The Impact of Loneliness and Resilience on Quality of Life among Elderly Living in Geriatric Homes

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Abstract

Background: Quality of life is a vital element in the care of old people and is an indicator of overall health. Loneliness and resilience are among the factors that affect elderly quality of life. This study aimed to evaluate the impact of loneliness and resilience on quality of Life among elderly living in geriatric homes. **Methods:** a descriptive correlational research design was utilized in the current study, a convenience sample of (30) elderly was selected. The research was implemented at three geriatric homes; Islamic Acquaintance Association for Elderly Care (Dar El Hana), Hedya Barakat Geriatric Home, and Maana Geriatric Home which all located at Giza Governorate, data were collected using four tools; personal data questionnaire, loneliness scale, resilience scale, and World Health organization quality of life scale. **Results:** results revealed low levels of loneliness among residents, moderate to high level of resilience and quality of life among majority of residents, significant negative statistical correlation between loneliness and both resilience and quality of life and positive statistical correlation between resilience and quality of life. **Conclusion:** both loneliness and resilience has impact on quality of life among elderly. **Recommendations:** programs to enhance social functioning and resilience may be effective in improving quality of life among elderly living at geriatric homes.

Keywords: Loneliness, Resilience, Quality of Life, Elderly.

Introduction

Over the last century, the average ages of individuals were expected to increase as more people are expected live to old age. Moving to old age means having many different experiences which are unique to this age period as retirement, loss of significant family members or friends, loss/change of societal and gender roles in addition to grieving and emotional distress due to death of loved ones. All of these factors can affect the structural and functional components of social relationships of elderly with increased risk for experiencing loneliness and social isolation **(Beridze et al., 2020).**

Dahlberg & McKee (2014) reported that, twelve percent to forty-six percent of elderly experienced some degree of loneliness which is generally noted in the gap between an individual's desired and actual social relationships, whether in quality or quantity of these relationships. Feeling of loneliness is an experience that can occur at any age but it is more prevalent and common among older ages. For example, the risk of experiencing social isolation represents about 50% of individuals aged over 60 years old, while one-third of them will experience some degree of loneliness **(Landeiro et al., 2018).**

It had been noted that low quality of life, deteriorated cognitive functioning, diminished well-being and loss of independence have been linked to loneliness among the old age. Longitudinal researches has shown that, older people who experience social isolation and loneliness for lasting or longer periods of time are at greatest risk of experiencing negative consequences for physical health and well-being **(Dahlberg & McKee, 2014 & Malcom & Cowie, 2019).**

Resilience is a personal attribute experienced by the individual to cope with physical, financial, and psychosocial adversities. Individuals' abilities to face life adversities include problem solving skills, self-control, and coping considering personal contexts, mechanisms, and ability to learn. Resilience is developed through different stages across life span through critical experiences such as disability, illness, loss, living with violence, and/or crises **(Lima, Figueira, Carvalho, Kusumota, & Caldiera, 2023).**

Resilience may be a potential characteristic in some individuals which become obvious when they experience some stressors or challenges in their lives. For older people, they can experience different adversities, stressors or challenges which may be temporary or lasting as the loss of a close friend, partner or other family member or the development of a chronic illness **[Centre for Policy on Aging (CPA), 2014].**

In older age, resilience refers to the ability of the elderly to cope or mange the different experienced adversities in the longer term using strategies/actions that can maintain the balance of their lives (CPA, 2014). Adaptive coping abilities of elderly people include performing self-care activities, keeping active, managing physical and cognitive limitations, and having a purpose in life. It can be said that; the more resilient the elderly, the more the adaptive outcomes and the less the impact on health considering its all aspects; biological, psychological, and social **(Lima et al., 2023).**

Furthermore, resilience in older age can be related to the availability of social relationships, social support and connectedness to the community. As the greater the elderly's social inclusion and connectedness within the community, the better their resilience **(Gallacher et al., 2012).** Meichebaum (2016) emphasized the importance of social relations in bolstering resilience in older adults, as social engagement with others and sense of belonging and connectedness help in enhancing resilience in the elderly.

