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Quality of Life and Geriatric Depression among Elderly Residents in Old Age Homes and Domestic Environments in Kerala.

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Abstract

Aging is a natural and essential part of human life. The Quality of Life (QoL) for the elders indicates their overall well-being and might be a risk factor for many conditions like geriatric depression. The study aims to compare older people living in domestic environments with those in Old Age Homes (OAH) to examine the variations in life quality and the prevalence of geriatric depression. The study followed a mixed-method approach and was conducted in two phases. Phase 1 includes a comprehensive understanding of QoL and geriatric depression that was established by an in-depth random data collection from 80 older adults aged between 60 and 90 years in Kerala, India, using the WHOQOL-BREF and Geriatric Depression Scale (GDS). Data was then analyzed statistically by using an independent sample t-test, Karl Pearson's correlation, linear regression, and descriptive statistics. In Phase 2, by using semi-structured interviews, a random sample of eight people aged between 60 and 80 years was chosen from the Phase 1 pool which involved comparing and identifying the factors influencing geriatric depression and QoL in both living situations using thematic analysis. The findings show that there is a significant negative relationship between quality of life and geriatric depression among older individuals. The elders in old age homes reported a higher quality of life and lower geriatric depression. There were negligible gender differences. Physical, psychological, social, and environmental factors affect the quality of life and geriatric depression. The study also reveals that old age homes provide a better environment for elderly care compared to domestic environments, as they provide enhanced social support, structured caregiving, and better access to healthcare. This study thus paves the way for more compassionate approaches to elderly care and well-being.

Keywords: Quality of life (QoL), Geriatric depression, Elderly, Old age homes (OAH), Domestic environments.

INTRODUCTION

As humanity keeps aging, the quality of life (QoL) and geriatric depression of older adults have become a major concern. Even though elderly perspectives have not been fully included in the different definitions and theories of QoL that have been put forth, researches indicate that older adults have a lower quality of life. QoL as an individual's ability to derive maximum enjoyment from the valuable opportunities in their lives. Factors like a person's physical, mental, and spiritual well-being, social relationships, educational

status, employment status, social status, financial level, sense of security, autonomy, safety, freedom, sense of social belonging, and physical surroundings altogether affect the quality of life of an elder individual. It is to be noted that a high standard of living is not the same as quality of life, which is mostly determined by income and economic status. QoL of an elder individual is often affected by Geriatric depression that includes having persistent feelings of sadness, hopelessness, and lack of enthusiasm for activities that were previously enjoyed. Geriatric depression is a clinical disorder that affects the well-being of older individuals, impairing their daily life and activities, and is often related to mood changes. Blazer, D. G. (2003) discovered a relationship between a higher risk of morbidity, higher risk of suicide, worsening physical, cognitive, and social functioning, and higher levels of self-neglect with each variable associated with a higher chance of dying. Causes of geriatric depression may of genetic and non-genetic biological and psychological factors, sleep deprivation, and other illnesses like cardiovascular diseases, neuro pathological alterations like dementia and Alzheimer's disease. Social factors like financial hardships, grief, loss of loved ones, interpersonal relationships, and conflicts may also lead to late-life depression. Fiske A. et al. (2009) state that increased financial status and education levels, involvement in meaningful activities, spiritual or religious affiliation, and age-related increases in psychological resilience are certain risk factors in later life.

In humans, old age represents the end of a typical life span. In Indian society and culture, the elderly is an integral part of a family. The joint family system has long been prevalent in India, where sons in particular were responsible for caring for their aging parents. However due to recent shifts in the family structure, the traditional joint family arrangement is becoming less common. With the surge in nuclear households, Indians are abandoning their ancient traditions. Thus, the elderly has also been impacted by homelessness, loneliness, and helplessness brought about by modern society. Old age also requires support and help in every aspect of their life, i.e. socially, psychologically, and physically. Industrialization and globalization have resulted in the institutionalization of the elderly, unlike the prior culture and tradition particularly followed in countries like India, pushing or forcing the elderly to live in old age homes away from their own homes since they couldn't catch up with the technological advancement and busiest global lives of their children and grandchildren. The flourishing growth of old age homes ensures people a good quality of life and decreases geriatric depression to establish the value of services provided to the elderly. Also, most of the older population has chronic disorders, and a cure is not an option, but care is needed to manage these terminal disorders. Thus, understanding the prevalence and severity of geriatric depression and quality of life would have a great impact on the lives of the elderly. Moreover, the concept of old-age homes is new to the people of Kerala but is fast flourishing. To match the objectives of care services to the expectations of older individuals, it is imperative to understand the things that they value in life. Identifying factors influencing their quality of life and depression from their perspectives enables the development of targeted interventions. Hence, the present study follows a mixed approach to understand, compare, and correlate the experiences of those in old age homes with the domestic environment, aiming to provide valuable insights; fostering a better mental health outcome for the elderly population in their last years.

Review of Literature

Papageorgiou et al. (2022) conducted a study on the association between depression and quality of life in the elderly, revealing that the elderly with depressive symptoms have a lower quality of life.

Vijayalakshmi et al. (2022), in their study, A Correlational Study on Depression and Quality of Life

among Older Persons, found that there is a highly significant negative correlation between depression and quality of life.

Karini et al. (2019), in a comparative study of depression among senior citizens in communities and old age homes in Visakhapatnam, India, show that older house inmates had a higher level of depression than community inmates.

Panday et al. (2015) conducted a study on the quality of life between elderly people living in old-age homes and within family setups at two old-age homes and two areas of Ranchi Kantatoli and Kanke. The findings of this study indicate that quality of life was better for elderly people who were living in old age homes in comparison to those who were living within a family setup.

Research questions

1. Is there any sufficient difference in the quality of life among the elderly in both living arrangements—old-age homes and their own homes—especially in countries like India where the old-age home is a new but flourishing concept?
2. From the older perspectives, what are the factors that affect the quality of life and geriatric depression of the elderly residing in old age homes and domestic environments?
3. How are the quality of life and geriatric depression different in two living arrangements—an old-age home and a domestic environment—from the perspectives of old-age people?
4. How are some aspects like social support, caregiving structures, and access to healthcare services different in old-age homes and domestic environments?

METHOD

Objectives

1. To find the relationship between quality of life and geriatric depression among the elderly.
2. To find out the difference in overall quality of life and geriatric depression among elderly individuals in old-age homes and domestic environments.
3. To identify the gender differences in quality of life and geriatric depression among the elderly.
4. To find the factors influencing the quality of life and geriatric depression in each living arrangement.
5. To compare the impact of old age homes and domestic environments on quality of life and geriatric depression, considering aspects such as social support, caregiving structures, and access to healthcare services.
6. To provide insight and recommendations to enhance the quality of life and mental health outcomes for the elderly in both living environments.

