



Assessment of Awareness and Attitude Towards Mental Illness Among Outpatient Attendees in a Tertiary Care Hospital of North Gujarat

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ABSTRACT

Background: Mental illness is a significant global health concern, and in India, it is compounded by a considerable treatment gap and widespread social stigma. This study aimed to assess the knowledge, attitudes, and practices towards mental illness among Outpatient Attendees in a Tertiary Care Hospital of North Gujarat, a region with limited existing data.

Methods: An observational, descriptive cross-sectional study was conducted on 400 adult participants attending Outpatient Department in a Tertiary Care Hospital of North Gujarat. Data were collected using a pre-designed, pre-tested questionnaire to evaluate the participants' knowledge, attitudes, and help-seeking behaviours regarding mental illness. The collected data were analyzed using descriptive statistics, with results presented in frequencies and percentages.

Results: The findings revealed a mixed level of mental health literacy. While 75.2% of participants correctly identified that individuals with mental illness could suffer from depression, a significant majority (96.0%) believed severe cases should be confined to a mental hospital. Over half (61.7%) perceived individuals with mental illness as prone to violence, and 76.0% attributed the illness to a lack of willpower. A profound attitudinal dichotomy was observed: while 88.0% of respondents agreed on the need for social acceptance, a substantial portion held stigmatizing views regarding marriage (56.5%) and employment (59.0%). In terms of help-seeking, 52.2% would consult a friend or family member, contrasting with only 24.5% who would see a general practitioner.

Conclusion: The study underscores the persistence of misconceptions and deeply rooted stigma towards mental illness in North Gujarat. The findings highlight a critical gap between acknowledging the existence of mental illness and a willingness to fully integrate affected individuals into society. Targeted public health interventions are urgently needed to address these prevailing myths and improve mental health literacy, thereby fostering a more inclusive and supportive community.

Key-words: Mental Illness, Awareness, Attitude, Stigma, North Gujarat

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INTRODUCTION

Mental illness represents a significant global health challenge, affecting millions of people worldwide and contributing substantially to the overall burden of disease.^[1,2] Despite its high prevalence, mental illness remains a topic shrouded in stigma, misunderstanding, and neglect, particularly in low- and middle-income countries.^[3] This lack of awareness and a negative attitude can have profound consequences, including delayed help-seeking, poor treatment adherence, social exclusion, and discrimination.^[4] In India, the situation is particularly concerning. The National Mental Health Survey (NMHS) of 2015-16 revealed that nearly 10.6% of the adult population suffers from a diagnosable mental disorder, with a considerable treatment gap exceeding 80% for common mental disorders like depression and anxiety.^[5] This gap is not solely due to a shortage of mental health professionals but also stems from a lack of public awareness and the deep-rooted societal stigma associated with mental health issues.^[6] The perception of mental illness as a personal weakness or a moral failing, rather than a legitimate medical condition, is a major barrier to seeking professional help.^[7] North Gujarat is a predominantly rural and semi-urban demographic where traditional beliefs and community structures significantly influence health-related decisions.^[8] While some studies have explored mental health awareness in other parts of India, specific data for North Gujarat is limited.^[9] Understanding the specific attitudes and awareness levels in this population is crucial for developing targeted and culturally sensitive mental health interventions. A study by Gholap et al. highlighted that health awareness programs in rural areas must be tailored to local beliefs to be effective.^[10] Therefore, a detailed assessment of the existing awareness and attitudes towards mental illness is a critical first step towards bridging the treatment gap and improving the mental health landscape in this region. This research aims to fill this knowledge gap by providing a comprehensive assessment of the awareness and attitudes towards mental illness among attendees of a tertiary care facility in North Gujarat, thereby providing valuable insights for future public health initiatives.

Methodology

A cross-sectional study was conducted on patients and relatives visiting Out Patient Department (OPD) of Medicine and allied branches in tertiary care hospital of North Gujarat. The research was conducted from November-December 2024.

Sample size: In the absence of prior prevalence estimates, a prevalence of 50 % was assumed for favourable attitude of general population towards individuals with mental illness and applying sample size formula of $4pq/l^2$. Obtained sample size was 400 participants. Where $p = 50\%$ $q = 1-p$ and allowable error was 5 %. So, in present study 400 participants were included.

