The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study

By
Disha Biswas

February 2023, Held in February 2024

This thesis is submitted in total fulfilment of the requirements for the subject RESEARCH 2 & 3 and partial fulfilment of the requirements for the degree of

Bachelor of Science in Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

Faculty of Medicine

University of Dhaka

Thesis completed by:

Disha Biswas
4th year, B.Sc. in Occupational Therapy
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

…….
Signature

Supervisor's Name, Designation, and Signature

Shamima Akter
Associate Professor
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

…….
Signature

Co-Supervisor's Name, Designation, and Signature

Luthfun Nahar
Lecturer
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

…….
Signature

Head of the Department's Name, Designation, and Signature

Sk. Moniruzzaman
Associate Professor & Head
Department of Occupational Therapy
Bangladesh Health Professions Institute (BHPI)
Centre for the Rehabilitation of the Paralysed (CRP)
Chapain, Savar, Dhaka: 1343

…….
Signature

Board of Examiner

Statement of Authorship

To affirm that the thesis entitled "The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study" has been completed by Disha Biswas, DU Roll No. 438 in the Department of B.Sc in Occupational Therapy, Bangladesh Health Professions Institute, Savar, Dhaka, Bangladesh. Except where it is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for any other degree or seminar. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any other degree in any other tertiary institution. The ethical issue of the study has been strictly considered and protected. In case of dissemination of the findings of this project for future publication, the research supervisor will be highly concerned, and it will be duly acknowledged as an undergraduate thesis.

Disha Biswas

4th year, B.Sc. in Occupational Therapy

Department of Occupational Therapy

Bangladesh Health Professions Institute (BHPI)

Centre for the Rehabilitation of the Paralysed (CRP)

Chapain, Savar, Dhaka: 1343

..……

Signature

Acknowledgement

I am glad that I could accomplish my thesis journey. As this Bible verse says, “I can do all things through Christ who strengthens me, Pillippines 4:13”. Indeed, I could only accomplish these or come this far by My LORD who was with me and strengthened me every time I asked for His help and guidance. And I also want to say thanks to my family, my parents, my sister who were also part of my journey and they were like a shield for me who gave me courage and provided a place for solace and reassurance.

I would like to acknowledge and give honor to my respected supervisor Shamima Akter ma’am and co-supervisor Luthfun Nahar ma’am for constant guidance, support and encouragement. I am also thankful to Md. Saddam Hossain sir and Arifa Jahan Ema ma’am for their support and guidance in my research. I would like to thank Professor Dr. Carol D. Ryff for giving permission to use and translate her Psychological Well-being scale and Theresa Berrie for contacting me and providing me with all the necessary documents and manual on behalf of Dr. Ryff. I also want to show gratitude to my department, Department of Occupational Therapy and Review Board for the constant guidance and feedback. Finally, I would not be able to complete my thesis without these two people, Md. Abdul Hafiz, the coordinator of Khola Janala Old Age Home and Assistant Professor Md. Mohsin Kabir Limon, Manager of old home of Bangladesh Association for The Aged & Institute of Geriatric Medicine (Probin Nibash). I want to thank them from the bottom of my heart for their permission to collect data from their organization and for the support they provided me during the data collection process. And thanks to my friends who were with me through challenges and helped me whenever I sought their support.

Dedication

Firstly, I want to dedicate my thesis to my LORD, Jesus Christ and secondly to my grandparents, To late Mr. Shushil Biswas and Mrs. Taru lota Biswas, late Mr. Chitto Ranjon Bairagee, late Mrs. Noni Bairagee.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

BAAIGM	Bangladesh Association for the Aged and Institute of Geriatric Medicine
BHPI	Bangladesh Health Professions Institute
CHD	Coronary Heart Disease
CRP	Centre for the Rehabilitation of the Paralysed
GSE	General Self-Efficacy
IRB	Institutional Review Board
NGO	Non-governmental Organization
OT	Occupational Therapy
OTs	Occupational Therapists
PWB	Psychological Well-Being
QoL	Quality of Life
SE	Self-Efficacy
TV	Television
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization
WMA	World Medical Association

Abstract

Background: As Bangladesh's population ages, new challenges are emerging. The traditional family structure is changing, and more elderly people are living apart from their families. This shift, along with the increase in residential care facilities, is changing how older adults are cared for. To improve the quality of life for older adults in Bangladesh, it's important to understand how different living arrangements affect their self-efficacy and their psychological well-being.

Aim: To investigate the self-efficacy and psychological well-being of elderly individuals residing in community and residential care facilities in Bangladesh.

Methods: The study employed a cross-sectional quantitative design, conducting face-to-face surveys among 159 elderly individuals, with 106 from the community and 53 residing in care facilities in Bangladesh. Data were collected using Ryff's 42-item Psychological Well-Being Scale and the General Self-Efficacy Scale and analyzed using descriptive statistics in SPSS 20 and Spearman's Rank correlation, Mann-Whitney U, Kruskal Wallis H tests.

Result: The study found that elderly individuals living in the community generally reported higher levels of psychological well-being and self-efficacy (mean = 4.08 ± 0.71 and 2.83 ± 0.84, respectively) compared to those residing in care facilities (mean = 3.28 ± 0.92 and 2.32 ± 1.028, respectively) with significant comparison analysis between these two groups ($p= 0.006$, $p= 0.000$). Additionally, correlation analysis indicated a positive correlation between self-efficacy and psychological well-being in both groups, particularly stronger in residential care facilities. Sociodemographic associations highlighted various factors influencing psychological well-being and self-efficacy in each setting, such as age,

marital status, educational qualification, mobility status, allowance, technology usage, leisure participation, community volunteering, social engagement, financial security, and satisfaction with living arrangements.

Conclusion: The findings suggest the importance of tailored interventions addressing sociodemographic factors to enhance psychological well-being and self-efficacy among elderly individuals in both community and residential care settings.

Keywords: Psychological Well-Being, Self-Efficacy, Older adults, Old home, Community Dwelling, Residential Care Facilities, Elderly Care.

CHAPTER I: INTRODUCTION

1.1 Background

Ageing is an inevitable process that is usually determined by chronological age (S. Singh & Bajorek, 2014). People 60 years of age and above are considered elderly citizens in Bangladesh (S. Rahman, 2017). The current global elderly population is 674 million, representing 8.9% of the world's population, according to the United Nations Population Division (United Nations Department of Economic and Social Affairs [UNDESA], 2019). By 2050, this number is anticipated to increase to 2.1 billion (World Population Ageing, 2017). In 2024 life expectancy for Bangladesh is 73.82 years and it increased by 0.34% from 2023 (MacroTrends, 2024). At this rate by 2050, it is predicted that 42.2 million elderly people would reside in Bangladesh (Haque et al., 2014, as cited in Alam et al., 2021). According to the main report of the Population and Household Census-2022, there are around 15.3 million people in this country who are over 60. They make up 9.28% of the entire population. In the 2011 census, this percentage was only 7.47% (Population and Housing Census, 2022; Prothom Alo, 2022). In a period of time shorter than that required by advanced countries, it is plausible that Bangladesh's population demography will change, with a higher percentage of older people and less number of young people (United Nations Fund for Population Activities [UNFPA], 2013, as cited in Kabir et al., 2016). Offspring in Bangladesh have always been expected to take care of their parents' emotional, instrumental, and financial needs. Parental care is viewed as both a moral and a very important religious requirement. 82% of older parents live with at least one adult offspring, indicating that intergenerational cohabitation is highly common (Ghuman & Ofstedal, 2004). Elderly people are frequently neglected and abused, especially in households with

low incomes. In a population-based study conducted in rural Bangladesh, researchers discovered that 45% of the subjects displayed depression symptoms (Wahlin et al., 2015, as cited in Amin, 2017). In Bangladesh, the progressive expansion of the nuclear family has also made older people more socially isolated, rendering them more vulnerable to physical and mental health issues (The Daily Star, 2016; Z. Islam, 2017, as cited in Sarker, 2021). Nowadays, the elderly often dwell alone because members of their family are too busy doing other responsibilities to spend enough time with them. Offspring now live in cities to earn a living or for their education, and because of their hectic lifestyle, they are unable to visit their elderly parents. Consequently, they feel lonely and isolated (M. Rahman & Ali, 2007). These issues have increased the significance of residential care facilities in the current sociodemographic environment. Elderly care facilities may therefore prove to be one way to offer stability in old life in the developing world, despite being a Western idea. In our country, the idea of old homes is growing (M. Rahman & Ali, 2007). There are 6 government and non-specific number of private residential care facilities in Bangladesh (Ministry of Social Welfare, 2022). The ones that exist frequently have too few members of staff to operate efficiently and lack the required resources to cope with the challenges of elderly individuals (Bangladesh Bureau of Statistics, 2015).

In order to properly adjust to everyday life and manage with life events, psychological well-being (PWB) has been defined as the balance between their expectations, desires, and visions, as well as realistic or attained reality, which can be portrayed as fulfillment (Molina & Meléndez, 2006). According to Ryff, PWB is a multifaceted, subjective concept that each person can define as the purpose and meaning of their own lives (Ryff and Singer, 2002; Ortiz and Castro, 2009, as cited in Toledano-

González et al., 2018).

A person's sense of self-efficacy (SE), or belief in individual's capacity to impact life events in life (Bandura, 1978), has been connected to a development of elderly individuals' self-care and their perceptions of healthy aging. It has been established that SE acts as a mediator between changes in health behaviors and how they are used in the healthcare system. SE has also been associated with higher levels of fulfillment in life, good sleep, greater energy, and less pain and distress in older adults (Kostka & Jachimowicz, 2010). Improving SE in elderly people is critical since it has been related to improved overall health and improved resilience to the development of depression (Scult et al., 2015). According to the literature, there are many people who struggle with low SE and depression, which results in a condition of poor quality of life (QoL) and well-being (Corcoran et al., 2016, as cited in Toledano-González et al., 2018).

So, conducting the study will bring out the real picture of SE and PWB of older adults in both context where they are living in community and at residential care facilities in Bangladesh.

1.2 Justification of The Study

1.2.1 Importance for Elderly Individuals in Bangladesh

Elderly population in Bangladesh, like in many parts of the world, frequently encounter difficulties in maintaining their independence, PWB, and overall QoL. This study aims to better understand and address these challenges by exploring the role of Occupational Therapy (OT) in enhancing their well-being. This research ultimately seeks to improve the lives of older adults by shedding light on the benefits of holistic interventions and the

importance of psychological factors like SE, also by providing them with effective tools and strategies to lead fulfilling and independent lives in their later years.

1.2.2 Importance in Occupational Therapy

In the subject of gerontology and geriatrics, OT is crucial because it helps patients become more independent, reinforce their development, and prevents disability, all of which enhance their QoL. Given that the patients are older adults, it is essential to improve their well-being and QoL through occupational therapy (Kielhofner, 2006, as cited in Toledano-González et al., 2018). Many older people today struggle to perform daily activities normally, but OT assessments frequently place sole emphasis on functional level, ignoring psychological factors, particularly the sense of competence and how it can affect the successful implementation of any type of activity we want to develop (Kirby et al., 2015, as cited in Toledano-González et al., 2018). OT might also be suitable due to its holistic approach, which aims to enhance the patient's functioning and overall well-being rather than only treating the impairment (Fine, 2001). Literature shows that OT improve in all the domains of PWB and in sense of SE (Toledano-González et al., 2018). The goal of treatments should not only be to increase a person's abilities and capacities, but also to address other factors that have the potential to enhance SE, wellbeing, affective state, and personal independence (Toledano-González et al., 2019).

1.2.3 Importance for Bangladesh

According to their minimum needs, elderly people should be involved in the development and implementation of programs and policies (Uddin et al., 2010). The nongovernmental organization (NGO) in Bangladesh is successful in its various programs for mothers and children, but it lacks visible initiatives to improve the support systems for the elderly. The

aged support facility should be run cooperatively by the government and nongovernmental organizations (N. Islam & Nath, 2012). The demographic shift towards an aging population is a demographic reality in Bangladesh. This research is pivotal as it addresses a pressing need to develop effective healthcare strategies and support systems for older citizens.

In conclusion, this research holds immense importance as it directly benefits older people by enhancing their QoL, empowers occupational therapists (OTs) by enriching their practice, and contributes to the well-being of the aging population in Bangladesh, ultimately fostering a more compassionate and supportive society for its elderly citizens.

1.3 Operational Definition

1.3.1 Psychological Well-Being (PWB)

"PWB encompasses self-acceptance, the creation of strong relationships with others; a feeling of independence in thinking and behavior; the capacity to control complicated situations to meet one's needs and values; the pursuit of meaningful goals and a sense of purpose in life; and ongoing personal development. Autonomy, environmental mastery, personal growth, positive relations with others, purpose in life, and self-acceptance are the six areas of PWB" (Ryff, 1989; *News | Wabash College*, 2005).

1.3.2 Self-Efficacy (SE)

"According to Bandura, 1977, SE is a person's unique set of beliefs that influence how successfully they can carry out a plan of action in possible situations. In simple terms, SE is a person's belief in their ability to succeed in a particular situation" (Bandura, 1977).

1.3.3 Elderly

"Although there isn't currently a clear numerical criterion set by the United Nations (UN), the elder population is defined as those who are 60 years of age or older" (WHO -

Definition of An Older or Elderly Person | PDF | Ageing | Old Age, n.d.). “The process of getting older is referred to as aging. According to the United Nations, anyone older than 60 is considered an older person. People 60 years of age and above are considered elderly citizens in Bangladesh” (S. Rahman, 2017).

1.3.4 Community

“A widely accepted definition of community is a collection of individuals with varying characteristics who are connected by social connections, have similar perspective, and work together in certain settings or locations” (MacQueen et al., 2001).

1.3.5 Residential Care Facilities

“Elderly people sometimes can no longer live in their own homes in a secure or comfortable manner because of the lack of support from family. There is a possibility that they will go to a residential setting, which includes assisted living, nursing homes, board and care homes, and continuing care retirement communities. A residential care facility can aid an older person’s needs by ensuring long-term care services. Some facilities offer only housing and housekeeping, but many also provide personal care, social and recreational activities, meals, and medical services” (National Institute on Aging, 2023).

1.4 Aim of the Study

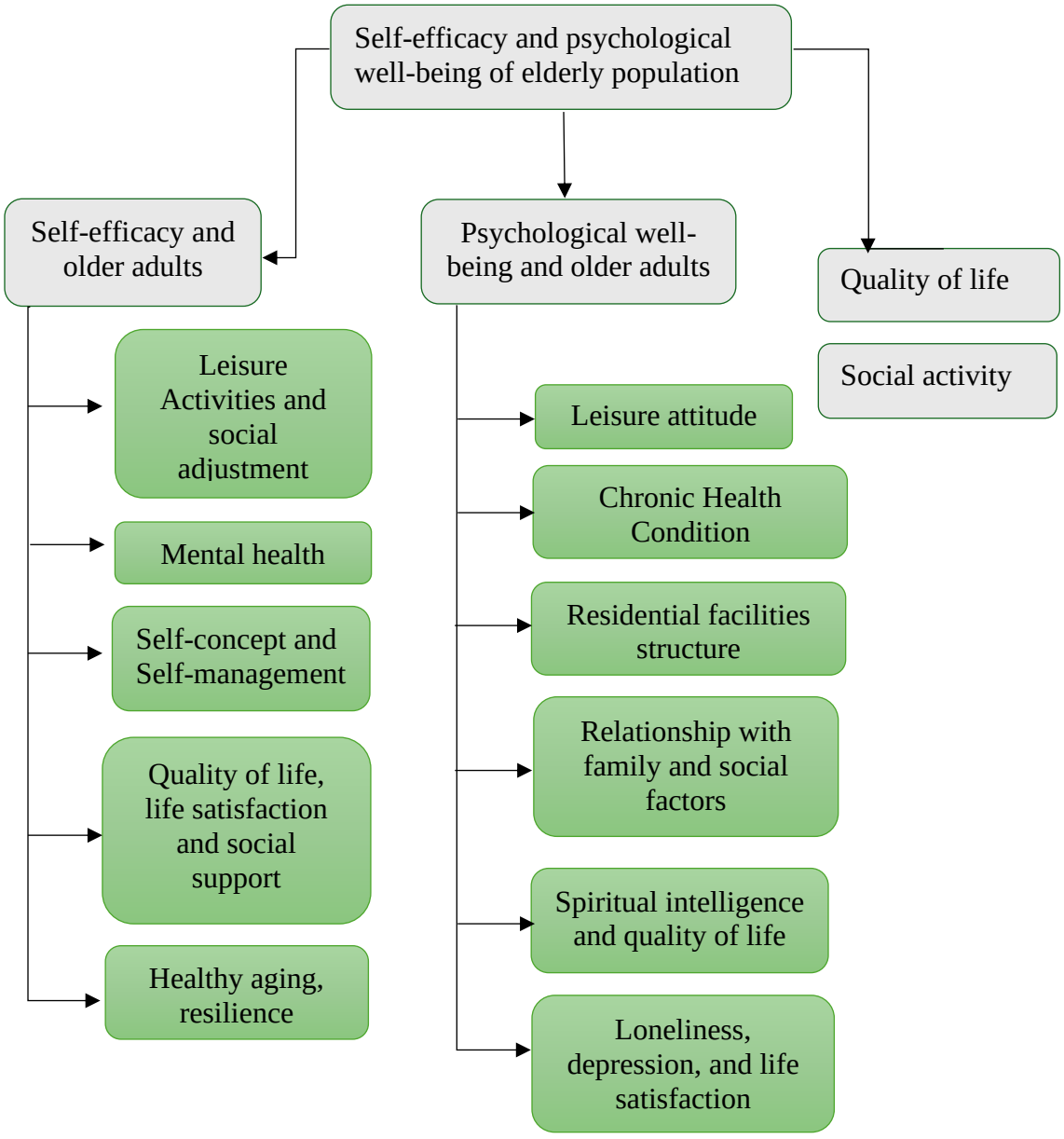
The aim of this study is to investigate the SE and PWB of elderly individuals residing in both community and residential care facilities in Bangladesh.

CHAPTER II: LITERATURE REVIEW

In this part, recent research was examined on the connection between SE and the PWB of the elderly across a range of contexts. In this review, significant gaps were identified in the knowledge of this topic and given a brief overview of the current studies.

Figure 2

Overview of Literature Findings



2.1 Self-efficacy and Elderly Population

SE and other variables such as their mental health, quality of life, life satisfaction, leisure activities, social adjustment, social support, healthy aging, resilience, self-concept and self-management are correlated with the elderly population in different settings: hospitals, nursing homes, community centers and community dwellings (Bum et al., 2021; Hosseingholizadeh et al., 2019; Kahe et al., 2018; Shaabani et al., 2017; Remm et al., 2023; Li et al., 2022; Kim, 2020; Bagheri-Nesami et al., 2013).

2.1.1 Mental Health

According to a cross-sectional study, promoting SE can improve elderly' mental health. The 480 elderly coronary heart disease (CHD) patients in rural Hebei Province, China, who participated in the study ranged in age from 60 to 85 years old, with 251 (52.3%) male patients and 229 (47.7%) female patients. However, because the study only included older people with a condition, it cannot be applied to elderly people without CHD (Li et al., 2022).

2.1.2 Quality of Life, Life Satisfaction and Social Support

According to the findings of a cross-sectional descriptive-analytic study done among 210 older people living in Tehran nursing homes in Iran, an increase in SE among nursing home residents aged 65 and older was associated with an improvement in their QoL. The amount of education and SE are significantly correlated. Additionally, reported a strong association between QoL and age (P=0.047) and education level (P=0.038) (Shaabani et al., 2017). According to another study, there are favorable links between SE, QoL, and a fourth factor called social support. In contrast, stress, the number of diseases, depression is inversely correlated with QoL among 113 elderly in their 60 or up, residing in cities in

South Korea. But due of the language hurdles, the procedure and settings were not made apparent (Kim, 2020). Also social support and SE significantly associated with life satisfaction was found in a cross-sectional study. This study was conducted among 129 elderly individuals of community in Sari, Iran. Additionally, they discovered a strong relationship between demographic factors including home condition and financial status and life satisfaction. Enhancing the social support and SE of elderly people can raise their life satisfaction. Only the abstract of this entire Persian-language article was available in English (Bagheri-Nesami et al., 2013). Another cross-sectional study of 456 elderly, 60 to 74 years, who were members of community centers in Tehran, Iran, revealed that social support and SE both influence social participation. This finding indicates the significance of social support and SE in social participation. Also sociodemographic factors like gender, level of education, reading habits, and living arrangements were also related to social participation (Hosseingholizadeh et al., 2019).

2.1.3 Leisure activities, Social Adjustment

A cross-sectional study looked at how active, passive, and sociable leisure activities influenced immigrants' SE and social adjustment in South Korea. The findings indicate that those who engage in active or social leisure activities have a high perception of their own SE and social adaptability among elderly population (Bum et al., 2021).

2.1.4 Healthy Aging, Resilience

Cross-sectional research of 143 older persons (mean age 79) in three public hospitals in Sydney, Australia, revealed positive correlations between SE, resilience, and healthy aging. Reduced mobility, physical activity, and mood were more frequently reported by those with poorer SE and resilience. The results show that despite the drawbacks of co-

morbidities, fostering resilience and SE may be able to support healthy aging in both the physical and psychological fields (Remm et al., 2023).

2.1.5 Self-Concept and Self-Management

A cross-sectional study enrolled 217 elderlies and 60-95 years; among these, 144 were women, and 73 were men from the sanatoriums of Tehran, Iran. The results showed that self-concept and SE could forecast approximately 14 percent of self-management, indicating strong links between these variables and self-management. Concluding that self-management improves by increasing the self-concept and SE of older adults. However, the study was exclusively for the elderly residents of nursing homes and cannot be generalized to the whole population (Kahe et al., 2018).

2.2 Psychological Well-Being and Elderly Populations

PWB of older adults is correlated with chronic health conditions, positive leisure attitude, loneliness, depression, life-satisfaction, social factors, spirituality, relationship with families and also with the structure of residential facilities in different settings such as retirement centers, nursing homes and who are living alone or with their children in the community (Jena et al., 2018; Kovalenko & Spivak, 2018; Rodríguez-cifuentes et al., 2024; Tang et al., 2020; Manca et al., 2019; Shamsabadi et al., 2022; Zamani et al., 2018; Lim & Kua, 2011; Almira et al., 2019; Homan, 2016; R. Singh & Bisht, 2019).

2.2.1 Chronic Health Conditions

A cross-sectional study in Denmark intended to evaluate the relationship between chronic health conditions and PWB across various age groups. Out of 10,781 participants, 35.7% were between 50 to 64, and 32.9% above 65. The study found that living with one or more chronic conditions, such as cardiovascular, endocrine, kidney, musculoskeletal, or cancer

conditions and mental, lung, neurological, gastrointestinal, or sensory condition, was connected with lower PWB across age groups (Tang et al., 2020).

