Psychological Effects of Institutional Care for the Older Persons: A Study at Kibre Aregawyan Megbare Senay Derejet (KAMSD)

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SCHOOL OF SOCIAL WORK

ADDIS ABABA UNIVERSITY

A Thesis Submitted to Addis Ababa University School of Social Work in Partial Fulfilment of the Requirements for the Degree of Master's of Social Work (MSW)

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October, 2016

Addis Ababa, Ethiopia

Addis Ababa University

School of Graduate Program

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Approved by Examining Board

Advisor Signature Date

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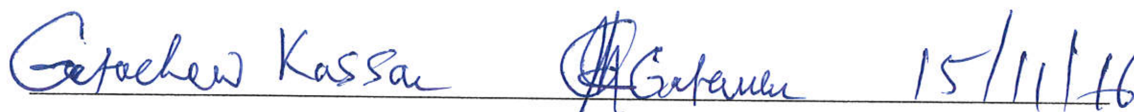

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Abstract

The aim of this study is to explore what psychological effects result from the institutionalized care on the resident elders of Kibre Aregawian Megbare Senay Derejet through understanding their lived experiences in the institution. The study also intends to find out how the care provided results in these problems and the coping mechanisms the elders use when they encounter these problems. This was achieved through the following research questions: What are the psychological problems of elders caused by the care given at the institution? How does the care provided in KAMSD result these problems? How do the elders in KAMSD cope up with these problems?

The qualitative research method was employed to understand the matter under examination. Data of the study were collected through semi structured interview. Elders, care takers and others who are in charge of caring for the elders were the sources of the data. The elders who are the major sources of the data were selected using purposive sampling. The selection was conducted by using a set of selection criteria. The data collected was analysed using content analysis. Results from the study indicate that there are at least four psychological effects namely low self-esteem, loss of control, depression and situational stress. The findings for the second question were institutionalization, dependency and lack of physical activities and loneliness as causes for the problems in question number one. Reading, sleeping and other types of coping mechanisms were included for the findings in question number three. The study finally recommends the attention from policy makers to be high towards the psychological problems resident elders encounter during their old ages in care centres. Social workers are expected to work closely with the elders and advocate for the better life quality of elders living in institutions. As future areas of research researchers can take each psychological problem mentioned in this study and make further detailed studies.

Acknowledgments

I wish to sincerely thank my advisor, Dr. Comm. Demelash Kassaye, as I would have never accomplished this endeavor without his constant guidance and direction. I wish to thank my parents, Ayu and Senile, for their support and overview.

I am also indebted to Zola and Fasilo. You were more than friends to me. If it was not for your advice and support, I would have never had the discipline to complete this study.

I wish to thank all the participant resident elders in KAMSD that volunteered for this study. KAMSD's founder W/ro Workenesh, Ato Sentayehu and all other staffs deserve to be thanked for their smiling faces and their cooperation.

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List of terms

KAMSD	Kibre Aregawian Megbare Senay Derejet
W.H.O	World Health Organization
MOLSA	Ministry of Labour and Social Affairs
ADL	Activities of Daily Life
UN	United Nations
LTC	Long Term Care
RCF	Residential Care Facility
HIV	Human Immuno deficiency Virus
NGOs	Non Governmental Organization/s
CBO	Central Budget Office
MEMDCC	Mekodonian Elderly and Mentally Disabled Care Center
KICCFE	Kality Institutional Care Centre for the Elderly
MIPAA	Madrid International Plan of Action on Ageing

Chapter One

Introduction

1.1 Background

It is widely thought that getting old is one of the last stages of life. Yet, this part of life has its own needs, wants and characters. People who reach this stage of life are considered lucky as they pass through different stages of life. As a result, they usually possess much wisdom and wide perspective of life. According to Aboderin (2007) older people can contribute to the development of a nation at least in the following four areas; participation in the informal economy as well as unremunerated work, including in the household and subsistence agriculture, role as guardians of traditions and cultural values which are passed from generation to generation, sharing resources, including pensions, with younger, poor family members, and critical role as carers for younger family members e.g. diseased or orphaned by the HIV/aids epidemic (p 11). As a result, to protect and to ascertain the quality of life of these people is to maintain one big asset of the society.

The number of people aged 60 and above is increasing across the world. The number of persons aged 60 and above was 378 million in 1980, doubled itself to 759million in 30 years and is estimated to rise to 2 billion by 2050 (UN, 2010). Likewise the Sub- Saharan African ageing population is increasing dramatically from 36.6million in 2005 to 62.5million in 2025 and 140.9millin in 2050 (UN, 2005). Ethiopia is no different in this matter that according to the three housing and census reports of the 1984, 1994, and 2007, out of the total population, the aging population age 65 and above was 3.7 percent in 1984 and 3.2 percent in 1994 and 2007 each. The latest housing and population census report of the agency in the year 2007 reveals that the total population of the country was 73,918,505 and number of older persons aged 60 and above was 3.6 million (nearly 5% of the total population) (Getnet, 2015).

The AU Plan of Action on Ageing for Africa (2002, p 5) asserts that apart from children, old people are the social group most vulnerable to the numerous ills facing Africa: poverty, food insecurity, civil strife, armed conflict, violence, inadequate social welfare services, to mention but a few.

Drawing from various studies on ageing, Aboderin (2007) stipulates the following four factors for the vulnerability of older Africans when compared to younger adults and youth.

- Diminished capacity to engage in productive work and to care for and support themselves due to physical, mental, physiological and social changes associated with ageing and poverty.
- The customary African family kinship support mechanisms through which younger relatives traditionally supported their older kin have become strained, and family support has become increasingly inadequate due to interactions between prolonged economic hardship on the one hand and rapid socio-cultural change on the other; and, more recently, the devastating impacts of the HIV/aids pandemic.
- As a result of the HIV/aids crisis, are increasingly called upon to care for their ill or orphaned younger kin, frequently at great cost to their own material, physical and emotional well-being
- In spite of the above, older people are often denied access to health services and, in most countries, typically have no recourse to pensions or other formal social security provisions. Where such provision does exist, moreover, it typically provides only insufficient protection. (p11)

The National Social Protection Policy of Ethiopia which was promulgated in March, 2012 also states that demographic vulnerability is one among the types of vulnerability

prevalent in Ethiopia, and that elder people are vulnerable as most of them don't have reliable sources of income (P3).

Older people get support and assistance from their family and community. Family members both from the descendants and ascendants involve in this process. However, when families or communities themselves face problems, it is difficult for older persons to get the usual support and assistance (MoLSA, 2006).

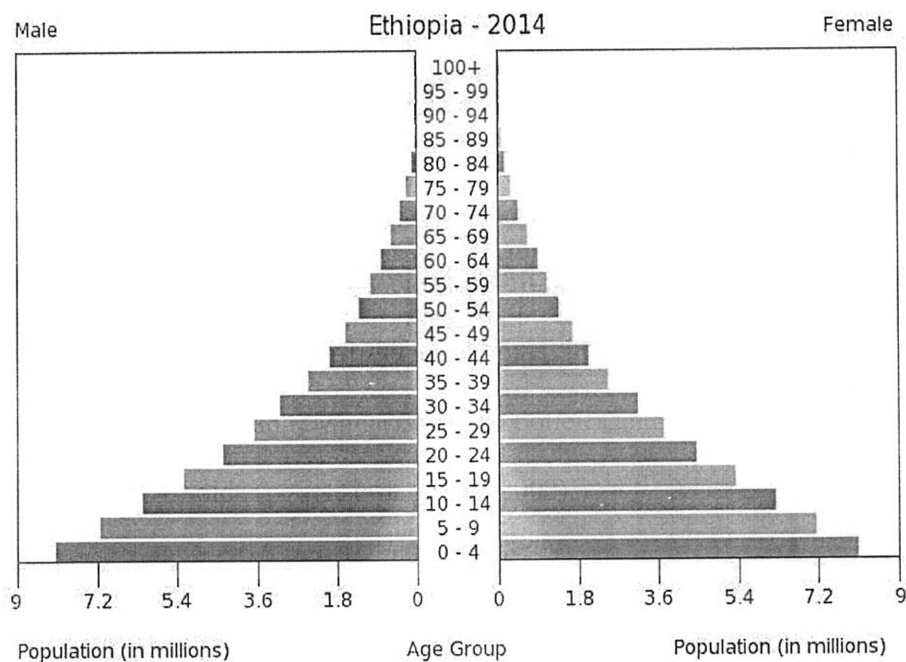
In Ethiopia, the intergenerational and mutual support which is very basic to maintain older persons is declining from time to time (Abdi, 2012). From the various reasons for the decline absence of good governance, growing globalization and modernization are some. On the other hand when the lack of intergenerational and mutual support from family members and the community mingles with factors like absence of social welfare coverage, health problems and diseases like HIV, shelter, income generation opportunities leads older people to poverty.

So it is in such times of distress that institutional care for the older persons comes to one's mind as a possible solution to alleviate the problems of the older persons. Currently there are three governmental old age homes in Addis Ababa, Harrar and Oromiya (MOLSA, et.al., 2006) and some established by philanthropists and Non- Governmental Organizations. One of these is Kebre Aregawian Megbare Senay Dereget (KAMSD). KAMSD is the pioneer private old age home in Ethiopia providing food, shelter and health services to the old persons in its home.

Though caring for the old persons is no doubt a contribution to maintain their lives, it would not be fair to stop at the good side and gloss over the side effects the institutional care has on the older persons. Such institutional care has social, economic, psychological, health and spiritual impacts on the elderlies found in the institutions. Thus, this study is interested to identify the psychological impacts that the institutional care can possibly pose on the elders found in KAMSD.

1.2 Statement of the Problem

The increasing number of older people and their vulnerability calls for a better care for the elder people and initiates research on the demands the ageing population presents. The Madrid International Plan of Action on Ageing (MIPAA) which was adopted in 2002 has a main goal of ensuring that older persons everywhere are able to age with security and dignity and to continue to participate in their societies as citizens with full rights (Getnet, et.al. p3). The AU Plan which was enacted in 1999 and adopted in 2002 aims to help member states design, implement, monitor and evaluate national policies and programs to meet individual and collective needs of older people (AU&HAI, 2002).



Source: CIA Factbook (2016)

The Ministry of Labor and Social Affairs of Ethiopia in 2006 adopted a 10 years National Plan of Action on Older Persons. This plan sets out two main priority directions: developmental and humanitarian aspects of aging based on the underlying principles of the United Nations, AU policy, and the development strategies and constitution of the country (MOLSA, 2006).

The Ethiopian constitution in its Article 41(5) stipulates that the state shall within available means allocate resources to provide rehabilitation and assistance to vulnerable age groups including the aged people. It can be seen that all the above mentioned policies and legal frameworks are recent concerns. According to Getnet, the reason why the issue of the ageing population has been a neglected social issue is due to the myth that the old aged persons in Africa were presumed to constitute low proportion and taken for their apparent relative unimportance (p 3).

Given the social, economic and physical challenges elders encounter, changes in their living arrangements is a crucial area deserving attention. As cited in Segniwork (2014, p24), Nelida and Peter (2009) explain that long term care and support to the elderly is given only a minimal attention in developing countries because policy makers have been slow to recognize the rapid growth of the elder populations and the attention is still held up by the younger generation, greater priority is still given to younger age groups, policy is dominated by concerns about formal pension programs, including contributory schemes and social pensions and due to the assumption that informal support networks continue to function relatively well in most developing countries.

In Ethiopia the three governmental old age homes and pension scheme are the services provided by the government. Pension serves those who were employees of an organization, be it private or public. Thus with the rest of elders there are three sectors to take care for them. They are the individual him/her self, kinship based support and the volunteer sector of NGOs (Abdi, 2012).The individual is vulnerable because of less competitiveness in the market and declined status while the kinship support is breaking down through time for reasons like when children are too poor to support their parents, when children move to seek jobs and other reasons. Consequently, for the elders who were not employees of organisations and/or who do not have kinship support the only option is to wait for the institutional based

or at home support from the volunteers/Non-Governmental Organizations. These NGOs of course do a splendid job by looking after the health, providing basic needs like food, shelter and cloth for the elders. According to the review of literature on the effects of long term care on the mental well-bieng of the elderly conducted by Sarah Heft (2004), these problems stem from the system of institutionalization which results in loss of privacy, dignity, personal freedom and independence, any combination of from the process of aging which involves the deterioration of physical and cognitive functioning, the denial of certain privileges such as driving and employment, and the increasing frequency of the deaths of friends and loved ones. The other important reason is elder abuse. (p. 2)

Similar to the attention by the policy makers, research on ageing in Africa has been a recent development. A study by Aboredin (2007) on development and ageing policy and approaches for research and advocacy in Sub- Saharan Africa reports that its only since 1996 that researches and scholars as well as NGOs especially led by HelpAge International started to conduct research and advocacy programs on the elders in the region (p.9).

