CHAPTER V

SUMMARY & CONCLUSION

“Mental illness is nothing to be ashamed of, but stigma and bias shame us all.”

–Bill Clinton

The present research study had carried out to study the existing attitudes and beliefs toward mental illness.

As far as attitudes and beliefs toward mental illness are concerned, the fear of the potential threat of patients with such illness to self and to the community always remains. Erroneous beliefs about causation and lack of adequate knowledge have been found to sustain deep-seated negative attitude about mental illness (Rico 2007). In a study (Link et. al. 2004) it was revealed that people are not caring and sympathetic toward mentally ill persons. These negative attitudes about mental illness often underline stigma, which can cause affected persons to deny symptoms, delay treatment, be excluded from employment, housing, or relationships, & interfere with recovery.

This present study was carried out among the public of Assam. Survey method was applied using mixed sampling technique. The sample had been selected from the three zones of Assam i.e., Upper Assam, Central Assam and Lower Assam. From each zone two districts had been selected which were again split into urban and rural setting. From each setting equal number of males and females has been selected among the age groups of 21 years to 40 years and 41 years to 60 years size distributed equally. Thus, multi staged sampling procedure had been used with the total sample size of 120 x 2= 240 x 2=480 x 3=1440 distributed equally.

The research design was 2x2x2 factorial design and there were three independent and three dependent variables. Independent variables were- Setting (Rural & Urban), Gender (Male
& Female), Age (21 years to 40 years & 41 years to 60 years). The dependent variables were Acceptance, Knowledge & Exposure, and Stigma & Discrimination.

Three different tools had been used for collection of data. Personal Data sheet to collect the demographic information; Semi-Structured Questionnaire developed and standardized by the researcher to support the third tool and to cover a wider area of related information; and A Case Vignette.

The researcher visited the geographical areas to be covered for research and approached the target groups individually as well as in groups to participate in the research. After getting their consent, responses were collected from the participants.

After collecting data scrutiny was done carefully, and finally 1440 questionnaires were selected with equal distribution. The frequencies and percentages were then calculated and finally Chi-Square test was applied.

It has been found from the results obtained that viewpoints of the public vary according to or depending on the setting i.e. rural or urban areas. Attitudes and beliefs also depend on gender of the respondents and also on their chronological age i.e. younger age group comprising of 21 years to 40 years and older age group comprising of 41 years to 60 years.

The findings of the study have been briefly listed below in table 5.1. and 5.2.

Table 5.1. Chi-Square table showing the values for Semi-Structured Questionnaire:

<table>
<thead>
<tr>
<th>Attitudes</th>
<th>Setting</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>19.139*</td>
<td>46.555**</td>
<td>29.126**</td>
</tr>
</tbody>
</table>
Comparing the two tables, the Chi-square values for Semi-structured Questionnaire and Vignette it is clear that the attitudes and beliefs reflecting the level of Acceptance with respect to the Setting and Gender was found to be significant in both the scale, whereas in respect to Age it was significant in the semi-structured questionnaire but in the vignette it was found not to be significant. Hence, in can be inferred that there may a significant difference of attitudes and beliefs reflecting the level of Acceptance with respect to setting and gender; but it is not clear with regards to age.

From the calculated Chi-square scores for Semi-structured Questionnaire it was clear that the attitudes and beliefs reflecting knowledge & exposure with respect to Setting was found to be significant. However, the vignette did not show such significance for knowledge & exposure. But with regard to Gender and Age it was found not to be significant in both the semi-structured questionnaire and Vignette. Thus, it may be inferred that there is a significant difference of attitudes and beliefs reflecting the level of Knowledge & Exposure with respect to setting only; but it is not so with regards to the gender and age.
The calculated chi-square values for attitudes and beliefs reflecting Stigma & Discrimination with respect to Setting, Gender and Age for the Semi-structured questionnaire and Vignette was found to be significant. Thus, it may be inferred that there might be a significant difference of attitudes and beliefs reflecting Stigma & Discrimination with respect to Setting, Gender and Age.

The findings of the present research may be summarized as follows-

1) Acceptance is higher in rural setting, females and younger age group,

2) Knowledge and Exposure is higher in younger age group, whereas a mix response has been found for setting and gender,

3) Stigma and discrimination is higher in urban setting, males and the older age group.

Majority of the respondents from urban setting in this study seemed to exhibit lower level of knowledge and exposure to persons with mental illness. Likewise it was seen that stigma was higher in urban society rather than in the rural society which is quite surprising as it appears to be widely believed that people from rural areas would be more stigmatized. Thus, it may be stated that more number of awareness programs need to be organized and the mass media also need to take active initiatives to make the people well sensitized about the root cause, possibilities, management and the consequences of mental illness in urban areas.

In India approximately 28% of the population lives in cities and this is expected to increase to 41% by the year 2020 (UN World Urbanization Prospects 2008). The people in urban areas have a totally different pattern of life then the rural dwellers with difference in life style, daily routine, family life, social life, economic status and psychological features. The people of urban areas lives with increased stressors and factors such as overcrowding, polluted
environment, competitive work field, high level of violence and reduced social support compared to the people from rural areas (Anon 1994, Murray CJ, Lopez AD 1997). The social interaction and family relationship in the rural areas are more than the urban people who are in need of more facilities to be made available and infrastructure to grow which lead to decreased social support and relationship (Desjarlaiset et al. 1995). It is seen in the urban areas the number of nuclear families are more and both the couple are employed and busy with the growth schedule of professionalism which lead to disengagement in family life and social involvement. Social involvement is only confined to small clubs and groups on an infrequent basis. This pattern of life probably makes social acceptance of the mentally ill different in both the setting. Though it is generally believed that stigma would be lower among the urban population with the number of educated people being high but the study reveals a different scenario. This is because acceptance depends on social involvement which, in turn, leads to lower stigma.

As such, it may be concluded that more effort has to be put in to bring persons with mental illness from urban settings into treatment, rehabilitation and ultimately include into the mainstream and urban masses need to be exposed to advocacy and educational programs on mental illness.