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Mental Health and Quality of Life Among Elderly in Bethlehem District

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Dedication

To my mother

To the Soule of my father …

To my sisters Manal and Abeer…

To my brothers

To my grandfather whose age 100 year

To my friends

To my teachers.

Suha Mostafa Mouhamad Albutmeh

Declaration:

I certify that this thesis submitted for the degree of Master, is the result of my own research, except where otherwise acknowledged, and that this study (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed

Suha Mostafa Mouhamad Albutmeh

Date

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Study Title: Mental Health and Quality of Life Among Elderly in Bethlehem District

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Abstract

This study focuses on the quality of life and mental health of the elderly in Bethlehem district. It aims to identify the most prevalent mental health problems among them, and how they evaluate their quality of life .

A cross-sectional study was conducted in the year of 2010 by using convenience sample on 300 elderly (aged 65 and above) who live in Bethlehem district in Palestine. A structural questionnaire on quality of life (WHOQOL-Bref) as well as the scale of BSI for current psychological status and distress were used for data collection . The findings of this study indicated that (24.7 %) of the respondents complained of severe - very severe level of somatization . (14.4 %) had sever - very severe level of obsessive compulsive symptoms. On the other hand , 9.3% of the respondents complained of severe - very severe level of anxiety symptom. In regards to depression , 12.7 % had sever - very severe level of depression. 8.9 % complained of “severe - very severe level of phobic symptoms, 14.1 % had severe level of paranoid ideation , and finally 10.3% reported of having severe level of psychticism.

Results show that 46.2 % of the Participants rated their quality of life as being good or very good .However participants had lower QOL scores in Physical health domain of WHO QOL-BREF scale (mean 50.9 , S.D 21.4) ,35.5 % of the participants perceived their

physical health as being good and very good while . In regard to the Social relationship domain 32.6 % of the participants evaluated their social life as very good or good , however 40 .4 % of the respondents were satisfied and very satisfied with their environment while . Nevertheless participants were having higher QOL scores in Psychological health with rate of 37.7% of the participant who think that their Psychological health was good and very good .

A stepwise regression analysis of the demographic variable indicated that increase in psychological symptoms was independently predicted by lack of education , living in rural area , economically dependent on others , and had chronic disease . Poor Quality of life was independently predicted by increased age, lack of education, living in the home of their sons and economically dependent on others

In view of the high proportion of chronic diseases among the participants and because of its negative impact on their psychological health and the quality of life, the study recommends the provision of better health care for the elderly especially in rural areas ,It also shows the importance of involving the elderly with volunteer work and social activities . On the other hand family and community support of the elderly is very important . As well the study recommends the importance of having special education programs for the elderly in regards to their physical and psychological health .

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Definitions Of Study Terms

Aging: is a biological reality which has its own dynamic, largely beyond human control. Ageing is an important part in all human societies because it reflects the biological changes and the cultural-societal conventions. (Aubrey and Grey, 2007). Other researcher defines ageing as a process of deterioration in the functional capacity of an individual that result from structural changes, with advancement of age (Mathew et al, 2009).

Elderly : person whose age 65 year and above (WHO, 2004)

Quality of life : Quality of Life is defined as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept, incorporating in a complex way individuals' physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of the environment. This definition highlights the view that quality of life is subjective, includes both positive and negative facets of life and is multi-dimensional (WHO ,1995) .

Operational definition of Quality of life : Quality of life was measured by WHOQOL-BREF Scale

Mental health : a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."(WHO, 2004)

Operational definition for mental health : Mental health was measured by Brief Inventory Scale (BSI)

Abbreviations

QOL : Quality Of Life

HR-QOL : Health related quality of life

GDs: Geriatric Depression scale

WHO: World health organization

OCD.: obsessive compulsive disorder

ADL : Activity daily living

GSI : Global severity index

BSIs : Brief symptom inventory Scale

SD : Standard Deviation

PCBS: Palestinian Central Bureau of Statistics

Chapter one

Introduction and need of the study

1.1 Introduction

Aging in humans refers to a multidimensional process of physical, psychological, and social and economic changes **(**Sheela and Jayamala, 2008; Sherina et al , 2005) . Some dimensions of aging grow and expand over time, while others decline. In old age, functions of the human body begin to be more vulnerable to daily wear and tear; there is a general decline in physical, and possibly mental, functioning. While emotional experience improves with age , older adults are better at regulating their emotions.
(en.wikipedia.org/wiki/Aging **) .**

The processes of ageing are not dependent only on the passage of time, but rather are the result of complex interactions of factors such as gender (women live longer than men), age of parents (long-lived parents have long-lived offspring), vulnerability to disease, environment, personality, socioeconomic conditions, functional status, individual values and beliefs habits and lifestyle, (WHO , 1999; Paschoal et al , 2007) .

Reductions in infant, child and maternal mortality in addition to decreases in fertility rates during the second half of the past century have resulted in an increase of older populations across the world with the concomitant impact on socio-economic development. While this growth of the old population is a global phenomenon, there are significant regional disparity (ESCWA, 2004) .

The world's population is aging and it is expected the aged population to increase from today’s 590 million to 1.2 billion in 2025 and to reach over two billions by the year 2050

(WHO, 2002; WHO, 1999). Between the years 2000 and 2050, the world wide proportion of persons over 65 years of age is expected to be more than double from the current 6.9% to16.4%. The proportion of oldest-old (those aged 80 years and older) will increase during this period from 1.9 to 4.2%. The population of centenarians in 2050 will be 16 times larger than that in 1998 with the male-to-female ratio of centenarians falling to approximately 1: 4 (WHO , 1999) .

In Palestine the average life expectancy rose by 5 to 6 years. In 2006, for example, average life expectancy reached 71.8 years for males and 73.3 years for females, compared to 67.0 years for both males and females in 1992. Indeed, the rise in life expectancy in the Palestinian territories has led to an increase in the number of older persons **(**PCBS, 2007**)** .

In spite of the gradual increase in the number of older persons in the Palestinian territories, it is expected that their growth rate will remain low, reaching 2.8 percent in 2015 and 2.9 percent in 2025. Absolute number of the population over the age of 65 is expected to be more than 172,000 elderly by 2020, compaed to 152000 in 2007 , although their percentage is not expected to exceed 4%.The PCBS attributed the stability in the percentage of older persons in the Palestinian territories to the rise in fertility rate, especially in Gaza Strip (PCBS, 2007**)** .

Elderly normally pass through physiological, social and psychological changes . The physiological decline in ageing refers to the physical changes an individual experiences because of the decline in the normal functioning of the body **.**As a result of the decline in body systems , the prevalence of chronic disease increased among elderly(Lena et al , 2009; Lye , 2002)**.** According to the PCBS, 65.5 % of elderly persons suffer from chronic diseases 24.9 % of them suffer from diabetes, 35.3 % have hypertension, 12.2 % have cardiac diseases, 6.1 % have ulcers, and 16.5 % have rheumatism (PCBS ,2009) .

The psychological aspect of aging is related to the person's capacity to adapt. Changes may occur in perception and memory; cognitive thinking , intelligence , learning, and problem-solving; mood and attitude; self-concept, and personality. (Gridley et al, 2000;

Cornett, 2006) in addition losses in old age are many. There may be loss of former roles and status; loss of spouse, family and friends; lack of social interaction; lack of social activity and decline in economic security; . These changes result in poor self-esteem and a lack of self-satisfaction and considered a major health risk factor(Cornet, 2006; British Columbia Ministry of Health, 2004**)**.

According to the PCBS survey 18.9 percent of the elderly live alone and in poor conditions ;14% complained that their children did not care for them; 44% did not have sufficient income; 66% received financial aid from their children (PCBS ,2006).

In addition to normal changes with aging , studies conducted in developing countries largely reflect that elderly suffer from financial insecurity , alienation from society, loss of purpose, reduced productivity, loss of social roles and high rate of other psychological problems as depression , anxiety and dementia (Hjazi and Aboghalia, 2009).

Elderly in Palestine face chronic stressor like siege, checkpoints, economic hardships, bad health care and inter-Palestinians tension . These factor increase the hardship that elderly in Palestine face(Ibtahim , 2008) .For example , The PNA Ministry of Social Affairs gives senior citizens a monthly stipend of 90 NIS (approximately 21$). This amount is not enough even to cover a small part of their daily expenses and needs of medications or health insurance(www.globalaging .org) .

Unlike the stage of childhood, the period of old age has not been given adequate concentration on either the national or international level, especially in developing countries. The regular rise in the number of older persons worldwide, due to the decrease in the child-mortality rate and the increase in life expectancy, will eventually affect social and economic development therefore there is an urgent need to address the means of providing older persons with the care and basic services that they need ,and to understand factors that guarantee not only will elderly people live longer , but also how to live with quality, satisfaction and happiness , It is important to enable older people to maintain their

mobility, independence, active contribution to society, and to respond effectively to the challenges of old age and in general bring an active aging for them ((Kirreh , 2007) .

When the WHO defined health as "A state of complete physical, mental and social well being not merely the absence of disease or infirmity, " and define Mental health as" a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." " (WHO ,2004) , it implied that the assessment of health and health care should not only include traditional measures of morbidity and mortality, but should also include broader assessment of quality of life. The WHO has defined this concept as "an individual's perception of their position in life, in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO group ,1996) .

Assessment of quality of life of an elderly person implies the adoption of multiple criteria of a biological, psychological, cultural, spiritual, and socio-structural nature, as well as ways of coping. Because several elements are pointed out as determinants or indicative of well-being in old age, longevity, biological health, mental health, satisfaction, cognitive control, intellectual functioning, social competence, productivity, activity, cognitive efficacy, social status, income, continuance of family and occupational roles, and continuance of informal relationships with friends (Martins,et al 2009): such factors or at least some of them worth exploration .

Quality of life and mental health assessment among elderly , giving the professionals valuable information that can indicate areas in which a elderly is most affected and help mental health practitioners in making the best choices in elderly care. (WHO,1997) .

Most researches who studied mental health of elderly focused on prevalence of mental disorders and its symptoms. Thus studying mental health and quality of life can help us know the impact of aging changes and impairment on daily activities and behaviors of elderly by their view of points This reflects the view that quality of life refers to a

subjective evaluation which is embedded in a cultural, social and environmental context (WHO, 1997) .

Studying quality of life and mental health among elderly in Palestine may direct attention of policymakers , practitioners in the health sector and mental health practitioner to promote the quality of life of the elderly and enable them to work and live independently in their own communities. In addition the study of elderly condition will provide healthcare systems and social security in old age; and to develop a social support system, both formal and informal, with a view to enhancing the abilities of relatives to take care of the elderly within the familial environment . In this sense, the present study aimed to assess quality of life and mental health in elderly Palestinian.

1.2Problem statement

In the Palestinian areas where conflicts, civil unrest, insecurity prevail and financial resources are scarce, elderly live in absence of basic health and social services ,and live alone as a result of migration of young people in addition to political and economic challenges that cause more stress to elderly. They live with the growing fear of disability, sickness, and isolation. These factors increase the risk for developing mental illnesses such as depression or anxiety which is the threats to independence and quality of life in older adults (Kort, N, 2007) .

Statistics show that 65.5% of elderly in Palestine are suffering from at least one chronic disease, 37.5% have one handicape , 26% complain from depression and 15% suffer from anxiety disorders . Approximately one-third (31.7%) of elderly people in the Palestinian Territory lack social services such as social care homes, health insurance, or other services (PCBS, 2006) .

For mental health professionals, the measurement of quality of life and mental health is a vital component for assessing the effect of their and interventions and development of mental health services in addition it help them in psycho education of elderly how to cope with aging process and in awareness for younger how to deal with this age group (Paschoal et al , 2007) .

Although the number of elderly in Palestine is expected to increase , they are still neglected and yet there is little baseline information about their quality of life and mental health problem. This lack of information can inhibit accurate predictions for future health care needs in this age group. For these reasons the researcher believe that it important to study the quality of life and mental health status among Palestinian elderly.

1.3Justification and the need of the study

Palestine is known to be a country of children and youth. However, the elderly comprise smallest percentage of all age groups and its percentage is 4.5% of the total population, reaching almost 5.7 percent in places such as the Old City of Jerusalem and 4.1 % in Bethlehem city (PCBS ,2007) .

It was revealed that elderly citizens (65+ years of age)of the West Bank are classified as among the most vulnerable groups of the Palestinian population and among the least assisted by the government and other institutions.(UNESCO , 2010) . This circumstance has left the seniors virtually forgotten and untargeted in most projects or services. Many Palestinian elderly feel totally forgotten and forsaken(www.globalaging .org) .

In Palestine , while considerable decline appears in the health of the elderly through years of getting older, their ability to obtain their health needs seems even getting worse than before. This is due to the reality that most of people lose their income source in ageing period and become economically dependent to others. On the other hand, medical expenses and prices increase every year in Palestine and this issue deteriorates the ability of elderly to pay for their medical needs particularly for those lacking any medical insurances; the privet sectors insurance companies refuse to provide elderly with its services . Only 54% of the elderly in the West Bank are covered by health insurance services . Almost 65 % of the elderly suffer from chronic diseases; 22.9 % are disabled and in need of mobility

assistance; and almost 14.7 % elderly persons have a vision disability(PCBS,2009). Unfortunately no researches studied how these issue affect the quality of life and the mental health of elderly .

Many changes in the Palestinian situation had occurred after Alaqsa Intifada led to deterioration of life for all population and particularly for elderly. The Separation Wall, the Israeli military checkpoints, and the resulting travel and mobility restrictions across the Palestinian Territories make life for elderly even worse (Sabella ,2007;Sarraj and Qouta, 2005). These barriers have divided family which increase loneless of elderly and cause deterioration of physical and mental health of them. On the other hand , the economic siege in 2006 led to economic deterioration , increasing poverty. Insufficient resources have led to insufficient and inadequate health and social services for all segments of the population, particularly elderly .The apparently poor health status and associated disabilities of the Palestinian elderly are made worse by the lack of social security and The lack of primary, secondary, and tertiary health care that is geared specifically to the elderly (Kort, 2007) .

There is lack of specialized personnel and professionals in geriatrics and gerontology contribute directly to the deteriorating health status of the elderly in the West Bank and Gaza Strip (Kort, 2007).

In addition to bad health , social and political situation of elderly in Palestine , there is lack of awareness among population about the importance of caring of elderly and the lake of statistics about the mental health of elderly . To the knowledge of the researcher, there is few published research that studied the quality of life and mental health among elderly in Palestine .This study will raise community awareness concerning the needs of the elderly and will provide some baseline information about mental health and quality of life of elderly which can contribute to raising awareness of both the public and the privet sector to the elderly population. Thus it will help in improving their quality of life and mental health and facilitate their integration in the society.

1.4Aim Of The Study

This study will focus on quality of life and mental health of elderly in Bethlehem district . The general aim of this study is to measure the dimensions of quality of life and mental health among elderly people and identify the factors that affect them.

Objectives:

1. Identify the most prevalent mental health problems among elderly in Bethlehem.
2. Identify how elderly evaluate their of quality of life.
3. Identify factors that affect quality of life among elderly in Bethlehem (physical health , social situation , psychological health , environment) .
4. Investigate the influence of demographic data on mental health and quality of life among elderly population in Bethlehem district .

1.5 Question of the study

1. What is the mental health status of elderly in Bethlehem district ?
2. How do elderly people evaluate their quality of life in Bethlehem district ?
3. How do demographic data affect mental health of elderly ?
4. How do demographic data affect the quality of life of elderly?

1.6 Hypothesis

- There are no significant differences in quality of life among elderly according to study variable (gender , age , educational level , living arrangement , district , employment status , source of money , marital status , physical health) .
- There are no significant differences in mental health among elderly according to study variable (gender , age , educational level , living arrangement , district , employment status , source of money , marital status , physical health) .
- There are no significant relationship between quality of life and mental health state of the elderly

1.7 Study boundaries

Place : This study was conducted in Bethlehem district : city ,camps and villages .

Population elderly people whose age above 65 years .

Time : This study was conducted between 15-1-2010 until 15-2-2011

Chapter 2

Conceptual Framework

2.1 Introduction

The literature review was conducted using searches of data bases including pubmed , and others as well as bibliography and reference tracing from articles. In this chapter, I review the literature related to the definition of ageing , ageing theories , Ageing Characteristics and Mental Health of the Elderly as well as the definition and conceptualization of quality of life, measurement of quality of life quality of life in elderly and several research studies related to the physical and mental health and quality of life among elderly .

2.2 Ageing Definition

There is no common or specific definition for ageing. For Example, Grey and Aubrey defines ageing as a biological reality which has its own dynamic, largely beyond human control. Ageing is an important part in all human societies because it reflects the biological changes and the cultural-societal conventions (Aubrey and Grey, 2007). Other researcher defines ageing as a process of deterioration in the functional capacity of an individual that result from structural changes, with advancement of age (Mathew et al, 2009).

Ageing consists of three major processes; the biological, psychological and social. All of them interact with each other over the life course. Also, Atanous, Howe and others define aging according to the following dimensions:

Physiological aging: refers to changes with the passage of time in the structure and the function of tissues, and changes in the major organs and systems of the body that can ultimately affect our health, behavior, functional capacity, and survival(Atanous et al, N.D, www.nynj.va.gov/docs/Module1) .

Social ageing includes transitions in roles, expectations about behavior, societal allocation of resources and opportunities, negotiations about the meaning and implications of chronological age, also the experience of individuals through their life course and negotiating about life stages. Social age is a way of grouping elders based on particular cultural experience, such as retirement, widowhood, or grandparenthood (Atanous et al,N.D., www.nynj.va.gov/docs/Module1) .

Psychological ageing processes : they include changes in personality, mental functioning and sense of self during the middle of people's lives until they become elders. Some changes are part of normal aging and others are resulted from the physiological changes in the way the brain works. However, personality does not undergo major changes with age and memory, and cognitive decline is not inevitable.

(Atanous et al, N.D., www.nynj.va.gov/docs/Module1)

Furthermore, there is another two terms related to aging , the ageing process and the process of ageing (WHO, 1999). The ageing process (‘normal ageing’)” represents the universal biological changes that occur with age and are unaffected by disease and environmental influences” (WHO, 1999). Not all of these age-related changes have adverse clinical impacts. On the contrary, the process of ageing” is strongly influenced by

the effects of environments, lifestyle and disease states that, in turn, is related to or change with ageing but is not due to ageing itself “. Often what was once thought to be a consequence of normal ageing is now more appropriately attributed to ageing-associated factors (WHO, 1999). Common definitions of ageing infrequently distinguish between the two processes. For instance, ageing has been defined as a progressive, generalized impairment of function that finally results in a loss of adaptive response to stress and in a growing risk of age associated disease (WHO, 1999). This definition dose not differentiates between the process of aging and aging process. On the other hand, ageing should be considered from two major perspectives: demographic and individual. From the demographic perspective; ageing is a population process, caused by decreasing in fertility and mortality rates, which manifests itself in the growing the number of the elderly in society. While individual ageing is an individual progression through the life course, particularly its latest stages. Therefore, it is important to consider both of these perspectives, and its effects on society, the individuals, and the family. (Chief, 2005).

In the previous definitions of ageing there are no general agreement on the age at which a person considered an old person, and what are the cut-off years that person must go beyond in order to be considered an old person.

Old age and the cut-off values of years(chronological age) cannot be defined exactly because they don't have the same meaning in all societies. In many parts of the world, people are considered old because of certain changes in their activities or social roles. For example, there is a country defines old age in relation to ability to work and the social attributes of experience and leadership. A person is therefore considered as old when he/she is unable to work due to advancement in years and reduced physical strength or poor health. In contrast, other country defines old age in relation to increasing dependency on others due to increasing need for security caused by physical weakness and deteriorating health (WHO, 1999) .

Despite of these differences, the timing of social role transitions such as becoming a parents or grandparents and losing the ability to reproduce emerge as indicators of old age in many societies. In western countries elderly defined when they have lived a certain number of years. In addition, most developed world countries have accepted the chronological age of 65 years as a definition of 'elderly' or old person, but like many

western concepts, this does not adapt well to the situation in developing country. At that moment, there is no standard numerical criterion in the United Nations, but the UN agreed that the cutoff is 60+ years to refer to the elderly population, however, the WHO agreed on the age of 65 to refer to the elderly population.

(/www.who.int/healthinfo/survey/ageingdefnolder/en/index).

Besides, Other opinions say that each country has its own history of when people could be considered elders .For example, a history that could be different for men and women, and a history that depends on social and economical changes, public health improvements, and personal consumption choices, simply considering men and women old when they reach the age of 65 or 60 ignores this history (Sanderson and Scherbov , 2008) . In many parts of the developing world, chronological time has little or no importance in the meaning of old age , other socially constructed meanings of age are more significant."(Heslop and Gorman,2002). Old is an individual-, culture-, country- and gender-specific term. (WHO , 1999). Sanderson and Scherbov define old age as beginning when people are at ages where remaining life expectancy is 15 or fewer years. (Sanderson and Scherbov, 2008**).** While another opinion to measure years of old age is the ages which is nearing or surpassing the average life span of human beings, and thus the end of the human life cycle. Euphemisms and terms for old people include seniors, senior citizens and the elderly **(**http://en.wikipedia.org/wiki/Old_age).

Study results published in 1980 provides a basis for a definition of old age in developing countries . Definitions have three main categories: 1) chronology 2) Change in the social role, such as change in the patterns of work, adult and children statues and menopause 3) change in capabilities such as; invalid status, senility and change in physical characteristics. When the preferred definition was chronological, it was most often accompanied by an additional definitions .

http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.

2.2. Ageing theories

Ageing theories describe the ageing process and what ageing implies. Ageing theories can be divided into two main groups: the biological theories and the psychosocial theories. The biological theories concern on what happen to the body during the ageing process. While the Psychosocial theories of ageing attempt to explain human development and ageing in terms of individual changes in cognitive functions, behavior, roles, relationships, coping ability and social changes (Wadensten, 2006) .

Psychosocial theories of ageing offer different perspectives on the ageing process and the meaning of ageing. So, theories describe the ageing process, but do not provide concrete guidance on how to care for the old people or how to support them in the process of ageing.. The theories of ageing have variously influenced society and staff as regards their views on the ageing process. Staffs' views on ageing affect how they address and treat the old people. Mental health practitioner acquires their theoretical perspective on ageing and views on how to accomplish care through societal norms and values, both in education and work. This is a brief explanation about psychosocial theories of ageing and how they describe ageing process (Wadensten, 2006).

2.2.1 Disengagement theory:

The disengagement theory considered the first real gerontological theories and it was set by Cumming and Henry in the 1960s, (Agahi, 2008) .The theory is based on 5 years of studying by 275 individuals in the US aged between 50 and 90 years.

The disengagement theory does not directly describe human development, but starts from the assumption that, from middle age onwards people begin to turn inward. Further the theory states that, as individuals grow older, they withdraw from previous roles and activities. Therefore, this leads to a gradual withdrawal from society, social roles and activities. The process is irreversible once it has started. As a preparation for death, the individual and society gradually separate from one another. The ageing person has an increased preoccupation with self and a decreased involvement with others. The society's tendency, at the same time, is to reject ageing individuals. This results in decreased interaction between the ageing person and others in their social life (Wadensten, 2006, Wadensten, 2003) .

The theory does not indicate whether society or the individual initiate the disengagement process. From individual perspective some disengagement is required such as disengagement because of retirement, decline in physical health, mental abilities and decline in the financial resources. Other disengagement may be voluntary due to ganging preferences (Agahi, 2008).

According to this theory the disengagement is satisfying both the individual and the society. Disengagement does not lead to dissatisfaction or problems for the individual; instead it is associated with satisfaction and harmony. This increasing isolation in older adults was suggested to be functional for the old people and those around them (Agahi, 2008) . For instance, retirement is a normative, expected phase of disengagement enabling the old people to move into a period of leisure and allow the younger people to move into the labor force. Thus, according to the disengagement theory perspective, successful ageing is best achieved through abandoning social roles and relationships and by the individual reducing both activities and involvement *(*Harwood, 2007 **,** Howe, 1987).

According to the disengagement perspective, the aged individual should reduce activities and social roles, thus staff should be passive and shouldn't try to active the old people. Instead staff should respect the old people's wish to be alone. Consequently, care of old people's needs is not including activities (Wadensten, 2006) .

This theory has been largely discredited. However, a more recent theory makes somewhat similar predictions and has received more support (Wadensten, 2006) .

2.2.2 Activity Theory:

In 1953, Havighurst published the first version of a book on the concept of developmental tasks in a lifespan perspective. Later on, the central organizational concept of the developmental tasks was named activity theory (Wadensten, 2006, Wadensten, 2003).

Havighurst describes the developmental tasks in a lifespan perspective, which included six developmental stages or age periods. Each stage has different tasks, and all of these tasks have biological, psychological and cultural values. According to this theory, the successful

achievement of each task leads to happiness and better chances of success with the next tasks. In addition, this theory implies that there are no differences between middle-aged and old people, with the exception of biological and health-related factors (Agahi, 2008). In the activity theory, it is assumed that maintaining the activity patterns and values typical of middle age is necessary to have a rich and satisfying life and vital to well-being. This theory emphasizes that well-being and life satisfaction which is defined as 'successful ageing' is reflected in old age by the extent to which the individual is able to remain involved in the social context, for example; to maintain social roles and relationships (Howe, 1987).

Extensive support for this theory emerges in studies of the elders who maintain hobbies, develop new ones, and remain socially active. These old people are happier, healthier, and live longer than those who do not maintain their activity level (Steinkamp and Kelly , 1987).The theory is based on the belief that one's self-concept is affirmed through activities associated with various forms of role support. When losses occur which are associated with ageing, they should be replaced with new and different roles, interests or people and it is important that new activities replace the activities which the old person can no longer do. Ageing should be denied as long as possible, and this should be accomplished by not changing the individual's personality. The theory also proclaims that society should apply the same norms to old age as well as to the middle age and not advocate diminishing activity, interest and involvement as its members become old (Wadensten, 2006; Agahi, 2008; Silverstein and Parker , 2002).

One of the limitations of activity theory is its disregard of the individual previous life style and personality pattern (Howe, 1987).

2.2.3 Continuity Theory:

Continuity theory was presented by Havens and developed in the late of 1980 by Robert Atchley .This theory reduces the changes associated with aging, and instead focuses on what doesn't change. Our personalities, our preferences and tastes, the activities we enjoy and those we don't enjoy all remain relatively stable and predictable in old age, so decisions of

future and behaviors remain the same and the latter part of life is a continuation of the earlier part .Therefore, the continuity theory of ageing could also be referred to as a developmental theory (Wadensten , 2006; Agahi 2008 ; Wadensten , 2003).

The continuity theory states that an individual develops habits and preferences and other dispositions during the process of becoming adult and these become connected with the personality. As adults strive to achieve their goals, their past experiences, decisions and behaviors will form the foundation for their present and future decisions and behaviors. The assumption of the continuity theory is that, as middle-aged and elderly adults adapt to changes associated with the normal ageing process, they will rely on existing resources and comfortable coping strategies. Also, maintaining continuous pattern is the most common strategy for adaptation to aging , adaptive strategies have been shown to help maintain life satisfaction , even when faced with aging changes (Atchley,1989) . Continuity of self occurs in two domains; internal and external. Internal continuity occurs when one wants to preserve some aspects of oneself from the past so that the past is sustaining and supporting one's new self. External continuity involves maintaining social relationships, roles and environments (Wadensten , 2006; Agahi 2008) .

2.2.4 Life-Span Developmental Approaches:

Erikson's psychodynamic theory is a theory of human's growth and maturation from birth to old age, which includes the process of ageing. Prior to Erikson's work, human development was something that stopped at the end of childhood and considers human development as a life-span phenomenon. In his works which are published in 1950s and 1960s, Erikson emphasized the life course from childhood to adulthood; in his later publications, however, he reconsidered the meaning of these stages. In 1982, he described the task of old age as balancing the search for integrity and wholeness with a sense of despair (Wadensten , 2006; Agahi 2008;Wadensten, 2003).

According to this theory, human development passes through eight stages .In each stage the person faces a crisis or problems that the person must resolve to move forward to the next stage, otherwise; if they are not solved it will result in an incomplete development (Saxon,

et al , 2010). Besides, the outcome of each stage results in personal growth. When the person arrived the last stage" eighth stage", it is hoped that an individual has attained a higher state of maturity. Therefore, Erikson considered that development as an evolutionary process based on sequencing biological, psychological and social events. Erikson also believed that the maturation of bodily functions was linked with the expectations of the society and culture in which the person lives. In Erikson's theory, successful way through the earlier developmental stages in life leads to a synthesis that may be the basis for development towards the last stage "old age" **(**Sterns, 2006) . Thus, the ego integration of the eighth stage refers to an integration of the elements of the earlier stages. During the last stage, the old person looks back upon the past life and sums it up. If the individual is able to accept with satisfaction the way life has turned out, he/ she will achieve 'ego integrity'. If the individual does not reach the eighth stage of ego integrity, he/she will experience despair and fear of death. Erikson called this negative component, in contrast to wisdom, disgust and contempt (Wadensten, 2006;Agahi 2008;Wadensten, 2003) .

2.2.5 Theory of Gerotranscendence:

The theory of gerotranscendence was developed by Tornstam in 1989. It describes the developmental process of ageing. Tornstam has based his theory on his own studies as well as on the theories and observations of others. The theory of gerotranscendence states that human development is a life-long process that continues into old age. Living implies a process during which the degree of gerotranscendence increases, but the process can be obstructed or accelerated by various aspects of the culture (Wadensten, 2007a ;Wadensten, 2007b ; Wadensten, 2003; Agahi, 2008) .

The theory of gerotranscendence assumes a predisposition for a progression towards maturation and wisdom. According to Tornstam, gerotranscendence is regarded as the final stage in a natural progression towards maturation and wisdom, and achieving gerotranscendence implies achieving wisdom. It offers an idea of what positive old age may entail and attempts to describe a positive and natural form of old people's life.

According to the theory, the individual develops towards gerotranscendence and may experience and appear a series of changes. In the process of gerotranscendence, the individual experiences a reconciliation and a redefinition of self and of relationships with others .Also, the individual will have and a new understanding of fundamental existential issues, for example, less self-occupied and at the same time more selective in his/her choice of social and other activities. Furthermore, old people who withdraw from physical and social activities should not be regarded as disengaged or apathetic because they have a great ability for changing. The signs of gerotranscendence can be described as ontological changes on three levels; the cosmic level, the self level and the level of social and personal relations (Bruyneel, et al , 2003).

In the perspective of gerotranscendence, it is important to encourage and support the old people. This involves putting the main focus on facilitating and furthering personal growth also reduce preoccupation with the body, ideas about conversations that stimulate personal growth and different ways to use reminiscence (Wadensten , 2006 Wadensten , 2003) .

2.3 Ageing Characteristics

Ageing is not a simple process. As adults grow older, physical, emotional, psychological, and social changes occur *(* Sheela and Jayamala , 2008) . The speed at which these changes occur and how they shape the individual is based on a number of aspects. Genetics, environment, health, stress, and diet all contribute to the way in which a person ages. Because of this, no two people age in precisely the same way or at the same rate. The science that studies the process of ageing and the elderly is called Gerontology, though this science deals not only with the physical process of ageing, but also with the related social , emotional and cultural factors . A related science, Geriatrics, is concerned with the diseases that affect the ageing population and the medical care of the old person (Stassi ,N.D. ; Pesic ,2007*;* www.ph.ucla.edu/umso*)*.

There are three aspects of ageing that must be considered when studying the elderly changes such as; physical, socio - economical and psychological changes.

2.3.1 Physical Changes among elderly:

Normal ageing affects all physiological processes. For instance, subtle irreversible changes in the function of most organs can be shown to occur by the third and fourth decades of life, with progressive deterioration with age. The rapidity of the decline in function varies with the organ system under consideration but is relatively constant within a given system. Thus, the rate of ageing is the same for 45 years-old man as it is for an 85-years-old man; the difference is that in the age of 85 there are more related changes have accumulated. It is important to distinguish between the normal attrition of function occurring in all persons with advancing age and the loss of function that marks the beginning of pathological changes from one or more of the diseases encountered with increased prevalence in the elderly (Boss and Seegmiller , 1981) .

Also, ageing is characterized by degenerative changes in both the structure and the functional capacity of organs and tissues, precipitated by a decreased capacity to respond to stressors (Kanonidou and Karystianou , 2007 ; Knapowski *et al* ,2007) .

Significant variability exists in the individual ageing process and it is often difficult to separate pathological processes from age-related physiological decline (Boss and Seegmiller , 1981) .

There are many changes that occur in in all organ systems as the following:

2.3.1.1. Changes in the cardio-vascular system:

There is normal atrophy of the heart muscle (Decreased heart size), especially in the left ventricle, also calcification of the heart valves, loss of elasticity in arte walls (arteriosclerosis) and intra-artery deposits (atherosclerosis). Besides, there is decreased

cardiac output (The cardiac output of an 80-year-old subject is approximately half that of a 20-year-old)., reduced blood flow and there is impaired blood pressure response to standing, volume depletion and heart attacks (Lata, and Alia, 2007 ; Boss and Seegmiller , 1981) . Also, there is an increase in systolic blood pressure with ageing but there is no change in diastolic pressure (Lye , 2000 , Boss and Seegmiller , 1981).

Cardiovascular disease is common in the elderly and effects 50% of those over the age of 65 years. It is the main cause of death among elderly , the mortality increases with age, 65-74 years, death rate = 1,300 per 100,000; over 85 years death rate = 7,300 per 100,000 (Lye , 2000) .

Age-specific death rates from CVD are increasing dramatically with age. Age-specific death rates for all cardiovascular diseases increase at least double between the age groups 65–74 years and 75–84 years in both sexes, with at least 50% higher rates for elderly men than for women (WHO, 2004) .

One of the most common cardiovascular diseases among elderly is Congestive heart failure which is defined as cardiac dysfunction leading to symptoms of breathlessness and fatigue. It is prevalent between elderly being 10% in those over the age of 80 compared to 1% in the 50-60 age groups. (Lye , 2000) .

Hypertension is also one of the common CVD among elderly and its prevalence is at least 30% in men over the age of 65 years and this is undiagnosed in almost a third and untreated in a similar proportion (WHO , 2004). Hypertension is more prevalent in elderly women than elderly men (Maddens *et al* , 2005 ,). According to Boss and Seegmiller , approximately 16 percent of the general adult population is hypertensive but about 50 percent of those over age 65 are hypertensive (Boss and Seegmiller , 1981) . There are many consequences of hypertension for example; incidence of stroke, coronary artery disease and congestive heart failure are all significantly greater in hypertensive elderly individuals than in normotensive elderly individuals. Some cases of hypertension is primary and others are being secondary to other diseases such as renal disease (Lye , 2000 ; Boss and Seegmiller , 1981) . Also, the old people do not tolerate high blood pressures better than their younger counterparts (WHO, 2004 ; Lye , 2000).

Health problems in cardiovascular system frequently lead to fear and anxiety but it can be prevented by healthy diet and exercising regularly (Saxon , 2010) .

2.3.1.2. Changes in the respiratory system:

Many changes happen in the respiratory system, for example; the airways and lung tissue become less elastic with reduced cilia activity. There is decrease in oxygen uptake and exchange, also the ability to breathe deeply is reduced, cough and expel carbon dioxide increased .Moreover, there is an increasing residual volume, losses in internal alveolar surface , reduced transverse thoracic diameter and calcification of costal cartilages with resulting increasing chest wall rigidity. This leads to shortness of breath and fatigue (Lata, and Alia, 2007; Lye , 2000 ; Boss and Seegmiller , 1981) .

One of the most common respiratory diseases among elderly is lung cancer. The elderly

people over the age of 65 are the most population suffering from lung cancer. Risk of diseases and death are increasing with ageing and it is prevalent among elderly male more than female because of tobacco use. The researches proved that two-thirds of men suffering from lung cancer were more than 60 years old (Gabryel and Foremska-Iciek, 2005; WHO, 2004). On the other hand, pneumonia infection is one of the most respiratory diseases that affect the elderly , in addition to Asthma which is defined as reversible airway narrowing which occurs either spontaneously or with drug treatment. It is found in 5% of men and 2% of women for those over the age of 70 years (Lye, 2000 ; Boss and Seegmiller , 1981 ; Kanonidou and Karystianou , 2007) .

2.3.1.2. Changes in muscular-skeletal system:

There is generalized atrophy of all muscles accompanied by a replacement of some muscle tissue by fat deposits. These results in some loss of muscle tone and strength , on the other side, with ageing lean body mass will be reduced. The amount of body fat in relation to the

overall composition of the body doubles by the time most individuals reach the age of 75 (Lata, and Alia, 2007; Boss and Seegmiller , 1981) . Mary E. Stassi mentioned that most men experience an increase in body weight until their mid- to late-fifties when weight begins to decrease. The rate of weight loss is faster in the sixth and seventh decades of life. In women, body weight usually increases until the late sixties then decreases throughout the rest of life, and the rate of decrease typically occurs at a slower rate in women than in men (Stassi, N.D.) .

Muscle strength decreases. Thus, cross-sectional, as well as longitudinal, data indicate that muscle strength declines approximately 15% per decade in the 6th and 7th decades and about 30% thereafter (Lata, and Alia, 2007; Boss and Seegmiller , 1981; Evans , 1997; WHO, 2004).

Some specific implications of this are reduced the ability to breathe deeply and reduced gastro-intestinal activity which can lead to constipation or bladder incontinence, particularly in women. Individuals who exercise regularly may be able to slow down some of these changes. Also the old person loses bone density. The decrease in bone density, along with changes to cartilage and disc composition between the vertebrae, result in a loss of up to two inches of height. In addition, the vertebrae can calcify, resulting in postural changes, the joints also undergo changes. In fact, arthritis, the degenerative inflammation of the joints, is the most common chronic condition in the elderly (Lata, and Alia, 2007; Boss and Seegmiller , 1981) .

The incidence of musculoskeletal disorders in elderly people increases with age. The most common disorders being osteoporosis, osteoarthritis, rheumatoid disease, osteomalacia and Paget's disease (Lye , 2000) . Osteoporosis is a common disease among the elderly and it is a major public health problem worldwide. When people reach the old age, the incidence of osteoporosis and resulting osteoporosis fractures is increasing. Although osteoporosis is more common in women than in men, the incidence in men is increasing (Lye , 2000 ; Srivastava, and Deal, 2002).

In the United States, the prevalence of osteoporosis increases from 15% in 50- to 59-year-old women to 70% in women aged 80 years. Epidemiologic studies in other countries have reported similar findings (Srivastava and Deal, 2002). On the other hand, One third of

women over the age of 65 have vertebral fractures. The patient is usually symptom free until a fracture occurs (Lye , 2000) .

One of the most cost-effective prevention strategies for musculoskeletal disorders is physical activity; such as an adequate intake of calcium, vitamin D and an exercise program that maximizes bone and muscle strength are also important (WHO , 2004) .

2.3.1.3. Changes in the skin:

The skin loses underlying fat layers and oil glands, causing wrinkles and reduced elasticity. In addition, the skin develops “age spots” due to deposits of melanin pigment. The hair gradually loses its pigmentation and turns gray. Also, the nails become thicker due to reduced blood flow to the connective tissues. The skin becomes somewhat less sensitive of many things such as heat, cold and injury .There is also a decrease in intracellular fluid levels which results in a loss of total body fluids, making dehydration a significant risk for the elderly. Subcutaneous tissue decreases and the overall appearance of the body changes. Moreover, hollows appear above the clavicles, around the eyes and in the axilla. This loss of subcutaneous fat is responsible for a decline in the body’s natural insulation. (Lata, and Alia, 2007; Lye , 2000 ; WHO,2004 ; Boss and Seegmiller , 1981) . these changes determined by many factors as gene , hormonal balance , diet , medication , exposure to radiation and sun (Saxon , 2010) .

Dermatological problems are prevalent in the elderly population and a full spectrum of noticeable disorders such as "Senile" , pruritus which is often accompanied by dry skin, eczema ; All types of eczema occur in the elderly, and Leg ulcers **(** Lye , 2000) .

2.3.1.4. Changes in the Gastrointestinal System:

Digestive problems are more common with increasing age. For example; there is decrease in intestinal motility occurs, atrophic gastritis reduction in the production of hydrochloric

acid by 5 meq/h per decade over the age of 30, digestive enzymes and saliva. These changes may result in gastrointestinal distress, impaired swallowing and delayed emptying of the stomach or constipation . The breakdown and absorption of foods may also be impaired; sometimes resulting in deficiencies of calcium, zinc, magnesium, vitamin B, C, and K or, malnutrition in extreme cases (Lata, and Alia, 2007; Lye , 2000 ;Boss and Seegmiller , 1981) .Also, Loss of appetite has been reported, as well as decrease in taste, smell and thirst sensations (WHO, 2004).

Malnutrition low dietary intake is common among the elderly. Sometimes, it is due to physiological changes, illness that causes increased nutrient requirements, increased nutrient loss, poor nutrient absorption, or a combination of these factors, in addition to a poor dietary habits inadequate food intake; such as food choices which lead to dietary deficiencies. Moreover, sociological factor such as loneliness, poverty or a poor housing situation and psychological factor as forgetfulness, depression can impact on the nutrition. Malnutrition and weight loss contribute to progressive decline in health, reduced physical and cognitive functional status, and increased mortality (Evans, 2005).

Gastrointestinal complaints are frequent in the elderly, and one of the most gastrointestinal disorders in the elderly is Stomach cancer. In 1990, the average age of stomach cancer detection for males was 62.9 years with average disease duration of 3.1 years. Among males 60 years and older, the incidence was 480 000 new cases, compared to 186 000 new cases in those 45–49 years old. Among females this distribution trend is even more pronounced, largely due to the fact that there are more women in the age group 60 years and over. It is estimated that death caused by stomach cancer will be increased by two-fold increase up to in 2020 .Other common type of cancer that increase with ageing is colorectal cancer and the average age of its detection was 63.8 years (WHO , 2004) .

