



Community Beliefs and Misconceptions Regarding Mental Illness: A Rural–Urban Comparison

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Abstract

BACKGROUND OF THE STUDY: In rural communities, mental illness is often associated with supernatural causes or moral weakness, leading individuals to seek help from faith healers rather than health professionals [18]. In urban settings, although people may recognize mental illness as a medical condition, fear of discrimination and social judgment continues to hinder timely help-seeking [19]. For nurses and other healthcare professionals, understanding prevailing community beliefs is essential. Identifying specific myths and misconceptions can help in designing targeted educational materials that are culturally appropriate and context-specific. **OBJECTIVES:** The aim of this study is to assess and compare the knowledge regarding myths and misconceptions about mental illness among adults in selected rural and urban communities. **MATERIALS & METHODS:** Study was conducted in selected rural and urban communities of Lucknow, Uttar Pradesh. The population included adults aged 18 years and above residing in selected rural and urban areas. A total of 60 participants were selected, 30 each from rural and 30 from urban communities. Stratified random sampling was adapted to select the samples. Descriptive statistics was used to analyze the demographic characteristic of participants. Fisher’s Exact Test and odds ratios (OR) were used to compare the frequency of myth-related beliefs about mental illness between rural and urban respondents. **RESULTS:** Rural adults were more than five times more likely to support the idea that mental disease results from personal weakness (OR = 5.09), even though this difference was not statistically significant ($p = 0.080$). Adults living in rural areas were more likely to think that mental health issues are uncommon or not significant (OR = 7.25). “People with mental illness are violent and dangerous” was more likely to be endorsed by urban adults (OR = 0.33; $p = 0.095$). Rural respondents were more likely to support the idea that mental illness is a curse brought on by transgressions from a previous life (OR = 3.06). Respondents from rural areas were more likely to concur that discussing mental health issues brings shame or misfortune (OR = 3.00). The statement “Medication is the only treatment for mental illness” was somewhat more common among respondents from rural areas (OR = 1.40), but the difference was not statistically significant. The only statement that showed a statistically significant rural-urban difference was “Children and adolescents do not experience mental illness” ($p = 0.013$; OR = 4.69). **CONCLUSION:** Overall, the study underscores the urgent need for targeted mental health awareness programs, especially in rural communities, focusing on correcting myths, reducing stigma, and promoting a bio psychosocial understanding of mental illness. Community-based education, school mental health programs, and culturally sensitive awareness campaigns can play a key role in improving knowledge and attitudes. Addressing these misconceptions is essential for encouraging early help-seeking, improving treatment acceptance, and ultimately strengthening mental health outcomes across both rural and urban populations.

Keywords: Mental illness, Myths and misconceptions, Stigma, Rural–urban differences, Mental health awareness factors; Rural–urban comparison

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INTRODUCTION

“Mental and behavioral disorders are present at any point in time in about 10% of the adult population worldwide. The burden of mental disorders is maximal in young adults, the most productive section of the population. Neuropsychiatry conditions together account for 10.96% of the global burden of disease as measured by disability-adjusted life years” [1,2]. According to the Results from the 2024 National Survey on

Drug Use and Health approximately 7.2 million nonmetropolitan adults reported having any mental illness (AMI) in 2024, accounting for 22.9% of nonmetropolitan adults. In addition, 1.7 million, or 5.5%, of adults in nonmetropolitan areas reported having serious thoughts of suicide during the past year.

“India contributes to 18% of the global population. WHO estimates that the burden of mental health problems in India is 2443 disability-adjusted life years (DALYs) per 10000 populations; the age-adjusted suicide rate per 100000 population is 21.1. The economic loss due to mental health conditions, between 2012-2030, is estimated at USD 1.03 trillion. The National Mental Health Survey (NMHS) 2015-16 by NIMHANS found that 10.6% of adults in India suffer from mental disorders. The lifetime prevalence of mental disorders in India is 13.7%. National studies reveal that 15% of India’s adult population experiences mental health issues requiring intervention. Urban areas have a higher prevalence (13.5%) compared to rural (6.9%). 70% to 92% of people with mental disorders do not receive proper treatment due to lack of awareness, stigma, and shortage of professionals” [3-8].

