Loneliness, Humor Style and Quality of life among Older Adults Living with Families and in Old-Age Homes: A Comparative Study

By

Syed Muhammad Taha

Dr. Muhammad Ajmal

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Syed Muhammad Taha

Approved by

(Ms. Saira Khan)
Supervisor

(Dr. Khekashan Arouj)
External Examiner

(Prof. Dr. Anila Kamal)
Director, NIP

Certificate

It is certified that Masters Dissertation titled **"Loneliness, Humor Style and Quality of life among Older Adults Living with Families and in Old-Age Homes: A Comparative Study"** prepared by **Syed Muhammad Taha** has been approved for submission to Quaid-i-Azam University, Islamabad.

(Saira Khan)

Supervisor

Dedicated to

Abu (late), Ammi & Sisters

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ABSTRACT

The present study aimed at studying the relationship between Loneliness, Humor style and Quality of life among older adults living in old-age homes and with families. The data was collected by convenience, purposive and snowball sampling techniques from older adults living in old-age homes (*N = 120*) and older adults living with families (*N = 140*). Loneliness Scale Urdu Version (Russell, 1978) was used to assess loneliness, Humor Styles Questionnaire (Martin & Doris, 2003) was used to measure humor and Quality of Life Scale (Urdu Version) developed by World Health Organization in 2004 was used to measure quality of life. Graphical analysis indicated that the major reason for coming to old-age home is lack of caregiver. Another reason was domestic problems and illness, elderly adults living in old-age homes were not able to meet medical expenses as well. Pearson product moment correlation indicated that positive humor (i.e. self-affiliative and self-enhancing humor) was positively related with quality of life (i.e. overall health, physical health, psychological health, social relationship and environmental health) in older adults living with family and in old-age homes. Whereas, loneliness was negatively related with quality of life (i.e. overall health, physical health, psychological health, social relationship and environmental health) in both elderly adults living with families and old-age homes. Loneliness and negative humor (i.e. aggressive and self-defeating humor) were found to be higher in older adults living in old-age homes as compared to living with families. Whereas, positive humor and quality of life were higher in the older adults living with families as compared to living with old-age homes. The predictor for quality of life in older adults living with families was positive humor style and similarly, whereas, the predictor for quality of life in older adults living in old-age homes was loneliness and negative humor style. Mediation analysis was conducted based upon literature support on the older adults living in old age homes as humor style being the mediator between loneliness and quality of life. It was found out the positive humor style act as a role of mediator in the individuals suffered from loneliness which works as coping mechanism in order to enhance the quality of life as giving them satisfaction, happiness and hope to live further. Implications and suggestions were discussed for future researches.

INTRODUCTION

Chapter I

Introduction

Humans go through various phases of life. Aging is a natural, continuous and complex process that begins with birth and ends at death. Old age is the last phase in human life cycle. Aging involves series of biological changes that follow a natural development from birth to old age and death. The term "aging" refers to the harmful sense of the biological process of aging, which some authors call "senescence". Aging involves the collection of changes that render people with age. Aging has been characterized as dynamic utilitarian decay or continuous weakening of physiological capacity with age, including a diminishing the energy of fertility.

The ageing process is a natural reality and its own particular elements that are far beyond the human ability to control. In any case, it is additionally subject to the developments by which each general public sees age. The age of 60 or 65, which in most advanced countries is about the same age as retirement, is referred to as the beginning of old age (Gorman, 1999). Aging is considered to be an age bond phenomenon and shows cultural variations. Furthermore for women age between 45 to 55 is considered as old age whereas for men age between 55 to 75 years are considered as old age (Vincent, 2006). Chronological age of 55 years in most developed countries have accepted the as a definition for "older" or older people (Ilmarinen, 2001).

Aging is the gradual process of becoming old. The term "old-age" and "elderly adult" is defined as a person older than 50 years. Old-age is termed as a period in which individuals experience changes in their physical health, psychological health and in social rules (e.g. retirement). These changes are very important for older adults because individuals who adapt to later life changes through social activity lead a happier and healthier life than those who do not (Cornwell, Laumann, & Schumm, 2008). The old-age defined as "any age after 50", eligibility for pension systems uses most age 60 or 65 years (Roebuck, 1979). Any one between the chronological age of 50 to 65 is considered as older adults based upon setting and the region (WHO, 2013).

Old-Age is associated with diminished physical capacity, declining mental capacity, the steady abandonment of pretends in financial exercises and a move in monetary status from monetary independence to monetary reliance on others for help (Gowri, 2003). Old-Age is the last period of the life expectancy. It is a period when individuals move far from more attractive periods or times of utility. Maturity is considered a curse associated with the decay of all physical, mental variables, the confinement of social, financial and different exercises. In social terms, this stage was considered as the whole of lived encounters (Panday, Kiran, Srivastava, & Kumar, 2015).

Theories of Aging

Modern biological theories of aging in humans can be divided into two main categories:

Modern non-programmed aging theories assert that we are maturing in light of the fact that our bodies don't give better security against regular wear and tear, for example, mechanical wear, oxidation and other harm. These circumstances exists in light of the fact that every species has just a developmental need to live and replicate for an animal types particular lifetime and, along these lines, has grown just the upkeep and repair abilities expected to manage that lifetime (Trindade, Aigaki, Peixoto, Balduino, & Heddle, 2013).

Modern programmed aging theories assert that we are maturing on the grounds that we have a natural suicide instrument or program that deliberately restrains the life expectancy to an animal type's particular incentive for transformative advantage. Living longer and imitating makes a transformative detriment that causes the advancement and upkeep of the life expectancy restricting component (Jin, 2010).

Biological Theories of Senescence

Theories that clarify the natural premise of human maturing are either stochastic speculations that hypothesize senescence as the consequence of unplanned harm to the life form, or they are customized speculations that express that senescence is the aftereffect of hereditarily decided procedures. Presently the most well-known

speculations include: (a) the free radical theory, which expresses that different responsive oxygen metabolites can cause broad aggregate harm (b) hormonal theory, for instance, that expanded levels of steroid hormones caused by the adrenal cortex can cause speedier maturing procedure; and (c) immunological speculations crediting a decrease in the invulnerable framework to age (Cristofalo, Tresini, Francis, & Volker, 1999; Watts-Roy, 2008).

Stress theories of aging. Stress theories contend that extreme physiological initiation has uncontrolled outcomes. Stress mechanisms are accepted to connect with age-related changes in the hypothalamic-pituitary-adrenocortical hub (HPA), which is one of the body's two fundamental administrative frameworks for reacting to stressors and keeping up inner homeostatic respectability. Singular contrasts in reactivity may in total prompt substantial individual contrasts in neuroendocrine maturing and to age-related sickness dangers (Finch & Seeman, 1999).

Psychological theories of aging. Psychological theories of aging may refer to both psychological changes due to aging processes and adaptive psychological mechanisms to counteract the losses associated with physical deterioration. For example, the field of cognitive psychology deals with age-related changes in cognitive performance and strategies to compensate for these changes (Wernher & Lipsky, 2015). Theories suggest that there are psychological gains and losses in all phases of life, but losses in old age far exceed profits. Baltes and Smith (1999) suggests that evolutionary development remains incomplete even in the very last stage of life, while social support is no longer sufficient to compensate for the decline in physiological infrastructure and loss of behavioral functionality (Baltes & Smith, 1999).

Wear and Tear aging theories. Many individuals trust that maturing is just the consequence of wear, oxidation, other atomic harm, or other unavoidable characteristic procedures that reason progressive degradation. Stochastic theories propose that aging is the result of random changes that have negative effects that affects organic frameworks. Maturing could be the consequence of the gathering of poisonous results, harm because of atomic radiation, entropy or some other slow decay process (Agogo, Milne, & Schewe, 2014).

Sociological theory. This theory with respect to human maturing demonstrates some imperative and promising advancement. The affirmation status of theory in social gerontology is enhancing; the legitimate structure of his sentences and contentions is worked out in total; the determinateness of hypothesis based forecasts is better; and social gerontological theory is progressively being enunciated with general sociological speculations of socialization, social aptitudes, and social change. The likelihood and likelihood of social reconciliation of the elderly in present day modern social orders has been illustrated. Finding a solitary effective approach to adjust to maturing, such as the retreat, is presently experimentally and hypothetically unjustified (Kohli, 1988).

Loneliness

Loneliness is defined as being connected to others, or more specifically, the feeling of unpleasant experience that occurs when an individual's attachments and connection is deficient with the other individuals of community (Kim, Larose, & Peng, 2009). Loneliness is a sense of social isolation in which a person desires that he or she has better social relationships (Sonderby & Wagoner, 2013).

Smith and Victor (2018) defined loneliness as a social gap and lack of willingness to share social and emotional experiences with people, it is a state in which individual does not interact with others even despite of having a potential, and a difference between the actual interaction and desired connection with others.

It can also be defined as a discrepancy between ideal and perceived social relationships. In other words, it's about displeasure that individuals do not feel bound to people so warmly, or so happy in their presence. It's a problem with hopes against reality (Hawkley & Cacioppo, 2010).

Loneliness is characterized as the upsetting background that happens when social connections are seen less quantitatively and, specifically subjectively than wanted. Being alone and experiencing loneliness is totally different from each other. The experience of loneliness is highly subjective; sometimes without feeling loneliness individuals can be alone and individuals can feel lonely even when they are with other (Heinrich & Gullone, 2006).

The lack of interpersonal relationships of an individual refer to loneliness. Individual feel loneliness when he or she wants close relational connections however can't build up them. According to Perlman (2004), loneliness is the disagreeable experience that emerges when a person fail to established a sufficient social network (Upadhayay & Khokhar, 2006).

Loneliness in the Modern Age

In modern era loneliness is an emerging problem. Recent studies revealed that modern life make us alone that persuaded toward public health problems. According to new findings mortality risk increases up to 26% because of loneliness. We are affected by loneliness at certain points of our lives. Some key times are as; moving or shifting to the new places, losing loved and starting a university studies. Literature suggests that loneliness is useful tool to reduce social pain as it motivates us to enhance attachment with others and seek new friendships (Holt-Lunstad, Smith, Harris, & Stephenson, 2015).

Loneliness is associated with an unpleasant emotional response leading to isolation. Loneliness usually involves nervous feelings about lack of attachment and communication with others. Loneliness can be prominent in the environment of other people because it includes social, mental, emotional and physical factors (Pittman & Reich, 2016).

Loneliness is more common among women than men and also associated with ageing, widowhood, low salary and education, weakness, physical illness, loss of attention, and lack of social interaction (Savikko & Routasalo, 2005).

Theoretical perspectives on loneliness

Reason of loneliness can be explored by using a number of theoretical perspectives. The four major theories are cognitive, existential, psychodynamic and interactional theories. None of this is characterized to age or later life (Victor, Scambler, & Bowling, 2000).

The cognitive theory. According to this theory, way of people think regarding loneliness is a detrimental factor in experience of loneliness. It has been

found that social support and supporting confidence reduce the feeling of loneliness. However, older adult with cognitive loss are not much affected by social supports and loneliness (Singh & Kiran, 2013).

Existential theory. This theory characterizes loneliness as a constructive opportunity that boosted by the experience of affection and attachment with others. Loneliness is considered a very important role in our life, and in the most familiar aspect of life we are basically alone. According to this theory individual cannot differentiate between the subjective sense of being alone and the objective nature of being alone (Singh & Kiran, 2013).

The psychodynamic theory. This theory is based on the Freudian method. This theory recommends that interpersonal, childhood, and virtuous connections and situations constitute a personality establishment that predicts future adapting policies. Some researchers observed loneliness as a mental state that is symptomatic of neurosis initiating from a past life, making it difficult for lonely older adults to form relationships. It focuses only on a pathological explanation, while ignoring the effects of aging, their culture and the social world of the elderly adults that's the limitation of this theory (Singh & Kiran, 2013).

Interactionist theory. Loneliness is initiated by a combination of the lack/loss of a caretaker and the lack of an adequate social support. It is believed that the experience of loneliness depends on the personality type of the individual. Loneliness is not necessarily negative and therefore other factors have to be included in the feeling of loneliness (Singh & Kiran, 2013).

There have been several studies on loneliness-related traits, and a variety of methods have been used.

Demographic Factors

Aging has been related with loneliness (Jylha, 2004). Researches revealed that, prevalence of loneliness is more common in older adults than younger adults (Savikko, 2008). It has been considered that age is related to loneliness or whether the

relationship is explained by changes in the lives of older persons, such as widowhood or a decline in physical ability (Ollonqvist, Palkeinen, & Aaltonen, 2008).

Gender has been also related with loneliness. Findings indicate that older men are lonelier as compared to older women (Wai, 2015; Jylha 2004). Previous literature also suggests that there are no gender differences on loneliness (Savikko, 2008).

Elderly adults living in old-age home seems to be related with an increased prevalence of loneliness as compared to those living with their families (Abot-Okelo, 2014). However, many previous findings have found no differences in loneliness between elderly adults living in old-age homes and elderly adults living with families (Bondevik & Skogstad, 1996) or between older adults living in residential homes (Broese & Thomese, 1996). This could be due to an increased need for social support and thus to social contacts with old-age home workers (Broese & Thomese, 1996).

The connection of income with loneliness has received much less attention in research as compared to living conditions (Andersson, 1998). Previous researches have found that loneliness is more prevalent among individuals who are not satisfied with their income than those individuals who view their salary as satisfactory (Borg, Hallberg, & Blomqvist, 2006).

Health and functional status. Several researches revealed that loneliness is associated with poor subjective health reduced health status or diminished quality of life (Victor, Scambler, & Bowling, 2000). Poor vision or hearing (Skaff, 2007) the presence of long-lasting diseases or health problems (Penning, Liu, & Chou, 2014) and reduced cognitive/mental utilities (Lindeboom, Portrait, & Berg, 2002) seem to increase prevalence of loneliness in older adults.

It is believed that older adult may place a different importance on their relationships with friends and neighbors than their children and their families. This may be due to the difference between the relationships. Elderly adults may feel that children remain partially connected because it is obligatory, while friends and neighbors can be more honest in the relationship (Pitkala & Tilvis, 2003).

Psychological health. Sintonen (2001) identified that psychological well-being is generated through numerous dimensions, such as absence of anxiety and emotional loneliness, sense of safety, life satisfaction, happiness, and future plans. Mental health is considered to be an important element of the quality of life of older adults (Felce & Perry, 1995).

Social contacts and satisfaction. Previous findings investigated that low frequency of social attachment with children, circle of relatives, neighbors and lack of friends has been related to loneliness in numerous studies (Routasalo & Pitkala, 2003).

Loneliness affects the quality of life in older adult and strong predictors of loneliness are the existence of long-lasting physical health issues and lack of hobbies. Elderly adults living alone need to be labeled as an excessive-danger group and therefore decision makers and medical examiner should be aware of the causes that can affect loneliness. In order to increase the quality of life of older people and the psychological well-being of older people, social support systems must be taken into account and older people encouraged participating in social activities (Arslantas, Adana, Ergin, Kayar, & Acar, 2015).

Loneliness has been described as a complex group of feelings that occurs when intimate and social needs are not adequately met and make individuals seek to fulfill those needs. It is a universal phenomenon that is found in humans and is closely linked to changing living conditions. Age is often perceived as loneliness. Studies have shown that loneliness is related with depression, a lower quality of life, and an increased susceptibility to physical and psychological health problems of the elderly. It has become common practice to distinguish emotional and social loneliness (Prince, Harwood, Blizard, Thomas, & Mann, 1997).

Emotional and Social Loneliness

Emotional loneliness lacks an intimate bond, like a spouse, and is accompanied by feelings of isolation and insecurity, and by having no one around, while social loneliness lacks a circle of friends and acquaintances that can instill a sense of belonging and membership in a community. One study found that older age,

absence of partner, dependency; institutionalization and health impairment were associated with an increased risk of loneliness. Factors such as cognitive function and limitations in activities of daily life were not associated with loneliness (Prince, Harwood, Blizard, Thomas, & Mann, 1997).

Researchers have found that loneliness is the maximum critical thing predicting a low-quality of life in caregivers. Older people in general point out that this is crucial in caring for the elderly. Hallberg Ekwall and Sivberg (2005) investigated that there were gender differences that are feelings of loneliness are higher in women than in men. Results indicated a significant correlation between loneliness, weak social support and low mental quality of life (Hallberg, Ekwall, & Sivberg, 2005).

Past researches investigated the impact of loneliness on the health and well-being of older adults in China. It has often been found social and emotional isolation. Many of the health factors including psychological, physical and social tends to contribute in the onset and experience of loneliness. In elder people, deterioration in their health is associated with loneliness (Dong & Simon, 2011).

Loneliness and anxiety are common in the elderly. A study conducted by Jakobsson and Hallberg (2005) has found that the relationship between loneliness, quality of life and anxiety among older people from a gender perspective. They found that loneliness was significantly associated with marital status, living in institution and gender. The results showed that loneliness are more reported prevalent in women as compared to men. They also found that loneliness is related to anxiety and fear and had lower quality of life who reported more anxiety and loneliness (Jakobsson & Hallberg, 2005).

Humor Style

Humor has been defined as "the creation of joyful moment and the playful recognition that helps to attain or maintain good mood." Humorous persons are those who can smile and laugh with others" (Edwards & Martin, 2014). The capability of the creation of humor in a person is called humor. The ability to triggers laughter,

identify humor or sense, whether this humor is created by others or oneself (Dozois, Martin & Bieling, 2009).

Humor encompasses several dimensions, including adaptive humor, maladaptive humor, emotional responses, behaviors that express humor, cognitive aspects, and aims to describe, explain, predict, and control humorous behavior (Ruch & Hofmann, 2017). Humor is an instrument that makes the peoples laugh, laughter and cause amusement (McGhee & Goldstein, 2014).

Sense of humor characterized into three separate components: the ability to humor (appreciation), the ability to enjoy humor (production) and humor as a disposition (or attitude). For more understanding of the concept, we found it necessary to consider motivational, emotional, cognitive, behavioral and social components of the sense of humor (Ziv, 1981).

Peterson and Seligman (2007) defined humor in three ways that are that includes a composed view of the adversities that make it possible to see its bright side and maintain a good mood, playful recognition, enjoyment, and incongruence; and an individuals' ability that create smile or laugh in others. Humor important to evaluate the strength of character because it is universally recognized virtues (Peterson & Seligman, 2007).

According to researcher, being a part of psychological traits humor is a multi-dimensional concept (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). Martin (2003) found that humor can be: (a) can be understand jokes (a cognitive ability), (b) may like specific types of education (an aesthetic answer), (c) Habit or laugh often or say a lot of jokes (habitual pattern of behavior), (d) A coping strategy or defense mechanism and (f) an attitude. Cheerfulness is the basic function of humor (Solomon, 1996).

Researches has focused on four distinct types of humor style.

Affiliative humor. This type of humor encompasses the jokes on those things which might find funny by everyone. The basic aim of humor is seeking a gathering of people to find the humor in daily life. The kind of jokes told and focus by

humorist in daily life always represent the respective types of jokes. The goal is to create a sense of happiness, community and well-being of others (Martin, 2003).

Self-enhancing humor. This can be categorized as laughing at oneself, therefore making a joke when a person is in a stressful condition or something bad happens with him. People high on self-enhancing humor try to find the humor in daily routine and achieve a goal of humor in a good way. It may be related with stress management (Martin, 2003).

Aggressive humor. This includes devaluations or insults to individuals. It is to threaten or psychologically harm others; mostly tyrants use this humor. Some viewers found this kind of humor funny while others thought this laugh is just to cover up a sense of discomfort (Martin, 2003).

Self-defeating humor. To show an aggression or "arrogant" is called self-destructive humor. Psychologists, sometime use bullying followers to prevent attacks from becoming a jackpot before others put down, this is unhealthy form of humor (Walecka-Matyja, 2017).

Humor can also serve as a coping strategy, such as laughing rather than crying Humor can also be conceptualized as habitual behavior, and in this regard, attention is paid to how sometime laughs or tells jokes to others (Martin & Lefcourt, 2004).

Psychological Benefits of Humor. Kennedy (2008) identified three things which are real that's: laughter, God and human foolishness. The first one is in our control while last two are away from our grasp. One of the advantages of humors is used as tools to reducing stress, discomfort and anxiety, and its psychological benefits and coping mechanism (Linstead, 1985). Sense of humor can use as a tool to reduce anger, frustration and boredom, it can offer to reduce the burdens present in older adults an escape from the harshness of reality (Weaver, Richard & Cotrell, 1987).

Sociological Benefits of Humor. According to Steele (1998) sociological theory of humor explains the means of transmitting cultural beliefs and better group collaborations. The most important functions of humor are being empathic with new members to society, socialization, kindhearted and to understand each other (Pollak &

Freda, 1997). The socialization process teaches us how to deal with other people and with life's challenges present in society/ community. Duncan (1984) identified that sense of humor is a binding force through which people improve group cohesiveness and moral values, share common experiences, and focused toward common goals.

Steele (1998) stated that laughter and sense of humor is the shortest distance between two individuals, and it is an effective way in interpersonal communication skills. Laughter is seen to organize human interaction, a resource in connection, and approval and invitation to elaborate for the hearer to respond in kind (Steele, 1998).

