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Resilience, Death Anxiety, and Depression Among Institutionalized and Noninstitutionalized Elderly

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The present study was designed to find out level of resilience**,** death anxiety, and depression among institutionalized and noninstitutionalized elderly. Purposive sampling was used and a total of 80 elderly aged 60 years and over participated in this study. There were 40 noninstitutionalized (20 men and 20 women) and 40 institutionalized elderly people (20 men and 20 women) in the sample. Urdu translated version of State-trait Resilience Checklist (Sawar, 2005), Death Anxiety Scale (Templer, 1970), and Siddique Shah Depression Scale (Siddiqui & Shah, 1997) were administered on participants. The results revealed that noninstitutionalized elderly scored high on state-trait resilience, whereas, institutionalized elderly were having more death anxiety and depressive symptoms. Results showed no gender difference on state resilience, but elderly men had more trait resilience than elderly women. According to findings both elderly women and men had equal level of death anxiety. However, elderly women were found more depressed than elderly men. Through findings, it was also revealed that unmarried elderly exhibit more death anxiety as compared to married and widows. The findings of the study highlighted the need of enabling elderly with different skills so that they could easily cope with challenges and stressors of their life.

Keywords: Elderly, resilience, death anxiety, depression

The elderly population with age of 60 years and above is increasing around the world, as due to decline in their mortality rate life expectancy has been increased (Shoaib, Khan, & Khan, 2011). Today the number of elderly is estimated to be 605 million in the world (Dawane, Pandit, & Rajopadhye, 2014), and a rise to this segment of population is estimated to 2 billion by 2050 (Perna et al., 2012). This growing old age population is showing the most difficult

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challenges for both the developed and developing countries. Pakistani society, where traditionally the elders are supposed to be respected and their care is still seemed as a family responsibility, is also facing issues as time has changed (Gulzar, Zafar, Ahmad, & Ali, 2008).

Jalaal and Younis (2012) indicated that 5.6% of Pakistan's inhabitants would be above 60 years of age and there is a possibility of increase up to 11% by the year 2025. In Pakistan, elderly people are 6% of the total population which is about 10 million and this ratio is expected to increase up to 15% till 2050 (Gulzar et al., 2008). The growing proportion of elderly in Pakistan now are expected to seem as unproductive, and economically and socially dependent portion of population (Saeed, Shoaib, & Ilyas, 2011). Since there is increase in life expectancy throughout the world and in Pakistan, there has been a rise observed in the population of the elderly. However, Pakistan seems to be facing a number of challenges due to having inadequate resources, while protecting their elderly population (Sabzwari & Azhar, 2010).

Krueger, Rogers, Hummer, LeClere, and BondHuie (2003) found that family income, occupational position, and unemployment consistently predict lower death rate and better health at the middle and early old ages. Most of the elderly population does not have such kind of familial and financial support and they have to live alone without their family (Brink, 1998). It means old age homes are a demand for senior citizens. Nursing homes present a place for poor and helpless elderly of 60 years and above to accommodate them. The senior citizens who are helpless and belong to middle or lower middle income groups are also included. The residents of old age homes are provided a familial environment (Behura & Mohanty, 2005). Today, institutions and old homes have become indispensable for helpless elderly people to provide them shelter. This idea of institutionalization has been borrowed from western culture and is getting popular in Asian cultures (Devi & Roopa, 2013).

In old age, institutionalized and noninstitutionalized elderly tend to experience losses of family, friends, work roles, relationships, health, income, so on. With growing age each loss gets with it a decline in the range of choices open to them (Brearley, 1990). Although, both groups experience such losses, but institutionalized are more vulnerable to take stress due to these problems (Mathew, George, & Paniyadi, 2009). However, older adults can be trained to cope well with aging by increasing their social network and engaging them in activities and enabling them to develop potential for recovery from disturbance (Zaninotto, Falaschetti, & Sacker, 2009). *Resilience* is a factor in an individual's personality that enhances the potential for

