PSYCHOLOGY AND EDUCATION (2021) 58(5), ISSN 1553 - 6939
Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

Quality of Life and Its Resources: A Comparative Study Of Institutionalized Versus Non-Institutionalized Elderly

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ABSTRACT

Quality of life is considered an important aspect for any age group. Due to various consequences, it is essential for the elderly population to have adequate quality of life - be it the institutionalized as well as non-institutionalized elderly. Quality of life is considered as a person's physical health, psychological state and level of independence, social relationships and their relationship to their environment. Therefore, it was considered worthwhile to investigate the differences in QoL and its resources in institutionalized and non-institutionalized elderly.

In recent years, relationship between affect and health (or adjustment) has been a topic of intense research in the domain of health psychology and behavioral medicine. Positive and negative feelings have independent effects on health of institutionalized and non-institutionalized elderly contributing towards their quality of life. One of the primary topics covered by positive psychology is the phenomenon of hope. The psychology of hope has become a dynamic branch of research that is being developed by numerous scientists across the world. Several practitioners and researchers have recognized the importance of religious/spiritual dimension towards health (Rowold, 2011). Researches showed that resilience helps in coping with the negative effects of stress and promotes adaptation, and this adaptation leads to life satisfaction (Wagnild, 2003). Wealth is related to many positive life outcomes (Furmham & Argyle, 1998). For example, people with a higher socio-economic status have better health and mental health, can afford improved health care services, and have greater longevity. Another social variable which also plays a vital role towards QoL of instutionalized and non-instutionalized elderly is social support. Social support stems from social interactions and networks of relationships that are intended to strengthen the well-being of their members. Thus, the main aim of the present investigation was to compare instutionalized and non-instutionalized elderly on quality of life and its resources, viz., affect, hope, spiritual well-being, resilience, socio-economic status, and social support.

The total sample of the present investigation comprised 320 institutionalized and non-institutionalized elderly. The sample for institutionalized elderly comprised those who were living in old age homes in and around Patiala and Chandigarh. The sample for non-institutionalized elderly (N=160; males=80 and females=80) comprised those who were living with their families in their homes. The selected age range was 60 to 75 years. All participants living in urban cities were taken in the present investigation. The tools used were Flanagan's Quality of Scale, Resilience Scale, Positive and Negative Affect Scale, Spiritual Well-Being Scale, Adult Hope Scale and Social Support Questionnaire. t-test (for independent samples) revealed that non-institutionalized elderly scored higher on QOL, positive affect agency (subscale of hope), pathways (subscale of hope), religious well-being and existential well-being (subscales of spiritual well-being) and social support than the institutionalized elderly whereas, the latter scored more than the former on negative affect and resilience, by and large. There was no difference between institutionalized elderly and non-institutionalized elderly on socio-economic status.

The findings are interpreted in terms of the disintegration of the family as well as social structure, and differential conditions and effects of institutionalisation in eastern rather than western cultures.

Keywords
Quality of life, positive affect, negative affect, existential well-being, religious well-being, agency, pathways, hope, resilience, socio-economic status, and social support

Introduction

In the present times, the family structure as well as relations are drastically changing from joint families to smaller/nuclear families with little scope for social networking, leading to isolation and disintegration of the family as well as the social structure. As a result, elderly people are typically facing problems, such as empty nest, lack of autonomy, paucity of economic and social resources, along with the biological effects of aging. Thus, the need of studying quality of life in institutionalized and non-institutionalized has become of utmost importance today especially with the increasing stresses and strains in life.

The idea of *institutionalization of the aged* has been, to a great extent, acquired from the western social orders, whose qualities and standards are not the same as that of India. Scholars feel that the need of institutionalization cannot be denied for those aged people who are neither able to manage their own affairs nor do they have any person to look after them. Usually, living in an old age home evokes a picture of apathy, dependence, and sadness. The inmates often confront problems due

to highly institutionalized, depersonalized and bureaucratic atmosphere in old age homes. They face problems of adjustment with tight and rigid schedule, total or near total separation from the family/social milieu, anxiety over entrusting oneself to a new environment, diminished physical capacity, and very close and frequent encounters with death and ailments in the institution.

Furthermore, emotional issues are associated with aging and *positive emotions* are found to have a significant favorable impact on the overall well-being of the elderly. Research has also shown that cultivated positive emotions not only reduce *negative emotions* but also broaden one's habitual modes of thinking and build one's personal resources for coping (Rathee, 2004). In a study by Khosla & Hangal (2004), it has been found that participants experiencing positive affect report more coping resources to deal with stress.

