The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 4, Issue 4, DIP: 18.01.151/20170404
DOI: 10.25215/0404.151
http://www.ijip.in | July-September, 2017

The International Journal of INDIAN PSYCHOLOGY

Original Research Paper

A Study of Perceived Stress and Loneliness in Older People with Depression

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ABSTRACT

It has been documented that elderly are more prone to psychological problems and depression is the commonest geriatric psychiatric disorders. In fact, the elderly in India face a multitude of psychological, social and physical health problems. In a cross-sectional study, it was found that in persons of 65 years and older, the perceived adequacy of emotional and tangible support was clearly associated with depressive symptoms. ***Aim and Objective:*** To study the relationship between Perceived Stress and Loneliness in Older People with and without Depression. ***Sample and Methodology:*** This study comprised of 60 (30 with depression and 30 without depression) participants of age 60 years or above. The sample was selected with purposive incidental sampling technique. ***Material used:*** Geriatric Depression Scale- 30, Perceived Stress Scale (PSS) and UCLA-loneliness scale were administered after taking consent from the participants. ***Results:*** Result shows the comparison of means between depressive (case-group) and non-depressive (control-group) as per the scores on Perceived Stress Scale and University of California Log Angeles Loneliness Scale. On UCLA-loneliness scale, the scores of depressive group were found to be statistically significant at 0.01 levels (t-value 19.547) in comparison to non-depressive group and on Perceived Stress Scale, the scores of depressive groups were also found to be statistically significant at 0.01 levels (t-value 14.716) in comparison to non-depressive group. ***Conclusion:*** In brief, the findings of the study show that perceived stress and loneliness are the contributory factors of depression. It has also been observed that depressed people perceive more stress, loneliness than non-depressed older people.

Keywords: *Depression, Perceived Stress, Loneliness, Older People*

India, in the past century has witnessed a decline in the birth rate and an improvement in life expectancy, with a substantial reduction in mortality amongst older persons. The next few decades are expected to see an unprecedented increase in the number of older people needing mental health interventions in India. (Rao & Shaji, 2007).

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Received: August 30, 2017; Revision Received: September 25, 2017; Accepted: September 30, 2017

It has been documented that elderly are more prone to psychological problems and depression is the commonest geriatric psychiatric disorders. In fact the elderly in India face a multitude of psychological, social and physical health problems. In a cross-sectional study, it was found that in persons 65 years and older, the perceived adequacy of emotional and tangible support was clearly associated with depressive symptoms. (Barg, Huss, Wittink, Murray, Bogner & Gallo, 2006)

With a rapidly aging society, geriatric mental health is emerging as an important public health concern. According to the WHO, prevalence of depression in adults aged ≥ 60 years in developed and developing countries was 0.5 million and 4.8 million respectively in 2004. In India, increased life expectancy led to a rise in the older adult population between 2001 and 2011, and is expected to reach 324 million by 2050 (WHO, 2005). Depression is common in the elderly and is a major public health problem. The WHO (2005) also emphasized that depression, can lead to physical, emotional, social and economic problems.

Perceived stress is an important indicator of mental and physical health. Stress occurs when individuals encounter situations they perceive as threatening, demanding, or that tax or exceed their capacity to address (Lazarus & Folkman, 1984). Perceived stress is associated with not only exposure to stressors, but also personal coping skills and resources to deal with stressful situations. (Pearlin & Skaff, 1996). Unmanaged stress can result in a series of negative changes on physiological processes and behavioral patterns, including depression (Hammen, 2005).

Older adults experience a number of new and unfamiliar stressors. Some of the most common stressors include: not having enough money to live on, loneliness or not having enough friends, having to depend on other people, family problems, and taking care of a sick spouse or relative (Choi & Jun 2009). It is important to understand the types of stressors experienced by older adults in order to help them cope.

