PSYCHOSOCIAL PREDICTORS OF MENTAL HEALTH AMONG THE ELDERLY IN OLD AGE HOMES IN NORTH WEST PROVINCE, SOUTH AFRICA

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PSYCHOSOCIAL PREDICTORS OF MENTAL HEALTH AMONG THE ELDERLY IN OLD AGE HOMES IN NORTH WEST PROVINCE, SOUTH AFRICA

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(Mafikeng Campus)

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DEDICATION

This study is dedicated to my two pillars of strength, my mom and dad,

Jan and Kgakgamatso Leshomo.

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First and foremost I would like to thank the Almighty for bringing me this far and also for providing me with the strength and will to continue when it became hard. It was not easy but through You I made it.

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SUMMARY

The aim of the study was to investigate the psychosocial predictors of mental health among the aged in old age homes in the North West Province, South Africa. Psychosocial factors include social support, resilience, satisfaction with life and mental health was measured using GHQ 28.

The study was anchored on four hypotheses and thereby (1) To determine the relationship between life satisfaction, perceived social support and resilience among the elderly, (2) to investigate the influence of marital status on mental health of the elderly, (3) to investigate the influence of level of education on mental health of the elderly, (4) to determine the influence of religious affiliation on mental health of the elderly. The study used a questionnaire with four (4) sections A, B, C and D. Section A entailed demographic items, while section B consisted of the General Health Questionnaire 28 scale that was used to measure mental health which consists of four subscales, the first section measures somatic complaints, second section measures anxiety as well as insomnia, third section covers social dysfunction and the last section measures depression, section C contained the Satisfaction with Life Scale with five (5) items, section D contained Social Support Questionnaire with twelve (12) items and section E contained the Brief Resilience Scale with five (5) items. All the scales used are valid and reliable.

Cross- sectional research was implemented to the study. Data was collected from two hundred and fifty (250) participants randomly selected from three old age homes in the North West Province. Both genders stood an equal chance of being participants hence there were 89 females and 161. Age of participants ranged from 65-75 years. The researcher visited three old age homes were sample was selected according to their intellectual functioning. The statistical analysis used Pearson r correlations, linear multiple regression, and One-Way Analysis of

Variance (ANOVA). The first hypothesis stated that life satisfaction, perceived social support, and resilience will independently and jointly influence mental health among the aged was tested with the use of simple linear multiple regression statistical analysis. The result for the first hypothesis revealed that life satisfaction, perceived social support, and resilience jointly contributed to the variance in mental health of the aged. $R^2 = 0.414$, $F(3,246) = 57.890$, $p < .001$). The result showed that jointly life satisfaction, perceived social support, and resilience accounted for about 41% of the variance in mental health among the aged. Also, the results revealed that independently, life satisfaction contributed significantly to mental health ($\beta = .656$, $t = -13.095$, $p < .001$). Meaning that as scores increased, the aged are reporting better mental health. However, perceived social support (β -.020, p = n.s) and resilience (β -.076, p = n.s) were not contributing significantly to mental health of the aged. Hence, hypothesis one was partly accepted. The second hypothesis stated that there would be a significant influence of marital status on mental health of the aged was measured using One-Way analysis of variance (ANOVA). The result revealed no significant influence of marital status on mental health of the aged ($F(5,244) = .786$; p = n.s). This means that the aged who were single (n = 31, mean = 62.839, SD = 15.312) compared to the aged who were married (n = 61, mean = 58.579, SD = 16.668), separated (n = 12, mean = 56.333, SD = 15.541), divorced (n = 12, mean 54.750, SD = 16.221), widowed (n = 100, mean 57.130, SD = 15.882) , and never married (n = 26, mean 58.324, SD = 16.005) are reporting the same level of mental health. This result did not confirm hypothesis two. The third hypothesis stated that there would be a significant influence of level of education on mental health of the aged was tested using One-Way analysis of variance (ANOVA). The result discovered a significant influence of level of education on mental health of the aged ($F(4,245) = 4.246$; $p < .002$). An observation of the mean differences showed that

aged who have below matric education reported more poor mental health (M = 60.789, SD = 15.080) compared to those who have matric (M = 53.976, SD = 18.461), college certificate (M = 48.500, SD = 12.808), university degree (M = 55.250, SD = 16.488), and postgraduate degree (M = 43.00, SD = 00), respectively. The third hypothesis was confirmed. Hypothesis four stated that there would be a significant influence of religious affiliation on mental health of the aged was tested using One-Way analysis of variance (ANOVA). The result revealed a significant influence of religious affiliation on mental health of the aged ($F(3,246) = 2.861$; $p < .038$). An observation of the mean differences showed that the age who were Christians significantly reported better mental health (M = 57.560, SD = 15.789) compared to the aged who were Muslims (M = 84.00, SD = 00), Non-religious (M = 66.625, SD = 18.165), and other categories (M = 67.778, SD = 14.734), respectively. This result confirmed hypothesis four.

It was distinguished in conclusion that the study contributed to the body of knowledge by showing that life satisfaction, perceived social support and resilience have a significant influence on mental health of elderly people. It was also noted that perceived social support and resilience do not contribute significantly to mental health of the elderly. It was also noted that there was no significant influence of marital status on mental health of the elderly. It was also noted that there was a significant influence of level of education on mental health of the elderly as well as a significant influence of religious affiliation on mental health.

PREFACE

Article format

For the purpose of this dissertation, as part of the requirements for a professional master's degree, the article format as described by General Regulation A.7.5.1.b of the North West University was chosen.

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The target journal for submission of the current manuscript is Journal of Social Sciences (JSS). For the purpose of examination, tables will be included in the text.

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The letter of consent from the co-authors, in which they grant permission that the manuscript "Psychosocial predictors of mental health among the aged in old age homes in North West Province, South Arica" may be submitted for purpose of thesis, is attached.

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PSYCHOSOCIAL PREDICTORS OF MENTAL HEALTH AMONG THE ELDERLY IN OLD AGE HOMES IN NORTH WEST PROVINCE, SOUTH AFRICA

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ABBREVIATIONS

ANOVA- Analysis of Variance

BRS- Brief Resilience Scale

CD- RISC- Connor-Davidson Resilience Scale

GHQ- General Health Questionnaire

ISEL- Interpersonal Support Evaluation List

QOL- Quality of Life

RRT -Relational regulation theory

SPSS- Statistical Package for Social Sciences

SSA- Statistics South Africa

SWLS- Satisfaction with Life Scale

UNFPA- United Nations Populations Fund

WHO- World Health Organization

Abstract

Objectives: The specific objectives of the study are identified as follows: (1) To determine the relationship between life satisfaction, perceived social support and resilience among the elderly, (2) to investigate the influence of marital status on mental health of the elderly, (3) to investigate the influence of level of education on mental health of the elderly, (4) to determine the influence of religious affiliation on mental health of the elderly.

Method: Data was collected from two hundred and fifty (250) participants, 161 males and 89 females randomly selected from three old age homes in the North West Province. Age of participants ranged from 65-75 years. A cross-sectional survey design was employed and statistical analysis used Pearson r correlations, simple linear multiple regression, and One-Way Analysis of Variance (ANOVA).

Results: Results for hypothesis one revealed that life satisfaction, perceived social support and resilience jointly contributed to the variance in mental health of the elderly, other results focused on hypothesis two revealed that there was no significant effect of marital status on mental health of the elderly. However, level of education and religious affiliation were found to have a significant effect on mental health of the elderly.

Recommendations: It is necessary to avail psychological and support to the elderly to help them to overcome problems and make peace whit what they have suppressed from their past and help them build their resilience in order to better their mental health.

Keywords: Mental health / homes/ North West Province/ South Africa.

Introduction and problem statement

World Health Organization (2001) characterizes mental wellbeing as a state of prosperity in which the individual understands his or her own particular capacities, can adapt to the ordinary anxieties of life, work profitably, and productively, and has the capacity make a commitment to his or her group. Mental wellbeing is more than the insignificant absence of mental issue. WHO's constitution focused on the positive measurement of mental wellbeing in its meaning of "Wellbeing is a state of complete physical, mental and social prosperity and not just the unlucky deficiency of ailment or sickness", (WHO, 2001).