Physiological Benefits of Humor. Humor and laughter are a great impact on our physiological health as it also called universal medicine. Sense of humor and laugh increases the ratio of oxygen in the blood, improves blood flow that make lungs healthier, diaphragm, and face muscles, enhance the immune system and defend against diseases (Cornett, 1986). Pleasure increases and pain decreases, because of the increase in endorphin secretion in our body. Laughing increases alertness by increasing catecholamine in our body. Sense of humor also leads to excitement, pleasure, and alertness that reduce the experience of tension and stress (Rainsberger, 1994).

Theories of Humor Style

Four theories of humor have been proposed: (a) superiority theory, (b) psychoanalytic theory, (c) relational theory, and (d) incongruence theory.

Superiority theory. According to Berger (1987) as the name implies, the purpose of humor according to this theory is to allow someone to feel superior to others. This conceptualization of humor can also be interpreted as the development of superiority or attainment of mastery over past mistakes, defects, or mistakes. Being able to laugh at one-self requires control over oneself and the environment, which means superiority (Robinson, 1983).

Psychoanalytic theory. The psychoanalytic theory of humor was first introduced in 1960. According to Freud, humor has been defined as a joke intended to distract the superego and is associated with sexual / aggressive inhibition, as non-

verbal sources of positive emotions. Both Inhibition and humor (defined as the perception of something incongruent that avoids negative affects) are associated with emotional inhibition Collicutt & Gray, 2012).

Relief theory of humor. This theory of humor (also known as the arousal theory of humor) is psychophysiological in nature. Relief theory was strongly influenced by the 19th century view of the nervous system (Martin, 2003). This theory suggests that humor can be understood on the basis of arousal and pleasure (Berlyne, 1972).

The incongruity theory of humor. This theory of humor is cognitive because it causes its frame of reference to be unexpectedly shifted to reconcile dissimilar information (Martin & Lefcourt, 2004). According to this theory, a joke or a situation is funny because of the expectation of one thing and the delivery of another. Incongruity is a common topic in jokes where the punch line is a complete surprise (Lodico, 1998).

It has been suggested that only positive forms of humor have a positive effect on mental health (Martin & Chen, 2007). Studies have suggested that in older age people's sense of making and understanding humor becomes diminished which cause them to make inappropriate jokes (Greengross, 2013).

Cultural Reflections on Humor and Humor Style

Humor is hard to define among individuals and may not be in all cultural groups, e.g. different races, ethnic groups or genders (Martin 2003). Lippa (2007) found that both men and women in same-sex and opposite-sex relationships in fifty-three nations crave humor. Although this suggests that humor is common, it does not prove that humor is universally conceived in the same way (Saroglou, Lacour & Demeure, 2010).

When looking at the individual literature on humor and loneliness, it is striking that they contrast with certain psychological health and interpersonal communication skills. It has been found that physical health, stress resistance and psychological health positively relates with humor as it improves social connection

and interaction (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). Hawkley and Cacioppo (2009) stated that lonely individuals (regardless of age) are more aware of everyday stressors as compared to those individuals who are not lonely.

Ruch and Proyer (2010) found that older adults laugh less and show less appreciation as compared to younger adults that they valued verbal humor for everyday activity (Ruch, & Proyer, 2010). Past studies identified that they are no major differences in gender related to humor, whereas men appreciate humor better than women. Shuster (2013) suggested that women use humor to get affection from others and create solidarity, while men use humor as a tool to reduce and to control aggression.

Quality of life (QOL)

Quality of life defined as a general well-being of individuals and societies that includes positive and negative aspects of life. Life satisfaction is a subjective part of quality of life that includes psychological/mental health, environmental health, physical health, family system and income, education, employment, wealth, and religious beliefs (Jacobson, Braffett, Cleary, & Larkin, 2013).

Quality of Life and Aging

World Health Organization (2015) defined quality of life is the combination of the overall health of an individual that are physical, psychological and environmental health, the social circumstances and interaction, the feelings of competence, the independence activities of daily life. It is an individual perception of one's self of life satisfaction in the perspective of the culture and value systems in which they live, expectations, standards and concerns and in relation to their goals (WHO, 2015).

Pavot and Diener (2004) defined as quality of life is a conscious cognitive judgment of satisfaction with one's life. Life satisfaction is planned to be a mental construct yet is utilized as an umbrella term for various results. However there is no expectation of creating hypothesis or of consistently understanding what causes fluctuation or variation in life satisfaction (Rejeski & Mihalko, 2001).

Health-Related Quality of Life

Minayo, Hartz and Buss (2000) explained that the quality of life is a multidimensional concept. Life satisfaction is not only limited to physiological and biological aspects. It includes many factors that may be affected their feelings, connection and attachment with others, the way we interact and communicate in their context the individual's perception of their surroundings, and their daily activities.

Quality of Life (QOL) is based on objective and subjective parameters because the quality of life may be affected by cultural values, religious and personal aspects and the way it is perceived. The objective parameters are related to the basic needs that enhance life satisfaction and well-being, while the subjective parameters related to personal happiness and achievement, self-esteem and psychological well-being among individuals (Diener & Suh, 1997).

According to Bell (2012) quality of life is the subjective perception of the good life that's related to the feelings of happiness, meaning in life and inner satisfaction. The quality of life does not meet the objective or external standards. In addition, the definition of success could be based on the subjective judgment about the quality of life. Person realizes that their life is meaningful when they have inner peace and happy, and then the successful and achieve a high quality of life. Moreover, it is understood that increasing inner peace, happiness, and meaning in life have a good quality of life.

Quality of life defined as the degree of satisfaction or dissatisfaction of people with various aspects of their lives. Or simply put, quality of life is providing the necessary conditions for happiness and satisfaction. Elderly people talk about quality of life in different contexts, but the most important components (most often named) of a good quality of life are: family (children), social contacts, health, mobility / ability, material circumstances, activities, happiness, youthfulness and living environment (Farquhar, 1995).

The concept of quality of life largely includes how an individual measures the goodness of several aspects of their lives. These assessments include the emotional responses to life, the disposition, the sense of fulfillment and gratification of life, and

the satisfaction with work and personal relationships (Diener, Suh, Lucas, & Smith, 1999).

Quality of life may include general life satisfaction (LS) and includes general feelings of well-being (WB) and other aspects such as economic situation, health, social and / or spiritual aspects of life. Generic Health Quality of Life typically includes areas such as physical, psychological, social and environmental assessments of life with positive and negative aspects. Therefore, generic health quality of life is a more comprehensive concept than the current health status of an individual (Bowling, 2005).

Quality of life can be defined in terms of life satisfaction, subjective well-being and happiness, etc. Life satisfaction, which includes factors such as health, education, interpersonal relationships, and socioeconomic status, is considered to be an assessment of life in general. Family and income status influences the perception of quality, and these factors also affect the quality of life. The loss of some social roles and independence, retirement, the deaths of friends and relatives, children leaving home, increasing loneliness, financial difficulties, and various illnesses resulting from these changes, affect the quality of life of older individuals (Beyaztas, Kurt, & Bolayir, 2012).

Life satisfaction continues to be an important construct in psychosocial geriatric research. It is one of the commonly accepted subjective conditions of quality of life and seems to be one of the facets of successful aging, both key concepts of aging. Research reports indicate that life satisfaction is strongly associated with socio-demographic and psychosocial variables (Iyer & Naganathan, 2008).

Researches examine the quality of life, depression and loneliness in elderly people living in old-age homes and living with community. They found that older people living with families reported high score on quality of life, while older people living in old-age shelter homes were more scored loneliness and had depressive symptoms. Findings have also revealed that older women were more depressed than older men, whereas widows and widower older adults reported more loneliness as compared to unmarried people (Cesetti, Vescovelli, & Ruini, 2017).

Being institutionalized or living in the community in the studied regions did not affect the quality of life in the analysis models. Factors such as age, education, self-assessment of health and recreational activities, when statistically controlled, influenced seniors' perceptions of their quality of life. The institutionalized individuals living in old-age homes generally reported a lower quality of life because they were older and had worse socio-economic and health conditions than their corresponding person. Nursing measures and interventions should be carried out in the context of primary health care, taking these differences into account to promote quality of life in this age group. Other variables of interest may be examined to identify factors that add to the quality of life perceptions of these individuals treated in this study (Diener & Suh, 1997).

Interventions must be designed to increase the life satisfaction of older people. Appropriate age management with important responses to the difficulties of older people is important for them to feel that they are an element of culture. Many of the elders are satisfied with the Geriatric Home Services (diet, room service, bathing, hygiene, clothing, and house staff relations), while being dissatisfied with some services such as environmental, social activities, entertainment, security measures and transportation (Sangar, Karem, Alireza, & Muaf, 2015).

No needy at home was the important reason in retirement homes. With the exception of food, all variables such as medical service, recreational facilities, safety, space availability, and personal availability in private nursing homes were significantly better. Similarly, the quality of life in private retirement homes was significantly better than in public retirement homes (Gupta, Mohan, Tiwari, & Singh, 2014).

The overall sentiments of older women living in families were better positioned than those of older women in the institution. Better social relationships were maintained by the family dwellers because they had regular interaction, feelings and support from the family. The condition of the elderly women living in the facility was that they felt lonelier, more depressed and less content with life. In this context, the need to preserve our tradition of a common family and the mutual cooperation and understanding between the younger and older generations could be more urgent (Dubey, Bhasin, Gupta, & Sharma, 2011).

High qualities of life is observed among older people who are well-educated, retired, belonging to the middle socio-economic state (SES) and have no habits whose spouses are young and retired. Among the various socio-demographic factors, SES has the highest relation to quality of life. A high quality of life is seen by nursing homes compared to seniors. However, the difference in mean quality of life was not statistically significant (Rayirala, Nallapaneni, Bhogaraju, & Mandadi, 2016).

Loneliness and Quality of Life

Several researches revealed that loneliness is associated with poor subjective health reduced health status or diminished quality of life (Victor, Scambler, & Bowling, 2000). Loneliness affects the quality of life in older adult and strong predictors of loneliness are the existence of long-lasting physical health issues and lack of hobbies. Studies have shown that loneliness is related with depression, a lower quality of life, and an increased susceptibility to physical and psychological health problems of the elderly. It has become common practice to distinguish emotional and social loneliness (Prince, Harwood, Blizard, Thomas, & Mann, 1997).

Loneliness and Humor Style

Adaptive humor style has been described as mediator for stressors of life for example loneliness. According to the past researches loneliness and humor style are related to psychological states and communication skills. It has been found that sense of humor positively correlates with stress resistance and psychological health as it improves social support (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). Consequently, individuals who are not lonely tend to have a happier life as compared to lonely individuals (Hawkley & Cacioppo, 2009). Sense of humor can use as a tool to reduce anger, frustration and loneliness, it can offer to reduce the burdens present in older adults an escape from the harshness of reality (Weaver, Richard & Cotrell, 1987).

Humor Style and Quality of Life

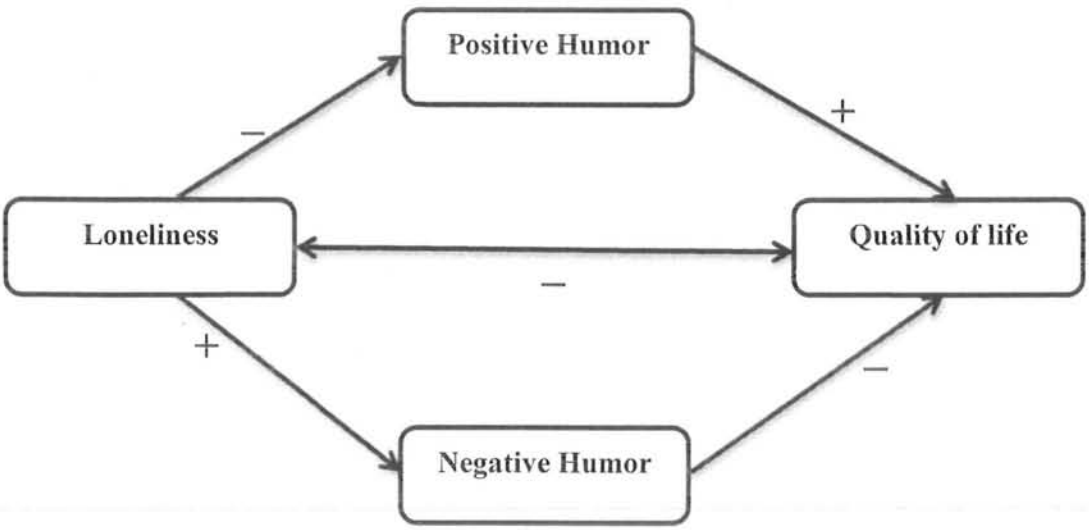
Past researches regarding humor styles and psychological adjustment suggested that endorsement of adaptive humor has been linked with better quality of

life. Kuiper (2012) proposed that adaptive humor works as a mediator for relationship of quality of life and loneliness. Incorporation of positive humor in life of individual increases social circle reduce feeling of loneliness and as a result enhances quality of life (Martin, 2003). Humor enables a more optimistic outlook to life and enhances quality of life (Kuiper, Martin, & Dance, 1992). Hampes (2005) explored that use of positive humor in life has been linked with healthy interpersonal relationships which as a result increases physical and psychological well-being.

Good sense of humor is associated with high quality of life in people. A study conducted by Martin and Dance (1993) indicated that sense of humor is indicator of better quality of life, including positive effects and personal role in response to everyday life events. Finding showed that humor facilities have a more positive attitude towards life. Less humorous persons reported lower life satisfaction and less pleasant as compared to more humorous persons (Martin & Dance, 1993).

Martin (2003) found that good sense of humor can facilitate the attainment of psychological well-being. Over the years, researchers have identified a number of processes through which a good sense of humor might support well-being. It has been also suggested that a good sense of humor avoid psychological distress and might play a role in supporting resilience and well-being.

Conceptual Framework



Loneliness and negative humor are negatively related with quality of life while positive humor is positively related with quality of life. There was negative relationship between loneliness and positive humor, whereas loneliness and negative humor were positively related with each other.

Mediating Role of Humor styles

Research regarding humor styles and psychological adjustment suggested that endorsement of adaptive humor has been linked with better quality of life. Incorporation of positive humor in life of individual increases social circle reduce feeling of loneliness and as a result enhances quality of life (Martin, 2003). Hampes (2005) explored that use of positive humor in life has been linked with healthy interpersonal relationships which as a result increases physical and psychological well-being. Positive humor style has been described as mediator for stressors of life (Lefcourt, 2001).

Kuiper (2012) proposed that adaptive humor works as a mediator for relationship of quality of life and loneliness. Researches found humor style work as mediator in relation between loneliness and shyness (Zhao, Kong, & Wang, 2012). Shyness is one of the factors that foster loneliness, individuals tended to use affiliative humor less, which led to more loneliness. Conversely, shy individuals tended to make more use of self-defeating humor style which may affect the quality of life. Shy people usually take an evasive attitude on social interaction, too prone to yield negative emotions, and tend to have a more negative evaluation of themselves and others, which make them less involved in social activities, and thus have a strong sense of loneliness (Ashe & McCutcheon, 2001). Humor also mediated the relation between negative self-evaluative standards and psychological health of older adults (Kuiper & Mchale, 2009).

Old-Age Homes (Alternative shelter for the older)

The concept of institutionalization for older adults has emerged from Western culture. Their norms and values are very different from the collectivist societies in the East. The need of old- age homes cannot be ignored for older adults who are unable to manage their own affairs or anyone who takes care of them. It is an alternative

reservation where older people can share their feelings, tastes, and experiences that they have in this type of settlement. They live in an institutional institution according to certain rules and regulations (Panday, Kiran, Srivastava, & Kumar, 2015).

Old-Age Homes in Pakistan

"Growing old homes in Pakistan", 2017 reported that in Pakistan, parents are considered to be next to God. Here people respect their parents so much that they consider it a sin not to obey their parents. Pakistani parents expect their children to take care of them as they age. When her son marries, they are overjoyed at the arrival of the daughter-in-law, feeling safer and more comfortable. Most Pakistani families respect their parents and take good care of them, but unfortunately there are people who treat their parents as liabilities and feel neglected. Of course, there are rare cases in which parents themselves prefer the privacy of retirement homes, but in most cases, the cold attitude of children forces parents to move into retirement homes. According to the World Health Organization (WHO), 4.2 percent of Pakistan's population is now over 65 years old. The UN-backed Global Age Watch Index 2013 found that Pakistan is the third worst country where a person can grow old ("Pakistan among worst countries to grow old in", 2013)

Najjat Old-Home runs retirement and retirement homes, cares for the elderly, homeless and abandoned people in Rawalpindi It caters to both men and women. The Old Home has all the facilities to meet the personal, medical and social needs of the inmates. The services are provided free of charge. There are 30 senior citizens, including 15 male and 15 female inmates. Gender vies Separate buildings. For medical treatment in emergency situations, all basic facilities are available, including groceries, laundry, medical management by qualified doctors, clothing and emergency services.

Dar-ul-Afiyat, a government agency, is a retirement home that currently accommodates 21 senior citizens over the age of 65. Nineteen males and two females are currently living in Dar-ul-Afiyat. It is located in Muslim Town, Khana Road, Rawalpindi. The Senior Citizen Foundation of Pakistan is a non-governmental non-profit organization dedicated to the well-being of Pakistani seniors. It was founded in 1986 and is based in Islamabad, as well as throughout the country.

Rationale of the study

The current World Health Organization report indicates that 5.6% of Pakistan's populations are over 60 years (Jalal & Younis, 2014). Throughout Pakistan, many older adults are neglected by their families. Their families think that they are a burden for them. In this situation, older adults are admitted to retirement homes. In Pakistan, there is an increasing demand for old-age homes. Meanwhile, there are many old-age homes in Pakistan to support the neglected elderly. Despite this fact, the tradition remains that most families look after older adults. The number of old age homes and older adults living in old-age homes has increased in the past (Ashiq & Asad, 2017). The majority of older adults in retirement homes are those either whose families refuse to take care of them or who have no family. Reason of coming to old homes vary from individual to individual, some of them can be taken up in retirement homes due to no family support, family members do not have time for them, or they may suffer from type of any physical illness (Hayat, Khan, & Sadia, 2016).

Esteem, expertise and piety are the key constructs attached to old age. Getting old is a natural phenomenon. According to the 1998 census, there are 7.3 million senior citizens in Pakistan a sizable growth from 2 million in 1951. Pakistan's society has constantly stood for excessive value, admire and dignity of human existence. The growing older phenomenon begins early in Pakistan and other growing nations, due to poverty and malnutrition (Qureshi, 2017). Especially the Pakistani women enter the old age in 30s due to the social and cultural set-up. Pakistan predominantly is a Muslim nation where family system is inspired by means of Islamic lifestyle and Islamic values, in which appreciate, care and sharing for every other are fundamental norm. But, because of the influx of western media and different outside impacts we see and find western family styles being extra appealing. It is extensively believed that the youngsters want to be extra impartial and the new married couples want to live separately and do no longer want to stay with their mother and father for need of privacy (Gull & Dawood, 2013).

It has been noted that lack of attachment and connection between children and parents and weakening relationships in families has been the reason for old people in families to move to shelter homes (Hayat, Khan, & Sadia, 2016). There has been weakening family bonds where senior citizens in families have been feeling neglected

and unworthy in their family environment. Old age demands affection and the new generation have been becoming materialistic and their attitude towards family has been changing over time (Hayat, Khan, & Sadia, 2016).

With the transition researchers are trying to study the psychological well-being and quality of life among elderly adults living in old age homes and with families. Researchers have established a relationship between anxiety, psychological well-being, social support and quality of life among elderly adults living in old age homes and living with families (Chodzko-Zajko et al., 2009). Researches conducted in indigenous context have found a relationship between anxiety and social support in everyday maintenance activities (Larson, 1990). Researches have extensively studied loneliness, social support, quality of life, fear of death, depression and the physical and social conditions of the elderly (Wiles et al., 2009).

Past literature indicates that older adults experience loneliness more frequently. Current estimates propose that greater than 1,000,000 human beings elderly over 65 frequently or constantly experience loneliness (Jones & Rowbottom, 2010). Social engagement is key determinant of quality of life at any age. Impaired social engagement has been connected with an expansion of health issues. Spending time alone, being widowed, unmarried or divorced, impaired mental health and having a perceived health status are a number of the vulnerability factors for loneliness (Victor & Yang, 2012). Loneliness may also result in extreme health-associated effects. It is one of the foremost factors that lead to depression and is a critical cause of suicide attempts as well (Green et al., 1992). Loneliness and social isolation have been linked with temperament and health. The quality of life decreases with accelerated feeling of loneliness. The psycho-social well-being of elderly adults suffering from loneliness can be lethal and lead to poor health (Golden et al., 2009).

Model of humor (Martin, 2003) has greatly illuminated the complicated and often counter-intuitive relationship between humor style and well-being. It has been found that, relying on how it's far utilized in daily life, humor can positively or negatively related to a wide form of manifestations of psychological well-being (Cann & Collette, 2014).

Elderly who have an Affiliative humor style use humor to attain interpersonal or social rewards. They use humor to entertain others in an effort to enrich the first-rate of social relationships whereas elderly who have a Self-enhancing humor style use humor to acquire intrapersonal rewards, that is, to beautify or keep high quality psychological nicely-being and distance themselves from adversity. They preserve a humorous outlook on lifestyles, dealing with hard instances with the aid of viewing them from a humorous perspective. Accordingly, self-improving humor is intently associated with coping humorousness (Martin, 2003).