Other gastrointestinal complains among elderly is Oral health problems. Limited information is available at the WHO Global Oral Data Bank and from a few national surveys that included some data on ageing population. It can be concluded that the major problems of the elderly are tooth loss, widespread and severe periodontal disease, dental root caries, facial pain, jaw joint pain and burning mouth. So, Oral health disability may also affect the nutritional status of this population (WHO , 2004) .

2.3.1.5. Changes in sexuality:

Sexual desire and performance may continue well into an individual's eighth and ninth decade although frequency may diminish. There are a number of changes in the genitourinary system among elderly women that results from hormonal transition and decreased levels of estrogen and testosterone, the latter being associated with decreased sexual libido, sensitivity, and response. Additional genitourinary effects associated with menopause include atrophic changes in the vagina, vulva, urethra, and neck of the bladder. Vaginal atrophy and diminished vaginal lubrication interfere mechanically with sexual comfort and pleasure . Illness and medications are a common source of sexual dysfunction in women because of the impact of these factors on the neuro-endocrine or the vascular system or both. Illness may have a negative influence on a woman's self-image, her physiological response, and her partner. For example, surgical treatment of breast cancer can contribute to a loss of self-esteem and altered body image and affect her partner's response (Gelfand , 2000) .

Ageing in Decline healthy men is associated by a gradual decline in reproductive function (both potency and libido). in reproductive function is associated with decrements in serum testosterone concentrations in most studies and clinical investigations. Approximately 20% of men 60–80 years old and 33% of men over the age of 80 have serum testosterone concentrations which are below the normal range for young adult men. The biological impact of decreasing testosterone concentrations in older men has been termed 'the andropause'. It is believed that the andropause has significant clinical implications to the ageing related reductions in physical capacity, diminution in muscle strength and mass, decline in bone mineral density, decline in psychological well-being, and impairment in libido and sexual function. Other sexual problems that face elderly men is Benign Prostatic Hypertrophy (BPH) which is non-malignant growth of the prostate gland surrounding the male urethra. BPH may be appearing in up to 10% of 40-year-old men and 80% of 80-year-old men (WHO ,2004).

2.3.1.6. Changes in the senses functions with ageing:

Sensory changes with age are some of the most critical and undervalued changes connected with the entire aging process. There are many changes in senses occur with

ageing such as; changes in vision, in hearing, in taste and smell these changes occur gradually and obstruct the elderly‘s ability to gather information about environment which is essential to maintain a high quality of life . Campbell *et al.* (1999) found that older people with sensory impairments reported poor health-related quality of life(Murphy et al ,2007).

Changes in vision: Many elderly people have weakening eye-sight and do not recognize impaired vision as a specific problem but relate it all to the changes associated with ageing. However, the vast majority of patients with impaired vision can be improved with simple measures*(* Lata, and Alia, 2007; Lye , 2000) .

In the fourth decade, the pupil begins to decrease in size and also react more slowly in response to darkness or bright light .Because of these changes, old people require three times the amount of illumination to see as compared to a younger person. Focusing takes longer time with an increase in nearsightedness, making small print harder to read. There is loss of accommodation which makes reading and close work difficult*(* Lata, and Alia, 2007; Lye , 2000) .

Besides, there is thickening and yellowing of the lens of the eye. This results in light diffraction, increased sensitivity to glare, decreased depth perception and more difficulty distinguishing pastel colors, especially blue and green, in addition to Decreased tear production *(* Lata, and Alia, 2007; Lye , 2000) .

One of the most common vision problem among elderly is cataracts which is major source of visual impairment in older people. Approximately 90% of people with cataracts live in developing countries, 60% of whom are elderly. In these countries, cataracts are the greatest cause of blindness and visual disability (WHO, 2004 ; Lye , 2000) .

According to Broman *et al(*2002)and Nirmalan *et al(* 2005) suffering from two vision impairments (cataracts and glaucoma) double the negative effect on an individual’s quality of life Even mild vision impairments result in individuals having substantially lower quality of life than those without visual impairments . on other hand mood level is also affected by visual impairment (Murphy et al ,2007).

In regards to changes in hearing: There is a loss of pure tone hearing due to a decrease in sensitivity to high frequency tones and decreased discrimination of similar pitches because of

changes in the bones and cochlear hair cells of the inner ear. Approximately 30% of all elderly persons have some hearing impairment. Any inability to communicate experienced by an elderly person leads to loss of independence and social isolation. Additionally, the sufferer is robbed of the ability to listen to radio and television programs and of telephone conversation. Ignorance may result in the deaf patient being labeled as puzzled or frantic and increasing social isolation may precipitate transfer from the community to residential care. As hearing loss is 2X as common in the institutionalized elderly, part of the hearing loss reported may be related to illness and trauma (Lata, and Alia, 2007; Lye , 2000) .

Hearing impairments are coupled with lower health-related quality of life (Murphy et al ,2007).

Changes in taste and smell: Taste and smell are interrelated and important for eating as well as checking for hazards in the environment such as spoiled food, smoke and fumes. Old people experience some decline in the ability to taste resulting from a reduction in the total number of taste buds, especially after the age of 80. The losses in taste and smell that occur with advancing age can lead to poor appetite, inappropriate food choices, as well as decreased energy consumption (Lata, and Alia, 2007; Schiffman and Graham , 2000) .

The loss of vision, hearing and other senses should be recognized as more than physical problems. Such conditions have profound effects on social and personal interactions, economic viability, and mental health of those affected, and should be treated seriously. (WHO, 2004) .

2.3.1.7. Changes in the Urinary System:

With ageing there is A gradual decrease in the volume and weight of the kidneys so that by the ninth decade renal size is about 70 percent of that of the third decade.

Tubular function also declines with aging , the total number of glomeruli falls by 30 to 40% by age 80 and the glomerular filtration rate (GFR) decreases by 50% over the time one ages from age 30 to 90 (Boss and Seegmiller , 1981).

One of the most common urinary problems among elderly is Urinary incontinence and its prevalence o has not been precisely measured in either men or women. According to WHO reports, up to 7% of elderly men and 20% of elderly women report regular incontinence . Boss and Seegmiller said that is Urinary incontinence which has been found in 17 percent of men and 23 percent of women older than 65 years. In about half of the women and a fifth of the men this was due to stress incontinence alone. The capacity of the bladder decreases with age from about 500 to 600 ml for persons younger than 65 to 250 to 600 ml for those older than 65. Perhaps more important, in younger persons the sensation of needing to void occurs when the bladder is little more than half filled but in many who are older the sensation occurs much later or sometimes not at all, leading to overflow incontinence. These changes appear to be due more often to central nervous system disease than to bladder dysfunction (Boss and Seegmiller , 1981). Urinary incontinence is one of the leading causes for nursing home admissions. It is both a medical concern and a socio-economic problem. Increased public awareness and education about incontinence may encourage those afflicted to seek professional help.

Incontinence is a physical condition with negative personal and social repercussions. Failure to address the condition may lead to increased anxiety, loss of self-esteem and depression. Self imposed isolation and social aversion may leave incontinent elderly without access to adequate social support or medical care. To avoid these problems, elderly should be informed that incontinence is a treatable condition, rather than an inevitable consequence of ageing (WHO, 2004).

Other urinary problems is urinary tract infection which increases with age and may be as high as 30% in women aged over 65 years (Lye , 2000). On the other hand there is a water conservation defect in the elderly which leads them to dehydration due to a decreased responsiveness to the vasopressin and decrease in the total water in the body with age. This is available more in women than in men (Lye , 2000).

2.3.1.8. Endocrine system:

Increasing age results in a progressive deterioration in the number and the function of insulin producing beta cells , resistance of peripheral tissues to the effect of insulin and this

is one of the reasons of hyperglycemia in the elderly in addition to the exercises and dietary changes among the elderly (Boss and Seegmiller , 1981) .

About 1 in 20 of the elderly population have diabetes mellitus (Lye, 2000) . According to PCBS in 2009, 25%of the elders suffer from diabetes and its is considered the second chronic disease among elderly in Palestine(PCBS, 2009).

Because of the complication of hyperglycemia, all elderly patients require annual review of eyes (dilated pupils), feet (nail care, neuropathy, etc.), renal function, metabolic

control and blood pressure(Lye, 2000).

Growth hormone(GH) also decline with age. Reduced GH levels, similar to decreased androgen levels which results in a decrease of general performance, reduced muscle mass and strength, and an increased tendency towards obesity. Since sleep in the elderly men is often shallow and fragmented and growth hormone secretion occurs predominantly with deeper stages of sleep, there seems to be a correlation between impaired sleep and reduced GH production in ageing. Similarly, there is a decline of melatonin secretion; a hormone regulating circadian rhythms and other physiological functions with age. Decreased melatonin concentrations may thus also contribute to some of the age-associated changes in elderly, especially in sleep disorders (WHO 2004) .

2.3.1.9. Changes in the nervous system:

The ageing process has a significant impact on the central nervous system. There is a decrease in the number of brain cells , some neurons shrink with age rather they completely lost although many neurons have increased dendrites growth into very old age to compensate neuron loss in some area of brain . Accompanying the loss of neurons is decrease in brain weight and size (Saxon , 2010) . Electrical activity is diminished due to reduced availability of neurotransmitters and post-synaptic receptors. The pyramidal tracts of the spinal cord, a long “chain” of neurons, which are responsible for voluntary motor movement, have a decline in function. So motor response is decreased and the ability to maintain balance and position is impaired. This decline results in an increased fall risk also sensory perception and reflexes is decreased (Saxon , 2010 ; Lye , 2000). Because of the reduced number of brain cells, mental processing is slower in the old

people. These changes could then account for the increased time older people usually need to perform simple tasks as well as for their poorer retention and increased suitability to distraction in learning and memory tasks (Saxon , 2010). As most people experience a modest increase in memory problems as they get older, mainly with regard to the ability to remember recent experiences. Also there is impairment of the ability to accumulate new information and to regain existing information from memory. In addition to a decrease in the capability to store new information once it is learned (Morewitz,.and Goldstein2007).

One of the nervous system disorders among elderly is Parkinson disease. This disease is associated with slowness of movement, fatigue, lack of alternative movements and difficulty in initiating movement. With rigidity or tremor the prevalence and incidence rates increase with increasing age and the disease rarely starts below the age of 55 (Lye , 2000).

According to intelligence , some abilities such as the ability to think abstractly are biologically determined, other intellectual abilities such verbal fluency reflects the knowledge and skills which the person has gained through life experience. Also, Intelligence tests have demonstrated a pattern of age-related changes in intellectual functioning. These tests show somewhat poorer performance by elderly on abstract thinking tests but little or no difference on tests of intelligence that gained through life experience (Lata and Alia, 2007).

2.3.1.10 Functional disability:

Disability is defined as a negative balance between a person's abilities and the environmental requirements. This makes it difficult to carry out various activities, such as walking, shopping, cooking and self-care. In the older population progression of severe disabilities is an important public health and considered as a major risk factors for institutionalization. In old age, pathology causes impairments, for example decreased muscle strength, poor balance and low oxygen consumption. Impairments predispose people to functional limitation such as slow walking which will cause disabilities like difficulties in mobility and self-care.(Lye , 2000 ; Cutler, 2001)

On the hand, Persons with more education are much less likely to be disabled than are those with less education, as are those with higher incomes and who worked (Cutler, 2001)

2.3.2 Social and economical Changes:

At the social level, studies have shown that the main consequences of ageing are social isolation and the feeling of being lonely, being a burden to people, motivation lost, and intimacy missed (Sheela and Jayamala , 2008 ; Hijazi and Abu Ghali 2008, Ibrahim, 2009).

Losses and grief also considered main social changes among elderly, other type of socio-economical changes is retirement and being financially insecure and dependent. These elements seem to be by far the most important concerns of the elderly(Gusmano, 2006; Butterworth , 2006 **)**.

2.3.2.1 Social isolation:

Because of stereotypes ideas as old age has always been considered to be the last stage before death, the elderly may be forced to deal with detrimental changes in roles with the family, community and work. Opportunities open to the elderly for remaining socially useful are severely undermined as retirement and widowhood terminate their participation in the principal institutional structures of society—the job and the family (Gill et al , 2006; Thomopoulou et al , 2010).

Also, a sense of isolation and frustration may occur when he or she is faced with a decline in socio-economical status and the stereotypic notion of being senile, unproductive, rigid, and tranquil lead poor quality of life (Cornett, 2006 ; Newsom and Schulz**,** 2000**) .**

Social support and social networks of mutual obligation, which generate a sense that one is cared for and loved, esteemed and valued are associated with positive health outcomes. Decrease in Social support is associated with increases in depression, anxiety, and other psychological problems (Fiksenbaum, 2005 ; Newsom and Schulz**,** 2000**) .**

Researches have shown that the elderly who feel loneliness was more common; about 50 percent of adults aged 80 and above often felt lonely(Lambert, 2005).

Changes in Social relations are one of the important changes that occur with ageing. There are some relations become stronger with ageing such as marriage. The quality of marriage

varies from couple to couple, but most elderly husbands and wives report greater happiness and satisfaction with their marriage during their later years than at any other time. Many say that companionship, respect, and the sharing of common interests develop during later adulthood (Lambert, 2005) .

A majority of elderly men live with their spouses. Women tend to live longer than men; therefore there are many more widows than widowers (Lambert ,2005) .

On the other hand, the elderly who remain single tend to have more emotional and physical pathology than the married elderly. Death rates are consistently higher among single and socially isolated people. Males are particularly vulnerable for being socially isolated, whereas older women typically establish a social support network (Lambert, 2005) .

2.3.2.2 Retirement:

Change in socio-economical status affects the individual's way of life. Elderly shift through many roles throughout their lives. One of the most dramatic changes is retirement (Mein et al , *2003*; Butterworth et al, 2006; Gill et al , 2006).

Retirees reactions to retirement may vary from delight to dread . Retirement can be viewed as an achievement, an accomplishment. The retiree has completed a major phase of life and now can enjoy their life due the removal of work demands and work induced stress. and it considered the time for rest and relaxation But for others, who have lived to work, this may be a time of difficult adjustment. It may represent relinquishing of power, control, and/or authority. For those whose life was their work, there can be a loss of identity Because they lost the work which provided the economical rewards as well as social status.. Even in the best of circumstances, retirement requires some adjustment and problems may emerge. Other problems that face elderly when they retire are isolation and lower income. Isolation can result for those whose social life revolved around time spent with co-workers and who never developed a circle of friends outside the workplace. Financial concerns are a major issue when facing retirement. Most people have not been able to arrange their retirement income to maintain the same standard of living experiencedduring the employed years. Adjusting to a reduced income can result in stress and worry about the financial stability of the future(Mein et al , *2003*; Butterworth , 2006;

Gill, 2006 ; http://www.articlesbase.com/mental-health-articles/emotional-problems-in-later-life-common-issues-in-late-life-are-retirement-divorce-widowhood-misues-of-prescription-drugs-suicide-and-neglect-2843728.html#ixzz1CvDp1rGY) .

On the other hand, research suggests that money is most missed in retirement. When people are assured an adequate income, they will retire early. Also many couples adjusted well to the transition from employment to retirement and often reported an improvement in their relationships especially when the wife retired (Szinovacz and Schaffer, 2000). Other research indicated that the loss of work roles as result of retirement is more threatening to the mental health of men than of women particularly in societies in which gender roles are much more strongly demarcated (Suk Jeon et al , 2006).

Independence is an important aim for the majority of elderly persons, regardless of their health status. It is an expression of self-respect and pride and help elderly to view him or her as a competent individual (Cornett, 2006).

2.3.2.3 Elderly abuse:

One of the important social problems in the life of elderly is elderly abuse. Elderly abuse and neglect cause unnecessary suffering to the old people. Abuse may be physical, psychological, financial or violation of basic rights. Physical abuse includes assault, trauma, bruises, burns, fractures, dehydration, malnutrition, pressure sores, hypothermia and over-sedation. Psychological abuse includes threats of abandonment or placing in home or verbal abuse. Violation of basic rights includes not being able to vote, practice ones religion. Financial abuse is more common as elders have more assets, particularly their own home, their properties and their savings (House of Commons, 2004).

Elderly women are much more likely to experience neglect and elder abuse. For example, in Palestine around 25% of elderly exposed to different type of abuse (PCBS , 2005). While a study surveyed over 2000 non-institutionalized elders in the United States found that the prevalence of elder abuse ranged from 4% to 10% of those 65 years and older; abuse was perpetrated more often by spouses (58%) than adult children (24%) .

Although empirical studies are lacking with regards to the consequences of abuse and neglect, Wolf reports that depression, learned helplessness, alienation, guilt, distrust, withdrawal, fear, shame, and post-traumatic stress disorder appear to be responses to

abuse. Similar to the victims of domestic violence and child abuse, the elderly tend to hide or minimize the abuse, fearing abandonment and rejection (House of Commons, 2004; http://www.articlesbase.com/mental-health-articles/emotional-problems-in-later-life-common-issues-in-late-life-are-retirement-divorce-widowhood-misues-of-prescription-drugs-suicide-and-neglect-2843728.html#ixzz1CvCyHY8Q).

2.3.2.4 Grief:

Loss is an inevitable consequence of ageing, Elderly are exposed to death of their spouse, relatives and close friends. Nevertheless, the threat of their forthcoming death seems to be less of a worry, also Grief is normal reaction to these losses. Grief in the elderly may be different from the younger person due to special factors such as; a greater degree of readiness, more physical, less psychological symptoms recognized. Psychiatric morbidity is prevalent, and older adults are vulnerable to depression and anxiety in the aftermath of loss. Many other losses which multiply effects, such as retirement, physical disabilities, poorer mobility, increased the possibility of suicide (Cindy ,2002) . Both men and women the same experience difficulties as a result of Widowhood, but men tend to remarry at a much higher rate than older women do(http://www.articlesbase.com/mental-health-articles/emotional-problems-in-later-life-common-issues-in-late-life-are-retirement-divorce-widowhood-misues-of-prescription-drugs-suicide-and-neglect-2843728.html#ixzz1CvDbUDtF).

However other study hypothesize that Older men may be more prone to loneliness than older women when they lose their spouses . Compared to women, more men rely on their spouses and less on family and friends for social support. Should anything happen to their spouse, older men may struggle and their quality of life may suffer (Bennett, 1998).

2.3.2.5 Social role:

Old age is not only a process of degradation. It can have positive, growing elements, too. Some positive ideas show elderly people as a resource for their families and for society,

and many of elderly are still have specific aims in future, but this depends on their good state of physical and mental health. Long after their active professional working life, elderly people are able to offer precious contributions like time, money and wisdom. This gives them many possibilities for playing a very helpful role in their families, communities, and in the wider society. Those who are able to do so very often give support to their children and grandchildren, or perhaps to other younger people .This is not only depending on chronological age, but also on external conditions like education of elderly, work or the family situation (Conference of European churches , 2007).

In Arab culture the elderly were respected as the repositories of inherited wisdom and experience and they were the principal decision-makers. Nowadays, the accumulated knowledge of the elderly is rarely viewed as the source of wisdom .It is commonly regarded as something outdated *(*Pesic, 2007).

Ageing can be described in terms of several distinct stages which describes social, economical and health changes. Some authors who seek to describe the double-edged

patterns of growing old have found it helpful to identify at least three phases of older adulthood.

First, the "young-old," who are persons roughly between ages sixty and seventy-five and who are markedly different from the outmoded stereotypes of old age. They are relatively free of the earlier responsibilities of work and family, generally healthy and vigorous. A pressing question for these post-retirees still in the prime of their life is, "What shall I do with the remaining years of my life?" (Kimble, 1989).

Second, the "middle-old" phase is made up of persons from ages seventy-five to eighty-five who are beginning to slow down and to suffer from the advent of chronic and even debilitating illnesses. They are also experiencing more radical changes and losses, often triggered by the acute illness or death of a spouse. Also, the balance between independence and dependence begins to be more tenuous for many during this stage and may even lead to admission to a long-term care facility(Kimble, 1989).

Finally, the "frail-old" (eighty-five plus) are those who have become increasingly dependent and are suffering from health problems of various kinds which frequently

require skilled care. Furthermore, Dementia or Alzheimer's disease may be involved in the last two stages(Kimble, 1989).

2.3.3. Psychological changes among the elderly:

The psychological feature of ageing is related to the person's ability to adapt. Changes may occur in perception and memory; thinking, learning, and problem-solving; mood and attitude, self-concept, and personality. Changes that mentioned above result in poor self-esteem and a lack of self-satisfaction and often precipitate significant crises (Cornett, 2006) **.**

Old people often face a great number of stresses that can be caused by a many events and situations. Stresses can be physical or social. In many times, Stress affects elderly physical health and can have an even stronger effect on their mental well-being. In addition to that, decline in physiological ability and loss of functional reserve can take a psychological toll on an individual and may be compounded by more general symptoms such as lack of energy, generalized weakness, difficulties in concentration, forgetfulness, irritability and sleep disorders (WHO, 1999).

There is an increasing body of evidence to suggest that the crisis of ageing and being old are a crisis of meaning. It has been observed that the enormous gains in longevity resulting from medical and technological progress have been accompanied "by widespread spiritual malaise and confusion over the meaning and purpose of life particularly in old age." The extent of the sense of emptiness and meaninglessness in older adults appears to be one of the major causes of depression and despair and reflected one of the reasons of suicide in the United States (Kimble, 1989) .

According Personality changes associated with ageing , there is an increased preoccupation with one's inner life, including greater attention to personal feelings and experiences and reduced extraversion. The other personality changes is gender role identity, with advancing age, men and women appear to become more similar in terms of their values and personality styles. Studies in a number of different cultures have found that men tend to become more nurturing, expressive and affiliation-seeking as they grow older, whereas women tend to become more instrumental and achievement-oriented (Lata and Alia, 2007) .

2.4 Mental health of the elderly

Elderly who has the ability to interact with environment and others in ways that support subjective well-being, and use mental abilities (cognitive, affective and relational), in optimal way to attain individual goals it said to be an elderly who has good mental health. The term “psycho geriatric” is frequently used, in relation to the target group, to indicate disturbances of cognition or behavior or conditions that occur in later life. It should be noted the circumstances or disorders experienced primarily by people over the age of 65 can also affect younger populations, specifically individuals in their 40s or 50s. (Barrett et al , 2002)

Furthermore, there are prominent mental disorders among elderly, such as dementia, depression, anxiety disorders ,somatization , sleep disorder and substance abuse(Neno et al , 2007 , Al-Offi, 2004) . Each one of them will be discussed in the following:

2.4.1 Dementia:

When people become older, they are increasingly more likely to be affected by organic cognitive disorders. These disorders include the condition usually referred to as senile dementia. Dementia in the elderly has been recognized since Esquirol described " dementia senile" in his textbook Des Maladies Mentales in 1838 **(**Al-Offi, 2004). Dementia is defined as a significant decline in two or more areas of cognitive functioning. The fundamental feature of dementia is impairment in short- and long-term memory, coupled with impairment of cognition and abstract thinking, impaired judgmentand other disturbances of higher cortical function, or personality change (Neno et al , 2007 Ramadan, 2005) . The disturbance is severe enough to interfere significantly with work and occupation or usual social and functional ability; it includes impairments in capacity to solve problems of day-to-day living, perceptual skills, language and communication and frequently involves disturbances of emotional reactions (Al-Offi, 2004) .

The diagnosis of dementia is not made if these symptoms occur only in the existence of reduced ability to maintain or shift attention to external stimuli, as in delirium; however delirium and dementia may coexist. Diagnosis of dementia is complex and often

uncertain; it is made even more complicated by the fact that the presenting symptoms may be caused by medication or alcohol abuse, malnutrition, depression, and situational stress. (Kimble, 1989) .

Depending on the degree of dementia, the observed impairment is variable, ranging from relatively isolated cognitive disturbances ,which may be undetectable in usual social circumstances to severe forgetfulness and global intellectual disturbance with loss of psychological and social functioning .(Ramadan, 2005)

On the other hand, the major causes of dementia are Alzheimer's disease (approximately 50%), dementia with Lewy bodies (approximately 20%), vascular dementia (approximately 20%) and other rarer causes including fronto temporal dementia, central nervous system infections; brain trauma; toxic-metabolic disturbances; normal-pressure hydrocephalus; Huntingdon's disease, and other dementias associated with Parkinson's disease. These disorders coexist in 15–20% of cases.(WHO, 2004)

The prevalence of dementia after 65 years was estimated as being between 4% and 7% in ten epidemiological studies, while prevalence doubles every 5 years such that rates rise from 1% at ages 65–74 to 7% at ages 75–84 to finally 25% after the age of 85. (WHO , 2004). Although it usually occurs after age sixty-five but the incidence is higher in women than in men. In one third of cases, dementia is associated with other psychiatric symptomatology, such as depressive disorder, adjustment disorder, generalized anxiety disorder, alcohol related problems (Al-Offi, 2004) .Alzheimer and other dementias ranked as the fourth leading cause of disease burden in adults age 60 and older worldwide, outranked only by heart disease and chronic obstructive pulmonary disease (Gellis , 2009

2.4.2 Depression:

is a common disorder in people over the age of 65 **(**Taqui et al , 2007; Akyo et al 2010) , with severe depression affecting 1–3% of the population and milder forms affecting 10–15%.. Other research suggests that 50% of sick elderly and 50% of the hospitalized elderly have significant depression. Furthermore, the recent medical research has suggested that the physiological changes may play a major role in the frequency of depression in the elderly (Neno et al , 2007).The American Association for Geriatric Psychiatry reports

about 25 percent of people experience depression and coexisting with a chronic illness **(** Al-Offi, 2004 **)**. The illnesses that particularly affect mental health in the elderly include: Ischemic heart disease, Stroke, Cancer, chronic lung disease, Arthritis, Alzheimer's disease and Parkinson's disease (Weintraub et al ,2002 , Blazer , 2003) . Also, a combination of depression with dementia in varying quantities is also a frequent occurrence (Gellis et al , 2009) . The high prevalence of depression among elderly who had health problems (illness and disability) are due to decreased mobility , severe pain; cognitive decline; damage to body image due to surgery or disease as well as prescription medications can trigger or exacerbate depression.

http://www.helpguide.org/mental/depression_elderly.htm).

A significant life trauma (as recent death of friends, family members, and spouse) has been reported as the cause in 70% of the elderly who suffer from depression (WHO,2004) .

The observed increase in the prevalence of depression especially in younger and middle-age may be the result of environmental changes, such as loss of identity due to retirement.. , increasing stresses and reduction of social support and living alone (Ghubas et al , 2004 ;Youssef , 2005;Thomopoulou et al , 2010) .

It may sometimes be a difficult diagnosis, as depression in late life can sometimes be caused by other disorders, such as dementia, concomitant administration of drugs, physical illness and disorders, such as hypothyroidism. (Evans and Mottram, 2000)

It is important to remember that although, as in all people, reaction and depressed mood may be a normal response to loss, prolonged and persistent depressed mood, particularly when associated with other biological symptoms, such as sleep disturbance, diurnal mood variation, appetite and weight loss, loss of libido, and suicidal ideation are an important pointer towards the presence of clinically significant depressed mood (WHO , 2004).

Moreover, there is a female predominance of depression at all ages, although this difference tends to diminish later on in life where men are almost as often affected as women. It appears to be true that women are more likely to have depression than men, although depression is undoubtedly the most common functional disorder affecting ageing males (WHO, 2004).

Despite the slight predominance of women in terms of those affected with depression, it is men who are most successful at committing suicide. Indeed, suicide rates rise with age so that the highest rates are seen in males over the age of 75. It must be remembered that about 90% of elderly men who attempt or complete suicide have depression, either undiagnosed or inadequately treated (WHO, 2004).

2.4.3 Anxiety disorders:

Anxiety is a common and major problem lately, yet it has received less attention than depressive disorders. Anxiety disorders are often associated with common age-related medical and chronic conditions such as asthma, thyroid disease, coronary artery disease, dementia, and sensory loss (Gellis et al. , 2009; Stein and Lang , 2002) . Besides chronic physical illness there are other factors that cause anxiety among elderly as having suffered extreme experiences as ware and violence and recent losses in the family, fear of death or dying and financial problems due to loss of work (Stein and Lang , 2002) .

Researchers and practitioners recognized that ageing and anxiety are not commonly exclusive; anxiety is common in the old people as well as in the young. Schaub and Linden (2000) examined 516 German subjects aged 70 years and older. They found that the weighted overall prevalence of anxiety disorders was 4.5%. They observed that anxiety disorders in the elderly did not appear much different from those in younger (Schaub and Linden ,2000) .

Even though anxiety disorders, like most psychiatric disorders , may be less widespread among older adults than among younger people , epidemiological facts suggests that anxiety is a major problem in late life. In the National Comorbidity Survey Replication, 9282 English-speaking adult American subjects were interviewed. Among all disorders, DSM-IV anxiety disorders showed the highest lifetime prevalence: 28.8 % overall and 15.3 % in the elderly. Elderly subjects had a lower prevalence for each of the anxiety disorders relative to the rest of the population. The overall lifetime prevalence in the whole sample and in the elderly subjects, separately, were 5.7% and 3.6% for GAD, 4.7% and 2.0% for panic disorder, 1.4% and 1.0% for agoraphobia without panic, 12.5% and 7.5% for specific phobia, 12.1% and 6.6% for social phobia, 6.8% and 2.5% for posttraumatic stress disorder, and 1.6% and 0.7% for obsessive-compulsive disorder (Kessler et al, 2005). The

data from the Palestine indicated that (23.5%) of elderly in institutions homes in Palestine felt anxiety(Ibrahim , 2009), 64.3% of elderly in Gaza strip suffered from anxiety (Hijazi and Abu Ghali ,2008).

According to Anxiety disorders , Phobias and Generalized Anxiety Disorders (GADs) account for most anxiety disorders in late life(Beekman, et al . , 2000; LeRoux et al , 2005; Stein and Lang , 2002) whereas most other anxiety syndromes seen in the elderly, (e.g., PD and OCD) reflect recurrence or worsening of an anxiety disorder that had its onset earlier in life (Stein and Lang , 2002) .This fact was improved by some studies as the Longitudinal Aging Study Amsterdam (LASA) which found that the overall prevalence of anxiety disorders in the community was estimated at 10.2%. GAD was most common in a 6-month time period (7.3%), followed by social phobia (3.1%), PD (1.0%), and OCD (0.6%) (Beekman, et al . , 2000) . Other study conducted by Epidemiologic Catchment Area (ECA) which reported on the 1-month prevalence of panic disorder, phobias, and obsessive-compulsive disorder among adults from five sites across the United States. In this study, the overall prevalence of anxiety disorders in the elderly subjects was 5.5% as compared to 7.3% in subjects of all ages. The prevalence of phobic disorder, panic disorder and obsessive-compulsive disorder in the elderly were 4.8%, 0.1%, and 0.8% respectively as compared to 6.2%, 0.5% and 1.3% in subjects of all ages (Regier et al , 1993).

Agoraphobia in older adults is usually a different phenomenon, with different etiology, from agoraphobia in younger adults In the elderly, the newonset of agoraphobia is rarely associated with spontaneous panic attacks, but instead is a maladaptive reaction to some form of medical illness experience that renders the individual fearful of being unable to function safely away from home. An example is an elderly woman who breaks her hip, and even after it has satisfactorily healed, is afraid to maneuver without help and therefore avoids leaving the house alone **(** Stein and Lang , 2002).

Besides, the prevalence of clinically significant anxiety, including symptoms that do not meet criteria for a specific disorder, is common among the elderly and may be as high as 20-29% . Anxiety symptoms may be expressed as somatic features or behavior changes, and the clinical presentation of anxiety in late life may be more likely to include depressive symptoms. (Gellis , 2009 ; Stein and Lang , 2002 ; Lenze et al , 2005) .

So anxiety in the elderly has been found to often co-occur with depression (Van der Weele et al , 2008; Beekman et al., 2000) . In fact, community survey research has revealed comorbidity of anxiety and depression as high as nearly 50% among the elderly (Beekman et al., 2000) . Pereira et al (2002) studied 698 geriatric patients attending a psychiatric hospital in Goa. The findings indicated that nearly 8.7% of the patients had neurotic, stress-related, and somatoform disorders of these, 42% of patients were diagnosed with mixed anxiety and depression (Pereira et al , 2002) .

The consequences of anxiety in late life are potentially serious and extend beyond that of emotional functioning. Anxiety symptoms are associated with functional limitations or r lack of ability to perform daily activity, increased fatigue, greater levels of chronic physical illness, increased disability, lower levels of well-being, worse life satisfaction, and inappropriate use of medical services among the elderly(Brenes et al. , 2005; Wetherell et al., 2004). Wetherell et al found that that older GAD patients report overall worse quality of life than individuals with recent acute myocardial infarction or type II diabetes (Wetherell et al., 2004). Also, the old people with anxious depression report an increased suicidal incident and reduced psychosocial support.

It should be kept in mind that anxiety is a result of inadequate coping and inadequate support in the face of stress; therefore, as stress is low and support is high in elderly subjects the prevalence and magnitude of anxiety disorders in the elderly may be lower.

2.4.4 Somatization:

Somatization in the elderly has been usually seen as a masked presentation of depression , Among the elderly depressed, somatization is common and may be commoner if physical illness is also present. Psychiatric illness, may be an important aetiological factor for somatization in the elderly (Sheehan , Banerjee , 1999) **.**

In a community sample of 764 persons aged ≥60 years, an increasing amount of subjective body complaints was associated with greater age in women and in persons with depressive mood **(**Schneider et al, 2003) . On the other hand, in a study of outpatients in an urban primary care practice, medically unexplained symptoms were more frequent in patients who lived alone **(**Schneider et al , 2003).

Sometimes the old people will somatize as a major way of communicating with their physician, pastor, or caregiver. Often their bodily complaints reflect treatable conditions such as unresolved grief, depression, and situational stress. The non psychotic somatized person who has no underlying etiologies usually responds to supportive and empathic approaches (Kimble, 1989) .

However, in this age group, accurate steps must be undertaken to exclude physical problems before ascribing symptoms to somatisation (Evans and Mottram , 2000).

2.4.5 Sleep disorders:

Sleep undergoes a number of changes with increasing age and tends to display more varied patterns. Sleep disorders are common among elderly people, affecting about 50% compared with about 26% of younger adults. This high prevalence of sleep disorders results in excessive daytime snoozing, fatigue, cognitive impairment, increased psychiatric morbidity*(* Jagus and Benbow, 1999).

There are numerous psychological and social factors contributing to quality and quantity of sleep (WHO, 2004). Elderly spent more time in bed because of increased spare time available to retired or bereaved people. Both employment and marriage have an organizing influence on sleep-wake patterns and following retirement or bereavement these patterns changes (Jagus and Benbow, 1999*).* Total sleep time decreases with age, but the amount of time spent in bed increases with a greater proportion of time in bed spent awake. The ratio of time spent sleeping to total time spent in bed decreases from 95% in adolescence to less than 80% in old age (WHO, 2004). Sleep onset takes longer with age, about 32% of elderly women and 15% of elderly men take over 30 minutes to fall asleep. Awakenings in the night are more frequent**;** over 50% of elderly people report more than 30 minutes of wakefulness after sleep onset. Overall, less time in bed is spent sleeping. Among 60- to 80-years-old sleep time averages 6-6.5 hours per night with 7.5-8 hours spent in bed. The elderly can be described as having an impaired capacity to maintain sleep. In a study of over 9,000 community-dwelling adults over age 65 years, 42% of subjects reported difficulty in initiating and maintaining sleep(Jagus and Benbow, 1999*).*

Sleep instability have significant and serious consequences. Sleep problems are associated with increased risk of falls in the elderly, even after controlling for medication use, for example, they may face difficulties in walking, in seeing, and depression .Studies have shown that elderly with difficulty sleeping reported poorer overall quality of life more frequently, as well as more symptoms of depression and anxiety, than those with no sleep difficulties. Chronic sleep difficulties at any age can lead to deficit in attention, response times, short-term memory, and performance level (Ancoli-Israel and Ayalon, 2009) **.** Also fragmented sleep influences in the growth hormone secretion which occurs with deeper stages of sleep (WHO, 2004) .

The most common intrinsic dyssomnias in the elderly are primary snoring, sleep apnea, restless legs syndrome and periodic movements of sleep. (Jagus and Benbow, 1999)

First of all, the primary snoring is very common in the elderly. It occurs in up to 60% of men and 40% of women .Also studies have shown that the prevalence rates of apnea ranging from 26 to 73% of elderly populations. Second, the periodical movements of sleep and restless legs syndrome are reported by approximately 5% of elderly people but may be present in up to 33% (Jagus and Benbow, 1999) .

Moreover, the medical, pharmaceutical and behavioral treatments are available to the patient and frequently improve the quality of sleep. However, the first step is the

recognition of the problem (WHO, 2004).

2.4.6 Paranoid Symptoms:

New- Onest Paranoid symptoms are common among older individuals. They can indicate an acute mental status change owing to medical illness, correspond to behavioral and psychological symptoms of dementia, or associate to an underlying affective or primary psychotic mental disorder (Chaudhary and Rabheru, 2008). With elderly persons there is sometimes an element of suspiciousness, especially when a person becomes more frail and consequently more dependent and vulnerable. This behavior may also be the result of inadequate, injudicious, and demeaning treatment at the hands of professional and family caregivers. The old person's suspicions and fears may be appropriate, based on negative past experiences.(Kimble , 1989). In a cross-sectional study was conducted by Bazargan et al

about Paranoid Ideation, among Elderly African American Persons, the sample was 998 independently living elderly African American persons. The study used the Brief Symptom Inventory to measure paranoid ideation. Results showed that the Paranoid ideation (symptoms of paranoia) was found in 10% of this sample. Income, instrumental support, hearing loss, stressful life events, self-reported memory deficit, and depression showed a significant relationship with paranoid ideation among elderly (Bazargan et al , 2008).

2.4.7 Medication Misuse:.

Data suggests that misuse and abuse of prescription medications by older adults is a growing problem (Donya et al , 2009) .

About 80% of elderly have some chronic medical condition, and the likelihood of multiple medical problems increases with advancing age. The elderly receive from 25% to 30% of all prescriptions and use these drugs at a rate as much as two and a half times that of younger persons . Seniors also are heavier users of proprietary or over the counter medications(Carlson, 1994 **;** Kimble, 198). In Palestine , a study conducted by Akkawi(2008) showed that the prevalence of polypharmacy among elderly of the three districts (Nablus, Tulkarm, and Jenin) was 41%. And the mean number of medications used by each elder of the study population was around 5 (Akkawi.2008). Multiple medical conditions, complex medication regimens, and the use of multiple care providers set up a situation for high risk of adverse drug reaction which is very frightening to the elderly; these occur with alarming frequency in the old people. Incidence of side effects which have been documented is three to seven times the frequency in other age groups. Also 10% of hospital admissions for elderly are due to such reactions. The elderly commonly self-treat with medications, often follow the dictum that “if one pill is good, two must be better.” It has been reported that the elderly may receive thirteen new prescriptions a year and may be taking three to seven medications at one time. The problem is compounded by the frequent use and abuse of over the counter medications. Some elderly persons, of course who are under use medications perhaps due to the fear of the effects. Side effects of some medications masquerade as delirium, disorientation, impotence. The elderly and their caregivers need carefully to monitor all medications being used (Carlson, 1994 **;** Kimble, 198).

General indicators of prescription medication misuse may include loss of motivation, memory problems, family or marital conflict, new difficulties with activities of daily living, drug-seeking behavior, and doctor shopping **(**Simoni-Wastila and Yang, 2006).

There is growing evidence that female sex is a major risk factor for problems associated with prescription drug abuse. (Simoni- Wastila and Yang, 2006).The two major classes of prescription drugs subject to abuse that are used by older adults are the sedative-hypnotics and the opioid analgesics (Simoni-Wastila and Yang, 2006).

2.5 Quality of life among elderly

2.5.1 Definition of quality of life

Over the last fifty years a many definitions of quality of life(which abbreviated as QoL or QOL) have emerged within health and social science disciplines, there is no single, agreed-upon definition of QoL. the most widely used and broadly derived definition is that by WHO (The WHOQOL Group, 1995): "Quality of Life is defined as individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns It is a broad ranging concept, incorporating in a complex way individuals' physical health, psychological state, level of independence, social relationships, personal beliefs, and their relationships to salient features of the environment (The WHOQOL Group, 1995, p. 1405).

Another definition has been provided by Lehman (1996) " patients' perspectives on what they have, how they are doing, and how they feel about their life circumstances. At a minimum, QoL covers persons' sense of well-being; often it also includes how they are doing (functional status), and what they have (access to resources and opportunities)". Lehman's model suggests that " QOL is a subjective matter, reflected in a sense of global well-being, and this experience depends on at least three types of variables: (a) personal characteristics, such as age and sex; (b) objective QOL in various domains of life, such as income level; and (c) subjective QOL in these same life domains, such as satisfaction with income (Basu, 2004; Ventegodt et al , 2003; Bowling and Gabriel, 2007).

In regards to Erikson (1993),who interested in the standard of living in a society, defines quality of life in terms of control over resources such as money, property, knowledge, mental and physical energy, social relations and security The individual is perceived as an active human being that uses his/her resources to follow and satisfy basic interests and needs. On other hand Lane (1996) understood high quality of life in terms of subjective well-being, human development, and justice (Beham et al , 2006; Bowling and Gabriel, 2007) .

In Canada, the Ontario Social Development Council defines quality of life as the "product of the interplay among the social, health, economic and environmental conditions which affect human and social development" (http://www.qli-ont.org/indexe.html).

Lawton (1991) defines quality of life as a collection of both objective and subjective dimensions, interacting together: it "is the multidimensional evaluation, by both intra-personal and socio-economic criteria of the person-environment system of the individual" (Smith , 2000; Bowling and Gabriel, 2007) .

Brown and Bowling defined Quality of life (QoL) as a multi-level and amorphous concept**,** and is popular as an endpoint in the evaluation of public policy (e.g. outcomes of health and social care). Quality of life has been defined in macro (societal, objective) and micro (individual, subjective) terms. macro level includes income, employment, housing, education, other living and environmental circumstances. micro level includes perceptions of overall quality of life, individual's experiences and values, and has included related, proxy indicators such as well-being, happiness and life satisfaction **(** Brown et al , 2004 , Bowling and Gabriel, 2007) .

