THERAPEUTIC EFFICACY OF SOLUTION FOCUSED BRIEF THERAPY (SFBT) FOR DEALING WITH THE PSYCHOSOCIAL PROBLEMS OF OLDER ADULTS LIVING IN OLD AGE HOMES

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THERAPEUTIC EFFICACY OF SOLUTION FOCUSED BRIEF THERAPY (SFBT) FOR DEALING WITH THE PSYCHOSOCIAL PROBLEMS OF OLDER ADULTS LIVING IN OLD AGE HOMES

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To my parents who always encouraged me to work towards my dreams and my daughters who have been an immense source of support throughout this endeavor.

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ABSTRACT

The purpose of this study was to investigate the efficacy of Solution Focused Brief Therapy (SFBT) in dealing with the psychosocial problems of older adults living in old age homes. A quasi-experimental, (2x3) mixed factorial design was used to conduct the study. Measures including Urdu versions of Lubben social network scale -6 (Lubben et al., 2006), generalized self-efficacy scale (Schwarzer & Jerusalem, 1995) and mental health continuum-short form (Keyes, 2009) were used to assess the variables in the study. *Phase I* of the study involved screening of participants for treatment groups, for which a sample of 44 older adults, both males *(n=30)* and females *(n=14)* aged between 60-90 years, were selected from private old age homes of Rawalpindi and Islamabad. The results of Pearson product moment correlation showed social isolation to be non-significantly correlated with self-efficacy and psychosocial well-being, while self-efficacy and psychosocial well-being were significantly and positively correlated. *Phase II* involved investigating the efficacy of SFBT for older adults living in old age homes. A sample of 18 older adults, both males *(n=8)* and females *(n=10)* who were screened in *Phase I*, were selected and divided into intervention (*N=9*, males; *n=4* and females; *n=5*) and control (*N=9*, males; *n=4* and females; *n=5*) groups. Results of two-way (2x3) mixed factorial ANOVA showed that after receiving SFBT, the scores on self-efficacy and psychosocial well-being (emotional well-being and psychological well-being) significantly improved for the intervention group, in post and follow-up assessments, as compared to the control group. However, the improvement in social well-being was non-significant. This study proves SFBT to be a suitable intervention in providing socially isolated older adults in old age homes with a sense of empowerment and well-being.

Keywords: Solution Focused Brief Therapy, Old Age Home, Self-Efficacy, Psychosocial Well-Being

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LIST OF ABBREVIATIONS

SFBT	Solution Focused Brief Therapy
WHO	World Health Organization
CBT	Cognitive Behavioral Therapy
SFBTA	Solution Focused Brief Therapy Association

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Chapter I

INTRODUCTION

The South Asian societies being predominantly collectivistic, generally prefer the joint family system, with aging parents living with their children and grandchildren (Yeung et al., 2018). However, with the increase in the pace of life and the migration of many younger people to foreign countries, grown children have less time to look after their aging parents (AshfaqB, 2016). In Pakistan too, the elderly, being dependent upon others at this stage of life, sometimes face a neglectful and insensitive attitude from their families (Jalal & Younis, 2014). A large proportion of the elderly in the country now live by themselves and are in need of alternate living arrangements to ensure the provision of a safe environment (Cassum et al., 2020). Many old age homes have been established in major cities across Pakistan and there is a growing trend of people moving to these facilities (Shahid & Tariq, 2023).

Research has shown that once elderly people move into old age homes, their communication with family and friends is greatly reduced (Tsai et al., 2011). Moreover, multiple issues like lack of intimate relationships, heightened dependency, speech impairment, hearing loss and decreased mobility, all contribute to an elevated level of isolation experienced by them (Boamah et al., 2021). They feel a deep sense of loneliness accompanied by feelings of being abandoned due to their inability to contribute to society and being dependent upon others (Vertejee et al., 2020).

The association between social isolation and feelings of sadness among the elderly is mediated by self-efficacy (Roskoschinski et al., 2023), however, old age home

residents have often been observed to have low self-efficacy (Cybulski et al., 2017). The experience of loneliness and decreased self-efficacy and have both been seen to predict the onset of depressive symptoms (Erzen & Cikrikci, 2018; Tu & Zhang, 2014), contributing to a reduced sense of well-being (Shabaani et al., 2017).

The well-being of residents of old age homes in Pakistan has been seen to be strongly associated with the number of family members who pay them frequent visits (Tariq et al., 2020) and a lack of social contacts and social engagement often leads to decreased well-being in the elderly (Zainab & Naz, 2017). As a result, older adults living in old age homes have often been observed to have a lower degree of well-being as compared to those who are community dwelling and interventions targeting their well-being have been recommended (Cesetti et al., 2017).

Solution Focused Brief Therapy (SFBT) has been successfully used internationally to facilitate older adults in the enhancement of their well-being, both with old age home residents (Seidel & Hedley, 2008) and in outpatient settings (Dahl et al., 2000). The present research is aimed to examine the efficacy of SFBT for improving the self-efficacy and well-being of older adults residing in old age homes.

Social Isolation

Social isolation refers to living without the presence of companionship, social support or social ties and the lack of significant individuals whom one relates with, trusts, and turns to at difficult times (Hawthorne, 2006). Leigh-Hunt et al. (2017) define it as discernably reduced interactions with other people and the larger network.

Zavaleta et al. (2014) have explained social isolation as insufficient social relations in both quality as well as quantity across various levels of human engagement, spanning individual, group, community, and broader social environments. According to Nicholson (2009), social isolation is characterized by a reduced perception of social involvement, few social relations, along with a dearth of fulfilling and quality relationships.

Holt-Lunstad et al. (2010) have described social isolation as the constant absence of a trusted companion, social interaction or engagement in social events. Social isolation can be conceptualized as a construct that encompasses objective elements, referring to the state where a person does not have relationships with others (Gierveld & Tilburg, 2006). Newall and Menec (2019) propose social isolation as being an objective construct, defining it as the actual absence or scarcity of interpersonal connections or relations.

Social isolation has two components. The *objective component* refers to the actual lack of social contacts in the individual's environment (Cacioppo et al., 2011). It is the quantitative aspect of the social network, encompassing factors like the frequency, number and quality of social interactions (Cornwell & Waite, 2009a). The *subjective component* refers to the feeling of not having or being incapable of relating to social relations. Subjective social isolation, pertains to an individual's perception of loneliness and feelings of being disconnected from others, regardless of the actual level of social engagement (Hawkley & Cacioppo, 2010). Subjective social isolation may also be termed as loneliness, which is perceived social isolation and is a primarily personal experience, and thus is more difficult to quantify (Holt-Lunstad et al., 2015). Both components have been found to be distinct, as research has shown that a person might be

surrounded by people and yet feel lonely or have few social contacts and yet not perceive a sense of isolation (Brooks-Wilson, 2013; Cornwell et al., 2009b).

Recent studies have indicated a concerning rise in reports of loneliness and social disconnection, particularly among elderly people (Holt-Lunstad et al., 2020). Social isolation's consequences extend beyond mere loneliness. Extended periods of social isolation have been linked to a number of negative outcomes, including a higher chance of depression (Teo et al., 2015), anxiety (Santini et al., 2020), cognitive deterioration (Lara et al., 2019), and even mortality (Holt-Lunstad et al., 2015).

Although social isolation can be experienced by all demographics, certain groups like older adults, are more susceptible than others to being isolated (Kannan & Veazie, 2023; Newall, 2019). There is evidence suggesting that social isolation increases with age due to a multitude of reasons, such as a decline in the social network's magnitude (Meyer-Wyk & Wurm, 2024) and an increase in the subjective feelings of loneliness (Spitzer et al., 2022). Social isolation is a significant public health concern, impacting a large number of older individuals and has been identified as a global epidemic among the elderly population (Murthy, 2017).

Among older adults, social isolation and subjective feelings of loneliness are also dependent upon the place of residence (Victor et al., 2020), especially for those living in residential care facilities, the likelihood of isolation increases (Autschbach et al., 2024). Additionally, a limited number of studies exist investigating the efficacy of psychotherapy in reducing feelings of isolation among nursing home residents (Grenade & Boldy, 2008).

Self-Efficacy

Albert Bandura (1977) defined self-efficacy as the conviction that a person has that he or she is able to effectively carry out the tasks necessary to generate the desired result. He further explained self-efficacy as the chief psychological source that motivates a person to act and guides how they choose to direct their lives. It relates to how a person perceives his capacity to organize and implement steps required in order to accomplish his goals. Jakubowska et al. (2020) classify self-efficacy as a psychological mechanism leading to change in behaviors, attitudes and actions which is possessed by each individual to varying extents and enables a person to plan their intentions and activities across difference domains.

Self-efficacy is a performance-oriented indicator of perceived ability, according to Zimmerman (2000). Chen et al. (2000) describe self-efficacy as the pervasive differences among people, in the degree to which they see themselves as competent enough at handling different tasks in various situations. They state that the construct encompasses the faith one has in their own capacity to accomplish goals in diverse areas. According to Eller at al. (2016), self-efficacy signifies the conviction that one is capable of using efforts to achieve the desired results.

Self-efficacy is conceptualized as the beliefs people hold about their capacities and how as a result of these beliefs, they establish their goals, decide upon the steps to take in order to achieve those goals and how they respond when they encounter challenges in the struggle for these goals (Chung et al., 2021). It pertains to what an individual feels he can do with his specific set of skills under specific circumstances,

despite facing unexpected difficulties (Gosselin & Maddux, 2003). In a broad context, self-efficacy is described as the confidence one holds in his or her capability to confront difficulties across a broad spectrum of demanding circumstances (Luszczynska et al., 2005).

Self-efficacy has been categorized into *(a) general self-efficacy,* which takes the construct as a broader sense of self autonomy that encompasses confidence in skills over a wide range of domains which relates to an individual's global belief in his abilities (Chen et al., 2000) and *(b) specific self-efficacy,* which can be understood as the confidence in one's capacity to perform a specific task. This domain specific self-efficacy varies according to a person's efficacious beliefs about a variety of activities and circumstances (Schwoerer et al., 2005).

Research has shown that people with a self-efficacious attitude have a greater tendency to face difficulties with persistence (Jung & Brawley, 2011), exert increased energy in tasks (Schönfeld et al., 2017) and set higher goals for themselves (Ansong et al., 2019). McAuley et al. (2011) have emphasized the need for maximization of self-efficacy as it mediates the relationship between physical activity, functional performance and the perception of functional limitations in older adults. They have also suggested that self-efficacy and physical performance have a reciprocal relationship, as improved physical performance can in turn serve as a source of perceived self-efficacy.

Health-related practices of older persons have been demonstrated to be positively impacted by self-efficacy. Self-efficacy improved the effect of interventions focusing on aging patients' physical activity (French et al., 2014). Self-efficacy being a strong

determinant of the quality of life in the elderly, should be a primary target for interventions (Fu et al., 2018).

Psychosocial Well-being

The concept of well-being is multifaceted, with its definitions varying across different age brackets and different cultures (Jardon & Roache, 2023). Seligman (2011) states that well-being is a complex construct comprising of a variety of elements, none of which can be considered to encompass the entire concept of well-being by themselves and thus must all be considered in totality.

Diener et al. (2003) define well-being as the emotional and cognitive appraisals an individual makes about his or her life. According to World Health Organization (WHO, 2014), a person is considered to be in a state of well-being when he is able to discern his abilities, manage day-to-day concerns and work in a productive manner, along with playing a significant role in society. According to Huppert (2009), psychological well-being is made up of both, a feeling of positivity and effective functioning and the ability to manage negative emotions that are a natural part of life.

According to Granlund et al. (2021), descriptions of well-being primarily center on individuals' overall assessment of their emotions, psychological state, and social welfare, either in the general scope of life or in specific domains such as work or recreation, encompassing aspects of pleasure, aspiration, or both. They state that well-being is inherent to the individual and can be viewed as a broad measure of one’s mental health across a variety of contexts.

Theorists generally view well-being from two perspectives. *The hedonic view* takes well-being to be equated with the attainment of happiness and pleasure. This relates to both physical and mental gratification and can include goal accomplishment (Thorsteinsen & Vittersø, 2020). According to this perspective, well-being is explained in terms of pleasure versus pain and the maximization of happiness (Kashdan et al., 2008). Emotional or affective facets of well-being come under the domain of hedonic well-being. *The eudaimonic view* takes well-being to be a step beyond subjective happiness and considers it a more virtuous form of meaningful contentment that has deeper and more worthwhile feelings of satisfaction. Proponents of this view note that desires that require immediate gratification are not always beneficial and do not lead to the fulfillment of an individual's actual potential (Ryff & Singer, 2006).

According to Keyes (2009), the definition of mental health combines emotional, social and psychological well-being. where emotional well-being is aligned primarily to the conceptualization of hedonia while social and psychological well-being together constitute the idea of eudaimonia.

There is has been an interest for researchers in the relationship between well-being and age. Research investigating the relationship between age and well-being has shown mixed results. Easterlin (2006) found that well-being increased between the ages of eighteen till middle age and then started to decline after that. Some researchers have found well-being to be at a minimum in the late 40s and at higher values at both younger and older ages (Blanchflower & Oswald, 2008). According to Steptoe et al. (2015), well-being has a stronger association with health than with age and the elderly with deteriorating health are likely to report lower levels of well-being.

The perception of well-being among senior citizens residing in assisted living facilities frequently declines as a result of depression, loneliness, and isolation. (Lotvonen et al., 2018) and the level of well-being has been found to be lower among old age home residents as compared to those who live in their own homes and the use of interventions to help elevate the sense of well-being of the former are suggested (Cesetti et al., 2017).

Psychological Interventions for Old Age

Usual interventions commonly used for increasing the self-regulation of younger populations have been found to be less effective in helping older adults (French et al., 2014). However, specifically designed interventions combing Cognitive Behavioral Therapy (CBT) and positive psychology principles and targeting self-efficacy have proven to have beneficial long-term effects (Scult et al., 2015).

Solution Focused Brief Therapy (SFBT)

Solution Focused Brief Therapy (SFBT) was developed by Steve de Shazer, Insoo Kim Berg and their colleagues starting in the early 1980s. The basic assumption of this approach is that no matter how severe or chronic a client's problem is, there are bound to be instances when that problem does not occur and such exceptions are the central point of the therapy as they lead to the workable solutions that lead to positive change (Iveson, 2002). The therapist focuses on this and collaborates with the client to gather all the details of what was different at the time of this exception and this information is then utilize in guiding the client's future decisions and behavior (de Shazer et al., 2007).

SFBT is a model of therapy based upon the competencies and resources of the client, with minimal emphasis on the previous shortcomings and difficulties of the clients

and primary focus on their strengths and past and future accomplishments (Bavelas et al., 2013). According to Miller and deShazer (2000), SFBT is an intervention that builds on the client's strengths and uses his resources as well as his motivation as primary tools, since the client's being the experts on their own lives are capable of generating the most viable solutions for themselves. SFBT assumes that each client comes with a unique set of experiences and that it is not advisable to try and fit them within a diagnostic framework of disorders (Nelson & Thomas, 2007).

SFBT has been used for a variety of issues like marriage conflicts (Huang, 2001), conduct disorders (Marinaccio, 2001), substance abuse (Kim et al., 2018) and depression (Spilsbury, 2012). It has also been used in many different settings, for example at schools (Franklin et al., 2008), in agency settings (Pichot & Dolan, 2014) and with mentally handicapped people (Westra & Bannink, 2006). SFBT is growing in popularity with a large number of researches being conducted on its efficacy throughout the world (Zak et al., 2023).

Theoretically, SFBT is similar to modes of therapy that focus on competency and resilience of the clients like motivational enhancement interviewing (Miller et al., 1992) and positive psychology (Seligman & Csíkszentmihályi, 2000). In their non-pathological, client centered approach and in the creation of alternate positive realities, SFBT and Narrative therapy also have common elements (Şanli et al., 2022).

Berg and Miller (1992) have outlined some basic assumptions of SFBT. The focus is on mental health as opposed to the diagnosis of mental disorders. There is a presupposition that the client has the necessary resources, will cooperate and will

inevitably change. SFBT does not generalize but approaches each client uniquely and keeps a present and future-oriented stance with minimal interest in the past.

Diminished well-being and a reduced quality of life have been linked with social isolation (Mgutshini, 2010). Research has indicated that a higher level of social engagement is linked with increased happiness and better health (Zaitsu et al., 2018). A higher likelihood of acquiring psychiatric problems such depression, anxiety, and substance abuse has been associated with prolonged social isolation. (Cacioppo et al., 2006).

The effect of social isolation and other sociocultural factors on depression levels has been demonstrated to be mitigated by self-efficacy (Gu et al., 2023). An increase in general self-efficacy was similarly linked to a decrease in feelings of isolation among the elderly (Bevilacqua et al., 2024). General self-efficacy was found to be negatively correlated with depression (Luszczynska et al., 2005) and positively correlated with various elements of well-being in the elderly population residing in residential care facilities (Ferrand et al., 2014).

