RELATIONSHIP BETWEEN SELECTED OLD AGE ATTRIBUTES AND MENTAL HEALTH OF THE ELDERLY LIVING IN RETIREMENT HOMES IN NAIROBI CITY COUNTY, KENYA

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OCTOBER 2024

DECLARATION

I declare that this dissertation is my original work and has not been previously published or submitted elsewhere for award of a degree. I also declare that this contains no material written or published by other people except where due reference is made and author duly acknowledged

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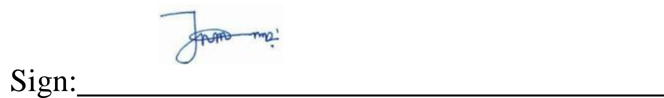

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ABSTRACT

The global population is aging rapidly, leading to an increase in the proportion of elderly individuals. This demographic shift poses significant challenges to mental health, particularly among those living in retirement homes. Mental health issues such as depression, anxiety, and cognitive decline are prevalent among the elderly and are influenced by factors such as social isolation, depression, and psychological distress. The purpose of the study was to establish the Relationship between selected old age attributes and mental health of the elderly living in retirement homes in Nairobi City County, Kenya. The study objectives were to establish the relationship between living status and the mental health of elderly citizens in retirement homes in Nairobi County, to determine the relationship between social isolation and the mental health of senior citizens in retirement homes in Nairobi County, to examine the relationship between depression and mental health of senior citizens as well as to find out the relationship between psychological distress and the mental health of senior citizens in retirement homes in Nairobi County. The study used cognitive behavioral therapy, Humanistic-existential theorists, and attribution theory. The study targeted 495 elderly people living in the homes. A sample of 149 individuals of the target population will be considered as 30% of the target population. The researcher the study used primary data collection procedures, and participants was identified by purposive sampling. The structured questionnaire was self-administered to older citizens or their caregivers in situations where the elderly are not able to respond adequately. Skilled research assistants aided in data collection. As a result, the researcher planned appointments with the participants and ensure that sufficient time is given to the elderly and caregivers to respond. The response recorded and transcribed for analysis. Conducting cross-sectional research to gather quantitative data was the first step in this initial phase. With this setup, objective and comprehensive quantitative data gathering from a large sample of Nairobi City County's elderly residents would be possible, ensuring that the qualitative focus group discussion method does not influence the participants' responses. The questionnaire consisted of standardized assessments related to specific research goals. The researcher analyzed and examine the quantitative data collected in this study using regression analysis, correlation analysis, and descriptive statistics. This phase presented an overview of the correlations between the variables and possible patterns and linkages. The findings revealed that there was no statistical significance between living status/lifestyle and mental health. More also the study established that isolation had no significance impact on mental health.. Psychological distress had significant impact on mental health of elderly living in retirement homes in Nairobi. The study therefore recommended that there is the need for the caregivers of the elderly to ensure that old age attributes do not adversely influence mental health of the elderly.Research by Patel et al. (2018) emphasizes the value of community and caregivers contribution in lowering mental health problems in African communities

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DEDICATION

To my wonderful family for being my support system.

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ACRONYMS & ABBREVIATIONS

CBT	-	Cognitive Behavioral Therapy
CPT	-	Cognitive Processing Therapy
DSM -5	-	Diagnostic and Statistical Manual of Mental Disorders
WHO	-	World Health Organization

CHAPTER ONE
INTRODUCTION

1.0 Introduction

This chapter provides an overview of the study, including the context and rationale behind it, the issues being addressed, the goals of the research, the key questions that the study is seeking to answer, the importance of the study, the underlying beliefs guiding the study, the boundaries and constraints of the research, and the definitions of important terms used in the study. The researcher used the following as old age attributes, Living Status, Loneliness, Social Isolation and Psychological Distress

1.1 Background of the study

Aging is a normal developmental process that occurs in all living beings. Between 2015 and 2050, the proportion of elderly persons is predicted to nearly double from 12% to 22% due to the aging of the global population (Bowling, 2015). Taking everything into account, an estimated 2 billion adults over 60 would replace the current 900 million. Because of this, elderly individuals may have particular physical and mental health problems, which should be taken into account (Martha & Kumar, 2015).

Aging affects every aspect of the organism and is characterized by a decrease in both functional efficiency and the ability to adapt to and recover from stress. In conclusion, because mental health is so important, adults especially those who live apart from their families may be exposed to factors that may affect their mental status. This is because growing older is a difficult stage of life, as evidenced by changing roles such as becoming a grandparent and other significant life events like losing a loved one, potentially having fewer social networks and supports, being impoverished, experiencing rejection, looking for meaning in life, being dependent, feeling hopeless and depressed, lamenting the past, and worrying about cognitive and physical decline as well as the possibility of passing away (Dahlberg, et al, 2015).

Because of the nation's rapidly increasing proportion of older citizens, shifting family dynamics, and other contemporary shifts in the psychological matrix and values, older people are frequently compelled to live alone or relocate from their own homes to institutions and old age homes (Akbar, et al. 2016). Seniors who reside in cities may occasionally send their aging relatives to institutions, which leaves them feeling alone and abandoned. Such living arrangements may have a substantial effect on the mental health of its occupants because

placement is often accompanied by emotions of lack of control over one's own life and inability to make decisions on daily affairs (Sridevi & Swathi, 2014).

Globally, the number of elderly individuals has sharply increased. Italy and Japan are the two countries with the oldest populations in the world. With 26.3% and 22.4% of their populations, respectively, 65 years of age or older, Japan and Italy have the largest percentage of elderly inhabitants globally. It is projected that 32.2% of Japanese population will be adults by 2030. Greece has one of the world's largest aging populations, with 21.4% of its residents over 65. There exist multiple other countries where a significant proportion of the population is 65 years of age or over. Among them are Germany, Portugal, Finland, Sweden, Latvia, and Malta. Their statistics show that the percentage of the relative population that is 65 years of age or older is 21.2%, 20.8%, 20.5%, 20.0%, 19.9%, 19.4%, and 19.2% (United Nations, Department of Economic and Social Affairs [UNDESA], 2015).

In regional context, it is estimated that there are currently 42 million Africans who are 60 years of age or older (World Health Organization, 2020). By 2050, that figure is likely to increase to 205-212 million. Over 15% of the population of Mauritius and Reunion was over 60 in 2015, making up the bulk of the continent's population. In the Seychelles, 11% of the population was 60 years of age or over in 2015; in South Africa, the elderly accounted for nearly 8% of the total population. According to projections made by the Uganda Bureau of Statistics [UBOS] and International Coach Federation [ICF] in the year 2012, the country's adult population is expected to increase from an estimated 1.6 million at present (or 5% of the total population) to 5.5 million by 2050. Out of the 33.5 million residents, 1.4 million (or roughly 4% of the total population) are over 60 (United Republic of Tanzania National Aging Policy,2016).

In Kenya there are over 2.7 million people who are the age of 65 out of the country's

38.6 million residents (Kenya National Bureau of Statistics, 2019). Roughly 5.2% of the

population is comprised of them. The population is made up of more men than women. Between the ages of 65 and 75, 68% of the elderly population reside in the country. This is expected to rise gradually by 2050. Kenya doesn't have a constitutional policy on the matter of elderly persons, despite having written a draft policy in 2009. The main source of support for the state is found in the sections of the constitution that safeguard everyone's rights. Article 57 mandates that the State defend the rights of elderly citizens to pursue personal development, participate in social activities, live in dignity and free from abuse, and get the proper care and

assistance from the State and their families. The elderly in Kenya no longer have access to long-term social security insurance, and private health insurance is scarce. They only receive a monthly stipend from the government of about ksh.2000 which may not be sufficient for personal and medical needs.

Older patients can receive medical care at government hospitals without any special considerations. Aging comes with a lot of challenges. One of the potential effects of the process is loss of independence, in addition to a decline in age and physical capacity. Changes associated with aging encompass biological, emotional, intellectual, social, and spiritual aspects. Despite this, a lot of people have a strong sense of independence. Others, however, require additional attention. Seniors frequently do not work due to societal attitudes, which makes earning money impossible. Older persons may therefore develop goals that parody these stereotypes (Olson, 2009). Elderly individuals do not have to age in indignity, even though they face many challenges in their later years.

As people age, their emotional demands can change, which may have an effect on theirmental health. Numerous elderly individuals sometimes have to cope with medical conditions, the loss of a spouse or loss of any agemate. It's probable that they no longer have the same support system as they did when they were younger due to retirement or children moving away. Having a supportive network or family members can be really helpful for an elderly person (Maryann, 2014). The elderly will also have areas to be concerned about, some of which are exhibiting symptoms already, and these will cause stress and fissures in their living arrangements. Actually, most nations have stable family relationships, and most old people either live with their children or receive assistance from them. Most families that engage in a range of economic activities believe that having older parents strengthens their emotional bonds and is great assistance with advice (Harandi et al., 2020).

In some societies, the elderly are tortured and put to death on the charge of witchcraft.

Numerous catastrophes, including famine, flooding, and other natural disasters, have been attributed to them (Otieno, 2019). They are usually killed, and their property destroyed. 11 elderly individuals, 8 female and 3 males, between the ages of 80 and 97, were killed in Kisii in May 2016 (Mbula, 2016). Otieno testified before the Hivisasa on February 7, 2019, alleging that 29 people—among them the area's assistant chief—were killed in Kilifi (on the seashore) as a result of witchcraft charges. Aging is accompanied by "positive and negative transitions and transformations". Even in Kenya, where the economy is tough, most people want to see

their aging parents live contentedly and with dignity. Some people employ caregivers to visit their homes, while others bring their parents to assisted living facilities. However, many elderly parents experience a variety of psychosocial challenges, are neglected (especially in rural and low-income households), and finally die tragically. The elderly are more vulnerable to abuse when a non-family member is engaged to provide care for them without ongoing supervision. This can lead to mental illness and premature death. Knowing the challenges that come with senior care facilities may help people decide if it's a good fit for their parents (Bowling, 2015).

Theorized aspects of old age are predicated on personality characteristics. An older citizen may get a severe mental health disorder as a result of personal predicaments such as being lone (Raheel et al.2014). A person's situation exposes them to a behavioral environment that mostly shapes certain aging traits. These include factors like living arrangements or lifestyle choices, which is one of the possible consequences of the world population aging faster than anticipated. This is a result of an increase in mental illness cases, which could eventually overwhelm global mental health institutions. About 15% of elderly people suffer from a mental disorder of some form. Between 2015 and 2050, the proportion of adults over 60 in the world will almost double, from 12% to 22% (WHO, 2022).

All countries will find it difficult to retain a workforce of medical professionals to treat and care for older persons with mental health disorders at a rate that keeps up with the population's age-related rise, regardless of their level of affluence. According to research, aging plays a major influence in the rise in psychopathology, which includes somatopoiesis, depression, anxiety, and obsessive-compulsive disorders (Harandi et al., 2020; Zis et al., 2017). Seniors' mental health is greatly impacted by problems related to biological, behavioral, psychological, and social elements. The mental health of the elderly is a serious problem that should worry the medical community as well as society. Many of the challenges that age presents to a person can have an effect on their mental health. Unfavorable life situations, such

as losing their financial status upon retirement, grieving the loss of a spouse or other family member, living alone, and having many medical illnesses, are more common among the elderly than in younger people. All of these unfavorable circumstances may have a negative effect on and contribute to their mental deterioration (Valtorta, Moore, Barron, Stow, & Hanratty, 2018).

As life expectancy increases globally, improvements in health care services and living standards are important (Cesario et al., 2014). But oftentimes, the mental health of the elderly is neglected. Seniors with mental diseases frequently experience grief and depression, which

diminishes their quality of life (Kim et al., 2011). In elderly individuals with pathological concerns, comparable situations may similarly increase rates of morbidity and mortality. This might lead to continued, regular use of medical services, which would greatly increase overall costs. Studies show that older men with physical disabilities have experienced a greater reduction in their quality of life (Mantzoukas et al., 2021). Furthermore, studies show that poor living conditions for older persons can contribute to mental health issues and suicide.

Social isolation is another concept that exacerbates the issue of aging mental health. This is based on the fact that, over the past ten years, the quantity and quality of social contactsin later life have emerged as one of the main challenges facing an aging society (Valtorta, Moore, Barron, Stow, & Hanratty, 2018). Landeiro, Barrows, Musson, Gray, and Leal (2017)find that one-third of older persons over 60 reports feeling lonely at some time in their later years, and that up to 50% of older adults globally are at danger of social isolation.

Numerous national initiatives have been started in Europe, North America, and Australia to lessen social isolation and loneliness among the elderly population. These campaigns include the END Loneliness campaign in the United Kingdom, the Monalisa project in France, the RISE campaign in Canada, and the Coalitie Erbij initiative in the Netherlands. Reducing loneliness through the Australian coalition and the Connect impact in the United States (Valtorta, Moore, et al., 2018). Studies have demonstrated that older adults whoparticipate in social activities had greater life expectancies, improved health, and higher well- being outcomes than older adults who do not (Vozikaki, Linardakis, Micheli, & Philalithis, 2017).

