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Relationship between morality, happiness, and social support among elderly people

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Abstract

Background: Various factors influence the lives of elders, such as social support, which is critical in preventing physical, psychological, and social difficulties. This study aimed to investigate the relationship between morality, happiness, and social support among elderly people. A descriptive correlational design was used in carrying out this study. This study was conducted at the Geriatric Social Club in El-Qawmia; Zagzig City, Alsharkia Governorate. A purposeful sample of 235 elders was recruited for this study. Four tools were used to collect data: A structured interview questionnaire, Philadelphia Geriatric Center Morale Scale (interview version), Multidimensional Scale of Perceived Social Support, and Oxford Happiness Questionnaire.

Results: Results denoted that less than half of studied elders had moderate score as regards morale scale and perceived social support. As well, less than three-fifths of them had moderate score regards total happiness. There were statistically significant relations between morality and both of age, income, chronic diseases, and taking medication. Perceived social support was positively statistically significantly related with elders' gender, marital status, chronic diseases, medication, and income. There were statistical significant relations between elderly happiness level and working condition, income, and with whom they live. Elders' perceived social support was highly positively statistically correlated with happiness and morality.

Conclusions: It was concluded that these variables were positively correlated with each one, where increasing perceived social support and feeling of happiness associated with enhancing feeling of morality among elders. The perceived social support and happiness were the key co-existences of elders' morality. Therefore, it is recommended to implement caring and training programs focusing on enhancing social support in order to develop morale among elders. The country should provide various kinds of assistance to the elderly, such as counseling services.

Keywords: Social support, Happiness, Morality, Elderly

Background

Senior is a distinctive experience, with possible hazards such as an increased risk of chronic diseases, solitude, seclusion, and a lack of social support. Individual independence is often jeopardized due to physical and mental incapacities [1]. Social support is described in terms of social link properties such as support from family, friends, neighbors, and other public members to assist individuals in coping with daily life, mainly in response to crucial situations [2]. Forms of social support have been identified as formal (given by institutions) and informal (supplied by family members, neighbors, and friends [3]. For the elderly, family is regarded as a unique source of support [4]. Despite the importance of social assistance in the fragile elderly society, it declines as people get older [5].

Social support is also described as a resource exchange between at least two people in which one of them believes it is intended to improve the recipient's well-being. It has been classified into two types: structural and functional, as well as perceived and received. The term "structural social support" refers to a person's

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organizational relationships to others [6]. Functional social support, on the other hand, is defined as the interchange of emotional, instrumental or material, informational, and appraisal assistance. It refers to the qualitative part of social support, such as social support satisfaction, having confidants, and social isolation. Received and perceived social supports are also phrases that can be used to define social support. The term "perceived social support" relates to a person's prospective access to social assistance, whereas "received social support" refers to an individual's reported exchange or use of social support services [7].

Moreover, the social evaluation and recognition of the surrounding groups considering themselves as harmonious and amicable members of society greatly contributes to the criterion for the pursuit of happiness [8]. Previous study conducted on Dutch elderly people to analyze "what activities" make them feel happier in their daily life, and found that the level of happiness increased when the elderly were engaged in social activities among daily activities in five categories (social activities, physical activity, relaxing activities, cognitive activities, housework activities) [9].

Happiness is defined as a positive inner sensation that arises from one's cognitive and emotional perception of one's life. Happiness is an all-inclusive notion underlain by two components, namely emotion and cognition, as mentioned in this description. The emotional component is concerned with pleasure (a balance of pleasant and unpleasant emotions), while the cognitive component is concerned with mental health. Considering results connected to happiness, a number of studies have recommended that feeling of happiness may be utilized as a foundation for treating mental diseases, promoting optimism, establishing psychological resilience, and enhancing defensive capacity against stress [10].

With the aging of the population, the priority of health issues in each community shifts, and problems related to aging, such as mental-psychological difficulties of elderly, especially their morale, become more significant in the health system. Morale is frequently used interchangeably with psychological or mental health, life satisfaction, and quality of life [11]. Life satisfaction is seen as a cognitive reflection or judgment of one's expectations of life so far and from the perspective of time is therefore placed more in the past. Happiness is experienced in the present and morale concerns attitudes toward the future and attainable goals [12].

Morale is a multi-dimensional concept that is influenced by a variety of factors, as well as social (such as family support and supportive services), functional (out-of-doors activities, exercise, and performing daily tasks independently), and medical (physical health, depression, and cognitive disorders) factors [13]. According to a descriptive definition of morality "Certain code of conduct put out by a community or group (such as a church), or adopted by an individual for her own conduct" [14]. Morality is intrinsic in every person's mind, and it is impacted by a variety of internal personality traits as well as exterior social variables because it is a social phenomenon [15].

Moral principles define what constitutes "good, righteous, fair, right, or ethical" behavior in people [16]. Individuals can be influenced by moral rules (does no harm) to engage in activity that has no evident instrumental value or direct benefit to them, such as empathy, justice, or compassion toward others. Individuals living together in social groups, for example, utilize moral standards and consequences for those who break them to keep them from being egocentric and from dishonest, cheating, or stealing from others [17, 18].

Acceptance, reliability, collaboration, life satisfaction, and happiness may all be enhanced in a family with social support. Happiness as a moral value in old age has been documented to be obtained through strong social support, which has a positive impact on the seniors' physical, psychological, and quality of life [19]. All elements of human health and welfare, as well as quality of life and life satisfaction, have been linked to social support as an independent and predictive variable. During difficult situations, social support is linked to the progress and improvement of adaptive mechanisms and psychological adaptations that make seniors feel safe, cool, and attached. Elders' mental health is influenced by social support and familial interactions, which are linked to culture [13].

