# A STUDY ON KNOWLEDGE, BELIEFS AND ATTITUDE TOWARDS MENTAL ILLNESS AMONG FAMILY MEMBERS OF MENTALLY ILL PATIENTS

## RESEARCH REPORT








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**2058-2059 (2001-2002)**

**SUBMITTED IN PARTIAL FULFILLMENT OF THE COURSE REQUIREMENT OF THE DEGREE OF BACHELOR OF SCIENCE IN NURSING, 4th YEAR CURRICULUM OF BPKIHS, DHARAN, NEPAL.**
**2002(2059)**

# APPROVAL SHEET

## A STUDY ON KNOWLEDGE, BELIEFS AND ATTITUDES TOWARDS MENTAL ILLNESS AMONG THE FAMILY MEMBERS OF THE MENTALLY ILL PATIENTS

**SUBMITTED IN PARTIAL FULFILLMENT OF THE 4TH YEAR COURSE REQUIREMENT OF THE B.SC. NURSING PROGRAMME AND FOR THE DEGREE OF B.SC. NURSING OFFERED BY BPKIHS**


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# ABSTRACT

A descriptive study was conducted to assess the knowledge, beliefs and attitude towards mental illness among family members of mentally ill patients. A structured multiple-choice questionnaire with 38 items scored on Likert scale was administered in the form of an interview to a total of 50 subjects selected by non-probability convenient sampling technique, attending the Psychiatric OPD in BPKIHS, DHARAN, during the period of the study.

The dependent variables: knowledge, beliefs and attitude were assessed based on the verbal responses of the subjects to 10 items on knowledge and 14 items on both beliefs and attitude. Results of the study revealed that most of the patients whose family members (subjects) were included in the study were, Schizophrenic followed by Depression, Mania, Bipolar affective disorder, Psychosis and Obsessive compulsive disorder in decreasing order. However, majority of the respondents were male falling into the age group of 20-30 years and belonged to the major hill caste. The educational status of most of the respondents was up to secondary level and agriculture was the primary occupation in majority of them. The highest number of the subjects was found to be from a joint family with 5-10 members in the family. Majority of them belonged to lower socio economic status and resided in urban area. Regarding the relationship of the subjects, most of them were found to be siblings of the patient. Findings further revealed that the respondents' level of knowledge was good on aspects concerning the cause and treatment of mental illness. Although some prejudice in relation to the traditional approaches to treatment were evident among the subjects, most of them verbalized a negative response to some of the culturally defined norms and stigma associated with mental illness. Nonetheless, the level of burden of the respondents differed in several aspects, and found to increase significantly among those holding more negative beliefs towards mental illness.

**Conclusion:**

The results of the above findings point out that all efforts are required to be taken to reduce social distance and rehabilitate the mentally ill patients in the community. These efforts should be directed towards raising public awareness and dispelling stereotypes in this area, as negative beliefs are bound to affect the social support system as well as help seeking behaviour of the mentally ill patients.

# ACRONYMS

| | |
|---|---|
| **B.P.A.D.-** | Bipolar Affective Disorder |
| **BPKIHS-** | B.P.Koirala Institute of Health Sciences |
| **B.Sc.Nursing-** | Bachelor of Science in Nursing |
| **e.g.-** | For example |
| **etc. -** | et cetera |
| **Fig.no.-** | Figure number |
| **i.e. -** | that is |
| **NHRC** | Nepal Health Research Council |
| **No. -** | Number |
| **O.C.D.-** | Obssessive Compulsive Disorder |
| **O.P.D. -** | Out Patient Department |
| **S/N -** | Serial number |

# TABLE OF CONTENTS

## CHAPTER IV

### DATA ANALYSIS AND INTERPRETATION



## CHAPTER V



## ANNEX

# LIST OF TABLES

# LIST OF FIGURES

# CHAPTER I

## INTRODUCTION:

Mental health problems cause enormous suffering to many people all over the world and especially to those in developing countries. A mental illness is a syndrome with specific symptoms that impairs an individual's cognition, perception, emotion and /or behavior and that recurs over an extended period. Mental illness not only takes a toll on an individual's quality of life but can also tax family's emotional, physical and financial resources. The family problems frequently become society's problems. Mental illness also places many other stresses on individuals, families and society as a whole.[1]

## BACKGROUND OF THE STUDY:

Mental illness was earlier viewed as demonic possession, the influence of ancestral spirits, the result of violating a taboo or neglecting a cultural ritual and spiritual condemnation. The mentally ill have been ridiculed, neglected, banned, persecuted and deprived of their freedom as a result of such stigma related to mentally illness.[2] The word stigma originally referred to bodily signs designed to show something bad about a person's moral status. Now it is used more often to show a discrediting attribute about a person. The absence of physical and objective signs in the case of mental illness has lead to a persistent belief that it is not a real illness and must be due to some moral weakness for which the person has been condemned and stigmatized.[3]

In the nineteenth century, mental illness was viewed as incurable and little, if any, humane treatment existed. Until 1820, the mentally ill were exhibited for a fee as diversion and entertainment to the public. Until 1886, the mentally ill were restrained in iron manacles. Beginning in 1950s, pharmacotherapy changed the picture of how mental illness was conceived; however, cultural conceptions of mental illness still have dramatic consequences for seeking psychological help, stereotyping and the kinds of treatment structures for people with mental illness.[2]

It has been widely appreciated that a social stigma surrounds psychiatric illness in a contemporary society like ours. However, the degree and type of stigmatization varies according to prevailing cultural norms. Many patients and especially their families suffer from shame, guilt and hopelessness.[4]

With the dramatic increase in the life expectancy in recent years, the dynamics of health care has undergone major changes. The world development report in 1993 concluded that mental health problems make up 8.1% of the total global burden of disease (GBD). The recent evidence for the importance of mental health has been so striking that the present leadership in the WHO decided to give it a priority focus during the year 2000.[5] Thus the WHO theme for the year was "STOP EXCLUSION, DARE TO CARE".

In the context of Nepal, mental illness has a social stigma attached to it and many patients and especially their families suffer from shame, guilt and hopelessness. Many patients feel it is a curse as a result of some crime committed in the previous life and do not seek medical treatment due to fear of how society will respond. Instead, they seek help of "dhami jhankri" (witch doctors). According to the data provided by Patan Mental

Hospital in Kathmandu, Nepal, there were 13,038 mentally ill patients in 1995 and the number has risen to more than 20,000 today. While there have been some significant and important developments, health services have remained limited or concentrated in Katmandu valley. Since only medicines and cursory psychiatric treatments services are available at government hospitals with no provisions for long- term counseling and rehabilitation, these patients generally land in prisons without having committed any crime. Many of such patients are also sent to the institutions as far away as Ranchi, India. Since there are no mental health services available in the rural areas, over the years many mentally ill people have been living and dying in prisons.[6]

## NEED FOR THE STUDY:

While the importance of health literacy for physical health is widely acknowledged, the area of mental health literacy has been comparatively neglected. All the aspects of mental illness, from the recognition of symptoms, treatment adherence to rehabilitation are influenced by stigma of that illness. Knowledge, beliefs and attitude of family members are paramount since they are directly involved in the care and management of mentally ill patients. Few, if any, systematic research studies of mental health literacy and the effects of stigmatization have been reported in Nepal; however, the topic is discussed frequently in the popular literature and newspapers.

## RESEARCH PROBLEM STATEMENT:

What are the knowledge, beliefs and attitude towards mental illness among the family members of mentally ill patients attending the Psychiatric outpatient department in BPKIHS?

## VARIABLES:

Independent variable: Demographic attributes of family members of mentally ill patients.

Dependent variables:

- Knowledge
- Beliefs
- Attitude

## OBJECTIVES:

- Describe patients' attributes and those of family members who accompany their mentally ill family member to the outpatient clinic at BPKIHS.
- Identify the knowledge, cultural beliefs (stigma) and attitude (burden) regarding mental illness among the family members.
- Identify the interrelationships among all the variables to describe their effects on each other.

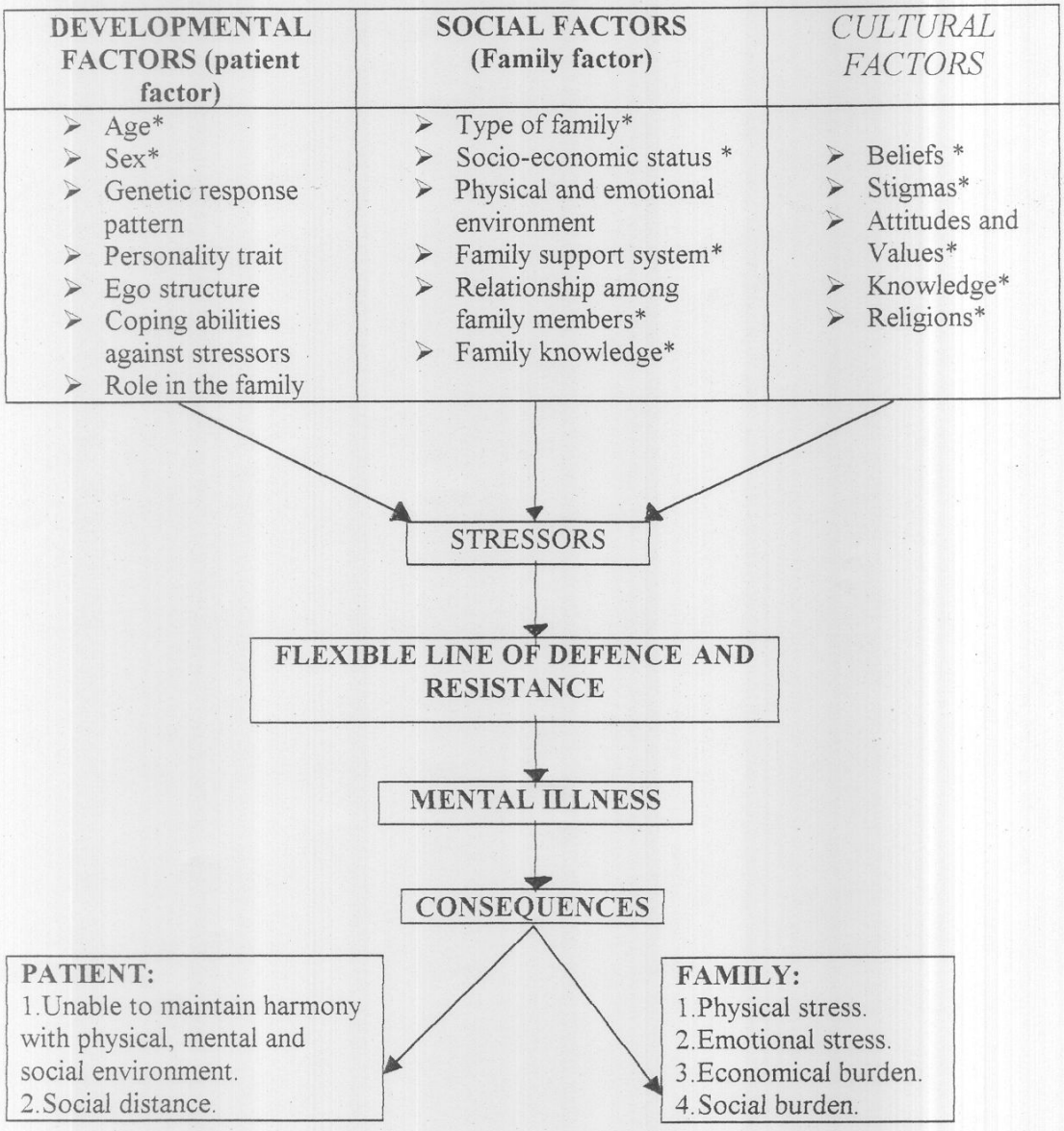
**DEFINITIONS:**

| CATEGORY | CONCEPTUAL | OPERATIONAL |
|---|---|---|
| Knowledge | Facts that a person knows about a subject through personal experiences, cultural practices or from others. . | Verbal responses to 10 structured questions on knowledge about mental illness on a 4-point scale with possible score: 1-40, the highest score indicating the highest knowledge and lowest score indicating the least knowledge. |
| Beliefs | A subjective feeling or value that a particular phenomena is real and true; in this study specifically the cultural beliefs and stigma unique to the local society. | Verbal responses to 14 structured questions on cultural beliefs common in Nepali society on mental illness on a 4-point scale with possible score: 1-56, the highest score signifying the most positive beliefs. |
| Attitude | Way of thinking, behaving, or regarding something; in this study the attitude toward the burden caused by the patient. | Verbal responses to 14 structured questions on the level of burden experienced by family members on a 3-point scale with possible score: 1-42, the highest score indicating the most burden and the lowest score indicating the least burden. |
| Family members | Set of parents and children or of relatives staying under the same roof. | Care givers in contact with the patients for at least six months prior to the study and attending Psychiatric OPD during the study. |

## THEORITICAL FRAMEWORK:

The framework for this research was based on the nursing model of Betty Newman; in particular, the concepts related to cultural response to mental illness. According to Newman, developmental, social and cultural factors affect the way individuals, families and groups respond to illness. In this study, the illness is mental illness. The following diagram depicts the concepts from this model and identify, define and operationalize the concepts from the model that are used as variables in this research indicated by a *.

***BETTY NEWMAN'S SYSTEMS MODEL IN CULTURAL RESPONSES TO MENTAL ILLNESS.***



## ASSUMPTION:

The family members attending the OPD with the mentally ill patients already had some previous knowledge and beliefs regarding mental illness.

# CHAPTER II

## REVIEW OF THE RESEARCH LITERATURE:

During the course of literature review, many books, articles, journals and medline news bulletin were searched. However only few studies regarding the knowledge, beliefs and attitude of the family members of mentally ill patients were found in the context of Nepal.

Both cultural beliefs related to stigma and the burden imposed on families as a result of mental and emotional illness has been studied.

The relative importance of negative and supportive social interactions in predicting different aspects of quality of life was studied in the United States of America (USA) in a sample of 104 persons diagnosed with severe mental illness. Negative social interactions were found to be the most important in predicting quality of life; however, additional analyses suggested that perceived stigma, whether actual or part of the family system of beliefs, partially mediated the relationship between negative social interactions and quality of life.[7]

A similar study was done on care giver burden and psychotic patient's perception of social support in a Nigerian setting to assess the burden among relatives of 75 schizophrenic and 20 major effective disorder cases. The purpose of the study was to identify the factors associated with burden and to assess the relationship between caregiver burden and patients perception of social support. The results showed that financial burden was greater than the effect on family routines in these Nigerian families.[8]

In the psychiatric outpatient department (OPD) of a General Hospital in Chennai, India a family burden assessment instrument was developed with a sample of 250 caregivers in a two-phase study using both qualitative and quantitative data. The resulting 40-item instrument was applied to the primary care givers of chronic mentally ill patients. The results showed a strong sense of hurt and responsibility particularly among women in the family coupled with a fear of rejection by society. Although many families found it difficult and stressful to look after the patient, most refused to consider the idea of a separation with the ill member.[9] Some items from this scale will be incorporated into the instrument used in this present study particularly to assess family burden.

