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Effectiveness of Psychoeducation on Myth and Misconception Related to Mental Illness among the Family Members of Patients with Mental Illness Attending OPD of LGBRIMH, Tezpur, Assam, India

Anamita Borah[1], Arunjyoti Barauh[2]

[1]Assistant Professor, M. Sc. Psychiatric Nursing, Rahman Institute of Nursing and Paramedical Sciences, Assam, India
[2]Professor & Head, Department of Psychiatric Nursing, M.Sc. in Psychiatric Nursing, M Phil in Nursing, Ph D in Psychiatric Nursing, LGB Regional Institute of Mental Health, Tezpur, Assam, India

Corresponding Author: Anamita Borah

ABSTRACT

Background: Mental illnesses are the disorders that affect thinking, behavior and perception. A myth can be defined as a story that has potent drama and deals with basic elements and norms of a culture or religion. Misconceptions are incorrect opinion that is usually based on distorted understanding. Developing awareness is the essential focus of a successful psycho education program for related myths and facts about mental illness.

Methodology: The study adopted the quasi experimental research design taking two groups in a pre test and post test design. The setting of the study was the OPD of LGBRIMH, Assam, India. Sample consisted of 100 family members of patients attending OPD. Among 100 samples, 50 were taken for experimental group and 50 for control group. Convenience sampling technique was used.

Result: A significant statistical difference in the post-test mean score (23.38±2.070) of experimental and control group (15.72±5.049) has indicated the effectiveness of structured Psychoeducation on Myths and Misconceptions related to mental illness. Result showed that there were no significant associations between pre-test score with the selected demographic variables

Conclusion: The findings concluded that the structured Psychoeducation module on Myths and Misconceptions related to mental illness was effective for the family members of patients with mental illness.

Keywords: Mental illness, Care-taker, educational, Psychoeducation

INTRODUCTION

A mental disorder or mental illness is a potential change in mental health condition that is reflected in behavior, changes in mood that is generally associated with distress or disability, and which is not considered as a part of normal development of a person's cultural background. Mental disorders are generally defined by a combination of a person's feels, acts, think or perceives. This may be associated with the brain functioning of or rest of the nervous system, often in a social context .[1]

A myth can be defined as a story that has potent drama and deals with basic elements and norms of a culture or religion. Myths explain about how the world began, how humans and animals came into existence, how certain customs, gestures or forms of human activity originated and how divine and human world interact. Myth-making often involves gods, deities, other supernatural powers and rules beyond human understanding.[2] Misconceptions are incorrect opinion that is usually based on

distorted understanding. Both myth and misconception related to mental illness is highly prevalent in the public which results in stigmatization of the individual suffering from mental illness.

Although mental disorders always existed, they have not always been recognized as health problems that are uniquely responsive to set of investigations. Instead mental disorders are often defined as religious political and philosophical problems and as such were subjected to non therapeutic treatments including exorcism (rituals to derive out the evil spirits in possession of one's body), imprisonment or social ostracism. Throughout the history of mental disorder were believed to have been caused by interplay of biological, spiritual and environmental factors. [3]

Fifteen epidemiological studies on psychiatric morbidity have been analyzed in India. The prevalence rates for 'all mental disorders, arrived at are 70.5 (rural), 73 (urban) and 73 (rural+urban) per 1000 population. Prevalence of Schizophrenia is 2.5/1000 and this seems to be the only disorder whose prevalence is consistent across cultures and over time. [4]

Families are bewildered, frustrated, and sometimes terrified by the irrational behavior and bizarre language of a mentally ill relative. Knowing that the behavior is due to a brain dysfunction rather than the outcome of a sin is an important factor to cope successfully. In addition, however, an empathic understanding of their relative's experience in living with mental illness is very necessary. Families of the mentally ill are avid to know all that they can about mental illness- its nature, causes, prognosis, management and treatment. [5] It is only with these kinds of understandings that they can relate to their relative appropriately and solve a myriad of problems that arise because of mental illness. [6]

Psychoeducational interventions generally emphasize the presentation of factual information about mental illness and treatment in order to address misperceptions and these interventions generally provide optimistic messages about treatability of mental health problems. [7]

Many patients and family members have negative myths in their about this illness. For example, people with mental health problem are violent and unpredictable. There is no treatment and helpful resources for people with mental health problems. If an individual member develops any mental health problems, the existing concept is that he will never recover.[8] This causes them to experience additional difficulties in coping with their diagnosis and complying with the treatment. Developing awareness is the essential focus of a psycho education program for this illness and reducing stigmatization.

