INTRODUCTION

"Never let the opinion of the others become the measure of yourself worth"

BACKGROUND OF THE STUDY:

Many persons with mental disease are challenged. They are struggling with clinical features and disabilities which occur due to the mental illness. They are questioned by the stereotypes which results by the misconceptions concern about mental disease. As results from mental disorder is robbed of the opportunities outline a top quality life, jobs, safe housing, satisfactory health care, with the various cluster of individuals. Though analysis is go way to the know of the impactness of the illness, this is solely recently begin the clarifying stigmatization in mental disease. Luckily, social psychologists and sociologists are finding out facts associated with stigma in different immaturity teams for many years.[1]

India is the country in which is a rapidly increasing in population and changing from a low-income to the middle-income related their socio demographic and epidemiology aspects. In India, 1.3 billion voters, statistics relating to the precise prevalence of people with mental illness. According to recent data of prevalence which is vary from 5.8% to 7.3% of the whole population, and around approx 150 million population of India is affected by mental disorder. The availability of health care providers like psychologists, public workers, and mental health nurses are still low in numbers and not allowed to urban population. In every of the central barriers to adequate treatment of mental illness in Asian country may have less funding

which results in showing inappropriate seek for help behavior and many time poorer treatment outcomes, which is relates to the stigma. Governmental health and social priorities termed by the changing in end in low-spending priorities toward mental health state care which intensifying the social and structural stigma toward mental illness.

A study which is conducted in 2010 that shows the mental state cost in many low-middle financial gain countries and located that within the Indian state of Kerala solely two of the national health budget was allotted to mental state care. Similarly pattern of national monetary priorities may be discovered in other way low-and middle-income countries, also in high-income countries like Federal Republic of Germany.

The stigma towards the peoples World Health Organization has the mental disorders in Asian countries is generally disproportionally in Western nations. In Southeast Asian nations, particularly in Asian nation, prejudice of unsound individuals being dangerous and aggressive adjunct with factors like faith and lower education lead to a better public want for social distance to affected people. Additionally there to, the substantial lack of adequate health-care suppliers not to mention a private burden and also the lack of awareness at intervals the population ultimately results in a deficient quality of psychological state.

They are common and affect greater than 25% in all the individuals at some time during their life. In spite of magnitude of people suffering from unsound, people do not get the adequate care they need, leading to increased overall burden to

society. Recent national mental health survey from 12 states of India had shown that lifetime prevalence of mental disorders in the surveyed population was 13.7%. Nearly, 150 million Indians are in need of active interventions. Nearly, 80% of persons suffering from mental disorders had not received any treatment despite the presence of illness for more than 12 months.

Multiple factors ranging from lack of awareness to affordability of care influence these wide treatment gaps. National Institute for Mental Health Survey suggests that one major factor responsible for this is stigma. Stigma contributes to the huge burden of mental morbidity, being a roadblock to treatment seeking. Social stigma and negative attitude can affect the quality of life for people with mental illness. Stigma has been described as a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid and discriminate people.

Stigma stands as an obstacle in the presentation, detection and treatment of mental illness. Stigma is an amalgamation of three inters related problems KAP: lack of knowledge (ignorance), negative attitudes (prejudice) and avoidance behavior (discrimination). There is a huge gap between knowledge, attitudes and behaviors or performance. People from rural areas even today attribute supernatural powers, witchcraft and black magic powers to be the cause of mental illness. They turn to faith healers and quacks for treatment. Similarly, out of ignorance, general practitioners do not refer patients to psychiatrists thus further delaying treatment (further widening the gap of KAP.)[2]

Stigmas concerning mental disease appear to wide support by the final public within the Western world. Research recommends that the bulk of voters within the United States and lots of Western European nations have stigmatizing attitudes concerning mental disease. Moreover, stigmatizing views concerning mental disease don't seem to be restricted to unacquainted with members of the final public; even well-trained professionals from most mental state disciplines subscribe stereotypes concerning mental disease. Stigma appears to be less evident in Asian and African countries, tho' it's unclear whether or not this finding represents a cultural sphere that doesn't promote stigma or a lack of analysis in these societies. The on the market analysis indicates that, whereas attitudes toward mental disease vary among non-Western cultures, the stigma of mental disease is also less severe than in Western cultures. gold-worker suggests that the shortage of differentiation between medicine and non-psychiatric sickness within the 3 nice non-Western medical traditions is a vital issue. whereas the potential for branding of medicine sickness definitely exists in non-Western cultures, it appears to primarily attach to the additional chronic kinds of sickness that fail to retort to ancient treatments. Notably, stigma appears virtually nonexistent in Islamic societies. Society examination of the ideas, experiences, and responses to mental disease square measure clearly required.[1]

Stigma associated with mental diseases is one all told the principal causes for unsound people not receiving adequate condition care and treatment. The study was conducted to assess the extent of stigma associated with psychological state and knowledge of psychological state among the community. it had been

Community-based, cross-sectional study was conducted among 445 respondents from Udupi district; the community perspective toward the unsound (CAMI) scale was used to assess stigma. the prospect proportional to sampling size technique was adopted to choose out the wards/blocks. Unit from blocks/wards were selected victimization convenience sampling. Self- administered semi-structured kind was used to collect the information. data was analyzed victimization the code SPSS version fifteen. Results: Of the general 445 respondents, the prevalence of stigma toward unsound people was seventy four.61% (95% confidence interval, 0.7057, 0.7866). The prevalence of stigma was high below all the four domains of CAMI scale. High prevalence of stigma was seen among females and people with higher gain. Conclusion of the study was the prevalence of stigma toward PWMI was found to be high. The stigma toward PWMI was associated with gender with relevancy AU, BE and CMHI. Hence, the study suggests that there is a strong got to be compelled to eliminate stigma associated with psychological state to reinforce the condition standing of the region.

When characteristic ways in which to cut back disapproval thanks to psychological state it's crucial to know causative factors. Social distance-the disposition to move in relationships of various intimacy with a person-is associate indicator of public attitudes toward persons with psychological state. Methods: multiple correlation toward the mean analysis of the results of a vignette-based opinion survey conducted on a representative population sample in Switzerland (n = 594). Results: the number of social distance can increase if things imply ‘social closeness.’ The vignette describing somebody with schizophrenia, attitudes to

general aspects of condition (lay serving to, community psychiatry), emotions toward those affected, and so the angle toward consequences of psychological state (medical treatment, medication side effects, negative sanctions, e.g., withdrawal of the driving force license) were found to predict social distance. Demographic factors like age, gender, and so the cultural background influence social distance. The explained variance (R2) is forty four.8%. Conclusions: Social distance may well be a varied plan influenced by, e.g., socio-economic and cultural factors, but together by the respondent's general perspective toward (mental) health issues. These results advocate that tons of knowledge regarding mental diseases, notably schizophrenia, might increase social distance. The findings given here might facilitate to focus anti-stigma campaigns not alone on transmission of knowledge, but on integration whole totally different approaches.[3]

Common Misconceptions regarding Mental Illness: -Young peoples and youngsters don't suffer from mental state issues. Peoples that want medical specialty care ought to be secured away in establishments. Someone UN agency has had a psychological state will ne'er be traditional. Insane persons are dangerous. Peoples with mental diseases will work low-level jobs however aren't fitted to extremely necessary or accountable positions.[4]

There is an expensive literature on the character of psychological state-related stigma and also the processes by that it severely affects the life possibilities of individuals with mental health issues. However, applying this data to deliver and appraise interventions to scale back discrimination and stigma in an exceedingly lasting manner may be a complicated and long-run challenge. In common with any

public health intervention, programs to scale back discrimination and stigma should be supported a series of selections, during this case: the scope to mental disorders to be enclosed, whether or not expressly or implicitly; the extent of intervention, whether or not structural, social, or self-stigma; whether or not to require a full population approach versus selecting target teams, and if the latter, that teams area unit priority targets in terms of either the frequency. Severity of the impact on folks with psychological state problems; what approach an intervention for a given cluster and at a given level ought to take; and the way to gauge the impact.[5]

People with status problems have to be compelled to address a double problem: first, the symptoms of the status disadvantage, and second, with the stigma of obtaining a status disadvantage. (1) Stigma might be a core construct in understanding the broader interaction between people and status services. Stigma has degree in-depth influence on the standing of status services, their resource allocation and attractiveness to work force. It constitutes a barrier that greatly contributes to low help-seeking among people with status problems, and affects provision of services negatively. Status professionals seem to share stigmatizing attitudes with the rest of the population.[6]

Severe mental disorders unit of measurement associated with social distance from the ultimate population, but there is lack of data on the stigma according by folks with common mental disorders. To identify the correlates and so the impact of stigma on peoples with common mental disorders. Health-related quality of life measured by the, work and activity limitation and social limitation were in addition

assessed. Among the 815 participants with a 12-month disturbance and important incapacity, 14.8% had perceived stigma. Stigma was significantly associated with low education, being married/living with someone and being idle. Perceived stigma was associated with weakened quality of life (SF-12 PCS score four.65; $p < 0.05$), higher work and role limitation and higher social limitation. folks with mental disorders unit of measurement extra probably to report stigma if they have lower education, unit of measurement married, or unit of measurement idle. Perceived stigma is expounded to considerably decrease in quality of life and role functioning. Health professionals and society at big ought to keep in mind of these findings that counsel that fighting stigma got to be a public health priority.[7]

Need of the Study

Follow the path of the unsafe, independent thinker. Expose your ideas to the danger of the controversy. Speak your mind and fear less the label of "crackpot" than the stigma of conformity. (Thomas Watson)

Mental and Behavioral disorders are common, affecting more than 25% of all people at some time during their lives. They are conjointly universal, touching individuals of all countries and societies, people the little bit ages, female and male, the wealthy and therefore the poor, from urban and rural environments. They need associate degree economic impact on societies and on the standard of lifetime of people and families.

Mental and behavioral disorders area unit gift at any purpose in time in regarding 100% of the adult population. Around 200 of all patients seen by primary health

care professionals have one or additional mental disorders. One in four families is probably going to own a minimum of one member with a behavioral or psychological disorder. These families not solely offer physical and emotional support; however conjointly bear the negative impact of stigma and discrimination in keeping with World Health Organization it absolutely was calculable that there are 450 million people in the world currently suffering from some kind of mental illness. This constitutes 14% of global burden of disease. The prevalence of mental disorders in India is high with an estimation of 58 per 1000 people. About 10 million Indians suffer from mental illness. On the other hand, there is a paucity of psychiatrists in India with less than 0.5 per 1lakh population. To remove barriers for those seeking or receiving treatment for psychiatric illness.

Stigmatization involves distinctive Associate in Nursing marking an undesirable characteristic in a very manner that narrows a person's social identity thereto characteristic. the implications of stigmatization embrace marginalization and, in some cases, debasement. stigmatization usually contributes to poor international health outcomes, significantly for the designation and treatment of infectious diseases and mental state. individuals with mental state issues say that the social stigma hooked up to mental health problem and therefore the discrimination they expertise will create their difficulties worse and create it tougher to recover. Most people World Health Organization expertise mental state issues recover totally, or square measure ready to support and manage them, particularly if they get facilitate early. however even supposing such a lot of individuals square measure affected, there's a powerful social stigma hooked up to mental health problem, and

folks with mental state issues will expertise discrimination all told aspects of their lives. Many people's issues square measure created worse by the stigma and discrimination they experience-from society, however conjointly from families, friends and employers. Nearly 9 out of 10 individuals with mental state issues say that stigma and discrimination have a negative result on their lives.[8]

Stigma and discrimination associated with positive diseases have remained a world public health concern over the years. Treatment stigma has junction rectifier to major barriers to accessing health care and illness management. Stigma has been including problems regarding info (ignorance) and attitudes (prejudice) whereas discrimination has largely been related to behavior. Differing types of stigma exist ranging from public (externalized or recent stigma) to self-stigma (internalized stigma). Though these forms of stigma area unit interlinked and one can end in the alternative, their overall effects on the people with condition (PWMIs) are method reaching. In addition to managing their illness, PWMIs got to have an effect on the social, psychological and economic consequences of psychiatrically stigma which could exacerbate low self-importance, marginalization from society, social isolation, social anxiety, poor social skills, difficulties in securing employment, housing difficulties in addition as poor social support, all of that area unit important for integration into the society. These effects, in turn can end in strained relationships, depression, low vanity, state and be a barrier to accessing health care, etc. These consequences area unit combined by poor access to health care among a health care system already challenged by widespread inequalities in resources and health personnel. Reducing stigma has

thus been referred to as a really vital issue which can improve the lives of those with condition.[9]

Many of research have measured experience of stigma and discrimination among people with mental disorders. Chemical analysis among service users highlights the very important role that status professionals and their classification systems have in creating identities, feelings of separateness and even self-stigmatization among service users. Quantitative info indicate that heaps of concerning one in three persons with a disorder experience stigma attributable to their disorder, and international comparisons indicate that non-public stigma of people with schizophrenic psychosis could be a minimum of not less common in Republic of European country than in different developed countries. Luckily, institutionalized discrimination in public services seems to be uncommon in Republic of European country. Another comprehensive set of studies, re-examine over fifty years, have measured attitudes towards people with mental disorders among the general population. Attitudes of older people square measure heaps of negative than attitudes of younger people, that has been understood as people result.

