International Journal of Public Health Asia Pacific

Open Access: e-Journal
ISSN: 2822-0587(Online)

Association between belief towards mental illness and help seeking behaviour among undergraduate students of Lalitpur district, Nepal

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ABSTRACT

Background: The prevalence of mental illness among adolescents is a growing concern, with projections indicating that one in five adolescents experience a mental illness annually. Persistent negative beliefs and stigma surrounding mental illness often lead to discrimination, creating barriers that hinder individuals from seeking the help they need. Additionally, the neglect of mental health issues, especially in developing countries like Nepal, is influenced by deep-seated social and cultural factors that are not widely acknowledged.

Objectives: To assess the association of belief towards mental illness and help seeking behaviour among undergraduate students of Lalitpur district, Nepal.

Methods: An analytical cross-sectional study was conducted among 400 undergraduate students of management faculty in Lalitpur district. Belief towards Mental Illness scale was used to assess belief and self-reported questionnaire was used for assessing help seeking behaviour. Univariate and multivariable logistic regression analyses were performed to assess the association between beliefs and help seeking behaviour adjusting for the confounders.

Results: More than half of the respondents had negative belief towards mental illness. Seventy-nine percent of the respondents had previously sought help while experiencing any kind of mental illness. The odds of not seeking help is higher by 1.71 times among those who had negative belief towards mental illness compared to those who had positive belief (95% CI 1.03,2.8) adjusting for the confounders.

Conclusion: Those students who had negative belief were less likely to seek help. This highlights the urgent need to address these negative beliefs through targeted interventions, aiming to alleviate such perceptions and foster improved help-seeking behaviour.

Keywords: Beliefs, Help seeking, Mental illness

1. Introduction

Mental illness typically emerges during youth, imposing a significant burden on individuals and society [1]. The youth's mental well-being is directly intertwined with factors such as lower education, substance abuse, violence, and inadequate education on sexual and reproductive health. Challenges such as the shortage of mental health care professionals, limited capacity and motivation among health workers, and societal stigma further escalate these issues [2]. Adolescence and young adulthood mark a crucial period where emotional changes occur, setting the stage for mental illnesses [3]. However, reluctance to seek treatment often arises as mental illnesses manifest later, leading to a rejection of necessary interventions.

Unfortunately, individuals with mental illnesses frequently experience abuse, rejection, and isolation due to the presence of stigma and misconceptions that mental illnesses are incurable and impair one's intelligence and decision-making abilities [4]. Community support plays a pivotal role in aiding those with mental illnesses, yet widespread beliefs, cultural influences, and customs significantly impact individuals' willingness to seek help [5].

In Nepal, around 5.2% of teenagers are experiencing mental health disorders. Among them, 3.9% are currently having thoughts of suicide, and 0.7% have attempted suicide at some point [6]. Similarly among adults, 10% have faced mental disorders in their lifetime, and currently, 4.3% are dealing with mental health issues [6]. In 2019, Nepal had approximately 3.9 million people with mental illnesses, where major depressive disorders and anxiety disorders were the most prevalent conditions [7]. The prevalence of mental illness among adolescents was a growing concern, with projections indicating that one in five adolescents will experience a mental disorder annually [8]. Depression has emerged as an alarming issue among adolescents, ranking itself among the leading causes of mental health challenges whereas self-harm stands as the third leading cause of death among this demographic [8]. While known factors such as stress, relationship issues, bullying, loneliness, and financial problems contribute to the mental health challenges faced by adolescents and young adults, there are lesser-known factors exacerbating the situation [9]. Persistent negative beliefs and stigma surrounding mental illnesses often lead to discrimination, creating barriers that hinder individuals from seeking the help they need [10]. Additionally,

the neglect of mental health issues, especially in developing countries like Nepal, is influenced by deep-seated social and cultural factors that are not widely acknowledged [11]. Therefore, this study assessed beliefs associated with help seeking behaviour regarding mental illness among undergraduate students of Lalitpur district, Nepal. There is need of this type of study in Nepal so as to prioritize mental health issues. It will help to plan and implement effective interventions to bring improvement in mental health status of adolescents as well as young adults.