Mental disorders are attached to negative and stigmatizing attitudes, often due to a lack of knowledge about mental illness [9]. People with mental illness are perceived as dangerous, unpredictable, and different from others, responsible for their condition, hard to talk to, and incurable in the community [10–12]. The concept of mental health problems and its causes vary in different communities [13]. The majority of society’s perception of mental illness is incompatible with scientific evidence, which could make it more difficult for people to seek and adhere to treatment [14].

People with mental illness are at risk of social isolation, with interpersonal conflict and communication challenges adding to the problems they face. A study published in *The Lancet Psychiatry* (2010) revealed that individuals with depression face difficulties in forming and maintaining interpersonal relationships, which can intensify depression symptoms due to a lack of social support [15]. Stigma which includes internalized shame and negative beliefs as well as structural stigma related to lack of mental health care and policies associated with mental health is a major obstacle to seeking treatment and social integration. People underdeveloped and developing countries, especially, are more vulnerable to the vicious cycles of isolation and deteriorating mental health because of the stigma associated with seeking mental health care (WHO, 2018). For example, a study published in *The Lancet Psychiatry* (2020) found that individuals with mental health illness, particularly those with complex conditions like schizophrenia, are frequently subject to discrimination and isolation. The lack of care diminishes the quality of their lives and decreases any chance of treatment or recovery [16].

Stigma, characterized by negative views, bias, and discrimination, is a significant barrier in mental health care, preventing the timely provision of this care and limiting

optimal health outcomes. Pervasive in all aspects of psychiatric care, stigma leads to delayed treatment, increased morbidity, and diminished quality of life for those with poor mental health [17]. In rural communities, mental illness is often associated with supernatural causes or moral weakness, leading individuals to seek help from faith healers rather than health professionals [18]. In urban settings, although people may recognize mental illness as a medical condition, fear of discrimination and social judgment continues to hinder timely help-seeking [19].

For nurses and other healthcare professionals, understanding prevailing community beliefs is essential. Nurses frequently serve as the first point of contact within the health system and play a key role in health education and advocacy. Identifying specific myths and misconceptions can help in designing targeted educational materials that are culturally appropriate and context-specific.

Lucknow capital of Uttar Pradesh India, being a mix of traditional rural communities and rapidly urbanizing areas, provides an appropriate setting to explore differences and similarities in mental health perceptions. The aim of this study is to assess and compare the knowledge regarding myths and misconceptions about mental illness among adults in selected rural and urban communities of Lucknow, Uttar Pradesh. Findings of this study are expected to contribute to community mental health promotion and strengthen nursing-led awareness initiatives.

METHODOLOGY

A quantitative research approach with a comparative cross-sectional design was adopted. The study was conducted in selected rural and urban communities of Lucknow, Uttar Pradesh. The population included adults aged 18 years and above residing in selected rural and urban areas. A total of 60 participants were selected, 30 each from rural and 30 from urban communities. Stratified random sampling was adapted to select the samples. Individual’s severe cognitive impairment was excluded. Data were collected using a structured questionnaire consisting of demographic variables and statements related to common myths and misconceptions about mental illness. Ethical approval was obtained prior to data collection. Informed consent was taken from all participants, and confidentiality was maintained throughout the study. Descriptive statistics was used to analyze the demographic characteristic of participants. Fisher’s Exact Test and odds ratios (OR) were used to compare the frequency of myth-related beliefs about mental illness between rural and urban respondents.

RESULT

The majority of participants are in the 26-35 years age group (25.0%) followed by 36-45 years 21.7%, 18-25 years 18.3%, 46 -55 years 18.3 % and 56 years and above accounting for 16.7% of respondents. Majority 55% of participants are male and females represented 45% of the population. The most common educational qualification is graduate (31.7%) followed by 26.7 secondary education, 18.3% post graduates, 15% primary education and 8.3% of the population are illiterates. The largest occupational group is employed (31.7%), followed by homemakers (25.0%), students 23.3% and unemployed 20%. A total of 60 adults participated in the study, with equal representation from rural (n = 30) and urban (n = 30) communities.

