RESEARCH

Knowledge and attitude towards mental illness of key informants and general population: a comparative study

Dilip Kumar, Pradeep Kumar[1], Amool Ranjan Singh[2], Samrat Singh Bhandari[3]

Psychiatric Social Worker, District Mental Health Programme, Ranchi Institute of Neuro-Psychiatry & Allied Sciences, Kanke, Ranchi, Jharkhand, India

[1]Psychiatric Social Worker, State Institute of Mental Health, Pt. Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana, India

[2]Professor and Head, Department of Clinical Psychology, Ranchi Institute of Neuro-Psychiatry & Allied Sciences, Kanke, Ranchi, Jharkhand, India

[3]Senior Resident of Psychiatry, Institute of Human Behaviour & Allied Sciences, Delhi, India

Abstract

Background: Adverse attitudes to mental illness are found in all societies in the world. The belief that mental illness is incurable or self-inflicted can also be damaging, leading to patients not being referred for appropriate mental health care. Aims of the present study were (1) to assess the attitude towards mental illness of key informant of patients and general population and (2) to compare the two groups in respect to attitude towards mental illness.

Material and methods: Sample based on purposive sampling technique consisting of 200 subjects (100 key informants and 100 from general population) within age range of 25-55 years had been taken. Sample of key informants was taken from Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) outpatients' department whereas the sample of general population was taken from Kanke area or within the radius of 5 K.M. from RINPAS, Kanke. Tools used were sociodemographic datasheet and self-developed checklist for assessing the attitude.

Results: (1) Significant difference was found in the area of nature, cause, after effect and community mental health ideology between both groups. (2) There was no significant difference in the area of treatment and stigma.

Conclusion: The findings of the present study suggested that there was growing awareness about mental illness even in general population and the people were being more receptive of the mentally ill people.

Kumar D, Kumar P, Singh AR, Bhandari SS. Knowledge and attitude towards mental illness of key informants and general population: a comparative study. Dysphrenia. 2012;3(1):57-64.

Keywords: Burden. Stigma. After effect. Community mental health. Awareness.

Correspondence: pradeep.meghu@gmail.com

Received on 24 November 2011. Accepted on 25 December 2011.

Introduction

A sound mental health is the key component of health. Absence of mental health could create a great deal of burden to the functioning of a nation.[1] Mental disorders are widely recognised as a major contributor (14%) to the global burden of disease worldwide.[2] The World Health Organization mentioned that approximately 45 million people are suffering from mental and behavioural disorders globally but small proportions of mentally ill people get adequate psychiatric treatment.[3] India, the largest country in South Asia, has to face the challenge of catering the burgeoning mental health needs of its people. In India, prevalence rates of mental and behavioural disorders are ranging from 9.54 to 370 per 1000 population.[4]

Stigma associated with mental illnesses acts as one of biggest hurdles in providing treatment to mentally ill people. Because of the stigma, the mentally ill people are perceived as "different" and are seen with negative attributes and are more likely to be rejected regardless of their behaviour.[5] Stigma is considered an amalgamation of three related problems: a lack of knowledge (ignorance), negative attitudes (prejudice) and exclusion or avoidance behaviours (discrimination). Scheff[6] reported that people who are labeled as mentally ill associate themselves with society's negative conceptions of mental illness and that society's negative reactions contribute to the incidence of mental disorder. The social rejection resulting from this may handicap mentally ill people even further.[7]

Of all the health problems, mental illnesses are poorly understood by the general public. Such 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 illnesses are treatable can encourage early treatment seeking and promote better outcomes.[8]

General public's view about mental illness remains largely unfavourable. The topic of mental illness itself evokes a feeling of fear, embarrassment or even disgust fostering negative attitudes towards mental illness and mentally ill people.[9] The reluctance to seek professional psychiatric help means late presentations are common. The extent to which patients benefit from improved mental health services is influenced not only by the quality and availability of services but also by their knowledge and belief systems.[10]

Verghese and Beig[11] found that people felt: marriage contributes to the improvement in the condition of the mentally ill, did not as to what extent could have caused mental illness and occurence of mental illness as a result of God punishment. Authoritarian attitudes were expressed by the higher economic group and by women.[12] Men expressed more benevolent attitudes. Heredity as the main cause of mental illness and traditional methods of treatment were preferred.[13]

Attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour.[14] In evaluating the patients and planning for their treatment and care, it also becomes necessary for the mental health professionals to assess the immediate social environment where the patient lives. The patient's social environment may actually become the primary target for therapeutic intervention.

