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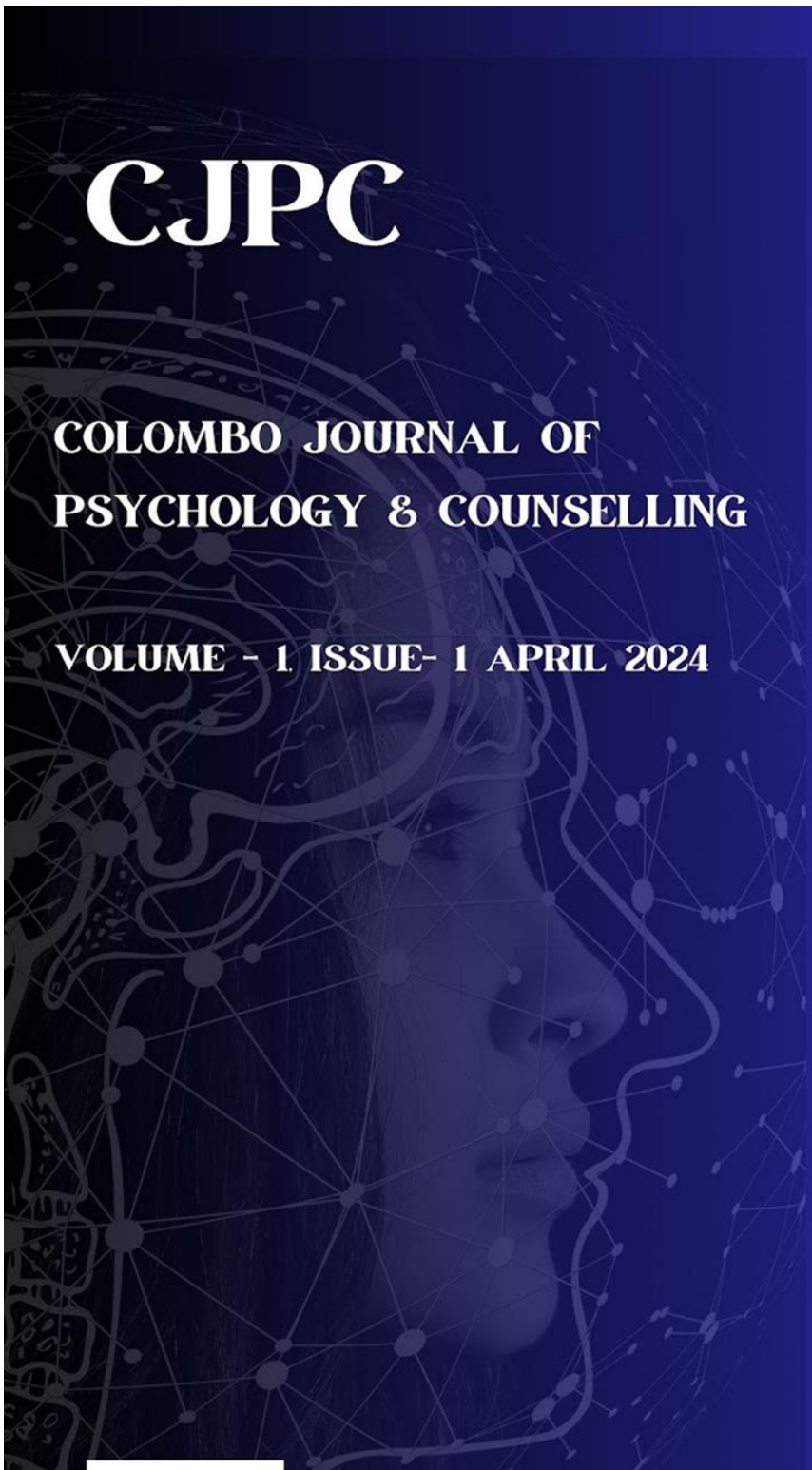

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CONTENT

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Social Functioning of patients with Schizophrenia in Sri Lanka

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Abstract

The current study was the first large-scale study of the functioning level of Sri Lankan Schizophrenia/ Psychotic patients and the first-ever study of this patient population by a psychologist therefore would shed light on the psychological perspectives of this population. Most judgments regarding the level of functioning of schizophrenia patients are derived from Indian studies. India is Sri Lanka's closest neighbor and therefore most Indian research assumptions are usually generalized to Sri Lanka. Yet the current study reports similarities as well as differences among Sri Lankan Schizophrenia patients when compared to Indian patients. These differences are attributed to the different social composition of Sri Lanka compared to the Indian society, despite the many shared similarities between the two countries. Women appear to have better social functioning compared to men. High rates of prosocial behavior and voting were observed in the sample. 77.5% of the sample reports never engaging in physical activities while 39.5 % report engaging in religious activities often. The study was conducted with a sample of 200 out-patients (n=200) from the National Institute of Mental Health (NIMH), Sri Lanka. A translated, validated version of the Social Functioning Scale (SFS) was used in the study. A convenient sample was used.

Keywords: Sri Lanka, Social Functioning, Schizophrenia, Psychosis

1. Introduction

1.1 What is Schizophrenia?

Patients with Schizophrenia experience chronic impairments, while the impairments are pervasive; they encompass a wide range of aspects of the functioning of an individual. A significant proportion of Schizophrenia patients experience long–term impairment, which result in significant impairment in people's personal, social, and occupational lives. The debilitating nature of schizophrenia is, well captured by a self-description by a patient, who has been quoted by Kraepelin.

> "My whole mental power has disappeared; I have sunk intellectually below the level of a beast" (O'Carroll, 2000).

The National Institute for Clinical Excellence (NICE) guidelines for the UK defines schizophrenia as "one of the terms used to describe a major psychiatric disorder (or cluster of disorders) that alters an individual's perception, thoughts, affect and behavior" (National Collaborating Centre for Mental Health, 2010, p. 16).

The Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders, defines schizophrenia as follows. Schizophrenia now refers to a group of disorders characterized by positive psychotic symptoms at some stage of illness, where mania and major depression are not prominent or persistent features, and where negative and cognitive symptoms are likely to be prominent and associated with a variable level of disability" (Royal Australian & New Zealand College of Psychiatrists Clinical Practice Guidelines Team for the Treatment of Schizophrenia & Related Disorders, 2005)

1.2 Social functioning in Schizophrenia.

Research suggests strong associations between certain aspects of neurocognitive functioning and social functioning (Addington and Addington, Neurocognitive and Social Functioning in Schizophrenia, 1999) a wide range of cognitive deficits such as deficits in the domains of attention, motor skills, executive function, and intelligence are affected. An interesting fact is that cognitive impairments date the illness and seem to be difficult to explain solely by the latter course of the illness such as medication side effects or the effects of relapses. Despite these and their strong influence on the level of functioning of patients, evidence has failed to explain the core features of the illness in terms of neurocognitive deficits.

When the functioning of Schizophrenia is considered the level of social functioning holds high importance as this aspect is easily affected by the onset of the illness. Though the level of social functioning is a much-discussed topic in schizophrenia, there is little consensus on the definition of this concept. "Social functioning has been defined globally, as the capacity of a person to function in different societal roles such as homemaker, worker, student, spouse, family member or friend" (Brissos, Molodynski, Dias, and Figueira, 2011). The importance of the measurement of the level of social functioning in patients with schizophrenia are well demonstrated in the DSM – --IV –TR by the statement that the level of social functioning is integral to the assessment of the efficacy of antipsychotic drugs in schizophrenia.

Deterioration of functioning is not solely due to the impairment caused by the disorder. "Unpleasant side effects of treatment, social adversity and isolation, poverty and homelessness also play a part" (National Collaborating Centre for Mental Health, 2010). Thus, gaining a better understanding of the functioning of

this group of patients is extremely important. Reducing other adverse variables for functioning can help patients increase their quality of life, and level of functioning and be better able to adapt themselves to living with a chronic condition. This can result in a better prognosis for Schizophrenia patients.

Outcomes for schizophrenia are believed to be better in developing countries compared to developed countries (Bhugra, 2005). Studies from India report better social functioning and overall quality of life in patients with schizophrenia. One such study reports that "67 percent of the 88 patients in the study were employed and that most of them were in full-time employment in mainstream jobs with minimal or no disability or support in the workplace" (Srinivasan and Tirupati as cited in Basi, Mathews, and Mathews, 2006). Though schizophrenia is perceived in the West as a severe, debilitating, chronic mental illness resulting in poor functional outcomes, at least two major international studies, the International Pilot Study of Schizophrenia (2) and the Determinants of Outcome of Severe Mental Disorders (3), have provided convincing evidence for a better outcome in India and other less developed countries than in the West (Basi, Mathews, and Mathews, 2006)

Basi, Mathews, and Mathews (2006) further argue that the reason for poor outcomes for schizophrenia in Western countries might be the result of perceiving the illness as purely "biological" one, resulting in reduced functional recovery and outcome. The severe stigma faced by the patients may also have a major role in keeping patients with schizophrenia on the fringes of the society, making it extremely difficult for them to find employment, thus drastically reducing opportunities for better functioning.

The better functional outcome of schizophrenia in non-western countries could be due to more positive cultural perceptions, expectations, and beliefs about the illness. It may be that these positive beliefs act as a self-fulfilling prophecy in helping patients return to pre- morbid functioning levels quickly. The more negative beliefs and expectations of the Western societies may be having the effect of a self–fulfilling prophecy resulting in poor outcomes. Thus "It is obvious that although schizophrenia may have a biological basis, good outcomes depend on a pharmaco-psycho-social approach, and the psychosocial aspect may well have the greatest impact on improved outcomes" (Basi, Mathews, and Mathews, 2006).

Thus, schizophrenia is understood as a complex clinical manifestation, which causes serious disability in all areas of functioning in an individual's life. Thus, the level of functioning is believed to be the a most important aspect of prognosis and treatment efficacy. This marked functional deterioration is observed to vary based on many disease-related variables such as the quality of the intervention, premorbid personality, level of adherence to antipsychotic medication, etc. Thus, it appears important to study the level of functioning as a whole and other disease-related variables that can substantially vary the functional outcome of patients with schizophrenia.

The current study attempts to obtain a comprehensive understanding of the level of social functioning, which captures the most important aspects of the overall functional capacity. This is expected to support clinicians in understanding the efficacy of current treatments provided and better understanding prognosis and the course of illness of the patients under their care.

The level of social functioning is seen as an important indicator of the efficacy of any treatment modality and as the level of social functioning is observed to be better in developing societies, it would be interesting to study this aspect in a sample of Sri Lankan patients.

At present, such studies have not been reported in Sri Lanka. Most studies that have reported better outcomes than in developed societies have been carried out in Indian societies. As the nearest neighbor to India, Sri Lanka shares a lot of ideological and other sociological variables with Indian society. Yet there can also be observed very complex differences in the Sri Lankan community as opposed to India. Thus, it would be interesting to investigate these aspects in a Sri Lankan community sample. An increased understanding of the level of functioning of patients with schizophrenia in Sri Lanka will be quite useful in treatment planning for clinicians. The current study is important especially because there are no similar studies reported in Sri Lanka.

2. Materials and Methods

2.1 The study population

A total of two hundred (200) participants (schizophrenia patients) took part in this study from the National Institute of Mental Health (NIMH) clinics, equally divided by gender and who were adequately stabilized at the time of participation. Only English or Sinhala-speaking patients were included in the sample, as the researcher is not competent in Tamil. Of the entire sample of male and female participants who participated in the study, all except one patient was Sinhala speaking.

Judgmental-nonrandom, convenient sampling (Based on medical judgment on the suitability to participate) was used to obtain the sample in the clinical setting of NIMH. The participants had to have received a diagnosis of Schizophrenia from a consultant psychiatrist.

