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In-Depth psychiatric research

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Abstract

This essay provides a summary of qualitative research and how it is used in psychiatry. It serves as an introduction and tries to explain the goals of qualitative research as well as its underlying philosophical foundation. After a description of the principles and procedures of qualitative research, we provide an introduction of the three primary research techniques: interviews, focus groups, and participant observation. We provide instances of situations where qualitative research has shed light on crucial issues in psychiatric research or has the capacity to do so throughout the paper. Following a brief review of qualitative analysis, relevant rigor checks, and the presentation of qualitative data, we outline sampling techniques. The paper concludes by arguing that qualitative methods may be an increasingly appropriate methodology to answer some of the demanding research questions being posed in 21st century psychiatry.

Clinical Implications: Psychiatry has used qualitative research less frequently than the other health sciences; however, this tendency appears to be changing. Qualitative research may be used to address several the innovative research concerns that are being brought up in contemporary psychiatry. Researchers and mental health professionals should familiarize themselves with the issues, possibilities, and challenges related to qualitative research.

Limitations: The distinct set of ethical difficulties addressed by qualitative research, for example, are not thoroughly discussed in this work. To offer a descriptive summary, we have somewhat simplified the processes, the analysis, and the epistemology. Only some research issues may be answered using qualitative research, which supports but does not replace conventional methods.

Keywords: Psychiatry, research methods, qualitative, sociology, anthropology

Introduction

Quantitative methods are heavily used in psychiatric research ^[1]. Less people use qualitative approach because they believe it to be essentially arcane, if not inferior, to mainstream psychology. By outlining qualitative research, its underlying philosophical underpinnings, and its primary methods of inquiry, we try to debunk this myth in this study. Where applicable, we cite instances of our position being fully utilized or having already been done so to substantiate our claims. We think that qualitative research may provide fascinating insights into the treatment, understanding, management, and prevention of mental illness. It may also help resolve present policy demands, such those for patient engagement and more complete service assessments ^[2, 3].

Overview of Qualitative Research

The phrase "qualitative research" refers to a wide range of distinct research paradigms and approaches that rely on the gathering, examination, and interpretation of non-mathematical data. Focus groups, participant observation, and in-depth interviews are the three basic techniques used in qualitative research ^[4]. They have a long history of usage in the social sciences and are the main research methodologies used in anthropology and sociology ^[5]. Documentary analysis is a qualitative approach that is less frequently used. We have avoided discussing this strategy because it is covered in length elsewhere, in order to keep the scope of this article as small as possible ^[6]. Nonetheless, readers who are interested might refer to a number of current research on mental health that used documentary analysis ^[1, 7, 8].

Aims of Qualitative Research

According to Malinowski, qualitative research prioritises subjective meaning and experience above all else in order to understand a phenomenon from a "native" point of view ^[9]. Others have described this as "world perspective documentation" ^[10]. As a result, the perspective of the responder frequently takes precedence over the researcher's predetermined framework.

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The researcher seeks to create a "thick description" of the phenomenon under examination in order to deepen understanding of the problem ^[11, 12]. Contrary to quantitative research, which places emphasis on condensing data into understandable units (such as averages), qualitative research conscientiously makes an effort to record the richness and diversity of experience. This may then be applied to develop theories ^[13]. To give an example, a recent qualitative study in psychiatry explored the experience and meaning of stigma, a deeply personal experience, by comparing data from focus groups of schizophrenia patients, their relatives, and health professionals. The "thick description" of stigma allowed the authors to theorize that stigma is dimensional and that appropriate interventions should be targeted to these various dimensions ^[14].