Hope is a positive motivational state that is based on an interactively derived sense of successful agency and pathways, with *agency* referring to goal-directed energy, and *pathways* referring to the planning that is required in meeting one's goals (Snyder, Irving, & Anderson, 1991). Research has shown that optimistic and hopeful people are happier and healthier; they have more effective immune systems, cope better with stress and have better social support networks (Peterson, 2000; Snyder, 2000; Schneider & Stevenson, 1999). Trama & Kaur (2009) also found that while "agency" beliefs were significant in predicting resilience in elderly males, it was the "pathways" beliefs that were found to do so for elderly females.

Also, *spirituality* is viewed as a basic human need, and is important because it has the potential to promote quality of life especially to the elderly, whether ill or well, since it does exist across the lifespan. As one ages, there is a need to hold onto something that has a meaningful purpose in their life whether this basic need are family, friends, or religious articles. Several studies have investigated the relationship between religious involvement and mental health. In most cases, they have found that higher levels of religious involvement are associated with greater well being and mental health (Moreira-Almeida & Koening, 2006).

In addition, resilient individuals believe that they can directly influence the events that occur in their lives and translate their beliefs into actions (Reivich & Shatte, 2002). *Resilience* helps to overcome day-to-day stressors and move towards opportunities. Coping with stress is a part of living, but how one beholds stressful life events and moves on is the basis of the resilience framework (Flach, 1988). Resilience tends to enhance one's quality of life.

Trama & Mehta (2020a) found that perceived stress emerged as the sole (positive) predictor of QoL in instutionalized elderly women whereas, in case of instutionalized elderly men, planful problem solving was found to do so positively. So, institutionalized elderly seem to differ in their QoL; higher levels of perceived stress may be regarded as "challenging" by institutionalized elderly women, who may respond to these higher levels of stress by being resilient and hardy.

Socio-economic status of the elderly may affect elderly care. Socio-economic status of the household reflects, in part, the adequacy of the family to take care of elderly members. Even the benefit of social support for individuals confronted with life crises has been the subject of research for more than two decades. It has been shown, for instance, that greater social integration during periods of high life stress may not only provide sustenance for the psychological well-being of an individual, but might also have a positive impact on a variety of discrete health outcomes which will improve one's quality of life.

Overall factors like affect, hope, spirituality, resilience, socio-economic status and *social support* tend to have important contribution towards quality of life of the institutionalized and non-institutionalized elderly. A limited number of studies have been concerned with the comparison of the elderly persons residing in old age homes and those residing with their families on quality of life and these diverse resources. Also, the literature review points towards the lack of comparative studies in this area. The present investigation was therefore, proposed to explore

the differences in QoL of institutionalized and non-institutionalized elderly. It is expected that the results of the study may provide empirical evidence regarding the same that may help psychologists, sociologists, social workers and other professionals as well as governments and policy makers of our nation to seek ways to enhance QoL of the elderly. The results revealed that institutionalized elderly scored higher on QoL, positive affect, hope.

Institutionalized versus non-institutionalized elderly:

Let us now unravel the difference in institutionalized versus non-institutionalized elderly on quality of life, affect, hope, spirituality, resilience, socioeconomic status, and social support.

Pinto & Prakash (1991) conducted a study on the elderly aged 60 years and above in Mangalore. It was a comparative study of quality of life of elderly institutionalized with those who are living in families, using a semi-structured interview schedule. 25 inmates from old age homes and 25 from families were interviewed individually. Lack of family support, dissatisfaction with children, absence of children, death of spouse and ailing health were found to be the reasons for institutionalization. The study also found that the homebound elderly were more active, more satisfied, and had more social contacts, and hence, were in a more privileged (better adjusted) position than the elderly in old age homes.

Antonelli, Rubini, & Fassone (2000) found that the institutionalized elderly have more negative affect, lower levels of self-esteem, and have a more restricted interpersonal self when compared to the non-institutionalized elderly.

A study conducted by Tejal (2010) on psychological well-being of elderly found that institutionalized elderly experience a poor sense of psychological well being than the non-institutionalized aged. Another research finding indicates that aged persons living in old age homes lag behind in hopefulness and mental health (Joseph & George, 2011).

Ntozini & Walton (2020) reported a significant positive correlation between psychological well-being and religiosity/spirituality in the elderly institutionalized population. Gull & Dawood (2013) also reported that for the institutionalized elderly, religiosity has a significant positive relationship with life satisfaction.