In earlier studies women had of negative attitudes, but of men have of negative attitudes. Education has consistently been coupled to the favorable attitudes. overall image given by a continuing population survey, implemented since 2005, indicates that in this short perspective general population attitudes in Republic of European country area unit rather stable, but there is a unit some signs of a positive development. inside the recent years, social acceptance seems to possess enlarged somewhat, and tons of people tend to believe that can live a full

life. A general population inquiry and results from a student survey indicate that attitudes in Republic of European country may even be less stigmatizing than in many different countries.[10]

People with a psychological state typically encounter stigma and discrimination from a variety of sources, reinforcing negative self-perceptions and influencing their health and well-being. Despite the fact that support systems and attitudes of the public act as powerful sources of stigma, views and perceptions command by people with psychological state together influence their sensitivity to the experiences they encounter.

The aim of this qualitative study was to appear at perceptions of stigma and discrimination and self-stigma in folks diagnosed with a psychological state. This study adopted a narrative, descriptive technique, using a semi structured interview guide to elicit participant perceptions regarding sources of stigma, discrimination, and personal factors which can influence their experiences. Twelve outpatients attending a clinic in African nation were interviewed. Thematic content analysis was completed and inflated by field notes. Participants' perceptions concerning personal impacts of stigma were found to be influenced by self-stigma, anticipated stigma and discrimination, perceived discrimination, and their info concerning their illness. for many participants, their views served to strengthen social views, then reinforce negative self-perceptions and their future. However, for different participants, their views served as a buffer at intervals the face of environmental things that mirror stigma and discrimination. Stigma may well be a advanced, socially-sanctioned development that will seriously have an impression on the

health of people with psychological state. As such, it desires coordinated strategies among public policy makers, governmental bodies, and health-care suppliers to contend with stigma on a social level, and to contend with its potential impacts on broad health outcomes for folks with psychological state.[11]

A cross-sectional study still as 796 individuals with a psychiatrically disorder was conducted in Croatia, Israel, Lithuania, Malta, Balkan nation and Sweden in 2010 planning to assess correlates of self-stigma. The Internalized Stigma of status (ISMI) was accustomed live self-stigma; whereas the state capital University authorization Scale was accustomed live the self-efficacy/self-esteem (SESE) and sense of power/powerlessness (PP). Perceived discrimination and devaluation was measured with the Perceived Devaluation and Discrimination (PDD) Scale. Thirty three you look after participants had moderate-to-high ISMI scores. In multivariable-adjusted analysis, important 'predictors' of high ISMI scores were: age-group of 50–59 years, current employment, lower social contacts, and minimal-to-low SESE and PP scores. Remarkably, no important association between ISMI and PDD was evident. What's additional, there was proof of a giant interaction between SESE and country. Study participants will not be representative to any or all individuals with mental disorders in countries boxed throughout this survey. Our findings indicate that folk with psychiatrically diseases suffer every self-stigma and perceived discrimination and devaluation. this may be one in every of the sole a number of reports lightness country variations and designation disparities of self-stigma among individuals with mental diseases. Between-country variations need to be thought-about and totally self-addressed

inside the strategy of policy formulation and interventional programs against stigma[12]

The perceived experiences of stigma and discrimination among people living with severe and chronic psychological state in assertive community treatment (ACT teams) settings in New South Wales (NSW), Australia. The Discrimination and Stigma Scale (DISC) was used during this cross-sectional study with people living with severe and chronic psychological state. The DISC can be a reliable and valid, quantitative and qualitative instrument accustomed explore and live levels of negative, anticipated and positive discrimination. Relevant clinical history and socio-demographic information were together collected. a complete of fifty shoppers participated, with forty (80%) reporting previous negative discrimination in an exceedingly minimum of 1 life area. Negative discrimination was most typically previous in being avoided or shunned (n=25, 50%), by neighbors (n=24, 48%) and family (n=23, 46%). Anticipated discrimination was common, with 1/2 participants (n=25, 50%) feeling the need to cover their psychological state designation. Discrimination was very prevailing in everyday aspects of life. Whereas attention professionals sometimes tend to increase perceived stigma and discrimination, this was entirely previous in interactions with general health professionals, whereas interactions with ACT team members ablated perceived stigma and enlarged positive discrimination. this suggests that focus professionals likely have a giant role in reducing stigma Associate in Nursing discrimination in psychological state that such a bearing might even be optimized in associate degree ACT team setting.[13]

AIM OF THE STUDY

To find out the factors responsible for the perceived stigma and discrimination on patients with mental illness.

Problem statement

Factors responsible for the perceived stigma and discrimination on patients with mental illness among people of selected urban and rural communities of Jodhpur

Objectives

1. To identify the factors responsible for the perceived stigma and discrimination on patients with mental illness in selected urban community.
2. To identify the factors responsible for the stigmatization and discrimination on patients with mental illness in selected rural community.
3. To compare the score of perceived stigma and discrimination on patient with mental illness among urban and rural communities.
4. To determine the association of perceived stigma and discrimination with selected demographical variables.

Operational definition

Stigma: In the study stigma means the view of the people of selected urban and rural peoples of Jodhpur regarding patient with mental illness and which is asses by the PDD scale.

Discrimination: In this study, discrimination refers to the way of treat the patient with mental illness by the peoples of selected urban and rural peoples of Jodhpur which is assess by the PDD scale.

Mentally ill person: A Person who suffers from mental illness.

Urban community: In this study the urban community means area of Partap Nagar.

Rural communities: In this study the rural community means area of Dhawa.

Hypothesis

H0:-There will be no significant difference in perceived stigma and discrimination on patients with mental illness among selected urban and rural community.

H_1: There will be significant association between the factors associated with stigma and discrimination towards patients with mentally illness among their selected demographic variable.

Assumptions

- There are factors which are responsible for perceived stigma and discrimination toward mentally ill patients by people of urban and rural community.

Delimitations

- The research is delimited to the people who are residing in selected urban and rural community, Jodhpur.

- The study is delimited to the age group of 20-60years.

Summary: -This chapter deals with the introduction, need of the study, aim of the study, problem statement of study, objectives of the study, operational definitions and delimitations of the study.

REVIEW OF LITERATURE

The second chapter deals with the literature review. Literature review is knowing what is already known or work done on particular topic or area by scholars

Review of literature is an important step in research process. Review of literature is a broad and comprehensive study of systematic and critical review of scholarly publications, unpublished materials, audio-visual materials and personal communications.

“A review of related literature is an essential aspect of scientific research. It is a written summary of the state of evidence on a research problem. It broadens the understanding of the research and help to gain an insight necessary for the development of a broad conceptual context into which the problem fits. (Polit and Beck)[45]

A review of literature is a description and analysis of the literature relevant to a particular research or topic. It provides an overview of the work that had been already carried out, the key researchers who did that work, the questions already answered regarding a particular area of research interest, methods and methodologies used to answer the particular questions and the prevailing theories and hypothesis.

The review of literature also provides a solid background for a research study. The objectives of the review are to discover certain aspects that need to be included into the study to confirm or refuse earlier findings, to find certain data that may be

available in interpreting the conclusion of the study. It was also necessary to ascertain, what has already been done in the field of study and what more needs to be done.

C. Nugent et al (2020) conducted a study to assess the risk factors associated with experienced stigma among people diagnosed with mental ill-health: a cross-sectional study to examine the relationship between religiosity, social support, trauma, quality of life and experienced stigma of mental illness amongst a population diagnosed with mental ill-health. Methods: A cross-sectional survey of day service users in Northern Ireland (n = 295) covering a range of issues including religiosity, social support, quality of life and prior experience of trauma. Stigma was measured using a recognized stigma scale. We used multinomial logistic regression to examine risk factors associated with experienced stigma. Univariate analysis showed significant associations between stigma and age, number of friends, social support, quality of life and prior experience of trauma. Age, quality of life, and trauma remained independently associated with stigma in a multivariate logistic regression model ($x2(12) = 98.40$, $p < 0.001$). Younger people, those with less social support, prior experience of trauma and with poorer quality of life are at increased risk of experiencing stigma related to their diagnosis of mental illness. The findings provide further understanding of stigma and are useful for those overseeing programmes to improve access to mental health treatment.[14]

Nigus Alemnew Engidaw et al (2020) conducted a study to asses Stigma Resistance and Its Associated Factors among People with Bipolar Disorder at Amanuel Mental Specialized Hospital, Addis Ababa, Ethiopia an institutional-

based cross-sectional study was conducted from May 8th to June 14th, 2016, at Amanuel Mental Specialized Hospital. The study participants were selected using a systematic random sampling technique. The stigma resistance subscale of the internalized stigma of mental illness was used to measure stigma resistance. Bivariable and multivariable logistic regression was computed to identify factors associated with stigma resistance. Accordingly, variables with *P* values of less than 0.05 were considered as statistically significant predictors of stigma resistance with a 95% confidence interval. In this study, 418 participants completed the interview with a response rate of 98.8%. The prevalence of low stigma resistance was 56.9% (95%CI = 51.9-61.6%). Being unemployed (AOR = 1.65; 95%CI = 1.35-1.87), high internalized stigma (AOR = 3.04; 95%CI = 1.83-5.05) and low self-esteem (AOR = 2.13; 95%CI = 1.72-6.76) were significantly associated with low stigma resistance. The study shows that more than half of the bipolar patients attending the Amanuel Mental Specialized Hospital had low stigma resistance. Therefore, stigma reduction programs have focused on improving self-esteem and reducing internalized stigma to increase their stigma resistance. Mental health information dissemination regarding community support and reengagement of people with bipolar disorder is highly recommended.[15]

Zhidong Zhang et al (2019) conducted a study to assess the Overview of Stigma against Psychiatric Illnesses and Advancements of Anti-Stigma Activities in Six Asian Societies. Psychiatric disorders are common in Asia but some Asians receive inadequate treatment. The objective of this systematic review was to provide an up-to-date overview of existing research and status on stigma

experienced by psychiatric patients and anti-stigma campaigns in China, Hong Kong, Japan, Singapore, Korea, and Thailand. A systematic literature search was conducted in the following databases, including PubMed, PsycINFO, Embase, Web of Science, and local databases. Any study on stigma related to any form of psychiatric illness in the six Asian societies was included. This study revels One hundred and twenty-three articles were included for this systematic review. This review has six major findings. Firstly, Asians with mental illnesses were considered as dangerous and aggressive, especially patients suffering from schizophrenia and bipolar disorder; second, psychiatric illnesses in Asian societies were less socially-acceptable and were viewed as being personal weaknesses; third, stigma experienced by family members was pervasive and this is known as family stigma; fourth, this systemic review reported more initiatives to handle stigma in Asian societies than a decade ago; fifth, there have been initiatives to treat psychiatric patients in the community; and sixth, the role of supernatural and religious approaches to psychiatric illness was not prevailing. This systematic review provides an overview of the available scientific evidence that points to areas of needed intervention to reduce and ultimately eliminate inequities in mental health in Asia.[16]

Etsedingl Hadera et al (2019) conducted a study to assess Magnitude and Associated Factors of Perceived Stigma among Adults with Mental Illness in Ethiopia A facility-based, cross-sectional study design with a consecutive sampling technique was employed from September 1 to 30, 2012. Data for perceived stigma were assessed by using the perceived devaluation-discrimination (PDD) scale

from new or returning patients. The data was analyzed by using the Statistical Package for the Social Sciences (SPSS) version 20. The results were described with the frequency table, graph, mean, and standard deviation. Bivariate analysis was used to get candidate variables for multivariate logistic regression analysis. Variables with a *P* value of < 0.05 at multivariate analysis were considered statistically associated with perceived stigma. The study revels A total of 384 participants were interviewed and the response rate was 100%. The prevalence of high and low perceived stigma was 51% and 44%, respectively. Having substance use history (AOR=0.6, 95% CI: 0.4–0.9) and family support (AOR=2.5, 95% CI: 1.5–4.3) and medication side effects (AOR=0.6, 95% CI: 0.5–0.8) were associated statistically with higher perceived stigma of people with mental illness.[17]

Dorota Szcześniak et al (2018) conducted a study to assess Internalized stigma and its correlates among patients with severe mental illness A study sample (n=114, mean age=42.46±14.1 years; 55% of females) consisting of patients with nonorganic psychotic disorders as well as unipolar and bipolar affective disorders was evaluated (58% of outpatients and 39% of inpatients). All patients filled in the Internalized Stigma of Mental Illness (ISMI) scale (maximum severity=4). The demographic and clinical data were collected. The study population demonstrated a mild level of internalized stigma (2.23±0.5). The highest score was observed in the alienation domain (2.63±0.8) and reflected moderate severity. The lowest score was noted in the stereotype endorsement domain (2.08±0.6). Moreover, the highest degree of internalized stigma was present in participants with unipolar affective disorder and was of moderate severity (2.46±0.6), while the level was

moderate in the alienation domain (2.85±0.8). The level of vocational training education was the only variable associated with higher internalized stigma (*P*=0.02). There were no associations between gender, employment, and marital status and internalized stigma. The duration of the disease was the only clinical factor showing a significant positive correlation with stigma internalization (*r*=0.23; *P*=0.01). The number of hospital admissions and suicide attempts was not significantly correlated with internalized stigma.[18]