The Philosophical Basis of Qualitative Research

According to Malinowski, qualitative research prioritizes subjective meaning and experience above all else in order to understand a phenomenon from a "native" point of view ^[9]. Others have described this as "world perspective documentation" ^[10]. As a result, the perspective of the responder frequently takes precedence over the researcher's predetermined framework. The researcher seeks to create a "thick description" of the phenomenon under examination in order to deepen understanding of the problem ^[11, 12]. Contrary to quantitative research, which places emphasis on condensing data into understandable units (such as averages), qualitative research conscientiously tries to record the richness and diversity of experience. This may then be applied to develop theories ^[13]. However, the comparison and integration of many similar qualitative studies may be used to generate more universal theory ^[13, 16]. Another orientation of qualitative research that differs somewhat from that of quantitative research is a belief in the importance of documenting and analyzing "folk" beliefs, especially when they may influence health outcomes, for example, regarding medication compliance or service use. In contrast to conventional biomedical epistemological presumptions, many qualitative researchers use the adage that the responder is the expert and the researcher is the layperson. For instance, recent research that looked at characteristics that affect the continuity of psychiatric care assigned both professional and "folk" knowledge equal weight ^[17]. Participant observation and in-depth interviews with patients and service providers were used to accomplish this. The findings revealed that patients' opinions of the efficacy of continuity of treatment are significantly influenced by the strategy used by mental health professionals, such as a readiness to adapt flexibly in times of crisis.

The Practice of Qualitative Research

The methods used to examine the resulting data and the design of qualitative research often differ from the similar processes in quantitative research ^[4]. There are several guidelines for this, such as the proper validity and reliability checks. Yet, power estimates, significance tests, and randomized controlled trials are not established criteria for qualitative research. The majority of quantitative research is conducted using the hypothetico-deductive approach under a positivist paradigm: data are collected to test a theoretically driven, predefined hypothesis, that may support or refute the said hypothesis ^[18]. Qualitative

research can also proceed according to this Popperian model, where researchers enter the field with a pre-structured design aiming to test a hypothesis. However, a lot of qualitative research also moves from data to theory, rather than vice versa. Such inductive studies usually begin with a loose research question rather than with a strict hypothesis. Data are then gathered and analyzed through inductive rather than deductive principles. Despite the use of induction is frequently seen as one of the characteristics of qualitative research, it may be more accurate to think of each given study as falling somewhere along the deductive-inductive spectrum ^[19]. An inductive study will require more back-end labor, whereas deductive qualitative research often entails more front-end work ^[16]. The creation of "grounded theory" will often comprise a significant portion of this back-end activity.

In a grounded theory, inductive content analysis is used to record and examine the respondents' main ideas and themes. A clever qualitative researcher will utilize this analysis to develop a local theory that is based on the facts and serves to explain local events and phenomena ^[13]. As the researcher dialectically combines his or her expert knowledge of earlier literature with the local theory created as a result of their particular investigation, a more general theory may subsequently be established. As an illustration, the applicability of Western psychiatric nosology in ethnographic research in China has been examined using qualitative technique ^[20, 21]. Western scholars have blended their own professional knowledge with themes and notions obtained through this loose research topic, which is perhaps best represented as being in the middle of the inductive-deductive spectrum. These data have been used to develop a new theory that Western systems of psychiatric nosology are not universally applicable but are, in fact, loaded with tacit cultural biases that may be invalid in other cultures. Through inductive analysis, it was found that other cultures have their own nosologically systems that may not overlap with Western systems of categorization. This finding led to the development of the important concept of "category fallacy," that is, the projection of one culture's diagnostic categories onto another culture that may in fact perceive, experience, and express mental illness quite differently ^[22].

The Temporal Procedure of Qualitative Research

The formation of an immutable design, data collecting, and data analysis are the three different and ordered categorical divisions that typically make up the temporal operation of quantitative research. Inductive qualitative research is frequently more adaptable and iterative, with less distinction between design, data collecting, and data analysis. However deductively orientated qualitative research might legitimately continue along similar lines. So, a qualitative study that is inductively oriented might be haphazardly planned to respond to a large research issue. Yet, one of the key objectives of this inductive study is to enter the field as soon as possible to collect general data that can be examined concurrently, with the results being used to direct future, more accurate data gathering. The complete process can thus be envisioned as circular rather than linear, with feedback loops affecting the ongoing research development. This form of inductive, circular research may be most appropriate when studying an under researched group or such complex realities as the experience of a new group of refugees in an urban context ^[23].

