ASSESSMENT OF PERCEPTION OF WELLBEING AMONG ELDERLY COUPLES IN RURAL AND URBAN AREAS OF KANYAKUMARI DISTRICT TAMILNADU

A DISSERTATION SUBMITTED TO THE TAMIL NADU Dr. M.G.R. MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT OF REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING

APRIL 2011

A COMPARATIVE STUDY TO ASSESS THE PERCEPTION OF WELLBEING AMONG ELDERLY COUPLES IN RURAL AND URBAN AREAS OF KANYAKUMARI DISTRICT TAMILNADU

APPROVED BY THE DISSSERTATION COMMITTEE ON : **15-09-2009**

RESEARCH GUIDE : _____

Prof. (MRS). SANTHI APPAVU, M.Sc (N), M.Phil (N).
PRINCIPAL & HEAD OF THE DEPARTMENT OF
MEDICAL & SURGICAL NURSING
CHRISTIAN COLLEGE OF NURSING, NEYYOOR.
KANYA KUMARI DISTRICT.

CLINICAL GUIDE : _____

Prof. (MRS).J. GRACIA, M.Sc (N).
HEAD OF THE DEPARTMENT OF
PSYCHIATRIC NURSING
CHRISTIAN COLLEGE OF NURSING, NEYYOOR.
KANYA KUMARI DISTRICT.

MEDICAL GUIDE : _____

Dr. Y. ARUL PRAKASH, M.D.D.P.M.,
ASSISTANT PROFESSOR OF PSYCHIATRY,
KANYAKUMARI GOVT. MEDICAL COLLEGE
HOSPITAL, ASARIPALLAM, NAGERCOIL.

A DISSERTATION SUBMITTED TO THE TAMIL NADU Dr.M.G.R. MEDICAL UNIVERSITY, CHENNAI, IN PARTIAL FULFILLMENT OF REQUIREMENT FOR THE DEGREE OF MASTER OF SCIENCE IN NURSING.

APRIL 2011

A COMPARATIVE STUDY TO ASSESS THE PERCEPTION OF WELLBEING AMONG ELDERLY COUPLES IN RURAL AND URBAN AREAS OF KANYAKUMARI DISTRICT TAMILNADU

Submitted in partial fulfillment of the requirement for the degree of Master of Science in Nursing Tamil Nadu Dr. M.G.R. Medical University, Chennai.

---------- ----------

Internal Examiner **External Examiner**

APRIL 2011

CERTIFICATE

Certified that the thesis titles **"A Comparative Study to Assess the Perception of Wellbeing among the Elderly Couples in Rural and Urban areas of Kanyakumari District, Tamil Nadu.**" is a bonafide work by T.Arul Shiney, II Year M.Sc., Nursing student of Christian College of Nursing, Neyyoor submitted in partial fulfillment of requirements of the Master of Science in Nursing under the Tamil Nadu Dr. M.G.R. Medical University, Chennai, April 2011.

Date: **Signature of Principal**

DECLARATION

Investigator, II Year M.Sc., Nursing student of Christian College of Nursing, Neyyoor do here by declare that this thesis, "**A Comparative Study to Assess the Perception of Wellbeing among the Elderly Couples in Rural and Urban areas of Kanyakumari District, Tamil Nadu."** has not been submitted by me for the award of any degree, diploma, title or recognition before.

Neyyoor, Investigator

LIST OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

ACKNOWLEDGEMENT

*"**Saying thank you is more than good manners. It is good spirituality."***

-Alfred Painter

I take this opportunity with much pleasure to thank all the people who have helped me through the course of my journey towards producing the thesis. I owe a deep sense of gratitude to all those who have contributed to the successful completion of this endeavors.

My heart bows down with immense gratitude to the Lord Almighty who has enabled me to accomplish the study, I thank Him for the blessings, He bestowed on me at each stage of this study and my life.

It is my honor to thank our correspondent **Adv**. **Mr. S. Sunder Singh, B.Sc., B.L.,** for giving me an opportunity to study in this esteemed institution which opened the door for post graduate programme in Kanyakumari District for further nurse researchers to serve people.

I owe my sincere gratitude to the great personality, **Prof. (Mrs) Santhi Appavu M.Sc (N)., M.Phil (N).,** Principal, Christian College of Nursing, Neyyoor, for the excellent guidance, expert suggestions, encouragement, concern and support throughout this work.

I express my grateful thanks to **Mrs. S.L. Diana M.Sc (N).,** Vice Principal, Christian College of Nursing, Neyyoor, for her constant encouragement and support for the success of this study.

I would like to express my hearty gratitude to my research guide **Prof. Mrs. Gracia M.Sc (N),** Head of the Department, Psychiatric Nursing**,** Christian College of Nursing, Neyyoor, for her timely guidance, valuable suggestions, innovative

ideas, enduring interest, constant support and motivation without which the study would not have been completed successfully.

I also take this opportunity to thank the biostatistician **Prof. Arumugam B.Sc., M.A., M.P.S., P.G.D.C.A.,** Lecturer in Statistics and Demography (Retd), Trinelveli Medical College for his valuable opinion, suggestion and guidance in analysis interpretation of data.

I wish to express my sincere thanks to **Mrs Rufa Mitzu** ***M.Sc(N),*** **Mrs Femila** ***M.Sc(N),*** **Mrs Jeha Juliet** ***M.Sc(N),*** and all the faculties of Psychiatric Nursing Department for their guidance and suggestions for the completion of the study.

My sincere gratitude goes to all the experts**,** for their valuable and proper guidance in validating the tool.

I extend my thanks to the members of dissertation committee for their healthy criticism and supportive suggestions.

My exuberant thanks to the library staff, **Mrs. V.S. Prameela B.Sc., MLISE., Mr. T. Gnana Dhas, Diploma in Opthalmic**., Christian College of Nursing, Neyyoor, for helping me in referring the journals and books. I thank all the office staff for their help to Photostat the study reviews.

I would like to express my sincere thanks to **Print Land, Image Xerox,** Nagercoil and **Mini Net Cafe**, Monday market for the excellent DTP work and untiring patience in preparing this study.

I extend my gratitude to the elderly couples who graciously offered not only their time and energy, but also their thoughts, their personal histories, their feelings, the motivations behind their choices, their secrets, their trust, and even the gift of friendship. I was privileged to bear witness to all that they shared; and I truly value what they taught and the time we spent together.

This study could also not have been successfully completed without the love and support of specific individuals who have either been part of my past, are those whom I have recently come to know, or are those who have been with me and have guided me consistently through the years

I offer my deepest gratitude to my friends. Any attempt at addressing them individually and expressing how much it has meant to have their love and support would be prohibitive in this minimal space. I therefore trust that each of them knows how much I value their presence in my life and their unique contributions.

Finally, I dedicate this study to my dearest father **N. Thanga Jeyaseelan**, my dearest mother **N. Joy Shanthy** and to my loving brother **Mr**. **Bellin Samuel**. I cannot find a single suitable word to thank my great parents and my brother for their unending love, understanding in the time of trouble, co-operation, enthusiasm, and guidance, moral support, willing to give courage and boost up in ups and downs throughout the course of my study. I thank you for continuing to be a significant part and influence on my life.

Above all, acknowledgement comes with a deep sense of gratitude to The Lord Almighty who helped me to meet the deadlines of the hard work.

ABSTRACT

A comparative study to assess the perception of wellbeing of elderly couples in rural and urban areas of Kanyakumari District, Tamil Nadu was conducted, in partial fulfillment of the requirement for the Degree of Master of Science in Nursing at Christian College Of Nursing, Neyyoor, which is affiliated to The Tamilnadu Dr. M.G.R. Medical University, Chennai during the year 2011.

The following objectives were set for the study

- To assess the perception of wellbeing of elderly couples in the rural areas.
- To assess the perception of wellbeing of elderly couples in the urban areas.
- To compare the perception of wellbeing of elderly couples in the rural and urban areas.
- To determine the association between the perception of wellbeing and the demographic variables such as age, education, type of family and monthly family income and number of living children.

The hypotheses formulated for the present study were

H_1- There will be significant association between the perception of wellbeing among the rural and urban elderly couples and the type of family.

H_2- There will be significant differences in the perception of wellbeing among the rural and urban elderly couples.

The entire hypotheses were tested at 0.05 level of significance.

The study was based on **Rosenstock's Health Belief Model (1975).** The design adopted for this study was Descriptive design to assess the perception of wellbeing among rural and urban elderly couples. In this study non probability convenience sampling

technique was used. The study was conducted in the 2 urban areas namely Nagercoil, Kottaram town panchayats and in the 2 rural areas namely Karumbatoor, Kanniakulam village panchayats of Kanyakumari District. The tool used for this study was Modified Wellbeing Assessment Scale. The content validity of the tool was established by seven clinical and nursing experts. Pilot study was conducted to find out the feasibility of the study. The tool was administered to the subjects and the data obtained were analyzed in terms of both descriptive and inferential statistics.

The significant findings of the study were as follows.

Assessment of Perception of wellbeing of rural elderly couples

Among the 30 elderly couples**,** 27 (90%) couples had perceived good wellbeing and the remaining 2 (6.7%) and 1 (3.3%) couples had perceived fair and poor wellbeing respectively.

Assessment of Perception of wellbeing of urban elderly couples

Among the 30 elderly couples, 2 (6.7%) couples had perceived best wellbeing and 15 (50%) couples had perceived good wellbeing. The remaining 11 (36.6%) and 2 (6.7%) couples had perceived fair and poor wellbeing respectively.

Comparison of perception of wellbeing of rural and urban elderly couples

The perception in all the domains of wellbeing except the social wellbeing had no significant difference between the rural and urban elderly couples. The rural couples' mean perception of wellbeing was 285.9 ± 38.1 and the same of their urban counter parts was 264.0 ± 59.8. The difference was not statistically significant ($P > 0.05$).

Association of perception of wellbeing of rural and urban elderly couples with the demographic variables

There was significant association between the perception of wellbeing of rural and urban elderly couples with the educational status, family income and number of living children.

But there was no significant association between the perception of wellbeing of rural and urban elderly couples with the mean age and type of family.

CHAPTER I

INTRODUCTION

I believe a human life is like a river, wandering through its course, rushing through rapids, flowing placidly over the plains, twisting and turning through countless bends until it spends itself. It is the same river, yet it looks very different from one place to another. So it is with our lives. Circumstances vary from one time to another in the course of a life, but I think each stage has its own value.

-Georgia

Ageing is a natural phenomenon and an inevitable process. Every living being born, develops, grows old and dies. Ageing is a process of gradual change in physical appearance and mental situation that cause a person to grow old. Ageing is such a mystery that is still not clearly defined even by the sciences. As the birth is an event and the pregnancy a process of it, old age is an event and ageing is its process. As soon as a man is born, ageing starts. This process continues forward by every second, day, weeks, months and years.

Different countries of the world term a man as an old after crossing certain age depending on prevailing socio-cultural norms and values. Almost countries have declared sixty years of age. Besides, wrinkled face, grey hair, loosed teeth, weak conditions of sense are other characteristics feature of old age **(**Bhandari 2001).

Whether or not there should be a fixed age group to define the elderly is often the subject of debate but it has been a common practice to define old age in terms of the beginning of the sixties in the life span, characterised by retirement from work and certain other social responsibilities (Indirani 2007).

Elderly people have to cope with various expectations on the part of younger generations concerning example of happy and peaceful life and the way to prepare themselves to enter the next world. Old age is the age of long and wide world and life experience. Aged ones are persons who express the truth to the world. Mental sufferings of the elderly are; agitation due to health problems, sorrows caused by departure from beloved ones or things, doubt concerning the nature of present and next life (Bhanman 2006)

It is a fact that human techno-cultural progress made so far is still not capable to stop ageing and death but has succeeded in lowering the process of ageing. Population statistics shows that the number of elderly has been increasing because of increment in the average life expectancy at birth. The size of India's elderly population aged 60 and above is expected to increase from 77 million in 2001 to 179 million in 2031 and further to 301 million in 2051. The proportion is likely to reach 12 per cent in 2031 and 17 per cent in 2051. (Irudaya Rajan 2003)

Revolutions regarding long life occurred during the twenty-first century. Average life expectancy at birth in 1950s moved up from 20 years to 66 years in 2002 and more 10 years will be added in 2050. Old population seems to be a major problem in the developing countries. (UNO-Madrid 2002)

According to Ayurveda, the ancient healing tradition of India, "aging in an illusion because your true self is neither your body nor your mind. Your essential nature, who you really are, is the domain of ever-present witnessing awareness that is beyond your physical and mental layers. This field of consciousness gives rise to both the thoughts in your mind and the molecules in your body."

Old age is not a problem in itself but it becomes a problem when the obvious physical and mental changes brought by old age make men unable to do their own necessary basic things. A wellness perspective is based on the belief that every person has an optimal level of health independent of his or her situation or functional ability. Even in the presence of chronic illness or multiple disabilities or while dying, movement toward higher wellness is possible if the emphasis of care is placed on the promotion of wellbeing in the least restricted environment,

with the support and encouragement for the person to find meaning in the situation, whatever it is (Acharya 2007)

The term "well-being" has two sources, either of which applies. The first describes "well-being" as "the state of being happy, healthy, or prosperous;" and the second includes an added descriptor and states that "well-being" is "a contented state of being happy and healthy and prosperous." (Wordnet 2005)

Wellbeing for those older than 60 years is strongly related to functional status but is affected also by socioeconomic factors, degree of social interaction, marital status and aspects of one's living situation and environment (Larson 1978).

NEED FOR THE STUDY

In India, the population of the elderly is growing rapidly and is emerging as a serious area of concern for the government and the policy planners. On account of high marriage rates in Asia as compared to other developed countries, a large majority of the elderly in the Asian countries have been married. With increases in life expectancy, the proportion of elderly who are widowed will go down further, and there will be more surviving elderly couples in the future. (Lee and Mason 2000)

At the same time, the process of aging will be accompanied by increased vulnerability to illness and death. All these features of aging imply that the problems of the elderly will need a special focus and approach.

Recent research has concentrated on learning about keeping people healthy and active for a longer period of time rather than extending their lives in a state of long term disability. It is therefore important to explore the perspectives of older individuals on themselves and their life to better understand their adaptation in aging process.