The study population comprised adults aged 18 years and above and are willing to give informed consent to participate. Institutional Ethical Committee permission was taken (GMCHP/Ethics/approval/079/24). Modified Prasad Classification was used to classify socio economic class. For selection of study samples, Patients and their accompanying relatives were initially listed using the daily OPD registration records. From this list, individuals meeting the inclusion criteria were assigned sequential serial numbers. Participant selection was then performed using a computer-generated random number sequence. Data collection spanned a total of 24 OPD days over the two-month study period. These specific data collection days were selected by systematically designating three alternate working days per week (e.g., Monday, Wednesday, and Friday) to account for potential day-of-the-week variations in patient footfall and to minimize selection bias.

Data were collected using a pre-designed, pre-tested questionnaire. The questionnaire's face and content validity were verified by expert faculty review prior to administration. The questionnaire was divided into two sections: the first section focused on collecting information regarding the participants' knowledge, attitude, and practice (KAP) toward mental illness, while the second section gathered their socio-demographic details. The attitude-related questions were based on the "Attitudes to Mental Illness Questionnaire," which includes items related to community attitudes and opinions on mental health services. To ensure reliability and consistency in data

collection, two trained interviewers were selected for the survey. The collected data were then entered into a statistical software program and analysed using descriptive statistics, presenting the results in terms of absolute numbers and percentages.

Results

The study assessed the knowledge, attitudes, and practices (KAP) related to mental illness among 400 adult outpatient attendees in North Gujarat. Table 1 presents the socio-demographic profile of the study

participants. A majority of the population were female (58.2%) and were graduates or had higher education (31.2%). The mean age of the participants was 39.25 years, with a standard deviation of 9.7 years. The occupation most frequently reported was unskilled work or being a housewife (25.2%), followed by semi-skilled workers (24.5%). Regarding socio-economic status, the largest proportion of participants belonged to class III (46.75%), followed by class IV (39.0%).

Table 1: Socio-demographic characteristics of the study population (N=400)

	Parameter	N	Percentage (%)
Sex	Male	167	41.7
	Female	233	58.2
Education	Illiterate	05	1.2
	Just literate	14	3.5
	Primary	76	19.0
	Middle school	77	19.2
	High school	103	25.7
	Graduate and above	125	31.2
Occupation	Unemployed	59	14.7
	Unskilled/ House wife	101	25.2
	Semi-skilled	98	24.5
	Skilled	50	12.5
	Clerical/shop owner	57	14.2
	Semi-professional	35	8.7
Socio-economic Status	I	00	0.0
	II	77	19.2
	III	187	46.75
	IV	156	39.0
	V	30	7.5

The knowledge of the study population about mental health is detailed in Table 2. A large majority of participants (96.0%) believed that severe cases of mental illness should be kept in a mental hospital. Over half (61.7%) of the respondents perceived that individuals with mental illness are prone to violence. In contrast, 75.2% of the participants correctly

identified that a person with mental illness could suffer from recurrent episodes of depression. While 45.0% believed that mental illness can be cured by medicine and 50.2% by counselling, only a small minority (10.5%) thought that people with severe mental illness could fully recover.

Table 2: Knowledge regarding mental health among the study population (n=400)

Statements	N (agree)	Percentage (%)
Statements that describe someone who is mentally ill		
Suffers from recurrent episodes of depression	301	75.2
Incapable to take simple decisions regarding his/her own life	102	25.5
Is born with some abnormality affecting the brain	86	21.5
Can't be held guilty for his/her own action	32	8.0
Is prone to violence for no reason	247	61.7
Severe cases has to be kept in mental hospital	384	96.0
Stigma - related mental health knowledge		
If a friend had a mental health problem, I know what advice to give them	58	14.5
Mental illness can be cured by medicine	180	45.0
Mental illness can be cured by counselling	201	50.2
People with severe mental illness can fully recover	42	10.5

Table 3 summarizes the attitudes of the participants towards mental illness across various domains. In the "Fear" category, a significant number of participants expressed stigmatizing attitudes, with 87.0% agreeing that a person showing signs of mental illness should be immediately hospitalized. A majority (59.0%) also agreed that a person with a history of mental illness should not be offered any official job. In the "Understanding and Tolerance" category, there was a positive outlook, with 88.0%

of respondents agreeing that mentally ill persons need to be accepted cordially. For "Integrating people with mental illness," while 72.0% of residents reported having nothing to fear from people coming into their neighbourhood to obtain mental health services, 40.0% felt that there was no justification to keep a mentally ill person separate from the general population. Regarding "Causes of mental illness," a substantial proportion (76.0%) believed that a lack of self-discipline and willpower is a main cause.