The aims and objective of the study was to assess the attitude towards mental illness of key informant of patients and general population and to compare the two groups in respect to their attitudes towards mental illness. The researchers have made two hypotheses: (i) There will be no significant difference between key informants and general population in respect to attitude towards mental illness and (ii) there will be no significant difference between key informants and general population in terms of nature, cause, treatment, after effect, stigma and community mental health ideology.

Methodology

The study was conducted during December 2003 to March 2004. Sample was based on purposive technique and 200 subjects (100 key informants and 100 from general population) was taken from outpatients' department of Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS) whereas the sample of general group had been taken from an area within the radius of 5 km from the institute. Sociodemographic data sheet was used which contained information about age, sex, education status, residence, marital status, type of family and size of family and the self-developed checklist which was derived from three scales. (i) Opinions about Mental Illness (OMI) scale, developed by Cohen and Struening.[15] This five point scale also drew upon existing scales such as the Custodial Mental Illness Ideology (CMI) scale,[16] the California F scale[17] and Nunnally's multiple-item scale.[18] The five OMI scales were labeled as follows: authoritarianism, reflecting a view of the mentally ill as an inferior class acquiring coercive handling; benevolence, a paternalistic, sympathetic view of patients based on humanistic and religious principles; mental hygiene ideology, a medical model view of mental illness as an illness like any other; social restrictiveness, viewing the mentally ill as a threat to society; and interpersonal aetiology, reflecting a belief that mental illness arises from stresses in interpersonal experience. (ii) The Community Attitudes towards the Mentally Ill (CAMI) scale developed by Taylor *et al*.[19] The item pool for pre test purposes comprises 40 statements, ten for each of the four categories (authoritarianism, benevolence, social restrictiveness and community mental health ideology). The response format for each statement was the standard Likert five-point labeled scales. (iii) Orientation towards Mental Illness (OMI) scale developed by Prabhu.[20] It is a 95 item scale and providing scores in 13 factors which can be probably grouped into four categories: (a) Area of causation, (b) Perception of abnormality, (c) Treatment and (d) After effects.

After evaluating the threes scales, these were modified to achieve the objectives of measure to attitude towards mental illness and this check list was developed. It is a set of 50 questions consisting of six areas. These are (a) nature, (b) cause, (c) treatment, (d) after effects, (e) stigma and (f) community mental health ideology. The response format for each statement was rated by two points i.e. yes/no. It consisted following items in each area: (A) Nature (seven items), (B) Cause (six items), (C) Treatment (12 items), (D) After effects (six items), (E) Stigma (ten items) and (F) Community mental health ideology (nine items). Sample was selected from both sexes, age range 25 to 55 years, either first degree relatives of patient or the person who knows patient and his family for long time (for the key informants); the informant or person having any major psychiatric problem or substance abuse were excluded. The obtained data was analysed using descriptive statistical measures and chi square was applied to test the difference between various categories of the groups.