A study on public conceptions of mental illness in a general social survey in the United States of America in 1966 reported that more than 90% of the respondents believed that stress was very or somewhat likely to be a cause of mental illness combined with biologic and genetic factors. The majority of the respondents (82.4%) believed that symptoms of mental illness are associated with potential violence. This explains the fear the public has about mental illness and their desire for limited social interaction with the mentally ill.[10]

Fabrega studied psychiatric stigma in non-western societies, concentrating on the cultural meanings associated with psychiatric illness. Stigma is an important variable in the more elementary societies, [4] in countries such as India and Nepal; and is used to distinguish how psychiatric illness is handled in community settings as opposed to the traditional medical approaches. The author noted that in India stigmatization was less prevalent among Islamic societal groups; however there are few Muslims in Nepal.

The largest number of studies on attitudes to mental illness comes from North America. Earlier studies have demonstrated that there was a general feeling of mistrust, fear and anxiety about mentally ill.

As Rabkin (1974) emphasized, "Upon their return home, ex-mental patient, often find that being an ex-mental patient is more a liability than being ex-criminal in the pursuits of having jobs and friends". [11]

It is important to note that the Joint Commission on Mental illness and Health (1961) reported that there exists a major lack of recognition of mental illness as illness and a predominant tendency to reject the mentally ill as well as their therapist.

Since the community mental health movement started to gain ground in the USA in the 1970, there have been several attempts to identify the variety of factors responsible for negative attitudes (Halpert 1965,1969). Placing the people who have spent long periods in hospital back into the community without adequate preparation will risk subjecting these patients to negative attitudes. [12]

However, Segal (1978) emphasizes that with moving of the mentally ill into the community, an educated contact with the mentally ill has proved beneficial in enabling the public to reduce the social distance, even though the basic concepts of mental illness as a serious unpredictable, dangerous disorder remain unchanged. [13]

However, the attitudes of the public in UK were often affected by the Church teachings. Men of power and church influenced the public opinion, which identified the attitudes and behavior of marginal social elements that could be dubbed, disturbed and hence, alien.

British broadcasting Corporation audience research department (1957) conducted a survey, which demonstrated that social distance was an important factor in accepting the mentally ill. Only 50% would work with someone who was or had a mental illness before and only25% felt that such an individual should be in a position of authority over others.[14]

Two surveys in North Hampshire and Nottingham shire revealed considerable reservation about mentally ill people. With more personal contact, attitudes become less liberal (Gatherer and Reid1963, Willcocks (1968). [15] Similarly, using a social distance scale, Whatley (1958-1959) was able to demonstrate that the tendencies to restrict social contact were most likely to arise in situation of closeness.[16]

In a small sample of general Surgery attendees in the UK, Bhugra and Scott found Majority, (80%) agreed that mental hospitals were necessary for the treatment of the mentally ill but nearly one-third did not know whether mental hospitals were like prisons.[17]

In the context of Indian studies, which also represents the eastern world, Prabhu et al. (1974) pointed out that not much information is readily available about socio-culturally based conceptions of mental illness and related problems. [18]

Verghese and Beig (1974) reported that 58% of their sample of 539 adults still saw a relationship between lunar cycle and mental illness. However, majority of the respondents were broadly sympathetic towards mentally ill patients.[19]

In a study conducted by Bhugra,(1991) findings reveal that among the 316 Indian teenagers, only 8 would send a mentally ill to the asylum. More than one third would seek medical attention, with a majority seeking help from specialists.[20]

Boral et al (1980) studied the family perception of mental illness. In this study, 240 relatives of psychiatric patients and 120 relatives of non-psychiatric patients were approached with a 22-item questionnaire. Less than one-third of the subjects would prefer traditional methods of treatment. [21]

Similarly, the results of the study conducted by Malhotra and Wig (1975) by developing a 14 case vignettes showed that the preferred sources for help were modern health services rather than traditional healers, though the latter were more likely to be consulted in cases of mental illness than of physical ones.[22]

Thus the majorities of the studies conducted in India show that the general trend of attitudes reported from India parallels that of the west. However, these studies are by and large from cities with a somewhat westernized population, and whether the results can be generalized to the rest of the population is questionable.

# CHAPTER III

## METHODOLOGY:

**1. *Research Design*:**
The research design was of descriptive study type.

**2.*Setting*:**
Psychiatric OPD, BPKIHS, Dharan, Nepal.

**3.*Population and Sample*:**
3.1 Target population: All the family members of mentally ill patients attending Psychiatric OPD in BPKIHS, Dharan during the study period and meeting the inclusion criteria.

***Inclusion criteria:***
- The attendants (caregivers) who had been staying with the patient for at least six month or more.
- Those willing to participate in the study.
- Those attending the clinic during the study period.
- Attendants of those patients who were under treatment in the outpatient department for diagnosed psychiatric disorder.

***Exclusion criteria:***
- Attendants, such as distant relatives, friend and neighbour.
- Family members who were less than 20 years.
- Those who were not capable or willing to participate due to any reason.

3.2 Sample size: In total 50 subjects were selected for the study according to the exclusion and inclusion criteria.

3.3 Sampling technique: Non-probability convenient sampling technique was used in the study.

**4.*Development of tools*:**
**Instrument**: A structured multiple-choice questionnaire with 38 items scale was administered in the form of interview to each participant. It was adopted from an instrument developed by Department of Community Medicine, All India Institute of Medical Sciences (AIIMS). Some changes had been made accordingly. The broad categories of the instrument include sociodemographic information, knowledge, common cultural beliefs and attitude on mental illness. The items concerning burden were selected and adapted from an instrument developed by Thara, Padmadvati, Shuba and Srinivasan.[9]

**5.*Pilot study*:**
The prepared interview schedule was pretested among 5 family members of mentally ill patients attending Psychiatric OPD in BPKIHS prior to the final study to find out the feasibility, practicability and ambiguity of the questions. The pretesting tool was in Nepali considering the convenience and level of understanding of the subjects under study. Necessary modifications in the questionnaire were made on the basis of findings of the pretest.

***6. Content validity:***

To evaluate the content validity of the instrument, the questionnaire was distributed to three mental health experts and teachers for their assessment of the appropriateness of the instrument items. Then according to their suggestions and comments, some items were modified and added as needed on approval of all.

***7. Procedures for data collection:***

Concerned personnel from the psychiatric and nursing departments were briefly informed about the research purpose, method, date, time and duration of data collection. A brief introduction was given and informed consent regarding the research process was taken from the subjects meeting the inclusion criteria. The interview took place in a separate room allocated for the purpose in the OPD itself. Both researchers interviewed the subjects together; one interviewed the subject while the other noted down the responses until 50 interviews were achieved. The average time taken to complete each interview was 30 minutes. The subjects were fully assured regarding the maintenance of confidentiality.

***8. Plan for data analysis:***

The data analysis plan appears on the following table:

| **Objectives** | **Methods** |
|---|---|
| 1. Demographic in formations of the subjects. (Age, sex, ethnicity, religion education, occupation, income, type of family, no. of family member, geographical distribution and relationship with the patient) | Descriptive statistics: Frequency and Percentage for ordinal and nominal data. |
| 2. Level of knowledge, beliefs and attitude regarding mental illness. | The scores for each item were summed and the range, mean, and standard deviation of the scores were tabled for each of the concepts. |
| 3. The interrelationships among all the variables were determined to describe their effects on each other. | Analysis of Variance (ANOVA) and Correlations 'r' were used to test the statistical significance of difference between the mean scores. |

***8. Ethical considerations:***

An informed consent was obtained from the subjects for inclusion prior to the study. The subjects had a right to refuse participation in the study and also the freedom to withdraw from it at any point. The identity of the respondents and their response was kept confidential and the data was used exclusively for research purpose for the partial fulfillment of B.Sc. Nursing course.

***9. Other Considerations:***

Departments involved: Department of Nursing, Department of Psychiatry, BPKIHS.

***Expected expenditure:***

1. Data manager
2. Photocopy paper
3. Photocopying
4. Stationaries (pencils, erasers, sharpners, staplers, pins, ball pens, rough papers, litho papers, diskettes) -
5. Supervision, Monitoring and Auditing Cost
    a. Computer work
    b. Computer printing
    c. Binding
6. Contingency

# CHAPTER IV

## DATA ANALYSIS AND INTERPRETATIONS

## RESULTS:

### 1. Demographic profile of the subjects

Table No.1.1: Age distribution of patients

| S/N | Age | Frequency | Percentage |
|---|---|---|---|
| 1 | <20 years | 9 | 18.0 |
| 2 | 20-30 years | 19 | 38.0 |
| 3 | 30-40 years | 10 | 20.0 |
| 4 | 40-50 years | 9 | 18.0 |
| 5 | 50 years and above | 3 | 6.0 |
| Total | | 50 | 100.0 |

Above table shows that most of the patients (38%) were from age group 20-30yrs and the average age was 30.42 years.

Table No.1.2: Sex distribution of patients

| S/N | Sex | Frequency | Percentage |
|---|---|---|---|
| 1 | Female | 25 | 50.0 |
| 2 | Male | 25 | 50.0 |
| Total | | 50 | 100.0 |

Above table shows the equal percentage of male (50%) and female (50%) patients.

Table No.1.3: Distribution of patients according to diagnosis

| S/N | Diagnosis | Frequency | Percentage |
|---|---|---|---|
| 1 | Schizophrenia | 14 | 28.0 |
| 2 | Mania | 12 | 24.0 |
| 3 | Depression | 13 | 26.0 |
| 4 | B.P.A.D. | 5 | 10.0 |
| 5 | O.C.D. | 2 | 4.0 |
| 6 | Psychosis | 4 | 8.0 |
| Total | | 50 | 100.0 |

Above table shows that the majority of the patients (28%) were diagnosed as Schizophrenia followed by Depression (26%), Mania (24%), Bipolar affective disorder (10%), Psychosis (8%) and Obssessive compulsive disorder (4%).

Table No.1.4: Distribution of patients according to duration of illness

| S/N | Duration of illness | Frequency | Percentage |
|---|---|---|---|
| 1 | <1 year | 10 | 20.0 |
| 2 | 1-5 years | 21 | 42.0 |
| 3 | 5-10 years | 9 | 18.0 |
| 4 | 10-15 years | 7 | 14.0 |
| 5 | 15 years and above | 3 | 6.0 |
| Total | | 50 | 100.0 |

Above table illustrates that most of patients (42%) had total duration of illness from 1-5 years.

Table No.1.5: Distribution of patients according to duration of treatment

| S/N | Duration of treatment | Frequency | Percentage |
|---|---|---|---|
| 1 | <1 year | 17 | 34.0 |
| 2 | 1-5 years | 22 | 44.0 |
| 3 | 5-10 years | 5 | 10.0 |
| 4 | 10-15 years | 5 | 10.0 |
| 5 | 15 years and above | 1 | 2.0 |
| Total | | 50 | 100.0 |

Above table reflects that the majority of patients (44%) were being treated for duration of 1-5 years.

Table No.1.6: Age distribution of subjects

| S/N | Age | Frequency | Percentage |
|---|---|---|---|
| 1 | 20-30 years | 16 | 32.0 |
| 2 | 30-40 years | 11 | 22.0 |
| 3 | 40-50 years | 6 | 12.0 |
| 4 | 50-60 years | 11 | 22.0 |
| 5 | 60 years and above | 6 | 12.0 |
| Total | | 50 | 100.0 |

Above table shows that majority of subjects (32%) were from the age group of 20-30yrs.

Table No.1.7: Sex distribution of subjects

| S/N | Sex | Frequency | Percentage |
|---|---|---|---|
| 1 | Female | 14 | 28.0 |
| 2 | Male | 36 | 72.0 |
| Total | | 50 | 100.0 |

Above table shows that 28% 0f the respondents were female and 72% of them were male.

Table No.1.8: Distribution of subjects according to ethnicity

| S/N. | Ethnicity | Frequency | Percentage |
|---|---|---|---|
| 1 | Hill native caste | 10 | 20.0 |
| 2 | Major hill caste | 17 | 34.0 |
| 3 | Terai middle caste | 13 | 26.0 |
| 4 | Others | 10 | 20.0 |
| Total | | 50 | 100.0 |

Above table shows that most of the subjects (34%) belonged to Major hill caste (Brahmin, Chhetri and Newar) followed by 26% Terai middle caste (Yadav, Choudhary and Mandal), 20% Hill Native Caste (Rai, Limbu, Magar and tamang) and few (20%) Others such as B.K, Sunar, Sarki.

Table No.1.9: Distribution of subjects according to religion

| S/N | Religion | Frequency | Percentage |
|---|---|---|---|
| 1 | Hindu | 46 | 92.0 |
| 2 | Muslims | 2 | 4.0 |
| 3 | Others | 2 | 4.0 |
| Total | | 50 | 100.0 |

Above table shows that majority of the subjects (92%) were Hindu, followed by Muslims (4%) and Others (4%), which include Buddhist and Christian.

Table No.1.10: Distribution of subjects according to educational status

| S/N | Education | Frequency | Percentage |
|---|---|---|---|
| 1 | No school | 9 | 18.0 |
| 2 | Primary school | 10 | 20.0 |
| 3 | Secondary school | 20 | 40.0 |
| 4 | Higher secondary school | 5 | 10.0 |
| 5 | Bachelor level and above | 6 | 12.0 |
| Total | | 50 | 100.0 |

Above table reveals that, although majority of the subjects (40%) had education up to secondary level, and a few (12%) up to bachelor level and above but still 18% of the respondents were illiterate.

Table No.1.11: Distribution of subjects according to occupation

| S/N | Occupation | Frequency | Percentage |
|---|---|---|---|
| 1 | Student | 6 | 12.0 |
| 2 | Office | 3 | 6.0 |
| 3 | Farmer | 12 | 24.0 |
| 4 | Business | 7 | 14.0 |
| 5 | Housewife | 10 | 20.0 |
| 6 | Unemployed/Retired | 5 | 10.0 |
| 7 | Others (specify) | 7 | 14.0 |
| Total | | 50 | 100.0 |

Above table shows that majority of the subjects (24%) were from agricultural background followed by Housewives (20%), Businessman and Others (Goldsmith, Laborers) both 14%, Unemployed/Retired (10%) and Office (6%).

Table No.1.12: Distribution of subjects according to type of family

| S/N | Type of Family | Frequency | Percentage |
|---|---|---|---|
| 1 | Joint | 29 | 58.0 |
| 2 | Nuclear | 21 | 42.0 |
| Total | | 50 | 100.0 |

Above table shows that 58% of the subjects were from joint family and 42% of them were from nuclear family.

Table No.1.13: Distribution of subjects according to size of family

| S/N | No. Of family members | Frequency | Percentage |
|---|---|---|---|
| 1 | <5 | 15 | 30.0 |
| 2 | 5-10 | 30 | 60.0 |
| 3 | 10-15 | 4 | 8.0 |
| 4 | 15 and above | 1 | 2.0 |
| Total | | 50 | 100.0 |

Above table shows that majority of the subjects (60%) belonged to the family comprising of 5-10 family members.

Table No.1.14: Distribution of subjects according to monthly family income

| S/N | Income | Frequency | Percentage |
|---|---|---|---|
| 1 | <Rs.1000 | 3 | 6.0 |
| 2 | Rs.1000-Rs.5000 | 23 | 46.0 |
| 3 | Rs.5000-Rs.10000 | 17 | 34.0 |
| 4 | Rs.10000 and above | 7 | 14.0 |
| Total | | 50 | 100.0 |

Above table shows that most of the subjects (46%) had family income ranging from Rs.1000-5000 per month.

