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Factors Associated with Anxiety and Depression among Elderly Living in Old Age Homes

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Abstract

Anxiety and depression are the most common psychological problems in older people. The older people living in older person's residential care facilities are more vulnerable. This study aims to explore anxiety and depression and associated factors of older people staying in care facilities in Nepal. This is a descriptive cross-sectional quantitative study. A total of 216 older people were recruited from Old Age Homes (OAH) of Kathmandu Valley. Anxiety was assessed using Beck Anxiety Scale and depression was assessed using the GDS-15 scale. Statistical software SPSS 23.0 was used for data entry and analysis. The mean of anxiety was 13.23±6.84. The prevalence of anxiety disorder in the study population was 8.8 % and depression disorder was 74.5%. Results show gender, marital status, religion, type of previous family, chronic illness, stress, and type of living facilities were significantly associated with anxiety. Similarly, that being male, having chronic diseases, comorbidities, and feelings of stress are related to depression. The difference was statistically significant ($p<0.05$). Depression and anxiety were also significantly positively correlated ($r=0.232$, $p< 0.01$). Elderly people living in care facilities had slightly low levels of anxiety and high depression. Government and residential care facilities should be aware to provide appropriate support, care, and early psychological care during the intervention for the elderly so that it will help to control anxiety depression and other health problems so that older people enjoy the quality of life.

***Keywords*:** Mental disorders, older people, aging, stress, health problems

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Introduction

Population aging refers to the increasing number of older people in the total population. As demographics continue to shift in the 21st century, the world's aging population will continue to be a focal point for many global decision-makers. Most countries worldwide have experienced population explosions, or are about to. Combining this with declining birth rates and falling mortality rates, the global senior population will continue to reach new heights (Chalise, 2006). It is estimated that by 2050, there will be 1.5 billion people aged 65 and older worldwide, more than doubling the number of individuals in this age group in the year 2020. The percentage of older people (65+) in the global population is expected to increase from 9.3% in 2020 to 16.0% in 2050, indicating that by the middle of the 21st century, one in six people worldwide will be 65 years of age or older (UN, 2020).

Mental disorders are a significant issue worldwide, with one in every eight people living with a mental disorder. Mental disorders involve significant disturbances in thinking, emotional regulation, or behavior, and can cause distress or impairment in important areas of functioning. In 2019, 970 million people around the world were living with a mental disorder, with anxiety and depressive disorders being the most common. Mental disorders are the leading cause of disability, causing 1 in 6 years lived with disability (Who, 2022). People with severe mental health conditions die on average 10 to 20 years earlier than the general population, mostly due to preventable physical diseases. COVID-19 has sparked or amplified much more serious mental health problems in some people.

Anxiety is a feeling of unease, such as worry or fear that can be mild or severe. Anxiety is a natural response to many life stressors. However, when those feelings of nervousness become overwhelming and make everyday life more difficult, it may be a sign of an anxiety disorder. Everyone has feelings of anxiety at some point in their life. Anxiety disorders can make it difficult to get through the day. According to BMGF (2019) anxiety disorders in older adults are fairly common, affecting 10% to 20% of people. However, anxiety disorders often go undiagnosed. Anxiety is found more often than depression and cognitive disorders in older adults.

Depression is another important mental disorder. In 2019, 280 million people were living with depression, including 23 million children and adolescents (BMGF, 2019). Depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. During a depressive episode, the person experiences a depressed mood (feeling sad, irritable, empty) or a loss of pleasure or interest in activities, for most of the day, nearly every day, for at least two weeks. Several other symptoms are also present, which may include poor

concentration, feelings of excessive guilt or low self-worth, hopelessness about the future, thoughts about dying or suicide, disrupted sleep, changes in appetite or weight, and feeling especially tired or low in energy. People with depression are at an increased risk of suicide. Yet, effective psychological treatment exists, and depending on the age and severity, medication may also be considered.

According to the 2021 census, there are 2.97 million older adults in Nepal, a 38.2% rise from the 2011 census (Chalise, 2023). Of Nepal's total population, the older demographic made up 10.21%. The average annual population growth rate in Nepal during the past ten years has been 0.92%, while the rate for the elderly population has been 3.29%. With the increase of older people, it has also increased the number of older people suffering from mental disorders. However, the mental health related issue is not getting priority and many people may think this is not a priority issue in health as well. Some studies have focused on depression (Chalise, 2014) but the anxiety of older people is ignored. Depression and anxiety are one of the major causes that may lead to dementia and many other health problems. On an ad hoc basis, there may be around 150 thousand people suffering from Dementia, and around 20% of them, around 30 thousand may have symptoms of Alzheimer's disease in Nepal.