The nurse-patient interaction has a professional aspect that is based on a caring ethic. Nurses should be aware of factors that impact the health of the elderly. Nurses play an important role in promoting elders' functional, physical, social engagement, and mental wellness, as well as providing high-quality, safe care, by implementing group interventions, such as healthy elderly courses, to help individuals manage the life events of elders more successfully, as well as educating the public about how to help elders age effectively, which can be attained through high social support and high morals [20].

Significance of the study

The increased number of elderly people is a worldwide phenomenon. According to the United Nations [21], the number of elderly people (those aged 60 and above) has grown significantly in most nations and regions in recent years, and this trend is expected to continue in the next decades. Between 2015 and 2030, the worldwide population of those aged 60 and above is expected to increase

by 56%, from 901 million to 1.4 billion, and by 2050, the global population of older people will have more than doubled, reaching approximately 2.1 billion.

In Egypt, the proportion of people aged 60 and more was 7.9% in 2015, and it is anticipated to rise to 9.9% by 2030 and 15.3% in 2050 [22]. The elderly are cherished and respected by their family and friends. Elderly adults can learn a lot of moral ideals via their relationships with their children, friends, and relatives. Moreover, levels of contact and social support can influence happiness, morale, and contentment in the elderly, as well as avoid mental and psychological suffering. Therefore, the present study was conducted to examine the relationship between morality, happiness, and social support among elderly people.

Aim of the study

The aim of this study is to investigate the relationship between morality, happiness, and social support among elderly.

This aim has been achieved through the following objectives:

- Assess morality, happiness, and perceived social support among elderly people.
- Investigate the relationship between morality, happiness, and perceived social support among elderly people.

Methods

Research questions

- What are the levels of morality, social support, and happiness among elderly people?
- What is the relation among morality, happiness, and social support, in elderly people?

Research design

A descriptive correlational study design was utilized in this study.

Subjects

A purposeful sample of 235 elders who attended El-Qawmia Geriatric Social Club in Zagazig City, Alsharkia Governorate. This club provides recreational and social services to the elderly, as well as some low-cost medical care.

Sample size

A purposeful sample of elders who attended the above-mentioned club and met the following requirements were included in the study: They were at least 60 years old, able to communicate effectively, and willing to participate. Elders who constituted this study sample were 235. The sample size was calculated using the OpenEpi statistical tool, using the following parameters: population size 600, expected frequency 50%, 95%confidence level, and a maximum error of 5%.

Tools of data collection

Four tools was used for data collection.

Tool I: a structured interview questionnaire

It was developed by the researchers to collect the necessary data for the study. It consisted of two parts:

Part 1: demographic characteristics of the studied elderly

It entails data about demographic characteristics of the study sample such as age, sex, residence, marital status, educational level, current and past occupation, number of sons, with whom they live, income and its source, number of rooms, and persons lived in house.

Part 2: history of chronic diseases, medications

This section dealt with the medical histories of the elderly people who were being researched. It asked about the number and types of chronic conditions, such as hypertension, diabetes, orthopedic diseases, renal diseases, cardio-vascular diseases, and gastrointestinal diseases, among others. Additionally, the number of medications taken on a daily basis.

Tool II: The Philadelphia Geriatric Center Morale Scale

The Philadelphia Geriatric Center Morale Scale was developed by Lawton [23]. It contains of 17 items which are responded by "Yes" or "No." The 17 items are divided into 3 subscales; namely agitation (6 items), attitude toward own aging (5 items), and lonely-dissatisfaction subscale (6 items). The scale has a maximum of 17 points, where each answer indicating high morale is given one point. The Philadelphia Geriatric Center Morale Scale was shown to be reliable; Cronbach's alpha coefficient (α) was (0.811).

Scoring system The total score ranged as follows: Low moral: a score of 1 to 5; Moderate moral: a score of 6 to 11; High moral: a score from 12 to 17.

Tool III: Multidimensional Scale of Perceived Social Support

The Multidimensional Scale of Perceived Social Support (MSPSS) was created by Zimet et al. [24]. It includes 12 items that assess how much support a person feels he/she gets from family, friends and significant others (4 items

for each). The Multidimensional Scale of Perceived Social Support (MSPSS) was shown to be reliable; Cronbach's alpha coefficient (α) was (0.807).

Scoring system Respondents rated statements on a seven-point Likert scale of 1 to 7, with 1 indicating very strongly disagree and 7 indicating very strongly agree. The score ranged from 1 to 7 after summation the total score of all items and divided by 12. The total scale score ranged as follows: a score of 1 to 2.9 reflected low support; a score of 3 to 5 reflected moderate support; a score from 5.1 to 7 could be reflected high support.

Tool IV: The Oxford Happiness Questionnaire

The questionnaire was developed by Hills and Argyle [25] at Oxford University. It consists of 29 items. The Oxford Happiness Questionnaire was shown to be reliable; Cronbach's alpha coefficient (α) was (0.94).

Scoring system Each item was scored on a six-point Likert scale ranged from 1 "strongly disagree" to 6 "strongly agree." Out of 29, 12 items (1, 5, 6, 10, 13, 14, 19, 23, 24, 27, 28, 29) were reversed scored. The score ranged from 1 to 6 after summation the total score of all items and divided by 29, the total scale score ranged as follows: Total score from 1−<3.5 indicated unhappy; Total score of ≥3.5 indicated happy.

Pilot study

Before beginning the actual study, the researchers conducted a pilot study on 10% of the elderly participants. It was done to assess the study questionnaire's clarity, ease of use, and feasibility, as well as to estimate the amount of time required to complete it. There were no changes made to the questionnaire. The elderly who participated in the pilot study were included in the study's main sample.

