CHAPTER – III

RESEARCH METHODOLOGY

3.1 INTRODUCTION

In this chapter the researcher has described the methodology of the study, objectives, operational definitions of the terms, significance of the study, the variables, research hypotheses, sampling, collection of data and statistical techniques in analyzing the data.

3.2 STATEMENT OF THE PROBLEM

Mental illness in all cultures affects the quality of life of people. Contrary to widely held beliefs, people with mental illness are equally disabled like those with common chronic physical conditions. To ensure that the assistance available to those seeking treatment is meaningful, the patients' psychosocial and mental health needs must be addressed at full range. For women services have to be made genuinely accessible. It is not an easy task to improve the mental health of a population. It involves multiple
decisions. Priorities should be set among the needs, conditions, services, treatments, preventive and primitive strategies.

The present investigation is entitled as **Women and Mental Health**.

Women with mental illness were selected attending out-patient care in the under inquiry hospitals, hence the number is less. Following pages will deal with other aspects of this investigation.

### 3.3 OBJECTIVES OF THE STUDY

The specific objectives of the study were;

- to study the socio-demographic correlations of the women in the sample regarding the morbidity patterns, help seeking behaviour and utilization of mental health services,
- to study the coping patterns adopted by women patients,
- to study the social burden experience by the families of women patients,
- to study the family careers orientation towards mental illness, and
- to study the implications for social work practice.
3.4 OPERATIONAL DEFINITIONS OF THE STUDY

Mental illnesses are basically divided into four major groups as mentioned in the introduction. Diagnostically a patient is treated by the concerned psychiatric beams of doctors in the hospital setting accordingly.

In the present study, mentally ill women patients who have been seen at the hospital as outpatients or the ones who have had a history of illness episodes and are being treated for such maladies have been included.

3.5 SIGNIFICANCE OF THE STUDY

Women are integral to all aspects of society. However the multiple roles that they play in society render them at greater risk of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mother and career minders of others. Mental illnesses affect women and men differently some disorders are more common in women, and some express themselves with different symptoms. In the present study, this is true for the parent caregiver group, where most of the caregivers were women. However, in the spouse caregiver group, there were more men, in the care giving role. Tap
areas of emotional burden specific to spouses, such as the effect of the illness on the patient’s ability to share responsibilities, sexual relations and the overall quality of the marital relationship. Intervention programs of processional social work should address the specific needs of spouses. In the light of this discussion the present study will help to know about the level of awareness and attitudes of the people regarding mental illness. This is very important because the lack of knowledge and awareness regarding appropriate help sources lead to the inevitable use of multiple coping techniques, which, many a times prove ineffective. The families tend to follow different course before bringing their mentally ill family members to the mental hospital.

3.6 DESIGN OF THE STUDY

For the present study descriptive research design was found suitable. However, following research hypotheses were framed depending upon objectives of the study. It was a fond desire for the researcher to study the mentally distressed and their problems. Being in a small city did not deter the researcher from enquiring into such turbulent issues for entire family and society, as well. Further, being a woman herself the researcher could empathize
with patients and caretakers. Sample may appear small but the reasoning is the availability and suitability of the individuals studied including caretakers. It sure was a difficult task catching hold of people and to extract information.

### 3.7 SAMPLING

The study aimed to understand the patterns of knowledge level of women suffering from various morbidities, the pathway taken to utilize the available services. The study also proposed to know the social burden faced by the family and coping patterns adopted by patients and caretakers respectively.

**Table No. 3.1 Sampling Design**

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Hospitals</th>
<th>Total</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Al-Ameen Medical College, Bijapur</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>BLDE’s Medical College, Bijapur</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Patients</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Family members/ Caretakers</td>
<td></td>
<td>100</td>
<td>200</td>
</tr>
</tbody>
</table>

For the present study purposive sampling technique was used. Data for the study was collected from the patients attending the OPD as well as in-patients in the psychiatric wards of hospitals
in Bijapur city. Along with this one member from patients’ families also was consulted to cull out the proper data pertaining to subject on hand namely caretakers point of view.

3.8 VARIABLES

A ‘variable’ is a symbol, which is assigned numerals or values. Fox (1969) views variable is a characteristic, which is given research studies, can have more than one value.

A variable is that factor which is measured, manipulated and observed by researcher (Tuckman, 1978). Whereas according to Kothari (1985) ‘a concept which can take different quantitative values is called a variable’.

In the present investigation, it is intended to study women and mental health.

