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Assessment of psychological and social status among geriatric people

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Abstract
The world's population is aging rapidly, and it is estimated that the proportion of older people in the world will double from about 12% to 22%. Older adults face special physical and mental challenges that must be recognized. More than 20% of adults aged 60 years and over have a psychiatric or neurological disorder (excluding headache disorders) and that these disorders are in the elderly population with disabilities.

A purposeful, non-probability sample of (201) elderly people of the age group (60 years -80 and above) was selected from the nursing home and social care in Najaf.

Data were collected through the use of the constructed questionnaire and the process of the self-administrative report for each caregiver as a mean of data collection methods, by using the Arabic version of the questionnaire. The caregivers were gathered in one place and the purpose of the study was explained a verbal consent to participation was obtained.

The questionnaire consisted of three parts. The first part concerns demographic characteristics. The second part relates: -: The psychological state scale that consists of (21) items: relaxation, thirst, feelings, shortness of breath, difficulty of activity, reactions, trembling hands, tension, shyness in excessive stress, preoccupation, and mental state. The third part relates to: The Daily Activities and Self-Care Scale which consists of (14) items: clothing, nutrition, toilet, hygiene, transportation, bathing, phone use, shopping, food preparation, housework, washing clothes, taking medicines and money.

Results: 59.2% of the elderly are males and the rest are females. The highest percentage appears in the age group 60-69 years between 39.3%. Marital status indicates that 33.3% of them are married and 29.4% of them are widows and widows. The highest percentage in education to 36.3% of those who read and write. And monthly income barely indicates enough among 44.8% of them.

The study recommended is necessary to recognize the symptoms of depression in older people as soon as possible, cause it can have negative implications on the mental health and self-esteem of older people, especially those living in nursing home. The strategy of humanization in nursing care for older people should be applied equally in NHs and community-dwelling states. This would reduce the incidence of mental disorders and positively impact the aging process.

Keywords: Geriatric people, psychological status, social status

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Introduction

Older adults those who are 60 years of age or older make important contributions to society as family members, volunteers, and active participants in the workforce. Although most elderly people are in good mental health, many are at risk of developing mental disorders, neurological disorders, or substance abuse problems, as well as other health ailments such as diabetes, hearing impairment and osteoarthritis. Moreover, the older people get, the more likely they are to have different health symptoms at the same time. Mental health and emotional wellness are as important in older adults as they are in any other period of life. Neuropsychiatric disorders in the elderly account for 6.6% of all total disability cases (disability-adjusted life years) in this age group. About 15% of adults aged 60 and over suffer from a mental disorder (WHO. 2017) [7].

The assessment of older people needs to cover the psychological domain of health, with a focus on the individual's behavior and mind. The main health problems affecting older people in this domain are cognitive impairment, depression and delirium.

Although these are different health issues, their symptoms overlap and may present simultaneously this complicates diagnosis and the choice of treatment. Careful assessment is key to reach the correct diagnosis, provide appropriate treatment and understand the patient's care needs.

The psychological state of the elderly is the result of many years of experience in which negative and positive factors have affected, to varying degrees, the mental health of the elderly, to eventually reach a formed psychological state, which is not equal for all the elderly, but varies according to each elderly and according to the environmental, social and economic conditions. Therefore, many differences appear among the elderly in social care homes, according to the environments from which they came (Journal of Psychological Sciences. 2016).

Caring for the elderly is necessary in societies that want to keep pace with progress, and this can only be done through their interest in human resources represented in the capabilities, capabilities and experiences of their members. If there is a call to care for young people, then the elderly who have spent their lives serving their communities in various fields should not be forgotten, as they provided all their experiences in order to build their better future. Therefore, taking care of them and taking care of them and working to address their social and psychological problems and taking care of them is a humanitarian and moral duty. Religiously, it is sanctioned by divine and man-made laws in all its forms, and it is also a social duty because of the values it bears of loyalty to the elderly. From societies to achieve progress and prosperity and at the same time have given each individual his right (The Jamea Journal of Psychological Studies and Educational Sciences. 2021).[8]