Research Philosophy & Paradigm

In this study, positivism and interpretivism are both applied. The researcher has combined both the objective and subjective data derived respectively from quantitative and qualitative research methodologies. Therefore, the researcher has used the pragmatic research philosophy.

Research Design

The present mixed study has followed the triangulation convergence model.

Phases of the Research Process

PHASE 1

In Phase 1, the study aimed to assess the relationship between geriatric depression and quality of life among senior citizens in both domestic settings and old-age homes. Additionally, the research focused on

identifying variations in geriatric depression and overall quality of life among seniors in these different environments while also exploring potential gender differences within these variables. The assessment utilized the Geriatric Depression Scale (GDS) short form for evaluating depression and the WHOQOL-BREF for finding the overall quality of life among the elderly participants.

Research design

The quantitative method of data collection was used in this phase.

Hypotheses

H1. There will be an extensive relationship between quality of life and geriatric depression.
H2. There will be a substantial relationship between quality of life and geriatric depression among elderly residents in old-age homes.
H3. There will be a substantial relationship between quality of life and geriatric depression among elderly residents in domestic environments.
H4. Elderly people will have a better quality of life in domestic environments than in old-age homes.
H5. Geriatric depression will be lower in domestic environments than in old-age homes.
H6. There will be an extensive gender difference in quality of life among the elderly.
H7. There will be a substantial gender difference in geriatric depression among the elderly.

Participants

A total sample of 80 elderly males and females from Kerala was selected randomly. The sample is divided into 20 males and 20 females in both old-age homes and domestic environments. The age range of the participants was 60 to 90.

Inclusion criteria

- Elderly residents from both old-age homes and domestic environments.
- Age between 60 and 90 years.
- Both married and unmarried.

Exclusion Criteria

- Bedridden patients and intellectually disabled.
- International people (other than Indians) and the elderly residing in other states besides Kerala.
- Other genders, besides male and female.

Data Collection Tools

Tool 1. The WHOQOL-BREF

The WHOQOL Group (1998) developed the 26-item World Health Organization Quality of Life Brief Version (WHOQOL-BREF), a condensed version of the 100-item WHOQOL-100 quality of life measure. According to Skevington et al. (1999) & Power, M. et al. (1999), Harper, A. E et al. (1998); the WHOQOL-BREF is a 26-item tool that comprises quality of life and general health questions in addition to four domains: physical health, psychological health, social relationships, and environmental health. WHOQOL-BREF is a five-point Likert scale. The scores range from 1 to 5 and are then linearly translated to a scale of 0 to 100.

Tool 2. The Geriatric Depression Scale (GDS) – short form

Sheikh, J. I et al. (1986) created the Geriatric Depression Scale (GDS); a short, 15-item survey that asks participants to rate their feelings from the previous week by selecting yes or no. Elderly people who are in good health, have a medical condition, or have mild to moderate cognitive impairment can use the GDS. In acute, long-term, and community care settings, it has been widely employed. Patients who are

physically sick and mildly to moderately demented, with short attention spans and easily fatigued, find it easier to use the short form. It takes 5 to 7 minutes to complete (Sheikh, J. I et al. 1986).

Procedure of Data Collection

The researcher conducted data collection in various old age homes and homes in Kerala, establishing a positive rapport with randomly selected elderly individuals. Each participant was presented with the WHOQOL-BREF and GDS scales, and the researcher ensured comprehension of the questionnaires by explaining their meaning and vocabulary. The participants marked their responses in the researcher's presence to prevent misunderstandings, with each tool taking approximately 15-30 minutes to complete. Additionally, a consent sheet was obtained from each participant, emphasizing their role in the study, and official consent was secured from old age homes to adhere to ethical guidelines.

Data Analysis

The data was analyzed using descriptive statistics with the help of Microsoft EXCEL and Statistical Package for the Social Sciences (SPSS) Version 25 software. The statistical tests used to analyze the data include independent sample t-test, Karl Pearson's product-moment correlation, linear regression, and descriptive statistics.

PHASE 2

The goals of Phase 2 are to identify the variables affecting each type of living arrangement's QoL and geriatric depression and to contrast the effects of domestic and assisted living facilities on these variables. The data collection was collected through semi-structured interviews.

Research design

The qualitative method of data collection was used in this phase.

Participants

The study employed a random sampling technique to select a total of eight participants, aged between 60 to 80 years, from the same pool as Phase 1. The sample included two males and two females from both Old Age Homes and domestic environments, ensuring gender balance and representation from each setting.

Inclusion criteria

- Old-age people from both old age homes and domestic environments.
- Males & females aged between 60 and 80 years.

Exclusion Criteria

- Intellectually disabled & bedridden patients.
- People residing in other states besides Kerala and from other nationalities besides India.
- Unmarried & illiterate.

Data Collection Tool

A semi-structured interview method was used to collect data. An informed consent sheet was collected from the participants. For this, the researcher has developed some interview questions:

1. What are the bodily disturbances that affect your current daily life activities?
2. What medical services and financial benefits do you get currently?
3. What more activities do you want to do in your life and what are the memorable experiences you had in your life?
4. How does your current relationship status with your family, spouse, friends, relatives, and community differ from earlier?

5. How are some aspects like social support, caregiving structures, and access to healthcare services different in old age homes and domestic environments?

Procedure of Data Collection

The researcher collected data from the elderly in residential settings across Kerala, India, by interviewing them in part after obtaining consent from assisted living facilities and volunteers. Individuals were randomly selected from the participants in the first phase, and the researcher established a good rapport with the participants and explained the purpose of the study. Phase 2 included a variety of sociodemographic information in a 40-minute anonymous interview per person, including age, occupation, education, health status, socioeconomic status, family background, interests, and characteristics are included. Recognizing the limitations of writing and transcription, audio recordings were used to harmonize the topics, to be accurate, and to keep the conversations natural.

Data analysis

The present study used a thematic analysis method for the data analysis.

Ethical consideration of the study

The ethical standards laid down by APA (American Psychological Association) were strictly followed by the researcher and an official permission was also sought from concerned authorities at old age homes. At the very beginning of the research, the researcher had prepared a synopsis of the research and presented it to the Department of Psychology, St. Joseph's College (Autonomous), Irinjalakuda, and received approval of the same. A consent sheet was obtained from the old age home and informed consent was obtained from participants before the study which clearly explained the purpose and meaning of the study. Participants were then interviewed by the researcher. The average time for one interview was about 30-40 minutes.