Table No.1.15: Distribution of subjects according to address

| S/N | Address | Frequency | Percentage |
|---|---|---|---|
| 1 | Rural | 12 | 24.0 |
| 2 | Urban | 38 | 76.0 |
| Total | | 50 | 100.0 |

Above table shows that most of the subjects (76%) were from urban area and only 24% of them were from rural area.

Table No.1.16: Distribution of subjects according to relationship with patients

| S/N | Relationship | Frequency | Percentage |
|---|---|---|---|
| 1 | Parents | 6 | 12.0. |
| 2 | Siblings | 16 | 32.0 |
| 3 | Son/Daughter | 13 | 26.0 |
| 4 | Spouse | 14 | 28.0 |
| 5 | Others (Uncle, Auntie) | 1 | 2.0 |
| Total | | 50 | 100.0 |

Above table shows that majority of the subjects (32%) were siblings of the patients and 28% of them were spouses.

**2. Level of knowledge, beliefs and attitude regarding mental illness**

Table No.2.1: Respondents' knowledge on mental illness

| S/N | Knowledge Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | Once a person develops a mental illness, he can become healthy as before. | 2.86 | 1.29 |
| 2 | Mental illness is caused by some physical or chemical changes in the brain | 2.84 | 1.04 |
| 3 | Mental illness can be caused by excessive mental stress due to work overload, financial problems and bad interpersonal relationships. | 3.34 | 0.92 |
| 4 | Mental illness may sometimes manifest itself as physical discomfort. | 2.82 | 1.10 |
| 5 | The treatment for mental illness is equally important as for physical illness. | 3.94 | 0.24 |
| 6 | Most of the mentally ill people can be treated at home. | 2.34 | 1.24 |
| 7 | The psychiatric treatment should continue even after the disappearance of symptoms. | 3.56 | 0.91 |
| 8 | Mental illness can best be treated by visiting a Psychiatrist. | 3.94 | 0.31 |
| 9 | Mentally ill people can never take care of themselves. | 2.00 | 1.34 |
| 10 | Mentally ill people can never take responsibilities of their family. | 2.18 | 1.40 |

Above table shows the calculated mean and standard deviation of the scores obtained by 50 samples on different knowledge items (total=10) on mental illness; maximum mean score (4) for the highest knowledge and minimum score (1) for the least knowledge.

Regarding the causes of mental illness the mean score was highest (3.34) for the knowledge item, which states that mental illness is caused by excessive mental stress due to work overload, financial problems and bad interpersonal relationships. Regarding the treatment of the mental illness, the highest mean scores obtained were for knowledge item 5 (3.94), 8(3.94) and 7 (3.56) which cites that the treatment for the mental illness is equally important as for physical illness and can best be treated by the Psychiatrist but should be continued even after the disappearance of the symptoms.

Table no.2.2: Respondents' common beliefs towards mental illness

| S/N | Belief Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | All mentally ill people are harmful and dangerous. | 2.60 | 1.34 |
| 2 | All mentally ill people are mad. | 2.88 | 1.38 |
| 3 | Mental illness can be cured by getting married. | 2.92 | 1.07 |
| 4 | Mental illness is caused because of some sins committed in the past life. | 3.32 | 1.15 |
| 5 | Mental illness is caused by ghost, evil spirit, witchcraft, and black magic. | 3.44 | 1.07 |
| 6 | Mental illness is a communicable disease. | 3.48 | 1.01 |
| 7 | Mental illness is always hereditary. | 2.84 | 1.18 |
| 8 | Young people and children do not suffer from mental illness. | 3.46 | 0.91 |
| ***The following activities are beneficial for the treatment of mental illness:*** | | | |
| 9 | Visiting traditional faith healers. | 2.80 | 1.12 |
| 10 | The shoes and socks should be given to smell to patients. | 3.32 | 1.00 |
| 11 | All mentally ill patients should be chained and locked up. | 3.58 | 0.86 |
| 12 | Unresponsive patients should be treated with application of red-hot iron bar. | 3.72 | 0.73 |
| 13 | The treatment with tablets and injections can make the condition worse. | 3.80 | 0.45 |
| 14 | Certain food like garlic, onion, meat and eggs should not be allowed. | 3.08 | 1.26 |

Above table reflects the calculated mean and standard deviation of the total score received by 50 samples regarding their common beliefs (stigmata) towards mental illness on 14 items scale; the maximum mean score (4) indicating positive beliefs and the minimum score (1) indicating negative beliefs towards mental illness.

The mean scores were found to be the highest for Belief items 13,12,11,6,8 and 5 (3.80, 3.72, 3.58, 3.48, 3.46 and 3.44 respectively) i.e. majority of the respondents believed that modern methods of treatment is helpful to the patients; unresponsive mentally ill persons should not be treated with the application of hot iron bar; they should not be kept chained and locked up; mental illness is not a communicable disease which can occur at any age. It is not caused by any ghost, evil spirit, witchcraft or black magic. However some of the respondents still hold misbelieves like mental illness is always hereditary; all mentally ill people are mad and so are harmful and dangerous to the society, which can be treated by getting married and seeking help from traditional faith healers.

Table no.2.3: Respondents' attitude towards mental illness

| S/N | Attitude Items | Mean | Std. Deviation |
|---|---|---|---|
| 1 | Does the patient cause disturbances at home? | 1.98 | 0.74 |
| 2 | Has your family stability been disrupted by patient illness? | 2.24 | 0.77 |
| 3 | Does the care of the patient prevent you from taking adequate care of others in the family? | 1.56 | 0.70 |
| 4 | Has your family's financial situation been worsened since the patient illness? | 2.08 | 0.83 |
| 5 | Has your workload been increased after the onset of the patient's illness? | 2.36 | 0.69 |
| 6 | Do you sometimes feel depressed and anxious because of the patient? | 2.48 | 0.65 |
| 7 | Would it bother you if any of your family got married in the family having any mentally ill member? | 2.20 | 0.95 |
| 8 | Do you feel any guilt or shame having this member in your family? | 1.58 | 0.84 |
| 9 | Has the quality of your marital relationship declined since husband's/wife's illness? | 0.46 | 0.81 |
| 10 | Do you often feel frustrated that the improvement of the patient is slow? | 1.94 | 0.89 |
| 11 | Does it bother you to work together with the patient in office/ business/field/ or class? | 1.78 | 0.95 |
| 12 | Does it bother you to stay in the same family? | 1.72 | 0.90 |
| 13 | Does it bother you to include him/her in social gatherings? | 1.70 | 0.86 |
| 14 | Does it bother you to travel together in bus, motorcycle, tampoo etc? | 1.32 | 0.68 |

Above table illustrates the calculated mean and standard deviation of the total score obtained by 50 samples regarding their attitude (level of burden) towards mental illness on 14 items scale with the maximum score (3) for negative attitude (highest level of burden) and the minimum score (1) for positive attitude (lowest level of burden) on mental illness.

The mean attitude scores for the items 2, 4,5,6 and 7(2.24, 2.08,2.36,2.48,2.20 respectively) indicate higher level of burden due to the illness i.e. most of the respondents' family stability has been disrupted; their financial condition has worsened and their workload has increased since the onset of the patient's illness. They were depressed and anxious about the patients' conditions. They would not be ready to establish marital relationships with the families having any mentally ill member.

However the mean scores obtained for attitude items 1,3,8,9,10,11,12,13 and 14 are relatively low (1.98,1.56,1.58, 46,1.94,1.78,1.72,1.70 and 1.32) which show positive attitude (lower level of burden) towards the illness i.e. majority of them had not have any guilt or shame having this member in the family and so would stay, work, travel with the patient and would not hesitate to include him/her in social gatherings.

### 3. Interrelationships among the variables

Table no.3.1: Respondents' knowledge, beliefs and attitude in relation to patients' diagnosis

| S/N | DIAGNOSIS | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Schizophrenia | 14 | 30.36 | 3.91 | 46.00 | 7.34 | 25.57 | 4.83 |
| 2 | Mania | 12 | 28.83 | 4.32 | 44.58 | 6.72 | 24.04 | 5.82 |
| 3 | Depression | 13 | 30.62 | 3.57 | 43.54 | 6.05 | 25.23 | 6.55 |
| 4 | Bipolar affective disorder | 5 | 30.40 | 2.51 | 44.20 | 5.93 | 27.00 | 4.53 |
| 5 | Obssessive compulsive disorder | 2 | 30.50 | 3.54 | 51.50 | 0.71 | 28.00 | 8.49 |
| 6 | Psychosis | 4 | 27.25 | 4.27 | 48.25 | 2.22 | 26.00 | 7.16 |
| p Value | | | 0.624 (NS) | | 0.529 (NS) | | 0.916 (NS) | |

The above table shows the calculated mean score and standard deviation for knowledge, beliefs and attitude of the respondents based on different categories of diagnosis of the patients. The mean knowledge score was highest for Depression (30.62) and the lowest (27.25) for Psychosis whereas the mean belief score was highest (51.50) for Obssessive compulsive disorder and the lowest (43.54) for Depression. Similarly, the mean attitude score was highest (28.00) for Obssessive compulsive disorder and the lowest (24.04) for Mania. However, the p value for the knowledge, beliefs and attitude with the different diagnostic categories is statistically insignificant.

Table no.3.2: Respondents' knowledge, beliefs and attitude in relation to patients' duration of illness

| S/N | DURATION OF ILLNESS | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | <1 year | 10 | 30.50 | 4.17 | 44.50 | 6.98 | 21.00 | 4.71 |
| 2 | 1-5 years | 21 | 28.95 | 3.38 | 45.95 | 4.96 | 26.24 | 6.26 |
| 3 | 5-10 years | 9 | 30.89 | 4.43 | 45.22 | 8.21 | 25.56 | 4.88 |
| 4 | 10-15 years | 7 | 30.86 | 4.22 | 43.14 | 7.90 | 28.57 | 3.55 |
| 5 | 15 years and above | 3 | 28.00 | 3.00 | 47.67 | 5.13 | 26.33 | 2.89 |
| p Value | | | 0.524 (NS) | | 0.820 (NS) | | 0.056 (NS) | |

The above table shows that the mean knowledge score is highest (30.89) for the respondents whose patients' had total duration of illness for 5 - 10 years and the lowest (28.00) for those with total duration of illness for >15 years. Whereas the mean beliefs score is highest (47.67) for those whose patients' had total duration of illness for >15 years and the lowest (43.14) for those whose patients' were ill for 10-15 years. The mean attitude score is highest for those (28.57) with their patients' duration of illness for 10-15 years and the lowest for those (21.00) whose patients' were ill for < 1 year.

Table no.3.3: Respondents' knowledge, beliefs and attitude in relation to patients' duration of treatment

| S/N | DURATION OF TREATMENT | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | <1 year | 17 | 30.00 | 3.91 | 45.82 | 5.65 | 22.00 | 5.89 |
| 2 | 1-5 years | 22 | 29.64 | 3.86 | 44.32 | 6.75 | 27.00 | 5.16 |
| 3 | 5-10 years | 5 | 30.80 | 4.97 | 50.00 | 2.83 | 26.00 | 4.85 |
| 4 | 10-15 years | 5 | 29.40 | 3.51 | 43.20 | 8.58 | 28.80 | 2.17 |
| 5 | 15 years and above | 1 | 28.00 | | 42.00 | | 28.00 | |
| p Value | | | 0.955 (NS) | | 0.387 (NS) | | 0.031 (SS) | |

The table above reveals that the mean scores for both knowledge and beliefs are highest (30.80, 50.00 respectively) for the respondents whose patients' were treated for 5-10 years and the lowest (28.00, 42.00 respectively) for those treated for >15 years. Whereas the mean attitude score is found to be highest (28.80) for those treated for 10-15 years and the lowest (22.00 for those treated for <1 year which is **statistically significant** where, **p value = 0.031**.

Table no.3.4: Respondents' knowledge, beliefs and attitude in relation to their age

| S/N | AGE | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | 20-30 years | 16 | 29.38 | 3.03 | 49.06 | 4.15 | 24.25 | 4.99 |
| 2 | 30-40 years | 11 | 29.45 | 4.01 | 44.55 | 7.31 | 24.09 | 4.46 |
| 3 | 40-50 years | 6 | 29.83 | 6.08 | 42.67 | 9.03 | 24.00 | 6.57 |
| 4 | 50-60 years | 11 | 31.45 | 2.94 | 43.73 | 5.06 | 26.45 | 5.94 |
| 5 | 60 years and above | 6 | 28.67 | 4.55 | 41.67 | 5.01 | 30.33 | 6.28 |
| p Value | | | 0.595 (NS) | | 0.042 (SS) | | 0.152 (NS) | |

The table above shows that the mean knowledge score is highest (31.45) for the respondents from 50 -60 years of age and the lowest (28.67) for >60 years of age. The mean belief score is highest (49.06) for the respondents from 20 - 30 years of age and the lowest (41.67) for >60 years of age which is **statistically significant** where, **p value= 0.042.** The mean attitude score is found to be the highest (30.33) among the subjects of >60 years of age and the lowest (24.00) among those who were in between 40 - 50 years of age.

Table no.3.5: Respondents' knowledge, beliefs and attitude in relation to their sex

| S/N | SEX | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Female | 14 | 30.00 | 3.44 | 45.14 | 6.38 | 27.00 | 5.25 |
| 2 | Male | 36 | 29.75 | 4.00 | 45.28 | 6.40 | 24.78 | 5.71 |
| p Value | | | 0.838 (NS) | | 0.947 (NS) | | 0.213 (NS) | |

The table above reflects that the mean knowledge and attitude scores are highest (30.00,27.00 respectively) among the female subjects whereas the mean belief score is highest (45.14) among the male subjects.

Table no.3.6: Respondents' knowledge, beliefs and attitude in relation to ethnicity

| S/N | ETHNICITY | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Hill native caste | 10 | 28.90 | 3.25 | 46.80 | 5.31 | 24.70 | 5.21 |
| 2 | Major hill caste | 17 | 29.53 | 4.30 | 48.65 | 4.30 | 24.06 | 5.98 |
| 3 | Terai middle caste | 13 | 31.77 | 3.35 | 42.62 | 7.67 | 26.77 | 6.37 |
| 4 | Others | 10 | 28.70 | 3.62 | 41.30 | 6.65 | 26.60 | 4.35 |
| p Value | | | 0.178 (NS) | | 0.006 (SS) | | 0.515 (NS) | |

The above table shows that the mean knowledge score is highest (31.77) for the respondents from Terai Middle Caste and the lowest (28.70) for the Others, which includes B.K., Goldsmith. Likewise, the mean belief score is highest (48.65) for the Major Hill Caste and the lowest (41.30) for the Others, which is **statistically significant** at **p value=0.006**. The mean attitude score is highest for the Terai Middle Caste (26.77) and the lowest (24.06) for the Major Hill Caste.

