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Perceived Mastery and Depressive Symptoms Among Older Adults in Urban Pakistan: A Contextualized Quantitative Analysis

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ABSTRACT

Depression is a significant yet underexplored mental health concern among older adults in Pakistan, where cultural stigma and limited institutional support often hinder diagnosis and care. This study aimed to examine the relationship between perceived mastery and depressive symptoms among older adults in urban Lahore, while assessing the moderating influence of gender and living arrangements. Using a quantitative, cross-sectional design, data were collected from 100 participants aged 55–75 years through purposive sampling. Two standardized instruments, the Geriatric Depression Scale–Short Form (GDS-SF) and the Pearlin and Schooler Mastery Scale, were administered alongside a pilot-tested Perceived Institutional Mastery Index (PIMI). Data were analyzed using SPSS (Version 27) through descriptive statistics, Pearson correlation, t-tests, and linear regression. Results indicated a significant negative correlation between mastery and depression ($r = –0.45$, $p < .001$), with lower mastery among women and institutional residents. The study concludes that Mastery serves as a key protective psychological factor against depression in older age. It recommends developing gender-sensitive and autonomy-enhancing mental health programs and integrating mastery-based interventions into community and institutional care to improve geriatric well-being in collectivist societies.

1. INTRODUCTION

According to the World Health Organization (2021), there are around 280 million diagnosed cases of depression across the globe. The lack of attention to depressive symptoms, particularly in the elderly population, is one of the most notable neglected concerns. In South Asia, the 'depression epidemic' among the elderly is particularly troubling, with nearly one in three older adults depressed. Regrettably, the majority of these cases are undiagnosed and untreated, primarily due to the stigma surrounding mental health and the region's fragmented mental healthcare system (Ganatra et al. 2008, Bhamani et al. 2013).

In Pakistan, particularly in urban centers such as Lahore, almost one-third of aged persons are estimated to suffer from depressive symptoms. These symptoms lead to increasingly problematic aging due to the erosion of familial systems and inadequate aging institutional care (Qadir et al. 2014, Mumtaz et al. 2021). Nonetheless, the psychological resilience factors, particularly perceived mastery, remain unexplored in Pakistani geriatric mental health issues.

Perception of significantly influential factors in one's life is referred to as mastery (Pearlin & Schooler, 1978). In modern literature, mastery is primarily identified as an aspect of protective psychological resilience to persistent and chronic depression, anxiety, and stress (Bierman, 2011). Mastery has been associated with better psychological and physical health since having lower levels of depression, and greater tendencies to utilize adaptive and active coping strategies (Infurna & Mayer, 2015). In Pakistan, which is a collectivist society where agency is often situated within structures of interdependence, familial and religious hierarchies, mastery might interact with psychological health differently (Ahmed & Mohamed, 2022; Hofstede et al., 2010). Most existing literature on mastery in Pakistani contexts has ignored socio-cultural constructs, which presents a gap in the research.

This study considers the gaps in the literature regarding mastery and depressive symptoms in older adults in Pakistan. Mastery has been proven to act as a psychological bulwark against distress in the Western world (Pudrovska et al., 2005; Cairney & Krause, 2008); however, the same cannot be said regarding South Asia. Additionally, there are only a handful of studies that analyze the impacts of social determinants of health, particularly gender and different living environments (e.g., community-dwelling versus institutionalized), on the above relationship. Pakistani older women experience a constellation of vulnerabilities, including widowhood, economic dependence, and caregiving (Assari & Caldwell, 2017; Bhamani et al., 2013). The same applies to older institutionalized adults who tend to report low mastery and high depression due to low social support and isolation (Jang et al., 2002; Cohen-Mansfield et al., 1990).

Accordingly, this study pursues three primary objectives:

1. To assess the prevalence and severity of depressive symptoms among older adults in urban Pakistan.
2. To examine the relationship between perceived mastery and depressive symptoms, and
3. To evaluate the influence of gender and living arrangements on this relationship. These aims are addressed through a quantitative, cross-sectional survey design using validated psychological instruments.

The following research questions guide the study:

RQ1: What is the prevalence and severity of depressive symptoms among older adults in urban Pakistan?

RQ2: How does perceived mastery correlate with levels of depression among older adults?

RQ3: To what extent do gender and living arrangements influence the relationship between Mastery and depressive symptoms?

Hypothesis: *There is a significant negative correlation between perceived mastery and depressive symptoms among older adults, such that higher mastery is associated with lower depression.*

This research is relevant both theoretically and practically. It aids in the cross-cultural validation of mastery theory and advances the conversation about mental health in South Asian gerontology. It also aids in the formulation of culturally relevant religious coping, family mental health, and community mental health interventions (Sultana et al., 2022; Abideen & Abbas, 2021). While most literature on aging and mental health focuses on individual factors, this research incorporates socio-cultural and psychosocial factors such as gender and institutionalized care. This research also empowers a silent demographic and contributes to the relevant policy and practice literature in the Global South.

