A Comparative Study to assess the Myths, Beliefs and Perceptions about Mental Disorders among the General Population in Selected Rural and Urban Areas at Gonda District, U.P. in the View to Develop an Information Booklet

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Abstract

The objective of the study is to compare the assessment of the myths, beliefs and perceptions about mental disorder in general population among urban areas. The conceptual framework used in this study was based on Rosenstock's and Becker's health Belief Model (1974). The study was used non-experimental descriptive and comparative study design. The sample comprised of general population Bhadhva Tarhar (Rural area) 300 + Pantnagar (Urban area) 300). Non-Probability convenient sampling technique was used to select the sample. Data was collected using Sociodemographic variables and likert Scale to assess the Myths, belief and perception among general population. The result presented that there was a significant difference in the rural and urban mean score and the findings were statistically significant at 0.05 level of significance. In rural 45.3% had bad level, 37.7% had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder. The investigator is grateful for the experience gained through this study.

Keywords: Myths; beliefs; Perception; General Population; Urban Area and Rural Area.

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INTRODUCTION

Mental and behavioral disorders are existing about 11% of the adult population all over the world. The mental disorders are highest among young adults, the most productive section of the people. Neuropsychiatry conditions together reason for 12% of the global problem of disease as measured by disability adjusted life years (DALYs). Plans estimation by the year 2020, neuropsychiatric conditions will account for 15%

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of disabilities worldwide, with unipolar depression alone responsible for 6% of DALYs and will stand second in top 10 leading causes of in capacity.[1] *(WHO, 2019)*.

In India, the occurrence of mental disorders are from 11 to 380 per 1000 population in different parts of the nation. The median conservative estimate of 65 per 1000 population has been given by Gururaj *et al.* (2015). The rates are high in females by 21-25%. As far as causation of mental illness is concerned, there are many issues similar to any other world community, but delayed health seeking behavior, cultural, illiteracy and geographic distribution of people are distinct for India.[2] *(Reddy & Chandrashekar, 2018)*.

Access to adequate mental health care always falls short of both implicit and explicit needs. This can be explained in part by the fact that mental illness is still not well understood, often unnoticed, and considered an offensive. The mentally ill, their families and relatives, as well as specialists providing particular care, are still the thing of marked stigmatization. These attitudes are intensely entrenched in society. The idea of mental illness is often related with fear of potential threat of patients with such diseases. Adverse, fear, attitude and ignorance of mental illness can result in an in adequate focus on a patient's physical fitness needs. The belief that mental illness is incurable or self-inflicted can also be damaging, leading to patients not being referred for suitable mental health care.[3] *(Kishore, 2014)*.

Need For the Study

Mental diseases have an effect on everybody in a way. Somebody World Health Organization has intimate with a mental illness at some purpose. However, there are still several hurtful attitudes around mental diseases that fuel stigma and discrimination and create it tougher to succeed in out for facilitate. the subsequent are the myths concerning mental state. Mental diseases aren't real diseases, mental diseases are simply associate degree excuse for poor behavior, unhealthy parenting causes mental diseases, folks with mental diseases are violent and dangerous, folks don't get over mental diseases, those who expertise mental diseases are weak and can't handle stress, those who expertise mental diseases can't work, youngsters can't have a mental state like depression and those are adult problems; everybody gets depressed as they age. It's simply a part of the aging method.[4]

Changing attitudes and behaviors takes time, and it would seem to be one person can't presumably build a distinction. Actually, everybody will realize tiny ways in which to assist. First, place confidence in wherever our info comes from. Thinking critically regarding wherever our info comes from will facilitate U.S. Separate sensational stories from balanced points of view. Second, all folks will support laws and practices in our communities that stop discrimination against people with mental diseases and promote inclusion. Third, all peoples will pay time with those that expertise mental diseases to share and learn from one another. This is often best once most are in associate degree equal position of power. Volunteering with a community organization could be a good way to attach with others.[5] *(Canadian Mental Health Association, 2017)*.