Individual well-being, perceived self-efficacy, self-sufficiency, capability, intergenerational dependence and recognition of the ability to recognise one's intellectual and emotional potential are concepts of mental health. The ability to cope with the usual stresses of life, work effectively and make a contribution to their societies as well as recognition of abilities by individuals has been defined as a state of wellbeing. Mental health might comprise an individual's potential to appreciate life, efforts to accomplish psychological resilience as well as creating a balance between life activities this is from the perspective of 'positive psychology' or 'holism'. According to Richards, Campania & Muse-Burke, (2010) an manifestation of emotions indicating a successful adaptation to a variety of demands defines Mental Health.

Diverse societies, clusters, cultures, organisations and professions have extremely different ways of conceptualizing nature and causes of mental health, determining what is mentally healthy, and deciding which mediations, if any, are suitable, as a result the methodology applied during treatment will be impacted by different cultural, class, political and religious background that various professional will have therefore determining mental health as a socially constructed and

socially defined concept. (Weare, 2000). European Commission (2004a) revealed that there are two dimensions of mental health being positive and negative mental health and they include and psychiatric disorders psychological distress. The concept of well-being as well as capability to manage in the face of variety is what is referred to by the positive dimension. The presence of symptoms is related to by negative dimension. Different aspects are covered by positive and negative mental health.

World Health Organization (WHO) categorized age groups in the following manner: middle age ranged from 45-59 years, while 60-74 years early old age and the late old age being from 75-89 years and finally 90years and above as very old age. It is recommended that these estimations should not be viewed as definite and unchangeable as biological ageing requires such a development. For the study the focus will be on elderly people from the age of 65 years onwards. The outcome of aging may elicit decline in the mental and physical capacities and a slowdown in the overall physical but the individual in question may not feel old. Old age is not a stagnant and stable period of life, but a life that involves the interaction of various powers throughout life. Accommodating the wisdom and insight to be able to sustain one's existence in spite of the strains of all life's phases is the foundation of these powers (WHO, 2001).

Just as other phases of life which are significant for all people, ageing is an inevitable process. Depending on the genetic features of the person, his or her nourishments, environmental circumstances and cultural efforts, problematic or problem-free aging happens sooner or later. People can do a lot to encourage good mental health and well being in later life as ageing is a gradual. Key factors include involvement in significant activities, solid personal relationships and good physical health (The Swedish National Institute of Public Health, 2006). 65 years of age has traditionally been seen as the entry point for 'old age'. Individuals who are close to the

age of 65 years compared to those close to the age of 85 years or older have been increasingly recognized to face some very different issues and challenges. These issues and challenges relate mainly to the quality of physical functioning and health, but they also involve different economic constraints and social opportunities (Whithourne, 2005).

Loss of their capability to live independently because of limited mobility, frailty or other physical or mental health problems are some of the special health challenges that the elderly face and need some form of long-term care. Health care professionals under-identify mental health problems of the elderly, and elderly people are often reluctant to seek help (Administration on Ageing, 2001). Recognizing that the mainstream of elderly society endure in good mental health is important. Events associated with poorer mental health are more likely to have been experienced by elderly people, for instance having to deal with a deterioration in physical health or bereavement and these are the key differences between older people and other age groups. The ability to recuperate from difficult or stressful situations and our resilience has been suggested that it is also likely to influence our wellbeing in later life is described by the term resilience (Kahn & Juster, 2002).

Events such as bereavements for example a loss of a partner, a child or someone close to them or bodily disability that have an effect on emotional well-being and can end result in poorer mental health are most likely to be experienced by the elderly. Maltreatment at home and in care organisations is some of the problems that the elderly may get exposed to (WHO, 2013). Alternatively, social support and family relations can boost the self-worth of older adults, and are probable to have a shielding role in the mental health results of this population. Elder maltreatment is a risk factor of importance to the health and mental health of the elderly, as well as an essential human rights issue, single or rehashed act, or absence of suitable activity,

happening inside any relationship where there is a desire of trust that causes damage or misery to a more seasoned individual is the way WHO characterizes abuse of the elderly. Physical, sexual, mental, passionate, budgetary and material misuse; relinquishment; disregard; and genuine loss of respect and self-esteem are the sorts of ill-use (UNFPA, 2012).

Approximately 4 to 6% of older persons in high-income nations have encountered some manifestation of abuse at home. Many elderly people are too terrified or are powerless to report maltreatment therefore making the frequency of maltreatment as high as it should be. Statistics up to so far indicates that maltreatments at home are less compared to those experienced at establishments such as hospitals, nursing homes and other long term care facilities even though data related to the problem is insufficient. Serious long-lasting psychological consequences, including depression and anxiety as well as physical injuries can be a result of elderly maltreatment (WHO, 2011). According to Jané-Llopis and Gabilondo (2008), an extensive variety of danger and defensive components at distinctive phases of the lifespan, including organic, mental, family and social variables can influence mental health status.

Psychosocial predictors

Predictors relating to the impact of social elements on a individual's brain or conduct, and to the interrelation of behavioural and social variables define psychosocial predictors in which the term psychosocial also covers internal, psychological predictors (e.g., anxiety) (Martikainen, Bartley & Lahelma, 2002).

The involvement of both psychological and social aspects defines psychosocial as stated by the Merriam Webster dictionary. Under this definition, psychosocial variables can be demographic factors, social relationships, personality, motivation, self-perception and perceived stress. Stress

is not an independent or inherent condition in the person or the environment but rather a result of the ongoing transaction, or interactions between and individual and his environment (Lazarus and Folkman, 1984; Lazarus, 1993), it is without doubt dependent on a person's psychosocial makeup to decide how everyday stimuli are perceived and interpreted.

Under this concept the focus will be investigating some of the factors on both the psychological and social aspects that can predict the functioning of the elderly population, investigating the ones that have a great deal of impact whether in a positive or a negative manner therefore affecting the mental health of the elderly by either promoting good mental health or compromising the mental health or leading to poor mental health. For the purpose of this study the researcher investigated how social support, life satisfaction, resilience can affect mental health as well as those psychosocial predictors that mostly affect the elderly, identifying those that promote positive mental health and those that compromise mental health.

Perceived Social support

Cobb (1976) put forward one of the first definitions of perceived social support, the individual belief that one is favoured for and loved, honoured and valued, and has a place with a system of correspondence and common commitments by an individual defines social support. Understanding the maintenance of health and the development of mental and somatic health problems is strategic for this concept as well as their prevention. Emotional, appraisal, informational and instrumental support are the different types of social support (Cobb, 1976). Social network, the ties to family, friends, neighbours, and other significant persons are the concepts strongly related to social support. Inside the idea of informal community, social support

is the capability of the system to give help. Structural and functional are the two separate domains of social support (Cobb, 1976).

Physical engagement of the support such as customary contact with companions or family, intentional associations or affiliations, religious administrations and other group administration form part of structural social support. Functional social support incorporates bliss with such zones as verbal and physical appraisal, tangible help with activities, correspondence of supportive data and direction and social companionship (Cobb, 1976; Cutrona, 1990). Structural social support is a necessary antecedent of functional support as suggested by social support theory (Queenan, Feldman-Stewart, Brundage & Groome, 2010). The awareness of social support (functional) is more prescient of positive wellbeing recieved or accessible social support this is suggested by evidence (Cohen, Doyle, Turner, Alper & Skoner, 2003; Sherebourne & Stewart, 1991).

The complexity of social networks and structures of social support has fascinated researchers for decades. To scrutinize the importance of social interaction for quality of life during old age there is research that is implemented. Three areas, each with a different focus was organised and summarised from various body of literature (Chappell, 1992). Literature has indicated the importance of social support on the lives of the elderly people but investigations have not indicated as to which of the different types of social support is indicated to be the best. To bring order to this literature, Chappell, (1992) established three substantive foci. Firstly, according to Chappell (1992), North American elderly lives were the first to be investigated on social support by describing the extent, sources, and types of social relationships. Secondly, the connection between social support and Quality of life (QOL) in old age was empirically examined as

knowledge was gained and investigators became knowledgeable, and thirdly, it the complexities of the concept of social support and the concept of QOL, along with the processes linking the two concepts were later the focus and were unravelled.

