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Cohen, A; Dias, A; Azariah, F; Krishna, RN; Sequeira, M; Abraham, S; Cuijpers, P; Morse, JQ; Reynolds, CF3rd; Patel, V; (2016) Aging and well-being in Goa, India: a qualitative study. *Aging & mental health*. pp. 1-7. ISSN 1360-7863 DOI: <https://doi.org/10.1080/13607863.2016.1236239>

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Aging and well-being in Goa, India: A qualitative study

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Acknowledgements: This research was supported by funding from the US National Institute of Mental Health (R34MH096997 and P30MH90333).

Word Count: 5193

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Abstract

Objectives

The population of India is aging rapidly. This demographic shift brings with it a host of challenges to the health and well-being of older adults, including the increased prevalence of non-communicable diseases, among them depressive disorders. In this paper, we report on qualitative research intended to inform the development of a locally acceptable and appropriate intervention to improve the well-being of older adults in Goa, India and, specifically, to prevent late-life depression.

Method

Semi-structured interviews with 20 individuals, aged 60 years and older, attending two primary care clinics in Goa, India. Transcripts were reviewed to identify emerging themes, a coding scheme was developed and thematic analyses were conducted.

Results

Analyses of the interview transcripts revealed the following key themes: 1) notions of old age tended to be negative and there were widespread fears of becoming widowed or incapacitated; 2) the most frequently reported health conditions were joint pain, diabetes and heart disease; 3) emotional distress was described using the terms “tension,” “stress,” “worry” and “thinking;” 4) family issues often involved financial matters, difficult relationships with daughters-in-law and conflicted feelings about living with the family or independently; 5) other than a pension scheme, participants did not know of community resources available to older adults.

Conclusions

Our findings are in general agreement with those of previous research, and with our experiences of working with older adults in Pittsburgh and the Netherlands. This research will inform the development of an intervention to prevent depression in older adults in Goa.

Keywords: late-life depression; prevention; Goa, India; qualitative research

Introduction

The population of India is aging rapidly. Between 2001 and 2031, the percentage of people 60 years and older will almost double, and by mid-century will increase to an estimated 20% (United States Census Bureau). In general, this has been brought about by the continuing declines in “communicable, maternal, neonatal and nutritional” causes of morbidity and mortality, to an increased burden of disease from non-communicable illness and injuries, including self-harm (Institute for Health Metrics and Evaluation). The resulting demographic shift brings with it a host of challenges to the health and well-being. For example, diseases of the elderly, e.g., cardiovascular conditions, diabetes, and cancer, are now among the leading causes of morbidity and mortality in India, and the prevalence rates of these conditions are expected to increase significantly in the coming decades (Patel et al., 2011). The prevalence rates of depressive and anxiety disorders are also expected to increase. For example, between 1990 and 2013 the burden of disease due to these conditions in India increased sharply in the general population, a trend that is expected to continue as the population ages (Charlson, Baxter, Cheng, Shidhaye, & Whiteford, 2016).

In India, estimates of the prevalence of late-life depression in community samples range from 8.9% to 62.16%, with a median prevalence of 18.2%, which is considerably higher than the global median rate of 5.4% (Grover & Malhotra, 2015). Aside from the increasing burden of depression (Charlson et al., 2016), the public health importance of late-life depression in India is increased by its association with chronic physical disorders (Grover & Malhotra, 2015; He, Muenchrath, & Kowal, 2012), the risk of suicide (Vijayakumar, 2010), and, as suggested by research in the West, elevated mortality (Cuijpers et al., 2014; Diniz et al., 2014) and risk for dementia (Diniz, Butters, Albert, Dew, & Reynolds, 2013).

Research from Europe and North America has shown the value and effectiveness of interventions to prevent late-life depression (Okereke, Lyness, Lotrich, & Reynolds, 2013;

Schoevers et al., 2006; Smits et al., 2008; van Zoonen et al., 2014; van't Veer-Tazelaar et al., 2011; van't Veer-Tazelaar et al., 2009). Although similar research has not been carried out in India, the research cited above indicates that the prevention of late-life depression would have substantial public health benefits and improve the general well-being of older Indians. In view of this, a pilot project, with funding from the United States National Institute of Mental Health (NIMH), has been initiated to develop a preventive intervention for older adults at risk for depression attending urban and rural primary care practices in Goa, India.