LITERATURE REVIEW

As illustrated in Figure 1, the literature is organized into three interconnected themes (i.e., aging, mastery, and depression) surrounded by interfacing parameters such as gender, cultural context, and dominant living patterns. This mental sketch demonstrates the literature review's thematic organization by associating sociocultural concepts with the primary ideas being investigated.

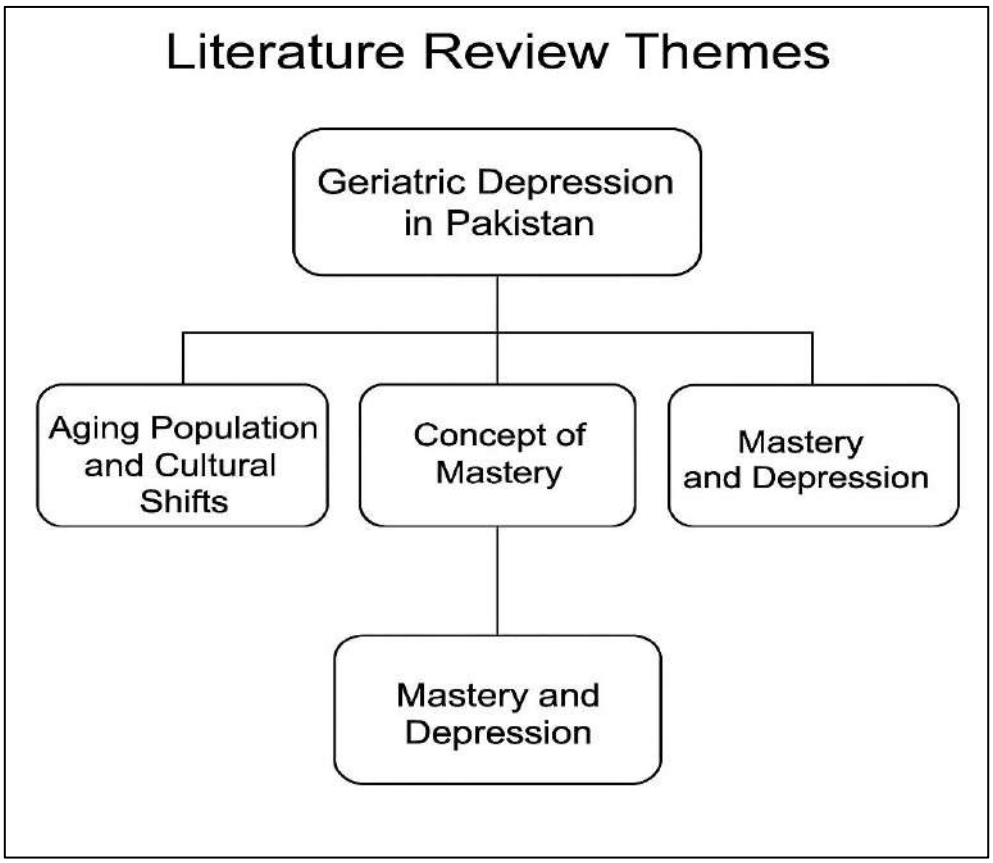

Figure 1. Key Themes in Literature Review: Aging, Mastery, and Depression

Mastery and Mental Health in Aging Populations

The concept of 'Mastery' delineated by Pearlin and Schooler (1978) has always been an extremely important factor of psychological health. Mastery is the belief an individual harbor concerning the extent to which they can control the events of their life and manage their outcomes, which protects them from stress and mental illness. In the Western world, studies have shown that older adults with high levels of mastery experience less depression, anxiety, and psychological distress (Infurna & Mayer, 2015; Nicolaisen, Moum, & Thorsen, 2018). Bierman (2011) states that mastery is both a mediator and a moderator of stress and depression and, therefore, an essential tool for mental health in old age.

Most of this work has been conducted in an individualistic cultural context that is likely to appreciate the importance of personal control, self-agency, and self-efficacy. In differently collectivist cultures in which said mastery is recognized, the construction, experience, and expression of mastery is likely to differ substantially. Consequently, 'Mastery' is a construct that, in translating Western research to South Asian countries, has been sorely in need of cultural relativism.

Cultural Dimensions of Mastery

Achievement is defined culturally in relation to values of interdependence and collectivism as well as filial piety. In Pakistan, Ahmed and Mohamed (2022) note that devotion, coupled with community and family relations, often takes the place of external mental health aids. In these circumstances, mastery, or the ability to accomplish something, is more often described as relational in the context of family systems and spirituality, as opposed to being individualistic or self-contained, something accomplished by self-determined decisions. This is a conceptualization that goes unnoticed in most psychological writings.