With a sample size of 200, the researcher expected to study 28.6% of the target population, as at any given time roughly there are about 700 inward patients with schizophrenia at NIMH. The reasoning behind this was that, as the research uses a convenient sample, the sample should include at least 1/4th of the patient population to be comfortable with the results. This was discussed with the principal supervisor. Studying 1/4th of the entire population was decided as large enough for the study. In arriving at this decision, the sample sizes of other schizophrenia research were reviewed and it was understood that most studies contained sample sizes less than 100 and less than 25% of the entire population. As it was not possible to exert rigorous scientific control over the study situation, it was decided to have a large sample, i.e. Larger than the average sample sizes used in most studies. This “largeness” was decided after reviewing previous studies.

2.2 Exclusion criteria

Patients with a diagnosis of pervasive developmental disorders were excluded. Those who did not speak either English or Sinhala were also excluded.

2.3 Data collection procedure

The Social Functioning Scale (SFS) was used to measure the level of social functioning of patients. Administration of the SFS was done by the principal researcher, in an available space of the clinic after obtaining verbal consent. As some clinic patients send their relatives to obtain monthly drugs, data was obtained both from patients and relatives using the Relatives' Version and the Individual’s version of SFS as appropriate. Both of the versions consist of the same items, adjusted to address the patient or the relative.

Before administering the tests, their suitability to participate in the study was discussed with the members of the medical team. Only patients with sufficient insight (according to the evaluation of the medical team) to give consent were allowed to participate and the plausible effects of the participation on psychotic symptoms (such as paranoid delusions) were discussed with the medical team before testing.

The participants were debriefed both before and after the test administration about the nature of the study, and its possible risks and benefits in a simple pre-prepared format. The patient's or relative's verbal consent was obtained prior to administering the tests and including other patient-related data in the research.

2.3 Instruments used in the study

2.3.1. Social Functioning Scale (SFS)

A translated and validated version of the Social Functioning Scale (Birchwood et al, 1990) was used for assessing the level of social functioning of the patients. The Social Functioning Scale (SFS), (Birchwood et al., 1990) is a 79-item questionnaire that assesses the following seven domains of social behavior: social engagement/withdrawal, interpersonal behavior, pro-social behavior, recreation, independence-competence, independence-performance, and employment/occupation in patients with schizophrenia. The Social Functioning Scale (SFS) was chosen based on its vast evidence base. It has been translated, and validated, in many languages (E.g. the Spanish version, Norwegian version) (Torres and Olivares, 2005). It has also been used in a wide variety of Schizophrenia related research, and shown to be valid and reliable (Birchwood, 1990). The SFS has been shown to have good internal consistency (Birchwood et al, 1990) (Henry, Bailey, and Rendell, 2007).

There are two versions of the SFS: The individual Version and the Relative version. Both the versions were translated and validated using the same procedures for this study, after obtaining permission from the main author.

The SFS was systematically translated in three rounds by a panel of three experts (Sumathipala and Murray, 2000). The content and consensual validation of the scale were carried out.

3. Results and Discussion

According to the distribution of SFS scores, there is observed a better level of social functioning in women compared to men. This is also higher than the mean level observed in the original validation of the SFS in a UK population. (Birchwood et al., 1990) This could be seen as a reflection of better social inclusion and a reduced level of stigma experienced by patients with schizophrenia in developing countries, as observed by prior research. This could also reflect that the quality of life for schizophrenia patients is better in Sri Lanka compared to that in developed countries as the level of social functioning has demonstrated a strong relationship with the resulting quality of life.

Neurocognitive deficits are strongly associated with both functional outcome and functional recovery. (Addington and Addington, Neurocognitive and Social Functioning in Schizophrenia, 1999) As Sri Lankan patients show higher levels of social functioning, this could be an indication of better cognitive functioning.

It is also observed that though there is a statistically significant difference in the overall social functioning of men and women, there is no such observed difference in any sub-domains of social functioning as

assessed by each sub-scale of the SFS. This may mean that there are no specific areas in which either males or females are particularly strong or weak.

Further high pro-social behavior was observed in the sample. 49% of the sample reports often attending social occasions such as funerals & weddings. Interestingly, 75.5% of the population reports voting often for elections. Only 13%reported never voting for elections.

77. 5% of the patients report never engaging in physical activities. This has strong implications on the national policy of Schizophrenia as physical activity is not only required for general well-being but also especially indicated with the side effects of antipsychotic medications.

Further 39.5 % reported engaging in religious activities often, while only 9.5% reported never engaging in religious activities.

4. Conclusions and recommendations

As patients are observed to be high in social functioning and receive family support, family interventions can be used to facilitate the relationship between the families and patients, not only to help patients continue to receive family support but also to improve the quality of life and communication between the patients and families and would result in manageable amounts of expressed emotion (EE), helping reduce further relapse. This would be especially important as there is a substantial number of inpatients deserted by their family members at NIMH.

As patients are already high in prosocial behavior, more community-based intervention modalities can be used to improve their global quality of life. The existing social institutions such as religious institutions, etc. can be included in such efforts.

As the need for outdoor sports and physical activity appears to be imminent, interventions targeted at this would be highly important.

The high level of social functioning may mean that interventions to include the patients in the Gross Domestic Production (GDP) in a meaningful way, such as supported employment programs, would be of great value. The need for such interventions is especially important, given the high unemployment rates among the patient group.

Designing Interventions for the subset of patients who are poor in the level of functioning and other illness-related variables is of prime importance. Psychometric tools developed for Sri Lanka are of prime importance in distinguishing such patients.

As antipsychotic medication alone has limited efficacy in improving the condition in schizophrenia patients, research has identified individual and family psychological interventions as a compulsory treatment in both acute and stabilized states of schizophrenia. Individual and family psychological therapies are of vital importance in early interventions for schizophrenia too.

There are no psychologists attached to the NIMH, as such, psychological interventions are not part of the routine care of the NIMH.

Yet integrating psychological treatments into current treatments received by patients is of prime importance. This is especially so given the research emphasis on multimodal treatment and psychological interventions being a compulsory component of this. Yet, though in all well-developed mental health systems psychologists play a leading role in the treatment of mental health problems in general and schizophrenia in particular, this is not observed in Sri Lanka. Therefore, it is of prime necessity to constitute a cadre of psychologists at NIMH and revise the organization of the institution to include the role of the psychologist in consultation with the leading mental health facilities in the world. This is especially so given the fact that NIMH is considered the place of excellence for mental health.

4.1 Study limitations and further research

The study has several limitations. The study has used a convenient sample. Many confounding variables were not controlled in the methodology. It has used subjective estimates of the majority of the variables studied. Therefore, it would be important to use a more random sample in more controlled conditions to explore the same variables, coupled with more objective measures of the variables studied.

Also, as this study does not have any similar studies in a Sri Lankan patient sample for comparison purposes, the need for similar studies to arrive at any conclusive evidence cannot be overemphasized. Therefore, further studies on similar illness-related variables and the result observed are of primary importance.

Declaration of Interest Statement

The authors declare that they have no conflict of interest.

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The Experience of Sri Lankan Women Migrant Domestic Workers in the Middle East: An Analysis Using Reflexive Thematic Analysis and Social Dominance Theory

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Abstract

Sri Lankan migrant domestic workers in the Middle East are major contributors to the country's economy. However, their own psychosocial and economic plight has been marred with severe deprivations of human rights. This report presents a qualitative analysis of a journalist's report published in a Sri Lanka Daily, Daily Mirror (20 February 2020) of the meaning of the experience of these migrant workers, using reflexive thematic analysis. The analysis generated three themes: rights violation in receiving countries, institutional exploitation of women's rights, and non-fulfilment of protection rights by the sending government. Explanations for the social group processes identified as rights violations are explored with the social dominance theory. The theoretical flexibility of reflective thematic analysis permitted the researcher's perspectives to be brought into the interpretation of findings. The depth of analysis was limited to some extent by the limited nuances and detail in the data corpus necessitated by the use of a secondary data set, which was primarily overcome by combining perspectives of activists and the writer of the news piece.

1. Introduction

The labour migration of Sri Lankan women to the Middle East is strategically important to Sri Lanka's economy (International Labour Organisation, 2020). Ironically, the migrants experience subhuman living conditions, including bullying, underpayment, discrimination, aggression (Jureidini & Moukarbel,2004; Withers, 2019) and their children are subject to violations of protection rights (Jayasuriya & Opeskin, 2011).

Although some descriptive writings are available about migrant women domestic workers (e.g., Abu-Habib, 1998; Eelens & Schampers, 1990), systematic qualitative psychological analyses of their subjective experience are few. This paper explores the meaning in the experience of Sri Lankan women migrants as domestic workers as portrayed in a journalist's reporting in a Newspaper article "Blood, sweat, and tears, fall on deaf ears". The analysis uses reflexive thematic analysis (RTA) (Braun & Clarke, 2012, 2021) to identify patterns of meaning of the experience of migrant workers and seeks to explain that experience through the social dominance theory (SDT) (Sidanius & Pratto, 1999, cited in Sidanius & pratto, 2004).

2. Study Aims and the Method of Analysis

The study aimed to understand the psychological underpinnings of the experiences that migrant women domestic workers face in their countries of immigration. This research question was explored with RTA within an interpretative and constructive paradigm respecting the women's subjective experiences and the opinions of the writer of the news item while allowing for my perspective of human rights as a researcher. The following section explains the theoretical assumptions underlying the analysis as required in any application of thematic analysis (Braun and Clarke 2012, 2021; Byrne, 2021).

2.1 Theoretical Assumptions

Conducting a thematic analysis begins with taking a stand as specified by Braun and Clarke (2012, 2021) on the position to stay along four continua: epistemologies as essentialist versus constructivist; orientation to data as experiential versus critical; analytic approach as inductive versus deductive; and coding of data as semantic versus latent. Articulating the approach taken with respect to these continua clarifies the conceptualization and appropriateness of the research question (Byrne, 2021).

This analysis adopted a constructionist rather than an essentialist epistemology; while the recurrence of a theme is important, codes were assigned primarily based on meaning and meaningfulness (Braun & Clarke, 2021). For example, expressions like "one meal a day" were coded as "food deprivation," thus going beyond reflecting surface meaning to create the underlying meaning related to human rights. Second, data interpretation adopted an experiential rather than a critical orientation, thus staying closer to the participants meaning and meaningfulness than any claim made by the researcher. For example, 'hard and long hours of work' was coded in women's own words as "slave-like labour." This stand was appropriate to the research question of the nature of the experience of the migrant women. In coding, keeping with RTA practice, no predetermined code lists or theoretical frameworks were used. A mix of deductive and inductive processes was used as it is not possible to exclusively use only one of these approaches (Braun & Clarke 2012, 2021). Inductive analysis guided the selection of participants' thoughts and feelings, such as "modern-day slavery,"

to ensure that participant and data-based meaning was relevant and meaningful to the research question (Braun and Clarke 2006, 2012, 2021). Deductive coding was through the researcher's active engagement in choosing a rights lens to interpret the data. With respect to the semantic versus latent coding continuum, a mix of both was used depending on when each was meaningful. Semantic coding, which considers the surface meaning of the words, such as "sale of women," was combined with the researcher's interpretation of the meaning as "abuse".

2.2 Analytical Process

Complying with the requirement that reporting of qualitative analysis adequately describes the analysis (Attride-Stirling, 2001; Braun & Clarke, 2012, 2021; Levitt et al., 2018), this section provides an account of the analytic process followed. The study closely adhered to Braun and Clarke's practical instructions for the six-phase procedure of RTA (2012), its conceptual and design elements (2021), and reporting standards (2019, 2021). It was also guided by the reporting standards of qualitative research proposed by Levitt et al. (2018).

The first phase was to familiarise with the data by reading the news item multiple times. In the second phase, initial codes were generated by labelling phrases of the text that informed the research question and appeared to relate to potential themes. In line with RTA practice, rather than using predetermined codes, a code that seemed to capture the characteristic of an was assigned. A mix of descriptive codes, e.g., "wages not paid as promised" and some interpretative codes, e.g., "Depriving of the right to health care," were used as necessary. The generated codes were outputs of the organic analytic process (Braun &Clarke, 2021) that were then reviewed and sometimes were split or combined or refined.

