LITERATURE REVIEW

PENGETAHUAN MASYARAKAT TENTANG ORANG DENGAN GANGGUAN JIWA

Oleh:

PUTU MAS PRAMITA KANIA DEWI
NIM. 16.321.2530

PROGRAM STUDI KEPERAWATAN PROGRAM SARJANA
SEKOLAH TINGGI ILMU KESEHATAN WIRA MEDIKA BALI
DENPASAR
2020

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PENGETAHUAN MASYARAKAT TENTANG ORANG DENGAN GANGGUAN JIWA

Diajukan kepada Sekolah Tinggi Ilmu Kesehatan Wira Medika Bali untuk memenuhi salah satu persyaratan menyelesaikan Program Sarjana Keperawatan

Oleh:

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2020

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LITERATUTE REVIEW

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Denpasar, 03 Juni 2020

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Literature review ini disusun dalam rangka memenuhi sebagian persyaratan untuk memperoleh gelar Sarjana Keperawatan pada Program Studi Keperawatan, Sekolah Tinggi Ilmu Kesehatan Wira Medika Bali.

Dalam penyusunan *literature review* ini, peneliti banyak mendapat bantuan sejak awal sampai selesainya *literature review* ini, untuk itu dengan segala hormat dan kerendahan hati, peneliti menyampaikan penghargaan dan terima kasih yang sebesar-besarnya kepada:

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Denpasar, 30 April 2020
Peneliti

Putu Mas Pramita Kania Dewi

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PENGETAHUAN MASYARAKAT TENTANG ORANG DENGAN GANGGUAN JIWA

Public Knowledge About People with Mental Disorders

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ABSTRAK

Latar Belakang: Penderita gangguan jiwa mengalami peningkatan disetiap tahunnya, hal itu dikarenakan kekeliruan masyarakat menanggapi gangguan jiwa dan kekeliruan tersebut disebabkan oleh kurangnya pengetahuan masyarakat mengenai gangguan jiwa. Kurangnya pengetahuan masyarakat mengenai gangguan jiwa menyebabkan masyarakat memberikan stigma negatif, tindakan deskriminatif pada penderita gangguan jiwa, dan penderita gangguan jiwa tidak mendapat penanganan yang tepat serta masyarakat tidak dapat memberikan dukungan kepada penderita gangguan jiwa.
Tujuan: Penelusuran *literature* ini bertujuan untuk menganalisa hasil penelitian terkait yang berfokus pada pengetahuan masyarakat tentang orang dengan gangguan jiwa.
Metode: Penelaahan ini dilakukan dengan metode *review* dari hasil penelitian yang berasal dari media elektronik seperti NCBI-Pubmed, Google Scholar, Sage Publication, Indian Journal, DOAJ (Directory of Open Access Journal), Cambridge Journal, ARC Journals yang di publikasikan mulai tahun 2016-2020 dengan kata kunci *community knowledge and mental disorders, public knowledge and mental health, knowledge level and mental disorders*. Jumlah literature yang diperoleh sebanyak 50 artikel dan 10 diantaranya memenuhi kriteria. Artikel diperoleh dengan artikel asli (*full text*) sehingga data yang disajikan lengkap dan mudah dalam penelaahan penelitian.
Hasil: Hasil Penelaahan menemukan bahwa pengetahuan masyarakat pada tingkat pengetahuan mengenai gangguan jiwa berada pada tingkat cukup dan rendah sehingga berpengaruh pada sikap, perilaku, dan persepsi kepada penderita gangguan jiwa, berpengaruh juga dalam memberikan pertolongan yang tepat kepada penderita gangguan jiwa, serta pengetahuan yang dimiliki oleh seseorang dipengaruhi dengan beberapa faktor seperti pendidikan, usia, pengalaman, pekerjaan, dan lingkungan.
Kesimpulan: Hasil *review* dari 10 jurnal didapatkan bahwa 4 jurnal diantaranya menyatakan bahwa pengetahuan masyarakat mengenai gangguan jiwa masih berada pada kategori rendah dan cukup. 3 jurnal diantaranya menyatakan bahwa pengetahuan masyarakat dipengaruhi oleh beberapa faktor. 4 jurnal diantaranya menyatakan bahwa pengetahuan mengenai gangguan jiwa memiliki pengaruh pada acara masyarakat bersikap kepada penderita gangguan jiwa.

Kata Kunci: Pengetahuan masyarakat, Gangguan Jiwa, Orang dengan Gangguan Jiwa.

ABSTRACT

Background: *Sufferers of mental disorders have increased every year, it is due to the lack og people responding to mental disorders and errors are caused by a lack of public knowledge about mental disorders. Lack of public knowledge about mental disorders causes the community to generate negative stigma of discriminatory actions in people with mental disorders, people with mental disorders don't get proper treatment and the community cannot provide support to people with mental disorders.*

Objective: *this literature search aims to analyze the results of related research that focuses on public knowledge about people with mental disorders.*

Method: *This research was conducted with a review method of the results of research originating from electronic media such as NCBI-Pubmed, Google Scholar, Sage Publication, Indian Journal, DOAJ (Directory of Open Access Journal), Cambridge Journal, ARC Journals published from the beginning of 2016-2020 with the keywords community knowledge and mental disorders, public knowledge and mental health, knowledge level and mental disorders. The amount of literature obtained was 50 articles and 10 of them met the criteria. The article was obtained with the original article (full text) so that the ata presented are complete and easy in the research review.*

Results: *The results of the study found that public knowledge at the level of knowledge about mental disorders is at a sufficient and low level so that it affects the attitudes, behaviors, and perceptions of people with mental disorders, aslso affects in providing appropriate assistance to people with mental disorders and the knowledge possessed by someone is influenced by several factors such as education, age, work experience, and environment.*

Conclusion: *The results of a review of 10 journals found that 4 of these stated that public knowledge about mental disorders as still in the low and sufficient category. 3 of these stated that public knowledge was influenced by several factors. 4 of these journal state that knowledge about mental disorgers has an influence on community events towards people with mental disorders.*

Keywords: *Public Knowledge, Mental Disorders, People with Mental Disorders*

PENDAHULUAN

Gangguan jiwa atau disebut juga dengan Orang Dengan Gangguan Jiwa (ODGJ) adalah orang yang mengalami gangguan dalam pikiran, perilaku, dan perasaan yang termanifestasi dalam bentuk sekumpulan gejala dan/atau perubahan perilaku yang bermakna, serta dapat menimbulkan penderitaan dan hambatan dalam menjalankan fungsi orang sebagai manusia (UU No. 18 Tahun 2018).

Menurut *Word Health Organization* (WHO, 2016 dalam Kemenkes RI, 2016) di dunia terdapat 450 juta orang dengan gangguan jiwa prevalensi gangguan jiwa menurut WHO pada tahun 2016 menunjukkan bahwa secara global diperkirakan 35 juta orang mengalami depresi, 60 juta orang menderita gangguan afektif bipolar, 21 juta orang menderita gangguan skizofrenia dan 47,5 juta orang di dunia mengalami demensia.

Data Riskesdas (2018) menunjukkan bahwa 7 dari 1000 rumah tangga terdapat anggota keluarga dengan Skizofrenia/ Psikosis, bahkan lebih dari 19 juta penduduk usia di atas 15 tahun terkena gangguan mental emosial, lebih dari 12 juta orang berusia di atas 15 tahun diperkiraan mengalami depresi. Jumlah angka kejadian gangguan jiwa berat yang ada di Indonesia sebanyak 286.654 jiwa (Riskesdas, 2018). Hal ini meningkat dari disetiap tahuannya, dimana pada tahun 2013 proporsi gangguan jiwa berat berada pada angka 1,7% sedangkan pada tahun 2018 meningkat menjadi 7%. Angka kejadian yang meningkat pesat menjadikan Indonesia pengidap gangguan jiwa tertinggi di Asia Tenggara. Hal tersebut dikarenakan kurangnya kesadaran dan pemahaman masyarakat terhadap kesehatan mental.

Pemahaman masyarakat masih banyak menganggap gangguan kesehatan jiwa disebabkan oleh hal-hal gaib dan mistis atau terkena roh halus, dan tidak kuat iman (Lilik DKK, 2019). Saat seorang mengalami gejala-gejala gangguan jiwa (seperti tertawa sendiri, melamun, mengamuk, berbicara sendiri, menangis), maka masyarkat menganggapnya hal yang berbeda seperti halnya gejala orang kerasukan, hal tersebut yang menyebabkan penderita gangguan jiwa di bawa kedukun atau orang pintar dan enggan membawa ke fasilitas kesehatan (Reyka, 2019). Pandangan mengenai gejala gangguan jiwa yang buruk tersebut menyebabkan timbulnya stigma buruk di masyarakat yang menyatakan penderita gangguan jiwa tidak dapat disembuhkan, penderita gangguan jiwa berbeda dari yang lainnya, dan tidak dapat hidup berdampingan dengan masyarakat lainnya serta menimbulkan sikap mencemooh (*bullying*), menjauhi, mengabaikan, mengasingkan (isolasi sosial), dan perilaku kekerasan fisik pada penderita gangguan jiwa (Asti, 2016).

Hal tersebut didukung oleh penelitian yang dilakukan oleh Nadira Lubis, DKK (2014) yang menyatakan bahwa Gangguan jiwa dapat mengenai setiap orang, tanpa mengenal umur, ras, agama, maupun status sosial-ekonomi. Gangguan jiwa bukan disebabkan oleh kelemahan pribadi. Di masyarakat banyak beredar kepercayaan atau mitos yang salah mengenai gangguan jiwa, ada yang percaya bahwa gangguan jiwa disebabkan oleh gangguan roh jahat, ada yang menuduh bahwa itu akibat guna-guna, karena kutukan atau hukuman atas dosanya. Kepercayaan yang salah ini hanya akan merugikan penderita dan keluarganya karena pengidap gangguan jiwa tidak mendapat pengobatan secara

cepat dan tepat. Di zaman ponsel pintar seperti sekarang, realitanya masih banyak masyarakat Indonesia yang masih awam tentang gangguan jiwa dan cacat mental. Masih lebih banyak orang yang mengabaikan pentingnya menimbang, mengupayakan dan mempertahankan kesehatan jiwa dan mental dibandingkan dengan kesehatan fisik. Sebagian anggota masyarakat baru akan memperhatikan masalah kesehatan jiwa dan mental, hanya disaat mereka dihadapkan pada gangguan kesehatan mental dan jiwa.

Penelitian yang dilakukan oleh Reyka DKK (2019) juga mendukung pernyataan diatas yang menyatakan bahwa sebagian besar masyarakat menganggap gangguan jiwa disebabkan oleh guna-guna dan penanganan dilakukan dengan berobat ke dukun. Yohanes Kartika, DKK (2017) juga menyatakan bahwa konsep tentang jiwa yang dirasuki oleh roh lain (*kerahuan*) yang dipahami oleh orang Bali menyebabkan kebingungan untuk memastikan apakah seseorang mengalami gangguan jiwa yang berupa halusinasi dan waham, atau sebab-sebab lainnya. Anggota keluarga tidak segera membawa ODGJ-nya ke professional kesehatan jiwa karena menganggap gangguan tersebut disebabkan oleh *kerahuan*. Kekeliruan mengenai gangguan jiwa membuat anggota keluarga dan masyarakat membawa penderita ke pengobatan alternatif dan memperlakukan ODGJ tanpa perlakuan medis.

Menurut Arnika, DKK (2016) juga menyatakan bahwa sebagian besar responden memberikan diskriminasi kepada penderita gangguan jiwa seperti menganggap orang dengan gangguan jiwa mengerikan, menakutkan, mengganggu, mamalukan, merupakan aib yang harus disembunyikan, dan merupakan orang yang terkena gunaguna/ilmu gaib. Sebagian warga juga masih memberikan diskriminasi kepada orang dengan gangguan jiwa seperti: bullying verbal, kekerasan, pengasingan atau isolasi sosial, dan pengurangan/peniadaan terhadap hak-hak dasar sebagai manusia dalam kehidupan. Banyaknya responden yang memberikan stigma buruk menyebabkan keluarga melakukan isolasi bahkan menyembunyikan anggota keluarganya yang menderita gangguan jiwa sebagai bentuk pengobatan dan enggan membawa ke fasilitas kesehatan karena malu.

Berdasarkan beberapa hasil penelitian dari tahun-ketahun menyatakan bahwa pengetahuan mengenai gangguan jiwa masih mengalami kekeliruan disetiap masyarakat dan cara penanganan yang dilakukan pun tidak sesuai dengan prosedur medis. Hal tersebut disebabkan oleh kurangnya pemahaman masyarakat mengenai kesehatan mental. Masyarakat kurang memahami mengenai konsep gangguan jiwa, yang dimulai dari pengertian, tanda gejala, penyebab, dan cara memberikan pertolongan.