According to Sultana et al. (2022), financial support and having a family were strong predictors of mastery in older adults residing in Bangladesh. This phenomenon was also observed in a pilot study conducted by Qadir et al. (2014) in Rawalpindi, Pakistan. In that study, older adults living in extended family forms reported feeling less depressed and having more perceived control over their lives versus their peers living in solitary conditions. These studies, however, provide no more than surface-level and superficial explanations in their attempts to account for the role of Mastery, as well as the rise of collectivism as an urban phenomenon, which is often ignored (Victor et al., 2018).

Mastery and Depression

Multiple research studies conducted across different age groups found a dichotomic linkage between mastery and depression. In a longitudinal study, Cairney and Krause (2008) showed that mastery is typically diminished with increased age, especially with chronic illness and disability. Similar pattern has been observed in a study by Yang (2006) suggesting that mastery in later life are strongly associated with depressive symptoms. This means that having strategies aimed at increasing mastery is likely to be the most beneficial later in life. According to Avery et al. (2022), mastery was correlated with functional independence, which in turn is significantly associated with physical mobility and emotional stability.

That said, a large part of the existing literature suffers from context blindness, and the social factors of gender, social context, and culture, which shape the nuances of the mastery–depression relation, are largely absent. For example, in her study, Blazer (2003) argues that depression is more common among elderly females with caregiving responsibilities. Gendered aspects of aging, mastery, and growing older in a more patriarchal context, particularly, have fewer studies reported for Pakistan.

Gender, Mastery, and Depression

Gender remains one of the most fundamental variables in mastery research, and yet the most inadequately addressed. Assari and Lankarani (2017) noticed concerning inequality in the relationship between mastery and depression in men and women, and postulated that men benefit more than women from increases in perceived control. This aligns with the conclusions reached by Bhamani et al. (2013), which indicated that depression among older women in urban Pakistan is more common due to financial dependence, widowhood, and social alienation.

Cultural stereotypes often relegate older women to the roles of caregivers and dependents, which diminishes their autonomy as well as their perception of control. These issues rarely appear in the mastery literature, which leads to a lack of integration of psychosocial factors. This study seeks to address this gap in the literature by conducting a gender sensitive analysis, which will enhance the availability of mental health resources.

Institutional Living and Diminished Mastery

Another aspect positioned as important in determining mastery and depression is one's living situation. According to Jang et al. (2002), older adults living in long-term care facilities tend to experience more helplessness and lower mastery because they have lost more autonomy and become more socially isolated. Similarly, Cohen-Mansfield et al. (1990) noted that environmental factors in institutions can lead to learned helplessness and, subsequently, more depression.

In Pakistan, elderly care in institutions is relatively new and often viewed with stigma. The residents in these institutions may suffer not only from social isolation but also from the emotional neglect that may arise as family connections become tenuous. Little is known about the impact of these factors on mastery. This study aims to close the gap by examining the social and nursing home contexts in Lahore, thereby shedding light on the impact of such environments on mental health.

Critique and Research Gap

Protection of mastery as a mental health construct is undoubtedly proven and established; however, its literature is lacking in several aspects. First, mastery-focused studies in a certain culture that includes values in and surrounding collectivism and religion are, at best, sparse. Second, in South Asia, pathways to mastery from a gendered approach are almost non-existent. Third, there is a notable absence of literature that integrates mastery, depression, and cross-sectional studies of institutional living.

This is especially true in Pakistan, where the urban context undergoing this particular study is relatively under-explored, adding gender and living conditions as primary aspects to the Mastery-depression correlation framework. This fully acknowledges the lack and need for research on aging mental health in a culturally specific and contextually advanced framework.

Contribution to Theory and Practice

Figure 2 presents the theoretical framework, adapted from Pearlin and Schooler (1978), which emphasizes how mastery may operate within collectivist environments.

Figure 2. *Theoretical Framework – Mastery Theory Adapted for Collectivist Societies*

This model described herein focuses on aligning perceived control, autonomy, and self-efficacy, reframed to incorporate socio-cultural factors related to the aging population in Pakistan.

The focus of this research is to test the theory of mastery to extend the theory to a non-Western culture and to contribute to the theory's cross-cultural applicability. From an applied perspective, it provides mastery of evidence-based community, faith, and gender-oriented interventions. I hope this research will engage and inform decision-makers, implementers, and academics since it can be significant for Pakistan and other South Asian countries in the context of their current demographic and socio-cultural changes.

The review of the literature shows that older people's mental health is influenced by their mastery, which is not well articulated in non-Western contexts.

To address this, the research situates the study in urban Pakistan, a culturally rich but unexplored area in terms of older people's mental psychosocial resilience, in this diverse context. This study intends to contribute to the mental health of aged care by focusing on the psychological aspect of resilience.

