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Attitudes and Beliefs Toward Mental Illness in Assam (Central)

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Abstract: *Background- The Stigma associated with mental illness is now well recognized in our community. The study is carried out to assess the beliefs and attitude toward mental illness in Central Assam. Materials and Methods- The sample was collected from two districts of Central Assam viz. Morigaon district and Sonitpur district. The size of the sample of the study is n = 480 equally distributed among male and female between the age group 21 years to 40 years and 41 years to 60 years according to Rural and Urban setting. A self-made questionnaire was used for beliefs and attitudes on three domains- acceptance, knowledge & exposure and stigma & discrimination. Results- There is a difference of beliefs and attitudes of public on acceptance based on their setting, gender and age. There is a difference of attitudes and beliefs of public on knowledge & exposure according to their setting and age but there is no difference in terms of gender. The result of the study shows that there is a difference in the beliefs and attitudes toward mental illness by the setting, gender and age. Conclusion- Educational programs in the community by developing psycho- educational intervention and sensitization campaigns are needed.*

Key words: *Beliefs, Attitudes, Acceptance, Knowledge, Exposure, Stigma and Discrimination.*

I. BACKGROUND:

Having of a good physical health does not mean remaining healthy but it includes a healthy mind. To behave appropriately and think well our mind should be healthy. Mental Health refers to our cognitive and emotional wellbeing- it is what and the way we think, perceive and act. Mental health can also be defined as free from mental illness. [1]

A sound mental health is the key component of health. Mental health issues can create a great deal of stress in the overall upliftment of the community.[2]

Mental illness comprises a broad range of problems, with different symptoms. When one is not able to think rationally, behave properly in a socially appropriate manner, it does not mean that he is behaving in that manner knowingly, but that he may be affected with mental illness. Anyone can be affected by mental illness irrespective of intelligence, caste, culture, gender, age or social status. It strikes the prime stage of one's life, often during adolescence and later childhood. Without treatment it can lead to hazardous situation, viz. - chronic disability, unemployment, substance abuse, homelessness, wasted lives & suicide. [3]

Mental illness is generally characterized by combination of abnormal thoughts, emotions, behaviors and interpersonal relationship. Most of these can be successfully treated. This also refers to the disturbances of an individual's act of behavior or the cognitive functioning which are not expected culturally and which might lead to behavioral disability, psychological distress or impaired overall functioning. They can take a form of mania, phobia, depression, anxiety, schizophrenia, and so on.[4] Expert says that anyone has the chance of getting affected with mental health issues irrespective of age, gender, socio-economic factor or religion to which they belong. The irony is that most person – or someone they care for- are bound to be affected by these problems at one time or another.

Worldwide millions of people are affected with mental illness. In order to promote positive mental health, it is important to strengthen the mental health care services at all levels. However, challenging the mental health issue will be possible only when public have positive attitudes toward mental illness and the people suffering mental illness.[5]

Stigma associated with mental illness acts as one of the biggest hurdles in providing treatment to people suffering from mental illness. Because of which the people who are suffering from mental illness are perceived as "different" and are seen with negative attributes and are more likely to be rejected regardless of their behavior.[6] Stigma is said to be a combination of three defined problems- a lack of knowledge that is ignorance, negative attitudes that is prejudice and exclusion or avoidance behaviors that is discrimination. Scheff [7] reported that "people who are labeled as person with mental illness accompanies themselves with

society's negative conceptions of mental illness and that society's negative response bestow to the occurrence of mental disorder; the social rejection resulting from this may handicap mentally ill people even further.[8]
Many studies done on attitudes toward mental disorders and people suffering from mental illness have shown persistent negative attitudes.
This negative attitude is often attributed to lack of knowledge regarding mental health and mental disorders.[9] Many studies done in different countries have found that many people do not properly recognize mental disorders.[10] Attitudes which hinder recognition and appropriate help-seeking have been commonly observed.

II. SIGNIFICANCE OF THE STUDY:

There have been some recent studies that reveal considerable changes in public attitudes toward mental illness.[4] This improvement in attitudes has been attributed to public education programs by mental health professionals and the mass media. Evaluation of beliefs and attitudes about mental illness will aid in their understanding, recognition, prevention and management. Also the common people and their attitudes towards persons with mental illness are important for the implementation of public sensitization concerning mental illness. Although there is a large number of related research works around the world, very little is known about public beliefs and attitudes in Assam, a state among the seven sisters and one brother in the north eastern part of India, as there is no research work to that effect as yet.[10] An exploratory study would bring to light the existing beliefs and attitudes toward the people with mental illness in Assam.