One component of the pilot project was to revisit the research of Patel and Prince (2001) for four reasons. First, this was a unique opportunity to determine whether concepts of and attitudes toward aging and mental health had changed in Goa over a period of about 15 years. Second, understanding the current concepts and attitudes is essential to the development of a locally acceptable and appropriate intervention to prevent late-life depression. Third, we believed it was essential to determine if older adults in Goa continued to face the same challenges to their health and well-being as described in the earlier research. Fourth, although research has provided an epidemiological profile of late-life depression in India (Grover & Malhotra, 2015), qualitative research on the broader issue of older adults and well-being is lacking. In sum, we wished to examine the risk factors for depression in older adults in Goa and to use that knowledge to inform the prevention intervention we are developing.

Methods

Setting

Goa, which is located on the western coast of India, is the smallest state in India. Compared to the rest of the country, Goa's Human Development Index, a combined measure of life expectancy, monthly per capita expenditure, and mean years of schooling, is the fourth

highest in India (Institute of Applied Manpower Research, 2011). A Portuguese enclave from the early 16th to the mid-20th Century, 25% of Goa's population remains Christian (predominantly Catholic), while 66% are Hindu, and 9% are Buddhist and other religions (Census of India 2011). International and domestic tourism dominate the economy.

In the state of Goa, primary, secondary and tertiary healthcare services for older adults are available free of cost in government funded facilities. Health services are also available on an out-of-pocket basis from the private sector. Alternate systems of medicine such as Ayurveda and Homeopathy are also available.

The Department of Social Welfare provides social security benefits to older adults with no financial resources.

Sample

We used purposive sampling to recruit 20 individuals 60 years of age and older who were attending primary health centers (one urban and one rural) in Goa, India. We recruited in these settings to understand: 1) the problems affecting the well-being older adults; 2) their concepts of depression; and, 3) issues pertinent to the development of an intervention for the prevention of late-life depression, a group that tends to be at high risk of depression (Patel et al., 2010). We sampled an equal number of males and females; their average age was about 70 years; half were married and half were widowed; and, half had no education and half primary school and above. The GHQ-12, a screening instrument for common mental disorders that has been validated for use in Goa (Sartorius et al., 1993) was administered after the interview so minimize the possibility of influencing the responses of participants. Participants' GHQ scores ranged from 0 to 6. Discussions about and analyses of the 20 interviews suggested we had reached the point of information saturation.

Ethical approval

The research reported on in this paper was given ethical approval by the following: 1) Institutional Review Boards at the University of Pittsburgh; 2) London School of Hygiene & Tropical Medicine; 3) Sangath, Goa, India; and, 4) Goa Medical College, India. All persons who participated in the research gave their informed consent prior to their inclusion in the study.

Interview

An interview guide was developed by the research team and followed broadly the earlier work of Patel and Prince (Patel et al., 2008). The guide included questions about the following topics: health problems, family issues, social status and the availability of community resources for older adults in Goa. At the end of the interview, a case vignette (the same one used in the previous research) was read to participants:

Mrs Naik is aged 73. She complains of different troubles at different times, general aches and pains and general weakness of the body and tiredness. She is not doing her housework as she usually does. She finds it difficult to fall asleep. In addition, she feels worried about problems such as money, her children and her flat. She is irritable with close relatives and friends and she cannot relax and enjoy herself properly.

We then asked participants a series of questions about the vignette, e.g., “Is this a health problem?” “What do you call it?” “What care does this person need?” The purpose of asking about the vignette was to make it possible to compare the present concepts and attitudes about mental illness to those found by Patel and Prince in the previous research.

The interview guide was translated into Konkani (the local language) and back translated into English.

All but one of the interviews were conducted in Konkani, the local language of Goa. One interview was conducted in English. Of the ten interviews in the urban area, nine were conducted in the primary health centre. In the rural area, all ten interviews were conducted in the homes of participants. On average, interviews lasted an average of 45-60 minutes. After obtaining consent from participants, interviews were audio recorded then translated and transcribed into English. Translations were conducted by individuals who are fluent in Konkani and English. We did not conduct back-translation, but the research team reviewed all of the transcripts for accuracy.