SFBT has been found to have successful results in improving both self-efficacy and psychosocial well-being (Beauchemin et al., 2023). It has also been used effectively with older adults (Dahl et al., 2000; Seidel & Hedley, 2008).

Theoretical Background

Bandura's Self Efficacy Theory

Bandura (1997) theorizes, that self-efficacy is malleable and is amenable to change through four main resources, namely *mastery experiences, vicarious experiences, social persuasion* and *emotional states*. *Mastery experiences* entail individuals' direct achievements in tasks or goals, serving as the most impactful factor in shaping self-efficacy. *Vicarious experiences* involve observing similar individuals succeed, thereby reinforcing one's confidence in their own abilities. *Social persuasion* relates to the process of getting encouragement or support from those in the surroundings, bolstering one's belief in their capabilities. Lastly, *emotional states* involve interpreting one's own bodily and emotional responses as indicators of competence, with positive feelings and arousal typically associated with higher levels of self-efficacy.

Self-efficacy then affects behavior through four types of processes, exerting an influence over a person's daily life and well-being. These include *cognitive processes* like judgement of ability, difficulty of the task at hand and visualization of future scenarios, *motivational processes* like causal attributions and outcome expectancies, *affective processes* like anxiety or excitement and *selection processes* like the choices a person makes about the activities and environments they choose for themselves (Bandura, 1994).

Berkman's Framework

A conceptual framework was developed by Berkman et al. (2000), describing interactions among societal factors and health through mediating factors. They state that the dynamics of interpersonal connections and belonging significantly impact both physical and mental health. They have explained it in the form of a sequential pathway

starting from broader social elements to psycho-biological processes and elaborated how their interconnection shapes this relationship.

Factors like cultural, financial and social situations affect the magnitude, form and characteristics of an individual's social networks. These attributes of the social network further affect psychosocial mechanisms like the level of support one has from the people in his surroundings, the influence he has upon others and his level of engagement and bonding with them. All of these social circumstances then impact his health through three types of pathways, health behavioral pathways; psychological pathways like self-efficacy and well-being as well as physiological pathways.

Theoretical Basis of SFBT

Although deShazer et al. (2007) frequently asserted that no theories have been formulated for the therapeutic framework of SFBT, there are some principles and conceptual frameworks that underpin its practice (Korman et al., 2021).

Social Constructionism. One of the central tenets of SFBT is rooted in social constructionist theory, which posits that reality is constructed through language and social interaction (Gergen, 1999). Theoretically, SFBT shifted away from the objectivist approach by not attempting to diagnose clients, as it focuses on the co-construction of the reality of the client's circumstances rather than accepting things at face value. de Shazer (1985) chose not to define a client's condition according to his symptoms but to develop a reality around his strengths instead, viewing the client as the expert in his own life.

Positive Psychology. SFBT shares its approach to therapy with positive psychology, a field prioritizing the study of the values and abilities possessed by humans (Seligman & Csikszentmihalyi, 2000). Like positive psychology, SFBT emphasizes the importance of building on clients' existing resources and fostering a strengths-based perspective. By helping clients identify and amplify their strengths, therapists can cultivate resilience and facilitate positive change.

Wittgenstein's Language Theory. According to Wittgenstein's *picture theory of language*, the language we employ shapes our perception of reality and our understanding of the external world as well as our comprehension of the state of our own minds is limited by the vocabulary available to us. He suggested that the words and sentences we use create a picture of the reality the way we see it and language reflects a specific aspect of our reality. When we have only a particular set of words to define our world, it only reflects a certain side of it. Expanding our vocabulary to incorporate new words or a shift of focus leads to a changed perception (Keyt, 2013).

The concept of *language games* proposed by Wittgenstein suggested that the meanings of the words used by an individual can only be understood within the context of their use and that everyone has their own rules of these language games (Kopytko, 2007). Thus, making a person's language game solution-focused as opposed to problem-focused brings about a change in the way they communicate with others as well as themselves, as they become more focused on positivity and hope (deShazer et al., 2007). SFBT uses the same principles, where the use of language is utilized to guide the clients' focus away from the challenges they are facing and to their strengths and the supportive elements present in their lives.

Summary

Social isolation is a rising concern on a global level as it has been shown to pose multiple health risks and especially people in the later stages of life frequently struggle with it (Holt-Lunstad et al., 2015; Lara et al., 2019; Santini et al., 2020; Teo et al., 2015). At this age, factors such as the hindrance posed by health issues and death of contemporary figures often result in reduced opportunities for socialization with peers (Grusec & Hastings, 2015). Residents of old age homes are most susceptible to being isolated (Autschbach et al., 2024; Boamah et al., 2021). Certain psychological factors like self-efficacy have been found to alleviate the effect of both objective and subjective social isolation (Gu et al., 2023; Bevilacqua et al., 2024). Increased self-efficacy is associated with more adaptive behavior patterns (Ansong et al., 2019; Jung & Brawley, 2011) and an enhanced sense of well-being (Ferrand et al., 2014; Luszczynska et al., 2005). However, residents of old age homes often report having low levels of self-efficacy (Cybulski et al., 2017).

The well-being of older adults is often compromised due to a variety of situational and health factors (Easterlin, 2006; Mrokzek & Spiro, 2005). Especially the elderly living in old age homes tend to have a sense of reduced well-being, which is often triggered by being socially isolated from family and friends (Lotvonen et al., 2018; Zainab & Naz, 2017). SFBT is a viable treatment for improving self-efficacy (Beauchemin et al., 2023) and increasing the sense of well-being in older adults (Dahl, 2000). SFBT centers around

utilizing the client's competencies and resources, while minimizing attention on their shortcomings and challenges (Bavelas et al., 2013).

Chapter II

LITERATURE REVIEW

A literature review offers insight into the research already undertaken and highlights the potential areas to be explored. This chapter examines some of the researches conducted in the past which are relevant to the present study.

Social Isolation

A research was conducted by Bevilacqua et al. (2024) to study factors affecting social isolation among the elderly over a period of one year. The Lubben Social Network Scale-6, the De Jong-Gierveld Scale and the Generalised Self-Efficacy Scale were used to assess 153 participants aged 80 years and above. Participants were also assessed on health issues and lifestyle. At follow up assessment after one year, it was seen that being married and having higher self-efficacy predicted being less socially isolated. Additionally, increase in self-efficacy predicted a decrease in emotional as well as overall loneliness.

A study by Mishra et al. (2023) examined into the potential mediating influence of demographic variables on the association between well-being and social isolation. 320 participants aged sixty and above were recruited and Lubben's Social Network Scale, the UCLA Loneliness Scale and the Psychological Well-Being scale were used for assessment. The findings demonstrated a significant relationship between psychological well-being and the independent variables of gender and education. However, the impact

of social isolation and loneliness on psychological well-being was not mediated by either gender or level of education but was partially mediated by married status.

In a survey with 21,543 participants aged 65 and above, Silberzan et al. (2022), investigated gender differences in social isolation among the elderly. They collected data about the socio-demographic characteristics of the sample and used three criteria to assess the social isolation of the subjects. They noted whether the participants were living by themselves, had spent the previous week in their homes or had never used the internet. They found that women were more socially isolated compared to men on all three criteria. Age, socio-economic status and ethnicity were additional variables linked to social isolation. Older people, those from a lower socio-economic class and those belonging to minorities were found to be at a significantly greater risk of being socially isolated.

Taylor et al. (2016) studied a national database to examine the effects of both objective and subjective social isolation from friends and relatives on feelings of depression and distress in the elderly for 1,439 older adults aged 55 and above. Results showed that many of the respondents did not perceive themselves as being socially isolated, and a greater number reported objective isolation as compared to subjective isolation. Objective social isolation had a non-significant relationship with both, feelings of depression and distress. Subjective isolation from both friends and family were found to be associated with an increase in feelings of depression, while this perception in relation to friends was associated with psychological distress.

Another study was conducted to investigate the interactions between loneliness, social isolation, and indicators of health among the elderly, using a sample of 5000 participants aged 60 and above. The short form of a Revised UCLA scale was used to measure loneliness. The index of social isolation was calculated by taking into account, social activity participation, frequency of interaction with friends, family, and children, and marital status. Social isolation was seen to be more common among the participants as compared to the subjective feeling of loneliness. Additionally, increased chances of inactivity, smoking and other health-risk activities were correlated with both (Shankar et al., 2011).

Kobayashi et al. (2009) conducted a research to compile data on social isolation and health in the elderly on the basis of social and demographic characteristics. They collected data through telephonic interview from a sample of 1064 older adults of ages 65 and above, using the Lubben Social Network Scale. Results showed that social isolation could be significantly predicted by gender as well as socioeconomic and marital status. Self-assessment of health, ownership of residence and duration of stay at the personal residence also affected the level of social isolation.

Cornwell & Waite (2009b) studied the data collected through a national database to investigate information about multiple elements of elderly peoples' degree of social disconnectedness and their perceived social isolation and decided to use these to create two separate scales for both and to investigate their presence among more than 2000 participants. Through the data they found that social disconnectedness was similar among different age groups, however perceived isolation was greater among the oldest old. It was also observed that those with health issues suffered more from both social

disconnectedness and perceived isolation. They found a weak to moderate association between the two variables and noticed that although there was a strong probability of the individuals who had fewer social contacts to feel socially isolated, interestingly many of them did not report feeling lonely. On the other hand, there were many individuals who reported feeling lonely despite having many such contacts. With respect to gender, they found females having lower scores than males on both scales.

Self-Efficacy

Roskoschinski et al. (2023) examined the impact of social support and self-efficacy on loneliness and depression among the elderly, using a sample of 135 participants, 65 years and older from a medical facility's geriatric ward. The assessment measures used were the Three Items Loneliness Scale, the Hospital Anxiety and Depression Scale, the Perceived Social Support Questionnaire and the General Self-Efficacy Expectancy Scale. They found that both depression and anxiety were associated with loneliness, low self-efficacy and reduced social support. Furthermore, the association between loneliness and depressive symptomology was mediated by self-efficacy.

Dzerounian et al. (2022) conducted a survey to study health knowledge and self-efficacy among older adults living in welfare accommodation. 599 participants aged 55 and above were recruited from welfare housing societies. In addition to demographic information, data about health knowledge and self-efficacy was collected using the Health Awareness and Behaviour Tool (HABiT). Results revealed a negative correlation

between age and self-efficacy and a positive correlation between health knowledge and physical activity.

Another survey was conducted to study factors influencing the self-efficacy of aging population, focusing on gender variations in self-efficacy. 7088 participants, aged 60 and above participated in the survey. The level of education, extroversion and quality of interpersonal relationships were found to have a positive correlation with self-efficacy and age. Furthermore, poor perception of health and psychological distress had a negative correlation with self-efficacy in both males as well as females. Personal income and self-efficacy were positively associated in females but not in males (Wang et al., 2019).

Tovel et al. (2017) examined whether self-efficacy mediated the association between physical functioning and the subjective perception of aging over two years. Data was collected from 892 older adults aged 75 and above, using in-person interviews based on the SF Short Form Health Survey, Instrumental Activities of Daily Living (IADL), the Attitude Toward Own Aging subscale of the Philadelphia Geriatric Center Morale Scale (PGCM), the General Self-Efficacy Scale (GSES) and the Function Self-efficacy Scale (FSES). They discovered that the association between the level of physical functioning and the self-perception of aging, at the beginning of the study and two years later, was fully mediated by self-efficacy.

Mullen et al. (2012) studied the effect of self-efficacy and functional performance on physical activity and functional limitations in 884 older adults with an average age of 74.8 from both residential and institutional settings from various cities in the United States. In order to participate, individuals had to be at least 65 years old and have lived in

the same location for the past 12 months. Results showed that those who increased their physical activity were likely to have higher levels of self-efficacy and functional performance, and they were also likely to have less functional limitations. Improved functional performance and lesser functional limitations were also linked to higher levels of self-efficacy. In turn, correlation between reduced functional limitations and improved functional performance was found to be significant.

In a study to investigate if self-efficacy and affect can predict physical activity over a period of several years, McAuley et al. (2007) assessed 174 participants with an average age of 66.7 years at 2 and 5 years following a physical activity intervention given for a period of six months. Physical activity and self-efficacy were assessed using the Physical Activity Scale for the Elderly (PASE) and the Exercise Self-Efficacy Scale (EXSE), while affect was measured by using the Memorial University of Newfoundland Scale of Happiness (MUNSH). It was observed that the subjects who engaged in physical activity at Year 2 were most likely to engage in it at Year 5. An association was also discovered between affect and self-efficacy at Year 2 and physical activity at Year 5.

McAuley et al. (2006) recruited 249 older women, aged 59 to 84, to investigate the effect of self-efficacy on physical activity and functional limitations. Participants were assessed on the variables at the beginning of a two-year study of physical activity and health quality of older women. Functional limitations were assessed through the Late-Life Function and Disability Instrument (LL-FDI) and self-efficacy was assessed using the Activity-Specific Balance Confidence Scale (ABC), the Gait Efficacy Scale (GES), the Exercise Self-Efficacy Scale (EXSE) and the Self-Efficacy for Walking Scale (SEW); while two trained testers evaluated physical activity. Results showed that both

self-efficacy for exercise and efficacy for gait and balance were significantly correlated with physical activity as well as with functional limitations. It was observed that these associations were not affected by demographic or health variables.

Stretton et al. (2006) studied the importance of self-efficacy as a determinant in the physical health of frail older people, the inter-relationships between performance-based and self-report measures of physical functioning, and predictors of physical aspects of quality of life. They recruited 243 older adults between the ages of 74 to 84 years (129 females and 114 males) with high levels of comorbid illnesses. The assessment measures included both performance-based measures like the Timed Up and Go Test, gait speed and the Berg Balance Scale and self-report measures like the Modified Falls Self-Efficacy Scale and the SF-36 questionnaire. Self-efficacy had a strong association with both performance and quality of life.

A multicultural validation study for the General Self-Efficacy Scale was conducted by Luszczynska et al. (2005) with a sample of 1,933 subjects from three different countries, from different walks of life and, between the ages of 16 and 86 years old. Some of the participants were chosen and grouped according to specific stressors such as cardiovascular diseases or recovery from surgery. Participants were tested on general self-efficacy, behavior-specific self-efficacy, social-cognitive constructs (goal intention, implementation intention, outcome expectancies, and self-regulation of attention), well-being, health behaviors, and coping strategies. General self-efficacy was found to be strongly associated with social-cognitive constructs. Depression levels in cardiovascular patients and the levels of anxiety in gastrointestinal patients were associated with the levels of self-efficacy. Cancer patients who were more self-

efficacious reported feeling less tired and depressed, with better emotional, social and cognitive functioning. With respect to health behaviors, it was seen that students with high self-efficacy would frequently engage in moderate physical activity. The self-efficacious cardiovascular patients were also likely to be more physically active. Higher self-efficacy was associated with more regular participation in physical activity, healthier dietary habits and use of active rather than passive coping strategies.

Allison and Keller (2004) investigated how levels of physical activity were affected by a self-efficacy intervention in a sample of 83 people aged 65 to 80 years and diagnosed with coronary heart disease, by using a self-efficacy intervention and an attention control intervention. Although the interventions did not show a significant increase in the level of self-efficacy, an indirect effect was observed on their physical performance.

Psychosocial Well-being

Matud at al. (2020) conducted a study to investigate the relationship between gender and well-being in the elderly population. A total of one thousand two hundred and one older adults between the ages of 65 and 94 participated in the study. The results showed that in the areas of self-acceptance, autonomy, life purpose, and environmental mastery, men performed better than women. Positive correlation was seen between psychological well-being and traits of both genders, but it was stronger for the masculine trait. Self-esteem and social support were found to be the most significant predictors of psychological well-being in both men and women. In addition, for females, education was strongly linked to psychological well-being.

To study how social engagement and self-efficacy affect the well-being in old-age home residents, Fu et al. (2018) recruited 307 participants aged 60 years and older from seven different old age homes. Data was collected through semi-structured interviews and the use of the Memorial University of Newfoundland Scale of Happiness (MUNSH) and General Self-Efficacy Scale (GSES). Well-being was positively correlated with satisfaction with physical environment, social support, social activity engagement and self-efficacy. Additionally, it was observed that the relationship between self-efficacy and psychosocial well-being was partially mediated by social engagement.

In another research to investigate how subjective well-being, health, demographic and social indicators in older adults are associated, a sample of 20,351 participants aged 60 and above, answered the National Socio-Economic Survey with respect to overall life satisfaction. Results found that having a spouse and being part of a social group were associated with greater life satisfaction. Additionally, males and individuals with better education or higher income, as well as older people and people who had access to better health facilities or a better perception of their own health were likely to be more satisfied with life (Roman et al., 2017).

The well-being of 60 older adults with an average age of 77 years was investigated by Cesetti et al. (2017). Half of the participants were from old age homes and the other half were community dwellers. They used the Satisfaction with Life Scale, Psychological Well-being Scale, Social Well-being Scale, Geriatric Depression Scale, and sleep quality to assess the differences between the samples. The subjects from the old age homes reported higher levels of depression and lower levels of well-being. They also

tested the efficacy of a narrative intervention which resulted in improvement of the well-being of the institutionalized sample.