The purpose of this article is to explore anxiety and depression and associated factors of older people staying in OAH in Nepal.

Literature Review

On a global scale, fertility is reducing, and infant mortality is declining. As a result, everywhere life expectancy at birth is rising (Chalise, 2019). According to CBS (2014) and Chalise (2023), Nepal's elder population climbed from 6.5% in 2001 to 8.1% in 2011 and 10.2% in 2021. According to a study, the percentage of adults 65 and older is predicted to be around 13% by the year 2050 (Chalise, 2018). But Chalise (2023) argues the Proportions of older persons are increasing more rapidly than we have expected due to rapid fertility decline. Longevity and increased life expectancy can be considered as successes for socioeconomic development and public health programs. However, it also puts pressure on society to deliver the required care and uphold a high standard of living (Chalise & Rosenberg, 2019).

According to Chalise and Rosenberg (2020), seniors have weakened immune systems and are more susceptible to a variety of diseases. According to a study, 52.6% of respondents in rural areas reported having mental health issues, 14.6% had some form of physical disability, and almost three-quarters of respondents had physical health issues (Chalise & Rosenberg, 2019). Physical pain, respiratory issues, gastritis, eye issues, blood pressure, and dental issues were the most often

stated physical health issues among older adults. According to a study carried out by Chalise (2012) in Kathmandu, approximately 60% of seniors had at least one chronic illness. The prevalence of depression among the elderly is significant, according to several research (Chalise, 2014; Manandhar et al., 2019; Sharma et al., 2018). According to a study conducted in Kathmandu, depression affects the elderly who live in the community in a range of 29.7% to 65% (Chalise & Rai, 2013; Manandhar et al. 2019; Sharma et al, 2018). The prevalence of depression among elderly residents of nursing homes ranged from 47.33% to 57.8%, according to research (Chalise, 2014; Ranjan et al., 2014). Additionally, according to a research of a Kathmandu old age home, 32.4% of respondents experienced anxiety (Timalsina et al., 2014). Studies suggest that two-thirds of the elderly in Nepal experience some form of loneliness (CBS, 2014; Chaudhury, 2004; Chalise et al., 2007; Chalise, 2010). Although, the majority of older persons reside with their family members (Chalise & Shrestha, 2005; Singh et al, 2021,). Even though the majority of senior Nepalis live with family members, they frequently express feelings of loneliness. Lack of contact with children and other family members as well as a sense of neglect in the family can both contribute to feelings of loneliness (Chalise et al., 2007b). According to Chalise's book chapter from 2021, a number of elements, including social, physical, and psychological disorders, are likely to contribute to loneliness (Chalise, 2021).

Social Security

Social Security does not have a single definition that everyone agrees on. It varies from country to country. This is significantly different due to laws, cultures, traditions, and values. The basic purpose of social security is to protect people from hardship if they cannot afford their own expenses (Malakar & Chalise, 2019). It is based on the ethical principles of social justice and human dignity. treating mother as a god and treating father as a god are the norms and customary values in Nepali society (Chalise, 2006; Chalise, 2021). In Nepalese culture, growing old is still considered respectable in some social contexts. In Nepal, agriculture is the main economic sector. The majority of Nepalese workers work in unorganized industries and therefore do not receive a regular pension or pension income. In Nepal, only 7% of the elderly are retirees (Chalise & Brightman, 2006). Most elderly people depend on their families, their own money or continue to work. According to Subedi's research from 2003, a significant portion (54%) of the elderly are engaged in non-economic activities of the household. For those working in the formal sector, the Nepalese government enacted the Labor Act 2017 and the Social Security Act 2017 in 2017. However, some business sectors have not yet registered for the scheme.

The Government of Nepal has introduced universal benefits for the elderly. All those

aged 68 and over receive Rs. 4,000 ($35) per month under this scheme. In addition, widows aged 60 and over and dalit residents of Karnali province of Nepal receive an old age allowance of Rs. 2,000 (USD 17) per month (Chalise, 2023; Chalise et al, 2022). Nepalese elders are very fond of it (Malakar & Chalise, 2019). The majority of older Nepalese are completely dependent on their children and other family members for help and care as they age (Chalise, 2021).

