that 34 percent of aged men and 27 percent of the women respondents had satisfactory income. Moreover, almost 55 percent of the male elderly and 90 percent of the female older adults had low economic status. Moreover this study also indicated that 67 % female and 33 % male respondents often felt loneliness which is a causative factor behind depression among elderly.

In another field study, it was concluded that four lac elderly in Pakistan were entitled to take monetary support from the national zakat and usher system. This indicated that majority of the older persons may be categorized in the poor category who were assisted by the families, mainly by their sons. Majority of the elders did not categorize in the group who enjoying good health and a noteworthy number of respondents did have proper diets. Most of the aged persons reported lack of respect as they grow older. Some of the respondents also expressed the feelings of loneliness (Clark, 1999).

The field survey conducted by National Council for Social welfare, in Islamabad and Lahore showed that 57 percent male elderly in urban area and 80 percent male elders in rural area had income one thousand or less in routine life. Moreover more than one third i.e. 77 % had no cash income. All the females were economically dependent on family member but two third were economically independent. A high proportion of elderly expressed their feeling regarding the status and respects were attached with the economic. This study also recommended the provision of financial assistance and health services to poor elderly (MSWWS, Govt. of Pakistan, 2000).

The Punjab Medical Research council (PMRC) conducted a study on elderly, when the elderly were asked about their economic dependence on families, 81 percent elderly exhibited the feelings that they are supported by family and almost half revealed fully supported by family, indicating full dependency to live routine life. The percentage of dependency regarding the economic affairs was found more

prevalent among female i.e. 71 percent among females and 32.4 percent among elderly male.

Religious behavior is important part of the routine life of elderly in Pakistan. 96 percent were Muslim, 3% Christian and 2% other religions in the sample. The elderly report very frequent religious practice, majority replied that they had regular schedule of praying five times in a day and offering fast in the whole Ramzan. Half of the respondents reported that they recite the Quran every day. Most of female elderly were illiterate and those women who reported that they did recite the holy Quran, they were being unable to recite (often due to illiteracy) is the most commonly cited reason for not reading from the Quran (PMRC, 2003).

This survey also encompass few questions regarding the satisfaction in routine life and in case of main problems, which reveal how happy the older adults reported themselves to be .As the level of satisfaction is an indicator to predict their mental health conditions. 40 percent of the elderly said that they are completely satisfied with their daily life. While among women the level of dissatisfaction were found; only 30.9 percent reported complete satisfaction in life, while 49.1% male elderly gave positive response towards satisfaction in routine matters of life. However, there were no variation were estimated between the level of satisfaction between the urban and rural community. 15.4 percent of the male elderly and 18 percent of the female have the same opinion about the life that they said life is just like a burden, the respondents did not more care for the difficulties in living conditions, occupation and housing while they acknowledged money and health as their main problems.

Interestingly, a few of the respondents acknowledged loneliness and family adjustment as a main concerns for better adjustment (PMRC, 2003).

Nizamuddin and Ahmed (2003) emphasized to study the rising number of aged populace in Pakistan. They presented several suggestions to formulate a national policy on the aging population. Moreover they also highlighted that Pakistan did not has any sound assertion to form a policy to address the needs of elderly. Ali and kiani (2003) used indicators of quality of life such as living conditions, gender, accommodation, and poverty and concluded that per capita food and non-food consumption was the main determinants in the quality of life of the older adults. Moreover, gender and accommodation had appreciably association with their quality of life. The findings of this study also focused on the need of provision of health facilities and reported that they frequently demanded for the medical care.

The findings of research conducted by Pakistan Medical Research Council on the health issue and living circumstances of the elderly indicated that the female elderly were residing in poor conditions than men and the rural elderly were less demanding for health care than urban elderly, who had poor health and cardiovascular problems. More than one third of the elderly wanted to continue work after reaching the 60 years, 28 % men and 8 % women received pension and only 6 percent of the elderly live alone while other residing with family. The condition of elderly living within joint family system was good as compared to the nuclear family system. More than two third of the respondents were supported by married sons and less than one half were reported to involve in family decision making (Pakistan Medical Research

Council, 2003). Another study concluded that a small proportion of elderly enjoying excellent health and more than one forth of them had poor health (Hafeez, 2004).

According to the Riaz (2005), a research study on age discrimination, concluded that going to be old in south Asia has a dissimilar cultural sense from the western community. Within Pakistani culture, the growing old is firmly attached with the raise in status and respect. You are respected and your opinion has importance on family issues being the oldest of family. The elderly people are considered as a centre especially in joint family system. This phenomenon is more prevalent in traditional and rural communities of Pakistan. They are considered as the back bone and every decision goes to the final stage after the permission of elders. Whether this respect or status emerges out of loyalty, love, fear, depending upon the family situation.

According to the study conducted by Ahmed and Hafeez (2006) in six localities of Lahore, found that 70.5 % of the respondents reported poor eye sight/vision problems. A small proportion reported cancer as a major chronic ailment. Along with these diseases, the elderly also suffering from high blood pressure, arthritis, diabetes, high cholesterol, obesity, Alzheimer's disease and heart diseases were reported as major chronic conditions. They categorized two mental health problems i.e. Alzheimer's disease (16 %) and Parkinson's disease (7.7 %). The study findings of this research work clearly indicate that the onset of chronic conditions started around fifty years of age in developing countries like Pakistan. Moreover, socio economic conditions, chronological age, environment, emotional and psychological factors seemed to be important in inducing limiting chronic conditions. This high rate of

prevalence of chronic conditions among poor segment of society is likely to raise demand for medical and financial support. This situation draws attention to formulate comprehensive policies and plans to address problems of growing number of the above mentioned chronic conditions. The self-reported medically diagnosed conditions by gender and age indicated that the percentage of various chronic conditions were more among females as compared to males. It also indicated that the prevalence of almost all chronic conditions consistently increased with the increase in chronological age.

According to Itrat et. al, (2007) the concept of 'Izat' (respect) has a peculiar meaning in Pakistani society. It is very powerful concept which is considered essential for the smooth function of family. Now it is a time of enjoyment for elderly people, seeing their children with their own families, participating in decisions making and receiving 'Izat' from them. But due to urbanization and industrialization, the family values are going to change that diminishes the concept of izat which is alarming situation for the care and respect of elderly in Pakistani society.

From the findings of research study entitles 'Situations of Elderly in Pakistan , Problems and Prospects' , it was concluded that the vulnerability of elderly increased when they lost their family support or become disable due to any physical injury. Due to reduced mobility, social 'invisibility' and the flawed assumption, older adults were frequently were ignored and fail to approach compassionate assistance and basic rights. When the families of older people were too poor and felt over burden to care for them, then their vulnerability becomes double. The elderly facing different

problems e.g. non provision of medical and health services, nutritional deficiencies, chronic diabetes, eye problems , dental problems, social isolation and neglect, and in crisis situations etc. In order to resolve these problems, there is need for comprehensive invention plans and psycho-social support. In spite of this huge pressure of socioeconomic conditions in Pakistan, Pakistani community has stand for value, respect and self-esteem of human life. The old age is remarked as a representation of high regard, wisdom and goodness in Pakistan. This may be ascribed to the strong relations that persists in the joint family system shaped by religious values which dignifies the status of older adults in society (The Situation of Elderly Population in Pakistan: Problems and Prospects, 2008).

Itrat and his research fellows (2008) conducted a cross sectional study on the 60 and above out patients elderly at Agha khan university. The major emphasis of this study was to know the present status of family in Pakistan, its changing structure and the implication of such trends on the health of elderly. 57% of respondents were living in the joint family system while 45 % were residing nuclear family system. Majority of them expressed their feelings about the change in family system i.e. from joint to nuclear family. 85 % of subjects were of the opinion that a system of family has a major influence on health care. Moreover joint family system was the favored family system in acute as well as chronic illness and in case of emergencies.

The Pakistani government founded a National senior Citizens Task force in 2002 to recognize the socio-economic needs and health issues of the elderly and to draft a national policy for elderly which fulfill the international commitments. In this regard,

the government provided exemption for elderly in public hospitals, public libraries, paying taxes, recreational activities and standing up in cues. Moreover, the government established a few old age homes only in major cities. Four old age homes named 'Affiat' (one in each city i.e. Lahore, Islamabad, Kasour, and Toba Tek Singh) are working in Pakistan under the administration of Department of Social welfare, Government of Pakistan. In 2004, government also commenced a bill in the national assembly to establish a National Seniors Citizens Council. Currently, in February 2008, the Ministry of Social Welfare and special Education and Ministry of Population Welfare and university of the Gujarat organized a seminar talk to 'Unmet Needs of the Elderly in Pakistan' to spur the enactment of the pending bill on the elderly (Khalid, 2006; Nizamuddin & Maqsood, 2010).

The research findings of survey 'How Elderly Live in Punjab' conducted throughout the Punjab indicated the level of satisfaction by choosing three options i.e. very satisfied, somewhat satisfied and very satisfied. This study found that about one half (49 %) reported that they were somewhat satisfied and 42 percent were very satisfied while ten percent were fully unsatisfied with their present life. It showed that more than half of the respondents were lying within the category of not satisfies as 49 % were somewhat satisfied. In addition, a major proportion of satisfaction with present life was significantly attached with those respondents who reported positive behaviour of family and whose family members listen them carefully. As more than one half (52 %) reported that their family and friends liked to listen to them (Nizamuddin & Madsood, 2010).

Moreover in this study, for the mental health of elderly respondents, they used a scale which was developed to estimate how the elderly felt as they become old, a sequence of questions were expressed from them to express their feelings about various daily experiences such as feelings of happiness, status of appetite, behaviour of people, sleeping conditions and feelings of loneliness. This scale comprises of twelve items. Then the responses against the scale of mental health were categorized into three classes i.e. often, occasionally and not at all. It was found that no significant variation were found between the results of urban and rural community dwellers. But they found a clear variation between different regions. The respondents from the southern Punjab reported more contentment and feelings of happiness. Similarly the urban people felt more loneliness than the rural dwellers and the urban people suffered from poor appetite. Moreover the respondents generally expressed that the people were unfriendly to them. This study did not determine the prevalence rate of mental health problems among elderly but only focus percentage of symptoms in various regions of universe (Nizamuddin & Madsood, 2010).

When we taking to the sleep of elderly, it is clear that most of the elderly cannot sleep whole night. The finding of survey conducted by Nizamuddin, indicated that the more than two fifth (41%) of respondents reported that they were habitual to sleep for four to six hours. In addition, when elderly were asked about the satisfaction with this sleep duration, more than two third (67%) of the respondents replied positively towards the satisfaction with sleep. As for as the gender is concerned, it was estimated that female were more dissatisfied with sleep than males. Approximately half of the male and female elder persons had chronic diseases whereas 66 percent

had joint pain. The percentage of female older adults suffering from illnesses was more than male. One half of the elderly reported that they consulted private consultants in case of medical treatment. Mostly rural community dwellers visited public basic health unit for treatment while few reported (3%) visiting a dispensary. The vast majority of respondents (71 %) visited doctor for health problem and 19 % went to traditional practioners. When the respondents were asked to find their tendency to ignore minor ailments until they become acute. More than one third of respondents replied that did not visit doctor even when they needed and prolonged their conditions towards acuteness of disease. About three fourth (73%) cited financial constraint as a major reason of not visiting medical practioners (Nizamuddin & Madsood, 2010).

The aged person will be increased in urban community whereas the number of female elderly will become increase as compared to male future. In addition, both elderly male and female population is prone to be more literate than nowadays. Moreover the percentage of dependency will also increase in future. Females at the old age required more care as mostly widow had lack of financial sources. She concluded that in 1998 30.9 percent of the aged population was economically active having 55.5 percent males and 1.6 percentage females. But currently the circumstances is adverse, as 17.5 percent (26.6 percentage male & 6.53 percentage female respondents) of aging populace is economically active. This analysis shows a clear picture of decline in number of economically active elderly, which will provide a foundation to discover other social causes and their implementation in the routine life of elderly in Pakistan (Cheema, 2011).

Ahmed, (2011) Concluded that social networks and social support were considered more important for the quality of life among elderly, where the formal support and network of social protection were lacking. He studied the need of social support for those elderly who were suffering from various chronic situations. Affliction with chronic condition and widowhood status were the major indicators of social blueprints in the targeted universe. The social support has important impact on the disability level (daily self-maintenance activities). In spite of having close ties within family setup, mostly elderly had close relationship with blood relations and close friends. But due to increasing trends of nuclear family system, the need for social support for elderly will be essential in future which will directly lead towards devising strategies for social protection program in Pakistan. Ahmed and Hafeez (2011) concluded that the social participation effect the both health and quality living among elders. There was clear association with the social and economic conditions, chronic health condition, widowhood status and gender. Socioeconomic variables were confused with the occurrence of chronic conditions i.e. heart complexities, Alzheimer's diseases, arthritis, which had adverse effect on health status.

## Chapter-III

### Depression

Depression is a pervasive mental health problem that extinguishes the glint of life. It had a great impact to destroy the quality of elderly lives. Depression diminishes the hope, joy, laughter, empathy, happiness and love and leaves the depressed one in the realm of loneliness and isolation (Hogstel, 1995).

Depression has been examined as a significant characteristic in later life. The second century Roman physician Galen, viewed that elderly are more prone to depression and he described a link between melancholia and aging (Jackson, 1969). But currently, older people are portrayed as a sad and withdrawn. It is considered that depression is due to losses experience in life, declining death, and their keeping out from position of influence and importance in society. Like other stereotypes, these images contain both elements of truth and distortion. However, depression is a most important and frequent mental health problems among the elderly in contemporary society (Zarit & Zarit, 1998 p. 63).

The modern mental health owes to the classical study of Sir Martin Roth (British psychiatrist), who in a landmark 1955 paper, ' The Natural History of Mental Disorder in Old Age ', examined the outcome of geriatric patients with different disorders who were considered inpatients in English mental hospitals. Roth discussed these disorders as the manifestation of brain disease and not much was expected of

elderly patients except further decline. But with the passage of time, it was examined that recovery of elderly patients did not depend upon the patients' age but it actually depends upon how to present the problem. For instance, people who were hospitalized with effective discharge as recovered and to have higher survival rate at six months and two years than people with symptoms of dementia. These positive findings, especially in that time when treatment of severe depression was relatively limited, spurred interest in identifying treatable mental health problems among elderly (Zarit & Zarit, 1998 p. 64).

In nineteenth century, Kraepelin (Cited by Kolb, 1977) conceptualized mental illnesses within the medical perspective and given its definite symptoms, heredity patterns, etiology, and prognoses. He divided functional psychoses into two categories i.e. dementia praecox and manic depression. According to him, manic depression covers all abnormalities of mood and is innate rather than the result of social and psychological forces. Contrary to above, Meyer (1908) described depression as the result of reaction to various life events, as the view point similar to the current researchers.

Depression has been viewed from different perspectives giving rise to various explanation of the phenomenon. This diversity pertains to the symptoms patterns and a description of features of depression. Depression is used to describe feelings of low moods, feelings of sadness and helplessness that are the results of normal reactions to the general stressful and difficult experiences of life. If you are suffering from the depression, it not only limits to the sadness but it also accompanies various physical

effects such as sleeplessness, loss of energy, physical weakness and physical aches. A depressed person may exhibit feelings of guilt, worthlessness, regrets, hopelessness, self hatred, delusion, and hallucination. A depressed person has poor memory, lack of social interaction and thoughts of death and suicide.

Freud indicated the depression as a process of mourning the loss of loved objects. He believed that melancholia is the expression of hostile feelings formerly associated with the lost object and currently directed inward (Beck, 1964, 1967). With the passage of time, various theories of depression have been presented and each theory discussed depression in its own perspective and school of thought.

Beck (1967) presented the idea of a negative cognitive triad. According to this idea a depressed person looks at the world in three negative dimensions; they have negative views about themselves, about the world and of future. So they perform different type of errors in thinking, just like taking any step at once without keeping in mind the results, disregarding pleasant events, focused mostly on unpleasant proceedings, and amplifying on unpleasant happenings that trigger their negative cognitive triads. Depressed people did not commit these mistake consciously but these are committed by them automatically and often these errors performed so actively that they became unaware that how they are interpreting the situation.

In the psychological perspectives, the concept of depression has been variously described as 'having the blues', sad feelings, hopelessness, guilty, helplessness, melancholy and grief due to the loss of some loved things. It is also described as a

symptom or feeling state, a syndrome or reaction, a character or life style and an illness or disorder (Schuyler, 1974). The etiology of psychological disorders is also based on the involvement of stress and trauma in life events. There are number of research studies that high light the role of major stressful life events in the onset of depression. In summarizing the above mentioned researches, it is very much clear that a strong correlation exists between the stressful events and onset of mood disorders (Kendler, Karkowski & Perscott, 1999).

Nicolson (2001) discussed bio psychosocial model of depression. According to him, depression is the result of previous mental distress, which is firmly attached with particular 'risk factors' related to the present situation such as social isolation and a particular 'trigger' or event as death in a family.

In the medical perspective, genetic predisposition and heredity factors play an essential role in the growth of bipolar and depressive disorders. Another medical model focused on the role of neurotransmitters (norepinephrine, serotonin, and to extant dopamine) as the reduction of norepinephrine, and serotonin is the synaptic cleft can cause depression. Moreover neurophysiologic abnormalities also have etiological significance in the development of depression (cited in Nolen-Hoeksema, 2001 p. 264).

According to Gilbert (2000) depression has adverse effects on human life. Depression did not only effect our feeling and thinking but is damaged our

concentration, lower energy, disturb our sleep, diminishes our sexual desire and adversely affect many other aspects of life.

"In depression you think you will never pick up and you feel so very ill all the time and you get no relief from it whatsoever, nothing is worth doing and you get no pleasure from anything at all" (Corob, 1987, p. 11).

The term depression refers to both symptoms and disorders. This dual nature creates some confusion when we are going to discuss about the prevalence of depression. The primary diagnostic categories in DSM-IV are major depressive disorder (MDD), dysthymic disorder, and adjustment disorder with depressed moods. Depression can also be a feature of bipolar mood disorders. Depressive symptoms are a defining feature of these disorders, but depressive symptoms can occur with some degree of severity and regularity among people who do not meet the criteria for diagnosis (Zarit & Zarit, 1998, p. 64).

The diagnostic and statistical Manual, 4<sup>th</sup> edition (DSM-IV), introduced a significant change in the approach used in psychiatric conditions among elderly. Although, distinction between the organic and functional disorders have been made in the previous diagnostic manual. But in the DSM-IV, the term 'organic mental disorder' has been eliminated entirely because of the implication that the other conditions were without an underlying organic component. Instead, the psychiatric disorders are examined independently with attention to the current foundation of clinical research information. This manual reflects the separation of clinical syndromes by their defining features. It suggests that all subjects with the same

syndrome are not mutually exclusive. Rather these categories for diagnosis assist to communicate important characteristics of a diagnostic category and paved the way of heterogeneity. The categories present basis for further researches to enhance the knowledge and understanding about that syndrome (Butler et al., 1998).

Mood disorders in the elderly broadly divided into three categories i.e. major depressive disorders, bipolar disorders, and dysthymic disorders. According to the DSM-IV, the essential features of a major depressive episode are the existence of depressed mood or marked loss of interests or pleasure for at least two consecutive weeks (Lipowski, 1983). This syndrome of major depressive disorder (MDD) involved a significant impairment in normal routine life activities. In order to meet the criteria of major depressive disorder, an individual must manifest one of the essential features and five or more of the nine symptoms, listed below.

Diagnostic features of a MDD episode as listed in the American Psychiatric Association's DSM-IV manual (American Psychiatric Association, 1994).

#### Essential features

- Depressed mood
- Loss of interest or pleasure

#### Symptoms

- In Depressed mood for almost whole day
- Distinct loss of interests in daily activities
- noteworthy change in appetite and loss of weight at least 5 %

- Almost daily insomnia or hypersomnia
- Almost daily physical agitation or retardation
- Almost daily decreased energy or fatigue
- Daily feelings of worthlessness , hopelessness and feelings of guilt
- Decreased concentration and decisiveness
- Frequently thoughts of death or suicide

Chronic Major Depressive Episode which has lasted continuously for the past two years is identified as chronic major depression. To meet the criteria for melancholic depression, one of the first two or three or more of the other symptoms must be present i.e. loss of interests in activities, lack of reactivity to usually pleasure stimuli, no improvement in mood with something happening, diverse quality of depressed mood, depression become adverse at morning time, early morning awaking, psychomotor retardation, loss of weight and unnecessary guilt (American Psychiatric Association, 1994, p.384). A seasonal major depression is also defined as recurrent MDD that occurs at regular times of the year. It begins in the fall or winter and lasts for sixty days.

Bipolar disorders are characterized as a sever swing of mood from depression to elation or has had one or more manic episode. Bipolar disorder typically occurs before age 30 but it also prevalent among older people. There are two types of bipolar disorders i.e. bipolar disorder itself, in which one or more manic episodes are linked with one or more major depressive episodes. Second one is Cyclothymia, it's a chronic mood disturbance lasting at least for two years and in which there is a

repeated history of hypomanic episode and these episodes are less severe than the manic episodes. A third bipolar disorder is 'bipolar disorder NOS' (not otherwise specified) (also called atypical bipolar disorder or bipolar II), in which an individual manifests hypomanic but not manic episodes along with major depressive episodes (Hogstel, 1995:127, & Butler et al., 1998, p. 97-98).

Dysthymic disorder is a mild form of depression and it also consistently present for at least two years in which the client displays a depressed mood. The dysthymic individual also has symptoms like, poor appetite or over eating, low self esteem, low energy, insomnia or hypersomnia, poor concentration and decision and hopelessness. The patient is not shown major depressive episode during the first two years of symptoms expression. Another disorder is 'adjustment disorder with depressed mood', which is a maladaptive reaction, lasting for less than six months (acute) or six months or longer (chronic) and reaction to a stressor can be identified. The reaction is expected in response to the stressor or malfunctioning in various occupational activities and social interaction in routine life. The symptoms are tearfulness, depressed mood and feelings of hopelessness (American psychiatric association, 1994).

'*Masked depression*', is a type of depression among elderly, which is characterized by the by the minimal sadness, guilt and self-reproach. The older adults at the first stage complain about decreased cognitive functioning, somatic and vegetative symptoms and atypical pain. About 3 % to 4 % of elderly suffer from a

temporary but severe depressive disorder that does not clearly fit any DSM-IV category (Blazer, 1986).

The term “minor *depression*” is usually applied to explain the depressive situations that are not of adequate harshness and duration to fulfill the standard for a major depressive episode (Angst and Merikangas, 1997 & Parker, 2000). The dysthemia has been used to categorize the minor depression in DSM-III, but minor depression long-lasting less than two years was doubled with uncharacteristic depression, diagnosed as depressive disorder not otherwise specified in DSM-III-R. In DSM-IV, minor depressive disorder was identified as a potential diagnostic category and relates it to the observed justification. The diagnostic criteria for minor depressive disorder is firmly attached with the occurrence of two to four symptoms of depression that prolong for at least two weeks and individuals with an earlier history of major depressive disorder was excluded.

The definition of minor depression has been defined by different investigators in different ways, and they presented some findings on the basis of their researches which are as;

- i) The prevalence rate of minor depression exist from 2 to 5 percent
- ii) Minor depression is linked with functional impairment and increased service utilization.
- iii) Minor depression is firmly attached with a rising threat of developing major depressive disorder.

- iv) This may lead to the increasing risk of malfunctioning in the coming future episode of major depressive disorder.
- v) The symptoms of depression are linked with repetition of number of episodes, length of episodes, intensity and nature of impairment, occurrence of comorbid diagnosis, and existence of psychiatric disorders in family history.
- vi) Those persons who have a history of major depressive disorder freely cross between major depressive disorder, minor depression, and subsyndromal depressive symptoms (Kessler et al., 1997 & Kessler et al., 1992).

Vascular depression is considered as a sub division of depression, particularly in older adults, but as well among younger ones, identified as a specific clinical exhibition and linked with (cerebro) vascular risk and disease (Paul et al., 2009). According to Alexopoulos et al., the distinctiveness of this vascular depression include more pronounced psychomotor retardation, increased cognitive impairment and physical disability, a few feelings of guilt and reduced insight.

Alexopoulos conducted this study in hospital settings and this may limit generalization to the wide-ranging populace. According to a study conducted in community settings, there was no particular link found between cerebrovascular risk factors (CVRFs) and sub divisions of depression among general community members (Naarding et al., 2007). The vascular depression is of clinical importance in case when a cardiac event is obvious. By applying a set of symptoms in a simple test case

to identify depressed individual at increased risk for cardiac events, it would be a facilitating to foresee the course of illness and to identify the impact of medication and other therapeutic interventions.

Besides these primary diagnoses of mood disorders, depression may also be an important feature of other psychiatric disorders. Koenig and Blazer (1992) differentiated three patterns of comorbidity among the older persons. First pattern is depressive symptoms that are resulted from medical illness and disability and these psychosocial in origin. Second, depressive symptoms can be due to the variety of illnesses and medication e.g. depression is a common characteristic of Parkinson's disease. Changes in level of dopamine and due to his or her growing disability and poor prognosis are the cause of depression among the Parkinson's diseased ones. The third pattern is 'masked depression', categorizing those patients whose medical complaints have no organic origin. Masked depressed person manifests depression themes i.e. hopelessness, helplessness and worthlessness. One another additional pattern is that depressive symptoms can be a part of other psychiatric disorders.

### **3.1 Prevalence of Depression**

Depression is a public health problem that stood at fourth position in the global burden of diseases and it will approach to second place by the year 2020. Among the eighteen years above men and women were 340 million people who had depressive disorders that added to an elevated suicide rate (Desjarlais, 2001). The sufferers of mental or behavioral disorders comprised of 450 million throughout the world. World health organization Global burden of diseases, 2001, revealed that 33 percent of the

years lived with disability (YLD) are caused due to neuropsychiatric disorders, unipolar depressive disorders also contributed up to 12 to 13% of years lived with disability and stand at third position in the global burden of diseases (WHO, 2006). The prevalence of depression and anxiety in the developing world touches to alarming threshold i.e. its occurrence rate reported from 10 percent to 44 percent (WHO, 2001).

Gadit and Mugford (2007) conducted a survey of three cities of Pakistan and reported a regional variation in the prevalence of depression between these three cities. The rate of depression in Lahore, Quetta, and Karachi was estimated to be 53.4%, 43.9% and 35.7% respectively. In Pakistan, due to the recent prevailing adverse conditions, the percentage of depression is high. By keeping in view this high percentage, Pakistan acquired scientific and systematic studies to highlight the causative factors lies behind this high prevalence.

Mirza and Jenkins (2004) conducted a study to present the prevalence of depression and anxiety and its risk factors. This study resulted depressive disorders and anxiety was 34% out of women i.e. 29 to 66% and of men i.e. 10 % to 33%. The female sex, middle age, low literacy, financial complexity, being a housewife and relationship issues and problems had significant association and diagnosed as major risk factors that accelerate the anxiety and depression percentage. 47% were reported the depression among the patients at a psychiatric clinic.

Another study conducted by Luni and his colleagues (2009), reported 43% prevalence rate of anxiety and depression in the community dwellers residing in a village of Sindh, Pakistan.

In developed countries a bulk of studies have been conducted (Chow et al., 2004; Heath, Brown, Kobylarz, & Castano, 2005; Wada et al., 2004) to identify the prevalence and risk factors of depression among the elderly while only few researches were conducted in the developing countries (Al-Shammari & Al-Subaie, 1999; Ganatra, Hammad, Zafar, Qidwai, and Rozi, 2008; Thongtang et al., 2002; Malhotra, Chan & Østbye, 2010)

Depression is one of the prominent disabling of health conditions throughout the world and about 350 million people in the world have depression (Gilbert, 2009). It is estimated that one in seven elderly was affected by depression (Chew-Graham et al., 2004). When we deal with the depression among community dwellers, it was found that community residents surprisingly indicated low percentage of major depression i.e. one percent to two percent of woman and less than 1 % among elderly men. But the prevalence of depressive symptoms was found considerable more often though the symptoms did not meet the doorstep of clinical diagnosis, with studies reporting rates of 15 percent or more. The rate of dysthymia, minor depression was 2 % and adjustment disorders with depressed moods reported 4% that was associated mostly with excessive disability, improved use of health services and poor health outcomes, including increased mortality. The percentage of these depressive states was lower

among elderly than in younger adults. About 20 % of elderly with early Alzheimer meet the criteria for major depression % of patients (Markides, et al., 2007 p. 145).

All the studies revealed significant variation existed regarding the occurrence and risk factors of depression. This prevalence rate may vary from 9 percent to 42 percent depending upon country situation and settings (Djernes, 2006). Studies of same nature reported variation ranging from 6 % to 50 % in case of depression among elder populace (Patel & Prince, 2001). Many studies reported the prevalence of depression among general populace but no recognizable work have been conducted to assess the occurrence of depression among elderly in community setting (Mirza & Jenkins, 2004).

Ganatra and his colleagues in 2008 estimated 22.9% frequency of depression among the older adults in Pakistani society. As this study was one of the few research studies to highlight the percentage of depression among elderly in Pakistan, so it may be compared with other studies carried out in other developing countries. Studies among community dwellers have estimated it to range from 6% to 50% in India (Patel & Prince, 2001) and 12.78% in Thailand (Thongtang et al., 2002).

According to Djernes (2006), the occurrence of depression among elderly Caucasians in developed countries lies between the percentages of 0.9 to 42. Moreover, it was concluded that the prevalence of depression in community dwellers (0.9–25%) was low as compared to those living in the institutional settings i.e. 14 to 42 percent.

In the study, conducted by Ganatra and his colleagues (2005), the prevalence rate of depression was found 22.9%. The respondents of this study were the older persons (60 years and above) in the primary health care centre, comprising of the patients and their attendants who did not suffering from acute illnesses. Therefore, it was viewed that if a study would be conducted in community setting in Pakistan, the pervasiveness of depression may be resulted low in contrast to institutional setting, but it depend on the researches in this domain i.e mental health of elderly in community setting (Ganatra, et al., 2008). The percentage of depressive symptoms among the elderly Korean was 15.2 % and among Japanese was 19.8% (Lee and Shinkai, 2005).

In Saudi Arabia, 39 % depression was reported at primary health care centers (Al-Shammari & Al-Subaie, 1999).The estimation of depressive symptoms among Sri Lankan elderly people was noted higher in comparison with other Asian countries. The occurrence of depressive symptoms among the Sri Lankan's elderly (27.8%) was more than that estimated in the majority studies of community-dwelling Caucasian (Djernes, 2006).

