# A STUDY ON DEPRESSION, LONELINESS AND PERCEIVED SOCIAL SUPPORT AMONG GERIATRIC POPULATION

Dissertation submitted to Kerala University

In partial fulfilment of the requirements for the award of the Degree of

**M.SC. COUNSELLING PSYCHOLOGY**

By

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## CERTIFICATE

This is to certify that the Dissertation entitled **"A STUDY ON DEPRESSION, LONELINESS AND PERCEIVED SOCIAL SUPPORT AMONG GERIATRIC POPULATION "** is an authentic work carried out by **SAFANA SUDHEER** Candidate code : **60422115019** under the guidance of Miss. Anila during the fourth semester of M.Sc. Counselling Psychology programme in the academic year **2022–2024**.

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## DECLARATION

I, Safana Sudheer , do hereby declare that the dissertation titled "**A study on depression, loneliness and perceived social support among geriatric population",** submitted to the Department of Counselling Psychology, Loyola College of Social Sciences, Sreekariyam, under the supervision of Miss. Anila, Assistant Professor of the Department of Counselling Psychology, for the award of the degree of Master's in Science of Counselling Psychology, is a bonafide work carried out by me and no part thereof has been submitted for the award of any other degree in any University.

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## ABSTRACT

The aim of the study is to explore the relationships between depression, loneliness, and perceived social support among geriatric individuals, including how these factors correlate with each other and the influence of gender on geriatric depression. Depression, a mood disorder characterized by persistent feelings of sadness, was measured using the Geriatric Depression Scale (GDS). Loneliness, a subjective feeling of social isolation, was assessed with the Revised UCLA Loneliness Scale, while perceived social support, the belief in the availability of social support from significant others, family, and friends, was evaluated using the Multidimensional Scale of Perceived Social Support (MSPSS). This quantitative study includes a sample of 120 participants, including 60 males and 60 females aged 65 and above, responded to these scales. The statistics used were Spearman's rho and Mann Whitney U test. The results revealed a positive correlation between geriatric depression and loneliness, and negative correlations between depression and perceived social support, as well as between loneliness and perceived social support. Further analysis demonstrated that higher levels of depression were linked to lower perceived support from significant others, family, and friends. Similarly, higher loneliness was associated with reduced perceived support from these sources. Additionally, the study found that males reported significantly higher levels of geriatric depression compared to females. These findings underscore the importance of social support in mitigating both loneliness and depression among the elderly.



*Keywords* : Depression, Loneliness, Perceived Social Support, Geriatric population

# CHAPTER 1

## INTRODUCTION

India is experiencing a major demographic shift, with an increasing number of older people. The proportion of people aged 60 and over is expected to increase from 8.6% in 2011 to 21% in 2050, with the elderly population expected to reach approximately 323 million, and by 2012, it will exceed the entire population of the United States. This comes with a range of health problems, including high rates of chronic diseases such as diabetes and hypertension. Older people are expected to account for approximately 45% of the disease burden in India by 2030, with many disabilities and health problems going undiagnosed. Additionally, approximately 60% of the population lacks access to improved sanitation, increasing the risk of serious illness. This change, influenced by the preference for nuclear families, labour migration, and changing social structures, may lead to a further decrease in informal care and problems. Financial poverty is widespread; less than 11% of adults receive a pension. Many people face savings problems, which contributes to continued participation in the labour force, especially in rural areas where banking services are limited. The elderly dependency ratio is also expected to increase by 2031.

In developing countries, older people contribute significantly to jobs such as agriculture; up to 70% of farmers in Mozambique are over the age of 45. This situation highlights the need to examine how older people can contribute financially and encourage their participation in society, particularly in the use of new technologies. It is important to understand these changes as the number of older people in the workforce increases. In urban areas, most older people are still employed in formal jobs, as evidenced by the fact that half of the population in the Philippines is in their 60s. Research on these trends can inform career development policies and conditions for older workers. In addition, older people often play a

significant role in family support and community participation by providing care and financial support across generations. For example, many older people in South Korea and India regularly support their families. Examining these changes is important for understanding the role of older adults in family structure and social protection, especially in emergencies. As the population ages, the number of health problems related to aging and chronic diseases increases, necessitating further research on the need for treatment and the impact of interventions that promote healthy aging.

Depression in older adults is strongly associated with feelings of loneliness, often leading to severe mental health outcomes. Major Depressive Disorder (MDD), a prevalent and severe mood disorder, impairs an individual's daily functioning. Research shows that loneliness independently heightens the risk of developing depressive symptoms, regardless of social isolation or perceived support, highlighting the potential of loneliness interventions to prevent depression in the elderly. Loneliness is characterized as an emotional state where an individual feels a deficit in meaningful social connections. Loneliness is often defined as the distressing feeling that arises when there is a discrepancy between desired and actual social relationships. Defined as the emotional discomfort stemming from a gap between desired and actual 7social relationships, loneliness significantly impacts the mental and physical well-being of older adults, worsening feelings of inadequacy and low mood. Over time, loneliness can act as a precursor to depression, increasing its severity.

Perceived social support, or the belief that one is cared for and has assistance from others, is essential in buffering stress and fostering well-being. It mediates the relationship between loneliness and depression, with higher levels of perceived support linked to reduced loneliness and depression in older adults. When the elderly feel supported by family, friends, or communities, they are less likely to experience loneliness and, consequently, depression. Examining the prevalence of depression and loneliness among elderly populations in India is

crucial, with estimates indicating a pooled depression rate of 34.4%. This data can help shape public health strategies to tackle mental health concerns in this vulnerable demographic.

The interconnectedness of depression and loneliness means that many elderly individuals experience both, often leading to worsening health outcomes. Social isolation and lack of support further aggravate these conditions, increasing physical health risks and dependence on healthcare services. Research consistently demonstrates that perceived social support is a key factor in elderly mental health, as it correlates with lower depression rates and better mental well-being. Understanding the interplay between social support, depression, and loneliness is vital for designing effective intervention strategies. As India's elderly population is projected to reach 19% by 2050, a focus on mental health in geriatric care becomes increasingly important. Shifting from joint to nuclear family structures in Indian culture may further contribute to feelings of isolation among the elderly, emphasizing the need for culturally informed mental health interventions.

**Need and significance of the study**

The purpose of the study was to investigate the relationship between depression, loneliness, and social support within the geriatric population. It sought to understand how these factors interact and influence the mental health and overall well-being of older adults.

This research is significant for several reasons. It provides insights into how loneliness and social support affect depression among the elderly, pinpointing specific dynamics that could be targeted for intervention. Addressing these issues is essential, given the high prevalence of depression and loneliness in older adults, which often leads to diminished quality of life and increased health care demands.

Additionally, the study offers valuable information for developing tailored mental health interventions and support systems. By using the findings to craft effective strategies, it

is possible to better meet the needs of older adults, thus alleviating depression and loneliness. Strengthening social support networks and fostering more inclusive environments can improve mental health outcomes and enhance overall well-being for the elderly. The research aims to contribute significantly to public health policies and community practices, promoting a more supportive and healthier environment for the aging population. Hence, this proposed study "A study on depression, loneliness and perceived social support among geriatric population."