2.2.2 Positive Leisure Attitude

In Spain a cross-sectional study with correlational design set out to explore the associations among leisure attitude, PWB and self-rated health. Simple random probability sampling was used to select participants of 409 elderly with a Mean age of 72.9 where 61.9% female, age ranging from 53-93 years. The results revealed a positive effect of leisure attitude on self-rated health and PWB (Rodríguez-cifuentes et al., 2024).

2.2.3 Residential Facilities Structure

High score of PWB is related with the high-humanization structure and user centered design of residential care facilities for older adults along with residential satisfaction and perceived environmental qualities seen in the 114 elderly (N = 114, females 67.54%, 65 to 98 years old) in 11 residential care facilities in Sardinia (Italy) (Manca et al., 2019).

2.2.4 Loneliness, Depression, and Life Satisfaction

According to a correlational study of 115 elderly people, 83 men and 32 women, aged 65 to 85, who were referred to retirement homes in Tehran, Iran, PWB and executive function are negatively linked to loneliness while PWB is directly correlated to executive function in older adults (Shamsabadi et al., 2022). In the Singapore Longitudinal Aging Study, a prospective cohort study of 2808 elderly with mean = 66 years where 211 (7.5%) were living alone and 344 (11.9%) are feeling lonely. The findings reveal that older adults who live alone have worse PWB, experience loneliness, and have depressive symptoms. However, they also have higher levels of social engagement and greater cognitive, and functional, medical disabilities as well as depressive symptoms (Lim & Kua, 2011). In a

correlational study, PWB were found as strong safeguards against depression where 120 subjects were selected randomly from Bhubaneswar, India (Jena et al., 2018). Also a cross-sectional study in the United States with 126 participants (89 women and 37 men) and their age rang 59-95 recruited from a community library and a senior day center revealed that self-compassion is positively and distinctively related to PWB and also associated with self-rated health, depression, and age of older adults (Homan, 2016).

2.2.5 Relationship with Family and Social Factors

To uncover various social elements influencing the PWB of elderly, a study examined 325 individuals of the Poltava region of Ukraine, ranging in age from 57 to 86 years. According to a study, elders who live with their families and have more trustworthy relationships with others generally have higher PWB than those who do not. The elderly's poor psychological health is a result of a variety of societal circumstances, including retirement and unemployment. Other elements include social isolation, health status, people's timetables and will, financial situation, etc. (Kovalenko & Spivak, 2018). A correlational study suggests, the PWB of 102 elderly parents who live with their children in Indonesia was negatively correlated with traits like lack of empathy, intrusion, failure to give needed assistance, and rejection or neglect from the child. They were between the ages of 60 and 88. forty-two percent of participants lived with their own children and grandkids, and the majority (74.5%) lived in three-generational households (Almira et al., 2019).

2.2.6 Spiritual Intelligence and Quality of Life

A quasi-experiment study was done consisting of 50 elderlies living in nursing care home in Bandar Abbas city, Iran. Education on spiritual intelligence for two months was received by intervention group. PWB and quality of life of elderly significantly improved after the

intervention suggesting the importance of spiritual intelligence for elderlies (Zamani et al., 2018). And in a cross-sectional study, 200 non-institutionalized and institutionalized elderly (over 65 years) from old age homes in Uttarakhand, India, and non-institutionalized elderly from the localities near to the old homes were evaluated for their level of spirituality and PWB using scales. Regardless of setting, the study's results showed that females have higher degrees of spirituality while males have greater level of PWB. However, this study found no link between spirituality and PWB (R. Singh & Bisht, 2019).

2.3 Self-Efficacy and Psychological Well-Being of Elderly Population

No studies were found which correlated only SE and PWB. But some variables such as QoL and social activity were associated along with SE and PWB of older adults (Bagheri et al., 2022; Lara et al., 2020; Fu et al., 2018).

2.3.1 Quality of Life

According to a correlational descriptive study, SE had a direct, significant correlation with both PWB and QoL. This study consisting of 200 elderly living in Tehran, Iran, who were chosen using convenience sampling also found that PWB had a direct positive relationship and indirectly related to QoL through SE. The material was published in Persian rather than English, therefore it was unable to determine the study's setting (Bagheri et al., 2022).

2.3.2 Social Activity

A cross-sectional study found that engagement in social activities, satisfaction with the physical surroundings, and social support all have a positive correlation with PWB. Also, 307 residents from seven nursing homes in Shanghai, China's Yangpu District found that social interaction partially mediated the effect of SE on PWB. Of these residents, 67.8% were female and 64.2% were between the ages of 80 and 90 (Fu et al., 2018). The

environment of nursing homes was not specifically evaluated in the current study. In another cross-sectional study, 154 Spanish elderly age ranging from 65 to 96 participated. In a province in southern Spain, the sample was drawn from a variety of locations, including private houses, public spaces, old homes, day centers, recreational facilities, and adult schools. When mental health status is considered, SE is a significant contributor to happiness in older people, and its benefits are dependent on two well-established psychosocial resources for wellbeing: optimism and social support. Self-efficacious elders appear to be more likely to experience well-being and increased happiness when social support and positivity are moderate to high (Lara et al., 2020).

2.4 Conclusion

Studies were found for elderly population in institutional based care such as, community centers, sanatoriums, nursing homes, hospital, retirement centers, residential care facilities in Iran, Australia, Italy, Spain, China. Different studies being done on community dwelling elderly population in rural, urban and cities and some living alone and also living with their families in China, Korea, India, Iran, Ukraine, Singapore, Indonesia. Comparatively fewer studies were found which were done in both institutionalized and non-institutionalized.

2.5 Key Gaps

- Scarcity of Bangladesh-specific literature regarding the SE and PWB and both variables of older adults is notable, as there may be diverse situations compared to international perspectives, given that Bangladesh has unique cultural and socio-economic perspectives.

- No study was accessible for the researcher on SE and PWB of elderly population in both institutionalized and community settings in Bangladesh and global perspective.
- Lack of accessibility of the study comparing the correlation of SE and PWB of older adults in both settings.
- Limited knowledge in socio-demographic association is with SE and PWB in Bangladesh perspective.

CHAPTER III: METHODS

3.1 Study Question, Aim, Objectives

3.1.1 Study Question

- What are the levels of SE and PWB among elderly individuals in community and residential care facilities in Bangladesh?
- Is there a significant correlation between SE and PWB among elderly individuals in community and residential care facilities in Bangladesh?
- What sociodemographic factors are associated with the levels of SE and PWB among elderly individuals in community and residential care facilities in Bangladesh?

3.1.2 Aim

The aim of this study was to investigate the SE and PWB of elderly individuals residing in both community and residential care facilities in Bangladesh.

3.1.3 Objectives

- To measure the SE levels among elderly individuals in community and residential care facilities in Bangladesh using a validated assessment tool.
- To measure the PWB levels of elderly individuals in community and residential care facilities in Bangladesh through standardized psychological assessments.
- To conduct a comparative analysis of SE and PWB between elderly individuals in community and residential care facilities in Bangladesh.
- To investigate the correlation between SE and PWB among elderly individuals in community and residential care facilities in Bangladesh.
- To identify sociodemographic factors associated with SE and PWB among elderly individuals in community and residential care facilities in Bangladesh.

3.2 Study Design

3.2.1 Study Method

The study used the quantitative research method, which is an intended, formalized, systematic method using statistics from the study in order to analyze or quantify SE and PWB of elderly population in Bangladesh and produce findings (Borry, 2012). Quantitative research, compared to qualitative, deal with numerical data or can be turn into numbers. Statistical techniques were being used for organizing, analyzing and interpreting the numerical data for this study (Sheard, 2018).

3.2.2 Study Approach

The Observational and descriptive-analytical cross-sectional study approach was used for this study. The researcher assessed the study populations' exposures and outcomes at the same time in a cross-sectional study. This descriptive cross-sectional study characterized the prevalence of the outcome. And as being analytical cross-sectional study, it aimed to compare and analyze differences and relationship by gathering information on independent variables or exposure which is their living arrangements, one is elderly individual living independently or with family in the community and another is elderly individual residing in facilities like old homes in Bangladesh and the dependent variables or outcomes which are PWB and SE at a single moment in time so that differences in outcomes was compared between people who were exposed. This study, although primarily focusing analyzing the variables this study also had descriptive elements in characterizing the living arrangements and the outcomes. so this was an analytical cross-sectional study with descriptive components (Wang & Cheng, 2020). This analytical cross-sectional study provided a ‘snapshot’ of the SE and PWB of older adults and the characteristics associated with it, at

a specific point in time and assessed relations among these parameters, comparing between elderly dwelling in community and in residential care in Bangladesh. It was used to identify patterns and mean, make predictions for future, evaluate correlations, and generalize findings to larger populations. Among all the study design and approach this study design serves best to accomplish my study objectives (Setia, 2016; Levin, 2006).

3.3 Study Setting and Period

3.3.1 Study Setting

This research study on SE and PWB among elderly individuals in Bangladesh encompassed two study settings for data collection: residential care facilities for the elderly and community-dwelling elderly individuals.

3.3.1.1 Residential Care Facilities. The first study setting involved data collection from various residential care facilities in Bangladesh. Although researcher have chosen possible list of residential care facilities for data collection, due to various reasons many residential facilities denied the access for the researcher and did not give permission to collect data. Finally, the researcher collected data from two old homes who gave permission under some conditions.

Khola Janala Old Home- located in Niribili, Falguni Housing, Nabinagar, Savar which specifically aims to provide assistance to elderly and claim that every segment of the society is represented among their clientele of Bangladesh. They offer nursing and medical services and food to elderly people and give attention to every individual's PWB (Khola Janala old home).

Bangladesh Association for the Aged and Institute of Geriatric Medicine (BAAIGM) located Probin Bhaban, E-10, Agargaon, Dhaka which is non-political, non-

governmental residential care facility that aim to combat the helplessness of elderly population and facilitate arrangements for health care, security, housing, food, clothes, leisure, and revenue-generating activities for elderly (Old Home – Bangladesh Association for the Aged and Institute of Geriatric Medicine).

3.3.1.2 Community-Dwelling Elderly. In addition to collecting data from residential care facilities, the study also included community-dwelling elderly individuals who reside in rural and urban area of Bangladesh. This includes elderly living alone or with their spouse or with their family members in community. The goal was to ensure a comprehensive representation of elderly individuals, both in residential care and living in community.

3.3.2 Study Period

The total study period was between May 2023 to February 2024 and data collection period was 1st December 2023 to 31st December 2023.

3.4 Study Participants

3.4.1 Study Population

In this research the target population was the complete set of individuals aged 60 and older in Bangladesh, who were living either in the community or in residential care facilities. This population represented the broader group to which this study's findings can be applied (Majid, 2018). This study population was narrowed down to focus on those individuals who met the specific criteria relevant to the research objectives.

3.4.2 Sampling Technique

Sampling Method is the method that researcher used to collect the estimated sample for this study (Setia, 2016). Two different sampling techniques were used in this research

because of the two different study settings and to make the sampling process valid and without any bias.

In Residential care facilities. The initial step involved creating a comprehensive list of residential care facilities across Bangladesh. The convenience sampling method which included using respondents who are "convenient" for the researcher was used during this study and researcher got permission only from two residential facilities from the list. So convenience sampling was best fitted which involved choosing participants based on their availability overcoming the research-related constraints (Galloway, 2004; Taherdoost et al., 2016).

In communities. Initially convenience sampling was used to select local communities convenient for the researcher. Then purposive sampling was used where key informants assisted for identification of eligible elderly participants from the selected communities. This sampling was used as it depended on the researcher's judgment in choosing the study population who could produce acceptable and useful information according to the established aim and objectives of this study (Sharma, 2017; Campbell et al., 2020; Taherdoost et al., 2016). These methods were employed sequentially to ensure a comprehensive and contextually appropriate participant recruitment process.

3.4.3 Inclusion and Exclusion Criteria

Inclusion Criteria

- Participants aged 60 years or older.
- Based on living arrangements two groups were included in the study: Inclusion Group 1 (Community-Dwelling Elderly): Individuals who were currently residing in their own homes, apartments, or with family members in a community setting in

Bangladesh and Inclusion Group 2 (Residential Care Facilities): Individuals who were currently living in residential care facilities, including nursing homes, assisted living facilities, or similar care settings in Bangladesh.

- Participants who were willing to provide informed consent to participate in the study.

Exclusion Criteria

- Participants with severe cognitive impairment preventing them from participating in the study.
- Individuals who were unable to provide informed consent due to reasons such as severe illness, psychiatric conditions.
- Individuals with a terminal illness with a life expectancy of less than six months, as determined by medical records or assessment.
- Participants with severe communication impairments that hindered their participation, even with assistance or alternative communication methods.

3.4.4 Sample Size

The sample size for this study was estimated using the Cochran formula.

$$\text{Sample size, } n = \frac{Z^{2\times} pq}{d^2}$$

Here,

Population Proportion (p): The estimated proportion of the elderly population was 9.28% (Population and Housing Census, 2022).

Confidence Interval: The desired confidence level for this study is 95%, corresponding to Z value of 1.96.

Level of Precision (d): A level of precision of 5% (0.05) is selected.

Complement of Population Proportion (q): q = 1 - p = 1 - 0.0928 = 0.9072

$$\text{Sample size, } n = \frac{(1.96)^2 \times 0.0928 \times 0.9072}{(0.05)^2}$$

$$= 129.36$$

Considering a 10% non-response rate, the adjusted sample size is:

Adjusted Sample Size = n + (10% of n) = 129.36 + 12.936 = 142.297 ≈ 143

Rounding up to the nearest whole number, the estimated sample size for this study was approximately 143 participants. During the data collection researcher collected data from 53 samples from two above mentioned residential care facilities and to compare the data, since community-dwelling elderly individuals typically constitute a larger proportion in Bangladesh context researcher collected data from 106 sample in community. So, the total sample size was 159 from which the researcher collected data to assess and compare their SE and PWB.

3.5 Ethical Consideration

3.5.1 Ethical Approval from IRB

The ethical clearance was given to the study from Institutional Review Board (IRB) of Bangladesh Health Professions Institute after explaining the research question, aim, objectives, study methods through the department of OT. IRB clearance number: CRP-BHPI/IRB/10/2013/750 (see Appendix A). Researcher adhered to all relevant laws, regulations, and ethical principles governing research involving human participants. Ethical principles of World Medical Association (WMA) which is created for medical studies are followed for the ethics of the studies (World Medical Association, 2022). The

researcher also sought permission from potential old homes across Bangladesh. And after getting permission through signed applications from two old home one was Khola Janala-Old Age Home and another was Bangladesh Association for The Aged & Institute of Geriatric Medicine (BAAIGM)- Old Home (Probin Nibash). (see Appendix A)

3.5.2 Informed Consent

Researcher ensured that all willing participants were informed about objectives, purpose and process of the research with fully understood on what they were agreeing with which includes possible risks and benefits through an information sheet. Researcher also took signed consent through a consent form to obtain written informed consent with a concise overview of the study and its methodologies, the possible benefits and issues of participation, duration, and the researcher's contact information confirming the willingness and informed involvement (see Appendix B).

3.5.3 Right of Refusal to Participate or Withdraw

Participants were fully free to choose whether they would or not participate in the study. Participants having right to withdraw their participation from the study whenever and without penalty was also ensured with a withdrawal form which was attached with the consent form (see Appendix B).

3.5.4 Unequal or Power Relationship

In this research, the researcher did not have any unequal or dependent relationship that may influence their decision in participation or providing the data. Also the power relationship was strictly prevented as researcher collected data using standardized questionnaire therefore there was no scope for influencing any participants.

3.5.5 Risk and Beneficence

The participants of the study were not involved in any kind of risks because of the research process. However, the researcher prioritized their safety and well-being. Although participants did not have benefit directly or financially from the researcher, this research result can contribute to benefit of the overall population and future practice regarding elderly individuals.

3.5.6 Confidentiality

In the research protocol, a robust plan was meticulously designed to ensure data protection. Researcher adhered to this strict protocol for data confidentiality and anonymity, protecting participants' identities and personal information as it is meticulously described in detail in the information sheet. Data was stored securely whether it was electronic and physical form, and only authorized personnel who were bound by confidentiality agreement, particularly researcher and supervisor had access to it.

3.6 Data Collection Process

3.6.1 Participants Recruitment Process

Figure 3.6.1

Overview of Participants Recruitment Process

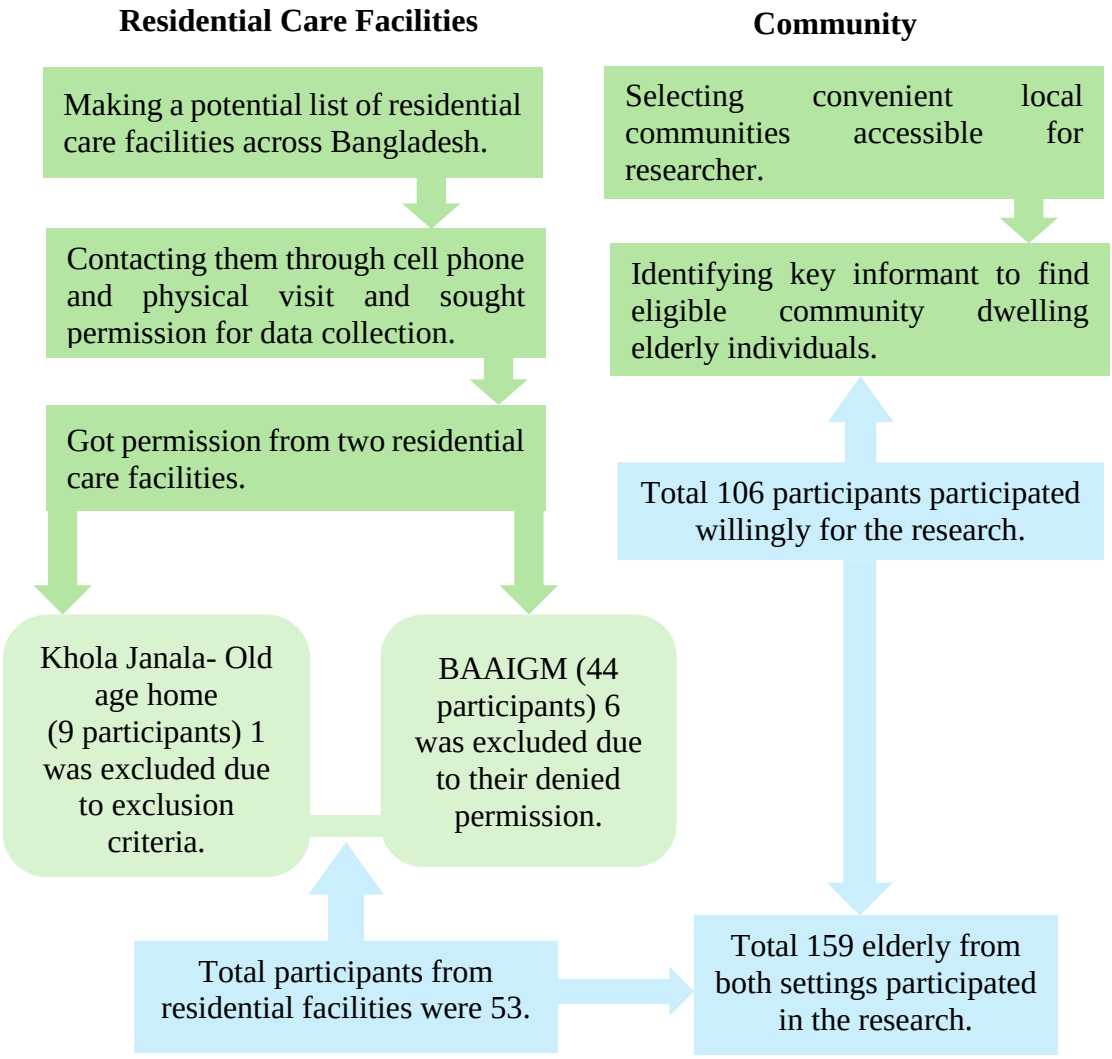


Figure 3.6.1 explains the participant recruitment process where it was divided into two as there were two different study settings. For residential care facilities, first crucial step involved creating a comprehensive list of residential care facilities located across Bangladesh. This list included essential details such as the names of facilities, their physical addresses, and contact information. Then researcher initiated contacting with these

facilities to seek their formal permission to conduct research within their premises. And after meeting with many rejections finally two old homes agreed. In parallel, the researcher actively identified key informants within the conveniently selected community. Overall, 159 was total participants we willingly participated in the study following the above recruitment process.

3.6.2 Data Collection Method

The researcher used face-to-face survey because of its flexibility and conversational interview format where researcher and participant had direct interpersonal interactions. In addition to administering the standardized items from a sociodemographic questionnaire, Ryff's Psychological Well-being Scale, and General Self-efficacy Scale, the researcher was physically present to help the participants explain, comprehend, and assist in answering the questions. (Doyle, 2005; Neuman, 2012).

3.6.3 Data Collection Instruments

Table 3.6.3

Data Collection Instruments

Data collection tools	Type of tools	Subscale	Items	Scoring	Interpretation
Ryff's 42-item Psycho-logical Wellbeing (PWB) Scale	Self-administered	"Autonomy (7) Environmental Mastery (7) Personal Growth (7) Positive Relations with Others (7) Purpose in Life (7) Self-Acceptance (7)"	42 items	6-point Likert scale	"There are no defined scores or cut-points to determine high or low well-being."
Generalized Self-Efficacy Scale (GSES)	Self-administered		10 items	4-point Likert scale	"The sum determines the final score. A higher score denotes greater self-efficacy."

By utilizing which the above Table 3.6.3 mentioned established and well validated and reliable instruments (Ryff, 2013; Scholz et al., 2002), Ryff's Psychological Well-being Scale-42 items (Ryff & Keyes, 1995; Ryff, 1989), General Self-efficacy scale (Schwarzer et al., 1995) the researcher aimed to ensure a consistent approach for data collection, enabling a comprehensive examination of both PWB and SE among the elderly population in Bangladesh. To gather socio-demographic information a self-developed questionnaire was utilized as shown in Appendix C. Researcher used two different questionnaires appropriate for two study settings.

3.6.4 Field Test

As preliminary survey to a subset of the intended audience, researcher conducted field test with three elderly people residing in the staff quarter within CRP premises. For the field test, researcher used Bengali translated questionnaire through forward and backward translation of the data collection instruments. Through this field test enriched the researcher perspective of what is in a "real world" setting and the challenges and how to bring out the actual responses. The field test aided in refining survey questions. Some wording of the Bengali questionnaire was simplified without changing the actual meaning for the sake of respondent's better understanding. General Self-Efficacy Scale items 1, 2 and 7 were changed slightly from the initial translation. And from the Ryff's Psychological Wellbeing scale items 1, 25, 27, 34 and 37 were changed to maintain the quality of the data.