Sen (1993), Nobel laureate defined quality of life in terms of the capability of a person to achieve valuable functioning (Beham et al , 2006) .

However, despite various definitions, the majority of them agree that the construct of quality of life is multidimensional, and has subjective as well as objective components (Beham et al , 2006) .

2.5.2 Characteristics of quality of life:

Although there is no consensual definition of QoL, there are areas of significant agreement among QoL researchers about some of the central characteristics of the QoL construct. These are:

Person -centeredness: Each individual personally evaluates how he or she views things and his or her feelings and ideas. QoL is leaning towards the experience gathered from the viewpoints of the consumer, client, or in our case, the elderly himself/herself. Therefore the final evaluator of the quality of the life is the person who lives that life, not some external specialist. (Basu, 2004).

Subjective and objective nature:. According to Noll (2004), two rather contrary approaches to quality of life have evolved in the past: the Scandinavian level of living approach (Erikson 1974) and the American quality of life approach (Campbell, Converse, and Rodgers 1976). While the Scandinavian approach focuses entirely on resources and objective living conditions, the American approach emphasizes the subjective well-being as perceived and experienced by the individuals.

Only recently, have scholars from various disciplines called for the complementary use of objective and subjective indicators in assessing QOL. Objectively similar living conditions may be perceived and evaluated quite differently by individuals (Basu, 2004; Beham et al , 2006; The WHOQOL Group, 1995; Smith , 2000 ; Bowling and Gabriel, 2007).

Objective indicators refer to reports of realistic conditions and obvious behavior (e.g. standard of living, physical health status, personal income , housing, employment, working conditions, education), whereas subjective indicators stand for measurement of attitudes,. satisfaction, happiness, and it include life satisfaction (global judgments of one's life), satisfaction with important life domains (e.g. work, family, health), positive affect (experiencing many pleasant emotions and moods), and low levels of negative affect (experiencing few unpleasant emotions and moods) (Beham et al , 2006; The WHOQOL Group, 1995; Smith , 2000, Ventegodt et al , 2003 , Bowling and Gabriel, 2007).

The joint use of objective and subjective indicators may provide alternative views and additional information not only about the quality of life of an individual, but also about the societal quality (Beham et al , 2006; The WHOQOL Group, 1995; Smith , 2000, Ventegodt et al , 2003 , Bowling and Gabriel, 2007).

Multi-dimensional nature*:* Another area of wide-ranging consensus is the multi-dimensional nature of QoL. They range from basic needs-based approaches, often derived from Maslow's hierarchy of human needs, to classic models based on psychological wellbeing, happiness, morale and life satisfaction , physical health and functioning, social expectations, and the individual's unique perceptions (Bowling and Gabriel, 2004).

At minimum, quality of life includes the following dimensions: physical (individuals' perception of their physical state), psychological m/;(individuals' perception of their cognitive and affective state), and social (individuals' perception of their interpersonal relationships and social roles in their life). Such further dimensions can be 'usual activities' (Brazier et al., 1993), 'role functioning' (Ware et al., 1993), 'work' (Bergner et al., 1981), or even 'spirituality/religion/personal beliefs' (WHOQOLGroup, 1995;Basu, 2004; Ventegodt et al , 2003) .

Assessing people's opinions on quality of life offers policy maker in an easy-to-accomplish way with information about what people really want. Measures of satisfaction with general life or certain life domains present good signs the level to which true needs are met in society (Beham et al , 2006) .

2.5.3 Quality of life among elderly :

Research in quality of life among elderly is relatively new. Current interest in quality of life research can be returned to a number of factors. Firstly, there are increasing proportions of older people, presenting challenges in terms of meeting health and social care needs in a time of socio-economic and physical limitations. Secondly, medical technological advances have added years to life but not necessarily quality to life (Smith , 2000).

Elderliness is a qualitatively different experience for each subject. It is good for some, and a bad experience for others. Between these two extremes of good and bad quality, there is

probably a continuum. Erikson has referred to the two extreme poles, satisfaction and dissatisfaction, as respectively the pole of ‘integration’ and of ‘despair’ (Xavier et al , 2003) .

Whether elderliness will be an pleasant stage depend on objective factors of this subject’s life and on the subjective interpretation of this reality by the elderly person.

Thus, the positive and negative quality of life of elderly people depends on the subject’s internal variables (his/her emotional attitude facing the facts of life, social and personal resources, self-mastery or control over life, autonomy and independence) and on external variables (environmental resources). (Xavier et al , 2003; Gabriel and Bowling, 2004) .

Several internal emotional/psychical characteristics such as personality , psychological outlook , coping strategies, social skills and material resources influence the possibility of having a pleasant elderliness. Characteristics such as the interpretation of losses, the previous personality and even the beliefs and positions facing aspects like death and separation can help keeping , developing or losing the wellbeing in elderliness. For many elderly people, the task of recovering from stressing factors is hampered due to the cumulative effect of losses close in time, when a new loss occurs before enough time had already passed in order to allow the resolution of grief. While these internal features influences are strong , the external factors have a main impact on peoples quality of life and it vary enormously from person to person fore example Level independency , financial resources, widowhood , physical health (Brown et al , 2004; Xavier et al , 2003).

After the occurrence of a negative life experience, the presence of certain aspects – such as solid family network economic resources – could reduce the impact of the experience on the subject’s well-being. For example widowhood in an environment of migrating elderly people, in which they lost their friendships of the youth when they moved from their country , is certainly worse than widowhood in a community without the mobility of migration. Therefore, elderliness having a preponderantly positive quality for elderly people depends on the internal emotional coordinates and on the external coordinates (Xavier et al , 2003). on the other hand research completed by Levin (1994) assessed the relationship between life satisfaction in the elderly and their internal and external environments and found that physical disabilities do not necessarily mean that quality of life is diminished if the eldrly had friends and social support **(**Watson**,** 2007).

The result of study which conducted by Bowling and Gabriel (2004) about elderly people´s definition of quality of life showed that The variables which explained most of the variance in quality of life ratings, were: social comparisons and expectations, personality and psychological characteristics (optimism-pessimism),

health and functional status, personal social capital (social activities, contacts and support, loneliness) and external, neighbourhood social capital (perceived quality of neighbourhood facilities and safety). Socio-economic indicators contributed relatively little to the model (Bowling and Gabriel,2004).

Based on what mentioned above, quality of life assessment in older people should include physical functioning and symptoms, emotional, behavioral cognitive and intellectual functioning, social functioning and the existence of social support, life satisfaction, health perceptions, economic status, ability to pursue interests and recreation, sexual functioning, energy and vitality. Darnton-Hill (1995) also emphasised the importance of income in determining life expectancy and quality of life in older age.

Overall, quality of life in older age are associated with good health and functional ability, a sense of personal adequacy or usefulness, social participation, the existence of friends and social support, and level of income or other indicator of socio-economic status (e.g. housing tenure) (Brown et al , 2004).

2.6 The Elderly in Palestine

The Palestinian Central Bureau of Statistics defines the elderly in the Palestinian Territory as of age 60 years and over. Also the results of the study which conducted by the Palestinian Central Bureau about the conditions and the requirements of elderly care in the Palestinian Territory in 1997-2007 showed that there is a continuous increase in the number of the elderly in the Palestinian Territory because the number increased from 132,000 in 1997 to 152,000 in 2007. Despite this increase in numbers of the elderly, their percentage of the total population decreased from 5.1% in 1997 to 4.5% in 2007. Also according to this study there is a rise in the number of female elderly, compared to male elderly, while the gender ratio in the elderly was 88.2 males vs. 100 females in 2007. The reason for this is that life

expectancy for women is greater than life expectancy for men for example; life expectancy in the Palestinian Territory is 70.5 years for males and 73.2 years for females in 2009, and it is expected to reach 72.0 years for males and 75.0 years for females in 2015) .On the other hand, there is a decrease in the percent of families which are headed by an elderly person from 18.3% in 1997 to 15% in 2007. As for the marital status, the highest percentage of elderly persons is married. The percentage of married males was 90% compared to 41.7% for females, while the percent of widowed in terms of gender reached 52.2% for females versus 8.7% only for males (PCBS , 2009; PCBS , 2005) .

Despite the increased percentage of educated people in Palestine, there is significant increase in the percentage of illiteracy among the elderly as more than half of the elderly (56.1%) are illiterate. Also the percentage of illiteracy among female elderly is 76.2% compared to 30% for males in 2006. In regards to health situation of elderly in Palestine, statistics reported by the PCBS indicate that there is a direct correlation between old age and illness. According to the PCBS, 65% of the elderly people suffer from one or more chronic diseases such as, hypertension, diabetes, arthritis, and heart diseases while the percentage of the elderly who enjoy good health is 33.2 %. Moreover, 14.8% of elderly (about 23,000 elderly persons) in the Palestinian Territory suffered from difficulty or disability in at least one or more type of disability in 2006. The most common difficulties among elderly people are the difficulty of understanding, communication and mobility.(PCBS , 2009;PCBS , 2005) .

Data showed that the elderly in the Palestinian Territory were economically active, for instance 22.7% of the elderly were engaged in different type of work are mostly males. The elderly people who are active economically are classified as the following:

42.7% of self-employed, 39.3% of paid employees, 11.4% of employers, and 3.2% working for the family without pay. In the same regard most of the elderly professions are not commensurate with their age and physical strength. They are concentrated in agriculture and elementary occupations or work as vendors in the markets. Also, there is a low percentage of elderly who work in occupations that do not require physical strength, such as technicians and clerks (PCBS , 2009; PCBS , 2005).

Furthermore, 34.1 of the elderly in the Palestinian territories were under poverty line which forming 5% of the total number of “the poor” in the Palestinian Territory. Statistics have also shown that about 28% of the elderly people are not satisfied with their health conditions. About 20% of the elderly believe that their housing conditions are inappropriate and uncomfortable. 75% of the elderly are not satisfied with the level of services provided by the government agencies for the elderly people while only 9% who considered the services provided by non-state actors to be satisfactory.

There are some changes on the Palestinian society, which in turn reflected on the social situation of the elderly, for example nuclear families increased from 73.3% of total households in 1997 to 80.7% in 2007, which indicates a higher probability for some of the elderly to live on their own without their children or grandchildren. This means on a general level, a reduction in care or care by children because they live in separate households.(PCBS , 2009; PCBS , 2005) .

Although the dominant characteristic of the Palestinian society is respect and care for the elderly, there are some exceptions to this rule. In 2006 about one quarter of the elderly had been subject to violence, as (24.7%) reported various forms of abuse by family members (PCBS , 2007) .

2.6.1 Services are provided for the elderly in the Palestinian Society:

Services are provided for the elderly through governmental institutions, such as ministry of social affairs and the international relief agency.

2.6.1.1 Ministry of Social Affairs:

The number of departments of Social Affairs in 1998 was 13 Directorate. Eight of these departments are in the West Bank and 5 of them in Gaza. The number of beneficiaries of Social Affairs is about 2700 elderly person in the year of 2006 nd the number increased to about 6700 elderly in the year 2008 . Accordingly, the policy of social affairs is that the elderly who reaches the age of 60 can be helped by them. Especially the elderly who is not able to provide his family and does not have an adequate income provided that to prove

that he needs help (Abofadala, 2009) . Moreover, if the elderly has sons and they don't spend money on their elderly parents, the elderly can bring suit against them. Then the elderly can provide a copy of this suit to the social affairs and request assistance from the departments of Social Affairs which deployed in the provinces. So the social workers visit the elderly and provide a full report to the director for assistance. (Palestine, Ministry of Social Affairs, 2002)

The assistance provided by the Ministry of Social Affairs is a monthly cash of 90NIS for the elderly, in addition to a funding assistance if it is available (Global Action on Aging ,2009). Besides, they can have a free health insurance in coordination with the Ministry of Health. Sometimes the social worker helps them to supply some of life requirements such as, glasses and hearing aids, but this service remains limited and insufficient to cover the daily needs. Also, the social worker can transfer the elderly to the residential institutions that do not provide them any services within the institution. MOSA provided medical and financial support to 5792 older adults only in the West Bank and 7000 older adults in the Gaza Strip in 2009, leaving a large number of older adults with no support (UNESCO, 2010) .

2.6.1.2 The International Relief Agency:

The international relief agency of the United Nations (UNRWA) provides services for the elderly through its program of hardship cases. This program provides a financial and health assistance through its Assembly**,** in accordance with the terms and aid adopted by UNRWA**.** Where the worth of assistance for those who reached the age of 60 years, and carry a refugees card and has no income and there is no children enrolled in his ID from the age of 18-60.

Furthermore, there were 4533 elderly who received assistance from UNRWA in the West Bank in 1998 and constitute around 52% of beneficiaries (Palestine, Ministry of Social Affairs, 2002) .

2.6.3 Institutions and non-governmental organizations:

2.6.3.1 Direct Services:

Residential Homes:

The residential homes are a social institutions offering permanent or temporary residence for the elderly. Their aim is to provide an appropriate and safe place for the elderly and to provide a healthy, psychological, and social care. Also, they provide the elderly with a feeling of security, freedom and stability, and develop their abilities and potential, and help them in a positive ways to keep them away from the feeling of isolation.

On the other hand, the monthly fees vary from one to another according to the ability of the elderly or his family to pay. Sometimes, the elderly who doesn't have a provider can receive a free service. The number of residential homes was 18 institutions in 2009. 15 of residential homes are in West Bank and it clearly concentrated in the Middle Region that is Jerusalem , Bethlehem and ramallah . In Gaza Strip there are 3 residential homes which administrated by civil and religious organizations. Only one of them is administrated by the Social Affairs. Besides, there were 7 institutions for females and 8 institutions for males and females (Abofadala , 2009). The number of accommodation institutions in 2008 was 16 institutions. Two institutions were established in 2005 and there are three institutions seeking to obtain a license from the Ministry of the Interior. Only 0.5% of elderly in Palestine were receiving this services (PCBS, 2009).

The researcher believes that the residential homes of elderly may be an appropriate place for elderly to live if these residential homes meets the required services of elderly and if the living conditions in these institution are improved **.**

Clubs and centers:

Clubs and centers have reached the number of 9 in 2009 (Abofadala , 2009). They provide many social activities, services, and an entertainment for the elderly such as, lectures, trips.

Also parts of these centers are popular; they serve several age groups including the elderly in special programs, On the other hand, the programs of the unofficial centers remain irregular due to a lack of financial resources and due to the absence of long-term plan and short-term to ensure continuity (Shehadeh and KORT , 1997) .

2.6.3.2 Indirect services:

Institutions and non-governmental organizations are working to provide services for the elderly indirectly; they provide services to all groups including the elderly. For example; the religious institutions such as churches, monasteries and Zakat committees are one of the indirect services. They contribute to provide financial and material assistance for the elderly who doesn't have a provider or monthly income. In addition to the health centers that provide treatment in a nominal fees.

These services are unknown for the majority of members of the community and in particular the elderly, so this depends on people's awareness.

A study conducted by Ibrahim in 2009 about Problems of Elderly People in Palestinian Society among 136 of elderly person who used social welfare Institutions showed that the problems that faced the officials in social welfare institutions for elderly people were Political problems ,Economic problems represented by the lack of the budget of the social welfare institutions and the economical siege forced on the Palestinian people that prevents them receiving money from abroad. Social problems , these problems represented by lack of co-ordination between the social welfare institutions for elderly people and UNRWA , lack of services of health and medical care introduced by the Ministry of Health(Ibrahim , 2009).

Problems concerning regulations and laws of the elderly welfare , there aren't laws or legislations about elderly welfare and service in Palestinian society, either for providing social insurance or health insurance. Technical problems there is a clear lack in the number of psychological or social specialists working in the fields, to provide counseling, psychological and social services to elderly people. In addition, it is indicated that the monthly salary of these specialists is low (Ibrahim , 2009).

3.6.4 Laws and legislation for the elderly:

There are no special laws to protect the elderly as much as the disabled people. The elderly has been mentioned in some legislation, including the health insurance system as the following:

The decision of the Ministry of Health (1) in 1998 which issued on January 8, 1998 in Gaza, Appendix 3, and Article 1 stipulates that the health insurance covers the insured's family whom are: the father provided that he doesn't have an income and over the age of 60 and the mother provided that she doesn't have an income, over the age of 60 and widow. Even with this law only 54% of the elderly in the West Bank are covered by health insurance service . On the other side, there is another law which is called the Social Insurance Law. This law was acknowledged in October 19, 2004 which includes the insurance of the elderly, life insurance and death; also it includes the employees in the private sector. The employee is obliged to deduct part of the salary for the benefit of the insurance fund and the money will be retrieved after reaching the age of 65 or 60. Also the objectives of this law is to provide elderly people (1000 elderly / year) medical utilities in order to facilitate their movement and provision and for the elderly who are below the extreme poverty line(1000 elderly / year) (PCBS, 2009) .

Other law related to elderly is social insurance fund . This fund is working to pay alimony to those who submit a complaint about the provider, so this fund pays the amount on a regular basis. In case that the provider doesn't pay, the fund will take legal procedures against him (masader , 2008) .

It is noted that the laws and legislation is addressed to the elderly directly. It focuses on the educated elderly who are working in governmental jobs through the retirement law. This law is effective more than the social insurance law and social insurance fund which is not applicable due to the political and economical conditions in Palestine

2.7 Previous studies

2.7.1 Palestinians studies:

Sansur . (1998)**: Prevalence of disability and its socioeconomic impact among adult and older people in the west bank**

A cross sectional study was conducted by Michael S.Sansour in 1998 about the prevalence of disability and its socioeconomic impact among adult and older people in the west bank this study examined the nature and extent of disability among elderly as it related to self perceived ill health and trauma and the availability and extent of utilization of services in Palestinian society , the research sample comprised 1700 Palestinian men and women aged 55 to 98 years randomly drawn from urban , rural and refugee camp communities in three major geographical areas of the West bank . Data were gathered through structured interview utilizing a questionnaire screening scales assessed self perceived physical and mental health including depression and cognitive function and primary and secondary activities in daily living .

Result showed that 16% of respondent suffered debilitating cognitive dysfunction and needed assistance by relative during interview . Up to 28 %showed dependency for secondary ADL, more than 50% of respondent showed depressive symptom , physical and mental health deteriorated linearly with advancing age with women's perceptions of their own health and well being significantly worse than men physical and mental health indicator were also sensitive to educational level , income and level of family support (Sansur , 1999) .

Alshalabi . (1999)**: Old-Age. Homes in the West Bank and the Gaza Strip: Reality and Future Prospects"**

A cross sectional study was conducted by alshalabi in 1999 about Old-Age. Homes in the West Bank and the Gaza Strip , the aim of this study was to survey elderly homes in west

bank and gaza strip and the quality of its services also it surveyed the main problem that face elderly in these homes and their satisfaction about the services in these homes

Data were gathered through structured interview utilizing three designed questionnaires

Result showed that the structure of these homes were not healthy and their interior design were not suitable for elderly , 13 % of the employee in these home said that the structure of these homes are not qualified for housing the elderly , 24 %of the employee said that theses homes lack entertainment services also result showed that the employee who work in these homes are not qualified , 12% of them are illiterate , 30 % of them elementary educated and only 15% of them had university degree on other hand the result found that 43 % of elderly in these homes were neglected from their families ,10% of them were receive tough treatment also 28% of them suffer from psychotic symptom and 28 % of them suffer from enuresis. 67 % of them consider isolation and neglecting are the major problem that face them .

Hasanain**.** (2001**): Elderly : situations , needs and sources of support**

A cross sectional study was conducted by Hasanain about the elderly situation in the old city of Jerusalem in 2001, the aim of this study was to survey demographic data about elderly in old city of Jerusalem , their socioeconomic situation and their health situation Data were gathered through structured interview utilizing designed questionnaire.

Result showed that 60% of elderly live with their children and 23 % of them live with their relative , 61% of the elderly said the relation with their children are very good , 30% of them share in social activity and 34% of them had good social relation with neighbors and relatives . on other hand 91.2 % of them suffer from different disorders and 68 % of them said that their health problem prevent them from doing their daily activity . also the result showed that 12.5 % of elderly had not any income resources and amore than 50% of them were not satisfied by their income and 74 % lived in rental house .

Eisikovits.et al (2004) **: The National Survey on Elder Abuse and Neglect Israel**

. The First National Survey on elder abuse was conducted during 2003 in Israel by Eisikovits and a Winterstein.,. The purposes of the survey were: to examine the incidence,

prevalence and severity of various forms of elder abuse., to examine the nature of abuse and neglect from the perspective of the victims and to examine the correlates and predictors of elder abuse and neglect.

The survey was based on a national representative sample of urban dwellers, 1045 persons. The survey used cluster sampling techniques , while sampling proportionately Arab and Jewish persons. The final sample included 89% Jews and 11% Arab .

The instrument developed for the survey included: a socio-demographic component, one

related to health status, an ADL component for daily functioning, a measure of safety among the elderly, a measure including seven kinds of abuse, (physical, emotional, verbal, limitation of freedom, financial exploitation, and sexual abuse), an attitudinal measure assessing attitudes towards the elderly in general and towards elder abuse in particular.

Findings indicate that about 18.4% of the informants were exposed to at least one kind of

Abuse. The highest rates of abuse were verbal. The rates of reported abuse are similar among the Jews and Arabs (18.3% and 19.6% respectively). A significant difference was found in exposure to physical and sexual violence. Women reported higher rates of this kind of violence. This was particularly true for Arab women who were victims of such abuse in far higher numbers.

In addition a higher proportion of Jewish men compared to Arab were subjected to verbal abuse.. Significant differences were found among Jews and Arabs, with Arab women experiencing the highest rtes of limitation of freedom which may be the outcome of cultural differences and a tendency towards more patriarchal family structure among the Arabs. Also 25% of the elderly were subject to neglect which means deprivation of basic needs invarious domains.60% of neglected elderly were Jewish nationality40% of them were Arab .

Alissly (2005)**:Problem of elderly in Palestine in light of the currant political situation**

A discretional study was conducted by abdallh in the west bank in 2005 the sample of the study were 319 elderly person whose age above 60 year . the aim of the study was to identify the needs of elderly in Palestine in the current situation and their problems

The result of the study showed that the first problem that face elderly in palest in was psychological problems then social relation problem then physical health problems and finaly recreation problem. Also result showed that elderly suffer from anxiety from future , irritability and insomnia . also elderly people with the lowest education complained from different type of problem higher than elderly people who are more educated. On other hand elderly people outside the labor force suffered from different type of problem more than those taking part in the labor force.

Azaiza (2005) **: The Aging of Israel's Arab Population: Needs, Existing Responses, and Dilemmas in the Development of Services for a Society in Transition**

A survey study was conducted by Azaiza in 2005 the aim of this study was to survey social, economic, educational, and cultural differences between arab elderly and jewesh elderly in Israel**.** the result of the study showed that Arab population is younger than the Jewish population in Israel. At the end of 2005, only 3% of the Arab sector were 65+ as compared to 12% among the Jewish 65+primarily due to the higher fertility of the Arab population. As a result, the proportion of Arabs among the elderly (6%) is smaller than in the total population (19%). The percentage of Arab elderly who are disabled and need help with activities of daily living is twice as high as that of the Jewish elderly population. At present, 30% of the Arab elderly (39% of the women and

20% of the men), compared to 14% of Jewish elderly (17% of the women and 11% of the men), need help in at least one ADL (bathing, dressing, eating, mobility in the home, rising and sitting, getting in and out of bed).

44% of the Arab elderly report having problems with their vision, and 45% with their teeth (that is, in chewing), compared to 34% and 31% of the Jewish elderly, respectively

smoking is extremely widespread among elderly Arab men: 24% vs. 12% of elderly Jewish men. Arab and Jewish elderly also differ considerably in other health- related behaviors, such as physical activity: approxi- mately 38% of the Jewish elderly report performing regularly some type of physical activity compared to only 3% of the Arab elderly.

Differences were found with regard to the utilization of preventive health services as well .also the study showed negative attitude of elderly in Arab population toward social services because the attitude of the elderly themselves and of their families toward the formal services offered by the municipality or the state or other official bodies.

Palestinian Central Bureau of Statistics. (2006) : **Violence against Elderly People**

A cross sectional study was conducted by Palestinian Central Bureau of Statistics about the violence against Elderly People in Palestine the aim of this study was to survey the Spreading of the Violence Against the Elderly Phenomenon and types of elderly abuse

Result showed that 24.7% of elderly people in the Palestinian Territory have been subjected to violence however, emotional abuse is the most frequented pattern of elderly abuse since household members have emotionally abused (17.5%) of this category of the society. The second most frequented abuse is medical ignorance since (8.6%) of elderly people suffer such abuse; (5.8%) of them suffer economic abuse; and (5.7%) suffer physical abuse . also the result showed that Elderly people with the lowest education become victims to abuse at rates higher than elderly people who are more educated.

And elderly people outside the labor force have been subjected to all kinds of abuse at higher rates than those taking part in the labor force.

Dkaidek (2006) **: violence against elderly in east Jerusalem : explanation of this phenomena in perspective of elderly people themselves**

Qualitative and quantitative study was conducted by Dkaidek about violence against elderly in east Jerusalem in 2006 , the aim of the study was to identify the prevalence elderly abuse in east Jerusalem and to understand the different patterns of this phenomena . the sample of the study were 10 elderly person for the qualitative part of the study and 101elederly for the quantitative part .

The result of the study showed that elderly in east Jerusalem exposed to different types of abusing such as badmouthing, insulting, degrading, or physical harming. The patterns also include economic abuse or medical ignorance. 17 % of elderly people complain of disrespectful treatment and badmouthing from their suns and daughters. 2% of elderly

people suffer physical abuse, 5 %of them suffer economic abuse , 33% of elderly people believe that their suns and daughters do not fully care for them in providing them health care . 12% reported neglect in primary needs such as nutrition.

Palestinian Central Bureau of Statistics.(2007): **The Conditions and Requirements of Elderly Care in the Palestinian Territory 1997-2007**

A survey study was conducted by Palestinian Central Bureau of Statistics in west bank and Gaza strip about elderly of west bank in 2007 . the aim of the study was to survey

The demographic data of elderly and their socioeconomic situation in addition to identify the available health services for them also the aim of the study was to compare demographic data of elderly between the survey of 1997 and 2007 .

Findings indicate that number of elderly population increased from 132 thousands in 1997 to 152 thousands in 2007 but their ratio decreased from 5.1% in 1997 to 4.5 in 2007

56.1% of elderly were illiterate ,65.5% of them suffer from chronic diseases 14.8% of them had at least one disability, on the other hand 34.1% of elderly were poorly also 28% of elderly were not satisfied by their physical health , 20% said that their homes were not suitable to their needs and 75% of them were not satisfied by governmental services . the result showed that number of elderly organizations in west bank and were 24 belong to privet sector and one organization belong to government sector .

PCBS (2007): **Palestinian Family Health Survey** .

A Survey study was conducted by PCBS in 2006 showed that 9.0% of elderly persons aged 60 years and over in the Palestinian Territory lives alone. Also 18.9% of elderly persons who lives alone or with other family members indicated that their living conditions does not reach their satisfaction, of them 12.1% indicated that cramped living space is the main reason for their un-satisfaction. On the other hand, survey data showed that 13.6% of elderly persons indicate that their sons and daughters did not care them well. Also 3.8% of them that their sons and daughters did not respect them.

Data showed that 14.8% of elderly persons suffer from at least on disability, of which 15.0% males and 14.6% females , 15.5% of elderly practice smoking; 31.6% for males and 3.3% for female. On the other hand 20.5% of elderly persons evaluate their health status bad. According to services data showed that 31.7% of elderly persons did not receive any social services such as social care houses or health insurance, 70.0% out of those did not receiving any social services indicated that their first priority is the availability of health insurance.

Ja'far (2008) : **The Neurotic disorders among the elderly at the residential homes in the Northern governorates of Palestine**

Cross sectional study was conducted by Ja'far about the neurotic disorders among the elderly at the residential homes in the Northern governorates of Palestine in 2007 / 2008. The study aimed to define the neurotic disorders level among the old people at the residential home in the northern governorates of Palestine , and to find out the effect of socio demographic data on the neurotic disorders among the old people . the study sample was chosen through stratified random method and it consist of 145 male and female old people . The finding of the study indicated that 100% of elderly living in residential home had neurotic symptoms ; 29% of them had anxiety disorders, 28% had depression , 18% had obsessive – compulsive disorder . also the result showed that there is no significant difference in neurotic disorders in relation sex , age and shocking. On the other hand there is significant difference in hypochondriacal disorder in relation to social situation , in addition there is significant difference in obsessive – compulsive disorder in relation to educational level also there is significant difference depression and anxiety in relation to level independency of elderly people and the period they spent in residential homes.

Mataria et al , 2008 : **The Quality of Life of Palestinians under a Chronic Political**

Conflict: Assessment and Determinants

The aim was of this study was to assesses the quality of life of Palestinians and its determinants; and compares the results to similar assessments from 17 other developed and

developing countries. A multi-stage cluster sample design was used to select a sample of 1023 adults (18 years and older) from the general population living in the West Bank and Gaza Strip. The interviews were conducted over a three-week period at the end of 2005 by the Palestinian Central Bureau of Statistics. QoL social domain scored the highest followed by the physical, psychological and environmental domains. In contrast, 42% of respondents rated the physical domain as the most important factor in affecting their QoL compared to only 4% for the social domain, when requested to rank the importance of each domain in contributing to one's own assessment of QoL. Comparing QoL and health satisfaction responses to self-rated global health results from the WHO IFT and PQoL revealed that the OPT population reported significantly worse QoL than the WHO IFT pooled population (all countries). Almost 11% of the WHO IFT population reported 'poor' or 'very poor' QoL compared to almost 26% for the OPT population . Almost 23% of the WHO IFT population reported being 'dissatisfied' or 'very dissatisfied' with their health compared to about 14% in the OPT population . When comparing the WHOQoL-Bref mean domain scores, the OPT population ranks significantly lower than the 17 pooled WHO IFT countries (at the 5% significance level), except for the social domainFactor analysis and multiple regression techniques were implemented to determine the association between principle demographic and socioeconomic characteristics and scores of extracted principal determinants, and estimated overall and domain-specific QoL scores. Chronic and acute exposure to violence and entrenched conflict over generations has resulted in significantly lower QoL of Palestinians.

Hijazi and Abu Ghali 2008 **: The Elderly's Problems and its Relation to Psychological Hardiness "A Pilot Study on A Sample of the Palestinian Elderly at Gaza Governorates"**

Cross sectional study was conducted by Hijazi and Abu Ghali about The Elderly's Problems and its Relation to Psychological Hardiness in Gaza . The study aimed to identifying the problems the Palestinian elderly complained of at Gaza governorates, recognizing the level of their psychological hardiness, investigating the relationship between these problems and their psychological hardiness, and reporting the differences

between the two sexes in the problems and the level of psychological hardiness. The study sample consisted of (114) one from all female and male elderly at Gaza governorate randomly selected . two scales were selected to collect the data one investigate elderly problem and the other measure psychological hardness . The study results showed that the problems dimensions found in the society of the Palestinian elderly were ranked as follows: socio-economic problems (63.7%), psychological problems (57.5%), and physical health problems (56.4%). Also elderly suffered from four psychological problems were ranked as follows :anxiety 64.3% , loneliness 58.6% , depression 54.8% and alienation 51.6 % . In addition to that, the results concluded that there was a high level of psychological hardiness among the Palestinian elderly with a ratio of (70%) as hypothetical level, and reverse correlative relation between the problems and the psychological hardiness was also revealed, as this relation was

statistically significant. It was also indicated that there were no statistically significant differences between the two sexes in problems; where as there were statistically significant differences between them in the level of psychological hardiness in favor of the males.

Ibrahim , 2009: **Problems of Elderly People in Palestinian Society A Field Study in Social Welfare Institutions for Elderly People in the West Bank**

Descriptive study was conducted by Ibrahim Q about Problems of Elderly People in Social Welfare Institutions for Elderly People in the West Bank . The purpose of this study was to detect the problems that the elderly people and officials face in social welfare institutions for the elderly people in Palestinian Society .data were collected by using an interview questionnaire for 136 elderly people who live in Social Welfare Institutions for Elderly People in the West Bank also deep interview was given to five officials who work Social Welfare Institutions for Elderly People. The result of the study showed that the relationship between the family and relatives and friends of the elderly people developed more as a result of the exchange of repeated visits and constant communication. According to social problems the result indicated that (44.9%) of the sample had feeling of loneliness , (30.1%) of them said there was no one to look after me , (22.1%) of them thinking of the past, in addition of that the results of the study showed these feeling in the elderly ; the feeling of depression (19.1%), continuous stress and tension (13.2%), illness

affected me a lot and feeling of insecurity and comfort (12.5%). However 68.4% of the elderly people dwelling in social welfare institutions for elderly people don't have any income and 72.1% of the elderly people don't receive any pension salary . In addition The results of the study showed these health problems: Pains in feet and difficulty walking (53.7%), weakness of hearing (47.8%), feeling of tiredness when doing any hard work (30.1%), blood pressure (29.4%), rheumatism pains (25.0%), weakness of sight (24.3%), diabetes (17.6%), lack of appetite and headaches (14.0%), heart illnesses (12.5%), pains in kidneys (11.8%), constipation (11.0%), stiffness of two arteries and clots in the brain (7.4%) and continual weight loss (6.6%). According the psychological problem the result showed that (31.6%) of the sample had feeling of loneliness and isolation despite of the time spent with others, (24.3%) of them felt of forgetfulness , (23.5%) felt anxiety, (16.9%) of the elderly said that they feeling that I am absent - minded, I suffer from a lack of sleep and the idea of being affected by illness worries me (14.7%) and an urgent need to wander (14.0%). In regard to The problems facing the officials in social welfare institutions for elderly people the result showed that the main problems that face the officials were Political problems ; Economic problems ;Social problems ; Problems concerning regulations and laws of the elderly welfare and Technical problems there is a clear lack in the number of psychological or social specialists working in the fields, to provide counseling, psychological and social services to elderly people .

Imam **(** 2010**) : Palestinian Elderly Women's Needs and their Physical and Mental Health**

Qualitative and quantitative study was conducted by Imam A about Palestinian Elderly Women's Needs and their Physical and Mental Health . The purpose of quantitative part of this study was to assess health-related quality of life (HRQoL) of elderly women in the West Bank and the aim of Qualitative part of this study was to acquire an in-depth, firsthand understanding of elderly women›s health-related quality of life concerns and the factors which might boost or deter their morale and influence their health and psychological well-being.

Fifty elderly women aged 65 years and over were interviewed using open-ended questions. At the same time, a cross-sectional survey of 402 elderly women using Short

Form Health Survey (SF- 36) was conducted. The analysis of interviews revealed that most participants suffered from more than one physical disease. The majority of respondents (92%) maintained good social relationships with family members, relatives and neighbors. However, they also reported being unhappy and unsatisfied in their lives. The main negative feelings revealed by participants are classified into depressive symptoms, anxiety and loss of control and autonomy.

The results of quantitative data analysis showed that the majority of participants were

widowed (56.7%), illiterate (60%), covered by health insurance (72%) and never had paid work (75%). Only 16.2% evaluated their own economic status as being good and most of them had moderate or poor economic status. Only 17.9% had social security. The majority had cardiovascular problems (58.7%). By conducting bivariate analysis, it was found that the physical health of participants aged 65 to 69 years was better than that participants aged 70 years and older ($p \leq 0.001$). However, participants aged seventy years and above have better mental health than those aged 65 to 69 ($p \leq 0.001$). Literate women had better physical health than illiterate, while illiterate had better mental health ($p \leq 0.001$). The results showed that elderly women who participated in social activities have better overall physical and mental health than those who did not have social activities ($p \leq 0.001$). The widowed women have more physical health problems than others but they enjoy better mental health status ($p \leq 0.001$). The economic status of the elderly women have positive influence on their physical health ($p \leq 0.001$). Elderly women who had social security enjoy better physical health ($p=0.05$).

Azaiza et al **. (2010) : Death and Dying Anxiety Among Elderly Arab Muslims in Israel**

Death and dying anxiety were examined among elderly Arab Muslims in Israel. A total of 145 people aged 60 and over were interviewed using a standardized questionnaire. Nursing home residents reported higher death anxiety than others; women and uneducated participants reported greater levels of fear of death and dying than others. There were no differences based on religiosity. Death anxiety was related to gender and education for

elderly living in the community, but social support and self-esteem were additional correlates for those living in nursing homes .

2.7.2 Arabic studies

El-Adawy and Nandakumar (1998) **: Perception of Health Status and Limitations in Activities of Daily Living among the Egyptian Elderly.**

cross sectional study was conducted by Nandakumar et al in 1998 as a part of a national household survey, the Egyptian Household Health Utilization and Expenditures Survey (EHHUES to examine how the elderly perceive their health status, the extent of self-reported limitations in performing Activities of Daily Living (ADLs), and the socio-economic and gender differences among those with ADL limitations in Egypt Individuals were asked whether they had difficulty performing ADLs. In that sense,. No independent tests were done to verify the extent of performing an ADL if they needed assistance (partial or total) in performing the activity.

The sample for the survey was designed to provide national estimates of all major variables as well as estimates for different types of areas and for the five geographic regions: Urban Governorates, rural Lower Egypt, urban Lower Egypt, rural Upper Egypt, and urban Upper Egypt.

The result of the showed that, 66% of the sample reported having had no schooling,. Those who were married represented 67.94% of the sample, 29.99% reported being widowed, and the remaining 2.07% was single. Only 5.35% of the sample reported living alone with the remaining 94.65% living with either a spouse or relative.

Also the result showed that 9.72% of the sample felt their health status was either excellent or very good, 32.43% felt their health was satisfactory, and 19.47% considered themselves to be in poor health. The percentage of individuals who thought their health was excellent or very good declines with age. The study showed that males are more likely than females to perceive their health as being good or better (53.93% versus 43.68%), , and a higher proportion of those who were not married thought their health was either poor or satisfactory as compared with those who were married (60.34% versus47.92%). 58% percent of those reporting ADL limitations lived in urban areas as compared with 43% for

the entire sample, while 74% of males with ADL limitations were married the comparable number for females was only 25%. 82% of males with ADL limitations and 76% of females with ADL limitations actually reported receiving assistance.

The results showed that age is significant and positively correlate to ADL limitation . Being married was significant and negatively related to an ADL limitation . Having some level of education was not significant in reporting an ADL limitation.

Mahasneh (2000): **Survey Of The Health Of The Elderly In Jordan**

Cross-sectional was carried out in the city of Amman by the Jordanian Ministry of Health and WHO about The health of elderly in Jordan **.**

The purpose of this survey was to describe the health status of the elderly in Jordan. and to describe the health of the elderly both from a physiological and psychological point of view . Data were collected using an interview questionnaire that was completed by the research assistants from 420 elderly persons at their homes. The results indicated that 6.7% of the sample lived alone, 14.8% lived with their spouse 44.3% with their spouses and unmarried children, 21.9% lived with their extended families and The majority of the sample (93.6%) felt that their houses were safe . About 38% of the sample had no assistance at home . thirty-five percent of The sample used eyeglasses, 17.4% used walking aides and 4.8% used hearing aides. Twenty percent of the sample indicated that they needed assistive aides but they were unable to obtain them .About 10.5% of the sample perceived that their health was excellent, while 26% believed that their health was poor. Also 51.7% believed their health was similar to others. More than a quarter of the sample suffered from an accident or illness that affected their abilities to perform activities of daily living The present health problems as perceived by the sample were arthritis (48.6%), high blood pressure(37.4%), diabetes (26.9%), heart problems (14.0%), and accidents and falls (11%). About three-quarters of the sample took medication and the majority was capable of taking it by themselves (91%). About 19% believed that health care was unavailable for a health problem they had at present. The main reasons for not receiving care were the high cost of care (70.1%), not covered by health insurance (14.3%). Approximately three-quarters of the sample sometimes or always had feelings of

loneliness, being tired all the time, had difficulty of sleeping, anxiety and depression. About 22% of the sample did not visit their relatives.

More than two thirds the sample felt that they were consulted on family matters. Only 10% knew of agencies that work with theelderly in the community. The services needed and notavailable in the community were health insurance for the elderly (34.9%), community care for them (34.9%), public gardens or clubs (14%), clinic nearby (9.2%). About 44% of the sample benefited from services provided by governmental and nongovernmental agencies .

Abolfotouh et al(2001) : **Psychosocial assessment of geriatric subjects in Abha City, Saudi Arabia**

Psychosocial assessment of geriatric subjects was carried out through a home-based survey of people aged 65 years and over . the aim of this study was to estimate the prevalence of depression among geriatric subjects according to the Geriatric Depression Scale, determine functional capacity, perceived health status and to assess of the health status of the geriatric subjects based on previous diagnoses and use of medication. All people aged 65 years and above in the catchment areas of three primary health care centres were allocated to the target group for this study. The three primary health care centres were selected from six centres in Abha The total number of geriatric subjects aged 65 years and above registered at these centres was 919. A total of 810 subjects responded to the study, giving a response rate of 88%. All the participants in the study, and/or their caregivers, were interviewed during a home visit using a structured questionnaire that include Sociodemographic data, seven basic activities of daily living and each participant was questioned about physical health, symptoms related to different body systems and age-related health problems. The short version of the geriatric depression scale was used to screen for depression. It consists of 15 questions to be answered by yes or no.

The finding of this study indicated that , 4.5% of all subjects were living alone, 24.4% had recently lost one or more close person, 17.9% suffered from one or more chronic medical conditions, 5.6% used five or more medications, and 25.7% were not satisfied with the primary health care services available. Female geriatric subjects made up a

significantly higher proportion of those living alone, those who were dissatisfied with health services , and those who took large numbers of drugs. On the other hand, the loss of a close person and presence of chronic conditions were significantly more common in men. Regarding caregivers, over half the subjects were dependent on their children or other relatives. Only 25.1% had no caregiver. Female subjects were significantly more dependent upon their children, while the wife was the main caregiver for males The government provided financial support for 36.3% geriatric subjects, children for 27.2% and charitable organizations for 21.6% of subjects. Of all the subjects, 17.5% were scored as depressed, 26.6% had impaired functional capacity and 52.4% rated their health status as average or poor. All these rates were significantly higher among females than males also very old geriatrics (75 years and more) were significantly more likely to be depressed (28.3% versus 11.8%,), have impaired functional capacity (38.9% versus 19.6%,) and have perceived impaired health status (65.3% versus 44.0%,).