Sampling

In qualitative research, purposive (or theoretical) sampling is more common than random sampling. Purposive sampling describes a process that deliberately recruits individuals or groups with the requisite demographic or clinical characteristics into the research, allowing the study to be grounded in a local context. It is generally not necessary to predefine an exact or desirable number of respondents before the research begins [24]. Data initially collected from diverse individuals can be analyzed simultaneously. This analysis can then direct numbers and groups to be involved in subsequent data collection. Again, an iterative relation exists, this time between data analysis, further sampling, ongoing data collection, and theoretical development [25]. Sampling and data collection may be terminated when the researcher judges that new respondents are not adding anything significant to the database a situation known as “theoretical saturation” and only reached once the researcher has consciously tried to sample groups or individuals that might stretch the diversity of the data. This is known as extreme case sampling; it is a check on validity, as it ensures adequate representation and precludes premature conclusions [26]. For example, a qualitative study evaluating patient satisfaction with a psychiatric outpatient service may find, after initial sampling and analysis, that one ethnocultural group’s responses differ radically from the responses of everyone else. A flexible design and sampling strategy will allow researchers to shift the focus to this subgroup for in-depth sampling and exploration.

Methods of Inquiry

Participant observation, focus groups, and in-depth interviews are the three basic inquiry techniques used in qualitative research. They can be utilised separately or in combination. Triangulation, which is known as the application of many approaches in a single research endeavor and the subsequent comparison of results, is highly recommended as a validity check. By broadening the scope of results and enabling cross-comparison, it enhances conclusions and enables the evaluation of overlap and disagreement [27].

Common Themes in Interviews and Focus Groups

Focus groups and interviews are perhaps the two most popular qualitative research techniques in psychiatry. Via one-on-one interviews or small, facilitator-led groups, they both entail the clarification of subjective meaning, experience, beliefs, and attitudes. These typically last between one and two hours, can be videotaped, and are transcribed for study afterwards. Most of the time, written prompts that serve as aides-memoir and serve to remind the researcher of important topics to address are used to guide focus groups and interviews. They are also referred to as subject guides, and the extent to which the researcher adopts an inductive or deductive perspective will determine how developed these are. With a review of the literature, group brainstorming with coworkers, and consideration of pertinent. The key points in the topic guide may be identified through literature review and brainstorming with colleagues and relevant lay people. A well-designed topic guide is essential to ensure a smooth research interaction and the collection of valid and reliable data. For example, the rank ordering of questions should be designed carefully to ease the respondent gently into the encounter. As rapport

builds, initial nervousness should dissipate, leading to self-disclosure of more private and controversial issues. Leading and closed questions, which may be useful in clinical interviews, should be avoided (for example, the open and neutral question, “Why did you stop taking your medication?” is superior to the suggestive question, “Did you stop taking your medication because of unpleasant side effects?”) Topic guides may be liberally followed because some respondents may forestall topics and in effect rearrange the guide, or they may raise interesting issues not on the guide that should be followed up.

