ANALYSING THE GENERAL PERCEPTION OF PUBLIC ON MENTAL HEALTH

THESIS REPORT SUBMITTED BY,

PRIYANKA S.P

(20PSW021)

THESIS SUBMITTED TO

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND

HIGHER EDUCATION FOR WOMEN,

COIMBATORE- 641043

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE

DEGREE OF

MASTER OF SOCIAL WORK

DEPARTMENT OF HOME SCIENCE EXTENSION EDUCATION

MAY 2022

ANALYSING THE GENERAL PERCEPTION OF PUBLIC ON MENTAL HEALTH

BY

PRIYANKA S.P

(20PSW021)

THESIS SUBMITTED TO

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE

AND HIGHER EDUCATION FOR WOMEN,

COIMBATORE- 641043

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF

MASTER OF SOCIAL WORK

MAY 2022

Signature of the Guide

Signature of the Head of the Department

Signature of the External Examiner

CERTIFICATE

CERTIFICATE

This it to certify that the dissertation entitled on **"Analysing the General Perception of Public on Mental Health"** submitted to the Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore-641043, in partial fulfilment of the requirements for the award of the degree of Master of Social Work is a record of original research work done by Priyanka S.P, during the period of the study in the Department of Home Science Extension Education, Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore-641 043, under my supervision and guidance, has not formed basis for the award of any Degree/Diploma/Associate ship/Fellowship or similar title of other University.

Signature of the Guide

Signature of the Head of the Department

DECLARATION

DECLARATION

I **Priyanka S.P** hereby declare that the thesis, entitled **"Analysing the General Perception of Public on Mental Health"**, submitted to the Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore, in partial fulfillment of the requirements for the award of the **Master of Social Work** is a record of original and independent research work done by me during six month under the Supervision and Guidance of **Dr. (Mrs.) S. Rajalakshmi, M.Sc., M. Phil, Ph. D, NET** and it has not formed the basis for the award of any Degree/Diploma/Associateship/Fellowship or other similar title to any candidate in any University.

SIGNATURE OF THE CANDIDATE

PRIYANKA S.P

(20PSW021)

ACKNOWLEDGEMENT

ACKNOWLEDGEMENT

The investigator exalts **God Almighty** for being her refuge and strength and praises him for his everlasting love, bountiful mercy and amazing grace showered on her throughout the study.

The investigator wishes to express her sincere thanks to **Dr. S.P Thyagarajan , Ph.D, M.D, D.Sc, FAMS, FNASc, FIMSA, FABMS, FFTM (Glasgow, UK), Chancellor,** Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for providing the opportunity to carry out this academic exercise leading to the award of **Master of Social Work** in Home Science Extension Education.

The investigator owes her special thanks to **Dr. V. Bharathi Harishankar, Ph.d, FRSA, Vice Chancellor,** Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for the facilities provided to carry out the study.

The investigator owes her sincere gratitude to **Dr. (Tmt.) Kowsalya, M.Sc., M.Phil., Ph.D., Registrar,** Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for her constant encouragement.

The investigator owes her heartfelt thanks to **Dr.(Tmt.) N. Vasugi, M.Sc., M.Phil., Ph.D., Dean,** School of Home Science, Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for her constant help and support at all times of need.

The investigator feels extremely happy and fortunate to place on record her sense of gratitude to **Dr. Mrs. S. Rajalakshmi, Associate Professor and Head of the Department of Home Science Extension Education,** Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for constant help and support at all times of need.

The investigator feels highly elated in manifesting her glowing sense of gratitude to her guide, **Dr. Mrs. S. Rajalakshmi, M.sc., M.Phil., Ph.D., NET,** Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for her valuable help, guidance and encouragement rendered throughout the period.

The investigator extends her heart full thanks to **all the respondents** who participated in this study, for spending their valuable time for this study.

The researcher would like to thank her **Teachers** in the Department of Home Science Extension Education and Avinashilingam Institute for Home Science and Higher Education for Women, Coimbatore for their advice and support throughout the study.

The investigator is deeply indebted and expresses her gratitude to her **Family and Friends** for their constant encouragement, steady support and valuable help during the completion of the study.

Lastly, she offers her regards and profound thanks to all those who supported her in any respect during the course and completion of the study.

CONTENTS

CONTENTS

CHAPTER NO.	TITLE	PAGE NO.
I	**INTRODUCTION**	1-11
II	**REVIEW OF LITERATURE** A. Concept of perception B. Factors influencing perception on mental health. C. Understanding the concept of mental health & mental disorders. D. Related studies.	12-24
III	**METHODOLOGY** A. Selection of area. B. Selection and size of samples. C. Selection of method and tools. D. Conducting pilot study. E. Obtaining ethical clearance for the study F. Rapport building G. Collection of data. H. Analysis and interpretation of data.	25-30
IV	**RESULT & DISCUSSION**	33-63
V	**SUMMARY AND CONCLUSION**	64-70
	BIBLIOGRAPHY	
	APPENDICES	

LIST OF TABLES

LIST OF TABLES

TABLE NO.	TITLE	PAGE NO.
I	Selection of Sample	27
II	Socio-Demographic Characteristics.	33
III	Awareness on characteristics of mental health	37
IV	Source of Knowledge of people on mental health	39
V	Knowledge on mental health Acts among respondents.	40
VI	Respondents' opinion about MH Acts	41
VII	Reasons for mental illness.	43
VIII	Attitude of selected people towards mentally ill people	44
IX	Knowledge about symptoms of stress.	46
X	Respondents' awareness on characteristics of depressed people.	47
XI	Respondents' awareness on physical symptoms of anxiety.	48
XII	Reasons for mental stress among the selected people.	50
XIII	Beck's depression test on selected people.	51
XIV	Beck's anxiety test on selected people.	53
XV	General State of mind of the selected people.	54
XVI	Satisfaction of the selected people on various aspects of life.	55
XVII	Emotional intelligence of the selected people.	56
XVIII	Physical Symptoms experienced by the respondents.	57
XIX	Social habits of the respondents.	58
XX	Coping Mechanism used by the respondents	60
XXI	Mobile using pattern of the respondents.	61
XXII	Pearson's correlation.	62

LIST OF FIGURES

LIST OF FIGURES

FIGURE NO.	TITLE	PAGE NO.
1	Mental illness stigma frame work	15
2	Area selected for the study	26
3	Design of the study	32
4	Socio-Demographic Characteristics	36
5	Characteristics of mental health.	38
6	Source of knowledge of Mental health.	39
7	Mental Health Acts.	40
8	Opinions of respondents on mental health acts.	41
9	Reasons for Mental illness	43
10	Attitude towards mentally ill people.	45
11	Symptoms of stress.	46
12	Knowledge about depression.	47
13	Knowledge on anxiety	48
14	Reason for stress.	50
15	Beck's depression test.	52
16	Symptoms of Anxiety	53
17	Satisfaction of people.	55
18	Social habits of people.	59
19	Coping Mechanism	60
20	Correlation of education and mental health characteristics.	62
21	Independent T-Test	63
22	T-test on Gender and attitude towards mentally ill people.	63

LIST OF PLATES & APPENDICES

LIST OF PLATES

PLATE NO.	TITLE	PAGE NO.
I	Interview with the selected people.	31

LIST OF APPENDICES

APPENDICES NO.	TITLE	PAGE NO.
I	An Interview Schedule to Elicit the Information about the perception of public on mental health.	76-86
II	Certificate of Human Ethical Clearance.	87

CHAPTER I
INTRODUCTION

"There are things known and there are things unknown, and in between are the doors of perception"

-Aldous Huxley

In today's dynamic world, one thing that never changes is, public voicing out their view on everything they see. Public opinion or public perception is important in order to provide public services. Public opinion is not only concerned with voicing out the need of collective people but also concerned with voicing out the collective perception of topics that are labelled as taboo. Only then such sensitive and complex but essential topic would be made simple and appropriate measures can be taken for its development.

Public opinion or perception means different things to different people. For example, public opinion is all about government, politics, and the influence it has on the development of government policies, according to political scientists. Sociologists believe it is the result of social interaction and communication. The emphasis here is on communication because they believe that public perception can only exist if they communicate their viewpoint. Aside from these definitions, public perception refers to a person's understanding or awareness of something through their senses such as seeing, touching, hearing, tasting, and thinking.

Thinking plays a vital role in perceiving things. That is how the process works. We usually see, feel, touch or hear something; think it through and have our own view about it. Sometimes, one person's perception can influence other person. The level of influence depends upon how strongly that person believe in it. Perceptions are dynamic because if a person comes in contact with more reliable and relatable source, it may change the view of that person. There are many factors that contribute to a person's perception. Those factors can be categorised into three attributes. They include:

Attribute of a person who perceives it: A perceiver's major characteristics include his or her attitude, mood, motive, interest, expectation, and cognition. For example, if a person has a positive attitude, a good mood, and is interested in a specific topic, and if the situation has met his/her expectations, his/her perception of the situation will be positive. If the opposite is true, a person's perception of that particular topic will be negative.

The target's attribute is the target's appearance, background, verbal and nonverbal communication with the objects. All of this is taken into account by the perceiver when perceiving. A situation's attributes include the location, time, and atmosphere in which the situation occurs. Perception and situational attribute are directly related in this case. This type of perception is easily changed if the perceiver encounters the same events in a different situation.

People use a variety of shortcuts to express their point of view. A situation is not always perceived as it is. People frequently make errors in perceiving external stimuli. These are known as perception errors.

Illusion is the perception of one thing as another. For example, we might recognise someone standing far away as someone we know. However, he is an unknown individual. An illusion is a type of false perception. This type of perception is common and can occur to anyone. Illusions are classified into three types. Stimulus distortion illusion includes auditory and optical phenomena; perceiver-distortion illusion includes visual perpetual illusion, sensory illusion, colour illusion, and weight illusion; inter sensory effects, and psychiatric illusions.

Hallucination is the perception of things that do not exist in the first place. For example, hallucination occurs when a person sees or hears the voices of someone who does not exist. This kind of perception is uncommon. It only affects people when they are on the verge of developing a mental disorder. There are various kinds of hallucinations. Auditory, visual, tactile, olfactory, and gustatory are some of them.

Collective perception is nothing more than people only considering things that are of interest to them. For example, when we see a group of dancers performing on a stage, we often focus on one dancer who meets our own beauty standards, such as costume, facial and physical features, and so on, even if everyone's performance is equal. This occurs when a perceiver is exposed to a large number of external stimuli at the same time.

Halo effect is one of the common perception error. Here, people will take into account a particular trait of the external stimuli for making judgement. For example: X judges a person by his/her looks. If that person’s beauty standard matches or not matches with X then X judge that person based on beauty and beauty alone even if they are talented in other ways.

Stereotyping is a type of perception error that is similar to the halo effect. The only difference is that it is entirely based on second hand information. For example, almost every foreigner believes that someone with wheatish skin is from India. However, they may also be citizens of other countries such as Pakistan, Bangladesh, and the Philippines.

Similarity is the type of perception error people usually do. It is nothing but acknowledging and accepting people or other external stimuli that are similar to the perceiver him/herself. For instance, an athletic interviewer with an outgoing personality might have an undeservedly positive impression of someone who is outgoing and athletic.

Horn effect is perception erring about a person in a negative way. For example: if a person is lazy in general but punctual at his/her job, people may just notice the laziness but not the punctuality in his/her job. This perception error not only affect the perceiver but also affect the external stimuli. People judge anything and everything they come in contact with using these short cuts. This doesn't often end well. Mental health is a topic which still is wrongly judged by the people.

Mental health is a person's emotional and social well-being. Here, emotional well-being refers to a person's feeling towards any situation in their life. If a person reacts to a situation in a matured and understanding way, then that person is considered as emotionally intelligent. Social well-being refers to a person's ability to manage a good relationship with his/her peers. These are some of the important criteria for an individual to be mentally stable and fit. Apart from that, mental health is what controls a person's daily activities and choices. In short, it is what will make a human function in a better way.

WHO (World Health Organization states that there is a direct relationship between mental health and economic growth of a country. Statistics shows that highest share of risk factors that contribute to mental disorder among adult in India include lead exposure. It is a type of metal poisoning caused by lead in body. Brain is the most sensitive part to lead poisoning. Other factors include bullying, witnessing traumatic incidents etc. Apart from these, there are many other factors that contribute to mental health of an individual. Those include family crisis, financial issue, age, gender, working environment etc.

Public education on mental health is lacking severely. Because many people have a negative perception of mental health. People frequently forget that being mentally fit is a requirement for being healthy. Their level of help seeking is also determined by their belief in mental illness. If they believe that being a victim of mental illness is something to be ashamed of, they will avoid talking about it and seeking help. When people are stressed, they are more likely to engage in unhealthy activities such as eating or binge watching.

Public people's understanding on the word mental health itself is biased. They often fails to realize that it is as important as physical health. They not only perceive it wrongly, but they spread their negative view to others as well. A lot of people perceive different meaning when they hear the term mental health. These believes are mostly from the sources such as social media, movies, books and peers. These sources unintentionally create a barrier for people with mental disability to function normally.

According to Patrick W Corrigan (1998), approximately 14% of the Indian population has mild to severe mental dysfunction. However, not all of them seek assistance. This is due to public or self-stigma surrounding mental illness. Only 41% of people with mental disabilities seek professional help, which is less than half of all mental disorder victims. This situation needs to be changed. To accomplish this, more emphasis should be placed on educating and raising awareness about the true meaning of mental health. The first step toward that goal is to eliminate pre-existing negative thoughts about mental health.

National Institute of Mental Health states that "mental illness is a situation in which our thoughts, feeling, mood, and behaviour are impaired or far from normal. They may last longer (chronic) or for a short period of time". Peoples' ability to function and empathize depends upon their mental health. It can be also called as mental illness or psychiatric disorder. This behavioural or mental pattern that causes significant distress or impairment of personal functioning.

Mental disorders are usually classified on the basis of the symptoms the victims explicit due to the occurrence of the disorder. That is, it is what victims of mental disorders do as a result of what they think and feel. This classification is essential in order to identify the patients with similar symptoms so that a researcher could possibly identify the causes, symptoms and outcome of the patients.

Anxiety disorder is characterised by feelings of fear, dread, and uneasiness. It may cause a person to sweat, feel tense and restless, and have a rapid heartbeat. Anxiety disorders are conditions in which a person experiences persistent anxiety that worsens over time. Symptoms can disrupt daily activities such as job performance, schoolwork, and relationships.

Anxiety disorders are classified into three types: generalised anxiety disorders, in which a person frequently worries about general issues such as income, family, health, and work. It

lasts for more than six months. The second type is panic disorders, which cause people to experience intense fear (panic attack) even when there is no danger. It only lasts a few minutes but causes breathing difficulties. The third category includes phobia. People who are prone to phobias are afraid of one specific thing. For example, any type of insect, blood, crowded places, and so on. Obsessive Compulsive Disorder (OCD) is a component of anxiety disorders. It is nothing more than a persistent feeling of obsession or compulsion. For example, repeatedly washing one's hands.

Mood disorders are not the same as having a bad mood in everyday life. People who are predisposed to this disorder have a low level of emotional stability. Depression is one of the symptoms of a mood disorder. Depression is the second most common type of classification. It is more than just being sad or lonely. Everyone feels this way once or several times in their lives. But the issue arises when it interferes with their daily lives. It has symptoms such as feeling empty inside, loss of interest in activities, binge eating or loss of appetite, fatigue, hopelessness, anxiety, or guilt, and so on. It has no clear cause. However, environmental, genetic, brain chemistry, and psychological factors all play a role.

American Psychiatric Association states that bipolar disorder is a type of mood disorder in which a person experience extreme mood swings. As the name itself suggests, a victim of this disorder experience either highly energised or up or elated. This stage is called manic episode. On the other hand, they may also feel sad, gloomy or down. This stage is called depressive episode. Sometimes they experience both at a peak level. It is called mixed episode.

Post-Traumatic Stress Disorder (PTSD) is a mental disorder that people experience after witnessing something terrifying that completely changes their lives. For example, sexual assault, car accidents, natural disasters, and so on. It is not always a dangerous one, such as losing loved ones or witnessing someone's death. It is normal to experience fear during and after a traumatic event. Fear causes a "fight-or-flight" response. This is one's way of assisting in the protection of his or her body from potential harm. It causes physiological changes such as the release of certain hormones and increases in alertness, blood pressure, heart rate, and breathing rate.

Psychotic disorders are severe mental illnesses characterised by abnormal thinking and perceptions. People suffering from psychoses lose touch with reality. Delusions and hallucinations are two of the most common symptoms. Delusions are false beliefs, such as believing that someone is plotting against the person with the disorder or that the television is sending secret messages to that person. Hallucinations are false perceptions that occur when someone hears, sees, or feels something that does not exist in reality.

Schizophrenia is a type of psychotic disorder. People with bipolar disorder may also have psychotic symptoms. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves. There are several type of schizophrenia that are classified based upon the symptoms the patient exhibit.

According to International Classification Disorder (ICD-10), people are diagnosed with unspecified schizophrenia when they exhibit symptoms that meet the general conditions for a diagnosis but do not fit into any of the above categories.

Mental health is usually determined by a variety of factors. Feeling lonely or isolated is one of them. When a person is alone, they may experience sadness, gloom, or depression. Isolation is the complete separation from one's close ones or environment. Every person has had this type of feeling at least once in their lives. Usually, such feelings pass quickly. However, when it does not, a problem arises.

National Centre for Chronic Disease Prevention and Health Promotion stresses that grief and loss is a natural reaction for a loss. A person experience grief when he/she loose a family or friend, loose a job, miscarriage, after a divorce or breakup of long term relationship, diagnosed with chronic disorder, when they age, when they gets abandoned. Every individual has different way to cope up with the grief. Some may want to be left alone while others wants to be surrounded by people as much as possible. It may last just for days or months or even for years. When it affects a persons' daily life or their relationships with others, it is the high time for them to consult their trusted doctor.

Domestic or family violence also has a significant impact on a person's mental health. It is when a person feels unsafe or threatened physically or emotionally at home, work, or elsewhere. They may feel threatened, insecure, or powerless over that person. Physical harm, controlling one's social life, not giving enough space or stalking continuously, humiliating or

blaming someone on purpose, controlling them financially, verbally abusing a person, sexually abusing, and so on are all examples of domestic or family violence behaviour. Emotional harm is as serious as physical harm. When a person feels disrespected, powerless, controlled, or intimidated by others, he or she may not express themselves fully, causing mental stress.

National Institute of Mental Health states that the amount of alcohol/other substance intake also plays a role in identifying a person's mental health. If a person is addicted to alcohol, then the probability of him having poor mental health is high. Because, the symptoms of alcohol addiction itself involves poor self-hygiene, lack of sleep, poor concentrating capacity and anxiousness. Roughly 50 percent of individuals with severe mental disorders are affected by substance abuse. 37 percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness. Of all people diagnosed as mentally ill, 29 percent abuse alcohol or drugs.

Many people fail to recognise that the occurrence of any mental disorder is not the patients' fault. They frequently judge the patients and avoid any kind of relationship with them. The following are some examples of how people can be judgmental and prejudiced against people with mental illnesses. They believe that people suffering from depression are lazy and frequently fail to complete their tasks properly. They only see the disorder, not the person.

People suffering from anxiety and PTSD, on the other hand, are frequently stigmatised as being exaggerative or dramatic as a result of their conditions. Because of their fear-related symptoms, they are frequently referred to as cowards. Simply put, people label patients with mental disorders as "crazy" because they seek treatment for mild mental disorders such as depression, anxiety, PTDS, and so on. Another common misconception is that people with mental illnesses are always violent. This is not entirely correct. Only 10% of people with a mental disorder engage in violent behaviour. Because of this belief, most people are afraid to approach and converse with people suffering from mental illnesses. All of these stigmas and judgments have an obvious impact on people.

According to the Mental Health Foundation nearly 9 out of 10 people with a mental illness feel stigma and discrimination negatively impact their lives. They also state that those with a mental health issue are among the least likely of any group with a long-term health condition or disability to find work, be in long-term relationships, live in good housing, and be

socially included in mainstream society. Stigma may not be obvious or be expressed in large gestures. It can come in the words people use to describe a mental health condition or people living with mental illness. This can involve hurtful, offensive, or dismissive language, which can be upsetting for people to hear.

Banyan Mental Health points a few misconceptions about mental disorders and mentally ill people. Some of them include: Spreading negative beliefs. Only a few people have non-judgemental attitude towards people with mental disorder. Since those people are of minority in number, even their thought can be changed by the majority class of people. The spreading of vile comments and beliefs against people with mental disorders should change. Most of people's thoughts are influenced based upon social media, movies and books. If it is done, then half the problem of stigmatization can be easily avoided.

American Psychiatric Association portrays that even normal people would lose all kinds of hope and happiness if they feel ashamed of themselves. If people with mental disorders feel ashamed of themselves, it not only worsen their mental health. There is a high chance that it affects their physical health as well. Because they might engage in addictive activities or worse, in self harming activities. So even if people are not contributing for improving their condition, they should at least stop worsening it.

Stigmatization leads people with mental disorder to face discrimination at their work place. Other people often consider them as incompetent and inefficient even if they are as efficient as others. This is because they see them merely as disorder and not for the person they are. Sometimes this may lead to unemployment which affect them even more severely because they have to depend on their family or friends to fund their treatment who may consider them as burden.

