

**SOCIAL SUPPORT AND SUBJECTIVE WELL-BEING OF OLDER PEOPLE
IN LAMKI CHUHA MUNICIPALITY, KAILALI DISTRICT**

A Dissertation

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POPULATION STUDIES

By

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DECLARATION

I hereby declare that this dissertation, entitled “Social Support and Subjective Well-Being of Older People in Lamki Chuha Municipality, Kailali District,” was submitted to the Office of the Dean, Faculty of Humanities and Social Sciences, Tribhuvan University (FOHSS-TU), is my own work and that it contains no materials previously published. I have not used its materials for the award of any kind or any other degree. Where other authors' sources of information have been used, they have been acknowledged.

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LETTER OF RECOMMENDATION

We certify that this dissertation, entitled "Social Support and Subjective Well-Being of Older People in Lamki Chuha Municipality, Kailali District," was prepared by Mr. Tilak Prasad Sharma under our guidance. We hereby recommend this dissertation for final examinations by the Research Committee of the Faculty of Humanities and Social Sciences, Tribhuvan University, in fulfillment of the requirements for the Degree of DOCTOR OF PHILOSOPHY in POPULATION STUDIES.

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ABSTRACT

The ageing population is a growing concern for poor and middle-income countries, especially given the lack of institutional social safety nets and the fact that family support systems are the main source of support for older persons. Demographic change, migration, and the disintegration of the joint family system have exacerbated the vulnerability of older people in Nepal. These difficulties raise questions about the adequacy of existing social support systems to facilitate psychological well-being in later life. But empirical examination of this link remains lacking in Nepalese rural areas. The present study seeks to fill this gap by investigating the aspects and drivers of subjective well-being among the older persons in Lamki Chuha Municipality, Kailali District, Nepal.

Three objectives motivated the research: to determine the level of subjective well-being among the older, to examine the interaction between social support systems and subjective well-being, and to explain the effects of socio-economic and demographic determinants on subjective well-being. The study used a quantitative cross-sectional design and structured interviews with 402 adults aged 60 years and above, recruited via systematic random sampling. Subjective well-being was assessed using the WHO-5 Well-Being Index, the Kessler Psychological Distress Scale (K10) and the Subjective Well-Being Inventory (SUBI). Social support was assessed by the Multidimensional Scale of Perceived Social Support (MSPSS) and the Interpersonal Support Evaluation List (ISEL). The data were analyzed using descriptive statistics, Pearson correlation, ANOVA and multiple linear regression.

The findings indicate that subjective well-being among older people in the study area is generally moderate, with notable variation within the group. The mean WHO-5 score was 53.03, marginally above the distress threshold of 50, and approximately

20.1% of participants were at risk for low psychological well-being. While most respondents reported moderate life satisfaction, the results highlight the dual nature of well-being in later life. Elevated levels of mental inadequacy and perceived poor health were observed across all age groups. Family emerged as the primary source of support, consistent with Nepalese cultural norms of intergenerational care. However, several forms of social assistance did not show a significant positive association with subjective well-being, suggesting a reverse reliance effect, in which increased receipt of help may reflect underlying vulnerability rather than directly enhancing well-being. Family and peer networks were found to provide distinct and complementary psychological benefits. Instrumental caregiving support was identified as the most deficient component. Caste identification, educational attainment, and employment status were the most influential socio-economic determinants of well-being. Dalit and illiterate older adults reported substantially lower well-being, indicating cumulative structural disadvantage. The greatest psychological impairment was observed among the oldest-old cohort (85 years and above). Gender, marital status, and family type were not significant predictors in any of the models analyzed.

This thesis asserts that subjective well-being in later life is multifaceted and shaped by structural factors. The study contributes to the empirical literature on Nepalese gerontology by demonstrating that structural inequalities related to caste and educational deprivation, rather than social role characteristics, are primary determinants of well-being. It is recommended that mental health services be integrated into elder care systems, instrumental support within communities be enhanced, and inclusive aging policies be developed for socio-economically disadvantaged older people.

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LIST OF ABBREVIATIONS/ACRONYMS

CBS	Central Bureau of Statistics
COVID-19	Coronavirus Disease 2019
GCN	Geriatric Center Nepal
GHQ	General Health Questionnaire
K-10	Kessler Psychological Distress Scale (10-item scale)
LS	Life Satisfaction
MSPSS	Multidimensional Scale of Perceived Social Support
NEPAN	Nepal Participatory Action Network
NGO	Non-Governmental Organizations
NPC	National Planning Commission
NPHC	National Population and Housing Census
NSO	National Statistical Office
PWI	Personal Well-Being Index
QoL	Quality of Life
SCA	Senior Citizens Act
SDGs	Sustainable Development Goals
SPS	Social Provision Scale
SPSS	Statistical Package for the Social Sciences
SSPSWQ	Support and Subjective Well-Being Questionnaire
SWB	Subjective Well-Being

UN	United Nations
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
WHO	World Health Organization
WHO-5	World Health Organization Five Well-Being Index

CHAPTER I

INTRODUCTION

1.1 Background of the Study

Population ageing is one of the major demographic trends of the twenty-first century and it is affecting social, economic and health systems worldwide. As medical care, standard of living and life expectancy increase, an increasing proportion of older people are being seen in developed and developing countries. The aging population has generated significant interest in the quality of life and well-being of older people. In this context, social support is important. Therefore, the relationship between social support and well-being in old age has become an important topic for academic research and policy discussion.

The United Nations (2019) defines older individuals as those aged 60 years and above, projecting that this demographic will constitute approximately 22 percent of the global population by 2050. By that year, the population aged 60 years and older is expected to surpass 2 billion persons (World Health Organization, 2022). This demographic transition introduces substantial social, economic, and policy challenges. As the number of older adults increases, demands on health services, long-term care facilities, and social assistance systems intensify. Older persons encounter multiple challenges, including chronic diseases, diminished physical health, uncertain income, and social isolation (World Health Organization [WHO], 2022). These factors significantly influence both physical and mental health. Recent research indicates that ageing should be addressed not only as a scientific issue related to disease and incapacity, but also as a social and psychological concern regarding well-being (Soylu

& Yılmaz Irmak, 2021). Consequently, the health needs of at-risk older adults are complex and require a comprehensive approach.

Ageing is a universal and complex phenomenon, involving biological, psychological and social modifications, which differ amongst individuals depending on their life experiences and socio-economic conditions. Functional dependence is often a result of advancing age and the deterioration in the quality of life and independence (Ferrucci et al., 2020). Aging diseases include frailty, falls and cognitive impairment lead to increased dependency of the patient and require care. Modern gerontology focuses on ageing as a physical and emotional process, with well-being also influenced by health, social ties and personal resources.

The notion of social support gained prominence in the 1960s and has since been acknowledged as a crucial factor influencing health and well-being. It comprises three essential components: the beneficiary (often a vulnerable demographic such as the older), the giver (family, community, or institutions), and the type of support rendered. Social assistance can be categorized as informal, originating from family and friends, or formal, provided by organizations and governmental entities (Taylor, 2011).

Social support encompasses the resources and assistance individuals receive from their social connections, which facilitate stress management and promote resilience and well-being. It is generally conceptualized in two dimensions: structural, referring to the size and nature of social networks, and functional, denoting the type and effectiveness of support provided (Helgeson, 2003). Functional support is commonly categorized into three types: emotional support, which includes empathy, affection, and trust; instrumental support, which involves practical assistance and services; and informational support, which comprises advice and guidance (Sherbourne & Stewart,

1991). These forms of support are complementary and collectively enable individuals to cope with life challenges and maintain psychological stability.

In Nepal, the significance of social assistance has grown because of its rapidly aging population. The population of people over 60 years of age increased in recent years, leading to increased need for emotional support, health care services and social protection (Chalise, 2023; National Statistics Office [NSO], 2025). Thus, strong social support systems are needed to satisfy the different requirements of the aged.

There is a large body of empirical evidence indicating that well-developed social support systems are associated with better health outcomes, both physically and psychologically. Social support alleviates stress and anxiety, minimizes loneliness, and enhances the feeling of belonging and purpose (Ozbay et al., 2007; Harandi et al., 2017). It promotes beneficial health behaviors and enhances the use of healthcare services (Martire & Franks, 2014). In summary, social support is integral to human well-being and a crucial determinant of quality of life, particularly in later years.

Subjective well-being (SWB) represents how people evaluate their lives, including their emotional responses and cognitive judgments (Diener, 1984). The SWB includes three main components: life satisfaction, positive affect and negative affect (Diener et al., 2018b). Higher levels of SWB are linked to more positive emotions, fewer negative emotions, and greater satisfaction with life experiences. Indeed, empirical evidence indicates that SWB is linked to better physical health, better immune function, better social interaction, better coping and longer life (Lyubomirsky et al., 2005). Well-being is particularly important for older people, helping them adapt to retirement, changing family roles, reduced physical abilities, and social change. Objective living conditions are important, but SWB is largely determined by how people perceive their circumstances, the availability of social support, and the presence

of existential meaning. Understanding the determinants of SWB is important in promoting healthy aging and designing effective supportive interventions.

Social support, which includes emotional, informational, and instrumental assistance from social networks, is a significant determinant of subjective well-being (SWB) (Helgeson, 2003; Sherbourne & Stewart, 1991). Emotional support involves empathy, trust, and care. Instrumental support refers to physical assistance, while informational support encompasses advice and guidance. Social support may be categorized as structural, referring to the size and composition of social networks, or functional, referring to the quality and effectiveness of the assistance provided.

Research indicates that social support reduces stress, loneliness, and psychological vulnerability, while enhancing resilience (Harandi et al., 2017; Ozbay et al., 2007). Older adults may seek support from family members, friends, neighbors, religious institutions, and community organizations. Robust social networks are linked to lower levels of depression, greater life satisfaction, and increased coping strategies during health crises.

Social support is a context-dependent activity and works only in specific socio-economic and cultural contexts. Migration to urban areas, modernization and institutionalized family structures can erode the traditional extended family support systems. More work is needed to better understand the role of social support for older people's well-being, especially in countries undergoing rapid demographic and social change. Nepal's population and social fabric are changing rapidly. The National Statistics Office estimates that by 2025, more than 10 per cent of the total population will be aged 60 or over. The figure has been increasing steadily in the last few decades. These demographic changes have serious consequences for the family, the social security and health care systems.

Older people in Nepal have always been supported by the joint family structure, providing emotional, financial and practical support. People respected and accepted the older as family and community members (Chalise & Brightman, 2006). But the way people of different generations live together is changing due to urbanization, migration and the rise of nuclear families. The younger family members often seek jobs, leaving many old people unattended.

The government has introduced social security benefits, yet many people still live in poverty, especially in rural areas. Research shows that the well-being of senior persons in Nepal is significantly affected by health, income security, and availability of social networks (Sharma, 2023). Urban-rural disparities also hinder people's access to health and social services. The collapse of traditional family support leads to social and developmental problems. Older people are more likely to be lonely, isolated from others and have mental health difficulties. Informal networks, community support and religious participation are vital in promoting health and resilience among older persons.

Previous research in Nepal has predominantly addressed the physical health, morbidity, living conditions, and economic status of older adults. Several studies have utilized subjective well-being as a multidimensional measure. While social support is recognized as an important factor, empirical research on how interactions among different types of social support, socio-economic status, and demographic factors influence subjective well-being (SWB) remains underexplored. Most existing studies have identified health or demographic variables as potential determinants, whereas social support systems have received comparatively limited attention. Given the ongoing demographic and social transformations in Nepal, it is necessary to examine the relative influence of social support, socio-economic status, and demographic variables on subjective well-being.

This study examines how elderly people in Nepal perceive their lives and explores how social support, economic status, and demographic factors affect their well-being. The findings help fill a research gap and offer useful information for policies, community programs, and strategies that support dignified and healthy aging.

1.2 Statement of the Problem

Nepal is experiencing significant social and economic transformation, accompanied by a rapidly aging population. Traditional support systems for older adults are deteriorating due to urban migration for employment and evolving family structures. Historically, joint families offered essential emotional, social, and daily assistance; however, these arrangements have become increasingly unstable. As a consequence, older generations, particularly in semi-urban areas such as Lamki Chuha, face greater challenges, including reduced social support, increased isolation, and heightened vulnerability to harm.

The proportion of individuals aged 60 years and above in Nepal is increasing rapidly (Chalise, 2023). This demographic shift coincides with significant social and economic changes, including increased urban migration for employment and the decline of the traditional joint family system, which has historically provided emotional, social, and practical support to older adults (S. Shrestha et al., 2021). Consequently, older adults in semi-urban and rural areas, such as Lamki Chuha, are increasingly susceptible to social isolation, reduced support from younger generations, and elevated risks to their mental health.

The concept of subjective well-being (SWB) in older age is not new; it is multidimensional, including emotional well-being, life satisfaction, social connectedness and functional autonomy (Diener et al., 1999). Current international evidence indicates that social support is a crucial determinant of the well-being of older

people. Nevertheless, to date, the analysis of empirical studies in Nepal has primarily focused on economic stability, physical well-being, and policy rights, with scant consideration of other dimensions. Comprehensive examination of the impact of several elements of social support on subjective well-being, particularly in semi-urban or rural environments (Tausig & Subedi, 2022).

Even though state programs such as the Social Security Allowance and the Senior Citizens Act provide financial and legal insurance, they are mostly income-related and lack adequate focus on psychosocial well-being and community-based support mechanisms (National Statistics Office [NSO], 2025). Moreover, the majority of the available literature is urban-based and primarily uses one-dimensional measures, creating a knowledge gap regarding the multidimensional and context-specific determinants of well-being among older people in changing municipalities.

Consequently, a discernible gap exists in studies regarding the causal and statistical impacts of social support systems on subjective well-being, employing verified, multidimensional variables within a local context in Nepal. There is a deficiency of empirical research about the impact of structural, functional, and perceived forms of social support on the well-being outcomes of various socio-economic categories among older individuals in Lamki Chuha Municipality.

The present work fills this gap, systematically analyzing the link between social support and subjective well-being in older individuals, using a cross-sectional approach and standardized psychometric instruments. This study specifically explores the subjective well-being levels in the study region, which are influenced by numerous social support systems and socio-economic factors. This research provides context-specific empirical information on the relationship between demographic changes,

societal changes, and psychological consequences that might inform inclusive and dignity-centered aging policy in Nepal.

1.3 Research Questions

As the global population ages, it is important to consider the well-being of older adults. Subjective well-being, which includes life satisfaction and emotional health, is a key factor in their quality of life. Support from family, friends, and community services can help older adults feel more positive about their lives. Still, we do not fully understand how different types of social support and well-being are connected. This study looks at how social support relates to the subjective well-being of older adults. The main research question is:

1. What is the current level of subjective well-being among older people?
2. How do various social support systems relate to the subjective well-being of older people?
3. To what extent do socio-economic and demographic factors influence the subjective well-being of this population?

1.4 Objective of the Study

The main objective is to study the relationship between social support and well-being in the older population. The study's particular objectives are as follows:

1. To identify the level of subjective well-being among older people.
2. To examine the relationship between existing social support systems and the subjective well-being of older people.
3. To explain the influence of socio-economic and demographic factors on the subjective well-being of older people.

1.5 Significance of the Study

Nepal is experiencing a significant demographic change marked by increasing life expectancy and a growing geriatric population. Concurrently, conventional kinship-based support structures are deteriorating as a result of urbanization, migration, and socio-economic transformation. This research will enhance the current literature on aging by analyzing the socio-economic, social support, and psychological factors influencing subjective well-being in non-traditional households.

Classical theories such as disengagement and activity theory provide a fundamental framework but require contextual confirmation in dynamically changing circumstances. The study uses standardized procedures, such as the World Health Organization Well-Being Index, which are credible and appropriate for comparison worldwide. The regression analysis, as a typical quantitative method, can make the empirical research more rigorous, because it helps to uncover the elements having the highest effect with high precision. The results give evidence to strengthen age-sensitive social protection and community-based policy activities. The article provides research-based advice for the health of aged people in Nepal.

The study has added to the existing literature through the exploration of the application of Western gerontological concepts such as Modernization Theory and the Convoy Model of Social Support in a semi-urban South Asian context. The results are anticipated to show that alternative support arrangements can successfully replace traditional kinship ties. The research will contribute to the understanding of how emotional and instrumental assistance reduces the psychological vulnerability of older people in times of social transition and will thus expand the theory of geodiversity in gerontological studies. The importance of the technique is that it is done in a rigorous way, ensuring validity and reliability.

The technique has been carried out with great care and thoroughness, which has given the results authority and trustworthiness. Methodologically, the present study moves beyond one-dimensional or purely economic measures, which are common in the Nepalese literature, to a multidimensional approach. The study provides an excellent framework for future studies to be produced utilizing standardized psychometric measures to assess well-being and social support in a specific local context, such as Lamki Chuha. This gives researchers a well-established methodological route to systematically study the psychological results in rural and semi-urban settings with quantitative analytical tools.

The research will give vital empirical information to help national policy makers to move from the existing exclusively income-focused social security (allowances) system towards holistic, psychosocial and dignity-oriented aging policies. It calls on the government to integrate mental health and social connectivity in the national health care agenda. The study will demonstrate the importance of community-based support systems for the community in general and Lamki Chuha in particular. The aim is to make local authorities and social workers aware of the need to organize inclusive social activities that will lessen the isolation of the older and foster intergenerational solidarity. The results at the individual level will show which form of support (emotional, functional, or perceived) has the most positive impact on life satisfaction. This will be understood by families and older people and will enhance attention to meaningful social bonds that improve functional autonomy and increase quality of life.

1.6 Limitations of the Study

It is important to understand a study's limitations to ensure its results are not misinterpreted. Setting boundaries clearly helps eliminate confusion and define the study's scope. This helps future scholars to identify gaps and broaden their theoretical

grasp of the subject. The study has its own limitations, such as its geographical coverage, which is limited solely to the Lamki Chuha municipality in Kailali district, Nepal.

Given Lamki Chuha's distinct social, economic, and cultural characteristics, these findings may not be directly transferable to other regions of Nepal or to urban and rural contexts in other countries. Nepal's cultural diversity may influence study outcomes, thereby limiting the generalizability of the results to different settings. Additionally, the interpretation and implications of these findings may vary depending on the nature of social support systems and their effects on subjective well-being across various cultural groups in Nepal.

A major concern is the limited sample size, which restricts the generalizability of the results to larger groups or at the national level. A larger sample size would have provided more reliable data for accurate, universal conclusions, thereby reducing the credibility of the study and the validity of the results. The methods of data collection and notably the structured interviews, might have biased the study to some extent due to the sensitive nature of the questions. The cross-sectional design of this study limits the capacity to determine causality, as it is a snapshot in time. To fully research changes in the well-being of the aged, longitudinal studies are required.

The exclusion of older folks in the designated Gaupalika zones by the Nepalese government and the exclusion of younger older people may limit the generalizability of the findings to the wider population. The current study provides insights into the well-being of older people in Lamki Chuha municipality, but it is important to acknowledge and address its shortcomings to increase its applicability and guide future research.

1.7 Definition of Key Terms

Satisfaction with life is a cognitive self-evaluation of a person's quality of life.

Subjective Well-being (SWB): Compared with objective indicators, self-reported well-being generally includes cognitive components of negative and positive affect, as well as life satisfaction.

Well-being: A successful and happy life of positive affect that includes comfort, happiness and health impacted by attitudes and experiences vital to overcoming challenges (negative affect) and the potential to acquire life achievements.

Functional social support is generally defined as the expectation that one's social network will provide critical resources, such as financial aid, emotional support, friendship, or information.

Physical health: This includes lifestyle choices that affect how well the body functions. What do they eat, and how active are older people?

Psychological health: This refers to how a person feels and thinks about themselves and their ability to cope with daily life. Researchers have classified it as either a positive emotion, such as happiness, or a negative emotion, as indicated by mental disorders, symptoms, and issues of support.

Sources of social support can come from different types, including families, friends, neighbors, and governmental and non-governmental organizations.

Structural social support refers to the quantity and variety of connections within a person's social network, including network size, housing type, and marital status.

1.8 Organization of the Study

This thesis comprises eight chapters that collectively examine the correlation between social support and subjective well-being in the elderly population. Chapter 1: Introduction, Background of the Study, Statement of the Problem, Aims of the Research, Research Questions, Significance of the Study, Theoretical Framework. Chapter II provides an extensive examination of the theoretical and empirical literature regarding social support and subjective well-being. It delineates the fundamental concepts and theories, prior research findings, and gaps in the existing literature, thereby substantiating the necessity for the current investigation.

The research methods employed are detailed in Chapter III. Concentrate on research design, study area, population and sample, sampling tactics, data collection methods, variable measurement, and data analysis techniques. Chapter IV delineates the demographic and socio-economic attributes of the respondents. This encompasses age, gender, marital status, education, occupation, income, and more pertinent background information.

Chapter V examines the nature, extent, and origins of social support accessible to the elderly, encompassing assistance from family, relatives, friends, neighbors, and community groups. Chapter VI examines the subjective well-being of the elderly and its relationship with different forms of social assistance. Chapter VII delineates the definition and evaluation of the factors of subjective well-being through statistical analysis and interpretation of the findings.

Chapter VIII concludes by summarizing the principal findings of the study, deriving conclusions from these findings, examining the policy and practical consequences, and offering recommendations for future research and interventions aimed at enhancing the well-being of older persons.

CHAPTER II

LITERATURE REVIEW

This section is a summary of the literature about the subjective well-being of older individuals and their social support networks. This part combines a conceptual review, a theoretical review, and an empirical evaluation centered on the subjective well-being of older individuals and their social support networks. The literature examining the factors challenging older well-being in developed and developing regions describes their emotional and psychological and social health needs in the conceptual review. This review uses a theoretical framework to examine how older people handle changes in their social positions and regulate their emotional states. The conceptual framework, based on available reviews, establishes how social support elements at different levels affect older people's subjective well-being.

2.1 Conceptual Review

2.1.1 Concept and Dimension of Social Support

Social support is the acknowledgment of an individual's worth, care, and integration within a network of mutual obligations. Social support encompasses the perception of being loved, cared for, respected, and valued by others, alongside belonging to a social network that promotes mutual aid and accountability. Social support is typically assessed through the composition of supportive networks or the services offered by network members. Certain researchers contend that social support functions as a means by which individuals interact to satisfy essential social needs, such as security, belonging, esteem, and approval (Thoits, 1986).

At least two people give each other resources as part of social support, and both people believe that the resources will help the other person's well-being. It may

originate from a partner, friends, family members, colleagues, social and community connections, and even beloved pets. People have used the idea of social support in many different ways. It can also be defined by the social support people receive and the social support they think they receive. "Perceived social support" means how much a person thinks they can get social support, while "received social support" means how much they actually use social support services (Allen et al., 2002).

The concept and practice of social aid is changing. In the 1980s, three main types of social support were identified: social integration, perceived social support and perceived support. There are four types of help: esteem support, informational support, social companionship support, and instrumental support. Four different types of support exist: quality of support, received support, emotional support, and structural support (Taylor, 2011). Social support networks provide many services, encompassing emotional, informational, and practical assistance. The goal of informational aid is to help someone deal with and understand tough situations. Instrumental support is tangible help, such as money or services. Showing someone you care and are concerned about them is a form of emotional support that lets them know they are important. Social support can also mean knowing that help is available when you need it, which makes you feel safe and at ease.

This form of social support illustrates the significance of interpersonal interactions within a social group. Numerous pre-industrial and industrial communities depended on family members to provide care for their older relatives. The term "family" frequently functions as a euphemism for women who primarily oversee the intimate dimensions of personal care and deliver long-term care (Walker et al., 1992).

Social support, especially from family, is very important for older people's health because it provides emotional, practical, and financial support. Different kinds

of social support can help older people in different ways. For example, family support can help with material needs, while friend support can make them feel better. Family members are the main source of material and instrumental help, and they are also very important for the older person's emotional health. A social portfolio comprises various activities and relationships with others. It helps people stay mentally healthy as they get older and build strong social networks (Wrzus et al., 2013).

Social support may originate from various sources, including family, friends, and professional networks. The effectiveness is frequently contingent upon the individual's requirements and desires (Southwick et al., 2017). Social support services are particularly vital for individuals navigating the move into adulthood, especially during the period known as emerging adulthood. The literature investigates the well-being of older persons and the impact of social support networks on their subjective well-being. The well-being of older individuals is influenced by their living environment, social companions, and personal circumstances.

Social support, which includes emotional, instrumental, informational, and evaluative aid, is crucial for mitigating stress and improving mental and physical health. This help is referred to as emotional, instrumental, informational, or appraisal support (House, 1983). Emotional assistance offers empathy and understanding, whereas instrumental support provides real help. Information assistance is information and guidance. Evaluation support is praise and criticism. The concept of social support and its comprehension have grown, and research has acknowledged its emotional, informational and practical dimensions (Jolly et al., 2021). Social support is a complex phenomenon that has garnered substantial interest in psychology and related fields because of its significant influence in an individual's general well-being and adaptation to different life circumstances.

Functional social support is the emotional and practical aid that benefits individuals' well-being (House, 1983). Emotional support may be characterized by empathy and compassion, and instrumental support by tangible aid, such as information or services (House et al., 1988). Structural support is the degree to which an individual is embedded in social surroundings, communal and individual interactions (Kawachi & Berkman, 2001). Berkman & Glass, 2000). According to Cohen et al. (1985), the measures are the amount and regularity of social contacts, participation in organizations and participation in networks. Functional support means the aspects that enable social relationships, such as giving emotional support and showing care. This support may be received or perceived, with perceived support showing a higher correlation with health outcomes (Uchino, 2004).

Social support comprises several components, with structural social support, also known as social integration, being particularly significant. Structural social support and social integration denote the size of an individual's social network and the extent of their engagement with others. This form of support is frequently conceptualized as a function of the number and intensity of interpersonal encounters (Hernandez et al., 2019). The structural component specifically refers to the objective characteristics of a person's social network, including its size, density, and interaction frequency (Webber et al., 2023).

Social support is a complex concept that helps meet basic needs and reduces stress (Cohen & Wills, 1985). Emotional support has been shown to improve both physical and mental health and offers protective benefits (Wethington & Kessler, 1986). Functional social support is important for well-being because it helps people manage stress and improve their health. This type of support means getting help from others that directly improves a person's well-being and ability to cope (Bedrov & Gable, 2023).

A third group of scientists has claimed that social support, as a multidimensional term, can work through both pathways. While most scholars have focused on the primary or buffering aspects of social support as a resource, this group contends that social support can also work through multiple pathways. Other theorists, however, have suggested that these two models are not antagonistic, but may explain how different aspects of social connection influence mental health, and how the direct or immersive effects of social support differ depending on the type of stress and support (Tham et al., 2024).

The present study investigates the complexity of social support, particularly the structural and functional aspects and their interplay in predicting individual resilience and mental health outcomes (Holz et al., 2023). Much research has found that functioning social support is related to better mental health (Barrera, 1986; Thoits, 2011 a). Functional support has been associated with resilience, which helps individuals cope with hardship and sustain mental health (Hobfoll, 2002).

Functional social support is complex and has extensive ramifications for an individual's psychological and physical health. The social subsystem of the family is believed to have the most significant influence on mental health and mental health problems. The family's obligations are supposed to assist in maintaining and promoting overall health, especially mental health.

2.1.2 Dimensions of Social Support and Health Outcomes

The physical and emotional well-being of an individual, particularly in later age, is associated with perceived support and social connections, two factors of social relationships. The correlation between social connections and felt support, alongside four health outcomes, mortality, functional status, self-assessed health, and depression, was examined utilizing data from four waves of a survey conducted among older

individuals in Taiwan. Research indicates that aspects of social interaction correlate with health; however, numerous impacts diminish when past health variables are accounted for. Favorable perceptions of support are psychologically beneficial and protective. In Taiwan, a minimal association exists between social support and health as individuals age (Comman et al., 2003).

Organized social support significantly impacts depression. An expansive social network is correlated with reduced depressive symptoms, somatic issues, and interpersonal difficulties. People with better structural social support have lower levels of depression and tend to develop depressed symptoms more slowly over time. This support also helps to prevent the onset of depressive symptoms and to manage symptom changes for those who are currently depressed (Cruwys et al., 2013). A strong association exists between the quality and availability of help, functional support, structural support, and drug use disorder, with differences by gender and sexual identity. Social support, including structural components such as social network composition and frequency of interaction, as well as functional components such as the quality of support, may act as a buffer against stress, and is associated with lower victimization and greater resilience to discrimination among sexual minorities. While the relationship between social support and drug use has been studied among teenage sexual minorities, its effect on substance use disorders in adult sexual minorities is still poorly understood (Rudzinski et al., 2017).

Functional social support affects physical health outcomes. Research reveals that those who have strong social networks had improved immune function, decreased risk of cardiovascular disease, and faster recovery from sickness (Shao et al., 2021). Research suggests that instrumental help can carry emotional weight, particularly in close relationships. But communicating with doctors is more about translating feelings.

While the impression and effectiveness of functional social support is subject to individual circumstances and environment, it is generally good. Support is not always understood the way it is offered, depending on what the recipient needs. Awareness of the two components of functional social support may improve the provision of help to address emotional and instrumental needs (Gottlieb & Bergen, 2010).

The study looks at how the health of older people is differently affected by contact with others. Health sciences theories support positive results, but empirical evidence may contradict them. The study analyzes the structural (interaction frequency) and functional (social support) aspects of the social ties of older people. The study focused on perceived social support and the frequency of relationships among Spanish people aged 62 and above to explain differences in health outcomes (Heinze et al., 2015). Studies also reveal that occasionally, when people accept help, they feel guilty or as if they owe somebody anything. This emotional strain may counteract the intended benefits of the support and so impact overall health results.

The study analyzes the association between social support and depression symptoms, in structural (social integration) and functional (emotional support) terms. The present study used structural equation modeling to investigate the longitudinal association between social support and depressed symptoms in the Northern Swedish Cohort. Results suggest that guys with depressed symptoms had higher levels of social support, especially functional support. But for women, the relationship is more complex, with effects going both ways. The research emphasizes the necessity of gender-sensitive therapy to improve social support, as depressive symptoms can interfere with women's ability to grow their social support network of people (Santini et al., 2015).

Networks' size and frequency have been associated with emotional and instrumental functions in social support studies with mixed impacts on health and subjective well-being (Cruwys et al., 2013; Shao et al., 2021). The probe was a mixed bag. Nevertheless, studies were showing adverse effects (Martire et al., 2002) and the Taiwanese respondents were scarcely affected. These aspects reveal sex discrepancies that complicate the research and a coherent theoretical model describing these differences is structurally missing which leads to the demand for stronger functional and structural integration.

The study examined differences in functional and structural social support among female and male veterans and civilians and the role of social support in health behaviors and outcomes. Previous research has revealed that veterans are less likely than civilians to get social assistance, but these findings are limited by methodological constraints. The study notes the role of sex in the differential social support between veterans and civilians, and the perception of this difference between men and women. The study points to the necessity for programs to provide social support to veterans and specifically female veterans who may need more help (Campbell et al., 2021).

Understanding the various effects of social support is important in order to find particular interventions to enhance networks and promote health resilience (Brannan et al., 2013). Standardized subjective well-being questionnaires allow reliable comparisons, but more research is needed to examine the impact of various types of assistance, particularly using longitudinal, cross-cultural, technological, and neurobiological studies within the older population. To improve the efficacy of the strategy to improve the quality of life, evaluation of the potential detrimental effects of support in the future is important. Social gatherings, mentorship programs, and training in communication and conflict resolution are among the most promising strategies to

help people feel they belong and are connected. In their prospective study in Alameda County, frequent formal and informal social encounters across 10 years were frequently related to healthier habits.

The standard methods by which social support influences diverse health outcomes, especially concerning physical and mental health, are predominantly similar. A considerable amount of empirical data supports the notion that deep and meaningful intimate relationships greatly influence human well-being, affecting both physical and mental well-being outcomes (Holt-Lunstad et al., 2015).

Recent studies indicate that belief in the availability of assistance from others for one's needs may alleviate psychological distress by reducing the duration of worry regarding personal issues and mitigating feelings of loneliness and distrust (Krause, 2005; Stansfeld et al., 2006). A person can learn rules about what is normal and what is not by comparing themselves to people in their reference groups who are like them. The research indicated that older individuals in supportive relationships exhibited lower levels of blood cholesterol and uric acid, along with elevated immune function indices, compared to those in less supportive partnerships. The molecular processes by which social support is predicted to affect physical health. Better physical health relates to better psychological well-being (Wang et al., 2020).

Health behaviors are generally characterized as social support pathways that first improve physical health and then promote improved mental health (Thoits, 2011 b), similar to biological pathways. One study examined the benefits of relational support on personal health. It differentiated between “OHI” (other-helper interactions) and “SHI” (significant-helper interactions). We found that engaging with less visible folks (Circle 3) affected OHI and SHI. Close links with key persons (Circle 1) were

highly associated with subjective health. This indicates the association between lack of social support and bad health outcomes as seen in previous studies (Okoye et al., 2022).

Interventions of medical and psychological support for older people mental health are intended to enhance their well-being through health and social programs (Holt-Lunstad et al., 2010). Information and engagement approaches provide some benefits, but the review does not demonstrate much evidence of effects from these programs since there is not enough proof that they function. Wang et al.'s (2020) work on biological pathways is still interesting, but the absence of intervention data, especially in a diverse setting such as Nepal, shows that applied research projects alone are insufficient.

The positive signs of mental health are harder to measure than the negative ones, which is why this study used the General Health Questionnaire to find people with poor mental health. (World Health Organization [WHO], 2013) lists demographics, social support, and stressful events among the epidemiological variables. The categories of social support, including structural (network size, contacts) and functional (emotional/instrumental assistance), have different effects on how people feel about their lives, depending on their demographics and experiences. Aspirations to comprehend the pathways of support influencing health outcomes (e.g., relative effects) are essential for interventions. This elucidates the significance of support in influencing health (Thoits, 2011 b).

The mechanisms that influence interpersonal interactions and social relationships remain inadequately understood, necessitating a theoretical framework (Feeney & Collins, 2015). Relational dynamics remain undefined; however, social support bolsters self-esteem, security, and a sense of belonging, thereby alleviating anxiety and sadness.

2.1.3 Dimensions of Subjective Well-Being

Subjective well-being derives from individual assessments of life, encompassing cognitive evaluations like life satisfaction and the presence of happy or negative emotions. People compare their lives or specific areas (e.g., work, health) with the ideals of a perfect life, with the researcher choosing the area and the relevant facts, not dictating them. Positive affect reflects attitudes towards the present and preferred life occurrences (Diener, 1984).

A crucial element of healthy aging is subjective well-being, defined as an individual's thorough and nuanced evaluation of life quality according to personal standards. According to Wilson et al. (2020), objective health alone cannot consistently forecast subjective well-being (SWB). Psychological well-being involves effective functioning; social well-being pertains to social functioning, and emotional well-being reflects an individual's subjective assessment of happiness. Well-being encompasses subthemes like life satisfaction, loneliness, and both positive and negative repercussions.

Community support is another component of the social support system that significantly influences the subjective well-being of older individuals. Perceived support denotes an individual's conviction that assistance and emotional backing from others are available when required. Research has found three forms of intergenerational support: financial, instrumental, and emotional. Intergenerational support refers to the familial social aid provided by adult offspring to their older parents. Optimism is a psychological characteristic defined by an individual's inclination to expect positive results in the face of adversity (Scheier & Carver, 1985).

Mental disorders, symptoms, and concerns often signify inadequate mental health and are utilized for its evaluation. Mental illnesses are acknowledged as clinically significant conditions characterized by alterations in thought, mood, or behavior associated with emotional distress and/or functional impairment (World Health Organization [WHO], 2022). Mental illnesses are conditions that deviate from the normative range psychologically, while psychiatrically, they are classified as abnormal or pathological phenomena. Researchers have conceptualized mental health in several ways. Concepts and viewpoints about mental health range between nations, cultures, social groupings, and genders owing to variations in value systems (WHO, 2022).

Mental health is positively seen as a personality trait encompassing psychological resources such as self-esteem, mastery, and resilience, defined as the capacity to withstand hardship. Positive emotions, including happiness, are seen as components of mental health (World Health Organization [WHO], 2013). The World Health Organization defines mental health as "a state of well-being in which an individual acknowledges their abilities, effectively manages the ordinary stresses of life, works productively, and contributes to their community." Zhang & Dong (2023) define SWB as an individual's comprehensive evaluation of their emotional and cognitive experiences concerning the quality of their life.

This research aims to investigate the impact of several factors mainly social support networks on subjective well-being and mental health of the older (Holt-Lunstad et al., 2010). Considering the specific psychological, social and physiological difficulties experienced by older people, it is necessary to measure the well-being of older individuals in an aging world population (World Health Organization [WHO], 2022). Subjective well-being of older people is sensitive to social, economic and health

conditions (Diener et al., 2018a). Well-being is influenced by housing, economic security, physical health, and social support systems (Ng et al., 2015). Social assistance is beneficial in reducing stress and increasing mental and physical health. Social support includes emotional, instrumental, informational, and evaluative aid.

The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, rather than merely the absence of disease or infirmity. This definition emphasizes holistic well-being, encompassing positive attributes in physical, mental, and social domains (Huber et al., 2011). Social support significantly influences both mental and physical health through various mechanisms. Numerous studies and theoretical frameworks have examined the effects of social support on overall well-being.

2.1.4 Life Satisfaction and Happiness

The word "life satisfaction" denotes a procedure wherein an individual assesses their degree of contentment against predetermined standards. Life satisfaction (LS) is a self-evaluation affected by factors like demography, socio-economic status, health, and social support. Life happiness is affected by various aspects, including health conditions, socioeconomic level, overall health, physical and mental wellness, social support and social adaptation. Life satisfaction is a crucial indicator of the pleasure of older folks and is intimately linked to their health.

Older individuals exhibit variability among themselves and in comparison to individuals of various age groups. Some individuals struggle with the aging process and long for their previous vitality, whereas others derive joy and satisfaction throughout their later years. A higher level of life satisfaction indicates their subjective well-being, which is associated with their health and mortality rates. Older persons in poor health

generally demonstrate reduced life satisfaction. Socioeconomic position, familial support, satisfaction with living conditions, and the ability to mature are all significant factors (Freund & Riediger, 2003).

Research suggests that several characteristics, such as race, marital status, education, self-esteem, and depression, may affect an individual's linguistic ability. Demographic factors, particularly advanced age, exert a more pronounced influence on the LS in females than in males. Prior research indicates a positive correlation between life satisfaction and both gender and age. Fluctuations in life satisfaction correlate with the progression of physical health alterations. Alterations in marital status and social engagements are correlated with the trajectory of life satisfaction, but recent widowhood is associated with morale. Individuals in formal marriages have greater life satisfaction compared to those in alternative relationship styles (Schoenborn, 2004). Socioeconomic status, including income and educational attainment, has a minimal impact on life satisfaction.

Eating, moving, dressing, washing, and using the restroom are all physical activities positively associated with learning difficulties. Certain investigations, however, have not demonstrated a conclusive association between LS and physical handicap. A survey by the Gallup organization, conducted in 132 nations, provides additional evidence that the health and longevity of older persons improve with age and the level of disability. This study demonstrates that established and emerging nations are distinct from one another. In economically disadvantaged, less developed nations, life satisfaction diminishes more significantly with age and infirmity (Deaton, 2008).

Older persons demonstrate increased apprehension regarding their health and long-term care as a result of inadequate work performance and financial insecurity. The World Health Organization asserts that four factors substantially affect an aged person's

quality of life: environment, social connections, and mental and physical health. Individuals with significant social support exhibit less stress and sadness, enhanced self-esteem, and increased life satisfaction (Cohen & Wills, 1985). Studies demonstrate that social support aids individuals in confronting obstacles and adjusting to new situations. Research indicates that social support, akin to hope, might enhance individuals' quality of life and assist in managing disease. Various forms of assistance can yield diverse benefits on well-being, contingent upon factors such as their quality, fairness, and righteousness.

Age, particularly in women, significantly influences life satisfaction (LS). Race/ethnicity, marital status, education, self-esteem, and depression are also influential factors. Positive marriages enhance life satisfaction, whereas poor health or physical disabilities diminish it. Research indicates that older individuals in high-income nations exhibit more life satisfaction than their counterparts in low-income nations. Australian research identified social characteristics, health, life stability, housing, acceptance, and adaptation as determinants of life satisfaction in older individuals (Pearson et al., 2012).

The synthesis delineates factors influencing subjective well-being and life satisfaction, including enduring health attributes, marital status, and economic indicators (Deaton, 2008; Schoenborn, 2004). The little influence of socio-economic position contrasts with worldwide variations in life satisfaction (Deaton, 2008), indicating that specific environments determine outcomes (Freund & Riediger, 2003). The ambiguous relationship between physical limitations offers a chance for deeper investigation into the differing evaluations of life satisfaction compared to health deterioration, requiring more comprehensive analysis. It significantly influences general health and cognitive decision-making abilities. Furthermore, research suggests that a person's housing situation does not influence their life satisfaction levels. The

majority of research analyzed daily tasks and activities as indices of the health status of older individuals with life satisfaction.

Life enjoyment was defined as the main measure of success. Life enjoyment was found to be a significant predictor of success motivation (Karaman & Watson, 2017). But being alone might detract from the joys of life. Older persons need to be able to communicate with people, need the support of families and flexibility. Physical health, marital status, career satisfaction, neighborhood relationships, economic status, familial relationships, friendships, and overall satisfaction with various life domains are some of the factors that can increase life satisfaction among the older (Han & Hong, 2011). In conclusion, the best physical condition, stable economic situations, and strong social and family relationships are important for increasing life enjoyment, especially for older people.

The quality of life in old age is associated with the influence of health, psychological, social factors and environmental situations on the general assessments of life quality of a person (Bowling et al., 2002). The main independent predictors of self-perceived general quality of life were social assessment and expectations, personality and psychological factors, health and functional status, and personal and neighborhood social capital.