Kaplan (2002) conducted a study to find out resilience of 50 senior citizens living in home for aged and 50 senior citizens living in the family set-up in Erode district. The findings indicated that majority of senior citizens in the home for aged had moderate resilience. Over all, mean score regarding resilience was found to be higher in senior citizens living in family set-up than the senior citizens living in home for the aged.

Elderly homeless people with poor socioeconomic conditions also contribute to institutionalization as the financial crisis and the lack of contact with the family consequently influences the institutionalization process (Borges, da Silva, Clares, de Menezes Nogueira, & de Freitas, 2015). A study by Chadha, Shah, & Mahajan (1991) reported that institutionalized elderly exhibit significantly smaller social networks than non-institutionalized elderly.

To sum up, it may be said that there is meagre research evidence regarding differences in the institutionalized and non-institutionalized elderly on personal/social resources of QoL. Moreover, the effects of institutionalization may also be evident in institutionalized elderly as compared with those residing with their families. These differences were proposed to be examined in the present investigation.

OBJECTIVES

The following objective was formulated in the present investigation:

1. To compare institutionalized and non-institutionalized elderly on quality of life, affect, hope, spirituality, resilience, socio-economic status, and social support.

HYPOTHESES

Keeping in view the objectives of the study, the following hypotheses have been framed:

1. Non-institutionalized elderly would score higher than institutionalized elderly on positive affect, hope, resilience, and social support.
2. Institutionalized elderly would score more than the non-institutionalized elderly on negative affect.
3. There would be no difference between the institutionalized and non-institutionalized elderly on spirituality and socio-economic status.

METHODOLOGY

SAMPLE:

The sample of the present investigation comprised 320 (160 males and 160 females) institutionalized and non-institutionalized elderly aged 60 to 75 years. The sample for institutionalized elderly (N=160; Males=80 and Females=80) comprised those who were living in old age homes (for at least 6 months) in and around Patiala and Chandigarh. The sample for non-institutionalized elderly (N=160; Males=80 and Females=80) comprised those who were living with their families in their homes. All participants living in urban cities of Patiala and Chandigarh were taken in the present investigation. Convenience sampling was done as those elderly were taken who met the inclusion criteria, and were willing to participate in the investigation.

INCLUSION/ EXCLUSION CRITERIA USED IN THE STUDY

Inclusion criteria for elderly people living in old age homes:

1) Educated up to fifth standard
2) Both males and females
3) Aged between 60-85 years
4) Living in old age home for at least past six months
5) Willing to participate in the study

Inclusion criteria for elderly people living within the family set-up:

1) Educated up to fifth standard
2) Both males and females
3) Aged between 60-85 years
4) Willing to participate in the study
5) Living with family members
6) Not involved in any occupation and professional work.

Exclusion criteria for elderly people living in old age homes/within the family set-up:

1) Those with prior history of major physical illness
2) Those with prior history of major psychiatric and neurological illness

TOOLS USED

1) QUALITY OF LIFE SCALE (FLANAGAN, 1978):

It is a self-administered questionnaire. It has 16 items. Items are rated on a seven-point scale ranging from "delighted" (7) to "terrible" (1). The instrument is scored by summing the items to make a total score (possible range of scores is 16 to 112). Higher score is indicative of better quality of life.

Estimates from the first study of 240 American patients with chronic illness (diabetes, osteoarthritis, rheumatoid arthritis, and post-ostomy surgery) indicated that the 15-item QOLS satisfaction scale has adequate internally consistency (α=0.82 to 0.92), and has high test-retest reliability over 3-weeks in stable chronic illness groups (r=0.78 to r=0.84) (Burckhardt, Woods, Schultz, & Ziebarth, 1989). Other researchers too, have reported similar reliability estimates for the 16-item scale (Wahl, Burckhardt, Wiklund, & Hanestad, 1998).

2) PANAS-SF (WATSON, CLARK, & TELLEGEN, 1988):

Trait pleasant and unpleasant affectivity was measured using the Positive Emotion and

Negative Emotion subscales respectively of the Positive and Negative Affect Schedule (PANAS-SF) (Watson & Clark, 1999; Watson, Clark, &Tellegen, 1988). PANAS-SF is a shorter and more concise version of the original PANAS test. I-PANAS-SF is the international version of the short-form PANAS-test, which allows all 10 concepts in each scale to be understood and interpreted in the same way by different nationalities, making it reliable and valid. In this test, all ambiguities and room for interpretation have been removed, and replaced by words that have an unambiguous meaning. This has resulted in a reliable and efficient test that can be used at an international level. The short form was modified by Thompson (2007) to enhance content validity, and to establish an English-language short form that could be employed in international contexts. This version demonstrated a reasonable two-factor (PA, NA) structure, temporal stability, internal reliability, and invariant item loadings (Thompson, 2007).