OBJECTIVE OF THE STUDY:

- To study the existing beliefs and attitudes of public toward people with Mental Disorders.

Specific Objectives:

- To find out the difference in attitude on acceptance toward person with mental illness between rural and urban setting.
- To find out the difference in attitude on exposure and knowledge toward person with mental illness between rural and urban setting.
- To find out the difference in attitude on stigma, discrimination and beliefs toward person with mental illness between rural and urban setting.
- To find out the difference in attitude on acceptance toward person with mental illness between male and female.
- To find out the difference in attitude on exposure and knowledge toward person with mental illness between male and female
- To find out the difference in attitude on stigma, discrimination and beliefs toward person with mental illness between male and female.
- To find out the difference in attitude on acceptance toward person with mental illness between age groups (21 years to 40 years and 41 years to 60 years).
- To find out the difference in attitude on exposure and knowledge toward person with mental illness between age groups (21 years to 40 years and 41years to 60 years).
- To find out the difference in attitude on stigma, discrimination and beliefs toward person with mental illness between age groups (21 years to 40 years and 41 years to 60 years).

MATERIALS AND METHODS:

Table 1: Factorial Design for one district:-

Gender		Male		Female		
Setting	**Age**	21yrs-40yrs	41yrs-60yrs	21yrs-40yrs	41yrs-60yrs	
Urban		30	30	30	30	**120**
Rural		30	30	30	30	**120**
Total-		**60**	**60**	**60**	**60**	**240**

The distribution of the sample for the study is n = 240 per district and (240*2) n = 480 per zone. Two districts were selected from each zone. Per district the respondents includes both male (n=120) and female (n=120) between the age group 21 years to 40 years (n=120) and 41years to 60 years (n=120). The distribution of the samples were according to Rural (n=120) and Urban (n=120). With the total sample size of 120*2= 240*2=480 was equally distributed.

Table 2:Variables:

Variables:	
Independent Variable (s):	**Dependent Variable (s):**
1. Setting (Urban and Rural)	1. Acceptance
2. Gender (Male and Female)	2. Exposure and Knowledge
3. Age (21years to 40 years and 41years to 60years)	3. Stigma and Discrimination

SAMPLE:

Mixed sampling technique has been used. The data have been collected in three stages and as such it is a Multi-Stage sampling design.

The sampling was done following a multi-stage Sampling Technique.

- *First Stage Unit (FSU)* – First, from the three zones of Assam Central Zone of Assam has been selected purposively, and 2 districts were selected randomly.
- *Second Stage Unit (SSU)* – From each district two settings that is 'urban' and 'rural' were selected by purposive sampling.
- *Third Stage Unit (TSU)* –Stratified Random Sampling with equal allocation was carried out by gender and age for 120 participants from each setting.

The total sample size comprise of 480 adults, male (n=240) and (n=240) from the age group of 21years to 40years and 41years to 60years from the Central Assam.

The different towns and villages selected for the study were: Marigaon district: Towns - Jagiroad, Nakhola, Mayong, Villages- Karaiguri, Neli, Sapkati, Singimari, Matiparbat. Sonitpur district: Towns - Tezpur, Bishwanath Chariali, Gahpur, Villages- Alisinga, Balichapori, Na-pam, Dolabari.

Short Description of the tools:

1. **Personal Identification sheet**

   The personal identification sheet is used to collect respondent's personal data like age, gender, locality, marital status, educational qualification, type of family, occupational status, exposure to mental disorders (illness).

   The sheet consists of the domains as cited above with multiple options.

2. **Semi-structured questionnaire-**

A semi-structured questionnaire was developed by Snigdha Ghosh and Dr. Indranee Phookan Barooah, 2012, to acquire additional information on beliefs and attitudes towards people with Mental Illness, in support of the vignette, to meet the objective of the study. The questionnaire was developed in English and Assamese as well. A pilot study was done and the irrelevant questions were removed from the questionnaire. The relevant questions were set and the questionnaire was finalized. The questions included fell under the following categories:

i) Beliefs & Attitudes reflecting acceptance of persons with mental illness- the category consists of 16 items.

ii) Beliefs & Attitudes reflecting knowledge and exposure to people with mental illness- the category consists of 8 items.

iii) Beliefs & Attitudes reflecting stigma, discrimination and beliefs toward people with mental illness- the category consists of 5 items.