Kerem Böge et al (2018) conducted on a study on Perceived stigmatization and discrimination of people with mental illness: A survey-based study of the general population in five metropolitan cities in India Samples were collected in five metropolitan cities in India including Chennai (n = 166), Kolkata (n = 158), Hyderabad (n = 139), Lucknow (n = 183), and Mumbai (n = 278). Stratified quota sampling was used to match the general population concerning age, gender, and religion. Further, sociodemographic variables such as educational attainment and strength of religious beliefs were included in the statistical analysis. Participants displayed overall high levels of perceived stigma. Multiple linear regression analysis found a significant effect of gender (P < 0.01), with female participants showing higher levels of perceived stigma compared to male counterparts. Gender differences in cultural and societal roles and expectations could account for higher levels of perceived stigma among female participants. A higher level of perceived stigma among female participants is attributed to cultural norms and female roles within a family or broader social system. This study underlines that while India as

a country in transition, societal and gender rules still impact perceived stigma and discrimination of people with mental illness.[19]

Annie B. et al (2018) conducted a study to assess Conceptualizing and Measuring Mental Illness Stigma: The Mental Illness Stigma Framework and Critical Review of Measures The last decade has seen a proliferation of research on mental illness stigma, lack of consistency and clarity in both the conceptualization and measurement of mental illness stigma has limited the accumulation of scientific knowledge about mental illness stigma and its consequences. In the present article, Researcher bring together the different foci of mental illness stigma research with the Mental Illness Stigma Framework (MISF). The MISF provides a common framework and set of terminology for understanding mechanisms of mental illness stigma that are relevant to the study of both the stigmatized and the stigmatize. Researcher apply this framework to systematically review and classify stigma measures used in the past decade according to their corresponding stigma mechanisms. Researcher identified more than 400 measures of mental illness stigma, two thirds of which had not undergone any systematic psychometric evaluation. Stereotypes and discrimination received the most research attention, while mechanisms that focus on the perspective of individuals with mental illness (e.g., experienced, anticipated, or internalized stigma) have been the least studied. Finally, Researcher use the MISF to discuss the strengths and weaknesses of mental illness stigma measurement, identify gaps in the literature, and provide recommendations for future research.[20]

Yin-Ling et al (2018) conducted a study to assess My bitterness is deeper than the ocean": understanding internalized stigma from the views of persons with dementia praecox and their family caregivers man of science integrated knowledge from standardized scales and narratives from semi-structured interviews obtained from eight family-dyads. Interview narratives regarding stigma were analyzed victimization directed content analysis and compared with responses from Chinese versions of the Internalized Stigma of psychological state Scale and connected Stigma Scale. Scores from the 2 scales and vary of text fragments were compared to spot consistency of responses victimization the 2 ways in which within which. The analyses educated that persons with dementia praecox and their caregivers each internalized negative valuation from their social networks and reduced engagement within the community. Family are varied within the extent that internalized stigma were previous by patients and caregivers.[21]

D. Krupchankaab et al (2018) conducted a study to assess the experience of stigma and discrimination in families of persons with dementia praecox at intervals. Mental health-related stigma and discrimination not entirely have a bearing on persons living with dementia praecox but jointly their whole families a qualitative study supported semi-structured in-depth interviews with relatives of patients diagnosed with dementia praecox at intervals the European nation. Initial respondents were renowned through native mental state services and users' organizations with a consecutive chain-referral sampling. Transcribed narratives were thematically analyzed within a pre-developed four-level thematic framework to comprehensively verify experiences of stigma and discrimination altogether

areas of the respondents' lives. This study revels Stigma experiences of 25 various members of the family of persons living with dementia praecox spanned four levels. Investigator developed a set of recommendations for policy-makers aimed toward reducing cognition and prejudice amongst the final public and professionals, up health and social services together with employment, housing and community integration and also the convenience of family support. [22]

Shirlene Pang et al, (2017) The study show the scale of stigma and social tolerance completely different in Asian cultures compared with Western cultures. Socio demographic variations in attitudes towards the unstable were found among youths living in Singapore. Misconceptions and negative attitudes towards psychological state are common, demonstrating a clear need for effective stigma reduction campaigns.[23]

Neupane Dipika et al (2016) conducted a study to assess Caregivers' perspective towards people were 42 and 28 severally, inter-quartile vary being eight every. angle score differed considerably by the sex of caregiver , academic standing of caregiver, sex of patient and sort of mental state . Perceived stigma score varied considerably by caregiver's sex , legal status, academic standing, occupation, relation with the patient and use of different treatment modalities. Sex of participant, academic standing, sex of patient and sort of mental state were the correlates of angle towards mental state. Similarly, sex of participant, legal status, academic standing, occupation, caregiver's relation with patient and use of different treatment modalities were correlates of perceived stigma. Findings of this

study counsel that interventions targeting these speculative populations could be helpful to assist build a positive angle and overcome the perceived social stigma.[24]

Aron Zieger et al (2016) conducted on a study on Perceived stigma of health problem mental disease psychopathy psychological state mental state it was a comparison between 2 metropolitan cities in Republic of India associate increasing variety of comparative studies area unit conducted on the disapproval of persons with mental illness, especially with relation to regional and diachronic variation. So far, there are no studies comparison disapproval of persons with psychopathy in 2 completely different regions of Republic of India. Therefore, we tend to examined the variations in perception of stigma connected to mental diseases in urban center and urban center, with relation to cultural and geographical variations to higher perceive the roots and origins of this issue. The surveys within the context of public attitudes toward folks with mental disorders were conducted among handily hand-picked members of the final population in urban center (n = 166) and urban center (n = 158) with identical methodology. Link's perceived devaluation-discrimination live was used. The calculated add score indicated that respondents from urban center had the next level of perceived discrimination toward persons with psychopathy than respondents from urban might offer U.S.A. with an improved understanding of the roots of perceived stigma in Republic of India[25.]

Singh Aakansha et al (2016) conducted a study to assess Stigma related to mental illness: abstract problems and specialize in stigma perceived by the patients with dementia praecox and their caregivers Among the assorted psychiatrically disorders, dementia praecox is taken into account to be related to high level of

stigma. This study reviews the abstract problems in understanding stigma, chiefly in reference to dementia praecox. The private stigma is any understood as perceived stigma, tough stigma, and self-stigma. The expertise of stigma among patients of dementia praecox is influenced by the sort and severity of psychopathology, insight, coping, causative beliefs, depression, social support, vanity, self-efficacy, and self-directness. Stigma influences medication compliance, quality of life, and social functioning. Analysis is scanty with relation to stigma perceived by caregivers of patients with dementia praecox. Besides the caregiver variables, completely different patient variables unambiguously modify the stigma tough by the caregivers.[26]

Ainul Nadhirah Hanafiah et al (2015) conducted a study to assess with fifteen psychological state professionals from each government and personal sectors together with psychiatrists, psychologists and counselors. The interviews were more or less 45- minutes long. The information was afterward analyzed mistreatment the fundamental thematic approach. The study revels Seven principal themes, every with their own sub-themes, emerged from the analysis of 'stigma of mental illnesses from mental health professionals' point of view. This is most evident amongst people suffering from conditions such as schizophrenia, bipolar disorder and depression. Stigma manifests itself most often in forms of labeling, rejection, social exclusion and in employment. Family, friends and workplace staff are reported to be the main perpetrators of discriminatory conducts.[27]

Bhumika et al (2015) conducted a study to assess Perception of stigma toward psychological state in South Republic of India. Stigma related to mental sicknesses related to psychological state and data of psychological state among the community related to psychological state to enhance the psychological state standing of the region.[28]

Elizabeth A Corker et al (2014) conducted a study to assess expertise of stigma and discrimination rumored by individuals experiencing the primary episode of schizophrenic disorder and people with a primary episode of depression schizophrenic disorder. Participants with schizophrenic disorder rumored a lot of discrimination with relevancy the police compared to participants with depression. Stigma and discrimination thanks to psychological state amendment within the course of the mental diseases. [29]

Mirja Koschorkea et al (2014) conducted a study to assess Experiences of stigma and discrimination of individuals with schizophrenic disorder in Republic of India The study used mixed strategies and was nested during a irregular controlled trial of community take care of schizophrenic disorder.[30]

Elizabeth A Corker et al (2014) Knowledge on four aspects of stigma intimate with by PLS and a number of other clinical variables were collected from 282 PLS and 282 caregivers and analyzed exploitation variable regression. Additionally, in-depth-interviews with PLS and caregivers (36 each) were allotted and analyzed exploitation thematic analysis. Quantitative findings indicate that expertise of negative discrimination were rumored less usually

(42%) than a lot of internalized varieties of stigma experience like a way of alienation (79%) and considerably less usually than in studies allotted elsewhere. Findings have implications for conceptualizing and activity stigma and increase the explanation for enhancing psycho-social interventions to support those facing discrimination. Findings additionally highlight the importance of addressing public stigma and achieving higher level social and political structural amendment.[31]

Eshetu Girma et al (2013) conducted the study to assess the general public Stigma against individuals with psychological state within the mean stigma score was a pair of.62 on a 5-point score. the bulk of the respondents (75.27%) believed that psychological state will be cured. Stress, poverty, and rumination were the foremost usually perceived causes of psychological state. Rural residents had considerably higher stigma scores (std. $\beta=0.61$, $P<0.001$). A statistically significant inverse relationship was found between the level of education and degree of stigma (std. $\beta=-0.14$, $P<0.01$), while higher income was significantly associated with more stigma (std. $\beta=0.07$, $P<0.05$). Respondents with higher scores for perceived supernatural causes (std. $\beta=-0.09$, $P<0.01$) and perceived psychosocial and biological causes (std. $\beta=-0.14$, $P<0.001$) had significantly lower stigma levels.[32]

Matthias et al (2013) conducted to analyze to what extent patients with dementia praecox or depression anticipate and skill stigmatization and the way this is often influenced by the sort of upset and therefore the social setting. a complete of 210 patients with dementia praecox or a depressive episode were interviewed, one 0.5

living during a town and therefore the alternative during a village. Most of the patients expect negative reactions from the setting, notably as issues the access to figure. Concrete stigmatization experiences were most often reported within the domain of social interaction. Conversely, patients living during a small-town anticipated stigmatization additional oft than patients from town, despite the fact that each had truly veteran stigmatization at an identical rate. [35]

Dereje Assefa et al (2012) conducted a study to assess ninety fifth 13.00; $p < 0.001$), single legal status (OR = 3.39; ninety fifth ninety fifth.40, 8.22; $p = 0.019$) and having distinguished psychotic symptoms (OR = 2.33; ninety fifth ninety fifth.17, 4.61; $p = 0.016$) were associated severally with a better stigma score. Virtually half those that interrupted their treatment reported that that they had done therefore attributable to perceived stigma. Those that had tried suicide (45.3%) were additional possible to possess a high stigma score (OR = 2.29; ninety fifth ninety fifth.27, 4.11; $p = 0.006$). [36]

Miguel Angel et al (2006) conducted a study to assess Stigma and discrimination towards individuals with dementia praecox and their family members)a qualitative study with focus teams of clinically stable schizophrenic outpatients (N = 18) and relatives (N = 26).Six classes of stigma and discrimination experiences were extracted from the patients' data: mental state vs. Lack of can, Prejudice associated with characteristic, Over-protection-infantilization, Daily social discrimination, Discrimination in health care, Descendants, Avoidance-social isolation. information from relatives were divided into 3 sets: discrimination towards the patients witnessed by relatives, discrimination suffered by the relatives

themselves and discrimination exerted by the relatives on the patients, this study reveals that Patients and relatives describe an excellent kind of stigma and discrimination experiences altogether areas of life, as well as health care. Isolation and turning away square measure common reactions to those experiences. advertising these stigma and discrimination experiences might facilitate to cut back stigmatizing attitudes in society and lead to healthier reactions from patients, affirmative an improved course of the sickness. [37]

Vanessa pen et al (2005) conducted a study to assess difficult Stigma and Discrimination in Communities: a spotlight cluster Study distinguishing kingdom psychological state Service Users' Main Campaign Priorities it is a qualitative study victimization focus cluster discussions, involving thirty three persons aged between twenty five and seventy five. This study reveals that triad of diminished quality, dis-empowerment with specific relevance communication issues and turning away by their social network outlined experiences of stigma. Reactions to stigma may be placed in four categories: avoid stigma, resign yourself thereto, challenge it, or distance yourself from others with a psychological state downside spread of solutions was mentioned with most affirmative changes among the health services that square measure presently supporting them over ancient instructional programs with the general public.[38]

Matthias et al (2004) conducted study to assess the prevalence of various parts of the stereotype of dementia praecox among the final public and examining their impact on the preference for social distance and therefore the acceptance of structural discrimination that's, imbalances and injustices inherent in legal rules

and therefore the provision of health care. In spring 2001, a survey were administrated in FRG involving people of German position aged eighteen years and older and living in non-institutional settings (n = five,025). A personal, totally structured interview was conducted, as well as an inventory of things covering the varied aspects of the stereotype, a social distance scale, and things assessing respondents' agreement with structural discrimination. [40]

SUMMARY:

This chapter discussed about the literature review, which is related to the factors related to perceived stigma and discrimination.

RESEARCH METHODOLOGY

For any research work the methodology of the investigation is of vital importance. Foundations of research are built and conducted over a structure called methodology and a valid study will always adapt encouraging research methodology. It consists the theoretical analysis of methods and principles associated with the branch of knowledge. Typically, it encompasses concepts such as paradigm, phases, theoretical model, and qualitative and quantitative techniques.

According to Polit and Beck: Methodology refers to ways of obtaining, organizing and analyzing data. A methodology decision depends on the nature of the research question. Methodology in research can be considered to be the theory of correct scientific decision.[45]

In this chapter, the researcher explains research methodology which includes approach, design, setting of the study, and sampling techniques. This chapter also deals with the development of tools, validity of content, reliability of tool, pilot study, collection of data, plan of data analysis.