Content validity and reliability

The content validity of the tools utilized in this study was established by three experts in psychiatric and mental health nursing, geriatric nursing, and statistics. They assessed the tools for applicability, clearness, comprehensiveness, understanding, relevance, and easiness for implementation. The researchers translated the study tools into Arabic language using the translation-back translation technique to confirm their original validity. The reliability of the utilized tools was estimated by Cronbach's alpha test in the statistical package for social sciences (SPSS), version 20.0. They showed a good level of reliability.

Fieldwork

After getting the necessary permission to perform the study, the researchers met with the Manager of the Geriatric Social Club to explain the purpose of the study, receive her agreement, and secure her cooperation in moving forward with data collecting. After informing the elderly about the study's purpose, the researchers conducted interviews to obtain their verbal consent to participate in the study. They questioned each elderly person personally, explaining each statement to him or her, and then filling in the senior's answers. It took about 45–60 min to complete each sheet. Data collection was completed in about three months (2 days/week) from the beginning of October to the end of December 2021.

Statistical analysis

All data were collected, tabulated, and statistically analyzed using the IBM SPSS (Statistical Package for Social Sciences) statistics for windows, version 23.0 IBM Corp., Armonk, NY: USA. Quantitative data were expressed as the mean ± SD and range, and qualitative data were expressed as absolute frequencies numbers and relative frequencies (percentages). Percent of categorical variables were compared using Chi-square test or Fisher's exact test when appropriate. Pearson's correlation coefficient was calculated to assess relationship between various study variables, (+) sign indicates direct correlation, and (−) sign indicates inverse correlation, also values near to 1 indicate strong correlation and values near 0 indicate weak correlation. All tests were two-sided. p value <0.05 was considered statistically significant (S), p value <0.001 was considered highly statistically significant (HS), and p value ≥0.05 was considered statistically non-significant (NS).

Multi linear regression

Situations frequently occur in which we are interested in the dependency of a dependent variable on independent variable.

Formally, the model for multiple linear regression, given n observations, is:

$$Y = a + \beta 1 * X1 + \beta 2 * X2 + \beta 3 * X3$$

Y= the variable that we are trying to predict
X = the variable that are using to predict
a= the intercept (constant(
β = coefficient of X, represents the mean change in the dependent variable) for one unit of change in the predictor variable (independent)
t test = test of significance

Results

Table 1 shows that more than half of studied elderly were female, aged 65 years or more with a Mean ±SD of 65.8±5.1, married, had higher education, living with husband/wife, and had sufficient income (57.4%, 52.8, 56.6, 55.7, 55.7, and 58.3 respectively). As well, the same table reveals that, slightly less than three quarters of studied elderly are not working (74.0%) and majority of them previously had governmental job (80.0%) and most of them depends on pension as a source of income (97.0%).

Table 2 shows that more than three-quarters of studied elderly had chronic disease and took regular medication (78.7%). The highest percent of disease among studied elderly was hypertension (47.2%) followed by diabetes and arthritis (32.8% and 32.3% respectively) and the lowest percent was thyroid diseases (3.8%). The number of medication taken by studied elderly ranged between 0 and 18 with a Mean ± SD of 3.1 ± 2.9.

Table 3 reveals that more than half of studied elderly (50.6%) had moderate agitation compared with 11.5% had high agitation with a Mean ± SD of 2.4 ± 1.5. As well, almost two-thirds of them (65.1%) had low attitude toward own aging compared with 5.5% had high attitude with a Mean ± SD of 1.3 ± 1.2. Less than half of studied elderly (48.5%) were moderately dissatisfied with lonely compared with more slightly than fifth (20.4%) were low with a Mean ± SD of 3.3 ± 1.9. Overall, total morality among studied elderly were moderate in less than half of them (46.8%) compared with 13.2% were high with a Mean ± SD of 7 ± 3.7. As regards social support, the same table shows that, slightly more than two-fifths of studied elderly were moderate in perceiving social support by significant others and friends (40.9% and 42.6% respectively) with a Mean ± SD of 14.6 ± 7 and 15 ± 6.7 respectively

Table 1 Socio-demographic characteristics of studied elderly people ($n = 235$)

Variables	No.	%
Age per years		
60–< 65	111	47.2
≥ 65	124	**52.8**
Mean ±SD	65.8 ± 5.1	
Range	60–81	
Gender		
Male	100	42.6
Female	135	**57.4**
Residence		
Rural	43	18.3
Urban	192	**81.7**
Marital status		
Single	4	1.7
Married	133	**56.6**
Divorced	7	3.0
Widowed	91	38.7
Education		
Illiterate/read and write	8	3.4
Primary education	16	6.8
Secondary	80	34.0
University or higher	131	**55.7**
Working condition		
Work	61	26.0
Do not work	174	**74.0**
Previous work		
Worker	6	2.6
Crafts man or farmer	5	2.1
Free business	3	1.3
Governmental job	188	**80.0**
Housewife	33	14.0
With whom life		
Wife/husband	131	**55.7**
One of the sons	44	18.7
One of the relatives	6	2.6
Alone	54	23.0
Income source		
Pension	228	**97.0**
Property income	7	3.0
Income		
Insufficient	78	33.2
Sufficient	137	**58.3**
Sufficient and save	20	8.5

Table 2 Health status problems of studied elderly people ($n = 235$)

Variables	No.	%
Chronic diseases	185	78.7
Types of chronic diseases		
Hypertension	111	**47.2**
Heart diseases	50	21.3
Renal disease	14	6.0
Arthritis	76	**32.3**
Diabetes	77	**32.8**
CNS diseases	11	4.7
Liver diseases	14	6.0
Osteoporosis	21	8.9
Respiratory system diseases	14	6.0
Digestive system diseases	35	14.9
Thyroid diseases	9	3.8
Medication	185	78.7
Number of medication		
Mean ±SD	3.1 ± 2.9	
Range	0–18	