Importance of the Study

There are multiple social, psychological, and biological factors that determine the level of a person's mental health at any point in time. In addition to the stereotypical stressors of life common to all people, many older adults lose their ability to live independently, due to limited mobility, chronic pain, weakness, or other psychological or physical problems, and require some form of long-term care. Additionally, older adults are more likely to experience incidents such as feelings of sadness and mourning, lower socioeconomic status in retirement, or disability. All of these factors can lead to isolation, loss of independence, loneliness, and psychological distress in the elderly. Mental health has an impact on physical health and vice versa; For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are in good medical condition. Conversely, not treating depression in an elderly person with heart disease can negatively affect the outcome of the physical illness. Older people are also vulnerable to elder abuse, which includes physical, sexual, psychological, emotional, financial and material abuse, abandonment, neglect, and significant loss of dignity and respect. Evidence indicates that 1 in 10 elderly people are abused. Elder abuse can lead not only to physical injury, but also to serious, sometimes long-term psychological consequences, including depression and anxiety (WHO. 2017) [7].

The world's population is aging rapidly, and it is estimated that the proportion of older people in the world will double from about 12% to 22% between 2015 and 2050. In absolute terms, this means an expected increase from 900 million to two billion people over the age of 60. Older people face special physical and mental health challenges, which should be recognized. More than 20% of adults aged 60 years and over suffer from a psychiatric or neurological disorder (excluding headache disorders) and 6.6% of all disabilities (disability-adjusted life years) among those over 60 are attributable to neuropsychiatric disorders. And that these disorders in the old population group lead to 17.4% of the years of life spent with disability. The most common neuropsychiatric disorders in this age group are dementia and depression. Anxiety disorders affect 3.8% of the elderly population, substance abuse problems affect nearly 1%, and about a quarter of deaths caused by self-harm are among those aged 60 years and over. Substance abuse problems among the elderly are often overlooked or misdiagnosed (General Assembly.2011) [9].

The aging stage is one of the stages that has its own peculiarity because of the changes that appear in it many and varied in terms of their nature, degree of severity, and direct and indirect causes, which ultimately result in many problems. It was (health, social, economic, psychological, recreational), which concluded that most of the elderly entered the care home willingly due to financial distress and bad news treatment for them, and a large number of elderly people have the desire to leave the care home and return to their families, but they do not return Because of the children's bad treatment of them, their poor financial condition, and the lack of a separate home for them (Sabah, 2010 p. 444) [10].

A quantitative descriptive correlation design has been utilized in this study as a way to examine the relationships among the main study variables including the predictor variables, which include the psychological wellbeing variables, and the dependent variable, which was self-care.

The study covers the elderly residents at nursing home in Najaf. The settings are traditional nursing homes that are run by administrators who keep schedules and adhere to a regular management style. The nursing homes harbor individuals according to certain criteria such as those who are no longer able to live independently, does not have permanent residence, does not have contagious diseases and mental disorders. Facilities, such as a kitchen and bathrooms and sometimes dormitories are shared by all the residents. Regarding the environment factors, the geographical location of nursing homes in each governorate is far from the city center and the noise around it is less. The gardens take up a limited space as it should be. Each room contains 1 – 2 persons. Also, the homes are responsible for preparing meals for the elderly regularly. The study has been carried out from Dec, 1st, 2021 to May, 2022 [8].

A non - probability purposive sample consist of (200) elderly persons that are selected from the total population of elderly residents at nursing homes. The study sample consists of 119 men and 81 women ranging in age from 60 to 80+ years.

Based on relevant literature and previous studies, the assessment tool has been constructed in a form of a questionnaire that has been adopted and modified by the researcher for the purpose of assessing the relationship between psychological well-being and self-care among the elderly residents at nursing homes. The final copy comprises the following parts:

Part 1: demographic characteristics which consisted of (14)

items: gender, age, social status, educational level, monthly income, length of stay, reason of stay, salary, relative visits, medical visits, services, health, smoking and chronic diseases, Depression, Anxiety and Stress Scale - 21 Items (DASS-21) Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows
0. Did not apply to me at all
1. Applied to me to some degree, or some of the time
2. Applied to me to a considerable degree, or a good part of time
3. Applied to me very much, or most of the time