People sometimes watch and learn what to believe from society. If majority of society stigmatize a particular class of people, we tend to stigmatize them too. It is called stereotyping. It is also one of the perception error. The main reason for stereotyping is lack of awareness and education.

The media is crucial in raising awareness about anything and everything, including mental health. A famous celebrity's endorsement of a simple but detailed documentary is critical in raising mental health awareness. Celebrities such as Priyanka Chopra Jonas discussed her mental health issues during the time of her father's death in her book "Unfinished." This will make people feel less alone in their exhausting journey of treatment and recovery from the disorder. Another critical point is to ensure the availability of easily understood and accessible articles and journals in sources such as the internet, the Indian Society of Psychiatry, educational institutions in this field, and so on.

Educational institution plays a vital role in making future India more aware of mental health. It is crucial to consider this source because of the fact that many chronic mental disorders have its onset during the adolescent period. So, if the awareness campaign is started at this point of time, de-stigmatization, early identification and removal of discrimination will be achieved easily.

Five important things that can be done in institutions to improvise mental health of students include: Academic courses should be accommodative of diversity; individual capability based assessment system; subsidize education and provide financial support; institute a mental health support team; appoint a mental health emergency crisis team.

Industry plays a vital role in improvement of mental health considering its contribution on the country’s economy. It is common for all the employers to undergo some mental pressure due to work stress. But it shouldn’t be in the level that it affects the company’s overall performance. So it is important to adopt measures that contribute towards improvement of mental health not only as a part of their Corporate Social Responsibility but also for their own benefit which is welfare of the employers and employees.

Government intervention has its major part in spreading awareness on mental health. Only through the involvement of specialized administration, one can ensure if the benefits are achieved in an even level from rural to urban areas. The development and implementation of well-defined mental health policies and plans are critical to good governance and leadership for mental health. These contribute to improving the organization, accessibility, and quality of service delivery, and fostering engagement with stakeholders, including people with lived experience, their care givers, and the community at large.

The National Mental Health Programme (NMHP) 1982 was implemented by the central government to achieve objectives such as: ensuring the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; encouraging the application of mental health knowledge in general healthcare and in social development and promoting community participation in the mental health service development and to stimulate efforts towards self-help in the community.

District Mental Health Program (DMHP) is another important program that was launched under. It was launched during the year 1996 at the time of 9th five year plan. It was based on Bellary Model which has components such as: Early detection & treatment; imparting short term training to general physicians for diagnosis and treatment of common mental illnesses with limited number of drugs under guidance of specialist. The Health workers will be trained to identify mentally ill persons; Information, Education and Communication (IEC) Public awareness generation on mental health and for monitoring and record keeping the activities.

The Mental Health Care Act 2017 was passed on 7 April 2017 and came into force from July 7, 2018.The law was established to provide necessary treatments for mentally ill people and also to protect their rights.

World Health Organization also plays a significant role in improving mental health. It supports Member States in establishing appropriate institutional, legal, financing and service arrangements to ensure that the mental health of the population is protected, promoted, and restored, and substance use is controlled. In addition, WHO regularly collects information on mental health policies and resources, through the collection hub called Mental Health Atlas, and collaborates with partners and networks to build leadership capacity and strengthen governance.

OBJECTIVES OF THE STUDY are to:

1. Analyse the socio demographic characteristics of the selected respondents.
2. Study the perception of people about the victims of mental illness.
3. Identify the stress, depression and anxiety level experienced by the selected respondents.
4. Assess the state of happiness among people. .
5. Analyse people’s view on mental health.

Need for the study is:

- To understand public's basic view on the topic "mental health".
- To find out how people gathered their knowledge on mental health.
- To know how people handle their own stress.

Scope of the study:

- To analyse which age group needs more awareness about mental health so that awareness program can be planned accordingly.
- To test the relationship between occupation and mental stress level.
- This study can be extended further based on the change the respondents felt on hearing the term mental health.

Limitations of this study:

1. This study included respondents from limited geographical area. So it cannot be completely generalised.
2. Complete honesty was not possible among some of the respondents.
3. Limited time allotted for data collection so number of respondents was reduced to 110 only.
4. The study covered only over all knowledge about mental health and illness. It did not cover a particular aspect in a detailed way.

Hypotheses:

- There is a significant relationship between knowledge on mental health and respondents' education qualification.
- There is a significant difference between gender and attitude towards mentally ill people.

CHAPTER II

REVIEW OF LITERATURE

"Our review of the literature says this appears to be bigger than in the past"

- Bob Dietz

The literature pertaining to the study entitled on **"Analysing the general perception of public on mental health"** consist of the following heads:

A. CONCEPT OF PERCEPTION
    a. Importance of perception.
    b. Perception errors.
    c. Measuring perception.

B. FACTORS INFLUENCING PERCEPTION ON MENTAL HEALTH.
C. CONCEPT OF MENTAL HEALTH AND MENTAL DISORDERS.
    a. Concept of mental health with reference to Indian context.
    b. Types of mental illness.
    c. Treatments for mental illness.
    d. Special Laws and Acts for mental health.

D. Related studies.

A. CONCEPT OF PERCEPTION.

IMPORTANCE OF PERCEPTION.

According to Kendra Cherry (2020), Perception includes the five senses; touch, sight, sound, smell, and taste. It also includes what is known as proprioception, a set of senses involving the ability to detect changes in body positions and movements. It also involves the cognitive processes required to process information, such as recognizing the face of a friend or detecting a familiar scent.

Victoria Sivrais (2018) stated that perception study can reveal peoples' candid views, uncover gaps in understanding, and pinpoint any potential objections or concerns people may have related to any change. Through direct conversations and, sometimes, quantitative surveys the study determines both what people like about a deal, and what they don't like. Both the

good and the bad should weigh into a researchers' story and help them fine tune their study for maximum impact when a researcher analyse and interpret the collected data.

Perception and perceptual decision-making are strongly facilitated by prior knowledge about the probabilistic structure of the world. While the computational benefits of using prior expectation in perception are clear, there are myriad ways in which this computation can be realized. (Peter Kok, 2018)

Perception is critical in understanding human behaviour because everyone perceives the world and approaches life problems differently. What we see or feel is not always the same as what is actually happening. It's because what we hear isn't always what is said, but rather what we perceive to be said. We buy things not because they are the best, but because we believe they are the best. Thus, it is through perception that we can determine why one person finds a job satisfying while another does not. (Dhiksha Kashyap, 2017)

PERCEPTION ERROR:

Cha and Carrier (2016) said that characteristic of the object and situation also affect what people select, how people organize what people perceive, and how people make interpretation. Most critical are the errors in judgments people make the world around us. A particularly interesting tendency is how people make causal inferences about what people perceived. People tend to attribute other people's behaviour to their personality rather than to situational forces.

Dr Asha Sharma (2019) states that a perceptual error is the inability to judge humans, things or situations fairly and accurately. Examples could include such things as bias, prejudice, stereotyping, which have always caused human beings to err in different aspects of their lives.

Researcher Winifred Strange (2011) conducted a study on "Automatic Selective Perception of first & second language speech". In this research, he stated that people generally interpret based on their interests, ideas, and backgrounds. It is the proclivity to ignore and forget the stimuli that cause emotional distress. For example, one might believe that recent graduates with grades above 80% will perform exceptionally well in technical interviews for their respective subjects.

Guilio Gabrieli et al (2021) opinionated about halo effect that it is a type of cognitive bias whereby our perception of someone is positively influenced by our opinions of that person's other related traits. The halo effect can influence our perceptions of others' intelligence and competence in a variety of settings, from the classroom to the courtroom.

Perry Hinton (2017) conducted a study on "Implicit stereotypes and the predictive brain: cognition and culture in "biased" person perception." He defined stereotype as overgeneralized attributes associated with the members of a social group, with the implication that it applies to all group members.

Dr Jung Juo (1992), a researcher hypothesised that contrast effect regulates cognitive process and emotions. He stated that contrast effect is the enhancement or diminishment, relative to normal, of perception, cognition or related performance as a result of successive (immediately previous) or simultaneous exposure to a stimulus of lesser or greater value in the same dimension.

John H. Boman et al (2015) stated that Projection-This is very common among Perceptual errors. Projection of one's own attitude, personality or behaviour into some other person. For example- To all honest people, everybody is honest.

David M G Lewis Et al (2022) conducted a research on "Error Management theory & biased first impression". He defined first impression error as type of bias that allows a person's initial judgment or first impression of anything or anyone good or bad to affect the person's feedback or decision.

MEASURING PERCEPTION:

Maristán Questionnaire was developed for testing stigma on mental illness on various categories of people. It consisted of 38 statements to which the respondents indicate their degree of agreement. The statements concerned stigma in personal, family and social life, the attitudes of health professionals, and stigma in the public sphere and work. The format was a Likert scale with a score of 1 indicating complete disagreement and 7 indicating complete agreement with each statement. (S Saldivia 2014)

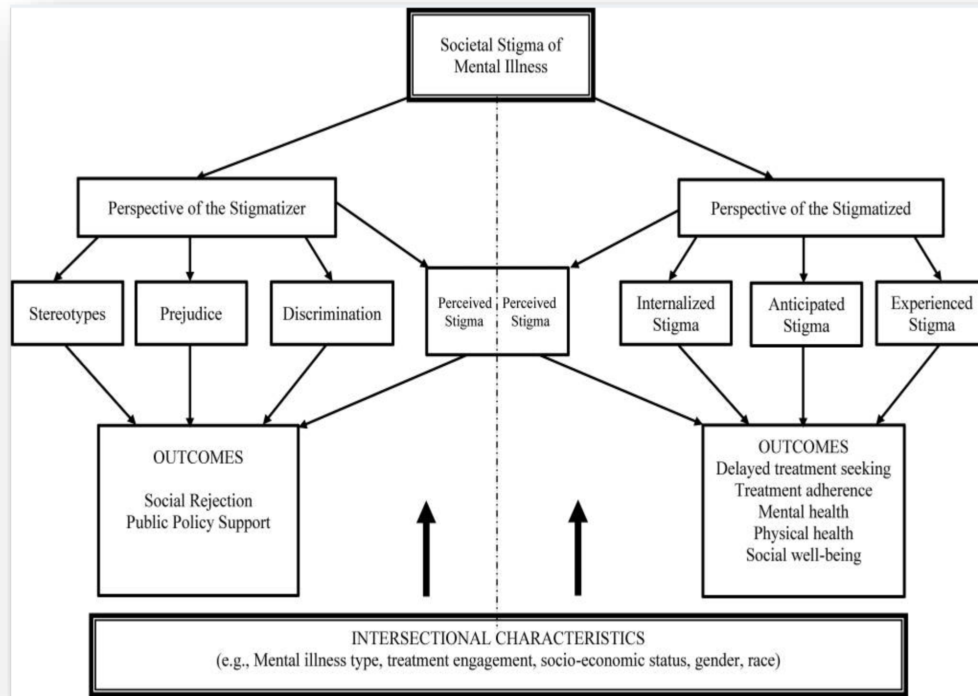


FIGURE 1

MENTAL ILLNESS STIGMA FRAMEWORK

The Positive and Negative Affect Schedule (PANAS) is one of the most widely used scales to measure mood or emotion. This brief scale is comprised of 20 items, with 10 items measuring positive affect (e.g., excited, inspired) and 10 items measuring negative affect (e.g., upset, afraid). Each item is rated on a five-point Likert Scale, ranging from 1 = Very Slightly or Not at all to 5 = extremely, to measure the extent to which the affect has been experienced in a specified time frame. The PANAS was designed to measure affect in various contexts such as at the present moment, the past day, week, or year, or in general (on average). Thus, the scale can be used to measure state affect, dispositional or trait affect, emotional fluctuations throughout a specific period of time, or emotional responses to events. (Watson, Clark, & Tellegen, 1988)

The Attribution Questionnaire (AQ-27) is a 27-item, self-administered measure of stigmatizing attitudes and beliefs toward people with mental illness. The AQ-27 is divided into nine subscales with each subscale consisting of three questions. The nine subscales consist of:

Blame, Anger, Pity, Help, Dangerousness, Fear, Avoidance, Segregation, and Coercion. Items are presented on a 9-point Likert-type scale, and subscale scores are calculated by summing the items corresponding to that subscale. A total score may be calculated as well. Higher factor scores represent greater endorsement of the corresponding attitude or belief. The AQ-27 is sensitive to changes in public stigma toward mental illness following anti-stigma interventions, and has been used successfully in diverse adult samples, including healthcare students and professionals. (Daniel J Fridberg, 2013)

The Bogardus scale is a social distance scale that measures prejudice—or, more precisely, the degrees of warmth, intimacy, indifference or hostility between an individual and any social, racial or ethnic groups. It was developed by Emory Bogardus in 1924 and named after him. The questions were framed in the form: "Would you like to be friends with a person who belong to this particular group" and the answer should be scored from 1 to 5 which shows the level of the acceptance. It is one-dimensional, which means it can be used to measure exactly one concept (prejudice). But though it was created to measure prejudice against other racial groups, it is broad enough it can be used in reference to almost any societal group (homeless people, artists, atheists, circus dancers etc) (F. Galliher, 2007).

B. FACTORS INFLUENCING PERCEPTION ON MENTAL HEALTH:

Stigma is a complex, socially sanctioned phenomenon that can seriously affect the health of people with mental illness. Sebastin Gyamti (2018) expressed that people with mental illness experience discrimination and isolated. Even though the greatest source of discrimination is general public, the opinion of people who are diagnosed with mental disorders on the discrimination and isolation is important as well. The researcher aimed to identify the perception on stigma, self-stigma and isolation of people with mental illness. Twelve out patients attending Ghana Clinic were interviewed. A few patients held a stigmatic view on mental illness as general public does. This affected their time of recovery and treatment; whereas most of the patients held a positive view on mental illness and knew their rights which played a great role in their recovery.

Public stigma against family members of people with mental illness is a negative attitude by the public which blame family members for the mental illness of their relatives. Family stigma can result in self social restrictions, delay in treatment seeking and poor quality of life. (Eshetu Girma, 2014)

Cultural diversity across the world has significant impacts on the many aspects of mental health, ranging from the ways in which health and illness are perceived, health seeking behaviour, attitudes of the consumer as well as the practitioners and mental health systems. "Culture influences what gets defined as a problem, how the problem is understood and which solutions to the problem are acceptable." (Narayan Gopalakrishnan, 2018)

Studies consistently show that both entertainment and news media provide overwhelmingly dramatic and distorted images of mental illness that emphasise dangerousness, criminality and unpredictability. They also model negative reactions to the mentally ill, including fear, rejection, derision and ridicule. The consequences of negative media images for people who have a mental illness are profound. They impair self-esteem, help-seeking behaviours, medication adherence and overall recovery. (Heather Stuart, 2016)

C. CONCEPT OF MENTAL HEALTH AND MENTAL ILLNESS:

CONCEPT OF MENTAL HEALTH WITH REFERENCE TO INDIAN CONTEXT:

Adrija Roy, Arvindh Kumar Singh et al (2020) said that most people think that people with mental health problems always behave violent and hostile. But the fact is the vast majority of people with mental health problems are no more likely to be violent than anyone else. Most people with mental illness are not violent and only 3%–5% of violent acts can be attributed to individuals living with a serious mental illness. In fact, people with severe mental illnesses are over 10 times more likely to be victims of violent crime than the general population.

Deena Dimple Desouza et al (2020) stated that factors affecting mental health include are biological factors like genes and brain chemistry, life experience like trauma or abuse, family history of mental health problems and a person's life style itself such as diet, physical activity and substance use.

TYPES OF MENTAL ILLNESS:

Depression:

Depression, in psychology, a mood or emotional state that is marked by feelings of low self-worth or guilt and a reduced ability to enjoy life. A person who is depressed usually

experiences several of the following symptoms: feelings of sadness, hopelessness, or pessimism; lowered self-esteem and heightened self-depreciation; a decrease or loss of ability to take pleasure in ordinary activities; reduced energy and vitality; slowness of thought or action; loss of appetite; and disturbed sleep or insomnia. (Viktor Frankl, 2021)

According to Juan Bueno Notivol, Patricia Gracia Et al (2021) depression is the most common psychiatric complaint, and it has been described by physicians since before the time of the ancient Greek physician Hippocrates, who referred to it as melancholia. The disorder's progression varies greatly from person to person; it can be mild or severe, acute or chronic. Depression can last four months or longer if left untreated. Women are twice as likely as men to suffer from depression. The typical onset age is in the twenties, but it can occur at any age.

Joelle LeMoult, Ian H Gotlib (2019) conducted a study on depression in cognitive perspective. He indicated that there are numerous causes of depression. Unfavourable life events can make a person more susceptible to depression or trigger a depressive episode. Negative thoughts about oneself and the world play an important role in the development and maintenance of depressive symptoms. However, both psychosocial and biochemical mechanisms appear to be important causes; the primary biochemical cause appears to be faulty regulation of the release of one or more naturally occurring neurotransmitters in the brain, specifically norepinephrine and serotonin. Reduced quantities or activity of these chemicals in the brain are thought to cause depression in some patients.

Anxiety:

Andre Pittig Et al (2018) conducted a study on title “The role of associative fear and avoidance learning in anxiety disorder”. In this study, the researchers reviewed that anxiety disorders are the most common mental disorders and are often chronic and disabling. Although exposure-based treatments are effective, a substantial number of individuals fail to fully remit or experience a return of symptoms after treatment. This narrative review examines the advances made in our understanding of associative fear and avoidance learning in anxiety disorders. Overall, the extant literature supports a key role of aversive associative learning in the development and treatment of anxiety disorders.

Tim J. Hartung, Michael Friedrich Et al (2018) conducted a study for the purpose of using Generalized Anxiety Disorder Screener. In his study he noted that anxiety disorders are more common in women. It could be caused by women's hormones, particularly those that fluctuate throughout the month. The hormone testosterone may also play a role. Men have more of it, and it may help with anxiety. It's also possible that women are less likely to seek treatment, exacerbating their anxiety.

Robert Sigstrom, Svante Ostling Et al (2010) stated that anxiety can be treated through Cognitive Behaviour Therapy (CBT). It is the most commonly used type of psychotherapy for anxiety disorders. CBT for anxiety teaches you to identify thought patterns and behaviours that lead to distressing feelings. Then you work on changing them.

Anxiety disorders are the most common mental health problems in the United States. They affect approximately 40 million Americans. They affect nearly 30% of adults at some point in their lives. Anxiety disorders are most commonly diagnosed in childhood, adolescence, or early adulthood. (Frank W Weathers, 2016)

Bipolar Affective Disorder:

American Psychiatric Association (2021) defines Bipolar disorder as a serious mental illness in which everyday emotions become intensely and frequently unpredictably magnified. Individuals suffering from bipolar disorder can experience extremes of happiness, energy, and clarity, as well as sadness, fatigue, and confusion. These shifts can be so devastating that people may commit suicide. Manic episodes — abnormally elevated or irritable moods that last at least a week and impair functioning — occur in all people with bipolar disorder. However, not everyone becomes depressed.

Attention Deficit Hyper Active Disorder (ADHD):

Daniel Bradies (2013) conducted a study on Non-pharmacological Interventions for ADHD. It is one of the most common childhood neurodevelopmental disorders. It is typically diagnosed in childhood and can last into adulthood. Children with ADHD may have difficulty paying attention, controlling impulsive behaviours (acting without considering the outcome), or being overly active. Non-pharmacological treatments are available for attention deficit hyperactivity disorder (ADHD), although their efficacy remains uncertain.

Schizophrenia:

Richerd Newton (2018) conducted a study to view the diverse definition of schizophrenia, a review literature based study. The study defined schizophrenia as a serious mental disorder in which people interpret reality abnormally. Schizophrenia may result in some combination of hallucinations, delusions, and extremely disordered thinking and behaviour that impairs daily functioning, and can be disabling. People with schizophrenia require lifelong treatment.

Amy Pinkham et al, (2016) stated that Paranoia is a common symptom of schizophrenia that may be related to how individuals process and respond to social stimuli. Positive symptoms of schizophrenia, such as delusions and hallucinations, characterise paranoid schizophrenia. These incapacitating symptoms blur the line between what is and isn't real, making it difficult for the person to live a normal life.

Peter Uhlhaas Et al (2016) conducted a study on Perceptual grouping in disorganized schizophrenia. It is distinguished by disordered behaviour and speech, as well as disturbances in emotional expression. Hallucinations and delusions are less prominent in disorganised schizophrenia, but there is evidence that they occur.

Yuta Saito, Hitoshi Sakurai Et al (2020) conducted a study to predict relapse with residual symptoms in schizophrenia. The researcher noted that While the symptoms of the other four subtypes of schizophrenia are often more extreme and include criteria such as delusions, hallucinations, disordered speech, and catatonic behaviour, in residual schizophrenia, the symptoms are milder.

TREATMENT FOR MENTAL ILLNESS:

Jessica Lambert, Fred Nantogmah et al (2020) conducted a review study on "The treatment of mental illness in faith-based and traditional healing centres in Ghana" in service users and healers perspective. Faith-based mental illness treatment centres and programmes address the medical and spiritual needs of recovering patients. The spiritual aspect of treatment is important, but traditional mental illness treating techniques are also important. To help manage symptoms, standard methods such as medically assisted pharmacotherapy and behavioural therapy are used.