Table 3 Frequency distribution of morale level, perceived social support level and Oxford happiness level among studied elderly people ($n = 235$)

Variables	High		Moderate		Low		Parameters Score	
	No.	%	No.	%	No.	%	Mean ± SD	Range
Agitation Sub-Scale	27	11.5	119	**50.6**	89	37.9	2.4 ± 1.5	1–6
Attitude Toward Own Aging Sub-Scale	13	5.5	69	29.4	153	**65.1**	1.3 ± 1.2	0–5
Lonely-Dissatisfaction Sub-Scale	73	31.1	114	**48.5**	48	20.4	3.3 ± 1.9	0–6
Total Morale Scale	**31**	**13.2**	**110**	**46.8**	**94**	**40.0**	**7 ± 3.7**	**1–16**
Social support by others	51	21.7	96	**40.9**	88	37.4	14.6 ± 7	4–28
Social support by family.	63	26.8	90	**38.3**	82	34.9	15.7 ± 7.4	4–28
Social support by friend.	58	24.7	100	**42.6**	77	32.8	15 ± 6.7	4–28
Scale of Perceived Social Support	**48**	**20.4**	**113**	**48.1**	**74**	**31.5**	**45.4 ± 17**	**12–84**
Oxford Happiness Scale	**98**	**41.7**	**137**	**58.3**	**0.**	**0.**	**96 ± 27**	**33–160**

and less than two-fifths of them were moderately supported by family (38.3%) with a Mean ± SD of 15.7 ± 7.4. Less than half of them had moderate score in total social support (48.1%) with a Mean ± SD of 45.4 ± 17. The same table shows that less than three-fifths (58.3%) of studied elderly were moderate in feeling of happiness compared with 41.7% had high score with a Mean ± SD of 96 ± 27.

Figure 1 illustrates that less than half of studied elderly had moderate score as regards morale scale and perceived social support (46.8% and 48.1% respectively). As well, less than three-fifths of them had moderate score as regards total happiness (58.3%).

Table 4 shows that there were statistically significant relations between morality level and age with low morale state among elderly 65 years or more ($p = 0.03$). As well, there were highly statistically significant relations between morality and income, chronic diseases, and taking medication ($p = 0.0001$). It is evident that morale state was low among studied elderly who had chronic diseases, taking regular medication and their income was insufficient.

Table 5 reveals that there were statistically significant relations between perceived social support level among studied elderly and gender, marital status, chronic diseases, and medication ($p < 0.05$). However, it was a highly statistically significant relation with income ($p < 0.001$). It is evident that elderly who had low perceived social support were male, single or divorced, had chronic diseases, take medication, and had insufficient income.

Table 6 indicates that there were statistically significant relations between elderly happiness level and working condition, and with whom they live, with lowering happiness level among do not working, not

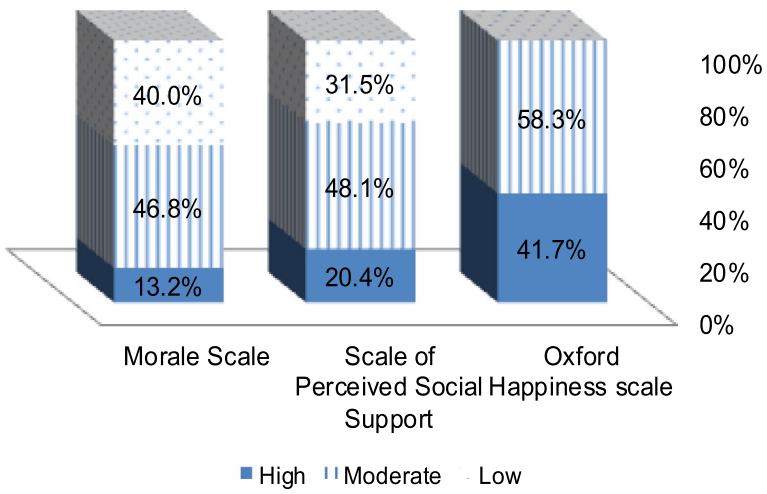

Fig. 1 Percent of morale level, perceived social support level and Oxford happiness level among studied elderly people ($n = 235$)

Table 4 Relations between morale level and socio-demographic characteristics of studied elderly ($n = 235$)