Muller et al. (2014) studied the effects of volunteering on three facets of subjective well-being on 5,564 participants of three age groups, ranging between 45 and 85 years old. They found that volunteering had an impact on the negative affect and positive affect facets of subjective well-being but not on the life satisfaction facet. The mediating role of self-efficacy was also not consistent across different age groups. And they found its effect to be significant only in the younger age group.

Another study was carried out in Germany to investigate the relationships between various support types, support providers, and aging adults' well-being. The researchers were particularly interested in the differences between support from relatives and non-relatives as well as, emotional and instrumental support. They chose 1,146 participants, 65 years or older and collected the data through interviews and questionnaires about the social support they had and the details about the relations in their lives. Their analysis showed that well-being was positively correlated with emotional support from relatives, but this association was not observed with non-relative providers. Instrumental support from non-kin providers had a positive association with well-being but from kin providers it had a negative association with one aspect of well-being. Better relationship quality with both type of providers had a positive association with well-being. Interestingly, if there was a positive relationship with a kin provider of instrumental support, it did not have the otherwise negative impact on well-being (Merz & Huxhold, 2010).

The association between intergenerational support and well-being was examined by Merz et al. (2009) in adult child-parent relationships. For this purpose, data from the Netherlands Kinship Panel Study was analyzed and 1,456 child-parent dyads were selected to study if the association between intergenerational support (from both the adult child provider and parent receiver's perspective) and the well-being of both was moderated by the quality of their relationship. The mean age of the adult children was 37.1 years and the mean age of the parents was 66.1 years. It was seen that the provision of instrumental support across generations was found to have a negative correlation with the well-being of both the child and the parent. The well-being of both generations was seen to benefit by the perception of the self as being the stronger and the wiser one in the relationship. The quality of the relationship strongly predicted the well-being of both parents as well as children.

Melendez et al. (2009) conducted a research to study the psychological and physical dimensions explaining life satisfaction among the elderly. 181 older adults aged 65 to 94 years participated in the study. Life satisfaction was found to be significantly affected by both physical and psychological well-being but the effect of the latter was stronger.

Solution Focused Brief Therapy (SFBT)

To compare the effectiveness of metacognitive therapy, SFBT and endurance training in improving self-efficacy in socially anxious female students, Bagheri et al. (2024) recruited sixty students aged 13 to 15. The Social Anxiety scale, along with the DSM-5 criteria for social anxiety disorder was used to select the participants who were

then divided into 4 groups. Three of the groups received one of the three modes of therapy each and the control group was put on the wait-list. The participants were assessed on the General Self-Efficacy Scale. A significant improvement in self-efficacy was seen at both the post-test and follow-up levels for all three treatment groups while there was no significant change in the control group.

A study was conducted to investigate the role of SFBT in enhancing wellness, satisfaction with life and happiness among college students. A sample of 133 participants aged 18 years and above was recruited. The participants were assessed on their degree of stress, satisfaction with life, well-being and subjective happiness at the pre-assessment level and then one week and six weeks after the therapy sessions. Four additional questions were asked to measure the participants' confidence in goal completion. Results showed that the wellness of the clients had improved after therapy, furthermore, these results remained consistent at the follow-up level. Results showed that confidence in the ability to attain goals had a positive correlation with wellness and life satisfaction and a negative correlation with perceived stress (Beauchemin et al., 2023).

Mahmudah et al. (2023) used a quasi-experimental design to investigate the effectiveness of SFBT in enhancing the psychological well-being of religious scholars. They recruited a sample of 53 students from religious boarding schools who were assessed before and after SFBT sessions using Ryff's Psychological Well-being Scale and a significant improvement in well-being was seen at the post-assessment level.

Using the group counselling format, Hendar et al. (2019) investigated the effectiveness of SFBT in improving the academic resilience and self-efficacy of students

using a sample of 14 students divided equally into experimental and control groups. The assessment measures used to test the participants before and after 6 sessions of SFBT were Design My Future (academic resilience) and Motivational Strategies for Learning Questionnaire (self-efficacy). The findings showed that both academic resilience and self-efficacy increased significantly only in the experimental group.

An online SFBT intervention was used to treat depression among adolescents and young adults. 263 participants aged between 12 to 22 years took part in the study. They were assessed for depression using the Center for Epidemiologic Studies Depression Scale (CES-D) at baseline and then at 9 weeks and 4.5 months past baseline against a waiting list control group. The chat sessions were conducted individually by trained therapists using SFBT principles. A significantly greater improvement was seen only in the group that received the therapy at both the follow up assessments. The difference at 9 weeks assessment was small but it increased at 4.5 months. The clinical group was assessed again at 7.5 months past baseline and further improvement was observed (Kramer et al., 2014).

A 6- week solution focused group therapy intervention was used to improve the self-efficacy of Norwegian children with social difficulties (Kvarme et al., 2010). 156, twelve to thirteen years old participants were selected for the study. Their general, social and assertiveness self-efficacy were assessed before therapy, immediately following the intervention and at follow-up three months after the intervention. Among the girls, self-efficacy had significantly increased in the experimental but not the control group, but this change was non-significant among the boys. At 3 months follow-up, there was a

significant increase in general self-efficacy for both sexes in both groups, though the increase in the experimental group was much larger. For the domain specific self-efficacy scores, an insignificant change was seen in both girls and boys in both of the groups from the baseline to the first post intervention assessment. However, the experimental group showed a larger increase than the control group. However, there was an insignificant difference between the groups at the follow-up assessment.

Franklin et al. (2008) tested the efficacy of SFBT, using a pretest/posttest design with children having behavioral problems, in a school setting. The participants were 67 students between the ages of 10 to 12 years, who were identified by the school management as needing therapeutic assistance for behavior issues. The Child Behavior Checklist was used to monitor the change in behavior and both its Youth Self Report and Teacher Report forms were used to assess the presence of Internalizing and Externalizing Problems. The findings of the study, after comparison of the treatment group against a control group showed that the therapy had significantly reduced the behavioral issues of the students who received the SFBT intervention.

Seidel and Hedley (2008) conducted a research to study the efficacy of SFBT with elderly subjects. They recruited 20 participants from old age institutions out of which 10 received the intervention and 10 constituted the control group. The age of the participants was 60 and above. One of the two therapists provided three SFBT sessions to the intervention group. At the post -test, they found a significant improvement on the Outcome Questionnaire, the Symptom Distress subscale of the Outcome Questionnaire,

the Participant Problem Severity Rating and the Assessor Problem Severity Rating. However, the difference in stress perception was nonsignificant.

In another study, SFBT group therapy was compared against a traditional problem focused therapy in the treatment of depressive symptoms in substance abuse patients. 56 clients referred for substance abuse were randomly assigned to treatment and control groups, but only 38 stayed through the entire research. The control group received a problem focused psychoeducational intervention while Solution Focused Group Therapy was provided to the treatment group, both groups had 6 sessions each. The subjects were between 18 to 50 years old and were assessed on their use of substances, level of depression and about social cost measures. The experimental group showed significant reduction in depressive symptoms and improvement in the outcome assessment as compared to the treatment group. (Smock et al., 2008).

Dahl et al., (2000) investigated SFBT's efficacy with an elderly population in an outpatient setting. 74 subjects aged 65 and above were recruited for the study. At post-test assessment, moderate improvement was seen in Goal Attainment and a significant increase was indicated in the Global Assessment of Functioning scores.

Indigenous Researches

A comparison of the factors affecting the quality of life (QoL) among Pakistani and Canadian aging population was conducted by Batool et al. (2024). 557 Pakistanis and 448 Canadians aged 60 to 80 years were included. In addition to the demographics, the assessments used were the World Health Organization Quality of Life Brief Scale, Health and Lifestyle Questionnaire, General Self-Efficacy Scale, Rosenberg Self-Esteem Scale

and Berlin Social Support Scale. Results showed that in the Pakistani participants, self-esteem was the main predictor of QoL followed by chronic illness, social support, health and lifestyle and self-efficacy respectively. The strength of the prediction was stronger for the Canadian participants and the order of the predictors was different with social support being the main predictor followed by self-efficacy, health and lifestyle, self-esteem and chronic illness respectively.

Tariq et al. (2023) studied the predictors of well-being in 250 older adults with ages over 60 years, living in old age homes in Punjab. The Perceived Control Measure Scale, the de Jong-Gierveld Loneliness Scale, the Service Quality Scale, the Duke Social Support Index and the General Well-Being Scale were used for this purpose. Results showed that the number of visitors, loneliness, control over relocation process and satisfaction with services all significantly predicted well-being in the participants.

A single case study of SFBT was conducted with a 39-year old woman with major depressive disorder was conducted by Liaquat and Saleem (2022). Depression was measured using Beck Depression Inventory (BDI-II) before and after therapy. They observed that the client's score on depressive symptoms was greatly reduced after six sessions of SFBT.

In a qualitative exploration of the life circumstances of the elderly in shelter homes in Karachi, data was gathered through semi structured interviews from participants of both genders aged 65 and above, residing in two different shelter homes. Some common themes were identified through the content analysis. The residents discussed their experience of leaving home, the challenges they faced at the time, how they coped

with them and what made them decide to move to the facility. They reported that they perceived a sense of neglect and a lack of support from their families and suffered from feelings of dependency, loneliness and distress at this stage of life. They had various reasons for having to move to the institution, like migration of their children to foreign countries, insensitive attitude of the children, having only female children and thus not having anyone to live with to name a few. Most of them shared that they had willingly come to the facility and although it was not an easy decision, it seemed like the most viable option at the time. Many of them were satisfied with the decision as they were surrounded by people there and had a regular source of basic necessities like food and lodging (Cassum et al., 2020).

In another study investigating how education was related to psychological well-being and coping strategies in older adults. The sample was 100 residents of old age homes with ages over 60 years. The Coping Strategies Questionnaire and the Trait Well-Being Inventory (with two subscales, Life Satisfaction and Mood Level) were used for the purpose. The level of education was found to significantly predict life satisfaction but not mood level (Gul & Dawood, 2015).

Qadir et al. (2014) investigated depression among both community-dwelling older adults as well as care home residents. 141 participants (108 from the community and 133 from care homes), aged 60 years and above, were assessed. While most of the community sample were home owners, very few care home participants reported that they had been living in their own homes before taking residence in the facility. None of the care home residents were employed, although many of them shared that they had some sort of pension as a source of finances. A majority of them reported that they did not have any

visits from their children. Depression was found to be more common among the care home residents as compared to the community residents. Being female and a lack of formal education also increased the likelihood of depression. A majority of participants from both groups who were screened out to be depressed reported a perceived lack of social support.

Summary of Literature

Numerous psychological and physiological health problems, including depression, sedentary behavior, smoking, and other health-risk behaviors, have been linked to social isolation. (Shankar et al., 2011; Taylor et al., 2016). Social isolation is particularly prevalent among the older demographic and at most risk are those who do not live in their own homes, increasing the risk for its detrimental effects (Cornwell & Waite., 2009b; Kobayashi et al., 2009).

It has been demonstrated that self-efficacy mediates the relationship between older adults' well-being and social isolation. (McAuley et al., 2006; Mullen et al., 2012; Tovel et al., 2017). Studies investigating the efficiency of interventions aimed at improving self-efficacy has given mixed results, however, it has been observed that such measures have a beneficial impact upon the physical performance of the elderly subjects, leading to improved health and well-being (Allison & Keller, 2004).

It has been seen that aging adults lacking social support are at risk for significantly reduced well-being (Muller et al., 2014; Roman et al., 2017). There is an immediate need for psychological interventions with quick results to help aging people living at old age institutions.

SFBT is a mode of therapy that has been found to be efficacious for a variety of issues and across different demographics (Franklin et al., 2008; Kramer et al., 2014; Kvarme et al., 2010). Additionally, it has been shown to have positive results for the psychosocial problems of older adults (Seidel and Hedley.,2008; Dahl et al., 2000).

Rationale

Residents of old age homes often suffer from a lack of close relationships, increased dependence upon others, speech and hearing difficulties and reduced mobility. These factors, along with infrequent visits from family often cause them to be socially isolated (Autschbach et al., 2024; Boamah et al., 2021). However, the impact of social isolation and other societal influences on older adults is mitigated by self-efficacy (Bevilacqua et al., 2024; Roskoschinski et al., 2023), which is also compromised among old age home residents (Cybulski et al., 2017). Social isolation and reduced self-efficacy, both have a detrimental effect on psychosocial well-being (Lam & García-Román, 2020) which has been seen to be low among this demographic (Shabaani et al., 2017; Lotvonen et al., 2018).

Ethnographic studies conducted with old age home residents have recognized issues such as diminished autonomy, damaged self-esteem, and a sense of purposelessness as fundamental existential challenges. These findings emphasize the need to prioritize the development of strategies aimed at adaptive coping and fostering self-efficacy (Bharucha et al., 2006). Therapies based upon positive psychology principles, like reminiscence therapy have been seen to have more promising results compared to traditional cognitive behavioral therapies in the improvement of well-being

of this population (Simning & Simons, 2017). Solution Focused Brief Therapy (SFBT) has also been used with this demographic and it has been shown to have a positive impact (Seidel & Hedley, 2008).

Several nursing homes have been set up in major cities across Pakistan, reflecting an increasing trend in the country for people to relocate to these facilities (Sabzwari & Azhar, 2010). Researches have shown that residents of these institutions often suffer from feelings of sadness and abandonment (Khan, 2014) with low levels of satisfaction with life (Hayat et al., 2016) and have suggested the use of interventions to help them adjust to the challenges of life (Tariq et al., 2020). However, there is a dearth of studies investigating the use of psychotherapy with residents of old age homes in Pakistan and there is a high need to propose an intervention to help them deal with their psychosocial issues. The current research aims to assess the effectiveness of Solution Focused Brief Therapy (SFBT) on low self-efficacy and on reduced well-being in older adults living in old age homes. In light of Bandura's Theory (Bandura, 1977), it is expected that self-efficacy will act as a mediator and that the therapy, acting as a form of social persuasion, will start a chain of processes that will lead to improvement in the well-being of the subjects.

Objectives of the Study

Phase I

- To investigate the relationship between social isolation, self-efficacy, psychosocial well-being and demographics among older adults living in old age homes.

Phase II

- To assess the effectiveness of SFBT in increasing the level of self-efficacy in the treatment group as compared to the control group at the post-assessment and follow-up levels among older adults.
- To assess the effectiveness of SFBT in increasing the level of psychosocial well-being in the treatment group as compared to the control group at the post-assessment and follow-up levels among older adults.

Hypotheses

Phase I

- There is likely to be a relationship between social isolation, self-efficacy, psychosocial well-being and demographics among older adults living in old age homes.

Phase II

- There is likely to be an increase in the level of self-efficacy in the treatment group as compared to the control group after SFBT at the post-assessment and follow-up levels among older adults.
- There is likely to be an increase in the level of psychosocial well-being in the treatment group as compared to the control group after SFBT at the post-assessment and follow-up levels among older adults.

Chapter III

METHODOLOGY

The present research consisted of two phases. *Phase I* involved screening of participants for treatment groups. *Phase II* was an outcome study to investigate the therapeutic efficacy of Solution Focused Brief Therapy (SFBT) for dealing with the psychosocial problems of older adults living in old age homes.

Phase 1

Sampling Technique and Sample

The sample consisted of (N=44) older adults, including (males; n=30 & females; n=14) with the age range from 60-90 years ($M^M = 70.57$, $SD^M = 8.72$, $M^F = 67.21$, $SD^F = 7.69$). The sample was recruited from 6 private old age homes of Rawalpindi and Islamabad using non-probability purposive sampling.

Inclusion Criteria.

- Individuals who were living in old age homes for at least one month were included in the study.
- Individuals who had intact cognitive functioning were included in the study.

Exclusion Criteria.

- Individuals who had physical disabilities were not included in the study.
- Individuals who had any major medical or mental health problems were not included in the study.

Operational Definitions

Social Isolation. Social isolation is operationally defined as the lack of social networks and social networks are those elements of social relations that are structural and objective, like the scale, regularity and density (Lubben et al, 2003). Low scores on the Lubben Social Network Scale -6 (LSNS-6) indicate a high level of social isolation and a cutoff score below 12 indicates high risk for social isolation.

Self-Efficacy. Self-efficacy is operationally defined as a broad and enduring perception of competence that a person holds about himself which helps him feel efficacious enough to deal with different stressors and challenges. It evaluates how strongly a person believes in his capacity to cope with setbacks and expects to be able to cope with the difficulties of life (Schwarzer & Jerusalem, 1995). High scores on the Generalized Self-Efficacy Scale (GSES) indicate a high level of self-efficacy.

Psychosocial Well-Being. Psychosocial well-being is operationally defined as the evaluations of people regarding the quality of their lives, it includes their experiences, relations, achievements, and further such culturally significant and important aspects of life functioning in the domains of emotional, social and psychological functioning (Keyes et al, 2009). High scores on the Mental Health Continuum-Short Form (MHC-SF) indicate a high level of psychosocial well-being.