Berdasarkan uraian tersebut, penulis ingin melakukan telaah *literature* lebih lanjut mengenai pengetahuan masyarakat tentang orang dengan gangguan jiwa. Tujuan dari *literature review* ini adalah untuk menganalisa hasil penelitian terkait yang berfokus pada pengetahuan masyarakat tentang orang dengan gangguan jiwa. Analisis ini diharapkan menjadi pertimbangan untuk melakukan pengukuran pemahaman mengenai kesehatan jiwa sehingga dapat melakukan promosi kesehatan yang tepat mengenai kesehatan jiwa sehingga dapat mencegah angka kejadian gangguan jiwa menjadi meningkat.

BAHAN DAN METODE

Penelusuran ini dilakukan dengan metode telaah *literature review* melalui media elektronik (internet) yang dipublikasikan mulai tahun 2016-2020. Pencarian database yang digunakan dalam pencarian artikel yang relevan meliputi NCBI-Pubmed, Google Scholar, Sage Publication, Indian Journals, DOAJ (Directory of Open Access Journal), Cambridge Journal, ARC Journals. Kata kunci yang digunakan dalam pencarian artikel yaitu *community knowledge and mental disorders, public knowledge and mental health, knowledge level and mental disorders*. Terdapat 50 artikel yang diperoleh dari hasil pencarian yang menyerupai variabel penelitian dan hanya diambil 10 artikel diantaranya yang memenuhi kriteria. Kriteria artikel yang sesuai yaitu sesuai dengan tujuan, fokus masalah, dan metode yang digunakan (kuantitatif). Artikel yang di ambil merupakan artikel asli (*full text*) sehingga data yang disajikan lengkap dan memudahkan dalam penelaahan penelitian.

HASIL DAN PEMBAHASAN

Hasil yang diperoleh dari pencarian dengan kata kunci *community knowledge and mental disorders, public knowledge and mental health, knowledge level and mental disorders* didapatkan pengetahuan masyarakat pada tingkat pengetahuan mengenai gangguan jiwa masih berada pada tingkat cukup dan rendah sehingga berpengaruh pada sikap, perilaku, dan persepsi kepada penderita gangguan jiwa, berpengaruh juga dalam memberikan pertolongan yang tepat kepada penderita gangguan jiwa, serta pengetahuan yang dimiliki oleh seseorang dipengaruhi dengan beberapa faktor seperti pendidikan, usia, pengalaman, pekerjaan, dan lingkungan.

1. Hasil *Review Artikel*

Tabel 1
Hasil *Review Artikel*

Penulis	Judul	Tujuan	Sampel dan Karakteristik sampel	Metodelogi Penelitian	Hasil
Magreth Benedicto, Erasmus Mndeme, DKK (2016)	Pengetahuan, Sikap, Dan Persepsi Masyarakat Terhadap Penyakit Mental Di Kota Dodoma, Tanzania	Mengetahui pengetahuan, sikap, dan persepsi masyarakat terhadap penyakit mental di Kota Dodoma	• Jumlah sampel pada penelitian ini berjumlah 384 responden • Masyarakat berusia 18 tahun ke atas yang tinggal di Kota Dodoma yang berjenis kelamin laki-laki dan perempuan. • Pengecualian pada masyarakat yang berusia kurang dari 18 tahun, penolakan untuk berpartisipasi, orang yang sakit parah, sakit mental dan kegagalan berbicara bahasa Swahili atau bahasa Inggris.	Cross-Sectional dengan kuesioner semi terstruktur	Hasil penelitian menunjukkan bahwa sebagian besar peserta 85,9% (n = 330) memiliki pengetahuan yang buruk tentang penyakit mental. Lima puluh satu persen (n = 196) tidak dapat mengidentifikasi jenis penyakit apa pun, 58,9% (n = 226) mengaitkan sikap negatif terhadap orang dengan penyakit mental. Selain itu 75,8% (n = 291) memiliki persepsi buruk tentang penyakit mental dimana, penelitian ini menunjukkan bahwa, sebagian besar responden memiliki sedikit pengetahuan tentang penyakit mental. Sebagian responden bereaksi aneh terhadap penderita gangguan jiwa dan 94,3% masyarakat tidak dapat mengidentifikasi jenis penyakit mental yang diderita sehingga mengekang kemampuan pencarian pengobatan dan menimbulkan salah persepsi.
Juan Li, Meng-meng Zhang, DKK (2018)	Evaluasi Sikap dan Pengetahuan terhadap Gangguan Mental dalam Sampel Populasi Cina menggunakan Pendekatan Berbasis Web	Mengevaluasi sikap dan pengetahuan tentang gangguan mental dalam sampel populasi umum Cina dengan dan mengidentifi-kasi karakteristik sosio demografis.	• Jumlah sampel sebanyak 1087 partisipan • Partisipan tidak terdiagnosa memiliki gangguan mental di masa lalu • Partisipan mencapai usia legal (16 tahun keatas)	Survei Cross-Sectional dengan menggunakan kuesioner elektronik yang dikirimkan melalui aplikasi obrolan internet	Hasil penelitian berdasarkan nilai rata-rata MHKQ (Mental Health Knowledge Questionnaire) menunjukkan responden yang memiliki usia 22-44 tahun memiliki skor pengetahuan yang tinggi, responden yang memiliki tingkat pendidikan lebih tinggi juga memiliki pengetahuan yang lebih tinggi mengenai penyakit mental. Penduduk yang

					tinggal diperkotaan cenderung memiliki pengetahuan lebih tinggi dibandingkan dengan penduduk pedesaan. Responden yang pernah kontak langsung dengan penderita penyakit mental, memiliki pertemuan pribadi dengan penderita, dan belajar dari media masa cenderung memiliki skor MHKQ Mental Health Knowledge Questionnaire) yang lebih tinggi (P <0,05), dengan kata lain cenderung memiliki pengetahuan kesehatan mental yang lebih besar.
Rivu Basu, Arkaprabha Sau, DKK (2017)	Sebuah Studi tentang Pengetahuan, Sikap, dan Praktik mengenai Penyakit Kesehatan Mental di Blok Amdanga, Benggala Barat	• Memvali-dasi Sikap Masyara-kat terhadap Penyakit Mental (CAMI). • Menilai berbagai faktor sosio-demografi di antara populasi penelitian. • Menilai pengeta-huan, sikap, dan praktik (KAP) mengenai penyakit mental di antara populasi penelitian.	• Jumlah sampel sebanyak 730 sampel yang terdiri dari 81 desa di Blok Pengembangan Komunitas Amdanga • Peserta dewasa berusia >18 tahun • Peserta yang sakit saat penelitian tidak diikut sertakan	Study Observasional deskriptif dengan desain Cross-Sectional dengan menggunakan kuesioner	Hasil penelitian berdasarkan hasil Uji Statistik menunjukkan bahwa sebagian populasi besar (73,3%) masih merasa bahwa pasien kesehatan mental harus dirawat di rumah sakit jiwa, 78,1% merasa bahwa mereka rentan terhadap kekerasan, dan 71% percaya bahwa penyakit mental dapat disembuhkan dengan pengobatan. Jika dikaitkan dengan sikap maka 52,5% dari populasi percaya bahwa seseorang wanita akan menjadi bodoh untuk menikahi pria yang telah menderita penyakit mental meskipun tampak sepenuhnya pulih, 90% mendukung bahwa pasien yang sakit mental perlu diperhatikan secara bertanggung jawab, 94,9% mengatakan bahwa mereka bersedia hidup dengan orang dengan penyakit mental. Perilaku pencarian layanan kesehatan menunjukkan bahwa 19,2% akan pergi ke dokter jika terjadi penyakit mental. Dalam penelitian ini ditemukan bahwa ada partisipasi positif dari masyarakat mengenai penyakit mental baik dari penerimaan, pengobatan, dan cara bersikap.

Meena Kolar Sridara Murthy, Aruna Rose Mary Kapanee, DKK (2019)	Menjelajahi Pengetahuan dan Sikap Masyarakat tentang Masalah Kesehatan Mental: Intervensi Percontohan untuk Promosi Kesehatan Mental yang Efektif	• Menilai dan meningkatkan pengeta-huan tentang masalah kesehatan mental. • Membang-un keteram-pilan yang diperlukan untuk campur tangan, membant, dan merujuk individu yang menga-lami masalah kesehatan mental	• Jumlah sampel sebanyak 86 responden dari Departemen Pendidikan Kesehatan Mental, NIMHANS, Bengaluru, India. • Responden terdiri dari mahasiswa, penasehat awam, dan dosen.	Studi Cross-Sectional dengan menggunakan kuesioner semi terstruktur dan diolah menggunakan statistic deskriptif	Hasil penelitian menunjukkan 56% masyarakat tidak memegang gagasan yang cukup dimana masih menganggap penderita penyakit mental adalah kekerasan dan tidak dapat diprediksi, serta 48% masyarakat menganggap orang dengan penyakit mental lebih seperti kelemahan daripada penyakit nyata. 73% mengatakan bahwa menjadi sehat mental dapat mengatasi stress yang dihadapi, 58% menyatakan ada harapan bagi orang dengan penyakit mental dapat sebuah tetapi tidak yakin. Mayoritas (44%) dari responden kelemahan pribadi merupakan penyebab masalah kesehatan mental. 87% mengidentifikasi awal tanda dan gejala dapat mebantu memberikan pertolongan. 62% dari responden menyatakan bahwa masalah kesehatan dapat dicegah. 65% responden dapat membantu seseorang dengan masalah mental. Kesimpulannya menyatakan bahwa responden menunjukkan kurangnya pengetahuan dalam memahami kesehatan mental, pengetahuan sebab-akibat, dan perawatan masalah kesehatan mental. Melakukan evaluasi pengetahuan masyarakat mengenai kesehatan mental dapat membantu pengembangan program untuk masalah kesehatan mental lebih lanjut.
Carla Abi Doumit, Chadia Haddad, DKK (2019)	Pengetahuan, Sikap, dan perilaku terhadap Pasien dengan Penyakit Mental: Hasil dari Penelitian Nasional Lebanon	Menilai pengetahuan, sikap dan perilaku terhadap stigma publik tentang penyakit kesehatan mental, di antara sampel populasi Lebanon.	• Jumlah sampel 2289 responden dari Beirut, Gunung Lebanon, Utara, selatan, dan Bakaa. • Semua orang yang tinggal dirumah dan memuhi syarat dan setuju mengikuti penelitian tersebut.	Studi Cross-Sectional dengan menggunakan analisis bivariate dan multivariate dengan independent simple t-test untuk membanding-kan 2 rata-rata dan ANOVA	Hasil penlitian menunjukkan bahwa masyarakat yang memiliki pengetahuan tinggi terhadap penyakit mental maka memiliki perilaku yang baik terhadap penderita penyakit mental. Pada usia 70 tahun keatas memiliki pengetahuan kurang mengeni penyakit mental. Pengetahuan yang dimiliki masyarakat di masing wilayah Lebanon sangat berbeda, antara daerah

			• Responden berusia di atas 18 tahun • Responden yang memiliki masalah kejiawaan tidak dijadikan resonden	untuk membanding-kan 3 rata-rata.	perkotaan dan daerah pedesaan. Pada masyarakat yang memiliki pengetahuan yang baik mengenai penyakit mental maka perilaku dalam menghadapi penderita penyakit mental itu lebih baik. Sikap masyarakat lebih sering menganggap penyakit mental merupakan mata jahat, sihir, dan hukuman dari Tuhan.
Jane Munika, Dr Ruth Simiyu1, Dr. Donald Kokonya (2018)	Pengetahuan Kesehatan Mental dan Penyakit Mental di antara Anggota Masyarakat di Kabupaten Bungoma, Kenya	Mengetahui pengetahuan kesehatan mental dan penyakit mental oleh masyarakat di Kabupaten Bungoma, Kenya.	• Jumlah sampel sebanyak 396 responden • Kepala rumah tangga yang berusia di atas 18 tahun	Study deskriptif cross-sectional (kuantitatif)	Hasil penelitian menunjukkan bahwa 268 (67,7%) tidak setuju bahwa penyakit mental adalah penyakit seperti yang lainnya. 240 (60,6%) tidak setuju bahwa salah satu penyebab utama penyakit mental adalah kurangnya disiplin diri dan kemauan. Mayoritas responden 292 (73,7%) setuju bahwa, jika orang sakit mental, mereka akan mudah sakit lagi. 300 responden (75,8%) responden setuju bahwa orang dengan penyakit mental memiliki kecerdasan yang lebih rendah. Mayoritas responden 352 (88,9%) setuju bahwa penyakit mental dan keterbelakangan mental adalah hal yang sama. Dengan hasil perhitugan skor dari 7 item pertanyaan diatas menyatakan level pengetahuan dalam 2 versi dimana 50,3% responden mencetak skor kurang dari 60% yang artinya memiliki pengetahuan kurang dan 49,7% responden memiliki skor lebih dari 60% yang artinya memiliki pengetahuan baik. Kesimpulannya responden memiliki pengetahuan yang buruk atau kurang mengenai penyakit mental.
Erna Irawan, Hudzaifah Al Fatih, dan Rika	Gambaran Pengetahuan dan Sikap Masyarakat Terhadap Pasien Gangguan Jiwa Dengan	Mengetahui bagaimana gambaran pengetahuan dan sikap masyarakat terhadap pasien gangguan	• Jumlah sampel sebanyak 60 responden dengan teknik accidental sampling.	Study deskriptif yang menggambar-kan variable pengetahuan dan sikap masyarakat.	Hasil penelitian menunjukkan bahwa hamper setengah responden (46,7%) memiliki pengetahuan yang baik tentang perilaku kekerasan dan Sebagian besar responden