The present study was carried out to assess Factors responsible for the perceived stigma and discrimination on patients with mental illness among people of selected urban and rural communities of Jodhpur

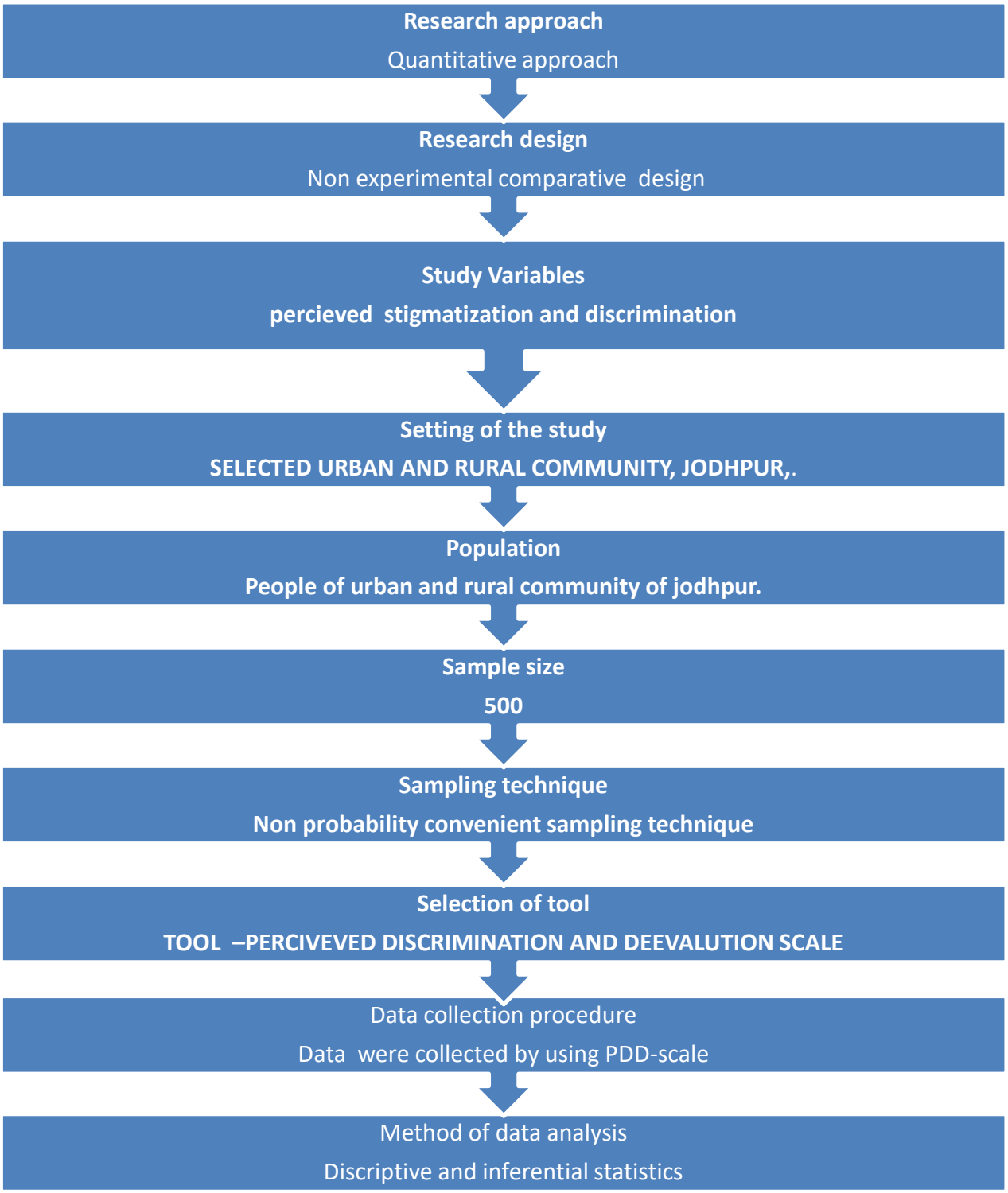

Fig. 1 Schematic Presentation of Research Design

Research Approach

It is an important element of the research process which governs the research designs. It involves the description of the plan to investigate the phenomenon under study. The approach helps to decide about the presence and absence of variables as well as manipulation and control over variables. It helps to identify the comparison between groups.

In present study Quantitative approach was used to find out the factors responsible for the perceived stigma and discrimination on patient with mental illness.

Research design

It is a framework or a guide used for coming up with, implementation and analysis of the study. Analysis style is outlined as a blue print to conduct a search study that involves the outline of analysis approach, study setting, sampling size, sampling technique, tools and methodology of knowledge assortment and analysis to answer specific analysis queries or for testing analysis hypothesis.

According to Polit and Beck: A research design refers to the researcher's overall plan for obtaining answer to the researcher's questions for testing the research. It incorporates some of the most important methodology decisions that the researchers make in conducting in a research study.

In the present study non-experimental descriptive comparative research design was used.

Variables:

According to Polit and Beck: A variable is, as the name implies, something that varies. A variable is any quality of an organism, group or event or environment that takes on different values.[45]

In present study variables consist two part:

Study variable: Perceived stigma and discrimination among people with mental illness

Demographic variable: These are age, gender, education, employment status, family income, marital status, religion and religious belief

Setting

Setting of the study: Research setting is an environment in which research is carried out. It could be natural, partially controlled or highly controlled.

According to Polit and Beck: “Setting is the physical location and the condition in which data collection take place in study’’. The present study was conducted at urban and rural community of Jodhpur[45]

Population

Population is the aggregation of all the units in which a researcher is invested. In other word, population is the set of people or entities to which the result of a research, are to be generalized. The entire set of individuals or objects having some common characteristics selected for a research study. It referred to as universe of the research study.

Target population: A target population consists of the total number of people or objects which are meeting the designated set of criteria. Target population for the present study includes peoples who are residents in urban and rural community of Jodhpur

Accessible population: It is the aggregate of cases that confirm to designated criteria and are also accessible as subjects for a study. Accessible Population of urban and rural residents of selected urban and rural community, Jodhpur

Sample and Sampling technique

A sample is a subset of a population that is used to represent the entire group as a whole. Sample is the subject of population selected to participate in research study.

According to Polit and Beck: “A sample is a small proportion of population selected for the observation and analysis”. Sampling is the process of selecting a representative segment of the population under study. Sampling is necessary because it is more economical and efficient to work with the small group of

elements, it improves the quality of data and results in the precision and accuracy of data. It also helps in quick study results.[45]

In the present study, Sample comprises of the general population of the community Non-probability connivance sampling technique was used to select the sample.

Non probability convenient sampling technique where the samples are selected from the population only because they are conveniently available to the researcher.

Sample size

Sample size is number of subjects, events, behavior, or situations that are examined in a study.

In this study, non-probability connivance sampling was used therefore, based on inclusion and exclusion criteria of the general population of the community urban and rural community of Jodhpur during the period of data collection.

Sampling technique: It is the method i.e. used to select the samples for data collection. In present study, Non-probability connivance Sampling was adopted.

Estimated sample size was 500 peoples.

Sample size is calculated through Cochran formula-

$$n_0 = \frac{Z^2 pq}{e^2}$$

- n_0 is the sample size.
- Z is 1.96 from Z table.
- e is the desired level of precision (i.e., the margin of error) i.e., 5% (0.05)
- p is the (estimated) proportion of the population which has the attribute in question,
- q is 1 – p.

So, for the present study, p is prevalence (prevalence of 17.8% prevalence of mental illness in India)

Variables

- Demographic variable: - Age, Gender, Marital status, Religion, Occupation, Educational status, Income and Strong religious belief.
- Research variable: -Perceived stigma and Discrimination

SAMPLE SELECTION CRITERIA

Criteria for sample selection: According to Polit and Beck: These criteria specify the characteristics that people in the population must possess in order to be included in the study.[45]

It consists of two parts: -

Inclusion criteria-

- People who are in the age group 20-60yrs.
- People who can read, write and speak Hindi.

- Peoples those who are willingly to participate.

Exclusion criteria-

- People who are mentally ill.
- Family members of mentally ill persons.
- People who are dumb and deaf and not able to provide information.
- Impaired cognitive function.

Development and description of tool

A research instrument is a device used to measure the concept of interest in a research project that a researcher uses to collect data. Depending on the nature of the information to be gathered different instruments are used to conduct study. In present study self-structured tool was prepared to assess knowledge of the caregivers and standardized tool was used to assess burden of the caregivers. Self-structured tool was prepared after doing intensive review of research and non-research literature and books, articles, journals, project reports and different online references. Formal and informal discussions were held with the guide and opinion of the experts was also taken.

Tool which are using in the present study as 2-section

Section-1: -Demographical variables developed by the investigator

Section-2: -Perceived discrimination and devaluation scale (PDD scale)

Both the investigator deep intensive review of literature from primary and secondary resources in developing and selecting the tools.

PART A – Items of demographic variables.

1) Age
2) Gender
3) Marital status
4) Religion
5) Occupation
6) Educational status
7) Income class
8) Strong religious beliefs (faith healers)

PART B – PERCEIVEDDISCRIMINATION AND DEVALUATION SCALE

In the present study, Perceived Discrimination and Devaluation Scale (PDD scale) was used. The PDD has a twelve-item tool which can measures the extent to which a person believes that most people will discriminate against some patients with a mental illness. For these questions, the respondents have to indicate their opinion on whether most peoples would agree or disagree with statements regarding former psychiatric or mentally ill patients. Their opinion is indicated on a 5-point Likert scale ranging from “definitely true” to “definitely not true. Lower scores correspond to lower levels of perceived discrimination, while higher scores correspond to higher levels of perceived discrimination. The scale consisted of 12 items covering participants’ view towards a variety of topics such as social acceptance, relationships, occupational and psychological on persons with mental illness. In this scale, scoring 1 is for strongly agree, 2 is for agree,3 is for

undecided, 4 is for disagree, 5 is for strongly disagree and items no.1,2,3,4,8,10 is having reverse scoring.

Table 1. Showing the characteristics of items of PDD scale

TOTAL ITEMS=12	**Positive items**	**Negative items**
Items	5,6,7,9,11,12	1,2,3,4,8,10
Total	6	6

Table 2. Showing the Brief review of the PDD scale

Domains	**No. of items**	**Cluster of items**	**Percentage**
Social acceptance	4	1,4,7,12	33.33%
Relationship	3	3,10, 11	25%
Occupation	3	6,8,9	25%
Psychological	2	2,5	16.67%
Total	12		100%

Interpretation: Interpretation was done by standardized mean score value of 5-point PDD scale. The high perceived stigma and discrimination was defined as an item mean score of 3 or higher score on PDD scales. Then perceived stigma scores were dichotomized as those participants scoring ≥ to the mean score of 3 on PDD scales as having “high perceived stigma and discrimination” and those scoring below the mean score as having “low perceived stigma and discrimination.

Factors responsible for the perceived stigma and discrimination were calculated on the basis of mean percentage score of each domain. Comparison of perceived stigma and discrimination of urban community and rural community was done by the using of T- test.

Validity and reliability of Tool

It is concerned with scope of coverage of the content area to be measured. More often it is applied in test of a person.

It is a degree of accuracy with which an instrument measures the attributes for which it is designed to measures.

The reliability of original PDD Scale questionnaire is 0.79 (Cronbach's alpha).

Ethical consideration

The ethical consideration was obtained from Institutional Ethical Committee of AIIMS, Jodhpur (IEC certificate reference number: AIIMS/IEC/2020-21/3021Dated-01/06/2020). Permission was obtained by competent authority and prior to administration of tool informed consent was taken from the subjects and they were assured of confidentiality and autonomy to withdraw self from study at any time of data collection.

Pilot study-

According to Polit and Beck: “Pilot study is the small version, or trial run, done in preparation for a major study.[45]

The purpose of the pilot study is two-fold: to make improvement in the research project and detect a problem that must be eradicated before the major study is attempted.”[45]

This research carried out at the end of the planning phase of study in order to explore and test the research elements to make relevant modification in tools and methodology.

It is a trial approach carried out before a research design to be finalized to assist to test the feasibility, reliability and validity of the proposed study design. Pilot study was conducted on 25 respondents from general population throughface-to-face interview from 21/09/2020 to 26/09/2020 at Dhawa (rural) and Pratap Nager (urban) community Jodhpur by using convince sampling technique.

The aim of pilot study was to assess the find out the factors responsible for the perceived stigma and discrimination on patients with mental illness. The pilot study was also designed to find out the practicability and feasibility of the study.

The purpose of the study was explained and subjects were assured about the confidentiality of their responses. Verbal and written consent were obtained from all the samples and then data was collected by using face to face interview method.

Findings of the pilot study revealed that study is feasible to conduct. The plan of the statistical analysis was also determined.

No major problem was faced during the pilot study

Data collection procedure

Data were collected after obtaining ethical consideration and permission from competent authority or institutional ethical committee of AIIMS, Jodhpur. Permission for using PDD scale interview has been taken from tool developer through mail. Sample were selected based on inclusion and exclusion criteria. Data collection was done from 28/10/2020 to 21/11/2020 by using non-probability convince sampling technique. Face to face interview method was used for collecting the data. Nature and purpose of the study was explained to them and subjects were assured about the confidentiality of their responses. Verbal and written consent were obtained from all the samples and flexible time duration was given while collecting data.