Focus Groups

Focus groups differ from one-on-one interviews in that they are a collective act that can access group norms, collective opinions, and shared “knowledge,” rather than individual views [28]. Focus groups provide an environment wherein respondents can share experiences with like-minded people, giving a feeling of safety in numbers. They have thus been used, for example, to access the opinions of family physicians regarding the detection and management of mental health problems in the primary care setting and perceived barriers to the optimal delivery of mental health care [29]. They are also advantageous in that, unlike interviews, they do not resemble the hierarchical doctor–patient relationship that may inhibit some participants. Focus groups are thus ideal for obtaining data from groups of people (for example, prisoners) who may feel intimidated or uncomfortable in one-on-one situations [30]. Focus groups can also usefully assist the identification of the active ingredients of multifaceted interventions. The success or failure of these interventions can be difficult to unpack quantitatively because they consist of various initiatives involving complex interactions. One study used this approach by convening 5 focus groups (2 for clinicians and 3 for patients) to help elucidate why psychiatric patients assigned to an integrated primary care clinic had greater improvements than those assigned to care as usual in a regular medical clinic. Clinicians and patients reported that the integrated clinic offered greater flexibility and smoother communication than did general medical clinics, which led to improved outcomes [31].

Interviews

Qualitative interviews differ from standard clinical interviews, as questions are generally open and structure loose; moreover, in inductively orientated studies, the interviewee is as much in control of the agenda as is the interviewer [32]. The intimate and open interaction of an interview can usefully explore why people act in certain health-promoting or health-damaging ways sensitive issues that may be less accessible in focus groups. Interviews may also be advantageous where data are gathered predominantly from key informants such as health managers, physicians, or other senior health staff. They may prefer the confidential atmosphere of the interview, or it may be impossible to practically organize focus groups with busy individuals. This approach was used with some success in a recent study of key informants’ opinions about the impact of policy changes on the health of recent immigrants and refugees living in the inner city [33]. A further example of the intelligent use of qualitative interviews in psychiatry is a study exploring aspects of the doctor–patient relationship through interviews with 30 family practitioners

and 30 people with depression^[34]. The study's aim was to explore the effect of perceptions of entitlement to time in consultations for depression. This perception is important because it may determine the patient's level of symptom disclosure, increasing the risk that the doctor will overlook the mental illness or misdiagnose it as a somatic complaint. The study in fact found that patients self-censored information to avoid taking up too much time, which they perceived as being overly precious to the physician, leading to a suboptimal interaction. Physicians reported that their time was indeed precious but that longer appointments could easily be arranged for people who needed them (for example, people with psychological complaints). Patients were generally unaware of this possibility. This research thus identified a simple intervention: raising awareness that longer appointments are possible can assist those seeking help for psychological reasons.

Participant Observation

Participant observation involves the systematic description and analysis of behavior and talk in such real-world settings as a clinic, a day center, or a hospital ward. It is theoretically driven, as relevant times and places are selected to explore a research question. Researchers may record everyday occurrences, speech, dress, acute events, interpersonal interaction, and unwritten rules of behavior. These are usually recorded as a collection of field notes that provide a basis for later analysis^[9, 11]. Participant observation often occurs as part of an in-depth case study. It progresses along the same lines as the ethnographic reports of anthropologists and has been used occasionally in psychiatry. The in-depth case study relies on the researcher's becoming intimately acquainted with a small and relatively homogeneous setting. Scope is deliberately limited and the intensity of assessment high, allowing maximum undivided attention to the setting^[35]. As the researcher becomes a familiar figure, the likelihood of valid and reliable responses increases. This familiarity and the vast amount of data generated allow the development of a thick description^[36]. Goffman used participant observation in a case study of a mental hospital to discover and document the intricacies of life therein from an insider's point of view^[37]. This study resulted in his formulation of the valuable concept of the "total institution," a place such as a mental hospital, army barracks, or boarding school, wherein a high degree of demoralizing rules and regulations cover individuals' daily lives. It led to a degree of reflection about the wisdom of total institutions and assisted those arguing for deinstitutionalization in psychiatry^[38]. Most case studies will have a limited applicability beyond the specific setting; extensions drawn by the researcher should generally be modest and grounded in the setting's particularities^[39]. However, detailed description of the particularities allows readers to judge for themselves the generalizability of the results and conclusions.