In a study conducted by Ruzanna Z et al concluded that psychoeducation program was effective in improving patient's insight.[9]

Ran and et al conducted a study on Effectiveness of psychoeducational intervention for rural Chinese families experiencing schizophrenia. The results showed a gain in knowledge, a change in the relatives' caring attitudes towards the patients and an increase in treatment compliance in the psychoeducational family intervention group. [10]

According to various studies and literature it was found that mental illness is a health problem that significantly affects how a per son thinks, behaves and interacts with other people. It does affect people of all ages, gender, educational background, income levels and cultures.

Therefore there is a need to conduct such study in which the myths and misconceptions about mental illness can be assessed among the family members of patients with mental illness and with effective psychoeducational intervention, the perceived negative myths and misconceptions could be corrected

MATERIALS AND METHOD

The aim of the study is to assess the effectiveness of Psychoeducation on Myths and Misconceptions related to Mental

illness among family members of patients with mental illness.

The study used a quasi-experimental research design. The present study follows the pre test-post test control group design. The samples in this study are the family members of patients with mental illness attending OPD of LGBRIMH, Tezpur, Assam which includes a total of 100 subjects [50 control group, 50 experimental group].The researcher adopted convenience sampling technique.

INCLUSION CRITERIA

- ✓ Family members accompanying patients attending OPD of LGBRIMH first time and diagnosed as a case of mental illness according to ICD-10 criteria
- ✓ Both male and female
- ✓ Family members who are willing to participate in the study
- ✓ Family members who are present at the time of study
- ✓ Family members who can read and write Assamese

DESCRIPTION OF TOOLS

A data collection tool or an instrument is a written device that researcher used to collect data[9] .The structured tool on Myths and Misconception related to Mental illness consist of two parts, first part socio-demographic data and second part Myths and Misconceptions questionnaires on Mental illness. The tool is developed by the researcher through the literature review, journal, and textbook and with the experts' opinion.

Part I: This part contains questions on socio demographic profile of the subjects. This includes the family member's and patients age, gender, marital status, educational status, occupation, religion, duration of staying with the patient and relationship with the patient.

Part II: This part consists of 25 items regarding Myths and Misconceptions related to Mental illness. The correct option scores one mark and the wrong score zero in the structured questionnaire. The maximum score is twenty-five. Here, high score indicates low Myths and Misconception.

The reliability of the instrument was established and the coefficient of internal consistency was computed for self structured tool by using split half technique. Spearman-Brown prophecy formula was used to establish the reliability and the result was found to be 0.86, indicating the tool to be reliable.

DEVELOPMENT OF PSYCHOEDUCATION MODULE

The psychoeducation module on Myths and Misconceptions related to Mental Illness was developed for 45 minutes, which is based on available literature, suggestions from experts and practical experience of the researcher.

The domains of Psychoeducation module includes:

1. Concepts and Misconceptions Related to Mental Illness
2. Causes of Mental Illness
3. Signs and Symptoms of Mental Illness
4. Treatment modalities for Mental Illness

DATA COLLECTION AND PROCEDURE

After the ethical committee clearance, formal permission was obtained from the authority of LGBRIMH, Tezpur as approved to conduct the study. The data collection procedure was carried out for 4 months, which includes 50 family members of patients as control group and another 50 family members of patients as experimental group. The pretest for both control and experimental group was administered. Psychoeducation was implemented to the experimental group. Post test was conducted after one month following the implementation of Psychoeducation to the experimental group where 5 subjects were dropped out thereby remaining a total of (N= 45). Also in the control group 4 subjects were dropped out, remaining (N=46) for post test. No intervention was given to the control group for post test and the same questionnaire was applied to assess

the effectiveness of psychoeducation on Myths and Misconceptions related to mental illness to both the experimental and control groups. The data was compiled in a master datasheet and analysis was done using SPSS 18.

RESULT

The study result showed that majority of the sample in the experimental group i.e. 70%were male, 30% were female category where as in control group majority of the samples were male i.e. 70% and 30% were female. In the distribution of sample according to religion majority in experimental group i.e. 58% belongs to Hinduism, 38% belongs to Islamic and 4% belongs to Christianity. Where as in control group majority of the sample i.e. 66% belongs to Hinduism, 28% belongs to Islamic and 6% belongs to Christianity. With respect to educational status majority in the experimental group i.e. 40% studied upto high school, 30% completed their middle school, 16% completed higher secondary and 14% are graduate and above. And in control group majority of the sample i.e.38% have completed primary school, 24% middle school, 20% high school, 14% higher secondary and 4% are graduate and above. On the basis of occupation majority of the sample in experimental group i.e. 26% does business, 18% were cultivator, 14% were daily wage earner, private service and house wife. 8% were unemployed and 6% does Govt. service. Whereas in control group majority of the sample i.e. 28% does business, 22% were cultivator, 16% does private service, 14% were house wife, 10% were daily wage earner, 8% does Govt. service and 2% were unemployed. On the basis of duration of stay with the patient, majority of the sample in the experimental group i.e., 64% were within >20 years, 24% were within >10-20 years, 10% were within >5-10 years and 2% were within 1-5 years. Whereas in control group majority of the sample i.e, 76% were within >20 years, 14% were within >10-20 years, 6% were within >5-10 years and 4% were within 1-5 years.

