2. METHODOLOGY
Man experiences upheaval in his body due to physiological and pathological disturbances. Upheavel created by mal-adjustment of physiological conditions in man's body is known as disease. Disease is classified variously: according to mode of onset, duration, outcome, etiology, the system involved, and then, the mode of transmission, pathology, and result of treatment etc.

The Oxford Dictionary defines the term disease as follows:

"Unhealthy condition of body, mind, plant, or some part thereof, illness, sickness, particular kind of with special symptom or location."¹

But this Oxford Dictionary definition is not of much help, as it takes into account the healthy condition of a plant or some of part of it too, which cannot be a part of the present problem.

The WHO definition of 'health' emphasizes that health is not merely an absence of disease, or infirmity, but a state of complete physical, mental, and social well being. This is neither sufficient nor helpful in the present context because it is neither complete, nor, is it clear by which term

'disease' is to be explained. Some sociologists and physicians have taken the term 'disease' to mean deviation from normalcy of health, and others take it as differences in the pathological conditions of the human body.

All these definitions and descriptions of disease mentioned above are not very clear as the term disease is very wide, which is understood differently by different groups of society. If we compare it with the cultural definition of disease then it becomes very difficult for us to decide which is to be taken as a standardized meaning of disease. Similarly, as Linton pointed, the manifest forms that many illness conditions are culturally patterned. He also says that if one knew the content of the culture, he could predict in a fairly reliable fashion the form which this condition would take. Although Linton's optimistic contention remains to be demonstrated, it is fairly clear that the social course many illnesses take, is largely influenced by the cultural content of a society, and well integrated with the patterns of life as they exist in that culture.

In his discussion of Tromba, a form of violent possession, (or what we might regard as a form of psychosis) which is defined as a state of being possessed by an ancestral spirit, Linton says:
"I know that an old woman, who seems to be rheumatic and decrepit, will dance sometimes for forty eight hours at a stretch, and dance down one partner after another, so shifts of dancers and of drummers have to be provided ..... ..... Individuals who have this form of possession are regarded as a nuisance, because one cannot really get anything out of the spirits. Therefore, their demands are a sort of supernatural blackmail. Yet, one can readily see that such seizures work to the advantage of the possessed, since the family is rather reluctant to cause them to have a tromba seizure by frustrating them."¹

Linton being an anthropologist has observed the disease in a way similar to those of other anthropologists. He also believes in the effectiveness of sorcery, performed on persons, either to cure them or make them sick. He has mentioned several cases of death due to sorcery in his study. Walter Cannon has also attempted to analyse this phenomenon from the physiological point of view, and says:

"A persistent and profound emotional state may induce a disastrous fall of blood-pressure, ending in death. Lack of food and drink would collaborate with the damaging emotional effects, to induce the fatal outcome. These are the

conditions which, as we have seen, are prevalent in persons who have been reported as dying as a consequence of sorcery. They go without food or water as they, in their isolation, wait in fear for their impending death. In these circumstances they might well die from a state of shock, in the surgical sense — a shock induced by prolonged and tense emotion.\(^1\)

Thus it seems that cultural beliefs have a profound influence on the health of people, for example, Indians may starve, but they are reluctant to kill their cattle, and will even share their homes and scarce food with them. They will often allow monkeys to plunder their crops because monkeys are sacred to them. If we take into account the observation described above, then disease can be defined as a health problem, faced by the people, as approved by a culture, because sometimes a person may really be sick but the culture to which he belongs may not recognize him as sick. Therefore, it is essential to adopt this meaning of disease for the purpose of the present study.

Sociologists have treated the social definition of illness in terms of the concept of sick role, which has been conceptualized as an ideal type for the purposes of attempting

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to define the social properties of sickness definitions, the conditions under which persons can legitimately claim illness, and their responsibilities in responding to their illness. In general we tend to regard illness as an individual concern, and, what people do, to care for themselves is for the most part, dependant on an individual's own judgement. There are, however, circumstances where illness poses a sufficient threat to the community, and therefore requires community action. Obviously if too many people in a society are sick, ill, or disabled, and there is a shortage of manpower, sickness will have serious implication for productivity, the family, and the community. On other occasions, illness endangers others, as well as, the person directly involved, and thus, Government assumes the right to intervene, and take measures to protect the health and welfare of the community.