Methods and Procedures

This is a cross-sectional study carried out in OAH of Kathmandu Valley, Nepal. Five OAHs of Kathmandu Valley permitted this study. The census of all older people living in these OAHs was carried out. Inclusion criteria included individuals 60 years and older living at an old age home and those who were willing to participate in this study and were able to listen and give responses. Individuals who had severe psychiatric disorders as reported by the care home authority were excluded. There were 330 older people in OAHs. Around 250 older people were found eligible for this study and 240 participated in this study. However, the questionnaire was completed by 216 older people. The final sample size for this study is 216.

Ethical Consideration

Formal approval for this study was obtained from the ethics committees of the institutional Review Board of Xiang-Ya School of medicine, Central South University, and Nepal Health Research Council. Permission from the concerned authorities of different care facilities in Kathmandu Valley, Nepal was taken.

Verbal informed consent which is commonly used in Nepal (Acharya et al, 2021) was taken from each respondent after explaining the purpose of the study. Respondents' participants in the study were voluntarily and were informed that they could withdraw from the study at any time without giving reason and without fear if they wish. Participants, who did not want to participate in the study, were not being forced for participate. Face-to-face interview method was used for data collection.

Measurements

General information measured in this study was age, sex, literacy status, marital status, religion, ethnicity, previous source of income, previous family type, family history of depression and anxiety, and worries regarding living at residential care facilities.

Depression was assessed using a short form of GDS-15 scale (WHO, 2017). The scale consists of 15 items. GDS (SF = 15) was the short version of the widely used Geriatric Depression Scale (GDS) (Yesavage et al, 1983). It is already used in Nepal (Chalise, 2014) with permission from the author. The score of GDS ranges

from 0-15, with a yes/no response of 15 questions. Scores of 0-4 are considered normal, depending on age, education, and complaints; 5-8 indicate mild depression; 9-11 indicate moderate depression; and 12-15 indicate severe depression. The Short Form is more easily used by physically ill and mildly to moderately demented patients who have short attention spans and or feel easily fatigued. It had good internal consistency in the study assessed by Cronbach's alpha (0.76)

Anxiety was assessed using the Beck Anxiety Inventory (BAI) (Beck et al., 1988). The scale consists of 21 items each describing common symptoms of anxiety. The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a 4-point ranging from 0-3. The items are assumed to obtain a total score that can range from 0-63. Scores between 0-21 indicate that anxiety is not present, scores between 22-32 indicate a mild level of anxiety, scores ranging from 33-48 indicate a moderate level of anxiety, and scores ranging in from 49-63 indicate an extremely severe level of anxiety. The Nepalese version of the scale has already been Validated (Kohrt et al., 2003). It has found good internal consistency in the study assessed by Cronbach's alpha (0.76).

Data Analysis

Data was analyzed through Statistic Package of Social Science (SPSS) version 23. The collected data were analyzed by using both descriptive statistics such as frequency, percentage, mean, Standard deviation, chi-square, cross-tabulation between the selected variables, and the Score of GDS.

Results

Table 1 presents the general characteristics of the respondents. The total 216 respondents' mean age was 74.13 years. The majority of respondents 70.4 % (152) were female and 29.6 % (64) of respondents were male. Most of the respondents 79.2 % (171) were illiterate and the minority 20.8 % (45) were literate. Regarding marital Status, 44.9 % (97) of the respondents are widows/widowers, 31.5 % (68) were unmarried and 23.6 %(51) were married. 63.9 % (138) of respondents had been staying in old aged homes for one to five years and the minority of the respondents 20(9.3%) had less than 1 year. Major respondents 51.4 percent is of the Brahmin/ Chhetri ethnic group, 44.4 percent (96) of the respondents were from Janajati, and others 4.2% which belong to Madhesi, Dalit, and Muslim. The majority of the respondents 87 % (188) were of Hindu Religion where as 13% (28 number) of respondents were Christian. Most of the respondents 125(57.9%) have no child and minority 37(17.1%) have one child. The majority of the respondent's previous family type is joint family140 (64.8%) and 76(35.2%) respondents had a nuclear family. Agriculture 63(29.2%) is the major occupation of respondents whereas 12(5.6%)

respondents were service holders previously.

