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Self-Esteem as a Predictor of Depression Among Institutionalized and Non-Institutionalized Elderly

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Abstract

The purpose of the research was to evaluate the effect of institutionalization on the level of self-esteem, and depression among elderly people. For this purpose, it is hypothesized that: Self-esteem would predict Depression in institutionalized elderly. The sample was comprised of 120 individuals in which 60 were institutionalized elderly and 60 were elderly who live in their homes. Authorities of old age homes in Karachi were approached and permission for data collection was obtained. Non-institutionalized sample was approached through snowball technique. Their age ranged from 60 years and above (M=66; SD=7.2). Urdu version of Rosenberg's Self- esteem Inventory (Sardar, 1998) and Siddiqui Shah Depression scale (Siddiqui & Ali, 1997) were used. Participants' permission was also taken and they were informed about the research through informed consent. After taking consent, Rosenberg's Self-esteem Inventory (Sardar, 1998) and Siddiqui Shah Depression scale (Siddiqui & Ali, 1997) were administered in individual setting. For statistical analysis, descriptive statistics and Linear Regression were applied through SPSS, version 23. Linear Regression Analysis showed that self-esteem is a significant indicator of depression (R^2 = .85, F = 653.86, p <.01) among institutionalized elderly.

Keywords: Institutionalized elderly, Non-Institutionalized elderly, Elderly, Self-esteem, Depression.

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INTRODUCTION

Old age is a phase of life that everyone experiences if the individual live long enough. It's a time when people get older and may face new challenges and changes. Understanding old age is important because it affects many aspects of life, such as health, relationships, and happiness.

Individuals during old age, faces various problems including, adjustments, physical, and psychological issues (Dhara & Jogsan, 2013). In general, the associated physical problems includes laziness, dependency, disability, disease and death; changes in temperament and interpersonal relations include ill temper, depression, sadness, isolation; as well as deteriorations in cognitive processes (Castelli, Zecchini, Deamicis, & Sherman, 2005; Palacios, Torres, & Mena, 2009). As elderly are unable to work and fulfill their basic duties of citizenship, therefore nursing homes are viewed as their destination (Finocchio, & Silva, 2011).

Elderly staying with families receives attention in form of love, respect, and importance from family members as compare to elderly living in nursing or shelter homes as they lack these advantages and likely to experience feeling of loneliness, emptiness, sadness and depress which may affect their mental health thus depression is more common among elderly living in nursing homes. Similarly various others researches that explored differences among institutionalized and non-institutionalized elderly are follows. Studies highlighted that Institutionalized elderly are more likely to negatively view the process of ageing as 'waiting for death', who becomes more isolated at social and emotional level (Anderson & Schoeny, 2010; Araújo, Coutinho, & Saldanha, 2005). Whereas, non-institutionalized elderly views the old age as associated with freedom, autonomy and socialization (Araújo, Coutinho, & Santos, 2006), therefore, only a small population of elderly people (approximately 4%) prefers institutional care (Anderson, & Schoeny, 2010). Furthermore, it is important to highlight the demographics of elderly who preferred nursing home incudes widow, divorce or unmarried, having no children or any close relatives, and low socio economic status bracket (Aytaç, 1998; Imamoglu, & Kilic, 1999; Unalan, 2000). It is also apparent among institutionalized elderly population 3 out of 5 elderly belongs to low level of income bracket (Donumcu, 2006).

There are considerable researches which stressed that depression is often found as less recognized or undertreated because it takes place in the contexts of other physical and social problems (Blazer, 2003; Crystal, Sambamoorthi, Walkup, Akincigil., 2003; Datto, Oslin, Streim, Scheinthal, & DiFilippo, et al., 2002; Miller, Malmstrom, Joshi, Andresen, & Morley, et al., 2004; National Healthcare Quality Report, 2003; Weintraub, Datto, Streim, Katz., 2002) especially when withdrawal, prolonged bereavement, social isolation, and economic problems are accompanied (Abraham, Neundorfer, Currie, 1992). It is apparent that depression is most burdensome and more prevalent mental illness among nursing home residents especially when