In the third phase, themes were developed inductively by grouping the codes to capture a related concept of the migrant workers' experience as viewed through a lens of human rights, and specifically, the ILO convention on migration for employment 1949 (Revised) (ILO, 2022). The sending country and receiving countries have an obligation to protect, promote, and fulfil workers' rights, including the right to decent work. The themes were organized around the concept of rights violations in sending and receiving countries and brokering institutions. Therefore, themes were generated as analytical outputs and not "discovered" lying in the data, a key feature in RTA emphasized by Braun and Clarke (see, e.g., 2012, 2021).
In the fourth phase, these themes were reviewed against the data to ensure their appropriateness, and to verify whether they are well-bounded, coherent, supported adequately by data and, helped address the research question (Braun & Clarke, 2012, 2021). In phase five, the themes were reviewed for internal homogeneity and inter theme heterogeneity by ensuring that violation of rights was the focus for receiving countries and agencies as appropriate, and lack of obligation to protect the rights was delimited for the sending country. Data extracts to describe each theme were selected to provide a meaningful and as thick a description as possible of the constitutive themes. In phase six, the final analysis and report writing, which had begun and continued recursively in earlier phases, was completed.

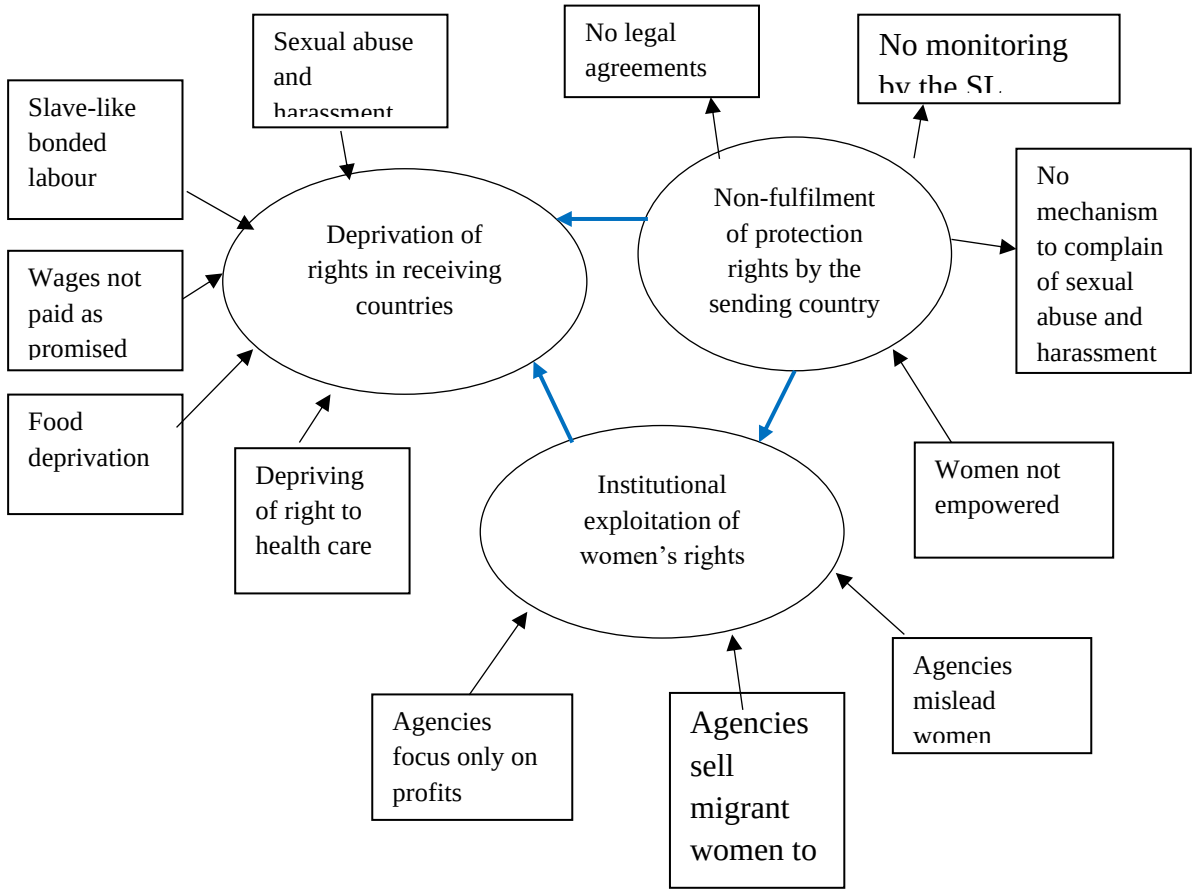
3. Results

As the analysis proceeded, the research question was honed (Braun & Clarke, 2012) to "What do Sri Lankan women migrant domestic workers in the Middle East experience with their human rights? In the reflexive

analytic process, I developed three themes as follows, each conceptualized within a category of duty bearers. The themes were

i. Rights violations in receiving countries
ii. Institutional exploitation of women's rights
iii. Non-fulfillment of protection rights by the sending government

Figure 1. The Thematic Map of the Final Themes and Their Constituent Codes



Note. Ellipses indicate themes. Rectangles indicate codes. Black arrows indicate codes that constitute the themes. Blue arrows show the relationships between themes.

Figure 1 provides a thematic map of the final themes, their constituent codes, and the relations between themes. The three themes are interconnected. Non-fulfillment of protection rights leads to violations by both the receiving countries and the agencies. Also, rights violations by the receiving countries expose the women to exploitation by the agencies. A description of the themes follows.

3.1 Rights Violations in Receiving Countries

The RTA identified as the first and most coded theme, the deprivation of workers' rights in their receiving country. Women used expressions as "bonded labor" and "slave-like work" to describe the long and arduous

work. The article's writer referred to it as “barbaric conditions” and a women’s rights activist as "modern-day slavery." Women’s inalienable human rights, such as the right to food and health care, were violated. One woman said that she had only one meal a day.

Another said she had to cook for 19 people daily. The article's writer reports instances where wages were not paid as promised. No health care facilities were available even when seriously ill. A woman who needed surgery had to return to Sri Lanka at her own expense. Besides discrimination, there was aggression and sexual abuse. The employers and even their children assaulted the women. The article's writer articulates the level of harassment as "many of them fall into mental illness” and "suffer trauma and anguish."

The social phenomena captured in this first theme is a group process of prejudice leading to discrimination that can be explained with the SDT (Sidanius & Pratto, 2004; Pratto et al., 2006). Groups of high social dominance, in this case, the employers tend to be prejudiced and discriminate against those of low social dominance in this case migrant women. Prejudice is a group phenomenon, which is usually a negative attitude based on irrational, faulty, unjustified generalizations (Brown, 2011). It is synonymous with terms like racism, sexism and extends beyond attitudes and cognitions to engage emotions and finds expression in behaviour (Brown, 2011). Migrant workers belong to groups defined by a looked down upon race and are women and hence subject to such group-based multifaceted discrimination based on race and ethnicity or language (Hogg & Vaughan, 2018), as in the case of migrant workers. Prejudice and discrimination are profoundly harmful social psychological phenomena experienced by humans (Hogg and Vaughan, 2018). Persons who experience perceived discrimination suffer both physically and psychologically (Pascoe & Richman, 2009).

According to SDT, discrimination operates through three group-based behaviours, namely, (i) institutional discrimination, (ii) aggregated individual discrimination, and (iii) behavioural asymmetry (Pratto et al., 2006). Middle Eastern employers' discrimination of migrant domestic workers is aggregated individual discrimination. They form an ingroup that is affluent, middle class, and of high social dominance. They view migrant women with low social dominance, with prejudice and exercise discrimination by denying them their due salaries, food, health care, and decent work conditions. The host group sees these practices as legitimate and instrumental in maintaining the group's superiority.

Migrant workers are highly vulnerable. If the employer does not renew the work status or the migrant leaves without informing, they fall into an irregular category liable for deportation (ILO, 2017). Migrant workers are excluded from national labour laws (ILO, 2017). This unregulated nature of migrants' status gives the employers considerable autonomy over the workers resulting in abuses such as retaining the passports, denial of fundamental rights related to employment, including remuneration, leave, and rest periods. This vulnerability can be considered as an arbitrary set criterion of the group. Hence discrimination against them could be much more violent and coercive than in age and gender-based group systems (Prato et al., 2006).

3.2 Institutional Exploitation of Women’s Rights

The second theme was the exploitation of migrant workers by the agencies that broker their travel and employment. According to the news item, these agents disregard the wellbeing of the migrant workers and focus only on making profits by exploiting the workers. They harass the women by sending them from

house to house instead of finding a suitable place of work. One woman exemplified this practice in her statement that she was sent to numerous houses daily by the agencies. The agencies also misled the women by ill-advising them to leave the houses if they were ill-treated. They sell the women to households. The writer of the news item highlighted, "Another major problem is the human trafficking mafia operating behind closed doors." The above practices are abusive and violations of the right to correct information enunciated in the ILO convention on migration for employment (Revised) 1949.

According to the SDT, this is the second level of group-based discrimination (Prato et al., 2006) mentioned earlier - institutional discrimination. The agencies consider themselves an ingroup of higher social dominance than the migrant domestic workers, who are treated as an outgroup of less social dominance. Their prejudice against migrant workers as deserving of substandard treatment is reflected in their discriminatory acts of harassment and abuse.

Agencies also behave as hierarchy-enhancing institutions according to the SDT, which explains formation and sustenance of group hierarchies through its sub theory of legitimising myths. Hierarchy-enhancing legitimising myths justify perpetuation of group-based inequalities and oppression based on numerous concepts such as race, religion, stereotypes, and doctrines. Hierarchy-attenuating legitimising myths counter social dominance. Examples include political reforms, human rights, and affirmative actions. Agencies by being profit maximising institutions are hierarchy-enhancing (Pratto, 2006). While functioning as a service institution, through exploitative actions, agencies enhance their superiority over the migrant workers.

3.3 Non-fulfilment of Protection Rights by the Sending Government

The third theme is the neglect of the protection rights of the migrant domestic workers by the sending country, Sri Lanka. The news item notes that there are no agreements between the sending and receiving countries to ensure the migrant women's safety and security or to define accountabilities. A woman activist summed up the unprotected situation as "These women are solely seen as objects and are exposed…". This attitude, coupled with the absence of any monitoring by the Sri Lankan embassies in host countries and lack of a mechanism to complain of sexual harassment and abuse, leaves the migrant workers vulnerable to abuse and their protection rights open to violation.

Not being empowered to negotiate (Sri Lanka Bureau of Foreign Employment, n.d.), they are forced to live oppressed while working hard. Although the Sri Lanka Bureau of Foreign Employment organizes pre-departure training programs (Sri Lanka Bureau of Foreign Employment, n.d.), they are inadequate to give the skills and knowledge to empower them (Jureidini & Moukarbel, 2004). The article emphasises: "Therefore it is imperative that the government intervene to safeguard migrant workers and uphold their labour rights, especially as they shed their sweat, and sometimes blood, to earn much-needed foreign exchange for the country."

According to the SDT, promotion of migration of domestic workers can be considered as a hierarchy-attenuating institution that provide benefits to migrant workers from remittance-dependent countries aiming to open access to more resources (Pratto et al., 2006). However, as Pratto et al. (2006) note these institutions lack power and resources to be effective. For this reason, perhaps, although migration is claimed to benefit

receiving countries, sending countries and the migrants – a triple win - research has shown that neither the sending country nor the migrants have benefited; Only the socially dominant receiving countries have benefited (Castles & Ozkul, 2014).