According to Malhotra and his colleagues (2009), the variation of prevalence rate depends upon the demographic and health that varying from 15.5 percent among elders who supposed having low income to 66.9 percent among those respondents who has physical disability. The respondents indicating depressive symptoms, clear variation by gender with respect to individual symptoms of Geriatric Depression Scale -15 were noted only for theses items i.e. “do you often feel helpless”, “do you

feel that your life is empty”, and “have you given up many of your activities or interests”. The women were more responsive in case of first and 2<sup>nd</sup> items and men in case of third item (Malhotra, Chan, & Østbye, 2009).

Steffens and his colleagues in 2000 reported that prevalence of major depression among community dwellers was reported low (from 1% to 4% ), but the variation gender wise had been observed, whereas no difference were found on the basis of ethnic and race. Results for dysthymia and minor depression are somewhat higher, with the similar variations across sex and race or ethnicity. In the North Carolina Epidemiologic Catchment Area (ECA) Study, in which the Diagnostic Interview Schedule (DIS) was used (71), the prevalence estimation was 0.8%, 2% and 4% for major depression, dysthymia, and for minor depression respectively (Blazer, Hughes, & George, 1987).

The symptoms of depression are more prevalent among people with medical illness. The percentage of depression among the medically ill persons in hospitals varies from study to study yet it ranges from 6 % to 44 % with an average of 12 % in the hospital settings. Other depressive diagnosis such as, dysphoria, adjustment disorders, has been found in 18 % to 26 % among depressed persons. At the next step when we study the rates of depression disease wise, it was estimated that rates are higher in the case of severe diseases , like cancer, cardiac illness, cerebrovascular accidents, chronic pains endocrine disorders and with greater functional disability (Koenig and Blazer 1992).

The Parmalee, Katz, and Lawtons (1992) reported that the older population in the nursing homes was also at risk. In the light of a complete study in the nursing homes, 15.7 % of long term residents met criteria of major depressive disorders and 16.5 % had significant depressive symptoms. During one year follow up of this sample population of elderly revealed, 5.6 % incidence of new cases of MDD and 6.3 % incidence of minor depression. Rates of depression among out patients with dementia and Parkinson's disease ones also show significant number in various studies.

This prevalence rate of major and minor depression varies with settings and methods used to recognize cases. Major depression was found 6 % to 10 % of older patients in primary care centers and in 10 % to 20 % of nursing home residences. It has also been reported that this proportion varies from 11 percent to 45 percent among elder patients requiring inpatient medical care. The prevalence rate among outpatient medical clinics varies from 8 % to 40 % in various studies. The major depression among elderly in the inpatients and outpatients psychiatric settings was reported up to 40 % and similarly the rate of bipolar disorder lie between the 3 % to 10 %. Old patients often, expressed somatic concerns and less frequently reported depressed moods or guilty. Among patients who refute sadness, constant loss of pleasure and interest in previously enjoyable activities is necessary for diagnosis of major depression, thus a person does not necessarily shows a depressed mood to meet criteria for major depression. Feelings of sadness, loss of appetite, and disturbance in sleep are common among bereaved older adults but usually resolve within two months. But, more than one out of ten bereaved adults develops major depression within the period of two years of loss (Markides, et al., 2007). Older people may

show different symptoms from younger people, such as, sadness may be less of a feature in older people, but appetite disturbance, change in sleep patterns and presentation of physical symptoms may be more apparent (Chew-Graham et al., 2004).

In USA, DSM criteria were mostly used for depression and it showed high rates of depressive symptoms but generally low rates of diagnosed disorders. The major investigation about the rates of mental illness in United States was the Epidemiological Catchment Area (ECA) study, which examined prevalence of disorders at five sites in the country. The ECA investigations used a structured interview i.e. Diagnostic Interview Schedule. A rate of 2.5 % was found among community dwelling people who were above 65 years. The prevalence for women was about twice as high as in women than men (Weissman et al., 1988). Weissman and Mayer, (1978) in another study, used different assessment instrument (Schedule for Affective disorders and Schizophrenia – SADS) and found somewhat high rate depression among a community sample of elderly i.e. 5.4 % with MDD and 2.7 % with minor depression.

The studies conducted by Gurland his colleagues (1983), using the CARE, which identifies people with clinically significant depressive symptoms, indicated that rates of depression among older community peoples lied between the range of 12.4 % to 17.3 %. The rates of DSM-III diagnosed depression much higher in Hobart than in other studies. Moreover, blazer also presented similar type of results about the

prevalence of depression among community population; he examined the rate among elderly in community setting ranging from 8 % to 15 % (Zarit & Zarit, 1998 p.66).

### **3.2 Etiology of Depression among Elderly**

The etiology of depression is linked to many different processes. Depression theories may have its origin in biological factors, early life experiences, cognitive style, stressful events and loss of reinforcement. In a human being biological psychological and social process occur simultaneously and they play their role in personality make up. Before talking about various theories, its better we should sort out whether causes of depression lies within the biological, social or psychological domain. The results of lot of research studies shows that depression is likely to be is the common outcome of many different pathways; with biological, psychological, and social process causing their effects in varying degrees.

Genetic theorists explain depression in the context of hereditary traits. The work of these researchers is based on studies of twins who have been raised separately (Minot, 1986). According to the neuroendocrine theorists, depression is due to the malfunctioning of neurotransmitters in brain. The activities of dopamine, norepinephrine, serotonin, and epinephrine are being closely scrutinized. With the aging, these chemicals start to decrease that may be causes of depression among elderly (St.Pierre et al., 1986). The problems in cortisol and thyroid hormones release may also be a cause of depression as many depressed persons have abnormal responses to thyrotropin-releasing hormones or dexamethasone challenges (Minot, 1986).

The role of neurotransmitters in depression supports biological theories in mental health field. Serotonin and norepinephrine had more effects yet dopamine, histamine, gamma-amino butyric acid, glutamate, glycine, and acetylcholine may play a part (shuchter, Downs, Zisook, 1996). A significant change has been occurred in the neurotransmitters with aging. Serotonin receptors are estimated to decrease by 20 % to 40 % in last years of aging. Similarly norepinephrine and dopamine are also decreases in the advanced age. So the amount of these various transmitters and balance among them contribute to depression (Cohen, 1992).

In the view of anatomical changes in the brain, various abnormalities of brain, including enlargement of ventricles, changes in white matters and other alterations are also causing geriatric depression. Ventricle enlargement in depressed patients has been found to be associated with poor performance on neuropsychological tests. These findings highlight that brain abnormalities may have role in the etiology of late onset depression. These types of problems may leads towards the presence of Alzheimer. Depression is among early symptoms of dementia and these findings about the brain abnormalities are included those people who have early dementia and comorbid depression (Abas, Sahakian, and Levy, 1990).

Depression may be in response of chronic disability or terminal illness. So it is very important for a doctor or psychiatrist to rule out physical conditions before diagnosing depression as a psychiatric disorder. Late-onset disease that is depression with first onset at age 65 and above, among aged population comprise an important source of heterogeneity in today increasing population. Due to improvement in aging,

the number of elderly will rise by 40 percent between 1984 and 2010 and will stand for almost 14 percent of the general U. S. populace. The number of depressed patients is going to increase day by day in both community and institutional setting. In 1985, it was found that 25 percent residents of nursing homes suffering from major depression and in this number the 63 percent cognitive impaired patients were excluded (NIH GUIDE, 1992).

The vulnerability to depression is going to increase due to the stress and loss in elderly population and the role of stressful events as a precipitant has become complex. Majority of the depressed persons identified negative events as precipitants. On one hand, it was considered that more biological form of depression did not have any environmental precipitant. But with the passage of time, with more in-depth investigations revealed the identification of triggering events. According to the study of Goodwin & Burney, it was found that many people who experienced negative life events do not become depressed. Some particular losses such as, retirement, loss friends and spouse death, may be very traumatic but do not necessarily lead to depression. (Goodwin & Bunney, 1973).

Psychosocial theories discussed the causes of depression within the context of person's internal mental feelings, relationship with environment and life events. Moreover these theories also have psychoanalytical, environmental, psychodynamic and cognitive explanation of depression (Minot, 1986).

In view of environmental explanation, depression may be caused in response to a relationship between stressors or inequalities in social support system and the

expression of depressive characteristics. Psychoanalytical theory discusses the role of psychic response to loss, anger turned against the self and regression in the development of depression. Psychodynamic theory deals with the development of personality over time and examines the impact of past relationships on the current self. Cognitive theory also presented the explanation of depression as the outcome of habitual reinforcement of negative thoughts about oneself, others and future.

Psychoanalytical theory views the role of psychic responses to anger turned against the self, loss and aggression in the development of depression. The environmental explanations of depression focused on the relationship between the stressor or lack of social support system and the expression of depressive characteristics. The habitual reinforcement of negative ideas about on self, others and the future are the main focus of cognitive perspective of depression. Practitioners, who applying the cognitive therapeutic interventions, they replace negative thinking with positive thinking and actions. Psychodynamic theory examines the development of personality over time and high lights the relationship between past and current self of individual (Minot, 1986).

Behavioral theories of depression have been presented by Ferster (1973) and Lewinsohn (1975), explained in a series of papers by Lewinsohn and his associates. This approach has a careful observation of the behavior of depressed people. Depressed ones engage in lower rates of behavior and receive lower level of positive reinforcement. The important aspect in depression, in view of behavioural theorists, is a loss of reinforcement, which may be due to the occurrence of losses of significant

people in one's life, erosion of positive exchange with other peoples. This decrease in positive reinforcement place a vicious cycle; the person reduces the out put of behaviour, further reducing the amount of reinforcement, which resulted in lower mood, behaviour output and so onward. Similarly the chances to become depressed increased due to decreased opportunities for obtaining positive reinforcement (Lewinsohn et al., 1976). Lewinsohn and his colleagues developed an instrument 'Pleasant Event Schedule' to examine a relationship between depression and behaviour. They expected that depressed people engaged in fewer pleasant activities and find fewer activities potentially enjoyable. This pattern has been found for both older and younger depressed ones (Lewinsohn & MacPhillamy, 1974).

A cognitive model of depression was presented by Beck and his colleagues. Cognitive model focused on the thinking patterns of depressed individuals. It deals with what the depressed people thin, how the people hold exaggerations and what they have negative appraisal of themselves and others? So this negative appraisal increases the chance of depression. They are not nor aware of their negative ideas and beliefs and theses cognitions are called automatic thoughts, as they constitute rapid and habitual ways to evaluate something. In this way, he distorts his or her cognition and emphasizes on the faulty logical patterns about the events and experiences of life (Beck, Rush, Shaw, & Emery, 1979).

According to cognitive theory the depression increases in the later life. Aging is linked with various types of negative stereotypes, expectations and many loses. All these negative views and losses with the passage of time cause the vulnerability

towards depression. One most important thing that is essential to become a good cognitive therapist is to be able to diagnose the distortion of person throughout the whole process (Zarit & Zarit, 1998 p. 73).

There is a distant overlapping between behavioural and cognitive approaches while dealing with depression. Lewinsohn's behavioural theory emphasize on negative thought patterns and social behaviour. Likewise, Beck's cognitive theory put stress on behavioural tasks as a helpful agent to generate and challenge negative cognitions (Zarit & Zarit, 1998).

### **3.3 Depression and Gender**

Depression among the general population has been estimated twice as common in women as in men (American Psychiatric Association, 1994). Older women were disproportionately represented among depressive diagnosis. One reason of this is the issue of survivability and higher females rather than males existed in the advanced age. Krause's (1986) study of older adults, indicated that older women showed more depressive symptoms associated with depressed affects, such as somatic complaints and retarded activities, than men do.

The family set up, occupation, education, age, gender, marital status, living style, personal and family income etc are the socioeconomic indicators in routine life. Our socio economic status is determined and measured by the factors such as the source of income of our parents (salary, investment, and a trust fund), their education, where we live, their occupation, and if our parents have money, how long they have had it (Kahl, 1957). Social class is also a sociological factor that is also important in

defining various characteristics of our lives. It influences quantifiable characteristics e.g. age at marriage, fertility and life expectancy (Bidwell, and Mey, 1999).

According to Blazer (2000), Depressive symptoms are more prevalent among aged persons and the percentage of depression triggers due to being a women, physical disability, increasing cognitive impairment, and low socioeconomic standing. If these factors eliminated then the relationship of aging and depression becomes weak. Among the oldest old, one year cases of clinically significant depressive symptoms are high which comprises 13% among those who aged 85 years or older (Meller, Fichter, & Schroppe, 1996).

The women who have chronic financial strain were identified having greater vulnerability to depression. In a study of 3332 non institutionalized elderly people in the city of Baltimore, it was concluded that the older adults residing in low status residential areas were showing three times more depressive symptoms as older living in middle status areas (Goldsmith et al., 1986).

### **3.4 Depression and Socioeconomic Indicators**

Faris, and Dunham (1939), were one of those who firstly indicated an inverse relationship between mental illness and socioeconomic status. They found a disproportionate rate of mental disorders in the poorest part of Chicago. Many other cross-sectional studies also shown that people in lower socioeconomic groups have more symptoms of common mental disorders (Skapinakis, 2006). Maclean and Hauser (2000) discussed an inverse relationship between depression and

socioeconomic status. It varies by age, gender and employment status. Measures of socioeconomic status (SES), particularly education and income showed a direct effect on depression in most studies.

All the indicators of socioeconomic status show their relationship with mental health yet community income, education and occupational status having more significant relationships. This indicates that economic status may be considered as major variable that draws a association mental illness and socio-economic status. This provided signification results about the direct and indirect impact of socioeconomic status with the unfavorable economic traumatic situation those groups having low income (Willenz, 2005). Moreover stressful life events, poorer coping styles, stress experience, and weak social support are reported as predictors of depression among the groups having low socio-economic status (Muntaner, et al., 2004).

The elderly may experience various losses as they grow older. During this passage, each loss triggers a grief reaction and each period of bereavement brings about changes. These changes will be resulted in the forms of confusions, disorientation and withdrawal. In this way each loss may be doubled and play a role of facilitator for the next one. This accumulation of loss added up in the older adults as they have no chance of getting new opportunities and new zest and zeal of life in contrast to the young ones (Matteson & McConnel, 1988). These losses are loss of job, retirement, change in social role, loss of significant others (Spouse, children, siblings, friends, pets), loss of strength and agility, loss of sexual power, poor health, loss in economic stability, relocation of home, loss of personal freedom, loss of

mental ability, loss of dreams, loss of self image and alteration in self image and decrease in acuteness of senses ( Hogstel, 1995 p. 119).

Some depressions are considered normal to the situation, just like the post and premenstrual depressions are different from pathological depression. Moreover, it is accepted if a person appears grief stricken when a significant other is lost, either through a temporary or permanent separation or through death. In Pakistan dependency on significant others is accepted if not encouraged. For instance in Pakistani society the children remain dependent on the social, economic and emotional support even when they become adult. The joint family system is used as an instrument to pertain and continue these feelings of interdependency. So in this environment a loss of significant others appear enormously, so intensive depressive reactions become inevitable. This phenomenon is more prevalent among the elderly people who always depends on others and phenomenon of significant others is essential in the last stages of life. Therefore the level of depression is greater among elders in society. (PhD thesis)

When an older adult person experiences feelings of separation from others, perceives a disruption of social relationships or experiences a discrepancy between the actual relationship and the desired relationship, then loneliness occurs (Copel, 1988). This phenomenon is prevailing rapidly, as 12 % to 40 % elderly were affected by isolation and it's the fourth major concern of the older adults, outranked only by poor health, financial difficulties, and crime (Burnside, 1988). Loneliness is an undesirable state. It is non-productive because the individual must expend energy to

protect himself or herself from the dreaded feelings of being isolated. When a person does not receive the required intimacy with others, at that stage he/she becomes emotionally paralyzed and helpless (Copel, 1988). Among elderly, forced separation from others have been identified as the major reason for loneliness, the loneliest older adults are those who have lost spouse within the last five years. Lack of contacts with children and old friends, lack of transport, phone calls, and accessible social activities may also precipitate loneliness (Ryan & Patterson, 1987)

Caregivers of the elderly play an important role in living normal life. The caregivers of physically and cognitively impaired older family members sometime feel anger, anxiety, and depression as a part of what has been termed care giver burden. Clinical depression has been found in family caregivers at greater rate than in the general population, so, the performance of care giver role must be considered a risk factor for depression (Cited in Hogstel, 1995, p. 124-125).

## Chapter- IV

### Coping

The concept of coping was derived from the researches of defense studies and psychoanalysis. The struggle of ego in response to the unpleasant ideas and feelings was called a defense by Sigmund Freud. Later on, Anna Freud supported the idea of defense mechanism and presented the idea that when an individual entangled within stressful conditions, he or she utilize preferred techniques. The Freud's thinking of unconscious efforts to manage distress provided a base to researches conducted on coping (Parker & Enler, 1996).

The advancement in the coping studies lies on the researches conducted by R.S. Lazarus. We observe that life events vary in nature and extent. Chronic life stressors require an individual to deal with repeated demands of the consequences in routine life. In this struggle, some individuals deal with the situation and use effective coping mechanism while others become helpless and do not deal the heavy load of mundane events of life.

According to the Lazarus (1966) the process of coping involves five stages i.e. environmental event, event appraisal (primary appraisal in which a person feel that something is at risk), secondary appraisal in which a person decides to change the situation, resource appraisal (coping activities ) where a person either adopt emotion focused or problem focused coping and at the end the coping outcomes

which may be either physiological (activation of the immune system, results in illnesses) or psychological impact (positive or negative mental health).

Coping has been derived from two different theoretical approaches. The first approach was based on the learning theory developed by Ivan Pavlov and his research fellow, who theorized that personality had been shaped by observable responses to the environment. Learning was based on classical and operant conditioning. This classical conditioning suggested that a learned response was either strengthened or weakened by positive or negative reinforcement (Schriver, 2004).

The second approach was based on Freud's theory of psychoanalysis. This process-oriented approach defined coping as a way of thinking and actions in response to handle the problematic situation. Then the research work of Folkman and Lazarus (1984) gave a new dimension to coping as a process, viewing coping as a continuous response to stress in various life events. They viewed that stress may be resulted from the environment and the individual response to the stress. According to Folkman and Lazarus (1988) this approach was based on four key concepts.

- i. It involves a process.
- ii. It deals with the management rather than mastery.
- iii. It involves no a priori judgement while dealing with types of the coping process.
- iv. Coping does not based on automatic responses but focused on cognitive process.

The trait oriented approach focused on the idea of coping as a personality construct, which remained constant in different situations. But the process oriented approach discussed the coping as; it may be judged in the context in which it appears. Its adaptation vary from situation to situation and will be adoptive in one situation but not in the other situation. For example, denial is considered maladaptive response but in certain situations it may be categorized as adoptive defense mechanism such as immediately following a trauma (Folkman & Lazarus, 1988).

In the broader sense, , coping is often conceptualized in two dimensions i.e. problem focused coping that directed towards direct dealing with the state of affairs and the other form of coping that deal with the management of negative effect of the prevailing condition is called emotion focused coping (Lazarus & Folkman, 1984). There may be different methods to mange in routine life coping. For instance, while coping emotionally, one person may ask for social support or he or she may apply denial and these may be categorized as adaptive or maladaptive ways in daily life (Carver, Scheier,& Weintraub,1989). These maladaptive strategies may initially helpful for a person to adjust a situation; but with the passage of time, the long term use of the strategy may not be so effective. For example, this expression of negative thoughts may be useful in the beginning stage, yet the continuous application of this strategy may divert attention from the real thing and it will create problems in effective coping (Carver et al., 1989).

Adaptive coping strategies facilitate the improvement in psychological well-being which results positive for medically ill populations. The application of strategies like acceptance, active coping and planning is beneficial to deal with the stressful

conditions. Carles apply these coping in a sample of heart patients and found positive results (Carels, 2004; Carver et al., 1993). In another study it also concluded that acceptance and humor has positive relation with lowering stress while denial and disengagement revealed negative association with distress among cancer patients. These maladaptive coping strategies have relation with increased negative emotions, low quality of life, and mortality (Burker, Evon, Sedway, & Egan, 2004; Carver et al., 1993).

There is difference between the problem solving coping and emotion oriented coping, viewing that emotional coping regulates the emotional responses to a problem while the second one is directed at managing and changing the situation. When a person becomes hopeless and consider that there is no solution to problem, he or she adopted emotion oriented coping to lessen the distress. It involves the cognitive strategies i.e. distancing, avoidance, selective actions, reappraisal and self criticism. One form of emotion oriented coping is called reappraisal, in which the actual situation remain the same but only the thinking of a client is changed. In case of amenable situation a person adopted the problem solving coping. In this case a person, triggers his or her inner self, looks at the alternative actions, judge the situation either positive or negative, then take action (Lazarus & Folkman, 1984).

#### **4.1 Coping and Adaptation**

People use several processes to deal with changes in everyday life. These changes require adaptations which can occur in ourselves or in the external environment. The human beings adjust to certain amount of changes automatically and exert no special

extra struggle in normal routine life. However some changes exceed our capacity for such routine adjustments that require unusual steps to deal with them. Now this process of making adjustment to fit a situation or environment is called adaptation. Adaptation is both internal and external process. It encompasses assimilation of new information about changes in the self and in the environment. Form the external view; it involves the behaviour modification in order to equalize the changes in the external world.

These particular coping skills may change with the passage of time in response to the perception level of individuals. We adjust to aging through regular routine life adaptations and by mobilizing coping skills to deal with crises. At the first stage, with the aging, the changes are dealt routinely but overtime a person reaches to a stage where he or she requires major adjustments and a corresponding mobilization of personal and social resources. But in case of sudden and serious changes in personal life, requires conscious coping and social support. For instance, we usually adopt to age changes in appearance gradually and routine wise, whereas adopting to sudden and severe disability requires proper coping skills and social support (Atchley & Barusch, 2004).

Clark and Anderson (1967) reported that people adopted various ways to deny aging. In case of physical appearance, they tried to avoid looking old through the use of cosmetics, hair dyes, figure control device. People also sought to deny aging by attributing their limitations to sickness and weakness rather than old age. Some people tried to deny aging by refusing to follow the rules. This strategy would not be considered bad if the person in actual had the capacity to handle the things. However,

it becomes maladapted behaviour when the individuals level of functioning means that continuation is not a real possibility.

However, many of the older adults realized that the long term understandings of life and achievements constituted a useful framework to adopt new life routines. This phenomenon exhibited among the retired elderly as they have to go through the shift in goals in routine life. For instance, in spite of seeking individual achievements, retired individuals may seek to contribute to the achievements of groups devoted for the community services. At the final stage, retired people considered that the material things had less importance and they drift towards the relational and spiritual values (Atchley, 1999).

Research studies shows that there is no consensus on the effective adaptations, some focused on the behavioural capacities or social integration, while the others emphasized on the person's subjective evaluation of his or her life. The internal adoptive process will be effective if the person has a high degree of life satisfaction which enable him or her to remain relatively psychologically autonomous and maintained a personal sense of life meaning. External adaptation will be called effective if the individuals maintain social ties and persist to take rewards for participation. These are not only the outcomes of effective adaptations and to cope with the situations but also there are many other pathways of effective adaptations (Rowe and Kahn, 1998).

## 4.2 Definitions of Coping

*Coping* can be defined as;

“Constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141).

“Coping styles are the specific ways individuals respond to stressful circumstances” (Murberg & Bru, 2001).

“Coping means contending with or attempting to overcome difficulties. Overtime , we develop various skills of thought and behavior i.e. coping skills, that we use to grapple with problems we encounter in everyday life” (Atchley & Barusch, 2004, p. 163).

## 4.3 Coping and Aging

Aging is frequently linked with prominent traumatic life changes and challenges. Physical disabilities may deter older adults to participate in routine life activities, the need for care and the feeling of becoming dependent not only pose challenges but create a sense of being a burden within the family set up , and the erosion of social support network starts with the loss of family and friends. In spite of these barriers, many older adults adapt various coping mechanisms/strategies to face the changes in their lives.

When a person grows older, he or she suffered from the decline in physical, functional, economic and role. Literature supports that all these deteriorating changes with aging are considered as major stressors among elderly (Ensel, peek, Lin, & Lai,

1996; Peek et al., 1997; Everard, Lach, Fisher, & Baum, 2000). Physical decline and functional changes causes deterioration in older African American whose preexisting state is already overwhelmed due to the limited health services,(Smedley, 1999; Fiscella,Franks, Gold & Clancy, 2000) and low socioeconomic status(Ren, Amick, & willaim, 1999). These changes drift the tendency of elder persons towards the emotional focused coping rather than problem solving coping.

Moreover, loss of important roles of elderly triggered stress and effect mental health, causing depression which impedes coping (Cochran, brown, & McGregor, 1999). This situation also triggered by economic losses. In the studies of elderly African Americans, economic conditions not only effecting adversely to aging but also reduces the resources for coping (smith, 1997; Bowles et al., 2000).

The acknowledgement of the changes in the environment is normal behavior to apply the normal coping mechanism. It is clear that aging pose effective change in the personal performance of individuals and if a person denies acknowledging these changes, then this maladaptive behavior creates an unbalance situation. This maladaptive reaction to age changes which prevents an internal reconciliation with an external environment is call denial.

The elderly encounters various physical, psychological and social changes as they grow older; therefore they have to adopt certain coping strategies to live normal life. Sometime these coping are made in response of positive changes i.e. enjoying the freedom from the routine life and leading satisfactory retired life. But on the other hand due to increased physical, financial and social dependency, an older adult has to

adopt various coping mechanisms as aging cause's changes in relationships, life style, housing needs, income and other matters of life. Three general strategies elderly use in adapting to aging i.e. continuity, anticipation, and compensation (Atchley, 1989, 1999).

According to Atchley, (1999) continuity means "Recurring themes and persistent patterns in which details can change as long as basic patterns are maintained same". Continuity is an adoptive strategy which can be internal and external. Internal continuity deals with the persistence of ideas and thinking whereas the external refers to living with familiar people in the familiar environment. Continuity does not mean that there will be no change but it deals with new experiences of life with a solid background of familiar and persistent attributes and processes of self and the environment. The level of continuity varies from person to person as the greater weight of previous experiences and skill in life exerts pressures towards continuity. The more experienced a person more the pressure towards continuity.

Atchley, (1989, 1999) talked about the continuity, with the concept 'fitting in' that he or she tried to adjust in the new situation to fulfill their needs by keeping in view the past perceived experiences. According to Kaufman, a constant restructuring allowed a person to sustain a feeling of harmony about themselves and a feeling of relation with the parts of their pasts that they believe related to those who they were at the present (Kaufman 1986, p. 150).

Anticipation is the realization of situation before actual happening that can minimize or eliminate negative aspects and promote the positive aspects of change e.g. millions of people are going to use proper exercise to maintain the blood

cholesterol level and financial planning to deal with social need with low income after retired life. Compensation involves taking measures to make up for a loss. People usually remain idle and accept the negative changes in life by considering that it's the will of God or fate. It is the first step that often elderly take to compensate losses with aging. For instance, eye glasses and hearing aids are the compensation for physical age changes but the social losses are compensated by social support through family members and people with whom to socialize (Atchley & Barusch, 2004).

Baltes (1993) developed a theory of adaptation relating the idea of compensation. He presented a theory that losses of functional capacity will be attained by a process of selective optimization with compensation. The main point is that people do not simply accept to functional decline; they use selection, optimization and compensation to create sufficient functional capacity to continue the enjoyment of life.

Some authors discussed the changing nature of coping mechanism as a person grows older. This change is visible as the sources of stress changes e.g. due to the health problems, elderly loses their control and they may mostly use emotion oriented approach to solve their problems. In another study of Lazarus, et al., 1998, he conducted a study between the younger having age group 34 to 44 and older 65 to 74 married couple and found that the younger adopt active and problem solving coping while the older people showed passive emotional coping.

Several theoretical approaches explain the coping and aging in literature. Attributional theory theorized that depressive reactions to the stressful events are

mostly occurring in response of stable and global causes. A stable attribution deals with unchangeable factors while the global attribution relates to the factors affecting many areas of life. Individuals who view the causes of negative events as unchangeable and affecting many areas of life may become the victim of depression more likely than others. Hopelessness leads towards the depression. The hopelessness theory also proposed that hopelessness is positively associated with depression. (Houston et al., 2000).

Rosenbaum (1990) presented concept of learned resourcefulness that based on set of control behaviours and skills to manage the distressing situation. People who have low learned resourcefulness are more likely to be depressed than those who have high resourceful learned behaviour (Lewinsohn & Alexander, 1990). Assimilative and accommodative coping are two different coping processes to adopt the confronting situation. In assimilative coping process, people stick to a self established definition or concept in daily life events while the accommodative coping process based on the reassessing of self-definition. Therefore the accommodative process facilitates to elderly in readjustment and keeps them away from depression (Brandtstadter et al., 1997).

#### **4.4 Coping Strategies among Elderly**

Atchley (1999) presented three major ways of elderly copings in daily routine life. They coped through relationships, positive attitudes and spirituality. These three coping mechanisms/strategies were estimated by 80 percent, 47 % and 25 % of the respondents respectively. He also presented others coping strategies i.e. situational

factors (sound mind, good health) and having goals-keeping productively busy, services to others and having responsibilities and obligations. Koenig (1995a) also reported that 30 % of the elderly from the community setting were used to adopt religion as a coping strategy.

The major coping strategy in case of lack of financial sources is learning to make do with less income. Living within own means is the best strategy among elders to pass their lives happily. As one elderly female told, 'i was raised and taught all my life, waste not want not', we never buy anything on credit if i did not have money. In the same way, the adjustment to reduced income lies within cutting the extra luxuries, such as transportation and special clothing etc. (Day, 1991, p. 260).

In case of physical disability, the older adults have to face the socio-cultural stigmas that constraint social opportunities. In the western culture where concept of person- hood assumes a fully functioning body and mind. So the people who have low mental and physical capacities, required for full adult functioning are often treated as less than fully human. Disabled and chronic ill persons internalize these negative feelings of society which can cause lower self esteem. In the reaction of this negative assessment, they inclined towards the withdrawal reactions such as social isolation (luborsky, 1994). In coping with theses physical and mental disabilities, elders are caught in the middle of two contradictory cultural principles; autonomy and institutionalized care. In this way on one side person tried to solve his or her problems with personal efforts and on other hand professional services should be provided to solve their problems (Atchley & Barusch, 2004).