Results

Sociodemographic variables: Majority of respondents from both groups (key informant and general population) were male (83% and 73%), above

Table 1. Sociodemographic characteristics of key informants and general population

Variables		Key informant (N=100)	General Population (N=100)
Sex	Male	83	73
	Female	17	27
Age range (in years)	up to 25	18	21
	26-35	49	57
	36-45	21	12
	46-55	12	10
Residence	Rural	70	31
	Urban	24	46
	Semi-urban	6	23
Educational status	Non matric	19	12
	Up to matric	27	21
	Above matric	54	67
Occupational status	Unemployed	13	14
	Housewife	13	7
	Agricultural activity	14	27
	Service	25	35
	Others	35	17
Marital status	Unmarried	31	69
	Married	69	31
	Others	0	0
Type of family	Nuclear	35	37
	Joint	65	63
Size of family	Up to 5	27	39
	Up to 10	54	37
	Above 10	19	24
Monthly family income (In INR)	1000-3000	38	17
	3000-6000	34	34
	6000-9000	12	28
	Above 9000	16	21

matriculation in education (54% and 67%), resided in a joint family (65% and 63%). While 69% of key informants were married, 31% of general population sample were married. Fifty eight percent of key informants visited a mental hospital and so did 40% of controls. Table 1 shows the detailed sociodemographic pattern of sample key informants and general population.

Nature: Table 2 and figure 1 indicate that key informants of the patients were more aware and exhibited more positive attitude towards mental illness in comparison to general population except in the response of item number N1, N2 and N5. Statistically significant difference was found in items 1, 4, 5 and 6.

Cause: Interestingly, it was noted that general population were little more aware and had positive attitude towards the cause of mental illness in comparison to key informants except item numbers C1 and C6. The items C1 and C6 signify 'unsatisfactory marital life' and 'conflict within family' as a cause of mental illness. However these results were not statistically significant.

After effect: Some significantly varying changes were found between the two groups when compared for after effects of mental illnesses. The key informants were more aware and had positive attitude towards mental illness on every item except AF4 which signified mental patient who had been already treated as the patient in mental hospital were not more dangerous in comparison to civilians. On the item AF5 the response given from both groups were equal and indicated that both groups had equal knowledge.

Community Mental Health: The key informants were more aware and had positive attitude to community mental health ideology on the response in item number CM15, CM17, CM18 and CM19 where the general population were having higher positive attitude towards community mental health ideology in context of mental illness. These items signified respectively 'mentally ill person should not get admitted in mental hospital until he/she does not harm to anyone,' 'to keep mental patient in residential area may be a good mode of treatment but it may endanger to the local people residing in that area,' 'mental patient should

Table 2. Items on each area showing total number of 'YES' responses in both the study groups (this table enlists statistically significant results)

Item number	Measure of attitude/ knowledge	Number of respondents who answered 'YES'		Chi-squared value	P-value
		Key-informants (n=100)	General Population (n=100)		
Nature					
1	Negative	88	75	5.604	0.02
4	Positive	60	44	5.128	0.05
5	Positive	44	61	5.794	0.02
6	Positive	86	68	9.147	0.01
After effects					
2	Positive	89	75	6.640	0.01
3	Positive	68	85	8.038	0.01
Community Mental Health					
2	Positive	97	89	4.916	0.05
6	Positive	81	64	7.248	0.01
Stigma					
2	Negative	32	16	7.018	0.01
6	Negative	31	18	4.568	0.05
7	Negative	81	56	14.483	0.001
Treatment					
2	Positive	83	93	4.735	0.05
3	Negative	51	75	12.355	0.001
8	Positive	100	88	12.766	0.001
9	Negative	53	24	17.759	0.001

be treated within the society,' 'if the person suffers from mental problem appears in locality then he should only be get admitted in mental hospital.'

Stigma: The pattern of responses was interesting here. When it came to questions about etiquette, high percentage showed positive outlook as in item number ten which was 'we should not laugh at mentally ill people.' However when it came to 'should the Mental Institutions be far from residential places,' around 50% people answered in affirmative. On the other items, positive attitude responses were ranging 25-40%. Thus it showed that stigma still was a problem with both general population and key informants as there was no difference of opinions between the groups.

Treatment: Both the groups scored equally in the item scores which measured the attitude towards treatment of mentally ill people. The values were towards positive side which showed better awareness and positive outlook to treatment of mentally ill people.