Table no.3.7: Respondents' knowledge, beliefs and attitude in relation to religion

| S/N | RELIGION | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Hindu | 46 | 29.74 | 3.90 | 45.85 | 6.20 | 25.41 | 5.80 |
| 2 | Muslim | 2 | 29.50 | 2.12 | 39.50 | 3.54 | 28.00 | .00 |
| 3 | Others | 2 | 32.00 | 4.24 | 37.00 | .00 | 22.50 | 2.12 |
| p Value | | | 0.718 (NS) | | 0.062 (NS) | | 0.628 (NS) | |

The table above implies that the mean knowledge score is highest (32.00) amongst the Buddhist and Christian respondents and the lowest (29.50) amongst the Muslims whereas the mean belief score is highest (45.85) for Hindus and lowest (37.00) for Buddhist and Christian. The mean score for attitude is highest (28.00) for the Muslims, and the lowest (22.50) amongst the Buddhist and Christian respondents.

Table no.3.8: Respondents' knowledge, beliefs and attitude in relation to education

| S/N | EDUCATION | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | No school | 9 | 30.22 | 3.31 | 40.44 | 7.09 | 28.11 | 5.56 |
| 2 | Primary school | 10 | 30.80 | 5.61 | 44.80 | 6.99 | 27.00 | 5.87 |
| 3 | Secondary school | 20 | 28.65 | 3.17 | 44.8 | 5.52 | 25.20 | 5.14 |
| 4 | Higher secondary school | 5 | 28.60 | 3.51 | 50.80 | 2.28 | 22.80 | 6.46 |
| 5 | Bachelor level and above | 6 | 32.50 | 1.76 | 50.00 | 1.90 | 21.50 | 4.59 |
| p Value | | | 0.191 (NS) | | 0.009 (SS) | | 0.138 (NS) | |

The table above shows that the mean knowledge score is highest (32.50) for the respondents educated up to bachelor level and above, and the lowest (28.60) for those educated up to higher secondary level. The mean belief score is highest (50.80) among those educated up to higher secondary level and the lowest (40.44) among those who had not been to any school, which is **statistically significant** at **p=0.009**. The mean attitude score is highest (28.11) amongst those who had not been to any school and the lowest (21.50) amongst those having a bachelor degree and above.

Table no.3.9: Respondents' knowledge, beliefs and attitude in relation to occupation

| S/N | OCCUPATION | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Student | 6 | 30.67 | 3.01 | 50.17 | 2.93 | 23.00 | 5.44 |
| 2 | Office | 3 | 31.00 | 5.29 | 50.00 | 3.61 | 20.00 | 1.73 |
| 3 | Farmer | 12 | 29.08 | 4.68 | 44.25 | 8.17 | 27.17 | 5.69 |
| 4 | Business | 7 | 31.57 | 2.30 | 44.14 | 5.24 | 24.43 | 6.08 |
| 5 | Housewife | 10 | 28.50 | 3.06 | 43.80 | 6.84 | 27.80 | 5.29 |
| 6 | Unemployed/Retired | 5 | 29.80 | 5.02 | 45.80 | 4.09 | 26.60 | 6.66 |
| 7 | Others | 7 | 30.00 | 4.12 | 43.43 | 6.16 | 23.43 | 4.65 |
| p Value | | | 0.739 (NS) | | 0.331 (NS) | | 0.224 (NS) | |

The above table reveals that the mean knowledge score is highest (31.57) for the respondents who were businessmen and the lowest (28.50) for housewives. Similarly, the mean belief score is highest (50.17) among the students and the lowest (43.43) among the Others including Goldsmith and Laborers. The mean attitude score is highest (27.80) among the housewives and the lowest (20.00) among those who work in the office.

Table no.3.10: Respondents' knowledge, beliefs and attitude in relation to type of family

| S/N | TYPE OF FAMILY | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Joint | 29 | 29.69 | 3.79 | 44.72 | 7.24 | 25.38 | 5.83 |
| 2 | Nuclear | 21 | 30.00 | 3.95 | 45.95 | 4.88 | 25.43 | 5.46 |
| p Value | | | 0.780 (NS) | | .504 (NS) | | .976 (NS) | |

The above table implies that the mean scores for the knowledge, beliefs and attitude are comparatively higher among the respondents from nuclear family (30.00, 45.95, 25.43 respectively) than the joint family.

Table no.3.11: Respondents' knowledge, beliefs and attitude in relation to size family

| S/N | NO. OF FAMILY MEMBERS | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | <5 | 15 | 28.93 | 4.08 | 43.67 | 6.45 | 26.60 | 6.46 |
| 2 | 5-10 | 30 | 29.87 | 3.39 | 46.07 | 5.56 | 24.93 | 5.34 |
| 3 | 10-15 | 4 | 30.25 | 3.30 | 49.50 | 2.65 | 22.50 | 2.52 |
| 4 | 15 and above | 1 | 40.00 | | 27.00 | | 33.00 | |
| p Value | | | 0.041 (SS) | | 0.006 (SS) | | 0.291 (NS) | |

The above table indicates that the mean knowledge score is highest (40.00) for the respondents who had >15 family members and the lowest (28.93) for those who had <5 family members which is **statistically significant** where, **p value** = 0.041. At the same time, the mean belief score is highest (49.50) for those with 10-15 family members and the lowest (27.00) for those with >15 members in the family which is also **significant statistically** at **p value=0. 006**. The mean attitude score is highest (33.00) for those with >15 family members and the lowest (22.50) for those with 10-15 family members.

Table no.3.12: Respondents' knowledge, beliefs and attitude in relation to income

| S/N | INCOME | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | <Rs.1000 | 3 | 31.00 | 2.65 | 49.33 | 4.16 | 29.00 | 7.00 |
| 2 | Rs.1000-Rs.500 | 23 | 30.35 | 4.07 | 44.57 | 6.63 | 25.83 | 5.46 |
| 3 | Rs.5000-Rs.10000 | 17 | 28.65 | 4.09 | 44.65 | 7.04 | 25.53 | 5.30 |
| 4 | Rs.10000 and above | 7 | 30.43 | 2.30 | 47.14 | 3.58 | 22.14 | 6.15 |
| p Value | | | 0.486 (NS) | | 0.525 (NS) | | 0.299 (NS) | |

The above table reflects that the mean scores for knowledge, beliefs, and attitude are highest (31.00, 49.33, 29.00 respectively) for the respondents who had their family income <Rs.1000 per month whereas the mean scores for knowledge and belief are found to be lower (28.65, 44.65 respectively) among those with monthly family income ranging from Rs.5000-10, 000 and the mean score for attitude is found to be the lowest (22.14) among those with monthly family income Rs.10, 000 and above.

Table no.3.13: Respondents' knowledge, beliefs and attitude in relation to address

| S/N | ADDRESS | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Rural | 12 | 29.58 | 4.21 | 45.83 | 7.67 | 25.58 | 6.10 |
| 2 | Urban | 38 | 29.89 | 3.75 | 45.05 | 5.95 | 25.34 | 5.55 |
| p Value | | | 0.808 (NS) | | 0.714 (NS) | | 0.898 (NS) | |

The above table implies that the mean knowledge score is higher (29.89) among the respondents from urban areas. However, the mean scores for beliefs and attitude are found to be higher (45.83, 25.58 respectively) among those who were from rural areas.

Table no.3.14: Respondents' knowledge, beliefs and attitude in relation to relationships with patients

| S/N | RELATION WITH PT. | N | KNOWLEDGE | | BELIEFS | | ATTITUDE | |
|---|---|---|---|---|---|---|---|---|
| | | | MEAN | SD | MEAN | SD | MEAN | SD |
| 1 | Parents | 6 | 29.83 | 3.43 | 49.67 | 2.73 | 22.17 | 6.15 |
| 2 | Siblings | 16 | 30.00 | 3.97 | 48.00 | 4.95 | 23.94 | 4.97 |
| 3 | Son/Daughter | 13 | 29.77 | 4.30 | 43.23 | 6.50 | 27.38 | 6.46 |
| 4 | Spouse | 14 | 30.00 | 3.66 | 41.79 | 6.67 | 26.43 | 4.94 |
| 5 | Others | 1 | 25.00 | | 49.00 | | 28.00 | |
| p Value | | | 0.811 (NS) | | 0.013 (SS) | | 0.254 (NS) | |

The above table reveals that the mean knowledge score is highest (30.00 each) for the respondents who were siblings and spouses of the patients and the lowest (25.00) for those with the Others (uncle, auntie) in relationship whereas the mean belief score is highest (49.67) for the parents of the patients and the lowest (41.79) for the spouses which is **statistically significant** where, **p value=0.013.** But the mean attitude score is found to be the highest (28.00) for those who are uncle, auntie in relation and the lowest (22.17) for the parents.

Table no.3.15: Correlations among respondents' knowledge, beliefs and attitude

| S/N | CORRELATION VARIABLES | CORRELATION COEFICIENT | SIGNIFICANCE (2- tailed t Test) |
|---|---|---|---|
| 1 | Knowledge vs. Belief | -.164 | .256 |
| 2 | Knowledge vs. Attitude | -.063 | .663 |
| 3 | Belief vs. Attitude | -.346* | .014 |

The table above reveals that knowledge has a negative correlation with belief and attitude as indicated by a shift towards negative beliefs and positive attitude (lower level of burden) with increasing level of knowledge. But this relationship is statistically not significant. On the other hand, belief has a negative correlation with attitude and vice versa indicated by the pValue –0.346 and sig. r =0.014. Thus, it can be interpreted that lower level of attitude (burden) was seen among the respondents having more positive beliefs towards mental illness.

Table no.4: Frequency and Percentage distribution of the sources of Information

| S/N | SOURCE | NO INFORMATION | SOME INFORMATION | MOST OF INFORMATION |
|---|---|---|---|---|
| 1 | Own experience of having mentally ill member | 0 | 6(12%) | 44(88%) |
| 2 | Heard from neighborhood | 14(28%) | 26(52%) | 10(20%) |
| 3 | Heard from Health personnel | 30(60%) | 19(38%) | 1(2%) |
| 4 | Newspapers, Magazines, Books, Radio and Television | 22(44%) | 26(52%) | 2(4%) |

Above table illustrates that 88% of the respondents received most of the information regarding mental illness from their own experience of having the mentally ill member in the family. Newspapers, magazines, books, radio and television were only some sources of information in 52% of the subjects. However, only 2% of the respondents have heard about mental illness from heath personnel.