Purnama Sari (2019)	Perilaku Kekerasan di Wilayah Upt Puskesmas Sukajadi	jiwa dengan perilaku kekerasan di Wilayah UPT Puskesmas Sukajadi			(61,7%) memiliki sikap yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan, dengan kata lain mayoritas responden memiliki pengetahuan baik dan sikap mendukung.
Dwi Ari Astanti, Deasti Nurmaguphita (2018)	Hubungan Tingkat Pengetahuan Dengan Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa di Dusun Ketingan Tirtoadi Sleman Yogyakarta	Mengetahui hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakata.	• Jumlah sampel sebanyak 50 responden dengan menggunakan teknik total sampling	Desain penelitian correlation study dengan pedekatan cross sectional dan diuji menggunakan uji Kendall Tau.	Hasil penelitian dianalisis dengan uji Kendall Tau, diperoleh nilai signifikan (p= 0,031 < 0.05) dengan keeratan hubungan sebesar 0,289 yang artinya memiliki keeratan hubungan sedang. Hasil penelitian juga menunjukkan masyarakat memiliki pengetahuan baik terhadap orang dengan gangguan jiwa, masyarakat mampu menjawab dengan baik pertanyaan mengenai gangguan jiwa, hal ini menggambarkan bahwa responden sudah memiliki informasi tentang gangguan jiwa, serta persepsi masyarakat memiliki persepsi positif terhadap orang dengan gangguan jiwa sebanyak 26 responden (52%). Dari hasil tersebut dapat disimpulkan bahwa terdapat hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta dimana semakin baik pengatuhan seseorang maka persepsi yang ditimbulkan pun positif.
Hidayatus Sya'diyah (2016)	Studi Tingkat Pengetahuan Masyarakat Tentang Gangguan Jiwa di Desa Banjar Kemantren Buduran Sidoarjo	Mengetahui tingkat pengetahuan masyarakat tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo	• Jumlah sampel sebanyak 171 responden • Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo yang memenuhi kriteria dengan pendekatannon probability sampling "purposive sampling	Study deskriptif dengan pendekatan cross sectional	Hasil penelitian diperoleh tingkat pengetahuan kurang 36 orang (21,1 %), cukup 105 orang (61,4 %), dan baik 30 orang (17,5 %). Angka ini menunjukkan bahwa rata–rata masyarakat (kepala keluarga) Desa Banjar Kemantren Buduran Sidoarjo mempunyai tingkat pengetahuan yang cukup mengenai gangguan jiwa. Pada penelitian ini tingkat pengetahuan didukung oleh tingkat pendidikan, usia,

					pekerjaan, pengalaman, dan status pernikahan. Pengetahuan yang cukup pada penelitian ini ditunjukkan dari masyarakat yang kurang mengetahui tanda dan gejala gangguan jiwa.
Novia Dewi Permata Sari (2018)	Tingkat Pengetahuan, Persepsi dan Sikap Masyarakat Terhadap Orang Dengan Gangguan Jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang	Menganalisis hubungan tingkat pengetahuan, persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang	• Jumlah sampel sebanyak 82 responden • Menggunakan Probability sampling dengan pendekatan Proportional Stratified random sampling • Dilakukan pada masyarakat Kelurahan Rowosari Kota Semarang	Deskriptif Korelasional dengan menggunakan desain Cross Sectional Data dilakukan pada masyarakat Kelurahan Rowosari Kota Semarang	Hasil penelitian menunjukkan bahwa pengetahuan masyarakat terhadap ODGJ Cukup baik (53,7%), persepsi masyarakat terhadap ODGJ Baik (63,4%), sikap masyarakat terhadap ODGJ positif (61,0%). Ada hubungan yang signifikan antara tingkat pengetahuan dan sikap masyarakat terhadap ODGJ dengan p value 0,000 (<0,05) dan Ada hubungan yang signifikan antara persepsi dan sikap masyarakat terhadap ODGJ dengan p value 0,000 (<0,05).

2. Pembahasan

Hasil literature *review* dari 10 artikel yang ditemukan mengenai pengetahuan masyarakat tentang orang dengan gangguan jiwa didapatkan hasil sebagai berikut: Jurnal pertama yang berjudul Pengetahuan, Sikap, dan Persepsi Masyarakat Terhadap Penyakit Mental di Kota Dodoma, Tanzania yang diteliti oleh Magret Benedicto, et.al (2016) didapatkan hasil bahwa pengetahuan, persepsi, dan sikap negatif yang buruk masih berlaku di Kota madya Dodoma meskipun ada fakta bahwa Rumah Sakit Jiwa Nasional berlokasi di sini. Hal ini karena kurangnya program pendidikan kesehatan mental masyarakat. Oleh karena itu ada kebutuhan akan pendidikan kesehatan mental masyarakat untuk meningkatkan pengetahuan, sikap, dan persepsi masyarakat terhadap penyakit mental. Ini dapat mendorong perilaku pencarian kesehatan dini, serta hasil pengobatan yang lebih baik. Penelitian ini memberikan dasar bagi petugas kesehatan untuk memberdayakan anggota masyarakat tentang pengetahuan penyakit mental, untuk mengubah sikap dan persepsi masyarakat, serta perilaku pencarian kesehatan orang-orang dengan masalah kesehatan mental. Menginformasikan pengembangan/ pembuat kebijakan kesehatan mental tentang kurikulum kesehatan mental, untuk mengembangan program yang akan membantu penyedia layanan kesehatan mental untuk membantu masyarakat, menyediakan perawatan dan memfasilitasi pendidikan kesehatan mental secara efektif. Pada akhirnya untuk merangsang penelitian lebih lanjut mengenai pengetahuan kesehatan mental, sikap, dan persepsi dalam rangka meningkatkan pengetahuan dan perubahan dalam sikap dan persepsi masyarakat, serta perilaku pencarian kesehatan orang-orang dengan masalah mental.

Jurnal kedua yang berjudul Evaluasi Sikap dan Pengetahuan tentang Gangguan Mental dalam Sampel Populasi Umum Cina menggunakan Pendekatan Berbasis Web yang diteliti oleh Juan Li, Men-meng Zhang, et. al (2018) didapatkan hasil bahwa pengetahuan kesehatan mental secara keseluruhan mungkin telah meningkat dalam populasi Cina selama bertahun-tahun, tetapi sebagian besar orang Cina masih memiliki sikap negatif terhadap gangguan mental, data ini lebih relevan di daerah perkotaan. Penting untuk melakukan anti-stigma untuk kemajuan kesehatan mental di masa depan di tiongkok. Beberapa kampanye bertujuan untuk meningkatkan pengetahuan kesehatan mental masyarakat, masih menjadi bahan perdebatan terbuka apakah peningkatan pengetahuan kesehatan mental sebenarnya dapat mengurangi sikap diskriminatif masyarakat terhadap orang-orang dengan gangguan mental atau tidak. Pada penelitian ini tidak ditemukan korelasi positif antara tingkat kontak peserta dengan orang-orang dengan penyakit mental dan sikap mereka terhadap orang-orang dengan gangguan mental, penelitian ini menemukan bukti serupa dalam penelitian lain. Dengan demikian, harus mengekplorasi hipotesis lebih lanjut bahwa kontak yang lebih sering dengan orang dengan gangguan mental dapat mengubah sikap negatif terhadap gangguan mental. Penelitian ini memberikan manfaat yaitu dapat membantu dalam merancang program yang bertujuan untuk mengurangi stigma publik terhadap gangguan mental dan dapat memberikan panduan bagi pemerintah untuk melakukan tindakan strategis lebih lanjut.

Jurnal ketiga yang berjudul Sebuah Studi tentang Pengetahuan, Sikap, dan Praktik mengenai Penyakit Kesehatan mental di Blok Amdanga, Benggala Barat yang diteliti oleh Rivu Basu, Arkaprabha Sau, et. al (2017) didapatkan hasil bahwa penelitian ini memiliki ukuran sampel besar dan menutupi blok secara ekstensif, dengan demikian representasi dari blok ini telah dilakukan secara luas. Namun, studi multi-sentris dapat memberikan validitas eksternal yang lebih baik. Jadwal yang digunakan telah divalidasi sebelumnya dengan menggunakan validitas versi Bengali dan bukan metric validitas. Dalam studi KAP (Knowledge, Attitude, and Practice) seperti ini, seringkali faktor-faktor merupakan hal yang kurang penting. Penelitian ini dapat memberikan manfaat berupa wawasan yang berharga ke dalam aspek kognitif dan afektif dari penyakit mental di antara populasi dan dapat membantu dalam menerapkan kebijakan yang lebih baik dalam penanganan penyakit mental. Pada penelitin ini memiliki tujuan yaitu memvalidasi sikap masyarakat terhadap penyakit mental (CAMI), menilai berbagai faktor sosio demografi di antara populasi penelitian, dan menilai pengetahuan, sikap, dan praktik (KAP) mengenai penyakit mental di antara populasi penelitian.

Jurnal keempat yang berjudul Menjelajahi Pengetahuan dan Sikap Masyarakat tentang Masalah Kesehatan Mental: Intervensi Percontohan untuk Promosi Kesehatan Mental yang Efektif diteliti oleh Meena Kolar Sridara Murthy, et.al (2019) didapatkan hasil bahwa program pengembangan kapasitas untuk pertolongan pertama untuk masalah kesehatan mental tampaknya efektik dalam meningkatkan pengetahuan dan keterampilan degan masalah kesehatan mental. temuan dari program menunjukkan kurangnya pengetahuan dalam memahami kesehatan mental. Umpan balik dari program pelatihan menunjukkan bahwa hal itu meningkatkan kemampuan para peserta dalam mengenali orang-orang yang mengalami masalah kesehatan mental dan membawa perubahan dalam keyakinan mereka tentang kesehatan mental, sikap, dan kebutuhan akan rujukan yang cepat. Hal ini juga berhasil meningkatkan kepercayaan diri para peserta dalam memberikan bantuan kepada seseorang dengan masalah kesehatan mental dan merujuk pada professional kesehatan mental yang tepat. Keterbatasan dari program ini adalah dilakukan dengan kelompok kecil. Hal yang sama dapat direplikasi ke populasi yang lebih besar dengan kelompok yang beragam, dan studi ini direkomendasikan untuk masyarajat luas. Berdasarkan hasil positif dari studi intervensi yang dilakukan, rencana masa depan untuk melakukan pelatihan program guru telah dipikirkan. Program tersebut ditujukan untuk para guru karena mereka akan memberikan pertolongan pertama kepada para siswa yang mungkin menghadapi krisis kesehatan mental. Studi ini dianggap efektif berdasarkan umpan balik yang diterima dari peserta untuk meningkatkan pengetahuan tentang kesehatan mental dan membangun keterampilan untuk membabtu orang yang menghadapi krisis kesehatan mental.

Jurnal kelima yang berjudul Pengetahuan, Sikap, dan perilaku terhadap Pasien dengan Penyakit Mental: Hasil dari Penelitian Nasional Lebanon yang diteliti oleh Carla Abi Doumit, Chadia Haddad, et.al (2019) didapatkan hasil bahwa di negara dimana gangguan kesehatan mental dan stigma berlaku, penting untuk menilai faktor-faktor yang berkontribusi terhadap stigma publik.

Pengetahuan, sikap, dan perilaku secara berbeda terkait diantara anggota masyarakat Lebanon yang berbeda. Temuan utama dari penelitian ini adalah lebih banyak pengetahuan dikaitkan dengan perilaku dan sikap yang lebih baik dan karenanya lebih sedikit stigma, itulah mengapa penting untuk memulai kampanye kesadaran di seluruh negeri dan terutama di sekolah-sekolah untuk mempersiapkan masyarakat yang lebih berpengetahuan dan berpikiran terbuka. Akibatnya, orang yang menderita gangguan kesehatan mental tidak akan merasa malu untuk mencari bantuan professional yang mereka butuhkan. Penelitian ini menggunakan sampel besar yang secara khusus untuk evaluasi stigma dan merupakan deskripsi pertama tentang tingkat stigma dalam populasi Lebanon. Kekurangan penelitian ini adalah cros-sectional dengan tingkat bukti yang rendah, instrument yang digunakan untuk menilai sikap, pengetahuan, dan perilaku terhadap penyakit mental belum divalidasi dalam konteks Lebanon, terjadinya bias informasi hasilnya tidak dapat digeneralisasi keseluruh populasi, dan data tidak dapat diperhitungkan untuk memperhitungkan desain pengambilan sampel.

