Mental illness can occur at any time, to anyone. It occurs when a state of physical, mental, social and spiritual well being is disturbed. According to the World (Mental) Health Report 2001, 24 million people worldwide suffer from schizophrenia and 121 million suffering from depression. Mood (affective) disorders, generally depression are the commonest mental disorders in both general and specialist clinical practice.

Mental disorders are a great source of distress, impaired productivity and diminished quality of life for several people and families. There is evidence of perception of care giving burden and other emotional problems in the family members due to the chronic nature of the illness. Lack of awareness about the illness and related informations may affect the coping process of patient and family with the illness.

Studies conducted in different parts of the world (Kurihara et al, Tewari et al, Razali et al) give evidence of inadequate knowledge and negative attitude towards mental illness among family members as well as mentally ill patients.

**Objectives**

The objectives of this study were:

1. To assess knowledge of family members towards mental illness in rural and urban areas.
2. To compare knowledge of family members in rural and urban settings.
3. To find correlation between knowledge of family members towards mental illness and selected socio-demographic variables in rural and urban settings. The research approach used in this study is non-experimental, descriptive, comparative and cross sectional survey type.

The out-patient department of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur and 5 rural extension clinics of LGBRIMH in Biswanath Chariali and Sootea (Itakhola, Koroiyani, Beluguri and Sootea) of Sonitpur district of Assam were used as setting.

The study population consisted of family members of all the patients with major mental disorders who were accompanying them to the out-patient services of a selected hospital during the period of data collection. The total sample size was 60 out of which 30 were rural (R) and 30 urban family members (U). Purposive sampling technique was used due to time constraint.

**Sampling criteria**

**Inclusion criteria:** Family members of patients suffering from major mental disorders like schizophrenia and mood disorders directly involved in the care of the patient, staying with the patient for more than one year, of both genders, of adult age group, and those who could understand the nature of the study and gave consent.

**Exclusion criteria:** Family members of patients with mental retardation, epilepsy, organic mental disorders, psychoactive substance use disorders, neurotic disorders, distant relatives of the mentally ill not involved in direct care of the patients, staying with the patient for less than a year, and family members who themselves are mentally ill.

**Data Collection Procedure**

Data collection was done using a questionnaire and by interviewing the participants in June and July 2008.

Tools used in the study were:

1. Socio-demographic and clinical data sheet of the patient and family member,
2. Tool to assess knowledge related to mental illness.

These semi structured tools were developed by the researcher following proper methods. The reliability of the structured tools was tested by using split-half technique as it was not feasible to use the test-retest method. Correlation coefficient of the tool was found to be 0.94.
Analysis and Interpretation

Analysis of collected data were done using chi-square test, independent ‘t’ test and Pearson’s product moment correlation. Non-parametric tests like Kruskal-Wallis test and Mann-Whitney U test were performed to see the relation of knowledge of subjects to their socio-demographic characteristics. Statistical package for social sciences (SPSS) was used for analysing and interpreting the findings.

Findings

1. Socio-demographic characteristics of the family members: The family members in both the groups were similar in socio-demographic characteristics except gender and occupation. Maximum numbers were of the age group of 20-40 years (60% R, 43.3% U), were educated upto matriculation (50% R, 53.3% U), married (80% R, 73.3% U), from nuclear family (70% R, 66.7% U). Majority of rural subjects earned below Rs.2000 and Rs.2000-6000 per month (36.7% in both categories) and maximum urban counterparts (43.3%) earned Rs. 2000-6000 per month. Majority were Hindu in both groups (83.3%), Assamese speaking (53.3%), parent by relation (40% R, 50% U), stayed more than 10 years with their patients (93.3% in both groups).

The groups significantly differed in gender and occupation (76.7% male in rural, 53.3% female in urban group, \( \chi^2 = 5.711, p=0.017 \)). Majority of the rural family member were cultivator (36.7%) by occupation, whereas maximum urban family members were in service (33.3%) (\( \chi^2 = 17.42, p=0.004 \)).