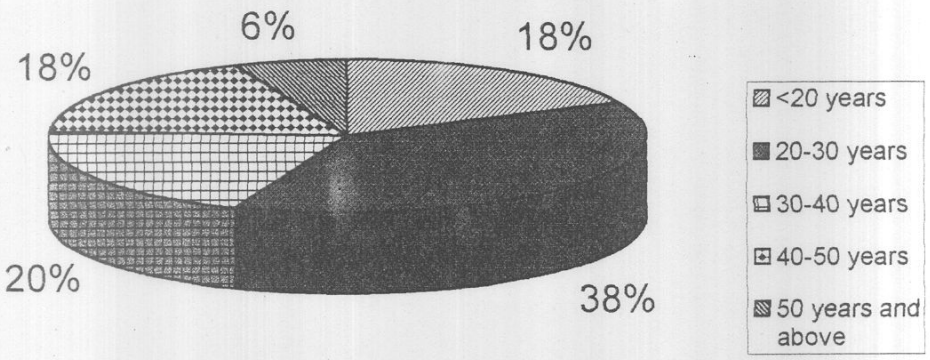



**Figure.1.1: Age distribution of Patients**

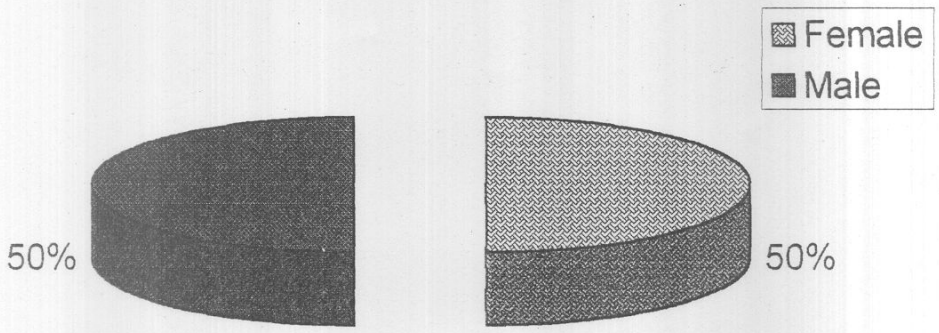



**Figure.1.2: Sex distribution of Patients**

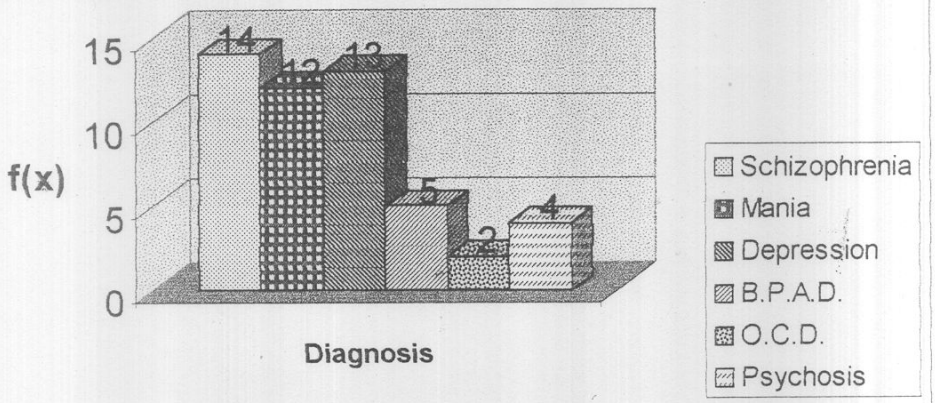



**Figure.1.3: Distribution of Patients according to Diagnosis**

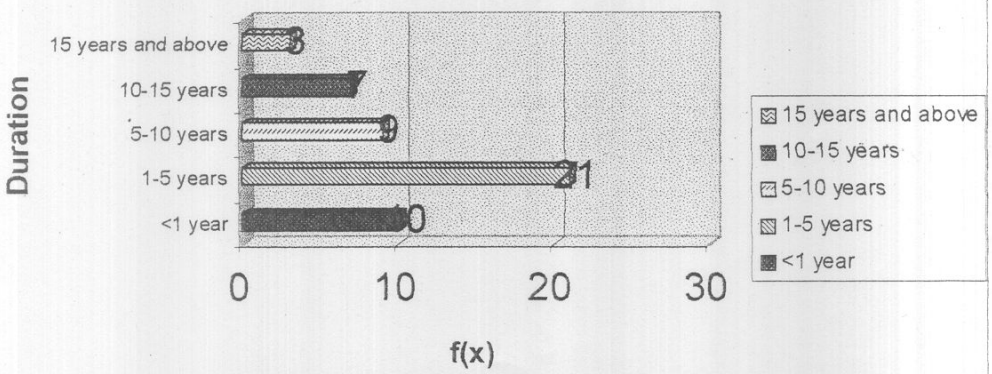



**Figure no.1.4: Distribution of Patients according to duration of illness**

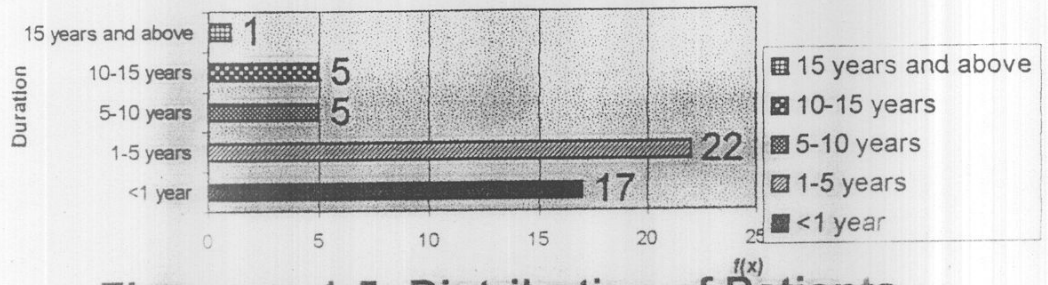



**Figure no.1.5: Distribution of Patients according to duration of treatment**

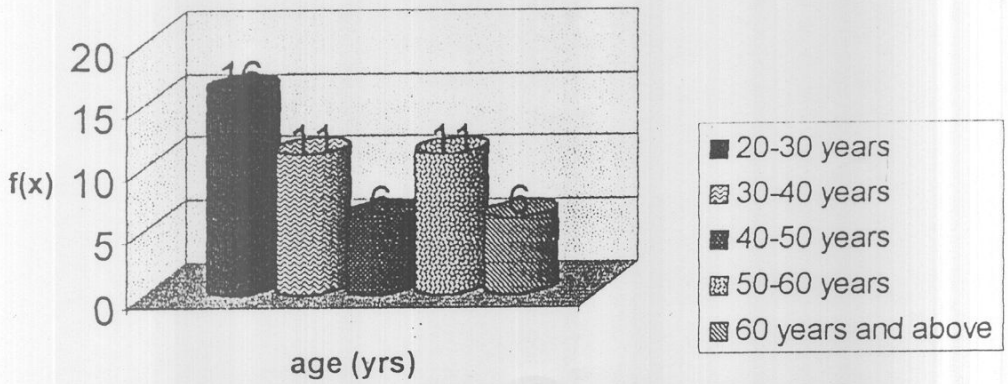



**Figure no.1.6: Age distribution of Subjects**

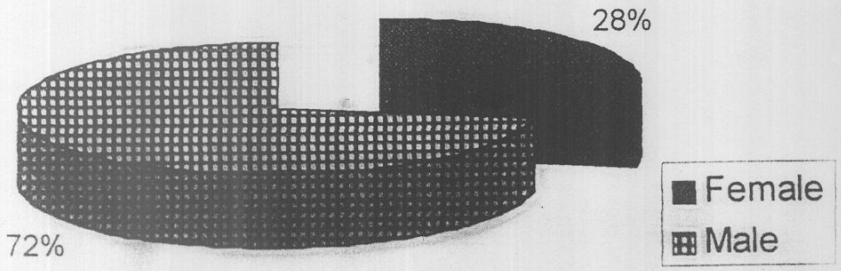



**Figure no.1.7: Sex distribution of Subjects**

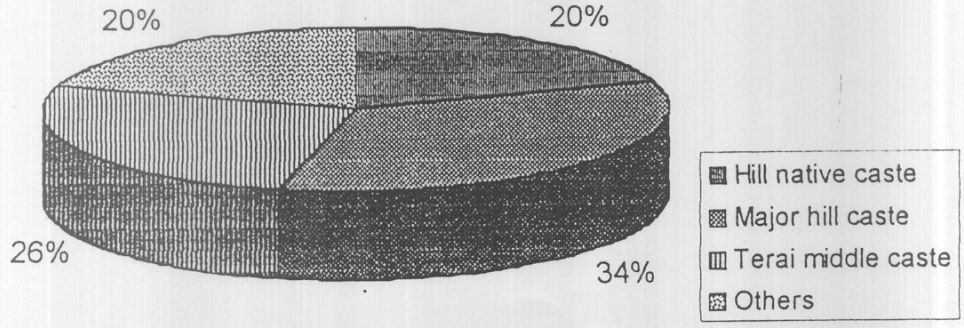



**Figure no.1.8: Distribution of subjects according to ethnicity**

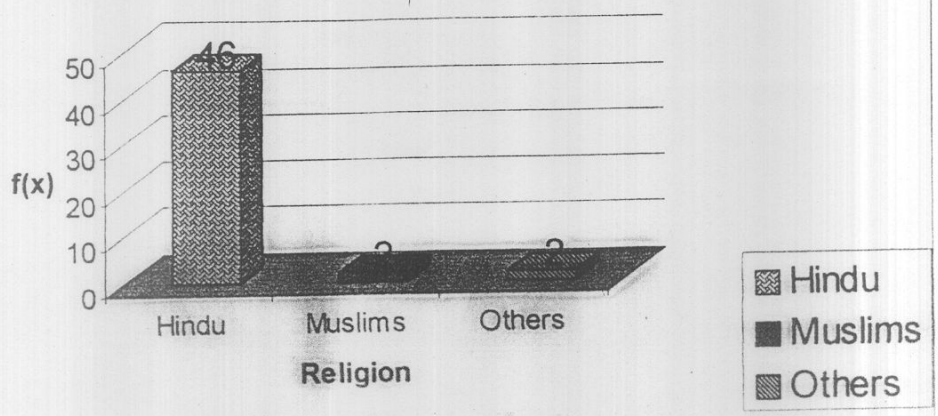



**Figure no.1.9: Distribution of subjects according to religion**

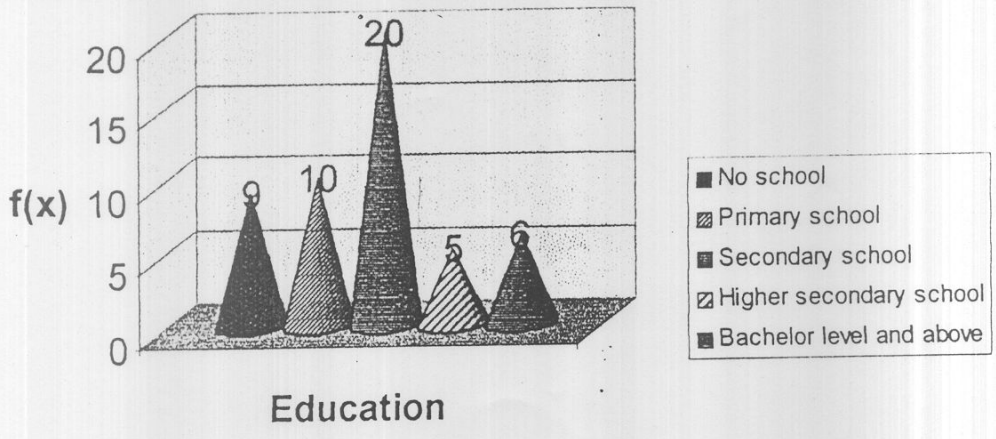



**Figure no.1.10: Distribution of subjects according to Education**

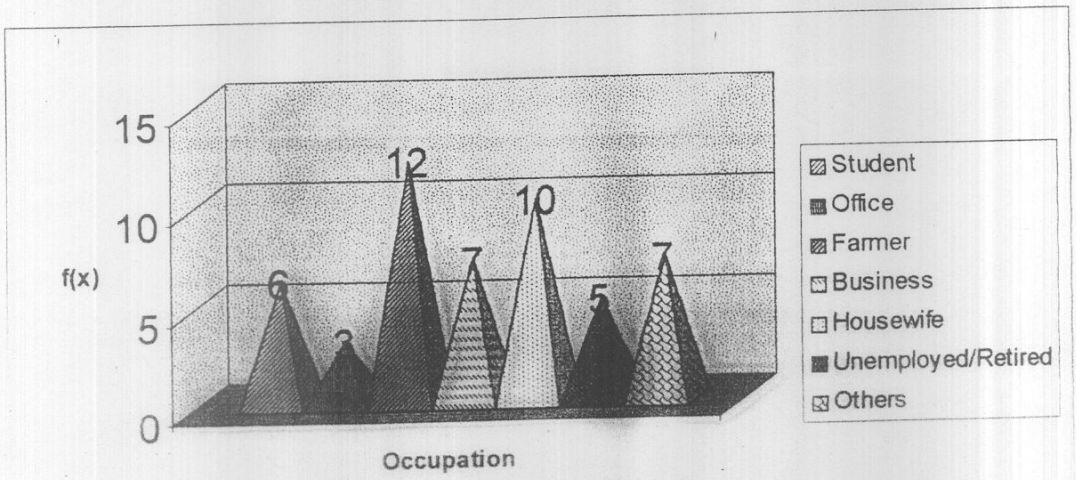



**Figure no.1.11: Distribution of subjects according to Occupation**

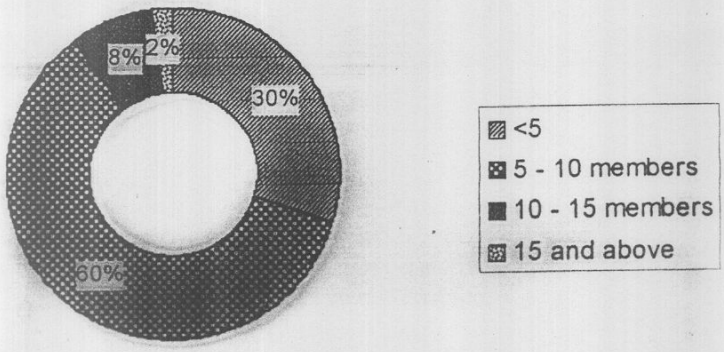



**Figure no.1.13: Distribution of subjects according to no. of family members**

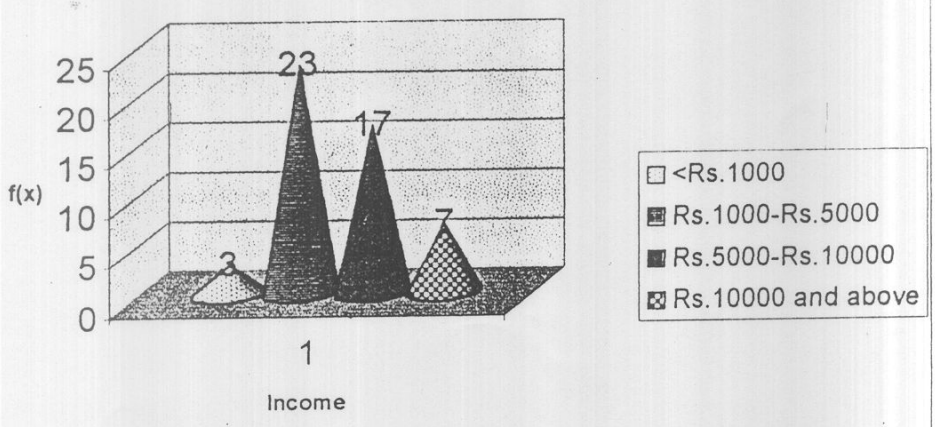



**Figure no.1.14: Distribution of subjects according to Income**

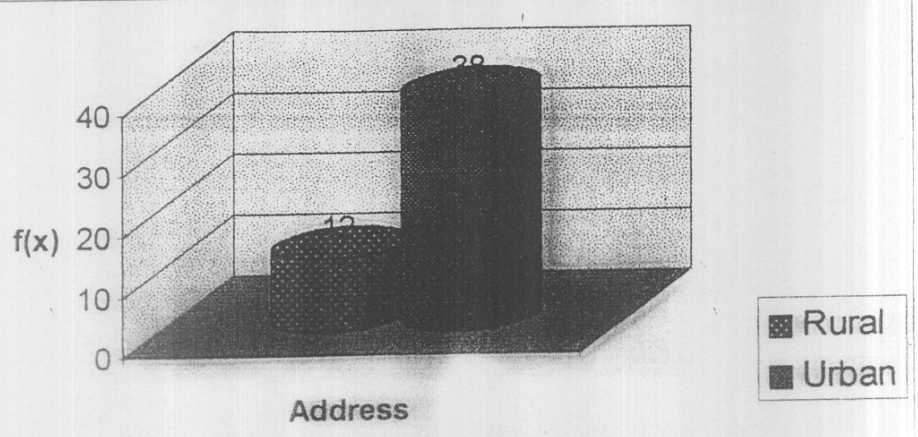



**Figure no.1.15: Distribution of subjects according to Address**

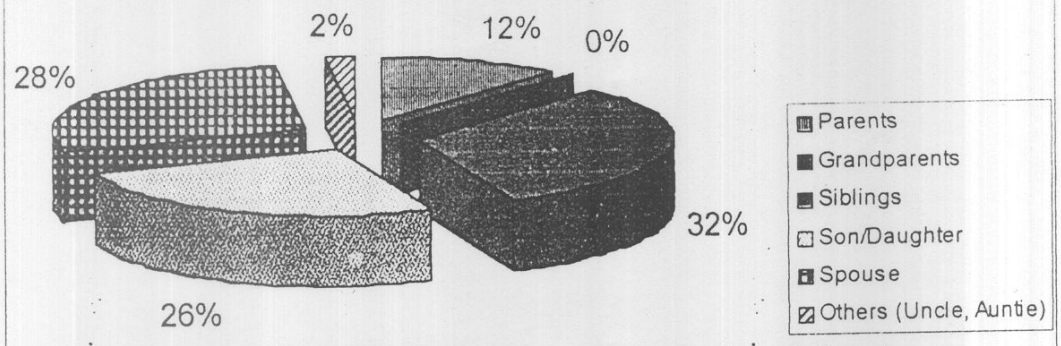



**Figure no.1.16: Distribution of subjects according to Relationship with the patients**

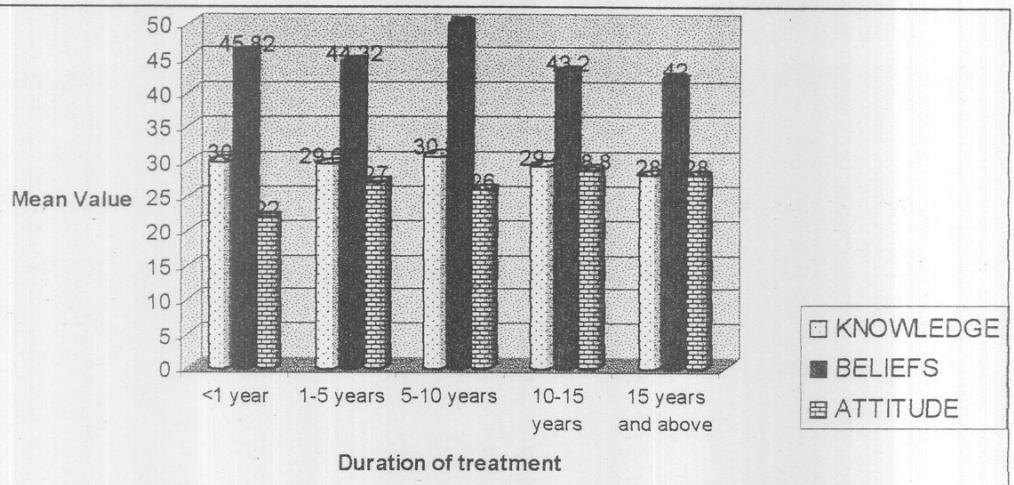



**Figure no. 3.3: Respondents' knowledge, beliefs, and attitude in relation to patients' duration of treatment**

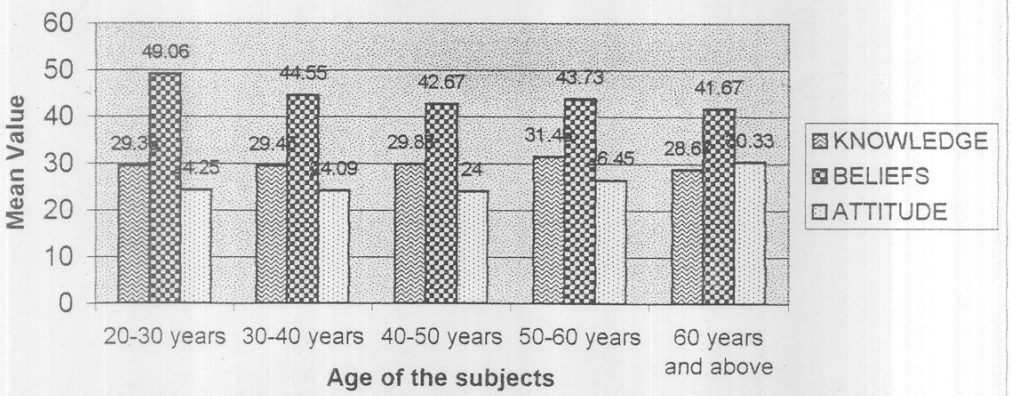



**Figure no.3.4: Respondents' knowledge, beliefs and attitude in relation to their age**

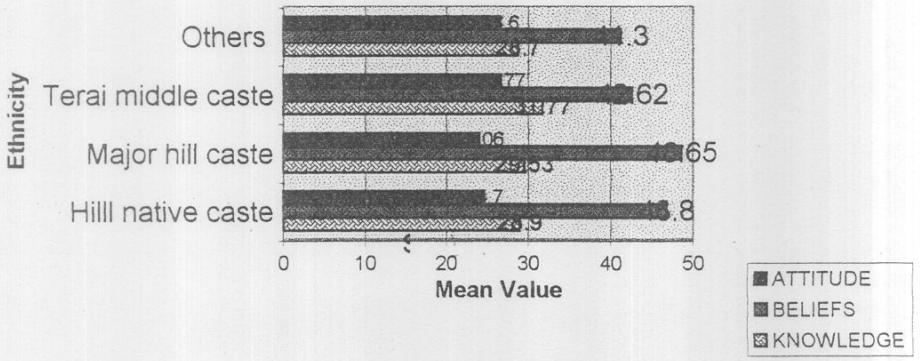



**Figure no.3.6: Respondents' knowledge, beliefs and attitude in relation to ethnicity**

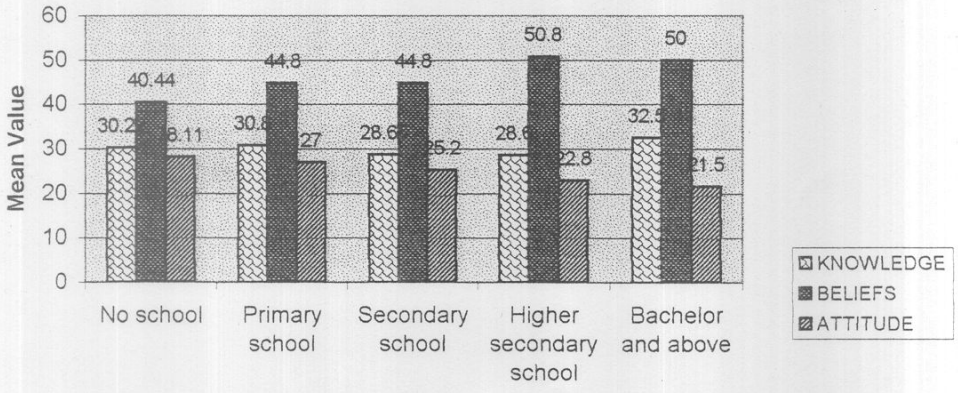



**Figure no.3.8: Respondents' knowledge, beliefs and attitude in relation to education**

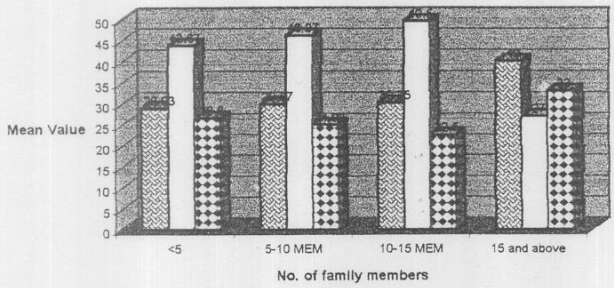



**Figure.no.3.11: Respondents' knowledge, beliefs and attitude in relation to size of family**

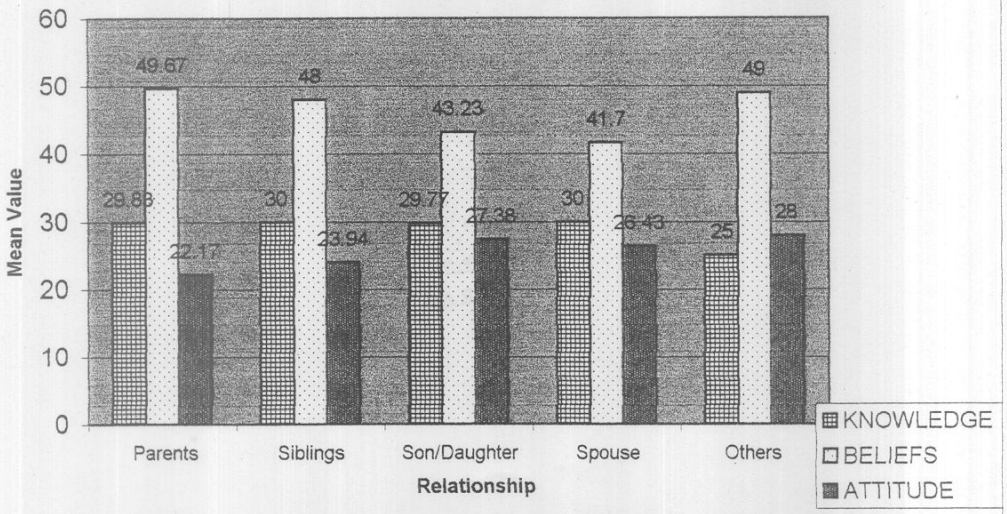



**Figure no.3.14: Respondents' knowledge, beliefs and attitude in relation to their relationship with the patients**

# CHAPTER V

## DISCUSSION:

The present study had been conducted with the broad objective to identify the knowledge, beliefs and attitudes of the family members of mentally ill patients on mental illness and the demographic attributes which influence them total of 50 respondents accompanying the mentally ill patients to the Psychiatric OPD, BPKIHS at the time of study were chosen using non-probability convenient sampling technique.
The findings of the present study have been discussed in accordance with the objectives of the research.

***First Objective***:

The analysis of the data regarding the first objective i.e. to describe the patients' attributes and those of the family members who accompany their mentally ill members to the Psychiatric O.P.D. at BPKIHS showed that most of the patients (38%) attending the clinic during the study period were of age group 20-30 years with an equal percentage of sex distribution. Most of the patients (28%) were diagnosed as Schizophrenics with the duration of illness as well as the treatment being 1 to 5 years.

However, most of the subjects (32%) were also of the same age group i.e. 20-30 years with male preponderance (72%). 34% of the subjects fell into the category of Major Hill Caste (Brahmin, Chhetri and Newar) and 92% were Hindu. In relation to their educational status, most of them (40%) were educated up to secondary level. But the results also revealed that majority of them (24%) had agriculture as their major occupation. With reference to the structure of the family, 58% of the respondents belonged to a joint families, which is consistent with the findings of having 5-10 members in 60% of the subjects. Although most of them (76%) were from urban area, their monthly family income was found to be quite low i.e.Rs.1000-5000. Data also revealed that among the six different categories of relationships, majority of the subjects (32%) were siblings of the patients.

***Second Objective:***

In reference to the second objective i.e. to identify the knowledge, beliefs (stigma) and attitude (burden) among the family members towards mental illness, The knowledge of the respondents was assessed based on their scores on verbal responses to10 structured questions on a 4-point scale with a possible score of 1 to 4 for individual item and1 to 40 for the sum of score on each knowledge item, the highest score signifying the most burden and the lowest signifying the least burden.

The analysis of the data pointed that majority of the respondents regarded excessive mental stress due to work overload, financial problems, bad interpersonal relationships to be the cause of mental illness which is indicated by the highest mean knowledge score (3.34), on the related items. The above finding is significant as it is consistent with the result of a general social survey conducted in USA in 1996 on "Public Conceptions On Mental Illness" which states that more than 90% of the respondents believed that Stress is or somewhat likely to be the cause of mental illness combined with biologic or genetic factors.

In relation to the treatment of mental illness, the high mean knowledge score i.e.3.94, 3.56 and 3.94 respectively on the related items indicate that majority of the respondents strongly agreed that the treatment of mental illness was as important as

physical illness, should be continued even after the disappearance of the symptoms and could be best treated by visiting a psychiatrist. This showed the knowledge of the respondents regarding the cause and treatment of mental illness to be fairly good, which could be due to the fact that most of them were educated up to the secondary level. However, only a few of the respondents supported the idea that mentally ill people can also be treated at home most of the times, indicated by a low mean score of 2.34 on the item.

The beliefs of the people were assessed based on their responses to 14 structured questions regarding cultural beliefs common in Nepali Society on a 4- point scale, with a possible score of 1 to 4 for individual item and1 to 56 for the sum of score on each belief item, the lowest signifying most negative beliefs and the highest being 4 most positive beliefs. In comparison to the respondent's level of knowledge as discussed earlier, it was surprising to discover that most of the respondents still believed all mentally ill patients to be mad and thus harmful and dangerous to the general public, revealed by a relatively low mean scores of 2.60 and 2.88 respectively. This is consistent with the findings of the study done on Public conceptions on mental illness in USA which reports that majority of the respondents (82.4%) believed symptoms of mental illness to be associated with potential violence.