recovery and provides healthy psychological functioning by developing the ability to respond well to changes in surroundings and to cope with life stressors (Perna et al., 2012). Resilience is a phenomenon that brings the capability to get ahead inspite of distress. This term is derived from Latin origin which means to jump or bounce back (Seccombe, 2002). Resilience is a composition of both state and trait of a person that comes from one's innate characteristics and situational factors of his/her life. Sometimes people shape their resilience through adverse circumstances and we take it as a state resilience that is related to different situational factors. But, in other situations an individual exhibit his resiliency as a genetic trait, which is more consistent in different crisis situations of one's life (Cummins & Wooden, 2014). In different researches, the concept of state-trait resilience has been used to assess resilience on both levels of state and trait (Hiew, Mori, Shimizu, & Tominga, 2000).

Moreover, there are three hallmarks of resilience including recovery from stress and bouncing back to a state of well-being. Then a person must have sustained a purpose to avoid boredom and have a continuous growth such as emerging stronger from stressful experience (Edwards, Hall, & Zautra, 2013). The study of life-span suggested that resilience and successful aging share important processes. In particular, the transition crises of each life stage, from middle age to old age, involved resilience as a process of adaptation (Ambriz, Izal, & Montorio, 2012). Moreover, with growing age, elderly face decline in functioning, fatigue, sleep problems, depression, anxiety; memory and other cognitive deficits; physical and mental illnesses. However, resilience can be distinguished as a capacity to help older adults to cope with adversity and get greater happiness (Chambers, 2012).

Due to lack of resilience, a person may feel more about problems, feel victimized, and become overwhelmed. The combination of institutionalization, lack of resilience, and old age has very adverse effects on individuals. It has various psychological pitfalls for elderly people. Psycho-physical imbalance is the major problem of aging that leads to different problems (Scocco, Rapattoni, & Fantoni, 2006). Progressive generalized impairment in functioning in old age decreases adaptive response towards stress (Miller & Segerstrom, 2004). These comorbid medical and psychological problems further lead to role impairment among elderly that is a risk factor for their healthy functioning (Abd-el-Rahman & Hassan, 2013).

In old age, particularly the death of closed ones would make a huge change in elderly's lives. Their social network becomes narrowed because of the changes. This change leads to increase in

feeling of loneliness and also related to the death anxiety. The death of closed ones would also remind them that soon they have to face death too (Chambers, 2012). *Death anxiety* is a term used for the apprehension produced by death awareness. It is considered now as a worldwide psychological problem for humans (Lehto & Stein, 2009). Death anxiety is a negative psychological reaction to the perspective of mortality (Templer et al., 2006). It is more of a universal fear and fear of death can be developed by anyone without having an anxiety disorder. Most of the people experience fear of death at some point in their lives. A morbid and persistent fear of death or dying is called death anxiety (Azaiza, Ron, Shoham, & Gigini, 2010). Tomer (2000) explained the death anxiety model having three determinants including regrets related to past, future related disappointment, and meaningfulness of death. The regrets related to early age is a person's perception of not having basic ambitions. The second determinant is a person's inability to fulfill the basic goals in future. The third determinant is meaningfulness and a person believes about death that might be positive or negative. According to this model, individual would experience high death anxiety after thinking about past and future related regrets.

People in old age tend to engage in life review and try to figure out purpose of their lives so that they can get the stage of integrity. Lau and Cheng (2011) found that feeling of a well-lived life is a predictor of life satisfaction and is related to lower death anxiety. Some scholars have proposed that death anxiety is a perceived inability to accomplish major life ambitions and a sense of regret (see e.g., Lehto & Stein, 2009). As people grow older, they experience change and loss in relationships, independence, and participation. When this occurs in combination with sense of regret and less physical activity, then it may lead to depressive symptoms in old age (Singh & Misra, 2009). Depressive symptoms can be associated with increased death anxiety in older adults (Arean et al., 2005). Feelings of being institutionalized and death anxiety create sense of loneliness that is a great risk factor for old age depression (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006). The major features of *depression* are low mood and displeasure in activities that can have a negative impact on a person's thoughts, behaviors, and feelings. Depression is the most prevalent type of mood disorder of later life (Beekman, Copeland, & Prince, 1999). In Pakistan, depression is one of the most common problems that elderly people face (Javed & Mustafa, 2013) and the major cause of depression among elderly is lack of family support (Taqui, Itrat, Qidwai, & Qadri, 2007). Depression in elderly receiving primary care is often not valued by physicians despite of