A cross-sectional study was administered with a sample of 436 subjects (360 subjects from urban and rural communities of Delhi and 76 medical professionals working in numerous organizations in Delhi). A pre-tested form consisting things on perceptions, myths, and beliefs regarding causes, treatment, and health seeking behavior for mental disorders was used. The mental disorders were thought to be owing to loss of semen or vaginal secretion (33.9% rural, 8.6% urban, 1.3% professionals), less sexual desire (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's social control for his or her past sins (39.6% rural, 20.7% urban, 5.2% professionals), and impure air (51.5% rural, 11.5% urban, 5.2% professionals). A lot of individuals in rural areas than in geographical area thought that keeping fasting or a religion expert will cure them from mental diseases, where as 11.8% of medical professionals believed the same. Most of the individuals rumored that they likable to travel to somebody close who might hear their issues, after they were unhappy and anxious. Only 15.6% of urban and 34.4% of the agricultural population rumored that they might prefer to head to a medical specialist after they or their relations are stricken by psychopathy. This study concluded that the myths and misconceptions are considerably a lot of prevailing in rural areas than in urban areas and also the individuals ought to be communicated to vary their behavior and develop a positive angle toward mental disorders so health seeking behavior will improve.[6] *(Jugal, Avni, Ram, & Patrick, 2011)*.

From the above study the researcher came to know there is lot of myths, beliefs and perception surveying in the society in bad level. It makes the people to away from psychiatric treatments. Therefore, it is necessary to find the level of myths, beliefs and perception on mental illness in

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different places, for that the researcher chose this comparative study, so that we can increase the awareness on mental illness mental health, reduce the bad level of myths, beliefs and perception on mental illness.

Problem Statement

A comparative study to assess the myths, beliefs and perceptions about mental disorders among general population in selected rural and urban areas at Gonda district, U.P. in the view to develop an information booklet.

Objectives of the Study

1. To assess the myths, beliefs and perceptions about mental disorder in general population among rural areas at Gonda District, U.P.
2. To assess the myths, beliefs and perceptions about mental disorder in general population among urban areas at Gonda District, U.P.
3. To compare the values of myths, beliefs and perceptions about mental disorder between the general population among selected rural and urban areas at Gonda district, U.P.
4. To associate the values of myths, beliefs and perceptions about mental disorder of rural and urban with their demographic values.
5. To develop an information booklet regarding myths, beliefs and perceptions about mental disorder.

Hypothesis

H_1: There will be a significant association between the values of myths, beliefs and perceptions about mental disorder of rural and urban with their demographic values.

H_2: There will be a significant difference between the values of myths, beliefs and perceptions about mental disorder of rural and urban area population.

Operational Definitions

Comparative Study: In this study it refers that comparative study is a research methodology that aims to make comparisons between population among selected rural and urban areas at Gonda district, U.P. to assess the myths, beliefs and perceptions about mental disorders.

Assess: In this study it refers that the evaluation or estimation of myths, beliefs and perceptions about mental disorders in general population among selected rural and urban areas at Gonda district, U.P. in the view to develop an information booklet.

Myths: In this study it refers, a widely held but false belief or idea that explaining a natural or social phenomenon, and typically involving supernatural beings or events in the cases of mental disorders.

Beliefs: An acceptance that something exists or is true, especially one without proof in the attitude towards mental illness.

Perceptions: In this study it refers, the ability to become aware of the nature of mental disorder.

Mental disorders: A mental disorder, also called a mental illness or psychiatric disorder, is a behavioral or mental pattern that causes significant distress or impairment of personal functioning. Such features may be persistent, relapsing and remitting, or occur as a single episode.

Information booklet: A small, thin book with paper covers, typically giving information on amyths, beliefs and perceptions about mental disorders in general population.

Assumptions

1. The information booklet helps an individual to get the knowledge about mental illness.
2. Myths, belief and perceptions are more common in rural areas.
3. There will be a little different in values of myths, beliefs and perceptions about mental disorder of rural and urban area population.
4. Information book let help to improve the awareness among rural and urban area population.

Delimitations

The study will be limited to:

1. 600 (300 from rural area+300 from urban area) general population from Bhadhva Tarhar (Rural Area) & Pantnagar (Urban Area).
2. This study only involves the general population from selected area from Gonda district, Uttar pardesh only.

Review of Literature

Review of literature related to prevalence of mental disorder.