People with an aggressive humor style use humor, now not to make interpersonal relationships extra profitable for the self and others, but alternatively as a means of criticizing or manipulating others. They tease and mock at others to demonstrate their superiority over others (Martin, 2003). The aggressive humor fashion has been shown to be unfavorable for interpersonal relationships. Sooner or later, human beings who've a self-defeating humor fashion poke a laugh at their own weaknesses in an effort to ingratiate themselves to others. Additionally they use humor as a means to keep away from confronting problems and dealing with poor emotions (Stieger, Formann, & Burger, 2011). Kuiper and McHale (2009), for instance, observed that humor styles mediate the connection among beliefs about self and low self-esteem.

The present study therefore aims to assess the relationship between loneliness, humor styles and quality of life in elderly people living with families and in old-age homes in Pakistani culture. The current research is also important because it identifies the significant impact of humor styles which is a positive factor among older adults to reduce loneliness, and enhance the quality of life. The study also aims to compare elderly adults living with families and in old age home on major constructs of loneliness, humor and quality of life.

METHOD

Chapter II

METHOD

Objectives

Objectives of present studies are as follows.

1. To find out the relationship between Loneliness, Humor Style and Quality of Life among older adults living in family and in old age homes.
2. To study the role of demographic variables (i.e. age, gender, place of living) with study variables.

Hypotheses

Hypotheses of present studies are as follows.

1. There will be a negative relationship between loneliness and quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) among older adults living with family and in old-age homes.
2. There will be a negative relationship between loneliness and positive humor style (i.e. self-enhancing and self-affiliative humor) in older adults living with family and in old-age homes.
3. There will be a positive relationship between loneliness and negative humor style (i.e. aggressive and self-defeating humor) in older elders living with family and in old-age homes.
4. There will be a negative relationship between quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) and negative humor style (i.e. aggressive and self-defeating humor) in older adults living with family and in old-age homes.
5. There will be a positive relationship between quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) and positive humor style (i.e. self-enhancing and self-affiliative humor) in older adults living with family and in old-age homes.

6. Positive humor style (i.e. self-enhancing and self-affiliative humor) will positively predict quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) in older adults living with family and in old-age homes.
7. Loneliness and negative humor (i.e. aggressive and self-defeating humor) will negatively predict quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) in older adults living with family and in old-age homes.
8. Humor style (i.e. positive and negative humor styles) will mediate relationship between loneliness and quality of life in older adults living with family and in old-age homes.
9. Older adults living in old age homes will score higher on loneliness as compared to older adults living with families.
10. Older adults living with family will score higher on quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) as compared to older adults living in old age homes.

Operational definition of Variables

Loneliness. Loneliness is defined as a response to a discrepancy between desired and achieved levels of social contact and that cognitive process, especially attributions, have a moderating influence on loneliness experiences (Sonderby, 2013). Cut-off scores of 50 or above on Revised-University of California, Los Angeles Loneliness Scale (Russell, 1978) indicates high loneliness and vice versa (Russell, Peplau, & Cutrona, 1980).

Humor Style. Humor style is defined as "the playful recognition, enjoyment, and/or creation of incongruity that allows one to sustain a good mood". The Humor Style Questionnaire (Martin, 2003) assesses uses of humor on the two dimensions; leading to the four styles of humor uses (self affiliative, self-enhancing, aggressive, and self-defeating). Affiliative humor includes jokes about things that everyone might find funny. Self-enhancing humor makes people capable of laughing at oneself, such as making a joke when something bad happened to an individual. Aggressive humor includes devaluations or insults to individuals. Self-defeating humor is to put oneself

in an aggressive manner (Martin, 2003). High scores on each sub-scale indicate high level of humor and vice versa.

Quality of Life. World Health Organization defines the concept of Quality of Life as 'individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (WHO, 2015). Quality of life includes areas such as psychological health, physical health, social relation, environmental health and overall health assessments of life with positive and negative aspects (WHO, 1995). High scores on each domain represent high quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) and vice versa (WHO, 2013).

Instruments

Demographic sheet

For the present study, a demographic sheet was developed. Participants were asked to provide demographic information including age, gender, education, marital status, and total number of family, number of children, source of income, physical illness and duration of illness.

Loneliness Scale Urdu Version

Urdu Version Loneliness Scale (Gul, 2015) was used to measure participants' experience of loneliness. Responses are marked on a 4-point scale (1 = never to 4 = always) how often they felt as described in each item. Scores on this scale could range from 20 to 80. Alpha coefficient of this scale was found to be .89 (Russell, 1996). Cut-off scores of 50 or above on Revised University of California, Los Angeles Loneliness Scale (Russell, 1978) indicates high loneliness and vice versa (Russell, 1980). Item numbers 1, 5, 6, 9, 10, 15, 16, 19, 20 are reverse scored.

Humor Styles Questionnaire

Urdu Version of Humor Style Scale (Khan, 1994)) was used. It consists of 32 items, each of which is a self-descriptive statement about particular uses of humor.

Respondents rate the degree to which each statement describes them on a scale from 1 (totally disagree) to 7 (totally agree). Scores are obtained for 4 subscales that consist 32 items (8 items for each subscale) measuring four humor styles: Affiliative (use of humor to amuse others and facilitate relationships) Self-enhancing (use of humor to cope with stress and maintain a humorous outlook during times of difficulty) Aggressive (use of sarcastic, manipulative, put-down, or disparaging humor) Self-defeating (use of humor for excessive self-disparagement, ingratiation, or defensive denial). Reported Cronbach's alphas for the four subscales were .77, .81, .80 and .75 respectively (Martin, Puhlik-Doris, Larsen, Gray, & Weir & 2003).

Quality of Life Scale (QoL)

Urdu Version of Quality of Life Scale (Khalid & Kausar, 2008) was used. The purpose of this scale is to assess subjective quality of life within the context of and individual's culture, value system, personal goals, standard and concerns. It contains 26 items and addresses four Quality of Life domains. Items number 3, 4, 10, 15, 16, 17, and 18 are related to mobility, daily activities, energy and fatigue, sleep, pain and discomfort. It assesses physical health. Items 5, 6, 7, 11, 19, and 26 are related to self-image negative thought, mentality, and positive attitude. It assesses psychological health. Items number 20, 21, 22 are related to personal relationship, social support and sexual activity and it assess social relationship. Items 8, 9, 12, 13, 14, 23, 24, and 25 are related to financial resource, freedom, physical safety and security, health and social care, it assess environmental health (Khalid & Kausar, 2008).

The reliability of sub-scales was found to be .78, .77, .82, .73 respectively. Item numbers 3, 4 and 26 are reversed. Responses are rated on a 5-point Likert scale with high scores indicating a high quality of life and lower scores indicating lower quality of life (Skevington, 2004).

Research Design

The research was designed to study the phenomena of loneliness, quality of life and humor style among older adults living with family and living in old age homes. This study used comparative study design which is a procedure for collecting, analyzing and quantifying the data in comparison with two different populations

within a single study, to understand the problem more completely (Ollerenshaw & Creswell, 2002). Data was collected by using survey method. The data obtained from the sample was computed as quantitative with the help of SPSS-21. The study also highlighted contemporary issues related to demographics of the sample studied. In order to optimize the perspective of complications of the sample, detailed demographic analysis has been also being conducted at first in the form of graphical representation for the older adults living in old age homes in Rawalpindi/Islamabad and older adults living with family by evaluating the open ended questions answered by the participants illustrated on the demographic sheet (see appendix A).

Sample

A sample of 260 older adults in which older adults living with family were N = 140, (male, n = 72, female, n = 67) whereas, older adults living in old age homes were N = 120 (male, n = 72, female, n = 48) with the age range of 50-77 years, (M = 59.8, SD = 5.80). The data was taken from elderly adults living with families and elderly adults living in old age homes in area of Rawalpindi and Islamabad, Pakistan. Foremost, the consent was taken by the organization conducting research and properly approval from the authorities of old age homes was taken.

Individuals consent was taken from the participant before the administration of questionnaire. Convenience, purposive and snowball sampling techniques were used to gather data. Due to fact that sample had to be living in old age homes, purposive sampling techniques was used in order to gather data. The inclusion criteria consisted of participants at least over 50 year of age and they must be living either with families or in any private or government old age homes.

Demographics of Old-Age Homes and Families

Table 1

Frequency and Percentages along Demographics Variables (N= 260)

Demographics Old-Homes (N=120)	f (%)	**Demographics of families** (N=140)	f (%)
Gender		**Gender**	
Male	72 (60)	Male	73 (52.1)
Female	48 (40)	Female	67 (47.9)
Age		**Age**	
50-60	42 (35)	50-60	88 (62.9)
60 and above	78 (65)	60 and above	52 (37.1)
Marital Status		**Marital Status**	
Married	10 (8.3)	Married	99 (70.7)
Unmarried	3 (2.5)	Unmarried	Nil
Widowed	36 (30)	Widowed	23 (16.4)
Widower	63 (52.5)	Widower	15 (10)
Divorced	8 (6.7)	Divorced	3 (2.1)
Occupation		**Occupation**	
Employed	Nil	Employed	71 (50.7)
Unemployed	90 (75)	Unemployed	17 (12.1)
Retired	25 (20.8)	Retired	27 (19.3)
Other/Business	5 (4.2)	Other/Business	25 (17.9)
Old-Homes in Islamabad/ Rawalpindi		**Residence**	
Najjat Old Age Home	28 (23)	With Children	127 (90.7)
Senior Citizen Foundation	14 (11)	With Relatives	13 (9.3)
Apka Apna Ghar	22 (18)		
Dar-ul-Afiyat Trust	21 (17.5)		
Baghbaan Old Home	19 (15)		
MGQ Trust	16 (13)		

The comparative data sample that has been collected indicates clear differences between the two samples living in two different conditions. Elderly adults

living with family comprised of 52% of males and 47% of females whereas, older adults living in old-age homes had 60% males and 40% of females. 65% of older adults living in old-age homes were above 60 years, whereas 62.9% of older adults living with families had age between 50-60 years.

Table 1 revealed that 70% of the older adults living with family were married, 16% were widowed and 10% as widower. Only 3% were divorced, whereas, for older adults living in institution/ Old-age homes 52% were widower, 30% were widowed, 8% were married and 6% were divorced. 50% of the individuals living with families were employed whereas 75% were unemployed of older adults living in old-age homes.

Procedure

For the data collection of older adults living with family, convenience sampling technique was used. Likewise, sample obtained from old age home was sensitive and collected with snowball sampling technique.

The old age homes included Najjat Old-Age Home, Senior Citizen Foundation, Apka Apna Ghar, Dar-ul-Afiyat Trust, Baghbaan Old-Home and MGQ Trust.

Data was collected through individual administration by selecting individuals over 50 years of age. Likewise, Old age home data collection was conducted after approval from residents' authorities to conduct research data collection. Inform consent was taken from each participant before the instrument was given. Participants were assured that their responses will be kept confidential. Appropriate statistical tests were applied for the analysis of the variables.

RESULTS

Chapter III

Results

The present research aims to study the relationship between Loneliness, Humor styles and Quality of life among elderly adults living with families (*N = 140*) and in old age homes (*N = 120).* Data was analyzed using Statistical Package for Social Sciences (SPSS 21.0 for Windows) for quantitative analysis. This study is based on empirical data so the results have been presented in the form of tables given below. The statistical analysis consists of descriptive and inferential statistics. In descriptive statistics, it includes items of scales/subscales, Cronbach α, mean, standard deviation, range, skewness, and kurtosis. Whereas, inferential statistics Simple linear regression, Pearson Product Moment Correlation, independent sample *t*-test and mediation were included. Furthermore graphs were used to show percentages of group differences for demographics.

The study was conducted on older adults living in old-age homes in the region of Islamabad/Rawalpindi. Data was collected from old-age homes mentioned in table 2. These old-age homes running in order to give shelter, food and care to frail and old individuals. The Old-Age homes organization working currently in Islamabad/Rawalpindi are:

Results of Older Adults living in Old-Age Homes

Table 2

Frequencies and Percentages of currently working old-age homes in Islamabad and Rawalpindi

Old-Age homes	*f* (%)
Najjat Old Age Home	30 (25)
Senior Citizen Foundation	14 (11.6)
Apka Apna Ghar	22 (18.3)
Dar-ul-Afiyat Trust	21(17.5)
Baghbaan Old Home	19 (15.8)
MGQ-Memorial Trust	14 (11.6)

According to the data collected from Islamabad/Rawalpindi, above mentioned Old-Age homes are well equipped, fully utilized and working properly. Only Dar-ul-Afiyat is run by Government authorities and other Old-Age homes are maintained by private authorities working as Non-Profit Organization (NGO). The current working old age homes includes: Najjat Old-Age Home, Senior Citizen Foundation, Apka Apna Ghar, Dar-ul-Afiyat Trust, Baghbaan Old-Home and MGQ Memorial Trust.

Table 3

Frequencies and Percentages of coming into old-age homes (N=120)

Reason for coming to Old-Age homes	***f* (%)**
Relatives left here forcefully	5 (4.2)
Children left here	4 (3.3)
Due to illness	24 (20.0)
Lack of caregiver	57 (47.5)
Domestic problems	28 (23.3)
Poverty/No Shelter	2 (1.7)

The factors that compelled the Old-Age Homes residents for residing in old age homes are summarized above. The most prominent reasons of coming to old-age homes were lack of caregiver (47.5%). The second most common reason of coming to old-age homes were domestic problems (23.3%). Other factors were due to illness (20%), relatives left them forcefully (4.2%), and children do not want to keep the elderly due to their physical and psychological illness (3.3%), and poverty/no shelter were (1.7%).

Figure 1

Percentages showing marital status across elder adults living with family and elder adults living with old age homes

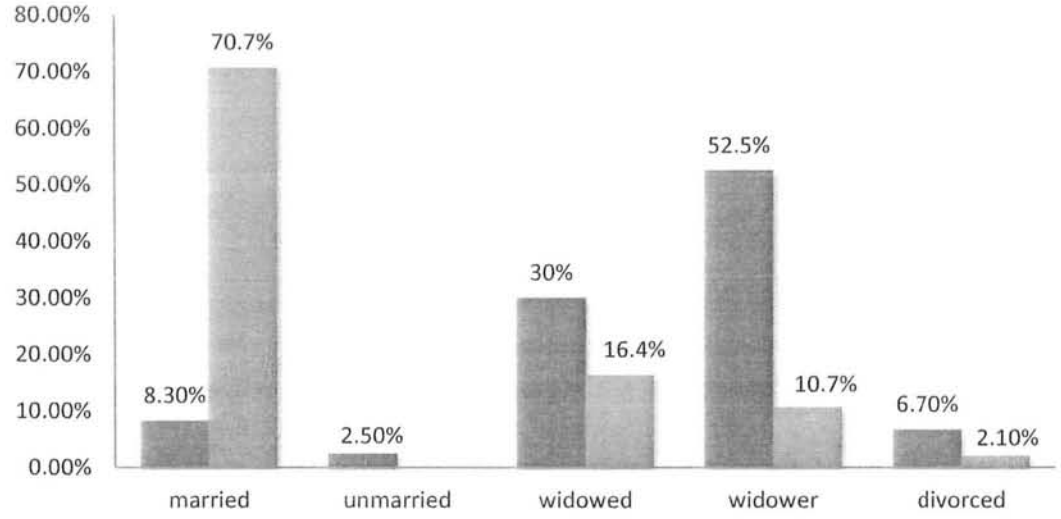


Figure.1 Marital status among older adults living with families and in old-age homes

Figure 1 illustrates a comparative analysis of marital status of elderly adults living in old age home and with families. 70.7% of elderly adults living with families were married as compared to 8.30% of elderly adults living in old age homes. 52.5% of elderly adults living in old age homes were widower in comparison to 10.7% of elderly adults living with family. 30% of females living in old age home were widowed as compared to 16.4% who live with their families.

Table 4

Frequencies and Percentages of the physical health of older adult living in old-age homes (N =120) and living with families (N =140)

	With Families (*N* =140)	Old-Age home (*N* =120)
Type of illness	***f*(%)**	***f*(%)**
No illness	100 (71.4)	20 (16.7)
Tuberculosis	4 (2.9)	10 (8.3)
Blood pressure	12 (8.6)	39 (32.5)
Joint pain	7 (5.0)	14 (11.7)
Hepatitis	4 (2.9)	7 (5.8)
Sugar	2 (1.4)	3 (2.5)
Poor Vision	1 (0.7)	13 (10.8)
Asthma	5 (3.6)	3 (2.5)
Epilepsy	1 (0.7)	3 (2.5)
Typhoid	1 (0.7)	1 (0.8)
Paralyzed	2 (1.4)	6 (5.0)
Heart patient	1 (0.7)	1 (0.8)

Table 4 demonstrates that 71.4% older adults living with families reported no illness in comparison to 16.7% older adults living in old homes. 2.9% of older adults living with families reported tuberculosis as compared to 8.3% of older adults living in old age homes. 32.5% older adults who live in old age homes reported that they have blood pressure comparatively to 8.6% of older adults who lives with families. 11.7% of older adults living in old homes reported joint pain as compared to 5% of older adults living with families. 10.8% of older adults who live in old age homes reported that they have poor vision comparatively to 0.7% of older adults who lives with families. Generally more health related issues have been reported by older adults living in old age homes.

Figure 2

Percentages showing type of illness in individuals living in Old-Age homes and with family (*N = 260*)

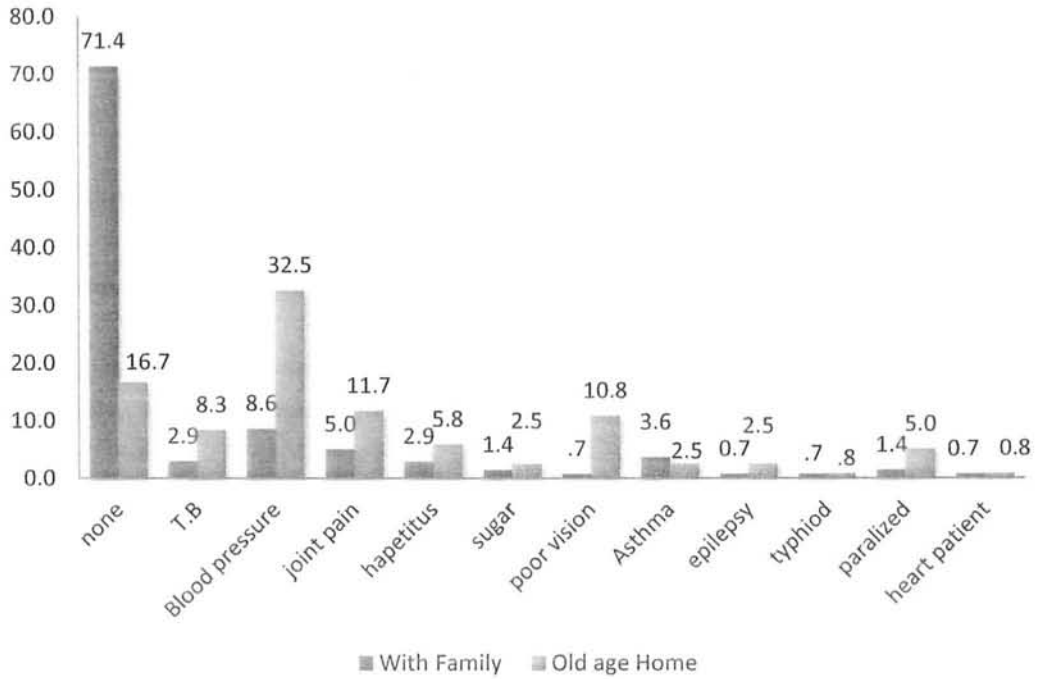


Figure 2 demonstrates types of illness in individuals living in Old-Age homes and with family. According to the results of current study, older adults living in old age homes are more prone to illness because of low family support, lack of caregiver, and unhealthy lifestyle in comparison to older adults living with families.

Figure 3

Visits of family members

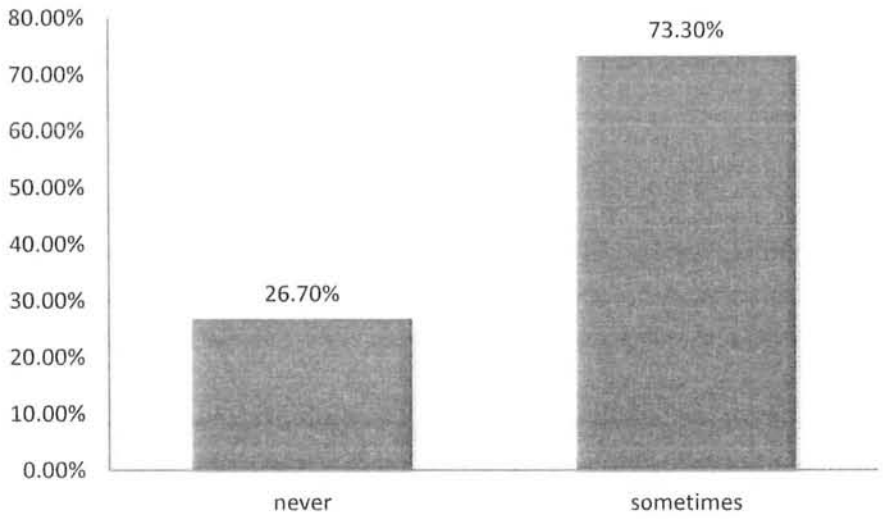


Figure illustrates percentages of visits of family members to meet their elder relatives living in old age homes. 73.30% of elder adults living in old age homes reported that their family members sometime visit whereas, 26.70% of them reported that their family members never visit to see them.

