

Assessment of the Knowledge and Attitude of Adults Regarding Mental Illness in Selected Rural Community, West Bengal

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ABSTRACT

A descriptive study was conducted to assess the knowledge and attitude regarding mental illness and to find out the relationship between knowledge and attitude among adults in selected rural community, WB. A co-relational survey approach was adopted. A self report questionnaire was developed and adopted for collecting information regarding background data, knowledge and attitude regarding mental illness. 100 samples were selected through purposive sampling technique for the study from Narayanpur village under B.P.H.C Sarisha. Data obtained regarding background of respondents was analyzed in terms of frequency and percentage distribution. Mean knowledge score was 12.63 ± 4.51 and most of the respondents scored had an average knowledge on mental illness. Knowledge was measured in the cause, signs and symptoms of mental illness, nature and types of mental illness and treatment, prevention and prognosis area. The mean attitude score was 112.8 ± 15.11 . In attitude the study revealed that community people held more had benevolent views 36.39 and tolerant attitude towards community mental health ideology 34.66. There is a positive relationship between knowledge and attitude of mental illness is 0.572 and t value 6.87. There is also association between knowledge with three selected variables i.e. education, religion and family history of mental illness and attitude with education. Based on these findings it can be concluded that awareness regarding mental illness is increasing and people are becoming tolerant towards mentally ill people. The study is of obvious importance of any policy aimed at promoting better knowledge and tolerance of mental illness by the public.

Key words- knowledge, attitude, adults, mental illness

INTRODUCTION

Health is “a state of complete physical, social, and mental well being and not merely the absence of disease or infirmity”. Mental health is not mere absence of mental illness. More recently the mental health is defined as “a state of balance between the individual and surrounding world, a state of harmony between oneself and others, a co-existence between the realities of the self and that of other people and that of the other environment”. Analysis done by World

Health Organization, shows that neuropsychiatric disorders have aggregate point prevalence of 10 percent of adults. About 450 million people were estimated to be suffering from neuropsychiatric conditions. ^[1]

India: Surveys of mental morbidity carried out in various parts of the country suggest a morbidity rate of not less than 18-20 per 1000 population and the types of illness and the prevalence are very much same as in the other parts of the world. The numbers of specialized hospitals for mental

disorder patient in the country are 47 with total number of beds about 10329. The number of outdoor mental disorder cases treated in the hospital during 2004 were about 896425 and 22361 cases were treated in the child guidance clinics. The total numbers of new outdoor cases during 2004 in specialized mental hospitals were 6737 psychotic substance users, 55869 schizophrenia, 31555 mood disorders, 38482 neurotic, stress related, 3417 behavioural syndromes, 906 of adult personality, 4256 mental retardation, 885 disorder occurring in childhood, 1151 psychological disorder, 4577 organic disorder, and 2904 unspecified mental disorders. [1]

The yearly incidence of a major depression is 1.59 percent (women, 1.89 percent; men, 1.10 percent). The annual incidence (number of new cases) of a major depressive episode is 1.59 percent (women, 1.89 percent; men, 1.10 percent). The annual incidence of bipolar illness is less than 1 percent, but it is difficult to estimate, because milder forms of bipolar disorder are often missed. Depression is more common in rural areas than in urban areas. The prevalence of mood disorder does not differ among races. [2]

In India according to National institute of Mental health the prevalence of schizophrenia, a severe mental disorder, is prevalent among 1.1 percent of the total population while overall lifetime prevalence rate of mental disorders is 10-12 percent. According to estimate by WHO, depression will become the second largest in terms of morbidity in another decade. It already affects one out of every five women and one in every 12 men. [3]

According to National Health Program (2009) during the last two decades, many epidemiological studies have been conducted in India, which show that the prevalence of major psychiatric disorder is about the same all over the world. The prevalence reported from these studies range from the population of 18 to 207 per 1000 with the median 65.4 per 1000 and at

any given time, about 2 -3 % of the population, suffer from seriously, incapacitating mental disorders or epilepsy. Most of these patients live in rural areas remote from any modern mental health facilities. A large number of adult patients (10.4 - 53%) coming to the general OPD are diagnosed mentally ill. However, these patients are usually missed because either medical officer or general practitioner at the primary health care unit does not ask detailed mental health history. Due to the under-diagnosis of these patients, unnecessary investigations and treatments are offered which heavily cost to the health providers. [4]