DASS-21 Scoring Instructions
The DASS-21 should not be used to replace a face to face clinical interview. If you are experiencing significant emotional difficulties you should contact your GP for a referral to a qualified professional .
Depression, Anxiety and Stress Scale - 21 Items (DASS-21)
The Depression, Anxiety and Stress Scale - 21 Items (DASS-21) is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress.
Each of the three DASS-21 scales contains 7 items, divided into subscales with similar content. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest / involvement, anhedonia and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset / agitated, irritable / over-reactive and impatient. Scores for depression, anxiety and stress are calculated by summing the scores for the relevant items .
The DASS-21 is based on a dimensional rather than a categorical conception of psychological disorder. The assumption on which the DASS-21 development was based (and which was confirmed by the research data) is that the differences between the depression, anxiety and the stress experienced by normal subjects and clinical populations are essentially differences of degree. The DASS-21 therefore has no direct implications for the allocation of patients to discrete diagnostic categories postulated in classificatory systems such as the DSM and ICD.
Recommended cut-off scores for conventional severity labels (normal, moderate, severe) are as follows :

Part 2: Psychological state scale which consisted of (21) items: relax, thirst, feelings, shortness of breath, difficulty activity, reactions, trembling hands, stress, shyness in excessive stress, busying, mental state…,

The 12-Item General Health Questionnaire (GHQ-12) (Goldberg & Williams, 1988) consists of 12 items, each one assessing the severity of a mental problem over the past few weeks using a 4-point Likert-type scale (from 0 to 3). The score was used to generate a total score ranging from 0 to 36. The positive items were corrected from 0 (always) to 3 (never) and the negative ones from 3 (always) to 0 (never). High scores indicate worse health.

Part 3: scale of daily activities and self-care which consisted of (14) items: dressing, nutrition, water cycle, cleanliness, mobility, shower, phone use, shopping, food preparation, home business, washing clothes, take medicine and money management,
The participants asked to rank each item on a scale of 0-4 (0-never, 1-rarely, 2-sometimes, 3-regularly, 4-always). The higher the score, the better the individual may be at taking time for self-care and wellness in each aspect of one`s life. The study instrument is use based on previous studies.
The data has been collected through the utilization of the developed questionnaire and by using structured interview technique with the elderly people living at nursing homes.
Initially, the researcher has explained the purpose of study and known the willingness to participate in the study while emphasizing that the participation has been not binding and the participant was free to withdraw and decline from the study any time. It has been made clear to the participants that no financial benefits will be given. After seeking the consent to participate, suitable time has been asked, places to interview is decided to meet their comfort, Confidentiality of data and the voice was assured. Then the same way of interview used with each participant through using the similar questionnaire of Arabic version of questions for the subjects of the study sample at nursing home in middle Euphrate. The duration of each interview has lasted approximately 45 minutes and guided by the willingness of the participant and level of fatigue.
By checking each resident's medical record, a detailed medical history has been obtained. Therefore, our research only involved residents who could communicate with the interviewer physically and mentally.

Statistical Analysis: The inferential analysis of data is employed to determine the relationship between the psychological wellbeing and self-care through the use of following
- Pearson's Correlation Coefficients to test the relationship or association between the studies variables according to its type.
- ANOVA and t-test to compare self-care scores on demographic data. The level of significance is taken at P- value <0.05.

Results

Table 1: Distribution of Sample according to their Socio-demographic Characteristics

List	Characteristics		f	%
1	Gender	Male	119	59.2
		Female	82	40.8
		Total	201	100
2	Age (years)	60 – 69	79	39.3
		70 – 79	76	37.8
		80 +	46	22.9
		Total	201	100
3	Marital status	Unmarried	13	6.5
		Married	67	33.3
		Divorced	30	14.9
		Widowed/er	59	29.4
		Separated	25	12.4
		Close mate	7	3.5
		Total	201	100
4	Level of education	Doesn't read & write	53	26.4
		Read & write	73	36.3
		Primary school	34	16.9
		Secondary school	24	11.9
		Institute	10	5
		College +	7	3.5
		Total	201	100
5	Monthly income	Sufficient	51	25.4
		Barely sufficient	90	44.8
		Insufficient	60	29.5
		Total	201	100

f: Frequency, %: Percentage

This table shows that 59.2% of old age are males and remaining are females. The highest percentage is seen with age group 60-69 years among 39.3%. The marital status refers that 33.3% of them married and 29.4% of them are widowed and widower.

The highest percentage regarding education refers to 36.3% who are read and write. The monthly income indicates barely sufficient among 44.8% of them.

