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Public Attitudes Toward Mental Illness : A Review

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Abstract

The study of the attitudes held by the general public, the patients themselves, their families and the various professional groups who come in contact with the mentally ill has become an area of special interest during the last few years. The studies conducted in this area in India have been presented. Attention has been given to the constructs and concepts used, tools utilised, methodology adopted and the populations studied by the different investigators. In view of the National Mental Health Programme with its emphasis on community participation in the action for mental health, future course of action that need to be planned in this area has been outlined.

Key words -
Mental illness,
Attitudes,
Opinions,
Developing countries,
Review

The rise of social and community psychology has given rise to a great deal of interest in the study of the opinions about mental illness held by the general public, the patients themselves, their families and the various professional workers who come in contact with the mentally ill. The logical extension of this is the attempt to modify these opinions in the desired direction by mental health education. The ultimate goal obviously is to have an insight into how all these shape the behaviour of various individuals towards the mentally ill. The main reasons for the current interest can be summed up as follows:

i. The opinions and attitudes of a community towards mental illness carry implications for the epidemiological studies of mental disorders, as these may influence the willingness of the subjects to declare symptoms in the course of surveys of psychiatric disorders in samples of general population. Declaration will also depend on the prevailing concepts of mental disorders, in the society and the resulting evaluation and interpretation of anomalies of behaviour.

ii. In almost all the countries there is at present a stress on providing more facilities for the treatment of the mentally ill. Health planners have to see that on the basis of the felt needs of the community, services are to be provided for conditions about which the community shows maximum concern. Secondly, availability of mental health facilities do not guarantee that these services would be

utilised by the population, as this is dependent on the community orientations towards mental illness. Early recognition of mental illness, enlistment of professional help at the right time, rehabilitation of the mentally ill in the community, in short a total involvement of the community in mental health programmes, is facilitated when the opinions held about mental illness are favourable and the attitudes sympathetic. The involvement described, if present, is likely to bring about further positive and continuous attitudinal change in the community.

iii. An essential prerequisite before embarking upon a programme of mental health education is to establish the parameters of existing opinions in the target population. Once these baseline studies are conducted, one can assess at a later stage the impact of lapse of time, the spread of mental health services and the influence of mass media on the existing opinions.

iv. All over the world there is a movement by professional workers to repel archaic legal provisions about mental illness in their countries and provide more humane acts. This would mean a complete change in the methods of admissions, discharges, rehabilitation and the maintenance of the mentally ill. The successful implementation of all this would depend on the awareness of the society - especially the various agencies - that are concerned with the deviant behaviour in society about the existing provisions as well as on its response to new provisions.

Despite the recognition of the importance of these studies systematic research in the area has been sparse. It is this paradox that made Wechsler et al [1] point out, "the volume of empirical research on mental health attitudes is microscopic... our decision to allocate an entire part of this volume to the topic of mental health attitudes is not based on the quantity of available research but rather on our conception of its importance .... with the hope that this might stimulate further research". A WHO Expert Committee [2] suggested that a series of studies are required to be undertaken in this area. It made a pointed reference to social scientists and psychologists as the two groups charged with a "particularly important task in connection with the investigation of prevalent areas of ignorance in relation to mental illness and the establishment of, and advice on educational methods". The Indian Council for Social Science Research [3] has given the very same area a top priority research rating in the Indian set up. Halpert, [4] Rabkin [5], [6] and Crocetti et al, [7] have reviewed in detail different aspects and issues concerning this area.

The Western Scene

The largest number of studies conducted in this area are from the United States of America and Canada. Majority of them showed that there is misinformation, fear and anxiety about the mentally ill which makes the public stigmatise and reject them. Star [8] pointed out that mental illness is something which people want to keep as far as possible. Cumming and Cumming [9] found that the response to mental illness is a sequence of "denial, isolation and rejection" while the Joint Commission on Mental illness and Health [10] pointed out that several studies have shown that there is a "major lack of recognition of mental illness as illness and a predominant tendency towards the rejection of both the mental patients and those who treat them". Yet when the recent studies [7] are inspected in detail, one detects a gradual variation in the trends of the results which tend to go in a direction opposite to the one pointed out by the Joint Commission.