- **Dependent Variables:**

  I. Social Burden and its Dimensions that is

  1. Impact of well being,
  2. Impact on marital relationships,
  3. Application for caring,
  4. Impact on relationships with others
  5. Perceived severity of the disease
II. Orientation Towards Mental Illness and its Dimensions that is

1. Folk belief,
2. Psychosocial stressor,
3. Organic causation,
4. Non-restrictive behavior,
5. Weak cognitive control,
6. Fidgety behavior,
7. Bizarre behavior,
8. Folk therapy,
9. Psychosocial manipulation,
10. Physical method of treatment,
11. Hopelessness,
12. Hypo-functioning and
13. Rejection of mentally ill

**Independent Variables:**

1. Age Groups (<25, 26-50, >50)
2. Relations with Patient (mother, sister/brother, husband and others)
3. Gender (male and female)
4. Religion (Hindu, non-Hindu)
5. Educational Qualifications (illiterates, up to secondary, degree)
6. Occupations (employed, housewife, others)
7. Income Groups (<1 lakh, above 1 lakh)
8. Nature Family (Joint, nuclear)
9. Types of Marriage (arranged, unmarried)
10. Current Place of Residence (Parents, husband, others)

3.9 FORMULATION OF HYPOTHESES

The hypotheses framed for the study are as follows based on the objectives:

1. There is no significant difference between age groups (<25, 26-50, >50) with respect to self reporting and coping pattern about mental illness of patients.

2. There is no significant difference between relations with patient (mother, sister/brother, husband and others) with respect to self reporting and coping pattern about mental illness of patients.

3. There is no significant difference between male and female with respect to self reporting and coping pattern about mental illness of patients.
4. There is no significant difference between religion (Hindu, non-Hindu) with respect to self reporting and coping pattern about mental illness of patients.

5. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) with respect to self reporting and coping pattern about mental illness of patients.

6. There is no significant difference between occupations (employed, housewife, others) with respect to self reporting and coping pattern about mental illness of patients.

7. There is no significant difference between income groups (<1 lakh, above 1 lakh) with respect to self reporting and coping pattern about mental illness of patients.

8. There is no significant difference between nature family (Joint, nuclear) with respect to self reporting and coping pattern about mental illness of patients.

9. There is no significant difference between types of marriage (arranged, unmarried) with respect to self reporting and coping pattern about mental illness of patients.
10. There is no significant difference between current place of residence (Parents, husband, others) with respect to self reporting and coping pattern about mental illness of patients.

11. There is no significant difference between male and female care takers with respect to burden of mental illness of patients and its dimensions scores that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

12. There is no significant difference between male and female care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

13. There is no significant difference between age groups (<25years, 25-50years, >50years) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships,
Application for caring, Impact on relationships with others and Perceived severity of the disease

14. There is no significant difference between age groups (<25 years, 25-50 years, >50 years) of caretakers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill.

15. There is no significant difference between relations (mother, husband, others) of caretakers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease.

16. There is no significant difference between relations (mother, husband, others) of caretakers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre
behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

17. There is no significant difference between Hindu and Non-Hindu care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

18. There is no significant difference between Hindu and Non-Hindu care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

19. There is no significant difference between unmarried and married care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring,
Impact on relationships with others and Perceived severity of the disease

20. There is no significant difference between unmarried and married care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

21. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

22. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) of care takers with respect to orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive
control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

23. There is no significant difference between occupations (employed, housewife, others) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

24. There is no significant difference between occupations (employed, housewife, others) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

25. There is no significant difference between type of marriage (arranged, unmarried) of care takers with respect to burden scores of mental illness of patients and its dimensions that is
Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

26. There is no significant difference between type of marriage (arranged, unmarried) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

27. There is no significant difference between income groups (<1 lakh, >1 lakh) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

28. There is no significant difference between income groups (<1 lakh, >1 lakh) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive
behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

29. There is no significant difference between types of family (joint, nuclear) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

30. There is no significant difference between types of family (joint, nuclear) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

31. There is no significant difference between current place of residence (parents, husband, others) of care takers with respect to burden scores of mental illness of patients and its
dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

32. There is no significant difference between place of residence (parents, husband, others) of caretakers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

33. There is no significant relationship between burden scores and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease with orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill scores of caretakers
34. There is no significant relationship between self reporting and coping pattern about mental illness of patients with burden scores and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease scores of care takers

35. There is no significant relationship between self reporting and coping pattern about mental illness of patients with orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill scores of care takers

3.10 TOOLS AND MATERIALS FOR THE DATA COLLECTION

The word “Tool” in evaluation is defined as an instrument or a means to collect evidences. In research it is necessary to acquire sufficient reliable, relevant and valid data adequate in a quality and quantity.
The following tools were used for collection of data:

- Socio demographic scale developed by the investigator
- Self Reporting Questionnaire developed by World Health Organization (WHO) (1994)
- Social Burden by Hell, Thara, Padmavati and Kumar (1998)
- Orientation towards Mental Illness by Prabhu (1985)
- Coping checklist by Rao, Subbakrishna and Prabha (1989)

1. **Socio Demographic Scale**

   Self anchored scale was used to collect information for this purpose.