Regardless of the societal stereotypes of aging and life conditions that each individual is facing, self-perceptions play an essential role in determining wellbeing of older individuals. Under the various challenges in old age, the ability to preserve positive self-identity may be a key for successful adaptation in aging.

The importance of self-perception over objective situations has received an increasing attention in gerontological research. Maier & Smith, (1999) suggested that positive self-perception of or attitude toward aging is beneficial for physical and emotional well-being.

Levy et al (2002) in the longitudinal study reported that older individuals with more positive self-perception of aging survived 7.5 years longer than those with less positive self-perception of aging.

Along the same line, self-perception of health has shown its significant ability to predict a variety of outcomes, including service

utilization, emotional distress, morbidity, and mortality (Maier & Smith, 1999).

Levy et al (2002) recognized that enhancement of positive self-perception has important practical implications because it is strongly connected with better adjustment to changes in old age and it leads to a higher quality of life regardless of objective life circumstances.

Research has shown over the years that the self perceptions of older adults about their health and wellbeing may be atleast as important as objective data for predicting the course of their health over time. The social environment shapes perceptions of health and wellbeing, as does body. Feelings, such as feelings about health and wellbeing are therefore key psychological behavioural bridge between the body and society (Blazer 2008).

Following a review of these studies, the researcher attempt to place these perceptions of health and wellbeing in a social context, and showed interest in assessing the perception of wellbeing among elderly couples in rural and urban areas.

STATEMENT OF THE PROBLEM

A Comparative study to assess the Perception of Wellbeing among Elderly Couples in Rural and Urban areas of Kanyakumari District, Tamil Nadu.

OBJECTIVES

- To assess the perception of wellbeing of elderly couples in the rural areas.
- To assess the perception of wellbeing of elderly couples in the urban areas.
- To compare the perception of wellbeing of elderly couples in the rural and urban areas.
- To determine the association between the perception of wellbeing and the demographic variables such as age, education, type of family, family income and number of living children.

HYPOTHESES

H_1- There will be significant association between the perception of wellbeing among the rural and urban elderly couples with the type of family.

H_2- There will be significant differences in the wellbeing of elderly couples among the rural and urban areas.

OPERATIONAL DEFINITIONS

Assess : it refers to a carefully defined opinion or observation.

Wellbeing : wellbeing refers to a state of physical, social, spiritual, emotional and intellectual health

Perception : it refers to the thinking or feeling about oneself

Elderly couples : it refers to life partners above 60 years of age.

Rural area : it refers to the area that comes under the Village Panchayat (Kanniyakulam, Karumbatoor)

Urban area : it refers to the area that comes under the Municipality and Town Panchayat (Nagercoil, Kottaram).

ASSUMPTION

- The perception of wellbeing will be high among the rural and urban elderly couples who have economic security.
- The urban elderly couples will show poor adjustment towards physical illness.

LIMITATION

- The study is limited to elderly people who have their spouse.
- The study is limited to a period of 6 weeks.

CHAPTER II

REVIEW OF LITERATURE

A literature review is a body of text that aims to review the critical points of current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic.

Wikepedia 2010

An extensive review of literature was done by the investigator to gain insight into the selected problem and is depicted under the following headings.

- Studies related to Wellbeing of elderly
- Studies related to Wellbeing of rural and urban elderly people
- Studies related to Perception of wellbeing among elderly people

Studies related to Wellbeing of elderly

Waddell et al (2010) examined in the study Predicting positive wellbeing in older men and women the effects of background, psychological and social variables on older adults' wellbeing and how this may differ for men and women. Participants included 800 adults from the 2002 Health and Retirement Study (HRS) aged 60 to 101 years old (M = 71.22, SD = 8.46), who completed the optional positive wellbeing module. Gender based regression models revealed that for men, marital status,

self rated health and depression were significant predictors and accounted for 32% of the variability in positive wellbeing. Similar to men, self rated health and depression was significant predictors of wellbeing for women.

Katt et al (2009) used Health and Retirement Study (HRS) and Consumption and Activities Mail Survey (CAMS) data to examine relationships between various activities of daily living and wellbeing in older adults. Using structural equation modeling, influences of direct and indirect factors that affect older individuals' cognitive and emotional wellbeing are analyzed. The data suggest ability to perform ADLs has little to do with cognitive wellbeing, but is an influential factor in determining emotional wellbeing.

Merz (2009) explored the association between the family support and wellbeing in the elderly paying particular attention to the possible moderating role of attachment style. Data from a community dwelling, ethnically dives, elderly sample (N=1118) were analyzed to determine the best linear combination of emotional support, instrumental support and attachment styles predicting wellbeing. Emotional support generally was associated with higher wellbeing whereas instrumental support was related to decreased wellbeing.

Strawbridge et al (2009) analyzed longitudinal relationships between older spouses' lower cognitive function and the health and wellbeing of their partners five years later. Subjects were 404 community dwelling older couples from the alameda Country Study. Follow up measures included five health and wellbeing outcomes. The finding

showed husbands' lower cognitive function was associated with subsequent poorer health and wellbeing for their wives. Wives' lower cognitive function was not associated with any outcomes for their husbands.

Windsor (2009) investigated associations of self rated health, control and relationship closeness with life satisfaction and positive and negative effect in a sample of 2,235 spousal dyads. Associations between health, control beliefs and wellbeing in later life are frequently conceptualized in terms of the characteristics of individuals. However, spousal interdependencies in psychosocial characteristics are also likely to be relevant for wellbeing. Results highlight the importance of couple interdependencies for contextualizing health and wellbeing in older adulthood.

Gautam (2008) identified the correlation of life satisfaction in elderly Nepalese adults living with their children. A convenience sample of 489 urban elderly was recruited from Katmandu, Nepal. Life satisfaction was measured using 9 of the 11 items of the Life Satisfaction Index by Liang. Results showed that the strongest correlate of life satisfaction was perceived financial satisfaction ($p < 0.0001$). High life satisfaction was also more likely reported by elderly who were educated ($p < 0.005$), and better perceived health ($p< 0.0001$).

Kalkstein (2008) administered the Daily Spiritual Experiences Scale (DSES) to 410 subjects who participated in a community study and to 87 residents at the Hebrew Home for the Aged at Riverdale the latter sample

consisting primarily of older Jewish respondents. All but one of the outcome measures of physical and psychologic wellbeing were found to be positively associated with the DSES so that more frequent daily spiritual experience correlated with less psychopathology more close friendships and better self rated health.

Luanaigh (2008) suggested that loneliness is common in older people and has strong associations with depression and may in fact be an independent risk factor for depression. Further more loneliness appears to have a significant impact on physical health being linked detrimentally to higher blood pressure, worse sleep, immune stress responses and worse cognition over time in the elderly.

Preito et al (2008) revealed through the Socio demographic and health factors explaining emotional wellbeing as a quality of life domain of older people in Madrid, Spain that health greatly influences emotional wellbeing with a relevant role of the subjective experience of health, together with social class as an indicator of educational level and socio economic status.

Peek et al (2006) revealed in the study Wellbeing in older Mexican American Spouses the evidence of an association between the wellbeing of one spouse and that of the other. Specifically, the self rated health of husbands and wives predicts that of their partners. However, there is evidence that husband's depressive symptoms and life satisfaction influence wives' wellbeing but not the reverse.

Quiroutette et al (1992) examined the relations between spousal variables and the psychological wellbeing of husbands and wives in older couples. One hundred twenty older married men and women completed standardized self report measures and a short interview. The results highlighted that spousal variables significantly predicted wives' wellbeing (R2 = 29%) with the three most influential predictor variables being the husbands' perception of the marriage, positive dimension of wellbeing and physical health. In contrast, spousal variables did not significantly predict husbands' wellbeing.

Studies related to Wellbeing of rural and urban elderly

Mair (2010) examines the hypothesized differences between informal strong ties and formal weak ties on the subjective wellbeing of older adults in rural, urban and suburban areas. Visiting with friends, neighbours or relatives has a stronger positive effect on subjective wellbeing for rural older adults than urban. These findings highlight that informal strong ties increase subjective wellbeing and the effect of informal strong ties differs by region.

Lin et al (2008) identified and described the predictors of quality of life of elderly living in rural and urban districts of Taiwan. Descriptive correlational design surveyed 192 Taiwanese elders selected at random from urban and rural areas. Multiple linear regressions showed that six variables predicted physical health and psychological wellbeing quality of life domains. The results highlight that the elderly who live alone in rural areas and suffer from depression are at high risk for a low quality of life.

Studies related to Perception of Wellbeing of elderly

Brown et al (2009) assessed the perceived social support and psychological distress in a representative sample of 273 low socio economic status (SES) Hispanic elders. Structural equation modeling was used to assess elders' perceived social support and psychological distress. Results highlighted that perceived social support was associated with reduced psychological distress after controlling for demographics.

Dorgo et al (2009) compared changes in perceived physical, mental and social function measured by the Short Form 36 (SF36vr2) in a group of older adults who were trained by peer mentors (PMs) versus a similar group trained by qualified kinesiology student mentors (SMs). A two arm repeated measures longitudinal intervention was conducted. Thus older adults who participated in a physical fitness program with peer support perceived overall improvement in physical and mental wellbeing, better social functioning, and enhanced ability to carry out physical and emotional roles, improved general health and increased level of vitality.

Reijula et al (2009) evaluated *A* new method to assess perceived wellbeing among elderly people by assigning a group of volunteers in care homes for the elderly for two weeks. Perceived wellbeing was assessed by using a Con-Dis device and by filling out an attached questionnaire consisting of questions concerning mood, pain and quality of life. A statistically significant correlation was found between perceived wellbeing and questionnaire based mood (r=0.66), Pearson Correlation Coefficient)

and quality of life (r=0.68). No statistically significant correlation was found between perceived wellbeing and pain (r=0.28).

Rennemark et al (2009) recognized the relationships between physical activity and perceived qualities of life in old age to investigate the relationships of different types of quality of life to strenuous and light physical activity in old age. Data from 585 men and 817 women 60 – 96 years of age were utilized. Correlations suggested there to generally be a positive relationship between physical activity and quality of life.

Collins et al (2008) from the Survey of Health and Living Status of the Near Elderly and Elderly in Taiwan examined associations among life satisfaction and perceptions of future happiness. Zero inflated Poisson regression was used to determine if current life satisfaction and perceptions of future happiness were independently related to the number of mobility limitations. Socio demographic characteristics, health status, social involvement and depressive symptoms at baseline were adjusted. The results suggest a protective relationship between psychological wellbeing and physical decline in later life.

Mookherjee (1997) examined the relationships of some selected sociodemographic variables to perception of well-being by elderly individuals living in nonmetropolitan areas in the United States. Data

used were from the National Opinion Research Center's (NORC) General Social Surveys. Analysis of variance and multiple regression analysis indicated marital status, education, financial status, and religious attendance were significantly related to perception of well-being and five attitudinal variables increased the total variance accounted for in perceived well-being.

Mossey and Shapiro (1982) in an investigation asked the question of 3,533 people aged sixty-five and older, “For your age would you say in general, your health is excellent, good, fair, poor or bad?” The findings indicated that “Self-rated health, in its own right, is an important predictor of mortality.

CONCEPTUAL FRAMEWORK

Conceptual framework formalizes the thinking process, so that the others may read and know the frame reference based on the research problem. The conceptual framework also enlightens the investigator to read relevant questions on the phenomena under study.

The conceptual framework of the study is based on Rosenstock’s Health Belief Model. Concept of health care is incorporated into the health belief model, a psychological and behavior theory that attempts to explain individual health behaviour. This model assumes that the health problems play an important role in health behaviour.

1. Individual Perception

a) Perceived Susceptibility:

A family history of certain disorder such as metabolic diseases, cardiac diseases, psychiatric diseases, psychiatric disorders and communicable diseases may make the individual feel out high risk. In the perception of the elderly couple, the illness cause death.

In this perceived susceptibility of elderly couples was regarding the severity of their health problems during aging.

b) Perceived Threat:

Perceived susceptibility and perceived seriousness combine to determine the total perceived threat of an illness to risk of elderly couples.

In this perceived threat of elderly couples was regarding health problems due to aging.

2. Modifying Factors:

Demographic variables include age, education, monthly family income, number of living children and type of family.

Cues to action

Cues can be either internal or external. Internal cues include feelings of fatigue, uncomfortable symptoms or thoughts about aging.

In these, cues to action include education regarding successful aging, common symptoms and illness, media information of aging and specific problems.

3. Likelihood of Action

The likelihood of a person taking recommended preventive health actions depends on the perceived benefits of the action minus the perceived barriers to the action.

In this perceived benefit of healthy lifestyle and perceived benefit of improved health status may lead the elderly couples to follow healthy behaviour and lifestyle and thereby attain improved health status.