Halpert [11] pointed out that the studies in this area "have only occasional areas of congruancy which permit meaningful comparisons". The main reasons that contribute to the equivocality of the findings can be summed up as follows:

i. Various studies have been conducted at different points in time since the study in 1943 by Al1en [12]

which is probably the earliest. As Halpert [11] points out that in the western world with the passing of time there is a forward motion in better public understanding of the mentally ill, a greater tolerance of them and a decrease in the defeatism about the prospects of treating them.

ii. To point out what they have studied different investigators have used different concepts. These include concepts like facts, knowledge, conceptions, information, image, idea, thinking, belief, notion, opinion, orientation, attitude, ideology, stereotype, prejudice, and stigma concerning mental illness and/or the mentally ill. As there can be considerable overlap among some of the concepts used it is not easy to clearly differentiate between them. A distinction can be made theoretically but it is difficult to presume that such subtle distinctions exist in the "minds of men" when they respond to various aspects of mental illness.

iii. The cardinal concept used in the various studies to indicate the phenomena studied is not identical. Concepts like psychoses (psychotic) neuroses (neurotic), mental illness, mental ill health, mentally ill, mental patient, mental disorder, psychiatric patient, emotionally disturbed person, mental health & psychologically maladjusted along with crude concepts like madness & madmen have been used. Each of these have the potential to bring about changes in the responses of those being studied.

iv. The tools and techniques used and the methodology followed has been different. Earlier studies were [8] introduced the vignettes which have been used extensively thereafter. Questionnaires made their impact around 1960 and several studies have used the Custodial Mental Illness Ideology Scale (CMI) [13] the Opinions about Mental Illness Scale (OMI) [14] and the scale by Nunally [15]. The use of Semantic differential, field experimental studies, content analysis of programmes on the mass media have also been resorted to. For a broader understanding of the phenomena in different communities the terminology used to refer to the mentally ill, existing legislation, arrangements made for the care of the mentally ill, the role assigned to the care giving agencies, study of the discharge rates of patients admitted to the hospitals, ready willingness with which therapeutic facilities are made use of by the community, analysis of ancient texts, folklore, mythology, reformist speeches, parliamentary debates, legal enactments, content analysis of films and popular literature have all been used though not very extensively. The methods thus utilised to study the phenomena are many, and hence before attempting to compare the results obtained by different investigators it is essential to note whether the methods used by them are similar or tend to differ.

v. Of necessity, the studies conducted have been restricted to limited geographical areas each of which had its own sociocultural milieu. It has been pointed out by different investigators that personality attributes of the respondents like dogmatism, authoritarianism, and locus of control influence their attitudes towards the mentally ill. Socio-demographic factors like sex, age, race, education. socio-economic level, occupation, marital status and rural/urban background are also known to have their impact. At a macro level political structure and climate of a society, its religious values, and the general orientation of the society - radical or conservative-towards social issues is potent in shaping these attitudes. The actual exposure and contact an individual had with the mentally ill has been repeatedly demonstrated as an important variable. However, no single factor seems to influence the attitudes all by itself in a simple and direct manner but it seems to be an unique configuration of factors. It is this diffused relationship which seems to bring about equivocality in the relationship which seems to bring about equivocality in the findings reported by various investigations. This would limit the possibility of generalising the results to groups which are dissimilar to the one on which a set of results have been attained.

Indian Studies

In any area of research, transplanting the findings of a study conducted in a particular socio-cultural setting to another is hazardous. This is all the more so when one finds that the area one deals with is such that it tends to give widely differing results in sociocultural settings, which though not identical, have something in common.