There are several researches conducted on elderly persons by social work students in the post graduate library of Addis Ababa University. But when it comes to the institution based care and support for the elderly people, the researches are limited in number.

Fasil in 2010 investigated the Kality Institutional Care Centre for Elderly Adults using an exploratory qualitative approach. Fasil explored the effects of institutional care on the life of elderly adults emphasizing the social, psychological, economic, spiritual and health service aspects of their lives. In terms of the psychological aspect, older persons had feelings of sadness due to loneliness, despair, sleeplessness and depression. In terms of health most of them had vision problems and in terms of economic aspects older persons experienced disappointment due to dependency on government services (Fasil, 2010).

In 2012, Abdi, an Ethiopian student from Lund University, Sweden conducted his Master's thesis on the issue of the breakdown of the traditional kin based reciprocal relationship between the elderly and the younger population in Ethiopia. He preferred KAMSD, the same institution chosen for the current study, for his research site. The research question for his study was to explore how the elders cope up with challenges facing them when traditional patterns of care fail. The participants of his study were selected both from the elders who are provided with KAMSD institutional care and support and the elders provided with KAMSD home based care and support. His related conclusions were that the elders who receive the institutional care suffer from depression, loneliness and shattered self-esteem when compared to the other category of elders (p. 24).

In 2013, Alemnesh studied the issue of the psychosocial support services in Bet Selihome Elder's Care Centre using phenomenological research technique in a qualitative design. Her study demonstrated that the health, dietary, financial and other issues like awareness creation among the staff were found to be the determinant factors for the psychosocial well-being of the elder people (Alemnesh, 2013).

Using qualitative approach in a case study design, in 2014 Segniwork Lemma conducted an assessment on experiences and practices of old age home care and support to the elderly living in the institutions at three selected institutions in Addis Ababa for her Social Work Master's thesis. She selected KAMSD, Mekodonian Elderly and Mentally Disabled Care Center (MEMDCC) and Kality Institutional Care Centre for the Elderly (KICCFE) for her research sites. The objective of her study was assessing the care and support methods and client's experiences of the care and living arrangements in the three institutions. She reports that there is an increasing demand for institutionalization. Regarding the positive practices of the institutions she concludes that the care and support provided by the institutions has changed the lives of the resident elders, that the elders are fine with their social life in the institutions though they still seek more visitors and community support and

that KAMSD and MEMDCC have good voluntarism value in practice. As practices needing improvements she recommends that professionalism and involving the community in the care and support must be worked upon by all the three institutions.

Besides their scarcity, these local studies were not conducted by taking the psychological effects the resident elders in institutions face as a result of the institution based care and support services provided for them as a sole issue. Abdi (2012) found out that elders who are provided with the institutional care are more depressed than the others who are provided with home based care and support on his way while trying to meet the main objective of his study which was exploring how do elders cope up with challenges they face when the traditional mutual support breakdown (p. 24).

Likewise Fassil's (2010) study on the effects of the Kality Institutional Care Centre for the Elderly was a general one that the psychological effects of the institutional care on the resident elders were taken as a single subject in the entire study. Consequently, he recommends that each of the effects explored in his findings can be taken as a distinct thematic area for future studies (p 9).

Thus, this study is designed in consideration of the gaps in the previous studies and the lack of sufficient emphasis on the psychological effects institutional care and support services result on the resident elders, with especial focus on the case of KAMSD.

Therefore, this research addresses the following research questions:

- What are the psychological problems which resident elders encounter due to the care and support service they are provided by KAMSD?
- How does the institutional care and support provided by KAMSD cause psychological problems on the KAMSD resident elders?

- What are the coping mechanisms used by the resident elders in KAMSD in order to alleviate these problems?

1.3 Objectives

The general objective of this study is to explore whether the institution based care and support provided by Kebre Aregawian Megebare Senay Derejet (KAMSD) have adverse psychological effects on the elders or not. The study has the following Specific Objectives,

- To demonstrate how the elders found in KAMSD are affected psychologically as a result of the institutional care and support provided to them by KAMSD.
- To identify which psychological problems are manifested by the resident elders.
- To explore how the resident elders found in KAMSD cope with the psychological effects

1.4 Significance of the Study

Research in this area is inadequate. As a result this study will contribute something of worth to the knowledge and practice to the field of institutional care and support to old people. Students, researchers, NGOs and other stake holders can also use it as one reference. Further, the study will produce recommendations that can improve the care and support to old people in the institutional setting. Policy developers and planners can also get a relative advantage to make another one supported by empirical evidences to further advance the standardizing of geriatric centres at the national level. Moreover, the current study is also expected to initiate researchers who are interested in the area of the institutional support to the elderly to make further advancements in the future.

1.5 Limitations

This study focuses only on resident elders under the care of the KAMSD and hence is unable to demonstrate a comprehensive picture to understand the situation found in all

organizations providing institutional support for the elderly. The other limitation is with regards to lack of sufficient previous local studies on the effects institutional care for elderly results on the elderly. Thus, the study has been forced to excerpt information from literature on elders in the western context.

1.6 Organization of the Study

The present study contains five chapters. The first chapter contains the intent of the study by stating the problem and explaining the significance and the objectives of the study. Chapter two deals with the development of the issue under study, the different perspectives on aging and the classification of the institutions providing care for the elderly as well as the two of the most related theories to the institutional care for the elderly by exploring the available literature. The third chapter focuses on the practical field work and collecting the targeted data. The scope of the chapter goes from data sampling techniques and collection process to data analysis. Chapter four presents the major findings and discussions while chapter five has the conclusion and social work implications.

Chapter Two

Literature Review

Before looking at the different perspectives it would be interesting to see what the reasons to study 'ageing' are. The first and most given reason is the demographics purpose. Recognizing the older population of the world or a given nation as one category of the entire population is the basis for this purpose as demographics deal with birth and death rates, life expectancy and the number of people in the different categories of the population in the given nation to be studied or the world. The second reason is humanistic one in which the interest is based on the curiosity of what would individuals at the stage of childhood, adulthood or different stages of life be like at the later stage of their life in terms of characteristics, physical appearance and cognition. Other reasons are the paradoxes and diversity related to old age. Paradoxes are like most people say they love their grandparents while they are not intimately related to other elders in their social life and the diversities are like why some elderly individuals become presidents of nations at the age of 60 or above and others become residents of residential care facilities.

2.1 The Different Perspectives on Ageing

Gerontology is the study of all problems of ageing: medical, psychological, social, economic and cultural (Sona, 1946). The field of Gerontology (the study of aging) is relatively new, and has become of both academic and policy interest with considerable expansion in the post war period, largely in response to the perceived problems of an ageing population (Christina, 2005). Hence, most people in the area come from other disciplines (e.g., there are gerontologists who were originally trained as psychologists). Hence, the study of aging tends to be interdisciplinary (www.sagepub.com).

2.1.1 The Biological Perspective

The biological perspective is concerned about the internal process in the body and external damage the body incurs from the interaction it has with the environment. The body has its own course of complications starting from illness to decline and ultimately death. Old aged people demonstrate typical changes such as grey hair and wrinkles. The key question is whether such changes are a result of ageing or growing older or whether they represent potentially modifiable changes resultant from social and environmental factors. Important terms in this perspective include longevity which refers to the maximum lifespan that a species could attain under `optimal' conditions and lifespan which refers to the period between one's birth and death. Ageing in this perspective is described as decreases in the efficient functioning of an organism with age as a result of natural processes rather than abnormal processes which bring about pathology and disease. Although there has been a continuous debate about the precise biological definition of ageing, (as cited in Christina 2005, Strehler 1962) suggests four criteria to distinguish ageing from other biological processes. The criteria are universality (it must happen to every member of a population), internality (it must result from internal processes and not reflect lifestyle or environmental factors), progressiveness (it is progressive, rather than acute, with cumulative effects) and harmfulness (it should demonstrate a deleterious, rather than benign, effect upon the organism and its ability to cope with its environment). There are at least twelve theories in the Biological Perspective. The common thread across all of these theories is that the body slowly wears itself out, whether as a function of internally produced complications or environmental damage. However, what is also clear from many of these theories is that some of the changes that we view as "inevitable" with aging could actually be addressed with preventative care (Sage, 2007).

2.1.2 The Psychological Perspective

This perspective has two categories favouring and contradicting decline and deficits in aging. The ones favouring decline propose that in old age there is a decline in memory and social contacts. Regarding the memory loss long term memory is not affected when compared to short term memory and regarding the social contacts it is said that older people claim to prefer their close contacts like families (for the purpose of a better reward) to peripheral contacts. But this decline is functional for the elders as well as those around them. On the other hand those contradicting these theories say that as long as elderly individuals stay alive and active the tastes, choices and preferences they had during their former stages of life will continue as they were. Thus there will be no decline either in social contacts or in memory.

2.1.3 The Sociological Perspective

The sociological perspective deals with issues like demography, societal structure and influence and the perception of the rest of the society on ageing. The demographic issues here are whether the social institutions available do or do not respond to the interests of the old people in the society. A good example is when the old people are moved from one place to another (why did they move or are relocated and whether the new place will be of convenience for them).

The other demographic issue is the sex ratio among the older population. The implications of the sex ratio are crucial for providing services, financial planning, health care decision making, and personal relationships. Regarding the influence of the society on aging, it is seen particularly by the dynamism and modernization of the society. The big question is whether the change occurring in the society has a place for the elders or not. Most usually class, sex and race have important place in structuring social life. So the issue here is to what extent does age particularly old age play this role in structuring social life. A good example is

the teen community around universities and the almost non-existent old age community in the same place. So where do older people belong in the social stratification of a given society?

The other concern of this perspective is the perception of the society and the negative impact of this perception in the life circumstances of old aged people. This part of the sociological perspective is known as the Political Economy of Ageing as it is concerned with how the social and economic structures maintain negative life circumstances for older people. The bio -medicalization of ageing is the noted concept here. The concept discusses how ageing has become to be seen as an exclusively medical and biological phenomenon— as something to be treated medically. This occurs because of the focus of the medical community on profit rather than health: for many medical institutions, it is in their interest to encourage older adults' dependence on the medical system, rather than encouraging older people toward health and independence. Thus, ill health and decline in old age can be understood as socially constructed phenomena: As a society we create the conditions in which it is easy for older people to buy into their own decline, and very difficult for them to maintain independence and health (http//:www.sagepub.com).

2.2 General Situations of the Elderly Population

During the second half of the last century the UN Population Division had observed that the global population of those persons aged 60 years and above almost trebled from 205 million to 606 million, and average global human life expectancy increased by 20 years from 46 years in 1950 to 66 years by 2000 (The Cambridge Handbook of Age and Ageing, 2005). According to the estimate of the UN, the number of people aged 60 and above is projected to reach 2.1 billion in 2050(MOLSA, 2006). This shows that the number of older people is increasing at an alarming rate. The increase in turn shows that the challenges and the quality of the lives of the elderly is just part of the same package to be considered critically.

Around 6% of older people in developed countries have experienced some form of maltreatment at home. Abusive acts in institutions include physically restraining residents, depriving them of dignity (by for instance leaving them in soiled clothes) and intentionally providing insufficient care (such as allowing them to develop pressure sores). The maltreatment of older people can lead to serious physical injuries and long-term psychological consequences. The number of older people who are no longer able to look after themselves in developing countries is forecast to quadruple by 2050. Many of the very old lose their ability to live independently because of limited mobility, frailty or other physical or mental health problems. Many require some form of long-term care, which can include home nursing, community care and assisted living, residential care and long stays in hospitals (WHO, 2014). This is a message to be taken with seriousness in regards to countries with less formal social security schemes like Ethiopia. As the only formal scheme of pension covers 16% of the ageing population, the intervention of volunteers and NGOs to help the older people live a better life is highly demanded.

2.3 The State of Old People and Care Provision in Ethiopia

In Ethiopia, old people are revered and respected traditionally. But recently due to globalization and urbanization this situation is decreasing gradually. According to the Summary and Statistical Report of 2007, out of the total population of 73,918,505, in Ethiopia 3,568,810 are older adults. The number of older males and females is 1,947,022 and 1,621,788 respectively. Due to the above mentioned reasons and more, it is common to see that older persons who have the knowledge and skill to help not only themselves but others are facing serious problems and resort to begging (MOLSA, 2006).

From the situations of the elderly, it is clear that there is a strong need of care and support for the elderly. Most of the help for the old people is expected to come from the

family. This includes the nuclear, extended family, the other spouse, descendants or members of family of origin (sisters, brothers, etc).