Allison Harvey, Catherine A (2021) conducted a study on "Applying the Science of Habit Formation to Evidence-Based Psychological Treatments for Mental Illness". He reviewed that it was an adherence to psychological approaches and techniques that are based on scientific evidence.

Rebecca Bogaers, Elbert Geuze et al (2022) conducted a study on "Seeking treatment for mental illness and substance abuse". The researcher expressed that detoxification is frequently performed in a hospital or inpatient therapy treatment centre. It usually takes one week to complete. Because physical withdrawal symptoms can be fatal, a person may be given medications to help prevent shaking, confusion, sweating, agitation, restlessness, and other withdrawal symptoms.

SPECIAL LAWS AND ACTS FOR MENTAL HEALTH:

Kanna Sugiura, Faraaz Mahomed et al (2020) reviewed articles on the subject rights and decision-making in mental health care. The article reviewed the impact historical trends and current mental health frameworks have had on the rights affected by the practice of involuntary treatment and describes some legal and organizational initiatives that have been undertaken to promote non-coercive services and supported decision-making. The evidence and examples presented could provide the foundation for developing a context-appropriate approach to implementing supported decision-making in mental health care.

Person With Disability Act (2016):

Choudhary Laxmi Narayan, Deep Shikha (2013) reviewed articles about Indian legal system and mental health. The researchers reviewed that the RPWD Act, 2016 provides that "the appropriate Government shall ensure that the PWD enjoy the right to equality, life with dignity, and respect for his or her own integrity equally with others." The Government is to take steps to utilize the capacity of the PWD by providing appropriate environment. It is also stipulated in the section 3 that no PWD shall be discriminated on the ground of disability, unless it is shown that the impugned act or omission is a proportionate means of achieving a legitimate aim and no person shall be deprived of his personal liberty only on the ground of disability.

Mental Health Care Act (2017):

Sharma, Eesha et al (2019) reviewed article about Mental Health Care Act 2017 in child and adolescent perspective. The researcher mentioned that the Mental Healthcare Act 2017 aims to provide mental healthcare services for persons with mental illness. It ensures that these persons have a right to live life with dignity by not being discriminated against or harassed. It decriminalizes suicide attempt by a mentally ill person. It also imposes on the government a duty to rehabilitate such person to ensure that there is no recurrence of attempt to suicide. A person with mental illness shall not be subjected to electroconvulsive therapy (ECT) therapy without the use of muscle relaxants and anaesthesia. Furthermore, ECT therapy will not be performed for minors.

D. RELATED STUDIES:

Anthony John (2006) conducted a survey to analyse public's ability to recognise mental disorders and their beliefs about treatment. The author particularly aimed to analyse changes in belief on recognition and treatment of mental illness of Australian people over 8 years. The

researcher used survey method to collect opinion among respondents. The survey was based on a vignette of a person with a mental disorder. This survey was carried out by the company AC Nielson following as closely as possible. Households were sampled from 250 census districts covering all states and territories, metropolitan and rural areas. The study resulted that the Australian people's beliefs have changed over 8 years to be more like those of mental health professional.

Andrea & Stephen, Hinshaw (2007) conducted a study on "Explicit and Implicit stigma against Individuals with Mental Illness". The researchers opinionated that stigma against mentally ill people keep spreading uncontrollably in many nation and cultures consisting a significant barrier to successful treatment. This research highlights the need for furthering explicit attitudinal measure of stigma which are susceptible to social desirability concerns.

Patrick Corrigan, Fred E et al (2004) conducted a study on topic "Structural level of mental illness stigma and discrimination". The researchers used sociological paradigm to apply the concepts of structural discrimination to have a broadening view on stigmatizing processes directed at people with mental illness. This study include private and government institutions that intentionally as well as unintentionally restrict the opportunities of people with mental illness.

Fahad Riaz Choudhry, Vasudevan Mani et al (2016) conducted a study on title "Beliefs and Perception about mental health issues; a Meta synthesis". The researchers of this study believed that this Meta-analysis will provide an opportunity to understand the different regarding mental disorders. The researchers used systematic review and Meta synthesis method. Fifteen published qualitative studies were used to analyse the belief and perception. The study revealed that there is a significant relationship between cultural beliefs and perception on mental health.

Coralie Wilson, Frank Deane (2012) conducted a study on title "Need for autonomy & other perceived barriers relating to adolescents' intention to seek professional mental health care". This study examined the relationship between belief based barriers to seek professional mental health care and help-seeking intentions in a sample of 1037 adolescents. The study proved that having lower perceived need for autonomy and believing that prior mental health care was helpful was significantly associated with higher intentions to seek future professional mental health care.

Matthais Angermeyer and Herbert (2005) analysed causal beliefs and attitudes to people with schizophrenia. The researcher aimed to examine how the German public's causal attribution of schizophrenia and their desire for social distance from people with schizophrenia. Trend analysis was carried out using data from two representative population surveys. This study revealed that German people had increase in the desire for social distance from people with Schizophrenia.

Jahirah Abdullah, Tamara Brown (2011) conducted a study on "Mental illness Stigma & Ethno-cultural beliefs, values and norms". This article examines the relationship between mental illness stigma & culture of American Indian, Asian, African, Latino, Middle Eastern and European descents. The analysed literature provided that there are difference in stigma among various cultural groups but the studies does not reveal about why these differences are prevailing.

Georg Schomerus, Julia Borsche et al (2006) conducted a population representative study on public's knowledge about causes and treatment for schizophrenia. The study aimed to explore the knowledge regarding causes & treatment of schizophrenia. 5025 respondents were chosen to conduct the study. During the interview, the respondents were given two open ended questions regarding causes and treatment of schizophrenia. The researcher categorized the respondents into 31 tables for beliefs and 46 categories for treatment recommendation. The study resulted as 54.2% of the respondents answering the question on possible causes for schizophrenia and 23.8% of the respondents recommended medications as their 1st treatment option.

Stefania Mannarini, Alisa Reikhar et al (2017) analysed the role of secure attachment empathetic self-efficacy and stress perception in causal belief related to mental illness. The study was cross cultural and the researcher analysed the difference of opinion of Italian and Israel people. The researcher hypothesised that there is a significant relationship between etiological beliefs and attitude towards mentally ill people. The researcher compared two cultures' (Italy & Israel) psychology students. Many Facet Rasch Model (MFRM) was applied in cross cultural perspective. The study resulted as Israeli students endorsing biogenetic causal belief model more frequently than the Italans.

Angermeyer MC & Dietrich S (2006) conducted Meta-analysis on public belief about and attitude towards people with mental illness. The researchers aimed to provide a review of

population based attitude research in psychiatry for past 15 years. The researcher conducted e-search using PubMed, Medline and Academic Search Premier Plus. Thirty three national studies and 29 local and regional studies were identified. The study revealed that attitude research in psychiatry made progress over past 15 years.

CHAPTER III

METHODOLOGY

INTRODUCTION:

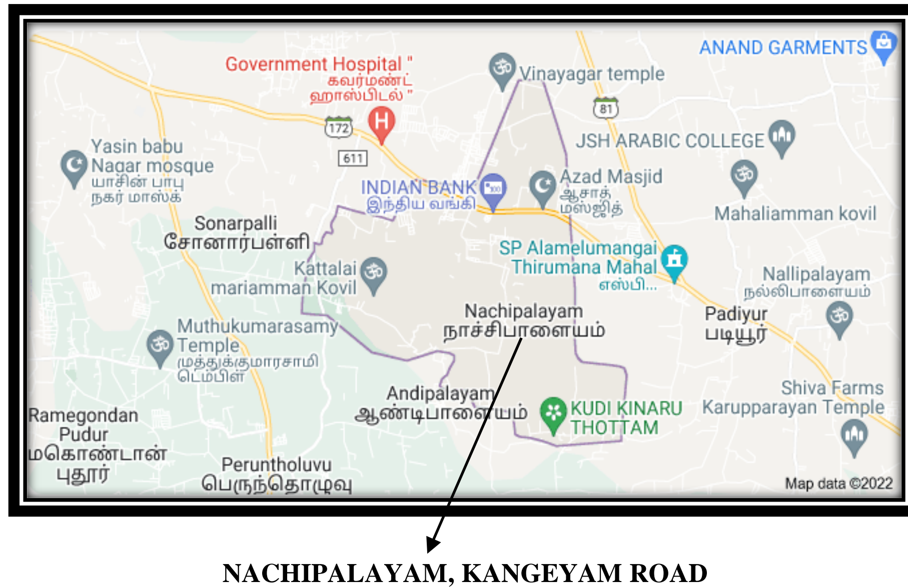
Methodology is defined as “careful consideration of study regarding a particular concern or problem using scientific methods”. The methodology for the study entitled on **“Analysing the General Perception of Public on Mental Health”** is clearly stated in the chapter. Public often tends to have perception on everything that exist. One cannot state that all views of public people are error free. Especially taboo topics like mental health issue, marital problems, divorce, LGBTQ (Lesbian, Gay, Bi-sexual, Transgender Queer) etc. So, the study of knowing people’s knowledge on mental health is necessary. The details regarding the area of the study, tools, methods, and public people who participate in the study are discussed as follows:

a. **Selection of the Area.**
b. **Selection of Sample and Size of the Selected Sample.**
c. **Selection of Methods and Tools.**
d. **Conducting Pilot study.**
e. **Obtaining Ethical Clearance for the study.**
f. **Rapport building.**
g. **Collection of Data.**
h. **Analysis and Interpretation of data.**

a. Selection of the Area:

The place selected for the present study is Tirupur. It is popularly known as “dollar city” since it has abundance of opportunities to earn for anyone and everyone who seek refuge in the city. It is the sixth largest city and also an urban agglomeration in Tamil Nadu since it covers up to 159.6 sq. km of Tamil Nadu. There are 52 wards in total. Ward number 6 is Nachipalayam, Kangeyam Road in Pongalur CD block and is selected for the present study. Kangeyam Road is one of the main area in Tirupur

and it stretches up to 16.56 Km. It connects to other major roads like Darapuram, Palladam and Pollachi.



NACHIPALAYAM, KANGEYAM ROAD

AREA SELECTED FOR THE STUDY

FIGURE 2

b. Selection of Sample and Size of the Sample:

According to Creswell (2012), "A subgroup of the target population that the researcher plans to study for generalizing about the target population". The sample should be representative of the population to ensure that we can generalise the findings from the research sample to the population as a whole.

There are numerous sampling techniques that can be used in a study**.** The sampling technique used in the present study is simple random sampling. According to Lauren Thomas 2020, "A **simple random sample** is a randomly selected subset of a population. In this sampling method, each member of the population has an exactly equal chance of being selected. This method is the most common and simple compared to all other types of sampling techniques in _probability sampling methods, since it only involves a single random selection and requires little advance knowledge about the population". This sample technique is used since the researcher just randomly chooses the respondents without any particular basis or criteria.

When a researcher conducts any type of research about a group of people, it's rarely possible to collect data from every person in that group. Instead, the researcher selects a sample. The sample is the group of individuals who will participate in the research.

Since everyone in ward 6 (Pongalur CD block) has equal probability of participation, public people are selected randomly by the researcher. Public people are selected irrespective of their socio-demographic details since mentality of each category of people is essential to outline the general perception. Among 12,130 people in ward 6 (Pongalur CD Block), 150 (1.21%) of them are chosen randomly to know their perception about mental health. Table 3 shows the selection and size of the sample.

TABLE I

SELECTION OF SAMPLE

S.NO	CATEGORY	NO. OF PEOPLE SELECTED		
		M	F	TOTAL
1.	School students above 15 years of age.	9	11	20
2.	College students	1	6	7
3.	Working women and men	25	24	49
4.	Home makers.	-	24	24
5.	Senior citizens.	5	5	10

c. Selection of Methods and Tools:

According to **Goode& Hatt (1952), "An interview schedule is a** set of questions which are asked by an interviewer and filled in on the spot in a face to face interaction with another person". It is basically a list containing a set of structured questions that have been prepared to serve as a guide for interviewers, researchers and investigators in collecting information or data

about a specific topic or issue. The schedule will be used by the interviewer, who will fill in the questions with the answers received during the actual interview.

Questionnaire has been used on the scheduled interview to collect information from the people. A questionnaire is a research instrument consisting of a series of questions for the purpose of gathering information from respondents. Questionnaires can be thought of as a kind of written interview. They can be carried out by direct contact through interview schedule, telephone and also through mail in the form of questionnaire. So in order to identify the general perception of public people on mental health, the researcher has prepared a detailed questionnaire which aids in gathering details like a person's socio demography, level of knowledge on mental health, a public peoples' attitude towards person with mental disorder, to know public peoples' source of knowledge about mental health, to test public peoples' level of happiness, anxiety and depression, to analyse a person's cause of mental stress, to study a person's personality and to know about a person's stress managing activities.

Beck's depression scale and anxiety scale is used to test respondents' mental health. The scoring is done as instructed in the scale based upon the response and the level of depression and anxiety is analysed.

Every information was gathered by the researcher directly through interview schedule with selected public people through questionnaire. Hence, it is a primary source of data.

d. Conducting Pilot Study:

A pilot study can be defined as "a small study often done to assist the preparation for larger and more comprehensive study" (**Thabane et al, 2010**). It is an initial study conducted by a researcher to ensure if the crucial elements of the research meet up with the objectives. For example: a researcher can identify if the questionnaire covers all aspects of the objectives.

The researcher conducted pilot study on 10 students from century foundation Mat. Hr. Sec. School, Infant Mat. Hr. Sec. School, Krishnammal College for women and Avinashilingam University through online mode for about 2 days to ensure if the study was able to meet up with the objectives and forecasted hypotheses.

e. Obtaining Ethical Clearance of the Study:

The ethical clearance was obtained with the reference number from Institutional Human Ethics Committee, Avinashilingam Institution for Home Science and Higher Education for Women, Coimbatore.

f. Rapport Building

The researcher visited Valliammai Nagar, the area chosen for the study a day before conducting interview schedule. This is done in order to develop a good rapport between researcher and public people chosen for the study and also to ensure their availability during the time of interview schedule. After that, the researcher briefed them about the study for incorporating some knowledge to the public people before conducting interview schedule.

g. Collection of Data:

Questionnaire was prepared to analyse public opinion on mental health. The questions were formed in such a way to test public people's knowledge on mental health, public people's stress anxiety and depression level, personality, view on people with mental disorder and happiness scale. The data was collected through online mode for school and college students.

h. Analysis and Interpretation of Data:

The data collected were integrated, categorised, tabulated, analysed and interpreted and presented in the chapter.

Statistical methods are used in order to conclude result from the collected data. They are mathematical formulas, models, and techniques that are used in statistical analysis of raw research data. The application of statistical methods extracts information from research data and provides different ways to assess the robustness of research outputs. After consolidation and tabulation, the data are analysed using co-relation and z-test.

Analyse the education qualification and knowledge on mental health:

Here, Education Qualification is considered as independent variable and knowledge on mental health is considered as dependent variable. The education qualification of the respondents are scored and compared with their knowledge on mental health with the application of correlation.

Analysing the gender and public's attitude towards mentally ill people:

The male and female respondents are numbered 1 and 2 respectively and compared with the score of attitudes of respondents towards mentally ill people. Independent t-test is used to check if there is any significant relationship between gender and attitude.

INTERVIEW WITH RESPONDENTS

PLATE 1

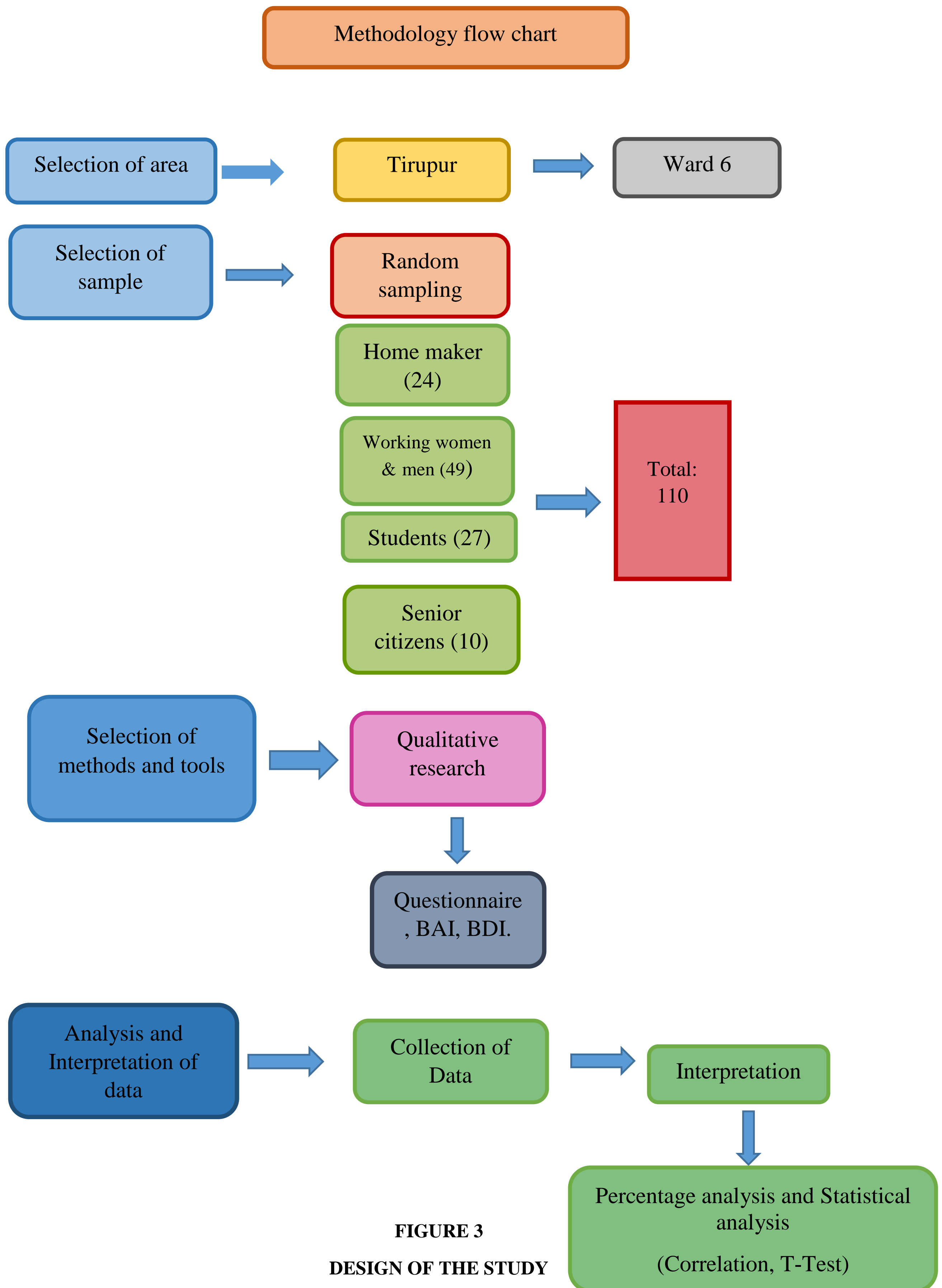


FIGURE 3

DESIGN OF THE STUDY

CHAPTER IV

RESULT AND DISCUSSION

The result pertaining to the study entitled on "Analysing the General Perception of Public on Mental Health" is presented and discussed under the following heads:

A. Socio – demographic characteristics of the selected respondents.
B. Knowledge about mental health among respondents.
C. Knowledge about mental illness among respondents.
D. Analysing physical and mental health of respondents.
E. Assessing the personal preference and habits of the respondents.

A. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS:

Table – II denotes the age, gender, family type, marital status, education, occupation and annual income of the respondents.

Table-II

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

				N=110
S.NO	**CHARACTERISTICS**	**CATOGORY**	**FREQUENCY**	**PERCENTAGE**
1.	Age (in years)	15-25	31	28
		26-35	28	25
		46-55	20	18
		36-45	19	17
		56-65	7	6
		66 and above	5	5
2.	Gender	Female	68	62
		Male	42	38
3.	Family type	Nuclear	60	55
		Joint	41	37
		Extended	9	8
4.	Marital status	Married	73	66
		Single	37	34

5.	Education	Graduate	38	35
		Higher secondary	37	33
		Post Graduate	24	22
		High school	11	10
6.	Occupation	Student	28	25
		Home maker	24	22
		Business	21	19
		IT	16	14
		Agriculture	8	7
		Banking	8	7
		Doctor, Teacher	5	5
7.	Annual Income (in Rupees)	2L-3L	49	45
		3L-4L	26	24
		1L-2L	19	17
		4L & Above	16	14

Age:

The age of the respondents are grouped as 15-25, 26-35, 36-45, 45-55, 56-65 and above 65. **Twenty eight per cent** of the respondents belong to the age group range between 15-25 followed by **twenty five per cent** belonging to the range between 26-35, **eighteen per cent** belonging to the range 46-55, **seventeen per cent** belonging to the range between 36-45, **six per cent** belonging to the range of 56-65 and **five per cent** of respondents belong to the range of 66 & above years.