2. Knowledge scores of the rural and urban family members related to mental illness: Majority of family members (83.33% R & 93% U) strongly agreed that mental illness is like any other illness. Highest number of subjects in both the groups (R 83.33% & U 90%) strongly agreed that anybody under severe stress can become mentally ill. Treatability of mental illness was strongly agreed by 83.33 percent rural and 80 percent urban family members. 63.33 percent and 56.66 percent subjects strongly agreed that alcohol and other addictive substances may cause mental illness. 63.33 percent and 56.66 percent subjects strongly agreed that chemical change in the brain is one of the causes of mental illness. Likewise half of the rural (50%) and majority of the urban (76.66%) family members strongly agreed that alcohol and other addictive substances may cause mental illness. Severe head injury is strongly considered as a possible cause of mental illness by most of the subjects in both the groups (80% R, 86.66% U); 60 percent rural and 70 percent urban family members strongly agreed chronic physical illnesses as a possible cause of mental illness. Good family environment is strongly agreed to be essential for mentally ill persons by majority number of subjects of both groups (93% R, 96.66% U); 90 rural and 96.66 urban family members strongly disagreed that once drugs are prescribed patients need not consult the doctor again. Most of the subjects (96.66% in both the groups) strongly agreed upon the fact that irregularities in taking medicines cause relapse of mental illness. But, highest number of family members in both groups (33.33% R, 40% U) were undecided in the item stating that tremors, excessive salivation, dryness of mouth, dizziness are some of the minor side effects of drugs used in mental illness. The majority of family members also strongly disagreed (76.66% R, 80% U) that when any side effect occurs, the medicines have to be stopped by self without consulting doctor. 86.66 percent of both rural and urban subjects strongly disagreed that the dosage of medicines can also be increased or decreased by self according to increase or decrease of patient’s symptoms. Most of them (96.66% R, 43.33% U) also strongly disagreed that mentally ill people often tell about committing suicide but they really do not mean it.

3. Comparison of Rural and Urban group on knowledge related to mental illness: No significant difference was found in knowledge towards mental illness between the rural and urban group.

4. Correlation of knowledge in Rural and Urban group in selected socio-demographic variables of the family members: Statistically no significant correlation was found among knowledge of family members with their selected socio-demographic variables in both rural and urban group.

To sum up, the scores of knowledge towards mental illness were high in both rural and urban family members; there was no significant difference between the knowledge scores of rural and urban family members; there was no correlation between knowledge of both rural and urban family members.
with their age, gender, education, occupation, income, religion, mother tongue, marital status, family type, relationship, duration of stay with patients etc.

Limitation of the study
1. The study was restricted to family member who attended inpatient and outpatient services and rural extension clinics of LGBRIMH, Tezpur from different places of Sonitpur district. Therefore, the data cannot be generalised.
2. The findings of knowledge are based on the responses of 60 family members only, as urban samples were difficult to come by within limited time period.
3. The study groups were selected by purposive sampling method, therefore, the sample was not representative of all families of mentally ill patients.

Implications for Nursing
Nursing practice: The findings of this study revealed that the family members were not aware about the side effects of psychiatric medicines. Therefore, this issue can be included as a component of educational and awareness activities planned for the patient and family members.

Nursing education: Findings of this kind of studies can help in conduct of evidenced-based nursing education and practice. This study has further implication in the area of curriculum planning for various courses in the nursing profession.

Nursing administration: Policies and programmes for health education should be made inclusive in basic care protocols for the patients and the families. District public health nurse can plan the activities that include awareness creation campaigns at school and college levels.

Nursing research: The findings of this study can be used in intervention-related research to see the effect of educational and teaching programmes on knowledge towards mental illness. Protocols or modules can be prepared based on the findings from this study.

Recommendations
In view of the findings of the present study, following recommendations are suggested:
♦ Similar study could be (a) extended to a large sample, (b) replicated in similar and different settings with different demographic backgrounds, (c) based on intervention.
♦ Topics like mental health, mental hygiene, mental illness etc. should be included in the syllabi of schools and colleges.

Conclusion
Mental illness has always looked down as a separate entity associated with anger, resentment, and a matter of shame by general people as well as family members. Lack of awareness about the illness leads to different adverse consequences related with treatment and acceptance of the illness as well as the patient. By assessing the knowledge of the family members, different programmes of intervention can be planned and implemented by the psychiatric nurse in the hospital as well as community for better treatment and maintenance of the mentally ill patients.

References
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