Chapter – III

Research Methodology
CHAPTER III
METHODOLOGY

3.1 INTRODUCTION

India is a country of too many paradoxes. It enjoys the twin glory of entering into the Forbes Book for having the richest in the world as well as, housing the highest number of people struggling for existence below the poverty line. Same is the case with Indian attitude towards and treatment of women. It is a country where deification of womanhood and female foeticide take place side by side. Women deities in this country equal the number of men deities. Women are glorified here by naming the river after her like Ganga, Kaveri, by calling the land of living as motherland and language spoken as mother tongue. But in reality women present a different and dismal picture. Born free she is found in chains everywhere. In childhood she is under the protective care of her father, then her brother - elder or younger becomes the guardian, and under the pretext of marriage she is enslaved by her husband; in her old age her very survival solely depends on the mercy of her sons. She is honoured as the home maker or creator of the family. But the irrefutable and bitter truth is that she is treated as the unpaid servant both in her mother's house and in her in – law’s house. In short, she is almost a bonded slave from cradle to grave.

In most of the developing countries women are worse off than men with regard to a number of important dimensions of human existence. Problems of ageing women are not due to age but due to psycho social environment, diminishing support and changes in life situation. The remarkable thing about older women in our culture is that they still survive despite all the odds. They continue to work till functional disabilities cripple them.

Even frail old women act as caregivers to their older spouses. Most dual career families in urban areas depend on old women for child care. In rural areas, home based farm work is still managed by women. In fact there is no
retirement for an elderly women till either death, dementia or disability chains her.

Depressed elderly women are more likely to be widowed, living lonely and experience greater financial and environmental stress.

It is nothing less than a miracle that despite such humiliation and neglect they could rise like the stars of great magnitude like Indira Gandhi and Kiran Bedi. But the likes of Indra and Kiran are few and far between.

The close association with and active participation in the social activities of Help Age India, an International Organization supporting the institutions working for the aged, for about a decade in the Nineteen Eighties enabled this researcher to gain a thorough knowledge of the pitiable plight of women, in general and the aged in particular. Deeply shocked by the stark reality of the pathetic plight of the almost orphaned old women and greatly influenced and inspired by the relevant literature on this topic the researcher decided to continue the investigation further with a view to finding solutions for the redressal of grievances. The researcher further decided to focus on the problems of aged women, an area which hitherto remained in the dark without proper recognition. The result is this thesis.

Women treat everyone with kindness. But the irony is that she is never paid back in her own life. On the contrary, she receives only brick – bats. The “unkindest cut of all” comes from her own ungrateful son. She nurtures a fond hope that her sons would offer her shelter in her old age. But the ingratitude of her son drives the last nail into her coffin. Her hope of a comfortable and peaceful life at home in old age is shattered to pieces when she is forcibly thrown out of her own home. Though she deserves a better deal, she is considered as an unwanted burden. Hence the house which has sufficient space for the immovable and inanimate objects like refrigerator, television, washing machine has no space to accommodate this living person. As a result, she becomes a refuge and seeks the support of outsiders for her survival.

Of course, many have lost their life partners by this time, as longevity of women is larger than that of men. In the early stage, they managed the house,
reared children, maintained interpersonal relationships and remained the invisible root of domestic harmony. Even if widowed in a young age, women, particularly women with children have no inclination for a second marriage even though no religion is against widow marriage. They shoulder the family responsibility, almost single handedly by entering into the work force. In their old age chances for economic independence begin to vanish. Physical ill health and growing weakness due to ageing adds fuel to fire. In short, women performing the roles of selfless daughter, sister, wife and mother become the very symbol of sacrifice and servitude.

Actually, she is mercilessly denied love and care when she most expects and needs it. On the contrary she is brutally thrown out or forced to leave the family and take refuge in an old age home. Poverty also drives some families to this unwelcome situation.