2. Methods

2.1 Study Area

This study was conducted in undergraduate colleges of Lalitpur district, Nepal.

2.2 Study Design

This is a cross-sectional analytical study.

2.3 Sample size and sampling

Due to the lack of previous studies, prevalence was considered to be 50%, thus making p=0.5.

Allowable error (e) = 5 % i.e. 0.05

(95% CI) = Z-value for α test = 1.96

q = (1-p) = 1-0.5 = 0.5

Sample size will be (z^2 pq)/e^2

= ((1.96)^2* 0.5* 0.5)/(0.05)^2

= 0.9604/0.0025

= 384.16 ≈ 384

Adding a 10% non-response rate, the anticipated sample size for this study was 422; however, only 400 participants were recruited.

Respondents were recruited conveniently from five colleges in Lalitpur district operating management faculty at the time of data collection. Study participants were drawn from the students' register maintained by colleges which included students' list.

2.4 Data Collection

Self-administered questionnaire was used for data collection and the questions for socio-demographic variable were adopted from national surveys in Nepal [12]. In addition, Belief regarding mental illness was measured using the Belief towards Mental Illness Scale (BTMI) developed by Hirai and Clum [13]. We translated the BTMI tool into Nepali language and got it back translated by independent researchers. We pretested the tool among 30 participants and calculated Cronbach's alpha to have the value of 0.83, thus ensuring internal consistency of the tool used. The tool consisted of 21 statements designed to assess negative stereotypical

views towards mental illness. Respondents rated each statement on a 6-point Likert scale, ranging from 'completely disagree' (0) to 'completely agree' (5). Higher scores on the scale indicated more negative beliefs. The questions were systematically organized into four distinct factors: i) danger, ii) social dysfunction, iii) incurability, and iv) shame.

We assessed help seeking behaviour from the self-reported responses to the question– "Have you ever sought help while experiencing any kind of mental illness"?

2.5 Data Analysis

Categorical data were presented as frequency and percentage, while numerical data were summarized using means and standard deviation. The prevalence of negative beliefs towards mental illness was determined based on the overall mean score, categorizing respondents scoring below the threshold as having positive beliefs and those scoring above as holding negative beliefs. To determine the association between belief and help-seeking behaviour, univariate and multivariable logistic regression models were employed. In the multivariate model, we adjusted for socio-demographic variables (age, sex, ethnicity, religion, marital status, and average household monthly income) based on prior literature review. Crude and adjusted odds ratios, along with 95% confidence intervals and p-values, were reported to quantify the relationship. All statistical analyses were performed using STATA version 13.0.

2.6 Ethical Clearance

Ethical clearance was obtained from the Institutional Review Committee of Nobel College, Kathmandu, Nepal (Ref no: PHIRC 144/2018) to conduct this study Permission was taken from respective colleges and written consent was obtained from all the participants prior to data collection. All the collected information from the respondents were kept confidential.

3. Results

Table 1 shows the socio-demographic characteristics of the respondent. The mean age of the respondent was 20.2 years with a standard deviation of 1. 3. More than half of the respondent (57%) were female. Most of the respondents belonged to Brahmin/Chhetri ethnicity (56.2%). Majority of the respondents were Hindus (87.3%) and unmarried (98 %). Nearly half of the respondents (48%) had average family monthly income of NPR 21,000 to NPR 50,000.

Table 1: Socio-demographic characteristics of the respondent (n=400)

Characteristics	Number (n)	Percentage (%)
Age (years), Mean (SD)	20.2(±1.3)	
Sex		
Female	228	57%
Male	172	43%
Ethnicity		
Bhrahmin/Chettri	225	56.2%
Janjati	155	38.8%
Others	20	5%
Religion		
Hindu	349	87.2%
Non-Hindu	51	12.8%
Marital status		
Unmarried	392	98%
Married	8	2%
Average household monthly income		
NPR 21,000 to NPR 50,000	192	48%
Above NPR 50,000	114	28.5%
NPR21,000 and below	94	23.5%