The responses are on 3 point scale. Along each item options are given as agree/ undecided/ disagree together with their corresponding points as 3, 2, 1 respectively. The subject has to read each state statement carefully and has to tick the response which s/he thinks to be the most suited for him/ her.

For example: agree undecided disagree
3 2 1

Procedure:

As the total sample is distributed in the two districts of Central Assam, one by one the district was selected and the data was collected. At first the blue print of the sample collection process was planned and started with Morigaon District. Initially approach was made to the known persons residing at the respective districts and then the researcher visited and resided there for collecting responses. Researcher visited neighbors for individual responses. Clubs, health camps, social institutions such as Naamghars etc. were visited and data were also collected in groups. The instructions and explanations given to the participants started with introduction of the researcher, objective of the research, and then they were provided the questionnaires and informed that the responses will be totally confidential. They were assured that their responses would be used only for research purpose, and that they are not compelled to respond. It was added that filling the questionnaire depicts their consent and willingness to participate in the study. Then they were asked to fill the questionnaire and if any of them did not understand any of the items they were explained.

At first the Personal Identification Questionnaire was given and then the Semi Structured Questionnaire. As they completed, the questionnaire were collected and they were thanked for their participation, time and responses. The total time taken to complete the process of response for each individual was approximately 15 minutes, the time fluctuating by ± 10 minutes with different places.

Result and Discussion:

Frequencies and percentages of the responses were calculated and the Chi-square test was then applied to see the significant differences by Setting, Gender and Age with regard to attitudes on the three categories towards the people with mental illness.

Table 3: Beliefs and Attitude reflecting the acceptance of people with Mental Illness

	Percentages		
	Agree	Undecided	Disagree
Special care should be taken of a person with MI	88.8	0.4	10
Be allowed to take food together with family	37.7	15	47.3
You should feel free to communicate with him/her	59.4	4.4	36
She should be allowed to be a member of the social institution	29.8	.6	69.6
A person with MI could also become a productive member of the society if proper care and treatment is provided	31	8.8	60.2

The responses of the participants shows that 88.8% of the participants believes that a person with mental illness should be should be taken special care, 59.4% of the participants believes that one should feel free to communicate with a person with mental illness, nearly 31 % of the participants believes that a person with mental illness could also become a productive member of the society if proper care and treatment is provided. 37.7% of the participant believes that a person with mental illness should be allowed to take food with the family. But only .6% of the respondent believes that a person with mental illness should be allowed to be a member of the social institution. Table 3 shows the percentages of responses in the questionnaire.

Table 4: Beliefs and Attitude reflecting the exposure and knowledge on Mental illness

	Percentages		
	Agree	Undecided	Disagree
Anyone at any moment of life could be affected with MI	75.6	12.5	11.9
It is an illness like any other disease	52.5	20.2	27.3
MI is treatable	73.19	7.3	19.2
Well educated and intelligent people could also develop MI	81.3	7.7	11
Not be locked in a room	29	23.8	47.3
Listen to him/her unpredicted behavior	30	26.9	43.1
Be sent to mental hospital or jail	54.8	6.7	38.5
Seek treatment from specialist	83.5	3.5	12.9

The responses of the participants shows that about 83.5% of the participants believes that a person with mental illness should seek treatment from the specialist, 81.3% of the respondent believes that well educated and intelligent people could also develop mental illness where 11% disagree, 75.6% of the respondent believes that anyone at any moment of life could be affected with mental illness. 73.19% of the respondent believes that mental illness is treatable, 29% of the respondent believes that a person with mental illness should not be kept locked in a room whereas 47.3% disagree. Table 4 shows the percentages of responses in the questionnaire.