The rest of the help provided to the older people is expected to come from the government. This is particularly true concerning financial and health sectors. Older people who were former employees of either public or private sectors obtain financial support from the pension scheme upon retirement even though this support is too small. Regarding the health care, individuals can get free health care from public facilities through administrational procedures. The procedure starts from the application of an individual to the Kebele where a committee is formed to review such applications. The committee will examine the means of livelihood of an applicant and grant a certificate that allows the individual to get free health care from public facilities. The validity of this certificate is only for a short period of time and eligible individuals can use the certificate for a maximum of three to six months. There are also three government run institutions namely Abraha Bahta Home for the Aged in Harrar, Beteselehome Home for the Aged in Oromia and Kality Institutional Care Centre for Elderly Adults in Addis Ababa providing care for the elderly. In Addis Ababa, there are 13 NGOs supporting older people. Out of the total 13 NGOs, three of them work only supplementary projects on old people while the remaining 10 NGOs provide directly the institution based care for the old people (B. Kedir, Personal Communication,15/8/2016).

With the declining Traditional Kinship based Elderly Care and Support and with a governmental system not covering enough space, the intervention of private/ non-governmental organizations is desired to fill the gap.

In a nutshell the care and support is often provided either by informal carers within the family or the community, or by actors in the private sector. When services are provided by the public sector, responsibilities are sometimes diluted as services may be highly decentralized (UNDESA, 2014).

One of the most common types of long term elderly support and care provided by NGOs is the Institution based Care. The institution based care is given to those aged persons (both male and female) not residing at their own homes due to different reasons. In- house and private home care are of the popular forms of care and support provided for those residing in their home. Home and community-based services allow children, adults and the elderly to stay in their own community rather than cut off from their own community as typically happens in nursing homes and other institutions (Watson, 2009).

2.4 Classification of Institutions Providing Elderly Care and Support

In an effort to classify institutions providing elderly care and support the US Congressional Budget Office (CBO) mentions in its report (Congressional Budget Office (CBO) report, 2013) that categorizing residential settings is difficult and often confusing because there is no commonly accepted terminology. However, there are at least three commonly known types of institutions providing care and support for the elderly (Tennessee Health Care Association, 2016).

1. **Nursing Homes:** this facility is provided for the old people who are chronically ill or injured, have health care needs as well as personal needs and are unable to function independently. The service provided id a 24- hours nursing care the nursing home care givers staff contain both medical and non-medical professionals. The care provided primarily focuses on the medical care though the social emotional and spiritual needs of the care are also attended to due to the holistic approach nursing homes should follow as a matter of standard by state regulations.
2. **Residential Homes (RCFs):** Residents in Residential Care Facilities are those aged people who are physically and mentally capable of finding their way out to safety in the events of emergency without any assistance from someone else. RCFs are not permitted to accept elders who need medical care. The services provided to the

residents are room, board as well as assistance with personal activities of daily living (ADL) like bathing, hair and nail grooming, dressing and laundry. Simple administration of medicine by a licensed nurse is permitted.

3. **Assisted Care Living Facilities:** These institution based care facilities are taken as bridges between RCFs and Nursing Homes. They provide similar care for their residents as RCFs but also provide assistance with certain medical services which can be self- administered e.g. daily insulin injections, or other special assistance like assisting resident elder with memory loss.

2.5 Kibre Aregawiyan Megbare Senay Derejet

A private philanthropist, W/ro. Workinesh Munie also called Workeye by the residents, has been supporting some elderly people for two years on her own through the provision of food, clothes and other supplies before legally establishing the KAMSD in 2007. After its legal establishment the KAMSD started providing support to the old people in two ways. These are the institution based care and the family based support including income generating activities, house renovation and financial support. Those elderly people who are sick, cannot work, who have no support and who live in the street and engaged in beggary are provided with institution based care where they are provided with food, clothing, shelter and limited medical service. Those elderly people who live with their families, who can work but have no income, are provided with the opportunity to engage in income generating activities. Those elderly people who live with their families, who cannot work and have housing problems, are included in house renovation programs. The final group is those who live with their families in rented Kebele houses and often find it difficult to pay house rents. This group is provided with monthly financial support from KAMSD.

From the categories of the institutions which provide support for the old people KAMSD's institutional setting resembles the Residential Care Facilities as it provides shelter/rooms, meal service, and limited medical services to its elderly residents.

Its current location is around Bole Bulbula area. The site is obtained as a grant from the government. Consequently, it is its third but permanent location as it has been moving from its first location to Mekanisa before being granted this one. Among the other humanitarian works KAMSD conducts or elders, the institutional care is the one of interest in this paper. Regarding the medical service provided to the resident older people, the KAMSD Nurse said,

> We provide First Aid service for our sick elders here. If it is beyond our capacity we send them to Health Center. If it is beyond that the Health Center shall refer them to Hospitals. There, they could be treated as outpatients or otherwise. We register their progress and appointments and follow up their health seriously.

With regards to the mental health and psychology of the elders, the Nurse told me that KAMSD invites volunteer psychiatrists and mental health specialists to counsel, advice and create awareness to the elders.

Currently there are 45 resident elders in KAMSD, of which 30 are male and 15 female. The dormitories of the elders are classified by sex. There is one big enough meal hall where the elders eat their food. There are two care givers who help those elders in need by cleaning themselves, their rooms, making their beds and in similar other activities. There is also one waiter who attends the elders during their meal times and a cook to prepare their food. W/ro Worknesh a devoted founder also lives within the same compound as the elders.

Related literature show that elderly persons lacking basic activities of daily living (ADL) i.e. bathing, dressing, transferring, eating and grooming (Lawrence & Allen, 1982) join Residential Care Facilities. But Abdi (2012) has found out that poverty is also the main reason for the residents in joining the KAMSD in addition to lack of ADL performances without assistance (p. 26).

Poverty has become more acute among older people and it is much more difficult for them to come out of it. Ill health, unsuitable residential areas, diminishing family and community support, limited social security services, lack of education and training opportunities, limited employment and income generating opportunities, and lack of balanced diet and shelter are some of the factors contributing to the poverty of older people. (Help Age, 2013)

Poverty alongside with declining reciprocal relationships in the family, insufficient support from the government and the community makes life harder for the elderly individuals. Consequently they start to seek for sources of income by themselves. Some go out to the street for begging while others try to do jobs usually labour works with their limited ability. Still there are others who are bedridden, sick or so weak due to old age.

Of course it is desired for all human beings to remain at home as far as possible. The concept of "ageing in place '' entails the right of everyone to live where they want and with whom they want (UNDESA et.al., p1). Despite the good wish and the rights of individuals for ageing in place, such type of ideal life is not found in abundance. That is why many old persons plight to carry their own weight. For these groups of people the care and support provided from organizations like KAMSD is at least expected to relieve them of such pressures. But the fact that these older persons are under life strain does not mean that someone else should either manipulate or make decisions on issues of a better care and support on their be -half. From the points in the concept of ageing in place and the Special Rapporteur on Health study under the UN Human Rights Council we can understand that

older persons need to be provided the time, opportunity and support to give their free, prior and informed consent to their choice of treatment, services and care, particularly in situations of dependency, end-of-life decisions and in the various life situations of long term care (UNDESA, 2014). Thus, elderly persons joining institutions of long term care should be made aware of situations, circumstances, terms and conditions in the facility so that they will make their own decisions regarding where and with whom to spend the later stages of their lives. On top of this they should be heard on their complaints, demands for a better quality of life on a continuous case by case basis after joining the long term care centres.

One important point to ponder is that in the West there are communities, volunteers or philanthropists' established RCFs providing free care and support services. The privately owned RCFs and institutions alike established for business purpose are much greater in number. The contemporary reality here in Ethiopia is quite different in that all RCFs are established by the government or NGOs who aimed to provide care and to the quality of life of the poverty ridden older people with the provision of free care and support services.

2.6 The Major Psychological Effects of the Institutional Care for the Older People on the Resident Old People

It is presumed that institutions providing the care and support to the old people try to make the social and physical environment as safe and conducive as possible for their resident older people. However, as it can be observed from related literature the resident older people suffer from various psychological problems which result from the care and support provided to them.

A study conducted on residents in four different older people support providing institutions found in Scotland (Gill, Susan & Munna, 2003), the resident old people suffer from social and emotional isolation as a result of the poor social interaction in the institutions. It is reported that the resident older people spend much of their time by doing nothing which

led them to be lonely and isolated. The researchers recommend that in order to improve the situation, the institutions should program the care provision settings enabling the resident older people to express themselves freely, try to narrow the cultural diversity among the resident elders and also design the buildings in the compounds in a way which makes social interaction among the resident old persons easy.

In her study conducted on the resident older people in Mekodonian Elders Care Centre, Eskedar (2015) reports that the resident elders experience bad feelings such as hopelessness, loneliness, despair, sleeplessness, grievance and depression. Some of the causes she states for the bad feelings of the older people like being dependent and unsatisfied on the care provided and separation from family ties, friends and neighbours are all related to the support provided from MECC.

Another study which was conducted on 330 resident older persons found in three elder care providing institutions found in Addis Ababa, namely Mekodonian Elders Care Centre, Yewedekuten Ansu Yearegaweyan Metoriya Derejet and Noble Cause Elder Care and Support, Tigist, Tefera, Emebet, Addis and Kenan reported that 98%, 97.6% and 81.5% of the study population suffer from hopelessness, sadness and worrying about potential death respectively. The researchers described the resident older people as vulnerable as they experience loss of their beloved ones, loss of their economic power, facing their own illness, loss of social relationship as well as potential mortality (2016, P. 4). The older people residing in all the three institutions fell being a burden, hopeless and lonely due to the fact that they couldn't go out door as they like and have to remain in the compounds, poor family and social relationships and spending much time idle (Tigist, Tefera, Emebet, Addis &Kenan ,et.al., P.5).

The Geriatric Nursing Training Materials published by the University of Iowa with the main goal of identifying the emotional and mental problems and the various sources of the behavioural and psychological symptoms that may be observed in older adults residing in

nursing homes and other residential settings states that loss of self-esteem, loss of control, situational stress and depression are the major among other psychological threats for older people living in the elderly care providing institutions (2005, P.1).

The manual further lists some of the causes as well as the symptoms for the psychological and emotional problems. The causes include unwanted changes in bodies, roles, abilities, and activities, mismatch between the person's behavior and what s/he "wants to be", the loss of ability to make even "simple" decisions, discomfort caused by physical illness or disability, loss of health and ability to function independently, loss of loved ones through death and relocation, financial problems or concerns, difficulties adjusting to communal living situations in the geriatric center.

These threats express themselves through the elder people by symptoms like criticism of self and self-pity: may say they are "stupid, no good, a born loser", criticism of others, things are never good enough, disturbed relationships: takes advantage, mistreats, abuses others, minimizing their own abilities: avoiding, neglecting, or refusing to see their real assets and strengths allows them to "never fail" because they "never try", they convince themselves that they are "no good", being short fused or on edge etc (p.39)

These threats mainly affect the typical ways of the old people thinking about themselves, what happens to them, relating to the world or the environment and their coping mechanisms. The life experiences the older individuals pass through in the institutions as well as their past do have direct relationship with the feelings, perceptions, interactions with the environment and the coping mechanisms they develop at their later ages.

2.7 Theoretical Framework

Epistemology, the study of origin, nature, and limits of knowledge has two aspects. The first one is how the observation/ investigation should be made towards discovering or understanding phenomena. A reliable and reasonable observation follows a correct method.

The second aspect is concerning the explanation of the observed phenomena. In short the second aspect of epistemology is about theories. This shows us that explaining the observed phenomena is as important as the methods of observation and its consequences.

Theories are explicit explanations in accounting for empirical findings (Bengtson, Burgess& Parrott, 1997). The explanations should be about phenomena observed. They may be based on previous explanations or attempts of explanations used by others who observed similar phenomena in the past. A certain theory at a certain age represents how far the knowledge in that field of study has progressed or to what extent it has been explained.

In gerontology (the study of ageing), theories describe the phenomena of ageing. There are various theories providing different lenses through which to view and explain phenomena of aging (Bengtson et al., 1997).

2.7.1 Learned Dependency Theory

The learned dependency theory is mostly taken to be one of the social psychological theories of ageing. Social psychological theories of ageing focus on individuals and how they respond to social stimuli. These theories explain how people think, influence and relate to others.

Learned dependency theory explains how dependent behaviours of elders are used to maintain the social contact around them. In the case of individuals living in a long-term care facility or at home with a live in care giver, any unnecessary dependency on the caregiver to help with minor daily activities such as getting dressed or reaching for far away objects might lead to the acceleration of the aging process via disuse of muscles and motor skills. Gerontologists Baltes and Cartensen (1999) explain that dependency of this nature is socially learned as a means of maintaining social contact in the effort to avoid loneliness.