Similarly in Nunnally's (1961) 6-year survey of 400 respondents revealed that the mentally ill were regarded with fear, distrust and dislike. Interestingly these" bad "conceptions were not because of misinformation but because of lack of proper information. Link et al (1987), in another study, demonstrated that the label of "previous hospitalization" fostered **more social distance** amongst those who perceived mental illness to be dangerous and **low social distance** amongst who did not see it as a threat. This clearly explains the fear the public has about mental illness.

In relation to respondents' perception to the stigma associated with the cause of mental illness, mean high score of the respondents on related belief items i.e.3.48, 3.32 and 3.44 showed that majority of the respondents did not agree that mental illness was communicable caused by some sins committed in the past life or due to the influence of ghost , evil spirit, witchcraft, black magic. This was in accordance with the results of the study conducted by Ramsey and Seipp's, which highlighted that the respondents with higher educational and occupational levels were less apt to view mental illness as punishment for sin or the outcome of poor living conditions.

As far as the treatment aspect of a psychiatric illness was concerned, a high mean scores (3.32,3.58, 3.72, 3.80and 3.08) against the culturally defined stigmata prevalent in our society revealed that the majority of the respondents verbalized a disagreement to some unscientific practices (like giving shoes and socks to smell to epileptic patients, keeping the mentally ill chained and locked up, application of red hot iron bar to unresponsive patients, avoidance of medical treatment with tablets and injections along with some food restrictions) to be beneficial in the treatment of the patients. However, data revealed a comparatively low mean score of 2.92 and2.80 on belief items which stated that mental illness could be cured by getting married and visiting a traditional faith healer, which was very close to the traditional approaches of treatment.

The above finding implied that, despite their fairly good knowledge on mental illness, (which might have been determined by their socioeconomic and educational status), they still hesitate to change their beliefs regarding some of the culturally defined misconceptions still prevalent in our society. The reason for this may be due to the negative image of psychiatry along with mental illness and being seen by a psychiatrist

Malhotra and wig (1975), based on their cross national study, also reported that the preferred sources of help were modern health services rather than traditional healers, **although** the latter were more likely to be consulted in mental illness as against physical illness. In a similar study conducted by Gurin et al (1960) reported that 42% of their subjects would seek out a clergyman for support, with only18% contacting a Psychiatrist.

The burden level (attitude) of the respondents was assessed based on their scores on verbal responses to14 structured questions on a 3-point scale with a possible score of 1 to 3 for individual item and1 to 42 for the sum of score on each attitude item, the highest score indicating the most burden and the lowest indicating the least burden.

As expected, the responses to the burden assessment questionnaire were found to vary in each item. The mean attitude score was found to be the highest (2.48) on the item indicating their present emotional state, according to which most of them felt depressed and anxious since the onset of patient's illness. Likewise, majority of the respondents reported frustration in relation to the slow improvement in the patients' present condition indicated by a relatively low attitude score (1.94) on the item. This may be because families' perception of mental illness has an important role to play in their expressed emotion.

Among, the 14 subjects who were the spouses of the patients, the mean attitude score was only 0.46 on the item indicating the influence of the patient's illness on their marital relationship. Hence the result showed a negligible effect on the marital relationship, which was quite opposite to the general expectations. However, considering the fact that the majority of the spouses accompanying the patients were females, they might have been hesitant to discuss a more personal matter such as this with the researchers inspite of being assured of complete confidence on several occasions.

In response to the items referring to their willingness to carryout certain activities with mentally ill patients, low mean scores i.e.1.78, 1.72,1.32and 1.70 on the related items implied that the respondents would not hesitate to work, stay, travel or socialize with a mentally ill person if the need arose. In relevance to the above findings, majority of the respondents did not report any feeling of guilt or shame associated with the patients' condition, pointed out by a relatively low mean score (1.58) on the item. However, this discovery in our study contradicts the statement given by Rabkin (1974) who emphasized that mental patients' handicaps are often attributable to public attitudes of rejection and avoidance.

In a similar study conducted by Whatley (1958-1959) on public attitude, the results suggested that the tendencies to restrict social interactions were found more in situations of closeness.

Although the respondents exhibited a desire for social interaction with mentally ill people on several occasions as mentioned above, majority of them were reluctant to establish marital relationship with the family having any mentally ill member, indicated by a low mean attitude score of 2.20.This is in accordance with the results of a study conducted by Verghese and Beig's (1974) which reported that a higher proportion of their subjects were against a marital alliance with the family having a positive history of mental illness.

***Third objective:***

Analysis of data regarding our third objective i.e.to identify the relationship among all the variables in order to assess their effects on each other pointed out that, although the highest mean scores differed for knowledge, beliefs and attitude among different diagnostic categories, the difference were statistically insignificant. Similarly,

the differences on mean score were found to be statistically insignificant based on different categories of duration of illness, sex of the caretaker, type of family, religion, occupation, income and residence of the family. In contrast to the above findings, a study conducted by Johnson and Beditz (1981) and others suggested that age, sex, education, social class, severity of illness presence of a diagnostic label to be important factors in the formation of attitude.

The difference in mean attitude score according to the different categories of duration of treatment on the other hand was found to be statistically significant, which revealed that with the increment in the duration of treatment, there was a corresponding increase in the respondents' perception of burden as well. This may be explained by the fact that as the duration of treatment increases, the family members become more physically, financially and emotionally involved with the patient, which tends to increase their level of burden.