Social support can take numerous forms as it is multidimensional. Caring and assistance has greatly received the attention of policy makers, practitioners and researchers for support of the elderly. Due to the increasing proportion of the elderly in society, because of concerns governments and policy makers have recognized this type of support. Since they are the most frequent providers of psychological care, families and friends have become concern about assistance. Decrease in life expectancy, and other forms of psychosocial problems can be due to lack of specific types of social support (Chappell, 1992).

Families, companions, neighhours, and volunteers or by satisfactory private or administrative associations, including religious associations and senior focuses that have elevated amounts of authenticity inside their group and their companion gathering give social help which incorporates both solid and emotional support. For instance, elderly persons may be dynamic in church gatherings, backed by a round of companions, or may get concrete help as homemaker or task administrations and home conveyed meals when required. Social support has been indicated as a vital indicator of great physical and mental wellbeing, life satisfaction, and diminished danger of systematization among more established elderly by an extensive body of research (LaGory & Fitzpatrick, 1992; Forster & Stoller, 1992; Sabin, 1993; & Steinbach, 1992). The adverse effects of various stressors common to aging may also be shielded by social support (Feld & George, 1994; Krause & Borawski- Clark, 1994). The situation, the person, and his or her needs will indicate the helpfulness of social support according to researchers; thus, goodness-of-fit is

essential. Elderly persons' independence or self-esteem may be reduced by the wrong type of support, unneeded and unwanted support (Pearlin & Skaff, 1995; Rowe & Kahn, 1998).

To assist loved ones adjust to life in facilities where elderly people live families apart from friends play a key role. Recurrent visitations and spending quality time together with loved ones is one approach to make the encounter more positive and agreeable. As recommended by Smyer and Qualls (1999), families structure a dynamic and compelling interpersonal setting for elderly persons. Mutual support during times of stress is usually when elderly people meet most of their social needs within the family. It is common to find fragile elderly persons being cared for by their children in most societies and cultures all over the world. In the overall health the two forms of informal relationships being family and friends are very important but for purposes of decreasing levels of loneliness and depression the role of these forms of relationship have not been ascertained. To reduce and to foresee the level of loneliness and melancholy in elderly persons living in facilities for elderly persons it is critical to examine which of the casual connections may be seen as paramount (Smyer & Qualls, 1999).

The prominence of social support on the well-being of the elderly has been revealed by research studies (Rodriguez-Laso, Zunzunegui & Otero, 2007). Facilities where the elderly live have different forms of social support. It can be as casual and formal support. Formal support was defined by Litwak (1985), as formal medicinal administrations, doctor guidance and different types of assistance from human services faculty, while casual was characterized as help given by relatives, companions and other close partners. Social support can be in different structures. To elderly residents it becomes important to make friends in the nursing homes as they see these

people most of the time and can unburden their heart regarding their fears and hopes regarding anything they are facing. It has been found to be important for elderly people to receive support from friends as it contributes to their well being (Adams & Blieiszner, 1995; Sherman, De Vries & Lansford, 2000). For elderly persons instrumental support and emotional support can be provided through friendship (Antonucci, 1989; Reinhardt & Fisher, 1989), particularly, but not exclusively to cognitively impaired elderly persons (Roberto, 1992).

Life satisfaction

Life satisfaction is a general evaluation of sentiments and state of mind about one's life at a specific point in time going from negative to positive. Life satisfaction is one of the three main indicators of well-being namely; life satisfaction, positive affect, and negative affect (Diener, 1984). Research studies often assesses satisfaction with current life circumstances, Diener, Suh, Lucas, & Smith (1999) longing to change one's life; fulfillment with past; fulfillment with future; and significant other's perspectives of one's life also form part of life satisfaction, (Beutell, 2006).

During old age life satisfaction is presumed to be unavoidably affected by health. The importance of the role of health status should be recognised by any investigation of life satisfaction among the elderly which is a second point to take into account. As explained by Smith, Borchelt, Maier, and Jopp (2002), proposals that subjective well-heing may decrease in old age (particularly among the most established old) are gotten from exploration reporting the accumulation of weakening wellbeing conditions, utilitarian disabilities, and individual misfortunes during old age. It is proposed that the expanded danger of frailty, loss of functional capacityt, and weakness during the time of exceptionally old age may put imperatives on life

satisfaction and overpower people to such an extent, to the point that they direct their interpretation of prosperity. In older age it is expected and generally assumed that life satisfaction will decline. The association between age and life satisfaction according to the general finding of the vast body of gerontological writing is that there is no age-related decrease in life fulfilment (Larson, 1978; Herzog & Rodgers, 1981; Horley and Lavery, 1995; Diener & Suh, 1997; Smith, Fleeson, Geiselmann, Settersten & Kunzmann, 1999).

In the psycho-social study of aging life satisfaction remains to be an imperative construct, and according to research reports life satisfaction is intensely associated to socio-demographic and psycho-social variables. It is one of the normally acknowledged subjective states of personal satisfaction and is by all accounts one of the aspects of effective aging, both of which are key ideas in aging (Iyer, 2003).

Resilience

Psychiatric and developmental studies are the origin of the concept of resilience (Luthar, Ciccheti & Becker, 2000). It is an idea that has been utilized basically as a part of studies concerning children and youngsters yet as of late it has additionally been utilized effectively within older populations (Ryff, Singer, Love, Essex, 1999; Staudinger & Lindenberger, 1999). Resilience is regularly seen as the capacity of individuals to oppose and successfully overcome difficulty but there is no agreement about what it is and how it can be defined (Schoon, 2006). Therefore for resilience, the existence of adversity is a necessary. Whether resilience is an identity characteristic or a process; the dimensions of resilience; the legitimacy of resilience as an idea and its consistency about whether; and the connections of resilience with adjustment are

different views on common understanding also whether it includes something new in formative and life course theories (Luthar, Ciccheti and Becker, 2000).

Resilience is the capability to adjust in the face of hardships (Ong, Bergeman, Bisconti & Wallace, 2006). Positive health outcomes are maintained and promoted by psychosocial factors and this is an important role (Zautra, Hall & Murray, 2010). Resilience is operationalize as a set of psychosocial behavioural qualities that permit one to prosper in spite of stressful occasions and therefore it is viewed as a multidimensional construct (Connor & Davidson, 2003; Davydov, Stewart, Ritchie & Chaudieu, 2010; Luthar, Cicchetti & Becker, 2000). More noteworthy resilience shields the negative impacts of offensive occasions and conditions on both mental and physical wellbeing have been hypothesized by theoretical models (Franco, Karnik, Osborne, Ordovas, Catt & van der Ouderaa, 2009; Tugade, Fredrickson & Feldman Barrett, 2004; Van Breda, 2001).

Despite age related challenges elderly accomplish and uphold a sense of well-being and one of the many elements causative to successful aging has been identified as resilience (Young, Frick & Phelan, 2009). A number of constructed psychometric measures to capture resilience have been used in previous studies with the elderly, including the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003), the Hardy-Gill Resilience Scale (Hardy, Concato & Gill, 2004), and the Resilience Scale (Wagnild & Young, 1993). More prominent social engagement, higher idealism, stronger hold quality, and useful autonomy have been found to be positively correlated with resilience by studies mentioned (Hardy *et al.*, 2004; Lamond, Depp, Allison, Langer, Reichstadt, Moore, Golshan, 2009; Wagnild, 2003; Wells, 2009). On the other hand, resilience has been discovered to be contrarily related with a scope of poor mental and physical wellbeing conditions, for example, expanded depressive symptomatology, post-traumatic anxiety

issue, and physical inability (Burns & Anstey, 2010; Connor, Davidson & Lee, 2003; Hardy *et al.*, 2004; Mehta, Whyte, Lenze, Hardy, Roumani, Suhahan, Huang & Studenski, 2008). Imperative understanding about the pathways by which they can attain better mental and physical wellbeing may be provided by examining the role of resilience among the elderly. Ong *et al,.* (2006) have exhibited that resilience controls the impact of day by day stress on negative feeling, and records for a generous extent of the difference in day by day stress resistance. compared with those with lower resilience, those with higher resilience were more inclined to encounter positive feelings and less inclined to experience issues controlling negative feelings and this is as indicated by their discoveries (Young *et al.*, 2009).