Jurnal keenam yang berjudul Pengetahuan Kesehatan Mental dan Penyakit Mental di antara Anggota Masyarakat di Kabupaten Bungoma, Kenya yang diteliti oleh Jane Munika, Dr Ruth Simiyu, Dr. Donald Kokonya (2018) didapatkan hasil bahwa penduduk Kabupaten Bungoma memiliki sedikit atau tidak ada pengetahuan tentang penyakit mental maka lebih banyak yang harus dilakukan untuk meningkatkan kesadaran akan masalah kesehatan mental di masyarakat melalui pendidikan informal, kampanye kesadaran publik, dan intervensi sekolah formal. Penilitian ini merekomendasikan bahwa kepekaan masyarakat atau publik terhadap penyakit mental adalah penting di Kabupaten Bungoma. Meningkatkan kampanye kesadaran publik untuk menjangkau lebih banyak orang melakukan pendekatan yang menargetkan kelompok anggota keluarga yang memiliki orang yang sakit jiwa. Penelitian ini juga mendorong penelitian lebih lanjut mengenai pengetahuan dan persepsi kesehatan mental untuk meningkatkan pengetahuan dan perubahan dalam sikap dan persepsi Komunitas Bungoma serta perilaku pencarian individu yang sakit mental. Dengan meningkatnya kesadaran akan penyakit mental, stigma akan berkurang serta mentalitas stereotip yang berdampak negatif pada orang yang sakit mental di masyarakat. Melatih lebih banyak petugas kesehatan masyarakat kearah persepsi positif untuk penyakit mental, dalam mengubah perilaku dan persepsi masyarakat serta perilaku mencari kesehatan orang yang sakit mental. Hal ini akan memberdayakan anggota masyarakat Kabupaten Bungoma mengenai pengetahuan penyakit mental dan sebagai hasilnya meningkatkan interaksi anggota masyarakat dengan orang-orang yang sakit mental di masyarakat.

Jurnal ketujuh yang berjudul Gambaran Pengetahuan dan Sikap Masyarakat Terhadap Pasien Gangguan Jiwa Dengan Perilaku Kekerasan di Wilayah UPT Puskesmas Sukajadi yang diteliti oleh Erna Irawan, Hudzaifah Al Fatih, dan Rika Purnama Sari (2019) didapatkan hasil bahwa hampir setengahnya responden (46,7%) memiliki pengetahaun yang baik tentang perilaku kekerasan dan sebagian besar responden (61,7%) memiliki sikap yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan. Masih terdapat responden yang berpengetahuan rendah dan sikap tidak mendukung sehingga dapat dilakukan

intervensi keperawatan untuk meningkatkannya. Penelitian ini memiliki manfaat dapat dijadikan referensi serta dapat melakukan penelitian terkait dengan faktor-faktor mendukung pengetahuan dan sikap masyarakat terhadap pasien gangguan jiwa dengan perilaku kekerasan.

Jurnal kedelapan yang berjudul Hubungan Tingkat Pengetahuan Dengan Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa di Dusun Ketingan Tirtoadi Sleman Yogyakarta yang diteliti oleh Dwi Ari Astanti dan Deasti Nurmaguphita (2018) didapatkan hasil bahwa tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki tingkat pengetahuan dalam kategori baik sebanyak 31 responden. Begitu juga dengan persepsi masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki persepsi positif terhadap orang dengan gangguan jiwa sebanyak 26 responden. Pada penelitian ini menghubungkan tingkat pengetahuan dan persepsi terhadap orang dengan gangguan jiwa dimana keeratan tersebut memiliki hubungan sebesar 0,298 yang artinya memiliki keeratan sedang. Dalam hal ini menyatakan bahwa jika masyarakat memiliki pengetahuan yang baik mengenai orang dengan gangguan jiwa makan masyarakat akan memiliki persepsi yang positif kepada orang dengan gangguan jiwa.

Jurnal kesembilan yang berjudul Studi Tingkat Pengetahuan Masyarakat Tentang Gangguan Jiwa di Desa Banjar Kemantren Buduran Sidoarjo yang diteliti oleh Hidayatus Sya'diyah (2016) didapatkan hasil bahwa tingkat pengetahuan masyarakat (kepala keluarga) tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo rata-rata cukup. Hal tersebut ditunjukkan dari hasil analisis pada kuesioner tingkat pengetahuan masyarakat kurang mengetahui tentang gejala gangguan jiwa. Pada penelitian ini pengetahuan dipengaruhi oleh tingkat pendidikan, usia, pekerjaan, pengalaman, dan status pernikahan.

Jurnal kesepuluh yang berjudul Tingkat Pengetahuan, Persepsi dan Sikap Masyarakat Terhadap Orang Dengan Gangguan Jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang yang diteliti oleh Novia Dewi Permata Sari (2018) didapatkan hasil bahwa hasil penelitian di masyarakat Kelurahan Rowosari Kota Semarang dengan responden sebanyak 82 didapatkan, sebagian besar responden dengan pengetahuan cukup sebanyak 44 orang (53,7%), sedangkan 28 orang (34,1%) memiliki pengetahuan baik dan 10 orang (12,2%) memiliki pengetahuan kurang baik. Sebagian besar responden dengan persepsi baik sebanyak 52 orang (63,4%), sedangkan yang terendah memiliki persepsi tidak baik sebanyak 30 orang (36,6%). Sebagian besar responden sikap positif sebanyak 50 orang (61,0%), sedangkan yang terendah memiliki sikap negatif sebanyak 32 orang (39,0%). Hasil ini menunjukkan ada hubungan yang signifikan antara tingkat pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang dan ada hubungan yang signifikan antara persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang. Hal ini menyatakan semakin baik pengetahuan masyarakat mengenai gangguan jiwa maka sikap dan persepsi masyarakat kepada gangguan jiwa juga memiliki sikap yang positif dan persepsi yang baik. Penelitian ini diharapkan masyarakat mampu memperbaiki pengetahuan, persepsi atau

penilaian yang tidak baik (buruk) terhadap orang dengan gangguan jiwa. Pengetahuan dan persepsi yang baik dapat menjadikan masyarakat memiliki sikap yang baik pula terhadap ODGJ.

Berdasarkan hasil review dari 10 jurnal didapatkan hasil bahwa pengetahuan masyarakat pada tingkat pengetahuan mengenai gangguan jiwa masih berada pada tingkat cukup dan rendah sehingga berpengaruh pada sikap, perilaku, dan persepsi kepada penderita gangguan jiwa, berpengaruh juga dalam memberikan pertolongan yang tepat kepada penderita gangguan jiwa, serta pengetahuan yang dimiliki oleh seseorang dipengaruhi dengan beberapa faktor seperti pendidikan, usia, pengalaman, pekerjaan, dan lingkungan.

Pengetahuan atau *knowledge* merupakan hasil penginderaan manusia atau hasil tahu seseorang terhadap suatu objek melalui panca indra yang dimilikinya. Panca indra manusia guna penginderaan terhadap objek yakni penglihatan, pendengaran, penciuman, rasa dan perabaan. Pada waktu penginderaan untuk menghasilkan pengetahuan tersebut dipengaruhi oleh intensitas perhatian dan persepsi terhadap objek. Pengetahuan seseorang sebagian besar diperoleh melalui indra pendengaran dan indra penglihatan (Notoatmodjo, 2014).

Pengetahuan mengenai gangguan jiwa menurut masyarakat pada penelitian yang dilakukan oleh Dwi Ari Astanti (2018) merupakan sindrom pola perilaku seseorang yang secara khas berkaitan dengan suatu gejala penderitaan (*distress*) atau hendaya (*impairment*) di dalam satu atau lebih fungsi yang penting dari manusia yaitu fungsi psikologik, perilaku, biologik, dan gangguan itu tidak hanya terletak dalam hubungan antara orang itu tetapi juga masyarakat.

Pada penelitian yang dilakukan oleh Carla Abi Doumit, et.al (2019) dimana pengetahuan masyarakat ada 2 jenis, yang pertama mengacu pada keakrababan masyarakat dengan berbagai gangguan seperti depresi dan skizofrenia, ini menunjukkan bahwa mereka sebagai kelaian sehingga lebih mungkin bagi mereka untuk menyarankan bantuan atau perawatan dari dokter. Kedua mengacu pada tingkat pendidikan yang tinggi yang berkolerasi dengan prasangka dan pemisah yang kurang terhadap pasien yang sakit mental. Masyarakat Lebanon percaya bahwa mata jahat, sihir, dan hukuman dari Tuhan sebagai penyebab terjadinya penyakit mental.

Menurut Rivu Basu, et.al (2017) menyatakan dalam penelitiannya bahwa pengetahuan masyarakat mengenai gangguan jiwa yang menganggap penyakit mental sama seperti penyakit lain dan dapat diobati dengan obat yang tepat dan keterlibatan normal sehari-hari. Pengetahuan masyarakat mengenai gangguan jiwa menurut penelitian yang diteliti oleh Magret Benedicto, et. al (2016) menyatakan bahwa mereka yang bereaksi aneh merupakan seseorang yang sakit mental pada masalah perilaku yang abnormal, sehingga siapapun yang berlaku abnormal disebut sebagai orang sakit jiwa.

Pada penelitian yang dilakukan oleh Jane Munika, et. al (2018) menyatakan bahwa pengetahuan masyarakat mengenai gangguan jiwa merupakan penyakit mental tidak sama seperti penyakit pada umumnya. Pada penderita penyakit mental akan kambuh lagi, penyakit mental juga memiliki kecerdasan yang rendah, serta penyeakit mental dan keterbelakangan mental adalah hal yang sama. Menurut Meena Kolar, et.al (2019) menyatakan dalam penelitiannya bahwa

penyakit mental disebabkan oleh kelemahan pribadi atau kurang karakter, mengidentifikasi tanda-tanda awal tekanan pada seseorang sangat penting dalam mengidentifikasi masalah kesehatan mental dan penyakit mental dapat dicegah.

Berdasarkan beberapa hasil review jurnal yang menyatakan pengetahuan masyarakat mengenai gangguan jiwa dapat disimpulkan bahwa gangguan jiwa atau orang dengan gangguan jiwa berbeda dari penyakit pada umumnya, dimana dalam penanganannya membutuhkan intervensi khusus dalam merawatnya. Penyakit mental bukan disebabkan oleh adanya mata jahat, sihir, atau gangguan gaib melainkan disebabkan oleh adanya tekanan atau stressor yang tidak tertangani dengan baik. Gangguan jiwa dapat diobati dan disembuhkan tetapi tidak menutup kemungkinan bahwa penderita gangguan jiwa dapat kambuh kembali, hal tersebut dapat diatasi oleh masyarakat dalam proses penyembuhan ODGJ dengan membantu dan memberikan dukungan pengobatan yang layah bagi penderita gangguan jiwa.

Pengetahuan itu sendiri memiliki tingkatan dalam domain kognitif, dimana tingkatan tersebut ada 6 yaitu tahu (*know*), memahami (*comprehension*), aplikasi (*application*), analisis (*analysis*), sintesis (*synthesis*), evaluasi (*evaluation*). Pencapaian tingkatan pengetahuan diharapkan masyarakat memiliki tingkat tahu jika memungkinkan maju ketahap memahami dan aplikasi yaitu bertindak mengimplementasikan hasil yang diketahuinya. Pencapain tingkat pengetahuan tersebut memiliki kriteria dalam pengukurannya yaitu pengetahuan kurang dengan nilai <55%, pengetahuan cukup dengan nilai 56 – 74%, dan pengetahuan baik dengan nilai >75% (Budiman dan Riyanto, 2014). Hal tersebut sejalan dengan hasil review dari kesepuluh jurnal yang mengukur pengetahan masyarakat tentang orang dengan gangguan jiwa dengan target pencapaian masyarakat mengetahui mengenai gangguan jiwa dan mengukur tingkat pengetahuan yang dimiliki oleh masyarakat apakah sudah memiliki pengetahuan yang baik, cukup, atau rendah mengenai gangguan jiwa.

