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Original Research Article

Assessment of Knowledge on Mental Illness and Its Determining Factors among People Aged 25-40 Years in Pokhara Valley, Nepal

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ABSTRACT

Introduction: Mental health is an essential component of health and a source to deal with the stresses of everyday life. Mental health encompasses positive aspects of well-being and healthy functioning as well as negative aspects of different mental illnesses. Mental illnesses are particularly troublesome in developing countries like Nepal which is going through the issues of rapid urbanization and modernization and where the problem is highly negligent.
Objective: To assess the Knowledge on mental illness and its association with socio-demographic factors among people of Pokhara.
Methods: The cross-sectional study was carried out during the month of January 2015 in central wards of Pokhara valley. 180 samples were collected by using self administered questionnaires to the people of age 25-40 years. Data were entered and analyzed using SPSS version 20.
Results: Almost all (91.1%) respondents were aware about mental illness. Two-third of respondents (66.6%) reported mental illness as a condition of showing unusual behaviour. Almost half (49.4%) respondents reported unemployed youths as most vulnerable groups of mental illness. Most (53%) reported early diagnosis and treatment to be the prevention of mental illness followed by stress reduction (47.6%). Almost (98.8%) all respondents knew that mental illness can be treated. More than half (61.6%) respondents were having poor level of knowledge regarding mental illness, 24.4% with satisfactory and 14% with good level. Level of knowledge was statistically significant with educational status and occupation of respondents ($p<0.05$).
Conclusion: Appropriate level of knowledge regarding mental illness was still lagging among respondents. Those who were highly educated were having good level of knowledge. This shows the necessity to introduce and promote mental health education in schools and colleges to increase awareness among the youths of urban society.

Keywords: Mental health, mental illness, knowledge, awareness, significant.

INTRODUCTION

Mental health is an individual and personal matter. It involves a living human organism or more precisely, the condition of an individual human mind. Mental health is one of many human values; it should not be regarded as the ultimate good in itself. [(1)]

Mental health is an essential component of health and is a resource to help us deal with the stresses and challenges of everyday life. Good mental health contributes to the quality of our lives as individuals, as communities, and as a society in general. Good mental health protects us and helps us to avoid risk

taking behaviors that contribute to poor mental health. [2]

Most mental health problems diagnosed in adulthood begin in adolescence. Half of lifetime diagnosable mental health disorders start by age 14; this number increases to three fourths by age 24. According to the Surgeon General's report and WHO, mental health encompasses positive aspects of well-being and healthy functioning as well as negative aspects of mental disorder and dysfunction. Common disorders include mood disorders such as depression; anxiety disorders; behavioural problems such as oppositional defiant disorder or conduct disorder; eating disorders such as anorexia nervosa and bulimia; addictive disorders; and other disorders commonly seen in childhood and adolescence such as autism, learning disorders and attention-deficit/hyperactivity disorder (AD/HD). [3]

As many as 450 million people worldwide are estimated to be suffering at any given time from some kind of mental or brain disorder, including behavioural and substance abuse disorders. In the World Health Report 2001 four of the ten leading causes of disability worldwide are neuropsychiatric disorders, accounting for 30.8% of total disability and 12.3% of the total burden of disease. This latter figure is expected to rise to 15% by the year 2020. More than 40% of countries have no mental health policy and over 30% have no mental health programme. Even countries that do have mental health policies often disappointingly neglect some of the more vulnerable populations. In addition to the health and social costs, those suffering from mental illnesses are also victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions. [4]

Mental health conditions negatively impact youths' development, quality of life and ability to fully participate in their communities. [5] Mental and behavioural conditions are the leading causes of health problems in young people in both high- and low-resource countries, accounting for one third of all years lost productivity due to disability. Suicide is the fifth highest cause of death in this age group globally and second highest in high-income countries. [6]

Mental health problem in Nepal have occupied 12-13 percent of total diseases while more than 4 million Nepali people are suffering from any sort of mental illness. According to the annual reports of DoHS 2065/2066, there were 19596 cases of depression, 20732 cases of anxiety (neurosis) and 6391 cases of psychosis. [7]

There is a stigma around mental health. Those with mental illness are often discriminated against by the community and their family and often not treated sympathetically by health workers. All aspects of mental illness, from recognition of the symptoms, treatment adherence to rehabilitation are influenced by stigma of that illness. Adequate knowledge and favourable attitudes towards mental illness as well as advocacy are essential to reduce the stigma attached with them.

