International Journal of Humanities Social Science and Management (IJHSSM)
Volume 2, Issue 1, pp: 40-49 www.ijhssm.org

Social Support: Predictor of Elderly Well-Being

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Date of Submission: 18-03-2022 Date of Acceptance: 01-04-2022

ABSTRACT
The present study aims to examine the association of social support with the mental well-being of old age people. It is hypothesized that the **H1**Elderly people with good support system would be less depressed as compared to Elderly with poor support system **H2** Elderly men would be less depressed as compared to Elderly women. **H3** Old aged people living with their spouse would be less depressed as compared to those living without them. A sample of 330 elderly, both male and female, take part in the current study. The participants were selected through purposive sampling technique. The scales administered in the research were in regional language to make sure the items were easily comprehended by the elderly, it included Urdu translated Geriatric Depression Scale Short Form(Sheikh &Yesavage, 1986), the multidimensional scale of perceived social support,(Rizwan&Aftab, 2009) along with consent form and demographic sheet. Results showed the significance of the multiple regression model and also significant mean differences between men and women experiencing depression. The results further indicate that lack of social support and living without a spouse are strong predictors of depression in elderly individuals.

KEY WORDS: Wellbeing, Social support, Depression, Gender Difference

I. INTRODUCTION

As an individual grows old they have to face a lot of economic ,physical and health challenges .It is estimated that universal population of people aged 60 and more was approximately 962 million in 2017, and is anticipated to double to 2.1 billion by 2050 (UN, 2017). Developing countrieswhich are already facing economic,political, health challenges would further have to face the burden of health and wellbeing issues of old aged people. Age is a significant factor in mental health. Old age is a period of transition during which one must cope with not just physical aging, but also difficulties to one's personal and psychological well-being. The total frequency of psychological and cognitive disorders tends to increase with time due to usual brain aging, worsening physical well-being, and cognitive disease (Ingle &Nath, 2008). Other important key factors that contributing to a higher frequency of psychological and behavioral disorders include disability caused by multiple illnesses, isolation, and a lack of family support, limited individual freedom and financial dependency.

According to an estimate Developing countries wouldaccount for two-thirds of the world's elderly population. According to forecasts, nearly eight out of ten old people would live in underdeveloped countries by 2050 (UN, 2017). Pakistan is a developing country with a population of 11.3 million people aged 60 and more in 2017, and that number is expected to rise to more than 43.3 million by 2050, which is equivalent to almost 16% of the overall population (Ashiq&Asad 2017) This indicates that health sector would be facing a lot of challenges in the upcoming years.

The reasons behind the increase in old population could be the extensive researches done to improve life expectancy. Globally, developing knowledge and practices, in combination with socioeconomic growth, have resulted in the growth of average life expectancy on one side, and a significant decrease in fertility levels on the other. These variations have resulted in population aging, from younger to older (Hashmi, 2003; Gavrilov&Heuveline, 2003). Chronic diseases, physical incapacities, mental illnesses, and other comorbidities are all on the rise as the population ages (Boutayeb&Boutayeb 2005). Globally, health-care systems have significant obstacles in improving the common health and quality of life of their aging populations (Knickman& Snell, 2002; Rechnitzer, 1983).

According to WHO (2021) Unipolar depression was diagnosed in 7% of the overall older population and it accounts 5.7% for individuals above 60 years. Depression is often under diagnosed and undertreated in health care settings. However, the incidence of depression is vary country to country (Volkert et al. 2013). Late life depression is mostly ignored by general public due to lack of awareness in Pakistan. Either they went under or over recognition of depression specifically in developing countries like Pakistan (Itrat et al., 2007; Zafar et al., 2006). Study conducted by Pakistani researcher revealed that the incidence of depression among elders is 22.9 percent, implying that every fifth old person over the age of 65 is depressed (Ganatra et al., 2008). Depression among older adults in Pakistan is on the rise, with various studies reporting rates ranging from 18 percent to 66 percent in both rural and urban areas (Taqui et al., 2007; Qadir et al., 2014, Zubair&Mansoor, 2015, Tariq et al., 2020). However, little research has been done on this group, especially with situation to the role of established major risk variables such as increased age, poor socioeconomic position (Blazer et al., 1998), gender (Djernes 2006), low education level, marital status (Luppa et al., 2012), cognitive impairment, and support systems (Djernes 2006; Tariq et al 2020) family disputes, rise in health care expenses, and death rate (Alexopoulos, 2005).Sociocultural variables have long been recognized as a key factor in predicting the unpredictability of depression in the elderly. Physical and mental health issues are frequently encountered in today's culture, which is on a never-ending march toward progress (Qidwai&Ashfaq, 2011). As a result of their distinctive behavior, the elderly are significantly influenced by health issues such as depression. Financial troubles, retirement, traumatic life events, the death of a family member, family conflicts, family members' ignorance, and health issues are all factors that contribute to late-life depression (Zisook et al., 2007; Fiske et al., 2009).