If we scan the Asian situation in general and the Indian scene in particular, not much of information is readily available about the socio-culturally based conceptions of mental illness and related problems. India has its ancient civilisation, a unique socio-cultural heritage, a religious background characterised by fatalism and external locus of control, an "unsophisticated" rural, illiterate population ridden by poverty and as yet limited but slowly increasing exposure to mass media of communication. In such a situation, it would be inadvisable to speculate on the basis of western studies on the concept of mental illness that is held by a lay person in India or his orientation towards mental illness.

Observations made by experienced and sensitive observers can be as valid as and at times more profound than the information collected by controlled and empirical methods. Scarcity of empirical data does not ipso facto mean that we do not possess valuable information. This is particularly so, if experienced observers displayed a high degree of agreement with one another. In India, perceptive observers [16], [17], [18] have commented about the social stigma attached to mental illness. Dube [19] points out that "a great deal of misconception, superstition and ignorance exists in respect of mental disease. Much stigma is often attached. Mental illnesses are viewed as a visitation of evil spirits of a goddess of a curse. This takes the form of exaggerated belief in mystic influences, excessive faith in the powers of saints, priests and medicaments. Among Muslims, the visitation takes the form of Sayyad. The medicaments, sorcerers, faith healers, priests etc. are frequently engaged to cure cases of mental illness, snake bites etc. There are a number of places of worship reputed as centres of treatment endowed with healing power due to a deity. One such place in this region is Balajee, where a large number of persons from this region go in the hope of a cure of mental disease. Many usually return disillusioned and come to Mental Hospital"

On the basis of his three decades of clinical work in the field of mental health, Varma [20] points out eight specific misconceptions prevalent among people in the north-eastern parts of India. It is believed that all mental illnesses are alike. The cause of mental disorders is considered to be a single shock, sexual starvation, result of "heat" or of possession. Mentally ill are viewed as people with no capacity for understanding. Pessimism pervades about the possibility of a cure and if any one gets better, complete physical rest is considered essential. Varma [20] points out that there is a strong stigma attached to mental illness and "most of these misconceptions are widespread among the educated and sophisticated sections of our people".

Gupta et al [21] pointed out that in an exclusive hospital for mental diseases at Ranchi 60 pet cent of the beds were occupied by long stay patients of whom just 7 percent had the need for hospitalisation. In his presidential address Bhaskaran [17] pointed out that the long term stay of the other 93 percent of "unwanted patients" is a reflection of the rejection of the psychiatric patient by the family and the society. The stigma associated with mental illness is a social problem in the main and concerns a change resistant situation of value orientations.

One of the earliest reports in this area is by Neki [22] who carried out a research project at Amritsar

which was funded by the Indian Council of Medical Research. On the basis of the survey he reported that a sizeable section of the public fears and tends to strongly reject the mentally ill. He adds that in the rural population there is still considerable tolerance for the mentally ill.

Nunally's Tests

A series of studies have been conducted in India wherein the tools developed by Nunally [15] in his Illinois studies were used.

Utilising the 20 item Mental Health Opinion Questionnaire of Nunaly [15], which elicits the responses on the basis of the 6 choices given in a multiple choice format, Sathyavathi et al [23] studied a group of 75 male and 75 female respondents with a professional background and a mean education of 15.7 years. The average age of the group was 34 years.

The study indicated "crystallised opinions about the concept of mental health and illness" in this group. They conceptualised a mentally ill person either as "highly intelligent" or as "an ignorant person". The neurotic person was either a "young woman" or an ignorant person" who has been unloved and lonesome in childhood. Childhood experiences and security were stressed as important aspects to maintain good mental health. Awareness regarding the centres of treatment existed in this group and the mental hospital represented a place of hope. They thought the role of a psychiatrist as that of making his clients work out their own problems. They were optimistic about the likely outcome of treatment if a patient is taken to a specialist early and treated for a fairly long time. Losing interest in the surroundings and losing self-control were the most commonly attributed symptoms of mental illness. The respondents expressed a willingness to interact with the mentally ill in various aspects of life, and did not find a need either to maintain social distance from the mentally ill or hide the fact if someone is ill in their own family. The investigators conclude that "the present group of subjects do not maintain any negative attitude towards mental patients or ex-mental patients".