Table 2: Distribution of Sample according to their Variable related to Residency Home

List	Variable		f	%
1	Period of residency	< 1 year	33	16.4
		1 – 3 years	76	37.8
		4 – 6 years	42	20.9
		7 – 9 years	40	19.9
		10 year +	10	5
		Total	201	100
2	Causes of residency	Voluntary	140	69.7
		Absence of caregiver	60	29.9
		Family will	1	.5
		Total	201	100
3	Have financial income	Yes	66	32.8
		No	135	67.2
		Total	201	100
4	Family, friends, and relative visits	Yes	88	43.8
		No	113	56.2
		Total	201	100
5	Medical visits	Yes	140	69.7
		No	61	30.3
		Total	201	100

f: Frequency, %: Percentage

This table indicates that 37.8% of old age is resident for period 1-3 years. 69.7% of them are admitted voluntarily. 32.8% of them are report they have financial income. 43.8% of them are reported they have regular family, friends, and relative visits and 69.7% are reported they have regular medical visits.

Table 3: Distribution of Sample according to their Satisfaction about Residency Home

List	Variable		f	%
1	Satisfied with services	Yes	131	65.2
		No	70	34.8
		Total	201	100
2	Sources of dissatisfaction	Heating lack	6	8.6
		Cooling lack	8	11.4
		Sanity	8	11.4

		Small place	28	40
		Water sanity	5	7.2
		Food	14	20
		Garden and spaces	1	1.4
		Total	70	100

f: Frequency, %: Percentage

This table shows that 65.2% of old age are satisfied with services of home care and remaining are dissatisfied. The sources of dissatisfaction refers to small place among 40% and food among 20% of those who dissatisfied.

Table 4: Distribution of Sample according to Variable related to their Health Status

List	Variable		f	%
1	Self-report of health	Excellent	18	9
		Very go od	13	6.5
		Good	65	32.3
		Accepted	77	38.3
		Poor	28	13.9
		Total	201	100
2	Current smoking	Yes	53	26.4
		No	148	73.6
		Total	201	100
3	Surgery	Yes	12	6
		No	189	94
		Total	201	100
4	Denture	Yes	9	4.5
		No	192	95.5
		Total	201	100
5	Consume alcohol	Yes	0	0
		No	201	100
		Total	201	100
6	Use medication	Yes	43	78.6
		No	158	21.4
		Total	201	100
7	Use herbal	Yes	14	7
		No	187	93
		Total	201	100
8	Chronic illness	Yes	131	65.2
		No	70	34.8
		Total	201	100

f: Frequency, %: Percentage

This table shows that 38.35 of old age reported accepted health while 32.3% reported good health. Only 26.4% of them are current smokers. 6% have previous surgery. Only 4.5% of them use denture. None of them are consumed alcohol. 78.6% use medications and only 7% use herbals. 65.2% of them are reported history of chronic diseases.

Table 5: Distribution of Sample according to Type of Chronic Illness

List	Chronic illness		f	%
1	Diabetes mellitus	Yes	88	43.8
		No	113	56.2
		Total	201	100
2	Hypertension	Yes	89	44.3
		No	112	55.7
		Total	201	100
3	Heart disease	Yes	58	28.9
		No	143	71.1
		Total	201	100
4	Renal disease	Yes	22	10.9
		No	179	89.1
		Total	201	100
5	Emotional and psychological disorder	Yes	23	11.4
		No	178	88.6
		Total	201	100
6	Thyroid disease	Yes	3	1.5
		No	198	98.5
		Total	201	100
7	Respiratory disease	Yes	27	13.4
		No	174	86.6
		Total	201	100

f: Frequency, %: Percentage

This table reveals the types of chronic illness; 43.8% reported with diabetes mellitus, 44.3% reported with hypertension, 28.9% reported with heart disease, 10.9% reported with renal disease, 11.4% reported with emotional and psychological disorder, 1.5% with thyroid disease, 13.4% with respiratory disease.

Table 6: Assessment of Depression among Old Age

Depression	F	%	M	SD
Normal	41	20.4		
Mild	20	10		
Moderate	61	30.3	9.23	4.723
Severe	41	20.4		
Extremely severe	38	18.9		
Total	201	100		

f: Frequency, %: Percentage, M: Mean for total score, SD: Standard Deviation Normal= 0-4, Mild= 5 – 6; Moderate= 7 – 10; Severe= 11 – 13; Extremely severe= 14 – 21. This table reveals that old age are associated with moderate depression (M±SD= 9.23±4.723).