One of the significant factors that impacts the symptoms of depression in older individuals is social support. The term "social support" refers to aability of a person to access a variety of resources through their social ties with others (Cooke et al 1988). Individuals receive information or awareness, emotional support, considerable assistance, and self-sufficiency through reciprocal interactions (Revenson et al., 1995). The amount of pleasure with being empathized, appreciated, and supported in society is characterized as perceived social support, also identified as subjective support (Xiao 1994). It shows how safe and companionable a person feels (Bozo et al., 2009). Because of its role in reducing stress and mental health problems, as well as limiting the negative impacts of physical handicap on psychological well-being, social support has gotten a lot of attention (Azam et al., 2013).

Asian and Pakistani families are usually patriarchal, collectivist joint families with three or more generations that provide a strong, durable, and long-lasting support network. Elderly individuals have a position of authority that requires considerable respect and adoration in a family (Kramer et al., 2002). Apart from their spouses, the elderly need support from their offspring, particularly male children, because females typically leave their parents' home after getting married (Kramer et al., 2002). This comprises social, economic, physical, and emotional assistance, and it has been linked to their psychological health in various studies (Cano et al., 2003; Marino et al., 2008) Any modification in the structure is likely to affect the original family setup's harmony and stability (Itrat et al., 2007). However, current societal developments have had an impact on both their respected standing in the family and their role as decision-makers. The traditional multigenerational family arrangement in Asia is being replaced by nuclear families as a result of rapid urbanization, and Pakistan is no exception (Bongaarts 2001). Pakistan is also experiencing a decline in the extended family system (Itrat et al., 2007). As a result, personal space, autonomy, and privacy supplant compassion, reciprocity, and a sense of belonging, reducing the provision of assistance from family (Aslam 2006). The purpose of the present research was to investigate the prevalence of depression and its relationship with social support in the elderly population of Karachi, Pakistan.

In the light of the above discussed researches the following hypotheses were formulated

H1 The elderly people withhigh level of social support will experience less depression and vice versa.

H2There would be gender differences in depression and perceived social support.

H3Elderly people who live without a spouse would be more depressed as compared to those elderly people who live with spouses.

II. METHODOLOGY

Research Design

A quantitative research design was employed in the current study by which relationship and comparison of variables has been found on gender and marital status. It helped in developing a better understanding of this psychosocial issue.

Sample

The purposive sampling strategy was used for data gathering. The current study's sample consisted of 330 elderly individuals aged rage 60 to 90 years (μ= 67.04, SD = 6.41), were approached in different areas of the city. All participants were selected on the bases of particular characteristics, the inclusion criteria in the study included such as: age 60 or above 60 years old, both genders, not suffering from dementia and or any psychological problem.

Instruments

Demographic sheet and informed consent form

The APA requires the use of an informed consent form. Participants were asked to take part in the research. The goal of the study, the time necessary to complete the questionnaire, and a statement of confidentiality were all included in the informed consent form. They were also told that they may opt out of the survey at any moment. Participants signed an informed consent form. Gender, age of participation, marital status, qualification, socioeconomic situation, occupation, living arrangements, source of personal income, and physical health condition are among the mandatory and optional elements collected on the demographic sheet.