Loneliness is defined in various ways, but all definitions share the same conceptualization that this is an unpleasant, anxiety inducing subjective experience that is the outcome of inadequate social relationships (Peplau & Perlman, 1982). It results when a person's network of social relationships is deficient in some important ways, either qualitative or quantitatively. Quantitative aspects of the network include the number of people as well as the composition of the network (family, friends). Qualitative factors are related to the level of satisfaction with the number and composition of the network and with what the network offers. Loneliness may be either a persistent, life-long phenomenon, or it may last for shorter periods and be tied with different situational factors that hamper the maintenance of social relationships. Loneliness is a major issue relating to quality of life and wellbeing facing the older adult. Older adults are often at risk for loneliness because of disruptions to social networks over time. For example, children may move to another city or country, and grandchildren may become independent. Retirement reduces social relationships that are related to work in this age group. Disability or illness may prevent them from participating in usual activities with

others, or may mean a loss of independence that necessitates moving away from familiar people and communities (Alpass & Neville, 2003).

Finally, friends and spouses may become ill or die. All of these situations can result in loneliness for the elderly. Researchers have identified a lack of confidential and close relations, absence of friends, spousal loss and limited social support networks as one of the major factors that increases loneliness in this age group (Tikainnen & Heikkinen, 2004). Older people with access to more social support report less loneliness and depression (Kahn, Hessling & Russell, 2003) in turn, concluded that loneliness was associated with a sense of proximity and security, whereas the presence of a spouse or a close relationship with the spouse was not (Mullins & Mushel, 1992). Contacts with peers and friends are equally important to old people as is the presence of a close person one trusts (Gupta & Korte, 1994).

The definition of stress refers to "the state manifested by a specific syndrome which consists of all the non-specifically induced changes within the biological system" (Selye, 1956). Stress can be described in a broader sense as the association between the environment and the present condition of the person. The response to the relationship tends to be distress or anxiety (Burke, 1991). Studies show that psychological stress occurs when an individual perceives that external demands of daily life exceed his or her adaptive capability. These studies focus on the incidence of environmental events that are continually testing the character of an individual and his or her ability to cope (Dyson & Renk, 2006). Another focal point is on the individuals' responses to events (how they react to them both physically and mentally) that can cause an overload from perceived stress, possibly resulting negative effects (Cohen, Janicki-Deverts & Miller, 2007).

Two most common forms of stress are known throughout the literature, distress and eustress. Hans Selye, also known as "the father of the stress construct in psychology", first proposed that distress is equated with leading to organismic breakdown.

Perceived stress is an important indicator of mental and physical health. Stress occurs when individuals encounter situations they perceive as threatening, demanding, or that tax or exceed their capacity to address (Lazarus & Folkman, 1984). Perceived stress is associated with not only exposure to stressors, but also personal coping skills and resources to deal with stressful situations (Pearlin & Skaff, 1996) Unmanaged stress can result in a series of negative changes on physiological processes and behavioural patterns, including depression (Hammen, 2005). In particular, compared with other age groups, stress indicates more severe and intense health effects for older adults.With increasing age, older adults are naturally exposed to new and unfamiliar stressors, but are challenged with obtaining adequate coping resources and skills. Adults are vulnerable to stress in their lives due to their increased risk of multiple losses, health-related problems in aging, dependence on caregivers, emotional loneliness, limited income and social support, and diminished resilience to transitions in later life (Donaldson & Watson, 1996; Ryan & Patterson, 1987; Choi & Jun, 2009).

Cohen and Janicki-Deverts in 2010 examined national poll and survey data for distributions of psychological stress in the United States for 1983, 2006, and 2009. Data from the Perceived Stress Scale were also available for each year (Cohen, Kamarack & Mermelstein, 1983) The PSS evaluates the degree to which certain situations in life are perceived as stressful. The researchers found that women, younger adults, people of lower socioeconomic status, and men who experienced substantial losses of income and wealth experienced the greatest stress.

Older adults experience a number of new and unfamiliar stressors. Some of the most common stressors include: not having enough money to live on, loneliness or not having enough friends, having to depend on other people, family problems, and taking care of a sick spouse or relative (Choi & Jun, 2009) It is important to understand the types of stressors experienced by older adults in order to help them cope.