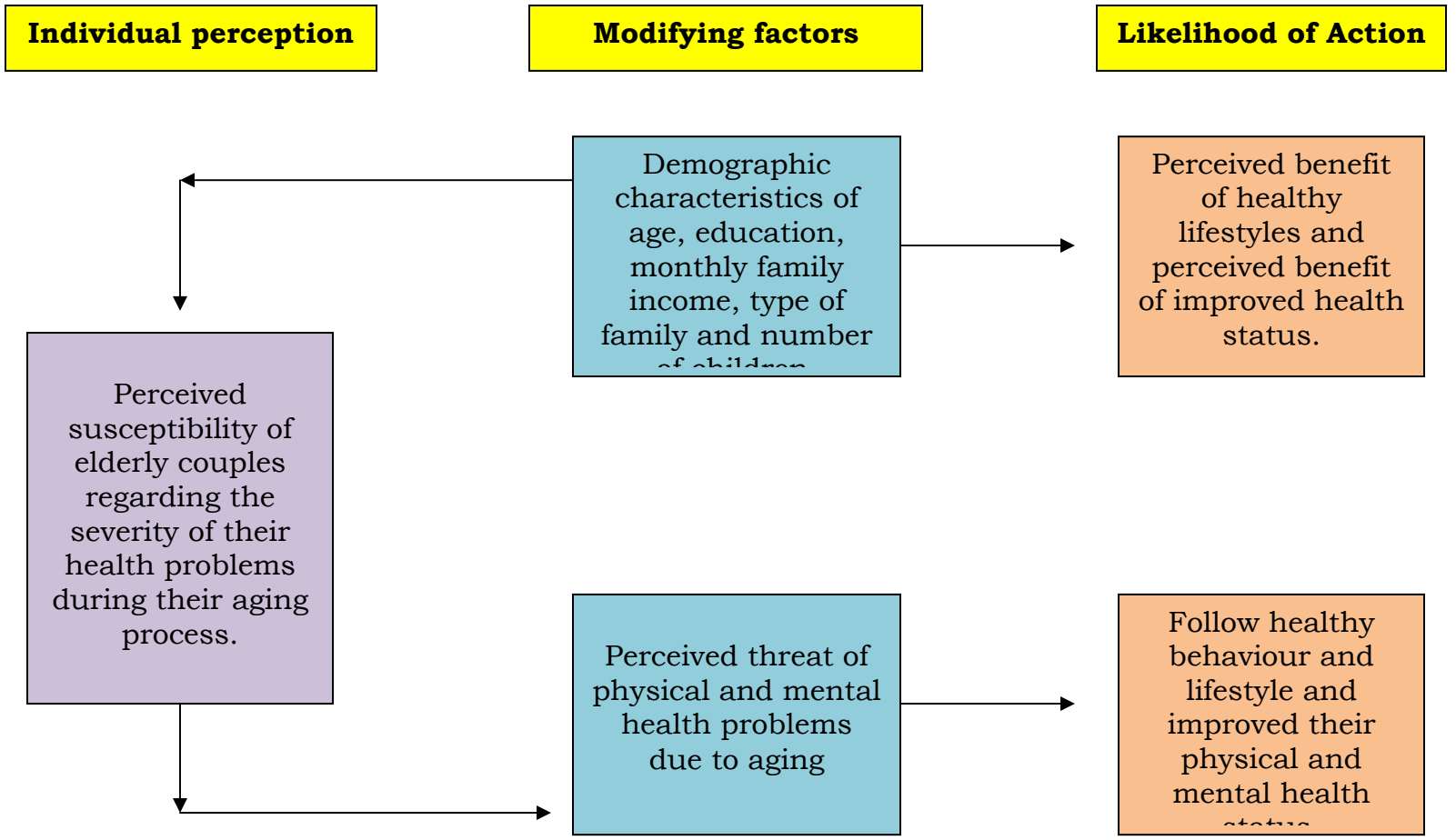


FIG-1: CONCEPTUAL FRAMEWORK BASED ON ROSENSTOCK'S HEALTH BELIEF MODEL (1975)

CHAPTER – III

METHODOLOGY

It is the method of science dealing with principles procedure in research and study. Methodology deals with research design setting, population and sample, data collection instruments and procedures, pilot study, content validity, reliability of the tool, data analysis and protection of human rights.

The present study was designed to assess the perception of wellbeing among the elderly couples in rural and urban areas of Kanyakumari District.

RESEARCH APPROACH

Research approach used for the study was a Quantitative approach to assess the perception of wellbeing among the elderly couples in rural and urban areas of Kanyakumari district, Tamil Nadu.

RESEARCH DESIGN

The research design is the plan of how when and where data are to be collected and analyzed (Parahoo-2006)

The research design selected for the study was Descriptive design.

VARIABLES

Variables are often inherent characteristics of research subjects (Polit 2008)

Independent variables were the domains of well being such as physical, emotional, social, spiritual and intellectual.

Dependent variable was Perception.

SETTING OF THE STUDY

Setting is the physical location and conduction in which data collection takes place in a study (Polit 2008).

The study was conducted among elderly couples from Nagercoil, Kottaram Town Panchayats and Karumbatoor, Kanniyakulam Village Panchayats of Kanyakumari District. The researcher selected these areas by lottery method among the 54 urban areas and 96 rural areas in Kanyakumari District. The elderly couples for the study were selected by Non Probability Convenience Sampling technique. A total of 60 samples 30elderly couples from the rural areas and 30 elderly couples from the urban areas) were selected for the study.

Considering the proximity, availability of subject, cooperation from authorities, feasibility of time, familiarity of setting for the investigator, money and material were added reasons for the selection of the setting of the study.

POPULATION OF THE STUDY

Population can be defined as the total number of units from which data can be potentially be collected (Parahoo 2006)

The target population for the study was the elderly couples above 60 years of age in the selected rural and urban areas of Kanyakumari District.

SAMPLE

Sample refers to a fraction or portion of the elements in a universe drawn out deliberately in a planned representative manner for studying interested characteristics of a larger group of population (Polit 2008)

The sample consisted of 60 elderly couples selected from rural and urban areas of Kanyakumari District who fit into the inclusion criteria

SAMPLE SIZE

Sample size is the total number of study participants participating in the study (Polit 2008)

The study sample consisted of 60 elderly couples in both groups i.e. 30 from selected rural areas and 30 from selected urban areas of Kanyakumari District.

SAMPLING TECHNIQUE

Sampling is the process of selecting a portion of the population to represent the entire population (Polit 2008)

In the study Nonprobability Convenience sampling was used for selecting the sample. Elderly couples who were above 60 years of age were taken as samples for the study. Elderly couples who fit in to the inclusion criteria were selected as samples.

CRITERIA FOR SAMPLE SELECTION

The sample was selected based on the following criteria.

Inclusion Criteria:

Elderly couples

- above 60 years of age.
- willing to participate in the study
- who were not employed.
- who can understand Tamil or English.

Exclusion Criteria

Elderly couples

- who were mentally disabled.

RESEARCH TOOL AND TECHNIQUE

Based on the objectives, Modified Wellbeing Assessment Tool was prepared to assess the physical, emotional, social, spiritual and intellectual wellbeing perceived by elderly couples. It is modified from the Wellbeing Assessment Tool from the Mckinly University, Illinois. The tool was modified after going through the related literature and with the guidance of experts in the field of medicine and nursing. The tool was prepared in English and translated in Tamil, without altering the meaning.

The tool used for the study included 2 sections.

Section I

It included demographic data such as age, education, income, no. of children and type of family.

Section II

It consisted of Modified wellbeing assessment tool. It has 5 domains of elderly, each consisting of 10 statements. The domains of wellbeing are the following

- Physical wellbeing
- Spiritual wellbeing
- Social wellbeing
- Emotional wellbeing
- Intellectual wellbeing

Scoring Procedure

Modified wellbeing assessment tool consisted of a 4 point Likert's scale. It comprised of 50 items to assess the perception of wellbeing of the elderly couples for which scoring was done.

Positive items

4 - Always

5 - Often

2 - Sometimes

1 - Rarely / Never

Negative items

4 - Rarely / Never

3 - Sometimes

2 - Often

1 - Always

The results were interpreted as follows

>175 best perception

125 -175 good perception

75 – 125 fair perception

<75 poor perception

TESTING THE TOOL

Validity

Validity is the degree to which an instrument measures what is intended to measure (Polit 2008)

The Wellbeing assessment tool was modified by the investigator based on the Wellbeing Assessment Tool from the Mckinly University, Illinois and the review of literature. The tool was given to six experts in the field of nursing and psychology for content validity.

Reliability

Reliability is the degree of consistency or dependability with which an instrument measures to attribute it is designed to measure (Polit 2008)

In this study, the reliability of the wellbeing Assessment tool was established by test retest method. There was a significant correlation between test and retest. Reliability was completed by using Cronbach

alpha, and it was found to be 0.94 and the Assessment questionnaire was found reliable for the study.

PILOT STUDY

A pilot study is a small scale version or trial run designed to test the methods to be used in a larger more rigorous study, which is sometimes referred to as the parent study (Polit 2008)

After obtaining permission from the concerned authority, a pilot study was conducted with 10% of sample size ,n=3 from the rural (Marthurkurichy) and 3 from the urban area (Marthandam), in a manner in which the study would be done to determine the feasibility, validity, reliability and predictability of the designed methodology. The period of the pilot study was one week. The result of the study was analysed and discussed with experts. The pilot study revealed that the study was feasible. Data were analyzed to find out suitability of statistics and was found to have significant difference in perception of wellbeing among elderly couples in rural and urban areas. The couples selected for the pilot study were not included in the main study.

DATA COLLECTION PROCEDURE

The data collection was done from 1-05-2010 to 12-06-2010 for six weeks between 9 am to 4 pm. Permission was obtained from the area Presidents of the two rural areas (Karumbatoor & Parvathipuram) and the two urban areas (Nagercoil & Kottaram). In this study 30 elderly couples from the rural areas and 30 elderly couples from the urban areas

were personally interviewed with the prepared schedule of the assessment tool. Each day the researcher interviewed about 2 to 3 elderly couples based on the inclusion criteria. The interview lasted for 1 to 1 ½ hours for each elderly couple who fit in to the inclusion criteria.

The researcher introduced and developed rapport with the couples. After explaining the purpose of study, the researcher obtained oral consent from the elderly couple.

The datas were collected using the Modified Wellbeing Assessment tool. The couples were asked to answer never, rarely, sometimes, often, always for the statements in the questionnaire and scoring was done according to the scoring procedure.

The respondents co operated well and the researcher thanked them for their co operation.

PLAN FOR DATA ANALYSIS

The data analysis was planned based on the objectives of the study by using descriptive and inferential statistics.

Descriptive Statistics:

Frequency, percentage, mean and standard deviation were used for the analysis of wellbeing perceived by the elderly couples.

Inferential Statistics:

Chi Square was used to determine the association between demographic variables with perception of wellbeing score.

Independent paired‘t’ test was used to determine the difference between perception of wellbeing of rural and urban elderly couples.

PROTECTION OF HUMAN RIGHTS

Research proposal was approved by dissertation committee of Christian College of Nursing, Neyyoor. Prior to the study, the written permission was obtained from the Presidents of the selected rural and urban areas. The oral consent of each study subject was obtained before starting data collection. Assurance was given to the study subject that anonymity of each individual would be maintained.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data which was collected from 60 samples consisting of the 30 rural and 30 urban elderly couples in Kanyakumari District.

Statistical analysis is a method of rendering quantitative information meaningful and intelligible statistical procedure enables the researcher to reduce, summarize, organize, evaluate, interpret and communicate numeric information. (Polit 2008)

The data collected from the subjects were tabulated, analyzed presented in the tables and interpreted under the following sections based on the objectives and hypothesis of the study.

1. To assess the perception of wellbeing of rural elderly couples
2. To assess the perception of wellbeing of urban elderly couples.
3. To compare the perception of wellbeing of rural and elderly couples
4. To find out the association between perception of wellbeing of rural and urban elderly couples with selected demographic variables such as age, education, monthly income, type of family and number of living children.

ORGANISATION OF FINDINGS

The rural and urban elderly couples were described in terms of percentages and averages wherever possible. The perception of wellbeing

and its components were assessed in terms of percentages. The wellbeing of couples was compared between rural and urban by the test of significant paired 't' test. The association between demographic variable of the rural and urban elderly couple was associated by chi square test. The P value <0.05 was considered as significant.

The data are presented under the following headings.

- Findings related to sample characteristics of the study.
- Findings related to frequency and percentage of perception of wellbeing under each domain in rural elderly couples.
- Findings related to frequency and percentage of perception of wellbeing under each domain in urban elderly couples.
- Findings related to frequency and percentage of total scores and percentage of wellbeing in rural and urban elderly couples.
- Comparison of rural and urban couples' perception of wellbeing.
- Findings related to association between perception of wellbeing of rural and urban elderly couples.

Description of the couples

The couples were described as rural and urban and compared with respect to their demographic variables age, education, income, type of family and number of living children. The above variables are common and compared between rural and urban elderly couples.

Findings related to sample characteristics of the Study

TABLE 1: FREQUENCY AND PERCENTAGE DISTRIBUTION OF SAMPLES ON SELECTED DEMOGRAPHIC VARIABLES N=30

Sl. No.	Variables	Components	Rural		Urban	
			No	%	No	%
1	Age (Men)	60 - 69	14	46.7	14	46.7
		70 - 79	13	43.3	12	40.0
		80 - 89	3	10.0	4	13.3
2	Age	60 - 69	22	73.3	21	70.0
	(Women)	70 - 79	8	26.7	8	26.7
		80 - 89	-	-	1	3.3
3	Education	Degree	7	23.3	13	43.3
	(Men)	Hr. Secondary	10	33.3	10	33.3
		High School	7	23.3	6	20.0
		Primary	3	10.0	-	-
		Illiterate	3	10.0	1	3.3
4	Education	Degree	5	16.7	12	40.0
	(Women)	Hr. Secondary	14	46.7	9	30.0
		High School	7	23.3	9	30.0
		Primary	-	-	-	-
		Illiterate	4	13.3	-	-
6	Family type	Nuclear Family	14	46.7	16	53.3

		Joint Family	16	53.3	14	46.7
7	No of living	≤ 2	18	60.0	14	46.7
	children	≥ 3	12	40.0	16	53.3

The above Table 1 describes and compares the elderly couples of rural and urban according to their demographic characteristics. In respect to rural elderly men, 14 (46.7%) were of 60 – 69 years of age, 13 (43.3%) were of 70 – 79 years of age, 3 (10%) were of 80 – 89 years of age. In respect to urban elderly men, 14 (46.7%) were of 60 – 69 years of age, 12 (40.0%) were of 70 – 79 years of age, 4 (13.3%) were of 80 – 89 years of age. In respect to rural elderly women, 22 (73.3%) were of 60 – 69 years of age, 8 (26.7%) were of 70 – 79 years of age, 0 (0%) were of 80 – 89 years of age. In respect to urban elderly women, 21 (70%) were of 60 – 69 years of age, 8 (26.7%) were of 70 – 79 years of age, 1(3.3%) were of 80 – 89 years of age.

In respect to the educational status of the rural elderly men, 7 (23.3%) were of degree holders, 10 (33.3%) had higher secondary education, 7(23.3%) were educated in the high school level, 3 (10%) were of primary school education and 3 (10.0%) were illiterates. In respect to the educational status of the urban elderly men, 13 (43.3%) were of degree holders, 10 (33.3%) had higher secondary education, 6(20.0%) were educated in the high school level, 0(0%) were of primary school education and 1 (3.3%) were illiterates. In respect to the educational status of the rural elderly women, 5 (16.7%) were of degree holders, 14

(46.7%) had higher secondary education, 7(23.3%) were educated in the high school level, 0 (0%) were of primary school education and 4 (13.3%) were illiterates. In respect to the educational status of the urban elderly women, 12 (40.0%) were of degree holders, 9 (30.0%) had higher secondary education, 9 (30.0%) were educated in the high school level, 0(0%) were of primary school education and 0 (0%) were illiterates.