The Geriatric Depression Scale (Short form)

The GDS (short form) was designed byYesavage and colleagues in 1986. It is frequently used for assessing depressive symptoms in the elderly population. It's a self-administered questionnaire, comprised of 15 item and is less time-consuming. Each item has a dichotomous response option (Yes = 1 and No = 0). A total score was determined by adding all of the items together, When 10 of the 15 items were answered affirmatively for indicating depressive symptoms, whereas 5 items 1, 5, 7, 11, and 13indicated depressive symptoms, when answered negatively. A score of less than 5 indicates no depression/ normal; 5 to 8 scores indicates mild depression; 9 to 11 scores indicates moderate depression; and higher than 11 scores indicates severe depression, depending on age, education, and symptoms. The GDS has good internal consistency withCronbach's alpha of r = .0.84 (Sheikh &Yesavage, 1986). The GDS (short form)-Urdu version was employed in this study, and it has strong inter-raterreliability .61-.90, p = .001 and test retest reliability with Cronbach alpha of r = .89. The present study demonstrated sufficient internal consistency with a Cronbach alpha of r = .93.

Multidimensional Scale of Perceived Social Support (MSPSS)

Zimet and colleagues created a multidimensional scale of perceived social support in 1988. It has the 12-items self-report assessment tool, measures the perceived social support from family, friends, and a significant other. Each item is graded on a 7-point Likert scale ranging from 1 to 7(very strongly disagree to very strongly agree). When all of the items were added together, the overall score ranged from 12 to 84. Individuals with great scores perceive a strong level of social support. The test-retest reliability of the MSPSS has (0.81 to 0.98) for non-clinical sample and (0.92 to 0.94) for clinical sample.The MSPSS-Urdu version (Rizwan&Aftab, 2009) was used in current study because it has adequate psychometric qualities.MSPSS has an excellent internal consistency of 0.89 and a sufficient test-retest reliability of 0.79.The current study had strong consistency with a Cronbach Alpha of 0.93 in the non-clinical group.

Procedure

Participants were approached in different areas of Karachi city and requested to participate in the study. In the initial stage those households were marked where there were old age family members.The approval for participation was take and date and time was decided with the participant's convenience. The respondents first completed the informed consent form, and later the information was gathered with the help of questionnaires followed byfilling in the demographic form. The Confidentiality and safety of the participant was ensured to the participants. As a token of appreciation for the participants, the incentive (prescribed medicine, juice, seasonal fruits) were offered to thank them for their time and cooperation. Finally, all of the scales' scores were computed and analyzed.

Analysis of statistics

Research data was entered to analysis via SPSS version 26.0.Tablesand graphs were used to explain the result to provide complete overview of findings. Each observation was given a significance rating. T-test was calculated to analysis the gender and marital status differences in depression and social support. Pearson correlation was applied to determine the relationship between research variables.In addition, multiple linear regression was used to see how independent variables affected the dependent variable.

III. RESULT ANALYSIS

Table 1Demographicalprofile of the study sample

Variables	Frequency N = 330	Percentages (% of sample)
Age of Elders		
60 to 64 years old	135	40.9
65 to 69 years old	96	29.1
70 to 79 years old	76	23
80 t0 90 years old	23	7
Gender		
Men	153	47.3
Women	177	53.7
Marital status		
Living with spouse	183	55.5
Living without spouse	147	44.5
Qualification		
Uneducated	74	22.4
Primary	37	11.2
Middle	57	17.3
Matriculation	79	23.9
Intermediate	44	13.3
Graduate	24	7.3
Post-graduate	15	4.5
Socioeconomic status		
Upper class	42	12.8
Middle class	230	69.7
Lower class	58	17.5
Living arrangement		
Joint	141	42.8
Nuclear	156	47.3
With relative	11	3.3
Alone	22	6.6
Employment Status		
Unemployed	34	10.3
Employment	118	35.7
Housewife	133	40.3
Retired	45	13.7
Personal income		
No personal income	64	19.4
Salary/ pension	163	43.4
Saving /property	63	19.1
Zakat	40	12.2
Health condition		
Very poor	18	5.45

Poor	90	23.7
Fair	107	32.42
Good	92	27.9
Very good	23	6.9

Table 2Percentage of the level of depression and perceived social support.