**Statement of the problem**

As the global population ages, understanding the mental health challenges faced by geriatric individuals becomes increasingly critical. Depression and loneliness are prevalent concerns in this demographic, often exacerbated by a perceived lack of social support. Despite extensive research in each area, there remains a gap in understanding the interplay between these variables within the elderly population. Specifically, the extent to which perceived social support can mitigate the effects of depression and loneliness in older adults is not well-documented. This study seeks to address this gap by investigating the correlations among depression, loneliness, and perceived social support among geriatric people. Identifying these relationships is crucial for developing targeted interventions and support systems that can improve the overall well-being and quality of life for the elderly.

Therefore, the problem statement for the present study has been entitled as *"A study on depression, loneliness and perceived social support among geriatric population."*

# CHAPTER II

# REVIEW OF LITERATURE

A literature review involves a systematic examination of existing research to identify, assess, and synthesize relevant data for coherent presentation (Fink, 2010). It is an in-depth analysis of a topic, as outlined by Jesson et al. (2011). This chapter is divided into two main sections: Theoretical Review and Empirical Review. The Theoretical Review delves into various theoretical frameworks and models related to the variables of interest, while the Empirical Review discusses relevant studies conducted by other researchers. This comprehensive review of the literature aims to clarify the concepts and relationships between the variables under investigation.

## Theoretical Review

To understand the concepts of Depression, Loneliness and Perceived social support. It is necessary to review theoretical perspectives associated with the variables. This section conceptual framework and various theories proposed by researchers related to the study of the current research variables.

## Depression

According to the World Health Organization, depression is the leading cause of disability worldwide. These mental illnesses are characterized by the disappearance of feelings of wonder, sadness, or joy for no apparent reason. Depression can damage relationships, create difficulties in the workplace, and protect health, and when severe, can lead to suicide. It causes about 40,000 suicides each year in the United States and affects people of all ages, including adults, teenagers, and children. Unlike normal feelings, depression can be a persistent sadness and lack of joy. Depression occurs despite changes in the situation and involves intense, long-lasting feelings that are unrelated to the situation. It is a persistent, not temporary, problem. The

most common type of depression is major depressive disorder (MDD), which is characterized by symptoms that last up to two weeks.

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5), MDD is diagnosed when a person experience

A. Five (or more) of the following symptoms have been pre- sent during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note**: Do not include symptoms that are clearly attributable to another medical condition.)

1. Depressed mood most of the day, nearly every day. as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). (**Note**: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or al- most all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective ac- count or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder,

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia. schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.(Butcher et al.,2019)

**Types of Depression:**

Persistent depressive disorder (PDD) and major depressive disorder (MDD) are two main forms of depression. While they share some symptoms, their causes and diagnostic criteria differ. PDD, formerly known as dysthymic disorder, affects about 1.5% of U.S. adults and is more common in females. MDD, affecting 7.1% of U.S. adults, is also more prevalent in females. PDD symptoms must last for at least 2 years for a diagnosis, while MDD involves major depressive episodes with a gap of at least 2 months. Symptoms of both disorders may overlap, and individuals can experience symptoms of both simultaneously.

Individuals with MDD may also experience symptoms of panic disorders, social anxiety disorders, and obsessive-compulsive disorder. Social functioning often deteriorates, impacting work, school, and family responsibilities, with individuals withdrawing from previously enjoyed activities and relationships.

**Theories of Depression:**

The theories that related to the depression includes :

1. **Psychological theories**: These theories emphasize the role of cognition and behaviour, suggesting that negative thought patterns and experiences can lead to depression. Cognitive behavioural therapy (CBT) can address these negative issues.
2. **Biological theories:** These theories focus on genetic factors, brain structure, neurotransmitter function, and hormones. For example, the monoamine theory links depression to a decrease in neurotransmitters such as serotonin. Although SSRIs were developed with this in mind, their effectiveness is debatable.

3. **Behavioural theory**: This theory proposes that depression is managed through avoidance behaviour. Attitudes encourage participation in meaningful activities to prevent withdrawal and improve mental health.
4. **Social Class Theory**: This theory, proposed by Stevens and Price, suggests that melancholia is an adaptive response by individuals with low social status to accept their status and avoid conflict, but has been criticized for its reduction.
5. **Intelligence Knowledge**: Ellis's ABC model suggests that false beliefs (B) about what is powerful (A) can lead to depression (C). Therapy aims to identify and challenge these beliefs.
6. **Beck's Negative Cognitive Triad**: Aaron Beck identifies three negative beliefs about the self, the world, and the future that contribute to depression. These negative thoughts reinforce each other, making symptoms worse.
7. **Seligman's Learning Disability**: Seligman said depression stems from a learning disability, in which people feel they have no control over negative situations. Challenging these beliefs can help you regain control and reduce symptoms of depression.

**Causes of Depression**

Depression does not have a single cause. Rather, it is caused by a combination of factors and consequences. In most cases, a combination of factors causes the condition. For example, a person may become depressed after being ill for a period of time and then experiencing a catastrophic loss that causes depression. A "downward spiral" of events is one way to explain how depression develops. For example, being in a bad relationship can lead to depression, decreased social interaction, and increased alcohol consumption, all of which can lead to depression. Studies show that the likelihood of depression increases with age and is more common in people with social and financial problems.

Genetics may also play a role, and genetics may contribute to major depression. The risk of depression increases if a person isolates themselves from friends and family and tries to solve problems on their own. have depression. These characteristics can be caused by pregnancy, early age, or a combination of both. If you have a parent or sibling who is depressed, you may have a genetic predisposition, but that doesn't guarantee that you will develop depression. In most cases, depression is caused by multiple factors, including family history. .

Postpartum depression can occur after birth, while antepartum depression occurs during pregnancy. In the first few years. Although menopause can cause mood swings and sadness, these symptoms are different from medical depression.

Some people turn to alcohol or drugs to cope with life's problems, which can lead to a vicious cycle that leads to more depression. Marijuana can provide temporary relief, but it can also cause depression, especially for young people. Similarly, alcohol disrupts brain chemicals, which can increase depression. Often overlooked, head injuries can cause mood swings and depression. In some cases, low thyroid function (hypothyroidism) can occur.

**Loneliness**

Loneliness is described as a distressing emotional state that arises from a perceived gap between desired and actual social relationships. This condition is not merely about physical solitude but rather the subjective experience of being isolated, regardless of one's actual social situation. Individuals experiencing loneliness often feel disconnected from others and may struggle to form or maintain meaningful relationships. This sense of isolation can lead to negative emotional outcomes and impact overall well-being, making it a significant area of concern in social psychology.

Loneliness is a complex and deeply personal emotion experienced universally. It does not have a single, common cause, making its prevention and treatment highly variable. Experts

suggest that loneliness is not solely about physical solitude but rather the feeling of being alone and isolated, even in the presence of others. It is characterized by a sense of isolation despite a desire for social connections, often perceived as an involuntary separation, rejection, or abandonment.

**Causes of Loneliness**

Loneliness can arise from various situational factors, such as physical isolation, relocating to a new area, or experiencing a divorce. The death of a significant person in one's life can also lead to feelings of loneliness.

It can also be a symptom of psychological disorders like depression, where individuals may socially withdraw, leading to increased isolation. Research indicates that loneliness can both contribute to and result from depressive symptoms. Internal factors such as low self-esteem can also play a role. Individuals who lack self-confidence may feel unworthy of social attention, leading to persistent loneliness.