The mean BTMI score was 48.8 ± 14.3 (min-max 6-92) with scores of 8.1 ± 3.5 for Dangerousness subscale, 18.8 ± 5.9 for social dysfunction subscale, 14.9 ± 4.8 for Incurability subscale, and 6.8 ± 4 for Shame subscale. (Table 2)

Table 2: Table 1: Scores on the Belief Towards Mental Illness (BTMI) Scale and subscales (n=400)

Scores (n=147)	Mean (SD)	Minimum score-Maximum score
Total BTMI score (0-105)	48.8(±14.3)	6-92
Subscales		
Dangerousness (0-20)	8.1(±3.5)	0-20
Social dysfunction (0-35)	18.8(±5.9)	0-35
Incurability (0-30)	14.9(±4.8)	1-27
Shame (0-20)	6.8(±4)	0-20

Figure 1 shows the prevalence of negative belief towards mental illness. More than half of the respondents (54.20%) had negative belief towards mental illness.

Table 3 presents health seeking behaviour of the respondents. 79% of the respondents had previously sought help while experiencing any kind of mental illnesses. Among those who sought help from informal sources, the mean score of informal help seeking was 1.2±0.5, where 82.9% of the respondent said that the source was helpful. 83% of the respondent had coped with their problem all alone (Table 3).

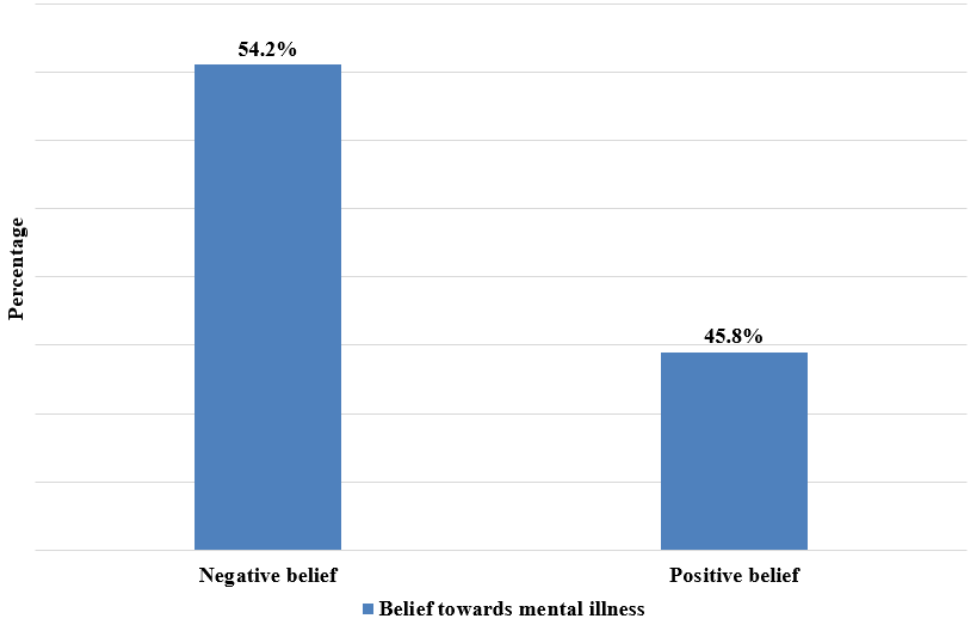

Figure 1: Prevalence of negative belief towards mental illness

Table 2: Help seeking behaviour of respondent (n=400)

Characteristics	Number	Percentage (%)
Previously sought help		
Yes	316	79%
No	84	21%
Source of help seeking		
Informal* **Mean (SD)**	1.2(±0.5)	
Formal* **Mean (SD)**	0.5(±0.6)	
Source helpful		
Helpful	332	82.9%
Can't say	59	14.9%
Unhelpful	9	2.2%
Ever coped with your problem alone		
Yes	332	83%
No	68	17%

*Informal source: friends, teacher, relatives, traditional healers
*Formal source: counsellor, psychologist, psychiatrist, general practitioner

There was a significant association between belief towards mental illness and help seeking behaviour (p=0.03). The odds of not seeking help are higher by 1.71 times among those who had negative belief towards mental illness compared to those who had positive belief (95% CI 1.03,2.8) adjusting for the confounders. (Table 4)