2.1.5 Emotional Stability and Self-Reported Happiness

Subjective well-being is an important facet of emotional stability, which describes the ability of an individual to balance and withstand stressful experiences in life. The older people who are highly emotionally stable are less prone to anxiety, sadness, and mood swings. Theoretically, emotional stability fits the low aspect of personality trait neuroticism; the greater stability, the lower the negative emotions and adjustment to

change (John, 1999). Empirical research shows that more emotionally stable older people are said to express more life satisfaction and fewer depressive symptoms, even considering the physical health differences (Schimmack & Diener, 2003). Adaptive coping, enhanced self-esteem, and superior quality of social relationships are associated with emotional stability, resulting in more favorable well-being outcomes in later life (Siegler et al., 2011).

Self-reported happiness is a self-judgment of one's positive emotional experiences and satisfaction. A person's level of happiness depends on his or her cognitive self-evaluation (Diener et al., 1998). It is a level of subjective well-being which is the affective one and that is a complement to life satisfaction and low negative affect (Diener, 1984). A study by researchers has shown that older people who report being happier are physically healthier, exhibit stronger social ties, and are more resilient to stress (Diener et al., 1999).

Longitudinal data also indicate that greater amounts of self-reported happiness are additionally associated with more advantageous age processes, such as reduced risk of depressive symptoms and better longevity (Stephoe et al., 2015). These supportive social networks, meaningful relationships and useful coping resources reinforce both emotional stability and self-reported happiness and suggest the interplay between internal psychological factors and external social supports in determining subjective well-being later in life.

2.1.6 Social Isolation, Loneliness, and Subjective Well-Being of Older People

Current theories of 'successful aging' suggest that participation in social and productive activities is crucial to the health of older people (Kahana et al., 2003). Social involvement encompasses personal relationships, community relationships and social

activity. Interpersonal interactions provide opportunities for reciprocal exchange, social support, and to feel relevant or worthwhile. Community participation helps create a sense of attachment and involvement in society, providing opportunities for contribution and intellectual development. Recently, the term social capital has been used in discussions of social commitment and mainly refers to the resources to which individuals and groups have access through their social ties and communities (Cannuscio et al., 2003).

Social isolation and loneliness are distinct concepts that are partly correlated but not directly connected. The magnitude of an individual's social network, along with the presence and interrelations of diverse social supports, serves as a quantifiable marker of social isolation. Loneliness is an emotional state characterized by a perceived lack of connection and social support. Providing emotional, practical, or informational resources to help a person manage anxiety and life events is known as social support and is linked to social connectedness (Cohen, 2004).

Prior studies have indicated that loneliness and social isolation may forecast depressive symptoms, along with health and cognitive functioning. Due to declining physical health, the loss of spouses and companions, an increased likelihood of living alone, and a reduction in intimate interactions, older people are especially susceptible to loneliness and social isolation (Victor & Bowling, 2012). This study provided a unique opportunity to investigate the relationships among different aspects of social contact and their association with health outcomes in a large and diverse sample of community-dwelling older people living alone. The association between living alone and these elements is complex, though it is linked to higher rates of loneliness and isolation. We cannot assume that people who live alone are lonely or lacking social support, as mentioned (Perissinotto et al., 2012).

Recent studies have demonstrated associations between depressive disorders, cardiovascular disease, quality of life, general health, biochemical health markers, cognitive function, and mortality with loneliness and social isolation (Courtin & Knapp, 2017). Social isolation and loneliness are now widely recognized as significant health concerns among older adults. This population is particularly susceptible to these conditions due to life changes, including retirement, bereavement, economic challenges, declining health, and reduced mobility. Current estimates suggest that more than 50% of community-dwelling adults aged 65 and older experience loneliness, with one in four older individuals affected (Cudjoe et al., 2020).

Social isolation and loneliness in older people highlight the increasing concerns surrounding these issues. Research indicates that loneliness and social isolation exert an impact on health outcomes comparable to other established risk factors such as smoking and obesity (Donovan & Blazer, 2020). Social interaction is vital for the quality of life in older people as it offers social support and a feeling of purpose. Social isolation and loneliness significantly impact mental and physical health, especially in older people (Unsar et al., 2016). The aging population will be a challenge for a period, alongside other demographic shifts, including changes in family structures and regional family dispersal. This is particularly significant in the context of the COVID-19 pandemic, as the necessity for social distancing restricts opportunities for social engagement, networking, and assistance. A multitude of research have investigated the potential effects of community boundaries on mental health and well-being (Armitage & Nellums, 2020).

A negative view of subjective well-being has been associated with bereavement, physical decline, misrepresented sexuality, deterioration, illness, dependency, and loneliness (Gewirtz-Meydan & Ayalon, 2017). This theme integrates research

demonstrating, with solid evidence (Courtin & Knapp, 2017), how social separation and loneliness negatively affect older SWB and their health status. The review demonstrates the complicated nature of living alone but fails to provide evidence about interventions that address these challenges, as reported by Perissinotto et al. (2012) and Armitage and Nellums (2020). Experimental research appears deficient because studies rely primarily on observational data to address these ongoing, widespread challenges.

Although families are preferable to orphanages for older children, this is not always true. Many individuals live alone. Living alone, with little money and minimal domestic requirements. Alternatively, family members may live separately while establishing their own houses. Social sensitivity from the community and family is essential for providing care, protection, and attention to older people (Farriol-Baroni, V. et al., 2021). The theme examines feelings of loneliness and isolation, which deepened as they researched residential situations. The research highlights family support as the preferred way to improve SWB, yet it also reveals the lack of solutions to make this approach accessible to individuals living as single members of households.

We also examined the impact of social isolation and loneliness on mental and cognitive outcomes separately, as the predictors may vary. In the investigation of health outcomes among the older, it is crucial to distinguish between social isolation and loneliness, as they are separate constructs with varying impacts on health metrics (Coyle & Dugan, 2012). The mechanisms via which social isolation and loneliness impact health remain unclear; yet, they are believed to influence health behaviors, sleep patterns, overall weariness, and social connection (Courtin & Knapp, 2017).

Understanding these distinct properties is crucial to the development of successful intervention programs. It was hypothesized that the more social support a person receives, the less often he or she will suffer from loneliness (Tiikkainen &

Heikkinen, 2005). Due to the various ways of measuring these dimensions, findings related to the incidence of social isolation, loneliness and social support in the older and associations of these parameters with health and well-being outcomes are diverse. There has been little research that synthesizes these components into a single analysis. Although there is a substantial body of literature regarding the correlation between social isolation, loneliness, and health outcomes, there is a paucity of information on effective interventions to mitigate existing issues of social isolation and loneliness and to avert future occurrences among vulnerable populations.

The differential vulnerability theory posits that women may exhibit more psychological responsiveness to social support due to their relationship-oriented nature and higher engagement in diverse forms of help compared to men (Uchino et al., 1996). This validates the theoretical perspective that social support from intimate relationships is essential for subjective well-being, especially for males (Stronge & Sibley, 2019).

2.1.7 Intergenerational Support and Older People's Well-Being

The aging process is linked to several aspects, including one's health, financial independence, expectations for one's function in the family, and respect for older people. The research on the quality of life of older people in the twenty-first century concentrates on three elements: social support, subjective well-being (SWB), and loneliness. Various theoretical viewpoints and studies to date suggest that receiving intergenerational support may alter outcomes related to elders' well-being (Choi et al., 2020). As a result, earlier studies have examined how optimism and social support affect health outcomes across a range of populations (Fitzpatrick, 2017).

The life course viewpoint stresses the interplay of familial relationships and professional standing and the significance of family as a social support system for the

older. Families are the most important sources of social support for older patients, and they have a great impact on their hospitalization and rehabilitation process. The older rely on family members to help them with their regular routines and to assist them when they are ill or in need. Spouses and children are the largest source of informal help and together account more than 70 percent of all support received. Family members provide four sorts of social support: instrumental (homework, personal care), emotional (listening, comfort), informational (advice, recommendations), and financial/housing aid (Wang, 2007).

Many studies show that the effect of familial support is more than friendship support in reducing negative effects among the older. Lower perceived family support was associated with increased negative affect and loneliness, whereas levels of friend support or objective network embedment were unrelated to bad affect (Walen & Lachman, 2000). It has been seen that as cultures evolve, extended families diminish and nuclear families expand. Kane and Kane (2001) found that countries with higher levels of educational attainment tend to have a higher level of internal migration and larger government-funded health and Social Security systems for the older.

The present study examines the impact of social support from family members on loneliness among older persons. Loneliness and its importance in the population of older people are the focus of the study. According to the declaration, loneliness might result in mental and physical health problems that might contribute to mental illnesses and a reduced quality of life (Syaharuddin et al., 2023). The study was undertaken on a quantitative basis to investigate the association of familial support and loneliness in older people. Older persons' sense of contentment with themselves is greatly influenced by support from the family. One study shows that even in the midst of physical ailment, optimism helps social support and results in people (Karademas, 2006).

The study also examined how increasing geographic mobility, greater racial and cultural diversity, evolving immigration patterns, and changing roles at home and work affect family life. Antonucci and Akiyama (1987) contended that the relationship between older family members and their offspring positively influences their life happiness. Family members provide affection, care, comfort, and support, which promotes the senior's well-being.

Glaser and colleagues discovered that, in contrast to individuals in a current relationship, older divorced or separated parents (aged 70 and above) in the UK were more inclined to get support from their offspring (Glaser et al., 2008). Trends in family behavior and job patterns, such as increases in divorce and early retirement from the workforce, may have weakened older people's social support networks and, consequently, their well-being. Like other developed nations, Britain has recently seen significant changes in family structure and relationships. These alterations imply that older people today have more diverse family networks than older people in past generations. Given these tendencies, researchers have started to concentrate on the connection between disruption in significant life events and the relationship between family disorders due to divorce, separation, death, or remarriage and support in later life (Mao & Han, 2018). Assistance from family members, particularly adult offspring, exerts a more significant influence on health-promoting behaviors and favorable aging outcomes than help from friends or neighbors (Wu & Sheng, 2019).

Research suggests that intergenerational support, particularly material and financial support, may have negative effects on the well-being of older people by generating familial stress and developing individual dependency as a result of the redistribution of scarce resources (Katz & Lowenstein, 2012). This is true even though most older people in poor nations experience a shrinking social network as they age and

an increasing dependence on family and especially children, for care and support. Such results highlight the importance of intergenerational assistance for the improvement of subjective well-being in later life. It also emphasizes that reciprocities with other family members, especially receiving help or care from adult offspring, have a positive cross-modal influence on the older person's subjective life level (Lowenstein et al., 2007). Analysis remains inconclusive about parental financial and time-linked support for their adult offspring because researchers have studied this topic less frequently and some studies indicate that divorce avoidance has a negative connection to these transfers. The Critical Synthesis section integrates key findings on the family's essential role in supporting aging adults by examining interfamily relationships.

Family systems provide the majority of instrumental and emotional assistance to older people, as supported by Wang (2007), but analytical research shows systematic conflicts, including financial dependency risks (Katz & Lowenstein, 2012) and inconsistent post-divorce support patterns (Glaser et al., 2008). Research indicates that family remains the primary support system in developing areas (Kane & Kane, 2001), but developed societies face changing family patterns that call for time-based studies about SWB evolution.

However, various studies have been unable to establish a link between intergenerational support and outcomes related to older people's well-being (Krzeczkowska et al., 2021). In their study, 'Family and Friends: Social connectivity among elders from a cross-cultural perspective,' there is inconsistent empirical research about the effects on elders' well-being and the amount of intergenerational care they receive. The study indicated that older parents receiving intergenerational assistance from their adult offspring exhibited enhanced health-related outcomes (Nguyen, 2020).

Research indicates that older parents receiving financial, instrumental, and emotional assistance from adult children may enhance health-related outcomes.

Consequently, specific family climate variables possess an etiological function. These include unhealthy and disruptive ways of talking to each other, a lack of family support and togetherness, and toxic relationships between family members, all of which make it hard to meet physical, emotional, security, and social needs. Older individuals select their chosen assisted living facility due to a diminished sense of social identity and feelings of loneliness. Typically, they must relocate to an assisted living facility (Gabriel & Bowling, 2004). Familial connections significantly influence the health of older individuals and deteriorating relationships, potentially resulting in institutionalization or isolation.

It is important to understand how intergenerational family structures have evolved and how they interrelate, especially in situations where government resources are limited. This knowledge can enhance the efficiency of both formal and informal support networks of needy individuals. Governments, non-governmental organizations, and families must participate in fostering healthy aging by enhancing the well-being of older individuals (Michel & Sadana, 2017). Previous studies have found the Social Support Rating Scale to be widely applicable for measuring social support. Nevertheless, with the transformation of society and the economy, the dimensions of social support have become more complex and difficult to measure (David M. Frost et al., 2020). These concerns point to a gap in the current research on how to adjust social support measuring instruments to evolving social situations.

Even though having a family is better than living in an orphanage, many older people live alone due to a lack of support, economic constraints, or family connections in other households (Carr & Utz, 2020). Caregiving needs to be supported, safeguarded,

and taken care of by communities and families, though changes in family relationships and finances may strain caregiving. Gender, marital status, finances, and health moderate social support-well-being relationships, highlighting the necessity to have a continuous subjective well-being scale and a critical analysis of other systems. The well-being of older individuals is affected by economic, cultural, and personal aspects; enhancements in these areas correlate with greater health and contentment. Emotional support and education are crucial for mental well-being and contentment.

Ironic outcomes between intergenerational support and health outcomes should be investigated through research on psychosocial mediators, such as optimism, particularly sex differences (S. Li et al., 2009). To my knowledge, research has not examined the mediating role of optimism in the sex-moderated effects of received intergenerational support on subjective well-being. While older individuals' subjective well-being has garnered support, investigations into putative intermediary mechanisms elucidating this relationship have been markedly less thorough (C. Peng et al., 2019). It is currently unknown whether this mediation effect holds for older people (Kestler-Peleg & Lavenda, 2021). This work uses multiple measures of well-being.

2. 2 Theoretical Foundation

2.2. 1 Direct Effect and Stress Buffering Models

Previous studies questioned the advantageous effects of social support, with the direct effects hypothesis asserting that it enhances mental and physical health during and following stressful situations. Social integration assessments frequently demonstrate direct correlations with mental and physical health, although they lack buffering effects (Thoits, 1986). The "primary effect model," also known as the "direct model," posits that social support is advantageous to health and consistently exists, irrespective of an individual's exposure to stressful situations. This hypothesis posits that social support

might mitigate adverse health problems for individuals. It will positively impact an individual's psychological well-being. Support is seen as a fundamental human necessity, and studies indicate that those with substantial social support exhibit superior mental health compared to those with minimal social support (Lakey & Orehek, 2011).

Research on both types of effects was uncovered after centuries of inquiry. The majority of the study has concentrated on two principal hypotheses on the impact of social support on mental health: the "primary effect" and the "stress buffering effect." Two principal ideas were posited: the primary effect, which posits that social support solely enhances health, and the stress-buffering effect, which contends that social support mitigates the adverse effects of stress on health.

The buffering hypothesis posits that social support is most efficacious during periods of acute stress, serving as a mitigative factor to reduce stress-related consequences. The "stress-buffering paradigm" asserts that social support alleviates the impact of stress and the physiological responses they elicit. The buffering effect occurs exclusively when an individual faces a stressful event, and it is further suggested that social support has no impact on health without the presence of stress (Taylor et al., 2003).

Social support may influence two points along the continuum, from stressors to depression. Initially, encountering a stressful event, the feeling of social support may foster less perilous interpretations of the circumstance, rendering it more bearable. Consequently, numerous studies concentrated on the efficacy rather than the fundamental effects of social support. Although less reliable than studies on the direct impacts of social support, fresh findings about the buffering effect hypothesis have emerged in the literature (Thoits, 2011a; Lakey & Orehek, 2011).

Conversely, subjective well-being and social support. Social support theories indicate that it can enhance psychological well-being. The Stress Buffering Hypothesis posits that social support enhances an individual's well-being by mitigating the adverse effects of stress (Cohen & Wills, 1985). Furthermore, there exists a notion concerning the impact of social support on mental health. The social capital idea posits that an individual's network of relationships serves as a resource that fulfills their wants and empirically hinders their enjoyment. Secondly, perceived or actual support following a stressful encounter may mitigate the adverse emotional responses to the event or the physiological and behavioral reactions to stress. Nevertheless, no model can elucidate the mechanisms by which social support affects health, despite much evidence about this issue, particularly in Western nations (Thoits, 2011).

Researchers proposed two primary hypotheses of stress reduction: the stress-buffering effect, which illustrates how social support mitigates the adverse health effects of stress. Scholars persist in their discourse over the methodologies for examining social support and mental health, as previously said. Numerous scientists recognize considerable ambiguity regarding the particular underlying process that dictates these events (Ibarra-Rovillard & Kuiper, 2011). Consequently, researchers have observed that the relationship between social support and mental health remains ambiguous for study. Nonetheless, the specific processes or mechanisms involved remain ambiguous.

Robust evidence indicates that dynamic psychological qualities correlate with long-term survival. Multidisciplinary research demonstrates that subjective well-being influences longevity and mortality across various populations. Research increasingly substantiates the assertion that enhanced life satisfaction and psychological resilience

correlate with a diminished risk of chronic illness, cognitive decline, and premature death (Fancourt & Steptoe, 2024).

Furthermore, social support has continuously demonstrated its significance as a health consequence. Prior studies indicate that social networks mitigate the negative impacts of stress and decrease morbidity and death (House et al., 1988). Recent meta-analyses indicate that individuals with robust social links are 50 percent more likely to survive compared to those with weaker connections (Holt-Lunstad et al., 2010). Social support operates through multiple channels: it enhances coping strategies and pleasant emotions, while reducing the physiological strain induced by chronic stress (Thoits, 2011b).

Therefore, the psychological well-being and social support frameworks need to be integrated in the theoretical context of aging and health. The role of personal resources and community-based support systems is vital in reducing stress and impacting functional health, quality of life, and longevity. In this sense, aging is an environment and biologically based phenomenon, strongly affected by psychosocial factors and social capital.

2.2.2 Socio-Emotional Selectivity Theory

The socio-emotional selectivity theory (SST) is widely used in several studies to investigate the social and emotional processes of an individual in different circumstances and stages of life. In this view, the quality-of-life goals for older people are social interactions and emotional well-being, not other domains. The primary claim of SST is that as people age, they become less preoccupied with the past and more preoccupied with the present. This shift of viewpoint is motivated by the understanding of the importance of time and the need to make the best use of it. Consequently, older

individuals are more inclined to prioritize their social and emotional connections over the pursuit of novel information and experiences (Bal et al., 2013).

Therefore, SST affects social relationships, personality development, health, and so forth. This idea is that, unlike younger people who are more concerned with novelty, older people value their social networks and psychological well-being, and hence are less likely to engage in health-risking behaviors (Choi, 2019).

2.2.3 Social Capital Theory

The social capital theory states that a person's networks of relationships are resources that support their needs and enhance wellbeing, yet empirical evidence suggests negative outcomes. It has been suggested that functional elements of social relationships, like emotional support, function through the stress-buffering mechanism by improving an individual's coping strategies, whereas structural elements, such as social networks, may operate through the main effect mechanism (Leung et al., 2007).

The precise mechanisms by which these alliances function remain unclear. Feeney and Collins (2015) proposed a theoretical framework indicating that social support enhances self-esteem, which correlates with reduced anxiety and depression. Moreover, social support is thought to enhance an individual's sense of self-worth, security, and belonging (Thoits, 2011a).

Optimism and self-esteem in coping with major stressful events are linked to perceptions of control over life, which in turn relate to levels of anxiety and pessimism (Taylor & Stanton, 2007). The fact that social support enhances outcomes led to a more positive strain of anxiety, consistent with the hypothesis that social support also increases scores on comprehensibility, meaningfulness, and coherence (Thoits, 2011b). Social support influences an individual's health behavior mainly via two mechanisms:

"social comparison" and "social control" (Thoits, 2011a). According to social-cognitive theory, personal expectations, including optimism, significantly influence human behavior, goals, and functioning. Researchers have observed that effective stress management techniques and self-assurance correlate with less anxiety and depression, whereas social support fosters a sense of meaningful structure. Therefore, available social support aids in battling mental health issues thanks to its power to boost the longing for self-nurturing, besides managing older stress-causing physiological alterations.

Subjective well-being and its dependence on individual development are studied across the lifespan, from infancy to late adulthood (Lansford, 2018). Positive mental health is valuable and can be viewed as a resource for health (Prati & Pietrantonio, 2010). Conversely, mental health has also been adversely affected, with investigations often focusing on detrimental psychological adjustment indicators such as burnout, depression, anxiety, and negative affect (Koutsimani et al., 2019). Research has increasingly focused on positive indices of mental health rather than negative ones ((World Health Organization [WHO], 2001). Furthermore, one hypothesis concerning the impact of social support on mental health posits that it functions as a stress mitigator; correlations may be more relevant to adverse rather than beneficial factors. Mental anguish is a complex construct arising from the intricate interplay of several socio-demographic, clinical, and psychosocial risk factors (Couture et al., 2005).

2.2.4 Social Convey Model

The social convoy model is a theoretical framework that examines the nature of relationships and how they impact an individual's health and well-being over the course of their lifetime. According to this definition, a convoy is a close-knit group of friends

and/or family members who offer a specific person valuable connections and resources in their personal life as well as across family, culture, and employment.

In the same way, the theory also presupposes that older people are rather limited in their choice of social contacts and are likely to be engaged only in those social activities that they are particularly fond of or that are important to them for providing emotional support and giving their lives some purpose.

2.3 Empirical Review

International Evidence

2.3.1 Social Support and Subjective Well-Being in the Context of Population

Ageing

Additional study is required to clarify the distinct effects of various forms of social support on subjective well-being, the long-term consequences of social support, and cross-cultural. Prior research has shown that those with greater social support are generally more likely to report higher levels of subjective well-being. They report greater life satisfaction and display more positive than negative emotions (Siedlecki et al., 2014). Research of older people in Iran indicated that significant social support can boost a person's happiness, self-confidence, self-disclosures and self-esteem. This will assist the person to get what they want and be content with their life and thus be happy. Good health and strong social support allow older people to be more productive and indicate that they are valuable members of society (Levasseur et al., 2015).

Research indicates that social support positively influences the immune system, cardiovascular health, cognitive function, and the overall well-being of older people, making it vital to their health. The two things that can make an older person happier are how much school they have and how much emotional support they get. Social support

is important for mental health and may also help relieve stress. Various types of social support have been associated with a reduced likelihood of developing physical frailty in older people, highlighting the positive impact of social support on health (Zhang & Dong, 2023). Studies indicate that the belief in the availability of assistance from others when needed can positively impact emotional and physical health. Many researchers have found a connection between general well-being and the feeling of having social support. Perceived support is positively correlated with health outcomes (Kafetsios & Sideridis, 2006).

A recent study indicates that the frequency of survey response calls may influence the population estimate of subjective well-being (SWB), revealing gender- and age-group differences. Women who were hard to reach reported lower happiness than women who were easy to reach, while men who were hard to reach reported a slight increase in happiness (Heffetz & Rabin, 2013).

Social support, encompassing social engagement and caregiving, is universally recognized as a crucial component of quality of life for older individuals. Research has shown that social engagement with family and friends is one of the strongest determinants of quality of life in later adulthood (Bowling et al., 2002). A wide number of studies revealed that social support from friends, relatives and colleagues greatly boosts the subjective well-being of older individuals (Ham & Kim, 2021). It has been proven that community activities such as volunteering and social activities can improve the overall subjective well-being of older people (Ding et al., 2022). They provide the individual with a continual social link, a purpose in life and the sensation of being respected by society.

The research shows that social support improves subjective well-being by offering benefits across emotional, cognitive, and physical dimensions. A substantial

body of research (Siedlecki et al., 2014; Zhang & Dong, 2023) substantiates this argument; however, the primary data source, correlation, necessitates caution in inferring causal relationships. Kafetsios and Sideridis (2006) conducted a study that underscores the difference between perceived and actual support. However, it does not consider the positive and negative effects, as well as the cultural context, on subjective well-being (SWB). The analysis indicates a need to expand the understanding of social support dynamics on overall subjective well-being.

The world's population is getting older because the number and percentage of old people in almost all countries are still going up (Shetty, 2012). In many rich countries, the older process started more than a hundred years ago and continued into the 20th century. However, it really took off in most developing countries in the 21st century (Sudharsanan et al., 2018).

A significant transformation in society in the twenty-first century is anticipated to be the demographic shift. This will affect nearly every aspect of society, encompassing labour and financial markets, the demand for goods and services such as housing, transportation, and social protection, along with family structures and intergenerational relationships. To ensure development continues, we need to prepare for the economic and social changes that come with an aging population. This is especially true for the Sustainable Development Goals (SDGs), which include ending poverty, promoting health, gender equality, employment, and sustainable human settlements, as well as lowering inequality within and between countries (Wilmoth et al., 2023).

The percentage of Asian national populations aged 65 and beyond is anticipated to increase significantly during the next 50 years. Southeast Asia is commencing the acceleration of the population ageing process, but it is already much more advanced in

East Asia, where economies are more developed. The rise in the proportion of older individuals highlights apprehensions that shifts in family structures would result in diminished assistance for the aged (Beard & Kunharibowo, 2001).

Population ageing has presented significant social and economic issues in both developed and developing nations. This alteration is attributable to an enhanced quality of life and an extended lifespan. In the last ten years, there have been more older people than children and adults. This means that the population has changed. Many older people prefer to stay with their families rather than move to an orphanage for psychological reasons. They are concerned about leaving their long-time home with memories and may have difficulty transitioning to a new area with different values (Ham & Kim, 2021).

Old age is the last stage of life that begins at different ages, defines people's roles in society and has diverse meanings in different cultures and social structures. Demographics, economy, social norms and culture all have an impact on the lives of older people. In industrialized countries, the population of older people has increased enormously due to a drop in deaths and births. Average life span has increased, but maximum life span has remained about the same. The older population varies significantly across countries (Marques et al., 2015). The presence of relatives affects the type of help a family can give and get from others. Different cultures and countries have different ways of living together as a family. The global trend of population growth is expected to persist, creating the challenge of how families can meet the needs of older members while adhering to cultural norms. As families around the world become more diverse, people, families, and communities will need to develop local solutions (Johnson & Climo, 2000).

The subject highlights the impact of population ageing on many societal sectors and global development objectives (United Nations [UN] 2019). The synthesis indicates that the global population of older individuals is increasing; however, it does not elucidate how this expansion differentially impacts subjective well-being across various cultures and nations. The focus on SDGs provides policy direction, but the lack of real-world well-being data makes in-depth analysis difficult and reveals weak links between population statistics and how people feel about them.

However, there are considerable gaps in understanding the influence of social support on individual subjective well-being across different demographic groups (Uchino, 2004). Future research should study these relationships, supporting categories, longitudinal implications, and cultural differences to develop tailored interventions to improve older people's well-being (Holt-Lunstad et al., 2015).

We collected demographic, stressor, and social support data using standardized measures to allow for comparability and methodological flexibility. According to Carr and Utz (2011), the higher the pleasurable social contacts, the higher the happiness. Being more connected has been found to have a protective effect. Moreover, social participation and maintenance of interpersonal ties are associated with increased life satisfaction in later life, emphasizing the importance of social activities for well-being (San Román et al., 2017). Therefore, poor social relationships contribute to improving the well-being of older people by means of the ability to have positive interactions (Bar-Tur, 2021).

The support and involvement of the community improved older people's happiness and satisfaction of life. Similarly, older persons' subjective well-being must take into account the amount of social support they receive, which highlights the fact that perceived support may be a better predictor of well-being than actual assistance

(Kaniasty, 2012). Social ties such as intimacy and sense of belonging are one of the basic needs for human existence. Subjective well-being (SWB) was shown to be more common in older people. A unique correlational study on social support and quality of life (Helgeson, 2003) found that some aspects of social interactions need to be studied to find out how different types of support can affect quality of life, especially in the later stages of life. In addition, social ties are important for health (Steptoe, Shankar, & Demakakos, et al., 2013). Older people with robust social support networks, including family and friends, report higher levels of happiness and life satisfaction. Socioeconomic status, demography, social affiliation, and occupation are some of the elements that may characterize a person's network (Sarla et al., 2020).

An isolated person reported lower enjoyment than a person with social contacts (Sarla et al., 2020). Destructive relationships can significantly affect the well-being and happiness of older people. Being socially connected can change how older people see their life and what they value. Positive and negative social relationships affect well-being through social support and social participation (Tang et al., 2019). This highlights the need to prioritize the enhancement of the growth and well-being of older persons, rather than merely focusing on pathological diseases.

Thus, the importance of social support and socio-emotional relationships is highlighted as it is vital for the well-being of older Americans to participate in personally meaningful activities, as suggested by Tang et al. (2019). Rafnsson et al. (2020) argue that the lack of social relationships results in fewer social contacts, less cognitive stimulation, a higher risk of cognitive decline and less overall well-being. Also, McNeil et al. (2022) emphasize the importance of social connection, and conclude that nature-based exercise (NBE) could perhaps enhance subjective well-being through the mediating role of social connectivity, but that nature connection did not show

evident individual impacts. Natural touch and social connection both were beneficial but this study indicated social connection impacted subjective well-being more than natural touch (McNeil et al., 2022).

Social contacts help older people when they experience social network loss or social network grief (e.g., family member or friend) or natural disasters like COVID-19, or emotional and interpersonal issues (Van Orden et al., 2020; Sarla et al., 2020).

One of the common criticisms against social support studies is the lack of consensus among these studies. (Williams et al., 2004) The first three categories were found not to influence the results of the research. These effects of social support on subjective well-being are significantly modified by the group of respondents. The finding reflects a significant difference between the older and disabled groups, suggesting that psychological differences between these groups could lead to group differences. Based on the research, there is a possibility that social skills, personal identity development and self-esteem can mediate the relationship between social support and subjective well-being (Farriol-Baroni et al., 2021). A significant analytical limitation of considering the effects of participant variation on subjective well-being outcomes is identified here.

The impacts of social connection on a host of health and well-being markers appear to be context-dependent with respect to the type of social interaction and the quality of the relationship and this warrants additional exploration. How we see ourselves is very much tied to age and health. The individual's health perspective (Jang et al., 2004) is also a mediator of the good view of health. This indicates an absence of knowledge of the intricate relationship between relationship quality and subjective well-being (SWB). Older individuals need more social support than younger people. As people grow older, their sensory, physical and mental capacities decline, which means

that they are less able to be autonomous and more dependent in society. As classmates, relatives and friends are lost to divorce or death, their social

Understanding the impact of various forms of social support, including friends, family, and exercise groups, as well as differing levels of physical activity, on the older is crucial. The nature and origin of social support might affect the association with physical activity, exhibiting variations across domains such as active transportation, recreation, household tasks, and professional endeavors. This signifies a study deficiency about the influence of particular support types on the subjective well-being of older individuals via physical activity.

In the past, philosophy and religion were the main ways to learn about what makes people happy. Recently, behavioral scientists have shifted their focus to studying what makes people feel complete and happy. Scientists today study how people personally judge their lives, which is called subjective well-being (SWB). This is different from the way philosophers and religious leaders defined a good life. Researchers do not impose their definitions of a fulfilling life; instead, they rely on individuals' perceptions informed by personal criteria (Diener et al., 2018b). Furthermore, the strength of familial relationships, encompassing marital contentment and intergenerational engagement, influences the subjective well-being of older persons (Umberson & Karas Montez, 2010).

support and SWB outcomes. Self-reports of subjective well-being (SWB) are generally reliable but susceptible to various biases, including item order effects, mood, daily/weekly fluctuations (e.g., increased happiness during midday, evenings, and Saturdays), and survey frequency (Golder & Macy, 2011; Heffetz & Rabin, 2013). Premeditative inquiries into significant life domains can help prepare well-being

evaluations. To improve measurement accuracy, researchers must consider these effects, especially gender and age disparities within hard-to-reach populations.

There are still concerns about how small factors, such as the weather and pre-assessment questions, can affect subjective well-being (SWB) ratings. Many large-scale studies, however, have shown that the weather has a small effect on SWB scores (Yap et al., 2017). This necessitates a significant enhancement in the SWB evaluation methodology.

2.3.2 Non-Family Social Support and Subjective Well-Being

Nonfamily social support refers to emotional, informational and practical support from individuals and groups outside the family, including friends, neighbors, community members, social organizations and support networks. Previous studies have shown that friends are more important than relatives in reinforcing self-worth (Montpetit et al., 2017). There are four reasons why older people may need help from friends more than from family. However, these reasons can apply to people of all ages. Initially, friendships are selected, although familial relationships may be maintained partially due to societal conventions and obligations. Secondly, buddies frequently belong to the same social circle and share analogous personalities, life experiences, and lifestyles. Third, friends are usually people you have fun with and spend time with, while family members often have to do hard work, like taking care of other family members. Fourth, friendships are often better than family relationships because it's easier to end a bad friendship than a bad family relationship.

Less research has been done on the impact of connections with people who are not family, including friends and neighbors. Outside of the family, however, social bonds are significant. Studies evaluating the impact of friendship and family ties on

mortality, for instance, found that the probability of dying was more closely associated with increased contact with friends than with family (Rasulo et al., 2005). Moreover, in the perinatal environment, perceived support was identified as a predictive factor for the alleviation of depression and post-traumatic stress symptoms in mothers, underscoring the importance of perceived support in maternal well-being (Kay et al., 2024).

In the United States, social support from friends significantly predicts health outcomes for older persons, while family support is more essential for younger populations. The majority of studies on social support and health have concentrated on specific populations in North America and Western Europe; the effects of social support differ according to cultural norms and beliefs. Kouvonen et al. (2012) discovered that persons who received substantial emotional support from their partner and met positive association criteria were more likely to sustain acceptable levels of positive affect over time. Strong social support from friends and family correlated with improved positive outcomes in women.

For example, recent research found that social connections, like marriage, close friendships, family ties, going to church, and being part of other groups, lower the risk of death over a 10- to 12-year follow-up period (Wang et al., 2020). Functional support from family and friends becomes increasingly important in later life in alleviating the burden of life changes, chronic disease, and bereavement (Antonucci, 2001).

Research examining characteristics linked to social isolation indicates that gender, marital status, material resources (e.g., automobile ownership), and health is predominantly positively correlated. For example, older people without automobiles reported a reduced likelihood of infrequent social interactions with family, friends, and neighbors (Davidson et al., 2003). The frequency of social interactions also affects how

well people function and how long they live. Individuals who express elevated satisfaction are more inclined to assess social contacts and connections favorably compared to older people who identify as lonely or socially isolated (Diener, 2002). Empirical data demonstrate that social support partially mediates the association between possessing a romantic partner and improved well-being, with a more significant impact on males.

The subject blends distinctive characteristics of the former SWB, such as friendships, and the analogy of assistance coming from family members. In particular, the interest is in the socially selected nature of friendships and their ability to enhance life span (Rasulo et al., 2005). The review points out an academic gap. Familial relationships are analyzed extensively, while links outside the family are not sufficiently studied. Research on gender differences (Kouvonen et al., 2012) shows that there are different results for both genders. However, the insufficient study of friendship dynamics in other cultures reduces the general significance of the results.

Peer interaction is very important in adolescence, since it is crucial for the development of the self and is related to coping with stressful situations (Allen et al., 2005). During the epidemic, support from peers and family has been provided to young individuals with mental health difficulties. Perceived social support (Doan et al., 2022). Functional social support is especially necessary during big life changes such as getting married, having children or retiring. Friends and relatives can aid and give emotional support. They can advise on practical concerns that may arise while shifting jobs or taking on additional responsibilities. They may also have suffered higher stress and bad health impacts due to a lack of help to accomplish these adjustments (Rauf et al., 2023). Adolescents who reported improved mental health were more likely to report both punishments from society and support from family and friends. The lack of such

assistance was associated with a higher frequency of mental health disorders and thus the demand for particular preventive efforts (Harahap et al., 2024).

Furthermore, the role of technology in the social support network, particularly in regard to online communities and social media, is an interesting research topic (Kawachi & Berkman, 2001). While there are numerous advantages to functional social support, it is important to recognize some issues and limitations. Requesting and accepting help/care may also be difficult for some individuals who may face social stigma, a sense of self-reliance and/or lack of trust in others (Thoits, 2011 b). There is a need for further research in this new field to complete the picture of what is known.

To customize therapies and support systems, it is essential to understand how diverse cultures and contexts shape individuals' perceptions of and utilization of functional social support. Health indicators in research demonstrate significant variability, including subjective well-being, quality of life, all-cause mortality, and cause-specific mortality (Barth et al., 2010). Researchers investigated interventions designed to improve support networks and the essential mechanisms that underlie their beneficial effects, as well as the influence of functional social support. Interventions generally involve forming new connections, improving current social ties, and facilitating efficient communication within social networks (Lakey & Orehek, 2011).

2.3.3 Cultural and Contextual Variation in Social Support

This theme brings together cultural factors affecting social support systems with SWB factors, thereby demonstrating substantial differences (Ku et al., 2007; Cid et al., 2008). Research based on Western perspectives (Matsumoto et al., 2008) yields difficult generalizations, and the studied regions (e.g., China, Latin America) do not adequately compare across cultures. Empirical evidence about SWB outcomes after women join

the workforce remains absent, while researchers mention the societal changes that affect SWB.

Cross-cultural research has revealed cultural subtleties in the display of support, as well as the influence of cultural norms on individuals' desire to seek or offer support (Matsumoto et al., 2008). The role of the hormonal system in moderating the impact of functional social support on stress alleviation and emotional health is garnering attention (Heinrichs et al., 2009).

Through qualitative interviews (n=23; ages 55-78), Chinese older individuals identified seven dimensions of subjective well-being (SWB): physical, psychological, developmental, material, spiritual, sociopolitical, and social (Ku et al., 2007). Active participants (n=16) linked healthy physical activity to enhancements in the physical, psychological, developmental, and social dimensions (Ku et al., 2007). Nonetheless, although SWB components exhibit similarities across cultures, significant disparities exist. Social support diminishes self-stigmatization, alleviates psychiatric disorders, and promotes community reintegration in acute mental health problems (Ma et al., 2024).

Cid et al. (2008) explore the influence of income, family composition, health and religion on subjective well-being in Argentina, Chile and Uruguay. They focused on data from the SABE survey, conducted among adults aged 60 and up in various Latin American nations. The primary findings indicate a positive correlation among elevated wealth, marital status, religious engagement, and increased subjective well-being. Malnutrition adversely affects happiness measures. The current literature indicates that social support significantly enhances subjective well-being (SWB), with several studies investigating the mechanisms and circumstances that underpin this relationship.

Consequently, perform a semi-structured survey to evaluate the quality of life in relation to ageing (Gabriel & Bowling, 2004).

Many Asian countries must deal with population growth. The older population wasn't viewed or interpreted correctly until lately. Population aging is a shift that affects the structure of families. Traditional family structures, functions and values are undergoing fast change. Families are confronted with a challenging issue regarding their status and duties towards their older relatives due to social, economic, and cultural changes. Even though changes are favorable markers of development, the family's ability to care for the older will inevitably run into problems. The amount of assistance for the older people is significantly down because so many women are joining the workforce. As a result, the International Year of the Family has urged the world to look after, strengthen, and defend the family to ensure it continues to play a crucial role in maintaining the status, dignity, and security of its older members (Dlugosz & Raziniak, 2014).

There is limited research on the association between social support and health outcomes across cultural contexts, particularly among older people. Variations in health outcomes have been identified between ethnic and racial groups in the United States, implying that disparities may exist elsewhere in the world. Comparing populations can help identify common social environmental factors that affect health outcomes (Schwartz & Meyer, 2010). Furthermore, there hasn't been much research on how life events affect support in later years. Although there are likely to be different chances for developing and maintaining social bonds and contacts between men and women due to disparities in labour force participation and family responsibilities, for instance, employment may increase opportunities for friendships, whereas a woman's function

as a kin-keeper may increase opportunities for relationships with family (Ellwardt et al., 2013). Those gaps call for cross-cultural and longitudinal studies.

This suggests that the correlation between social support and subjective well-being may differ across cultures, as many cultures prioritize distinct forms of social support (Uchida & Ogihara, 2012). The significance of social support for general well-being differs between cultures; some emphasize interpersonal harmony over individual achievement. The study concludes that social support enhances well-being and decreases mortality by alleviating emotions of loneliness, despair, and cognitive decline. This highlights a significant deficiency in cultural distinctiveness.

These legal procedures, however, do not give the required attention, priority, health and other services to the old people along with the financial help “promised” by these laws. The government of Nepal is aware that it needs to meet the needs of the older in theory but this is not reflected in practice. It points out that older individuals are not included in the priority population in the National Health Policy and Long-Term Health Plans. Furthermore, older persons are denied health care services due to macro-level structural concerns such as low income or economic position, living in rural areas, and belonging to specific castes or ethnic groups. A substantial number of older people have health problems but do not attend health services (Acharya et al., 2019). There is not much information available on this; however, the Nepalese government offers free medical services to the older in public hospitals and clinics. Specialist geriatric care is not often guaranteed by the government and access to services has been shown to vary by one’s race, income and level of education (Acharya et al., 2019).

Inadequate implementation has hindered the effective delivery of aid and services for the older population of Nepal (Shrestha, 2013). Some people say that social security measures are hampered by the shortcomings in government responsibilities,

poor administrative personnel, opposition to the programs by local populations, lack of internal coordination and poor program management (National Planning Commission [Nepal], 2012). The implementation of the Act has been criticized for the long policy-making process, lack of understanding of roles and responsibilities, personal and party interests, the inability of local governments to plan, budget, manage and monitor health programs, disjointed and inconsistent prioritization, corruption, and lack of human resources (Bhandari et al., 2020). Nepal has attempted to develop institutional frameworks and policies for recognizing and responding to the needs of older people; nevertheless, the implementation of adequate support systems has been limited (National Planning Commission, 2012; Bhandari et al., 2020; Kunkel & Subedi, 1995).

High out-of-pocket expenditures and lack of access to frequent examinations may prevent many older people with health concerns from seeking medical assistance. There are also no skilled healthcare workers in geriatrics and older-friendly hospitals, which are concentrated in major cities (Acharya et al., 2019). The implementation issues of the government programs and projects, namely, the Old Age Allowance and the Geriatric Health Service Strategy (2021-2023), are putting pressure on Nepal's social support system for older persons. Many older farmers in rural areas are poor, unhealthy and cannot get necessities. "Elder care policies are mostly based on social programs like allowance and pensions, but their effectiveness is hampered by poor implementation."