Assessment Measures

In *Phase 1* of the present research, the following three measures and the demographic information form were used for assessment. These measures included:

Demographic sheet. A demographic sheet was developed to obtain information about the participants' age, gender, education level, marital status, number of living sons, daughters, sisters and brothers, health issues and duration of stay at the old age home.

Lubben Social Network Scale-6 (LSNS-6). Lubben Social Network Scale -6 (LSNS-6) was used to measure the respondent's level of social isolation. It was developed by Lubben et al (2006) and is a self-report measure of social engagement with family and friends. It has 6 items with two subscales; *Family* (*social engagement with family*, item# 1,2,3) and *Friends (social engagement with friends*, item# 4,5,6). Each item measures the number of people in a category that the individual interacts with at least once a month. Each item is assessed on a 6-point Likert Scale from 0 (none), 1 (one), 2 (two), 3 (three or four), 4 (five through eight), to 5 (nine or more). Total scores range from 0 to 30 (with subscale scores ranging from 0 to 15) and both subscales are scored so that lower scores indicate a higher degree of social isolation. The authors suggest a cut-off point of 12 for the scale, with scores lower than this indicating high risk for social isolation. For the subscales, the cut off points of 6 are suggested for each. The internal consistency is established by a Cronbach alpha value of 0.83. The subscales have Cronbach alpha values of 0.84 to 0.89 and 0.80 to 0.82 respectively. The scale was translated into Urdu using Mapi guidelines.

Generalized Self-Efficacy Scale (GSES). The Generalized Self Efficacy Scale was developed by Schwarzer and Jerusalem (1995) to measure the construct of self-efficacy. It is a 10-item self-report questionnaire in which each item is assessed on a 4-point Likert Scale from 1 (not at all true), 2 (hardly true), 3 (moderately true), to 4 (exactly true). Total scores range from 10 to 40 and are scored so that lower scores

indicate a lower level of self-efficacy. The authors have not recommended a cutoff score for determining a low level of self-efficacy and have suggested using the median score of a sample if a cutoff is required. The scale has high internal consistency with Cronbach's alpha coefficient of 0.87 and a test-retest reliability of (r=0.84). Urdu translated version of GSES by Tabassum and Rehman (2003) was used.

Mental Health Continuum-Short Form (MHC-SF). The Mental Health Continuum-Short Form (MHC-SF) developed by Keyes (2009) is a self-report questionnaire to measure the construct of well-being. It has 14 items with three subscales representing different facets of well-being, divided into *hedonic (emotional well-being*, 3 items); *eudaimonic (social well-being*, 5 items); and *eudaimonic (psychological well-being*, 6 items). Each item measures the frequency with which each symptom of positive mental health is felt over the past one month. Each item is assessed on a 6-point Likert Scale with a score from 0 (never), 1 (once or twice a month), 2 (about once a week), 3 (two or three times a week), 4 (almost every day), to 5 (every day). Total scores range from 0 to 70 (with emotional well-being, social well-being and psychological well-being subscale scores ranging from 0 to 15, 0 to 25 and 0-30 respectively) and all subscales are scored so that lower scores indicate a lower level of wellbeing. No cut off score has been recommended by the authors so median will be used as a cut-off score. The scale has shown excellent internal consistency with Cronbach's alpha of 0.87 and has shown good convergent and discriminant validity. Urdu translated version of GSES by Faran et al. (2021) was used.

Translation of the Lubben Social Network Scale-6 (LSNS-6)

Lubben Social Network Scale -6 (LSNS-6) developed by Lubben et al. (2006) was translated into Urdu language by standardized forward-backwards translation procedure of Mapi guidelines. The purpose was to develop a conceptually translated version of the scale rather than a literal one.

Forward Translation. The aim of the forward translation was to derive a translated measure of social isolation that would be conceptually equivalent to the original and easily understood by the sample for which it was aimed. Forward translation of both, the instructions and the items of the scale were done by three bilingual experts who were fluent in the target language (Urdu) and were clinical psychologists.

The translations were then compared in terms of conceptual and connotational equality, clarity of speech, comprehensibility and cultural linguistics by two bilingual psychology experts along with the researcher. Observations were made and inconsistencies were noted and suitable translated items were selected. The translations were then reviewed by the supervisor and the discrepancies of the sentence formation were corrected. An Urdu translation draft was developed and matched with the English version to check for any discrepancies.

Backward Translation. The purpose of the backward translation was to compare the English source and translated English version to see any discrepancies due to contextual differences. For this purpose, the Urdu translation draft of the LSNS-6 was given to two other bilingual experts, who had not seen the original English scale, to translate it back into the source language (English). The translators were trainee

psychology students. The translations were then discussed with two bilingual psychology lecturers who had not seen the original version of the scale and the researcher and the most suitable items were selected. The translations were reviewed and compared by the researcher and the supervisor, the discrepancies were checked and those items conveying the precise meaning of the original item were selected. After deciding on one backward translated version, it was compared with the original scale and no major discrepancies were found.

Review and Scrutiny. After final changes in the scales an individual with a master's degree in Urdu linguistics was consulted for the syntactic design of the words used in the scales. No significant disparities were found.

Try Out. Pilot study was done by administering the final version of the scale on 5 older adults above the age of 60 and the Urdu version was finalized for data collection.

Procedure

The topic was first reviewed by the Ethical committee and the competent authority of the university. The modifications suggested by the committee were incorporated into the study. Before using the assessment tools, permission was taken for the use and translation of the Lubben Social Network Scale -6 (LSNS-6) from the author. The translation of the scale was done using the Mapi guidelines under the supervision of the research supervisor. Permission was also sought for the use of the translated versions of the Generalized Self Efficacy Scale (GSES-U) and the Mental Health Continuum-Short Form (MHC-SF) from the respective authors. For approaching the targeted sample,

6 old age homes in Rawalpindi and Islamabad were selected and permission was taken by their management.

Informed consent to apprise the participants about the rationale of the study, assurance of confidentiality and the freedom to leave the study at any stage of the assessment was taken on the consent form. The demographic information was taken on the demographic sheet. The questionnaires were then administered. The participants who were unable to read due to illiteracy or poor vision were aided in recording their responses. Data was analyzed by using SPSS 27.0.

Ethical Considerations

- The topic of the research was approved by the Ethics committee.
- The permission to use the required scales was taken by the respective authors.
- Permission was taken from the management of the old age homes to approach the residents for data collection.
- Before data collection the management of the old age homes was briefed about the research.
- Informed consent was taken from the participants and they were briefed about the purpose of the research.
- They participants were assured about the confidentiality of the information gathered from them.
- The right of withdrawal at any point was explained to the participants.
- The results were analyzed and accurately represented

Phase II

Research Design

A quasi-experimental, (2x3) mixed factorial design was used.

Sampling Technique and Sample

For individual therapy sessions, the sample consisted of (N=18) (males; n=8 & females; n=10), participants who were screened in *Phase I*, with the age range from 60-90 years (M^M *=72.62*, SD^M*=7.63*, M^F*=64.10*, SD^F*=3.66*). The sample was recruited from 4 private old age homes of Rawalpindi and Islamabad using non-probability purposive sampling.

Inclusion Criteria.

- Those individuals who scored below the median on General Self Efficacy Scale (GSES) and on Mental Health Continuum- Short Form (MHC-SF) were included in the study
- Those individuals who were able to converse easily in Urdu were included.

Intervention

The intervention used in the present study was Solution Focused Brief Therapy (SFBT). SFBT was developed by Steve de Shazer (1985). It was designed to help people cope with their psychological struggles by focusing on their strengths instead of on the causes and manifestations of the problem (Bavelas et al, 2013). SFBT differs from other approaches in its minimal emphasis on the detailed underpinnings of a problem to seek a resolution and its lack of focus on assessments aimed at diagnosing the client under a

predefined criterion. The expertise of the therapist lies instead on bringing change through language in which the client is encouraged to search for positive and functional elements that he or she wants to incorporate into the future (de Shazer, 1994).

Solutions are developed through conversation that yield a description of the client's and goals. Then the therapist and client construct small behavioral steps based on the elements that already work in the client's life. There is no specified number of sessions or duration of individual sessions suggested by the authors, but they suggest that the average number of sessions for the therapy is four (Kim, 2008). For the present study, five therapy sessions were conducted followed by post assessment one week after the last therapy session and a follow-up assessment two weeks after the post assessment.

SFBT Techniques. The Solution Focused Therapy Treatment Manual for Working with Individuals 2nd Version (Bavelas et al, 2013) was consulted for the use of SFBT techniques in the sessions.

Solution Focused Goals. The best hopes question is usually asked at the very beginning of therapy to encourage the client to verbalize what they wish to achieve from therapy in clear terms.

Miracle Question. With the miracle question, the client is asked to imagine that a miracle happens while they are sleeping which solves the problem that they are hoping for therapy to solve, they are then asked to explain the whole miracle day in detail.

***Previous solutions*.** In this technique, the client is asked to think of solutions that they have used some time in the past for a similar problem in the similar circumstances.

Exception Questions. In this technique, the client is asked to recall situations where the problem did not occur despite the same circumstances.

Compliments. Throughout all the sessions, the therapist remains alert for complimenting and encouraging the client for any mention of their strengths and adaptive coping strategies.

Scaling Questions. Scaling questions are used to help quantify different elements, like the client's current mood status, their level of motivation, their level of expectations etc. Usually a scale of 0 to 10 is used for this purpose.

Constructing solutions. In this technique, the client is encouraged to consider the strengths and resources available to them and come up with viable solutions to their problems.

Coping questions. With coping questions, the clients are given indirect compliments and encouragement by asking them details of the different ways they use to cope with the difficulties in their lives and keep up their motivation.

Taking a break and reconvening. The purpose of taking a break a little before closing the session is to study the notes made through the sessions and make a list of the client's strengths and resources and decide upon the feedback to be given to the client.

Experiments and homework assignments. Homework assignments in SFBT are not formulated by the therapist and are not considered essential to the therapy process. They are suggested as optional experiments to try what the client thinks might work or something that has worked before.

Review of change. Each subsequent session after the first is started by asking the client about what is better since the last session. The client has done to maintain or improve things is focused upon and complimented.

Treatment Protocol

Initial session	Subsequent sessions
The first session format will be kept more or less the same, except when the client's responses require the use of other solution focused techniques at that point.	The progress review will be done at the beginning and the session break and feedback at the end, the other techniques do not have a fixed order and are not required to be utilized in each session as their use is determined by the client's responses to the questions.
• Best hopes: Ask the participants about what they can hope and expect to achieve from the therapy sessions. Help to formulate positively worded goals. • Coping Questions: Ask what helps them maintain their sense of hope and what they do to deal with the difficulties in their lives. Discuss the details of their positive coping to orient them towards the solutions. • Miracle Question: Ask the miracle question to generate a detailed picture of their preferred future in order to motivate them to work towards attaining that future. Search for signs of the preferred future already happening in their lives.	• Review of change and Scaling: Begin by assessing the progress of the clients towards their goals and discussion of the resources and manifestations of the progress. Use of scaling questions to enable the clients to rate their progress with 10 representing their preferred future achieved and 0 representing being nowhere near the preferred future. Encouragement will be provided in the form of genuine compliments on any noticeable signs of progress. • Exception Questions: Ask what is different about the situations when they feel different and bring their attention to positive instances. Discuss these in detail.

Initial session	Subsequent sessions
• Scaling: Use scaling to help them discover how much of the miracle already exists in their lives, with 10 representing that the miracle day has been completely achieved and 0 representing that there are no traces of the miracle in their lives. Discuss how they can work towards getting closer to the miracle day and towards achieving their best hopes. • Session break: Take a small break of a few minutes to compile the points discussed in the session • Compliments: Compliment the client on all their strengths and positive behaviors throughout the sessions, but specially in the feedback. • Feedback and suggestions: Go over the strengths and resources of the client, compliment them and ask if they would like to continue with the sessions and ask them to note any positive changes in their mood and behavior.	• Previous solutions: Inquire about successful strategies the participants have utilized in the past for their problems within the same setting that they do not use any more. • Constructing Solutions: Ask the client to consider other viable solutions that are likely to bring about positive change. • Coping Questions: Choose any of the coping strategies discovered in the previous session and discuss its use and manifestations to highlight their strengths. • Compliments: Compliment the client on all their strengths and positive behaviors throughout the sessions. • Session break: Take a small break of a few minutes to compile the points discussed in the session and formulate the feedback. • Feedback and suggestions: Go over the strengths and resources of the client, compliment them and ask if they would like to continue with the sessions and ask them to note any positive changes in their mood and behavior.

Procedure

The researcher first attended a training and certification program for the use of Solution Focused Brief Therapy and then attended the Solution Focused Brief Therapy Association's (SFBTA) 2023 online conference with multiple lectures on the use of solution focused therapy research and its application in a variety of settings, with the provision of videos of therapy sessions from the developers and SFBT master practitioners.

Since SFBT does not have a standardized sessional treatment plan, the session plan for the research was formulated using the Solution Focused Therapy Treatment Manual for Working with Individuals 2nd Version (Bavelas et al., 2013), de Shazer's article for suggestions for SFBT researchers (de Shazer & Berg, 1997) and by consulting previous researches (Franklin et al., 2008; Żak et al., 2023). Two books, Solution Focused Brief Therapy:100 Key Points and Techniques (Ratner et al., 2012) and 1001 Solution-Focused Questions: Handbook for Solution-Focused Interviewing (Bannink, 2010) were also consulted for understanding the theory and practice for the use of solution focused techniques according to the needs of the client. The session plan was then discussed and amended in collaboration with the SFBT trainer.

After providing rationale and complete information about therapeutic sessions, consent for the participation of residents was taken from the management of four old age homes in Rawalpindi. Participants for the treatment and control groups were selected from the screening phase based on their obtained score (below the median) on assessment tools (used for self-efficacy and psychosocial well-being). Initially two groups, one treatment group (N=10, males; n=5 and females; n=5) and one control group (N=10,

males; n=5 and females; n=5) were formed, but later on in the treatment group (N=9, males; n=4 and females; n=5) (1 male dropped out after 2 sessions due to health issues) and in the control group (N=9, males; n=4 and females; n=5) (1 male dropped out due to relocation to another city) were retained. Informed consent was taken from the participants after briefing them about therapy and the requirement of making audio recordings of their sessions and explaining about the confidentiality of the sessions.

The schedule for conducting therapeutic sessions was made, all logistics (e.g. room for the sessions) were discussed with the old age home management and therapy was started accordingly. A total of five weekly sessions were conducted individually with each participant in the treatment group, with each session lasting for 30 minutes on average. Audio recordings of the sessions were shared with the thesis supervisor and SFBT trainer to ensure fidelity to SFBT. The sessions were discussed in detail with the thesis supervisor and SFBT trainer. After completion of the therapy, a post assessment was done using the same assessment scales as phase 1 in order to assess the efficacy of SFBT and a follow up assessment was done two weeks after termination of therapy to check the sustainability of the improvements. Data analysis was done by using SPSS 27.0. Results were accurately reported.

Summary of therapeutic sessions

Participant 1. The participant had been living at the institution for the past eleven years and he did see any purpose of his life. He resented being abandoned by his children and being dependent upon the old age home staff. His hopes from the therapy were to feel more energized and to start looking forward to waking up in the morning. He shared

that to cope with his feelings of sadness and abandonment, he recites duas from the Quran and reads religious books. In the past he used to read newspapers but he hasn't read one in months. Answering the miracle question, he described a day when he would feel full of energy and would be less dependent upon others for his everyday tasks. The goals generated by the end of the first session were being able to do some of his own daily chores and resuming some of his old hobbies. On scaling, he rated being at 0 (on a scale of 0 to 10) on both goals. In the subsequent sessions, the client shared his passion for poetry and recited both Urdu and Punjabi poems during the sessions. Using this hobby to engage in conversation with the staff and fellow residents was discussed. In following sessions the client's energy level increased and he started to engage in various activities to keep himself busy and to feel useful. By the end of the therapy sessions, his rating on all of his goals had improved. He also reported feeling happier and more confident in his abilities.

Participant 2. The participant had been living at the institution for the past one year. Due to arthritis and weak eyesight, he felt like he did not have the ability to deal with the challenges of life and did not feel like a contributing member of society. He often felt sad about having lost his son, his home and his career. His hopes from the therapy were to feel happier and have more energy to socialize with his fellow residents and participate in the daily chores. He shared that in order to cope with feelings of sadness, he regularly read the Quran and engaged in *zikr*. Answering the miracle question, he said that he feels that waking up every morning with good health was itself a miracle. The goals generated in the first session were doing more chores around the institution, increased social interaction with fellow residents and engaging in hobbies

utilizing his interests. On scaling, he rated being at 2,2 and 1 (on a scale of 0 to 10) on the goals. In the subsequent sessions he shared that he had started sitting with his fellow residents after night and recited *naats* for which he recieved a lot of encouragement. He also started to mend things around the home using his sewing kit, which made him feel useful. By the end of the therapy sessions he shared that he was satisfied with the improvement on all of his goals and felt more efficacious in facing his own difficulties as well as in helping others around him.