Quality of Life (QOL) is a complex multidimensional construct that clarifies an individual's subjective evaluation of all dimensions of his health including its physical, emotional, psychosocial parts **(Kousha et al., 2022).** Quality of life in elderly refers to life satisfaction with domains such as health status, financial income, social relationship, sexual life, and/or participating in leisure activities **(Mohammed, Fathy, & Osman, 2020).** In addition to being a good indicator of all dimensions of individual's health, quality of life has also been reported to be influenced by loneliness among older people in certain countries **(Jacobson & Hallberg, 2005 &Verhagen et al., 2014).**

In older ages, coping or living with a significant illness or hardship can be understood to be ageing well and indeed to be resilient which require the integration of both personal and environmental community resources. Thus, resilience is a useful concept framing how ageing well can incorporate multidimensional pathways including vulnerability, well-being, and improved quality of life **(Wiles et al., 2012).**

Significance of the study

One of the most significant social transformations that occurred over the last century is aging of population. The issue that affects many sectors of society, including financial situations, the demand for services, such as health facilities, housing, transportation and social security, as well as family structures and relationships between the consecutive generations **(United Nations, 2017).**

By 2030, 1 in 6 people in the world will be aged 60 years or over. At this time the number of the population aged 60 years and over will increase from 1 billion in 2020 to 1.4 billion. By 2050, the world's populations of people aged 60 years and older will double (2.1 billion). The number of persons aged 80 years or older is expected to triple between 2020 and 2050 to reach 426 million **[World Health organization (WHO), 2022].**

While the population ageing started in the developed countries (for example in Japan 30% of the population is already over 60 years old), it is expected that developing countries will experience this great change. By 2050, two-thirds of the world's population over 60 years will live in low and middle income countries **(WHO, 2022).** Until July 2022, the number of old people in Egypt had reached 6.9 million (3.7 million males and 3.2 million females) **[Central Agency for Public Mobilization and Statistics (CAPMAS), 2022].**

While longer life is a resource, to realize the probability of a longer life span, the ideas about development must be adjusted so that the extra years are not just tacked on to retirement, but expand an individual's years of productivity. Health is a key determinant for not just adding more years to life, but adding more life to years **(United Nations, 2017).**

In addition, it has been recommended that, disease-centered curative health systems embrace integrated care focusing on the bio-psychosocial needs of older people. Thus, assessment of QOL is seen as an essential element in the care of older people **(Cerin et al., 2016),** and improving their QOL has become a prioritized element in their medical care **(WHO, 2002).** Hence, identifying the factors associated with QOL is needed and the relation between QOL, loneliness and resilience should be fully investigated to provide implications for proposing new interventions on improving QOL among Egyptian older people.

Aim of study

This study aims to evaluate the impact of loneliness and resilience on quality of Life among elderly living in geriatric homes.

Research Questions

1- What are the loneliness, resilience, and quality of life levels among elderly living in geriatric homes?

2- What are the relationships between loneliness, resilience and quality of life among elderly living in geriatric homes?

Study Sample

A convenience sample of (30) elderly people was selected for participation in the current study. A convenience sample is a sampling in which the researchers utilize a sample which is readily available and they have access to, and also it is the sample in which the availability of participants is more concern during the process of choosing and when they couldn't select from many various populations and research sites (Golzar, Noor, & Tajek, 2022). In the current study, the investigators identified the population of the study by selecting three geriatric homes at Giza Governorate and select all elderly people available in these homes who met the inclusion criteria.

The inclusion criteria include the following:

- Elderly over 60 years old, voluntarily agree to participate in the study.
- Residence within the geriatric institutions for at least one year.
- Elderly who are free from cognitive impairments as Alzheimer disease and dementia.

Study Setting/s

This study was conducted at three geriatric homes; Islamic Acquaintance Association for Elderly Care (Dar El Hana), Hedaya Barakat Geriatric Home, and Maana Geriatric Home which all located at Giza Governorate.

Research Design

This study employed a descriptive correlational research design to identify the relationships between the study variables, namely; loneliness, resilience and quality of life among elderly in geriatric homes.

Tools of Data Collection

There are four tools that used in this study:

Personal Data Questionnaire: (developed by the investigators):

It was divided into two parts; the 1st part is concerned with information of personal identification as code number, age, gender, and the level of education. The second part is concerned with marital status, economic status, the presence of any medical illness or physical disability.