The elders in long term care facilities interact continuously with their social partners i.e. the long term care facility staff and fellow residents (Rose & Puncho, 1999). One of the

effects of such an interaction is that of dependence. It is said that elders who are dependent on the staff or caregivers are rewarded with attention and quick response while those on the other side are punished or rather ignored. For this reason residents learn that dependence do serve their desires and needs better. Thus from this trend comes the theory of learned dependency.

For a realistic explanation and better understanding of this situation in elderly care facilities to look at the two approaches on dependency is worthwhile.

The supply- side approach: this approach focuses on the role of the caregivers reinforcing dependency from the residents. Thus, caregivers support the elders' with dependent behaviours while ignoring the other ones showing autonomy. This is a mixture of caregiver's attitude and the institution's policy. Institutions most usually want to avert the risks coming out of preventable injuries e.g. falling so much so that they render the system urging the elders to ask everything they want from their caregivers. Here, the risks averted are insurance/ medical cost, threats of legal action and negative publicity.

The other reason is the task demands of care giving. It is submitted that the basic roles of care giving are accomplished efficiently when the care giver takes an active role in it. The care givers make plans to address the residents in a line on a day- to- day basis which in turn makes the elders dependent on the time and schedule of the care givers as well as entrenches the feeling of discouragement to do things by their own during the rest of their time.

Stereotypes to aging are also an important reason. Usually care givers are young, untrained, and may thus have naïve conceptions of aging and developmental loss (Burgio & Burgio, 1990). This attitude by the care givers disapproves the autonomy of the residents and urges the care givers to show more inclination to the dependent residents and less to the others.

The demand side approach: the main emphasis here is the different characteristics of the resident elders. Seeking attention, desire to enjoy social contact, conforming to social

expectations can be illustrative examples for the characteristics in this approach. Therefore, elders with such dispositions will obviously solicit for care and attention than expected, provided their physical conditions. This shows us that dependent behaviour can become a means of gaining social contact and exerting control over the environment.

2.7.2 The Socio- Emotional Selectivity Theory

Socio emotional selectivity theory is a social- psychological theory of aging and also one of the exchange theory of aging (Bengtson, Burgess& Parrott, 1997) which maintains that time horizons influence one's goals in life (Mather & Carstensen, 2005). The theory suggests that the social goals of people are the same throughout life while their saliences differ depending on the stage of life the individual is.

The salience of social goals in old age is that, in particular, the regulation of emotion becomes increasing over the life course, while acquisition of information and the desire to affiliate with unfamiliar people decreases (Carstensen, 1995). In other words, the reasons for social interaction and exchange of non-material resources change over the life course from a need to acquire information, to affirmation of self- concept, to regulation of emotion (Bengtson et al., 1997). The social interaction is the manifestation of the self- interest for an emotionally close and rewarding social contact with a selected group of individuals like an adult child or a spouse.

The reduction of social contact size which comes due to the process of selection by the older persons is because of the reason that old people construe that time is running against them in life or that a little more time is left for them or that death is approaching. Carstensen (1995) explains this better by saying "when the future is perceived as limited attention shifts to the present, immediate needs such as emotional states become most salient"(p. 54).

Therefore the theory has two focuses for the elderly actively managing their social worlds. The first takes into consideration the long term goals of acquiring deeper knowledge

of themselves and their loved ones. Larger circles of loosely knit friends tend not to allow time for the development of long term friendships. The second area of focus is on the short term goals of emotional connections and meaning. These goals are perceived to be more easily attained through smaller, closer groups of friends and more intimate relationships. Hence, while older adults' networks of social relationships do get smaller, it is incorrect to view this as a decline of any kind (www.sagepub.com). Rather, it reflects focusing and shifting emphasis. This type of goal setting, whether it is conscious or not, is one element of successful aging encouraged in many of the homes for elders (Sarah, 2004).

2.8 Elder Abuse

Elder abuse is one of the most common events in older adult's long term care centres. Abusers are usually the care givers of the resident elders. The relationship of the care givers and the elders is so close and characterized by the dependency of the recipients on the providers. As a result the care givers' attitude and mood in addition to lack of professional knowledge and skill highly affects the physical and psychological life of the elders.

Modern reports of elder abuse were first noted in the medical literature in England in 1975 when the British Medical Journal published a report of ''granny battering'' (Gorbien & Eisenstien, 2005). Since then the issue has been devoted a growing attention and has even made it to the legislations in many countries including the U.S.A. and England. In the effort of defining elder abuse the 1985 U.S. Elder Abuse Prevention, Identification and Treatment Act defined abuse as the ''wilful infliction of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm or pain or mental anguish, or the wilful deprivation by a caretaker of goods or services which are necessary to avoid physical harm, mental anguish or mental illness'' (Gorbien & Eisenstien, 2005). Literature in this area show that there is a close to consensus in the types of elder abuse (Lachs & Pillemer, 2004; Gorbien & Eisenstien, 2005). The identified types of elder abuse are (1) physical abuse,

which includes acts done with the intention of causing physical pain or injury; (2) psychological abuse, defined as acts done with the intention of causing emotional pain or injury; (3) sexual assault; (4) material exploitation, involving the misappropriation of the old person's money or property; and (5) neglect, or the failure of a designated carer to meet the needs of a dependent old person.

In institutional settings, as mentioned earlier caregivers are the primary abusers. Abuse may also be perpetrated by other residents or visitors (Lachs & Pillemer, 1995). However regarding the primary abusers Ramsey-Klawsnik in the year 2000 suggested the following 5 types of personalities.

The overwhelmed: This group is well intentioned and generally qualified to provide care. When care needs exceed what they can provide, they may abuse verbally or physically. They do not look for victims.

The impaired: This group is well intentioned but has problems that prevent them from delivering care. These caregivers may suffer from mental or physical problems that serve as barriers to providing adequate care. They may be unaware of the deficits in their care delivery. Neglect is more common in this group, and they may tend to control the victim through abuse.

The narcissistic: These caregivers enter into caregiving relationships to meet their own needs. They are more likely to steal from seniors and neglect them. They see the relationship as a means to an end and may be attracted to nursing homes or centers where they can enter into relationships with vulnerable adults.

The domineering or bullying: This group may feel entitled to exert power and authority. They may have narcissistic tendencies and often feel that the

victim deserved the maltreatment. This type of offender may honour limits in other settings and has insight into the nature of the maladaptive behaviour. This type of offender is prone to neglect and financial abuse. This type of offender may engage in sexual abuse.

The sadistic: Offenders of this type often have sociopathic personalities and take pleasure in the mistreatment of their victim. Their abuse of others allows them to have feelings of power and importance.

On the other hand aside from the personalities of the care givers Gorbien & Eisenstien, (2005) have listed risk factors which play roles in the prevalence of elder abuse in institutional settings. These risk factors are

- Older age
- Lack of access to resources
- Low income
- Social isolation
- Minority status
- Low level of education
- Functional impairment
- Substance abuse by elder or caregiver
- Previous history of family violence
- History of psychological problems
- Caregiver stress
- Cognitive impairment

2.9 Coping Mechanisms

The concept of coping was first adopted by psychologists in the 1960s and 1970s and was applied to refer to the struggle of overcoming and managing the stresses of living and adapting (Hanevold, 2013). Coping is defined as progressive change in cognitive and behavioural ability to control certain external or internal needs considered to have exceeded the resources of the person in question. Coping is also seen to be related to human personality

trait and a time changing process in accordance with the situation we found ourselves in (Kuria, 2012).

Elderly people face series of challenges such as illnesses and irreversible loses during the phase of ageing process. This process works against the will and interest of the elderly people. Acute illness comes with lots of problems and there may be a need to keep in shape one's emotions, self-image, ability, relationship.

Kuria (2012) in her thesis has categorized coping based on individual perspectives and said that its applications depend on the state of health and nature of the elderly people. Coping style could be problem focused, emotion focused, active, adaptive, avoidant, problem solving, corrective or preventive.

Problem-focused coping is when the elderly can change the situation caused by aging process and direct efforts specifically to the main problem. When the elderly cannot change the situation, they rather change their perception about the problem and try to give it another meaning that is future promising; such coping is called emotion-focused.

In active coping, idea is directed towards gaining control over one's problem. Besides, this could be a move to change an unfavourable condition, dealing with one's emotions through seeking beneficial information or by avoiding the situation from taking control over one's life. This is done by seeking for something else to do or by socializing with people.

Preventive coping is an effort to avert or delay the occurrence of the age related changes in the elderly while corrective is a measure(s) spelt out to put the situation back to nor-mal after the occurrence (p. 42).

Chapter Three

Research Methods

When there is a small data regarding the subject chosen for study and when the phenomena to be investigated in the research are not easy to quantify or measure accurately or where such measurement would be arbitrary and inexact qualitative research can be judged appropriate. The phenomena can be personal experiences (for example, of a condition, treatment or situation), processes (for example, action research, practitioner or patient views on the acceptability of using new technology), personal values and beliefs (for example, about death, birth, disability), interactions and relationships (for example, the quality of the teacher-pupil relationship, the openness of a counselling relationship), service evaluations (for example, what was good or bad about teachers' experiences in discussion group)(http : / / www.Black well publishing.com). According to Patton (1990) qualitative research attempts to understand the unique interactions in a particular situation. The purpose of understanding is not necessarily to predict what might occur, but rather to understand in depth the characteristics of the situation and the meaning brought by participants and what is happening to them at the moment. Likewise for Denzin and Linclon (1984) it focuses on interpretation of phenomena in their natural settings to make sense in terms of the meanings people bring to these settings. Qualitative research involves collecting information about personal experiences, introspection, life story, interviews, observations, historical, interactions and visual text which are significant moments and meaningful in peoples' lives (http : / / www.Black well publishing.com).

Phenomenology is one type of qualitative research which focuses on the common experiences of different individuals regarding a phenomenon. The phenomenon has to be an object of human experience. The purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence (Creswell, 2007).

Being taken care of in a geriatric centre during peoples' old age is an object of human experience. The understanding of meaningful concrete relations implicit in the original description of experience in the context of a particular situation is the primary target of phenomenological knowledge. The researcher reduces data gathered as lengthy interviews describing the shared experiences of several informants to a central meaning, or "essence" of the experience (Moustakas, 1994). To this end there are some major psychological effects that come out of this type of old age care. As the aim of this paper is to explore and describe the common experience of the care recipients in KAMSD with regards to the care provided to them and the adverse psychological effects resulting from it, I used the phenomenology research technique in the qualitative research design.

3.1 Sources of Data

The primary sources of data are resident old people in KAMSD. The secondary sources include different books written in relation to older adults, policy documents, seminar proceedings on aging through internet and by hard copy. Goggle Scholar and other search engines and web sites are used for the internet literature review. Five KAMD resident older people participated in the interview. The nurse who provides the medical aid to the elders, and an employee of the institution were also used as key informant interviewees. Key informant interviews were conducted mainly to obtain important information about the resident elders' behaviours.

3.2 Eligibility Criteria

Even though all the residents in the institution are potential sources of data due to their living experience, it is a must to select some amongst all for different reasons like inability to express consent or talking or listening impairment or less sufficient knowledge and experience due to short duration in the institution, etc... Therefore the following criteria have been used to select the research participants:

- Residents aged 60 and over.
- Residents in a state of good mental health (those with known serious mental problems were excluded)
- Residents with no hearing and talking impairments
- Residents residing in KAMSD for a period of one year or more.
- Nurse/attendants of the resident old people working in KAMSD for a period of 6 months or more.
- The criteria do not discriminate between male and female residents for equality of sampling

3.3 Research Site

The institution selected for this research is Kibre Aregawian Megbare Senay Deregit (KAMSD). The reason for the selection is because the research base for this study is a previous Lund University Master's graduating thesis by Abdi in 2010 which was conducted in the same institution. One of the study's finding is that "the generational support between the elders in KAMSD and their close kinship is breaking down and also the older people under KAMSD institutional support feel more depressed, lonely and being a burden on the institution (2010, p.24). Thus, I want to further demonstrate the psychological effects the KAMSD resident older people face as a result of the institutional support provided to them.

3.4 Data Collection Methods and Process

Family Health International (2005) mentions that participant observation, in-depth interviews, and focus group discussions are the three most common qualitative methods and explains their uses as follows:

• *Participant observation* is appropriate for collecting data on naturally occurring behaviours in their usual contexts.

• *In-depth interviews* are optimal for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored.

• *Focus groups* are effective in eliciting data on the cultural norms of a group and in generating broad overviews of issues of concern to the cultural groups or subgroups represented.

However, there are disadvantages of using participant observation when there is a chance for the participants to change their behaviour in cognition of the presence of an observer during their activities. And for this purpose non- participant observation is recommended (Jonathan, 2008). Therefore in this study I have used non- participant observation, semi structured and key informant interviews to collect the data needed.