Surveying resilience in diverse racial and ethnic populaces is essential, as gathering members frequently impart different social practices and convictions that, thus, influence interior (mental) and outer (social and physical)resources (Ungar, 2010).

Individual's ability to adapt and recuperate from crisis, maintain a feeling of reason and imperativeness, and develop stronger from distressing encounters; it is also active characteristic that might modify according to the conditions making resilience the outcome of successful adaptation to adversity which is made known. A result of physical or mental recuperation from a traumatic occasion; a characteristic that portrays an individual's persisting capacity to adapt; or a methodology of recuperating from an upsetting occasion and moving forward are the many forms through which resilience can be manifested (Fry & Keyes, 2010). The resources that lead to resilience can outcome in positive outcomes regardless of how resilience is viewed. More established elderly people really have a larger amount of subjective prosperity than people in some other age groups even though resilience is seldom associated with the elderly due to losses they experience and decline in physical health. The capacity to recoup from adversity, flourish

with a sustained purpose, and develop in a universe of turmoil, change, and chronic ailment in older adults is provided by resilience thinking. In the face of loss, disability, or disease resilience is a regenerative capacity that maintains health and function. Resilience thinking permits the elderly to acknowledge the wear and tear of maturing, while additionally managing issues and crisis – like losing a friend or family member, spousal consideration giving, or gaining a handicap in ways that abandon them feeling stronger than they would have been whether they had not experienced those crises. Growth is derived from failure according to resilience thinking (Fry & Keyes, 2010).

In a few investigations of resilience, solid mental wellbeing status and high resilience levels were discovered to be connected. Wagnild (2003) discovered a positive relationship between morale, life satisfaction, and resilience. Depression, and resilience were found to be among some of the mental disorders that have an inverse relationship (Hardy *et al.*, 2004; Wagnild & Young, 1990). Nygren and colleagues (2005found that mental wellbeing was associated with resilience in women, however not men. Mehta et al. (2007) The relationship of apathy, resilience, and handicap with depression was found to he influenced hy age. Several studies of older adults have supported the relationship that better mental health status had the strongest connotation with high resilience levels (Easley & Schaller, 2003; Hardy et al., 2004; Hinck, 2004; Kinsel, 2005; Lamond, 2009; Lee, Brown, Mitchell & Schiraldi, 2008; Mehta et al., 2007; Nygren et al., 2005; Wagnild, 2003; Wagnild & Young, 1990; Yoon & Lee, 2007).

Resilience Hallmarks

Recovery: The return to a balanced state of well being and bouncing back from stress. About everybody knows somebody who has come back from a crisis as solid, or maybe stronger than some time recently, and frequently better ready to avoid or manage future negative circumstances.

Sustained purpose: Avoidance of boredom and self satisfaction as well as having vested interests in causes or activities is enabled with the capability to continue to move forward.

Growth: Even after having experienced stress rising stronger as viewed as a sign of growth and new model of resilience capacities is created by failure, (Hall, Zautra, Borns, *et al.*, 2010).

Aim of study:

The aim of the study was to investigate the psychosocial predictors of mental health amongst the elderly in old age homes in the North West Province, South Africa. Psychosocial predictors will include social support, resilience and satisfaction with life and mental health will be measured using GHQ 28.

Objectives of the study:

The specific objectives of the study are identified as follows:

- To determine the relationship between life satisfaction, perceived social support and resilience among the elderly.
- To investigate the influence of marital status on mental health of the elderly.
- To investigate the influence of level of education on mental health of the elderly.

- To determine the influence of religious affiliation on mental health of the elderly.

Significance of the study:

The study had practical and theoretical significant. Conclusions made from this elderly study will help to advance the understanding of the elderly especially those that reside in old age homes in the North West Province; throughout the process of working on this research the researcher has discovered that there is very limited information regarding the elderly people in South Africa as well as the world. The elderly are an important key factor for the younger generation to learn from. They hold great information regarding aspects such as cultural background that is essential to be preserved for the youth that will continue to come.

There are different beneficiaries that will obtain information from this research; families of the elderly will be able to get information as to what makes their elderly family members to have good or poor mental health, government organization will be able to know as to how they can assist the elderly to necessary resources that each and every elderly person will benefit from, management and personnel working in institutes that cater for the elderly will be provided with adequate information as to what the needs of the elderly and how they can make their living arrangements conducive for them and how they also can assist in promoting good mental health and helping curb poor mental health and this will help the elderly to have minimal mental health problems such as anxiety.

The study critically analyzed mental health of the elderly as well as psychosocial predictors that can either be positive or negative to the elderly people's mental health. The findings of the study will contribute to the understanding of the elderly population and psychosocial predictors that

can compromise their mental health therefore helping to find solutions to these problems that they may point out during the interviews. The participants' families will also learn about their elderly family members and how to make their lives better as they will be having different experiences in their lives which may lead to them being confused and lost.

Moreover the study also provided findings on the relationship between psychosocial predictors and mental health among the elderly people in South Africa. Health professionals and existing policy makers such as government and NGO's, will obtain information that will help provide multiple strategies and re- looking existing ones to desirable quality standards that are inclusive to the individuals and cultural dynamics of elderly people of south Africa with mechanisms on how to improve their lives.

Theoretical background

According to Schroots (1996) different authors have categorized theories of aging in different ways, some calling them psychological and others developmental theories. Those most well known were He categorized these theories as psychosocial theories of ageing and described those most well known. Human advancement and aging as far as individual changes in cognitive capacities, conduct, roles, connections, adapting capacity and social changes are attempted to be explained by psychosocial theories of ageing. How older people could be treated or what is important in care of the elderly people is not described in these theories.

Erik Erikson: Stages of Life

As indicated by Erik Erikson's "Eight Stages of Life" theory, the human identity is produced in a series of eight stages that occur from the time of conception and proceed all through an individual's complete life. The period of "Integrity vs. Despair", during which an individual

concentrates on reflecting back his life were characterized as old age by Erikson. Many regrets will be experienced and felt by those individuals that were not successful during the stage as they would feel like they wasted time and did not get to achieve what they wished to achieve. Bitterness and despair are the feelings that one would be left with. A sense of integrity will be felt by those individuals that feel proud of their accomplishments and successfully carrying out this stage means reflecting back with few regrets and a general feeling of satisfaction. Wisdom will be attained as well as even when confronting death by these individuals. During the aging process to push ahead with life and not be "trapped" previous, coping is a very important skill that is needed. The way a person adapts and copes, reflects his aging process on a psycho-social level (Griffiths & Thinnes, 2011). Erikson's theory of development serves to give a theoretical background into the life satisfaction of elderly people.

Social Support Theory

To clarify principle impacts between perceived support and mental wellbeing Relational regulation theory (RRT) was designed (Lakey and Orehek, 2011). Both buffering and immediate impacts on mental health were found in perceived support. According to Wethington and Kessler (1986) RRT was proposed keeping in mind the end goal to clarify perceived support's principle consequences for mental health which can't be clarified by the anxiety and adapting theory. Lakey and Orehek (2011) reported that RRT hypothesizes that the connection between perceived support and mental health originates from individuals managing their feelings through standard discussions and shared exercises as opposed to through discussions on the most proficient method to adapt to stretch. This regulation is social in that the help providers, discussion points and exercises that help manage feeling are basically a matter of individual taste. Demonstrating that the biggest piece of perceived support is social in nature was supported by previous work

(Lakey, (2010), it is therefore stated that when people feel supported then their mental health is likely to be good the RRT brings forth that people feel that non- directed conversations with loved ones and people around them makes them feel supported.

According to Uchino, (2009), Life-span theory is an alternate hypothesis to clarify the connections of social support and wellbeing, which emphasizes the contrasts in the middle of perceived and received support. Social support creates for the duration of the life span, however particularly in youth connection with parents and this is according to the life span theory. Social support creates alongside adaptive identity qualities, for example, low hostility, low neuroticism, high idealism, and also social and adapting abilities. Proof forever compass hypothesis incorporates that a segment of social support is attribute like (Lakey, 2010) and that prceived support is connected to versatile identity attributes and connection encounters (Uchino, 2009). RRT and life span theory discuss the importance of support received from friends, families with mental health, the theories emphasize that for an individual having the feeling and noticing that they have the necessary support provides them with the will to overcome difficulties that they experience in life or rather their life time. The support viewed as of importance starts at the early stages of the person's life which then continues throughout their lives.