In case of increased dependency, the major task for the elderly is to learn how to accept help from others without losing one's own self respect rather than only the provision of assistance. In this regard, Lieberman and Tobin (1983) suggested that individuals who are able to adjust well to increased dependency need two things. First, sufficient physical and mental resources to mobilize the energy used to adopt and secondly, tough mindedness about their own worth. Gerontologists emphasize on the loss of roles among the older adults. Havighurst (1963) and Rosow (1967) presented activity theory, in which they focused that unless the physical and social dependency in old age, elderly had the same social and psychological requirements as the middle aged persons. They theorized that participation of aged people decreased due to the withdrawal of society from aging people and most of them dislike this societal withdrawal and they wanted to continue their role and status in society. However this concept of activity theory was also supported by the research work of Cutler and Hendricks (1990) as the reduction with age in the number of roles are related to reduction in opportunity.

Elders who are engaged in different activities and have a lot of assignment to do, they do not need to find new roles and activities to substitute for those they lose. They feel relaxed and easily redistribute their remaining roles and activities. Atchley in his earlier work called this consolidation. In case of retirement, people used to adopt this coping strategy to compensate their role loss through consolidation.

Consolidating approach is not applicable for those elders who already have few activities and in case of loss of these few activities they undergo feelings of

depression and loneliness. Thus these people are forces to disengage. Consolidation may also not a good solution if most important tasks are lost by a person. For instance in the Asian society, the important family matters (decision making and matrimonial matters) are solved and managed by the elders. If they lose this role, they become tensed and frustrated.

Streib and Schneider (1971) suggested the concept of differential disengagement in which people withdraw from some activities but engage in some other type of activities to balance and maintain their participation level. This differential approach is similar to the consolidation approach. This concept also supported by Troll, who discussed the role shifting of elders within the family set up. She reported that the older people compensate their loss of roles by increasing their involvement within the other family matters.

Martin and his research fellows (2001) conducted a study to review age, gender, education and ethnicity in precise modular coping behaviour. They found that support a positive association of education, religion and specific coping behaviour among elderly. It was investigated, the oldest old person in comparison with other old age groups used more religious coping, acceptance, and depended less on others. Gender differences were also noted in coping methods. As most of research studies revealed the women to be more religious than men (Levin, Taylor, Chatter, 1994; Krause, 1995). Similarly the educated people used problem focused coping while the less educated were used to pray or religious coping. The education increased the ability to cope with the stress through problem solving coping (Lazarus & Folkman, 1984).

Robert and Elder (2008) conducted a study on elderly men and discussed the four aging aspects to confine the appreciable complication of adjustment, activity, and engagement in the later life. They reported that some respondents experience decline and tension in later life while the remaining considered as a new arrival and activity. It was concluded not a single factor or a few happening may contributed to built these patterns of life at the time of old age but it shaped by the complex experience in the physical, psychological and social world. These lifelong experiences influence aging style in their own right by capturing the nature of the individual pathways throughout life, not simply by establishing current circumstances.

This study present current idea of aging research by keeping in view successful adjustment among older adults. The four styles of aging, well rounded, family focused, less adjusted and career oriented were finalized. Contemporary health and socio-economic status pointed out more successful aging styles i.e. away from current circumstances, stability in long term marital relation, alcoholism, religious involvement patterns, and particular traumatic experiences also related to aging style. Moreover, similarities existed between the less adjusted and the career-focused men, whereas family-oriented and those having better adjustment respondents revealed the similarities in coping styles in later life.

Older people felt threat to self-concepts due to the loss of independence and increasing vulnerability. They may cope with these threats by using the defense mechanism, develop an acceptance of themselves as aging people and focused their maintained competence. Majority of elders use the past to maintain their image as a

worthwhile. The company of friends and familiar community members facilitated this process of sustaining the image of self respect and worth. In this way they interact with their fellow beings, sharing their past and may well had participated in his or her life history. When we interact with elderly in routine life, we must kept in mind that talking about the past accomplishments form a basis for their maintenance of self esteem. Moreover, the acceptance of change in roles and responsibilities among elderly that were appropriate to evaluate their self may also form a basis for maintaining self esteem. Apart from their capacities to continue in position of leadership and other achievements, societal disengagement and age discrimination combine to make continuation an unrealistic goal for many elderly ( Atchley & Barusch, 2004).

Krause (1999) studied the coping among the elderly and found that self worth is intimately related to the roles occupied by the elders. Krause reported that the elderly in the stressful situations were less likely not to throw away roles but hold on to important roles. The most important roles were spouse and parent.

Some older adults were not able to maintain a sense of continuity and failed to compensate the loss of aging in later life. In this condition, they crossed the limits of trying to cope the situation that leads towards the escape through isolation, drugs addiction and suicide. However, the use of alcohol and drugs were less among older person rather than younger ones. But the isolation and suicide was more prevalent among elderly than young people and then white older persons had greater ratio than black older persons. People with addiction problems in later life tend to have had the

problem when they were young. Research studies reported that white men over 75 were much more likely to commit suicide rather than other age-sex groups in the united nations. Depression, bereavement, rapid physical deterioration, cognitive impairment and living within the institutional setup are the prominent risk factors towards the suicide among older people (Atchley & barusch, 2004).

When we are talking about the effectiveness of coping strategies, its clear the coping strategies are effective among healthy older adults rather than elderly who are mentally ill. As coping effectiveness is difficult to assess because number of parameters are involved to observe the effectiveness of coping such as long term health, psychological well being, and perceived effectiveness. McCracc and Costa (1986) studies coping effectiveness in 151 elderly men and women. The coping strategies were found more effective in problem solving strategies than emotion oriented strategies including hostile reactions, self blame, wish full thinking and passivity. It was also investigated that coping strategies were found positively associated with the psychological well-being (McCracc and Costa, 1986).

#### **4.5 Religious Coping and Mental Health Problems**

In stressful situations the religious coping refers to behavioural and cognitive responses. In the early studies, religious coping was only considered as source of soothing and support but in the later research work it was taken as a specific religious coping pattern with its positive and negative influence on health of individuals. In this regard, Pargament and his co-workers (1997) studied a relationship between religious coping style and mental health outcomes. Stress and coping model by Pargament,

religion plays a multifarious role while operating as a coping mechanism in response to the stressors. Moreover, religion not only influences the coping process but also deal with its outcomes where religion acts as a motivating force. According to Pargament (1997p.90) religious-spiritual coping is defined as;

"A process that people engage in to attain significance in stressful circumstances"

Pargament, Smith, and Koenig (1998) described two types of religious coping as follows.

I) Positive religious coping includes religious persistence of beliefs, assessing the stressful situation by having a generous spiritual way of coping with the situation, seeing God as loving, a relationship with God, seeking support from God, from clergy and religious persons and engaging in religious rituals.

II) Negative religious coping, encompasses feeling of unhappiness, abandonment, feeling of insecurity, hopelessness and resentment from God.

Religion acts as a stress bumper in case of stressful conditions and mental health problems in routine life activities. Religion coping is more effective in depression and anxiety. In this case a person felt a support, transcendent force and protection and love of God, this significant relationship between a person and spiritual force decreased the feelings of loneliness which built a hope and consequently decreasing the depression (Krause and Tran, 1989).

The recent studies on religiosity and coping indicated a complex relationship between religious practice and mental health problems. A relatively mentally fit

person who has adequate resources may find no need for religious solace whereas an individual with fewer resources having mental distress may turn to religion. Therefore religion seems to be more important in the lives of the elderly than it is in the general population. Religious coping seems to be greater important for aged persons because it is firmly believed that religious coping increases as person become vulnerable to sickness or nearer to death (Bosworth, 2003; Koenig, 2006; Pickard, 2006). Moreover Koenig indicated that 67 % of seniors aged lying between the age group i.e. 65-75 years reported that religion is very important to them (Koenig, 2006)

Another research work conducted with Chinese elders aged 60 years and above examined adherence to tradition and depressive symptoms. This study reported a positive association between adherence to traditions (including religious practice) and lower level of depression (Mjelde-Mossey, 2006). The persons who were more depressed tended to use more emotional oriented coping rather than problem oriented coping (kraaij, Garnesfski, & Maes, 2002).

Braam and his research fellows (2004) conducted a longitudinal study to report a link between the indicators of religious attachment and six years course of depressive symptoms among Netherland's elderly. They found positive association between church attendance and depressive symptoms. Those who regular went church had low level of depression.

#### **4.6 Gender Difference in Coping Styles**

When we are talking about the variation in coping styles, the research reflects mixture of results. Classic coping research work has revealed that emotional coping

style is more adopted by female rather male (Ptacek, Smith, & Zanas, 1992; Simon, 1995; Stone & Neal, 1984; Vitaliano et al., 1990). current studies also estimated that women use more emotion-focused techniques like crying, looking for assistance, and dwelling on the source and reasons for their depression in comparison with elderly men (Anshel, Sutarso, & Jubenville, 2009; Garnefski et al., 2003; Li et al., 2006). A contemporary study (Daughtry & Paulk, 2006) focused to assess sex differences in coping qualitatively rather than using traditional quantitative methods. They found that both men and women utilized many coping strategies, comprising of various types of coping responses and showing greater percentage regarding the help seeking behavior as compared to males.

According to Hagedoorn and his research fellow, due to differences in gender identities, stressors having a negative effect on women may did not have negative effect on men, and the stressor for males have different nature than women. Literature depicted that women were more stressed by the social and family relationships. On the other hand, financial issues caused more tension among men. In the same pattern, life partner's mood and health conditions were strongly associated with the elderly female's psychological well being rather male (Hagedoorn et al., 2002).

Another current study (Hoverton & Gundy, 2009) resulted the extent of difference by sex. This research focused three coping styles i.e. Problem focused, emotion focused, and avoidance focused. Results indicated complex association among sex, coping, chronic strain, and depression. There was no difference in case of problem-focused coping by sex, while women used avoidance-focused strategies frequently.

This more use of emotional coping among women did not demonstrate any harmful impact in daily life of women. Previous researches pointed out that this difference of coping strategies between men and women was due to the increased stress experiences among women. That's why women used more emotion and avoidance coping style rather men because they have to face more chronic stresses as compared to men.

## **Chapter V**

### **Research Methodology**

Methodology techniques are of key importance to investigate the social phenomenon in empirical way. The scientific methodology is a system of explicit rules and procedures upon which research is based and against which claims for knowledge evaluated (Nachmias, 1992). These research approaches vary from discipline to discipline and depending upon the nature of study conducted. In order to inquire various research questions different study designs are applied. Quantitative research acquires to make out determinants in a sample that can be assessed to be true of the targeted universe. The sequence of methodology to carry out research for data collection and for estimation is described in terms of the universe of the study, respondents' selection, sampling techniques, sample size, interview development and data analysis techniques. It furnishes the study design, criteria for respondents' selection, sampling, sample size, selection and tool development and various statistical applications used for data analysis and interpretation.

There are three types of research studies i.e. descriptive, causal, and exploratory. Current study is basically descriptive, descriptive research involves collecting of data to test hypotheses or answer research questions relating to the status of the theme of the study (Gay, 1996).

#### **5.1 A Brief Overview of the Study Area**

It's essential to have a brief indication of the targeted universe so as to make the

reader to have a clear understanding of the research techniques and methodology being adopted for the study before probing various tools and techniques used for the current study.

### **5.1.1 Pakistan**

Pakistan (Islamic Republic of Pakistan), its population 153.45 million (NIPS, 2005) which has been raised to 193, 238,868 according the Pakistan Demographic Profile, 2013.

Pakistan is encircled by India on the East, the Arabian Sea on the South; Pakistan got independence in 1947 by British, and emerged to be its descendant which was segmented on religious basis. After the independence, it comprised of east and west portions but after twenty five years restricted to only west region. Geographically, Pakistan was the centre of the Indus valley civilization in primeval period that was invaded by Aryans, Persians, Greeks, Arabs, Turks, and other rulers. Islam was pioneered in 711 in this era as the main religion. After this, the Mughal Era started and their rule prolonged from the 16<sup>th</sup> to 18<sup>th</sup> century but later on it was occupied by British. During the British government, the Muslim community has to face multifarious problems as majority of them were illiterate. This discrimination with the Muslims forced them to struggle for a separate country and then Britain had to accept their demand of separate home land. At the end Pakistan came into being as an independent state in August, 1947.

The inhabitants of Pakistan belonging to different races or tribes who are enjoying various cultural traditions in different regions. In northwest of Pakistan, the province

of Punjab is situated. Pakistan is an Islamic state where Urdu is used as a national language while Punjabi, Sindhi, Pashto, Balochi and Brahvi are spoken as regional languages in respective areas. With the advancement in the medical sciences and improvement of health services the physical and mental health status of Pakistani inhabitants has been improved. But still there existed medical issues i.e. illness, disease and undernourishment and still required efforts to improve the standard of living of Pakistani population.

Almost half of Pakistani economy base on agriculture and rice, wheat, sugarcane, cotton and tobacco comprised as major crops of Pakistan. Live stock as well adopted by Pakistani population to earn their livelihood. Due to the extensive irrigation system, it has become self-sufficient in food. Industrial network enabled it to render many of the country's requirements and the natural resources of country fulfill the demand of raw material in textile, oil, metal processing and fertilizer production. The overseas Pakistanis contribute in the Pakistani foreign exchange as second largest source.

### **5.1.2 Punjab: The Study District**

The province of Punjab is most thickly populous and affluent in Pakistan where Punjabi residing along with a variety of other groups. Punjab is the most peopled province of Pakistan, having 86084,000 million populace in 2005 (Wikipedia, 2009). Lahore is the provincial capital of Punjab. The name Punjab literally translates from the Persian words *Pañj*, meaning "five", and *Āb* meaning "water". Thus "Punjab" can be translated as "(the) five waters"- and hence the *land of the five rivers*, representing

to the Indus, Ravi, Sutlej, Chenab and Jhelum rivers. The populace of the province is estimated to be 86,084,000 in 2005 (Govt.Of Punjab, 2009)

The proposed study will be conducted in the central Punjab. Punjab has three zones i.e. Southern Punjab, Central Punjab, and Northern Punjab (Nizamuddin, & Masood, et al. (2010). The major reason to selected central zone of the Punjab is that it is the largest zone in terms of population and it has impact of mass media, industrialization, changing life styles and family structure, cultural diffusion as compared to other zones. Moreover the reason for selecting central zone is its geographical proximity to the researcher. The data will be of quantitative nature.

## **5.2 Research Questions**

1. Which group of the aged, gender and area wise, faces more mental health problems?
2. How mental health problems affect their social functioning?
3. How do they cope with their mental health problems?

## **5.3 Objectives**

1. To find out the major causes of mental health problems among aged.
2. To study the attitudes of family members towards aged.
3. To probe into the coping mechanism of aged with their problems.
4. To share the findings of the study with the concerned departments for welfare of aged.

#### **5.4 Hypotheses of the study**

1. Female elderly have higher levels of mental health problems than male elderly.
2. Mental health problems are more prevalent in urban areas than in rural areas.

#### **5.5 Scope of the Study**

This is qualitative and quantitative work to describe and understand the recent situation of elderly people and social forces which affect their mental health. It is important to gain an objective understanding of what happens to people as they reach the age of 60 years. The main focus of study will be on the fact finding of the major causes of mental health problems among aged people and attitude of family members towards aged that may lead them to the disturbance of mental health. Generally, the researcher would highlight the factors, changes, challenges, risks and opportunities causing mental health problems to elderly people that have not yet been fully explored.

This segment of elderly population is more affected by these factors as compared to younger and other adults. Moreover the evidences relating to the disconnected and separate lifestyle of elderly people is going to increase day by day. Examples of these neglects and abuse, as well as violence against the elderly, are no more ignorable. Though the adults are caring their elders, yet a large number of the elderly are living in distress and uncomfortable circumstances.

Moreover, this study will accumulate information regarding the policy and national plan of actions for the aged persons in coming future at the national level as

no consolidated work has been done on this topic in Pakistan, in general, and particularly in the province of Punjab.

## 5.6 Universe of the Study

Universe is the area of the study where investigation and research is to be conducted. The universe of this study was Central Punjab and elder persons (60 years old and above) were taken as a human universe from four districts (Sargodha, Gujrat, Kasur and Toba Taik Singh) of the central Punjab, Pakistan.

## 5.7 Sample Size

The sample size was 624 elderly. The elderly population constitutes six percent of the total population of the Pakistan (aged population 11.5 million and Pakistan population 185 million). (Nizamuddin, & Maqsood, et al., p. 8) Therefore, the 6% population of the aged was drawn statistically from the total population of the central Punjab i-e 2921280 which is consider the target population to take sample. The total size of the sample would be taken by using the formula  $N/1+Ne^2$  given by Taro Yamane (Yamane, 1967, p. 95) in 1967. The sampling error is fixed to 4%. Male and female (60 & above) were interviewed for this study.

$$\text{Sample size} = N/1+Ne^2$$

N= Total population

e= Margin of error

$$\text{Sample size} = N/1+Ne^2$$

$$=2921280 / 1+2921280 * .0016$$

$$=624$$

### 5.7.1 Sampling Design

Multistage sampling method is used. Central Punjab is divided into sixteen districts.

- At first stage, one-fourth of the districts from Central Punjab were selected by applying simple random sampling technique. The simple random is a probability sampling technique, means ‘that each one in the survey populace has an equal probability of being selected for investigation’. (Browne, K. 2002. P. 424). This is most commonly done by numbering all the names in the sampling frame and then getting a computerized numbers at random to fill the sample size.
- At the second stage, one tehsil from each selected district is picked through simple random sampling technique.
- At the third stage, urban and rural blocks/strata are selected from each of the selected tehsils. Both rural and urban areas i-e city and town have been divided into blocks consisting of an average 250 households. In this way, 250 households represent one block/stratum both in rural and urban areas.
- At the fourth stage the total sample is finalized by applying the formula i.e.

$$\text{Sample} = \frac{\text{Total Blocks of Selected Tehsils}}{\text{Total Blocks of District}} * \text{Required Sample}$$

### Total Blocks of all Tehsils

- Last step being the selection of respondents, snow ball sampling technique was applied. Equal representation will be given to both rural and urban areas.

### 5.7.2 Sample Drawn From Rural Areas

Sr. No	Selected Districts of central Zone of Punjab (in bold)	Population	Selected Tehsils/ Towns ( in Bold)	Total Households*	Total Blocks	Total Sample
1	<b>Sargodha</b>	<b>3091000</b>	Balwal Sillanwali <b>Sargodha</b> Shahpur Sahiwal	<b>94489</b>	<b>378</b>	<b>83</b>
2	Gujranwala	4210000				
3	<b>Gujrat</b>	2421000	Kharian <b>Gujrat</b> Sarai Alamgir	<b>108309</b>	<b>433</b>	<b>95</b>
4	Hafizabad	988000				
5	Jhang	3333000				
6	<b>Kasur</b>	2894000	Chunian Kausur <b>Pattoki</b>	<b>73346</b>	<b>293</b>	<b>65</b>
7	Lahore	8188000				
8	Sheikhupura	2508000				
9	Sahiwal	2167000				
10	Narowal	1466000				
11	Pakpattan	1553000				
12	Okara	2678000				
13	Faisalabad	6555000				
14	Sialkot	3277000				
15	<b>Toba Tek Singh</b>	1902000	Gojra Kamalia <b>Toba Tek</b>	<b>78512</b>	<b>314</b>	<b>69</b>
16	Nankana Sahib	1457000				
Total		<b>48688000</b>		<b>354656</b>	<b>1418</b>	<b>312</b>

\*Source: PCR, 1998, Census Bureau of Organization, Islamabad

### 5.7.3 Sample Drawn From Urban Areas

Sr. No	Selected Districts of central Zone of Punjab (in bold)	Population	Selected Tehsils/ Towns	Total Households*	Total Blocks	Total Sample
1	<b>Sargodha</b>	<b>3091000</b>	<b>Sargodha</b> Sillanwali Bhalwal Shahpur Sahiwal	<b>66156</b>	<b>265</b>	<b>146</b>
2	Gujranwala	4210000				
3	<b>Gujrat</b>	2421000	<b>Gujrat</b> Kharian Sarai Alamgir	<b>51936</b>	<b>208</b>	<b>114</b>
4	Hafizabad	988000				
5	Jhang	3333000				
6	<b>Kasur</b>	2894000	Chunian Kausur <b>Pattoki</b>	<b>15499</b>	<b>62</b>	<b>34</b>
7	Lahore	8188000				
8	Sheikhupura	2508000				
9	Sahiwal	2167000				
10	Narowal	1466000				
11	Pakpattan	1553000				
12	Okara	2678000				
13	Sargodha	3091000				
14	Sialkot	3277000				
15	<b>Toba Tek Singh</b>	1902000	Gojra Kamalia <b>Toba Tek Singh</b>	<b>7948</b>	<b>32</b>	<b>18</b>
16	Nankana Sahib	1457000				
<b>Total</b>		<b>48688000</b>		<b>141539</b>	<b>567</b>	<b>312</b>

\*Source: PCR, 1998, Census Bureau of Organization, Islamabad

## 5.8 Tools of Data Collection

1. Three instruments have been used in this study to access primary data which are named as:
  - Interview Schedule developed by the researcher.
  - Self Reported Questionnaire (SRQ-20) developed by WHO.
  - Geriatric Depression Scale (15-items)
2. Secondary data will be collected from library studies of existing literature.

The interview schedule has been developed by the researcher after getting in depth site to the relevant literature and keeping in view of the prevailing culture in the target population. Interview schedule was developed to collect information. It contains closed ended and open-ended questions to access specific and in detail information. Interview schedule constitutes four sections i-e Socio-economic profile of the respondents, family attitude, risk factors of mental health problems and coping mechanism of elderly.

The current study has been conducted in community setting rather than psychiatric setting and the researcher was primarily concerned with the mental health problems of the aged ranging from feelings of insecurity and unproductiveness, maladjustment, loneliness, frustration, dissatisfaction, stress, depression and anxiety.

### **5.8.1 Self Reporting Questionnaire (SRQ-20)**

The WHO recommended the SRQ to test the psychoanalysis distress and mental health problem while dealing with different situations in different settings. It was used by WHO in Third World countries where the mental health services are not improved (WHO Division of Mental Health, 1994 p.43). In this study the SRQ-20 will be used to evaluate the mental health problems of aged population in Central Punjab. It is expected to show reliability and validity for case detection in the target population. This questionnaire consists of twenty questions, which have to be answered yes or no. It contains the neurotic items only, reflecting depressive symptoms, anxiety and psychosomatic complaints. This instrument is self reporting questionnaire but in case of illiterate respondents, it may be used as interviewer administered questionnaire. Therefore questions may be asked aloud by the interviewers in local/regional language (Scholte, et al., 2011). The SRQ-20 had been used in many community based surveys conducted in developing countries (Ventevogel, 2007).

The SRQ-20 items are scored 0 (absence of symptoms i-e No) and 1 indicates to the presence of symptoms i-e Yes. These item scores have been summarized to obtain a total score. A cut off score has been used 7 to 8 in most of the studies and same cut off used in the current study. However the optimal cut-off score varies across cultures, gender, languages, and settings etc (Scholte, et al., 2011).

### **5.8.2 Geriatric Depression Scale (GDS-15)**

As the needs and problems of elderly people and their daily life activities are different from adults, so I used Geriatric Depression Scale (GDS-15) to measure depression in the community settings that deals particularly with depression among elder, as depression is considered inevitable in this stage of life and stood at fourth position as a public health problem (WHO, 2001).

There are many scales to diagnose depression in community and institutional settings. This geriatric depression scale is a self-report instrument having thirty questions. Depression, in particular minor depression, is common among community-dwelling elderly (Beekman et al., 1999 and David, J. et al., 2004). The recognition of depression among aged population is difficult due to somatic co-morbidities and depressive symptoms may be expressed as a result of frequently happening of negative life events and illnesses (Pouget et al., 2000). The 15-item Geriatric Depression Scale (GDS-15) developed in 1986, is short, less time taking version that has been considered to screen for depression among elderly (Sheikh and Yesavage, 1986).

Of these fifteen items, ten represents the presence of depression when answered positively, while the remaining (question numbers 1, 5, 7, 11, 13) indicated depression when answered negatively. From 0 to 4 are considered normal, 5-8 point out towards the mild depression while 9-11 indicate moderate depression and 12 to 15 indicate severe depression.

## **5.9 Pre-Testing of Interview Schedule**

Pre- testing of the questionnaire is the pre-condition of data collection. It provides not only accuracy and understanding of the questionnaire but also the possibilities of discovering new facet of problem considered. The ambiguities encountered during this trial and error stage were carefully rectified on revision and modification of the interviewing schedule (Goode and Hatt, 1952). A quantitative method was used to get meaningful and detailed information.

The interview schedule was pre-tested on thirty people (5 %) including fifteen males and fifteen females to examine the workability and sensitivity of the questionnaire. After pre-testing few changes were made in the interview schedule and were finalized and approved by the supervisor.

## **5.10 Collection of Secondary Data**

Secondary data was collected from secondary sources, various authentic documents, reports, official records of the Government of Pakistan, Government of Punjab, non-governmental organizations, the libraries of Various Universities, books, articles in journals, census reports, UN reports, Higher Education Commission digital library, online books, published and unpublished articles and books.

## **5.11 Analysis of Data**

At the first step of data analysis, the researcher used the SPSS-17 software that stood for the Statistical package for the Social Sciences. Hull and Bent (1968) developed SPSS statistical software system in order to analyze a big volume of social

sciences data gathered in various research studies.

SPSS is one of the most widely used software of social sciences. It has been very crucial in facilitating the data of research using individuals as well as discrete units of analysis (Wellman, 1998). Further SPSS has made difficult analytical targets easier by advances in usability and to data access and also enabling the researchers to benefit from the use of quantitative techniques in making decisions.

Then prepared a data file in the SPSS software after assigning classification and codification of data. In case of large number of subjects, codification of data was necessary. All the data had to convert into numerical values and when data passed through the database management program since long entries get significant space and contribute to typographical and spelling errors that jumble up subsequent manipulations (Gay, 1996).

In this study, the researcher employed descriptive statistics to summarize and describe the data whereas inferential statistics such as t-test and Multiple Binary Regression were used to examine the relationship between predictors and response variables.

## Chapter-VI

### Results of Study

#### 6.1 Basic Demographic Profile of Respondents

**Table 6.1 Age of the Respondents**

<b>Classes</b>	<b>Frequency</b>	<b>Percent</b>
60 to 69	284	45.5
70 to 79	206	33
80 to 89	93	14.9
90 to 99	34	5.4
100 and Above	7	1.1
Total	624	100

The table 6.1 reveals the age of the respondents. The average age of respondents was 73 years. 45.5 % (284) respondents were in the age group 60 to 69 years. And 33 % (206), 14.9% (93), 5.4 % ( 34) and 1.1 (7) were categorized in the age groups of 70 to 79 years, 80 to 89 years, 90 to 99 years and 100 and above respectively.

**Table 6.2 Education of the Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Literate	147	23.6
Illiterate	477	76.4
Total	624	100

Table 6.2 shows the educational status of the respondents. It depicts that majority of the respondents were illiterate i-e 76.4 % (477) were illiterate and 23.6% i-e (147) were literate.

**Table 6.3 Educational Level of Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Primary	68	10.9
Middle	24	3.8
Metric	24	3.8
Inter	17	2.7
Graduation	13	2.1
Post Graduate	1	0.2
Illiterate	477	76.4
Total	624	100

This table interprets that majority of the respondents were illiterate i-e 76.4% (477). Among the literate ones, 10.9 % ( 68) had primary education. 3.8%(24), 3.8%(24 ) ,2.7% (17), 2.1%(13), 0.2%(1) respondents had middle, metric, intermediate, graduation and post graduation levels of education respectively.

**Table 6.4 Types of Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Nuclear	211	33.8
Joint	323	51.8
Extended	90	14.4
Total	624	100

The table 6.4 represents family system of respondents. Most of the respondents were residing within the joint family system. As 51.8 % (323) respondents lived in joint family system while 33.8 % (211) had nuclear family and 14.4% (90) had extended family system.

**Table 6.5 Family Size of Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
1-3	55	8.8
4-6	179	28.7
7-9	208	33.3
10-12	92	14.7
13-15	42	6.7
16 and above	48	7.7
Total	624	100

This table shows the size of the respondents' family. The average (mean) family size of current study was 8. The average family size of Pakistan had been determined to 7 per household by the census bureau of statistics, Pakistan. It presents that the major proportion of target population had 4-9 family size. As the 33.3% (208) and

28.7% (179) had 7-9 and 4-6 members of family respectively. While the remaining were 14.7% (92), 8.8% (55), 7.7 % ( 48) and 6.7% (42) in the range of 10-12, 1-3, 16 & above, and 13-15 family size respectively.

**Table 6.6 Marital Status of the Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Married	453	72.6
Unmarried	11	1.8
Widow	146	23.4
Divorced	14	2.2
Total	624	100

Table 6.6 presents the marital status of respondents. Majority of respondents were married i.e 72.6% (453). Less than one forth i.e. 23.4% (146) were widow, 2.2% (14) were divorced and 1.8% (11) were unmarried.

**Table 6.7 Respondents' Children**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	587	94.1
No	37	5.9
Total	624	100

**Table 6.8 Number of Respondents' Children**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
1-3	193	30.9
4-6	253	40.5
7-9	112	17.9
> 9	29	4.8
None	37	5.9
Total	624	100

The table 6.7 and 6.8 represent the number of children of respondents. This shows that majority of respondents had children i-e 94% (587) while 5.9% (37) did not have children. 40.5% (253) respondents had 4-6 numbers of children. 30.9% (193) had 1-3 children. 17.9% (112) and 4.8% (29) had children 7-9 and 9 & above number of children respectively.

**Table 6.9 Status of the Children**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Working	518	83
Studying	51	8.2
Working and Studying	18	2.9
Not Applicable	37	5.9
Total	624	100

Table 6.9 indicates the working status of respondents' children. It shows that majority of the children were engaged in their economic activities i-e 83% (518) and 8.2%(51) were engaged in their studies. Moreover a slight proportion of respondents' children i-e 2.9% (18) were in studying and working conditions while 5.9% (37) were in the category of not applicable as these respondents did not have children.

**Table 6.10 Respondents' Working Status**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Working	147	23.6
Stopped Working	171	27.4
Looking for Work	4	0.6
Never Work and Not Looking	9	1.4
House Wife- Non Working	293	47
Total	624	100

Table 6.10 is about the working status of respondents. It depicts that an overwhelming majority of female respondents i-e 47% (293) of elderly were not involved in any of the work activity and almost all of them were living as house

working except few of them who were running small shops in their homes. 23.6% (147) were engaged in working and 27.4% (171) stopped work. Moreover 0.6 % (4) was looking for work and 1.4 %( 9) respondents were in the category of never work and not looking for work.