increase in prevalence of depressive symptoms with age (Silveira et al., 2005).

Depression is a serious issue worldwide and prevalence is more in the elderly population (Rezende, Coelho, Oliveira, & Penha-Silva, 2009). Depression in the elderly is a frequent disorder and it is treatable as in younger age groups. Although, in young age it is not recognized properly due to which remains undertreated (Stoppe, Sandholzer, Huppertz, Duwe, & Staedt, 1999). In later life, depression is related with a prominent reduction in cognitive abilities which leads to a decrease in social and physical activities (Teixeira, Raposo, Fernandes, & Brustad, 2013). Elderly often experience life-threatening illnesses that lead to a reduction in their functional capacity (Ong & Bergman, 2004).

According to available literature, it was found that those who were identified as more resilient to overcome depression reported better quality and satisfaction with life and higher anticipation of survival (Demakakos, Nazroo, Breeze, & Marmot, 2008). Ambriz et al. (2012) conducted a study on resilience and proposed a model which explained the relation between stress and psychosocial resources that may enhance positive adjustment on entire life cycle. It revealed that the positive adaptation process is improved by a group of psychosocial resources that intervenes the effects of stress.

Among psychosocial resources, social support is an important factor that can reduce the effects of stress. Close relationships can increase self-esteem and may be a buffer against death anxiety, whereas, disruption of such relationships may lead to death awareness and concerns (Mikulincer, Florian, Birnbaum, & Malishkevich, 2002). Literature revealed that childlessness and being single may lead to difficulties. If a person does not marry and failure to have children could result in isolation in old age (Keith, 1983). So, marital status is an important factor to discuss with institutionalization because social support and self-esteem were higher among elderly living in the community than institutionalized people (Azaiza, Rimmerman, Araten-Bergman, & Naon, 2006).

All above mentioned details indicated that low level of resilience could lead to poor mental health, which can precipitate death anxiety and depressive symptoms among elderly population. Institutionalized and noninstitutionalized elderly need an environment where they could flourish and live life to the fullest as long as possible. The challenge for communities and councils is to help elderly people to stay healthy and active and to encourage their contribution in the community. Those whose physical strength and health have begun to

deteriorate also deserve to enjoy life fully and there is need to find new ways to support them. The changes elderly people used to face in old age is a global phenomenon that demands to take actions on international, national, regional, and local level. This area of research has been neglected in Pakistan and scarcity of literature is the main reason to conduct this study. Furthermore, there are very few old-homes in Pakistan that has become the main reason of indigenous research deficiency in this area.

In our society, the emerging social and cultural transformations are leading to a decline in traditional family values as we are segregating from joint family system, which is directly affecting elderly population particularly in the form of institutionalization. This changing value system makes elderly people mentally isolated from their families that make them vulnerable for psychological disturbances such as death anxiety and depression (Ghosh, 2006). Their resilience works as a component of successful psychosocial adjustment and is associated with mental health and decrease the level of death anxiety and depression (Davydov, Stewart, Ritchie, & Chandieu, 2010). These factors have been overlooked in our society, so there is strong need to highlight this area empirically. The purpose of this research was to highlight these factors in comparison between institutionalized and noninstitutionalized old age population.