untreated, inadequately treated, or depression is unresponsive to treatment which can lead to other adverse health related outcomes i.e malnutrition, weakness, lack of hydration, functional impairment, impaired quality of life, and death (American Geriatrics Society and American Association for Geriatric Psychiatry, 2003; Blazer, 2003). Other studies of institutionalized elderly reported the prevalence rate of depression ranges from 11% to 78% (Brown, Lapane, Luisi, 2002; Jones, Marcantonio, Rabinowitz, 2003) which is substantially greater than rates of depression among elderly living in community (Blazer, 2003; Rovner, 1993). A study of institutionalized elderly conducted in Kuala Lumpur reported 54% of depressed elderly. The outcomes and prognosis of chronic diseases in elderly aggravated by depression, which leads to impairment in physical and psychological functions as well as increases healthcare expenses that ultimately influence overall life expectancy (Steensma, Loukine, Orpana, et al. 2016). The risk factors that are responsible for depression among elderly include socio- environmental, interpersonal and psychological factors. Therefore, depression should be consider as important public health concerns rather than considering as normal aging process associated with old-age. Erikson believed that the individual psychological development during different stages depends on how efficiently individual coped up with problems in the past, the effective the coping is the more individual encounter a sense of growth and excellence which otherwise leads to disappointment and despair in old-age. Hence an elderly individual, who is disappointed with the past, feels desperate and see the life with unpleasantness (Abdoli, Shamsipor, Shams, 2010). Scientific writings ascertained that depression negatively affects the self-esteem (Antunes, Mazo, Balbé, 2011; Meurer, Luft, Benedetti, & Mazo, 2012). The effect of self-esteem on social and psychological development highlighted in the same manner by other researchers as well, as it was emphasized in Erik Erikson's theory of psychosocial stages of development (Ochse & Plug, 1986; Slater, 2003).

Other researchers stressed several interpersonal and intra personal factors that affect the self-esteem that eventually contribute to depressive symptoms. One of the interpersonal factors is low level of self-esteem that causes abstinence from activities and affects social reinforcement which is associated with depression. Among intra personal factor is excessive reassurance seeking for personal worth from others to upsurge his self- esteem that increases the risk of being rejected by significant others thereby more prone to depression. Individuals with lack of self-esteem are more sensitive to rejection that affects interpersonal relations and closeness after having clash, which eventually decreases the attachment, support, and satisfaction in close relationships (Orth, Robins, Trzesniewski, Maes, & Schmitt. 2009). Coopersmith (1967) reported that self-esteem is found significantly linked with personal satisfaction and effective functioning. It is observed that as the child grows older there is increase in self-esteem level as well as increase in mastery and autonomy. However, variations appears in the level of self-esteem during adolescence, some teenagers experiences decline in self-esteem which may attributed to hormonal problems while others do not get affected and finds greater personal autonomy and freedom. Self-esteem during young

adulthood is again observed to be increasing as this pattern of increasing in self-esteem is attributed to the fact that during adulthood, people takes more complex social roles and responsibilities, which ultimately leads to personality grooming associated with those social roles such as an employee, spouse, and parent. Consequently, such improvement in personality is attributed to greater self-esteem, which ultimately leads to better functioning in these social roles, therefore people throughout their adulthood experiences enhanced self-esteem.

The surge in the level self-esteem peaks around the age of 60 to 70 years, which later begins to decline, as just explored previously that increase in the level of self-esteem throughout adulthood is because of assuming new and more complex social roles, then follows the loss of these social roles in elderly thus results in decrease of self-esteem level. Moreover, the decline in level of self-esteem in old-age also attributed to deterioration in health, physical and cognitive function. This idea is supported by several researchers as highlighted that self-esteem and age relations is curvilinear i.e. increasing up to middle age and then decreasing as the individual gets older (Bloom, 1961; Hess & Bradsha, 1970). Howe (1973) highlighted that self-esteem gradually reduces from youngest to oldest age group which is evident among three age groups i.e. 25-30, 45-55, and 60-70 years which is attributed to youth orientation of society. This view was also supported by other researchers who also evidenced the decline of self-esteem with age (Kogan and Wallach, 1961; Mason, 1954). Klopfer (1958) in his research found that active elderly were having higher self- esteem which was also supported by Park and his colleagues (et al., 2014) i.e. elderly with healthy behaviors more probably spend their old-age successfully.