4. Discussion

The reflexive thematic analysis of the news item on the experience of Sri Lankan women migrant domestic works generated three themes: (i) Rights violation in receiving countries (ii) Institutional exploitation of women's rights (iii) non-fulfilment of protection rights by the sending government. Each of these themes clustered the patterns of meaning in the expressions made by the migrant women and the writer of the news content; They complemented one another contributing to an overarching sense of despair resulting from the sweeping violations of rights of the migrant women, the lens through which I engaged with the data and reflected.

The paper provided an explanation that the social psychology theory SDT offers to the first two themes of social phenomena through group processes of prejudice and discrimination by socially dominant groups of employers and agents to maintain their supremacy over the less socially dominant group of migrant workers. The theme relating to the government found some explanation through the concept of hierarchy-attenuating institutions. Sri Lanka's implementation of the international legal instruments on migration, has been challenging (ILO, 2019) with lack of political will resulting in failure to provide tools for implementation (Bahba cited in Jayasuriya and Opsekin, 2011). On the other hand, the high level of cooperative behaviour with substantial resilience and robustness of migrant women, enable group-based hierarchies to perpetuate (Sidanius & Pratto, 2004).

Violation of rights thematized in this study is due to a lack of social justice, which is an aspect that psychology has not addressed adequately (Beauregard, 2021; Ilyes, 2020; Perrin, 2013; Pilgrim, 2008; Teo, 2011). Further, psychology encompassed advocating for social justice only recently (Toporek et al., 2009), and the psychologists' obligation and role in promoting social change remains unclear (Hailes et al., 2020). Walsh (2015, p100), has argued that "psychologists have lacked moral preparation for progressive engagement in society" Echoing these concerns, Hailes et al. (2021) proposed guidelines for social justice work, including focusing resources and effort on vulnerable groups' priorities. He is joined by Beauregard (2021, p.11), who extolls the humanistic psychologists to collectively "…operate from a socially just humanistic praxis that raises the voices of the marginalized…".

4.1 Strengths, limitations, and future research

In this study, the rigorous use of RTA to understand and interpret the experience of migrant domestic workers, probing the meaning behind the lexicon they use to express the sense they make out of their experience, offered several advantages. It offered theoretical flexibility in coding and theme development procedures and freedom for complex, interactive and creative analysis (Trainor et al., 2020). A second advantage was that in RTA, the importance of an item does not derive from the frequency of its occurrence (Braun & Clarke, 2013, 2021). For example, the women did not reference empowerment; only the article' writer and a woman activist did. The flexibility of RTA (Braun & Clarke, 2012, 2021) allowed to recognise the importance of the lack of empowerment in leaving the women open to abuse. Thirdly, RTA was an

appropriate method for a single researcher study: Unlike in other forms of TA, codes and themes do not require multiple coders or inter-researcher verification, agreement, and consensus.

The researcher's views, through a lens of human rights, could be brought to bear on the coding process (Braun & Clarke, 2021). When reflecting on the analytic process, I recognize my interest and perspective of obligations of states to promote and protect human rights, not leaving out the vulnerable groups, leaned the overarching conceptual framework towards a rights perspective.
Among the limitations of the study is the limited data corpus being a very brief text of expressions made by a few women migrant workers interspersed by opinions of its writer. These expressions may not have captured the depth, complexity and richness without the researcher's interaction with the participants of experiences. The homogeneity of experience of workers, strong articulations of typical feelings, and the news article's writer largely countered this limitation. Secondly, the analysis attempted to explain the complex social-individual interactions with one single social psychological theory. However, no single theory can explain a multifaceted social phenomenon as creation and maintenance of social hierarchies (Tunçgenç, 2010).

Social psychological research aiming influence social change with more in depth, more rigorous qualitative analysis could help alleviate the oppression and rights violations of future migrant workers.

5. Conclusion

In conclusion, it is time to consider the relative merits and demerits of Sri Lanka's unequivocal dependence on remittances from migrant workers, which benefits neither the country nor the migrants (Withers, 2019). The qualitative analysis done in this study provides a view of the migrant workers' experience of violation of their and their families' basic human rights. The adverse impacts on the physical and psychological health of migrants, disappointments of their families, and precarious economic benefits all seem to indicate the need for policy and practical rethinking of continued use of migrant workers for seeming economic gain.

Declaration of Interest Statement
The authors declare that they have no conflict of interest.

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Exploring Cancer Patients' Perception of Psycho-Oncology-Based Research and Their Motives to Consent

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Abstract

The current study was done as a part of an ongoing psychology-based study that is being conducted at Kotelawala Defence University Hospital (KDUH) with cancer patients as consenting participants to discuss "locus of control". The authors noticed a lack of prior studies discussing patient perspectives on such psycho-oncology-based research in the Sri Lankan context. Thus, the current study attempted to identify patients' motives for consenting to the main study and their perspectives about the main study and psychology-based studies in general. Data were collected through semi-structured, conversational face-to-face interviews with ten outpatients from the KDUH oncology unit who consented to participate in the main study. The collected data were then thematically analyzed through manual coding. The current study identified several factors that motivated patients to partake in the main study. Co-operating for a 'good cause', helping other patients, the study's trustworthiness and their convenience were identified as primary motivations. Overall, most patients were uncertain about psychology-based research while still acknowledging its usefulness and necessity. Some identified it as 'understanding patients' mental situation, while a few patients showed interest in learning about the main study and psychology-based studies and interventions in general. Most respondents showed a lack of understanding of psychology-based studies and mental health. However, altruistic reasons and factors like convenience and trustworthiness in the study motivated the respondents to participate. Several patients had a general idea about how such research could help the community, which gives an image of positive patient perception towards psychology-based research.

Keywords: cancer patients' perception, Psycho-oncology, Psychology-based research

1. Introduction

Cancer patients' perspective on research and willingness to consent as a participant is a worldwide topic of interest. Prior literature provides many examples of studies investigating cancer patient perspectives and willingness to consent to clinical trials, which ultimately benefit the recruitment process (Bradley et al., 2016), (Moorcraft et al., 2016). However, there is a significant dearth of studies on cancer patients' perspectives regarding psychology or psycho-oncology-based research and their willingness to consent to them, especially in the Sri Lankan context. It can be considered a barrier to conducting more efficient research, essential to developing and implementing evidence-based treatments for cancer patients (Li et al., 2016).

In most developed countries, psycho-oncology is incorporated to address psychological, social, and behavioral issues related to the cancer experience in cancer patients, caregivers, and family members. It is, however, a novel concept in developing countries such as Sri Lanka, which could be a reason for the lack of prior studies on the topic of interest in the Sri Lankan context.

A recent study that reviewed progress in psycho-oncology in developing countries highlighted the need for longitudinal studies of psychosocial experiences and culturally appropriate interventions (Murthy and Alexander, 2019).

Undoubtedly, patient participation is required to design mental health-based research when developing more culturally nuanced intervention programs.

Therefore, Sri Lankan cancer patients' perspectives toward psychology-based research need to be explored. Since psycho-oncology is recognized as a part of cancer treatment (Gregurek et al., 2010), and studies underscore the need to incorporate psycho-oncology as a part of cancer treatment in developing countries (Murthy and Alexander, 2019), patient perspectives need to be investigated to develop holistic care for cancer patients in Sri Lanka in the long run.

A psychology-based study being carried out at University Hospital- KDU intends to investigate views on "locus of control" among cancer patients. It attempts to understand patients' perspectives and create culturally nuanced intervention programs accordingly. The main study relies on patient participation and willingness to share their honest opinions to achieve its objectives.

The current study attempted to explore the perspective of ten cancer patients who are participants of the research, 'explanatory models of cancer among a convenient sample in Colombo, Sri Lanka,' about psycho-oncology-based research and what motivated them to consent to the original study. The main aim of the current study is to present the observations that the researchers made during the data collection process of the main study. The focus of the current study was not to achieve theoretical saturation but to explore and understand the respondents' perspectives about psychology-based research related to cancer and their willingness to consent to the original study.

2. Materials and Methods

The current study implemented a quantitative method because an exploratory approach was most appropriate to achieve the study's objectives. Ten patients diagnosed with cancer who were respondents of the main study, 'Exploratory models of cancer among a convenient sample in Colombo, Sri Lanka' took part in the current study. Data were gathered through semi-structured, conversational face-to-face interviews and thematically analyzed. The semi-structured, conversational face-to-face interview method was appropriate for the study as it enables researchers to build rapport with respondents, which is essential to create conversations regarding their perspectives and allows researchers to observe the emotional responses to the questions while providing the opportunity to minimize any potential distress respondents may feel.

Questions for the semi-structured interviews were developed to explore the patients' perspectives toward psychology-based cancer research under two domains such as the perspective of cancer patients on psychology-based research related to cancer and motivations to participate in the main study.

Domain 1 covered patients' thoughts and opinions on psychology-based cancer studies and their purpose, while domain 2 investigated what motivates them to partake in research. The two separate domains cover patient perspectives on psychology-based research and factors that motivate them to consent to the study.

Interviews took place at the oncology department at University Hospital-KDU. Patients were approached by interviewers requesting consent to participate in the main study. Out of which, ten patients who consented were interviewed. The setting was busy and somewhat crowded, with cancer patients and healthcare professionals discussing patients' healthcare information. Therefore, audio-recording the interviews was not appropriate. Detailed notes were recorded of the interviews instead. However, acknowledging the restrictions that come with this approach, measures were taken to maintain the quality of the data collected. It was considered that it could be challenging for the interviewer to engage with the interviewee, build rapport, follow up on interesting points, and draw attention to inconsistencies in answers while taking notes. Thus, the two interviewers took turns interviewing, taking notes, and observing the interviews. The interviewer also took notes right after each interview. Then the interviewer and the observer took time after each interview to compare each other's notes and observations.

Measures were also taken not to lead the respondents in the interview, and it was essential to ensure they did not feel obligated to give politically correct answers. Therefore, the respondents were encouraged to share their honest thoughts by explaining that it was valued the most and that there were no right or wrong answers. Besides, since the rapport was built, respondents were more open to expressing themselves comfortably. The collected data was transcribed. After transcription, phrases in the text were highlighted with specific colors corresponding to different codes. The transcript of each interview was carefully read and responses that came across as relevant were highlighted. After highlighting all the sentences that matched the codes, the data were arranged per different categories identified by code. Afterward, patterns were identified among the created codes, followed by creating themes. After reviewing the themes against the data set, the list of themes was finalized. The themes were then named and defined to formulate what each theme refers to.

3. Results and Discussion

Ten patients who consented to the study 'Exploratory models of cancer among a convenient sample in Colombo' took part in the semi-structured interview process. The participants' ages ranged from 41 to 68 years. The current study did not make attempts to specify the types of cancer or the stages of cancer among the sample as those details were not planned to be considered for the analysis process.

Table 1: Themes identified across two domains in the interviews

Theme	Frequency (n=10 interviews)
Domain 1: Perspective of Cancer patients on psychology-based research related to cancer	
Uncertain	8
Studying the minds of cancer patients	7
Useful and Necessary	5
Domain 2: Motivations to participate in psychology-based cancer research	
To support a good cause	9
Trustworthiness	9
To help cancer patients	9
Convenience	8

The current study identified multiple themes across the two domains.

Domain 1, which focused on the perspective of cancer patients on psychology-based research related to cancer, highlighted themes such as uncertainty about what psychology-based cancer studies do. Themes such as "studying the mind of cancer patients" occurred about the purpose of psychology-based studies. There was also an acknowledgment that psychology-based cancer research can be 'useful and necessary' to cancer patients. Several remarks made by respondents such as "It could help those in need", and "Patients with weak minds need help" indicated a lack of understanding and stigma towards mental health care which may have also affected the perceptions.