Socio-demographic data

The participant's socio-demographic data was collected which included name (not compulsory), age, sex, religion, marital status, physical and psychological illness (if any), education, occupation, family type (if any), no: of children (if any), Socio economic status, place of living, residential place, hobbies and bad habits (if any).

Table 1: Demographic Details of Participants in Phase 1 (n = 80)

		n	Percentage
Age	60 – 69	36	45 %
	70 – 79	34	42.5 %
	≥ 80	10	12.5 %
Marital status	Married & living together	27	33.75 %
	Unmarried	12	15 %
	Divorced	9	11. 25 %
	Widow/ widower	32	40 %
Educational status	Illiterate	32	40 %
	Primary education	23	28.75 %
	Secondary education	19	23.75 %
	Graduate & above	6	7.5 %
Occupation	Yes	10	12.5 %
	No	70	87.5 %

Mode of wages	Supported by family Pension Supported by old age home Self	42 33 40 10	52.5 % 41.25% 50 % 12.5 %
Number of children	1 – 5 6 – 10 No children	51 9 20	63.75 % 11.25 % 25 %
Physical illness	Diabetics Thyroid Hypertension Heart disease Other	61 52 75 44 66	76.25 % 65 % 93.75 % 55 % 82.5 %

n = number of samples

Table 2: Demographic Details of Participants in Phase 2 (n= 8)

	Participant number	**Age**	**Sex**	**Education**	**Occupation**	**Mode of wages**	**No: of children**
Old Age Home	Participant 1	80	Male	Graduate	No	Pension and support from OAH	2
	Participant 2	63	Male	Secondary	No	Support from OAH	2
	Participant 3	76	Female	Secondary	No	Support from OAH	0
	Participant 4	65	Female	Primary	No	Support from OAH	2
Domestic Environment	Participant 5	70	Male	Graduate	Yes	Self and pension	4
	Participant 6	78	Male	Secondary	Yes	Self and pension	3
	Participant 7	74	Female	Primary	No	Pension	6
	Participant 8	65	Female	Secondary	No	Support from family	4

n = number of samples, OAH = old age home

Table 1 and 2 shows the demographic details of the participants in Phase 1 and Phase 2 respectively.

RESULT & DISCUSSION

The result and discussion are discussed in five sections:

Section 1: Relationship between quality of life and geriatric depression among the elderly.

This section provides an overview of descriptive statistics of all the variables taken in the present study and the relationships between them.

Table 3: Descriptive Statistics of all Variables.

Variables	N	Mean	Standard Deviation
Physical Health (D1)	80	44.687	11.769
Psychological Health (D2)	80	46.406	19.108
Social Relationships (D3)	80	45.546	12.535
Environment (D4)	80	51.250	16.888
QoL	80	46.972	12.246
Geriatric Depression	80	8.950	2.525

D = domain

Table 3 represents descriptive statistics of all variables. The overall QoL of the elderly is moderate with a mean value of 46.972 and a standard deviation of 12.246. Elderly people have moderate depression with a mean value of 8.950 and standard deviation of 2.525. For domains of QoL; the mean value for D1, D2, D3 & D4 are 44.687 (low), 46.406 (moderate), 45.546 (low), and 51.250 (moderate) respectively.

Table 4: Correlation between overall Quality of Life (QoL), Different Domains of Quality of Life, and Geriatric Depression of Older Adults.

Variables	1	2	3	4	5	6
1. Physical Health (D1)	-					
2. Psychological Health (D2)	0.643**	-				
3. Social Relationships (D3)	0.281*	0.494**	-			
4. Environment (D4)	0.621**	0.682**	0.372**	-		
5. QoL	0.777**	0.906**	0.645**	0.855**	-	
6. Geriatric Depression	-0.706**	-0.774**	-0.554**	-0.770**	-0.879**	-

D= domain, N = 80, **$p < 0.01$, *$p < 0.05$

Table 4 depicts Pearson's correlations between the four sub-domains of quality of life, overall quality of life, and geriatric depression among old age people. It is noteworthy that QoL and Geriatric Depression have a significantly strong negative correlation (r = -0.879, $p = 0.000$), which denotes that an increase in quality of life is related to a significantly strong decrease in depression among old age people. According to Vijayalakshmi et al. (2022), there is a highly significant negative relationship between respondents' QoL and depression.

It is also evident from Table 4 that among the sub-dimensions of quality of life, psychological health is the domain that has the strongest negative correlation with depression (r = -0.774, $p = 0.000$), followed by the environment domain (r = -0.770, $p = 0.000$), physical health domain (r = 0.643, $p = 0.000$) and social relationships domain (r = -0.554, $p = 0.000$). Therefore, the alternate hypothesis (H1); There will be an extensive relationship between quality of life and geriatric depression is accepted.

To understand if the residential pattern of older adults affects this relationship between QoL and Depression, Pearson's correlation was calculated separately for the older adults living at the old age homes and living in domestic residences and the results of the same have been shown in Tables 5 and 6.

Table 5: Correlation between Overall Quality of Life (QoL) and Geriatric Depression of Older Adults Residing in Old Age Homes.

Variables	1	2
1. QoL	-	
2. Geriatric Depression	-0.804**	-

N = 40, **$p < 0.01$

Table 5 represents the correlation between overall Quality of Life (QoL) and Geriatric Depression of older adults residing in old age homes. Depression has a significantly strong negative correlation (r = -0.804, $p = 0.000$) among old age people living in old age homes. Therefore, the alternate hypothesis (H2); There will be a substantial relationship between quality of life and geriatric depression among elderly residents in old-age homes is accepted.

Table 6: Correlation between Overall Quality of Life score (QoL) and Geriatric Depression of Older Adults Residing in Domestic Environments.

Variables	1	2
1. QoL	-	
2. Geriatric Depression	-0.898**	-

N = 40, **$p < 0.01$

Table 6 depicts the correlation between the overall quality of life score (QoL) and geriatric depression of older adults residing in domestic environments. From the table, it is evident that depression has a significantly strong negative correlation (r = -0.898, $p = 0.000$) among old age people living in domestic environments. Therefore, the alternate hypothesis (H3) that There will be a substantial relationship between quality of life and geriatric depression among elderly residents in domestic environments is accepted.

Table 7: Linear regression predicting Geriatric Depression by Quality of Life among Older Adults.

	B	SEB	β
Constant	17.465	0.540	
QoL	-0.181	0.011	-0.879**

R^2 =0 .773, ** $p < 0.01$, N = 80

Table 7 shows the linear regression conducted with the dependent variable being geriatric depression of older people clarifies that QoL significantly predicts geriatric depression by 77.3 percent ($R^2 = 0.773$, $p < 0.01$). A decrease of 0.879 units of quality of life increases geriatric depression by one unit (β = -0.879, $p < 0.01$). It clarifies that a minor difference in quality of life is potent enough to develop or induce geriatric depression among older adults.