In Nepal, community structures and customs differ across ethnic groups, caste systems, and rural and urban areas. Older people frequently benefit from neighborhood social capital, such as local community groups and female community health volunteers, which help them access health and social services. Religious social capital, provided by official and informal religious groups, also contributes to the social well-

being of older people. While these clubs provide frequent interaction, a sense of identity, and social support to older people, their influence on their health and well-being is unclear (Shrestha et al., 2021). Traditional family arrangements are under threat due to cultural shifts such as the youth movement, declining family numbers and urbanization, which isolates a huge number of older people. Local groups and community networks are critical for helping. Nepal's five-year plans aim to enhance healthcare and social security for older people, but other adjustments are needed to fully satisfy their needs. Several health-care programs have been established to provide free medication and treatment to older people living in poverty. However, the distribution of these services has been challenged as unfair.

The small families, employment of young people, and mobility are causing a decline in traditional norms, deteriorating family structures, and leaving the older without support (Ghimire et al., 2018). This identifies a disparity in assessing the community support efficacy, particularly in low-income nations such as Nepal, where little is understood. Research is required to substantiate and test the findings and the intermediary effect of depression between poor mental/nutritional health, life satisfaction, financial independence, social networks, and the policy implications on the older.

While filial obligation remains an integral part of supporting aged parents, social transformation and limited governmental support for the care of the older in Nepal pose considerable challenges that require policy innovation and are best accompanied by proper research and support structures. Alternative living and care arrangements outside of the conventional family-based support networks are therefore becoming increasingly necessary (Paudel & Tiwari, 2022).

Older people in Nepal primarily rely on personal networks within their families and community connections because Nepalese society values family bonds, and living with adult children remains a common living arrangement that meets their everyday needs (Shrestha et al., 2024). Family respect drives Nepalese elders to keep their relatives at home even after the emergence of retirement communities because traditional customs urge families to support senior family members (Shrestha et al., 2024). According to cultural standards, older family members must receive financial, emotional, and physical assistance, which undermines the pride and esteem of those who provide it. A core value of Nepalese culture requires younger members to assume their caregiving responsibilities toward their parents and other older relatives as part of traditional family relationships (Paudel & Tiwari, 2022). The intergenerational solidarity model includes this family practice because mutual dependency between generations creates benefits when resources are exchanged within families (Acharya et al., 2023).

The busy lives of nuclear families cause disappointment in hoped-for family connections that include love, sustenance, happiness and friendship, which creates heavy burdens for the older generation (Chalise, 2023). Alternative living approaches and care options are growing in popularity, as evidenced by rising numbers of care facilities, warranting the establishment of rules that support these new alternatives for elder care (Speck & Muller-Boker, 2021).

2.3.4 Demographic Factors Influences on Subjective Well-being

Couture et al. (2005) identified age, gender, family structure, domicile, education level, income, marital status, and employment as essential demographic characteristics for the development and targeting of mental health promotion initiatives. This conclusion is founded on extensive studies indicating that these factors are associated with variations

in mental health, including among the older (Krause, 2005). In contrast, cultural environments demonstrate that conceptualization and predictors of happiness and hence SWB varied significantly. The research found that in certain cultures, enjoyment is linked to interpersonal harmony and emotional support rather than personal accomplishment or high-arousal feelings.

International research, including older populations, has demonstrated a significant negative link between depression and factors such as spirituality, optimistic attitude, optimism, hope, social support, and life satisfaction (Orth et al., 2022). The relationship between age and psychological suffering is not linear; both younger and older individuals experience higher levels of psychological agony compared to middle-aged adults. Psychological distress symptoms are more prevalent in older women, and widowed older individuals are more susceptible to mental problems compared to their married counterparts. Moreover, lower socioeconomic status and reduced educational attainment may increase the likelihood of psychological challenges (Krause, 2005).

These stressors may elevate the risk of mental disorders in the older (Bozo et al., 2009). The mental health and well-being of the older have emerged as a critical concern due to the severity of global ageing (Nyqvist et al., 2013). Many older people are observed to be content with their older status despite suffering from physical disease or cognitive decline, which suggests that excellent health and SWB form a complex corresponding relationship (Xiao et al., 2014). Demographics, socioeconomics, health, psychology (including personality, self-esteem and self-efficacy) and other factors all have an impact on SWB (Peng et al., 2015; Zhang et al., 2017). Academic study has shown a significant link between various personality attributes and results connected to social support and welfare, including fundamental self-evaluation (Tian, 2016).

Individual well-being during emerging adulthood is heavily influenced by family relationships. According to research, feeling supported by family members at this era increases happiness and life satisfaction and lowers the risk of depression. Despite the long-term importance of sibling relationships on family dynamics, few studies have been conducted, especially on these links throughout emerging adulthood (Crocetti et al., 2023). Social control refers to the deliberate actions taken by social support services to oversee, guide, prompt, or coerce an individual into maintaining positive behavioral standards and encouraging the adoption of healthy practices, such as smoking cessation (Berkman & Glass, 2000; Lakey & Cohen, 2000). Previous research indicates that social support generally mitigates the adverse effects of discrimination on mental health. In a study on parents, social support was established to moderate discrimination and stress or depressive symptoms or mental health, affirming the significance of social support (Alvarez et al., 2017).

The low socio-economic status individuals typically received significantly higher levels of care from family members, even after adjusting for other factors like sex, age, disability and marital status, according to analyses that looked at each country separately. In contrast, other characteristics like age, health and marital status were significantly responsible for the disparities in socioeconomic level in the receipt of care from private or public sources (Van Groenou et al., 2006). Furthermore, prior research has indicated gender variations in subjective well-being, optimism and rates of obtaining support from adult children (Singh et al., 2014).

Moreover, an individual can benefit from receiving feedback and reassurances about their capabilities, which allows them to sustain a sense of mastery and autonomy in their lives (Uchino et al., 2012; Thoits, 2011 a). Enhanced motivation for self-care

and modulation of the neuron-endocrine stress response may subsequently inhibit the development of mental disorders (Kawachi & Berkman, 2001; Cohen, 2004).

Wasson (1993) looked at the position and function of older housewives and retired women in the family and community regarding diminished self-worth and abuse of power. Housewives were more likely than retired women to struggle with adjustment. Marital status, socioeconomic position, education, family structure and decision-making engagement all had an impact on adjustment. She observed that older women with high levels of social participation, control over domestic affairs and busy schedules faced more adjustment difficulties. Those who demonstrated detachment and accepted their lack of accountability, on the other hand, were more adaptable.

Older individuals may face more stressors than younger people, such as chronic diseases, functional decline, retirement, children leaving home and the loss of a spouse and friends (Muramatsu & Hedeker, 2010). Stressful life experiences are another significant factor that may have an impact on mental health, as was previously mentioned (Kim & Jang, 2021). The analysis assembles demographic data effects on SWB through studies of gender, along with age sets and socio-economic parameters (Krause, 2005; Peng et al., 2015). The review neglects to explain how age-related factors connect since the relationship follows a non-linear pattern (Krause, 2005) and reveals resilience across health deterioration (Xiao et al., 2014). Stressors stand as the main research emphasis according to Muramatsu and Hedeker (2010), but researchers should expand their investigations through social support-focused coping strategies analysis.

Martire et al. (2002) suggest that sometimes support efforts intended to help individuals may not have the desired positive impact. This could be due to various reasons, such as miscommunication, a lack of understanding of the recipient's needs, or

ineffective support strategies. The previous generations of American women were brought up with a clear awareness of gender expectations and conventions, which characterized a woman's primary responsibilities as being to her family and home (Shenk et al., 2004).

When significant resources are devoted to supporting care and treatment of the older population, the number and growth rate of the nation's older population will become a significant social problem. A comprehensive approach must be used to meet the growing concerns of the aged, considering the social, economic and cultural changes that have taken place (Raju, 2002).

The study presented by Martire et al. (2002) indicates that support strategies meant to benefit a person might produce unexpected negative consequences. Multiple factors, including unclear communication and misunderstanding of recipient requirements as well as insufficient support approaches, may explain this phenomenon. Previous American women received explicit instructions about gender norms that required them to prioritize their family and household work (Shenk et al., 2004).

Research on parental transfers to adult children remains uncertain because limited studies exist and contrary results show negative relationships between time and money support with parent-child relationships. Research on teenage respondents showed that both parental and friend support existed as positive factors for leisure-time physical activity, but friend support demonstrated consistent effects on active transportation physical activity. Better social and healthcare systems that provide support for Nepalese senior citizens must be developed according to the research findings. Scientists today examine the brain mechanisms that shape health results (Eisenberger & Cole, 2012). Research establishes a social support gap between veterans

and civilians, thus demonstrating the necessity for programs dedicated to assisting female veterans.

2.4 National Perspectives

2.4.1 Demographic Trend and the Growing Need for Support

The population of older people in Nepal has increased significantly over the last decade. According to the National Population and Housing Census, the population aged 60 years and above made up 8.13% of the population in 2011 and 10.21% in 2021 (Central Bureau of Statistics [CBS], 2012, 2023). This means that there are more older people. The ageing population is a demographic change, and initiatives are needed to help older people cope with the issues they face. In Nepal, younger social workers can contribute to improving the general well-being of older people and reducing feelings of loneliness.

The study explores the status of the older population, their views and requirements for social support, sources of social support, structural and functional aspects of social support, and the mental health of the older population. It also explores the relationships between social support, mental health, family ties, attachment, well-being, and social interactions among older people in Nepal, as well as policies and programs for the old in the country. Research showed that the subjective well-being of Croatian individuals increases significantly with their greater engagement in these activities. The study examines literacy rates, as well as the 2015 survey findings and Nepalese statistics data. This research examines features of ageing using regression analysis. The last predictive model produces respectable results using factors such as religion and socioeconomic status (Sharma, 2022).

The results showed that older Nepalese adults generally have low subjective well-being (SWB) and experience loneliness. Friends, neighbours and children living

with the older person eased loneliness; yet children living apart also had a good impact on stability and quality of life. The presence of family and relatives sometimes negatively affected the subjective well-being of older guys, indicating that family obligations do not inevitably improve psychological health (Chalise et al., 2007). By contrast, the help of friends has a greater impact on self-esteem and general well-being than the help of family. There were differences between the males and women. Older women, especially those who were housewives, were more able to adapt to ageing than those retired women who were more socially active. Women who had fewer possibilities for socialization or decision-making were more likely to feel lonely

A study investigating the impact of Nepal's aging population on the health and well-being of adults aged 60 and above included 289 senior citizens from a Kathmandu outpatient clinic. The questionnaires included a concise nutritional evaluation, a depression screening tool for seniors, and a life satisfaction assessment. The study revealed a link between insufficient mental and nutritional health and reduced life satisfaction (Ghimire et al., 2018). These findings enhance our understanding of quality of life in older years and have substantial implications for public policy (Chalise et al., 2007). The survey shows how important it is for Croatians to spend time with friends. It says that, besides watching TV, the most popular activities for Croatians in their free time are going to bars or clubs and visiting friends or family (Schoemaker, 2023).

2.4.2 Challenges of Older People in Nepal: Health, Family, and Rural Contexts

Older people in Nepal experience health outcomes influenced by demographic, socio-economic, and family factors. Sharma (2023) conducted research to examine how Nepalese older people reported their health, investigating factors including age, gender, education levels, financial status, diet patterns, and medical accessibility. Research results demonstrated that male respondents rated their health condition more positively

than females, yet respondents with advanced education tended to indicate poorer health outcomes. A better economic situation, together with better nutrition, improved the health outcomes among these subjects. A person received fundamental well-being support from their families by receiving advice from them.

The social support network in Nepal operated by the government lacks sufficient capabilities to properly care for older people because care centers and old age facilities often lack necessary staffing and facilities and available resources. Through its business venture programs, the older people's association provides financial assistance that connects seniors to social activities, thereby reducing their loneliness and depressive symptoms (Shrestha et al., 2021). This proposal is criticized for overlooking current population changes and the poor economic state, and for failing to consider crucial social variables, including negative labelling and senior citizen stereotypes, as well as their everyday survival needs and care requirements (Shrestha, 2013).

Hundreds of rural Nepalese seniors manage their lives through agricultural work while fighting poverty because they lack available resources and insufficient earning options and regularly experience shortages of food, clothing, housing, healthcare and drinkable water, according to NEPAN (2010). The older face disadvantages of poor health and education deficits and prejudicial treatment when reaching their senior years empty-handed. The transition from joint to nuclear families affects older people through social isolation and inadequate care because they move to cities (Chalise, 2023).

The changes in demographic data stem from declining birth rates and increasing life expectancy. Loneliness and social isolation significantly affect older people, correlating with adverse mental and physical health consequences (Luanaigh & Lawlor, 2008). Chronically lonely older individuals engage in less physical activity, consume

more tobacco, experience a greater prevalence of chronic illnesses, exhibit elevated depression levels, and have a higher frequency of nursing home visits compared to their non-lonely counterparts (Theeke 2010).

2.4.3 Government Policies for Older People in Nepal

The Nepalese government has acknowledged the need to implement policy measures to address the needs of the senior population through the National Planning Commission [Nepal] (2012). The Local Self-governance Act of 1999 established policy decentralization, enabling local village development committees to gain increased oversight of policy funds and decisions (Shrestha et al., 2021). The Older People's Policy Act of 1998 recommended authorizing financial benefits in combination with social security programs, along with treatment services and social inclusion for older people. Family members must provide care and support to older people, according to their financial standing and social status, as stated in the Older Citizens Act of 2006. Under the 2008 Older People Regulation, the rules defined how to establish and maintain daycare centers along with nursing homes and "old-age" homes.

The current provision under this program gives older people over 70 years old a bare minimum "Old Age Allowance" each month, along with payments for both those 75 years old and older and widowed women starting at 60 years old (Dhakal, 2012). The program distributes resources to disabled persons and widows, orphans, children, and races identified as endangered by "National Planning Commission [Nepal]" (2012). Various legislative measures and initiatives address older people's needs by protecting their rights and providing financial benefits and medical services. A lack of funding challenges the implementation of these principles, although national policies, acts, and rules have been established to support the older population (Shrestha, 2013).

The Nepalese government has introduced various five-year initiatives to improve the physical health and social welfare of the country's elderly population (National Planning Commission, 2019). In the Seventh Five-Year Plan, the government introduced social security programs for the aged who were cared for by families and communities (National Planning Commission, 1992). The old-age facility development and healthcare service delivery programs were laid down under the Eighth Five-Year Plan. The Ninth Five-Year Plan featured plans for the elderly and financial support for building of senior homes. In the Tenth Five-Year Plan period, the state raised the rate of pension disbursement and built focused medical services, with measures to link outsourced businesses to the operations of elder care. The Thirteenth Plan enhanced financing for old-age benefits, expanded healthcare facilities and provided protection for senior residents. The government concentrated on strengthening social security programs for the elderly, building aging-friendly facilities, and promoting active health outcomes for older individuals throughout the Fourteenth Plan. The Fifteenth Plan continues with the pension increases and health care improvements and promotes active involvement of the elderly population (National Planning Commission [Nepal], 2024).

The Geriatric Health Service Strategy (2021-2030) provides healthcare facilities, financial support, and social programs to safeguard the health and welfare of seniors through financial assistance, local welfare implementation groups, and aged care service provision (Ministry of Health and Population [Nepal], 2022).

2.5 Critical Analysis and Research Gap

There is already evidence that social support is important in enhancing subjective well-being (SWB) and boosting psychological resilience, life satisfaction, and emotional stability among older people (Cohen & Wills, 1985). However, there are inconsistencies: the benefits of emotional and instrumental support are dependent on

individual traits, cultural contexts and situational circumstances (Williams et al., 2004). These differences point to theoretical gaps in the recognition of contextual modifiers.

Theoretical models, such as stress-buffering (Cohen & Wills, 1985), social exchange (Walker, 1992), and attachment theory (Helgeson, 2003), provide mechanisms but are more focused on psychological and interpersonal phenomena and do not consider structural factors, such as income, education, health status, and family structures. This poses a major shortcoming in that there are few complete frameworks that combine support dimensions with sociodemographic determinants, especially outside of Western settings. Empirical studies provide evidence of the influence of mediators such as self-esteem and social skills on the support and subjective well-being relation (Farriol-Baroni et al., 2021).

Research tends to isolate the consequences of loneliness or mental health, missing a broader perspective on subjective well-being (Diener et al., 2018a). Vulnerabilities increase with aging: physical degradation lowers social networks, therefore leading to more isolation (Luanaigh & Lawlor, 2008; Lo & Chan, 2023). Further examination of the quality, frequency and sources of help with a specific focus on family and friends/community is needed.

The demographic transition in Nepal has increased urgency. An increasing senior population (NSO, 2025) is struggling with dissolution of joint families, young migration, and nuclearization, challenging conventional caring and causing loneliness (Chalise, 2023; CBS, 2012). However, there are still gaps in our understanding of how these changes impact subjective well-being. Socioeconomic and demographic variables, including education, income, health, gender, and nutrition, have a great impact on subjective well-being (Chalise et al., 2007; Sharma, 2023). However, they are often separated from the support dynamics in the evaluation. Such interactions

should take inequities and limited services into account in resource-constrained settings. Policy frameworks also demonstrate further weaknesses. Nepal's Senior Citizens Act and health programs (Bhandari et al., 2020) strive to improve welfare, but their practical efficacy in rural and semi-urban areas has not been assessed.

Theoretical gaps downplay cultural and socioeconomic integrations, empirical studies deconstruct subjective well-being, Nepal-centric research fails to account for support-demographic synergies, and the effect of policy remains unevaluated.

Table 2.1

Empirical Review of Subjective Well-Being and Social Support

Author	Method	Major Findings	Identified Research Gap / Implication for the Study
Siedlecki et al. (2014)	Correlational study using standardized measures	Family embeddedness and perceived support predicted positive affect, while provided support predicted negative affect.	Conducted in developed countries, context-specific evidence from Nepal is limited.
Chalise et al. (2007)	Household survey in Kathmandu	Older people reported low subjective well-being and high loneliness; family and neighborhood support reduced loneliness.	Focused on loneliness, not on a comprehensive measurement of subjective well-being and its determinants.
Beard & Kunharibowo (2001)	Case study approach	Population ageing and changes in family structure may reduce traditional support systems.	Lacks empirical testing of how declining family support influences well-being among older people in specific communities.
Gabriel Bowling (2004)	Interview survey among adults aged 65+ in Britain	Well-being is influenced by health, financial security, independence, and social participation.	Findings are based on Western societies; comparative evidence from developing countries such as Nepal remains limited.

Table 2.2*Theoretical Perspective on Social Support and Subjective Well-Being*

Author and Year	Theory	Description	Identified Research Gap/ Implication for the Study
Krause (2005).	Stress	Social support acts as a protective factor that helps individuals cope with stressful situations and life events.	Most applications focus on health outcomes rather than measuring subjective well-being among older people in developing contexts, particularly Nepal.
Pilisuk & Parks (1983)	Network and Social Connection Perspective	Social support is provided through emotional, instrumental, and informational resources within social networks.	Limited empirical testing of how different support networks (family, friends, community) influence the well-being of older people in local communities.
Walker et al., (1992)	Social Exchange Theory	Family relationships involve reciprocal exchanges, often with women bearing the primary caregiving role.	Few studies examine how reciprocity and family caregiving dynamics influence the well-being of older people in South Asian societies.
Taylor et al. (2003)	Cognitive-Behavioral Perspective	Social support reduces the negative effects of stress by influencing individual perceptions and coping strategies.	Insufficient evidence on how perceived support affects older populations' subjective well-being in rural or semi-urban settings.
Helgeson (2003)	Attachment Perspective	Social relationships, personal traits, and social capital influence quality of life.	Lack of integrated studies combining social capital, demographic characteristics, and well-being among the older in Nepal.
Mao & Han (2018)	Attachment Theory	Life events such as divorce, death, or family disruption influence later-life support.	Limited research examining how life-course experiences affect social support and well-being in later life in developing countries.

2.6 Conceptual Framework

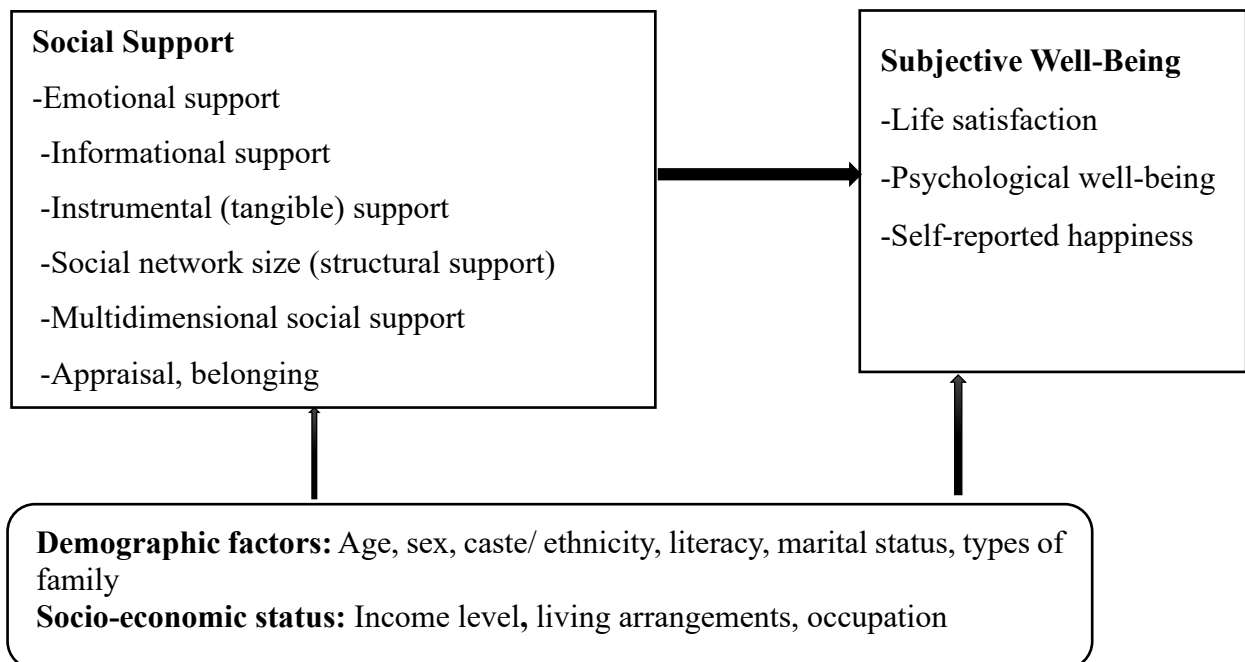
The conceptual model (see Figure 2.1) elucidates the relationship between social support and subjective well-being (SWB) among older people. This framework is grounded in House's (1983) social support typology and the Stress-Buffering Theory, positing that social support is a multidimensional independent variable including three essential dimensions: functional, physical, and structural support. The approach is grounded in the Stress-Buffering Theory, which posits that social support mitigates age-

related stressors, including health issues, unemployment, and financial dependency (Uchino, 2004; Thoits, 2011a).

Robust networks characterized by variability mitigate the psychological and physiological effects of stress, serving as a source of resilience and elevated subjective well-being (SWB). The dependent variable is subjective well-being (SWB), assessed via life satisfaction and emotional stability, both of which are established gerontological indicators of quality of life (Diener et al., 2018a; Topp et al., 2015). Support net effects are separated from sociodemographic effects using control variables (marital status, income, living arrangements).

Figure 2.1

Conceptual Framework of Social Support and Well-Being of Older People



Note. Adapted from *Work Stress and Social Support* (J. S. House, 1983). Addison-Wesley Publishing Company.

CHAPTER III

RESEARCH METHODOLOGY

This chapter describes the techniques and methodologies employed to conduct the study. The document covers research design, the geographical area for the field study to collect data, methodology for determining sample size and the selection of study area, clarification of data sources, the sampling frame, research instruments, study hypothesis, dependent and independent variables, methods for measuring social support and well-being through the social support system and implementation of advanced statistical analysis.

3.1 Research Paradigm

A research paradigm is the set of shared beliefs, values and methodologies of a scientific community. A paradigm provides a framework of principles or guidelines that determine what questions are to be asked and what are to count as acceptable explanations (Kuhn, 1970). It deals with ontology (nature of reality), epistemology (nature of knowledge), methodology (how knowledge is gained) and axiology (the effect of values on research).

The study is situated within the positivist paradigm, which presupposes that social reality exists independently of individual perception and can be measured objectively, even when investigating constructs such as subjective well-being. The study examined the association between social support and subjective well-being in older people using validated self-report measures (MSPSS, ISEL-12, AVAT, AVSI). The constructs being studied are subjective in nature but the use of structured questionnaires and quantitative analysis allows the production of reliable and replicable results within the positivist paradigm.

This study brings together the subjectivism of self-report data with the positivist paradigm by employing reflexivity and cultural sensitivity. The survey instruments were translated, back-translated, and pre-tested to ensure that they are culturally relevant to older individuals in Nepal and that the measurement properties are standardized. This approach considers the interpretative context of responses while remaining objective, replicable and statistically rigorous. Statistical analysis is used to identify patterns and relationships, providing empirical evidence of the effect of social support on well-being.

3.1.1 Epistemological Concept

From a positivist standpoint, knowledge is verifiable and objective, acquired through empirical research. This study posits that social facts, encompassing perceived social support, can be evaluated without altering participants' responses. Quantitative research provides precise, generalized data regarding the impact of social support on the well-being of older individuals (Kuhn, 1970).

3.1.2 Axiology

Value neutrality is the basis of positivist research. The research design reduces the researcher's influence by using standardized instruments and statistical analysis, thereby ensuring that results are replicable and objective. Cultural adaptation and reflexivity emphasize the importance of responses and help find a balance between objectivity and relevance to the situation.

3.2 Research Design

Depending on the research purpose, social science investigations apply different research designs. A descriptive cross-sectional approach was deemed appropriate to investigate the association between social support and older people's well-being. A cross-sectional survey is a survey that collects data from a particular population at one

moment in time to determine trends and statistical correlations across variables (Borg & Gall, 1984).

The study was conducted among older persons of Lamki Chuha Municipality by using a structured face-to-face interview. The instrument was a multi-section questionnaire comprising validated and standardized sets of indicators such as the Kessler Psychological Distress Scale (K10) and the WHO-5 Well-Being Index. These tools have been extensively used to evaluate subjective well-being and psychiatric distress (Andrews and Slade, 2001; Perera et al., 2020). This design is appropriate for delineating associations and predictive relationships among variables within a defined population at a specific temporal juncture. However, because it is a cross-sectional survey, it does not establish causality.

3.3 Population and Sampling

3.3.1 Population

Lamki Chuha municipality is the fourth-largest municipality of the 13 local levels of Kailali district. The district consists one sub-metropolitan city, six municipalities, and six rural municipalities. The population of Lamki Chuha Municipality is 90,971, with 42,441 men and 48,530 women, according to the 2021 Population and Housing Census of Nepal. 8,372 persons aged 60 and older represent 9.2% of the municipal population. The percentage of older guys (3,783) and older females (4,589) in the total male population is 8.9% and 9.5%, respectively. Table 3.1 shows the distribution of older people aged 60 and older by sex. The Lamki Chuha Municipality is connected to the East-West Mahendra Highway, lies between Mohanyal Rural Municipality in the north, Bardagoria Rural Municipality in the west, Karnali River and Bardiya district in the

east, Janaki Rural Municipality in the south and Joshipur Rural Municipality in the southwest.

Table 3.1

Age and Sex Composition of the Older Population

Age group	Total		Male		Female		Sex Ratio
	N	%	N	%	N	%	
60-64	2,569	30.7	1,150	30.4	1,419	30.9	81.0
65-69	2,094	25.0	964	25.5	1,130	24.6	85.3
70-74	1,983	23.7	874	23.1	1,109	24.2	78.8
75-79	1,060	12.7	505	13.3	555	12.1	91.0
80-84	390	4.7	170	4.5	220	4.8	77.3
85-89	167	2.0	80	2.1	87	1.9	92.0
90-94	75	0.9	32	0.8	43	0.9	74.4
95+ years	34	0.4	8	0.2	26	0.6	30.8
Total 60 +	8,372	100.0	3,783	100.0	4,589	100.0	82.4
Total Population (all ages)	90,971	9.2	42,441	8.9	48,530	9.5	87.5

Note. NSO (2025) National Population and Housing Census 2021.

Kailali district has a wide range of cultural and ethnic diversity, that could be observed throughout the Lamki- Chuha Municipality. It is anticipated that the ongoing, rapid social and economic change will have a significant effect on the lives of older people in the municipality in the future.

Lamki Chuha was chosen as it represents a semi-urban municipality where traditional extended family structures and contemporary nuclear family models coexist. Migration, cultural diversity, and socioeconomic transition are also high in the area, and it is a good place to explore the effects of these dynamics on the social support and well-being of older people.

3.3.2 Target Population

The study targeted all men and women aged 60 years and above residing in the study area. The area is a combination of different castes and ethnicities, with diverse socio-economic backgrounds. This wide coverage enables the representation of the older population across various demographics and social classes in the study location.

The study's target group consists of adults aged 60 and above, as stipulated by the Senior Citizens Act, 2063 (2006). Participants will be selected from Lamki Chuha Municipality to investigate subjective well-being in a semi-urban environment predominantly inhabited by the older (NSO, 2025). To ensure diversity in experiences and viewpoints about quality of life and social support, the sample will encompass individuals from various caste, ethnic, and socio-economic backgrounds.

3.3.3 Study Population and Sample Size Determination

Yamane's (1967) simplified formula to calculate sample sizes is applied to determine the sample size of 8,372 old age population (60+) from the selected study area, i.e., Lamki-Chuha Municipality. A 95 percent confidence level and $p = 0.5$ is assumed for the equation. Formula,

$$n = N / (1 + N(e)^2)$$

$$n = 8,372 / (1 + 8,372(0.05)^2)$$

$$n = 382$$

Considering a 5 percent nonresponse rate, the sample size was $382 / 0.95 = 402$. Hence, the required sample size is 402. The research population consists of 402 persons aged 60 years or older residing in the Municipality.

3.3.4 Sampling Procedure

The research employed a multi-stage sampling methodology. The chosen municipality for the study comprises 10 wards. Of which two wards (1 and 4) are chosen for the sample survey using the lottery method? The second stage of sampling includes the selection of households using PPS and systematic random sampling methods. Complete listing of the households (Ghar-Dhuri list) residing in the selected wards was obtained from the registers of the respective ward office. The 402 older persons (age 60+) to be selected as the sample population of the study were allocated between two wards according to the proportionate to population size (Table 3.2). In the third stage. A systematic random sampling applies to the sample interval (6.4) is applied to select households residing at least one older person aged 60 and above.

Table 3.2

Selection of the Sample Population

Selected ward	Total older population (60+)	Proportion of total population	Sample size
Ward no. 1	1,540	0.60	241
Ward no. 4	1,035	0.40	161
Total	2,575	1.00	402

Note. The sample size was determined using the proportionate probability sampling method from two selected wards of Lamki Chuha Municipality in Kailali District. The total aged 60 years and above was calculated from the census data at the ward level.

Systematic random sampling was used to select respondents from each ward.

The sampling interval (k) was calculated using the following method.

Ward No.1: $k = 1540/241 = 6.3$ (Rounded to 6)

Ward No. 4: $K = 1035/161 = 6.4$ (Rounded to 6)

The sample of respondents was selected systematically, with 3 as the random starting point. The third household on the registry was approached, followed by all the

sixth households in sequence. A strict within-household selection protocol was used to ensure independent observations and eliminate clustering bias by ensuring that each household had only one older individual (60+). In homes with only a single qualified older person, that person was selected to conduct the interview. Where there was more than one eligible older person in a household (a couple or an extended family), a lottery was used to select one respondent. Additionally, if a sampled household had no eligible occupants, the researchers replaced it with the next household on the registry to reach the required sample.

3.4 Quality Control: Pilot Testing

A pre-test was conducted with 41 older people, who comprised 10 percent of the complete sample, in a ward with a similar socio-demographic profile to that of the study area. This pre-pilot stage was important for the completion of the survey instrument, since it allowed for some adjustments. The first one increased clarity of the language by finding technical phrases in the Subjective Well-being Inventory (SWI) that were conceptually difficult to translate into the local lingo and were subsequently replaced with simpler and more culturally suitable terminology. Second, the pre-test helped the researchers to establish the flow and length of the interview, which was approximately 45-50 minutes. The observation helped to strategize the order of questions so that the responders would remain engaged and not fatigued.

The pilot served as a sensitivity test, allowing the researchers to streamline the process of asking questions about family support and neglect. This also ensured that sensitive issues were addressed empathetically but without being overbearing, thereby creating a secure atmosphere in which participants could comfortably tell their stories.

3.5 Validity and Reliability

3.5.1 Validity

Content validity was established through a thorough literature review and validation of previously published empirical studies. The chosen tools were evaluated for relevance to the Nepalese older population. The conceptual appropriateness of standardized scales developed in the West was also assessed through a thorough review of the scales to ensure they are conceptually relevant to the local socio-cultural context. To ensure the language and contextual suitability, the questionnaire was translated into Nepali. A pre-test was conducted to determine the clarity, cultural relevance, and understanding of the items. The cognitive debriefing method was used in the pre-test stage, in which respondents were asked to define their terms to ascertain conceptual equivalence.

There were also measures to minimize response bias, especially the social desirability bias. The interviews were conducted in a personal context to reduce external factors introduced by family members or others, thereby increasing internal validity.

3.5.2 Reliability

Previous research has demonstrated adequate internal consistency for standardized measures such as the Kessler Psychological Distress Scale (K10), Satisfaction with Life Scale, and Interpersonal Support Evaluation List (ISEL-12), with Cronbach's alphas exceeding 0.80. This study assessed internal consistency reliability using Cronbach's alpha for each multi-item scale. satisfactory to good dependability, signifying the consistency of the items assessing each construct.

In conclusion, appropriate procedures were implemented to ensure the validity and reliability of the instruments in the Nepalese context. The acquired values are indicated. Prior studies have demonstrated adequate internal consistency for

standardized instruments such as the Kessler Psychological Distress Scale (K10), Satisfaction with Life Scale, and Interpersonal Support Evaluation List (ISEL-12), with Cronbach's alphas exceeding 0.80. This study evaluated internal consistency reliability by Cronbach's alpha for each multi-item scale. Reliable, indicating the consistency of the items evaluating each concept. In conclusion, appropriate procedures were implemented to ensure the validity and reliability of the instruments in the Nepalese context.

3.6 Ethical Considerations

To ensure that older people were not revictimized on sensitive subjects such as abuse and scolding, sympathetic and secure data collection was of priority in the study. Training focused on empathetic interviewing, where participants were instructed to use non-judgmental language and to end the session with sensitive questions after building rapport. To maintain participants' privacy and safety, one-on-one interviews were held; if other family members were present, sensitive topics were deferred or rescheduled to avoid family conflict. Lastly, informed consent was strictly followed, as participants had the right to refuse uncomfortable questions or to leave the interview at will, without coercion or penalty, which was clearly explained to them.

3.7 Tools and Methods of Data Collection

3.7.1 Tools of Data Collection

The data utilized in this study were gathered via a structured questionnaire developed, adjusted, and translated into Nepali for the Nepal setting (Appendix 1). The instrument amalgamated socio-demographic and socio-economic data with a series of globally acknowledged scales assessing social support, subjective well-being, psychological health, and both physical and mental health status (Van et al., 2012).

Socio-demographic and socio-economic features of the respondents were collected in the first part of the questionnaire. The items contained data on age, sex, caste or ethnicity, religion, marital status, educational attainment, occupation, sources of income, family structure and living arrangements. Housing and living conditions questions were also to be asked, addressing access to household amenities, access to drinking water, access to sanitation and dissatisfaction with present living arrangements. Social support was measured with certain conventional measures. The main tool used was the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988). The 12-item scale measures perceived social support from three sources: family, friends and significant others. Data were taken on a 7-point Likert scale (1=very strongly disagree, 7=very strongly agree) with a score above 3 representing perceived firm support.

The Interpersonal Support Evaluation List-Short Form (ISEL-12) (Cohen et al., 1985) was used to assess three specific dimensions of social support: appraisal support, belonging support, and tangible support. The ISEL-12 has 12 items rated on a 4-point Likert scale (1 = false, 4 = true), with reverse scoring where relevant. Furthermore, two subscales were incorporated to represent the structural and functional aspects of support: Availability of Social Integration (AVSI) evaluates the frequency and quantity of social interactions, whereas Availability of Attachment (AVAT) examines the existence of intimate and supportive connections.

The researchers also quantified the subjective well-being and psychological health with several validated scales. A short measure of positive well-being (the WHO-5 Well-being Index), which asked respondents 5 questions about their mood and energy over the preceding 2 weeks on a 6-point scale (0 = at no time, 5 = always). The Satisfaction with Life Scale (SWLS) (Diener, 1984) was incorporated to assess

cognitive evaluations of overall life satisfaction, comprising 5 questions scored on a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree).

The Kessler Psychological Distress Scale (K10) comprises 10 items, each rated on a 5-point scale from 1 (none of the time) to 5 (all the time), yielding a total score of 10 to 50. Higher scores indicate more psychological distress. Standard cut-off points describe levels of distress as follows: 10–19 indicates that the individual is likely well, 20–24 shows mild distress, 25–29 indicates moderate distress and 30–50 indicates considerable psychological pain (Andrews & Slade, 2001; Kessler et al., 2002).

The Subjective Well-being Inventory (SUBI) was used to measure well-being and comprised positive and negative aspects, with structured three-point response items. Some of the scales related specifically to psychological well-being in later life, including feelings of usefulness, happiness, despair and social connectedness.

The final segment of the questionnaire addressed physical and mental health issues. They were also asked to disclose the presence of chronic diseases, such as diabetes, hypertension, asthma, heart disease, or renal issues, as well as any form of handicap (auditory, visual, physical, or psychological). Additional measures assessed perceived health limitations, discomfort, physical vitality, mobility, and the ability to execute daily activities autonomously.

3.7.2 Measurement Considerations

In total, the combination of these validated scales and socio-demographic and health-related items enabled a thorough evaluation of social support systems and their relationship to the well-being of older people in Nepal.

Even though the majority of the previous literature on aging and social support has been conducted using instruments developed in the West, these instruments might

not reflect the collectivist values and culturally specific considerations for the well-being of Nepalese older people (Chalise et al., 2007). To overcome this, the study used a stringent cultural adaptation procedure of the measurement instruments. This was included: providing the survey instruments with translations and back-translations into Nepali and local dialects to ensure semantic and conceptual equivalence. A small group of older people would be interviewed using cognitive interviewing to determine which items are confusing, culturally inappropriate, or irrelevant.

Pilot testing to assess readability, pattern of responses and practicality of the Lamki Chuha rural setting. Measurement invariance tests to prove that the instruments have been adapted to be applicable between demographic groups (e.g., gender, widowhood, literacy status). Through these processes, the research aims to ensure that the constructs of subjective well-being and social support are closely measured in a culturally valid manner, thus bridging the gap identified in the previous literature.

3.7.3 Method of Data Collection

The researcher used structured questionnaires to gather data for this study. The questionnaire was created in the Kobo Toolbox. Three enumerators were trained on the Kobo Toolbox platform to ensure they would collect data efficiently and without error. Training involved simulated data-collection activities that were similar to real life, making the enumerators familiar with the objectives of communicative and general problems.

The researcher undertook several weeks of fieldwork, with close supervision and monitoring. To ensure quality, the researcher was directly involved in data collection and continuously guided enumerators. Field data were uploaded to the server via Kobo Toolbox. Once error checking and editing were complete, the dataset was

downloaded as an Excel file, and additional data handling, such as cross-validation of errors and outliers, was carried out in SPSS.

This approach was appropriate to the research methodology, as it is mandatory to include and exclude criteria to clarify the selection of respondents (Creswell & Creswell, 2017). The following were the inclusion criteria: respondents had to be 60 years of age and above, permanent residents of the selected wards of Lamki Chuha Municipality for at least 6 months, and willing and able to make an informed consent. The exclusion criteria were the older people who had a severe speech or hearing loss, diagnosed mental disorders, which prevented them from participating in the interviews, non-residents or temporary visitors, and those who did not want to give consent. The characterization of older individuals was founded on the World Health Organization's proposal for the necessity for aging research in low- and middle-income nations (World Health Organization, 2021).

3.8 Lessons Learned in the Field Study

The field study in Lamki Chuha Municipality was informative regarding the cultural applicability of research instruments across the Tharu and Pahadi communities. Subjective questions are also applicable but need to be interpreted within a context; an example of this is that Tharu older people see support in the form of communal connections and Pahadi groups see it in Sammaan (respect) and household control. Certain queries for informational support appeared redundant because, in traditional joint families, advice-giving is a daily kinship duty rather than an event. Given the high rates of urbanization and migration in Kailali, it is reasonable to include questions about land ownership and digital connectivity, which are currently shaping the capabilities of older people in the evolving socioeconomic environment, such as power and social security.

3.9 Elder Abuse

A structured questionnaire inspired by the Elder Abuse Suspicion Index (EASI), the World Health Organization recommendations on measuring abuse in the older (WHO, 2022), assessed abuse. The questions included experiences of physical violence, emotional violence and neglect. Response categories were: No violence, Physical violence, Emotional violence and both physical and emotional violence. The questionnaire had been pre-tested to ensure clarity and cultural appropriateness. Some small changes were made based on feedback, and then the final administration was completed.

3.10 Measures of Constructs

3.10.1 Independent Variable: Social Support System

The other three functional characteristics of social support were measured by stages using the questionnaire: confiding support, practical support and negative aspects of intimate relationships. The confident support measure, which contains seven aspects, covers the desire to confide, the act of confiding, sharing interests, boosting self-esteem, and reciprocity. Practical help (4 questions) included evidence of received aid. Negative aspects of intimate relationships (4 items) measured damaging interactions and conflicts. Items were rated on a 4-point Likert scale (Stansfeld & Marmot, 1992).

The subscale was used to measure the functional characteristics of social support, measuring the quality of emotionally intimate and supportive relationships. The subscale has five items that examine respondents' beliefs of being supported and appreciated and their ability to ask people for help or favours. Responses were rated on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Higher scores represent more felt attachment and available functional support.