Preserving the independence of elderly helps in the betterment of standard of life and minimizes the cost of healthcare (Bayat & Styne, 2008; Khalili et al., 2012) which improves the level of self-esteem among elderly. Elderly with this surge in the level of self- esteem can more effectively manage the stressful life events as well as hardships without any negative psychological outcomes as the research outcomes of Nosek et al. (2003) shown the direct relation between health problems and self-esteem. Some other studies found that self-esteem closely linked to individual psychosocial need (Rosenberg, 1965; Coopersmith, 1967). The desire to be loved, and accepted, and feel secured, significant and worthwhile are the psychological and emotional needs of institutionalized elderly identified by Routh (1968) that directly affects and ravage the self-esteem (Schwartz, & Arthur, 1975). Antonelli and his colleagues (2000) in his research revealed that level of self-esteem found lower among institutionalized elderly compared to non- institutionalized elders. Institutionalization itself is the critical factor affecting the self- esteem of its residents. Mason (1954) found that the institutionalized elderly had lower self-esteem than elderly respondents who were living independently. Lieberman, Prock, & Tobin, (1968), in his cross-sectional research of comparative study between the elderly living in institution and non-institutionalized elderly, noted that institutionalized elderly exhibits lower self-esteem than the community samples. Institutionalization among elderly is viewed as a crisis and has a negative impact on self-

esteem which however through appropriate nursing interventions can be reduced (Robinson & Kathy 1974).

LITRATURE REVIEW

According to Hawley, (2003) Entering the elderly phase marks a significant transition in one's life journey. As people grow older, they encounter various changes and experiences that shape their daily lives.

Different approaches have been adopted to understand the elderly population. According to Mayor (2006), some considers chronological age as the criteria for aging while others focus on physical changes such as impairment in eye-sight or hearing, and decline in sexual functioning. Still others assess aging on the basis of capacity to do work, as per standards set in earlier years, or there is a tendency to rethink about the past rather than dwelling on present or ponder about future. Ageing is a universal biological phenomenon through which individual suffers some age-related changes based on numerous factors including biological factors such as changes at cellular or tissues level known as primary aging, whereas aging which is due to controllable factors such as lack of physical activity and poor diet is known with secondary aging (Whitbourne, Susan & Whitbourne 2010). Riley & White (1978) stated that the process of aging is a lifelong which involves change on physical, psychological, and social levels. Ismail, Ibrahim, Ahmad & Mahmud, (2007) reported four approaches to understand aging. The first approach toward understating Old-age is based on the view that individuals who has reached to the age of 65 years and above. The second approach states changes in physical characteristics of the individual such as discoloring of hair, hearing impairment and vision problem. The third approach is changes in social roles, like those who have attained retirement or who have become a grandfather or grandmother. Fourth approach is based on the individual's perception of himself whether he feels young or not. Elderly people with advancing age experience deleterious changes in cells and tissues which is integral part of aging that increases the risk for various diseases and death (Harman 2003).