Hypotheses

The present study was undertaken to consider following hypotheses:

1. Noninstitutionalized elderly have more state-trait resilience as compared to institutionalized elderly.
2. Institutionalized elderly have more death anxiety and depression as compared noninstitutionalized elderly.
3. Elderly men have more state-trait resilience as compared to elderly women.
4. Elderly women have more death anxiety and depression as compared to elderly men.
5. Unmarried elderly have more death anxiety as compared to married or widowed institutionalized and noninstitutionalized elderly.

Method

The study was comparative in nature and target was to find the level of resilience, death anxiety, and depression among institutionalized and noninstitutionalized elderly.

Sample

A total of 80 elderly aged 60 years and over (M = 67.55) participated in this study by using purposive sampling technique. There were 40 noninstitutionalized (20 men and 20 women) and 40 institutionalized elderly (20 men and 20 women) in the sample. Data were collected from Lahore. Only physically and psychologically healthy individuals were included in the sample, so that direct effects of institutionalization can be seen in the sample. Elderly with less than 60 years and those who were unable to respond properly due to any kind of difficulty (serious illness, language barrier, unwillingness, etc.) were excluded from the sample. Elderly people under psychiatric and medical treatment for any serious problem were also excluded from the sample. There were almost 10-12 people in this category.

Instruments

State-trait Resilience Checklist. In order to measure state and trait resilience in adults throughout the life-span, State-trait Resilience Checklist with possible score range of 33-165 with a cutoff score of 130 was selected. Score above 130 showed high resilience, below 130 was mild, and 130 was considered as moderate (Hiew et al., 2000). Urdu translated version (Sawar, 2005) was used in current study. The scale comprised 33 items, which included 15 items of State Resilience and 18 items of Trait Resilience without any negative item. The reliability of Urdu version was reported as .88 by author. The participants were supposed to indicate their responses on a five-point Likert type scale, 1 for *never* and 5 for *always.*

Death Anxiety Scale (DAS). It was developed by Templer (1970) and translated in Urdu by using standardized translation procedure to measure death anxiety among elderly. The purpose behind translating the scale in Urdu was to make questionnaire comprehensible for elderly population because in our culture most of the elderly would not have command on English language. After taking permission from author of the scale, forward and backward translations were completed and reviewed in committee comprising of two bilingual experts (Lecturers) and two professional psychologists for each translation that is forward and backward. At the end of this process the pre-test was carried out on 22 bilinguals in order to have item by item correlation of original scale in English and translated Urdu scale. Urdu and English version was administered with intervals of 10 days. Overall, item-to-item correlation coefficients obtained of Urdu and English versions of Death Anxiety Scale which was .81

($p < .01$). The obtained minimum value of item-to-item correlation was .46 and maximum value was .79 ($p < .01$), which ensured the accuracy of translation (Gausia et al., 2007).

The scale covered the act of dying and certainty of death and consisted of 15 items with a reliability of .83 ($p < .01$). There were only two scoring options of this scale that is *true* and *false* and the scoring procedure was to score 1 for a *true* response on items 1, 4, 8, 9, 10, 11, 12, 13, 14 and to score 0 for *false* response on items 2, 3, 5, 6, 7, 15. Score could be as high as 15 and as low as 0.

Siddiqui Shah Depression Scale (SSDS). It was developed by Siddiqui and Shah (1997) to identify the intensity of depressive symptoms among elderly. The participants had to rate themselves on a 4-point scale ranging from 0 for *not at all* to 4 for *every time* on each statement. It consisted of 36 items without any negative item. The scores ranging from 26 to 36 were considered as mild depression. The obtained scores that lied between 37 and 49 were considered as moderate depression, while 50 and above was indicating severity of depressive symptoms. Split-half reliabilities of the scale with spearman-brown correction were .84 ($p < .01$) as reported by authors.

Procedure

The data collection started after getting permission from Lahore's old-age home authorities and from the institutionalized and noninstitutionalized participants. They were briefed about the nature of research being carried out. They were assured that collected information would be kept confidential and would be used for research purpose only. Most of the questionnaires were administered by researcher through reading aloud and few ones were completed by participants. Because most of the participants were either illiterate or uncomfortable in reading due to which they were not able to self-report on the questionnaires. After administration, brief counseling was provided to participants to help out in their problems and suggestions were also given to institutionalized administration about need of clinical consultancy. At the end of session, participants were thanked and debriefed.