3.10.2 Structural Social Support

To assess the structural dimensions of social support, we measured the accessibility and volume of social networks of respondents. The self-reported network data were collected on the frequency of encounters with relatives, friends, and colleagues, and involvement in social or religious activities (Henderson et al., 1980). The overall social network score was calculated by summing the total number of relatives or friends seen each month or more regularly. Structural social support was assessed using the Availability of Social Integration (AVSI) subscale of the Interview Schedule for Social Interaction (ISSI).

The AVSI subscale measures the extent of networks through four indicators: the number of people with whom the respondents share interests, the number of people with whom they interact weekly, the number of friends who can visit them at home comfortably and the number of people with whom they can communicate candidly. Structural social support was measured by four items. Responses were graded on a scale of 1 (none), 2 (1–2), 3 (3–5), 4 (6–10), 5 (11–15), or 6 (more than 15). Higher scores reflected larger and more interconnected networks. This study employed sex (male/female) solely as a grouping variable for comparative analysis, rectifying the previous misstatement that sex was used to measure structural support.

3.10.3 Appraisal, Belonging and Tangible Support

Interpersonal Support Evaluation List (short version): A 12-item questionnaire assessing perceptions of social support. It investigates a range of support dimensions, namely emotional, practical and network-related factors, to improve the insight into the impact of social ties on general well-being. This is a shortened form of the original ISEL, which had 40 items (Cohen & Hoberman, 1985). The exam comprises three

subscales that assess different types of perceived social support: evaluation support (items 2, 4, 6, and 11), belonging support (items 1, 5, 7, and 9), and tangible support (items 3, 8, 10, and 12). Support for appraisal means advice, feedback, or guidance. Belonging support refers to social contact and identification with a group. Tangible support means practical or physical support. Each subscale is composed of four items with response options in a four-point scale: certainly, true, to obviously false. Total score on the scale (0 to 36) was calculated as a combination of all items and subscale scores. Research has shown that higher ISEL-12 scores are associated with network integration and life engagement, whereas lower scores are associated with stress, anxiety, and depression. These relationships are small in magnitude.

Social support as a separate functional component may promote well-being through the buffering of harmful stress effects in the form of its impact on physiological stress reactions (Cohen & Wills, 1985). Perceived social support (PSS) was measured by the Interpersonal Support and Evaluation List-12 (ISEL-12), a 12-item instrument that assesses the perceived availability of social resources, such as companionship for activities, a confidant for discussion of problems, and the availability of material assistance when needed. Responses were scored on a 4-point Likert scale (some items were reverse-coded) from 1 (definitely false) to 4 (definitely true), with total scores ranging from 12–48 (Cohen et al., 1985). Higher ratings indicate better or more favorable social support.

The ISEL-12, a shortened version of the original 40-item Interpersonal Support Evaluation List, is a measure of perceived social support in three domains: appraisal support, belonging support, and tangible support. The short form consists of 12 items, 4 for each subscale. Each question's response is scored on a 4-point Likert scale from 1 to 4 (definitely false). Certain items are reverse-coded to minimize response bias. The

subscale scores are calculated separately, but you can also get an overall support score. The test has good psychometric properties with internal consistency reliability (Cronbach's α) mostly above 0.80 (Cohen et al., 1985).

Perceived social support (PSS) was assessed using the Interpersonal Support and Evaluation List-12 (ISEL-12), a 12-item scale designed to measure perceived access to social resources: availability of someone to do things with, someone to discuss problems with, and someone to provide material aid if needed. The answers were rated on a 4-point Likert scale (some items reverse-coded) from 1 (definitely false) to 4 (definitely true) so that the total score could range from 12 to 48 (Cohen et al., 1985). Higher ratings indicate more or more positive social support.

The ISEL-12, a shortened version of the original 40-item Interpersonal Support Evaluation List, is a measure of perceived social support in three domains: appraisal support, belonging support, and tangible support. The short form consists of 12 items, 4 for each subscale. Each question's response is scored on a 4-point Likert scale from 1 to 4 (definitely false). Certain items are reverse-coded to minimize response bias. Subscale scores are calculated separately, but an overall support score can be obtained. The test has good psychometric properties with internal consistency reliability (Cronbach's α) usually above 0.80 (Cohen et al., 1985)

3.10.4 Multidimensional Scale of Perceived Social Support (MSPSS)

Zimet et al., 1988. MSPSS is a 12-item measure of perceived support from multiple sources. It assesses three dimensions: family, platonic and romantic support. The participants rate the items on a 7-point Likert scale. The total score ranges from 12 to 84. Population norms are not available due to potential discrepancies. Respondents can be classified according to their MSPSS scores, using the response descriptions of the scale as a guide. Mean scores on this scale ranging from 1.0 to 2.9 indicate little support,

from 3.0 to 5.0 moderate support, and from 5.1 to 7.0 high support. Social support was assessed by the Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet et al. (1988).

The instrument comprises 12 items divided into three subscales: support from family, support from friends, and support from significant others, with each subscale including 4 items. Participants evaluate each issue using a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Total scores range from 12 to 84, with higher values indicating more perceived social support; subscale scores can also be calculated independently. The MSPSS has strong psychometric properties, with an internal consistency (Cronbach's α) from 0.85 to 0.91 and has proven concept validity.

3.11 Dependent variable: Subjective Well-Being

3.11.1 Psychological Well-Being (Kessler Psychological Distress Scale, K10)

This study utilized the Kessler Psychological Distress Scale (K10) to evaluate psychological distress, a measure of mental health (Kessler et al., 2002). The K10 scale was created as a screening tool to evaluate psychological distress in the general populace. It precisely distinguishes between cases and non-cases according to the Diagnostic and Statistical Manual of Mental Disorders (Kessler et al., 2002) and demonstrates a strong correlation with Composite International Diagnostic Interview (CIDI) diagnoses of anxiety and affective disorders (Andrews & Slade, 2001).

The K10 scale is a 10-item questionnaire that measures the distress experienced by an individual in the past four weeks. The scale includes the following specific items: 1) Did you have excessive tiredness? 2) Were you anxious? 3) Was your anxiety so bad that nothing could relieve your distress? 4) Did you feel powerless? 5) Were you feeling restless, fidgety? 6) Were you so restless that you could not sit still? 7) Are you having

symptoms of depression? 8) Does everything seem hard? 9) Is it really depressing that there is nothing to make you feel better? 10) Does it count for nothing? Each item has five response categories: 'none of the time', 'a little of the time', 'some of the time', 'most of the time' and 'all of the time'. The answers are used to compute a cumulative score, which will be between 10 and 50. Higher scores indicate more psychological distress. The measure has good internal consistency ($\alpha = 0.88$).

The Kessler Psychological Distress Scale (K10) is a basic self-report measure commonly used to assess psychological distress and to identify individuals who may require additional examination for anxiety and depression. Its initial purpose was for use by the general population, but it is also a potentially important clinical tool. The K10 consists of 10 questions, each graded on a 5-point scale from 5 'all the time' to 1 'none of the time'. Participants are asked to choose the answer that best describes their experiences during the past 4 weeks. The scores are added, the highest is 50, which means extreme discomfort and the minimum is 10, which means no suffering. The K10 score assesses psychological distress as follows: 10-15 (low), 16-21 (moderate), 22-29 (severe),

3.11.2 Life Scale Satisfaction

The contentment with Life Scale (SWLS) is a five-item scale to measure an individual's global contentment with life independent of any specific outcome. Each item is scored on a 7-point Likert scale (1 = strongly disagree; 7 = strongly agree). The total score ranges from 5 to 35. 31-35 implies severe contentment, 26-30 satisfaction, 21-25 moderate satisfaction, 20 neutralities, 15-19 small unhappiness, 10-14 dissatisfaction, and 5-9 extreme discontent (Diener, 1984).

Life satisfaction was assessed with a single-item query, adapted from the World Health Organization Quality of Life (WHOQOL-BREF): How do you evaluate your overall quality of life? Responses were assessed using a 5-point Likert Scale, where 5 denotes Very Good, 1 signifies Very Bad, and an option for Don't Know is included. This approach has been extensively employed in population-centric aging research (WHOQOL Group, 1998).

3.11.3 Satisfaction with Living Conditions and Life Scale (SLCLS)

Contentment with living conditions and life in general was assessed using a seven-item questionnaire adapted from validated quality of life and life-satisfaction measures (e.g., Contentment with Life Scale). Participants rated their pleasure with respect to (i) housing situation, (ii) health, (iii) ability to participate in daily activities, (iv) interpersonal relationships, (v) residential environment, (vi) life and (vii) overall quality of life. Items 1–6 were rated on a 5-point Likert scale (1 = Very satisfied to 5 = Very unhappy). Item 7 was rated on a 5-point scale (1 = Very good to 5 = Very bad) with “Don't know” purposefully treated as missing data. Scale scores were computed by summing across all valid elements. The scores might have ranged from 7 to 35. The lower the score, the higher the satisfaction and quality of life.

3.11.4 Subjective Well-Being Inventory

To measure the subjective well-being of the respondents, the subjective well-being scale developed by Sell and Nagpal (1992) was used. This measure includes 40 items, 19 of which measure positive effects in various dimensions of well-being, including general well-being, positive affect, expectation-achievement congruence, coping confidence, transcendence, familial support, and social support. The other 21 items refer to negative effects related to personal life problems within dimensions of ill-being. (Problems in

the main group, lack of mental control, poor health, lack of social contact, general well-being, unpleasant emotions)

The answer options for each statement were very good, quite decent and not good. For items 14, 27 and 29, there is an additional option of “not applicable” scored as 3, 2 and 1 for positive things and opposite scores for negative items. Subjective well-being was assessed using the Subjective Well-Being Inventory (SUBI), developed jointly by the World Health Organization (WHO) Regional Office for South-East Asia and the Indian Council of Medical Research (ICMR) (Sell, 1992). The questionnaire measures positive and negative characteristics of well-being, including happiness, social support, coping, anxiety, irritability, and perception of health in many areas.

SUBI is a 40-item subjective well-being measure. Each item is scored on a 3-point scale, with the response alternatives adapted to the content of the item (e.g., 1 = not at all, 2 = to a certain degree, 3 = to a significant extent). The scale offers separate scores for positive and negative categories as well as a composite indicator of well-being. The SUBI has been well validated in both Western and non-Western groups, including South Asia and has exhibited good internal reliability (Sell, 1992).

3.11.5 Self-reported Happiness

The World Health Organization Five Well-Being Index (WHO-5) is a concise five-item instrument and one of the most widely used measures of subjective psychological well-being. It has been utilized since its inception in 1998. WHO-5 is a succinct, self-reported instrument used to evaluate well-being over the preceding 2 weeks (Topp et al., 2015). It comprises five positively phrased statements that individuals evaluate on a 6-point Likert scale from 0 (never) to 5 (always). The raw results are then converted to a scale of 0 to 100, with lower scores indicating diminished well-being. A score of

≤50 indicates that an individual's well-being is suboptimal, necessitating further assessment to identify potential depressive symptoms. A score of 28 or lower indicates the existence of depression (Topp et al., 2015).

3.11.6 Control Measures Socio-Demographic Status

The study includes socioeconomic and sociodemographic data to control for any confounding factors. Age, sex, caste/ethnicity, literacy level, marital status, and family structure were examples of sociodemographic variables. The socio-economic factors included income level, living status, and occupation. The variables were introduced into regressions to control for the background factors that can independently affect subjective well-being.

3.11.7 Variables in Social Support System

In the regression models, the social support system's variables were operationalized as continuous composite variables. Functional support, structural support, evaluation support, belonging support, and tangible support were all measured using multi-item measures. Using standard scoring techniques, the dimensions were computed by summing the Likert-scale items for each dimension. The perceived levels of social support increase with higher scores. Moreover, the summative MPSS support score was calculated as the sum of all support dimensions. These composite scores were treated as continuous variables and directly included in the multiple linear regression models.

3.12 Data analysis

3.12.1 Data Analysis Procedure

A data analysis dealing with quantitative data was conducted using univariate, bivariate and multivariate methods. All the calculations were done on SPSS software (IBM

Corp., Armonk, NY, USA). The main variables were determined, and the measurement tool's reliability was evaluated with the help of the Cronbach alpha coefficient.

Three dependent variables, psychological well-being, life satisfaction, and self-reported happiness, were correlated with five independent variables—social support (functional, structural, appraisal, belonging, and tangible support) and socio-demographic and economic variables as controls using the conceptual framework. Every dependent variable was used in the linear regression analyses. It was feasible to concurrently evaluate the predicted associations among variables while accounting for potential correlations through multivariate analysis. Before performing multiple linear regression, categorical sociodemographic variables such as age group, sex, and caste/ethnicity were converted into binary dummy variables (0 = reference category; 1 = category present).

To achieve a certain level of validity, reliability and quality control, pre-tested instruments were implemented, culturally adjusted to the needs of the Nepalese older population and implemented with a strict ethical code of conduct, such as informed consent and protection of privacy.

3.12.2 Level of Subjective Well-Being of Older People

Age, gender, and socioeconomic position were among the demographic groupings whose well-being scores were evaluated using statistics (mean, standard deviation, median). Using the Subjective Well-Being Inventory (SUBI), a two-way ANOVA was used to examine family and friend support. Likert-scale averages were used to transform both measures into three ordinal categories: Low (1–2.9), Moderate (3–5), and High (5.1–7).

SUBI scores were used as a dependent continuous variable. Assumptions were checked: the Shapiro-Wilk test revealed non-normality ($p < .05$), yet ANOVA was used because of the large sample size ($N = 402$) and equal group sizes (Field, 2024). The Levene test confirmed homogeneity of variance ($p = .18$). ANOVA (Analysis of Variance) was used to assess variations in subjective well-being by social support and sociodemographic categories, with a significance level of $p = .05$. Because the dependent variables (SWB dimensions) and independent factors (friend support, family support, and the combination of the two) were continuous, this method was appropriate.

The statistical significance of the mean difference between the groups was assessed using ANOVA; F-values and p-values were reported, and the R² value indicates the proportion of variance explained. When interaction effects were present, factorial ANOVA was utilized. Additionally, covariates were included to control for confounding variables, thereby improving the study's reliability. Additionally, the mediating effects of social support on loneliness, physical health, and subjective well-being.

3.12.3 Social Support and Subjective Well-Being of Older People

The degree and predictors of older people subjective well-being were examined using both descriptive and inferential statistics. To represent the central tendencies and variability, the proportions of the mean, median, and standard deviation for each well-being measure by sex were determined. Correlation analysis was used in the inferential analysis to examine relationships between the well-being outcomes (subjective well-being, life satisfaction, and happiness) and the continuous social support dimensions (family, friends, significant others, and structural and functional support). To ascertain the strength and direction of association without establishing a cause-and-effect

relationship, correlation was the appropriate method. All analyses were done on continuous scores and the standard of significance was 0.05.

3.12.4 Factors Affecting Psychological Well-Being

Four distinct multiple linear regression models were estimated in accordance with the study's goals and conceptual framework to investigate how social support networks and sociodemographic traits affect various aspects of subjective well-being. To evaluate each predictor's independent and net impacts while adjusting for other model variables, multiple regression was used. The general form of the regression model is:

$$Y = \beta_0 + \beta_1 FS + \beta_2 SS + \beta_3 MPSS + \beta_4 AS + \beta_5 BS + \beta_6 TS + \beta_7 AG + \beta_8 SEX + \beta_9 HH + \beta_{10} CASTE + \beta_{11} MS + \beta_{12} FAM + \beta_{13} LIT + \beta_{14} OCC + \epsilon$$

Model I: Overall Subjective Well-being

$$SWB = \beta_0 + \sum \beta_i X_i + \epsilon$$

This model looks at how sociodemographic traits and social support factors affect the total subjective well-being score.

Model II: WHO-5 Well-being Index

$$WH05 = \beta_0 + \sum \beta_i X_i + \epsilon$$

This model assesses the predictors of emotional well-being measured through the WHO-5 Well-being Index.

Model III: Psychological Distress (K10)

$$K10 = \beta_0 + \sum \beta_i X_i + \epsilon$$

This model estimates the effects of social support systems and socio-demographic variables on psychological distress.

Model IV: Life Satisfaction

$$LS = \beta_0 + \sum \beta_i X_i + \epsilon$$

This model evaluates the association between social support systems, socio-demographic characteristics, and life satisfaction. All predictors were entered simultaneously in each model to determine their independent contributions to the respective well-being outcomes.

3.12.5 Factors Affecting Life Satisfaction

Life satisfaction was measured using the Satisfaction with Life Scale (SWLS) and SLCLS. The independent and control variables were identical to those in the example above. The effects of social support and demographic/socioeconomic determinants on life satisfaction were investigated using multiple linear regression. The regression assumptions were tested using histograms, P-P plots, VIFs (under 10), tolerances (>0.1), standardized residuals, scatter plots, and the Durbin-Watson statistic (Field, 2024).

3.12.6 Factors Affecting Happiness

Self-reported happiness was assessed using the WHO-5 Well-Being Index, and only selected SUBI items were used to assess subjective positive affect. The control and independent variables were the same as in previous models. Multilinear regression was used to evaluate the predictive associations between social support and self-reported happiness using the same assumptions as for psychological well-being and life satisfaction.

The arithmetic mean of the two life indicators and the two subjective well-being scores is used to compute this. The Composite Index of Subjective Well-Being is determined by taking the arithmetic mean of the two life indicators and the two

subjective well-being scales. A composite score was created by standardizing the three dependent variables (life satisfaction, psychological well-being, and self-reported happiness) and summing them. The effects of social support and control factors on subjective well-being were investigated using multiple regression. Given its alignment with the conceptual framework, this could examine the direct and indirect effects of social support on older people's well-being.

3.12.7 Diagnostic Test for Regression Analysis

Regression diagnostics were used to examine several linear regression models. The residuals were tested for normality using the Shapiro-Wilk test, a histogram, and a normal probability (P-P) plot. Multicollinearity was assessed using the variance inflation factor (VIF) and tolerance (TOL) values, which were considered acceptable when $VIF < 10$ and $TOL > 0.1$. Linearity and homoscedasticity were checked by plotting standardized residuals versus predicted values. To test for autocorrelation, the Durbin-Watson statistic was used. Values of around 2 indicate no significant autocorrelation. The diagnostic test results indicated that the regression models were appropriate for analyzing the association between social support and subjective well-being in older persons.

CHAPTER IV

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The literature available at present indicates that the socio-economic and demographic characteristics of respondents are of great importance for understanding social processes. The socioeconomic profile of the older cannot be neglected in exploring potential sources of social support for senior family members. The socioeconomic standing of older people is affected by their age, sex, religion, family structure, number of children, education, current employment, and health, among other factors. The socioeconomic and demographic variables in the study allow us to analyze and infer the effect of these characteristics on the total care and assistance families provide to older people.

4.1 Demographic Attributes

The numerous facets of a population's sociodemographic situation influence the quality of life of older people. It includes age, gender, caste, religion, marital status, family type, family structure and literacy level. These affect a person's well-being and quality of life in later life. Therefore, knowing these factors enables us to assess the influence of the social, cultural, and economic sectors on older people. The age of the older person directly or indirectly affects the degree of family care and support they require. The "younger" group in the older population in Table 4.1 is people aged 60-69. They will be mostly active and will need little or no help from family members. Caregivers are constantly stressed in their duties, having negative health implications with physical symptoms, including despair and anxiety.

Table 4.1*Socio-Demographic Characteristics of the Respondents*

Characteristics	Male		Female		Total	
	No.	%	No.	%	No.	%
<i>Mean (SD)</i>	69.8 (6.3)		69.8(6.3)		69.8 (6.3)	
Age Group						
60-64	46	21.7	31	16.3	77	19.2
65-69	71	33.5	67	35.3	138	34.3
70-74	54	25.5	57	30.0	111	27.6
75-79	19	9.0	20	10.5	39	9.7
80-84	15	7.1	9	4.7	24	6.0
85 and above	7	3.3	6	3.2	13	3.2
Caste and Ethnicity						
Brahmin	71	33.5	59	31.1	130	32.3
Kshetri	70	33.0	72	37.9	142	35.3
Tharu	51	24.1	41	21.6	92	22.9
Dalit	17	8.0	15	7.9	32	8.0
Others	3	1.4	3	1.6	6	1.5
Religion						
Hindu	209	98.6	188	98.9	397	98.8
Buddha	2	0.9	2	1.1	4	1.0
Christian	1	0.5	0	0	1	0.2
Marital Status						
Married	173	81.6	160	84.2	333	82.8
Unmarried/Divorced/Widowed	39	18.4	30	15.8	69	17.2
Family Type						
Nuclear, Couple Only	15	7.1	11	5.8	26	6.5
Couple with Unmarried Children	22	10.4	22	11.6	44	10.9
Joint	174	82.1	153	80.5	327	81.3
Alone	1	0.5	4	2.1	5	1.2
Literacy Status						
Illiterate	115	54.2	179	94.2	294	73.1
Non-formal education	51	24.1	6	3.2	57	14.2
Primary (1-5 grade)	32	15.1	3	1.6	35	8.7
Secondary (6-10 grade)	10	4.7	1	0.5	11	2.7
SLC and above	4	1.9	1	0.5	5	1.2
Total	212	100	190	100	402	100

Note. The result from the data analysis of the field survey.

Table 4.1 shows that caste has a big effect on well-being because Dalits and other oppressed groups have to deal with discrimination, limited access to medical care, and economic inequality, which all make their lives worse (Thapa et al., 2021). The 65-69 age group had the highest response rate (34.3%). The next most affected were the

70-74 age group (27.6%), followed by the 60-64 age group (19.2%), and the least were the 85 and over age group (3.2%). In the sample, the majority of respondents are from the Kshetri (35.3%) and Brahman (32.3%) communities. The share of Tharu and Dalits is 23% and 8%, respectively, among the total respondents. This indicates that the municipality comprises caste/ethnic diversity among its residents, with the majority of residents belonging to the Kshetri and Brahman communities. The remaining 1.5% came from different ethnic groups, indicating that people of all types were included in society. These differences in caste and ethnicity are important for understanding how culture and social structures affect the health of older people.

Religion plays a crucial role in shaping the social and cultural environments of older people, as it influences how their support networks function. The sample showed that Hindu believers accounted for 98.8 percent of older respondents, while Buddhism accounted for 1.0 percent and Christianity for 0.2 percent. The high levels of religious homogeneity suggest a shared cultural structure that both promotes and limits the well-being of older individuals. In Hindu beliefs, elders are honored along with family duty principles that strengthen social support bonds among multigenerational family members. Religious beliefs and practices serve as vital coping mechanisms for senior adults, positively affecting their emotional health and shaping their healthcare decisions (Abdelrahman et al., 2020). Religious family activities enhance respect and care toward older people and foster stronger family connections.

The level of care and support is highly affected by their marital status. To address isolation among the older, a partner is essential. The movement of older people becomes increasingly limited or challenging in old age, especially in the oldest age, resulting in reduced social engagement with neighbors, friends and family outside the home. The psycho-emotional state of an older person with low social connections

worsens - both psychologically and physically. Loneliness doesn't have to be such a chronic problem.

In the sample, 82.8 percent of the respondents were married, and 17.2 percent were unmarried, divorced, or widowed. The majority of respondents (82.8%) are married, and 17.2% are single, divorced, or widowed. The different family types are: nuclear (6.5%), couple alone (10.9%), couple with son or daughter not married (10.9%), blended family (81.3%) and single respondents (1.2%).

An individual's educational experience plays a big role in many areas of life. It has a strong impact on their work opportunities and financial perspective and leads to a more optimistic perspective. More education, on the other hand, is associated with more responsible, compassionate lifestyles. Furthermore, older people with higher education are more financially independent and have better access to high-quality care and assistance.

The data showed that in the older study population, 73.1 percent of respondents were illiterate. Globally, 26.9 percent were literate, 14.2 percent had non-formal education, 8.7 percent had education up to the primary level, 2.7 percent had education up to the secondary level, and 1.2 percent had obtained a School Leaving Certificate (SLC) or higher. The study data show that the majority of respondents are older, highly illiterate individuals. The study participants were divided into six age groups: 19.2% were in the 60–64 age group, 34.3% were in the 65–69 age group, 27.6% were in the 70–74 age group, 9.7% were in the 75–79 age group, 6.0% were in the 80–84 age group, and 3.2% were 85 or older. The sociodemographic descriptions offer a crucial basis for comprehending older people's living standards and well-being needs.

4.2 Socio-Economic Characteristics

Socioeconomic status is one of the more significant measures of an individual's quality of life, and is related to their education, employment, and social services support. This study has primarily examined how older people's quality of life is affected by their socioeconomic status and the importance of establishing fairness guidelines in this area. In the discussion that follows, a cross-sectional assessment of several complex sociodemographic traits across three older age groups (60 to 69, 70 to 79, and 80 or more) is presented. Table 4.2, which separates respondents into three age groups: 60–69, 70–79, and 80+, presents their socioeconomic characteristics.

There are more males than females in both age groups (60-69 and 80+), with 54.4% and 59.5%, respectively. According to the statistical results, females outnumber males as 51.3 percent vs. 48.7 percent in the age group 70-79 years old. The overall study population comprises 52.7% males and 47.3% females. This gender distribution results from differences among age groups, which may be influenced by other demographic features, such as the longevity and marriage status of older people. Marital status is one of the determinants of older people's SEP. Mixed results were found for marriage status among older people: 91% of 60- to 69-year-olds and 82.0% of 70- to 79-year-olds were currently married. Only 37.8% of those aged 80 and older are married; the rest (62.2%) are separated, widows, or divorced. The highest age group is composed of women (62.2 percent), as they are the ones who have become widows or divorced, or separated from their partners and no longer live with them. Advanced marital status is more prevalent among females and this indicates a pattern in the aging population that will bring social and economic issues in advanced marital status.

Table 4. 2*Socio-Economic Status of Respondents by Age Groups*

Characteristic	60-69 Age group	70-79 age group	80+ age group	Total (No.)	%
Sex					
Male	54.4	48.7	59.5	212	52.7
Female	45.6	51.3	40.5	190	47.3
Marital status					
Married	91.2	82.0	37.8	333	82.8
Unmarried/divorced/widowed	8.8	18.0	62.2	69	17.2
Family size					
1-4 members	80.5	82.0	97.3	332	82.6
5 or more members	19.5	18.0	2.7	70	17.4
Occupation					
Agricultural	72.3	82.3	68.6	294	75.8
Non-agricultural	27.7	17.7	31.4	108	24.2
Dependency status					
Partially dependent others	36.7	39.3	37.8	152	37.8
Fully dependent on others	40.0	52.0	51.4	183	45.5
Not dependent on others	23.3	8.7	10.8	67	16.7
Old age allowance					
Yes	47.9	96.7	97.3	284	70.6
No	52.1	3.3	2.7	118	29.4
Educational status					
Illiterate	67.4	80.0	78.4	294	73.1
Non-formal education	14.4	13.3	16.2	57	14.2
Primary (1-5)	12.1	5.3	2.7	35	8.7
Secondary (6-10)	3.7	1.3	2.7	11	2.7
SLC and above	2.3	0.0	0.0	5	1.2
Total	100.0	100.0	100.0	402	100

Note. The result from the data analysis of the field survey.

Table 4.2 shows that a significant number of older individuals and especially those within the age groups of 60-69 and 70-79, tend to reside alone. Among respondents, 80.5 percent of those aged 60 to 69 and 82.0 percent of those aged 70 to 79 live in households with 1 to 4 members. This number increases further in the 80+ age category, where 97.3 percent live in smaller family units. On the contrary, just 17.4 percent of respondents reside in households with five or more members, suggesting a decrease in family size among the older population, particularly among the very old. This change signal points to women's ability to age well, particularly their need for

more social and emotional support. In the study, more than 80 percent (80.8 percent) of the respondents are married, and 19.2 percent are single, divorced, or widowed.

Furthermore, 73.1 percent of the population surveyed are unable to read or write, with more counts among the aged population. To be specific, 67.4 percent of respondents in the 60 to 69 age range are illiterate, while 80.0 percent of respondents in the 70 to 79 age range and another 78.4 percent of respondents aged 80 and above are also illiterate. The rates of non-formal education are 14.4 percent in the 60-69 age group, 13.3 percent in the 70-79 age group, and 16.2 percent in the 80 years and above age group. 12.1 percent of primary-level education is completed among the aged 60-69, 5.3 percent among the aged 70-79, and 2.7 percent among the aged 80 and above. Only 2.7 percent have attained secondary education, while 1.2 percent have progressed to the SLC level. These findings point to educational inequalities among older people, which may, in turn, affect their economic or social welfare. On the contrary, over 64.8 percent of literate respondents aged 60–69 years have attained some level of education, but the provision of education decreases with age, suggesting that education was accessible to some generations more than to others.

Table 4.2 shows that, as for the type of work, 72.3 percent of respondents aged 60-69 are engaged in agricultural work and this statistic is still significant in the other age groups, such as those aged 70-79, who have 82.3 percent and those aged 80+ have 68.6 percent, also indicating engagement in agricultural activities. Only 75.8 percent of the older respondents are engaged in agricultural work, while 24.2 percent are in nonagricultural occupations. While it is known that dependency tends to rise with age, the fact that 68.6 percent of the 80+ age group is engaged in farming seems paradoxical; this group may still experience increased dependency needs, as evidenced by their overall socio-economic baseline.

Furthermore, that at the old-age pension benefits, it can be observed that while only 47.9 percent of the active population in the 60-69 age category receives that particular monetary benefit, this proportion improves considerably in the next age groups 70-79 and 80+, where 96.7 and 97.3 percent, respectively, are reported to receive said benefit. In essence, 70.6 percent of respondents are covered by old-age benefits schemes, while 29.4 percent are not. In particular, this trend reflects the growing financial resources required for survival in old age, thereby highlighting the ever-increasing costs and economic burden on older people.

Table 4.2 shows that older people aged 60–69 have better access to health care services than their counterparts aged 80 or older. The younger older tend to engage socially and economically, which could explain the improved health care access. The behaviour of older people leads them toward passivity while their families provide them with reduced support. A large portion of 37.8% respondents identified partial dependency situations, yet 45.5% indicated being fully dependent on others' help, while independent caregivers made up just 16.7% of the participants. Research results demonstrate that dependency levels increase with age, indicating deterioration in quality of life and personal independence among seniors.

The study reveals numerous social inequalities that affect older people through their high dependency ratios and their involvement in subsistence farming and their low levels of literacy. Social equity improvements among older people depend heavily on solving differences related to family size, as well as education levels and employment status and income streams and possession of assets.

4.3 Access to the Necessary Facilities Among the Older Population

The following, on older age groups and the percentage opting for available services, refers to the number of active elders using community-based facilities. Community facility services involved age, gender, caste, relationship status, and independent factors. The following facilities among the older people have been covered: piped water, television, radio, computer, wired and mobile phones, and the internet.

Table 4.3 indicates that in the lower older age groups (60-69 years), it is easy to access all the facilities, as all of them have access to toilets (100.0%) and a considerable number have access to piped water (72.6%) as well as television (48.8%). The situation begins to change in the 70-79 groups, where the availability index for piped water is 81.3 percent, television is 41.3 percent, and phone or mobile is 20.7 percent. In the 80 years and over age group, access to television further declines to 35.1 percent, while that of radio is slightly higher at 32.4 percent. In general, men have more access to the facilitating structures as opposed to women, with that of piped water standing at 75.5 percent for men and 76.8 percent for women, television access being 45.3 percent for males and 44.2 percent for women and phone or mobile accessibility being 89.6 percent for men and 90.0 percent for women.

This suggests there is a moderate gender disparity in facility use among older respondents. Furthermore, the Brahman and Kshetri enjoy more accessible facilities than other castes. Toilets are available to all drawn respondents (100%), followed by piped water (82.3%) and television (39.2%). The Kshetri respondents also have high access levels: all respondents have access to toilets, 100 percent have piped water, and 47.9 percent have access to television.

Table 4.3

Percentage Distribution of the Respondents by Enjoying Household Facilities and Background Characteristics

Background attributes of older	% of the older people enjoying the facilities							Total (N)
	Toilet facility	Piped water	Television	Phone/mobile	Radio	Computer	Internet	
Age								
60-69	100.0	72.6	48.8	32.1	32.1	7.0	31.6	215
70-79	99.3	81.3	41.3	20.7	20.7	2.7	29.3	150
80+	100.0	75.7	35.1	32.4	32.4	8.1	35.1	37
Sex								
Male	99.5	75.5	45.3	89.6	28.3	5.7	32.1	212
Female	99.8	76.8	44.2	90.0	27.4	5.3	30.0	190
Caste								
Brahaman	100.0	82.3	39.2	92.3	33.1	6.9	31.5	130
Kshetri	100.0	77.5	47.9	90.8	33.1	7.0	38.7	142
Tharu	98.9	69.6	53.3	83.7	8.7	3.3	22.8	92
Dalit	100.0	59.4	31.2	93.8	40.6	0.0	15.6	32
Other	100.0	100.0	33.3	83.3	16.7	0.0	50.0	6
Religion								
Hindu	99.7	76.1	44.8	89.7	27.7	5.5	30.7	397
Non-Hindu	100.0	80.0	40.0	100.0	40.0	0.0	60.0	5
Family type								
Nuclear	100.0	96.2	30.8	73.1	30.8	3.8	7.7	26
Couple with an Unmarried son/daughter	100.0	65.9	27.3	84.1	31.8	0.0	38.6	44
Joint	99.7	76.5	48.9	92.4	26.9	6.4	32.1	327
Alone	100.0	40.0	0.0	60.0	40.0	0.0	20.0	5
Total	100	100	100	100	100	100	100	402

Note. The result from the data analysis of the field survey.

Table 4.3 shows that these facilities for Tharu respondents are average: 98.9 percent have toilet and water facilities, 69.6 percent have piped water, and 53.3 percent have access to television. On the other hand, the Dalit respondents have the least access: 59.4 percent have access to a piped system, 31.2 percent to television, and none to

computers. The 'Others' caste group has equal access to both piped water and toilet facilities, but lesser access to other services. The study also found and analyzed disparities in access to facilities, with Brahman and Kshetri respondents having the most access, while Dalit respondents had the least in most categories.

Furthermore, Hindus have a high ownership of toilets (99.7%), access to piped water (76.1%), and own televisions and computers to a lesser extent (44.8% and 5.5%, respectively). There is, however, a high ownership of mobile phones (89.7%) and internet access (30.7%) among them. Non-Hindus have almost the same level of access to toilets and piped water, 100 percent and 80 percent, respectively, while access to Wi-Fi is higher (60.1%), and ownership of television (40.1%) and computers (40.1%) is lower than that of other facilities.

The results indicate that in joint families, facilities are more readily available, as 76.5 percent have piped water, 48.9 percent own televisions, and 92.4 percent possess phones. About 26.9 percent of joint families own radios, 6.4 percent have computers and 32.1 percent are connected to the internet. In families composed solely of couples, the availability of piped water is high at 96.2 percent, all have toilets (100%), and 73.1 percent have no new families without a television. Families where all the children are still single have phones about 84.1 percent of the time, whereas access to piped water is rather average at 65.9 percent, and 38.6 percent have access to the World Wide Web. People who live alone tend to have very few facilities available to them, suggesting that socioeconomic barriers may exist.

Though such resources may be made available to them, resource-wise, and even for a longer time, gender-adjusted age differences mean that younger older people (ages 60-69) and males had more facilities. Younger older individuals were aged 60-69 years, while older individuals were aged 70 and above, and males received more facility

support. The tendency of women from the Brahman and Kshetri castes is to adopt modern technologies and their services. Expansion of family types causes variation in distribution and in the range of facilities available to family members, with joint families found to have more.

4.4 Composite Socio-Demographic Indicators

The composite socio-demographic indicators for the older respondents offer an analytical and integrated picture of their structural and socio-economic factors. The table presents a clear yet comprehensive profile of the study population by integrating essential factors such as age, gender, marital status, family structure, education, occupation, dependency, social protection, and household amenities. The factors can be synthesized, allowing for a comprehensive understanding of the living conditions, socio-cultural background, and resource accessibility of the older population in the study area, thereby highlighting their strengths and weaknesses.

Table 4.4 presents the composite socio-demographic indicators for the older respondents, providing a structural and socio-economic discussion of the sample. In the age analysis, a majority (53.5 %) of respondents were 60-69 years old, and only 46.5 % were 70 years or older, indicating relatively equal representation of early- and late-older respondents. The gender distribution was even, with males (52.7%) and females (47.3%).

The marital security was also good, with only 17.2% of the respondents being widowed, divorced or unmarried, and 82.8% being in a stable marital relationship, the most common population examined. The respondents reported that 81.3% of them resided in joint families, while 18.7% of the respondents lived in nuclear or single families. The level of literacy was low as 73.10% of the respondents were illiterate,

while 26.90% had received some formal education, thus signifying limited access to educational opportunities. Agriculture was the primary socio-economic activity, being the occupation of 75.8% of all the respondents, against 24.2% from the non-agricultural activities.

Table 4. 4

Composite Socio-Demographic Indicators of Older Respondents

Domain	Indicator	n	%
Age Structure	60–69 years	215	53.5
	70 years and above	187	46.5
Gender Composition	Male	212	52.7
	Female	190	47.3
Marital Status	Currently Married	333	82.8
	Not Married (widowed/divorced/unmarried)	69	17.2
Living Arrangement	Joint Family	327	81.3
	Non-joint (nuclear + alone)	75	18.7
Educational Level	Illiterate	294	73.1
	Literate (any level)	108	26.9
Economic Engagement	Agricultural Occupation	294	75.8
	Non-agricultural	108	24.2
Dependency Status	Fully Dependent	183	45.5
	Partially Dependent	152	37.8
	Independent	67	16.7
Social Protection	Receiving Old Age Allowance	284	70.6
	Not Receiving	118	29.4
Access to Basic Household Amenities	Toilet	401	99.8
	Piped Water	306	76.1
	Television	180	44.8
	Internet	124	30.8

Note. The result from the data analysis of the field survey.

Table 4.4 shows that the dependency rates show that a high proportion of the older were dependent to some extent: 45.5 per cent were completely dependent; 37.8 per cent were partially dependent; and only 16.7 per cent were not dependent at all.

Moderate access to formal social security measures was found, with 70.6% of respondents embarking on social protection using old-age allowances. In the area of basic household facilities, nearly all respondents (99.8%) could access toilets and 76.1% had piped water. However, access to modern media and communication technology was still weak: 44.8 percent of households had television, and 30.8 percent had access to the internet, indicating a lack of information exposure and digital divide. these indicators point to a population that is characterized by traditional family structures, low level of education, large agricultural activities, high levels of dependency and moderate levels of social security coverage.

CHAPTER V

LEVEL AND DIMENSIONS OF SUBJECTIVE WELL-BEING

5.1 Subjective Well-Being and Its Dimensions

This chapter assesses subjective well-being (SWB) among older persons in the research area to evaluate their overall well-being. The chapter employs descriptive, composite, and inferential analyses in this context. The relationships among respondents' satisfaction with their living conditions, overall quality of life, and access to social assistance are elucidated through percentages, averages, and standard deviations. The WHO-5 Well-Being Index, Kessler Psychological Distress Scale (K10), and Subjective Well-Being Inventory (SUBI) evaluate many dimensions of well-being, simplifying complex data into understandable metrics.

A comparison of differences in well-being across socio-demographic, socioeconomic, and social support variables is conducted using inferential statistics, including ANOVA, to identify significant differences and trends. The presence of all the tables and statistical instruments is therefore a deliberate technique that could be used to establish the extent of well-being, quantify its many-dimensional aspects and make estimates on how well-being is correlated to the most important demographic and social support factors to ensure a systematic and rigorous approach to the research purpose of the chapter.

Subjective well-being (SWB) is therefore categorized as the emotional reaction of the person to the way of living or the life incidents and then a brief assessment of the reaction. Hence, SWB plays a significant role in the older as it determines the quality of life they live. Due to demographic shifts and the rise in the average life expectancy of the older population, the subjective well-being of the older has become of paramount

significance. To measure subjective well-being, one should either use objective measures or conduct a self-report survey to track the parameters to be measured and analyzed. Physical and mental health quality comparisons are linked to subjective well-being on a separate scale and to social support among older individuals.

5.2 Socio-Demographic Variation in Living Satisfaction

Living arrangements and other sociodemographic characteristics, such as age, gender, and literacy, have a direct impact on later-life subjective well-being. The general expectations for quality of life (QOL) and contentment with living conditions are determined by these factors. Peggy A. Thoits (2011b) asserts that social support and socioeconomic level have a significant impact on psychological well-being. As a starting point for subsequent statistical analysis, the following section offers a succinct descriptive assessment of the connections between the primary demographic factors and living satisfaction and perceived quality of life.

5.2.1 Satisfaction with Living Arrangements

Resident satisfaction with living conditions tends to differ with the nature of the environment they live in. Generally, residents of supportive and comfortable environments tend to report high satisfaction levels, whilst those living in cramped or substandard housing tend to be unhappy. Water for recreation and socialization facilities is generally associated with satisfying experiences, while a lack of such facilities or services is associated with the opposite. Satisfaction levels differ with age. The results indicate that the youngest older group (60–69) exhibits an impressive satisfaction rate: 26.5 percent are very satisfied and 55.8 percent are satisfied, while 16.3 percent report neutrality, and very few express dissatisfactions (0.5 percent dissatisfied and 0.9 percent very dissatisfied). Satisfaction in the 70–79 age group was reported similarly, though

with slightly more dissatisfaction (2.7%) and neutrality (17.3%). Of all the groups, the 80+ group had the highest share of individuals who were very satisfied (32.4%) and reported being very satisfied with their self-assessment.

Furthermore, when it comes to gender, a higher percentage of men were very satisfied (30.2%) than women (21.6%), although women had a slightly higher overall satisfaction rate (58.9%). More females (17.9%) than males (13.2%) reported equal levels of satisfaction, indicating a small gap between the genders, with males leaning toward higher satisfaction.