Sabbah et al , 2003 : **Quality of life in rural and urban populations in Lebanon using SF-36 health survey**

SF-36 was administered in a cross-sectional study, to collect sociodemographic and environmental variables. A representative sample containing 524 subjects, randomly selected aged 14 years and over. The translation, cultural adaptation and validation of the SF-36 followed the International Quality of Life Assessment methodology. Multivariate analysis (generalized linear model) was performed to test the effect of habitat (rural on urban areas) on all domains of the SF-36. The result indicated that patients resident in rural areas had higher vitality scores than those in urban areas. Older people reported more satisfaction with some domains of life than younger people, except for physical functioning. The QoL of women is poorer than men; certain symptoms and morbidity independently influence the domains of SF-36 in this population.

Ghubash et al , 2004 **: Profile of mental disorders among the elderly United**

Arab Emirates population: sociodemographic correlates

Cross-sectional was carried out in United Arab Emirates to investigate the prevalence, nature and sociodemographic correlates of mental disorders among the elderly United Arab Emirates (UAE) population.

Study subjects and sample UAE nationals aged 60 years or more, were recruited from within a random sample of households representing the UAE national population, irrespective of the age of individuals in each household. The sample included 843 households . Geriatric Mental State Interview and a short questionnaire for relevant sociodemographic data were used to collect data . One Arabic speaking doctor and seven arabic speaking nurses, were recruited as interviewers for this study. All of them had prior experience with community psychiatric research. They visited the targeted sample households to interview study subjects at their homes.

Results of this study found that total number of screened subjects was 610: 166 (27.2%) in Al-Ain; 286 (46.9%) in Dubai and 158 (25.9%) in Ras Al-Khaimah. There were 347 (56.9%) male subjects and 263 (43.1%) female subjects. The mean age of the interviewed subjects was 68.6 (SD 8.3). the prevalence of mental disorder were depression (20.2%), anxiety (5.6%), hypochondriasis (4.4%) , organic, mostly cognitive impairment with or without dementia (3.6%), Obsession(1.8%) and Phobia 0.2%.

Organic syndrome, as an independent entity, showed significant correlation only to older age, while the rest of the mental disorders showed significant correlation with female gender, insufficient income and being single, separated, divorced or widowed.

Moquaddam, et al (2005)**: General Practitioner's View of Geriatric Care in Kuwait**

Cross sectional study was conducted by Moquaddam. F et al about General Practitioner's View of Geriatric Care in Kuwait in 2005 , the aim of the study was to evaluate the availability and quality of geriatric medical careat the primary health care level from the general practitioner's point of view . Data were collected using Arabic and English questionnaire for general practitioners in 20 primary care centers covering five health areas in Kuwait. The result of the study showed that Eighty eight percent of general practitioners opined that the most frequent service provided by primary care was follow-up of chronic patients. Regular home visits and preventive health check ups were provided by

10 and 16% of practitioners respectively. Fifty percent of doctors rated geriatric care in Kuwait as good. Almost all doctors believed that regular healthy check ups are necessary to enhance the quality of general health in the elderly. 71% of doctors were not aware of the availability of any specialized geriatric care centers in Kuwait

An important barrier reported by 55.2% of the doctors for geriatric care was the absence of guidelines

Youssef (2005) **: Comprehensive health assessment of senior citizens in Al-Karak governorate, Jordan**

A community-based survey was conducted in Al-Karak governorate, south Jordan by Youssef between January and April 2004 the objective of this study was to assess the health status, mental well-being and functional capacity of senior citizens in a community. A cluster sample survey was used to identify 300 subjects aged 60 years and over . Data were collected by the researcher in the homes of elderly using a questionnaire that consisted of Sociodemographic characteristics , Chronic health problems endured based on previous diagnosis , Self-reported health status which included 14 questions pertinent to symptoms and complaints common to old age , Instrumental activities of daily living (IADL, Basic activities of daily living (ADL) , Limitation of basic movement using the Nagi physical disability scale , Evaluation of the mental status using a set of 10 questions on the participants' capabilities to know the date and day of the week, his age and year of birth…etc , Screening for depression was performed using the short version of the geriatric depression scale which includes 15 questions.

The result of this study indicated that Chronic health problems were reported by 74.4% of the participants; this was reported significantly more among women. Half of respondents had insomnia), lack of energy to perform daily activities (51.3%), constipation (46.0%), poor appetite (30.0%), impaired vision (30.0%), incontinence (26.0%) and hearing impairment (22.0%) were reported . Only 8.0% of the elderly participants were able to carry out all activities independently, More than a quarter of the participants (28.0%) reported impairment of activities of daily living, Limitation of one or more of the basic movements was encountered by 59.7% of the participants and 44.0% had a negative health

perception. A quarter of participants (24.3%) scored 5 or more points which indicates the presence of depression. Depression was significantly more likely among women , the uneducated , those who were single and those who lived alone. A higher risk of depression also was associated with deterioration of mental status , negative self reported health status (greater number of reported symptoms), poor self perception of health, limitation of movement as well as deterioration of instrumental and basic activities of daily living Women were more likely to have a poor self-perception of health , suffer memory impairment and limitation of functional capacity.

Abdel Rahman (2006): **Anxiety and Depression in Lone Elderly**

A cross sectional study was done by Abdel Rahma T about anxiety and depression among elderly aged 60 years or more in Cairo city , The aim of this study was to evaluate the prevalence of anxiety & depression in lone elderly living at their own homes & going to geriatric clubs regularly or living at geriatric homes. Subjects and method: 164 lone elderly participants from geriatric clubs (group I) & 168 lone elderly participants from geriatric homes (group II) were included in this study. Hamilton Anxiety Scale & Hamilton Depression Rating Scale were used for detection of anxiety & depression respectively. Result of this study was found that anxiety and depression are more prevalent in group II than in group I. Also depression is more common than anxiety in lone elderly. The prevalence of depression is 56.1% & 81% in group I and group II respectively ($p<0.001$), while, the prevalence of anxiety is 36.6% & 58.3% in group I and group II respectively ($p<0.001$). The co-occurrence of anxiety and depression is 34.1% & 57.1% in group I and group II respectively, while depression per se is 22.0% and 23.8% and anxiety per se is 2.4% and 1.2% in group I and group II respectively ($p<0.001$). multivariate logistic regression analysis revealed that living at geriatric homes, male gender and age group 60 to 70 are at higher risk for developing depression than those living at their own homes and going to geriatric clubs, female gender and age group above 70also it found that the independent risk factors for anxiety are living at geriatric homes and age group 60 to 70.

Chemali, et al (2008) **:Older adult care in Lebanon: towards stronger and sustainable reforms**

Elderly care in Lebanon was assessed through direct observation and review of the literature and legislation with the aim of drawing attention to the current situation and the need for improvement, and providing suggestions to address the problems. The weaknesses of elderly care in Lebanon and obstacles to reform include the stigma of age, an inefficient health care system, a lack of geriatric specialists and social/volunteer services, and inadequacies in nursing homes. Countering the negative perception of ageing, promoting social welfare, refurbishing nursing homes and empowering volunteer services are needed to improve the lives and care of the elderly. Sustained initiatives by governmental agencies, physicians, volunteer services and the community are essential. Adequate funding is also imperative.

Tohme , et al (2010) : **Socioeconomic resources and living arrangements of older adults in Lebanon: who chooses to live alone?**

This study conducted in depend on data from the Pan Arab Population and Family

Household Health Survey that was conducted by the Lebanese Ministry of Social Affairs in collaboration with the League of Arab States in 2004 as part of the 'Pan Arab Project for Family Health' (PAPFAM). the objective of this study was to assess the levels of various living arrangements and to examine the correlates of living alone, with a focus on economic resources. The sample was drawn using a three-stage, stratified, cluster-sampledesign. In the first stage, a systematic random sample of 15 geographical areas was selected covering Lebanon's six governorates. In the second stage, 459 probability sampling units were chosen randomly, and at the third stage, a random selection of 7,098 houses proportionate to population size was undertaken. Sample size was 1,759 elderly (aged 65 or more years) .

The findings of this study indicated that more than one-half of the participants had no formal schooling, and significantly more women (63%) than men (46%). Almost 15 per cent were beyond the retirement age but still working, including significantly more of the

men (25.8%) than women (2.8%). More than half of the sample were financially dependent on others, but almost two-thirds were satisfied with their current income, which was received either from their children (74.8%) or self-acquired (25.2%) .

Hypertension (36.8%), heart disease (23.2%), diabetes (21.6%) and rheumatic problems (19.2%) were the most prevalent reported chronic conditions.. Almost 15 per cent of the sample suffered from at least one ADL limitation . Around 12 per cent lived alone, with the percentage being around three times higher among women (17.3%) than men (6.2%). The majority were living with unmarried children and non-children others (43.9%), mainly in their own homes (89.2%). Supplementary analysis revealed that the percentage of those who were financially independent was highest among those living in their own homes (20.3%) and lowest among those living in another relative's home. (13.2%) ($p<0.001$) The propensity to live alone was significantly higher among women and among the oldest-old compared to their counterparts. Financially better-off older adults and those who reported being satisfied with their income were, respectively, 4.4 and 1.7 times significantly more likely to live alone than their counterparts .

2.7.3 International studies:

Lobo, et al (1995) : **The prevalence of dementia and depression in the elderly community in a southern European population. The Zaragoza study.**

A two-stage screening was completed in 1080 elderly. Sampling with replacement was done, and the cumulative response rate was 88%. In phase 1, lay interviewers administered the Spanish versions of the Mini-Mental State examination and the Geriatric Mental State Schedule-Automated Geriatric Examination for Computer Assisted Taxonomy package. In phase 2, research psychiatrists administered the same instruments and the History and Aetiology Schedule to all the probable cases and a similar number of randomly selected, probably normal subjects. The finding of this study indicated that 5.5% of the elderly were considered to have a dementia disorder, the most prevalent types being primary degenerative dementia, Alzheimer's type (4.3%), and multi-infarct dementia (0.6%). Depressive disorders were found in 4.8% of the elderly. Psychiatric morbidity, specifically depression, was associated with lower educational levels. "Case levels" of depression were

documented in 25.4% of the demented cases and case levels of "organic" disturbance were seen in 18.2% of cases of major depression.

Newsom and Schulz (1996)**: Social Support as a Mediator in the Relation Between Functional Status and Quality of Life in Older Adults.**

The relations among physical functioning, social support, depressive symptoms, and life satisfaction were examined in a national sample of 4, 734 adults age 65 and older. Regression analyses were used to examine the relative importance of objective and subjective support measures in understanding the relation between physical impairment and quality of life. Impairment was associated with fewer friendship contacts, fewer family contacts, less perceived belonging support, and less perceived tangible aid, but only measures of perceived support predicted depressive symptomatology. A structural equation modeling approach was then used to explore the mediational role of perceived social support in the relation between impairment and quality of life variables. Results of study showed that lower reported social support is an important reason for decreases in life satisfaction and increases in depressive symptoms found among older adult populations. Implications for understanding the role of social support in attenuating the effects of physical disability in older adults are discussed.

Kempen ,et al .(1997): **Adaptive responses among Dutch elderly: the impact of eight chronic medical conditions on health-related quality of life.**

Survey study aimed to analyze the impact of eight common chronic medical conditions on functional, social, and affective domains of health-related quality of life among community-based Dutch elderly (n = 5279). METHODS: Health-related quality of life was measured with six domains of the MOS Short-Form General Health Survey. This study found that compared with other domains of health-related quality of life, mental health was the least affected by chronic medical conditions. Back problems and rheumatoid arthritis/other joint complaints accounted for relatively high proportions of the variance in health-related quality of life (from 35.5% to 68.3%), except for health perceptions (22.6%), indicating that health-related quality of life is most affected by these two conditions.

Kohn , et al. (1997):**Clinical features of obsessive-compulsive disorder in elderly patients.**

This study describes the symptoms and characteristics of OCD among 32 outpatients age 60 or older and 601 younger patients meeting DSM-III-R criteria and given the Yale-Brown Obsessive-Compulsive Scale (YBOCS), NIMH scale, and a 41-item symptom questionnaire. Elderly patients had a later age at onset compared with younger patients. No differences were found in severity of symptoms on the YBOCS. Elderly patients had fewer concerns about symmetry, need to know, and counting rituals. Handwashing and fear of having sinned were more common. There were few differences in clinical features of OCD among the elderly patients compared with younger OCD patients.

Beekman *et al* . (1998) : **Anxiety disorders in later life: a report from the Longitudinal Aging Study Amsterdam.**

Longitudinal Aging Study Amsterdam (LASA) was conducted on a random sample of 3107 older adults to study the prevalence and risk factors of anxiety disorders in the older (55-85) population of The Netherlands. Stratified method for age and sex, which was drawn from the community registries of 11 municipalities in three regions in The Netherlands was used . Anxiety disorders were diagnosed using the Diagnostic Interview Schedule in a two-stage screening design. The risk factors under study comprise vulnerability, stress and network-related variables. Both bivariate and multivariate statistical methods were used to evaluate the risk factors.

Result of the study showed that the prevalence of anxiety disorders was estimated at 10.2%. Generalized anxiety disorder was the most common disorder (7.3%), followed by phobic disorders (3.1%). Both panic disorder (1.0%) and obsessive compulsive disorder (0.6%) were rare. Ageing itself did not have any impact on the prevalence in both bivariate and multivariate analyses. The impact of other factors did not change much with age. Vulnerability factors (female sex, lower levels of education, having suffered extreme experiences during World War II and external locus of control) appeared to dominate, while stresses commonly experienced by older people (recent losses in the family and chronic physical illness) also played a part.

Bennett (1998): **Longitudinal changes in mental and physical health among elderly, recently widowed men**

Longitudinal study was conducted between May and September 1985, during which time 1,042 people, both men and women, randomly sampled from Family Practitioner Committee lists, and demographically representative of the British elderly population, were interviewed in their own homes. The interview questionnaire contained a total of 318 items and covered aspects of health, lifestyle, demographic and socioeconomic status. The aim if the study was to assess mental and physical health, morale and social functioning among elderly widowed men and to compare them with a sample of age-matched still-married controls . The first complete follow-up of survivors, using identical methods and materials, was conducted between May and September 1989. All respondents who had participated in 1985, and who were still living in Nottingham, were invited to participate. The finding of the study indicated that there were no significant differences as a result of either marital status or time for mental health, morale or social functioning. However, there were significant interactions between time and marital status for these variables. Those men who had recently become widowed showed declines in mental health, morale and social functioning. Physical health showed a significant difference for time alone, with both the widowed and still-married men showing declines in physical health over the four year period.

Fry (2000) **:Whose Quality of Life Is It Anyway? Why Not Ask Seniors To Tell Us About It?**

Three hundred and thirty-one older adults participated in a study designed to examine their perceptions of what constitutes a reasonable quality of life. Participants responded to an open-ended questionnaire in which they were asked to state their priorities, preferences, aspirations, and concerns about their present and future quality of life. Responses were subjected to a principal components factor analysis which yielded four factors: 1) respondents demands for specific guarantees; 2) respondents aspirations and expectations for future quality of life; 3) fears and anxieties; and 4) external factors presenting a threat to quality of life. These factors accounted for 15 percent, 12 percent, 9.2 percent, and 7.1 percent, respectively, of the total variance. Additionally, data obtained from in-depth interviews with thirty-seven older adults were analyzed using a qualitative approach.

Contrary to stereotypic notions that elderly persons are frail, vulnerable, and resigned to deteriorating conditions of well-being in late life, the results of both the qualitative and quantitative components of the study showed the majority of respondents as having clear demands for autonomy, control, and independence in making decisions, including the decision to terminate life. Implications are discussed in terms of future research on quality of life of older adults.

Gee et al (2000) **: Living arrangements and quality of life among Chinese Canadian elders.**

This study examined the role of living arrangements in the quality of life of community-dwelling Chinese elders (aged 65 and over) currently residing in Vancouver and Victoria, British Columbia. Data are based on a random sample of 830 persons], who were interviewed in their homes in the language of their choice in 1995-96. Three dimensions of quality of life - satisfaction, well-being and social support - are examined for married men and women [living with spouse alone vs. living intergenerational] and widowed women [living alone vs. living intergenerational]. Few differences are found for married persons, especially women; for widows, living alone significantly reduces quality of life in a number of areas. Regression analyses indicate that living arrangements are not a significant predictor of life satisfaction or well-being for married men and women. For widows, living arrangements determine well-being but not life satisfaction. Overall, age, health status, and social support (having friends/confidante) are better predictors of quality of life for elderly Chinese Canadians than are living arrangements.

Bazargan et al , 2001 : **Paranoid Ideation Among Elderly African American Persons**

cross-sectional study was conducted among a sample of 998 independently living elderly African American persons **.** The aim of the study was to investigate The prevalence and correlates of paranoid ideation among elderly , the study used the Brief Symptom Inventory to measure paranoid ideation and 14 independent variables, including demographic characteristics, cognitive deficit, depression, selfreported memory functioning, emotional and instrumental support, stressful life events, limitation of daily activities, self-rated health status, and self-rated hearing and vision. The study found that Paranoid ideation (symptoms of paranoia) was found in 10% of this sample. A multiple

regression analysis of the data revealed that of the 14 independent variables used in this study, 6 (income, instrumental support, hearing, stressful life events, self-reported memory deficit, and depression) showed a significant relationship with paranoid ideation

Xavier et al.(2003) **: Elderly people´s definition of quality of life** .

Quanitative and qualitative study was conducted by Xavier and Ferraz about Elderly people´s definition of quality of life in Southern Brazil The aims of study were to identify the prevalence of octogenarian people who evaluate their current life as being mainly characterized by a positive quality and which were the domains that they identified as being the determinants of this positive quality. A same parallel study was conducted with subjects who evaluated senescence as a preponderantly negative experience. Out of a population of 219 subjects aged above 80, a random representative sample of 77 subjects (77/219 or 35%) of the octogenarian people, living residing in the community, was selected among the dwellers of the city of Veranópolis, state of Rio Grande do Sul. A semi structured questionnaire on quality of life quality with 5 non-inductive questions and open answers was proposed to the subjects as well as the scale of depressive symptoms Geriatric Depression Scale (GDS) and the index of general health Cumulative Illness Rating Scale (CIRS).. was used to quantify the general medical comorbidity. Data were collected by one geriatric physician and one psychiatrist. Each researcher applied part of the instruments being the global geriatric exam applied by the geriatric physician and the semi-structured clinical interview for quality of life, by the psychiatrist. The result of the study showed that more than half of the studied sample (57%) defined their current quality of life with positive evaluations, whereas 18% presented a negative evaluation of it. A group 0f 25% defined their current lives as neutral or having both values (positive and negative). On the other hand, the functionality to perform daily activities, the religiosity and the objective socioeconomic level of dissatisfied subjects were not different from satisfied ones Those who were dissatisfied presented more health problems according to the CIRS and more depressive symptoms when evaluated by the GDS. Satisfied subjects ones had different reasons to justify this state, however, the dissatisfied had mainly the lack of health as a reason for their suffering. The main source of reported daily well-being was the involvement with rural or domestic activities. Among the interviewed, lack of health was the main source for not presenting well-being, although there was interpersonal variability

regarding what each subject considered as loss of health. The presence or absence of satisfaction among the subjects was not associated to the gender.

Mein et al (2003) : **Is retirement good or bad for mental and physical health functioning? Whitehall II longitudinal study of civil servants**

Longitudinal study was conducted by Mein et al among civil servants aged 54 to 59 years at baseline, comparing changes in SF-36 health functioning in retired (n=392) and working (n=618) participants at follow up. Data were collected from self completed questionnaires**.** The aim of the study of the study was to determine whether retirement at age 60 is associated with improvement or deterioration in mental and physical health, when analysed by occupational grade and gender. The findigs of the study indicated that mental health functioning deteriorated among those who continued to work, but improved among the retired. However, improvements in mental health were restricted to those in higher employment grades. Physical functioning declined in both working and retired civil servants.

Canbaz, et al (2003)**. The Prevalence of Chronic Diseases and Quality of Life in**

Elderly People in Samsun

A cross-sectional study was conducted between March 1 and April 30,2001 to evaluate chronic diseases and measure the quality of life of elderly people in Samsun.

There were 8350 elderly people in the study area. The study group consisted of 835 elderly people, Except for 98 (11.7%) individuals, 737 of 835 elderly people participated in this study. In the first step of the study, the data of 737 elderly people were used, and then in the second step the data of 150 elderly people with a chronic disease were compared with the data of 150 elderly people, matched according to age, without any

chronic disease. All data were analyzed by using analysis of covariance (ANCOVA) for continuous and post-hoc Bonferroni test.

Ninety-six males (26.6%) and 54 females (14.4%) stated they did not have a chronic disease. In the study group, the scores of the SF-36 life quality scale subgroup decreased

with age in most of the categories except pain ($P < 0.05$). Participants with a chronic disease possessed significantly lower scores in all subgroups of the scale than the participants without a chronic disease ($P < 0.001$).

Alpass and Neville(2003)**.: Loneliness, health and depression in older males.**

This study investigated relationships between loneliness, health, and depression in 217 older men (≥ 65 years). Participants completed self-report measures of loneliness, social support, depression, and physical health. Regression analysis showed that a diagnosis of illness or disability was unrelated to depression, however self-reported health was associated with depression, with those reporting poorer health experiencing greater depression. Social support variables were unrelated to depression. The most significant relationship to depression was that of loneliness, with lonelier men reporting higher scores on the Geriatric Depression Scale (GDS).

Demura and Sato (2003) **: Relationships between Depression, Lifestyle and Quality of Life in the Community Dwelling Elderly: A Comparison between Gender and Age Groups**

This study aimed to investigate the relationships between depression and the characteristics of lifestyle and quality of life (QOL) of healthy, community dwelling elderly, and compare them according to gender and age groups. 1302 subjects (657 males and 645 females) were used for analysis. The investigators in this study were researchers working at universities in each prefecture. Data collection was conducted in a general delivery survey and interview setting or an education class setting. The geriatric depression scale (GDS) consisting of 15 items with a dichotomous scale was used to assess depression symptoms in the elderly. In addition, 16 items were used to assess the lifestyle of the community dwelling elderly. Family structure , Occupation , Subjective evaluation of health status:, Satisfaction with economic situation , Attending a hospital , Subjective evaluation of physical fitness , Sleeping status, Regularity of food habits , Smoking habit , Drinking habits , Frequency of going out , Frequency of exercise, Duration of continuing

exercise , Participation in volunteer activity , Prospects of life plan and goals in the future, Number of friends.

Furthermore, this study investigated life satisfaction, morale, and physical function with the LSI scale, PGC morale scale and the ADL scale of the Ministry of Education, Science and Culture, respectively. The finding of this study indicated that , depression characteristics of the elderly differ between gender and age groups. the mean values of the GDS score for gender and age groups were greater in female groups than male groups, and they were greater in the old-old groups than in the young-old groups.

The factors significantly related to depression in community dwelling elderly were the number of friends and morale. In particular, an increase in the number of friends was related to a decrease in depression. Depression in the old-old elderly was more significantly related to many lifestyle items compared with the young-old elderly, and especially in the old-old elderly, the extent of social activities related to a decrease in depression.

Gabriel and Bowling (2004)**. Quality of life from the perspectives of older people**

qualitative and quantitative study was conducted based on 999 people aged 65 or more years living in private households in Britain.The 999 survey respondents were interviewed in their own homes with a semi-structured survey instrument, and 80 were followed-up in greater depth at one and two years after the baseline interview. The material from the in-depth interviews is presented here. The main QoL themes that emerged were: having good social relationships, help and support; living in a home and neighbourhood that is perceived to give pleasure, feels safe, is neighbourly and has access to local facilities and services including transport ; engaging in hobbies and leisure activities (solo) as well as maintaining social activities and retaining a role in society ; having a positive psychological outlook and acceptance of circumstances which cannot be changed; having good health and mobility ; and having enough money to meet basic needs, to participate in society, to enjoy life and to retain one's independence and control over life. The results

have implications for public policy, and supplement the growing body of knowledge on the composition and measurement of quality of life in older age.

Robinson (2004). **Older Adults and Sexuality: The relationship to Quality of life**

descriptive correlational study,was conduted to examine the relationships among quality of life, sexuality, and intimacy in a sample of older adults. Also, the importance of sex life and the predictors of sexuality and quality of life for older adults were explored.

The convenience sample included 430 community-dwelling older adults between the ages of 60 and 99. The sample consisted of 271 females and 99 males who considered themselves to be healthy. Forty-two percent were married and thirty five percent had a university degree. The Quality of Life of Older Adults study was used to obtain the data for this study. It was found that sex life was considered to have the lowest relative importance of various aspects of quality of life. The most important aspect of quality of life for the participants in this study was ability to perform activities of daily living. Men considered sex life to be more important than women. Partnered participants considered it more important than non-partnered participants, and younger participants found it more important than older participants. Satisfaction with personal relationships, health status, and sexual activity were found to be predictors of quality of life in this sample, explaining 3 1% of the variance. Satisfaction with personal relationships explained the highest portion of the variance of quality of life, 22%. Intimacy, marital status, gender, and age were found to be predictors of sexual activity, explaining 76% of the variance. The portion of variance of sexual activity explained by intimacy was 67.

Breeze et. al (2004) **:Association of quality of life in old age in Britain with socioeconomic position: baseline data from a randomised controlled trial**

Randomised controlled study was conducted in 23 general practices in Britain to identify socioeconomic differentials in quality of life among older people and their explanatory factors. Outcome measures were being in the worst quintile of scores for, respectively, the Philadelphia geriatric morale scale and four dimensions of functioning from the sickness impact profile (home management, mobility, self care, and social interaction). People aged 75 years and over on GP registers at the time of recruitment, excluding those in nursing

homes or terminally ill. Of 9547 people eligible, 90% provided full information on quality of life and 6298 also did a brief assessment.

The results showed that the excess risk of poor quality of life for independent people renting rather than owning their home ranged from 27% for morale to 62% for self care. Self reported health problems plus smoking and alcohol consumption accounted for half or more of the excess, depending on the outcome. Having a low socioeconomic position in middle age as well as in old age exacerbated the risks of poor outcomes. Among people living with someone other than spouse the excess risk from renting ranged from 24% (95%CI −10% to 70%) for poor home management to 93% (95%CI 30% to 180%) for poor morale.

Ritchie et al (2004) : **Prevalence of DSM—IV psychiatric disorder in the French elderly population**

retrospective study was conducted by Ritchie et al in France to estimate current and lifetime prevalence and age of onset of psychiatric disorder. A study group of 1873 non-institutionalized persons aged 65 years and over was randomly recruited from the Montpellier district electoral rolls. The Mini International Neuropsychiatric Interview was used to assess current and lifetime symptoms. Cases identified by the application of DSM — IV criteria were re-examined by a clinical panel. The finding of this study showed that , 45.7% of the population sampled had experienced at least one psychiatric disorder in their lifetime and 17.4% were currently suffering from such a disorder. Lifetime . The prevalence of current depressive illness was 3.1% and the lifetime prevalence of major depression was 26.5%. Both lifetime and current prevalence were twice as high in women than in men . lifetime prevalence of anxiety disorders was 29.4% . Current prevalence rates were 14.2% for anxiety disorders, 10.7% for phobia, and 1.7% for psychosis. .

Sherina et al (2005) *:* **The prevalence of depression among elderly in an urban area of Selangor, Malaysia**.

A cross sectional was conducted in an urban area in the District of Selangor, Malaysia. by Sherina et al , the aim of this study was to determine the prevalence of depression and its

associated factors among the elderly (60 years old and above). All the elderly in Bandar Baru Bangian, an urban area of the state of Selangor, Malaysia were interviewed during a two month period. A 30-item Geriatric Depression Scale (GDS) questionnaire was used as the main screening instrument. Out of 316 elderly subjects, 300 were interviewed giving a response rate of 94.9%. The results showed that 6.3% of the elderly respondents were found to have depression. Gender (p=0.015), ethnicity (p=0.028), chronic illness (p=0.028), functional disability (p=0.000) and cognitive impairment (p=0.000) were found to be significantly associated with depression among the elderly respondents. The prevalence of depression among the elderly respondents in this study was 6.3% , the prevalence of functional disability was 23.3% and the prevalence of cognitive impairment was 8.3%. Gender, ethnicity, presence of chronic illness, functional disability and cognitive impairment were statistically significant associated with depression in the elderly .

Butterworth , et al(2006) : **Retirement and mental health: analysis of the Australian national survey of mental health and well-being.**

A cross-sectional survey of 10,641 Australian adults was conducted to explore the relationship between retirement and mental health across older adulthood, whilst considering age and known risk factors for mental disorders. Data were from the 1997 National Survey of Mental Health and Well-being,. The prevalence of depression and anxiety disorders was analysed in the sub-sample of men (n = 1928) and women (n = 2261) aged 45-74 years. Mental health was assessed using the Composite International Diagnostic Instrument. The finding of the study indicated that The prevalence of common mental disorders diminished across increasing age groups of men and women. Women aged 55-59, 65-69, and 70-74 had significantly lower rates of mental disorders than those aged 45-49. In contrast, only men aged 65-69 and 70-74 demonstrated significantly lower prevalence compared with men aged 45-49. Amongst younger men, retirees were significantly more likely to have a common mental disorder relative to men still in the labour force; however, this was not the case for retired men of, or nearing, the traditional

retirement age of 65. Men and women with poor physical health were also more likely to have a diagnosable mental disorder. The findings of this study indicate that, for men, the relationship between retirement and mental health varies with age. The poorer mental health of men who retire early is not explained by usual risk factors.

Gill, et al. (2006) : **Mental health and the timing of men's retirement**.

This study was conducted by using data from the Household, Income and Labour Dynamics (HILDA) in Australia survey (2003). The aim of this analysis was to investigate this pattern of results in a national sample of Australian men, and the mediating role of socio-demographic factors. The analyses included men aged 45-74 years who were active in the labour force (n = 1309), or retired (n = 635). Mental health was assessed using the mental health scale from the Short-Form 36 Health Questionnaire.

Results indicated that retirees were more likely to have mental health problems than their working peers, however this difference was progressively smaller across age groups. For retirees above, though not below, the age of 55 this difference was explained by poorer physical functioning. When age at retirement was considered it was found that early retirees who were now at or approaching the conventional retirement age did not display the substantially elevated rates of mental health problems seen in their younger counterparts. Further, men who had retired at age 60 or older did not display an initially elevated rate of mental health problems.

Borglin et al (2006). **Older people in Sweden with various degrees of present quality of life: their health, social support, everyday activities and sense of coherence.**

The aim of the study was to investigate the characteristics of a sample of people (75+) reporting various degrees of Quality of Life (QoL) with respect to QoL in different areas, as well as self-rated health, health problems, social support, everyday activities and sense of coherence. A postal questionnaire was sent out in spring 2001 to a randomly selected population-based sample (n= 600) in the southern parts of Sweden. A two-step cluster analysis was performed (n= 385, mean age 84.6, SD = 5.7) with 'present QoL' as clustering

attribute. Three groups were disclosed, classified as high, intermediate and low present QoL, of which 33.8% could be regarded being at risk of low QoL. Those with low present QoL (18.4%) were the oldest and most vulnerable, a majority were women with 'poor or bad' self-rated health, high frequencies of health problems, low total QoL, low social support and sense of coherence and less physically active. Those with high present QoL (47.8%) reported more 'excellent or good' self-rated health, physical activity, satisfactory social support and higher sense of coherence and total QoL than the other two groups. Those with intermediate present QoL (33.8%) had more of 'poor or bad' self-rated health, more health problems were less physically active, had lower total QoL and sense of coherence, and less social support than those with high present QoL. The sample seemed to reflect the ageing process in that the respondents were at different stages of ageing. However, the fact that the level of social support, sense of coherence and self-rated health followed the same curve as QoL may indicate that some are more vulnerable to low present QoL given the same health and these should be targeted in preventive programmes since they report low QoL.

Hewitt et al (2006): **Marriage dissolution and health amongst the elderly: the role of social and economic resources**

Survey study was conducted in Australia to examine the association between marital status and self reported general health in a population sample of Australian men and women aged 60 and over , The sample included 1195 women and 1105 men. SF-36 scale was used to measure health related quality of life . Results of study showed strong association between marital status and health among elderly women, where the divorced, widowed, and never married report better health than the married.. By contrast study found a weak association between marital status and health among elderly men.

Cleary and Howell **(2006) :Using the SF-36 to Determine Perceived Health-Related Quality of Life in Rural Idaho Seniors.**

The purpose of this study was to establish the perceived health-related quality of life (HRQoL) in people aged 65 and older in rural southeastern Idaho. Ninety-five people aged 65 and older completed the Short Form 36 version.

Subject scores were then compared to established normative values for the general U.S. adult population and specifically to normative values for people aged 65 and older. In general, the participant's HRQoL was lower than that of the general population. However, females aged 75 and older had higher physical component summary (PCS)

scores than their age- or gender-matched mates. Results of a regression analysis indicated that number of prescription medications taken ($p = 0.004$) was the only variable predictive of PCS scores. Results suggest that participants aged 75 and older have a higher HRQoL than suspected, which could indicate that rural residence is not an immediate indicator of decreased quality of life in the elderly.

Aris and Draman (2007): **Physical and Mental Health Problems of the Elderly in Nursing Homes in Kuantan, Pahang**

A cross-sectional study design was carried out by Aznan and Draman among the The elderly in two selected nursing homes in Kuantan **.** The aim of study was To describe the residents of nursing home for the elderly in relation to their socio-demographic, physical and mental profiles. The respondents were interviewed using a structured questionnaire which included the biodata, social background, and medical illness, presence of cognition, depression and ability to perform basic activities of daily living (ADL). The Results of this study found that most respondents (86.1%) suffered from chronic illness, 61.1% were functional dependent, 33.3% have cognitive impairment and 22.2% have depression (according to GDS-14). The most common functional dependence was mobility on level surface (47.2%), followed by climbing stairs (38.9%).

Jeon et al , (2007) **: Gender differences in correlates of mental health among elderly Koreans.**

Survey study was carried to examine the differential impact of social roles and socioeconomic resources on the mental health of Korean men and women aged 65 years or older. The study sample was a weighted population of 930 people aged 65 years or older who had responded to the health behavior survey of the 2001 Korean National Health and Nutrition Examination Survey. The finding of this study showed remarkable gender differences in the correlates of poor mental health. Living alone was significantly associated with depressive symptoms and suicidal ideation in men but not in women.

Living in a multigenerational family without a spouse and having a lower household income were significantly associated with poor mental health in both men and women.

Taqui et al ,(2007)**: Depression in the elderly: Does family system play a role? A cross-sectional study.**

A cross-sectional study was carried out in the premises of a tertiary care hospital in Karachi, Pakistan. All consenting subjects, aged 65 years and above, and who were permanent residents of Karachi (residing more than 2 years in the city) were included in the study. The subjects comprised of both patients and attendants and the sample size was 426 subject . Questionnaire based interviews were conducted among the elderly people visiting the hospital. Depression was assessed using the 15-item Geriatric Depression Scale.

The result of the study showed that the age of majority of the subjects ranged from 65 to 74 years. Seventy eight percent of the subjects were male. The prevalence of depression was found to be 19.8%. Multiple logistic regression analysis revealed that the following were significant independent predictors of depression: nuclear family system, female sex, being single or divorced/widowed, unemployment and having a low level of education. The elderly living in a nuclear family system were 4.3 times more likely to suffer from depression than those living in a joint family system

Ormel et al (2007) **: Mental disorders among persons with heart disease — results from World Mental Health surveys.**

Eighteen surveys were carried out in 17 countries in the Americas (Colombia, Mexico and United States), Europe (Belgium, France, Germany, Italy, The Netherlands, Spain and Ukraine), the Middle East/Africa (Israel, Lebanon, Nigeria and South Africa), Asia (Japan and China, and the South Pacific (New Zealand) about Mental disorders among persons with heart disease . the objectives of this study were to estimate the prevalence of specific mood, anxiety and alcohol use disorders among persons with and those without heart disease and to assess whether these associations are consistent across

culturally and socioeconomic diverse countries . All surveys were based on multistage and clustered area probability household samples. All interviews were carried out face to face by trained lay interviewer . The World Health Organization (WHO) translation protocol was used to translate instruments and training materials . All surveys used the World Mental Health (WMH) . Survey Version 3.0 of the WHO Composite International Diagnostic Interview a fully structured diagnostic interview, to assess disorders and treatments. Disorders considered in this study include anxiety [generalized anxiety disorder (GAD), panic disorder and/or agoraphobia, posttraumatic stress disorder (PTSD) and social phobia], mood (dysthymia and major depressive disorder) and alcohol use (alcohol abuse and dependence) disorders. Disorders were assessed using the definitions and criteria of the Diagnostic and Statistical Manual of Menta Disorders, Fourth Edition . In a series of questions about chronic conditions adapted from the U.S. Health Interview Survey . respondents were asked about the presence of selected chronic conditions. More specifically, respondents were asked if a medical doctor or any other health professional had ever told them that they had a heart disease.

Finding of this study indicated that Specific mood and anxiety disorders occurred among persons with heart disease at rates higher than those among persons without heart disease. for alcohol abuse/dependence among persons with versus those without heart disease. These patterns were similar across countries.

The specific anxiety disorders (GAD, panic disorder/agoraphobia, social phobia and PTSD) were generally less prevalent as compared with major depression. Among persons with heart disease, the prevalence rates of GAD ranged from approximately 0.3% in Lebanon to approximately 5% in Ukraine, the United States and France, The prevalence of agoraphobic/panic disorder among persons with heart disease typically fell in the range of 1–5% . The prevalence rates of social phobia ranged from 1% (Spain) to 6% (United States) among persons with heart disease in the remaining surveys . PTSD was relatively uncommon among persons with heart disease in many of the participating surveys but had a prevalence of 2% or higher in the United States, France, Italy, The Netherlands and Ukraine. association of depression with heart disease, was actually not stronger than the association of anxiety disorders with heart disease. This held true for the total population and for respondents aged 50 years or older.

HSU (2007): **Gender Differences in Health-related Quality of Life among the Elderly in Taiwan**

The aime of This study was to examines the gender disparity in the elderly's health-related quality of life in Taiwan. Data came from the National Health Interview Survey, a series of nation-representative face-to-face interviews held in Taiwan in 2001. The samples were chosen from those aged 65 or over, including populations drawn from the Taiwan area (with a number *n*=1845), remote mountain areas (*n*=169), and offshore islands (*n*=179). Health-related quality of life (HQOL) was measured by SF-36, including the dimensions of physical functioning, role limitation due to physical problems, bodily pain, general health, vitality, social functioning, role limitation due to emotional problems, and mental health. Two-stage linear regression models were used for analysis. Results of study indicated that elderly women showed lower HQOL in almost every dimension in the Taiwan area and offshore islands. After controlling for age, education, marital status, activities of daily living, and numbers of chronic diseases, women elderly showed a lower score in HQOL than men, and the difference was the most prominent in bodily pain which had a 23.6% lower score. The elderly in offshore islands and mountain areas had a lower HQOL than that in the Taiwan area. Other effects were greater than gender for the elderly in remote mountain areas.

Weele1 et al (2008) **. Co-occurrence of depression and anxiety in elderly subjects aged 90 years and its relationship with functional status, quality of life and mortality.**

A population based cohort study to examine the prevalence of concurrent depression and anxiety and its relationship with functional status, quality of life and mortality in individuals at age 90.

Depression (15-item Geriatric Depression Scale) and anxiety (Anxiety Screening Questionnaire) were assessed in all 90-year old subjects with_19 points on the Mini Mental State Examination (MMSE). Functional status included: cognitive function (MMSE) and disability in activities of daily living (Groningen Activity Restriction Scale). Quality of life included: loneliness (Loneliness Scale of De Jong-Gierveld) and life satisfaction (Cantril's ladder). For all subjects mortality data were available up to a maximum age of 95.3 years.

Results Of the subjects aged 90 years with MMSE _19 points (56 men, 145 women), 50 subjects experienced depression and 25 subjects anxiety; of them 34 (17%) experienced depression only,

9 (4%) anxiety only, and 16 (8%) both depression and anxiety. Presence of depression was associated with an overall decreased functional status and quality of life and with increased mortality.Within the depressed group, subjects with anxiety did not differ from subjects without anxiety, except for higher loneliness scores.

Ross and Zhang (2008)**: Education and Psychological Distress Among Older Chinese.**

Suray study was conducted by Ross and Zhang to see if more highly educated older Chinese have lower levels of distress than do their poorly educated counterparts and whether engaging in cognitively stimulating activities such as reading and playing mahjong explains the association. The results of the study found a significant negative association between education and psychological distress. Much of the association is mediated by activities,. Reading, playing mahjong, and watching television all negatively correlate with distress.

Lulecia et al(2008) **:Assessing selected quality of life factors of nursing home residents in Turkey .**

The aim of this study was to investigate the relationship between socio-demographic factors, health-related behaviors, residents' satisfaction, and functional disability levels among elderly people living in nursing homes in Turkey using the World Health Organization's Quality of Life-BREF (WHOQOL-BREF). Data regarding socio-demographic characteristics, chronic health problems, health-related behaviors (smoking, alcohol consumption, physical activity, etc.) were collected from the study group (N = 107) by a structured questionnaire during face-to-face interviews. Dependencies in activities of daily living (ADL) of the study group were also assessed using Katz's ADL index. The mean WHOQOL-BREF scores were significantly higher in participants who had independence in performing ADL (bathing, dressing, toileting, transfer, continence, feeding) . It was found that WHOQOL-BREF scores were positively associated with having physical exercise habits and residents' satisfaction with nursing homes; being dependent in dressing were significant predictors of in the study. Residents' satisfaction

from living nursing homes and participation in physical exercise were significant predictors of WHOQOL-BREF scores for those that participated in this study.