The attitudes of the 40 respondents who had a mental patient in their family did not differ significantly from that of others. Comparing the findings with that of Nunally, [15] on his American sample similarity was seen on all concepts except that of a neurotic.

Utilising Nunally's [15] sixty item questionnaire, Sathyavathi and Dwarki [24] studied 120 subjects who had a minimum of eleven years of schooling. They found that mental health information held by the respondents was neither influenced by their sex nor their contact with a mentally ill person in the family. They concluded that the respondents did have limited information on mental health issues which was not crystallised and to a large extent they were uninformed and not misinformed.

Making use of the 40 items that went into the 10 information factors enunciated by Nunally [15], Rahmathulla and Sathyavathi [25] studied an educated group of 250 subjects in the age range of 19 to 48 years. They found that on the 5 factors-avoidance of morbid thoughts, guidance and support, immediate external environment, non-seriousness, and age function-the information possessed by the respondents was consistent, stable and crystallised. The respondents showed areas where they lacked information but gross misinformation did not seem to exist.

Basumallik and Bhattacharyya [26] using a modified version of the mental health in-formation questionnaire developed by Nunally [15] studied an incidental sample of 369 educated layman and 122 mental health experts. The response reflected a return rate of 81.3% and 69.3% of those approached to

fill in the questionnaire. Where necessary, the investigators used a Bengali version of the questionnaire. The modified version differed from the questionnaire used by Nunally in that in addition to the 40 items on the 10 factors that Nunally used, the questionnaire included ten items developed by the authors. The rating scale used in the study for response recording had 5 steps instead of the 7 steps that Nunally used.

Responses of both the groups studied were scored and analysed in terms of the 10 original factors generated by Nunally on the American population. In general, the findings confirmed Nunally's conclusions that the mental health information held by the educated lay persons are not well crystallised, yet their views are not markedly different from those the experts as both had neutral rather than firm opinions. The less educated as well as older respondents were more misinformed.

Cross culturally, the experts from India were in agreement with the views of their American counterparts though the Indian experts more emphatically rejected the factors of "non-seriousness" and "hopelessness."

Culture Specific Questionnaire

During the period 1967-1975, a series of studies in this area were conducted by Prabhu [27] at Delhi. Initially questionnaires developed in the West CMI, OMI, Nunally and Mclean-were used but as the item relevance and factor stability were found to be unsatisfactory, efforts were made to develop a tool which is socio-culturally relevant. From an item pool of 900 items which referred to the causes, characteristic features, treatment and after effects of mental illness, a 235 item preliminary questionnaire was developed. These items were information centered which could be answered by experts in the field of mental health by accepting or rejecting them on the basis of current day scientific knowledge. The questionnaire was administered to an urban, adult, educated and English knowing sample to 350 individuals who were selected by way of a systematic sample with a random start from 3 representative residential localities of Delhi. Factor analysing the responses, a shorter, refined and factorially validated 95 item orientation towards mental illness scale was evolved. The scale consisted of 13 factors which referred to folk therapy, psychosocial stress, organic causation, non-restrained behaviour, weak cognitive control, fidgety behaviour, bizzare behaviour, folk therapy, psycho-social manipulation, physical methods of treatment, hopelesness, hypofunctioning and rejection of mentally ill.

Four of the factors derived-psychosocial stress, organic causation, hopelessness and rejection-had partial resemblance to the scales included in the factorially derived tests from the West. 2 factors-folk belief and folk therapy -were uniquely culture specific. The other factors were not unique but were independent in nature when compared to the dimensions with which Western scientists are concerned. This is significant as nearly 70% of the initial 235 input items had resemblance to the items used in Western tools. It is clear that factor analytically derived scales have no universal validity and as such using them as "Indian adaptations" without establishing the factor stability across populations is rather hazardous.