Table 1

Characteristics of Socio-Demographic Data of the Respondents (N = 216)

Variables	Frequency	Percentage
Age	Mean= 74.13	
60-69	66	30.6
70-79	85	39.4
>80	65	30.1
Sex of Respondents		
Male	64	29.6
Female	152	70.4
Level of Education		
Literate	45	20.8
Illiterate	171	79.2
Marital Status		
Married	51	23.6
Unmarried	68	31.5
Widow/Widower	97	44.9
Ethnic Group		
Brahmin/Chhetri	111	51.4
Janajati	96	44.4
Others	9	4.2
Religion		
Hindu	188	87
Christian	28	13
Number of Children		
No Child	125	57.9
Only one Child	37	17.1
Two or More Child	54	25
Previous Type of Family		
Nuclear	76	35.2
Joint	140	64.8
Duration of Stay		

Less than one Year	20	9.3
One to five years	138	63.9
>five year	58	26.9

Table 2 presents the health-related information of the respondents living in OAH. More than two-thirds (70.8%) of elderly were suffering from at least one chronic disease and 55% have co-morbidity. 29.6% elderly were found worried about their situation. Nearly half (49.1%) have feeling of stress. 15.7% had family history of anxiety and 15.7% had depression history.

Table 2

Health Related Information of Respondents (N=216)

Variables	Frequency	Percentage
Chronic Illness		
Yes	153	70.8
No	63	29.2
Presence of co morbid		
Presence of more than one Chronic Disease	119	55.1
Presence of more than one disease	34	15.7
Presence of Worries		
Yes	64	29.6
No	152	70.4
Feeling of Stress		
Yes	106	49.1
No	110	50.9
Family History of Anxiety		
Yes	34	15.7
No	182	84.3
Family History of Depression		
Yes	34	15.7
No	182	84.3
Types of Organization		
Government	107	49.5
Non-Government	109	50.5

Status of Depression and Anxiety

The mean and standard deviation of depression in the present study was 7.55±3.56. Below table 3 shows 74.5% older people are suffering from some form of

depression. Among the total population 13.4% have severe depression, 31.0% have moderate depression and 30.1% have mild level of depression.

The mean and standard deviation of anxiety of the respondents were 13.23±6.838. 8.8% older people reported suffering from Anxiety. Among them 5.6% had mild anxiety and 3.2% had severe anxiety. No cases of severe anxiety disorder is found.

Table 3

Descriptive Statistics of Depression and Anxiety and their Categories (N=216)

Depression	Frequency	Percent	Mean
Depression Situation			
Depression	216	74.5	7.55
Normal	55	25.5	2.84
Mild Depression	65	30.1	6.72
Moderate Depression	67	31	9.88
Severe Depression	29	13.4	12.97
Anxiety Situation			
Anxiety	19	8.8	13.23
Normal	197	91.2	11.77
Mild Anxiety	15	5.6	26.47
Moderate Anxiety	4	3.2	35.5
Severe Anxiety	-	-	-

Factors Associated with Depression

Table 4 and 5 shows the association between demographic social and health-related variables with depression in older people. It shows age, marital status, living duration, educational attainment, previous family type, religion, number of children, and duration of stay are not significantly associated with depression. On the other hand mean score of depression was statistically significant with sex, presence of chronic disease, presence of comorbid illness, feeling of stress and type of organization.

Table 4

Association between Socio-demographic Characteristics and Depression

Variables	Frequencies	Mean ± SD	t-Test	F-Test	P
Gender					

Male	64	8.77±3.274	3.32		.001*
Female	152	7.04±3.564			
Educational level					
Literate	45	7.82±3.576	.573		.567
Illiterate	171	7.48±3.565			
Marital status					
Married	51	7.59±3.68		.244	.783
unmarried	68	7.31±3.826			
Window/widower	97	7.70±3.323			
Ethnicity					
Brahmin/Chhetri	111	7.22±3.47		2.238	.109
Janajati	96	7.74±3.66			
Others	9	9.67±2.95			
Religion					
Hindu	188	7.62±3.659		.582	.446
Christian	28	7.07±2.827			
Number of Children					
No Child	125	7.18±3.632		1.818	.165
Only One Child	37	7.81±3.620			
Two or More Child	54	8.25±3.291			
Previous Family Type					
Nuclear	76	7.37±3.762	-.55		.580
Joint	140	7.65±3.458			