Interviews with the elderly were conducted in order to find out how they see the institutional care provided to them, what experiences they have in their life in KAMSD i.e. their relationship with other residents and the care givers as well as the administration staff in participation of decision making regarding the quality of life in the institutional setup. The semi- structured guide was sorted by the three questions and the major psychological problems discussed in the literature review. The particular questions in the guide concerning the major psychological problems were adopted from The Geriatric Nursing Training Materials published by the University of Iowa in 2006. The justification for the adoption is that the material was designed to help Nurses and other Care Givers in Geriatric Centres better understand the major psychological problems their causes and symptoms resident old people in Geriatric Care Settings (2005, p.). It also has questions which the care givers should ask to the resident older people in order to better understand their psychological problems.

As leverage and flexibility is expected during the data collection process, some questions in the guide were modified on the spot after conducting the first interview with the first elder. Semi structured interviewing technique is used to collect qualitative data by setting

up a situation (the interview) that allows a respondent the time and scope to talk about their opinions on a particular subject. The focus of the interview is decided by the researcher and there may be areas the researcher is interested in exploring. The objective is to understand the respondent's point of view rather than make generalisations about behaviour. It uses open-ended questions, some suggested by the researcher and some arise naturally during the interview.

Key informant interviews were conducted with the nurse of the institution and the coordinator. The interview with the former focused on the behaviours of the elders, how the elders interact with each other and the overall health facilities the institution provides. It also involved the case reports based on complaints submitted by the elders emerging from their relationships with each other and/ or their caregivers. As the nurse has a frequent contact with the elders, the interview was very important in giving good insights for the job ahead. Brief informal discussions were held with the coordinator and the founder and manager of KAMSD. The goals of these were to clarify the aims of my research, to agree on terms and conditions of the procedures of the data collection process, to list and select the elders for the interview based on the eligibility criteria. In addition to these further information was obtained on the history and profile of KAMSD from the sessions with the coordinator and the manager.

3.5 Sampling Techniques

The study population for this research were residents in a Non-Governmental Organization called Kibre Aregawiean Megbare Senay Derejet. Most usually it is neither possible nor necessary to collect data from everyone on the field. For this reason in qualitative research purposive sampling is used often to select a sample population for the study. Purposive sampling is a sampling technique where the researcher selects individuals and sites for study because they can purposefully inform an understanding of the research problem and central phenomenon. Sample sizes, which are mostly small in purposeful

sampling method, may or may not be fixed prior to data collection, depend on the resources and time available, as well as the study's objectives. Purposive sample sizes are often determined on the basis of theoretical saturation (the point in data collection when new data no longer bring additional insights to the research questions) (Family Health International, 2005). Creswell (2007) strongly advises that being flexible in choosing the sample size and selecting the individuals in the sample population is important as unpredictable or unforeseen circumstance might occur on the field.

Three male and two female elders were interviewed during the process. The sample was initially three elders appointed by the coordinator. The remaining two were added one at a time until the saturation point i.e. a point where no new information is obtained, is reached. The selection of the individuals for inclusion in the sample was based on the eligibility criteria and the research questions. Richie and Lewis (2003) confirm that prescribing sample criteria is a key feature of purposive sampling.

3.6 Data Collection

All of the interviews with the elders were conducted before lunch time. The reason for this is to utilize the morning fresh and active mind of the elders. On average each interview took around 35 minutes. The interviews were done in the meal hall of the elders which is clean and conducive for interview.

The data collection process was started by contacting the institution over the phone and notifying them the research intention and fixing a day for my physical appearance to discuss on the details of the data collection process. On the next day I made my first physical appearance at the institution, submitted the supporting letter from the School of Social Work discussed on the procedures for the data collection using an employee of the organization as a gatekeeper. The next step was to conduct key informant interviews with the facilitator and the nurse. After that I went on to observe and interview the sample resident elders of

KAMSD. During all the interviews and observations, I took notes on important points and on things I can't record on my audio recorder like the environment, gestures on the faces of interviewees etc. the interview and observation took seven days as a whole. Before interviewing each elder and key informant I have secured their consent to be interviewed and be recorded by my audio recorder. By the time I finished my data collection I thanked all the participants and the staffs and promised to provide one copy of the final research output and left the site. Transcribing the audio data in Amharic and translating it to English was started right after the interview to keep the researcher fresh to remind the points not attended in the notes and tape recordings.

3.7 Data Analysis

According to Creswell (2007) qualitative data analysis involves three steps. The first one is data management by preparing or organizing the collected data. This includes transcription, forming a database and paving for ease of access of data from the database. The second step is data analysis which is composed of activities like reading the data, memoing i.e. writing short words or phrases on the side of field notes or on the foot of photographs, coding i.e. classifying and interpreting the data by the researcher's own perspective or perspectives obtained in literature review. The third and final point is report writing where the researcher presents his/her findings and accounts in texts or tabular form.

By reading the transcribed data and listening to the audio recorded interviews repeatedly the personal experiences of each research participant older persons were clustered into different themes. The themes formed were basically the three research questions and the particulars in each of the research questions. After clustering the personal experiences of each research participant in each interview into themes, a summary was prepared by clustering again the common themes identified in each interview. Here care must be taken not to cluster common themes if significant differences exist (Gronewald, 2004). Finally the data analysis was concluded by writing the composite summary. The composite summary transforms

participants' everyday expressions into expressions appropriate to the scientific discourse supporting the research (Sadala and Adorno 2001, P. 289 as cited in Gronewald et.al. p. 21). As phenomenological research data analysis emphasises on the personal experiences of participants and the particular meanings the participants give to their personal experiences, the researcher has referred the audio recorded as well as the transcribed interview and the field notes repeatedly throughout the data analysis process. This is important because the researcher must be familiar with the words of the interviewee/ informant in order to develop a holistic sense (Hycner, 1999). Another important procedure the researcher must follow throughout the phenomenological research data analysis is not to take position either in favour of against the phenomena described by the research participants. This is called 'Bracketing Out' the researcher's meanings and interpretations or theoretical concepts from entering the unique world of the informant/participant (Gronewald, et.al. p 18).

Chapter Four

Findings and Discussions

Researches link the major psychological problems of nursing home resident elders to factors which are usually inevitable whether the elders join these homes or not. The most common findings in connection with this trend are loss of loved ones, physical change due to ageing, loss of social role, loneliness and the like (Fatma, 2013; Hanevold, 2013; Martha & Gail, 2002). The psychological impacts posed by the institutional based care are not considered by themselves. "Less well understood is what comparable provisions are required within institutional settings for meeting the psychological needs of residents, and the promoting subjective well-being and vitality of the elders" (Kasser & Ryan, 1999). Therefore, in this chapter the major findings from the data collected and the analysis are recounted. The purpose of the research is to identify what adverse psychological effects does the institution based elderly care has on the resident elders.

By taking my research questions as major themes, I have organized the major findings from the collected data. Thus, the major themes are the adverse psychological effects of the institutionalized care, the cause of these psychological problems and the coping mechanisms used by the KAMSD residential elders.

S. No.	name	Age	Gender	Education	Birth Place	Work Experience	Period of Stay in KAMSD
1	I_1	86	M	-	Wello	Farmer	3 Years
2	I_2	72	F	-	Harrar	-	2 Years
3	I_3	69	M	Church Education	Gondar	Farmer	2 Years
4	I_4	83	M	Secondary Education	-	Civil Servant	3 Years
5	I_5	67	F	-	-	Cook	4 Years

Table 1. Profile of KAMSD resident research participant older people

4.1 The Major Psychological Effects of the Institution Based Care on the KAMSD Resident Older People

As this study is conducted in the qualitative phenomenological research design its aim is not to build a cause and effect relationship between the psychological problems manifested by the resident older people in KAMSD and the causes of the problems rather to explore the experiences of the residents and their view towards the support they are provided to them by KAMSD. In addition to this, in order to make a cause and effect relationship a rich data is needed which this study is short of. Therefore it must be clear that the psychological problems and the causes presented in this study are identified by the participants themselves in response to the questions on their lived experience in KAMSD and how they see the support provided to them by KAMSD.

4.1.1 Low self-esteem

Self-esteem is how we view ourselves positively or negatively, and our overall attitude towards oneself. An individual with high self-esteem will respect and assume himself as a useful individual. The individual low with self-esteem would not accept himself and assume he is useless and needy (Halit, 2014). I_1 replied to the meaning of being an elderly person as follows:

> Time never stops whether you succeed or fail. One cannot be happy if he does not work but is a burden on another person. Look how much we are burden on this girl (Workeye). And in the future we may get bed-ridden and add to her burden. We are nothing but burdens. So our life is over and we expect nothing afterwards.

I_5 also explained what she thinks about herself in such a way that

> I feel sad when I remember that I don't work for around two decades. I finished all my money to get my health back but I can't. Now I live by the support of an institution. I have no relative. I worry because I have nowhere to go if by same tough chance we have to get out of here. Nobody wants me as I am a good for nothing elder.

There are several factors that influence the development of one's self esteem. Among them is the respect, acceptance, and attention received from significant people in one's life, including family members. From the interview with I5 I have understood that she has almost no contact with her families for entering KAMSD. In addition to that she is very pro-socialization. She has stressed on the point that KAMSD elders need to socialize with the society around one way or another, for I_5 with her very short circle one of the most significant activity is going to church. But the church attendants don't welcome or rather try to exclude the KAMSD elders according to I_5. So this has made I_5 to take herself as out casted, resulting in low self-esteem attitude towards herself.

Low self-esteem occurs when a person's behavior does not match with what that person wants to be. For this reason the individual may constantly blame others for the current situations he/she is in. Such persons try to build themselves up by finding the faults for their situation in others "putting others down".

I_2, a female elder blames her husband, her dead daughter and her niece for ending up in KAMSD, a place which reminds her spoiled past. She replied to the question "do you blame yourself for ending up in KAMSD or do you consider yourself as unlucky?"

> When I ran away my ex-husband didn't try to look for me. He had a job and a salary but he was drunkard, doesn't respect me and batters me. So I ran away.

> He is responsible for everything. I came to Addis Ababa to my niece to live. There I had an operation for my eyes but she disrespected me every time. I couldn't stand her mistreatment. So I applied to the Kebele and I came here.

And when asked if she has lost a loved one, she answered that she has lost a daughter due to HIV. Her daughter died at a young age after marrying at the age of 18. So I_2 blames her late daughter, for ending up in KAMSD.

> She rebuked me when I advised her to continue her education. Rather she got married at the age of 18 and died due to HIV following her husband. Had she been alive today she would have supported me by doing any low jobs even and I wouldn't have been here.

From the interviews conducted with these 3 elders, it can be learned that they view themselves in a lower status. The care and support they receive by living in the institution reminds I_1, I_2 and I_5 that they are burden on somebody, useless and good-for-nothing victims of actions from close family members respectively.

4.1.2 Loss of control

Loss of control over one's life can happen at any time in life. It is not a feeling allocated for elders. Dana (2007) recommends to see loss of control in terms of powerlessness and its opposite power and endorse the following definition.

> The perception that one's own action will not significantly affect an outcome; a perceived lack of

> control over a current situation or immediate happening. (Wilkinson as cited in Dana, 2007).

The Geriatric Nursing Materials of University of IOWA (2005) also defines loss of control to be ones feeling that his/her actions will not actually make a difference in what happens to him/her.

Feeling loss of control manifests in all aspects including the Social, environmental, health and physical aspects of one's life. One of the factors in loss of control in the environmental aspect of life in elders' institutions is lack of privacy resulting from the shared rooms and other shared spaces.

I_3 is an elder resident who has been a monk since 1984 E.C. He has been praying during the night prayer times fixed by the Ethiopian Orthodox Tewahido Church for long years. He told me the difference in his life experience. Before and after joining KAMSD in this regard as follows

> Upon the complaint of elders with whom I share the room I quitted praying at night. They said I disturb them when I turn on the light and pray aloud. I doubt if my voice was louder. Anyway I pray only during the day times now. I wish I could have been able to pray in the night time like I did for long time before.

Juliah (2012) stresses that the other environmental factor which makes the elders in long term care facilities feel loss of control or powerless is when they see the health of their co-inhabitant's deteriorates.

I_4 first mentioned that he has never taken control of his life because everything is under the control of the Creator. He breathed heavily and said that even Emperor Haile

Selassie who was taken as the earth rightful ruler could not anticipate his end. It was God who dethroned him, not man. But on his reply to another question he said

> I don't complain about anything. But here, I have lost my appetite for the sight of other resident's agony and pain when they get sick. So I entreat God to take me away without pain and soon. I don't mind if I eat a dry bread with water for the whole day.

Studies mention that mentioned that many problems experienced on daily basis in long-term care had to do with the concept of autonomy, which is achieving autonomy when it refers to decisions and activities based on individual's own choices. This involves both practical issues and problems based on ideas; these problems are due to external characteristics of long-term care and its routines (Juliah, 2012).