It cannot be denied that family is the only right and appropriate place for all the aged to live in. The changing concept of family institutions does not allow their dreams to be translated into reality. Desire for a safer home at the most needed hour remains but a mirage. There is no change in her condition for the past quarter of a century. Instead, the condition has worsened resulting in the phenomenal growth of institutions. In due course, the situation has so worsened that organization, which rendered exclusively free social service has begun to commercialize the services. As a result, today, the paid institutions outnumber the free homes. The pathetic plight of the women, summarily rejected by their own kith and kin haunted the researcher aggressively as to force her to pursue this matter further and deeply. The study of their problems has naturally paved the way for an in-depth analysis of the functioning of the organizations – both free and paid homes working for the welfare of the aged in general and women in particular.

For many, familial reunion is no more a matter of thought. For many, own home or in institution does not make any difference. All these women have a totally different way of living in the institution. They are free from being exploited by others and their basic needs are being met in the homes.
But, there is an imbalance of Psychological status of these women, when they are uprooted from their own family environment.

3.2 NEED FOR THE STUDY

As the psychological problems of these unfortunate women, whether self admitted or forced – have not so far been given due recognition, the researcher decided to focus on the emotional status of these women, who were brutally removed from their familiar places. However, a careful study of the surveys on the problems of old aged women in the old age homes revealed that only a few studies have been conducted on limited areas. Further, no study has been conducted to the researcher’s knowledge, to find out the ‘Life-Satisfaction’ of the old aged, particularly the women in the old age homes and what are the factors contributing for the life-satisfaction of these deprived and unfortunate women.

Considering the deficiencies in the knowledge pertaining to this issue, as individuals in the previous chapters, the various problems faced by the old aged women in the institutions and the factors contributing for their life satisfaction, it was decided to take up this study. The researcher also felt discomfort in understanding the gap in the knowledge, which compelled her to select the topic for the study, and it is important to find suitable answers to the following research questions that the researcher has identified after reviewing the existing literature on the topic.

1. How far do aged women adapt and adjust in the institution?
2. What sort of psychological problems do they face in the institution?
3. Do they socialize with their fellow inmates in the institution?
4. Is there any relationship between the religious attitude and satisfaction in life?
5. What levels of self esteem do they have?
6. What are the factors contributing for life satisfaction?
7. Is there any association between the socio-demographic variables and the factors that contribute for their life satisfaction?
8. Is there any association among the various factors that determine life satisfaction?

This chapter on Research Methodology explains the methods, techniques and procedure followed in this research study. According to Fred.N.Kerlinger, Research Design is a planned structure and the strategy of investigation conceived is prior hand with an aim of obtaining answers to research questions. The research questions were described in the previous chapter based on their review of literature and the gap in the knowledge found by the researcher. The researcher has followed the steps in proper direction to reach the goal and this chapter describes the steps taken by the researcher.

In this chapter, the researcher discusses the methodology for carrying out the present study and expresses scope of the study, objectives of the study, research hypothesis, research design, universe and sample design, tools of data collection, methods of data collection, operational definitions, statistical tests, limitation of the study and the problems encountered by the researcher.

3.3 TITLE OF THE STUDY

“A Study on the Factors influencing Life Satisfaction among the Aged Women under Institutional care in Madurai district”.

3.4 AIM

To find out the Factors influencing Life - Satisfaction of the Aged Woman in Institutional care services in Madurai District.

3.5 OBJECTIVES

1. To study the socio demographic characteristics of the Aged Women.
2. To assess the psychological faculty of the aged women in terms of a) adjustment, b) self-esteem and c) depression of the Aged Woman
3. To assess the social dimensions of the aged women namely a) socialization, b) attitude towards religion of the Aged Women.
4. To assess the factors that contribute for the life satisfaction of the aged women.
5. To find out the association between the socio, demographic variables and the factors that could contribute for life satisfaction.
6. To find out the relationship among the various subject dimensions such as adjustment, socialization, self-esteem, depression and religious attitude and its contribution for life satisfaction.

3.6 DEFINITION OF THE TERMS:

3.6.1 Old Age

According to Elizabeth B. Hurlock (1976) the last age (elderly) in the life span is divided into early old age, which extends from the age of 60-70 years and advanced old age which begins at 70 years and above. In this study also, the researcher defined the old age as senior citizen who has completed sixty and above.