Pengetahuan masyarakat mengenai gangguan jiwa masih mengalami kekeliruan dan cenderung pada tingkatan kurang dan cukup. Pengetahuan masyarakat yang kurang didukung oleh penelitian yang dilakukan oleh Hidayatus (2016) yang menyatakan masyarakat Desa banjar Kemantren Buduran Sidoarjo memiliki pengetahuan cukup dan itu ditunjukkan dari masyarakat kurang mengetahui tanda dan gejala gangguan jiwa. Hal tersebut juga didukung oleh Magreth, et.al (2016) juga menyatakan sebagian responden 85,5% (n=330) memiliki pengetahuan buruk tentang penyakit mental dimana responden merespon aneh terhadap penderita gangguan jiwa dan 94,3% responden tidak dapat mengidentifikasi jenis penyakit mental. Serupa juga dengan penelitian yang dilakukan oleh Meena Kolar, et.al (2019) menyatakan bahwa 56% masyarakat tidak memegang gagasan yang cukup, dimana masih menganggap penderita penyakit mental adalah kekerasan tidak dapat diprediksi, 48 % masyarakat menganggap orang dengan penyakit mental seperti kelemahan daripada penyakit nyata, 65% menyatakan dapat membantu seseorang dengan perawatan mental, dimana dengan artian responden menunjukkan kurangnya pengetahuan dalam memahami kesehatan mental, pengetahuan sebab-akibat, dan perawatan masalah kesehatan mental. Penelitian yang dilakukan oleh Jane Munika, et.al (2018) juga

menyatakan dari 7 skor item pernyataan didapat hasil dimana 50,3% responden mendapat skor kurang dari 60% yang artinya memiliki pengetahuan kurang dan 49,7% reponden memiliki skor lebih dari 60% yang artinya memiliki pengetahuan baik, dengan ini menyatakan pengetahuan responden buruk atau kurang mengenai penyakit mental.

Berdasarkan pernyataan-pernyataan di atas memang benar menyatakan bahwa pengetahuan masyarakat mengenai gangguan jiwa memang masih berada dalam tingkat rendah dan cukup. Pengetahuan buruk dan cukup didapat dari masyarakat belum memahami pengertian gangguan jiwa, penyebab gangguan jiwa, tanda dan gejala gangguan jiwa, dan cara memberikan bantuan. Hal ini terbukti dari penelitian yang dilakukan oleh Lilik & Gaury (2016) yang menyatakan bahwa masyarakat menganggap roh halus sebagai penyebab gangguan jiwa dan tidak kuat ilmu ada juga yang mengangap tekanan batin sebagai penyebab. Masih sedikit perhatian pada penderita gangguan jiwa, memperlakukan penderita gangguan jiwa secara tidak manusiawi, merasa tidak nyaman dengan keberadaan gangguan jiwa, dan ingin mendapat pelayanan kesehatan yang baik dan penderita gangguan jiwa dapat berinteraksi dengan orang lainnya. Menurut Yohanes, DKK (2017) dalam penelitiannya menyatakan bahwa masyarakat menganggap gejala yang muncul pada penderita gangguan jiwa disebabkan karena dirasuki oleh roh lain (kerahuan) sehingga membingungkan masyarakat dan keluarga dan penderita gangguan jiwa tidak segera di bawa ke rumah sakit tetapi di bawa ke dukun. Hal ini sejalan dengan penelitian yang dilakukan oleh Reyka Agusdia (2019) yang menyatakan masyarakat beranggapan bahwa gangguan jiwa disebabkan oleh gangguan mistis seperti guna-guna dan penanganan yang dilakukan dengan berobat ke dukun. Pernyataan-pernyataan tersebut ada dikarenakan masyarakat kurang memiliki pengetahuan mengenai gangguan jiwa, dimana masyarakat kurang mendapat paparan informasi mengenai gangguan jiwa.

Baik dan buruknya pengetahuan yang dimiliki oleh seseorang tersebut dipengaruhi oleh beberapa faktor. Faktor yang mempengaruhi pengetahuan ada 2 yaitu faktor internal dan faktor eksternal. Faktor internal yang mempengaruhi pengetahuan yaitu umur, pengalaman, pendidikan, pekerjaan, jenis kelamin sedangkan faktor eksternal yang mempengaruhi yaitu informasi, lingkungan, dan sosial budaya (Wawan dan Dewi, 2010). Hal tersebut sejalan dengan penelitian yang dilakukan oleh Juan Li, et.al (2018) yang menyatakan responden yang memiliki usia 22-44 tahun memiliki skor pengetahuan yang tinggi, responden yang memiliki tingkat pendidikan lebih tinggi juga memiliki pengetahuan yang lebih tinggi mengenai penyakit mental. Penduduk yang tinggal diperkotaan cenderung memiliki pengetahuan lebih tinggi dibandingkan dengan penduduk pedesaan. Responden yang pernah kontak langsung dengan penderita penyakit mental, memiliki pertemuan pribadi dengan penderita, dan belajar dari media masa cenderung memiliki cenderung memiliki pengetahuan kesehatan mental yang lebih besar. Sejalan juga dengan penelitian yang dilakukan oleh Carla Abi Doumit, et.al (2019) menyatakan bahwa usia peserta di atas 70 tahun ke atas memiliki pengetahuan kurang mengenai penyakit mental begitu pula pada daerah pedesaan dan perkotaan memiliki pengetahuan yang berbeda. Pada penelitian

yang dilakukan oleh Hidayatus (2016) juga menyatakan bahwa tingkat pengetahuan didukung oleh tingkat pendidikan, usia, pekerjaan, pengalaman, dan status pernikahan, dimana usia di bawah 45 tahun yang mendominasi responden cenderung lebih mudah dan cepat menngingat untuk mendapatkan dan mencari informasi mengenai gangguan jiwa. Pekerjaan responden yang didominasi oleh pegawai swasta cendrung memiliki pengetahuan yang baik, begitu juga dengan status pernikahan cenderung status menikah memiliki pengetahuan yang cukup dikarenakan dalam keluarga menjalankan fungsi sosialisasi sehingga saling bertukar informasi, memberi dukungan, dan berinteraksi antar anggota keluarga. Pengalaman juga sangat berpengaruh dalam pengetahuan seseorang dimana semakin banyak pengalaman yang dimiliki oleh seseorang makan semakin baik pengetahuan yang dimiliki. Tingkat pendidikan juga mendukung dalam pengaruh tingkat pengetahuan, semakin tinggi tingkat pendidikan maka pemahaman akan suatu hal akan semakin tinggi pula.

Pengetahuan yang dimiliki masyarakat mengenai gangguan jiwa berpengaruh pada cara masyarakat bersikap dan memberikan pertolongan kepada penderita, seperti halnya semakin baik pengetahuan yang dimiliki oleh masyarakat maka masyarakat mampu memberikan sikap positif kepada penderita gangguan jiwa, sehingga kekeliruan yang terjadi pada penderita gangguan jiwa dapat diatasi. Menurut Notoadmodjo (2014) pengetahuan merupakan domain yang sangat penting untuk terbentuknya tindakan seseorang (over behavior), dikarenakan dalam pengalaman dan penelitian ternyata perilaku yang didasarkan oleh pengetahuan akan lebih langgeng dari pada perilaku yang tidak didasari oleh pengetahuan. Hal tersebut sejalan dengan penelitian yang dilakukan oleh oleh Ema Irawan (2019) yang menyatakan bahwa responden yang memiliki pengetahuan yang baik tentang perilaku kekerasan juga memiliki sikap yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan. Dwi Ari Astanti (2018) juga menyatakan masyarakat yang memiliki pengetahuan baik terhadap ODGJ maka memiliki juga persepsi positif terhadap ODGJ. Sejalan juga dengan penelitian yang dilakukan oleh Novia Dewi (2018) yang menyatakan bahwa masyarakat yang memiliki pengetahuan cukup baik sehingga memiliki sikap yang positif kepada ODGJ dan dari sikap yang positif memiliki juga persepsi yang baik kepada ODGJ. Penelitian yang dilakukan oleh Rivu Basu, et.al (2017) juga menyatakan bahwa adanya partisipasi positif dari masyarakat mengenai penyakit mental baik dari penerimaan, pengobatan, dan cara bersikap, hal itu terbukti dari masyarakat percaya bahwa penyakit mental dapat disembuhkan, penderita penyakit mental harus di rawat di rumah sakit jiwa, penderita penyakit mental perlu diperhatikan dengan penuh tanggung jawab, responden juga bersedia hidup dengan orang penyakit mental.

Pengetahuan mengenai gangguan jiwa harus dimiliki dengan baik oleh masyarakat dimana pengetahuan tersebut sangat bermanfaat di dalam membantu mengurangi stigma negatif yang terjadi pada penderita gangguan jiwa dan membuang kekeliruan mengenai penyebab dan dapat memberikan pertolongan pada penderita gangguan jiwa, sehingga akan membuat angka kejadian gangguan jiwa tidak meningkat serta dalam proses perawatan penderita gangguan jiwa

mendapat dukungan penuh dari masyarakat sekitar dan mempercepat proses penyembuhan penderita gangguan jiwa.

SIMPULAN DAN SARAN

Berdasarkan hasil review dari 10 jurnal disimpulkan bahwa 4 jurnal diantaranya menyatakan bahwa pengetahuan masyarakat mengenai gangguan jiwa masih berada pada kategori rendah dan cukup, dimana masyarakat kurang memahami kesehatan mental tentang sebab-akibat, tanda gejala, dan perawatam kepada penderita gangguan jiwa. 3 jurnal lainnya menyatakan bahwa pengetahuan yang dimiliki oleh masyarakat dipengaruhi oleh beberapa faktor seperti usia, jenis kelamin, pekerjaan, tingkat pendidikan, pengalaman, dan lingkungan. 4 jurnal lainnya menyatakan bahwa pengetahuan mengenai gangguan jiwa memiliki pengaruh pada cara masyarakat bersikap kepada penderita gangguan jiwa, seperti halnya sikap positif yang dimiliki masyarakat berasal dari pengetahuan baik atau cukup yang dimiliki oleh masyarakatmengenai gangguan jiwa.

Hasil *literature review* merekomendasikan bagi petugas kesehatan untuk meningkatkan pengetahuan masyarakat mengenai kesehatan jiwa ataupun gangguan jiwa dengan cara memfasilitasi dalam pemberian pendidikan kesehatan mengenai kesehatan jiwa, mengembangkan program dalam penyedia layanan perawatan kesehatan mental, membuat program kampanye anti stigma mengenai gangguan jiwa, mempedayakan dan melatih anggota masyarakat dalam penguatan pengetahuan mengenai gangguan jiwa, dengan ini dapat meningkatkan pengetahuan kesehatan jiwa masyarakat sehingga dapat bersikap dan memberikan pertolongan kepada penderita gangguan jiwa dengan baik serta membawa perubahan yang baik dalam stigama-stigma buruk yang terjadi selama ini. Bagi peneliti selanjutnya literature review ini dapat dijadikan acuan dalam melakukan penelitian yang lebih mendalam mengenai pengatahuan masyarakat tentang orang dengan gangguan jiwa.

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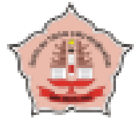

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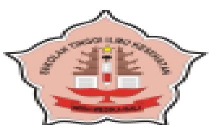
Masa Bimbingan :
Judul Penelitian : ***Literature Review:* Pengetahuan Masyarakat Tentang Orang dengan Gangguan Jiwa**

Pembimbing I		
Tgl	**Materi Bimbingan**	**Paraf**
Selasa, 05 Mei 2020	• Apapun Bahasa asing ditulis miring • Tingkatan CUKUP itu berapa? Tolong diuraikan. • Jangan meletakkan saran di bagian pembahasan. • Uraikan gambaran masyarakat bukan level pengetahuan masyarakat, misalnya: hasil telaah review diperoleh tingkat pengetahuan cukup dan rendah sehingga diperoleh masyarakat berperilaku sesuai dengan tingkat pengetahuannya dan masyarakat kurang memaknai arti perawatan jiwa masyarakat.	
Minggu, 10 Mei 2020	• Dalam membuat kesimpulan buat dalam kalimat yang sederhana dan mudah dimengerti. • Dalam saran buat secara operasional jangan munculkan konsep kembali, missal: lakukan wawancara dengan masyarakat atau keluarga sekalian mengukur pengetahuan melalui isi pembicaraan.	
Senin, 11 Mei 2020	ACC UJIAN	

Pembimbing I		
Tgl	**Materi Bimbingan**	**Paraf**
Senin, 11 Mei 2020	• Latar belakang masih menggunakan yang lama sehingga gap teori tidak terlihat. • Hasil table jadi tidak nyambung dengan pembahasan. • Perkuat permasalahannya.	
Jumat, 15 Mei 2010	• Kata-kata yang digunakan masih relevan atau tidak dan hati-hati dalam pemilihan kata. • Saran: cari literature untuk latar belakang mengenai pemahaman masyarkat tentang gangguan Jiwa. • Fokus pada gambaran pengetahuan atau masyarakat paham mengenai gangguan jiwa	
Selasa, 19 Mei 2020	• Isi sitasi siapa yang mengungkapkan bahwa gangguan jiwa disebabkan oleh ilmu gaib. • Gunakan Bahasa yang tidak membingungkan agar tidak tumpeng tindih dengan kalimat/paragrap sebelumnya. • Perhatikan pemilihan kata dan Bahasa pada translate hasil	



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	jurnal sehingga bahasa tidak membingungkan dan jelas kaitannya.	
Rabu, 27 Mei 2020	• Semua judul jurnal yang berbahasa asing diterjemahkan menjadi Bahasa Indonesia agar seragam	
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Community Knowledge, Attitudes and Perception towards Mental Illness in Dodoma Municipality, Tanzania

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Abstract: *Community attitude and perception towards mental illness play a major role in successful treatment and social reintegration of people with mental health problems. The aim of this study was to determine the knowledge, attitude and perception of the community towards mental illness in Dodoma Municipality. A multistage sampling technique was employed to select a sample size of 384 from the study population. A descriptive cross-section study was employed and semi-structured questionnaire were used in this study. The results showed that most of participants 85.9% (n=330) had poor knowledge about mental illness. Fifty one percent (n=196) could not identify any type of illness, 58.9% (n=226) connoted negative attitude towards persons with mentally illness. Moreover 75.8% (n=291) of these had poor perceptions about mental illness. Poor knowledge, perception and negative attitude still prevail despite the fact that there is a National Mental Hospital located in Dodoma Municipality, Tanzania.*

Keywords: Attitude, *Community, Knowledge, Mental health, Mental illness, Perception*.