The result shows that the degree of satisfaction was high in the Brahman and Kshetri caste. The status of Brahman has a satisfaction rate of 64.6 percent. In this case, no responder has classified themselves as highly unsatisfied. However, similar levels were not observed among the Tharu and Dalit castes, where satisfaction levels were substantially lower. Tharu respondents had the highest proportion of indifferent responses at 25.0 percent, and the lowest proportion of displeased responses at 3.3 percent. The distribution was informal within the Dalit group, with 34.4 percent of respondents very satisfied and a higher-than-average level of dissatisfaction compared with the Brahman and Kshetri castes. Furthermore, the patterns of satisfaction levels among religious affiliations differ slightly. In particular, the ordinary satisfaction (56.9%) and very high satisfaction (25.9%) among Hindus were the highest, compared with other reported levels of dissatisfaction (1.3%). However, the smaller sample of non-Hindus showed very high satisfaction (40.0% very satisfied) and lower levels of neutrality or dissatisfaction than the other group, suggesting differences in religious or community support.

Table 5.1

Percentage Distribution of the Respondents by Living Satisfaction: Age Group, Sex, Caste/Ethnicity, and Religion

Background characteristics	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	N
Age group						
60–69	26.5	55.8	16.3	0.5	0.9	215
70–79	24.0	56.0	17.3	2.7	0	150
80+	32.4	64.9	2.7	0	0	37
Total	26.1	56.7	15.4	1.2	0.5	402
Sex						
Male	30.2	54.7	13.2	1.4	0.5	212
Female	21.6	58.9	17.9	1.1	0.5	190
Total	26.1	56.7	15.4	1.2	0.5	402
Caste/ethnicity						
Brahman/Chhetri	27.7	64.6	7.7	0	0	130
Kshetri	25.4	56.3	16.2	0.7	1.4	142
Tharu	21.7	50.0	25.0	3.3	0	92
Dalit	34.4	46.9	15.6	3.1	0	32
Others	33.3	50.0	16.7	0	0	6
Religion						
Hindu	25.9	56.9	15.4	1.3	0.5	397
Non-Hindu	40.0	40.0	20.0	0	0	5

Note. The result from the data analysis of the field survey. Contentment with living conditions was assessed utilizing a 5-point Likert scale (5 = Extremely satisfied, 4 = Satisfied, 3 = Neutral, 2 = unhappy, 1 = Extremely unhappy).

Table 5.1 shows that marital status is more important to their satisfaction than anything else. The majority of older couples feel moderate satisfaction (56.8%), while a greater percentage feel neutral (16.8%). The unmarried, divorced, or widowed were more likely to be very satisfied (31.9%) and less likely to be neutral (8.7%), which may indicate a role for marriage in satisfaction with living arrangements in the older age group.

Table 5.2

Percentage Distribution of the Respondents by Living Satisfaction: Marital Status, Literacy Status, Dependency Status, and Living Condition

Background characteristics	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied	N
Marital status						
Married	24.9	56.8	16.8	0.9	0.6	333
Unmarried/divorced/widowed	31.9	56.5	8.7	2.9	0	69
Total	26.1	56.7	15.4	1.2	0.5	402
Literacy status						
Illiterate	24.5	57.8	16.0	1.4	0.3	294
Non-formal education	24.6	52.8	21.1	1.8	0	57
Primary (1–5)	40.0	54.3	2.9	0	2.9	35
Secondary (6–10)	36.4	45.5	18.2	0	0	11
SLC and above	20.0	80.0	0	0	0	5
Dependency status						
Partially dependent	23.7	58.6	14.5	3.3	0	152
Fully dependent	23.0	59.0	17.5	0	0.5	183
Not dependent	40.3	46.3	11.9	0	1.5	67
Living condition						
Spouse	25.1	59.6	14.2	0.5	0.5	183
Children and in-laws	22.4	59.4	16.4	1.2	0.6	165
Grandchildren	37.9	37.9	17.2	6.9	0	29
Others	44.0	40.0	16.0	0	0	25
Total	26.1	56.7	15.4	1.2	0.5	402

Note. The result from the data analysis of the field survey. The assessment of satisfaction with living circumstances using a 5-point Likert scale (5 = Very satisfied, 4 = Satisfied, 3 = Neutral, 2 = Dissatisfied, 1 = Very dissatisfied).

Table 5.2 indicates that living with a spouse or children tends to yield greater satisfaction, as 59.6 percent of respondents living with a spouse reported satisfaction. Curiously, respondents who lived with grandchildren exhibited considerable variability in response, reporting both high levels of satisfaction (37.9%) and high levels of neutral responses (17.2%), while respondents categorized under others reported the highest levels of very high satisfaction at 44.0 percent. This could mean that residents' support and satisfaction are affected by specific living situations.

5.2.2 Life Satisfaction

Life satisfaction is a broad and subjective concept that varies widely among people. It assesses global and/or specific self-evaluations of one's life satisfaction and physical, social, and mental health. While some older people tend to show moderate levels of unhappiness given the circumstances, others may have high levels of life satisfaction, suggesting a positive view of the world. Table 5.3 presents the presence of subjectivity in life satisfaction and the factors that contribute to it, especially among older people in hospitals awaiting procedures or treatment.

The difference in life satisfaction among the older is also influenced by the age group one belongs to. Table 5.3 shows that respondents aged 60 to 69: 45.6 percent indicated a moderate quality of life, 39.1 percent good, 10.2 percent very good, and 1.9 percent. Respondents in the 70 to 79 age group reported similar findings, with 48.8 percent indicating a good quality of life and 49.8 percent reporting moderate quality of life. The 80+ age group recorded the highest percentage of very good (13.5%) and good (43.2%) quality of life, indicating an optimistic perspective about life satisfaction with increasing age.

The results indicate that patterns of satisfaction show strong gender differences, with males on average more satisfied (47.6%) than females (45.8%) regarding a good quality of life. Those who say the highest level of satisfaction possible is very good seem to be almost a fifty-fifty split, as 9.0 percent of males and 10.0 percent of females opted for this. 'Very bad', however, is male-dominated, with 3.7 percent of women who classified their status reporting more dissatisfaction than men, who did not even indicate 'Very bad' as an option.

Furthermore, the majority of Hindus express a sense of good (43.6%) or average (42.6%) satisfaction with life, with only a few (1.5% and about 1.8%, respectively) registered as dissatisfied, “Bad,” and “Very bad”. Non-Hindus, though the sample size was relatively smaller, produced quite different response patterns, where 80.0 percent demonstrated a moderate quality of life and a lot more (20.0%) reported “Very good”, suggesting that satisfaction levels may differ according to beliefs or cultures.

The results indicate that the caste groups, Brahmans, had higher good life satisfaction scores (55.4%) than any other caste group, whereas Kshetri respondents were inclined towards moderate life satisfaction scores (51.4%). However, among the Tharu respondents, there was a fair distribution between good (46.7%) and moderate (40.2%) life satisfaction, with a few (3.3%) reporting poor life satisfaction. Most Dalits were moderately satisfied (50.0%), with a significant number reporting “Very good” (12.5%). The “Others” reported moderate satisfaction (83.3%), while a small group (16.7%) reported very good life satisfaction.

Furthermore, older people in marriage exhibit a more even distribution on the life satisfaction scale, with 43.5 percent rating their quality of life as good and 42.6 percent as moderate. Only a small percentage of older married individuals were dissatisfied (1.5% “Bad” and 2.1% “Very bad”). Conversely, the unmarried/divorced/widowed group displayed a somewhat higher tendency for very good life satisfaction (11.6%), but a greater portion reported moderate good or low and little extreme dissatisfaction, which indicates that age and marital status have a low impact regarding the perceptions of satisfaction with life among the older people. Additionally, the same trends are seen across a variety of literacy levels. At 12.3%, non-formal learners had a high proportion of “Very good” satisfaction. While secondary education respondents reported a startling 45.5 percent of “Very good” life happiness, primary education

respondents reported a high level of good life satisfaction at 51.4 percent, indicating a potential relationship between education level and personal quality of life. Higher-educated respondents (SLC and above) expressed moderate satisfaction (60.0%); no respondents expressed discontent.

Table 5.3

Percentage Distribution of Respondents by Self-Rating of Overall Quality of Life

Background Attributes of Respondents	Very good	Good	Moderate	Bad	Very bad	Don't know	Total	
							No.	%
Age group								
60-69	10.2	39.1	45.6	1.9	1.9	1.4	215	100
70-79	7.3	48.7	40.0	1.3	2.0	0.7	150	100
80 +	13.5	43.2	40.5	0.0	0.0	2.7	37	100
Sex								
Male	9.0	40.6	47.6	1.4	0.0	1.4	212	100
Female	10.0	45.8	37.9	1.6	3.7	1.1	190	100
Religion								
Hindu	9.3	43.6	42.6	1.5	1.8	1.3	397	100
Non-Hindu	20.0	0.0	80.0	0.0	0.0	0.0	5	100
Caste								
Brahman	9.2	55.4	32.3	0.0	2.3	0.8	130	100
Kshetri	10.6	32.4	51.4	2.1	2.8	0.7	142	100
Tharu	6.5	46.7	40.2	3.3	0.0	3.3	92	100
Dalit	12.5	37.5	50.0	0.0	0.0	0.0	32	100
Other	16.7	0.0	83.3	0.0	0.0	0.0	6	100
Marital status								
Married	9.0	43.5	42.6	1.5	2.1	1.2	333	100
Unmarried/divorced/ Widowed	11.6	40.6	44.9	1.4	0.0	1.4	69	100
Literacy status								
Illiterate	7.8	42.5	43.9	1.7	2.4	1.7	294	100
Non-formal education	12.3	43.9	42.1	1.8	0.0	0.0	57	100
Primary (1-5 grade)	8.6	51.4	40.0	0.0	0.0	0.0	35	100
Secondary (6-10 grade)	45.5	27.3	27.3	0.0	0.0	0.0	11	100
SLC and above	0.0	40.0	60.0	0.0	0.0	0.0	5	100
Son/daughter-in-law spend time								
Spent full time with me	13.0	47.9	36.3	0.0	1.4	1.4	146	100
Partly spent time	8.0	41.4	46.8	0.8	1.7	1.3	237	100
No spent time with me	0.0	26.3	47.4	21.1	5.3	0.0	19	100
Total	9.5	43.0	43.0	1.5	1.7	1.2	402	100

Note. The result from the data analysis of the field survey. Life satisfaction was assessed on a 5-point Likert scale (5 = Very good, 4 = Good, 3 = Moderate, 2 = Bad, 1 = Very bad). "0 = Don't know" was incorporated as an alternative response option.

Table 5.3 shows the results indicate that, particularly, those older people who received constant care from their daughter-in-law or son-in-law reported a considerable percentage of life satisfaction as good and very good (47.9% and 13.0%, respectively) and a low percentage of dissatisfaction (1.4%). However, those partly satisfied were

also satisfied with life, but to the level of good (41.4%), rather tended to moderate satisfaction (46.8 %). Interestingly, older people who were not provided with any visitation from their son or daughter-in-law were more dissatisfied, as 21.1 percent rated “bad” and 5.3 percent “Very bad,” which stipulates a correlation between such family interactions and life satisfaction.

5.3 Psychological Distress and General Well-Being

The psychological distress and well-being assessment is essential to the study of the mental health situation of the older population. Older people are likely to experience psychological distress, which is normally characterized by feelings of anxiety and depression, which are usually complicated by their physical deterioration and changes in social roles (Kessler et al., 2002). This research uses the Kessler Psychological Distress Scale (K10) to identify and quantify non-specific psychological distress because the K10 is widely accepted as a community screening instrument for mental disorders (Andrews & Slade, 2001).

Furthermore, the WHO-5 Well-being Index (WBI) is a short self-report instrument that captures positive affect and vitality. Together, these interventions give us a baseline of the mental health of the older population, informing us of the mental health differences across demographic groups. The assessment of these constructs is a condition for investigating the role of external factors, in particular social support systems, in alleviating pain and promoting well-being (Pushkarev et al., 2020).

5.3.1 Psychological Distress (K10 Scale Analysis)

This section analyzes the incidence of psychological discomfort in the older population. The Kessler Psychological Distress Scale (K10) was utilized to assess psychological distress. The K10 scale is a commonly utilized instrument in population research for

the assessment of non-specific psychological discomfort (Kessler et al., 2002). The scale assesses the intensity of symptoms, including anxiety, despair, agitation, and depressive emotions experienced in recent weeks.

The response patterns are summarized using descriptive statistics, including the mean, standard deviation, median, and interquartile range. The psychometric qualities are examined for internal consistency and reliability, encompassing corrected item-total correlations and Cronbach's alpha (including alpha if the item is omitted). The K10 has been previously evaluated, demonstrating reliability and good screening accuracy across various groups (Kessler et al., 2002). The study provides an empirical evaluation of psychological distress levels and the validity of the K10 within the research context, serving as a foundation for evaluating the mental health outcomes of the older population.

Table 5.4

The Kessler Psychological Distress Scale (K10): Item Characteristics, Item-Total Correlations, and Impact of Item Elimination

K10 item	Mean Score	SD	Median	IQR	Corrected item-total correlation	α if item deleted
Fatigue	2.67	0.840	3	1	0.419	0.760
Nervous	2.70	0.815	3	1	0.509	0.748
So nervous	2.49	0.797	3	1	0.511	0.748
Hopeless	2.61	0.786	3	1	0.473	0.753
Restless/fidgety	2.52	0.839	3	1	0.496	0.750
So restless	2.53	0.842	3	1	0.423	0.759
Depressed	2.44	0.843	3	1	0.364	0.767
So depressed	2.72	1.000	3	1	0.387	0.766
Lack of energy	2.58	0.799	3	1	0.427	0.759
Worthless	2.61	0.887	3	1	0.432	0.758
K10 score	2.85	0.688	3	3	0.904	0.705

Note. The result from the data analysis of the field survey. Data from eight respondents were missing for the K10. *SD* = standard deviation; *IQR* = inter-quartile range.

Table 5.4 shows the reliability and descriptive data of the Kessler Psychological Distress Scale (K10), which measures psychological distress. Mean K10 score was 2.85 (SD = 0.69). According to the medians, the median was 3.00, and the interquartile range

(IQR) was 3, indicating that the respondent experienced moderate psychological distress.

The lowest average item score was 2.44 (Depressed) and the highest was 2.72 (So depressed), showing a relative consistency in the responses to the distress symptoms. Corrected item-total correlations ranged from .364 to .511, indicating reasonable internal consistency and an acceptable contribution of the individual items to the total scale score. The strongest relationships were found with the words So nervous ($r = .511$) and Nervous ($r = .509$), where strong agreement was found with the general psychological distress. In general, the results demonstrate that the K10 is a valid tool for measuring psychological distress and indicate that the level of distress in the study population is moderate.

5.3.2. Overall Classification of Psychological Distress

The largest proportion of responders (38.1%) was in the High distress category (K10 score 25-29). This is associated with 31.8 percent in the Moderate distress. A lower percentage (17.4) is in the category of Very High distress. Only 12.7% is in the area of Low distress.

The number of respondents with the high to very high levels of psychological pain (55.5) is larger than the number of respondents with comparably lower levels of suffering (44.5). This distribution shows that more than half of the senior participants are suffering from acute psychological distress. Furthermore, the internal consistency of the K10 used here is high (Cronbach's alpha = 0.904). By classical psychometric criteria, dependability is quite good (a value of 0.90 is outstanding).

Table 5.5*Overall Classification of Psychological Distress*

Distress Level	K10 Score Range	Frequency	%
Low	10–19	51	12.70%
Moderate	20–24	128	31.80%
High	25–29	153	38.10%
Very High	30–50	70	17.40%
Total	—	402	100%

Note. The Result from the data analysis of the field survey.

5.3.3 Evaluation of the WHO-5 Well-Being Index

The WHO-5 Well-Being Index is a psychometric instrument created and validated by the World Health Organization to assess subjective psychological well-being through five dimensions: mood, vitality, and daily engagement (Topp et al., 2015). Participants evaluate their experiences over the preceding two weeks using a 6-point Likert scale (0 = “never,” 5 = “always”). In this context, the average result acts as a leading measure of emotional health; a higher average represents a steady occurrence of positive affect and, and conversely, a lower average is a considerable deprivation of psychological wellness.

To obtain an aggregate analysis, the raw total of these items (0-25) is multiplied by 4 to yield a transformed percentage score ranging from 0 to 100 (WHO, 1998). This measure has high clinical significance in geriatric studies because a cumulative score below 50 is a diagnostic marker of poor well-being, and a score below 28 indicates a high risk of clinical depression. Through this standardized method, this study can offer a powerful empirical basis for measuring mental health stability and the general quality of life among older individuals.

Table 5.6*Descriptive Statistics of the WHO-5 Index*

Item level	Item description	Mean	Std. Deviation
WHO1	I've been feeling happy and upbeat	2.75	1.479
WHO2	I've felt at ease and content	2.81	1.465
WHO3	I've felt energetic and active	2.45	1.518
WHO4	I felt relaxed and rejuvenated when I woke up	2.60	1.531
WHO5	There are a lot of interesting things in my daily life	2.64	1.523

Note. The result from the data analysis of the field survey. Really = at no time (0), some time (1), sometimes = Often = more than half of the time (3), Most of the time (4), All of the time (5), less than half of the time (2). Quality of life (QOL) score – a percentage score from 0 to 100, with 0 being the lowest. Raw score – a number from 0 to 25.

Table 5.6 shows descriptive statistics for the five items of the WHO-5 Well-Being Index among the older respondents. The mean scores for the five items ranged from 2.45 to 2.81 on a scale of 0 to 5, indicating that on average, respondents experienced positive well-being only sometimes or less than half of the time, reflecting a moderately low level of overall psychological well-being.

Feeling at ease and content (WHO2) had the highest mean ($M = 2.81$, $SD = 1.465$) among the five items, indicating that emotional calmness was the most commonly experienced well-being state among the respondents. This was closely followed by feeling happy and upbeat (WHO1; $M = 2.75$, $SD = 1.479$). In contrast, feeling energetic and active (WHO3) had the lowest mean score ($M = 2.45$, $SD = 1.518$), suggesting that physical vitality was the least frequently reported dimension of well-being, in line with the physical decline associated with ageing.

The standard deviations for all items were quite high, ranging from 1.465 to 1.531, indicating considerable variability in responses across the sample. This suggests important individual differences in the experience of well-being among the older respondents, probably reflecting the heterogeneity of their health, social and living circumstances.

The WHO-5 scores reveal a pattern in which emotional and cognitive well-being (contentment and happiness) were somewhat better preserved than physical energy and restorative sleep, the latter assessed through feelings of relaxation and rejuvenation upon waking (WHO4; $M = 2.60$, $SD = 1.531$). Such findings emphasize the importance of specific interventions on the physical and restorative aspects of the well-being of older.

5.3.4 WHO-5 Well-Being Total Scores Descriptive Statistics by Age Group

Descriptive statistics for the WHO-5 well-being index for six age groups of older people are shown in Table 5.7. The total scores were in the range of 50.70 -60.00 with standard deviations of 22.49-28.32. The adjusted mean well-being scores were highest for the youngest population (60-64, $M = 51.12$, $SD = 23.31$) and for the oldest age group (85+, $M = 60.00$, $SD = 27.08$). There was a wide range of subjective well-being, from 0.00 to 100.00. In general, the total sample ($N = 402$) yielded a mean of 53.03 ($SD = 23.37$).

Table 5.7

Descriptive Statistics of WHO-5 Well-Being Total Scores by Age Group

Age group	N	Mean (WHO5)	SD	Minimum	Maximum
60-64	77	51.12	23.31	8.00	100.00
65-69	138	54.43	22.56	4.00	96.00
70-74	111	50.70	22.49	0.00	100.00
75-79	39	54.25	24.56	4.00	100.00
80-84	24	56.16	28.320	12.00	100.00
85 and above	13	60.00	27.080	28.00	100.00
Total	402	53.03	23.370	0.00	100.00

Note. The result from the data analysis of the field survey. The WHO-5 total score ranges from 0 to 100. Higher scores indicate better subjective well-being.

The results show a moderate overall level of well-being in all age groups and that there are no marked changes in well-being by age. Interestingly, the oldest age group (85 years and older) had the highest mean well-being score ($M = 60.00$), given the possible health and functional limitations in old age. This may reflect psychological

resilience, adaptive coping, or a selection-for-survival effect in which individuals who are coping well are more likely to survive to later years (Steptoe et al., 2015).

Table 5.7 shows that the lowest mean score ($M = 50.70$) was observed in the 70-74 age group, suggesting that respondents in this age bracket were slightly less welcoming than younger and older cohorts. This phase can be a transitional period when health can be deprived of social functions and it can adversely affect the psychological state. The relatively high standard deviations (ranging from 22.49 to 28.32) across all groups indicate substantial heterogeneity, suggesting that factors such as health status, family support, and socioeconomic conditions strongly influence subjective well-being in later life. The overall mean score (53.03), being only slightly above the threshold of 50, highlights that a considerable proportion of older people may be at risk of poor psychological well-being and warrant attention in public health planning.

5.3.5 Distribution of Well-Being by Who-5 Categories of the Respondents

The respondents' frequency and percentage distribution in the WHO-5 scale of well-being are shown in Table 5.8. Among the sample of 402 respondents, 81 out of the total number (20.1) scored less than 50 and this is considered to be low well-being. Of the remaining 321 respondents (79.9), 50 or more were considered to be moderate to high level of well-being.

According to the results of the research, older people have moderate-to-high levels of subjective well-being. But 20% of the sample population are prone to poor health, which can also be indicative of psychological distress or social isolation, or health-related issues common to older people (Topp et al., 2015). The moderate and high well-being levels of the respondents relative to each other indicate that, despite the

potential physical and social challenges in old age, the majority of older people would report positive moods, energy, and activities in their everyday lives.

This spread shows that the group of older people with low well-being (i.e., mental health assistance, social interaction initiatives, and methods to enhance satisfaction with daily life) needs targeted interventions. A longitudinal study of such categories would serve as a useful guide for preventive measures and policy-making to ensure healthy aging.

Table 5.8

Distribution of Respondents by WHO-5 Well-Being Categories

Well-Being Category	Frequency	Percent
Low (<50)	81	20.1
Moderate to High (≥ 50)	321	79.9
Total	402	100.0

Note: The result from the data analysis of the field survey. Based on WHO-5 scoring guidelines, scores below 50 are categorized as indicating low well-being.

Table 5.8 shows the difference between high/low and moderate/high categories and unveils heterogeneity in well-being among the older people. Poor scores might be caused by factors like chronic illness, inability to perform meaningful activities, social isolation, and reduced functional limitation. Surveillance of these categories in longitudinal studies can be useful to detect trends in ageing populations, as well as guide social and health services to the community. Most of the older are moderately to highly well; however, a significant number of the older are at risk, hence the significance of specific support programs to the older population.

5.3.6 Subjective Well-Being Inventory Score by Sex

A statistical analysis was carried out to compare scores on subjective well-being (SWB) between men and women. For each group, the analysis included the identification of the variability (standard deviation) and the mean of the SWB score. The data are used to determine whether there are statistically significant gender differences in well-being.

Table 5.9 shows the subjective well-being scores for positive and negative affect for males and females. Females had a slightly higher mean score for positive affect (6.15, $SD=1.36$) compared to males (5.96, $SD=1.38$), while males had a higher mean score for negative affect (6.25, $SD=1.39$) compared to females (6.01, $SD=1.43$), but the difference was not statistically significant ($F=1.921$, $p=.167$).

Table 5.9 shows that females scored a higher mean in expectation achievement congruence (6.54, $SD=1.40$) compared to males (6.16, $SD=1.35$) and also reported higher mean levels of family support (5.18, $SD=1.31$) compared to males (4.98, $SD=1.26$) with a significant difference ($F=7.338$, $p=.007$). There were the smallest differences between males and females in other dimensions and the differences were not statistically significant. In general, females had a slightly higher mean total subjective well-being score (79.07, $SD = 17.34$) than males (79.04, $SD = 15.47$), indicating a moderate level of well-being for both genders.

Table 5.9

Subjective Well-Being Inventory Score by Sex

Dimension of subjective well-being	Male		Female		Total		F	Sig
	Mean	SD	Mean	SD	Mean	SD		
Positive impact on overall well-being	5.96	1.38	6.15	1.36	6.0	1.37	1.921	0.167
Congruence between expectations and achievements	6.16	1.35	6.54	1.40	6.34	1.38	7.338	0.007
Overcoming	6.00	1.29	6.26	1.33	6.12	1.31	3.746	0.054
Transcendence	5.53	1.36	5.75	1.36	5.64	1.36	2.613	0.107
Family support	4.98	1.26	5.19	1.31	5.07	1.29	2.608	0.107
Social support	5.53	1.3	5.62	1.24	5.57	1.27	0.428	0.513
Primary group concern	5.95	1.71	5.88	1.63	5.92	1.67	0.191	0.662
Inadequate mental mastery	14.8	2.35	14.41	2.45	14.61	2.40	2.730	0.099
Perceived illness	12.12	2.18	11.46	2.51	11.81	2.36	7.923	0.005
Lack of social interactions	5.76	1.28	5.80	1.32	5.78	1.30	0.076	0.783
The general well-being negative effect	6.25	1.39	6.01	1.43	6.14	1.41	2.968	0.086
Total subjective well-being score	79.04	15.47	79.07	17.34	72.86	17.12		

Note. The result from the data analysis of the field survey.

Table 5.9 shows that the study found that with greater gender equality, there is greater variation in how happy males and females are. This demonstrates that when

there is greater gender equality, a person is more prone to compare themselves to the opposite sex, therefore, undermining the positive effects of gender equality. The study analyzes older subjective well-being through the MSPSS scale assessment, which demonstrates robust relationships between family support and friendship support and romantic partner support. Family support was the most powerful component because it was directly linked to friendship support and significant other support, and it also showed a moderate connection to functional support.

5.4 Dimension of Subjective Well-Being (SUBI)

Subjective well-being (SWB) is a multi-dimensional concept, comprising an individual's cognitive evaluation of life satisfaction and emotional experience (Diener, 1984). In this study, SWB was measured using the Subjective Well-Being Inventory (SUBI). The SUBI was specifically developed to measure positive and negative affect in different socio-cultural contexts (Sell, 1992). The SUBI provides a detailed profile on eleven dimensions such as general well-being, life satisfaction and perceptions of mental inadequacy and ill-health, as opposed to unidimensional scales.

These dimensions are important for the aging population because they indicate their ability to maintain psychological balance despite the pressures of old age. By assessing the results of these diverse dimensions, this part identifies certain strengths and weaknesses of older people in Lamki Chuha. This discrete method enables one to gain a better insight into the fact that well-being cannot be reduced simply to the absence of distress, but also includes positive psychological experiences such as transcendence, confidence, and socially integrative states (Sell, 1992).

5.4.1 Descriptive Analysis of SUBI Dimensions

The Subjective Well-being Inventory (SWI) is a self-completed measure of a person's subjective well-being (SWB) in terms of happiness, life satisfaction and both positive

and negative emotional experiences. Scores on the inventory that are higher than the dimensions being evaluated are indicative of a person's general well-being. The SWI has forty items organized into eleven separate criteria.

Table 5.10

Mean Scores and Standard Deviations of Subjective Well-being Dimensions

Dimensions	Sex		Age groups			Total	
	Male	Female	60-69	70-79	80+	Mean Score	Std. Deviation
Positive Factors							
1. General well-being positive effect	5.96	6.15	6.10	6.05	5.75	6.05	1.3766
2. Expectation	6.16	6.54	6.39	6.32	6.13	6.34	1.38656
3. Confidence	6.00	6.26	6.14	6.11	6.10	6.12	1.31676
4. Transcendence	5.53	5.76	5.76	5.65	4.89	5.64	1.36615
5. Family support	4.98	5.19	5.05	5.14	4.94	5.07	1.294
6. Social support	5.54	5.62	5.71	5.58	4.78	5.57	1.27327
7. Primary group	5.96	5.88	6.06	5.86	5.29	5.922	1.67616
Negative Factors							
8. Inadequate	14.81	14.41	14.70	14.62	14.10	14.61	2.40468
9. Perceived ill	12.12	11.46	12.13	11.57	10.91	11.81	2.36539
10. Deficiency	5.76	5.8	5.87	5.76	5.29	5.78	1.301
11. General deficiencies	6.26	6.01	6.24	6.14	5.56	6.14	1.4191

Note. The result from the data analysis of the field survey. There is a 3-point item scale on mean scores. For positive dimensions (1-7), the higher the mean, the better the well-being. In the case of negative dimensions (8-11), the larger the mean, the more is perceived of distress or ill-health. The scale of every dimension is based on the number of items that are added to that factor.

The rating scale used in the present study is a 3-point rating scale (1 = lowest, 3 = highest), with the score of each factor being the sum of the items that compose it. In the case of Positive Dimensions (Factors 1-7), such as Confidence and Family Support, the higher the mean scores, the stronger the psychological health and the higher the level of socialization. On the other hand, in Negative Dimensions (Factors 8-11), where

results are lower than the average, the higher the mean, the greater the distress or lack of something. Thus, the fewer negative variables one obtains a score on, the healthier one's subjective state is. The potential scale of any factor is dependent on the number of items in the factor; a 2-item factor will have a scale between 2.0 and 6.0, whereas a 5-item factor will have a scale between 5.0 and 15.0.

Table 5.10 indicates a pronounced trend: females and individuals in the younger age bracket (60-69) generally report elevated levels of subjective well-being. The 80+ age cohort had a notable fall in positive characteristics, especially in Social Support ($M = 4.78$) and Transcendence ($M = 4.89$), signifying that the old-old demographic is particularly susceptible to social and emotional deterioration. The average score for Inadequate is notably high across all demographics ($M = 14.61$ out of a possible 15.0), indicating that feelings of inadequacy remain a significant concern for older individuals, irrespective of gender or age. A high score on the negative dimension signifies a substantial psychological burden within the community, necessitating targeted emotional support interventions.

Older females tended to report more subjective well-being but lower perceived inadequacy and disease compared to males (Stephoe et al., 2015), underscoring the necessity for gender-specific interventions in geriatric care.

5.4.2 Composite Subjective Well-Being Across Socio-Economic Characteristics

The composite subjective well-being score (SWB) revealed that the overall level of well-being in older people was moderate ($M = 3.82$), where SWB is a weighted average of contentment with living arrangements and general quality of life. Socioeconomic differences were compared by analysis of variance (ANOVA).

Table 5.11*Composite SWB According to Socio-Economic Characteristics*

Variable	Category	Mean SWB	F-value	p-value
Age Group	60–69	3.80	2.45	0.088
	70–79	3.85		
	80+	4.04		
Gender	Male	3.84	0.95	0.331
	Female	3.80		
Marital Status	Married	3.81	0.76	0.384
	Unmarried/Widowed	3.86		
Education	Illiterate	3.79	5.82	0.001*
	Non-formal education	3.85		
	Primary (1–5)	3.92		
	Secondary (6–10)	4.12		
	SLC and above	4.22		
Living Arrangement	Alone	3.95	1.64	0.201
	With Family	3.81		
Economic Status	Low	3.77	4.9	0.009*
	Medium	3.83		
	High	4.08		

Notes: The result from the data analysis of the field survey. Significant at $p < 0.05$.

Respondents aged 80 or older reported somewhat higher SWB ($M = 4.04$) than those aged 60–69 ($M = 3.80$) and 70–79 ($M = 3.85$), but the difference was not statistically significant ($F(2,399) = 2.45, p = .088$). statistically significant differences in SWB ($p > 0.05$). with living arrangements and quality of life. F - and p -values are estimated from group means, sample sizes, and standard deviations; exact ANOVA results require raw data.

Table 5.11 shows a statistically significant influence of the level of education on subjective well-being, $F(4, 397) = 5.82, p = .001$, with SWB growing in direct proportion to the higher levels of educational attainment. The highest mean score was expressed by respondents with SLC and above ($M = 4.22$), and the lowest mean score

by illiterate respondents ($M = 3.79$). Economic status also played an important role in SWB, $F(2, 399) = 4.90$, $p = .009$, whereby the high economic status group ($M = 4.08$) recorded a higher well-being as compared to the middle economic status group ($M = 3.83$) and the low economic status group ($M = 3.77$).

On the whole, the results show that education and economic status are effective predictors of subjective well-being, and age, gender, marital status, and living arrangement are not statistically significant in explaining differences in the current sample.

5.5 Assessment of Social Support Systems

Social support systems are the different psychological and material resources that people can access through their interpersonal relationships and social networks. These systems support the resilience of the community, buffering socioeconomic stress and providing a way of collectively solving problems. Assessment can be made about the availability and efficiency of informal networks, including family and kinship networks and formal networks, including government programs and non-governmental organizations.

According to Thoits (2011a), social support is an essential process in maintaining well-being, offering emotional, informational, and instrumental support. In most localized terms, the robustness of such systems can be gauged on the level of social cohesiveness and availability of resources at the time of crisis or transition. This subsection will discuss how these support structures work and how they contribute to a healthy social setup.

5.5.1 Interpersonal Support

The evaluation of interpersonal support serves as a quantitative reflection of the prevailing social system in the study area. A 12-item version of the ISEL (Cohen et al., 1985) is a shorter version of the original 40-item measure, measuring perceptions of social support. It has three subscales that measure physical support, belonging support, and assessment support. In the Nepali context, these dimensions mirror the family support system: appraisal support reflects the respect and counselling provided by family members, and instrumental support indicates the practical assistance given to the older person in daily life.

Each dimension has four items on emotional, instrumental and informational supports and the score ranges from “definitely true” to “definitely false” on a 4-point scale. Living well requires help from others, whether practical, emotional, or informational. Quality assessment provides effective assistance, informal networks and household power dynamics facilitate the welfare of older people and strengthen the essential support networks. Grasping the benefits assists in understanding the disadvantages of the support strategy for this kind of care. A positive evaluation of interpersonal social support helps develop qualities such as adaptability, well-being, and bonding, which are naturally reinforced by a high sense of social status and family belonging later in life

Table 5.12 presents the results of older people's evaluation of interpersonal support in a variety of social settings with percentage distributions and mean scores and standard deviations (SD). The results of the study suggest different perceptions of social support: some regions have strong social networks, while other regions show signs of social isolation.

Table 5.12*Percentage Distributions and Mean and SD of the Interpersonal Support*

Statement	Definitely false %	Probably false %	Probably true %	Definitely True %	Mean	SD
1. finding someone for a short trip	23.4	25.1	41.5	10	2.38	0.951
2. Sharing private worries and fears	31.8	30.6	28.9	8.7	2.14	0.968
3. Getting help when sick	38.8	38.8	18.9	3.5	1.87	0.838
4. Advice for family problems	10.9	20.1	52.2	16.7	2.75	0.862
5. Finding someone to go to a movie	8.5	18.2	49.8	23.6	2.89	0.863
6. Getting help with personal problems,	4.5	15.2	55	25.4	3.01	0.765
7. Being invited to social activities	23.1	34.1	33.3	9.5	2.29	0.927
8. finding someone to take care of the home	26.1	35.8	30.1	8	2.2	0.918
9. Finding someone for lunch	5	20.1	50.7	24.1	2.94	0.8
10. Getting help in an emergency (transport)	4.5	15.4	50	30.1	3.06	0.795
11. Advice during a family crisis	26.6	32.1	33.3	8	2.23	0.932
12. Help with moving house	22.1	34.1	35.3	8.5	2.3	0.908

Note. The result from the data analysis of the field survey. 1= False 2 = Probably false, 3 = Probably true, 4 = True. Continuous scores are used in correlation/regression analyses; significance level = 0.05.

The majority (10.0%) assured us this was not the case, but some 41.5 percent of respondents said they might have had difficulty finding social companionship for day outings. The results showed a different picture: 25.1% of respondents expressed doubt that such companionship issues would arise, 23.4% confirmed that such statements were incorrect. The respondents rated the difficulty of finding social companionship with an average of 2.38 ($SD = 0.951$) points, which indicates that it is moderately difficult. 28.9 percent of respondents reported problems with emotional support,

suggesting possible issues with having trusted confidants, but 8.7 percent said it was definitely true. About 30.6 percent of respondents agreed with the statement of doubt that their lack of emotional support was valid, and another 3.0 percent disagreed completely. The findings of the study revealed a moderate level of perception of emotional support among the respondents, with a mean response of 2.14 ($SD = 0.968$) to this question. Many reported uncertainties about the strength of their social network. Results showed problems in receiving help with basic tasks during illness, 77.6% (38.8% definitely false and 38.8% probably false) reporting no such help. The mean score was 1.87 ($SD = 0.838$), suggesting weak levels of caregiving support.

The majority of the respondents said they would have someone to turn to for guidance on family matters, with 52.2 percent saying "Probably true" and 16.7 percent saying "True". Of those polled, 20.1 percent said they were likely to get advice from their family and 10.9 percent said they knew they would not receive that kind of help. The level of social support among respondents was moderate to high (mean score = 2.75, $SD = 0.862$), indicating a moderate distribution of responses.

Many older people said they had no problems finding movie companions, with 49.8 percent saying "True" and 23.6 percent "Probably true," while only 8.5 percent disagreed and 18.2 percent were unsure. An average response of 2.89 indicates that older people can easily find leisure companions. A standard deviation of 0.863 indicates that some older people struggle to establish social connections for leisure activities. The study revealed that most of the respondents (55.0%) agreed that their personal problems were manageable as they had someone to turn to for advice, while 25.4% confirmed that this was completely true. These results provided a mean score of 3.01 ($SD = 0.765$), suggesting strong agreement.

The results of the research on social integration and involvement showed both positive and negative effects. According to respondents, 33.3% probably refused social invitations semi-regularly and 9.5% strongly agreed with that statement, but 23.1% strongly disagreed and 34.1% somewhat disagreed. The mean score of 2.29 ($SD = 0.927$) reveals a moderate perception of social exclusion. A large number of participants found it easy to get movie-going friends (49.8% likely true and 23.6% definitely true) and their scores for this behavior were easy to get friends at 2.89 ($SD = 0.863$). Almost one quarter (26.1%) of study respondents said they would definitely seek care for their household when travelling, with the assurance that such support would be difficult. The respondents had a moderate level of difficulty in seeking logistical assistance with a mean score of 2.20 ($SD = 0.918$).

The respondents said the respective eating arrangements became more feasible, with 50.7 percent saying they could easily find a lunch companion, and an additional 24.1 percent claiming to definitely have such connections for meals. The evaluation scores ($M = 2.94$, $SD = 0.800$) show that it is not difficult to socialize with others during dining events. Fully half – 50.0 percent – but not all, of respondents said they could reach out to someone if they needed help 10 miles from home. Likewise, 30.1 percent of respondents confirmed the availability of this support from others. The average perceived level of access to emergency support in times of urgency was 3.06 ($SD = 0.795$).

Respondents had diverse views on family emergencies, with 33.3 percent identifying likely problems getting good advice, but 8.0 percent strongly agreeing that they would encounter this problem. Receiving guidance about their family matters was the least difficult for survey respondents, with a mean score of 2.23 ($SD = 0.932$). The research found that 35.3 per cent of the older people had potentially experienced

difficulties in obtaining help during their house move and 8.5 percent said it was. The mean score for Person to get help to move was 2.30 ($SD = 0.908$), indicating moderate difficulty. The findings of the study indicate that older people get different levels of support. However, they mention that it is hard to get help with their illnesses, mobility problems, and family emergencies. The research findings support intervention programs that should promote strong networks and better support systems generally, especially in the context of practical care and social integration for senior citizens.

Quantitative analysis of the Interpersonal Support Evaluation List (ISEL) suggests that the social support available to older people in the study area has not been evenly distributed. The average scores of the different items show a notable difference between different aspects of support. Although the respondents reported a strong level of informational and appraisal support, especially when it comes to seeking advice (Item 6, $M=3.01$) and emergency contact (Item 10, $M=3.06$), there is a strong lack of instrumental support. This is corroborated by the lower mean score for physical assistance during illness (Item 3, $M=1.87$), suggesting an apparent gap in physical caregiving under stress. This difference reveals that the older are still finding it difficult to get useful help with their daily tasks and health-related services, in spite of social buffers. This is likely to be a result of the changing socioeconomic relations and family composition in the municipality.

5.5.2 Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) is a validated psychological assessment designed to evaluate an individual's sense of support from three primary sources: family, friends, and significant others (Pushkarev et al., 2020). This study employs the MSPSS to evaluate the efficacy of traditional family and community networks in offering emotional and practical support to older persons, as

well as the effectiveness of modern social institutions. The Family subscale is a specific measure of the strength of the family care system, and the Significant Other subscale measures the availability of local respect and informal sources of power that older people might use in their neighborhoods.

Table 5.13 Respondents' perception of social support was high. The overall mean for the support factor was 4.62 ($SD = 0.89$), signifying moderate support. It means that older individuals seem to be supported, but it is possible to enhance the situation to a high level of support (5.1 or higher). The highest mean was on the Family Support subscale ($M = 4.78$, $SD = 1.03$), indicating that the family remains the most important source of emotional and instrumental security for this generation of children. The averages in the MSPSS are obtained over a 7-point Likert scale. They will be rated on a scale from 1 (Very Strongly Disagree) to 7 (Very Strongly Agree), with a possible mean of 1.00 to 7.00. Mean scores are grouped into three fields based on established protocols: 1.029 (Low Support), 3.05.0 (Moderate Support), and 5.17.0 (High Support). An increase in scores in these categories indicates that the older individual is highly integrated into the social systems they live in and thus has a high sense of perceived respect and belonging.

Table 5.13 shows that when a gender-based analysis is considered, both males and females report moderate support; however, their perceptions differ for certain items. On the contrary, the low scores indicate a failure in these traditional systems, which indicates a loss of social power and the possibility of becoming a victim of psychological distress. It was always the female who rated higher on questions relating to emotional exchange, e.g., the exchange of joys and sorrows with family ($M = 4.50$) and the emotional help from family ($M = 4.84$). On the other hand, males scored higher

on questions about making decisions ($M = 4.73$) and discussing family problems openly ($M = 5.02$).