Domain 2,' Motivations to participate in psychology-based cancer research', identified multiple themes on patients' different considerations to partake in psychology-based research regarding cancer. One of the themes revealed that respondents were motivated by the need to support a good cause. Other themes included the trustworthiness of the research, helping other patients, and convenience (time). Most participants explained that they consented as they wanted to help a "good cause." The interviewees were prompted to elaborate on the nuanced term "good cause" Participants mentioned that they perceive it as a good cause because it could benefit cancer patients. Interviewers followed up by asking how they think it could help cancer patients. It should be noted that their answers were vague regarding how it could benefit them even though they perceived it as good. The answers indicated that they were not consenting by fully understanding how the study's purpose is a good cause.

On the other hand, a few participants were interested in understanding the main study (e.g., asking questions regarding the main study and how the information they provided would help the main study). Some also mentioned their interest in knowing about the main study's findings.
Another theme was trustworthiness in the study. Most participants' answers ranged from "It is a good thing if the hospital is involved" and "doctors I know are involved." The original study's association with the hospital and their trusted doctors' involvement influenced them to perceive the research as trustworthy and consent-worthy. The revelation highlights the importance of trust in respondents to consent to a study.

Patients also mentioned that they wish to help other cancer patients by participating in the study. Some mentioned having a sense of "responsibility" while another responded, "I want to do good for others, myself, other cancer patients, or anyone else."

Convenience was another theme highlighted when discussing what motivated patients to participate in the study. When the study was first introduced to get consent, some respondents asked if their participation required them to wait long hours or if they needed to be present at the hospital, especially for the study. During follow-up questions and conversations, most respondents made remarks about the current fuel crisis in Sri Lanka, explaining how traveling would be inconvenient.

It was noticed that most respondents' answers were vague and based on uncertain assumptions. Although unsure, some patients identified psychology-based research findings as helpful to patients in psychological distress. However, some answers indicated an apparent stigma towards mental health in general. Most respondents did not associate themselves when speaking about emotional distress. Instead, they expressed that the research can help other patients in distress. However, based on the conversations made, respondents indirectly gave insight into the potential distress they felt in their lives (e.g., unsupportive family members, helplessness, loneliness).

Although the concerns were related to mental health, respondents did not admit they could use help through mental health care. The lack of understanding of psychology/mental health care, which was also apparent in the conversations made, could be a potential reason for not admitting the need for help for psychological distress (Eakin and Strycker, 2001). It must also be noted that in Sri Lanka, psychology/mental health is viewed with intense stereotypical perspectives and stigma (Samarasekare et al., 2012), which could also be a reason for not associating themselves with psychological distress and not admitting help. More studies

should be conducted examining cancer patients' views on mental health care. The input could be beneficial when developing psychology-based studies and intervention programs that are culturally nuanced for Sri Lankan patients in the long run (Schuit et al., 2021).

Altruistic and personal concerns influenced patients to participate. The findings align with prior studies conducted regarding patient willingness to partake in clinical trials (Bradley et al., 2016), (Dias et al., 2016), (Moorcraft et al., 2016).

Other than that, trustworthiness in the study was also a motivating factor. Here, trustworthiness refers to the involvement of familiar healthcare professionals and the hospital in the main study. The findings align with prior studies that found trust in institutions common among the sample (Guillemin et al., 2018). Similarly, patients' altruistic reasons included helping other cancer patients and a good cause. The motivations highlighted in the current study align with the findings in prior literature addressing patient motives to participate in clinical trials (Moorcraft et al., 2016), (Nurgat et al., 2005). However, respondents' answers indicated they perceive the research as a good cause that has little to do with the actual purpose or objectives of the study. Instead, they wanted to help as they presumed it was good and potentially helpful to patients. This behavior was previously identified by a study that investigated peoples' motivation for participation in a community-centered study on environmental health, which found that most participants wanted to cooperate for a good cause even though they were unsure how it would be helpful (Carrera et al., 2018). Convenience was also identified as a motivating factor for participating in the study. Interestingly, answers indicated that patients tried to weigh altruistic reasons and personal concerns such as convenience and the need to support a good cause. This raises the question of whether respondents are motivated mainly by altruism (Carrera et al., 2018) and whether personal concerns could overrun it.

3.1 Limitations

The study has potential limitations. First, limitations regarding the data collection and analysis process should be mentioned. Although the interviewees took several steps to maintain the data quality, the results should be considered with the knowledge that the data were based on field notes and observations of relatively experienced interviewers. Another significant limitation was that the data collected were analyzed manually without using software by researchers who were relatively inexperienced with thematic analysis, which could have affected the results. Future studies should address the limitations by conducting audio-taped interviews, using standard software, or an outside contractor to transcribe the interviews.

Also, the study did not consider patient demographic information when analyzing data. Although it does not impact the validity of the results, thick data like patient characteristics could have contributed to the results even further. Future studies should analyze patient demographic information such as gender, age, and educational level. Also, the type of cancer and stage of cancer among selected respondents should be considered in future studies.

Other than that, the current study was not meant to represent the entire sample of the main study. Therefore, the current study's findings are not encouraged to be used to draw causal conclusions. Future studies should reconstruct the current research among a larger sample.

3.2 Clinical implications

The need for studies regarding the mental health of cancer patients in developing countries has been emphasized (Murthy and Alexander, 2019). Understandably, patient participation is crucial for success in such research. The findings made through this small study on understanding patient perspective and their motivation to partake in psychology-based research can further benefit the recruitment process and development of patient-centric research in the long run.

4. Conclusion

The current study aimed to serve two purposes such as exploring cancer patients' perceptions regarding psychology-based research related to cancer, and what motivates them to consent to research.
Based on the findings made through the study, most patients' perceptions regarding psychology-based cancer research were uncertain. Even though they view the purpose of psychology-based research related to cancer as to investigate cancer patients' minds and identify its use and necessity, most of the answers were vague, implying a lack of a clear understanding of mental health care in general. The underlying stereotypical views indicated in some answers implied a general stigma related to mental health care.

Patients' willingness to participate in the study was more or less influenced by altruistic reasons and potential personal concerns. Several patients were keen on understanding factual information regarding the study which is an indication to actively involve such patients in future research while providing awareness to others about mental health care and its cancer research.

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Declaration of Interest Statement

The authors declare that they have no conflict of interest.

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Gender Differences in Attitude towards Mental Illness in Young Adults

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Abstract

Background: Attitudes held towards mental illnesses are shown to influence how individuals interact with, support, and provide opportunities for people with mental illnesses.

Aims: The objective of the study is to understand the attitudes towards mental illness in the Sri Lankan young adult population, and how gender affects these attitudes in this population.

Method: The study consisted of 80 participants, 40 male and 40 female participants. Quantitative research was conducted with a descriptive study design. The Attitudes to Mental Illness Questionnaire Singapore Version (AMI-SG) questionnaire was administered as an online survey among young adults aged 18 to 35, assessing attitudes towards mental illnesses through four factors namely social distancing, tolerance/support for community care, social restrictiveness, and prejudice and misconception.

Results: Analysis of the study showed that both male and female Sri Lankan young adults held negative attitudes in social distancing, social restrictiveness, and tolerance/support for community care and neutral attitudes in prejudice and misconception and no significant difference was seen between males and females in their attitudes towards individuals with mental illnesses.

Conclusion: The study found that Sri Lankan young adults showed negative attitudes and had no gender-based differences in their attitudes towards individuals with mental illnesses, and further confirmed that cultural differences influence attitudes held towards mental illness, emphasizing the need for delivering culture-specific programs to educate and raise awareness of mental health and illnesses and the need for resources for mental illness awareness among Sri Lankan young adults.

Keywords: Mental illness stigma, attitudes towards mental illnesses, Sri Lanka, young adults, gender differences

1. Introduction

Mental illnesses accounting for one third of the adult health problems in the world, is said to be the pandemic of the 21st century. About 450 million people worldwide are diagnosed with mental illnesses, with Asia being ranked as the second in prevalence of mental illnesses (World Health Organization, 2018b). Depressive disorders, schizophrenia, substance use disorders, and bipolar disorder are some of the mental health problems present in both developed and developing countries associated with poverty, war, and disasters (Lake and Turner, 2017) affecting all ages. Even though the prevalence of mental illnesses is high, studies have shown that about 70% of adults and young individuals living with mental illnesses worldwide do not receive any treatment (Zhang et al., 2019) which is influenced by stigma and various contextual and cultural issues (Mitchell et al., 2017).

Sri Lanka being a developing South Asian country has had its fair share of ordeals in the last few decades with civil war lasting over 30 years, the tsunami in 2004, and the recent Easter bombings shown to have serious reverberations on the mental health of the Sri Lankan people (Wickrama and Wickrama, 2007) Sri Lanka is shown to have high mental health needs (Jenkins et al., 2012), about 5-10% of the Sri Lankan population is said to be suffering from mental illnesses (Castillo, 2009; Samarasekare et al., 2012). According to Siva (2010), Sri Lanka reported more than 20 suicides per 100,000, one of the highest suicide rates in the world and it is estimated that 802,321 individuals, 4.1% of the total population are diagnosed with depression in Sri Lanka, being common mostly in females (Epidemiology Unit Sri Lanka, 2017).

Mental illnesses are defined considering disability due to impairment or behavioral patterns resulting in distress, disability leading to impairment of life functions, or loss of freedom (American Psychiatric Association, 2000). Mental illnesses unlike other illnesses evoke various attitudes among members of the society. This might lessen the societal value of people with mental illnesses and often lead to experiencing social exclusion and prejudice worldwide (Rössler, 2016). Attitudes towards mental illnesses are beliefs held towards people with mental illnesses and how they must be treated (Nunnally, 1961; Yuan et al., 2016), affecting public interactions, and varying from acceptance to stigma. Consisting of positive attitudes leading to inclusion and support and negative attitudes leading to exclusion and discrimination (Yuan et al., 2016) and inaccurate perceptions (Crisp et al., 2005; Weiner et al., 1988).

Individuals living with mental illnesses are subjected to stigma and discrimination (Gaiha et al., 2020), in many aspects of their lives, such as relationships, marriage, social interactions, and employment (Harangozo et al., 2014). Negative attitudes, including beliefs and stereotypes in the general population such as dangerous, crazy, incompetent, and unpredictable associate fear, and avoidance towards individuals with mental illnesses (Al Omari et al., 2019; Juan Li et al., 2018; Ma and Hsieh, 2020). Stigma model shows that stigma is a conscious effort to avoid or exclude an individual or a group from social interaction (Coorigan and Watson, 2002) resulting in social distance, through stereotyping, emotional reactions, separating, and labeling (Madianos et al., 2012). The Classical Conditioning Model and the Misattribution Model explain mental illness stigma seen in society associating stigma with a stimulus which might lead to negative attitudes (Ottati et al., 2005).

“Mental illness strikes with a two-edged sword. On one side, people must struggle with the symptoms and disabilities that prevent them from achieving many of their life goals. On the other, the stigma of mental illness further hampers their opportunities and aspirations” (Corrigan et al., 2004, p. 489).

Public stigma is the reaction of the general community to people with mental illnesses consists of three components namely stereotypes, prejudice, and discrimination. Stereotypes are social beliefs representing common agreed-upon ideas about certain groups of people (Krueger, 1996).

Prejudice is a cognitive and affective response that endorses or promotes stereotypes and results in generating negative emotions, involving negative evaluation (Corrigan and Watson, 2002; Eagly and Chaiken, 1993). Giving rise to emotional reactions such as fear or anger towards stigmatized individuals or groups, anger can lead to hostile behavioural reactions and fear could lead to avoidance when linked with mental illness (Corrigan and Penn, 1999).