When I_2 was asked If she makes some decisions (ever minor ones) or submit everything to the Nurse, coordinator, manager, she said that she does neither because she thinks that they (KAMSD) know what they (resident elders) need and so there is no issue as making decisions in her KAMSD life. Likewise, I_5 said that she "does not make decisions because making decisions is not up to the elderlies there in KAMSD. A woman expecting her death cannot make complaints and decisions."

Regarding mobility or physical loss of control the nature of being resident in an institution says much of it. For I_3, with whom the researcher conducted the interview just when the former was about to leave in a haste for a hospital appointment, the sense institutionalization is a difficult test for him. He asserted that it is not only due to his deteriorating health that presents this test of mobility, it is also due to the duty to respect the rules and norms of the institution to stay in the compound all the time.

For a clear understanding I have asked the resident elders if they feel general loss of control over their lives after joining KAMSD. This is how I_2, I_3 and I_5 replied directly.

I_2 I have never been happy in my life. It was my relatives previously and now it's the institution taking control. But now it is better. Anyways I have no issues.

I_3 Previously I used to work and support myself. But now I am in the hand of somebody else. So I have to shut up and utilize whatever is provided for me.

I_5 I feel it so much. I wish if I could own a house prepare 'Shero', 'Berbere' (pepper), condole the grieved like anyone. I feel sad. Here, I own nothing. Everything is by their charity.

4.1.2 Depression

Depression is an emotional disorder that can happen to anyone regardless of age, gender on socio-economic layers. The elderly are at a higher risk of depression due to the loss that will occur at the later stage of human life (Halit, 2014). The loss could be in terms of role, health, loved ones or sense of belongingness in a change of place / venue. These losses may or may not have to do long term care facilities for the elders.

Out of the five KAMSD resident elders I Interviewed, four of them except I_4 reported that they feel depression. Out of these four only I_3 reported that his depression is due to a loss of mobility resulting from the nature of institutionalization. Idleness is the other reason of I_3 for depression. All in all this is how I_3 replied.

There is depression here. One thing is that I sit idle. The other thing is that I was active in the past. But

> now I must keep myself in this compound. At least I used to travel and visit relatives to refresh my mind when I feel a prolonged depression in the past.

I_1 also adheres to the issue of idleness as a related to the institutionalization cause for depression. He expressly said that the gets depressed because most of the day time pass without any physical activity. He said that he wishes if there could be some work he could do.

I_5 on the other hand states that her depression is associated with the isolation the society shows for resident elders of KAMSD. She thinks that it's only because she is a KAMSD resident the society stigmatize when she goes to church. I hear some people say "here come the resident elders" and they try to keep away from us. This makes me sad and depressed.

All the four of the resident elders for example have said that they feel depressed, sad and useless when they remember their loss of health. Simultaneously they have admitted that the loss started before they joined KAMSD and it has shown improvement due to the treatment in KAMSD, even more. Other reasons also like loss of financial status, loss of marriage and the like happened before the elders came to KAMSD. Even though depression is prevalent among the KAMSD elders, much of the causes behind are not related to the care or the system of the institution.

The incorrect view others have towards such institutions and resident elders has another story of depression with I_5. She has lost the where about of her one and only 39 years old son. She said that they used to contact each other by phone even after she has joined KAMSD.

> But he did not know I was living here. So some people told him that I have become a beggar in Addis Ababa. They took me for a beggar. He then

> got offended because he thought what they told him was true and stopped our only means of communication, talking over the phone.

I_5 strongly feels that she lost her son just because she resides is KAMSD and her relatives wrong attitude on resident elders of elderly care institutions.

4.1.3 Situational Stress

Stressors are mostly referred to as threat to general body well-being which results to emotional disturbances. Psychological stress is defined as a situation in which man finds himself in an immediate surrounding that he could not manage and his health is placed at risk due to inability to control the situation (Kuria, 2012).

Although stress at old age is not mandatory, physical changes like change in hair color, hearing and sight problems, mental abilities loss and forgetfulness and the like may happen jointly or severally. Elders may get into stress following such changes because most of these changes have their impact in relation to function in daily activities.

Other reasons that may possibly bring stress to elders include loss of close families in relation to love and support, change of place in relation to sentiment and inability to get familiar to new place setting and new people and financial problems or concerns. All the cause mentioned above are common to elders in general. Elders not living in long term are also affected by such causes of stress.

Therefore, by looking at the findings from the interviews of the resident elders of KAMSD, we shall try to see what possible causes of stress result from the care or the system of such centers.

I_2 and I_3 have stated that they had experienced stress where they first entered KAMSD because of the difficulty in adjusting to the communal living in KAMSD.

I_2's problem was his personal fear of how she will get along with various types of behaviors that she is going to encounter in KAMSD. She was in such stress of not being able to familiarize herself with strangers. "But" she said "but Workeye look a good take care of me and I got familiar slowly."

I_3's problem was also similarly how to get along with many people and their characters.

> How will our characters get along? Some elders complained that I disturb them when I pray at night and frequently go out of our dorm for toilet as I can't keep my urine due to the disease on my gall bladder. This still worries me because some elders are dreadful to interact with me. I ask myself if this is because of my disease.

Although their some of their stress has stopped now due to the treatment and dispute settlement of the KAMSD, I_3 has a still going stress. He stated it as follows.

> What worries me most now is financial problems. Before joining KAMSD, I somehow get some money even by begging from strangers sometimes, for my needs. Now I really have most of my needs covered by KAMSD. But I need a little money to go to the hospital for my frequent appointments and for mobile card to call my relations. I worry because I must go to the hospital and get cured from my disease.

I_5 has a different cause from I_2 and I_3. Loss of her son for residing in KAMSD and insecurity if she by any chance gets out of KAMSD worry her much.

> You know it is difficult to live by the support of others as your only means. I worry because I have nowhere to go if by some though chance we have to leave KAMSD. Nobody wants me as I am a good for nothing elder.

From the interviews held regarding situational stress, three of the five elders reported that they have stress due to insecurity of the future for sole dependence on KAMSD, lack of income or financial problems and difficulties in adjusting with communal living. Other reasons for stress which were stated at the beginning of this sub topic are also present in KAMSD elders. But they are not related to the specific situation of being a KAMSD / an elderly care center / resident.

4.2 Reasons for Joining KAMSD Institutional Care and Support

Poverty is the common denominator for all of the five elders to join KAMSD. All of their other stories come before the time they were about to join KAMSD. From the key informant interview with the nurse, I have understood that there are elderlies in KAMSD who have lived their lives upstairs, specially their ages from youth until they reach 50 years old. The KAMSD nurse said that there are elders who were bank managers, who used to own an organization and also elders who used to lead a comfortable life and family.

There are also elders who were a country side farmer and butters of some rich families properties as well as a head cook of government organization staff lounge on the other end.

I_2 has been a farmer in Wello region during his youth but got sick before coming to Addis Ababa where he become less fortunate and ended up on the street at the end of the day.

I_3 was a head cook of a government organization staff lounge and the hot steam from the sauce (wot) heat her eyes and prohibited her vision eventually. She was pushed around by her close family members then joined KAMSD by fleeing them.

All of the five elders were finally stricken by poverty. Upon joining KAMSD they had to bring a conformation letter from the Kebele that they were living in that they are poor, have no source of income and social support and a cooperation request to KAMSD to accept that elder in its long term care facility. This finding on poverty is also supported by Abdi (2010) and MOLSA's Draft Standard Guideline for Geriatric Centers (2013, p 2).

Having said that on the reasons why the resident elders joined KAMSD, let us see the causes of the common psychological problems of the KAMSD resident elders resulting from the care and support provided by KAMSD.

4.3 Causes of the Common Psychological Problems of KAMSD Resident Older Persons as a Result of the Support Provided by KAMSD

4.3.1 Institutionalization

The life of institutionalization is a routine. Everything repeats itself in the very same way every next day. The resident elders in the words of I_2 "eat, drink, sit and chat and sleep finally when the day draws to end." This routine takes place in a place with a definite boundary, in a compound and an elder need to secure a permit to step out of that compound. From their past life experience the elders know that the world is wide but after being institutionalized they have to repeat the same routine every day. This reality has created the sense that they no more control their lives. The routine is set and they just pass through it to survive. Accordingly they think that their choices are already made by the institution and any choice they make or any decision they take, if any, has no significant result in their future lives. Such elements of institutionalization have mainly caused the feeling of loss of control over life on the elders. But the influence was also seen in the other psychological problems of the elders too.

4.3.2 Dependency

All the resident elders were very poor with no source of income as well as social support before they joined KAMSD. Even though they are better off now the fact that they are elders and rely on KAMSD for the provision of every day's basic needs and more, creates the feeling that they are born- losers, useless and charity recipients. This perception of dependence has contributed to the feelings of low self- esteem and situational stress on the elders.

4.3.3 Lack of Physical Activities and Loneliness

From the interviews conducted I have understood that the elders spend much of their time idle, sitting, talking and sleeping. But still there are some elders who want to work or engage in simple domestic activities in the compound, for instance I_1 and I_3. For this reason the elders have much time to spend alone. As life in institutionalized condition is routine there are hardly new things to talk, discuss on or chat about with co- residents always. Therefore, the lack of engagement in simple activities which also results in loneliness gives rise to depression and situational stress in the elderly.

Internal and external social life

The internal social life starts from the first day at KAMSD as a new resident. We have seen in the first sub section that two of the interviewees were afraid of this entry point and thus developed a situational stress for a while. The issue of familiarizing with many elders who have been there already worries new elders. But the social life also has another feature. I_3 explains.

> When some elders here try to keep away from me or show that they don't want to stay with me or shut me up when I return from the hospital, I ask myself if they are doing this to me just because I am sick.

I_2 also expresses herself that there are some individual elders she does not want to be close to because they always back bite others. Therefore she said "I know with whom I must spend time and with whom I must not to. I am highly selective in that".

The fact of being an elder residing in KAMSD labels that elder a KAMSD resident elder. According to I_5's experience at the nearby church and I_2's experience with her only son and other relatives being a KAMSD or other elderly care centers resident could bring an unfavorable meaning to the residents. It could mean an unwelcome person or even a beggar. In both types of social lives there are intentions of exclusion and the resulting feelings of isolation, stress, low self-esteem and depression.

Even though these are the causes for the major psychological problems stated in sub section one of this chapter, one psychological problem could also be a cause for another one. For example an elder resident may have a low self- esteem because he/ she is extremely dependent on KAMSD and cannot afford anything for himself by his own. Again this feeling of low self- esteem may cause him/ her depression.

4.4 Coping Mechanisms

According to Kuria (2012), when life reaches at the last stage and the age related changes seem irreversible, adaptive coping is the best coping skill. Adaptation comes with change in the way old people think, people become less interested in the material things, develop more love for people around them and show less fear for death and life. The religious ones go spiritual as a way of adapting to condition by becoming prayerful and hope for the best (Kuria, 2012).

Matching with the above finding $I_2 I_3$ and I_4 prefer to go to church and pray when they feel emotional distress or any discomfort in life. I_4 said the following.

> I read religious books, go to church and pray when I
> feel low for some reason. I pray for God to make

my death a painless one. I don't worry for my life
that much because I don't have much time to live.

Religious coping is a concept designed to assist people in the search for a variety of significant ends in stressful times: a sense of meaning and purpose, emotional comfort, personal control, intimacy with others, physical health, or spirituality (Hanevold, 2013). But I_2 in addition to going to church she likes to mingle with her close friends and socialize when she feels depressed. I_2 said that there are insulting, nagging even senile elders there. So she selects those elders with whom she can spend time and go to them when she feels depressed.

On the other hand I_5 copes with emotional stressors by avoiding them. She said that she just sleeps in such times. And that when she wakes up all the bad feelings vanish. ''Sleeping is my only cure.'' Coping with stress is mostly taken care of through avoidant attitude (Kuria, 2012).

4.5 Ageing in place

The concept following from ageing in place is that everyone has the right to age in the place and with the social contacts he/she desires. This provides the elders the freedom of choice on the setting for their later life period, it is believed that if the ageing in place principle is respected the quality of life of elders will also be enhanced. Based on what individual elders experienced in their life they may prefer to spend their later life in elderly care centres. Out of the five participants in this study only two of them joined KAMSD wilfully. Of course every resident elder must be without sufficient income source and social support to apply for admission in any elder care facility (MOLSA, 2006).But when the factors which led the elders to apply for admission are seen, only the two out of the five participant resident elders applied by thinking that long term care facilities are the right place to end their lives. They have responded that they will not withdraw out of KAMSD

even if they could be provided with better conditions along with their significant social contacts. The rest three participants joined KAMSD only because they had nowhere to turn to and they needed a refuge by then. Consequently the fact that they are ageing in KAMSD reminds them that there are significant people cut out from their life and also there are things which they did not accomplish in their past life. Thus, they feel stress, depressed and lonely.