3.7 Data Management and Analysis

Data management is the systematic method of handling, organizing, and guaranteeing the quality and accessibility of data during the study period. In this study, data management began with gathering data through face-to-face surveys using standardized questionnaires.

The data was then processed, cleansed and loaded into Statistical Package for Social Science (SPSS) version 20 to convert the raw data appropriate for analysis. After fixing duplicate entries or inconsistency, data storage on Google Cloud was ensured for the data to be conveniently accessible, safe. Then most important aspect was to conduct data analysis which accomplished the goals and objectives of the study. Researcher used descriptive statistics analysis to calculate means, standard deviations and frequency distributions for PWB and SE of elderly individuals in both groups. After checking the normality and assumptions of the tests, the non-parametric Mann-Whitney U test was used to compare the outcome variables and correlation between these was analyzed using Spearman's rank correlation coefficient. Sociodemographic variables were analyzed using Mann-Whitney U test alternative to independent sample t-test for the variables with two categories and Kruskal Wallis H test alternative to one way ANOVA for more than two categories (Trochim, 2004; T. Islam, 2020). Next stage involved data sharing process with supervisors to ensure data quality while maintaining privacy and ethical compliance. And to disseminate the findings and insights gained from the data analysis it was expressed through tables, and reports. The data preservation and archiving stage ensured that the information was now stored in a secure and accessible manner. After ten years, data will be safely destroyed to safeguard privacy. These procedures were guided by the framework called the research data management cycle (Manu & Gala, 2018).

3.8 Quality Control and Quality Assurance

Quality control and quality assurance was maintained throughout the study period starting form choosing the appropriate study design that best suited with the aim and objectives of this study and sampling method and sampling size which represented the target population

accurately. Moreover, researcher followed the standardized procedures and have done field test and made necessary improvement beforehand to maintain the quality of the research. Researcher used two standardized questionnaires to assess the PWB and SE which has established literature to prove their reliability and validity. The description of above section 3.7 on how researcher followed the steps and guidelines of data management makes the quality control and assurance of this research more evident. Researcher obtained ethical approval from the institutional review board and undergoing ongoing review to ensure ethical compliance. Researcher maintained transparency in reporting actual data and never tried to influence the result by her own standards adhering to appropriate reporting guidelines. Researcher also involved her responsible supervisors in every step of the research procedure to ensure sound methodology and resolve any issues raised during the feedback process.

CHAPTER IV: RESULTS

This chapter consists of the findings of the study. The study findings are presented in tables and figures. The study objectives were emphasized through the study findings.

4.1 Socio-demographic Characteristics

Table 4.1

Socio-demographic Characteristics of Elderly Individuals in the Community and Residential Care Facilities [Table 4.1 extends from page 30-31]

		Community		Residential facilities	
Variables	**Category**	**n**	**%**	**n**	**%**
Demographic Information					
Age	60 to 69 years	47	44.3	21	39.6
	70 to 79 years	40	37.7	25	47.2
	80 to 105 years	19	17.9	7	13.2
	Mean (± SD) age	71.54 (±8.058) Years		71.83 (±6.226) years	
	Minimum age	60 Years		60 years	
	Maximum age	105 Years		87 years	
Sex	Male	44	41.5	22	41.5
	Female	62	58.5	31	58.5
Marital Status	Married	68	64.2	15	30
	Widowed	36	34.0	26	52
	Divorced	2	1.9	0	0
	Single	0	0	9	18
Education	Primary Education	35	33	10	20
	SSC*	15	14.2	8	16
	HSC*	18	17	5	10
	Undergraduate	12	11.3	3	6
	Postgraduate	5	4.7	5	10
	Illiterate	11	10.4	14	28
	Signature	10	9.4	5	10
Health and Mobility status					
Mobility Status	Independent	82	77.4	27	50.9
	Dependent	24	22.7	26	49.1
Chronic Health Condition	Yes	70	66	34	69.4
	No	36	34	15	30.6

		Community		Residential facilities	
Variables	**Category**	**n**	**%**	**n**	**%**
Financial Status					
Financial Dependency	Yes	74	71.9	39	86.7
	No	29	28.1	6	13.3
	On Husband	12	11.7	0	0
	On Self	29	28.2	5	17.9
	On Children	60	58.3	11	39.3
	On Grandchildren	2	1.9	0	0
	On relatives	0	0	11	39.3
	On old home	0	0	1	3.6
Financial Security	Secure	73	68.9	7	19.4
	Neutral	16	15.1	16	44.4
	Insecure	17	16	13	36.1
Old Age Allowance	Yes	17	16	7	18.9
	No	89	84	30	81.1
Living Situation					
Satisfaction with their living arrangement	Dissatisfied	22	20.8	13	29.5
	Neutral	15	14.1	12	27.3
	Satisfied	69	65.1	19	43.2
Social Function and leisure					
Social Engagement	Socially engaged	63	59.5	13	33.4
	Not socially engaged	64	40.6	26	66.7
Involved in Community Volunteer Activities	Yes	19	17.9	5	9.8
	No	87	82.1	46	90.2
Use Technology	Yes	66	62.3	24	52.2
	No	40	37.7	22	47.8
Engage in Leisure Activities	Yes	101	95.3	33	73.3
	No	5	4.7	12	26.7

SSC* Secondary School Certificate HSC* Higher Secondary Certificate

The above Table 4.1 shows the overall socio-economic characteristics of elderly individuals in the community and in residential care facilities which includes their age, sex, marital status, educational qualifications, financial status, living situation, health and mobility status, social function and their leisure participation.

4.1.1 Demographic Information

In community dwelling elderly (106), males were 41.5% and female 58.5% interestingly same male and female ratio was found in residential care facilities (53) and in community most were between the age range 60 to 69 which is 44.3% and for residential facilities most of them was between 70 to 79 years old which is 47.2% and the mean age of both setting is similar. In the community most of them were married, which was 64.2%, but in another setting most of them were widowed (52%) but also were living in the facilities despite being married, which was 30%. Most of them had only primary education in community which was 33% on the other hand in residential care facilities maximum residents had no education.

4.1.2 Health and Mobility Status

82 community dwellers among 106 were independent in their mobility which was 77.4% and 22.7 % were dependent who needed from minimal to moderate assistance for mobility. But in residential care facilities the ratio of them being dependent and independent was almost equal. And in both settings almost 70% elderly were suffering from chronic illness that hamper their daily living some sort.

4.1.3 Financial Status

In both setting most of the elderly were financially dependent on others such as on their adult offsprings, grandchildren, relatives but the percentage was higher for elderly in residential facilities while 68.9% felt financially secured in community setting and only 19.4% in these facilities. And in both settings only a few get govt. old age allowance indicating most of the elderly were not involved in the govt. scheme for elderly.

4.1.4 Living situation

Among community dwelling elderly 65.1% were satisfied with their living arrangements but in residential care facilities 43.2% were satisfied.

4.1.5 Social Function and Leisure

Comparatively community dwelling elderly were more socially engaged than the residents of care facilities. And in both settings their participation in community volunteer activities was limited. 62.3% in the community and 52.2% in care facilities used technology such as Television (TV), and mobile phones. And comparatively more elderly individuals engaged in various leisure activities such as reading magazines, newspaper, books, watching TV, gardening, socializing with others, walking, religious practices etc.

4.2 Level of Self-Efficacy of Elderly Individuals

Table 4.2

Level of Self-Efficacy of Elderly Individual in Community and Residential Care Facilities

Items	Community Elders	Residents of Care Facilities
	Mean ± SD	
1. I can always manage to solve difficult problems if I try hard enough.	2.93 ± 1.01	2.28 ± 1.06
2. If someone opposes me, I can find the means and ways to get what I want.	2.92 ± 0.93	2.36 ± 1.12
3. It is easy for me to stick to my aims and accomplish my goals.	2.68 ± 1.01	2.38 ± 1.02
4. I am confident that I could deal efficiently with unexpected events.	2.78 ± 1.03	2.42 ± 1.16
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.	2.90 ± 1.05	2.36 ± 1.14
6. I can solve most problems if I invest the necessary effort.	3.00 ± 1.04	2.43 ± 1.11
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	2.78 ± 1.06	2.32 ± 1.14
8. When I am confronted with a problem, I can usually find several solutions.	2.88 ± 1.05	2.32 ± 1.15
9. If I am in trouble, I can usually think of a solution.	2.69 ± 1.13	2.26 ± 1.11
10. I can usually handle whatever comes my way.	2.81 ± 1.06	2.15 ± 1.21
Overall General Self-efficacy	**2.83 ± 0.84**	**2.32 ± 1.02**

The above Table 4.2 presents the mean scores (± standard deviation) for SE items and the overall general SE among elderly individuals in community and residential care facilities in Bangladesh. Across all SE items, it is evident that community-dwelling elderly individuals tend to have higher mean scores compared to residents of care facilities. This indicates that individuals living in the community perceive themselves as more capable of

solving problems, managing difficulties, and handling unforeseen situations compared to those residing in care facilities. The overall general SE score, calculated as the average of all SE items, also demonstrates a similar trend. Community-dwelling elderly individuals had a higher mean score (2.83 ± 0.84) compared to elderly individuals residing in care facilities (2.32 ± 1.02), indicating a higher overall sense of SE among the former group.

Notably, in community elders expressed relatively high levels of confidence in their efforts, resourcefulness, skills to overcome challenges, as evidenced by the strong agreement with statements such as. “I can solve most problems if I invest the necessary effort (3.00) and I can always manage to solve difficult problems if I try hard enough, mean (2.93) and If someone opposes me, I can find the means and ways to get what I want (2.92) and Thanks to my resourcefulness, I know how to handle unforeseen situations where mean is (2.90).” However, there are slightly lower mean, as illustrated by the statements such as “It is easy for me to stick to my aims and accomplish my goals, (2.68) and If I am in trouble, I can usually think of a solution (2.69).” These discrepancies indicate that while certain aspects of SE are well-established, there are differences in participants' perceptions across specific domains of SE. And here looking into the specific items compared to community dwellers, here their highest mean found (2.43) and (2.42) in the statements of their confidence in solving most of the problems by exerting necessary effort and dealing unexpected events efficiently. The lowest mean (2.15) was found in the statement, I can usually handle whatever comes my way indicating low perception of SE.

These findings suggest that although SE of both groups indicate moderate level living in the community may be associated with greater perceived SE among elderly individuals in Bangladesh. Community-dwelling elderly individuals may feel more

confident in their abilities to handle challenges, solve problems, and cope with unexpected events compared to those living in residential care facilities. This difference could be attributed to various factors such as autonomy, social support networks, and a sense of independence that community living offers. However, it's important to note that the standard deviations were relatively high, indicating variability in SE levels within each group. This variability suggests that individual differences and unique circumstances may influence SE perceptions among elderly individuals, regardless of their living arrangement.

4.3 Level of Psychological Well-Being of Elderly Individuals

Table 4.3

Level of Psychological Well-Being of Elderly Individuals in Community and Residential Care Facilities

	Community Elders	**Residents of Care Facilities**
	Frequency %(n)	
Overall Psychological Well-Being		
(1.14- 2.76) Low well-being	3.8 (4)	30.2 (16)
(2.77- 4.39) Moderate well-being	65.1 (69)	60.4 (32)
(4.40- 6.00) High well-being	31.1 (33)	9.4 (5)
	Community Elders	**Residents of Care Facilities**
	Mean ± SD	
Overall Psychological Well-Being	4.08 ± 0.71	3.28 ± 0.92
Sub-Scales		
Autonomy	4.27 ± 0.96	3.85 ± 1.02
Environmental mastery	4.00 ± 0.89	2.90 ± 0.96
Personal growth	3.59 ± 0.83	3.02 ± 1.13
Positive relation with others	4.51 ± 0.91	3.81 ± 1.07
Purpose in life	3.75 ± 1.03	2.77 ± 1.02
Self-acceptance	4.38 ± 0.96	3.31 ± 1.43

The above Table 4.3 depicts the level and frequency of overall PWB and mean scores (± standard deviation) for overall PWB and its six subscales among elderly individuals in community (106) and residential care facilities (53) in Bangladesh. Overall PWB was measured by subtracting the minimum score (mean=1.14) from the maximum score (mean= 6.00), and it was categorized into 3; low well-being (1.14- 2.76), moderate (2.77- 4.39) and high well-being (4.40- 6.00). Although both in community and care facilities

they exhibited moderate level of well-being, community dwelling elderly individuals had higher mean score (4.08 ± 0.71) compared to elderly residing in care facilities (3.28 ± 0.92) where 65.1% in community and 60.4% in care facilities were in moderate level but in care facilities 30.2% were in low level whereas only 3.8% had low levels of wellbeing for community dwelling elderly.

Now looking into further specification of individual subscales the highest mean for community dwelling elderly was of the 'Positive Relation with Others' (4.51) that falls in the category of high level suggesting that they have warm and trusting relationships and capable of empathy, affection. But for residents of care facilities, 'Autonomy' (3.85) had the highest mean for them indicating that the residents of these facilities tend to be more self-determined, independent and evaluate themselves on their personal standard. 'Positive Relation with Others' subscale which is also comparatively higher among the residents of care facilities (3.81). In community subscales, 'Purpose in life' (3.75) and 'Personal growth' (3.59) exhibited comparatively lower mean but still in moderate level. Similarly, the subscale 'Purpose in life' also is the lowest mean 2.77 for the residents of care facilities which is lower border of moderate level suggesting their lack of sense in meaning and direction of life having few or no goals and aims across the participants of residential care facilities. It is evident that at later stage of life with age the purpose for living and setting goals in life and sense of further development and taking part in new experiences die down.

This comparative analysis of PWB in elderly individuals residing in both community and residential care facilities reveals that while community-dwelling elderly individuals demonstrated a strong focus on positive relationships and self-acceptance, with a subtle shift away from pursuing new goals and personal growth, in residential care

facilities’ elderly residents displayed priorities in autonomy, suggesting a crucial need for a sense of independence and self-determination. Despite shared emphasis on positive relations, the residential care group showcased challenges in environmental mastery and purpose in life domains. This understanding shed light on the diverse well-being dynamics, underscoring the importance of tailored approaches in fostering PWB based on living arrangements and individual needs. However, it's important to note that the standard deviations are relatively higher for elderly individuals of residential care facilities than in communities suggesting the more individualized and holistic intervention approach for mentioned group.

4.4 Comparison of PWB and SE of Elderly Individuals Between Community Dwellers and Residential Care Facilities Residents

Table 4.4

Comparison of Psychological Well-Being and Self-Efficacy of Elderly Individuals Between Two Groups (Community vs. Residential Care Facilities)

Variables	Elderly individuals	n	Mean Rank	Mann-Whitney U	r= $\frac{\lvert Z \rvert}{\sqrt{N}}$	P
Self-Efficacy	Community	106	87.07	2059.5	0.21	0.006
	Residential Care facilities	53	65.86			
Psychological Well-Being	Community	106	92.82	1450	0.39	0.000
	Residential Care facilities	53	54.36			
Sub-Scales of Psychological Well-Being						
Autonomy	Community	106	86.48	2122	0.19	0.012
	Residential Care facilities	53	67.04			
Environmental mastery	Community	106	95.68	1147	0.48	0.000
	Residential Care facilities	53	48.64			
Personal growth	Community	106	87.66	1997.5	0.23	0.003
	Residential Care facilities	53	64.69			
Positive relation with others	Community	106	89.66	1785.5	0.29	0.000
	Residential Care facilities	53	60.69			
Purpose in life	Community	106	93.75	1351.5	0.42	0.000
	Residential Care facilities	53	52.50			
Self-acceptance	Community	106	91.45	1595.5	0.35	0.000
	Residential Care facilities	53	57.10			

In this comparative study Mann- Whitney U test was used to identify significant differences of PWB and its domains and SE exist between elderly individuals of community and residential care facilities. As it is shown in the table the overall PWB were significantly higher in the community dwellers (Mean rank= 92.82) compared to the residents of

residential care facilities (Mean rank= 54.36), p= 0.000, with a medium effect size r= 0.39 according to (Cohen, 1992) which defines the magnitude of the statistical significant differences between the groups. And further looking at the six domains the test revealed significant differences in all of the domains and community dwelling elderly had higher score in all six domains with small to moderate differences. Statistically significant difference was also found in SE between these groups and here too SE was higher among the community dwellers (Mean rank= 87.07) compared to residential care facilities residents (Mean rank= 65.86), p= 0.006 with a small effect size r= 0.21. According to the finding community dwellers had higher PWB and SE than residents of residential care facilities with effect size r= 0.39, r= 0.21 indicating medium and small significant differences in these two groups and although in all domains community dwellers scored higher they had moderate differences in environmental mastery, purpose in life and self-acceptance and had small differences in autonomy, personal growth and positive relation with others.

4.5 Correlation of Psychological Well-Being and Self-Efficacy of Elderly

4.5.1 Correlation among Subscales of Psychological Well-being and Self-Efficacy of Elderly Individuals in Community

Table 4.5.1

Correlation among Subscales of Psychological Well-being and Self-Efficacy of Elderly Individuals in Community

		A	EM	PG	PR	PL	SA	PWB	SE
Sub-Scales	**A**	1.00							
	EM	.49**	1.00						
	PG	.39**	.49**	1.00					
	PR	.38**	.45**	.32**	1.00				
	PL	.48**	.58**	.63**	.36**	1.00			
	SA	.57**	.61**	.37**	.59**	.38**	1.00		
	PWB	.73**	.79**	.70**	.69**	.76**	.77**	1.00	
	SE	.31**	.39**	.42**	.08	.52**	.19*	.41**	1.00

Note: Autonomy: A, Environmental Mastery: EM, Personal Growth: PG, Positive Relation with others: PR, Purpose in Life: PL, Self-acceptance: SA, Psychological wellbeing: PWB and Self-efficacy: SE.

**. Correlation is significant at the 0.01 level (2-tailed), *. Correlation is significant at the 0.05 level (2-tailed).

According to the objective to determine the correlation between PWB and its domains and SE of elderly individuals in community, spearman's correlation test was done. In this correlation, The spearman correlation analysis showed all domains of PWB were moderate to strong positively correlated with each other in elderly individuals in community. As expected overall PWB was very strongly correlated with all six domains having spearman's rho higher than 0.7. And spearman correlation was tested with SE and overall PWB and its domains. A moderately positive correlation was found with SE and PWB ($r_s = 0.41$, $p < 0.01$) indicating increasing SE causes increased PWB. SE had moderate to strong positive

relation with the domains of PWB. There is moderate positive correlation with 'Autonomy' ($r_s = 0.31$, $p < 0.01$), 'Environmental mastery' ($r_s = 0.39$, $p < 0.01$), 'Personal growth' ($r_s = 0.42$, $p < 0.01$) and had strong correlation with 'Purpose in life' ($r_s = 0.52$, $p < 0.01$). SE of this group had weak ($r_s = 0.19$, $p < 0.01$) but Positive correlation with 'Self-acceptance' and had no correlation ($r_s = 0.08$, $p < 0.01$) with 'Positive relation with others'.

4.5.2 Correlation among Subscales of Psychological Well-Being and Self-Efficacy of Elderly Individuals in Residential Care Facilities

Table 4.5.2

Correlation among Subscales of Psychological Well-Being and Self-Efficacy of Elderly Individuals in Residential Care Facilities

		A	EM	PG	PR	PL	SA	PWB	SE
Sub-Scales	**A**	1.00							
	EM	.51**	1.00						
	PG	.52**	.79**	1.00					
	PR	.40**	.52**	.66**	1.00				
	PL	.59**	.74**	.76**	.55**	1.00			
	SA	.60**	.76**	.85**	.68**	.61**	1.00		
	PWB	.70**	.85**	.92**	.75**	.84**	.90**	1.00	
	SE	.66**	.59**	.71**	.58**	.59**	.66**	.75**	1.00

Note: Autonomy: A, Environmental Mastery: EM, Personal Growth: PG, Positive Relation with others: PR, Purpose in Life: PL, Self-acceptance: SA, Psychological wellbeing: PWB and Self-efficacy: SE.

**. Correlation is significant at the 0.01 level (2-tailed).

The finding of spearman correlation was significant in this group of elderly individuals in residential care facilities. Here all the correlations shown in the table ranged from strong to very strong positive correlations among the domains, SE and overall PWB. Here all the domains were strongly positively correlated with each other. The overall PWB was very strongly correlated with its six domains among the elderly in residential care facilities. And

in correlation with SE and PWB there was very strong positive correlation between SE and PWB having spearman rho (r_s) = 0.75 p < 0.0.1 and with the domains of PWB, SE had very strong positive correlation with 'Personal growth' (r_s = 0.71, p < 0.01) and strong positive correlation with 'Autonomy' (r_s) = 0.66, 'Environmental mastery' (r_s) = 0.59, 'Positive relation with others' (r_s) = 0.58, 'Purpose in life' (r_s) = 0.59 and 'Self-acceptance' (r_s) = 0.66. These statistics suggest that the relation of SE and PWB is more significant in the elderly individuals in residential care facilities than the community dwellers. SE was strongly positively correlated with PWB and vice versa indicating that greater PWB influence to have greater SE and similarly greater SE achieve overall high well-being.

Notably, the correlation between SE and overall PWB was stronger for individuals in residential care facilities (r_s =0.75, p<0.01) compared to community dwellers suggesting importance of focusing these variables on implications for interventions aimed at enhancing the well-being of elderly individuals in different living arrangements.