Institutionalization

The elderly are a part of the population of any country and they need respect and attention equally like any other segment of the population (Nwakasi & Roberts, 2021; Tang, 2021). But the children of the elderly after their marriage forcefully kicked them in old age homes and never contact them back (Benson, Schwarz, Tofle, & Parker Oliver, 2018). Even they don't attend their funeral as well (McGrath, Sidhu, & Mahl, 2017). New economic orders compel families to focus more on amenities than the aged people (Souralová & Žáková, 2020). Even then, many if not the majority of the older persons are not helped by their families to fulfill their immediate requirements and facing hardships like less respect, no care,

no attention, sickness, and physical maltreatment, and violence against them (Saeed & Shoaib, 2012; Saeed, Shoaib, & Ilyas, 2011; Shoaib, Khan, & Khan, 2011)

A survey recently carried out by National Alliance for Caregiving (NAC) and AARP Public Policy Institute (2015b) about the "financial strain" of caregiving conveyed that thirty-six percent of research population who are taking care of elderly of over 50 years of age people rated moderate to high levels of financial burden. The residents of old-age homes confront various problems including adjustment issues, anxiety, separation from social milieu and family, seeing death of members at old homes and suffering from ailments in the institutions as evident from research which makes them vulnerable to psychological or psychiatric morbidities (Hedge, Srinivas, Rao, Pai, Mudgal 2012). Depression is found to be the most common psychiatric morbidity among elderly that significantly affect the quality of life in elderly population (Oliveira, Gomes, Oliveira, 2006). Institutionalization develops feelings of loneliness among elderly which is a great risk factor of depression in old-age (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006). Research suggested that elderly who suffers with any serious physical issues, isolation, and recent relocation are more prone to depression (Katon 2011, Steffens, Fisher, Langa, Potter, & Plassman, 2009). Robinson (1974) reported that when institutionalization is viewed by elderly as crises it produces negative impact on the self-esteem of older people.

Depression

Depression is characterized by isolation, withdrawal, lack of energy, lack of pleasure, low mood, low self-esteem, crying spells, disturbances in eating and sleeping (APA, 2000). Depression among elderly population is recognized as a major mental health problem (Alexopoulos, 2005; Boorsma, Joling, Dussel, Ribbe, & Frijters et al., 2012; Lebowitz, Pearson, Schneider, et al., 1997). As people grow older and experience loss of independence, decreased physical activity together with sense of regret, may lead to depressive symptoms in elderly (Singh & Misra, 2009). Jongenelis, et al., (2004) found multiple factors that are responsible for depression among elderly including biological factors (e.g. diseases such as hypothyroidism, stroke, and diabetes) and psychosocial factors (e.g. retirement, mourning, and institutionalization). Major depression disorder is serious illness that affects the individual life style, interpersonal life, professional life, and general health (Harris, 2007) which affects an estimated 1 to 4 percent of older population (Alexopoulos, 2005). In Brazil an estimated 15 percent of elderly population found to have depressive symptomology. Depressive symptoms are found to be associated features of many illnesses that are common among older adults (Langa, Valenstein, Fendrick, Kabeto, & Vijan, 2004). Javed & Mustafa (2013) reported that depression is one of the most common problems among elderly population in Pakistan and lack of family support is found to be the major cause (Taqui, Itrat, Qidwai, & Qadri, 2007).

Therefore, existing literature supports the significant prevalence of depression in older people living in shelter homes as compared to community dwelling elderly (Allen, 2015;

Gordon, Franklin, Bradshaw, Logan, & Elliot, et al., 2014; Kennedy, Sylvia, Bani- Issa, Khater, & Forbes-Thompson, 2005; McLaren, Turner, Gomez, McLachlan, & Gibbs, 2013; Morgan, Perez, Frankowski, Nemec, & Bennett, 2016; Nazemi, Skoog, Karlsson et al., 2013). Survey of USA long-term shelter home residents revealed that elderly faced severe depression during their first year which is largely because of pain, physical health issues, and prior institutionalization (Hoover, Siegel, Lucas et al., 2010). Furthermore, decline of health among shelter home residents also affects the relationships and interactions in daily life, and is found to be the cause of isolation, separation from others, loneliness, and more severe depression (Sandhu, et al., 2013). Ismail, Ibrahim, Ahmad & Mahmud, (2007) stated that elderly people suffering un-pleasurable life experience depression. Seligman (1990) reported that depressed person usually has low self-esteem and rarely experiences contentment. Rosenberg stated that low self-esteem can lead to depression due to being unsuccessful to acquire positive self-acceptance (Khaidzir & Ong, 2007).