**Table 6.11 Respondents' Nature of Work/What Type of Work**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Professional	5	0.8
Business	26	4.2
Skilled Manual	10	1.6
Domestic Service	16	2.6
Agriculture Work	50	8
Labour	17	2.7
Shop Keeper	25	4
Males-Not Working	179	28.7
House Wife- Non Working	293	47
House Maid	3	0.5
Total	624	100

Table 6.11 presents the respondents' nature of work. Major proportion had no economic activity i-e 47% (293) females were living as house wives and 28.7% (179) males had no engagement regarding work. Among the elderly people who were still working 8% (50) were engaged in agriculture and 4.2% (26) were businessmen. 4% (25), 2.7% (17), 1.6 %( 10), 0.8 %( 5) and 0.5 %( 3) were shopkeeper, labourer, skilled manuals, professionals and house maids respectively.

**Table 6.12 Monthly Income of the Respondent**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
1000-3000	11	1.8
3001-5000	18	2.9
5001-7000	18	2.9
7001-9000	13	2.1
9001-11000	18	2.9
11001-13000	15	2.4
13001-15000	23	3.7
15001 and above	36	5.8
No Income	472	75.6
Total	624	100

Table 6.12 shows the monthly income of respondents. An overwhelming majority i-e 75 % (472) had no income. The average income (mean) of one forth respondents who had economic source was Rs. 10289. 2.9 % (18) respondents earned in the range of Rs. 3001-5000, Rs. 5001-7000 and Rs. 9001-11000 in each case. 5.8 % (36) had 15001 and above, 3.7 % (23) had Rs. 13001-15000 income. 2.4 % (15), 2.1% (13) and 1.8 % (11) were earning Rs. 11001-13000, Rs. 7001-9000, and Rs. 1000-3000 respectively.

**Table 6.13 Respondents' Reason to Stop Working**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Retired Formally	25	4
Ill Health	30	4.8
Age Factor	124	19.9
Working	152	24.4
Not Applicable (House wives)	293	47
Total	624	100

This table indicates the reason to disengage from the economic activity. An overwhelming majority of respondents i-e 47 % (293) fall within the category of not applicable as in Pakistan the majority of females were house wives and they did not involve in any economic activity. Almost half of the males i-e 24.4 % (152) were still working. In the remaining half of males mostly i-e 19.9 % (124) stopped work due to age factor while 4.8 % (30) and 4% (25) disengaged the work due to ill health and retirement.

**Table 6.14 Respondents' Age of Disengagement from Work**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
40-45	5	0.8
46-50	12	1.9
51-55	20	3.2
56-60	94	15.1
61-65	24	3.8
66-70	14	2.2
71 and above	10	1.6
Not Applicable	445	71.3
Total	624	100

This table shows the disengagement of elderly targeted population from work. It indicated that slightly less than three fourth respondents i-e 71.3 % (445) were in the class of not applicable. It included the house wives female and the elderly who were still engaged in working. In the remaining proportion, 15.1 % (94) stopped work in the age group 56-60, as in Pakistan the official retirement age is 60 years. 3.8 % (24), 3.2 % (20), 2.2 % (14), 1.6 % (10) and 0.8 % (5) ended their economic activity in the 61-65 age group, 51-55 age group, 66-70 age group, 70 & above age group and 40-45 age group respectively.

**Table 6.15 Respondents' Financial Support to Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	137	22
No	487	78
Total	624	100

Table 6.15 indicates the financial support of elderly to their families. It interprets that majority of respondents i-e 78 % (487) did not support their families as most of them disengaged from the economic activity. Slightly less than one fourth of respondents' i-e 22 % (137) supported their families.

**Table 6.16 Respondents' Family Income**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
1000-5000	52	8.3
5001-10000	83	13.3
10001-15000	88	14.1
15001-20000	105	16.8
20001-25000	65	10.4
25001-30000	67	10.7
30001 and above	164	26.3
Total	624	100

Table 6.16 represents the family income of target population. The mean income of all families was determined Rs. 19793. Almost one fourth of respondents i-e 26.3 % (164) had family income in the range of above thirty thousand rupees and the second major percentage i-e 16.8 % (105) lies within the range of Rs. 15001-20000. 14.1 %

(88) had Rs. 10001-15000. 13.3 % (83), 10.7 % (67), 10.4% (65), and 8.3 % (52) had Rs.5001-10000, Rs. 25001-30000, Rs, 20001-25000 and Rs. 1000-5000 monthly income respectively.

**Table 6.17 Involvement of Respondents in House Hold Chores**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	168	26.9
No	144	23.1
Not Applicable for Males	312	50
Total	624	100

Table 6.17 shows the involvement of female respondents in the household chores as in Pakistan only females are involved in house hold chores rather than males, therefore 50 % males are excluded in this question. In the remaining half of females more than half i-e 26.9 % (168) were still involved in house hold chores while 23.1 % (144) reported not being involved in household activities.

## 6.2 Family Relations and Attitude towards Respondents

**Table 6.18 Educational Status of the Family**

Responses	Frequency	Percent
yes	268	42.9
No	356	57.1
Total	624	100

Table 6.18 indicates the educational status of the respondents' family. It presents that more than half of the respondents belong to uneducated family set up i-e 57.1 % (356) and 42.9 % ( 268) had educational background.

**Table 6.19 Living status of the Respondents**

Responses	Frequency	Percent
Alone	9	1.4
With Spouse	69	11.1
With Family	530	84.9
With Relatives	16	2.6
Total	624	100

Table 6.19 presents the living status of respondents. As in Pakistan still the family system is sustained and all the basic needs are provided by family so most of the respondents were residing with their families i-e more than three forth 84.9% (530) were living with family. Only a few respondents i-e 11.1 % (69) were living with spouse, either they had no children or their children were living in another city. 2.6 % (16) living alone and 1.4 % (9) were living with their relatives.

**Table 6.20 Respondents' Children Living Status (Residing in Separate Homes)**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
In the Same City	433	69.4
In the Other City	108	17.3
Abroad	46	7.4
Not applicable ( No Children)	37	5.9
Total	624	100

Table no. 6.20 represents the results of respondents' children living status. It shows that 69.4 % (433) were living in the same city within a separate house and 17.6% (108) were living in other cities. 7.4 % (46) were living abroad and 5.9 % (37) respondents did not have children.

**Table 6.21 Respondents' Visits to Children Living Separately**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Every Day	53	8.5
Two Times Per Week	107	17.1
Once Per Month	154	24.7
Less Than Once Per Month	89	14.3
Not at all	53	8.5
Living abroad	46	7.4
Once within 3 or 4 Months	85	13.6
Not applicable ( No Children)	37	5.9
Total	624	100

Table 6.21 shows the visits of respondents to their children living in their separate homes within the same city and within other cities. 24.7 % (154) elderly went to see

their children once in a month and 17.1 % (107) visited two times per week. 14.3 % (89) visited less than once in a month and 13.6 % (85) once within three or four months. While 8.5 % (53) did not go to see their children, 8.5 % (53) went every day and, 7.4 % (46) children living abroad. 5.9 % (37) respondents did not have children.

**Table 6.22 Respondents' Source of Family Care**

Responses	Frequency	Percent
None	145	23.2
Spouse	115	18.4
Son	44	7.1
Daughter	197	31.6
Daughter in law	93	14.9
Servant	12	1.9
Relatives	18	2.9
Total	624	100

Table 6.22 is regarding the source of care to older peoples. Slightly more than one third i-e 31.6 % (197) were taking care by their daughters and 18.4 % (115) were looking after by their spouses. 14.9 % (93) had daughter in laws who care them within family set up. 7.1 % (44) and 1.9 % (12) look after by sons and servants respectively. While 23.2 % (145) reported that no family member took responsibility to care them. 2.9 % (18) were taking care by their relatives. The two categories i-e 'none and relatives' included those elderly who did not have children or their family members did not take responsibility to care them.

**Table 6.23 Nature of Relationship with Children Living Separately**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Favourable	228	36.5
Unfavourable	69	11.1
Normal	223	35.7
Not Applicable	104	16.7
Total	624	100

Table 6.23 shows the nature of relationships of older peoples with the children living in their separate homes. It shows that 36.5 % (228) had favorable relations and 35.7 % (223) had normal. 11.1 % (69) had unfavorable relations while 16.7 % (104) were not applicable that means either their children lived abroad or had only single children or living with their relatives and did not have children.

**Table 6.24 Respondents' Source of Financial Support of Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Self ( pension, working, property)	175	28
Children	296	47.4
Charity	23	3.7
1 & 2 options	23	3.7
Husband	59	9.5
Relatives	48	7.7
Total	624	100

Table 6.24 shows the respondents' source of finance. It reported that almost half of the respondents i-e 47.4 % (296) were financially supported by their children. 28 %

(175) were self dependents regarding their financial needs. 9.5 % (59), 7.7 % (48), 3.7 % (23), and 3.7 % (23) had husbands, relatives, 1 & 2 options means self and children, and charity as a financial source of support respectively.

**Table 6.25 Extent of Family Attention/Care to Respondents.**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
To Some Extent	95	15.2
Moderate	160	25.6
A Lot	202	32.4
Not at All	167	26.8
Total	624	100

Table 6.25 shows the extent of care to older peoples in family set up. It explains that 32.4 % (202) received a lot care by their care takers. 25.6 % (160) were getting moderate family's attention. Slightly more than one forth i-e 26.8 % (167) was in the category of not at all, as anybody care for them. 15.2 % (95) had to some extent care.

**Table 6.26 Respondents' Needs Met by Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	373	59.8
No.	77	12.3
To Some Extent	174	27.9
Total	624	100

Table 6.26 interprets the provision and fulfillment of basic need to respondents. It shows that more than half of the respondents i-e 59.8 % (373) replied positive regarding the provisions of need. While slightly more than one forth i-e 27.9 % (174) provided needs to some extent and 12.3 % (77) replied negatively about the provision of needs.

**Table 6.27: Respondents' Needs Fulfilled by the Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Accommodation	102	16.3
Food	34	5.4
Health	19	3
Finance	20	3.2
Social Support	46	7.4
All of Above	326	52.2
Nothing	77	12.3
Total	624	100

Table 6.27 interprets the views of respondents regarding the fulfillment of needs by family. It indicates that half of the respondents were satisfied by the fulfillment of needs by the family members as 52.2 % (326) were receiving all the needs (accommodation, food, health, finance and social support). While 12.3 % (77) refused about the fulfillment of needs by family. Moreover, 16.3 % (102), 7.4 % (46), 5.4 % (34), 3 % (19) and, 3.2 % (20), had proper accommodation, social support, food, health, and financial needs, so their needs were partially fulfilled.

**Table 6.28: Health Status of Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	289	46.3
No	335	53.7
Total	624	100

Table 6.28 represents the health status of respondents. It shows that 53.7 % (335) replied that they did not have any physical disease and 46.3 % (289) were facing various diseases.

**Table 6.29 Respondent's Type of Disease**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Joint Pain	57	9.1
Diabetes	46	7.4
Stomach Problems	72	11.5
Heart Disease	52	8.3
Blood Pressure	44	7.1
Healthy	335	53.7
Asthama	18	2.9
Total	624	100

Table 6.29 represents the type of diseases suffering to respondents. 53.7 % (335) were healthy while the four diseases i-e stomach problems, joint pain, diabetes and blood pressure were common. 11.5 % (72) had stomach problems, 9.1 % (57) were suffering from joint pain, 7.4 % (46) were diabetic patient and 8.3 % (52) were heart patients. While 7.1 % (44) had Blood pressure and 2.9 % (18) were suffering from

Asthma. Among the diseased respondents, half of them have been suffering from common diseases that are mostly linked with the age factors in developing countries.

**Table 6.30 Provision of Medical Treatment by Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	381	61.1
No	243	38.9
Total	624	100

Table 6.30 interprets that 61.1 % (381) took them to doctor and provided medical treatment in case of illness by the family while 38.9 % (243) refused the provision of medical treatment.

**Table 6.31 Respondents' Extent of Honor/ Respect in Young Age given to Older when they were Young**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
A Lot	427	68.4
Moderate	178	28.5
Not At All	19	3
Total	624	100

Table 6.31 represents the extent of respect to elderly people when they were young. The respondents reported that more than half i.e. 68.4 % (427) had a lot of respect and 28.5 % (178) had moderate respect in their families. While only a few respondent i-e 3 % (19) did not have respectable status in family when they were young.

**Table 6.32 Respondent's extent of Honor/Respect in Old Age**

Responses	Frequency	Percent
A Lot	282	45.2
Moderate	238	38.1
Not At All	104	16.7
Total	624	100

Table 6.32 represents the extent of respect to elderly people in old age. The respondents reported that less than half 45.2 % (282) had a lot of respect and 38.1 % (238) had moderate respect in their families. While 16.7 % (104) did not have respectable status in family when they became old.

**Table 6.32 (a) Respondent's Extent of Honor in Old Age Respect's Verses Extent of Honor in Young Age – A Cross Tabulation**

Responses		Respect's Extent of Honour in Young Age			Total
		A Lot	Moderate	Not At All	
Respondent's extent of Honour in Old Age	A Lot	261	15	6	282
	Moderate	131	102	5	238
	Not At All	35	61	8	104
Total		427	178	19	624

This table reveals a comparison between the respondents' extent of respect in young age and in old age. It shows a remarkable difference of decrease in respect with increase in age is visible. 3 % (19) did not have respect in young age while this phenomenon had been increased to 17 % (104). Similarly a marked difference also

observed within the category of ‘A Lot’ in both age groups i.e. 68 % (427) in young age and 45 % (282) in old age.

**Table 6.33 Respondent’s Acceptance of Opinion in Family Matters**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	390	62.5
No	234	37.5
Total	624	100

Table 6.33 shows the respondents acceptance of opinion. It represents that 62.5 % (390) had acceptance of opinion and 37.5 % (234) reported the non acceptance of opinion in different family matters.

**Table 6.34 Respondent consulted in Family Matters**

<b>Areas of Consultation</b>	<b>Frequency</b>	<b>Percentage</b>
Daily life Activities	212	34
Property Matters	21	3.4
Business	8	1.3
Kinship and Marriage	78	12.5
Every Matter	202	32.4
No Consultation	103	16.5
Total	624	100

Table 6.34 interprets the consultation of respondents in various family affairs and matters. As 34 % (212) respondents were consulted only in simple daily life activities and 16.5 % (103) refused about the consultation in any matter. One third proportion i.e 32.4 % (202) had consultation in every matter of life. While 12.5 % (78), 3.4 % (21), and 1.3 % (8) were consulted in marriages and kinships, property and business matters respectively.

**Table 6.35 Respondent's Status regarding Accompany for Outing**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Accompany	304	48.7
left Behind	320	51.3
Total	624	100

Table 6.35 shows the respondents' family behaviour when they go for outing. It shows that 51.3 % (320) replied that their family members left them at home and 48.7 % (304) were accompanied their families when they go for outing or in any other family functions.

**Table 6.36 Respondents, Views regarding participation in Family Ceremonies and Visits to Relatives**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	426	68.3
No	198	31.7
Total	624	100

Table 6.36 represents the respondent's views regarding the feelings of enjoyment to join the family functions and ceremonies. It shows that 68.3 % (426) older people enjoy and wanted to participate family ceremonies and 31.7 % (198) did not want to join family functions.

**Table 6.37 Respondents Views Regarding the Non-Participation in Family Ceremonies**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Age Factor	85	13.6
Personal tensions and Conflict within Family	27	4.3
Not applicable	54	8.7
Health Problems	426	68.3
Hopeless ness	24	3.8
Total	8	1.3
	624	100

Table 6.37 interprets the respondents' views regarding reasons of non participation in family functions. As 13.6 % (85) respondents replied that they did not like to attend the family functions due to age factor. While 8.7 % (54) did not participate due to the family conflicts. 4.3 % (27), 3.8 % (24) and 1.3 % (8) were not participated due to personal tensions, health problems and hopelessness in life. 68.3 % (426) were in the class of not applicable as they like to participate in family functions.

**Table 6.38 Respondents' Satisfaction to the Behaviour of Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	380	60.9
No	244	39.1
Total	624	100

Table 6.38 reveals the satisfaction of older people to their family. 60.9 % (380) were satisfied by the family behaviour and 39.1 % (244) express their feeling of dissatisfaction.

**Table 6.39 Reasons of Dissatisfaction to the Family's Behaviour**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Busy Routine of Family	62	9.9
Ignoring attitude of Family	75	12
Dependency	107	17.1
Not Applicable ( Satisfied)	380	60.9
Total	624	100

Table 6.39 interprets the reasons of respondents' dissatisfaction by family behavior. Among the dissatisfied elderly , it was noticed that 17.1 % (107) respondents replied 'Dependency' as the major cause of dissatisfaction to family behavior as in this age a person become physically and mentally disturbed and dependent to others and the feelings of dissatisfaction would be common. 9.9 % (62) expressed the feelings of dissatisfaction due to engagement of family members in routine work and lack of time for them. 12 % (75) reported 'ignoring attitude' of

family as a reason of dissatisfaction. 60.9 % (380) were satisfied with the family behaviour.

**Table 6.40 Respondents' Time Spent with Family**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
0 to 2	80	12.8
03 to 05	235	37.7
06 to 08	146	23.4
09 to 12	93	14.9
Half Hour or No Time	70	11.2
Total	624	100

Table 6.40 shows the respondents' time with family. As majority of respondents i.e 37.7 % (235) spent only 3-5 hours with family and 23.4 % (146) spent 6-8 hours with family. 14.9 % (93), 12.8 % (80) and 11.2 % (70) were 9-12 hours, 0-2 hours and a few time with family respectively. The average time spent with family was five hours.

**Table 6.41 Respondents' Behaviour of Family in Tension and Frustration**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Advice to stop take Tension	362	58
They Stop to Talk	105	16.8
Frightened and remained Silent	104	16.7
They Stop my Entry in Home	53	8.5
Total	624	100

Table 6.41 indicates the behaviour of family to the elderly when they become tensed and frustrated in daily routine life. 58 % (362) replied their family member advice them to be relax and did not take tension and 16.7 % (104) respondents, family members became silent in his/her respect and remained silent. While 16.8 % (105) reported that their family stop to talk with them and 8.5 % (53) had to face the rude behaviour of family who stopped their entry to home.

### 6.3 Factors linked with Mental Health of Respondent

**Table 6.42 Respondents' Views about the Factors Linked with Positive Mental Health**

Responses	Frequency	Percent
Economic Support	110	17.6
Stress Free Family Environment	113	18.1
Emotional Resilience & Positive Thinking	65	10.4
Good health	57	9.1
Faith in God	121	19.4
2, 5 Options	44	7.1
Options 1, 2, 3	68	10.9
Options 1, 2	46	7.4
Total	624	100

Table 6.42 indicates the respondent's views regarding factors linked with positive mental health. It shows that majority of respondents focused on the economic support, family attitude and faith in God as the indicators to live a healthy and tension free life. 19.4 % (121) expressed that faith in God is foremost for positive mental health. 18.1 % (113) and 17.6 % (110) respondents were of the opinion that stress free family environment and economic support or wellbeing are linked with positive mental health. 10.9 % (68) elderly considered options 1, 2, 3 means economics, family environment and positive thinking, three factors were linked with positive mental health. In case of multiple choice responses question as most of the respondents gave more than one response regarding the factors linked with positive health. 10.4 % (65), 9.1 % (57), 7.4 % (46) and 7.1 % (44) considered emotional

resilience and positive thinking, good health, economics & family and family & faith in God linked with positive mental health.

**Table 6.43 Undesirable Events in Life**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	226	36.2
No	398	63.8
Total	624	100

Table 6.43 shows the undesirable events faced to the respondents. More than half i.e 63.8 % (398) did not face but 36.2 % (226) had to face the undesirable events.

**Table 6.44 Type of Undesirable Events in Life**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Death of Near Ones	145	23.2
Loss of Property and Business	77	12.3
Not Applicable	398	63.8
Separation of Family	4	0.6
Total	624	100

Table 6.44 explains the respondents' views regarding different type of undesirable events. Majority of the older people i.e 23.2 % (145) had to face the death of blood relatives and 12.3 % (77) had to face loss in property and business. While a small proportion 0.6 % (4) got separation. A majority of respondents i.e 63.8 % (398) did not face any event that disturbed their life.

**Table 6.45 Respondents' Sense of Control**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	274	43.9
No	350	56.1
Total	624	100

Table 6.45 presents the respondents' sense of control. More than half i-e 56.1 % (350) had sense of control and 43.9 % (274) undermined the sense of control in their feelings and behaviour due to multiple factors.

**Table 6.46 Reasons of Undermining the Sense of Control**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Aging	81	13
Lower Level of education and	26	4.2
Economic Dependency	100	16
Misfortunes of Life	67	10.7
Not Application	350	56.1
Total	624	100

Table 6.46 indicates the reasons of undermining their sense of control. It shows that 56.1 % (350) did not undermine control on their senses. Among the older ones who undermine their control, 16 % (100), 13 % (81) replied that they lose their control due to economic dependency and aging process. While a 10.7 % (67) and 4.2 % (26) told the misfortunes of life and lower level of education and awareness as the reason of undermining the sense of control.

**Table 6.47 Elderly Abuse of Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	154	24.7
No	470	75.3
Total	624	100

Table 6.47 indicates the respondents' views regarding elderly abuse. An overwhelming majority, three fourth i-e 75.3 % (470) did not face abuse while 24.7 % (154) were facing abuse.

**Table 6.48 Type of elderly Abuse among Respondents**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Physical Abuse	31	5
Psychological Abuse	123	19.7
Not Applicable	470	75.3
Total	624	100

Table 6.48 interprets the types of elderly abuse among elderly. As majority did not face abuse i-e 75.6 % (470). The remaining proportion of elderly had to encounter with the psychological abuse while a few i-e 5 % (31) were facing physical abuse.

**Table 6.49 Feelings of comfort at Home**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	490	78.5
No	134	21.5
Total	624	100

Table 6.49 interprets the feeling of elderly regarding comfort at home. Majority of the respondents i-e 78.5 % (490) expressed positive views about soothe at home while 21.5 % (134) complaints about the discomfort at home.

**Table 6.50 Reasons of Discomfort at Respondents' Home**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Respondents' own Frustration & Tension	28	4.5
Family Misbehavior	47	7.5
Economic Problems	34	5.4
Lack of Social Interaction	25	4
Feeling Comfort at Home	490	78.5
Total	624	100

Table 6.50 indicates the reasons reported for discomforts at home. 7.5 % (47) reported about the family misbehavior. Moreover, 5.4 % (34), 4.5 % (28) , and 4.0% (25) had the view that economic problems, personal frustrations due to age and lack of social interaction were the major reasons of discomfort in home settings. While an overwhelming majority i-e 78.5 % (490) were at ease in their homes.

**Table 6.51 Risk Factors of Mental Health Problems among Elderly**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Dysfunctional Family Life and Changing Values	118	18.9
Economic Dependency	127	20.4
lack of Elderly Care	77	12.3
Loneliness and Lack of Social Support	45	7.2
Negative and Stressful Life Events	41	6.6
Lack of Faith in God	109	17.5
1,2, 5, and 6, options(dysfunctional family, economics, stressful events and faith)	38	6.1
1, 2 and 3 Options (dysfunctional family, economics, stressful events and lack of care )	69	11.1
<b>Total</b>	<b>624</b>	<b>100</b>

Table 6.51 interprets the major risk factors of mental health problems among the elderly. The results highlights three major risk factors of mental health problems i-e, economic dependency, dysfunctional family life and lack of faith in god with the percentages i- e 20.4 % (127), 18.9 % (118) and 17.5 % (109) respectively. 12.3 % (77) replied that lack of elderly care was a risk factor of mental health problems. While 11.1 % (69) respondents gave multiple responses, dysfunctional family life, economic dependency and lack of elderly care are collectively responsible for the disturbance in mental health. 6.1 % (38) expressed that family economic conditions, negative stressful life events and faith in God were collectively considered as risk factors that trigger the mental health problems in later life. While 7.2 % (45) and 6.6 % (41) having the views that loneliness, lack of social interaction and negative and stressful life events were also considered as risk factors which caused mental health problems.

**Table 6.52 Respondents' Coping Mechanism with Disengagement (Males)**

<b>Respnses</b>	<b>Frequency</b>	<b>Percent</b>
Engaged in House Hold Activities	58	9.3
Reading News Papers and Watching TV	39	6.2
Join the Company of Age Group	90	14.4
Attend the Spiritual Mehfiles and offer Prayers	65	10.4
Join any Welfare organization	11	1.8
1 and 4 options (house hold activities and prayers )	30	4.8
2 and 3 options (reading papers and company of	19	3
Not Applicable for Females	312	50
Total	624	100

Table 6.52 indicates the male respondents' coping regarding the disengagement. Most of the elderly in Pakistani culture discarded some activities in later life, for instance, the activities relevant to economics and job and hectic route life due to physical weakness. The proponents of disengagement theory believes that the gradual withdrawal from the social system is inevitable and Howard Kaplan (1971) also supported this assumption of disengaged theory by saying that people are too often evaluated not in terms of where in the life cycle they are, but rather in terms of where they are going or where they have been. Majority of the respondents as reported in the results of socio economic profile of this interview schedule, were found free from their socio-economic affairs. As only 152 respondents were still engaged in economic activities. So they engaged themselves in other activities, keeping in views their temperament, professions and family set up.

It shows that 14.4 % (90) join the company of their age groups when they free and had no responsibility. 10.4 % (65) and 9.3 % (58) attend the spiritual mehfiles and say prayers and engaged in household activities. While 6.2 % (39) read news papers & watch T.V, 1.8 % (11) joined any welfare organization for the welfare of community. Some respondent tick the multiple response i-e 4.8 % (30) engaged in household activities & offered prayers while 3 % (19) were engaged in news paper readings and attend the mehfiles & say prayers. The results show that majority of respondents used company of age fellows, household duties, and prayer as coping mechanism.

**Table 6.53 Respondents' Coping Mechanism of Disengagement (Females)**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Engaged in House Hold Activities/Child Caring	82	13.1
Reading News Papers and Watching TV	53	8.5
Attend the Functions and visits relatives & friends	25	4
Join Any Welfare Organizations	12	1.9
Attend the Spiritual Mehfiles And Say Prayers	91	14.6
2 and 3 options	35	5.6
1 and 3 Options	14	2.2
Not Applicable for males	312	50
Total	624	100

Table 6.53 interprets the female respondents coping mechanisms of disengagement. It shows that most of the female i-e 14.6 % (91) were using 'attend the mehfiles & offer prayers' and 13.1 % (82) 'engagement in household activities and child caring' as coping mechanisms for disengagement. 8.5 % (53) were watching TV and reading news papers. 4.0% (25) and 1.9 % (12) were engaged in family functions and join welfare organizations. While 5.6 %(35) engaged in dual activities as coping i-e read the news papers and attend the family functions. 2.2 % (14) also used to engage in household activities and visited relatives to participate in family ceremonies.

**Table 6.54 Coping in Case of Illness and Increased Physical Dependency**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Insist for Treatment	95	15.2
Seek Family Support	168	26.9
Accept the Situation Pray to God	178	28.5
Try to Cope the Problem Personally	183	29.3
Total	624	100

Table 6.54 interprets the respondents coping regarding the illness. More than one forth i-e 29.3 % (183) took courage and tried to adjust him/her self personally. 28.5 % (178) compromised the situation and pray to God by keeping in view it's the will of God. They considered that physical dependency had become essential in later life stages. Slightly more than one forth i-e 26.9 % (168) seek the family support while 15.2 % (95) become anxious and insist for proper treatment.

**Table 6.55 Respondents' Coping in Loss of Roles and Status**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Demand for Your Participation in Decision Making	64	10.3
Become Irritating and Assertive	93	14.9
Compromise the Situation and Consider its Will of God	195	31.3
Engage in Other Activities	64	10.3
Try to Cope with Problems and Seek Social Support	208	33.3
Total	624	100

Table 6.55 indicates the respondents' coping mechanism as they lose their status and roles in old age. A majority of respondents admitted the realities of life and considered that now they wanted to relax, considering role shifting was natural. Therefore, 33.3 % (208) become courageous and tried to cope with the problems relevant to loss of roles and status issues and seek social support. One third respondents i.e 31.3 % (195) compromised the situation and consider it's the will of God. While 14.9 % (93) and 10.3 % (64) become assertive and demanded for participation in decision making respectively.

**Table 6.56 Respondents' Coping on Account of Family's Misbehaviour**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Compromise the Situation	186	29.8
Become depressed	98	15.7
Become Emotional	109	17.5
Become Isolated	77	12.3
Pray to God & Seek Social Support	154	24.7
Total	624	100

Table 6.56 indicates the respondents' reaction on account of family misbehavior. It shows that 29.8 % (186) compromised the situation. Slightly less than one forth i.e. 24.7 % (154) used both spiritual coping (pray to God) and seek social support as a coping mechanism. While the remaining half of respondents' revealed the resentment with family and 17.5 % (109) become emotional, 15.7 % (98) become depressed and 12.3 % (77) become isolated and restricted family interaction.

**Table 6.57 Respondents' Coping in Stress**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Become Depressed	77	12.3
Become Emotional	107	17.1
Recite Holy Quran and Say Prayers	108	17.3
Become Autonomic	199	31.9
Need the Family and Friend's Help	133	21.3
Total	624	100

Table 6.57 indicates the respondents' coping mechanism to deal with stress. One third of respondents i-e 31.9 % (199) replied that they become autonomic (take the courage and try to solve the problem). 21.3 % (133) seeks the support by family and friends. 17.3 % (108) recite holy Quran and consider it's the will of God. While 17.1 % (107) become emotional and 12.3 % (77) become depressed.

**Table 6.58 Respondents' Coping on Account of Problematic Situation**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Internalize Negative Assesment	222	35.6
Inclination to Withdraw	186	29.8
Become Autonomic	216	34.6
Total	624	100

Table 6.58 interprets the respondents' coping when they entangled within the problematic situation. Slightly more than on third of respondent 35.6 % (222) internalize negative assessment while coping with problematic situations. 34.6 %

(216) become autonomic; means become courageous and tried to solve the problems personally. While the 29.8 % (186) drifts towards the inclination to withdraw.