Loneliness Scale for Elderly (LSE) (Gierveld & Kamphuis, 1985):

This scale was developed by Gierveld and Kamphuis in 1985 to measure the loneliness levels of adults and the elderly. This scale is consisting of 11 items with 3-point Likert scale ranging from (0) rarely, (1) sometimes, (2) often. The score of this scale is ranging from 0 to 22. The level of loneliness is determined according to the score as the level increases with increased scores. The internal consistency coefficients were reported as .79 for emotional loneliness, .81 for social loneliness and .85 for the total scale respectively.

The 14- item Resilience Scale (RS- 14) (Wagnild & Young, 1993):

This scale was developed by Wagnild & Young in 1993. The RS is the first instrument developed to measure resilience and can be applied in a wide variety of age groups, from adolescents to older people. The scale is

consisted of 14 items with a 5-point Likert type scale from 1 (Strongly disagree) to 5 (Strongly agree) for each item. Higher scores mean superior levels of resilience tendencies. Scores are calculated by a summation of response values for each item, thus scores range from 14 to 70. Reliability for all items ranging from 0.42 to 0.64 and the Cronbach's alpha coefficient of the scale was 0.93.

World Health Organization Quality of Life-BREF (WHOQOL-BREF) (WHO, 2002):

This scale was developed by WHO to measure quality of life through four domains (physical, psychological, social, and environmental).The scale is consisting of 26 questions with five point likert scale ranging from (1) completely not satisfied, (2) not satisfied, (3) uncertain, (4) satisfied, (5) completely satisfied. Scores calculated using a formula varies between 0-100% and the QOL increases as the score increases. The internal consistency coefficients were .68, .78, .61 and .76 for the physical, psychological, social, and environmental dimensions, respectively.

The investigators translated English formats of loneliness scale and short resilience scale into Arabic language. The resulting versions were translated back into the original language by bilingual experts, and minor discrepancies in the content were found and necessary modifications were done. The investigators also obtained the Arabic version of QOL measure as the scale was available in different languages. The study tools were tested for content validity by five experts in the field of psychiatric and community nursing and necessary modifications were done in addition to examining its reliability.

Ethical consideration

The investigators obtained an official approval to implement the study from the research ethics committee at the Faculty of Nursing, Cairo University. Also official approvals were obtained from the managers of the study settings. The investigators obtained written informed consents from elderly who accepted to participate in the study. All participants were reassured about confidentiality of collected data and informed that their participation in the study is anonymous and used only for research purpose. Finally, they had the right to withdraw from the study.

Procedure

An official permission was granted upon a letter issued from the ethical committee of the Faculty of Nursing- Cairo University. Research's aim, content, and procedure were discussed with geriatric homes administrators before data collection. After the institutional approval form obtained from the administrators, the investigators interviewed the participants; explained the purpose of the research, assure them about confidentiality and anonymity by using code number and assured their right to draw out from the study without giving any reason.

A written consent was obtained from each participant before data collection. The investigators collected data from participants individually in more than one session with total duration lasts from 45minute to 60 minute. Structured interviews were used as the questionnaires were read, interpreted and the answers were recorded by the investigators.

Statistical design

Statistics was done by using version 22 of statistical package for social science (SPSS). Frequency, percentage, mean, and standard deviation were used for numerical data. Pearson correlation (r) was used to study correlation between variables. Chi square test (x2) was used to study difference between variable levels of the two groups. Independent sample "t" test was used to study difference between the mean scores of two groups. ANOVA (analysis of variance) test was used for correlation between demographic data and scores. Results were considered significant if $p < 0.05$ and highly significant if $p < 0.01$.

Results

Table (1a) shows that, 63.3% of studied sample were male, 30% of studied sample aged from 70 to less than 75 years and 40% of them aged from 60 to less than 65 years and 80 years with equal 20% for each category. Regarding educational level, 40% of the studied samples were graduated with bachelor degree, 23.3% were at secondary school. The same table

reveals that, 50% from the studied sample were widow, while 36.7% of them were single.