Therefore even though all residents made their decisions to age in KAMSD when they wrote their admissions requests the motive behind their application differs. Accordingly, the two elders' belief was that they will age and die gracefully in KAMSD and that they will fit with both the social and physical environment of the institution. For this reason they relatively reported less depression, a settled and better satisfied KAMSD ageing than the other three who reported more depression, seeking social contacts with the external population e.g. the church community and stress.

4.6 The Learned Dependency Theory

This theory explains that unnecessary interactions between resident elders and care givers could result in dependency of the former over the latter. The demand could generally arise from both sides. The care givers may demand the dependency of the elders on them due to the low risk and good business good- will maintenance policy of the institution while the resident elders may demand their dependency over the caregivers for additional attention and fighting loneliness.

From the observation and the interviews conducted I have seen that such over dependency doesn't exist in KAMSD. As a policy the institution lets the elders help themselves in the basic activities of their daily lives. Such activities include washing, making their own beds, cleaning, and the like. It is only the disabled elders who are assisted in their every activity. One elder complained that he still washes his clothes despite the disease on his bladder and is thinking to inform the manager that he needs assistance. Two other elders also reported for idleness. Their idleness is caused from the fact that their daily

duties are accomplished in a very short while that they spend the rest of their day time sitting and chatting and sleeping.

The theory also says that such dependence could result in acceleration of the ageing process via disuse of muscles and motor skills. The resident elders usually as mentioned above spend much of their day time sitting and sleeping. But this is not because of their learned dependence rather due to the fact that they finish their tasks within a short time and that there are no simple domestic activities they can engage themselves in. such idleness may fasten their ageing process by the disuse of muscle and motor skills. Therefore the findings of this study don't agree with the premise of the theory but complement the result.

4.7 The Socio-Emotional Selectivity Theory

The socio-emotional selectivity theory hypothesized three testable statements. (1) The reduction of social contact does not just happen suddenly in old age, but over time. (2) Other variables such as geographical location, perception of time will influence the selection of social partners. (3) Emotions become more salient over time (Carstensen, 1995, 2006).

As individuals grow older in life they perceive the remaining time to be shorter and want to live their lives positively. Therefore, they through time select the social contacts they want to continue with intimately based on significance. Maintaining the strong link with these short listed people gives so much meaning to the elders. The identity of these people differs from spouse to grandchildren and a fellow resident elder. While passing through the process of selection and maintaining the contact, the elders will be emotionally affected.

The participant KAMSD resident elders have all mentioned that there is no much time for them to live. This feeling does not look too fresh. It is obvious that it has been with them at least for some considerable time in the past. Except one elder out of the five participants, all worry about their children and grandchildren. Out of the four one elder is visited by his son and his grandchildren for holidays and on random Sundays. This fact has

helped the elder to keep calm and extend his social contact with a short circle of resident elders who are interested in Ethiopian Orthodox religious dialogues. The elder who does not worry about his kin or other relatives said that it's the fellow residents whom he take for his brothers and sisters because it has been a very long time since he came to Addis Ababa and that his families never tried to find out his whereabouts ever since. The rest of the three elders have lost their connections to their close family members and they feel depressed, stress and lonely due to that lost contact. Regarding the other residents they take them as just friends at the eleventh hour.

Sarah (2004) says that this theory contributes to the psychological wellbeing of institutionalized elders as it predicts that the elders will select among the residents for close companions based on significance (p. 7). This is based on the assumption that the small number of the resident older people in the institutional care centres which will make the emotional selection easy for the resident older people to create a small circle of a closer relationship. Albeit the small number of KAMSD resident older persons in the institutional care setting, I_2 ,I_3 and I_5 seem to be hurt by the loss of their nuclear family contacts. As a result they couldn't accept the fact that they can make good companions from their fellow KAMSD resident older persons. They have expressly stated that they feel lonely and depressed due to the circumstances in which the KAMSD institutional support is provided to them. Therefore the assumptions in theory of the Emotional Selectivity do not work for these KAMSD resident older persons.

I_4's situation partially supports the theory as he selects among the KAMSD resident older persons who are interested in the Ethiopian Orthodox Church faith for his emotional small circle. But he is able to do this because his son visits hi occasionally. The visit by his son has helped him much. From how he has replied it can be gathered that he prioretize his nuclear family relationship and that the occasional visit from his son has relived him from worrying about his nuclear family whereabouts and well- being that he feels calm and stable

to get along with the social life in KAMSD by selecting fellow elders in the Ethiopian Orthodox Church faith line.

However, I_1 has lost hope in his nuclear and extended familial kinship contact that he has taken the KAMSD resident older persons as his only possible human relation. As a result he accepts them as his brothers and sisters and tries to get along with them in every way he can.

Therefore, according to the findings of this study the theory of Emotional Selectivity is totally incompatible to the three KAMSD resident older persons, partially working to one and perfectly matching to the remaining one participant KAMSD older person.

Chapter Five

Conclusions and Social Work Implications

When poverty is added to the frailty of old age life becomes very strained. The Draft Guidelines for Geriatric Centres (MOLSA, 2006) says that elderly care institutions should admit such poor elders with no social support and no income source. The guideline also says that such institutions should keep the quality of life of these elders to the maximum.

However, this study has explored that the institutional based care for the elderly in KAMSD poses depression, low self- esteem, loss of control and situational stress on its residents. The system the institution runs has left the elders idle thus lonely and depressed KAMSD should survey the skills its resident elders have and engage the ones with no physical impairments in activities in accordance.

Even though resident elders can go to their religious institutions and visit their relations on permit from the KAMSD management, there is no way the external community at least the one in the neighbourhood is linked to the elders. This created a discord between the two sides of the society. Therefore, KAMSD should prepare programs like volunteer service provision and fund raising events so that interested individuals and groups could visit and help the elders. In addition to minimizing the isolation and discord, it will create a stage for the elders to transfer their valuable life experiences and knowledge to the rest of the society especially the youth. This will help in building a high self-esteem and also the feeling of being part of the society at large.

"The role of the social worker in a long-term care facility is to enable each individual to function at the highest possible level of social and emotional wellness" (Perrin & Polowy, 2008, p 8). To enhance the quality of life of the resident elders, social workers should work closely with the elders, the staff, the community and the government. By looking at the lives of the KAMSD resident elders they should work on the lacking points.

Efforts of linking the external community with the residents by implementing programs to be used as bridges are expected from social workers. Helping the management in showing the psychological and other effects of the institutionalized care on the residents and suggesting solutions as well as advocating the issues of the resident elders by magnifying the problems to different levels of the government are the roles of social workers. Such efforts will help to foster a positive self-image for the residents through promoting continued social contact, decision-making opportunities, and independence (Perrin & Polowy, 2008).

Regarding implications for future research in social work, four psychological problems have been identified in this study resulting from the institutional based care in KAMSD. Each problem can be taken and studied alone intensively.

The causes of these problems were identified to be institutionalization, dependence, lack of physical activity and loneliness and internal and external social life. Therefore studies on the causes will defiantly be vital in assuring the quality of the resident elders' lives. In addition there are situations where these problems cross cut each other (for instance low self-esteem may be a cause of depression). So the relationship between these problems is also a field for future studies.

References

Abdi Ayana. (2012). *Who takes care of the Elderly in Ethiopia when Reciprocal Relationships Breakdown?* Lund University Department of Sociology, Spring Term

African Union & HelpAge International. (2002). *AU policy framework and plan of action on aging*. Retrieved from www.inpea.net/images/HAINewsletterMarch07.pdf

Alemnesh Teka. (2013). *Assessment of psychosocial support of older adults in institutional care: A study at Bet Selihome Elders Care Center* . Unpublished Master's Thesis, Addis Ababa University,

Baltes, Margret M., Thomas Kindermann, Rainer Reisenzein, and Ulrich Schmid. 1987.

Black well publishing.com/content retrieved at March 2015

BOLSA, Personal Communication (15/8/2016). Ato Berhanu Kedir, a Documentation and NGOs' Projects Follow up officer in BOLSA.

Challenges of Service Provisions. Addis Ababa, Ethiopia

Christina Victor, (2005). The Social Context of Ageing: A Text Book of Gerentology, Taylor & Francis e-Library

Dana E. Dryer. (2007). The Phenomenon of Powerlessness in the Elderly. College of Nursing and Health Sciences. Saginaw Valley State University.

Eskedar Sibuh. (2015). *Exploring Effects of Institutional Care on the Life of Elderly: The Case of Mekedonia Humanitarian Association.* Unpublished Master's thesis, Addis Ababa University.

Family Health International. 2005. Qualitative Research Methods: A Data Collector's Field Guide

Fasil Nigussie.(2010). *Exploring the Effects of Institutional Care on the Life of Older Persons.* Unpublished Master's Thesis, Addis Ababa University

Further Observational Data on the Behavioural and Social World of Institutions for the Aged. *Psychology and Aging.* 2(4): 390-403.

Getinet Ashenafi.(2015).*Aging and Retirement among Ethiopian Elderly: Adjustment, Challenges and Policy Implications.* Unpublished Master's Thesis, Addis Ababa University

Gill H., & Munna G. (2003) Meaningful Social Interactions Between Older People in Institutional Care Settings, Ageing&Society 23, 99-114.

Gorbien & Eisenstein. (2005). Elder abuse and neglect: an overview. *Clin Geriatr Med 21 279– 292*

Guro Hanevold. (2013). Coping and Depression in Old Age: A Literature Review.

HAI.,(2013). The State of Health and Ageing in Ethiopia: A Survey of Health Needs and

Isabella Aboderin. (2007). Development and Ageing Policy in Sub-Saharan Africa: Approaches for Research and Advocacy.

John W. Creswell. (2007). Qualitative Inquiry and Research Design: Choosing among the five approaches.

Laura L. Carstensen. (Oct., 1995). Evidence for a Life-Span Theory of Socio-emotional Selectivity. *Current Directions in Psychological Science*, Vol. 4, No. 5 pp. 151-156

Congressional Budget Office, (2013). Report

Marianne., S. (2005). Whose Problem Is It? Mental Health and Illness In Long Term Care Centers. Support Materials. University of Iowa, Iowa.

Mark S Lachs, Karl Pillemer (October 2, 2004). Elder abuse. *Lancet* Vol. 364. P.1263-72

Mark S. Lachs and Karl Pillemer. (1995). Abuse and neglect of elderly persons. New England Journal of Medicine: 332:437-443.

Ministry of Labor and Social Affairs. (2006). *National plan of action on older persons (2006-2015).* Addis Ababa: MOLSA.

Ministry of Labor and Social Affairs. (2012). *National Social Protection Policy of Ethiopia [Final draft].* Addis Ababa: MOLSA.

Ministry of Labour and Social Affairs (2006). Collective educational materials regarding older persons, MOLSA.

Miriam S. Rose and Rachel A. Pruchno. (*1999).* Behaviour Sequences of Long-Term Care Residents and Their Social Partners. *Journal of Gerontology: SOCIAL SCIENCES,* Vol. 54B, No. 2, S75-S83

MOLSA, (2006)Current status of old people. Retrived from http://www.un.org/esa/socdev/aging/documents/publications/current-status-older-persons.pdf

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Novella Perrin & Joanne Polowy. (2008). *The role of the social worker in the long-term care facility.* Printed by the Missouri Long-Term Care Ombudsman Program worker.

Post graduate Medical Journal (1946) 22: 185-190, Gerentology: A Modern Science with a Long History.Sona Rosa Burstein.

Ramsey-Klawsnik H. (2000).Elder-abuse offenders: a typology. *Generations*: 2:17– 22.

Segniwork Lemma. (2014). *Experiences and practices of old age home care and support to the Elderly Living in the Institutions: Assessment at Three Selected Institutions in Addis Ababa.* Unpublished Master's Thesis, Addis Ababa University

The Cambridge Handbook of Age and Ageing, Cambridge University Press, New York, 2005

The Effects of Long-Term Care on the Mental Well-Being ofthe Elderly: An Extensive Literature Review, Sarah Heft, 2004

Theory, Explanation, and a Third Generation of Theoretical Development in Social Gerontology. (1997).Vern L. Bengtson, Elisabeth O. Burgess, and Tonya M. Parrott. *Journal of Gerontology: SOCIAL SCIENCES*, Vol. 52B, No. 2, S72-S88.

Types of Long Term Care (Tennessee Health Care Association, n.d.). Retrived (05/08/2016) from www.THCA.org

UNDSEA, (2014) Workshop on the Social Integration and Rights of Older Persons in the Asia-Pacific region, Bangkok

United Nations. (2010). Current status of the social situation, well-being, participation in development and rights of older persons worldwide. Retrieved from

Watson, Sidney D. (2009) "From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid's History," *Georgia State University Law Review*: Vol. 26: Iss. 3, Article 13.