2. **Self Reporting Questionnaire (SRQ)**

   The self reporting questionnaire (SRQ) was developed by WHO as an instrument designed to screen for psychiatric disturbance, especially in developing countries. The SRQ consists of 20 questions, which have to be answered by yes and no. It may be used either as self-administered or an interviewed administered questionnaire. Various additional questions have been used with the SRQ –20 to screen for psychotic disorder and substance abuse.

   **Scoring:** Each of the 20 items is scored 0 or 1. A score of 1 indicates that the symptom was presenting the past month a score
of 0 indicates that the symptom was absent. The maximum score is there 20.

**Validity:** Mari and Williams (1985) calculated a correlation coefficient of $+0.74$ ($n=260$), since coefficient of more than 0.60 are usually regard as a highly acceptable, the results suggest the SRQ as good criterion validity. Aarya *et al* (1992) calculated the correlation Coefficients between the total on the Spanish translation of the revised clinical interview schedule and the score on the SRQ and found a figure $r = +0.96$.

### 3. Orientation Towards Mental Illness

The attitude scale on mental illness developed by Prabhu (1985), was used in the current study. The scale has 95 items, which aims to measure an individual orientation to mental illness. It is most applicable for measuring the orientation of an Indian literate, English speaking lay people.

Initially, a 235 item scale in English, with a five point Likert format evolved after 7 experts in the field of mental health scrutinized the items with regard to contents, structure and suitability. It was administered to a systemic sample of 350 in Delhi. The obtained data was subjected to factor analysis and the
following 13 factors which could be interpreted accounted for a little over 40 percent of the item variance. The factors are:

1. Folk belief
2. Psychosocial stressor
3. Organic causation
4. Non-restrictive behavior
5. Weak cognitive control
6. Fidgety behavior
7. Bizarre behavior
8. Folk therapy
9. Psychosocial manipulation
10. Physical method of treatment
11. Hopelessness
12. Hypofunctioning
13. Rejection of the mentally ill

These 13 factors broadly cover four areas, that is causation (factor 1, 2, and 3), perception of abnormality (Factor 4, 5, 6 and 7), treatment (Factors 8, 9 and 10) and after effects (Factors 11, 12 and 13). Of the 13 factors, four were found to have resemblance to sub scales included in the factorially derived tests in the West (Factors 2, 3, 11 and 13), two factors were found to be unique and
culture specific to India (Factors 1 and 8) while other factors (Factors 4, 5, 6, 7, 9, 10 and 12) were not unique but were independent in nature when compared to the dimension in the Western tests.

Based on this analysis, a 95 item scale was developed and administered to another sample of 300 and the same factors were identified.

In the present study, a shortened version of the 95 item scale consisting of 67 items has been used. The items dropped from the 95 item scale are those which were found to be unstable across different populations by the author. For the completion of the scale an individual took approximately 35 – 40 minutes. It is scored on a five point Likert format ranging from one to five, where one indicates complete disagreement, five indicates complete agreement and three indicates uncertainty regarding the item. The total score of each individual is obtained by adding up the scores for each item marked by the respondent. Certain number of items comes for each factor and the total of those items is the total of each factor.

The score range from 67 – 335 in the shortened version. The higher the score, the greater the degree of unfavorable orientation towards mental illness indicated. However, the present study
modified the scale from five points to three points, as may be seen in the appendices.

4. Social Burden

Social Burden was developed by Hell, Thara, Padmavati and Kumar (1998). This tool describes the process of developing an instrument to quantify the subjective burden as perceived by care-givers to a chronic psychotic person. The methodology applied is qualitative-quantitative where extensive ethnographic work is followed by quantification of the concepts which emerged during the qualitative field work. As expected, some of this concepts were statistically confirmed in factor analysis other merged or split up. Each item is rated on a three point scale (“not at all”, “to some extent”, “very much”). The result is a 20 item questionnaire representing five factors or concerned which reflect care-givers main feeling about their car giving role. The questionnaire is divided in five factors. The details are as below:

**Factor 1: Impact on well being**

This factor contains items describing the impact of the presence of chronic psychotic on the care-giver in terms of feeling of exhaustion, frustration, depression and impact on health in general
Factor 2: Impact on marital relationships

The items reflect the ability of the mentally ill patient to give adequate attention and affection to other members of the family and to satisfy the emotional needs of her/his partner.

Factor 3: Appreciation for caring

This is a positive factor which reflects the satisfaction of caregivers from the appreciation and acknowledgement of their good care from friends and family members, and the pride of still being able to take good care of the rest of the family. This factor seems to be of particular importance because it hints at a very important component to care giving families.

Factor 4: Impact on relations with others

This factor includes items which refer to the disruption of family and other social relations as a consequence of the present of the mentally-ill person.