Table 7: Assessment of Anxiety among Old Age

Anxiety	F	%	M	SD
Normal	28	13.9		
Mild	36	17.9		
Moderate	22	10.9	8.60	4.571
Severe	31	15.4		
Extremely severe	84	41.8		
Total	201	100		

f: Frequency, %: Percentage, M: Mean for total score, SD: Standard Deviation. Normal= 0-3, Mild= 4 – 5; Moderate= 6 – 7; Severe= 8 – 9; Extremely severe= 10 – 21. This table indicates that old age are experiencing severe anxiety (M±SD= 8.60±4.571).

Table 8: Assessment of Stress among Old Age

Stress	f	%	M	SD
Normal	69	34.3		
Mild	41	20.4		
Moderate	38	18.9	9.40	4.700
Severe	39	19.4		
Extremely severe	14	7		
Total	201	100		

f: Frequency, %: Percentage, M: Mean for total score, SD: Standard Deviation. Normal= 0-7, Mild= 8 – 9; Moderate= 10 – 12; Severe= 13 – 16; Extremely severe= 17 – 21. This table shows that old age are experiencing moderate stress (M±SD= 9.40±4.700).

Table 9: Assessment of Daily Life Activities among Old Age

Daily life activities	F	%	M	SD
Low dependent	123	61.2		
Moderate dependent	57	28.4	22.95	6.996
High dependent	21	10.4		
Total	201	100		

f: Frequency, %: Percentage, M: Mean for total score, SD: Standard Deviation. Low= 14 – 23.33, Moderate= 23.34 – 32.67, High= 32.68 - 42 This table indicates that old age are showing low dependency with their daily life activities (M±SD= 22.95±6.996).

Table 10: Assessment of General Health among Old Age

General health	F	%	M	SD
Poor	24	11.9		
Fair	128	63.7	19.92	6.636
Good	49	24.4		
Total	201	100		

f: Frequency, %: Percentage, M: Mean for total score, SD: Standard Deviation. Poor= 0 – 12, Fair= 12.1 – 24, Good= 24.1 – 36
This table reveals that old age are associated with fair level of health (M±SD= 19.92±6.636).

Table 11: Association among Depression, Anxiety, and Stress with regard to Sociodemographic variables of Old Age

Variable	Depression		Anxiety		Stress	
	C.C	P-value	C.C	P-value	C.C	P-value
Gender	.192	.103	.162	.246	.196	.090
Age	.328	.002	.281	.028	.327	.002
Marital status	.416	.003	.424	.002	.449	.001
Level of education	.420	.002	.278	.665	.303	.441
Monthly income	.413	.001	.348	.001	3.66	.001

C.C: Contingency Coefficient, P: Probability

This table indicates that there are significant difference in depression with regard to age, marital status, education, and monthly income at p-value=.002,.003,.002, and.001.
There are significant differences in anxiety with regard to age, marital status, and monthly income at p-value=.028,.002, and.001. There are significant differences in stress with regard to age, marital status, and monthly income at p-value=.002,.001, and.001.

Table 12: Association among Daily Life Activities and General Health with regard to Sociodemographic variables of Old Age

Variable	DLA		GHQ	
	C.C	P-value	C.C	P-value
Gender	.090	.439	.124	.208
Age	.460	.001	.355	.001
Marital status	.337	.004	.260	.152
Level of education	.259	.156	.325	.008
Monthly income	.240	.010	.235	.019

C.C: Contingency Coefficient, P: Probability

This table shows that there are significant differences in daily life activities with regard to age, marital status, and monthly income at p-value=.001,.004, and.010.

There are significant differences in general health with regard to age, marital status, and monthly income at p-value=.001,.008, and.019.

Table 13: Association among Depression, Anxiety, and Stress with regard to Residency variables of Old Age

Variable	Depression		Anxiety		Stress	
	C.C	P-value	C.C	P-value	C.C	P-value
Period of residency	.464	.001	.335	.063	.478	.001
Causes of residency	.239	.144	.207	.346	.232	.180
Financial source	.430	.001	.329	.083	.278	.398
Family & friend visits	.374	.001	.314	.005	.254	.087
Medical visits	.284	.024	.230	.187	.153	.778
Satisfaction with services	.273	.003	.236	.018	.199	.082

C.C: Contingency Coefficient, P: Probability

This table indicates that there are significant difference in depression with regard to period of residency, financial source, family visits, medical visits, and satisfaction with services at p-value=.001,.001,.001,.024, and.003.
There are significant difference in anxiety with regard to family visits and satisfaction with services at p-value=.005 and.018.
There is significant difference in stress with regard to period of residency at p-value=.001.