Gender:

Sixty two per cent of the respondents are female followed by **thirty eight percent** are male.

Family type:

Majority **sixty per cent** of the respondents belongs to nuclear family followed by **thirty seven per cent** of the respondents belong to joint family and **eight per cent** of the respondents belong to extended family.

Marital Status:

Sixty six per cent of the respondents are married and **thirty four per cent** of the respondents are single.

Education:

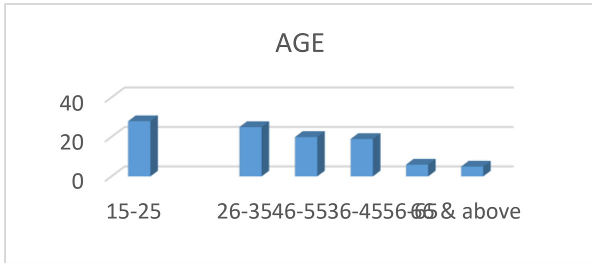
Thirty five per cent of the respondents are under graduate out of which, **thirty per cent** of the respondents completed their graduation and **five per cent** of the respondents are students and they are still pursuing their graduation. **Thirty four per cent** of the respondents have studied till higher secondary out of which **eighteen per cent** of the respondents are students and **sixteen per cent** of the respondents are educated up to higher secondary. **Twenty two per cent** of the respondents are post graduates out of which **twenty per cent** of the respondents completed their graduation and **two per cent** of the respondents are still pursuing their post-graduation degree and **ten per cent** of the respondents have completed only up to high school.

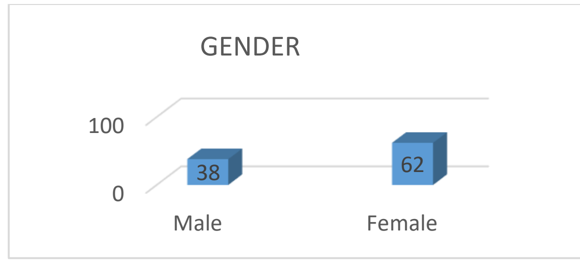
Occupation:

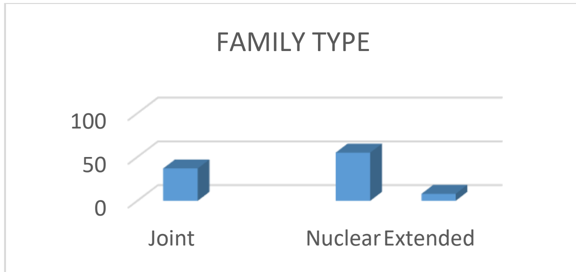
Twenty five per cent of the respondents are students followed by **twenty two per cent** of the respondents are home makers, **nineteen per cent** of the respondents are engaged in business followed by **fourteen per cent** of the respondents are working in IT companies followed by **seven per cent** of respondents working in agriculture and banking sector and **five per cent** of the respondents are working in teaching and doctor as profession.

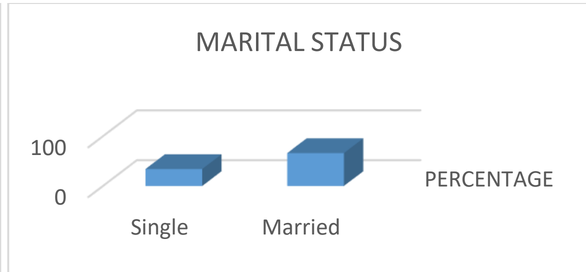
Annual income:

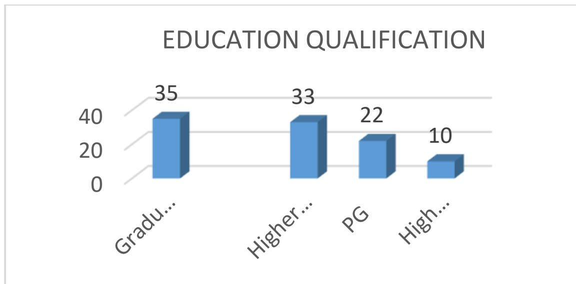
Forty five per cent of the respondents' annual income is between 2L-3L followed by **twenty four per cent** of the respondents' annual income between 3L-4L, **seventeen per cent** of the respondents' annual income between 1L-2L and **fourteen per cent** of the respondents annual income is 4L & above.

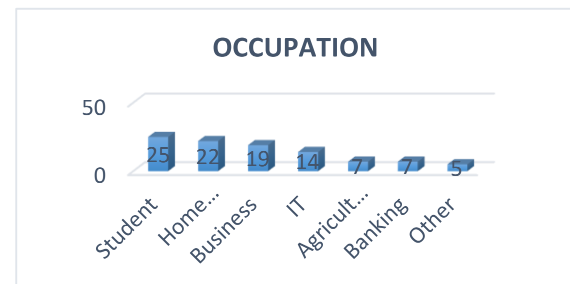












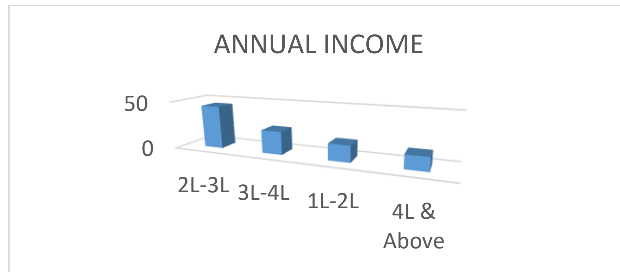


FIGURE 4
SOCIO-DEMOGRAPHIC CHARACTERISTICS

B. KNOWLEDGE ON MENTAL HEALTH AMONG RESPONDENTS:

The knowledge on mental health among respondents are discussed and presented in the following headings:

a. Awareness on characteristics of mental health.
b. Source of knowledge of respondents on mental health.
c. Knowledge of respondents on mental health acts.
d. Opinions of respondents on mental health acts.

a. Awareness on characteristics of mental health:

Table –III depicts the respondents' perception on characteristics of mental health. Some of the characteristics that are listed include: Some of the characteristics of mentally health

Table-III
AWARENESS ON CHARACTERISTICS OF MENTAL HEALTH

							N=110
S.NO	**CHARACTERISTICS**	**AGREE**		**NEUTRAL**		**DISAGREE**	
		N	**P**	**N**	**P**	**N**	**P**
1.	Mental health is associated with physical health.	96	87	10	9	4	4
2.	It is social and emotional well-being.	65	59	39	35	6	5
3.	It helps to maintain good relationship with others.	62	56	33	30	15	14
4.	Affects how people feel, think & act.	67	61	31	28	12	11
5.	Aids in making good decision.	59	54	40	36	11	10
6.	Makes people be more empathetic towards others.	59	54	39	35	12	11
7.	Mental health is not being intelligent.	30	27	22	20	58	53
8.	Mental health is related to IQ.	26	24	18	16	66	60
9.	Mental health is absence of mental disorders.	30	27	20	18	60	55
10.	Mental health is as important as physical health.	93	85	15	14	2	2

Majority (**Eighty seven per cent**) of the respondents have agreed that mental health is associated with physical health. **Sixty per cent** of the respondents disagreed for the statement that mental health is related to IQ **and thirty six per cent** of the respondents have neutrally responded to mental health aiding in decision making. Only **two per cent** of the respondents think that mental health is not as important as physical health. From this table it is clear that most of the respondents understood the over-all characteristics of mental health.

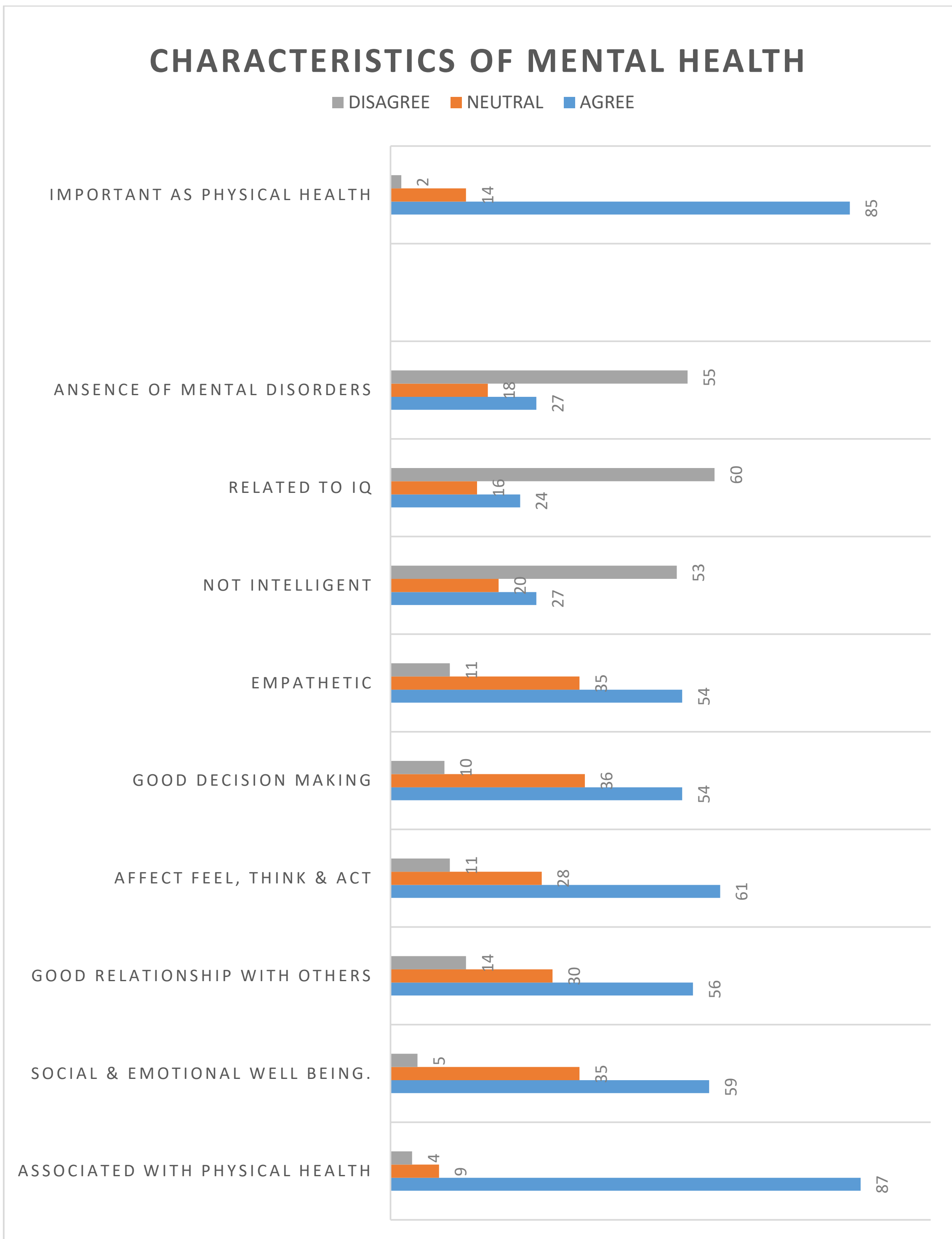


FIGURE 5
CHARACTERISTICS OF MENTAL HEALTH

b. Source of knowledge of respondents on mental health:

Table IV shows the source of knowledge about mental health among selected respondents. It lists out sources like movies, news articles, peers & family talk etc.

Table –IV

SOURCE OF KNOWLEDGE OF RESPONDENTS ON MENTAL HEALTH

N=110

S.NO	SOURCE	YES		NO	
		N	P	N	P
1.	Watching movies.	99	90	11	10
2.	Education back ground	14	13	96	87
3.	Newspaper articles.	83	75	27	25
4.	Social media and books	82	75	28	25
5.	Through peers and family talks.	96	87	14	13
6.	Consulted a therapist for my own mental stress and disturbance.	19	17	91	83
7.	Family member / friend is a therapist.	19	17	91	83

Majority **(ninety per cent)** of the respondents came to know about mental health and disorders by watching movies and **only thirteen per cent** of the respondents hold relevant degree to mental health. From this table, it can be interpreted that most of the respondents' source of knowledge on mental health are not much reliable.

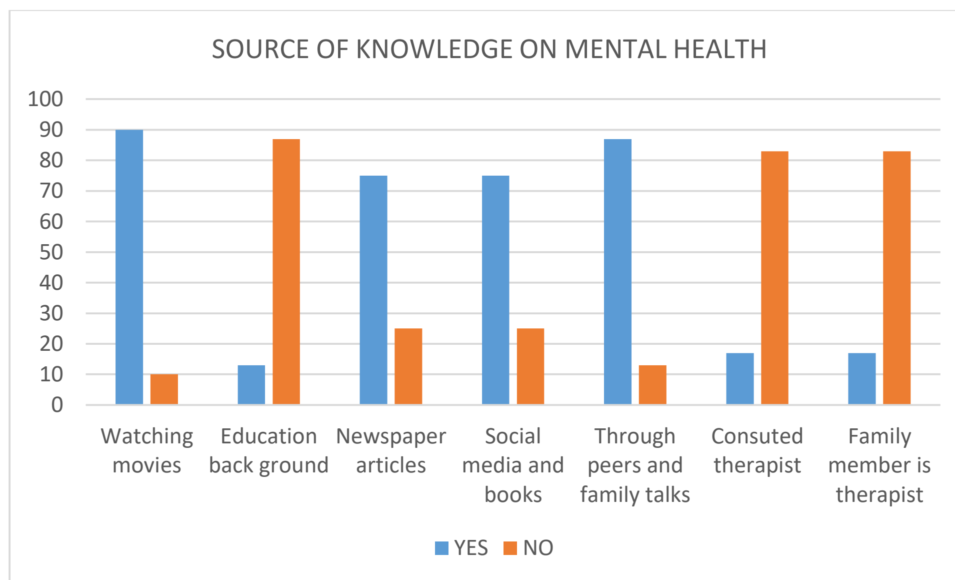


FIGURE 6

SOURCE OF KNOWLEDGE OF MENTAL HEALTH

c. Knowledge of mental health acts among respondents

Table V expresses knowledge of mental health Acts among respondents.

Table V
KNOWLEDGE OF MENTAL HEALTH ACTS AMONG RESPONDENTS

N=110

S.NO	KNOWLEDGE ABOUT ACTS	AWARE		NOT AWARE	
		N	P	N	P
1.	Mental health Act, 1987	15	14	95	86
2.	The protection of Human rights Act, 1993.	16	14	94	85
3.	Persons with disability Act, 1995.	18	16	92	84
4.	Disability Act care for people's individual need.	25	23	85	77
5.	National Trust Act, 1999	14	13	96	87
6.	Mental Healthcare Act, 2017.	19	17	91	83

Majority (**eighty per cent**) of the respondents are not aware about the National Trust Act, 1999 and merely **thirteen per cent** of the respondents are aware of it. Since, mental health is not a common topic discussed, most of the respondents except for those who hold relevant degree are not aware of the acts that aid and protect the rights of mentally ill people.

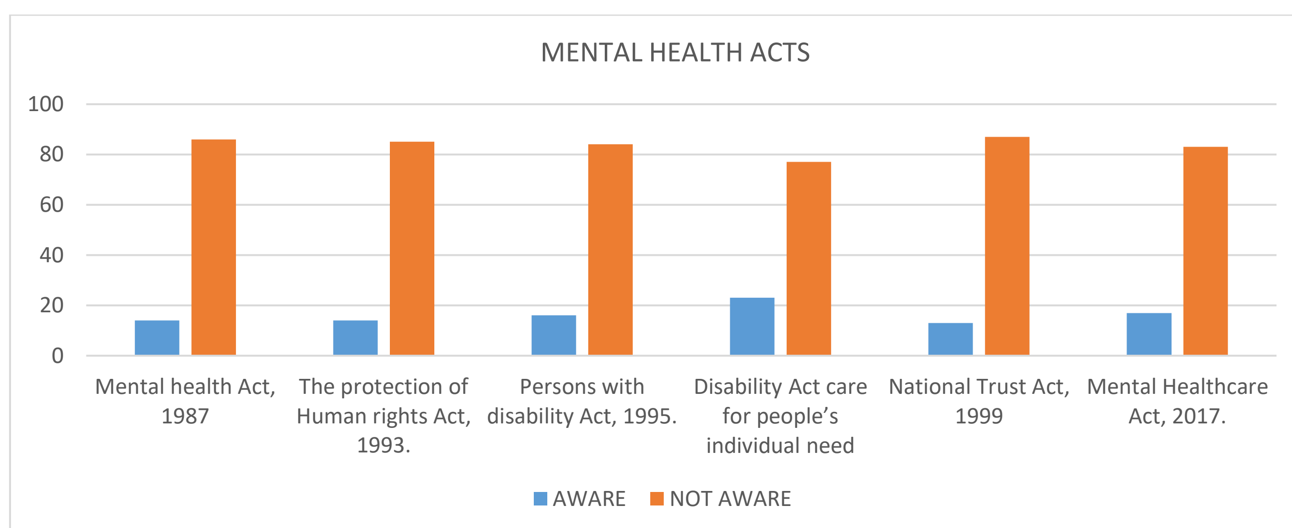


FIGURE 7
MENTAL HEALTH ACTS

d. Opinion on mental health acts among respondents:

Table-VI lists out the opinion of respondents on mental health acts.

Table –VI
RESPONDENTS' OPINION ABOUT MENTAL HEALTH ACTS

N=110

S.NO	OPINIONS	YES		MAYBE		NO	
		N	P	N	P	N	P
1.	Mental health day is celebrated to spread awareness on MH issues.	16	15	83	75	11	10
2.	There should be regular upgrade on Mental Health Act every year.	74	67	29	26	7	6
3.	Youngsters should be involved in spreading awareness on laws & acts.	88	80	17	15	5	5
4.	Mental Health Act alone is enough to protect the rights of disabled.	40	36	25	23	45	41

Every individual might have an opinion on how mental health act should be. Some of the common opinions are listed in the table. Majority **(eighty eight per cent)** of the respondents think that youngsters should be involved more in spreading awareness about mental health and its laws and Acts. **Sixty seven per cent** of the respondents think that the laws should be closely monitored and updated regularly according to the need and only **five per cent** of the respondents think that there is no need for regular update in mental health laws & acts. From the above table, it can be observed that most of the people know the importance of laws and act in the subject of mental health.

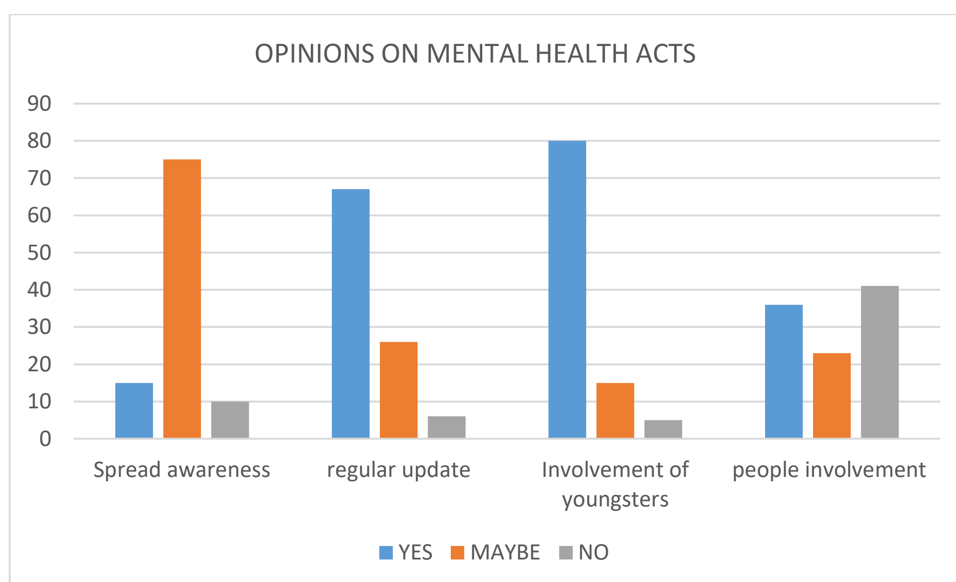


FIGURE 8

OPINIONS OF RESPONDENTS ON MENTAL HEALTH ACTS

C. KNOWLEDGE ABOUT MENTAL ILLNESS AMONG RESPONDENTS:

The knowledge on mental illness among respondents are discussed under the following heads:

a. Reason for mental illness.
b. Attitude of respondents towards mentally ill people.
c. Knowledge about meaning and symptoms of stress.
d. Awareness on characteristics of depressed people.
e. Awareness on anxiety's physical symptoms.

a. Reasons for mental illness:

Table-VII indicates about various reasons for mental illness stated by the selected respondents.