Accessible Summary

- Mental and behaviour disorders are one of the challenges facing the world today. This study assessed knowledge, attitude and perception of the community towards mental illness in Dodoma Municipality. The study was completed in Tanzania.
- The community showed poor knowledge concerning mental illness, inability to identify types of illness and had negative perception about mental illness.
- The findings of this study show that, a good number of respondents had little knowledge about mental illness. The inability to identify the type of mental illness could be due to lack of health education on mental health and therefore lack of awareness for the appropriate treatment.
- This study provides the baseline findings for supporting health workers to empower the community members regarding knowledge of mental illness, in order to change the attitudes and perception of the community, as well as establishing health seeking behaviour for treatment of mentally illnesses.

1. Introduction

Mental illness (MI) is the term used to describe a broad range of mental and emotional conditions. It is also refer to mental impairments other than mental retardation, organic brain and learning disabilities (WHO, 2001). MI can be experienced over many years; the type, intensity and duration of symptoms vary from person to person. The most common forms of MI are anxiety disorders and depressive disorders.

Mental and behaviour disorders are so prevalent that more than 25% of people at a global level are estimated to experience this condition at some point in their life time. They affect each part of fabric of society including poor, rich, young or adult (World Health Report 2001).

The prevalence is on the increase each day as reported by the National of Mental Health in the United States of America (2003) indicated a probability of 20% of the population would be affected by some kind of mental illness at any one point of time of their lives and that a probability of 25% of people would have been familiar with someone with Mental illness.

Studies have shown that people have limited knowledge and negative perception about mental illnesses in the community, and whenever there is any knowledge, it is based on prevailing local understanding of the nature and causation of MI (Asuni *et al.* 1994). People's beliefs regarding MI should not only be known, but the purpose of their beliefs should be understood; such attitudes and beliefs about MI can only be studied within a cultural context (Gureje *et al.*2006).

Community attitudes influence the help seeking behaviour of mental health sufferers. Ignorance about advances in the diagnosis and management of MI, the availability of effective treatment, and the fear of stigmatization may prevent people with mental disorders from seeking professional help (Hugo *et al.* 2003). Moreover, the community attitude and perception towards behaviour disorder or mental illness play a major role in successful treatments and social reintegration of the mentally ill persons. Also, these help in the determination of help seeking behaviour and adherence to drug treatment (Hugo *et al*. 2003).

Mental illness is a major problem in which two thirds of people who require treatment for MI have been reported that do not seek help because of stigma associated with the illness and its treatments (Stuart 2005). Since MI is a major problem globally and it is on the rise, therefore a study which explore the community's knowledge, attitudes and perceptions towards mental illness might useful to ameliorate this problem. There are numerous studies on knowledge and perception towards mental illness. However to best of our knowledge, to date, there is no any study explored the community knowledge, attitude and perception towards MI in Dodoma Municipality, Tanzania.

2. METHODS

The research design was a descriptive cross-sectional study a quantitative method.

2.1. Inclusion Criteria

This study included people aged 18 years and above residing in Dodoma Municipality who were both males and females.

2.2. Exclusion Criteria

Those aged less than 18 years, refusal to participate, seriously ill persons, mentally sick and failure to speak Swahili or English were not included because consent was needed before administering the questionnaire.

2.3. Sampling Technique

A multistage cluster sampling was adopted for this study. In the first stage, by the use of the lottery method, one division among the four divisions of the Municipality of Dodoma was randomly selected. In the second stage, by using simple random sampling method, wards were selected from division that was selected in the first stage. In the third stage streets were chosen from the wards, which were obtained in the second stage. In the fourth stage, households were enumerated from each selected street and then were randomly chosen so as to get the required sample size. Any participant aged 18 years – old or above, from each household was considered a respondent for this study. In case of any refusal to participate, the replacement was made.

2.4. Methods of Data Collection

Data was collected from the respondents using a semi-structured questionnaire. The content of the questionnaire included socio-demographic variables, knowledge of the mental illness and its causes, attitude and perception of community members about mental illness. The sources of the questionnaire were from Ng and Chan (2000) a modified version of the questionnaire about mental illness in the Chinese Community; but modification was made to suit this study. A semi-structured questionnaire was adopted in this study in order to allow the respondents to give out their views concerning the questions asked. The questionnaire was designed in English language and then sent to the English department and then to the Kiswahili departments at St. John's University of Tanzania (SJUT) for translation into Swahili language. Finally it was again sent to the English department (SJUT) for final editing and to check for its validity.

2.5. Validation of Research Instrument

In order to test validity of the research instrument, pilot study was done before the actual study, where by 20 participants from two villages with characteristics similar to the study participants were interviewed. The participants included in the pilot study were not included in the actual study. In

order to measure for reliability, Cronbach's alpha was calculated and the value of 0.791 was obtained from the data collected from the pilot study. Then, the researcher made the necessary corrections and modification of the instruments which were used in the actual study.

2.6. Data Analysis

The data were entered, cleaned and then analyzed by using the Statistical Package for Social Sciences (SPSS 17). Results are also presented using bar charts and graphs, which are used for the interpretations and discussions. Descriptive analysis was performed for proportions, percentages, means and their corresponding standard deviations.

2.7. Scoring System

Knowledge on mental illness was scored against questions which were asked. All responses were given equal weight. The mean score was calculated by taking total scores of knowledge on mental illness divided by the total number of all study participants; the correct answer was awarded one point and the wrong one zero point. Total knowledge score was 20 with a mean of 11.4, total score for attitude was 7 with a mean of 2.71 and total perception score was 3 with a mean of 1.21.

The mean score was used as a cutoff point to categorize the level of knowledge on mental illness. Respondents who got above the mean score were categorized as having a good knowledge while those who got less than the mean score were categorized as having poor knowledge towards mental illness.

2.8. Ethical Issues and Confidentiality Consideration

The ethical approval to conduct the study was obtained from the Research and Publications Committee of the University of Dodoma. Permission to conduct the research was obtained from the Municipal Director of the Dodoma Municipality. During the data collection, respondents were informed on the purpose of the study. Before questionnaire administration, consent form was given to each participant to sign and no name was required. In order to allow them to make an informed choice, informed consent included description of the aim and advantages of the study, the foreseeable and anticipated risks, care for psychological trauma that could result from the study and its duration were stipulated. The participants were free to withdraw from the study at any time when the feel so without any penalty.. Furthermore, to maintain privacy and confidentiality the answered questionnaires were kept and locked safely at a place where only the principle investigator can have access.

3. RESULTS

3.1. Social Demographic Characteristics

Table1. *Distribution of the study sample by socio-demographic characteristics (N=384)*

Particular	Category response	Frequency and percents n(%)
Gender	Male	230(59.9)
	Female	154(40.1)
Religion	Christian	217(56.5)
	Muslim	162(42.2)
	Others	5(1.3)
Age	18-24	88(22.9)
	25-34	139(36.2)
	35-44	103(26.8)
	45-54	45(11.7)
	55+	9(2.3)
Marital status	Single	163(42.4)
	Married	206(53.6)
	Separated	9(2.3)
	Divorced	4(1.0)
	Widowed	2(0.5)
Employment	Peasants	48(12.5)
	Unemployed	83(21.6)
	Employed	162(42.1)
	Small scale business	91(23.7)

Education	Informal	12(3.1)
	Primary	112(29.2)
	Secondary	159(41.4)
	College	70(18.2)
	University	26(6.8)
	Others	5(1.3)

This study was done from December 2011 to June 2012. A total of 384 respondents were interviewed in which n= 230 (59.9%) were males. Mean age was 34.3 (SD 2.3) years. With regards to education category n=159 (41.4%) of respondents were secondary educated, n= 206 (53.6%) were married, n= 217 (56.5%) were Christians and n= 162 (42.1%) of the respondents were employed. The description on Table 1 above provides the detailed results of socio-demographic characteristics found in this study.

3.2. Community Knowledge of Mental Illness

Measurement of knowledge of mental illness focuses mainly on the general understanding of mental illnesses without necessarily focusing on the knowledge of specifics, knowledge of common signs that describes one to have a mental illness, knowledge of types, knowledge of causes and knowledge of treatment options for mental illnesses.

Aiming at obtaining the respondents' broad knowledge about mental illness, the variables were assessed by asking the responded on how much they knew about mental illness. More than half of the respondents n=225 (58.6%) reported little knowledge of MI, as opposed to less than one tenth n= 32 (8.3%) who claimed a good knowledge about MI. The description on Table 2 below provides the detailed results of knowledge that was found in this study.

Table2. *Community knowledge on mental illness (N=384)*

	Frequency		Percent
Responses	(n)		(%)
A good deal	32		8.3
A little	225		58.6
Very little	95		24.7
Don't know	32		8.3

3.3. Community Knowledge on Sign and Symptoms of Mental Illness

Ninety four percent (94.3%, n=362) of the respondents reported to have had ever seen a MIP and n= 22(5.7%) had never seen one. Common symptoms of MI reported by respondents were abnormal behaviors n= 183 (50.3%), and talking alone n=50 (13.7%) as indicated by Figure 1 below.

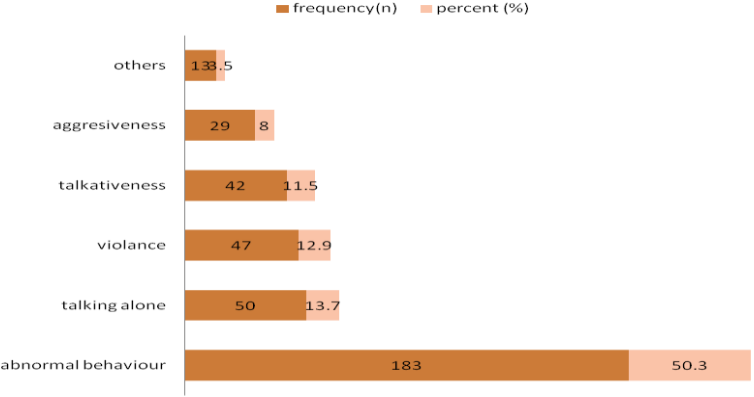

Figure1. *Distribution of study population by knowledge on signs and symptoms of mental illness (N=364)*

3.4. Community Knowledge on Types of Mental Illness

Results shows that, a total of respondent n=196 (51.0%) did not know the types of MI while drug induced psychosis was reported by many respondents; n= 66 (17.2%). Further description of what respondents reported about the types of mental illness are found in Figure 2 below.

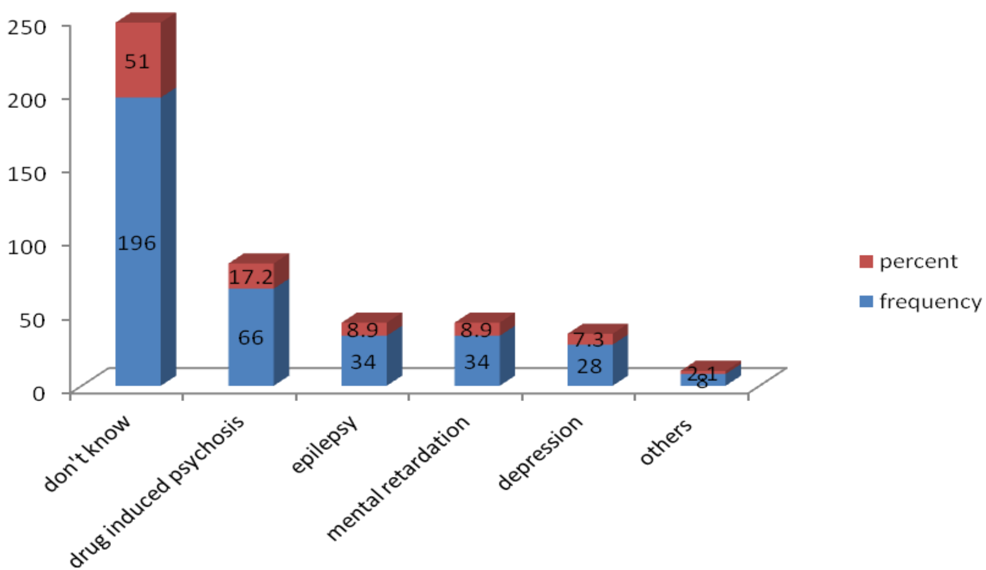

Figure2. *Distribution of study population by knowledge on types of mental illness (N= 384)*

3.5. Community Knowledge of Causes of Mental Illness

Substance abuse (alcohol and/or drugs, but mainly the latter) was identified by majority of respondents (n= 289 (75.3%)) as a causes of MI, while very few n= 40 (10.4%) agreed that curses could be causes of mental illness. Many other causes were identified by respondents to be the causes of mental illness as is shown in Figure 3 below.