Numerous social isolation-related characteristics have been shown to be associated with poor health outcomes in older adults (Li & Zhang, 2015). In particular, there is a substantial association between mortality (Teguo et al., 2016), depression (Okura et al., 2017), cognitive decline (Okura et al., 2017), dementia (Shankar, McMunn, Banks, & Steptoe, 2011), cardiovascular illnesses (Dröes et al., 2017), social disengagement and loneliness. Together,

these socioeconomic factors may influence how elderly adults' mental health, one component of their total health, develops, progresses, or turns out. Recent studies indicate that up to one-third of people in developed countries suffer from loneliness (Cacioppo and Cacioppo, 2018), with young people and the elderly being the most likely demographics to do so (Victor and Yang, 2012). Loneliness has been negatively connected with a number of health outcomes, including mental and physical health (Wang et al., 2018), sleep (Smith et al., 2012), cognition

(Ayalon et al., 2016), and cardiovascular health (Holt-Lunstad et al., 2015). Additionally, loneliness has been connected to higher rates of illness and mortality (Rico-Uribe et al., 2018), as well as a decline in functioning and a lower quality of life (Perissinotto et al., 2012). Meta-analyses have validated these results. Furthermore, loneliness has been connected to a decrease in cognitive function and an increase in the prevalence of mental health issues including depression and anxiety (Beutel et al., 2017; Courtin and Knapp, 2017). However, it's critical to recognize the distinctions between social support, loneliness, and social isolation. While loneliness is a subjective experience, social isolation is an objective measure of social connectedness. These are two distinct ideas that are not meant to be used together.

According to Yanguas et al. (2018), social vulnerability the inability of an individual to manage and/or withstand external stressors as well as a lack of social support resources are just two of the many facets that make up the complex concept of loneliness. Contexts, it is relevant in that normal clinical care for the elderly no longer assesses and treats loneliness. This study based on previously studied attributes will therefore consider attributes such as living status, social isolation, loneliness and psychological distress.

The elderly care system has seen significant development as a result of population aging. For countries like Kenya, providing comprehensive and all-encompassing home care fortheir older citizens is more important than ever due to the constantly changing demographics and the high expense of healthcare. The main objective of building more senior care facilities is to divert patients from hospitals as much as feasible. Rossi (2009) discovered that transferring elderly patients from hospitals to home care centers significantly reduces their out-of-pocket medical costs. Either private businesses or the county government owns elder care facilities. Patients who are unable to remain at home due to their physical condition but do notrequire constant medical attention may be admitted to elderly care facilities. Nairobi County's five historic residences are the Little Sisters of the Poor Kasarani, Kariobangi Cheshire House,

Mother Teresa, Huruma, Nyumba ya wazee Ruaraka, and Mji and Huruma, Runda. These five facilities for the elderly houses more than 400 elderly persons who are receiving care (National Institute of Health and Welfare (NIHW, 2015). The accommodations consist of one or two-room apartments with either continuous or only intermittent assisted nursing care. This suggests that, for example, senior persons can receive care from nurses or other caregivers for twenty-four or twelve hours a day. The buildings are usually recommended to be spacious, with reduced mobility to allow easy movement.

1.2 Statement of the Problem

The use of senior homes as retirement communities is becoming more and more popular, especially among individuals without close family members to provide adequate care. As a result, many people have been forced to deal with mental health issues like depression and anxiety. The World Health Organization (2022) has established that elderly individuals who are not prepared for retirement suffer from trauma, which negatively affects their mental health. The elderly therefore not getting the care they would like, which increases their risk of mental health issues. Their well-being is negatively impacted by this.

Studies on the welfare of the senior citizens living in Kenya's retirement communities ha hardly been done. a study conducted in Mombasa County in order to understand the services offered in both government and faith-based eldercare facilities with reference to the requirements of the elderly in Kenya (Osongo, 2012)). A research based on assisted living amenities are accessed by elderly inhabitants at Kasarani's Kariobangi Cheshire Home for the Aged established that adequate amenities reduce mental health of the elderly (Mutea's, 2011)). A study on the risk variables associated with nutritional status among senior citizens living in certain retirement communities in Nairobi and Kiambu, Kenya established that lack of nutrition value amongst the elderly induces their mental health (Mwaniki, 2005)) . Moreover, no known studies that have been conducted regarding the effects of living conditions, social isolation, and loneliness on the wellness of senior citizens living in retirement communities in Nairobi County.

Furthermore, the relationship between aging attributes and mental health and how it impacts senior citizens well-being has not been covered in any of previous studies as indicated. This means that further research is necessary to ascertain whether certain aspects of aging andthe mental well-being of older adults living in retirement homes in Nairo The purpose of this study was to examine the relationship between selected old age attributes and the mental

health of the elderly living in retirement homes in Nairobi City County, Kenya

1.3 Objectives of the study

i. To establish the relationship between living status and the mental health of elderly citizens in retirement homes in Nairobi County.

ii. To determine the relationship between social isolation and the mental health of senior citizens in retirement homes in Nairobi County.
iii. To find out the relationship between depression and mental health of senior citizens.
iv. To find out the relationship between psychological distress and the mental health of senior citizens in retirement homes in Nairobi County.

1.4 Research questions

i. What are the forms of lifestyle of the senior citizens in retirement homes in Nairobi County?
ii. What are the levels of social isolation among elderly citizens in retirement homes in Nairobi County?
iii. Does depression have any effect on mental health among the elderly in retirement homes in Nairobi County?
iv. How does the psychological distress levels influences mental health amongst the elderly in retirement homes in Nairobi County?

1.5 Assumptions of the Study

The study assumes that old age is associated with mental health of elderly living in retirement homes in, Nairobi County. This is based on assumptions of the variables that there was positive correlation between living status and mental health of elderly people living in retirements homes. The study also assumed that social isolation will be positively correlated with mental health of elderly people living in retirements homes Nairobi County. The study further assumed that loneliness was positively correlated with mental health of elderly people living in retirement's homes, Nairobi County.

1.6 Significance of the Study

Further research on the connection between aging and the mental health of senior individuals

living in retirement homes is vital. Because of this, the study's findings have significant implications for a wide range of stakeholders, including caregivers who can use the concept to lessen the risk that poor mental health poses to the elderly. This is because of how the study was conceptualized.

They will be able to understand that the elderly need love and care while they are beingcared for. The study had a big effect on Kenya's government as well because it made them include caregivers in the planning of services for the elderly. If they don't, they risk having their caregivers imprisoned for providing subpar care, which makes the elderly more likely to

commit vices rather than improve their mental health. The study could be very valuable to future researchers since it gave them more understanding of the current study's focus on issues related to aging and mental health based on different features.

1.7 Scope and Limitations of the study

This study focused on relationship between selected old age attributes and mental health of theelderly living in retirement homes in Nairobi city county, Kenya which is very essential area towards the area under study. These examined in relation to both academic and non-academic aspects of past research outcomes. The geographical scope of the study was retirement homesin Nairobi City County. The research elicited the perceptions of caregivers in order to elucidatetheir experience towards their daily routine on mental health of those who are under their care.The study focused specifically on Nyumba Ya Wazee (Little Sisters of the Poor), Thogoto Home for The Aged, Rosewood Retirement Home.

The findings of the study were limited in terms of generalizability. Since the research was conducted in a specific home in Nairobi, the results may not be representative of other regions within Kenya or internationally. Therefore, caution should be exercised when applying the findings to different populations. The study relied on self-reported data, there is a possibility of self-report bias. Participants might provide socially desirable responses or inaccurately report their experiences, potentially affecting the reliability of the data.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter presents the theoretical framework and empirical review of the study to depict the variables relationships based on the four aspects of living status and lifestyle, social isolation, loneliness, and psychological distress on senior citizens' mental health. It also presents the knowledge gaps that this inquiry seeks to address and the conceptual framework that serves asthe study's foundation.

2.2 Empirical Literature Review

2.2.1 Relationship between Living status and the mental health

The effects of living status and lifestyle decisions on mental health have been the subject of several studies. A study by Callaghan et al. (2021) in Ireland where the target population was 25 studies noted that higher-density residential and commercial structures define metropolitan regions; these structures also result in restricted access to green areas, heightened exposure to substance use, both legal and illegal, and more stressful social environments. Investigation on how urban green spaces affect mental health concurs with similar conclusions. This suggests that living status may negatively affect the mental health of older persons due to circumstances that are typical in dense communities hence the study concur with the current study.

A study by Pun et al. (2018) in Nepal on issues related to mental health where 618 adults were interviewed revealed that the place dimension significantly affects older persons' mental health. Place-based qualities include things like housing, public open spaces, land usage, and physical shape. Eleven studies looked at a variety of land use topics, including sportsfacilities, service accessibility, and the diversity of land uses. Women who have better access to transit hubs typically have better mental health. Recreational and commercial facilities directly

impact the mental well-being of senior citizens. Research considers the access factor, which includes service access, connectivity, mobility, pedestrian settings, and public transportation (Khosravi & Tehrani, 2019). Loneliness is associated with poor mental health, and loneliness is more likely in areas where walking is difficult. This study exposits a researchgap in that the current study is based on living status and mental health of elder people

Barnett et al. (2018) studied in Ambridge on how the physical form comprises elementssuch as residential density, natural landscapes, safety, slope and topography, accessibility to green space, physical barriers, physical permeability, familiarity with the surroundings, and

proximity to roads. Older people's sense of safety is linked to both their mental and physical health. Additionally, reducing physical barriers and local violence enhances older folks' mental health. Public open spaces were the subject of thirteen papers that focused on issues such as street lighting, social disorders, crime prevention, accessibility to water spaces, recreational areas, outdoor quality, noise pollution, traffic, environmental cleanliness, coverage of green and blue spaces, restoration of serenity, nature restoration, social restoration, landscape restoration, and a sense of rejuvenation. The current study is based on on elderly not children hence exposit a research gap.

Crucially, because public open spaces significantly improve the mental health of olderadults, green and blue infrastructures in the neighborhood and around beaches and lakes are associated with lower antidepressant usage (McDougall et al., 2021). Green spaces are also associated with increased levels of physical activity, older individuals' mental health, and improved mental health perspectives and well-being. Seniors' general, mental, and physical health is influenced by the safety and quality of housing in their neighborhoods. The exterior design of a building, as well as its interior design, facilities, and interior living spaces, all have a big impact on elderly citizens' mental health. This therefore exposit a research gap as it does not reveal where the study was carried out.

Dye (2008) investigated the risk of urban living for adults and discovered evidence thatliving in metropolitan areas in Singapore where the study targeted 270 adults revealed that increases the likelihood of mental health problems in adults despite contradictory results. The most prevalent mental health conditions linked to urbanization are symptoms of anxiety and sadness, notwithstanding the attention-grabbing link between urbanization and schizophrenia. The study's findings demonstrate the need for senior adults to live in a highly supportive environment free from health concerns, especially those pertaining to mental health, which are exacerbated by living in an urban setting and have a detrimental effect on seniors' quality of

life. This study therefore concur with the current study.

A study by Pluess (2015) in London whereby the target population was 1958 children and the findings revealed that distinct components of living status have not been included in the greater environmental context that forms a living environment on individual differences in environmental sensitivity. Focusing on one or two particular environmental factors or viewing urbanization as a single, all-encompassing risk factor is insufficient to develop targeted preventative and therapeutic programs that span from individual psychological counselling to

urban planning. Similar to other residential settings, the urban environment consists of interrelated components that might work together to produce characteristics that either increase or lower the likelihood of mental illnesses. This study highlights the significance of living a healthy lifestyle devoid of isolated factors that may be detrimental to mental health.

As per Uher and Zwicker's (2017) research work in Canada based on "Etiology in Psychiatry: Embracing the Reality of Poly-Gene-Environmental Causation of Mental Illness," there is presently no information available about the relationships between exposure toenvironmental profiles and brain structure in relation to mental illnesses in urban or other environments. Furthermore, individuals differ when faced with environmental hardship; genetic variation is a major contributing factor to these individual differences. Genetic variations impact biological mechanisms that modulate the effects of stressful environmental stimuli on the brain and psychiatric illnesses, such as the stress response. The findings of this study clearly indicate that a healthy lifestyle, which includes an effective manner of living and a clean environment, is essential for brain development.

A study by Calderón et al. (2014) regarding the harm that air pollution does to a child's growing brain. One of the detrimental effects of metropolitan environments on the nervous system that is receiving more and more attention is exposure to ambient pollution. This emphasizes the necessity of using a multidisciplinary strategy to handle the issue's complexity. This is based on the complex mixture of air contaminants found in the urban atmosphere, especially in many megacities, such as lead, ozone, polycyclic aromatic hydrocarbons (PAHs), fine particulate matter, and others. This showed that seniors require very supportive environments to help them avoid stress in their later years. Though this study exposit a research gap base don location, it on the other hand reveals the issue at hand based on mental health

Wilker et al. (2015) found that measurements of brain anatomy that contribute to exposure to air pollutants, long-term exposure to fine particulate matter, and brain atrophy are all

associated with an increased risk of stroke, covert infarctions, and brain atrophy. The number of PAHs exposed to fetuses is also associated in a dose-response manner with alterations in brain white matter volume, cognitive decline, and signs of attention-deficit disorder. This study demonstrated the significance of leading a healthy lifestyle free from exposure to possible health hazards. This means that further study is required to evaluate more on how living status influences the mental health of senior citizens in Nairobi County

2.2.2 Relationship between social isolation and the mental health

A study by Emerson (2018) in waves 8 and 9 of Understanding Society, the UK's main annual household panel study based on social isolation is a universal human experience that periodically affects entire societies and serves as a persistent reminder of our need for connection Everyone has encountered existential, interpersonal, and intrapersonal solitude in various forms and at various phases of their development. Research has shown that prolonged periods of social distancing are linked to an increased risk of heart disease, mental health problems, and mortality. For this reason, healthcare professionals must understand the various manifestations of isolation as well as how to offer purpose in life as a protective factor. In order to enhance people's long-term health, mental health practitioners need to learn more and be more receptive to developing innovative solutions to people's persistent isolation.