Analysis:

During a research meeting in Goa, and informed by prior teleconferences and email communications, members of the research team read the transcripts and used the interview guide as an overall framework for coding (see above). We also identified emerging themes, e.g., uncertainty about the future, notions of old age, alcohol use, relations with daughters-in-law and feelings of sadness. The final coding scheme was achieved by consensus. One of the researchers (AC) uploaded the transcripts into MAXQDA 11 (software for the analysis of qualitative data – <http://www.maxqda.com/>) and applied the coding scheme. The other researcher (FA) inserted the codes into Word™ files of the transcripts. AC then compared and reconciled any differences in how the codes were applied and created a final MAXQDA 11 file to be used for the analyses. In the course of analyzing the transcripts several additional themes emerged, e.g., causal attributions of physical and mental illnesses and the importance of food. and AC created and applied the new codes to the analysis file.

Results

Notions of old age

Three-quarters of the participants made statements that reflected feelings about what it meant to grow old. These statements depicted mostly negative beliefs, many reflecting a fatalism about decline in health status (“In old age there is always health damage” and “Once you become old, people get fever, they start coughing, anything could happen, legs pain, they get cold.”) and resignation about diminishment of physical capacity (“Once you have become old you can’t do anything”).

Participants, half of whom had experienced the death of a spouse, also expressed fears of being widowed or incapacitated. In regard to widowhood, the following statement is illustrative of the practical challenges: “She has no one; no husband, no children. Who will cook and serve her food?...Who will get her rice, logs to put [on the] fire?” Participants also recognized the emotional challenges of widowhood. For example, one participant spoke of the pain and sadness of being widowed: “The one who survives will constantly get thoughts of their partner. If he was alive they would have stayed happily together. They will not like to continue living.” And another participant spoke of the risk of premature mortality that is a risk of being widowed: “It happens many times. Husband and wife are very much fine, and...if one person dies...the other dies very soon.”

The fear of becoming incapacitated by illness was expressed by six participants. Above all, there were the practicalities: “If I don’t feel well, who will get things from the shop? I am not able to walk, who will cook food? If I become bedridden who will cook and serve food for me?” The fear of incapacity prompted one participant to say, “Anything can happen anytime to old people...I just think and pray to God for happy death.” And this fear brought another to similar feelings: “Hope God remembers me suddenly if I become bedridden.”

Health conditions

Participants were asked about their health conditions and their perceptions of the health of older adults in Goa, in general. The most frequently reported condition was pain in the joints (n=15), which was predominately associated with knee pain (n=11). Diabetes (n=11), heart disease (n=10, with an additional 3 reports of blood pressure problems), respiratory ailments, e.g., colds, asthma (n=9), and visual problems (n=6) were also reported. In some cases, it was difficult to determine the exact nature of the health condition, e.g., “When I walk, this body of mine gets very tired and my head starts paining and I feel giddy. Once I start feeling giddy I can’t walk properly and I wait thinking that I will fall....”

Six participants spoke of increases in illness among older adults in Goa. Two attributed this to the loss of an idyllic past when people had better eating habits and, as a result lived to be more than 100 years old. In a similar vein, one participant attributed supposed increases in illness to “adulterated” food. Another participant compared life in Goa to an idealized world elsewhere and asserted, “Abroad people live for 110 to 120 years [but] here people die just like that.” A fourth participant attributed the increase in illness because of “adulterated” food, while the two others believed that alcohol – “Now everyone drinks too much” – and women having only one child were responsible for shortened life expectancies.

Participants used the terms “tension,” “stress,” “worry” and “thinking” to refer to states of emotional distress, and attributed the distress to social factors or health problems: 1) family relationships or worrying about their adult children (N=12), e.g., “When my children trouble me I feel like committing suicide;” and, 2) being alone, especially after the death of a spouse (N=13), e.g., “The one who survives will constantly get thoughts of their partner...They will not like to continue living anymore.” Five participants also believed that states of distress could lead to physical ill health, e.g., “If the children misbehave then they

think. If there are lots of children in the house, they are not able to feed them, this also is a reason to think. Thinking a lot on such matters can affect blood pressure. They can get high BP and headache.”

Neglect and abuse

Older adults in Goa are subjected to neglect and abuse. Fourteen participants reported fights (especially over money and property), abusive language, and a perception that older adults were not wanted. Eight participants reported older adults were beaten, and five stated the beatings were the result of children drinking alcohol: “Some [children or family members] drink alcohol and come and beat them. They say they want food, if it’s not there they beat, break their head... They ask for money, if you don’t give they beat.”

Fifteen participants stated money and property were sources of family tensions and disputes that ranged from losing respect if the older adult had no money to being abused. In regard to money, one participant reported, “If [children] do not get their mother’s money, she is beaten. This happens in most of the houses,” and, in regard to property, another stated, “If elders have property and they don’t give it to children then son gets angry.” Still another participant observed, “Some [children] take away the money and property and throw the old people out of the house.”