Personality traits may contribute as well. For example, introverts may be less inclined to seek out social interactions, which can exacerbate feelings of isolation and loneliness.

**Health Risks Associated with Loneliness**

Loneliness has been linked to various negative impacts on physical and mental health, including:

- Misuse of alcohol and drugs
- Altered brain function
- Progression of Alzheimer's disease
- Antisocial behaviour
- Cardiovascular disease and stroke

- Reduced memory and learning abilities
- Depression and suicidal thoughts
- Increased stress levels
- Poor decision-making

**Theories of loneliness**

**Attachment Theory**

Loneliness has been a part of human experience for ages, but its study within psychology is relatively new. Attachment theory, introduced by psychiatrist John Bowlby in the latter part of the 20th century, emphasizes the significance of a secure emotional bond between infants and their caregivers. This theory suggests that loneliness can emerge in children with insecure attachment patterns who experience peer rejection, which disrupts their social skill development and fosters mistrust, thereby perpetuating their feelings of loneliness.

**Weiss's Social Needs Theory**

Expanding on attachment theory, sociologist Robert S. Weiss developed a comprehensive theory of loneliness, identifying six crucial social needs: attachment, social integration, nurturance, reassurance of worth, reliable alliance, and guidance during stressful situations. Weiss argued that while friendships are important, they cannot completely replace the intimate connection of a close partner in alleviating loneliness.

**Behavioural Approach**

The behavioural approach to loneliness links the condition to certain personality traits that contribute to problematic social interactions. Traits such as social anxiety, shyness, sadness, hostility, distrust, and low self-esteem are associated with loneliness and can hinder effective and fulfilling social engagement. Individuals who are lonely often face challenges in

forming and maintaining meaningful relationships and are less inclined to share personal information, which can result in diminished intimacy with close friends.

**Cognitive Approach**

The cognitive approach to loneliness examines how differences in perception and attribution influence the experience of loneliness. Lonely individuals generally have a more negative outlook on people, events, and their own social abilities compared to those who are not lonely. They tend to blame themselves for their difficulties in forming satisfactory relationships. This approach builds on attachment and behavioural theories by explaining how unmet social needs create perceived gaps in relationships, which are experienced as loneliness. It also highlights how loneliness can be reinforced by a self-fulfilling prophecy, where poor social skills lead to unsatisfactory relationships, further negative self-perceptions, and increased isolation.

**Perceived Social Support**

Social support encompasses an individual's belief in the availability of help from family, friends, and significant others. It serves as a crucial psychological resource that helps individuals manage stress, shields them from challenging situations, improves social adaptability, and enhances resilience in adverse circumstances. Social support generally includes both received and perceived forms. Received social support refers to the actual support provided by those close to an individual, focusing on the amount and quality of that support. In contrast, perceived social support pertains to an individual's subjective evaluation of the availability and adequacy of their social network, including family, friends, and significant others. While received social support is important, perceived social support often offers a more meaningful and effective indicator of an individual's mental health.

## Theories of Social Support

Several theories explain how perceived social support impacts individuals' well-being. These theories explore different aspects, including stress coping mechanisms, social integration, and cognitive appraisal.

### Stress-Buffering Theory

The leading theoretical perspective on social support suggests that it alleviates the negative effects of stress on health by serving as a buffer. This theory proposes that social support can manifest in two ways: through direct actions from others, such as advice and reassurance, or through the belief in the availability of support. Direct supportive actions are thought to improve coping skills, while the perception of available support helps individuals view potentially threatening situations as less daunting. This theory is closely associated with stress and coping research and is extensively covered in key reviews and theoretical discussions on social support (Lazarus, 1966; Lazarus & Folkman, 1984; Moos & Billings, 1982).

### Social Constructionist Perspective

Social constructionism, informed by social cognition and symbolic interactionism, provides an alternative lens for understanding social support. Despite differing intellectual traditions and methodologies, these perspectives share common roots in pragmatist philosophy, notably the ideas of James, Dewey, and Mead. According to this view, reality, including concepts like social support and the self, is seen as a social construct. This means that people's perceptions are shaped by their social contexts rather than reflecting an objective reality (Dewey, 1917/1997). The absence of a universal consensus leads to individual and group differences in how social support is perceived (Kelly, 1969).

From this perspective, there is no single definition of supportive behaviour. Additionally, this viewpoint underscores the interconnectedness of the self and social

environment, suggesting that an individual's sense of self is largely influenced by others' perceptions (Mead, 1934).

## Social Cognition

A contemporary application of social constructionism is found in social cognition, which examines how individuals perceive and interpret social support (Barone et al., 1997). This approach is informed by social-cognitive theories of personality and psychopathology (e.g., Beck, Rush, Shaw, & Emery, 1979; Markus, 1977). Social-cognitive theories emphasize that individuals' enduring beliefs about the supportiveness of others shape their daily thoughts about social support. Those who perceive high levels of support are likely to interpret similar behaviours as more supportive, have better recall of supportive actions, pay greater attention to supportive behaviours, and think about support more easily (Baldwin, 1992; Lakey & Cassady, 1990; Lakey & Drew, 1997; Mankowski & Wyer, 1997; T. Pierce et al., 1997).

While objective aspects of the social environment do influence perceived support, individuals' impressions of supporters' personalities often have a stronger impact on perceived support than the actual support provided (Lakey, Ross, Butler, & Bently, 1996). Social-cognitive models also explain how negative perceptions of social relationships can overlap with negative self-thoughts, leading to emotional distress (Baldwin & Holmes, 1987; Lakey & Cassady, 1990; Sarason, Pierce, & Sarason, 1990). Research indicates that perceived support is closely related to self-evaluation and that cognitive representations of social relationships can affect self-evaluation and emotions (Baldwin, Carrell, & Lopez, 1990; Baldwin & Holmes, 1987; Baldwin & Sinclair, 1996).

## Empirical Review

This empirical review examines research on depression, loneliness, and perceived social support in older adults. It looks at how these factors are related and their effects on the

mental health of the elderly. By summarizing various studies, this review aims to clarify how loneliness and perceived social support influence depression among older people. The findings will help design better interventions and support strategies to enhance mental well-being in the geriatric population.