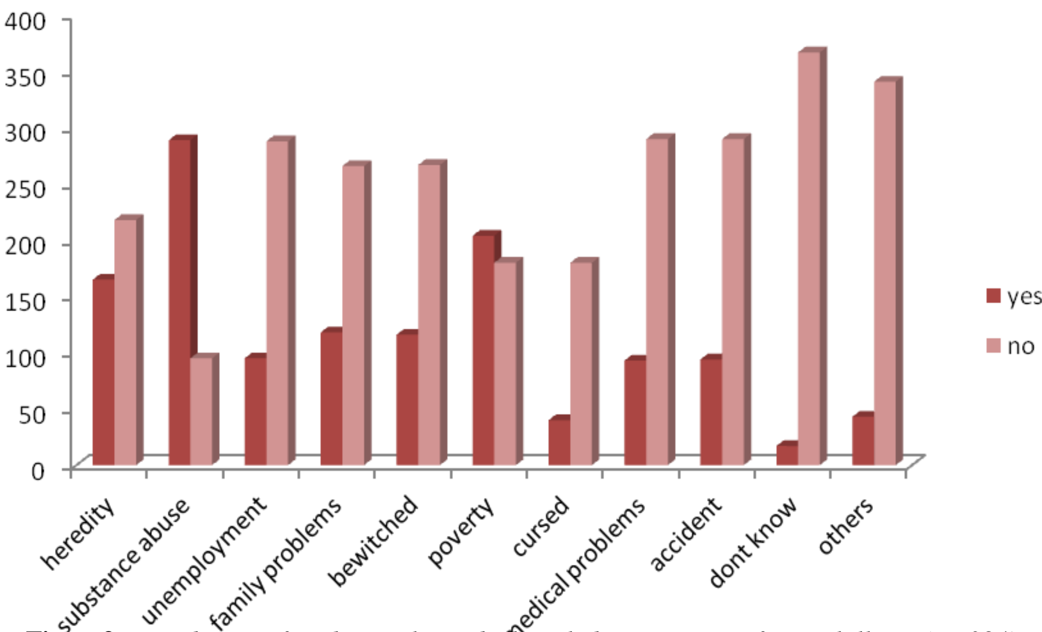

Figure3. *Distribution of study population by knowledge on causes of mental illness (N=384)*

3.6. Community Knowledge about Treatment of Mental Illness

One among other, in the measurement of knowledge of mental illness, was knowledge of treatment options. Total number n=330 (86.2%) of respondents, identified mental hospital/institution to be the treatment option for mental illnesses and while other group of respondents n= 148 (38.5%) identified counselling to be their option for treatment of mental illnesses as summarized in Figure 4 below.

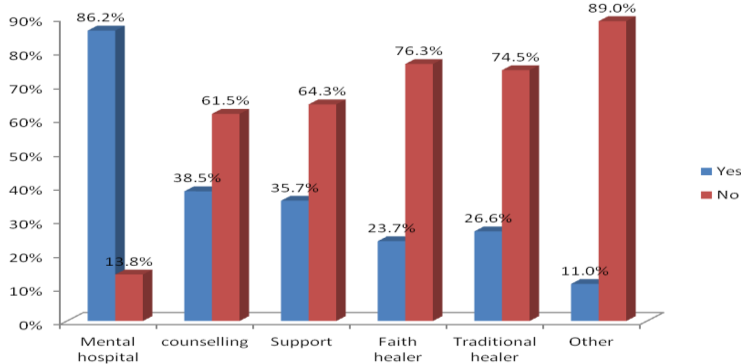

Figure4. *Participants' knowledge on treatment measures of mental illness (N=384)*

When respondents were asked if a mentally sick person could live a healthy life in the community, n= 205 (53.4%) said no. Stigma was cited as the reason for not living a health life by n=120 (60.9%) while n= 254 (66.1%) reported that they cannot make friendship with a MIP. Other findings are indicated in Table 3 below.

Table3. *Attitudes and perceptions toward mental illness among the participants in the study sample (N= 384)*

	Responses	Participants	
		Frequency (n)	Percent (%)
Live health life in community?	Yes	179	46.6
	No	205	53.4
Reasons for Not living health life (n=197)	Stigma	120	60.9
	Poor thinking	28	14.2
	Community is afraid of them	24	12.2
	Harm/kill	20	
	Other	5	2.5
Reasons for mentally ill persons to live healthy life in community	Treatment	65	35.1
	Support	82	44.3
	Involving	31	16.8
	No reason	6	3.2
	Others	1	0.3
Make friendship	Yes	130	33.9
	No	245	66.1
Reason for not making friendship with Mentally sick	Violence	176	45.8
	Aggressiveness	24	6.3
	Unpredictable	5	1.3
Reason not to socialize in the community	Aggressive	24	20.3
	Violence	30	25.4
	Poor thinking	16	13.6
	Go against	40	33.9
	Others	8	6.8

A total of n=193 (50.5%), of the participants reported that a MIP cannot do a regular job when asked if a mentally ill person could do a regular job (figure 5); while n=69 (35.6%) reported that they cannot have a regular job because they will be making mistakes and ruin the job (Table 4).

Table4. *Participants' perception on reasons for Mental Ill People not to do regular job (N=194)*

		frequency	percent
Responses		(n)	(%)
make mistakes		69	35.6
poor concentration		58	29.9
causes damage		49	25.3
need treatment first		17	8.8
other		1	0.5

Eighty six percent, n=332 (86.5%) of the study population reported that they will feel good if a mental health facility was set up in their community and the reasons are summarized in Table 5 below.

Table5. *Participants' attitude towards mental health facility set up in the community (N= 379)*

Responses	Frequency (n)	Percent (%)
Save the patients	184	48.5
Reduce the number of patients	62	16.4
Center of education	49	12.9
Increase manpower	27	7.1
Bring noise	26	6.9
May harm people	12	3.2
Increase interaction	10	2.6
Move away	9	2.4

4. DISCUSSION

To best of the researcher's knowledge, this is the first study to explore the community knowledge, attitudes and perception towards mental illness in Dodoma municipality. The outcomes of this study suggested that knowledge about mental illness was poor in Dodoma community.

In the present study, the majority of the respondents (41.1%) had secondary school education which implies that one would expect that they could have sufficient knowledge and good perceptions about MI, and therefore have positive attitudes towards people with mental health problems. However, on the contrary, their knowledge of MI was found to be poor. The reason behind could be due to the absence of mental health education program to the community members.

The findings of this study showed that a good number of respondent, 58.6% had little knowledge about MI. These further indicated that they could react strangely to someone who is mentally ill. In addition, 50.3% of the respondent claimed that they would recognize a person with mental health problems by his or her abnormal behaviour. This kind of perception would induce the community to brand anyone with abnormal behaviour as being mentally ill even when this person might be merely acting out. Moreover this implies that the community would not be able to recognize a person in remission or less severe phases of MI. This finding is in agreement with what was found in a study done in Ethiopia by Deribew & Tamirat (2005) which reported 60% of the respondents reported abnormal behaviour as the sign of MI.

Despite the fact that a great number of the respondents (94.3%) in this study reported to have seen a person with mental health problems, they could not identify the type of MI the person was suffering from. This could be due to the fact that in Dodoma, one is likely to see a MIP because a mental hospital is located in this community. The inability to identify the type of MI could be due to lack of health education on mental health and therefore lack of awareness of the types of MI. The unawareness can curb the capability to help a MIP seek proper treatment and in turn lead to misperception about MI and negative attitude towards people with mental health problems.

The identification of substance abuse, drugs in particular, by most of the participants (75.3%) in this study as a major cause of MI can make members of the community to be prone to sweeping generalizations or stereotyping that all people with mental health problems are drug and/or alcohol addicts. This finding concurs with what was found in a study done in Nigeria by Gureje *et al.* (2005) in which substance abuse was stated to be the major cause of MI by 80.8% of respondents.

The finding in this study show that there was almost an equal split between those (53.1%) who asserted that poverty was the cause of MI and those (46.9%) who disagreed. These results are in agreement with the findings of the study conducted by Deribew and Tamirat (2005) which found out that 55% of the respondents chose poverty. Furthermore, the observations indicate that the study population did not attribute heredity and family problem as being possible cause of MI. This implies that the study population was unaware of other possible causes of MI.

This also underscores the belief of the Dodoma community that substance abuse is the prime cause of MI. This ignorance could result into negative perceptions about the condition.

The finding in this study shows that the majority of the respondents (86.2%) mentioned the best model of treatment as the hospital concurs with what was found in a study by Kabir *et al.* (2004) in North Nigeria. However, this finding is in disagreement with what was found in a study by Gureje *et*

al. (2005) in Nigeria in which traditional healing was the most preferred treatment. The preference of hospital treatment of MI noted in this study (86.2%) could be attributed to a number of reasons such as higher education of the study population, the presence of a mental hospital in Dodoma and religiousness of the studied community.

In this study, negative attitudes towards people with mental health problems were very prevalent among the study population (58.9%) indicated by responses such as MIP cannot live a better life and that they cannot make friendship with them. This is in agreement with what was found in study done on health workers in Delta State in Nigeria by Kamla (2009). Factors which facilitated this negative attitude towards MI included stigma, violence behaviour of MIP, impaired cognitive functioning and lack of knowledge towards MI among community members. The findings in this study are also supported by the study done in Kinondoni Tanzania by Chikomo (2011).

Also the responses such as MI cannot perform a regular jobs, are aggressive and dangerous indicate that perceptions of the study population towards people with mental health problems generally poor. These perceptions are true only for patients in the acute phase of MI but not when the patients are in remission or after getting effective treatment. Although majority of respondents said would feel good if a mental health facility is set up in the street, some of the explanations would reduce the number of patients in the street implies that they have a negative attitude and poor perception toward mental illness.

5. Conclusion

Poor knowledge, perception and negative attitude still prevail in Dodoma Municipality despite the fact that there is a National Mental Hospital located here.

This was due to lack of community mental health education programs. Therefore there is a need for community mental health education in order to improve the knowledge, attitudes and perception of the public towards MI. This may encourage early health seeking behavior, as well as better treatment outcomes.

This research provided a baseline to health workers to empower the community members regarding knowledge of MI, in order to change the attitudes and perception of the community, as well as the health seeking behaviour of people with mental health problems.

Also to inform the mental health policy developers/makers of the mental health curriculum, to develop programs which will help mental health care providers to assist the community, provide care and facilitate mental health education effectively. And finally to stimulate further research regarding mental health knowledge, attitudes and perception, in order to improve knowledge and a change in the attitudes and perception of the community, as well as the health seeking behaviour of people with mental health problems.

Recommendation

The Ministry of Health and Social Welfare should sensitize the community, through campaigns and workshops in churches, schools, Non Governmental Organisations and all sectors raise community awareness and to modify the negative attitudes and perception of the community towards people suffering from MI.

There should be educational programs conducted by mental health care providers for rehabilitation of people with mental health problems and their families in the community.

More qualitative research should be done to explore more on the factors which contribute to negative attitudes and poor perception of people living with mental illness.

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Evaluation of attitudes and knowledge toward mental disorders in a sample of the Chinese population using a web-based approach

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Abstract

Background: People with mental disorders often encounter stigmatizing attitudes related to their conditions. Stigma often represents one of the critical obstacles that stand in the way of delivering mental health care. The main aim of the study was to assess the knowledge and attitudes toward mental disorders in a sample of the Chinese population; furthermore, we also aimed to identify and explore the socio-demographic characteristics associated with specific knowledge and attitudes towards psychiatric disorders.

Methods: A cross-sectional survey was created and delivered through an Internet chat application over the period June–December 2017. The Mental Health Knowledge Questionnaire and the Perceived Devaluation and Discrimination Scale were used to evaluate the participants' mental health knowledge and attitudes toward mental disorders.

Results: A total of 1087 participants were recruited in for our survey. The mean score of the MHKQ and PDD were (15.89 ± 2.69) and (33.77 ± 6.66), respectively. Univariate analyses showed that young people and rural residents tended to show more positive attitudes toward mental disorders with respect to older people and urban residents ($P < 0.05$). People with higher education levels, those who had contact with people with mental disorders, and those who learned about mental disorders by personal encounter resulted to have had higher MHKQ scores ($P < 0.05$).