WHO (2012), *Definition of an older or elderly person, Proposed Working Definition of an Older Person in Africa for the MDS Project*, Retrived 8/12/2014. www.who.org

www.molsa.gov.et. retrieved 08/12/2014

WHO (2014), Facts about ageing, Retrieved 17/01/2015 from www.who.org

Winnie Kuria. (2012).Coping with age related changes in the elderly.

Declaration

I have approved Bruck Ayalew's thesis for review and oral defence. Please accept this is an official approval of the thesis as the adviser of the above named student.

Comm. Demelash Kassaye (Ph. D)

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Date:______________________

የፍቃደኝነት መግለጫ ፎርም (Consent Form)

ቀን..........................

እኔ...................................... በክብረ አረጋውያን ምግባረ ሰናይ ድርጅት ነዋሪ ስሆን በአዲስ አበባ ዩኒቨርሲቲ ሶሻል ወርክ ዲፓርትመንት የማስተርስ ዲግሪ ተማሪ የሆነው ብሩክ አያሌው ማሞ በድርጅት ማዕቀፍ የሚደረግ የአረጋውያን ድጋፍ በድርጅቱ ውስጥ የሚኖሩ አረጋውያን ላይ የሚያደርሰው የሥነ-ልቦና ተፅዕኖ/ውጤት፤ በKAMSD ላይ የተደረገ ጥናት (The Psychological Effects of Institutional Based Care for the Older Persons: A Study at Kibre Aregawyan Megbare Senay Derejet (KAMSD)) በሚል ርዕስ የመመረቂያ ጥናቱን እንደሚሰራ ተረድቻለሁ፡፡ እኔም በዚህ ጥናት እንድሳተፍ በተጠየኩት መሠረት ተማሪ ብሩክ አያሌው ለሚጠይቀኝ መረጃ የማውቀውን ለማካፈል እና የሰጠሁትንም መረጃ በጥናታዊ ጽሁፍ ላይ እንዲጠቀምበት ሙሉ ፈቃደኝነቴን በፊርማዬ አረጋግጣለሁ፡፡

ስም...

ፊርማ......................................

ከአረጋውያን ጋር ለሚደረገው ቃለመጠይቅ የተዘጋጁ ጥያቄዎች

Interview Guide (for elders)

1. ስም................ 2. ዕድሜ....... 3. ፆታ...... 4. በድርጅቱ የቆይታ ጊዜ..........
5. ህይወት በKAMSD እንዴት ነው? 6. አረጋዊ መሆን ማለት ለእርሶ ምን ማለት ነው?
   5.1. ወደ KAMSD እንዴት ተቀላቀሉ?
   5.2. KAMSD ከመምጣትዎ በፊት የነበረውን ህይወት በሙሉ ንገሩኝ
7. አሁን በKAMSD ያሉበት ሁኔታ / ድጋፍ ምን ያህል ያስደስቶታል?

Guiding Questions on Low Self- esteem

8. በ KAMSD ለመኖር መብቃቶት ተጠያቂው እራሴ ነኝ /የኔ ጥፋት ነው/ ብለው እራሶን ይወቅሳሉ? ወይስ ዕድለ ቢስ ስለሆንኩ ነው ብለው በራስዎ ያዝናሉ?
9. ስለሌሎቹ የ KAMSD ኗሪ አዛውንቶች ምን ያስባሉ? ግንኙነታችሁስ በፍቅር ወይስ በጥላቻ የተሞላ ነው?

Guiding Questions on Loss of Control

10. በKAMSD ህይወቶት ውስጥ የራሶት ውሳኔ የሚያስፈልጋቸው ጉዳዮች ሲያጋጥሞት በራሶት ይወስናሉ ወይስ ለነርሶች/አስተዳደር እንዲወስኑሎት ያቀርባሉ?ለምን? ምን ስሜት አሳደረቦት?
11. አሁን በKAMSD ውስጥ አብዛኛው ጉዳይ በእርዳታ የሚቀርብሎት ነው፡፡ በዚህ ሁኔታ ህይወቴ ከቁጥጥሬ ውጪ ወጥቷል /በሌላ ሰው ቁጥጥር ሥር ነው ብለው ያስባሉ? ምን ስሜት አሳደረቦት?
12. ራሶትን ችለው ለመንቀሳቀስ ወይም የፈለጉትን ለማድረግ የሚያግድ የጤና እክል አለቦት?ምን ስሜት አሳደረቦት?

Guiding Questions on Situational Stress

13. ጤንነቶት በKAMSD ከመግባቶት በፊት እና በኋላ ልዩነቱ ምን ያህል ነው? ምን ስሜት አሳደረቦት?
14. በ KAMSD ያለውን የጋራ ኑሮ ለመላመድ ያስቸግር ነበር? ምን ሚት አሳደረቦት? አብራሩልኝ፡፡
15. የገንዘብ እጥረት ያሳስቦታል? እጥረቱ ካለ ምን ስሜት አሳደረቦት?ገንዘብ ቢኖሮትስ ምን ያደርጉበት ነበር?

Guiding Questions on Depression

16. KAMSD ከገቡ በኋላ ያደርጉ ወይም ይሳተፉበት ከነበረው እንቅስቃሴዎች አሁን የታቀቡበት /ያቆሙት አለ? ካለ ለምን አቆሙ? ሌሎች አረጋውያን ለእርስዎ የመቆጣት፣ የትችት፣ የሐሜት ስሜት አሳይተዎት ያቃሉ?ምን ስሜት አሳደረቦት?
17. KAMSD ከገቡ በኋላ ደስታ የማጣት፣ የመደበር፣ ተስፋ የማጣት ስሜት ይሰማዎታል? በተለይ ከምን ጋር በተያያዘ የተፈጠረ ስሜት እንዲሆነ ሊገልፁልኝ ይችላሉ?
18. በሞት የተለዩት በጣም ያቀርቡት የነበረ /ይወዱት የነበረ/ ሰው አለ? ምን ስሜት አሳደረቦት? በመለየቱ አሁን የደረሰቦት ጉዳት ካለ KAMSD ባይገቡ የተለየ ስሜት ይሰማዎት ነበር?

Guiding Questions on Elders Abuse

19. በKAMSD ቆይታዎ በነርሶች፣ በአስተዳዳሪዎች ያለፍቃድዎ አካልዎትን ተነክተው ያውቃሉ? ምን ስሜት አሳደረቦት?
20. በKAMSD ቆይታዎ በነርሶች፣ በአስተዳዳሪዎች በግዳጅ ሥራ ሠርተው ያውቃሉ? ምን ስሜት አሳደረቦት?
21. በKAMSD ቆይታዎ በነርሶች፣ በአስተዳዳሪዎች ማስፈራራት፣ ቁጣ ደርሶቦት ያውቃል? ምን ስሜት አሳደረቦት?
22. በKAMSD ቆይታዎ እርዳታ እንደሚፈልጉ እያስታወቁ በነርሶች፣ በአስተዳዳሪዎች ችላ የተባሉበት አጋጣሚዎች አሉ? ምን ስሜት አሳደረቦት?

Guiding Questions on Coping Mechanisms

23. ድብርት፣ ተስፋ ማጣት፣ እገዛን ፈልገው ማጣት ሲሰማዎት ይህንን ለመቋቋም ምን ያደርጋሉ? ሊምሳሌ ፀሎት፣ መጠጥ መጠጣት.....
24. በአረጋውያን ሥነ ልቦታ ሁኔታ ለማሻሻል ከKAMSD በኩል ምን እንዲደረግ ይሻሉ?

Interview Guide for the interview to be held with the elders living in KAMSD

1. Name............ 2. Age...... 3. Sex......
4. Period of stay in KAMSD .... 5. How is life in KMASD?
6. What does being an elder mean to you?
   6.1. How did you join KAMSD?
   6.2. Tell me your life before joining KAMSD
7. How pleasing is the support you get in KAMSD?

Guiding Questions on Low Self- esteem

8. Who do you think is responsible for you to end up in KAMSD? Do you blame yourself for it? Do you take yourself as unlucky and feel sad?
9. What do you think about other KAMSD resident elders? And how do you describe your relationship with them, peaceful or otherwise?

Guiding Questions on Loss of Control

10. In your KAMSD life do you make any decisions by yourself or present it to the nurses/administrators? Why? How do you feel about it?
11. Currently you are living by the support from KAMSD. So do you think you have lost control over your life/ someone else is controlling your life? How do you feel about it?
12. Do you have health problem which hinders you from activities you want to make? How do you feel about it?

Guiding Questions on Situational Stress

13. How different is your health before and after joining KAMSD? How do you feel about it?
14. Was getting familiar to the KAMSD communal life difficult for you? How do you feel about it? Explain.
15. Is financial shortage a worry for you? If yes, how do you feel about it? What would you do with it if you had the money while staying in KAMSD?

Guiding Questions on Depression

16. Are there any activities that you used to take part but quitted participating, both after joining KAMSD? If yes, why? Do other resident elders criticize, scowl or back bite you? How do you feel about it?
17. Do you feel depression, unhappiness, helplessness after joining KAMSD? Can you please tell me how it happened?
18. Have you lost any of your loved ones through death? How do you feel about? Do you believe that the feeling would be any different if you had not joined KAMSD?

Guiding Questions on Elders Abuse

19. Have you ever been touched by KAMSD nurses, caretakers, or administrators on your body without your consent? How do you feel about it?
20. Have you ever been compelled by KAMSD nurses, caretakers, or administrators to do any kind of work? How do you feel about it?
21. Have you ever been threatened or scolded by KAMSD nurses, caretakers, or administrators? How do you feel about it?
22. Have you ever been ignored by KAMSD nurses, caretakers, or administrators while they know you are seeking their help? How do you feel about it?

Guiding Questions on Coping Mechanisms

23. How do you cope with/ what do you do when you feel depression, hopelessness or being ignored while you seek help? For instance praying, drinking alcohol...
24. What do you suggest to KAMSD should do to improve the psychological status of elders living in KAMSD?

በKAMSD ከሚኖሩ አረጋውያን ተንከባካቢዎች እና ነርሶች ጋር የሚደረግ ቃለመጠይቅ

1. ስም.. 2. ፆታ.................. 3. ዕድሜ.........
4. በKAMSD የቆይታ ዕድሜ........... 5. የትምህርት ደረጃ.........................
7. ሥራ በKMASD እንዴት ነው?
8. አረጋዊ መሆን ማለት ላንቺ/ተ ምን ማለት ነው?
9. በKMASD ያሉ አረጋውያን እርስ በርስ ያላቸውን ግንኙነት እንዴት ትገልጪዋለሽ?
   9.1. ትችት የሚያበዙ አሉን? 9.3 ቁጣ የሚያበዙ አሉ?
   9.2. የሚተናኮሉ/የሚደባደቡ አሉ?
10. ካሉት አረጋውያን ውስጥ በድብርት የሚጠቁ አሉ?
   10.1 ራሳቸውን የሚወቅሱ /የሚማረሩ/ የሚቆጡ አሉ?
   10.2.በፊት ያደርጉ/ይሳተፉበት ከነበረው እንቅስቃሴ የታቀቡ/ራሳቸውን ያገለሉ አሉ? ካሉ ምክንያታቸው ምን ይመስልሻል?
   10.3.ድብርታቸውን ለመቋቋም በአብዛኛው ምን ያደርጋሉ?
11. አረጋውያኑ ሳይፈቅዱልሽ አካላታቸውን ነክተሽ ታውቂያለች? ካወቅሽ ምን ምላሽ ሰጡሽ?
12. አራጋውያኑ እርዳታሽን እንደፈለጉ እያወቅሽ ችላ ያልሽበት አጋጣሚ አለ? ተደጋጋሚ ነው?
13. በKAMSD በኩል የአረጋውያኑ የሥነ-ልቦና ሁኔታ ለማሻሻል እንዲደረግ የምትሰጪው አስተያየት አለሽ?

An interview guide for the interview to be held with the Care Takers and Nurses of the elders in KAMSD

1. Name.................................. 2.Sex................. 3. Age.........

4. Period of stay in KAMSD ...... 5. Level of Education...............

7. How is work in KMASD?

8. What does being an elder mean to you?

9. How do you describe the interaction amongst the elders in KMASD?

    9.1. Criticizers/fault finders? 9.3 Scolders?

    9.2. Provokers/bullies?

10. Are there elders who are victims of depression?

    10.1 How about self- blaming elders?

    10.2. Are here elders who have quitted/excluded themselves/ from the activities they used to participate previously? If yes, what do you think are their reasons?

    10.3. How do they cope with their depression?

11. Have you ever touched their body parts without their consent? If yes, what was their response?

12. Have you ever ignored them while you know they are in need of your help? If yes, how frequent was it?

13. What do you suggest to improve the psychological status of the elders in KAMSD?