Adjustment: Adjustment is defined as the process of making or becoming suitable or adjusting to the circumstances such as Home, Health, Emotional and Social Factors in the study Bell Adjustment Scale (Bas) (Bell, 1978) is used to measure the Adjustment.

The inventory consists of 128 items which assesses the individual's adjustment on the following four dimensions of adjustment.

- **Home:** Individuals scoring high tend to be unsatisfactorily adjusted to their home environment.
- **Health:** High Score indicates unsatisfactory health adjustment. Low score indicates satisfactory adjustment.
- **Emotional:** Individuals scoring high tend to be unstable emotionally. Individuals with low score are emotionally stable.
- **Social adjustment:** Individuals scoring high tend to be submissive and retiring in their social contacts. Individuals with low score are aggressive in their social contacts.
The scoring in the inventory is 1 for ‘yes’ and 0 for ‘no’. The description of the total score on the inventory is as mentioned in the above paragraph.

The coefficient of the reliability of each dimension of the Bell Adjustment Scale is as follows: Home: 0.91, Health: 0.81, Social: 0.88, Emotional: 0.91 and Total Score: 0.94: Bell Level of Adjustment Scale is interpreted as (-) Higher the score, higher the unsatisfactory adjustment i.e high score means high maladjustment.

3.6.2 Self Esteem

It is an automatic and inevitable consequence of sum of individuals choices in using their consciousness in following areas of self evaluation including overall self –worth, social – competence, problem solving activity, intellectual calibre, self –competence and worth relative to other people. In this study Self Esteem Rating Scale (SERS) (NUGENTW.R., et al., 1993) is used to measure Self Esteem.

The SERS is a 40 item instrument that was developed to provide the measure of self esteem with a clinical accuracy that can indicate not only problems in self esteem but also positive and non problematic levels. The items were written to tap into a range of areas of self evaluation including overall self worth, social competence, problem solving ability, intellectual calibre, self competence and worth relative to other people. The SERS is a very useful instrument for measuring both positive and negative aspects of self esteem in clinical practice.

The SERS is scored by scoring the items 3, 4, 6, 7, 8, 9, 10, 14, 15, 18, 19, 21, 24, 26, 28, 29, 32, 35, 36, 37 positively and the remaining items negatively by placing a minus sign before the item score. The items are summed to produce a total score ranging from -120 to +120. Positive scores indicate more positive levels of self esteem and negative scores indicate more negative levels of self esteem.
SERS has excellent internal consistency with an alpha of 0.97. The standard error of measurement is 5.67. Data on stability was not reported. The SERS is reported as having good content and factorial validity. The SERS has good constructive validity, with significant correlations with the index of self esteem and the generalized contentment scale. The score of this scale in interpreted as Self Esteem (+) : Higher the score higher will be Self Esteem

3.6.3 Social Behaviour

It has process that begins at infancy and continues in one’s life by which a person acquires values, behaviours skills and performs different roles such as institutional activities, supportive roles, spare time activities and relationship. In this study Social Behaviour is measured is using the Social Behaviour by Assessment Schedule (SBAS) (PLATT et al., 1980).

SBAS was used to assess the level of social behaviour among the inmates of the home for the aged. This schedule was prepared on the basis of SBAS developed and discussed by Platt et al in 1980. The modified tool used for this study has 40 items totally with 4 dimensions such as: 1) Institutional Activities, 2) Supportive Role, 3) Spare time Activities, 4) Relationship.

3.6.3.1 Role Performance Of The Inmates To Maintain The Four Dimensions

3.6.3 1. a) Institutional Activities:

It has 10 items assessing the frequency of subjects participation in the institutional activities related to religion, fund raising, household work, cultural activities, shopping, maintenance of cleanliness, informant to visitors etc.

3.6.3.2 b) Supportive role:

It also has 10 items to elicit the information regarding the situations, incidental problems, health problems, interpersonal problems, unmet religious needs, motivation and expressing the concern at the time of loneliness.
3.6.3.3 c) Spare time activities

This dimension has 10 items to explore the pattern of activities that involved the subjects to spend the spare time. They are activities related to gardening, listening to radio, watching movies and T.V, writing letters, attending organized lectures, participating in social gathering, playing games, reading books and spending time in groups.