Similarly, the mean belief score (49.06) was found to be highest for age group 20-30years and lowest (41.67) for >60years, which is statistically significant (p=0.42). This points out that subjects from age group of 20-30years had the most negative response to the various stigmata associated with mental illness in our society and vice versa for the people above 60years of age. Taking into consideration their educational status respondents of lower age group rely more on scientifically based facts and hence do not tend to follow the traditional myths and stereotypes associated with mental illness.

The statistical test applied to assess the difference in mean score for knowledge and attitude depending upon the number of family members showed a significant difference in knowledge and belief of the respondents. Surprisingly, the mean scores on both the knowledge and belief were highest among those having higher number of family members. Although no literature was available as such to support this finding, people coming from a larger family background are usually seen to be more cohesive with a greater sense of responsibility to each other. Hence they tend to be more knowledgeable and less stereotype in their perception towards mental illness.

The difference in the level of knowledge, beliefs and attitude among three ethnic groups showed a significant difference in the mean score on beliefs (p=0.006) with the highest mean score among those belonging to major hill caste. This indicates that a more positive belief and less stigma on mental illness are prevalent among the ethnic groups viz: Brahmin, Chhetri and Newar which can be explained to some degree by the fact that the people from this ethnic group usually belong to a higher socioeconomic and educational status considering their upper rank in the social hierarchy of caste system in our society .A study conducted by Hollingshead and Redlich (1958) also reported that members of the lowest social class almost never actively sought psychiatric help for themselves or their relatives.

The differences in mean scores on knowledge and attitude depending on the educational status of the respondents were found to be statistically insignificant. However, the mean attitude score was found to be highest (28.11) among those who had not been to school and lowest (21.50) among those having a bachelor degree and above. On the other hand, with the highest belief score (positive belief) of 50.80 among the respondents educated up to higher secondary level and lowest score (negative belief) 40.44 among the illiterates, statistically significant at p=0.009 showed that the level of education of the subjects greatly influenced their beliefs towards the common myths and stigma attached to mental illness in our society.

It was interesting to find the mean belief score to be highest among the parents and lowest among the spouse which is significant at the level of p=0.013.However no literature review was available to support this finding.

Although the relationship between knowledge, beliefs and attitude were insignificant at the level of p>0.05, in our study, some of the literatures on Public Attitudes in America suggest that there exists a relationship between public knowledge on mental illness and their attitude towards mentally ill most of the times. With a scientific base of knowledge on mental illness, negative beliefs tends to decline which subsequently decreases their perception of burden towards mentally ill.

However, findings also revealed that as the positive belief increases there is a corresponding decrease in the perception of burden among the respondents significant at p=0.014 and r=-.346. This is in agreement with the results of the study conducted in United States of America on the relative importance of negative and supportive social interactions in predicting different aspects of quality of life for mentally ill, which suggested that perceived stigma, whether actual or part of the family system of beliefs, partially mediated the relationships between negative social interactions and the quality of life of the mentally ill. The prejudice and stereotypes held by the public that stem from a lack of awareness and understanding, no doubt determines their perception of burden and desire for social interaction with the mentally ill patients.

The media and several other sources of information greatly influence the opinion society holds against mental illness. However, media may not always play a constructive role. In our study, it was found that, 88% of the subjects received most of their information regarding mental illness from their own experience of having a mentally ill in the family. Similarly, only in 52% of the cases media served as some source of information. However it was surprising that only in 2 %of the subject health professionals were a major source of information which may be because most of the subjects had approached friends, local physicians, neighbours and faith healers first before resorting to Psychiatry.

## SUMMARY:

This descriptive study was conducted to assess the demographic attributes of the family members, their level of knowledge, beliefs and attitude towards mental illness and the relationship of all the variables with each other. Samples for the study were the family members of mentally ill patients attending the Psychiatric OPD during the period of the study. Non-probability convenient sampling technique was applied for the purpose. Structured multiple-choice questionnaires with 38 items were administered to all 50 samples in the form of an interview. Written Consent from each subject was taken prior to the interview. The collected data were analyzed by calculating the percentage, mean, range and standard deviation of the mean scores. Assumptions were formulated and statistical tests-ANOVA and Correlation(r) were applied to determine the significance of difference between the mean score and the interrelationship among the variables.

An analysis of the demographic attributes of the patients revealed that maximum number of both the patients and the family members were of the age groups20-30 years. The sex distribution was equal among the patients but there was male predominance among the subjects. Although the study is not aimed at describing the knowledge, beliefs and attitude of the respondents depending on the diagnostic categories of the patients, analysis of the data revealed that the maximum number of the patients was diagnosed as

Schizophrenia followed by Depression, Mania, Bipolar affective disorder, Psychosis and Obsessive compulsive disorder in decreasing order. The duration of illness and treatment being 1-5 years in most of the cases.

The distribution of the respondents according to categories of religion and three categories of ethnic groups showed most of the respondents to be Hindu and related to major hill caste (Brahmin, Chhetri, and Newar). The educational status was found to be up to secondary level although agriculture was the primary occupation in majority of the subjects.

However, maximum number of the subjects was from joint families with 5-10 family members. Although most of the subjects resided in urban area, majority reported their average family income to be in the range Rs1000-5000. Majority of them were found to be siblings of the patients.

With regard to the respondents' level of knowledge on cause of mental illness, although a few of them thought that mental illness is caused by some physical or chemical changes in the brain, majority of the respondents agreed mental illness to be caused by excessive mental stress due to work overload, financial problems and bad interpersonal relationship. Regarding the treatment, most of them said that, the treatment for mental illness is as equally important as the physical illness and can best be treated by a Psychiatrist but it should be continued even after the disappearance of the symptoms.

In relation to the, common beliefs (stigma) towards mental illness in our society, majority of the respondents gave negative responses to the belief that mental illness is a communicable disease caused by some sins committed in the past, ghost or evil spirit and is associated with a strong family history most of the times. On the contrary, certain misconceptions such as "all mentally ill people are mad and so are harmful and dangerous for the society " were evident among most of them. Inspite of the fact that psychiatric help was considered the best choice of treatment for mental illness, most of them still preferred to consult a traditional faith healer first.

Regarding the respondents attitude towards mental illness, most of them agreed that the patients' illness has disrupted the stability of the family, worsened the family's financial situation and has increased the workload on other family members. Most of the respondents were depressed and anxious because of the illness, however they were also pessimistic to some extent about the outcome and the gradual improvement in the patients' well being. Although majority of them denied any feeling of guilt or shame of having a mentally ill family member, in contrast they were hesitant to establish a marital relationship with a family having any mentally ill member.
However most of them did not hesitate to stay in the same house, work, travel or include him or her in social gatherings.

The interrelationship among the demographic variable: knowledge, beliefs and attitudes tested by ANOVA and Correlation test showed that duration of treatment, age of the caretaker, number of family members, ethnicity, educational status and the relation with the patient significantly influences level of knowledge, belief and attitude of the respondents. Similarly, it was seen that, with an increase in the level of positive belief there was a subsequent decrease in the level of burden (attitude) indicated by a negative correlation, which is statistically significant.

## IMPLICATIONS:

Several implications can be drawn from the findings of this research study.

***1. Public awareness programme:***
People in the society still hold negative beliefs and attitude towards mental illness, which may be a result of lack of information's regarding scientific facts, related to mental illness among the general public. In order to create a public awareness on the subject, health education programme may be planned and implemented based on these findings so that they would be motivated to support the mentally ill member in the society.

***2. Community Involvement:***
Since the family members are considered to be the most responsible towards the care, treatment and rehabilitation of the mentally ill patients, an assessment of the level of their knowledge, beliefs and attitudes towards mental illness will help the mental health professionals to modify and plan the treatment accordingly so that these mentally ill patients can be treated and rehabilitated in their own community.

***3. Research***
Such type of research study may serve as a source of information for those interested to address the lacunae in the same area.

***4. Policy Making Body:***
The results of this study may help the policy making body in planning and implementation of sensitization and information programs concerning mental disorders, in the sense that increasing the knowledge of mental disorders could lead to significant achievements in the important fight against the stigma surrounding psychiatric patients.

***5. Traditional Faith Healers:***
The public beliefs existing in our society towards traditional approaches to treatment may be assessed from this study in order to incorporate traditional faith healers in the proper management of mentally ill patients.

## RECOMMENDATIONS:

1. Similar study can be conducted on a larger population covering different geographical areas.

2. A similar comparative study can be done between to assess the difference in knowledge beliefs, and attitude among the people from different ethnic or religious groups.

3. Further study can be conducted on different categories of personnel working in the hospital to assess their views on mental illness.

4. Other factors influencing the level of knowledge, beliefs and attitude in the society can also be explored.

5.The result of this research will be helpful in planning various public awareness programmes on mental illness in the community.

**LIMITATIONS:**

1.The study is limited to the family members of the mentally ill patients.

2.Since this research study is conducted for partial fulfillment of the course requirement for the degree of 4th year BSC Nursing programme offered by BPKIHS, only 50 subjects were include in the study due to limited time frame.

**PLAN FOR DISSEMINATION:**

The investigators have planned to share the findings of this study to the concerned persons and places as below.

1.BPKIHS-Nursing Coordinator, College of Nursing
2.BPKIHS-Supervisors /Guides
3.BPKIHS Library
4.NHRC
5.Publications of the article taking permission of the concerned authority.

# ANNEX

## BIBLIOGRAPHY:

1. Mary Jo Clark: Cultural influences on Community Health-Attitudes toward mental illness. Nursing in the Community; Second edition, Chapter –14, pp289.

2. Barbara Schoen Johnson: Historical views of mental illness. Psychiatric Mental Health Nursing-Adaptation and Growth; First edition 1986, pp 5-17.

3. Anthony Clair: Public attitudes and problem of stigma: psychiatry and the media. The Subject Matter of and Approach to Psychiatry, vol (1), pp 5-7.

4. Fabrega H.Jr.: Psychiatric stigma in the classical and medieval period: a preview of the literature, Department of Psychiatry, pp 1328-1332.

5. World Bank (1993): World Developmental Report-Investing in health. Oxford University Press.

6. Tashi D.Thinley: Mentally retarded continue to end up in streets. The Kathmandu Post, Sunday, August19, 2001.

7. Yanos PT, Rosenfield S, Horwitz AV: Negative and supportive social interactions and quality of life among persons diagnosed with severe mental illness. Community Mental Health Journal, October2001; 37(5): 405-419.

8. Ohaeri JU: Caregiver burden and psychotic patients' perceptions of social support in a Nigerian setting. Social psychiatry, February 2001; 36(2): 86-93.

9. R.Thara, R.Padmawati, Shuba Kura andLatha Srinivasan: Burden assessment schedule instrument to assess burden on caregivers of chronically mentally ill. Indian Journal of Psychiatry, Jan-Oct.1988; 40(1): 21-29.

10. Bruce G.Link, Jo C.Phelan, Michaeline Bresnahan, Ann Stueve and Bernice A: Public conceptions of mental illness-label, causes, dangerousness and social distance. American Journal of Public Health, September1999; 89(9): 1328-1332.

11. Rabkin J. (1974) Public attitude towards mental illness: a review of the literature. Schijophrenia Bulletin10, 9-23.

12. Halpret H.P (1969) Public acceptance of mentally ill, Public Health Reports.84, 59-64

13. Segal S.P (1978) attitudes toward mentally ill: a review. Social Work 23,211-217

14. British Broadcasting corporation (1957) *The Hurt Mind*: An Audience Research Report.BBC, London.

15. GarthererA and Reid J.J.A. (1963) *Public Attitudes and Mental Health Education*: Nothamptom Mental Health Project. Northampton Country Council, Northampton.

16. Whatley C. (1958-59) Social attitudes towards discharged patients. *Social Problems* 6,113-320.

17. Bhugra D. and Scott J. (1989) The public image of psychiatry-a pilot study. *Psychiatric Bulletin of Royal college of Psychiatry*. 13,330-333

18. 15.PrabhuG.G Raghuram A; Verma and Maridess A.C. (1984) Public attitude toward mental illness: a review National Institute of Mental Health and Neurosciences Journal 2,1-14

19. Verghese A. and Beig A. (1974) Public attitudes toward mental illness: the Vellore Study. Indian Journal of Psychiatry 16, 8-18.

20. 9.Bhugra.D (1991) Indian Teenagers Attitude Towards mental illness. Research report, Institute of Psychiatry, London

21. 10.Boral G.C, Bagchi R. and Nandi D.N. (1980) An opinion survey about the cause and treatment on mental illness and the social acceptance of mentally ill patients. *Indian Journal of Psychiatry* 22,235-238

22. 11.Malhotra H.K and Wig N.N (2973) Vignettes for attitudinal Research in Psychiatry, Indian Journal of Psychiatry17, 195-199.

# CONSENT FORM

This questionnaire is designed to find out your opinion on mental illness. Your name will be kept anonymous and your response will be kept confidential. The information gathered here will be used only for research and not for other purpose.

The purpose of the study has been explained clearly along with its implications. I here by willingly give my consent to participate in the study.

.....

Signature

## सहमति पत्र

**"Knowledge, beliefs and attitude towards mental illness among the family members of the mentally ill patients"** मा गर्न लागिएको अध्ययन अनुसन्धानका अनुसन्धानकर्ताले यसका उद्देश्य तथा प्रयोजनहरुको सम्बन्धमा मलाई पूर्ण जानकारी गराएको हुंदा, म यस सहमति पत्रमा सहमत छु भनी सही गर्दछु ।

.....