In respect of the family income, it is less than Rs 5,000 per month in 9 (30%) of the rural elderly couples and greater than Rs 5,000 per month in 21 (70.0%) of the rural elderly couples. The family income is less than Rs 5,000 per month in 3 (10%) of the urban elderly couples and greater than Rs 5,000 per month in 27 (90.0%) of the urban elderly couples.

In respect to the family type, 14 (46.7%) of the rural elderly couple belong to nuclear type of family and 16 (53.3%) belong to joint family. 16 (53.3%) of the urban elderly couple belong to nuclear family and 14 (46.7%) of the urban elderly couple belong to joint family.

18 (60%) of the rural elderly couple have one or two living children and 12 (40%) of the rural elderly couple have 3 or more living children. In the urban elderly population, 14 (46.7%) have 1 or 2 children and 16 (53.3%) have 3 or more children.

The median ages of the males of rural and urban were 70 years of each. The mean ages of males of rural and urban were 70.2±6.7 and 71.2 ± 6.9 respectively. The difference between the mean ages was not

statistically significant. The females' median ages of rural and urban were 64 and 64.5 years respectively. The rural and urban females' mean ages were 65.6±5 and 66.6 ± 6 years respectively. The difference of means was not statistically significant (P > 0.05). The educational levels of both sexes were not significantly different (P > 0.05). The family income of rural couple was significantly lesser than the income of the urban couples (P < 0.05). In respect of type of family, the rural couples and urban couples were not significantly different (P > 0.05). The above matching of rural and urban elderly couples was comparable in respect of their perception of wellbeing.

FIG 2: PERCENTAGE DISTRIBUTION OF AGE OF RURAL AND URBAN ELDERLY MEN IN YEARS

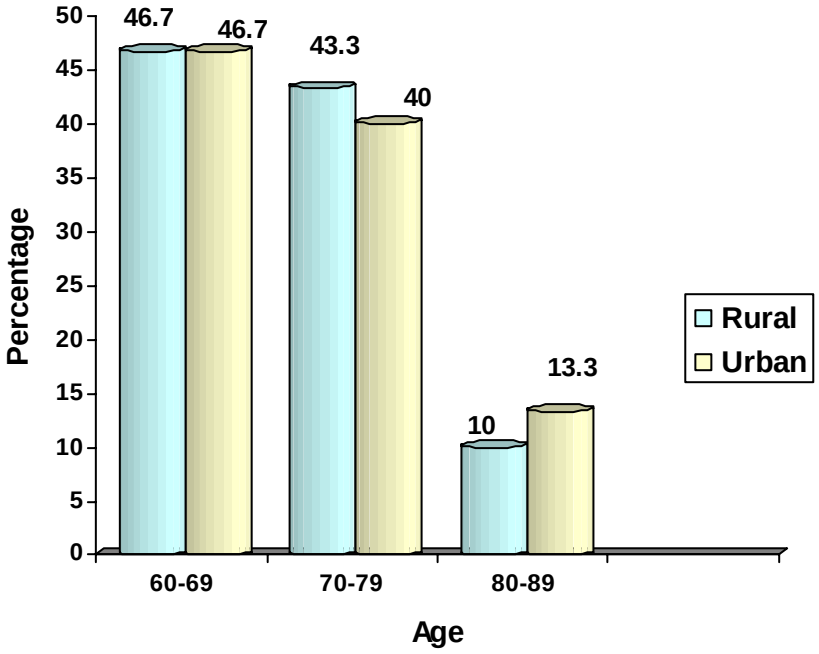


FIG 3: PERCENTAGE DISTRIBUTION OF AGE OF RURAL AND URBAN ELDERLY WOMEN IN YEARS.

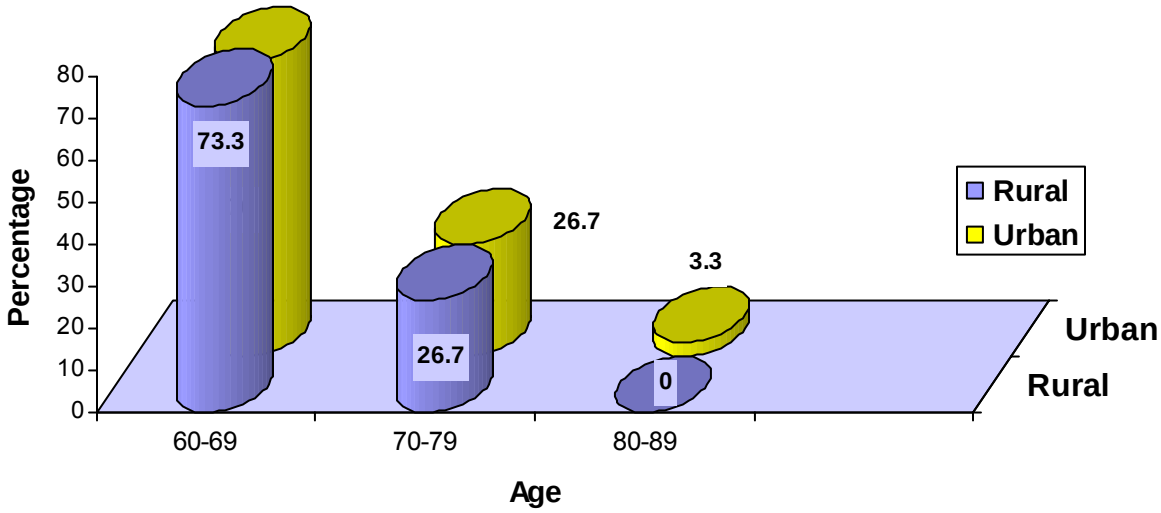


FIG 4: PERCENTAGE DISTRIBUTION OF EDUCATION OF RURAL AND URBAN ELDERLY MEN

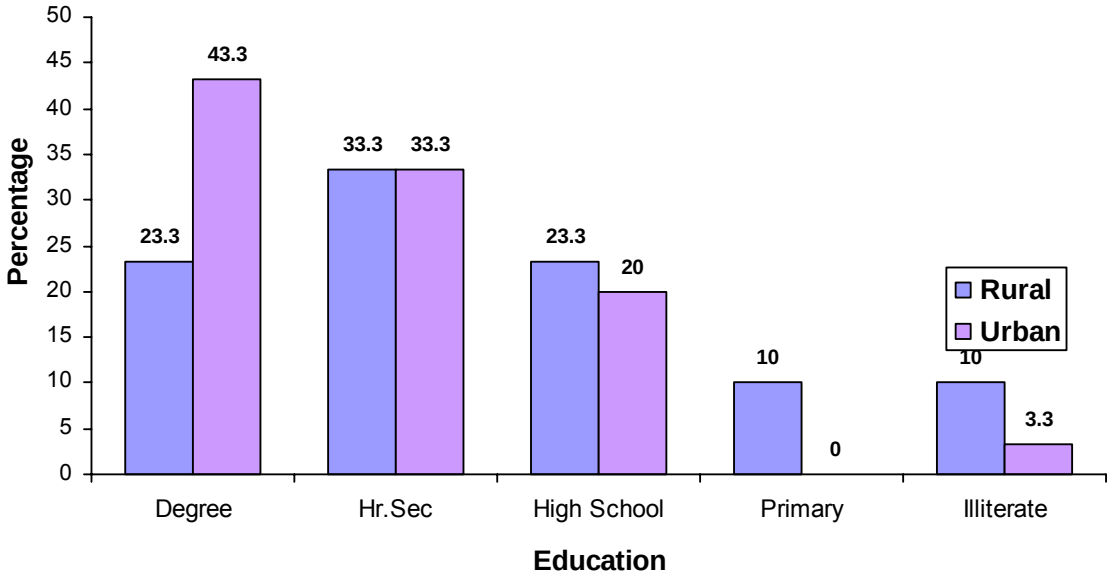


FIG-5: PERCENTAGE DISTRIBUTION OF EDUCATION OF RURAL AND URBAN ELDERLY WOMEN.

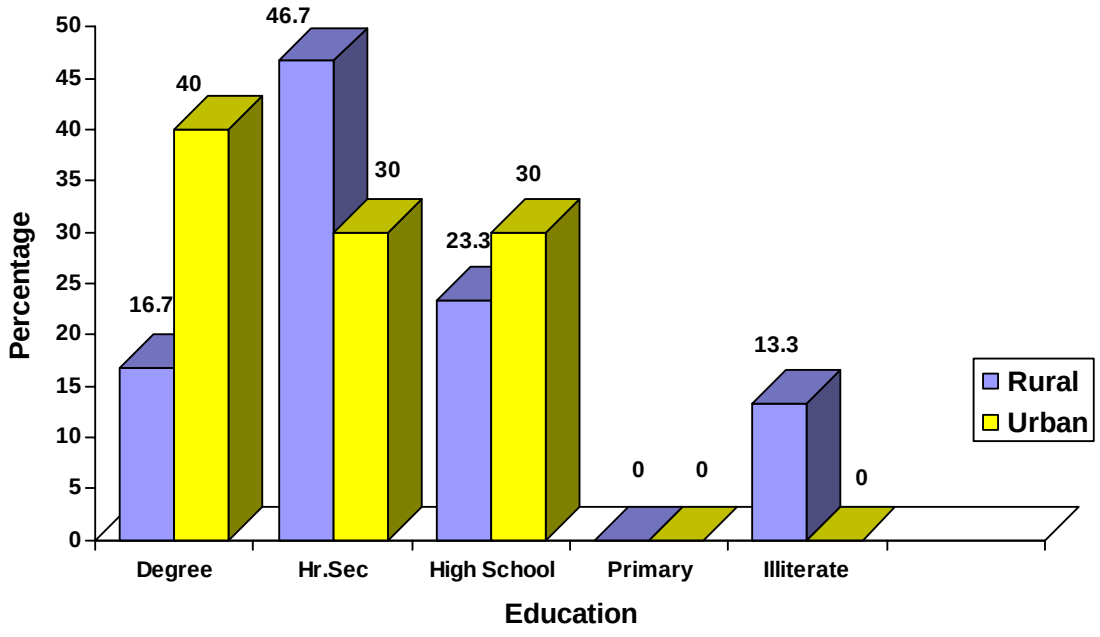


FIG 6: PERCENTAGE DISTRIBUTION OF MONTHLY FAMILY INCOME OF RURAL & URBAN ELDERLY COUPLES

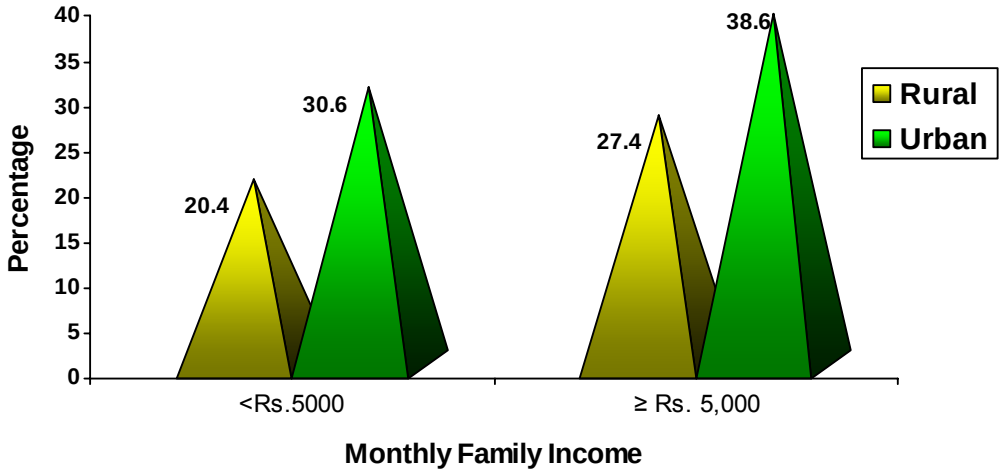
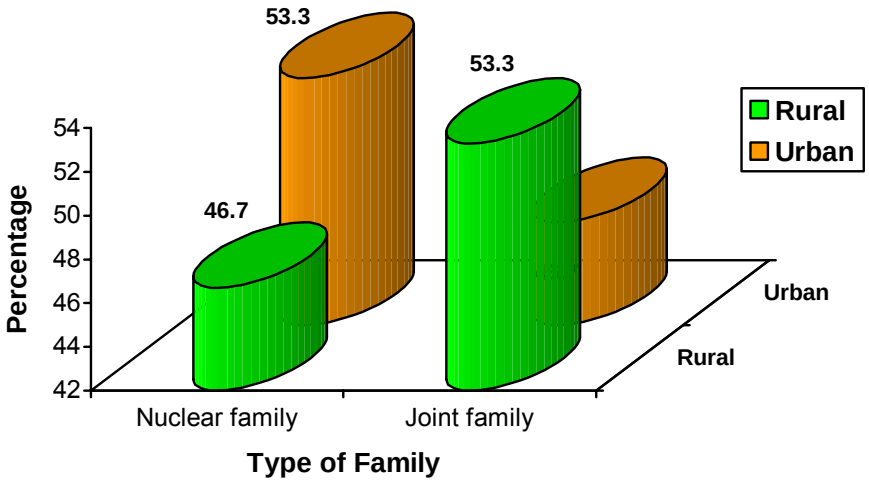


FIG 7: PERCENTAGE DISTRIBUTION OF TYPE OF FAMILY OF RURAL AND URBAN ELDERLY COUPLES



Findings related to frequency and percentage of perception of wellbeing under each domain in rural elderly couples

The perception of wellbeing of the elderly couples living in rural areas was assessed as follows. In respect of wellbeing, the domains of wellbeing such as physical health, social health, emotional health, spiritual health and intellectual health were assessed.

TABLE 2: FREQUENCY AND PERCENTAGE DISTRIBUTION OF PERCEPTION UNDER THE 5 DOMAINS OF WELLBEING IN THE RURAL COUPLES.