Table –VII
REASONS FOR MENTAL ILLNESS

N=110

S.NO	REASONS	AGREE		NEUTRAL		DISAGREE	
		N	P	N	P	N	P
1.	Being unconstraint	31	28	15	14	64	58
2.	Living in unhealthy environment.	82	75	27	24	1	1
3.	**Incident** & Accident	90	82	17	15	3	3
4.	Witnessing traumatic incidents.	73	66	30	27	7	6
5.	Loss of loved ones.	60	55	35	32	15	13
6.	Negative thoughts.	55	50	37	34	18	16
7.	Uneven sleeping pattern	58	53	38	34	14	13
8.	Consuming drugs and alcohol	89	81	17	15	4	4
9.	Genetic	46	42	55	50	9	8
10.	Being workaholic.	26	24	24	22	60	54
11.	Stress	55	50	30	27	25	23
12.	Isolation	66	60	33	30	11	10
13.	Health problem.	47	42	33	30	30	27
14.	Financial issues.	10	9	12	11	88	80

Majority (**eighty one per cent)** of the respondents think that excessive consumption of drugs and alcohol might be the reason for mental illness and merely **four per cent** disagrees to it. Only **one per cent** disagrees that living in an unhealthy and abusive environment can cause mental illness. From the table, it can be understood that people are only aware of the most common reason for mental illness. They are not aware about other reasons like stress, financial issues and unhealthy sleeping pattern will eventually lead to mental illness in some cases.

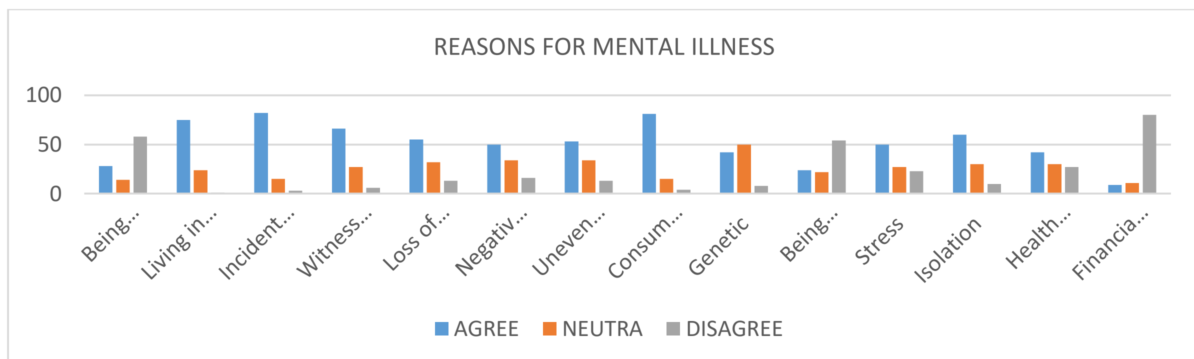


FIGURE 9
REASONS FOR MENTAL ILLNESS

b. Attitude of respondents towards mentally ill people:

Table VIII shows the attitude of respondents towards mentally ill people.

Table- VIII

ATTITUDE OF RESPONDENTS TOWARDS MENTALLY ILL PEOPLE

N=110

S.NO	ATTITUDES	AGREE		NEUTRAL		DISAGREE	
		N	P	N	P	N	P
1.	Mild mental disordered people are capable of pursuing career.	18	16	27	25	65	59
2.	Treat mentally ill people normally.	44	40	44	40	22	20
3.	Afraid to go near a mentally ill person.	34	31	49	45	27	24
4.	Initiate conversation with mentally ill people without hesitation.	25	23	54	49	31	28
5.	Mentally ill people are not capable of having marital life.	41	37	40	36	29	26
6.	Not stigmatized to discuss mental ill problem of family members with others.	39	35	44	40	27	25
7.	Feel curious to know about a person's mental illness.	54	49	51	46	5	5
8.	Feel pity towards mentally ill people.	48	44	48	44	14	12
9.	Mentally ill people should be sent to rehabilitation centre.	40	36	30	27	40	36

Fifty nine per cent of the respondents disagreed that people with mild mental disorders are capable of pursuing career and **sixteen per cent** of the respondents agrees to the statement. **Twelve per cent** of the respondents do not feel pity over them and **five per cent** of the respondents are not curious about how and why an individual get mental illness. The respondents not only think that mentally ill people are incapable, they also are unsure about how to behave with them.

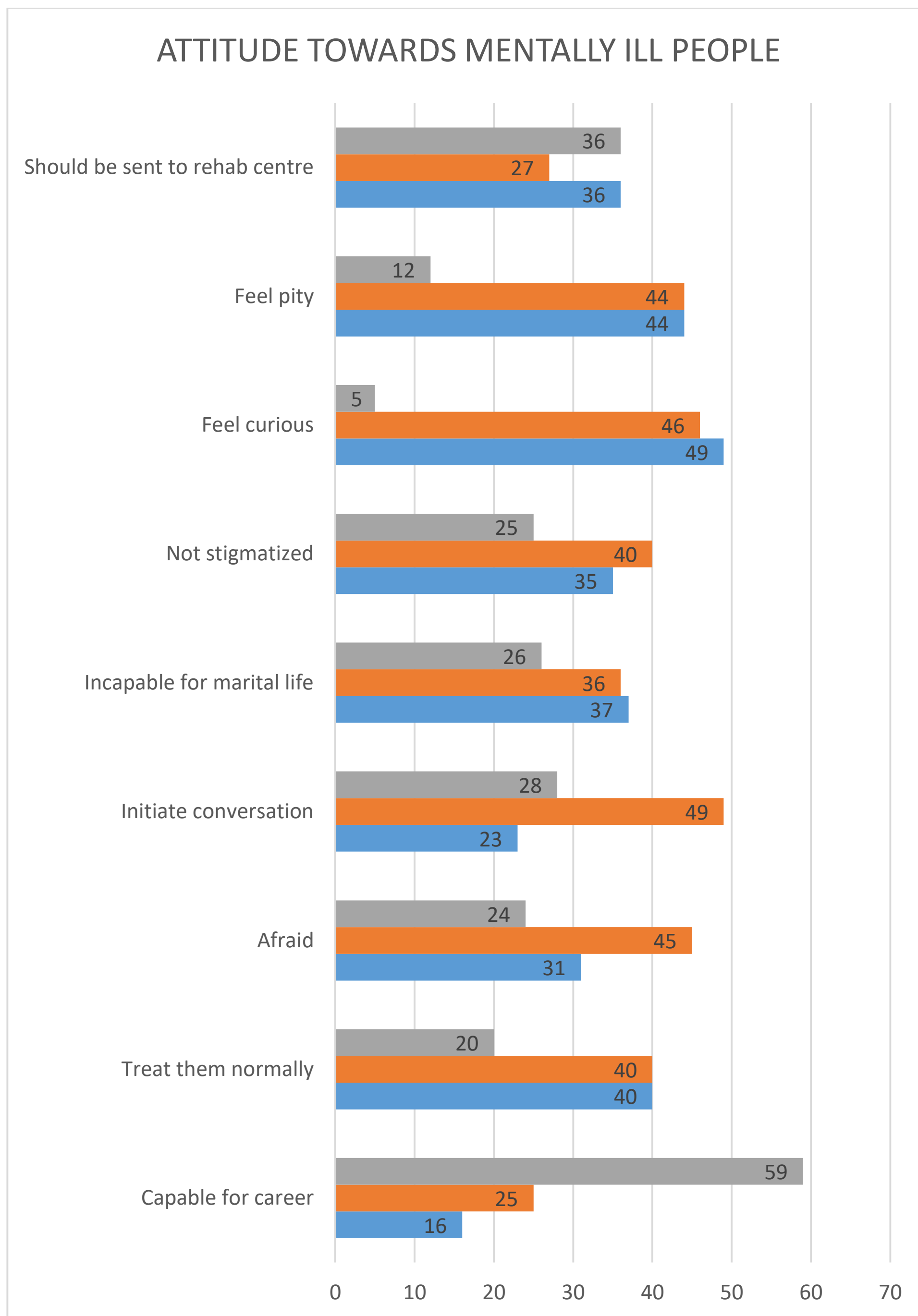


FIGURE 10
ATTITUDE TOWARDS MENTALLY ILL PEOPLE

c. Knowledge about symptoms of stress:

Table IX depicts the knowledge of respondents about meaning and physical symptoms of stress.

Table IX
RESPONDENTS' KNOWLEDGE ON SYMPTOMS OF STRESS

N=110

S.NO	SYMPTOMS	AGREE		MAYBE		DISAGREE	
		N	P	N	P	N	P
1.	Tension in an individual.	101	91	8	7	1	1
2.	Constant worry	96	87	13	12	1	1
3.	Work pressure.	96	87	13	12	1	1
4.	Stress may trigger anger in a person.	88	80	20	18	2	2
5.	Back pain and head ache are symptoms of stress.	56	51	27	24	27	24
6.	Stress can increase blood pressure of a person.	76	69	24	22	10	9
7.	Rapid heartbeat is one of the symptoms of stress.	72	65	31	28	7	6
8.	Caused by person itself.	45	41	21	19	44	40
9.	Stress is caused by external factors alone.	25	23	49	45	36	32

Majority (**ninety per cent**) of the respondents agreed that stress is tension in an individual and **six per cent** of the respondents disagrees that stress can cause rapid heartbeat. **One per cent** of the respondents disagrees that stress is tension in an individual. From the table, it can be interpreted that most of the people understood the meaning of stress and also have over all idea about the symptoms of stress.

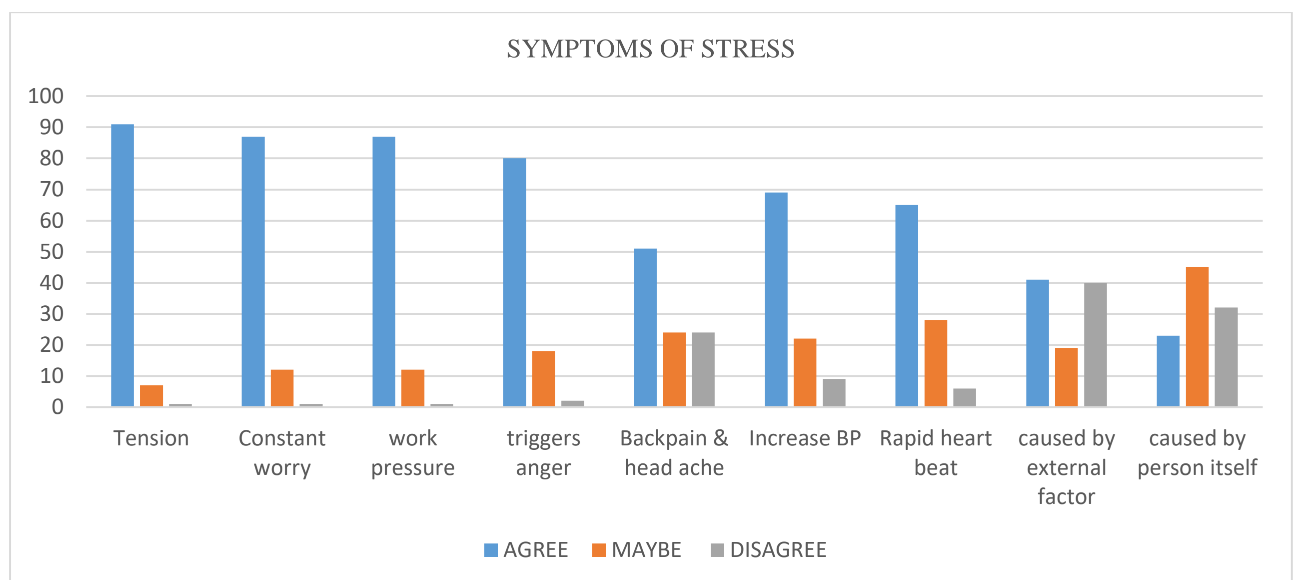


FIGURE 11
SYMPTOMS OF STRESS

d. Awareness on characteristics of depressed people:

Table X expresses knowledge on meaning and symptoms of depression among the respondents.

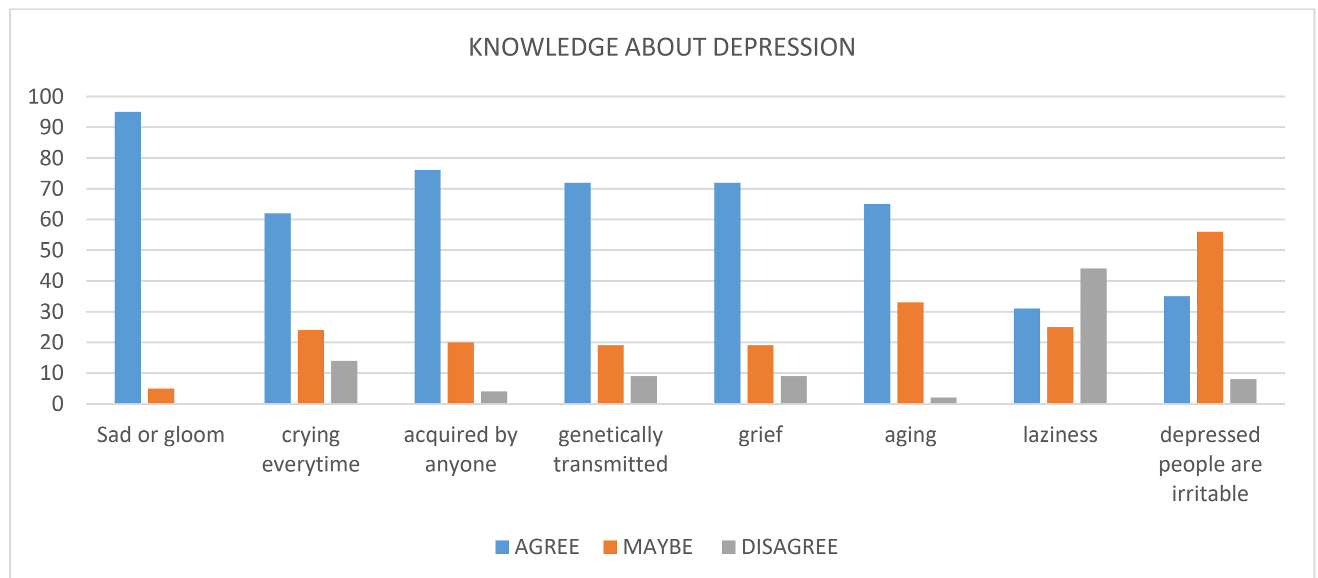
Table X

RESPONDENTS' AWARENESS ON CHARACTERISTICS OF DEPRESSED PEOPLE

N=110

S.NO	CHARACTERISTICS OF DEPRESSED PEOPLE	AGREE		MAYBE		DISAGREE	
		N	P	N	P	N	P
1.	Depression is feeling sad or gloom.	105	95	5	5	--	0
2.	Crying every time.	68	62	26	24	16	14
3.	Anyone can acquire depression.	84	76	22	20	4	4
4.	Transmitted genetically.	79	72	21	19	10	9
5.	Grief cause depression.	79	72	21	19	10	9
6.	It is the result of aging.	72	65	36	33	2	2
7.	Laziness cause depression.	34	31	28	25	48	44
8.	Depressed people often feel irritable for no proper reason.	39	35	62	56	9	8

Majority (**ninety five per cent**) of the respondents agree that depression is feeling sad or gloom. Only **two per cent** of the respondents disagreed that depression is not a part of aging. **Fifty six per cent** of the respondents believe that depressed people might be lazy and **eight per cent** of the respondents disagree to this statement. From the table it can be analysed that Most of the respondents have knowledge about depression but they lack knowledge about characteristics of depressed people.



KNOWLEDGE ABOUT DEPRESSION
FIGURE 12

e. Awareness on anxiety and it's physical symptoms among respondents:

Table XI expresses the awareness of anxiety and its physical symptoms among respondents.

Table XI

RESPONDENTS' AWARENESS ON PHYSICAL SYMPTOMS OF ANXIETY

							N=110
S.NO	**ANXIETY'S PHYSICAL SYMPTOMS**	**AGREE**		**MAYBE**		**DISAGREE**	
		N	**P**	**N**	**P**	**N**	**P**
1.	Being nervous.	99	90	11	10	--	**--**
2.	Constant worry.	85	77	24	22	1	1
3.	Overthinking.	67	61	33	30	10	9
4.	Anyone can acquire anxiety attack.	85	77	17	15	9	8
5.	Caused because of witnessing trauma	85	77	21	19	4	4
6.	Only teenage girls get anxiety.	29	26	28	25	53	48
7.	Having nightmare is one of the symptom of anxiety.	75	68	30	27	5	5
8.	People with anxiety have difficulty in concentrating.	79	72	26	24	5	4
9.	People with anxiety feel tired all the time.	73	66	32	29	5	5
10.	Anxiety attack leads to heart attack.	44	40	25	23	41	37
11.	Physically weak people get anxiety.	47	43	42	38	21	19

Majority (**ninety per cent**) of the respondents agreed that being nervous is anxiety; **four per cent** of the respondents disagree to the fact that people with anxiety have difficulties in concentration. Even though the respondents have knowledge about meaning and characteristics of people with anxiety, they lack knowledge on some of the symptoms of anxiety.

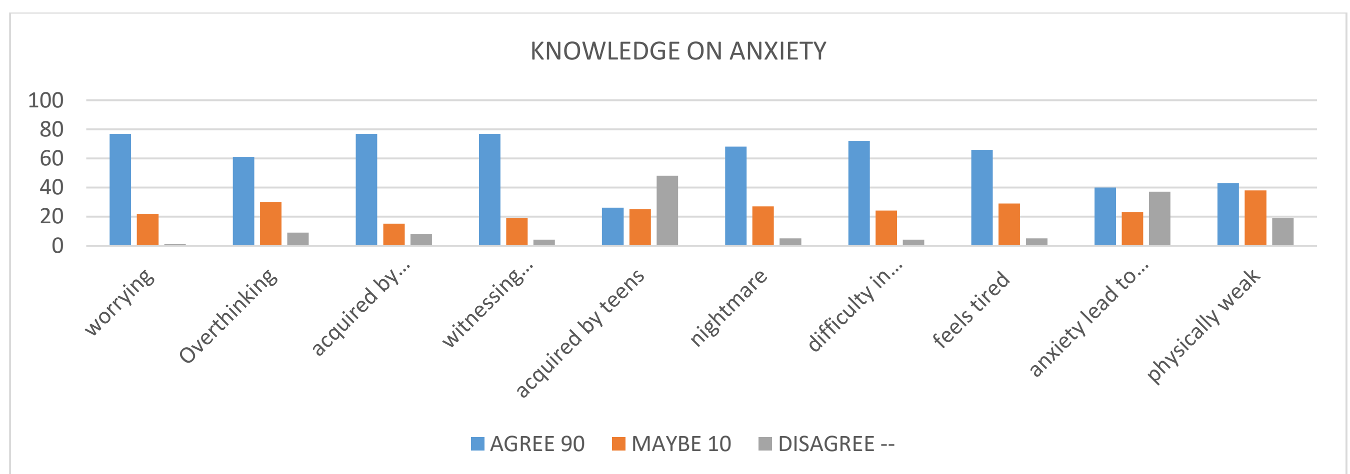


FIGURE 13
KNOWLEDGE ON ANXIETY

D. ANALYZING PHYSICAL & MENTAL HEALTH OF RESPONDENTS:

The details about physical and mental health of respondents are analysed and discussed under the following heads:

a. Reasons for mental stress among respondents.
b. Beck's depression test on respondents.
c. Beck's anxiety test on respondents.
d. General state of mind of respondents.
e. Satisfaction of respondents on various aspects of life.
f. Level of emotional intelligence of respondents.
g. Analysing the physical health of the respondents.

a. Reasons for mental stress among respondents.

Table XII explains the various reasons of stress stated by the respondents

Table-XII
REASONS FOR MENTAL STRESS AMONG RESPONDENTS.

N=110

S.NO	REASONS	AGREE		NEUTRAL		DISAGREE	
		N	P	N	P	N	P
1.	Studies	73	66	4	4	33	30
2.	Work	57	52	26	24	27	24
3.	Unexpected changes in life like moving to new place.	27	24	12	11	71	65
4.	Constant worrying about family and friends.	78	71	24	22	8	7
5.	When I have nothing to do.	42	38	53	48	15	14
6.	Physical health.	41	37	21	19	48	44
7.	Financially inadequate.	37	34	29	26	44	40
8.	Thinking about future.	58	53	25	23	27	24

Seventy one per cent of the respondents agreed that worrying about family and friends cause them stress and only merely **seven per cent** of the respondents disagreed to this statement. **Sixty per cent** of the respondents stated that studies is one of the reason for their stress because most of the respondents are students.

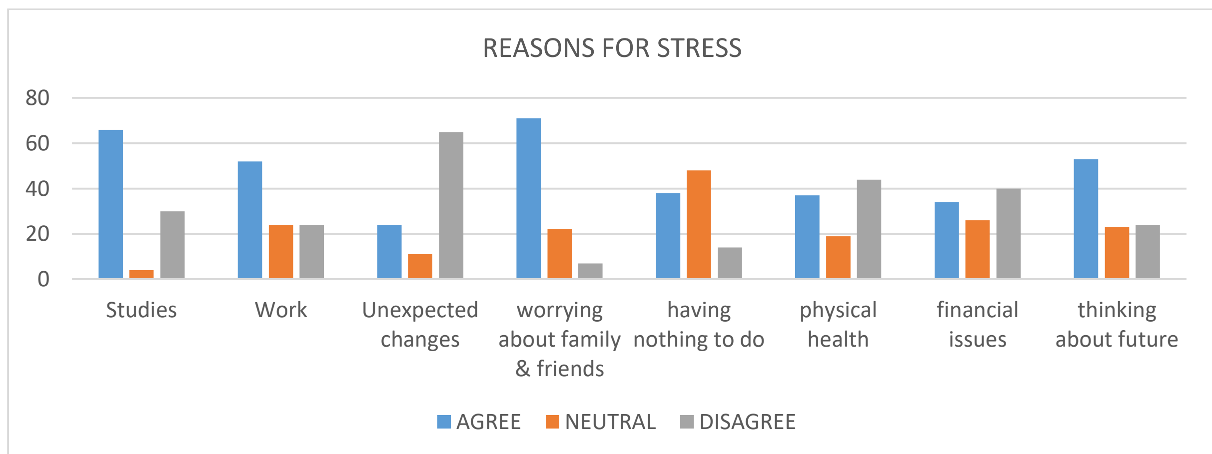


FIGURE 14
REASONS FOR PEOPLE'S STRESS

a. Beck's depression test on respondents.