Table 14: Association among Daily Life Activities and General Health with regard to Residency variables of Old Age

Variable	DLA		GHQ	
	C.C	P-value	C.C	P-value
Period of residency	.367	.001	.254	.084
Causes of residency	.312	.001	.296	.001
Financial source	.208	.333	.384	.001
Family & friend visits	.306	.001	.287	.001
Medical visits	.180	.149	.252	.009
Satisfaction with services	.168	.055	.235	.003

C.C: Contingency Coefficient, P: Probability

This table indicates that there are significant difference in daily life activities with regard to period of residency, causes of residency, and family visits at p-value=.001,.001 and.001.

There are significant difference in general health with regard to causes of residency, financial source, family visits, medical visits, and satisfaction with services at p-value=.001,.001,.001,.009, and.003.

Table 15: Association among Depression, Anxiety, and Stress with regard to Health variables of Old Age

Variable	Depression		Anxiety		Stress	
	C.C	P-value	C.C	P-value	C.C	P-value
Current smoking	.241	.411	.252	.324	.216	.634
Surgery	.122	.555	.151	.324	.120	.568
Denture	.173	.185	.123	.547	.138	.421
Use medication	.170	.201	.154	.301	.238	.017
Use herbal	.178	.160	.091	.797	.096	.757
Chronic illness	.339	.001	.302	.010	.354	.001

C.C: Contingency Coefficient, P: Probability

This table shows that there is significant difference in depression with regard to chronic illness at p-value=.001.
There is significant difference in anxiety with regard to chronic illness at p-value=.010.
There are significant differences in stress with regard to use medication and chronic illness at p-value=.017 and.001.

Table 16: Association among Daily Life Activities and General Health with regard to Health variables of Old Age

Variable	DLA		GHQ	
	C.C	P-value	C.C	P-value
Current smoking	.172	.411	.116	.842
Surgery	.101	.356	.095	.398
Denture	.160	.071	.013	.982
Use medication	.033	.894	.048	.791
Use herbal	.035	.881	.132	.168
Chronic illness	.286	.001	.150	.327

C.C: Contingency Coefficient, P: Probability

This table shows that there is significant difference in daily life activities with regard to chronic illness at p-value=.001.

Discussion
The results of table 1 show that the majority of elderly were male (59.2). This finding is consisting with [Mohsin, 2014] [1] the majority of study sample (66%) were males.

The first table also shows that more of the elderly in age group to the study sample were within (60 – 69) years was (39.3%). This finding is consisting with [Wood et al., 2017] [2] that the age group of elderly more than 60 years old (61.9%).

Also, in regarding to material status, the results show that was (33.3%) married. This finding is not consisting with [Wood et al., 2017] [2] that (78%) were widow. In regarding to level of education (36.3%) of elderly have (Read & write) level. This finding is not consisting with [Wood et al., 2017] [2] that (55%) bachelor degree.

And the results show that half of elderly their monthly income was barely sufficient (44.8%). This finding is supported with [Nordtug et al., 2014] [3] that the income was mingy.

The results of table 2 show that the more of them had 1 – 3 years residency period (37.8%), and the majority of them choose Voluntary the residency home (69.7%), and have financial income (67.2%). half of them don't have family, friends, and relative visits (56.2%), but majority of them have medical visits (69.7%). This finding is supported with [Marsa et al., 2020] [4] that the elderly majority of them had volition on home-dwelling and had financial support.

The results of table 3 show that the elderly was satisfied with services (65.2%), but the rest of them their sources of dissatisfaction Cooling lack (11.4) and Sanity (11.4). This finding is supported with [Wood et al., 2017] [2] that the

elderly was not complaining about living in nursing elderly home.

The results of table 4 show that elderly Self-report of health more of them reported accepted (38.3%), and most of them not smoking (73.6%), with no surgery (94%) or Denture (95.5%). All of them not Consuming alcohol (100%). Most of them Use medication (78.6%) and not using herbal (93%) with Chronic illness (65.2%). This finding is supported with [Marsa et al., 2020] [4] that (43.9%) of nursing home residents have chronic disease.