Resilience

Within developmental psychopathology and ecosystems perspectives resiliency theory is a developing theoretical point of view that has been produced and is impacted by anxiety and adapting theories. Despite the fact that this theory has not been explicitly created as an outgrowth of life span theory, it is formative in center, and theory driven research ordinarily inspects a particular ordered life arrange as a starting point. This theoretical framework addresses wellbeing

advancement of at-danger populations, and overcoming anxiety and affliction to accomplish functional outcomes either amid a life organize, a particular trajectory (e.g., educational or deviancy), or for the duration of the life compass (Daining, 2005; Smith, 2003; Smith- Osborne, 2006). The idea of resilience was created to "portray relative imperviousness to psychosocial danger encounters" (Rutter, 1999b). It has been further characterized as "an element procedure incorporating positive adjustment inside the setting of significant adversity" (Luthar, Cicchetti, & Becker, 2000) and "the methodology of adapting to misfortune, change, or opportunity in a way that bring about the recognizable proof, fortification, and enhancement of resilient qualities or defensive variables" (Richardson, 2002, p. 308). Research on anxiety responses and recuperation from anxiety, with suggestions for instruction, has likewise educated this theory (Benotsch, Brailey, Vasterling, Uddo, Constans, & Sutker, 2000); D'Imperio, Dubow, & Ippolito, 2000; Dubow, Schmidt, McBride, Edwards, & Merk, 1993; Dubow, Tisak, Causey, Hryshko, & Reid, 1991; Garmezy & Rutter, 1983; Lazarus, 1993; Lazarus & Folkman, 1984). In this way, resilience is conceptualized as relative resistance to psychosocial stressors or difficulty. Although differing models of resiliency have been tried, researchers and theorists concur that the build is remarkable in the connection of anxiety and affliction and is not agent without ecological stressors (Jew, Green, & Kroger, 1999).

Hypotheses:

1. Life satisfaction, perceived social support, and resilience will independently and jointly influence mental health among the elderly.
2. There would be a significant influence of marital status on mental health of the elderly.

3. There would be a significant influence of level of education on mental health of the elderly.

4. There would be a significant influence of religious affiliation on mental health of the elderly.

Methodology

Setting of the study

According to Statistics South Africa (2003), North West is in the focal north of South Africa and is totally landlocked. The province encases 116 320 km2, constituting 9.5% of the aggregate area region of the nation. SSA (2003) evaluated, 3 753 128 individuals existed in North West, constituting 8.3% of South Africa's aggregate populace. The area obliged somewhat more women (50.3%) than men (49.7%). One-third of the populaces were more youthful than 15 years, 64% were in their 'monetarily dynamic' years (15-64), and 6% were elderly 60 years or more seasoned. Correlation with 2001 Census: absolute populace 3 669 349 (SSA had 83 779 more); 8.2% of South Africa's aggregate populace; 50.4% female; 91.5% Black African, 1.6% Colored, 0.3% Indian, 6.7% White. Census done in 2011 on the population of North West province showed that the elderly 65-69 (both males and females) made up a population of 71 692, 70-74 (51 710), 75-79 (34 216), 80-84 (21 483) and 80+ (18 754) (SSA, 2003).

Design:

This study was based on a cross- sectional survey design within a quantitative research approach. The variables are psychosocial predictors (resilience, satisfaction with life and social support) and mental health.

Sample:

The total number of 250 elderly took part in this study. The participants who resided in Lapa la botlhe, Mafikeng and Lichtus Old Age Homes located in different parts of North West Province were used in the study. Two centres are located in Mafikeng while the other is located in Lichtenburg, in the North West Province, South Africa. The researcher approached the management of the different old age homes by calling the later having a face to face meeting with them and later the researcher was introduced to the participants. The selection was based on the participants cognitive functioning. The age of all participants ranged between 65-75 years. The number of elderly people who completed the four (4) questionnaires was male = 161 (64.4) and females = 89(35.6).

Table: sample characteristics of the elderly (n=250)

Demographic Variables	**No. of Respondents %**	
Age		
a) 60-65	84	(33.6)
b) 66-70	52	(20.8)
c) 71-75	44	(45.6)
Gender		
a) Male	161	(64.4)
b) Female	89	(35.6)
Marital Status		
a) Single	31	(12.4)
b) Married	69	(27.6)
c) Separated	12	(4.8)
d) Divorced	12	(4.8)
e) Widowed	100	(40.0)

f) Never married	26	(104)

Children

a) Yes	213	(85.2)
b) No	37	(14.8)

Children Alive

a) Male
b) Female

If yes

Male

a) None	156	(62.4)
b) One male	35	(14.0)
c) Two males	29	(11.6)
d) Three males	14	(5.6)
e) Four males	6	(2.4)
f) Five males	2	(0.8)
g) Six males	3	(1.2)
h) Seven males	2	(0.8)
i) Eight males	1	(0.4)
j) Nine males	2	(0.8)

Females

a) None	163	(65.2)
b) One female	26	(10.4)
c) Two females	21	(8.4)
d) Three females	19	(7.6)
e) Four females	11	(4.4)
f) Five females	6	(2.4)
g) Six females	3	(1.2)
h) Seven females	1	(0.4)

Male children alive

a) None	116	(46.4)

b) One male	46	(18.4)
c) Two males	48	(19.2)
d) Three males	18	(7.2)
e) Four males	11	(4.4)
f) Five males	5	(2.0)
g) Six males	5	(2.0)
h) Eight males	1	(0.4)

Female children alive

a) None	110	(44.0)
b) One female	58	(23.2)
c) Two females	48	(19.2)
d) Three females	17	(6.8)
e) Four females	12	(4.8)
f) Five females	2	(0.8)
g) Six females	2	(0.8)
h) Seven females	1	(0.4)

Race

a) Black	170	(68.0)
b) White	67	(26.8)
c) Asian	5	(2.0)
d) Coloured	8	(3.2)

Home Language

a) English	17	(6.8)
b) Afrikaans	61	(24.2)
c) Sesotho	124	(49.6)
d) Sepedi	18	(7.2)
e) isiNdebele	2	(0.8)
f) isiZulu	8	(3.2)
g) isiSwati	18	(7.2)
h) Xitsonga	2	(0.8)

Highest Education level

a) Below matric	175	(70.0)
b) Matric	42	(16.8)
c) College Certificate	20	(8.0)
d) University Degree	12	(4.8)

e) Post Graduate Degree	1	(0.4)

Religion

a) Christian	232	(92.8)
b) Islam	1	(0.4)
c) Non Religious	8	(3.2)
d) Other	9	(3.6)

Instruments and psychometric properties

The study used a questionnaire with four (4) sections ; A, B, C and D. section A consisted demographic items, section B consisted of the General Health Questionnaire 28 scale used to measure mental health with four subscales – somatic complaints, anxiety and insomnia, social dysfunction and depression, section C consisted of the Satisfaction with Life Scale with five (5) items, section D contained Social Support Questionnaire with twelve (12) items and section E contained the Brief Resilience Scale with five (5) items.

Socio-Demographic Information

The socio-demographic information collected included age, gender, race, children, home language, marital status, level of education, religious affiliation.

General Health Questionnaire (GHQ 28)

The general health questionnaire consisting of 28 items has been used to quota mental health status particularly in revealing of emotional disorders such as distress (Goldberg, 1978). Goldberg presented the GHQ in 1978, and since then it has been interpreted into 38 separate languages, confirmation to the validity and reliability of the questionnare. reliability coefficients of the survey have ranged from 0.78 to 0.95 in a variety of studies. The GHQ has four versions

based on the number of items; GHQ-60, GHQ-30, GHQ-28 and the shortest version GHQ-12. Each item is accompanied by four responses, characteristically being 'not at all', 'no more than usual', 'rather more than usual' and 'much more than usual'.