2. METHODOLOGY

Research Design and Approach

This study seeks to identify the relationship between depressive symptoms and perceived mastery among older adults in urban Pakistan. In this case, the quantitative approach is much more useful as it is more objective, easily replicable, and more able to identify population-level epidemiological trends. The cross-sectional method enables the analysis of the relationship between mastery and depression, although on a time-restricted basis, on a defined portion of a time continuum relevant to the study.

Study Population and Sampling Strategy

The target population comprised older adults aged 55 to 75 residing in Lahore, Pakistan. A total of 100 participants were selected using purposive sampling. This sampling method was suitable for the nature of the research and the intention to include specific subgroups, namely, community-dwelling older adults and those residing in nursing homes.

The sampling technique allowed focused, relevant participants to be included based on the aims of the study. Out of the 100 participants, 44 were men, while 56 were women. Among the total samples, 57% were from the community, while 43% were from the nursing home. The

participants were aged 55 -75 years and above were included; individuals with any severity and disability (cognitive impairment) were excluded.

Data Collection Instruments

The study utilized two standardized, validated tools to measure the core constructs:

Pearlin and Schooler Mastery Scale (1978)

A 7-item Likert scale measuring perceived control over life circumstances. It has demonstrated good internal consistency and validity in prior international and South Asian research contexts.

Geriatric Depression Scale – Short Form (GDS-SF)

a 15-item yes/no instrument commonly used to assess depressive symptoms in older adults. It has been validated in Pakistan and other LMICs and is known for its ease of administration.

In addition, the researcher pilot-tested a supplementary tool, the Perceived Institutional Mastery Index (PIMI), that is meant to evaluate a sense of autonomy residents might have in an institutional setting. This pilot gave context to the community and institutional participants, although the main analyses were on the mastery and GDS-SF mastery and GDS-SF measures.

These instruments were selected for their utility, validity, and cross-cultural applicability. To facilitate the participation of illiterate individuals, all questionnaires, including instruments and the mastery and GDS-SF mastery and GDS-SF measures, were translated into Urdu and were administered by trained field staff deployed for the purpose.

Data Collection Procedure

Within the course of four weeks, data collection was finalized. Following the ethical approval process, and after the informed consent was obtained, all the participants were interviewed in private and quiet rooms to ensure confidentiality and comfort. The interviewers were trained in the following areas: ethical development of the research, accuracy of the obtained data, and ethical communication in different cultures. The interviews were conducted for roughly thirty minutes.

Ethical Considerations

Ethical approval was secured from the relevant institutional review board. Participants were fully informed about the study's purpose, their right to withdraw at any time, and the confidentiality of their responses. Verbal and written informed consent were obtained. Any participant who was identified as having high depressive symptoms was gently advised and referred to local mental health services for follow-up support.

DATA ANALYSIS

The data analyzed and processed within SPSS (Version 27) include the demographic data alongside the descriptive statistics covering the mastery and depression scores, composed of means, standard deviations, frequencies, and percentages, and the other data were mostly quantitative in nature. A Pearson correlation addressed the association of mastery with depression. Difference in scores of mastery and depression across gender and living arrangement (male, female, community, nursing home) was indicated with the use of independent t-tests. The depression severity predicted from the mastery scores was evaluated with simple regression. The threshold for significance was 0.05.

Justification of Methodology

The chosen quantitative design ensured a systematic approach to data collection, allowing for objective statistical analysis of the associations. Using standardized instruments increased the

reliability and validity of the findings, while face-to-face administration helped enhance data completeness and minimize missing responses. Including gender and living arrangements as grouping variables enabled subgroup analyses, adding depth to the study and improving external validity. Overall, the transparent and replicable methodology offers future researchers a clear framework for similar investigations.

Research Design Alignment

Table 1. *Research design alignment with objectives*

Research Question	Methodological Approach	Sample Segment	Key Instruments/Analyses
RQ1: Prevalence and severity of depressive symptoms among older adults?	Quantitative survey (descriptive)	All participants	Geriatric Depression Scale – Short Form (GDS-SF); Descriptive statistics
RQ2: How does perceived mastery correlate with depression levels?	Correlational analysis	All participants	Pearlin & Schooler Mastery Scale; GDS-SF; Pearson correlation
RQ3: Influence of gender and living arrangements on mastery–depression link?	Comparative statistical tests	Males vs. Females; Community vs. Nursing Home	Mastery Scale; GDS-SF; Independent t-tests; Linear regression

The systematic method promotes clarity, reproducibility, and trustworthiness, and lets researchers expand on the results and test them in other socio-cultural contexts. The approach can also serve as a framework for new inquiries in the developing and transitional regions.