Table 3: Distribution of the study population according to attitude regarding mental illness n=400)

Questions	Strongly agree N (%)	Agree N (%)	Neutral N (%)	Disagree N (%)	Strongly disagree N (%)
Fear about mental illness					
As soon as a person shows signs of mental illness, he/she should be immediately hospitalized	4 (1.0)	348 (87.0)	10 (2.5)	26 (6.5)	12 (3.0)
People with mental illness are a burden on society	10 (2.5)	22 (5.5)	68 (17.0)	288 (72.0)	12 (3.0)
People with mental illness should not be given any responsibility	32 (8.0)	192 (48.0)	8 (2.0)	162 (40.5)	6 (1.5)
A person shouldn't marry anyone who has suffered from mental illness even though he/she seems fully recovered	10 (2.5)	216 (54.0)	50 (12.5)	124 (31.0)	0 (0.0)

I would not want to live next door to someone who has been mentally ill	8 (2.0)	120 (30.0)	148 (37.0)	120 (30.0)	4 (1.0)
Anyone with a history of mental illness shouldn't be offered any official job	8 (2.0)	236 (59.0)	52 (13.0)	84 (21.0)	20 (5.0)
Understanding and tolerance of mental illness					
Anyone can become mentally ill	26 (6.5)	320 (80.0)	26 (6.5)	28 (7.0)	0 (0.0)
We need to accept mentally ill persons cordially	28 (7.0)	352 (88.0)	0 (0.0)	20 (5.0)	0 (0.0)
We have to take responsibility of mentally ill persons as best as possible	0 (0.0)	374 (93.5)	10 (2.5)	16 (4.0)	0 (0.0)
People with mental illness do not deserve our sympathy	4 (1.0)	38 (9.5)	6 (1.5)	296 (74.0)	56 (14.0)
Increased spending on mental health services is a waste of money	4 (1.0)	10 (2.5)	26 (6.5)	350 (87.5)	10 (2.5)
Mental health services should be provided through community-based facilities	0 (0.0)	332 (83.0)	54 (13.5)	14 (3.5)	0 (0.0)
Integrating people with mental illness into the community					
Mental illness is an illness like any other	26 (6.5)	344 (86.0)	16 (4.0)	4 (1.0)	10 (2.5)
No justification to keep mentally ill person separate from general population	12 (3.0)	150 (37.5)	78 (19.5)	160 (40.0)	0 (0.0)
Mental hospitals are an outdated means of treating people with mental illness	4 (1.0)	20 (5.0)	6 (1.5)	340 (85.0)	30 (7.5)
No one has the right to exclude people with mental illness from their neighborhood	12 (3.0)	356 (89.0)	4 (1.0)	14 (3.5)	14 (3.5)
People with mental illness are far less of a danger than most people suppose	4 (1.0)	116 (29.0)	124 (31.0)	156 (39.0)	0 (0.0)
The best therapy for many people with mental illness is to be part of a normal community	0 (0.0)	270 (67.5)	84 (21.0)	46 (11.5)	0 (0.0)
Residents have nothing to fear from people coming into their neighborhood to obtain mental health services	0 (0.0)	288 (72.0)	76 (19.0)	36 (9.0)	0 (0.0)
Causes of mental illness and the need for special services					
There are sufficient existing services for people with mental illness	4 (1.0)	56 (14.0)	126 (31.5)	214 (53.5)	0 (0.0)
One of the main causes of mental illness is a lack of self-discipline and willpower	20 (5.0)	304 (76.0)	40 (10.0)	36 (9.0)	0 (0.0)
There is something about people with mental illness that makes it easy to tell them from normal people	38 (9.5)	338 (84.5)	18 (4.5)	0 (0.0)	6 (1.5)

The reported and intended behaviours of the study population reflect significant indicators of social distancing as presented in Table 4. Only a small percentage of participants (8.0%) reported having lived with a person with a mental health problem, and 9.0% had a

neighbour with such a problem. More concerning, intended behaviours highlighted deep-seated stigma: only 2.0% were willing to live with someone with a mental health problem, while 25.0% were willing to work with them and 23.5% were willing to live nearby.

Table 4: Reported and intended behaviour of persons toward mental illness (n=400)

Question	N (agree)	Percentage (%)
Reported		
Lived with someone with a mental health problem	32	8.0
Worked with someone with a mental health problem	84	21.0
Had a neighbor with a mental health problem	36	9.0
Had a close friend with a mental health problem	77	19.2
Intended "In the future, I would be willing to..."		
Live with someone with a mental health problem	08	2.0
Work with someone with a mental health problem	100	25.0
Live nearby to someone with a mental health problem	94	23.5
Continue a relationship with a friend who developed a mental health problem	102	25.5

Table 5 details the participants' health-seeking behaviours. A majority (52.2%) preferred discussing mental health issues with friends or family members, whereas only 24.5% opted to consult a general practitioner (GP).