Data analysis: Data analysis is the schematic organization and synthesis of research data and the testing of research objectives using those data. It was planned to analyze the data on the basis of objectives. After data collection, the collected data was coded and summarized by the use of Microsoft excel sheet and all the entries were cross checked to avoid any kind of error. Analysis was done by using SPSS version 20.Data were analyzed by using descriptive and inferential statistics.

Descriptive statistics: Frequency, percentage, mean and standard deviation were the analytical part of the descriptive statistic, which were used to describe characteristics of demographic variables, and for finding the factors responsible for the perceived stigma and discrimination.

Inferential statistics: Chi-square was the analytical part of inferential statistics to seek association of perceived stigma and discrimination with their selected demographic variables.

Summary:

The research design gives an overview of entire process taking a problem in scientific and systematic manner. It includes approach, design, variables under study, population, setting, sampling technique, development of tool, validity of content, reliability, ethical consideration, pilot study, procedure for data collection, plan for data analysis.

ANALYSIS, INTERPRETATION AND DISCUSSION

The chapter deals with the analysis and interpretation of data collected from the general population of the urban and rural communities of Jodhpur with the help of PDD standardized scale. The purpose of the study was to identify the factors responsible for perceived stigma and discrimination towards patients with mental illness and and to find out the association between perceived stigma and discrimination with the selected demographic variables. Analysis and interpretation of data is the important phase of research process which involves the computation of certain measures along with searching for patterns of relationships that exist among data groups. Data collection is followed by analysis and interpretation of data, where collected data are analysed and interpreted in accordance with study objectives. Analysis and interpretation of the data includes compilation, editing, coding, classification and presentation of data. The purpose of analyzing the data collected in a study is to describe the data in meaningful terms, as the raw data collected does not answer the research questions. The data used are to be systematically analyzed so that trends and patterns of relationships can be detected.

According to Polit and Beck (2015) “Interpretation is the process of making sense of the results of the study and examining their implications”.[45]

Analysis and interpretation of the data were done using descriptive and inferential statistics on the objectives of the study.

Descriptive statistics: Frequency, percentage, mean and standard deviation were the analytical part of the descriptive statistics and it was used to describe demographic variables of the participants.

Inferential statistics: Chi-square was the analytical part of inferential statistics to seek association of factors responsible for perceived stigma and discrimination with selected demographic variables. For comparing the perceived stigma and discrimination used the independent T-test method for urban and rural communities.

The data and findings from the quantitative study have been organized and presented under the following sections:

Section 1: Description of Frequency and percentage of demographic variables of the study.

Section 2: Identify the factors responsible for the perceived stigma and discrimination on patients with mental illness.

Section 3: Comparison of mean score of finding related to perceived stigma and discrimination of the urban and rural community.

Section 4: Findings related to association of the perceived stigma and discrimination with selected demographic variable.

Section 1: Description of Frequency and percentage of demographic variables of the study.

Table 3-Frequency and percentage distribution of demographic variables of the Urban community.

N-250

DEMOGRAPHICAL VARIABLES	FREQUANCY	PERCENTAGE
A) AGE		
20-30	56	22.4
31-40	77	30.4
41-50	73	29.9
51-60	44	17.34
B) GENDER		
Male	123	49.2
Female	127	50.6
C)MARITAL STATUS		
Unmarried	49	19.6
Married	190	76
Separated/widowed	11	4.4
D)RELIGION		
Hindu	182	72.8
Muslim	68	27.2
E)OCCUPATION		
Gov.employed	74	29.6
Self employed	153	61.2
Unemployed	23	9.2
F)EDUCATION		
Primary education	48	19.2
Secondary education	52	20.8
Higher education	150	60
G)INCOME STATUS		
<10000	70	28
10001-20000	49	19.6
20001-30000	76	30.4
>30000	55	22
H)RELIGIOUS BELIEF		
No	179	71.6
Yes	71	28.4

Description of Table 3: The above table describe frequency and percentage distribution of the demographic variables of the subjects. Result reveals that among 250 respondents 30.4 %were between the age group of 31-40, 29.2 % were between the age group of 41-50 and 22.4 % participants were in the age group between 20-30 and remaining 17.24% were in the age group inbetween 51-60years. In gender distribution 50.8% were female and 49.2% were male. In religion 72.8% were hindu and 27.25% were muslin.In occupation 61.2% were self-employed, 29.6% were government job and 9.2% were un employed. In educational group 60% were having higher education, 20.8% were having secondary education, and 19.2% were having primary education. In monthly income 30.4% were having income 20000-30000 per month, 28% were having income <10000, 22% were having >30000 and 19.6% were having 10000-20000 income status.71.6% respondents were having no strong religious belief towards faith healers and 28.4% respondents were having the strong religious belief.

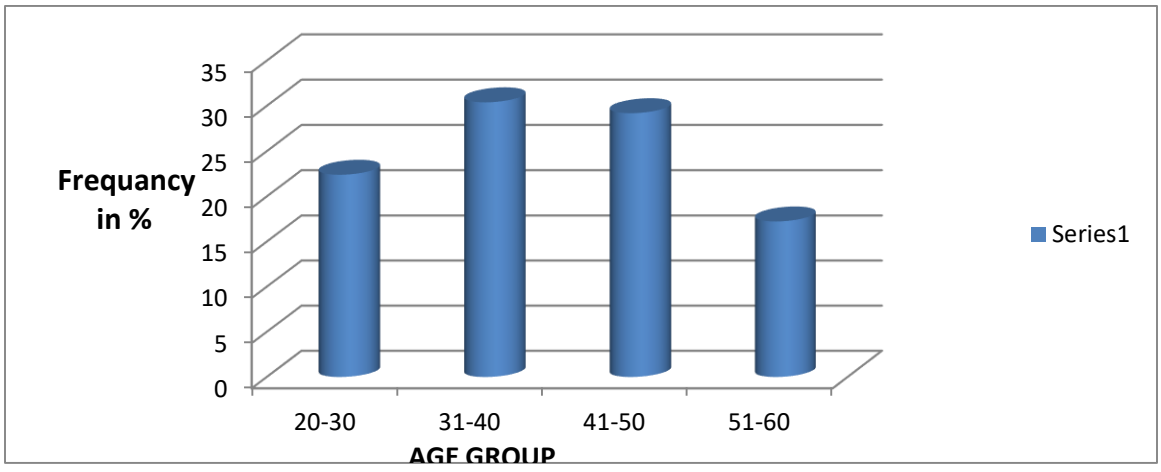

Figure II: Bar diagram depicting Age wise % distribution of respondents. (N=250)

Section 1: Description of Frequency and percentage of demographic variables of the study.

Table 4 - Factors responsible for the perceived stigma and discrimination of the rural community.

N=250

DEMOGRAPHICAL VARIABLES	FREQUANCY	PERCENTAGE
A)AGE		
20-30	59	23.6
31-40	72	28.8
41-50	70	28
51-60	49	19.6
B) GENDER		
Male	131	52.4
Female	119	47.6
C)MARITAL STATUS		
Unmarried	16	6.4
Married	223	89.2
Separated/widowed	11	4.4
D)RELIGION	209	83.6
Hindu	41	16.4
Muslim		
E) OCCUPATION		
Gov.employed	66	26.4
Self employed	161	78.13
Unemployed	23	9.2
F) EDUCATION		
Primary education	54	21.6
Secondary education	55	22
Higher education	141	56.4
G) INCOME STATUS		
<10000	84	33.6
10001-20000	36	14.1
20001-30000	81	32.4
>30000	49	19.6
H) RELIGIOUS BELIEF		
No	188	75.2
Yes	62	24.8

Description of Table 4: The above table describes frequency and percentage distribution of the demographic variables of the subjects. Result reveals that among 250 respondents28.8 % were between the age group of 31-40, 28.2%were between the age group of 41-50 and, 23%were between the age group of 20-30 and remaining 19.6 were in between 51-60 year of age group. In gender distribution 52.4% were male and 47.6% were female. 89.2%were married and 6.4% were unmarried and 4.4 were single. In religion 83.6 were Hindu and 16.6. In occupation status 78.13%were self-employed, 26.4% were government job and 9.2% were un employed. In educational group 56.4% were having higher education, 22% were having secondary education, and 21.6% were having primary education. In monthly income 33.6 were having income<10000, 32.4% were having income 20000-30000 per month, ,19.6were having >30000 and 14.1 were having 10000-20000 income status.75.2%respondents were having no strong religious belief towards faith healers and 24.8% respondents were having the strong religious belief.

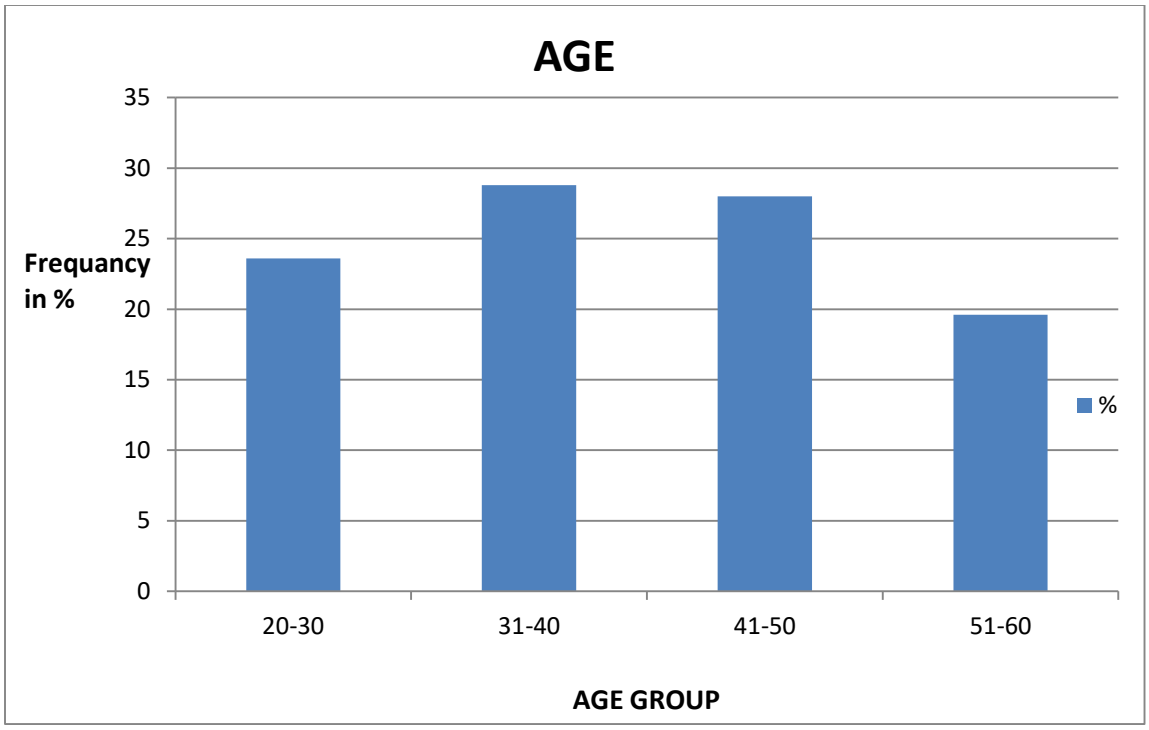

Figure III: Bar diagram depicting Age wise % distribution of respondents. (N=250)

Section 2: Identify the factors responsible for the perceived stigma and discrimination on patients with mental illness.

Table 5 - Factors responsible for the perceived stigma and discrimination of the urban community.

S.N	Factors	No.of items	Mean	mean %	SD
1	Social Acceptance	1,4,7,12	13.06	65.3	2.95
2	Relationship	3,10,11	10.29	68.6	2.82
3	Occupation	6,8,9	8.9	59.33	2.25
4	Psychological	2,5	5.76	57.6	2.05

Description of Table 5. Table shows the mean % distribution of factors of the PDD (Perceived devaluation and discrimination scale). Result reveals that the factor relationship is responsible for the higher level of perceived stigma and discrimination with highest mean percentage score 68.6 % in urban (Pratap nager) community. And the psychological factor is responsible for low level of perceived stigma and discrimination with lowest mean percentage score 57.6 %in urban community

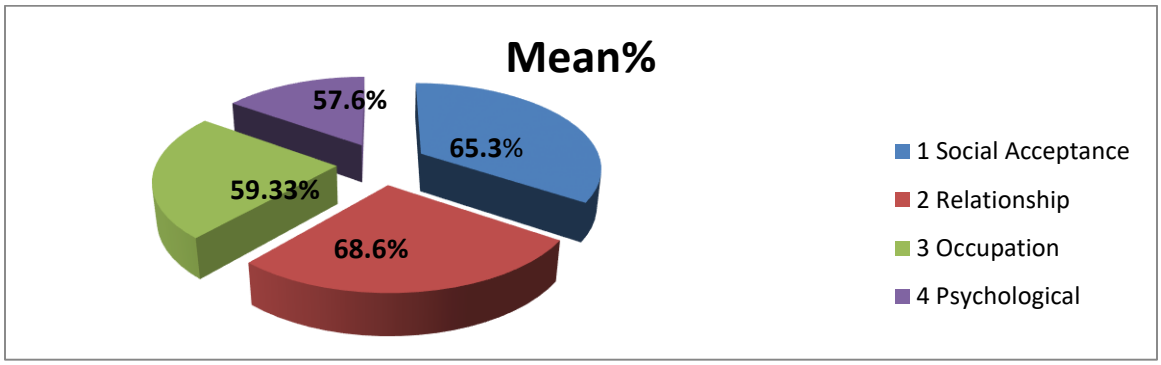

Fig. IV: Pie Diagram showing factors responsible for perceived stigma and discrimination in urban community.