Social analysis of the factors leading to differential treatment of persons, with various illnesses, and behaviour problems, not only helps us to understand the social context of illness, but also illuminates social processes, and social points of view generally.

Relevant to an analogous issue, in the field of criminology is, Sutherland's observation, according to which a large variety of offences, involving social harm, are not
usually treated as crimes, and when action is at all taken, it is most typical, that it is in a civil, rather than a criminal court. And since, this category of 'crimes' is most usually committed by businessmen and persons with upper class status, while pursuing their occupations, Sutherland has called them white collar crimes. Mental patients, in contrast, are frequently detained involuntarily, not usually because of their particular social status, but because, it is commonly assumed, that person exhibiting bizarre symptoms are not in a position to apprise their situation rationally, and, thus, to ascertain what is best for them.  

Apart from this, patients have been found to have developed their own behaviour, and attitudes of patients, towards diseases differ, according to place, sex, religion, economic position, and, the level of education. In order to understand the attitudes of patients towards diseases, several stages of illness have been taken into consideration, starting from symptom experience, to assumption of the sick role; and from assumption of the sick role, to medical care contact stage; and from that, to dependant patient role and, ultimately, to recovery and rehabilitation stage. In the first stage of symptom experience, a person experiences certain problems and takes a decision, and tries to apply some sort of folk medicine, or, self

The Stages of Illness Experience

FIG. NO. 2
medication, depending upon his behaviour. Ultimately the patient either gets a denial, or, is delayed acceptance, and, finally assumes the sick role, which is the second stage, and in this stage a person leaves a normal role, and through his behaviour, tries to validate the role that he has assumed. The outcome is either denial, or, acceptance, and finally, comes the third stage, known as the medical-care contact-stage, when the patient seeks advice from professionals and tries to reach an authoritative legitimization for his sick role, and negotiates a treatment procedure, after the confirmation of the disease. He now becomes dependent on the physician, and others, and assumes the dependent-patient-role, accepts professional treatment and undergoes treatment procedure for illness - follows regimen and ultimately there is rejection or secondary gains or acceptance, and finally he is cured and rehabilitated which becomes the fifth stage, i.e. the stage of recovery and rehabilitation. Now the patient relinquishes his sick role, resumes normal roles, and accepts a normal life. These stages of illness behaviour of the patients, and the outcome, have been shown in Figure No.2, which is very explicit about the patients, and their attitude towards disease.

With these stages of illness in mind, Aligarh district was taken as a field of investigation, for the purpose of the
present study, because Aligarh has a Medical College Hospital also, where patients come not only from Aligarh district, but also from other districts of Uttar Pradesh, and, from other states of India as well, because it has a well developed hospital, where both out-door and in-door patients are treated. The in-door patients studied, were those, who were admitted for treatment in Jawaharlal Nehru Medical College Hospital of Aligarh Muslim University, during the years 1979, and 1980. In order to know the attitudes of patients towards diseases, the survey conducted was to achieve certain objectives.

OBJECTIVES

This empirical study aims at achieving the following objectives:

1. To assess the attitudes of patients towards diseases.
2. To study the different stages of illness, and patients' attitudes towards these stages.
3. To find out the differences in the attitudes of urban and rural patients.
4. To find out the relationship, if any, between urban and rural patients, and their attitudes towards diseases, in all the five stages.

1. Figure No. 3: Map of Aligarh City.
5. To study the relationship between urban and rural patients, on the basis of sex, education, religion, and economic status, and also their attitudes towards the different stages of illness.

6. To study the basic difference in the attitudes of urban and rural patients towards treatment of diseases.

**HYPOTHESIS**

It is proposed to test the following sets of hypothesis:

1. That the attitudes of patients towards diseases are framed by social environment, i.e., urban and rural, and also by sex, level of education, religion, and by the patient's economic condition.

   OR

   That the attitudes of patients towards diseases differ from area to area, sex to sex, religion to religion and because of different levels of education and economic statuses.

1(a) Most of the patients from an urban community, differ in the method of treatment, from the patient of rural areas. The urban patients have different attitudes towards life and diseases, and resort to treatment immediately after they feel some problem.
1(b) The rural patients differ in their attitudes towards life and diseases, and do not go for treatment immediately, but contact the physician at a very critical stage.

1(c) The patients were both male and female, and had different attitudes towards diseases.

1(d) Male patients differ in their attitudes towards diseases on the basis of area, level of education, religion, and economic status.