People who live alone, experience abuse, lack a strong support system and are members of marginalized groups are more likely to experience depression and anxiety, according to Danita's (2019) research on self-concealment, perceived discrimination, and African American Treatment Choices for Major Depression. Being by themselves can be both painful and relieving for these folks. Isolation is a result of anxiety and depression because some people utilize it as a self-inflicted coping mechanism to deal with excessive concern and avoid social involvement. This study emphasizes the need to avoid social isolation in order to prevent mental health issues, as well as the link between it and mental health at any age.

González (2020) study in Mexican population whereby 18 years and above population was used as target population to show on how the 2020 coronavirus pandemic affected mental health in its early stages and discovered that loneliness is a significant contributor to anxiety and depression, which in turn causes a desire for the stimulation and support that come from socialization. Mental Health America and other organizations, whose websites have numerous pages devoted to comprehensive information and resources, are prime examples of the need to

treat mental health issues. This shows that social isolation may result from a phenomenon that affects older people's mental health.

In their study, Ge et al. (2017) looked at the relationship between a number of social isolation and loneliness variables and the symptomatology of depression. Data were collectedthrough a health survey that was open to all residents of Singapore's central region who were 21 years of age or older. There were three ways to measure the degree of social isolation: living arrangement, degree of family or friend connection, and marital status. The degree of connectivity with close people was assessed using the six-item Lubben Social Network Scale-

6, which measures the frequency of social contact with the perceived social support from family and friends. This revealed that social isolation can have a number of detrimental implications on mental health, especially for older persons.

According to Ge et al. (2017) study in Rural China whereby 557 participants indicated that grandparent-child cohesion and friendship quality predicted children's emotional adaptation, 26.3% of the sample said they felt alone, and this sample percentage was associated with factors like aging, divorce, unemployment, and a lack of formal education. Furthermore, the study's findings show that friendships have a greater influence on depression symptoms than doe's family interaction and that depression symptoms are more prevalent in individuals who experience social isolation. This implies that depression is a mental health disorder to which social isolation is a major contributing component.

Coyle and Dugan (2012) assembled a sample cohort of American people over 50 using information from the Health and Retirement Study (HRS). The HRS is a study that collects data every two years from a representative group of adults over 50 using questionnaires. This analysis's data matches the waves that happened in 2006 and 2008. Finally, the sample group consisted of 11,825 persons. The study employed a ten-concept scale to measure social isolation, which pertains to the frequency of relationships with family or friends. The main conclusions of this study demonstrated that loneliness and social isolation are two different phenomena that can exist independently of one another and have no connection to one another.

This means that further study is required to evaluate more how social isolation influences the mental health of senior citizens in Nairobi County

2.2.3 Relationship between depression and the mental health

Domènech-Abella (2019) study in Irish based on Ageing, a total of 5066 adults aged ≥ 50 years identifies a lack of positive affect as the hallmark of depression, which manifests as avoidance, withdrawal, and decreased activity. Sleep issues, a feeling of worthlessness, and a lack of

interest in or enjoyment from activities are all signs of depression. A 2021 study by Hutten et al. on the relationship between loneliness and depression found a high link, which further reinforced this.

Grover et al.'s (2019) investigation on the relationship between social connections and loneliness and depression in the elderly discovered a connection between physical symptoms and loneliness in adults and older people. Seen as unsettling or unsettling, somatic sensations are only physical. The study was carried out in India whereby a total of 140 healthcare workers

which revealed that somatic symptoms include headaches, pain, and dizziness. If somatic symptoms are persistent, clinically significant, and affect a person's thoughts, feelings, and behavior, they may develop into a mental illness.

The DSM-5 lists somatic symptom disorder (SSD) as a mental condition, per a 2013 American Psychiatric Association study. Among the somatoform disorders that SSD replaces are somatization disorder, undifferentiated somatoform disorder, and hypochondriasis. The criteria for diagnosing SSD include the presence of one or more somatic symptoms that are distressing or interfere with daily functioning, along with one or more excessive thoughts, feelings, or behaviors related to the symptoms, such as disproportionately high levels of anxiety and catastrophizing. It is also necessary to have somatic symptoms that are persistent and have lasted for at least six months.

Although there has not been any research on the relationship between SSD and loneliness, other studies have shown that somatoform disorders, such as fibromyalgia, undifferentiated somatoform disorder, and irritable bowel syndrome, are associated with higher levels of loneliness and feelings of social rejection and invalidation (Kool et al., 2010). Less is known about the precise mechanisms via which loneliness impacts health despite past research linking loneliness to both mental and physical health.

According to Segrin et al. (2010), there is widespread agreement that loneliness functions as a mediating element and causes issues with physical and mental health. Previous research has found mediating elements that explain the relationship between loneliness and physical and mental health. According to the literature, one kind of mediator is social support. Social support and loneliness are distinct despite their fundamental similarities. Social support is the extent to which an individual receives guidance, support, comfort, and information from their social networks.

This means that further study is required to examine how depression influences the mental

health of senior citizens in Nairobi County

2.2.4 Relationship between Psychological distress and the mental health

Psychological distress is commonly defined as an emotional state of suffering that encompasses feelings of melancholy and worry. In the general population, it ranges from roughly 5% to 27%, according to (Koster & Taylor, 2011) study where respondents aged 18 years and over ina South Australian. Psychological discomfort, according to Wheaton (2017), is an emotional disturbance that impairs a person's performance in social interactions and day-to-day activities.

This study looked at the prevalence and occurrence of anxiety, depression, restlessness, hopelessness, and worthlessness in the student population.

In an Australian study, Mulder and Cashin (2015) used an online survey to assess 609 participants' elements of health and well-being. 16.5% of the students as a whole said they were in really high psychological discomfort. College students who had significant discomfort over thirty days. They claimed that they had to cut back on their workload for an additional twelve days and were unable to work or study for ten days owing to academic demands. Ninety-six percent of the students exhibiting distress reported having mental health issues. The Kessler Psychological Distress Scale (K10) indicates that feeling anxious, tired, and like "everything is an effort" are the three most distressing items. A regional Australian study found that distress negatively impacted students, and the current study will concentrate on senior citizens and the elderly.

Levecque et al. (2017) conducted a study on mental health problems and the work structure of PhD students in Belgium. Their research revealed that 32% of PhD applicants were vulnerable to common mental illnesses, including sadness. One in two doctorate applicants experience psychological distress. For one in three individuals, a common mental illness is a risk factor. They used the General Health Questionnaire to measure psychological pain (GHQ-12). The results of the study indicate that there is a moderate likelihood of psychological suffering among postgraduate students. The current study used the K-10 to gather additional information about psychological discomfort. The K-10 has proven to be more reliable and more adept at identifying deeper aspects of psychological distress than the more general GHQ.

In a study by Deasy et al. (2017) on psychological distress and coping among college students in Ireland, 41.9% of undergraduate students said they were suffering from psychological distress. They used a mixed-method approach using the GHQ-4 to find the self-

reported psychological distress of a total sample (n = 1557) of undergraduate nursing and teacher education students. Individual interviews (n = 59) allowed for a thorough understanding of students' experiences with psychological distress and coping mechanisms. This study correlates with the Belgium study in terms of the high prevalence of psychological distress and the GHQ-4 method employed to quantify it. However, in contrast to the present study, which examines seniors and the elderly, this one assessed the student body.

In Kenya, Otieno et al. (2014) carried out a closely connected investigation. This research examined the prevalence of depression and its sociodemographic correlates among

university students in Kenya. They used a sample of 923 University of Nairobi students to administer the Center for Epidemiological Studies Short Depression Scale (CES-D10). Based on the provided data, 5.6% of students experienced severe depression, and up to 35.7% of students had mild depression, indicating that students may face difficulties. Although the survey included a general overview of Kenya's undergraduate mental health situation, it did not address the needs of the elderly. This made it necessary to carry out the current investigation to look for any inequalities within the population under study.This means that further study is required to evaluate more on how psychological distressinfluences the mental health of senior citizens in Nairobi County.

2.2.5 Mental Health

Research on variations in mental health symptoms, gains in quality of life, and shifts in mental health status over time are primarily necessary to comprehend the intricate web of relationships between family support and mental health. Longitudinal studies by Brown and Barlow (2015) emphasize the value of monitoring mental health trajectories across time and acknowledge the inherent connection of these trajectories with support systems, such as family dynamics.

The varied social and economic contexts found across the African continent complicate the examination of these dependent variables. Research by Patel et al. (2018) emphasizes the value of community and family support in lowering mental health problems in African communities. Examining changes in symptomatology, quality of life, and mental health status from an African cultural viewpoint brings unique perspectives. It emphasizes the vital role that familial ties have in mental health outcomes.

Mochache et al.'s (2019) research indicates that family support plays a critical role in the healing process and that mental health issues are becoming more widely recognized in Kenya. Variations in symptomatology, improvements in quality of life, and changes in the overall state of mental health over time are important markers of the effectiveness of programs

and policies aimed at mental health well-being in Kenya.

In conclusion, the dependent variables, living status/lifestyle, social isolation, loneliness, and psychological distress, serve as crucial touchstones in this exploration.

2.3 Theoretical Framework

This research is guided by cognitive behavioral therapy, Humanistic-existential theorists, andattribution theory.

2.3.1 Cognitive Behavioral Therapy

This cognitive behavioral therapy was developed by Aaron Beck (1960). It was anchored on evidence-based therapies like behavioral therapy and rational emotive behavioral therapy, which can effectively alleviate the negative impacts of isolation and loneliness. In addition to learning and using problem-solving strategies, engaging in enjoyable activities outside the home, and continuing to participate in social activities, these therapies include behavioral interventions aimed at improving mood and reducing anxiety. Unfortunately, these treatment procedures provide little guidance in resolving unpleasant emotional reactions to continued isolation because the catalyst of pain persists.

Certain minority groups are unable to effectively complete therapy because of their locus of control or other external issues that persist throughout their life (Dardeck & Stephenson, 2019). The study's authors discovered that until the external causes of anxiety and depressive symptoms are addressed, marginalized communities will continue to suffer from depression and anxiety. Ahmed and Conway's research indicates that managing external stress is a prerequisite for treating anxiety and depressive symptoms (Ahmed & Conway, 2019). These days, many therapists employ crisis-based strategies to stabilize their patients. These strategies may include brief, solution-focused sessions, suicidal evaluations, or referrals to organizations that can offer the necessary resources right away. Crisis-based solutions offer stabilization and triage as one waits for a routine visit. However, since loneliness is inescapable for some people, the sadness and anxiety continue. It seems clear that isolated living, cut off from one's community and the things that give life meaning is the root cause of a pervasive sense of unhappiness and anxiety.

Mental health services ought to address these forms of isolation from a standpoint that does not require control over external variables that may contribute to feelings of loneliness. Based on this theory arising from therapism exclusion from individual especially the elderly, the

find themselves in loneliness and isolation concept which triggers emotionalism hence mental disorder. This idea is essential to the research since it shows how aging's effects on mental health may manifest due to loneliness and isolation.

2.3.2 Humanistic-existential theorists

This theory has long seen isolation as one of the existential givens, along with freedom and meaninglessness. Existential isolation includes the pervasive, basic feeling of estrangement from one's surroundings. Yalom (1980) distinguished between existential, interpersonal, and intrapersonal isolation. Humans have an interior world that is both private and vital to their

existence. As such, loneliness will unavoidably strike to some extent. Even more concerning is the realization that our time here on Earth is limited and that we, along with everyone we care about, will someday die. Existential loneliness or death concerns go unnoticed because one is typically spending cognitive resources to fulfill a purpose, like working or having a family.

One can become conscious of existential loneliness through big life events such as loss, catastrophe, and other situations that highlight isolation. The realization of approaching death and the resulting separation brings to light the fallibility of humanity. Death can happen at any time, loss is inevitable, and there is no perfect relationship. Being alone gives one the opportunity to reflect on their life, evaluate their relationships, and make decisions about their next steps. However, the intense desire to flee the discomfort of existential loneliness competes with the possibility of meaningful growth and creation.

Defense mechanisms serve to keep emotion and cognition apart in order to avoid the suffering and hopelessness that come with existential isolation. In this way, aspects of the self-separate from one another. "One stifles one's sentiments or... distrusts one's judgment, or buries one's potential," according to Yalom, is when intrapersonal isolation happens. This is typically the point at which someone asks for mental health care. Psychodynamic, Gestalt, humanistic-existential, and interpersonal depth psychologies are among the theories that emphasize the restoration of psychological wholeness the most. Developing relationships with other people is one path to wholeness.

Furthermore, if isolation is inevitable because loneliness is a fundamental aspect of being human, then universal solitude also provides a way to connect. Everybody looks for life and purpose in the world, and everyone fears dying. Interpersonal isolation, which is a social disconnection that often leads to loneliness, is known as love. As Buber put it, "A great relationship... penetrates the walls of a high isolation, subdues its harsh law and casts a bridge

from self-being too self-being across the abyss of dread of the universe." It is important to remember that loneliness or interpersonal isolation can happen even when people are around. Matthews et al. (2016) presented research showing no relationship between social ties and loneliness. Other characteristics that are stronger predictors of loneliness include chronic pain, individualistic cultural ideals, low-quality relationships, lack of face-to-face contact (technologizing relationships), and even a genetic tendency towards loneliness.