N=30

Scores	**% of scores**	**Category of Wellbeing**	**Physical**		**Social**		**Emotional**		**Spiritual**		**Intellectual**	
			No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
70–80	87.5-100	Best	1	3.3	2	6.7	1	3.3	3	10.0	3	10.0
50-70	62.5-87.5	Good	26	86.7	26	86.7	26	86.7	20	66.7	22	73.3
30-50	37.5-62.5	Fair	2	6.7	1	3.3	2	3.3	6	20.0	5	16.7
< 30	<37.5	Poor	1	3.3	1	3.3	1	3.3	1	3.3	0	0
Total			30	100	30	100	30	100	30	100	30	100

In the table 2, the wellbeing of the rural elderly couples was assessed. Among the 30 couples, 1(3.3%) couples perceived best physical wellbeing, 26 (86.7%0 perceived good physical wellbeing, 2 (6.7%) perceived fair physical wellbeing and 1 (3.3%) perceived poor physical wellbeing, 2 (6.7%) perceived best social wellbeing, 26 (86.7%) perceived good social wellbeing, 1 (3.3%) perceived fair social wellbeing, 1 (3.3%) perceived poor social wellbeing, 1 (3.3%) perceived best emotional wellbeing, 26 (86.7%) perceived good emotional wellbeing, 2 (6.7%) perceived fair emotional wellbeing, 1 (3.3%) perceived poor emotional wellbeing, 3 (10%) perceived best spiritual wellbeing. 20 (66.7%) perceived good spiritual wellbeing, 6 (20%) perceived fair spiritual wellbeing, 1 (3.3%) perceived poor spiritual wellbeing, 3 (10%) perceived best intellectual wellbeing, 22 (73.3%) perceived good intellectual wellbeing, 5 (16.7%) perceived fair intellectual wellbeing, 2(6.7%) couples perceived best wellbeing, 24 (80%) couples perceived good wellbeing, 3 (10%) perceived fair and 1 (3.3%) couples perceived poor wellbeing.

Findings related to frequency and percentage of perception of wellbeing under each domain in urban elderly couples

The perception of wellbeing of the elderly couples living in urban areas was assessed as follows. In respect of wellbeing, the domains of wellbeing such as physical health, social health, emotional health, spiritual health and intellectual health were assessed.

TABLE 3: FREQUENCY AND PERCENTAGE DISTRIBUTION OF PERCEPTION UNDER THE 5 DOMAINS OF WELLBEING IN THE URBAN COUPLES.

N=30

Scores	**% of scores**	**Category of Wellbeing**	**Physical**		**Social**		**Emotional**		**Spiritual**		**Intellectual**	
			No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
70–80	87.5-100	Best	3	10.0	2	6.7	2	6.7	4	13.3	2	6.7
50-70	62.5-87.5	Good	16	53.3	19	63.3	15	63.3	14	46.7	15	50
30-50	37.5-62.5	Fair	9	30.0	7	23.3	11	23.3	12	40	11	36.6
< 30	<37.5	Poor	2	6.7	2	6.7	2	6.7	0	0	2	6.7
Total			30	100	30	100	30	100	30	100	30	100

0	0	0

In the table 3, the wellbeing of the urban elderly couples was assessed. Among the 30 couples, 3(10%) couples perceived best physical wellbeing, 16 (53.3%)perceived good physical wellbeing, 9 (30%) perceived fair physical wellbeing and 2 (6.7%) perceived poor physical wellbeing, 2 (6.7%) perceived best social wellbeing, 19(63.3%) perceived good social wellbeing, 7 (23.3%) perceived fair social wellbeing, 2 (6.7%) perceived poor social wellbeing, 2 (6.7%) perceived best emotional wellbeing, 15 (50%) perceived good emotional wellbeing, 11 (36.6%) perceived fair emotional wellbeing, 2 (6.7%) perceived poor emotional wellbeing, 4(13.3%) perceived best spiritual wellbeing. 14(46.7%) perceived good spiritual wellbeing, 12 (40%) perceived fair spiritual wellbeing, 0 (0%) perceived poor spiritual wellbeing, 2 (6.7%) perceived best intellectual wellbeing, 15 (50%) perceived good intellectual wellbeing, 11 (36.6%) perceived fair intellectual wellbeing, 2(6.7%) couples perceived poor intellectual wellbeing, 3 (10%) couples had perceived best wellbeing, 16 (53.4%) perceived good, 10 (33.3%) perceived fair and only one couple had perceived poor wellbeing.

Findings related to frequency and percentage of total scores and percentage of wellbeing in rural and urban elderly couples

TABLE 4: FREQUENCY AND PERCENTAGE DISTRIBUTION OF PERCEPTION OF WELLBEING IN RURAL AND URBAN ELDERLY COUPLES

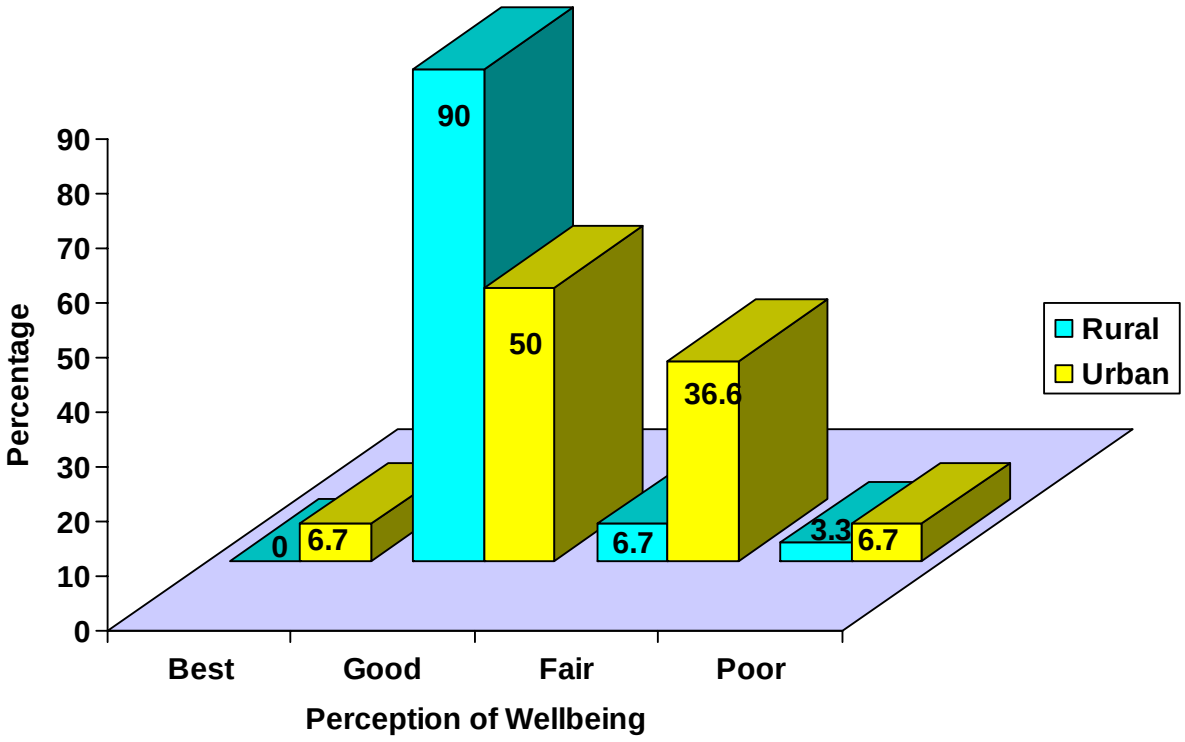
N=30

Total scores of wellbeing components	Percentage of scores	Category of wellbeing	Elderly couples			
			Rural		Urban	
			No	%	No	%
350-400	87.5-100	Best	-	-	2	6.7
250-350	62.5-87.5	Good	27	90.0	15	50
150-250	37.5-62.5	Fair	2	6.7	11	36.6
<150	<37.5	Poor	1	3.3	2	6.7
Total			30	100	30	100

The above table 4 reveals the assessment of total score of wellbeing perceived by rural and urban couples. In rural 27 (90%) couples had perceived good wellbeing and the remaining 2 (6.7%) and 1 (3.3%) couples had perceived fair and poor wellbeing respectively. In urban area,

2 (6.7%) couples had perceived best wellbeing and 15 (50%) couples had perceived good wellbeing. The remaining 11 (36.6%) and 2 (6.7%) couples had perceived fair and poor wellbeing respectively.

FIG-8: PERCENTAGE DISTRIBUTION OF PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES



Comparison of rural and urban couple's perception of wellbeing

The wellbeing perceived by the rural and urban couples was compared in each domain and total score of wellbeing as follows.

TABLE 5 COMPARISON OF PERCEPTION OF WELLBEING IN RURAL AND URBAN ELDERLY COUPLES.

Domains of wellbeing	Rural elderly couples		Urban elderly couples		't'	d.f	Significance
	Mean	SD	Mean	SD			
Physical	57.0	8.2	53.8	12.8	1.166	58	P > 0.05
Social	58.3	8.9	52.1	12.5	2.288	58	P < 0.05
Emotional	57.7	9.0	52.8	13.2	1.668	58	P > 0.05
Spiritual	55.7	9.6	52.7	12.6	1.036	58	P > 0.05
Intellectual	57.2	8.9	52.3	12.4	1.740	58	P > 0.05
Total	285.9	38.1	264.0	39.8	1.689	58	P > 0.05

The table 5 compares the perception of wellbeing by the couples living in rural and urban with the domains of wellbeing. Except social health, the other domains had not been different significantly between the rural and urban couples. The rural couples' mean perception of wellbeing was 285.9 ± 38.1 and the same of their urban counter parts was 264.0 ± 59.8. The difference was not statistically significant (P > 0.05).

Findings related to association between the perceptions of wellbeing with demographic characteristics

The perception of wellbeing by the rural and urban couples were associated with their demographic variables such as age, education, income, type of family and number of living children.

TABLE 6: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THE AGE OF ELDERLY MEN.

Age of elderly men	Rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	< med	≥ med	Total				<med	≥med	Total			
<med	4	10	14				6	8	14			
≥med	7	9	16	0.741	1	P > 0.05	11	5	16	2.039	1	P > 0.05
	11	19	30				17	13	30			

The table 6 explains the association between the age of men and perception of wellbeing of couples in rural and urban areas. In both the rural and urban areas, ages of men were not associated with the perception of wellbeing by the elderly couples (P >0.05).

TABLE 7: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THE AGE OF ELDERLY WOMEN.

.

Age of elderly women	rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	<med	≥med	Total				<med	≥med	Total			
<med	3	10	14	0.067	1	P > 0.05	6	9	15	0.536	1	P > 0.05
≥med	8	9	16				11	4	15			
	11	19	30				17	13	30			

The association between the rural and urban elderly couples' perception of wellbeing and the age of elderly women is shown in the above table 7. The results reveal that there was no statistical significant association between them (P > 0.05).

TABLE 8: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THE EDUCATIONAL STATUS OF ELDERLY MEN.

Edn. of elderly men	rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	<med	≥med	Total				< med	≥ med	Total			
Degree	2	5	7				4	9	13			
Hr. Sec	0	10	10				6	4	10			
High school	4	3	7				6	0	6			
Primary	3	0	3	13.595	4	P< 0.05	1	0	1	7.757	3	P < 0.05
Illiterate	2	1	3				-	-	-			
Total	11	19	30				17	13	30			

From the above table 8, the male educational status of rural and urban elderly was associated with the couples' perception of wellbeing. The results showed that there was statistical significant association between the educational level of men and wellbeing perception of couples in both rural and urban areas.

TABLE 9: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THE EDUCATIONAL STATUS OF ELDERLY WOMEN.

Edn. Of Elderly Women	Rural			Chi Sq	d.f	Sig	Urban			Chi Sq	d.f	Sig
	< med	≥ med	Total				< med	≥ med	Total			
Degree	1	4	5				7	5	12			
Hr. Sec	2	12	14				4	5	9			
High school	5	2	7				7	2	9			
Primary	-	-	-	8.530	3	P< 0.05	-	-	-	2.106	2	P > 0.05
Illiterate	2	2	4				-	-	-			
Total	10	20	30				18	12	30			

The above table 9 states the association between the educational status of women with the wellbeing perception of elderly couples in rural and urban areas. The rural elderly couples' perception of wellbeing was associated with the educational status of elderly women (P > 0.05).But the urban women's education was not associated with the wellbeing perception the urban elderly couples.

TABLE 10: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THEIR MONTHLY FAMILY INCOME.

Income	Rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	<med	≥med	Total				< med	≥ med	Total			
<5000	12	5	17	6.652	1	P < 0.05	6	5	11	0.144	1	P > 0.05
≥5000	3	10	13				9	10	19			
	15	15	30				15	15	30			

The table 10 shows the association between monthly income with the perception of wellbeing by the couples in both rural and urban areas. The rural couples' wellbeing perception was associated with their monthly family income significantly ($P< 0.05$). But in the urban area, the monthly family income did not associate with the perception of wellbeing of the elderly couples ($P > 0.05$).

TABLE 11: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THEIR TYPE OF FAMILY.

Type of family	Rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	<med	≥med	Total				< med	≥ med	Total			
Nuclear	9	5	14	2.43	1	P > 0.05	10	6	16	2.43	1	P > 0.05
Joint	6	10	16				5	9	14			
	15	15	30				15	15	30			

The above table 11 states that there was no significant association between the type of family with wellbeing perception of the elderly couples in rural and urban areas.

TABLE 12: ASSOCIATION BETWEEN THE PERCEPTION OF WELLBEING OF RURAL AND URBAN ELDERLY COUPLES WITH THEIR NUMBER OF LIVING CHILDREN.

Living children	Rural			Chi sq	d.f	Sig	Urban			Chi sq	d.f	Sig
	<med	≥med	Total				<med	≥med	Total			
<3	8	10	18	0.556	1	P > 0.05	4	10	14	4.821	1	P < 0.05
≥ 3	7	5	12				11	5	16			
	15	15	30				15	15	30			

The table 12 states the association between the number of living children with the couple's perception of wellbeing. The rural couples' perception of wellbeing was not associated with living children (P > 0.05).

But the urban couples' perception of wellbeing was statistically significantly associated with the number of living children ($P < 0.05$).