Ganguli (2015) conducted a study, during these fifteen epidemiological studies on psychiatric morbidity in India are analyzed. National all India prevalence rates for 'all mental disorders' and 5 specific disorders are discovered the national prevalence rates for 'all mental disorders' found out are 71 (Rural), 73 (Urban) and 73 (Rural + Urban) per 1000 population. Prevalence of schizophrenia

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is 2.5/1000 and this looks to be the sole disorder whose prevalence is consistent across cultures and over time. Rates for depression, neurosis, hysteria and stupidity are provided. Urban morbidity in India is 4% over the rural rate, however rural urban variations aren't consistent for various malady classes. In Hindi speaking north India, mental morbidity amongst factory staff is 2 and half times that of the non-industrial urban inhabitants and 5 times the rural morbidity. This information is anticipated to function baseline rates for mental health planners and for psychiatrists curious about epidemiological studies.[7]

Review of Literature related to Myths, Beliefs and Perception about Mental Disorder

Jugal, Avni, Ram, & Patrick, (2011) conducted a cross-sectional study. They administered with a sample of 436 subjects there in 360 subjects from urban and rural communities of city and 76 medical professionals working in several organizations in Delhi. A pre-tested questionnaire consisting things on perceptions, myths, and beliefs regarding causes, treatment, and health-seeking behavior for mental disorders was used. The collected knowledge was statistically analyzed exploitation laptop software system package Epi-info. The result shows that the mental disorders were thought to be owing to loss of humor or channel secretion (33.9% rural, 8.6% urban, 1.3% professionals), less physical attraction (23.7% rural, 18% urban), excessive masturbation (15.3% rural, 9.8% urban), God's penalty for his or her past sins (39.6% rural, 20.7% urban, 5.2% professionals), and impure air (51.5% rural, 11.5% urban, 5.2% professionals). A lot of individuals (37.7%) living in joint families than in nuclear families (26.5%) believed that unhappiness and unhappiness cause mental disorders. 34.8% of the agricultural subjects and 18 of the urban subjects believed that youngsters don't get mental disorders, which suggests they need conception of adult oriented mental disorders. 40.2% in rural areas, 34% in urban areas, and 8% professionals believed that mental diseases are untreatable. Only 15.6% of urban and 34.4% of the rural population according that they might wish to attend a psychiatrist once they or their members of the family are stricken by mental illness.[8]

MATERIALS AND METHODS

Research Approach: Research approach could be a arrange and procedure that consists of the steps of broad assumptions to elaborate technique of information collection, analysis and interpretation. it's thus, supported the character of the analysis drawback being self-addressed. The research approach selected for this study is quantitative approach.

Research Design: The research design refers to "the researcher's overall plan for obtaining answer to the research question and it spells out strategies that the researcher adopted to develop information that is accurate, objective and interpretable."[9]

It helps the researcher in selection of subjects, comparison of two groups. In this study the non-experimental descriptive and comparative study design was done. This design helps the researcher to compare two groups to find the different between the variations among samples.

Variables under the study

Study Variable: The study variable in this study is general populations' level of myths, beliefs and perception about mental illness.

Socio Demographic Variables: It consists of gender, age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family.

Setting of the Study: Setting is a physical location and condition in which data collection takes place. The investigator selected two areas Bhadhva Tarhar (Rural area) & Pantnagar (Urban area) in Gonda district for the present study.

Population: Bhadhva Tarhar (Rural area) compresses the population of approximate 4930 and Pantnagar (Urban area) compresses the population of approximate 3500.

Sample: In this study the samples are from Bhadhva Tarhar (Rural area) 300 + Pantnagar (Urban area) 300.

Sample Size: In this study the sample size is 600. 300 from Bhadhva Tarhar (Rural area) and another 300 from Pantnagar (Urban Area).

Sampling Technique: For selection of the sample the Non-Probability convenient sampling technique was used.

Sampling Criteria: The sample was selected with the following predetermined set criteria during the period of study.

Inclusive Criteria:

1. Those who are interested to participate in this study.
2. Those who are available on the day of data

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collection.

3. Those who can speak Hindi Language.
4. Those who are aged more than 14 years.

Exclusion criteria:

1. Those who are not able to understand the concept of the research study.
2. Those who don't know Hindi language.
3. Those who are aged less than 15 years.

Description of the Research Tool

Section A: Demographic variable which include gender, age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family.