Section 2: Identify the factors responsible for the perceived stigma and discrimination on patients with mental illness.

Table 6 - To identify the factors responsible for the perceived stigma and discrimination on patients with mental illness in selected rural community.

S.N	Factors	No. of items	Mean	mean %	SD
1	Social Acceptance	1,4,7,12	10.56	52.8	3
2	Relationship	3,10,11	7.86	52.4	1.69
3	Occupation	6,8,9	8.7	58	2.12
4	Psychological	2,5	6.12	61.2	2.06

Description of Table 6. Table shows the mean % distribution of factors of the PDD (Perceived devaluation and discrimination scale). Result reveals that the factor psychological is responsible for the higher level of perceived stigma and discrimination with highest mean percentage score 61.6 % in rural (Dhawa) community. And the relationship factor is responsible for low level of perceived stigma and discrimination with lowest mean core percentage score 52.4 % in rural (Dhawa) community.

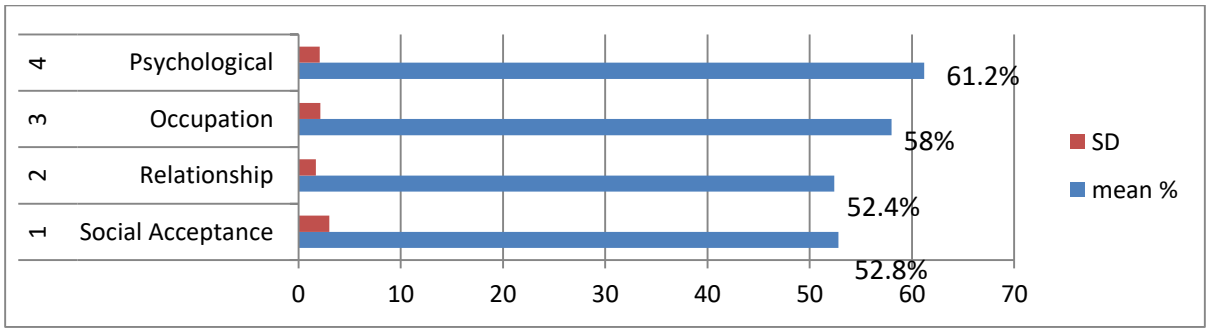

Fig. V: Bar Diagram showing factors responsible for perceived stigma and discrimination in urban community.

Section 3: Comparison of mean score of finding related to perceived stigma and discrimination of the urban and rural community.

Table 7: Comparison of mean score of finding related to perceived stigma and discrimination of the urban and rural community.

H0:-There will be no significant difference in perceived stigma and discrimination on patients with mental illness among selected urban and rural community.

H_1: There will be significant association between the factors associated with stigma and discrimination towards patients with mentally illness among their selected demographic variable.

(No.500)

COMPARITIVE TABLE

	Mean	SD	t(cal)	t(tab)	df	P-value	Remark
Urban	38.372	6.135					
			9.707	1.96	498	<0.00001	significant
Rural	33.396	5.38					

Description of Table 7: -The above table revels that the calculated T-value (9.70) is more than table T-value (1.96) with the degree of freedom 498. Hence, there is a significant difference in mean score of stigma and discrimination on patient with mental illness among people of urban and rural communities. The above table revels that there is a statically significant difference (P-value-0.0001) in mean scores of perceived stigma and discrimination on patient with mental illness among people of urban and rural communities. Therefore, null hypothesis is rejected at P-value <0.05.

Section 4: Findings related to association of the perceived stigma and discrimination with selected demographic variable.

Table 8: Association of the perceived stigma and discrimination with selected demographic variable of the urban community. **N=250**

S.No.	DEMOGRAPHICALVARIABLES	HIGH	LOW	TOTAL	X^2	df	p value	Remark
1	**AGE**							
	20-30	36	20	56				
	31-40	55	22	77	0.943	3	0.815	NS
	41-50	48	25	73				
	51-60	29	15	44				
2	**GENDER**							
	Male	82	41	123	0.031	1	0.86	NS
	Female	86	41	127				
3	**MARITAL STATUS**							
	Unmarried	29	20	49				
	Married	134	56	190	4.74	2	0.063	NS
	Separated/widowed	5	6	11				
4	**RELIGION**							
	Hindu	123	59	182	0.44	1	0.833	NS
	Muslim	45	23	68				
5	**OCCUPATION**							
	Gov.employed	50	24	74				
	Self employed	105	48	153	1.33	2	0.513	NS
	Unemployed	13	10	23				
6	**EDUCATION**							
	Primary education	33	15	48				
	Secondary education	35	17	52	**0.072**	**2**	0.965	NS
	Higher education	100	50	150				
7	**INCOME STATUS**							
	<10000	48	22	70				
	10000-20000	31	18	49	**0.455**	**3**	**0.929**	**NS**
	20000-30000	52	24	76				
	>30000	37	18	55				
8	**RELIGIOUS BELIEF**							
	No	121	58	179	**0.045**	**1**	0.832	NS
	Yes	47	24	71				

* - Significance ($p<0.05$), $\chi 2$ – (Chi square), NS- Not significant ($p>0.05$)

Description of Table 8. Table depicts about association between Perceived stigma and discrimination and selected demographic variable. It was found that age, gender, marital status, religion, occupation, education, family income status and strong religious belief were not found statistically significant at $p<0.05$ in urban community.

Section 4: Findings related to association of the perceived stigma and discrimination with selected demographic variable.

Table 9. Association of the perceived stigma and discrimination with selected demographic variable of the urban community.

N=250

S.No.	DEMOGRAPHICAL VARIABLES	HIGH	LOW	TOTAL	X^2	df	p value	Remark
1	**AGE**							
	20-30	16	43	59				
	31-40	26	46	72	2.983	3	0.394	NS
	41-50	25	45	70				
	51-60	21	28	49				
2	**GENDER**							
	Male	43	88	131	0.681	1	0.409	NS
	Female	45	74	119				
3	**MARITAL STATUS**							
	Unmarried	5	11	16				
	Married	77	146	223	1.958	1	0.376	NS
	Separated/widowed	6	5	11				
4	**RELIGION**							
	Hindu	72	137	209	0.314	1	0.575	NS
	Muslim	16	25	41				
5	**OCCUPATION**							
	Gov.employed	16	58	74				
	Self employed	68	85	153	10.166	2	0.006	Significat
	Unemployed	4	19	23				
6	**EDUCATION**							
	Primary education	21	33	54				
	Secondary education	24	31	55	**3.4**	**2**	0.182	NS
	Higher education	43	98	141				
7	**INCOME STATUS**							
	<10000	29	55	84				
	10000-20000	9	26	35	**1.916**	**3**	**0.59**	**NS**
	20000-30000	31	50	81				
	>30000	19	30	49				
8	**RELIGIOUS BELIEF**							
	No	65	123	188	**0.13**	**1**	0.718	NS
	Yes	23	39	62				

* - Significance ($p<0.05$), $\chi 2$ – (Chi square), NS- Not significant ($p>0.05$)

Description of Table 9. Table depicts about association between Perceived stigma and discrimination and selected demographic variable. It was found that occupation of rural community was statistically significant with the level of perceived stigma and discrimination at $p<0.05$, whereas, age, gender, marital status, religion, education status, employment status, and strong religious belief were not found statistically significant at $p<0.05$ in rural community.

RESULT AND DISCUSSION

RESULT: - The study reveals that among 250 participants from the urban community the factor relationship is responsible for the higher level of perceived stigma and discrimination with highest mean percentage score 68.6% whereas the psychological factor is responsible for low level of perceived stigma and discrimination with the lowest mean percentage score 57.6%. Among 250 participants from the rural community the psychological factor is responsible for the higher level of perceived stigma and discrimination with highest mean percentage score 61.2% whereas the relationship factor is responsible for low level of perceived stigma and discrimination with lowest mean percentage score 52.4%. And overall, the perceived stigma is found in urban communities with (38.37) mean score than in rural communities with (33.39) mean score. And after comparing the perceived stigma and discrimination in between urban and rural community it is found that there is a statically significant difference (P-value-0.0001) in mean scores of perceived stigma and discrimination on patient with mental illness, therefore, the null hypothesis is rejected at P-value <0.05.

Along with the association of perceived stigma and discrimination with demographical variables only occupation shows the statically significant difference at P-value <0.05 from the rural community whereas remaining all other variables age, gender, marital status, religion, education status, income status, and strong religious belief of urban and rural are non-significant.

DISCUSSION

The aim of this study is to assess the perceived stigma and discrimination and factors responsible for the perceived stigma and discrimination in urban and rural community among patients with mental illness. The present study shows from the urban community the result reveals that out of 250 respondents between the age group of 31-40, 77 (30.4 %) participants completed the interview. Similarly, the study conducted by **Nigus Alemnew Engidaw et al** shows from the urban area, out of 423 individuals invited to participate in this study, 418 participants completed the interview Among them respondents, 39.2% were within the age range of 25-34 year. In present study the 123 (49.2%) were male out of 250 respondents whereas similarly the study conducted by **Nigus Alemnew Engidaw et al** shows about 51.5% of the participants were males. The present study shows regarding the marital status 49 (19.6%) were unmarried whereas similarly the study conducted by **Nigus Alemnew Engidaw et al** shows about marital status (53.3%) were not married. The present study shows regarding the religion 182 (72.8) were Hindu whereas similarly the study conducted by **Nigus Alemnew Engidaw et al** shows (55.0%) of them were orthodox in religion. The present study shows regarding occupation majority of people were 153 (61.2%) were self-employed contradicted the study conducted by **Nigus Alemnew Engidaw et al** shows the majority (63.2%) of them were employed.

Regarding the factors in the present study in urban community the factor relationship is responsible for the higher level of perceived stigma and

discrimination whereas the psychological factor is responsible for low level of perceived stigma and discrimination contradictory the study conducted by **Etsedingl Hadera, et al** shows the Psychosocial factors having the large number of the participants believed that the cause of their mental illness as similarly in the rural community which shows that factor whereas the relationship factor is responsible for low level of perceived stigma and discrimination.

In the present study the association between the association between the perceived stigma and discrimination towards patients with mental illness relevant with socio demographical variables including age, gender, religion, marital status, occupation, educational status, income status, and strong religious belief similarly the study conducted by the **Kerem Böge et al,** which shows the association between perceived stigma toward mental illness and relevant socio demographic factors of the respondents including gender, age, educational attainment, religion, and strength of religious beliefs.

In the present study the mean score of rural community is (33.39) on the 5- point Likert scale whereas contradicted study conducted by **Eshetu Girmaetal, et al,** which shows, of the total of 845 respondents, 68.17% were from rural districts. Rural residents had significantly higher stigma scores (std. $\beta = 0.61$, $P<0.001$). Contradictory in present study which shows the urban community having the higher level of perceived stigma than the rural.

In the present study occupation from the rural community shows the statically significant whereas contradictory the study conducted by the **Eshetu Girmaetal,**

et al, shows the statistically significant inverse relationship was found between the level of education and higher income was significantly associated with more stigma.

In my study the result displays the influence of socio-demographic variable on level of perceived stigma including age, gender, marital status, religion, occupation, education, income status and religious belief are statically non-significant in urban community whereas in rural community occupation is statically significant and other variable are statically non-significant. The similar, results found in study conducted by **Kerem B, et al** which displays the influence of each socio-demographic variable including gender, age, educational attainment, religion, and strength of religious belief on the level of perceived stigma. No significant effect of age, marital status, educational attainment, the strength of religious beliefs, or religion was detected.

In present study urban community having higher level of stigma than in rural community. The similar, results found in study conducted by **Aron Zieger, et al,** which display the results showed that perceived stigma was higher in Kolkata than in Chennai. The correlation of higher stigma with lower education was in line with the previous research, and interestingly, it was found that higher stigma correlated with weaker religious devotion. Further studies exploring a wider variety of factors may provide us with a better understanding of the roots of perceived stigma in India.

In present study urban community have find the more level of perceived stigma and discrimination as similarly study was conducted by the **Thi Minh Tam Ta et al** which shown the Less negative perception of stigma attached to peoples with mental illness this was observed on the rural population in the Hanoi area may be interpreted in the light of possibly more demanding living conditions in modern urban Vietnam with less opportunities for mentally ill patients and points toward a dynamic interaction with rapidly changing living conditions in Asian megacities.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary: The current study was conducted on general population of community by using descriptive research design who are meeting the inclusion criteria. The data was collected from 500 subjects with connivance sampling technique.

Objectives of the study:

1. To identify the factors responsible for the perceived stigma and discrimination on patients with mental illness in selected urban community.
2. To identify the factors responsible for the stigmatization and discrimination on patients with mental illness in selected rural community.
3. To compare the score of perceived stigma and discrimination on patient with mental illness among urban and rural communities.
4. To determine the association of perceived stigma and discriminationwith selected demographical variables.