3.6.3.4 d) Relationship

This dimension has 10 items, on information related to subjects’ views about their connectedness with one another in the old age home and their initiation in and response to developing relationships.

Each item in the scale is scored on 3 point scales, namely never, sometimes and often. The score value of 1 is awarded to ‘never’, 2 to ‘sometimes’ and 3 to ‘often’. Total score of each subject is consolidated to assess their level of socialization. The interpretation is that the high score on SBAS indicates the high level of social behaviour and the low score indicates the low level of socialization. The score is interpreted as Social Behaviour (+) : Higher the score, higher will be the level of socialization.

3.6.3.5 e) Religious Attitude

Religious Attitude among the respondents is measured using Religious Attitude Inventory (Ausubal And Schoort, 1957)

This is a 50 item Likert type scale developed by Ausubal and Schoort in 1957. It measures attitude towards the following religious referents: religious doctrine, immortality, God and the place of worship. Most of the respondents belonged to the Hindu religion. Hence the researcher referred to the term “temple” instead of church, to those respondents, who belongs to Hindu religion and referred to the term “mosque” to those respondents who belong to the religion Muslim. The researcher referred the term temple, mosque and
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Church accordingly, as the statements were related to belief system which is common to all the religions.

Five - point scale: strongly agree (pro-religious) to 1 (strongly disagree). It was developed to study the accuracy of the perception of persons holding extreme versus neutral views on a relevant topic. In the composition of the scale, 159 statements were collected and administered to subjects, and the mean item rating was determined. The final scale was constructed by choosing the 25 items as each extreme of the distribution of item values.

The response alternatives for positive (pro religious) item were weighed from 5 (Strongly agree) to 1 (strongly disagree). Weights for alternatives of the negative (anti religious) items had to be reversed. The persons score is the sum of the weighted alternative endorsed by him. High scores indicate acceptance and following of religion and religious doctrine.

The split half reliability coefficient of 0.97 was reported by the authors. Items were chosen for their ability to discriminate extreme scores. Further the authors tested the significance of the difference between mean scores of the high, middle and low groups of subjects and found that it was significant at the 0.01 level. The scale apparently possessed content validity. Religious attitude (+): Higher the score higher the acceptance of religion.

3.6.5 Geriatric Depression

Depression is defined as fluctuation in mood that may deepen and persist when equilibrium cannot be restored because of poor internal regulation or external stress and the range of depressive, phenomena, including loss, cognitive complaints, somatic complaints and self image among older adults. The Geriatric Depression is measured using Geriatric Depression Scale (GDS) (BRINK T.L., 1983).

The GDS is a 30 item instrument to assess the depression in the elderly. The GDS is written in simple language and can be administered in an oral or written format. The main purpose of the development of GDS was to provide a screening test for the depression in the elderly population that would be simple
to administer and no special training necessary for the interviewer. The GDS has been used successfully with both physically healthy and ill samples of the elderly.

Of the 30 items, positive answers of 20 indicate the presence of depression while negatives 10 (items – 1, 5, 7, 9, 15, 19, 21, 27, 29, 30) indicate depression. The GDS scored by totalling one point counted for each depressive answer and zero for a non-depressive answer.

The GDS has excellent internal consistency with an alpha of 94 and split half reliability of 94. It also has excellent stability with a one week test-retest correlation of 85. Besides it has excellent concurrent validity, with correlations of 83 between the GDS and Zung’s self rating depression scale and 84 with the Hamilton Rating Scale for depression. It has well known group validity in distinguishing significantly among respondents classified as normal, mildly depressed and severely depressed.

The GDS also has distinguished between depressed and non-depressed physically ill elderly and between depressed and non-depressed elderly undergoing cognitive treatment for senile dementia. Geriatric Depression (-) : Higher the score higher the depression.

3.6.6 Life satisfaction

Life Satisfaction is a reality enduring cognitive assessment of attainment of one’s desired goals or overall conditions of life and measure the psychological well being of the elderly. The Life Satisfaction among the respondents is measured using Life Satisfaction Index Z (LSIZ) (NEUGARTEN. B., 1961).