4.6 Sociodemographic Variables Association with Psychological Well-Being, Self-Efficacy of elderly individuals

4.6.1 Association between Sociodemographic Variables and Psychological Well-Being, Self-Efficacy of Elderly Individuals in Community

Table 4.6.1.1

Mann-Whitney Test for Identifying Significant Difference between Psychological Well-Being, Self-Efficacy and Sociodemographic Variable with 2 Categories in Community

			Psychological Well-Being			Self-Efficacy		
Variable	**Categories (2 levels)**	**n**	**Mean Rank**	**Mann Whitney U**	**P**	**Mean Rank**	**Mann Whitney U**	**P**
Demographic Information								
Sex	Male	44	60.4	1059	0.50	58.4	1147	0.163
	Female	62	48.5			50.0		
Health and Mobility status								
Mobility status	Independent	82	58.9	536.5	**0.001**	58.9	537	**0.001**
	Dependent	24	34.8			34.8		
Chronic health condition	Yes	70	51.4	1118.5	0.345	48.4	903	0.017
	No	36	57.4			63.4		
Financial Status								
Financial dependent	Yes	100	51.8	139	0.829	51.7	128.5	0.673
	No	3	55.6			59.1		
Old age allowance	Yes	17	39.1	512	0.35	28.9	338.5	**0.000**
	No	89	56.2			58.2		
Social Function and leisure								
Socially engaged	Yes	63	60.1	933.5	**0.007**	60.0	941	**0.008**
	No	43	43.7			43.8		
Community volunteer	Yes	19	69.5	522	**0.012**	68.4	543	**0.019**
	No	87	50.0			50.2		
Use technology	Yes	66	58.7	971	**0.023**	56.2	1138	0.235
	No	40	44.7			48.9		
Engage in leisure	Yes	101	54.9	105.5	**0.028**	53.5	249	0.958
	No	5	24.1			52.8		

To identify any significant differences in PWB and SE with Sociodemographic variables with 2 categories (sex, allowance, health condition, mobility status, volunteer activities,

using technology, engagement in leisure and their social engagement and financial dependency) Mann-Whitney U test was conducted.

Difference in PWB based on their Sociodemographic Variables. PWB significantly differed between elderly who were independent in their mobility and who were not ($P = 0.001$, $p < 0.05$) and between who were involved and not involved in volunteer activities ($P = 0.012$, $p < 0.05$), and between who used technology and did not use technology ($P = 0.023$, $p < 0.05$) and between who engaged and did not engage in social ($P = 0.007$) and leisure activities ($P = 0.028$). PWB was higher for them who were independent in mobility, who were involved in community volunteering, who used technology and who engaged in social and leisure activities.

Difference in SE based on their Sociodemographic Variables. SE significantly differed among community dwellers between who got and did not get any old age allowance ($P = 0.000$) and between elderly who were independent in their mobility and who were not ($P = 0.001$, $p < 0.05$) and between who were involved and not involved in volunteer activities ($P = 0.019$, $p < 0.05$) and between who engaged and did not engage in social activities ($P = 0.008$). SE was higher for them who did not get any allowance and who were involved in volunteering, who were independent in their mobility and for them who engaged in social activities.

Table 4.6.1.2

Kruskal-Wallis Test for Identifying Significant Difference between Psychological Well-Being, Self-Efficacy and Sociodemographic Variable with more than 2 Categories in Community

			Psychological Well-Being			Self-Efficacy		
Variable	**Categories (>2 levels)**	**n**	**Mean Rank**	**χ^2**	**P**	**Mean Rank**	**χ^2**	**P**
Demographic Information								
Age	60-69 Y	47	55.84	1.977	0.372	57.47	2.251	0.324
	70-79 Y	40	55.00			52.86		
	80-105 Y	19	44.55			45.03		
Marital status	Married	68	59.79	8.061	**0.018**	57.97	4.528	0.104
	Divorced	2	35.25			60.50		
	Widowed	36	42.63			44.67		
Educational qualification	Primary	35	49.39	4.993	0.545	50.90	8.462	0.206
	SSC*	15	55.97			66.67		
	HSC*	18	64.11			56.56		
	Under-graduate	12	44.63			56.38		
	Postgraduate	5	67.20			67.80		
	Illiterate	11	52.32			36.41		
	Signature	10	50.20			45.55		
Financial Status								
Financial security	Secure	73	58.70	7.216	**0.027**	61.21	15.361	**0.000**
	Neutral	16	45.94			40.66		
	Insecure	17	38.29			32.50		
Living Situation								
Satisfaction with living arrangements	Dissatisfied	22	41.66	11.902	**0.003**	54.82	5.173	0.075
	Neutral	15	36.53			36.90		
	Satisfied	69	60.96			56.69		

To identify any significant differences in PWB and SE with Sociodemographic variables more than 2 categories (age, marital status, education, employment status, financial security, living status, satisfaction with their living arrangements) Kruskal-Wallis test was conducted.

Differences in PWB based on their Sociodemographic Variables. Among the community dwellers elderly PWB significantly differed among who were married, divorced and widowed ($\chi^2 = 8.062$, $p = 0.018$), among who were secure, insecure and neutral about their financial condition ($\chi^2 = 7.216$, $p = 0.027$), among who were satisfied, dissatisfied and neutral about their living arrangement ($\chi^2 = 11.902$, $p = 0.003$). And post-hoc test showed significant differences in widowed and married group ($p = 0.020$) and insecure and secure groups ($p = 0.041$) and neutral and satisfied group and dissatisfied and satisfied group ($p = 0.016$, $p = 0.031$). PWB was higher for who are married, who were financially secure, and satisfied with their living arrangements.

Differences in SE based on their Sociodemographic Variables. Among the community dwellers SE significantly differed among who were financially secure, insecure, and neutral ($\chi^2 = 15.361$, $p = 0.000$) and post hoc test indicated that SE was different in insecure and secure group ($p = 0.020$) and between neutral and secure group ($p = 0.046$). SE was higher for who are financially secure.

These finding indicate that PWB and SE have relationship with sociodemographic factors such as their marital status, sense of financial security, satisfaction with living arrangements, community volunteering, social and leisure participation, their technology use and most importantly their mobility status across the elderly individuals in community.

4.6.2 Association between Sociodemographic Variables and Psychological Well-Being, Self-Efficacy of Elderly Individuals in Residential Care Facilities

Table 4.6.2.1

Mann-Whitney Test for Identifying Significant Difference between Psychological Well-Being, Self-Efficacy and Sociodemographic Variable with 2 Categories in Residential Care facilities

			Psychological Well-Being			Self-Efficacy		
Variable	**Categories (2 levels)**	**n**	**Mean Rank**	**Mann Whitney U**	**P**	**Mean Rank**	**Mann Whitney U**	**P**
Demographic Information								
Sex	Male	22	26.1	322	0.732	26.8	336.5	0.935
	Female	31	27.6			27.1		
Health and Mobility status								
Mobility status	Independent	27	34.6	144.5	**0.000**	35.0	132.5	**0.000**
	Dependent	26	19.0			18.6		
Chronic health condition	Yes	34	23.8	217	0.410	22.8	182.5	0.114
	No	15	27.5			29.8		
Financial Status								
Financial dependent	Yes	39	23.1	112	0.867	22.9	114	0.920
	No	6	22.1			23.5		
Old age allowance	Yes	7	13.4	66	0.130	14.0	70.5	0.179
	No	30	20.3			20.1		
Social Function and leisure								
Socially engaged	Yes	12	24.3	112.5	0.092	26.1	89.5	**0.017**
	No	26	17.8			16.9		
Community volunteer	Yes	5	38.9	50.50	**0.041**	36.0	65	0.112
	No	48	24.6			24.9		
Use technology	Yes	24	28.7	138.5	**0.006**	29.3	123	**0.002**
	No	22	17.8			17.0		
Engage in leisure	Yes	33	25.2	122.5	0.053	25.0	130	0.080
	No	12	16.7			17.3		

To identify any significant differences in PWB and SE with Sociodemographic variables with 2 categories (sex, allowance, health condition, mobility status, volunteer activities, using technology, engagement in leisure and their social engagement and financial

dependency and their family meets up) among elderly in residential care facilities Mann-Whitney U test was conducted.

Difference in PWB based on their Sociodemographic Variables. PWB significantly differed between elderly of residential care facilities who were independent and dependent in their mobility ($P = 0.000$, $p < 0.05$) and between who were involved and not involved in volunteer activities ($P = 0.041$, $p < 0.05$), and between who used technology and did not use technology ($P = 0.006$, $p < 0.05$). PWB was higher for them who were independent in mobility, who were involved in community volunteering and who used technology.

Difference in SE based on their Sociodemographic Variables. SE of elderly individuals in residential care facilities significantly differed between elderly who were independent in their mobility and who were not ($P = 0.000$, $p < 0.05$) and between who used technology and did not use technology ($P = 0.002$, $p < 0.05$) and between who were socially engaged and not socially engaged ($P = 0.017$). SE was higher for them who are independent in their mobility and who used technology and for them who engaged in social activities.

Table 4.6.2.2

Kruskal-Wallis Test for Identifying Significant Difference between Psychological Well-Being, Self-Efficacy and Sociodemographic Variable with more than 2 Categories in Residential Care facilities

			Psychological Well-Being			Self-Efficacy		
Variable	**Categories (>2 levels)**	**n**	**Mean Rank**	**χ^2**	**P**	**Mean Rank**	**χ^2**	**P**
Demographic Information								
Age	60-69 Y	21	27.57	8.165	**0.017**	26.29	6.789	**0.034**
	70-79 Y	25	30.74			31.20		
	80-105 Y	7	11.93			14.14		
Marital status	Married	15	21.94	2.135	0.344	23.50	0.720	0.698
	Divorced	26	22.63			23.80		
	Widowed	9	28.38			27.17		
Educational qualification	Primary	10	21.75	12.302	0.056	20.55	14.197	**0.028**
	SSC*	8	23.44			33.13		
	HSC*	5	27.90			26.70		
	Under-graduate	3	45.33			39.67		
	Postgraduate	5	35.80			37.30		
	Illiterate	14	18.96			17.14		
	Signature	5	30			25.10		
Financial Status								
Financial security	Secure	7	21.79	8.045	**0.018**	21.57	4.565	0.102
	Neutral	16	22.44			21.19		
	Insecure	13	11.88			13.54		
Living Situation								
Satisfaction with living arrangements	Dissatisfied	13	14.73	8.972	**0.011**	14.62	7.326	**0.026**
	Neutral	12	30.08			27.42		
	Satisfied	19	23.03			24.79		

To identify any significant differences in PWB and SE with Sociodemographic variables with more than 2 categories (age, marital status. educational qualification, financial security, satisfaction with living arrangements) among elderly in residential care facilities Kruskal-Wallis test was conducted.

Difference in PWB based on their Sociodemographic Variables. Among elderly in residential care facilities, PWB significantly differed among age groups 60 to 69 years old, 70 to 79 years old and 80 to 105 years old ($\chi^2 = 8.165$, $p = 0.017$), among who were financially secure, insecure and neutral ($\chi^2 = 8.045$, $p = 0.018$), among who were satisfied, dissatisfied and neutral with their living arrangements ($\chi^2 = 8.972$, $p = 0.011$). In Post hoc test of this variable significant difference was found between 80 to 105 years and 70 to 79 years age groups $p = 0.013$, and between who felt insecure and neutral financially, ($p = 0.022$) and between who were dissatisfied and neutral with their living arrangements ($p = 0.008$). PWB was higher in 70 to 79 age groups, who were financially neutral, and who felt neutral with their living arrangements.

Difference in SE based on their Sociodemographic Variables. Among elderly in care facilities SE significantly differed among 60 to 69 years, 70 to 79 years and 80 to 105 years age groups ($\chi^2 = 6.789$, $p = 0.034$) and among their educational qualification ($\chi^2 = 14.197$, $p = 0.028$) and among who were satisfied, dissatisfied and neutral about their living arrangements ($\chi^2 = 7.326$, $p = 0.026$). The Post hoc test revealed significant difference between 80 to 105 years and 70 to 79 years age groups ($p = 0.037$) and who were dissatisfied and neutral ($p = 0.037$) with their living arrangement. SE was higher for 70 to 79 age groups, who had bachelor's degree, and felt neutral with their living arrangements.

The finding can be interpreted that the PWB and SE of elderly of residential care facilities have relationship with sociodemographic characteristics such as their age, educational qualification, financial security and their satisfaction with their living arrangements.

CHAPTER V: DISCUSSION

This study aims to compare and identify different relationships of PWB and SE of elderly individuals residing in community settings and residential care facilities in Bangladesh. Addressing the aim and objectives of this research, the following discussion outlines the key findings, their interpretations, and the broader implications for understanding and supporting the well-being of older adults in distinct living arrangements.

Here the sociodemographic characteristics of elderly individuals, the finding indicates that the elderly were between 60 to 105 years old and mean age for community dwelling elderly individuals (n=106) is 71.54 years and 71.83 years for residential care facilities residents (n= 53). In both setting the female participants were higher than the male. Interestingly the percentage of male and female of both setting was found same which is male was 41.5% and female 58.5%. Likewise in different cross-sectional study was done with elderly individuals, aged 60 to 74 (Hosseingholizadeh et al., 2019) mean age 79 (Remm et al., 2023), 60-95 years old (Kahe et al., 2018) and 65 to 98 years old (Manca et al., 2019) and 65 and 96 (Lara et al., 2020). In some correlational study older adult was aged 65 to 85 (Shamsabadi et al., 2022) and 60 and 88 (Almira et al., 2019). And as in this study female participants were higher similarly in several study 144 were female, and 73 were male (Kahe et al., 2018) and 67.54% females (Manca et al., 2019) and 37 male and 89 female (Homan, 2016) were among the cross-sectional and correlational research of older adults. This is because theory suggest that female live on the average 4-7 years longer than male (Ginter & Simko, 2013).

According to the first objective, for community-dwelling elderly (n=106), they had moderate level of SE (2.83 ± 0.847) on the other hand, elderly individuals in residential

care facilities (n=53) exhibited a lower SE (2.32 ± 1.028), also indicating a moderate level. This finding can be found consistent with other studies. In a cross sectional study in nursing home of elderly in Tehran, Iran, SE of residents of the facilities were found in low level (Shaabani et al., 2017). Also systemic review and meta-analysis shows significant differences in SE of older adults who receives any kind of health services with lower SE among older adults (Whitehall et al., 2021). And looking into specific items, in community, the highest mean score was for the statement showing confidence in their necessary efforts, and lowest mean score for goal accomplishment and sticking to aims. Similar to community dwellers, in care facilities, they had higher mean where they rely on their necessary efforts, but lowest score was found in statements related to problem-solving, handling whatever comes their way. In community, although they are confident in their capabilities, they may face challenges in translating this confidence into achievements and maintaining consistency in their pursuits. In residential care facilities, they scored lowest in statements related to problem-solving and handling whatever comes their way. This is because maybe of varying levels of autonomy and support available in each setting. Elderly individuals in residential care facilities may experience a more structured environment with limited opportunities for decision-making and problem-solving, thus impacting their SE levels. This support the theory that SE is contextual (Luszczynska et al., 2005; Whitehall et al., 2021).

Accordance with second objective, for community-dwelling elderly, the overall PWB indicates a moderate level (4.08 ± 0.71). For elderly individuals in residential care facilities also indicates a moderate level (3.28 ± 0.92) of the overall PWB. A cross sectional study done in Poltava region, Ukraine with 325 elderly found overall low level of PWB in

elderly but found higher level of PWB of elderly individuals who are living with their family then who lives alone (Kovalenko & Spivak, 2018). Another cross-sectional study that examined PWB between non-institutionalized and institutionalized elderly in India found that moderate level of PWB of elderly individuals. These also may be because of factors and cultural and social context (R. Singh & Bisht, 2019). In community, 'Positive relations with others' had the highest mean, emphasizing warm and trusting relationships, but there was a noticeable shift away from 'Personal growth' having the lowest mean score. This finding is consistent with literature as a literature review shows that level of satisfaction in social relationships usually higher for older adults than young generation (Luong et al., 2011). This is because elderly engage in strategies that optimize positive social experiences and with age their ability to manage personal relationships problems also increases (Lang & Carstensen, 1994; Blanchard-Fields, 2007). Also older adults are often treated with more positivity and forgiveness by others in community than the younger adults (Fingerman & Pitzer, 2007, as cited in Luong et al., 2011). Literature suggests that 'Personal growth' may decline in older age due to various factors such as physical limitations, cognitive changes, and shifting priorities (Keyes, 2012). In residential care facilities they emphasized 'Autonomy' however, challenges in 'Purpose in life' domains were evident in this group. The theory behind high autonomy among older adults in residential care facilities can be because of self-determination theory which suggests that individuals have an innate psychological need for autonomy and in the context of residential care facilities, older adults opportunity to exercise autonomy may be higher because here they live alone and control their various expect such as daily routines but in community older adults may be dependent of their family members in decision making

(Deci & Ryan, 2008). Another study also suggest that when older adults perceive that they have the freedom to make choices and decisions they are more likely to experience a greater sense of empowerment and self-determination, leading to higher autonomy (Chen & Schulz, 2016). Also, older adults in this setting may face limitations in their ability to pursue new activities or purpose due to factors such as physical health issues, cognitive decline, or reduced opportunities for social engagement. As a result, they may prioritize maintaining autonomy rather than seeking new purposes in life. Also the socio-emotional selectivity theory suggest that as individuals age, they prioritize emotionally meaningful experiences over acquiring new knowledge or achieving future-oriented goals (Carstensen, 2006).

As per third objective, in the comparative analysis community dwellers exhibited higher overall PWB and SE compared to residents of residential care facilities, with a medium and small effect size ($r = 0.39$, $r = 0.21$), signifying a meaningful difference. Specifically, community dwellers scored higher in all domains of PWB. Community dwelling elderly had overall higher in PWB because many study suggest that elderly people who lives with family and with others have higher level of PWB than who lives alone both in community and residential care facilities (Lim & Kua, 2011; Kovalenko & Spivak, 2018). Another study in India found significant difference in psychological level among the elderly living in the families and old age home (Tandon, 2017).

With the forth objective of this study, in the term of correlation with PWB and SE, in community moderate positive correlation was found between SE and PWB ($r_s = 0.41$, $p < 0.01$). SE had moderate to strong positive correlation with the domains of PWB. And in residential care facilities very strong positive correlation was found between SE and PWB

along with its domain ($r_s = 0.75$ $p < 0.01$) suggesting that the correlation of SE and PWB is significant in the elderly individuals in residential care facilities than the community dwellers. But in both groups this correlation indicates that increase in PWB or its domains can cause increased SE and vice versa. SE is correlated with the mental health of elderly, a research done in rural Hebei Province found positive correlation of SE with mental health of elderly people (Li et al., 2022). Another study in Tehran, Iran also found SE had a direct positive relationship with PWB (Bagheri et al., 2022). Studies that measured SE with general self-efficacy scale found positive associations between higher levels of SE and better PWB across different populations and contexts (Schwarzer et al., 1995). Another study find that individuals with higher SE are more likely to engage in prosocial behaviors and report greater life satisfaction (Caprara & Steca, 2005). A cross-cultural study examining the relationship between general SE and various domains of human functioning, demonstrate consistent positive associations between SE beliefs and well-being across diverse cultural contexts (Luszczynska et al., 2005).

The final objective to find sociodemographic relationships, for community-dwelling elderly, PWB was associated with their marital status, mobility status, usage of technology, leisure participation, community volunteering, social engagement, financial security and their satisfaction with living arrangements. SE was associated with their allowance, mobility status, community volunteering, social engagement and their financial security. In residential care facilities, PWB was associated with their age, mobility status, usage of technology, financial security, community volunteering and their satisfaction with living arrangements. SE was associated with their age, educational qualification, mobility status, usage of technology, social engagement and their satisfaction with living

arrangement. Several associations found here in the study is consistent with other studies such as age, mobility status, satisfaction with living arrangement, education and social engagement, leisure activities. SE and PWB has strongly positive correlation with physical activities and functional status (Juwita, 2022; Hung et al., 2013). Age is related with PWB, studies shows that progressive decline of PWB with age (Steptoe et al., 2015). Higher PWB are related with the satisfaction of living arrangement where, significant positive correlations emerged between elders' PWB and perceived environmental qualities (Manca et al., 2019). In the several studies of Iran, they found significant correlation between the education level and SE also SE is lower for the elderly with chronic disease, and who lives alone (Shaabani et al., 2017; Aslani et al., 2017). Another study in Denmark shows that chronic health condition was connected with lower PWB across age groups (Tang et al., 2020). The influence of social engagement on PWB and SE also found in several studies (Hosseingholizadeh et al., 2019; Whitehall et al., 2021). Several studies found positive leisure attitude and participation positively influence SE and PWB in South Korea and Spain (Bum et al., 2021; Rodríguez-cifuentes et al., 2024).

CHAPTER VI: CONCLUSION

6.1 Strengths and Limitations

6.1.1 Strengths

- This study employed two standardized scale Ryff's psychological well-being scale and General self-efficacy scale enhancing the validity and comparability of the results with the permission from the author.
- Researcher used forward and backward Bengali translated questionnaire in order to align it with cultural context and did a field test for validity and reliability.
- The calculated sample sized was 143 but ultimately with a sample size of 159 participants (106 community dwellers and 53 residential care facility residents), the study provides a substantial dataset for analysis, contributing to the reliability of the findings.
- This study maintained the adherence to the correct methodology and ethical boundaries.

6.1.2 Limitations

- Many residential facilities denied access for data collection.
- Even after having permission to collect data from the residents, these old home's authority provided some restrictions to ask some sociodemographic questions.
- As being the data collection tool a self-report measures so there may be potential for social desirability bias or subjective interpretation.
- There may have some mistakes considering the novice researcher.

6.2 Practice Implication

6.2.1 Recommendation for Future Practice

- OTs can utilize the findings to decide interventions based on the living arrangements of elderly individuals. Enhancing SE and PWB in residential care by focusing on problem-solving, coping skills, and purpose and environmental mastery. For community-dwelling elderly, prioritizing problem solving, goal accomplishment and personal growth and purpose in life.
- As SE and PWB strongly correlated with each other OTs can focus on the domains of PWB and SE to influence each other. Mostly important for elderly in residential care facilities.
- OTs can encourage social and leisure participation, community volunteering and access to technology in improving SE and PWB in elderly individuals.
- OTs can focus on modification of their environment to improve their satisfaction with living arrangement to enhance SE and PWB.
- As OTs majorly focus on one's independence, ensuring their participation in meaningful activities and ensuring mobility can bring out well-being and SE of elderly.
- OTs need to involve family in therapy sessions in both setting for support and to enhance PWB and SE.
- This study ultimately strengthens the concept of utilizing Occupational Therapy practice in enhancing PWB and SE in elderly adults.
- This study influences the establishment of OT services specific to older adults in CRP, in institution-based care and in community level.

6.2.2 Recommendation for Future Research

- Identifying how cultural factors influence PWB and SE among older adults.
- Exploring the subjective experiences and perspectives of older adults through qualitative approach.
- Identifying the role or OT interventions that target the enhancement of PWB and SE among older adults.

6.3 Conclusion

In conclusion, this comparative study has provided a thorough analysis of the PWB and SE of elderly individuals in Bangladesh perspective of community and residential care settings. The moderate PWB and SE that were found in both community and residential care facilities highlight older individuals' adaptation and resilience in a variety of living situations. Nonetheless, the difference in PWB levels where elderly of communities reporting higher levels of well-being underlines the impact of living conditions on mental health. In the same way, community dwellers' greater levels of SE highlight the benefits of family and social environments. The significant differences in SE and PWB emphasize the necessity of specialized interventions and support networks that address the unique requirements of elderly across various living arrangements. Moreover, the correlations that have been found between SE and PWB support the reciprocal relationship between these variables indicate that increases in PWB could result in higher levels of SE and vice versa. Also, the sociodemographic factors can be emphasized for better PWB and SE of elderly individuals. The results of this study provide important insights that can guide targeted OT interventions, support networks, and policies meant to promote the holistic PWB and SE of older persons in various circumstances.