3. RESULTS

The final sample consisted of 100 older adults aged 55 to 75 (Mean age = 62.5 years, SD = 5.1). Of the participants, 44% were male, and 56% were female. In terms of residence, 57% were community-dwelling, while 43% resided in nursing homes.

Prevalence of Depression and Mastery

The manifestation of depressive symptoms in the sample was very high: 89% of participants experienced some form of depressive symptoms. More specifically, GDS-SF categorizations show that 48% of respondents experienced mild depression, 9% moderate, and 3% severe. With respect to perceived control, 90% of participants scored in the low mastery range while only 10% reported high levels of mastery.

Differences by Gender: Depression and Mastery

Analyzing the data by gender revealed some striking differences (see Figure 3). With respect to the male participants (n = 44), 13.6% clinically relevant depression was absent, which is a clear contrast to 8.9% of females (n = 56) who refrained from exhibiting any symptom. Male (56.8%) and female (58.9%) respondents diagnosed with mild depression were almost at par. However, mild depression was more prevalent in females (26.8%) than in males (25.0%), and this was more pronounced albeit weak for severe depression, with women (5.4%) being admitted more than men (4.5%). With respect to mastery, high mastery was reported by 18.2% of men and 3.6% of women, which indicates that low mastery was more common among women (96.4% of women compared to 81.8% of men).

Table 2. *Depression and Mastery Levels by Gender.*

Gender	High Mastery (%)	Low Mastery (%)	No Depression (%)	Mild (%)	Moderate (%)	Severe (%)
Men (n = 44)	18.2	81.8	13.6	56.8	25.0	4.5
Women (n = 56)	3.6	96.4	8.9	58.9	26.8	5.4

Note: Female participants show a higher prevalence of depressive symptoms and lower Mastery levels compared to male participants.

Table 2 shows significant gender differences in depression severity and perceived mastery among older adults in urban Lahore. Males in this sample appear to have more favorable psychological states: 13.6% of participants report being symptom-free, and 18.2% have high mastery scores. In contrast, 96.4% of females are classified as low mastery, and only 3.6% attain high mastery, which also means high depression. Women, indeed, are less healthy than men: 26.8% of women and 25.0% of men are classified as having moderate depression, and 5.4% of women and 4.5% of men have severe depression.

These findings point to gender as a major factor influencing psychological well-being in later life. For women, having less control and more depressive symptoms is a consequence of having structural disadvantages such as gendered economic dependency, unpaid caregiving, social isolation, and widowhood, which decline one's perceived agency. This agrees with previous studies, which state that men are more likely than women to benefit from increases in perceived control and that women are more restricted than men in terms of socio-cultural mastery. Thus, mastery and mental health interventions in older populations need to be explicitly gender responsive, with a focus on aging women from collectivist countries like Pakistan being more responsive to issues of empowerment, social support, and economic independence.

Differences by Living Arrangement: Depression and Mastery

There were differences in how severely individuals in a community setting, compared to those in a nursing home, experienced depression, as well as differences in how they mastered life (as shown in Figure 4). Among nursing home residents, 16% were classified as not depressed, with 58% depressed mildly, 19% depressed in moderate fashion, and 7% depressed severely. Comparatively, community-dwelling older adults had 56% with no depression and 40% with mild depression, as well as 2% with moderate and 0% with severe depression, suggesting that the community group had lower depression overall. In mastery, the community group maintained increasingly positive and more favorable results than the nursing home group, as indicated by the results of 5% with high mastery (nursing home residents) and 14% with low mastery in community group.