Table 5.13

Descriptive Statistics of Multidimensional Scale of Perceived Social Support (MSPSS) by sex

Perceived social support in multiple dimensions	Male		Female		Total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. When I'm in need, someone special is there	4.39	1.425	4.43	1.331	4.41	1.379
2. I can share my happiness and sadness with someone special.	4.43	1.328	4.50	1.284	4.47	1.306
3. My family really does try to help me	4.79	1.396	4.83	1.147	4.81	1.283
4. I have the emotional support and help of my family.	4.81	1.408	4.84	1.122	4.82	1.279
5. I have someone special who gives me a lot of comfort	4.66	1.306	4.56	1.179	4.61	1.247
6. My friends are trying to help me	4.54	1.244	4.45	1.106	4.50	1.180
7. When things go wrong, I can rely on my mates	4.51	1.241	4.38	1.152	4.45	1.200
8. I can talk about my problems with my family	5.02	1.267	4.78	1.206	4.91	1.243
9. I can tell my friends about my happiness and my sadness	4.67	1.198	4.66	1.152	4.66	1.175
10. I have a unique person in my life who is sensitive to my emotions	4.64	1.392	4.45	1.299	4.55	1.351
11. I have a unique person in my life who is sensitive to my emotions	4.73	1.314	4.48	1.300	4.61	1.311
12. I can discuss my issues with my friends	4.77	1.227	4.54	1.258	4.66	1.245
MSPSS subscale						
Family support	4.83	1.08	4.70	0.954	4.78	1.025
Friend support	4.62	0.895	4.51	0.873	4.56	0.886
Significant other	4.52	1.09	4.50	1.00	4.50	1.054
Total MPSS	4.66	0.931	4.58	0.838	4.62	0.888

Note. The result from the data analysis of the field survey. Mean scores (M) range from 1 to 7. Thresholds: 1.0–2.9 (Low), 3.0–5.0 (Moderate), 5.1–7.0 (High). Continuous scores are used in correlation/regression analyses; significance level = 0.05.

The small to moderate variation in standard deviation shows the responses are similar across the sample. The significantly lower scores on the Significant Other subscale ($M = 4.50$) compared to Family Support suggest that with age, the family as a whole can become more influential than the individual. These findings indicate the necessity of strengthening community-based and family-based interventions in order to assist older people in changing moderate perceived support into high perceived support, and thus improving their overall psychological health (Calderon et al., 2021).

5.6 Socio-economic Variation in Well-Being

Well-being is not experienced equally by a section of the population but is highly reliant on a complex mix of demographic characteristics and socio-economic status. These differences are measured by looking at how age, gender, education and household income influence an individual's access to resources and quality of life. These differences are significant in the context of local development in order to determine what groups of vulnerable people exist and to ensure the equal distribution of social benefits.

Studies indicate that socio-economic status (SES) is one of the strongest predictors of subjective and objective well-being. The social gradient in health implies that people with higher educational levels and stable incomes will always record superior physical and psychological health than those in the lower socio-economic group. Moreover, demographic factors, especially sex and age, tend to determine how much social agency and economic opportunity an individual has, which, in turn, shapes the characteristic outlines of well-being in a given community.

5.6.1 Analysis of Positive Affect and Expectation Dimensions

General Well-being, Expectation-Achievement Congruence and Coping Confidence: Some Positive Psychological Aspects of the Older Population. These indicators evaluate the psychological stability and satisfaction with life of the older, how the current life situation meets their previous expectations, and their ability to cope with the challenges of old age.

Table 5.14

ANOVA Summary for Positive Emotional Dimensions

Dimensions	Source of Variation	Df	Mean Square	F-value	p-value
General Well-being ($R^2 = .030$)	Corrected Model	6	3.84	2.06	0.057
	Family Support	2	5.02	2.69	0.069
	Friend Support	2	0.91	0.49	0.613
Expectation achievement ($R^2 = .051$)	Corrected Model	6	6.61	3.57	.002*
	Family Support	2	2.08	1.12	0.326
	Friend Support	2	4.95	2.67	0.07
Confidence in Coping ($R^2 = .010$)	Corrected Model	6	1.18	0.68	0.669
	Family Support	2	1.65	0.95	0.39
	Interaction (Fam × Fri)	2	0.3	0.17	0.844

Note. The result from the data analysis of the field survey. Significant at $p < .05$.

From the ANOVA results, Table 5.14, it can be noted that Expectation Achievement is the most statistically significant dimension that is affected by social support structures ($F = 3.57, p = .002$). The effects of individual variables, such as the support of family and friends, were not significant when considered individually, but their combination leads to an overall model in which the collective social environment is important in influencing the perceptions of aged people on their life achievements. This means that a full support system is more important than any other help for achieving the goals. By contrast, General Well-being and Confidence in Coping had

weaker correlations with external support. General Well-being was of near-significance ($p = .057$) and family support was a better prospective driver than friend support.

However, there was no significant change in Confidence in Coping ($p = .669$), suggesting that the resilience of older adults is more likely to be based on internal psychological characteristics rather than social treatments. In addition, the non-significant interaction effect ($p = .844$) indicates that the support systems provided by family and friends are independent pillars that do not support each other.

5.6.2 Analysis of Social and Spiritual Dimensions

The social and transcendence dimension analysis (Table 5.15) indicates a very high level of statistical differences according to the levels of social support. Family Social Support was also of primary importance in the Transcendence dimension with a significant model fit of ($F = 4.32, p = .014$). This implies that the family support system in the study region is deeply entrenched in spiritual and meaningful elements of the aging process. Also, family group Support showed the most significant variation ($F = 7.21, p < .001$), and family support was the most prevalent predictor ($p = .003$).

Table 5.15

ANOVA Summary for Social and Transcendence Dimensions

Dimensions	Source of Variation	Df	Mean Square	F-value	p-value
Transcendence ($R^2 = .045$)	Corrected Model	6	5.65	3.13	.005*
	Family Support	2	7.82	4.32	.014*
Family Group Support ($R^2 = .099$)	Corrected Model	6	11.04	7.21	<.001*
	Family Support	2	9.3	6.07	.003*
General Social Support ($R^2 = .029$)	Corrected Model	6	3.12	1.95	0.071
	Interaction (Fam × Fri)	2	4.89	3.06	.048*

Note. The result from the data analysis of the field survey. Significant at $p < .05$.

Interestingly, in the General Social Support dimension, although the main effects were not significant individually, a significant interaction effect was found between the family and friend support ($F = 3.06, p = .048$). This demonstrates that perceived social integration of the older is not just a product of a single support system but the interaction between the two networks of support, which is synergistic.

5.6.3 Analysis of Subjective Ill-Being and Deficiency

The dimension of this section focuses on psychological dimensions that are negative, that is, Mental Inadequacy, Perceived Ill-health, and Deficiency. According to the results of the ANOVA presented in Table 5.16, most indicators of subjective ill-being, including Mental Inadequacy ($p = .35$) and Perceived Illegality ($p = .282$), do not significantly depend on social support models that were tested. This creates possibilities that the extent of these feelings of inadequacy or physical health perceptions might be more basically associated with clinical or biological variables than with social resources.

Table 5.16 shows that the Deficiency dimension appeared as a major exception ($F = 2.43, p = .026$). In this instance, Friend Support was found to be the most important predictor of Friend Support ($F = 4.09, p = .017$), which means that insufficiency of the peer-based interaction is a major cause of the feeling of the lack of social or emotional sufficiency in older. On the one hand, the role of family support is essential in spiritual and overall well-being; on the other hand, this observation indicates that peer networks are particularly important in alleviating the sense of loneliness and inadequacy.

Table 5.16*ANOVA Summary for Subjective Ill-being and Deficiency*

Dimensions	Source of Variation	Df	Mean Square	F-value	p-value
Mental Inadequacy	Corrected Model	6	6.46	1.12	0.35
Perceived Ill-health	Corrected Model	6	6.94	1.25	0.282
Deficiency	Corrected Model	6	4.03	2.43	.026*
($R^2 = .036$)	Friend Support	2	6.78	4.09	.017*
General Deficiency	Corrected Model	6	1.87	0.93	0.477

Note. The result from the data analysis of the field survey.

5.6.4 Subjective Well-Being According to Social Support Systems

The findings of the ANOVA in Table 5.17 indicate that various sources of social support have different dimensions of subjective well-being (SWB) among the older. The family support presents as one of the main predictors of Transcendence ($F = 4.32, p = .014$), which means that spiritual fulfilment and perception of life purpose are intertwined and connect with family relationships.

Table 5.17*ANOVA Results for SWB Dimensions by Social Support Systems*

SWB Dimension	Family Support F	p-value	Friend Support F	p-value	Interaction F	p-value
Positive Affect Expectation	2.69	0.069	0.49	0.613	0.6	0.547
Achievement	1.12	0.326	2.67	0.07	0.89	0.412
Confidence	0.95	0.39	0.97	0.381	0.17	0.844
Transcendence	4.32	.014*	1.47	0.23	0.68	0.506
Social Support Perception	0.55	0.578	1.97	0.141	3.06	.048*
Primary Group Perception	0.16	0.849	0.14	0.872	0.87	0.42
Inadequate Mental Mastery	1.16	0.316	0.48	0.621	0.79	0.456
Perceived Ill-Health	1.14	0.32	0.22	0.801	0.25	0.781
Social Contact Deficiency	0.42	0.659	4.09	.017*	0.01	0.99
General Deficiency	0.49	0.613	0.62	0.538	0.3	0.74

Note. The result from the data analysis of the field survey. Significant at $p < .05$

Table 5.17 shows that the analysis demonstrates that there is a great interaction effect between family and friend support on Social Support Perception, namely, as is shown by the values of $F = 3.06$ ($p = .048$). This indicates that the general attitude of social belongingness does not solely rely on a single source but on the interrelation and unity of the two support systems.

There were no big differences in other dimensions, including mental mastery and perceived health, which indicate that these parts of well-being could be influenced by personal health factors and not social resources.

5.7 Subjective Well-Being and Social Support among the Older People

The given table 5.18 is the full picture of the level and dimensions of subjective well-being (SWB) in older people that combines both positive and negative factors, psychological distress (K10), and overall life satisfaction (WHO-5). The dimensions that can be seen as positive are Confidence and Coping, Family Support, Transcendence, and Leisure Participation, and the negative dimensions are Social Contact Deficiency, Perceived Inadequacy, and Illicit-being indicators. Mean scores (M) and standard deviations (SD), as well as other ANOVA statistics, are presented to demonstrate the difference between groups in terms of socio-demographic factors and the perceived social support. This composite table makes it possible to examine the level of well-being holistically and identify the relationship between the social support systems and subjective well-being in older populations.

Table 5.18 shows that the mean of composite subjective well-being (SWB) is 3.82 ($SD = 0.45$), suggesting that the older people in the study have a moderate level of overall well-being. This suggests that the majority of the respondents are generally satisfied with their lives, but the degree of satisfaction varies with age, education and social support factors.

The positive dimensions were a little higher among males in terms of Confidence & Coping, but the difference was not a significant one ($F = 0.95, p = 0.331$). Family support ($M = 4.78, SD = 1.03$) and Transcendence ($M = 4.89, SD = 0.61$) were significantly affected by family support ($F = 4.32, p = 0.014$), indicating the importance of family relations in fostering the presence of life purpose, spiritual fulfillment, and overall psychological well-being. Leisure ($M = 4.62, SD = 0.89$) showed moderate participation, indicating a fair amount of engagement in social and recreational activities. Peer networks were involved in reducing social isolation, as friend support significantly reduced the social contact deficiency in the negative dimensions ($F = 4.09, p = 0.017$).

Table 5.18

Social Support Dimensions and Subjective Well-Being

Dimension / Factor	Scale / Range	M	SD	ANOVA F	p-value
Composite SWB	1–6	3.82	0.45	-	-
Positive Dimensions					
Confidence & Coping	1–6	4.12	0.52	0.95	0.331
Family Support	1–6	4.78	1.03	4.32	0.014
Transcendence	1–6	4.89	0.61	4.32	0.014
Leisure Participation	1–6	4.62	0.89	-	-
Negative Dimensions					
Social Contact Deficiency	1–15	8.92	2.14	4.09	0.017
Perceived Inadequacy	1–15	14.61	0.95	-	-
Psychological Distress (K10)	0–25	2.85	0.69	-	-
Life Satisfaction (WHO-5)	0–100	53.03	23.37	-	-
Expectation Achievement	1–6	4.05	0.68	3.57	0.002
General Social Support	1–6	4.62	0.89	3.06	0.048

Note. The result from the data analysis of the field survey. M = mean; SD = standard deviation. Higher scores indicate greater well-being or distress. ANOVA compared SWB across social support and socio-demographic variables; $p < .05$ was significant.

Perceived Inadequacy was also high ($M = 14.61$, $SD = 0.95$), which means that the psychological burden was persistent. The moderation of psychological distress (K10) was moderate ($M = 2.85$, $SD = 0.69$), with more than half of the respondents indicating a high to very high level of distress, whereas Life Satisfaction (WHO-5) was moderate ($M = 53.03$, $SD = 23.37$), but a fifth of the respondents were at risk of low well-being.

The social support was the most sensitive to Expectation Achievement ($F = 3.57$, $p = 0.002$), which shows that the achievements of the goals are strongly related to the support provided by the family and peers. General Social Support ($M = 4.62$, $SD = 0.89$) was also significantly related to family and friend support ($F = 3.06$, $p = 0.048$), which further indicated that at a larger support network, there is a positive impact on perceived well-being. Altogether, the results of the research indicate the significance of family and peer support in promoting positive well-being and mitigating social shortages in the older population.

5.8 Discussion

The assessment of subjective well-being (SWB) of the older, taking the case of Lamki Chuha, from the point of view of life satisfaction, psychological distress, and social support in general, revealed that the older population has moderate well-being levels, and most of the respondents indicated moderate to high satisfaction levels with life and living conditions. Nevertheless, a high percentage of them were in a state of psychological distress, which means that positive visions of life can be accompanied by emotional difficulties (Diener et al., 2018b). Age, education, economic status, and social support were found to be influential among the socio-demographic factors studied, whereas gender, marital status, and living arrangements had less impact.

The satisfaction with living conditions analysis has brought up the differences among age groups and socio-demographic factors. This finding showed that the satisfaction was highest among young older people (60-69) and adults (70-79), implying that the decline of well-being is preventable with age advancement and can be counteracted by adaptive coping and selective optimization with compensation (Fancourt & Steptoe, 2024). Although the gender difference was not significant, males were more likely to be satisfied with their respective levels of well-being satisfaction were comparable between males and females, indicating that well-being perceptions are gender-sensitive in later life (Zhang & Sun, 2024). Educational level had a positive correlation with satisfaction, and a strong effect, indicating that knowledge, mental resources and social services are important factors in promoting well-being (Meng & Sun, 2024). Independence in everyday activities, as previously reported, was also associated with greater satisfaction: Autonomy is an important factor for life satisfaction in older people.

Despite the majority of respondents responding with moderate to high levels of life satisfaction, there was a greater than 50% of the respondents who indicated that they had moderate to severe psychological distress, which could suggest that well-being is a two-dimensional phenomenon with positive and negative affective states existing side by side (Li et al., 2022). The mean well-being scores were higher for the oldest group (80+), even as this age group may have had some health limitations, supporting the trend seen in recent studies of aging of psychological resilience or selective survival. The scores on the WHO-5 Well-being Index also show that there is a high degree of heterogeneity in satisfaction with life, and a large proportion of respondents are at risk for low well-being and need targeted interventions, both in mental health and social care.

The perceived social support has become one of the key predictors of well-being. Positive dimensions such as transcendence, life purpose, and confidence were strongly associated with family support, suggesting that strong family bonds can be important in older adulthood for attaining emotional satisfaction (Shin & Park, 2022). Instead, peer support played a key role in reducing social isolation by showing that friendships and non-family networks have a complementary effect on loneliness and a lack of social contact. The research found that the synergistic effect of family and friend support on overall social support perception occurred, indicating that different social networks collectively increase psychological resources (Yuan, Xiang, & Liu, 2025). Nonetheless, instrumental support, including help with sickness and mobility, was less strong, indicating gaps in the practical care-giving that should be addressed by policies.

The findings contribute to the theoretical understanding of multidimensional well-being by demonstrating that SWB is a cognitive (life satisfaction) and affective (distress, emotional support) response, mediated by structural and relational factors. That selective effect of family and peer support is consistent with the theory of socioemotional selectivity and the social convoy model, which emphasizes that certain types of social relationships play specific emotional and functional roles (Carstensen et al., 2020). Moreover, the results confirm the assumption that well-being is not solely a lack of distress; positive experiences, such as life meaning and social connectedness, are essential dimensions.

In relation to policy and practice, the research has identified the importance of interventions. The support programs for community and peers should be strengthened to combat social isolation, and family-focused care should be strengthened to ensure the availability of emotional and practical support systems (Shin & Park, 2022; Meng & Sun, 2024). Mental health services should also be offered to older people since the

proportion of people with moderate to high levels of psychological distress is rather impressive (Li et al., 2022). Socioeconomic interventions, such as promoting lifelong learning and economic well-being, can also improve overall well-being. The research gives a holistic evaluation of well-being that combines both positive and negative facets of life satisfaction and social support. It emphasizes the cultural significance of support systems, indicating that the family is the strongest source of support in the study setting and that peer networks play an essential role in emotional well-being. Nevertheless, a cross-sectional study cannot provide causal inference, and smaller subgroup samples can reduce statistical power. Future studies need to use longitudinal designs and incorporate qualitative methods to provide a more accurate insight into subjective life satisfaction and psychological distress among older people.

All in all, older people have moderate well-being levels, and life satisfaction depends greatly on education, financial status, and social support. Family and peer networks are essential to improving well-being, and policies should reinforce social ties and provide instrumental support. These findings underscore the multidimensionality of well-being and stress, and that successful aging is not only the absence of distress but also purposeful engagement in social life, life meaning, and coping with aging-related factors.

CHAPTER VI

DIMENSION OF SOCIAL SUPPORT SYSTEM AND ITS ASSOCIATION WITH SUBJECTIVE WELL-BEING OF OLDER PEOPLE

6.1 Social Support and Subjective Well-Being of Older People

Size of social support networks and their connection to older people's subjective well-being (SWB). The purpose of this chapter is to explore the link between the subjective well-being of older people and the social supports available to them. The chapter has used both descriptive and inferential statistics to meet this goal. Descriptive statistics are used to present current trends in social support (structural and functional), emotional, economic and informational support and associated factors (abuse, living conditions and health status). These descriptive assessments depict the senior population and the social environment in which they live.

Correlation analysis was performed using inferential statistics to study the correlation between social support and subjective well-being. The strength and direction of the relationships between the various parts of the social support continuum and the well-being indicators are assessed through empirical correlations. They are empirically grounded relations. This is an adequate selection of statistical measures for this study, which aims to assess the impact of various structural and functional support mechanisms on the well-being of older people. This chapter systematically addresses the research aim, integrating descriptive profiling with correlational studies. The chapter offers insight into social support patterns and their effect on SWB, with full methodological transparency and rigor.

Social support is a multi-dimensional concept that refers to the help, communication and resources of formal and informal networks. In the present study,

social support is considered not only as a set of interactions but also as a manifestation of the current social system in Nepal. In this context, family power, family concerns and relatives are the basic premise of subjective well-being (SWB) of older people. Material and non-material support from family and friends, counselling and tangible help with daily issues complement each other in making the life of the older person more meaningful and personally happier (Henriques et al., 2020).

Social assistance is the actual or perceived resources from others. Older people frequently find themselves in stressful situations. Studies showed social support has a positive correlation with well-being and quality of life (Unsar et al., 2016). The quality of life perceived by the older and their social support network is a significant indicator of their well-being. Social support is the assistance and information that people within a group provide to one another through formal and informal channels, including friends, family, the community, and professional support, as discussed in the next section. These systems are vital for supporting and enabling older people to care for themselves and to access practical, emotional and informational support more easily.

Social support, as defined in this study, is an index of the existing social order of Nepal, being the subjective experience of wellbeing mediated by family dynamics, cultural respect and household authority, rather than a mere set of contacts. Family and friends can support a person's quality of life and happiness in many ways, for example, providing tangible support, counselling on issues related to their life and providing practical support in daily life. These resources are also associated with the access to and quality of these support systems, and with reduced levels of stress, loneliness, poor mental health and increased self-efficacy among older people. Social support contributes to the successful resolution of older persons' problems, thus improving their quality of life. This chapter has focused on the issues and relationships between social

support and subjective well-being and highlighted the necessity of effective social support for achieving a good quality of life.

The linear correlation between each social support system and subjective well-being (SWB) is examined using the mean, median by sex, and Pearson correlation (r). Further, some social and demographic factors are shown to be predictive using linear regression. The selected methods are designed to capture the roles of specific support networks and socio-economic factors in the variability in the psychological health of older people.

6.2 Social Support Systems of Older People

In the study region, the systems of support for older people are heavily based on traditional family structures and cultural norms. The key caregiving system of family support continues to be intergenerational co-residence. Secondly, apart from the physical care, the cultural significance of respect (*Sammaan*) for the aged provides a psychological cushion, giving them a sense of dignity and societal value. Furthermore, the self-efficacy and subjective well-being of older people are directly dependent on the power and decision-making authority they have in the household (which is usually associated with property ownership or their role as heads of the family). These non-formal social organizations are promoting appraisal and belonging in healthy aging.

Widowed older people need social support from family, friends, and neighbors. In particular, daughters and friends provide emotional and practical support that is useful to SWB in rural settings (Cheng et al., 2022). One of the studies found that people living in a city who are older have a higher rate of depression than people with a well-developed social network. It means that well-established social networks can reduce loneliness and make people happier (Kim & Jang, 2021). Participation in community

activities has been shown to improve SWB by reducing anxiety, especially among the more educated (Qing et al., 2024). The present study examined social support among older people and its relationship to subjective well-being. As seniors' social networks shrink, friendships, family, neighborhood organizations, and medical professionals are important to their overall well-being. This study investigated how support networks influence the health of older people. It focused on the benefits of having strong social ties and the negative consequences of lacking social ties.

6.2.1 Informal and Kinship Support Systems

Within the study area, the family is the foundation of care for older people as an intergenerational transcendental cooperative and moral responsibility. Physical care, coupled with cultural *Sammaan* (respect), is a psychological buffer that guarantees dignity among the aged individuals in the domestic setting. In addition, the studies in the locality reveal that the well-being of the older people is strongly connected to the household authority; household body roles like the position of the head of the household or property ownership can provide a substantial degree of self-efficacy and self-determination.

The gendered aspect of kinship is also established through emotional support, where the females, especially daughters and spouses, are most of the time seen as the main carers. Such a close circle of support plays an important role in the subjective health of older people as it reduces perceptions of loneliness and offers a stable feeling of safety (Cheng et al., 2022).

6.2.2 Community and Structural Support Networks

Outside the home, the older people in the region under study are highly dependent on extended social networks to survive and integrate into social environments. One of the

factors contributing to a lower incidence of loneliness and depression in old age is peer networks, which involve friends and neighbors.

Also, social engagement, attending religious organizations, community meetings, local groups, etc., is a very important buffer against anxiety. This type of structural support is especially helpful for those with higher literacy levels, as it gives them a sense of community and provides intellectual and social stimulation (Qing et al., 2024). Such community-based relationships thus contribute to kinship by providing an extended platform for social interaction and emotional support.

6.2.3 Socio-demographic variation in Overall Quality of Life

The overall quality of life (QOL) variable was categorized into three groups for analysis: positive, neutral and negative in order to facilitate multivariate interpretation. Table 6.1 provides an integrated overview of the structural and socio-economic context by showing the distribution of these categories by key socio-demographic characteristics of the respondents before looking at the association between social support and subjective well-being.

Table 6.1 shows that most respondents have a positive overall quality of life (52.5%), 43.0% have a neutral idea, and only 3.2% have a negative opinion (N = 402). The positive ratings increased with age: 49.3% aged 60-69 years, 56.7% aged 80 years and above, with minimal negative ratings across age groups. There are sex differences with women reporting a higher percentage of positive quality of life (55.8 %) than males (49.6 %), though women had a slightly higher percentage of negative responses (5.3 % vs 1.4 %).

Table 6.1*Variation of Quality of Life by Socio-Demographic Characteristics*

Variable	Category	Positive (%)	Neutral (%)	Negative (%)	N
Age Group	60–69	49.3	45.6	3.8	215
	70–79	56.0	40.0	3.3	150
	80+	56.7	40.5	0.0	37
Sex	Male	49.6	47.6	1.4	212
	Female	55.8	37.9	5.3	190
Marital Status	Married	52.5	42.6	3.6	333
	Not Married/divorced, widow	52.2	44.9	1.4	69
Literacy Status	Illiterate	50.3	43.9	4.1	294
	Literate (any level)	57.4	40.7	1.8	108
Overall Total	All Respondents	52.5	43.0	3.2	402

Note: The result from the data analysis of the field survey. Positive = Very Good + Good; Negative = Bad + Very Bad; “Don’t know” responses excluded from analytical grouping.

There was little difference in marital status and both married and not married respondents had a similar positive perception (52.5 % and 52.2 %, respectively). The status of literacy showed a slight difference in favor of the literate participants, who made higher positive ratings (57.4 %) and lower negative ratings (1.8 %) than the illiterate participants (50.3 %). The results indicate a generally positive attitude about quality of life among older people, with slight diversity in the light of socio-demographic indicators.

6.3 Profile of Existing Support System

The descriptive portrait of support systems reflects a multi-layered system of social resources. These systems are split between informal networks consisting mostly of family, kin and peer networks and formal mechanisms such as community-based organizations and local welfare programs. The family is the most essential support

structure in this context; it provides basic emotional and material support, and friends' networks are the main sources of socialization and aid.

The social support is as good as possible, based on the availability of different forms of help, such as instrumental, informational, and emotional resources (Thoits, 2011b). The current support profile shows that family relationships have a strong influence on spiritual and existential well-being, and that peer-based configurations are vital for meeting the social connectivity criterion.

6.3.1 Structural Aspects of Social Support

Structural social support is characterized by networks in which individuals have a chance to interact, share companionship, and receive help. This is a quantitative dimension that represents the strength and volume of available social ties, rather than the quality of the relationship. These connections primarily represent the family's and the extended family's support systems within the existing social structures of the research area. The measures of the structural support used in the research were based on the four items, viz: the number of people the respondent spends time with, how many times the respondent meets with them in a week, the number of friends who visited the respondent at home, or the customers with whom the respondent can communicate freely.

Table 6.2 shows the dimensions of structural support, scored on a 6-point categorical scale, and each item is assigned a numerical value based on the network's weight. The scale is split in the following manner: 1 denotes "None," 2 denotes 1-2 persons, 3 denotes 3-5 persons, 4 denotes 6-10 persons, 5 denotes 11-15 persons and 6 denotes over 15 persons. The implication of this classification is a possible mean score of 1.00 to 6.00. Interpretatively, when the mean score increases, this indicates an

extensive social network, which in many cases reflects a strong traditional family setup and community participation. A low mean score, on the other hand, close to 1.00, will be taken to imply high social restriction. This low level of connectedness indicates the deterioration of the social connections of the past. This is among the primary dangers of loneliness and reduced degrees of cognitive stimulation during adulthood, which depicts the vulnerability of ageing patients having fewer structural support networks and lacking family or locality-based authority.

Table 6. 2

Structural Aspects of Social Support of Older People by Sex

Structural aspects	Male (n=212)		Female (n=190)		Total (N=402)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. People who share your interests	3.17	1.2	2.9	1.1	3.05	1.1
2. Person met/talked to during a weekly	3.14	1.2	3.0	1.2	3.11	1.2
3. Friends who visit the home	2.79	1.1	2.8	1.1	2.80	1.1
4. Persons speak openly	2.99	1.2	2.9	1.3	2.96	1.2

Note: The result from the data analysis of the field survey. Mean scores (*M*) range from 1.00 to 6.00. A score of 3.0 represents a network of 3–5 persons. Continuous scores are used in correlation/regression analyses; significance level = 0.05.

Table 6.2 reveals that the structural level of social support is fairly similar between the sexes and the overall mean score of the total subjects is almost 3.00. This indicates that the mean respondent has a social network comprising three to five individuals in most dimensions. The most supportive level of frequency is the weekly contact ($M = 3.11$). nevertheless, friends visiting the home recorded the lowest mean ($M = 2.80$). A 2.80 score is technically equivalent to the 3–5-person group, but since it is so close to the lower limit, it may indicate that to most respondents, the inner group of intimates, home-visiting friends, is more delimited than their overall weekly acquaintances. The standard deviations exceeding 1.10 signify the level of

heterogeneity, which means that there is a vulnerable group at the bottom (Scores 1-2), which consists of zero to two social contacts.

6.3.2 Functional Aspect of Social Support

Social support is valued by older people and has various effects on their physical and mental health, thereby improving their quality of life. It creates psychological benefits for physical health, enhances social performance, and helps people to cope with life's challenges more effectively so that they can live happier, more fulfilling lives. The functional approach emphasizes the particular benefits of social support, particularly during stressful situations. In the well-established social support system of the community, the older are culturally respected and have authority in the home, as a direct outcome of functional support. Emotional support is a key component of social support, making people feel accepted, relaxed and understood. Within a traditional family support structure, emotional support can boost self-esteem, foster a sense of belonging, and decrease feelings of loneliness, isolation, and anxiety (Telebuh et al., 2023).

In this study, the average of the functional dimensions of social support is calculated using a 4-point Likert scale, which is designed to measure the degree of agreement of the respondents with various support claims. The items are weighted on a scale from 1 (strongly disagree) to 4 (agree) therefore the mean values of the items could be between 1.00 to 4.00. These values have an implication; a higher mean score of a nearer score of 4.00 is said to show a strong perception of trustworthy, reliable social support which implies strong and effective informal care system, and lower means score of a nearer score of 1.00 denotes lack of functional support, which may put older people at risk of social isolation and psychological vulnerability especially in case of reduced traditional family buffers or household role in the decision making.

Table 6.3*Functional Aspect of Social Support by Sex*

Functional support	Male (n=212)		Female (n=190)		Total	
	Mean	SD	Mean	SD	Mean	SD
1. Someone I genuinely think has my back	2.85	0.743	2.75	0.762	2.80	0.753
2. A special person in my life	2.75	0.739	2.78	0.723	2.77	0.731
3. People appreciate what I do for them.	2.87	0.632	2.81	0.642	2.84	0.637
4. Someone from whom I may easily request favors	2.85	0.697	2.77	0.682	2.81	0.690
5. I have strong bonds with non-family members that I can turn to in difficult times.	2.63	0.758	2.70	0.674	2.66	0.720

Note. The result from the data analysis of the field survey. Mean ratings (M) were computed using a 4-point Likert scale (1 = strongly disagree, 4 = agree). Greater perceived functional support is indicated by higher ratings. Regression and correlation analyses were conducted using continuous scores; $p < .05$.

The data in Table 6.3 reveal that males and females indicated moderate to high levels of functional social support with a total mean score range of between 2.66 and 2.84. Based on a 4-point scale, the values show that respondents usually agree that they can get support. The males had a slightly higher mean in the understanding that other people value their work ($M=2.87$, $SD=0.632$) and that they find it easy to request favors ($M=2.85$, $SD=0.697$).

The result showed that females scored slightly higher in terms of help received out of the family when in distress ($M=2.70$, $SD=0.674$) than males ($M=2.63$, $SD=0.758$). This implies that both sexes do not lack any support system, although females might have a relatively more varied circle outside of the nuclear family. The standard deviations of all items are relatively low, which indicates that the subjects had a homogenous experience, which is a fixed setting of social acceptance and coping (Uhing et al., 2021). On balance, the data indicate that the functional support level is considered reliable by older people involved in this study, and it needs to mitigate loneliness and increase life satisfaction.

6.3.3 Psychological Health (Feelings) of Older People

The changes and difficulties in the psychology of older people are relevant, as these hormonal and physiological changes are observed and experienced. The reason behind this is that the aspects of loneliness, isolation and emptiness are linked to the death of family members or their roles in society. The family support system's stability and household power retention are of the essence here; once an older individual loses decision-making status, it tends to hasten the process of uselessness. Besides, an individual becomes unintelligent. It is a natural state of older individuals, who begin to experience lapses in memory or attention needed to think clearly and logically and solve problems (Krivanek et al., 2021). But respecting culture (Sammaan) will serve as a protective veil; when older residents feel respected by the younger generation, their mental capacity will improve, even amid physical deterioration. In this regard, they are to receive individualized attention and care to support their overall well-being.

Table 6. 4

Psychological Feelings of Older People by Marital Status

You have the following feelings	Married (n=333)		Unmarried/divorced/widowed (n=69)		Total	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Have as much energy as before	1.78	0.546	1.78	0.565	1.78	0.549
2. As I get older, I am less useful.	2.03	0.537	1.99	0.63	2.02	0.553
3. There is a lot of fun in life.	2.03	0.435	2.07	0.431	2.03	0.434
4. I felt depressed/ upset	1.93	0.374	1.96	0.268	1.94	0.358
5. feel very happy after doing things I want	2.27	0.514	2.26	0.474	2.27	0.507
6. Feel neglected/ days are worthless.	1.87	0.481	1.9	0.489	1.88	0.482
7. Willing to contact others.	1.98	0.591	1.94	0.639	1.98	0.599
8. I like to be alone.	1.71	0.565	1.83	0.513	1.73	0.557
9. Narrow-minded, minded/ angry easily	1.9	0.456	1.91	0.411	1.91	0.448

Note: The result from the data analysis of the field survey. Mean scores (*M*) were based on a 3-point scale (1 = None, 2 = Sometimes, 3 = Always). Higher scores indicate greater well-being for positive items and greater distress for negative items; significance level = 0.05.

Table 6.4 shows that the frequency scale used to obtain the mean scores for respondents' psychological feelings is a three-point scale that quantifies the incidence of different emotional conditions. All items will be scored numerically: 1 = "None," 2 = "Sometimes," and 3 = "Always," yielding a potential score range of 1.00 to 3.00. The definition of these values depends on the character of the particular statement. In the case of positive emotions, e.g., happiness or enjoyment of life, a higher mean of 3.00 or more indicates sound psychological health and frequent positive affect. Good results like this are closely linked to strong social support networks in which older people feel appreciated and connected. On the other hand, in terms of negative emotional measures, e.g., the sentiment of depression or being neglected, the higher the mean, the higher the frequency of experiencing psychological distress, the lower the mean, the higher the emotional adaptability and the lack of negative emotions.

The psychological experiences of older people were studied in two types of marital status, as shown in Table 6.4. The results show there is a little difference in the mean scores of married respondents ($n = 333$) and unmarried, divorced, or widowed respondents ($n = 69$) in most psychological dimensions. The average score of having as much energy as before was the same in both groups ($M = 1.78$). On the same note, the two groups indicated almost similar degrees of satisfaction on the issue of feeling happy after doing the things they want ($M = 2.27$ and $M = 2.26$, respectively).

Nevertheless, a slight difference was found in the preference of being alone; the unmarried and widowed reported a slight difference in the mean of the unmarried and widowed who liked being on their own ($M = 1.83$) over those of the married elders ($M = 1.71$). The findings are in accordance with the literature that concludes that marriage as a mental health protective factor in vulnerable groups acts as a buffer against societal and physiological strain (Ochoa Pacheco et al., 2021).

6.3.4 Health Problems of Older People

As people age, many physiological systems begin to fail, increasing the risk of health problems. This may cause diseases that are not transmissible and infections. Some of the physical health conditions among older people include joint pain, breathing problems, hypertensive difficulties, blood sugar issues and stomach illnesses. All of these problems impede the standard of living and necessitate continuous management for these persons. The table below depicts the prevalence of physical health issues within the older demographic segments of 60-69, 70-79, and 80+ years.

Table 6.5 shows that the majority of older individuals are afflicted with certain physical health problems based on their demographic age groups. A good number of the older people suffer from co-morbidity, 88.8 percent of the population of the age group of 60-69 years, 95.3 percent of the age group of 70-79 years and 94.6 percent of the aged over 80 years suffer from several diseases. All the old persons in every age category can report having a certain degree of health problems, with a very small number of them, especially the younger people, being able to play the clear health status narrative 11.2 percent for the age group of 60-69 years, 4.7 percent for 70–79-year-olds and 5.4 percent for those aged 80 years and above.

The studies have found that older people across all age groups consider themselves to have more than one ailment. The results indicate that the highest percentage of health problems is recorded in the 70–79 age group (95.3%). It is almost equal between the age group 80 years and older (94.6%) and the 60-69 years age group (88.8%). Across all age groups, a very small number of respondents reported no sickness, with the lowest figure in the 70-79 age group (4.7%). This scenario indicates a worldwide quest to address growing health complications with age. Furthermore, in the older age group, physical injuries are the most prevalent health problems, with the

highest proportion in the 70-79 age group (82.4%), followed by 80 years and above (81.8%) and 60-69 years (76.8%).

Table 6.5

Percentage Distribution of Having Health Problems by Age

Types of health problems	60-69 Age	70-79 Age	80 + Age	Total
	%	%	%	N
Have many health problems	88.8	95.3	94.6	369
No health problems	11.2	4.7	5.4	33
Total	215	150	37.0	402
Disease				
Physical pain (joints, knee, back, stomach)	76.8	82.4	81.8	293
Respiratory diseases	21.1	19.7	33.3	80
Blood presser	20.6	19.7	9.1	71
Sugar diabetes	13.9	25.4	15.2	68
Gastric	41.8	38.7	33.3	147
Asthma bath	11.9	16.2	15.2	51
Heart disease	1.0	4.2	0.0	8
Teeth problem	19.6	19.7	24.2	74
Eye problem	23.7	34.5	36.4	107
Kidney urinary	1.0	0.0	3.0	3
Uric acid	2.1	2.1	0.0	7
HIV	0.0	1.4	0.0	2
Dementia	0.0	0.7	0.0	1
Others	1.5	2.1	0.0	6
Total (N)	194	142	33	369

Note. The result from the data analysis of the field survey.

Respiratory diseases tend to affect older people and this is reflected by 33.3 percent in the 80+ age group, 19.7 percent in the 70-79 and 21.1 percent in the 60-69 age group. Hypertension tended to be highest in the age groups 60-69 (20.6%) and 70-79 years (19.7%), but was lower among those aged 80 years and above (9.1%). Diabetes mellitus is most prevalent in the 70-79 age group among the other age divisions (25.4%), but decreases in order of occurrence in the 60-69 (13.9%) and 80+ (15.2%)

age groups. Complaints of an upset stomach are most common in the 60-69 cohort (41.8%) and decrease with older age. The prevalence of asthma also increased, particularly with advancing age, with 60-69 age groups reporting 11.9 percent, 70-79 age groups having 16.2 percent and the 80+ age groups having 15.2 percent. The majority of cases occurred in the 70-79-year age group, with a prevalence of 4.2 percent.

There was an age-related pattern for dental problems, with only 19.6 percent of the population aged 60-69 years having such problems, while it increased to 24.2 percent for the population aged 80 years and above. Also, problems with vision appeared to have a similar pattern, where the 60-69 age group had a prevalence of 23.7 percent and this increased to 36.4 percent in the 80+ age group. Instances of genital and urinary system disorders are quite rare, with the highest being recorded in age groups 60-69 (1.0%) and 80+ (3.0%). Broadly, there are increasing age-related disturbances in physical health among the older population, with certain conditions being age-specific.

6.3.5 Satisfaction with Living Conditions

Satisfaction with living conditions is a complex construct, reflecting an older person's subjective evaluation of his or her environment, safety, and everyday life. This satisfaction in the study area does not pertain to physical infrastructure but to what is essentially provided by the prevailing social support systems. When older people live with a stable family support system, they are more likely to be satisfied with their living arrangements because intergenerational care is provided. Respect (Sammaan) is also an important cultural practice; older individuals who feel respected in their households are more satisfied with their living conditions. Moreover, happiness is closely related to the concept of Power or autonomy; individuals who still have some choice in their place of living and household feel much more content.

Table 6. 6*Level of Satisfaction with the Living Conditions of Older People by Sex*

Life and life situation.	Male (n=212)		Female (n=190)		Total (N= 402)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
1. Satisfaction with house condition	1.87	0.72	2.00	0.70	1.93	0.71
2. Satisfaction with health	2.35	0.88	2.61	0.92	2.48	0.91
3. Ability to perform daily living activities?	2.33	0.86	2.54	0.89	2.43	0.88
4. Satisfaction with personal relationships	2.07	0.68	2.24	0.73	2.15	0.71
5. Conditions in the living place	2.09	0.71	2.10	0.72	2.10	0.71
6. Life as a whole these days	2.17	0.75	2.26	0.68	2.21	0.72
7. overall quality of life	2.47	0.79	2.46	0.91	2.47	0.85
8. General well-being rating	2.38	0.84	2.38	0.81	2.38	0.82

Note. The result from the data analysis of the field survey. Mean scores are derived from a 5-point Likert scale (1 = Very Dissatisfied to 5 = Very Satisfied). Continuous scores are used in correlation/regression analyses. Continuous scores are used in correlation/regression analyses; significance level = .05. $X^2(7, N = 402) = 15.82, p = .027$.

The arithmetic mean of the level of satisfaction scores is computed to give a quantitative account of this well-being. The fact that the mean score is higher will confirm that the environment (both social and physical) is successful in addressing the needs of the older people, and that there is a significant correlation between strong social support and life satisfaction. On the other hand, the low mean scores indicate that the living conditions, which in many cases are further worsened by the absence of social support or family neglect, lack the psychological or physical comfort.

Through these associations, one can easily see that the subjective well-being of older people is directly affected by the effectiveness and inclusiveness of the community's traditional support structures. Table 6.6 findings indicate that females reported higher satisfaction than males across most areas, especially in health (mean difference of 0.26) and daily life activities (mean difference of 0.21).

The overall mean scores across all categories, however, range from 1.93 to 2.48. These scores on a 5-point Likert scale (3.0 = neutral) indicate that respondents tend to be dissatisfied especially with their living conditions ($M = 1.93$). The low standard deviations among items imply a uniform trend in the responses; that is, low levels of satisfaction are prevalent among the group. Although females may have higher scores due to factors such as social support and access to resources, the low scores, in general, point to the need to change health services and environmental conditions to improve the quality of life of all older people in the study area (Papi & Cheraghi, 2021).

The relationship between the general well-being and familial support was not significant ($p = .602$). General well-being is about physical and mental health, relations, purpose, fundamental needs and surroundings. Family support entails comfort, support, exchange of information, feedback, bonding, communication and past experiences. Family support is the main driver of well-being in Nepal's current social support system, as the level of Respect shown by family members directly increases the older individual's sense of purpose.