Discussion

The present study had been specially planned and designed to examine the attitude of key informant of the patients coming for psychiatric consultation at the RINPAS and also on the adult individual without having known family history of mental illness. It had been found that majority of the subjects had nonacceptance of patients with mental illness and a negative attitude towards mental illness.[21] Numerous studies have been carried out in past to examine the outcome of a given mental disorder in context to psychosocial background and the results had clearly indicated that the patients coming from families with positive attitude towards the patients seemed to give better result because of better therapeutic compliance.[8] Social and family support had been found to strengthen the confidence of the patients for his or her early recovery from the illness.[22] Some researchers suggested that social support served as a protective buffer.[23,24] Other studies reported that individuals with schizophrenia had small circle of supportive people than usual and shown that small size of social network found among individuals with schizophrenia could negatively affect the course of their illness.[24-27]

The results of the present study suggested that there was significant difference between the attitude of key informant of the patients and general population. The main area of difference was in the knowledge and orientation about nature, cause, after effect and community mental health ideology. The key informants of the patients were found to be more aware about the nature of illness in comparison to controls. The same can be explained on the basis of the fact that the general population has a vague idea about the clinical picture of the mental illness. But the key informant who saw the

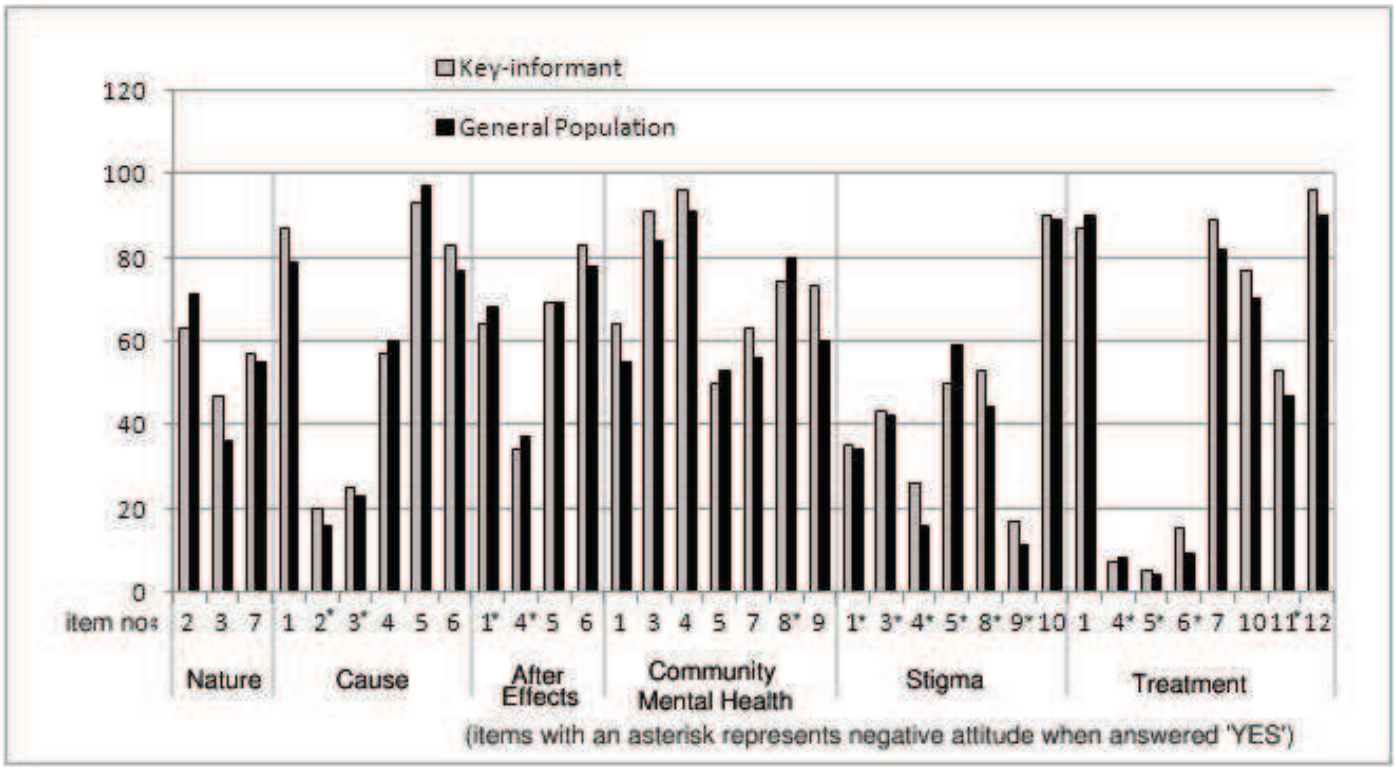

Figure 1 Items on each area showing total number of 'YES' responses in both the study groups. This figure shows statistically non-significant results (P value > 0.5)

process of development of mental illness could see the clinical picture in more personal way.

Majority of the key informants reported that they could easily distinguish the person suffering with and without mental illness. Higher number of key informant in this category reflects or can easily be explained on the basis that the institute is a tertiary care center for psychiatric patients. The institute caters patients from different parts of the state including neighbouring state. More than 99% of the total cases are brought when the patients are highly excited, unusually disturbed, manifesting major behavioural problem including lack of personal hygiene and communication. Hence the perceptions of such guardians are obvious by the fact that they can easily recognise mentally ill person who actually does not include the patients with mild psychological disturbances. Similar findings were reported by Padamadan.[28]

On the other hand the controls are from the periphery of the institute which is a suburban area and has three large mental hospitals in the locality. They are in touch with various newspapers, reading different articles about different type of milder psychological disturbances which are mostly authored by mental health professionals of these mental hospitals. This explains the possible reason of better understanding about mental illness of this group on item numbers N1, N2, N5 in comparison to key informants who come from distant place, mostly from rural background.