**Table 6.59 Respondents' Reaction in Case of Internalize Negative Assessment**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Become Depressed	91	14.6
Become Violent	71	11.4
Become Self Critical	60	9.5
Not Applicable	402	64.5
Total	624	100

Table 6.59 presents the explanation of coping to those respondents who used to apply 'internalize negative assessment' as a coping mechanism. 64.5 % (402) were in the category of not applicable as their coping mechanism was autonomic or inclination to withdraw. Among the internalize negative assessment, 14.6 % (91) become depressed, 11.4 % (71) become violent and 9.5 % (60) engage in self criticism as a coping strategy.

**Table 6.60 Respondents' Reaction in Case of Inclination to Withdraw**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Become Isolated	77	12.3
Leads to Sleeplessness	15	2.4
Hope for Miracle	14	2.2
Consider it Will of God	80	12.8
Not Applicable	438	70.2
Total	624	100

Table 6.60 presents the explanation of coping to those respondents who used to apply 'inclination to withdraw' as a coping mechanism. 70.2 % (438) were in the category of not applicable as their coping mechanism was autonomic or internalize to negative assessment. Among the inclination to withdraw, 12.8 % (80) shifted towards God will and considered it was the will of God. 12.3 % (77) become isolated, 2.4 % (15) lead to sleeplessness condition and 2.2 % (14) used 'hope for a miracle' as a coping strategy.

**Table 6.61 Respondents' Reaction in Case of Autonomic**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Discuss with Others	62	9.9
Tries to Clear View point to Others	40	6.4
Think about the Positive aspect of Problem	57	9.1
Solve the Problem in the Light of other' s Advice	45	7.2
Try to Remove the Lope holes by Self Assasment	12	1.9
Not Applicable	408	65.4
Total	624	100

Table 6.61 presents the explanation of coping to those respondents who used to apply 'become autonomic' as a coping mechanism. 65.4 % (408) were in the category of not applicable as their coping mechanism was inclination to withdraw or internalize to negative assessment. Among the respondents who become autonomic, 9.9 % (62) discuss their problems with others and seek social support. 9.1 % (57) thought about the positive aspect of problems. 7.2 % (45) respondents tried to solve their problems in the light of other's advice. While 6.4 % (40) tried to clear their view points to others and justify their status. Only a few older people 1.9 % (12) used self assessment to clear and to remove the lope holes in their personality.

**Table 6.62 Respondents' Views Regarding the Change of Environment****(Accommodation)**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Yes	128	20.5
No	496	79.5
Total	624	100

Table 6.62 interprets the views of older people regarding the change of accommodation. An overwhelming majority i-e 79.5 % (496) did not want to change their accommodations as they had affiliation with family and friends. While 20.5 % (128) were desirous to change their residence due to family conflicting situations.

**Table 6.63 Respondents' Adaptation Regarding the Change of Accommodation**

<b>Responses</b>	<b>Frequency</b>	<b>Percent</b>
Change of Accommodation Within Community ( with family)	86	13.8
Within the Institutional Setup (old Age Homes )	42	6.7
Not Applicable	496	79.5
Total	624	100

Table 6.63 indicates the view point of respondents regarding change of accommodation and either they wanted to continue to live within family set up or within institutional set up. As majority of respondents did not want to change their accommodation that indicated in the 'not applicable' class i-e 79.5 % (496). The remaining proportion of respondents i-e 13.8 % (86) were desirous to change their accommodation but within the community set up, with those family members who

provided them care and had good behaviour. While 6.7 % (42) wanted to change their accommodation, and demanded for the old age homes as they wanted to live within institutional Setting.

**Table 6.64 Prevalence of Mental Health Problems**

<b>Prevalence of Mental Health Problems (MHP)</b>	<b>Healthy</b>	<b>Suffering from MHP</b>
Healthy Respondents	361	57.9
Suffering from Mental Health Problems	263	42.1
Total	624	100

**Table 6.65 Prevalence of Depression among Elderly**

<b>Depression</b>	<b>Frequency</b>	<b>Percent</b>
Non –depressed	485	77.7
Depressed	139	22.3
Total	624	100

Table 3.64 and 3.65 reported the prevalence of mental health problems and depression among respondents respectively. 42.1 % (263) were reported symptoms of mental health problems while the remaining proportion i.e. 57.9 % (361) was diagnosed as healthy individuals. Similarly table 3.66 interprets the prevalence of depression. It was found that slightly more than three fourth of the elderly i.e. 77.7 % (485) did not suffering from depression whereas 22.3 % (139) were estimated to become sufferer of depression by using the Geriatric Depression Scale (GDS-15).

## 6.4 T- Test and Regression Analysis

**Table 6.66 Cross Tabulation between Respondents' Gender and Mental health Problems (SRQ-20)**

Gender	Mental Health Problems –SRQ-20 Scale		Total
	Healthy (f)	Suffering from MHP	
Male	214	98	312
Female	147	165	312
Total	361	263	624

Table 6.66 interprets the relationship between dependent variable i-e mental health problems with gender. It shows that 58 % (361) respondents were healthy and 42 % (263) were suffering from various mental health problems. 38 % (98) males reported mental health problems while 62 % (165) females had become the victims of mental health problems. It indicates that the percentage of mental health problems is more prevalent in females. Similarly 59 % (214) males were healthy and 41 % (147) females did not show any symptoms of mental disturbance.

**Table 6.67 Cross Tabulation between Respondents' Community and Mental health Problems (SRQ-20)**

Community	Mental Health Problems –SRQ-20 Scale		Total
	Healthy (f)	Suffering from MHP	
Urban	184	128	312
Rural	177	135	312
Total	361	263	624

Table 6.67 interprets the relationship between two variables i-e mental health problems and community. It shows that 58 % (361) respondents were healthy and 42 % (263) were suffering from various mental health problems. 49 % (128) respondents reported mental health problems within urban community while 51 % (135) had become the victims of mental health problems within the rural community. It indicated slight difference of prevalence of mental health problems between rural and urban community. Similarly 51 % (184) urban community dwellers were healthy and 49 % (177) rural community did not have mental health problems.

**Table 6.68 (a) Hypothesis: Females will have higher levels of mental health problems than males**

**T-Test- Group Statistics**

Mental Health Problems	Sex	N	Mean	Std Deviation
TSRQ( Mental Health Problems –SRQ-20)	Male	312	0.3141	0.4649
	Female	312	0.5288	0.49997
TGDS (Depression )	Male	312	0.0801	0.27193
	Female	312	0.3654	0.48231

**Table 6.68 (b) Independent Samples Test**

**T-test ( Gender and Mental Health Problems SRQ-20)**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference		95% Confidence Interval of the Difference	
							Lower	Upper	Lower	Upper
	<b>MHP</b>									
TSRQ	Equal variances assumed	46.225	0	-5.556	622	0	-0.2147	0.03865	-0.2907	-0.1388
	<b>Equal variances not assumed</b>			<b>-5.556</b>	<b>618.74</b>	<b>0</b>	<b>-0.2147</b>	<b>0.03865</b>	<b>-0.2907</b>	<b>-0.1388</b>
TGDS	Equal variances assumed	452.466	0	-9.1	622	0	-0.2853	0.03135	-0.3468	-0.2237
	<b>Equal variances not assumed</b>			<b>-9.1</b>	<b>490.572</b>	<b>0</b>	<b>-0.2853</b>	<b>0.03135</b>	<b>-0.3469</b>	<b>-0.2237</b>

**TSRQ** stands for the total mental health problem rate estimated by Self Reporting Questionnaire

**TGDS** stands for the total depression rate estimated by using Geriatric Depression Scale

Table 6.68 (a) & (b) : An independent-sample T-test was conducted to compare mental health problems (by using Self Reporting Questionnaire SRQ-20 WHO scale) for equal proportion of males and females i-e 312 males and 312 females respondents. The guide lines for level of significance (proposed by Julie Pallant, 2007 pp. 234-35), if the significant level of Levene's test will be  $P = .05$  or less, then the variance (variation) of the two groups will not be same. As in this study, the value of significance level/p was .000, also less than 0.05; it means that there was difference between two groups. As the two groups were not same, therefore the information in second line of t-test, reference 'equal variance are not assumed' will be used for final results and its highlighted in table.

There was significant difference in scores for male respondents taken from Group Statistics table ( $M = .31$  and  $SD = .46$ ) and for female ( $M = .53$  and  $SD = .49$ ). The data from Independent Sample Test table showed df (618.74),  $t = -5.56$  and  $p = .000$  (2-tailed).

To determine the magnitude of difference between the two groups i.e. the difference of mental health problems among male and female elderly, it was used the effect size or Eta Square statistics. It provides an indication of the magnitude of difference between two groups. The formula for the Eta Square is as follows.

$$\text{Eta Square} = \frac{t^2}{T^2 + (N_1 + N_2 - 2)}$$

The guide lines (proposed by Cohen 1988, pp 284-7) for interpreting this value.

.01 = Small effect

.06 = moderate effect

.14 = large effect

$$\begin{aligned} \text{Eta Square} &= \frac{t^2}{T^2 + (N_1 + N_2 - 2)} \\ &= \frac{(-5.56)^2}{(-5.56)^2 + (312 + 312 - 2)} \\ &= \frac{30.91}{30.91 + 622} \\ &= 0.05 \end{aligned}$$

The eta square value concluded in this study was 0.05 which was smaller than .06. So according to the above mentioned guidelines, there was smaller variance in mental health problems between the two groups of target population. Therefore, the

hypothesis i.e. Female respondents will have higher level of mental health problems than male, has been supported.

### **T-test (Gender and Depression)**

An independent-sample T-test was conducted to compare depression (by using Geriatric Depression Scale GDS-15) for equal proportion of males and females i.e. 312 male elderly and 312 female respondents. The guide lines for level of significance (proposed by Julie Pallant, 2007 pp. 234-35), if the significant level of Levene's test will be  $P = .05$  or less, then the variance (variation) of the two groups will not be same. As in this study, the value of significance level/p was .000. It means that there was difference between two groups. As the two groups were not same, therefore the information in second line of t-test, reference 'equal variance are not assumed' will be used for final results and its highlighted in table.

There was significant difference in scores for male taken from Group Statistics table were ( $M = .0801$  and  $SD = .27193$ ) and for female ( $M = .3654$  and  $SD = .48231$ ). The data from Independent Sample Test table indicated  $df (490.57)$ ,  $t = -9.10$  and  $p = .000$  (Sig. 2-tailed).

To determine the magnitude of difference between the two groups i.e. the difference of prevalence of depression among males and females, it was used the effect size or Eta Square statistics. The eta square value concluded in this study was 0.11 which indicated the moderate level of variance in depression by gender.

**Table 6.69 (a) Hypothesis: Mental health problems are more prevalent in urban areas than in rural areas.**

**T-TEST- Group Statistics**

Mental Health Problems	Community	N	Mean	Std. Deviation
TSRQ	Urban	312	0.4103	0.49267
	Rural	312	0.4327	0.49624
TGDS	Urban	312	0.2244	0.41783
	Rural	312	0.2212	0.41569

**Table 6.69 (b) Independent Samples Test**

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	Df	Sig. (2-tailed)	Mean Difference	Error Difference	95% Confidence Interval of the Difference	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper	Lower
MHP	Equal variances assumed	1.262	0.262	-0.567	622	0.571	-0.0224	0.03959	-0.1002	0.05531
	Equal variances not assumed			-0.567	621.967	0.571	-0.0224	0.03959	-0.1002	0.05531
TGDS	Equal variances assumed	0.037	0.848	0.096	622	0.924	0.00321	0.03337	-0.0623	0.06873
	Equal variances not assumed			0.096	621.984	0.924	0.00321	0.03337	-0.0623	0.06873

**TSRQ** stands for the total mental health problem rate estimated by Self Reporting Questionnaire

**TGDS** stands for the total depression rate estimated by using Geriatric Depression Scale

**T-test (Community and Mental Health Problems SRQ-20)**

Table 6.69: An independent-sample T-test was conducted to compare mental health problems score from urban and rural community i.e. 312 respondents from Urban and 312 respondents from rural areas. The guide lines for level of significance

(proposed by Julie Pallant, 2007 pp. 234-35), if the significant level of Levene's test will be  $P = .05$  or less, then the variance (variation) of the two groups will not be same. As in this study, the value of significance level/p for Levene's test was .262. It is larger than the cut-off of .05, so the assumption of equal variance assumed has not been violated. Therefore the information in first line of t-test, reference 'equal variance assumed' will be used for final results and it's highlighted in table.

There were no significant difference in scores taken from urban and rural community. The Group Statistics table presented the mean and standard deviation for urban area ( $M = .41$  and  $SD = .49$ ) and for rural areas ( $M = .43$  and  $SD = .49$ ). The table- Independent Sample Test table interpreted  $df (622)$ ,  $t = -.57$  and  $p = .57$  (2-tailed).

To determine the magnitude of difference between the two groups i.e. the difference of prevalence of mental health problems within urban and rural community, it was used the effect size or Eta Square statistics. The eta square value concluded in this study was 0.000; indicated a no variance in mental health problems by community. Therefore the hypothesis i.e. mental health problems are more prevalent in urban areas than in rural areas was not supported.

### **T-test (community and depression)**

An independent-sample T-test was conducted to compare depression scores for urban and rural community i.e. 312 respondents from Urban and 312 respondents from rural areas. The guide lines for level of significance (proposed by Julie Pallant,

2007 pp. 234-35), if the significant level of Levene's test will be  $P = .05$  or less, then the variance (variation) of the two groups will not be same. As in this study, the value of significance level/p for Levene's test was .848. It is larger than the cut-off of .05; so the assumption of equal variance assumed has not been violated. Therefore the information in first line of t-test, reference 'equal variance assumed' will be used for final results and it's highlighted in table.

There was no significant difference in scores taken from urban and rural community. The Group Statistics table presented the mean and standard deviation for urban area ( $M = .22$  and  $SD = .42$ ) and for rural areas ( $M = .22$  and  $SD = .41$ ). The data from Independent Sample Test table was  $df (622)$ ,  $t = -.096$  and  $p = .924$  (2-tailed).

To determine the magnitude of difference between the two groups i.e. the difference of prevalence depression within urban and rural community, it was used the effect size or Eta Square statistics. The eta square value concluded in this study was 0.001 which indicated no significant effect size in depression by community.

## Logistic Regression

**Table 6.70 Omnibus Tests of Model Coefficients**

Omnibus Tests	Chi-square	Df	Sig.
<b>Step 1</b>	137.492	9	0
<b>Block</b>	137.492	9	0
<b>Model</b>	137.492	9	0

**Table 6.71 Model Summary**

Step	-2 Log likelihood	Cox & Snell R Square	Nagelkerke R
1	712.101(a)	0.198	0.266

A Estimation terminated at iteration number 4 because parameter estimates changed by less than .001.

**Table 6.72 Hosmer and Lemeshow Test**

Step	Chi-square	df	Sig.
1	3.229	8	0.919

**Table 6.73 Contingency Table for Hosmer and Lemeshow Test**

		TSRQ <sub>rec</sub> = .00		TSRQ <sub>rec</sub> = 1.00		Total
		Observed	Expected	Observed	Expected	
Step 1	1	54	54.214	7	6.786	61
	2	53	52.531	12	12.469	65
	3	44	45.98	18	16.02	62
	4	47	43.827	14	17.173	61
	5	41	39.024	20	21.976	61
	6	37	37.47	25	24.53	62
	7	28	32.965	35	30.035	63
	8	28	26.862	35	36.138	63
	9	20	18.855	43	44.145	63
	10	9.272	54	53.728	63	

**Table 6.74 Binary Logistic Regression Analysis of Factors Associated with Mental Health Problems among Elderly Population of Punjab, Pakistan.**

		B	S.E.	Wald	df	p- value/ Sig.	Exp(B) / Odd Ratio	95.0% C.I.for EXP(B)	
		Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Step 1(a)	Financial Support to family -BV14	0.883	0.245	12.988	1	0	2.419	1.496	3.911
	Educational status of Family- FAV1(1)	0.546	0.186	8.574	1	0.003	1.726	1.198	2.486
	Undesirable events - CMH2(1)	-0.423	0.191	4.908	1	0.027	0.655	0.45	0.952
	Undermining Sense of control-CMH4(1)	-0.539	0.186	8.4	1	0.004	0.583	0.405	0.84
	Domestic abuse - CMH6(1)	-0.769	0.235	10.732	1	0.001	0.463	0.292	0.734
	Feelings of discomfort at home -CMH8(1)	0.688	0.254	7.317	1	0.007	1.99	1.209	3.276
	Views regarding change of accommodation-coping11(1)	-0.416	0.238	3.071	1	0.08	0.66	0.414	1.05
	Behaviour of family	-0.442	0.225	3.856	1	0.05	0.643	0.413	0.999
	Age of respondents	0.587	0.222	6.974	1	0.008	1.798	1.163	2.779
Constant	0.179	0.412	0.189	1	0.664	1.196			

Table 6.74 interprets the binary logistic regression analysis of factors associated with mental health problems of respondents. It was performed to assess the impact of these factors on the mental health problems (dependent variable) reported by the elderly. The model contains the nine independent variables (financial support to

family, educational status of family, undesirable events of life, undermining the sense of control, domestic abuse, feelings of discomfort at home, change of accommodation, family's behavior and age of respondents). The full model containing all the predictors was statistically significant,  $X^2(9, N = 624) = 137.49$  (according to the omnibus tests of Model Coefficient table).

P-value is smaller than .001, indicating that the model was able to distinguish between the respondents who had the mental health problems and who were healthy by using the SRQ-20 scale. The model as a whole explained difference between 19.8 % (Cox and Snell R Square-given in summary table) and 26.6 % (Nagelkerke R Squared) of the variance in mental health status, and correctly classified 70 % of cases (classification table).

In this table eight independent variables associated with the dependent variable as p-value was less than 0.05 in the above table while change of accommodation is less associated (according to rule, if the p- values will be less than 0.05 then association exists and if the p-value will be greater than 0.05, association did not exist). All these factors were the risk factors of mental health problems as they have close association with the mental health problems indicating very low p-value. The strongest predictor (independent variable) was financial support to family, recording an odd ratio (OR) of 2.42. This indicates that respondents who did not have financial source to support family were two times more likely to report a mental health problem than those who have finance to support their families, controlling all other factors in the model. It means, financial dependency played a key role in the

disturbance of mental health of older peoples and financial dependency has been categorized as the major risk factor linked with mental health problems.

## **Chapter-VII**

### **Major Findings of the Study**

#### **7.1 Basic Demographic Profile of Respondents**

The average age of respondent was 73 years and almost half of the respondents were in the age group 60 to 69. Most of the respondents were illiterate. Among the literate one, majority had primary level education. Slightly more than half of the respondents (57.1 %) belong to uneducated family set up. Almost half of the respondents (51.8 %) lived in joint family system while one third of them were residing within nuclear family system. The average (mean) family size of this study was 8. Majority of respondents were married i.e. 72.6% while less than one forth were widows. More than three forth i.e. 83 % respondents children were engaged in economic activity while remaining were either engaged in study or doing work and study as well. When we discuss the working status of respondents, it was reported that almost half of the respondents were females who did not have any economic activity as mostly Pakistani females living as house wife and all expenses were the responsibility of male partner. However, in case of male respondents and a few female ones (3 % female running small shops in their homes) slightly less than one forth was economically independent, having economic sources/activity. The elderly who still engaged in work/economic activity, major proportion was attached with agriculture and business while remaining were shopkeeper, laborers, skilled manuals, professionals and house maids. Almost half of the female elderly were engaged in

house hold chores. As in Pakistan only females are involved in house hold chores rather than males, therefore fifty percent males are excluded in this case. The average income (mean) of one forth respondents who had economic source was Rs. 10289 whereas average family income of respondents was estimated Rs. 19793. Among the elderly who were engaged in work, mostly stopped work due to age factor while remaining disengaged from the work due to ill health and retirement. Majority of respondents stopped work in the age group 56-60 years, as in Pakistan the official retirement age is 60 years.

## **7.2 Family Relations and Attitude towards Respondents**

As in Pakistan still the family system is sustained and all the basic needs are provided by family so most of the respondents were residing with their families i-e more than three forth (84.9%) living with family while only a few respondents living alone. In case of respondents' visits to their children living in their separate homes within the same city and within other cities. Almost one fourth (24.7 %) elderly went to see their children once in a month and 17.1 percent visited two times per week while 8.5 % did not go to see their children. The nature of relationship with those children who living in their separate home shows that almost one third had favorable relations and one third normal relations while 11.1 % did not have good relations. Slightly less than one third (31.6 %) were taking care by their daughters and other major fraction of source of care was their spouses and daughter in laws. While slightly less than one fourth (23.2 %) reported that no family member took responsibility to care them. In case of respondents' source of finance almost half of

the respondents (47.4 %) were financially supported by their children and 28 % were self dependents. The extent of care of respondents were found that more than one fourth (32.4 %) received a lot of care while one fourth did not receive any care and 15.2 % had been receiving care to some extent within family setting. When respondents asked about the provision/fulfillment of basic need by family, more than half (59.8 %) reported positively in this regard. One half of elderly were getting enjoy all need i.e. accommodation, food, health, finance and social support while the needs of remaining half of elderly were partially fulfilled by family.

Almost two third of elderly respondents were provided medical treatment in case of illness by the family while 38.9 % (243) refused the provision of proper medical treatment. They used self medication, dispenser or traditional medical practioner. While comparing the level of respect to elderly people when they were young and presently when they become old, a remarkable difference of decrease in level of respect with increase in age of elderly has been observed, such as 3 % of respondents reported that they did not have respect in young age while the proportion of those elderly who reported about the lack of respect goes to increase as they going to old, such as 17 % replied about reduction in level of respect in old age. Similarly a marked difference also visible within the category of 'A Lot' in both age groups i.e. 68 % elderly were getting a lot respect in young age while this percentage of respect reduced to 45 % in old age. When we view the acceptance of opinion, it is revealed almost two third (62.5 %) had acceptance of opinion and remaining had non acceptance of opinion in different family matters.

The consultation of older adults in family matters and others revealed that small proportion of them were consulted in prestigious matters i.e. 12 % in marriage and only five percent in property and business matters. One third consulted in simple routine matters and 16.5 % did not consulted in any matter. This shows that the perception of common people of Pakistani society about the elderly involvement in various activities based on the disengagement theory of aging. They considered that the elderly losses their potential and capabilities, so they should take rest and remained away from key and valuable decision of life. This attitude of family triggers the feelings of loneliness, deprivation, loss of roles and status. Theses loses may paved the way to become victims of mental health problems. Half of the respondents were accompanied by the family going outside for recreation purpose. Moreover, 68.3 % older people enjoyed and wanted to participate family functions and ceremonies while remaining dislike taking part in functions. In addition, among those elderly who did not like to participate in functions, expressed that they did not participate due to personal tensions, health problems and hopelessness in life.

In case of elderly views about their satisfaction with family behavior, almost two third (60.9 %) were satisfied by the family behaviour and slightly more than one third (39.1 %) express their feeling of dissatisfaction. Among the dissatisfied elderly , 'Dependency' was concluded as the major cause of dissatisfaction to family behaviour as in this age a person become physically, mentally and economically dependent which triggers feelings of dissatisfaction. However, others complaint about the engagement of family members in other personal matters and also their ignoring attitude.

According to this study, almost one fourth of elderly was facing domestic abuse and majority of them were facing psychological abuse while a few facing physical abuse. More than three fourth respondents expressed positive views about soothe at home while remaining (21.5 %) complaints about the discomfort at home. The major reasons of discomfort at home were family misbehavior and economic problems.

Each elder person almost spent five hours a day with family and spent rest of time with friends or engaged in other activities. In case of the behavior of family to the elderly when they become tensed and frustrated in daily routine life. More than half of the family members expressed mild reactions just like, to advice them to be relax and did not take tension while almost one forth behaved harshly by making them socially isolated i.e. stop to talk with them (16.8 %) and stop their entry to home (8.5 %).

### **7.3 Mental Health Status of Respondents**

The results shows that almost two third of the respondents were healthy and slightly more than one third were suffering from mental health problems (MHP). The gender wise percentage of mental health problems indicated difference i.e. prevalence rate of MHP was more prevalent among female respondents rather than male while there was slight difference of prevalence of mental health problems between rural and urban community. An independent-sample T-test was conducted to compare mental health problems (by using Self Reporting Questionnaire SRQ-20 WHO) for equal proportion of males and females i.e. 312 male and 312 female respondents. The significance level was 0.000 which support the hypothesis that female elderly have

higher level of mental health problems than male elderly. The eta square value indicates that there was no variance in mental health problems by community (between urban community and rural community). Therefore, the hypothesis i.e. MHPs are more prevalent in urban community than in rural community was not supported.

In case of health status of respondents, 53.7 % replied that they did not have any physical disease and 46.3 % were facing various diseases. Stomach problems, joint pain, diabetes and blood pressure were common among the diseased aged people and asthma was reported by few ones. Similarly it was found that the prevalence rate of depression varies gender wise while there was slight difference area wise i.e. rural and urban community.

The binary logistic regression analysis of factors (risk factors) associated with mental health problems of respondents used to assess the impact of these risk factors on the mental health problems (dependent variable) reported by the elderly. The model contains the nine independent variables (financial support to family, educational status of family, undesirable events of life, undermining the sense of control, domestic abuse, feelings of discomfort at home, change of accommodation, family's behaviour and age of respondents). Results of this analysis shows that eight factors were associated with MHP while only change of accommodated was less associated. All these associated factors were considered risk factors of MHP. The financial support to family was reported as a strongest predictor (independent variable) among risk factor of mental health problems. It means that the financial

dependency was the major risk factor that played a key role in the disturbance of mental health of older people.

In addition, undesirable event of life was concluded as a risk factor of MHP. In this case almost two third of elderly did not face any undesirable events in life while others had to face the undesirable events including death of loved ones and loss of property and business. Aging factor is positively linked with undermining sense of control which is a risk factor of MHP, 43.9 percent undermined the sense of control in their feelings and behaviour due to multiple factors. Among these factors aging, economic losses and misfortunes of life were the prominent.

As in this study most of the respondents were illiterate and did not have proper/clear concept of positive mental health, therefore their general views about the healthy living style prevailing among common masses of Pakistani society were kept in mind while dealing this aspect of positive mental health. It shows that majority of respondents focused on economic support, family attitude and faith in God as the indicators to live a healthy and tension free life. They considered these three aspects essential for positive mental health. When the respondents were asked directly about the causes of mental health problems among the elderly. They reported four major causes of mental health problems i.e. economic dependency, dysfunctional family life, absence of firm faith in god, and lack of elderly care. The comparison between views of elderly about the positive health and causes of mental health problems, it was concluded majority focused on the economic dependency, family environment and faith in god as religion and family institution is still deep rooted in Pakistani

society. Moreover, the results of binary logistic regression analysis about risk factors of MHP were almost similar to the above mentioned directly asked risk factors of mental health problems.

#### **7.4 Coping Mechanism of Elderly**

Most of the elderly in Pakistani culture disengaged from their routine life near to 60 years of their age group. Majority of the respondents as discussed in the results of basic data section, were free from their socio-economic affairs. As only 152 respondents were still engaged in economic activities. So the elderly who were free from economic activity adopted various coping mechanisms of disengagement, keeping in views their temperament, professions and family set up. Majority join the company of their age groups when they free and had no responsibility and remaining adopted ‘the spiritual mehfil’, ‘say prayers’ and ‘engagement in household activities’ as a coping strategies in case of disengagement. On the contrary, the female respondents coping mechanisms of disengagement, were different from males as their most of activities revolves around the household activities. Majority were using ‘attend the mehfil & offer prayers’, ‘engagement in household activities’ and ‘child caring’ as coping mechanisms of disengagement. In addition, few were watching TV and reading news papers because most of them were illiterate.

In case of respondents coping regarding the illness, more than one fourth (29.3 %) took courage and tried to adjust him/her self personally. 28.5 % compromised the situation and pray to God by keeping in view it’s the will of God. While the others seek the family support and become tensed and insist for proper treatment. In case of

respondents' coping mechanism against loses their status and roles in old age, more than one fourth, admitted the realities of life and considered that now they wanted to relax, considering role shifting was natural. They become courageous and tried to cope with the problems relevant to lose of roles and status issues. In addition, 31 percent compromised the situation and consider it's the will of God. While one fourth showed emotional coping as they become aggressive and demanded for participation in decision making.

When the respondents were asked about their reaction on account of family misbehavior, more than one fourth compromised the situation. While the others used both spiritual coping (pray to God) and seek social support as a coping mechanism. In addition almost one fourth become emotional, depressed and isolated and restricted family interaction. Almost one third of respondents replied that they become autonomic (take the courage and try to solve the problem) when they felt stress in routine life. While the others used 'seeking support by family and friends,, 'become emotional', and 'depressed, as coping mechanism in case of stress.

When a person entangled within the problematic situation, he/she manifest three types of behaviour in order to cope the situation i.e. internalize negative assessment, inclination to with draw , and autonomic (means become courageous and tried to solve the problems personally) (Atchley, 2004) . Either he/she shows emotional reaction or coping or tries to adopt problem solving approach as in case of elderly the emotional coping is prominent rather than problem solving. The autonomic reaction is problem solving coping while the other both inclination to with draw and

internalize negative assessment are emotional coping behavior. In case of respondents' coping when they entangled within the problematic situation. Slightly more than one third of respondent (35.6 %) internalize negative assessment while coping with problematic situations. 34.6 % become autonomic. While the remaining one third drifted towards the inclinations to withdraw. It indicates that two third elderly adopt emotional coping and one third exhibits problem solving coping. So the emotional coping is more prevalent among elderly rather than problem solving coping. This emotional coping initially may be useful but with the passage of time if a person regular uses emotional coping that leads towards the mal-adaptation initiating MHP. These results were also supported in the previous research work (Lazarus and Folkman, 1984; carver, et al., 1989). Moreover, the coping of elderly in case of illness, stress, loss of roles and status, almost majority of older persons adopted emotional coping in this research study.

Among the internalize negative assessment category, the respondents become depressed, become violent an become the victims of self criticism as a coping mechanism/strategies. Among the inclination to withdraw, the respondents adopted 'compromise with the will of God', 'isolation', and 'sleeplessness condition' as a coping mechanism. At the end, the explanation of coping to those respondents who used to apply 'become autonomic' as a coping mechanism, it was concluded that they discussed their problems with others and tried to solve them. In addition, they thought about the positive aspect of problems while remaining tried to solve their problems in the light of other's advice. Moreover some of them tried to clear their view points to others and justify their status.