3) SPIRITUAL WELL-BEING SCALE (PALOUTZIAN & ELLISON, 2009):

This scale is a general indicator of perceived well-being which may be used for the assessment of both, individual and congregational spiritual well-being. It provides an overall measure of the perception of spiritual quality of life as well as subscale scores for Religious and Existential Well-Being (EWB). The Religious Well-Being (RWB) subscale provides a self-assessment of one's relationship with God, while the Existential Well-Being Subscale gives a self-assessment of one's sense of life purpose and life satisfaction.

The spiritual well-being scale comprises twenty items, ten of which assess religious well-being specifically, and ten of which assess existential well-being.

The Spiritual Well-Being score is a measure of perceived overall well-being. Each spiritual well-being scale item is scored from 1 to 6, with a higher number representing greater well-being. Negatively worded items are reverse scored. Summing up the scores for the positively worded items (11 items) and negatively worded items (9 items) will give the total score for spiritual well-being (SWB). A score in the range of 20–40 reflects a sense of low overall spiritual well-being, 41–99 reflects a sense of moderate spiritual well-being, A score in the range of 100 –120 reflects a sense of high spiritual well-being.

The religious well-being, existential well-being, and spiritual well-being scales/subscales have adequate reliability. For the religious well-being subscale, test-retest reliability coefficients across four studies, viz., Ellison (1983); Upshaw (1984); Brinkman (1989); and Kirschling & Pittman (1989), with 1-10 weeks between testings, are 0.96, 0.99, 0.96, and 0.88 respectively. For the existential well-being subscale, the coefficients are 0.86, 0.98, 0.98, and 0.73 respectively. For total spiritual well-being, the coefficients are 0.93, 0.99, 0.99, and 0.82 respectively.

4) ADULT HOPE SCALE (SNYDER, IRVING, & ANDERSON, 1991):

Hope was measured using the Adult Hope Scale (AHS, Snyder et al., 1991). It comprises 12 items; four agency items, four pathways items, and four filler items. Participants are asked to rate how much each statement describes them. Examples of agency items include ‘‘I energetically pursue my goals” and ‘‘I meet the goals that I set for myself”. Examples of pathways items include ‘‘I can think of many ways to get out of a jam” and ‘‘I can think of many ways to get the things in life that are important to me”. Participants use an eight-point likert scale with one representing ‘‘definitely false” and eight ‘‘definitely true”. Internal consistency (alpha reliability) has been reported as ranging from 0.74 to 0.78, and a test–retest correlation over a 10-week period of 0.82 (Snyder et al., 1991). Total hope scale scores range from a minimum of 8 to a maximum of 64, while agency and pathway scores range from a minimum of 4 and a maximum of 32 with high scores reflecting high levels of hope.

5) RESILIENCE SCALE (WAGNILD & YOUNG, 1993):

It describes the psychological ability that allows a person to cope effectively with life stresses. It is a 25-items scale. Items are scored on a seven-point scale ranging from 1 (strongly disagree) to 7

(strongly agree). Scores range from 25 to 175, with higher scores indicating greater resilience. Wagnild & Young (1993) have given the following scoring for the total score 25-100 = Very low, 101-115 = Low, 116-130 = On the low end, 131-145 = Moderate, 146-160 = Moderately high, and 161-175 = High. This scale has two major factors, viz., acceptance of self and life, and individual competence (Wagnild & Young, 1993). This scale is appropriate for younger individuals as well as middle-aged and older adults.

Cronbach's alpha coefficients have been found to range from 0.72 to 0.94 (Neill & Dias, 2001). Test-retest reliability has been reported to range between 0.67 to 0.84 by Killien & Jarretiss (1993). This scale has shown considerable construct validity with constructs such as morale and life satisfaction (positively related), and depression and perceived stress (negatively related) as reported by Ahern, Kiehl, Sole, & Byers (2006).

6) SOCIO-ECONOMIC STATUS SCALE (SES SCALE; AGGARWAL, BHASIN, SHARMA, CHHABRA, AGGARWAL, & RAJOURA, 2005)

It assesses the social status of the individual. The scale has 22 statements including financial, educational, family possessions, etc. of the family of the individual. This scale has been developed for all sections of the Indian society. The present instrument is proposed to measure the socio-economic status of the family. This scale consists of 22 items. The score range for this scale is 9-100. Score of 76 or above indicates upper high social status, score of 61-75 indicates high class, 46-60 score indicates upper middle class, score of 31-45 indicates lower middle class, score of 16-30 indicates poor class, and score of 15 or less indicates very poor class.