Table (1b) reveals that, 50% of the studied sample were retired, 20% of them were house wife while 16.7% worked at free jobs. Concerning the income 60% of the studied sample reported that, their income were adequate for them, 23.3% with none income and 16.7% were with inadequate income. Regarding the type of residence 70% of the studied samples were live in paid elderly home and the remaining 30% were at free elderly home.

As shown in table (2), there is a significant statistical difference between paid and free groups in four items only of loneliness scale in relation to, "there is always someone I can talk to about my day-to-day problems”, “I miss having a really close friend”, “There are many people I can trust completely”, and “I miss having people around me” with (p value) = (0.041, 0.015, 0.010 & 0.011) respectively.

Table (3) shows that, there was low level of loneliness among all residents of both paid and free groups, and also there was no significant difference between two groups in relation to loneliness levels.

Concerning resilience scale, table (4) indicates that, there is a highly statistically significant difference between paid and free groups in resilience scale total score with (p value) = 0.000. The same table elaborates a highly statistically significant difference between paid and free groups regarding sub items in relation to "I usually manage one way or another”, “I feel proud that I have accomplished things in my life”, and “I usually take things in stride”, and “I am determined” with (p value)= (0.034, 0.000, 0.000 & 0.000) respectively.

In addition table (4) also reveals that, there is a significant difference between paid and free groups in sub items in relation to "I keep interested in things”, “I can usually find something to laugh about”, “My belief in myself gets me through hard times”, and “When I’m in a difficult situation, I can usually find my way out of it” with (p value) = (0.014, 0.003, 0. 036 & 0. 002) respectively.

Concerning levels of resilience, table (5) reveals that, there is a statistical significant difference between the two groups in relation to level of resilience at p=0.02; as 88.9% of free residents had moderate level of resilience compared to 38% of paid group at the same level, while 52.4% of paid residents had high level of resilience compared to 0% of free group at the same level.

Table (6) demonstrates that, there is no significant difference between paid and free groups concerning overall quality of life and general health, physical health, psychological health and social health sub dimensions, while there is a highly statistically significant difference in relation to environmental dimension of quality of life with (p value) = 0.003.

In relation to levels of quality of life, table (7) illustrate that, 77.8% of free residents had moderate level of quality of life compared to 33% of paid residents, while 57.1% of paid residents had high level of quality of life compared to 22% of free residents.

Table (8) demonstrates that, there are highly statistically significant positive correlations between all quality of life dimensions including overall QOL and general health , physical health, psychological health, social relations and environment and the total quality of life with (p value) = 0.000 for all dimensions.

As shown in table (9), there is a negative correlation between loneliness and both resilience and quality of life with (p value) = (0.005 & 0.000) respectively. Also the same table shows a highly statistically significant positive correlation between resilience and quality of life with (p value) = (0.000).

As elaborated in table (10), there is no correlation between personal data and loneliness scale score nor with quality of life scale score, while there is a highly significant positive correlation between resilience scale score and personal data in relation to income among free and paid studied subjects with (p value) = (0.03).

Table (1a): Socio-demographic characteristics among studied sample (N= 30).

Personal data	No.	%
Gender		
Male	19	63.3
Female	11	36.7
Age		
60-<65	6	20.0
65-<70	8	26.7
70-<75	9	30.0
75-<80	1	3.3
80+	6	20.0
Education		
Illiterate	3	10.0
Primary	3	10.0
Elementary	3	10.0
Secondary	7	23.3
Bachelor degree	12	40.0
Post graduate	2	6.7
Marital status		
Single	11	36.7
Widow	15	50.0
Divorced	4	13.3

Table (1b): Socio-demographic characteristics among studied sample (N= 30).

Personal data	No.	%
Job		
None	4	13.3
Retired	15	50.0
House wife	6	20.0
Free work	5	16.7
Income		
None	7	23.3
Adequate	18	60.0
Not adequate	5	16.7
Residence		
Free	9	30.0
Paid	21	70.0

Table (2): Loneliness scale among studied sample paid versus free residents (N= 30).