The aim of the study is to assess the level of knowledge on mental illness and explore the association between the knowledge level and socio-demographic factors of study population.

MATERIALS AND METHODS

A descriptive cross sectional study was carried out among 180 adults within the age of 25-40 years in selected 9 central wards of Pokhara valley using multistage sampling technique. 20 samples were collected from each selected wards. Data collection was conducted during the month of January 2015 using semi-structured and self administered questionnaire. Coding of the data was done in the questionnaire itself. Code lists were prepared and computer entry was done accordingly. The data were entered and analysed using SPSS version 20. Chi-square to test the

association between dependent and independent variables was used for analysis. P-value less than 0.05 was taken as the measure of statistically significant and value <0.01 was taken as highly significant. Regarding the level of knowledge, it was categorised by using arbitrary scales. Respondents who secured more than 60% of total score were categorised under Good Knowledge, who secured between 40% to 60% of total score as Satisfactory Knowledge and those who secured less than 40% of total score under poor knowledge.

Permission was taken from the research committee of Akal School of Public Health, Eternal University, Baru Sahib, India as well as from the District Public Health Office, Kaski, Nepal prior to study. Verbal informed consent was obtained prior to collect data from respondents. Confidentiality of respondents was maintained. Questionnaire was developed into Nepali language for the feasibility of data collection.

RESULTS

Socio-demographic information

The study findings indicate that almost half (47.2%) respondents were between the age of 25 to 30 years followed by 30.6% and 22.2% within the group of 36-40 and 31-35 years respectively. More than half (61.1%) of total respondents were female and the remaining (38.9) were male. Most respondents (92.8%) were following Hindu religion followed by 6.7% and 0.6% to be Buddhism and Christianity respectively. Maximum respondents (42.2%) were engaged in non-governmental service; about one fourth were doing some kind of business followed by labor, governmental service, student, agriculture and housewife respectively. Most of the respondents (45.6%) had completed graduation level of education. More than half (53.9%) were living in nuclear family whereas 46.1% belonged to joint family.

Awareness and Level of knowledge of respondents

Table 1: Distribution of respondents by their awareness

Aware	Frequency(n)	Percentage (%)
Yes	164	91.1
No	16	8.9

The findings from Table 1 show that most (91.1%) respondents were aware about mental illness.

Among those who were aware about mental illness majority (66.6%) reported mental illness as a person showing unusual behaviour followed by 42.6%,18.5%, 5.6% and 4.3% as unable to perform one's tasks, looking aggressive or calm, quarrelling with others, to consume narcotic drug, alcohol and tobacco as mental illness respectively. Almost half (49.4%) of respondents had reported unemployed youths as the most risk groups of mental illness whereas 44.5% reported adolescents.

Majority (42.9%) of respondents reported individual life events as the most significant cause of mental illness whereas 36.2% reported personal and family impacts. More than half (53%) reported early diagnosis and treatment to be the prevention of mental illness followed by stress reduction (47.6%), mental health education (43.3%), family counseling (32.9%), mental health promotion activities targeting youths (29.9%), mental health services (28.7%), rehabilitation (18.3%), early childhood preventive (16.5%) and programmes targeted to vulnerable groups (15.9%). Almost (98.8%) all respondents had the knowledge about the treatment of mental illness. (Table 2)