The relation between quality of life (QoL) and geriatric depression among the aged is negative. It may be due to the interplay of various factors. Firstly, physical health affects signs of depression and QoL significantly. The quality of life (QoL) of persons is greatly reduced by chronic illnesses, functional restrictions, and pain, as these factors hinder their everyday activities and overall pleasure of life. Also, physical health frequently causes feelings of powerlessness, dissatisfaction, and melancholy; the emotions that are frequently linked to geriatric depression in older persons. Secondly, social isolation seems to be an important factor influencing both psychological health and QoL. This happens when lonely people lack somebody to share their problems with hence, end up keeping everything to themselves thereby making the emotional burden too heavy for them alone which eventually leads to stress. The decreasing sense of belonging and social support have restricted social engagements reporting lower quality of life. Social isolation breeds feelings of worthlessness, hopelessness, and emotional upheaval. Thirdly, cognitive declination, memory loss, and worsened decision-making reduce people's sense of autonomy and independence, which lowers their quality of life (QoL). Moreover, frustration, unwanted worries, anxiety, and a sense of identity loss are common reactions to cognitive impairment in older persons and are all indicatives of depression. Lastly, environmental stressors including financial instability, housing facilities, exposure to traumatic life events, and climatic variations can further worsen QoL.

Section 2: Variation in overall quality of life and geriatric depression among the elderly.

This section depicts the difference in QoL and also determines the severity and prevalence of geriatric depression among old age people living in both environments.

Table 8: t-test on domains of QoL – D1, D2, D3, and D4 along with the overall QoL and Geriatric depression of older adults based on type of residence.

Grouping variable	**Old age homes**			**Domestic environments**			**t-value**	***p***
Dependent variable	**N**	**Mean**	**SD**	**N**	**Mean**	**SD**		
Physical Health (D1)	40	52.142	9.997	40	37.232	8.163	7.306	0.000
Psychological Health (D2)	40	61.666	11.486	40	31.145	11.400	11.927	0.000
Social Relationships (D3)	40	53.020	13.005	40	38.072	5.878	6.624	0.000
Environment (D4)	40	62.734	15.035	40	39.765	9.006	8.288	0.000
QoL	40	57.391	7.214	40	36.554	5.391	14.632	0.000
Geriatric depression	40	7.325	1.745	40	10.575	2.110	-7.505	0.000

SD = standard deviation, D = domain, N = Number of samples

Table 8 represents a t-test on dimensions of QoL like physical health (D1), psychological health (D2), social relationships (D3), and environment (D4), along with the overall QoL and geriatric depression of older adults based on type of residence. It becomes evident from Table 8 that there are significant

differences in quality of life and geriatric depression among the older adults belonging to old age homes when compared with the ones living in domestic residences. The result of the study is that there is a highly significant increase (t = 14.632, *p* = 0.000) in the QoL experienced by the people living in old age homes (M = 57.391, SD = 7.214) when compared with their counterparts living in domestic residences (M = 36.554, SD = 5.391). The old age people in OAH have a moderate QoL whereas the QoL is low in elderly living in a domestic environment. There is a similarly significant increase in scores of all four dimensions of QoL among the older adults living in OAH when compared to the ones living in domestic residences. The domains in OAH; D1, D2, D3, and D4 has the mean and standard deviation of M = 52.142, SD = 9.997 (moderate); M = 61.666, SD = 11.486 (moderate); M= 53.020, SD = 13.005 (moderate); and M = 62.734, SD = 15.035 (moderate) respectively. Similarly, the domains in domestic environments; D1, D2, D3, and D4 has the mean and standard deviation of M= 37.232, SD = 8.163 (low); M = 31.145, SD = 11.400 (low); M = 38.072, SD = 5.878 (low) & M = 39.765, SD = 9.006 (low) respectively. Therefore, the H4 (Hypothesis 4); Elderly people will have a better quality of life in domestic environments than in old-age homes, is rejected.

Similarly, on the other hand, there is a significant difference (t = -7.505, *p* = 0.000) in the Depression scores of people belonging to two different residence types with the comparatively higher depression score found among older adults living in domestic residences (M = 10.575, SD = 2.110) when compared with the ones living in old age homes (M = 7.325, SD = 1.745). From the values, it is clear that old people in OAH have mild depression, and elderly people in domestic environments have moderate depression. It is because of the better facilities and social relationships found in OAH compared to domestic residences. Therefore H5 (Hypothesis 5); Geriatric depression will be lower in domestic environments than in old-age homes, is rejected.

OAH offers a controlled and encouraging environment that enhances residents' QoL and reduces geriatric depression when compared to domestic settings. Here, people can build strong social networks which fosters a sense of belonging and reduces feelings of isolation and loneliness. In OAH, people get somebody of their age to share their feelings. It is evident from Participant 7 from OAH who reported that all of them have some or the other problems. But they share, console each other, and lead a happy life. She added *"...I am grateful that we have someone of our age to chat to at this advanced age. We complete a family here."*

Compared to domestic situations, the extensive support and amenities offered by old age homes with the help of committed employees and staff such as caretakers and medical professionals foster an environment that is favourable to a higher quality of life and a lower incidence of geriatric melancholy among older persons. OAH also provides a controlled living environment that reduces stress related to safety and security, allowing the residents to concentrate on living life to the fullest and engaging in leisure activities.

Section 3: Gender differences in quality of life and geriatric depression among the elderly.

This section depicts an understanding of gender differences in QoL and Geriatric depression among old age people prevailing in both OAH & domestic residences.

Table 9: t-test on domains of QoL – D1, D2, D3, and D4 along with the overall QoL and Geriatric depression of older adults based on type of gender.