Variables	Elderly moral level						No	χ^2	*P*
	High $N = 31$		Moderate $N = 110$		Low $N = 94$				
	No.	%	No.	%	No.	%			
Age (in years)									
<65	13	11.7	62	55.9	36	32.4	111	7.04	**0.03**
≥65	18	14.5	48	38.7	58	46.8	124		
Gender									
Male	16	16.0	44	44.0	40	40.0	100	1.3	0.51
Female	15	11.1	66	48.9	54	40.0	135		
Residence									
Rural	11	25.6	14	32.6	18	41.9	43	8.4	**0.015**
Urban	20	10.4	96	50.0	76	39.6	192		
Marital status									
Single	0	0.0	2	50.0	2	50.0	4	2.8	0.83
Married	20	15.0	63	47.4	50	37.6	133		
Divorced	0	0.0	3	42.9	4	57.1	7		
Widowed	11	12.1	42	46.2	38	41.8	91		
Education									
Illiterate/read and write	0	0.0	3	37.5	5	62.5	8		
Primary education	2	12.5	9	56.3	5	31.3	16	9.4	0.15
Secondary	13	16.3	44	55.0	23	28.7	80		
University or higher	16	12.2	54	41.2	61	46.6	131		
Working condition									
Work	13	21.3	28	45.9	20	32.8	61	5.4	0.074
Do not work	18	10.3	82	47.1	74	42.5	174		
Previous work									
Worker	0	0.0	0	0.0	6	100.0	6		
Crafts man or farmer	0	0.0	3	60.0	2	40.0	5	12.6	0.12
Free business	0	0.0	2	66.7	1	33.3	3		
Officer	28	14.9	86	45.7	74	39.4	188		
Housewife	3	9.1	19	57.6	11	33.3	33		
With whom live									
Wife/husband	20	15.3	61	46.6	50	38.2	131		
One of the sons	5	11.4	21	47.7	18	40.9	44	2.5	0.86
One of the relatives	0	0.0	4	66.7	2	33.3	6		
Alone	6	11.1	24	44.4	24	44.4	54		
Income source									
Pension	30	13.2	105	46.1	93	40.8	228	2.1	0.34
Property income	1	14.3	5	71.4	1	14.3	7		
Income									
Insufficient	3	3.8	31	39.7	44	56.4	78	20.2	**0.0001**
Sufficient	22	16.1	69	50.4	46	33.6	137		
Sufficient and save	6	30.0	10	50.0	4	20.0	20		
Chronic diseases									
Yes	14	7.6	91	49.2	80	43.2	185	24.2	**0.0001**
No	17	34.0	19	38.0	14	28.0	50		
Medication taken									
Yes	14	7.6	91	49.2	80	43.2	185	24.2	**0.0001**
No	17	34.0	19	38.0	14	28.0	50		

χ^2 Chi-square test

$p < 0.05$ significant; $p < 0.001$ highly significant; $p > 0.05$ non-significant

Table 5 Relations between elderly perceived social support level, among studied elderly people and their demographic characteristics ($n = 235$)

Variables	Elderly perceived social support level						No	χ^2	*P*
	High *N* = 48		Moderate *N* = 113		Low *N* = 74				
	No.	%	No.	%	No.	%			
Age (in years)									
<65	21	18.9	56	50.5	34	30.6	111	0.53	0.77
≥65	27	21.8	57	46.0	40	32.3	124		
Gender									
Male	10	10.0	54	54.0	36	**36.0**	100	11.6	**0.003**
Female	38	28.1	59	43.7	38	28.1	135		
Residence									
Rural	6	14.0	24	55.8	13	30.2	43	1.7	0.41
Urban	42	21.9	89	46.4	61	31.8	192		
Marital status									
Single	0	0.0	0	.0	4	**100.0**	4		
Married	19	14.3	68	51.1	46	34.6	133	23.2	**0.001**
Divorced	0	0.0	3	42.9	4	**57.1**	7		
Widowed	29	31.9	42	46.2	20	22.0	91		
Education									
Illiterate/read and write	1	12.5	3	37.5	4	50.0	8		
Primary education	4	25.0	6	37.5	6	37.5	16	7.4	0.28
Secondary	20	25.0	43	53.8	17	21.3	80		
University or higher	23	17.6	61	46.6	47	35.9	131		
Working condition									
Work	12	19.7	34	55.7	15	24.6	61	2.3	0.32
Do not work	36	20.7	79	45.4	59	33.9	174		
Previous work									
Worker	0	0.0	4	66.7	2	33.3	6		
Crafts man or farmer	3	60.0	2	40.0	0	.0	5	11.8	0.16
Free business	0	0.0	3	100.0	0	.0	3		
Officer	37	19.7	87	46.3	64	34.0	188		
Housewife	8	24.2	17	51.5	8	24.2	33		
With whom live									
Wife/husband	19	14.5	68	51.9	44	33.6	131		
One of the sons	13	29.5	20	45.5	11	25.0	44	11.6	0.063
One of the relatives	0	0.0	2	33.3	4	66.7	6		
Alone	16	29.6	23	42.6	15	27.8	54		
Income source									
Pension	46	20.2	110	48.2	72	31.6	228	0.26	0.86
Property income	2	28.6	3	42.9	2	28.6	7		
Income									
Insufficient	2	2.6	33	42.3	43	**55.1**	78	66.4	**0.0001**
Sufficient	32	23.4	78	56.9	27	19.7	137		
Sufficient and save	14	70.0	2	10.0	4	20.0	20		
Chronic diseases									
Yes	37	20.0	82	44.3	66	**35.7**	185	7.5	**0.022**
No	11	22.0	31	62.0	8	16.0	50		
Medication									
Yes	37	20.0	82	44.3	66	**35.7**	185	7.5	**0.022**
No	11	22.0	31	62.0	8	16.0	50		

χ^2 Chi-square test

$p < 0.05$ significant; $p < 0.001$ highly significant; $p > 0.05$ non-significant

Table 6 Relations between elderly happiness level, among studied elderly people and their demographic characteristics ($n = 235$)