Table XIII states the depressive symptoms experienced by the respondents.

Table – XIII

BECK'S DEPRESSION TEST ON RESPONDENTS

N=110

S.NO	DEPRESSION SYMPTOMS	OFTEN		SOMETIMES		NEVER	
		N	P	N	P	N	P
1.	I feel sad most of my day.	29	26	57	52	24	22
2.	I feel discouraged when I think about my future.	12	11	70	64	28	25
3.	I feel like I have been failing my entire life.	14	13	61	55	35	32
4.	I feel dissatisfied in everything I do.	12	11	68	62	30	27
5.	I feel guilty for no reason.	22	20	51	46	37	34
6.	I feel like I am not doing adequately in my life	13	12	68	62	29	26
7.	I blame myself if things that are not in my control goes wrong.	9	8	69	63	32	29
8.	I always feel like crying most of the day.	11	10	56	51	43	39
9.	I feel irritated most of my day for no reason.	13	12	61	55	36	33
10.	I am disinterested in other people.	11	10	66	60	33	30
11.	I feel like I am lacking in my decision making skills.	14	13	67	61	29	26
12.	I am inactive most of my day.	15	14	58	53	37	34
13.	I sleep less during night and feel sleepy during day time.	13	12	56	51	41	37
14.	I feel tired most of the day.	11	10	65	59	34	31
15.	I don't have appetite for anything.	8	7	66	60	36	33
16.	My weight keep changing due to my lack of appetite.	13	12	59	54	38	34
17.	I often worry about my health.	20	18	54	49	36	33
18.	I lost interest in meeting other people and maintaining good relationship with people.	9	8	62	56	39	35

Sixty four per cent of the respondents stated that they sometimes feel discouraged when they think about their future. From the Depression scale, it can be evaluated that **fifty six per cent** of the respondents have mild mood disturbance; **Thirty one per cent** of the respondents mood swings are normal and **thirteen per cent** of the respondents have severe depression. Only seven per cent of the respondents stated that they often lack appetite.

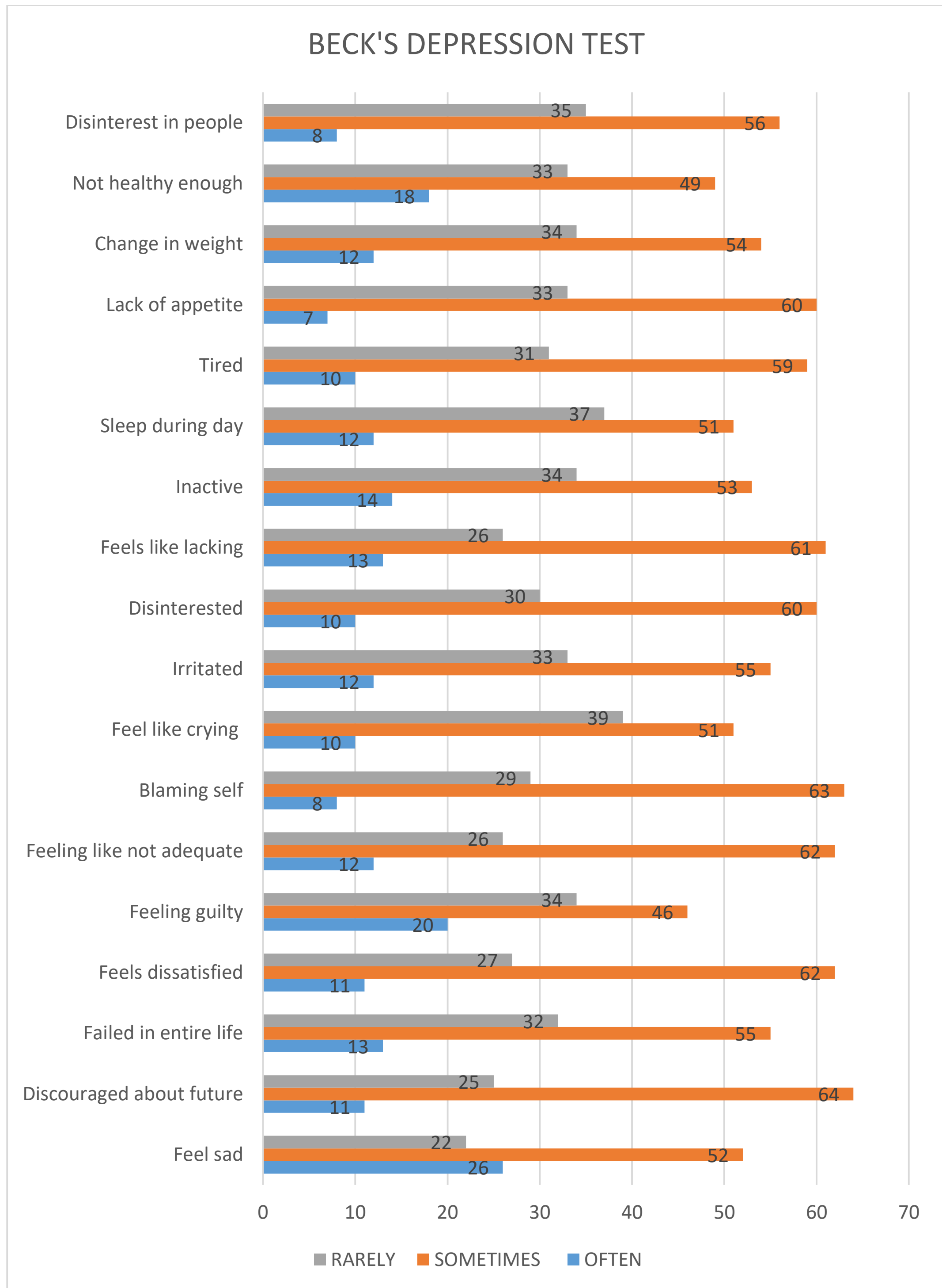


FIGURE 15
BECK'S DEPRESSION TEST ON RESPONDENTS

b. Beck's anxiety test on respondents:

Table XIV shows the anxiety symptoms experienced by the selected respondents.

Table-IV
BECK'S ANXIETY TEST ON RESPONDENTS

N=110

S.NO	ANXIETY SYMPTOMS	NONE		MILDLY		SEVERELY	
		N	P	N	P	N	P
1.	I sometimes feel numb.	61	55	47	43	2	2
2.	I have wobbly legs.	62	56	43	39	5	5
3.	I don't feel relaxed at all.	34	31	65	59	11	10
4.	I always fear of worst happening.	35	32	56	51	19	17
5.	I sometimes feel dizzy	54	49	51	46	5	5
6.	I feel nervous even for small things.	39	35	57	52	14	13
7.	My hands tremble for no reason.	52	47	52	47	7	6
8.	I have indigestion or food aversion.	43	39	56	51	11	10
9.	I always look flustered.	43	39	61	55	6	5
10.	I am experiencing profound sweating.	51	46	53	48	6	5
11.	I have difficulty in breathing.	56	51	48	44	6	5

Fifty nine per cent of respondents mild feel that they are mot relaxed at all. And merely **two per cent** of respondents stated that they feel numb. From the table, it can be interpreted that around **thirty nine per cent** of the respondents have low anxiety; **Forty nine per cent** of respondents have moderate anxiety and **eight per cent** of the respondents have potentially concerning level of anxiety.

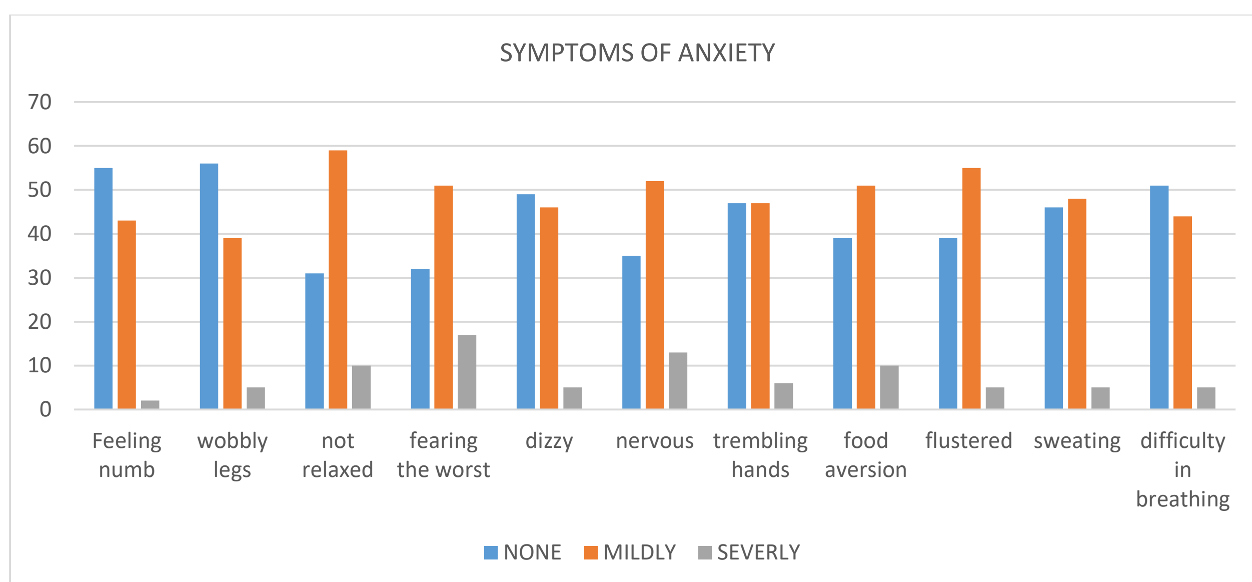


FIGURE 16
SYMPTOMS OF ANXIETY

c. State of mind of respondents:

Table XV states the present state of mind of respondents:

Table-XV

STATE OF MIND OF RESPONDENTS

N=110

S.NO	STATE OF MIND	YES		MAYBE		NO	
		N	P	N	P	N	P
1.	I am 100% physically & mentally healthy.	56	51	28	25	26	24
2.	I discuss my mental discomfort with others.	39	35	31	28	40	36
3.	Sometimes I feel like I need to consult a therapist.	25	23	52	47	33	30
4.	I feel stigmatized to talk about my mental stress	35	32	31	28	44	40
5.	I feel irritable even for small things.	27	24	46	42	37	34
6.	My sleeping pattern is improper.	33	30	38	34	39	35
7.	I have nightmares so I cannot sleep properly.	14	13	39	35	57	52
8.	My appetite is normal.	40	36	39	35	31	28
9.	I feel like I cannot control the happenings in my life.	31	28	41	37	38	34
10.	I always think and worry about my future.	22	20	41	37	47	43
11.	I feel like crying without any reason.	25	23	36	33	49	44
12.	At times, I wonder if I have depression.	26	24	42	38	42	38
13	I isolate myself from others for no reason.	30	27	40	36	40	36
14.	I often avoid public gathering by making fake excuses to friends and families.	28	25	43	39	39	35
15.	I feel left out though others include me in their conversation.	31	28	40	36	39	35

Fifty one per cent of the respondents have agreed that they are physically and mentally healthy and only **twenty three per cent** of the respondents have agreed that they feel like they should consult a therapist. From the table, it can be observed that over half of the respondents think that they are not normal but don't take any actions regarding it.

d. Happiness scale of respondents:

Table XVI portrays about satisfaction level of respondents on aspects such as work, financial management, social relationship, family and marital life, legal issues, communication skills and short term goals.

Table-VI
HAPPINESS SCALE OF RESPONDENTS

							N=110
S.NO	**HAPPINESS SCALE**	**AGREE**		**NEUTRAL**		**DISAGREE**	
		N	**P**	**N**	**P**	**N**	**P**
1.	Satisfied with work.	59	54	26	24	25	23
2.	Satisfied with financial management.	45	41	50	45	15	14
3.	Good social relationship.	47	43	60	54	3	3
4.	Satisfied with family & marital life.	80	73	25	23	5	4
5.	No legal issues so far.	92	84	14	13	4	3
6.	Good communication skills.	52	47	55	50	3	3
7.	Achieved my short term goals.	34	31	26	24	50	45

Majority (**eighty four per cent**) of the respondents agreed that they have no legal issues; **fifty per cent** of the respondents responded neutrally and not much satisfied about their communication skills; and about **forty five per cent** of the respondents are dissatisfied with their goal achievement.

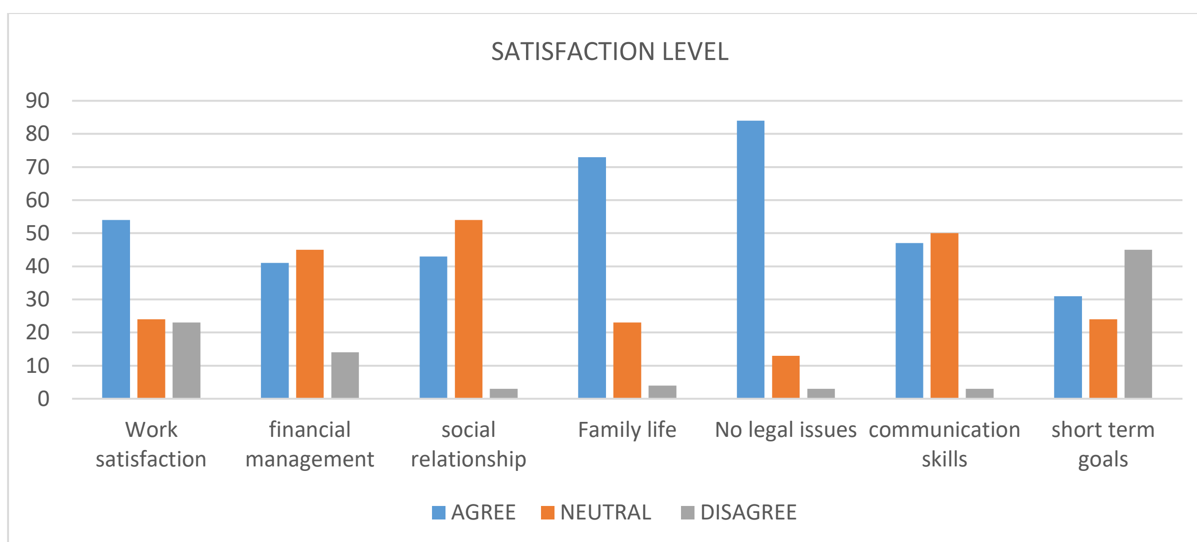


FIGURE 17
SATISFACTION OF PEOPLE

e. Level of emotional intelligence of respondents:

Table XVII expresses the characteristics of emotionally intelligent people.

Table-XVII

LEVEL OF EMOTIONAL INTELLIGENCE OF RESPONDENTS

N=110

S.NO	EMOTIONAL INTELLIGENCE	AGREE		NEUTRAL		DISAGREE	
		N	P	N	P	N	P
1.	I am emotionally a strong person.	61	55	44	40	5	5
2.	I can identify what emotion I feel when I experience them.	40	36	65	59	5	5
3.	I listen well when other people share about their emotions	37	34	68	62	5	5
4.	I know how to calm myself down when I feel stressed.	39	35	62	56	9	8
5.	I give up easily when I experience challenge in pursuing my goals.	24	22	60	54	26	24
6.	I can understand others emotions even though they are not expressive about it.	33	30	68	62	9	8
7.	I set short-term and long-term goals and monitor my progress regularly.	35	32	46	42	29	26
8.	I know my strength and weakness.	36	33	51	46	23	21
9.	I take measures to strengthen my weaknesses.	33	30	49	45	28	25
10.	I am short tempered when I am frustrated.	18	16	59	54	33	30
11.	Others find me more approachable.	45	41	58	52	7	6
12.	I ask help only if situation gets out of control.	37	34	54	49	19	17
13.	I intervene and negotiate conflicts among my friends or family.	34	31	59	54	17	15
14.	I can make spontaneous decisions quickly.	39	35	52	47	19	17
15.	I ask feedback from others about myself to improvise.	23	21	38	34	49	45
16.	Others' feedback alone is what makes me feel assured about my behaviour.	12	19	37	34	61	55

Fifty per cent of the respondents agreed that they are emotionally strong and merely **five per cent** of the respondents have disagreed to this statement. **Sixty per cent** of the respondents neutrally responded to the characteristic that they listen well when others talk about their problem and understand others emotions and **five per cent** of the respondents disagreed to the statement.

f. Analysing the physical symptoms experienced by the respondents:

Table XVIII expresses the physical health of the respondents.

Table XVIII
PHYSICAL SYMPTOMS EXPERIENCED BY THE RESPONDENTS

N=110

S.NO	PHYSICAL SYMPTONS	AGREE		NEUTRAL		DISAGREE	
		N	P	N	P	N	P
1.	I am physically 100% fit.	51	46	25	23	34	31
2.	I take tablets for some health issues.	38	35	21	19	51	46
3.	Does the tablet have any side effects?	31	28	15	14	64	58
4.	I take vitamin tablets.	23	21	15	46	72	65
5.	I feel exhausted at the end of the day.	23	21	56	51	31	28
6.	I have back pain when I sit without any support for a long time.	17	15	53	48	40	36
7.	I cannot stay out on a sunny day for long period of time.	15	14	53	48	42	38
8.	Sometimes, I feel like I lack stamina to do my regular routine.	18	16	49	44	43	40
9.	I feel dizzy or lightheaded when I stand up fast.	16	14	53	48	41	38

Sixty per cent of the respondents disagreed that they take additional supplements of vitamins and **fourteen per cent** of the respondents have shown neutral response. **Fifty one per cent** of the respondents have shown neutral response to the symptom that they are feeling exhausted and **twenty one per cent** of the respondents agreed to this statement; **forty six per cent** of the respondents agreed that they are physically fit and **thirty one per cent** of the respondents answered neutrally.

ANALYSING THE HABITS & PERSONAL PREFERENCE OF THE RESPONDENTS:

The details about analysing the habits and personal preference of the selected respondents are presented under the following head:

a. Social habits of the respondents.
b. Coping mechanism used by the respondents to avoid stress.
c. Mobile using pattern of the respondents.

a. Social habits of the respondents:

Table XIX express the social habits of the respondents.

Table-XIX

SOCIAL HABITS OF THE RESPONDENTS

N=110

S.NO	SOCIAL HABITS	OFTEN		SOMETIMES		NEVER	
		N	P	N	P	N	P
1.	Visit friends & relatives regularly.	48	44	54	49	8	7
2.	Attend all functions & social gatherings.	47	43	56	51	7	6
3.	My relatives and friends find me approachable.	50	45	56	51	4	4
4.	I help my relatives and friends if they ask me.	47	43	52	47	11	10
5.	I feel delighted when my family/friends visit my home.	47	43	56	51	7	6
6.	I organize get togethers because I enjoy being with family and friends.	43	39	62	56	5	4

Fifty six per cent of the respondent's states that they enjoy attending and organizing get together sometimes and **fifty per cent** of the respondent's states that their friends and family find them approachable and merely **four per cent** of the respondents disagreed to the statement. **Six per cent** of the respondents states that they never enjoy organizing and attending get together.

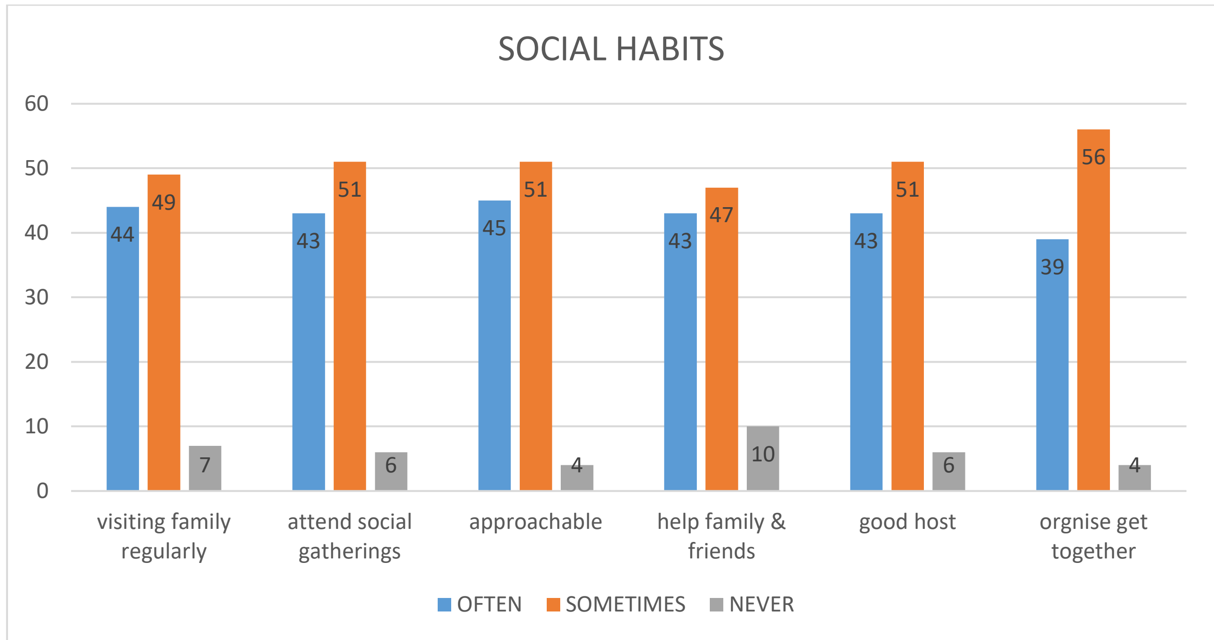


FIGURE 18

SOCIAL HABITS OF PEOPLE

b. Coping mechanism used by the respondents to avoid stress.