It must be noted, however, that none of the participants reported being beaten or abused themselves. If any had reported abuse to themselves, this would have been reported to the appropriate authorities, as per our risk management protocol.

Daughters in law

The interviews revealed the complexity of the relationship between older adults and their daughters-in-law, and how this relationship was a critical element in family relations.

For the most part, participants described this relationship was a source of conflict and how daughters-in-law don't respect their mothers-in-law. The marriage of a son often marked a sharp disruption in family relations, e.g., "Once the son gets married and the daughter-in-law comes in the house, there are problems." Another participant spoke of how changes in social roles, which have been brought about by economic development, have resulted in strained relationships, e.g., "When the mother-in-law used to move about for work, she used to get money. Now she has to depend on her daughter-in-law for money... this becomes a reason for fights." And one participant reported that daughters-in-law "beat the old people."

However, not all participants believed this relationship was necessarily negative. At least five participants would agree with the following: "The situation differs in each house. In some houses the mother-in-law and daughter-in-law go well together. The daughter-in-law is like her daughter. While in some houses there is friction."

Complexity of family relations

The complexity of family relationships is best represented in what older adults expressed in regard to whether they wanted to live independently or with their families. Despite conflicts around money and property, the strained relationships between mothers-in-law and daughters-in-law, and the reports of neglect and abuse, 16 of the participants reported a preference to live with family. The primary reasons were practical. For example, "How can [older adults] stay alone? They must be with their children or else who will take them to the doctor when they fall sick?" Another participant stated, "There's lot of danger staying alone...If in future any problem happens then family is required...There are loads of benefits living together with children." One of the benefits is getting and preparing food: "Only if my family gives me, then I will have my food."

Aside from the practicalities of daily living or in the event of health crises, about half of the participants (N=9) spoke of the emotional benefits of living with their families, e.g., “There is too much tension if you stay alone.” One participant spoke of the need for companionship, while another spoke of how being alone posed a risk to emotional well-being: “When they stay alone they will think. If they stay with family then they can tell their problems.” And one participant expressed fear at the prospect of living alone, “When you stay alone there is fear. I feel I need people in the house.” Finally, one stated that older adults preferred to live with their extended families, “because they need companionship.”

Although the practicalities and emotional benefits of living with family were generally acknowledged by participants, some also reported the difficulties. For example, one participant stated “Staying together is good,” but then went on to note the challenge of living with a daughter-in-law and that “children now a day drink and start abusing.” Thus, the participant concluded, “it is better for me to stay separate.” The challenge of living with a daughter-in-law was also noted by another participant who said, “I want to stay with my children but what to do they do not like me. They are trained by their wives to stay away from their parents.”

Social roles and community resources

All of the participants reported that older adults took part in household chores, e.g., cooking, cleaning, laundry and child care. At the same time, most participants (N=16) reported that outside of the home there were no designated roles or work for older adults. Six participants felt there should be work for older adults, e.g., “Something should be there, some light work,” with the implication this would supplement the pensions available to older adults. Only four participants reported they or people they knew were engaged in such work as

selling food (bananas, rice, coconuts), working on cashew plantations, or gathering and selling wood.

A majority of participants (N=13) believed older adults were generally shown respect by members of their communities. A typical statement was, “Elders are respected, people speak to them well, be good to them.” Four participants did not give definitive answers, e.g., “Who will tell? I don’t know to say.” Of the remaining three participants, one spoke of how the younger generation did not respect older adults, another said, “I do not have a position in the society,” and one made contradictory statements.

Participants reported they did not know of any community resources, e.g., clubs for older adults. At the same time, all but three of the participants spoke of how older adults are now eligible to receive Rs 2,000 per month from the Dayan and Security Scheme of the Department of Social Welfare, Government of Goa. Older adults (one per household) who do not have any other source of income are eligible for the scheme.

The vignette

When asked what they would call the woman’s condition, half of the participants (n=10) provided non-specific responses, e.g., “You can say she faces some problem,” or “She needs help,” or could not give it a name. Only two participants identified the woman’s condition as a psychological problem or mental illness, while the remaining participants (N=8) either used non-specific terms, e.g., “Her health is not well from within,” or “She has some problem with her head,” or used the common idioms of distress “worry” and “tension.” When asked if they had heard of “depression” or if they thought the woman in the vignette had depression, only four participants answered positively, although their answers were vague, e.g., “It could be depression; there is pressure on the brain.”