According to WHO report 2005 The people in rural areas are unable to access the services of the qualified doctors and other mental health professionals, where just 0.2 psychiatrists, 0.05 psychiatric nurses, 0.03 psychologists per 100,000 people , and 0.26 mental health beds per 10,000 populations, 0.2 in mental hospital and 0.05 in general hospitals are available for the whole country. Interestingly, the number of availability of psychiatrist has gone down during 2001 and 2005. To make the resources equitable, India needs about 140,000 psychiatrists whereas we have about 3000 psychiatrists and 75% of them are working in urban areas where less than 28% of the population lives. The government expenditure on mental health is another concern where it spends just 0.83 percent of its total health budget on mental health. [5]

The report of District Health and Family Welfare Office of Dakshina Kannada showed that nearly 238 neurotic and 300 psychotic cases of mental disorder were recorded during the year 2007-2008. Among these cases only 59 neurotic and 77 psychotic cases had approached for the treatment. This signifies that lack of awareness regarding mental illness among the general public holds on the help seeking behaviour. [6]

Stigma associated with mental illness acts as one of biggest hurdles in

providing treatment to mentally ill. The mentally ill people are perceived as different and are seen as negative attributes and are more likely to be rejected regardless of their behaviour. [7] Stigma is considered as amalgamation of three related problems: lack of knowledge (ignorance), negative attitudes (prejudice) and exclusion or avoidance behaviours (discrimination). [8]

Of all the health problems, mental illness is poorly understood by the general public. Such a poor knowledge with negative attitude (which again is a result of poor knowledge) threatens the effectiveness of patient care and rehabilitation. Better knowledge is often reported to result in improved attitudes towards people with mental illness and a belief that mental illness are treatable can encourage treatment seeking and promote better outcomes. [9]

The reluctance to seek professional psychiatric help means late presentations of cases are common. The extent to which patient gets benefit from improved mental health services is influenced not only by quality and availability of services but also by their knowledge and belief systems. Knowledge and attitude of the patient and all those members surrounding him that belongs from the community itself have profound impact on their chances of accessing mental health services, morbidity and continuation of availing services.

METHODOLOGY

Keeping the objectives in mind survey research approach was adapted for the study. A descriptive co-relational design was used and based on the study criteria 100 adults at age group of 20-60 years were selected from Sarisha, Diamond Harbour block II through purposive sampling technique. Data was collected from 1.1.2014 to 30.1.2014 through self prepared structured questionnaire (Tool -1) to assess the background information and knowledge level of adults of rural community. It was planned in two sections section A contains questions regarding demographic data and section B contains structured knowledge

questionnaire regarding knowledge on mental illness. In section- A questions regarding age, sex, religion, educational status, family monthly income, occupation, type of family, marital status, previous history of mental illness in family and help of mental health services taken were asked. For preparation of Section- B the objectives and specific content were outlined. It consisted of 20 items on different aspects of mental illness such as nature of mental illness, causes, types, signs and symptoms, treatment, prevention and prognosis of mental illness. It was validated by seven experts. The reliability was calculated by split half method and reliability coefficient was found to be 0.83 by Spearman Brown Prophecy formula. In Tool- 2 attitude was assessed through structure attitude scale CAMI which was a standardized tool prepared by Taylor, Dear and Hall for assessing community attitude towards mental illness (1979). It involves assessment of attitude in 4 domains that is authoritarian, benevolence, and social restrictiveness and community mental health ideology with total 40 items. The reliability coefficient tested by Cronbach's α method and r was found to be 0.76. The tool was translated to Bengali and then retranslated to English by language experts. Pretesting of the tool and pilot study was done prior the final study. Anonymity and confidentiality was maintained and informed consent was taken from each participants. Maximum 6-8 participants were taken each day to fill up the questionnaire. House hold survey was done and literate and willing participants were purposely selected. Descriptive statistics was used to determine the sample characteristics. Mean, median and S.D was derived of the knowledge and attitude score of community people. The relationship between knowledge and attitude was determined by Pearson Product moment method. Chi-square test to use to determine the association of knowledge level and attitude with selected demographic variables.