Regarding the cause of mental illness significant difference was found between both the groups. The controls were slightly more aware about the cause of mental illness. The probable reason about such kind of awareness might be associated with the fact of suburban residence, reading newspapers which publish topics on mental problem. Whereas on the item ‘unsatisfactory marital life may be cause of mental illness’ and ‘family conflict was supposed to be a cause of mental illness’ where the key informants were little more aware, the probable reason may be that they are familiar to the family of mentally ill person and seen the development of mental illness. It can also be argued that counseling regarding psychosocial aspect of mental illness has affected positively the guardians or key informants in the area of “after effect.” In area of community mental health ideology it can be said that gradually the general public has started understanding the necessity of delivery of health services at their door steps. Similar views have emerged in respect to the mental health care. The subjects of our both the groups also expressed the need of such services for providing community mental health care. Still marginally higher number of subjects belonging to key informant group highlighted the better understanding of such community based requirement. This might be due to various sociovocational rehabilitation programmes which are being undertaken especially for the patients who did not have any employment/occupation prior to the admission in the institute. The guardians of the patients are always counseled to keep the recovering patients in one or other vocational activity when the patients go back home from the institute. Follow up is the other major problem for the patients coming from distance places. So their preference of community mental health programme is obvious.

In the present study no significant difference had been found regarding social stigma associated with mental illness and treatment of mentally ill whereas social stigma was seen in various studies.[29-32] Previous studies reported that social stigma was positively associated with negative attitude towards the mental illness however the findings of the present study indicated that majority of subject in both the groups did not find social stigma being negatively associated with mental illness. This showed better understanding about the nature of illness of our subjects belonging to both the category.

Regarding treatment, both of the groups had more or less real perception about the scientific mode of treatment and its efficacy. So their misconception about the treatment modalities was destigmatising, updated and becoming more scientific. It may be because of close association with mental hospital.

Conclusions

The findings of the present study suggested that there was growing awareness about mental illness even in general population and the people were being more receptive of the mentally ill people. The findings also highlighted some major deficits in terms of information and knowledge about mental illness specially in context of: Mentally ill person could be easily discriminated in comparison to normal, relatively less awareness in general population in term of unsatisfactory marital relationship and family conflict as a causative factor of mental illness, mentally ill person should not get admitted in hospital until he/she does not harm to any one, mentally ill person should be treated within society. In the area of stigma and treatment no significant difference was found.