Participants mostly attributed the woman's behaviour to social factors such as lack of money and relationships with her children that, in turn, resulted in tension, stress, worry or thinking. One participant agreed the woman had a health problem, but attributed it to, "She keeps thinking about children." Similarly, another participant who did not believe the woman had a health problem believed the woman's her distress was, "because her children don't care for her." Five participants suggested old age was the cause of the woman's behavior.

When asked what care would help the woman, a majority of participants (N=13) thought the woman needed to consult a doctor, including two who mentioned psychiatrists, specifically. One participant suggested the woman needed to take pills to help her sleep, but did not mention the need to see a doctor. Nine participants believed the woman would feel better if she spoke with others, e.g., neighbors or family, and that family members should initiate conversations with the woman. One participant stated the woman should not be alone: "If she is staying with people this thing will not come, because she will be sharing with each other." The need for family support extended to practical matters as well, e.g., seven participants cited the need to make certain that she had food.

Discussion

There is scant qualitative research about the lives of older adults in Goa. The interviews conducted during our pilot project to develop an intervention to prevent late-life depression provide a unique opportunity to better understand the lives of older adults in Goa and those factors that have significant consequences for their well-being and may put them at risk for depression. Furthermore, our research takes advantage of a unique opportunity to visit the earlier work of Patel and Prince (2001). In general, our findings are in accord with

that earlier research, as well as our experiences of working with older adults in Pittsburgh and in the Netherlands.

Health conditions such as pain in the knees, heart disease, diabetes and respiratory ailments were particular concerns for the participants in the current study. Although this is consistent with the findings of Patel and Prince, there was, however, one important difference: whereas diabetes was mentioned in only one of five focus groups in the earlier study, more than half of participants in the current study expressed concerns about diabetes. No doubt this reflects the rapid increase in diabetes in India during the past two decades (Patel et al., 2011), and in Goa, specifically (Vaz, Ferreira, Kulkarni, & Vaz, 2011). The concerns about health conditions, diabetes and physical disability in particular, are consistent with our experiences in Pittsburgh, especially with African-American participants (Reynolds III et al., 2012; Reynolds III et al., 2014), and the Netherlands (Haringsma, Engels, Cuijpers, & Spinhoven, 2006; Onrust, Willemse, van den Bout, & Cuijpers, 2010; Zegwaard, Aartsen, Grypdonck, & Cuijpers, 2013). Given that depression is frequently co-morbid with chronic diseases and is also associated with relatively poor health outcomes (Moussavi et al., 2007), these findings suggest the need for efforts to prevent late-life depression to include a component about the management of chronic health conditions.

Many participants articulated notions about what it meant to be old. Not surprisingly, many of their statements conveyed a sense of uncertainty about the future, e.g., fears of becoming widowed or incapacitated by illness. These concerns mirror those of the participants in the study by Patel and Prince, especially the prospect of becoming bedridden and dependent on their children.

On first impression, both studies found that older adults in Goa command respect. On closer inspection, however, this respect appears to be either a veneer or that it is on the wane. For example, some participants in the current study claimed the younger generation lacked

respect for older adults and that changing social roles, e.g., daughters-in-law working outside the home and earning money, were causing tensions between the generations. Certainly the reports of neglect and abuse in the studies call into question the extent of respect actually bestowed on older adults.

Since the earlier study, the government pension scheme for older adults has increased from Rs100 to Rs 2,000 per month. At the time of the previous study, Rs100 could buy about 5 kilos of rice or sugar. With the current pension, it is possible to purchase considerably more: approximately 10 kilos of rice, 2 kilos of wheat, one piece of fruit per day, as well as gas, vegetables and pay for a proportion of electricity and water bills. Having a Senior Citizen Card also provides benefits, e.g., travel concessions. In addition, it appears that getting these benefits has become easier, i.e., the previous study reported that few people were taking advantage of the scheme because of bureaucratic hurdles, while the participants in the current study gave the impression that most older adults were receiving the pension.

Differences over time in the availability of community resources are more complicated to assess. Patel and Prince reported the absence of clubs for older adults, and reports by participants in the current study agree with this. However, according to one of the authors (AD), the government of Goa and several churches have been initiating programmes for older adults, e.g., day care centers, public libraries, and clubs. While it may be true that not all of these initiatives have reached the neighborhoods in which the participants lived, it is certainly true the participants were not aware of community resources that may exist. This suggests a need for depression treatment and prevention programmes to include a social work component that will inform older adults of these resources and then help them to take advantage of the resources that are available.