The behavioural impact of stigma is discrimination, which could take four forms namely withholding support, coercive treatment, avoidance, and social avoidance of individuals with mental illness (Corrigan and Watson, 2002). According to Harangozo et al. (2014) and Martin et al. (2000), people with mental illnesses experience discrimination as people are not willing to socialize, work with, or have a family member marry them due to their mental illness.Stigma and discrimination are shown to impede access to care at various levels such as individual, community (behaviours and attitudes), and institutional (funding, legislation) levels (Henderson et al. (2013), Less money is allocated for the treatment and research of mental health and illnesses when compared with diseases such as cancer, exhibiting unintended structural discrimination (Link and Phelan, 2001). Discrimination is a major risk factor for mental health leading to poor evaluation and prognosis (Vauth et al., 2007; Harangozo et al., 2014). Acting as a barrier delaying help-seeking behaviours (Samarasekare et al., 2012), the healing process (Juan Li et al., 2018), and adherence to the treatment (Rodríguez-Almagro et al., 2019).

The Societal Reaction Theory shows how stigma might affect individuals with mental illnesses in how they perceive themselves. People with mental illnesses might internalize negative perceptions and believe that their value in society is downgraded (Corrigan and Kleinlein, 2005; Link and Phelan, 2001). Community views towards mental illnesses are also associated with both the individual and the family experiencing public stigma (Samarasekare et al., 2012).

Research shows that people with a better understanding of mental illnesses are less likely to possess or endorse stigmatizing and discriminative ideas (Link and Cullen, 1986). Educating the public provides information on which the public can make more informed and educated decisions about mental illness and individuals affected, improving attitudes and aiding in disassociating themselves from negative stereotypes (Corrigan and Watson, 2002; Penn et al., 1994).

Investigating and addressing public attitudes and stigma through culture-specific and age-appropriate interventions might reduce stigmatization and negative beliefs held towards people with mental illnesses and provide information on whether gender-specific characters should be acknowledged in interventions developed to raise awareness to both genders (Hadjimina and Furnham, 2017). Social workers and mental health professionals will gain insight into groups more likely to hold stigmatizing attitudes (Erazo, 2020), thereby increasing engagement with individuals with mental illnesses and mental health services due to better awareness and knowledge about mental illnesses and mental health.

The aims of this study are: 1) to understand the attitudes towards mental illness in the young adult population in Sri Lanka, and 2) how gender affects attitudes towards mental illnesses in this population. There is a wealth of research on attitudes towards mental illnesses in young adults however research is

limited in a Sri Lankan Context therefore extending research in a Sri Lankan context will shed light on gender differences in the existing attitudes to mental illnesses in young adults in Sri Lanka.

2. Methodology

2.1 Participants

Data was collection from 80 participants consisting of equal numbers of both males and females (40 males and 40 females) representing the young adult population of Sri Lanka through volunteer sampling. Inclusion criteria of the study was participants being 1) Sri Lankan citizens; 2) in the age group of 18 to 35 years; 3) able to complete the questionnaire in English and the exclusion criteria of the study was that anyone who feels distressed at completing the questionnaires might not participate.

2.2 Research Design

Quantitative research was conducted and a descriptive study design was employed to assess the attitudes towards mental illness in the young adult population of Sri Lanka and to investigate gender differences in these attitudes.

2.3 Data Collection Instrument

Primary data was collected through the validated Attitudes to Mental Illness Questionnaire Singapore Version (AMI-SG). The AMI-SG was adapted from the Attitudes to Mental Illness questionnaire developed by the Department of Health UK to suit the general population of Singapore (see Appendix A). The AMI-SG questionnaire was selected for the study as it was adapted to the Asian context as the attitudes were assessed in Sri Lankan young adults in an Asian context. AMI-SG questionnaire accessed public attitudes through a four-factor structure consisting of social distancing, tolerance/support for community care, social restrictiveness, and prejudice and misconception (Yuan et al., 2016). A 5-point Likert scale ranging from '1 = strongly agree' to '5 = strongly disagree 'was used to rate the items of the questionnaire.

2.4 Data Collection Procedure

AMI-SG questionnaire was administered as an online survey through Google Forms within two/three months., participants were provided with an information sheet regarding the study (see Appendix C). The survey was sent to potential participants through social media platforms WhatsApp and Messenger (Facebook), and consent for participation in the study was assumed when participants proceeded to the online survey via the link provided with the description of the study. Socio-demographic information was also collected including age, ethnicity, gender, marital status, education level, employment, and information on whether there are any mental illness diagnoses in any close family and/or friends was also collected (see Appendix B for socio-demographic form).

2.5 Data Analysis

The independent variable of the study was the gender of the participants, males and females and the dependent variables were the four factors of the AMI-SG questionnaire assessing attitudes towards people with mental illness, social distancing, tolerance/support for community care, social restrictiveness and prejudice and misconception. Data collected by the questionnaire was analyzed using the SPSS Software Version 26.0 for Windows, descriptive statistics and graphical analysis were used to analyze the socio-

demographic information of the participants, and parametric and non-parametric measures (Mann Whitney U test) of the independent samples *t-test* was used to determine whether there are gender-based differences between attitudes towards mental illnesses in males and females. The null hypothesis is that there is no gender-based difference in attitudes towards mental illness and the alternative hypothesis is that there is a gender-based difference in attitudes towards mental illness.

3. Results

3.1 Descriptive Statistics

Descriptive statistics were used to analyze the socio-demographic information of the participants. The results showed that both female and male participants were of equal percentages, had an average age of 25.18 (SE = 0.532), participants were mostly Sinhalese (94.5%) and were followed by Tamils (3.8%), and Muslims (1.3%). About 72.5% of the participants were never married while 21.3% were married and 6.3% were widowed, separated, or divorced. Almost three-quarters of the participants had a university level education (67.5%) and participants with education levels of Advanced level or diploma were 28.7%. About 57.5% of the participants were employed and 28.7% were students. Only 26.3% of the participants reported a family member or friend diagnosed with a mental illness**.**

3.2 Social Distancing

The mean AMI-SG factor score for social distancing was 10.850 in females and 10.400 in males. The scores do not differ between the groups and both females and males show higher social distancing attitudes, as positive attitudes towards people with mental illnesses are characterized by lower social distancing (Yuan et al., 2017).

3.3 Tolerance/Support for community care

The mean AMI-SG factor scores for tolerance/support for community care were 17.793 for females and 18.342 for males. Both females and males show less tolerance/support for community care attitudes with no difference between the two groups as positive attitudes towards people with mental illnesses are characterized by higher scores for tolerance/support for community care (Yuan et al., 2017).

3.4 Social Restrictiveness

The mean AMI-SG factor score for social restrictiveness was 11.898 in females and 11.175 in males. Both females and males show higher social restrictiveness attitudes with no difference between the two groups as positive attitudes towards people with mental illnesses are characterized by lower scores for social restrictiveness (Yuan et al., 2017).

3.5 *Prejudice and misconception*

The mean AMI-SG factor score for prejudice and misconception was 15.35 in females and 15.75 in males. Both females and males show neutral prejudice and misconception attitudes with no difference between the two groups as positive attitudes towards people with mental illnesses are characterized by lower scores for Prejudice and misconception (Yuan et al., 2017).

Table 1: AMI-SG scoring of Females and Males for the four factors

	Females	Males	Score Range
	Mean	Mean	
Social Distancing	10.850	10.400	3-15
Tolerance/Support for community care	17.793	18.342	9 – 45
Social Restrictiveness	11.898	11.175	3 – 15
Prejudice and misconception	15.35	15.75	5 - 25

The results of the study showed no gender-based differences in all four factors social distancing, social restrictiveness, tolerance/support for community care, and prejudice and misconception accessing attitudes towards mental illness in males and females. Both males and females showed higher negative attitudes in social distancing, social restrictiveness, and tolerance/support for community care, and neutral attitudes in prejudice and misconception.

4. Discussion

There is a wealth of research on attitudes towards mental illnesses in young adults however research is limited in a Sri Lankan Context (Fernando, 2010). Hence, the study focuses on extending research findings from a Sri Lankan context. Disagreeing with the hypothesis, the results of the study showed that both males and females showed no statistically significant difference in all four attitudes assessed social distancing attitudes, tolerance/support for community care attitudes, social restrictiveness, and prejudice and misconception towards individuals with mental illness. Negative attitudes were held by both males and females showing higher social distancing and social restrictiveness and lower tolerance/support for community care. Neutral attitudes were seen in prejudice and misconception attitudes as both males and females showed moderate prejudice and misconception.

Differences in attitudes of women were shown in various studies conducted in different country contexts. Showing positive attitudes (Angermeyer et al.,1998) and social distancing (Holzinger et al., 2012; Reavley and Jorm, 2011; Song et al. 2005). In Singapore, the AMI questionnaire showed females with less social restrictiveness, less prejudice and misconception, and more tolerance and support for community care towards people with mental illness (Yuan et al., 2016). However, the findings of the current study were not consistent with the findings of other studies as females showed lower tolerance and support for community care, higher social restrictiveness and social distancing, and moderate prejudice or misconception. Further emphasizes that attitudes towards mental illnesses can vary across various cultural contexts (Lauber et al.,2000) and the need for more information on the culture-specific aspects of attitudes towards mental illnesses in Sri Lanka (Fernando, 2010).

Various studies show education to determine familiarity with mental illness and more knowledge among individuals with more years of education associated with low levels of prejudice and misconception (Angermeyer and Dietrich, 2006; Arikan et al.,1999 ; Holmes et al., 1999; Subramanian et al., 2017) and the AMI-SG scale has consistently shown negative attitudes toward mental illness when associated with low educational levels (Yuan et al, 2016). However, the results seen in the current study showed negative tolerance/support or community care, social distancing and social restrictiveness attitudes, and moderate attitudes toward prejudice and misconception which is inconsistent with the findings of the earlier studies as more than 95% of the participants had educational levels of university and advanced level. Indicating that the educated Sri Lankan young adults held negative attitudes toward mental illnesses, however, familiarity with mental health and mental illnesses might also play a role in their attitudes.

Low Stigma (Fernando, 2010) and greater tolerance towards mental illnesses are seen in developing countries rather than nuclear families in the West (Littlewood, 1998), due to extended family structure, rural agrarian society, perceiving behaviour as reversible, attributing mental illnesses to external factors, and strong family bonds (Sartorius and Schulze, 2005). However, these attitudes were not reflected even with a prevalence of extended families in Sri Lanka in tolerance attitudes towards individuals with mental illnesses.

Research has shown that educating the youth reduces stigma (Sartorius and Schulze, 2005). Therefore, Sri Lanka must plan culture-specific strategies for effective awareness campaigns that could address negative attitudes towards individuals with mental illness in young adults. Some effective strategies could be awareness and educational campaigns in schools, education and awareness through public campaigns, workshops and media in various settings, and interactions with or exposure to people with mental illnesses (Kakuma et al., 2010).

Limitations of the study are, the use of the general term “mental illness” in the questionnaire, responses being highly dependent on the interpretation of this term (Yuan et al., 2016) and the lack of language diversity in the questionnaire, limiting the study to English-speaking Sri Lankan young adults even though approximately 74% of the population of Sri Lanka use Sinhala (Premawardena, 2007). The research investigated only binary male and female genders, which might be a limitation as other gender identities were excluded (EMU Research, n.d.).For further studies using the AMI-SG questionnaire in Sri Lanka, the questionnaire could be translated into Sinhala, and Tamil together with English, the research can also consider the correlations between attitudes towards mental illnesses of participants and their socio-demographics such as their ethnicity.

5. Conclusion

This research aimed to find gender differences in attitudes towards mental illnesses in Sri Lankan young adults. Based on a quantitative research design and assessing attitudes towards mental illnesses through the four factors social distancing, tolerance/support for community care, social restrictiveness, and prejudice and misconception. It can be concluded that no differences were seen among males and females in their attitudes toward mental illnesses across the four factors assessed. Both males and females showed negative attitudes toward social distancing, social restrictiveness, tolerance/support for community care, and neutral attitudes toward prejudice and misconception. These results indicate that attitudes towards individuals with

mental illnesses vary across different cultural contexts further confirming earlier studies showing differences in attitudes across different cultures. Further studies could explore the attitudes held by Sri Lankan young adults and how Sri Lankan culture affects their attitudes toward mental illnesses. The findings of the study support the need for delivering culture-specific programs to educate and raise awareness of mental health and illnesses and the need for resources for mental illness awareness among Sri Lankan young adults.