Table XX portrays coping mechanism used by respondents to overcome stress.

Table-XX

COPING MECHANISM USED BY THE RESPONDENTS

N=110

S.NO	COPING MECHANISM	OFTEN		SOMETIMES		NEVER	
		N	P	N	P	N	P
1.	Watching movies/ series.	49	45	54	49	7	6
2.	Eating.	42	38	53	48	15	14
3.	Use social media.	63	57	30	27	17	15
4.	I read book to feel relaxed.	6	6	46	51	58	53
5.	Walking/ physical activities.	8	7	28	25	74	67
6.	Drawing/ painting.	26	24	28	25	56	51
7.	Outing with family & friends.	46	42	57	52	7	6
8.	Talking out with family & friends.	38	35	56	51	16	14
9.	Yoga & meditation.	46	42	30	27	34	31
10.	Writing diary.	16	14	32	29	62	56
11.	Visiting temple.	41	37	43	39	26	24
12.	Shopping.	42	38	32	29	36	33
13.	Listening to music.	75	68	30	27	5	5

Sixty eight per cent of the respondents often listen to music when they feel stressed which is followed by **forty nine per cent** of the respondents binge watching movies and series. Only **six per cent** of the respondents read books to relieve themselves from stress. From the table, it can be depicted that most of the respondents follow unhealthy method to cope up with their stress.

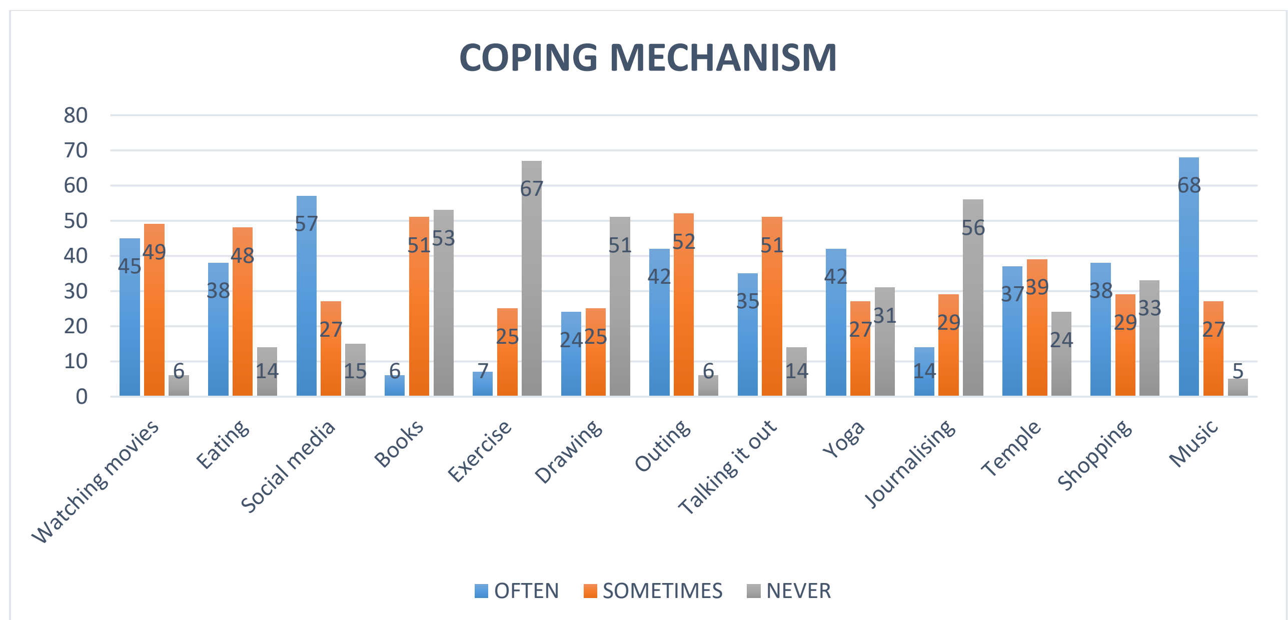


FIGURE 19

COPING MECHANISM

c. Mobile using pattern of the respondents:

Table XXI shows usage of mobile phone by respondents.

Table-XXI

MOBILE USING PATTERN OF THE RESPONDENTS

N=110

S.NO	USAGE	YES		MAYBE		NO	
		N	**P**	**N**	**P**	**N**	**P**
1.	Use mobile more than 4 hours in a day.	93	85	15	14	2	2
2.	Using mobile is part of job. (IT)	22	20	83	75	5	5
3.	Use it for relaxation.	98	89	9	8	3	3
4.	Use it for accessing social media.	84	76	21	19	5	5
5.	Use it to gather daily news.	73	66	33	30	4	4
6.	To run online business.	20	18	87	79	3	3
7.	To play online games.	69	63	29	26	12	11
8.	I feel guilty after using mobile while procrastinating work.	31	28	49	45	30	27
9.	I try to control my mobile usage time, but failed.	25	23	51	46	34	31
10.	I don't feel good when I am without my mobile.	20	18	61	55	29	26
11.	I sometimes miss social gatherings just to use mobile phone.	15	14	68	62	27	24
12.	I use mobile until late at night. So it affect my sleeping pattern.	27	24	53	48	30	27
13.	I get back pain and neck pain due to my sitting position while I'm using mobile.	32	29	43	39	35	32

Majority (**Eighty nine per cent)** of the respondents states that they use mobile for relaxation **eighty five per cent** of the respondents use mobile phone more than 4 hours a day; **sixty eight per cent** of the respondents feel that they maybe be avoiding social gathering just to use mobile phone. From the table, it can be analysed that respondents themselves feel that they have unhealthy way of using mobile phones.

TESTING HYPOTHESES

Table-XXII Pearson's Correlation for testing relationship between education qualification and respondents' knowledge about characteristics of mental health:

Table XXII

PEARSON'S CORRELATION

Correlations

		Education qualification	TOTAL SCORE
Education qualification	Pearson Correlation	1	.657**
	Sig. (2-tailed)		.000
	N	110	110
TOTAL SCORE	Pearson Correlation	.657**	1
	Sig. (2-tailed)	.000	
	N	110	110

** Correlation is significant at the 0.01 level (2-tailed).

HYPOTHESES:

H0: There is a significant relationship between education qualification and knowledge about characteristics of mental health.

H1: There is no significant relationship between education qualification and knowledge about characteristics of mental health.

Pearson's correlation was applied to find out whether there is a significant relationship between education qualification and knowledge about characteristics of mental health. Since the significant value is less than 0.01, the null hypothesis is rejected at 1% level. Hence it is proved that there is no significant relationship between education qualification and knowledge about characteristics about mental health.

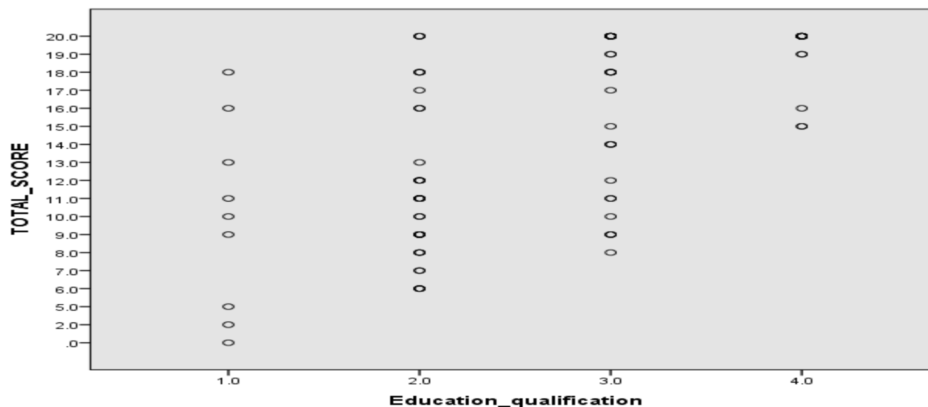


FIGURE 20
CORRELATION OF EDUCATION AND MENTAL HEALTH CHARACTERISTIC

Independent t-test is used for finding relationship between gender and attitude of respondents towards mentally ill people:

T-Test

[DataSet1]

Group Statistics

	GENDER	N	Mean	Std. Deviation	Std. Error Mean
TOTALSCORE	1.0	42	9.310	4.4639	.6888
	2.0	68	8.735	4.5437	.5510

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
TOTALSCORE	Equal variances assumed	.352	.554	.648	108	.518	.5742	.8858	-1.1816	2.3300
	Equal variances not assumed			.651	88.170	.517	.5742	.8821	-1.1786	2.3271

FIGURE 21

INDEPENDENT T-TEST

HYPOTHESIS:

H0: There is a significant difference in male and female attitude towards mentally ill people.

H1: There is no significant difference in male and female attitude towards mentally ill people.

Independent t-test is used to test if there is a relationship between gender and respondents' attitude towards mentally ill people. Since the significant value is more than 0.05, the null hypothesis is accepted and it is proved that there is a relationship between gender and attitude towards mentally ill people.

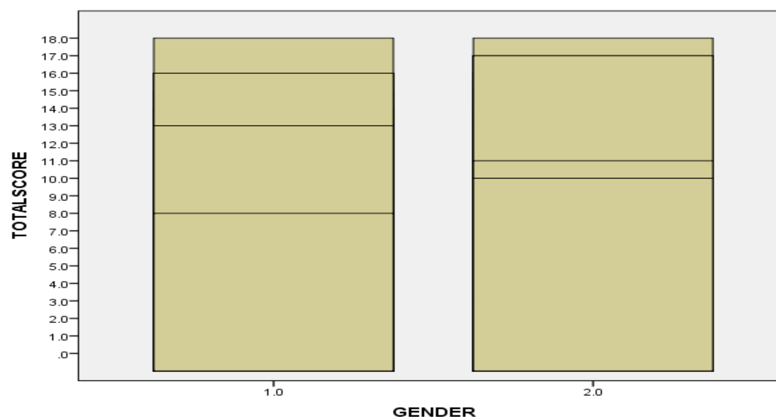


FIGURE 22

T-TEST ON GENDER AND ATTUDUDE TOWARDS PEOPLE WITH MENTAL ILLNESS

CHAPTER V

SUMMARY AND CONCLUSION

The study on "**Analysing the general perception of public on mental health**" was under taken with the following objectives are

OBJECTIVES of the study are as follows:

i.) Analysing the socio demographic characteristics of the selected respondents.

ii.) Studying the perception of people about the victims of mental illness.

iii.) Assessing the stress, depression and anxiety level experienced by the selected respondents.

iv.) Assessing the state of happiness among people.

v.) Knowing the food habits of people.

vi.) Knowing people's view on mental health.

HYPOTHESIS:

1. **H1:** There is no relationship between education qualification and knowledge about characteristics of mental health.
2. **H0:** There is a significant difference between male and female attitude towards mentally ill people.

The area chosen for the present study is Nachipalayam, Kangeyam Road in Tirupur district. A sample of 110 people were selected for this study. The selected samples were between the age group 15 to 70 years. The sampling method used for this study is simple random sampling method. In the present study, interview schedule method is used to elicit information from general public related to socio demographic details, respondents' knowledge on mental health, respondents' mental health and their habit and preferences. The respondents were informed about the questionnaire content prior to the interview schedule and rapport was built. Both dependent and independent variables were used for this study. The collected data was integrated, tabulated, analysed and interpreted using SPSS (Statistical Package of Social Science), an analytical software. Pearson's Correlation and Independent variable t-test was used for testing hypotheses. The findings are interpreted in the following chapter.

The major highlights of the study are as follows:

SOCIO-DEMOGRAPHIC DETAILS OF THE RESPONDENTS:

Twenty eight per cent of the respondents belongs to the age group range 15-25, followed by 25 per cent of the respondents belonging to the age group 26-35, 17 per cent of the respondents belonging to the age group range 36-45, 18 per cent of the respondents belonging to the age group range 46-55, 6 per cent of the respondents belonging to the age group range 56-65 and 5 per cent of the respondents belonging to the age group 66 & above.

Sixty two per cent of the respondents are female and 38 per cent of the respondents are male.

Sixty per cent of the respondents belong to nuclear family, 37 per cent of the respondents belong to joint family and 8 per cent of the respondents belong to extended family.

Sixty six per cent of the respondents are married and 34 per cent of the respondents are single.

Thirty five per cent of the respondents have completed up to under graduate, 36 per cent of the respondents have completed up to high school, 22 per cent of the respondents have completed post graduate and 10 per cent of the respondents have studied up to high school.

Twenty five per cent of the respondents are students, 22 per cent of the respondents are home makers, 19 per cent of the respondents are engaged in business, 14 per cent of the respondents are in IT field, 7 per cent of the respondents are engaged in agricultural and banking sector and 5 per cent of the respondents are engaged in profession such as teacher, professor and doctor.

Forty five per cent of the respondents' annual income is between 2L-3L followed by 24 per cent of the respondents' annual income between 3L-4L, 17 per cent of the respondents' annual income between 1L-2L and 14 per cent of the respondents annual income is 4L & above.

KNOWLEDGE ABOUT MENTAL HEALTH AMONG RESPONDENTS:

Eighty seven per cent of the respondents stated that mental health is associated with physical health, 36 per cent of the respondents answered neutrally to statement that mental health aids in decision making and 60 per cent of the respondents disagreed to mental health being related to IQ.

Ninety per cent of the respondents agreed that their source of knowledge about mental health is by watching movies and 87 per cent of the respondents do not have educational background related to psychology or mental health.

Twenty three per cent of the respondents are aware that Disability act care for people's individual need and 87 per cent of the respondents are not aware about National Trust Act.

Eighty per cent of the respondents think that youngsters should be involved in spreading awareness about mental health laws and act; 75 per cent of the respondents think that mental health day may be celebrated to spread awareness about mental health and 41 per cent of the respondents think that mental health act alone is sufficient to protect rights of mentally ill people.

KNOWLEDGE ABOUT MENTAL ILLNESS:

Eighty two per cent of the respondents agreed that mental illness is caused due to accidents and incidents; 50 per cent of the respondents answered neutrally to mental illness being genetically transmitted and 80 per cent of the respondents does not believe that financial issues and stress can cause mental illness.

Forty nine per cent of the respondents agrees that they feel curious to know about a person's mental illness; 49 per cent of the respondents answered neutrally when they were asked if they could initiate a conversation with mentally ill people without hesitation and 59 per cent of the respondents states that people with mild mental disorders are not capable of pursuing career.

Ninety one per cent of the respondents agrees that stress is tension in an individual; 45 per cent of the respondents think that external factors alone may be the cause of stress and 40 per cent of the respondents think that rapid heartbeat is not a symptom of stress.

Ninety five per cent of the respondents agree that depression is a feeling of sad and gloom; 56 per cent of the respondents think that depressed people may feel irritable for no reason and 44 per cent of the respondents disagree that laziness cause depression.

Ninety per cent of the respondents think that anxiety is being nervous, 38 per cent respondents think that being physically weak might cause anxiety and 48 per cent of the respondents think that teen age girls alone do not acquire anxiety.

ANALYZING PHYSICAL & MENTAL HEALTH OF RESPONDENTS:

Seventy one per cent of the respondents agree that worrying about family and friends cause them stress; 48 per cent of the respondents think that they may be stressed when they

have nothing to do and 65 per cent of the respondents think that unexpected changes in life do not cause them stress.

Twenty six per cent of the respondents stated that they often feel sad most of the day; 64 per cent of the respondents stated that they sometimes feel discouraged when they think about their future and 39 per cent of the respondents stated that they never feel like crying.

Fifty six per cent of the respondents stated that they never had wobbly feeling in their legs, 59 per cent of the respondents stated that they sometimes do not feel relaxed at all and 17 per cent of the respondents stated that they always fear of worst happening to them.

Fifty one per cent of the respondents think that they are physically and mentally fit; 47 per cent of the respondents stated that they sometimes feel like consulting a therapist and 52 per cent of the respondents stated that they do not have nightmares.

Eighty four per cent of the respondents agreed that they do not have any legal issues; 54 per cent of the respondents answered neutrally to the statement that if they have good social relationship and 45 per cent of the respondents disagreed that they have achieved their short term goals.

Forty six per cent of the respondents stated that they do not have any physical health issues; 51 per cent of the respondents stated that they sometimes feel exhausted and 65 per cent of the respondents do not take any additional vitamin supplements.

ANALYSING THE HABITS & PERSONAL PREFERENCE OF THE RESPONDENTS:

Ninety per cent of the respondents agree that they often eat more than 3 times a day; 57 per cent of the respondents stated that they sometimes intake food with high oil content and 56 per cent of the respondents stated that their daily diet have healthy grains apart from carbs.

Forty five per cent of the respondents stated that their friends and family find them approachable; 56 per cent of the respondents stated that they sometimes organize get together to be with friends and families and 10 per cent of the respondents stated that others don’t find them approachable.

Forty per cent of the respondents stated that they often prefer to go out with friends and family in their free time; 55 per cent of the respondents only initiate conversation sometimes in gatherings and 44 per cent of the respondents never take any initiatives.

Eighty nine per cent of the respondents prefer to watch movies during their long holidays; 41 per cent of the respondents sometimes prefer to spend their holidays productively and 57 per cent of the respondents do not prefer adventurous activities.

Sixty eight per cent of the respondents often listen to music when they are stressed; 52 per cent of the respondents go outing with family and friends sometimes and 56 per cent of the respondents do not prefer to journalise when they are stressed.

Eighty nine per cent of the respondents use mobile phone for relaxation; 75 per cent of the respondents sometimes use mobile because it is part of their profession; Only 32 per cent of the respondents stated that they do not have any physical pain due to sitting position while using mobile phone.

TESTING HYPOTHESES:

Pearson's correlation was applied to find out whether there is a significant relationship between education qualification and knowledge about characteristics of mental health. Since the significant value was less than 0.01, the null hypothesis is rejected at 1% level of confidence interval.

Independent t-test was used to test if there is a relationship between gender and respondents' attitude towards mentally ill people. Since the significant value was more than 0.05, the null hypothesis is accepted and it is proved that there is a relationship between gender and attitude towards mentally ill people.

CONCLUSION:

Mental health is a social and psychological well-being. It makes people feel, think and act in a better way. This study aimed to understand how the respondents (Public people) perceive the term mental health. It was analysed on various ways such as testing public people's knowledge about mental disorders, causal factors of mental illness and their attitude towards mentally ill people. It can be concluded that the respondents have basic knowledge about mental health and its importance but they have wrong perception about mental illness and mentally ill people. This was the case irrespective of the respondents' education qualification. This is the situation because most of the people's source of knowledge on mental illness was by watching movies. People should use more reliable source to learn about such sensitive topics.

People's mental health was also tested by using Beck anxiety and depression scale and stress symptoms list. More than half of the people have mild mood disturbances. They still do not think about consulting therapist because they still feel stigmatised to open up about their feelings. Some even stated that treatment will not be much effective. People's coping mechanism was also analysed and more than half of the selected people use social media as their coping mechanism and it is not a healthy way to manage stress.

From this study, it can be concluded that people don't have much knowledge about mentally ill people and how to treat them and they fail to give more importance to their own mental health and never seek professional help.

Recommendation to Public:

1. People should use a healthy way to de-stress themselves.
2. People should trust only reliable source to read about mental illness.
3. People should consult therapist if they feel low without feeling stigmatised.
4. People should discuss about mental health and illness only if they are very sure about the topic.

Recommendation to Government:

1. Government should focus on other mental disorders like clinical depression, anxiety and bi-polar since these are becoming more common nowadays.
2. Government should initiate on spreading awareness on mental health from starting from school level.

Recommendation to parents:

1. Parents should monitor their children without overprotecting them.
2. Parents should monitor their children's mobile using pattern.
3. Parents should spend time with their children and make them open up about their feelings in case they are hesitant.

Recommendation to Students:

1. College students should take initiative to spread awareness on mental health to people who are unaware about it.
2. Students whose education background is related to psychology should focus on conducting community organization program in rural areas regarding mental health improvisation.
3. Students should be more aware of Acts that strive for the rights of mentally ill people.