LSIZ is an 18 item instrument designed to measure the life satisfaction of older people. The LSIZ was developed from a rating scale that was designed to be used by interviewers rating respondents and it may be administered as a self report instrument orally or in writing. Items were selected on the basis of their correlations with original rating scale and their ability to discriminate between high and low scores on the rating scale. Based on research, on this
instrument it is recommended that LSIZ be used mainly with individuals over 65 years.

The LSIZ is easily scored by assigning one point to each item that is ‘correctly’ checked and summing those scored. The correct score is ‘agree’ on items 1, 2, 4, 6, 8, 9, 11, 12, 13, 14, 17; other items are correct if the respondents answers ‘disagree’. No data was reported on reliability but the rating scale from which the LSIZ was developed had excellent inter observer agreement. The LSIZ showed moderate correlation with the instrument from which it was developed, the Life Satisfaction Rating Scale indicating some degree of concurrent validity. The LSIZ also demonstrated the form of known group’s validity by successfully discriminating high and low scores on the Life Satisfaction Rating Scale. Life Satisfaction (+): Higher the score higher will be the life satisfaction or well being.

3.7 PILOT STUDY

‘Pilot study’ is the process of knowing the feasibility of conducting a research study in the field chosen. The researcher did a pilot study in the selected homes for the aged at Madurai, to know the possibility and feasibility of conducting the study by discussing the same with the aged women at the old age home and was satisfied to find out that the study could be conducted. The researcher met the Presidents and the Secretaries of the aged homes and explained the purpose of the study and obtained permission. Simultaneously, the researcher collected the secondary data (Books, Annual Reports, Attendance Register to know the number of inmates, Fees studies, Admission procedures etc.). The researcher met few inmates and explained the purpose of the study. The researcher also observed the living and working conditions of the inmates.

3.8 RESEARCH DESIGN

Research design is a plan or a scheme used to carryout a research in a systematic manner to achieve some specific goal. Diagnostic design is used in
this study. Diagnostic design is a design that diagnoses the nature of variables and explains the relationship and its degree between two variables in the given study. The study is focused on the solution of a specific problem by the discovery of the relevant variables that are associated with it in varying degrees. In this study, analysis has been made to find the inter-relationship between the level of adjustment, self-esteem, social behaviour, religious attitudes and depression visavis Life Satisfaction. Existing studies were scanned in order to validate the findings. Thus Diagnostic Research Design is the suitable design for this study.

3.9 HYPOTHESES

1. Higher the adjustment, higher will be the life satisfaction
2. Higher the self esteem, higher will be the life satisfaction.
3. Higher the level of socialization, higher will be the life satisfaction.
4. Higher the religious attitude better will be the life satisfaction.
5. Higher the depression, lesser will be the life-satisfaction.
6. Aged women from different socio demographic background do not differ with regard to their level of adjustment, self-esteem, socialization, religious attitude and depression.
3.10 SELECTION OF RESPONDENTS

All the registered homes for the aged situated in Madurai District in Tamil Nadu is the universe for the study. The list of Homes as on 1st January 2006 was obtained from the Help Age India is an international funding organization that promotes the welfare of the aged. The researcher also got the list of registered homes from the District Social Welfare Office, which is the authority for registration of old age homes. Both the lists were verified and all the registered homes shortlisted for preparation of unit for study. All the organizations were visited by the researcher and the details of the inmates were collected before setting the population frame.

3.11 OLD AGE HOME DETAILS

- Total No. of Home for the Aged = 53
  - Not functioning = 8
  - Only for men = 1

- Homes taken for the Study = 44 (53-9)

- Total No. of inmates:
  - Men = 507
  - Women = 586

- No. of aged women not able to answer due to illness = 21
- Not available at the time of interview = 8
- Not willing to participate = 4

Total No. of Aged Women Interviewed = 586 - 33 = 553

3.12.1 The following are the inclusions and exclusion criteria

3.12.2 Inclusion Criteria

- Women aged 60 years and above.
- Women those who are willing to participate in the study.
- Women from registered homes.
3.12.3 Exclusion Criteria

- Women who are not able to communicate.
- Women with terminal or severe mental illness.
- Women who are not willing to participate.
- Women who are not in registered homes.