CHAPTER V

DISCUSSION

The aim of the study was to assess the perception of wellbeing among the rural and urban elderly couples of Kanyakumari District. The study was conducted in the urban areas (Nagercoil, Kanniyakulam) and in rural areas (Kottaram, and Karumbatoor). Totally 60 elderly couples (30 elderly couples from rural areas and 30 elderly couples from urban areas) were selected by convenience sampling method. The tool was Modified Wellbeing Assessment Tool. The data obtained were classified, grouped and analyzed statistically based on the objectives of the study. The objectives were

1. To assess the perception of wellbeing of rural elderly couples
2. To assess the perception of wellbeing of urban elderly couples.
3. To compare the perception of wellbeing of rural and elderly couples
4. To find out the association between perception of wellbeing of rural and urban elderly couples with selected demographic variables such as age, education, monthly income, type of family and number of children.

Description of Demographic and Clinical Characteristics

The mean ages of males of rural and urban were 70.2 ± 6.7 and 71.2 ± 6.9 years respectively. The difference between the mean ages was not statistically significant ($P>0.05$). Similarly, the women also did not

differ significantly in respect of their ages (P> 0.05). The education status of rural and urban elderly couples did not differ significantly (P> 0.05). The family income of the rural and urban elderly couples differed significantly (P<0.05). In respect of the type of family and number of living children, the rural and urban elderly couples differed significantly (P>0.05) (Table – 1).

First objective: To assess the perception of wellbeing of rural elderly couples

Regarding rural couples' perception of wellbeing, 1(3.3%) couples perceived best physical wellbeing, 26 (86.7%0 perceived good physical wellbeing, 2 (6.7%) perceived fair physical wellbeing and 1 (3.3%) perceived poor physical wellbeing, 2 (6.7%) perceived best social wellbeing, 26 (86.7%) perceived good social wellbeing, 1 (3.3%) perceived fair social wellbeing, 1 (3.3%) perceived poor social wellbeing, 1 (3.3%) perceived best emotional wellbeing, 26 (86.7%) perceived good emotional wellbeing, 2 (6.7%) perceived fair emotional wellbeing, 1 (3.3%) perceived poor emotional wellbeing, 3 (10%) perceived best spiritual wellbeing. 20 (66.7%) perceived good spiritual wellbeing, 6 (20%) perceived fair spiritual wellbeing, 1 (3.3%) perceived poor spiritual wellbeing, 3 (10%) perceived best intellectual wellbeing, 22 (73.3%) perceived good intellectual wellbeing, 5 (16.7%) perceived fair intellectual wellbeing, 2(6.7%) couples perceived best wellbeing, 24 (80%) couples perceived good wellbeing, 3 (10%) perceived fair and 1 (3.3%) couples perceived poor wellbeing.

The total scores of perception of wellbeing were assessed. . In the rural areas no couples had best perception of wellbeing, 27 (90%) couples had good perception, 2 (6.7%) had fair perception and 1(3.3%) had poor perception.

Second objective: To assess the perception of wellbeing of urban elderly couples

In respect of the urban area, among the 30 elderly couples, 3(10%) couples perceived best physical wellbeing, 16 (53.3%)perceived good physical wellbeing, 9 (30%) perceived fair physical wellbeing and 2 (6.7%) perceived poor physical wellbeing, 2 (6.7%) perceived best social wellbeing, 19(63.3%) perceived good social wellbeing, 7 (23.3%) perceived fair social wellbeing, 2 (6.7%) perceived poor social wellbeing, 2 (6.7%) perceived best emotional wellbeing, 15 (50%) perceived good emotional wellbeing, 11 (36.6%) perceived fair emotional wellbeing, 2 (6.7%) perceived poor emotional wellbeing, 4(13.3%) perceived best spiritual wellbeing. 14(46.7%) perceived good spiritual wellbeing 12 (40%) perceived fair spiritual wellbeing, 0 (0%) perceived poor spiritual wellbeing, 2 (6.7%) perceived best intellectual wellbeing, 15 (50%) perceived good intellectual wellbeing, 11 (36.6%) perceived fair intellectual wellbeing, 2(6.7%) couples perceived poor intellectual wellbeing, 3 (10%) couples had perceived best wellbeing, 16 (53.4%) perceived good wellbeing, 10 (33.3%) perceived fair and only one couple had perceived poor wellbeing.

The total scores of perception of wellbeing were assessed. In urban area 2(6.7%) had best perception, 15(50%) had good perception, 11(36.6%) had fair perception and 2(6.7%) had poor perception.

Third Objective: To compare the perception of wellbeing of rural and elderly couples

In respect of the domains of wellbeing perceived by rural and urban elderly couples, except social wellbeing, all the other domains such as physical, emotional, spiritual and intellectual wellbeing did not show significant statistical difference (P>0.05). The mean social wellbeing of the rural couples was 58.3 ± 8.9 and the same was statistically significantly greater than the urban social wellbeing of 52.1 ± 12.5. This may be attributed to the nepotism and rapport among the rural people. The total wellbeing perceived by the elderly couples did not differ significantly between the rural and urban couples (P>0.05) (Table5). Hence the hypothesis stated earlier that there will be significant differences between perception of wellbeing among the rural and elderly couples can be rejected.

Fourth objective: To find out the association between perception of wellbeing of rural and urban elderly couples with selected demographic variables.

The age of the couples had no association between the perception of wellbeing in both rural and urban couples. (Table 6 & 7)

The educational level of the men in both areas had significantly associated with the perception of wellbeing of the couples. (Table 8)

The rural women educational level was significantly associated with the perception of wellbeing of the couples ($P<0.05$). But the urban women educational level had no significant association with the perception of wellbeing of the couples ($P>0.05$)

(Table 9)

The rural couples family income was statistically associated with the perception of wellbeing of rural couples ($P<0.05$). But the urban couples family income had no significant association with their perception of wellbeing ($P>0.05$). (Table 10)

In both the rural and urban areas, the type of family had no significant association with the perception of wellbeing of the couples ($P>0.05$) (Table 11). Hence the hypothesis stated earlier that there will be significant association between the type of family and the perception of wellbeing of rural and urban elderly couples can be rejected.

The number of living children of the rural elderly couples was not significantly associated with the perception of wellbeing of rural elderly couples. The number of living children of the urban elderly couples showed significant association with the perception of wellbeing of urban elderly couples ($P<0.05$). (Table12)

CHAPTER VI

SUMMARY, IMPLICATION, RECOMMENDATIONS AND CONCLUSION

This chapter deals with the summary of the study and the conclusions drawn. It clarifies the limitation of the study and the implications. The recommendations are given for different areas like nursing education, nursing practice, nursing administration and nursing research.

SUMMARY

This study was undertaken to assess the perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District, Tamil Nadu.

OBJECTIVES

1. To assess the perception of wellbeing of rural elderly couples
2. To assess the perception of wellbeing of urban elderly couples.
3. To compare the perception of wellbeing of rural and elderly couples
4. To find out the association between perception of wellbeing of rural and urban elderly couples with selected demographic variables such as age, education, monthly income, type of family and number of children.

Descriptive design was used for this study. The conceptual framework of the study was based on Rosenstock's Health Belief Model. Totally 60 elderly couples (30 from the rural areas and 30 from the

urban areas) were selected by convenience sampling method. Data collection was done for 6 weeks. The tool used was Modified Wellbeing Assessment Tool. The tool was validated and subjected to reliability testing and was found valid. Pilot study was conducted and the tool was found to be valid and reliable. Data analysis was done based on the objectives of the study by using descriptive and inferential statistics.

MAJOR FINDINGS OF THE STUDY

1. The perception of social wellbeing of rural elderly couples was significantly greater than the perception of social wellbeing of urban elderly couples.
2. The educational level of rural and urban elderly men had significant association with the perception of wellbeing of rural and urban elderly couples
3. The educational level of rural elderly women was significantly associated with the perception of wellbeing of rural elderly couples.
4. The rural couples' family income was significantly associated with the perception of wellbeing of rural elderly couples.
5. The number of living children of the urban elderly couples was associated with the perception of wellbeing of the urban elderly couples.

NURSING IMPLICATIONS

The findings of the study had several implications in the following fields.

Nursing Practice:

The health professionals including nurses and health care practitioners are able to make significant contributions to promote the wellbeing of elderly couples.

Nurses can intervene to alter the physical discomfort and psychological isolation which will affect the wellbeing of elderly couple.

Wellbeing of elderly couple can be improved by strengthening the coping mechanism in areas like physical, social, emotional, spiritual and intellectual health.

Continuing education program can be planned for nurses regarding the importance of wellbeing among elderly couples to update their knowledge and attitude.

Nursing Education:

The nurse educator should give importance to educate the students regarding wellbeing in comprehensive care of elderly couples.

Provide in-service education to the health personnels to increase the educational objective regarding wellbeing among rural and urban elderly couples.

Conduct seminar, workshop, conferences, symposium and microteaching program on coping measures to improve the wellbeing among rural and urban elderly couples.

Nursing instructors can conduct community health programmes on issues related to the wellbeing of elderly couples.

Nursing Research:

Nurse researchers should accept the challenge to perform scientific work and take part in assessment, application and evaluation of wellbeing of elderly couples.

Motivate the investigators to conduct study regarding the assessment of perception of wellbeing among rural and urban elderly couples.

Encourage the researchers to long term goals to promote the wellbeing and stimulate them to achieve that goal.

Nurse researchers should focus on wellbeing as an outcome of professional nursing care and prove that it is an important indicator of quality care.

Nursing Administration:

Nurse Administrators can encourage nursing staff to make important contribution to the geriatric care services.

Nurse Administrators can announce the importance of wellbeing among elderly couples through Medias, posters, chart and handout.

Nurse Administrators can encourage nursing staff to conduct various projects and research on wellbeing of elderly couples.

Nurse Administrators can help and prepare skilled nurses to meet the need of elderly in all domains of wellbeing.

RECOMMENDATIONS

1) The study can be conducted with large number of sample for better generalization.
2) A similar study can be done among elderly couples in various other setting.
3) A comparative study can be done to assess the actual wellbeing of elderly couples.
4) The duration of the study can be increased to find out the improvement.
5) A study can be carried out to assess the effectiveness of psychoeducation and self instructional module as measures to improve the wellbeing of elderly couples.

CONCLUSION

Based on the findings of the study the following conclusions are drawn.

1. There was no significant difference in the perception of wellbeing between the rural and urban elderly couples. But the perception of social wellbeing of rural elderly couples was significantly greater than the perception of social wellbeing of urban elderly couples.
2. There was significant association between the perception of wellbeing of rural and urban elderly couples with the educational status and family income. There was significant association

between the perception of wellbeing of urban elderly couples with their number of living children.

3. There was no significant association between the perception of wellbeing of rural and urban elderly couples with their mean age and type of family. There was no significant association between the perception of wellbeing of rural elderly couples with their number of living children.

REFERENCE

TEXT BOOKS

Birren, James E., R. Bruce Sloane, and Gene D. Cohen. (1992).Handbook of Mental

Health and Aging. 2nd edition. San Diego: Academic Press.

Chopra, Deepak and David Simon.(2001). Grow Younger, Live Longer: 10 Steps to

Reverse Aging. New York: Harmony Books.

Bose, AB and K.D.Gangrade, (ed) 1988. Aging in India: Problems and Potentialities.

New Delhi Abhinov Publication: Citizenship Development Society Publication.

Denise, P.F. (2004), Nursing Research Principles and Methods. (7th edn.). New York:

Lippincott Williams & Wilkins 85-124.

Learly, Z.O. (2005). The Essential Guide in doing Research. (1st edn.). New Delhi:

published by Vistarr Publication. 85-90

Mahajan. (1997). Methods in Biostatistic. (6th edn.). New Delhi: Jaypee Brothers Medical

Publishers Pvt. Ltd. 329-330.

Malhotra, S. (2006). Clinical Research, Solan: Mash Print & Publishers Ltd. 60-69.

Mohr, R.W.(2006). Psychiatric- Mental Health Nursing. (6th edn.). Philadelphia:

Lippincott Williams & Wilkins. 578-584

Oliver, P. (2005). Writing your Thesis. (2nd edn.). New Delhi: Vistarr Publications,

109-111.

Parahoo, K. (2006). Nursing Research Principles Process and Issues. (2nd edn.). China:

MacMillan 92-95.

Pasher, M.E. (2001). Nursing Theories. (2nd edn.). New Delhi: Jaypee Brothers Medical

Publishers Pvt. Ltd. 23-27.

Polit, F. & Beck, C. (2008). Nursing Research. (8th edn.). New York: Lippincott Williams

& Wilkins 85-124

Rao, S. & Richard, J. (2001). An Introduction to Biostatistics. (3rd edn.). New Delhi:

Prentice Hall of India. 123-126.

Taylor, E. (2006). Health Psychology. (6th edn.). New Delhi: Tata McGraw Hill

Company Publisher. 133-149.

JOURNAL REFERENCE

Bhanman, T.R. (2006). Promotion of Spiritual Health for the Elderly, , A journal of

Ministry of Women, Children and Social Welfare, Government of Nepal,

Kathmandu, Nepal 5 Vol. 1 (8): 36-38

Dorgo, S. (2009). The effectiveness of a peer mentored older adult fitness program on

perceived physical, mental and social function. Journal of American Academy of

Nurse Practice, 21(2):116-122.

Irudaya Rajan, S, Mishra, US and Sarma, PS. (2003). Demography of Indian Ageing,

2001-2051, Journal of Ageing and Social Policy, 15(2&3), 11-30.

Jai Prakash, I. (1998). Maintenance of Competence in Daily Living and Well-being of

Elderly. Research & Development Journal. Vol. 4: 2 & 3

Kalkstein,S. (2008). The daily spiritual experiences scale and wellbeing: demographic

comparisons and scale validation with older Jewish adults and a diverse internet

sample. Journal of Religious Health, 48(4):402-417.

Katt, J.A. (2009). Doing well: a SEM analysis of the relationships between various

activities of daily living and geriatric wellbeing. Journal of Geriatric Psychology,

170(3):213-226.

Lee, S. and Mason, A. (2000). Population Aging Raises Questions for Policymakers.

Asia-Pacific Population and Policy. Number 53.