With aging older people often find themselves dealing with obstacles or problems. Some individuals deal with these problems or obstacles well and others do not. Coping styles play an important role in stress management. Yancura and Alclwin in 2008 grouped coping into five main categories: problem-focused coping, emotion-focused coping, social support, religious coping, and cognitive reframing. Coping goes hand in hand with resilience. There is current interest in building resilience (Newman, 2005). Resilience is often defined as "bouncing back" from a stressor (Earvolino-Ramirez, 2007). Resilient individuals have the ability to adapt to tragedy, trauma, adversity, hardship, and ongoing life stressors (Newman, 2005).

Objectives

1. To assess the level of perceived stress and loneliness among older people with depression
2. To assess the level of perceived stress and loneliness among older people without depression
3. To compare the level perceived stress and loneliness between older people with depression and without depression

Hypothesis: *Keeping in view the aforementioned objective, the following hypotheses were framed:*

1. There would be significant difference in scores of perceived stress and loneliness between older people with depression and without depression
2. There would be positive correlation between social support and depression

RESEARCH METHODOLOGY

Research Design

This study was cross-sectional and comparative in nature. Face-to-face interview survey method using structured questionnaires was adopted for this study.

Sample

An incidental purposive sample of 60 subjects (30 with diagnosis of depression and 30 without depression) aged 60 years or above fulfilling the inclusion criteria were selected for the study.

Inclusion criteria for case group

1. Patient aged 60 years or above (Any gender) with diagnosis of depression as per ICD-10 DCR (Non-psychotic Features)
2. Able to read and write English/Hindi/Punjabi
3. Score ≥ 10 on Geriatric depression Scale
4. Patient who gave consent for participation in study

Exclusion criteria for case group

1. Patient who had co-morbid substance abuse, intellectual disability or any other psychiatric disorder
2. Patient with definitive diagnosis of dementia or non-depressive psychiatric illness, which may preclude accurate screening for depression

Inclusion Criteria for Control Group

1. Patient aged 60 years or above (Any gender)
2. Geriatric Depression Score < 9
3. One who could read /write Hindi/English/Punjabi
4. Patient who gave consent for participation in study

Exclusion Criteria for Control Group

1. Patient who had co-morbid substance abuse, intellectual disability and any other psychiatric disorder
2. Patient with definitive diagnosis of dementia

Material Used

1. **Geriatric Depression Scale-Hindi Version (GDS-H):** The Geriatric Depression Scale (GDS) was created in 1983 by Yesavage, Brink, Ros, Lum, Huang, Adey and Leirer. The instrument has been tested and used extensively with the older population in many countries and translated into many languages. The target population for the GDS is healthy or medically ill and mild to moderately cognitively impaired older adults. It has been used in research among older adults in community, acute and long-term care settings. Hindi version of GDS is prepared by Ganguli, Dube, Johnston, Pandav, Chandra and Dodge in 1999. It is found to have 92% sensitivity and 89% specificity.
2. **University of California Log Angeles loneliness Scale:** The UCLA Loneliness Scale (Version 3) developed by Russell in 1996 is to be used in this study to measure loneliness. The scale consists of 20 questions, and is designed to identify feelings of loneliness in large groups of respondents, including older adults. Respondents are asked to respond to each question on a 1-3 scale, from ‘never’ to ‘often’. An item is worded to

suggest a general, present-day experience that relates to both social and emotional dimensions of loneliness (e.g. I feel a part of a group of friends' No one really knows me well'). The wording of the items and response format has been simplified to facilitate administration of the measure to less educated populations such as the elderly. Higher scores on this scale indicate more intense feelings of loneliness. Higher scores on this scale indicate more intense feelings of loneliness. According to Perry's loneliness classification scheme, a score of 50–60 indicates a moderately high degree of loneliness, a score of 35–49 indicates a moderate degree of loneliness, and a score of 20–34 indicates a low degree of loneliness (Perry, 1990). Russell also reported that alpha coefficients for the UCLA Loneliness Scale ranged from 0.89 to 0.94 (Russell, 1996).