Variables	Elderly happiness level				No	χ^2	*P*
	Happy ≥ 3.5		Unhappy < 3.5				
	No.	%	No.	%			
Age (in years)							
<65	48	43.2	63	56.8	111	0.21	0.65
≥65	50	40.3	74	59.7	124		
Gender							
Male	43	43.0	57	57.0	100	0.12	0.73
Female	55	40.7	80	59.3	135		
Residence							
Rural	20	46.5	23	53.5	43	0.5	0.42
Urban	78	40.6	114	59.4	192		
Marital status							
Single	0	0.0	4	100.0	4		
Married	57	42.9	76	57.1	133	2.9	0.4
Divorced	3	42.9	4	57.1	7		
Widowed	38	41.8	53	58.2	91		
Education							
Illiterate/read and write	0	0.0	8	100.0	8	6.9	0.073
Primary education	6	37.5	10	62.5	16		
Secondary	38	47.5	42	52.5	80		
University or higher	54	41.2	77	58.8	131		
Working condition							
Work	34	55.7	27	44.3	61	6.7	**0.01**
Do not work	64	36.8	110	**63.2**	174		
Previous work							
Worker	3	50.0	3	50.0	6		
Crafts man or farmer	3	60.0	2	40.0	5	6.3	0.18
Free business	0	0.0	3	100.0	3		
Officer	83	44.1	105	55.9	188		
Housewife	9	27.3	24	72.7	33		
With whom life							
Wife/husband	57	43.5	74	56.5	131		
One of the sons	12	27.3	32	**72.7**	44	11.4	**0.01**
One of the relatives	0	0.0	6	**100.0**	6		
Alone	29	53.7	25	46.3	54		
Income source							
Pension	96	42.1	132	57.9	228	f	0.7
Property income	2	28.6	5	71.4	7		
Income							
Insufficient	20	25.6	58	**74.4**	78		
Sufficient	65	47.4	72	52.6	137	14.6	**0.001**
Sufficient and save	13	65.0	7	35.0	20		
Chronic diseases							
Yes	82	44.3	103	55.7	185	2.4	0.12
No	16	32.0	34	68.0	50		
Medication							
Yes	82	44.3	103	55.7	185	2.4	0.12
No	16	32.0	34	68.0	50		

χ^2 Chi-square test, *f* Fisher exact test

$p < 0.05$ significant; $p < 0.001$ highly significant; $p > 0.05$ non-significant

sufficient income, and elderly who lived with one of the sons or relatives ($p < 0.05$).

Table 7 shows that there were highly statistically significantly positive correlations among perceived social support and its subscales (social support by others, social support by family, and social support by friend), total morale scale and its subscales (agitation, attitude toward aging, and lonely-dissatisfaction), and total happiness ($p = 0.0001$). Whereas, there was a statistically positive correlation between perceived social support by others and attitude toward own aging ($p = 0.015$).

Table 8 detects that highly statistically significant predictors of elderly morality score were happiness score, and social support score.

Discussion

Social support is especially important for the elderly, as they are more likely to be exposed to numerous stressors later in life, such as the start of chronic diseases and functional limits, the loss of sources of income, and the death of spouses and loss of confidants [26]. Happiness is an essential factor for healthy aging. The elderly population in receiving emotional and instrumental support can enhance their happiness level [27]. Various social and health-related factors such as social support, chronic conditions, and self-rated health have previously been associated with level of morale in old age [28]. Therefore, community mental health nurses must pay close attention to the elderly, give essential support, investigation and assess their wants in all aspects of life.

The aim of this study was to investigate the relationship between morality, happiness, and social support among elderly people. The findings generally answered the research questions.

The current study results showed that more than half of studied elderly were female, married, had higher education and living with husband/wife. Less than three-quarters of them were not working and most of them were depending on pension as a source of income; this may be due to that the majority of studied elders had previously governmental job and more than half of them aged 65 years or more and in Egypt the official retirement age in civil servants is 60 years. In the same line, Ibrahim and Ali [26], who carried out a study in Damanhour and Alexandria, found that more than half of the participants were women, married, and one-third of them lived with their husband, and approximately two-thirds of the seniors investigated relied only on their pension.

The present study results revealed that the elders' mean age was 65.8 ± 5.1, more than half of studied

Table 7 Correlation matrix between, elderly morality score and its subscales, elderly social support score and its subscales, and happiness score of studied elderly ($n = 235$)

Variables	1 r (P)	2 r (P)	3 r (P)	4 r (P)	5 r (P)	6 r (P)	7 r (P)	8 r (P)
1-Agitation sub-scale	**1**							
2-Attitude Toward own aging sub-scale	0.502** (0.0001)	**1**						
3-Lonely-dissatisfaction sub-scale	0.557** (0.0001)	0.439** (0.0001)	**1**					
4-Total morale scale	0.837** (0.0001)	0.735** (0.0001)	0.864** (0.0001)	**1**				
5-Social Support by others	0.283** (0.0001)	0.158* (0.015)	0.434** (0.0001)	0.381** (0.0001)	**1**			
6-Social Support by family.	0.586** (0.0001)	0.431** (0.0001)	0.572** (0.0001)	0.493** (0.0001)	.658** (0.0001)	**1**		
7-Social Support by friend.	0.499** (0.0001)	0.369** (0.0001)	0.559** (0.0001)	0.481** (0.0001)	0.598** (0.0001)	0.596** (0.0001)	**1**	
8-Total perceived social Support	0.553** (0.0001)	0.388** (0.0001)	0.631** (0.0001)	0.661** (0.0001)	0.797** (0.0001)	0.851** (0.0001)	0.831** (0.0001)	**1**
9-Oxford happiness scale	0.513** (0.0001)	0.466** (0.0001)	0.606** (0.0001)	0.657** (0.0001)	0.285** (0.0001)	0.625** (0.0001)	0.582** (0.0001)	0.603** (0.0001)

(*r*) Correlation coefficient

*Significant $p < 0.05$; **highly significant $p < 0.001$

Table 8 Multiple linear regression model for predict elderly morality score among studied patients ($n = 235$)

Variable	Unstandardized coefficients		*t*	*Sig.*	*r*	R^2
	B	Std. error				
(Constant)	− 2.451	0.621				
Happiness score	0.056	0.008	7.283	0.0001	0.736	0.541
Social support score	0.090	0.012	7.464	0.0001		