Loneliness items	Free (N=9)		Paid (N= 21)		T	P
	Mean	Sd±	Mean	Sd±		
I can talk with someone about my problems	0.56	0.73	1.00	0.89	2.094	0.041*
I miss having a close friend	1.67	0.71	1.14	0.91	2.515	0.015*
I experience a sense of emptiness	0.89	0.93	1.05	0.92	0.670	0.506
There are people I can lean on	0.67	0.87	1.05	0.86	1.701	0.094
I miss the pleasure of the company of others	1.00	1.00	1.05	0.86	0.208	0.836
I have too limited friends	1.67	0.71	1.48	0.81	0.966	0.338
I can trust people	0.44	0.73	1.00	0.89	2.665	0.010*
There are people I feel close to	1.11	0.93	0.71	0.85	1.739	0.087
I miss having people around me	0.44	0.53	0.95	0.92	2.631	0.011*
I often feel rejected	0.89	0.93	0.67	0.86	0.951	0.345
I can call on my friends when I need	1.00	1.00	0.67	1.15	1.186	0.240
Total	**10.33**	**3.35**	**10.76**	**6.67**	**0.316**	**0.753**

*significant at p-value<0.05

**highly significant at p-value<0.01

Table (3): Levels of loneliness among studied sample paid versus free residents (N= 30).

Levels	Free		Paid		X2	p
	No.	%	No.	%		
Low	9	100.0	21	100.0	0.01	0.99
Moderate	0	0.0	0	0.0		
High	0	0.0	0	0.0		

*significant at p-value<0.05

Table (4): Resilience scale among studied sample paid versus free residents (N= 30).

Resilience items	Free (N=9)		Paid (N= 21)		T	P
	Mean	sd±	Mean	sd±		
1. I usually manage one way or another.	2.89	1.36	3.62	1.24	2.173	0.034*
2. I feel proud about my accomplishments.	2.78	1.39	4.00	1.00	3.902	0.000**
3. I usually take things in stride.	2.67	1.12	3.76	0.83	4.283	0.000**
4. I am friends with myself.	3.22	1.39	3.76	0.94	1.763	0.083
5. I feel that I can handle many things at a time.	2.67	1.32	2.67	1.32	0.000	1.000
6. I am determined.	2.00	0.87	3.52	0.98	6.353	0.000**
7. I can get through difficult times.	3.44	1.01	3.14	1.28	1.008	0.318
8. I have self-discipline.	3.67	1.12	3.71	1.06	0.142	0.888
9. I keep interested in things.	2.44	1.13	3.24	1.30	2.544	0.014*
10. I can usually find something to laugh about.	2.44	1.33	3.43	1.16	3.073	0.003**
11. My belief in myself gets me through hard times.	3.11	1.27	3.71	0.85	2.150	0.036*
12. In an emergency, I'm someone people can rely on.	2.89	1.36	3.38	1.02	1.579	0.120
13. My life has meaning.	3.00	1.32	3.24	1.09	0.768	0.446
14. I can find my way out of difficult situations.	2.78	0.97	3.57	0.87	3.321	0.002**
Total	**40.00**	**5.15**	**48.76**	**11.08**	**3.927**	**0.000****

*significant at p-value<0.05
**highly significant at p-value<0.01

Table (5): Levels of resilience among studied sample paid versus free residents (N= 30).

Levels	Free		Paid		X2	P
	No.	%	No.	%		
Low	1	11.1	2	9.5	7.7	0.02*
Moderate	8	88.9	8	38.1		
High	0	0.0	11	52.4		

*significant at p-value<0.05

Table (6): Quality of Life scale and its dimensions among studied sample paid versus free residents (N= 30).

Quality of life dimensions	Free (N= 9)		Paid(N= 21)		T	P
	Mean	sd±	Mean	sd±		
Overall quality of life and general health	6.78	1.48	6.19	2.11	1.254	0.215
Physical health	20.44	3.13	20.48	3.76	0.045	0.964
Psychological	17.89	3.22	18.86	3.61	1.098	0.277
Social relations	8.11	2.98	8.90	2.61	1.092	0.279
Environment	23.00	2.69	27.33	7.09	3.128	0.003**
Total	**78.33**	**9.22**	**84.38**	**16.65**	**1.741**	**0.087**

*significant at p-value<0.05
**highly significant at p-value<0.01

Table (7): Levels of Quality of Life among studied sample paid versus free residents (N= 30).