Two recommended methods for scoring the GHQ are recommended. A range from 0 to 3 respectively has been found to be the first scoring methods. The second scoring method used binary scoring technique (with the two slightest symptomatic answers scoring 0 and the two most symptomatic answers scoring 1 – i.e. 0-0-1-1). The aggregate conceivable score on GHQ-28 ranges from 0 to 84 and takes into consideration means and disseminations to be ascertained, both for the worldwide aggregate, and also for the four sub-scales: somatic symptoms, anxiety/insomnia, social dysfunction and severe depression, (Goldberg, Gater, Sartorius, Ustun, Piccinelli, Gureje & Rutter, 1997).

The GHQ-28 coordinates four separate subscales, which are: somatic symptoms, anxiety and insomnia, social dysfunction and severe depression. Viljoen (2004, refered to in Leach, 2006) acquired a Cronbach alpha of 0.71 for the somatic symptoms subscale, 0.79 for the anxiety and insomnia subscale, 0.74 for the social dysfunction subscale and 0.80 for the depression subscale. To make the GHQ instrument pertinent in South African setting the scale has been utilized and accepted for South African tests (Idemudia & Matamela 2012).

Social Support Scale:

Perception of social support is measured using a 12 item measure. This measure is an abbreviated variant of the first ISEL (40 things; Cohen & Hoberman, 1983). The Interpersonal Support Evaluation List-12 (ISEL-12; Cohen, Mermelstein, Kamarck, & Hoberman, 1985) is comprehensively utilized as a short-structure measure of the customary ISEL, which measures

functional (i.e., perceived) social support. This questionnaire has three separate subscales intended to measure three dimensions of perceived social support.

The Purpose of the measure was to evaluate perceived accessibility of four types of social support being appraisal, belonging, self-esteem, and tangible. Reduced mortality has been linked to availability of social support (Rosenberg, Orth-Gomer, Wedel, & Wilhemsen, 1993) and enhanced psychological state (Cohen & Wills, 1985).

Narrative of the measure is that respondents demonstrate the degree to which sentences depicting accessibility of diverse sorts of social support in their lives are genuine or false. There is no indication of time frame or referent period is required. The scaling of the different answers available is as follows: 0- Definitely False; 1- Probably False; 2- Probably True; 3- Definitely True.

An example of sample items are: "If I were sick, I could easily find someone to help me with me daily chores." (Tangible) "I don't often get invited to do things with others." (Reversed; belonging) "When I need suggestions on how to deal with a personal problem, I know someone I can turn to."

The reliability of the measure was obtained from students as well as the general population and the following reliability was discovered undergraduate students, alpha = .77 - .86 while overall population, alpha = .88 - .90. The current study revealed a reliability coefficient of 0.423.

The validity of the measure correlates positively with other support scales for example Inventory of Socially Supportive Behaviours , with number of close friends, and with the measure of the nature of marital relationships (Partner Adjustment Scale). The sub-scales are additionally related in the a predicted direction with related characteristic measures: respect toward oneself

subscales associates with respect toward oneself measure though evaluation subscale partners with disclosure toward oneself.

The measure has different types of support that are covered and the following explains which items form part of which type of support, Appraisal is obtained using item numbers 2, 4, 6, 11, while Belonging is found on item numbers 1, 5, 7, 9, and lastly Tangible is described with item numbers 3, 8, 10, 12. The measure is scored in the following manner; by summing up the items to create an overall social support score. Items 1, 2, 7,8,11 and 12 are reverse scored.

Satisfaction with Life Scale:

Global life satisfaction has been measured widely with the usage of the Satisfaction With Life Scale (SWLS) through five statements interrelated to quality of life (Updegraff & Suh, 2007), these include declarations tapping on cognitive components of satisfaction (Anaby, Jarus & Zumbo, 2010). Diener, Emmons, Larsen & Griffin, (1985), conveyed the internal consistency of the SWLS as .87, and the test–retest correlation as .82. The current study revealed a reliability coefficient of 0.905. Satisfaction with Life scale was used to measure the elderly's overall satisfaction with the life they have lived. Advantages .The widespread utilization of the SWLS is an advantage and therefore it has been utilized with participants of various ages. The length of the measure was also accommodative to the elderly people as it did not require for a lot of time to be used. In addition, it allows investigators to link respondents of dissimilar ages (Pavot, Diener, Colvin & Sandvik, 1991). Researchers have used the SWLS with undergraduate students (Gouveia, Milfont, Fonseca & Coelho, 2009), adults (Tucker, Ozer, Lyubomirsky & Boehm, 2006), and elderly individuals (Elavsky, McAuley, Motl, Konopack, Marquez, Hu, et al., 2005; Minardi & Blanchard, 2003).

In order to evaluate satisfaction with the respondent's life as a whole, the Satisfaction with Life Scale (SWLS) was invented. The measure does not evaluate fulfilment with life spaces, for example, wellbeing or finances however permits subjects to incorporate and weigh these domains in whatever way they pick. Regularizing information are exhibited for the scale, which demonstrates great united validity with different scales and with different sorts of evaluations of subjective prosperity. Life satisfaction as surveyed by the SWLS demonstrates a level of successive dependability (e.g., .54 for 4 years), yet the SWLS has uncovered sufficient affectability to be possibly essential to discover change in life satisfaction during the course of clinical mediation. Further, discriminant validity from enthusiastic prosperity measures was demonstrated by the scale, because it assesses an individuals' conscious evaluative judgment of his or her life hy using the person's own criteria the SWLS is recommended as a complement to scales that focus on psychopathology or emotional well-being.

Scoring should be kept continuous by summing up scores on each item, the cut-offs are to be used as benchmarks: 31-35 being extremely satisfied, 26-30 being satisfied, 21-25 described as slightly satisfied and with 20 being neutral, on the other hand the following are viewed as dissatisfied 15-19 being slightly dissatisfied, 10-14 dissatisfied and 5-9 being extremely dissatisfied.

Brief Resilience Scale

Brief resilience scale was used in this study to measure the resilience of the elderly. The measure of six items of the brief resilience scale (BRS). Items 1, 3, and 5 are positively worded, and items 2, 4, and 6 are negatively worded. The BRS is scored by reverse coding items 2, 4, and 6 and discovering the mean of the six things. The accompanying guidelines are utilized to regulate the

scale: "Please indicate the extent to which you agree with each of the following statements by using the following scale: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree (Smith, Dalen, Wiggins, Tooley, Christopher & Bernard, 2008).

The purpose of the BRS is to measure the ability for an individual to rebound back or recuperate from anxiety.

Description: The brief resilience scale (BRS; Smith et al., 2008) is a six item instrument premeditated to measure an individual's capability to bounce back or recuperate after stressful circumstances, with a focus on application in the healthcare setting. In particular the authors wanted to design the brief instrument that measures resilience in its original, most simple meaning and not focus on the individual attributes that may push positive adjustment .The usefulness of this type of measurement lies in the idea that for populations that are already ill, the particular capacity to recuperate may be more essential than evaluating the capacity to oppose disease. Containing an equal number of positivity and negativity worded items, the BRS may be useful to researchers and practitioners who desire a concise measure of the person's capability to spring back or recuperate from anxiety. Therefore the BRS may provide useful information about people with health related stressors.

The administration of the measure has two options, BRS may be self administered or administered in an interview and it takes less than two minutes to complete generally.

The scoring is done in the following manner the BRS is scored by reverse coding items 2, 4, and 6, then finding the mean (average) of the six items.

Reliability: the instrument authors assessed internal consistency of the BRS with two samples of undergraduate students (*n=128 and 64*), a sample of cardiac rehabilitation patients (*n=112*), and adults women (*n=50*), finding evidence of good internal consistency (samples *1-4=.84, .87, .80,.*

.91, respectively) (Smith et al., 2008). Evidence of temporal stability was also noted for 1 month *(r=0.69, n= 48, p< .001)* and 3 month *(r=0.62, n=60, p< .001)* (Smith et al., 2008). The current study revealed a reliability coefficient of 0.088.

Validity: factor analysis conducted in the initial validation study revealed a single factor structure, which was replicated across four different samples (Smith et al., 2008). In relation to convergent and discriminant validity, the BRS obtained modest correlations in the expected direction with several scales measuring life orientation, purpose in life, alexithymia, coping and resilience (Smith et al., 2008).