LIST OF REFERENCES

Ageing, W. P. (2017). World Population Ageing 2015: Highlights. In *World Population Ageing 2017: Highlights*. https://doi.org/10.18356/cba8beb6-en

Alam, M. R., Karmokar, S., Reza, S., Kabir, M. R., Ghosh, S., & Mamun, M. A. Al. (2021). Geriatric malnutrition and depression: Evidence from elderly home care population in Bangladesh. *Preventive Medicine Reports*, *23*, 101478. https://doi.org/10.1016/j.pmedr.2021.101478

Almira, L., Hanum, L., & Menaldi, A. (2019). Relationship with children and the psychological well-being of the elderly in Indonesia. *SAGE Open Medicine*, *7*. https://doi.org/10.1177/2050312119836026

Amin, I. (2017). Perceptions of Successful Aging among Older Adults in Bangladesh: An Exploratory Study. *Journal of Cross-Cultural Gerontology*, *32*(2), 191–207. https://doi.org/10.1007/s10823-017-9319-3

Aslani, M., Amidi Mazaheri, M., & Batavani, M. (2017). Self-efficacy Among Older Adults in Fereydunshahr City. *Salmand*, *11*(4), 558–565. https://doi.org/10.21859/sija-1104558

Bagheri-Nesami, M., Sohrabi, M., Ebrahimi, M. J., Heidari-Fard, J., Yanj, J., & Golchinmehr, S. (2013). The relationship between life satisfaction with social support and self-efficacy in community-dwelling elderly in Sari, Iran, 2012. *Journal of Mazandaran University of Medical Sciences*, *23*(101), 37–47.

Bagheri, M. J., Farid, A. A., & Nasrolahi, B. (2022). *The Relationship Between Self-Efficacy and Quality of Life Through the Mediating Role of Psychological Well-Being in the Elderly*. *8*(1), 39–54. https://doi.org/10.22126/JAP.2022.7431.1602

Bandura, A. (1977). Thought Reform and Cultural Revolution: An Analysis of the Symbolism of Chinese Polemics. *American Political Science Review*, *71*(1), 67–85. https://doi.org/10.1017/S0003055400259303

Bandura, A. (1978). Self-efficacy: Toward a unifying theory of behavioral change. *Advances in Behaviour Research and Therapy*, *1*(4), 139–161. https://doi.org/10.1016/0146-6402(78)90002-4

Bangladesh Bureau of Statistics. (2015). *Elderly population in Bangladesh : current features and future perspectives.*

Blanchard-Fields, F. (2007). Everyday Problem Solving and Emotion. *Current Directions in Psychological Science*, *16*(1), 26–31. https://doi.org/10.1111/j.1467-8721.2007.00469.x

Borry, P. (2012). Medical Ethics, Use of Empirical Evidence in. *Encyclopedia of Applied Ethics: Volume 1-4, Second Edition*, *1–4*, 70–77. https://doi.org/10.1016/B978-0-12-373932-2.00371-9

Bum, C. H., Lee, J. H., & Choi, C. H. (2021). The effects of leisure activities on self-efficacy and social adjustment: A study of immigrants in South Korea. *International Journal of Environmental Research and Public Health*, *18*(16), 10–19. https://doi.org/10.3390/ijerph18168311

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: complex or simple? Research case examples. *Journal of Research in Nursing*, *25*(8), 652–661. https://doi.org/10.1177/1744987120927206

Caprara, G. V., & Steca, P. (2005). Selbstwirksamkeitsüberzeugungen als Determinanten

für prosoziales Verhalten, das die Lebenszufriedenheit über alle Altersstufen hinweg begünstigt. *1946 - Journal of Social and Clinical Psychology*, *24*(2), 191–217.

Carstensen, L. L. (2006). The influence of a sense of time on human development. *Science*, *312*(5782), 1913–1915. https://doi.org/10.1126/science.1127488

Chen, Y. R. R., & Schulz, P. J. (2016). The effect of information communication technology interventions on reducing social isolation in the elderly: A systematic review. *Journal of Medical Internet Research*, *18*(1). https://doi.org/10.2196/jmir.4596

Cohen. (1992). Review of Quantitative methods in psychology. *Psychological Bulletin*, *112*(1), 155–159. https://doi.org/10.1037/h0051737

Deci, E. L., & Ryan, R. M. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology*, *49*(3), 182–185. https://doi.org/10.1037/a0012801

Doyle, J. K. (2005). Face-to-Face Surveys. *Encyclopedia of Statistics in Behavioral Science*. https://doi.org/10.1002/0470013192.BSA215

Fine, J. (2001). The effect of leisure activity on depression in the elderly: Implications for the field of occupational therapy. *Occupational Therapy in Health Care*, *13*(1), 45–59. https://doi.org/10.1080/j003v13n01_04

Fu, F., Liang, Y., An, Y., & Zhao, F. (2018). Self-efficacy and psychological well-being of nursing home residents in China: the mediating role of social engagement. *Asia Pacific Journal of Social Work and Development*, *28*(2), 128–140. https://doi.org/10.1080/02185385.2018.1464942

Galloway, A. (2004). Non-Probability Sampling. *Encyclopedia of Social Measurement*,

859–864. https://doi.org/10.1016/B0-12-369398-5/00382-0

Ghuman, S. J., & Ofstedal, M. (2004). *Gender and family support for older adults in Bangladesh.*

Ginter, E., & Simko, V. (2013). Women live longer than men. *Bratislavske Lekarske Listy*, *114*(2), 45–49. https://doi.org/10.4149/BLL_2013_011

Homan, K. J. (2016). Self-Compassion and Psychological Well-Being in Older Adults. *Journal of Adult Development*, *23*(2), 111–119. https://doi.org/10.1007/s10804-016-9227-8

Hosseingholizadeh, N., Sadeghi, R., Ardebili, H. E., Foroushani, A. R., & Taghdisi, M. H. (2019). The Correlation of Self-efficacy and Social Support with Social Participation: A Cross Sectional Study among the Elderly. *Journal of Medicine and Life*, *12*(3), 239–246. https://doi.org/10.25122/jml-2019-0010

Hung, L. L., Chen, H. M., Lan, Y. H., Clark, M. J., & Chao, S. Y. (2013). Life values, family support and psychosocial adaptation among older people in Taiwan: An institutional and community comparison. *Asia Pacific Journal of Social Work and Development*, *23*(2), 75–90. https://doi.org/10.1080/02185385.2013.793018

Islam, M. N., & Nath, D. C. (2012). A Future Journey to the Elderly Support in Bangladesh. *Journal of Anthropology*, *2012*, 1–6. https://doi.org/10.1155/2012/752521

Islam, M. T. (2020). *Learning SPSS Without Pain.*

Jena, N., Das, S., & Deo, Himansu, K. (2018). Quality of Life, Psychological Well-Being and Depression among Elderly: a Co relational Study. *Global Journal of Intellectual & Developmental Disabilities*, *4*(2). https://doi.org/10.19080/gjidd.2018.04.555635

Juwita, C. P. (2022). The impact of self-efficacy on physical activity in the elderly.

International Journal Of Community Medicine And Public Health, *9*(5), 2101. https://doi.org/10.18203/2394-6040.ijcmph20221224

Kabir, R., Kabir, M., Gias Uddin, M. S., Ferdous, N., & Khan Chowdhury, M. R. (2016). Elderly Population Growth in Bangladesh: Preparedness in Public and Private Sectors. *IOSR Journal of Humanities and Social Science*, *21*(08), 58–73. https://doi.org/10.9790/0837-2108025873

Kahe, M., Vameghi, R., Foroughan, M., Bakhshi, E., & Bakhtyari, V. (2018). The relationships between self-concept and self-efficacy with self-management among elderly of sanatoriums in Tehran. *Iranian Journal of Ageing*, *13*(1), 28–37. https://doi.org/10.21859/sija.13.1.28

Keyes, C. L. M. (2012). Toward a Science of Mental Health. In *The Oxford Handbook of Positive Psychology, (2 Ed.)*. https://doi.org/10.1093/oxfordhb/9780195187243.013.0009

Kim, H. K. (2020). Effects of Stress, Depression, Self-efficacy, and Social Support on Quality of Life of Community Dwelling Elderly with Chronic Diseases. *Medico-Legal Update*, *20*(4), 1234–1238. https://doi.org/10.37506/mlu.v20i4.1996

Kostka, T., & Jachimowicz, V. (2010). Relationship of quality of life to dispositional optimism, health locus of control and self-efficacy in older subjects living in different environments. *Quality of Life Research*, *19*(3), 351–361. https://doi.org/10.1007/s11136-010-9601-0

Kovalenko, O. H., & Spivak, L. M. (2018). Psychological well-being of elderly people: the social factors. *Social Welfare : Interdisciplinary Approach*, *8*(1), 163–176. https://doi.org/10.21277/sw.v1i8.323

Lang, F. R., & Carstensen, L. L. (1994). Close emotional relationships in late life: Further support for proactive aging in the social domain. *Psychology and Aging*, *9*(2), 315–324. https://doi.org/10.1037//0882-7974.9.2.315

Lara, R., Vázquez, M. L., Ogallar, A., & Godoy-Izquierdo, D. (2020). Optimism and social support moderate the indirect relationship between self-efficacy and happiness through mental health in the elderly. *Health Psychology Open*, *7*(2). https://doi.org/10.1177/2055102920947905

Leal Filho, W., & Kovaleva, M. (2015). Research Methods. *Environmental Science and Engineering*, *5*(3), 81–82. https://doi.org/10.1007/978-3-319-10906-0_5

Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-Based Dentistry*, *7*(1), 24–25. https://doi.org/10.1038/sj.ebd.6400375

Li, L., Wang, J., Wang, Y.-L., Jiao, J., Meng, J., Su, Y., Du, X.-J., Wang, Y., Sun, G.-P., & Li, Y.-L. (2022). Relationship between the Self-Efficacy and Mental Health of Elderly Patients with Coronary Heart Disease in Rural Hebei Province. *Proceedings of Anticancer Research*, *6*(2), 14–19. https://doi.org/10.26689/par.v6i2.3701

Lim, L. L., & Kua, E. H. (2011). Living alone, loneliness, and psychological well-being of older persons in Singapore. *Current Gerontology and Geriatrics Research*, *2011*. https://doi.org/10.1155/2011/673181

Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care | National Institute on Aging. (n.d.). Retrieved January 18, 2024, from https://www.nia.nih.gov/health/assisted-living-and-nursing-homes/long-term-care-facilities-assisted-living-nursing-homes

Luong, G., Charles, S. T., & Fingerman, K. L. (2011). NIH Public Access. *National*

Institutes of Health, *28*(1), 9–23. https://doi.org/10.1177/0265407510391362.Better

Luszczynska, A., Gutiérrez-Doña, B., & Schwarzer, R. (2005). General self-efficacy in various domains of human functioning: Evidence from five countries. *International Journal of Psychology*, *40*(2), 80–89. https://doi.org/10.1080/00207590444000041

MacQueen, K. M., McLellan, E., Metzger, D. S., Kegeles, S., Strauss, R. P., Scotti, R., Blanchard, L., & Trotter, R. T. (2001). What Is Community? An Evidence-Based Definition for Participatory Public Health. *American Journal of Public Health*, *91*(12), 1929. https://doi.org/10.2105/AJPH.91.12.1929

MacroTrends. (2024). *Bangladesh Life Expectancy 1950-2024 | MacroTrends*. https://www.macrotrends.net/global-metrics/countries/BGD/bangladesh/life-expectancy

Majid, U. (2018). Research Fundamentals: Study Design, Population, and Sample Size. *Undergraduate Research in Natural and Clinical Science and Technology (URNCST) Journal*, *2*(1), 1–7. https://doi.org/10.26685/urncst.16

Manca, S., Cerina, V., & Fornara, F. (2019). Residential Satisfaction, Psychological Well-Being and Perceived Environmental Qualities in High- vs. Low-Humanized Residential Facilities for the Elderly. *Social Psychological Bulletin*, *14*(2). https://doi.org/10.32872/spb.v14i2.33570

Manu, T., & Gala, B. (2018). Research Data Management lifecycle: an overview. *Trends, Challenges and Opportunities for LIS Education and Practice (Festschrift Volume in Honour of Prof. Muttayya M. Koganuramath), January*.

Ministry of Social Welfare. (2022). *Madrid International Plan of Action on Ageing (MIPAA) Ministry of Social Welfare People ' s Republic of Bangladesh*.

Molina Sena, C. J., & Meléndez Moral, J. C. (2006). Psychological well being in elderly from the Dominican Republic. *Geriatrika*, *22*(3), 25–32.

Neuman, L. W. (2012). Designing the face-to-face survey. *Handbook of Survey Methodology for the Social Sciences*, 227–248. https://doi.org/10.1007/978-1-4614-3876-2_14/COVER

News | Wabash College. (n.d.). Retrieved January 17, 2024, from https://www.wabash.edu/alumni/news.cfm?news_ID=3570

Old Home – Bangladesh Association for the Aged and Institute of Geriatric Medicine. (n.d.). Retrieved January 15, 2024, from https://baaigm.org.bd/old-home/

Population and Housing Census 2022. (n.d.).

Rahman, M. I., & Ali, A. M. (2007). Population Aging and Its implications in Bangladesh. *Jahangirnagar Review Part II Social Science*, *31*, 1–20. http://ssrn.com/abstract=1349447

Rahman, M. S. (2017). Aging and Negligence in Bangladesh. *Journal of Gerontology & Geriatric Research*, *06*(03), 10–11. https://doi.org/10.4172/2167-7182.1000423

Remm, S. E., Halcomb, E., Peters, K., Hatcher, D., & Frost, S. A. (2023). Self-efficacy, resilience and healthy ageing among older people who have an acute hospital admission: A cross-sectional study. *Nursing Open*, *January*, 1–10. https://doi.org/10.1002/nop2.1960

Rodríguez-cifuentes, F., Topa, G., Belo, P., López-gonzalez, M. A., Rubio-garay, F., Pocinho, R., Silva, S., & Fernández-muñoz, J. J. (2024). *Leisure Attitude , Self-Rated Health , and Psychological Well-Being in Older Adults : A Moderated Mediation Model*. *March*, 1417–1431.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, *57*(6), 1069–1081. https://doi.org/10.1037/0022-3514.57.6.1069

Ryff, C. D. (2013). Psychological well-being revisited: Advances in the science and practice of eudaimonia. *Psychotherapy and Psychosomatics*, *83*(1), 10–28. https://doi.org/10.1159/000353263

Ryff, C. D., & Keyes, C. L. M. (1995). The Structure of Psychological Well-Being Revisited. *Journal of Personality and Social Psychology*, *69*(4), 719–727. https://doi.org/10.1037/0022-3514.69.4.719

Sarker, A. R. (2021). Health-related quality of life among older citizens in Bangladesh. *SSM - Mental Health*, *1*(October), 100031. https://doi.org/10.1016/j.ssmmh.2021.100031

Scholz, U., Doña, B. G., Sud, S., & Schwarzer, R. (2002). Is general self-efficacy a universal construct? Psychometric findings from 25 countries. *European Journal of Psychological Assessment*, *18*(3), 242–251. https://doi.org/10.1027//1015-5759.18.3.242

Schwarzer, R., Jerusalem, M., & Johnston, M. (1995). *Generalized Self-Efficacy Scale*. *January 2021*.

Scult, M., Haime, V., Jacquart, J., Takahashi, J., Moscowitz, B., Webster, A., Denninger, J. W., & Mehta, D. H. (2015). A healthy aging program for older adults: effects on self-efficacy and morale. *Advances in Mind-Body Medicine*, *29*(1), 26–33.

Senior citizens growing in numbers, no attention to healthcare | Prothom Alo. (n.d.). Retrieved September 12, 2023, from

https://en.prothomalo.com/bangladesh/49ozhgo002

Setia, M. (2016). Methodology Series Module 5: Sampling Strategies. *Indian Journal of Dermatology*, *61*(5), 505. https://doi.org/10.4103/0019-5154.190118

Setia, M. S. (2016). Methodology Series Module 3: Cross-sectional Studies. *Indian Journal of Dermatology*, *61*(3), 261. https://doi.org/10.4103/0019-5154.182410

Shaabani, J., Rahgoi, A., Nourozi, K., Rahgozar, M., & Shaabani, M. (2017). The Relationship Between Self-Efficacy and Quality of Life Among Elderly People. *Salmand*, *11*(4), 518–527. https://doi.org/10.21859/sija-1104518

Shamsabadi, A. E., Gerami, G. K., & Shamsabadi, P. E. (2022). The Role of Executive Functions in the Relationship Between Loneliness and PsychologicalWell-Being of the Elderly. *Iranian Journal of Psychiatry and Behavioral Sciences*, *16*(2). https://doi.org/10.5812/ijpbs-114188

Sharma, G. (2017). Pros and cons of different sampling techniques. International journal of applied research. *International Journal of Applied Research*, *3*(7), 749–752. www.allresearchjournal.com

Sheard, J. (2018). Quantitative data analysis. *Research Methods: Information, Systems, and Contexts: Second Edition*, 429–452. https://doi.org/10.1016/B978-0-08-102220-7.00018-2

Singh, R., & Bisht, N. (2019). Spirituality and Psychological Well-being of Elderly: Gender Perspective. *Current Journal of Applied Science and Technology*, *37*(2), 1–10. https://doi.org/10.9734/cjast/2019/v37i230283

Singh, S., & Bajorek, B. (2014). Defining 'elderly' in clinical practice guidelines for pharmacotherapy. *Pharmacy Practice*, *12*(4). https://doi.org/10.4321/S1886-

36552014000400007

Steptoe, A., Deaton, A., & Stone, A. S. (2015). Psychological wellbeing, health and ageing NIH Public Access. *Lancet*, *385*(9968), 640–648. https://doi.org/10.1016/S0140-6736(13)61489-0.Psychological

Taherdoost, H., Business, H., Sdn, S., Group, C., & Lumpur, K. (2016). Sampling Methods in Research Methodology ; How to Choose a Sampling Technique for. *International Journal of Academic Research in Management (IJARM)*, *5*(2), 18–27.

Tandon, M. (2017). A study on psychological well-being among elderly. *International Journal of Home Science 2017*, *3*(1), 387–389. https://www.homesciencejournal.com/archives/2017/vol3issue1/PartI/3-1-89.pdf

Tang, L. H., Thygesen, L. C., Willadsen, T. G., Jepsen, R., la Cour, K., Frølich, A., Møller, A., Jørgensen, L. B., & Skou, S. T. (2020). The association between clusters of chronic conditions and psychological well-being in younger and older people—A cross-sectional, population-based study from the Lolland-Falster Health Study, Denmark. *Journal of Comorbidity*, *10*, 2235042X2098118. https://doi.org/10.1177/2235042x20981185

Toledano-González, A., Labajos-Manzanares, T., & Romero-Ayuso, D. (2019). Well-Being, Self-Efficacy and Independence in older adults: A Randomized Trial of Occupational Therapy. *Archives of Gerontology and Geriatrics*, *83*(December 2018), 277–284. https://doi.org/10.1016/j.archger.2019.05.002

Toledano-González, A., Labajos-Manzanares, T., & Romero-Ayuso, D. M. (2018). Occupational therapy, self-efficacy, well-being in older adults living in residential care facilities: A randomized clinical trial. *Frontiers in Psychology*, *9*(AUG).

https://doi.org/10.3389/fpsyg.2018.01414

Trochim, W. M. (2004). *What is the Research Methods Knowledge Base ? Using the KB in a Course About the Author*. *August*.

Uddin, T., Chowdhury, M. A. I., Islam, M. N., & Baher, G. U. (2010). Status of elderly people of Bangladesh: Health perspective. *Proceedings of the Pakistan Academy of Sciences*, *47*(3), 181–189.

United Nations Department of Economic and Social Affairs. (2019). World population prospects 2019. In *Department of Economic and Social Affairs. World Population Prospects 2019.: Vol. ST/ESA/SER* (Issue 141). http://www.ncbi.nlm.nih.gov/pubmed/12283219

Wang, X., & Cheng, Z. (2020). Cross-Sectional Studies: Strengths, Weaknesses, and Recommendations. *Chest*, *158*(1), S65–S71. https://doi.org/10.1016/j.chest.2020.03.012

Whitehall, L., Rush, R., Górska, S., & Forsyth, K. (2021). The general self-efficacy of older adults receiving care: A systematic review and meta-analysis. *Gerontologist*, *61*(6), E302–E317. https://doi.org/10.1093/geront/gnaa036

WHO - Definition of An Older or Elderly Person | PDF | Ageing | Old Age. (n.d.). Retrieved January 17, 2024, from https://www.scribd.com/document/190077600/WHO-Definition-of-an-Older-or-Elderly-Person

World Medical Association. (2022). WMA International Code of Medical Ethics. *Journal of the Indian Medical Association*, *120*(11), 83–86. https://doi.org/10.4314/sjmrp.v10i2.4

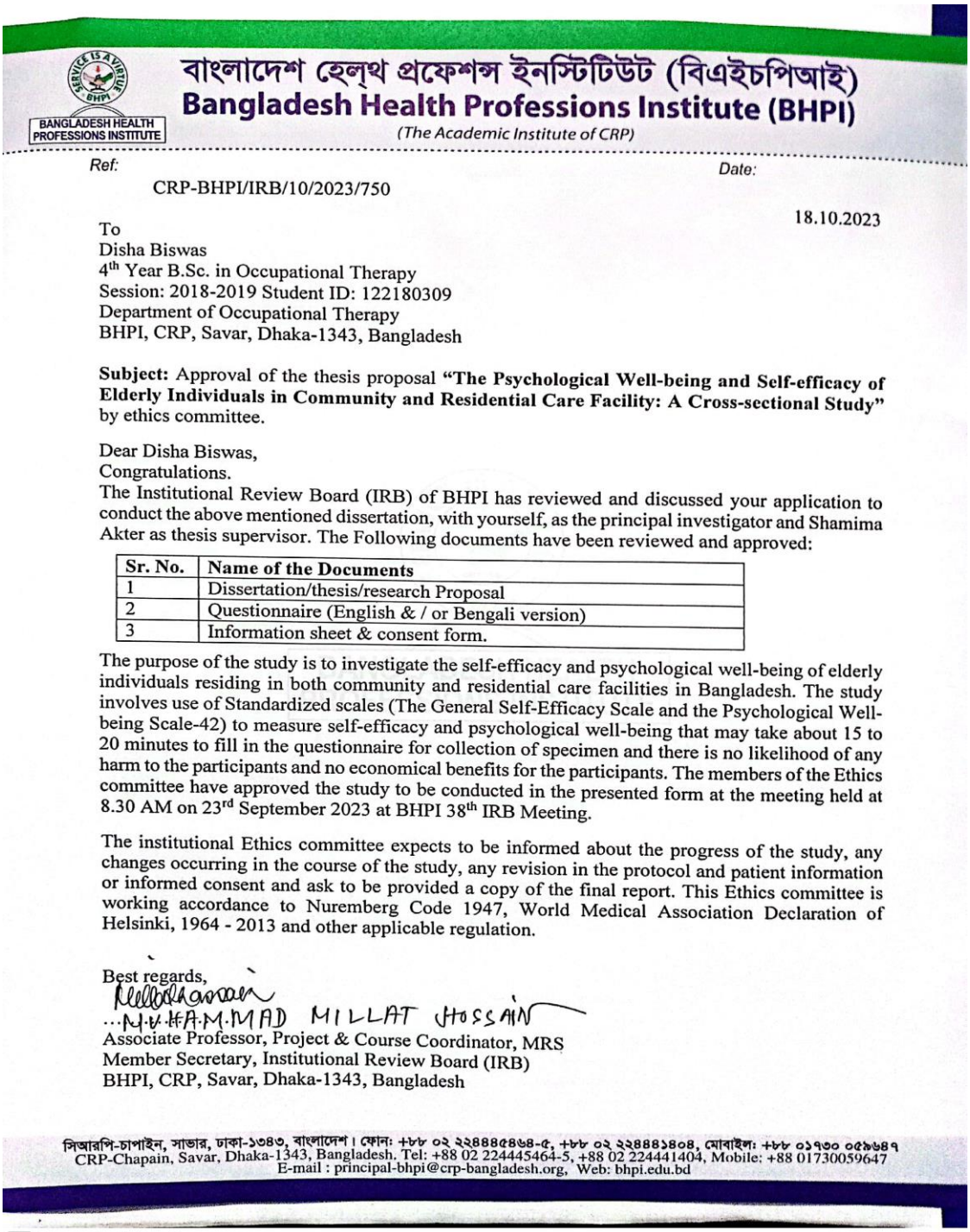
Zamani S, Bahrainian S A, Ashrafi S, & Sh, M. (2018). *Effect of Spiritual Intelligence on*

Quality of life and Psychological well Being among Elderly Living at Nursing homes in Bandar Abbas. 82–94.