Mair, C.A. (2010). The strength of strong ties for older rural adults: regional distinctions

in the relationship between social interaction and subjective wellbeing.

International Journal of Aging Human Development, 70(2):119-143.

Merz, E.M. (2009). The association of family support and wellbeing in later life depends

on adult attachment style. Attachment Human Development, 11(2):203-221.

National Sample Survey Organisation. (2006). Morbidity, Health Care and the Condition

of the Aged, 60th round (2004), Ministry of Statistics and Programme Implementation, New Delhi.Government of India.

Peek, M.K. et al. (2006). Wellbeing in older Mexican American Spouses. Gerontologist,

46(2): 258-265.

Quiroutte, C. (1992). Spousal Characteristics as Predictors of Wellbeing in Older

Couples. International Journal of Aging Human Development, 34(4):257-269.

Rennemark, (2009). M. Relationships between physical activity and perceived qualities

of life in old age. Aging Mental Health, 13(1):1-8.

Reijula, J. (2009). A new method to assess perceived wellbeing among elderly people- a

feasibility study. BMC Geriatrics, 3(9):55

Strawbridge, W.J. (2009). The influence of spouse lower cognitive function on partner

health and wellbeing among community dwelling older couples: moderating roles

of gender and marital problems. Aging Mental Health, 13(4):530-536.

United Nations, (2002). World Population Ageing 1950-2050, Population division,

Department of Economic and Social Affairs, New York. United Nations

Waddell, E.L. (2010). Predicting Positive Wellbeing in older men and women.

International Journal of Aging Human Development, 70(3):181-197.

Windsor, T.D. (2009). Individual wellbeing in middle and older adulthood: do spousal

beliefs matter? Journal of Gerontology Psychological Science and Social Science,

64(5):586-596.

ELECTRONIC VERSION

Cheng et al., (2009). Self Perception of Wellbeing. Retrieved from

http://www.ncbi.nlm.nih.gov/pubmed/19739918.

Indirani Gupta, (2007). Health Wellbeing of Elderly. Retrieved in 2007 from http://www.agingcare.com/health _conditions/.

Preito et al (2008). Socio demographic and health factors explaining emotional wellbeing

as a quality of life domain of older people in Madrid, Spain.2005. retrieved from mprieto@ieg.csic.es.

Princeton, (2010). Definitions of Wellbeing. Retrieved on 26 December 2010 from

http://www.definitions.net/definition/well_being.

Wikepedia, (2010). Literature Review. Retrieved on 27 November from

http://www.en.wikipedia.org/wiki/literaturereview/.

APPENDIX – A (i)

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

CHRISTIAN COLLEGE OF NURSING
C.S.I. KANYAKUMARI DIOCESE
(Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)
Approved by Indian Nursing Council New Delhi and Tamil Nadu Nurses and Midwives Council, Chennai
NEYYOOR - 629 802
KANYAKUMARI DISTRICT, TAMIL NADU, INDIA.

Principal
Prof. (Mrs.) SANTHI APPAVU, M.Sc.(N),M.Phil.
Phone : Per : 04651-221599, Off : 04651-221411

Fax : 04651-224382
E-mail : ccn.neyyoor@yahoo.com
Web : www.ccnneyyoor.org

Date : 26.04.2010

53/M.Sc.(N)/2

To

The President,
Karunbatoor Village Panchayat,
Kanyakumari District.

Respected Sir,

Sub : Requisition for getting permission to do research study **to assess the**

Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This is to introduce Miss. T.Arul Shiney, II year M.Sc. Nursing student of this College. She is to conduct a research project which is to be submitted to the Tamil Nadu Dr. M.G.R. Medical University, Chennai in partial fulfillment of University requirements for the award of M.Sc. degree in Nursing.

Topic:

A comparative study to assess the Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This student is in need of your esteemed help and co-operation as she is interested in conducting her research study in the area under your administration in Kanyakumari District.

This is to request you to kindly extend necessary facilities to her work on her proposed study during the month of May and June 2010.

Thanking you

CHRISTIAN COLLEGE OF NURSING HOSTEL NEYYOOR 629 802 Kanyakumari Dist.

Yours Faithfully,

PRINCIPAL
CHRISTIAN COLLEGE OF NURSING
NEYYOOR - 629802
K.K.DIST., TAMILNADU

APPENDIX –A (ii)

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

CHRISTIAN COLLEGE OF NURSING
C.S.I. KANYAKUMARI DIOCESE
(Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)
Approved by Indian Nursing Council New Delhi and Tamil Nadu Nurses and Midwives Council, Chennai
NEYYOOR - 629 802
KANYAKUMARI DISTRICT, TAMIL NADU, INDIA.

Principal
Prof. (Mrs.) SANTHI APPAVU, M.Sc.(N),M.Phil.
Phone : Per : 04651-221599, Off : 04651-221411

Fax : 04651-224382
E-mail : ccn.neyyoor@yahoo.com
Web : www.ccnneyyoor.org

Date : 26.04.2010

54/M.Sc.(N)/2

To

The President,
Kottaram Town Panchayat,
Kanyakumari District.

Respected Sir,

Sub : Requisition for getting permission to do research study **to assess the**

Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This is to introduce Miss. T.Arul Shiney, II year M.Sc. Nursing student of this College. She is to conduct a research project which is to be submitted to the Tamil Nadu Dr. M.G.R. Medical University, Chennai in partial fulfillment of University requirements for the award of M.Sc. degree in Nursing.

Topic:

A comparative study to assess the Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This student is in need of your esteemed help and co-operation as she is interested in conducting her research study in the area under your administration in Kanyakumari District.

This is to request you to kindly extend necessary facilities to her work on her proposed study during the month of May and June 2010.

Thanking you

CHRISTIAN COLLEGE OF NURSING HOSTEL NEYYOOR 629 802 Kanyakumari Dist.

Yours Faithfully,

PRINCIPAL
CHRISTIAN COLLEGE OF NURSING
NEYYOOR - 629802
K.K.DIST., TAMILNADU

APPENDIX –A (iii)

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

CHRISTIAN COLLEGE OF NURSING
C.S.I. KANYAKUMARI DIOCESE
(Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)
Approved by Indian Nursing Council New Delhi and Tamil Nadu Nurses and Midwives Council, Chennai
NEYYOOR - 629 802
KANYAKUMARI DISTRICT, TAMIL NADU, INDIA.

Principal
Prof. (Mrs.) SANTHI APPAVU, M.Sc.(N),M.Phil.
Phone : Per : 04651-221599, Off : 04651-221411

Fax : 04651-224382
E-mail : ccn.neyyoor@yahoo.com
Web : www.ccnneyyoor.org

Date : 26.04.2010

55/M.Sc.(N)/2

To

The President,
Kanniyakulam Village Panchayat,
Kanyakumari District.

Respected Sir,

Sub : Requisition for getting permission to do research study **to assess the**

Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This is to introduce Miss. T.Arul Shiney, II year M.Sc. Nursing student of this College. She is to conduct a research project which is to be submitted to the Tamil Nadu Dr. M.G.R. Medical University, Chennai in partial fulfillment of University requirements for the award of M.Sc. degree in Nursing.

Topic:

A comparative study to assess the Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This student is in need of your esteemed help and co-operation as she is interested in conducting her research study in the area under your administration in Kanyakumari District.

This is to request you to kindly extend necessary facilities to her work on her proposed study during the month of May and June 2010.

Thanking you

CHRISTIAN COLLEGE OF NURSING HOSTEL NEYYOOR 629 802 Kanyakumari Dist.

Yours Faithfully,

PRINCIPAL
CHRISTIAN COLLEGE OF NURSING
NEYYOOR - 629802
K.K.DIST., TAMILNADU

APPENDIX –A (iv)

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

CHRISTIAN COLLEGE OF NURSING
C.S.I. KANYAKUMARI DIOCESE
(Affiliated to the Tamil Nadu Dr. M.G.R. Medical University, Chennai)
Approved by Indian Nursing Council New Delhi and Tamil Nadu Nurses and Midwives Council, Chennai
NEYYOOR - 629 802
KANYAKUMARI DISTRICT, TAMIL NADU, INDIA.

Principal
Prof. (Mrs.) SANTHI APPAVU, M.Sc.(N),M.Phil.
Phone : Per : 04651-221599, Off : 04651-221411

Fax : 04651-224382
E-mail : ccn.neyyoor@yahoo.com
Web : www.ccnneyyoor.org

Date : 26.04.2010

56/M.Sc.(N)/2

To

The Chairman,
Nagercoil Municipality,
Kanyakumari District.

Respected Sir,

Sub : Requisition for getting permission to do research study **to assess the**

Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This is to introduce Miss. T.Arul Shiney, II year M.Sc. Nursing student of this College. She is to conduct a research project which is to be submitted to the Tamil Nadu Dr. M.G.R. Medical University, Chennai in partial fulfillment of University requirements for the award of M.Sc. degree in Nursing.

Topic:

A comparative study to assess the Perception of wellbeing among elderly couples in rural and urban areas of Kanyakumari District.

This student is in need of your esteemed help and co-operation as she is interested in conducting her research study in the area under your administration in Kanyakumari District.

This is to request you to kindly extend necessary facilities to her work on her proposed study during the month of May and June 2010.

Thanking you

CHRISTIAN COLLEGE OF NURSING HOSTEL NEYYOOR 629 802 Kanyakumari Dist.

Yours Faithfully,

PRINCIPAL
CHRISTIAN COLLEGE OF NURSING
NEYYOOR - 629802
K.K.DIST., TAMILNADU

APPENDIX – B

LETTER SEEKING EXPERTS OPINION FOR VALIDITY OF TOOL

From

T. Arul Shiney,
II Year M.Sc Nursing.,
Christian College of Nursing,
Neyyoor.

To

Respected Sir / Madam,

Sub: Experts opinion on validity of the tool related to assessment of perception of wellbeing of elderly couples among rural and elderly areas in Kanyakumari District.

I have prepared Demographic data, Modified Wellbeing Assessment Tool. I hereby kindly request you to evaluate the tool based on the evaluation criteria. Your opinion and suggestion will enable the investigator to modify and restructure the tool.

Thanking You,

Place: Yours Sincerely,
Date:

(T. Arul Shiney)

APPENDIX - C
EVALUATION CRITERIA CHECKLIST FOR TOOL VALIDATION

Instruction

The expert is requested to go through the following criteria for evaluation of checklist. Three columns are given for response and a column for remarks. Kindly place a tick mark in the appropriate column and give remarks.

Interpretation of columns

Column I - Meets the criteria
Column II - Partly meets the criteria
Column III - Does not meet the criteria

S.No	Criteria	I	II	III	Remarks
1	**Scoring** • Appropriateness • Adequacy • Accurateness • Clarity • Simplicity				
2	**Content** • Organization a. Logical sequence b. continuity • Adequacy • Appropriateness • Relevance				
3	**Language** • Appropriateness • Clarity • Simplicity • Concise • Precision				
4	**Practicability** • Easy to score • Precisely measure the skill • Utility				

Any other Suggestions

_____

Signature :
Name, Designation :
Address :

APPENDIX – D

LIST OF EXPERTS FOR TOOL VALIDITY

1. Mrs. S. Santhi, M.Sc (N),
   Professor,
   Dept. of Mental Health Nursing,
   Sri Ramachandra College of Nursing,
   Porur, Chennai.

2. Mr. Raja A., M.Sc (N),
   Asst. Professor,
   Dept. of Mental Health Nursing,
   S.S.N.M.M. College of Nursing,
   Varkala.

3. Mr. A. Ian Clement, M.Sc (N),
   Lecturer,
   Dept. of Mental Health Nursing,
   S.S.N.M.M. College of Nursing,
   Varkala.

4. Mr. Justin, M.Sc (N),
   Lecturer,
   Dept. of Mental Health Nursing,
   Nightingale College of Nursing,
   Trivandrum.

5. Mrs. Beena,
   Clinical Psychologist,
   Dept. of Psychiatry,
   Dr. S.M.C.S.I Medical College Hospital,
   Karakkonam.

6. Dr. K. Girish,
   Clinical Psychologist,
   M.H.C. Peroorkada,
   Trivandrum.

APPENDIX – E

SECTION – A

DEMOGRAPHIC DATA

Instruction: Read the following items carefully and complete them by placing a (X) mark in the space provided.

Sample Number:

1**. Age**

a.60 – 69 years ( )

b.70 – 79 years ( )

c. 80 and above ( )

2. **Education**

a. Degree ( )

b. Hr. Secondary ( )

c. High School ( )

d. Primary ( )

e. Illiterate ( )

3. **Type of Family**

a. Joint Family ( )

b. Nuclear Family ( )

4. **Monthly Family Income**

a. <Rs. 5,000/- ( )

b. ≥Rs. 5,000/- ( )

5. **No. of living children**

a. 1 or 2 ( )

b. >3 ( )

SECTION - B

MODIFIED WELLBEING ASSESSMENT TOOL

Read the following statements carefully and put a (X) mark on the space provided under that which best describes you.