**Studies related to depression, loneliness, and social support**

Elsayed,E.B.M., El-Etreby, R.R., and Ibrahim,A.A (2019), conducted a study on the relationship between social support, loneliness, and depression among elderly individuals was examined. The research utilized a descriptive-correlation design involving 150 elderly participants selected based on specific criteria from El Badala village in El-Mansoura District, Egypt. Data collection tools included the Mini-Mental State Examination (MMSE), a socio-demographic and clinical data structured interview schedule, the UCLA Loneliness Scale, the Multidimensional Scale of Perceived Social Support (MSPSS), and the Geriatric Depression Scale (GDS). Results indicated that 80% of the elderly reported moderate social support, 86% experienced mild loneliness, and 56% had mild depression. The findings revealed a significant positive correlation between loneliness and depression and a significant negative correlation between social support and both loneliness and depression, suggesting that increased social support is associated with lower levels of loneliness and depression among the elderly. (Elsayed., et al.,2019)

In a study by Jeannette Golden, Ronán M. Conroy, Irene Bruce, Aisling Denihan, Elaine Greene, Michael Kirby, and Brian A. Lawlor(2009) examined the relationship between social networks, loneliness, mood, and wellbeing in elderly community-dwelling individuals in Dublin. Utilizing the GMS-AGECAT, 1,299 participants aged 65 and over were interviewed at home. The study found that 35% of participants experienced loneliness, with 9% describing it as painful and 6% as intrusive, and 34% had non-integrated social networks. Interestingly, 32%

of those with an integrated social network also reported loneliness, highlighting that the constructs are distinct. Loneliness was more prevalent among women, the widowed, and those with physical disabilities, although its association with age became non-significant when controlled for age-related variables. Both loneliness and non-integrated social networks were independently associated with poorer wellbeing, depressed mood, and hopelessness, with loneliness particularly explaining the higher depression risk among the widowed. The population attributable risk (PAR) was 61% for loneliness and 19% for non-integrated social networks, with a combined PAR of 70%. The study concluded that loneliness and social networks independently and significantly impact mood and wellbeing in the elderly, contributing to a considerable proportion of depressed mood (Golden et al., 2009)

**Studies related to depression and loneliness**

Barakat, M. M., Elattar, N. F., & Zaki, H. N. (2019). This descriptive exploratory study aimed to evaluate levels of depression, anxiety, and loneliness among elderly residents in geriatric homes. The research was conducted at facilities in Benha City, Kaluobia Governorate, and Tanta City, Gharbiya Governorate. A purposeful sample of 50 elderly individuals (both males and females) living in geriatric homes was included. Data collection utilized a Structured Interview Questionnaire Schedule, Beck's Depression Inventory, Geriatric Anxiety Scale (GAS), and UCLA Loneliness Scale (Version 3). Results revealed that approximately three-quarters of the elderly participants experienced depression, and more than two-thirds reported anxiety, with a majority suffering from severe loneliness. Significant correlations were found between loneliness and depression ($p < 0.001$), as well as between geriatric anxiety and depression ($p < 0.001$). A statistically significant correlation was also observed between loneliness and geriatric anxiety ($p < 0.05$). The study concluded that elderly individuals residing in geriatric homes exhibited elevated levels of depression, anxiety, and loneliness(Barakat et al.,2019)

Domènech-Abella et al. (2017) examined the link between loneliness and depression in older adults in Spain, emphasizing the impact of social networks. Using data from 3,535 individuals aged 50 and above, loneliness was measured with the three-item UCLA Loneliness Scale, while social network characteristics were assessed using the Berkman–Syme Social Network Index. Depression over the past year was determined using the Composite International Diagnostic Interview (CIDI). Logistic regression analysis revealed that loneliness was more prevalent among women, those aged 50–65, singles, separated, divorced, widowed individuals, rural residents, and those with infrequent social interactions and smaller social networks. These groups also exhibited higher rates of major depression. Notably, lonely individuals with depression tended to be married with smaller social networks, whereas non-lonely depressed individuals were often previously married. The study suggests that expanding social networks may be more effective than cognitive interventions for reducing loneliness and depression among older adults in Spain. (Abella et al., 2017).

Domènech-Abella, J., Mundó, J., Haro, J. M., & Rubio-Valera, M. (2019). Anxiety, depression, loneliness and social network in the elderly: Longitudinal associations from The Irish Longitudinal Study on Ageing (TILDA). This study utilized data from 5066 adults aged 50 years and older participating in The Irish Longitudinal Study on Ageing (TILDA). Loneliness was measured using the UCLA loneliness scale, and social integration was assessed with the Berkman–Syme Social Network Index. Major depressive disorder (MDD) and generalized anxiety disorder (GAD) were diagnosed using the Composite International Diagnostic Interview (CIDI). Logistic regression models revealed bidirectional associations between loneliness and subsequent MDD or GAD, with loneliness as the stronger predictor. Additionally, social isolation predicted higher likelihood of subsequent MDD or GAD, and loneliness was associated with deterioration in social integration over time. The findings underscore the independent impact of objective and perceived social isolation on mental health

outcomes, emphasizing the importance of addressing both subjective factors like loneliness and objective factors such as social network size to enhance the mental well-being of older adults(Abella et al., 2019).

Singh, A., & Misra, N. (2009). Loneliness, depression and sociability in old age. This study aimed to explore the relationships among depression, loneliness, and sociability in elderly individuals. A sample of 55 elderly participants of both genders was assessed using the Beck Depression Inventory, UCLA Loneliness Scale, and Eysenck's Sociability Scale. Findings indicated a significant association between depression and loneliness. The results suggested that the majority of elderly individuals exhibited average sociability and preferred to remain engaged in social interactions(Singh, et al., 2009)

**Studies related to depression and social support**

Kim and Seo (2022) explored factors affecting healthy aging in older adults with chronic diseases, in line with global aging trends and WHO's strategy. The study involved 116 participants aged 65 and older from four cities. Analysis showed positive correlations between healthy aging and health status, gerotranscendence, self-efficacy, and social support, while a negative correlation was found with depression. Key predictors of healthy aging included health status, self-efficacy, education, exercise, gerotranscendence, and lower depression, accounting for 68.2% of the variance. The study highlights the need for interventions focusing on health education, exercise, managing health status, reducing depression, promoting gerotranscendence, and enhancing self-efficacy to support healthy aging (Kim et al.,2022)

In a descriptive, cross-sectional study by Seddigh et al. (2020), the relationship between perceived social support and depression was compared among elderly individuals in senior day centers, nursing homes, and those living at home. The study involved 315 participants selected through stratified random sampling. Data were gathered using demographic questionnaires, the

Barthel Index for Activities of Daily Living (ADL), the Social Support Appraisals (SSS -As) scale, and the Geriatric Depression Scale short form (GDS-15). Analysis using ANOVA, Chi-square, Pearson correlation, and linear regression revealed that increased social support was associated with decreased depression in all groups. This relationship was statistically significant in the elderly living in nursing homes ($r = -0.19$, $p = 0.044$) and those attending senior day centers ($r = -0.18$, $p = 0.049$). The study concluded that senior day care centers effectively enhanced perceived social support and significantly reduced depression through participation in daily and social activities compared to the other groups (Seddigh et al., 2020).