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Declaration of Interest Statement

The authors declare that they have no conflict of interest.

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Appendices

Appendix A

Attitude to Mental Illness questionnaire – Singapore Version (AMI-SG)

Items of the questionnaire will be rated on a 5-point Likert scale ranging from '1 = strongly agree' to '5 = strongly disagree'.

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. Having mental health facilities in a residential area downgrades the neighbourhood.	1	2	3	4	5
2. It is frightening to think of people with mental problems living in our neighbourhoods.	1	2	3	4	5
3. I would not want to live next door to someone who has been mentally ill.	1	2	3	4	5
4. We have a responsibility to provide the best possible care for people with mental illness.	1	2	3	4	5
5. Anyone can become mentally ill.					
6. Increased spending on mental health services is a waste of money.	1	2	3	4	5
7. We need to adopt a more tolerant attitude toward people with mental illness in our society.	1	2	3	4	5
8. As far as possible, mental health services should be provided through community based facilities such as policlinics, GPs and family counselling services.	1	2	3	4	5

9. 'People with mental illness are not as dangerous as most people think they are'.	1	2	3	4	5
10. The best therapy for many people with mental illness is to be part of a community.	1	2	3	4	5
11. Residents should not be afraid of visiting mental health services in their neighbourhood.	1	2	3	4	5
12. No-one has the right to exclude people with mental illness from their neighbourhood.	1	2	3	4	5
13. Anyone with a history of mental problems should be excluded from the public/civil service.	1	2	3	4	5
14. People with mental illness should not be given any responsibility.	1	2	3	4	5
15. People with mental illness are a burden on society.	1	2	3	4	5
16. As soon as a person shows signs of mental disturbance, they should be hospitalized.	1	2	3	4	5
17. Mental hospitals are the only means of treating people with mental illnesses.	1	2	3	4	5
18. There are sufficient existing services for people with mental illness.	1	2	3	4	5
19. One of the main causes of mental illness is a lack of self-discipline and will-power.	1	2	3	4	5
20. There is something about people with mental illness that makes it easy to identify them from normal people.	1	2	3	4	5

Appendix B

Socio-demographic Questionnaire

1. Age?

2. Gender

☐ Male

☐ Female

3. Marital Status

☐ Married

☐ Never married

☐ Other (separated, divorced, widowed)

4. Ethnicity

☐ Sinhalese

☐ Tamils

☐ Muslims

☐ Burghers

5. Education level

☐ Primary and below

☐ Secondary education including Ordinary Level

☐ A Level and or diploma

☐ University

6. Employment Status

☐ Employed

☐ Unemployed

☐ Student

☐ Homemaker

7. Family or close friends diagnosed with mental illness

☐ Yes

☐ No

Appendix C

Information Sheet

Gender Differences in Attitudes towards Mental Illnesses in Young Adults

We would like to invite you to take part in the above named research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please therefore take time to read the following information carefully

Purpose of the study

The objective of this study is to gain a better understanding of attitudes towards mental illnesses in the Sri Lankan context, by understanding the attitudes towards mental illness in the young adult population of Sri Lanka, and whether there are gender differences in attitudes towards mental illnesses in this population.

Invitation to participate

Sri Lankan young adults in the age group of 18 to 35 with the ability to complete the questionnaire in English are invited to take part in the project, and the study aims to collect data from 80 participants in total.

Participation

Your participation in this study is strictly voluntary. No financial reimbursements or incentives will be given for the participation in this study.

Consent is assumed when participants proceed to participate in the online survey via the link provided, participants will be assured of guilt free withdrawal from the study and that it is not necessary to participate if they do not want to**.**

Participation will involve

This study will be conducted over a period of approximately one year. For the voluntary participation in this research, we kindly ask you to

- Fill out a socio demographic form
- Fully and accurately complete the questionnaire which consists of twenty items, this should take up to a maximum of 5 to 10 minutes.

Risks associated

For the purpose of this research, no significant risks have been identified. However, if you experience any discomfort whilst administering the questionnaire, contacts for help and their details has been made available to you at the end of the information sheet.

Potential Benefits

Participation in this study will help me in my Undergraduate project for the completion of my BSc in Psychology.

Results of the Research

The results of the study will form part of a dissertation for the completion of the researchers Bachelor of Science degree in Psychology.

Confidentiality

Confidentiality of all collected data is guaranteed, and no information will be released or published from which participant identity will be revealed as there will be no identifying marker asked in any of the questionnaire sheets such as name of the participant. Only the demographic data will be what is required for the study. All information given by participants will be always kept strictly confidential. The collected data will be stored in password protected laptop for analysis and the information will be accessed only by the researcher and supervisor.

For further clarifications

If you have any questions about any of the tests/procedures or information, please feel free to contact any of the persons listed below:

Academic Supervisor: Ms. Pavani Boralassa

Email address: pavani@icbtcampus.edu.lk

Contact number:

Thank you

Helplines and contacts for help

Sumithrayo: A SriLankan government approved mental health charity with confidential and anonymous mental health support. There are ten Sumithrayo centres across SriLanka. Face-to-face, over the phone, and email consultations available.

Hotline: +94 11 2 682535 / +94 11 2 682570

Address: 60/7, Horton Place, Colombo

Website: www.sumithrayo.org

CCC-line: Free telephone helpline service provided for individuals of all ages providing psychological support and guidance. Callers are connected to trained counsellors as problem requires. Operates all day of the week from 7am to 5am.

Address:379/4,GalleRoad,Colombo03

Helpline:1333

Website: www.cccfoundation.org.au/

Shanthi Maargam: Youth counselling centre for psychological and emotional support for young adults, as well as carrier guidance and future planning.

Address: 69/17, Gothami Road, Borella

Contact number: 0717639898

Email: shanthimaargam@gmail.com

ArnahaCenter for Wellbeing: Trained therapists helps with a range of mental challenges such as depression, emotional crisis, low mood, self-esteem issues, anxiety, phobias, anger, OCD, and bereavement.

Address: 111/12 A, Vishnu Kovil Cross Road, Dehiwala

Contact number: 077 051 8173

Email: arnahawellbeing@gmail.com

Website: www.arnahawellbeing.com

Appendix D

Ethics Approval Letter

Siriwardana, Punchihewage Sandha Ranmalee
Cardiff School of Sport and Health Sciences

Dear applicant

Re: Application for Ethical Approval 'Gender Differences in Attitudes towards Mental Illnesses in Young Adults'

Project Reference Number: UG-4051

Your application for ethical approval of the above project was considered by Cardiff School of Sport and Health Sciences under the Cardiff Metropolitan University Ethics Framework, and I'm pleased to inform you that it was APPROVED on **01/04/2021**

Minor issues may still need addressing before you commence any work, and if so these will be listed below:

N/A

Where changes to the information sheet, consent form and/or procedures are deemed necessary you must submit revised versions through the CSSHS Ethics Process. If you are a student, your supervisor must do this on your behalf.

Note: Failure to comply with any issues listed above will nullify this approval.

Standard Conditions of Approval

1. Your Ethics Application has been given a Project Reference number, noted above. This **MUST** be quoted on all documentation relating to the project (e.g. consent forms, information sheets), together with the full project title.

2. All documents must also have the approved University Logo and the Version number in addition to the information highlighted in point 1.

3. A full **Risk Assessment** must be undertaken for this proposal, as appropriate, and be made available to the School if requested.

4. Any changes in connection to the proposal as approved, must be referred to the School for consideration **without delay, quoting your Project Reference Number**. Changes to the proposed project may have ethical implications therefore must be approved.

5. Any untoward incident which occurs in connection with this proposal must be reported back to the School **without delay**.

6. If your project involves the use of **human samples**, your approval is given on the condition that you or your supervisor **notify the HTA Designated Individual** of your intention to work with such material by completing the form entitled "Notification of intention to Work with Human Material". This form must be submitted to the Person Designated (PD) **BEFORE** any activity on this project is undertaken.

7. It is the responsibility of the Principal Investigator to ensure the project aligns with Cardiff Metropolitan University's policies and procedures regarding GDPR compliance. For further information please click here.

This approval expires on **01/04/2022.** It is your responsibility to reapply/request extension if necessary.

Ethics Committee
Cardiff School of Sport and Health Science

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The Correlation Between Young Adult's Partner Sexual Compatibility and Marriage Satisfaction

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Abstract

This study investigates the relationship between sexual compatibility among adolescents and their marriage satisfaction levels. Using correlation and regression analyses, it was found that strong sexual compatibility among partners leads to higher levels of happiness in marriages. This highlights the importance of sexual success in promoting courtship satisfaction. Regression analysis was used to evaluate how sexual compatibility predicts marriage satisfaction. The regression model, which included sexual compatibility as a predictor variable, explained a significant portion of the variance in married couples' satisfaction levels. The standardized coefficient for sexual compatibility demonstrated a robust and favorable association between sexual compatibility and marriage satisfaction. The analysis of the coefficients supported the hypothesis that sexual compatibility strongly influences marriage satisfaction among the population. The unstandardized coefficient also showed its impact on married couples' happiness. The consistent time period in the regression model underscored a fundamental level of marital satisfaction among adolescents, regardless of their sexual compatibility. The results offer valuable insights into how sexual compatibility impacts young adults' marriage satisfaction levels and emphasize the need for tackling sexual dynamics in courtship therapies to promote healthy and fulfilling romantic relationships among teenagers. This research uncovers the intricate connection between sexual compatibility and marital satisfaction, providing valuable insights for researchers and practitioners in the field of relationship science.

Keywords: Partner, Sexual Compatibility, Marriage Satisfaction, Young Adults, Relationship Dynamics

1. Introduction

1.1 Background of the study

Sexual pleasure and fulfillment in relationships are inextricably linked, as supported by studies and therapists (Sprecher, 2002). However, the connection between having a relationship and being sexually satisfied may be influenced by other factors, such as the length of time spent together. These findings on contentment and attraction were based on personal responses, capturing only one person's view of their satisfaction with their connection (McCabe, 1999).

Sexual and interpersonal fulfilment are not always connected with high levels of other forms of sexual behavior. Additional variables related to sexual and intimate satisfaction include communication, connection, mental wellness, psychosocial well-being, and personality traits (Klusmann, 2002). The amount of real compatibility (compatibility of elements that effect excitation) and perceived sexual compatibility have not been assessed for forecasting sexually and marriage pleasure (Tao & Brody 2011). Actual sexual compatibility refers to the degree to which both partners share commonalities in terms of their sexual preferences (Christensen, 2004). A person's perception of their spouse's sexual views, tastes, wants, and desires is a key factor in determining the degree of compatibility. Sexual compatibility is achieved when individuals of a dyad share similar sexual wants, actions, admires, and dislikes (Purnine & Carey, 1997).

Perceived sexual complementarity has a significant relationship to both sexual fulfilment and sexual agreement. It is impossible for two people to experience sexual satisfaction when one partner wants to engage in a behavior that the other partner finds unpleasant (Heino & Ojanlatva, 2000). Studies on compatibility has, for the majority of part, focused on examining perceived compatibility by evaluating just one individual in a dyadic relationship, which has led to the exclusion of possible relevant data. For instance, Rombough (1996) discovered that observed sexual compatibility was connected with sexual attraction in women, although the respondents' male companions were not taken into account in the evaluation. The authors of this study hypothesized that women's sexual desires were influenced by their perceptions of their spouses' sexual compatibility. In a different piece of research focusing on women, Hurlbert, Apt, Hurlbert, and Pierce (2000) examined women's perceptions of their sexual compatibility and gathered information from participants who had hyperactive sexual desire disorder.