Table 3: Association between belief towards mental illness and help seeking behaviour of respondent (n=400)

Factors	Help sought		Univariable			Multivariable		
	No n (%)	Yes n (%)	OR	95% CI	p- value	aOR*	95% CI	p-value
Age	20.2(±1.3)		1.10	0.92-1.31	0.28	1.73	0.89,1.29	0.43
Sex								
Male	43 (51.19)	128 (40.82)	Ref			Ref		
Female	41 (48.81)	187 (59.18)	0.65	0.40-1.06	0.08	1.07	0.40,1.09	0.10
Ethnicity								
Brahmin/Chhetri	49 (58.33)	176 (55.70)	Ref			Ref		
Janjati	29(34.52)	126 (39.87)	0.82	0.49-1.38	0.46	0.74	0.40,1.36	0.33
Others	6(7.14)	14 (4.43)	1.53	0.56-4.21	0.40	1.18	0.38,3.62	0.77
Religion								
Hindu	69(82.14)	280 (88.61)	Ref			Ref		
Non-Hindu	15(17.86)	36 (11.39)	1.69	0.87-3.26	0.11	2.10	0.98,4.50	0.05
Marital status								
Unmarried	80(95.24)	312 (98.73)	Ref			Ref		
Married	4(4.76)	4 (1.27)	3.9	0.95-15.93	0.05	3.91	0.82,18.60	0.08
Average household monthly income								
NPR21,000 and below	17(20.24)	77 (24.37)	Ref			Ref		
NPR 21,000 to NPR 50,000	38(45.24)	154 (48.73)	1.11	0.50-2.19	0.73	1.19	0.61,2.35	0.59
Above NPR 50,000	29(34.52)	85 (26.90)	1.54	0.78-3.03	0.20	1.59	0.76,3.32	0.21
Belief towards mental illness								
Negative belief	54 (64.29)	163 (51.58)	Ref			Ref		
Positive belief	30 (35.71)	153 (48.42)	1.68	1.02, 2.77	0.03	1.71	1.03, 2.86	0.03

*Adjusting for age, sex, ethnicity, religion, marital status, household average monthly income
OR- Odds ratio, aOR- adjusted odds ratio

4. Discussion

One of the most critical aspects of seeking help for mental illness is belief associated with it. However, negative belief exists and it might have an impact on help seeking behaviour. So far, not much research has been carried out in this aspect in context of Nepal. This study showed that the negative belief towards mental illness was prevalent among 54.2% of the respondent. The mean score of Belief Towards Mental Illness (BTMI) Scale in the study was 48.8 with standard deviation of 14.3 which was relatively more compared to the study which showed a mean value of 41±14.4 adolescents and 42.8±17.8 for older adults [14]. This result could be affected by the environmental factors such as culture and social norms, education, media influence, availability of support, health care system that may contribute to the variations observed in belief patterns [15]. In this study, 79% of respondents sought help while experiencing

any kind of mental illnesses which was high as compared to the study in Somerset, where help was sought by 20% of the respondents [16]. The prevalence of help seeking might be high in this study due to presence of informal sources which included friends, relatives, teachers, and traditional healers and also due to the variation in the age group of the study participants in these two studies.

Firstly, this study provides a unique opportunity to explore belief and help seeking behaviour of undergraduate students in Nepal. We used BTMI, a validated tool to measure belief towards mental illness. There were some limitations in our study. Firstly, belief was a subjective experience hence, it was challenging to thoroughly evaluate through standardized scales. Secondly, respondents might have had their true sentiments, due to social desirability bias, potentially resulting in an underreporting of our findings. Thirdly, there was a lack of generalizability as we chose only few colleges from one district of Nepal.

5. Conclusion

More than half of the respondents had negative belief towards mental illnesses. Those participants who had negative belief were less likely to seek help. This highlights the urgent need to address these negative beliefs through targeted interventions, aiming to alleviate such perceptions and foster improved help-seeking behaviour.

Acknowledgement

We would like to acknowledge all the respondents and the respective colleges.

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