Table 2: Distribution of respondents by their knowledge

Knowledge on	Parameters	Frequency(n)	Percentage (%)
what is mental illness*	Unable to perform his/her task	69	42.6
	To consume alcohol	7	4.3
	To consume narcotic drug	7	4.3
	To consume tobacco	7	4.3
	Quarrel with other	9	5.6
	Showing unusual behavior	107	66.0
	Looking Aggressive or calm	30	18.5
Risk groups of mental illness*	Children	13	7.9
	Adolescents	73	44.5
	Older people	27	16.5
	Unemployed youths	81	49.4
	Orphan children	20	12.2
	Employed people due to workload	41	25.0
Causes of mental illness*	Genetic	54	33.1
	Birth and Pregnancy	33	20.2
	Social Factor	53	32.5
	Ill behavior	48	29.4
	Disease and Injury	55	33.7
	Individual life events	70	42.9
	Personal and family impact	59	36.2
	Side effect of medication	47	28.8
	Personality and character disorder	39	23.9
Prevention of mental illness*	Mental health education	71	43.3
	Early diagnosis and treatment	87	53.0
	Early childhood preventive	27	16.5
	Mental health promotion activities for youth	49	29.9
	Programs related to vulnerable group	26	15.9
	Mental health services	47	28.7
	Reduce stress	78	47.6
	Family counseling	54	32.9
	Rehabilitation	30	18.3
Treatment of mental illness	Yes	160	98.8
	No	2	1.2

*multiple responses

Table 3: Distribution of respondents by their level of knowledge

Level of knowledge	Frequency(n)	Percentage (%)
Poor	101	61.6
Satisfactory	40	24.4
Good	23	14.0
Total	164	100.0

Study findings indicate that more than half (61.6%) respondents were having poor level of knowledge regarding mental illness followed by only 14% having good level of knowledge. (Table 3)

Perception of respondents regarding mental illness

Table 4: Distribution of respondents by their perception about mental illness

Parameters	Frequency(n)	Percentage (%)
Mental illness is infectious		
Yes	144	87.8
No	20	12.1
Mental illness can be treated by visiting a psychiatrist		
Yes	141	86.5
No	22	13.5
People with mental illness can take responsibility of their family		
Yes	26	15.9
No	138	84.1
People with mental illness can take care of themselves		
Yes	23	14
No	141	86

The data from table 4 indicates about the perception of respondents regarding mental illness. Majority (87.8%) perceive mental illness as infectious. Most (86.5%) respondents believed that mental illness can be treated by visiting a psychiatrist. Maximum (84.1%) respondents perceived that mentally ill

people can never take responsibility of their family and 86% thought mentally ill people can never take care of themselves.

Association between awareness and level of knowledge with socio-demographic factors

Awareness was found to be highly statistically significant with occupation of respondents (χ^2 value =27.648, p-value<0.001). However no significant association was found with other socio-demographic characteristics of study population. (Table 5)

Level of knowledge was found statistically significant with respondents occupation (χ^2 value =7.857, p-value=0.020) and highly significant with educational status of respondents (χ^2 value =9.896, p-value=0.007). However no significant association was observed with other socio-demographic variables. (Table 6)

Table 5: Distribution of respondents by their association of awareness with socio-demographic variables

Characteristics	Aware		χ^2 value	df**	P-value
	Yes	No			
Age groups					
25-30	81(95.3)	4(4.7)	3.481	2	0.175
31-35	35(87.5)	5(12.5)			
36-40	48(87.3)	7(12.7)			
Gender					
Female	100(90.9)	10(9.1)	0.14	1	0.905
Male	64(91.4)	6(8.6)			
Type of family					
Nuclear	88(90.7)	9(9.3)	0.039	1	0.843
Joint	76(91.6)	7(8.4)			
Education					
Upto higher secondary	40(74.1)	14(25.9)	27.648	1	<0.001*
Above higher secondary	124(98.4)	2(1.6)			
Occupation					
Formally engaged[a]	148(90.2)	16(9.8)	1.713	1	0.191
Unengaged[b]	16(100)	0(0)			

#Figures in parenthesis indicate percent
[a] business, agriculture, government service, non-government service, labor
[b] housewife, student
*Statistically highly significant at p<0.001
**df degree of freedom

Table 6: Distribution of respondents by their association of level of knowledge with socio-demographic variables