The shorter 95 item questionnaire was administered to a fresh sample of 300 individuals selected as in the earlier phase. Responses were also sought from 50 mental health experts from Hindi speaking States of India as to what they thought should be known by the educated lay public about mental

illness on the various items. The educated lay public differed significantly from the experts on all the factors except the one on psycho-social stress. However, they did not hold views opposed to those of the experts thus showing that there is no misinformation among them though there is a pervasive lack of information.

Scores on the various factors were influenced by age, education and sex to a very minimal extent though those over 50 years of age differed more with the experts, looked upon mental illness as a hopeless condition and preferred to maintain greater social distance from the mentally ill. Women showed sliglitly better awareness of mental illness than men. Higher education and contact with the mentally ill did not seem to influence the respondents orientation towards mental illness.

Generally the educated lay persons viewed the mentally ill as aggressive, violent and dangerous. Optimism about the outcome of treatment was not high. There was a lack of awareness about available facilities to treat the mentally ill Pervasive defeatism and a tendency to reject the mentally ill existed in the sample studied.

A structured interview schedule which permits the coverage of the 13 areas in the questionnaire and which can be gone over in about an hour was also developed as a part of this study.

Vignette Studies

Following the pattern of the Star [8] abstracts, Malhotra and Wig [28], [28a] constructed fourteen vignettes which are socio-culturally meaningful and understandable. They picturised a person with schizophrenia, paranoid schizophrenia, hysteria, depression, behaviour disorder, physiological night emissions, obsessive compulsive neurosis, anxiety, psychogenic impotence, mania, alcoholic addiction, dementia and antisocial personality disorder. One vignette depicted a 'normal' individual. 107 qualified Indian psychiatrists participated in the process of validating the picturisation contained in each vignette. Using 6 of these vignettes Malhotra and Wig [29] and Malhotra, Wig and Inam [30] investigated the ways in which the public manages an individual showing deviant behaviour and concluded that psychological persuasion, social manipulation, medical intervention, dietary regulation, mental health consultation, mystical and religious modes along with a tendency of not seeking any type of intervention constituted 7 ways of handling deviant behaviour. These are used in different combinations and sequences which is influenced to a large extent by the socio-economic strata to which the individual with deviant behaviour and those managing him belong to. Malhotra, Wig and Verma [31] used a single vignette depicting the picturisation of a depressive patient to find out how many of the respondents perceive psychiatric illness in him and the causes they attribute to depressive illness.

Murthy [32] used vignettes to study the attitudes towards mental disorders in the Manke village of Punjab by interviewing 100 respondents. From a household only one respondent was taken. Methodological constraints forced the author to pool the data into very broad heterogenous categories and he concluded that more serious forms of psychiatric disorders (psychoses) are correctly recognised and are considered as serious enough to be taken for medical intervention. Half the respondents showed a lack of sensitivity to recognise the problems of the alcoholic addict and the child with behaviour disorder. They were aware of the existence of a mental hospital situated at a distant place while they lacked similar information about a psychiatric facility in the general hospital setting at a

close proximity.

Within the framework of a WHO research programme [33] to introduce community mental health services as a part of primary health care in developing countries, investigations were carried out in India, Sudan and Philippines to study how mental disorders were perceived in 3 communities in these countries. Raipur Rani, a village in Haryana, with a population of 64,000 was the study area in India. Data was gathered by inteviewing key informants who had lived in the concerned community and were occupying positions of trust and respect due to which they came in regular contact with the members of the community. Approximately 3 informants per thousand of general population were contacted. 7 vignettes which portrayed mental retardation, epilepsy, acute psychosis, mania, depressive psychosis, process schizophrenia and depressive neurosis along with a standardised interview schedule were the tools used. The aim was to study the perception of mental disorders, the reaction to them, the help seeking behaviour and the perception of the role of traditional medicine and healers in caring for the mentally ill. Similar information was collected in relation to some physical disabilities to study the differential perception and attitudes concerning physical and mental disorders.