There can be number of reasons which contribute to lack of family visits to old homes but it is evident that visits of family member make them hopeful for life. Empirical researches (Choi & Wyllie, 2008) described that how regularly loved ones visits old homes and its impacts on well-being of elders. Current findings described that family visits were not much frequent, 26.7% reported that their family never visits them in old age home *(see Figure 3)*.

Figure 4

Satisfaction of elderly with living condition in old age homes

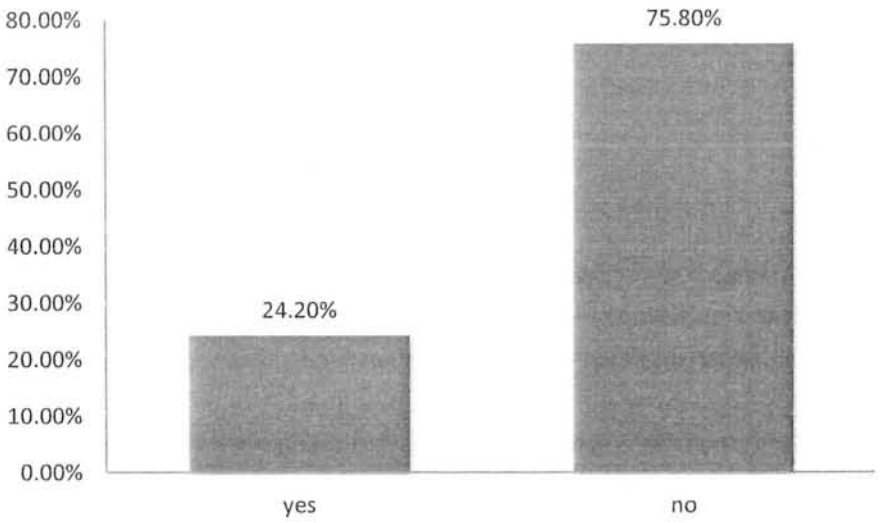


Figure 4 illustrates satisfaction of elderly adults with living conditions of old age homes. 75.8% of elderly adults reported that they are not satisfied with living conditions of old age homes whereas 24.2% reported that they are satisfied.

Figure 5

Problem faced by elderly at old age homes

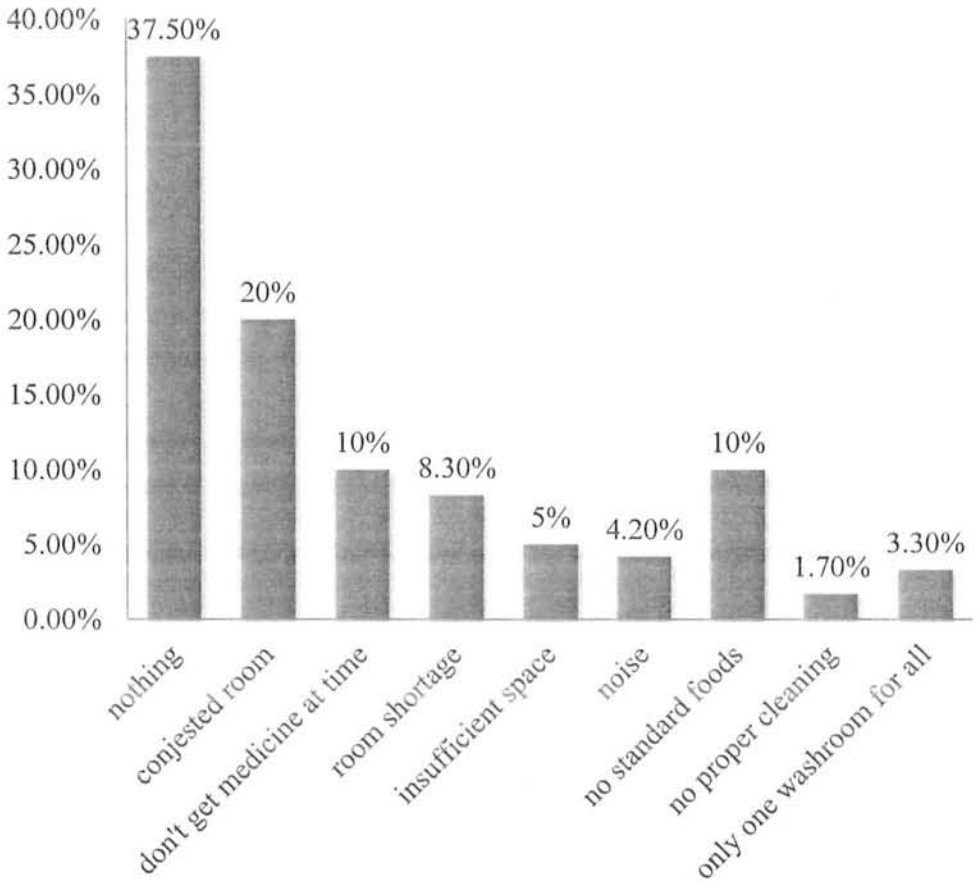


Figure 5 illustrates problems faced by elderly adults in old age homes. 37.5% reported that they don't have any problem whereas 20% reported problem related to room for example sharing room with others and small sizes of rooms. 10% of elderly adults reported prevalence of medicine and food related issues in old age homes.

Descriptive Statistics and Psychometric Properties of Scales

To see the descriptive statistics and psychometric properties alpha coefficients, mean standard deviation, range, skewness and kurtosis of Loneliness Scale Urdu Version (Russell, 1996), Humor Styles Questionnaire Urdu Version (Martin, 2003) and its subscales (Self Affiliative, Self-Enhancing, Aggressive and Self-Defeating) and Quality of Life Scale Urdu Version (WHO, 2003) and its subscales (Overall Health, Physical Health, Psychological Health, Social Relationship and Environmental Health) of older adults living with family(*N = 140*) and living in old-homes (*N =120*).

Table 5

Alpha Coefficient and descriptive statistics Loneliness Scale(Urdu Version), Humor Styles Scale(Urdu Version) and its subscales (Self Affiliative, Self-Enhancing, Aggressive and Self-Defeating) and Quality of Life Scale Urdu Version and its subscales (Overall Health, Physical Health, Psychological Health, Social Relationship and Environmental Health) living with family(N = 140) and living in old-homes (N =120)

	0ld-age home									**With Family**					
		Reliability				**Range**						**Range**			
Scales	Items	old-age	Family	*M*	*SD*	*Potential*	*Actual*	Skew	Kurtosis	*M*	*SD*	Potential	Actual	skew	kurtosis
LN	20	.73	.70	55.02	6.29	20-80	41-68	.04	-.64	33.85	5.36	20-80	23-50	.32	-.12
QoL	26	.91	.88	47.84	10.9	26-130	32-77	.63	-.53	107.9	10.76	26-130	81-124	-.70	-.53
OH	2	.64	.73	3.37	1.21	2-10	2-8	1.03	1.24	8.49	1.30	2-10	6-10	-.26	-1.18
PH	7	.72	.70	16.21	3.62	7-35	9-24	.38	-.69	28.53	3.42	7-35	15-35	-.81	1.09
PsyH	6	.66	.70	10.97	2.50	6-30	7-15	.11	-1.31	25.65	3.16	6-30	17-30	-.80	-.04
SR	3	.63	.62	4.84	1.52	3-15	3-9	.77	.03	12.95	1.88	3-15	4-15	-1.56	1.05
En	8	.87	.62	14.70	4.93	8-40	8-28	1.03	.06	32.32	3.42	8-40	20-39	-.94	1.30
AfH	8	.76	.55	24.01	6.95	8-56	14-48	1.13	.85	45.58	4.30	8-56	30-55	-1.03	.97
SE	8	.86	.66	23.35	8.27	8-56	12-42	.83	-.87	43.40	5.45	8-56	27-54	-.66	-.21
AgH	8	.81	.70	43.15	6.91	8-56	24-53	-1.34	.75	20.78	6.05	8-56	11-41	.62	-.29
SD	8	.59	.84	44.65	3.82	8-56	32-52	-1.17	1.78	19.10	7.92	8-56	10-40	1.13	.20

Note: LN = Loneliness, QOL = Quality of life, OH = Overall Health, PH = Physical Health, PsyH = Psychological Health, SR = Social Relationship, En = Environmental Health, HS = Humor Style, AfH = Affiliative Humor, SE = Self-Enhancing humor, AgH = Aggressive Humor, SD = Self-Defeating Humor

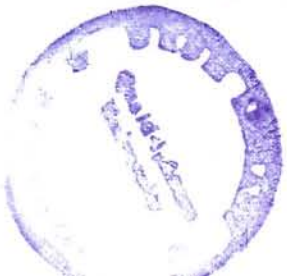


Table 5 shows the descriptive statistics of Loneliness Scale, Quality of life Scale and its subscales; Overall Health, Physical Health, Psychological Health, Social Relationship and Environmental Health and Humor Styles Scale including subscales; Self Affiliative, Self-Enhancing, Aggressive and Self-Defeating among elderly adults living in old age homes and families. Skewness and Kurtosis values of both sample is 2 indicating that the data is normally distributed.

Old age homes

Across Old age homes alpha reliability of loneliness was .73 whereas for quality of life and its sub-scales (Overall Health, Physical Health, Psychological Health, Social Relationship and Environmental Health) were .91, .64, .72, .66, .63, .87 respectively. Cronbach alpha for subscales of humor style (Self Affiliative, Self-Enhancing, Aggressive, and Self-Defeating) were 76, .86, .81, .59 respectively among elderly adults living in old age homes.

Family

Across elderly adults living with families alpha reliability of loneliness was .70 whereas for quality of life and its sub-scales (Overall Health, Physical Health, Psychological Health, Social Relationship and Environmental Health) were .88, .73, .70, .70, .62, .62 respectively. Cronbach alpha for subscales of humor style (Self Affiliative, Self-Enhancing, Aggressive, and Self-Defeating) were .55, .66, .70, .84 among elderly adults living with families.

Table 6

Correlation matrix among variables for older adults living with family (N = 140) and older adults living in old age homes (N = 120)

Variables	Ln	QoL	OH	PH	PsyH	SR	En	AfH	SE	AgH	SD
Ln	-	-.28**	-.21**	-.19*	-.24**	-.35**	-.20*	-.34**	-.15	.28**	.04
QoL	**-.60****	-	.68**	.81**	.88**	.77**	.82**	.46**	.73**	-.74**	-.76**
OH	**-.36****	**.73****	-	.49**	.62**	.55**	.39**	.57***	.62**	-.66**	-.66**
PH	**-.63****	**.84****	**.47****	-	.64**	.49**	.49**	.29**	.60**	-.54**	-.56**
PsyH	**-.59****	**.84****	**.56****	**.64****	-	.60**	.65**	.40**	.72**	-.66**	-.71**
SR	**-.62****	**.53****	**.32****	**.56****	**.37****	-	.61**	.48**	.51**	-.64**	-.55**
En	**-.34****	**.88****	**.69****	**.58****	**.67****	**.24****	-	.30**	.50**	-.59**	-.61**
AfH	**-.39****	**.78****	**.68****	**.52****	**.68****	**.27****	**.80****	-	.51**	-.56**	-.44**
SE	**-.35****	**.76****	**.67****	**.50****	**.71****	**.10**	**.80****	**.85****	-	-.73**	-.76**
AgH	**.33****	**-.69****	**-.61****	**-.45****	**-.64****	**-.25****	**-.70****	**-.79****	**-.77****	-	.83**
SD	**.12****	**-.45****	**-.42****	**-.25****	**-.39****	**-.16**	**-.50****	**-.57****	**-.51****	**.65****	-

Note Ln = Loneliness, QoL = Quality of life, OH = Overall health, PH = Physical Health, PsyH = Psychological Health, SR = Social Relationship, En = Environmental health, HS = Humor style, AfH = Affiliative Humor style, SE = Self-Enhancing humor, AgH = Aggressive Humor, SD = Self-defeating Humor. *$p < .05$, **$p < .01$, ***$p < .001$.
Bold = old age home correlation, Un-bold = Correlation of with family sample

Table 6 demonstrate results of Pearson product moment correlation of study variables that includes Loneliness Scale, Quality of life Scale including subscales; overall health, physical health, psychological health, social relationship and environmental health and Humor Styles Scale including subscales; self affiliative, self-enhancing, aggressive and self-defeating among elderly adults living in old age homes and families. Significant negative correlation was apparent between loneliness, quality of life (overall Health, physical Health, psychological health, social relationship and environmental health) and positive humor (self-affliative and self-enhancing), whereas, significant positive relation was observed between loneliness and negative humor (aggressive and self-defeating) among older adults living in old-age homes and older adults living with families.

Significant positive relationship was apparent between quality of life (overall health, physical health, psychological health, social relationship and environmental health) and positive humor (self-affliative and self-enhancing), while significant negative relation is observed between all domain of quality of life and negative humor. Significant negative relation was apparent between positive humor (self-affliative and self-enhancing) negative humor (aggressive and self-defeating) for both samples.

Predictors of Quality of Life in old age homes ($N = 120$)

To check the simple predictive role of Loneliness, Humor style Scale (Urdu Version) and its subscales (affiliative, self-enhancing, aggressive and self-defeating) for overall Quality of life Simple linear regressions analysis was carried out.

Table 7

Simple linear regression showing the effect of humor style and loneliness on Quality of life of older adults living in old homes (N =120)

				95% CI	
Variables	*B*	*β*	*S.E*	*LL*	*UL*
Constant	69.11		11.74	45.84	92.37
Ln	-.60	-.34***	.08	-.77	-.42
AfH	.52	.33**	.15	.22	.83
SE	.35	.26**	.12	.11	.59
AgH	-.14	-.08	.1	-.41	.13
SD	-.07	-.02	.17	-.42	.28
R^2	.75				
ΔR^2	.74				
F	69.9**				

Note: Ln=loneliness, AfH= Affiliative humor, SE= Self-Enhancing Humor, AgH= Aggressive Humor, SD= Self-Defeating Humor

Table 7 indicates role of Loneliness, Humor style Scale (Urdu Version) and its subscales (Self Affiliative, Self-Enhancing, Aggressive and Self-Defeating) for predicting overall Quality of life. Results revealed that Loneliness and Humor style significantly predicts Quality of life in elderly adults living in old age homes. Overall model explained 74% variance in dependent variable with ($F = 69.9***$, $p = <.00$)

Predictors of Quality of Life with families

To check the predictive role of different humor style and loneliness for quality of life simple linear regression analysis was computed. (Table 8)

Table 8

Simple linear regression showing the effect of Humor style and its subscales (Self Affiliative, Self-Enhancing, Aggressive and Self-Defeating) and Loneliness on Quality of life of older adults living with family (N = 140)

				95% CI	
Variables	*B*	*B*	*S.E*	*LL*	*UL*
Constant	114.27		11.95	90.62	137.92
Ln	-.37	-.18**	.11	-.59	-.15
AfH	-.01	.00	.15	-.32	.29
SE	.54	.27**	.15	.22	.85
AgH	-.24	-.13	.18	-.61	.12
SD	-.58	-.43***	.14	-.86	-.30
R^2	.68				
ΔR^2	.66				
F	57.20**				

Note: Ln=Loneliness, AfH= Affiliative Humor, SE= Self-Enhancing humor, AgH= Aggressive Humor, SD= Self-Defeating Humor

Table 8 illustrates simple linear regression analysis with humor styles and loneliness as predictor variables for quality of life among elder adults living with families. Findings suggest that 66% of variance in quality of life is significantly accounted to loneliness and humor styles.

Mediation Analysis for older adults living in old-age homes

Mediation model is one that seek to identify and explicate the mechanism or process that underlies an observed relationship between an independent variable (X) and a dependent variable (Y) via the inclusion of a third explanatory variable known as a mediator variable (M)

Table 9

Mediation analysis for Positive humor style in Relationship between Loneliness and quality of life among older adults living in old-age homes (N = 120)

Variables	Model 1	Model 2	S.E	95% CI	
	B	*B*		*LL*	*UL*
Constant	105.7***	57.5***	5.74	46.22	68.93
Loneliness	-1.05***	-.60***	.09	-.78	-.43
Positive humor		.50**	.04	.42	.57
R^2	.37	.75			
F	69.21***	174.2***			

*z = -4.31****

Table 9 shows mediating role of positive humor for the relationship between loneliness and quality of life. The results indicate that loneliness negatively predict (*B* = -1.05***) and explain 37% of variance for quality of life. Inclusion of positive humor as mediator in model 2 of regression showed positive prediction (β = .50**) for quality of life. Furthermore, the positive humor mediated the relation between loneliness and quality of life and explained 38% additional variance. Value of Sobel effect is (*z* = -4.31***).

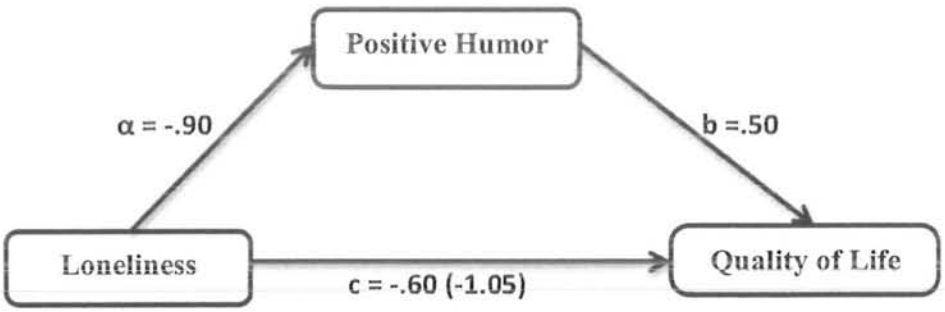


Figure 6. Mediation pathway for Positive humor style in relationship between Loneliness and quality of life among older adults living in old-age homes

Table 10

Mediation analysis for Negative humor style in Relationship between Loneliness and Quality of life among older adults living in old-age homes (N = 120)

	Model 1	Model 2		95% CI	
Variables	*B*	*β*	S.E	*LL*	*UL*
Constant	110.0***	148.8***	6.95	135.1	162.6
Loneliness	-1.0***	-.82***	.10	-1.02	-.61
Negative humor		-.61***	.07	-.75	-.48
R^2	.37	.64			
F	69.5***	102.1***			

z = -3.03***

Table 10 shows mediating role of negative humor for the relationship between loneliness and quality of life. The results indicate that loneliness negatively predict (*B* = -1.05***) and explain 37% of variance. Inclusion of negative humor as mediator in model 2 of regression showed that it negatively predict (*β* = -.61***) quality of life. Furthermore, the negative humor mediated the relation between loneliness and quality of life and explained 27% additional variance. Value of Sobel effect is z = -3.03***

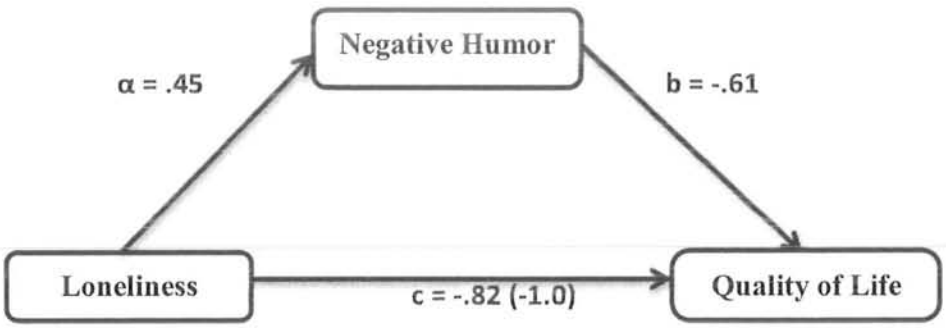


Figure 7. Mediation pathway for Negative humor style in relationship between Loneliness and Quality of life among older adults living in old-age homes

Mediation Analysis for older adults living with families

Mediating role of different types of Humor Styles in predicting quality of life. Mediation model is one that seek to identify and explicate the mechanism or process that underlies an observed relationship between an independent variable (X) and a dependent variable(Y)via the inclusion of a third explanatory variable known as a mediator variable(M)

Table 11

Mediation analysis for Positive humor style in Relationship between Loneliness and quality of life among older adults living with families (N = 140)

	Model 1	Model 2		95% *CI*	
Variables	*B*	*β*	S.E	*LL*	*UL*
Constant	127.4***	38.9***	9.17	20.8	57.0
Loneliness	-.58***	-.21***	.08	-.45	-.04
Positive humor		.85***	.13	.70	1.01
R^2	.08	.50			
F	12.3***	69.8***			

$z = -3.17$***

Table 11 shows mediating role of positive humor for the relationship between loneliness and quality of life. The results indicate that loneliness negatively predict (*B*

= -.58***) and explain 8% of variance in model 1. Inclusion of positive humor as mediator in regression model 2 showed positive prediction (β= .85**) for quality of life and explained 42% additional variance. Sobel effect showed (z = -3.17***). It shows significant indirect effect of positive humor on Quality of life.