Ceremnych (2008) **. Quality of life by age in older women living in Vilnius community and their views on health and social care**

The aim of this study was to assess, using the WHOQOL-100 questionnaire, different aspects of quality of life (QOL), overall QOL and satisfaction with health and social care in a representative sample of older women living in the Vilnius community.

. Respondents (389 elderly females) were randomly selected from the Vilnius community register. Information was obtained by interviews. The sample was stratified

according to age; The main outcome measures were the mean scores of the WHOQOL-100 subscales (QOL domains and aspects) and the total score of overall quality of life. WHOQOL-100 facet scores were calculated according to the WHOQOL scoring methodology . Comparison of the mean values of WHOQOL-100 subscales revealed association with age. No significant difference in the evaluation of the overall QOL was found among the age groups of elderly females. Also the lowest QOL scores were reported for the oldest females in three domains: physical capacity ($p = 0.004$), the level

of independence ($p = 0.0001$), environment ($p = 0.047$).and about 25% of females in all age groups were dissatisfied with the availability of care services.

Tajvar et al (2008) **:Determinants of health-related quality of life in elderly in Tehran, Iran.**

cross-sectional survey was conducted by Tajvar et al about Determinants of health-related quality of life in elderly in Tehran, The purpose of this study was

to measure health-related quality of life (HRQoL) of elderly Iranians and to examine the association between several important characteristics of elderly people in Tehran including sex, age, education, living status, marital status and economic status with HRQoL. And to

understand whether these variables are the significant predictors for HRQoL in the elderly people or not. The sampling method was based on a multi-stage

stratified sampling approach and 400 elderly Iranians aged 65 years and over were interviewed. HRQoL was measured using the Short From Health Survey (SF-36). The SF-36 includes 8 subscales namely: Physical functioning (PF), Role physical (RP), Bodily pain (BP), General health (GH), Vitality (VT), Social functioning (SF), Role emotional (RE), and Mental health (MH). It also provides two summary scales, Physical Component Summary (PCS) and Mental Component Summary (MCS). The study participants were interviewed at their homes. Uni-variate analysis was performed for group comparison and logistic regression analysis conducted to predict quality of life determinants. The finding of this study indicated that the majority of the participants were men (56.5%) and almost half of the participants were illiterate (n = 199, 49.8%). Eighty-five percent of the elderly were living with their family or relatives and about 70% were married. Only 12% of participants evaluated their economic status as being good and most of people had moderate or poor economic status. The mean scores for the SF-36 subscales ranged from 70.0 (SD = 25.9) for physical functioning to 53.5 (SD = 29.1) for bodily pain and The mean (SD) of physical and mental summary scores were 55.01 (25.66) and 63.86 (23.86) respectively; indicating that the mental status of the participants was significantly better than their physical condition ($P < 0.0001$). The result found that women reported significantly poorer HRQoL. Multiple logistic regression analysis showed that for the physical component summary score of the SF-36, age, gender, education and economic status were significant determinants of poorer physical health-related quality of life; while for the mental component summary score only gender and economic status were significant determinants of poorer mental health-related quality of life. The analysis suggested that the elderly people's economic status was the most significant predictor of their HRQoL.

Nejati1 et al (2008)**: Quality of life in elderly people in Kashan, Iran.**

A cross-sectional study was conducted by Nejati about Quality of life in elderly people in Kashan, 389 elderly persons (aged ≥ 60 years) was selected randomly from 120 zones of Kashan city. Data for this study were collected between April 2005 and

April 2006. The sample was restricted to people living in non-institutional settings

The objective of this study was to identify determinants of quality of life and investigate their association with physical and social functions, physical and emotional roles, and physical and mental health among older people in Kashan, Iran. structured interview consisted of 36 questions including sub-questions related to different aspects of life by using on SF-36 health survey. SF-36 is a generic questionnaire for the measurement of quality of life, and covers 8 dimensions of health status and 2 summary areas, one physical and one mental. The result of the study showed that mean age of participants was 69.8±7.74 years. There were no significant differences in the mean age (P=0.465) and marriage condition (P=0.125) between the two genders, but illiteracy was more frequent in women (P<0.0001). Literacy was found in 31.2% of men and only 8.5% of women, whereas only 1.4% of men and 0.5% of women had a postgraduate degree.The mean score of aspects of physical function (P<0.0001), general health perception (P<0.0001), physical role (P<0.0001), vitality (P=0.0007), mental health (P=0.003),

and bodily pain (P<0.0001) in men was higher than in females, whereas social function (P=0.844) and emotional role (P=0.397) were similar between the two genders. Illiteracy is common in elderly people, and quality of life in men was higher than women in all aspects.

Martins, et al (2009) **. Quality of life among elderly people receiving home care**

services

cross-sectional study was conducted to assess and describe the quality of life of elderly people receiving home health care services. . A random sample of 50 elderly people who were registered in the Family Health Program of four Healthcare Units participated in the study. Data were collected with the WHOQOL-100 questionnaire. The finding of the study indicated that participants were having difficulties to perform activities of daily living and needing assistance with medication use, environment safety, and access to healthcare. The participants also had difficulty with their sexuality and financial resources**.**

Lima at el (2009) : **Impact of chronic disease on quality of life among the elderly in the state of São Paulo, Brazil: a population-based study**

A cross-sectional and population-based study was carried out by Lima , Barros and others about Impact of chronic disease on quality of life among the elderly in the state of São Paulo, Brazil from 2001–2002. The aims of study were to to assess the impact of chronic disease(arthritis, back-pain, depression/anxiety, diabetes, hypertension, osteoporosis, and stroke) on the various aspects of health-related quality of life (HRQOL) among the elderly. Sampling for this study was carried out through a two-stage stratified cluster procedure , sample size was 1 958 individuals who were 60 years of age or more. Data were collected by the SF-36 Health Survey which include 8 scales(physical functioning, role-physical, bodily pain, vitality, general health, role-emotional, social functioning, and mental health) that was administered directly to the sampled individuals by trained interviewers. The result of the study showed that 13.6% reported not having any of the illnesses, whereas 45.7% presented three or more chronic conditions. the presence of any of the seven chronic illnesses studied had a significant effect on the scores of nearly all the SF-36 scales. HRQOL achieved lower scores in

role-physical and role-emotional for those with diabetes; role-emotional for back-pain; social functioning for stroke; social functioning and role-emotional for osteoporosis; social functioning for arthritis/ rheumatism/arthrosis; and role-physical for depression/anxiety . quality of life achieved lower scores when related to depression/

anxiety, osteoporosis, and stroke . The higher the number of diseases, the greater the negative effect on the SF-36 dimensions. The presence of three or more diseases significantly affected HRQOL in all areas. The bodily pain, general health, and vitality scales were the most affected by diseases.

Lena et al (2009) **: Health and Social Problems of the Elderly: A Cross-Sectional Study in Udupi Taluk, Karnataka.**

Descriptive study carried out in the Department of Community Medicine in South India by Lena A about Health and Social Problems of the Elderly in India over a period of 1 year from January to December 2003 . the aim of the study was to identify health and social problems of the elderly and their attitude towards life . A total of 213

elderly patients (60 years old and above) who attended the outreach clinics were interviewed using a pre-tested schedule. Findings of the study showed that 73% of the sample belonged to the age group of 60-69 while a small fraction (2.8%) were 80 years old or older years old Only 12.1% of the elderly men were

widowed while 67.7% of the women were widows. The unmarried group of 2.3% was comprised of only men. . Nearly half of the respondents were illiterate. 98% of the respondents felt that old age had affected their day-to-day life. Among these, 86.4% felt that age had partially affected their daily activities. Half of the people interviewed felt neglected by their family members, while 47% felt unhappy in life and 36.2% felt they were a burden to the family. A majority of them had health problems such as hypertension followed by arthritis, diabetes, asthma, cataract, and anemia. About 68% of the elderly said that the attitude of people towards the elderly was that of neglect. 40% of the respondents interviewed had feelings of insecurity while around 56.3% were deprived of financial security, 48% of the respondents felt sad mainly because of poverty followed by illness (41.3%). 68.5% of the respondents had friends and social contacts outside the home. In case of a conflict with family members, nearly half of the respondents (45%) preferred to sleep in order to get over it, 33% preferred to discuss it with others, and 20% preferred to find a solution.

52% of the respondents felt that old age affected their role in the family. A total of 35% of the respondents felt they were not consulted by the family members for making decisions. They felt they were ignored by family members because of their physical illness and economic dependence. In spite of being unhappy due to these problems, they still preferred their home to an old age home for their residence

Etemadi and Ahmadi (2009) **: Psychological Disorders of Elderly Home Residents.**

a descriptive study was conducted by Etemadi and Ahmadi on the elderly living at nurseries in Tehran, Iran The aims of this study was to asses old age problems especially for those living at elderly homes and extending counseling services to the vast and new field of geriatrics in Iran. In this study 120 old people who lived at governmental and private elderly homes in Tehran, Iran were randomly selected and studied using SCL90 and Beck Depression Inventory. The results showed that 62% of the residents of nurseries had at least one symptom of psychological disorders. The most frequent symptoms were, in decreasing order, seen in the following scales: depression 32.5%, somatization 27.5%, obsessive-compulsive 19.1%, anxiety 18.3%, interpersonal sensitivity 15.8%, hostility 12.5%, psychoticism 9.1%, paranoid ideation 8.3% and phobic anxiety 5.9% . The most worrying issues for the elderly were economic status (55.8%), lack of social relations (55%), dissatisfaction with old age (45.8%) and lack of favorite activities (45%) .

In all studied clinical scales, the rate of psychological symptoms was more among women than men. The most important worries of the elderly were economic status, social relations, dissatisfaction with old age, lack of favorite activities and their family members` treatment. Since living at an elderly home means staying away from family support and that it is considered reproachable, attending to psychological and emotional needs of the elderly home residents is essential.

Glasser et al (2009) **:Geriatric depression assessment by rural primary care physicians**

A survey study was carried out among 162 rural family physicians and general internists to assess rural primary care physicians' practices, attitudes, barriers and perceived needs in the diagnosis and treatment of geriatric depression. The survey focused on current practices, attitudes and perceptions regarding geriatric depression, barriers to and needs for improvement in depression care and physician and practice characteristics.

The finding of the study indicated that 76 physicians (47%) responded. The rural physicians indicated that over one-third of their patients aged 60 years and older were depressed. All reported routine screening for depression, with 24% using the Beck Depression Inventory. Overall, physicians expressed positive attitudes about their involvement in treating older depressed patients. However, 45% indicated a 'gap' between

ideal and available care in their rural practices. Physicians with higher proportions of elderly patients in their panels were more likely to feel that more training in residency in geriatric care would be helpful in improving care, and that better availability of psychologists and counselors would be important for improvement of care for older, depressed patients.

Kirmizioglu , et al. (2009)**. Prevalence of anxiety disorders among elderly people.**

The objectives of this study were to determine current and lifetime prevalence of anxiety disorders and also to explore the relationship, if any, between possible risk factors and anxiety disorders, amongst elderly people living in the Sivas province of Turkey. The research sample consisted of 462 persons. A Socio-demographic Data Form was given to the participants and the Anxiety Module of SCID-I was applied. The current prevalence for all types of anxiety disorder was found to be 17.1% overall and the lifetime prevalence was found to be 18.6%. The current prevalence rates for particular disorders were found to be 0.4% for panic disorder, 3.2% for obsessive-compulsive disorder, 1.9% for post-traumatic stress disorder, 2.8% for social phobia, 11.5% for specific phobia, 6.9% for generalized anxiety disorder (GAD). Lifetime prevalence rates for these disorders (except GAD) were 1.1%, 3.2%, 3.0%, 2.85%, 11.5% respectively. Anxiety disorders are more common among elderly people than was previously thought. The lifetime prevalence of specific phobia amongst the elderly is higher than that of general population; the lifetime prevalence ratios of obsessive-compulsive disorder and social phobia are similar to that of the general population in Sivas.

Akyol et al. (2010)**. Quality of Life and Level of Depressive Symptoms in the Geriatric Population.**

This study was conducted to investigate the effects of the general state of health and personal characteristics on quality of life in elderly patients, and to evaluate the relationship between the level of depressive symptoms, pain intensity, and quality of life.

One hundred twenty individuals ≥65 years of age were included in the study. All subjects were evaluated using a questionnaire form, including items about demographic and clinical information ,the intensity of pain was assessed by a visual analogue scale (VAS), quality of life was assessed by the Short Form-36 (SF-36), and the level of depressive symptoms was assessed by the Geriatric Depression Scale (GDS).

Results of this study showed that the Chronic diseases were present in 80.8% of the subjects (n=97) and hypertension was the most prevalent disease (49.7%). There was a significant negative correlation between quality of life and pain intensity and level of depression. When evaluated according to educational status, significant differences were found between the groups in some quality of life parameters (physical functioning, social functioning, mental health, and bodily pain) and the GDS ($p<0.05$). When evaluated according to the presence of chronic diseases, significant differences were also found between the groups in physical functioning, social functioning, vitality, and bodily pain subscales of quality of life measures and the GDS ($p<0.05$).

Paskulin et al. (2010)**: Elders' perception of quality of life**

cross-sectional descriptive study was conducted to explore the perception of quality of life of elders from a health care district in Porto Alegre, and to identify the most common dimensions of voice by the elders. The following open question was used : What quality of life means to you? and Portuguese version of the WHOQOL-100 and the module WHOQOL-OLD.

Participants consisted of 260 elders who were residents of Porto Alegre,. Results showed that the majority of participants reported that quality of life was synonym of good health. The most common dimensions of quality of life were positive feelings, personal relationships, and access to food.

Thomopoulou et al (2010)**:The differences at quality of life and loneliness between elderly people**

The purpose of the present study was to examine the differences at quality of life and loneliness between elderly people. Data were collected from 180 persons aged 60 - 93 years old from Greece. Quality life was estimated through the Quality of Life Index, loneliness through the UCLA Loneliness Scale, and demographic characteristics with a questionnaire. The finding of the study indicated that males had higher scores of QOL than females, older than oldest old and finally married than divorced and widows/ers respectively. Concerning loneliness, males scored lower than females, older than oldest old and married than divorced and widows/ers respectively. The internal consistency of the Quality of life .

2.7.4 Comments on previous studies:

Through the educational literature, reviewed by the researcher, she noticed the lack of Palestinian and Arab studies on the subject of the elderly compared to foreign studies. It should be noted that the first study of the elderly in Palestine was in (1998), and this indicates that ,scientific interests in studying elderly conditions in Palestinian is very new . The researcher also noticed that there are only two Palestinian studies that deals with the elderly quality of life .

As for the Foreign Studies, she noticed the diversity of foreign studies that deals with the issues of the elderly ,these studies have examined the different variables and their relationship to mental health and quality of life for them ,and these are what local and Arab studies lack of.

For these reasons we can consider this study as one of the few local and Arab studies that deals with the elderly quality of life in our community .

It also studied the mental health of the elderly from more than one side, and the results that this study have, may give some more indications for the researcher or other researchers to carry out more specialized studies in this field.

Chapter Three

Methodology

3.1 Study design

A cross-sectional correlational study, was carried out in 2010 and 2011, and was conducted on a convenience sample of elderly people (ages 65 and above) residing in Bethlehem district in Palestine. In this study, a structured questionnaire on quality of life (WHOQOL-Bref) as well as the scale of BSI for current psychological status and distress was used for data collection .

Cross sectional methodology was chosen because it is quick and cheap in terms of the design. In addition, the cross sectional studies are the best way to determine prevalence of mental disorders ' and are useful in identifying associations between many factors and quality of life (Sorli, 1995) .

3.2 Setting

Bethlehem is a Palestinian city in the center of the West Bank, approximately 10 kilometers south to Jerusalem, with a population of about 131433 people, which composes 7.5% of the total population of the west bank; 67286 are males and 64174 are females.

Bethlehem has a Muslim majority, but it is also a home to one of the largest Palestinian Christian communities. The Bethlehem agglutination includes the towns of Beit Jala, Beit Sahour, and Duha as well as the refugee camps of 'Aida, Azza ; and Dhesha in addition to 64 villages (PCBS , 2007).

According to PCBS's 2007 census Bethlehem district had a population of 131433 ; 50076 person live in rural area ,accounting for(38%), 10554 ; persons are refugees, accounting for(8 %) of the district population and the remain population live urban area . In 2007, the age distribution of Bethlehem's inhabitants was (57.4%)are children(0-18) ,37.1 % from 18- 64 , and 4.1 % above the age of 65 which is the highest percent in the west bank . The total number of elderly in Bethlehem district is 5439 , (45.4 %)of them are males and (54.6 %) are females ;(89%) of them are economically dependent on others (PCBS, 2007).

3.3 Target population

The population base for the survey comes from the 2007 census of elderly whose ages are 65 and above in Bethlehem district a total of 5439 (4.1 %)of elderly. Two thousand four hundred and seventy (45.4%) are males and 2969(54.5%) are females (PCBS, 2007) .

3.4 Sample size

The independent variables of the study: (age, sex, district, educational level, marital status, economic situation and physical health) were taken into consideration to calculate the sample of the study. The following equation was used to calculate the

sample size, by considering that elderly whose age is 65 year and above is 4.1 %, with a significant error of 10% , level of community is 3 (city , camp , village).

$$n = \frac{t^2 * S^2}{E^2} * lc$$

N: sample size

t^2 : Value of selected alpha level

S^2 : Variance of a sample

E^2: Significant error

LC: level of community

So the total sample size was 300 people distributed between urban, rural and camp locations as shown in table (3.1) .

Table 3.1 sample distribution according to localities

Location	Sample size	Percentage
Bethlehem	90	30%
Beit Sahor	60	20%
Dehesha Camp	35	11.6%
Al-khader	20	6.6%
Zatara	20	6.6%
Beit Fjar	20	6.6%
Obedieh	20	6.6%
Tiqoua	20	6.6%
Husan	15	6%

3.5 Sampling technique

Sampling was performed through stratified convenience of old adults in different levels and it was used as follows:

1. A threefold geographical divisions of city, villages and refugee camps were selected as the main population groups that were surveyed. Bethlehem district was divided to 4 cities, 3 camps and 64 villages .

2. From the four cities, two cities were randomly selected and from the three camps, one camp was randomly selected and from the sixty four villages , six villages were randomly selected.

3. Based on the natural population distribution in Bethlehem district, 54% of the survey sample were from urban sides , 38 % were from rural areas and 8% were from refugee camps.

4. In each site (city , villages and camps) the study subjects were chosen according to age(65years and obove) .

From each site, households were selected in a convenience way based on the following question that was asked to the residents of each house: do you have an elderly person above 65 years? If the answer was yes then the interview was conducted.

These three different settings were chosen because they pose different challenges for old people. For example, those in villages live in traditional houses and have some opportunities to form close social networks of support, whereas those residing in the city live in residential multi-storey flats which post various problems regarding mobility. Old people living in refugee camps suffer from the problem of overcrowding. On the other hand, those living in cities have better opportunities of receiving better health and publicly organized social care than those living in villages (Zanoon, 2003). Proportionate allocation sampling was used to identify a sampling fraction for the three localities. Stratified convenience sample was selected because it is economical, easy and not time consuming.

All participants were interviewed at their homes. After identifying eligible subjects, WHO QOL Bref and BSI 50 scale were administered with a face-to-face interviews by the researcher.

3.5.1 Inclusion criteria:

The following are the criteria for inclusion of the participant:

- Age > 65 years at the time of the visit.
- Elderly who live in non-institutional settings (e.g. in their own homes or with their families)

3.5.2 Exclusion criteria:

- Elderly people who live in institutions , because they usually have more health Problems and lower functional capacity and they might have difficulties in completing a long interview.
- Individuals who are very ill or hospitalized, and are mentally ill patients.

3.6 Sample description

Originally the sample includes 300 elderly who were above 65 years, however nine elderly could not complete the questionnaire because of their bad health situation, so the sample size was 291 person and the response rate is 97% . The mean age of participants is 72.8 years.; 59. % (172 persons) of the sample were females with mean age 71.6 years and 41 % (119 persons) were males with mean age 74.5 years . (See figure 3.1)

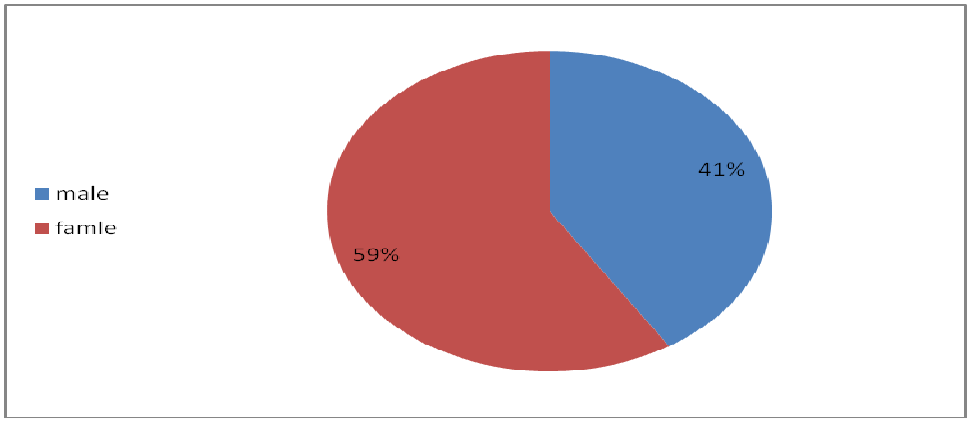

Figure (3.1) sample distribution according to sex.

Fifty two and half percentage of the survey sample were from urban sides, 39 % from rural areas, and 8.5% from refugee camps, see figure 3.2

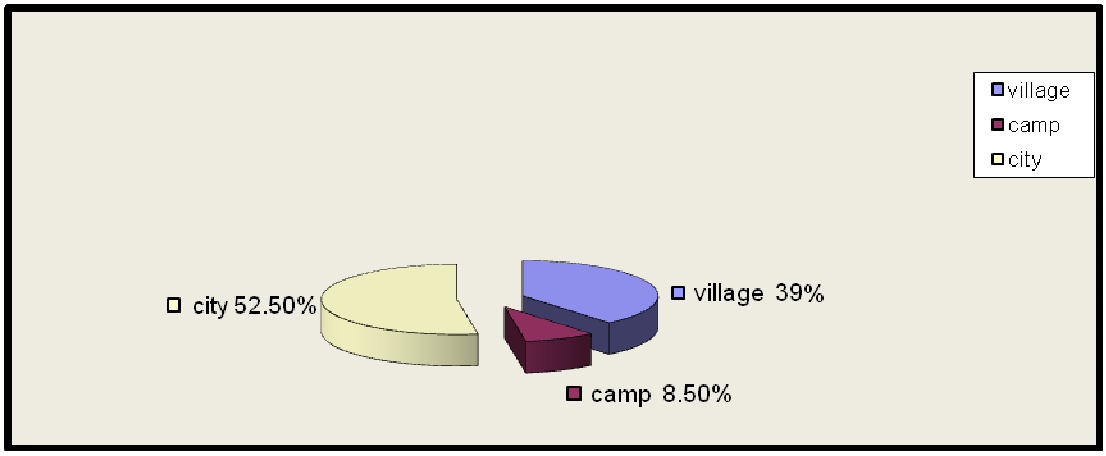

figure (3.2) : elderly distribution according to district

The analysis of the marital status of the elderly indicate that 59.1 % of elderly are married while 32.6 are widowed, only 5.5% of them are divorced and only very few 2.7% of them are single . See figure 3.3

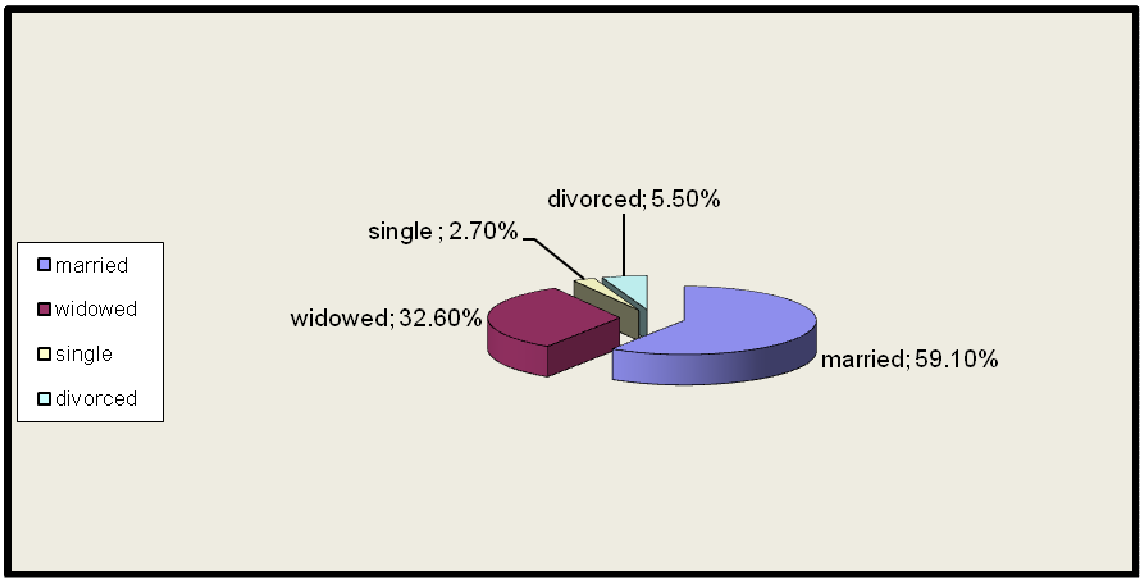

Figure 3.3 sample distribution according to marital status .

There was a variation of marital status in relation to the gender of participants. Forty-two and four tenths percent of female participants were married compared to 83.2% of men ; 45.3 % of female participants were widowed compared to 14.3 % of men ; 0.8% of men are single compared to 4.1% of women are single .See figure 3.4 and table 3.2 .

Figure 3.4 sample distribution according to social situation and its relation to gender

Nuclear family system was the most common with the rate of (84.1%) among the sample and the remaining comes from the extended family.

Data related to the educational status of the participants highlighted that 59.1% of them were illiterate(33.7% were males and 66.3 % were females) , 28.2 % had primary education ; 8.9 % of them were secondary educated while 3.8 % had the bachelor degree (90.9% of them were male and 9.1 % of them were female). see figure 3.5

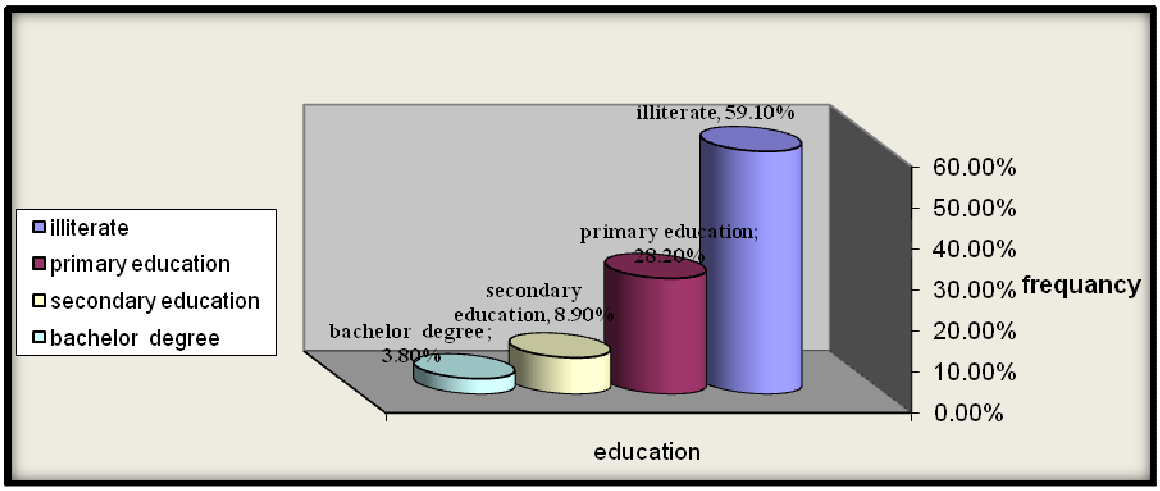

Figure 3.4 sample distribution according to education

Also there was a difference in the education level in relation to the gender of the subjects. Forty-eight and seven tenths percentages of males were illiterate compared to 66.3 % of females. Eight and four tenths of participant males had bachelor degree while only 0.6% of the participant females had bachelor degrees.

The results based on where the participants live showed that 21.6 % of them live alone while 45.7% of them live with their spouse and children and the remaining live with their children who are married.

80.8%of the respondents were economically inactive and did not have work; 71.8% were economically dependent on their children and their relatives ; 15.3 % of them were economically independent and have enough income from their work, small fraction which is about 3.8 % were dependents on the Pension salary.

Table 3.3 shows that 77 % of the respondents had health problems; 43.4% of them were males and 65.6 % were females.

The most common illness was hypertension with rate of 34.6 %, diabetes with rate of 21.5%; osteoarthritis with rate of 20.5 % heart disease with rate of 10.5%. Others include Asthma with rate of 4.6%, Urinary incontinence with rate of 2.5 %and peptic ulcer 5.9%. It is seen that some respondents had more than one health problem. All health problems were found to be more common among females except Peptic ulcer which was more common among males.

Table (3.2): sample distribution according to physical illness .

Physical illness	**Male**	**Female**	**Total**
Hypertension	35%	65%	34.6%
Diabetes	30%	70%	21.5%
Osteoarthritis	37.4%	62.6%	20.5 %
Heart diseases	44.3%	55.7%	14.4%
Asthma	15%	85%	7.6%
Urinary incontinence	71.4%	28.6%	2.5%
Stomach ulcer	76.5%	23.5%	6.3%

3.7 Variables

The dependent variables are

- Scores of the WHOQOL-BREF scales: physical health, psychological, social and environmental.
- Score of The BSIs 53- scale : somatization, obsessive-compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

The independent variables of this study were the demographic and socioeconomic characteristics which were:

- Gender

- Age: it has four categories (65 to 69, 70 to 74, 75 to 79 and 80 years or more).
- Marital status: it has two categories: with a spouse and without spouse.
- Economic situation: if there is a source of money or not and the type of this source.
- Education: it has four categories: illiterate, basic education, secondary education , diploma and university education and post education.
- The living status was represented by 3 main categories: living alone, with their partner in their home, living in the home of their children.
- Living area: it has three categories city, villages and camps.
- Physical health: the presence of any type of illness and handicaps.

3.8 Instrument

3.8.1 WHO QOL BREF:

The WHOQOL-BREF was developed from the WHOQOL-100, a cross-cultural QOL Instrument developed by the World Health Organization (WHO) for assessing the Individual's subjective perception and feelings of life. The WHOQOL-100 contains 100 items for 25 facets (The WHOQQOL Group 1994).

However, the WHOQOL-100 is too lengthy for some uses, and the participants may not have enough time or ability to complete all items. Thus, the WHOQOL- 100 was simplified into a brief version, called the WHO QOL BREF, by selecting 24 items from 24 facets of the WHOQOL100 scale (one item per facet) and two items from the general facet (Skevington et al, 2003). These 24 items cover four domains, including physical health, psychological state, social relations, and environment (look Appendix 4). These four domain scores were used to indicate an individual's QOL (Skevington et al, 2003). Since then, the WHOQOL- BREF was commonly applied to academic research, clinical evaluation, cross culture comparison, and so on. The participants rated each item on a 5-point scale ranging from (1) not at all satisfied to (5) very satisfied. The first transformation method converts scores to range between 4 -20, comparable with the WHOQOL-100. The second transformation method converts domain scores to a 0-100 scale.

Values between Zero and 39 indicate poor quality of life, while the values between 40 and 59 show the average evaluation of quality of life, but values higher than 60 indicate to the evaluation of good and excellent quality of life .

The WHOQOL-BREF is self administered if respondents have sufficient ability: otherwise, interviewer-assisted or interview-administered forms should be used.

The brief version of the World Health Organization Quality of Life instrument (WHOQOL-BREF), including four domains, has been culturally adapted into Arab populations of elderly people. Also it has been found to be valid (discrimination validity) and reliable in a Palestinian epidemiological study (Mataria et al ,, 2008, Thabet et al ..2008)

Previous Palestinian studies showed that The WHOQOL-BREF has high internal consistency (Cronbach's alpha: 0.80 -0.91), test retest reliability (0.7 to .89), splitting half was(0.87 to 0.89) **(**Eljedi, et al ., 2006; Mataria,et al., 2007, Thabet et al., 2008) . In this study, the split half reliability of the scale was high (r = .84). The internal consistency of the scale was calculated using Chronbach's alpha, and was also high (α = .93).

Domains and Facets incorporated within domains are:

1. Physical health:

- Dependence on medicinal substances and medical aids.
- Energy and fatigue.
- Mobility.
- Pain and discomfort.
- Sleep and rest.
- Work Capacity.

2. Psychological health and Body image and appearance:

- Negative feelings.
- Positive feelings.
- Self-esteem.
- Spirituality / Religion / Personal beliefs.
- Thinking, learning, memory and concentration.

3. Social relationships:

- Social support.
- Sexual activity.

4. Environment and financial resources:

- Freedom, physical safety and security.
- Health and social care: accessibility and quality.
- Home environment.
- Opportunities for acquiring new information and skills.
- Participation in and opportunities for recreation / leisure activities.
- Physical environment (pollution / noise / traffic / climate).

Transport (WHOQOl Group, 94, P: 45). Look appendix (2)

3.8.2 Symptom checklist (Brief symptom inventory 53):

The BSI was developed from its longer parent instrument, the SCL-90-R, and psychometric evaluation reveals it to be an acceptable short alternative to the complete scale. Both test--retest and internal consistency reliabilities are shown to be very good for the primary symptom dimensions of the BSI, and its correlations with the comparable dimensions of the SCL-90-R are quite high (Derogatis and Melisaratos,1983) .

The BSI is a 53-item self-report scale used to measure nine primary symptom dimensions include somatization (7 items), obsession (6 items), interpersonal sensitivity (4 items), depression (6 items), anxiety (6 items), hostility (5 items), phobia (5 items), paranoid (5 items), psychoticism (5 items), and addition (4 items) symptom, and three global indices Global Severity Index (GSI), Positive Symptom Distress Index (PSDI), and Positive Symptom Total (PST). Look appendix (3)

Each item of the scale was scored from 0 to 4; a higher score represents a more severe case. The BSI is a widely used scale assessing current psychological distress and symptoms in both patient and non-patient populations. The BSI measures the experience of symptoms in the past seven days including the day the BSI was completed. There are no cut-off points in the original scale. The GSI scoring comes from the total mean scores of the 9 subscales (Derogatis and Melisaratos,1983) . Previous Palestinian studies showed that the BSI has

high internal consistency (Cronbach's alpha: 0.87 -0.94), test retest reliability(0.7 to .91), splitting half (0.87 to 0.89) (Al-Krenawi et al.,2009, Slone et al , 1998) .

In this study, the split half reliability of the scale was high (r = .86). The internal consistency of the scale was calculated using Chronbach's alpha, and was also high (α = .91).

Socio-demographic data included age, sex, living arrangement, living area, marital status, education, work status, source of money and physical health was also collected.

3.9 Pilot Study

A pilot study was conducted before starting the data collection to test the acceptability of questions, clarity of language used, reliability of the questionnaire, the desire of population to participate, and how much time is needed to conduct and complete the questionnaire. For this purpose, 15 elderly persons were selected for the pilot study , changes were done to the questionnaire as necessary. A second pilot study was conducted on 6 elderly people to ensure that there were no vague questions.

- Some changes were done to the questionnaire as: a short definition of quality of life was added because many elderly persons did not understand what quality of life is. Some sentences were clarified in more simple way. As the following: Do you have enough energy for everyday life, the term energy in Arabic (taqa) changed into Himmeh or Heil .

The modified questionnaire is attached in the appendix(1).

3.10 Recruitment and training of the interviewers

Seven students were selected to do the interviewe based on the following criteria:

1. Resident in Bethlehem district.
2. A student in human science related field.
3. Expresses high responsibility.

4. Cooperative.
5. Possesses friendly personality.

Training

Three informal sessions were conducted by the researcher to provide information and guidelines to the interviewers about their task that includes the following items:

1. Introduction about mental health and quality of life of the elderly.
2. Objectives of the study.
3. Methodology on how to select the sample.
4. The approach to conduct the interview and complete the questionnaire.
5. How they must introduce themselves.
6. The questionnaire items were carefully discussed with the interviewer, after that a role play about the interviewing process was done by the interviewer with a supervision from the researcher to ensure that interviews will be conducted as planned.

Finally the interviewer was instructed to stay in a direct contact with the researcher for further clarification and information concerning the process of data collection.

3.11 Data collection

A personal interview of the subjects were conducted which is the oldest data collection technique that involves oral questioning of the respondent, and it is very suitable to use with illiterate people and leads to much higher response rate compared to obtaining written answers to questionnaires. Data collection was started in the middle of May 2010 and ended in August.

3.12 Ethical consideration

A consent form about the research was provided to all subjects before the interview was conducted, and it is attached in (appendix 2). The form included the following information and explanation:

1. Who is conducted in the research?
2. Objectives of the research.
3. Confidentiality of the collected information.

All subjects verbally agreed to participate in the study.

3.13 Data analysis

Data was analyzed by using SPSS ver .16 for data entry and analysis : Means , standard deviation (SD.) , frequencies was calculated to answer research questions**.**

ANOVA and T tests were calculated to test hypothesis when data normally distributed. Mann – Whitneyand Kruskal-Wallis non-parametric tests were conduct to test hypothesis when data not normally distributed .

In order to investigate the relationship between the global severity index scores and quality of life, and its domains, Pearson coefficient correlation test was done

A stepwise regression analysis investigated which of the demographic variable were independently predictor for the dependent variable (GSI and QOL scores)

3.14 Limitation of the study

The following are the main limitations of the study:

1. The researcher bias.
2. Bad health situations of some of elderly inhibited them from answer the questionnaire accurately .
3. Elderly found difficulty in ranking their answers of some questions; they use the phrase “thanks god” as an answer of many questions and the interviewer had to repeat and use the needed explanation to the question to get the nearest answer.
4. Using convenience sample technique so the researcher could not generalized the results of the study to the total population .

Chapter Four

Results

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a. Introduction

Data of this study was collected by two tools. The Brief Symptom Inventory Scale that was used to asses mental health and the QOL-BREF questionnaire was used to assess quality of life. Statistical analysis was performed using the Statistical Package for Social Sciences (SPSS) version 16. Mean (SD) and percentages were used for descriptive purpose. To examine the differences in dependent variable (mental health state and quality of life) in relation to independent variables(socio demographic) , T test and ANOVA tests were used if distribution was normal and Kruskall-Wallis test was used if distribution was not normal. On the other hand to examine the relationship between independent variables (socio demographic) and dependent variable (mental health state and QOL), Pearson's product correlation (if distribution was normal) and Spearman's teat (if distribution was not normal) was completed.

4.2 Research question one

What is the mental health status among elderly in Bethlehem ?

This question was answered through the result of BSI_ 53 , a mean score of 1.5 or above which represent a moderate level of symptoms was taken as a base for diagnosis , after coding of the data obtained from the 291 respondents , simple calculations of the severity of symptom of the GSI and 9 diminutions were made in order to identify the prevalence of psychological complaint among the respondents of the current study .

The global severity index (GSI) is the main indicator of the mental health state of the respondents . The mean score of the respondents for the GSI was 1.35 with standard deviation of 0.67 . Fifty two percent of the 291 respondent met the criteria of not present at all or mild GSI . Forty two percent had moderate symptom and 5.5% had severe symptom (see table 4.1).

As can be observed in table(4.1) and (4.2) of the 9 symptom diminutions ,the mean score of somatization was (2.044) . Twenty nine percent of respondents had " not at all" or mild level of somatization ,(36.1%) the respondents complained of moderate symptom ,and (34.7 %) complained of " sever" and " very sever " level of somatization . In regards to

obsessive compulsive symptoms , the mean score was 1.53 with standard deviation of 0.78. Forty-six point seven percent of respondents had “not at all” and “ mild “ level of obsessive compulsive symptoms , (39.9%) complained of “moderate “ level of obsessive compulsive symptoms and (13.4 %) had “sever” and “ very sever “ level of obsessive compulsive symptoms. However , the mean sore of interpersonal sensitivity symptoms was 1. 1 with Sd. 0.76 ; (66%) of the respondents had “not at all” or” mild “ level of interpersonal sensitivity symptoms , (27.8 %) of the respondents had moderate level of interpersonal sensitivity symptoms and (6.2 %) of the respondent had sever level of interpersonal sensitivity symptoms .

On the other hand , the mean score of anxiety symptom was 1.31 with SD. 0.84 . Thirty two percent of the respondents complained of mild level of anxiety symptom and 9.3% of the respondents complained of “sever” and “ very sever “ level of anxiety symptom. Nevertheless , in regards to depression ,(34.7 %) of participants report moderate level of depression symptom compared to (12.7 %) had sever and very sever level of depression. However when looking at phobic anxiety (mean = 1.07 , SD= 0.84), (20.3%) of the 291 respondents complained of “moderate” level of phobic symptoms compared to 8.9 % complained of “sever” and “very sever” level of phobic symptoms. Concerning hostility (mean score =1.06, SD= 0.90),16.2 % of the respondents reported having mild level of hostility compared to 4.5 % who had sever level of hostility symptoms .On the other hand 22.3 % of respondents reported having mild levels of paranoid ideation and 14.1 % had sever and very sever level of paranoid ideation . As for the last symptom dimension psychoticism, 33.3% of the respondents reported having moderate level of psychoticism and 10.3% of participants reported having sever level of psychticism .