Participant 3. The participant had been living at the institution for the past two years. He often felt sad as both his children lived in other cities and he missed them a lot. He had very low self-confidence and felt that he was not capable of dealing with the challenges of life due to his age. His hopes from the therapy were to feel happier and more confident. He shared that to cope with his feelings of sadness he engaged in *zikr* and *namaz.* He also went out for long walks out in the street which helped him relax. Answering the miracle question, he described a day when he would feel happy and relaxed and would chat with fellow residents. The goals generated in the first session were, socializing more with his fellow residents and engaging in more chores around the home. On scaling, he rated being at 1 and 2 (on a scale of 0 to 10) on the goals. In the subsequent sessions he started feeling more relaxed and his fellow residents complimented him on his sense of humour which made him feel better about himself. Additionally, he took the regular responsibility of a few duties around the institution which gave him a sense of importance in his social circle. His rating on both his goals improved and he started to feel happier and more satisfied with life.

Participant 4. The participant had been living at the institution for the past seven months. He often felt sad thinking about the past when he lived at his own home and had a busy and engaging life. He said that his existence seems purposeless now and other people don't give him the respect that they used to. His hopes from the therapy were to feel happier with life and to be able to talk to others with confidence. He shared that to cope with sadness, he went out for long walks outside the institution. He said that even though he often had low energy due to being diabetic but he continued his daily walk because it helped him relax. Answering the miracle question, he described a day when he would feel happy and full of energy and would have a sense of confidence. The goals generated in the first session were indulging in activities that he enjoyed and increasing his capacity to talk to others with confidence. On scaling, he rated being at 1 (on a scale of 0 to 10) on both the goals. In the subsequent sessions, he started feeling happier and his self-confidence also improved. He started to do more of his own daily chores like making his bed and ironing his clothes which made him feel more independent. He also began to sit and chat with others at *chai* stalls when he went out on his walks. His rating on both his goals improved and he felt more satisfied with life.

Participant 5. The participant had been living at the institution for the past three years. She shared that she felt angry and betrayed as her husband had thrown her out of her home and married another woman. Her children did not visit her either and as a result she felt like she does not have any significance in the world. Her hopes from the therapy were to be able to regulate her feelings of anger and to achieve a sense of purpose in life. She shared that to cope with her emotions, she reads religious books and recites *durood*. She also enjoys talking to fellow residents and playing board games with them.

Answering the miracle question, she described a day when she would feel that she has forgiven her husband and let go of her feelings of anger. She shared that the staff and residents at the institution would be able to see this change in her as she would be laughing and taking part in different activities. The goals generated in the first session were to be able forgive her husband and children, to engage in more chores and social activities around the institution. On scaling, she rated being at 0, 1 and 2 (on a scale of 0 to 10) on the goals. In the subsequent sessions, she reported feeling more relaxed as she was able to let go of her feelings of anger. She also began to do more chores around the home that made her feel more needed. Her rating on all three goals improved and she reported feeling more confident and satisfied with life.

Participant 6. The participant had been living at the institution for the past one year. She suffered from feelings of worthlessness due to being left at the institution by her children, who rarely visited her. Her hopes from the therapy were to feel happier and more confident. She shared that in order to feel better she prays regularly, recites *durood* and tries to help others around her. Answering the miracle question, she described a day when she would wake up fresh and feel respected by others. The goals generated in the first session were to engage in hobbies to keep herself busy and to volunteer for chores around the home that would help her feel more fulfilled. On scaling, she rated being at 1 and 2 (on a scale of 0 to 10) on the goals. In the subsequent sessions, she revealed a talent and passion for reciting *naats* and that was incorporated in her solutions to tackle her sadness. Her rating on her goals improved and she reported feeling more satisfied with life.

Participant 7. The participant had been living at the institution for the past three years and often felt lonely and anxious. She also found it difficult to sleep at night due to ruminations about the past. Her hopes from therapy were to be able to feel happier within the atmosphere of the home and for her sleep to improve. She shared that to cope with her emotions, she did *zikr, astaghfar* and recited *durood shareef.* She described her miracle day as a day when she would feel relaxed and feel closer to Allah. The goals generated in the first session were engaging in more social activities with her fellow residents and having good appetite and better sleep patterns. On scaling, she rated being at 1, 2 and 2 (on a scale of 0 to 10) on the goals. In the subsequent sessions, she reported feeling less anxious and the rating on all her goals had improved.

Participant 8. The participant had been living at the institution for the past nine months. She suffered from feelings of sadness and worthlessness as she had a busy life as a lawyer in her middle age. Due to health challenges she had to move into the institution as she was unmarried and did not have any siblings. Her arthritis affected her mobility and she resented being dependent upon others. Her hopes from the therapy were to feel happier and more confident in her skills. She shared that to cope with sadness she tried to socialize with others around her and read books. Describing her miracle day, she shared that she would feel more energized and would try to participate in activities around the home. The goals generated in the first session were to find out ways to feel useful and increase her activity level. On scaling, she rated being at 1 (on a scale of 0 to 10) on both goals. In the subsequent sessions, she shared that she had started reading some of her old law books to refresh her memories and also began reading newspapers to feel updated with current news. She also began to have phone conversations with her old colleagues

that made her feel more engaged and worthier. She also started to teach different games to the institution staff and residents. Her rating on both her goals improved and she reported feeling more satisfied with her life.

Participant 9. The participant had been living at the institution for the past four years. She shared that she misses her life back at her own home and resents having to live according to the institution rules which makes her feel like she can't exert her own will in her life. She often feels sad at having to be dependent upon others but doesn't have a choice. Her hopes from the therapy were to feel more independent and happier with the atmosphere around the home. She shared that to cope with her emotions, she prayed regularly, did *tasbeeh* and read religious books. She said that if a miracle occurred, she would start to feel happier, useful and less dependent upon others. The goals generated in the first session were to feel happier with life and to start engaging in activities that utilized her teaching experience. On scaling, she rated being at 2 and 0 (on a scale of 0 to 10) on the goals. In the subsequent sessions, she shared that she had started to teach some English words to the staff and residents at the home which made her feel like she could still play a useful role in society. She had also started to do some of her own chores that made her feel less dependent. Her rating on her goals improved and she shared feeling happier.

Ethical considerations

To conduct this study, the following ethical considerations were followed.

- The researcher was trained in Solution Focused Brief Therapy and its various techniques.

- Permission was sought from Solution Focused Brief Therapy Association for use of the therapy in the research and the fidelity requirements list was obtained.
- The audio recordings of the sessions were discussed with the supervisor and with the SFBT trainer to ensure fidelity of SFBT therapeutic techniques.
- Permission was taken from the old age homes' management to approach their residents and use their premises for therapy.
- Informed consent was taken from all the participants and they were debriefed about the research.
- The anonymity of the participants and confidentiality of their data was maintained.
- The data was analyzed and was accurately reported.

Chapter IV

RESULTS

The current research consisted of two phases. *Phase I* involved screening of participants for intervention and control groups. *Phase II* was an outcome study aimed to investigate the therapeutic efficacy of Solution Focused Brief Therapy (SFBT) for dealing with the psychosocial problems of older adults living in old age homes.

Phase I

The data for the screening sample was analyzed in two steps. In step I, descriptive statistics were calculated for the demographic characteristics of the sample. Additionally, the descriptive statistics and reliability analysis were also calculated for social isolation, self-efficacy and psychosocial well-being (emotional well-being, social well-being and psychological well-being) of the sample. In step II, Pearson product moment correlation analysis was executed in relation to demographic variables (gender and education level), social isolation, self-efficacy and psychosocial well-being (emotional well-being, social well-being and psychological well-being).

Descriptive Statistics

The descriptive statistics of demographic characteristics (age, education level, duration of stay at the old age home, number of living children, number of living siblings, gender, marital status and health issues) of the participants are presented in Table 1.

Table 1

Descriptive Statistics of the Demographic Characteristics of the Sample (N=44).

Characteristics	***f (%)***	***M(SD)***
Age (years)		69.50(8.47)
Education (years)		6.84(4.99)
Duration of Stay (months)		29.33(6.97)
Number of Children		
0	21(47.7)	
2	7(15.9)	
3	6(13.6)	
4	7(15.9)	
5	2(4.5)	
7	1(2.3)	
Number of Siblings		
0	19(43.2)	
1	4(9.1)	
2	7(15.9)	
3	6(13.6)	
4	4(9.1)	
5	2(4.5)	
6	2(4.5)	
Gender		
Male	30(68.2)	
Female	14(31.8)	
Marital Status		
Unmarried	9(20.5)	
Married	1(2.3)	
Separated	10(22.7)	
Widowed	24(54.5)	

Note. *f*=frequency, *%*=percentage, *M*=mean, *SD*=standard deviation

Table 1 shows that the average age of the participants was found to be 69.50 years, their average education in years was 6.84, whereas the mean duration of their stay

at the old home was 29.33 years. The number of children the participants had are as follows. 47.7% had no children, 15.9% had 2 children, 13.6% had 3 children, 15.9% had 4 children, 4.5% had 5 children and 2.3% had 7 children. The number of siblings the participants had are as follows. 43.2% had no siblings, 9.1% had 1 sibling, 15.9% had 2 siblings, 13.6% had 3 siblings, 9.1% had 4 siblings, 4.5% had 5 siblings and 4.5% had 6 siblings.

In regard to the gender of the participants, 68.2% were males and 31.8% were females. Regarding marital status, 20.5% of the participants were unmarried, 2.3% were currently married, 22.7% were separated from their spouses and 54.5% were widowed.

Descriptive Statistics and Reliability Analysis

Table 2

Descriptive Statistics and Cronbach's Alpha for Social Isolation (Family and Friends) Self-Efficacy and Psychosocial Well-Being (Emotional Well-Being, Psychological Well-Being and Social Well-Being) in Older Adults (N=44).

Variables				*Range*		
	K	*M*	*SD*	*Actual*	*Potential*	*α*
Social Isolation	6	3.25	3.89	0-16	0-30	.83
Family	3	2.36	2.58	0-9	0-15	.85
Friends	3	0.75	1.38	0-6	0-15	.73
Self-Efficacy	10	26.30	9.72	10-40	10-40	.97
Psychosocial Well-being	14	37.45	16.36	7-61	0-70	.95
Emotional Well-being	3	8.66	4.36	1-15	0-15	.90
Social Well-being	5	12.30	5.75	1-23	0-25	.88
Psychological Well-being	6	16.40	7.69	3-28	0-30	.93

Note. *K* = number of items, *M* = mean, *SD* = standard deviation, *α* = Cronbach's Alpha.

Table 2 shows the descriptive statistics, including (mean, standard deviation, actual and potential ranges) and internal consistency using Cronbach's alpha reliability of social isolation (family and friends) self-efficacy and psychosocial well-being (emotional well-being, psychological well-being and social well-being) in older adults. The reliability evaluation exhibited an excellent internal consistency for self-efficacy, psychosocial well-being and for the emotional and psychological subscales of

psychosocial well-being; good internal consistency for social isolation and both its subscales and for the social subscale of psychosocial well-being.

Pearson Product Moment Correlation Analysis

It was hypothesized that there is likely to be a relationship between demographic variables, social isolation, self-efficacy and psychosocial well-being among older adults living in old age homes. Pearson product moment correlation analysis was carried out to examine this relationship and the results of the analysis are presented in Table 3.

Table 3

Bivariate Correlation between Social Isolation (Family and Friends), Self-Efficacy, Psychosocial Well-Being (Emotional Well-Being, Psychological Well-Being and Social Well-Being) and Demographic Variables (Gender, Education Level (N=44)

Variables	1	2	3	4	5	6	7	8	9	10
1**. Social Isolation**	-	.90***	.79***	.16	.09	.06	.07	.17	-.30*	.32*
2. Family		-	.53***	.21	.12	.09	.18	.18	-.31*	.28
3. Friends			-	.11	.06	.06	-.06	.15	-.20	.29
4**. Self-Efficacy**				-	.91***	.82***	.77***	.90***	-.36*	.30
5**. Psychosocial Well-Being**					-	.87***	.90***	.97***	-.31*	.32*
6. Emotional Well-Being						-	.63***	.82***	-.22	.21
7. Social Well-Being							-	.81***	-.31*	-.27
8. Psychological Well-Being								-	-.31*	.34*
9. Gender									-	.00
10. Education level										-

Note: Low scores on the social isolation scale indicate high levels of isolation.

**p<0.5, **p<.01, ***p<.001*

The results of Pearson product moment correlation analysis show that social isolation and its subscales were found to be non-significantly correlated with self-efficacy and psychosocial well-being. Self-Efficacy was found to be significantly positively correlated with psychosocial well-being and its subdomains (emotional well-being, social well-being and psychological well-being).

Gender was found to be significantly negatively correlated with social isolation and its family subscale, self-efficacy and psychosocial well-being and its subdomains of social and psychological well-being showing that females were more socially isolated, showed lower levels of self-efficacy and psychosocial well-being as compared to the males.

Education level was significantly positively correlated with social isolation and psychosocial well-being and its subdomain of psychological well-being, showing that those who were more educated were less socially isolated and reported higher levels of psychosocial well-being. However, education was not found to b significantly correlated with self-efficacy.

Phase II

The data for the intervention and control groups was analyzed in two steps. In step I, descriptive statistics were calculated for the demographic characteristics of the sample. Additionally, the descriptive statistics and reliability analysis were calculated for social isolation (family and friends), and for the pre, post and follow-up assessments of self-efficacy and psychosocial well-being (emotional well-being, social well-being and psychological well-being) for the sample in Phase 2. In step II, two-way mixed factorial ANOVA was carried out to assess the interaction effect of the pre, post and follow-up assessments of SFBT and the intervention and control groups in terms of self-efficacy and psychosocial well-being (emotional well-being, social well-being and psychological well-being) in older adults living in old age homes.

Descriptive Statistics.

The descriptive statistics of demographic characteristics (age, education level, duration of stay at the old age home, number of living children, number of living siblings, gender, marital status and health issues) of the participants are presented in Table 4.

Table 4

Descriptive Statistics of the Demographic Characteristics of the Sample (N=18).

	Intervention Group (n=9)		*Control Group (n=9)*	
Characteristics	*f (%)*	*M(SD)*	*f (%)*	*M(SD)*
Age (years)		67.67(9.26)		68.11(4.54)
Education (years)		5.78(5.40)		5.22(3.42)
Duration of Stay (months)		35.11(39.08)		39.67(36.18)
Number of Children				
0	4(44.4)		3(33.3)	
2	2(22.2)		2(22.2)	
3	1(11.1)		2(22.2)	
4	0(0)		2(22.2)	
5	1(11.1)		0(0)	
7	1(11.1)		0(0)	
Number of Siblings				
0	3(33.3)		4(44.4)	
1	0(0)		0(0)	
2	1(11.1)		2(22.2)	
3	2(22.2)		3(33.3)	
4	1(11.1)		0(0)	
5	0(0)		0(0)	
6	2(22.2)		0(0)	
Gender				
Males	4(44.4)		4(44.4)	
Females	5(55.6)		5(55.6)	
Marital Status				
Unmarried	2(22.2)		2(22.2)	
Married	1(11.1)		0(0)	
Separated	2(22.2)		3(33.3)	
Widowed	4(44.4)		4(44.4)	

Note. *f*=frequency, *%*=percentage, *M*=mean, *SD*=standard deviation

Table 4 shows that among the intervention group, the average age of the participants was found to be 67.67 years, their average education in years was 5.78, whereas the mean duration of their stay at the old age home was 35.11 years. The number of children the participants had were as follows. 44.4% had no children, 22.2% had 2 children, 11.1% had 3 children, 11.1% had 5 children, 11.1% had 7 children. The number of siblings the participants had were as follows. 33.3% had no siblings, 11.1% had 2 siblings, 22.2% had 3 siblings, 11.1% had 4 siblings, 22.2% had 6 siblings. In regard to the gender of the participants, 44.4% were males while 55.6% were females. Regarding marital status, 22.2% of the participants were unmarried, 11.1% were currently married, 22.2% were separated from their spouses and 44.4% were widowed.

Among the control group, the average age of the participants was found to be 68.11 years, their average education in years was 5.22, whereas the mean duration of their stay at the old age home was 39.67 years. The number of children the participants had were as follows. 33.3% had no children, 22.2% had 2 children, 22.2% had 3 children, 22.2% had 4 children. The number of siblings the participants had were as follows. 44.4% had no siblings, 22.2% had 2 siblings, 33.3% had 3 siblings. In regard to the gender of the participants, 44.4% were males while 55.6% were females. Regarding marital status, 22.2% of the participants were unmarried, none were currently married, 33.3% were separated from their spouses and 44.4% were widowed.

Descriptive Statistics and Reliability Analysis.

The descriptive statistics and reliability analysis of social isolation (family and friends), self-efficacy and psychosocial well-being (emotion wellbeing, social wellbeing and psychological well-being) are presented in Table 5.