Levels	Free		Paid		X2	P
	No.	%	No.	%		
Low	0	0.0	2	9.5	5.1	0.07
Moderate	7	77.8	7	33.3		
High	2	22.2	12	57.1		

*significant at p-value<0.05

Table (8): Correlation between Quality of Life dimensions and total Quality of Life among studied sample (N= 30).

Quality of life dimensions	Total quality of life	
	R	P
Overall quality of life and general health	0.68	0.000**
Physical health	0.79	0.000**
Psychological	0.85	0.000**
Social relations	0.66	0.000**
Environment	0.91	0.000**

*significant at p-value<0.05
**highly significant at p-value<0.01

Table (9): Correlation between Loneliness, Resilience and Quality of life among studied sample (N= 30).

Scores	Loneliness		Resilience		Quality of life	
	R	P	R	P	R	P
Loneliness	1					
Resilience	- 0.5	0.005*	1			
Quality of life	- 0.71	0.000*	0.82	0.000*	1	

*significant at p-value<0.05
**highly significant at p-value<0.01

Table (10): Correlation between personal data of studied sample and their loneliness, resilience and QOL scores (N= 30).

Personal data	Loneliness		Resilience		Quality of life	
	Mean	sd±	Mean	sd±	Mean	sd±
Gender						
ANOVA	0.01		0.31		0.06	
P	0.99		0.58		0.8	
Age						
ANOVA	0.5		1.2		0.3	
P	0.66		0.3		0.87	
Education						
ANOVA	0.4		1.3		1.1	
P	0.77		0.2		0.42	
Marital status						
ANOVA	0.93		0.79		0.33	
P	0.4		0.46		0.71	
Job						
ANOVA	0.19		1.1		0.67	
P	0.9		0.35		0.57	
Income						
ANOVA	1.7		3.9		2.1	
P	0.19		0.03**		0.14	

*significant at p-value<0.05
**highly significant at p-value<0.01

Discussion

The current study results revealed that, 63.3% of studied sample were males. And 50% of the studied sample were retired from work. These results are consistent with Mohamed, Mourad, & Abd El-Fatah, (2020) who conducted a study on twenty elderlies lived in the geriatric home in Beni-Suef governorate, Egypt and found that, 55% of studied subjects were males, and 40% of the studied subjects reported that, they had governmental working. This can be explained by the similarity of characteristics between elderly residents at different elderly home at Egypt country, as most of elderly male who was working and retired from their work and didn't had person to care for them prefer to live at geriatric home even paid homes to find people who can care for them and also to find a company who can talk with them.

In relation to income, 60% of the studied sample reported that, they had adequate income, these results compatible with a study done by Abdel Aleem, Al Nagar, Eita & Shattla, (2020) who conducted a study on 53 elderly from geriatric nursing home in Berket EL Sabba and Alsadat City, Menoufia, Egypt and results revealed that, about more than three quarters of the sample have enough monthly income. This can be due to the availability of pension for retired elderly resident at geriatric home. On the other hand, 16.7% of studied sample of the current study reported that, they had inadequate income while 23.3% of them had no income, this can be explained as some of the elderly especially in the free geriatric homes were working in free affairs with no governmental pension, some of them were homeless, and others were females who had spent all of their lives as house wives with no independent income as after the death of their husbands there is no one to spend on them. These causes clarifies why elderly go to free geriatric homes as they can't spend on themselves and can't obtain their basic needs; they seek these homes to provide them with a secure shelter, meet their basic physiological needs, maintenance of physical health in addition to some psychological benefits as the presence in companionship.

Regarding loneliness levels among free and paid residents, there were low levels of loneliness among all residents of both paid and free groups and also there was no statistical difference between two groups regarding loneliness levels. These findings are in contrast to Gardiner, Laud, Heaton & Gott, (2020) who investigated the prevalence of moderate and severe loneliness among older people living in nursing care homes and concluded that, levels of moderate and severe loneliness among residents were high. Current study result also contradicted by Abdel Aleem, Al Nagar, Eita & Shattla, (2020) who conducted a study on 53 elderly from geriatric nursing home in Berket EL Sabba and Alsadat City, Menoufia, Egypt and concluded that, approximately 50% of the study sample had high loneliness levels and one third of them had moderate levels while only one fifth had low levels of loneliness. This contradiction between results can be explained as in the current study residents living in geriatric homes which are considered a social living setting, where residents can interact with staff members, other residents and/or visitors. Researchers suggest that the ability of residents to establish superficial relationships with other residents and staff may deceive them as being truly connected or being in deep relationships; simply they accept the available.