It alleviates stress, enhances health, generates a sense of belonging, offers assistance and promotes growth. Most importantly, the role of the decision-maker, or the Power of an older individual in the household, is an important element of the given association; as long as the family has autonomy and respects the voice of an aged person, their subjective well-being rises considerably. Conversely, general well-being leads to a good environment, reduced caregiver workload, strengthened bonds, healthy functioning, and improved quality of life among family members. Therefore, the correlation between these two is not only about being taken care of but also about having a respectable social status in the residential setup.

To test the relationship between sex and living conditions, a Chi-square test was used. The finding ($\chi^2 = 7, N = 402$) = 15.82, $p = .05$, indicates a statistically significant difference between males and females in Lamki Chuha regarding satisfaction. This suggests that gender influences older individuals' views and experiences of their living situations, as women in this study region demonstrated a comparatively greater level of happiness in health and everyday functioning than men.

6.3.6 Abuse against Older People

Table 6.7 presents the distribution of physical abuse, emotional abuse and physical and emotional abuse experienced by older people in terms of their associated demographic factors such as age group, sex, caste/ethnicity, religion, marital status, level of education, dependency status and living condition. Abuse in the past 12 months was measured using a structured questionnaire adapted from the Elder Abuse Suspicion Index (EASI) and WHO guidelines. The recorded types were no violence, physical violence, emotional violence, and physical and emotional violence, enabling a more detailed examination of patterns of elder abuse. Besides the general level of prevalence of abuse, this analysis shows the existence of vulnerable subgroups with demographic and social factors and the need for specific interventions. The results show that the largest percentage of abuse overall was among older people aged 60–69 years (52.7%), followed by 70–79 years (38.0%) and 80 years and over (9.3%).

Physical abuse was the most commonly reported abuse, with the 60-69 years group comprising 66.7% and emotional abuse (55.3%). The chi-square test ($\chi^2 = 2.574, p = 0.860$) demonstrates the absence of a significant statistical association between age and type of abuse. Although younger older people (60–69 years) report abuse more often, age does not appear to be a significant predictor of the type of abuse. 52.7 percent of the respondents were males and 47.3 percent were females.

Table 6.7

Types of Abuse Experienced by Older People in the Last 12 Months by Age Group, Sex, Caste/Ethnicity, and Religion

Background characteristics	Both (%)	Physical (%)	Emotional (%)	No violence (%)	N	%	χ^2	p-value
Age group							2.574	0.860
60–69	52.7	66.7	55.3	80.0	215	53.5		
70–79	38.0	33.3	34.2	20.0	150	37.3		
80+	9.3	0.0	10.5	0.0	37	9.2		
Sex							2.715	0.438
Male	52.7	66.7	55.3	20.0	212	52.7		
Female	47.3	33.3	44.7	80.0	190	47.3		
Caste/ethnicity							29.333	0.004
Brahman	34.8	16.7	15.8	0.0	130	32.3		
Kshetri	35.7	33.3	31.6	40.0	142	35.3		
Tharu	20.1	33.3	44.7	40.0	92	22.9		
Dalit	7.9	16.7	7.9	0.0	32	8.0		
Others	1.4	0.0	0.0	20.0	6	1.5		
Religion							18.987	0.004
Hindu	98.9	100.0	100.0	80.0	397	98.8		
Non-Hindu	1.1	0.0	0.0	20.0	5	1.2		

Note. The result from the data analysis of the field survey. Abuse was assessed using an adapted Elder Abuse Suspicion Index (EASI) and a WHO-based questionnaire. Categories were no violence, physical violence, emotional violence, and both physical and emotional violence in the last 12 months. χ^2 = chi-square statistic; $p < 0.05$ indicates statistical significance.

No significant differences between males and females were found as to the overall abuse (52.7% and 47.3%, respectively). More males were victims of physical abuse (66.7%). The prevalence of emotional abuse was similar in both sexes. The chi-square test ($\chi^2 = 2.715$, $p = 0.438$) shows that sex is not significantly associated with the type of abuse. No significant role was found for gender in determining the probability or the kind of abuse; however, some differences in physical and emotional abuse instances were observed.

Also, the patterns of abuse were significantly different among the caste/ethnicity groups ($\chi^2 = 29.333, p = 0.004$). Kshetri (35.7%), Brahman (34.8%), Tharu (20.1%) and Dalit (7.9%) respondents reported the highest overall abuse. More physical abuse was reported by Kshetri (33.3%) and Tharu (33.3%) respondents and more emotional abuse was reported by Tharu respondents (44.7%). The strong association between caste/ethnicity and form of abuse suggests that social and cultural factors could be determinants of abuse dynamics among older people.

As the results show, the majority of respondents were Hindu (98.9%), while very few were non-Hindu (1.1%). All the respondents who reported any form of abuse were Hindu (100.0%), while none of the non-Hindu respondents reported any abuse. There is a statistically significant relationship between religion and type of abuse ($\chi^2 = 18.987, p = 0.004$). Although the sample size of non-Hindus is very small, the results suggest that religion could be one of the factors contributing to the patterns of abuse that older people experience

6.3.7 Elder Abuse by Socio-Demographic and Household Factors

The results indicate that the majority of the respondents were married (82.4%), while the unmarried, divorced, or widowed accounted for 17.6%. A higher prevalence of abuse was found among married older people (82.4%). However, there is no significant correlation between the type of abuse and marital status ($\chi^2 = 1.362, p = 0.715$) as shown by the chi-square test. Thus, marital status would not seem to be an important factor in the experience of abuse among older people.

Further, most of the respondents were illiterate (73.1%) followed by non-formal education (13.6%) and primary level education (8.8%). Most of the abuse was reported by illiterate persons (73.1%). No significant association between education level and

abuse was found ($\chi^2 = 7.722, p = 0.562$). Level of education did not significantly affect exposure to abuse, although older illiterate people reported a higher prevalence.

The results showed that older people were identified as partially dependent (36.3%), totally dependent (46.5%) or not dependent (17.3%). Partially dependent persons were found to have the highest rate of physical abuse (83.3%) and fully dependent older people were found to have the highest rate of emotional abuse (44.7%). There was no statistically significant association between dependency status and abuse ($\chi^2 = 9.711, p = 0.137$). However, this association is not statistically significant. But dependency level can affect the type of abuse suffered, especially physical abuse.

Table 6.8

Types of Abuse Experienced by Older People in the Last 12 Months by Marital Status, Education Status, Dependency Status, and Living Condition

Background characteristics	Both (%)	Physical (%)	Emotional (%)	No violence (%)	N	%	χ^2	p-value
Marital status							1.362	0.715
Married	82.4	100.0	84.2	80.0	333	82.8		
Unmarried/divorced/widowed	17.6	0.0	15.8	20.0	69	17.2		
Education status							7.722	0.562
Illiterate	73.1	66.7	71.1	100.0	294	73.1		
Non-formal	13.6	16.7	21.1	0.0	57	14.2		
Primary (1–5)	8.8	16.7	7.9	0.0	35	8.7		
Secondary (6–10)	3.1	0.0	0.0	0.0	11	2.7		
SLC and above	1.4	0.0	0.0	0.0	5	1.2		
Dependency status							9.711	0.137
Partially dependent	36.3	83.3	39.5	80.0	152	37.8		
Fully dependent	46.5	16.7	44.7	20.0	183	45.5		
Not dependent	17.3	0.0	15.8	0.0	67	16.7		
Living condition							46.086	0.004
Spouse	45.9	50.0	42.1	40.0	183	45.5		
Children and in-laws	41.4	33.3	42.1	20.0	165	31.6		
Grandchildren	7.4	16.7	5.3	0.0	29	6.5		
Others	5.4	0.0	10.5	40.0	25	3.0		
Total (N)	353	6	38	5	402	100		

Note. The result from the data analysis of the field survey. Abuse was assessed utilizing modified EASI and WHO-based instruments. Categories encompassed non-violence, physical violence, emotional violence, and a combination of both. χ^2 represents chi-square; $p < .05$ denotes statistical significance.

Furthermore, the highest overall abuse was reported among older people living with a spouse (45.9%), followed by older people living with children and in-laws

(41.4%). Living arrangement significantly influenced the prevalence of abuse ($\chi^2 = 46.086, p = 0.004$). Physical abuse was most common in those living with a spouse (50.0%) and emotional abuse was most common in those living with children and in-laws (42.1%). These results indicate a strong influence of living arrangements on the probability and type of abuse, with older people living with immediate family members being differentially vulnerable.

The results suggest a strong association between different types of abuse experienced by older people and caste/ethnicity, religion and living conditions, with all of these factors showing statistically significant associations. On the other hand, age, sex, marital status, education and dependency status were not found to be statistically significantly associated. Younger older persons (60–69 years) and those living with a spouse or who are partially dependent are more likely to experience physical abuse, whereas fully dependent older persons and Tharu respondents are more likely to experience emotional abuse. These findings emphasize the importance of socio-cultural and living conditions as correlates of elder abuse and point to the need for targeted interventions to reduce at-risk populations.

6.4 Relationship with Social Support Systems

The results show a discriminating effect of sources of social support. Family support is important for enhancing spiritual and existential well-being, especially transcendence, and friends can only partially compensate for the lack of social contact. This implies that relationships within a family help a person develop a sense of purpose, and peer networks help keep the individual out of social isolation. Social support acts as a buffer against stress, and the benefits of various types of relationships differ in terms of psychological value (Thoits, 2011 b). The significant interaction effect on social support perception also indicates that the joint effect of family and friends increases community

integration. Also, the model fit the expectation achievement expectation significantly ($p < .05$), demonstrating that the broader social environment plays a crucial role in shaping how individuals perceive the attainment of life goals.

6.4.1 Correlation Between Different Variables of Well-Being

Subjective well-being (SWB), along with life satisfaction, shows weak correlations with happiness and support from family members, friends and significant others, according to data presented in Table 6.8, which shows the smallest but insignificant positive connection between SWB and life satisfaction, with a correlation rate of $r = 0.060$. The relationship between family support and SWB produces a negative statistical relationship ($r = -0.079$). Thus, subjectively higher family support does not always lead to better subjective well-being.

Table 6.9

Correlation Between Variables of Well-Being and Social Support

	1	2	3	4	5	6
1. SWB	1					
2. Life satisfaction	.060	1				
3. Family Support	-.079	.065	1			
4. Friend Support	-.077	.080	.700**	1		
5. Significant other support	-.048	.002	.746**	.680**	1	
6. Happiness	.131**	-.017	-.080	-.063	-.084	1

Note. The result from the data analysis of the field survey. SWB = Subjective Well-Being. ** $p < 0.01$.

Continuous scores are used in correlation/regression analyses; significance level = 0.05.

The findings show a negligible negative relationship of friend support ($r = -0.077$) and significant other support ($r = -0.048$) with SWB. The research reveals a positive statistical correlation ($r = 0.131$) between SWB levels and happiness ($p < 0.01$), as higher scores of happiness are directly linked to higher levels of subjective well-

being. Family support is strongly positively correlated ($r = 0.700, p < 0.01$) with friend support, meaning the better the family support one has, the better the friend support one has. Different social support systems are highly correlated with each other. Significant other support is positively correlated with family support at a high level ($r = 0.746, p < 0.01$) and significant other support is positively correlated with friend support ($r = 0.680, p < 0.01$). The analysis shows that happiness and SWB have the strongest significant correlation value of $r = 0.131 (p < 0.01)$ because happiness is essential for subjective well-being. Direct support from family and friends and significant others has the least impact on subjective well-being, but strong social connections are important for overall well-being. The research findings by Buhler et al. (2021) concur that social networks improve psychological well-being.

This study looks at the older emotional well-being together with their assessment of social support and presents different cases of obtaining practical and social help. People generally had no problem finding a company to have lunch together or to go to the movies, but they had problems when they asked for help with housework, when they were sick or when families were in emergencies.

The mean scores indicated moderate to high levels of social support. Men had slightly higher levels of total support, especially in decision-making support. Women had higher levels of emotional caring behaviors. The results of the study showed that family support was rated highest but had an unexpectedly low correlation with subjective well-being (SWB), indicating the need for further research about particular influential factors on older well-being.

6.4.2 Relationship Between Social Support and Well-Being

Table 6.10 There appears to be a strong relationship between the dimensions of supportive social networks in the older population. Family support correlates with friend support (0.700) and with support provided by a significant other (0.746). In this instance, one can assume that kinship and friendship networks are interactive in the sense that each may provide some of the functions that will otherwise be performed by family and friends. Total MPSS Support scores demonstrate a more substantial correlation with the types of aids, especially family (0.913) and significant other support (0.909), pointing to the all-encompassing interaction of all the relationships considered as 'social support' to the older individual. An in-depth analysis was carried out on the correlation coefficients between the various dimensions of social support and well-being measures for older people to obtain insights into how different forms of assistance can affect an individual.

Table 6.10 results indicate that structural support, which concerns the actual existence of social connections, has lower associations with a particular kind of support than friend support (0.103) and functional support (0.169). Functional support, which assesses the qualitative dimensions of practical and emotional support, has a higher degree of positive relationships with the three primary support sources (family, friend, and significant other), ranging from 0.501 to 0.603. This suggests that structural support may be necessary, but functional support shows deeper involvement among the social networks. There seems to be little or no correlation, or even a slightly negative correlation, between the general well-being of individuals and the types of social supports that exist. General well-being is very slightly, negatively associated with support for family, friends and other significant persons, although none of these correlations are statistically significant. General well-being appears to be weakly and

negatively correlated with structural (-0.161) and functional (-0.150) support, suggesting that support availability alone does not necessarily increase general well-being in older people.

Table 6.10, the expectation variable exhibits a negative correlation with most social support dimensions, particularly with functional support (-0.233) and friend support (-0.139). This implies that older people with more severe expectations of the support systems may feel less satisfied with these relationships. The negative relationship between expectation and both structural and functional support indicates that the tangible forms of social support might not align with older people's expectations, which may have a bearing on individuals' subjective well-being.

Table 6.10

Intercorrelation between Dimensions of Social Support and Subjective Well-Being

Among Older

Variable	1	2	3	4	5	6	7	8	9
Social support system									
1. Family Support (MSPSS)	—								
2. Friend Support (MSPSS)	.700**	—							
3. Significant Other Support	.746**	.680**	—						
4. Total MSPSS Support	.913**	.871**	.909**	—					
5. Structural Support	0.028	.103*	0.093	0.082	—				
6. Functional Support	.501**	.518**	.603**	.603**	.169**	—			
Well-being Dimensions									
7. General Well-being	-.056	-.035	-.008	-.036	-.161**	-.150**	—		
8. Expectation	-.121*	-.139**	-.129**	-.144**	-.144**	-.233**	.534**	—	
9. Subjective Well-being	-.081	-.079	-.049	-.077	-.129**	-.147**	.515**	.527**	—

Note. The result from the data analysis of the field survey. MSPSS multidimensional perceived social support. * $p < .05$. ** $p < .01$ (2- 2-tailed).

Table 6.10 shows the relationships between perceived social support and well-being among the older group. The family, friends, and significant other dimensions of the Multidimensional Scale of Perceived Social Support showed a high positive correlation. Friend support was strongly correlated with family support ($r = .700$) and significant other support ($r = .746$), thereby supporting the good internal consistency of the MSPSS scale as a whole.

Even structural support demonstrates weak and insignificant correlations with MSPSS dimensions, except that friend support has a small, significant correlation ($r = .103$). Conversely, the functional support shows moderate and significant positive relationships with all the MSPSS components ($r = .501$ to $.603$), showing consistency between functional and perceived support. One of the most important results is that social support has a negative relationship with the well-being dimensions, mostly. All support variables have a negative relationship with general well-being, and structural ($r = -.161$) and functional support ($r = -.150$) have significant correlations. All dimensions of support have a significant negative correlation with expectation ($r = -.121$ - $.233$) and subjective well-being is also negatively correlated with structural ($r = -.129$) and functional support ($r = -.147$).

Table 6.10 shows that well-being dimensions are interconnected positively. Expectation ($r = .534$) and subjective well-being ($r = .515$) have a strong correlation with general well-being, which indicates conceptual coherence. All in all, the negative correlation indicates that increased support can indicate vulnerability among the older. Lastly, despite the close interrelations of social support dimensions, the negative predictive of well-being indicates that the greater the support, the more vulnerable older persons may be. In the meantime, the constructs of well-being dimensions interrelate positively, which proves their consistency and coherence.

6.5 Discussion

The study examined the social support measures and their association with the subjective well-being (SWB) of the older individuals in the study region. The results showed that senior people generally indicate that they have a positive opinion of the quality of their life and 52.5% of the participants said that their well-being is positive, while 43% are indifferent and only 3.2% gave negative replies. Positive ratings were positively related to age, with the highest result of 49.3% in the 60 -69 years of age group, 56.7% in the 80 years or older age group, indicating that the age effect does not always decrease subjective assessments of life satisfaction, possibly due to adaptive coping and life experience (Buecker et al., 2023).

The overall quality of life among females was higher than among males (55.8% vs. 49.6), which may reflect the possible gender disparities in the sense of well-being perceptions and experiences, similar to previous studies that have suggested that women tend to have more resilient social networks with aging (Zhang & Sun, 2024). Literacy seemed to have a beneficial effect on well-being, and literate people rated higher on positive (57.4) and lower on negative (1.8) than illiterate respondents, a manifestation of the educational impact on increasing access to social resources and empowerment.

Females reported a higher quality of life than males (55.8% vs. 49.6%), reflecting potential gender differences in perceptions and experiences of quality of life. This is consistent with previous research indicating that older women have stronger social networks than older men (Zhang & Sun, 2024). Well-being appeared to be positively impacted by literacy. The positive scores (57.4) and negative scores (1.8) were higher among literate than among illiterate respondents, indicating an educational advantage in increasing access to social resources and empowerment.

Structural social support included the size and frequency of social networks – the average older adult had three to five people with whom he or she was in contact, with contact with one or more persons per week being the most common ($M = 3.11$). The smallest number was friends visiting the home ($M = 2.80$), which is still a moderate number in the network, suggesting a small amount of close social interaction. The provided structural composition highlights that older people interact most frequently within family and intimate circles of friends, whereas larger friendship groups are less prevalent (Kendig, 2023). Social connectivity is highly heterogeneous, with standard deviations exceeding 1.10, indicating that the vulnerable population has very few contacts.

Functional social support, defined as perceived availability and reliability of help, was moderate to high ($M = 2.66, 2.84$). This indicates that older persons tend to feel supported. Men declared that they feel more confident that they are valued and they can easily ask favours. Women stated that they have a slight advantage of being supported by their extended family in times of distress. In the end, there are slight gendered differences in their dependence on their social networks. The standard deviations are small, suggesting that the participants' experiences were quite homogenous, with most seeing available support at all times. The research also found that functional support is qualitatively important and has a closer relationship with well-being than structural network size (Hossen & Salleh, 2025).

Psychological experiences were very similar across marital status groups, with married and unmarried/widowed reporting similar ratings for both happiness and energy. The need for solitude showed a marginally significant difference, with single or widowed adults having a slightly higher preference for isolation, consistent with the literature on emotional self-regulation and autonomy in later ages. Regarding physical

health, respondents in all age categories indicated at least one comorbid condition. 88.8 percent of respondents aged 60-69 years reported at least one comorbidity, as did 95.3 percent of respondents aged 70-79 years and 94.6 percent of respondents aged 80 years and beyond. Injuries, respiratory problems, eye and dental problems have been recorded in different age groups. All of them are ascribed to the physical weakness of ageing and are similar to those seen around the world (Li et al., 2022).

Life and health satisfaction were moderate, and females had slightly higher levels in most areas. Notably low scores in housing living conditions are found ($M = 1.93$), which reflects the lack of environmental and infrastructural support, highlighting the necessity to change the policies to improve the quality of life of older people (Khodabakhsh, 2022). Family support was not significantly correlated with general well-being, which implies that intangible dimensions of family support, like respect, autonomy and personal choice, are more important factors for well-being than instrumental help alone (Shin & Park, 2022).

The study also included the stories of abuse, and there were more instances of abuse among the younger older people (60-69 years) as well as trends that were connected to caste, religion and living arrangements. The physical abuse of most of the males was the case and less gender differentiation was seen in emotional abuse. The occurrence of abuse was largely associated with the caste and ethnicity, and it proves that the vulnerability is determined by the socio-cultural factors. Likewise, the living conditions influenced the exposure to abuse, and individuals who lived with a spouse or children were more exposed to physical and emotional abuse, which means that culturally competent interventions need to be carried out (Buhler et al., 2021).

Correlation analysis revealed that SWB in older people was only weakly associated with several dimensions of social support, including support from family,

friends, and significant others. Although these sources of support are traditionally viewed as important, the low correlation coefficients suggest that social relationships or network size alone are not sufficient to enhance well-being. What appears to be more important is the quality of support, in particular, how it is viewed by people and if it satisfies the emotional and psychological needs of people. This indicates that older people may value meaningful, responsive, and emotionally rewarding interactions more than having numerous social contacts.

The results indicated that subjective well-being had the strongest correlation with happiness ($r = 0.131, p < 0.01$). The correlation was moderate yet statistically significant. This indicates that emotions such as happiness, satisfaction, and emotional fulfillment are significant determinants of overall well-being. The findings indicate that subjective well-being (SWB) is not merely a consequence of exterior social systems, but is also significantly shaped by internal psychological states and personal viewpoints.

A significant discovery is the differentiation between functional support (the quality of support, such as emotional, informational, and practical assistance) and structural support (the quantity of support, including the number and frequency of social interactions). The findings indicated a favorable correlation between functional assistance and other forms of support ($r = 0.501-0.603$). Statistically significant connections were observed.

Findings suggest that older people report moderate to high levels of both structural and functional social support, with differential effects on well-being. Functional support was found to be a stronger predictor, because it was directly related to emotional comfort, resolution of problems and a sense of belonging. Personal satisfaction, autonomy and emotional fulfillment, above and above structural criteria

such as network size, turned out to be more important aspects to subjective well-being. Together, these data underscore the idea that subjective well-being is a large, multifaceted concept that no single indicator can capture.

CHAPTER VII

FACTORS INFLUENCING THE SUBJECTIVE WELL-BEING OF OLDER PEOPLE

7.1 Factors Influencing the Subjective Well-Being

The study of older people's subjective well-being (SWB) seeks to identify the extent to which socioeconomic and demographic factors influence their well-being. Multiple linear regression models are used to do this for well-being measurements such as the Subjective Well-Being Inventory, the WHO-5 Well-being Index, the Kessler Psychological Distress Scale (k10) and life satisfaction ratings. Regression analysis provides a rigorous conceptualization of the determinants of well-being, allowing the researcher to examine the simultaneous effects of multiple independent variables on a dependent outcome, quantify the strength and direction of the relationships, and control for potential confounding factors.

The regression models demonstrate that socio-economic, demographic, and structural factors substantially predict several aspects of subjective well-being. Through the systematic use of regression analysis, the chapter identifies major predictors of well-being and psychological distress, the relative roles of these predictors, and provides an empirical foundation for understanding the delicate nature of the interaction between personal attributes and the outcomes of life. Such analyses are hence vital for directly addressing the research objective and providing evidence-based information on what influences the well-being of older people in the research sample.

This study explores the links between social support and sociodemographic characteristics and subjective well-being of older people. To test the impacts of perceived, structural, and functional social support on older people well-being, linear

regression was used. The research proposal indicates the degree of prediction of older people subjective well-being by variation across different forms of social support and demographic characteristics. This study is of particular interest in identifying the social support elements and demographic profiles most strongly associated with indices of well-being because they may inform interventions to increase the quality of life for older individuals.

7.2 Factors Associated with Subjective Well-Being

Aspects like psychological, social, economic and environmental conditions contribute to individual perception of happiness, i.e., subjective well-being (SWB). The use of multivariate analysis allows for the determination of certain aspects, such as socio-economic and social support. Recognition of such factors aids in crafting appropriate policies that will assist in improving the quality of life of different populations. In this regard, multiple regression analysis was carried out on how different demographic, socio-economic and social support variables impacted the dependent variables, i.e., subjective well-being.

Table 7.1 presents the outcome of the multiple linear regression model that was performed to identify the determinants of Subjective Well-Being (SWB) among the older. The model constant was 92.271 ($p < .001$), which is the base SWB score when all the predictors are set at the same level. Age was a very significant predictor in the demographic context. The oldest-old (85 years and above) group had a very strong negative connection with SWB ($B = -6.458, p = .022$). This implies that the perceived well-being decreases with old age. Other age groups did not, however, demonstrate statistically significant differences.

Table 7.1

Multiple Linear Regression Analysis of Factors Associated with Subjective Well-Being Inventory (SWB)

Predictors	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	92.271	4.780		19.304	.000
Social support factors					
Functional support	-.480	.221	-.135	-2.174	.030
Structural support	-.227	.122	-.094	-1.854	.065
Total MPSS supports	.011	.054	.013	.208	.835
Appraisal support	.329	.273	.081	1.206	.229
Belonging support	-.565	.284	-.131	-1.993	.047
Tangible support	.075	.310	.013	.243	.808
Age group (ref: age 60-64)					
65-69	.688	1.280	.036	.538	.591
70-74	-.562	1.358	-.028	-.414	.679
75-79	-1.716	1.789	-.056	-.959	.338
80-84	-3.957	2.222	-.103	-1.781	.076
85-above	-6.458	2.799	-.125	-2.308	.022
Sex (Female ref.)					
Male	.784	1.021	.043	.768	.443
Household head (ref: Female)					
Male	-1.747	1.449	-.059	-1.206	.229
Caste (ref: Tharu)					
Brahman	-1.800	1.262	-.092	-1.426	.155
Kshetri	-1.851	1.224	-.097	-1.512	.131
Dalit	-6.197	1.883	-.184	-3.292	.001
Other	-1.295	3.779	-.017	-.343	.732
Marital status (ref: Unmarried/divorced)					
Married	1.588	1.281	.066	1.240	.216
Types of family (ref: Nuclear)					
Joint family	-1.684	1.171	-.072	-1.438	.151
Literacy status (ref: Literate)					
Illiterate	.735	1.165	.036	.631	.529
Current occupation (ref: Working)					
Not working	1.363	1.089	.062	1.252	.211

Note. The result from the data analysis of the field survey. $N = 402$; $R = .351$; $R^2 = .123$; Adjusted $R^2 = .074$; $F(21, 380) = 2.537$, $*p < .05$, $p < .001$. All categorical predictors were entered into the regression models as dummy variables using appropriate reference categories.

Moreover, the gender, household headship, and marital status were not significant predictors, which means that there was a certain amount of stability in well-being among these social positions. Socio-economic factors such as literacy status, occupation and family type were also not significant. Nevertheless, a caste-based difference could be seen; the Dalit category was highly associated with a negative SWB

($B = -6.197, p = .001$) than the reference group. Socially, only belonging support had a statistically significant negative influence on the SWB scores ($B = -0.565, p = .047$).

Although functional support ($B = -0.480, p = 0.3$) and structural support ($B = -0.227, p = .065$) had negative coefficients, they were not statistically significant at the level of $p = 0.05$. These findings underscore that the old-old and the marginalized caste groups are the most vulnerable, and indicate that not every dimension of social support has a positive impact on the subjective well-being of older people in that regard.

7.3 Factors Associated with the WHO-5 Well-Being Index

World Health Organization well-being index (WHO-5) takes into account various aspects such as age, gender, economic status, health and social support, making it a well-known well-being index. A multivariate analysis reveals that these variables and strategies are designed to improve life satisfaction and promote better psychological well-being among individuals. A multiple regression analysis was performed in order to study how demographic, socioeconomic and social support factors affect the well-being index (WHO-5).

Table 7.2 presents the multiple linear regression analysis of the effects of demographic, socio-economic, and social support factors on the WHO-5 Well-being Index among older people. The model's outcomes indicate that it fits the data well [$F(21, 380) = 2.537, p < .001$], explaining about 15.5% of the variance in psychological well-being in this sample.

Table 7.2

Multiple Linear Regression Analysis of Factors Associated with the WHO-5 Well-being Index

Predictors	Unstandardized coefficients		Standardized coefficients	T	Sig.
	B	Std. Error	Beta		
(Constant)	24.251	12.016		2.018	.044
Social support system					
Functional support	.255	.555	.028	.460	.646
Structural support	.943	.307	.153	3.066	.002
Total MPSS supports	-.329	.136	-.150	-2.409	.016
Appraisal support	.499	.686	.048	.727	.468
Belong in support	2.047	.713	.186	2.872	.004
Tangible support	.704	.779	.047	.904	.366
Age group (ref: age 60-64)					
65- 69	4.190	3.217	.085	1.302	.194
70 -74	2.629	3.414	.050	.770	.442
75-79	2.418	4.498	.031	.538	.591
80-84	4.900	5.586	.050	.877	.381
85 above	11.625	7.036	.088	1.652	.099
Sex (ref: Female)					
Male	.750	2.566	.016	.292	.770
Household head (ref: Female)					
Male	5.015	3.642	.066	1.377	.169
Caste of respondent (ref: Tharu)					
Brahman	-6.376	3.173	-.128	-2.010	.045
Kshetri	-7.229	3.077	-.148	-2.349	.019
Dalit	.437	4.733	.005	.092	.927
Other	2.239	9.501	.012	.236	.814
Marital status (ref: Unmarried/divorced)					
Married	-.776	3.221	-.013	-.241	.810
Types of family (ref: Nuclear)					
Joint family	.863	2.944	.014	.293	.770
Literacy status (ref: Literate)					
Illiterate	-7.672	2.929	-.146	-2.619	.009
Current occupation (ref: Working)					
Not working	-6.720	2.737	-.119	-2.455	.015

Note. The result from the data analysis of the field survey. * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. Significance level = 0.05, dependent variable = well-being index WHO 5., $N = 402$; $R = .394$; $R^2 = .155$; Adjusted $R^2 = .108$; $F(21, 380) = 2.537$, $p < .001$.

The analysis indicates that the variables of age, sex, and household headship are not important predictors of well-being in this sample ($p = .05$). Nonetheless, caste proved to be an influential variable and Brahman ($B = -6.376$, $p = .045$) and Kshetri ($B = -7.229$, $p = .019$) respondents were significantly lower in terms of well-being scores in comparison to the reference group. Socio-economic status also had a significant influence on illiteracy ($B = -7.672$, $p = .009$) and being unemployed/not working ($B = -$

6.720, $p = .01$ Such findings point to the susceptibility of less educated and occupationally engaged people. Regarding social support, the study shows that the relationship is subtle. Structural support ($B = .943, p = .002$) and belonging support ($B = 2.047, p = .004$) were positive and significant predictors of psychological well-being, suggesting that increased psychological well-being is associated with stronger ties to the community and a greater sense of belonging. In contrast, Total MPSS support ($B = -0.329, p = .016$) was significantly negatively associated. This may be a reflection of high perceived general support in the particular context and may point to underlying dependencies or other complex psychosocial needs negatively impacting well-being scores.

7.4 Factors Associated with Psychological Distress (K10)

One of the most used instruments for assessing psychological distress is the Kessler Psychological Distress Scale (K10). Regression analysis is used to look at the connections between different elements and levels of psychological distress, helping to identify key factors that could lower the risk of mental disorders in older people.

The regression model reveals the associations between the K10-scale psychological distress and the demographic, socioeconomic and social support variables. The regression coefficient was 1.718 ($p = .001$), reflecting the amount of psychological distress at the base with all predictors constant.

The only demographic variable to achieve statistical significance was age. Respondents aged 85 years and older had significantly higher levels of psychological discomfort than the reference group (60–64 years old) ($B = 0.921, p = .002$). There was no substantial variance in other age groups.

Table 7.3*Multiple Linear Regression Analyses: Factors Associated with Psychological Distress**(K10)*

Predictors	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	1.718	.507		3.391	.001
Social support factors					
Functional support	.030	.023	.082	1.292	.197
Structural support	.013	.013	.050	.965	.335
Total MPSS supports	.004	.006	.047	.723	.470
Appraisal support	-.056	.029	-.134	-1.953	.052
Belonging support	.022	.030	.050	.745	.457
Tangible support	.018	.033	.030	.551	.582
Age group (ref:60-64)					
65-69	-.029	.136	-.015	-.215	.830
70-74	.014	.144	.007	.099	.921
75-79	.074	.190	.023	.388	.698
80-84	.374	.235	.094	1.589	.113
85-above	.921	.297	.172	3.105	.002
Sex (ref: Female)					
Male	-.131	.108	-.069	-1.212	.226
Household head (ref: Female)					
Male	-.081	.154	-.027	-.529	.597
Caste (ref: Tharu)					
Brahman	-.148	.134	-.073	-1.105	.270
Kshetri	-.105	.130	-.053	-.809	.419
Dalit	.092	.200	.026	.462	.645
Other	.697	.401	.089	1.740	.083
Marital status (ref: Unmarried/divorced)					
Married	.191	.136	.076	1.408	.160
Types of family (ref: Nuclear)					
Joint family	.015	.124	.006	.117	.907
Literacy status (ref: Literate)					
Illiterate	.064	.123	.030	.520	.603
Current occupation (ref: working)					
Not working	.191	.115	.084	1.658	.098

Notes. The result from the data analysis of the field survey: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. $N = 402$; $R = .312$; $R^2 = .097$; Adjusted $R^2 = .048$; $F(21, 380) = 1.945$, $p < .01$.

Table 7.3 Multiple linear regression results of factors associated with psychological distress (K10) in older people. The model had a significant baseline constant of 1.718 ($p = .001$). Age was the strongest demographic predictor. Particularly, respondents aged 85 years and older reported significantly more psychological distress ($B = 0.921$, $p = .002$) than the reference group of 60- to 64-year-olds. No major difference was detected among other age groups. K10 scores were not significantly linked with sex, household headship, caste, marital status and literacy ($p > .05$). The

other caste category ($B = 0.697, p = .083$) and non-working occupational position ($B = 0.191, p = .098$) had a marginal tendency towards increased psychological distress, though not highly significant. When it comes to social support, most dimensions (functional, structural, belonging and tactile support) were not substantially associated with psychological discomfort. Appraisal support ($B = -.056, p = .052$) was marginally negatively associated and may be a potential buffer against psychological distress. The findings indicate that age 85+ is most strongly related to psychological discomfort in this population. Perceived evaluation support appears to be a key target for psychosocial intervention.

7.5 Factors Associated with Life Satisfaction

Assessment of well-being is very important as older people tend to experience certain levels of happiness in life depending on factors such as economic status, health, etc.

Table 7.4 Multiple linear regression analysis of characteristics associated with Life Satisfaction in the older. No significant association was found between age groups and life satisfaction. Also, sex and household headship were not significant predictors, suggesting no substantial difference in life satisfaction between men and women, or between male and female heads. Such factors can be explained through multivariate analysis and it assists researchers in determining the predictors to improve the quality of life for individuals of particular groups of older people.

Table 7.4*Multiple Linear Regression Analysis of Factors Associated with Life Satisfaction*

Predictors	Unstandardized coefficients		Standardized coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)		24.170	4.075	5.932	<.000
Social support system					
Functional support	-.180	.188	-.062	-.960	.338
Structural support	-.108	.104	-.055	-1.034	.302
Total MPSS supports	.079	.046	.114	1.717	.087
Appraisal support	-.045	.233	-.014	-.193	.847
Belonging support	.057	.242	.016	.236	.814
Tangible support	-.177	.264	-.037	-.670	.503
Age group (ref: Age 60-64)					
65-69	1.551	1.091	.100	1.422	.156
70-74	.408	1.158	.025	.352	.725
75-79	-.758	1.525	-.030	-.497	.619
80-84	.525	1.894	.017	.277	.782
85-above	1.056	2.386	.025	.442	.658
Sex (ref: Female)					
Male	.405	.870	.027	.466	.642
Household head (ref: Female)					
Male	.413	1.235	.017	.334	.738
Caste (ref: Tharu)					
Brahman	.025	1.076	.002	.023	.981
Kshetri	-1.267	1.044	-.082	-1.214	.226
Dalit	.167	1.605	.006	.104	.917
Other	-.091	3.222	-.001	-.028	.978
Marital status (ref: Unmarried/divorced)					
Married	-.367	1.092	-.019	-.336	.737
Types of family (ref: Nuclear)					
Joint family	-.571	.998	-.030	-.572	.567
Literacy status (ref: Literate)					
Illiterate	-.062	.993	-.004	-.063	.950
Current occupation (ref: Working)					
Not working	.209	.928	.012	.225	.822

Note. The result from the data analysis of the field survey: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$. $N = 402$; $R = .215$; $R^2 = .046$; Adjusted $R^2 = .008$; $F(21, 380) = 0.872$, $p = .627$. Dependent Variable: Life Satisfaction Score.

Table 7.4 Results of Multivariate regression analysis concern the relationships between life satisfaction and demographic variables, socioeconomic status and social support. If all the predictors are zero, then the intercept value is 24.170, signifying basic life satisfaction. Multiple linear regression analysis of the effects of demographic, economic and social support determinants on life satisfaction of the older age group. The model constant is 24.170 ($p = .001$), which means that the baseline level of life satisfaction, controlling for all predictors, is 24.17 points on the life satisfaction scale.

The results showed that the overall model was not statistically significant [$F(21,380) = 0.872, p = .627$] and the predictors had no statistically significant predictive value [$p = .05$]. Demographic and socio-economic variables such as age, sex, home headship, caste, marital status, literacy were analyzed and shown to be not significant predictors ($p = .05$). This suggests that life happiness is rather stable across various categories of social and economic groups in the sample studied.

On the same note, there was no significant difference in specific dimensions of social support (functional, structural, appraisals, belonging, and tangible) about life satisfaction. Even though there was a slight positive trend in Total MPSS support ($B = .079, p = .087$), it did not reach the traditional level of statistical significance. Such results indicate that life satisfaction here might be due to unmeasured qualitative variables beyond the particular demographic and support variables analyzed in this framework.

7.6 Discussion

This study has investigated demographic, socio-economic, and social support variables that can influence the well-being of older people (measured in four domains: Subjective Well-being (SWB), the WHO-5 Well-being Index, Psychological Distress (K10), and Life Satisfaction). Results indicate that aging, caste identity, literacy, and employment are strong predictors, though they operate in complex and contradictory ways. Age was found to be a significant predictor of psychological outcomes, especially among the oldest-old.

The respondents 85+ years had significantly lower SWB scores ($B = -6.458, p = .022$) and significantly higher levels of psychological distress ($B = 0.921, p = .002$) than the 60-64 reference group. The results are in line with previous research suggesting that successful aging is often accompanied by declining health, reduced independence

and social networks, all leading to a decline in well-being (Diener et al., 2018a). Interestingly, age was not a predictor of life satisfaction, suggesting that global ratings of life may remain stable even in the presence of age-associated physiological or psychological decline.

The results reveal considerable caste-based disparities in terms of well-being across both variables. Consistent with the existing evidence of the relationship between social marginalization and poor psychological outcomes in the South Asian context (Thapa et al., 2021; Borooah, 2010), Dalit respondents had significantly lower subjective well-being (SWB) than the reference group ($B = -6.197, p = .001$). However, the results of the WHO-5 scale were lower in the Brahman and Kshetri groups compared to the reference group, indicating that the caste-based difference in well-being was contingent on the measurement index used. Social support was a significant predictor of well-being. Belonging support ($B = 2.047, p = .004$) and structural support ($B = 0.943, p = .002$) positively predicted WHO-5 scores, confirming the function of social integration and community belonging (Antonucci et al., 2019; Keyes et al., 2005).

Having unemployment ($B = -6.720, p = .015$) or illiteracy ($B = -7.672, p = .009$) was associated with worse well-being. Literacy and economic participation in later life is also strongly influenced by resilience, purpose and life happiness (Stone et al., 2010; Helliwell et al., 2025). The overall regression model for life satisfaction was not statistically significant ($p = .627$) (Table 7.4) and most components were of little importance. Total perceived social support was positively associated with life satisfaction, but this association was weak ($B = .079, p = .087$). This suggests that aid is more relevant to global evaluations of one's life than to momentary well-being. The

findings are in line with the findings that life pleasure is the overall judgment of life, not specific social support mechanisms (Diener et al., 2018b).

The results indicate that the very poorest and most excluded caste groups, the illiterate and the jobless, are most vulnerable to poor well-being. Social support is contextual: the structural support and appraisal support have a positive effect on well-being, while high functional dependency can generate a psychological obligation.

CHAPTER: VIII

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

8.1 Summary

The present study investigated the relationship between social support systems and subjective well-being (SWB) of senior people in Lamki Chuha Municipality, Kailali District, Sudurpashchim Province, Nepal. The study used a quantitative methodological framework based on a positivist paradigm and a descriptive cross-sectional research design to analyze the multidimensional factors of social support and well-being. A total of 402 older people aged 60 years and above were selected from Ward 1 and Ward 4 of the municipality, utilizing a two-stage selection technique of simple random sampling and systematic random sampling with proportional allocation. Data were collected using systematic face-to-face interviews and validated tools such as the Multidimensional Scale of Perceived Social Support (MSPSS), the WHO-5 Well-Being Index, Subjective Well-Being Inventory (SWBI) and Kessler Psychological Distress

The study was based on House's (1983) Social Support Typology and the Stress-Buffering Theory and social support was operationalized as a multidimensional independent variable consisting of the structural (network density), functional (emotional and informational) and tangible (instrumental and financial) dimensions. The dependent variable was subjective well-being, which was defined as life satisfaction, positive affect, and psychological discomfort. Control variables included socio-demographic and socio-economic factors, including age, gender, caste, education, marital status and occupation. Data analysis was conducted using IBM SPSS Statistics (Version 20). Three study objectives were achieved through the use of descriptive statistics, bivariate analysis (correlation and two-way ANOVA) and

multivariate analysis (multiple linear regression and mediation analysis). The results indicate the low level of subjective well-being among the older in the study area, where the family-based social networks

8.2 Findings

Objective 1: Level of Subjective Well-Being Among Older People

The first objective of the study was to find out the level of subjective well-being (SWB) of the older people in the study area. Three valid questionnaires – WHO-5 Well-Being Index, Kessler Psychological Distress Scale (K10), Subjective Well-Being Inventory (SUBI) and descriptive variables of life satisfaction and satisfaction with living arrangements were used to assess subjective well-being. The subjective well-being appears to be moderately high on all dimensions, with significant intergroup variation.