$R^2 = 0.541$ % of predictors

Model ANOVA: $F = 136.8$, $p = 0.0001$

elderly were living with husband/wife, and more than three quarters of studied elderly had chronic diseases. The mean number of medication taken was 3.1 ± 2.9, and near half of them had hypertension, followed by slightly less than one-third had diabetes and arthritis chronic diseases. In similar studies as that conducted in Turkey by Unsar et al. [29], who explored the social support and quality of life of Turkish older individuals and concluded that an association between social support and quality of life was found, that the mean age of the group was 68.0 ± 5.90, and more than half of them were living with their husband. However, most of them had health issues; the mean number of daily oral medications was found as 3.3 ± 2.3. Similarly Ibrahim and Ali [26] found that the bulk of the seniors were suffering from health issues. Hypertension and diabetes mellitus were the greatest common disorders stated by the seniors (denoted 70% and 55.3% correspondingly) which were much higher than percentages of the current study.

The current study findings showed that the elders' overall perceived social support mean score was 45.4 ± 17 with range of 12 to 84, which are higher than those reported in the study of Dai et al. [30] who studied social support and the self-rated health of older people as a comparative study, in Tainan Taiwan and Fuzhou Fujian province, which found that, the mean total social support was 36.54 ± 7.38 out of a range of 17–54. This may be due to the use of a different social support scale that was applied on a different population in this study.

The present study results revealed that slightly less than half of studied elderly had moderate level of social support which is lower than the percentage revealed by Ibrahim and Ali [26] who in a similar study, stated that higher than two-thirds (68.8%) of the studied elders had moderate perceived social support. As well, this result disagreed with that of Thiratanachaiyakul [31] who carried out a study in Thailand and reported that the participants had high level of social support.

The current study results revealed that a statistically significant relation was found between elders' perceived social support level and their gender which means that perceived social support decreased in males comparing with females. This may be related to that collection of data from the Social Club whose visitors had relation with each other and most of the participants were female. This result is similar to that of Hosieni et al. [32] who stated that there was a significant variance between the old male and female with deference to social support. Moreover, Ibrahim and Ali [26] found that there was a statistically significantly positive relation between elders' gender and social support.

In this study, a statistically significant relation was found between elders' perceived social support level and their marital status; however, the relation was highly statistically significantly related with income. This means that elders who had low perceived social support were single or divorced, and had no sufficient income. These results might be interpreted as marriage can produce a sense of affection, love, and empathy, which are forms of social support. These results were consistent with those of Ibrahim and Ali [26] who found that there were statistically significantly positive relation between marital status, income, and multidimensional measure of perceived social support. As well, according to Moeini et al. [10], their study results revealed that marital status exposed a significant association with social support and Dai et al. [30] who reported that social support was significantly correlated with marital status ($r = 0.326$, $p < 0.001$).

The current study results revealed statistically significant relation between elders' perceived social support and chronic diseases; elders who had low perceived social support had chronic diseases. Social support may be particularly beneficial for supporting health behaviors. In a similar previous study, Bélanger et al. [19] clarified that robust social networks with high levels of social support usually denote a defensive factor for preserving good wellbeing and quality of life in later life.

This study finding indicated that less than three-fifths of elders had moderate level in feeling of happiness. It may be related to that about two-thirds of the participants do not had work, and that most of them had moderate social support, which means that the increasing social support led to increase feeling of happiness. These

results disagreed with those of Thiratanachaiyakul [31] who in a very recent study, carried out in Thailand, found that the participants had low average score level of happiness. This may be due to different sample size used in this study, and different culture of population.

The current study result showed statistically significant relation between elders' happiness level and income; this means that elders who had insufficient income were unhappy. This may be related to that most of the elders under study were not working and also they are required to have many responsibilities and obligations toward their families and their health that led to more stress which interferes with happiness. Similarly, Shah et al. [33], who recently studied factors associated with happiness among Malaysian elderly, found that happiness was significantly connected with high household income. Additionally, Moeini et al. [10], who previously studied the association between social support and happiness among elderly in Iran, detected that happiness was significantly positively related with income.

Statistically significant relations were detected between elders' happiness level and working condition, income, and with whom they live; the explanation for these findings is that elders not working had not sufficient income, and elders living with sons or relatives had lower happiness level; this may be due to the Egyptian culture, where parents remain responsible for their sons and relatives until the end of their lives. This result was consistent with that of Thiratanachaiyakul [31] who recently studied the influence of social support and quality of life on happiness of elderly people in Bangkok, and found that the elders' happiness is mostly produced by employment, having adequate income, and having consistent income, which allow them to care for themselves and their families. Additionally, having love, stable family, and strong family relations also contributes to the elders' happiness.

Concerning elders' total morality level, the current study results revealed that slightly less than half of them had moderate level of morality. This finding could be explained by the fact that the elders investigated are involved in major activities such as caring for their grandkids or a family member; this raises the moral value of self-worth, purpose in life, and altruism in the elderly. Furthermore, more than half of the studied elders stated that they have sufficient family income; their financial support is influenced by their pension or children's assistance. This could raise the moral value of self-sufficiency and being loved by others. This result was congruent with that of Ibrahim and Ali [26] who found that more than half of the participants had medium level of morality.

The current study result showed that statistically significant relation was found between elders' morality and their age which means that elders aged 65 or more were low in morale state. This result was in accordance with that of Nasman et al. [34] which showed that elder period was independently related with subordinate morale. Additionally, De Guzman et al. [35] previously stated that elder period was connected with inferior morale (age span 65 to 85+).

Highly statistically significant relation was found between elders' morality and income. This means that morale state was less among studied elderly who had lower income. This result was in agreement with that of Ibrahim and Ali [26] who found that there was a significantly positive relation between elders' income and moral score.