Grouping variable	Males			Females			t-value	*p*
Dependent variable	N	Mean	SD	N	Mean	SD		
Physical Health (D1)	40	44.553	6.469	40	44.821	15.450	-0.101	0.920
Psychological Health (D2)	40	44.479	14.507	40	48.333	22.837	-0.901	0.370
Social Relationships (D3)	40	47.447	11.867	40	43.645	13.039	1.368	0.177
Environment (D4)	40	50.390	13.148	40	52.109	20.083	-0.453	0.652
QoL	40	46.717	8.061	40	47.227	15.448	-0.185	0.854
Geriatric Depression	40	8.500	1.648	40	9.400	3.128	-1.610	0.111

SD = standard deviation, D = domain, N = Number of samples

Table 9 represents a t-test on dimensions of QoL like Physical health (D1), Psychological health (D2), Social relationships (D3), and Environment (D4), along with the overall QoL and geriatric depression scores of older adults based on type of gender. From the table, it is also clear that the domains of QoL also have no significant difference based on gender. Different domains of quality of life – D1, D2, D3, and D4 also have no significant difference based on gender. Similarly, geriatric depression in males (M = 8.500, SD = 1.648) has no significant difference with females (M = 9.400, SD = 3.128). When interpreting the results of depression, according to GDS, older males have mild geriatric depression whereas females have moderate depression. Thus, the H6 (Hypothesis 6); There will be an extensive gender difference in quality of life among the elderly, is rejected. Also, H7 (Hypothesis 7); There will be a substantial gender difference in geriatric depression among the elderly is rejected.

The absence of an overall gender difference in quality of life (QoL) and geriatric depression can be attributed to several factors. Societal advancements in healthcare facilities and access to resources for both men and women have led to increased awareness among them. It results in more equitable opportunities for maintaining physical and mental well-being in later life. Older adults regardless of gender, face similar challenges such as chronic illness, functional inabilities, and isolation, which can impact their QoL and depression.

Section 4: Factors influencing the quality of life and geriatric depression.

This section depicts the different factors influencing the quality of life and geriatric depression in each living arrangement from the perspectives of the elderly.

Table 10: Themes, sub-themes and codes extracted from the participants' interviews.

Themes	Subthemes	Codes
1. Physical factors	1.1.Presence of chronic conditions/ problems	1.1.1. Diabetics 1.1.2. Thyroid 1.1.3. High blood pressure 1.1.4. Heart-related diseases

	1.2.Functional inabilities	1.2.1. Sleep 1.2.2. Muscular pain including arthritis. 1.2.3. Inability to meet daily life activities.
	1.3.Access to medical services	1.3.1. Access to doctors and hospitals. 1.3.2. Access to medicines.
2. Psychological factors	2.1.Emotional declination	2.1.1. Death of loved ones. 2.1.2. Separation from children and home
	2.2. Cognitive declination	2.2.1. Memory loss 2.2.2. Poor judgement and decision making.
	2.3. Resilience	2.3.1. Spirituality 2.3.2. Positiveness and prior experience. 2.3.3. Hobbies & leisure time
3. Social factors	3.1 Social interaction	3.1.1. Relationship with family, friends, relatives, and others. 3.1.2. Family support
	3.2 Job	3.2.1 Education 3.2.2 Unemployment
	3.3 Marriage & marital life	3.3.1 Marital discord, divorce, and satisfaction. 3.3.2 Sex life satisfaction 3.3.3 Culture
4 Environmental factors	4.1 Economic factors	4.1.1 Financial insecurity 4.1.2 Sense of security & autonomy. 4.1.3 Technological involvement in elderly life.
	4.2 Housing factors	4.2.1 Adaptability 4.2.2 Housing Conditions.
	4.3 Natural changes	4.3.1 Climatic variability 4.3.2 Urbanisation

Table 10 shows different themes and sub-themes identified from the perspectives of older people residing in both OAH & domestic environments. After the interview with the elderly, the investigator found four different major themes - physical factors, psychological factors, social factors, and environmental factors that affect or influence the QoL of the elderly, leading them to depression. It is evident from Table 8 that the physical, psychological, social, and environmental domains have a negative correlation with depression.

Theme 1: Physical Factors

Physical factors like chronic illness, daily life functional inabilities, and timely access to medical services affect the life quality of the elderly. Chronic conditions like heart disease, hypertension, and thyroid lead to functional inabilities like discomfort and insomnia. The availability of medical services, such as prompt doctor visits, hospital stays, and the provision of essential medications, has an impact on the physical

health of senior citizens. Functional inabilities include sleeping problems, muscular pain including arthritis, and inability to meet daily life activities. But physical limitations are effectively managed in OAH, unlike domestic environments, further enhancing residents' QoL. In OAH, activities of daily living, such as bathing, dressing, and mobility, are supported by trained staff who assist residents with their individual needs. This level of support improves autonomy among residents, contributing to a sense of dignity and well-being. The condition is reversed in domestic settings.

According to the study findings by Lena et.al. (2009), most of the elderly suffered from conditions including high blood pressure, which was followed by anaemia, diabetes, asthma, cataracts, and arthritis. Participant 1 from the domestic environment reported that how he has mobility problems due to arthritis. He stated "…. having arthritis make me difficult to move around and do my daily routines. I feel a significant pain in my leg when I walk."

It seemed that daily intake of medicines also gave rise to an addiction to prescribed drugs and an emotional decline. Old people usually love to visit the doctors and some even need more medicines. Participant 4 from the domestic environment reported that "…without taking my hyper pressure med I feel empty and distorted. Every month I need to see my doctor".

Timely consultations with doctors, hospital visits, and availability of necessary medications by OAH to the elderly unlike those found in domestic environments, increase QoL of the elderly people. Participant 8 from OAH reported, "…I occasionally need to see a doctor due to my physical issues but I never have had any problems here because the physicians visit us weekly."

Access to medical services is comparatively less in domestic settings due to low financial status. Another factor contributing involves the separation from children making limited access by to children to their parents in case of any emergency. This even doesn't mean the same in all cases but children in domestic settings are mostly settled abroad can be an added reason for the same. Participant 3 from the domestic environment reported, "…With my physical problems, I have difficulty in meeting my daily life activities; say I feel dizzy while bathing, with nobody to care and help makes everything a bit difficult." Thus, by managing and treating these physical variables appropriately, it may be possible to enhance the quality of life and lessen depressive symptoms.

Theme 2: Psychological Factors

Psychological factors include a wide range of experiences and emotions like emotional distress stemming from the loss of loved ones and separation from children and home environments leading to depressive symptoms among this population. However, resilience factors such as spirituality, the ability to adapt and bounce back from challenges, and engaging in hobbies serve as protective factors against depression. It is vital for maintaining psychological well-being positive outlook. Participant 3 from the domestic environment reports that she was living alone in her house besides having six children. She added "…I am not taken care of by my children. I live alone and feel alone. But belief in my God keeps me going."

Participant 6 from OAH says "…ever since my wife passed away, I've felt anxious and alone. But my fellow inmates are my buddies and they constantly make me feel wonderful." He further added "… I enjoy sketching and covers my usual leisure time." Participant 1 from the domestic environment also shared his emotional decline due to the death of his parents, siblings, and relatives, he further said "…but involving in religious practices, spirituality, and charity gives me a sense of peace".