Liu et al. (2020) studied the relationships between health literacy, social support, depression, and frailty among older adults with hypertension and diabetes in Sichuan Province, China. Data from 637 participants aged 65 and older were analyzed using structural equation modeling. The study found that 42.4% of participants experienced frailty. Moderate levels of health literacy, social support, depression, and frailty were reported. Social support was linked to reduced frailty, while depression increased frailty. Health literacy was positively associated with social support and negatively with depression, indirectly reducing frailty. These findings highlight the need to improve health literacy and social support while addressing depression to reduce frailty in older patients with chronic conditions. (Liu et al., 2020)

Emaminaeini et al. (2019) explored the link between depression and perceived social support among elderly people in Tehran. The study involved 580 participants, with an average age of 69.66 years, using standardized questionnaires like the Beck Depression Inventory and the Zimet Perceived Social Support Scale. Results showed that 51.87% of participants experienced some level of depression, with 72.38% reporting adequate social support. A significant negative correlation was found between depression and social support ($r = -0.388$), meaning that higher social support was linked to lower depression. Factors such as marital status, home ownership, health insurance, and life satisfaction were significantly related to both

social support and depression, while gender was not. The study highlights the importance of improving economic, cultural, and social conditions to enhance the well-being of the elderly. (Emaminaeini et al.,2019)

Pourtaghi et al. (2019) conducted a correlational study to explore the impact of depression and social support on morale among elderly individuals in Mashhad. The study included 70 participants from urban health centers, using tools such as the Geriatric Depression Scale, Duke Social Support Scale, and Philadelphia Geriatric Center Morale Scale. Multiple regression tests and Pearson correlation were performed using SPSS version 16. The results revealed a significant negative relationship between depression and morale, indicating that higher levels of depression were linked to lower morale. Conversely, a significant positive relationship was found between social support and morale, showing that increased social support was associated with higher morale. The study underscores the need for programs that prevent depression and enhance social support to boost morale among the elderly. (Pourtaghi et al., 2019)

In a study by Ibrahim et al. (2013), the impact of social support and depression on the quality of life among elderly residents of a rural Federal Land Development Authority (FELDA) community in Malaysia was examined. Using a cross-sectional design, the study involved 162 elderly participants from FELDA Sungai Tengi. The researchers used the SF-12, Geriatric Depression Scale (GDS-15), and MOS-Social Support to measure quality of life, depression, and social support. Results showed that the elderly had a high quality of life, especially in physical health, compared to mental health. Emotional role scores were the highest, while social functioning scores were the lowest. The physical health score (74.40) was higher than the mental health score (51.51). About 23.5% of participants had mild depression, and 2.5% had severe depression. (Ibrahim et al., 2013)

**Studies related to social support and loneliness**

Shafiq, Mah, and Bano (2020) conducted a correlational study to examine how social support and adjustment problems affect perceived loneliness among elderly individuals in Pakistan. The study included 150 participants aged 60 and above, split between old age homes in Lahore (n=75) and households in Gujrat (n=75). Data were collected using the Multidimensional Scale of Perceived Social Support, the Scale for Adjustment Problems for Adults, and the De Jong Gierveld Loneliness Scale. Findings revealed a significant negative correlation between social support and loneliness, and a positive correlation between adjustment problems and loneliness. Family support and adjustment problems were significant predictors of loneliness, highlighting differences between elderly residents of old age homes and those living with families. The study emphasizes the importance of social support and managing adjustment issues in reducing loneliness among the elderly(Shafiq et al., 2020)

Kang, Park, and Wallace (2016) studied how perceived social support, loneliness, physical activity (PA), and quality of life (QoL) are related in older adults in South Korea. Using data from 332 individuals over 65, analyzed with structural equation modeling, they found that social support increased PA and QoL while reducing loneliness. PA also improved QoL, whereas loneliness decreased it. Loneliness mediated the link between social support and QoL. These results suggest that integrating social support into PA programs can enhance the QoL for older adults, offering insights for effective health interventions in South Korea (Kang et al.,2016)

Chen, Y., & Hugh, T. (2013). Social support, social strain, loneliness, and well-being among older adults: An analysis of the Health and Retirement Study. This study examined the relationships among social support, social strain, loneliness, and well-being in older adults using data from the Health and Retirement Study, a national sample of adults aged 50 years

and older (N = 7,367). Structural equation modeling was employed to analyze the data. The findings indicated that higher support and lower strain from spouse/partner and friends were associated with reduced loneliness and improved well-being. Conversely, higher strain from these sources intensified loneliness. Overall, greater support and lower strain from various relational sources were directly and indirectly linked to improved well-being, with loneliness mediating these effects. The study concluded that in later life, different sources of support and strain have distinct impacts on loneliness and well-being, highlighting loneliness as a crucial psychological pathway through which support and strain influence overall well-being. (Chen et al.,2013)

**Research Gap**

Despite a wealth of research on the relationships between social support, loneliness, and depression among elderly populations in various global contexts, there is a notable gap in the literature concerning these issues in specific regions such as Trivandrum. The studies reviewed predominantly focus on diverse locations like Egypt, Dublin, Spain, China, Malaysia, and South Korea, highlighting different patterns and predictors of depression, loneliness, and social support. However, the unique socio-cultural and demographic characteristics of Trivandrum have not been adequately explored. This lack of localized research presents a significant gap, indicating a need for studies that address how these factors specifically affect elderly individuals in Trivandrum, which could inform more culturally relevant interventions and support mechanisms for this population.

# CHAPTER III

# METHODOLOGY

Research methodology refers to the systematic and theoretical examination of the procedures employed in a given field of study. It involves outlining, elucidating, and forecasting phenomena to tackle specific issues. This encompasses research designs, target populations, sample sizes and sampling methods, data collection instruments, and data analysis techniques. Rather than offering direct solutions, methodologies provide the theoretical framework for determining which approach or combination of techniques is most appropriate for a particular context (Kothari, 2004).

## AIM

The aim of the study is to explore the relationships between depression, loneliness, and perceived social support among geriatric individuals, including how these factors correlate with each other and the influence of gender on geriatric depression.

## VARIABLES UNDER STUDY

The variables in the current study are depression, loneliness and perceived social support

## OPERATIONAL DEFINITION OF VARIABLES

Geriatric Depression refers to the measurable level of depressive symptoms experienced by individuals aged 65 years and older, as assessed using a standardized and validated instrument such as the Geriatric Depression Scale (GDS). The GDS will be administered, and scores above a predetermined threshold will indicate the presence of clinically significant depressive symptoms.

Loneliness is a subjective feeling of being alone or isolated, regardless of the actual level of social contact. It can be evaluated using validated scales like the UCLA Loneliness Scale, with higher scores indicating greater feelings of loneliness

Perceived Social Support is the subjective appraisal of the availability and adequacy of support from interpersonal relationships. This will be measured using a self-report instrument, such as the Multidimensional Scale of Perceived Social Support (MSPSS), where participants rate the extent to which they feel supported by family, friends, and significant others. Higher scores on the scale will indicate a greater perceived level of social support

**OBJECTIVES OF THE STUDY**

1. To investigate the correlation between depression and loneliness in geriatric individuals
2. To explore the relationship between perceived social support and depression among the elderly
3. To study the correlation between perceived social support and loneliness in geriatric individuals
4. To study the influence of gender on geriatric depression.

**HYPOTHESIS**

- There will be a significant relationship between depression and loneliness among geriatric individuals.
- There will be a significant relationship between perceived social support and depression among geriatric individuals.
- There will be a significant relationship between perceived social support and loneliness among geriatric individuals.
- There will be a significant difference between males and females on geriatric depression.

## RESEARCH DESIGN

The research design used for the present study is Correlational comparative research design**.**

## PARTICIPANTS

A total population of 120 old age people, of which 60 males and 60 females above age 65 was collected using convenience sampling method. The sample consist of old age peoples belonging to various places in Trivandrum district.

## TOOLS USED FOR DATA COLLECTION

The following scale was used to measure Depression:

### Geriatric Depression Scale (GDI)

The scale was developed by Yesavage et al., in 1983 to measure depressive symptoms among older adults. The GDS is a multidimensional, multidisciplinary diagnostic and therapeutic activity that helps find patients with risk of /with depression. The scale is intended for the geriatric population. It is comprised of 15 items where the participant has to choose between yes or no regarding how they felt over the past week.