Fisher’s Exact Test and odds ratios (OR) were used to compare the frequency of myth-related beliefs about mental illness between rural and urban respondents. For the statement “Children and adolescents do not experience mental illness”, the association between place of residence and response was statistically significant (Fisher’s p = 0.013; OR = 4.69),

indicating that rural adults were more likely to endorse this belief than urban adults.

For the remaining six statements, there were no statistically significant differences between rural and urban respondents (Fisher’s p > 0.05), although the direction and magnitude of odds ratios varied:

“Mental illness is a result of personal weakness or lack of willpower” showed higher odds of agreement among rural adults compared to urban adults (OR = 5.09; p = 0.080). “Mental health issues are not serious and not common” also had higher odds in the rural group (OR = 7.25; p = 0.103). “People with mental illness are violent and dangerous” was more likely to be endorsed by urban adults (OR = 0.33; p = 0.095). “Mental illness is a curse due to past life sins (karma)” was more frequently endorsed by rural respondents (OR = 3.06; p = 0.095). “Talking about mental health brings bad luck or shame” showed higher odds among rural respondents (OR = 3.00; p = 0.069). “Medication is the only treatment for mental illness” had slightly higher odds in the rural group but without significance (OR = 1.40; p = 0.773). These results indicate that while many misconceptions were common in both rural and urban groups, one key belief about child and adolescent mental health differed significantly between them.

(n=60)							
<i>Statement</i>	<i>Agree (Rural)</i>	<i>Disagree (Rural)</i>	<i>Agree (Urban)</i>	<i>Disagree (Urban)</i>	<i>Odds Ratio</i>	<i>Fisher’s p-value</i>	<i>Interpretation</i>
<i>Mental illness is a result of personal weakness or lack of will power</i>	8	22	2	28	5.09	0.080	<i>Not Significant</i>
<i>Mental health issues are not serious and not common</i>	6	24	1	29	7.25	0.103	<i>Not Significant</i>
People with mental illness are violent and dangerous	17	13	24	6	0.33	0.095	<i>Not Significant</i>
<i>Mental illness is a curse due to past life sins (Karma)</i>	24	6	17	13	3.06	0.095	<i>Not Significant</i>
<i>Talking about mental health brings bad luck or shame</i>	20	10	12	18	3.00	0.069	<i>Not Significant</i>
<i>Medication is the only treatment for mental illness</i>	16	14	9	11	1.40	0.773	<i>Not Significant</i>
<i>Children and adolescents do not experience mental illness</i>	15	16	5	25	4.69	0.013	Significant

Table 1 Comparison of Myths and Misconceptions among Rural and Urban adults

DISCUSSION

The current study looked at how persons living in rural and urban areas differed in certain myths and misconceptions around mental illness. In addition to providing statistical significance, using odds ratios and Fisher's Exact Test allowed for a more complex analysis by revealing the direction and intensity of relationships.

Mental illness is a result of personal weakness or lack of will power

Rural adults were more than five times more likely to support the idea that mental disease results from personal weakness (OR = 5.09), even though this difference was not statistically significant ($p = 0.080$). This finding aligns with previous research highlighting that “in many Indian communities, mental illness is still perceived as a character flaw rather than a health condition, with 43% of respondents in their study believing that people with depression could recover if they wanted to try harder” [20]. “This belief contributes to significant barriers to care, as individuals may internalize blame, thereby delaying or avoiding seeking professional help”.

Mental health issues are not serious and not common

Adults living in rural areas were more likely to think that mental health issues are uncommon or not significant (OR = 7.25). This pattern is consistent with national epidemiological statistics demonstrating widespread under recognition of mental diseases in community settings, even if it is not statistically significant [21]. According to the World Health Organization, “one in four people worldwide will be affected by mental or neurological disorders at some point in their lives. In India specifically, an estimated 150 million people require mental health interventions, yet there remains a significant treatment gap, with less than 10% receiving appropriate care. This gap is partially fueled by the misconception that mental illness is uncommon, leading to inadequate resource allocation and policy attention” [22].