Results

Independent sample *t*-test and One Way Analysis of Variance is used to test hypotheses.

The reliability of State-trait Resilience Checklist was .87, Death Anxiety Scale's obtained reliability was .79, whereas Siddiqui Shah Depression Scale had a reliability of .92. Pearson Product Moment Correlation of both English and Urdu version of Death Anxiety Scale was strongly correlated as coefficient value was .81 (p<.01). It also indicates that translated version items were having same meaning as original English version (Cha, Kim, & Erlen, 2007; Gausia et al., 2007). The obtained minimum value of item to item correlation was .46 and maximum value was .79.

Resilience, Death Anxiety, and Depression Among Institutionalized and Noninstitutionalized Elderly

In result section, mainly differences were found out among institutionalized and noninstitutionalized elderly population. First, the independent sample *t*-test was carried out to see the differences of state-trait resilience, death anxiety, and depression among institutionalized and noninstitutionalized elderly population. Then differences on the study variables were explored on the basis of gender and marital status.

Table 1

Mean, SD and t-value of Institutionalized and Noninstitutionalized Elderly on State-trait Resilience, Death Anxiety, and Depression (N = 80)

	Institutionalized (n = 40)		Noninstitu-tionalized (n = 40)				95% CI		
Variables	*M*	*SD*	*M*	*SD*	*t*	*p*	*LL*	*UL*	*Cohen's d*
State Resilience	50.43	7.72	57.03	8.63	3.60	.00	-10.24	-2.95	0.80
Trait Resilience	70.72	8.8	74.95	8.9	2.1	.00	8.19	.255	0.47
Death Anxiety	8.42	3.2	6.07	3.8	2.97	.00	.775	3.92	0.66
Depression	34.90	13.01	25.57	17.85	2.67	.01	2.36	16.28	0.59

Note. CI = Confidence Interval, *LL* = Lower Limit, *UL* = Upper Limit.

Table 1 demonstrates that there is a significant difference between two independent groups institutionalized and noninstitutionalized elderly on all study variables. By comparing means of institutionalized and noninstitutionalized groups, it is evident that noninstitutionalized elderly have more state and trait resilience than institutionalized elderly and results of *t*-test are

significant ($p < .001$). Institutionalized elderly are having more death anxiety as compared to noninstitutionalized elderly ($p < .01$). The mean for depression is more in institutionalized elderly people as compared to noninstitutionalized elderly indicating more depression in institutionalized elderly than noninstitutionalized elderly.

Gender Differences on Resilience, Death Anxiety, and Depression Among Elderly

To examine the differences between men and women on study variable, independent sample *t*-test was computed.

Table 2

Mean, SD and t-value of Elderly Men and Women on State-trait Resilience, Death Anxiety, and Depression (N = 80)

	Men (n = 40)		Women (n = 40)				95% CI		*Cohen's*
Variables	*M*	*SD*	*M*	*SD*	*t(78)*	*p*	*LL*	*UL*	*d*
State Resilience	53.50	10.21	53.95	7.21	2.28	.82	-4.38	3.48	0.05
Trait Resilience	75.55	8.64	70.13	8.85	2.77	.00	1.53	9.32	0.61
Death Anxiety	6.57	2.98	7.92	4.23	1.64	.10	-2.98	.28	0.36
Depression	25.95	16.35	34.52	15.08	2.43	.01	-2.98	.28	0.74

Note. CI = Confidence Interval, *LL* = Lower Limit, *UL* = Upper Limit.

Results in Table 2 show nonsignificant difference on state resilience among elderly men and women. However, there are significant differences between two groups ($p < .05$) for trait resilience showing elderly men have more trait resilience as compared to elderly women. Furthermore, the findings show that there is not much difference between death anxiety of elderly men and women. Moreover, *t*-value is significant for depression and mean values show more depression in elderly women than men.