The composite SWB score for the sample yielded a mean score of $M = 3.82$ ($SD = 0.45$) on a 1-6 scale for overall well-being that fell in a moderate range. The mean score of the WHO-5 Well-Being Index on a 0-100 scale was $M = 53.03$ ($SD = 23.37$), which is just above the threshold suggested by Topp et al. (2015) for poor psychological well-being ($M < 50$). Notably, 20.1% of respondents ($n=81$) were rated low well-being (<50) and the remaining 79.9% ($n=321$) were rated moderate to high. Large age group differences in standard deviations (22.49 in the 70-74 age group to 28.32 in the 80-84 age group) indicate that health status and family support and socioeconomic factors are significant moderators of psychological well-being in the older age groups. Contrary to the common expectation that the oldest age group (85+) would show the lowest score, the mean WHO-5 score for this group ($M = 60.00$, $SD = 27.08$) was in fact the highest, a pattern that could reflect the psychological resilience or effect of selection-for-

survival, in which those who are psychologically tougher are more likely to reach old age (Steptoe et al., 2015).

The analysis of the SUBI dimension showed that the positive dimension generally ranged from moderate to high. The highest mean score in positive dimensions was for Expectation-Achievement Congruence ($M = 6.34$, $SD = 1.39$), followed by Confidence in Coping ($M = 6.12$, $SD = 1.32$) and General Well-Being Positive Effect ($M = 6.05$, $SD = 1.38$). Family Support ($M = 5.07$) and Social Support ($M = 5.57$) were comparatively lower, while the old-old were the most vulnerable with a decrease in Social Support ($M = 4.78$) and Transcendence ($M = 4.89$). Inadequate Mental Mastery was also quite high and significant ($M = 14.61$) and characterized by a generalized and enduring feeling of psychological burden, regardless of gender or age. Perceived Ill-Health ($M = 11.81$, $SD = 2.37$) was the second most salient negative dimension, reflecting the high proportion of chronic health conditions seen in the sample: 88.8% of those aged 60–69, 95.3% of those aged 70–79, and 94.6% aged 80+ reported having at least one chronic health condition.

Regarding satisfaction with living arrangements, 82.8% of respondents stated they were satisfied or extremely satisfied, and 1.7% stated they were dissatisfied. The age group 80+ had the highest degree of satisfaction (Very Satisfied: 32.4%). The very satisfied was somewhat greater among males (30.2%) than among females (21.6%). The overall quality of life rating was good in 52.5% of the respondents, and literate respondents had a greater positive quality of life (57.4%) than illiterate respondents (50.3%), confirming the protective impact of education. Psychological distress (K10) was somewhat high ($M = 2.85$, $SD = 0.69$) and skewed, with a considerable proportion of participants expressing some moderate to high level of distress.

The results show that most older persons are in good health, but a significant number are at high risk of mental health and social support requirements and in need of specific intervention and support. The SUBI dimension analysis indicated that the positive dimension was generally moderate-to-high. In positive dimensions, the highest mean score was for Expectation-Achievement Congruence ($M = 6.34$, $SD = 1.39$), followed by Confidence in Coping ($M = 6.12$, $SD = 1.32$) and General Well-Being Positive Effect ($M = 6.05$, $SD = 1.38$). Family Support ($M = 5.07$) and Social Support ($M = 5.57$) were somewhat lower. The old-old were the most vulnerable with a reduction in Social Support ($M = 4.78$) and Transcendence ($M = 4.89$). Inadequate Mental Mastery, defined as a widespread and persistent sense of psychological burden regardless of gender or age, was also very high and significant ($M = 14.61$). The second most salient negative dimension was Perceived Ill-Health ($M = 11.81$, $SD = 2.37$), reflecting the high proportion of chronic health conditions seen in the sample: 88.8% of those aged 60–69, 95.3% of those aged 70–79, and 94.6% aged 80+ reported having at least one chronic health condition.

With respect to the satisfaction with living arrangements, 82.8% of respondents stated they were satisfied or extremely satisfied, and 1.7% were dissatisfied. The greatest satisfaction level was in the 80+ age group (Very Satisfied: 32.4%) and very satisfied was somewhat more in males (30.2%) than females (21.6%). The general evaluation of quality of life was favorable for 52.5% of the respondents, with the positive quality of life being greater among literate respondents (57.4%) compared to illiterate respondents (50.3%), thus reaffirming the protective impact of education. Psychological distress, as measured on K10, was moderate in mean ($M = 2.85$, $SD = 0.69$), but skewed, with a considerable proportion expressing some moderate to high level of distress. These results indicate that the majority of older persons are in good

health, but a considerable proportion is at high risk for mental health and social support requirements and need specific intervention and assistance.

Objective 2: Relationship Between Social Support Systems and Subjective Well-Being

The association between social support provided and the subjective well-being of older people. The social support was assessed using the Interpersonal Support Evaluation List (ISEL), the Multidimensional Scale of Perceived Social Support (MSPSS) and the structural and functional characteristics of social network components. The nature and breadth of these associations were examined using correlation and analysis of variance (ANOVA).

The MSPSS total score varied from 0 to 7 and was moderate ($M = 4.62$, $SD = 0.89$). Family support was the most important source of perceived support ($M = 4.78$, $SD = 1.03$), followed by friend support ($M = 4.56$, $SD = 0.89$), and then support from a significant other ($M = 4.50$, $SD = 1.05$). The significance of family is in line with the socio-cultural setting

ISEL analysis revealed that the distribution of the support was not symmetrical in the functional domains. Informational and appraisal support were reasonably excellent, with decent access to guidance in crises ($M = 3.06$) and help with personal concerns ($M = 3.01$). Instrumental support ($M = 1.87$) was considerably lacking; 77.6% reported that instrumental help was definitely or probably lacking while they were sick. The difference between perceived informative and instrumental help shows that informational and emotional support are not enough and instrumental support is a crucial necessity for older individuals. In terms of structural social support, the average person reported having between 3 and 5 persons they felt they could turn to for help,

and the highest structural mean was weekly contact ($M = 3.11$). Functional support was rated at moderate to moderately high levels ($M = 2.66 - 2.84$ on a 4-point scale), which means older people rarely experience support in all of its moments.

The pattern of relationships between social support and SWB shown by Pearson correlation analysis was complex. Happiness, not surprisingly, had the largest and the only statistically significant positive connection with SWB ($r = .131, p < .01$), again pointing to the importance of internal positive affect in SWB. There were very low (and non-significant) negative correlations between family support ($r = -0.079$), friend support ($r = -0.077$), and substantial other support ($r = -0.048$) and SWB, contrary to conventional sense. The negative correlations and significant negative associations between general well-being and structural support ($r = -.161, p < .01$) and functional support ($r = -.150, p < .01$) may be explained as a reverse dependency effect, meaning that older people who score high on support may do so because of higher levels of functional impairment or vulnerability (Buhler et al., 2021).

This is not to say that social support is not important, but rather that emotional meaningfulness, responsiveness and quality of social support can make as much if not more difference to wellbeing as availability of social support. The ANOVA investigations demonstrated that for certain particular sectors, there is a significant effect of social support on SUBI dimensions. The Expectation-Achievement Congruence dimension ($F = 3.57, p = .002$) is most significantly related to the social environment, indicating that perceptions of goal attainment are substantially correlated with the quantity and quality of social ties. Family Support ($F = 4.32, p = .014$) and Family Group Support ($F = 7.21, p < .001$) were the greatest predictors of Transcendence. This validates the spiritual and existential worth of familial bonds as an adult.

A main effect for both family and friend support, as well as a significant interaction effect between the two, was obtained for the General Social Support Perception ($F = 3.06, p = .048$), indicating a synergistic rather than independent effect on perceived social integration. Peer networks were particularly significant in the reduction of Social Contact Deficiency ($F = 4.09, p = .017$), highlighting the complementary nature of non-familial networks in reducing loneliness. No relationship was found between these dimensions of mental health (Mental Inadequacy and Perceived Ill-Health) and social support, indicating that these components of subjective ill-health are more closely related to clinical or biological factors than to social support alone.

Objective 3: Influence of Socio-Economic and Demographic Factors on Subjective Well-Being

The third objective studied the effect of socio-economic and demographic factors on the subjective well-being of older persons. Four well-being indicators (i.e., SWB Inventory, WHO-5 Well-Being Index, K10 Psychological Distress, and Life Satisfaction) were used to perform multiple linear regression analysis with adjustments for age, sex, household headship, caste/ethnicity, marital status, family type, literacy, occupation, and dimensions of social support.

The age of the children proved to be a key determinant of psychological outcomes, especially those for the oldest-old. Cumulative disadvantage theories suggest a cumulative effect of age on health, social, and functional status, as seen by the statistically significant negative association between SWB ($B = -6.458, \beta = -.125, p = .022$) and the elevated psychological distress among those aged 85 and older compared to the 60–64 reference group. But this was not a statistically significant predictor of Life Satisfaction [$F(21, 380) = 0.872, p = .627$], and this is the well-documented

paradox of ageing: that despite objective functional decline, global evaluative assessments of Life Satisfaction do not decline. Despite this, there was no significant difference in older age groups (65-79 years) compared to the reference group on any of the outcomes, indicating that resilience in well-being is widely maintained in early and middle old age.

About well-being, the direction of this relationship was mixed, but the relationship of caste identity was strong and consistent across measures. The Dalit respondents also had significantly lower subjective well-being than the Tharu reference group ($B = -6.197, \beta = -.184, p = .001$), which reflects the structural disadvantages of the lives of Dalit elders in rural Nepal, including economic marginalization, social discrimination, and health care access barriers (Thapa et al., 2021). In the WHO-5 model, the scores of Brahman ($B = -6.376, p = .045$) and Kshetri ($B = -7.229, p = .019$) respondents were significantly below the scores of the reference group, which was interpreted as a higher self-evaluative standard among higher caste respondents on dimensions of hedonic well-being. This caste effects found to be construct dependent highlight the methodological value of using multiple measures of well-being in studies of socially diverse populations.

Well-being was favorably and consistently connected to educational attainment. ANOVA ($F(4, 397) = 5.82, p = .001$) indicated that the mean scores of educations were increasing from illiterate to SLC level or higher. The WHO-5 regression model showed illiteracy as a significant negative predictor ($B = -7.672, \beta = -.146, p = .009$), which means that older people who did not have any formal education scored almost 7.7 points lower on psychological well-being than older people who did have any formal education, controlling for all other factors. This finding is consistent with the human capital hypothesis of aging, which argues that expenditures in education across the life

course have a protective effect on well-being that diminishes with age (Stone et al., 2010).

The model of the WHO-5 showed a significant negative relationship between occupational disengagement and psychological well-being ($B = -6.720$, $\beta = -.119$, $p = .015$), indicating that maintaining purpose, social participation and identity continuity are related to being productively engaged in one's occupation. This gradient was again confirmed with a composite SWB analysis by economic status [$F(2, 399) = 4.90$, $p = .009$], with respondents in the high economic status group reporting the highest level of wellbeing ($M = 4.08$) than the medium ($M = 3.83$) and low ($M = 3.77$) groups.

In the regression models, none of the gender, marital status, household headship, or family type variables were statistically significant predictors of SWB, WHO-5, K10, or Life Satisfaction. Descriptive data showed that males had slightly higher percentages of very satisfied responses to living arrangement items, while females had marginally higher percentages of overall very satisfied responses to well-being items; these differences were not significant after controlling for other covariates, which is consistent with literature indicating that gender differences in well-being are due to social roles and not to gender alone (Zhang & Sun, 2024). When the dimensions of social support were entered into the regression models together, belonging support was a significant positive predictor of WHO-5 well-being ($B = 2.047$, $p = .004$), and structural support also was positively significant ($B = 0.943$, $p = .002$), indicating that community integration and perceived belonging are important positive contributors to psychological well-being. Older people in high-demand social networks, on the other hand, had negative associations with belonging support ($B = -0.565$, $p = .047$), a contradiction that was explained as reflecting the psychological obligation of older people in high-demand social networks. Collectively, the regression models account for

7.4%–10.8% of the adjusted variance in well-being outcomes, but there is still a significant proportion of variance in the outcomes that is not explained by the regression models that variance could be due to qualitative factors that are not measured in the data, such as personal meaning, autonomy and relational quality, highlighting important directions for future qualitative and longitudinal inquiry.

The subjective well-being in older persons was moderate but variable. Poor psychological well-being was found in about one in five older people. Family is the most important source of social support, but emotional and appraisal support is more important for well-being than belonging to a large social network. Sex or marital status has a less significant impact on well-being than other factors like caste, education, occupation and advanced age. Dalit, illiterate and oldest-old (85+) people are more vulnerable and require customized policy attention.

8.3 Conclusion

This study has revealed that subjective well-being is a multidimensional and stratified phenomenon influenced by the interplay of social, psychological, economic, and cultural factors among older people in the Lamki Chuha Municipality. The general level of SWB was found to be moderate; however, the percentages found indicate that about 20% of the respondents were at clinically significant risk of psychological distress, a percentage that is not demographically insignificant. This study confirms that the experience of ageing in a semi-urban Nepali context is not uniform and is highly structured by caste, education, and socio-economic status. The most vulnerable subgroups are the oldest-old (85 years and older), Dalit respondents, the illiterate, and the economically inactive, who suffer from compounded disadvantages that do not diminish because of the general level of family-based social support. The overall results are in line with the evidence presented at the international level on structural

inequalities in ageing and support the need for culturally specific and equity-focused policies in the context of Nepal's Senior Citizens Act.

Theoretically important findings of the study are the identification of a social support paradox in a collectivist culture. The emotional, appraisal, and belonging dimensions of support were positively associated with SWB, whereas excessive reliance on instrumental and functional dimensions of support was negatively associated with SWB, leading to reduced autonomy, self-esteem, and perceived adequacy. The study challenges the policy and care-practice premises underlying a "more is better" approach to providing greater support to older people. Rather, quality, reciprocity, and valuing individuals' dignity in support interactions are the more compelling factors shaping well-being. The findings supported the importance of Family Systems Theory in the context of ageing in Nepal, as the processes of decision-making power, personal autonomy, and cultural dignity at the household level were found to have a significant relationship with psychological well-being, whereas larger structural/community level networks were found to have a weak association with psychological well-being.

The gender differences in well-being were quantitatively small but, in qualitative terms, significant in highlighting the differences in ageing experience between men and women. While marital status had a significant impact on women's well-being, it had a greater impact on men's well-being. Concurrently, the burden of chronic illness was more pronounced among women than among men, as was the burden of gendered care responsibilities, highlighting the importance of not only the material disadvantage, but also the invisible labour and health vulnerabilities of women's experience of advanced age in Nepal. This transition from age to well-being found in this study from the age of 70–74 as the trough of this curve to apparent

resilience of the oldest-old may represent a psychologically critical period of adjustment, defined by retirement, physical decline and changing roles in society. The finding has implications for psychosocial interventions for older people, particularly regarding timing and targeting.

The study finds that, in order to achieve effective and dignified ageing in Nepal, the current paradigm of welfare provision, which is passive, dependency-based and discriminatory, needs to be shifted towards more proactive, inclusive and autonomy-enhancing welfare models. Policies and programmes must also take into account the structural inequalities at the basis of caste, literacy and economic insecurity, while at the same time reinforcing the capacities of the family and community to ensure the role of older people in maintaining their agency and dignity, and investing in their psychological resilience capacities at all stages of the life course. Although this study is cross-sectional, it provides a strong empirical and policy base for understanding the social, structural, and psychological factors influencing ageing and well-being in Nepal and presents a validated, culturally adapted methodological framework that is replicable in other similar contexts in South Asia.

8.4 Contribution to Knowledge

This thesis makes contributions of fresh knowledge to the subject of older well-being in semi-urban Nepal in four practical ways. First, it provides culturally validated assessment methods (WHO-5, K10, SWBI, MSPSS) for local health workers and NGOs to identify the mental well-being of older persons. Second, it recognizes the most vulnerable populations, the oldest old (85+ years) and Dalit communities, so that focused interventions can be made. Third, it brings the Social Support Paradox to the Nepali context, showing that too much functional support without respect for autonomy might decrease subjective well-being. Fourth, it provides empirical evidence on how

shifting family structures in semi-urban settings enhance older people's psychological distress, which may directly inform social policy and community action in Nepal.

8.5 Recommendation for Further Research

Based on the results of this thesis, the following areas are suggested for further research: First, longitudinal studies are needed to explore the trajectories of well-being, social support, resilience and mental health throughout age in Nepal. Second, qualitative research is needed to understand older people's lived experiences of autonomy, dignity, and family support. Third, more research should study the contribution of digital inclusion on alleviating social isolation in older groups. Fourth, the effectiveness of community-based active aging treatments should be assessed in semi-urban settings. Future studies should explore the role of spirituality, cultural resilience and geographic variety on the well-being of older individuals in Nepal.

APPENDIXES

Appendix I

Questionnaire

Doctor of Philosophy (PhD) from Tribhuvan University, Kathmandu, Nepal

My name is Tilak Prasad Sharma. I am doing a Ph.D. from the Faculty of Humanities and Social Sciences, Tribhuvan University (TU), Kirtipur, Kathmandu. I have been carrying out a survey on the subjective well-being of the older people through the social support system in Lamki Chuha Municipality, Kailali district. So, I am visiting your house to ask some questions about this relationship. Your information will be kept confidential, and no individual information will be published. This interview takes about 45 minutes. You are fully entitled to give us an interview or not. Would you please give us time for an interview?

A. HOUSEHOLD IDENTITY (Note: Write Numbers in English Numerical Digits)

0112	
02	Ward Number	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
03	Tole	<input style="width: 100%; height: 20px;" type="text"/>
04	Selected household number (copy from sampling frame)	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
05	Date of interview (DD/MM/YY) (in Bikram Sambat)	<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Month </div> <div style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Date </div> </div> <input style="width: 20px; height: 20px;" type="text"/>
06	Name of respondent	<input style="width: 100%; height: 20px;" type="text"/>
07	Name of Interviewer	<input style="width: 100%; height: 20px;" type="text"/>

Socio-demographic characteristics

Name of the selected older people: _____

QN	Questions	Coding Categories	Skip
1.	Age		
2.	Sex	Male1 Female....2 Third sex....3	
3.	Who is the head of the household?	Male.....1 Female.....2	
4.	Caste/ethnic group of the respondent	Brahmin1 Kshetri2 Tharu4 Dalit5 Other (specify)	
5.	Religion of the respondent	Hindu1 Buddhist2 Islam3 Christian4 Kirat5 Other (specify)	
6.	Is this the nuclear or joint family? <i>Joint families are made up of parents and their children's</i>	Nuclear, couple only1 Nuclear, coupled with an unmarried son/daughter2 Joint.....3	

	<i>families, while nuclear families are made up of a couple of adults and a child.</i>	Alone.....4
7.	Can you read and write	Can read and write both1 Read Only 2 Write only3 No, both 4
8.	What is the highest level of education that you have completed?	informal.....1 Primary2 Some secondary3 SLC and above.....4
9.	Your current marital status?	Never married..... 1 Married..... 2 Divorced..... 3 Separated..... 4 Widowed5

B. Socio-Economic Status: Economic status and living arrangements of older living

you depend	Does your household possess the following utilities/amenities?	Yes No Toilet facility 1 2 Piped drinking water 1 2 Television 1 2 Phone/Mobile 1 2 Radio 1 2 Computer 1 2 Internet 1 2
2.	What is the main source of drinking water for your household?	Tap1 Public tap2 Hand pump3 Well4 River/Pond/Stream5 Others (Specify).....9
3.	What kind of toilet facility does your household have?	Own pit toilet/ latrine1 Shared pit toilet2 Public pit toilet3 No facility/bush/field4 Others (Specify).....9
4.	Which livestock does the household own?	Cow Yes 1 No 2 Buffalo Goat Others (Specify.....) 9
5.	What is the main source of lighting for your house?	LP Gas.....1 Electricity2 Guitha.....3 Bio-Gas4 Kerosene5 Wood.....6 Others (Specify.....) ...9
6.	What is your main family occupation? <i>(Definition: the primary occupation is the one on which the family's survival depends.)</i>	Agriculture1 Business2 Service3 Industry.....4 Labour5 Other (specify)
7.	What is your current job?	Government employee.....1 Non-government employee.....2

		Self-employed.....3
		Employer.....4
		Farming5
		Agri-labor.....6
		Others Specify.....9
		Not working for pay.....7
8.	What is the main reason you are not working for pay?	Homemaker/ caring for family.....1
		Looked but can't find a job.....2
		doing unpaid work / voluntary activities....3
		Studies/training.....4
		Retired / too old to work.....5
		Ill health.....6
		Others.....9
9.	How do you meet your daily needs?	Self-earnings.....1
		Bank balance2
		Pension3
		Depending on others4
10.	State of economic dependence	Partially dependent on others.....1
		Fully dependent on others.....2
		Not depending on others.....0
11.	If you depend on others, who supports you economically?	Spouse1
		Son2
		Daughter3
		Relatives4
		Friends5
		Allowance6
		Others (specify.....)9
12.	Do you receive any form of old-age benefit from any source?	Yes1
		No2
13.	How much benefit are you getting?in rupees)
14.	Do you receive any help from that scheme/allowance?	Yes1
		No2
15.	What is the reason for living elsewhere?
16.	For how long has she/he stayed away from you?month
	years
17.	How often does he/she visit you?	Regularly 1
		Sometimes 2
		Rarely 3
		Never 4
18.	How often do you visit him/ her?	Regularly 1
		Sometimes2
		Rarely3
		Never4
19.	No of children away from you.	Son.....1
		Daughter.....2
20.	If children are away from you, how often do they visit you?	Regularly 1
		Sometimes2
		Rarely3
		Never4
21.	Does your son/daughter-in-law spend some time with you?	Yes 1
		No 2
		N.A.9
22.	If yes, why did he spend time with you/when and how long?
23.	Does your daughter spend some time with you?	Yes 1
		No 2
		N.A. 9

24	Does your grandchild spend some time with you?	Yes... No....
25.	If yes, why did he/ she spend time with you/when and how long?
26.	With whom are you staying?	Living alone.....1 Only spouse2 Spouse with unmarried son/s 3 Spouse with married son/s4 married son/s5 Married daughter/s.....6 Others relatives7 Others (specify.....) 9
26.	Who decided that you should stay with this person?	Yourself..... 1 Spouse 2 Sons....3 Daughters4 Relatives.....5 Friends.....6 Others (specify.....)9
27.	In the time since you completed 60 years of age, have you faced any type of abuse or violence or neglect or disrespect by any person?	Yes.....1 Never2
28.	What kind of abuse did you face, and from where?	a) Physical Abuse b) Verbal Abuse c)Economic Abuse d)Showing disrespect e) Neglect f) Other (SPECIFY)_____
29.	Have you faced any type of physical or emotional abuse or violence in the last month?	No 1 Physical 2 Emotional 3 Both, physical and emotional ... 4
30.	From whom did you face the abuse during the last month? (CIRCLE ALL RELEVANT RESPONSES)	Spouse1 Son.....2 Daughter.....3 Son-in-law.....4 Daughter-in-law.....5 Domestic helper.....6 Grandchildren.....7 Relatives8 Neighbors.....9 Other (SPECIFY)_____99
31.	Did you suffer any health problems because of the abuse you faced in the last month?	Yes1 No2

C. Housing conditions**QN Questions and Filters**

	Coding Categories	Skip
1. Do you have a separate room for yourself?	Yes1 No2	
2. If no, with whom do you share?	Spouse1 Son2 Daughter3 Daughter-in-law4 Grand children5 Relative6 Neighbour7 Other (specify)9	
3. Do you have a comfortable bed (including clothes) for sleeping?	Yes.....1 No2	
4. Does this house have a Toilet?	Yes1 No2	
5. If yes, is it inside the house or outside of it?	Inside the house1 Outside the house2	

D. Satisfaction with living conditions

Now, let's talk about your life and life situation.

Indicators of satisfaction	Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	very dissatisfied
1. How satisfied are you with the living conditions here in this dwelling?	1	2	3	4	5
2. How satisfied are you with your health?	1	2	3	4	5
3. How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
4. How satisfied are you with your personal relationships?	1	2	3	4	5
5. How satisfied are you with the conditions in your living place?	1	2	3	4	5
6. Taking all things together, how satisfied are you with your life as a whole these days?	1	2	3	4	5
7. How would you rate your overall quality of life? Read responses	1. Very good 2. Good 3. Moderate 4. Bad 5. Very bad 6. Don't know				
8. Taking all things together, how would you say you are these days? Read responses	1. Very happy 2. Happy 3. Neither happy nor 4. Unhappy 5. Very unhappy 6. Don't know				

E. Life satisfaction (Diener et al., 1998)

	strongly disagree (1)	Disagree (2)	slightly disagree (3)	neither agree nor disagree (4)	slightly agree (5)	Agree (6)	strongly agree (7)
1. In most ways, my life is close to my ideal							
2. The conditions of my life are excellent							
3. I am satisfied with my life.							
4. So far, I have gotten the important things I want in life							
5. If I could live my life over, I would change almost nothing.							

F. Psychological health

Being aged, an old person may have some different feelings.

<i>Do you have the following feelings?</i>	<i>1=none</i>	<i>2=sometimes</i>	<i>3=always,</i>
1. Despite old age, I have as much energy as I had			
2. As I get older, I am less useful.			
3. There is a lot of fun in life.			
4. I feel depressed, getting upset.			
5. I feel very happy after doing things I want to			
6. I feel nothing to do, being neglected, days are passing as uninteresting and worthless.			
7. I am willing to contact others.			
8. I like to be alone			
9. Getting old, I have become narrow-minded, often taking things to heart, and getting angry easily.			

Psychological well-being (Distress Scale (KPDS)-(K10)) (Kessler et al., 2002).

It is a measure of psychological distress. The numbers attached to the patients' 10 responses are added up, and the total score is the score on the Kessler Psychological Distress Scale (K10). Scores will range from 10 to 50. People seen in primary care who score under 20 are likely to be well score 20-24 are likely to have a moderate mental disorder score 25-29 are likely to have a moderate mental disorder score 30 and over are likely to have a severe mental disorder

<i>These items included, "In the last 30 days, about how often did you feel</i>	<i>None of the time, (1)</i>	<i>A little of the time, (2)</i>	<i>Some of the time, (3)</i>	<i>Most of the time (4)</i>	<i>All of the time (5)</i>
1 "Tired out for no good reason?"					
2 "Nervous or uneasy?"					
3 "So nervous that nothing could calm you down?"					
4 "Hopeless?"					
5 restless or fidgety					
6 So restless you could not sit still?"					
7 Depressed?,"					
8 That everything was an effort?"					

-
- 9 So sad that nothing could cheer
you up?"
- 10 Worthless?"
-

SECTION III: PHYSICAL AND MENTAL HEALTH STATUS

H. Physical Health Status

Questions	Coding Categories
Do you have any physical health problems now?	Yes.....1 No..... 2
If yes, types of diseases	Do you feel you have a (type of) disease? Yes..... 1 No 2 ↓
Physical pain (joints, knee, back, stomach pain, etc.)	Yes 1 No 2
Respiratory diseases	
Blood pressure	
Sugar/Diabetes	
Gastric	
Asthma/bath	
Heart diseases	
Teeth problem	
Eye problem	
Kidney/urinary	
Uric acid	
Cholesterol	
Delivery/pregnancy related	
(Ask only for women)	
HIV/AIDS	
Cancer	
Prostate gland problem	
(Ask only for men)	
Dementia (recent memory loss) and Alzheimer's	
Others (specify)	

Physical Disability

QN	Questions and Filters	Coding Categories	Skip
1.	Are you suffering from any sort of disability? <i>(Multiple answers possible)</i>	Hearing disability 1 Visual disability 2 Physical disability 3 Psychiatric disability 4 No disability 95	
2.	Do you need the help of other persons for personal care due to a health problem? <i>(Definition: Personal care refers to eating, bathing, dressing, and getting around the house)</i>	Yes, always 1 Yes, sometimes 2 Not at all 3 Cannot say 4	

I. Mental and Physical Health Status

		Strongly agree (1)	Neither agree nor disagree (2)	Disagree (3)	Strongly disagree (4)
1	I feel lucky compared to most people.	1	2	3	4
2	I tend to look on the bright side.	1	2	3	4
3	I have a lot of physical energy.	1	2	3	4
4	Pain affects my well-being.	1	2	3	4
5	My health restricts me from looking after myself or my home.	1	2	3	4
6	I am healthy enough to get out and about.	1	2	3	4

J. SUBJECTIVE WELL-BEING INVENTORY

1. Do you feel your life is interesting?
Very Much 1 To some extent 2 not so much 3
2. Do you think you have achieved the standard of living and the social status that you had expected?
Very Much 1 To some extent 2 not so much 3
3. How do you feel about the extent to which you have achieved success and are getting ahead?
Very good 1 quite good 2 not so good 3
4. Do you normally accomplish what you want to?
Most of the time 1 Sometimes 2 Hardly ever 3
5. Compared with the past, do you feel your present life is:
Very happy 1 quite happy 2 not so happy 3
6. On the whole, how happy are you with the things you have been doing in recent years?
Most of the time 1 Sometimes 2 Hardly ever 3
7. Do you feel you can manage situations even when they do not turn out as expected?
Most of the time 1 Sometimes 2 Hardly ever 3
8. Do you feel confident that in the case of a crisis (anything that substantially upsets your life situation), you will be able to cope with it/face it boldly?
Very much 1 to some extent 2 not so much 3
9. The way things are going now do you feel confident in coping with the future?
Very much 1 to some extent 2 not so much 3
10. Do you sometimes feel that you and the things around you belong very much together and are integral parts of a common force?
Very much 1 to some extent 2 not so much 3
11. Do you sometimes experience moments of intense happiness, almost like a kind of ecstasy or bliss?
Quite often 1 sometimes 2 Hardly ever 3
12. Do you sometimes experience a joyful feeling of being part of mankind as one large family?
Quite often 1 sometimes 2 hardly ever 3
13. Do you feel confident that relatives and/or friends will help you out if there is an emergency, e.g., if you lose what you have by fire or theft?
Very much 1 To some extent 2 Not so much 3
14. How do you feel about the relationship you and your children have?
Very good 1 quite good 2 not so good 3 not applicable 4

15. Do you feel confident that relatives and/or friends will look after you if you are severely ill or meet with an accident?
Very much 1 to some extent 2 Not so much 3
16. Do you get easily upset if things don't turn out as expected?
Very much 1 to some extent 2 Not so much 3
17. Do you sometimes feel sad without reason?
Very much 1 to some extent 2 Not so much 3
18. Do you feel too easily irritated, too sensitive?
Very much 1 To some extent 2 Not so much 3
19. Do you feel disturbed by feelings of anxiety and tension?
Most of the time 1 Sometimes 2 Not so much 3
20. Do you consider it a problem for you that you sometimes lose your temper over minor things?
Very much 1 to some extent 2 Not so much 3
21. Do you consider your family a source of help to you in finding solutions to most of the problems you have?
Very much 1 to some extent 2 Not so much 3
22. Do you think that most of the members of your family feel closely attached?
Very much 1 to some extent 2 Not so much 3
23. Do you think you would be looked after well by your family in case you were seriously ill?
Very much 1 to some extent 2 Not so much 3 NA 4
24. Do you feel your life is boring /uninteresting?
Very much 1 to some extent 2 Not so much 3
25. Do you worry about your future?
Very much 1 to some extent 2 Not so much 3
26. Do you feel your life is useless?
Very much 1 to some extent 2 Not so much 3
27. Do you sometimes worry about the relationship you and your wife/husband have?
Very much 1 to some extent 2 Not so much 3 Not applicable 4
28. Do you feel your friends/relatives would help you out if you were in need?
Very much 1 to some extent 2 Not so much 3
29. Do you sometimes worry about the relationship you and your children have?
Very much 1 to some extent 2 Not so much 3 Not applicable 4
30. Do you feel that minor things upset you more than necessary?
Very much 1 to some extent 2 Not so much 3
31. Do you get easily upset if you are criticized?
Most of the time 1 Sometimes 2 Hardly ever 3
32. Would you wish to have more friends than you actually have?
Very much 1 to some extent 2 Not so much 3
33. Do you sometimes feel that you miss a real close friend?
Very much 1 to some extent 2 Not so much 3
34. Do you sometimes worry about your health?
Very much 1 to some extent 2 Not so much 3
35. Do you suffer from pains in various parts of your body?
Most of the time 1 Sometimes 2 Hardly ever 3
36. Are you disturbed by palpitations/a thumping heart?
Most of the time 1 Sometimes 2 Hardly ever 3
37. Are you disturbed by a feeling of giddiness?
Most of the time 1 Sometimes 2 Hardly ever 3
38. Do you feel you get tired too easily?
Most of the time 1 Sometimes 2 Hardly ever 3
39. Are you troubled by disturbed sleep?
Most of the time 1 Sometimes 2 Hardly ever 3
40. Do you sometimes worry that you do not have a close personal relationship with another person?

Most of the time 1 Sometimes 2 Hardly ever 3

K. WHO-5 Well-being Index

	All of the time (5)	Most of the time (4)	More than half the time (3)	Less than half the time (2)	Some of the time (1)	At no time (0)
1						
2						
3						
4						
5						

Scoring: The raw score is calculated by totaling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing the worst possible and 25 representing the best possible quality of life. To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents the worst possible, whereas a score of 100 represents the best possible quality of life.

L. Structural Social support

The first subscale was the Availability of Social Integration (AVSI) which reflects **structural aspects** of social support through four questions: 'For each of these questions, the response options were: 'None' (1), '1-2' (2), '3-5' (3), '6-10' (4), '11-15' (5) and 'More than 15' (6).

	None (1)	1-2 (2)	3-5 (3)	6-10 (4)	11-15 (5)	More than 15 (6)
1. How many people who share your interests do you know and have contact with?	1	2	3	4	5	6
2. 'How many people do you know that you meet or talk to during a week?'	1	2	3	4	5	6
3. How many friends do you have who can visit you in your home and feel "at home"?'	1	2	3	4	5	6
4. How many people can you speak openly with?'	1	2	3	4	5	6

M. Functional aspects of social support

were captured through the second subscale, Availability of Attachment (AVAT), which includes the following five statements:

	Disagree completely (1)	Disagree (2)	Agree (3)	Agree completely (4)
1. There is someone special who I really feel supports me.				
2. There is someone special who is close to me.				
3. Others appreciate what I do for them.				
4. There is a person around me whom I can easily ask for favors.				
5. Other persons outside my family are close to me and whom I can turn to in times of hardship.				

N. Multidimensional scale of perceived social support Rate, the following statements using the following scale: 1=Very Strongly Disagree, 2=Strongly Disagree, 3=Disagree, 4=Neither agree nor disagree, 5=Agree, 6=Strongly Agree, 7=Very Strongly Agree

		Very Strongly Disagree 1	Strongly Disagree 2	Disagree 3	Neither Agree nor Disagree 4	Agree 5	Strongly Agree 6	Very strongly Agree 7
1	There is a special person who is around when I am in need	1	2	3	4	5	6	7
2	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
3	My family really tries to help me.	1	2	3	4	5	6	7
4	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
5	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6	My friends really try to help me.	1	2	3	4	5	6	7
7	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8	I can talk about my problems with my family	1	2	3	4	5	6	7
9	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12	I can talk about my problems with my friends	1	2	3	4	5	6	7

O. Interpersonal support evaluation list shortened version -12 items

12-item measure of perceptions of social support. This measure is a shortened version of the original ISEL (40 items; Cohen & Hoberman, 1985). This questionnaire has three different subscales designed to measure three dimensions of perceived social support. These dimensions are: 1.) Appraisal Support 2.) Belonging Support 3.) Tangible Support. Each dimension is measured by 4 items on a 4-point scale ranging from "Definitely true" to "Definitely false". Scale

Statement	Definitely false 1	Probably false 2	Probably true 3	Definitely true 4
1. If I wanted to go on a trip for a day (for example, to the country or mountains), I would	1	2	3	4

have a hard time finding someone to go with me				
2. I feel that there is no one I can share my most private worries and fears with.	1	2	3	4
3. If I were sick, I could easily find someone to help me with my daily chores.	1	2	3	4
4. There is someone I can turn to for advice about handling problems with my family.	1	2	3	4
5. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.	1	2	3	4
6. When I need suggestions on how to deal with a personal problem, I know someone I can turn to	1	2	3	4
7. I don't often get invited to do things with others.	1	2	3	4
8. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).	1	2	3	4
9. If I wanted to have lunch with someone, I could easily find someone to join me.	1	2	3	4
10. If I were stranded 10 miles from home, there is someone I could call who could come and get me.	1	2	3	4
11. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.	1	2	3	4
12. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.	1	2	3	4

Instructions: This scale is made up of a list of statements, each of which may or may not be true about you. For each statement, circle "definitely true" if you are sure, it is true about you and "probably true" if you think it is true but are not certain. Similarly, you should circle "definitely false" if you are sure the statement is false and "probably false" if you think it is false but are not certain.

Scoring: Items 1, 2, 7, 8, 11, 12 are reverse scored. Items 2, 4, 6, and 11 make up the Appraisal Support subscale. Items 1, 5, 7, and 9 make up the Belonging Support subscale. Items 3, 8, 10, 12 make up the Tangible Support subscale. All scores are kept continuous.

APPENDIX B

Preliminary Statistical Analyses

Four preliminary analyses were conducted before the primary regression analysis: (a) tests of normality, (b) group differences based on demographic variables, (c) intercorrelations between social support subscales, and (d) justification for using multiple linear regression where formal tests of normality were not significant. All analyses were conducted using IBM SPSS Statistics (Version 29), $N = 402$.

A.1 Normality Tests

Statistical significance was shown for all variables for the Kolmogorov-Smirnov and Shapiro-Wilk tests ($p < .001$), indicating formal deviation from normality. However, the skewness (range: $-.544$ to $.363$) and kurtosis (range: $-.982$ to 1.618) scores were acceptable ($|\text{skewness}| < 2.0$; $|\text{kurtosis}| < 7.0$), indicating that the distributions were not severely non-normal in terms of practical significance.

Table B1

Descriptive Statistics and Tests of Normality ($N = 402$)

Variable	M	SD	Skewness	Kurtosis	K-S	S-W	p
Subjective Well-Being	79.12	9.12	-.109	1.618	.081	.978	< .001
Life Satisfaction (SWLS)	13.29	3.23	.363	.245	.158	.963	< .001
Psychological Distress (K10)	2.83	.69	-.544	.614	.346	.795	< .001
WHO Quality of Life	53.03	23.37	.025	-.982	.083	.970	< .001

Note. M = mean; SD = standard deviation; K-S = Kolmogorov-Smirnov (Lilliefors correction); S-W = Shapiro-Wilk. $ps < .001$. SWLS = Satisfaction with Life Scale; K10 = Kessler Psychological Distress Scale; WHO, WHOQOL-BREF.

A.2 Demographic Variables and Differences between Groups

Nonparametric tests were used to examine demographic subgroups to determine whether there were differences in subjective well-being and life satisfaction. None of the comparisons were statistically significant (all $ps > .05$), suggesting that caste/ethnicity, marital status, education level and family size did not significantly confound the primary analyses.

Table B2

Summary of Nonparametric Group Comparison Tests

Variable	Test	Grouping Factor	Statistic	df	p	Decision
Subjective Well-Being	K-W H	Caste/Ethnicity (5 groups)	chi2(4) = 6.348	4	.175	No significant difference
Subjective Well-Being	M-W U	Marital Status (2 groups)	U = 10,234.50, Z = -1.629	—	.103	No significant difference
Life Satisfaction	K-W H	Level of Education (4 groups)	chi2(3) = 3.660	3	.301	No significant difference
Life Satisfaction	K-W H	Family Size (2 groups)	chi2(1) = 2.167	1	.141	No significant difference

Note. K-W H = Kruskal-Wallis H test; M-W U = Mann-Whitney U test. Alpha = .05. No statistically significant group differences were found for any demographic variable.

A.3 Correlations between Social Support Subscales

All Spearman rank-order correlations between social support subscales were statistically significant ($ps < .001$) and moderate in magnitude ($rs = .244$ to $.665$), indicating that the subscales share meaningful variance and are sufficiently distinct. This supports their use as distinct predictors in the regression model and is consistent with the multidimensional structure of the MSPSS.

Table B3

Spearman Rank-Order Correlations Among Social Support Subscales (N = 402)

Subscale Pair	rs	P	N	Strength
Appraisal — Belonging Support	.582	< .001	402	Moderate
Appraisal — Tangible Support	.339	< .001	402	Moderate
Belonging — Tangible Support	.342	< .001	402	Moderate
Family items (internal, N3-N11)	.487–.665	< .001	402	Moderate–Strong
Friend items (internal, N6-N12)	.244–.505	< .001	402	Moderate

Note. rs = Spearman's rank-order correlation coefficient. All correlations were significant at $p < .001$ (two-tailed). MSPSS = Multidimensional Scale of Perceived Social Support. Internal item correlations for Family and Friend subscales are shown as ranges.

A.4 Rationale for Multiple Linear Regression

Although the formal normality tests reached statistical significance, the multiple linear regression was still considered appropriate for this data set for the following reasons. First, the Central Limit Theorem states that with $N = 402$, estimates of regression coefficients will be approximately normally distributed irrespective of the distribution of the variables. Second, the skewness and kurtosis values were within acceptable practical limits, showing that deviations from normality were not severe. Third, there was no multicollinearity between the predictors. Together, these conditions satisfy the practical requirements for valid ordinary least squares regression with large samples.

Table B4*Evaluation of Regression Assumptions and Justification Summary*

Criterion	Threshold	Result	Justification for Regression
Normality (formal tests)	$p > .05$	Not met ($ps < .001$)	Large N (402) invokes the Central Limit Theorem; regression coefficients are asymptotically normal
Normality (practical: skewness)	$ \text{skew} < 2.0$	Met (-.544 to .363)	All variables within acceptable limits
Normality (practical: kurtosis)	$ \text{kurt} < 7.0$	Met (-.982 to 1.618)	No severe kurtosis detected
Sample size	$N > 200$ recommended	$N = 402$	Adequate for stable regression estimates
Multicollinearity	$\text{TOL} > .10$; $\text{VIF} < 10$	Met	Predictors are sufficiently distinct
Independence of errors	DW: 1.50–2.50		

Note. TOL = Tolerance; VIF = Variance Inflation Factor; DW = Durbin-Watson. [Insert DW value from SPSS regression output before final submission.] Regression assumption criteria follow Field (2018) and Hair et al. (2019).

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