The researcher visited all the 53 homes for the aged in the target area. Using the inclusion and exclusion criteria, a list of inmates was prepared for each home. Thus, census method using inclusion and exclusion conditions was adapted for this study. All the shortlisted inmates were interviewed for this study.

3.13 PRE-TEST

Pre-test is a process of verification of the tool selected for the study. In the study, the researcher used an Interview Schedule and Scales to collect data. With the help of pre-test, the researcher could find repetition of some of the questions, inappropriate variables on which the respondents were confused and some variables that did not show any variance. Based on the experiences, the researcher made necessary corrections and sharpened the tool for data collection. During the pre test for following observations were made by the researcher.

It took 1 hour 30 minutes on an average to administer all the instruments to each of the Institutionalized Aged Women. This included a detailed orientation of the study and each of its instruments and an assurance that the process of data collection was a very confidential one and the data provided by the respondents will not be shared with the authorities concerned or in-charge, in order to alleviate their fears. Some of the respondents at times felt tired due to advancing age. The researcher had to offer refreshments at times so that they could overcome fatigue and continue the interview with necessary vigour. However, many showed interest by their participation as all the questions were relevant to their life and their present condition. Further, they hardly have
someone to talk with them and were eagerly longing for someone to share their inner mind.

None of the items in instruments were identified as the incompatible culturally or unsuitable to the psycho – socio – cultural contexts of the respondents. All the items were found relevant and appropriate to their life contexts.

When the instruments were applied to the respondents, a majority of them expressed their concern regarding the contents of the items. Referring to their psychological status, they displayed a lot of emotions with tearful eyes. They showed aversion and dejection explicitly towards their family members. It appeared that they feared a probable identification of something psychologically abnormal in them. This type of emotional reaction also warranted attention while gathering data from such concerned or apprehensive subjects. Empathetic understanding and universalizing their experience as normal human response during abnormal times was found to be remedial in majority of the cases. However many of them were generally experiencing pain, distress and emptiness but were provided with certain psychosocial care and support.

3.14.1 Based on the observations and experiences gained during the pre-test, the following changes were adopted to collect the data:
1. The respondents were oriented about the study and were provided with sufficient information before the session was initiated. At the same time, the researcher also addressed the specific doubts of the respondents. This had resulted in saving time and reducing the unnecessary disturbances and distractions at the time of interview. The process of gathering the data was brought down to a time span of about one hour on an average.

2. Specific appointments were fixed with the respondents to identify an appropriate time suitable for them, so that they would be entirely free to focus on the topic on hand with as less distractions and interruptions as
possible. Mostly, data collections were arranged before lunch and after tea, as a result of which there was betterment in the quality of data gathered.

In short, all the instruments and the items therein were retained. The modes of collection of data were modified to make it simple to understand and to respond. Whenever self doubts, psychological concerns and related subjective apprehensions were noted, the respondents were provided with necessary clarification or assurances or psychosocial care and support as per indications. These efforts paid rich dividends in making the phase of actual data collection, a productive outcome.

3.15 TOOLS FOR DATA COLLECTION

- A semi structured interview schedule was prepared by the researcher to assess the socio-economic conditions of the respondents.
- Bell Adjustment Scale (BAS) (Bell, 1978) to assess the level of adjustment of the respondents.
- Self Esteem Rating Scale (SERS) (Nugent W.R., et al., 1993) to assess the self esteem of the respondents.
- Social Behaviour Assessment Schedule (SBAS) (Platt et al., 1980) to assess the social behaviour of the respondents.
- Religious Attitude Inventory (RAI) (Ausubal and Schoort, 1957) to assess the religious attitude of the respondents.
- Geriatric Depression Scale (GDS) (Brink T.L., 1983) to assess the level of depression among the respondents.
- Life Satisfaction Index Z (LSIZ) (Neugarten. B., 1961) to assess the life satisfaction of the respondents.

3.16 DESCRIPTION OF TOOLS

3.16.1 SEMI STRUCTURED INTERVIEW SCHEDULE:

A Semi structured interview schedule was prepared by the researcher to understand the socio-demographic details of the respondents that includes personal profile, family profile, institutional profile, health status, hobbies,
dietary pattern and the likes. It consisted of 44 items. The details of other tools are given in the previous pages.