Difference of Death Anxiety on the Basis of Marital Status

Furthermore, to examine the difference between different marital statuses such as married (M), unmarried (UM), and widowed (W) with their level of death anxiety, One Way Analysis of Variance was computed.

Table 3

One-way Analysis of Variance showing Mean, Standard deviation, and F-values of Marital Status of Elderly on Death Anxiety (N = 80)

	M (n = 29)	UM (n = 20)	W (n = 31)			Mean	95% CI	
Variable	*M*(*SD*)	*M*(*SD*)	*M*(*SD*)	*F*	i-j	D.(i-j)	*LL*	*UL*
Death Anxiety	6.66(3.49)	10.23(1.78)	6.31(3.70)	5.67**	M<UM	-3.57*	-6.57	-5.8
					M>WH	.34	-1.91	2.5
					UM<WH	3.91*	1.00	6.83

Note. M = Married, UM = Unmarried, W = Widowed; *LL* = Lower Limit, *UL* = Upper Limit.

$p < .01$.

Table 3 shows ANOVA results in which *F*-value is highly significant along marital status. There is a significant difference between the mean scores of death anxiety. The results of Post hoc analysis reveal that unmarried respondents experience significantly more death anxiety as compared to married individuals and significantly less anxiety as compared to widowed.

Discussion

The aim of present study was to investigate the level of resilience, death anxiety, and depression among elderly living in old age homes and who are living in community with their families. With an increasing life-expectancy rate of population, it has become a challenge for younger generation to deal the issues related to elderly (Singh & Mahato, 2014). Current trends of shelter homes for elderly people highlight the need to shed light on this tradition as well as the population. Nowadays, this tradition is practiced by families to unburden themselves from their elderly parents and relatives without knowing the adverse effects of this action (Kim et al., 2005). To study this area the sample of 80 with equal numbers of institutionalized and noninstitutionalized elderly were selected including both men and women. Institutionalized old age people were of both urban and rural areas. There were multi-factors involved behind the reason for living in institution such as family carelessness, being single, and dependency on other family members due to lack of financial support, and so on (Suvera, 2012).

The results of current study showed that there was a significant difference in state-trait resilience of participants of institutionalized and noninstitutionalized elderly. Through State-trait Resilience

Checklist, it was revealed that noninstitutionalized elderly had more state-trait resiliency as compared to institutionalized elderly. The reason of being resilient might be the family support system of noninstitutionalized people. The families of noninstitutionalized elderly fulfill their financial, social, and emotional needs due to which they could easily bounce back in adversities as compared to institutionalized elderly who are having no support. Similarly, Shoaib et al. (2011) mentioned in their study that family support and children's company have a positive impact on elderly. So, this feeling of belongingness with family and contentment may make noninstitutionalized elderly more resilient to deal with their current stressful events successfully. Apart from that, another study (Thanoi, 2009) explained that adversities in life and rumination have an effect on resilience. It means that the elderly living in old-age homes had less state resilience because of the influence of negative life events.

The findings revealed that institutionalized elderly were having more death anxiety due to apprehensions about not being with family, loneliness, and separation from family that led to death anxiety as compared to noninstitutionalized elderly. A study by Azaiza et al. (2010) found sense of being with supportive social and family network is important in decreasing death anxiety. The current study is supporting the results that noninstitutionalized elderly having more family and social support due to which they were having less death anxiety as compared to institutionalized elderly.

Lehto and Stein (2009) showed that living in stressful environment for longer period of time may decrease death anxiety so cultural difference might be a reason. In literature (as cited in Lehto & Stein, 2009), some antecedents of death anxiety have also been mentioned including experience of unpredictable circumstances, diagnosis of a life-threatening illness, and experience of a life-threatening event.