Four issues emerged from the current study in regard to the complexity and, at times, conflictual relationships between older adults and their families. First, money and ownership

of property figured prominently, especially as a source of conflict and, potentially, abuse of older family members. This was also reported by Patel and Prince. Second, the custom of daughters-in-law living with the families of their husbands (or at least in the same community) often leads to strained relationships with older in-laws who are dependent on their male children. Third, participants reported that neglect and abuse of older adults were frequent, although none of the participants said they had been neglected or abused. Nevertheless, fear of maltreatment, whether actual or anticipated, have negative consequences for emotional well-being. These impressions are congruent with the earlier research in Goa. Fourth, much like their counterparts in the previous research, participants in the current study recognized that living with their families was fraught with potential problems. Yet, three-quarters of participants in the current study thought it was best to live with their families. To a great extent, this preference was based on practical matters, e.g., getting and cooking food and help with health care, as well as the positive effect of family life on emotional well-being.

Only half of the participants in the current study thought the woman in the vignette was suffering from a health problem. This is in broad agreement with the research by Patel and Prince. However, one possible difference is that although participants in the earlier study reported depression as common, few participants in the current study used or were familiar with the term “depression.” Nevertheless, participants in both studies used similar terms to designate states of emotional distress, e.g., “worry” or “tension.” Participants in both studies also attributed emotional distress mostly to social factors such as problematic family relationships, including disputes about money and property. The interpersonal, social and economic context for causes of emotional distress in old age is also prominent in our studies in Pittsburgh (Gilman, Bruce, et al., 2013; Gilman, Fitzmaurice, et al., 2013; Jimenez et al., 2015; Stahl, Albert, Dew, Lockovich, & Reynolds, 2014).

Based on comparisons of findings from the current study and those of Patel and Prince it would appear that the conditions of life for older adults in Goa have not changed substantially during the past decade and a half. This is true, in particular, in regard to older adults' feelings of uncertainty about the future and the challenges of being dependent on their families. Furthermore, comparisons confirm that concepts of and the terms used to designate emotional distress have remained similar.

Several limitations of our research must be noted. First, the sample is relatively small and this must be considered when generalizing our results. For example, we cannot examine possible gender, religious or urban/rural differences. Second, it is possible that a larger sample that includes individuals from the community would provide other perspectives on the aging process and emotional well-being. Third, caution must be exercised when considering the comparisons with the research by Patel and Prince because their work examined concepts of depression and dementia among a more varied sample of participants. These details aside, the following gives us confidence in our findings: the external congruence of our findings with those of Patel and Prince; the internal congruence indicated by the saturation of information in the 20 interviews; and, that the sample was purposively derived from the population of interest (older adults attending primary care clinics) and was inclusive. Thus, we are confident that our findings, and their implications, will be transferable to our work in the future.

In conclusion, the findings reported here have at least three implications for the work we are now conducting on the development of an intervention to prevent depression among older adults in Goa. First, the term "depression" is unfamiliar in this context and use of the terms "worry," "tension" and "thinking" (with its implication of rumination) is preferable when speaking with older adults about emotional distress. Second, the interviewees' concerns about chronic health conditions, and the limits these put on the ability of older

adults to live independently, has become a paramount concern. Thus, the intervention now includes a component that offers information and management strategies for older adults who are experiencing chronic aches and pains. Counselors now also provide information about free medical services in Government hospitals. Third, given the attribution of emotional distress to social factors, especially family and financial issues, the intervention now places an emphasis on practical problems and the social realities of the lives of older adults in Goa. Thus, we now include a case management component to the intervention. This includes providing participants with information about accessing resources that will assist older adults to deal with such issues as finances, personal care, and remaining socially active, as well as supporting them to pursue solutions to these ongoing problems. In sum, our original intention to employ Problem Solving Therapy for Primary Care (Reynolds III et al., 2014) for implementation by lay counselors has undergone substantial adaptation in order to make it more acceptable and effective for older adults in Goa.

There is a fourth implication of our work, too. The evidence from Pittsburgh and the Netherlands appears to be congruent with the evidence in Goa: in all three settings health problems, increasing physical limitations, uncertainty about the future, social factors and challenging family issues shape the lives of older adults and may put them at risk for emotional distress.

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