Major findings:

- The study reveals that among 250 participants from the urban community the factor relationship is responsible for the higher level of perceived stigma and discrimination with highest mean percentage score 68.6% whereas the psychological factor is responsible for low level of perceived stigma and discrimination with the lowest mean percentage score 57.6%. Among 250 participants from the rural community the psychologicalfactor is responsible for the higher level of perceived stigma and discrimination with highest

mean percentage score 61.2% whereas the relationship factor is responsible for low level of perceived stigma and discrimination with lowest mean percentage score 52.4%.

- And overall, the perceived stigma is found in urban communities with (38.37) mean score than in rural communities with (33.39) mean score.
- And after comparing the perceived stigma and discrimination in between urban and rural community it is found that there is a statically significant difference (P-value-0.0001) in mean scores of perceived stigma and discrimination on patient with mental illness, therefore, the null hypothesis is rejected at P-value <0.05.
- Along with the association of perceived stigma and discrimination with demographical variables only occupation shows the statically significant difference at P-value <0.05 from the rural community whereas remaining all other variables age, gender, marital status, religion, education status, income status, and strong religious belief of urban and rural are non-significant.

Limitation of study:

The study is confined to:

- The study is delimited to the people who are residing at selected urban (Pratap Nagar) and rural (Dhawa) community, Jodhpur.
- A larger sample size may prove beneficial.

- Including more community in different regions of the country may provide a wider scope for comparison and understanding.

Implication of the study:

Nursing is an art and science. It is based upon the current knowledge i.e., frequently changing with discoveries, ideas, techniques, methodologies and motivations.The finding of the study has implications on nursing practices, nursing administrations and nursing research.

Nursing Education

- The nursing education should emphasis on the importance of health education regarding factors responsible for the perceived stigma and discrimination.
- By the present study, help to the future nurses for finding the level of perceived stigma and discrimination towards patients with mental illness.
- The theory publication of this study will help to the future student nurse for conducting the similar study.
- The identifying factors from the urban and rural community helps to the future nurse to taking steps for developing the programmes.
- This study also helps for the surveillance in the community. Provide the opportunity to doing the work in community.
- Through continuing education and in-service education nurses can update their knowledge and practices.

Nursing Practice

- Best practice can be supported with the new and good evidences.
- The community nurse also gets help from the study “factors responsible for perceived stigma and discrimination into urban and rural community” that help to implementation of the programme.
- Community nurse also can find out the prevalence of the mental illness.
- Nurses working in community area may get chance to understand patient’s problem in depth, and this study is related to community setting, so direct care can be provided to patients suffering from any kind of mental illness.
- The comfortable environment should be provided to the client, by which the patient is able shares their problems easily.
- Practice is guided by knowledge and knowledge comes with the new information, by continuously searching for evidences will definitely help to get answers for all the problems faced by nurses.

Nursing Research

- This study will help nurses to plan care of mentally ill patient accordingly which helps in better outcome in terms of reducing the stigma and discrimination.
- The publication of this study will help to more community study on patients with mental illness.
- Current study will help the new researcher to get an idea about such studies and planning more in-depth studies.

- This study helps to finding out the best health care delivery system in community.

Problem faced while collecting data:

- Some respondents were not willing to share their information.
- Some respondents left the interview in between as they were showing less interest to talking about the mental ill patient.

Recommendation:

- Similar studies can be conducted at large sample size for finding out the more factors which are responsible for the perceived stigma and discrimination.
- Cross-sectional study can be done.
- Study can be done by the using of randomized sampling technique which helps to finding the more factors.
- Health education and awareness can help to minimise the perceived stigma and discrimination of the peoples.
- It is clear that to gain a more accurate reading of a society, a larger sample size may prove beneficial.
- Through this study the finding is, relationship factor is responsible for the perceived stigma and discrimination in urban community and psychological factor is for rural community helps to the further studies for finding more factors responsible for perceived stigma and discrimination.
- Furthermore, including more community in different regions of the country may provide a wider scope for comparison and understanding.

- On that note, it would also be interesting if similar studies were conducted in other low and middle-income countries as well as developed countries to provide a helpful comparison of differing cultures, societies, and norms.
- Similarly, it would also be helpful in future studies to look at a wider variety of possible influencing factors that may have had a significant impact on the level of perceived stigma and discrimination.

Conclusion: This study underlines that still community people are having perceived stigma and discrimination of people with mental illness. Additional researches with qualitative study methods are also suggested, in order to explore the relation of socio-demographic and perceived stigma and discrimination

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APPENDIX-1

अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर
All India Institute of Medical Sciences, Jodhpur
संस्थागत नैतिकता समिति
Institutional Ethics Committee

No. AIIMS/IEC/2020/3102 **Date: 01/06/2020**

ETHICAL CLEARANCE CERTIFICATE

Certificate Reference Number: **AIIMS/IEC/2020-21/**3021

Project title: **"Factors responsible for the perceived stigma and discrimination of patients with mental illness among people of selected urban and rural communities of Jodhpur."**

Nature of Project:	**Research Project Submitted for Expedited Review**
Submitted as:	**Student Research Project, as a part of Academic Programme**
Investigator:	**Anu Panwar**
Supervisor:	**Mr. Aashish Parihar**
Co-Supervisor:	**Dr. Navratan Suthar**

Institutional Ethics Committee after thorough consideration accorded its approval on above project.

The investigator may therefore commence the research from the date of this certificate, using the reference number indicated above.

Please note that the AIIMS IEC must be informed immediately of:

- Any material change in the conditions or undertakings mentioned in the document.
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Investigator must report to the AIIMS IEC in the prescribed format, where applicable, bi-annually, and at the end of the project, in respect of ethical compliance.

AIIMS IEC retains the right to withdraw or amend this if:

- Any unethical principle or practices are revealed or suspected
- Relevant information has been withheld or misrepresented

AIIMS IEC shall have an access to any information or data at any time during the course or after completion of the project.

Please Note that this approval will be rectified whenever it is possible to hold a meeting in person of the Institutional Ethics Committee. It is possible that the PI may be asked to give more clarifications or the Institutional Ethics Committee may withhold the project. The Institutional Ethics Committee is adopting this procedure due to COVID-19 (Corona Virus) situation.

If the Institutional Ethics Committee does not get back to you, this means your project has been cleared by the IEC.

On behalf of Ethics Committee, I wish you success in your research.

Dr. Praveen Sharma
Member Secretary

Member secretary
Institutional Ethics Committee
AIIMS Jodhpur

APPENDIX-2

To

Principal,

All India Institute of Medical Sciences,

Jodhpur, Rajasthan.

Subject: Regarding permission for data collection in community

Respected Sir,

Myself Miss. Anu Panwar, pursuing M.Sc. Nursing (Batch2019) from College of Nursing, AIIMS, Jodhpur. As an academic requirement of M.Sc. Nursing, I have undertaken research project entitled, "Factors responsible for the perceived stigma and discrimination of patients with mental illness among people of selected urban and rural communities of jodhpur." under supervision of Mr. Aashish Parihar, Lecturer, (Department of Psychiatric Nursing) College of Nursing, AIIMS, Jodhpur. Regarding my research project I have selected urban and rural community for data collection. So, I want permission for collecting data from community for 20 days.

Kindly allow me for the same.

Thanking you.

Yours' truly,

Miss. Anu Panwar

M.Sc. Nursing 2nd year (Batch-2019)

Speciality: Psychiatry Nursing

Phone no: 9887595668

Date:

Email: annnyparmar@gmail.com

Forwarded & Recommended

20.10.2020

permitted

24/10/20

APPENDIX-3

COLLEGE OF NURSING

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, JODHPUR

RESEARCH PROJECT

CERTIFICATE OF LANGUAGE VALIDITY OF THESIS (ENGLISH)

I, Dr. / Mr. / Mrs. Nirmala Chauna hereby certify that the thesis titled **"Factors responsible for perceived stigma and discrimination of patients with mental illness among people of selected urban and rural communities of Jodhpur"** prepared by Anu Panwar, M.Sc. Nursing (Batch – 2019) is found to be valid and up-to date in English language.

Place:

Date:

Nirmala Chauna
अध्यापक
Signature & Seal of Validator

APPENDIX-4

SECTION: A DEMOGRAPHIC VARIABLES

Note: The investigator will ask the items listed below and place the tick mark (√) against the response given by the respondents. This information will be treated as confidential.

S. No	DEMOGRAPHICAL VARIABLES
1	**AGE**
	20-30
	31-40
	41-50
	51-60
2	**GENDER**
	Male
	Female
3	**MARITAL STATUS**
	Unmarried
	Married
	Separated/widowed
4	**RELIGION**
	Hindu
	Muslim
5	**OCCUPATION**
	Gov.employed
	Self employed
	Unemployed
6	**EDUCATION**
	Primary education
	Secondary education
	Higher education
7	**INCOME STATUS**
	<10000
	10001-20000
	20001-30000
	>30000
8	**RELIGIOUS BELIEF**
	No
	Yes

APPENDIX-5

1)आयु

20- 30 साल

31- 40 साल

41 - 50 वर्ष

51-60 वर्ष

2)लिंग

पुरुष

महिला

3) वैवाहिकस्थिति

अकेला

विवाहित

c) अलगकियागया/विधवा

4) धर्म

हिंदू

मुस्लिम

5) व्यवसाय

सरकारीकार्यरतहै

स्व-नियोजित

बेरोजगार

6) शैक्षिकस्थिति

प्राथमिकशिक्षा

माध्यमिकशिक्षा

उच्चशिक्षा

7) आयवर्ग

<10000
10001-20000
20001-30000
>30000

8) मजबूतधार्मिकविश्वास

नहीं

हाँ

APPENDIX-6

Perceived discrimination and devaluation scale (PDD scale)

In the following statements we want you to tell us, what in your opinion the general public thinks about <u>former psychiatric</u> or <u>former mentally ill persons</u>. Thus the following statements deal with opinions of what most people think (general public).

Please answer if the statement for <u>most people in India</u> would be true or not true.

Please mark a cross at <u>each</u> line.

		definitely true	probably true	un-decided	probably not true	definitely not true
A	Most people would willingly accept a former mental patient as a close friend.	☐1	☐2	☐3	☐4	☐5
B	Most people believe that a person who has been in mental hospital is just as intelligent as the average person.	☐1	☐2	☐3	☐4	☐5
C	Most people believe that a former mental patient is just as trustworthy as the average citizen.	☐1	☐2	☐3	☐4	☐5
D	Most people would accept a fully recovered former mental patient as a teacher of young children in a public school.	☐1	☐2	☐3	☐4	☐5
E	Most people feel that entering a mental hospital is a sign of personal failure.	☐1	☐2	☐3	☐4	☐5
F	Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time.	☐1	☐2	☐3	☐4	☐5
G	Most people think less of a person who has been in a mental hospital.	☐1	☐2	☐3	☐4	☐5
H	Most employers will hire a former mental patient if he or she is qualified for the job.	☐1	☐2	☐3	☐4	☐5
K	Most employers will pass over the application of a former mental patient in favor of another applicant.	☐1	☐2	☐3	☐4	☐5
L	Most people in my community would treat a former mental patient just as they would treat anyone.	☐1	☐2	☐3	☐4	☐5
M	Most young women would be reluctant to date a man who has been hospitalized for a serious mental disorder.	☐1	☐2	☐3	☐4	☐5
O	Once they know a person was in a mental hospital, most people will take his opinion less seriously.	☐1	☐2	☐3	☐4	☐5

APPENDIX-7

PDD scale Hindi version

निम्नलिखित कथनों में हम चाहते हैं कि आप हमें बताएं, आपकी राय में आम लोगपूर्वमानसिकयापूर्वमानसिकरूपसेबीमारव्यक्तियोंकेबारेमेंक्यासोचतेहैं।इसप्रकारनिम्नलिखितकथनउनरायोंसे निपटतेहैंजोअधिकांशलोगसोचतेहैं) सामान्यजनता(।

कृपयाजवाबदेंकिक्याभारतमेंअधिकांशलोगोंकेलिएवयानसहीहोगायानहीं।

कृपयाप्रत्येकपंक्तिमेंएकक्रॉसचिह्नितकरें।

		निश्चित सत्य	शायदसही	दुविधामेंपड़ाहुआ	शायदसचनहींहै	निश्चित रूपसेसचनहींहै
	अधिकतर लोग ऐसे आदमी को अपना करीबी दोस्त बनाना चाहेंगे जो कभी मानसिक रोगी रहा हो ।	☐	☐	☐	☐	☐
2.	ज्यादातर लोगों का मानना है कि वह व्यक्ति जो मानसिक अस्पताल में है, औसत व्यक्ति की तरह ही बुद्धिमान है।	☐	☐	☐	☐	☐
3.	ज्यादातर लोगो का मानना हैं कि एक आदमी जो पहले से मानसिक रोगी रहा हो वह औसत नागरिक के रूप में भरोसेमंद है।	☐	☐	☐	☐	☐
4.	ज्यादातर लोग पब्लिक स्कूल में युवा बच्चों के लिए शिक्षक को स्वीकार करेंगे जो पहले मानसिक रोगी रहा हो , चाहे अब वह पूरी तरह से ठिक है।	☐	☐	☐	☐	☐
5.	ज्यादातर लोगों को लगता है कि मानसिक अस्पताल में प्रवेश करना व्यक्तिगत असफलता का संकेत है।	☐	☐	☐	☐	☐
6.	अधिकतर लोग अपने पूर्वजों की देखभाल करने के ऐसे आदमी को नियुक्त नहीं करेंगे जो पहले रोगी रहा हो भले ही वह कुछ समय से ठीक हो।	☐	☐	☐	☐	☐
7.	ज्यादातर लोग मानसिक अस्पताल में रह चुके व्यक्ति के बारे में कम सोचते है।	☐	☐	☐	☐	☐
8.	अधिकांश नियोक्ता एक ऐसे आदमी को नौकरी के लिए नियुक्त करेंगे जो पूर्व मानसिक रोगी रहा हो यदि वह नौकरी के योग्य है।	☐	☐	☐	☐	☐
9.	अधिकांशनियोक्ताकिसीअन्यआवेदककेपक्षमेंएकपूर्वमानसिकरोगीकेआवेदनसेगुजरेंगे।	☐	☐	☐	☐	☐
10	मेरे समुदाय के अधिकांश लोग एक पूर्व मानसिक रोगी का इलाज उसी तरह करेंगे जैसे वे किसी का इलाज करते हैं।	☐	☐	☐	☐	☐
11	ज्यादातर युवा महिलाएं एक ऐसे व्यक्ति को डेट करने से हिचकिचाएंगी जिसे गंभीर मानसिक बीमारी के लिए अस्पताल में भर्ती कराया गया है।	☐	☐	☐	☐	☐
12	एक बार जबवे जानते हैं कि एक व्यक्ति मानसिक अस्पताल में था, तो ज्यादातर लोग उसकी राय को कम गंभीरता से लेंगे।	☐	☐	☐	☐	☐