Loneliness can induce varied degrees of distress, depending on an individual's hereditary vulnerability to this emotional condition. True interpersonal connections are not satisfied by meaningless and inauthentic interactions, which can result from excessive levels of distress intolerance associated with isolation and an obsessive search for connection at all costs (Lara et al., 2019). Avoiding uncomfortable conversations to please friends, staying in abusive relationships, engaging in too many activities to support fragile relationships, and relying only on technology to connect with people are all attempts to avoid loneliness or out of practical necessity. Still, they fall short of achieving true interpersonal connections. In certain cases, the other in an I-Thou (I-You) mutually meaningful relationship is replaced by the object in an I-It functional relationship—a person or people being used to avert loneliness.

In other words, loneliness may cause people to look for comfort in tenuous relationships. Even though loneliness can be harmful to one's physical and mental health if it lasts for a long period, there are benefits to loneliness. Humanistic-existential theorists may bethe source of the suggestion to "sit in the discomfort and breathe through to possibilities" (Readet al., 2020). They are permitting oneself to be alone and experience the discomfort that accompanies it, leading to a deeper understanding of loneliness and togetherness.

The human experience of loneliness probably motivates people to take care of their social needs, self-preservation, and personal interests. When there is no interpersonal connection, there is a chance to reflect on and create meaning for oneself. These perspectives hold that loneliness is a natural part of being human and can help people live more mindfully and truthfully. How can I improve my relationships to feel more connected to others? What might my seclusion be pointing to as a cause of anxiety? (Self-preservation)" Alternatively, "How do I feel about myself right now?" are possible questions to ask (Social needs). (Personal inclinations). I am asking thoughtful and introspective questions to aid in the development of a meaningful schema that aids in the person's understanding of difficult life events, such as

prolonged periods of isolation. This concept will, therefore, be crucial to the research in order to understand how old age, loneliness, and inactivity might lead to poor mental health.

2.5 Conceptual Framework

The goal of this study is to assess the connection between senior citizens' mental health and attributes of old age in Nairobi. The dependent variable is Mental Health, while the independent variables are the significant qualities relevant to living status and lifestyle, social isolation, depression, and psychological distress, as presented in Figure 1.

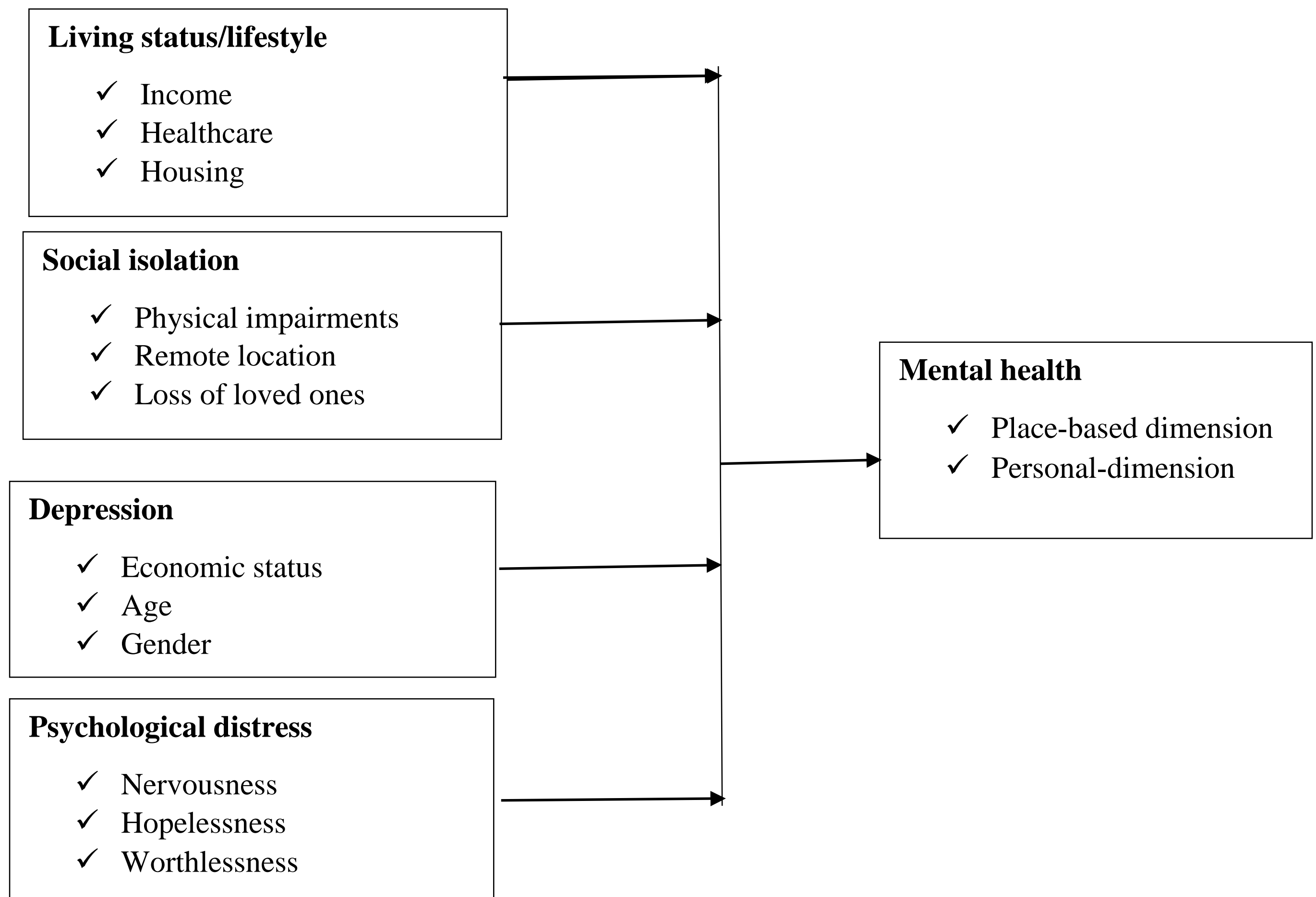

FIGURE 1:
Conceptual Framework

Study objective one is based on how living status/lifestyle influences mental health, with determinants based on the caregivers' income levels, health, and housing.

The second specific objective was based on how social isolation influenced the mental health of the senior citizens in Nairobi County. Its determinants were aligned to physical impairments, remote location, and the loss of a loved one.

The third objective was based on how depression is attributed to the mental health of senior citizens in Nairobi County. The determinants used were economic status, age, and the gender context.

The fourth objective of the study will be based on how psychological distress has influenced

the mental health of senior citizens in Nairobi County, whereby the determinants used will be a state of nervousness, hopelessness, and worthlessness.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents the research methodological approach that was used for the study. It covered the following subjects: research design, study location, target population, validity and reliability of the research instruments, sampling strategies and sample size, data collection methods, data processing methodologies, and ethical considerations.

3.2 Research Design

A research design that meets the study's challenges is valid, unbiased, accurate, efficient, and economical. According to Trochim (2020), a research design is a framework and investigative approach for handling research problems. The study used a descriptive research design. This is based on finding who, what, where, and how of a phenomenon is the aim of a descriptive study (Mugenda & Mugenda, 2020). By acquiring information about the population under study, the descriptive research design aims to present a truthful and accurate picture of the state of affairs currently (Kothari, 2010). With a primary focus on a case study of homes for older people in Nairobi County, this study used a descriptive research approach to investigate the effect of old age attributes on the mental health of senior citizens in Nairobi County The study location was retirement's homes for the elderly in Nairobi City County. Most elderlyhome is located in and around Nairobi City County. This makes the study viable in the County

3.4. Study Population

According to Etikan et al. (2016), target populations are any individuals or objects that belong to the study's target population and share similar observable characteristics. In Nairobi City County, in accordance to survey report from Nairobi City County Government ministry of social services, 2023, there are a total of 6 retirement's homes for the elderly. The target

population for this study consisted of all older persons who live in the selected retirement homes. The study mostly relied on this cohort's replies about how they believe aging-related traits contribute to mental health.

The following table illustrates the number of senior citizens residing in the aforementioned home for the aged based on a survey report from the Nairobi County Government Ministry of Social Services as of 2023, with a total of 495 senior citizens.

Name of the institution	Population	Percentage
Nyumba ya wazee	66	13
Rosewood retirement home	60	12
Littles sister of the poor	70	14
Kariobangi Chesire home	60	12
Mother Teresa	105	21
Mji wa Huruma	134	28
Total	**495**	**100**

Source: Nairobi City County Government Ministry of Social Services (2023)

TABLE 1:

Target Population

3.5 Sampling Procedure and Sampling Size

The sampling procedure involves determining and selecting the sample size for the study.

3.5.1 Sample Size

A sample is a subset of the target population. This implies that it offers features similar to the target population but at a manageable scale (Erlingsson & Brysiewicz, 2017). According to Mugenda and Mugenda, (2019) a sample size of between 10% and 30% is appropriate for a descriptive study. Thirty five percent (30%) of the elderly (0.30 of the population became the sample in each category) which was drawn randomly as representative of the rest. Therefore, stratified random sampling method was used to obtain the sample of 149 respondents.

Name of the institution	Population (N)	Sample size (30% of N)
Nyumba ya wazee	66	20
Rosewood retirement home	60	18
Littles sister of the poor	70	21
Kariobangi Chesire home	60	18
Mother Teresa	105	32
Mji wa Huruma	134	40
Total	**495**	**149**

TABLE 2:
Sample Size

3.5.2 Sampling Techniques

Due to the purposive sample size being from different distinct homes, this study employed thestratified random sampling procedure. Stratified sampling allows each stratum population to have an equal chance of responding through Lottery or Random number method. The primary goal of the instrument is to gather data on mental health, which made it simpler because the questions were standardized to align with the study's main objective (Maglne, 2015).

This plan involved selecting each category. This study considered gathering quantitative and qualitative data. Structured questionnaires and focus group discussion were used to collect the data. To guarantee that they comprehend the study and are comfortable participating in the research, participants were made aware of their rights and the purpose of the investigation. The study was conducted ethically in accordance with ethical standards to protect the participants' privacy and guarantee that their participation won't harm them. Overall,the use of simple random sampling ensured that every individual had a chance to be selected.

3.6 Data Collection Procedures

The study used primary data collection procedures and participants were identified by

purposive sampling. The structured questionnaire was self-administered to older citizens or their caregivers in situations where the elderly are not able to respond adequately. Skilled research assistants aided in data collection. As a result, the researcher planned appointments with the participants and ensured that sufficient time is given to the elderly and caregivers to respond. The response recorded and transcribed for analysis. The process of collecting data followed ethical guidelines, which include protecting participants' anonymity and privacy.

3.6.1 Data Collection Techniques

Conducting cross-sectional research to gather quantitative data was the first step in this initialphase. With this setup, objective and comprehensive quantitative data gathering from a large sample of Nairobi City County's older residents would be possible, ensuring that the qualitativefocus group discussion method does not influence the participants' responses. The questionnaire consisted of standardized assessments related to specific research goals. The researcher analyzed and examine the quantitative data collected in this study using regression analysis, correlation analysis, and descriptive statistics. This phase presented an overview of the correlations between the variables and possible patterns and linkages.

Based on the quantitative data, a purposive sample of participants were selected from the participants. This subgroup included those who self-reported as having great mental healthas well as those who performed well or poorly on tests measuring age-related traits. To learn more about the participant's experiences, the researcher conducted focus group discussion after the quantitative survey. This approach ensured that participants' qualitative responses are unrestricted because they have already finished the formal questionnaire. The researcher conducted interviews to learn more about these individuals' viewpoints, experiences, and contextual details related to the study variables' context. The qualitative information came from a thematic analysis of the focus group discussion. Analyzing the participant narratives revealed recurring themes, patterns, and subtleties. The objective is to understand better the experiences and underlying factors affecting the connections discovered during the quantitative phase.

3.6.2 Data Collection Tools

With a focus on raising awareness of mental health issues among older persons, the current study used two data collection tools: structured questionnaire and focus group discussion. The questionnaire had two main sections, section A entailed demographic data and section B contained questions pertaining the old age attributes, that is, living status and lifestyle, social

isolation and loneliness. In addition, the researcher used focus group discussion as research tools to collect qualitative data.

The structured questionnaire that covered a wide range of subjects, such as living arrangements and way of life, loneliness and social isolation, and the effect of psychological pain on mental health. The carefully chosen items presented in Likert scale form captured the nuances of aging traits and their impact on mental health. The predetermined answer categories on these

questions made it easy for participants to select their responses. Research assistants with the necessary training distributed the questionnaire to the selected persons.

This approach aims to maximize the questionnaire response rate and ensure accurate data collection that can be quickly processed, measured, and analyzed. A particular emphasis was on developing products that explore the various aspects of traits related to aging. The questionnaire enquired about specific aspects of aging that older person's encounter. This approach shed light on the nuances of this relationship and aid in understanding senior citizens' mental health. Through focus group discussion, participants provided in-depth qualitative insights to augment and improve the data collected via the questionnaire. These thoughtfully crafted guidelines aim to facilitate in-depth discussions on the pertinent elements inside the study's framework.

The research team created and pre-test the questionnaire and focus group discussion toensure their validity and reliability in assessing the variables of interest. This had a major positive impact on the instruments' ability to capture the intricate linkages between the outcomes of study participants. The combined use of structured questionnaires and focus group guides enabled a thorough understanding of the relationships under investigation. By highlighting these characteristics in both the questionnaire and the focus group guides, the research got a more nuanced understanding of the critical influence that old age attributes have on older citizens' mental health and well-being.

3.6.3 Ethical Considerations

The study followed ethical guidelines, with approval from the National Commission for Science, Technology, and Innovation (NACOSTI). All participants were required to sign informed consent forms prior to the commencement of the study. The researcher promises to protect the confidentiality and privacy of the information gathered. The study also strived to minimize interference with the respondent's harmonious coexistence with the surroundings.