Prevalence of depression	N= 330	%
Yes	167	50.6
No	163	49.09
Level of depression		
Mild depression	103	31.21
Moderate depression	62	18.70
Severe depression	3	0.91
Level of Perceived social support		
Low	58	17.6
Moderate	150	45.5
High	122	37.0

Figure 1 Level of depression among elderly

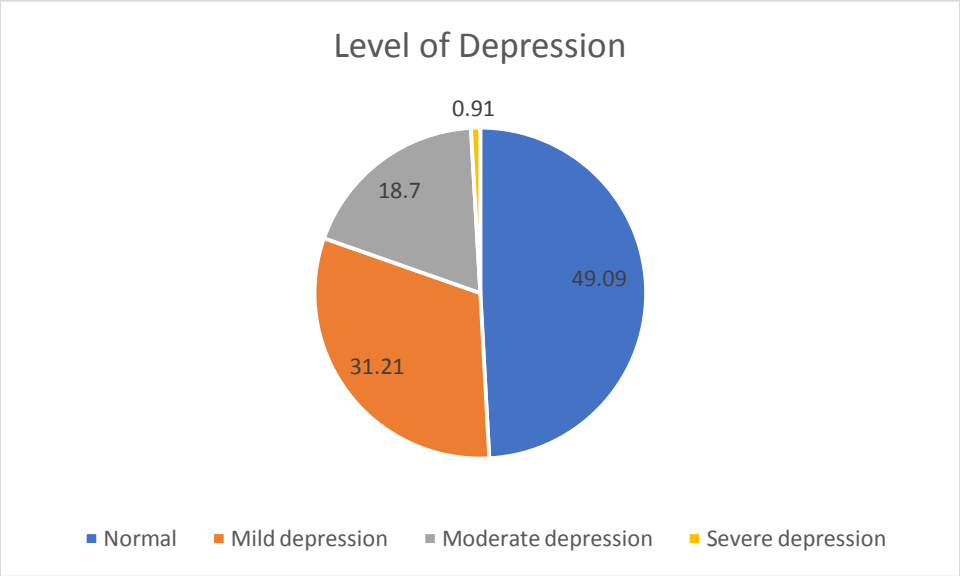

Figure 2Percentage of level of perceived social support among elderly individuals.

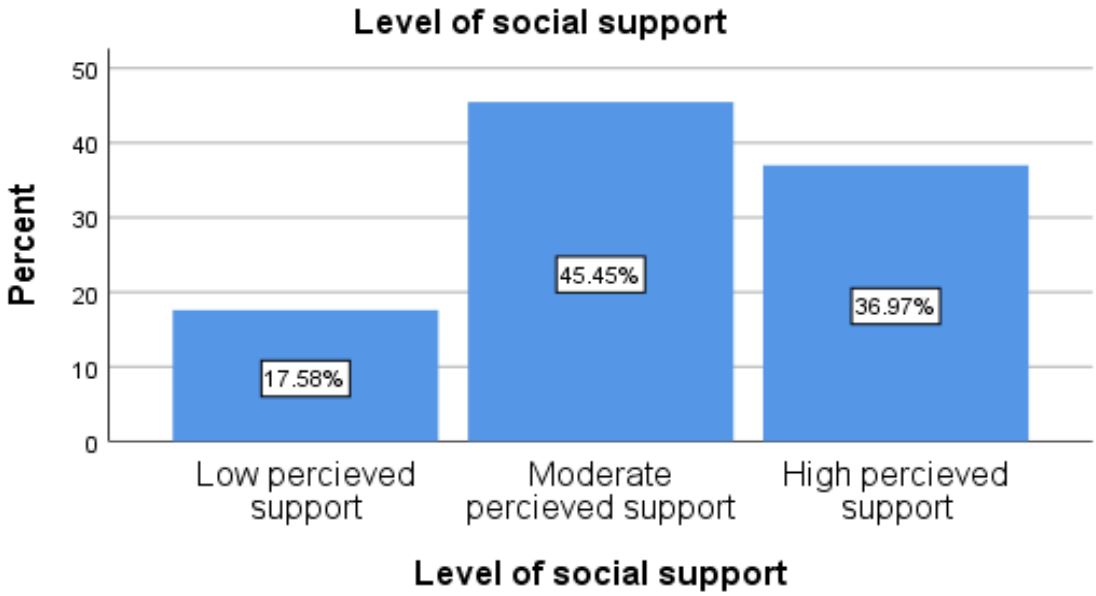

Table 2Descriptive statistics and analysis of Pearson correlation.