Analysis of Results

Qualitative data analysis is usually ongoing during data collection, with the one usually informing the development of the other. However, at the end of data collection and following a period of withdrawal from the field for reflection, many researchers will engage in what could be termed a grand analysis. This grand analysis attempts to synthesize all the data into a thick description. If the

research is at the deductive end of the spectrum, this thick description can be used to test the specific hypothesis. At the more inductive end of the spectrum, it can be used to generate, first, local grounded theory that may be situation-specific and then, more generic theory. Various methods are commonly used to assist these processes, most of which are variants on the same theme, content analysis. Content analysis has been described as the "systematic examination of text (field notes) by identifying and grouping themes and coding, classifying, and developing categories"^[4]. Content analysis involves systematically distilling the massive amounts of raw data into a comprehensible description without losing the complexity inherent in the original responses. This may best be conceptualized as a process of "mapping," whereby themes are identified, appropriately weighted, and then related^[16]. This is a lengthy and wordy process, which perhaps explains why many qualitative studies are published as books rather than as journal papers (for example, 20, 37). A commonly employed form of content analysis is known as constant comparative analysis^[13]. It relies on theoretically informed constant comparison between subgroups, for example, between doctors and patients, from whom differential thematic responses are extracted; or between coding frames within the data, for example, between positive or negative opinions about a subject^[40]. As a result of this analysis and comparison, the researcher should be able to document a theory grounded in the respondents and the setting. Several computer software packages have been designed to aid the analysis of qualitative data. These are useful for the systematic indexing, coding, storing, and management of the large amounts of data generated by a qualitative study. However, they do not obviate the need for close manual analysis, because they cannot formulate the thick description or theoretical framework in themselves; they are simply tools to assist this process^[41].

Maintaining Rigour

A traditional critique of qualitative research is that it is subjective, anecdotal, and highly prone to investigator bias. Nonhypothesis-driven qualitative research may be particularly at risk of these accusations, as the researcher may be tempted to selectively interpret data to fit into conscious or unconscious preconceptions^[9, 11]. This critique is anchored in the awareness that some well-known, mostly anthropological, qualitative studies for example, Margaret Mead's portrayal of the Samoans^[42] have been considerably criticized for painting a distorted picture of other people's reality.^[43] Most qualitative researchers accept that the risk of investigator bias is high; however, several checks and balances have been developed in response, which can be employed to reduce this risk. We have already mentioned some of these, such as triangulation, extreme case sampling, and use of a theoretically informed topic guide. Two others commonly employed methods of adding rigour to qualitative studies are respondent validation and multiple coding. Respondent validation involves taking key themes and grounded theory back to respondents near the end of the research to discern levels of congruence between researchers' and respondents' theories^[44]. This reduces the likelihood of misrepresenting respondents' views. Multiple coding involves 2 or more researchers analyzing the same data set and then comparing and discussing findings. Again, this diminishes investigator bias and can be seen as a

qualitative form of interrater reliability ^[27]. Combining these developing epistemological canons should add rigour to studies employing qualitative research.

Presentation of Results

Miles and Huberman offer a popular 3-stage approach for the presenting of results that is similar to that used in literary criticism ^[16]. This paradigm entails thematic data reduction, the presentation of chosen data samples to support claims, and the inference of conclusions from the data itself. The goal should be to present a persuasive collection of findings and recommendations that effectively capture the research's advancements. It has been suggested that the findings should be accompanied with an explicit and replicable explanation of the analytical procedure (sometimes referred to as a "audit trail") ^[45]. The design, analysis, and interpretation of the research topic under consideration may then be evaluated by the reader as to whether they are suitable and rigorous.