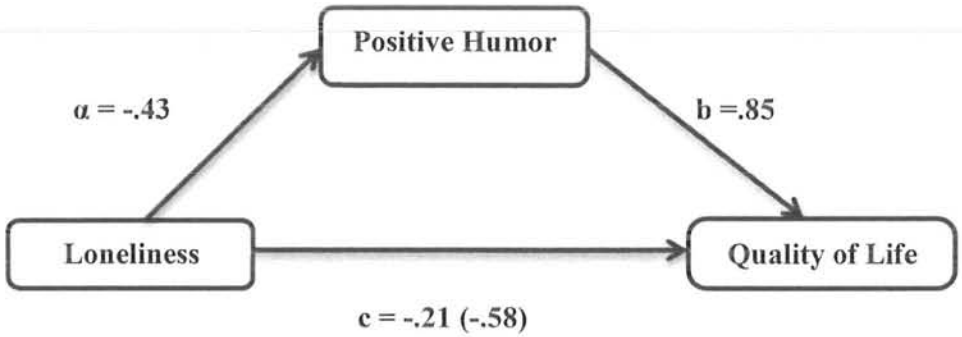


*Figure 8. M*ediation pathways for Positive humor style in relationship between Loneliness and quality of life among older adults living with families

Table 12

Mediation analysis for Negative humor style in Relationship between Loneliness and Quality of life among older adults living with families (N =140)

	Model 1	Model 2		95% *CI*	
Variables	*B*	β	S.E	*LL*	*UL*
Constant	127.4***	143.6***	3.6	136.4	150.9
Loneliness	-.58***	-.33***	.10	-.54	-.13
Negative humor		-.61***	.04	-.69	-.53
R^2	.08	.65			
F	12.3***	126.0***			

z = -1.86***

Table 12 shows mediating role of negative humor for the relationship between loneliness and quality of life. The results indicate that loneliness negatively predict (B = -.58***) quality of life and explain 8% of variance in model 1. Inclusion of negative humor as mediator in model 2 of regression showed negative prediction (β = -.61***) for quality of life. Furthermore, the negative humor mediated the relation between loneliness and quality of life and explained 57% additional variance. Sobel effect

showed (z = -1.86***). It shows significant indirect effect of negative humor on Quality of life.

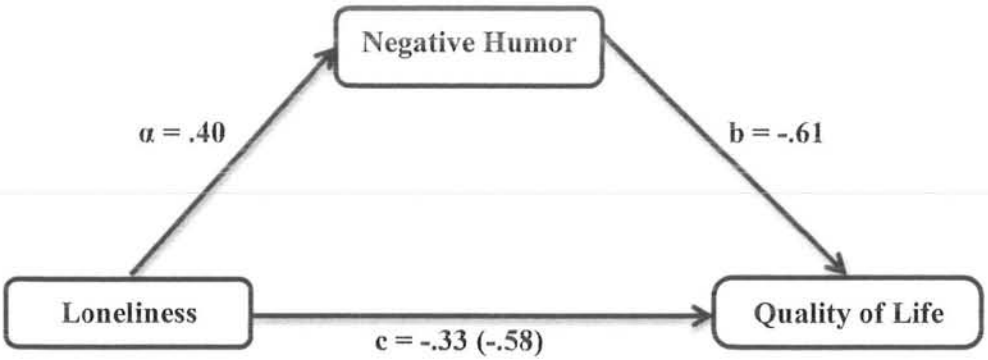


Figure 9 Mediation pathways for Negative humor style in relationship between Loneliness and quality of life among older adults living with families.

Table 13

Differences of study variables loneliness, quality of life and its subscales Overall health, Physical health, Psychological health, Social relationship, Environment, Humor style and its subscales including Affiliative, Self-enhancing Aggressive and Self-defeating humor among elder adults living with families and elder adults living in Old age homes.(N = 260)

	Family (N = 140)		Old home (N = 120)				95% CI		Cohen's
Variables	***M***	***SD***	***M***	***SD***	***t*(258)**	***p***	***LL***	***UL***	*d*
Ln	33.85	5.36	55.02	6.29	29.26	.00	-22.59	-19.74	3.28
QOL	107.96	10.76	47.84	10.90	44.62	.00	57.46	62.77	5.54
OH	8.49	1.30	3.37	1.21	32.51	.00	4.80	5.42	4.07
PH	28.53	3.42	16.21	3.62	28.12	.00	11.45	13.18	3.49
PsyH	25.65	3.16	10.97	2.50	40.95	.00	13.96	15.38	5.15
SR	12.96	1.88	4.84	1.52	37.77	.00	7.69	8.54	4.74
En	32.32	3.42	14.70	4.93	33.81	.00	16.58	18.63	4.15
AfH	45.58	4.30	24.01	6.95	30.50	.00	20.17	22.96	3.73
SE	43.40	5.45	23.35	8.27	23.35	.00	18.35	21.74	2.87
AgH	20.78	6.05	43.15	6.91	27.80	.00	-23.94	-20.78	3.44
SD	19.10	7.92	44.65	3.82	32.25	.00	-27.11	-23.99	4.10

Note: LN = Loneliness, QOL = Quality of life, OH = Overall Health, PH = Physical Health, PsyH = Psychological Health, SR = Social Relationship, En = Environmental Health, HS = Humor Style, AfH = Affiliative Humor, SE = Self-Enhancing humor, AgH = Aggressive Humor, SD = Self-Defeating Humor

Independent Sample t-test has been conducted to study variables loneliness, quality of life and its subscales Overall health, Physical health, Psychological health, Social relationship, Environment, humor style and its subscales including Affiliative humor, Self-enhancing Aggressive humor and Self-defeating humor to see the group difference among older adults living with families and older adults living in Old age homes.

Significant differences were observed in table 10 on loneliness and negative humor style (i.e. aggressive and self-defeating humor) among older adults living in old-age homes and living with families. Elderly adults living in old age homes scored higher on loneliness and negative humor styles as compared to older adults living with families. In comparison older adults living with families scored higher on Quality of life, and positive humor style.

Table 14

Gender differences in loneliness, quality of life and its subscales Overall health, Physical health, Psychological health, Social relationship, Environment, humor style and its subscales including Affiliative humor, Self-enhancing Aggressive humor and Self-defeating humor among elder adults living in old homes (N = 120)

	Male (n = 72)		Female (n = 48)				95% CI		Cohen's
Variables	*M*	*SD*	*M*	*SD*	t(258)	*p*	*LL*	*UL*	d
Ln	54.84	6.16	55.29	6.55	.37	.70	-2.77	1.88	
QOL	48.18	10.93	47.33	10.96	.42	.88	-3.19	4.88	
OH	3.38	1.32	3.35	1.04	.15	.87	-.41	.48	
PH	16.25	3.69	16.16	3.56	.12	.90	-1.26	1.42	
PsyH	11.22	2.46	10.60	2.54	1.32	.18	-.30	1.54	
SR	4.79	1.41	4.91	1.69	.43	.66	-.69	.44	
En	14.73	4.60	14.66	5.43	.75	.27	-1.75	1.89	
AfH	24.22	6.64	23.70	7.46	.39	.69	-2.06	3.08	
SE	24.01	8.55	22.35	7.80	1.07	.28	-1.39	4.71	
AgH	42.84	7.10	43.60	6.67	.58	.55	-3.31	1.80	
SD	44.69	3.93	44.60	3.71	.12	.90	-1.32	1.50	

Note: Ln = Loneliness, OH = Overall Health, PH= Physical Health, PsyH = Psychological Health, SR= Social Relationship, En = Environmental Health, AfH = Affiliative Humor style, SE= Self-enhancing humor, AgH = Aggressive humor, SD = self-defeating Humor

Non-significant differences were apparent on study variables with reference to gender (See table 14)

DISCUSSION

Chapter IV

Discussion

The present study aims to find out the relationship between loneliness, quality of life and humor style among older adults living with families (*N = 140*) and older adults living in old-age homes *(N=120)*. The instruments included demographic sheet, Loneliness Scale Urdu Version III (Russell, 1996) was used to assess participants experience of loneliness; Humor Styles Questionnaire Urdu Version (HSQ) (Martin, 2003) was used to assess the positive humor style (self-affiliative, self-enhancing) and negative humor style, (aggressive, and self-defeating); Quality of life Urdu Version (WHO, 2003) was used to assess subjective quality of life.

In the present study, comparative research method was used. Data has been collected by purposive and convenience sampling technique from older adults living with families, whereas convenience and snowball sampling technique has been used to collect data from old-age homes found in the city of Islamabad, Rawalpindi. The age of the sample ranged from 50 to 80 years (M = 64.6 and SD = 5.36). In order to find out the relationship between variables, Pearson product moment correlation, simple linear regression analysis and independent sample t-test were conducted along with mediational analysis. Comprehensive demographic analysis for the old home population is elaborated for deeper understanding of the population. The descriptive analyses indicate that tools are reliable and data normally distributed. The value of skewness and kurtosis lies within the acceptable range of ±2.

Graphs were used for comparative analysis of both samples. In present study 30% of females living in old age home were widowed as compared to 16.4% who live with their families (*see figure 1)*. Most of the elderly adults living in old age homes were widowed/widower. Reportedly, one of the prominent reasons of elders to stay away from family could be death of spouse. Most of the elderly have been left as single after death of their partner. In Pakistan, the prevalence of remarriage of widowed/divorced is lower among women and men. This is because of the cultural taboos inhabiting widowed/divorced women's and men's remarriage. This contributes to maintain the percentage of widowed or divorced among the older adults in old age homes (Salahuddin & Jalbani, 2006).

Figure 2 illustrates comparison between prevalence of different illnesses among older adults living in old age homes and living with families. Finding of the present study suggested that there is more diseases are prevalent in elder adults living in old-age homes as compared to older adults living with family. Chakrabarti (2009) reported that elderly living in family setting have good health and satisfaction of life as compared to older adults living in old age homes. In present study 10% older adults living in old-age homes reported that they have suffered non availability of standard food which increases higher risk of malnutrition with respect to the elderly population living with families *(see Figure 5)*. Previous findings also identified that malnutrition and lack of care could be reasons of more prevalence of diseases in older adults living in old age homes as compared to older adults living with family (Pai, 2011).

There can be number of reasons which contribute to lack of family visits to old homes but it is evident that visits of family member make them hopeful for life. Empirical researches (Gaugler, Roth, & Mittelman, 2008) described that how regularly loved ones visits old homes and its impacts on well-being of elders. Current study revealed that family visits were not much frequent, 26.7% reported that their family never visits them in old age home *(see Figure 3)*. Despite the fact that they stay away from family, visits from family members and contact could be helpful for enhancing their quality of life. Family involvement is vital for the quality of life of aged. Lack of family support can reduce quality of life in elderly as it may cause loneliness and depression in them. Most of the elderly adults sense happiness and feel satisfied after family visits which affect their overall well-being. According to elderly adults their family members visits them rarely because of their busy routine. Moreover, Elderly adults feel they're no longer essential for their family that's why they experience loneliness frequently (Alam, Singh, Gupta, Bhawnani, & Soni, 2016).

75.8% of elderly adults reported that they are not satisfied with living conditions of old age homes whereas 24.2% reported that they are satisfied (see *Figure 4)*. Previous researches found that life satisfaction is positively related to quality of life. Elderly adults who tended to not satisfied with their living condition possess low quality of life (Yildirim, Kilic, & Akyol, 2013). Common problems reported by older adults in old age homes were congested room and non-availability

of medicines at time that caused them to not satisfy with living conditions of old homes (see *Figure 5).*

Based upon the literature support objectives and hypotheses were tested. First objective was to test the relationship across study variables in older adults living with families and older adults living in old-age homes. *Hypothesis 1* is related to the first objective. It was hypothesized that there will be negative relationship between loneliness and quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) among older adults living with family and in old-age home. Finding of Pearson moment correlation confirmed this hypothesis. Past researches also argue that loneliness leads to impaired quality of life (Dahlberg, Andersson, McKee, & Lennartsson, 2015). The result of linear regression also showed that loneliness is negative predictor of all domains of quality of life. Total variance accounted by model in old home was 74% and with families variance was 66%. Model includes positive and negative humor as well. Poor subjective health (Dahlberg, 2011), decreased health status or impaired quality of life has been found to be associated with loneliness. Other factors that add in quality of life such as presence of chronic diseases or health problems has been related to increase the prevalence of loneliness among elderly adults (Penning, Liu, & Chou, 2014). Decreased health status of the older adults makes social contacts difficult, which in term increase risk for loneliness. Loneliness also causes impaired psychological health which decreased quality of life (Ekwall, Sivberg, & Hallberg, 2005).

It was hypothesized in *Hypothesis 2* that there will be negative relationship between loneliness and positive humor style (Self-enhancing and Self-affiliative) in older adults living with families and living in old-age home. Results of Pearson moment correlation confirmed this hypothesis; previous researches also explained that positive humor impact loneliness negatively and function as a mechanism to reduce loneliness (Schiau, 2016). Positive humor has been regarded as a source of positive emotions, which can distract the individual from negative aspects of life and thus reduce negative feelings and decreases loneliness (Samson & Gross, 2012). According to Caron (2002), humor produces the positive emotion of joy, which helps individuals cope with negative situations. Hampes (2005) found that affiliative and self-enhancing humor style had a moderate negative relationship with loneliness. Theoretically, affiliative humor is an interpersonal form of humor that includes telling

jokes, saying funny things to amuse others, to improve relationships, and reduced loneliness (Martin, 2003). Self-enhancing humor relates to perspective taking and using humor to regulate emotions and cope, as well as to reducing loneliness. By using sense of humor positively in interpersonal relationships feeling of connectedness can be enhance that's why positive humor and loneliness's negatively related to each other in both samples (Martin, 2003).

Hypothesis 3 stated that there will be positive relationship between loneliness and negative humor style (Aggressive and Self-defeating) in older adults living with family and in old-age home. It is evident by findings of previous researches that maladaptive humor style (self-defeating and aggressive humor) involves excessively self-disapproving humor, attempts to amuse others by doing or saying funny things at one's own expense as a means of gaining approval, and laughing along with others when being ridiculed or criticized. Negative humor styles have been associated with maladaptive schemas which increase possibility of depression. Previous researches found that loneliness has been significantly linked with depression (Kazarian & Martin, 2004; Martin, 2003). People who use negative humor tend to have low self-esteem (Peplau & Perlman, 1982; Weiss, 1973) and low self-esteem has also been related with loneliness (Martin, 2003). People with low self-esteem use negative humor which can adversely affect interpersonal relations, as a result make people lonelier (Cecen, 2007).

It was stated in *hypothesis 4* that there will be negative relationship between quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) and negative humor style (Aggressive and Self-defeating) in older adults living with family and in old-age home. The result conducted by Pearson product correlation also revealed that negative humor had negative relation with quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health). Previous literature also supported the findings that the use of maladaptive humor negatively affects the quality of life in older adults (McGuire & Boyd, 1993; Powell & Thorson, 1993). Results of linear regression also showed that negative humor negatively predict quality of life. Model includes positive humor and loneliness as well. Total variance accounted by model in old home was 74% and with families variance was 66%. This result indicated that individuals using positive humor seem to be appealing to other

people as compared to people who use negative humor that act as mean of destroying healthy relationships. When people use humor as a way of insulting others then they themselves can't live happily by lacking satisfaction, happiness and good quality of life. Humor is an element that uses for building satisfying interpersonal relationships instead of demoralizing others by making jokes of them which as a result makes person to live lonely (Hampes, 2005).

Hypothesis 5 stated that quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) will be positively related to positive humor style (self-enhancing and self-affiliative) in older adults living with family and in old-age home. The result of Pearson product correlation revealed that positive humor had positive impact on quality of life. Previous literatures also supported these finding. Results of regression also showed that positive humor positively predict quality of life and accounted for 74% of variance in old home and 66% in older adults living with family. Adaptive humor has been demonstrated for reducing discomfort and easing tension as a result makes life pleasant (Linstead, 1985). Positive humor has been served as a channel (though temporary) for frustration, apathy, resentment, hostility and anger, it can offer an escape from the harshness of reality and lighten the burdens of life in older adults. Incorporating positive humor in interpersonal relations helps individuals to get rid of negativity and enhance quality of life. Positive humor is good for physical and emotional health, reinforces interpersonal relationships with family, friends and coworkers. As a result, person's quality of life increases (Weaver, Richard, & Cotrell, 1987).

Hypothesis 8 stated that humor styles (positive and negative humor) will mediate relationship between loneliness and quality of life in older adult living in old age homes and living with family. In order to check mediating role of humor style (positive and negative humor) mediation analysis were carried out which show significant mediating role of positive and negative humor for both samples. Humor enables a more optimistic outlook to life and enhances quality of life (Kuiper, Martin, & Dance, 1992). Hampes (2005) explored that use of positive humor in life has been linked with healthy interpersonal relationships which as a result increases physical and psychological well-being. Adaptive humor style has been described as mediator for stressors of life (Lefcourt, 2001). Kuiper and Nicholl (2004) proposed that

adaptive humor works as a mediator for relationship of quality of life and loneliness. Previous researches found that humor style work as mediator in relation between loneliness and shyness. Shyness is one of the factors that foster loneliness, individuals tended to use affiliative humor less, which led to more loneliness. Conversely, shy individuals tended to make more use of self-defeating humor style which may affect the quality of life. Shy people usually take an evasive attitude on social interaction, too prone to yield negative emotions, and tend to have a more negative evaluation of themselves and others, which make them less involved in social activities, and thus have a strong sense of loneliness (Ashe & McCutcheon, 2001). Research regarding humor styles and psychological adjustment suggested that endorsement of adaptive humor has been linked with better quality of life. Incorporation of positive humor in life of individual increases social circle reduce feeling of loneliness and as a result enhances quality of life (Martin, 2003).

Hypothesis 9 stated that older adults living in old age homes will score higher on loneliness as compared to older adults living with family. To test the hypothesis, *t*-test was carried out between the older adults living with families and older adults living in old-age homes. The results showed that older adults living in old age homes scored higher on loneliness and negative humor style as compare to older adults living with families. In comparison older adults living with families scored higher on Quality of life (i.e. overall health, physical health, psychological health, social relationship, and environmental health) and positive humor style (i.e. self-enhancing and self-affiliative). Declination of ages comes with dependency on others, feeling of loneliness, lack of caregiver and a worst case of physical illness as well. Loneliness is more prevalent in the population living in old-age homes because the lack of caregiver and domestic problems in their life. The results supported in accordance with the previous research findings. A study conducted by Jakobsson and Hallberg (2005) on older adult reported that loneliness is more prevalent in older adults living in institution as compared to older adult living with families. Living in old-age homes seems to be associated with an increased prevalence of loneliness because people living in old age homes are generally less surrounded by people and love from family as compared to people living with families so they experience more loneliness as they have experienced family life as well which make them nostalgic (Jylha 2004; Nilsson, Lindstrom, & Naden, 2006).

Hypothesis 10 stated that older adults living with family will score higher on quality of life (i.e. overall health, physical health, psychological health, social relationship, environmental health) as compared to older adults living in old-age homes. In order to check the difference, independent sample t-test analysis has been conducted among older adults living with families and older adults living in old-age homes. The results revealed significant higher scores on all domain of quality of life (overall health, physical health, psychological health, social relationship, environmental health) in older adults living with families as compared to older adults living in old-age homes. Many researchers conducted in Pakistan in regards to the quality of life in older adults reported that quality of life is better in individuals who live with family than those who lives in institutionalized setup because elder living in old age homes lack in availability of standard food, proper medicine at time and genuine love and support of family which affect their physical health as well as psychological health (Hayat, Khan, & Sadia, 2016). Quality of life includes many factors including health, interpersonal relations, satisfaction of life so people living with family score high on all these domains of quality of life as compared to elder living in old homes (Grande, Farquhar, Barclay, & Todd, 2009).

Family plays a vital role in every phase of life especially in society like ours where family support is crucial for wellbeing. People living away from families deprived of that family support lead to less life expectancy. Residents of old homes were tears while had speaking their hearts and sharing stories of their lives. They needed only one thing that is time of their loved ones. They were suffering in a lot of ways, e.g. ageing, different types of disease, lack of proper caregiver, lack of family support and lack of home environment. There is a lot to do for elder people of our society. Some of them were highly educated and served their whole life fulfill needs of their family but after getting retired from their jobs, there were no one to support them.

Limitations and Suggestions

Sample of the study was constrained to old-age homes located in twins cities (Islamabad and Rawalpindi).

- By using convenience sampling techniques participants of the study were approached from area of Islamabad/Rawalpindi, that's why findings cannot be

applied to overall population. There can be cultural variations which don't allow generalization of results.

- Self-report measures generate concerns about accuracy of findings.
- It is suggested to future researcher to use longitudinal or mixed method to explore factor that contributes in loneliness and quality of life among older adults living with families and in old-age homes.

Implications

There is a great need of improving life standards of people living in old age homes. The study will help to understand lives of older adults living apart from families. Quality of life should be increased along with efforts to cope effectively with life challenges of older adults living in old-age homes and living with families. This study will help to understand importance of incorporating humor in lives of elderly people for making them feel connected by decreasing loneliness and enhancing their quality of life.

Conclusion

Present study explored relationship between loneliness, quality of life and humor style among older adults living in old-age homes and living with families. Present study has explored that older adults living in old-age homes scored higher on loneliness, negative humor and scored lower on quality of life and positive humor as compared to older adults living with families. Finding of the present study revealed that positive humor positively predicted quality of life among older adults living in old-age homes and living with families. This study has revealed that peoples living with families has more positive humor and they use it as a tool to cope loneliness, consequently they have more happiest and satisfactory life as compare to older adults living in old age homes.