Variables	Mean	SD	R
Social support	54.6636	17.21116	
Depression	4.48	3.809	**-.749**

****p<0.01**

Table 4Multiple linear regression on depression as dependent variable

	Depression		
Variables	**B**	**B**	**B**
Gender	-.135	.291	-.018
Marital status	-.207	.358	-.027
Elderly age	1.305	.162	.328**
Education	.125	.081	.057
Socioeconomic Status	.831	.236	.120**
Employment Status	.045	.125	.013
Source of personal income	-.024	.133	-.006
Living Arrangement	-.110	.119	-.029
Physical health	-.750	.156	-.202**
Social support	-.100	.013	-.454**
R^2	.687		
F	70.17**		

*Note: **p<.001, *P<0.05*

The results (R^2= 0.687, F = 70.17 p < 0.01) revealed the significance of the regression model. A significant prediction found social support and depression (β = -.454. p<.001) as predicted that social support was inversely related with the depression among the elderly individuals. A significant prediction of elderly growing old age and depression (β = .328, p<.001) and socioeconomic status and depression (β = .120, p<.001) and physical health and depression (β = -.202, p<.001)

Table 5Compression of gender difference for depression and social support.

Variables	Gender Group						
	Elderly men= 153		Elderly women=177				
	Mean	SD	Mean	SD	df	t	Sig.
Depression	3.16	3.43	5.61	3.77	328	-6.134	.000
Perceived social support	63.75	15.64	46.82	14.46	328	10.21	.000

An independent t-test was administered to observe the gender difference in depression and social support. A significant difference (t [328] = -6.134, p = .000) was found in depression between the groups of elderly men (μ = 3.14, SD = 3.43) and elderly women (μ = 5.61. SD = 3.77). Results also exposed significant differences (t [328] = 10.21, p = .000) between the groups of elderly men (μ = 63.75, SD = 15.64) and elderly women (μ = 46.82. SD = 14.46) on social support.

Table 6Compression for depression and social support between elderly who live with and without a spouse.

Variables	Group of marital status						
	Living with spouse = 183		Living without spouse =147				
	Mean	SD	Mean	SD	df	t	Sig.
Depression	2.56	3.07	6.86	3.27	328	-12.33	.000
Perceived social support	65.91	13.24	40.68	9.69	325.3	19.98	.000

An independent t-test was administered to observe the difference in depression and social support between elderly who live with spouses and those who are not. A significant difference (t [328] = -12.33, p = .000) was found in depression between the groups of elderly who live with spouses (μ = 2.56, SD = 3.07) and elderly who live without spouses (μ = 5.61. SD = 3.77). Results also exposed a significant difference (t [325.3] = 19.98, p = .000) was found between the groups of elderly who live with spouses (μ = 65.91, SD = 13.24) and elderly who live without spouses (μ = 40.68. SD = 9.69) on social support.

IV. DISCUSSION

During the investigation, it was discovered that having any form of health concerns, too much financial, emotional, or physical dependence on others were all significant factors associated with depression. Physiological and mental issues may arise as a result of this condition. The existing study is designed to find out the role of social support in elderly well-being, social support is associated to reduce depression. This study is based on the phenomenon that high social support in the elderly leads them to overcome their life stressors. Another key goal of the current study is to examine the difference in depression, social support in gender, and marital status.

The existingfindings revealed that (figure 1), the occurrence of depression was 50.6 % in the total sample. A similar result also found that 51.8 % of elderly people suffer from high rates of depression (Sabzwari et al 2019). The large numbers of depression were identified because socioeconomic and environmental variables, as well as illness, may impact on well-being, and hence need to be investigated further.