### Reliability and Validity

Studies reported that GDS 15 to have excellent internal consistency, both Cronbach alpha coefficient of 0.92. The scale has a good validity.

### Scoring

The questionnaire was administered to the respondents personally. The instructions were given to the respondents and are asked to respond how frequently they have experienced for the past week. The participant has to respond yes or no for each statement. The score 10-

15 shows depression likely to present. The scores between 6-9 shows the possibility of depression. Finally, the score 0-5 shows depression unlikely.

The following scale was used to measure loneliness :

**Revised UCLA Loneliness Scale**

The scale was developed by Russell et al. in 1980 to measure one's subjective feelings of loneliness as well as the feeling of isolation. The scale consists of 20 items and scored on a four-point scale: Never, Rarely, Sometimes and often. Some items on the scale (1, 5, 6, 9, 10, 15, 16, 19 and 20) are reverse scored.

**Reliability**

The scale has a strong reliability across various studies. Internal consistency is particularly high, with Cronbach's alpha values typically ranging from 0.89 to 0.94, indicating that the items on the scale consistently measure the same underlying construct of loneliness. The scale has also shown strong test-retest reliability over time, suggesting that it provides stable and consistent results when administered to the same individuals under similar conditions across different time points.

**Validity**

The validity of the Revised UCLA Loneliness Scale means that it does a good job of measuring loneliness, as it was designed to.

**Scoring**

The scale consists of 20 items and scored on a four-point scale: Never, Rarely, Sometimes and often. Some items on the scale (1, 5, 6, 9, 10, 15, 16, 19 and 20) are reverse scored. Participant rate each item on a scale from 1 (Never) to 4 (Often).

The following scale was used to measure Perceived social support:

**Multidimensional scale of perceived social support (MSPSS)**

It is a instrument designed to measure an individuals perception of support from 3 sources : family, friends and a significant other. The instrument is 12 item scale.

**Reliability and Validity**

The scale has good internal and test-retest reliability. The scale shows good validity

**Scoring**

To calculate the total score: Sum across all 12 items. This total score can also be calculated as a mean score (divide by 12). In this approach total score between 12-35 is interpreted as Low level of perceived support, score between 36-60 is interpreted as medium level of perceived support and score of 61-84 is interpreted as high level of perceived support.

**PROCEDURE OF DATA COLLECTION**

Informed consent was first collected which includes the terms of confidentiality and the purpose of the study was given to the participant to ensure their voluntary participation. For the purpose of data collection, the samples were collected from elderly people above the age of 65 using convenience random sampling. Sample size chosen was 120 elderly people of age above 65 includes both males and female of equal number, that is 60 each. The data was collected by using offline surveys. 10- 15 minutes were utilized to completing the questionnaires. Before asking each question, a good rapport was established for genuine responses. After data collection, scoring was done and subjected to statistical analysis.

## STATISTICAL TECHNIQUES USED FOR DATA ANALYSIS

The following were the statistical technique used for the data analysis. The statistical analysis for data collection was done using the SPSS (Statistical Package for Social Sciences) version.

### The Shapiro-Wilk test

The Shapiro-Wilk test, developed by Samuel Shapiro and Martin Wilk in 1965, is used to assess whether a dataset follows a normal distribution. It is especially useful for small to moderate sample sizes, up to about 2000 observations. The test calculates a W statistic, with a value close to 1 indicating normality. A p-value below 0.05 suggests that the data significantly deviate from a normal distribution. Commonly used in fields like psychology and biology, the Shapiro-Wilk test helps verify the normality assumption required for parametric tests such as t-tests and ANOVA. However, it can be sensitive to outliers and less effective for very large samples, where alternative tests like the Kolmogorov-Smirnov or Anderson-Darling might be preferable.

### Non-parametric Spearman's rho

Spearman's rho is explained as a non-parametric statistic used to measure the strength and direction of a monotonic relationship between two ranked variables. Unlike Pearson's correlation coefficient, it does not require the assumption of linearity or normality, making it a more robust choice for ordinal or skewed data. Spearman's rho works by converting data into ranks and then calculating the correlation between these ranks. The coefficient ranges from -1 to +1, where values closer to 1 indicate a strong positive relationship, values closer to -1 indicate a strong negative relationship, and a value of 0 suggests no correlation. This method is particularly useful in behavioural and social sciences where the data often do not meet parametric assumptions.

**Mann Whitney U test**

The Mann-Whitney U Test, is a non-parametric test used to compare two independent samples to determine whether they come from the same distribution. This test is particularly useful when the assumptions of the parametric t-test, such as normality, are not met. It ranks all observations from both groups combined and then analyses the differences between the ranks of the two groups. The U statistic is calculated to assess whether one group tends to have higher ranks than the other, making it a suitable alternative to the t-test when dealing with ordinal data or non-normally distributed interval data.

# CHAPTER IV

## RESULTS AND DISCUSSION

The present chapter addresses the results and discussion of a study focusing on depression, loneliness, and perceived social support among the geriatric population. This study involved 120 elderly individuals, equally divided between males and females, selected from various locations within Thiruvananthapuram district using a convenience sampling method. Data collection was carried out using three established scales: the Multidimensional Scale of Perceived Social Support (MSPSS) by Zimet et al. (1988), the Geriatric Depression Scale (GDS) by Yesavage et al. (1983), and the UCLA Loneliness Scale by Russell et al. (1980). Scoring was performed according to standardized manuals for each scale. The collected data were analyzed using SPSS, with descriptive statistics applied initially. The statistical techniques employed included frequency distribution and percentage, mean and standard deviation, and Spearman's correlation method.

This study investigates the relationships among depression, loneliness, and perceived social support within the geriatric population. The focus is on understanding how these three variables interact with each other and whether males and females' experiences these on the same level. The results for these variables are presented in the tables below, and the findings are discussed in relation to the study's objectives and hypotheses

**Normality of the test**

**Table 1:**

*Normality test table of Depression, Loneliness, Perceived social support, Family, Friends and Significant Others(N=120)*

| Shapiro- Wilk | | |
|---|---|---|
| **statistic** | **df** | **Sig.** |
| .902 | 120 | .000 |
| .941 | 120 | .000 |
| .947 | 120 | .000 |
| .939 | 120 | .000 |
| .944 | 120 | .000 |
| .922 | 120 | .000 |

***Lilliefors Significance Correction**

From the results of the above table, Shapiro-Wilk tests indicates that the data for all variables deviate significantly from normality ($p < .01$) for all. This deviation demands the use of non-parametric tests.