Physical Wellbeing	**Rarely**	**Some times**	**Most of the time**	**Always**
1. I feel good about the condition of my body.	( )	( )	( )	( )
2. My appetite is good.	( )	( )	( )	( )
3. I find difficult to sleep.	( )	( )	( )	( )
4. I am able to avoid most infectious diseases.	( )	( )	( )	( )
5. I do exercises designed to strengthen my body.		( )	( )	( ) ( )
6. I can perform things actively.	( )	( )	( )	( )
7. I need help from others to do my activities.	( )	( )	( )	( )
8. I have a very bad memory.	( )	( )	( )	( )

9. I find difficult to even sit and stand. ( ) ( ) ( ) ( )

10. I have problem in my bowel and bladder habits. ( ) ( ) ( ) ( )

Social Wellbeing	**Rarely**		**Some times**	**Most of the time**	**Always**
1. I engage myself in variety of social activities	( )	( )	( )	( )	( )
2. It is difficult for me to adjust with my family members.	( )	( )	( )	( )	( )
3. I respect the feelings of others.	( )	( )	( )	( )	( )
4. I'm open and honest to others.	( )	( )	( )	( )	( )

5. I can share my feelings with others. ( ) ( ) ( ) (
)

6. I am impatient to others. ( ) ( ) ( ) (
)

7. People irritate me. ( ) ( ) ( ) (
)

8. I listen patiently to what others say. ( ) ( ) ( ) (
)

9. I am selfish. ( ) ( ) ( ) (
)

10. People feel happy about me ( ) ( ) ( ) (
)

Emotional Wellbeing	**Rarely**	**Some times**	**Most of the time**	**Always**

1. I am happy ( ) ( ) ( ) (
)

2. I can sit down and relax quietly ( ) ( ) ( ) (
)

3. I shout at others when I feel tensed ( ) ( ) (
) ( )

4. I have an uncomfortable feeling in the stomach ( ) ( ) (
) ( )

5. I get angry with myself ( ) ( ) ( ) (
)

6. I get scared for no very good reasons. ( ) ( ) ( ) (
)

7. I am a chronic worrier. ( ) ( ) ( ) (
)

8. I consider myself inferior to others. ( ) ( ) ( ) (
)

9. My friends consider me as an emotionally
strong person. ( ) ( ) ( ) ( )

10. I am flexible to changes and I can adjust
easily to those changes. ( ) ( ) ( ) (
)

Spiritual Wellbeing	**Rarely**		**Some**	**Most Always**
	times	**of the time**		
1. I consider life as a priceless treasure.	( )	( )	( )	( )
2. I take time to enjoy nature.	( )	( )	( )	( )
3. I take time to think about what's important in life.	( )	( )	( )	( )
4. I have belief in the importance of things beyond myself.	( )	( )	( )	( )
5. I engage in acts of caring and good will without expecting something in return.	( )	( )	( )	( )
6. I feel sorrow for those who are suffering and try to help them in difficult times.	( )	( )	( )	( )
7. I feel confident that I have touched the lives of others in a positive way.	( )	( )	( )	( )
8. I work for peace in my interpersonal relationships, in my community, and in the				

world at large. ( ) ( ) ( ) ( )

9. I am content with who I am. ( ) ( ) ( ) ( )

10. I experience life to the fullest. ( ) ( ) ( ) ( )

Intellectual Wellbeing	**Rarely**	**Some times**	**Most of the time**	**Always**
1. I tend to act impulsively without thinking about the consequences.	( )	( )	( )	( )
2. I learn from my mistakes and try to act differently the next time.	( )	( )	( )	( )
3. I follow directions or recommended guidelines and act in ways likely to keep others and myself safe.	( )	( )	( )	( )
4. I consider the alternatives before making decisions.	( )	( )	( )	( )

5. I am not ready to respond to life's challenges. ( ) ( ) ( ) ( )

6. I tend to let my emotions and act without thinking. ( ) ( ) ( ) ( )

7. I am not good in making decisions. ( ) ( ) ( ) ( )

8. I manage my time well. ( ) ( ) ( ) ( )

9. My friends and family trust my judgment. ( ) ( ) ( ) ( )

10. I am unable to concentrate while doing any work. ( ) ( ) ( ) ( )

APPENDIX – F

eyd; kjpg;gPL ml;ltiz gl;oay;

புள்ளி விபரப் பட்டியல்

1. **தங்கியிருக்கும் இடம்** : கிராமபுரம், நகர்புறம்

2. வயது

a. 60 – 69

b. 70 – 79

c. 80- க்கு மேலே

3. கல்வி தகுதி :

a. படிக்காதவர்

b. தொடக்கக்கல்வி

c. மேல்நிலைக்கல்வி

d. பட்டதாரி

4. மாத குடும்ப வருமானம் :

a. < Rs.5,000/-

b. > Rs.5,000/-

5. குடும்பம் :

a. தனிக்குடும்பம்

b. கூட்டுக்குடும்பம்

6. பிள்ளைகள் :

a. 1 அல்லது 2

b. > 3

வ. எ ண்	உடல் நலன்	எப்பொழுதாவது இல்லவே இல்லை	சில சமயம்	பெரும்பாலான நேரம்	எப்பொழுதும் எல்லா நேரமும்
1.	எனது உடல் நலத்தைக் குறித்து மகிழ்ச்சி அடைகிறேன்	( )	( )	( )	( )
2.	எனக்கு நன்றாக பசியெடுக்கிறது	( )	( )	( )	( )
3.	நான் தூங்குவதில் சிரமப்படுகிறேன்	( )	( )	( )	( )
4.	தொற்றுநோய்களை என்னால் தவிர்க்க முடிகிறது	( )	( )	( )	( )
5.	நான் உடம்பை வலுவாக வைத்துக் கொள்வதற்கான உடற்பயிற்சிகளை மேற்கொள்கிறேன்	( )	( )	( )	( )
6.	சோர்வில்லாமல் எனக்கு வேலைச் செய்ய முடிகிறது	( )	( )	( )	( )
7.	எனது கரியங்களை செய்வதற்கு பிறர் உதவி எனக்கு தேவைப்படுகிறது	( )	( )	( )	( )
8.	எனக்கு ஞாபகமறதி இருக்கிறது	( )	( )	( )	( )
9.	எழுந்து நடப்பதற்கும் நிற்பதற்கும் எனக்கு சிரமமாயிருக்கிறது	( )	( )	( )	( )
10.	சிறுநீர், மலம் கழிப்பதில் எனக்கு பிரச்சினை உள்ளது	( )	( )	( )	( )

வ. எண்	சமூக நலன்	எப்பொழுதாவது இல்லவே இல்லை	சில சமயம்	பெரும்பாலான நேரம்	எப்பொழுதும் எல்லா நேரமும்
1.	அநேன சமூக நிகழ்வுகளில் நான் பங்கெடுத்துக் கொள்கிறேன்	( )	( )	( )	( )
2.	குடும்ப அங்கத்தினர்களுடன் ஒத்துபோவது எனக்கு கடினமாயிருக்கிறது	( )	( )	( )	( )
3.	மற்றவர்களது உணர்வுகளுக்கு நான் மதிப்பளிக்கிறேன்	( )	( )	( )	( )
4.	நான் வெளிப்படையாகவும் நேர்மையாகவும் மற்றவர்களிடம் பழகுகிறேன்	( )	( )	( )	( )
5.	எனது உணர்வுகளை பகிர்ந்து கொள்ள எனக்கு வாய்பிருக்கிறது	( )	( )	( )	( )
6.	நான் மற்றவர்களிடம் பொறுமையாய் நடந்து கொள்வதில்லை	( )	( )	( )	( )
7.	பிறர் என்னை எரிச்சலடைய செய்கிறார்கள்	( )	( )	( )	( )
8.	நான் பெறுமையோடு மற்றவர்கள் கூறுவதை கவனிக்கிறேன்	( )	( )	( )	( )
9.	நான் சுயநலத்தோடு செயல்படுகிறேன்	( )	( )	( )	( )
10.	மற்றவர்களிடம் நான் பழகும்போது அவர்கள் என்னைக் குறித்து மகிழ்ச்சியடைகிறார்கள்.	( )	( )	( )	( )

வ. எண்	மன நலன்	எப்பொழுதாவது இல்லவே இல்லை	சில சமயம்	பெரும்பாலான நேரம்	எப்பொழுதும் எல்லா நேரமும்
1.	நான் மகிழ்ச்சியுடன் இருக்கிறேன்	( )	( )	( )	( )
2.	எனக்கு நன்றாக ஓய்வெடுத்துக் கெள்ள முடிகிறது	( )	( )	( )	( )
3.	உணர்ச்சிவசப்பட்டு மற்றவர்களிடம் நான் சத்தம் போடுகிறேன்	( )	( )	( )	( )
4.	எனது வயிற்றில் பட்டாம் பூச்சி பறப்பது போன்ற உணர்வு எனக்கு ஏற்படுகிறது	( )	( )	( )	( )
5.	என்னைக் குறித்து நான் எரிச்சலடைகிறேன்	( )	( )	( )	( )
6.	நான் தேவையில்லாமல் பயப்படுகிறேன்	( )	( )	( )	( )
7.	நான் துக்கமுடையவராய் காணப்படுகிறேன்	( )	( )	( )	( )
8.	நான் தாழ்வுமனப்பான்மை உடையவர்	( )	( )	( )	( )
9.	நான் மனவலிமை உடையவர் என்று எனது நண்பர்கள் கருதுகிறார்க்ள	( )	( )	( )	( )
10.	மாற்றங்களுக்கு ஏற்ப என்னை வளைந்துக்கெடுத்து அதனை அனுசரித்து போகிறேன்	( )	( )	( )	( )

வ. எண்	ஆன்மீக் நலன்	எப்பொழுதாவது இல்லவே இல்லை	சில சமயம்	பெரும்பாலான நேரம்	எப்பொழுதும் எல்லா நேரமும்
1.	வாழ்க்கை என்பதனை விலைமதிப்பில்லா பொக்கிஷமென கருதுகிறேன்	( )	( )	( )	( )
2.	இயற்கையை ரசிப்பதற்காக நான் நேரத்தை ஒதுக்குகிறேன்	( )	( )	( )	( )
3.	இந்த வாழ்க்கையில் எனது முக்கியமான பங்கு என்ன என்பதை உணர்ந்து கொள்ள நான் நேரம் எடுத்துக்கொள்கிறேன்	( )	( )	( )	( )
4.	எனக்கும் மேலான காரியங்களில் எனக்கு நம்பிக்கை இருக்கிறது	( )	( )	( )	( )
5.	கைமாறு கருதாமல் நான் பிறருக்கு உதவுகிறேன்	( )	( )	( )	( )
6.	துன்பப்படுபவர்களுக்காக நான் வருத்தப்பட்டு அவர்களுக்கு உதவுகிறேன்	( )	( )	( )	( )
7.	அநேகருடைய வாழ்க்கையில் நல்லதொரு தாக்கத்தை நான் ஏற்படுத்தியிருக்கிறேன்	( )	( )	( )	( )
8.	சமுதாயத்தின் சமாதானத்திற்காக நான் உழைக்கிறேன்	( )	( )	( )	( )
9.	என்னைக் குறித்து நான் திருப்தி அடைகிறேன்	( )	( )	( )	( )
10.	வாழ்க்கையை முடிந்தவரை நன்றாக அனுபவிக்கிறேன்	( )	( )	( )	( )

வ. எண்	அறிவு நலன்	எப்பொழுதாவது இல்லவே இல்லை	சில சமயம்	பெரும்பாலான நேரம்	எப்பொழுதும் எல்லா நேரமும்
1.	பின்விளைவுகளைக் குறித்து சிந்திக்காமல் கொடூரமாக செயல்படுகிறேன்	( )	( )	( )	( )
2.	எனது தவறுகளை திருத்திக் கொண்டு அது மீண்டும் ஏற்படாதவாறு கவனமாய் இருக்கிறேன்	( )	( )	( )	( )
3.	நான் பரிந்துரைக்கப்பட்ட விதிமுறைகளை கடைபிடிக்கிறேன்	( )	( )	( )	( )
4.	பல வழிகளை ஆராய்ந்து பின்னரே ஒரு முடிவை எடுக்கிறேன்	( )	( )	( )	( )
5.	நான் சவால்களை எதிர்கொள்ள தயாராக இல்லை	( )	( )	( )	( )
6.	எந்த ஒரு செயலையும் யோசிக்காமல் செய்கிறேன்	( )	( )	( )	( )
7.	நான் சரியாக முடிவெடுப்பதில்லை	( )	( )	( )	( )
8.	எனது நேரத்தை கவனமாய் செலவழிக்கிறேன்	( )	( )	( )	( )
9.	எனது உறவினர்களும், நண்பர்களும் நான் எடுக்கும் முடிவை மதிக்கிறார்கள்.	( )	( )	( )	( )
10.	நான் செய்யும் செயல்களில், என்னால் கவனம் செலுத்த முடியவில்லை	( )	( )	( )	( )

APPENDIX – G

SCORE OBTAINED BY THE RESPONDENTS

Rural Samples

Sample	***Physical Wellbeing***	***Social Wellbeing***	***Emotional Wellbeing***	***Spiritual Wellbeing***	***Intellectual Wellbeing***	***Total Score***
1	53	58	56	58	50	275
2	56	53	56	44	45	254
3	51	51	56	59	52	269
4	64	59	55	59	60	297
5	52	63	54	52	54	275
6	26	24	24	27	31	112
7	62	55	60	51	49	267
8	61	56	69	59	64	309
9	70	57	68	64	61	320
10	63	57	55	64	61	300
11	46	55	62	61	59	283
12	58	59	58	55	59	289
13	59	60	60	63	63	305
14	57	55	60	48	56	276
15	64	60	58	55	59	296
16	58	59	66	54	71	310
17	55	68	48	51	58	280
18	66	72	67	70	72	347
19	54	65	68	55	67	308
20	66	63	69	56	68	322
21	60	54	56	46	53	259
22	63	69	64	66	59	321
23	59	60	50	62	65	296
24	58	61	52	72	61	304
25	48	54	55	50	55	262
26	59	68	55	58	56	296
27	55	57	45	49	43	249
28	51	71	61	73	53	309
29	65	65	72	61	72	335
30	51	53	60	45	48	257

Urban Samples

Sample	***Physical Wellbeing***	***Social Wellbeing***	***Emotional Wellbeing***	***Spiritual Wellbeing***	***Intellectual Wellbeing***	***Total Score***
1	72	64	66	68	62	332
2	60	60	65	52	62	299
3	70	52	64	57	59	282
4	53	60	59	48	56	276
5	57	61	64	68	65	315
6	58	53	43	31	43	228
7	65	61	61	76	65	328
8	49	53	58	57	54	271
9	60	52	65	58	66	301
10	66	66	68	70	69	339
11	50	50	40	37	44	221
12	66	57	65	54	70	312
13	68	61	62	55	57	303
14	44	49	55	54	47	249
15	39	52	49	53	49	242
16	69	71	70	73	74	357
17	63	51	58	54	57	283
18	50	41	37	46	33	207
19	46	41	44	49	46	226
20	74	72	71	73	72	382
21	54	57	50	52	55	268
22	29	21	21	30	26	127
23	29	13	23	33	24	122
24	42	44	48	43	40	217
25	49	46	41	44	42	222
26	33	46	37	40	40	196
27	35	46	44	48	50	223
28	61	60	60	64	55	300
29	53	52	49	56	48	258
30	49	50	47	39	49	234