Section B: It consists of likert Scale to assess the Myths, belief and perception among general population. It has 30 questions. Each question has 5 likert scale options such as strongly agree, mildly agree, neutral, mildly disagree and strongly disagree.

Maximum Mark per items = 4; Minimum Mark per item = 0; Maximum mark for the questionnaire = 120; Minimum mark for the questionnaire = 0.

For Positive Questions: Strongly agree = 4; Mildly Agree = 3; Neutral = 2; Mildly Disagree = 1; Strongly Disagree = 0.

For Negative Questions: Strongly agree = 0; Mildly Agree = 1; Neutral = 2; Mildly Disagree = 3; Strongly Disagree = 4.

Pilot Study: Pilot study was conducted from 28-11-2018 to 16-12-2018 in Bhadhva Tarhar (Rural area) & Pantnagar (Urban area). The pilot study was conducted to check the clarity, reliability and feasibility of the research tool. 60 samples who fulfilled the inclusion criteria were selected by Non-Probability convenient sampling technique. 30 from rural area and 30 from urban area.

RESULTS

Table 1: Percentage and frequency distribution of respondents by gender, age in years, type of family and family income per month

N = 300+300=600

Demographic Variable	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Gender				
Male	150	50	150	50
Female	150	50	150	50
Age in years				
15-25	42	14	44	15
26-35	80	27	55	18
36-45	90	30	121	40
46-55	61	20	51	17
56 and above	27	9	29	10
Type of family				
Nuclear family	94	31	155	52
Joint family	206	69	145	48
Family income per month (in Rupees)				
Below 10000	81	27	55	18
10000 to 20000	189	63	163	54
Above 20000	30	10	82	27

The above table 1 implies that in rural and urban area maximum 150 (50.0%) respondents are males. In rural area maximum 90 (30.0%) respondents were 36-45 years old. In urban area maximum 121 (40.3%) respondents were aged between 36-45 years old. In rural area maximum 206 (68.7%) respondents were belongs to joint family In urban area maximum 155 (51.7%) respondents were from nuclear family. In rural area maximum 189 (63.0%) respondents family income per month was Rs. 10000 to Rs. 20000. In urban area maximum 163 (54.3%) respondents family income per month was Rs. 10000 to Rs. 20000.
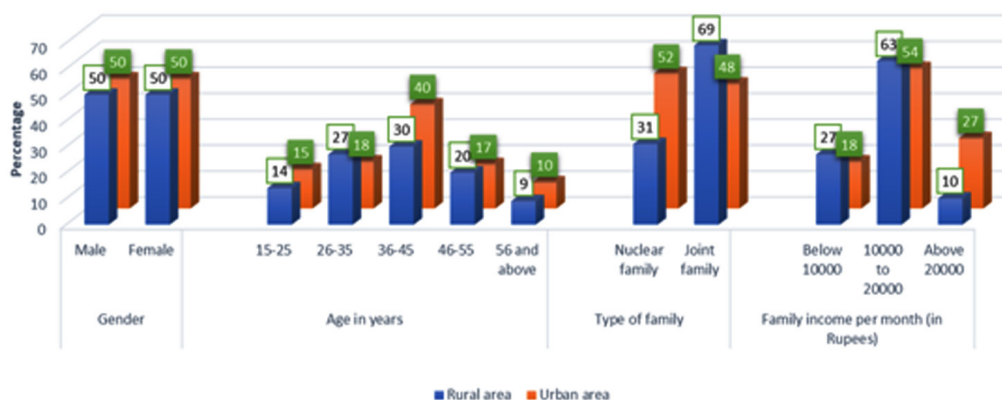
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Fig. 1: Percentage distribution of gender, age in years, type of family and family income per month

Table 2: Percentage and frequency distribution of respondents by education, religion, occupation and experience of mental disorders in family.

