CHAPTER THREE

Methodology
CHAPTER III

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GENERAL PLAN AND SAMPLING PROCEDURE

It was initially planned that this work would primarily deal with case histories emphasizing the home environment, neighbourhood and place of work of the mental patients. However, this was not fully accomplished since most of the patients lived in distant rural areas. Earlier, it was also decided to study the cured mental patients from both the Central Mental Hospital and the Sasson General Hospital located at Pune, India. However, since the authorities of the Sasson General Hospital could not easily control the mobility of the patients in their hospital, it was not always possible to obtain complete case histories from these patients and their relatives. Therefore, only the Central Mental Hospital was chosen as the venue for the present study.

The data collected from this hospital was carried out at two levels:

1. The total universe or the patient population hospitalised for the first time in the year 1974.

2. Case histories of the first 100 male and the first 100 female cured patients provided by
a senior psychiatrist between the years 1975-1977 based on certain socio-demographic constants and exhibiting chiefly a socio-cultural or psychological etiology.

The analysis of the hospital case records of the 1168 first admissions in the year 1974 was carried out with a view of identifying the demographic and socio-cultural characteristics of the patients. The analysis of this quantitative data assisted the researcher in determining the dominant characteristics of the patients which were fixed as constants for the second phase of work.

In view of the extent of the universe, objectives of the study and the individual resources of the researcher, it was considered reasonable that 15 percent of the average annual admission rate be studied in depth. Thus, between January 1975 and March 1977 intensive case histories of 100 male and 100 female cured mental patients were collected. Some of these patients were awaiting final permission for discharge, while others were waiting for their relatives or friends to take them home with the consent of the hospital authorities.

For want of training in clinical psychology and psychiatry, and also having recognized the problems involved in case detection, the assistance of trained psychiatrists, clinical psychologists and psychiatric social workers were solicited.
Only after careful screening and diagnosis of the patients, did the psychiatrists permit the researcher to interview the relatives of the patients and the cured patients themselves who exhibited an etiology belonging to the psycho-social and cultural area.

Although the earlier "Macroscopic" study of the 1168 mental patients exposed a cross section of the culture and provided a horizontal view which cut across a vast surface of data, it furnished relatively little depth material. Hence, the later "Microscopic" study of 200 cured patients, permitted detailed case histories which provided a vertical view as well.

COVERAGE AND SELECTION OF VARIABLES (Refer Appendix I & II)

With the hospital records of 1168 mental patients, the researcher was able to collate the information and prepare a code sheet of 39 categories with 303 variables that were later transferred into IBM cards. These cards were punched, verified and sorted by a technician for simple frequency tables. Later the information was programmed and fed into a computer at the Indian Statistical Institute (ISI), Calcutta, India, for cross tabulations. The salient features of this work and the test of significance ($X^2$) administered to various cross-variables are presented in Chapter four.
The dominant characteristics of the patients that were determined by the analysis and fixed as constants for the case histories were:

1. Age Group: 15 to 34
2. Religion: Hindu
3. Marital Status: Married
4. Educational Status: Literate
5. Diagnosis: Schizophrenia

The intensive case histories of the 200 cured patients incorporated the following areas which were gathered in an interview schedule:

1. Personal and Demographic Data
2. Parental Family
3. Childhood and Siblings
4. Adolescence
5. Education
6. Occupational Background
7. Socio-economic History
8. Married Life
9. Sex Life
10. Religion
11. Habits
12. Status of Health and Medical History
13. Mental Health
14. Anti-social History
15. Social Participation
The above areas carried 157 structured as well as open ended questions which were subjected to careful analysis for the identification and discussion of the socio-cultural determinants of mental disorders within the Maharashtrian Culture.