The data indicated that (52.2%) of the respondents did not have psychological symptom that are diagnostic however the rates of those who complained of moderate psychological distress were still high . The participants who reported moderate levels of distress in any of the nine symptom dimensions might need psychiatric treatment or interventions if their state did not improve by itself . On the other hand there were low rates of those who had severe level of psychological distress . Nevertheless , those who had sever symptom may need professional help because they have full criteria for psychopathology .

Table (4.1): descriptive statistics of the 9 dimensions and the GSI of the BSI-50.

The 9 symptom dimensions and the GSI	Mean	S. D
GSI	1.3564	.67225
Somatization	2.0440	.97641
Obsessive compulsive	1.5355	.78019
Interpersonal sensitivity	1.1057	. 76042
Depression	1.3417	.80853
Anxiety	1.3121	.84284
Hostility	1.0679	.90253
Phobic anxiety	1.0742	.84998
Paranoid ideation	1.2002	.94760
Psychoticism	1.2664	.81638

Table (4.2): frequencies and rates of the GSI and 9 dimensions

As classified to severity of complaint for 291 respondents.

Index diminution	Not at all present	Mild symptom	Moderate symptom	Sever symptom	Very sever symptom
GSI **Frequency**	71	81	122	16	0

Percent	24.4	27.8	41.9	5.5	
Somatization					
Frequency	43	42	105	62	39
Percent	14.8	14.4	36.1	21.3	13.4
Obsessive compulsive					
Frequency	49	87	116	33	6
Percent	16.8	29.9	39.9	11.3	2.1
Interpersonal sensitivity					
Frequency	122	70	81	15	3
Percent	41.9	24.1	27.8	5.2	1
Depression					
Frequency	80	73	101	32	5
Percent	27.5	25.1	34.7	11.	1.7
Anxiety					
Frequency	86	93	85	23	4
Percent	29.6	32	29.2	7.9	1.4
Hostility					
Frequency	148	47	73	13	10
Percent	50.9	16.2	25.1	4.5	3.4
Phobic anxiety					
Frequency	141	65	59	19	7
Percent	48.5	22.3	20.3	6.5	2.4
Paranoid ideation					
Frequency	124	65	62	32	9
Percent	42.6	22.3	21	11	3.1
Psychoticism					
Frequency	106	57	97	30	0
Percent	36.4	19.6	33.3	10.3	

4.3 Research question two

How do elderly people evaluate their quality of life?

This question was answered through the result of the QOL- Bref , which measured the individual's perceptions of quality of life and health via two items ('How would you rate your quality of life?' and 'How satisfied are you with your health?') .

The results showed that (46.2 %) of the Participants rated their quality of life as being good or very good compared to (22.1%) of participants who rated their quality of life as being poor or very poor . On the other hand (45.1%) of respondents were satisfied and very satisfied with their general health compared to (24.1 %)of the respondents who were very dissatisfied or dissatisfied with their general health .

Table 4.3 shows the mean and standard deviation of each domains of the QOL . As can be observed , participants were having lower QOL scores in Physical health domain of WHO QOL-BREF scale (mean 50.9 , S.D 21.4) ,(35.5 %) of the participants perceived their physical health as being good and very good while (27.5%) of the participants perceived their physical health as being poor or very poor . Fifty two percent of the participant were satisfied with their ability to perform their daily living activities compared to 7.2% of the participant who were very dissatisfied with their sleep .

In regard to social relationship domain (mean 51.8, S.D 22.7) , (32.6 %) of the participants evaluated their social life as very good or good compared to(22%) of participants who evaluated their social life as poor or very poor . In this regard , (64.6 %) of the participant were satisfied with their personal relationships. However when looking at environment domain (mean = 53.01, S.D= 17.7),(40 .4 %) of the respondents were satisfied and very satisfied with their environment while (16.5 %) of the respondents were either dissatisfied or very dissatisfied with their environment . In this regard (63.9%) of the participant were satisfied with the conditions of their living place . However (2.4%) of the participant had complete access to the information that they need in their day-to-day life . Nevertheless, the participants had higher QOL scores in Psychological health (mean = 55.3, S.D= 16.7) , (40.9%) of the participant saw that their Psychological health was good and very good however (16.4%) of participant saw that their Psychological health was poor or very poor ; (47.1 %) were satisfied with their bodily appearance while only 4.5 % of participant said that they enjoy their life.

Table (4.3): Means and S.D of QOL-Bref domains

QOL-Bref domains	Mean	S.D

Physical health domain	50.9606	21.47283
Psychological health domain	55.3694	16.79860
Social relationship domain	51.8045	22.73495
Environment domain	53.0172	17.79736

Table (4.4): Frequency responses (%) for domains of the WHOQOL (N = 291).

QOL-Bref domains	Very poor	Poor	Neither Poor nor good	Good	Very good
Physical health domain					
Frequency	25	55	107	79	24
%	8.6	18.9	36.9	27.2	8.3
Psychological health domain					
Frequency	8	40	124	90	29
%	2.7	13.7	42.6	30.9	10
Social relationship domain					
Frequency	27	37	95	71	24
%	9.3	12.7	32.6	24.4	8.2
Environment domain					
Frequency	13	35	125	102	15
%	4.5	12	43	35.2	5.2

4.4 hypotheses testing

4.3.1 Hypotheses one : there is no significant difference in mental health state of the respondents of the present study in relation to study variable : gender , age , living area , marital status , economic situation , education level , living arrangement , and physical health .

In the following section a comparison among the respondents of the current study was done based on eight independent variables these variables were gender , age , marital status , economic situation , education level , living arrangement , living area and physical health . The dependent variables that were tested against the nine independent variables were : Global Severity Index (GSI) , somatization , obsession , interpersonal sensitivity , depression , anxiety , hostility , phobia , paranoid and psychoticism .

Because of the distributions of the GSI and the nine diminutions of BSI were not normal , Kruskall- Wallis test and Man-whitney was used to examine relationship between the more than 2 groups of the independent and dependent variables and Man-whitney was used to examine relationship between 2 groups of the independent and dependent variables .

4.3.1 .1 mental health state among elderly in relation to gender:

A statistically significant difference was observed between male and female for GSI (p =0.026) . The mean rank of females was higher (154.7) than males who had a mean rank of(132.3) ; therefore females had higher psychological symptoms or GSI than males.

In regards to the 9 symptom diminutions of BSI , there was significant difference between females and males for somatization symptom (p= 0.013) , depression symptoms (p= 0.011) , interpersonal sensitivity (p= 0.003) and phobic anxiety (p= 0.013) as shown in table (4.5) . Therefore data indicate that females respondents of the present study had higher psychological complains in the 4 dimensions that mentioned above and the GSI than males (table, 4.5) .

However there were no significant differences between males and females for anxiety (p= 0.27) , obsessive compulsive symptom (p= 0.15) , paranoid ideation (p=0.76) , hostility (p= 0.9) and psychoticism (p= 0.51) .

Table (4.5): Man – Whitney Test result for GSI and 9 diminutions pf BSI according to sex.

GSI and 9 diminutions	Sex	Mean Rank	P Value
somatization	male	131.23	.013
	female	156.22	
Anxiety	male	139.48	.271
	female	150.51	
Obsessive compulsive	male	137.51	.151
	female	151.87	
Depression	male	130.90	.011
	female	156.44	
Psychoticism	male	141.67	.515
	female	148.17	
Hostility	male	146.68	.908
	female	145.53	
Phobic anxiety	male	131.33	.013
	female	156.15	
Paranoid ideation	male	147.74	.768
	female	144.79	
Interpersonal sensitivity	male	128.23	.003
	female	158.29	
GSI	male	132.37	.026
	female	154.64	

4.3.1.2There is no significant difference in mental health state of the respondents of the present study in relation to age

There were no statistically significant differences among four age groups for global severity index at an 0.05 level significance (p = 0.06) . In addition there were no statistically significant differences among age groups for anxiety (p= 0.78) ; psychoticism (P= 0.42) ; paranoid ideation (P= 0.57) and interpersonal sensitivity (P= 0.38) . Therefore, age was not significantly related to the above mentioned diminutions and GSI and the nul hypotheses were retained for the relationship between age group and symptomatology .

However the age groups differed significantly for somatization (P< 0.001) ; obsessive compulsive (P= 0.017) ; depression (P= 0.031) ; hostility (P=0.01) and phobic anxiety (P= 0.005) . Therefore the null hypotheses were rejected for these diminutions . Mean ranks scores decreased with advancing age ; table 4.6 revealed that group 4 (above 80 year) had highest mean ranks for somatization(189.34) ; obsessive compulsive (175.28) ; depression(171.43) and phobia(179.8) , therefore the respondents of this group had more psychological symptom in relation to the above mentioned dimensions than respondent of the other three groups of age .In regard to hostility, age group two (70- 74) scored the highest mean ranks (166.9) .

Table (4.6-a): Kruskal Wallis Test result for GSI and diminutions of BSI according to age.

BSI-50	Age groups	Frequency	Mean rank	P value
somatization	65 – 69	116	132.23	**.000**
	70 – 74	72	136.90	
	75 – 79	44	139.09	
	Above 80	59	189.34	
obsessive compulsive	65 – 69	116	134.11	0.017
	70 – 74	72	147.45	
	75 – 79	44	135.70	
	Above 80	59	175.28	
depression	65 – 69	116	131.62	0.031
	70 – 74	72	148.15	
	75 – 79	44	146.28	

	Above 80	59	171.43	
hostility	65 – 69	116	130.44	0.01
	70 – 74	72	166.90	
	75 – 79	44	133.23	
	Above 80	59	160.61	
phobia	65 – 69	116	136.42	0.005
	70 – 74	72	143.68	
	75 – 79	44	129.73	
	Above 80	59	179.80	

On the other hand group one (65- 69 years) scored the lowest mean ranks for somatization (132 .23); obsessive compulsive (134.11) ; depression(131.62) and hostility (130.44) , therefore the respondents of this group had lower psychological symptom in relation to the above mentioned dimensions than respondent of the other three groups of age. In relation to phobia, age group three (75- 79) scored the lowest mean rank (129.73).

4.3.1.3 There is no significant difference in mental health state of the respondents of the present study in relation to living area:

The Kruskal Wallis Test indicated that there were statically significant differences among respondents who lived in cities , villages and refugee camps for the Global severity index and the nine symptom dimensions . P value for GSI and all symptom dimensions < 0.001 , thus the null hypotheses was rejected . The highest mean ranks scores of respondents were obtained in villages for GSI(189) and the nine symptom dimensions; Somatization(175.53) ; Obsessive compulsive (184.26) ; Interpersonal sensitivity ; Depression (181.19) ; Anxiety (186.97) ; Hostility (127.29) ; Phobic anxiety (173.22)Paranoid ideation (189.22) and Psychoticism(172 .03) .

This result indicated that the respondents who live in villages had more psychological symptoms than respondents who live in refugee camps and cities .

However respondents who live in cities scored the lowest in mean ranks for GSI(113); somatization (114.52) ; depression (107.49) ; psychoticism (108.16) ; hostility (115.36), paranoid ideation (113.97) and interpersonal sensitivity (126.53) , therefore this group had lowest psychological symptom for the dimensions that mentioned above .

While respondents who live in refugee camps scored the lowest in mean ranks for anxiety (99.43) ; obsessive compulsive (106.55) and phobia (108.16) , therefore this group had lowest psychological symptom for these two dimensions .

Table 4.7 Kruskal Wallis Test result for GSI and 9 diminutions of BSI according to living area.

GSI and 9 BSI dimensions	District	Mean rank
somatization	village	175.53
	city	114.52
	camp	148.71
Anxiety	village	186.97
	city	127.15
	camp	93.43
Obsessive compulsive	village	184.26
	city	124.16
	camp	106.55
Depression	village	181.19
	city	107.49
	camp	151.52
Psychoticism	village	186.77
	city	108.16
	camp	133.47
Hostility	village	177.29
	city	115.36
	camp	142.71
	village	173.22

Phobic anxiety	city	134.76
	camp	108.16
Paranoid ideation	village	189.22
	city	113.97
	camp	118.13
Interpersonal sensitivity	village	172.03
	city	126.53
	camp	129.61
GSI	village	189.29
	city	113.00
	camp	116.73

4.3.1.4 There is no significant difference in mental health state the elderly respondent of the present study in relation to level of education:

A statistically significant difference was observed amongst the four groups of education for global severity index ($p < 0.001$); mean rank scores decreased steadily with higher education level .The mean ranks for GSI decreased from(171.66) in group 1 (illiterate) to (124.69) in group 2 (primary educated) to (78.02) in group 3 (secondary educated) and the lowest mean rank were obtained from group four (diploma and bachelor educated) . It seems that the higher level of education of elderly , the less the psychological complaint .

Also there were statistically significant difference amongst the four groups of education for all the 9 dimensions of the BSI 53 ($p < 0.001$) ,therefore the null hypotheses was rejected for groups of education for all the 9 dimensions of the BSI 53 . As demonstrated in table 4.8 , group four (diploma and bachelor educated)had the lowest mean ranks for all symptom dimension , group three (secondary educated) scored second in mean ranks for all symptom dimensions, group two of education (primary educated) scored third in mean ranks for all symptom dimensions ; group one of education (illiterate) had the highest mean ranks for all symptom dimensions .

The above data indicated that the respondents who had the highest level of education manifested the lowest scores on the global severity index and all the nine symptom dimensions . These result indicate that education could protect elderly from psychological distress .

Table (4.8): Kruskal Wallis Test result for GSI and 9 diminutions of BSI according to education level .

GSI and 9 BSI dimensions	Education level	Mean ranks	P
somatization	Illiterate	169.83	< 0.001
	Primary education	125.55	
	Secondary education	99.60	
	Diploma and bachelors education	35.41	
Anxiety	Illiterate	162.56	< 0.001
	Primary education	131.17	
	Secondary education	117.60	
	Diploma and bachelors education	64.73	
Obsessive compulsive	Illiterate	164.20	< 0.001
	Primary education	138.29	
	Secondary education	88.88	
	Diploma and bachelors education	53.91	
Depression	Illiterate	175.24	< 0.001
	Primary education	118.65	
	Secondary education	79.50	
	Diploma and bachelors education	49.86	
Psychoticism	Illiterate	170.51	< 0.001
	Primary education	123.27	
	Secondary education	84.86	
	Diploma and bachelors education	57.91	

Hostility	Illiterate	165.87	< 0.001
	Primary education	131.76	
	Secondary education	80.02	
	Diploma and bachelors education	97.41	
Phobic anxiety	Illiterate	162.99	< 0.001
	Primary education	129.69	
	Secondary education	113.60	
	Diploma and bachelors education	78.59	
Paranoid ideation	Illiterate	170.06	< 0.001
	Primary education	120.57	
	Secondary education	68.00	
	Diploma and bachelors education	143.68	
Interpersonal sensitivity	Illiterate		< 0.001
	Primary education	161.58	
	Secondary education	143.08	
	Diploma and bachelors education	85.90	
GSI	Illiterate	66.18	< 0.001
	Primary education	171.66	
	Secondary education	124.69	
	Diploma and bachelors education	78.02	
		45.00	

4.3.1.5 There is no significant difference in mental health state the elderly respondent of the present study in relation to marital status

there were statistically difference among the groups of marital status for the global severity index (GSI) (p = 0.031) at the 0.05 level of significant , therefore the null hypotheses was rejected for social situation .group one (single) had the lowest mean ranks(86.14) , there fore they had the

lowest psychological distress . group two(married) scored the second mean rank for GSI (136.94) , on the other hand the respondents of group three (divorced) and group four (widowed) had higher mean ranks than the other groups and also had no significant difference in mean ranks (170.93, 162.28) there for these groups had less psychological complain tan the other two groups

In regards the nine symptom dimension of BSI 50 , social situation group differed significantly in somatization (p= 0.001) , obsessive – compulsive (p=0.013) depression(P= 0.001) and psycoticism (P=0.023) . however social situation groups did not differ significantly in anxiety (P= 346) , phobia (P=0.112), paranoia (P=0.165) , hostility (P=0.407) and interpersonal sensitivity (P= 0.346).

A through examination of the groups of social situation in relation to the 4 dimensions that were found to be statistically significant was mad . group one (single) had lowest ranks for somatization symptom (69.69) , obsessive –compulsive(71.44) , depression(103) and psycoticism (69.14) than the other groups of social situation therefore single elderly scored the lowest level of psychological complain for the mentioned symptoms , group two (married) scored the second for somatization symptom (136.12) , obsessive –compulsive(141.29) , depression(132.12) and psycoticism (140. 43)

Group three (divorced) and group four (widowed) had relatively no significant difference mean ranks and also highest mean ranks for somatization symptom (165.86, 168.88) , obsessive – compulsive(170.79 , 159 .05) , depression(164.57, 172 . 93) and psycoticism (181.21, 156.15) therefore they score highest level of psychological complain .

Table 4.9 Kruskal Wallis Test result for GSI and diminutions pf BSI according to marital status .

	social situation	Mean Rank	P value
Somatization	single	69.69	.001
	married	136.12	

	devoiced	165.86	
	widowed	168.88	
Obsessive – compulsive	single	71.44	.013
	married	141.29	
	divorced	170.79	
	widowed	159.05	
Depression	single	103.00	.001
	married	132.12	
	divorced	164.57	
	widowed	172.93	
Psychoticism	single	69.14	.023
	married	140.43	
	divorced	181.21	
	widowed	156.15	
GSI	single	86.14	.031
	married	136.94	
	divorced	170.93	
	widowed	162.28	

4.3.1.6 There is no significant difference in mental health state the respondents of the present study in relation to employment status :

There were statistically significant difference among respondent in relation to employment status for the global severity index (GSI) (p = <0.001) at the 0.05 level of significant , therefore the null hypotheses was rejected in relation to work . The mean rank of respondents who did not work was higher (152.5) than working respondents (106.47) ; therefore the respondents who did not engage in paid work had higher psychological symptoms or GSI than respondents who continued to engage in paid work.

In regards to the 9 symptom diminutions of BSI , there was significant difference among respondents in relation to work for somatization symptom (p= 0.001) , obsessive

compulsive symptom (p< 0.001) ;anxiety (p< 0.001) ; depression symptoms (p= 0.002) , interpersonal sensitivity (p= 0.017); phobic anxiety (p= 0.01) and psychoticism (p= 0.003) . Therefore work was significantly related to the above mentioned diminutions and GSI and the nul hypotheses were rejected for the relationship between work and symptomatology . However there were no significant differences among respondents in relation to work for, paranoid ideation (p=0.64) and hostility (p= 0.07) .

Further examination of the differences according to work revealed that respondents who did not engage in paid work had the higher mean ranks for somatization symptom (152.19) , obsessive compulsive symptom (156.33) ;depression symptoms (151.65) , interpersonal sensitivity (150.05) ;anxiety (152.61 ;phobic anxiety (150.48) and psychoticism (150.95) . On the other hand respondents who work had lower ranks for somatization symptom (110.39) , obsessive compulsive symptom (92.03) ;depression symptoms (112.81) , interpersonal sensitivity (119.19) ;anxiety (108.54);phobic anxiety (118) and psychoticism (113.33) .

Above data indicated that respondents who did not engage in paid work had higher psychological complains in the 7 dimensions that mentioned above and the GSI than respondent who continued to engage in paid work (table 4.10)

Table (4.10): Mann-Whitney Test result for GSI and 9 diminutions pf BSI according to employment status .

GSI and diminutions of BSI	**Work**	**Mean rank**	**P value**
Somatization	Yes	110.39	0.001
	No	152.19	
Anxiety	Yes	108.54	0.000
	No	152.61	
Obsessive-	Yes	92.03	0.000

compulsive	No	156.33	
Depression	Yes	112.81	0.002
	No	151.65	
Psychoticism	Yes	113.33	0.003
	No	150.95	
Hostility	Yes	125.86	0.07
	No	148.70	
Phobic anxiety	Yes	118.00	0.01
	No	150.48	
Paranoid ideation	Yes	139.80	0.648
	No	145.56	
Interpersonal sensitivity	Yes	119.91	0.017
	No	150.05	
GSI	Yes	106.47	0.000
	No	152.50	

4.3.1.7 There is no significant difference in mental health state of the respondents in relation to source of money:

There were statistically significant difference among respondent in relation to source of money for the global severity index (GSI) (p = <0.001) at the 0.05 level of significant , therefore the null hypotheses was rejected in relation to source of money . The mean rank for GSI was the lowest for respondent who had pension (71.32) while respondents who earn salary from their work scored the second for GSI (109.82) . Those who are taking their money from their children or relatives scored the third mean ranks(149.82) among the 4 groups of source of money , while respondents who take their money from charities and institutions scored the hgiest mean rank(189.75) .

Also there were statistically significant difference among the four groups in relation to source of money for 7 dimensions of BSI-50, somatization symptom (p= 0.004) , obsessive compulsive symptom (p< 0.001) ;anxiety (p< 0.001) ; depression (p<0.001) , interpersonal sensitivity (p= 0.002); phobic anxiety (p= 0.006) and psychoticism (p= 0.004) . Therefore source of money was significantly related to the above mentioned diminutions and GSI and the nul hypotheses were rejected for the relationship between source of money and symptomatology .

However there were no significant differences among respondents in relation to source of money for, paranoid ideation (p=0.14) and hostility (p=0.157) . Further examination of the differences according to source of money revealed that respondents who take their money from pension had the lower mean ranks for somatization symptom (83.27) , obsessive compulsive symptom (93.32) ;depression symptoms (76.09) , interpersonal sensitivity (103.05) ; ;anxiety (73.00);phobic anxiety (82.36) and psychoticism (94.27) . On the other hand respondents who earn salary from their work scored the second mean ranks for somatization symptom (119.22) , obsessive compulsive symptom (95.81) ;depression symptoms (115.65) , interpersonal sensitivity (139.74) ;anxiety (111.91) ; phobic anxiety (118.74) and psychoticism (123.35) .

The third group (the respondent who is taking their money from their relative and children) scored the third mean ranks for somatization symptom (150.12) , obsessive compulsive symptom (152.88) ;depression symptoms (147.09) , interpersonal sensitivity (144.44) ; ;anxiety (150.23);phobic anxiety (153.14) and psychoticism 144.64). While respondents who take their money from charities and institutions scored the hgiest mean rank for somatization symptom (176.50) , obsessive compulsive symptom (180.71) ;depression symptoms (206.86) , interpersonal sensitivity (203.02) ; ;anxiety (180.40);phobic anxiety (150.71) and psychoticism (196.45).

Table (4.11) Kruskal Wallis Test result for GSI and 9 diminutions of BSI according to source of money.

GSI and 9 BSI dimensions	Source of money	Mean ranks	P
Somatization	Pension	83.27	0.004

	Paid work	119.22	
	Support from children or relatives	150.12	
	allocations from charitable organizations or religious	176.50	
Anxiety	Pension	73.00	0.000
	Paid work	111.91	
	Support from children or relatives	150.23	
	allocations from charitable organizations or religious	180.40	
Obsessive compulsive	Pension	93.32	0.000
	Paid work	95.81	
	Support from children or relatives	152.88	
	allocations from charitable organizations or religious	180.71	
Depression	Pension	76.09	<0.001
	Paid work	115.65	
	Support from children or relatives	147.09	
	allocations from charitable organizations or religious	206.26	
Psychoticism	Pension	94.27	.004
	Paid work	123.53	
	Support from children or relatives	144.61	
	allocations from charitable organizations or religious	196.45	
Hostility	Pension	93.64	.157
	Paid work	128.84	
	Support from children or relatives	149.75	
	allocations from charitable organizations or religious	147.10	

Phobic anxiety	Pension	82.36	.006
	Paid work	118.74	
	Support from children or relatives	153.14	
	allocations from charitable organizations or religious	150.71	
Paranoid ideation	Pension	95.09	.142
	Paid work	139.47	
	Support from children or relatives	144.14	
	allocations from charitable organizations or religious	173.38	
Interpersonal sensitivity	Pension	103.05	.002
	Paid work	121.73	
	Support from children or relatives	144.44	
	allocations from charitable organizations or religious	203.02	
GSI	Pension	71.32	0.000
	Paid work	109.82	
	Support from children or relatives	149.82	
	allocations from charitable organizations or religious	189.75	

4.3.1.8 There is no significant difference in mental health state of the respondents in relation to physical health:

A statistically significant difference was observed between respondents who had physical illness and respondents did not complain from any physical problems for GSI ($p < 0.001$) . The mean rank of respondents who had physical illness (154.22) was higher than respondents who did not complain from any physical problems with a mean rank of(111.15) ; therefore respondents who had physical illness had higher psychological symptoms or GSI .

In regards to the 9 symptom diminutions of BSI , there was significant difference between the two groups of respondents for somatization symptom (p<0.001), obsession compulsion, (p<0.001) ,anxiety (P= 0.012) , depression symptoms (p= 0.008) ,psychoticism (0.009) interpersonal sensitivity (p= 0.009) and phobic anxiety (p= 0.027) ,.

Table (4.12): Mann- Whitney Test result for GSI and 9 diminutions of BSI according to physical health.

GSI and 9 BSI dimensions	Physical illness	Mean ranks	P value
somatization symptom	Yes	159.70	0.000
	No	94.34	
Anxiety	Yes	151.62	0.012
	No	122.19	
Obsession compulsion	Yes	154.81	0.000
	No	111.18	
Depression	Yes	152.00	0.008
	No	120.86	
Psychoticism	Yes	151.44	0.009
	No	120.70	
Hostility	Yes	150.05	0.055
	No	127.58	
Phobic anxiety	Yes	150.83	0.027
	No	124.90	
Paranoid	Yes	150.80	0.028

ideation	No	125.02	
Interpersonal sensitivity	Yes	151.86	0.009
	No	121.36	
GSI	Yes	154.22	0.000
	No	111.15	

4.3.1.9 There is no significant difference in mental health state of the respondents in relation to living arrangement:

A statistically significant difference was observed amongst the three groups of living arrangement for global severity index and the 9 symptom dimensions of BSI except interpersonal sensitivity (p = 0.199), at the 0.05 level of significant , therefore the null hypotheses was rejected for living arrangement . The observed value of P was <0.001 for GSI ; somatization ; depression ; paranoid ideation and psychoticism , 0.002 for phobic anxiety; (0.011) for obsession compulsion; 0.001 for anxiety and 0.003 for hostility . Group three (respondents who live with their family) had the lowest mean ranks for GSI (123.36) in the mentioned dimensions , somatization symptom (124.56); depression symptoms(117.32) ; paranoid ideation (124.29) ;psychoticism (123.66) , phobic anxiety; (131.39) ; obsession compulsion(131.11) ; anxiety (128.06) and hostility (128.22) , there fore they had the lowest psychological distress . Group one (respondents who living alone) scored the second mean ranks for GSI (152.93) , somatization symptom (159.64); depression symptoms(165.92) ; paranoid ideation (146.98) ;psychoticism (142.98) , phobic anxiety; (139) ; obsession compulsion(149.06) ; anxiety (144.68) and hostility (155,65) , on the other hand the respondents of group three (respondents who living with children family) had higher mean ranks than the other groups for GSI (172.73) ; somatization symptom (166.96); depression symptoms(172.94) ; paranoid ideation (175.75) ;psychoticism (177.51) , phobic anxiety; (170,35) ; obsession compulsion(164.83) ; anxiety (171.99) and hostility (164.49) .There for this group had higher psychological complain than the other two groups .

Table (4.13): Kruskal Wallis Test result for GSI and 9 diminutions of BSI according to living arrangement.

GSI and 9 BSI dimensions	Living arrangement	Mean ranks	P
somatization	Living Alone	159.64	<0.001
	Living with their child family	166.96	
	Living with their family	124.56	
Anxiety	Living Alone	144.68	.001
	Living with their child family	171.99	
	Living with their family	128.06	
Obsessive compulsive	Living Alone	149.06	.011
	Living with their child family	164.83	
	Living with their family	131.11	
Depression	Living Alone	165.92	0.000
	Living with their child family	172.94	
	Living with their family	117.32	
Psychoticism	Living Alone	142.98	0.000
	Living with their child family	177.51	
	Living with their family	123.66	
Hostility	Living Alone	155.65	.003
	Living with their child family	164.49	
	Living with their family	128.22	
Phobic anxiety	Living Alone	139.00	.002
	Living with their child family	170.35	
	Living with their family	131.92	
Paranoid ideation	Living Alone	146.98	0.000
	Living with their child family	175.75	

	Living with their family	124.29	
Interpersonal sensitivity	Living Alone	150.56	.199
	Living with their child family	156.06	
	Living with their family	136.65	
GSI	Living Alone	152.93	0.000
	Living with their child family	172.73	
	Living with their family	122.36	

4.3.2 Hypotheses two:

There is no significant difference in quality of life among the respondents of the present study in relation to study variable : gender , age , living area , marital status , economic situation , education level , living status , and physical health

In the following section a comparison among the respondents of the current study was done based on eight independent variables. These variables were gender , age , marital status , economic situation , education level , living status , living area and physical health . The dependent variables were : physical health , mental health , social life and environmental conditions .

Because of the distributions of the 4 diminutions of QOL- BREF were normal . T test and one way ANOVA were used to examine the relationship between the independent and dependent variables .

4.3.2.1 There is no significant difference in quality of life among the respondents in relation to gender:

In order to find differences in gender and quality of life, T independent test was conducted in which total quality of life (24 items) and 4 domains were entered separately as the dependent variable and sex as independent variable. The results showed no statistically

significant sex differences in mean general quality of life (Male vs. Female) (68.4 vs. 65.1) (t = 1.8, p = 0.068), psychological (57vs 54,1) (t = 1.4 ,p = 0.15), And environmental domain (53.9vs 52.3) (t = 0.75, p= 0.45). Thus , the null hypotheses was retained .

On the other hand there were statistically difference between males and females for physical domain(54.5vs 48.4)(t= 2.3, p= 0.019) and social domain (55.7 vs 48.8) (t = 2.4, p = 0..017) and the null hypotheses was rejected for these domains

Table (4.14) : T independent test of differences between sex and quality of life.

QOL-BREF	Gender	Mean	SD	P value
General total quality of life	male	68.4526	14.29380	0.068
	female	65.1852	13.81667	
Physical domain	male	54.5018	21.77615	0.019
	female	48.4962	20.97146	
Psychological domain	male	57.0728	17.26124	0.151
	female	54.1909	16.41808	
Social domain	male	55.7339	22.70022	.017
	female	48.8506	22.38699	
Environmental domain	male	53.9725	17.77495	0.450
	female	52.3619	17.83486	

4.3.2.2 There is no significant difference in quality of life among the respondents of the present study in relation to age:

There were statistically significant differences among age groups for psychological domain (P= 0.045) and physical domain (P= 0,002) at the 0.05 level of significance. There was a steady decrease in mean scores of physical and psychological domains with increasing age; higher mean scores in QOL mean better quality of life . Tukey test shows

that the differences in physical health were between age groups one (65-69) and the oldest age group(above 80 year) in favor of age group 65-69 . and the differences between age groups two (70 - 74) and the oldest age group(above 80 year) were in favor of age group two (70- 74) . Similar result was observed for physical domain , these results indicated that the respondents evaluated their quality of life as worst with older age . Nevertheless no significant differences were observed among the four groups of age for the total quality of life (p = 0.55) environmental domain (p=0.174) and social domain (p=0.172). Therefore , age was not significant for total quality of life and these two domains and the null hypothesis were retained.

Table (4.15): ANOVA test result for general quality of life and its 4 domains according to age.

QOL-BREF	Age group	Mean	SD	P value
General quality of life	1(65- 69)	69.3504	12.46907	0.055
	2 (70- 74)	66.6667	13.81425	
	3 (75- 79)	66.3303	13.07797	
	4 (>80)	60.7222	16.87560	
Physical domain	1(65- 69)	55.1724	22.24802	.002
	2 (70- 74)	52.6660	19.62400	
	3 (75- 79)	49.2695	19.57031	
	4 (>80)	41.8886	21.03320	
Psychological domain	1(65- 69)	58.4052	14.82571	.045
	2 (70- 74)	55.9028	16.41163	
	3 (75- 79)	46.8409	15.37570	
	4 (>80)	50.6356	20.58492	
Social domain	1(65- 69)	55.8494	21.87539	.172
	2 (70- 74)	49.6154	22.50727	

	3 (75- 79)	50.9009	22.97205	
	4 (>80)	46.7014	23.86549	
Environmental domain	1(65- 69)	55.6304	16.05770	.174
	2 (70- 74)	52.2135	16.80359	
	3 (75- 79)	53.0540	16.55638	
	4 (>80)	48.7608	22.22804	

4.3.2.3 There is no significant difference in quality of life among the respondents of the present study in relation to living area:

The ANOVA test indicated that there were statically significant differences among respondents who lived in cities , villages and refugee camps for the social relation domain with P value = 0.014 , environmental domain with P value = 0,002 and psychological domain with P value = 0.02 , thus the null hypotheses was rejected for these domains . In regards to the environmental domain Tukey test shows that the differences were between respondents who live in villages and respondents who live in camps in favor of respondents who live in villages . Moreover, there are differences between respondents who live in city and respondents who live camps in favor of respondents who live in city .

Tukey test shows that the differences in social relation and psychological health were between respondents who live in villages and respondents who live in city in favor of respondents who live in cities .

This result indicated that the respondents who live in cities evaluated their quality of life as being better than either respondents who lived in camps or villages .

Table (4 .16): ANOVA test result for general quality of life and its 4 domains According to living area.

QOL-BREF		Mean	Sd	P value
General quality of life	villages	65.0330	14.52533	0.138
	Cities	68.7320	12.76541	
	Camps	65.4667	15.66674	
Physical domain	villages	48.5119	20.17429	.187
	Cities	53.6017	22.54662	
	Camps	50.6181	21.59970	
Psychological domain	villages	53.0992	16.57552	.020
	Cities	58.6864	15.95318	
	Camps	53.1250	18.20654	
Social domain	villages	47.1726	23.264	.014
	Cities	55.8824	19.57287	
	Camps	54.3750	26.62039	
Environmental domain	villages	53.7190	18.79038	0.002
	Cities	55.6144	16.03136	
	Camps	45.3431	17.45947	

4.3.2.4 There is no significant difference in quality of life among the respondents of the present study in relation to level of education.

A statistically significant difference was observed amongst the four groups of educational level for total quality of life(p=0.000) and its four domain; environmental domain (p =0.002); social , psychological and physical domains (p = 0.001) . Tukey test shows that the differences in environmental condition were between diploma and bachelor educated respondents and illiterate in favor of diploma and bachelor educated respondents . Moreover, there are differences between diploma and bachelor educated respondents and primary educted respondents in favor of diploma and bachelor educated respondents. Tukey test shows that the differences in social relation condition were between illiterate respondents and primary educted in favor of primary educted respondents , there were

differences between illiterate and secondry educated respondents in favor of secondry educated respondents , there were differences between illiterate and diploma and bachelor educated respondents in favor of diploma and bachelor educated , there were differences between primary educated respondents in favor of and diploma and bachelor educated respondents in favor of diploma and bachelor educated , and , there were differences between secondary educated respondents in favor of and diploma and bachelor educated respondents in favor of diploma and bachelor educated .

On the other hand Tukey test shows that the differences in psychological health were between illiterate and diploma and bachelor educated respondents in favor of diploma and bachelor educated ,and there were differences between illiterate respondents and primary educted in favor of primary educted respondents .
Tukey test shows that the differences in physical health were between illiterate and diploma and bachelor educated respondents in favor of diploma and bachelor educated ,and there were differences between illiterate respondents and primary educted in favor of primary educted respondents , there were differences between primary educated respondents in favor of and diploma and bachelor educated and , there were differences between secondary educated respondents in favor of and diploma and bachelor educated respondents in favor of diploma and bachelor educated.

The above data indicated that the respondents who had the highest level of education satisfied with their life and had positive evaluation for all domains of quality of life .

Table (4.17): ANOVA test result for general quality of life and its 4 domains According to education level.

QOL-BREF	Education level	Mean	SD.	P value
General quality of life	Illiterate	63.5	13.4	0.000
	Primary education	69.3	14.14	
	Secondary education	67.2	12.05	

	Diploma and bachelors education	83.3	7.1	
Physical domain	Illiterate	46.6165	19.62762	0.000
	Primary education	56.0105	20.83147	
	Secondary education	52.0604	26.42226	
	Diploma and bachelors education	78.2468	12.72297	
Psychological domain	Illiterate	51.1143	16.12074	0.000
	Primary education	60.8740	16.81717	
	Secondary education	59.1346	13.38631	
	Diploma and bachelors education	71.9697	10.05038	
Social domain	Illiterate	45.7207	21.72386	0.000
	Primary education	59.7032	21.20109	
	Secondary education	58.7121	24.05314	
	Diploma and bachelors education	67.4242	17.65980	
Environmental domain	Illiterate	50.7675	17.06202	0.002
	Primary education	54.6113	19.11442	
	Secondary education	55.4087	16.23936	
	Diploma and bachelors education	70. 45	11.38	

4.3.2.5 There is no significant difference in quality of life the respondents of the present study in relation to marital status:

Anova test showed statistically significant differences in quality of life ($p < 0.001$) ; environmental domain (0.032) ; social domain ($p < 0.001$) ; psychological domain ($p < 0.001$) and physical domain ($p < 0.001$) in relation to marital status., therefore the null hypotheses was rejected for marital status .

Tukey test shows that the differences in physical health , psychological health , social relation and environmental condition were between single respondents and divorced respondents in favor of single respondents and there were differences between single respondents and widowed respondents in favor of single respondents . More over Tukey test shows that the differences in physical health , psychological health , social relation and environmental condition were between married respondents and divorced respondents in favor of married respondents and there were differences between married respondents and widowed respondents in favor of married respondents .

table 4.18 ANOVA test result for general quality of life and its 4 domains according to marital status .

QOL-BREF	Marital status	Mean	SD	P value
General quality of life	Single	70.5	15.3	< 0.001
	Married	69.3	12.9	
	Divorced	60.5	12.4	
	Widowed	60.1	14.6	
Physical domain	Single	71.8750	21.1	0.000
	Married	55.0125	20.6	
	Divorced	38.7755	22.3	

	Widowed	43.2331	19.5	
Psychological domain	Single	65.6250	14.562	0.000
	Married	58.3576	15.36391	
	Divorced	47.9167	14.95631	
	Widowed	49.6491	17.64277	
Social domain	Single	44.4444	25.63996	.000
	Married	57.4297	15.36391	
	Divorced	29.7619	20.33751	
	Widowed	42.2980	20.99606	
Environmental domain	Single	56.6406	19.58252	.032
	Married	54.9055	16.89158	
	Divorced	56.6964	19.60614	
	Widowed	48.4043	18.06398	

4.3.2.6There is no significant difference in quality of life among the respondents in relation to employment status .

There were statistically significant difference among respondent in relation to working status for the general quality of life (p =0.001) ; social domain (p =0.016) ; psychological domain (p =0.001) and physical domain (p = 0.000) , therefore work was significantly related to the above mentioned domains and the general quality of life and the null hypotheses was rejected for these domains .However, there were no significant differences among respondents in relation to working status for the environmental domain (p=0.105) .

The mean QOL scores were higher for respondent who continued to engage in paid work than respondent who did not engaged in paid work .The results for respondents who continued to engage in paid work were as follows : 72.6 for the general quality of life ; 59 for social domain ; 61.9 for psychological domain and 61,2 for physical domain. However respondents who did not engaged in paid work scored 65.6 for the general quality of life; 50 for social domain; 53.7 for psychological domain and 48.4 for physical domain .

Therefore respondent who continued to engage in paid work had positive evaluation and were more satisfied in their life than respondents who did not work .

Table (4. 19): ANOVA test result for general quality of life and its 4 domains according to employment status .

QOL-BREF	Work	Mean	P value
General quality of life	Yes	72.6619	0.001
	NO	65.1590	
Physical domain	Yes	61.2534	0.000
	NO	48.4585	
Psychological domain	Yes	61.9497	0.001
	No	53.7766	
Social domain	Yes	59.0426	0.016
	No	50.2033	
Environmental domain	Yes	56.6038	0.105
	NO	52.2302	

4.3.2.7 There is no significant difference in quality of life among the respondents of the present study in relation to source of money:

There were statistically difference among respondents in relation to source of money for the general quality of life(p = 0.000) , social domain (P = 0.023) ; psychological domain (p= 0.001); physical domain (p< 0.001) and environmental domain (p= 0.043) at the 0.05 level of significant. Therefore the source of money was significantly related to the general quality of life and its four domains and the nul hypothesis was rejected in relation to source of money . Tuky test of the differences according to source of money revealed that the differences in psychological health , physical health , social relation and environmental condition were between those who had pension and those who take their money from their children or relatives in favor of respondents who had pension and threre were differences between respondents who had pension and those who take their money from charities and institutions in favor of respondents who had pension . Also tukey test shows differences in psychological health , physical health , social relation and environmental condition were between the respondents who earn salary from their work and those who take their money from their children or relatives in favor of respondents who earn salary from their work **and** threre were differences between respondents who earn salary from their work and those who take their money from charities and institutions in favor of respondents who earn salary from their work .

Table (4.20): ANOVA test result for general quality of life and its 4 domains according to source of money .

QOL-BREF	Source of money	Mean	SD	P value
General quality of life	Pension	77.7374	11.9	.000
	Paid work	71.4530	15.78361	
	Support from children or relatives	65.5196	13.24832	

	allocations from charitable organizations or religious	56.2778	14.74848	
Physical domain	Pension	71.4286	13.83208	. 000
	Paid work	60.5	13.9	
	Support from children or relatives	48.3877	20.8	
	allocations from charitable organizations or religious	40.7143	20.9	
Psychological domain	Pension	68.1818	17.10595	.001
	Paid work	59.9432	17.36000	
	Support from children or relatives	54.3487	16.1	
	allocations from charitable organizations or religious	46.0317	18.3	
Social domain	Pension	62.8788	13.10409	.042
	Paid work	58.5470	26.45525	
	Support from children or relatives	50.3724	21.93832	
	allocations from charitable organizations or religious	42.1569	25.25402	
Environmental domain	Pension	61.0795	18.76893	.023
	Paid work	55.1847	20.65145	
	Support from children or relatives	53.1250	17.31653	
	allocations from charitable organizations or religious	41.8155	15.48299	

4.3.2.8 There is no significant difference in quality of life among the respondents of the present study in relation to physical health:

A statistically significant difference was observed between respondents who had physical illness and respondents who did not complain from any physical problems for the general quality of life (p =0.015) ; psychological domain(p = 0.004) and physical domain (p=0.000) , and the nul hypotheses was rejected for the relationship between physical health and quality of life .