Protecting participant confidentiality and anonymity is crucial to reducing the possibility that biases or interpersonal relationships would affect data processing. Before starting the survey or the qualitative interviews, each participant gave informed consent. The study strictly protected the participants' confidentiality and anonymity. The researcher promises to store all collected data securely and to use it exclusively for the study.

3.7 Validity and Reliability of the Instrument

3.7.1 Pilot Study

The piloting phase of the research study will involve a representative sample of elderly people from Thogoto home for the aged in Kiambu County. The study used 50% of the elderly in Thogoto whom are 17 in number from overall 33 total. This sample identified any ambiguities, duplications, or inaccuracies in the questionnaire and interview guide and make necessary modifications before the data collection procedure. Participants from the piloting phase was not included in the study itself.

3.7.2 Validity of the Research Instruments

How well research instruments measure the phenomenon they examine is a key component of validity. The study used expert opinions to assess the validity of the research instruments. In particular, the researcher will speak with caregivers from the home for the elderly to determine whether the study questions could appropriately assess the variables of interest. These individuals provided professional opinions on how well the research tools evaluate the factors under investigation. In addition, the supervisors from the university reviewed the instruments to assess the content's appropriateness and pinpoint any sections that need to be changed to conform to the study's goals. The proficiency of the university supervisors ensured that the research tools are pertinent and appropriate for the study's objectives.

3.7.3 Reliability of the Research Instruments

Reliability is known as the consistency and stability of research tools in measuring the relevant variables. Using the test-retest reliability method, the study was determined whether the research instruments are reliable. This approach entails giving the same test to the same subjects twice in similar environments and comparing the level of correlation between the two sets of results.

This approach was helpful in determining dependability because it looks at how consistently the research tools produce data throughout time, assuming that the phenomenon under observation doesn't change. The research team intends to use the Statistical Package forSocial Sciences (SPSS) to analyze and determine the method's reliability coefficient. To calculate the test-retest reliability coefficient, the researchers utilized Cronbach's Alpha.

According to the Pearson correlation coefficient function, high correlation values (near 1.0) indicate excellent dependability, whereas low correlation values (near 0) indicate poor reliability. The research team examined the reliability analysis results to ensure that the study

equipment will be dependable in measuring the variables of interest. The study findings of the pilot study were presented as shown below

Variable	No. of items	Cronbach Alpha	Comment
Mental health	9	.910	Reliable
Living status and lifestyle	7	.850	Reliable
Social isolation	7	.833	Reliable
Depression	6	.792	Reliable
Psychological distress	7	.837	Reliable

TABLE 3:

Reliability Test Results

The study findings of reliability revealed that al the variables under the study had a Cronbach Alpha of above the threshold of .7 hence the instrument was reliable

3.8 Data Analysis

The researcher employed quantitative and qualitative methodologies to examine the collected data. The researcher used the statistical package for social sciences (SPSS) software to analyze the quantitative data because of its ability to assess large datasets. Before preparing the completed questionnaires for analysis, the first stage was to check their accuracy and completeness. The data was then coded and put to SPSS for analysis. Measures of central tendency, such as percentages and frequencies, was produced. Qualitative information collected from the focus group discussions were analyzed thematically and presented in a narrative form.

Using inferential statistics, the researcher was calculating the significance of the link between the independent and dependent variables. The researcher used Pearson correlation analysis to test the relationship between the research variables as guided by the above hypotheses. A correlation value of +1 denotes a perfect positive connection between the variables, a correlation coefficient of -1 denotes a perfect negative correlation, and a zero- correlation

coefficient indicates no correlation. The study employed multiple regression

analysis to investigate the significance of the correlation between the independent and dependent variables. The expression for the equation is as follows:

$Y = \beta + \beta 1\ X1 + \beta 2\ X2 + \beta 3\ X3 + \beta 4\ X4 + e$

Where:

Y = Mental Health

β = Constant

$X1$ = living status and lifestyle

$X2$ = social isolation

$X3$ = Depression

$X4$ = psychological distress

$\beta 1$, $\beta 2$, $\beta 3$ = the slope of the independent variable

e = error term

The qualitative information gathered from key informant interviews and open-ended questions will be analyzed based on the study goals. The researcher was carefully reviewing the interview transcripts for emerging themes or patterns that connect to the study objectives. Narratives and verbatim quotes were included in the later presentation of qualitative data.

To provide a thorough understanding of the research problem, the procedures of analysis and interpretation combined both quantitative and qualitative data. The outcomes of the two phases together enhanced a whole outcome. The results of the study were included in a final research report that was presented at conferences and published in academic publications. This approach guaranteed that the combined insights result in a deeper understanding of the relationships under study.

CHAPTER FOUR

DATA ANALYSIS, FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter focuses on three key aspects: the examination of the gathered data, the explanationof the study's discoveries, and the ensuing discussion. After thoroughly analyzing all the gathered data, the study's results are presented in alignment with the survey's goals. Responses to the study variables are depicted using a 5-point rating scale, while statements related to the same topic are evaluated using a Likert scale. Additionally, this chapter includes an assessment of regression, a summary of the model used in the study, and the conclusions drawn from thatmodel.

4.2 Response Rate

The study had a sample size made up of 146 respondents obtained using a factor of 0.556 (55.6%)of the target population. A sum of 146 questionnaires were administered to the elderly citizens living in the elderly homes through their caregivers and 126 were returned when fully filled. The rate of return showed indicated 86.3% response rate. The response obtained was enough to arrive at the conclusion and summary of the findings since the rate was above 70%, hence was recommended as highlighted by Orodho (2012).

TABLE 4: Rate of the responses

Indicators	Frequency	Percentage Representation
Respondents	126	86.3%
Non-Respondents	20	13.7%
TOTAL	146	100

Source: Research Data (2024)

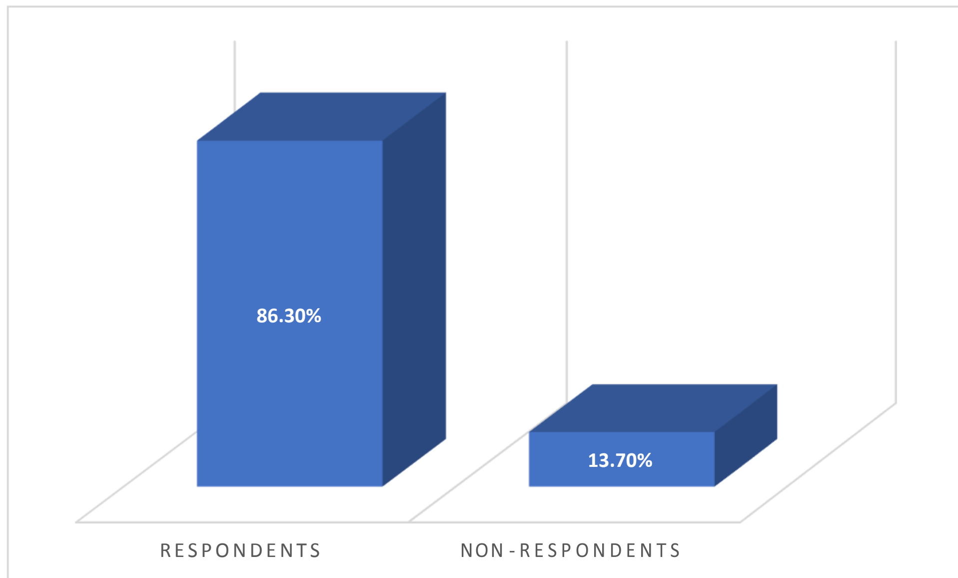

FIGURE 2:
Response Rate

4.3 Demographic characteristics of the Respondents

4.3.1 Gender of the Respondents

The respondents were requested to indicate their gender in the research instruments as the researcher was interested in knowing the actual respondents' gender. It was determined by the survey that male was the dominant gender, indicated by 51.6% of all the respondents with the female being represented by 48.4%. This is an indication that the researcher considered all the genders and therefore there was no gender bias.

TABLE 5:Gender of the respondents

Gender Type	Number	Percentage
Male	65	51.6%
Female	61	48.4%
Total	**126**	**100%**

Source: Research Data (2024)

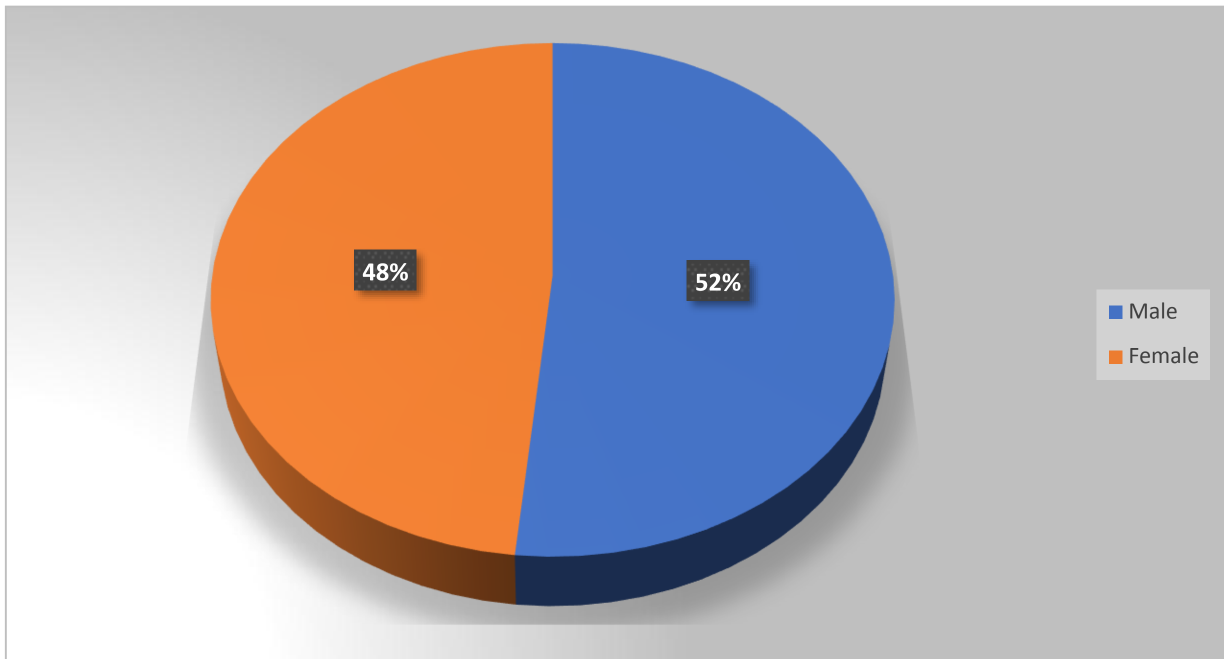

FIGURE 3:
Gender of Respondents

4.3.2 Age of Respondents

The table below shows the findings based on the age group of the respondents as requested bythe researcher in the questionnaires. Based on the outcome from the study with regard to age of the respondents, it was determined that those who are above 75 years of age are 13, which is 10.4% of all the total respondents. Besides, those respondents having an age range between65-70 were represented by 32.8% of the total respondents, indicated by 41 out of the total 126. The respondents having the ages between 60-65 years recorded the highest representation as they were only indicated by 45 rated at 45 respondents out of all the possible 126. On the other hand, those having ages ranging between 70-75 years had the highest presentation as determined by 32.8% of all the total respondents which was equivalent to 26 out of the total

126. The age range distribution for the respondents was therefore well established.

TABLE 6:Age group of the respondents

Indicators	Frequency	Percentage
Between 60-65 years	45	36%
Range of 65-70	41	32.8%
Range of 70-75	26	20.8%
More than 75	13	10.4%
Aggregate	**126**	**100%**

Source: Research Data (2024)

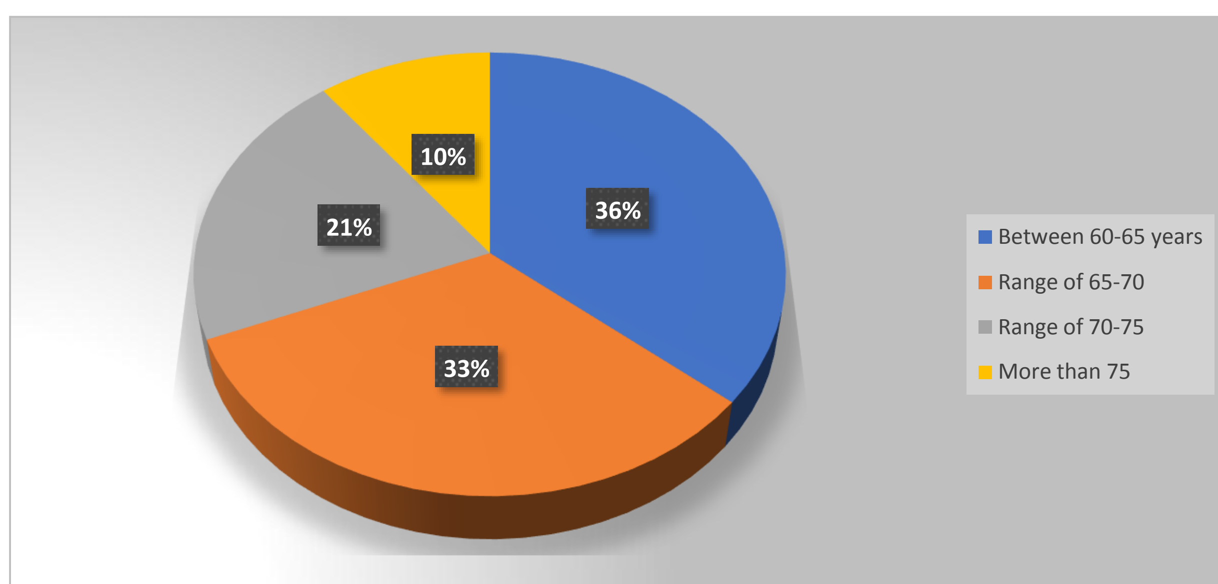

FIGURE 4: Age distribution of the respondents

4.3.3 Period they have lived in the elderly home

The researcher was keen to determine the period of the to which the respondents had lived in the elderly home. The findings from the study highlighted that majority of the elderly have lived in the elderly homes for a period between eight and ten years as indicated by 35.7% of the entire study respondents whereas 34.1% of the respondents had lived in the elderly home between 5-8years. Those who had lived in those elderly homes below 5 years was indicated by

14.3% (18), having a least representation. These who had lived in elderly homes for a period of more than 10 years were determined to be 20 senior citizens out of the 126 respondents.