In Raipur Rani the 50 key informants interviewed were married men working in health care, agriculture or industry with average age around 51 years. Each informant knew more people with mental disorders than those with physical disabilities and could name on an average 2.7 mentally ill individuals. The reported preferred sources for help were modern health services rather than traditional healers though recourse to the latter was sought more often in case of mental disorders than in the case of physical illnesses. In the order of frequency the 3 conditions identified by the key informants were epilepsy, acute psychosis and mental retardation.

Using a 3 point scale the responses of each of the informants to the conditions described in the vignettes were rated to obtain the attitudinal ratings about the gravity, prognosis, marriage prospects, possibility of their living at home and being able to work or study. From utilising pooled and averaged ratings graphic attitude profiles for each disorder have been drawn up which represent a distillation of the attitudes of the informants on the 5 dimensions mentioned above to each of the 7 conditions depicted in the vignettes. Acute psychoses was perceived as the condition with most serious consequences, while mania and process schizophrenia were felt to be almost as serious but with somewhat more hopeful attitude towards the individual as being able to live at home. The prognosis for both depressive psychosis and neurosis was seen as bad but the social consequences.-marriage, living at home, and work-were seen to be less serious. Mental retardation was perceived as the least serious condition. In general the data suggested that in Raipur Rani there are strikingly pessimistic community attitudes towards the social consequences of mental disorders.

The report emphasises the undesirability of imposing on the community either a preconceived and standardised perception or inducing a favourable optimistic view of the mentally ill. Changing the conceptions based on stigma or lack of information, no doubt, need to be attempted but generally the community should develop realistic, humane and sympathetic responses to mental illness which takes account of the real hardships and problems faced by the mentally ill and their families.

The Field Survey

As a part of a larger epidemiological study, Verghese and Beig [34] interviewed 517 adults during

which time they were asked 10 questions about mental illness. The sample satisfactorily reflected the characteristics of the general population with regard to socio-economic status and religion. The median age of the group was 35 years. As the group was predominantly urban wherein 72% were women and those who were illiterate constituted just 10% of the group there was a bias in the sample.

Ninety six percent of the respondents had seen a mentally ill person. Twenty five percent of those respondents agreed that there are varying types of mental disorders with differing degrees of seriousness but the others were uncertain about the nature and differing severity of mental illness.

One third of the population studied did not know as to what could have caused mental illness. Twenty nine percent, mainly those with higher education, believed that emotional factors play a predominant role. Occurrence of mental illness as a result of God's punishment for sin, excessive thinking and organic factors was attributed, in each case by approximately 10% of the respondents. Very small number of respondents attributed the causation to poverty, heredity and evil spirits though 58 percent felt that there is a relationship between moon and mental illness.

Majority of the respondents were sympathetic towards mental patients and accepted modern methods of treatment available in hospitals. However, 10, 4 and 2% of the respondents preferred to seek recourse to witchcraft, religious centres and the ayurvedic systems respectively. 26 percent of the respondents felt that marriage contributes to the improvement in the condition of the mentally ill. Optimism about the outcome of the treatment, especially if given early, was expressed though nearly two thirds of the respondents felt that the cure can only be partial. Pessimism that mental illness are incurable was seen in a small segment of 3 percent of the respondents.

The general trend of attitudes of this group of respondents from the city of Vellore was a positive one. This trend showed a correlation with higher education and income. Yet, two thirds of the respondents were against a marital alliance with a family where there is a positive history of mental illness.

Family Perception

Kshama and Channabasavanna S M [35] studied the opinion of 100 relatives of hospitalised psychiatric patients. The tool used was the 0M1 [14] which was modified on ad hoc basis. The study aimed at studying the influence of socio-demographic variables on the opinions about the mentally ill.

Compared to the urban the rural population was more authoritarian, socially restrictive and thought in terms of inter-personal etiology. The urban population expressed more benevolent attitudes. Authoritarian attitudes were expressed by the higher economic group and by women. Men expressed more benevolent attitudes. Mental hygiene ideology did not show a relationship with any of the socio-demographic factors.