Conclusion

This essay provides a condensed introduction of qualitative psychiatric research. As a result, we have not given some general difficulties in qualitative research the attention they require. Although while we have provided an overview of several qualitative research techniques, we have refrained from going into great length on the practical elements of performing qualitative research, such as recruiting people or groups, as these are covered in general qualitative textbooks ^[5, 11, 15]. Furthermore, we haven't covered the special ethical concerns that arise when conducting qualitative research in recognisable communities or among individuals who may have mental health difficulties. Thankfully, there is a sizable and growing body of literature devoted to qualitative research ethics, and we may point interested readers there ^[46, 47]. Notwithstanding these drawbacks, we anticipate that this paper will improve readers' capacity to perform, evaluate, and understand qualitative research in psychiatry. At root, research methodology should be judged on its suitability to answer the question under discussion. In many cases, quantitative research is well suited to answer typical questions posed in psychiatry. However qualitative research may be better suited to answer some of the innovative questions arising out of contemporary psychiatry, especially where it is intelligently combined with parallel quantitative research ^[48-50]. This is especially so in a changing policy climate, where demands are increasing for evidence-based medicine, patient involvement, and evaluation of services in the desirable shift toward health promotion and a "new public health".

References

1. Crawford MJ, Ghosh P, Keen R. Use of qualitative research methods in general medicine and psychiatry: publication trends in medical journals 1990-2000. *Int. J Soc Psychiatry*. 2003;49:308-11.
2. Jones R. Why do qualitative research? *BMJ*. 1995;311:2.
3. Ashton J, Seymour H. *The new public health*. Milton Keynes: Open University Press; c1988.
4. Pope C, Mays N. Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research. *BMJ*. 1995;311:42-5.
5. Pope C, Mays N. *Qualitative research in health care*. London: BMJ Books; c2000.
6. Silverman D. *Interpreting qualitative data*. London: Sage; c2001.
7. Landeen J, Pawlick J, Rolfe S, Cottee I, Holmes M. Delineating the population served by a mobile crisis team. *Can J Psychiatry*. 2004;49:45-50.
8. Whitley R, Prince M. Are inner-cities bad for your health? Comparisons of residents' and third-parties' perceptions of the urban neighborhood of Gospel Oak, London. *Sociol Health Illn*. 2005;27:44-67.
9. Malinowski B. *A scientific theory of culture and other areas*. Raleigh (NC): University of North Carolina Press; c1990.
10. Kuhn T. *The structure of scientific revolutions*. Chicago (IL): University of Chicago Press; 1962.
11. Spradley JP. *Participant observation*. London: Thomas Learning; c1980.
11. Geertz C. *The interpretation of cultures*. New York: Basic Books; c1973.
12. Glaser B, Strauss A. *The discovery of grounded theory*. Chicago (IL): Aldine; c1967.
13. Schulze B, Angermeyer MC. Subjective experience of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Soc Sci Med*. 2003;56:299-312.
14. Lincoln Y, Guba E. *Naturalist inquiry*. London: Sage; c1985.
15. Miles M, Huberman A. *Qualitative data analysis*. Thousand Oaks (CA): Sage; c1994.
16. Ware N, Tugenberg T, Dickey B, McHorney C. An ethnographic study of the meaning of continuity of care in mental health services. *Psychiatr Serv*. 1999;50:395-400.
17. Popper K. *The logic of scientific discovery*. London: Hutchinson; c1959.
18. Weisner TS. The ecocultural project of human development: why ethnography and its findings matter. *Ethos*. 1997;25:177-90.
19. Kleinman A. Social origins of distress and disease: depression, neurasthenia, and pain in modern China. New Haven (CT): Yale University Press; c1986.
20. Kleinman A, Kleinman J. Somatisation: the interconnections in Chinese society among culture, depressive experience, and the meaning of pain. In: Kleinman A, Good B, editors. *Culture and depression*. Berkley (CA): University of California Press; c1985.
21. Kleinman A. *Rethinking psychiatry*. New York: The Free Press; c1988.
22. Rousseau C, Mekki-Berrada A, Moreau S. Trauma and extended separation from family among Latin American and African refugees in Montreal. *Psychiatry*. 2001;64:40-59.