Self-esteem

Literature highlighted different models including Vulnerability Model that narrates the association between depression and self-esteem. Vulnerability model views self-esteem as an element contributing to depression which means that low level of self-esteem among people have higher risk of depression or depressive symptoms (Beck 1967; Butler, Hokanson, & Flynn 1994; Metalsky, Joiner, Hardin, & Abramson, 1993; Roberts & Monroe 1992). Steiger (2014) in his research found the predictive association between self- esteem and depression as well as low self-esteem model takes the opposite approach toward understanding the relation between self-esteem and depression which states that depression is the causal risk factor for low self-esteem. Depression even after settlement leaves its scar on the self-esteem (Lewinsohn, Steinmetz, Larson, Franklin 1981; Rohde, Lewinsohn and Seeley, 1990). A growing body of researches supported the idea of vulnerability model that self-esteem predicts depression (Lewinsohn, Hoberman, & Rosenbaum, 1988). Sowislo and Orth (2013) carried out meta-analysis of 53 researches of longitudinal design to evaluate an association concerning depression and self-esteem that yielded support for both models, but most of the studies overwhelmingly supported the notion of vulnerability model. However, both of these models are not mutually exclusive because they may simultaneously exist, resulting in reciprocal relational model. Another more acceptable model is diathesis-stress model that reveals the relation between depression and self-esteem which states that low level of self-esteem acts as a predisposing factor that exerts its impact if concurrently found with stressful life events i.e loss of love, identity, or self-worth, and death of a loved one (Hammen, 2005; Metalsky, Joiner, Hardin, & Abramson, 1993). In challenging circumstances, people with low self-esteem are predisposed to depression due to fewer coping resources (Orth & Robins, 2013). This model predicts that low self-esteem along with stress predisposes the individual for experiencing depression.

A survey was conducted on residents of nursing homes which concluded that institutionalization is considered a major contributing factor to low self-esteem, as it was highlighted that most of the elderly population living in institutions are found to be dissatisfied and had low self-esteem due to inadequate attention being paid to their health (Blazer, Hughes, George, 1987). Comparative analysis between residents of nursing homes and community-dwelling elderly revealed that institutionalized elderly have lower level of self-esteem as compared to the non-institutionalized elders (Antonelli, Rubini, Fassona, 2000; Mason 1954; Lieberman, Prock, & Tobin, 1968). Thus, individuals living with their family had higher levels of self-esteem than those who are living alone or away from immediate family.

HYPOTHESIS

Self-esteem would predict Depression in institutionalized elderly.

METHODOLOGY

Current research is conducted to determine the predictive relationship of self-esteem, and depression among institutionalized and non- institutionalized elderly people.

Participants

The present study was conducted on a sample of 120 elderly individuals (M= 62, F= 58) through snow ball and purposive sampling. 60 participants were institutionalized in old age homes located in different areas of Karachi, and 60 non- Institutionalized participants living with their family were included. Participants of both gender were included in the sample. Their age ranged from 60 years old and up. The mean age of the sample was 66 years and Standard Deviation (SD) 7.2. The education level of the participants was primary to masters. Sample was selected on the following predetermined inclusion and exclusion criteria as per requirement of the study:

- Participants must not have education lower than primary so that they can understand the language of questionnaire.
- Marital status such as single unmarried, divorced and widow were included.
- Individual with any kind of physical disability or a major illness were not included.
- Individual with any psychological disorder were not included.
- Only those participants were included in the study who volunteered and gave their consent.

Measures

Demographic Information Sheet

Demographic Information Sheet is a self-developed data sheet. It includes age, gender, education, family system, marital status, financial and medical status of participants. It is developed by the researchers, as per the requirement of this research project.

Rosenberg Self Esteem Scale (RSE)

Rosenberg Self Esteem scale comprise of ten items. A 4-point likert scale is used for rating, ranging from strongly agree to strongly disagree. Description of the ratings is: "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. Items 2, 5, 6, 8, 9 are the reverse score items. Higher scores reflect high self- esteem. The reliability of scale 0.92, and internal consistency is 0.87. In the present study Urdu translated version of RSE (Sardar, 1998) was used that shows internal consistency of .71.