References

1. Kumar A. District Mental Health Programme in India: a case study. Journal of Health and Development. 2005;1:24-35.

2. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, *et al*. No health without mental health. Lancet. 2007;370:859-77.

3. Levav I, Rutz W. The WHO World Health Report 2001 new understanding—new hope. Isr J Psychiatry Relat Sci. 2002;39:50-6.

4. Math SB, Chandrashekar CR, Bhugra D. Psychiatric epidemiology in India. Indian J Med Res. 2007;126:183-92.

5. Arkar H, Eker D. Effect of psychiatric labels on attitudes toward mental illness in a Turkish sample. Int J Soc Psychiatry. 1994;40:205-13.

6. Scheff TJ. Being mentally ill: a sociological theory. Chicago: Aldine, 1966.

7. Scheff T J. Accountability in psychiatric diagnosis: a proposal. In: Millon T, Klerman G, editors. Contemporary directions in psychopathology: toward the DSM-IV. New York: Guilford; 1986. p. 265-78.

8. Stuart H, Arboleda-Flórez J. Community attitudes toward people with schizophrenia. Can J Psychiatry. 2001;46:245-52.

9. Bhugra D, Buchanan A. Attitude towards mental illness. In: Bhugra D, Leff J, editors. Principles of social psychiatry. Oxford: Blackwell Scientific Publications; 1993. p. 385-399.

10. Kleinman A. Rethinking psychiatry: from cultural category to personal experience. New York: Free Press; 1991.

11. Verghese A, Beig A. Public attitudes towards mental illness: The Vellore Study. Indian J Psychiatry. 1974;16:8-18.

12. Kshama R, Channabasavanna S M. A study of attitudes of relatives of mentally ill undergoing hospitalization. Indian J Soc Work. 1974;3:21-4.

13. Boral GC, Bagchi R, Nandi DN. An opinion survey about the causes and treatment of mental illness and the social acceptance of the mentally ill patients. Indian J Psychiatry. 1980;22:235-8.

14. Eagly AH, Chaiken S. The psychology of attitudes. Fort Worth, TX: Harcourt Brace Jovanovich; 1993.

15. Cohen J, Struening EL. Opinions about mental illness in the personnel of two large mental hospitals. J Abnorm Soc Psychol. 1962;64:349-60.

16. Gilber DC, Levinson DJ. Ideology, personality, and institutional policy in the mental hospital. J Abnormal Psychol. 1956;53:263-71.

17. Adorno T W, Frenkel-Brunswik E, Levinson DJ, Sanford RN. The authoritarian personality. Oxford: Harpers; 1950.

18. Nunnally J. Popular conceptions of mental health: their development and change. New York: Holt, Rinehart and Winston; 1966.

19. Taylor SM, Dear MJ, Hall GB. Attitudes toward the mentally ill and reactions to mental health facilities. Soc Sci Med Med Geogr. 1979;13D:281-90.

20. Prabhu GG. Mental illness: public attitudes and public education. Prof. M.V. Gopala Swamy Memorial Oration. Indian J Clin Psychol. 1983;10:13-26.

21. Ganesh K. Knowledge and attitude of mental illness among general public of Southern India. National Journal of Community Medicine. 2011;2:175-8.

22. Alloway R, Bebbington P. The buffer theory of social support—a review of the literature. Psychol Med. 1987;17:91-108.

23. Thoits PA. Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. J Health Soc Behav. 1982;23:145-59.

24. Cohen S, Wills TA. Stress, social support, and the buffering hypothesis. Psychol Bull. 1985;98:310-57.

25. Hamera EK, Peterson KA, Handley SM, Plumlee AA, Frank-Ragan E. Patient self-regulation and functioning in schizophrenia. Hosp Community Psychiatry. 1991;42:630-1.