RESULTS

Table No- 1: Frequency distribution of background data of respondents according to their characteristics

SL No	Characteristics	Frequency	
1.	Age		
	20-30	57	
	31-40	25	
	41-50	12	
2	Gender		
	Male	55	
	3	Religion	
		Hindu	76
Muslim	24		
4	Education		
	Secondary	55	
	Higher secondary	18	
5	Occupation		
	Service	14	
	Business	18	
	Farmer	4	
	Home maker	37	
	Unemployed	12	
	Self employed	5	
	Daily labour	10	
6	Type of family		
	Nuclear	52	
7	Married		
	Yes	73	
8	History of mental illness in family		
	Yes	14	
9	Taken help of mental health services		
	Yes	14	

Data in **table- 1** shows that majority 57% of the respondent falls in the age group of 21-30 years. Majority 55% males and most 75% is Hindu. Majority 55% of them were

Secondary in educational level. Maximum of them 37% is homemaker. Maximum 52% belongs to nuclear family. 14% of respondents have family history of mental illness and majority is from maternal side. 14% of the respondents have taken help of mental health services available.

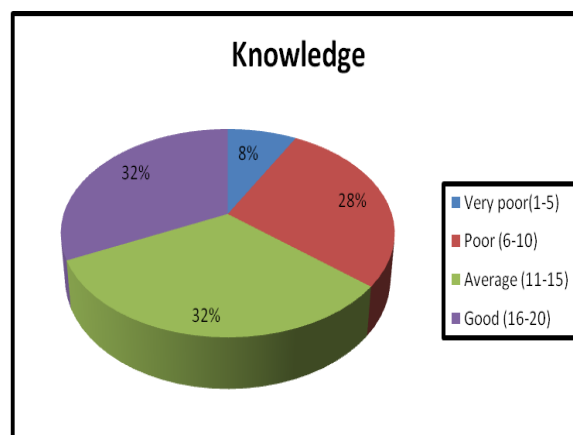


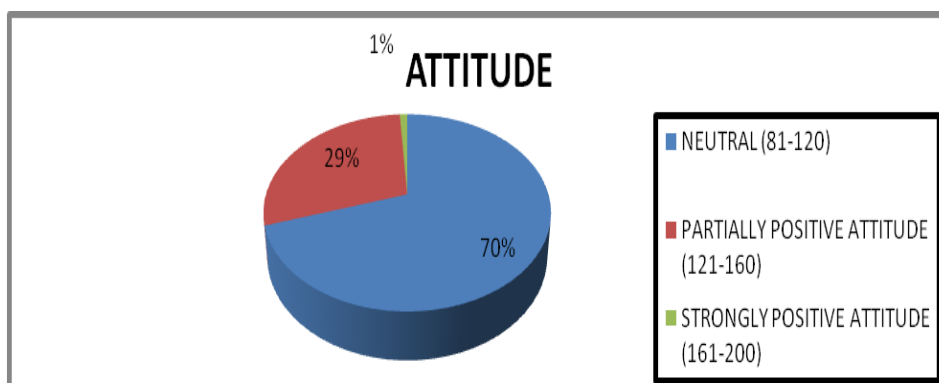
Fig. 1: Pie graph showing frequency percentage distribution of knowledge score of respondents

The figure 1 shows that maximum 32% of respondents have scored good knowledge and 32% average knowledge regarding mental illness