Furthermore, a small minority (16.7%) felt comfortable talking to a current or prospective employer about their mental health, and 34.2% recognized that individuals with mental illness face active stigma and discrimination.

Table 5: Health care seeking behaviour of participants (n=400)

	N (agree)	Percentage (%)
Consulting a GP about a mental health problem	98	24.5
Talking to a friend or family member about your mental health problems	209	52.2
Talking to a current or prospective employer about your mental health problems	67	16.7
Opinion regarding facing stigma and discrimination by mentally ill persons	137	34.2

DISCUSSION

The present study provides crucial insights into the mental health landscape of North Gujarat, indicating a mixed understanding of mental health issues with notable areas

requiring targeted public health interventions. Regarding **awareness and knowledge** about mental disorders, a significant proportion of the North Gujarat population demonstrated some

recognition of symptoms, with 75.2% recognized depression as one of the major manifestations of mental illness. However, there were also misconceptions, such as 61.7% believing individuals with mental illness are prone to violence and 96.0% stating that severe cases must be kept in mental hospitals. This overwhelming preference for confinement likely stems from a lack of public awareness regarding modern psychiatric medications, which allow for the outpatient management of severe cases, as well as media portrayals that sensationalize mental illness. This suggests a tendency to associate mental illness with danger and institutionalisation. Similarly, a study among university students in Delhi^[11] found that while most subjects (70%-80%) had good awareness about identifying mental disorders, understanding of risk factors and stigmatisation remained unsatisfactory. Another study in West Bengal^[12] revealed that 94.5% of participants believed mentally ill patients should be kept in mental hospitals, and 45.5% thought they were prone to violence. These findings across different Indian regions highlight a common societal perception that mental illness necessitates segregation, possibly driven by fear or a lack of nuanced understanding.

The **attitudes** towards individuals with mental illness in North Gujarat displayed a dichotomy. While a high percentage (86.5%) agreed that anyone can become mentally ill and 95.0% believed in the need to accept mentally ill persons cordially and take responsibility for them, pervasive stigmatising attitudes were also evident. A substantial majority (87.0%) felt individuals showing signs of mental illness should be immediately hospitalised, and 61.0% thought those with a history of mental illness should not be offered official jobs. This dichotomy may stem from limited exposure to community-based recovery models and a pervasive cultural narrative that equates psychiatric disorders with unpredictability. Furthermore, 56.5% would not marry someone who had suffered from mental illness, even if seemingly recovered, and 32.0% would not

want to live next door to them. This is consistent with findings among Delhi^[11] university students, where stigmatisation was present, especially higher for psychosis, and comfort levels dropped significantly regarding marriage or developing relationships with individuals who had past mental illnesses. A study in West Bengal^[12] similarly reported that 57.5% believed one should not marry someone who had recovered from mental illness, and 60.5% thought they should not be offered official jobs. These collective findings underscore the deep-rooted societal stigma that leads to social exclusion, despite a general willingness to acknowledge the prevalence and societal responsibility for mental illness. Even healthcare providers, as noted in a study in Tunisia,^[13] can exhibit negative attitudes, particularly nurses, highlighting the pervasive nature of stigma.

Regarding the **perceived causes of mental illness**, a concerning 81.0% of the North Gujarat participants attributed mental illness to a lack of self-discipline and willpower. Furthermore, a significant proportion believed it to be caused by supernatural power (47.3%) or God's punishment for wrongdoing (34.9%), while only a minority (17.8%) recognised biological, psychological, or physio-social factors. These traditional and spiritual attributions are likely reinforced by lower regional health literacy regarding the biological etiology of psychiatric conditions, contrasting with heavily urbanized populations. This reflects a more traditional or spiritual understanding of mental illness. In contrast, the study involving Delhi^[11] youth indicated that psychosocial and environmental factors were primarily identified as causes for depression and psychosis (60-80%), with a third acknowledging genetic causes for psychosis. The Tanzanian^[14] study also showed similar traditional beliefs, with 47.3% attributing mental illness to supernatural power and 34.9% to God's punishment. These discrepancies highlight the varied cultural contexts influencing beliefs about the aetiology of mental disorders, which can significantly impact help-seeking behaviours.