Norms/ reference standards: high scores reflect higher levels of resilience (Smith et al., 2008).

Procedure

Ethical agreement for the study was acquired from the North West University Ethics Committee, as well as other institutions were data was collected. The nursing home administrators were contacted as the intermediate persons were contacted and met, thereafter the research was explained to them and they approached patients to request approval for the researcher to talk with them. All tests were administered in the same request to make it steady and each meeting endured around 30-45 minutes relying upon the level of functioning. Participants were questioned in the privacy of their room All participants gave verbal agreement in the presence of the manager or the assistant depending on who was there at that time.

Data analysis

Results

This section presents the result of the data analyses and hypotheses tested. In all four hypotheses were tested using Pearson r correlations, linear multiple regression, and One-Way Analysis of Variance (ANOVA).

The study was anchored on four hypotheses and in so doing (1) life satisfaction, perceived social support and resilience jointly contributed to the variance in mental health of the elderly, (2) there was no significant influence of marital status on mental health of the elderly, (3) there was a significant influence of level of education on mental health of the elderly, (4) there was a significant influence of religious affiliation on mental health of the elderly.

The first analysis involved inter-correlations among variables of study using Pearson r correlational analysis. This was done to test the direction and strength of the relationship between the variables of the study. The results obtained are presented in Table 1.

Table 1: Correlation Showing the Relationship among the Variables of Study (n=250)

Variables	1	2	3	4	5	Mean	S.D
1. Mental health	-					58.32	3.73
2. Life satisfaction	-.639**	-				25.22	3.59
3. Social support	-.005	-.020	-			33.10	3.19
4. Resilience	-.072	.225**	.024	-		19.30	3.04
5. Gender	-.046	.134*	.054	.054	-		

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

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

The results showed a significant negative relationship between life satisfaction and mental health ($r = -.639$; $p < .01$). This means that elderly who are scoring higher on life satisfaction are more likely to score lower on mental health problems. There was no significant relationship between social support and mental health ($r = -.005$; $p > .05$), indicating that increase or decrease of scores on social support has nothing significantly to do with whether the elderly will report poor or better mental health. Similarly, there was no significant relationship between resilience and mental health ($r = -.072$; $p > .05$), indicating that scoring higher or lower on resilience has nothing significantly to do with whether the elderly will report poor or better mental health. There was no significant relationship between gender and mental health ($r = -.046$; $p > .05$), this implies that being a male or female has nothing significantly to with whether the elderly will report poor or better mental health.

Other results revealed no significant relationship between life satisfaction and social support ($r = -.020$, $p > .05$). This means that scores of the elderly on life satisfaction has nothing significantly to do with their scores on social support. Surprisingly, there was a significant positive relationship between life satisfaction and resilience. This means that age who reported higher scores on life satisfaction are also reporting higher scores on resilience. The results further indicated a significant positive relationship between life satisfaction and gender ($r = .134$; $p < .05$), this implies that elderly who are male are more likely to score higher on life satisfaction. Other results did not indicate any significant relationship. These findings set the stage for further analyses and the variables to consider.

The first hypothesis stated that life satisfaction, perceived social support, and resilience will independently and jointly influence mental health among the elderly was tested using simple linear multiple regression statistical analysis. The result is presented in Table 2.

Table 2: Multiple Regression Showing Influence of life-satisfaction, social support, and resilience on mental health

Variables	R	R^2	F	P	ß	t	P
Life satisfaction					-.656	-13.095	<.001
Social support	.643	.414	57.890	<.001	-.020	-.401	n.s
Resilience					.076	1.522	n.s

Dependent Variable: Mental health

n.s = not significant

The result revealed that life satisfaction, perceived social support, and resilience jointly contributed to the variance in mental health of the elderly. $R^2 = 0.414$, F (3,246) = 57.890, p < .001). The result indicated that jointly life satisfaction, perceived social support, and resilience accounted for about 41% of the variance in mental health among the elderly.

Also, the results demonstrated that independently, life satisfaction contributed significantly to mental health (β = .656, t = -13.095, p < .001). Meaning that as scores increased, the elderly are reporting better mental health. However, perceived social support (β -.020, p = n.s) and resilience (β -.076, p = n.s) were not contributing significantly to mental health of the elderly. Therefore, hypothesis one was partly accepted.

The second hypothesis stated that there would be a significant effect of marital status on mental health of the elderly was tested using One-Way analysis of variance (ANOVA). The result is presented in Tables 3 and 3a.

Table 3: One-Way ANOVA showing the effect of marital status on mental health

Source	SS	Df	Mean Square	F	P
Between	1011.178	5	202.236	.786	n.s
Within	62775.578	244	257.277		
Total	63786.756	249			

Table 3a: Descriptive statistics of effect of marital status on mental health

Marital status	N	Mean	Std. Deviation
Single	31	62.839	15.312
Married	61	58.579	16.668
Separated	12	56.333	15.541
Divorced	12	54.750	16.221
Widowed	100	57.130	15.882
Never married	26	59.423	15.908
Total	250	58.324	16.005

The result revealed no significant effect of marital status on mental health of the elderly (F (5,244) =.786; p = n.s). This means that the elderly who were single (n = 31, mean = 62.839, SD = 15.312) compared to the elderly who were married (n = 61, mean = 58.579, SD = 16.668), separated (n = 12, mean = 56.333, SD = 15.541), divorced (n = 12, mean 54.750, SD = 16.221), widowed (n = 100, mean 57.130, SD = 15.882) , and never married (n = 26, mean 58.324, SD = 16.005) are reporting the same level of mental health. This result did not confirm hypothesis two.

The third hypothesis stated that there would be a significant effect of level of education on mental health of the elderly was tested using One-Way analysis of variance (ANOVA). The result is presented in Tables 4 and 4a

Table 4: One-Way ANOVA showing the effect of level of education on mental health

Source	SS	Df	Mean Square	F	P
Between	4135.353	4	1033.838	4.246	< .002
Within	59651.403	245	243.475		
Total	63786.756	249			

Table 4a: Descriptive statistics of effect of level of education on mental health

Level of education	N	Mean	Std. Deviation
Below matric	175	60.789	15.080
Matric	42	53.976	18.461
College certificate	20	48.500	12.808
University degree	12	55.250	16.488
Postgraduate	01	43.000	-
Total	250	58.324	16.005

The result revealed a significant effect of level of education on mental health of the elderly (F (4,245) = 4.246; p < .0o2). An observation of the mean differences showed that elderly who have below matric education reported more poor mental health (M = 60.789, SD = 15.080) compared to those who have matric (M = 53.976, SD = 18.461), college certificate (M = 48.500, SD = 12.808), university degree (M = 55.250, SD = 16.488), and postgraduate degree (M = 43.00, SD = 00), respectively. This result confirmed hypothesis three.

The fourth hypothesis stated that there would be a significant effect of religious affiliation on mental health of the elderly was tested using One-Way analysis of variance (ANOVA). The result is presented in Tables 5 and 5a.

Table 5: One-Way ANOVA showing the effect of religion affiliation on mental health

Source	SS	Df	Mean Square	F	P
Between	2150.170	3	716.723	2.861	< .038
Within	61636.586	246	250.555		
Total	63786.756	249			

Table 5a: Descriptive statistics of effect of religion affiliation on mental health

Religion Affiliation	N	Mean	Std. Deviation
Christianity	232	57.560	15.789
Islam	01	84.000	-
Non-religious	08	66.625	18.165
Others	09	67.778	14.734
Total	250	58.324	16.005

The result revealed a significant effect of religious affiliation on mental health of the elderly ($F(3,246) = 2.861$; $p < .038$). An observation of the mean differences showed that the age who were Christians significantly reported better mental health ($M = 57.560$, $SD = 15.789$) compared to the elderly who were Muslims ($M = 84.00$, $SD = 00$), Non-religious ($M = 66.625$, $SD = 18.165$), and other categories ($M = 67.778$, $SD = 14.734$), respectively. This result confirmed hypothesis four of the study.

Discussion and conclusion

In summary, the study was anchored on four hypotheses and thereby (1) To determine the relationship between life satisfaction, perceived social support and resilience among the elderly, (2) to investigate the influence of marital status on mental health of the elderly, (3) to investigate the influence of level of education on mental health of the elderly, (4) to determine the influence of religious affiliation on mental health of the elderly.