INSTRUMENTS AND TECHNIQUES OF DATA COLLECTION

With the permission from the Director, Medical and Health Services, Maharashtra State, data was collected from the Central Mental Hospital, Yervada, Pune, India during 1975-1977. An interview schedule was carefully prepared and data was collected from various primary sources after repeated pretesting and modifications. The schedule covered most of the relevant stages in the life history of the patients (Refer to Appendix). The study is essentially a systematised composite of interviews, observations and case histories. Interviewing the patients after their cure, their parents or relatives, doctors and the para-medical staff was the main tool of data collection. This is understandable because according to Lowrey (1952: 18-19) "the most pertinent data, at least those of greatest value in understanding the dynamics of the situation, are derived from interviews with the client." It is true that all cured mental patients cannot always be relied upon for information for scientific use, but the fact remains that patients in psychiatric situations are the most significant source of
data. Masserman (1955:17) states: "Information about the patients can obviously be obtained from many sources, though most conveniently and significantly from the patient himself." The patient's own versions of his past experience have far greater psychiatric import in most cases than any seemingly "objective" biography furnished by others. This study is thus largely based on primary data gathered from the cured patients. All the cases have been grouped and given serial numbers to ensure maximum confidentiality. Only such case numbers will be referred to throughout this study.

PROCESSING AND ANALYSIS OF DATA

As mentioned earlier, the first part of this study which deals with the quantitative data of 1168 mental patients was analysed with the help of a technician and the computer at the Indian Statistical Institute, Calcutta, which printed-out various cross tabulations. These tables were carefully examined and cyclograms drawn to depict the outstanding features. The test of significance ($X^2$) was applied to many of them to bring out the dominant characteristics and the association of variables which worked together effecting the mental state of the patients.

The second stage involved a content analysis of the case histories of 200 cured patients. These case histories assisted the researcher in isolating the predisposing and
precipitating psycho-social and cultural factors that were detrimental to the mental state of the patients. These detrimental factors were carefully studied and separately listed based on the sex of the patients.

Then the quantification and statistical analysis of the case histories was carried out in the following manner:

1. All the predisposing and precipitating factors or tensions occurring in each case were listed on separate cards.

2. From the information on the cards, the diversified tensions for both the sexes were grouped separately into three major areas namely: Somatic or Physiological, Psychological and Socio-cultural. With the help of a master chart bearing thirty-seven sub-categories or major tension areas, the frequencies of the tensions were obtained separately for both the sexes.

3. Although we know that stress tolerance varies from individual to individual, for this section it was considered to be equal for all the patients. Then, on the basis of rank contribution the Somatic, Psychological and Socio-cultural tensions to mental disorders were determined. The
percentages were calculated by taking the highest response as 100% and computing the successive responses on the basis of the highest response.

4. A tension pyramid showing the percentage values for the fifteen most common tensions arranged rankwise among the male and female patients was then constructed.

5. Since the frequencies in the Somatic or Physiological area were small, with the help of a bimanuar graph, the percentage distribution of only the Socio-cultural and Psychological tensions in both the sexes were studied.

6. With another chart, the frequencies of the Socio-cultural and the Psychological tensions operating in pairs among both the sexes were studied.

7. A closer examination of the predisposing and precipitating factors or tensions revealed the fact that they could be clearly divided into seven subareas namely: Marital problems, Personal problems, Interactional problems, Economic problems, Somatic problems, Religious problems and Resultant problems. These tensions were carefully distributed among the above mentioned sub-areas for both the sexes.
8. With the master chart exhibiting all the male and female tensions separately; the incidence in each sub-area noted above, the occurrence in pairs or clusters, and the average tension load per patient was determined.

9. With the information on the above chart, a histogram showing the number of unit tensions that were responsible for the mental disorder among the cured patients was prepared.

10. Since the case histories showed that death of the parents was one of the major contributing factors to mental disorder, this factor was also studied among all the cases and a chart prepared keeping in view the following states of their parents: No father, No mother, No father and mother.

11. A related chart depicting for all the cases, the birth order in relation to the state of the parents was also prepared.

12. To avoid unnecessary weightage and redundancy in the explanation of similar behavioural patterns of the cured patients belonging to more or less the same physical and socio-cultural environment, only 35 male and
35 female cases that covered in brief most of the typical problems were sorted out, typed and used in the thesis to supplement the hypothesis. The other detailed case histories have been deliberately omitted.