N = 300+300=600

Demographic Variable	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Education				
Illiterate	191	64	22	7
Primary Education	49	16	116	39
Graduate	31	10	100	33
Postgraduate	29	10	62	21
Religion				
Hindu	182	61	150	50
Muslim	69	23	96	32
Christian	27	9	28	9
Other religion	22	7	26	9
Occupation				
Unemployed	21	7	15	5
Private job	59	20	99	33
Government job	42	14	56	19
Business	32	11	63	21
Coolie	76	25	42	14
Agriculture	70	23	25	8
Experience of mental disorders in family				
Yes	61	20	70	23
No	239	80	230	77

The above table 2 implies that in rural area maximum 191 (63.7%) respondents were illiterate. In urban area maximum 138 (46.0%) respondents' maximum education was primary education. In rural area maximum 182 (60.7%) respondents and in urban area 133 (44.3%) respondents were Hindu. In rural area maximum 76 (25.3%) respondents are coolie workers. In urban area maximum 99 (33.0%) respondents were in private job. In rural area maximum 239 (79.7%) respondents and in urban area 230 (76.7%) respondents were not experienced mental disorder in their family.
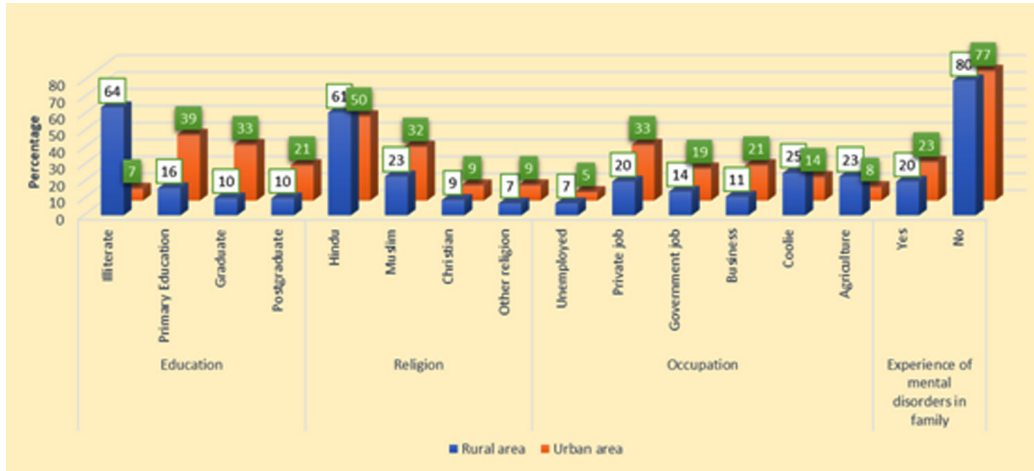
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Fig. 2: Percentage distribution of education, religion, occupation and experience of mental disorders in family

Table 3: Compare the level of myths, beliefs and perceptions about mental disorder between the general population among selected rural and urban areas

N=300

Level	Rural Area		Urban Area	
	Frequency	Percentage	Frequency	Percentage
Bad	136	45%	55	18%
Poor	113	38%	146	49%
Good	51	17%	99	33%

Above table 3 compares the rural and urban area samples level of myths, beliefs and perceptions about mental disorder. In rural 45.3% had bad level 37.7% had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder.

Table 4: Find the significant difference between rural and urban area general populations' level of myths, beliefs and perceptions about mental disorders

N=300+300=600

S. no.	Area	Mean	Mean %	SD	SE	'z' value	'p' value
1	Rural	60.39	50.3	29.637	2.18	9.3	0.05
2	Urban	81.00	67.50	23.390			

The above table 4 shows that the calculated z value is more than the tabulated value 2.0 at 0.05 level of significance, therefore the hypothesis H2 was accepted. It shows that there is a significant difference between the rural and urban area general populations level of myths, beliefs and perceptions about mental disorder.

Table 5: Associate the values of myths, beliefs and perceptions about mental disorder of rural area with their demographic values.

N=300

Demographic variables	Level		N	df	χ2	P-value	P<0.05
	Below Median	>= Median					
Gender							
Male	78	72	150	1	0.05	3.84	NS
Female	76	74	150				

table cont.....