Table 5

Descriptive Statistics and Cronbach's Alpha for Social Isolation (Family and Friends, Self-Efficacy and Psychosocial Well-Being (Emotional Well-Being, Psychological Well-Being and Social Well-Being) in Older Adults (N=18).

Variables		*Intervention Group (n=9)*		*Control Group (n=9)*		*Ranges*			
						Actual			
						Intervention Group	*Control Group*	*Potential*	
	K	*M*	*SD*	*M*	*SD*				*α*
Social Isolation	6	2.11	2.93	2.00	3.16	0-9	0-10	0-30	.85
Family	3	1.56	1.94	1.44	1.88	0-5	0-6	0-15	.75
Friends	3	0.56	1.33	0.56	1.33	0-4	0-4	0-15	.77
Self-Efficacy	10	17.00	5.34	16.11	2.67	10-25	12-20	10-40	.83
		24.33	**6.18**	**16.67**	**4.42**	**15-34**	**12-25**	**10-40**	**.93**
		21.78	*5.19*	*17.00*	*2.74*	*15-30*	*13-21*	*10-40*	*.90*
Psychosocial Well-Being	14	22.11	6.95	21.22	6.89	9-29	12-30	0-70	.81
		30.89	**9.06**	**20.89**	**8.07**	**15-39**	**9-32**	**0-70**	**.93**
		28.56	*7.49*	*22.11*	*6.29*	*17-36*	*14-30*	*0-70*	*.86*
Emotional Well-being	3	4.22	1.09	5.56	1.24	3-6	4-8	0-15	.53
		8.33	**2.34**	**5.78**	**2.11**	**6-12**	**3-9**	**0-15**	**.95**
		7.00	*1.94*	*5.67*	*1.12*	*5-10*	*4-8*	*0-15*	*.80*
Social Well-being	5	8.33	3.84	7.33	3.46	1-13	3-14	0-25	.76
		9.56	**4.19**	**7.00**	**3.61**	**1-14**	**3-14**	**0-25**	**.86**
		9.56	*3.24*	*7.33*	*4.06*	*5-14*	*2-15*	*0-25*	*.80*
Psychological Well-being	6	9.56	3.54	8.33	3.74	4-15	3-16	0-30	.78
		13.00	**4.33**	**8.11**	**4.20**	**6-17**	**2-16**	**0-30**	**.89**
		12.00	*4.06*	*9.11*	*3.33*	*5-16*	*4-16*	*0-30*	*.80*

Note. K= number of items, α = Cronbach's Alpha, M = mean, SD = standard deviation. Un-bold=Pre-Assessment, Bold = Post Assessment, Italic = Follow-up Assessment

Table 5 showed the descriptive statistics for pre, post and follow-up assessments, including (mean, standard deviation, actual and potential ranges) and internal consistency using Cronbach's alpha reliability of social isolation (family and friends) self-efficacy and psychosocial well-being (emotional well-being, psychological well-being and social well-being) in older adults. The reliability evaluation exhibited good internal consistency for social isolation and its subscales. The internal consistency for self-efficacy was good for the pretest and excellent was the post and follow-up assessments. The internal consistency for psychosocial well-being was excellent for the post test and good for the pretest and follow-up. The reliability for the pretest of emotional well-being was poor for the pretest, excellent for the post test and good for the follow up. The internal consistency for the social and psychological well-being was good for all the times of assessment.

Two-Way 2x3 Mixed Factorial ANOVA

It was hypothesized that SFBT would likely increase self-efficacy of the intervention group at post-assessment and follow-up levels in older adults. A 2x3 mixed ANOVA was conducted to assess the differences between the intervention and control groups across pre, post and follow-up assessments and the results of the analysis are presented in Table 6.

Table 6

Two-way mixed factorial ANOVA comparing Pre, Post and Follow-up Assessments of Self-Efficacy across Intervention (n=9) and Control (n=9) Groups.

Variables	Pre Assessment				Post Assessment				Follow-up Assessment					
	Intervention Group		*Control Group*		*Intervention Group*		*Control Group*		*Intervention Group*		*Control Group*			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(2,32)*	*Partial* η^2
Self-Efficacy	17.00	5.34	16.11	2.678	24.33	6.19	16.67	4.42	21.78	5.19	17.00	19.39	16.39***	.506

**p<0.5, **p<.01, ***p<.001*

The results of two-way mixed factorial ANOVA showed that there was a significant main effect for groups (intervention and control) in terms of self-efficacy for older adults living in old age homes, which depicted that the participants who received SFBT (in intervention group) showed significant improvement in self-efficacy as compared to the participants who did not receive the intervention (in control group). Whereas the evidence for significance of the main effect for assessments (pre, post and follow-up) was also found in terms of self-efficacy. The interaction effect of groups (intervention and control) and assessments (pre, post and follow-up) was also found to be significant for the self-efficacy of the participants. The findings showed that the participants who received SFBT showed significant improvement in post and follow up assessment in self-efficacy as compared to the pre-assessment. The partial eta square represents large effect size.

It was hypothesized that SFBT would likely increase the level of psychosocial well-being (emotional well-being, psychological well-being and social well-being) for the intervention group at post-assessment and follow-up levels in older adults. A 2x3 mixed ANOVA was conducted to assess the differences between the intervention and control groups across pre, post and follow-up assessments and the results of the analysis are presented in Table 7.

Table 7

Two-way mixed factorial ANOVA comparing Pre, Post and Follow-up Assessments of Psychosocial Well-Being (Emotional Well-Being, Social Well-Being, Psychological Well-Being) across Intervention (n=9) and Control (n=9) Groups.

Variables	Pre Assessment				Post Assessment				Follow-up Assessment					
	Intervention Group		*Control Group*		*Intervention Group*		*Control Group*		*Intervention Group*		*Control Group*			
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F(2,32)*	*Partial* η^2
Psychosocial Well-Being	22.11	6.95	21.22	6.89	30.89	9.06	20.89	8.07	28.56	7.49	22.11	6.29	30.34***	.655
Emotional Well-Being	4.22	1.09	5.56	1.23	8.33	2.40	5.78	2.11	7.00	1.94	5.67	1.12	23.80***	.598
Social Well-Being	8.33	3.84	7.33	3.46	9.56	4.19	7.00	3.61	9.56	3.24	7.33	4.06	3.18	.166
Psychological Well-Being	9.56	3.54	8.33	3.74	13.00	4.33	8.11	4.20	12.00	4.06	9.11	3.33	13.80***	.463

**p<0.5, **p<.01, ***p<.001*

The results of two-way mixed factorial ANOVA showed that there was a significant main effect for assessments (pre, post and follow-up) was found in terms of psychosocial well-being, emotional well-being and psychological well-being. The interaction effect of groups (intervention and control) and assessments (pre, post and follow-up) was also found to be significant for the psychosocial well-being, emotional well-being and psychological well-being of the participants. The findings showed that the participants who received SFBT showed significant improvement in post and follow up assessment in psychosocial well-being, emotional well-being and psychological well-being as compared to the pre-assessment. The partial eta square represents large effect size.

The results indicated a non-significant main effect for groups (intervention and control) across social well-being for older adults living in old age homes, which depicted that the participants who received SFBT (in intervention group) did not show significant improvement in social well-being as compared to the participants who did not receive the intervention (in control group). The evidence for significant main effects for assessments (pre, post and follow-up) was also not found in terms of social well-being. The interaction effect of groups (intervention and control) and assessments (pre, post and follow-up) was also found to be non-significant for the social well-being of the participants. The findings showed that the participants who received SFBT did not show significant improvement in post and follow up assessment in social well-being as compared to the pre-assessment.

Post hoc analysis (Sidak) was carried out for the pair-wise comparisons. See Table 8.

Table 8

Pairwise Comparison of Assessments in Self Efficacy, Psychosocial Well-Being (Emotional Well-Being, Social Well-Being and Psychological Well-Being) for Intervention Group (N=9)

Dependent Variable	*Pairs of Assessments*		*MD*	*p*	*95%CI*	
					LB	*UB*
Self-Efficacy	Pre	Post	-7.33	.000	-10.98	-3.69
	Pre	Follow-up	-4.78	.004	-7.82	-1.74
Psychosocial Well-Being	Pre	Post	-8.78	.000	-12.48	-5.07
	Pre	Follow-up	-6.44	.000	-9.20	3.70
Emotional Well-Being	Pre	Post	-4.11	.000	-5.73	-2.50
	Pre	Follow-up	-2.78	.000	-3.87	-1.68
Social Well-Being	Pre	Post	-1.22	.088	-2.62	.17
	Pre	Follow-up	-1.22	.159	-2.87	.42
Psychological Well-Being	Pre	Post	-3.44	.002	-5.33	-1.56
	Pre	Follow-up	-2.44	.007	-4.11	-.78

Note. MD = Mean Difference; CI = Confidence Interval; LB = Lower Bound; UB = Upper Bound

The pairwise comparison of self-efficacy, psychosocial well-being, emotional well-being and psychological well-being for the intervention group showed significant differences between pre- and post-assessments and pre-and follow-up assessment. After receiving SFBT, the scores on self-efficacy, psychosocial well-being, emotional well-being and psychological well-being were significantly improved among old age home residents. However, the pairwise comparison of social well-being for the treatment group did not show significant differences between pre- and post-assessment and pre-and follow-up assessment. After receiving SFBT, the scores on social well-being were not significantly improved among old age home residents Additionally, no pairwise difference was found in the pair of post and follow-up assessments.

Summary of Findings

- Pearson product moment correlation showed that social isolation demonstrated non-significant correlations with self-efficacy and psychosocial well-being, while self-efficacy and psychological well-being were significantly positively correlated. Gender had a significant negative correlated with social isolation, self-efficacy and psychosocial well-being and level of education had a significant positive correlation with social isolation and psychosocial well-being and a non-significant correlation with self-efficacy.
- Two-way mixed factorial ANOVA showed that after receiving SFBT, the scores of the intervention group on self-efficacy, psychosocial well-being, emotional well-being and psychological well-being increased significantly in post and follow-up assessments as compared to the control group.
- Two-way mixed factorial ANOVA showed that after receiving SFBT, the scores of the intervention group on social well-being did not increase significantly in post and follow-up assessments as compared to the control group.

Chapter V

DISCUSSION

The present study was planned to investigate the relationship between the demographics and psychosocial problems of older adults living in old age homes and to assess the efficacy of Solution Focused Brief Therapy (SFBT) for reducing their psychosocial problems. In this section, the findings of the present study are linked with existing literature.

First, it was hypothesized that there is likely to be a relationship between social isolation, self-efficacy, psychosocial well-being and demographics among older adults living in old age homes. In the present research social isolation and its subscales (family and friends) were not found to be significantly correlated with self-efficacy and psychosocial well-being. A possible explanation for this result is that small sample sizes often reflect weak and unstable correlations (Schönbrodt, 2013). The high level of social isolation among nearly all of the residents of old age homes, is likely to have resulted in low variability in the sample as compared to those older adults who live in their own homes, which could have weakened the associations (Hung,2017). Previous researchers have noted that although social isolation from family and friends is often unavoidable and ubiquitous among residents of old age homes, its repercussions vary among them depending upon factors like individual coping strategies (Neves et al., 2019).

The relationship between social isolation and self-efficacy has also been observed by past researchers to be stronger among community dwelling older adults as compared to those living in old age homes as there is high prevalence of social isolation among the latter (Heidar et al., 2016). Mishra et al. (2023) found that self-efficacy among old-age home residents was not significantly impacted by their level of social isolation. Social isolation among old age home

residents has been seen to be associated with depression (Nikmat et al., 2015), however, this association has not consistently been found to be significant among this population (Lapane et al., 2022). Šare et al (2021) found that due to the prevailing high levels of social and emotional challenges involved in institutionalized living, the association of both self-efficacy and well-being with social and demographic variables like social isolation was weaker among old age home residents than in the older adults living in their own homes.

Self-Efficacy was found to be significantly positively correlated with psychosocial well-being and its subscales (emotional well-being, social well-being and psychological well-being). This is consistent with past literature as a strong association between self-efficacy and well-being has been observed among the elderly and it has been seen that more self-efficacious older adults have higher levels of well-being despite having social and health difficulties (Bagheri et al, 2022; Hajek et al., 2019). Self-efficacy impacts the well-being of the elderly through its influence on their engagement in daily living activities, their capacity to modify their health and their ability to cope with illness (Whitehall et al., 2021). Fu et al (2018) found self-efficacy to be significant contributing factor to the wellbeing of old age home residents. Another research also found self-efficacy and resilience to be predictors of well-being in older adults (Sharma, 2013).

Findings in the current study showed social isolation and its family subscale to be significantly negatively correlated with gender, showing that females were more socially isolated as compared to males. Previous studies have shown elderly females living in their own homes to be significantly more socially isolated than males due to factors like reduced frequency of going out of their homes and lesser use of social mediums like the internet as compared to males (Silberzan et al., 2022). Other studies have shown that although females in old age homes also report being more isolated than males (Pitkala, 2016; Aung et al., 2017), the association between

gender and social isolation is not consistently significant (Nikmat et al., 2015). Interestingly, some studies have also found males old age home residents to be more socially isolated (Gardiner et el., 2020). The higher social isolation level among females in the present study can be explained by the patriarchal setup of Pakistani society as elderly women from lower socio-economic groups are often excluded from social networks, especially if they have physiological or psychological health issues and a compromised social standing (Mobeen et al., 2024). Additionally, reduced mobility also contributes to social isolation among elderly females as they are unable to leave their place of residence due to social constraints while men are able to go out for social and religious activities like congregational prayers at mosques (Al-Rashid et al., 2023).

Social isolation was significantly positively correlated with education level, showing that those who were more educated were less socially isolated. This finding is also consistent with existing literature which states that educated people are likely to be more knowledgeable and may be able to come up with more strategies to deal with loneliness (Wang et al., 2024). Wang et al. (2023) found lower level of education to be a strong contributor to social isolation in the elderly. Silberzan et al. (2022) discovered that that older adults faced a reduced risk of social isolation if their level of education extended beyond high school, resulting in a better financial status and stronger social contacts. Luo et al. (2021) found that the level of education moderated the association between social isolation and depression among male older adults however this trend was not observed in females.

Self-efficacy had a significant negative correlation with gender, showing females to have reduced levels of self-efficacy compared to males. This is a common trend in male-dominated eastern societies due to the established gender specific roles, as males are expected to be dominant and are required to adopt the traits of autonomy and ambition, while women are raised

to be reliant upon men and to accept their judgments instead of developing a strong sense of confidence in themselves (Ma et al., 2015). Past studies investigating gender differences in self-efficacy among older adults have also found males to be significantly more self-efficacious as compared to females (Morowatisharifabad et al., 2006; Wang et al., 2019).

Interesting, the present study did not show self-efficacy to be significantly correlated with education level as seen in past literature (Hur, 2018; Wang et al., 2019). As proposed by Bandura (1997), it is possible for a person's self-efficacy to improve due to the experience of successfully managing responsibilities in life, despite spending lesser time in the attainment of formal education. In a study by Reid et al. (2018) self-efficacy was not found to be associated with education level, but with the years of experience people have in their field of work. Dzerounian et al. (2022) found that among older adults living in welfare accommodation, knowledge about personal health issues was found to significantly predict self-efficacy, but no such association was shown between formal education and self-efficacy.

Psychosocial well-being and its subdomains of social and psychological well-being were significantly negatively correlated with gender, showing that females were found to have lower levels of psychosocial well-being as compared to males. Past literature has also shown that elderly females report lower levels of financial independence and self-rated health, contributing to reduced psychosocial well-being (Mukherjee & Paul, 2022). Matud at al. (2020) found that males exhibited a greater sense of autonomy, self-esteem and better mastery, resulting in a higher level of overall well-being. Female old age home residents have generally been found to be more willing to express their feelings of reduced well-being as compared to males due to the stigma attached with the latter showing vulnerability (Alarcão et al., 2019).

Psychosocial well-being and its subdomain of psychological well-being were significantly positively correlated with education level, showing that those who were more educated reported higher levels of psychosocial well-being. This is consistent with past literature, Gul and Dawood (2015) found that higher level of education significantly predicts increased well-being in older adults. Education has also been seen to moderate the effect of social isolation on the well-being of the elderly (Luo et al., 2021). Mishra et al. (2023) found that although education did not mediate the relationship between social isolation and psychological well-being in old-age home residents, it had a significant independent impact upon psychological well-being. Education has been found to give a sense of empowerment to older people and to keep their psychosocial functioning from declining. Additionally, it strengthens their resistance to the changes that accompany an aging person's diminished sense of control and hopelessness, which benefits the elderly population's psychological health (Mitchell et al, 2018).

It was hypothesized that there is likely to be an increase in the level of self-efficacy in the treatment group as compared to the control group after SFBT, at the post-assessment and follow-up levels among older adults. The findings of the current study showed a significantly greater increase in the level of self-efficacy of the intervention group as compared to the control group at both the post assessment and follow up levels. Consistent with our results, studies in the past have shown the effectiveness of SFBT in enhancing self-efficacy, as the goal of SFBT is to rapidly boost patients' confidence and ability to find solutions to their issues (Knekt et al., 2015).