26. Cohen CI, Sokolovsky J. Schizophrenia and social networks: ex-patients in the inner city. Schizophr Bull. 1978;4:546-60.

27. Gottlieb BH. Assessing and strengthening the impact of social support on mental illness health. Soc Work. 1981;30:293-301.

28. Padamadan JG. Society views mental illness. Dissertation (DM & SP) submitted to the Bangalore University, Bangalore; 1974.

29. Bhaskaran K. The unwanted patient. Indian J Psychiatry. 1970;12:1-12.

30. Neki JS. Problems of motivation affecting the psychiatrist, the general practitioner and the public in their interactions in the field of mental health. Indian J Psychiatry. 1966;8:117-24.

31. Raguram R, Venkateswaran A, Ramakrishna J, Weiss MG. Traditional community resources for mental health: a report of temple healing from India. BMJ. 2002;325:38-40.

32. Thoits PA. Resisting the stigma of mental illness. Soc Psychol Q. 2011;74:6-28.

Appendix

CHECKLIST FOR ATTITUDE TOWARDS MENTAL ILLNESS

NATURE:

People with mental illness can be better identified?
People taking excessive substances can be labeled as psychiatric patients?
Epileptic patients can be grouped under psychiatric patients?
Harming others can be said as mental illness?
Suicide can be said as a symptom of mental illness?
“Talking to oneself” is a symptom of mental illness?
“Suspecting people” is one of the symptoms of mental illness?

CAUSES:

Unsatisfied marital life is one of the causes of mental illness?
Evil spirits causes mental illness?
Too much hard work causes mental illness?
Failure in life can be considered as one of the causes?
One of the causes of mental illness is tension and pressure?
Disharmony in the family can cause mental illness?

AFTER EFFECT:

Many women who have taken indoor treatment in mental hospital behave as child?
Patients with mental illness can live as normal people after treatment?
Patients who have taken treatment from psychiatric hospitals are less dangerous than who have not taken?
After recovery from mental illness patients cannot do technical works?
Patients taken indoor treatment in a psychiatric hospital are more dangerous than normal people?
Mental illness affects social relations?

COMMUNITY MENTAL HEALTH IDEOLOGY:

Patient with severe mental illness should be kept in the category of disabled?
It is our duty to take better care of people with mental illness?
Family can play important role in the treatment of patient with mental illness?
Patients with mental illness should get special benefits from government?
Patient with mental illness should not be admitted in psychiatric hospital until he harms himself or others?
There is no danger in establishing psychiatric facilities in residential areas?
It is good to establish psychiatric facilities in residential areas but it poses danger to the normal population of that area?
People with mental illness should be treated in the society?
People with psychological problems when seen should be admitted in a psychiatric hospital?

STIGMA:

After treatment patient with mental illness should not be allowed to work in government offices?

People once affected with mental illness keeps on doing thing against social norms?

It is unwise to marry person with mental illness?

To keep patient with mental illness under control it is better to keep them inside locked room?

Patients with mental illness should not be given any responsibilities?

Patients with mental illness are unwanted load on society?

Psychiatric hospital should be away from cities so that normal people does not get any problems?

It is dangerous to live in the neighborhood of person with mental illness?

It is wise to take divorce once the spouse is affected with mental illness?

Even though people with mental illness may behave inappropriately but it is no good to laugh at them?

TREATMENT:

Solving problems is considered important in the treatment of patient with mental illness?

Psychosocial treatment along with pharmacological treatment is important for people with mental illness?

Marriage usually cures mental illness?

Electroconvulsive therapy is the only treatment of mental illness.

Treatment from faith healers is the only way to treat mental illness?

Person with mental illness are treated by keeping them away from others or by keeping them chained?

The best way to treat mental illness is by teaching to control emotions?

Family support plays significant role in the treatment of mental illness?

The only treatment of mental illness is medicines.

Persons with mental illness when motivated to work as per their abilities treat their illness?

Religious activities help in the treatment of mental illness?

Good company helps in the treatment of mental illness?