Even though, a total of 100 sample were included in pre test but 9 sample were dropped out, thereby remaining a total of 91 sample for post test. A significant statistical difference in the post-test mean score (23.38± 2.070) of experimental and control group (15.72± 5.049) has indicated the effectiveness of structured Psychoeducation on Myths and Misconceptions related to mental illness. Result showed that there were no significant associations between pre-test score with the selected demographic variables.

Table 1:Mean, standard deviation and paired '*t*' test value of pre-test and post-test score in both control and experimental group N= 46 (Control group), N = 45 (Experimental group)

CONTROL GROUP					EXPERIMENTAL GROUP				
Para-meters	**Mean**	**SD**	**'*t*' (df)**	**P value**	**Para-meters**	**Mean**	**SD**	**'*t*' (df)**	**P value**
Pre-test score	15.93	4.777	0.540 (45)	0.592	Pre-test score	14.47	3.900	15.557 (44)	.000
Post-test score	15.72	5.049			Post-test score	23.38	2.070		

**= significant at 0.05 level*

't_{45}'= 1.671 (control group)

The data presented in table 1 showed that mean and SD of pre- test score for control group (15.93±4.777) was almost similar with post test score (15.72± 5.049) of control group. The calculated value of '*t*' ('*t*' = 0.540, p<0.05) is less than the tabulated value ('t'= 1.671) at 0.05 level of significance. Hence the hypothesis (H_1) is rejected and null hypothesis (H_{01}) is accepted at 0.05 level of significance.

Whereas in the experimental group the mean and SD of post- test score (23.38± 2.070) is greater than the pre- test score (14.47± 3.900) .The calculated value of *'t'* (*'t'* = 15.557, p<0.05) is greater than the tabulated value ('t'= 1.671) at 0.05 level of significance. Hence the null hypothesis (H_{02}) is rejected and the alternative hypothesis (H_2) is accepted at 0.05 level of significance.

Table 2: Mean, Standard deviation and independent '*t*' test value of pre-test and post- test in experimental and control group. N=100 (Pre test), N= 91 (Post test)

Parameters	Mean	SD	'*t*' (df)	P value
Experimental Pre-test score	14.22	5.163	1.471 (98)	.000
Control Pre-test score	15.60	4.166		
Experimental Post-test score	23.38	2.070	9.505 (89)	.000
Control Post-test score	15.72	5.049		

'*t*'$_{98}$ = 1.980 *= significant at 0.05 level

The data presented in table 2 showed that mean and SD of pre -test score in experimental group (14.22± 5.163) is less than control group pre- test score (15.60± 4.166). The calculated value of '*t*' ('*t*'= 1.471, p< 0.05) is less than the tabulated value ('t'= 1.980) at 0.05 level of significance. Thus, the alternative hypothesis (H_3) is rejected and the null hypothesis (H_{03}) is accepted at 0.05 level of significance.

Whereas the mean and SD of post-test score in experimental group (23.38± 2.070) is greater than control group post-test score (15.72± 5.049). The calculated value of '*t*' ('*t*'= 9.505, p< 0.05) is greater than the tabulated value ('t'= 1.980). Hence the result showed significant difference between post-test score of experimental and control group. Thus, the null hypothesis (H_{04}) is rejected and the alternative hypothesis (H_4) is accepted at 0.05 level of significance.