APPENDICES

Appendix A: Approval Letter and Permission Letter

IRB Approval Letter



বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

BANGLADESH HEALTH PROFESSIONS INSTITUTE

Ref: CRP-BHPI/IRB/10/2023/750

Date: 18.10.2023

To
Disha Biswas
4th Year B.Sc. in Occupational Therapy
Session: 2018-2019 Student ID: 122180309
Department of Occupational Therapy
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

Subject: Approval of the thesis proposal **"The Psychological Well-being and Self-efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study"** by ethics committee.

Dear Disha Biswas,
Congratulations.
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned dissertation, with yourself, as the principal investigator and Shamima Akter as thesis supervisor. The Following documents have been reviewed and approved:

Sr. No.	Name of the Documents
1	Dissertation/thesis/research Proposal
2	Questionnaire (English & / or Bengali version)
3	Information sheet & consent form.

The purpose of the study is to investigate the self-efficacy and psychological well-being of elderly individuals residing in both community and residential care facilities in Bangladesh. The study involves use of Standardized scales (The General Self-Efficacy Scale and the Psychological Well-being Scale-42) to measure self-efficacy and psychological well-being that may take about 15 to 20 minutes to fill in the questionnaire for collection of specimen and there is no likelihood of any harm to the participants and no economical benefits for the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 8.30 AM on 23rd September 2023 at BHPI 38th IRB Meeting.

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964 - 2013 and other applicable regulation.

Best regards,
MUHAMMAD MILLAT HOSSAIN
Associate Professor, Project & Course Coordinator, MRS
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP, Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ। ফোন: +৮৮ ০২ ২২৪৪৪৫৪৬৪-৫, +৮৮ ০২ ২২৪৪৪১৪০৪, মোবাইল: +৮৮ ০১৭৩০ ০৫৯৬৪৭
CRP-Chapain, Savar, Dhaka-1343, Bangladesh. Tel: +88 02 224445464-5, +88 02 224441404, Mobile: +88 01730059647
E-mail : principal-bhpi@crp-bangladesh.org, Web: bhpi.edu.bd

Permission Letter (Bangladesh Association for the Aged and Institute of Geriatric Medicine [BAAIGM])

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 22.10.2023

To
President
Bangladesh Association for the Aged & Institute of Geriatric Medicine
Probin Bhaban, E-10, Agargoan, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B.Sc in Occupational Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Disha Biswas would like to collect data in your organization from 28.10.2023 to 31.12.2023. Her title: "Comparative study on the psychological Well-being and Self efficacy of elderly individuals: Community- Dwelling vs. Residential Care Facility Residents in Bangladesh".

We shall remain grateful to you if you could kindly allow us in conducting the placement.

With regards

Sk. Moniruzzaman
Associate Prof. & Head
Dept. of Occupational Therapy
BHPI.

Bangladesh Health Professions Institute (BHPI) ★ Date

Permission Letter (Khola Janala-Old age home)

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনষ্টিটিউট (বিএইচপিআই)
BANGLADESH HEALTH PROFESSIONS INSTITUTE (BHPI)
(The Academic Institute of CRP)
CRP-Chapain, Savar, Dhaka, Tel: 02224445464 , 02224441404, Website: www.bhpi.edu.bd

Date: 22.10.2023

To
Executive Director
Khola Janala- Old age home
Niribili, Falguni Housing, Cantonment,
Ashulia, Savar, Dhaka.

Subject: *Regarding Data collection for dissertation.*

Greetings from Bangladesh Health Professions Institute (BHPI). I would like to inform you that, BHPI, the Academic Institute of CRP is running B.Sc in Occupational Therapy Course, under Faculty of Medicine, University of Dhaka.

According to the content of 4th year of University course curriculum, the students have to do Research and Course work in different topics to develop their skills. Considering the situation, your institute will be the most appropriate place to collect data.

4th year students of BHPI Disha Biswas would like to collect data in your organization from 28.10.2023 to 31.12.2023. Her title: "Comparative study on the psychological Well-being and Self efficacy of elderly individuals: Community- Dwelling vs. Residential Care Facility Residents in Bangladesh".

We shall remain grateful to you if you could kindly allow us in conducting the placement.

With regards

Sk. Moniruzzaman
Associate Prof. & Head
Dept. of Occupational Therapy
BHPI.

Bangladesh Health Professions Institute (BHPI) ★ Date

Permission granted
Md. Abdul Hafiz
(মোঃ আব্দুল হাফিজ)

Appendix Ba: Information Sheet, Consent Form, Withdrawal Form (English)

Information Sheet (English)

Bangladesh Health Professions Institute (BHPI)

Department of Occupational Therapy

CRP, Chapain, Savar, Dhaka- 1343

Research Title: The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study

Name of researcher: Disha Biswas, 4th year, B.Sc in Occupational Therapy, Department of Occupational Therapy, BHPI, session: 2018-19

Supervisor: Shamima Akter Swapna, Associate Professor, Department of Occupational Therapy, Bangladesh Health Professions Institute (BHPI), CRP, Savar, Dhaka-1343

Introduction

Dear Participant,

I, Disha Biswas, would like to invite you to participate in a research study. You need to understand the purpose of the research and how you fit into it before making your decision. Please read the provided material carefully. You can ask me if you have any questions or need additional information after reading.

Background and Aim of This Research

I am Disha Biswas, studying B.Sc. in occupational therapy in Bangladesh Health Professions Institute (BHPI) which is under the Medicine faculty of Dhaka University, an academic institute of Centre for the rehabilitation of Paralysed. As a part of B.Sc curriculum I am going to conduct a research activity under the assistant professor of occupational therapy, Shamima Akter Swapna. The study's focus is on the psychological well-being and self-efficacy of older people in Bangladesh who are living in the community and in residential care facilities. The purpose of this study is to compare older people living in residential care facilities versus those living in the communities of their psychological well-being and self-efficacy in Bangladesh.

Participation details

As I will measure self-efficacy and psychological well-being, I will be using two standardized questionnaire or scales. Also, your socio-demographic information will be

included. All the questions from the standardized tool should be answered by the participants. The entire process is expected to take approximately 15-20 minutes of your time.

Why you are invited to participate

As the topic of my research is psychological well-being and self-efficacy of older people in Bangladesh who dwells in the community and in residential care facilities. I need to invite the elderly participants who are community dwelling and who are currently taking institutional based care like, old home, residential care facilities etc. and to compare them in terms of their psychological well-being and self-efficacy.

Voluntary participation

The study's participants' participation is entirely voluntary. Participants' consent should be obtained prior to participation. After taking part, each person will be held accountable for responding to all the questions. Participants will receive a consent withdrawal form so they can withdraw their consent at any time within two weeks after the survey's completion.

Possible risks and opportunities

There are no direct financial benefits associated with participating in this study. Moreover, there is no physical or mental risks involved in completing the questionnaire. If you experience any discomfort or require assistance, medical and psychiatric support will be available. Additionally, by participating in this study, people will learn about the psychological well-being and self-efficacy of older adults in Bangladesh This knowledge can be used to develop better healthcare services and support systems for the elderly population.

Confidentiality

Researcher will strictly maintain the secrecy of the research. Name of the participants will be cited only in the consent paper. To maintain the secrecy of the participants a code system will be maintained in the question and response paper of the participants. Only the relevant researcher and the supervisor will have immediate access to this information. The participants will not be named in any reports, publications, or presentations that may come from this study.

Data storage and protection

Informational paper will be kept secure in a drawer, and electronic information will be

stored on the researcher's own password-protected laptop and in the occupational therapy department of BHPI.

Outcome of the research

By this research we can detect the actual self-efficacy and well-being of older adults. By doing so many health services can be established based on the results. The study result will help to ensure mental health among elderly people. Other researchers will be able to do further research based on the knowledge of the research.

Dissemination of the results

The result of this research have the potential to be published in scientific journal and presented through print media electronic/social media, conferences and criticism.

If you have any question you can contact through the given address

Researcher: Disha Biswas

Bangladesh Health Professions Institute (BHPI)

B.Sc. in occupational therapy

Session 2018-19, Roll: 01

Savar, Dhaka

Email: biswasdishaot567@gmail.com

Contact number: 01736740887

Supervisor: Shamima Akter Swapna,

Associate Professor

Bangladesh Health Professions Institute (BHPI)

Savar, Dhaka

Email: shamimaakterot@gmail.com

Contact number: 01716806864

We appreciate your consideration and look forward to your valuable participation in this study.

Thank you.

Consent Form (English)

Consent Form

Research Title: The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study

Name of researcher: Disha Biswas, 4th year, B.Sc in Occupational Therapy, Department of Occupational Therapy, BHPI, session: 2018-19

Please (✓) mark the check box

➢ I confirm that I have read and understood the information sheet and the nature of my participation in the research.	
➢ I confirm that I had the opportunities to consider the information, ask questions, and had these answered satisfactorily.	
➢ I recognize my right to withdraw my consent and discontinue participation in the study within two weeks of survey completion without any consequences.	
➢ I understand that my activities and data generated by my participation will remain strictly confidential and all information will be kept private and secure.	
➢ I have been informed about all risks and benefits and I voluntarily consent to taking part in the study.	

Name of the participant:_____ Signature:_____

Signature of the researcher:_____ Date:___/___/____

Withdrawal Form (English)

Withdrawal Form

Research Title: The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-sectional Study

Name of researcher: Disha Biswas, 4th year, B.Sc in Occupational Therapy, Department of Occupational Therapy, BHPI, session: 2018-19

I_____hereby formally withdraw my participation from the research. I am providing this notice to confirm my decision to withdraw from the research without any consequences.

By signing this form, I confirm my withdrawal from the research study and request that my data and any associated information collected up to this point be removed from any further analysis or use in the study.

Name of the participant:_____ Signature:_____

Signature of the researcher: _____ Date:_____

Appendix Bb: Information Sheet, Consent Form, Withdrawal Form (Bangla)

Information sheet (Bangla)

তথ্য পত্র

বাংলাদেশ হেলথ প্রফেসন্স ইনস্টিটিউট (বি,এইচ, পি, আই)

ডিপার্টমেন্ট অব অকুপেশনাল থেরাপি

সি আর পি, চাপাইন, সাভার, ধাকা-১৩৪৩

গবেষণার শিরোনাম: বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতা সম্পর্কিত তুলনামূলক গবেষণা: বাংলাদেশে কমিউনিটি-বাসকারী বনাম আবাসিক সুবিধাপ্রাপ্ত বয়স্ক।

গবেষকের নাম: দিশা বিশ্বাস ৪র্থ বছর, বি এস সি ইন অকুপেশনাল থেরাপি, সেশনঃ ২০১৮-১৯

তত্ত্বাবধায়কঃ শামীমা আক্তার স্বপ্না, সহকারী অধ্যাপক, ডিপার্টমেন্ট অব অকুপেশনাল থেরাপি, বাংলাদেশ হেলথ প্রফেসন্স ইনস্টিটিউট (বি,এইচ, পি, আই), সি আর পি, চাপাইন, সাভার, ধাকা-১৩৪৩

ভূমিকা

প্রিয় অংশগ্রহণকারী,

আমি, দিশা বিশ্বাস, আপনাকে একটি গবেষণায় অংশ নেওয়ার জন্য আমন্ত্রণ জানাতে চাই। আপনার সিদ্ধান্ত নেওয়ার আগে আপনাকে গবেষণার উদ্দেশ্য এবং আপনি কীভাবে এটিতে ভুমিকা রাখেন তা বুঝতে হবে। অনুগ্রহ করে প্রদত্ত তথ্য পত্র মনোযোগ সহকারে পড়ুন। পড়ার পরে আপনার যদি কোনও প্রশ্ন থাকে বা অতিরিক্ত তথ্যের প্রয়োজন হয় তবে আপনি আমাকে জিজ্ঞাসা করতে পারেন।

এই গবেষণার পটভূমি এবং উদ্দেশ্য

আমি দিশা বিশ্বাস, পক্ষাঘাতগ্রস্তদের পুনর্বাসন কেন্দ্রের একাডেমিক প্রতিষ্ঠান ঢাকা বিশ্ববিদ্যালয়ের মেডিসিন অনুষদভুক্ত বাংলাদেশ হেলথ প্রফেশন্স ইনস্টিটিউটে (বিএইচপিআই) অকুপেশনাল থেরাপিতে অধ্যয়ন করছি। বি এস সি কারিকুলামের অংশ হিসেবে অকুপেশনাল থেরাপির সহকারী অধ্যাপক শামীমা আক্তার স্বপ্নার অধীনে একটি গবেষণা কার্যক্রম পরিচালনা করতে যাচ্ছি। গবেষণায় বাংলাদেশের বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং আত্ম-কার্যকারিতার উপর দৃষ্টি নিবদ্ধ করা হয়েছে। এই গবেষণার উদ্দেশ্য হলো

যারা সমাজে এবং বৃদ্ধাশ্রমের মত আবাসিক প্রতিষ্ঠানে বসবাস করছেন এমন বয়স্ক ব্যক্তিদের তাদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতার তুলনা করা।

অংশগ্রহণের বিবরণ

যেহেতু আমি স্ব-কার্যকারিতা এবং মনস্তাত্ত্বিক সুস্থতা পরিমাপ করব, আমি দুটি স্ট্যান্ডার্ডাইজড প্রশ্নাবলী বা স্কেল ব্যবহার করব। এছাড়াও, আপনার আর্থ-সামাজিক তথ্য অন্তর্ভুক্ত করা হবে। স্ট্যান্ডার্ডাইজড এই প্রশ্নাবলী থেকে সমস্ত প্রশ্নের উত্তর অংশগ্রহণকারীদের দিতে হবে। পুরো প্রক্রিয়াটি আপনার সময়ের প্রায় ১৫-২০ মিনিট সময় নেবে বলে আশা করা হচ্ছে।

কেন আপনাকে অংশগ্রহণের জন্য আমন্ত্রণ জানানো হচ্ছে

আমার গবেষণার বিষয় হিসেবে বাংলাদেশের বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতা, যা যারা সমাজে এবং বৃদ্ধাশ্রমের মত আবাসিক প্রতিষ্ঠানে বসবাস করছেন এমন বয়স্ক ব্যক্তিদের মধ্যে তুলনা করা হবে। যার জন্য আমি প্রবীণ অংশগ্রহণকারীদের আমন্ত্রণ জানাতে চাই যারা সমাজে বসবাস করছেন এবং যারা বর্তমানে প্রাতিষ্ঠানিক ভিত্তিক সেবা নিচ্ছেন যেমন, ওল্ড হোম, নার্সিং হোম ইত্যাদি।

স্বেচ্ছায় অংশগ্রহণ

গবেষণায় অংশগ্রহণকারীদের অংশগ্রহণ সম্পূর্ণ তাদের স্ব-ইচ্ছার উপর নির্ভর করবে। অংশগ্রহণের আগে অংশগ্রহণকারীদের সম্মতি নেয়া হবে। অংশ নেওয়ার পরে, প্রত্যেকে সমস্ত প্রশ্নের উত্তর দেওয়ার জন্য বাধ্য থাকবে। অংশগ্রহণকারীরা একটি প্রত্যাহার পত্র পাবেন যাতে তারা জরিপ শেষ হওয়ার দুই সপ্তাহের মধ্যে যে কোনও সময় তাদের সম্মতি প্রত্যাহার করতে পারেন।

সম্ভাব্য ঝুঁকি ও সুযোগ সুবিধা

এই গবেষণায় অংশগ্রহণের সাথে কোনও সরাসরি আর্থিক সুবিধা নেই। প্রশ্নাবলী সম্পূর্ণ করার সাথে কোনও শারীরিক বা মানসিক ঝুঁকি জড়িত নেই। আপনি যদি কোনো অস্বস্তি অনুভব করেন বা সহায়তার প্রয়োজন হয় তবে চিকিৎসার সহায়তা দেয়া হবে। উপরন্তু, এই গবেষণায় অংশগ্রহণের মাধ্যমে, মানুষ বাংলাদেশের বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতা সম্পর্কে জানতে পারবে এবং এই জ্ঞানটি বয়স্ক জনগোষ্ঠীর জন্য উন্নত স্বাস্থ্যসেবা এবং সহায়ক ব্যবস্থা বিকাশে ব্যবহার করা যেতে পারে।

গোপনীয়তা

গবেষক কঠোরভাবে গবেষণার গোপনীয়তা বজায় রাখবেন। অংশগ্রহণকারীদের নাম শুধুমাত্র সম্মতি পত্রে উল্লেখ করা হবে। অংশগ্রহণকারীদের গোপনীয়তা বজায় রাখার জন্য অংশগ্রহণকারীদের প্রশ্নপত্রে একটি কোড সিস্টেম বজায় রাখা হবে। শুধুমাত্র প্রাসঙ্গিক গবেষক এবং সুপারভাইজার এই তথ্য জানবেন। অংশগ্রহণকারীদের এই গবেষণা থেকে আসা কোনো প্রতিবেদন, প্রকাশনা বা উপস্থাপনায় নাম দেওয়া হবে না।

ডেটা সংরক্ষণ এবং সুরক্ষা

কাগজ ভিত্তিক তথ্য একটি ড্রয়ারে সুরক্ষিত রাখা হবে এবং ইলেকট্রনিক তথ্য গবেষকের নিজস্ব পাসওয়ার্ড-সুরক্ষিত ল্যাপটপে এবং বিএইচপিআইয়ের অকুপেশনাল থেরাপি বিভাগে সংরক্ষণ করা হবে।

গবেষণার ফলাফল

এই গবেষণার মাধ্যমে আমরা বয়স্ক ব্যক্তিদের প্রকৃত স্ব-কার্যকারিতা এবং মানসিক সুস্থতা সনাক্ত করতে পারি। এতে করে ফলাফলের ওপর ভিত্তি করে অনেক স্বাস্থ্যসেবা প্রতিষ্ঠা করা যাবে। গবেষণার ফলাফল বয়স্ক ব্যক্তিদের মধ্যে মানসিক স্বাস্থ্য নিশ্চিত করতে সহায়তা করবে। অন্যান্য গবেষকরা গবেষণার জ্ঞানের উপর ভিত্তি করে আরও গবেষণা করতে সক্ষম হবেন।

গবেষণার ফলাফলের প্রচার

এই গবেষণার ফলাফল বৈজ্ঞানিক জার্নালে প্রকাশিত হওয়ার এবং প্রিন্ট মিডিয়া ইলেকট্রনিক / সোশ্যাল মিডিয়া, সম্মেলন এবং সমালোচনার মাধ্যমে উপস্থাপিত হওয়ার সম্ভাবনা রয়েছে।

আপনার যদি কোনও প্রশ্ন থাকে তবে আপনি প্রদত্ত ঠিকানার মাধ্যমে যোগাযোগ করতে পারেনঃ

গবেষকের নাম: দিশা বিশ্বাস

৪র্থ বছর,

বি এস সি ইন অকুপেশনাল থেরাপি,

সেশনঃ ২০১৮-১৯

বাংলাদেশ হেলথ প্রফেসন্স ইনস্টিটিউট (বি,এইচ, পি, আই),

সি আর পি, চাপাইন, সাভার, ধাকা-১৩৪৩

ই-মেইলঃ biswasdishaot567@gmail.com

মোবাইল নাম্বারঃ ০১৭৩৬৭৪০৮৮৭

তত্ত্বাবধায়কঃ শামীমা আক্তার স্বপ্না,

সহকারী অধ্যাপক,

ডিপার্টমেন্ট অব অকুপেশনাল থেরাপি,

বাংলাদেশ হেলথ প্রফেসন্স ইনস্টিটিউট (বি,এইচ, পি, আই),

সি আর পি, চাপাইন, সাভার, ধাকা-১৩৪৩

ই-মেইল: shamimaakterot@gmail.com

মোবাইল নাম্বার: 01716806864

আমরা আপনার বিবেচনাকে সম্মান জানাই এবং এই অধ্যয়নে আপনার মূল্যবান অংশগ্রহণের অপেক্ষায় রয়েছি।

ধন্যবাদ।

Consent Form (Bangla)

সম্মতি পত্র

গবেষণার শিরোনাম: বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতা সম্পর্কিত তুলনামূলক গবেষণা: বাংলাদেশে কমিউনিটি-বাসকারী বনাম আবাসিক সুবিধাপ্রাপ্ত বয়স্ক।