Old age is filled with experiences and take the positivity from past life. They often seem to review their past life experiences so happily. Participant 1 reported how he takes the positiveness from the past experiences and how often he advices the younger ones with it. He stated "… I have faced a lot of

difficulties in my professional and personal journey. But every bit of moment gives us something to study about. Learning is not something exclusively for children, we must also learn from our mistakes and try to move on. This makes you feel proud of your overcoming and also makes you the strongest."

Cognitive decline, including memory loss and poor judgment, is a common concern among elderly individuals. Participant 1 said "…Forgetting is a major issue I am facing today. For me, it affects my job as a Principal. I forget the things I kept and wanders in search of it"

What makes an old age home different from domestic settings is due to many reasons. Firstly, structured grief counseling sessions and group therapy activities provide OAH residents with opportunities to process their emotions and receive support from peers, contributing to a healthier emotional state. Secondly, the presence of trained staff members who understand the unique needs of elderly individuals with cognitive decline ensures that residents receive appropriate support and assistance in their daily activities, promoting a higher QoL. Participant 8 from OAH reported that she often forgets to take medicine and even does some daily life activities. But the assistants in OAH make her remember the prescription every time. She said, "…. Many times, I had and have forgotten to take my meds but these people walk my back and make me eat every time." Thirdly, old age homes provide opportunities for residents to cultivate resilience through spiritual practices, positive thinking, and engaging in hobbies and leisure activities such as painting or gardening, providing residents with a sense of purpose and fulfillment, and enhancing their overall sense of well-being. Participant 7 from OAH said "… I am a Hindu and I always believe in God especially, Ganapathi (a Hindu religious God) but to me, all religions seem to be one. Here we all recite The Gita, The Ramayana often read The Bible, and at dawn, we chant 'Dikr' (holy chant of Muslims) daily irrespective of the religion, caste, and culture."

It seems most old people are involved in reading. When compared with domestic settings OAH people get more leisure time and are involved in their hobbies. In domestic settings participants especially, females reported a lack of time to engage in their past hobbies. Participant 7 from OAH reported "…I love doing crafts and I read a lot. Reading helps me to get rid of my unwanted thoughts. It's a leisure time with my fellow inmates and we all do this together, talking about our problems and happiness. After having meals and completing daily life activities, we engage ourselves with these crafts. Here we also get paid for what we do, say, for a paper cover we get Rs 5." Participant 3 from the domestic setting added "…I love gardening but now my health is weak. Usually, I don't have time to engage in my leisure activities, but I read my Holy book at dawn."

At OAH, trained staff and living together boost relationships and support from colleagues, crucial in promoting psychological stability. Old people staying at home may be isolated and hence don't receive psychological support meant for them thus, the quality of their psychological life may be affected adversely.

Theme 3: Social Factors

Several social factors like social interactions & relationships, unemployment, job, education, and marital factors influence the quality of life of the elderly. When comparing the social factors between old age homes and domestic environments, it becomes evident that old age homes offer a higher quality of life (QoL) for elderly individuals, particularly in terms of social interaction, job-related factors, and marital life. Family, friends, and peers influence the welfare of senior citizens. When elderly individuals engage in consistent social interactions and there is a substitution of emotional connections in the social sphere, their well-being increases while the incidence of depressive symptoms is reduced. Participant 6, who is a

resident at old-age home, said, "...I cherish the friends I have made in this place. We always stand by each other in every situation just like a family."

People in domestic settings on the contrary seem to miss their family, spouses, and children. Without a person to talk to of their age, they often have an emotional declination. Women especially seem to miss their children, friends, and spouses more than men. Sometimes having no family is the reason to be in an OAH. Marital satisfaction and the quality of relationships with spouses or partners significantly influence the well-being of elderly individuals. It is understood that the individuals reporting higher levels of marital satisfaction tend to have better QoL outcomes and lower rates of geriatric depression. It is noted that the elderly who maintain positive relationships with their spouses or partners experience greater emotional well-being. Participant 1 from domestic settings reported how he feels so relieved in his hard times after talking with his spouse. He said, "…I am so lucky in my marriage and profession. I talk to her whenever I feel stuck and lost. We both help and support each other in every part of our life. I must say everyone should enjoy a love life". The widows and widowers miss their spouses and retrieve how good & happy their life was with them. It is also understood from their perspectives that women when they get aged, have low marital and sex life satisfaction compared to men. Some of them even collaborated on the concept of marriage in a culture where some couldn't complete their studies. Participant 7 from OAH reported "Culture is what I feel pushed to me stop my studies when I got married. I got married to a family with sufficient members and my in-laws don't believe their bahu (daughter-in-law) going to a college for her studies and getting a job. We had a dominant society where husbands will pay for the daily meals". She further related this to be a reason for a paid job now; "I do feel education and having a job is very important in women's life. I didn't feel it before because my husband was alive. But now I feel if was educated much more then I would have started a tuition center for children. But here I don't need any money".

It seems that old age homes provide opportunities for leisure activities through various programs. This helps the residents stay mentally active and engaged. Moreover, unemployment is not a concern in old age homes, as residents can participate in volunteer work or recreational activities that align with their interests and abilities. Participant 6 from OAH reported, "…. Here we take orders from companies and shops for money. We make paper covers or boxes and women stich clothes or bags. We get paid for each bag; say Rs 5 to Rs 10, sometimes even more depending upon the items".

Therefore, providing opportunities for social interaction, fostering positive relationships, and promoting community involvement may help promote healthy aging and improve the overall QoL of elderly populations.

Theme 4: Environmental Factors

Environmental factors including economic, housing, and natural changes affect the quality of life of the elderly. In terms of economic factors, old age homes offer a sense of financial security for residents than who may face financial insecurity in domestic environments. Residents in old age homes have access to a stable cost of living, without any financial worries. It also provides a sense of security and autonomy for residents unlike in domestic settings. Participant 5, a resident in an old age home, expressed, "…Knowing that I have a stable living situation here gives me peace of mind and a sense of autonomy over my life."

The integration of technology into elderly people is frequently promoted in assisted living facilities by offering assistive technology and other amenities specifically designed to meet the needs of senior citizens, improving their quality of life in general. Participant 7 from OAH reported "…I think we cannot withstand the technology our younger ones uphold." Participant 2 from domestic settings reported that "…It is very difficult to compete with newer technology. But having a good housing facility with these newer

technologies can improve our living a little bit. People like us cannot afford it either". Pointing to the surgery mark in his knee, further added "… my house has an outside separate Indian toilet. Thus, I have to go out even at midnight. In one night, I fell and my leg went into the mouth of this toilet and was broken. I had surgery later."