The mean scores of respondents who had physical illness was lower than respondents who did not complain from any physical problems for the general quality of life (65.3 vs 70.2) ; physical domain (47.5 vs 61.7)and psychological domain (53.6 vs 60.8) ; therefore respondents who had physical illness were less satisfied with the quality of their lives and their psychological and physical health .

On the other hand, there were no statistically significant differences in social domain (p = 0.96)and environmental domain (p= 0.19) in relation to physical health .

Table (4.21): ANOVA test result for general quality of life and its 4 domains according to physical health.

QOL-BREF	Physical illness	Mean	P value
General quality of life	Yes	65.3425	0.015
	NO	70.2534	
Physical domain	Yes	47.5176	0,000
	NO	61.7033	
Psychological domain	Yes	53.6272	0.004
	No	60.8974	
Social domain	Yes	51.6239	0.963
	No	52.4854	
Environmental	Yes	52.3262	0.198

domain	NO	54.8077	

4.3.2.9 There is no significant difference in quality of life among the respondents of the present study in relation to living arrangement:

A statistically significant difference was observed amongst the three groups of living arrangement for total quality of life and its four domain (p 0.000) , at the 0.05 level of significant , therefore the null hypotheses was rejected for living arrangement . tukey test shows that the differences in physical health , psychological health social relation and environmental comdition were between respondents who live with their family and respondents who live alone in favor of respondents who live with their family . Moreover there were differences between respondents who live with their family and respondents who living with children's family in favor of respondents who live with their family .

Table (4.22): ANOVA test result for general quality of life and its 4 domains according to living arrangements.

QOL-BREF	Living arrangement	Mean	Sd	P value
General quality of life	Living Alone	63.0355	17.43223	0.000
	Living with their child family	61.5172	13.36990	
	Living with their family	71.7087	11.17083	
Physical domain	Living Alone	46.6553	23.12659	0.000
	Living with their child family	45.1504	20.77209	
	Living with their family	57.1970	19.54152	

Psychological domain	Living Alone	51.4550	19.63144	0.000
	Living with their child family	49.1667	14.85748	
	Living with their family	61.6541	14.38592	
Social domain	Living Alone	46.2766	23.93937	0.000
	Living with their child family	42.2414	22.58322	
	Living with their family	60.9028	18.61183	
Environmental domain	Living Alone	50.2520	23.56471	0.000
	Living with their child family	48.5197	16.64766	
	Living with their family	57.5188	14.17536	

4.4 Relationship between the independent variables (demographic characteristics) and mental health status of the respondents

In order to investigate the relationship between the independent demographic variable and mental health status, spearman coefficient correlation test was done. Only age and educational level were used in correlation analysis because the remaining independent variables were nominal . The results showed that there were statistically significant negative correlation between educational level and GSI ($r = -0.418$, $p < 0.001$).

With regards to the 9 –symptom dimensions , there were statistically significant negative correlation between educational level and somatization ($r = - 0.375$, $p < 0.001$) , obsessive-compulsive($r = - .307$, $p < 0.001$) , interpersonal sensitivity ($r = -.273$, $p < 0.001$), depression ($r = - .449$, $p < 0.001$), anxiety($r = - .259$, $p < 0.001$) , hostility($r = .-315$, $p < 0.001$) , phobic anxiety ($r = -.262$, $p < 0.001$), paranoid ideation ($r = -.355$, $p <$

0.001), psychoticism (r = -.393 , p < 0.001). These results indicated that the higher level of educational of the respondents , the least prevalent of the psychological complaint .

However there were statistically significant positive correlation between age and GSI

(r =.134, p = .022) , somatization (r = .245, p < 0.001) , obsessive-compulsive(r = .157 , p = .007) , depression (r = .173, p = .003), hostility(r = .137, p = .020) and phobic anxiety (r = .140, p =.017) . The data indicated that the older age of the respondents the higher prevalence of the mentioned symptoms .

Table (4.23): Spearman correlation of educational level and age variables with the GSI and 9 symptom diminutions.

GSI and 9 BSI dimensions	Age by group	Education level
somatization		
Correlation Coefficient	.245(**)	-.375(**)
Sig. (2-tailed)	<0.001	<0.001
Anxiety		
Correlation Coefficient	.042	-.259(**)
Sig. (2-tailed)	.474	<0.001
Obsessive compulsive		
Correlation Coefficient	.157(**)	-.307(**)
Sig. (2-tailed)	.007	<0.001
Depression		
Correlation Coefficient	.173(**)	-.449(**)
Sig. (2-tailed)	.003	<0.001
Psychoticism		
Correlation Coefficient	.094	-.393(**)
Sig. (2-tailed)	.111	<0.001
Hostility		
Correlation Coefficient	.137(*)	-.315(**)
Sig. (2-tailed)	.020	<0.001

Phobic anxiety Correlation Coefficient Sig. (2-tailed)	 .140(*) .017	 -.262(**) <0.001
Paranoid ideation Correlation Coefficient Sig. (2-tailed)	 .006 .919	 -.355(**) <0.001
Interpersonal sensitivity Correlation Coefficient Sig. (2-tailed)	 .020 .737	 -.273(**) <0.001
GSI Correlation Coefficient Sig. (2-tailed)	 .134(*) .022	 -.418(**) <0.001

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

* Correlation is significant at the 0.05 level (2-tailed).

A stepwise regression analysis of the demographic variable indicated that only educational level , district of living , source of money , and physical health significantly predicted the global severity index .

Education level was negatively correlated with the(GSI) (r = -.344, p < 0.001) . Variance in education alone accounted for 17.1% of the variance in GSI . When all the independent variables were held constant , the correlation with a negative(r) indicated an inverse relationship between educational level and GSI. This means that the higher level of education of the respondent , the less GSI or psychological distress they had.

Variance in district alone accounted for 13.7 % of the variance in GSI . Together education and district accounted for 25.5 % of the variance in the GSI. Psychological distress (GSI) is more prevalent among poorly educated respondents who live in non urban areas .

Also physical health was negatively correlated with the global severity index (r = -.355, p < 0.001) . Variance in physical health accounted for 5.7% of the variance in GSI . Together education , district , physical health accounted for 30.7 % of the variance in the GSI. On the other hand source of money was positively correlated with the global severity index (r = 0.250, p < 0.001) . Variance in physical health for 5.5% of the variance GSI . together education , district , physical health and source of money accounted for 32.2 % of the variance in the GSI. Thus , participants who have less education , live in rural areas, have bad physical health and are dependent on charity and others for money are are the most psychologically distressed

Table (4.24): stepwise regression analysis for global severity index and education level.

	Coefficients B	**Std. Error**	**t value**	**Sig.**
(Constant)	1.897	.079	24.101	.000
Education level	-.344	.045	-7.731	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 59.774	R Square .171
Regression	22.396	1	22.396			
Residual	108.282	289	.375			

Table (4.25): Stepwise regression analysis for global severity index and district.

	Coefficients B	Std. Error	t value	Sig.
(Constant)	1.951	.095	20.472	.000
District	-.338	.050	-6.772	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. <	F	R Square
Regression	17.897	1	17.897	0.001	45.862	.137
Residual	112.781	289	.390			

Table (4.26): Stepwise regression analysis for global severity index and source of money.

	Coefficients B	**Std. Error**	**t value**	**Sig.**
(Constant)	.637	.171	3.719	.000
Source of money	.250	.058	4.303	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. <	F	R Square
Regression	7.909	1	7.909	0.001	18.519	.061
Residual	122.580	287	.427			

Table (4.27): stepwise regression analysis for global severity index and physical health.

	Coefficients B	Std. Error	t value	Sig.
(Constant)	1.794	.114	15.723	.000
Physical health	-.355	.087	-4.083	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 16.673	R Square .055
Regression	7.128	1	7.128			
Residual	123.550	289	.428			

Table (4.28) stepwise regression analysis for global severity index and physical health , district , source of money and educational level.

	Coefficients B	**Std. Error**	**t value**	**Sig.**
(Constant)	2.279	.220	10.348	.000
Educational level	-.253	.042	-5.975	.000
District	-.280	.046	-6.045	0.000
Physical health	-.331	.076	-4.365	0.000
Source of money	.132	.051	2.586	0.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 33.737	R Square .322
Regression	42.032	4	10.508			
Residual	88.457	284	.311			

4.5 Relationship between the independent variables (demographic characteristics) and quality of life of the respondents

In order to investigate the relationship between the independent demographic variable and quality of life, and its domains, Pearson coefficient correlation test was done. Only age and educational level was used in the correlation analysis because the remaining independent variables were nominal . The results showed that there were statistically significant negative correlation between age and quality of life in which people who were older had lower general quality of life ($r = -0.282$, $p < 0.001$).

However , in relation to the various domains of quality of life , the results indicated that there were significant negative correlation between age and physical domain ($r = -0.292$, $p < 0.001$);

psychological domain ($r = -0.230$, $p < 0.001$); social domain ($r = -0.145$, $p = 0.021$), and

environmental domain ($r = -0.195$, $p < 0.001$).

On other hand, there were statistically significant positive correlation between educational level and quality of life in which people who had higher education level had better general quality of life ($r = 0.278$, $p < 0.001$).

In regards to psychological domain , there was positive correlation with educational level ($r = 0.304$, $p < 0.001$). As well , there was positive correlation between social domain and educational level ($r = 0.295$, $p < 0.001$),as well physical domain ($r = 0.273$, $p < 0.001$),and environmental domain ($r = 0.200$ $p < 0.001$).

Table (4.29): Pearson correlation of educational level and age variables With quality of life.

	Age by group	Education level
Total quality of life Pearson correlation Sig. (2-tailed)	-.282(**) .000	.278(**) .000
Physical domain Pearson correlation Sig. (2-tailed)	-.292(**) .000	.273(**) .000
Psychological domain Pearson correlation Sig. (2-tailed)	-.230(**) .000	.304(**) .000
Social domain Pearson correlation Sig. (2-tailed)	-.145(*) .021	.295(**) .000
Environmental domain Pearson correlation Sig. (2-tailed)	-.195(**) .001	.200(**) .001

A stepwise regression analysis of the demographic variable indicated that educational level, source of money , age and living arrangement significantly predicted the total quality of life.

Education level was positively correlated with the quality of life ($r = 4.7$, $p < 0.001$) . Variance in education alone accounted for 7.7 % of the variance in the general quality of life . This means that the higher level of education of the respondents , the better general quality of life they had.

Variance in age alone accounted for 8 % of the variance of the general quality of life . Together education, district, and age accounted for 12.9 % of the variance in the general quality of life. Quality of life decreased between respondents who were poorly educated, who live in rural area and older .

The source of money was negatively correlated with the total quality of life (r = -5.141, p < 0.001) . Source of money accounted for 5.9% of the variance of the general quality of life . Together education , age and source of money accounted for 15.8 % of the variance in the total quality of life . On the other hand, living arrangement was positively correlated with the total quality of life (r = 5.33, p < 0.001) . variance in living arrangement accounting for 8.3 % of the variance of the general quality of life . Together education , age , living arrangement and source of money accounted for 20.5 % of the variance in the general quality of life .

Table (4.30): Stepwise regression analysis for the general quality of life and educational level.

	Coefficients B	**Std. Error**	**t value**	**Sig.**
(Constant)	59.032	1.859	31.756	.000
Education level	4.746	1.037	4.577	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig.	F	R Square
Regression	3853.881	1	3853.881	< 0.001	20.950	.077
Residual	46172.988	289	183.956			

Table (4.31): stepwise regression analysis for total quality of life and age.

	Coefficients B	Std. Error	t value	Sig.
(Constant)	104.601	8.191	12.770	.000
Age	-.524	.112	-4.665	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 21.767	R Square .08
Regression	3853.881	1	3853.881			
Residual	46034.749	289	183.405			

Table (4.32): stepwise regression analysis for total quality of life and source of money.

	Coefficients B	Std. Error	t value	Sig.
(Constant)	81.185	3.813	21.293	.000
Source of money	-5.141	1.305	-3.939	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 15.516	R Square .059
Regression	2932.362	1	2932.362			
Residual	47057.496	289	188.986			

Table (4.33): stepwise regression analysis for total quality of life and living arrangement.

	Coefficients B	Std. Error	t value	Sig.
(Constant)	54.410	2.698	20.165	.000
living arrangement	5.333	1.121	4.758	.000

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 22.635	R Square .083
Regression	4138.161	1	4138.161			
Residual	45888.709	289	182.824			

Table (4.34): stepwise regression analysis for total quality of life and age , living arrangement , source of money and educational level .

	Coefficients B	Std. Error	t value	Sig.
(Constant)	89.582	9.200	9.737	.000
Educational level	2.567	1.037	2.475	.014
Age	-.354	.110	-3.215	.001
Living arrangement	4.185	1.095	3.822	.000
Source of money	-3.873	1.241	-3.121	.002

Source of variation	Analysis of variance ANOVA					
	Sum of Squares	Degree of freedom	Mean Square	Sig. < 0.001	F 15.848	R Square .205
Regression	10242.488	4	2560.622			
Residual	39747.371	284	161.575			

4.6 Association between mental health scores and quality of life

In order to investigate the relationship between the global severity index scores and quality of life, and its domains, Pearson coefficient correlation test was done. The results showed that there was statistically significant negative correlation between global severity index (GSI) scores and quality of life in which people who scored more in global severity index (GSI)had less total quality of life ($r = -0.596$, $p < 0.001$), physical domain ($r = -0.524$, $p < 0.001$), psychological domain ($r = -0.620$, $p < 0.001$), social domain ($r = -0.480$, $p < 0.001$), and environmental domain ($r = -0.440$, $p < 0.001$).

The data indicated that the respondents who had higher level of psychological complains were dissatisfied with their quality of life and its domains .

Table (4.35): person correlation quality of life and its four domain with the GSI.

Quality of life domain	By global severity index
Total quality of life Pearson correlation Sig. (2-tailed)	 -0.596 (**) <0.001
Physical domain Pearson correlation Sig. (2-tailed)	 -0.524 (**) <0.001
Psychological domain Pearson correlation Sig. (2-tailed)	 -0. 620 (**) <0.001
Social domain Pearson correlation Sig. (2-tailed)	 -0. 480 (**) <0.001
Environmental domain Pearson correlation Sig. (2-tailed)	 -0. 440 (**) <0.001

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

Chapter 5

Discussion

5.1 Introduction

This chapter presents the interpretation and discussion of the results of the existing study. It also presents critical analysis of the respondent's characteristics in comparison to total

population. Mental health state, and quality of life of the respondents are explained and discussed in light of the Palestinian context and in reference to the international literature.

5.2 Discussion of the research's question one

What is the mental health status among elderly in Bethlehem?

Findings of this study indicate that the mean score of GSI was (1.35). Forty two percent of the participants had moderate symptom and 5.5% had severe symptoms. The data indicates that more than half of the respondents did not have psychological symptoms , however the number of those who complained of having moderate psychological distress was still high. This result is relatively close to the results of some other Palestinian Studies. Alissly (2005) found that the first problem that faces the elderly in Palestine was the psychological problem, Hijazi and Abu Ghali (2008) found that (57.5%) of the elderly in Gaza strip had psychological problems.

The findings of this study shows less psychological symptoms in comparison with the results of Ja'far's(2008) who found that 100% of the elderly who live in residential homes in Palestine had neurotic symptoms. Etemadi, and Ahmadi(2009) found that 62% of the elderly residents in nurseries homes in Iran had at least one symptom of psychological disorders. The above mentioned figures indicate that elderly people who live in institutions, usually have more health problems, lower functional capacity, and more social isolation .

It seems that several factors play significant role in leading to high psychological complaints among the participants. Older people tend to deal with worse objective conditions than the young. However, research suggesst, that health is a much more important factor for older people as compared to their younger counterparts. The onset of chronic disease tends to increase with age, and a prior research found that people with physical diseases are more likely to experience psychological complaints (Ormel , 2007).

In regards to the elderly in Palestine, 65.5% of them suffer from one or more chronic diseases. In addition, the political situation and the severe restrictions on travel and movement that are imposed on Palestinians due to the Israeli checkpoints, make travelling between some towns and cities virtually very difficult . These factors have significant

impact on the ability of elderly people to access many health services.,which leads to deterioration of their physical and psychological health status .

Other factors that increased the psychological complaint among the respondents are the socio economical factors. Some researchers suggested that losing work is an important social factor which contributes to poor mental health in older people (Maimaris et al , 2010) . It is a believed that loss of responsibility, loss of role and loss of social contact that follows the loss of work can lead to psychological complaints. Rosow (1967), states that the later years of adulthood are a time of role losses .In later life, many older adults(above 80 year s) have few assigned roles, most of them are no longer employed and few of them are responsible for young children ; this had broad implications on their self-concept and social integration.

The researcher seethat there are other factors that explain occurrence of mental disorder among elderly in Palestine, which are considered as serious threats, such as conflicts, and disasters which may affect the mental health of the elderly people. Poverty , low levels of education, insecurity , hopelessness ,and the risks of violence explain the great vulnerability of the elderly in Palestine to common mental disorders. In addition , it has been observed that the accumulation of life events (bereavement, defeats, demolition of houses, displacement, humiliation etc.) that elderly face during their lifetime often cause mental and physical disorders.

On the other hand , The data indicate that more than half of the respondents did not have psychological symptoms, this can be explained by stating the fact that there are many positive demographic characteristics of the Palestinian population ,which should have a positive and protective effect on the mental health of its citizens. These include the high levels of social support for example a supportive extended family , the importance of religion, and a strong sense of the national identity. In addition to the high level of psychological hardiness among the Palestinian elderly (Hijazi and Abu Ghali , 2008).

In Palestine, as in most Arab countries, socio-cultural values still promote the protection of older people ,and meet their needs. Other opinions argued that aging is associated with intrinsic reduction in the susceptibility to anxiety and depression, and this was attributed to the possibility of reducing the emotional responsiveness, increasing the emotional control and psychological immunization to stressful life events in old age (Jorm, 2000) .

In regards to the nine symptom diminutions , the higher proportion of participant had somatization symptoms. The finding of this study indicates that the mean score of somatization is 2.04 and (36.1%) of the respondent complained from moderate symptom, (34.7 %) complained from " sever" and " very sever " level of somatization .

Somaization in elderly, is frequently an adaptive response to an unfamiliar, serious social stress, like partial isolation, socioeconomic restrictions, and the deterioration in marital satisfaction due to prolonged disability, and loss of partner, in addition to the deterioration of physical health that accompanies the ageing process. Elderly in the Arab culture (as all population) do not deal with these stressors directly so they unconsciously shift in to the body and thus into physical symptoms. On the other hand, somatization among elderly is a way to gain secondary advantages such as obtaining support both in practical and financial terms and gaining sympathy, understanding and attention .

The rate of soamtization in this study is higher than what Etemadi, and Ahmadi(2009) found. They found that 27.5% of the elderly residing in nursery homes in Iran had somatization symptoms.

In regards to depression, 34.7 % of the participants report moderate level of depression symptoms, compared to 12.7 % who had severe and very severe levels of depression.

Depression is the most common mental health disorder in later life (Sherina et al , 2005). The etiology of this psychiatric disorder in elderly may include physiological changes, which play a major role in the frequency of depression in the elderly . The illnesses that particularly cause depression in the elderly include: Ischemic heart disease, Stroke, Cancer, chronic lung disease, Arthritis, Alzheimer's disease and Parkinson's disease (Weintraub et al ,2002 , Blazer , 2003). High incidence of chronic diseases among the participants of this study (77% of the participant in this study had physical disorders) which may be one of the reasons that explain the high rate of depression.

Depression in late life is frequently combined with other elderly mental disorders such as dementia and this increases the prevalence of this disorder among the elderly (Gellis et al , 2009) Another factor that increases the prevalence of depression especially in younger and middle-aged elderly is the environmental changes, such as unemployment, the increase in stress, and the reduction of social support associated with modern living .In Palestine,

there is a shift in the pattern of Palestinian families, from the extended family pattern that prevailed decades ago, to the nuclear family pattern. Nuclear families increased from 73.3% of total households in 1997 to 80.7% in 2007, which indicates a higher probability for some of the elderly to live on their own without their children or grandchildren. This means, on a general level, a reduction in the amount or level of care by children because they live in separate households and an increase in the feeling of loneliness, This issue has been exacerbated with the ongoing emigration of the younger generation outside of Palestine.

The violence of the Israeli occupation, the deterioration of the economic conditions due to embargo policy, the social insecurity and deterioration in many values due to the absence of law; all these increase the risk of elderly to be depressed.

Palestinian studies of elderly showed different results of the prevalence of depression among elderly. The result of the current study is in agreement with other local studies. Sansur (1999), found that 50.1% of the elderly in the West Bank had depression symptoms, Hijazi and Abu Ghali (2008) found that 54.8% of elderly in Gaza had feeling of depression As well, Imam (2010) found that 30% of the elderly women she studied were unhappy, 28% were unsatisfied, 18% were bitter, and 20% of them were waiting for death to come . Other studies showed lower prevalence of depression among elderly. Ibrahim (2009) found that(19.1%) of elderly in institutional homes had feeling of depression, Ja'far(2008) found that 28% of elderly living in residential homes in Palestine had depression symptoms . Abdel Rahman (2006), found that 22.0% of lone elderly participants in geriatric clubs had depression compared to 23.8% of(lone) elderly participants from geriatric homes in Cairo city . Youssef (2005), found that one quarter of participants (24.3%) of elderly in Al Karak city suffer from depression. Abolfotouh (2001), found that 17.5% of the subjects in Saudi Arabia were scored as depressing , Etemadi and Ahmadi (2009), found that 32.5% of the elderly residing in nursery homes in Iran had depression symptoms. Sherina et al (2005), showed that 6.3% of the elderly respondents in Malaysia were found to have depression . Lobo et al (1995) found that depressive disorders were found in 4.8% of the elderly in southern Europe. Taqui(2007), found that the prevalence of depression among elderly in Karachi was 19.8% and Ritchie et al (2004), found that the prevalence of depression among elderly in France was 3% . . The reason of

these differences may be due to the different cultures and scales that are used to measure depression among the elderly

However the result of the current study indicates that the mean score of anxiety symptom is (1.31) . Thirty two percent of respondents complained from moderate level of anxiety symptoms, 9.3% of respondents complained from “severe” and “ very severe “ levels of anxiety symptoms. Whereas ,it had been previously believed that anxiety disorders decline in prevalence to age. The current study indicates high prevalence of anxiety and anxiety related disorders among elderly .

The high occurrence of anxiety among elderly can be a result of inadequate coping, and inadequate support during stress time; therefore, as stress is high and support is low in elderly subjects, the prevalence and magnitude of anxiety disorders in the elderly may be higher. Elderly in Palestine face high level of stress as well as high level of poverty ,which reached (34.1%), besides the inappropriate and uncomfortable housing conditions, and changing place of residence as a result of displacement. On the other side, support, and services provided by the government agencies are not satisfying to 75% of the elderly. In addition to that, elders at this age start to change their lives; they retire and suffer from shrinkage of their social activities and their roles. This represents a sort of stress on the elderly resulting into anxiety (PCBS).

Other factors that increase the prevalence of anxiety among elderly may be associated with common medical conditions such as asthma, thyroid disease, coronary artery disease, and dementia, as well as adjustment disorders which follows significant late life stress, a thing that is common among the elderly . On the other hand, fear of death is another factor that cause anxiety among elderly specially if they failed to accept death as the final stage of growth.

The elderly people in Palestine, who suffer from chronic sicknesses are always in stress, they think to secure their medication and treatment however, only 54% of the elderly in the West Bank are covered by health insurance services and the PNA Ministry of Social Affairs gives senior citizens a monthly stipend of 90 NIS which is not enough even to cover a small part of their daily expenses, needs and medications. These factors increase the stress of the elderly concerning their health conditions. As well, past experiences of wars such as the war in 1948,1956 and 1967, dependence on others, frequesnt illnesses,

financial insecurity and long periods of unrest are considered risk factors for anxiety among the Palestinian elderly. This may explain the high prevalence of anxiety and its related disorder.

This finding is congruent with other local studies. Ibrahim (2009), found that (23.5%) of elderly in institutions homes in Palestine have anxiety, Ja'far(2008), found that 29% of elderly living in residential homes in the North of Palestine had anxiety disorder. International studies such as Le Roux et al. (2005), found that approximately 25% of their subjects reported onset of anxiety after the age of 60 years. Other local studies showed higher prevalence of anxiety. For example, Hijazi and Abu Ghali (2008) found that 64.3% of elderly in Gaza strip suffered from anxiety.

However some studies conducted in other countries showed lower prevalence of anxiety. For instance, Abdel Rahman (2006), found that the prevalence of anxiety among lone elderly living at their own homes and going regularly to geriatric clubs is 2.4% compared to 10.8 % among elderly living at geriatric homes in Cairo .The same results were reported by Etemadi, and Ahmadi(2009) , Ritchie et al (2004) and Schaub and Linden (2000) .

Previous epidemiologic studies of anxiety showed differences in their results .These differences are probably due to the differences between communities and cultures, may be an artifact of measurement error, or it could be due to differences in the way older individuals report anxiety. In addition, the differences may be due to limitation in participation of the community-dwelling older adults ; the use of other measurement to assess anxiety level for elderly populations.

Regarding the anxiety related disorders such as obsessive compulsive symptoms , (39.9%) complained of having "moderate " level of obsessive compulsive symptoms and (13.4 %) had "severe" and " very severe " levels of obsessive compulsive symptoms. However when looking at phobic anxiety,(20.3%) of the 291 respondents complained of "moderate" levels of phobic symptoms compared to (8.9 %) who complained of "severe" and "very severe" levels of phobic symptoms.

One of the explanations of Phobic anxiety (specially agoraphobia) in the elderly is the maladaptive reaction to some forms of medical illness experiences that renders the fearful individual from being unable to function safely away from home (Stein and Lang, 2002)

.The results of the current study indicated that participants had higher rates of phobia than what reported by other researchers in the world , for example, Ritchie et al (2004), found that the occurrence rates for phobia among institutionalized persons aged 65 years and above in France were (10.7%) . On the other hand, the Epidemiologic Catchment Area (ECA) study reported that the overall prevalence of phobic disorder in the non-institutionalized elderly people was 4.8%; Beekman (1998) found that the prevalence of social phobia was (3.1%); the National Comorbidity Survey Replication in America indicated that the occurrence of agoraphobia was 1.0% in the elderly, 7.5% for specific phobia, and 6.6% for social phobia (Kessler et al, and 2005).

In regards to obsessive compulsive disorder (OCD), the data reflects recurrence or worsening of an anxiety disorder that had its onset earlier in life. The finding of this study matches the findings of other local studies . Foe instance, Ja'far(2008) found that 18% of the elderly living in residential homes in the North of Palestine had obsessive - compulsive disorder ; Etemadi, and Ahmadi(2009), found that19.1% of the elderly residing at nursery homes in Iran had obsessive-compulsive symptoms,which is somehow higher than the rate in the present study .

To the contrary, all international studies (which are very few) indicated very low prevalence of OCD. For example, the Epidemiologic Catchment Area (ECA) study reported that the overall prevalence of obsessive-compulsive disorder in the non-institutionalized elderly people was 0.8% ; Beekman(1998) indicated that the prevalence of OCD among elderly was (0.6%); the National Comorbidity Survey Replication in America indicated that the prevalence of obsessive-compulsive disorder among elderly was 0.7%. (Kessler et al, 2005).

On the other hand, (14.1 %) of the respondents reported having severe and very severe levels of paranoid ideation (The term paranoid ideation refers to a suspicious or delusional disorder that is non schizophrenic) and (10.3%) of the participants reported having severe levels of psychotics. Limited epidemiological studies of paranoid ideation and psychotics among elderly people were available. Bazargan et al (2001) found that the prevalence of paranoid ideation among African American elderly was (10%); Etemadi, and Ahmadi(2009), found that 8.3% of the elderly residing at nursery homes in Iran had paranoid ideation and 9.1% of them had psychotics symptoms

New-onset paranoid symptoms among elderly are being mostly secondary to identifiable medical causes however, the psychotic symptoms among elderly may be due to the general medical condition such as the central nervous system disease, substance-induced psychosis, withdrawal from pharmacological or toxic agents, and delirium (Neno ,R. et al , 2007).

Bazargan ,M., Bazargan, S., and King, L. (2001) argued that vulnerable individuals who are unable to respond effectively to the challenges of advancing age, owing to lack of personal and social resources, often feel increasingly isolated, helpless, and misunderstood and experience a lack of acknowledgment or confirmation. Over time, their sensitivity may increase to the point that they become suspicious of other's intentions towards them. A Swedish study of Forsell and Henderson (1998), reported that paranoia symptoms were found among individuals with higher levels of depression, lower levels of social support and poorer physical health (Bazargan ,M et al , 2001).

5.3 Discussion of the Research's question two

How do elderly people evaluate their quality of life?

The results show that (46.2 %) of the Participants rated their quality of life as being good or very good compared to (22.1%) of the participants who rated their quality of life as being poor or very poor .

The findings of this study are in agreement with the findings of other local studies . Mataria et al (2008) found that the total Palestinian population reported significantly worse QOL than the WHO IFT pooled population (which composed from11049 respondents from 17 countries) . Almost (11%) of the WHO IFT population reported 'poor' or 'very poor' QOL compared to almost(26%) of the Palestinian population.

The results clearly indicate that nearly there is a similar quality of life evaluation among the participants of the current study when compared to the Palestinians population. However, there is a lower quality of life of the paricipants on this sytudy when compared to most of the other countries as reported in Mataria et al study. This can be explained by the fact that elderly people in Palestine live in war-like conditions and they are exposed to

violence. Poor quality of life among elderly in Palestine demonstrates the negative impact of exposure to long-life conflicts violence and insecurity.

Despite the high psychological symptoms among participants , the increase of dependency , loss of control and deterioration of health, still the proportion of older people who rated their life as good and very good were nearly twice the elderly who rated their life as poor and very poor. This means that the participants subjectively rated their quality of life higher than what might be described with objective measurement. Objective economic and socio-demographic indicators are less powerful in explaining the quality of life variances than the subjective ratings of the well-being and health for older adults (Robinson,2004).

One explanation for the above results is that people may use adaptive strategies as they age in order to maintain a strong sense of subjective well-being, and that is done by changing goals, changing social comparators or developing alternative selves (Murphy et al , 2007, p: 60) . This adaptive strategy is called accommodation. Individuals may, for example, compare their health and well-being to others, who are in their view, worse off than themselves (Murphy et al , 2007, p :60). Lundh and Nolan (1996) found that "...older individuals who are able to employ 'accommodation' have a good subjective quality of life". Many people with chronic disease and poor socio economic situations describe their quality of life as good or even excellent (Bowling and Gabriel, 2005).

Consciously or unconsciously, people may accommodate or adjust to deteriorating circumstances whether in relation to health, socioeconomic status or other factors, because they want to feel good about themselves. O'Boyle (1997) suggests that an individual's ability to cope and adapt to deteriorating circumstances, can contribute to successful ageing. But simply, individuals, even in difficult circumstances, may choose to 'look on the bright side' of things (Lawton, 1983).

On the other hand, spirituality plays a part in an individual's ability to cope with illness and stress, and maintain his or her well-being. Spirituality plays a powerful force that guides elderly during periods when they may be lonely or have negative feeling (Molinatti , 2005) . Unsurprisingly, many participants consider these poor conditions as acts of God " Qada' and Qadar " and they must be satisfied with this condition because they believe that God wants the best for them and they always say " "Thanks God ".

Nevertheless (45.1%) of the respondents are satisfied and very satisfied with their general health compared to(24.1 %) of the respondents who were very dissatisfied or dissatisfied with their general health. This result is in agreement with PCBS(2007) showed that about (28%) of the elderly people are not satisfied with their health conditions.

This result indicates that the participants who were very dissatisfied or dissatisfied with their general health were higher than Mataria et al (2008) results who found that almost 14% of the Palestinian population reported being 'dissatisfied' or 'very dissatisfied' with their health. This is due to the prevalence of chronic diseases and disabilities among participants, which could transform them from being independent to being dependent within a short period.

Health status has an important influence on the quality of life (Murphy, 2005). Older people frequently nominate health as an important element of quality of life. Indeed, Bowling et al. (2003) concluded that health is the most important factor that influences the quality of life. It is possible that, for the elders, a negative quality of life would be equivalent to a loss of health and the positive quality of life would be equivalent to Good health. Borglin et al. (2006) found that(48 %) of those who reported a high quality of life also had 'excellent' or 'good' self-rated health. From this we can conclude that the participants who were dissatisfied with their health had moderate and poor quality of life. This can explain the similarity in satisfaction of the general health and the positive evaluation of quality of life among the participants of the current study.

The impact of health on quality of life will be discussed in details through the discussion of quality of life domains.

In regards to the quality of life domains, participants were having lower QOL scores in Physical health domain of WHO QOL-BREF scale (mean50.9 , S.D 21.4) , The mean score of the physical domain indicates that there is moderate satisfaction among participants about their health ; (35.5 %) of participants perceived their physical health as being good and very good while (27.6%) of participants perceived their physical health as being poor or very poor. Fifty two percent of the participants were satisfied with their ability to perform their daily living activities and (7.2%) of the participants were very dissatisfied with their sleep.

The score of physical domain of QOL (50.9) was lower than Mataria et al (2008) result who found that the Palestinian population scored their quality of physical health to be (60). This may be due to high frequencies of chronic diseases among the participants.

Although many chronic diseases are not fatal, chronic conditions affect the QOL of elderly people and contribute to their disability and their decline of being independent in livings and increase the need for long-term care and this result in limiting elderly people daily activities of life. Chronic disease also result in limiting the mobility and with the presence of the environmental disabling barriers, for example stairs, this cause the inability to perform daily tasks .

Poor physical health, pain and fatigue were almost the reasons of the inability of the participants to undertake some or all of the activities of living. These people were totally dependent on others for help in all activities of living, which they found frustrating and depressing. On the other hand, being healthy allows respondents to participate in activities, thus contributing to feelings of enjoyment and having a role in life (Grewal et al., 2006). This explains the low percentage of participants who were satisfied with their ability to perform their daily living activities.

Canbaz et al (2202). reported that the points of all subgroups of SF- 36 were higher for participants without a chronic disease than for those with a chronic disease. While Sabbah (2003) showed that SF-36 domains scores are not affected by diabetes and hypertension, which could be explained by psychological adaptation to chronic disease.

Accordingly, the dissatisfaction with the quality of sleeping has numerous psychological and social factors contributing to quality and quantity of sleep. With age, several changes occur that can place one at risk for sleep disturbance including increased prevalence of medical conditions, increased medication use and environmental and lifestyle changes. For example, elderly spend more time in bed because of increased spare time available to retired or bereaved people (WHO, 2004). Foley et al 1995 found that 42% of dwelling adults over age 65 years reported having difficulty in initiating and maintaining sleep. Between 23% and 34% had symptoms of insomnia and between 7% and 15% percent rarely or never felt rest after waking up in the morning. Sleep disturbances have significant and serious consequences, As the risk of falls in the elderly and deficit in attention increase, this causes poorer overall quality of life. (Ancoli-Israel and Ayalon, 2009) .

In regards to the social relationship domain (mean 51.8, S.D 22.7) The mean of this domain indicates that the social relation among participants is relatively good. Thirty two pecent of participants evaluated their social life as very good or good compared to (22%) of participants who evaluated their social life as poor or very poor. In this concern,(64.6 %) of participants were satisfied with their personal relationships.

The reasons of personal relationships satisfaction among participants are connectedness to family, friends and neighbors who are still strongly present in the Palestinian society. Families provide not only practical support but emotional support also, which may be essential in helping the individual cope with their changes and losses. Participants in Palestine remain in contact with children and grandchildren who provide them with the emotional and practical support. On the other hand, the participants were able to play a reciprocal role by taking care of and helping their grandchildren, which is associated with giving meaning and value to life; participants took great satisfaction in the achievements of their children and grand children.

While aspects of social relationships detracted from quality of life among participants may be due to the death of a spouse, relatives or close friends, participants reduce social contacts and feel that they are alone , family disputes or not having enough time to visit them , the decline of contacting with neighbors and friends as communities change makes them more insular.

Disability among elderly however made it more difficult to engage in recreational activities because of their limited physical capacity, sensory problems, transportation issues and motivation. Elderly may find that group activities are too difficult for them and this may lead them to withdraw from social life. Also, if the surrounding environment that helps people relate to their neighborhoods are not in place, then this may affect their quality of life. For example, check points, the segregation wall, lack of transportation facilities, and lack of money may prevent an old person from leaving his/her home.

Social interaction is usually beneficial and have positive influence on quality of life. People who do not have relations with others often experience loneliness, which detracts from quality of life. (Borglin et al.(2006) ,Murphy et al (2005) and Bowling et al. (2003) reported that good social relationships among elderly were critical to quality of life, and those with the highest self-rated quality of life had ‘excellent’ or ‘good’ social support.

However when looking at the environmental domain (mean = 53.01, S.D= 17.7), 40 .4 % of respondents were satisfied and very satisfied with their environment while 16.5 % of respondents were dissatisfied and very dissatisfied with their environment. In this regard 63.9% of participants were satisfied with the conditions of their living place while(2.4%) of participant had complete access to the information that they need in their day-to-day life. This result fits with PCBS, 2007 that found about (74.4%) of the elderly in Palestine are satisfied with their homes and environments.

Satisfaction of participants with their living place can be explained by the results of PCBS, 2007 which found that about(90%) of the elderly people in the West Bank own their houses, and most of these houses are connected to the public electricity and water network. In this manner, elderly can adapt their own homes in order to maximize their independence. This is easier for those who own their homes than it is for those living in rented accommodations. Adjustments could include stair rails, reorganization of the kitchen, improving wheelchair accessibility, and installing showers, ramps and raised toilet seats (PCBS, 2007).

According to PCBS, 2007 about (80 %) of elderly in Palestine believe that their housing conditions are appropriate and comfortable and(70.3%) of the elderly in the Palestinian territories can move easily and safely between the neighborhood and their place of residence. On the other hand, some studies suggest that, even if the surrounding environment is not ideal, quality of life is more likely to be determined by how the individual relates to his or her environment. This would suggest that individuals are flexible and can adapt to different environments (Murphy et al, 2005) .

The reasons of dissatisfaction of the participants with their environments may be due to less access to public services. The capacity to physically access local amenities and networks, and the ability to interact with the local and regional environments depend on where the participant live, and wither he or she has a car or the availabllity of public transportation. Participants who are living in rural communities who find difficulty in public transportation had the biggest problems . In addition to that, only 16.1% of elderly in Palestine own a car which reduces their quality of life. Also and according to PCBS(2007) half of the elderly people live in small houses ,one third of them are not connected to the public sanitation network, and they depend on wood for heating.

Lake of access to information that they need in their day-to-day life may be due to the high percentage of illiterate participants who cannot read books and news paper. However, only 13.7 % of elderly in Palestine have a library in their homes and 3.3 % of them have computers. Borglin et al.'s research (2006) and Grewal et al. (2006) found that individuals with the highest quality of life also had the highest satisfaction with their residential environment .

Nevertheless, the participants had higher QOL scores in psychological health domain, (Mean = 55.3, S.D= 16.7). Thirty-seven and seventen percent of the participants said that their Psychological health was good and very good, however(17.4%) of the participants said that their psychological health was poor and very poor ;(47.1 %) were satisfied with their body appearance while only (4.5 %) of the participants said that they enjoy their life.

The reasons of poor or good psychological wellbeing among participants were discussed in the first question. However the positive relation between quality of life and psychological well-being was supported by a number of studies. For example, Grewal et al. (2006) found that 38 % of the respondents spoke of psychological outlook and well-being as contributing to quality of life. .. In addition, Xaviera et al (2003) found that (18%) of elderly had a negative assessment of their current quality of life and dissatisfied subjects , had more health problems and more depressive symptoms.

There are marked changes in appearance across the adult life span (mentioned in chapter 2), which lead to expectation of concomitant changes in the body image and a decrease in the attractiveness of the participants and this causes dissatisfaction of the body appearance. On the other hand, many elderly had positive body attitude (men more than women) . They believed so due to the decreased importance of weight-related issues and the changes in the beauty standards among elderly when compared to young adults . Franzoi and Koehler 1998 found that elderly women expressed greater satisfaction than young women towards their appetite, and weight. As well, Janelli (l992) found that old men (older than 60) are fairly satisfied with their body parts . Tiggemann, (2004) found that the body dissatisfaction was remarkably stable across the adult life span for women, at least until they are quite old. In contrast, the importance of body shape, weight and

appearance decreased as women get older, underscoring an important distinction between evaluation and importance of the body.

5.3 Discussion of research's question three:

How do demographic data affect mental health and quality of life of the participants?

The finding of this study revealed that there are significant differences in psychological symptoms according to the following factors: gender district, education, marital status, work , source of money , living arrangement and physical health. A stepwise regression analysis of the demographic variables indicated that education level , district , source of money , and physical health were independent significant predictors of global severity index. In the same manner, education level, source of money, age and living arrangement significantly predicted the total quality of life.

5.3.1 Gender:

A statistically significant difference was observed between male and female for GSI. On the other hand, the results showed no statistically significant sex differences in general quality of life. In the present study, there is an association between gender and mental health symptoms. This association, disappeared when regression analysis were done for other demographic factors. Regression analysis suggest that the increased level of psychological symptom among female respondents can be explained by other factors, for example ,the lack of education , single status , chronic disease and poor physical health were significantly higher among females than males in addition to that, most females did not have an independent income .