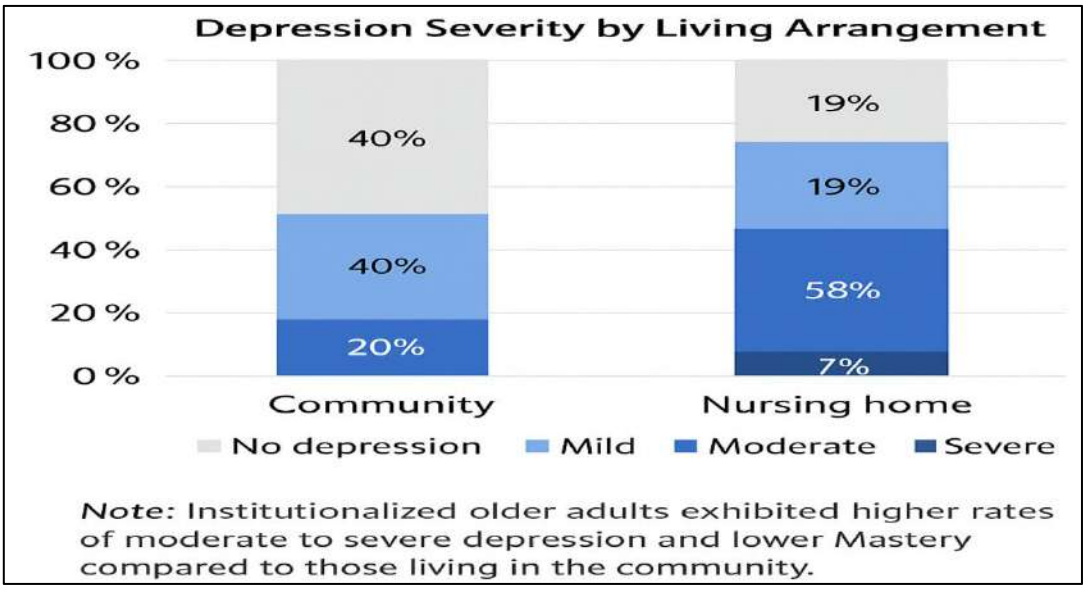

Figure 3. *Depression Severity Distribution by Living Arrangement.*

Figure 3 shows that institutionalized older adults exhibited higher rates of moderate to severe depression and lower mastery compared to those living in the community.

Statistical Comparisons and Correlations

The group comparisons confirmed that the observed differences were not random occurrences. The residents in the nursing homes were found to have lower average mastery scores compared to the community residents, as confirmed by the independent t-test ($M = 12.5$, $SD = 3.8$), $t\ (98) = -3.45$, $p < 0.01$, Cohen's $d = 0.5$) ($M = 15.2$, $SD = 4.1$). A similar observation was noted, where female participants had lower mastery scores ($M = 13.1$, $SD = 4.0$) compared to male participants ($M = 14.8$, $SD = 3.7$), $t\ (98) = -2.35$, $p < 0.05$. Both cases suggest a moderate effect.

In this case, the analysis conducted by Pearson revealed a significant correlation, which in this case was negative, concerning mastery scores as well as the scores received in depression ($r = -0.45$, $p < 0.001$). What this suggests is that students perceived mastery to a lesser extent, and in turn, were more likely to have depressive symptoms. A negative slope can be used to visualize this correlation.

Regression Analysis

The depression score was analyzed as an outcome in an outcome regression analysis, and a simple linear regression for the outcome was conducted with depression score as the outcome and mastery score as the predictor. Mastery was shown to explain 14.1% of the variance of depression, and R-squared was benchmarked at 0.141. As the GDS-SF depression score increased, there was lessened mastery score – in fact the regression showed, that for each one-point increase in mastery score a –0.36 lower score in depression was observed ($B = –0.36$, $SE = 0.09$) ($\beta = –0.36$, $t = –4.01$, $p < 0.001$; 95% CI for $B = [–0.54, –0.18]$).

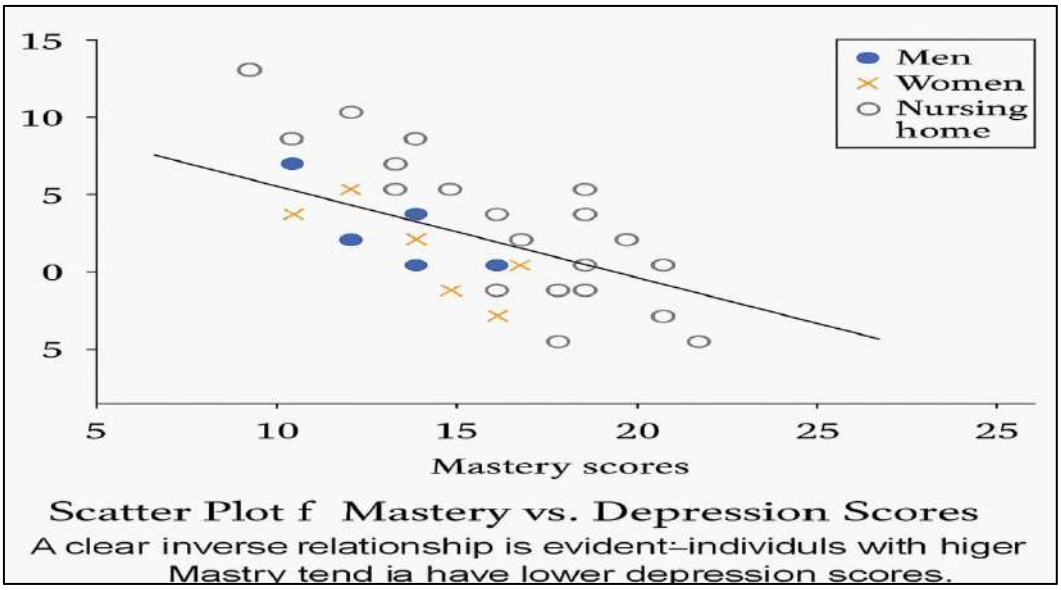

Figure 4. *Scatter Plot of Mastery vs. Depression Scores.*

In Figure 4, there is an identifiable inverse correlation between mastery and depression scores, in which individuals with greater mastery tend to experience less depression. The data, which is clustered by gender and living arrangement, identifies areas, particularly among women and residents in nursing homes, who are disproportionately located in the greater depression/lower mastery region. Overall, the data suggest that mastery, in the case of older adults, is particularly prevalent in those experiencing depression. More specifically, mastery is less prevalent in depressed individuals, particularly among women and those in more restrictive institutional settings, which is a concerning pattern.