1(e) Most of the females, irrespective of area, religion, education, and economic status, have the same attitudes towards diseases.

1(f) Educated, and uneducated patients, have different types of attitudes towards diseases, but in the matter of treatment, education does play a dominant role.

1(g) Religion too plays an important role in determining the attitudes towards diseases.

1(h) Hindu patients differ from Muslim patients, in their attitudes towards diseases.

1(i) The patients are both from rich and poor classes, and, the rich patients have different attitudes towards diseases in comparison to poor patients.
HYPOTHESES AND ATTITUDES

Fig No 4
The hypothesis Figure No.4 shows the relationship between sub-hypothesis and attitudes of patients.

NATURE AND SCOPE OF THE STUDY

The present study is exploratory-cum-diagnostic. It is exploratory, in the sense that some unexplored areas have been explored. It is diagnostic in the sense that attempt has been made to find out which trait is responsible to form attitudes towards diseases. Certain conditions are conducive to certain type of attitudes towards diseases. A patient who lives under different conditions, gets encouragement to have a particular type of attitude towards diseases. These casual relationships are established between various traits of culture, such as, environment, sex, education, religion, and economic status, and the attitudes towards diseases.

In terms of respondents, the sample comprises 600 patients who were selected from the Aligarh District of Uttar Pradesh; out of the 600 patients 300 patients are from urban area, and 300 from rural area.

LIST OF VARIABLES UNDER STUDY

Age, sex, marital status, economic status, including monthly income; structure of family, i.e. unitary or joint; religion, education; and, area, i.e. urban and rural.
INDEX MAP
OF
DISTRICT ALIGARH

LEGEND
STATE BOUNDARY
DISTRICT BOUNDARY
TENANT BOUNDARY
REGIONAL BOUNDARY
DISTRICT HEAD QUARTER
TENSIL HEADQUARTER
BLOCK HEAD QUARTER
MATERIAL ROAD
RAILWAY (B G)
HIGHWAY (M G)
WATER
MINE

N.K. KULSHRESHTHA
PROJECT ECONOMIST
STATISTICS OFFICE
ALIGARH

SCALE - 1 CM = 7 KILOMETERS
VARIOUS TERRITORIAL AREAS OF ALIGARH DISTRICT

Aligarh district is classified into two parts:

1. Aligarh City
2. Remaining areas of Aligarh district

Aligarh is one of the important cities of Uttar Pradesh, specially from two points of view:

a) Aligarh is famous for its Lock Industry all over the world, and,

(b) It has a residential university—Aligarh Muslim University, which is an internationally renowned seat of learning. Thousands of students from all over India and abroad study in Aligarh Muslim University.

Aligarh city is divided into 15 wards and its total population is 3,77,031.¹

2. The remaining parts of Aligarh district are divided into 17 Development Blocks (As shown in Figure No.5). The names of these blocks are as under²:


¹ Census of 1981
² Census of 1981
In the selection of respondents a list of patients admitted during 1979-80 in Jawaharlal Nehru Medical College Hospital was obtained, and 600 patients were chosen from the Aligarh District, out of which, 300 patients were from the Aligarh City itself, and 300 were from the rural areas, and belonged to various development blocks of Aligarh district.

In order to carry out selection of respondents, a separate list of patients admitted in Jawaharlal Nehru Medical College Hospital, during the years 1979, and 1980 was prepared for Aligarh city, and rural Aligarh, and the selection of respondents was carried out on the basis of proportionate stratified random sampling procedure. The selection was carried out separately in each stratum (zones). It was a selection of elements, because the elements (respondents) were selected individually and separately. In order to keep proportion, the number of elements from each stratum in the sample, was made to correspond to the number of elements from each stratum in the population, the strata i.e. Aligarh city and Aligarh rural. Separate lists of patients, with their detailed addresses were prepared, and 300 patients from Aligarh city and 300 patients from rural area were picked up random. Out of 3102 patients admitted in Jawaharlal Nehru Medical College Hospital, from Aligarh city, 300 patients were selected on the basis of proportion calculated, and every
10th patient was selected. And, in the second stage, i.e., from the rural area of Aligarh district, out of 7333 patients admitted in Jawaharlal Nehru Medical College Hospital, Aligarh, 300 patients were selected on the basis of proportion calculated, and every 24th patient was selected for the purpose of the study. This has been shown in the chart given below:

**PATIENTS ADMITTED IN JAWAHARLAL NEHRU MEDICAL COLLEGE HOSPITAL**

**DURING THE YEAR 1979-1980**

<table>
<thead>
<tr>
<th>Total patients</th>
<th>Aligarh District</th>
<th>Aligarh City Zone A</th>
<th>Aligarh Rural Zone B</th>
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<tr>
<td>20,870</td>
<td>10,435</td>
<td>3,102</td>
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<table>
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<table>
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<tr>
<th>Proportionate</th>
<th>5.75</th>
<th>9.67</th>
<th>4.09</th>
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</table>

**CONSTRUCTION OF INDIVIDUAL SCHEDULE**

The major tool for collecting data for the present study was a pre-coded interview schedule, which included questions pertaining to the following areas:

1. Identity and personal characteristics of the respondents such as age, marital status, religion, type of family,
place of origin, occupation, and income.

2. Attitudes: In this context questions relating to the be-

haviour of the respondents towards diseases, and method

of treatment; also seriousness towards disease were in-

cluded and their opinion of following 5 stages of illness

was obtained:

(1) Symptom Experience (2) Assumption of the Sick Role

(3) Medical Care Contact Stage (4) Dependent-Patient

Role and, (5) Recovery and Rehabilitation.

PRESENTATION OF DATA

Data collected through the administration of the inter-

view schedule, to the respondents under study, have been

statistically analysed, and presented in tabular form. In

the tables, the frequencies and their correspondent percentage have been given. Weighted scores have been obtained

and analyzed accordingly.

ANALYSIS OF DATA

The data was statistically analyzed by the help of

computer No.IBM-1130, by which certain statistical tests,
such as analysis of variance test (ANOVA), Duncan's range

test, and the Chi-square test were applied,

and while interpreting data, impressionis-
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<th>Rural</th>
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<td>No. of Patients Rural</td>
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</table>

No. of Patients

Chart No. 2

Age Group of Urban and Rural Patients
tics and subjective interpretation have been avoided. Only factual analysis, and the conclusion arising out of that, have been presented. The Chi-square test has been used to find out the association and their statistical significance between urban-rural patients and other variables have been determined. Apart from this, analysis of variance test was also applied for finding out the relationship among different factors.

**RESPONDENTS PERSONAL ATTRIBUTES**

The present survey considered every patient of the list supplied by Jawaharlal Nehru Medical College Hospital record section, who had been discharged from hospital after treatment.

**SAMPLE SIZE**

600 patients were selected from the universe of Aligarh district. Out of 600 patients, 300 were from Aligarh city and 300 from rural Aligarh, on the basis of proportionate random sampling. Of these 600 patients, 431 (71.83%) were male respondents, and 169 (28.16%) were female respondents (Refer Chart No.1).

**AGE OF RESPONDENTS**

The age of sample group ranges from 18 years to 65 and above (Refer Chart No.2).
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FAMILY STRUCTURE OF URBAN & RURAL FAMILIES

CHART NO 3
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<td>Unmarried</td>
<td>113</td>
<td>32</td>
</tr>
<tr>
<td>Widow</td>
<td>58</td>
<td>129</td>
</tr>
<tr>
<td>Widower</td>
<td>300</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td>300</td>
</tr>
</tbody>
</table>

**Chart No. 4**

**Marital Status of Urban and Rural Patients**
RELIGIOUS COMPOSITION OF RESPONDENTS

Out of 600 patients, 372 (62%) were Hindus, and 228 (38%) were Muslims. Incidentally no other religion group fell in the sample (Refer Chart No.1).

EDUCATIONAL STATUS OF THE SAMPLE GROUP

Out of 600 patients in the sample, 288 (48%) were educated and 312 (52%) were uneducated (Refer Chart No.1).

ECONOMIC STATUS OF THE RESPONDENTS

Out of the 600 patients considered, 353 (58.83%) were of rich economic status, and 247 (41.16%) had low economic status (Refer Chart No.1).

TYPES OF FAMILY OF THE RESPONDENTS

Out of the 600 patients in the sample, 308 (51.33%) were from Unitary Family, and 292 (48.66%) were from Joint Families (Refer Chart No.3).

MARITAL STATUS OF THE RESPONDENTS

Out of the 600 patients considered, 210 (35%) were married, 242 (40.33%) were unmarried, 67 (11.16%) were widows and 81 (13.5%) were widowers (Refer Chart No.4).