**Table 2***: Correlation Analysis (Spearman's rho) of Geriatric depression, loneliness, Perceived Social support, family and friends.(N=120)*

| | GDS | Loneliness | PSS | Sig. Other | Family | Friends |
|---|---|---|---|---|---|---|
| **GD** | ( ) | | | | | |
| **Loneliness** | -0.388** | ( ) | | | | |
| **PSS** | -0.484** | -0.392** | ( ) | | | |
| **Sig. Other** | -0.365** | -0.337** | 0.871** | ( ) | | |
| **Family** | -0.437** | -0.420** | 0.848** | 0.776** | ( ) | |
| **Friends** | -0.30** | -0.405** | 0.705** | 0.609** | 0.509** | ( ) |

**** Correlation is significant at 0.01 level (2-tailed)**

The table above shows the findings of correlation analysis of geriatric depression, loneliness and perceived social support among elderly ( n=120). Correlation between the 3 variables was analysed using Spearman's Rho. The table shows that that the observed correlation is statistically significant at 0.01 level (2 tailed). From the table, the key findings are:

- There is a significant positive correlation between Geriatric depression and loneliness ($\rho = 0.388$, $p < 0.01$)
- There is a significant negative correlation between geriatric depression and perceived social support among elderly. ($\rho = -.484$, $p < .01$)

- There is a  negative correlation between loneliness and perceived social support ($\rho$ = -.392,$p < .01$).
- There is a negative correlation between Geriatric depression and significant others of Perceived social support ($\rho$ = -0.365, $p< .01$).
- There is a significant negative correlation between Geriatric depression and Perceived social support from family ($\rho$ = -0.437, $p< .01$ ).
- There is a significant negative correlation between Geriatric depression and Perceived social support from friends ($\rho$ = -0.30, $p< .01$).
- There is a significant negative correlation between loneliness and Perceived social support from significant others. ($\rho$ = -0.337, $p< .01$).
- There is a significant negative correlation between loneliness and Perceived social support from family ($\rho$ = -0.420, $p< .01$).
- There is a significant negative correlation between loneliness and Perceived social support from friends ($\rho$ = -0.405, $p< .01$).
- A significant positive correlation was observed between geriatric depression and loneliness ($\rho = 0.388$, $p < 0.01$), indicating that higher levels of depression are associated with increased loneliness.
- There was a strong significant negative correlation between geriatric depression and perceived social support ($\rho = -0.484$, $p < 0.01$), suggesting that as depression increases, perceived social support decreases.
- Similarly, loneliness showed a significant negative relationship with perceived social support ($\rho = -0.392$, $p < 0.01$), with higher levels of loneliness being linked to lower perceived social support.

- Further, the study revealed significant negative correlations between geriatric depression and support from significant others ($\rho = -0.393$, $p < 0.01$), family ($\rho = -0.437$, $p < 0.01$), and friends ($\rho = -0.300$, $p < 0.01$).
- Likewise, loneliness has significant negatively correlated with perceived support from significant others ($\rho = -0.337$, $p < 0.01$), family ($\rho = -0.420$, $p < 0.01$), and friends ($\rho = -0.405$, $p < 0.01$).

*Table 3: Hypothesis test summary of Mann Whitney U Test.(N=120)*

| Null Hypothesis | Test | Sig. | Decision |
|---|---|---|---|
| The distribution of GDS is the same across categories of gender | Independent Samples Mann-Whitney U Test | .005 | Reject the null hypothesis |

**Asymptotic significance is displayed. The significance level is 0.05.**

Null hypothesis states that there is no difference between male and female in geriatric depression but from the above table, Mann Whitney u test is actually rejecting the null hypothesis that means there exist a difference between male and female.

*Table 4: The comparison of mean and standard deviation of males and females on geriatric depression.(N=120)*

**Group Statistics**

| | GENDER | N | MEAN | S D |
|---|---|---|---|---|
| **DEPRESSION** | FEMALE | 60 | 6.05 | 4.18 |
| | MALE | 60 | 8.08 | 3.60 |

From the above table, it is concluded that there is a significant difference in the means scores of males and females on geriatric depression, which indicates that male tends to be more depressed than female in t test.

# CHAPTER V

# SUMMARY AND CONCLUSION

## SUMMARY OF THE STUDY

The study aimed to examine depression, loneliness and perceived social support among geriatric population in some areas of the Trivandrum district. The sample size of the present study was 120 both male and female above age 65. The samples are selected for the present study by using the Convenient sampling technique. To measure the variables of interest, existing standardized measures are used such as depression by Geriatric Depression Scale (GDI) (Yesavage et al., 1983), loneliness by UCLA Loneliness Scale (Russell et al. 1980) and perceived social support by Multidimensional scale of perceived social support (MSPSS) (Zimet, G.D et al., 1988). Informed consent and personal data sheet were collected from the participants directly. The data was collected through face-to-face interaction in their convenient setting. Before asking the questions, initial rapport is established for genuine response. After data analysis, non-parametric test such as Spearman's Rho and Mann- Whitney U test is used for the statistical analysis of the data. The results obtained by the analysis are discussed comprehensively with respect to objectives and the hypothesis.

This study examined the relationships between depression, loneliness, and perceived social support among a sample of 120 elderly individuals, with equal representation of males and females. The findings reveal significant associations among these variables, indicating that higher levels of depression and loneliness are linked to lower perceived social support from significant others, family, and friends. Specifically, the study found correlations, emphasizing the interconnectedness of emotional well-being and social support systems in the elderly population.

## MAJOR FINDINGS

1. There is a significant positive correlation between Geriatric depression and loneliness, indicating that higher levels of depression are associated with higher levels of loneliness.
2. There is a significant negative correlation between geriatric depression and perceived social support among elderly, suggesting that higher levels of depression are associated with lower perceived social support.
3. There is a significant negative correlation between loneliness and perceived social support, indicating that higher levels of loneliness are associated with lower perceived social support.
4. There is a significant negative correlation between Geriatric depression and Perceived social support of significant others.
5. There is a significant negative correlation between Geriatric depression and Perceived social support of family.
6. There is a significant negative correlation between Geriatric depression and Perceived social support of friends.
7. There is a significant negative correlation between loneliness and Perceived social support of significant others.
8. There is a significant negative correlation between loneliness and Perceived social support of family.
9. There is a significant negative correlation between loneliness and Perceived social support of friends.

10. The mean score for the male group is significantly higher than that for the female group, suggests that males in the study tend to report higher levels of geriatric depression compared to females.

**IMPLICATIONS OF THE STUDY**

The present study emphasizes the crucial influence of perceived social support on the emotional well-being of older adults. Negative correlations were observed between depression, loneliness, and the support perceived from significant others, family, and friends. These findings underscore the need to build and maintain robust support networks for the elderly. Social isolation, which often contributes to feelings of depression and loneliness, can be alleviated by reinforcing these support systems. Healthcare providers, caregivers, and family members should focus on cultivating environments that foster social interaction and offer emotional support, as this can significantly diminish depressive symptoms and loneliness in older adults.

Additionally, the study suggests that interventions aimed at enhancing social support—whether through family involvement, community programs, or friendships—could effectively reduce both loneliness and depression in the elderly. Programs that encourage social engagement, provide peer support, or offer counseling services may be instrumental in increasing perceived social support. This is particularly relevant in environments like retirement communities or long-term care facilities, where structured social activities can help prevent isolation and promote better mental health.

The study also revealed a gender difference, with elderly males reporting higher levels of depression compared to females. This suggests that interventions should be tailored to address the specific needs of elderly men. Mental health initiatives may benefit from adopting gender-specific strategies to effectively address depression and social isolation among older

adults. Policymakers and healthcare professionals should consider these findings when developing public health strategies aimed at improving both the emotional and social aspects of aging, ultimately enhancing the quality of life for the elderly.