3.17 TRANSLATION OF THE SCALES:

Respondents who were selected for the study were institutionalised aged women in Madurai District. Most of them could speak, some of them could read and write Tamil. Hence, all the tools were translated into Tamil. The initial Tamil translations of the instruments for data collection was done by experts in Tamil. Later, that was translated into English by another set of language experts, fluent in both Tamil and English. The original and the back translated versions were compared to ensure that the translated version intended to measure what was expected. For this purpose, the help of experts from mental health field, who are familiar with both the languages and the field of gerontology were elicited. Thus translation validity was done using experts views and content validity.

3.18 DATA COLLECTION

The researcher, after pre-test did the finalization of the instruments for the data collection. The researcher did the pre-testing at Inba-Illam. She obtained an informal consent from the respondents explaining the purpose of the study and administered the tools, which took approximately one hour and thirty minutes for the researcher to interact with a respondent and complete the data. After the completion of the pre-test, the researcher was able to complete the interview in 60 minutes. This time schedule was followed in collecting the data from all the respondents. It took nearly 18 months from March 2007 to August 2008 to gather the data.

Data Collection consumed much time. Though the researcher fixed appointments in prior to the interview, it was postponed sometimes due to some or other urgent and unforeseen circumstances. These factors were not in the control of the investigator because most of these delays were attributable to
the health and mental conditions of the Institutionalized Aged Women. Thus the data collection took a considerable period.

3.19 DATA ANALYSIS

The data collected on the six instruments were coded for the purpose of computer data entry. Coding was done on the assessment sheet itself. Statistical Package for Social Sciences SPSS version 16.0 was used to analyze the data.

The following statistical analysis was used to analyze the data. The descriptive statistics were used to measure the frequency distribution and percentage was calculated for the socio demographic profile and each item of the instruments used for the study. Simple frequency tabulation adapted by the researcher to make it more explanatory and present the actual distribution of the respondents thought the length of the reports exceeds than its originally planned the researches also feels the simple frequency data analysis will help the interest group to gain better information about the detailed description of the respondents on socio demographic factors to plan their strategic interventions. The central tendencies like Mean and Standard Deviation were calculated for the calculated frequencies and percentage. Pearson’s correlation was calculated to find out the association among the different variables which included Socio Demographic Profile, Adjustment, Self Esteem, Socialization, Religious Attitude and Level of Depression.

Step-wise Regression analysis was done to find out the significance of the predictors of the dependent variables.

3.20 ETHICAL ISSUES

- The aged women who were taken for the study were duly informed of the purpose of the study. The objectives of the study were made clear to the respondents before the data collection, and it was also made clear that it will not raise any hope or expectation of help.
- Informal consent was obtained from the respondents considered for the study.
• It was ensured that the confidentiality of the given information will be maintained.
• The researcher herself handled the psychological care and support during the data collection.

3.21 LIMITATION OF THE STUDY
• The researcher restricted her study with the institutionalized aged women and left out aged men, which is a limitation and the opportunity for future study.
• Further, the study area was restricted to Madurai District. Thus, the study provides less chance for the researcher to compare the plight of the aged person in metropolitan cities.
• To have a better understanding about the plight of the institutionalized aged women, the administrators of the old aged homes, and the family members could be included as study groups, which the researcher did not consider to accommodate in her study. But these are the areas to consider for future study.
• However, the researcher satisfied herself, as she focused specifically to study the plight of the aged women, the most underprivileged, uncared and unnoticed members of the society.

3.22 CHAPTERIZATION
The present research study is divided into five chapters. The background of the study is given in the Chapter I. The review of literature in the concerned subject is given in the Chapter II. The chapter III is deals with the research methodology, where the methods and techniques used to carry out this research were presented. The empirical data collected from the field were analyzed, interpreted and presented in the form of tables in Chapter IV. The findings of the present study are given in Chapter V. The suggestions and recommendations and scope for future research are given in chapter VI. The
copy of the questionnaire, the case studies old age home list and the bibliography are given in the annexure I, II and III.