On the other hand, current results clarified a significant statistical difference between the free and paid residents in four items of loneliness scale; "there is always someone i can talk to about my day-to-day problems" at p=0.041 with mean 0.56 for free residents compared to higher mean for paid residents with 0.89. "I miss having a really close friend" at p=0.015 with mean 0.1.67 for free residents compared to 1.14 for paid residents, "there are many people i can trust completely" at p=0.001with mean 0.44 for free residents compared to 1.00 for paid residents, and finally "I miss having people around me with" at p=0.011 with mean 0.44 for free residents compared to 0.95 for paid residents. These findings can be explained as residents in the free geriatric homes are mostly have no relatives to ask about them, lost their significant loved ones as husband or wife, some of them were homeless and admitted to

the free home as a physical shelter only which rescue them from the cruelty of life and people with no need to talk to or trust anyone even in the geriatric homes, they were satisfied with only some superficial relationships in the geriatric home. Feelings of 'un-belonging' and difficulty in communication with residents of different mental capacities are all factors contribute to loss of their social connectedness with others. Residents in free geriatric homes may have few chances to make decisions or exert control over their life. Thus, feelings of loneliness and boredom can result from this lack of control in addition to being passive in daily activities as doing nothing, waiting, and sleeping. While residents of paid group were having some relatives as sons, daughters, or friends who can ask about them, visiting them and talk with them about their problems, they also can form new friendships in the geriatric home, some of them were able to go out the home and visit his friends, family members, or even go to the club.

Concerning levels of resilience, study results approved that, the majority of residents' resilience in both free and paid groups was ranging from moderate to high levels. Results also revealed a statistical significant difference between free and paid residents in relation to levels of resilience at p=0.02. This statistical difference can be explained as residents in paid group had higher resilience levels which reflects their ability to come back from adversities, stressors, or hard situations as they reported ability to manage and control their life situations, they were more proud with their achievements in life, were more determined, still have interest in many things in life and have confidence in themselves to overcome hard situations than residents in free group. This study finding is consistent with Macleod et al., (2016) who implemented a systematic review study to evaluate the impact of resilience between older adults and inform potential intervention design that may benefit them, they concluded that, high resilience has been reported in elderly in range of 14% to 35% and suggested that higher levels of resilience are connected with growing age. This consistency in results can be explained as the essential element of high resilience among elderly may be related to bio-psychosocial factors as adaptive coping strategies, hopefulness, positive emotions, connectedness to others, social support, and being physically active which are common shared factors between elderly in both studies.

Present results clarified that, the reported quality of life among the majority of residents in both free and paid groups was ranging from moderate to high levels. This current finding is in disharmony with Mohammed, Mourad, & Abd-Elfattah, (2020) who conducted a study to assess life quality of elderly residents at geriatric homes and found that (70%) of the sample were having low quality of life. This discrepancy in findings can be explained as elderly in the current study either in the free or paid group were considering the geriatric home as a rescue shelter which save them from deprivation of basic needs, protect them from loneliness after death of loved ones or after being abandoned from surrounding others, also it provides accepted health services in addition to some recreation. All of these reasons made the residents to positively estimate their current quality of life in the geriatric homes which definitely differs from their suffering before joining these homes.

In relation to quality of life dimensions, Findings of this study exhibited that no significant difference found between paid and free groups concerning total quality of life and its physical, psychological and social sub-dimensions while it showed a statistical significant difference in relation to its environmental aspect at (p value) = 0.003 with mean 23.00 for free group compared with 27.33 for paid group. This statistical difference may be related to the quality and availability of services; mainly health and recreational, in paid geriatric homes were better than free homes which reflected in residents' evaluation of their environment. This current study finding is in line with Trybusińska & Saracen, (2019) who carried out an exploratory study on 250 ageing care home residents in Poland to assess their feeling of loneliness and life quality and found that, the environmental dimension was estimated as best by both males and females of studied sample. This congruence in results reveals the positive relation that developed between the elderly and the place he/she is

living in as their life now revolves around these homes.