Factor 5: Perceived severity of the disease

In this factor covered items which represent the severity of the disorder, such as disturbing or unpredictable behaviour rendering the care giver unable to hold or take up a regular job.
Reliability

Inter-rater reliability was established verbally administering the draft questionnaire to 50 care-givers with the response independently being coded by two field workers listening to the interview. Internal consistency for the full scale as measured by the alpha coefficient is 0.81.

5. Coping Checklist

Coping checklist was developed by Kiran Rao et al. (1989). The purpose of this checklist is to find out how people deal with or handle difficult situations that they have to face. The list provides some of the commonly used methods of handling stress and reducing stress.

This scale aims at identifying preventive strategies for suicide prevention. Most of the suicides are impulsive at the stress situations. These situations are overcome through different coping patterns that are used consciously or unconsciously by everybody but sometimes it is difficult to develop a pattern of coping. Those coping methods by which they found some relief or solution to their problems are identified. There are 70 items, each statements you are using or not in stressful situation that indicates yes or no.
Whether each method is used or not in stressful situation is indicated as yes or no. It covers a wide range of cognitive, behavioral and emotional responses that are used to handle stress. There are seven subscales: problem solving, denial, positive distraction, negative distraction, acceptance, religion/faith and social support seeking.

Space is provided for including any other method that is used. This checklist does not have any ratings, so the researcher has used this scale to identify better coping pattern from experimental and control group from the assumption that control have better coping pattern than those who show suicidal behaviour.

**Reliability and Validity:** The test-retest reliability for a one-month period is 0.74 and the internal consistency for the full scale is 0.86.

**3.11 COLLECTION OF DATA**

Bijapur city has two big hospitals with medical colleges (Al-Ameen and BLDE’s). Attempts were made to understand the patterns of utilization of the mental health services by women. Besides this the social burden faced by the family and coping patterns adopted were also studied.
This investigation mainly aimed at studying the socio-demographic characteristics, awareness about mental illness and pathways followed before accessing the services from the Government and Private hospitals for mental care. The study is primarily descriptive in nature and aims at throwing light on the dynamics of influencing factors in utilizing mental health services by women. The data was collected from 100 mentally ill patients and 100 caretakers from the two hospitals as mentioned. The list of patients enrolled in the OPD of these two hospitals were obtained with the help of Psychiatric Social Workers.

The present study may throw light on dark sides of the so far unknown patterns of behaviour to utilize the available mental health services in this part of Karnataka. The data had to be elicited both from patients and parents/family member/caretakers simultaneously. The total sample was 200 of which 100 were women patients and family members were 100.
3.12 ANALYSIS OF DATA AND STATISTICAL TECHNIQUES USED

In order to test the hypotheses stated in this study the following statistical techniques were employed.

1. Socio-Demographic Data Analysis
2. Descriptive Analysis
   - Patient Data Related Tables
   - Caretakers Data Related Analysis
3. Differential Analysis
4. Correlation Analysis

3.13 LIMITATIONS OF THE STUDY

1. It was not possible to get mentally ill married women in large number at a time
2. These two medical college hospitals, under inquiry have limited infrastructural facilities for such in-patients
3. Finding patients along-with their “willing” caretakers for the interview was a difficult task with every patient
4. Researcher had to be very sympathetic towards patients and caretakers for extracting information as per requirement.
3.14 OVERVIEW OF THE STUDY

The thesis is organized in five chapters.

The first chapter includes Introduction, The concept of vocation and interest, theoretical framework of the study, The rights and role of women in the society, difference of gender in mental health, Gender inequality and risks to women’s mental health, Gender stereotyping and bias, Gender differences in mental health disorders, Women and common mental disorders, Promoting women’s mental health, Nature of abuse experienced by women, Barriers to disclosing domestic violence, Women’s experiences of mental distress and domestic violence, Precautionary steps for mental health problem women, WHO’s focus in women's mental health, A brief profile of psychiatric disorder and psychosocial distress, Gender ideologies and healthy policies, mainstreaming gender perspectives in mental health policy gendered voices, Healthy policies and mental health policies, Recommendations for specific initiatives in mental health services and training, Triumphs and challenges, Statement of the problem, Objectives of the study, Limitations of the study, Overall view of the study

Second chapter deals with review of related literature of women and mental health at various levels.
Third chapter explains the research methodology adopted for the present study. The chapter includes statistical tools to measure the mental health of women, hypotheses, statistical techniques used for analysis of the data.

In the fourth chapter, analysis and interpretation of data are presented.

Chapter fifth presents a brief summary of the study. It presents findings and conclusions in relation to the variables and educational implications with suggestions for further study.

Bibliography and Appendices are presented at the end.

In the next chapter, analysis and interpretation of data, which includes Descriptive analysis, Differential analysis and Correlation analysis are given in the tabular and graphical form with interpretation.