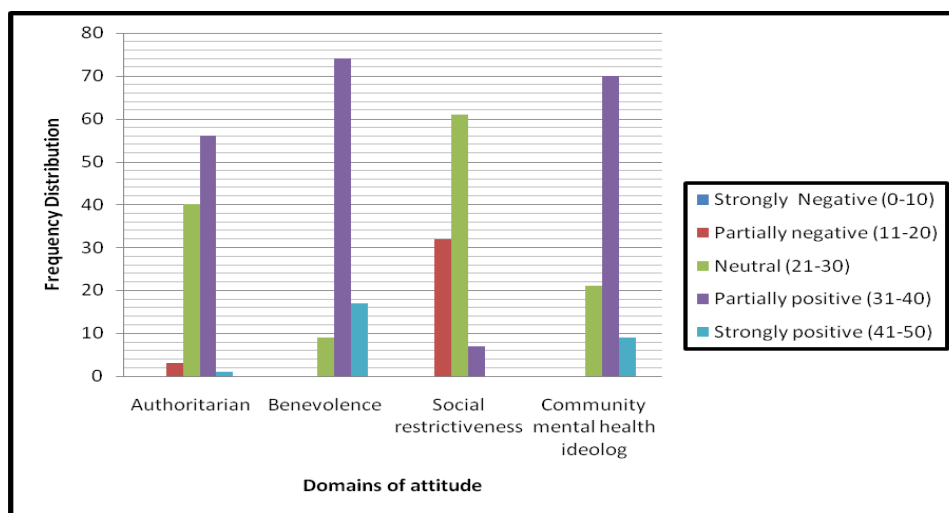
Table – 2: Mean and mean% distribution of area wise knowledge score

Area	Max possible score	Mean	Mean %
Nature and type	4	2.48	62
Cause	5	4.11	68.5
Signs and symptoms	6	3.1	51.6
Treatment, prevention and prognosis	5	3.33	66.6

The data presented in table 2 shows that maximum 4.11 mean and 68.5 mean % is scored in the cause area of mental illness. N=100



The figure 2 shows that majority 70% have neutral attitude towards mental illness



N.B Authoritarian and social restrictiveness domain denotes negative attitude towards mental illness

Fig.3: Bar diagram showing domain wise frequency distribution of attitude score

The figure 3 shows that majority 74% of the respondent shows partially positive benevolence attitude towards mental illness.

Table 3: Mean, median, S.D, r and t calculated between knowledge and attitude of respondents regarding mental illness

Variables	Mean	Median	S.D	r	t value
Knowledge	12.63	13	4.51		
Attitude	112.8	111.5	15.11	0.572	6.87*

*t(98) = 1.99; *p < 0.05

Table 3 represents that the r value calculated by Pearson product moment method is 0.572 this shows that there is positive correlation between knowledge and attitude of respondents and it is true not by chance as evident by the computed t value 6.87 which is greater than the table t value at 0.05 level of significance.

Table 4: mean, median, S.D and r of knowledge with selective domain of attitude

Variables	Maximum possible score	Mean	Median	S.D	r	t value
Authoritarian domain	50	30.72	31	4.49	-0.467	5.20*
Benevolence domain	50	36.39	36	4.26	0.400	4.31*
Social restrictiveness	50	27.48	27	5.43	-0.495	5.68*
Community mental health ideology	50	34.66	35	5.02	0.427	4.68*

*t(98) = 1.99; p * < 0.05

Data in table 4 shows that benevolence domain has highest mean 36.39 which means community people are more benevolent towards people with mental illness. Knowledge is positively correlated with benevolence and community mental health ideology domain and negatively correlated with authoritarian and social restrictiveness.

Table 5: Association of knowledge score with demographic variables

SL.No	Variables	<Median	>Median	Chi square	dF	Table Value
1.	Age 20-30 31-40 Above 41	22 10 12	34 15 17	3.40	2	5.99
2.	Gender Male Female	26 18	29 27	0.53	1	3.84
3.	Education Secondary and below Above secondary	31 13	25 31	6.662*	1	3.84
4.	Type of family Nuclear Joint	27 17	25 31	2.76	1	3.84
5.	Family history of mental illness Yes No	3 41	11 45	4.51*	1	3.84

Data presented in table 5 shows that showed there is association of knowledge score with education and family history of mental illness at 0.05 level of signoficance

Table 6: Association of attitude score with demographic variables

SL.No	Variables	<Median	>Median	Chi square	dF	Table Value
1.	Age 20-30 31-40 Above 41	29 10 11	27 15 9	2.186	2	3.841
2.	Gender Male Female	29 21	26 24	0.363	1	5.99
3.	Education Secondary and below Above secondary	21 29	35 15	7.95*	1	6.64
4.	Type of family Nuclear Joint	28 22	24 26	0.641	1	3.841
5.	Family history of mental illness Yes No	46 4	40 10	2.99	1	3.841

Data presented in table 6 shows that showed there is association of attitude score with education at 0.01 level of significance.