In the current findings, it was evident that elderly living in old-age homes were having more depressive symptoms; the reasons could be being detached from family; having no privacy; lacking special care, love, and affection. These findings are consistent with Venkatesan and Ravindranath (2011) who highlighted that circumstances surrounding elderly are critical factors while living in institutions and could easily affect their quality of life.

Gender differences have been studied widely with references to resilience and psychological problems in elderly population (Luppa, Luck, Weyerer, Konig, & Riedel-Heller, 2009; Miller & Weissert, 2000; Wells, 2010). The independent sample *t*-test was carried out to

examine the cultural manifestation of gender differences on state-trait resilience, death anxiety, and depression among elderly men and women. The results showed that elderly men and women have same level of state resilience, managing their own behavior and feeling a sense of control. A study by Wagnild and Young (2005) revealed that elderly men had more trait resilience than elderly women because women are supposed to be submissive, dependent on men or family even for their decisions, and have less sense of control, which makes them more vulnerable to adversities and less resilient. In context of gender differences, biosocial processes, cultural and environmental influences are recognized as significant factors to be considered (Maginess, 2007). Although, a few studies indicated that women in old age experience more death anxiety than elderly men (Lehto & Stein, 2009; Mimrot, 2011), but findings of current study showed that both elderly women and men had equal level of death anxiety. Death anxiety may vary by culture, as in our culture, religiosity was closely related to death anxiety and elderly turn to religion to overcome death anxiety (Safara & Bhatia, 2008).

Results indicated that elderly women had more depression than elderly men as men, might be suppressing or denying it, but women could cry and express their feelings and concerns easily. It was evident from a study that women experience more negative impacts of aging being divorced, widowhood, lack of social security, and lack of socioeconomic support, hence, women have more chance to develop depression in old age as compared to men (Gulzar et al., 2008). According to Ghufran and Ansari (2008) due to death of spouse, senior citizens develop more death anxiety, but according to our findings, in our culture unmarried elderly had more death anxiety as compared to married and widowed institutionalized and noninstitutionalized elderly. Although, death anxiety and other psychological disturbances are not conditioned with marital status but risk of institutionalization is demonstrating the importance of loss of social and instrumental support. Nonavailability of spouse in old age brings a hard time and the single person has to face all the problems of old age all alone (Nihtila, MSocSc, & Martikainen, 2008). Most of the people seek support and emotional strength through their marriage bond and it prevents them from various deprivations of life. Being single, as unmarried, cause lot of stress that can further lead to anxiety. It might be a reason of high death anxiety among unmarried people (Waite & Lehrer, 2003). Another reason could be that being single is taken as a stigma in our culture.

According to literature, most of the elderly felt the attitude of the younger generation as unsatisfactory towards them, especially, those

who were in old age homes in terms of getting respect, love, and affection from the family members, instead they were considered as burden for others (Dubey, Bhasin, Gupta, & Sharma, 2011). On the other hand, elderly living in family setup were having better social relations with family because they had regular interaction, expressions of feelings, and that family support. The overall findings of current study also indicated people who are institutionalized suffer a lot as compared to noninstitutionalized.

Implications

The findings will provide awareness about condition and issues that elderly people are facing both living in old-age homes and community along with gender differences. The current findings highlight a neglected area that is resilience building activities in old-age, so that we can make them cope with adversities and to improve their functioning. The results of the present study will help the authorities of old-age homes to arrange counseling workshops to promote resilience and to take steps to reduce depressive symptoms and stressors. Involvement in different activities will provide them sense of meaning which will lead to optimism and self-efficacy. Elderly should be encouraged and trained to participate in resilience building activities such as joining a social group, starting a stress management program, exercising or to develop a new hobby. So that they will have something to look forward to and would have less time to think about adversities of life.

Conclusion

The present study concluded that noninstitutionalized elderly are more resilient as compared to institutionalized group. Moreover, death anxiety and depression was found more prevalent among institutionalized elderly population. Findings also revealed that elderly women were more prone to death anxiety and depression as compared to elderly men. Elderly men were found to have more trait resilience as compared to women.

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