In terms of housing, OAH provides flexible living areas that are tailored to the requirements of senior citizens. These areas are furnished with grab bars, wheelchair ramps, and handrails, all of which enhance accessibility and safety for locals with limited mobility. Old-age homes also uphold strict standards for maintenance, cleanliness, and safety procedures, which guarantees its inhabitants a secure and comfortable living environment. In case of natural changes, old-age homes provide stability and consistency in the face of climatic variability and urbanization. Residents in old-age homes are sheltered from the adverse effects of extreme weather conditions and urbanization-related challenges such as pollution and overcrowding. The controlled environment of old age homes helps mitigate the impact of natural changes on residents' overall well-being and QoL. On the other hand, elderly people living in domestic settings could encounter unknowns and difficulties about natural changes, housing circumstances, and economic concerns. Some also believe that globalization and urbanisation has separated them from their children. Participant 1 from domestic settings stated "…It is very difficult to shift from your house to some global cities where my children live. I didn't feel the comfort of my home there in all aspects."

One of the biggest natural calamities faced by the people of Kerala is the recent flood that occurred in the consequent three years- 2018, 2019 & 2020. It had affected the lives of many especially the poor coastal lives. Participant 2 from domestic settings recalled the calamity and its adverse effects on them; "…We were displaced. Our ground to roof were covered with water and we were in schools for many months. It was very difficult." Another disaster that affected the lives of people was due to Coronavirus (2020) which negatively affected the physical health of many. "…After corona, I have a deteriorating physical health, I have had breathing issues since then", complained Participant 1.

The quality of life of the elderly may be significantly impacted by unstable finances, subpar housing, exposure to weather variations, and stressors associated with urbanization. Elderly individuals residing in old age homes reported lower levels of financial insecurity compared to those living in domestic environments, contributing to a higher quality of life.

Section 5: Comparison of old age homes and domestic environments considering aspects like social support, caregiving structures, and access to healthcare services.

This section delves into the comparison of social support, caregiving structures, and access to healthcare services between old age homes and domestic environments for older adults.

1. Social support.

Old age homes offer an environment where residents can socialize and engage with other residents and staff. It plays a crucial role in shaping the quality of life (QoL) and overall well-being of elderly individuals. Living close to people going through comparable life stages can foster the development of social support networks where members can exchange their life stories, offer emotional support, and be companions to one another. The living environment in OAH encourages social interactions and lessens the emotions of loneliness and isolation that are sometimes experienced in household settings, which eventually improves residents' quality of life and mental health. In the domestic environment, the condition is reversed. Children of these elderly have no time to interact with these poor people and feel all alone in their homes. No particular leisure activities were found by the researcher in domestic environments.

Participant 1 from the domestic environment reported how he misses his children and grandchildren who are settled abroad. He added "…they are settled in aboard and come annually for some countable days. I miss them. I sometimes wonder how our lives would be with them."

2. Caregiving structures.

In most cases, old age homes have established caregiving systems in place, and skilled staff members are on hand to help residents with everyday requirements as well as offer individualized care and assistance unlike, domestic environments. These facilities include a variety of services, such as help with daily living activities, prescription administration, and access to medical services. Professional caregivers in OAH guarantee that residents receive thorough care and support giving residents and their families peace of mind. Old age homes provide residents with an organized caring environment that enhances their general well-being and enables them to age in comfort and dignity. Residents benefit from this sense of security and support. Conversely, caregiving in domestic environments is primarily provided by family members, whose ability to provide care may be influenced by various factors such as availability and resources. Family caregivers may demonstrate genuine dedication and commitment to caring for their elderly loved ones, but the informal nature of caregiving in domestic environments can pose challenges in terms of consistency and expertise. Participant 3 from the domestic environment clearly states how she is abandoned by her children and finds it very difficult to get financial help from others for medical and hospital bills. She reported: "I sometimes feel very devastated since I have no money to pay for my daily medicines since my husband's death. I struggle with my daily household chores and daily life activities. I even cannot afford a household helper"

3. Access to medical services.

Unlike domestic environments, old age homes typically place a strong priority on the health and well-being of their residents by providing easy access to healthcare resources and services. Often, these institutions have on-site physicians and nurses who can handle residents' medical requirements and make care arrangements as needed. OAH includes specialized healthcare services like physical therapy, occupational therapy, and wellness programs in contrast to domestic environments where financial security is a major concern. Elderly care facilities are typically supported by wealthy and charitable individuals. All things considered, having easy access to healthcare improves residents' overall health and capacity to age gracefully and freely in senior living facilities. Participant 5 from OAH reported: "…there is less concern about medical bills and consultations since we have weekly doctor visits".

Contrastingly, various factors such as geographical location, transport barriers, health facilities, and limited availability of service providers affect the seniors accessing medical care in the domestic environment. Some seniors may have access to local health services, while others living in rural or remote areas may have difficulty accessing timely medical care. Participant 4, an elderly woman living in a rural area, shared her challenges traveling to the nearest hospital for a doctor's appointment, especially in bad weather, "…we don't have a private car or a driver, it's very difficult to visit the hospital, especially in bad weather. We are poor."

IMPLICATIONS

Specific themes and factors identified that influence the quality of life and geriatric depression among the elder people might help in developing targeted intervention strategies including mental health programs, community-based initiatives, and better access to healthcare. The findings of this mixed-method study highlight the need for customized policies & interventions that can consider the various needs of the

elderly in domestic settings and old age homes, offering a strong research framework for subsequent research. The study can be utilized to raise awareness among families about challenges faced by the elderly and thereby help build an age-friendly environment, especially in domestic settings.

LIMITATIONS

The study exclusively targeted a selected region, Kerala, restricting the applicability of its findings to broader cultural and geographical contexts. In Phase 2, the study is restricted to the age range between 60 and 80 years thus, may not capture the challenges faced by those who are aged 80 and above. The study lacks representation of non-binary and other gender identities. The study potentially misses the valuable insights from caregivers or healthcare professionals that could provide a better understanding of the factors influencing quality of life and geriatric depression. Limiting the unmarried and illiterate individuals in Phase 2 as well as the bedridden and mentally disabled in both phases may limit the comprehensive obstacles that these individuals confront.

SUGGESTIONS FOR FUTURE RESEARCH

Future research can include a variety of geographical locations by extending beyond the current focus; Kerala, India. Using longitudinal research designs would enable a more nuanced understanding of the changes in the quality of life and geriatric depression among the aged, as well as the causal links between them. Research in the future may concentrate on a broader age range than that of this study. Other genders, unmarried individuals, mentally disabled, bedridden, and more socio-demographic variables can be included. Future research can investigate themes that may not have been thoroughly examined in the current study. Performing cross-cultural comparative studies would help us comprehend how cultural differences affect, how findings are interpreted and applied in various international contexts. Future studies might include the opinions of caregivers, medical professionals, and other stakeholders.