(सही)

# QUESTIONNAIRE

## PART I

**Demographic data:**

1. Age of patient:
   1-<20 years
   2-20-30 years
   3-30-40 years
   4-40-50 years
   5-50-60 years
   6-60 and above

2. Sex of patient: 1- Female 2- Male

3. Diagnosis:
   1-Schizophrenia
   2-Mania
   3-Depression
   4-Bipolar Affective Disorder
   5-Obsessive Compulsive Disorder
   6-Psychosis

4. Duration of illness:
   1-<1 year
   2-1-5 years
   3-5-10 years
   4-10-15 years
   5-15 and above

5. Duration of treatment:
   1-<1 year
   2-1-5 years
   3-5-10 years
   4-10-15 years
   5-15 and above

6. Your age:
   1-20-30 years
   2-30-40 years
   3-40-50 years
   4-50-60 years
   5-60 and above

7. Your sex: 1-Female 2- Male

8. Ethnicity:
   1-Hill native caste (Rai, Limbu, Magar, Tamang)
   2-Major hill caste (Brahmin, Chhetri, Newar)
   3-Terai middle caste (Mandal, Chaudhary, Yadav, Mehata)
   4-Others (specify)

9. Religion:
   1-Hindu
   2-Muslim
   3-Other (specify)

10. Education:
   1-no school
   2-Primary
   3-Secondary
   4-Higher secondary
   5-Bachelor and above

11. Occupation:
   1-Student
   2-Office
   3-Farmer
   4-Business
   5-Housewife
   6-Unemployed / Retired
   7-other (specify)

12. Type of family:
   1-Joint
   2-Nuclear

13. Number of family members living in the home:
   1-<5
   2-5-10
   3-10-15
   4-15 and above

14. Family Income (Rupees/month):
   1-<1000
   2-1000-5000
   3-5000-10000
   4-10000 and above

15. Address:
   1-Rural
   2-Urban

16. Relationship with the patient:

1-Parents
2-Sibling
3-Son/daughter
4-Spouse
5-Other (Uncle, Auntie)

## PART II

**Knowledge regarding mental illness:**

**Key: 4=Strongly agree; 3=Agree; 2=Not sure; 1=Disagree**

17. Once a person develops a mental illness, he can become healthy as before.

18. Mental illness is caused by some physical or chemical changes in the brain.

19. Mental illness can be caused by excessive mental stress due to work overload, financial problems, bad interpersonal relationships etc

20. Mental illness may sometimes manifest itself as physical discomfort.

21. The treatment for mental illness is equally important as for physical illness.

22. Most of the mentally ill people can be treated at home.

23. The psychiatric treatment should continue even after the disappearance of symptoms.

24. Mental illness can best be treated by visiting a Psychiatrist.

**Key: 1=strongly agree; 2=agree; 3=not sure; 4=disagree. (For question no. 25-26)**

25. Mentally ill people can never take care of themselves.

26. Mentally ill people can never take responsibilities of their family.

## PART III

**Common beliefs regarding Mental illness:**

**Key: 1=strongly agree; 2=agree; 3=not sure; 4=disagree**

27. All mentally ill people are harmful and dangerous.

28. All mentally ill people are mad.

29. Mental illness can be cured by getting married.

30. Mental illness is caused because of some sins committed in the past life.

31. Mental illness is caused by ghost, evil spirit, witchcraft and black magic.

32. Mental illness is a communicable disease

33. Mental illness is always hereditary.

34. Young people and children do not suffer from mental illness.

***The following activities are beneficial for the treatment of mental illness:***

35. Visiting traditional faith healers.

36. The shoes and socks should be given to smell to patients of epilepsy.

37. All mentally ill patients should be chained and locked up

38. Unresponsive patients should be treated with application of red-hot iron bar.

39. The treatment with tablets and injections can make the conditions worse.

40. Certain food like garlic, onion, meat and eggs should not be allowed.

## PART IV

**Attitudes (Burden) regarding Mental illness:**

**Key: 1= Not at all; 2= To some extent; 3= Very much**

41. Does the patient cause disturbances at home?

42. Has your family stability been disrupted by patient illness?

43. Does the care of the patient prevent you from taking adequate care of others in the family?

44. Has your family's financial situation been worsened since the patient illness?

45. Has your workload increased after the onset of the patient's illness?

46. Do you sometimes feel depressed and anxious because of the patient?

47. Would it bother you if any member of your family got married in the family having any mentally ill member?

48. Do you feel any guilt or shame having this member in your family?

***If the spouse is the ill member in your family, please answer the following question;***

*49. Has the quality of your marital relationship declined since your family member's illness?

50. Do you often feel frustrated that the improvement of the patient is slow?

***Carrying out activities with mentally ill people if needed?***

**KEY: 1= Not at all; 2= To some extent; 3= very much**

51.Does it bother you to working together in office/ business/ field or class?

52.Does it bother you to stay in the same family?

53.Does it bother you to include him/ her in social gatherings?

54.Does it bother you to travel together in bus, motorcycle, tampoo etc?

*SOURCE OF INFORMATION ABOUT MENTAL ILLNESS*

**KEY: 1= No information from this source; 2= Some information; 3= most of my information**

55. From your own experience of having a mentally ill person in the family.

56. Heard from other people or seen somebody in neighborhood.

57. Heard from Doctors or any other Health personnel.

58. From Newspapers, Magazines, Books, Radio and Televisions

# प्रश्नावली

व्यक्तिगत परिचयात्मक तथ्यहरु :

१. बिरामीको उमेर:
   १. <२० वर्ष
   २. २० देखि ३० वर्ष
   ३. ३० देखि ४० वर्ष
   ४. ४० देखि ५० वर्ष
   ५. ५० देखि ६० वर्ष
   ६. >६० वर्ष

२. बिरामीको लिंग: १. महिला २. पुरुष

३. रोगको नाम:

४. बिरामी भएको अवधि:
   १. <१ वर्ष
   २. १ देखि५ वर्ष
   ३. ५ देखि १० वर्ष
   ४. १० देखि१५ वर्ष
   ५. >१५ वर्ष

५. उपचार अवधि :
   १. <१ वर्ष
   २. १ देखि १० वर्ष
   ३. ५ देखि १० वर्ष
   ४. १० देखि १५ वर्ष
   ५. >१५ वर्ष

६. तपाईंको उमेर :
   १. २० देखि ३० वर्ष
   २. ३० देखि ४० वर्ष
   ३. ४० देखि ५० वर्ष
   ४. ५० देखि ६० वर्ष
   ५. >६० वर्ष

७. लिंग : १. महिला २. पुरुष

८. जाति :
   १. राई/लिम्बु/मगर/तामोङ्ग
   २. बाहुन/क्षेत्री/नेवार
   ३. मन्डल/चौधरी/यादव/मेहेता
   ४. अन्य

९. धर्म :
   १. हिन्दू
   २. मुसलमान
   ३. अन्य

१०. शिक्षा :
   १. अशिक्षित
   २. प्राथमिक
   ३. माध्यमिक
   ४. उच्च माध्यमिक
   ५. स्नातक वा बढि

११. पेशा :
   १. विद्यार्थी
   २. कर्मचारी
   ३. खेतीपाती
   ४. व्यवसाय
   ५. गृहिणी
   ६. बेरोजगार
   ७. अन्य

१२. परिवारको बनावट :
   १. संयुक्त
   २. एकल

१३. परिवारको सदस्य संख्या :
   १. <५
   २. ५देखि १०सम्म
   ३. १० देखि १५ सम्म
   ४. >१५

१४. परिवारको मासिक आम्दानी :
   १. < रु. १०००
   २. रु. १००० देखि रु.५००० सम्म
   ३. रु. ५००० देखि रु. १०,००० सम्म
   ४. ≥ रु. १०,०००

१५. ठेगाना :
   १. सुगम
   २. दुर्गम

१६. बिरामीसंगको सम्बन्ध :
१. अभिभावक
२ दाजुभाइ/दिदीबहिनी
३. छोरा/छोरी
४. श्रीमान/श्रीमति
५. अरु कोही

मानसिक रोग र रोगीको बारेमा तपाईंको जानकारी

१७. एकपल्ट मानसिक रोग लागेको व्यक्ति फेरि पहिलेको जस्तो स्वस्थ हुन सक्छ ।
४.एकदमै ठीक हो ३.ठीक हो २.भन्न सक्दिन १.ठीक होइन

१८. मस्तिष्कमा केही भौतिक तथा रसायनिक परिवर्तनको कारणले मानसिक रोग लाग्छ ।
४.एकदमै ठीक हो ३.ठीक हो २.भन्न सक्दिन १.ठीक होइन

१९. मानसिक रोग आर्थिक समस्या,आपसी सम्बन्धमा कटुता र बढी कामको चाप जस्ता मानसिक तनावले गर्दा हुन्छ।
४.एकदमै ठीक हो ३.ठीक हो २.भन्न सक्दिन १.ठीक होइन

२०. कहिलेकाहीं मानसिक रोग शारिरिक तकलिफको रुपमा पनि प्रकट हुन सक्छ ।
४.एकदमै ठीक हो ३.ठीक हो २.भन्न सक्दिन १.ठीक होइन

२१. शारिरिक रोगको जस्तै मानसिक रोगको पनि उपचार गर्न उत्तिकै आवश्यक छ ।
४.एकदमै ठीक हो ३. ठीक हो २.भन्न सक्दिन १. ठीक होइन

२२. अधिकांश मानसिक रोगीको उपचार घरमै रहेर पनि गर्न सकिन्छ ।
४. एकदमै ठीक हो ३. ठीक हो २.भन्न सक्दिन १. ठीक होइन

२३ मानसिक रोगको उपचार रोगका लक्षणहरु हराइसकेपछि पनि जारी राख्नुपर्छ ।
४. एकदमै ठीक हो ३. ठीक हो २.भन्न सक्दिन १. ठीक होइन

२४.ानसिक रोगीको उपचार मानसिक रोग विशेषज्ञलाई गराउनु सबैभन्दा प्रभावकारी हुन्छ ।
४. एकदमै ठीक हो ३. ठीक हो २.भन्न सक्दिन १.ठीक होइन

२५.मानसिक रोगीहरु आफ्नो हेरचाह आफैंले कहिले पनि गर्न सक्दैनन् ।
४.ठिक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

२६.मानसिक रोगीहरुले आफ्नो परिवारको हेरचाह कहिले पनि गर्न सक्दैनन् ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

मानसिक रोग र रोगीहरु सम्बन्धि केही जनविश्वासहरु

२७ सबै मानसिक रोगीहरु हिंस्रक र खतरनाक हुन्छन् ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

२८.सबै मानसिक रोगीहरु पागल हुन्छन् ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

२९. मानसिक रोग बिहे गरेमा ठीक हुन्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३०. मानसिक रोग पूर्व जन्मको पापले गर्दा हुन्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३१. मानसिक रोग भूत, प्रेत, बोक्सी र जादूमन्त्रले हुन्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३२. मानसिक रोग सरुवा रोग हो ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३३. मानसिक रोग सधै वंशानुगत हुन्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३४ बाल - बालिका तथा युवाहरुलाई मानसिक रोग लाग्दैन ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

मानसिक रोगीहरुको उपचारको लागि निम्न लिखित उपायहरु लाभदायक हुन्छन् ।

३५. धामीझांकीकोमा जानु पर्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३६. छारे रोग लागेको व्यक्तिलाई जुत्ता र मोजा सुघांउनु पर्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३७. सबै मानसिक रोग लागेको व्यक्तिहरुलाई बांधेर र थुनेर राख्नुपर्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३८. औषधि उपचारले निको नभएमा त्यस्तो बिरामीलाई तातो फलामको छडले डाम्नुपर्छ ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

३९. मानसिक रोगीलाई चक्की र सुई दिएमा स्थिति झन् बिग्रन सक्छ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

४०. केही खानेकुरा जस्तै प्याज, लसुन, मासु र अण्डा दिनुहुदैन ।
४.ठीक होइन ३.भन्न सक्दिन २.ठीक हो १.एकदमै ठीक हो

मानसिक रोग र रोगीहरुप्रति केही जनधारणाहरु

४१. के बिरामीले घरमा खेलाबेला मच्चाउंछ ?
१. मच्चाउदैन २.अलिअलि मच्चाउंछ ३.धेरै मच्चाउंछ

४२. के बिरामीको रोगले गर्दा तपाईंको पारिवारिक स्थिरता खल्बलिएको छ ?
१.छैन २.अलिअलि ३.धेरै खल्बलिएको छ

४३. के बिरामीलाई ध्यान पुर्‍याउनु पर्दा, तपाईं परिवारका अन्य सदस्यहरुलाई उत्तिकै ध्यान पुर्‍याउन सक्नुहुन्छ ?
१.धेरै जसो सक्छु २.कहिलेकाही सक्छु ३.सक्दै सक्दिन

४४. के बिरामीलाई रोग लागेदेखि तपाईंको परिवारको आर्थिक स्थिति बिग्रदै गएको छ ?
१.छैन २.अलिअलि ३.धेरै

४५. के बिरामीले गर्दा परिवारमा तपाईंको कार्यभार बढेको छ ?
१.छैन २.अलिअलि ३.धेरै

४६. के तपाईं बिरामीको कारणले गर्दा अत्याधिक दुखित र चिन्तित हुनुहुन्छ ?
१.छैन २.अलिअलि ३.धेरै

४७. के तपाईं परिवारको कुनै सदस्यको बिहे त्यस्तो परिवारमा स्थापना गर्न तयार हुनुहुन्छ जुन परिवारमा मानसिक रोगी छ ?
१.तयार छु २.भन्न सक्दिन ३.तयार छैन

४८. के तपाईंलाई परिवारको सदस्य मानसिक रोगी भएकोले गर्दा अरुको अगाडि लाज हुन्छ ?
१.हुदैन २.अलिअलि हुन्छ ३.धेरै हुन्छ

***यदि मानसिक रोगी तपाईंको श्रीमान/श्रीमति भएमा कृपया तलको प्रश्नको उत्तर दिनुहोस्**

*४९.के तपाईंको श्रीमान/श्रीमतिको मानसिक रोगको कारणले तपाईंको वैवाहिक सम्बन्ध बिग्रदै गएको छ ?
१.छैन २.अलिअलि ३.धेरै

५०. के तपाईं बिरामीको स्थितिमा ढिलो सुधार भएको देखि हतोत्साहित हुनुहुन्छ ?
१.छैन २.अलिअलि ३.धेरै

के आवश्यक परेको खण्डमा तपाईं मानसिक रोगीसंग बसेर निम्नलिखित कार्य गर्न सक्नुहुन्छ ?

५१. सहकार्य गर्नु (अफिस, व्यापार, खेतीपाती, कक्षा आदि) ?
१.सक्छु २.भन्न सक्दिन ३.सक्दिन

५२. एकै घरमा बस्नु ?
१.सक्छु २.भन्न सक्दिन ३.सक्दिन

५३. सामाजिक जमघटमा समावेश हुनु ?
१.सक्छु २.भन्न सक्दिन ३.सक्दिन

५४. साथसाथ यात्रा गर्नु (बस, मोटरसाइकल, टेम्पो आदि) ?
१.सक्छु २.भन्न सक्दिन ३.सक्दिन

**मानसिक रोग र रोगीहरुको बारेमा माथि उल्लेखित जानकारी र अनुभवहरु कहांबाट प्राप्त भएको हो?**

५५. आफ्नो परिवारको सदस्यमा मानसिक रोग भएकोले
१. केही पनि होइन२. अलिअलि ३. धेरै जसो

५६. अरु कुनै मानसिक रोगी छिमेकमा देखेर वा त्यस्ता रोगीको बारेमा अरुबाट सुनेर
१. केही पनि होइन२. अलिअलि ३. धेरै जसो

५७. चिकित्सक वा स्वास्थकर्मीबाट सुनेर
१. केही पनि होइन२. अलिअलि ३. धेरै जसो

५८. अखवार, पत्रपत्रिका, किताब, रेडियो, टेलिभिजन, आदिबाट
१. केही पनि होइन२. अलिअलि ३. धेरै जसो

# WORK PLAN SCHEDULE

| S/N | Research activities | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Identification of the problem | | | | | | | | | | | | |
| 2. | Groundwork | | | | | | | | | | | | |
| 3. | Review of literature | | | | | | | | | | | | |
| 4. | Preparation of conceptual framework | | | | | | | | | | | | |
| 5. | Presentation of proposal | | | | | | | | | | | | |
| 6. | Pilot study | | | | | | | | | | | | |
| 7. | Data collection | | | | | | | | | | | | |
| 8. | Data analysis | | | | | | | | | | | | |
| 9. | Interpretation of results and discussion | | | | | | | | | | | | |
| 10. | Preparation of abstract | | | | | | | | | | | | |
| 11. | Reporting and dissemination regarding the result | | | | | | | | | | | | |

THANK YOU