APPENDIX-8

Seeking permission for using standardized tool

Inbox

Anny Parmar <annnyparmar@gmail.com> Fri, Jan 31, 2020, 11:24 AM

to Kerem.boege

Respected sir ma'am,

This is to inform you that I am miss. Anu Panwar pursuing my M.sc nursing in psychiatry from AIIMS, Jodhpur Rajasthan, India. I have to complete a research project during my course. The title of my research project is " Factors responsible for the perceived stigma and discrimination of patient with mental illness among the general population of selected urban and rural communities of Jodhpur"

For the completion of this research project I require a standardized tool to assess the perceived stigma and discrimination. I believe that PDD scale will be helpful for me as it is an effective tool. I also seek permission for modification of tool in hindi as I will use this tool in India. I will assure you for the proper citation of tool in my research project. Your consent to my request would be greatly appreciated.

Awaiting for your positive feedback.

Thank you,

Sincerely,

Anu Panwar

M. SC. Nursing student

AIIMS, Jodhpur

Anny Parmar <annnyparmar@gmail.com>
to Kerem.boege

Sat, Feb 1, 2020, 9:25 AM

Böge, Kerem <kerem.boege@charite.de>
to me

Mon, Feb 3, 2020, 12:51 PM

Dear Anu,

attached I am sending you the PDDS scale. Of course you can happily use it for your research.

I wish you all the best,

Kerem

Kerem Böge

M.Sc. Psychologe

Charité Universitätsmedizin Berlin

Klinik für Psychiatrie und Psychotherapie

Campus Benjamin Franklin

Hindenburgdamm 30 | 12203 Berlin

Tel.: (+49)30 – 450 517636 | 517789

kerem.boege@charite.de

Anny Parmar <annnyparmar@gmail.com> **Mon, Feb 3, 2020, 2:41 PM**
to Kerem

Thank you sir

Anny Parmar <annnyparmar@gmail.com> **Tue, Feb 4, 2020, 1:52 PM**
to Kerem

Respected sir/ma'am,
I also want to do modification in tool if hindi version is not available. Kindly permit me.
Thank you
Anu Panwar
M. Sc Nursing 1st year
AIIMS Jodhpur

Böge, Kerem <kerem.boege@charite.de> **Tue, Feb 4, 2020, 2:08 PM**
to me

Yes of course

APPENDIX-9

CONSENT FORM

English

Informed consent from

Title of the research study: **"Factors responsible for the perceived stigma and discrimination of patients with mental illness among people of selected urban and rural communities of Jodhpur**

Name of the investigator: Anu panwar

Subject identification number:

I.....S/o,D/o,orW/o.....
.....R/o.....given my full, free voluntary consent to be a part of the study "Factors responsible for the perceived stigma and discrimination of patients with mental illness among people of selected urban and rural communities of Jodhpur give my full, free voluntary consent to be a part of the study" The procedure and nature of which has been explained to me in my own language to my full satisfaction. I confirm that I have had the opportunity to ask question.

I understand that my participation is voluntary and I am aware of my right to opt out of the study at any time without giving any reason.

I understand that the information collected about me and any of my medical records may be looked at by responsible individual from AIIMS, Jodhpur Rajasthan. I give permission for these individual to have access to my records.

Date .....

Place .....

.....

Signature / thumb impression

This to certify that the above consent has been obtained in my presence.

Date .....

Place.....

Signature of investigator.....

APPENDIX-10

हिन्दी

सहमतिसूचना प्रपत्र

परियोजनाका शीर्षक

अन्वेषकका नाम

पहचानसंख्या

मैं..... पुत्र / पुत्री / पत्नी.....निवासी, "जोधपुर के चयनित शहरी और ग्रामीण समुदायों के लोगों के बीच मानसिक बीमारी के साथ रोगियों के कथित कलंक और भेदभाव के लिए जिम्मेदार कारक नामक अध्ययन कि प्रकिया और प्रकृति मुझे मेरी अपनी भाषा में पूर्णसंतुष्टि के साथ समझा दी गई है मैं भाग लेने के लिए अपनी पूर्ण स्वतंत्र एवंस्वेछिक सहमति देता/ देती हूँ मैं पुष्टि करता / करती हूँ कि मुझे सवाल पूछने का अवसर दिया गयाहै मैं सहमति / सहमत हूँ कि मेरी भागीदारी स्वेछिक है और मैं अपने इस अधिकार से अवगतहूँ कि मैं किसी भी समय बिना कोई कारण दिये इस अध्ययन से अपना नाम वापस ले सकता/सकतीहूँ मैं समझता / समझती हूँ कि मेरे बारे मैं एकत्र जानकारी एम्सजोधपुर के किसी भी जिम्मेदार व्यक्ति द्वारा या नियामक अधिकारियो द्वारा देखी जासकती है मैं उपरोक्त व्यक्तियों को मेरे द्वारा दी गई जानकारी देखने कि अनुमतिदेता / देती हूँ|

दिनांक..... .

स्थान.....

हस्ताक्षर.....

यहप्रमाणित है कि उपरोक्त सहमति मेरी उपस्थिति में प्राप्त की गई है

दिनांक.....

स्थान .....

अन्वेषक हस्ताक्षर.....

APPENDIX-11

LIST OF FORMULA USED FOR DATA ANALYSIS

FORMULA 1: Arithmetic mean

$$\bar{x} = \frac{\sum X}{n}$$

FORMULA 2: Standard Deviation

$$S = \sqrt{\frac{\sum (X - \bar{x})}{n-1}}$$

FORMULA 3: Chi Square Test

$$\chi^2 = \frac{\sum (O - E)^2}{E}$$

APPENDIX-12

CODING SHEET FOR DEMOGRAPHIC VARIABLES

S.No	DEMOGRAPHICAL VARIABLES	CODING
1	**AGE**	
	20-30	1
	31-40	2
	41-50	3
	51-60	4
2	**GENDER**	
	Male	1
	Female	2
3	**MARITAL STATUS**	
	Unmarried	1
	Married	2
	Separated/widowed	3
4	**RELIGION**	
	Hindu	1
	Muslim	2
5	**OCCUPATION**	
	Gov.employed	1
	Self employed	2
	Unemployed	3
6	**EDUCATION**	
	Primary education	1
	Secondary education	2
	Higher education	3
7	**INCOME STATUS**	
	<10000	1
	10001-20000	2
	20001-30000	3
	>30000	4
8	**RELIGIOUS BELIEF**	
	No	1
	Yes	2

APPENDIX-13

Master Data sheet for urban community

Respondent/Q.N.	1	2	3	4	5	6	7	8	9	10	11	12
1	4	4	5	5	4	4	2	5	1	5	4	1
2	4	4	5	5	2	5	1	5	1	5	5	1
3	4	1	5	3	1	1	4	2	2	1	5	4
4	5	1	1	1	3	2	1	5	1	4	1	1
5	5	5	4	3	3	1	2	4	2	5	5	1
6	5	4	1	2	3	4	1	4	1	5	1	4
7	1	2	2	5	2	2	5	1	4	5	2	5
8	2	5	5	5	1	4	5	5	1	5	1	2
9	4	1	5	5	3	4	1	4	2	5	1	5
10	5	1	5	1	5	1	5	4	1	5	1	4
11	5	1	5	2	5	2	4	5	2	5	2	5
12	4	4	5	5	4	4	2	5	1	5	4	2
13	5	1	1	5	2	5	1	5	1	5	5	1
14	1	5	4	3	1	1	4	2	2	1	5	4
15	2	1	5	5	3	2	1	5	1	4	1	1
16	5	1	1	1	4	2	4	3	2	5	1	1
17	2	5	5	4	5	5	1	5	1	5	1	5
18	4	4	5	5	1	2	5	4	2	5	5	5
19	5	1	5	3	3	1	1	5	1	5	1	4
20	5	1	5	1	1	4	1	1	5	5	1	1
21	5	4	5	2	3	5	4	4	1	5	2	5
22	4	1	5	5	1	1	5	5	2	5	1	4
23	2	1	4	3	5	2	1	3	1	1	1	3
24	2	5	1	1	4	5	1	5	5	1	1	5
25	3	4	5	1	3	2	4	3	4	1	1	4
26	2	5	5	5	1	4	5	5	1	5	1	2
27	4	1	5	5	3	4	1	4	2	5	1	5
28	5	1	5	1	5	1	5	4	1	5	1	4
29	5	1	5	2	5	2	4	5	2	5	2	5
30	4	4	5	5	4	4	2	5	1	5	4	2
31	5	1	1	5	2	5	1	5	1	5	5	1
32	1	5	4	3	1	1	4	2	2	1	5	4
33	2	1	5	5	3	2	1	5	1	4	1	1
34	5	1	1	1	4	2	4	3	2	5	1	1
35	2	5	5	4	5	5	1	5	1	5	1	5
36	4	4	5	5	1	2	5	4	2	5	5	5
37	5	1	5	3	3	1	1	5	1	5	1	4
38	5	1	5	1	1	4	1	1	5	5	1	1
39	5	4	5	2	3	5	4	4	1	5	2	5
40	4	1	5	5	1	1	5	5	2	5	1	4
41	2	1	4	3	5	2	1	3	1	1	1	3
42	2	5	1	1	4	5	1	5	5	1	1	5
43	3	4	5	1	3	2	4	3	4	1	1	4
44	2	5	5	5	1	4	5	5	1	5	1	2
45	4	1	5	5	3	4	1	4	2	5	1	5
46	5	1	5	1	5	1	5	4	1	5	1	4
47	5	1	5	2	5	2	4	5	2	5	2	5
48	4	4	5	5	4	4	2	5	1	5	4	2
49	2	5	5	5	1	4	5	5	1	5	1	2
50	4	1	5	5	3	4	1	4	2	5	1	5

51	3	2	2	1	2	1	3	1
52	3	2	2	1	2	2	3	2
53	2	1	2	2	2	1	3	1
54	1	1	1	1	2	2	3	2
55	1	1	1	2	2	3	4	1
56	2	1	1	2	2	3	1	2
57	3	1	2	2	2	3	3	1
58	4	1	2	2	2	1	4	1
59	1	1	1	2	3	3	1	1
60	1	1	1	2	2	3	1	1
61	1	1	1	1	2	3	1	1
62	3	2	2	1	2	3	2	1
63	1	2	1	1	2	3	1	1
64	3	2	2	1	2	3	3	1
65	1	2	2	1	2	3	4	2
66	2	2	2	1	1	3	3	1
67	2	2	2	1	1	3	3	1
68	2	2	2	2	2	3	1	1
69	3	2	2	1	2	3	1	1
70	3	2	2	1	2	3	1	1
71	1	2	2	2	2	2	2	2
72	2	1	1	1	2	2	2	2
73	2	2	2	1	2	2	2	1
74	2	2	2	1	2	2	1	1
75	2	2	2	1	2	2	1	1
76	3	1	2	1	2	3	3	1
77	2	1	2	1	2	3	4	2
78	2	2	2	2	2	2	1	2
79	1	2	2	2	2	3	2	1
80	4	1	2	2	2	3	4	1
81	2	2	2	1	1	3	3	2
82	4	1	2	2	1	1	3	2
83	4	2	2	1	2	1	1	2
84	3	2	3	1	1	1	1	2
85	4	2	3	1	1	1	1	2
86	4	2	2	2	2	1	1	2
87	4	2	2	1	2	1	1	1
88	4	1	2	1	2	2	4	1
89	2	2	2	1	1	3	2	1
90	3	2	2	1	1	3	2	1
91	3	2	2	1	2	1	1	1
92	4	1	2	1	2	1	4	1
93	3	1	2	1	2	2	3	1
94	3	2	2	2	2	3	3	1
95	3	2	2	2	2	2	2	1
96	3	2	2	1	2	2	2	1
97	2	2	2	1	2	3	1	1
98	2	2	2	1	1	3	3	1
99	3	1	2	1	1	2	3	1
100	1	2	1	1	1	3	3	1

101	1	1	1	1	1	3	4	1
102	1	1	1	1	3	3	1	1
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Master Data sheet for rural community

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