3. **Perceived Stress Scale-14:** The Perceived Stress Scale (PSS) is developed by Cohen and Tom in 1983. It is the most widely used psychological instrument for measuring the perception of stress. It is a measure of the degree to which situations in one's life are appraised as stressful. Items are designed to tap how unpredictable, uncontrollable, and overloaded respondents find their lives. The scale also includes a number of direct queries about current levels of experienced stress. The PSS was designed for use in community samples with at least a junior high school education. The items are easy to understand, and the response alternatives are simple to grasp. Moreover, the questions are of a general nature and hence are relatively free of content specific to any subpopulation group. The questions in the PSS ask about feelings and thoughts during the last month.PSS-14 scores are obtained by reversing the scores on the seven positive items, e.g., 0=4, 1=3, 2=2, etc., and then summing across all 14 items. Items 4, 5, 6, 7, 9, 10, and 13 are the positively stated items.Following are the Psychometric properties of PSS: Reliability: alpha = .78, Validity: Correlates in a predicted way with other measure of stress (Job Responsibilities Scale, life events scales) (Cohen & Williamson, 1988).

Procedure

30 elderly participants with diagnosis of depression (Age = 60 or above) were recruited in case group for the study from OPD services of Department of Psychiatry of a Medical College in Chandigarh and 30 non-depressive geriatric subjects were recruited from the registration counter of the same Hospital. An informed written consent for the study was taken from the patients meeting inclusion criteria. Thereafter Socio-demographic details were recorded and GDS, UCLA Loneliness Scale and Perceived Stress Scale-14 were administered. No interference was done by the investigators in treatment and no advice was provided regarding the treatment. These cases were referred back to respective consultant after data collection. Data collected from the assessment were analyzed using relevant statistical methods. The assessment procedure with each individual took about 1 hour.

RESULTS AND DISCUSSION

Table 1 Mean and Standard Deviation of age of depressive and non-depressive group

	Group	N	Mean	Standard Deviation
Age	**Depression**	30	65.57	4.94
	Non-depression	30	65.70	5.49

Table-1 shows the mean age of depressive group i.e. case group, was 65.57 years with standard deviation of 4.94. In non-depressive i.e. control group, the mean age was 65.70 year with standard deviation of 5.49. Both the groups had similar mean age around 65 years.

Table 2 Socio-demographic characteristics of Depressive and Non-depressive group

Variables		Groups					
		Depressive N=30	Percentage (%)	Non-depressive N=30	Percentage (%)	χ^2	p values
Gender	**Male**	18	60.00%	22	73.33%	1.200	0.273
	Female	12	40.00%	8	26.67%		
Marital Status	**Married**	27	90.00%	26	86.67%	0.219	0.896
	Unmarried	1	3.33%	1	3.33%		
	Widowed	2	6.67%	3	10.00%		
Education	**Illiterate**	2	6.67%	3	10.00%	11.10	0.085
	Primary	10	33.33%	6	20.00%		
	Middle	7	23.33%	1	3.33%		
	Matric	3	10.00%	12	40.00%		
	Inter/ Diploma	3	10.00%	3	10.00%		
	Graduate	3	10.00%	3	10.00%		
	Post Graduate	2	6.67%	2	6.67%		
Domicile	**Rural**	9	30.00%	10	33.33%	0.77	0.781
	Urban	21	70.00%	19	63.33%		
Income	**Nil**	1	3.33%	1	3.33%	3.073	0.381
	Up to 5000	9	30.00%	4	13.33%		
	5000-10000	6	20.00%	5	16.67%		
	Above 10000	14	46.67%	20	66.67%		
Family Type	**Nuclear**	10	33.33%	14	46.67%	4.867	0.088
	Extended	6	20.00%	10	33.33%		
	Joint	14	46.67%	6	20.00%		

*** Significant at 0.01 (2 tailed) * Significant at 0.05 (2 tailed)*

Table-2 shows that out of 60 subjects, majority were males. In case group and control group, 60% and 73.33% respectively were males. In case group, most of the subjects (90%) were married. In control group too majority of the subjects (86%) were married. Majority (33.33%) of the subjects were educated up to primary in depression group whereas most of the subjects (40%) of non-depressive group were educated up to matriculation. Majority of the subjects in both groups were urban. In case group 70% and in control group 63.33% were urban. In case group majority of subject (46.67%) had income above 10,000. In control group (66.67%)

subjects had income above 10,000. In case group most of the subjects (46.67%) were living in joint families whereas in control group majorities (46.67%) were from nuclear families.
As shown in table-2, on each socio-demographic variable the chi-square value was found to be statistically non-significant, so both groups were comparable on all socio-demographic variables.