The views of older people regarding the change of accommodation shows that an overwhelming majority (79.5 %) did not want to change their accommodations as they had affiliation with family and friends. While 20.5 % were desirous to change their residence due to family conflicting situations. Among the fraction of those elderly who wanted to change accommodation, mostly were desirous to live within the community set up, with those family members who provided them care and had good behaviour as in Pakistan most of the elder persons were used to live with families. While remaining small proportion of elderly demanded for the old age homes as they wanted to live within institutional Setting.

## Chapter VIII

### Discussion

The prevalence of mental health problems symptoms among elderly were estimated highly significant i.e. slightly more than one third was suffering from mental health problems (MHPs). Moreover, the percentage of depression among elderly in the current study was also estimated by using GDS-15 as the major contributor to the mental ill health burden is depression, which including anxiety and somatic complaints, influences one in three persons with their life time (WHO, 2001a). This study reported slightly less than one fourth (22.3 %) depression rate among elderly which is in line with a study conducted in Karachi, Pakistan ( Taqui, Irat, Qidwai and Qadri, 2007). A recent analysis indicated that the pervasiveness of anxiety and depressive disorders in Pakistan was 34% (Mirza and Jenkins, 2004). In 2009, Luni, Ansari, Jawad, Dawson, and Baig reported 44.1 % prevalence of depression and anxiety among the elderly in a Pakistani community. In 2004, Harpham and his fellow researchers reported prevalence of poor mental health range from 18 % to 42 % by using the SRQ-20 in the community setting. Moreover, in the local studies, the variation in the prevalence of mental health problems varies from 10 % to 66 %. ( Ganatra, Zafar, Qidwai, and Rozi, 2008; Hussain, Cree and Thomenson, 2000; Mumford, Minhas, Akhtar, and Mubbashar, 1997; Mumford, Minhas, Akhtar, and Mubbashar, 2000). It is not clear either this difference points out methodological differences in study designs and instruments or true differences in prevalence. The

percentage of occurrence of depression in this study is estimated high which is a cause of concern.

The variation of prevalence of depression among Caucasian elderly in the West varies from 1 percent to 42 percent (Djernes, 2006). In the neighborhood of Pakistan, India having same socio-demographic structure. The prevalence rates for depression in community setting of elderly in India have wide-ranging from 6-50% (Rao, 1993; Nandi, 1993; Banerjee, Mukherjee, Nandi, and Nandi, 1997).

As the studies conducted in the western countries among community dweller elderly indicated low percentage of mental health problems rather elderly who residing in hospitals and old age homes. But the prevalence of mental health problems among community dwelling elderly in Pakistan reported high percentage. The possible explanation of this finding could be that in our society a huge majority of population is living below poverty line and 33 percent Pakistani population is living below poverty line (Qureshi and Arif , 2001) and have no proper source of income that they meet the basic needs of life. Many previous studies supported these findings (Hauser, 2000; Skapinakis, 2006 & Willenz, 2005). It is supported by the research work of Willenz (2005). Moreover, they did not have proper health facilities. The family system is also going to change from extended to nuclear. These factors contributed in this accelerated rate of mental health problems among elders residing in the community setting. This study also shows a significant relationship between financial support and mental health problems that is validated by the results of previous studies. The reason could be that their dependency on others to meet their basic needs may be a source of distress in their life. Similarly, elderly who reported a

lower living index also tended to have more depressive symptoms. This finding support other studies which document that financial stress leads to psychological distress (Gresenz et al. 2001; Miech and Shanahan 2000; Mirowsky and Ross 2001; Muramatsu 2003).

In case of health status of respondents, almost half of the respondents suffering from various diseases such as, stomach problems, joint pain, diabetes and blood pressure and asthma. These results are in consistent with the survey conducted in the central Punjab, Pakistan (Nizamuddin, Maqsood, Ahmad, & Ahmad, 2010). These findings are propped up by Ahmed and Hafeez (2006) who reported that the onset of chronic conditions started around fifty years of age in developing countries like Pakistan. This high prevalence of physical diseases also paved the way to mental health problems. The previous studies consisted with the results that physical diseases are directly linked with mental health and currently WHO and World Bank (1993) introduced a new method to assessing the burden of ill health, which not only considered mortality but took morbidity into account as well (World Bank, 1993).

Moreover, the mental health problems increases with the poor health conditions and health problems and our society health provision are at rudimentary stage. These physical health problems considered with the constant chronic illnesses to become quite awkward, one problem triggers another problem till a deteriorating ferocious cycle is formed. Health problems are categorized to become much more of a burden in the geriatric populace (Borglin et al., 2005 & Djernes, 2006). All these factors are responsible for this high percentage of the prevalence of mental health problems among elderly.

The gender wise percentage of mental health problems indicated difference i.e. prevalence rate of MHPs was more prevalent among female respondents rather than male while there was slight difference of prevalence of mental health problems between rural and urban community.

Similarly, a clear variation was observed between the prevalence of depression between male elderly and female elderly but no variance was found between the rural and urban community. The current study confirmed the findings of the previous studies in Pakistan and other countries that the prevalence of depression is greater among female rather than male (Barry et al. 2008; Husain, Chaudhry, Afridi, Tomenson, Creed, 2007; Mumford, Nazir, Jilani, Baig, 1996; Luni, et al. 2009; Lai 2004; & Unutzer et al. 2003). Males are egoistic in nature and do not express their feelings of distress while female elderly are more expressive. So when they were asked question during data collection, the females replied more questions in 'Yes' response rather than male elderly.

One reason of this is the issue of survivability that is higher among female rather male elderly. Krause's (1986) study of older adults, indicated that older women showed more depressive symptoms associated with depressed affects, such as somatic complaints and related activities than do men. Moreover, in our society, majority of males engage in various routine matter activities and like social networking, so they become less victims of mental health problems. As Ahmed (2011) concluded that social networking and social support were considered more important for quality of life among elderly. Contrary to the men, women have to reside within the four walls of home and live alone at home. Living alone was also

linked with a three- to six fold rise in the encounter of depressive symptoms (Lee & DeMaris, 2007). It is our social norm that female have to live within the house and her duty is to look after the household responsibilities.

The explanation of this study shows that the greater level of mental health problems among elderly women is due to the more strongly gendered traditional norms governing the roles of men and women in Pakistani society and the same results are presented by Jeon et al. (2007). They reported that the more strongly gendered pattern of mental health among those who live alone points out the traditional norms leading the roles of male and female among Korean society. They have no proper source of income and they are more dependent than males as our findings showed that almost all female elderly are house wives and completely rely on male member of family for economic support. This women's traditional social burden may be intensified later in life. All these factors increase the rate of mental health problems among elderly women than men. Social components of gender differences in mental health may differ throughout diverse cultures and due to this diversity the variation among the men and women mental health problems may varies society to society. In Asian countries women are facing more mental health problems than men but in Europe and America the results were found in contrast to Asia and the previous researches provided empirical evidence of this phenomenon.

As Mirza and Jenkins (2004) concluded that female sex, middle age, low literacy level, financial hardships, being a housewife, and relationship problems were factors had positive association with anxiety and depressive symptoms. Taqui et al. (2007) supported this that elderly women were suffering from depression more than men as

they because the dominant gender and generational asymmetries in extended family system are likely to place elderly women at a risk of non-support, particularly in case of changes that lowering the traditional family system of care.

The results of this study presented no variation of prevalence of depression in the urban and rural community which is in line with the survey conducted by Nizamuddin and his fellow researchers (2011) in central Punjab, Pakistan. They found no significant variation between the mental health status in urban and rural community but they observed variation between different regions. But in most of the studies, community wise variation was estimated (Liu et al., 1997 & Maqsood et al. 2013). A possible explanation of this finding could be that in Pakistani culture elderly live with their children, especially sons, and have high status in these extended households in the villages and small cities and only in metropolitan cities people live within the nuclear family system. In Pakistan, majority population residing within villages and small cities. The people who lived in nuclear family system in villages, towns and small cities did not have pure nuclear family system like western countries in which people had no relations with their other blood relations. Due to this family system and strong bonds no difference was observed.

In contrast to our society, the results of studies conducted in USA (Hughes & Waite, 2002), where independence in later life is more cherished, concluded that living together with children can be harmful to the psychological well-being of older adults. But in Pakistani society they are well connected with other relatives in various family matters. Therefore, to some extent their guidance and suggestions are valued by their children and grand children. This valued position in the family may reduce

the risk of depressive symptoms. As the findings of previous studies revealed direct relationship between family system and level of depression ( Taqui, Itrat, Qidwai, & Qadri, 2007).

In Pakistan still the family system is sustained and all the basic needs are provided by family so most of the respondents were residing with their families i-e more than three forth (84.9%) living with family while only a few respondents living alone.

While comparing the level of respect to elderly people when they were young and presently when they become old, a remarkable difference of decrease in level of respect level with increase in age has been observed. 3 % reported that they did not have respect in young age while this phenomenon had been increased to 17 % in old age. Similarly a marked difference also visible within the category of 'A Lot' in both age groups i.e. 68 % elderly were getting a lot respect in young age while this percentage of respect reduced to 45 % in old age. When we view the acceptance of opinion, it is revealed almost two third (62.5 %) had acceptance of opinion and remaining had non acceptance of opinion in different family matters. The findings are not in line with the study of Riaz (2005) who reported that in the Pakistani culture, the growing old is firmly associated with the hoist in status and respect of elderly. This may be justified in the sense that when we see current scenario of Pakistani society in the light of changing family patterns, impact modernization, complex life style and urbanization. All these factors may caused reduction in respect and prestigious status of older adults.

In case of consultation of older adults in family matters, it was reported that small proportion of them were consulted in prestigious matters and the remaining were consulted in routine life matters that are of less importance. This shows that the perception of common people of Pakistani society about the elderly involvement in various activities based on the disengagement theory of aging. The assumptions of this theory are more applicable in simple, less developed and traditional societies. They considered that the elderly losses their potential and capabilities, so they should take rest and remained away from key and valuable decision of life. This attitude of family triggers the feelings of loneliness, deprivation, loss of roles and status. Theses loses may paved the way to become victims of mental health problems.

The findings about their satisfaction with family behavior, almost two third were satisfied by the family behavior and slightly more than one third express their feeling of dissatisfaction. However, elderly complaint about the engagement of family members in other personal matters and their ignoring attitude as well. The Nizamuddin and Maqsood (2010) also found similar results regarding the attitude of family members of elderly.

According to this study, almost one forth of elderly was facing elderly abuse and majority of them were facing emotional abuse while a few facing physical abuse. More than three fourth respondents expressed positive views about soothe at home while remaining (21.5 %) expressed their feelings about the discomfort at home. The major reasons of discomfort at home were family misbehaviour and economic problems.

The result of binary regression indicates the association between mental health problems and elderly abuse, feelings of discomfort at home, and family's behavior. Thus elderly abuse and family behavior influencing the mental health problems of elderly and our results are in line with prior reviews which found the negative aspects of social relationship contributed directly to mental health problems. According to the Stafford, McMunn, Zaninotto, CStat and Nazroo (2011) Negative exchanges with family and with friends were linked with depression. Across all relationship types combined, these positive and negative facets of social relationships contributed independently to depression. In case of broken down by relationship type, the study resulted that positive and negative exchanges with lie partners and with children contributed independently to depression. More negative exchanges with other family members and, to a lesser extent, with friends contributed to depression independently of covariates, but positive exchanges did not. Moreover, the results of many other researches also had association with the findings of this study. The domestic violence, criticism, and lack of reciprocity, were the negative aspects that have consequences for depressive symptoms in general population samples (Newsom, Nishishiba, Morgan, & Rook, 2003; Newsom, Rook, Nishishiba, Sorkin, & Mahan, 2005).

The binary logistic regression analysis of factors (risk factors) associated with mental health problems of respondents used to assess the impact of these risk factors on the mental health problems (dependent variable) reported by the elderly. The model contains the nine independent variables (financial support to family, educational status of family, undesirable events of life, undermining the sense of control, elderly abuse, and feelings of discomfort at home, change of accommodation,

family's behaviour and age of respondents). Results of this analysis show that eight factors were associated with MHP while only change of accommodation was less associated. All these associated factors were considered as risk factors of MHPs that causes disturbance in mental health status of elderly.

These results are validated in the previous studies that low level of education, lack of financial support, family misbehavior are in association with the mental health problems and these factors are considered the risk factors. Abundant of risk factors among geriatric depression have been recognized in the previous studies such as low literacy levels, poor vision, swallowing difficulties, financial lack, dissatisfaction in life, poor self perceived health, bereavement, sleeplessness, impairment of memory, prior depression, female gender, disturbing family relationships, physical illness, use of medication, dependency in routine life activities, unemployment, divorced or widowed status, isolation and urinary incontinence (Chow et al., 2004; Cole & Dendukuri, 2003; Garcia Serrano & Tobias Ferrer, 2001; Heun & Hein, 2005; Maqsood, 2013; Mirza & Jenkins, 2004; Kaneko, Mothohashi, Sasaki, & Yamaji, 2007; Thongtang et al., 2002).

Kaneko, et al. (2007) reported a significant association of depressive symptoms with family misbehavior that include irritating attitude of family and the lack of friendly environment. Familial stress was reported among one fourth of the elderly persons. Although family is considered to be a source of social support for mental health, yet in case of Japanese traditional communities, it was reported as a source of psychological stress for elderly.

The financial support to family was reported as a strongest predictor among risk factor of mental health problems. It means that the financial dependency was the major risk factor that played a key role in the disturbance of mental health of older peoples. Taqui et al. (2007) also reported that unemployed or retired respondents were reported two times more prevalence of depression than those who were engaged in any economic activity. In relation to lack of financial support as risk factors, Abas and Broadhead (1997) found a noteworthy association with formal employment, below average income. The results also supported by the previously conducted researches (Bae, Kim, & Yoon, 2005; Jeon, 2007; Kahn & Fazio, 2005; Mirza and Jenkins, 2004; Taqui et al. 2007, WHO, 1999; Montally labour Review, 2001; Stankunas, Kalediene, Starkuviene, Kapustinskiene, 2006; Frese, Mohr, 1987).

In addition, undesirable event of life was concluded as a risk factor of MHPs. In this case almost two third of elderly did not face any undesirable events in life while others had to face the undesirable events including death of loved ones, loss of property, and business. Aging factor is positively linked with undermining sense of control which is a risk factor of MHP, 43.9 percent undermined the sense of control in their feelings and behaviour due to multiple factors. Among these factors aging, economic losses and misfortunes of life were the prominent. In relation to risk factors, Abas and Broadhead (1998) found an association with humiliation or entrapment and with death or other loss.

As in this study most of the respondents were illiterate and did not have clear concept of positive mental health, therefore their general views about the healthy living style prevailing among common masses of Pakistani society were kept in mind

while dealing this aspect of positive mental health. It shows that majority of respondents focused on the, economic support, family attitude and faith in God as the indicators to live a healthy and tension free life. They considered these three aspects essential for positive mental health. When the respondents were asked directly (through interview schedule) about the causes of mental health problems among the elderly. They reported four major causes of mental health problems i.e. economic dependency, dysfunctional family life, absence of firm faith in god, and lack of elderly care. These results are in line with the previous studies that the domestic violence, criticism, and lack of reciprocity, have significant association with depressive symptoms among general population ( Fogarty, Fredman, Heeren, & Liebschutz, 2008 & Leung, Chen, Lue, & Hsu, 2007)Mavandadi, Rook, & Newsom, 2007).

In research work that have considered both negative and positive exchanges in intimate relationships, the negative exchanges appear to be more strongly linked with depression (Mavandadi, Sorkin, Rook, & Newsom, 2007). The comparison between views of elderly about the positive health and causes of mental health problems, it was concluded majority focused on the economic dependency, family environment and faith in god as religion and family institution is still deep rooted in Pakistani society. Moreover, the results of binary logistic regression analysis about risk factors of MHP were almost similar to the above mentioned directly asked questions (in the Interview Schedule) about the causes of mental health problems.

Most of the elderly in Pakistani culture disengaged from their routine life near to 60 years of their age group. Majority of the respondents as discussed in the results of basic data section, were disengaged from economic affairs and leading retired life. As only 152 respondents were still engaged in economic activities. So the elderly adopted various coping mechanisms of disengagement, keeping in views their temperament, professions and family set up. Majority join the company of their age groups when they free and had no responsibility and remaining adopted 'the spiritual mehfiles', 'say prayers' and 'engagement in household activities' as a coping strategies in case of disengagement. These results correlates with finding of Atchley (1999) who reported three major ways of elderly coping in daily life. They coped through relationships, Positive attitude and spirituality.

On the contrary, the female respondents coping mechanisms of disengagement, were different from males as their most of activities revolves around the household activities. Majority were using 'attend the mehfiles & offer prayers', 'engagement in household activities' and 'child caring' as coping mechanisms of disengagement. These results are in line with the previous studies. (Atchley & Bausch, 2004). Troll (1971) also supported this shifting of economic activity into familial affairs, as she talked of disengagement into the family, meaning that older people cope with lost roles by increasing their involvement with their families.

In case of respondents coping regarding the illness, almost one forth elderly compromised the situation and prayed to God by keeping in view it's the will of God. These results are in consistent with the studies by Koenig (1995) who reported that 30

% of his community sample of elders mentioned religion as a coping strategy. The results in case of respondents' coping mechanism against loses their status and roles in old age, more than one forth, admitted the realities of life and considered that now they wanted to relax, considering role shifting was natural. They become courageous and tried to cope with the problems relevant to lose of roles and status issues. In addition, 31 percent compromise with the situation and consider it's the will of God. While one fourth showed emotional coping as they become aggressive and demanded for participation in decision making.

These findings regarding role and status loss is supported by the result presented by the proponents of disengagement theory, who believed that disengagement was inevitable and adaptive. But these results are in contrast to the believer of proponents of activity theory. Moreover these resulted are also in line with the assumption of continuity theory, it does not assert that one must be disengaged or active in later life, but rather that the decision regarding which roles are to be discarded and which maintained will in large part be determined by the individual history and preferred life style (Cox, 2001). Atchley (1989) also supported this by saying that past experiences have taught most elders to recognize the things they do well and avoid those they do poorly. As in the above mentioned results of this study indicated clearly that almost one third of the respondents' role and status loss is inevitable and remaining wanted to continue their past life style. Havighurst (1963) and Rosow (1967) presented activity theory, in which they focused that unless the physical and social dependency in old age, elderly had the same psychological and social needs as the middle aged persons. They theorized that participation of aged people decreased

due to the withdrawal of society from aging people and most of them dislike this societal withdrawal and they wanted to continue their role and status in society.

When a person entangled within the problematic situation, he/she manifested three types of behavior in order to cope the situation i.e. internalize negative assessment, inclination to with draw, and autonomic (means become courageous and tried to solve the problems personally). Either he/she shows emotional reaction or coping or tries to adopt problem solving approach as in case of elderly the emotional coping is prominent rather than problem solving. It is propped up by Lasarus et al., (1998), they reported that the younger adopted active and problem solving coping while the elder people showed passive emotional coping.

The autonomic reaction is problem solving coping while the other both inclination to with draw and internalize negative assessment are emotional coping behavior. It was revealed that two third elderly adopt emotional coping and one third exhibits problem solving coping. The results of current study have similar findings to the previous studies, as emotional coping was directly related or had positive relations with the stressors of life. In old age, the vulnerability towards the stressors becomes uncontrolled and aged persons facing loses of roles and status and loss of employment. Therefore, the emotional coping is more prevalent among elderly rather than problem solving coping. Similarly the studies conducted by Stone & Neale (1984) supported the above discussion by describing that when stressors are supposed as unmanageable, then emotion-focused coping styles are most commonly used.

As majority of elderly were illiterate and adopted emotional coping more as compared to the problem solving coping. In this fact one factor of awareness and

education may also contributed. The results of the study that literate elderly adopt problem solving coping rather than emotional coping are supported by Lazarus & Folkman (1984) who reported that educated people used problem focused coping while the less educated were used to pray or religious coping. The education increased the ability to cope with the stress through problem solving coping.

The emotional coping is more prevalent among elderly rather than problem solving coping. This emotional coping initially may be useful but with the passage of time if a person regular uses emotional coping that leads towards the maladaptation initiating mental health problems. These results were also supported in the previous research work (Lazarus and Folkman, 1984; carver, et al., 1989). In addition, emotion-focused strategies are the approach most frequently used by older individuals (Folkman, Lazarus, Pimley, & Novacek, 1987). Moreover, the coping of elderly in case of illness, stress, loss of roles and status, almost majority of older persons adopted emotional coping in this research study.

In the current study, when crosstab coping styles with gender, there was no difference exhibited which is in contrast to the previous studies. In previous studies, gender difference was noted that the women exhibited more emotional coping such as crying, seeking help, and dwelling on the source and reasons for their depression when compared to men (Anshel, Sutarso, & Jubenville, 2009; Garnefski et al., 2003; Li et al., 2006). But the results of this study are contrast to the previous studies and this will be explained by saying that the results indicated that majority of Pakistani elderly women residing within family setup as house wife and they do not undergo

changes in life style as men have to loss the roles and status and loss of economic activities.

According to Hagedoorn et al. (2002) the elderly men felt distressed mostly because of work and financial issues. But the elderly women did not have any economic activity and in their younger age they were dependents of their husbands but in later life they would have to dependents of their sons, so they did not have to face any change in case of dependency regarding economic activity. Moreover, being elderly, they achieve more status and respect in family setup which is a prevailing characteristic of Asian families. Due to this prestigious position, women did not exhibit difference gender wise in coping style i.e. women did not use more emotional coping rather problem solving coping in current study.

This social phenomenon also explained by Cox (1998) while discussing the disengagement variation among elderly men and women. He indicated that disengagement is seen as abrupt for men because of their career while women, even when employed, are seen as concerned principally with family matters. Substitute roles following retirement, which bring the respect of others and thereby self esteem, are always readily available to women but not to the men. It not to say that men cannot assume alternative roles after retirement, but rather that such roles are not merely as apparent and accessible as they are for women.

Another study (Hoverton & Gundy, 2009) resulted the difference by focusing the three coping styles i.e. Problem focused, emotion focused, and avoidance focused. It was concluded that no sex differences were observed in the use of problem-focused

coping, while dissimilarity were examined in case of avoidance-focused coping i.e. female adopt more avoidance coping rather male older adults.

But in this study we only observe gender variation in coping of routine life, such as male older persons spend most of time among friends while female engaged in house hold activities and attend the Spiritual rituals. Furthermore, variation exhibited in spiritual coping, women become more religious rather than males in later life. As most of the previous studies revealed that women to be more religious than men (Levin, Taylor, Chatter, 1994; Krause, 1995).

The views of older people regarding the change of accommodation shows that an overwhelming majority (79.5 %) did not want to change their accommodations as they had affiliation with family and friends. While 20.5 % were desirous to change their residence due to family conflicting situations. Among the fraction of those elderly who wanted to change accommodation, mostly were desirous to live within the community set up, with those family members who provided them care and had good behavior as in Pakistan majority of elderly were used to live with families. While remaining small proportion (6.7 %) of elderly demanded for the old age homes as they wanted to live within institutional Setting. In Asian countries, the family is the best source of social support and care is entirely a matter of responsibility by family so majority of elders wanted to reside within family and community setting rather than institutional setting. The results are in line with the view point of Folkman and Lasarus (1984) who reported that Social support is a source that assists in successful adaptation to stress, often through allowing individuals to preserve or recover physical and psychological resources. Physical and emotional well-being of

individuals has strong association with social support (Thoits, 1995). In addition to this the findings of a recent study conducted by the Senior Citizens Welfare Trust, it was reported that 98 per cent of the elderly population prefer to stay with their families rather than be resided at old age homes. The emotional and social satisfaction of living with their grandchildren cannot be reinstated by the desolate atmosphere of homes managed by strangers (Challenges for Senior Citizens , 2014)

The finding regarding the continuity of their adjustment within family environment also strengthening by the Atchley's concept of continuity. According to Atchley (1999), continuity is an adoptive strategy, which is divided into two i.e. internal continuity and external continuity. Internal continuity deals with the thinking of individuals and external continuity refers to living with familiar people in the familiar environment.

## Chapter-IX

### Recommendations

- i. According to the results of study, economic dependency was concluded as the major risk factor of mental health problems. Moreover, majority of elders were consulted in normal routine matters rather than business property matters. In addition, almost half of respondent's basic needs were partially filled by family. Therefore, the government should introduce universal pension system both contributing and non contributing for all elderly at national level just like India and Nepal.
- ii. The prevalence of mental health problems among older adults has been found up to the alarming percentage, so the provision of mental health services should be given priority in policy making for elderly and in addition, special units should be established at District & Tehsil head quarter hospitals to provide free mental health services.
- iii. It is clear from the results of study that an overwhelming majority of respondents preferred to live within the community setting rather than institutional settings (old age home). Moreover, almost one forth of respondents reported misbehaviour of family members. Therefore, a comprehensive advocacy campaign should be launched at the platform of Department of Social Welfare, Govt of Pakistan for strengthening the family values and respect & status of elderly at community level and participation of NGOs should be ensured to implement this campaign at gross root level.

- iv. According to the results, 25 percent elderly become the victim of abuse and the percentage of female abuse is more than males and almost half of the females still engaged in house hold chores. The literature supports that elderly abuse are positively associated with mental health problems i.e. depression, anxiety and stress (Zink et al., 2004). Therefore, there should be intention to introduce comprehensive intervention models as a preventive strategy against elderly abuse in household settings.
- v. The age of retirement (60 years) should be increased to 65 considering that our country does not fulfil the gap of human resource created by the retirement of skilled professional, especially in the field of education. Moreover, the disengagement of elders triggers them toward the adoption of new activities. If this new adoption fails to compensate the losses of retire life, he/she moves towards the depressed moods (Atchley and Barusch, 2004).
- vi. It is clear from the results of study that 43.9 % respondents reported that they had undermined their sense of control due to aging, economic dependency and misfortunes of life. As undermining sense of control is positively associated with the risk factor of mental health problems (MHP) in this study, so a campaign in both electronic and print media should be initiated on national and local level to create the awareness among the people about the care of elderly.
- vii. According to the results of study, one third elderly used problem solving coping while the remaining two third used to emotional coping to

- cope with the problematic situation, therefore they should be provided favourable and stress free environment for normal social functioning.
- viii. As the 31.7 percent respondents reported that they did not like to attend the family functions, this situation demand policy intervention to enhance social participation of older adults in community life and especially for the older females who have to reside most of time within household setting.
- ix. The enactment for the establishment of council for seniors and execution of present enactment for elderly and UNO guidelines should be ensured by the National Assembly.
- x. It is observed that only a few NGOs are working on the issues of older adults in Pakistan, so it is recommended that the social welfare department should take practical steps to mobilize the community workers to register more NGOs in the field of aging.
- xi. An advocacy organization should be established to mobilize public and private resources for elderly, as well as to conduct researches on elderly issues and endeavour for the implementation of laws regarding elderly issues.
- xii. Social welfare and health department should take step to conduct researches to identify prevalence rate of mental health problems, and to find facts that place the elder's mental health at risk, as well as present the interventions that stops or at least limits the risk factors of mental health problems among elderly.

- xiii. According to the research findings, one fourth respondents were dissatisfied from the family behaviour which had been concluded as the cause of mental health problems. So, there is a need to conduct studies on family dynamics to commence programs of family counselling with the objective to teach caregivers how to reduce the intensity of stress and other regretted feelings of elderly that may leads them to the anxiety and depression.
- xiv. Only four old age homes are working at national level which are insufficient to provide care at institutional level and that's why government should established more institutions to provide free residence to homeless and poor older adults.

## Bibliography

- Abas, M. A., Sahakian, B. J., & Levy, R. (1990). Neuropsychological deficits and scan changes in elderly depressives. *Psychological Medicine*, 20, 507–520.
- Abas, M., & Broadhead, J. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychol Med*, 27, 59–71.
- Afzal, M. (1999b). *Family Structure and the Elderly in Pakistan' in the Family and Older Persons in Bangladesh, Pakistan, and Sri Lanka*. New York, USA: United Nations Economics and Social Commission for Asia and the Pacific (ESCAP).
- Afzal, M. (1999a). *Growing Old in Pakistan: Challenges for the New Millennium*. Islamabad: Pakistan.
- Afzal, M. (1994a). *Local Level Policy Development on Consequences of Aging: Country Case Study in Pakistan*. New York, United Nations: ESCAP Asian Population Studies.
- Afzal, M. (1994b). *Local Level Policy Development on consequences of Aging: Country Case Study in Pakistan*. New York: United Nations Economics and Social Commission for Asia and the Pacific (ESCAP).
- Age and Retirement Age Declines again in 1990s. (2001). *Monthly Labor Review*.
- Ahmed, K. (n.d.). Older adult's social support and its effect on their every day self-maintenance activities: Finding from the house hold survey of urban Lahore, Pakistan. *Research Journal of South Asian Studies*, 26(1), 37–52.

- Ahmed, K., & Hafeez, M. (2006). *Population Aging: An Emerging Social and Economic Issues in Pakistan*.
- Ahmed, K., & Hafeez, M. (2011). Factors affecting social participation of elderly people: A study in Lahore. *The Journal of Animal and Plant Sciences*, 21(2), 283–289.
- Akiskal, H. S., & McKinney, W. T. (1973). Depressive Disorders: Towards a Unified Hypothesis. *Science*, 5, 20–29.
- Al-Shammari, S. ., & Al-Subaie, A. (1999). Prevalence and correlates of depression among Saudi elderly. *International Journal of Geriatric Psychiatry*, 14(9), 739–747.
- Alexopoulos, G. S., Meyers, B. S., Young, R. ., Campbell, S., Silbersweig, D., & Charlson, M. (1997). “Vascular depression” hypothesis. *Archives of General Psychiatry*, 54, 915–922.
- Ali, S. M., & Kiani, M. F. K. (2003). *Ageing and Poverty*. Pakistan Institute of Developmental Economics. Islamabad: Pakistan: Pakistan Institute of Developmental Economics.
- Ambuel, B., Hamlett, K. ., Marx, C. ., & Blumer, J. L. (1992). Assessing distress in pediatric intensive care environments: The Comfort Scale. *Journal of Pediatric Psychology*, 17, 95–109.
- Angst, J., & Merikangas, K. (1997). The depressive spectrum: diagnostic classification and course. *Journal of Affective Disorders*, (45), 31–39.