Boral, Bagchi and Nandi [36] studied the opinions about mental illness among 240 relatives of psychiatric patients and 120 relatives of non-psychiatric patients. The groups were selected from those seeking help in a hospital practising modern system of medicine. The 2 groups were matched for age, sex, education and socio-economic status. A 22 item questionnaire was used to elicit the required information.

Both the groups stressed heredity as the main cause of mental illness. Traditional methods like faith healing, ojha's magic, homeopathic and ayurvedic methods of treatment were preferred by less than one third of the subjects studied. Awareness of psychotherapy as a form of treatment was absent in

both the groups and its acceptance was very low-less than the acceptance shown to ojha (magic healer), ayurvedic treatment and homeopathy. Majority felt that drugs and ECT helps the patient.

Regarding the acceptance of the mentally ill, both groups showed a reluctance to establish marital relationship between a cured mental patient or a person belonging to the family of such a patient and a member of their own family. However, both the groups favoured giving jobs to cured mental patients.

Majority of the individuals in both the groups attributed mental illness to be due to unemployment, financial stress, loss of job, sudden loss in business, bereavement, failure in love affair, sexual frustration and guilt due to excessive masturbation. Majority of the respondents favoured marriage of the patient as a method of cure .

All the respondents felt that excited mental patients must be hospitalised, while 40 percent felt that even the non-excited ones must be hospitalised and should not be treated when they continue to stay at their home.

Awareness among Physicians

Devadasan [37] studied 28 graduate doctors in South Kerala. The tool used was a 25 item questionnaire consisting of stereotypes about personality disorders. The stereotype was defined as 'an emotional concept which is not changed by attempts to demonstrate its absurdity or falsity'. One doctor accepted more than 75% of the stereotypes, 6 accepted more than 50%, 17 accepted more than 25% and 24 accepted more than 10% of the stereotypes. The investigator concluded that "it appears that most of our medical men are not as much conversant with the nature, causes and cures of mental disorders as they are with physical diseases".

Gautam [38] made a comparative study of 20 graduate medical practitioners and 20 medical practitioners with training in different indigenous medical systems. The tool used was an 18 item questionnaire developed on an ad hoc basis. The investigator found that the general practitioner's attitudes were 'not negative' but at the same time 'were not fully satisfactory' and there is a 'necessity to equip the general practitioners with greater knowledge of mental illness'. The better educated graduate medical practitioners and the younger members of the group were better informed than the rest.

Opinion of Students

Sinha and Roy Kishore [39] studied the attitudes of 100 college students towards mental illness. The tool used was a 20 item questionnaire prepared by them on an ad hoc basis. The concepts used in 18 of the 20 items of the questionnaire were of "going mad" "mad member" or "madness". The remaining two items made use of the concept of "mental illness" and that of loss of "mental equilibrium". The authors point out that "educated enlightenment has not worked in the direction of eradicating or reducing some of the illogical convictions held by people about mental illness or about mentally ill persons". There was no rural/urban differences seen nor a difference between 'Arts' and 'Science' students in their conception of mental illness. Lack of 'moral strength', inferiority complex, and sexual dissatisfaction were the most often attributed causes of mental illness.

Padamadan [40] studied the attitude of 100 male and 100 female students towards several groups of

individuals including the mentally ill. A series of tools were used to collect the data from the groups of students studied.

The student population did not show an awareness about different types of mental illness or an understanding about broadly classifying them into "neurotics" and "psychotics". Their image of a mental patient was characterised by an individual who is dirty, bizarre, quarrelsome, unpredictable and dangerous. They had positive attitude towards the physically handicapped but expressed a negative attitude and a tendency to maintain social distance from those who are mentally ill.

Mental Retardation & Illness

Gandhi and Agarwal [41] and Char [42] studied the attitudes of the public at Delhi towards the mentally retarded and have concluded that the public does not differentiate between 'retardation' and insanity'. Murthy et al [43], using a vignette [28], [28a], studied three groups of respondents-village leaders, community health workers and school teachers-at the Raipur Rani village. Each group had 36 respondents and in the main they considered mental retardation to be a mental health problem needing help from health professionals.