Table 3: Mean, Standard Deviation, and t-value of Geriatric Depression Scale (GDS) scores of Depressive and Non-Depressive groups

Variable	Group	N	Mean	Standard Deviation	Standard Error Mean	t-value	p-value
GDS	**Depressive**	30	23.33	4.18	0.76	20.373	0.000**
	Non-depressive	30	5.53	2.33	0.42		

*** Significant at 0.01 (2 tailed) * Significant at 0.05 (2 tailed)*

Table-3 shows the comparison of means between depressive (case-group) and non-depressive (control-group) as per the scores on **Geriatric Depression Scale** (GDS) .The mean score (23.33) of depressive group was higher than that of non-depressive group (5.53). The t-value (4.867) was found to be statistically significant at 0.01. (p-value 0.000).

Table 4: Mean, Standard Deviation and t-value of UCLA-Loneliness Scale (UCLA-LS) scores of Depressive and Non-Depressive Groups

Variable	Group	N	Mean	Standard Deviation	Standard Error Mean	t-value	p values
UCLA-LS	**Depressive**	30	43.90	7.90	1.44	19.547	0.000**
	Non-depressive	30	10.93	4.78	0.87		

*** Significant at 0.01 (2 tailed) * Significant at 0.05 (2 tailed)*

Table-4 shows the comparison of means between depressive (case-group) and non-depressive (control-group) as per the scores on **UCLA-loneliness scale**. The mean score (43.90) of depressive group was higher than that of non-depressive group (10.93). The t-value (19.547) was found to be statistically significant at 0.01. (p-value 0.000).

Table 5: Mean, Standard Deviation and t-value of Perceived Stress Scale (PSS) scores of Depressive and Non-Depressive Groups

Variable	Group	N	Mean	Standard Deviation	Standard Error Mean	t-value	p values
PSS	**Depressive**	30	36.00	6.40	1.16	14.716	0.000**
	Non-depressive	30	15.43	4.19	0.76		

*** Significant at 0.01 (2 tailed) * Significant at 0.05 (2 tailed)*

Table-5 Shows the comparison of means between depressive (case-group) and non-depressive (control-group) as per the scores on **Perceived Stress Scale (PSS)**. The mean score (36.00) of depressive group was higher than that of non-depressive group (15.43). The t-value (14.716) was found to be statistically significant at 0.01. (p-value 0.000).

Table 6: Correlation among variables of the study

Variables	GDS	UCLA-LS	PSS
GDS	1	.910**	.897**
UCLA-LS	.910**	1	.861**
PSS	.897**	.861**	1

*** Significant at 0.01 (2 tailed) * Significant at 0.05 (2 tailed)*

Table- 6 shows that Loneliness Scale Scores are positively correlated (r = .910) with GDS Scores and are significant at 0.01 level and score of PSS scores are also positively correlated (r =.897) with GDS scores with 0.01 level of significance.

CONCLUSION

In brief, the findings of the study show that perceived stress and loneliness are the contributory factors of depression. It has also been observed that depressed older people perceive more stress and loneliness than non-depressed older people. Similar findings are investigated in several studies in which it was found that unmanaged stress can result in a series of negative changes on physiological processes and behavioral patterns, including depression (Hammen, 2005). With increasing age older adults are naturally exposed to new and unfamiliar stressors and this increases their vulnerability to health-related problems in aging, dependence on caregivers and emotional loneliness (Donaldson & Watson, 1996; Ryan & Patterson, 1987; Choi & Jun, 2009).

Acknowledgments

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest: The author declared no conflict of interest.

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How to cite this article: Saini S S, & Mandeep (2017). A Study of Perceived Stress and Loneliness in Older People with Depression. *International Journal of Indian Psychology*, Vol. 4, (4), DIP:18.01.151/20170404, DOI:10.25215/0404.151