This result is in agreement with the results of other studies as Abolfotouh et al (2001) who found that female geriatric subjects were 2.6 times more likely to suffer depression than males respondents in Abha Cityof Saudi Arabia. Youssef (2005) found that depression was significantly more likely among women elderly in Al-Karak city, Ghubas et al (2004) found that depression, anxiety and hypochondriacs were greater among

females when compared to males in the Arab Emirates. Abdel Rahman(2005) found that being male is an independent risk factor for depression.

As well, Demura and Sato (2003) , Taqui et al (2007): studies Found that being a female was a significant independent predictor of depression.. Etemadi andAhmadi found that the rate of the psychological symptoms among women were more than in men in all diminution of the scale. and Beekman et al (2000) found that being a female was a significant independent predictor of anxiety disorders in later life

Some studies supported the notion that there is a difference in quality of life among genders. Thomopoulou et al (2010)found that elderly males in Greece had higher scores for quality of life than females aad Tajvar et al (2008) found that women reported significantly poorer HR QOL and for the mental component summary score (only gender were significant determinants of poorer mental health-related quality of life). And Nejati1; et al (2008) found that the mean score of aspects of physical function , general health perception , physical role , vitality , mental health , and bodily pain in men was higher than in females.

Hui-Chuanhsu, (2007)found that elderly women showed a lower health-related quality of life in every dimension, especially in bodily pain, physical functioning, and mental health. On the other hand, the findings of the current study were not in consistency with other studies. Hijazi and Abu Ghali (2008) found that there were no statistically significant differences between the two sexes in psychological problems. The report that was conducted in the occupied Palestinian Territories by the Steering Committee for Mental Health, Palestinian Ministry of Health (2004),showed that the overall prevalence of mental and behavioral disorders do not seem to be different among men and women. However, anxiety and depressive disorders are more common among women, while substance use disorders and anti-social personality disorders are more common among men. Xavier and Ferraz (2003) found that the presence or absence of satisfaction among the subjects was not associated with the gender. Robinson et al (2004) found that no significant relationship was found between gender and quality of life.

5.3.2 Age:

There were no statistically significant differences among the four age groups for global severity index; while there were statistically significant differences among groups of age for psychological domain and physical domain of quality of life . There was a steady decrease in mean scores of physical and psychological domains with increasing age; higher mean scores in QOL mean better quality of life.

People may use adaptive strategies as they age in order to maintain a strong sense of subjective well-being, by changing goals and expectations (Murphy et al., 2006).. People may adjust to deteriorating circumstances that are combined with aging whether in relation to health, socioeconomic status or other factors . On the other hand, elderly who live longer to a very old age where multiple health problems and disability are common, consequently, they spend more time in a disabled state and this explains the poor physical and psychological domains of quality of life with increasing age.

There are conflicting reports about the relationship between age and quality of life and mental health. The finding of the current study is in agreement with Tajvar et al (2008) who found that the age was not a significant determiner of poorer mental health. Beekman et al (2000) found that ageing did not have any impact on the prevalence of anxiety disorders in later life. However , Abolfotouh et al(2001), found that Psychosocial symptoms were significantly higher among very old geriatrics (75 years and more) in Abha City, Saudi Arabia . Abdel Rahman (2006)found that a group aged from 60 to 70 are vulnerable to independent risk factors for anxiety, depression or mixed anxiety in Cairo.

On the other hand, Demura and Sato (2003), found that the mean values of depression score were greater in the old-old groups than in the young-old groups. In addition, Tajvar et al (2008) found that age was a significant determiner of poorer physical health-related quality of life. Thomopoulou et al (2010) found that elderly in Greece had higher scores for quality of life than oldest old. . Nevertheless , Imam (2010) found that the physical health of participants aged 65 to 69 years was better than the participants aged 70 years and older and participants aged seventy years and above have better mental health than those aged 65 to 69.

5.3.3 District:

There were statically significant differences among respondents who lived in cities, villages and refugee camps for GSI and all other symptoms. The highest mean scores of respondents were obtained in villages for GSI. This result indicated that the respondents who live in villages had more psychological symptoms than respondents who live in refugee camps and cities. However respondents who live in cities scored the lowest in mean ranks for GSI.

According to quality of life, there were statically significant differences among respondents who lived in cities, villages and refugee camps for the social relation domain, environmental domain and psychological domain. This result indicated that the respondents who lived in cities evaluated their quality of life as being better than either respondents who lived in camps or villages in relation to social domain and psychological domain . In regards to environmental domain, refugee camps respondents had the lowest mean scores.

Quality of life and mental health were the best in urban areas and the worst in rural areas because most mental health services are located in the urban areas while fewer specialists serve in rural areas. On one hand, participants in urban areas had access to shops and recreational facilities due to the availability of public transportation . In rural areas, hospitals, clinics, shops and recreational facilities were often far from the participant's home, while public transportation was far away and infrequent. Checkpoints and the segregation wall made transportation inflexible or inaccessible to; which may prevent an old persons from leaving their homes and reducing their ability to interact with their relatives and friends and reduce their quality of life.

Life style in rural areas moves towards modern urbanization that reduces social support (which was a feature of rural areas) and have negative consequences on mental health among participants. Also the Israeli oppressive practices, including the Wall, prevented participants from reaching their agricultural lands which are considered the main source of work and activity, and disconnected the participants from their relationship with the

landscape which had moral value for them and reduced the satisfaction of participants who lived in villages.

In relation to refugee camps, the respondents had the lowest mean scores in environmental domain, but better mental health and quality of life than other participants. People in refugee camps are lacking of pleasant landscapes. Have overcrowded unhealthy surroundings ; and do not have sanitation services. This explains the lowest score of environmental domain in quality of life. But on the other hand participants in refugee camps have health insurance and they receive regular aids by UN and this made them less anxious about their health and their basic needs which may explain why they had better mental health and quality of life than participants in villages.

There are some studies that support this finding as the Mental Health Council of Australia, (2009) who found that the prevalence of mental health conditions in rural areas in Australia is probably equivalent to the levels in cities . However, there is evidence that rural Australians face greater challenges in accessing services to obtain timely help, so that the burden of associated disease is proportionately higher. While the report that was conducted in the occupied Palestinian Territories by the Steering Committee for Mental Health, (2004) , showed that living in urban Palestinian areas have negative consequences on mental health through the influence of life stresses and adverse life events such as the overcrowded and polluted environments and reduced social support. However , Xavier et al (2003) found that elderly in rural areas had the opportunity to continue their roles and work and participate in rural activities, and possibly this continuity is the source of pleasure while elderly people from industrial communities, are unlikely to continue their work , which can cuase dissatisfaction.

5.3.4 Education level:

The findings of this study show significant difference amongst the four groups of education for global severity index and quality of life. Psychological complain decreased steadily with higher educational level. Also higher level of education of the respondents means higher total quality of life. A stepwise regression analysis of the demographic variable indicated that education was the strongest predictor for the global severity index (GSI);variance in

education alone accounted for (17.1%) of the variance GSI. On the other hand variance in education alone accounted for(7.7 %) of the variance of the total quality of life.

In mental health studies, education has been identified as a significant factor associated with insight into symptoms of mental disorders and attitudes towards treatment (Steele et al. 2007). Lower levels of insight into the significance of emotional symptoms and social problems may make less well-educated individuals more likely than educated individuals to develop psychological complains and mental disorders. Also highly educated individuals are more likely to seek help and treatment when they face any psychological complaint and this prevents them from deteriorating and help individuals to cure. In addition to that, elderly who are educated engage in cognitively stimulating activities, have better economic circumstances, and engage more in physical activities.

The above mentioned finding is in agreement with those of other studies particularly Sansur (1999) , Ja'far(2008) and Yousef (2005) who found that depression was significantly more likely among the uneducated , Tajvar et al. (2008) found that higher education was associated with better physical and mental health (HRQol)., Abolfotouh et al(2001) found that Uneducated and unemployed subjects were 5 times and 1.7 times more likely to have depression than those who were educated and employed respectively, Lobo (1995) found that psychiatric morbidity, specifically depression, was associated with lower educational levels. As well, the PCBS (2006) results showed that elderly people with the lowest education become victims to abuse at higher rates than elderly people who are more educated .

Although Imam (2010) found that illiterate women have better mental health on the contrary (Ghubas, 2004) found that there was no significant correlation between the level of education and the occurrence of mental disorder in old age and Robinson (2004) found that education and quality of life are not significantly related.

5.3.5 Health:

There was astatisticaly significant correlation between participants according to the presence of physical illness and GSI and quality of life .The respondents who had physical illness had higher psychological symptoms and lower quality of life.

Chronic diseases are characteristics of old age and they are the prime cause of deterioration of physical health. There is a close connection between physical and mental well-being. Older people with physical illness had higher levels of mental illness, particularly depression (Neno et al , 2007). Chronic diseases are conditions that tend to stay with individuals for a long period of time and often require prolonged periods of treatment. Such situations lead to incapacity and limit the independence among elderly individuals. Consequences and impairments of chronic diseases have negative effect on autonomy of the elderly and make them more dependent on the family, society and health services. This loss of autonomy could be one of the reasons of depression and anxiety among elderly.

On the other hand, physical illness or disability impairs elderly ability to perform certain activities in their life. They are unable to fill certain roles and there is a disruption in their occupation. This disruption will lead to a disruption in the sense of self. This can lead to a diminishing sense of personal competence and overall well-being (Lee , 2009) . Also, physical health is a factor that affects the participation of elderly in social life and leisure activities. Elderly who have good physical health (no chronic disease) and few physical limitations seem to participate more in leisure activities, community organizations, social life and reported better mental health and quality of life. Lima (2009) said that mental, social, and emotional aspects among elderly people may be affected by Osteoporosis and musculoskeletal diseases due to insecurity, fear of falling, and consequently, decreased mobility and increased social impairment.

Other factor that may explain the effect of physical illness on mental health of elderly is medications; Some medications have side effects, and cause symptoms of depression or make a pre-existing depression get worse. For elderly individuals with multiple prescriptions, the risk of medication-induced depression is particularly high.

http://helpguide.org/mental/depression_elderly.htm.

Also chronic disease among elderly does not only have a profound impact on patients, but also on their spouses. Women may be more strongly affected by the health condition of their spouse, in terms of psychological distress, than men (Hagedoorn, 2001) .

The result of this study is in agreement with other studies. Lindeman et al. (2001), showed that elderly with type 2 diabetes had significantly higher GDS scores than those without diabetes. Abolfotouh et al (2001), found that the prevalence of depression was significantly higher among geriatric subjects with one or more chronic medical conditions than among those without any such conditions. Those who rated their health as average or poor had a 5 - 8 times increased risk of depression respectively compared to those who rated their health as good.

Several studies supported the positive correlation between physical health and mental health. For example, Beekman (1998), postulates that chronic physical illness is a risk factor for anxiety among elderly ; Youssef (2005) found that a higher risk of depression was also associated with poor physical health ;Lima et al ,(2009) found that the higher the number of diseases, the greater the negative effect on the SF-36 dimensions ; Sherina et al (2005), found that chronic and functional disability were found to be significantly associated with depression among the elderly respondents; Ormel et al (2007) found that specific mood and anxiety disorders occurred among elderly persons with heart disease at rates higher than those among persons without heart disease; Widar et al.(2004) and Canbaz et al (2002) found that the health of older people with a chronic disease obtained lower scores of quality of life

5.3.6 Source of money:

The results show that mental health was better among those who had pension than who were still engaged in paid work. The two groups had regular and steady income also they are independent in securing their income and less worried about securing their needs; they have more choices in the type of lifestyle they can enjoy (this depends on the value of pension or salary) .

Lowest psychological complaints among participants who receive pension may be understood as the benefits of the removal of work demands and work induced stress, also they may spend more time with their families . Mein et al(2003) found that mental functioning declined among those who continued to work and improved among those who had retired. On the other hand Sugisawa (1997) results showed that there was no significant effect of retirement on mental health.

Elderly who take their money from their children or relatives may suffer from economic insecurity and they are always in stress and worry about the financial stability of the future. Being dependent on others to obtain their income had a negative effect on the feeling of dignity among elderly and had negative consequences on their mental health and quality of life. On the other hand, high proportion of Palestinian population are considered poor, so many families can't save adequate food, clothing, or shelter for elderly people who depend on them and this condition puts them in high stress. The rapid urbanization and societal modernization has brought in a breakdown in family values and the framework of family economic support makes elderly have low economic status. Persons with low socio-economic status have poorer mental health (Molarius et al, 2009) .

Local studies showed that elderly face financial exploitation and economic abuse by their children and relatives with rate of (5.8%) (Dkaidek,2006; PCBC , 2006).

In regards to the respondents who take their money from charities and institutions they had the highest psychological symptom and this result explained by the poor economic and social support they received. Most of the times they don't have children or relatives who care about them and empower them with social and economic support. Social support is a protecting factor that acts a buffer in psychosocial crisis situations and strain. On the other hand , this group, usually live under poor living conditions and irregular income. Common mental disorders are most prevalent among those with poor living condition (Weich and Lewis 1998) .

In addition, personal economy had a strong association with mental health symptoms. Subjects with economic problems had a higher prevalence of anxiety/depression than subjects without economic problems (Molarius, 2009). Ghubas(2004), found that depression, anxiety and hypochondriasis were greater with insufficient income. Etemadi and. Ahmadi (2009), found that, the most common worries of the elderly were related to economic status.

5.3.7 Work:

There were statistical significant differences among respondents in relation to work for the global severity index (GSI) and quality of life; social domain; psychological domain and physical domain. Respondents who continued to be engaged in paid work had lower psychological symptoms or GSI and better quality of life than respondents who were not engaged in paid work.

Elderly who work regularly or volunteer enjoy better mental health and live longer, because they maintained continued income and are exposed to stimulating environments that increase cognitive activity (Sheila et al, 2007). Elderly who work had greater access to social, psychological, and material resources which play a role in improving their wellbeing. On the other hand, work helps older adults develop knowledge and skills that boost their self-images and mental outlooks. Also, work helps older adults mitigate the loss of the sense of purpose.

However, elderly who did not engage in any work had more psychological symptoms because they are no longer able to view themselves as productive, contributing members of society. Also, they cannot avoid boredom from the long free time they have (Zedlewski and Butrica, 2007; Charles, 2002) .

Activity theory, emphasizes that well-being and life satisfaction is reflected in old age by the extent to which the individual is able to remain involved in the social context and maintain work which makes elderly remain active.

This finding is reinforced by the finding of other local studies such as Sansour (1998), who found that the mean depression scores were lower for those respondents who are engaged in paid work where retired respondents and those who never engaged in paid work scored highest mean score. In addition, PCBS, (2006) results showed that elderly people outside the labor force have been subjected to all kinds of abuse at higher rates than those taking part in the labor force. Alissly (2005), found that elderly people outside the labor force suffered from different types of problems more than those taking part in the labor force and Tajvar et al (2008), suggested that the elderly people's economic status was the most significant predictor of elderly HRQoL.

A number of cross-sectional studies (Aquino et al, 1996; Christ et al;2007; Gill et al, 2006; Butterworth et al, 2006) reported an improvement in the mental health in people who work

beyond retirement age. for instance, Molarius (2009) found elderly who were not engaged in work, had a higher level of anxiety/depression than the employed elderly. Also a number of longitudinal studies (Lum and Lightfoot, 2005. Musick and Wilson, 2003) measured the effect of paid or voluntary work on depression scores, and the result of these studies reported significantly lower depression scores in paid or voluntary workers compared to retirees. As well Hunter and Linn (1980) found that elderly who are engaged in work had significantly higher degree of life satisfaction, stronger will to live, and fewer symptoms of depression, anxiety, and somatization compared to elderly who did not engage in any type of work .

The finding of this study did not agree with other studies which showed the negative aspects of work and that elderly prefer to relax and spend time with family, friends, and hobbies after long stressful years at the work. Tokuda et al (2008) found that workers had lower overall mental health scores than retirees and Charles (2002) found that retirement improves mental health.

5.3.8 Marital status:

Results indicated that there were statistically significant differences in psychological symptoms, quality of life and its 4 domains in relation to marital status. Participants who were divorced and widowed were more dissatisfied with their quality of life and had more psychological symptoms than participants whowere married or single respondents.

The elderly who were divorced or widows/ers who had lost suppose, interpersonal relationships and social activities, depended financially most of the times on their children and felt lonely. Losing a partner, either by divorce, or death, show social inactivity or humiliating conditions of living while in married elderly couple, the presence of a partner gives a feeling of secure and social support, and they exhibit better psychological health and lower loneliness (Thomopoulou et al , 2010)

Loss of a spouse is generally considered to be one of the most serious threats to health, well being, and productivity during the middle and later years. Studies in the United States have also noted that the single most important cause of social disengagement(Lee, 2009).

Thomopoulou et al (2010) found that, Greek married elderly had better quality of life and lower loneliness than divorced and widows. Ghubas et al (2004) found that the

prevalence of depression, anxiety and hypochondriacs symptoms were higher among single, separated, divorced or widowed when compared to married ones .

Widar et al (2004) found that married participants living at home were more likely to experience poor mental and physical health than unmarried patients who live with a family. Bennett (1998) found that men who had recently become widowed showed declines in mental health, morale and social functioning. Also it shows that men reduce their participation in social activities following bereavement.

However, Lima et al (2009) , found that the quality of life scores differences between elderly individuals with and without spouse were not significant. Hewitt et al (2006) , results showed a strong association between marital status and health among elderly women, where the divorced, widowed, and never married report better health than the married, which contradicts previous research about marriage as a protective factor for emotional conditions

5.3.9 Living arrangement:

A statistically significant difference was observed amongst the three groups of living arrangement for global severity Index, total quality of life and its four domains. Respondents who live with their family had the lowest mean ranks for GSI and higher score for quality of life, respondents who live alone scored the second mean ranks for GSI and quality of life. On the other hand the respondents who live with their children and family had higher mean ranks than the other groups for GSI and lower scores in quality of life.

Family is an important factor for older people to maintain their autonomy and maintain their health, it provides not only practical support but emotional support also, which may be essential in helping the individuals cope with their changes and losses. Family contacts were associated with giving meaning to life for elderly; also children provide important opportunities for the development of intimate relationships. Living with family promotes and supports the healthy behavior, and the supply and consumption of economic resources.

On other hand in the Arab society, especially in rural communities, children assume full responsibility of their elderly parents whether they are living with them or in their own homes. When the elderly live with their children family they rely on them even if they

have no strong need for their help and this may let them be completely dependent on their children. So elderly who live in their own homes with their supposes and children are more independent than elderly who live with their children in one home. This support the finding of this study, that the respondents who live within their own families had the lowest psychological symptoms and highest quality of life than respondents who live alone and the respondents who live with children family.

To the contrast , there is a belief that says if elderly who live in their child family did not have social support then their quality of life would not be better than elderly who live alone and may be worse. Loneliness can occur in both the presence and absence of social contact . So the concept is in the quality of social support not in the living arrangement.

Tohome et al(2010) postulated that of all the various living arrangements, living alone is a controversial issue with respect to older adults. Solitary living may signify financial and psychological independence; while on the other hand, it might indicate social isolation and social deprivation. However , living alone promotes independence, individualism and the purchase of privacy among older adults specially if they had high income, this explains the result of this study that indicates that elderly who live alone had lower psychological symptom and better quality of life than who live with children family .

This result is in consistency with other local and international studies, Youssef (2005) results demonstrated that old people living alone were at a much higher risk of depression although they are able to maintain independence. In addition Lee (2009) found that the elderly living with spouse are more active than elderly who live with their children's family, but older adults uniformly felt a deep need to keep in close touch with their children. Thomopoulou et al (2010) found that the elderly who live with their family are able to adapt to their new reality more easily than those who live alone with health problems, low income and dissatisfaction for their life.

The elderly who live close to their family have social support, exhibit better psychological health and less feeling of loneliness. Widar et al. (2004) also found that health-related quality of life for people with stroke can be improved by support from family members., patients said that family support was the most important influence on their quality of life. Grewal et al. (2006), found that all of the subjects who are interviewed spoke of how important relationships and family were to them.

To the contrary, Gee (2000) in her study of (Chinese Canadian) indicated that living arrangements are not a significant predictor of life satisfaction or well-being for married men and women. For widows, living arrangements determine well-being but not life satisfaction.

5.4 Recommendations

Depending on the study's results, and taking into consideration the importance of the elderly in our society, t I recommends the following:

Specific recommendations for decision makers in government and private institutions

1. The elderly should have the right to choose, whether to continue , or retire from their work, when they reach the age of sixty . This age should not be the age of retirement, because they could be given a chance to have a part time job, that fits their health status. This procedure supports their financial status , provides them with an independent life and sustains their continuous role in society.

2. Provide special psychological assistance for the elderly, especially in rural areas ,where they can't reach the services provided in towns. This can be done by establishing a psychological clinic, which will be visited by a specialized psychologist, and a specialized counselor, at least once a week.
3. entertainment clubs must be available for the elderly so they can interact with the local society.
4. Involve the media especially the radio and TV channels in presenting programs to raise awareness of the elderly problems , concerns, and how to satisfy their needs and solve their problems, besides offering programs that promotes the idea of taking care of the elderly.

5. Develop special programs with relevant authorities to diminish illiteracy among the elderly, as illiteracy is so high among elderly and has negative consequences on their mental health and quality of life .
6. Urging the Palestinian universities to develop academic courses related to elderly care. Also, include geriatrics and aging issues in some of the academic courses at the universities, in addition to developing materials about the elderly (their role in society, how to care about them, etc.) in part of the educational curriculum.
7. Allocate part of the governmental budget to support the elderly, through the ministry of health's budget to follow up the chronic health conditions among elderly. Besides assigning some budget to guarantee the provision of the basic needs of the elderly.
8. Clear policies are also needed in relation to health financing and insurance coverage for elderly people.
9. Establishing specialized health care centers or units for elderly care, and providing them with free health insurance.
10. Establishing more advanced and specialized institutions to provide services to the aged, through residential homes for those in need ,or day care centers along with home visits for the aged living in their own homes, whether alone or within family members.
11. Improve the environmental conditions in the camps and improve the services provided by UNRWA .

Special recommendations to the local society and the elderly relatives :

1. Support the social role of elderly people in public life and take advantage of their abilities, and energies in the developmental programs. This can be done through community service centers, and day care centers or programs, which allow the aged to contribute or offer their experiences to the community.
2. Spread the culture of voluntary work (in the domain of elderly care) to reach the elderly in their households, and to help their families. Volunteers can be recruited from universities or youth centers whose members can pay frequent visits to the homes of the elderly, and can recruits specialized psychiatrists to follow up their conditions.

3. Strengthen the role of the Palestinian families and increase their ability to take care of their elderly , and support those families by helping them in taking care of those elderly. Relatives, neighbors and friends who take care of the elderly should understand the elderly emotional and mental difficulties. Teaching or additional programs should be provided by community health and social agencies .
4. Involve the elderly in the familydecisions and not to take over the role they used to play as the head of their families
5. The elderly have to take their health problems seriously and not to deal with them as being a result of their advanced age, so they have to get the appropriate needed treatment. Also they have to make use of the supporting medical tools when they suffer from disabilities such as wearing glasses when they have optical problems .

Special recommendations to the psychiatric counselors, mental health specialists and students of mental health:

1. Encourage mental health students, community health students and research centers to study everything related to the elderly and come up with practical recommendations to increase the mental health level and quality of life for the elderly.

2. Periodic selection of psychological and social geriatric people via home visits with special emphasis on the more vulnerable groups, such as women and uneducated persons, whether they are single or living alone. This could be performed by mental health students.

3. Due to the high proportion of elderly people who suffer from somatization symptoms, and in the absence of local and Arabic research in this regard , the researcher recommends that somatization must be studied to understand the reasons of the high percentage of somatization symptoms and the ways to deal with it.

4. Provide the psychiatric counselors who work with the elderly with ways and tools that help the elderly to adapt with the changes in their lives such as losing life partners , jobs and social roles.

5. Training programs should be developed for all staff in geriatric health care, with special emphasis on psycho geriatrics. Moreover, create psychosocial support programs for those working in the elderly care centers, and learn how to deal with them. The focus in these programs would be on the psychological aspects, rather than focusing on the physical and health services only.
6. Mental health practitioner have to make sure that that physical complains of elderly is a result of physical illness and not due to somatization, which is a psychological disorder that needs special attention.

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Appendices

Appendixes 1

جامعة القدس

كلية الدراسات العليا

برنامج الصحة انفسية والمجتمعية

سيدتي الكريمة / سيدي الكريم

انا الطالبة سهى البطمة اقوم بعمل بحث للتعرف على قدرة المسن/ة على التعايش مع مرحلة الشيخوخة بالاضافة الى فحص الوضع النفسي لهم ومدى تأثير التقدم في العمر عليهم . وهذا البحث هو متطلب لرسالة الماجستير الخاصة بي واتعهد لك ان تستخدم اليانات لاغراض البحث العلمي فقط . من فضلك حاول أن تجيب على كل الأسئلة الموجودة فى هذا الإستبيان . لا يوجد خطأ أو صواب فى هذه الأسئلة وإذا كانت هناك صعوبة فى أى سؤال فيمكنك أن تسأل الشخص الذى أعطاك الإستبيان . ونود أن اشكرك على تعاونك معنا فى إتمام هذه الدراسة التى تتعلق بقيمة حياتك وصحتك النفسية .

مع فائق الحب والاحترام

في البدايةارجو أن تجيب على بعض الأسئلة العامة عن نفسك وذلك بوضع اشارةX بجانب الإجابة الصحيحة أو بملء الفراغ:

الجنس ١. ذكر□ ٢. أنثى□

العمر بالسنوات : .....

مستوى دراستك

١. أمى□ ٢. تعليم اساسي □٣. تعليم ثانوي □٤. دبلوم / تعليم جامعي □ . ٥دراسات عليا□

مكان السكن : ١. قرية □، ٢. مدينة□، ٣. مخيم □

المنزل :١. اسكن لوحدي □،٢. اسكن مع اسرة احد أبنائي □ ،٣. اسكن مع اسرتي □

هل تعمل حاليا ؟١. نعم □،٢. لا □

اذا كانت الاجابة نعم حدد ما هو العمل

١ .□ عمل بالتجارة

٢. □ اعمل بالصناعة والحرف (حدادة ، نجارة ، خياطة .... الخ)

٣. □ اعمل بالزراعة

٤.□ وظيفة

ماهو مصدر دخلك ؟

١. □راتب تقاعدي ، ٢ .□ راتب شهري او الدخل العائد من العمل ، ٣. □ دعم من الاولاد او الاقارب، ٤.□ مخصصات من مؤسسات خاصة او دينية ، ٥ . □مصادر اخرى

وما قيمته ؟.....

ما هى حالتك الإجتماعية

١. أعزب/اء□ ٢. منفصل/ة□ ٣. متزوج/ة□ ٤. مطلق/ة□ ٥. أرمل/ة□

هل لديك أي نوع من الامراض ؟

١. نعم □

حدد ما هي الأمراض : ١. □ امراض قلبية ..... ، ٢ .□ .. امراض عضلات ومفاصل.....

، ٣ . □.امراض في الجهاز البولي .....٤، □..امراض في الجهاز الهضمي .....٥ .

□..امراض في الغدد الصماء والهرمونات .....٥.□ امراض الجهاز التنفسي .....٦ . □. امراض الجهاز التناسلي .....

٧ . □ نفسية وعصبية (خرف ، الزهايمر ، باركنسون) .....

٢. لا □

هل لديك أي نوع من الاعاقة ؟

١. نعم□ ، حدد : ١.□ .سمعية ، ٢ □.بصرية .٣.□ .حركية .، ٤.، □.غيره .....

٢. لا□

نوع العائلة: 1 ممتدة □، 2 نووية □

هل يشملك التامين الصحي ؟

١. نعم□ ، ١. حدد تامين تابع للحكومة□ ،٢. تامين تابع لوكالة الغوث□ ، ٣. تامين تابع لشركة خاصة □

٢. لا□

ملاحظات الباحث :

التعليمات:

القسم الأول

هذا الإستبيان يتعلق بمدى رضاك عن صحتك صحتك وا لجوانب المحيطة بحياتك. من فضلك أجب على كل الأسئلة . إذا لم تكن متأكدا من الإجابات التى تريد إختيارها ' حاول أن تختار الإجابة التى تلائمك أكثر والتى يمكن إعتبارها إجابتك الأولى . إننا نسألك أن تفكر فى حياتك خلال الأسبوعين الماضيين على وجه التحديد.

	ضعيف جداً	ضعيف	متوسط	جيد	جيد جداً
١كيف تقيم جودة حياتك؟ (انا راضي عن حياتي الاجتماعية والصحية والنفسية والبيئية التي اعيش فيها وكانت مثل توقعاتي)					

	غير مقتنع تمامًا	غير مقتنع	متوسط	مقتنع	مقتنع تماماً
٢- إلى أى مدى أنت مقتنع بصحتك؟					

	ابدا	قليلاً	إلى حد متوسط	كثيرا جداً	إلى أبعد الحدود
٣- إلى أى مدى تشعر أن الألم الجسمانى يمنعك من القيام بأداء شىء تحب تأديته؟					

٤- إلى أى مدى تحتاج إلى العلاج الطبى حتى تؤدى وظيفتك اليومية؟(الادوية مثلا)					
٥- إلى أى مدى تستمتع بالحياة؟(مبسوط وسعيد بالحياة)					
٦- إلى أى مدى تشعر أن حياتك ذات قُيمة؟(حياتك مهمة بالنسبة لك وللاخرين)					

الأسئلة التالية تستفسر عن مدى حجم أشياء معينة تعرضت لها خلال الإسبوعين الماضيين :

٧- إلى أى مدى أنت قادر على التركيز؟					
٨- إلى أى مدى تشعر بالأمان فى حياتك اليومية؟					
٩- إلى أى مدى تشعر بملاءمة البيئة المحيطة بك لحياتك واحتياجاتك وتعتبرها بيئة صحية ؟(المكان الذي تعيش فيه يتوفر فيه كل ما يلزمك ولا يوجد به ما يضر صحتك)					
١٠- هل لديك الطاقة(الهمة) الكافية لممارسة حياتك اليومية؟(هل انت قادر على ممارسة حياتك اليوميو بدون مساعدة)					
١١- هل لديك القدرة على قبول مظهرك الجسمانى؟(هل انت راضي عن شكلك)					
١٢- هل لديك المال الكافى لتلبية إحتياجاتك؟					
١٣- إلى أى مدى تتوفر لديك المعلومات التى تحتاجها فى حياتك اليومية ؟					
١٤- إلى أى مدى تتاح لديك الفرصة للأنشطة الترويحية عند الفراغ؟(هل					

تقضي وقت الفراغ في امور تسعدك مثل رحلات ، اعراس، مناسبات اجتماعية)					

الأسئلة التالية تستفسر عن مدى شعورك بالإستحسان أو الرضا عن جوانب متعددة فى حياتك خلال الإسبوعين الماضيين :

	قليلا جداً	قليلاً	متوسط	جيد	جيد جداً
١٥- مـا هـو مـدى قـدرتك الجسـمية علـى التحـرك ؟(هل تتحرك بسهولة)					

	غير مرتاح ابدا	غير مرتاح	متوسط	مرتاح	مرتاح جداً
١٦- إلى أى مدى تشعر بالإرتياح فى نومك؟					
١٧- إلى أى مدى أنت راض عن مقدرتك فى أداء أنشطك اليومية؟(اكل ، لباس ، حمام)					
١٨- إلى أى درجة أنت راض عن مقدرتك فى أداء عملك؟					
١٩- إلى أى مدى أنت راض عن نفسك؟					
٢٠- إلى أى مدى أنت راض عن علاقاتك الشخصية؟(راض عن علاقتي باولادي وزوجتي واقرابائي وجيراني)					
٢١- إلى أى مدى أنت راض عن حياتك الجنسية؟(للمتزوجين)					

٢٢- إلى أى مدى أنت راض عن المساندة التى تجدها من أصدقائك؟(هل اصدقائك يزوروك ويدعموك)					
٢٣- إلى أى مدى أنت راض عن حالة المكان الذى تعيش فيه؟(هل انت راض بالمنزل الذي تعيش فيه وتعتبره منزل مريح؟)					
٢٤- إلى أى مدى أنت راض عن حصولك على الخدمات الصحية؟(ادوية ، تامين صحي ، عيادرات قريبة)					
٢٥- إلى أى مدى أنت راض عن توفر وسائل النقل لديك؟					

السؤال التالى يستفسر عن مدى شعورك أو تجربتك للقيام بأشياء معينة خلال الإسبوعين الماضيين :

	أبدا	نادرا	أحيانا	فى معظم الأحيان	دائما
٢٦- إلى أى مدىتنتابك مشاعرسلبية مثل الحزن واليأس والإكتئاب؟					

القسم الثاني :

امامك قائمة مشاكل او شكاوي يعاني منها بعض الناس . اقرأ كل عبارة بتمعن وضع اشارة x عند المستوى الذي يبين الى أي مدى عانيت من هذه المشاكل في الشهر الاخير حتى اليوم . الرجاء عدم ترك أي جملة .

	الى أي مدى عانيت من :					
		مطلقا	نادرا	احيانا	غالبا	دائما

١	العصبية					
٢	الشعور بالاعياء او الاغماء او الدوخة مثلا الارهاق الشديد					
٣	الاعتقاد بان شخصا ما يستطيع السيطرة على افكارك					
٤	القاء اللوم على الاخرين في معظم متاعبك					
٥	صعوبة في تذكر الاشياء					
٦	الشعور بسرعة الاستثارة والمضايقة (بتعصب لاسباب بسيطة مثل وجود اطفال صغار حولك)					
٧	الاحساس بالم في القلب او الصدر					
٨	الشعور بالخوف في الأماكن المفتوحة او الشوارع					
٩	التفكير في إنهاء حياتك					
١٠	الشعور بعدم الثقة في معظم الناس					
١١	ضعف الشهية للطعام					
١٢	الخوف او الرعب المفاجئ بدون سبب					
١٣	نوبات من الغضب لا تستطيع السيطرة عليها					
١٤	الشعور بالوحدة عندما تكون مع مجموعة اشخاص					
١٥	عدم القدرة على اتمام اعمالك					
١٦	الشعور بالوحدة والعزلة					
١٧	الشعور بالحزن والانقباض					
١٨	الشعور بعدم الاهتمام بما حولك					
١٩	الشعور بالخوف					
٢٠	الاحساس بان مشاعرك يمكن ان تجرح بسهولة					
٢١	الشعور بعدم صداقة الناس لك او انهم لا يحبونك					
٢٢	الشعور بانك اقل من الاخرين (الشعور بالنقص)					

٢٣	غثيان او مغص في المعدة					
٢٤	الشعور بان الاخرين يراقبونك او يتحدثون عنك					
٢٥	صعوبة الاستغراق في النوم					
٢٦	محاسبة النفس (تحاسب نفسك على كل صغيرة وكبيرة					
٢٧	الشعور بصعوبة في اتخاذ القرارات					
٢٨	الخوف من الركوب في الباص او المواصلات العامة					
٢٩	الشعور بصعوبة في التنفس					
٣٠	الاحساس بنوبات من السخونة والبرودة في جسمك					
٣١	الاضطرار الى تجنب أشياء او أفعال او اماكن معينة لانها تسبب لك الاحساس بالخوف					
٣٢	الشعور بان ذهنك خالي من الافكار					
٣٣	تنميل او خدران في اجزاء من جسمك					
٣٤	الشعور بالذنب وانك تستحق العقاب على خطأك					
٣٥	الشعور بالتوتر او انك مشدود داخليا (مش مرتاح)					
٣٦	صعوبة التركيز					
٣٧	الشعور بالضعف في جميع انحاء جسدك (انك مرهق)					
٣٨	عدم القدرة على القيام بالاعمال على احسن وجه كالاخرين					
٣٩	التفكير بالموت (الخوف من الموت)					
٤٠	الاحساس بدافع ملح لان تضرب او تجرح او تؤي شخصا معينا					
٤١	الاندفاع لتخريب وتكسير الاشياء					
٤٢	الاحساس بالخجل والهيبة في وجود الاخرين					

٤٣	الشعور بعدم الراحة النفسية بان كل شيئ عناء في عناء (الدنيا تعب في تعب)					
٤٤	الشعور بالوحدة والاغتراب حتى في وجود الاخرين					
٤٥	نوبات من الخوف والفزع بدون سبب					
٤٦	الدخول في كثير من الجدل والمناقشات					
٤٧	الشعور بالغضب عندما تكون وحيدا					
٤٨	الشعور بان الاخرين الايعطونك ما تستحق من ثناء وتقدير على اعمالك وانجازاتك					
٤٩	الشعور بعدم الاستقرار لدرجة لا تمكنك من الجلوس هادئا في مكان (تكثر حركتك)					
٥٠	الشعور بانك عديم الاهمية					
٥١	الشعور بان الناس يستغلونك					
٥٢	الشعور بالذنب لأتفه الأسباب					
٥٣	الشعور بان شيء ما لا تحمد عقباه قد يحدث لك (مصيبة مثلا)					

Appendix 2

BSIs-53 items

The items comprising each of the 9 primary symptom dimensions are as follows:

Somatization: Items 2, 7, 23, 29, 30, 33, and 37

Obsession-Compulsion: Items 5, 15, 26, 27, 32, and 36

Interpersonal Sensitivity: Items 20, 21, 22, and 42

Depression: Items 9, 16, 17, 18, 35, and 50

Anxiety: Items 1, 12, 19, 38, 45, and 49

Hostility: Items 6, 13, 40, 41, and 46

Phobic Anxiety: Items 8, 28, 31, 43, and 47

Paranoid Ideation: Items 4, 10, 24, 48, and 51

Psychoticism: Items 3, 14, 34, 44, and 53.

Items 11, 25, 39, and 52 do not factor into any of the dimensions, but are included because they are clinically important. These items are included when calculating Global Severity Index (GSI)

Appendix 3

QOL-BERF Items

Physical domain : Q3 ,Q4 , Q10 ,Q15 , Q16 , Q17 , Q18

Psychological Domain : Q5 , Q6 ,Q7 ,Q11 ,Q19 ,Q26

Social Domain :Q20 ,Q21 , Q22

Enviromental Domain : Q8 , Q9 , Q12 ,Q13 , Q14 , Q23 , Q24 ,Q25

General quality of life : Q1

General physical health :Q2

المخلص

عنوان الدراسة : الصحة النفسية ونوعية الحياة لدى المسنين في محافظة بيت لحم

اعداد : سهى مصطفى محمد البطمه

إشراف : د. نجاح الخطيب

تركز هذه الدراسة على جودة الحياة والصحة النفسية للمسنين في منطقة بيت لحم. وهي تهدف إلى تحديد أكثر مشاكل الصحة االنفسية السائدة لديهم، وكيف يقيمون جودة حياتهم.

لقد تم اجراء دراسة استعراضيه مسحية في العام 2010 باستخدام عينة ملائمه تمثل 300 مسن (من ذوي الفئه العمريه ٦٥ فما فوق) والذين يعيشون في منطقة بيت لحم بفلسطين. وقد تم جمع البيانات باستخدام استبيان منظمة الصحة العالمية المختصر لجودة الحياة (WHOQOL - Bref) ومقياس (BSI 53) لقياس الحالة النفسية للمسنين.

اشارت نتائج هذه الدراسة الى أن (24.7 ٪) ممن شملهم هذا الاستطلاع قد اشتكوا من توهم المرض بدرجة حادة الى حادة جدا وان (14.4 ٪) يعانون من مستوى حاد الى حاد جدا من أعراض الوسواس القهري .

ومن جهة أخرى،فقد اشتكى(9.3) ٪ من المستطلعين انهم يعانون من القلق بدرجه حاد الى حاد جدا . اما فيما يتعلق بالاكتئاب، فقد اشار(12.7 ٪)من المشاركين انهم يعانون من الاكتئاب بدرجه شديد الى شديد جدا. وكان (% 8.9) منهم قد اشاروا الى معاناتهم من والخوف المرضي بدرجه شديد الى شديد جدا.

وتبين ان(14.1 %) منهم يعانون من اعراض جنون العظمه، واخيرا فان 10.3% منهم يعانون من اعراض ذهانية .

تشير النتائج ايضا ان(% 46.2) من المستطلع اراءهم قد صنفوا مستوى جودة معيشتهم بالجيد الى جيد جدا. وقد حصل مجال الصحة الجسدية في تقيم جودة الحياة عند المسنين على ادنى متوسط حسابي (50.9) كما ان (% 35.5) من المشاركين يعتقدون ان صحتهم بين جيده الى جيده جدا، واما في مجال العلاقات الاجتماعيه فان (% 32.6)من المشاركين قد قيموا علاقاتهم الاجتماعيه بين جيده جدا وجيده ، اما في مجال البيئة المحيطة فاظهرت النتائج ان(% 4. 40) من المشاركين راضون الى راضون جدا عن البيئه التي يعيشون فيها. وفي مجال الصحة النفسية اظهرت النتائج ان (37.7%) من المشاركين قيموا صحتهم النفسيه على انها في مستوى جيد الى جيد جدا.

وأشار معامل الانحدار ان تدني المستوى التعليمي ، العيش في المناطق الريفية، الاعتماد على الآخرين اقتصاديا، ووجود الامراض المزمنه تعتبر متنبئات لتدني الوضع النفسي عند المسنين وكذلك فان التقدم في العمر ، تدني المستوى التعليمي ،العيش في المنزل الخاص باحد الابناء ، والاعتماد الاقتصادي على الاخرين . تعتبر متنبئات على سوء جودة الحياه.

نظرا لارتفاع نسبة الأمراض المزمنة بين المشاركين ولما له من تأثير سلبي على صحتهم النفسية وجودة حياتهم، توصي الباحثة بتوفير رعاية صحية أفضل للمسنين وخاصة في المناطق الريفية، كما انها تظهر أهمية إشراك المسنين في العمل التطوعي والأنشطة الاجتماعية ، ومن ناحية اخرى توصي الدراسة ضرورة دعم المجتمع والاسرة للمسن ،. كذلك أوصت الدراسة على أهمية وجود برامج تعليمية خاصة لكبار السن فيما يتعلق بالصحة الجسدية والنفسية.