Chapter – IV
Methodology
4.1 NEED FOR THE STUDY:

In 1946, the United Nations established the World Health Organization that put out the definition as: “Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (WHO, 2006).

According to Stone (1987), definitions of health fall in two categories: those that portray health as an ideal state and those that portray health as movement in a positive direction. The first category definitions implies that any disease or injury is a deviation from good health and that removing the disease or disability can restore the ideal state. The domain of health was dominated by mind-body dualism. The clinical psychologist, who was traditionally concerned with health related issues, was largely ill equipped to understand the psychological aspects of physical health problems.

Health is more than the mere absence of disease. It is multidimensional: biological, psychological, and social. A fourth dimension of spirituality is also being considered now (WHO, 1986). Biological health is a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. Some biological functions are normal blood pressure, superior cardiac output, a high level of respiratory volume, ability to withstand stress, infection, and physical injury. Psychological manifestation of health is a subjective well-being and
MAP 1: GULBARGA DISTRICT MAP

Karnataka
mastery over environment. Social manifestation of health includes the capacity for high level of social productivity and participation in the social system and low demands on the health care system.

Health psychology is the study of the relation between psychological variables and variables and health. The field of health psychology emerged in the context of realization that biological mechanisms alone are insufficient to maintain and promote health and well-being. To alleviate the physical pain, one has to examine the attitudes, expectations, beliefs and emotional support which the patient has, not just his or her response to the drug treatment. The patients are not mere passive recipients of certain treatment regimen, they should be considered as equal partners acting jointly in achieving the common goal of health. These issues were not attended to by scientific psychology. Clinical psychology was confined to the study of classification of mental illnesses, etiology, diagnosis and treatment of the afflicted patients. However, their role remained subsidiary to those of the psychiatrists.

Health psychology grew with the realization and research evidence that psychological knowledge can make important contribution in the wide range of health related domains.

Psychological research in the area of health has gradually accumulated to provide overwhelming evidence to argue that mental states.
In view of this, an attempt is made to assess the effect of social support on death anxiety and psychological well-being of HIV positive and HIV TB co-infected patients. The aim of the present study was to find the relationship between psychological factors: social support, death anxiety and psychological well-being of HIV positive and HIV TB co-infected sample. Besides, demographical factors are included.

4.2 OBJECTIVES:

The following are major objectives of the study:

1) To assess the effect of social support on death anxiety and psychological well-being of HIV positive and HIV TB co-infected patients.

2) To examine the differences in death anxiety and psychological well-being between HIV positive and HIV TB co-infected sample.

3) To study the differences in death anxiety and psychological well-being between rural and urban groups.

4) To examine the gender differences in death anxiety and Psychological well-being of the sample sub groups.

4.3 HYPOTHESES:

The following are the hypotheses of the study:

1. There would be no significant effect of social support on death anxiety and psychological well-being of HIV positive and HIV TB co-infected patients.
2. There would be no significant differences in death anxiety and psychological well-being between HIV positive and HIV TB co-infected sample.

3. There would be no significant differences in death anxiety and psychological well-being between rural and urban groups.

4. There would be no significant difference in death anxiety and psychological well-being between male and female HIV positive and HIV TB co-infected sample.

4.4 SAMPLE DESIGN:

Table – 1: Distribution of sample

<table>
<thead>
<tr>
<th>Sex</th>
<th>HIV Positive Patients</th>
<th>HIV TB Co-infected Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
</tr>
<tr>
<td>Male</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Female</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

The sample of the present study consists of 400 (200 HIV positive and 200 HIV TB co-infected patients) selected from Govt. Hospitals, Private Hospitals, and NGO’s in Gulbarga District. The sample is matched with social support, type of disease, domicile, and gender.
4.5 TOOLS:

In the present study the following scales were used:

1. PGI Social Support Questionnaire:

The scale is constructed and standardized by Dr. Ritu Nehera, Dr. Parmanad Kulhara and Dr. Santosh K. Verma (1998). The scale consists of 18 statements. For each statement the response is given in four forms i.e., Extremely, Quite a bit, A little bit, and Not at all.

**Scoring:** Scoring pattern (of 4 to most agree to 1 to least agreed response) was attained. Thus, higher the score better is the perceived social support.

After deleting items No. 16 and modifying item No. 10, the 18 item final scale in Hindi was finalized. Item No. 2 but item No. 1, 3, 5, 6, 7, 10, 13, 14, 15, 16 and 17 are negative items and have to be scored in the reverse order. The total score indicates the amount of social support perceived by the individual. Higher Score indicates more perceived social support. The PGI SSQ scoring pattern of 4 to most agreed to 1 to least agreed response.

**Reliability:** The 18 item scale was administered on 50 subjects and repeated after an interval of two weeks. M can differences (using difference method) were insignificant (t = 0.64 n.s.) and the relative reliability was highly significant and satisfactory (r=.59, p<.01).

**Validity:** The concurrent validity was established by (a) correlative score on Hindi adaptation of PGI Social Support Questionnaire with that of
clinician’s independent judgments on 14 subjects. These rating were done on a 4-point scale by a concurrent psychiatrist. The score ranged from full agreement to full disagreement. The obtained correlation of 0.80 was highly significant (p<.01) (b) an external criterion was also selected, in the form of social support sub-scales from the Family Interaction Pattern Scale of Bhati et al. (1986). Both the scales were administered to 21 subjects. The correlation of -0.65 was highly significant (p<.01). This correlation was expected to be negative as high social support was indicated by lower scores on Batti et al. scales.

2. Death Anxiety Scale: (Upinder Dhar and Others, 1971)

The Scale is constructed and standardized by Upinder Dhar and others (1971). The scale consists of 10 statements, with two response categories. Each item or statement which is checked as “Yes” or “No” should be awarded the score of “1” or “0” respectively as per manual. The sum of scores of all items is the death anxiety score. One who scores higher is said to have more death anxiety and vice-versa. The reliability and the validity of scale are significant and adequate.

3. Psychological Well-being:

The Scale is constructed and standardized by Sudha Bhogale and Prakash (1995). The scale consists of 27 statements. For each statement response is given in two form i.e., Yes or No.
**Scoring:** The scoring is done with the help of scoring key. Accordingly one who scores higher is said to have higher psychological well-being and vice-verse. The reliability of the scale is 0.87 which is significant. The validity of the test is also satisfactory.

### 4.6 DATA COLLECTION:

In the present study primary data was collected from all the respondents i.e., HIV Positive and HIV TB co-infected patients. The sample were collected from District Hospital (ART centre) Gulbarga, Govt. General Hospital, Chittapur, G.G.H. Jewargi, NGO’s, and Community Care Centre from Gulbarga District. HIV Positive sample (N=200) and HIV TB co-infected (N =200). The purpose of the visit was made known to the incharge of the respective centers. In case of ART centre and Doctor incharge community care centre, the purpose of visit was made known to the Doctor and brief proposal of the study was submitted to them for the approval. Upon approval at research was introduced to patients by the respective centers counselor and after establishing rapport with patients. After earning the trust and confidence of them. The researcher administered the social support, death anxiety and psychological well-being scale. After receiving the questionnaire back the scoring was done as per manual.

Information relating to the respondents demographic factors like sex, education, occupation, background, family types, type of diseases were collected from the sample.
4.7 STATISTICAL ANALYSIS:

The following statistical tests were used in the present study:

1. t-test to examine the difference between sample subgroups.

2. ANOVA to assess effect of independent variables on dependent variables.

3. Correlation to examine the relationship between independent and dependent variables.