Results of the study showed a significant negative relationship between life satisfaction and mental health, the results also showed that there was no significant relationship between resilience and mental health. Other results showed that there was no significant relationship between gender and mental health, while other results showed no significant relationship between life satisfaction and social support but surprisingly there was a significant positive relationship between life satisfaction and resilience.

The first hypothesis expected that life satisfaction, perceived social support, and resilience will independently and jointly influence mental health among the elderly, the results therefore revealed that life satisfaction, perceived social support and resilience jointly contributed to the variance in mental health of the elderly but also revealed that independently, life satisfaction contributed significantly to mental health, however perceived social support and resilience were not contributing significantly to mental health of the elderly therefore hypothesis one was partly accepted. An academic performance is influenced by satisfaction in all life spaces. Studies show that life satisfaction is a key indicator of quality of life. For instance, individuals with higher degrees of life satisfaction accomplish better life conclusions, including academic accomplishment, self-esteem, financial success, self-efficacy, steady connections, compelling

adapting, mental health, and even physical wellbeing and life span (Gilman & Huebner, 2006, Proctor et al., 2009 and Suldo & Huebner, 2006). Life satisfaction has been characterized by (Diener et al. 1984) as one's positive evaluation of his entire life according to the criteria determined by the individual himself. Satisfaction with life is associated to affirmative feelings of a person's experiences in important areas in one's life for example school/college, job, family and so forth compensating negative feelings (Diener, 2000).

Hypothesis two stated that there would be a significant influence of marital status on mental health of the elderly, the results revealed no significant effect of marital status on mental health of the elderly, however the results did not confirm hypothesis two. Marital status is viewed to be an significant factor of mental health, it was discovered that widowed and divorced individuals have poorer mental health (Lehtinen, Michalak, Wilkinson, Dowrick, Ayuso-Mateos, Dalgard, Casey, Vazquez-Barquero, & Wilkinson, 2003; Carta, Bernal, Hardoy, & Haro-Abad, 2005). Mental disorders are more regular among persons who were either never married or formerly married and presently have no accomplice (Alonso et al. 2004c). Having a classified relationship appears to have a defensive impact on the mental health of an individual.

The third hypothesis indicated that there would be a significant influence of level of education on mental health of the elderly; the results did confirm hypothesis three revealing that there is a significant effect of level of education on mental health of the elderly. The relationship between educational achievement and mental health is complex and prone to be non-straight. In addition, the causality in the middle of education and mental health could be turned around; Currie and Stabile (2004) or Heckman et al. (2006) give confirmation of the effect of non-cognitive abilities, for example, consideration, respect toward oneself and locus of control on educational achievement. A few studies discovered connections between the pervasiveness of mental

disorders and financial burdens. By and large, generally high frequencies of mental disorders are connected with poor education, material disadvantage, low family pay, unemployment and pension (Beekman et al. 1999; Alonso et al. 2004c; Fryers at el 2005; Lehtinen et al. 2005; Carta et al. 2005).

The fourth hypothesis stated that there would be a significant influence of religious affiliation on mental health of the elderly, the results obtained revealed a significant effect of religious affiliation on mental health of the elderly therefore confirming hypothesis four. The positive effect religion has on mental health has been documented by a large selection of research documents (Ellison & Levin, 1998; Larson et al., 1992), even though some study proposes that religion can have a detrimental influence on mental health as well (Krause, 2004; Krause, Ellison, & Wulff, 1998). When people get older they become more religious, this was revealed by recent research. Particularly for the individuals who are at the end of life more elderly individuals think that religion is more vital to them as compared to young people (Koenig et al., 2004; Moreira-Almeida, 2006). There exist diverse clarifications concerning why elderly persons are obviously a greater number of religious than more youthful individuals, for example, for psychological compensation after retirement. Whichever clarifications are more remarkable in delineating the relationship, religious inclusion is clearly a basic variable for elderly individuals to adapt better and have better social and mental changes while confronting the incapacitating methodology of aging. Without a doubt, there have been expanding observational confirmation in gerontological, medical, social psychological and psychiatric writing that support the positive effects of religiousness on mental wellbeing in the elderly population (Ayele et al., 1999; Braam et al., 2004; Strawbridge et al, 2001), particularly the positive relationship in the middle of religiousness and depression in old ages. In the Journal of Religion and Health,

(2002), "spirituality and Health Outcomes in the Elderly", it was discovered that there was a defensive variable of religion to health and that religious belief assumed a part in turning away physical and mental wellbeing issues. Moreover, religious responsibility helped encourage adapting procedures to disease and recuperation. Additionally, religion, in multiple populations, has a positive relationship to mental prosperity and a deterrent impact against morbidity (Meisenbelder & Chandler 2002). Their results discovered a significant and positive relationship between mental wellbeing and the importance of Faith. Moreover, a positive relationship was found between mental wellbeing and religious practices, for example, prayer and church participation. In any case, these files could be clarified by a more critical component importance of Faith. Generally speaking, their study demonstrated attitudinal measures as the more precise indicies of the relationship of religiosity and mental wellbeing in the elderly (Meisenhelder & Chandler 2002:250).

- Life satisfaction, perceived social support and resilience jointly contributed to the variance in mental health of the elderly.
- Perceived social support and resilience do not contribute to mental health of the elderly.
- There was no significant effect of marital status on mental health of the elderly.
- Significant effect of level of education on mental health of the elderly.

Limitations

Limitations of the study include the language problem as some respondents were not very good when it came to communicating in English. There was minimal literature on the research topic, making it difficult for the researcher to obtain the necessary information. It was a challenge to

obtain scales or questionnaires that are specifically for elderly people or that could be used to assess elderly people.

Recommendations

It has been noted that more research needs to be done on the elderly people not only in the North West Province but for the entire South Africa. The mental health of the elderly is at great jeopardy due to issues that can be addressed with ease. Future studies should include other factors that affect the mental health of the elderly as well as an in depth study on relationships between the elderly in old age homes and their children and how it can be improves. Different government departments need to be linked with the different old age homes in order to assist those elderly people with, for example obtaining identity documents and pension funds. Health professionals need to assist the elderly deal with psychological problems that they have. One may ask as to who will benefit from the above mentioned study; throughout the process of working on this research the researcher has discovered that there is very limited information regarding the elderly people in South Africa as well as the world. The elderly are an important key factor for the younger generation to learn from. They hold great information regarding aspects such as cultural background that is essential to be preserved for the youth that will continue to come. There are different beneficiaries that will obtain information from this research; families of the elderly will be able to get information as to what makes their elderly family members to have good or poor mental health, government organization will be able to know as to how they can assist the elderly to necessary resources that each and every elderly person will benefit from, management and personnel working in institutes that cater for the elderly will be provided with adequate information as to what the needs of the elderly and how they can make their living arrangements conducive for them and how they also can assist in

promoting good mental health and helping curb poor mental health and this will help the elderly to have minimal mental health problems such as anxiety. Moreover the proposed study will also provide findings on the relationship between psychosocial predictors and mental health among the elderly people in south Africa to health professionals and inform existing policy makers such as government, NGO's that can provide multiple strategies and re- looking existing ones to desirable quality standards that are inclusive to the individuals and cultural dynamics of elderly people of south Africa with mechanisms on how to improve their lives. Furthermore, the proposed study can be carried out further investigating other elderly people from all the provinces in South Africa, the different cultures and races still using qualitative research method as it will give in depth knowledge of the participants. Based on the literature and articles found, there has not been much research conducted on the psychosocial predictors of mental health among the elderly people in North West Province, South Africa let alone the other provinces.

It is also recommended that there be creation of scales and questionnaire that are suitable and specifically for elderly people and that they should not be lengthy as the elderly people get easily irritable and tired therefore making it difficult to continue or conclude the interviews.

Furthermore, the proposed study can be carried out further investigating other elderly people from all the provinces in South Africa, the different cultures and races still using qualitative research method as it will give in depth knowledge of the participants. Based on the literature and articles found, there has not been much research conducted on the psychosocial predictors of mental health among the elderly people in North West Province, South Africa let alone the other provinces.

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