That discovered that women which thought that they had a sexually suitable relationship with their spouses had lower rates of depression and sexual anxiety, indicated higher degrees of sexual desire and drive, and had a more optimistic outlook on sexual fantasizing. Women whom reported feeling sexually compatible with their spouses had a higher level of motivation to engage in sexual activity compared with individuals who reported feeling sexually incompatible with the other person. However further study has revealed as the amount of way perceived sexual compatibility influences various parts of a sexual connection might be different for women and men. This is one of the hypotheses which has been put up to explain this apparent discrepancy. Although it was shown that women link sexual satisfaction with psychological intimacy in the context of a connection (Hurlbert, Apt, & Rabehl, 1993), it is possible that women appreciate sexual compatibility more highly than men do. According to Offman and Matheson (2005), some people might consider sexual compatibility as an indicator of the total amount of closeness that exists during a relationship. If, on the other hand, compatibility is evaluated in regard to the desired quantity of sexual encounters, then it is possible that men will place equal importance on it. The researchers Nicolosi, Moreira, Villa, and Glasser (2004) discovered that compatibility in regards to the anticipated number of sexual

interactions was an excellent indicator of sexual functionality in males. This was shown to be the case in both heterosexual and homosexual couples. Offman and Matheson (2005) discovered that a person's self-assessment of their sexual compatibility as well as their partner's view of their sexual compatibility was both indicative of a person's level of sexual pleasure.

1.2 Research gap

Even while the link among sexual compatibility and sex satisfaction, as well as, to a lesser degree, to relational fulfilment, has been discussed in the investigation that has been conducted up until this point, there are a number of areas in which this study is constrained. To begin, the majority of the studies that have been conducted in this field have only included women or clinical samples (Hurlbert et al., 2000). Researchers participated in a few of the early studies on sexual compatibility, proposed the notion that one of the primary reasons of sexual incompatibility was conflicting desires for certain sexual actions among spouses (Hurlbert et al., 2000). This constitutes one of the primary causes of sexual incompatibility. Notwithstanding the fact that it is an initial finding, there has not been any study done to far that has explored compatibility with regard to of elements that restrict or improve sexual arousal and the way this can affect sexual and relationship pleasure. However, investigators have long proposed that comprehending one member of the dyad despite knowing the setting of the other participant of the dyad lacks an enormous quantity of data (Kerr & Bowen, 1988) . However, little research has looked into the relationship among sexual compatibility and relationship fulfilment whereas examining both sides of a dyad.

1.2 Rationale

The notion of being content in one's marriage is a comprehensive and multidimensional term that incorporates psychological, financial, and spiritual aspects. In point of fact, indicators of marital satisfaction differ depending on the investigator who is conducting the study as well as the operative term for marital satisfaction that they employ. Particularly, the prerequisites for a good married relationship might be very variable and can perhaps rely on a one-of-a-kind collection of culturally imposed customs, duties, and beliefs.

According to the insights of the studies, sexual relations take precedence over everything else in a married person's life, and having sexual gratification may lead to a more pleasant and fulfilling marriage. In regard to fact, marital contentment is determined by a variety of elements having a sexual connection that is both safe and pleasant has been identified as being one of the most significant aspects, as indicated by several studies. The experience of sexuality is one of the most difficult and significant facets of a woman's life. A person's level of sexual pleasure may be thought of as "an efficient reaction that results from one's relative assessment of the positive and negative aspects related to one's sexual connection".

However just a handful of research have been carried out on the Sri Lankan community in order to reveal specific facts on marital unhappiness, it has been shown that sexual dissatisfaction is the leading source of Sri Lanka.

1.3.1 Research Aim

The goal of the research is to evaluate the impact of sexual compatibility and on relationship satisfaction in a preliminary group of heterosexual spouses who were dedicated to one another.

1.3.2 Research questions

The research has been building with relating to two research questions.

- What is the association between young adult's partner sexual compatibility and marriage satisfaction?

1.3.3 Research objectives

The research has been building with relating to two research question.

- Determine the relationship between young adult's partner sexual compatibility and marriage satisfaction.

1.3.4 Research hypotheses

- H1- There's a positive association between young adult's partner sexual compatibility and marriage satisfaction.
- H0- There' a significant impact from young adult's partner sexual compatibility on marriage satisfaction.

2 Materials & Methods

2.1 Research design

In the initial stage, the reliability test will be carried out utilizing the Cronbach's alpha statistic. In addition, multiple linear regression (MLR) as well as descriptive stats were utilized throughout the process of carrying out quantitative studies for the purpose of this study. To begin, a pilot study consisting of a rather small group will be carried out. In order to conduct an analysis of demographic details and operationalized factors, descriptive data analysis was utilized. Secondly, MLR was utilized in order to do research on the elements that influence variables for satisfied marriage, including tasks which have interdependence.

The questionnaires that will be utilized for carrying out the survey are divided into two portions, both including a total of 30 questions. Five of the questions pertain to demographic information, while the remaining questions pertain to the variables which will be measured. The measuring factors were acquired from another investigation which was conducted in a comparable area of research, and most of the material which was utilized in the study came from secondary materials. These secondary materials included papers, governmental data, and publications which were obtained from a reputable source that conducted research in a comparable field.

2.2 Data analysis

Quantitative findings for the research aim can be derived from the examination of the material, together with philosophical underpinnings for the proper references. Investigators can get insight into the findings by either examining the data themselves or doing statistical analysis of the information to look for changes and trends (data interpretation). The information might be displayed in tabulated or graphical representations, after the assessment and classification processes that are carried out by a Specialized assessment tool. In order to create responses that may potentially be used for assumptions, the researcher entered the original information onto the SPSS analyzing & processing entities and executed a battery of trials. The verification of the neutral assumption by a third party is the primary emphasis of the evaluation procedure. It is essential that the data obtained from the Reliability Testing be as precise and exact as is feasible. Checking the evidence for normality, co-linearity, descriptive evaluation, connections, and multiple linear analyses should be done before making any definitive results based on the data in question. This should be done prior making any conclusions at all.

2.3 Sampling

According to Hair (2019), there are basically two fundamental categories of sampling methods: probabilistic and non-probabilistic. This is a fact which is generally accepted by the scientific community. Whenever refers to a method for selecting a sample from a greater population, the term "probabilistic sampling" is employed to indicate a method which is founded on the idea of probability. This method is employed when selecting a sample within the bigger population. Every individual in the population is taken into account, and participants are chosen in accordance with a set of criteria that has been established. In non-probabilistic evaluation, a representative sample is chosen for examination by the researcher or observer on the basis of their prior expertise and practical experience. Non-probabilistic sample techniques include the employing of criteria and restricted sampling, whereas statistically likely sample techniques include simple random sampling, clustering, and stratified sampling. Examples of non-probabilistic sample techniques include the usage of ceilings and restricted sampling. Investigators commonly use a non-probabilistic sampling strategy that is referred to as the snow ball sampling technique. This is done so that they can assure that all demography groupings are accurately depicted in their findings. A participant from each of the identified items was requested to either distribute survey forms to their friends or provide the researchers with a database of names and emails of individuals who they believed might be interesting in getting involved with the investigation. This was done in order to provide a straightforward method for sampling participants. Employing online communities is one of the strategies that will be utilized in this approach to expand the number of individuals whom taking part in research endeavors. The phrase "sampling" encompasses a wide variety of methods that are used to figure out a subset of a population or draw conclusions regarding the population as a whole. In order to prevent surveying, the entire population yet still achieve results that are statistically significant, market investigators make use of a diverse variety of sampling strategies. For the purpose of the study, the investigator has made the decision to collect data from a sample that is intended to be typical of present-day marriage couples.

2.4 Sample Size

The primary factor that contributed to the bounding was the utilization of efficient sampling strategies. Despite this, the investigator is aiming for a responses rate of at least 90% from sample of 100 participants who will be selected randomly.

2.4.1 Exclusion criteria

- Under aged people
- Over 40 aged people
- Unmarried people

2.4.2 Inclusion criteria

- Young people on the age of 20 to 35 who have been married over 4 years

2.4.3 Measurement

The Hurlbert Index of Sexual Compatibility (Hurlbert et al., 1993) was used to assess how sexually compatible two people were. The HISC is a 25-items survey which measures how two people in a relationship feel about overall sexual compatibility with one another.

The ENRICH Marital Satisfaction Scale is a 15-point scale that could possibly be used to measure how well both partners are satisfied in a marriage. Each question is scored on a 5-point scale from 1 (strongly disagree) to 5 (strongly agree). The score will be updated in real time. The greater the score, the happier the responder feels in their romantic partnership.

3 Results & Discussion

Studies have found a significant positive association between sexual compatibility and marriage satisfaction among young adults. This suggests that individuals who are more attuned to their partners' sexual harmony levels are more likely to experience greater satisfaction in their marriages. Sexual success plays a crucial role in the development of average courting pride. A regression analysis showed that sexual compatibility significantly contributed to explaining variance in an individual's happiness level due to their marriage. Enhancements in sexual compatibility may lead to corresponding increases in marital contentment. The regression model also showed that maintaining a consistent time period in the regression model indicates a fundamental level of marriage satisfaction among adolescents, regardless of their sexual compatibility. These findings underscore the importance of understanding sexual dynamics within relationships and addressing any issues that may arise. The study reveals a strong link between sexual compatibility among couples and the pride adolescents feel in their marriages. This research has the potential to significantly contribute to the understanding of dating technology and the dynamics of love relationships. The Investment Model, Interdependence Theory, and Social Exchange Theory offer insights into the dynamics of love relationships and the sense of pride associated with marriage.

The Investment Model suggests that relationship satisfaction is influenced by factors like commitment, options, and investments (Erulkar, 2013). Couples with strong sexual chemistry may feel more committed to their relationship, leading to higher levels of satisfaction and connection (Robles, 2014). The Interdependence Theory emphasizes the importance of interdependence and mutual affect in establishing the dynamics of dating relationships. Stronger sexual compatibility is linked to higher levels of marital happiness among young individuals, lending credibility to this perspective (Sezgin & Punamäki, 2020b).
The Social Exchange Theory provides a perspective to understand the reciprocal dynamics present in romantic relationships. It suggests that individuals should engage in partnerships that provide benefits and help reduce costs. The study results provide evidence for this perspective by emphasizing the strong connection between sexual compatibility and the amount of happiness adolescents feel in their marriages (Carlson & Dermer, 2016).

4. Conclusion

The study highlights the importance of addressing sexual dynamics in relationship therapies designed to enhance the well-being and satisfaction of married couples. Interventions based on these findings can help raise awareness about the importance of enhancing communication and understanding of sexual desires and fantasies between partners. One way to address this is by implementing strategies based on the research. Additionally, treatments may aim to tackle disparities in sexual preferences and desires by highlighting the importance of education and skill development through engaging in sports competitions. By exploring sexual compatibility within their relationships, interventions can help couples cultivate more closeness, enjoyment, and longevity in their unions.

In conclusion, the study provides valuable insights into the complex connection between sexual compatibility and marital satisfaction, which is intricate and aligns with several established hypotheses associated with courting technology.

4.1 Ethical considerations

All phases of this study's application, data collection, and submission were conducted in accordance with the highest ethical standards. Before giving out surveys, the investigator made many efforts to secure participants' informed permission. Participants' independence is taken into consideration in addition to the research's main objective and technique. The researcher ensured the subjects' confidentiality. In addition, everyone involved was free to leave whenever they liked. In addition, no one felt compelled to lie or break confidentiality in order to forward the aims of the study. No participant was put in a situation where they felt forced to participate in the research. It was made clear to all respondents how their responses would be used. The investigation did not cause any harm or distress to the participants in any way. Lack of dependency on a single funding or organization does not compromise the study's autonomy. At each stage of the investigation, the researcher provided detailed explanations of the study's goals, anticipated results, anticipated applications of acquired data, and data retention techniques.

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