TABLE 7:Period of Service in the Gender Department

Indicators	Frequency	Percentage
Below 5 years	18	14.3%
5-8 Years	43	34.1%
8-10Years	45	35.7%
More than 10 years	20	15.9%
Aggregate	**126**	**100%**

Source: Research Data (2024)

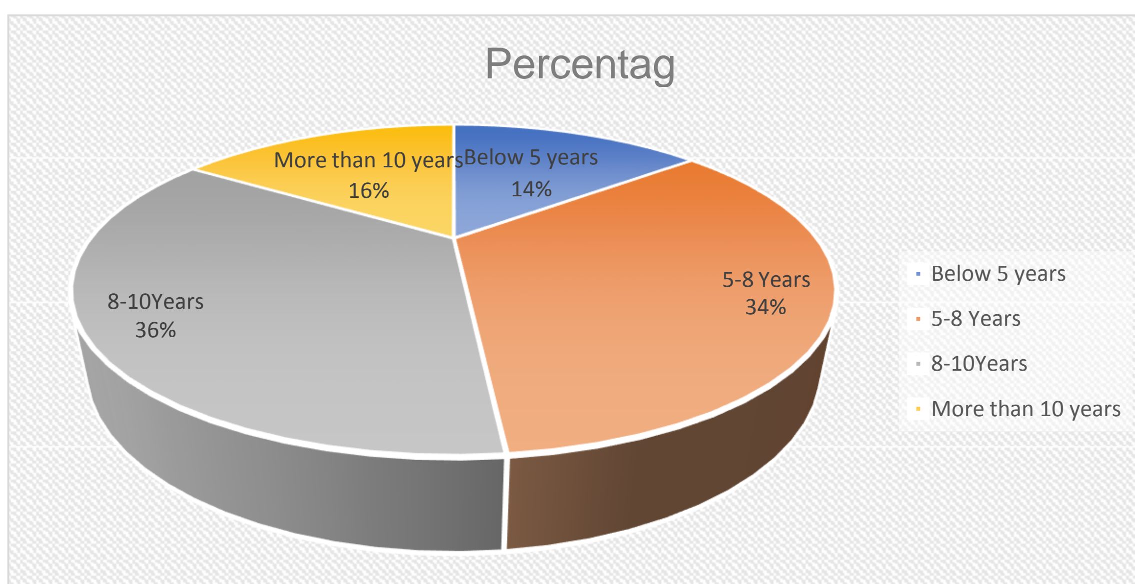

FIGURE 1 :
Period of Service in the Gender Department

4.3.4 Level of Education of Respondents

The researcher went ahead to ask the respondents to indicate their highest level of education. It was determined that majority of the respondents had attained up to University Degree level of education, determine 63.5% whereas, 17.5% of the respondents achieved up to postgraduate level of education. Those respondents who attained up to Certificate and

Diploma

educational level as their highest level of education was determined to be 10.3% of the study respondents whereas only 8.7% attained other levels of education as their highest educational level. Based on the study findings, it was evident that the respondents were well educated and could comprehend all the study questions.

TABLE 8: Level of Education of Respondents

Indicators	Frequency	Percentage
Certificate/ Diploma	13	10.3%
University Degree	80	63.5%
Postgraduate	22	17.5%
Others	11	8.7%
Aggregate	**126**	**100%**

Source:
Research Data (2024)

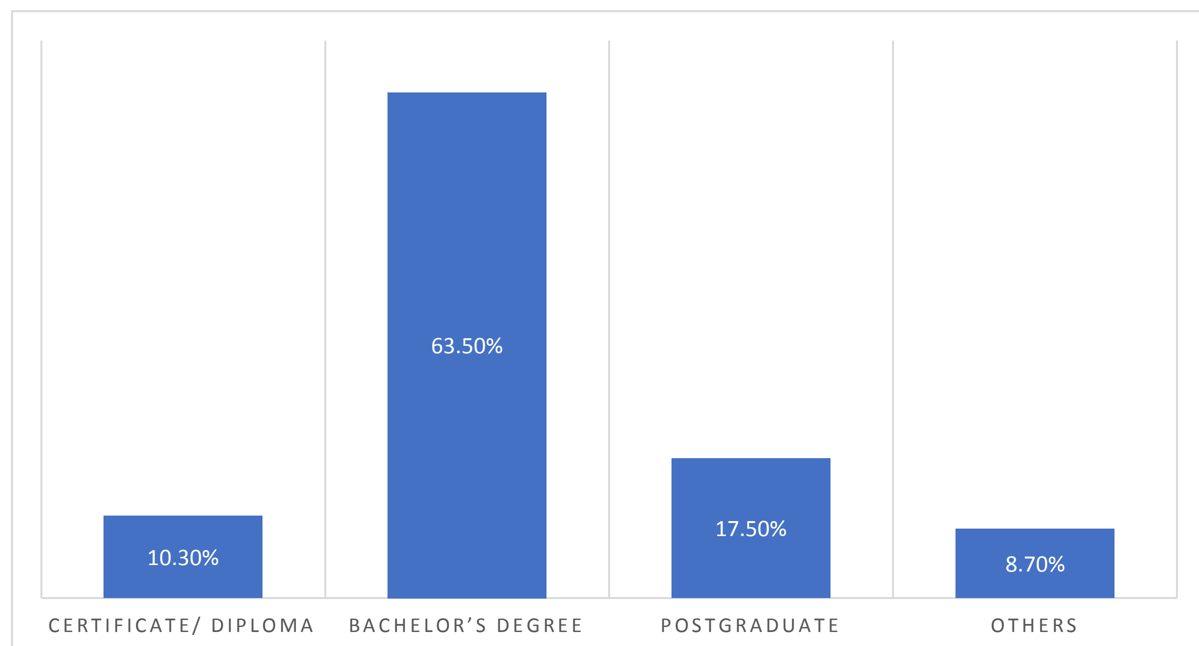

FIGURE 5:
Level of Education of Respondents

4.4 Descriptive Statistics on old age attributes on mental health

The researcher considered the use statistical measures and analyses to help in indicating the extent of data analysis through mean values, standard deviations and coefficient of variation.

4.4.1 Living status/lifestyle

The researcher went ahead to determine the influence of living status/lifestyle on mental healthof elderly living in retirement homes in Nairobi. Respondents were required to rate the extent of agreement with the following statements that seek to establish the relationship old age attributes and mental health of the elderly living in retirements homes in Nairobi.

The findings from the study determined the respondents' levels of incomes was not sufficient to keep them in their own place. This was determined by significant mean value of
4.01 and standard deviation of 1.18. It was also determined by the study that respondent could not access healthcare at ease due to poverty hence looked for external assistance (mean=3.90 std dev=1.16). The housing conditions that they used to live was not conducive (mean=3.89 std dev=1.26). Further, the study found out that the place the respondent used to live was not very accommodative to their age as determined by significant mean values of (mean=4.11 std dev=1.20). In relation to the respondents' relatives disowned them from where they used to live hence pushed them out of the place (mean=3.98 std dev=1.56). The study more also revealed that the respondents was not able to afford food and shelter due to harsh economic crisis (Mean=3.98, std. dev=1.16). furthermore, the study established that the respondent's health conditions were not favorable to be with their family outside there (Mean=3.86, std dev.=1.24).

The findings from the study were determined to be matching those for several authors. In essence, the findings were established to be similar to that of A study by Pluess (2015) it is noted that distinct components of living status have not been included in the greater environmental context that forms a living environment on individual differences in

environmental sensitivity which highlighted the significance of living a healthy lifestyle devoid of isolated factors that may be detrimental to mental health.

As per Uher and Zwicker's (2017) research work, "Etiology in Psychiatry: Embracing the Reality of Poly-Gene-Environmental Causation of Mental Illness and found out that that a healthy lifestyle, which includes an effective manner of living and a clean environment, is essential for brain development. A study by Calderón et al. (2014) regarding the harm that air pollution does to a child's growing brain which stipulated that senior require very supportive environments to help them avoid stress in their later years. Wilker et al. (2015) found that measurements of brain anatomy that contribute to exposure to air pollutants, long-term exposure to fine particulate matter, and brain atrophy are all associated with an increased risk of stroke, covert infarctions, and brain atrophy and established that the significance of leading a healthy lifestyle free from exposure to possible health hazards.

TABLE 9: Living status/lifestyle

Descriptive Statistics

	N	Mean	Std. Deviation
My level of income was not sufficient to keep me in my own place	126	4.0079	1.18319
I could not access healthcare at ease due to poverty hence looked for external assistance	126	3.8968	1.25749
The housing conditions that I used to live was not conducive	126	3.8889	1.25998
The place I used to live was not very accommodative to my age	126	4.1190	1.20404
My relatives disowned me form where I used to live hence pushed me out of the place	126	3.9762	1.15561
I was not able to afford food and shelter due to harsh economic crisis	126	3.9762	1.15561
My health conditions were not favorable to be with my family outside there	126	3.8571	1.23751
Valid N (listwise)	126		

4.4.2 Social isolation and mental Health

The study was also keen to determine the relationship between social isolation and mental health of elderly living in elderly retirement homes in Nairobi. Respondents were required to rate the extent of agreement with the following statements that seek to establish the relationship between amongst the study statements.

The findings from the study highlighted that the respondents were disowned due to physical impairment as determined mean and standard deviation values of (mean=3.82 std dev=1.18). The study further established that respondents used to live in a very remote location where there was no flow of people (mean=3.68 std dev=1.31). The study further established that respondents lost their loved ones hence living alone (mean=3.68 std dev=1.29). this was also in line that family members and friends accused respondents of witchcraft hence they hadto be segregated (mean=4.09 std dev=1.09).

There were falsely accusations of the respondent’s wealth hence was left wandering alone in the village (mean=4.03 std dev=1.09). The findings also found that lack of children made the respondents family members desert them alone in their house (mean= 3.99 std dev=1.22). Poor health made the respondents relatives to flee away from them hence left alone (mean= 4.02 std dev=1.04).

Danita's (2019) research on self-concealment, perceived discrimination, and African American Treatment Choices for Major Depression who established that were in correlation to those of People who live alone, experience abuse, lack a strong support system and are members of marginalized groups are more likely to experience depression and anxiety. In their study, Ge et al. (2017) looked at the relationship between a number of social isolation and loneliness variables and the symptomatology of depression and revealed that social isolation can have a number of detrimental implications on mental health, especially for older persons. According to Ge et al. (2017), 26.3% of the sample said they felt alone, and this sample percentage was associated with factors like aging, divorce, unemployment, and a lack of formal education and found out that those friendships have a greater influence on depression symptoms than doe’s family interaction and that depression symptoms are more prevalent in individuals who experience social isolation

TABLE 10: Social isolation and mental Health

Descriptive Statistics

	N	Mean	Std. Deviation
I was disowned due to physical impairment.	126	3.8175	1.17576
I used to live in a very remote location where there was no flow of people	126	3.6825	1.31241
I lost my loved ones hence living alone.	126	3.6825	1.29399
Family members and friends accused me of witchcraft hence I have to be segregated.	126	4.0873	1.08826
There were falsely accusations of my wealth hence was left wandering alone in the village.	126	4.0317	1.09498
Lack of children made my family members desert me alone in my house.	126	3.9921	1.22308
Poor health made my relatives to flee away from me hence left alone.	126	4.0159	1.03525
Valid N (listwise)	126		

4.4.3 Depression and mental Health

The study was also keen to determine the relationship between depression and mental health of elderly living in retirement homes in Nairobi. Respondents were required to rate the extent of agreement with the following statements that sought to establish the relationship between the study statements from the context of depression and mental health. The findings from the study determined that when the respondent's economic status became obsolete, they become weak.as determined by significant mean and standard deviation values of 3.69 and 1.23 respectively. The study also established that the respondents found themselves struggling emotionally due to their gender incapacitation (mean=3.75 std dev=1.25).

Besides, it was determined by the study that the respondents age advancement, let to their full body becoming weak hence stressed always (mean=3.82 std dev=1.34).

The study findings highlighted that the respondents were unable to keep themselves free from drugs hence left distressed (mean=3.79 std dev=1.21). Further, the study determined

that inability to provide for their relatives after retirement left them stressed (mean=4.15 std dev=1.10). Further, the survey determined that the loss of respondent's family members through different natural calamities left them to suffer alone (mean=3.89 std=1.30).