4. DISCUSSION

This study's results also support attributing perceived mastery with a positive impact on the mental health of older adults, which the literature also validates. Mastery – depression correlation of ($r = – 0.45$) also associates with the literature (Pudrovska et al, 2005; Infurna & Mayer, 2015) and reinforces the reasoning with regard to Mastery being a protective factor (Pearlin & Schooler, 1978; Bierman, 2011). Among older adults, the prevalence of depression is lower with higher Mastery. Depression is less common in older age, as the level of mastery increases.

This study presents the gendered gaps in contributing to the understanding of the relationship between mastery and depression. In the sample of older women, mastery was significantly lower, and the symptoms of depression were much more severe, compared to the men. This is in line with previous work and is the reality of Pakistan, where numerous older women suffer from widowhood and caregiving, and then have to rely on inadequate healthcare, and then face severe sociocultural and economic subordination (Assari & Caldwell, 2017). This study illustrates that the loss of mastery control, which is associated with higher risks for depression, is a distinctly feminine problem. This underlines the gaps within the mental health policy approach, which is more complex and deeper when considering gender. Most importantly, the policies should focus on community-level investments for the mastery and resilience building of older women integrated with mental health supportive services and economic counseling.

The 'environmental context' in the results also presents an important aspect. Among older adults living in institutions (nursing homes), levels of mastery were significantly lower and

depression levels significantly higher than among elders living in the community. This gap corroborates the findings of Jang et al. (2002) and Cohen-Mansfield et al. (1990), who examined the psychology of loss of control and the isolation that comes from being within an institution. In Pakistan, the situation is arguably worse due to the cultural stereotypes that exist around nursing homes and the generally poor-quality care that is available in these institutions. The data strongly underline the necessity of improving the psychosocial environment in these institutions through the organization of routine social contact, stabilizing family, autonomy-supportive care practices, and community-centered psychosocial services to postpone or minimize the necessity for institutionalization.

The regression analysis indicated that mastery held significance in predicting depression severity, although it explained only a modest proportion of the variance (around 14%). This means that while mastery is a significant predictor of depression among older adults, it is not the only factor at play, which is consistent with the notion of depression in the elderly being multifactorial. Still, the ability to identify mastery as one of the modifiable predictors is important, as it means that it is possible to develop targeted interventions. These findings are supported by study of Yang (2006), revealing about depressive symptoms and association with mastery at old age.

Theoretically, this study extends the boundary of mastery theory to a South Asian collectivist culture context. That mastery possesses protective functions even in a culture that limits personal agency due to family and sociocultural systems is indicative of the relevance of this construct across cultures, albeit with varying manifestations. These findings are a testimony to the need for cultural contextualization in psychology: mastery theory is westernized and so would need cultural adjustments to enhance its mastery in Pakistan (e.g., advocacy for family, spiritual advocacy, and community activism).

The practical implications of this research are considerable. Mental health programs specifically designed for older populations should focus on ways to enhance perceived control and self-efficacy. For example, cognitive restructuring is one of the cognitive behavioral therapy (CBT) techniques that can be adapted for seniors to help them alter control coping paradigms. Life skills and problem-solving training could be organized at community centers or integrated in elder support programs to equip seniors with the confidence to deal with everyday problems. For instance, in the case of institutionalized seniors, the inception of controlled activities for the residents to choose from and have even minimal participation in decision-making helps them to gain a sense of control and self-governance.

The findings particularly highlight the support of two marginalized groups: the aged female population and individuals living in care facilities. Among the aged population, the micro-finance model of lending and supporting self-help groups and clubs, which helps in mastering self-support strategies, may help alleviate the social-financial dependency. Among the residents of the care facilities, enhancing the mental well-being could be achieved through purposeful visitation and outing programs, therapy targeting adjustment to the cared-for condition, and training caregivers towards encouraging self-care and participation of the residents over unintentional dependency.

These results are also useful for policymakers and healthcare practitioners in Pakistan and many other low and middle-income countries. As mental health issues gain recognition in the aging population, the attention given to mastery means public health initiatives should address the ways mastery is achieved. This might include policies that encourage community-based elder care, the incorporation of mental health care in primary health services for older persons, and the

construction of new long-term care facilities for older persons designed to maximize autonomy and social engagement.