- Anshel, M. ., Sutarsu, T., & Jubenville, C. (2009). Racial and gender differences on sources of acute stress and coping style among competitive athletes. *The Journal of Social Psychology*, (45), 159–177.
- Atchley, C. R. (1988). *Social Forces and Aging*. Californai: Wadsworth Publishing Company.
- Atchley, R. . (1989). A continuity of normal aging. *The Gerontologist*, (29), 183–190.
- Atchley, R. . (1999). *Continuity and Adaptation in Aging: Creating Positive Experiences*. Baltimore: Johns Hopkins University Press.
- Atchley, R. ., & Barusch, A. S. (2004). *Social Forces and Aging: An Introduction to Social Gerontology* (10th ed.). Australia: Thomson Wadsworth.
- Atchley, R. C. (1967). *Retired Women: A study of Self and Role*. In Atchley, R. C. and Barusch, A. S. (2004). *Social Forces and Aging: An Introduction to Social Gerontology* (10th ed.). Australia: Thomson wadsworth.
- Ather, M., & Taqui, A. I. (2007). Depression in the elderly: Does family play a role? A cross-sectional study. *BMC Psychiatry*, 7, 57–62.
- Bae, J. Y., Kim, W. H., & Yoon, K. A. (2005). Noinui uul mit jasal senggake yiseoseo saheoigeock jijjui wanchung hyogwua [Depression, suicidal thoughts and the buffering effect of social support among the elderly]. *Journal of the Korean Gerontological Society*, 25, 59–73.
- Baltes, P. B. (1993). aging mind: potential and limits. *The Gerontologists*, 33(5), 580–94.

- Beck, A. T. (1967a). : Clinical, experimental and Theoretical Aspects. In S. Nolen-Hoeksema. (2001). *Abnormal Psychology* (2nd ed., p.270). New York: McGraw-Hill Companies.
- Beck, A. T. (1967b). *Clinical Experimental and theoretical aspects*. New York: Harper and Row.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guilford Press.
- Bidwell, L. D., & Mey, B. J. . (1999). *Sociology of the Family: Investigating Family Issues*. Boston: Allyn and Bacon.
- Blazer, D. (1986). Depression: Paradoxically a cause for hope. In Hogstel, M. O. (1995). *Geropsychiatric Nursing* (2nd ed.). St. Louis: Mosby- Year Book, Inc.
- Blazer, D., Burchet, B., Service, C., & George, L. (1991). The association of age and depression among the elderly: an epidemiologic exploration. *J Gerontol Med Sci*, 46, 210–215.
- Blazer, D., Hughes, D., & George, L. (n.d.). The epidemiology of depression in an elderly community population. In Blazer, D. G., (2009). *Depression in late life: review and commentary*. Retrieved August 18, 2011, from [focus.psychiatryonline.org](http://focus.psychiatryonline.org).
- Blazer, D., Swart, M., Woodbury, M., Manton, K., Hughes, D., & George, L. (1988). Depressive symptoms and depressive diagnoses in a community population. *Arch Gen Psychiatry*, (45), 1078–1084.
- Bluglass, R. (1983). *A Guide to the Mental Health Act 1983*. Edinberg: Longmans Group ltd.

- Borglin, G., Jakobsson, U., Edberg, A. K., & Hallberg, I. R. (2005). Self-reported health complaints and their prediction of overall and health-related quality of life among elderly people. *International Journal of Nursing Studies*, *42*(2), 147–158.
- Bosworth, H., Kawang-Soo, P., MCQuoid, D., Hays, J., & Steffens, D. (2003). The impact of religious practice and religious coping on geriatric depression. *International Journal of Geriatric Psychiatry*, *18*, 905–914.
- Bowles, J., Brooks, T., Hayes-Ream, P., & Butts, T. (2000). Frailty, family and church support among urban African American elderly. *Journal of Health Care for the Poor and Underserved*, *11*(1), 87–99.
- Braam, A. W., Erikheim, Deeg, D. H., Twisk, J. R., Bechman, A. F., & Tilberg, W. (2004). Religious involvement and 6-Year course of depressive symptoms in older dutch citizens: Results from the longitudinal aging study Amsterdam. *Journal of Aging and Health*, *16*, 457–489.
- Brandtstadter, J., Ruthermund, K., & Schmitz, U. (1997). Coping resources in later life. *European Journal of Applied Psychology*, *4*(2), 107–113.
- Broadhead, J., & Abas, M. (1998). Life events, difficulties and depression among women in an urban setting in Zimbabwe. *Psychol Med*, *28*, 29–38.
- Browne, K. (2002). *Introducing Sociology For AS Level*. Cambridge: Polity Press.
- Buesenberg, M., & Blumer, J. (1994). *A User's Guide to the Self Reporting Questionnaire*. Geneva: WHO Division of Mental Health.

- Burker, E. J., Evon, D. M., Sedway, J. A., & Egan, T. (2004). Appraisal and coping as predictors of psychological distress and self-reported physical disability before lung transplantation. *Progress in Transplantation, 14*(3), 222–232.
- Burnside, I. (1988). *Nursing and the Aged* (3rd ed.). New York: McGraw Hill.
- Butler, R. N., Lewis, M. I., & Sunderland, T. (1998). *Aging and Mental health: Positive Psychosocial and biomedical Approaches* (5th ed.). Boston: Allyn and Bacon.
- Carels, R. A. (2004). The association between disease severity, functional status, depression and daily quality of life in congestive heart failure patients. *Quality of Life Research, 13*(1), 63–72.
- Carver, C. S., Pozo, C., Harris, S. ., Noriega, v, Scheier, M. ., & Robinson, D. S. (1993). How coping mediates the effect of optimism on distress: A study of women with early stage breast cancer. *Journal of Personality and Social Psychology, 65*(2), 375–390.
- Carver, C., Scheier, M., & Weintraub, J. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology, 56*, 267–283.
- Center for History and New Media. (n.d.). Zotero Quick Start Guide. Retrieved from [http://zotero.org/support/quick\\_start\\_guide](http://zotero.org/support/quick_start_guide)
- Chema, A. N. (2011). Upcoming scenario of aging population: Pakistan. *International Journal of Business and Social Sciences, 2*(16), 188–198.
- Chew-Graham, C., Baldwin, R., & Burn, A. (2004). Treating Depression in Later life. *British Medical Journal, 32*(6), 381–329.

- Chopra, R. (2005). *Academic Dictionary of Psychology*. Dehli: Isha Books.
- Chow, E. S., Kong, B. M., Wrong, M. ., Draper, B., Lin, K. L., Ho, S. K., & et al. (2004). The prevalence of depressive symptoms among elderly Chinese private nursing home residents in Hong Kong. *International Journal of Geriatric Psychiatry, 19*(8), 734–740.
- Clark, G. (1999). Pakistan Zakat and Usher System and Old People in Pakistan. Presented at the Forth International Conference on Global Aging, Montreal: Canada: International Federation on Aging.
- Clark, M., & Anderson, B. (1967). *Culture and Aging*. In Clark, W. A. V., and Suzanne, D. (1990). Elderly mobility and mobility outcomes: households in the later stages of the life course. *Research on Aging, 12*(4), 430-62.
- Clarke, I. J. (1970a). *Aging Population*. In Talat, B. (2005). Old and old old population distribution in Punjab. *Pakistan Geographical Review, 60*(1), 12-18.
- Clarke, I. J. (1970b). *Population Geography*. New York: Pergamon Press.
- Cochran, D., Brown, D., & MC Gregor, K. (1999). Racial differences in multiple roles of older women: implications for depressive symptoms. *The Gerontologist, 39*(4), 465–472.
- Cohen, G. D. (1992). The future of mental health and aging. In Zarit, H. S., & Zarit, M. J. (1998). *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatments*. New York: Guilford Publications, Inc.

- Cole, M. ., & Dendukuri, N. (2003). Risk factors for depression among elderly community subjects: A systematic review and meta-analysis. *American Journal of Psychiatry*, *160*(6), 1147–1156.
- Copel, L. C. (1988). Loneliness. *Journal of Psychological Nursing*, *86*(3), 288–291.
- Copeland, J. (2003). Some thoughts on older people and mental health.
- Corob, A. (1987). Working with depressed women. In Nicolson, P. (2001). Postnatal depression: Facing the Paradox of Loss, Happiness, and Motherhood. West Sussex: John Wiley & Sons Ltd.
- Corsini, R. J. (1999). *The Dictionary of Psychology*. New York: Taylor & Francis Publishing Company.
- Cowgill, D., & Holmes, L. (1972). *Aging and Modernization* (3rd ed.). In Miller, A. In the eyes of bachelor: Contemporary issues in Stereotyping. New York: Praeger.
- Cox, H. G. (2001). *Later Life : The Realities of Aging* (3rd ed.). New Jersey: Prentice Hall.
- Crosnoe, R., & Elder Jr, G. H. (2002). Successful adaptation in the later years: A life course approach to aging. *Social Psychology Quarterly*, *65*(4), 309–328.
- Cutler, S. J., & Jon Hendricks. (1990). Leisure and time use across the life course. In Robert, H. B., & Linda, K. J. (n.d). *Handbook of Aging and the Social Sciences* (3rd ed.). New York: Academic Press.
- Challenges for Senior Citizens. (2014) Retrieved April 5, 2014, from <http://www.dawn.com/news/663749/challenges-for-senior-citizens>.

- Dar, R. H. (1996). *Status of the aged in Modernizing Society*. Department of Sociology, University of the Punjab, Lahore: Pakistan.
- Darby, S., Cramp, M. J., & Scurfield, M. (1999). *Old People Nursing and Mental Health*. London: Read Educational and Professional Publishing.
- Davis, M. (2000). *The Blackwell Encyclopaedia of Social Work*. USA: Blackwell Publishers.
- Day, A. T. (1991). *Remarkable Survivors: Insight into Successful Aging Among Women*. Washington:DC: Urban Institute Press.
- Dejernes, J. K. (2006). Prevalence and predictors of depression in populations of elderly: a Review. *Acta Psychiatrica Scandinavica*, 113, 372–387.
- Department of Health. (2000). *Human Resources Performance Framework*. London.
- Department of Health. (2004). *National Service Framework for Children. Young People and Maturity Services: The Mental Health and Psychological Well being of Children and Young People*. London.
- Department of Health and Human Services. (n.d.). *Substance Abuse and Mental Health*. Maryland.
- Desjarlais, R. (2001). *World Health Report*. Geneva: World Health Organization.
- Diagnostic and Statistical Manual*. (1994) (4th ed.). Washington, DC: Diagnostic and Statistical Manual.
- Diagnostic and Statistical Manual*. (n.d.) (4th ed.). Washington, DC: American Psychiatric Association.

- Djernes, J. K. (2006a). Prevalence and predictors of depression in populations of elderly: a review. *Acta Psychiatr Scand*, *113*, 372–387. doi:10.1111/j.1600-0447.2006.00770.x.
- Djernes, J. K. (2006b). Prevalence and predictors of depression in populations of elderly: A review. *Acta Psychiatrica Scandinavica*, *113*(5), 372–387.
- Dowd, J. (1975). *Social Exchange theory*. In Hayes, N. (1984). *A first Course in Psychology*. , Edinburg: Nelson.
- DSM-IV diagnostic and Statistical manual od mental disorders*. (n.d.). Washington, DC: American Psychiatric Association.
- Ensel, W., Peek, M., Lin, N., & Lai, G. (1996). Stress in life course –A life history approach. *Journal of Aging and Health*, *8*(3), 389–416.
- European Commission. (2008). *Mental Health in EU Key Facts, Figures and Activities, a back ground paper provided by the support project, 2008*. Luxembourg.
- Everard, K., Lach, H., Fisher, E., & Baum, M. (2000). Relationship of activity and social support to the functional health of older adults. *Journal of Gerontology: Social Sciences*, *55*(4), 208–212.
- Faris, R. E. L., & Dunham, W. W. (1939). Medical disorder in urban areas. In C.G. Hudson, (2005). Socioeconomic status and mental illness: test of the social causation and selection hypotheis. *American Journal of Orthopsychiatry*. *75* (1), 3-18.

- Fiscella, Franks, P., Gold, M., & Clancy, C. (2000). Inequality in in quality addressing socio-economic, racial and ethnic disparities in health care. *Journal of the American Association*, 283(19), 2579–2584.
- Fogarty, C. T., Fredman, L., Heeren, T. C., & Liebschutz, J. (2008). Synergistic effects of child abuse and intimate partner violence on depressive symptoms in women. *Preventive Medicine*, 46, 463–469.
- Folkman, S., Lazarus, R., Pimley, S., & Novacek, J. (1987). Age differences in stress and coping processes. *Psychology and Aging*, 2(2), 171–184.
- Folkman, S., & Lazarus, R. S. (1988). *Ways of Coping Questionnaire*. Menlo Park: Consulting Psychologists Press, Inc.
- Frese, M., & Mohr, G. (1987). Prolonged unemployment and depression in older workers: a longitudinal study of intervening variables. *Soc Sci Med*, 25, 173–178. doi:10.1016/0277-9536(87)90385-6
- Gadit, A. A., & Mugford, G. (2007). Prevalence of Depression among Households in Three Capital Cities of Pakistan: Need to Revise the Mental Health Policy. *PLOS ONE*, 2(2), 209–215. doi:10.1371/journal.pone.0000209
- Ganatra, H. ., Zafar, S. ., Qidwai, W., & Rozi, S. (2008). Prevalence and predictors of depression among an elderly population of Pakistan. *Aging & Mental Health*, 12(3), 349–356.
- Ganatra, Hamad, A., Zafar, S. N., Qidwai, W., & Rozic, S. (2008). Prevalence and predictors of depression among an elderly population of Pakistan. *Aging & Mental Health*, 12, 349–356.

- Garcia Serrano, M. J., & Tobias, F. J. (2001). Prevalence of depression in patients over 65 years of age. Profile of the elderly at risk. *Atencion Primaria*, 27(7), 484–488.
- Garland, B. J., Copeland, J., Kuriansky, J., Keelher, M. J., Sharpe, L., & Dean, L. (1983). *The Mind and Mood of Aging*. New York: Haworth.
- Garnefski, N., Teerd, J., Kraaij, J., Legerstee, J., & Van den Kommer, T. (2003). Cognitive emotion regulation strategies and depressive symptoms: Differences between males and females. *Personality and Individual Differences*, 36, 267–276.
- Gearing, B., & Slater, R. (1988). Attitudes, Steriotypes and Prejudice about Aging. In Mental Health Problems in Old Age. Milton Keynes: Open University
- General, D. (1999). *Men Ageing And Health*. World Health Organization.
- Gilbert, P. (2000). Overcoming depression. In Nicolson, P. (2001). Postnatal depression: Facing the Paradox of Loss, Happiness, and Motherhood. West Sussex: John Wiley & Sons Ltd.
- Goldsmith, J., Jakson, D., Kramer, M., Brenner, B., Stiles, D., Tweed, D., ... Mackenzie, E. (1986). Strategies for investigating effects of residential context. *Research on Aging*, 8(4), 609–631.
- Goodwin, F. K., & Bunny, E. (1973). Psychobiological aspects of stress and affective illness. In Scott, J. P., & Senay, E. C. (2003). Separation and depression: Clinical and research aspects. Washington, DC: American Association for the Advancement of Science.

- Government of Pakistan. (2000). *Pakistan Aging Survey. National Council of Social Welfare. Ministry of Women Development, Social welfare and Special Education*. Islamabad: Pakistan.
- Government of Pakistan. (2005). *Economic Survey of Pakistan*. Islamabad.
- Gresenz, C. R., Sturm, R., & Tang, L. (2001). Income and mental health: unraveling community and individual level relationships. *The Journal of Mental Health Policy and Economics*, 4(4), 197–203.
- Grunfeld, A. F., Larsson, D. M., Mackay, K., & Hotch, D. (1996). Domestic violence against elderly women. *Canadian Family Physician*, 42, 1485–1493.
- Hafeez, M. (2004a). Aging and Family: perceived life situation of an elderly population in Pakistan: Gender Based Finding from Urban, Lahore. Sharing Population and Development Research Across South and West Asia (pp. 365–385). Presented at the Fifth Annual Research Conference Proceedings 14-16, lahore: Population Association Pakistan.
- Hafeez, M. (2004b). Perceived Life Situation of an Elderly situation in Pakistan: Gender based Findings in Lahore. In Nizamuddin, M., Maqsood, F., Ahmed, J. S., and Ahmed, M. N. (2010). How the Elderly Live in Punjab. United Nations Population Fund (UNFPA) and University of Gujrat, Pakistan.
- Hagedoorn, M., Sanderman, R., & Bunk, B. (2002). Failing in spousal care giving: The “identity-relevant stress” hypothesis to explain sex differences in caregiver distress. *British Journal of Health Psychology*, 7, 481–94.

- Harphom, T., Reichenheim, M., Oser, R., Thomas, E., Hamid, E., Jaswal, S., & et al. (2003). How to do ( or not to do) measuring mental health in a cost-effective manner. *Health Policy and Planning, 18*(3), 344–349.
- Hashmi, S. M. H. (2003). *Aging of the Population. Population of Pakistan: An Analysis of 1998 Population and Housing Census* (pp. 313–326). PIDE.
- Havigurst, R. J. (1963). Successful aging. In Richard. H. W., Clark. T., and Wima, D. (1990). *Process of Aging: Social and Psychological Perspectives*. New York: Atherton.
- Heath, J. M., Brown, M., Kobylarz, F. ., & Castano, S. (2005). The prevalence of undiagnosed geriatric health conditions among adult protective service clients. *Gerontologist, 45*(6), 820–823.
- Herman, H., & et al. (2005). *Promoting Mental Health; Emerging evidence, Practice*. Geneva: WHO Department of Mental Health.
- Heun, R., & Hein, S. (2005). Risk factors of major depression in the elderly. *European Psychiatry, 20*(3), 199–204.
- Hogstel, M. O. (1995). *Geropsychiatric Nursing* (2nd ed.). St. Louis: Mosby- Year Book, Inc.
- Houston, D., McKee, K., & Wilson, J. (2000). Attributional style, efficacy, and the enhancement of wellbeing among husbands and older people. *Basic and Applied Social Psychology, 22*(4), 309–317.
- Hoverton, A., & Gundy, K. . (2009). Sex difference in coping styles and implications for depressed moods. *International Journal of Stress Management, 16*(4), 333–350.

- Hughes, M. E., & Waite, L. J. (2002). Health in household context: Living arrangements and health in late middle age. *Journal of Health and Behaviors*, 43(1), 1–21.
- Hussain, N., Chaudry, I. B., Afridi, M. A., Tomenson, B., & Creed, F. (2007). Life stress and depression in a tribal area of Pakistan. *British Journal of Psychiatry*, 190, 36–41.
- Hussain, N., Creed, F., & Tomnson, B. (2000). Depression and social distress in pakistan. *Psychological Medicine*, 30, 395–402.
- Itrat, A., Tauqi, A. ., Qazi, F., & Qidwai, W. (2007). Family system: Perception of elderly patients and their attendants presenting at a university hospital in Karachi, Pakistan. *Journal of Pakistan Medical Association*, 57(2).
- Jamison, D. ., Feacham, R. G., Macgoba, M. W., & et al. (2006). *Disease and Mortality in Sub-Saharan Africa* (2nd ed.). Washington:DC: John Willey and Sons LTD.
- Jeon, J. ., Jang, S. N., Rhee, S. J., Kawachi, I., & Cho, S. (2007). Gender differences in correlates of mental health among elderly Koreans. *Journal of Gerontology: SOCIAL SCIENCES*, 62 B(5), 323–329.
- Jhoda, M. (1958). *Current Concept of Positive Health*. New York: Basic Books.
- Joseph, J. (1986). *Sociology of Everyone*. USA: Polity Press.
- Kahl, J. (1957). The American Class Structure. In Ansari, K. (2003). Personality Traits and socio-economic status as a Predictor of Marital Adjustment in Working Women. Unpublished doctoral dissertations, Institute of Clinical Psychology, University of Karachi, Pakistan.

- Kaneko, Y., Motohashi, Y., Sasaki, H., & Yamaji, M. (2007). Prevalence of depressive symptoms and related risk factors for depressive symptoms among elderly persons living in a rural Japanese community: a cross-sectional study. *Community Mental Health Journal, 43*(6), 583–589.
- Karban, K. (2011). *Social Work and Mental Health*. USA: Polity Press.
- Karen, M. J. (1988). Assurance in New York State: Resident-centred protocols the basis. Provider: for long term care professionals. *American Journal of Psychiatry, 24*(12), 21–26.
- Katschnig, H. (1997). How useful is the concept of quality of life in psychiatry? *Current Opinion in Psychiatry, 10*, 337–345.
- Kendler, K. S., Karkowski, L. M., & Percott, C. A. (1999). *Fear and Phobias: Reliability and Heritability*. In Barlow, D.H., & Durand, V.M. (2002). *Abnormal Psychology* (3rd ed., p. 213). Belmont, CA: Wadsworth Group.
- Kessler, R. C., Zhao, S., Blazer, D., & Swart, M. (1997). Prevalence, correlates, and course of minor depression and major depression in the National Comorbidity Survey. In Mark H. R., Lewis L. J., Pamela J. S., Kimberly A., Michael E. T., David J. K., Ellen F., John M. P., Gary D. T., & A. John Rush. (2005). A descriptive analysis of minor depression. *Focus the Journal of Life long Learning in Psychiatry, 3*(1) 27-36.
- Khalid, M. (2003). *Social Problems of Pakistan*. Karachi: Kafi Academy.
- Koeing, H. . (1995). *Aging and God: Spiritual Pathways to Mental Health in mid Life and Later Years*. New York: Howarth Pastoral Press.

- Koeing, H. G. (2006). Religion, spirituality and aging. *Aging and Mental Health*, *10*(1), 1–3.
- Koenging, H. G., & Blazer, D. (1992). Mood disorders and suicide. In Zarit, H. S., & Zarit, M. J. (1998). *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatments*. New York: Guilford Publications, Inc.
- Kolb, L. C. (1977). *Modern Clinical Psychiatry*. Philadelphia: Saunders.
- Kraaij, V., Garnefski, N., & Maes, S. (2002). The joint effect of stress, coping and coping resources on depressive symptoms in the elderly. *Anxiety, Stress and Coping*, *15*(2), 163–177.
- Krause, D. (1986). Stress and sex difference in depressive symptoms among older adults. *Journal of Gerontology*, *41*(6), 727–731.
- Krause, N. (1995). Religiosity and self-esteem among older adults. *Journal of Gerontology*, *50*(5), 236–247.
- Krause, N. (1999). Assessing change in social support during late life. *Research on Aging*, *21*(4), 539–569.
- Krause, N., & Van Tran, T. (1989). Stress and religion involvement among older blacks. *Journal of Gerontology: Social Sciences*, *44*, 4–13.
- Kubie, S. (1954). The Fundamental nature of the distinction between Normality and neurosis. *Psychoanalytical Quarterly*, *23*, 167–204.
- Lampert, L. (1996). Women's strategies for survival: Developing agency in abusive relationships. *Journal of Family Violence*, *11*, 269–290.
- Lasch, C. (1980). *The Culture of Narcissism*. New York: Abacus Press.

- Lavikainen, J., Lahtinen, E., & Lehtinen, V. (2001). *Public health approach on mental health in Europe*. Helsinki: STAKES.
- Lazarus, R. S. (1966). *Psychological Stress and the coping process*. New York: McGrawHill.
- Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping*. New York: Springer.
- Lee, Y., & Shinkai, S. (2005). Correlates of cognitive impairment and depressive symptoms among older adults in Korea and Japan. *International Journal of Geriatric Psychiatry, 20*, 576–586. doi:10.1002/gps.1313
- Leung, K. K., Chen, C. Y., Lue, B. H., & Hsu, S. T. (2007). Social support and family functioning on psychological symptoms in elderly Chinese. *Archives of Gerontology & Geriatrics, 44*, 203–213.
- Levin, J., Taylor, R., & Chatter, L. (1994). Race and gender differences in religiosity among older adults: Findings from four national surveys. *Journal of Gerontology: Social Sciences, 49*(3), 137–145.
- Lewinsohn, P., & Alexander, L. (1990). Coping and depression. In Rosenbaum (Ed.), *learned resourcefulness on Coping Skills, Self Control and adoptive Behavior*. New York: Springer Publishers.
- Lewinsohn, P. M., Biglan, A., & Zeiss, A. M. (1976). Behavioural treatment of depression. In Davidson, P.O. (Ed.), *The behavioural management of anxiety, depression and pain*. New York: Brunner/Mazel.
- Lewinsohn, P. M., & MacPhillamy, D. (1974). The relationship between age and engagement in pleasant activity. *Journal of Gerontology, 29*, 290–294.

- Li, C. ., DiGiuseppe, R., & Froh, J. (2006). The roles of sex, gender, and coping in adolescent depression. *Adolescence*, *41*, 409–415.
- Lieberman, M. A., & Tobin, S. S. (1983). *The Experience of Old Age: Stress Coping and Survival*. New York: Basic Books.
- Lipowski, Z. J. (1983). Transient cognitive disorders (delirium, acute confusion states) in the elderly. *American Journal of Psychiatry*, *140*, 1426–1436.
- Liu, C. Y., Wang, S. J., Teng, E. L., & et al. (1997). Depressive disorders among older residents in a Chinese rural community. *Psychologic Med*, *27*, 943–949.
- Longino, C. F., & Wilmoth, J. (2007). *Demography of Aging*. In Ahmed, K., and Hafeez, M. (2006). Population Aging: An Emerging Social and Economic Issues in Pakistan. Retrieved on December 13, 2011. From [http:// drhafeez.com/uploads/publications/source/publicationsource\\_14.pdf](http://drhafeez.com/uploads/publications/source/publicationsource_14.pdf).
- Luborsky, M. R. (1994). The cultural adversity of physical disability: Erosion of full adult personhood. *Journal of Aging Studies*, *8*, 239–54.
- Luni, F. K., Ansari, B., Jawad, A., Dawson, A., & Baig, S. . (2009). Prevalence of depression and anxiety in a village in Sindh. *Journal of Ayub Medical College Abbottabad*, *21*(2). [http://www.ayubmed.edu.pk/JAMC/70\\_PAST/21-2/Faraz.pdf](http://www.ayubmed.edu.pk/JAMC/70_PAST/21-2/Faraz.pdf).
- Maclean, A., & Hauser, R. M. (2000). *Socioeconomic status and depression among adult siblings*. Department of sociology, Centre for Demography of Health and Aging, University of Wisconsin-Madison.

- Malhotra, R., Chan, A., & Østbye, T. (2009). Prevalence and correlates of clinically significant depressive symptoms among elderly people in Sri Lanka: findings from a national survey. *International Psychogeriatrics*, 22(2), 227–236. doi:10.1017
- Maqsood, F., Flatt, D. ., Albert, S. ., Maqsood, S., & Nizamuddin, M. (2013). Correlates of self-reported depressive symptoms: a study of older persons of punjab, Pakistan. *J Cross Cult Gerontol*, 28, 65–74.
- Martin, P., Rott, C., Poon, L., Courtenay, B., & Lehr, U. (2001). A molecular view of coping behavior in older adults. *Journal of Aging and Health*, 13(1), 72–91.
- Maslow, A. H. (1968). *Toward a Psychology of Being*. Princeton: Princeton university press.
- Matteson, M. A., & McConnel, E. S. (1988). *Gerontological nursing: Concepts and Practice*. Philadelphia: Saunders.
- Mavandadi, S., Rook, K. S., & Newsom, J. T. (2007). Positive and negative social exchanges and disability in later life: An investigation of trajectories of change. *Journals of Gerontology: Psychological and Social Sciences*, 62, 361–370.
- Mc Crae, R. R., & Costa, P. T. (1986). Personality, coping and coping effectiveness in an adult sample. *Journal of Personality*, 54(2), 385–405.
- Meller, I., Fichter, M., & Schroppel, H. (1996). Incidence of depression in octo- and nonagenerarians: results of an epidemiological follow-up community study. *European Archive Psychiatry Clinical Neuroscience*, 46, 93–99.

- Meyer, A. (1908). The aims and meanings of psychiatric diagnosis. *American Journal of Insanity*, 74, 163–168.
- Miech, R. A., & Shanahan, M. J. (2000). Socioeconomic status and depression over the life course. *Journal of Health and Social Behavior*, 41, 162–176.
- Mildred, O. H. (1995). *Geropsychiatric Nursing*. Texas, USA: Mosby publishers.
- Minot, S. R. (1986). Depression: What does it mean? *American Journal of Nursing*, 86(3), 284–288.
- Mirowsky, J., & Ross, C. E. (2001). Age and the effect of economic hardship on depression. *Journal of Health and Social Behavior*, 42(2), 132–150.
- mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *BMJ*, 32(4), 780–794. doi:10.1136/bmj.328.7443.794
- Mirza, I., & Jenkins, R. (2004a). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: a systematic review. *British Medical Journal*, 328(7443), 794.
- Mirza, I., & Jenkins, R. (2004b). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *British Medical Journal*. doi:10.1136/bmj.328.7443.794
- Mjelde-Mossey, L. A., Chi, I., & Lou, V. W. Q. (2006). Relationship between adherence to traditions and depression in chine elders in china. *Aging and Mental Health*, 10(1), 19–26.
- Mosby's Dental Dictionary. (2008). Elsevier, Inc.

- Mumford BD, M. F. (2000). Stress and psychic disorder in urban Rawalpindi community survey. *British Journal of Psychiatry*, 557–562.
- Mumford BD, Minhas, F. A., Akhtar, I., Akhtar, S., & Mubashar, M. . (2000). Stress and psychiatric disorder in urban Rawalpindi. Community survey. *British Journal of Psychiatry*, 177, 557–562. doi:10.3109/09540269309028307
- Mumford BD, Nazir, M., Jilani, F. U., & Baig, I. Y. (n.d.). Stress and psychiatric disorder in the Hindu Kush: a community survey of mountain villages in Chitral, Pakistan. *British Journal of Psychiatry*, 68, 299–307.
- Mumford BD, Saeed, K., Ahmed, I., Latif, S., & Mubashar, M. H. (1997). Stress and psychiatric disorder in rural Punjab. A community survey. *British Journal of Psychiatry*, 170, 473–478.
- Muntaner, C., Eaton, W., Miech, R., & O' Campo, P. (2004). Socioeconomic positions and major mental disorders. In Skapinakis, P. (2006). Socio-economic positions and common mental disorders: longitudinal study in the general population in uk. *The British journal of Psychiatry*. 189(2)109-117.
- Muramatsu, N. (2003). County- level income inequality and depression among older Americans. *Health Service Research*, 38, 1863–1884.
- Murberg, T. A., & Bru, E. (2001). Coping and mortality among patients with congestive heart failure. *International Journal of Behavioral Medicine*, 8(1), 66–79.
- Murray, C. J., & Lopez, A. D. (1997a). Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet*, 349, 1498–504.