Siddiqui & Shah Depression Scale

Siddiqui & Shah Depression Scale is a self-report measure of depression in Urdu language, developed by Siddiqui (1997). The scale is comprised of 36 items and four point likert scale is used to rate each item ranging from 0 (Never) to 3 (Every time). The scale measures the frequency of depression indicators. The description of rating is "0" for "Never", "1" for "Sometimes", "2" for "Most of the times" and "3" for "Every time". The cutoff scores of scale for different levels of depression are "less than 26" means "No depression", "26-36" means "Mild depression", "37-49" means "Moderate depression" and "50 & above" is regarded as "Severe depression". Items of scale are categorized into different domains including Hopelessness, Interpersonal conflicts, Guilt, Worthlessness, Somatic complaints and Death wish. The test retest reliability of scale is 0.85. The scale is found to be significantly correlated with Zung's depression scale, ($r = 0.55$) and subjective mood ratings for clinical group ($r = 0.40$).

Procedure

In current research participants were approached through purposive and snow ball sampling technique. In order to accomplish the requirement of the current research, a letter of consent describing the purpose of the research along with the questionnaires was provided to the authorities of randomly selected nursing homes. After getting permission from authorities of these centers, participants were approached. Before starting the questionnaires, the researcher established rapport with the participants individually, and the objective of the research was briefly explained they were informed that they have the right to quit from the study. Confidentiality was also assured, after informed consent participants were requested to fill the demographic form.

After acquiring demographic details, questionnaires were distributed among the participants to fill in. Introduction about the objective of the research was verbally given to participants. After briefing they were requested to complete Urdu translated version of Rosenberg's Self-esteem Inventory (RSES) and Urdu translated version of Siddiqui & Shah Depression Scale. All the measures were administered individually to all the respondents. Participants were asked to read the instructions carefully and mark the responses which best describe them. Later on they were thanked for participation in the current study.

Statistical analysis

Results were analyzed to find out the statistical significance of the data through Statistical Package for Social Sciences (SPSS 23) by using linear regression analysis. Linear Regression Analysis was used to assess predictive association between variables.

Ethical Considerations

In order to make all the procedures of the study ethically conducted, the researcher followed all procedures and ethical guidelines approved by Advanced Study and Research Board (ASRB), University of Karachi. All the scales i.e Rosenberg Self Esteem Scale, and Satisfaction with Life Scale were available online and were allowed to use for research purposes by author. Further research was conducted in a manner in which respect, dignity, right and welfare of the participants were not affected. Participants were assured about the purpose and benefits of the research and about the confidentiality of personal information taken during the study to protect their rights to conceal their identity. Further, Consent was taken from the participants describing the purpose of the study and its procedure to them. Only those participants were recruited as the sample of the study who were willing to take part in it. They were also informed that they have a right to withdraw from the study. Participants were not provided any economic incentives for their participation. Researcher focused and maintained the above mentioned ethical considerations throughout study.

Operational Definitions

Self Esteem

The sum of person's feelings and thoughts with reference to his or her own self is referred as self-esteem (Rosenberg, 1965).

Depression

Depression is a mood state characterized by a sense of inadequacy, feeling of hopelessness, decrease in activity, pessimism, sadness and related symptoms (Siddiqui & Shah, 1997).

Institutionalized Elderly

Elderly people of age 60 years and above who are living in shelter homes.

Non- Institutionalized Elderly

Elderly people of age 60 years and above who are residing with family.

RESULTS

In this section, results are presented in the form of tables along with their description after the statistical analysis data. Descriptive and inferential statistical analysis was done for

interpreting the data with help of statistical package for social science (SPSS-23).