Present study results showed highly significant statistical positive correlation between total quality of life and social relations as one of its sub- domains. This finding is congruent with Areeckal & Arunkumar, (2021) who conducted a study on 160 elderly to evaluate quality of life among elderly in geriatric homes and geriatric population within their families in India and concluded that, presence of statistically significant (p<0.001) difference in social domain of QOL. From the researchers' point of view, this results emphasize the importance of social relations (in the form of personal relations, friends availability, and continuous support from surrounding others) in elderly life specially those who reside at geriatric homes, it also emphasizes the reciprocal relationship between quality of social relations and quality of life among elderly.

Existing study results also indicated a highly statistically significant positive correlation between resilience and quality of life with (p value) = (0.000). This result is matched with Hayat, Khan, & Sadia, (2016) who conducted a study on 212 elderly adults, 88 of them lived at geriatric home, in Pakistan and found that, resilience was significantly and positively related to life satisfaction which consequently reflected on their quality of life positively. Current findings also are consistent with Gerino, Rollè, Sechi & Brustia, (2017) who conducted a study on 290 Italian elderly to study effects of mental health and resilience on their quality of life, in specific terms to clarify the relationship between loneliness and quality of life with its physical and psychological dimensions; they found that as the degree of resiliency increased, the perceived physical and psychological life quality among elderly increased. They also noticed reduced depressive and anxiety symptoms at the same time. This consistency of results proves the importance of resilience; in terms of strong social networks, being physically active, and having positive emotions, in improving quality of life.

Present findings showed that, a statistical negative correlation was evident between loneliness and both resilience and quality of life with (p value) = (0.005 & 0.000) respectively. These results is in agreement with Tan, Tam, Goh, Ow & Wu, (2021) who conducted a study on 60 residents of elderly persons at nursing homes and day care units and found that, resilience and loneliness were correlated with QOL and its domains. It is also consistent with Trybusińska & Saracen, (2019) who conducted a research on 250 elderly in nursing residence situated in Poland, and found significant inverse correlations between loneliness and quality of life dimensions.

Concerning correlation between personal data of studied subjects and study variables, outcomes of the present study displayed that, there was no correlation between loneliness and age, gender, educational level, marital status and job. The same finding was indicated by Abdel Aleem, Al Nagar, Eita & Shattla, (2020) who conducted a study on 53 elderly from geriatric nursing home at Menoufia governorate in Egypt and manifested that, no correlation was found between loneliness and socio-demographic data of studied sample specifically age, gender, occupation, educational background, level of income and presence of chronic diseases. While the same results of 2020's study revealed that, there was significant correlation between marital status and loneliness which is contrasted to results of the current study. This difference may be due to that about two thirds of elderly in that study was widow compared to about one half in the current study. This indicates that, elderly who were having a spouse or life partner in their lives reported more feeling of loneliness as they miss their life partner for whom they used to.

A positive correlation is found between resilience and personal data in relation to income among free and paid studied subjects with (p value) = (0.03). This result is matched with Mutepfa & Shaiba, (2022) who conducted a study to determine the key factors associated with resilience in older people in Botsuana, and they found five major predictor variables; depression, quality of life, impairment of social functioning, education, and whether services are free or paid. The ability to pay for services

is consistent with the level of elderly income as elderly with low income joined free homes and experience low level of resilience while elderly with satisfactory income joined paid homes and experience higher levels of resilience as they can receive better services and have more control over their environment.

Conclusion

As it is shown in the study findings, there was a low level of loneliness among elderly in geriatric homes, moderate to high levels of resilience and quality of life among majority of elderly. In addition, it is evident that there was a significant negative statistical correlation between loneliness and both resilience and quality of life and positive statistical correlation between resilience and quality of life of elderly.

Recommendations

1- Designing programs to enhance social functioning and resilience may be effective in improving quality of life among elderly living in geriatric homes.

2- Providing training programs to activate the role of psychiatric and community health nurse at geriatric homes to provide bio-psychosocial integrative care for elderly.

3- Further researches should be conducted to identify different factors that affect quality of life of elderly to enhance well-being of this vulnerable group.

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