The findings from the study were found to be similar to that of Domènech-Abella (2019) who identified a lack of positive affect as the hallmark of depression, which manifests as avoidance, withdrawal, and decreased activity. Sleep issues, a feeling of worthlessness, anda lack of interest in or enjoyment from activities are all signs of depression. A 2021 study by Hutten et al. on the relationship between loneliness and depression found a high link, which further reinforced this.

Grover et al. (2019) investigated on the relationship between social connections and loneliness and depression in the elderly discovered a connection between physical symptoms and loneliness in adults and older people. Seen as unsettling or unsettling, somatic sensations are only physical isolation. According to Segrin et al. (2010), there is widespread agreement that loneliness functions as a mediating element and causes issues with physical and mental health and established that social support and loneliness are distinct despite their fundamental similarities

TABLE 11: Depression and mental Health

Descriptive Statistics

	N	Mean	Std. Deviation
When my economic status became obsolete, I become weak.	126	3.6905	1.22940
I found myself struggling emotionally due to my gender incapacitation	126	3.7540	1.25019
My age advancement, let to my full body becoming weak hence stressed always.	126	3.8175	1.34105
I was unable to keep myself free from drugs hence left distressed.	126	3.7857	1.21067
Inability to provide for my relatives after retirement left me stressed	126	4.1508	1.09594
The loss of my family members through different natural calamities left me to suffer alone.	126	3.8889	1.30367
Valid N (listwise)	126		

4.4.4 Psychological distress and the mental Health

The study was also keen to determine the relationship between psychological distress and the mental health h of elderly living in retirement homes in Nairobi. Respondents were required to rate the extent of agreement with the following statements that sought to establish the relationship between the study statements from the context of psychological distress and mental health. The findings from the study determined that the respondents had high level of nervousness as determined by significant mean and standard deviation values of 3.80 and 1.31 respectively. The study also established that the respondents found themselves hopeless to live with others (mean=4.05 std dev=1.19).

It was established that the respondents felt worthless while living with other community members (mean=4.05 std dev=1.28). The study findings highlighted that inability to provide for my family caused me to be distressed psychologically (mean=3.60 std dev=1.26). Further, the study determined that severe medical illness caused their life to be obsolete (mean=3.98 std dev=1.10). Further, the survey determined that the traumatic experiences such as loss of respondent's family members induced them to distress (mean=4.05 std=1.02). More also major life changes such as not lack of a proper living standard led to traumatization (mean=3.94 std=1.24).

The findings from the study were found to be similar to that of Mulder and Cashin (2015) used an online survey to assess 609 participants' elements of health and well-being and established they had to cut back on their workload for an additional twelve days and were unable to work or study for ten days owing to academic demands. It was further in line with the findings of Levecque et al. (2017) conducted a study on mental health problems and the work structure of PhD students in Belgium and established that there is a moderate likelihood of psychological suffering among postgraduate students. It further supports findings of Otieno et al. (2014) carried out a closely connected investigation. This research examined the prevalence of depression and its sociodemographic correlates among university students in Kenya and found out that students experienced severe depression while others had mild depression, indicating that students may face difficulties

TABLE 12:Psychological distress and mental Health

Descriptive Statistics

	N	Mean	Std. Deviation
I had high level of nervousness	126	3.8016	1.31465
I found myself hopeless to live with others.	126	4.0476	1.18563
I was worthless while living with other community members	126	4.0476	1.28285
Inability to provide for my family caused me to be distressed psychologically.	126	3.5952	1.25971
Severe medical illness caused my life to be obsolete	126	3.9841	1.07319
Traumatic experiences such as loss of my family members induced me to distress.	126	4.0476	1.10892
Major life changes such as not lack of a proper living standard led to traumatization.	126	3.9365	1.24416
Valid N (listwise)	126		

4.4.5 Descriptive Statistics on mental health

The study was keen to measure the extent of mental health amongst elderly living in retirement homes in Nairobi. The findings from the study determined that the place the respondents usedto live acted as a catalyst for their social health (mean=3.86 std dev=1.14). Study also determined that frequent life challenges induced respondents to mental health issues (mean=3.82 std =1.23). Inability to provide for themselves traumatized them (mean=3.73 stddev=1.12). Further, the survey determined that lack of support from family members made them insane (mean=3.91 std dev=1.41). False accusation of witchcraft made them feel like committing suicide (mean=3.65 std dev=1.35). Further the study established that Hopelessnessmakes them feel ill-fated (mean=3.80 std dev=1.38). When respondents are always sleeping, they always find myself very weak fated (mean=3.67 std dev=1.35). Lack of concentration makes them feel abnormal (mean=3.94 std dev=1.29). Implementation of performance management system contributes towards quality services offered by the schools to various stakeholders (mean=4.33 std dev=1.08). Obsessed through eating makes their life unbearable (mean=3.99 std dev=1.16).

The study findings affirmed those of Brown and Barlow (2015) who emphasized the value of monitoring mental health trajectories across time and acknowledge the inherent connection of these trajectories with support systems, such as family dynamics. Patel et al.

(2018) emphasized the value of community and family support in lowering mental health problems in African communities. Examining changes in symptomatology, quality of life, and mental health status from an African cultural viewpoint brings unique perspectives. It emphasizes the vital role that familial ties have in mental health outcomes. Mochache et al.'s (2019) research indicates that family support plays a critical role in the healing process and that mental health issues are becoming more widely recognized in Kenya

TABLE 13:Descriptive Statistics on Mental Health

Descriptive Statistics

	N	Mean	Std. Deviation
The place is used to live acted as a catalyst for my social health	126	3.8571	1.14343
Frequent life challenges induced me to mental health issues.	126	3.8254	1.22689
Inability to provide for myself traumatized me	126	3.7302	1.12009
Lack of support from family members made me insane.	126	3.9127	1.41433
False accusation of witchcraft made me feel like committing suicide	126	3.6508	1.35243
Hopelessness makes me feel ill-fated	126	3.8016	1.37997
When am always sleeping I always find myself very weak.	126	3.6667	1.35056
Lack of concentration makes feel abnormal	126	3.9444	1.29185
Obsessed through eating makes my life unbearable.	126	3.9921	1.15583
Valid N (listwise)	126		

4.5 Inferential Statistics

4.5.1 Regression Analysis Model Summary

The findings indicated that the R square value was determined to be 0.619 meaning that 61.9% of the variation in old age attributes on mental health of elderly living in retirement homes in Nairobi. The remaining 38.1 percent is due to other factors not tested in this model. On the other hand, the correlation was determined by an overall coefficient of correlation of (R) to be 0.1787. Besides, from the regression model, the adjusted R square value was determined to be

0.606 meaning that 39.4% of the variation in old age attributes determined the mental health of elderly living in retirements homes in Nairobi.

TABLE 14:Model Summary

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.787[a]	.619	.606	.60989

a. Predictors: (Constant), P.D, S.I, DE, L.S.L

4.5.2. Analysis of Variance

The ANOVA analysis results showed that there was a statistically and significant relationship between the independent variables (loneliness, living status/lifestyle, depression and psychological distress) and the dependent variable (mental health) at F=49.107, p=0.00. The findings indicated that the variance was significant in predicting old age attributes on mental health of elderly living in retirement homes in Nairobi at 95% confidence level hence the datais suitable for making conclusions about the population. The findings are presented in the tablebelow

TABLE 15:ANOVA

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	73.063	4	18.266	49.107	.000[b]
	Residual	45.007	121	.372		
	Total	118.071	125			

a. Dependent Variable: M.H
b. Predictors: (Constant), P.D, S.I, DE, L.S.L

4.5.3. Correlation Analysis

Correlation analysis was conducted to test the existing relationship between the independent variables (loneliness, living status/lifestyle, depression and psychological distress) and the dependent variable (mental health). The analysis showed that there existed a significant correlation between living status/lifestyle and mental health, as determined by a factor (r=.674, p=000). On the other hand, social isolation is positively and significantly correlated with mental health (r=.741, p=.000). More also depression was statistically significant with mental health (r=0.792, p=0.000). The study also affirmed that psychological distress was statistically significant with mental health (r=.8041, p=.000).

From the inferential statistics, it is evident that the study variables significantly influence mental health of elderly living in retirement homes in Nairobi.

TABLE 16: Correlation analysis

Correlations

		Living Status/Lifestyle	Social Isolation	Depression	Psychological distress	Mental health
Living Status/Lifestyle	Pearson Correlation	1	.741**	.792**	.804**	.674**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	126	126	126	126	126
Social Isolation	Pearson Correlation	.741**	1	.710**	.753**	.636**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	126	126	126	126	126
Depression	Pearson Correlation	.792**	.710**	1	.778**	.609**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	126	126	126	126	126
Psychological distress	Pearson Correlation	.804**	.753**	.778**	1	.780**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	126	126	126	126	126
Mental health	Pearson Correlation	.674**	.636**	.609**	.780**	1

	Sig. (2-tailed)	.000	.000	.000	.000	
	N	126	126	126	126	126

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

4.5.4. Coefficients of Regression

The coefficient of regression was conducted to determine the level of influence of the independent variables on the dependent variable.

The regression analysis conducted to test the existing relationship between the independent variables (loneliness, living status/lifestyle, depression and psychological distress) and the dependent variable (mental health). The analysis showed a no significant correlation between lifestyle /living status and mental health, as determined by r=.151, p=.213 . On the other hand, social isolation is positively but insignificantly correlated with mental health. This was evident by the correlation factor of r=0.111, p=0.304.it was also evident that there was no statistical relationship between depression and mental health r=.-.091, r=.422. the study established that there was a positive and statistically significant relationship between psychological depression and mental health of elderly living in retirement hoes in Nairobi (r=.746, p=.000)

From the inferential statistics, it is evident that the only psychological distress significantly influenced mental health of elderly living in retirement homes in Nairobi

TABLE 17: Coefficients

Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.215	.280		.766	.445
	Living status/ Lifestyle	.151	.121	.136	1.252	.213
	Social isolation	.111	.108	.095	1.032	.304
	Depression	-.091	.113	-.082	-.806	.422
	Psychological distress	.746	.122	.662	6.135	.000

a. Dependent Variable: M.H

$$Y = \beta 0 + -\beta_{1X1} - \beta 2X_2 + \beta 3X_3 + \varepsilon \text{ that is}$$

$$Y = .215 + 0.151X_1 + 0.111X_2 - 0.091X_{3+}.746\ X_4$$

Factored in as $Y=0.215+0.746X4$

The model shows that when other factors are held constant, an increase in the use of independent variables living status/lifestyle, social isolation, depression and psychological distress) by 1% deteriorates mental health of elderly living in retirement homes in Nairobi. The level of mental health of elderly living in retirement homes in Nairobi County would be increase by 0.151 when all the variables are held constant. A unit increase in social isolation would change mental health of elderly living in retirement homes in County of Nairobi County by 0.111. On the other hand, a unit change in depression would lead to a decrease in mental health by -.091 of mental health of elderly living in retirement homes in Nairobi Nairobi County. The study also established that a unit increase in psychological distress would lead to an increase in mental health of elderly living in retirement hoes in Nairobi by .746. Hence, the independent variables are determinant of mental health of elderly living in retirement homes in Nairobi County.

The response that was arrived at based on what influenced the elderly to come to stay in the retirement homes for the elderly revealed that based on majority was as a result of family neglect.

In terms of what they do on daily basis activities, the study response revealed that majority were idle as they had nothing to do at their age. Initially before they came into the retirement homes for the elderly, majority said that they had vibrant life before they were accused of causing problems to the family members such as causing death due to witchcraft and hence whatever they were doing in their areas they were no longer able to do them anymore. When asked if they were marketer, they would recommends friends to come to retirement homes, they said that they would not encourage so because the life in those homes were not bearable

only that they had nowhere else to go to and therefore they would not even like to inform them of the current homes they are living in. when asked if they would like the owner of the homes they were living to make it better, they said that they would recommend them to enable them secure some well engaging activities to make their lives bearable. They also said that the staffs were welcoming and were so social as they could engage them in some activities on daily basis. They pinpointed some of the staffs that were most kind to them based on their individual experience and therefore they would like to encourage them to be more kind and if given a chance, they would encourage them to be more vibrant. If they were given a chance to go back to their homes, they said they would not be happy as some would be killed hence being there was a privilege to them tis was attributed by the fact that stay in some of these homes gave them hope for tomorrow.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This section of the survey report indicates summarization of the outcome for the survey, conclusion drawn from the survey and the best course of actions made by the researcher. The survey further points out on the key suggestions. Summary, conclusion and study recommendations have all been made with regard to the variables investigated.

5.2 Summary of Findings

5.2.1 Living Status

The study involved gathering responses from respondents who were asked to rate their level of agreement with various statements related to living status/lifestyle. The findings revealed that living status/lifestyle insignificantly influenced mental health of elderly living in retirement homes in Nairobi. The findings from the study determined the respondents' levels of incomes was not sufficient to keep them in their own place. This was determined by significant mean value of 4.01 and standard deviation of 1.18. It was also determined by the study that respondent could not access healthcare at ease due to poverty hence looked for external assistance (mean=3.90 std dev=1.16). The housing conditions that they used to live was not conducive (mean=3.89 std dev=1.26). Further, the study found out that the place the respondent used to live was not very accommodative to their age as determined by significant mean values of (mean=4.11 std dev=1.20). In relation to the respondents' relatives disowned them from where they used to live hence pushed them out of the place (mean=3.98 std dev=1.56). The study more also revealed that the respondents was not able to afford food and shelter due to harsh economic crisis (Mean=3.98, std. dev=1.16). furthermore, the study established that the respondent's health conditions were not favorable to be with their family outside there (Mean=3.86, std dev.=1.24).