DISCUSSION

The present study reveals that mean knowledge score of respondents is 12.63 ± 4.5 . Respondents have scored maximum 68.5% in the cause area, 51.6% in signs and symptoms of mental illness, 62% in nature and type of mental illness, 66.6% in treatment, prevention and prognosis area. It supports a cross sectional survey in October 2008 with 100 subjects selected conveniently in general public of Southern India by Ganesh K. Mean knowledge score was 5.90 ± 1.22 . Item wise awareness were common mental disorders 60%, causes 35%, signs and symptoms 60%, treatment 42% and prognosis 30%. The findings support my study. [10]

The findings of the present study reveal community people held more authoritarian 30.72 and social restrictive views 27.48. They also had more benevolent views 36.39 and tolerant attitude towards community mental health ideology 34.66. It supports a cross sectional study by Vijayalakshmi P, Ramachandra, Redemma K, Math SB in 2012 carried out in Karnataka India with $n=102$ by a house to house survey. It revealed that community held more authoritarian attitude (32.3 ± 3.18) and social restrictiveness views (31.9 ± 3.25) they are benevolent (29.1 ± 3.51) and

tolerant attitude towards community mental health ideology (31.8 ± 2.69) [11]

The present study showed that r value of relationship with knowledge and attitude of mental illness is 0.572 and t value 6.87. This shows that there is a positive relationship between knowledge and attitude regarding mental illness. The findings support a cross sectional study carried out by Babita Singh in 2013 showed that correlation between knowledge is 0.23 in rural community and 0.51 in urban community which also reports similar findings in present study [12]

The findings of the present study reveal that there is important association of knowledge and attitude of mental illness with education, religion and family history of mental health services. The findings support descriptive study undertaken by More VP, Jadhav PK, Puranik R, Shinde VS, Pakhale S (2012) to assess public knowledge in a public opinion survey regarding mental illness in Jalgaon, Maharashtra in a control region. In this study the target population of size 100 community people of age group 21- 41 Years, were randomly chosen, residing in 50 rural and 50 urban area of Jalgaon. There was strong association of knowledge and attitude with education and economical status. [12]

The findings of the present study have implications in the field of nursing education, nursing practice, nursing administration and nursing research. Study shows that community attitude towards mental illness varies in wide range according to education, religion and culture. Thus nurse educator can develop community awareness program based on the findings of the study by keeping the cultural variations in mind. It also enhances the scope in preparation of different educational interventions on increasing awareness and attitudes towards mental illness among general public. It will help in early identification of cases in the community and positive attitude will prevent relapse. Nursing administrator can evaluate the effectiveness of community based mental health services provided through the findings of the study. The study stimulates the need of more extensive research in the field of knowledge, attitude and practice regarding mental illness.

Descriptive survey approach gives a broad range of data about all range of community perceptions and beliefs. The findings related to the study would help to give developmental interventions to individual, family and group. The multidimensional scale helps us to identify both the positive and negative aspects of attitude and knowledge where we can work on to intervene, reinforce and enhance a more positive living environment for persons with mental illness. The results revealed that the population had more benevolent attitude towards mental illness and puts moderate social restriction on mentally ill as example no one has the right to exclude mentally ill from the neighbourhood. However they were relatively more authoritarian. Therefore the benevolent attitude does not guarantee acceptance of rehabilitation in community.

The study has limitations too like the study was conducted only in a small rural community under B.P.H.C Sarisha. Participants were selected through purposive sampling. The study was

conducted only on those participants who can read and write Bengali so it did not cover the illiterate part of rural community. Practise part is not assessed in the study.

The recommendations for another study are a comparative study can be done to find out the attitude regarding mental illness in urban and rural population and an experimental study can be done to find out the effectiveness of awareness programme regarding mental illness.

CONCLUSION

The study concluded that most of the people had average knowledge regarding mental illness. The attitude of the community people is benevolent towards mentally ill people but there is also presence of authoritarian and social restrictive views. So it led us to belief that still there is a definite lack of knowledge and attitude towards mental illness

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