Note: SD: Standard Deviation, *represents p<0.05

Table 5

Association between Socio-health Characteristics and Depression

Variables	Frequencies	Mean ± SD	T-Test	F-Test	P value
Duration of Stay					

Less than one Year	20	7.80±3.518			
1 to 5 year	138	7.39±3.650		.383	.682
>5 years	58	7.84±3.397			
Presence of Chronic Illness					
Yes	153	8.58±3.428	1.56		.045*
No	63	7.30±3.608			
Presence of Co-morbid Illness					
Yes	119	8.53±3.740	3.43		.047*
No	34	7.22±3.135			
Worries living					
Yes	64	8.61±3.40	2.88		.004*
No	152	7.11±3.54			
Feeling of Stress among Respondents					
Yes	106	8.87±3.412	-1.28		.002*
No	110	7.21±3.690			
Types of Organization					
Government	107	7.01±3.672	1.885		.030*
Non-Government	109	8.10±3.40			

Note: SD: Standard Deviation, *represents $p<0.05$

Factors Associated with Anxiety

Table 6 shows the bivariate analysis of anxiety with selected socio-demographic and health variables. Factors associated with Anxiety were gender, religion, education, marital status, presence of chronic illness, Place of living, and feeling of stress among respondents ($p<0.05$). Being woman, illiterate, unmarried/widow/widower, having chronic health problems, feeling of stress and living in private institutions were positively correlated with anxiety.

Table 6

Association between Socio-demographic Characteristics and Anxiety

Distribution		**Mean ± SD**	**Pearson Value**	**T-Test Value**	**F-Test Value**	**P value**
Gender						
Male		10.05±5.035		4.709		**.001***
Female		14.57±7.064				
Educational Level						
Literate		11.41±6.362		-2.009		**.046***
Illiterate		13.71±6.897				
Marital Status						
Married		10.69±6.320		5.070		**.007***
unmarried		13.56±7.593				
Widow/widower		14.34±6.240				
Ethnicity						
Brahmin/Chhetri		12.26±6.476		2.543		.081
Janajati		14.13±6.973				
Others		15.67±8.573				
Religion						
Hindu		12.85±7.014		4.694		**.031***
Christian		15.82±4.861				
Previous Family Type						
Nuclear		13.18±7.86	-.075			**.020***
Joint		13.26±6.24				
Chronic Illness						
Yes		13.90±6.745	-2.267			**.024***
No		11.60±6.843				
Co-morbid Illness						
Yes		13.60±7.037	-1.836			.068
No		11.60±6.843				
Type of organization						
Private		14.03±6.907	1.116			.007*

Government		12.89±6.804			
Feeling of Stress					
Yes		15.05±6.970	-3.959		**.001***
No		11.48±6.257			

Note :(1) (SD) Standard Deviation (2); *represents p<0.05

Further, a positive correlation was found between Geriatric Depression Scale and Beck Anxiety by Pearson Correlations R=0.232(p=0.001) and had significance relationship among the factors with P < 0.01. It is not shown on the table.

Discussion

Depression

This study found the prevalence of depression was 74.5%. Previous studies from Nepal found the prevalence of depression is generally quite high among institutionalized older people and it is higher than 50% in institutional settings in Nepal (Chalise, 2014; Chalise, 2021; Chalise & Basnet, 2017).

This study further found, being male, having chronic diseases, comorbidities, and feelings of stress are related to depression. Many studies show women have higher depression (Chalise, 2014; Dhungana, 2020). Similarly, a study by Anbesaw and Fekadu (2020) in Ethiopia shows educational status, income, cognitive impairments, family history of mental illness, and poor quality of life were significantly associated with depression. Further, this study shows older people living in government care facilities have lower depression compared to private care facilities. It may be due to older people's worry about managing the cost of living in private care facilities and service is accessible in government care facilities. High depression among residential care facilities may be due to a change in traditional living arrangements and increasing health-related problems (Chalise & Rosenberg, 2020; Singh et al., 2022). Traditionally older people used to live with family members and family members were responsible for care and support during old age. Due to the migration of the young generation, many older people are forced to live in care facilities (Dhital et al., 2015; Khanal et al, 2018; Rai et al, 2018). It has increased anxiety among older people about their social security. The social security system of Nepal is not well developed and is fully dependent on family members (Chalise, 2021; Chalise et al, 2022; Malakar & Chalise, 2019).

Anxiety

This study found; the prevalence of anxiety was 8.8%. Bhattarai et al. (2021) found 27.4% had anxiety whereas 13.1%, 3.6%, and 10.7% had mild, moderate, and severe anxiety respectively in a study in Kathmandu. A study from Turkey shows all types of anxiety disorder prevalence of 17.1% (Kirmizioglu et al., 2009). A previous study from Nepal shows the crude prevalence of anxiety was 22.7 % (Risal et al, 2016). The low anxiety reported in this study is not clear. The low perception of anxiety may be due to cultural differences in understanding the anxiety-related questionnaire in the Nepalese context.