The findings from the study were determined to be matching those for several authors. In essence, the findings were established to be similar to that of A study by Pluess (2015) it is noted that distinct components of living status have not been included in the greater environmental context that forms a living environment on individual differences in environmental sensitivity which highlighted the significance of living a healthy lifestyle devoid of isolated factors that may be detrimental to mental health.

5.2.2 Social isolation and mental health

The study's findings shed light on the critical role that the social isolation plays in mental health of elderly living in retirement homes in Nairobi. The findings from the study highlighted that the respondents were disowned due to physical impairment as determined mean and standard deviation values of (mean=3.82 std dev=1.18). The study further established that respondents used to live in a very remote location where there was no flow of people (mean=3.68 std dev=1.31). The study further established that respondents lost their loved ones hence living alone (mean=3.68 std dev=1.29). this was also in line that family members and friends accused respondents of witchcraft hence they had to be segregated (mean=4.09 std dev=1.09). There were falsely accusations of the respondent's wealth hence was left wandering alone in the village (mean=4.03 std dev=1.09). The findings also found that lack of children made the respondents family members desert them alone in their house (mean= 3.99 std dev=1.22). Poorhealth made the respondents relatives to flee away from them hence left alone (mean= 4.02 stddev=1.04).

The findings also found that lack of children made the respondents family members desert them alone in their house. Poor health made the respondents relatives to flee away fromthem hence left alone. These findings therefore supported those of Danita's (2019) research onself-concealment, perceived discrimination, and African American Treatment Choices for Major Depression who established that were in correlation to those of People who live alone, experience abuse, lack a strong support system and are members of marginalized groups are more likely to experience depression and anxiety. In their study, Ge et al. (2017) looked at the relationship between a number of social isolation and loneliness variables and the symptomatology of depression and revealed that social isolation can have a number of detrimental implications on mental health, especially for older persons.

5.2.3 Depression and mental health

The research uncovered key insights regarding the relationship between depression and mentalhealth. The findings from the study determined that when the respondent's economic status became obsolete, they become weak.as determined by significant mean and standard deviationvalues of 3.69 and 1.23 respectively. The study also established that the respondents found themselves struggling emotionally due to their gender incapacitation (mean=3.75 std dev=1.25). Besides, it was determined by the study that the respondents age advancement, let to their full body becoming weak hence stressed always (mean=3.82 std dev=1.34). The study

findings highlighted that the respondents were unable to keep themselves free from drugs hence left distressed (mean=3.79 std dev=1.21). Further, the study determined that inability to provide for their relatives after retirement left them stressed (mean=4.15 std dev=1.10). Further, the survey determined that the loss of respondent's family members through different natural calamities left them to suffer alone (mean=3.89 std=1.30).

These findings therefore were in support of those of Domènech-Abella (2019) who identified a lack of positive affect as the hallmark of depression, which manifests as avoidance, withdrawal, and decreased activity. Sleep issues, a feeling of worthlessness, and a lack of interest in or enjoyment from activities are all signs of depression. A 2021 study by Hutten et al. on the relationship between loneliness and depression found a high link, which further reinforced this. Grover et al.'s 2019 investigation on the relationship between social connections and loneliness and depression in the elderly discovered a connection between physical symptoms and loneliness in adults and older people. Seen as unsettling or unsettling, somatic sensations are only physical isolation. According to Segrin et al. (2010), there is widespread agreement that loneliness functions as a mediating element and causes issues with physical and mental health and established that social support and loneliness are distinct despite their fundamental similarities.

5.2.3 Psychological distress and mental health

The research uncovered key insights regarding the relationship between psychological distress and mental health. The findings from the study determined that the respondents had high level of nervousness as determined by significant mean and standard deviation values of 3.80 and 1.31 respectively. The study also established that the respondents found themselves hopeless to live with others (mean=4.05 std dev=1.19). It was established that the respondents were worthless while living with other community members (mean=4.05 std dev=1.28). The study findings highlighted that inability to provide for my family caused me to be distressed psychologically (mean=3.60 std dev=1.26). Further, the study determined that severe medicalillness caused their life to be obsolete (mean=3.98 std dev=1.10). Further, the survey determined that the traumatic experiences such as loss of respondent's family members induced them to distress (mean=4.05 std=1.02). More also major life changes such as not lack of a proper living standard led to traumatization (mean=3.94 std=1.24).

These findings supported those Levecque et al. (2017) who established that there is a moderate likelihood of psychological suffering among postgraduate students. It further

supports findings of Otieno et al. (2014) carried out a closely connected investigation. This research examined the prevalence of depression and its sociodemographic correlates among university students in Kenya and found out that students experienced severe depression while others had mild depression, indicating that students may face difficulties

5.3 Conclusions of the study

5.3.1 Living status/lifestyle

The conclusions drawn from the findings of the research in retirement homes in Nairobi County are quite clear. Living status/lifestyle insignificantly influenced mental health of elderly livingin retirement homes in Nairobi. This was based on the fact that the respondents' levels of incomes were not sufficient to keep them in their own place. Respondent could not access healthcare at ease due to poverty hence looked for external assistance. The housing conditionsthat they used to live was not conducive. The place the respondent used to live was not very accommodative to their age. The respondents' relatives disowned them from where they usedto live hence pushed them out of the place. The respondents were not able to afford food and shelter due to harsh economic crisis. furthermore, the respondent's health conditions were notfavorable to be with their family outside there.

5.3.2 Social isolation and mental health

It can be concluded from the findings that respondents were disowned due to physical impairment. Respondents used to live in a very remote location where there was no flow of people. respondents lost their loved ones hence living alone. This was also in line that family members and friends accused respondents of witchcraft hence they had to be segregated. There were falsely accusations of the respondent's wealth hence was left wandering alone in the village. The findings also found that lack of children made the respondents family members desert them alone in their house. Poor health made the respondents relatives to flee away from them hence left alone

5.3.3 Depression and mental health

In conclusion when the respondent's economic status became obsolete, they become weak. The study also established that the respondents found themselves struggling emotionally due to their gender incapacitation. It was determined by the study that the respondents age advancement, let to their full body becoming weak hence stressed always. The respondents were unable to keep themselves free from drugs hence left distressed. Further, inability to provide for their relatives after retirement left them stressed. Further, the survey determined

that the loss of respondent's family members through different natural calamities left them to suffer alone.

5.3.4 Psychological distress and mental Health

The study concluded that respondents had high level of nervousness. The respondents found themselves hopeless to live with others. It was established that the respondents were worthless while living with other community members. Inability to provide for their family caused them to be distressed psychologically. Further, the study determined that severe medical illness caused their life to be obsolete. Further, the survey determined that the traumatic experiences such as loss of respondent's family members induced them to distress. More also major life changes such as not lack of a proper living standard led to traumatization

5.4 Recommendations of the study

The study based on conclusion recommends that there is the need for the living status /lifestyle of those living in elderly homes in retirement homes to be embraced based on their critical condition. This can be affirmed through ensuring that they have better accommodations as that they are not affected by harsh weather condition. It can also be through enhancement of their wellbeing which can give them more life bearing. In terms of social isolation, the study recommends that there is need for the elderly in the retirement homes to be offered support whenever they find themselves in isolation as this may lead to their health becoming deteriorated. Furthermore, having adequate support may reduce their isolation aspect. The study also recommends that when it comes to depression, there is the need to ensure that the elderly is cared for effectively so that they don't fall in the depression mood which may shorten their lives. Finally, the study recommends that when it comes to issue of psychological distress, there is the need to ensure that the elderly don't fall in that situation as it may cause them to have adversely effect of their mental health.

5.5 Recommendations for Further Research

The present survey was carried out to establish the relationship between selected old age attributes and the mental health of the elderly living in retirement homes in Nairobi City County, Kenya. However, it will be relevant for future scholars who will conduct studies in the days to come to consider a study with the same subject scope in different counties across Kenya from which comparative studies could be done. In addition, future researchers may also conduct a similar study that focuses much on the benefits that can be achieved upon effective enhancement of old age attributes towards reducing mental health of elderly living in retirement homes.

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APPENDIXES

Appendix I: Knowledgeable consent for the Elderly

I am aware that the goal of this research is to examine the relationship between selected old age attributes and mental health of the elderly living in retirement homes in Nairobi city county, Kenya. I am aware that my involvement in this study is entirely voluntary and that I can end it whenever I choose to without facing any consequences. I also understand that any personal data gathered for this study will be treated anonymously and that the study's interpretations and findings will only be utilized for that reason.

Signature of Elderly:___________________Date___________________.

Home Manager/Staff_______________________Date__________________:

Appendix II: Letter of Introduction

Daisy Chepkoech O'maera,

KCA University, Nairobi, Kenya;

May 1, 2024.

RE: REQUEST TO CARRY OUT THE RESEARCH

I am a postgraduate student obtaining a master's degree in arts in counselling at KCA University. I'm working on a research project titled "the relationship between selected old age attributes and mental health of the elderly living in retirement homes in Nairobi City County "as one of the prerequisites for receiving the degree. I would request to collect data from senior citizen residences in Nairobi County. I'm requesting you to help me give the questionnaires to the senior citizens living in your institution. I will much appreciate your help. For your review, kindly find the letter from KCA University attached. With gratitude in advance.

Sincerely yours,

Daisy Chepkoech O'maera,

0725709953

Appendix III: Elderly Research Questionnaire

CONFIDENTIAL

There are three sections in this questionnaire: Section I, Section II, and Section III. Please note that your name will not appear on the answer sheet since it will only be used for research purposes. All responses will be treated strictly confidentially. Please tick appropriately

SECTION A: Demographic information

1. Gender

Male ( ) Female ( )

2. Age

60-65 years ( ) 65-70 years ( )

70-75 years ( ) Above 75 years ( )

3. Highest level of education

College ( ) University degree ( )

Postgraduate level ( ) Other levels ….indicate ( )

4. How long have you lived in this elderly home?

Below 5 years ( ) 5-8 years ( )

8-10 years ( ) Above 10 years ( )

SECTION B: OLD AGRE ATTRIBUTES

In this section you will be required to indicate your level of agreement based on the stated statements. Likert scale will be used whereby 5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

SECTION B1: LIVING STATUS/LIFESTYLE

Please tick appropriately

5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

Statement	**SA**	**A**	**N**	**D**	**SD**
My level of income was not sufficient to keep me in my own place					
I could not access healthcare at ease due to poverty hence looked for external assistance					
The housing conditions that I used to live was not conducive					
The place I used to live was not very accommodative to my age					
My relatives disowned me form where I used to live hence pushed me out of the place					
I was not able to afford food and shelter due to harsh economic crisis					
My health conditions were not favorable to be with my family outside there					

SECTION B2: SOCIAL ISOLATION

Key: 5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

Statement	SA	A	N	D	SD
I was disowned due to physical impairment.					
I used to live in a very remote location where there was no flow of people.					
I lost my loved ones hence living alone.					
Family members and friends accused me of witchcraft hence I have to be segregated.					
There was falsely accusations of my wealth hence was left wandering alone in the village.					
Lack of children made my family members desert me alone in my house.					
Poor health made my relatives to flee away from me hence left alone.					

SECTION B3: DEPRESION

Key: 5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

Statement	SA	A	N	D	SD
When my economic status became obsolete, I become weak.					
I found myself struggling emotionally due to my gender incapacitation					

My age advancement, let to my full body becoming weak hence stressed always.					
I was unable to keep myself free from drugs hence left distressed.					
Inability to provide for my relatives after retirement left me stressed					
The loss of my family members through different natural calamities left me to suffer alone.					

SECTION B4: PSYCHOLOGICAL DISTRESS

Key: 5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

Statement	**SA**	**A**	**N**	**D**	**SD**
I had high level of nervousness					
I found myself hopeless to live with others.					
I was worthless while living with other community members					
Inability to provide for my family caused me to be distressed psychologically.					
Severe medical illness caused my life to be obsolete					
Traumatic experiences such as loss of my family members induced me to distress.					
Major life changes such as not lack of a proper living standard led to traumatization.					

SECTION B5: MENTAL HEALTH

Key: 5-strongly agree, 4-agree, 3-Neutral, 2-Disagree and 1-Strongly disagree

Statement	**SA**	**A**	**N**	**D**	**SD**
The place is used to live acted as a catalyst for my social health					
Frequent life challenges induced me to mental health issues.					
Inability to provide for myself traumatized me					
Lack of support from family members made me insane.					
False accusation of witchcraft made me feel like committing suicide					
Hopelessness makes me feel ill-fated					
When am always sleeping I always find myself very weak.					
Lack of concentration makes feel abnormal					
Obsessed through eating makes my life unbearable.					

Thank you for your participation

Appendix IV: Focus Group Discussion

1) What influenced you to come to have a stay in this home?
2) What do you do on daily basis activities while in this home and how do you plan for those activities?
3) Let each of us take time and flashback how life was before coming to this home.
    a. Kindly tell me some of the activities that you used to undertake before coming to this Home.
    b. Have you been able to continue with some of those activities that you used to undertake to enlighten your fellows here at your specific home?
4) I want you to imagine that you are either a marketer, would you recommend your friends to come to this home in their old age?
5) What would you like to inform them about your current home?
6) What would you like the owners of this home to change in order to make it better that it is now?
7) In general, how can you relate the home staffs and your experience with them?
8) In relation to this, what do you love most about those staffs?

9) What would you like to inform the kindest staff who has been very concerned about you?
10) If given a chance to go back where you used to live, would you be happily as you are here?
11) How would you describe your stay in your respective home?