## LIMITATIONS OF THE STUDY

- The researcher reading the questions aloud could have affected participants' responses, possibly introducing bias.
- The study might not fully capture individual differences in how elderly people perceive or report social support.
- A small or limited sample size may restrict the ability to apply the findings to a wider elderly population.
- Since the study is cross-sectional, it doesn't allow for insights into the long-term effects of social support on depression and loneliness.
- Participants may have been influenced by social desirability, responding in ways they thought were expected rather than expressing their true feelings.
- Reliance on self-reported data might lead to inaccuracies, as individuals may not fully recognize or disclose their own feelings of loneliness or depression.
- The study may overlook other important factors like physical health or financial situation, which could also influence emotional well-being in older adults.

## SUGGESTIONS FOR FUTURE RESEARCH

- Future research should include a larger and more varied group of older adults to get a clearer picture of the entire elderly population.
- Long-term studies could look into how ongoing social support affects depression and loneliness over time.

- Future studies could investigate how other factors, like health, money, or living situations, impact emotional well-being.
- Using more objective methods, such as observations or assessments by others, might reduce the reliance on self-reported data.
- Research could test different types of support, like community programs or family involvement, to see which are most effective at reducing isolation and improving mental health.
- Future studies might explore how cultural differences affect how social support is perceived and its effectiveness among older adults.
- Research could focus on creating specific interventions for elderly men, given their higher rates of depression, and see if tailored approaches work better.

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## APPENDIX 1

## INFORMED CONSENT

Dear participant,

My name is ********* and I am a postgraduate student pursuing M.Sc. counselling Psychology in *********. I have undertaken a research study entitled "A Study on depression, loneliness and perceived social support among geriatric population." under the guidance of **********, Assistant professor, Department of Counselling Psychology, *******College.

You are invited to participate in this research study which will examine the severity of geriatric depression and level of perceived social support. To decide whether you wish to participate in this study, you should know about the risks and benefits involved to make an informed judgment. This sheet gives you detailed information about the study and you should feel free to ask any other questions that you may have. Once you understand the study procedures you may choose to participate by signing the attached form.

**Study procedures**

Preliminary screening: In the screening session, I will explain all the details of the study and answer any questions you may have. At this meeting, you will be asked questions to confirm that you meet the requirements to take part in the study.

**Risks and Inconveniences**

There are no major risks involved in the study, however there are minor risks and inconveniences which are listed below. The study altogether may take up to 20-30 minutes and you may feel tired or uncomfortable. If needed you may take breaks in between.

**Safety**

To ensure your safety the following precautions will be taken:

i) All adequate precautions will be taken and procedures will be explained to you.

ii) Support will be available to you for the entire duration of the study

**Benefits**

By participating in this study, you will not have any direct benefit. Your participation will contribute to scientific knowledge.

**Confidentiality**

If any reports or publications result from this study, no information will be revealed that will permit readers to identify you. If you would like to know the results of the study or your individual results on any of the measures, I would be happy to reveal them to you after the data has been completely analysed. All the information obtained in this study will be kept confidential to the extent permitted by the law.

**Voluntary Participation**

You are free to choose not to participate. If you choose to participate you are free to withdraw from the study at any time without giving any reason.

**Discontinuing the study**

If the study investigator determines that it is not in your best interest to continue in the study, your involvement may be discontinued any time.

**Questions**

Please feel free to ask about any terms you don't understand.

**Undertaking by the investigator**:

Your consent to participate in the above study by ******* is sought. You have the right to refuse consent or withdraw the same during any part of the study without giving any reason. The information you provide will be stored and maintained safely and confidentially. The data will be used solely for research purposes . Results will be published as dissertation and may be presented in academic conferences or published in scientific journals, without identifying the participants. If you have any doubts about the study, please feel free to clarify the same.

_____

Name & Signature

## APPENDIX II

## PERSONAL DATA SHEET

| | |
|---|---|
| NAME | |
| AGE | |
| GENDER | |
| MARITAL STATUS ( single/ married/ widow/ divorced/ separated) | |
| RELIGION | |
| EDUCATIONAL QUALIFICATION | |
| PROFESSION | |
| Are you suffering from any life style diseases ( Diabetics, Hyper tension, respiratory problem, cancer, liver diseases etc. | |
| Is anyone in your immediate family suffering from psychotic disorders? | |
| Number of children | |

## APPENDIX III

## GERIATRIC DEPRESSION SCALE (SHORT FORM)

**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**

**Total score** _____

## APPENDIX IV

### REVISED UCLA LONELINESS SCALE

**Instructions:** indicate how often each of the statements below is descriptive of you.

| | **STATEMENTS** | **NEVER** | **RARELY** | **SOMETIMES** | **OFTEN** |
|---|---|---|---|---|---|
| **1** | I feel in tune with the people around me | **1** | **2** | **3** | **4** |
| **2** | I lack companionship | **1** | **2** | **3** | **4** |
| **3** | There is no one I can turn to | **1** | **2** | **3** | **4** |
| **4** | I do not feel alone | **1** | **2** | **3** | **4** |
| **5** | I feel part of a group of friends | **1** | **2** | **3** | **4** |
| **6** | I have a lot in common with the people around me | **1** | **2** | **3** | **4** |
| **7** | I am no longer close to anyone | **1** | **2** | **3** | **4** |
| **8** | My interests and ideas are not shared by those around me | **1** | **2** | **3** | **4** |
| **9** | I am an outgoing person | **1** | **2** | **3** | **4** |

| | | | | | |
|---|---|---|---|---|---|
| **10** | There are people I feel close to | **1** | **2** | **3** | **4** |
| **11** | I feel left out | **1** | **2** | **3** | **4** |
| **12** | My social relationships arc superficial | **1** | **2** | **3** | **4** |
| **13** | No one really knows me well | **1** | **2** | **3** | **4** |
| **14** | I feel isolated from others | **1** | **2** | **3** | **4** |
| **15** | I can find companionship when I want it | **1** | **2** | **3** | **4** |
| **16** | There are people who really understand me | **1** | **2** | **3** | **4** |
| **17** | I am unhappy being so withdrawn | **1** | **2** | **3** | **4** |
| **18** | People are around me but not with me | **1** | **2** | **3** | **4** |
| **19** | There are people I can talk to | **1** | **2** | **3** | **4** |
| **20** | There are people I can turn to | **1** | **2** | **3** | **4** |

## APPENDIX V

## MULTIDIMENSIONAL SCALE OF PERCEIVED SOCIAL SUPPORT

**Instructions:** We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you Very **Strongly Disagree**

Circle the "2" if you **Strongly Disagree**

Circle the "3" if you **Mildly Disagree**

Circle the "4" if you are **Neutral**

Circle the "5" if you **Mildly Agree**

Circle the "6" if you **Strongly Agree**

Circle the "7" if you **Very Strongly Agree**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. There is a special person who is around when I am in need | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 2. There is a special person with whom I can share my joys and sorrows. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 3. My family really tries to help me | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 4. I get the emotional help and support I need from my family. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 5. I have a special person who is a real source of comfort to me | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 6. My friends really try to help me. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 7. I can count on my friends when things go wrong. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| .8. I can talk about my problems with my family. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| .9. I have friends with whom I can share my joys and sorrows. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 10. There is a special person in my life who cares about my feelings. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 11. My family is willing to help me make decisions. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| 12. I can talk about my problems with my friends. | **1** | **2** | **3** | **4** | **5** | **6** | **7** |