Table 5: Beliefs and Attitudes reflecting the stigma and discrimination

	Percentages		
	agree	undecided	Disagree
Women are mostly affected by MI	36.3	29.4	34.4
MI is due to evil spirit, wrath of God or black magic	46	26.2	27.5
MI is inherited	48.3	10.4	41.3
One should not marry a person in whose family there is MI people	61.7	9.2	29.2
MI people can best be helped by getting them married	52.7	7.5	39.8
The unacceptable behavior of a person with MI is done knowingly	13.3	19.8	66.9
If a mentally ill person refuses to take food or medicine it is best to ignore such person	24.6	31.3	42.2
Be punished for unacceptable behavior	26.9	9	64.2
Not be allowed to go out and meet new people	94.2	5.4	.4
Not be allowed to attend family functions	67.1	7.7	25.2
s/he should not be invited to visit you	61.5	3.8	34.8
You should not visit the family	20.8	26.7	52.5
Your children should not be allowed to play with him/her	88.8	0	11.3
During ones job period if one is affected with MI s/he should be soon dismissed	76	1.3	22.7
Faith healer can solve the problem	26.7	26	47.3
Should not be allowed to attend the social functions in the community	29.8	.6	69.6

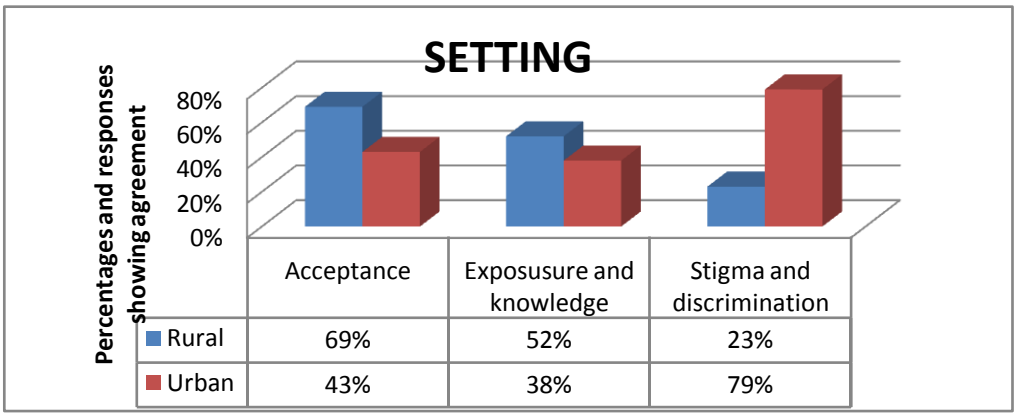
It was seen that 94.2% of the respondent has the believe that a person with mental illness should not be allowed to go out and meet new peoples, 88.8% believes that their children should not be allowed to play with a person having mental illness, 76% of the participants believes that during ones job period if one is affected with mental illness s/he should be soon dismissed, 61.7% believes that one should not marry a person in whose family there is mentally ill people, 36.3% of the respondent believes that women are mostly affected with mental illness. 31.3% of the respondent believes that if a mentally ill person refuses to take medicines it is bet to ignore such person, 46% believes that mental illness is due to evil spirit, wrath of God or black magic, 48.3% believes that mental illness is inherited, 26.7% of the respondent believes that faith healer can solve the problem, the respondent has the belief and attitude that a person with mental illness should not be allowed to attend the social functions in the community that is only 29.8%. 19.8% of the respondent believes that the unacceptable behavior of a person with mental illness is knowingly, 26.9% of the respondent believes that a person with mental illness should be punished for his/ her unacceptable behavior. Table 5 shows the percentages of responses in the questionnaire.

Table 6: Chi Square Values for Various Categories of Attitudes and Values

	Setting	Gender	Age
Beliefs and Attitudes toward Acceptance	6.561**	6.462**	75.163*
Beliefs and Attitudes toward Exposure and Knowledge	7.356**	4.255	7.491**
Beliefs and Attitudes toward Stigma and Discrimination	19.141*	2.325	8.558**

(*P < .01 ** P < .05)