BIBLIOGRAPHY

- Adrija Roy, Arvindh Kumar(2020), "Mental health implications of COVID-19 pandemic and its response in India", International Journal of Social Psychiatry", Vol.67, No.5.

- Asha Sharma (2019), "Perception and its effect on judgement", Journal of Management Research and Analysis, Vol.6, No.4, 164-168.
- Amy E. Pinkham (2016), "Paranoid individuals with schizophrenia show greater social cognitive bias and worse social functioning than non-paranoid individuals with schizophrenia", Elsevier Inc, Vol.3, 33-38.
- Andre Pittig Et al (2018), "The role of associative fear and avoidance learning in anxiety disorders", National Centre for Biotechnology Information, Vol.8, 117-140.
- Annie B Fox, Valerie A Earnshaw (2019), "Conceptualizing and measuring mental illness stigma, National Centre for Biotechnology Information, Vol.3, No.4, 348-376.
- Catherine Bouchard (1999), "Responsibility and perfectionism in OCD: an experimental study" Vol.37, No.3, 239-248.
- Cha, M. Y., & Carrier, C. (2016) "Contingent faculty perceptions of organizational support, workplace attitudes" J Study Postsecondary Tertiary Educ. Vol. 16, No.1, 121-151.
- Daniel Bradies, "Non-pharmacological Interventions for ADHD", The American Journal of Psychiatry, Vol.170, 271-289.

- Daniel J Fridberg, (2013) "Neural correlates of performance monitoring in chronic cannabis users and cannabis-naive controls", National Centre for Biotechnology Information, Vol. 27, No.6, 515-525.
- David M G Lewis, (2022) "Error Management Theory and biased first impressions", Elsevier, Vol. 43, No.2, 87-96.
- David. L. Corsun, (2008) "Overcoming managers' perceptual shortcuts through improvisational theatre games", Journal of Management Development, Vol.25, No.4.
- Deena Dimple Desouza, "Online Gaming During the COVID-19 Pandemic in India", Nature Public Health Emergency Collection, Vol.20, No.1, 296-302.

- Dhiksha Kashyap (2017), “Value Perception among High School Students, A gender wise analysis”, Indian Journal of Applied Research, Vol.7, No.9

- Emil Kraepelin (2010) “Hebephrenia - a viable psychopathological construct”, National Centre for Biotechnology Information, Vol.89, No.1, 18-26.
- Emma C Palmer (2018), “Evaluation of perceptions and knowledge of mental illness in the United States through crowdsourcing”, Mental Health Clinician, Vol.8, No.5, 227-234
- Eshetu Girma, “Public Stigma against People with Mental Illness in the Gilgel Gibe Field Research Centre”, Plos One, Vol.10, 137.

- Galliher (2007), “Emory Bogardus and the Origins of the Social Distance Scale”, American Sociology”, Vol. 38, No.4, 383-395.

- Fahad Riaz Choudhry, (2016) “A systematic review of mental health literacy in Pakistan, Asia Pacific-Psychiatry, Vol.12, No.4.

- Frank W Weathers, “Clinician-administered PTSD scale: A review of the first ten years of research”, Journal of Traumatic Stress, Vol.13, No.3, 132-156.

- Guilio Gabrieli (2021), “An Analysis of the Generalizability and Stability of the Halo Effect during the COVID-19 Pandemic Outbreak”, National Centre for Biotechnology Information, Vol.12, No.63.
- Heather Stuart (2012), “Media Portrayal of Mental Illness and its Treatments”, Springer Nature, Vol.20, No.6, 99-106.
- Ioana Todor, (2013) “Opinions about Mental Illness”, Elsevier, Vol.82, 209-2014.
- J.F Coeterier (1996), “Dominant attributes in the perception and evaluation of the Dutch landscape”, Elsevier Publication, Vol.34, No.1.

- Joelle LeMoult (2020), “From Stress to Depression: Bringing Together Cognitive and Biological Science”, Journal of Sage, Vol.29, No.6.

- John H. Boman (2015), “level error correlations correct for projection bias in perceived peer deviance measures”, American Psychiatric Association, Vol.32, No.1, 89-102.

- Joseph Reitz (2017), “The external control of organizations”, Academy of Management Review, Vol.4, No.2.

- Juan Bueno Notivol, (2020), “Prevalence of depression during the COVID-19 outbreak”, International Journal of Clinical and Health Psychology, Vol. 21, No.1

- Dr. Jung Juo, (1992) “Effects of contrast ratio and text color on visual performance with”, International Journal of Industrial Ergonomics, Vol.31, No.2, 65-72.

- L. Losenthal, (2016) “Stereotypes of Black American Women Related to Sexuality and Motherhood”, Psychology of Women, Vol.40, No.3.

- Louis Jolyon West, (2006) “The Anatomy of Illusion: Religious Cults and Destructive Persuasion”, American Journal of Psychiatry, Vol.145, No.1, 123-124.

- M.Snyder, (2016) “(Dis) similarity in Impulsivity and Marital Satisfaction: A Comparison of Volatility, Compatibility, and Incompatibility Hypotheses”, National Centre for Biotechnology Information, Vol.61, 35-49.

- Marcus YL Chiu, (2007) “Community Attitudes towards Discriminatory Practice Against People with Severe Mental Illness”, International Journal of Social Psychiatry, Vol.53, No.2, 159-174.
- Narayan Gopalakrishnan, (2018), “Burden of mental illness: a review in an Indian context”, International Journal of Culture and Mental Health, Vol.11, No.4, 553-563.

- Patrick W Corrigan (1998), “How Stigma Interferes With Mental Health Care”, Journal of American Psychology, Vol.59, No.7, 614-625.

- Perry Hilton (2017), “Implicit stereotypes and the predictive brain: cognition and culture in “biased” person perception”, Humanities & Social Sciences Communications, Vol.33, No.17.

- Peter Kok (2018), “Expectation Shaping Perception”, Cognitive Sciences, Vol.22, No.9,
- 764-779.

- Robert Sigstrom, “Changes in the expression of worries, anxiety, and generalized anxiety disorder with increasing age”, International Journal of Geriatric Psychiatry, Vol.34, No.2, 249-257.

- S Saldivia (2014), “The Maristán stigma scale: a standardized international measure of the stigma of schizophrenia and other psychoses”, BMC Psychiatry, Vol.14, No.6, 182.

- Salima Al Mashrafi (2020), “Determinants Affecting the Perception toward Mental Health Problems among Residents at Oman Medical Specialty Board”, Clinical and Experimental psychology”, Vol.6, No.1, 1-4.
- Sebastin Gyamti, (2018) “Individual factors that influence experiences and perceptions of stigma and discrimination towards people with mental illness in Ghana”, National Centre for Biotechnology Information, Vol.27, No.1, 368-377.
- Tevfik Bedirhan (2017), “WHO Perspectives on International Classification”, National Centre for Biotechnology Information, Vol.35, No.2, 62-66.

- Tim J. Hartung, “The Generalized Anxiety Disorder Screener (GAD-7) and the anxiety module of the Hospital and Depression Scale”, Journal of the Psychological, Behavioural and Social Dimension of Cancer, Vol.27, No.6, 1509-1516

- Vasudevan Mani (2016), “Beliefs and perception about mental health issues: a meta-synthesis”, National Centre for Biotechnology Information, Vol.12, 2807-2818.
- Victoria Sivrais (2018), “Perception studies: A review article”, Clermont Partner, Vol.18, No.26, 33-39.

- Watson, Clark, & Tellegen, “Development and validation of brief measures of positive and negative affect: The PANAS scales”, American Psychological Association, Vol.56, No.4, 1063-1070.
- Winifred Strange, (2011) “Automatic selective perception (ASP) of first and second language speech”, Journal of phonetics, Vol.39, No.4, 456-466.

WEBSITE:

- https://www.medicalnewstoday.com/articles/323454?c=913750179725#prevention
- https://www.simplypsychology.org/halo-effect.html
- https://www.psycom.net/paranoid-schizophrenia
- https://www.webmd.com/schizophrenia/mental-catatonic-schizophrenia-overview
- https://www.mdpi.com/1424-8220/21/1/159
- https://www.medicalnewstoday.com/articles/undifferentiated-schizophrenia#what-it-is
- https://www.verywellmind.com/perception-and-the-perceptual-process-2795839
- https://www.healthline.com/health/psychotic-disorder
- https://www.verywellmind.com/what-are-hallucinations-378819
- https://www.clermontpartners.com/blog/perception-studies/
- https://www.sciencedirect.com/topics/medicine-and-dentistry/positive-and-negative-affect-schedule

APPENDIX
Analysing the General Perception of Public on Mental Health
QUESTIONNAIRE

I. GENERAL INFORMATION:

1. Name:
2. Age:
3. Phone number:
4. Mail ID:
5. Address:
6. Name of the institution studying/ working:

II. SOCIO DEMOGRAPHIC DETAILS OF SELECTED PEOPLE

CATEGORY	TICK BELOW	
Gender	Male	
	Female	
Caste	SC	
	ST	
	MBC	
	BC	
	OC	
Religion	Hindu	
	Muslim	
	Christian	
Family type	Nuclear	
	Joint	
	Extended	
Marital status	Single	
	Married	
Education qualification	Primary school	
	Higher secondary	
	Diploma courses	
	Graduate	
	Post graduate	
Occupation	Government employee	
	Private employee	
	Self-employed	
	Un-employed	

III. PUBLIC PEOPLE'S KNOWLEDGE ON MENTAL HEALTH:

a. Questions on public people's awareness of mental health.

S.NO	KNOWLEDGE	AGREE	NEUTRAL	DISAGREE
1.	Mental health is associated with physical health.			
2.	Mental health is social and emotional well-being.			
3.	A person with good mental health can maintain good relationship with others.			
4.	Mental health affect how you feel, think and act.			
5.	A person with good mental health have good decision making skills.			
6.	A person with good mental health is more empathetic.			
7.	Intelligent people re not necessarily mentally healthy.			
8.	Mental health and IQ is not related			
9.	Mental health is not just absence of mental disorders.			
10.	Mental health is as important as physical health.			

b.) Questions on public people’s awareness and opinion about mental health day and mental health laws.

S.NO	STATEMENT	AGREE	NEUTRAL	DISAGREE
1.	Mental health day is celebrated on October 10.			
2.	Mental health day is celebrated to spread awareness on mental health issues.			
3.	There is a federation for mental health found by WHO.			
4.	IDEA take care of individual needs of disabled people.			
5.	There should be regular upgrade on Mental Health Act every year			
6.	Youngsters in school and college should be involved in spreading awareness on mental health.			
7.	Mental Health Act alone is not enough to protect rights of mentally disabled people.			

c.) Questions on factors causing mental illness:

S.NO	FACTORS	AGREE	NEUTRAL	DISAGREE
1.	Mental illness can be caused if a person is not disciplined.			
2.	If a person live in unhealthy and abusive environment, his/her mental health will be affected.			
3.	Brain injury in an accident may result in mental illness.			
4.	If a person have witnessed a traumatic incident especially in their childhood, it may result in mental illness.			
5.	Grief and loss can cause mental illness.			
	Having negative thoughts can lead to mental illness.			
7.	Unhealthy habits like uneven sleeping pattern result in mental illness.			
8.	Use of drugs and alcohol continuously leads to mental illness.			
9.	If any person’s family member has a history of mental illness, then he/she most likely			

	develop mental health issues.			
10.	Mental illness is a result of wrong doing a person have committed during his/her previous birth.			

IV. PUBLIC PEOPLE'S ATTITUDE TOWARDS MENTALLY ILL PEOPLE:

S.NO	ATTITUDES	AGREE	NEUTRAL	DISAGREE
1.	People with mild mental disorders are capable of pursuing career.			
2.	People with mental illness deserve equal treatment like normal people.			
3.	I am afraid to even go near a mentally ill person.			
4.	I can initiate a conversation with mentally ill person without hesitation.			
5.	They are not capable of having a happy marital life.			
6.	I feel comfortable to discuss the mental health issue of my family/ peers with others.			
7.	When I see a person with mental disability, I feel curious to know about it.			
8.	I feel pity when I see a person with mental disability.			
9.	One should not keep a person with disability at home.			

V. PUBLIC PEOPLE'S SOURCE OF KNOWLEDGE ON MENTAL HEALTH

S.NO	SOURCES	YES	MAYBE	NO
1.	I have learnt about mental illness and people with mental illness by watching movies.			
2.	I know about mental health because I hold degree in psychology/social work.			
3.	I learnt about mental health through newspaper articles.			
4.	I came to know about mental illness and health through social media and books.			
5.	I know about mental illness through peers and family talks.			
6.	I know about mental illness and mental health because have consulted a therapist for my own mental stress and disturbance.			
7.	I have a family member who is a therapist.			

VI. PUBLIC PEOPLE'S MENTAL HEALTH:

a.) General questions on people's feeling of gloom and mood swings.

S.NO	STATEMENTS	YES	NO	MAYBE
1.	I can say that I am 100% mentally and physically healthy.			
2.	I feel comfortable to talk to others when I feel mentally discomfort.			
3.	Sometimes I feel like I need to consult a therapist.			
4.	I feel stigmatized to talk about my mental stress			
5.	I think mental health and physical health are related.			
6.	I feel irritable even for small things.			
7.	My sleeping pattern is improper.			
8.	I have nightmares so I cannot sleep properly.			
9.	My appetite is normal.			
10.	I feel irritable even for small things.			
11.	I feel like I cannot control the happenings in my life.			
12.	I always think and worry about my future.			
13.	Sometimes I feel like crying without any reason.			
14.	At times, I wonder if I have depression.			
15.	I isolate myself from others for no reason.			
16.	I often avoid public gathering by making fake excuses to friends and families.			
17.	I feel left out even if others include me in their conversation.			

b. Knowing about public people's knowledge on stress:

S.NO	KNOWLEDGE	FACT	SLIGHTLY TRUE	FALSE BELIEF
1.	Stress is tension of an individual.			
2.	Stress is constant worrying or work pressure.			
3.	Stress may trigger anger in a person.			
4.	Back pain and head ache are symptoms of stress.			
5.	Stress can increase blood pressure of a person.			
6.	Rapid heartbeat is one of the symptoms of stress.			
7.	The person itself is the only reason for his/her stress.			
8.	Stress is caused by external factors alone.			

c. List of reasons for public people's stress:

S.NO	REASONS	AGREE	NEUTRAL	DISAGREE
1.	I feel stressed because of my studies.			
2.	I feel stressed because of my work.			
3.	Unexpected changes in life like moving to new place can increase my stress.			
4.	Constant worrying about family and friends cause my stress.			
5.	I feel stressed when I have nothing to do.			
6.	I feel stressed when I think about my physical health.			
7.	I feel stressed when I am financially inadequate.			
8.	My stress increases when I think about my future.			
9.	I feel stressed when I think about my career life.			

VII. PUBLIC PEOPLE'S WAY OF MANAGING STRESS:

S.NO	ACTIVITIES	OFTEN	SOMETIMES	NEVER
1.	I continuously watch movies/series when I am stressed.			
2.	I continuously eat when I am stressed.			
3.	I use social media as my stress buster.			
4.	I read book to feel relaxed.			
5.	I go for a walk or do physical exercise to feel relaxed.			
6.	I draw or paint to feel relaxed.			
7.	I go out with friends and family to relax myself.			
8.	Talking about my mental stress with friends and family makes me feel relaxed.			
9.	I do yoga and meditation to feel relaxed.			
10.	Writing diary makes me feel relaxed.			
11.	I visit temple to feel relaxed.			
12.	I go for shopping to feel relaxed.			
13.	I listen to music to feel relaxed.			

VIII. DEPRESSION TEST ON PUBLIC PEOPLE:

a.) People's knowledge on depression.

S.NO	KNOWLEDGE	FACT	SLIGHTLY TRUE	FALSE BELIEF
1.	Depression is feeling sad or gloom.			
2.	If a person is crying for even small things, then he/she is suffering from depression.			
3.	Anyone can acquire depression.			
4.	If a person's blood relative is suffering from depression, then he/she will most likely have depression.			
5.	If a person has lost his or her loved ones, then he/she will definitely suffer from depression.			

6.	Most of the adolescent people and old age people suffer from depression.			
7.	Depressed people are lazy in nature.			
8.	Depressed people often feel irritable for no proper reason.			

b.) Beck's depression scale:

S.NO	SYMPTOMS	OFTEN	RARELY	NEVER
1.	I feel sad most of my day.			
2.	I feel discouraged when I think about my future.			
3.	I feel like I have been failing my entire life.			
4.	I feel dissatisfied in everything I do.			
5.	I feel guilty for no reason.			
6.	I feel like I am not doing adequately in my life.			
7.	I blame myself if things that are not in my control goes wrong.			
8.	I always feel like crying most of the day.			
9.	I feel irritated most of my day for no reason.			
10.	I am disinterested in other people.			
11.	I feel like I am lacking in my decision making skills.			
12.	I am inactive most of my day.			
13.	I sleep less during night and feel sleepy during day time.			
14.	I feel tired most of the day.			
15.	I don't have appetite for anything.			
16.	My weight keep changing due to my lack of appetite.			
17.	I often worry about my health.			
18.	I lost interest in meeting other people and maintaining good relationship with people.			

IX. ANTIETY TEST ON PUBLIC PEOPLE:

a.) People's knowledge on anxiety.

S.NO	KNOWLEDGE	FACT	SLIGHTLY TRUE	FALSE BELIEF
1.	Anxiety is being nervous.			
2.	Anxiety is constantly worrying about something.			
3.	Anxiety is acquired due to overthinking.			
4.	Anyone can acquire anxiety attack.			
5.	People who experienced trauma is more prone to anxiety			
6.	Only teenage girls get anxiety.			
7.	Having nightmare is one of the symptom of anxiety.			
8.	People with anxiety have difficulty in concentrating.			
9.	People with anxiety feel tired all the time.			
10.	Anxiety attack leads to heart attack.			

X. TESTING EMOTIONAL INTELLIGENCE OF PEOPLE

S.NO	STATEMENT	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1.	I am emotionally a strong person.					
2.	I can identify what emotion I feel when I experience them.					
3.	I listen well when other people share about their emotions.					
4.	I know how to calm myself down when I feel stressed.					
5.	I give up easily when I experience challenge in pursuing my goals.					
6.	I can understand others emotions even though they are not expressive about it.					
7.	I set short-term and long-term goals and monitor my progress regularly.					
8.	I know my strength and weakness.					
9.	I take measures to strengthen my weaknesses.					
10.	I am short tempered when I am frustrated.					
11.	Others find me more approachable.					
12.	I ask help only if situation gets out of control.					
13.	I intervene and negotiate conflicts among my friends or family.					
14.	I can make spontaneous decisions quickly.					
15.	I ask feedback from others about myself to improvise.					
16.	Others' feedback alone is what makes me feel assured about my behaviour.					

XI. HAPPINESS SCALE OF PUBIC PEOPLE:

S.NO	STATEMENTS	STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE
1.	I am happy and satisfied with my work.					
2.	I am satisfied with my financial management.					
3.	I have a good social relationship.					
4.	I am satisfied with my marital and family life.					
5.	I have no legal issues so far.					
6.	I have good communication skills.					
7.	I feel like I have achieved my short term goals.					

XII. PHYSICAL HEALTH OF PUBLIC PEOPLE:

S.NO	STATEMENTS	YES	MAYBE	NO
1.	I am physically 100% fit.			
2.	I take tablets for some health issues.			
3.	If yes, does it have any side-affects like hair fall, weight gain or weight loss.			
4.	I take vitamin tablets.			
5.	I feel exhausted at the end of the day.			
6.	I have back pain when I sit without any support for a long time.			
7.	I cannot stay out on a sunny day for long period of time.			
8.	Sometimes, I feel like I lack stamina to do my regular routine.			
9.	I feel dizzy or lightheaded when I stand up fast.			

XIII. SOCIAL HABITS OF PEOPLE:

S.NO	SOCIAL HABITS	YES	MAYBE	NO
1.	I visit my relatives and friends regularly.			
2.	I attend all functions and social gatherings if I am invited.			
3.	My relatives and friends find me approachable.			
4.	I help my relatives and friends if they ask me without any hesitation.			
5.	I feel delighted when my family/friends visit my home.			
6.	I organize get togethers because I enjoy being with family and friends.			

XIV. PEOPLE'S USAGE OF ELECTRONIC DEVICE:

S.NO	STATEMENTS	YES	MAYBE	NO
1.	I use mobile more than 4 hours a day.			
2.	I work in an IT company. So my screen time is more than 8 hours.			
3.	I use mobile for relaxation.			
4.	I mostly use social media when I use			
5.	I sometimes use mobile for gathering daily news.			
6.	I use mobile to run online business.			
7.	I use mobile purely for entertainment purpose.			
8.	I play digital games mostly when I use mobile.			
9.	I feel guilty after using mobile while procrastinating work.			
10.	I try to control my mobile usage time, but failed.			
11.	I don't feel good when I am without my mobile.			
12.	I sometimes miss social gatherings just to use mobile phone.			
13.	I use mobile until late at night. So it affect my sleeping pattern.			
14.	I get back pain and neck pain due to my sitting position while I'm using mobile.			