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Demographic variables	Below Median	>= Median	N	df	χ^2	P-value	P<0.05
Age in years							
15-25	20	22	42				
26-35	44	36	80				
36-45	37	53	90	4	10.20	9.49	S
46-55	33	28	61				
56 and above	20	7	27				
Type of family							
Nuclear family	40	54	94				
Joint family	114	92	206	1	4.22	3.84	S
Family income per month							
Below 10000	47	34	81				
10000 to 20000	88	101	189	2	4.90	5.99	NS
Above 20000	19	11	30				
Education							
Illiterate	87	104	191				
Primary Education	42	7	49				
Graduate	18	13	31	3	34.89	7.82	S
Postgraduate	7	22	29				
Religion							
Hindu	87	95	182				
Muslim	42	27	69				
Christian	18	9	27	3	9.31	7.82	S
Other religion	7	15	22				
Occupation							
Unemployed	12	9	21				
Private job	29	30	59				
Government job	27	15	42				
Business	15	17	32	5	14.79	11.07	S
Coolie	27	49	76				
Agriculture	44	26	70				
Anybody experienced mental disorder in the family?							
a) Yes	22	39	61				
b) No	132	107	239	1	7.14	3.84	S

S=Significant; NS=Non-Significant

The above chi-square Table 5 shows the following that there is a significant association between myths, beliefs and perceptions score and age in years, type of family, family income per month, education, religion, occupation and experienced mental disorder in family as the chi-square value 10.20 is higher than the tabulated value 9.49. Therefore, the H1 is accepted.

Table 6: Associate the values of myths, beliefs and perceptions about mental disorder of urban area with their demographic values.

N=300

Demographic variables	Level		N	df	χ^2	P-value	P<0.05
	Below Median	>= Median					
Gender							
Male	82	68	150	1	0.34	3.84	NS
Female	87	63	150				

table cont.....

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Age in years							
15-25	24	20	44	4	9.65	9.49	S
26-35	40	15	55				
36-45	64	57	121				
46-55	23	28	51				
56 and above	18	11	29				
Type of family							
Nuclear family	81	74	155	1	2.17	3.84	NS
Joint family	88	57	145				
Family income per month							
Below 10000	30	25	55				
10000 to 20000	94	69	163	2	0.26	5.99	NS
Above 20000	45	37	82				
Education							
Illiterate	11	11	22	3	7.93	7.82	S
Primary Education	73	43	116				
Graduate	59	41	100				
Postgraduate	26	36	62				
Religion							
Hindu	80	70	150				
Muslim	57	39	96	3	9.91	7.82	S
Christian	22	6	28				
Other religion	10	16	26				
Occupation							
Unemployed	8	7	15				
Private job	54	45	99				
Government job	38	18	56	5	6.46	11.07	NS
Business	29	34	63				
Coolie	26	16	42				
Agriculture	14	11	25				
Anybody experienced mental disorder in the family?							
Yes	47	23	70	1	4.34	3.84	S
No	122	108	230				

S=Significant; NS=Non-Significant

The above chi-square Table 6 shows that there is a significant association between myths, beliefs and perceptions score and age in years, education, religion, and experience of mental disorder in family as the chi-square value 9.65 is higher than the tabulated value 9.49. Therefore, the H1 is accepted.

DISCUSSION

In this study the comparison of the rural and urban area general population's level of myths, beliefs and perceptions about mental disorder says that in rural area 45.3% had bad level 37.7 % had poor level and 17.0% had good level of myths, beliefs and perceptions about mental disorder, where as in urban area 18.3% of the samples had bad level, 48.7% showed poor and 33.0% of the samples remained with good level of myths, beliefs and perceptions about mental disorder.

A similar study result was observed by (Jugal, Avni, Ram, & Patrick, 2011) they said 74.4% of rural subjects, 37.1% of urban subjects had bad level of myths, beliefs and perception about mental illness. They conducted a cross sectional study with a sample of 436 subjects from urban and rural community in Delhi, India.

CONCLUSION

The finding of the study shown that there was a

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poor or bad level of myths, beliefs and perceptions. This need to be changed therefore, based on this study different measures can be taken at various levels to improve their understanding and performance towards mental disorder. The findings of the study have implications for nursing practice, education, administration and research.

Summary

The investigator felt a deep sense of satisfaction for having undertaken this study. The investigator has drawn many conclusions based on the study findings. The expert opinions and directions from the guide and the experience during the study helped to give suggestions and recommendations for further studies. This chapter suggested ways and means that could be adopted in future to improve the general population knowledge on mental illness. The direction, support and encouragement given by the guide were appreciable and made the experience fruitful and highly rewarding.

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