The internal consistency of items in the different scales was assessed by calculating Cronbach's alpha. All the 22 items of scale were divided among these four components called *prominence, paying capacity, assets* (parental support and land for cultivation) and *affordability* based on their factor loadings. Items under the first component (*prominence in society*) with strong factor loading were locality, education of husband/wife, occupation of husband/wife, family possessions, caste and monthly per capita income. The Intra Class correlation (ICC) coefficients of the scale were estimated to be 0.786 (0.716, 0.838), 0.915 (0.888, 0.936), 0.92 (0.894, 0.94) and 0.952 (0.937, 0.964), respectively (Dudeja, Bahuguna, Singh, & Bhatnagar, 2015).

7) PGI SOCIAL SUPPORT QUESTIONNAIRE (NEHRA & KULHARA, 1995):

This scale was developed by Nehra & Kulhara in 1987, and adapted by the same authors in Hindi in 1995 based on "Social Support Scale" by Pollock & Harris (1983) which consisted of 23 items. Based on the content analysis of these 23 items, 18 were adapted with modification of 7 items. Its concurrent validity has been found to be satisfactory. The scale measures "perceived social support". Out of total 18 items, 7 are positive worded, and 11 are negatively worded. Each item is followed by a question "agree to what extent," and scored on seven-point scale from "fully agree" to "not at all". SSQ has a test–retest reliability of 0.59, and correlation with clinician's assessment at 0.80, and with items of social support from Family Interactions Pattern Scale Chubon, (1987) at 0.65 of social support perceived by the individual. Higher score indicates more perceived social support.

STATISTICAL ANALYSES:

The present investigation proposed to examine the difference in personal and social resources of quality of life in institutionalized and non-institutionalized elderly. To compare institutionalized and non-institutionalized elderly on quality of life, affect, hope, spirituality, resilience, socio-economic status, and social support, t-test (for independent samples) was applied. The data was analyzed using the software SPSS (version 20).

PSYCHOLOGY AND EDUCATION (2021) 58(5), ISSN 1553 - 6939
Article Received: 22th November, 2020; Article Revised: 26th March, 2021; Article Accepted: 26th April, 2021

RESULTS

1. t-TEST

In order to examine differences in quality of life, affect, spirituality, hope, resilience, socio-economic status, and social support in institutionalized and non-institutionalized elderly men and women, t-test (for independent samples) were applied.

TABLE 1: SUMMARY TABLE SHOWING MEANS, S.D's AND t-TEST^{+} FOR INSTITUTIONALIZED (N=160) AND NON-INSTITUTIONALIZED ELDERLY (N=160) ON ALL VARIABLES

VARIABLES	GROUP	N	MEAN	S.D	STD. ERROR OF Mean	t-VALUES
QOL	Home	160	85.32	18.70	1.48	**4.10****
	Institution	160	76.32	20.52	1.62	
PA	Home	160	31.63	5.70	0.45	**7.93****
	Institution	160	26.44	6.01	0.48	
NA	Home	160	30.61	6.66	0.53	**5.65****
	Institution	160	34.44	5.37	0.42	
Agency	Home	160	20.19	6.65	0.53	**5.85****
	Institution	160	16.36	4.93	0.39	
Pathways	Home	160	22.23	6.02	0.48	**13.29****
	Institution	160	14.89	3.54	0.28	
RWB	Home	160	45.45	22.05	0.69	**31.35****
	Institution	160	18.67	8.69	0.51	
EWB	Home	160	52.21	6.42	0.35	**47.78****
	Institution	160	21.66	6.74	0.53	
Resilience	Home	160	111.88	24.69	1.95	**2.54***
	Institution	160	118.31	20.35	1.61	
SES	Home	160	44.75	6.39	0.51	1.36
	Institution	160	45.71	6.19	0.49	
Social Support	Home	160	29.54	8.75	0.69	5.37**
	Institution	160	24.63	7.55	0.60	

* $p < 0.05$
** $p < 0.01$
\+ one-tailed values

A perusal of table 1 reveals that non-institutionalized elderly reported higher scores on quality of life ($t=4.10$, $p<0.01$), positive affect ($t=7.93$, $p<0.01$), agency ($t=5.85$, $p<0.01$), pathways ($t=13.29$, $p<0.01$), religious well-being ($t=31.35$, $p<0.01$), existential well-being ($t=47.78$, $p<0.01$), and social support ($t=5.37$, $p<0.01$) as compared with institutionalized elderly.