- Murray, C. J., & Lopez, A. D. (1997b). Alternative projections of mortality and disability by cause 1990-2020: Global Burden of Disease Study. *Lancet*, 349(1498), 504.
- Naarding, P., Tiemeier, H., Breteler, M. M. ., & et al. (2007). Clinically defined vascular depression in the general population. *Psychol Med*, 37, 383–392.
- Nandi, P. S., Banerjee, G., Mukherjee, S., Nandi, S., & Nandi, D. (1997). A study of psychiatric morbidity in an elderly population in a rural community in West Bengal. *Indian Journal of Psychiatry*, 39, 122–129.
- National Institute for Mental Health. (1992). *Depression in Late Life*.
- National Institute for Mental Health. (2005). *A Directory for Mental Health*. England.
- National Statistics. (2003). *Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain*.
- Newsom, J. T., Nishishiba, M., Morgan, D. L., & Rook, K. S. (2003). The relative importance of three domains of positive and negative social exchanges: A longitudinal model with comparable measures. *Psychology of Aging*, 18, 746–754.
- Newsom, J. T., Rook, K. S., Nishishiba, M., Sorkin, D. H., & Mahan, T. L. (2005). Understanding the relative importance of positive and negative social exchanges: Examining specific domains and appraisals. *Journals of Gerontology: Psychological Sciences and Social Sciences*, 60, 304–312.
- NHS Health Advisory Service. (1995). *Together We Stand: The Commissioning, Role and Management of Child and Adolescent Mental Health Services*. London.

- Nicolson, P. (2001). *Postnatal depression: Facing the Paradox of Loss, Happiness, and Motherhood*. West Sussex: John Wiley & Sons Ltd.
- Nizamuddin, M., & Ahmed, J. S. (2003). *Report of the First International Summer Workshop on Population Ageing*. USA: United Nations Fund for Population ageing and Columbia University.
- Nizamuddin, M., Ahmed, J. S., & Maqsood, F. (n.d.). Demography on Aging. In *Encyclopaedia of Life support System*.
- Nizamuddin, M., Maqsood, F., & Ahmed, J. S. (2010). *How the Elderly Live in Punjab-A Field Survey of the Living Conditions and Health Status of the Elderly of Punjab 2009*. University of Gujrat, Pakistan.
- Nolen-Hoeksema, S. (2001). *Abnormal Psychology* (2nd ed.). New York: McGraw-Hill Companies.
- Nour, K., & Herbert, M. (2010). Older Adults with mental health problems; A community collaboration. *Journal of the Centre de Recherche et Expertise En Gerontologie Sociale, 1*, 15–23.
- P et.al. (2002). Prevalence and incidence of depression in the Thai elderly. *Journal of the Medical Association of Thailand, 85*(5), 540–544.
- Pakistan Medical Research Council. (2003). *Survey on the Health and Living Conditions of the Elderly Population of Pakistan*. Islamabad: Pakistan.
- Pargament, K. I. (1992). Of means and ends: Religion and the research for significance. *International Journal for the Scientific Study of Religion, 2*, 201–229.

- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (n.d.). Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, 37, 710–724.
- Parker, G. (2000). Classifying depression: should paradigms lost be regained? *American Journal of Psychiatry*, 157, 1195–1203.
- Parker, J., & Enler, N. (1996). Coping and defense: A historical overview. In M. Zeidner & N. Enler (Eds.), *Hand Book of Coping, Theory, Resoures and Applications* (pp.323). New York: Wiley.
- Parmalee, P. A., Katz, I. R., & Lawtons, M. P. (1992). Incedence of depression in lonng term care settings. *Journal of Gerontology*, 47, 189–196.
- Patel, V., & Prince, M. (2001). Ageing and mental health in a developing country: Who cares? Qualitative studies from Goa, India. *Psychological Medicine*, 31(1), 29–38.
- Paul, N., Milke, V., Marijke, B., Dorly, D., Aartjan, T. F., & Beekman. (2009). The symptom profile of vascular depression. *International Journal of Geriatric Psychiatry*. doi:10.1002/gps.2203
- Pek, C., Coward, R., Henretta, J., Duncan, R., & Dougherty, M. (1997). Differences by race in the decline of health overtime. *Journal of Gerontology: Social Sciences*, 52(6), 336–344.
- Pickard, J. G. (2006). The relationship of religiosity to older adults' mental health service use. *Aging & Mental Health*, 10(3), 290–97.
- Pilgrim, D. (2010). *Key Concepts in Mental Health* (2nd ed.). London: Sage Publications.

- Pouget, R., Yersin, B., Wietlisbach, V., Burnand, B., & Bula, C. J. (2000). Depressed mood in a cohort of elderly medical inpatients: prevalence, clinical correlates and recognition rate. *Aging (Milano)*, *12*, 301–307.
- Pritchard, C. (2006). *Mental Health Social Work; Evidence-Based Practice*. London: Routledge.
- Psychiatry and the oldest old. (2000). *Am J Psychiatry*, (157), 1915–1924.
- Ptacek, J. T., Smith, R. E., & Zanas, J. (1992). Gender, appraisal, and coping: A longitudinal analysis. *Journal of Personality*, *60*, 745–770.
- Qureshi, Sarfraz K., and Arif, G. M. (2001). Profile of Poverty in Pakistan, 1998-99. Pakistan Institute of Development Economics, Islamabad (MIMAP Technical Paper Series No. 5.
- Regier, D. A., Goldberg, I. D., & Taube, C. A. (2001). The de facto United States mental health services system. *Arch.Gen.Psych*, *35*, 685–693.
- Ren, X., Amick, B., & William, D. (1999). Racial ethnic disparities in health: The interplay between discrimination and socio-economic status. *Ethnicity and Disease*, *9*(2), 151–165.
- Research and Development Centre for Welfare and Health, STAKES Ministry of Social Affairs and Health*. (n.d.).
- Riaz, U. (2005). The experience of Old Pakistani People in Bradford, Research on Age and Discrimination. Retrieved on June, 10 2011, from <http://eolss.net/eolss-sampleallchapter.aspt>.

- Robins, E., & Guze, S. (1970). Establishment of diagnostic validity in psychiatric illness: its implication to schizophrenia. *American Journal of Psychiatry*, *120*, 983–987.
- Rosow, I. (1967). *Social Integration of the Aged*. New York: Free Press.
- Roth, M. (1995). The natural history of mental disorders in old age. *Journal of Mental Science*, *101*, 281–189.
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: usual and successful. *Science*, *237*, 143–149.
- Ryan, M., & Patterson, J. (1987). Loneliness in the elderly. *Journal of Gerontological Nursing*, *13*(5), 6–12.
- Scholte, W. ., Verduin, F., Lammeren, A. V., Rutayisire, T., & Kamperman, A. M. (2011). Psychometric properties and longitudinal validation of the self reporting questionnaire (SRQ-20) in a Rawandan community setting: a validation study. *Medical Research Methodology*, *11*. [http// www. Biomedcentral.com/1471/11/116](http://www.Biomedcentral.com/1471/11/116)
- Schuyler, D. (1974). *The Depressive Spectrum*. New York: Aronson.
- Scull, A. (1979). *Museum of Madness*. Penguin: Harmondsworth.
- Semedely, B. (1999). The cancer gap: research needs of African Americans. In Spriggs, W. (1999). *The State of Black Americans*. New York: National Urban League.
- Sheikh, J. A., & Yesavage, J. A. (1986). *Geriatric depression scale (GDS): recent findings and development of a shorter version*. In *Clinical Gerontology: A Guide to Assessment and Intervention*. New York: Howarth Press.

- Shuchter, S. R., Downs, N., & Zisook, S. (1996). *Biologically informed Psychotherapy for depression*. New York: Guilford Press.
- Simon, R. (1995). Gender, multiple roles, role meaning, and mental health. *Journal of Health and Social Behavior, 36*, 182–194.
- Skapinakis, P. (2006). Socio-economic positions and common mental disorders: longitudinal study in the general population in uk. *The British Journal of Psychiatry, 189*(2), 109–117.
- Smith, J. (1997). Wealth inequality among older American. *The Journal of Gerontology, 52*, 74–81.
- St. Pierre, J., Craven, R., & Bruno, P. (1986). Late life depression: A guide for assessment. *Journal of Gerontological Nursing, 12*(7), 5–10.
- Stafford, M., McMunn, A., Zaninotto, P., CStat., & Nazroo, J. (2011). Positive and negative exchanges in social relationships as Predictors of depression: evidence from the English longitudinal study of aging. *Journal of Aging and Health, 23*(4), 607–628.
- Stankunas, M., Kalediene, R., Starkuviene, S., & Kapustinskiene, V. (2006). Duration of unemployment and depression: a cross-sectional survey in Lithuania. *BMC Public Health, 6*, 174–79. doi:10.1186/1471-2458-6-174.
- Steffens, D., Skook, I., & Norton, M. C. (n.d.). Prevalence of depression and its treatment in an elderly population: the Cache County study. In Blazer, D. G., (2009). Depression in late life: review and commentary. Retrieved August 18, 2011, from [focus.psychiatryonline.org](http://focus.psychiatryonline.org).

- Stone, A. A., & Neale, J. M. (1984a). Effects of severe daily events on mood. *Journal of Personality and Social Psychology*, *46*, 137–144.
- Stone, A. A., & Neale, J. M. (1984b). Effects of severe daily events on mood. *Journal of Personality and Social Psychology*, *46*, 137–144.
- Streib, G. F., & Schneider, C. J. (1971). *Retirement in American society*. Ithaca, NY: Cornell University Press.
- Talat, B. (2005). Old and old old population distribution in Punjab. *Pakistan Geographical Review*, *60*(1), 12–18.
- Taqi, A. ., Itrat, A., Qidwai, W., & Qadri, Z. (2007). Depression in the elderly: Does family play a role? A cross-sectional study. *BMC Psychiatry*, *7*, 57–62.
- The American Heritage Medical Dictionary. (2007). Houghton Mifflin Company.
- The Leiden 85-plus Study. (n.d.). *The 15-item Geriatric Depression Scale (GDS-15) detects changes in depressive symptoms after a major negative life event*.
- The Office for National Statistics Psychiatric Morbidity report. (2001). <http://www.mentalhealth.org.uk/help-information/mental-health-statistics/UK-worldwide/>. Retrieved December 5, 2011, from
- The Situation of Elderly Population in Pakistan: Problems and Prospects. (2008). <http://www.specialsedu.com/2011/01/situation-of-elderly-population-in.html>. Retrieved January 12, 2012, from
- The World Health Organization quality of life assessment (WHOQOL). (1995). *Social Science and Medicine*, *41*, 1403–1409.
- Thomas, M., & Pierson, J. (1999). *Collins Educational Dictionary of Social Work*. London: Harper Collins Publishers.

- Thongtang, O., Sukhatunga, K., Ngamthipwatthana, T., Chulakadabba, S., Vuthiganond, S., & Pooviboonsuk. (2002). Prevalence and incidence of depression in the Thai elderly. *J Med Assoc Thai*, 85, 540–48.
- Tilbury, D. (2002). *working with mental illness: A Community –based Approach* (2nd ed.). Basingstoke: Palgrave.
- United Nation Department of Economics and Social Affairs. (2009). *World Population Prospects: The 2008 Revision. United Nations*. New York.
- United Nation Population Fund. (1999). *Growing Old in Pakistan: Study on the Situation of Elderly People in Pakistan*.
- US Department of Health and Human Services. (2001). *Culture, Race, and Ethnicity, A Supplement to Mental Health : A Report of the Surgeon General*.
- Venkoba Rao, A. (1993). Psychiatry of old age in India. *International Review of Psychiatry*, 5, 165–170. doi:10.3109/09540269309028307
- Ventevogel, P., Devries, G., Scholte, W. F., Rasa, S. N., Faiz, H., Nassery, R., & et al. (2007). Properties of the Hopkins symptoms checklist 25 (HSCL-25) and the self reporting questionnaire (SRQ-20) as screening instrument used in primary care in Afghanistan. *SOC Psychiatry Psychiatric Epidemiol*, 42, 328–335.
- Vitaliano, P. P., Dewolfe, D. J., Maiuro, R. D., Russo, J., & Ensel, W. (1990). Appraised changeability of a stressor as a modifier of the relationship between coping and depression—A test of the hypothesis of fit. *Journal of Personality and Social Psychology*, 59, 582–592.

- Wada, T., Ishine, M., Sakagami, T., Okumiya, K., Fujisawa, M., Murakami, S., & et al. (2004). Depression in Japanese community-dwelling elderly—prevalence and association with ADL and QOL. *Archives of Gerontology and Geriatrics*, 39(1), 15–23.
- Weissman, M. M., & Myer, J. K. (n.d.). Affective disorders in a U. S. urban communities. In Zarit, H. S., & Zarit, M. J. (1998). *Mental Disorders in Older Adults: Fundamentals of Assessment and Treatments*. New York: Guilford Publications, Inc.
- Weissman, M. M., Leaf, P. J., Tischler, G. L., Blazer, D. J., Carno, M., Bruce, M. L., & Floria, L. P. (1988). Affective disorders in five United States communities. *Psychological Medicine*, 18, 141–153.
- Welsh Assembly Government. (2002). *Adult Mental Health services: A National Service Framework for Wales*. Cardiff.
- What are mental health problems. (n.d.). Retrieved October 5, 2010, from <http://www.mentalhealth.org.uk/help-information/an-introduction-to-mental-health/what-are-mental-health-problems/> .
- Willenz, P. (2005). Low socio-economic status in a risk factor for mental illness. Retrieved April 24, 2009, from [http:// www. Eurekaalert.org/pub\\_release/2005-03/apa-Iss030205.php](http://www.Eurekaalert.org/pub_release/2005-03/apa-Iss030205.php)
- World Health Organization. (2001b). *Basic Documents*. Geneva.
- World Health Organization. (2001d). *Strengthening mental health promotion*. Geneva.

- World Health Organization. (1951). *Technical Report series No. 31*. Geneva.
- World Health Organization. (1986). *Ottawa charter for health promotion*. Geneva.
- World Health Organization. (2001a). *The World Health Report: Mental Health*. Geneva.
- World Health Organization. (2001b). *World Health Report*. Geneva.
- World Health Organization. (2005). *Mental Health Promotion*. Geneva.
- World Health Organization. (2006). *Mental Health*. Retrieved from [http://who.int/mental\\_health/en/](http://who.int/mental_health/en/)
- World Population Aging 1950-2050*. (2002). United Nations.
- Yamane, T. (1967). *Elementary Sampling Theory*. New Jersey: Prentice Hall.
- Young-Ho, K. (2003). Correlation of Mental Health Problems with Psychological Constructs in Adolescence: final result form 2-year Study. *International Journal of Nursing Studies*, 40, 115–124.

## Appendix –I

### INTERVIEW SCHEDULE

Serial No. \_\_\_\_\_ Date: \_\_\_\_\_

Respondent's Name \_\_\_\_\_ Sex \_\_\_\_\_

Address: \_\_\_\_\_

Union Counsel/Town

\_\_\_\_\_ Tehsil \_\_\_\_\_ District \_\_\_\_\_

\_\_\_\_\_ community: Rural \_\_\_\_\_ Urban \_\_\_\_\_

### **BASIC ATTRIBUTES AND FAMILY MAKE UP**

#### 6.1 Age

- i. 60-----69
- ii. 70-----79
- iii. 80-----89
- iv. 90-----100
- v. More than 100

#### 6.2 Educational Status

- i. Literate \_\_\_\_\_
- ii. Illiterate \_\_\_\_\_

#### 6.3 If educated, level of education

- i. Primary \_\_\_\_\_
- ii. Middle \_\_\_\_\_
- iii. Matric \_\_\_\_\_
- iv. Intermediate \_\_\_\_\_
- v. Graduation \_\_\_\_\_
- vi. Post-Graduation \_\_\_\_\_
- vii. Any other \_\_\_\_\_

## 6.4 Type of family

- i. Nuclear \_\_\_\_\_
- ii. Joint \_\_\_\_\_
- iii. Extended \_\_\_\_\_

## 6.5 Family size

\_\_\_\_\_

## 6.6 Marital status of respondent

- i. Married \_\_\_\_\_
- ii. Unmarried \_\_\_\_\_
- iii. Widow \_\_\_\_\_
- iv. Divorced \_\_\_\_\_

## 6.7 Do you have children?

- i. Yes \_\_\_\_\_
- ii. No \_\_\_\_\_

## 6.8 If yes, specify the number of children.

\_\_\_\_\_

## 6.9 What is the status of children?

- i. Working
- ii. Studying

## 6.10 Are you currently working? (skip 9-15 in case of females)

- i. Working \_\_\_\_\_
- ii. Stopped working \_\_\_\_\_
- iii. Looking for working \_\_\_\_\_
- iv. Never work and not looking for work \_\_\_\_\_

## 6.11 If working, then what type of work you engaged in?

- i. Professional (technical, managerial) \_\_\_\_\_
- ii. Business \_\_\_\_\_
- iii. Skilled manual \_\_\_\_\_
- iv. Domestic services \_\_\_\_\_

- v. Agriculture \_\_\_\_\_
- vi. Labour \_\_\_\_\_
- vii. Shopkeeper \_\_\_\_\_
- viii. Any other, specify \_\_\_\_\_

6.12 What is your monthly income?

Rs. \_\_\_\_\_

6.13 If not working, then why did you stop working?

- i. Retired formally \_\_\_\_\_
- ii. Ill health \_\_\_\_\_
- iii. Age factor \_\_\_\_\_
- iv. Other, specify \_\_\_\_\_

6.14 At what age did you stop working?

Years \_\_\_\_\_

6.15 Do you provide financial support to your family?

- i. Yes \_\_\_\_\_
- ii. No \_\_\_\_\_

6.16 What is your family income?

Rs. \_\_\_\_\_

6.17 Did you still engage in house hold chores?

- i. Yes \_\_\_\_\_
- ii. No \_\_\_\_\_

### **FAMILY ATTITUDE TOWARDS THE ELDERLY**

6.18 Do your family members are educated?

- i. Yes \_\_\_\_\_
- ii. No \_\_\_\_\_

6.19 What is your living status.

- i. Alone
- ii. With Spouse
- iii. With family
- vi. Other (Please Specify) \_\_\_\_\_

6.20 If your children are not living with you, then where they are living.(skip for those living within same boundary or have on child)

- i. In the same city    ii. In other city     iii. Abroad

6.21 4. In case of living out of city, how many times do they visit you?

- i. Every day        ii. Two times per week    iii. Once per month   
 iv. Less than once per month  v. Any other specify \_\_\_\_\_

6.22 Who provides you primary care?

- i. None        ii. Spouse     iii. Son    iv. Daughter   
 v. Daughter in law    vi. Private Nurse     vii. Servant   
 ix. Other (please specify) \_\_\_\_\_

6.23 What is the extent of relationship with other children living in separate home?

- i. Favorable    ii. Unfavorable    iii. Normal

6.24 What is the source of your financial support?

- i. Self        ii. Children     iii. Pension-private   
 iv. Pension-government     v. Charity     vi. Others (please specify)

6.25 How much your families pay attention to you?

- i. To some extent \_\_\_\_\_  
 ii. Moderate \_\_\_\_\_  
 iii. A lot \_\_\_\_\_  
 iv. Not at all \_\_\_\_\_  
 v. Another (specify) \_\_\_\_\_

6.26 Do you consider that your family takes care of all your needs?

- i. Yes \_\_\_\_\_  
 ii. No \_\_\_\_\_  
 iii. To some extent \_\_\_\_\_

6.27 Which types of your needs are fulfilled by your family?

- i. Accommodation\_\_\_\_\_
- ii. Health\_\_\_\_\_
- iii. Food\_\_\_\_\_
- iv. Financial\_\_\_\_\_
- v. Social support\_\_\_\_\_
- vi. All of above \_\_\_\_\_

6.28 Do you suffering from any disease?

- i. Yes\_\_\_\_\_
- ii. No.\_\_\_\_\_

6.29 If yes, then what disease?

\_\_\_\_\_

6.30 Do they provide proper and in time medical treatment?

- i. Yes\_\_\_\_\_
- ii. No\_\_\_\_\_

6.31 How much honour and respect you got in the family when you were young?

- i. A lot \_\_\_\_\_
- ii. Moderate \_\_\_\_\_
- iii. Not at all\_\_\_\_\_

6.32 How much honour and respect you got in the family when you are old or getting old?

- i. A lot \_\_\_\_\_
- ii. Moderate \_\_\_\_\_
- iii. Not at all\_\_\_\_\_

6.33 Is your family listen you carefully and accepted your opinion?

- i. Yes\_\_\_\_\_
- ii. No\_\_\_\_\_

6.34 In which family matters you are consulted?

- i. Daily life activities\_\_\_\_\_
- ii. Property matters\_\_\_\_\_
- iii. Business \_\_\_\_\_

iv. Kinship and marriage\_\_\_\_\_

v. Every matter \_\_\_\_\_

vi. Any others, specify\_\_\_\_\_

6.35 If your family plans for outing are you asked to accompany or left behind to guards the house?

i. Accompany\_\_\_\_\_

ii. Left behind\_\_\_\_\_

6.36 Do you feel comfortable and enjoyment to participate in ceremonies of the family?

i. Yes\_\_\_\_\_

ii. No\_\_\_\_\_

6.37 If no, then why?

i. \_\_\_\_\_

ii. \_\_\_\_\_

iii. \_\_\_\_\_

6.38 Are you satisfied with the behavior of family members?

i. Yes\_\_\_\_\_ ii No\_\_\_\_\_

6.39 If no, what are the reasons?

i. Family members do not have  
enough time to take care of you\_\_\_\_\_

ii. They did not want to take care of you \_\_\_\_\_

iii. Sometime they take care of you\_\_\_\_\_

iv. They ignore you \_\_\_\_\_

v. You are exclude form your family \_\_\_\_\_

vi. Any other, specify\_\_\_\_\_

6.40 How much time you spend with your family?(only for males)

\_\_\_\_\_

6.41 What was the behaviour of your family when you become tense and frustrated?

- i. They advice me to stop take tension \_\_\_\_\_
- ii. They stop to talk with me\_\_\_\_\_
- iii. They frightened and remained silent \_\_\_\_\_
- iv. They stop my entry in home\_\_\_\_\_
- v. Any other (specify) \_\_\_\_\_

**Causes of Mental Health Problems**

6.42 What factors are linked with positive mental health?

- i. Economic support\_\_\_\_\_
- ii. Strong social network\_\_\_\_\_
- iii. Emotional resilience and positive thinking \_\_\_\_\_
- iv. Stress free environment\_\_\_\_\_
- v. Faith in God\_\_\_\_\_
- vi. Good health \_\_\_\_\_

6.43 Would you have to face any undesirable event in your life?

- i. Yes \_\_\_\_\_
- ii. No\_\_\_\_\_

6.44 If yes, then which type of event?

.....  
 .....  
 .....

6.45 Do you undermine your sense of control after getting old?

- i. Yes\_\_\_\_\_
- ii. No\_\_\_\_\_

6.46 If yes, then what are the reasons contribute to this factor?

- iv. Losses of aging \_\_\_\_\_
- v. Lower level of education and awareness \_\_\_\_\_
- vi. Dependency\_\_\_\_\_
- vii. Misfortunes of life \_\_\_\_\_

viii. Any other(specify)\_\_\_\_\_

6.47 Are you facing any abuse?

i. Yes\_\_\_\_\_ ii. No.\_\_\_\_\_

6.48 If yes then what type of abuse?

i. Physical \_\_\_\_\_

ii. Psychological\_\_\_\_\_

6.49 Do you feel comfortable at home?

i. Yes\_\_\_\_\_ ii. No\_\_\_\_\_

6.50 If no, what are the reasons?

i. Due to sleeplessness\_\_\_\_\_

ii. Due to your tension and frustration\_\_\_\_\_

iii. Due to family misbehavior\_\_\_\_\_

iv. Due to family conflict \_\_\_\_\_

v. Due to noise \_\_\_\_\_

vi. Due to uncomfortable room \_\_\_\_\_

vii. Due to non-availability of room \_\_\_\_\_

viii. Due to worries/ poverty \_\_\_\_\_

6.51 What are the social factors that may be considered the causes/risk factors of mental health problems?

i. Dysfunctional family life \_\_\_\_\_

ii. Economic dependency\_\_\_\_\_

iii. Loneliness\_\_\_\_\_

iv. Low self esteem\_\_\_\_\_

v. Death/ divorce \_\_\_\_\_

vi. Launching of children \_\_\_\_\_

vii. Lack of social support \_\_\_\_\_

viii. Negative and stressful life events \_\_\_\_\_

ix. Changing societal values and belief\_\_\_\_\_

x. Any other(specify)\_\_\_\_\_

### Coping Mechanism of the Elders

6.52 How would you manage your time after getting retirement or disengagement from business activities and agriculture?( for males)

- i. Engage yourself in household activities\_\_\_\_\_
- ii. Become lethargic and rest at home\_\_\_\_\_
- iii. Reading news papers and watching TV\_\_\_\_\_
- iv. Join the company of your age group\_\_\_\_\_
- v. Attend the spiritual Mehfiles and offer prayers \_\_\_\_\_
- vi. Join a welfare organization\_\_\_\_\_
- vii. Any others, specify \_\_\_\_\_

6.53 How would you manage your time after the disengagement from household activities (for females)?

- i. Engage yourself in child caring\_\_\_\_\_
- ii. Become lethargic and contented \_\_\_\_\_
- iii. Reading newspapers and watching TV\_\_\_\_\_
- iv. Attend the family functions \_\_\_\_\_
- v. Attend the spiritual Mehfiles and offer prayers \_\_\_\_\_
- vi. Join a welfare organization\_\_\_\_\_

6.54 What is your coping, in case of illness and increased physical dependency due to aging?

- i. Insist for treatment to family \_\_\_\_\_
- ii. Seek social support by family\_\_\_\_\_
- iii. Compromise the situation\_\_\_\_\_
- iv. Try to cope the problem personally \_\_\_\_\_
- v. Others, specify \_\_\_\_\_

6.55 How would you cope the loss of roles and status?

- i. Demand for your participation in decision making \_\_\_\_\_
- ii. Become irritating and aggressive \_\_\_\_\_

- iii. Compromise the situation \_\_\_\_\_
- iv. Become isolated and withdraw from social responsibilities \_\_\_\_\_
- v. Discuss the problem with others \_\_\_\_\_
- vi. Engage themselves in other activities \_\_\_\_\_

6.56 What is your reaction on account of misbehavior of your family?

- i. Compromise the situation \_\_\_\_\_
- ii. Talk with others \_\_\_\_\_
- iii. Become emotional \_\_\_\_\_
- iv. Become isolated \_\_\_\_\_
- v. Others, specify \_\_\_\_\_

6.57 When you stressed, how you cope with it?

- i. Avoid the situation to face \_\_\_\_\_
- ii. Took courage and think about solution \_\_\_\_\_
- iii. Wept on my helplessness \_\_\_\_\_
- iv. Recite Holy Quran and say prayers \_\_\_\_\_
- v. Shouted while thinking about the problem. \_\_\_\_\_
- vi. Dreamed about the solution of the problem. \_\_\_\_\_
- vii. Need the help of your family and friends \_\_\_\_\_
- viii. Engage in other activities \_\_\_\_\_

6.58 When you entangled within the problematic situation, how do you cope with it?

- i. Internalize negative assessment \_\_\_\_\_
- ii. Inclination to withdraw \_\_\_\_\_
- iii. Become Autonomic \_\_\_\_\_  
(Take courage and do their function whatever possible)

6.59 In case of internalize negative assessment, what's your reaction?

- i. Become depressed \_\_\_\_\_
- ii. Become violent \_\_\_\_\_

iii. Become the victim of self-criticism\_\_\_\_\_

6.60 In case of inclination to withdraw, what's your reaction?

i. Become isolated \_\_\_\_\_

ii. Leads to sleeplessness \_\_\_\_\_

iii. Started Addiction \_\_\_\_\_

iv. Started over-eating \_\_\_\_\_

v. Hoped for a miracle \_\_\_\_\_

vi. Consider it the will of God \_\_\_\_\_

6.61 In case of Autonomic, what's your reaction?

i. Discuss the problem with  
people facing same situation\_\_\_\_\_

ii. Tries to clear my view point to others\_\_\_\_\_

iii. Think about the positive aspect of problems\_\_\_\_\_

iv. Try to solve the problem in the light of other's advice\_\_\_\_\_

v. Try to remove the lope holes in my \_\_\_\_\_  
personality by self-assessment

6.62 Would you like to change the environment (accommodation)?

i. Yes \_\_\_\_\_ ii. No \_\_\_\_\_

6.63 If yes, what's your adaptation regarding migration/ change of  
accommodation?

i. Wanted to live within the same community separately \_\_\_\_\_

ii. Within family set up \_\_\_\_\_

iii. Within the institutional setup\_\_\_\_\_

**Appendix –II**  
**Geriatric Depression Scale (GDS-15)**

Questions	Yes	No
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel happy most of the time?		
4. Do you prefer to stay at home, rather than going out and doing new things?		
5. Are you in good spirits most of the time?		
6. Do you think it is wonderful to be alive now?		
7. Do you feel full of energy?		
8. Do you feel that your life is empty?		
9. Do you often get bored?		
10. Are you afraid that something bad is going to happen to you?		
11. Do you often feel helpless?		
12. Do you feel you have more problems with memory than most?		
13. Do you feel that your situation is hopeless?		
14. Do you think that most people are better off than you are?		
15. Do you feel pretty worthless the way you are now?		

Total GDS score:

(1) 0 - 4      Normal (No depression)      [ ]

(2) 5 - 15      Screen positive for depression      [ ]

**Appendix –III**  
**Self Reporting Questionnaire (SRQ-20)**

Questions	Yes	No
1. Do you often have headaches?		
2. Is your appetite poor?		
3. Do you sleep badly?		
4. Do you easily frightened?		
5. Do your hands shake?		
6. Do you feel nervous, tense or worried?		
7. Is your digestion poor?		
8. Do you have trouble thinking clearly?		
9. Do you feel unhappy?		
10. Do you cry more than usual?		
11. Do you find it difficult to enjoy your daily activities?		
12. Do you find it difficult to make decisions?		
13. Is your daily work suffering?		
14. Are you unable to play a useful part in life?		
15. Have you lost interest in things?		
16. Do you feel that you are a worthless person?		
17. Has the thought of ending your life been on your mind?		
18. Do you feel tired all the time?		
19. Do you have uncomfortable feeling in your stomach?		
20. Are you easily tired?		