REFERENCES

References

Abot-Okelo, M. (2014). Loneliness among elderly people in Finnish health care institutions. The role of psychological and social wellbeing. *Gerontology*, *57*(6), 549-558.

Agogo, D., Milne, G. R., & Schewe, C. D. (2014). Time benders: A model of subjective aging in aging adults. *Health Marketing Quarterly*, *31*(4), 383-398.

Alam, M. N., Singh, S. P., Gupta, V. S., Bhawnani, D., & Soni, G. P. (2016). A study on mental health status in elderly people of Raipur city, Chhattisgarh, India. *International Journal of Community Medicine and Public Health*, *3*(11), 2982-2986.

Andersson, L. (1998). Loneliness research and interventions: a review of the literature. *Aging & Mental Health*, *2*(4), 264-274.

Arslantas, H., Adana, F., Ergin, F. A., Kayar, D., & Acar, G. (2015). Loneliness in elderly people, associated factors and its correlation with quality of life: A field study from Western Turkey. *Iranian Journal of Public Health*, 44(1), 43–50.

Ashe, D. D., & McCutcheon, L. E. (2001). Shyness, loneliness, and attitude toward celebrities. *Current Research in Social Psychology*, *6*(9), 124-133.

Ashe, D. D., & McCutcheon, L. E. (2001). Shyness, loneliness, and attitude toward older adults. *Current Research in Social Psychology*, *6*(9), 124-133.

Ashiq, U., & Asad, A. Z. (2017). The Rising old age Problem in Pakistan. *Journal of the Research Society of Pakistan*, *54*(2), 43–50.

Baltes, P. B., & Smith, J. (1999). Multilevel and systemic analyses of old age: Theoretical and empirical evidence for a fourth age. In Bengtson, V. L., Schaie, W. K., (Ed.). *Handbook of Theories of Aging* (pp. 153-173). New York, NY: Springer Publishing Company.

Barrientos, A., Gorman, M., & Heslop, A. (2003). Old age poverty in developing countries: contributions and dependence in later life. *World Development*, *31*(3), 555-570.

Bell, R., (2012). WHO European review of social determinants of health and the health divide. *The Lancet*, *380*(9846), 1011-1029.

Bengtson, V. L. (1986). Sociological perspectives on aging, families and the future. Perspectives on aging. *The Journal of Clinical Nursing*, *15*(5), 237-261.

Berger, A. A. (1987). Humor: an introduction. *American Behavioral Scientist*, *30*(3), 6-15.

Berk, R. A. (2001). The active ingredients in humor: Psychophysiological benefits and risks for older adults. *Educational Gerontology*, *27*(3), 323-339.

Berlyne, D. E. (1972). Humor and *its* kind. In J. H. Goldstein & P. E. McGhee (Eds.), *The psychology* of *humor: Theoretical perspectives* and *empirical issues* (pp.43-60). Newyork, NY: Academic.

Beyaztas, F. Y., Kurt, G., & Bolayir, E. (2012). Life satisfaction level of elderly people: a field study in Sivas, Turkey. *Journal of the Pakistan Medical Association*, *62*(3), 221-225.

Bondevik, M., & Skogstad, A. (1996). Loneliness among the oldest old, a comparison between residents living in nursing homes and residents living in the community. *The International Journal of Aging and Human Development*, *43*(3), 181-197.

Borg, C., Hallberg, I. R., & Blomqvist, K. (2006). Life satisfaction among older people (65+) with reduced self-care capacity: the relationship to social, health and financial aspects. *Journal of Clinical Nursing*, *15*(5), 607-618.

Borglin, G., Edberg, A. K., & Hallberg, I. R. (2005). The experience of quality of life among older people. *Journal of Aging Studies*, *19*(2), 201-220.

Bowling, A. (2005). *Ageing well: Quality of life in old age*. McGraw-Hill Education (UK). *Journal of Clinical Nursing*, *15*(5), 607-618.

Broese, M., & Thomese, F. (1996). The relative importance of independent living for the social functioning of the elderly. *Tijdschrift Voor Gerontologie En Geriatrie*, *27*(4), 150-158.

Cacioppo, J & Hawkley, L (2003) Social isolation and health, with an emphasis on underlying mechanisms in Perspectives in Biology and Medicine, *46*(3) Supplement: S39-S52

Cacioppo, J. T., Hawkley, L. C., & Berntson, G. G. (2003). The anatomy of loneliness. *Current Directions in Psychological Science*, *12*(3), 71-74.

Cankovic, S., Ac-Nikolic, E., Mijatovic-Jovanovic, V., Kvrgic, S., Harhaji, S., & Radic, I. (2016). Quality of life of elderly people living in a retirement home. *Vojnosanitetski Pregled*, *73*(1), 42-46.

Cann, A., & Collette, C. (2014). Sense of humor, stable affect, and psychological well-being. *Europe's Journal of Psychology*, *10*(3), 464-479.

Cann, A., Stilwell, K., & Taku, K. (2010). Humor styles, positive personality and health. *Europe's Journal of Psychology*, *6*(3), 213-235.

Caputo, A. (2015). The relationship between gratitude and loneliness: the potential benefits of gratitude for promoting social bonds. *Europe's journal of psychology*, *11*(2), 323-334.

Caron, J. E. (2002). From ethology to aesthetics: Evolution as a theoretical paradigm for research on laughter, humor, and other comic phenomena. *Humor*, *15*(3), 245-282.

Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: a systematic review of health promotion interventions. *Ageing & Society*, *25*(1), 41-67.

Cecen, A. R. (2007). Humor styles in predicting loneliness among Turkish university students. *Social Behavior and Personality: An International Journal*, *35*(6), 835-844.

Celso, B. G., Ebener, D. J., & Burkhead, E. J. (2003). Humor coping, health status, and life satisfaction among older adults residing in assisted living facilities. *Aging & Mental Health*, *7*(6), 438-445.

Cesetti, G., Vescovelli, F., & Ruini, C. (2017). The promotion of well-being in aging individuals living in nursing homes: a controlled pilot intervention with narrative strategies. *Clinical Gerontologist*, *40*(5), 380-391.

Chakrabarti, R. (2009). Locating diversity: race, nativity and place in health disparities research. *Geo Journal*, *74*(2), 107-113.

Chodzko-Zajko, W. J., Proctor, D. N., Singh, M. A. F., Minson, C. T., Nigg, C. R., Salem, G. J., & Skinner, J. S. (2009). Exercise and physical activity for older adults. *Medicine & science in sports & exercise*, *41*(7), 1510-1530.

Choi, K. S., Stewart, R., & Dewey, M. (2013). Participation in productive activities and depression among older Europeans: Survey of Health, Ageing and Retirement in Europe. *International Journal of Geriatric Psychiatry*, *28*(11), 1157-1165.

Choi, N. G., & Wyllie, R. J. (2008). Depression in older nursing home residents: The influence of nursing home environmental stressors, coping, and acceptance of group and individual therapy. *Aging and Mental health*, *12*(5), 536-547.

Collicutt, J., & Gray, A. (2012). "A merry heart doeth good like a medicine": humour, religion and wellbeing. *Mental Health, Religion & Culture*, *15*(8), 759-778.

Cornett, C. E. (1986). *Learning through Laughter: Humor in the Classroom.* Indiana, US: Phi Delta Kappa Educational Foundation Bloomington.

Cornwell, B., Laumann, E. O., & Schumm, L. P. (2008). The social connectedness of older adults: A national profile. *American Sociological Review*, *73*(2), 185-203.

Cristofalo, V. J., Tresini, M., Francis, M. K., & Volker, C. (1999). Biological theories of senescence. In Bengtson, V. L., Schaie, W. K., (Ed.). *Handbook of Theories of Aging,* (pp. 98-112) New York, NY: Springer Publishing Company.

Cumming, E., & Henry, W. E. (1961). *Growing old: The process of disengagement*. New York, NY: *Handbook of Theories of Aging,* (pp. 98-112) New York, NY: Springer Publishing Company.

Cutler, D. (2012). Tackling Loneliness in Older Age. *International Journal of Geriatric Psychiatry*, *28*(11), 1157-1165.

Dahlberg, L. (2011). Loneliness in old age. . *Aging & mental health*, *19*(5), 399-405.

Dahlberg, L., Andersson, L., McKee, K. J., & Lennartsson, C. (2015). Predictors of loneliness among older women and men in Sweden: A national longitudinal study. *Aging & mental health*, *19*(5), 409-417.

Denes, Z. (1980). Loneliness in old age. Zeitschrift fur Alternsforschung, 35(6), 475-480. *Handbook of Theories of Aging* (pp. 98-112). New York, NY: Springer Publishing Company.

Diener, E., & Suh, E. (1997). Measuring quality of life: Economic, social, and subjective indicators. *Social indicators research*, *40*(2), 189-216.

Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological bulletin*, *125*(2), 276-302.

Dong, X. Q., Simon, M. A., (2011). Elder abuse and mortality: The role of psychological and social wellbeing. *Gerontology*, *57*(6), 549-558.

Dozois, D. J., Martin, R. A., & Bieling, P. J. (2009). Early maladaptive schemas and adaptive/maladaptive styles of humor. *Cognitive Therapy and Research*, *33*(6), 585-596.

Dubey, A., Bhasin, S., Gupta, N., & Sharma, N. (2011). A study of elderly living in old age home and within family set-up in Jammu. *Studies on Home and Community Science*, *5*(2), 93-98.

Duncan, W. J. (1984). Perceived humor and social network patterns in a sample of task-oriented groups: A reexamination of prior research. *Human Relations*, *37*(11), 895-907.

Edwards, K. R., & Martin, R. A. (2014). The conceptualization, measurement, and role of humor as a character strength in positive psychology. *Europe's Journal of Psychology*, *10*(3), 505-519.

Ekwall, A. K., Sivberg, B., & Hallberg, I. R. (2005). Loneliness as a predictor of quality of life among older caregivers. *Journal of advanced nursing*, *49*(1), 23-32.

Farquhar, M. (1995). Definitions of quality of life: a taxonomy. *Journal of Advanced Nursing*, *22*(3), 502-508.

Fayers, P. M., & Machin, D. (2013). *Quality of life: the assessment, analysis and interpretation of patient-reported outcomes*. England: John Wiley & Sons. *International Journal of Geriatric Psychiatry*, *28*(11), 1157-1165.

Felce, D., & Perry, J. (1995). Quality of life: Its definition and measurement. *Research in Developmental Disabilities*, *16*(1), 51-74.

Finch, C. E., & Seeman, T. E. (1999). Stress theories of aging. *Handbook of theories of aging*, (pp. 81-97). New York, NY: Springer Publishing Company.

Finch, C. E., Pike, M. C., & Witten, M. (1990). Slow mortality rate accelerations during aging in some animals approximate that of humans. *Science*, *249*(4971), 902-905.

Fitts, S. D., Sebby, R. A., & Zlokovich, M. S. (2009). Humor styles as mediators of the shyness-loneliness relationship. *North American Journal of Psychology*, *11*(2), 257-271.

Forman, D. E., Arena, R., Boxer, R., Dolansky, M. A., Eng, J. J., Fleg, J. L., ... & Lewis, E. F. (2017). Prioritizing functional capacity as a principal end point for therapies oriented to older adults with cardiovascular disease: a scientific statement for healthcare professionals from the American Heart Association. *Circulation*, *135*(16), 894-918.

Fry, W. F. (1986). Humor, physiology, and the aging process. In N. Lucille & A. Kathleen (Eds.) *Gerontologist, Humor and aging* (pp. 81-98). Orlando, FL: Academic Press.

Gaugler, J. E., Roth, D. L., Haley, W. E., & Mittelman, M. S. (2008). Results from the New York University caregiver intervention study. *Journal of the American Geriatrics Society*, *56*(3), 421-428.

Golden, J., Conroy, R. M., Bruce, I., Denihan, A., Greene, E., Kirby, M., & Lawlor, B. A. (2009). Loneliness, social support networks, mood and wellbeing in community-dwelling elderly. *International Journal of Geriatric Psychiatry*, *24*(7), 694-700.

Gorman, M. (1999). Development and the rights of older people. *Health & Social Care in the Community*, *9*(2), 61-71.

Gowri, G. B. (2003). Attitudes towards old age and ageing as shown by humor. *Gerontologist*, *17*(2), 220-226.

Grande, G. E., Farquhar, M. C., Barclay, S. I., & Todd, C. J. (2009). Quality of life measures (EORTC QLQ-C30 and SF-36) as predictors of survival in palliative colorectal and lung cancer patients. *Palliative & Supportive Care*, *7*(3), 289-297.

Green, B. H., Copeland, J. R. M., Dewey, M. E., Sharma, V., Saunders, P. A., Davidson, I. A., & McWilliam, C. (1992). Risk factors for depression in elderly people: a prospective study. *Acta Psychiatrica Scandinavica*, *86*(3), 213-217.

Greengross, G. (2013). Humor and aging-a mini-review. *Gerontology*, *59*(5), 448-453.

Gul, N., (2015) Translation and adaptation: The loneliness scale University of California Los Angeles.

Gull, F., & Dawood, S. (2013). Religiosity and subjective well-being amongst institutionalized elderly in Pakistan. *Health promotion perspectives*, *3*(1), 124-128.

Gupta, A., Mohan, U., Tiwari, S. C., & Singh, V. K. (2014). Quality of life of elderly people and assessment of facilities available in old age homes of Lucknow, India. *National Journal of Community Medicine*, *5*(1), 21-24.

Hallberg, I. R.., Ekwall A. K, & Sivberg, B., (2005). Loneliness as a predictor of quality of life among older caregivers. *Journal of Advanced Nursing*, *49*(1), 23-32.

Hampes, W. P. (2005). Correlations between humor styles and loneliness. *Psychological Reports*, *96*(3), 747-750.

Hawkley, L. C., & Cacioppo, J. T. (2009). Loneliness predicts reduced physical activity: cross-sectional & longitudinal analyses. *Health Psychology*, *28*(3), 354-363.

Hawkley, L. C., & Cacioppo, J. T. (2010). Loneliness matters: a theoretical and empirical review of consequences and mechanisms. *Annals of Behavioral Medicine*, *40*(2), 218-227.

Hayat, S. Z., Khan, S., & Sadia, R. (2016). Resilience, Wisdom, and Life Satisfaction in Elderly Living with Families and in Old-Age Homes. *Pakistan Journal of Psychological Research*, *31*(2), 475-494.

Heinrich, L. M., & Gullone, E. (2006). The clinical significance of loneliness: A literature review. *Clinical psychology review*, *26*(6), 695-718.

Hellstrom, Y., & Hallberg, I. R. (2001). Perspectives of elderly people receiving home help on health, care and quality of life. *Health & Social Care in the Community*, *9*(2), 61-71.

Hellstrom, Y., Persson, G., & Hallberg, I. R. (2004). Quality of life and symptoms among older people living at home. *Journal of Advanced Nursing*, *48*(6), 584-593.

Hendricks, J., & Achenbaum, A. (1999). Historical development of theories of aging. In V. L. Bengtson & K. W. Schaie (Eds.). *Handbook of Theories of Aging* (pp. 21-39). Newyork: Springer Publishing.

Hinton, W. L., & Levkoff, S. (1999). Constructing Alzheimer's: narratives of lost identities, confusion and loneliness in old age. *Culture, Medicine and Psychiatry*, 23(4), 453-475.

Holt-Lunstad, J., Smith , M., Harris, T., & Stephenson, D. (2015). Loneliness and social isolation as risk factors for mortality: a meta-analytic review. *Perspectives on Psychological Science*, *10*(2), 227-237.

Hooyman, N. R., & Kiyak, H. A. (2011). *Social gerontology: A multidisciplinary perspective* (9th ed.). Upper Saddle River, NJ: Pearson. *Health & Social Care in the Community*, *9*(2), 61-71.

Ilmarinen, J. E. (2001). Aging workers. *Occupational and Environmental Medicine*, *58*(8), 546-546.

Iyer, S., & Naganathan, V. (2008). Medication withdrawal trials in people aged 65 years and older. *Drugs & aging*, *25*(12), 1021-1031.

Jacobson, A. M., Braffett, B. H., Cleary, P. A., &. Larkin, M. E., (2013). The long-term effects of type 1 diabetes treatment and complications on health-related quality of life. *Diabetes Care*, *36*(10), 3131-3138.

Jakobsson, U., & Hallberg, I. R. (2005). Loneliness, fear, and quality of life among elderly in Sweden: a gender perspective. *Aging Clinical and Experimental Research*, *17*(6), 494-501.

Jalal, S., & Younis, M. Z. (2014). Aging and elderly in Pakistan. *Ageing International*, *39*(1), 4-12.

Jin, K. (2010). Modern biological theories of aging. *Aging and disease*, *1*(2), 72-74.

Jones, M., & Rowbottom, C. (2010). The role of telecare in overcoming social exclusion in older people. *Journal of Assistive Technologies*, *4*(3), 54-59.

Joung, H.-M., & Miller, N. J. (2007). Examining the effects of fashion activities on life satisfaction of older females: Activity theory revisited. *Family and Consumer Sciences Research Journal, 35*(4), 338–356.

Jylha, M. (2004). Old age and loneliness: cross-sectional and longitudinal analyses in the Tampere Longitudinal Study on Aging. *Canadian Journal on Aging/La Revue Canadienne Du Vieillissement*, *23*(2), 157-168.

Kazarian, S. S., & Martin, R. A. (2004). Humor styles, personality, and well-being among Lebanese university students. *European journal of Personality*, *18*(3), 209-219.

Kennedy, (2008). A Toddler's Use of Humor To Explore, Interpret, and Negotiate Her Familial Environment During a Day in the Life. *Journal of Research in Childhood Education*, *23*(1), 5-18.

Khan, G. (1994). Dermatology Life Quality Index (DLQI), a simple practical measure for routine clinical use. *Clinical and Experimental Dertmatology*, 19(3), 210-216.

Khalid, T., & Kausar, R. (2008). Depression and quality of life among caregiver of people affected by stroke. *Asia Pacific Disability Rehabilitation Journal, 19*(2), 103-110.

Khan, M. N., Jais, P., Cummings, J., Di Biase, L., Sanders, P., Martin, D. O., & Potenza, D. (2008). Pulmonary-vein isolation for atrial fibrillation in patients with heart failure. *New England Journal of Medicine*, *359*(17), 1778-1785.

Kharat, S. M., Sagare, S. M., & Pandve, H. T. (2009). Comparative Study of Nutritional Status among Elderly Population Residing in Community Dwellings and Old Age Homes. *Health & Social Care in the Community,* 4(2)15-18.

Kim, J., Larose, R., & Peng, W. (2009). Loneliness as the cause and the effect of problematic Internet use: The relationship between Internet use and psychological well-being. *Cyber Psychology & Behavior*, *12*(4), 451-455.

Kirkwood, T. B. (2005). Understanding the odd science of aging. *Cell*, *120*(4), 437-447.

Kohli, M. (1988). Ageing as a challenge for sociological theory. *Ageing & Society*, *8*(4), 367-394.

Kowal, P., & Dowd, J. E. (2001). Definition of an older person. Proposed working definition of an older person in Africa for the MDS Project. *Journal of Psychology* 13(12), 173-183

Kuiper, N. A. (2012). Humor and resiliency: Towards a process model of coping and growth. *Europe's*, *8*(3), 475-491.

Kuiper, N. A., & McHale, N. (2009). Humor styles as mediators between self-evaluative standards and psychological well-being. *The Journal of psychology*, *143*(4), 359-376.

Kuiper, N. A., & Nicholl, S. (2004). Thoughts of feeling better; Sense of humor and physical health. *Humor*, *17*(2), 37-66.

Kuiper, N. A., Martin, R. A., & Dance, K. A. (1992). Sense of humour and enhanced quality of life. *Personality and Individual Differences*, *13*(12), 1273-1283.

Kundu, R., Sethi, N., Ghose, A., & Chaudhary, R. (2013). Age old dapsone in the treatment of idiopathic thrombocytopenic purpura-A case report with review. *American Journal of Therapeutics*, *20*(6), 723-725.

Larson, R. W. (1990). The solitary side of life: An examination of the time people spend alone from childhood to old age. *Developmental review*, *10*(2), 155-183.

Lefcourt, H. M. (2001). The humor solution. In C. R, Snyder (Ed.) *Coping with stress: Effective people and processes* (pp. 68-92). New York: University Press.

Lindeboom, M., Portrait, F., & Van den Berg, G. J. (2002). An econometric analysis of the mental-health effects of major events in the life of older individuals. *Health Economics*, *11*(6), 505-520.

Linstead, S. (1985). Jokers wild: The importance of humour in the maintenance of organizational culture. *The Sociological Review*, *33*(4), 741-767.

Lippa, R. A. (2007). The preferred traits of mates in a cross-national study of heterosexual and homosexual men and women: An examination of biological and cultural influences. *Archives of Sexual Behavior*, *36*(2), 193-208.

Lodico, C. A. (1998). *An investigation of the efficacy of a stress-management intervention that utilizes humor as a central aspect of the program* (Doctoral dissertation). University of central Florida, US.

Lopez-Otín, C., Blasco, M. A., Partridge, L., Serrano, M., & Kroemer, G. (2013). The hallmarks of aging. *Cell*, *153*(6), 1194-1217.