Table 1

Frequency Distribution of Non-Institutionalized and Institutionalized Elderly

Groups	***Non- Institutionalized Elderly*** (N=60)		***Institutionalized Elderly*** (N=60)	
Age	F	%	F	%
60-70	48	80	44	73.33
71-80	10	16.7	15	25
81-90	02	3.3	1	1.66
SES				
Less than 14000	3	5	26	43.33
14000- 30000	15	25	22	36.67
More than 30000	42	70	12	20
Gender				
Male	33	55	29	48.33
Female	27	45	31	51.67

Marital Status				
Married	52	86.7	38	63.33
Unmarried	5	8.3	8	13.33
Widowed/Divorced	3	5	14	23.33
Qualification				
Primary	13	21.66	11	18.33
Middle	3	5	8	13.33
Matric	7	11.66	14	23.33
Intermediate	4	6.7	5	8.33
Graduation	16	26.66	16	26.67
Master	17	28.3	6	10

F=Frequency, SES=Socioeconomic Status

Table 2

The mean and SD of participants' age

	N	Minimum	Maximum	Mean	Std. Deviation
Valid N	120	60	88	66.97	7.208

Table 2 represents descriptive overview about age of participants (N= 120) with the Minimum age (60) and Maximum age (88), further Mean age among participants is 66 with 7.20 standard deviation.

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Table 3 (a)

Summary of Linear Regression Analysis with Self-Esteem as predictor of Depression in Institutionalized Elderly

Predictor	R^2	ΔR^2	*F*	*Sig.*
Self-Esteem	.85	.84	653.86	.00*

*p <.01, df = 118

Table 3 (b)

Coefficients for Linear Regression with Self-Esteem as predictor of Depression in Institutionalized Elderly

Model	*B*	*SE B*	ß	*t*	*Sig.*
Constant	77.2	1.932		39.97	.00
Self-Esteem	-1.9	.07	.92	-25.57	.00

Table 3 a & b shows the results of Linear Regression Analyses. The results show that self- esteem is a significant predictor of depression in institutionalized elderly (R^2 = .85, F = 653.86, p <.01).

DISCUSSION

The purpose of the research was to measure the effect of institutionalization on the level of self-esteem, and life satisfaction among institutionalized and non- institutionalized elderly people. For this purpose it was hypothesized that Self-esteem would predict depression in institutionalized elderly. The current study showed that self-esteem is a significant predictor of depression in institutionalized elderly (R^2 = .85, F = 653.86, p <.01) thus supported this hypothesis (Table No. 3).

Self-esteem and depression have been studied by multiple researchers over the past few decades including Orth and Robins (2013), Sowislo and Orth (2013), Steiger et al. (2014), Trzesniewski et al. (2006). Vulnerability model explains the causal link existing between these two concepts, that people with low self-esteem are at greater risk in having depression (Klein, Kotov, and Bufferd 2011). Steiger and his colleagues (2014) explored the long-term impact existing between self-esteem and depression which highlighted that low self-esteem predicts depression in old-age. Also a case study conducted by Ali along with her colleagues (2016) on an elderly of nursing home, shown that low level of self-esteem attributed to depression among geriatric population. Beside these many other empirical studies have supported that negative assessment or convictions about one-self are important element of depression (Beck 1967; Franck, Raedt, & Houwer 2007; Steiger et al. 2014).

During interaction with elderly of old-age homes, it was witnessed that they were having depressive symptoms including helplessness, hopelessness and lack of purpose and goal in life accompanied with low level of self-esteem evident from feeling of unproductiveness, assume themself as a burden on others and thrown by their families to nursing homes as their destination. Many of them joined nursing home due to death of spouse, declining in health and inability to look after oneself due to physical inability. Participants also reported that they perceive themselves as unable to work and even in some cases participants expressed that they are unable to fulfill their basic duties of citizenship may due to loss of functional activities. Beside these there are other considerable factors that makes the institutionalized elderly susceptible to psychological issues including adjustment issues, loneliness, loss of independence, loss of social support and loved ones, lack of opportunities, loss of caregivers and family separations which leaves an impression that they are all alone and nobody is here to look after them.

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