People with mental illness are violent and dangerous

The likelihood of urban respondents agreeing with this assertion was higher (OR = 0.33). Media portrayals often sensationalize connections between mental illness and violence, leading to the misconception those individuals with mental health conditions poses a threat to society. Crime dramas, news reports, and films frequently depict characters with mental illness as unpredictable and dangerous. The reality, however, is quite different. Studies consistently show that the vast majority of people with mental illness are not violent. In fact, individuals with serious mental illness are far

more likely to be victims of violence than perpetrators. According to research, “below 5% of violent acts can be attributed to individuals with serious mental illness, and these instances typically occur when other risk factors are present, such as substance abuse or lack of treatment” [23,24].

Mental illness is a curse due to past life sins (Karma)

Rural respondents were more likely to support the idea that mental illness is a curse brought on by transgressions from a previous life (OR = 3.06). A similar study conducted to assess the myths, beliefs and perceptions about mental disorders and health-seeking behavior among adults in Konaseema, Andhra Pradesh revealed that “significantly higher proportion (39.4%) of rural respondents believed that mental illness is the punishment given to patients by God for their past sin, as compared to urban subjects and professionals”. This emphasizes the impact of cultural and spiritual beliefs in rural areas which influence their health seeking behavior for mental health disorders [25].

Talking about mental health brings bad luck or shame

Respondents from rural areas were more likely to concur that discussing mental health issues brings shame or misfortune (OR = 3.00). In many cultures, mental health remains a taboo subject, shrouded in silence and shame. Families may discourage open discussions about mental health, fearing judgment or ostracism from their communities [26]. Social anxieties about being labeled and judged by others may be the source of this stigma [27]. This silence not only isolates individuals but also perpetuates ignorance about the realities of mental health conditions. Systemic reviews reveal that fear of social consequences is a significant obstacle to open communication and requesting assistance across cultural boundaries [28].

Medication is the only treatment for mental illness

This opinion was somewhat more common among respondents from rural areas (OR = 1.40), but the difference was not statistically significant. This implies that both groups could not fully comprehend all aspects of successful interventions, such as community support and psychosocial therapies [29]. Evidence strongly supports the combined use of medication and psychosocial approaches for many conditions, such as depression and anxiety [30].

Children and adolescents do not experience mental illness

The only statement that showed a statistically significant rural-urban difference was this one ($p = 0.013$; OR = 4.69). Adults in rural areas were far more inclined to think that younger people are unaffected by mental illness. These findings are similar with previous study which was conducted

to explore the myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India. This suggests that “34.8% of the rural subjects and 18% of the urban subjects believed that children do not get mental disorders, which means they have conception of adult-oriented mental disorders”[20]. Major classes of mental disorders tend to emerge early, with many beginning by adolescence, underscoring the need for early awareness and care [31]. “Recent Indian child mental health studies report rising prevalence of anxiety, depression, and behavioral disorders in school-aged populations, underscoring the need for adult awareness”.

CONCLUSION

The present study highlights that myths and misconceptions about mental illness continue to exist among both rural and urban adults, with stronger and more persistent misconceptions observed among rural respondents. Although many of the differences were not statistically significant, the use of odds ratios and Fisher’s Exact Test provided valuable insight into the direction and strength of these beliefs. Rural adults were consistently more likely to view mental illness as a result of personal weakness, past-life sins, bad luck, or

something that does not affect children and adolescents. Such beliefs reflect the strong influence of cultural, spiritual, and social norms on mental health perceptions.

The finding that a significant proportion of adults believe mental illness does not affect children and adolescents are particularly concerning, as it may delay early identification and timely intervention. Similarly, the belief that mental health problems are uncommon or not serious can reduce help-seeking behavior and widen the treatment gap. Misconceptions linking mental illness with violence and the overreliance on medication alone further indicate gaps in mental health literacy.

Overall, the study underscores the urgent need for targeted mental health awareness programs, especially in rural communities, focusing on correcting myths, reducing stigma, and promoting a bio-psychosocial understanding of mental illness. Community-based education, school mental health programs, and culturally sensitive awareness campaigns can play a key role in improving knowledge and attitudes. Addressing these misconceptions is essential for encouraging early help-seeking, improving treatment acceptance, and ultimately strengthening mental health outcomes across both rural and urban populations.

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