The possible biases and limitations of this study must also be noted. The cross-sectional design of our study does not allow for causal inferences; for example, although low mastery is associated with depression, one cannot conclude that mastery deficits are what cause depression; depression may, in fact, reduce one's sense of control, mastery over depression, or there may be some reciprocal relationship (as some theorists posit). Self-report questionnaires and interviews, despite being face-to-face, are also prone to biases; in this case, participants may have downplayed their depressive symptoms due to stigma or answered in ways that they thought were expected of them. Assured confidentiality in this study and the use of trained interviewers would certainly have lowered this risk of non-social response, but not social desirability bias. Furthermore, the sample was non-random and drawn from one urban location, which may limit the ability to generalize the results. Mastery and depression among older adults in rural areas and in diverse cultural regions of Pakistan may be different.

An additional point to note is that mastery was assessed using a scale that was created within a Western paradigm. Even though this scale has been utilized in different contexts, it is likely that in the case of elderly Pakistanis, it misses some aspects of their construct of perceived control. This was addressed to some extent by pilot testing the PIMI in institutional contexts, but more work is needed on culturally modifying mastery scales, or the employment of qualitative methods should be used to deepen understanding of the quantitative results.

Lastly, the regression's modest R^2 value suggests that a considerable amount of variance in depression, relative to the factors in our model, is missing. Physical health, social support, and prominent life changes, while a strong focus for this work, are certainly important. Subsequent studies would do well to include a broader range of factors.

5. CONCLUSION

This study reveals the worth of perceived mastery and its manageable correlates of depressive symptomology at an older age in an urban setting in Pakistan. Psychological constructs such as mastery could be studied through Western-centric frameworks, but they can also be used in collective societies within proper frameworks. Older adults with more mastery usually report depressive symptomology to a lesser degree. On the contrary, and especially among older women and those in long-term care, a lack of mastery tends to be associated with increased depression. These associations suggest the need for more psychosocial layers in the existing medical model of mental health in older age.

More straightforwardly, mastery could be seen as a psychological 'reserve' for older persons' mental health. This scenario points to the need for understanding, by all possible parties involved, including policymakers, health practitioners, healthcare system organizers, community-minded citizens, and social workers, the need to focus not only on the psychological disempowerment of older people but also on depression prophylaxis. This is the motivation behind creating strategies, services, and programs that foster social inclusion, rather than social disempowerment, for older people.

6. RECOMMENDATIONS

Based on the study findings, the following recommendations are proposed:

Focus on Mastery-Enhancing Strategies

Interventions that aim to bolster coping capabilities for the elderly are greatly neglected within mental health services, yet are critical. Psychotherapeutic approaches such as CBT,

problem-solving therapy, and other forms of resilience training should have to be adjusted for older adults to reinforce their coping and agency. Systems for program delivery should be established within the community and health promotion centers.

Special Consideration for Elderly Women And Those In Institutions

Develop tailored outreach and support for older women and those residing in institutions. For older women, community-based organizations may provide support groups or training that address caregiving, financial literacy, and social networking. Those in nursing facilities should have access to a range of organized cognitive activities, counseling, family participation, and the opportunity to make choices about daily activities.

Increase Community Participation

Develop and support initiatives that focus on older adults and help them perform valuable activities. Intergenerational activities, volunteer activities, and senior citizen clubs offer older persons opportunities that are worthwhile and within their control. Local authorities, together with non-governmental Organizations, should develop safe community centres where older people can come together, learn, and participate actively.

Enhance practices of Care.

Policies and administrators of care facilities are to ensure that there are improvements in nursing homes in the form of adequate training to staff on person-centred care approaches that promote the autonomy and dignity of each resident. Small changes, such as enabling a resident to select preferred activities and meals to carry out, customizing their quarter, and doing the same things in the same order each day, can greatly enhance perceptions of mastery and mental health.

Promote Policy Reforms

More broadly, a national health strategy should include the mental health of older adults. This implies funding mental health programs aimed at the older population, embedding mental health assessments at every level of primary health care for older adults, and developing and implementing standard operating procedures for mental health services of a facility's continuum of care. Advocating for pensions, or more generally supporting the finances of older women, directly allows them to overcome economic insecurities, thus supporting mastery.

Future Research

In order to expand on this work, future research ought to assess how mastery and depression change over time and attempt to establish causal directions within these constructs. Other social, more social support, general health, and cultural factors should also be examined concerning their interaction with mastery on depression outcome. Additionally, qualitative research could elucidate how older adults in Pakistan perceive and experience "control" or "mastery" in everyday life, shaped by cultural narratives, to inform more culturally sensitive practices.

This research improves our understanding of geriatric depression by adding factors about the psychological empowerment of older adults and the cultural issues around aging. With Pakistan and other countries in the Global South facing rapid population aging, these considerations will be critical to the practice and policy developed to address the mental health and well-being of older citizens.

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