Further, this study found being woman, illiterate, unmarried/widow/widower, having chronic health problems, feeling of stress and living in private institutions were positively correlated with anxiety. The feeling of anxiety is also related to social insecurity. The social security system of Nepal is not well developed and is fully dependent on family members (Chalise & Brightman, Chalise, 2021; Malakar & Chalise, 2019; Chalise et al., 2022; Khanal & Chalise, 2020). Older people living in private institutions had higher anxiety as they have to worry to pay the monthly costs but government institutions provide all the services free of cost (Suwal & Chalise, 2023).

Anxiety and depression in the elderly is a major public health challenge in many developing countries. Anxiety and depression can worsen older adults' physical health, impair their ability to perform daily activities, and decrease their sense of well-being. This study found more than 70% older people have chronic diseases. Therefore, the older people living in these OAHs are more vulnerable to anxiety and depression.

On the other hand, In Nepal, the elderly population is growing rapidly (Chalise, 2006, Chalise, 2020, Chalise, 2023). Since fertility is declining rapidly (Chalise, 2023) it suggests a trend to further increase in the coming days (Chalise, 2023; Chalise, 2018). Studies show that older adults are susceptible to different types of diseases as they age (Chalise & Rosenberg, 2020). With the rapid increase in the number of elderly people, Nepal is likely to face social, demographic, economic, health, and aged care challenges in the coming days (Chalise, 2023). Further, the number of older people suffering from anxiety and depression will also increase in the coming days.

Studies in Nepal show that the long-established culture and traditions of respecting older people are eroding day by day (Chalise, 2021; Khanal & Chalise, 2020). Younger generations move away from their birthplace for employment opportunities elsewhere. Consequently, traditional living arrangements are changing (Pandit & Chalise, 2023; Singh et al., 2021). Many older people are living either with a spouse, alone, or in an institution (Khanal et al., 2018; Rai et al., 2018), and are vulnerable to mental problems like depression, loneliness, and many other physical diseases (Chalise & Khanal, 2021; Chalise et al., 2007; Chalise, 2014; Chalise & Lamsal, 2017; Chalise & Paudel, 2020; Suwal & Chalise, 2023; Maharjan et al., 2018; Mishra & Chalise, 2019). This study has focused on the situation of older people's depression living in different care facilities. This study found; the prevalence of depression was 74.5%. Previous studies from Nepal found the prevalence of depression is generally quite high among institutionalized older people and it is higher than 50% in institutional settings in Nepal (Chalise, 2014; Chalise, 2021; Thapa et al., 2018).

A study from India has found that the mental health status of the older people living in a family is better than institutionalized (Ashis, 2016). In Nepal, many older people want to live with family members, but the out-migration of young people has resulted in institutionalized. The elderly are unable to maintain their land and home duties because young family members frequently move from rural to urban areas or abroad (Dhital et al., 2015). In Nepal, practically all old people want to live with their families despite the embarrassment this causes. Due to the young leaving the family, parents who are left at home alone now feel isolated and alone. Generally, older people do not feel happy living in the absence of their children and may have anxiety and depression. The culture of living in the institution is not well developed. A study shows elderly living in Private institutions have better health than government institutions (Mishra & Chalise, 2019a; Mishra & Chalise, 2019b). On the other hand, the social security system of Nepal is not well developed (Malakar & Chalise, 2018: Chalise et al., 2022) and Nepal may face further problems in maintaining healthy aging (Chalise, 2022; Chalise, 2023), reducing anxiety (Pakwan & Chalise, 2023), and the quality of life of Nepalese older people (Joshi et al, 2018; Joshi & Chalise, 2021).

Conclusion

Anxiety and depression in older people are increasing public health concerns. This study shows the prevalence of depression is high among older people living in OAHs but the prevalence of anxiety (8.8%) seems not so bad. Results show gender, marital status, religion, type of previous family, chronic illness, stress, and type of living facilities were statistically significantly associated with anxiety. Further, this study found the prevalence of depression was 74.5%. This study further found, that being male, having chronic diseases, comorbidities, and feelings of stress are related to depression. With the increasing the older people and the poor social security system, anxiety and depression disorders may increase in the coming days. Government and local policymakers should formulate appropriate policies to make older people active and healthy so that they can enjoy the quality of life.

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