গবেষকের নাম: দিশা বিশ্বাস ৪র্থ বছর, বি এস সি ইন অকুপেশনাল থেরাপি, সেশনঃ ২০১৮-১৯

অনুগ্রহ করে (✓) টিক চিহ্ন দিন

➢ আমি নিশ্চিত করি যে আমি তথ্য পত্রটি পড়েছি এবং বুঝতে পেরেছি এবং গবেষণায় আমার অংশগ্রহণের ধরনও বুঝতে পেরেছি।	
➢ আমি নিশ্চিত করি যে আমি তথ্য বিবেচনা করার, প্রশ্ন জিজ্ঞাসা করার সুযোগ পেয়েছি এবং এগুলির সন্তোষজনক উত্তর পেয়েছি।	
➢ আমার সম্মতি প্রত্যাহার করার এবং কোনও পরিণতি ছাড়াই জরিপ শেষ হওয়ার দুই সপ্তাহের মধ্যে অধ্যয়নে অংশগ্রহণ বন্ধ করার অধিকার সম্পর্কে অবগত।	
➢ আমি নিশ্চিত করি যে, আমার ক্রিয়াকলাপ এবং আমার অংশগ্রহণদ্বারা উৎপাদিত তথ্য কঠোরভাবে গোপনীয় থাকবে এবং সমস্ত তথ্য সুরক্ষিত রাখা হবে।	
➢ আমাকে সমস্ত ঝুঁকি এবং সুবিধা সম্পর্কে অবহিত করা হয়েছে এবং আমি স্বেচ্ছায় অধ্যয়নে অংশ নিতে সম্মতি দিয়েছি।	

অংশগ্রহণকারীর নাম: _____ স্বাক্ষর: _____

গবেষকের স্বাক্ষর: _____ তারিখ: _____

Withdrawal Form (Bangla)

সম্মতি প্রত্যাহার পত্র

গবেষণার শিরোনাম: বয়স্ক ব্যক্তিদের মনস্তাত্ত্বিক সুস্থতা এবং স্ব-কার্যকারিতা সম্পর্কিত তুলনামূলক গবেষণা: বাংলাদেশে কমিউনিটি-বাসকারী বনাম আবাসিক সুবিধাপ্রাপ্ত বয়স্ক।

গবেষকের নাম: দিশা বিশ্বাস ৪র্থ বছর, বি এস সি ইন অকুপেশনাল থেরাপি, সেশনঃ ২০১৮-১৯

আমি _____ আনুষ্ঠানিকভাবে গবেষণা থেকে আমার অংশগ্রহণ প্রত্যাহার করছি। আমি কোনও পরিণতি ছাড়াই গবেষণা থেকে সরে আসার সিদ্ধান্তটি নিশ্চিত করার জন্য এই নোটিশটি সরবরাহ করছি।

এই ফর্মটিতে স্বাক্ষর করার মাধ্যমে, আমি এই গবেষণা থেকে আমার প্রত্যাহার নিশ্চিত করি এবং অনুরোধ করি যে, সংগৃহীত তথ্য কোনো বিশ্লেষণ বা ব্যবহার থেকে সরানো হোক।

অংশগ্রহণকারীর নাম:_____ **স্বাক্ষর:**_____

গবেষকের স্বাক্ষর: _____ **তারিখ** ____/____/_____

Appendix Ca: Questionnaire (English)

Socio–demographic Questionnaire (English)

Socio-demographic Information: Community

Please answer the following question and mark the (✓) relevant answer:

1. The Age:

2. The Gender: [ ] Male [ ] Female [ ] Something Else:_____

3. The Religions: [ ] Islam [ ] Hinduism [ ] Christianity [ ] Buddhist [ ] Other (please specify): 4. Marital Status: [ ] Unmarried [ ] Married [ ] Divorced [ ] Widow [ ] Other (please specify):

5. Educational Qualification: What is the highest level of education you have completed?

[ ] Primary [ ] SSC [ ] HSC [ ] Bachelor's Degree [ ] Master's Degree or above

[ ] Illiterate [ ] Literacy [ ] Other (please specify): _____

6. The Are you currently engaged in a job?

[ ] Employed (full-time) [ ] Employed (part-time) [ ] Retired

[ ] Unemployed (looking for work) [ ] Housewife [ ] Other (please specify):

7. Income: What is your estimated annual family income? TK. _____

8. The Are you financially dependent on someone? [ ] Yes (please specify)_____ [ ] No

9. The Financial Security: How secure do you feel about your finances?

[ ] Very secure [ ] Somewhat protected [ ] Neutral [ ] Somewhatnon-secure [ ] Very non-secure [ ] Very unprotected

10. Old Age Allowance: Do you receive any government old age allowance? [ ] Yes [ ] No

11. Do you have children? [ ] Yes (how many)_____ [ ] No

12. Who are you currently living with?

[ ] Single [ ] Spouse/Partner [ ] Children [ ] Other family members

[ ] Residential institutions like old age homes [ ] Nursing homes [ ] Other (please specify):

13. How many years have you lived in your current residence? _____

14. Between 1 and 5, how satisfied are you with your current living arrangements? (1 = Very Dissatisfied, 5 = Very Satisfied); [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

15. Residential Area: [ ] Village [ ] City [ ] Mofussil

16. What kind of social support or help do you receive from family, friends or society?

[ ] Adequate [ ] Limited [ ] No social support

17. Do you have a chronic illness or disability that affects your daily life? [ ] Yes (please specify)_____ [ ] No

18. How much help do you need to move?

[ ] Self-Help [ ] Little Help [ ] Overall Help [ ] Many Help [ ] Through Wheelchair

19. Exercise and physical activities: How often do you engage in exercise or physical activity?

[ ] Every day [ ] Several times a week [ ] Once a week [ ] Rarely [ ] Never

20. Social Involvement: How socially involved do you consider yourself to be? (For example, participation in social activities, clubs or social gatherings)

[ ] Very socially involved [ ] Moderately socially engaged

[ ] Not very socially engaged [ ] Isolated or rarely involved

21. Are you actively involved in community organizations or volunteer activities?

[ ] Yes (please specify)_____ [ ] No

22. Use of technology: Do you regularly use technological devices (e.g., smartphones, computers)? [ ] Yes [ ] No

23. Do you get involved in any leisure activities in your spare time? [ ] Yes [ ] No

24. Which of the following leisure activities do you enjoy taking part in?

[ ] Reading (books, newspapers, magazines) [ ] Watching TV or movies [ ] Gardening [ ] Socializing with others [ ] Other (please specify): _____

Socio-demographic Information: Residential Care Facilities

Please answer the following question and mark the (✓) relevant answer:

1. The Age:

2. The Gender: [ ] Male [ ] Female [ ] Something Else:_____

3. The Religions: [ ] Islam [ ] Hinduism [ ] Christianity [ ] Buddhist [ ] Other (please specify):

4. Marital Status: [ ] Unmarried [ ] Married [ ] Divorced [ ] Widow [ ] Other (please specify):

5. Educational Qualification: What is the highest level of education you have completed?

[ ] Primary [ ] SSC [ ] HSC [ ] Bachelor's Degree [ ] Master's Degree or above

[ ] Illiterate [ ] Literacy [ ] Other (please specify): _____

8. The Are you financially dependent on someone? [ ] Yes (please specify)_____ [ ] No

9. The Financial Security: How secure do you feel about your finances?

[ ] Very secure [ ] Somewhat secure [ ] Neutral [ ] Somewhat unsecure [ ] Very unsecure

10. Old Age Allowance: Do you receive any government old age allowance? [ ] Yes [ ] No

11. Do you have children? [ ] Yes (how many)_____ [ ] No

12. Who are you currently living with?

[ ] Single [ ] Spouse/Partner [ ] Children [ ] Other family members

[ ] Residential institutions like old age homes [ ] Nursing homes [ ] Other (please specify):

13. How long have you been living in this residential facility? _____

14. Between 1 and 5, how satisfied are you with your current living arrangements? (1 = Very Dissatisfied, 5 = Very Satisfied) [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5

15. How much help do you need to move?

[ ] Self-Help [ ] Little Help [ ] Overall Help [ ] Many Help [ ] Through Wheelchair

16. Type of Accommodation: [ ] Separate One Room [ ] Public Room

17. How often do you see your family? [ ] Weekly [ ] Monthly [ ] Sometimes [ ] Never

18. What improvements would you recommend to improve your living arrangement here? (Mark relevant answer)

[ ] More diverse meals [ ] Increase recreational and leisure activities

[ ] Improve communication with employees [ ] Privacy system

[ ] Better provision of personal needs [ ] Other (please specify): _____

19. What kind of social support or help do you receive from family, friends or society?

[ ] Adequate [ ] Limited [ ] No social support

20. Do you have a chronic illness or disability that affects your daily life? [ ] Yes (please specify)_____ [ ] No

21. Exercise and physical activities: How often do you engage in exercise or physical activity? [ ] Every day [ ] Several times a week [ ] Once a week [ ] Rarely [ ] Never

22. Social Involvement: How socially involved do you consider yourself to be? (For example, participation in social activities, clubs or social gatherings)

[ ] Very socially involved [ ] Moderately socially engaged

[ ] Not very socially engaged [ ] Isolated or rarely involved

23. Are you actively involved in community organizations or volunteer activities?

[ ] Yes (please specify)_____ [ ] No

24. Use of technology: Do you regularly use technological devices (e.g., smartphones, computers)? [ ] Yes [ ] No

25. Do you get involved in any leisure activities in your spare time? [ ] Yes [ ] No

26. Which of the following leisure activities do you enjoy taking part in?

[ ] Reading (books, newspapers, magazines) [ ] Watching TV or movies [ ] Gardening [ ] Socializing with others [ ] Other (please specify): __

Information about organizations that provide residential facilities:

1. The Facility Type: [ ] Residential Care Facility [ ] Nursing Home [ ] Other

2. The Institution Size: [ ] Small (1-50 residents) [ ] Medium (51-100 residents) [ ] Large (101+ residents)

3. The Type of Services Provided: [ ] Personal Care [ ] Medical Care [ ] Social Work [ ] Rehabilitation Services [ ] Other (please specify)_____

4. Total number of inhabitants:_____ male_____female_____

5. Average age of residents:

6. The General Facilities: [ ] Dining Hall [ ] Recreation Rooms [ ] Outdoor Space [ ] Library [ ] Prayer Room [ ] Other (please specify)_____

7. Community Engagement Program: [ ] Regular Events [ ] Volunteer Programs [ ] Educational Programs [ ] Other (please specify)_____

Ryff's Psychological Well-Being- 42 item (English)

The following set of questions deals with how you feel about yourself and your life. Please remember that there are no right or wrong answers.

Circle the number that best describes your present agreement or disagreement with each statement.	Strongly Disagree	Disagree Somewhat	Disagree Slightly	Agree Slightly	Agree Somewhat	Strongly Agree
1. I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.	1	2	3	4	5	6
2. In general, I feel I am in charge of the situation in which I live.	1	2	3	4	5	6
3. I am not interested in activities that will expand my horizons.	1	2	3	4	5	6
4. Most people see me as loving and affectionate.	1	2	3	4	5	6
5. I live life one day at a time and don't really think about the future.	1	2	3	4	5	6
6. When I look at the story of my life, I am pleased with how things have turned out.	1	2	3	4	5	6
7. My decisions are not usually influenced by what everyone else is doing.	1	2	3	4	5	6
8. The demands of everyday life often get me down.	1	2	3	4	5	6
9. I think it is important to have new experiences that challenge how you think about yourself and the world.	1	2	3	4	5	6
10. Maintaining close relationships has been difficult and frustrating for me.	1	2	3	4	5	6
11. I have a sense of direction and purpose in life.	1	2	3	4	5	6
12. In general, I feel confident and positive about myself.	1	2	3	4	5	6
13. I tend to worry about what other people think of me.	1	2	3	4	5	6
14. I do not fit very well with the people and the community around me.	1	2	3	4	5	6

15. When I think about it, I haven't really improved much as a person over the years.	1	2	3	4	5	6
16. I often feel lonely because I have few close friends with whom to share my concerns.	1	2	3	4	5	6
17. My daily activities often seem trivial and unimportant to me.	1	2	3	4	5	6
18. I feel like many of the people I know have gotten more out of life than I have.	1	2	3	4	5	6
19. I tend to be influenced by people with strong opinions.	1	2	3	4	5	6
20. I am quite good at managing the many responsibilities of my daily life.	1	2	3	4	5	6
21. I have a sense that I have developed a lot as a person over time.	1	2	3	4	5	6
22. I enjoy personal and mutual conversations with family members or friends.	1	2	3	4	5	6
23. I don't have a good sense of what it is I'm trying to accomplish in life.	1	2	3	4	5	6
24. I like most aspects of my personality.	1	2	3	4	5	6
25. I have confidence in my opinions, even if they are contrary to the general consensus.	1	2	3	4	5	6
26. I often feel overwhelmed by my responsibilities.	1	2	3	4	5	6
27. I do not enjoy being in new situations that require me to change my old familiar ways of doing things.	1	2	3	4	5	6
28. People would describe me as a giving person, willing to share my time with others.	1	2	3	4	5	6
29. I enjoy making plans for the future and working to make them a reality.	1	2	3	4	5	6
30. In many ways, I feel disappointed about my achievements in life.	1	2	3	4	5	6

31. It's difficult for me to voice my own opinions on controversial matters.	1	2	3	4	5	6
32. I have difficulty arranging my life in a way that is satisfying to me.	1	2	3	4	5	6
33. For me, life has been a continuous process of learning, changing, and growth.	1	2	3	4	5	6
34. I have not experienced many warm and trusting relationships with others.	1	2	3	4	5	6
35. Some people wander aimlessly through life, but I am not one of them.	1	2	3	4	5	6
36. My attitude about myself is probably not as positive as most people feel about themselves.	1	2	3	4	5	6
37. I judge myself by what I think is important, not by the values of what others think is important.	1	2	3	4	5	6
38. I have been able to build a home and a lifestyle for myself that is much to my liking.	1	2	3	4	5	6
39. I gave up trying to make big improvements or changes in my life a long time ago.	1	2	3	4	5	6
40. I know that I can trust my friends, and they know they can trust me.	1	2	3	4	5	6
41. I sometimes feel as if I've done all there is to do in life.	1	2	3	4	5	6
42. When I compare myself to friends and acquaintances, it makes me feel good about who I am.	1	2	3	4	5	6

Scales & Items:

Items shaded grey (# 3, 5, 8, 10, 13, 14, 15, 16, 17, 18, 19, 23, 26, 27, 30, 31, 32, 34, 36, 39, 41) should be reverse scored:

Six Scales:	Items in that Scale (in the questionnaire below):						
Autonomy	1	7	13	19	25	31	37
Environmental Mastery	2	8	14	20	26	32	38
Personal Growth	3	9	15	21	27	33	39
Positive Relations with Others	4	10	16	22	28	34	40
Purpose in Life	5	11	17	23	29	35	41
Self-Acceptance	6	12	18	24	30	36	42

Interpretation of Scores (for all scale lengths):

- There are no specific scores or cut-points for defining high or low well-being. Those distinctions can be derived from distributional information from the data collected. For example, high well-being could refer to scores in the top 25% (quartile) of the distribution, whereas low well-being could be scores in the bottom 25% (quartile) of the distribution. Another alternative is to define high well-being as scores that are 1.5 standard deviations above the mean, whereas low well-being is scores that are 1.5 standard deviations below the mean.
- To obtain an overall psychological well-being score, scores on individual scales can be combined into a composite score, which could be interpreted following the above guidelines.
- It is possible to use only some of the six dimensions of well-being that are meaningfully connected to the research questions of a particular study.

Response Format and Reverse Scoring:

- To create the overall assessment scale, items from the separate scales are **mixed** by putting them in alphabetical order by scale name and then taking one item from each scale successively into a continuous self-report instrument.
- **Response formats:** strongly disagree (1), disagree somewhat (2), disagree slightly (3), agree slightly (4), agree somewhat (5), strongly agree (6).
- Responses to **negatively scored items (—)** are reversed in the final scoring procedures so that high scores indicate high self-ratings on the dimension assessed. That is, negatively worded items are flipped so that a "6" (Strongly Agree) is recoded as a "1", “5” is recoded as a “2,” and so on.

General Self-Efficacy Scale (English)

About: This scale is a self-report measure of self-efficacy.

Items: 10

	Not at all true	Hardly true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try hard enough	□	□	□	□
2. If someone opposes me, I can find the means and ways to get what I want.	□	□	□	□
3. It is easy for me to stick to my aims and accomplish my goals.	□	□	□	□
4. I am confident that I could deal efficiently with unexpected events.	□	□	□	□
5. Thanks to my resourcefulness, I know how to handle unforeseen situations.	□	□	□	□
6. I can solve most problems if I invest the necessary effort.	□	□	□	□
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	□	□	□	□
8. When I am confronted with a problem, I can usually find several solutions.	□	□	□	□
9. If I am in trouble, I can usually think of a solution	□	□	□	□
10. I can usually handle whatever comes my way.	□	□	□	□

Scoring:

	Not at all true	Hardly true	Moderately true	Exactly true
All questions	1	2	3	4

The total score is calculated by finding the sum of all items. For the GSE, the total score ranges between 10 and 40, with a higher score indicating more self-efficacy.

Appendix Cb Questionnaire (Bangla)

কোড নংঃ

আর্থ-সামাজিক তথ্য

আর্থ-সামাজিক তথ্য: কমিউনিটি-বাসকারী

দয়া করে নিম্নলিখিত প্রশ্নের উত্তর দিন এবং (✓) প্রাসঙ্গিক উত্তরটি চিহ্নিত করুন:

১। বয়স:

২। লিঙ্গ: [ ] পুরুষ [ ] মহিলা [ ] অন্য কিছু:_____

৩। ধর্ম: [ ] ইসলাম [ ] হিন্দু [ ] খ্রিস্টান [ ] বৌদ্ধ [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

৪। বৈবাহিক অবস্থা:

[ ] অবিবাহিত [ ] বিবাহিত [ ] তালাকপ্রাপ্ত [ ] বিধবা [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

৫। শিক্ষাগত যোগ্যতা: আপনি কোন সর্বোচ্চ স্তরের শিক্ষা সম্পন্ন করেছেন?

[ ] প্রাইমারি [ ] এস এস সি [ ] এইচ এস সি [ ] ব্যাচেলর ডিগ্রি [ ] মাস্টার্স ডিগ্রি বা তদুর্দ্ধ

[ ] নিরক্ষর [ ] সাক্ষরতা [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন): _____

৬। আপনি কি বর্তমানে কোনো কাজে নিয়োজিত আছেন?

[ ] নিযুক্ত (ফুল-টাইম) [ ] নিযুক্ত (খণ্ডকালীন) [ ] অবসরপ্রাপ্ত

[ ] বেকার (কাজ খুঁজছেন) [ ] গৃহিণী [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

৭। আয়: আপনার আনুমানিক বার্ষিক পারিবারিক আয় কত? _____টাকা

৮। আপনি কি আর্থিক ভাবে কারো উপর নির্ভরশীল? [ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

৯। আর্থিক সুরক্ষা: আপনি আপনার আর্থিক অবস্থা সম্পর্কে কতটা সুরক্ষিত বোধ করেন?

[ ] খুব সুরক্ষিত [ ] কিছুটা সুরক্ষিত [ ] নিরপেক্ষ [ ] কিছুটা অসুরক্ষিত [ ] খুব অসুরক্ষিত

১০। বয়স্ক ভাতা: আপনি কি কোনো সরকারি বয়স্ক ভাতা পান? [ ] হ্যাঁ [ ] না

১১। আপনার কি সন্তান আছে? [ ] হ্যাঁ (কয়জন)_____ [ ] না

১২। আপনি বর্তমানে কার সাথে বসবাস করছেন?

[ ] একা [ ] স্বামী/স্ত্রী /সঙ্গী [ ] সন্তান [ ] পরিবারের অন্যান্য সদস্য

[ ] বৃদ্ধাশ্রমের মত আবাসিক প্রতিষ্ঠান [ ] নার্সিং হোম [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

১৩। আপনি আপনার বর্তমান বাসস্থানে কত বছর বসবাস করেছেন? _____

১৪। ১ থেকে ৫ এর মধ্যে, আপনি আপনার বর্তমান বসবাসের ব্যবস্থা নিয়ে কতটা সন্তুষ্ট? (১ = খুব অসন্তুষ্ট, ৫ = খুব সন্তুষ্ট); [ ] ১ [ ] ২ [ ] ৩ [ ] ৪ [ ] ৫

১৫। আবাসিক এলাকাঃ [ ] গ্রাম [ ] শহর [ ] মফস্বল

১৬। আপনি পরিবার, বন্ধুবান্ধব বা সমাজ থেকে কেমন সামাজিক সাহায্য বা যেকনো সাহায্য পেয়ে থাকেন?

[ ] পর্যাপ্ত [ ] সীমিত [ ] কোন সামাজিক সহায়তা নেই

১৭। আপনার কি কোনও দীর্ঘস্থায়ী অসুস্থথা বা অক্ষমতা রয়েছে যা আপনার দৈনন্দিন জীবনকে প্রভাবিত করে? [ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

১৮। আপনার চলাফেরা করতে কি পরিমাণ সাহায্যের দরকার হয়?

[ ] স্বনির্ভর [ ] অল্প সাহায্য [ ] মোটামটি সাহায্য [ ] অনেক সাহায্য [ ] হুইলচেয়ারের মাধ্যমে

১৯। ব্যায়াম এবং শারীরিক কার্যক্রম: আপনি কতবার ব্যায়াম বা শারীরিক কার্যক্রমে জড়িত হন?

[ ] প্রতিদিন [ ] সপ্তাহে কয়েকবার [ ] সপ্তাহে একবার [ ] খুব কমই [ ] কখনও নয়

২০। সামাজিক সম্পৃক্ততা: আপনি নিজেকে কতটা সামাজিকভাবে জড়িত বলে মনে করেন? (উদাহরণস্বরূপ, সমাজিক কার্যক্রম, ক্লাব বা সামাজিক সমাবেশে অংশগ্রহণ)

[ ] খুব সামাজিকভাবে জড়িত [ ] পরিমিতভাবে সামাজিকভাবে জড়িত

[ ] খুব সামাজিকভাবে জড়িত নয় [ ] বিচ্ছিন্ন বা খুব কমই জড়িত

২১। আপনি কি কোনো কমিউনিটি সংগঠন বা স্বেচ্ছাসেবী কার্যক্রমে সক্রিয়ভাবে জড়িত?

[ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

২২। প্রযুক্তির ব্যবহার: আপনি কি নিয়মিত প্রযুক্তিগত ডিভাইস (যেমন, স্মার্টফোন, কম্পিউটার) ব্যবহার করেন? [ ] হ্যাঁ [ ] না

২৩। আপনি কি আপনার অবসর সময়ে কোনো অবসর কার্যক্রমে জড়িত হন? [ ] হ্যাঁ [ ] না

২৪। নিম্নলিখিত অবসর ক্রিয়াকলাপগুলির মধ্যে কোনটি আপনি অংশ নিতে উপভোগ করেন?

[ ] পড়া(বই, খবরের কাগজ, ম্যাগাজিন) [ ] টিভি বা সিনেমা দেখা [ ] বাগান করা [ ] বোর্ড গেমস বা কার্ড খেলা [ ] অন্যদের সাথে সামাজিকীকরণ [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

_____

আর্থ-সামাজিক তথ্য: আবাসিক সুবিধাপ্রাপ্ত

দয়া করে নিম্নলিখিত প্রশ্নের উত্তর দিন এবং (✓) প্রাসঙ্গিক উত্তরটি চিহ্নিত করুন:

১। বয়স:

২। লিঙ্গ: [ ] পুরুষ [ ] মহিলা [ ] অন্য কিছু:_____

৩। ধর্ম: [ ] ইসলাম [ ] হিন্দু [ ] খ্রিস্টান [ ] বৌদ্ধ [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

৪। বৈবাহিক অবস্থা:

[ ] অবিবাহিত [ ] বিবাহিত [ ] তালাকপ্রাপ্ত [ ] বিধবা [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

৫। শিক্ষাগত যোগ্যতা: আপনি কোন সর্বোচ্চ স্তরের শিক্ষা সম্পন্ন করেছেন?

[ ] প্রাইমারি [ ] এস এস সি [ ] এইচ এস সি [ ] ব্যাচেলর ডিগ্রি [ ] মাস্টার্স ডিগ্রি বা তদুর্দ্ধ

[ ] নিরক্ষর [ ] সাক্ষরতা [ ]অন্যান্য (দয়া করে নির্দিষ্ট করুন): _____

৮। আপনি কি আর্থিক ভাবে কারো উপর নির্ভরশীল? [ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

৯। আর্থিক সুরক্ষা: আপনি আপনার আর্থিক অবস্থা সম্পর্কে কতটা সুরক্ষিত বোধ করেন?

[ ] খুব সুরক্ষিত [ ] কিছুটা সুরক্ষিত [ ] নিরপেক্ষ [ ] কিছুটা অসুরক্ষিত [ ] খুব অসুরক্ষিত

১০। বয়স্ক ভাতা: আপনি কি কোনো সরকারি বয়স্ক ভাতা পান? [ ] হ্যাঁ [ ] না

১১। আপনার কি সন্তান আছে? [ ] হ্যাঁ (কয়জন)_____ [ ] না

১২। আপনি বর্তমানে কার সাথে বসবাস করছেন?

[ ] একা [ ] স্বামী/স্ত্রী /সঙ্গী [ ] সন্তান [ ] পরিবারের অন্যান্য সদস্য

[ ] বৃদ্ধাশ্রমের মত আবাসিক প্রতিষ্ঠান [ ] নার্সিং হোম [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন):

১৩। আপনি কতদিন ধরে এই আবাসিক সুবিধায় বসবাস করছেন? _____

১৪। ১ থেকে ৫ এর মধ্যে, আপনি আপনার বর্তমান বসবাসের ব্যবস্থা নিয়ে কতটা সন্তুষ্ট? (১ = খুব অসন্তুষ্ট, ৫ = খুব সন্তুষ্ট) [ ] ১ [ ] ২ [ ] ৩ [ ] ৪ [ ] ৫

১৫। আপনার চলাফেরা করতে কি পরিমাণ সাহায্যের দরকার হয়?

[ ] স্বনির্ভর [ ] অল্প সাহায্য [ ] মোটামটি সাহায্য [ ] অনেক সাহায্য [ ] হুইলচেয়ারের মাধ্যমে

১৬। বাসস্থানের ধরণঃ [ ] আলাদা এক রুম [ ]গণ রুম

১৭। পরিবারের সাথে আপনার কতবার দেখা হয়? [ ] সাপ্তাহিক [ ] মাসিক [ ] মাঝে মাঝে [ ] কখনও না

১৮। এখানে আপনার জীবনযাত্রার ব্যবস্থা উন্নত করার জন্য আপনি কী কী উন্নতির পরামর্শ দেবেন? (প্রাসঙ্গিক উত্তরটি চিহ্নিত করুন)

[ ] আরও বৈচিত্র্যময় খাবার [ ] বিনোদনমূলক এবং অবসর কার্যক্রম বৃদ্ধি

[ ] কর্মীদের সাথে যোগাযোগের উন্নতি [ ] গোপনীয়তা ব্যবস্থা

[ ] ব্যক্তিগত প্রয়োজনের আরও ভাল ব্যবস্থা [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন): _____

১৯। আপনি পরিবার, বন্ধুবান্ধব বা সমাজ থেকে কেমন সামাজিক সাহায্য বা যেকনো সাহায্য পেয়ে থাকেন?

[ ] পর্যাপ্ত [ ] সীমিত [ ] কোন সামাজিক সহায়তা নেই

২০। আপনার কি কোনও দীর্ঘস্থায়ী অসুস্থথা বা অক্ষমতা রয়েছে যা আপনার দৈনন্দিন জীবনকে প্রভাবিত করে? [ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

২১। ব্যায়াম এবং শারীরিক কার্যক্রম: আপনি কতবার ব্যায়াম বা শারীরিক কার্যক্রমে জড়িত হন?

[ ] প্রতিদিন [ ] সপ্তাহে কয়েকবার [ ] সপ্তাহে একবার [ ] খুব কমই [ ] কখনও নয়

২২। সামাজিক সম্পৃক্ততা: আপনি নিজেকে কতটা সামাজিকভাবে জড়িত বলে মনে করেন? (উদাহরণস্বরূপ, সমাজিক কার্যক্রম, ক্লাব বা সামাজিক সমাবেশে অংশগ্রহণ)

[ ] খুব সামাজিকভাবে জড়িত [ ] পরিমিতভাবে সামাজিকভাবে জড়িত

[ ] খুব সামাজিকভাবে জড়িত নয় [ ] বিচ্ছিন্ন বা খুব কমই জড়িত

২৩। আপনি কি কোনো কমিউনিটি সংগঠন বা স্বেচ্ছাসেবী কার্যক্রমে সক্রিয়ভাবে জড়িত?

[ ] হ্যাঁ (দয়া করে নির্দিষ্ট করুন)_____ [ ] না

২৪। প্রযুক্তির ব্যবহার: আপনি কি নিয়মিত প্রযুক্তিগত ডিভাইস (যেমন, স্মার্টফোন, কম্পিউটার) ব্যবহার করেন? [ ] হ্যাঁ [ ] না

২৫। আপনি কি আপনার অবসর সময়ে কোনো অবসর কার্যক্রমে জড়িত হন? [ ] হ্যাঁ [ ] না

২৬। নিম্নলিখিত অবসর ক্রিয়াকলাপগুলির মধ্যে কোনটি আপনি অংশ নিতে উপভোগ করেন?

[ ] পড়া(বই, খবরের কাগজ, ম্যাগাজিন) [ ] টিভি বা সিনেমা দেখা [ ] বাগান করা [ ] বোর্ড গেমস বা কার্ড খেলা [ ] অন্যদের সাথে সামাজিকীকরণ [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন): __

আবাসিক সুবিধা প্রদান করে এমন প্রতিষ্ঠানের তথ্যঃ

১। সুবিধার ধরণ: [ ] আবাসিক যত্ন সুবিধা [ ] নার্সিং হোম [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন)

২। প্রতিষ্ঠানের আকার: [ ] ছোট (১-৫০ বাসিন্দা) [ ] মাঝারি (৫১-১০০ বাসিন্দা) [ ] বড় (১০১+ বাসিন্দা)

৩। প্রদত্ত পরিষেবার ধরণ: [ ] ব্যক্তিগত যত্ন [ ] মেডিক্যাল কেয়ার [ ] সামাজিক কর্মকাণ্ড [ ] পুনর্বাসন সেবা

[ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন)_____

৪। মোট বাসিন্দার সংখ্যা:_____ পুরুষ_____নারী_____

৫। বাসিন্দাদের গড় বয়স:

৬। সাধারণ সুবিধাসমুহ: [ ] ডাইনিং হল [ ] বিনোদন কক্ষ [ ] আউটডোর স্পেস [ ] লাইব্রেরী

[ ] প্রার্থনা কক্ষ [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন)_____

৭। কমিউনিটি এনগেজমেন্ট প্রোগ্রাম:

[ ] নিয়মিত ইভেন্ট [ ] স্বেচ্ছাসেবক প্রোগ্রাম [ ] শিক্ষামূলক কর্মসূচী [ ] অন্যান্য (দয়া করে নির্দিষ্ট করুন)_____

মনস্তাত্ত্বিক সুস্থতার স্কেল

প্রতিটি বিবৃতির সাথে আপনার বর্তমান সম্মর্থন বা মতবিরোধকে সর্বোত্তমভাবে বর্ণনা করে এমন সংখ্যাটি বৃত্তাকার করুন।	দৃঢ়ভাবে একমত নই	একমত নই	কিছুটা একমত নই	কিছুটা একমত	একমত	দৃঢ়ভাবে একমত
১। যখন বেশিরভাগ মানুষই আমার মতামতের বিরোধিতা করে, তখনও আমি আমার মতামত বলতে ভয় পাই না।	১	২	৩	৪	৫	৬
২। সাধারণত, আমার মনে হয়, আমি যে পরিস্থিতিতে বাস করি তার দায়িত্বে আমি আছি।	১	২	৩	৪	৫	৬
৩। আমি এমন কাজগুলো করতে আগ্রহী নই যা আমার চিন্তার গভীরতাকে বৃদ্ধি করবে।	১	২	৩	৪	৫	৬
৪। বেশিরভাগ মানুষই আমাকে স্নেহশীল এবং স্নেহপূর্ণ হিসাবে মনে করে।	১	২	৩	৪	৫	৬
৫। আমি একদিন করে বাঁচি এবং ভবিষ্যত নিয়ে তেমন ভাবি না।	১	২	৩	৪	৫	৬
৬। আমি যখন আমার জীবনের গল্পের দিকে তাকাই, তখন যা কিছু, যেভাবে হয়েছে সেটাতে আমি সন্তুষ্ট হই।	১	২	৩	৪	৫	৬
৭। আমার সিদ্ধান্ত সাধারণত অন্য সবাই কি করছে তার দ্বারা প্রভাবিত হয় না।	১	২	৩	৪	৫	৬
৮। দৈনন্দিন জীবনের চাহিদাগুলো আমাকে প্রায়শই হতাশ করে।	১	২	৩	৪	৫	৬
৯। আমি মনে করি নতুন অভিজ্ঞতা অর্জন করা গুরুত্বপূর্ণ যা নিজের এবং বিশ্ব সম্পর্কে কীভাবে চিন্তা করা হয় তা চ্যালেঞ্জ করে।	১	২	৩	৪	৫	৬
১০। ঘনিষ্ঠ সম্পর্ক বজায় রাখা আমার জন্য কঠিন এবং হতাশাজনক ছিল।	১	২	৩	৪	৫	৬
১১। আমার জীবনের একটি নির্দিষ্ট দিক এবং উদ্দেশ্য আছে।	১	২	৩	৪	৫	৬
১২। সাধারণভাবে, আমি নিজের সম্পর্কে আত্মবিশ্বাসী এবং ইতিবাচক বোধ করি।	১	২	৩	৪	৫	৬
১৩। অন্য লোকেরা আমার সম্পর্কে কি ভাবে তা নিয়ে আমি চিন্তিত থাকি।	১	২	৩	৪	৫	৬

১৪। আমি আমার আশেপাশের মানুষ এবং সমাজের সাথে খুব ভাল মানানসই নই।	১	২	৩	৪	৫	৬
১৫। এই বিষয়ে আমি চিন্তা করে দেখছি, যে আমি বছরের পর বছর ধরে একজন ব্যক্তি হিসাবে সত্যিই খুব বেশি উন্নতি করিনি।	১	২	৩	৪	৫	৬
১৬। আমার প্রায়ই একা লাগে কারণ আমার খুব কমই কাছের বন্ধু আছে যাদের সাথে আমি আমার চিন্তাগুলো শেয়ার করতে পারি।	১	২	৩	৪	৫	৬
১৭। আমার দৈনন্দিন কাজকর্ম প্রায়ই আমার কাছে তুচ্ছ এবং গুরুত্বহীন বলে মনে হয়।	১	২	৩	৪	৫	৬
১৮। আমার মনে হয় যে, আমি জীবন থেকে যা পেয়েছি, আমার পরিচিত অনেক মানুষই তার থেকে বেশি পেয়েছে।	১	২	৩	৪	৫	৬
১৯। আমি দৃঢ় মতামতের লোকদের দ্বারা প্রভাবিত হই।	১	২	৩	৪	৫	৬
২০। আমি আমার দৈনন্দিন জীবনের দায়িত্বগুলো বেশ ভালোভাবে সামলাতে পারি।	১	২	৩	৪	৫	৬
২১। আমার মনে হয় যে সময়ের সাথে সাথে আমি একজন ব্যক্তি হিসাবে অনেক উন্নতি করেছি	১	২	৩	৪	৫	৬
২২। আমি পরিবারের সদস্য বা বন্ধুদের সাথে ব্যক্তিগত এবং পারস্পরিক কথাবলা উপভোগ করি	১	২	৩	৪	৫	৬
২৩। আমি জীবনে যে কী অর্জন করার চেষ্টা করছি সে সম্পর্কে আমার ভাল ধারণা নেই।	১	২	৩	৪	৫	৬
২৪। আমি আমার ব্যক্তিত্বের বেশিরভাগ দিকই পছন্দ করি।	১	২	৩	৪	৫	৬
২৫। সবার মতের বিপরীত হলেও আমি আমার মতামতের উপর আস্থা রাখি।	১	২	৩	৪	৫	৬
২৬। আমি প্রায়ই আমার দায়িত্বগুলো দ্বারা অনেক বেশি অভিভুত হয়ে পরি।	১	২	৩	৪	৫	৬
২৭। আমি সাধারণত যেভাবে কাজ করে থাকি, তা পরিবর্তন করতে বাধ্য করে এমন নতুন পরিস্থিতিতে থাকতে পছন্দ করি না।	১	২	৩	৪	৫	৬

২৮। লোকেরা আমাকে, অন্যকে সময় দেয় এমন ব্যক্তি হিসাবে বর্ণনা করবে, অন্যদের সাথে আমার সময় সেয়ার করতে ইচ্ছুক থাকি।	১	২	৩	৪	৫	৬
২৯। আমি ভবিষ্যতের জন্য পরিকল্পনা করতে এবং সেগুলিকে বাস্তবে পরিণত করার জন্য কাজ করতে পছন্দ করি।	১	২	৩	৪	৫	৬
৩০। অনেক দিক থেকেই, আমি আমার জীবনের অর্জন সম্পর্কে হতাশ বোধ করি।	১	২	৩	৪	৫	৬
৩১। বিতর্কিত বিষয়ে আমার নিজের মতামত প্রকাশ করা কঠিন।	১	২	৩	৪	৫	৬
৩২। আমার কাছে যা সন্তোষজনক সেভাবে আমার জীবনকে সাজাতে অসুবিধা হয় ।	১	২	৩	৪	৫	৬
৩৩। আমার জন্য জীবন, শেখার, পরিবর্তন এবং বৃদ্ধির একটি ধারাবাহিক প্রক্রিয়া ছিল।	১	২	৩	৪	৫	৬
৩৪। আমি অন্যদের সাথে তেমন আন্তরিক এবং বিশ্বাসযোগ্য সম্পর্ক অনুভব করিনি।	১	২	৩	৪	৫	৬
৩৫। কিছু মানুষ জীবনে উদ্দেশ্যহীনভাবে ঘুরে বেড়ায়, কিন্তু আমি তাদের একজন নই।	১	২	৩	৪	৫	৬
৩৬। নিজের সম্পর্কে আমার মনোভাব সম্ভবত ততটা ইতিবাচক নয় যতটা বেশির ভাগ মানুষ নিজের সম্পর্কে অনুভব করে।	১	২	৩	৪	৫	৬
৩৭। আমি যা গুরুত্বপূর্ণ মনে করি তার দ্বারা আমি নিজেকে বিচার করি, অন্যরা যা গুরুত্বপূর্ণ মনে করে তা দিয়ে নয়।	১	২	৩	৪	৫	৬
৩৮। আমি আমার পছন্দ মতো নিজের জন্য একটি আবাস এবং একটি জীবনধারা তৈরি করতে সক্ষম হয়েছি।	১	২	৩	৪	৫	৬
৩৯। আমি অনেক আগে থেকেই আমার জীবনে বড় উন্নতি বা পরিবর্তন আনার চেষ্টা ছেড়ে দিয়েছি	১	২	৩	৪	৫	৬
৪০। আমি জানি যে আমি আমার বন্ধুদের বিশ্বাস করতে পারি, এবং তারা জানে যে তারা আমাকে বিশ্বাস করতে পারে।	১	২	৩	৪	৫	৬
৪১। আমার মাঝে মাঝে মনে হয় জীবনে যা	১	২	৩	৪	৫	৬

করার ছিল তার সবই আমি করে ফেলেছি।						
৪২। যখন আমি নিজেকে বন্ধুবান্ধব এবং পরিচিতদের সাথে তুলনা করি, তখন আমি আমাকে নিয়ে ভালো অনুভব করি।	১	২	৩	৪	৫	৬

সাধারণ স্ব-কার্যকারিতা স্কেল

	একদমই সত্য না	খুব কমই সত্য	পরিমিত রুপে সত্য	একদমইসত্য
১। আমি যদি যথেষ্ট চেষ্টা করি, তাহলে সবসময় কঠিন সমস্যাগুলো সমাধান করতে পারি।	□	□	□	□
২। কেউ আমার বিরোধিতা করলেও, আমি যা চাই তা পাওয়ার উপায় খুঁজে বের করতে পারি।	□	□	□	□
৩। যেকোনো লক্ষ্যে লেগে থাকা এবং তা অর্জন করা আমার পক্ষে সহজ।	□	□	□	□
৪। আমি আত্মবিশ্বাসী যে আমি অপ্রত্যাশিত ঘটনাগুলো দক্ষতার সাথে মোকাবেলা করতে পারব।	□	□	□	□
৫। আমি আমার দক্ষতাকে ধন্যবাদ দিই যে আমি জানি কিভাবে অপ্রত্যাশিত পরিস্থিতি মোকাবেলা করতে হয়।	□	□	□	□
৬। আমি যদি প্রয়োজনীয় শ্রম দেই, তবে আমি বেশিরভাগ সমস্যার সমাধান করতে পারি।	□	□	□	□
৭। আমি আমার, পরিস্থিতি মোকাবেলা করার ক্ষমতার উপর নির্ভর করতে পারি বলে, অসুবিধার সম্মুখীন হলে শান্ত থাকতে পারি।	□	□	□	□
৮। যখন আমি সমস্যার মুখোমুখি হই তখন আমি সাধারণত কয়েক ধরনের সমাধান খুঁজে বের করতে পারি।	□	□	□	□
৯। যদি আমি কোনো সমস্যায় পড়ি তবে আমি সাধারণত একটি সমাধান ভাবতে পারি।	□	□	□	□
১০। আমি সাধারণত আমার পথে যা আসে তা সামলাতে পারি।	□	□	□	□

Bangladesh Health Professions Institute
Department of Occupational Therapy
4th Year B. Sc in Occupational Therapy
OT 401 Research Project

Thesis Supervisor- Student Contact; face to face or electronic and guidance record

Title of thesis: The Psychological Well-Being and Self-Efficacy of Elderly Individuals in Community and Residential Care Facility: A Cross-Sectional Study

Name of student: Disha Biswas, 4th year
B.Sc in Occupational Therapy, BHPI

Name and designation of thesis supervisor: Shamima Akter
Associate Professor
Dept. of Occupational Therapy, BHPI

Appointment No	Date	Place	Topic of discussion	Duration (Minutes/ Hours)	Comments of student	Student's signature	Thesis supervisor signature
1	08.08.23	OTD(2), BHPI	Overview of research Supervision guideline	30 minute	Helpful introduction to initiate work	Disha Biswas	
2	10.08.23	OTD(2), BHPI	Methodology, Design, approach	1 hour	learned many things.	Disha Biswas	
3	16/9/23	OTD(2), BHPI	Scale and Questionnaire	20 mins	got a clear concept	Disha Biswas	
4	20.09.23	OTD(2), BHPI	Overview & overall guideline about research proposal	2hour	got a structured guidline	Disha Biswas	
5	25.09.23	OTD(2)	Scale feedback	10 min	got clear idea	Disha Biswas	

6	31.09.23	OTD(2), BHPI	Research Proposal feedback	1hr	Helpful for thesis writing		
7	7.10.23	OTD(2), BHPI	How to write literature review	30 min	got clear idea on how to write		
8	19.10.23	OTD(2), BHPI	Information sheet, consent form, withdrawal form	15 min	learnt my mistakes		
9	10.12.23	OTD(2), BHPI	Guidline on how to collect data	20min	Got propere guidelines		
10	19.12.23	OTD(2), BHPI	Guidline on participants number and permission issue	10min	Helpful to resolve some issues		
11	20.12.23	OTD(2) BHPI	Data input in spss(20)	1hr	learnt about how to input data		
12	25.12.23	OTD(2) BHPI	feedback on data input	10min	learnt and got clear concept		
13	30.12.23	OTD(2) BHPI	feedback on data analysis and tables	1hr	Working on result part		
14	28.02.24	OTD(2), BHPI	Feedback on first draft	30min	Redoing my result section		
15	15.03.24	OTD(2) BHPI	Discussion and conclusion of the research	1hr	Got propere guideline		
16	21.03.24	OTD(2), BHPI	feedback on the correction of the draft	1hr	Again rearranging my result		

17	18.03.24	OTD(2), BHPI	Feedback on rescelt & discussion part	30min	updating my discussion section		
18	23.03.24	OTD(2) BHPI	Feedback on next draft	45min	Mistakes are identified		
19	1.04.24	OTD(2) BHPI	Feedback on reference, literature review	25 min	Added some more points to literature		
20	8.04.24	OTD(2), BHPI	feedback on final draft and presentation	1hr	got clear guideline.		

Note:

1. Appointment number will cover at least a total of 40 hours; applicable only for face to face contact with the supervisors.
2. Students will require submitting this completed record during submission your final thesis.