On the other hand, institutionalized elderly reported higher levels of negative affect ($t=-5.65$, $p<0.01$) and resilience ($t=2.54$, $p<0.05$) in comparison with non-institutionalized elderly. There was no significant difference between institutionalized elderly and non-institutionalized elderly on socio-economic status.

TABLE 2: SUMMARY TABLE SHOWING MEANS, S.D's AND t-TEST^{+} FOR INSTITUTIONALIZED AND NON-

INSTITUTIONALIZED ELDERLY MALES ON ALL VARIABLES (EACH N=80)

VARIABLES	GROUP	N	MEAN	S.D	STD. ERROR OF Mean	t-VALUES
QOL	Home	80	91.78	15.06	1.68	**3.03****
	Institution	80	82.96	21.20	2.37	
PA	Home	80	34.53	5.50	0.62	**5.52****
	Institution	80	30.15	4.46	0.50	
NA	Home	80	25.03	3.23	0.36	**18.78****
	Institution	80	36.39	4.36	0.49	
Agency	Home	80	22.80	5.78	0.65	**6.32****
	Institution	80	16.89	6.06	0.68	
Pathways	Home	80	24.63	5.40	0.60	**13.29****
	Institution	80	15.54	2.87	0.32	
RWB	Home	80	44.14	8.64	0.97	**27.90****
	Institution	80	15.60	3.00	0.33	
EWB	Home	80	49.09	3.30	0.37	**30.95****
	Institution	80	23.86	6.50	0.73	
Resilience	Home	80	117.76	22.77	2.55	1.59
	Institution	80	123.19	20.31	2.27	
SES	Home	80	43.86	6.44	0.72	0.80
	Institution	80	44.66	6.28	0.70	
Social Support	Home	80	30.95	7.67	0.86	**4.16****
	Institution	80	25.91	7.66	0.86	

* $p < 0.05$
** $p < 0.01$
\+ one-tailed values

A perusal of table 2 reveals that non-institutionalized elderly males reported higher scores on quality of life (t=3.03, p<0.01), positive affect (t=5.52, p<0.01), agency (t=6.32, p<0.05), pathways (t=13.29, p<0.01), religious well-being (t=27.90, p<0.01), existential well-being (t=30.95, p<0.01), and social support (t=4.16, p<0.01) as compared with institutionalized elderly males.

On the other hand, institutionalized elderly men reported higher levels of negative affect (t=18.78, p<0.01) than non-institutionalized men. There were no significant differences between non-institutionalized and institutionalized elderly males on resilience and socio-economic status.

TABLE 3: SUMMARY TABLE SHOWING MEANS, S.D.'s AND t-TEST^{+} FOR INSTITUTIONALIZED AND NON-INSTITUTIONALIZED ELDERLY FEMALES ON ALL VARIABLES (EACH N=80)

VARIABLES	GROUP	N	MEAN	S.D.	STD. ERROR OF Mean	t-VALUES
QOL	Home	80	78.86	19.81	2.21	**3.10****
	Institution	80	69.68	17.57	1.96	
PA	Home	8	28.7	4.2	0.48	**8.17****

		0	4	7		
	Institution	80	22.73	4.99	0.56	
NA	Home	80	36.20	3.97	0.44	**4.84****
	Institution	80	32.49	5.59	0.63	
Agency	Home	80	17.58	6.46	0.72	**2.20***
	Institution	80	15.84	3.40	0.38	
Pathways	Home	80	19.84	5.67	0.63	**7.19****
	Institution	80	14.25	4.02	0.45	
RWB	Home	80	46.76	8.58	0.96	**19.73****
	Institution	80	21.75	7.41	0.83	
EWB	Home	80	55.33	3.10	0.35	**45.83****
	Institution	80	19.46	6.27	0.70	
Resilience	Home	80	106.00	25.26	2.82	**2.09***
	Institution	80	113.43	19.30	2.16	
SES	Home	80	45.64	6.25	0.70	1.13
	Institution	80	46.75	5.95	0.67	
Social Support	Home	80	28.14	9.56	1.07	**3.57****
	Institution	80	23.35	7.27	0.81	

* p < 0.05
** p < 0.01
\+ one-tailed values

A perusal of table 3 reveals that non-institutionalized elderly females reported higher scores on quality of life (t=3.10; p<0.01), positive affect (t=8.17, p<0.01), negative affect (t=4.84, p<0.01), agency (t=2.20, p<0.05), pathways (t=7.19, p<0.05), religious well-being (t=19.73, p<0.01), existential well-being (t=45.83, p<0.01) and social support (t=3.57, p<0.01) as compared with institutionalized elderly females.