Concerning **help-seeking behaviour and treatment preferences**, the North Gujarat population showed a higher inclination to talk to friends or family members (52.2%) about mental health problems compared to consulting a general practitioner (24.5%). This reliance on informal networks may reflect structural barriers, such as a lack of accessible psychiatric services in the immediate vicinity, as well as a cultural preference for handling familial issues privately to avoid public stigma. While 45.0% believed mental illness could be cured by medicine and 50.2% by counselling, only 10.5% believed in full recovery for severe mental illness. Furthermore, 92.5% considered mental hospitals *not* outdated, and 83.0% endorsed community-based facilities. This aligns with findings from West Bengal, ^[12] where 54.5% would seek help from a general practitioner, and 52% would talk to friends or family. The Delhi study noted that while psychiatrists were considered the most reliable professional help (84%), immediate community members like close friends, family, and self-help groups were also widely endorsed (60-70%). That study also highlighted a preference for interpersonal and non-pharmacological interventions, such as love, affection, listening, and physical activity, over pharmacological treatments. The sustained belief in mental hospitals as a primary treatment location, despite the endorsement of community-based care, suggests a dualistic approach to treatment that may stem from a lack of clarity regarding modern mental healthcare modalities.

Conclusion

The present study highlights the persistence of misconceptions, stigma, and discriminatory attitudes toward mental illness among outpatient attendees in North Gujarat, despite a basic recognition of its prevalence and symptoms. While many respondents acknowledged the need for acceptance and community integration of mentally ill individuals, a significant proportion continued to associate mental disorders with violence, supernatural causes, and the necessity of institutionalisation. These findings underscore the critical gap between awareness and acceptance, reflecting deeply rooted cultural beliefs. Addressing these gaps is essential for reducing stigma, improving treatment-seeking behaviour, and fostering inclusive mental health care.

Recommendations

Based on the study findings, mental health interventions must focus on targeted community awareness programs tailored to local cultural beliefs. Schools, colleges, and workplaces should integrate mental health education to challenge myths and normalise open discussions. Healthcare providers, including general practitioners and community health workers, should receive specialised training in mental health literacy and stigma reduction. Collaboration with religious leaders and community influencers can help counter supernatural explanations of mental illness. Furthermore, policy initiatives should promote community-based services, reduce reliance on institutionalisation, and enhance access to affordable counselling and psychiatric care. Such measures are crucial to bridge treatment gaps.

REFERENCES

1. World Health Organization. Mental health: a state of the world's population report. Geneva: WHO; 2022.
2. World Health Organization. Mental disorders fact sheet. Geneva: WHO; 2022.
3. Thornicroft G, Mehta N, Clement S, et al. Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*. 2016;387(10023):1184-1197.
4. Henderson C, Evans-Lacko S, Thornicroft G. Mental illness stigma, discrimination and public health. In: *The Oxford Handbook of Public Mental Health*. Oxford: Oxford University Press; 2014. p. 1-15.
5. National Institute of Mental Health & Neuro Sciences. National Mental Health Survey of India 2015-16: Prevalence, patterns and outcomes. Bengaluru: NIMHANS; 2016.
6. Patel V, Saxena S, Lund C, et al. The Lancet Commission on global mental health and sustainable development. *The Lancet*. 2018;392(10157):1553-1598.
7. Shrivastava A, Johnston M. Stigma of mental illness: an overview. *Indian J Psychiatry*. 2011;53(3):260-262.
8. Gholap SR, Katti SM, Katti SP. Socio-cultural factors affecting health in rural India. *J Health Res Rev*. 2018;5(3):141-145.
9. Deka K, Hazarika S. A study on awareness and attitude towards mental illness among a section of general population in Assam. *Int J Med Sci Public Health*. 2017;6(12):123-127.
10. Gholap SA, Katti SM, Katti SP. Socio-cultural beliefs and its influence on health care seeking behaviour: a qualitative study from rural Maharashtra, India. *J Health Res Rev*. 2020;7(2):100-105.
11. Dev A, Gupta S, Sharma KK, Chadda RK. Awareness of mental disorders among youth in Delhi. *Curr Med Res Pract*. 2017;7:84-9.
12. Bagchi, Sarkar, Basu. Knowledge, attitude and practice towards mental health illnesses in an urban community in West Bengal: a community based study. *Int J Community Med Public Health* 2020;7:1078-83.
13. Askri F, Lagha M, Ben Younes K, Ben Romdhane I, Wided H, Labbane R. Attitudes and knowledge toward mental disorders among healthcare providers in psychiatric departments. *Eur Psychiatry*. 2024;67(Suppl S1):EPVo774. doi:10.1192/j.eurpsy.2024.1405.Mvandal SP, Mushi R, Mponzi K. Knowledge and Attitude among Nyamagana Community Members towards Mental illness, Tanzania. Preprints. 2020. doi:10.20944/preprints202010.0630.v1.