Figure 1: Shows the differences of attitudes according to their setting

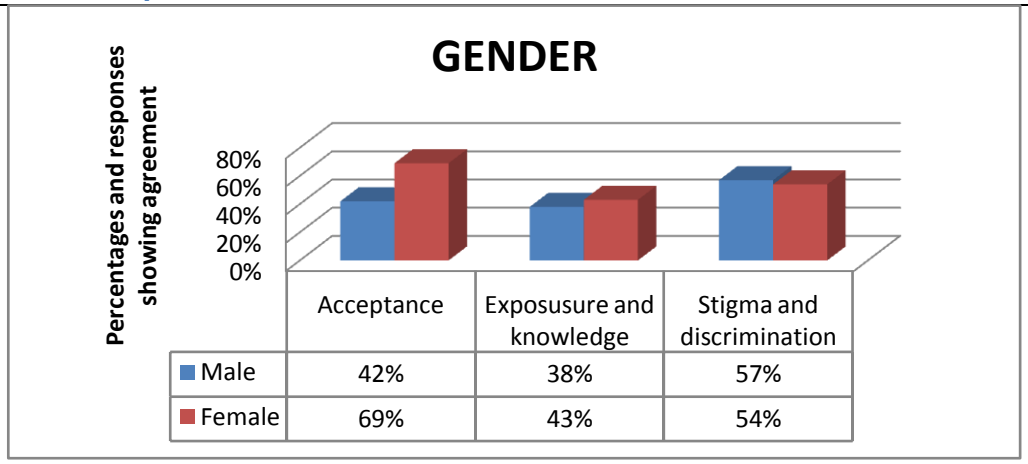


It was found that the calculated X2 value for beliefs and attitudes reflecting acceptance by setting is 6.561 (Table 6.) which was found to be significant at 0.05 level and hence it is inferred that there is a significant difference in beliefs and attitudes reflecting the acceptance by people from rural and urban setting. The percentages (figure 1) show the difference that the response of acceptance in rural setting i.e 69% is more than that of urban i.e 43%.

It was found that the calculated X2 value for beliefs and attitudes reflecting exposure and knowledge towards mental illness is 7.356 (Table 6.) which was found to be significant at the 0.05 level and hence it is inferred that there is a significant difference in the beliefs and attitudes reflecting exposure and knowledge towards mental illness by rural and urban setting. The percentages (figure 1) shows the difference in beliefs and attitudes reflecting exposure and knowledge towards mental illness in rural setting i.e 52% is more than that of urban i.e 38%. The people in the community at South Africa has less exposure and positive knowledge about mental illness.[11] It was found that the calculated X2 value for beliefs and attitudes reflecting stigma and discrimination towards mental illness is 19.141 (Table 6) which was found to be significant at the 0.01 level and it can be conclude that there is a significant difference in the beliefs and attitudes reflecting stigma and discrimination towards mental illness by rural and urban setting. The percentages (figure 1) show the difference in beliefs and attitudes reflecting stigma and discrimination towards mental illness, that there is a low percentage i.e 23% for stigma and discrimination in the rural setting than that of the urban setting i.e 79%. A study reveals that there are still misconceptions within the society regarding the signs and symptoms of psychopathology as minacious and discomfort which leads to the attitude that frequently nurture and promote stigma and discrimination toward the people with mental health problems.[12]

Figure 2: Shows the differences of attitudes according to their Gender

It was found that the

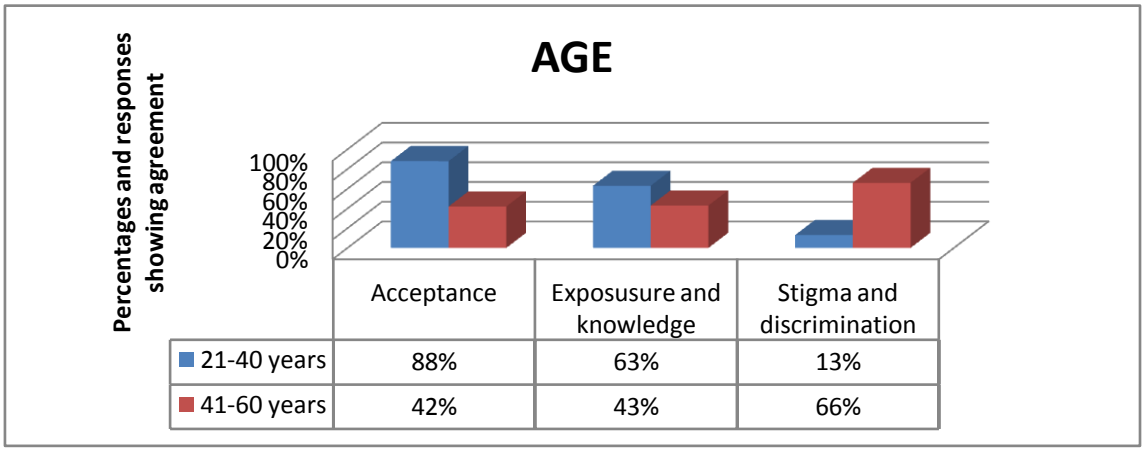


calculated X2 value for beliefs and attitudes reflecting acceptance of the people with mental illness is 6.462 (Table 6.) which was found to be significant at the 0.05 level and thus it may be concluded that there is a significant difference in the beliefs and attitudes reflecting as far as gender is concerned. The percentages shown above (figure 2) shows that the level of acceptance among female i.e 69% is higher than the male i.e 42%.