On the other hand, institutionalized elderly females reported higher levels of resilience (t=2.09, p<0.05), than non-institutionalized elderly females. There was no significant difference between non-institutionalized and institutionalized elderly females on socio-economic status.

DISCUSSION

Globally, QoL of the institutionalized/non-institutionalized elderly has generated a lot of discussion as there is now a high concern in maintaining the overall health of these people so that they can age with dignity. Thus, defining QoL in the elderly is a very complex task, since it involves dimensions such as physical, emotional, and family well-being, functional capacity, spirituality, social respect, sexuality and occupation. These factors, when integrated, keep one in balance with oneself and with the environment.

t-test revealed that non-institutionalized elderly (males, females as well as the total sample) reported higher scores on quality of life as compared with institutionalized elderly which can be attributed to the fact that non-institutionalized elderly are in a warm, loving environment than institutionalized elderly. Also, they experience more positive emotions which eventually helps in spiritual enlightenment, hopefulness thus, improving one's quality of life which is in line with a comparative study by Bakhshi & Sandhu (2002) who examined the differences in the problems faced by institutionalized and non-institutionalized aged people in the aspects of physical, social, financial, emotional, and religious areas. The results revealed that institutionalized elderly had more problems than non-institutionalized aged in all the five dimensions. Institutionalized elderly, whether males or females, have higher feelings of

loneliness and depression than non-institutionalized elderly.

It is very difficult for them to adjust in old age homes because they have lived their entire life in their own home where they used to be the autonomous. Due to various circumstances, they have to shift in old age homes which is very painful for them. They were used to getting importance of the family and they had adequate decision making powers, but now, they have lost their position and autonomy due to which they have lost their self-esteem, thus affecting their quality of life.

Results revealed that non-institutionalized elderly (males, females as well as the total sample) reported higher scores on positive affect as compared with institutionalized elderly which is in line with the first hypotheses of the present investigation stating that non-institutionalized elderly would score higher than institutionalized elderly on positive affect, It possibly explains that being in homes, family bonds are there. The next generation is busy earning their livelihood, and the grandparents have to cater their grandchildren and because of that, grandchildren respond well to their grandparents. Thus, they feel important and satisfied which makes them feel happier and enhances their ability to handle various stressors which is confirmed in a study by Adelmann (1994) who observed that there is a strong positive association between multiple roles and psychological wellbeing among aged people. Multiple roles (like spouse, parent, homemaker, grand parent, caregiver, employee, volunteer, etc.) are associated with higher life satisfaction and lower depressive symptoms.

On the other hand, institutionalized elderly (males as well as the total sample) reported higher levels of negative affect than non-institutionalized elderly which is in line with the second hypotheses of the present investigation stating that institutionalized elderly would score more than the non-institutionalized elderly on negative affect. The possible reason could be that the non-institutionalized elderly were staying with their families and thus, had a lot to occupy their time, such as grandchildren, neighbours, friends and relatives. The institutionalized elderly, on the other hand were sort of isolated from the community in an institutional set-up where they did not have much autonomy and independence. They did not have control over their immediate environment, which could have led to a lower life satisfaction which leads to more negative affect. These findings are in conformity with the results of previous researches such as those by (Antonelli, Rubini, & Fassone (2000) who found that the institutionalized elderly have more negative affect, lower levels of self-esteem, and have a more restricted interpersonal self when compared to the non-institutionalized elderly.

Surprisingly, non-*institutionalized elderly females were found to report higher levels of negative affect than institutionalized elderly females* which is in contradiction to our second hypotheses. A study by Newall, Chipperfield, Clifton, Perry, Swift, & Ruthig, (2009) found that women tend to outlive their male partners, and often find themselves alone and lonely in later life. Another study by Malatesta (2007) also confirmed our results that who found that older women are found to be more likely to be diagnosed with anxiety, depression, and post-traumatic stress disorder than men. Thus, non-institutionalized elderly women were found to report higher levels of negative affect than institutionalized women.

Non-institutionalized elderly (males, females as well as the total sample) reported higher scores on agency and pathways beliefs as compared with institutionalized elderly which is in consonance with the first hypotheses of our study stating that non-institutionalized elderly would score higher than institutionalized elderly on hope. A previous study by Joseph & George (2011) also confirmed our results. They found that aged persons living in old age homes lag behind in hopefulness and mental health. This could be because of the fact that non-institutionalized elderly, being high on positive affect, were more hopeful (because positive emotional states help us in becoming making more hopeful).