Implications

No review can claim itself to be complete as efforts put in can at best make it comprehensive. The overview presented aims at this goal. During the last two decades since the time when sensitive observers expressed their impressions as to what the public knows and feels about mental ill-ness to the contemporary period, research studies have been conducted in this area but when one considers the size of the country and the heterogenity of the population more studies in the area seem to be necessary.

The present and the next decade are of special significance to the field of mental health in India. The Integrated Child Development Services Scheme (ICDS) [44] which has been accorded a high national priority lays stress on taking into account the psychological and social well being of the developing child during the formative years. As a signatory to the Alma-Ata Declaration, the country has committed itself to provide primary health care for all its citizens by the year 2000 AD. The National Mental Health Programme [45] envisages the integration of mental health care along with primary health care. This stresses not only a multisectoral involvement by the way of co-operation between health, education and social welfare sectors but also the participation of the community. All this would mean not only an increase in the mental health facilities but also the development of alternative strategies for mental health care. The global programme IMPACT which aims at the prevention of avoidable disability-including mental disability -and the rehabilitation of the disabled has been formally launched by the President of India on the 2nd of October, 1983, thereby making India the first country in the world to do so. The parliament of the country is deliberating on a new mental health bill to replace the existing Indian Lunacy Act of 1912. The successful implementation of all these would depend on the information possessed and the attitudes held by various segments of society towards mental health issues as this would influence to a very large extent their involvement in the action for

mental health. Carefully designed empirical studies in this area therefore become a high priority necessity as forerunners to planned programmes for mental health education and action.

In the light of current evidence that information held by the general public is uncrystallised and diffused, it is clear that in research studies dealing with the attitudes of the general public using technical and differentiated concepts like "neuroses", "psychoses" etc. would not be as desirable as utilising general concepts like "mentally ill". The empirical demonstration [27] of the lack of stability of different factors embedded in questionnaires developed in the West has shown the hazards involved in using the western tests per se with minor modifications. The development of the fourteen socio-culturally relevant vignettes [28], [28a] for attitudinal studies, a culture specific valid and reliable questionnaire [27] and the later development of a structured interview schedule to cover the 13 major dimensions found necessary to be covered provide the necessary tools for scientific research in this area. The vignettes [28], [28a] would measure the respondents perception of mental illness & the mentally ill while the questionnaire and the interview schedule [27] the orientations towards it. Each one of them would have their advantages depending on the situation in which it is used.

The general trend of the studies carried out in India so far indicate that the lay public - including the educated urban groups - are largely uninformed about the various aspects of mental health and the information possessed by them remains uncrystallised. The mentally ill are perceived as aggressive, violent and dangerous.There is a lack of desirable degree of awareness about available facilities to treat the mentally ill and a pervasive defeatism exists about the possible outcome after therapy. A tendency to maintain social distance from the mentally ill and to reject them makes its existence felt. Despite this general trend the results are not unequivocal. The Bangalore studies [23], [24], [25] and the Vellore study [34] provide an optimistic picture while the Amritsar [22], Raipu Rani [33], Delhi [27] studies along with the Ranchi experiences [17], [20], [21] provide a pessimistic view. It would be difficult to generalise whether these differences are real and reflect different types of attitude that exist in different parts of the country or are expressed because of the characteristics of the samples studied.

The evidence available from the Indian studies to arrive at even tentative conclusions about the personality or socio-demo graphic factors that influence the opinions held and attitudes expressed about mental illness and the mentally ill is too diffuse.

Any such relationship observed in the studies of a general nature can at best be taken as a possible indication for further studies which should test specific hypothesis to establish the initially perceived relationships. As Wechlser et al [1] pointed out, one can conclude that the necessity for the present review is not based on the quantity of available research but because of the importance of the area in the contemporary mental health field in India.

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