Maddox, G. L. (1970). Themes and issues in sociological theories of human aging. *Human Development*, *13*(1), 17-27.

Martin, R. A. (2003). Sense of humor. Positive psychological assessment: A handbook of models and measures, *Journal of Psychology*, 4(1), 313-326.

Martin, R. A., & Chen, G. H. (2007). A comparison of humor styles, coping humor, and mental health between Chinese and Canadian older adults living with families. *Health & Social Care in the Community*, 3(2), 281-221

Martin, R. A., & Dance, K. A. (1993). Humor, coping with stress, self-concept, and psychological well-being. *Health & Social Care in the Community*, *9*(2), 61-71.

Martin, R. A., & Lefcourt, H. M. (2004). Sense of humor and physical health: Theoretical issues, recent findings, and future directions. *Humor and Health*, *17*(2), 1-20.

Martin, R. A., Puhlik-Doris, P., Larsen, G., Gray, J., & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of Research in Personality*, *37*(1), 48-75.

Mathieu, S. I. (2008). Happiness and humor group promotes life satisfaction for senior center participants. *Activities, Adaptation & Aging*, *32*(2), 134-148.

McGhee, P. E., & Goldstein, J. H. (2014). The psychology of humor: Theoretical perspectives and empirical issues. Elsevier Science. *Journal of Research in Personality*, *9*(1), 111-115.

McGuire, F. A., & Boyd, R. K. (1993). The role of humor in enhancing the quality of later life. *Sage Focus Edition*, *161*(2), 164-164.

Mezuk, B., Choi, M., DeSantis, A. S., Rapp, S. R., Roux, A. V. D., & Seeman, T. (2016). Loneliness, Depression, and Inflammation: Evidence from the Multi-Ethnic Study of Atherosclerosis. Public Library of Science *one*, *11*(7), e0158056.

Miczo, N. (2004). Humor ability, unwillingness to communicate, loneliness, and perceived stress: Testing a security theory. *Communication Studies*, *55*(2), 209-226.

Minayo, M. C. D. S., Hartz, Z. M. D. A., & Buss, P. M. (2000). Quality of life and health: a necessary debate. *Ciência & Saúde Coletiva*, *5*(1), 7-18.

Mio, J. S., & Graesser, A. C. (1991). Humor, language, and metaphor. *Metaphor and Symbol*, *6*(2), 87-102.

Mushtaq, R., Shoib, S., Shah, T., & Mushtaq, S. (2014). Relationship between loneliness, psychiatric disorders and physical health. A review on the psychological aspects of loneliness. *Journal of clinical and diagnostic research, 8*(9), 30-35.

Nahemow, L. (2001). Humor and Grenetology: Nilsen English Department Arizona State University Tempe,. *Educational Gerontology*, *27*(4), 323-339.

Neugarten, B. L. (1996). *The meanings of age: Selected papers*. University of Chicago Press. *Health & Social Care in the Community*, *9*(2), 61-71.

Nilsson, B., Lindström, U. Å., & Nåden, D. (2006). Is loneliness a psychological dysfunction? A literary study of the phenomenon of loneliness. *Scandinavian Journal of Caring Sciences*, *20*(1), 93-101.

Ollerenshaw, J. A., & Creswell, J. W. (2002). Narrative research: A comparison of two restorying data analysis approaches. *Qualitative Inquiry*, *8*(3), 329-347.

Ollonqvist, K., Palkeinen, H., Aaltonen, T. (2008). Alleviating loneliness among frail older people–findings from a randomised controlled trial. *International Journal of Mental Health Promotion*, *10*(2), 26-34.

Pai, M. K. (2011). Comparative study of nutritional status of elderly population living in the home for aged vs those living in the community. *Biomedical Research,* 22(1), 120-126.

Pakistan among worst countries to grow old in (2013, October 2), *Dawn News.* Retrieved from https://www.dawn.com/news/1046917/Pakistan-among-worst-countries-to-grow-old-in.

Panday, R., Kiran, M., Srivastava, P., & Kumar, S. (2015). A study on quality of life between elderly people living in old age home and within family setup. *Dysphrenia*, *6*(2), 128-131.

Pavot, W., & Diener, E. (2004). The subjective evaluation of well-being in adulthood: Findings and implications. *Ageing International*, *29*(2), 113-135.

Penning, M. J., Liu, G., & Chou., (2014). Measuring loneliness among middle-aged and older adults: the UCLA and de Jong Gierveld Loneliness Scales. *Social Indicators Research*, *118*(3), 1147-1166.

Peplau, L.A.; Perlman, D. (1982). "Perspectives on loneliness". In Peplau, Letitia Anne, Perlman & Daniel (Eds.). *Loneliness: A Sourcebook of Current Theory, Research and Therapy (*pp. 1-18). New York: John Wiley and Sons.

Perlman, D. (2004). European and Canadian studies of loneliness among seniors. *Canadian Journal on Aging/La Revue Canadienne Du Vieillissement*, *23*(2), 181-188.

Perlman, D., & Peplau, L. A. (1982). "Perspectives on loneliness". In Peplau, Letitia Anne, Perlman & Daniel (Eds.). *Loneliness: A Sourcebook of Current Theory, Research and Therapy (*pp. 1-18). New York: John Wiley and Sons.

Peterson, C., & Seligman, M. E. (2007). Strengths of character, orientations to happiness, and life satisfaction. *The Journal of Positive Psychology*, *2*(3), 149-156.

Pitkala, K., & Tilvis, R. S. (2003). Long-term changes in mood of an aged population: repeated Zung-tests during a 10-year follow-up. *Archives of gerontology and geriatrics*, *36*(2), 185-195.

Pittman, M., & Reich, B. (2016). Social media and loneliness: Why an Instagram picture may be worth more than a thousand Twitter words. *Computers in Human Behavior*, *62*(3), 155-167.

Pollak, J. P., & Freda, P. D. (1997). Humor, learning, and socialization in middle level classrooms. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, *70*(4), 176-178.

Prince, M. J., Harwood, R. H., Blizard, R. A., Thomas, A., & Mann, A. H. (1997). Social support deficits, loneliness and life events as risk factors for depression in old age. The Gospel Oak Project VI. *Psychological medicine*, *27*(2), 323-332.

Proyer, R. T., Ruch, W., & Müller, L. (2010). Sense of humor among the elderly. *Zeitschrift für Gerontologie und Geriatrie*, *43*(1), 19-24.

Qualter, P., Vanhalst, J., Harris, R., Van Roekel, E., Lodder, G., Bangee, M., ... & Verhagen, M. (2015). Loneliness across the life span. *Perspectives on Psychological Science*, *10*(2), 250-264.

Qureshi, K. (2017). Ageing: Gender, Social class and Health in Pakistan. *The Journals of Gerontology Series A: Biological sciences and medical sciences*, *56*(2), 23-35.

Rainsberger, C. D. (1994). Reducing Stress and Tension in the Classroom through the Use of Humor. *The Journal of Positive Psychology*, *2*(3), 149-156.

Rayirala, A., Nallapaneni, N. R., Bhogaraju, A., & Mandadi, G. D. (2016). A cross sectional comparative study assessing the psychiatric morbidity in elderly living in old age homes and community. *Archives of Mental Health*, *15*(1), 89-92.

Rejeski, W. J., & Mihalko, S. L. (2001). Physical activity and quality of life in older adults. *The Journals of Gerontology Series A: Biological sciences and medical sciences*, *56*(2), 23-35.

Robinson, V. M. (1983). Humor and health. *Handbook of humor research*, *2*(2), 109-128.

Salahuddin, K., & Jalbani, A. A. (2006). Senior Citizens: A Case Study of Pakistan. *Journal of Independent Studies and Research (JISR)*, *4*(2), 26-31.

Samson, A. C., & Gross, J. J. (2012). Humour as emotion regulation: The differential consequences of negative versus positive humour. *Cognition & emotion*, *26*(2), 375-384.

Sangar, M. A., Karem, F. A., Alireza, N. N., & Muaf, A. K. (2015). Old age satisfaction regarding geriatric home services in Erbil city. *Journal of medicine and life*, *8*(3), 195-198.

Saroglou, V., Lacour, C., & Demeure, M. E. (2010). Bad humor, bad marriage: Humor styles in divorced and married couples. *Europe's Journal of Psychology*, *6*(3), 94-121.

Savikko, N. (2008). Loneliness of older people and elements of an intervention for its alleviation. *International Migration Review*, *38*(3), 1160-1205.

Savikko, N., Routasalo, P. (2005). Predictors and subjective causes of loneliness in an aged population. *Archives of Gerontology and Geriatrics*, *41*(3), 223-233.

Schiau, I. (2016). Loneliness, Social Interactions and Sense of Humor. A Quantitative Study Comparing Romanian Students and Older Adults. *Studies and scientific researches. Economics edition*, 23(2), 133-144.

Shammi, P., & Stuss, D. T. (2003). The effects of normal aging on humor appreciation. *Journal of the International Neuropsychological Society,* 9(6), 855-863.

Sharma, S., & Mahajan, N. (2015). Menopausal symptoms and its effect on quality of life in urban versus rural women: A cross-sectional study. *Journal of Mid-life Health*, *6*(1), 16-20.

Shuster, M. (2013). Humor as an Optics: Bergson and the Ethics of Humor. *Journal of the Gerontology and Geriatrics*, *28*(3), 618-632.

Simon, J. M. (1988). Humor and the older adult: implications for nursing. *Journal of Advanced Nursing*, *13*(4), 441-446.

Simon, J. M. (1990). Humor and its relationship to perceived health, life satisfaction, and morale in older adults. *Issues in Mental Health Nursing*, *11*(1), 17-31.

Singh, B., & Kiran, U. V. (2013). Loneliness among elderly women. *International Journal of Humanities and Social Science Invention*, *2*(2), 10-14.

Singh, S., Raut, N. B., Subramanyam, A. A., Kamath, R., Pinto, C., & Shanker, S. (2014). Perception of old age and self: A comparative study of elderly females living in community and in old age home. *Journal of Geriatric Mental Health*, *1*(1), 32-37.

Sintonen, H. (2001). The 15D instrument of health-related quality of life: properties and applications. *Annals of Medicine*, *33*(5), 328-336.

Sivertsen, H., Bjorklof, G. H., Engedal, K., Selbaek, G., & Helvik, A. S. (2015). Depression and quality of life in older persons: a review. *Dementia and Geriatric Cognitive Disorders*, *40*(6), 311-339.

Skaff, M. L. (2007). *Predicting longitudinal loneliness in older adults* (Master dissertation). Lowa State University. Capstone.

Skevington, S. M., Lotfy, M., & O'Connell, K. A. (2004). The World Health Organization's WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of life Research*, *13*(2), 299-310.

Smith, J., & Baltes, P. B. (1999). Trends and profiles of psychological functioning in very old age. *The Berlin Aging Study. Aging from*, *70*(3), 197-226.

Smith, K., & Victor, C. (2018). Typologies of loneliness, living alone and social isolation and their associations with physical and mental health. *Ageing and Society*, *12*(4), 73-78.

Solomon, J. C. (1996). Humor and aging well: a laughing matter or a matter of laughing?. *American Behavioral Scientist*, *39*(3), 249-271.

Sonderby, L. C., & Wagoner, B. (2013). Loneliness: An integrative approach. *Journal of Integrated Social Sciences*, *3*(1), 1-29.

Steele, K. E. (1998). The Positive and Negative Effects of the Use of Humor in the elderly adults. *Journal of Personality and Social Psychology*, 75(5), 1333-1349.

Stieger, S., Formann, A. K., & Burger, C. (2011). Humor styles and their relationship to explicit and implicit self-esteem. *Personality and Individual Differences*, *50*(5), 747-750.

Thane, P. (1978). Muddled history of retiring at 60 and 65. *New Society*, *45*(826), 234-236.

Theeke, L. A., & Mallow, J. A. (2015). The development of listen: a novel intervention for loneliness. *Open journal of nursing*, *5*(2), 136-143.

Theofilou, P. (2013). Quality of Life: Definition and Measurement. *Europe's journal of psychology*, *9*(1), 21-34.

Thorson, J. A., & Powell, F. C. (1993). Development and validation of a multidimensional sense of humor scale. *Journal of clinical psychology*, *49*(1), 13-23.

Tilvis, R. S., Laitala, V., Routasalo, P. E., & Pitkala, K. H. (2011). Suffering from loneliness indicates significant mortality risk of older people. *Journal of aging research*, *20*(5), 1-5.

Trindade, L. S., Aigaki, T., Peixoto, A. A., Balduino, & Heddle, J. G. (2013). A novel classification system for evolutionary aging theories. *Frontiers in genetics*, *4*(3), 25-29.

Tse, M. M., Lo, A. P., Cheng, T. L., Chan, E. K., Chan, A. H., & Chung, H. S. (2010). Humor therapy: relieving chronic pain and enhancing happiness for older adults. *Journal of aging research*, *20*(6), 1-9.

Upadhayay, B. K., & Khokhar, C. P. (2006). Personality Traits and Feeling of Loneliness in Unemployed Youths. *Europe's Journal of Psychology*, *2*(4), 183-203.

Victor, C. R., & Yang, K. (2012). The prevalence of loneliness among adults: a case study of the United Kingdom. *The Journal of psychology*, *146*(2), 85-104.

Victor, C. R., Scambler, S. J., Bowling, A. N. N., & Bond, J. (2005). The prevalence of, and risk factors for, loneliness in later life: a survey of older people in Great Britain. *Ageing & Society*, *25*(6), 357-375.

Victor, C., Scambler, S., & Bond, J. (2008). *The Social World Of Older People: Understanding Loneliness And Social Isolation In Later Life: Understanding Loneliness and Social Isolation in Later Life*. United Kingdom: McGraw-Hill Education.

Victor, C., Scambler, S., & Bowling, A. (2000). Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology*, *10*(4), 407-417.

Vincent, J. A. (2006). Ageing contested: Anti-ageing science and the cultural construction of old age. *Sociology*, *40*(4), 681-698.

Vitorino, L. M., Paskulin, L. M. G., & Vianna, L. A. C. (2013). Quality of life of seniors living in the community and in long term care facilities: a comparative study. *Revista latino-americana de enfermagem*, *21*(4), 3-11.

Wai, K. M. (2015). Impact of social support networks on loneliness among the older persons in Myanmar. Suffering from loneliness indicates significant mortality risk of older people. *Journal of aging research*, *20*(5), 11-53.

Walecka-Matyja, K. K. (2017). Relationship with siblings as a predictor of empathy and humor styles in early adulthood. *Archives of Psychiatry and Psychotherapy*, *3*(4), 43-51.

Wanzer, M. B., Booth-Butterfield, M., & Booth-Butterfield, S. (1996). Are funny people popular. An examination of humor orientation, loneliness, and social attraction. *Communication Quarterly*, *44*(1), 42-52.

Watts-Roy, D. M. (2008). Delaying Aging and Extending Life–An Ancient Dream Revisited: Using Body Regimens as a Window to Reflect on Aging, Identity, and the Body (Doctoral dissertation). Boston College, Massachusetts.

Weaver, I. I., Richard, L., & Cotrell, H. W. (1987). Ten specific techniques for developing humor in the classroom. *Education*, *108*(2), 167-179.

Weinert, B. T., & Timiras, P. S. (2003). Invited review: Theories of aging. *Journal of Applied Physiology*, *95*(4), 1706-1716.

Weiss, R. S. (1973). Loneliness in senior citizenship living in institution: The experience of emotional and social isolation. *Health Economics*, *11*(6), 505-520

Wenger, G. C., Davies, R., Shahtahmasebi, S., & Scott, A. (1996). Social isolation and loneliness in old age: review and model refinement. Ageing & Society, *16*(3), 333-358.

Wernher, I., & Lipsky, M. S. (2015). Psychological theories of aging. Disease-a-Month, *61*(11), 480-488.

WHO Group. (2003). Loneliness, health and depression in older males. *Aging & mental health*, *7*(3), 212-216.

WHOQoL Group. (1995). The World Health Organization quality of life assessment (WHOQOL): position paper from the World Health Organization. *Social science & medicine*, *41*(10), 1403-1409.

Wiles, J. L., Allen, R. E., Palmer, A. J., Hayman, K. J., Keeling, S., & Kerse, N. (2009). Older people and their social spaces: A study of well-being and attachment to place in Aotearoa New Zealand. *Social Science & Medicine*, *68*(4), 664-671.

World Health Organization. (2013). Definition of an older or elderly person: proposed working definition of an older person in Africa for the MDS Project. Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology*, *10*(4), 407-417.

World Health Organization. (2015). World health statistics: monitoring health for the SDGs sustainable development goals. *Quality of life Research*, *4*(2), 29-35

World Health Organization's WHOQOL-BREF (2004). Quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Quality of life Research*, *13*(2), 299-231

Wrvs, G. (2012). Loneliness amongst older people and the impact of family connections. Being alone in later life: loneliness, social isolation and living alone. *Reviews in Clinical Gerontology*, *10*(4), 407-417.

Yildirim, Y., Kilic, S. P., & Akyol, A. D. (2013). Relationship between life satisfaction and quality of life in Turkish nursing school students. *Nursing & health sciences*, *15*(4), 415-422.

Zhao, J., Kong, F., & Wang, Y. (2012). Self-esteem and humor style as mediators of the effects of shyness on loneliness among Chinese college students. *Personality and Individual Differences*, *52*(6), 686-690.

Ziv, A. (1981). The self concept of adolescent humorists. *Journal of adolescence*, *4*(2), 187-197.

Ziv, A. (1988). Teaching and learning with humor: Experiment and replication. *The Journal of Experimental Education*, *57*(1), 4-15.

APPENDICES

Annexure-A

معلوماتی شیٹ برائے سروے

السلام وعلیکم!

میرا نام سید طہ رضوی ہے۔ میں قائداعظم یونیورسٹی اسلام آباد میں ایم ایس سی کا طالب علم ہوں۔ یہ ایک تعلیمی اور تحقیقی ادارہ ہے۔ اور مختلف موضوعات پر تحقیق کرتا ہے۔ یہ تحقیق بھی اسی سلسلے کی ایک کڑی ہے اس تحقیق کا مقصد گھروں اور فلاحی اداروں میں رہائش پذیر بزرگوں کا موازنہ کرنا ہے۔ اس تحقیق میں آپ کی شرکت رضا کارانہ ہے۔ آپ کو چار سوالنامے دیئے جائیں گے اور آپکی رائے دریافت کی جائے گی۔ ہر سوالنامے کو پر کرنے کے لیے الگ سے ہدایت دی گی ہیں۔ آپ سے درخواست ہے کہ ہدایات کے مطابق ہر سوالنامے کو پر کریں۔ آپ کو یہ یقین دلایا جاتا ہے کہ آپ کی رائے کو صرف تحقیقی مقاصد کے لیے استعمال کیا جائے گا۔

اگر آپ جواب نہ دینا چاہیں اور چھوڑ کر جانا چاہیں تو آپ کو مکمل آزادی ہے۔

آپ کی مدد اور تعاون کا شکریہ۔

Annexure-B1

ذاتی کوائف

عمر: _____ جنس: _____

ازدواجی حیثیت: ☐ شادی شدہ ☐ غیر شادی شدہ ☐ بیوہ

☐ رنڈوا ☐ طلاق یافتہ

تعلیم: _____

بچوں کی تعداد: ☐ بیٹے ☐ بیٹیاں:

بیماری یا معذوری: ☐ ہاں ☐ دورانیہ ☐ نہیں

آپ کس کے ساتھ رہتے/رہتی ہیں؟

☐ بچوں کے ساتھ ☐ رشتہ داروں کے ساتھ

کام کی حیثیت: ☐ ملازم پیشہ ☐ بے روزگار ☐ ریٹائرڈ ☐ کچھ اور

کیا آپ پنشن لے رہے ہیں؟ _____

ماہانہ آمدنی؟ _____

کیا آپ کبھی گھر پر تنہائی محسوس کرتے ہیں؟

☐ کبھی نہیں ☐ کبھی کبھار ☐ ہمیشہ

آپکی تنہائی کی وجہ کیا ہے؟ _____

کیا آپ اپنے گھر والوں کو ساتھ احساسات کا اظہار کرتے ہیں؟ ☐ ہاں ☐ نہیں

کیا آپ اپنے گھر والوں کے ساتھ خوش ہیں؟ ☐ ہاں ☐ نہیں

کیا گھر والے آپ کی ضروریات پوری کرتے ہیں؟ ☐ ہاں ☐ نہیں

آپ کے گھر والوں کے ساتھ آپ کا تعلق کیسا ہے؟ _____

اگر آپ ابھی بیمار ہیں تو کون آپ کی دیکھ بھال کرتا ہے؟ _____

آپکی بیماری کے اخراجات کون برداشت کرتا ہے؟ _____

وہ کون سی چیزیں ہیں جو آپ کے گھر پر نہیں؟ _____

گھر والوں کے ساتھ گھومنے جاتے ہیں؟ ☐ کبھی نہیں ☐ کبھی کبھار ☐ زیادہ تر

روزمرہ معلومات:

صبح اٹھنے کا ٹائم _____ ورزش ٹائم _____ ناشتہ ٹائم _____

دوپہر کا کھانا _____ رات کا کھانا _____ سونے کا ٹائم _____

Annexure-B2

ذاتی کوائف

جنس: _____ عمر: _____

تعلیم: _____

ازدواجی حیثیت: ☐ شادی شدہ ☐ غیر شادی شدہ ☐ بیوہ

☐ رنڈوا ☐ طلاق یافتہ

بچوں کی تعداد: _____

بیماری یا کوئی معذوری: ☐ ہاں ☐ نہیں ☐ دورانیہ

معذوری کی نوعیت؟ _____

1- اگر آپ ابھی بیمار ہیں تو کون آپ کی دیکھ بھال کر رہا ہے؟ _____

2- آپ کتنے عرصے سے یہاں رہ رہے ہیں؟

☐ پچھلے چھ ماہ سے ☐ ایک سال یا دو سال سے ☐ چار سال سے

3- کام کی حیثیت: ☐ ملازم پیشہ ☐ بے روزگار ☐ ریٹائرڈ ☐ کچھ اور

4- ماہانہ آمدنی: _____

5- کیا آپ پنشن لے رہے ہیں؟ _____

6- کیا آپ یہاں رہنے کا کرایہ ادا کرے ہیں؟ ☐ ہاں ☐ نہیں

7- کرایہ ادا کرنے کا طریقہ؟

☐ ماہانہ ☐ استطاعت کے مطابق ☐ کوئی دوسرا

8- اس اولڈ ایج ہوم میں آنے کی وجہ کیا ہے؟ _____

9- آپ کی بیماری کے اخراجات کون برداشت کرتا ہے؟ _____

10- کیا آپ اپنے اولڈ ہوم/ فلاحی ادارے کی خدمات سے مطمئین ہیں؟ _____

11- اس اولڈ ایج ہوم میں کیا سہولیات ہیں؟ _____

12- اس اولڈ ایج ہوم میں کیا مسائل موجود ہیں؟ _____

13- کیا آپ اس ادارے میں اپنے احساسات کا اظہار کرتے ہیں؟ _____

14- یہاں رہنیا ور گھر پر رہنے میں کیا فرق ہے؟ _____

15- کیا آپ یہاں رہتے ہوئے اکیلا محسوس کرتے ہیں؟ _____

16- آپ یہاں زیادہ کیا کمی محسوس کرتے ہیں؟ _____

17- کیا آپ کے گھر والے آپ سے ملنے آتے ہیں؟ ☐ کبھی نہیں ☐ کبھی کبھار ☐ روزانہ

18- یہاں رہنے والے دوسرے بزرگوں سے آپ کا تعلق کیسا ہے؟ _____

19- روزمرہ معمولات:

صبح اٹھنے کا ٹائم: ☐ ناشتہ ٹائم: ☐ دوپہر کا کھانا: ☐ رات کا کھانا: ☐

سونے کا ٹائم: ☐

Annexure-C

Loneliness Scale Urdu Version

مندرجہ ذیل بیانات میں بتایا گیا ہے کہ لوگ بعض اوقات کیا محسوس کرتے ہیں۔ آپ سے درخواست ہے کہ ہر بیان کو غور سے پڑھئے اور اپنی شخصیت کو سامنے رکھتے ہوئے بتائیے کہ آپ ہر بیان کے حوالے سے کیا محسوس کرتے ہیں۔ اس مثال کی طرح:

آپ کب خوش ہوتے ہیں؟

اگر آپ کبھی بھی خوش نہیں ہوتے ہیں تو جواب میں, کبھی بھی نہیں، کے سامنے نشان لگائیں اور اگر آپ ہمیشہ خوش ہوتے ہیں تو جواب میں, ہمیشہ، کے سامنے نشان لگائیں۔

نمبر شمار	بیانات	کبھی بھی نہیں	کبھی کبھار	بعض اوقات	ہمیشہ
-1	کیا آپ اکثر یہ محسوس کرتے ہیں کے آپ اپنے آس پاس کے لوگوں سے مطابقت رکھتے ہیں؟				
-2	کیا آپ اکثر کسی دوست کی کمی محسوس کرتے ہیں؟				
-3	کیا آپ اکثر یہ محسوس کرتے ہیں کہ کوئی ایسا نہیں جسکی طرف آپ مدد کے لیے دیکھ سکیں؟				
-4	کیا آپ اکثر اپنے آپ کو تنہا محسوس کرتے ہیں؟				
-5	کیا آپ اکثر اپنے آپ کو دوستوں کے گروہ کا حصہ محسوس کرتے ہیں؟				
-6	کیا آپ اکثر یہ محسوس کرتے ہیں کہ آپ اور ارد گرد لوگوں کی بہت سی باتوں میں مشابہت پائی جاتی ہے؟				
-7	کیا آپ اکثر یہ محسوس کرتے ہیں کہ اب آپ کسی کے قریب نہیں رہے؟				
-8	کیا آپ اکثر یہ محسوس کرتے ہیں کہ ارد گرد کے لوگ آپ کے خیالات سے متفق نہیں ہوتے؟				
-9	کیا آپ اکثر یہ محسوس کرتے ہیں کہ آپ کا مزاج دوستانہ ہے؟				
-10	کیا آپ اکثر خود کو لوگوں کے قریب محسوس کرتے ہیں؟				
-11	کیا آپ اکثر یہ محسوس کرتے ہیں کے آپ کو چھوڑ دیا گیا ہے؟				
-12	کیا آپ اکثر یہ محسوس کرتے ہیں کے دوسروں کے ساتھ آپ کے تعلقات بامعنی نہیں ہوتے؟				
-13	کیا آپ اکثر یہ محسوس کرتے ہیں کہ کوئی بھی آپ کو بہتر طور پر نہیں جانتا؟				
-14	کیا آپ اکثر اپنے آپ کو دوسروں سے تنہا/کٹا ہوا محسوس کرتے ہیں؟				
-15	کیا آپ اکثر یہ محسوس کرتے ہیں کہ آپ جب چاہیں ایک دوست تلاش کر سکتے ہیں؟				
-16	کیا آپ اکثر یہ محسوس کرتے ہیں کہ کچھ لوگ ہیں جو آپ کو واقعی سمجھ سکتے ہیں؟				
-17	کیا آپ کو اکثر لوگوں کے درمیان شرم محسوس ہوتی ہے؟				
-18	کیا آپ اکثر یہ محسوس کرتے ہیں کہ لوگوں کے ہوتے ہوئے بھی آپ تنہا ہیں؟				
-19	کیا آپ اکثر یہ محسوس کرتے ہیں کہ کچھ لوگ ہیں جن سے آپ بات کر سکتے ہیں؟				
-20	کیا آپ اکثر یہ محسوس کرتے ہیں کہ کچھ لوگ ہیں جنکی طرف آپ رجوع کر سکتے ہیں؟				

Annexure-D

Humor Style Scale Urdu Version

برائے مہربانی ہر بیان کو غور سے پڑھیں اور شرح بتائیں جس سے آپکو اتفاق ہو یا جس کے ساتھ متفق نہیں ہیں۔ اور برائے مہربانی ہر بیان کا ایمانداری سے جواب دیں۔

نمبر شمار	بیانات	بالکل غیر متفق	درمیانہ غیر متفق	کچھ غیر متفق	نہ متفق نہ غیر متفق	کچھ متفق	درمیانہ متفق	بالکل متفق
-1	میں زیادہ تر لوگوں کے ساتھ ہنستا یا مذاق نہیں کرتا۔	1	2	3	4	5	6	7
-2	اگر میں پریشان ہوں تو میں با آسانی اپنے آپکو مذاق کر کے ہنسا سکتا ہوں۔	1	2	3	4	5	6	7
-3	اگر کوئی غلطی کرے تو میں اکثر اسے تنگ کروں گا۔	1	2	3	4	5	6	7
-4	میں خود سے زیادہ لوگوں کو خود پہ ہنسنے یا مذاق اڑانی کی اجازت دیتا ہوں۔	1	2	3	4	5	6	7
-5	میں قدرتی طور پر ہنس مکھ انسان ہوں اسلیے مجھے لوگوں کو ہنسانے پہ زیادہ محنت نہیں کرنی پڑتی۔	1	2	3	4	5	6	7
-6	میں اکثر تب بھی زندگی کی بے وقوفیوں پر خوش ہوتا ہوں جب میں اکیلا ہوتا ہوں۔	1	2	3	4	5	6	7
-7	لوگ کبھی میری حس مذاق سے ناراض یا دکھی نہیں ہوئے۔	1	2	3	4	5	6	7
-8	میں اکثر خود کو گرا دوں گا اگر یہ میرے خاندان اور دوستوں کو خوش کرتا ہے۔	1	2	3	4	5	6	7
-9	میں بہت کم دوسروں لوگوں کو اپنے بارے میں مذاحیہ کہانیاں سنا کر ہنساتا ہوں۔	1	2	3	4	5	6	7
-10	اگر میں پریشان یا ناخوش ہوں تو میں خود کو اپنے اردگرد کے حالات سے کوئی مذاحیہ چیز سوچ کر ہنساتا ہوں۔	1	2	3	4	5	6	7
-11	جب میں مذاق کرتا ہوں یا کوئی مذاحیہ چیز سناتا ہوں تو میں اس بارے میں پرواہ نہیں کرتا کہ لوگ میرے بارے میں کیا سوچیں گے	1	2	3	4	5	6	7
-12	میں کوشش کرتا ہوں کہ میں اپنی کسی کمزوری ، بے وقوفی یا غلطی کے بارے میں کوئی مذاحیہ بات کروں جس سے لوگ مجھے پسند اور قبول کر لیں۔	1	2	3	4	5	6	7
-13	میں اپنے دوستوں کے ساتھ بہت زیادہ ہنسی مذاق کرتا ہوں۔	1	2	3	4	5	6	7
-14	زندگی کی مختلف چیزوں کے بارے میں میرا مذاق مجھے بہت زیادہ پریشان ہونے سے بچاتا ہے۔	1	2	3	4	5	6	7
-15	مجھے برا لگتا ہے جب لوگ مذاق کر کے کسی کو تنقید کا نشانہ یا نیچا دکھائیں۔	1	2	3	4	5	6	7

16-	میں اپنے آپ کو نیچا کر کے کبھی مذاحیہ بات نہیں کرتا۔	1	2	3	4	5	6	7
17-	مجھے لوگوں کو ہنسانا یا ان کے ساتھ مذاق کرنا پسند نہیں۔	1	2	3	4	5	6	7
18-	اگر میں اکیلا ہوں اور نہ خوش ہوں تو میں کود کو ہنسانے کے لیے کسی مذاحیہ بات کے بارے میں سوچتا ہوں۔	1	2	3	4	5	6	7
19-	کبھی کبھی میں کچھ ایسا سوچتا ہوں جو بہت زیادہ مذاحیہ ہو تو میں اس کو کہنے سے خود کو روک نہیں سکتا حیی کہ اگر یہ مناسب صورت حال کے لیے نہیں ہے۔	1	2	3	4	5	6	7
20-	جب میں مذاق کر رہا ہوں یا مذاحیہ بننے کی کوشش کر رہا ہوں تو میں خود کو گرا دینے کی حد سے بھی گزر جاتا ہوں۔	1	2	3	4	5	6	7
21-	مجھے لوگوں کو خوش رکھنے میں بہت مزا آتا ہے۔	1	2	3	4	5	6	7
22-	اگر میں پریشان ہوں یا اداس ہوں تو میں اپنی مذاق کرنے کی صلاحیت کھو دیتا ہوں۔	1	2	3	4	5	6	7
23-	اگر میرے تمام دوست کسی دوسرے پر ہنس رہے ہوں تب بھی ایسے کام میں حصہ نہیں لیتا۔	1	2	3	4	5	6	7
24-	خاندان یا دوستوں میں ہوتے ہوئے میں ان کے لیے کوئی مذاق اڑانے والی چیز کی طرح ہوتا ہوں۔	1	2	3	4	5	6	7
25-	میں اپنے دوستوں کے ساتھ مذاق نہیں کرتا۔	1	2	3	4	5	6	7
26-	میرا تجربہ ہے کہ کسی صورتحال کو کسی مذاحیہ انداز میں دیکھنا مشکلات پر قابو پانے کا ایک موثر ذریعہ ہے۔	1	2	3	4	5	6	7
27-	اگر میں کسی کو پسند نہیں کرتا تو میں اگر کس کا مذاق اڑاتا ہوں یا است تنگ کرتا ہوں۔	1	2	3	4	5	6	7
28-	اگر مجھے کوئی مسئلہ ہو یا میں پریشان ہوں تو میں اسے مذاق کر کے چھپا لیتا ہوں یہاں تک کے میرے قریبی بھی اندازہ نہیں لگا سکتے کہ میں کیا محسوس کر رہا ہوں۔	1	2	3	4	5	6	7
29-	جب میں لوگوں کے ساتھ ہوتا ہوں تو میں حاضر جواب نہیں ہوتا۔	1	2	3	4	5	6	7
30-	مجھے خوشی محسوس کرنے کے لیے دوسرے لوگوں کے ساتھ کی ضرورت نہیں ہوتی جب میں اکیلا ہوتا ہوں تب بھی کوئی ایسی چیز ڈھونڈ لیتا ہوں جو مجھے خوش رکھ سکے۔	1	2	3	4	5	6	7
31-	اگر کوئی مذاحیہ چیز کسی کو بری لگ رہی ہو تو میں ہنسنے اور مذاق کرنے سے روک جاؤں گا۔	1	2	3	4	5	6	7
32-	دوسروں کو خود کا مذاق اڑانے کی اجازت دینا اپنے دوستوں اور خاندان کو خوش رکھنے کے لیے ٹھیک ہے۔	1	2	3	4	5	6	7

Annexure-E

Quality of Life Scale (Urdu Version)

برائے مہربانی ہر سوال کو غور سے پڑھیں اور پچھلے دو ہفتوں کے دوران اپنے احساسات کی روشنی میں سکیل میں دیئے گئے اس نمبر پر دائرہ لگائیں جو آپ کے احساسات کی بہترین ترجمانی کرتا ہوں۔

	بہت خراب	خراب	نہ خراب نہ اچھی	اچھی	بہت اچھی
1-آپ اپنے معیار زندگی کو کس سطح پر پاتے ہیں؟	1	2	3	4	5

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ غیر مطمئن	مطمئن	بہت مطمئن
2-آپ اپنی صحت کے بارے میں کس حد تک مطمئن ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	معمولی مقدار میں	درمیانی مقدار میں	کافی مقدار میں	انتہائی مقدار میں
3-جو کام آپ کو کرنے کی ضرورت ہے آپ کا جسمانی درد کس حد تک اس میں رکاوٹ بنتا ہے؟	1	2	3	4	5
4-آپ کو اپنی روزمرہ زندگی میں کام کے لیے طبی علاج کی کتنی ضرورت ہے؟	1	2	3	4	5
5-آپ زندگی سے کتنا لطف اندوز ہوتے ہیں؟	1	2	3	4	5
6-آپ کس حد تک اپنی زندگی کو بامعنی محسوس کرتے ہیں؟	1	2	3	4	5

	بالکل نہیں	معمولی	درمیانہ/ درمیانی	بہت	بہت زیادہ
7-آپ میں توجہ مرکوز کرنے کی صلاحیت کتنی اچھی ہے؟	1	2	3	4	5
8-آپ اپنی روزمرہ زندگی میں خود کو کتنا محفوظ محسوس کرتے ہیں؟	1	2	3	4	5
9-آپ کا طبعی ماحول کتنا صحت مند ہے؟	1	2	3	4	5

مندرجہ ذیل سوالات ان تجربات سے متعلق ہیں جو پچھلے دو ہفتوں کے دوران آپ پر گزرے۔

	بالکل نہیں	تھوڑا سا/تھوڑی سی	کچھ حد تک	بہت حد تک	مکمل طور پر
10-کیا آپ روزمرہ زندگی کے لیے کافی توانائی رکھتے ہیں؟	1	2	3	4	5
11-کیا آپ اپنی جسمانی شکل وصورت کو قبول کر پاتے/ پاتی ہیں؟	1	2	3	4	5
12-کیا آپ کے پاس اپنی ضروریات پوری کرنے کے لیے کافی رقم ہے؟	1	2	3	4	5
13-آپ کو اپنی روزمرہ زندگی کے لیے درکار معلومات کتنی میسر ہیں؟	1	2	3	4	5
14-آپ کو فرصت کے لمحات گزارنے کے مواقع کس حد تک میسر ہیں؟	1	2	3	4	5
15-آپ اپنی آپ کو کسی کام کے لیے جسمانی طور پر آمادہ کر پاتے ہیں؟	1	2	3	4	5

مندرجہ ذیل سوالات میں پوچھا گیا ہے کہ آپ نے اپنی زندگی کے مختلف پہلوؤں کے بارے میں گزشتہ دو ہفتوں کے دوران کتنا اچھا اور مطمئن محسوس کیا۔

	بہت غیر مطمئن	کافی حد تک غیر مطمئن	نہ مطمئن نہ ہی غیر مطمئن	مطمئن	بہت مطمئن
16-آپ اپنی نیند سے کتنے مطمئن ہیں؟	1	2	3	4	5
17-آپ اپنی روزمرہ زندگی کے معمولات ادا کرنے کی اہلیت سے کتنا مطمئن ہیں؟	1	2	3	4	5
18-آپ کام کے لیے اپنی استعداد سے کتنا مطمئن ہیں؟	1	2	3	4	5
19-آپ اپنی آپ سے کتنا مطمئن ہیں؟	1	2	3	4	5
20-آپ اپنے ذاتی تعلقات سے کتنا مطمئن ہیں؟	1	2	3	4	5
21-آپ اپنی جنسی زندگی سے کتنے مطمئن ہیں؟	1	2	3	4	5
22-آپ اپنے دوستوں سے ملنے والے سہارے سے کتنے مطمئن ہیں؟	1	2	3	4	5
23- آپ جس جگہ رہتے ہیں وہاں کے حالات سے کتنا مطمئن ہیں؟	1	2	3	4	5
24- آپ طبی سہولیات تک رسائی سے کتنے مطمئن ہیں؟	1	2	3	4	5
25- آپ اپنے ذرائع آمدورفت سے کتنا مطمئن ہین؟	1	2	3	4	5

	کبھی نہیں	شاذونادر	بعض اوقات	اکثر اوقات	ہمیشہ
26- آپ کو کتنی بار منفی احساسات جیسا کہ افسردگی، مایوسی، اضطراب، ڈیپریشن ہوتے ہیں؟	1	2	3	4	5

Re: Request for permission to use scale 2 Yahoo/Inbox

TR **taha rizvi** <taharizvi75@yahoo.com> Feb 23 at 11:03 AM
To: ali25_moh@yahoo.com

Ms. Nighat Gul

It is state that I, Syed Muhammad Taha am a student of M.Sc. Psychology program of the National Institute of psychology, Quaid-i- Azam Universty ,Islamabad Pakistan . As a part of our compulsory academic course , each of us student has to conduct a research under the supervision of our qualified supervisor .i am doing my master thesis titled as Loneliness, Humor style and Quality of life among elders living in old houses under the supervision of mam Saira khan .
Searching for the measurement of the construct loneliness, i came across R-UCLA loneliness scale translated by you, therefore, i humbly request that you send me the instrument along with its psychometric details. Also as a matter of following the research ethics i need your permission for using the scale for my research work. Kindly grant me the permission to use this scale.I would be highly obliged. Looking forward for a favorable response.

Regards,
Syed Muhammad Taha
M.Sc. Psychology
National Institute of psychology
Center of Excellence,
Quaid-i- Azam Universty

Nighat <ali25_moh@yahoo.com> Feb 27 at 3:36 PM
To: taha rizvi

I authorize you use UCLA urdu version scale for mater level study purpose

regard
ms nighat gul

Show original message

Reserved ri....docx
9.6kB

Re: Fwd: QoL 2 Yahoo/Inbox

Nasar Khan <psychiatry.sims@gmail.com>
To: taharizvi75@yahoo.com
Aug 18, 2017 at 3:55 PM

I hope it will be helpful in your research. Take care

Dr.M. Nasar Sayeed Khan
Professor of Psychiatry
President Pakistan Psychiatric Society

Begin forwarded message:

On Thursday, March 16, 2017, 6:30 AM, Psychiatry Department SIMS <psychiatry.sims@gmail.com> wrote:

> You have permission to use scale for research and academic purposes.
>
> Take care
>
> ---------- Forwarded message ---------
> From: Psychiatry Department SIMS <psychiatry.sims@gmail.com>
> Date: Sat, 8 Oct 2016 at 6:12 AM
> Subject: Fwd: QoL
> To: <isbahsaleem.8@gmail.com>

---------- Forwarded message ----------
From: **Nasar Khan** <psychiatry.sims@gmail.com>
Date: Wednesday, 7 September 2016
Subject: QoL
To: shafiquefaiza@gmail.com

You have permission to use this scale for research purpose.

Dr M. Nasar Sayeed Khan
Professor of Psychiatry

Sent from Yahoo Mail for iPhone

Begin forwarded message:

On Sunday, August 21, 2016, 9:31 PM, Nasar Khan <psychiatry.sims@gmail.com> wrote:

> Sent from Yahoo Mail for iPhone
>
> Begin forwarded message:
>
> On Monday, August 1, 2016, 7:45 AM, Psychiatry Department SIMS <psychiatry.sims@gmail.com> wrote:
>
> > Please find attached the Quality of life scale and the scoring method. You have the permission to use the scale. Take care
> >
> > If possible let me know and send a paper out of it. I can get it published in an international Joirnal.
> >
> > Regards