Statistically significant relations were found between elders' morality and chronic diseases. This means that elderly who had chronic diseases were having less morale state; this might be due to having feelings that they are a burden to others and they need special care. Similarly, Loke et al. [28] who studied assessment of factors influencing morale in the elderly, in Malaysia, they reported that a chronic disease has a robust effect on morale in the elders. As well, De Guzman et al. [35] who stated that chronic disorders have earlier been connected with level of morale in elderly.

The current study result revealed that highly statistically significantly positive correlation was found between elders' total perceived social support score and total morality score. This may be interpreted as when an elderly person perceived social support, help in creating feelings of love, care, self-esteem, and value among the elders this will automatically enhance his/her morality level. This result was congruent with that of Ibrahim and Ali [26] who revealed that there is a significant relation between elders' perceived social support and their level of morality. In line with earlier scattered researches, as those of Nasman et al. [34] and De Guzman et al. [35], which indicated that social interactions and social support were related with morale. In the same line, Loke et al. [28] found that a robust and significant relation was detected between social support and morale among elderly.

Highly statistically significantly positive correlation was found between total perceived social support and total happiness. This could be interpreted in that elders suffer from problems such as loneliness, depression, anxiety, and ultimately physical and mental problems due to "automated" life, so elders need social support to solve their problems and allow them to have a sense of happiness. As well, values for happiness show cultural differences, such as the importance of individual achievement in Western cultures versus relationships in Eastern ones [36]. People in Eastern cultures seek happiness in more socially involved ways, such as spending time with family

or friends, and happiness motivation predicted high levels of well-being in East Asia, but not in the USA or Germany [37].

These results were consistent with those of Beygzadeh et al. [38] who concluded that there was significantly positive association between social support and life fulfillment with happiness. However, Shah et al. [33] highlighted that elder individuals receiving emotional support showed a more positive opinion of happiness, as well, Thiratanachaiyakul [31] found that social support factors affect happiness at a high level, and Shahsavar et al. [39] in Iran reported that perceived social support had positively and significantly resulted on happiness ($p < .05$), and similarly, Brailovskaia et al. [40] who carried out of study in the USA and Russia found that significantly positive correlation between social support and happiness.

The current study result revealed that highly statistically significantly positive correlation was found between elders' perceived social support subscale and total happiness. This result could be interpreted as social support is helping them achieve goals, satisfaction with life, and consequently, happiness. Similarly, Rey et al. [41] who studied clarifying the links between perceived emotional intelligence and well-being in older people, in Spain, found that the three subscales of social support were positively correlated with life fulfillment and happiness (r ranging from .31 to .47, $p < .01$).

The present study results revealed that elders' social support subscales (social support by others, family, and friends) were highly positively statistically significantly correlated with total morality; this explains that elderly individuals in this stage of age are in need for being revered and respected by family and friends who assist them to coping with everyday life. This result was consistent with that of Ibrahim and Ali [26] who concluded that there is a significant relationship between morals and multi-dimensions perceived social support in public seniors' residences.

Finally, the present study results showed that significant predictors of elders' morality score were happiness score, and social support score. This explains that those who receive more social support enjoy higher levels of happiness which consequently affects the level of morality. Moreover, levels of interaction and social support in comparing this result with that of Pourtaghi et al. [13] who studied relationship between depression and social support and morale in the elderly, in Iran, and found that social support was a statistically significantly reverse and direct association with morale among elderly. As well, Dogruel et al. [42] clarified that the presence of belonging to a family with social support can enrich the elders' moral values as acceptability, reliability, collaboration, life fulfillment, and happiness. In accordance with the previous researches' findings, Lambert et al. [43] reported that happiness as a moral value in elder people can be obtained with a lot of social support.

Conclusions

Studied elders were having moderate level of social support, happiness, and morality and these variables were positively correlated with each one; these are increasing perceived social support and feeling of happiness which associated with enhancing feeling of morality. Therefore, the perceived social support and happiness were the key co-existences of elders' morality. On the basis of the current study findings, the following recommendations are suggested: Respecting the elders' decisions through their family members, it will indicate that they are still appreciated, desired, and helpful; this will enhance their morale and increase their sense of fulfillment; Elders should be encouraged to participate actively in the economic, political, social, and cultural lives of their communities; Social support by implementing group intervention should provide various kinds of assistance to the elderly, such as counseling services; Further research to investigate the effectiveness of social support, happiness, and morals among the seniors; and Implement caring and training programs focusing on enhancing social support in order to develop morale among elders.

Abbreviations

OHQ: The Oxford Happiness Questionnaire; MSPSS: Multidimensional Scale of Perceived Social Support; PGCMS: The Philadelphia Geriatric Center Morale Scale.

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Authors' contributions

The research concept was suggested by HA. All authors contributed to the collection, interpretation, and editing of the manuscript by designing the research methodology, writing the manuscript, editing the manuscript, developing the study methodology, revising the data analysis, and developing the study methodology. The final manuscript was read and accepted by all contributors.

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Availability of data and materials

As detailed in the "References" section, all data was accessible through the Internet.

Declarations

Ethics approval and consent to participate

The researchers submitted an official letter from the scientific Research Ethics Committee in the Faculty of Nursing, Zagazig University, and the Dean of the

Faculty of Nursing issued a formal letter to the Director of the Geriatric Social Club to obtain permission to conduct the study. The committee's reference number is unavailable. Subjects who agreed to participate after learning about the study's goals signed a written informed consent form, indicating that they were given the option to withdraw from the study at any time without explanation and that the information they provided would be kept confidential and used only for research purposes.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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