It was found that the calculated X2 value for beliefs and attitudes reflecting exposure and knowledge towards mental illness is 4.255 (Table 6.) Which was found to be significant at the 0.05 level and hence it can be inferred that there is no significant difference in the beliefs and attitudes reflecting exposure and knowledge towards mental illness with respect to the gender. The percentages shown above (figure 2) shows that the exposure and knowledge towards mental illness among female i.e 43% is higher than the male i.e 38%. The knowledge of mental illness among the general public is quite poor in Southern India.[12]

It was found that the calculated X2 value for beliefs and attitudes reflecting stigma and discrimination towards mental illness respect to the gender is 2.325(Table 3.) which was not found to be significant at 0.05 level and hence it can be inferred that there is no significant difference in the beliefs and attitudes reflecting stigma and discrimination towards the people with mental illness with respect to the gender, indicating that both males and female have similar beliefs and attitudes reflecting stigma and discrimination towards mental illness. But the percentages shown above (figure 2) shows a difference in the response in beliefs and attitudes reflecting the stigma and discrimination towards mental illness among male i.e 57% from female i.e 54% but it is not a significant or mark able difference.

Figure 3: Shows the differences of attitudes according to their Age:



It was found that the calculated X2 value for beliefs and attitudes reflecting by age group is 75.163 (Table 6.) which was found to be significant at 0.01 level and hence it can be inferred that there is a significant difference in the beliefs and attitudes reflecting acceptance of the people with mental illness. The percentages shown above (figure 3) show that that there is high difference of attitudes between the two age groups. It was seen that the percentage of acceptance is higher in the 21-40 years age group i.e. 88% than that of the 41-60 years age group i.e. 42%. Whereas in US adults are sympathetic towards people with mental illness thus they has more acceptance.[13]

It was found that the calculated X2 value for beliefs and attitudes reflecting exposure and knowledge towards mental illness with respect to age is 7.491(Table 6.) which was found to be significant at 0.05, and hence it can be inferred that there is a significant difference in the beliefs and attitudes reflecting exposure and knowledge towards mental illness with respect to age. The percentages shown above (figure 3) show a high difference of attitudes between the two age groups. It was seen that the percentage of exposure and knowledge towards mental illness is higher in the 21-40 years age group i.e. 63% than that of the 41-60 years age group i.e. 43%.

It was found that the calculated X2 value for beliefs and attitudes reflecting stigma and discrimination towards mental illness with respect to age is 8.558 (Table 6) which was found to be significant at 0.05 level and hence it can be inferred that there is a significant difference in the beliefs and attitudes reflecting stigma and discrimination towards mental illness with respect to age. The percentages shown above (figure 3) show the difference in the percentages that reflects beliefs and attitudes on stigma and discrimination towards the people with mental illness within the 21-40 years age group i.e. 13% having low percentage of stigma than that of the 41-60 years age group i.e 66%. Stigma and discrimination attached to mental illness was identified as a strong factor in availing treatment in Goa. [14]

III. CONCLUSION:

The finding of the study highlights the existing attitudes on acceptance, exposure and knowledge, stigma and discrimination on the people with mental illness among the people of two representative districts, that is Morigaon district and Sonitpur district of the Central Assam. The study reflects that there is a difference in beliefs and attitudes towards the people with mental illness by the setting, gender, and age as well.
Summary of the findings:

1) Acceptance is higher in rural setting, younger age group and female,
2) Exposure and knowledge is higher in rural setting, younger age group and female,
3) Stigma and discrimination is higher in urban setting, older age group and male.

Majority of the respondents from urban setting in this study seems to have fewer amounts of knowledge and exposure to the person with mental illness. Likewise it was seen that the stigma is higher in the urban society than that of the rural society which was always believed in other way as rural area to be more stigmatized. Therefore it can be said that more awareness program need to be conducted and the mass media need to take initiatives to make the people well aware about the root cause its possibilities, management and the consequences in urban areas.

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