Table 3: Chi square (χ^2) test value between pre test score for experimental group with selected demographic variables N= 50

Variables		Pre test score		χ^2 value	P value	(df)	Significant
		1-16	17-25				
Age	18-35 years	20	8	0.836	0.361	1	NS
	36-60 years	13	9				
Gender	Male	25	10	0.216	0.216	1	NS
	Female	8	7				
Religion	Hinduism	17	12	1.676	0.196	1	NS
	Islamic, Christianity, others	16	5				
Duration of stay	<20 yrs	12	6	0.006	0.941	1	NS
	>20 yrs	21	11				
Relationship with patient	Parents, Spouse	10	7	0.591	0.442	1	NS
	Children, siblings, others	23	10				
Educational status	Primary, middle, high	26	9	3.569	0.059	1	NS
	higher secondary, graduate and above	7	8				
Occupation	Unemployed, daily wage earner, cultivator, Pvt. Service	19	8	0.500	.480	1	NS
	Govt service, housewife, business	14	9				
Monthly income	<RS 5000	13	5	0.485	.486	1	NS
	Rs (5000-10000), Rs (10000-20000), >Rs 20000	20	12				

The data presented in table 3 showed the Chi square test value computed between the pre-test score of experimental group with selected demographic variables. The result showed that there were no significant association of demographic variables with the pre-test score the experimental group. Hence, the alternative hypothesis (H_6) is rejected and null hypothesis (H_{06}) is accepted at 0.05 level of significance.

The data presented in table 4 showed the Chi square test value computed between the pre-test score of control group with selected demographic variables. The result showed that there was no significant association with the pre-test score for the control group. Hence, the alternative hypothesis (H_5) is rejected and null hypothesis (H_{05}) is accepted at 0.05 level of significance.

The present study intended to find out the effectiveness of Psychoeducation on myths and misconceptions related to mental illness among the family members of patients with mental illness. Prior to the study, structured psychoeducation module on myths and misconceptions was developed by the investigator with expert's opinion and after an extensive search. Also, a structured questionnaire to assess the myths and misconceptions consisting of 25 questions were developed and got validated

from experts. Both the structured psychoeducation module and questionnaire were validated from experts. With the acceptance of the content areas on the structured psychoeducation module and questionnaire, the psychoeducation was implemented in the Outpatient department of LGBRIMH.

The findings of the result showed there were significant changes in score regarding myths and misconceptions related to mental illness in the experimental group following the implementation of structured psychoeducation program.

A similar finding was obtained from the study conducted by Rahmani et al[11] that psychoeducation improves family attitude towards mental illness. Training methods like group psych education for the families of mental patients can be effective on their attitudes towards mental illness. Also, the present study findings is consistent with the study findings from Worakul et al[12] which concluded that Psycho-educational program on schizophrenia increase the knowledge and shape the attitude of caregivers.

Table 4: Chi square (χ^2) test value between pre test score for control group with selected demographic variables.N=50

Variables		Pre test score		χ^2 value	P value	(df)	Significant
		1-16	17-25				
Age	18-35 years	7	12	0.248	5.99	2	NS
	36-53 years	11	6				
	54-75 years	7	7				
Gender	Male	16	19	0.857	0.355	1	NS
	Female	9	6				
Religion	Hinduism	14	19	2.228	0.136	1	NS
	Islamic, Christianity, others	11	6				
Duration of stay	<20 yrs	6	6	0.000	1.000	1	NS
	>20 yrs	19	19				
Relation	Parents, spouse, children	15	15	0.000	1.000	1	NS
	Siblings, others	10	10				
Educational status	Primary, middle	14	5	6.876	0.009	1	NS
	High, higher secondary, graduate and above	11	20				
Occupation	Unemployed, daily wage earner, cultivator, Pvt. service	12	13	0.080	0.777	1	NS
	Govt service, housewife, business	13	12				
Monthly income	<RS 5000	8	6	0.397	0.529	1	NS
	RS(5000-10000), RS (10000-20000), >RS 20000	17	19				

0.05 level of significance, S= Significance, NS= Not significant

LIMITATION OF THE STUDY

The limitations of the present study are as follows:

- ❑ The study is limited only to the family members accompanying the patient to LGBRIMH, at the time of data collection.
- ❑ Family members were assessed only once after the implementation of psychoeducation module, stability remains unexplored.

RECOMMENDATIONS

On the basis of the findings of the study, the following recommendation have been made

- ❑ Similar study can be conducted in other setting.
- ❑ An explorative study can be carried out to find the presence of stigma related to mental illness
- ❑ A comparative study can be carried out to assess the Myths and Misconceptions among family members of rural and urban population
- ❑ A study can be conducted to develop a standardized tool to assess the Myths and Misconceptions related to mental illness.

CONCLUSION

The present study was conducted with the aim to assess the effectiveness of Psycho education on Myths and Misconceptions related to Mental illness among family members of patients with mental illness. From the findings it was

concluded that Myths and Misconceptions related to mental illness is quite prevalent among the family members. After the implementation of Psychoeducation module there were significant changes among the family members. The study result revealed that the Psychoeducation module is effective.

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