Multiple regression analysis of the current study also revealed that low levels of social support, worsening physical health, socioeconomic status, and growing age of the elderly individual were associated with depression (Table 4). Low level of social support has been associated to poor psychological health outcomes and has been hypothesized to decrease an individual's personal resources for managing with social stress (George et al., 1989).

According to the current demographic result, one-fourth of the elderly individuals reported worsening physical health. When the older individuals suffer from persistent physical condition and experience functional decline, they are more vulnerable to depression (Djernes, 2006). Higher

Quality of life in terms of physical health is linked to emotional/instrumental support, which the elderly receive from their family members, neighbors, or the community as a whole. This suggests that the emotional components of social assistance improve the elderly's quality of life (Krause & Shaw, 2000). Through their social identity, material aid, facilities, knowledge, and new social relationships, social networking assists a person in meeting his or her emotional requirements. Social support consists of helpful connections that assist people in staying healthy or adapting to stress more effectively. It is also a defensiveaspect for psychological and physical health condition of the elderly populations (Cutrona et al, 1986).

The current result also demonstrated that growing old age is also associated with rising depression symptoms. When elderly people are growing old and the family members are getting (old age), the tolerance level starts reducing due to their health issues and there are a lot of complexes that they have lost such as retirement, leaving a job due to health concerns, not being independent and controlled by their family members. They are instated dependent on their families which shelter their self-esteem and their ego which make them feel sad when once that was controlled or now, they are being controlled resulting they are getting depressive symptoms. Apart from this, the attitude of the family members is also changed when the elderly contribute to the household, they get a lot of respect and are involved in decision-making and social gatherings by their family members that make themselves valuable and useful. Whereas due to medical concerns most of the elderly are not contributing in the household and are unable to do the domestic chore that makes themselves useless and worthless.

The existing findings demonstrated that depression and perceived social support differed significantly by gender and marital status of the elderly individuals.It has been noticed that older women become more depressed and perceive less social support than men (Majdi et al., 2011). Men even in old age are less dependent financially, emotionally etc. which reduces their risk of being depressed. . On the contrary, Asian women in their late life were unable to manage with everyday life concerns and household chores as well as they had previously because of the aging factor. On the other hand, contrasting elderly women in the Western world, most Pakistani women are housewives and do not do jobs or attend social events or have to seek permission before leaving their home premises or making any decisions for themselves making them feel dependent and helpless thus increasing the risk for depression. This is relatively clear from presentevidence that 40.3 percent of elderly women who were housewives had less power and resources and were financially reliant on their spouse and sons.Additionally,low level of family support can generate a sense of insecurity, making them more vulnerable to depression (Taqui et al., 2007).

In the present result, Single (widow, unmarried, and divorced) women were more depressed and perceived low social support as compared to married ones because elders who live without spouses, find it extremely difficult to exist in this world on their own. Everyone wants to share with somebody their later stages of life. One of the most basic requirements of the elderly is companionship and support from a spouse in life. Spending time with someone as a companion to talk about daily life difficulties. At any age, the death of a spouse may have an impact on an individual's psychological health as well as their ability to survive (Victor, et al., 2000). On the other hand, elderly individuals are particularly susceptible as their dependence on a spouse grows with age (Taqui et al., 2007).Married elderly individuals have been demonstrated to live long and healthy life than single elderly persons (Scafato et al., 2008). The absence of a companion towards the end of life led a person into depression. Unmarried elderly persons are more susceptible to depression than married elderly ones (MODH et al., 2003).

V. CONCLUSION

According to current findings, almost 50.6 percent of Karachi's elderly population is likely to be depressed. Further, the research indicates that elderly women, especially those who live without spouses, are at a greater risk for depression. The presence of social support was discovered to have a substantial link to the psychological health of the elderly. More study is needed in this vital yet understudied segment of the population. Similar studies from other Pakistani cities are also required to provide a nationwide picture of the mental health of the elderly in Pakistan.These studies' findings can be utilized to improve policy and build appropriate prevention and intervention initiatives to improve the physical and psychological health condition of elderly individuals.The practical implication for health care professionals was that when family members or medical professionals want to help patients with depression, they should pay greater attention to subjective support and focus on the level of support use.

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