CONCLUSION

This study has tried to shed an important light on the intricate interactions between variables affecting older people's quality of life and risk of geriatric depression in both domestic settings and old age homes. The comparison of living arrangements has brought to light particular subtleties in the dynamics of caregiving systems, social support networks, and healthcare service accessibility. The results call for targeted interventions and support networks to meet the special requirements of senior citizens. Furthermore, the research has enhanced the understanding of different factors of aging like environmental, social, psychological, and physical factors. Despite acknowledging significant limitations, including the possibility of sampling bias and the cross-sectional design, this study establishes a basis for further research and provides insights for the creation of comprehensive policies aimed at improving the quality of life for the senior population as they age.

APPENDICES

APPENDIX A
CERTIFICATE

ST. JOSEPH'S COLLEGE (AUTONOMOUS), IRINJALAKUDA

DEPARTMENT OF PSYCHOLOGY

CERTIFICATE

This is to certify that this dissertation titled **"Quality of Life and Geriatric Depression among Elderly Residents in Old Age Homes And Domestic Environments In Kerala"** submitted to St. Joseph's College (Autonomous), Irinjalakuda (University of Calicut) for the award of the Degree of Master of Science in Psychology is a bonafide record of the research work carried out by **SAHLA V A; REG NO:** [redacted] under my supervision and guidance and that it has not been submitted to any other university or institution for the award of any degree, diploma, fellowship, title or recognition before.

Place: Irinjalakuda

Department of Psychology
St. Joseph's College (Autonomous)
Irinjalakuda

Date: 05-04-2024

Remya Chithran K. C.

Assistant Professor &

Head of the Department of Psychology

APPENDIX B
CONSENT SHEET FROM OLD AGE HOME

This is the consent sheet from my institution to conduct the project- Quality of Life & Geriatric Depression among Elderly Residents in Old Age Homes and Domestic Environments in Kerala of Miss SAHLA V A, of St. Joseph's College (Autonomous), Irinjalakuda as a part of her post-graduate studies in Psychology. I have understood the meaning and purpose of the study; also, the data collected will be kept confidential by the researcher and will be only used for the study purposes. I am also aware that I can withdraw my consent at any part of the study if found uncomfortable and will not affect me and the study. All queries have been answered to my satisfaction. Thereby I give my consent to collect the data from my institution.
Name:

Date:
Place:

APPENDIX C
INFORMED CONSENT SHEET

I fully consent to participate in the research work of SAHLA V A; a postgraduate student in Psychology at St. Joseph's College (Autonomous), Irinjalakuda on the topic- Quality of Life and Geriatric Depression in elderly residents in Old Age Homes and Domestic Environments in Kerala. I also understand that the information collected as part of this study will be used for research and training purposes only. I understand that the researcher will not provide any personal information about me in any reports and that my personal information will remain secure as a participant in this study. I can withdraw and stop participating at any time. I understand that if I refuse to participate or withdraw from the study, I will not face any hardship. I understood the explanation given to me about this research. All queries have been answered to my satisfaction. I voluntarily agree to participate in this study.

Name:
Date:
Place:

APPENDIX D
SOCIO-DEMOGRAPHIC DATA

Name (not compulsory) -
Age -
Sex -
Religion -
Marital Status -
Spouse -
Education -
Occupation -
Family type (if any) -
Domicile -
No: of children (if any) -
No: of grandchildren (if any) -
Socio economic status -
Income (if any) -
Language -
Retirement pension (if any) -
Place of living -
Residential place -
Diseases (if any) -
Psychological illness (if any) -
Hobbies -
Any bad habits (if any) -

APPENDIX E
THE WHOQOL-BREF (26 items)

		Very poor	Poor	Neither poor nor good	Good	Very good
1 (G1)	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied

2 (G2)	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last two weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3 (F1.4)	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4 (F11.3)	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5 (F4.1)	How much do you enjoy life?	1	2	3	4	5
6 (F24.2)	To what extent do you feel your life to be meaningful?	1	2	3	4	5
7 (F5.3)	How well are you able to concentrate?	1	2	3	4	5
8 (F16.1)	How safe do you feel in your daily life?	1	2	3	4	5
9 (F22.1)	How healthy is your physical environment?	1	2	3	4	5

		Not at all	A little	Moderately	Mostly	Completely
10 (F2.1)	Do you have enough energy for everyday life?	1	2	3	4	5
11 (F7.1)	Are you able to accept your bodily appearance?	1	2	3	4	5
12 (F18.1)	Have you enough money to meet your needs?	1	2	3	4	5
13 (F20.1)	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14 (F21.1)	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15 (F9.1)	How well are you able to get around?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16 (F3.3)	How satisfied are you with your sleep?	1	2	3	4	5
17 (F10.3)	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18 (F12.4)	How satisfied are you with your capacity for work?	1	2	3	4	5
19 (F6.3)	How satisfied are you with yourself?	1	2	3	4	5
20 (F13.3)	How satisfied are you with your personal relationships?	1	2	3	4	5
21 (F15.3)	How satisfied are you with your sex life?	1	2	3	4	5
22 (F14.4)	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23 (F17.3)	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24 (F19.3)	How satisfied are you with your access to health services?	1	2	3	4	5
25 (F23.3)	How satisfied are you with your transport?	1	2	3	4	5

		Never	Seldom	Quite often	Very often	Always
26 (F8.1)	How often do you have negative feelings such as blue mood, despair, anxiety, Depression?	1	2	3	4	5

APPENDIX F

GERIATRIC DEPRESSION SCALE (SHORT FORM) - (15 items)

Instructions: Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life? Yes / No
2. Have you dropped many of your activities and interests? Yes / No
3. Do you feel that your life is empty? Yes / No
4. Do you often get bored? Yes / No
5. Are you in good spirits most of the time? Yes / No
6. Are you afraid that something bad is going to happen to you? Yes / No

7. Do you feel happy most of the time?	Yes / No
8. Do you often feel helpless?	Yes / No
9. Do you prefer to stay at home, rather than going out and doing things?	Yes / No
10. Do you feel that you have more problems with memory than most?	Yes / No
11. Do you think it is wonderful to be alive now?	Yes / No
12. Do you feel worthless the way you are now?	Yes / No
13. Do you feel full of energy?	Yes / No
14. Do you feel that your situation is hopeless?	Yes / No
15. Do you think that most people are better off than you are?	Yes / No

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SAHLA V A

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