Non-institutionalized elderly (males, females as well as the total sample) reported higher scores on religious well-being and existential well-being as compared with institutionalized elderly which is in contradiction to our third hypotheses of the

present study stating that there would be no difference between institutionalized and non-institutionalized elderly on spiritual well-being. The present results are supported by a study by Roh, Lee, & Yoon (2013) who found that that non-institutionalized participants scored significantly higher than did the institutionalized participants on self-esteem and spiritual well-being. This possibly explains that being in homes, they are in their comfort zones. They can participate in religious and spiritual practices as per their convenience, but this is not possible for the elderly staying in old age homes because they have a very strict routine to follow, and they have to abide by the rules and regulations of the institutions. Moreover, being in old age homes may make them (females and the total sample) feel less hopeful, and more filled with agony and despair, which may lead to diminished levels of meaning in life. As such, they reported lower levels of existential than the ones living in their families,

Due to urbanization and industrialization in India, the traditional family system is weakening. Elderly persons are perceived by youth as obsolete and worthless because of their passive role in the society. As such, the elderly gradually lose things that previously occupied their time, and gave them life purpose. For example, their job may change, they may eventually retire from their career, their children may leave home, or other friends and family may move far away. Fan (2010) found that negative beliefs regarding aging such as boredom and feelings of uselessness directly challenged an individual's desires to search for a sense of meaning, purpose, and security later in life, and thus, appeared to contribute to the feelings of vulnerability. This possibly explains as to why institutionalized elderly had poorer existential well-being than non-institutionalized elderly.

Further, the present findings revealed that *institutionalized elderly (females and the total sample) were more resilient than non-institutionalized elderly* which is contrary to our first hypotheses of the study stating that non-institutionalized elderly would score higher than institutionalized elderly on resilience. This is because being in institutions, they don't have to shoulder many responsibilities. They are with like-minded people who provide them better support which, in turn, makes them better able to handle life stresses, which makes them more resilient. Other probable reason could be that resilience factor comes in place where there is persistence of harsh life experiences (Azam & Naaz, 2015). The roots of research on resilience can be found in Warner's (1993) research on children born into poverty who faced difficult life circumstances. In these conditions, they not only faced problems but also flourished. As such, it is possible that institutionalized elderly, who faced many hardships in life, responded to these circumstances by becoming more resilient.

However, there was no difference in the levels of resilience reported by institutionalized versus non-institutionalized elderly men (who reported adequately higher levels of resilience than women). It is possible that these elderly men faced a lot of issues in aging due to which they had to face institutionalization at this age. They were no longer in such authority situations as males generally are in a patriarchal society as ours. Hence, they may have responded to their life stressors by becoming more resilient. This is in line with a research by Trama & Mehta (2020a) who found that stress emerged as a positive predictor of QoL in institutionalized elderly women. High levels of stress could have made them become more resilient in order to cope with their circumstances.

Further, there was no difference in the socio-economic status reported by institutionalized versus non-institutionalized elderly which could be attributed to fact that sample chosen for the research had same kind of socio-economic staus.

Non-institutionalized elderly (males, females as well as the total sample) reported higher scores on social support as compared with institutionalized elderly which supported our first hypotheses stating that non-institutionalized elderly would score higher than institutionalized elderly on social support. This could be attributed to fact that family is a big support system. Moreover, non-institutionalized elderly are able to meet their friends on a regular basis in comparison to institutionalized elderly. Also, they tend to be more in touch with their social associations which

is also supported in a study by Luppa, Luck, Weyerer, König, Brähler, & Riedel-Heller (2010) who found that lack of social support can be the major reason for elderly shifting into old age homes .

Hence, the findings revealed that institutionalized and non-institutionalized elderly differed on quality of life, affect, spirituality, hope, resilience, and social support with non-instutionalized elderly reporting higher scores on a QoL and almost all its resources (viz., positive affect, agency, pathways, religious and existential well-being, and social support) with the exception of negative affect and resilience which were found to be more, by and large, in institutionalized rather than non-instutionalized elderly.

CONCLUSION

To sum up, it may be said that there is meagre research evidence regarding differences in the institutionalized and non-institutionalized elderly on personal/social resources of QoL especially in India. Moreover, the effects of institutionalization may also be evident in institutionalized elderly as compared to those residing with their families in a socio-cultural context such as ours in which old age homes lack the ambience and provisions in comparison to the ones found in the western countries. Being in an old age home is often stigmatized in our society. Hence, it is possible that institutionalized elderly faced extremely adverse circumstances due to which they had to shift to old age homes, indicating their plight and despair, which adversely affected their QoL and its resources.

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