Bagheri et al. (2024) studied the efficacy of SFBT and two other therapies against a control group in increasing self-efficacy levels among female students having social anxiety. At both the post assessment and follow-up levels, all three therapies were found to have significantly increased the self-efficacy of the participants, while the control group showed no

significant change. Another research investigated the role of SFBT in improving self-efficacy of students. After seven weekly sessions, those who received the therapy were found to have considerably greater self-efficacy scores than a waiting list control group (Farkoush et al., 2021).

A pretest posttest control group study was conducted which showed significantly increased self-efficacy in the group receiving SFBT while there was no significant change in the control group (Hendar et al., 2019). Another study was conducted to evaluate if SFBT would help to improve participants' self-efficacy in facing a difficult situation. It was observed that while the level of self-efficacy of the treatment and control group showed no significant difference before the intervention, a significant improvement was seen in self-efficacy of the treatment group after receiving SFBT sessions the self-efficacy of the control group had no significant change (Rakauskiene & Dumciene, 2013).

It was also hypothesized that there is likely to be an increase in the level of psychosocial well-being in the treatment group as compared to the control group after SFBT at the post-assessment and follow-up levels among older adults. The findings of the current study showed a significantly greater increase in the level of psychological well-being of the intervention group as compared to the control group at both the post assessment and follow up levels. These findings are supported by past literature which states that therapies that enhance the sense of self-efficacy in older adults also lead to an improvement in their psychosocial well-being (Toledano-González, 2018), since an increased belief in personal capabilities boosts engagement in activities, which leads to a greater sense of well-being (Müller et al., 2014). Bandura (1997) proposed that social persuasion and mastery experiences impact self-efficacy, which then acts as a trigger for further processes that impact well-being. Studies in the past have shown the efficacy of SFBT in enhancing psychosocial well-being. Beauchemin et al. (2023) tested a digital SFBT

intervention's impact on the well-being of participants and a significant improvement was observed in the wellness, satisfaction in life and happiness facets of well-being of the participants. The effects were found to be maintained at a six week follow up assessment providing evidence for the lasting effects of the intervention.

In another study, the efficacy of SFBT for increasing the psychological well-being of religious scholars was investigated. The participants' psychological well-being was seen to have improved significantly after the intervention (Mahmudah et al., 2023). Another study investigated the efficacy of SFBT group counselling for enhancing psychological well-being by comparing pre, post and follow-up assessments of SFBT intervention group against a control group. The intervention group showed a significant improvement in psychological well-being at post and follow up assessment as compared to pre-assessment (Sucipto et al., 2020).

The findings of the current study showed that SFBT significantly increased the level of emotional and psychological facets of well-being. It also increased the level of social well-being, however this change was not statistically significant. This has also been noted by past researchers, as Kim (2007) in his meta-analysis on the effectiveness of SFBT across various domains, found that SFBT has been seen to be more effective with internalizing problems like depression, anxiety and low self-esteem, but appears to have mixed results in addressing social difficulties. The results of a meta-analysis examining the efficacy of SFBT in clinical settings by Zhang et al. (2018) also aligned with this finding. In a study investigating the efficacy of SFBT with work related social issues in participants, the researchers found that although there was an improvement in their attitude, the change was not significant (Wells et al., 2010). However, studies have shown SFBT to be effective at improving social well-being in group therapy

settings which address interpersonal dynamics by involving interactions between members of social groups that impact each other (Franklin et al., 2019; Gingerich & Peterson, 2013).

Conclusion

The present study was designed to explore the associations between social isolation, self-efficacy and psychosocial well-being and to evaluate the efficacy of SFBT for dealing with the psychosocial problems of older adults living in old age homes. It has been concluded from the research that there is a positive association between self-efficacy and psychosocial well-being and SFBT helps to increase the levels of self-efficacy and psychosocial well-being of old-age home residents.

Older adults living in old age homes usually suffer from high levels of social isolation, leading to feelings of loneliness and depression (Neves et al., 2019). Additionally, they also tend to have low levels of self-efficacy which can act as a bufferer against the negative impacts of social isolation (Bevilacqua et al., 2024; Roskoschinski et al., 2023). Together, these factors cause them to have a reduced sense of psychosocial well-being (Lam & García-Román, 2020) and raises the need for interventions to help them deal with these issues (Tariq et al., 2020). SFBT has been shown to have promising results with this population in the past. The present study's findings add to the evidence in support of the use of SFBT for older adults as it was effective in increasing the levels of self-efficacy and psychosocial well-being among the participants.

Limitations

- Due to shortage of time, the duration between follow-up and post-assessment was not long enough to show the maintenance of the effects of therapy over a longer period of time.

- The generalizability of the study is affected by the small sample size and lack of randomization.
- Due to a shortage of staff, the assessments were carried out by the experimenter and there is a risk of participant bias having affected the responses of the subjects.
- The researcher was not fluent in the local language of the region due to which only those participants who could speak Urdu fluently were included in the study.
- The participants were only recruited from old age homes so the results cannot be generalized to older adults living in their own homes.

Implications

- The present study established the efficacy of Solution Focused Brief Therapy in mitigating the psychosocial impacts associated with the challenges of aging and social isolation.
- The utilization of therapies demonstrating rapid positive outcomes, as opposed to traditional problem-focused therapies, could be considered to reduce the time required for assessments and diagnoses.
- Therapists should consider societal factors and refrain from offering direct suggestions to older adults, as they are more receptive to the idea of utilizing their own past experiences to manage current emotional challenges, rather than adopting new behaviors to improve their well-being.
- The staff of old age homes can be trained to use a solution-focused approach towards the residents to ensure better cooperation and a more pleasant environment.

Recommendations

- Future studies should consider extending the interval between post-assessment and follow-up assessment to evaluate the stability of therapeutic effects.

- Future researchers may employ multiple intervention groups to compare the effects of SFBT with other therapies within this population.
- Researchers may also explore the effectiveness of SFBT in addressing the psychosocial challenges of community-dwelling older adults as well as residents of old age homes, and subsequently compare the outcomes of both groups.

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ANNEXURES

ANNEXURE A

INFORMATION SHEET

تحقیق کے متعلق معلوماتی شیٹ

میرا نام ردا خان ہے، میں بحریہ یونیورسٹی اسلام آباد کے طبی نفسیات ڈیپارٹمنٹ آف پروفیشنل سائیکالوجی کی طالبہ ہوں۔ یہ ریسرچ میرے تحقیقی مقالہ (Thesis) کا حصہ ہے۔ یہ تحقیق بحریہ یونیورسٹی اسلام آباد کے طبی نفسیات ڈیپارٹمنٹ آف پروفیشنل سائکولوجی کی ڈاکٹر آفرین کومل کی زیرِ نگرانی کی جارہی ہے۔ آپ کے اس تحقیق میں حصہ لینے سے پہلے، آپکے لیے یہ جاننا ضروری ہے کہ یہ تحقیق کیوں کی جارہی ہے اور اس میں حصہ لینے والوں کو کیا کرنا ہوگا۔ براہِ مہربانی نیچے دی گئی معلومات کو غور سے پڑھیں۔

تحقیق کا مقصد

اس تحقیق کا مقصد یہ جاننا ہے کہ:

1- بزرگ افراد پر اکیلے پن کے کیا نفسیاتی اثرات ہوتے ہیں؟

2۔ اس مقصد کو پورا کرنے کے لیے کچھ سوالنامے ترتیب دیئے گئے ہیں جو آپ کو دیئے جائیں گے تا کہ ان کی مدد سے اکیلے پن کے اثرات کے متعلق معلومات حاصل کی جائیں اور حاصل کردہ معلومات کو تحقیق کے باقی شرکت کنندگان کی معلومات کے ساتھ ملا کر استعمال کیا جائے گا۔

3۔ ان معلومات کا تجزیہ شماریاتی کمپیوٹر کے پروگرام کی مدد سے کیا جائے گا جس میں کسی بھی شرکت کنندہ کی شناخت ظاہر نہیں ہوگی

حق

یہ آپ کی مرضی پر منحصر ہے کہ آپ؛

1۔ اس تحقیق میں شامل ہوں۔

2۔ سوالنامہ میں موجود کسی سوال کا جواب نہ دیں۔

3۔ ہمیں بغیر وجہ بتائے اس تحقیق کو کسی بھی وقت چھوڑ دیں۔

4۔ ہماری پوری کوشش ہوگی کہ آپ کو اس تحقیق کی وجہ سے کسی بھی ذہنی دباؤ یا پریشانی کا سامنا نہ کرنا پڑے لیکن اگر ایسا ہوتا ہے تو آپ ہمیں فوراً بتائیں تا کہ آپ کو مناسب پیشہ ورانہ رہنمائی اور مشاورت فراہم کی جائے جس کے لیے آپ کو کوئی فیس ادا نہیں کرنی پڑے گی۔

ان تمام معلومات کو سمجھنے کے بعد آپ کی اس تحقیق میں شمولیت کا فیصلہ آپ کے ہاتھ میں ہے اگر آپ اس معلوماتی شیٹ کو سمجھتے ہوئے اس تحقیق میں حصہ لینا چاہتے ہیں تو برائے مہربانی اجازت نامہ پر دستخط کر دیجئے۔ ہم آپکے قیمتی وقت اور تعاون کے لیے ہم آپ کے بے حد شکر گزار رہیں گے۔

ANNEXURE B

CONSENT FORM

اجازت نامہ

میں اس بات کی تصدیق کرتا/کرتی ہوں کہ مجھے مس ردا خان نے اپنی تحقیق کے اہم اغراض و مقاصد کے بارے میں آگاہ کر دیا ہے جو کہ بحریہ یونیورسٹی اسلام آباد کے طبی نفسیات ڈیپارٹمنٹ آف پروفیشنل سائیکالوجی کی ڈاکٹر آفرین کومل کے زیر نگرانی کی جا رہی ہے۔

اس تحقیق کا مقصد یہ جاننا ہے کہ بزرگ افراد پر اکیلے پن کے کیا نفسیاتی اثرات ہوتے ہیں؟

میں اپنی پوری رضامندی سے اس تحقیق میں حصہ لے رہا/رہی ہوں اور مجھ پر اس حوالے سے کوئی دباؤ نہیں ڈالا گیا۔ مجھے اس بات سے بھی آگاہ کر دیا گیا ہے کہ میں جب چاہے اس تحقیق کو چھوڑ سکتا/سکتی ہوں۔ لہٰذا ان تمام حقائق اور اغراض و مقاصد کو مدنظر رکھتے ہوئے میں اس تحقیق میں حصہ لینے کے لئے پوری طرح رضامند ہوں۔

دستخط تحقیق کنندہ۔۔۔۔۔۔۔۔۔۔۔۔۔۔۔۔

دستخط شرکت کنندہ۔۔۔۔۔۔۔۔۔۔۔۔۔۔۔۔

ANNEXURE C

DEMOGRAPHIC SHEET

ذاتی کوائف نامہ

عمر:_____ جنس:_____ تعلیم_____

ازدواجی حیثیت: غیر شادی شدہ_____ شادی شدہ_____ علیحدگی_____ بیوہ/رنڈوا:_____

اگر آپ شادی شدہ ہیں تو آپ کے/کی میاں/بیوی کہاں رہتے ہیں؟_____

بچوں کی تعداد:_____ بیٹے:_____ بیٹیاں:_____

بہن بھائیوں کی تعداد:_____ بہنیں:_____ بھائی:_____

آپکو صحت سے متعلق کوئی مسائل درپیش ہیں؟ ہاں_____ نہیں_____

اگر ہاں تو کونسی؟_____

آپ کتنے عرصے سے یہاں مقیم ہیں؟_____

ANNEXURE D

LUBBEN SOCIAL NETWORK SCALE-6

LUBBEN SOCIAL NETWORK SCALE—6-Item Version.

LSNS-6

FAMILY: *Considering the people to whom you are related either by birth or marriage …*

1. How many relatives do you see or hear from at least once a month?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

2. How many relatives do you feel close to such that you could call on them for help?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

3. How many relatives do you feel at ease with that you can talk about private matters?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

FRIENDSHIPS: *Considering all of your friends including those who live in your neighborhood ….*

4. How many of your friends do you see or hear from at least once a month?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

5. How many friends do you feel close to such that you could call on them for help?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

6. How many friends do you feel at ease with that you can talk about private matters?

0 = *none* 1 = *one* 2 = *two* 3 = *three or four* 4 = *five through eight* 5 = *nine or more*

(LSNS-6)

خاندان لوگوں کو مدنظر رکھتے ہو جن سے آپ کا پیدائشی، ازدواجی یا لے پالک رشتہ ہو یا علاوہ ازیں

1-آپ اپنے کتنے رشہ داروں سے مہینے میں کم سے کم ایک بار ملتے/ دیکھتے ہیں یا بات کرتے ہیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

2-ایسے کتنے رشتہ دار ہیں جن سے آپ نجی معاملات پر آسانی سے بات کر سکتے ہیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

3-ایسے کتنے رشتہ دار ہیں جن سے آپ اتنا قریب محسوس کرتے ہیں کہ مدد کیلئے ان کو بلا سکتے ہیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

دوستی اپنے تمام دوستوں کو مدِنظر رکھتے ہوئے بشمول ان کے جو آپ کے پڑوس میں رہتے ہیں

4-آپ اپنے کتنے دوستوں سے مہینے میں کم سے کم ایک بار ملتے/ دیکھتے ہیں یا بات کرتے ہیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

5-ایسے کتنے دوست ہیں جن سے آپ نجی معاملات پر آسانی سے بات کر سکتے ہیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

6-ایسے کتنے دوست ہیں جن سے آپ اتنا قریب محسوس کرتے ہیں کہ مدد کیلئے ان کو بلا سکیں؟

0=کوئی نہیں 1=ایک 2=دو 3=تین یا چار 4=پانچ سے آٹھ 5=نو یا زیادہ

ANNEXURE E

GENERAL SELF EFFICACY SCALE

	Not at all true	Barely true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try hard enough.	1	2	3	4
2. If someone opposes me, I can find means and ways to get what I want.	1	2	3	4
3. It is easy for me to stick to my aims and accomplish my goals.	1	2	3	4
4. I am confident that I could deal efficiently with expected events.	1	2	3	4
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.	1	2	3	4
6. I can solve most problems if I invest the necessary effort.	1	2	3	4
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	1	2	3	4
8. When I am confronted with a problem, I can usually find several solutions.	1	2	3	4
9. If l am in a bind, I can usually think of something to do.	1	2	3	4
10. No matter what comes my way, I'm usually able to handle it.	1	2	3	4

(GSES)

ہدایات

نیچے دیئے گئے ہر بیان کے آگے 4 ممکنہ جوابات دیئے گئے ہیں۔ ہر بیان کو غور سے پڑھ اور یہ فیصلہ کیجئے کہ وہ آپ کی ذات کے بارے میں کس حد تک درست یا غلط ہے۔ اب آپ ان چار ممکنہ جوابات میں سے کسی ایک منتخب جواب کے ہندسے کے گرد دائرہ لگائیں۔

ا- میں ہمیشہ مشکل مسائل کو حل کرنے میں کامیاب ہو سکتا/سکتی ہوں، اگر میں پوری کوشش کروں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

1۔ اگر کوئی میری مخالفت کرے تو میں جو چاہتا/ چاہتی ہوں وہ حاصل کرنے کیلئے راستے اور ذرائع تلاش کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

3- مجھے یقین ہے کہ میں اپنے مقاصد حاصل کر سکتا/سکتی ہوں-

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

4- مجھے اعتماد ہے کہ میں غیر متوقع واقعات کا مستعدی سے مقابلہ کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

5۔ میرے باتدبیر ہونے کی بدولت میں غیر متوقع حالات کا مقابلہ کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

6۔ میں اکثر مسائل کو حل کر سکتا/سکتی ہوں، اگر میں ضروری کوشش کروں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

7۔ میں مشکلات کے سامنے پرسکون رہ سکتا/سکتی ہوں، کیونکہ میں اپنی مقابلے کی صلاحیتوں پر بھروسہ کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

8۔ جب میں کسی مسئلہ سے دوچار ہوتا/ ہوتی ہوں تو میں اس کیلئے حل تلاش کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

9۔ اگر میں کسی مشکل میں پڑ جاؤں تو میں اس کا ایک اچھا حل سوچ سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

10۔ میں ہر قسم کے حالات کا مقابلہ کر سکتا/سکتی ہوں۔

1۔ بالکل غلط 2۔ کچھ حد تک درست 3۔ کافی حد تک درست 4۔ بالکل درست

ANNEXURE F

MENTAL HEALTH CONTINUUM - SHORT FORM

Please answer the following questions are about how you have been feeling during the past month. Place a check mark in the box that best represents how often you have experienced or felt the following:

During the past month, how often did you feel …	NEVER	ONCE OR TWICE	ABOUT ONCE A WEEK	ABOUT 2 OR 3 TIMES A WEEK	ALMOST EVERY DAY	EVERY DAY
1. happy						
2. interested in life						
3. satisfied with life						
4. that you had something important to contribute to society						
5. that you belonged to a community (like a social group, or your neighborhood)						
6. that our society is a good place, or is becoming a better place, for all people						
7. that people are basically good						
8. that the way our society works makes sense to you						
9. that you liked most parts of your personality						
10. good at managing the responsibilities of your daily life						
11. that you had warm and trusting relationships with others						
12. that you had experiences that challenged you to grow and become a better person						
13. confident to think or express your own ideas and opinions						
14. that your life has a sense of direction or meaning to it						

MHC-SF

مندرجہ ذیل بیانات کو پڑھیں اور اس خانے میں نشان لگائیں جو کہ آپ کے تجربات اور احساسات کی بہترین عکاسی کرتا ہے۔

پچھلے مہینے کو ذہن میں رکھتے ہوئے جواب دیجئے کہ آپ نے کتنی مرتبہ درج ذیل طریقوں سے محسوس کیا		کبھی نہیں	ایک یا دو مرتبہ	ہفتے میں تقریباً ایک مرتبہ	ہفتے میں دو یا تین مرتبہ	تقریباً ہر روز	ہر روز
.1	خوش	0	1	2	3	4	5
.2	زندگی میں دلچسپی لینا	0	1	2	3	4	5
.3	زندگی سے مطمئن	0	1	2	3	4	5
.4	کہ آپ کے پاس کچھ ایسا اہم موجود ہے جس سے آپ معاشرے کو فائدہ پہنچا سکیں	0	1	2	3	4	5
.5	کہ آپ کا تعلق ایک معاشرے سے ہے (مثلاً سماجی گروہ، اسکول، ہمسائیگی ،وغیرہ)	0	1	2	3	4	5
.6	کہ ہمارا معاشرہ تمام لوگوں کے لیئے ایک اچھی جگہ ہے یا بہتر جگہ بن رہی ہے	0	1	2	3	4	5
.7	کہ لوگ بنیادی طور پر اچھے ہیں	0	1	2	3	4	5
.8	کہ ہمارے معاشرے کا کام کرنے کا طریقہ آپ کے لیئے قابل فہم ہے	0	1	2	3	4	5
.9	کہ آپ کو اپنی شخصیت کے زیادہ تر پہلو پسند ہیں	0	1	2	3	4	5
.10	آپ اپنی روز مرہ زندگی کی ذمہ داریوں کو اچھے طریقے سے سنبھال لیتے ہیں	0	1	2	3	4	5
.11	کہ آپ کے دوسروں کے ساتھ پُر اعتماد تعلقات ہیں	0	1	2	3	4	5
.12	کہ آپ ایسے (دشوار) تجربات سے گزرے ہیں جنہوں نے آپ کو میچور ہونے اور ایک بہتر انسان بننے میں مدد کی	0	1	2	3	4	5
.13	سوچنے اور اپنے نظریات اور رائے کے اظہار میں پُر اعتماد ہونا	0	1	2	3	4	5
.14	کہ آپ کی زندگی باسمت اور بامعنی ہے۔	0	1	2	3	4	5

ANNEXURE G

REQUEST FOR DATA COLLECTION

Bahria University
Discovering Knowledge

February 14, 2024

TO WHOM IT MAY CONCERN

REQUEST FOR DATA COLLECTION

It is stated that **Ms. Rida Khan** Enrollment No. 01-275222-017 is a student of MS Clinical Psychology Bahria University Islamabad Campus conducting research on "**Social Isolation, Self Efficacy and psychosocial Wellbeing of Older Adults Therapeutic Efficacy of Solution Focused Brief Therapy**" under supervision of undersigned. It is requested that kindly allow her to collect the data from your esteemed institution.

Regards,

Dr. Afreen Komal
Assistant Professor
Bahria School of Professional Psychology
Bahria University
E-8 Islamabad

ANNEXURE H

PERMISSIONS TO USE THE SCALES

Permission to use Lubben Social Network Scale-6 Inbox

rida khan 15 Feb
to lubben

Respected Sir,

I hope you are in good health. I am Rida Khan, a student of MS Clinical Psychology at Bahria University in Islamabad, Pakistan. For my thesis I am conducting a research on aging population living in old homes.

The topic of my research is Social Isolation, Self Efficacy and Psychosocial Wellbeing of Older Adults: Therapeutic Efficacy of Solution Focused Brief Therapy. For the analysis of the construct of Social Isolation, I have a requirement for the Lubben Social Network Scale-6 (LSNS-6)

For this purpose, I would like to request for your permission to use the scale.

Thanking you,
Rida Khan

James Lubben 17 Feb
to me

Rida Khan:

Thank you for your interest in the LSNS. You certainly have my permission to use LSNS-6 or any of the three versions of the LSNS (LSNS-R, LSNS-18 or the LSNS-6). There is no charge for the use of these scales. You may wish to review the following website for additional information about the LSNS:

https://www.bc.edu/content/bc-web/schools/ssw/sites/lubben/description.html

Good luck with your research project. I look forward to reading about it.

All the best,
James Lubben
UCLA: Professor Emeritus, Luskin School of Public Policy
Boston College: Professor Emeritus, School of Social Work
& Louise McMahon Ahearn Professor (retired)

Selected publications regarding LSNS:

1. Lubben, J. (2017). Addressing social isolation as a potent killer! *Public Policy & Aging Report.* 27(4):136-138. doi:10.1093/ppar/prx026. https://doi.org/10.1093/ppar/prx026

2. Crooks, VC, Lubben, JE, Petti, DB, Little, D & Chiu, V. (2008). Social Network, Cognitive Function and Dementia Incidence in Elderly Women. *American Journal of Public Health.* 98(7):1221-1227. https://doi.org/10.2105/

February 17, 2024

Show quoted text

rida khan 17 Feb
to James

Respected Sir,

Thank you for your permission and your comprehensive recommendations. I will thoroughly review the information in the suggested links before starting my research.

Regards,
Rida Khan

Request to Translate the Lubben Social Network Scale in Urdu Inbox

Rida Khan 20 Feb
to lubben@bc.edu

Respected sir,

I hope you are in good health. I am Rida Khan, a student of MS Clinical Psychology at Bahria University in Islamabad, Pakistan. I had written to you earlier, to request you for permission to use for the Lubben Social Network Scale-6 (LSNS-6) for my thesis research with aging population living in old homes. You had been extremely kind to grant me permission and share additional resources to add to my information on the topic.

I further request the permission to translate the scale into Urdu as I have found that a majority of the population for my research is unable to understand English. If you can kindly allow me to do so, I will proceed with my research.

Thanking you,

Rida Khan

Sent from Mail for Windows

James Lubben 25 Feb
to me

Rida Khan,
You indeed have my permission to translate the LSNS-6 into Urdu. I look forward to seeing the translation in print.
All the best,
Jim Lubben

rida khan 25 Feb
to lubben

Thank you sir, I will surely share the translation with you.

Rida Khan

Freie Universität Berlin

Fachbereich Erziehungswissenschaft und Psychologie
- Gesundheitspsychologie -

Professor Dr. Ralf Schwarzer
Habelschwerdter Allee 45
14195 Berlin, Germany

Fax +49 30 838 55634
health@zedat.fu-berlin.de
www.fu-berlin.de/gesund

Freie Universität Berlin, Gesundheitspsychologie (PF 10),
Habelschwerdter Allee 45, 14195 Berlin, Germany

Permission granted

to use the General Self-Efficacy Scale for non-commercial reseach and development purposes. The scale may be shortened and/or modified to meet the particular requirements of the research context.

http://userpage.fu-berlin.de/~health/selfscal.htm

You may print an unlimited number of copies on paper for distribution to research participants. Or the scale may be used in online survey research if the user group is limited to certified users who enter the website with a password.

There is no permission to publish the scale in the Internet, or to print it in publications (except 1 sample item).

The source needs to be cited, the URL mentioned above as well as the book publication:

Schwarzer, R., & Jerusalem, M. (1995). Generalized Self-Efficacy scale. In J. Weinman, S. Wright, & M. Johnston, *Measures in health psychology: A user's portfolio. Causal and control beliefs* (pp.35-37). Windsor, UK: NFER-NELSON.

Professor Dr. Ralf Schwarzer
www.ralfschwarzer.de

Request to use the Urdu Translation of the Mental Health Continuum Short Form

RK **Rida Khan <ridakhan1@gmail.com>**
15/02/2024 11:30 PM

To: clmkeyes@gmail.com

Respected Sir,

I hope you are well. I am Rida Khan, a student of MS Clinical Psychology at Bahria University in Islamabad, Pakistan. For my thesis, I am conducting an intervention-based research to study the efficacy of Solution Focused Brief Therapy (SFBT) in improving the psychosocial health of residents of old age homes.

For this purpose, I would like to request for your permission to use the Urdu version of the Mental Health Continuum Short Form by Faran et al. (2021), as a majority of the population of my study is unable to understand English.

I would further like to inform you that I have received the Urdu translation of the scale, along with its scoring criteria from the authors, and only need your permission to use the scale in order to proceed with my research.

Thanking you,
Rida Khan

Re: Request to use the Urdu Translation of the Mental Health Continuum Short Form

CK **Corey Keyes <clmkeyes@gmail.com>**
27/02/2024 11:55 AM

To: Rida Khan

Save all attachments

3.29 KB

Urdu Version of MHC-SF.docx
37.08 KB

Rida,

I have attached the Urdu version of my scale and wish you the best with your work.

Dr. Keyes

Re: Request to use the Urdu Translation of the Mental Health Continuum Short Form

RK **rida khan <ridakhan1@gmail.com>**
27/02/2024 12:24 PM

To: Corey Keyes

Respected Sir,

Thank you for your kind permission.

Rida Khan

.

ANNEXURE I

PERMISSION TO USE SOLUTION FOCUSED BRIEF THERAPY

SFBT research plan with geriatric population Inbox

rida khan 30/12/2023
to Franklin, Johnny.Kim

Hello Cynthia,

I hope you are well. I had the honour of attending the SFBTA conference in October and feel fortunate to have learnt a lot from the experts in the field. For my thesis, I have planned to use SFBT as an intervention, to help improve the psychological well-being of participants belonging to the geriatric population living in old homes in Pakistan.

I am very excited to use SFBT, as I have been studying up on it since June and my passion for it is increasing every day. In addition to the conference, I took a certification master class from an SFBT practitioner and trainer in Pakistan. I have read many research papers on SFBT and I would love to contribute to further research on the therapy.

The ethics committee at my university is concerned whether one can use SFBT in an intervention-based research, without having attended a supervised training course and suggested that this might be a hindrance in publication of the research in the future.

I need your guidance on the matter, as I have read many researches that used SFBT in therapeutic settings and were approved, based on their usage of the fidelity guidelines proposed by Steve de Shazer.
Kindly give your esteemed suggestions on the matter.

Very grateful for your support,

Rida Khan Sherwani

Franklin, Cynt... 30/12/2023
to me, Johnny.Kim@d...

Hello Rida khan:

I am glad you were able to attend the SFBT conference and are interested in SFBT. It is important for the therapist delivering the intervention to be clinically trained in SFBT and if a student supervised by someone trained in it.

Good luck with your study.

All my best,

Cynthia Franklin

Cynthia Franklin, PhD, LCSW-S, LMFT
Director of External Relations
Stiernberg/Spencer Family Professor in Mental Health
Steve Hicks School of Social Work
University of Texas at Austin

Courtesy Professor
Department of Psychiatry and Behavioral Sciences
Dell Medical School
University of Texas at Austin

Editor-in-Chief
Encyclopedia of Social Work
Oxford University Press

VERIFICATION OF CLINICAL SUPERVISION

I am writing to confirm that Ms. Rida Khan, a student of MS Clinical Psychology- 4 (A) at Bahria University, Islamabad undertook my supervision in taking therapy sessions of residents of old-age homes in Rawalpindi, using Solution Focused Brief Therapy techniques. These sessions were part of her thesis titled 'Therapeutic Efficacy of Solution Focused Brief Therapy (SFBT) for Dealing with the Psychosocial Problems of Older Adults Living in Old Age Homes'.

During the period from March 2024 to May 2024 she had regular meetings with me to discuss how to conduct the sessions. She consulted me regarding the planning of the sessions and the use of Solution-Focused Therapy Techniques. Audio recordings of the sessions were used to ensure fidelity and effective use of this approach.

Throughout this period, Rida Khan demonstrated a strong commitment to learning and developing her therapeutic skills. She exhibited professionalism, empathy, and understanding of SFBT principles and techniques during the therapy sessions and adhered to ethical guidelines and standards of practice.

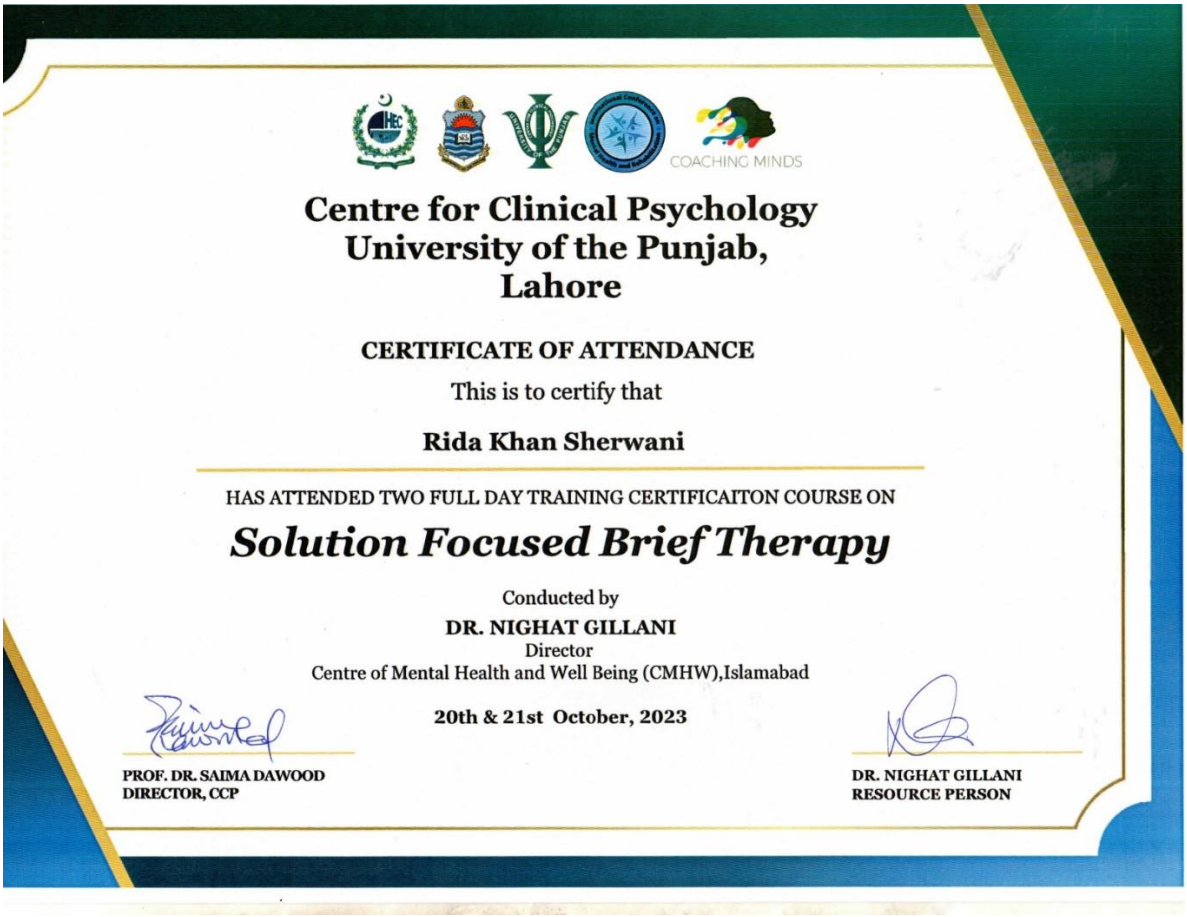
Sincerely,

Dr. Nighat Gilani

Director

Center for Mental Health and Wellbeing

Islamabad



COACHING MINDS

Centre for Clinical Psychology
University of the Punjab,
Lahore

CERTIFICATE OF ATTENDANCE

This is to certify that

Rida Khan Sherwani

HAS ATTENDED TWO FULL DAY TRAINING CERTIFICAITON COURSE ON

Solution Focused Brief Therapy

Conducted by

DR. NIGHAT GILLANI
Director
Centre of Mental Health and Well Being (CMHW),Islamabad

20th & 21st October, 2023

PROF. DR. SAIMA DAWOOD
DIRECTOR, CCP

DR. NIGHAT GILLANI
RESOURCE PERSON

CERTIFICATE OF ATTENDANCE

PROUDLY PRESENTED TO

Rida Khan Sherwani

This document confirms participation in the *Solution Focused Brief Therapy Association's* annual conference held online October 19-21, 2023.

(15.5 hours)

Carol Buchholz Holland
Conference Chair

Marcella Stark
SFBTA Board President

ANNEXURE J

PLAGIARISM REPORT

jgh

ORIGINALITY REPORT

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