The results of table 5 show that many of elderly had Diabetes mellitus (43.8%), Hypertension (44.3%), heart disease (28.9%), renal disease (10.9%), Emotional and psychological disorder (11.4%), Thyroid disease (1.5%), respiratory disease (13.4%). This finding is supported with [Nordtug et al., 2014] [3] that major chronic disease among elderly was chronic obstructive pulmonary disease (35%).

5.2. Discussion of clinical data:
The results of table 6 show that level of depression among elderly is moderate (30.3%). This finding is supported with [Ali, 2021] that the elderly had fair level of depression.

The results of table 7 show that level of anxiety among elderly is extremely severe (41.8%). This finding is disagreeing with [Lee et al., 2019] [5] that elderly had high level of anxiety.

The results of table 8 show that elderly have normal level of Stress (34.3%). This finding is supported with [Marsa et al., 2020] [4] that the level of stress was normal.

The results of table 9 show that elderly have low dependent in their daily life activities (61.2%). This finding is supported with [Vaughan et al., 2020] [6].

The results of table 10 show that assessment of elderly general health is fair (63.7%). This finding is supported with [Vaughan et al., 2020] [6].

Discussion of Association
The results of table 9 show that there are significant association between depression and age, marital status, education, and monthly income. Also, there are significant association between anxiety and age, marital status, and monthly income. And, there are significant association between stress and age, marital status, and monthly income. This finding is disagreeing with [Lee et al., 2019] [5].

The results of table 12 show that there are significant association between daily life activities and age, marital status, and monthly income.

Also, there are significant association between general health and age, marital status, and monthly income. This finding is disagreeing with [Lee et al., 2019] [5].

The results of table 9 show that there are significant association between depression and period of residency, financial source, family visits, medical visits, and satisfaction with services. And there is significant difference

in anxiety and family visits and satisfaction with services. Also, there is significant association between stress and period of residency. This finding is supported with [Marsa *et al*., 2020] [4].

The results of table 14 show that there are significant association between in daily life activities and period of residency, causes of residency, and family visits. And there are significant association between general health and causes of residency, financial source, family visits, medical visits, and satisfaction with services. This finding is supported with [Marsa *et al*., 2020] [4].

The results of table 15 show that there are significant association between depression and chronic illness. And there is significant association between anxieties with regard to chronic illness. This finding is supported with [Marsa *et al*., 2020] [4].

Also, there are significant association between stress and use medication and chronic illness. This finding is supported with [Marsa *et al*., 2020] [4].

The results of table 15 show that there are significant association between daily life activities and chronic illness. This finding is supported with [Marsa *et al*., 2020] [4].

Conclusions
1. The demographic data show majority of elderly were male, in age group (60 - 69) years and married, with Read & write educational level, half of elderly their monthly income was barely sufficient, they had 1 - 3 years residency period and choose Voluntary the residency home.
2. The level of depression among elderly is moderate, but level of anxiety among elderly is extremely severe, with normal level of stress and low dependent in their daily life activities, but elderly's general health is fair, because old people practice a kind of loneliness.
3. There are significant association between depression, anxiety & stress, daily life activities and general health with sociodemographic variables: age, marital status, education, and monthly income, because the majority of elderly are single and have low educational status.
4. There are significant association between residency variables with depression, anxiety & stress, daily life activities and general health. Because the elderly chooses Voluntary the residency home.
5. There are significant association between health variables if elderly with depression, anxiety & stress, daily life activities and general health. Because more than half (65.2%) of elderly have chronic disease.

Recommendations
1. Assessing depression, anxiety and stress of elderly with chronic disease and the heathy elderly, separately.
2. Assessing health variables and general health of elderly with chronic disease and the heathy elderly, separately.
3. Including large number of samples to generalization the results.
4. Establishing counseling centers in the Ministry of Labor and Social Affairs to present information and services for elderly.
5. There must be a psychologist and social specialist resident in home, as well as encouraging the media to shed light on the issues of ageing populations and community awareness.
6. It is necessary to recognize the symptoms of depression

in older people as soon as possible, cause it can have negative implications on the mental health and self-esteem of older people, especially those living in nursing home.
7. The strategy of humanization in nursing care for older people should be applied equally in NHs and community-dwelling states. This would reduce the incidence of mental disorders and positively impact the aging process.
8. Public health programs aimed at maintaining mental health in elderly people are needed.

Conflict of Interest
Not available

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