Characteristics	Level of knowledge			χ^2 value	df**	P-value
	Poor	Satisfactory	Good			
Age groups						
25-30	51(63)	18(22.2)	12(4.8)	0.679	4	0.954
31-35	21(60)	10(28.6)	4(1.4)			
36-40	29(60.4)	12(25)	7(14.6)			
Gender						
Female	62(62)	24(24)	14(14)	0.023	2	0.988
Male	39(60.9)	16(25)	9(14.1)			
Type of family						
Nuclear	54(61.4)	25(28.4)	9(16.2)	3.211	2	0.201
Joint	47(61.8)	15(19.7)	14(18.4)			
Education						
Upto higher secondary	33(82.5)	5(12.5)	2(5)	9.896	2	0.007*
Above higher secondary	68(54.8)	35(28.2)	21(16.9)			
Occupation						
Formally engaged[a]	86(58.1)	39(26.4)	23(15.5)	7.857	2	0.020*
Unengaged[b]	15(93.8)	1(6.2)	0(0)			

#Figures in parenthesis indicate percent
[a] business, agriculture, government service, non-government service, labor
[b] housewife, student
*Statistically significant at p=0.05
**df degree of freedom

DISCUSSION

The results of the study showed the majority (42.9%) reported individual life

events as the major cause of mental illness followed by personal and family impact (36.2%) and disease and injury (33.7%), only one third (33.1%) reported the genetic factor. In the study by Kabir M and associates in Karfi village in northern Nigeria, 34.3% reported drug misuse including alcohol, cannabis, and other street drugs as a major cause of mental illness, followed by divine wrath/ God's will (19%), and magic/spirit possession (18.0%) which is dissimilar with this findings. [8]

Whereas in the study conducted by Shrestha MR in mental hospital, Lagankhel, Nepal majority had shown their knowledge about cause of mental illness as genetic (78.6%) and biochemical disturbances (97.2%) which is higher than this study as this study was conducted among general population whereas the study conducted in Lagankhel was done among the hospital patients. [9]

In this study most (98.8%) reported that mental illness can be treated. In the study conducted by Ganesh K only 42% had knowledge about the treatment of mental illness which is much lower than this study finding. [10]

The findings of the study showed that majority (42.9%) of respondents reported individual life events as the most significant cause of mental illness whereas 36.2%, 33.7%, 33.1%, 32.5%, 29.4%, 28.8%, 23.9%, 20.2% reported personal and family impacts, disease and injuries, genetic factors, social factors, ill behavior, some side effects of medication, personality and character disorders and birth and pregnancy respectively. This contrasts with the findings by Gureje et al (2005) which revealed that most respondents expressed substance misuse (alcohol/drugs) could result in mental illness. The next most commonly endorsed cause of mental illness was a belief that it could be due to possession by some evil spirits. Only one in ten respondents believed that biological factors or brain disease could be the cause of mental illness. [11] In the study by Kermode M in rural Maharashtra, India (2007) the most commonly acknowledged causes of the problems were a range of socioeconomic factors. Supernatural and biological explanations were not widely endorsed. This study shows almost half (49.4%) reporting unemployed youth as most vulnerable to mental illness followed by 44.5% reported adolescents. This is indifferent with the study in rural Maharashtra where women, the unemployed and the poor were judged as more likely to develop mental disorders, while both young and older people were perceived to be less vulnerable. [12]

The findings of this study shows only small proportion (14%) had good level of knowledge on mental illness. This is consistent with the findings given by Yeap R in a Malaysian context. This study reveals that level of knowledge was found statistically significant with respondents' occupation and educational status only. This is different from the findings by Yeap R which found the ethnic background, religion, educational level and residential location all to be significantly related to the respondent's knowledge on mental health issues. [13]

CONCLUSION

The study shows that almost all respondents were aware about mental illness but the level of knowledge regarding mental illness was substantial. Almost half reported unemployed youth population is at high risk of developing mental illness. Most of them reported that mental illness could be treated. Most of the respondents were engaged in some forms of occupation and those who were employed were having satisfactory and good level of mental illness than those who were not employed. Those who were educated above higher secondary level were having good level of knowledge than those who were educated below higher

secondary level. This suggests that mental health education should be promoted early in schools and colleges to increase proper knowledge and reduce stigma attached to mental illness among the youths of the society.

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