Conclusions: In our sample of the Chinese population, negative attitudes toward mental disorders were often reported. General education programs may not be an effective way to decrease stigma, while anti-stigma campaigns targeted for specific groups, such as urban residents and the older people, should be carried out in the future in China.

Keywords: Mental health knowledge, Stigma, Discrimination, Mental disorders, China

Background

Although there are now a variety of effective treatments for mental disorders, still a significant number of people do not receive proper treatment for mental disorders [1]. Even those who receive care and assistance from mental health services often tend to exhibit a significant delay between symptoms' onset and seeking treatment and this can exacerbate their conditions and increase the psychological and financial burdens [2]. The fear of being discriminated against has been reported to play a significant role in creating barriers and increasing the delay in seeking treatment [3]. Stigma and discrimination are widely experienced by people with mental disorders in many domains of their daily life, such as in employment, social activities, personal relationships, housing, marriage, and so on [4–8]. In China, words like "violent," "crazy," "strange", and "useless" are often used to describe people with mental disorders [9, 10]. Stigma and discrimination surrounding mental disorders represent not only factors that hamper treatment-seeking [11], but may also delay the healing process for people with mental disorders [12] and prevent people with mental disorders from achieving their social rights and full participation in the life of their community.

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Moreover, the family members of people with mental disorders are often blamed by the public [13]. Empirical evidence showed that families of people with mental disorders are likely to ignore the problem when their family members experience discrimination: they may hide them from public life, delay treatment seeking, or even reject professional help. Such attitudes and behaviors may determine a pejorative illness course and increase the psychological and financial burdens on the families [14–16].

In order to reduce the treatment gap and provide more consistent and accessible mental health services, the World Health Organization (WHO) has encouraged countries to integrate mental health services into their primary care systems. However, negative attitudes toward mental disorders among the general population are likely to represent an obstacle to the development of more efficient community mental health services [17].

Additionally, the general public could, through greater social engagement and more acceptance of mental disorders, play an essential role in rehabilitating the mentally ill. This is no easy task, since people with mental disorders have often been labeled as "violent" and "dangerous", and the attitudes of the general public have contributed to exacerbating the conditions of people with mental disorders [18].

Thornicroft et al. [19] defined stigma as an overarching term that refers to three main elements: problems of knowledge (ignorance), problems of attitude (prejudice), and problems of behavior (discrimination). It has been reported that lack of accurate mental health knowledge may be one of the leading factors that may contribute to stereotyping people with mental disorders [20]. However, it has also been found that health professionals, who are supposed to have greater knowledge concerning mental health issues with respect to the general population, often have more negative attitudes toward mental disorders than the general public [21–23]. This finding contradicts a common assumption that greater knowledge of mental disorders results in less of a discriminatory attitude, and thus it throws into question the, supposedly positive, relationship between mental health knowledge and discriminatory attitudes.

The main aims of this study were to evaluate attitudes and knowledge about mental disorders in a sample of the Chinese general population and to explore their relationships with socio-demographic characteristics. Results from this study could yield some applications: first, it could help in designing programs that would aim to reduce public stigma against mental disorders; second, it could provide guidance for the government to undertake further strategic action.

Methods

Participants

A "snowball" sampling method was used to recruit participants. A digital version of a self-made schedule and of two standardized questionnaires was sent to 50 people known to the study authors (including families, friends, and other acquaintances), who previously agreed to participate in the study and to share the digital questionnaires through the Internet chat application "We-Chat", which has over 800 million active members in China. A standardized statement accompanying the questionnaire encouraged all the participants to transmit the electronic questionnaire to their friends or family members. Participants were informed, at the beginning of the survey, that expression "mental disorders" in the questionnaire referred to schizophrenia, depression, and bipolar disorder. All potential participants were also informed that they had a chance to win a raffle prize as a reward.

Participants were finally asked to provide anonymous informed consent in electronic format, before taking part in the survey. The survey was conducted from June to December 2017. The study protocol was approved by the Research Ethics Committee of the Second Affiliated Hospital of Xinxiang Medical University.

Instruments

A self-made questionnaire was used to collect participants' basic demographic data (including age, gender, level of education, and place of residence).

The Mental Health Knowledge Questionnaire (MHKQ) was developed to evaluate public knowledge and awareness of mental health by the Chinese Ministry of Health (MOH) in 2009. It contains 20 self-administered items. Items 1–16 (the first section) require participants to select "true," "false," or "unknown" about statements concerning mental health. For items 1, 3, 5, 7, 8, 11, 12, 15 and 16, a "true" answer corresponded to a 1-point score, while a "false" or "unknown" answer corresponded to score of 0. By contrast, for items 2, 4, 6, 9, 10, 13 and 14, a "false" answer gave a score of 1, while "true" or "unknown" answers corresponded to score of 0. Finally, items 17–20 (the second section) are statements concerning previous knowledge about the "four mental health promotion days". Total scores range from 0 to 20, with higher scores indicating greater knowledge of mental health issues. The Cronbach's coefficient of MHKQ was reported to be 0.61 [24].

The Perceived Devaluation and Discrimination Scale (PDD) [25] was used to assess the degree of stigmatizing attitudes toward people with mental disorders. It contains 12 items and each item is rated on a 5-point scale, ranging from 1 (totally agree) to 5 (totally disagree). Items 1, 2, 3, 4, 8 and 10 required reverse scoring. Total scores ranged from 12 to 60, with higher scores indicating lower levels of stigma. The Chinese version of the PDD has been reported to have strong internal consistency (Cronbach's $\alpha = 0.70$).

Participants were also requested to answer three additional questions concerning their source of information about mental disorders (i.e., portrayals in mass media vs. direct encounter), level of contact with mentally ill people, and their attitude toward psychotropic drugs (with the following four response options: "Effective", "They make people worse", "Ineffective" and "Likely to lead to dependency").

Data analysis

Descriptive statistics were used to explore basic socio-demographic data. The scores obtained from PDD and MHKQ were then compared among sample subgroups, created according to demographic characteristics, using one-way analysis of variance. The demographic information used to create subgroups included gender, age, education, place of residence, sources of information, and level of contact with people with mental disorders. The correlation between knowledge about mental disorders and attitudes toward those disorders was examined by the Pearson's correlation coefficient. For all statistical analyses SPSS v18 was used and the level of significance was set at $P < 0.05$.

Results

Sample characteristics

A total of 1104 participants finished the questionnaires, but 15 participants were excluded because they reported having been diagnosed with mental disorders in the past and two participants were excluded because they were below legal age for providing informed consent (i.e., 16 years). A total of 1087 participants were finally included in our survey and their mean (±SD) age was 33.93 (±9.76) years, within a range of 16–67 years. Our participants were predominantly female ($N = 693$; 63.8%). The socio-demographic characteristics are summarized in Table 1.

Contact with and general knowledge about mental disorders

The majority of our respondents declared previous contact with people suffering from mental disorders (64.9%; $n = 706$), although 59.7% ($n = 649$) of participants reported that they learned about mental disorders from portrayals in mass media, while 40.3% ($n = 438$) had personal encounters with mentally ill people as a primary source of knowledge about mental disorders. With respect to the participants' attitudes toward psychotropic drugs, 66.9% ($n = 727$) of them considered them effective, 3.7% ($n = 40$) of participants believed that they would lead to a worse outcome, 25.8% ($n = 280$) envisaged the risk to lead to dependency, and 3.7% ($n = 40$) considered them "ineffective".

Table 1 Characteristics of the participants ($n = 1087$)

Variable	N	%
Gender		
Male	394	36.2
Female	693	63.8
Age (years)		
16–24 25–	114	10.5
34	558	51.3
35–44	235	21.6
45 and above	180	16.6
Education		
Junior high school or less	97	8.9
Senior high school	160	14.7
College degree/undergraduate	608	55.9
Postgraduate or above	222	20.4
Place of residence		
Urban area	901	82.9
Rural area	186	17.1

Responses frequencies for the PDD and MHKQ

The mean total score for the PDD was 33.77 (SD = 6.66), and scores ranged from 12 to 57. The answer for each item is displayed in Table 2.

As for the MHKQ, the total scores ranged from 5 to 20 with a mean score of 15.89 (±2.69). The mean score for the first section (true vs. false questions) was 13.50 (± = 2.17), and 159 (14.6%) participants got a score of 16.

For the second section of MHKQ, there were 258 (23.7%) participants who recognized all four mental health promotion days. The rate of correct responses is displayed in Table 3.

PDD and demographic variables

Table 4 shows the mean PDD scores for different subgroups of participants, stratified according to basic socio-demographic characteristics. There were statistically significant differences in the scores that matched with age and place of residence. Analysis of variance showed that those under 25 years old scored higher than those above that age, but the difference was significant only with respect to those aged 35–44 years ($F = 5.37$, $P = 0.001$). Participants from rural areas scored significantly higher than those from cities ($t = -2.42$, $P = 0.016$). Differences in the stigma level according to participants' gender, educational level, sources of information about mental disorders, and contact levels with people with mental disorders were not statistically significant.

MHKQ and demographic variables

Table 5 shows the mean MHKQ scores for different demographic groups of participants. The impact of

Table 2 The results of PDD (n = 1087)

Items	Strongly agree (n, %)	Agree (n, %)	Unsure (n, %)	Disagree (n, %)	Strongly disagree (n, %)
1. Most people would accept a former mental patient as a close friend.	49 (4.5)	149 (13.7)	545 (50.1)	253 (23.3)	91 (8.4)
2. Most people believe that a person who has been in a mental hospital is just as intelligent as the average person.	123 (11.3)	300 (27.6)	418 (38.5)	187 (17.2)	59 (5.4)
3. Most people believe that a former mental patient is just as trustworthy as the average citizen.	92 (8.5)	259 (23.8)	422 (38.8)	249 (22.9)	65 (6.0)
4. Most people would accept a fully recovered former mental patient as a teacher of young children in a public school.	98 (9.0)	285 (26.2)	286 (26.3)	258 (23.7)	160 (14.7)
5. Most people believe that entering a mental hospital is a sign of personal failure.	23 (2.1)	120 (11.0)	213 (19.6)	357 (32.8)	374 (34.4)
6. Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time.	360 (33.1)	421 (38.7)	169 (15.5)	96 (8.8)	41 (3.8)
7. Most people think less of a person who has been in a mental hospital.	116 (10.7)	397 (36.5)	256 (23.6)	233 (21.4)	85 (7.8)
8. Most employers will hire a former mental patient if he or she is qualified for the job.	73 (6.7)	198 (18.2)	455 (41.9)	268 (24.7)	93 (8.6)
9. Most employers will pass over the application of a former mental patient in favor of another applicant.	199 (18.3)	496 (45.5)	256 (23.6)	101 (9.3)	35 (3.2)
10. Most people in my community would treat a former mental patient just as they treat anyone.	83 (7.6)	311 (28.6)	440 (40.5)	209 (19.2)	44 (4.0)
11. Most young women would be reluctant to date a man who has been hospitalized for serious mental disorder.	365 (33.6)	443 (40.8)	208 (19.1)	53 (4.9)	18 (1.7)
12. Once they know a person was in a mental hospital, most people will take his or her opinions less seriously.	124 (11.4)	430 (39.6)	342 (31.5)	162 (14.9)	29 (2.7)

participants' ages, educational level, areas of residence, sources of information about mental disorders, and level of contact with mentally ill people was significant over the MHKQ scoring. The analysis of variance showed that those aged 25–44 years had significantly higher MHKQ total scores than those above 45 years old. Participants with higher education levels had higher MHKQ scores ($F = 65.72$, $P < 0.001$). Urban residents had higher MHKQ scores than rural residents ($t = 7.32$, $P < 0.001$). Those who had previous contact with people with mental disorders ($t = -4.85$, $P < 0.001$) and who had learned about mental disorders with personal encounters ($t = -2.10$, $P = 0.036$) had higher MHKQ scores.

The relationship between PDD and MHKQ

We didn't find any statistically significant relationship between the total scores of the PDD and MHKQ scales ($r = -0.032$, $P = 0.293$).

Discussion

To the best of our knowledge, this is the first study to evaluate the general public knowledge of and attitudes toward mental disorders through a web-based survey in China. Although our samples couldn't represent the entire Chinese population, we can still provide a reliable account of attitudes and knowledge toward mental health in China. Compared with previous studies [26–28], our results showed that mental health knowledge has improved recently, while most people's attitudes toward mental disorders are still negative. Hence, it is vital to further discuss how to improve mental health knowledge and what might be the impact of such programs on people's attitudes toward mental disorders.

In terms of knowledge on mental disorders and stigmatizing attitudes, we didn't find any differences with respect to participants' gender, in line with previous studies [20, 24]. However, there were also studies that investigated such measures in medical students and mental health staff that demonstrated that women tend to have greater knowledge about mental health and that they were more willing to interact with people with mental disorders [29, 30]. In our survey, we did not report such significant differences and thus this issue should be further explored in order to properly discuss the need of developing gender-specific anti-stigma interventions in China.

In contrast to other studies [26], our study also found that residents in rural areas had more positive attitudes toward people with mental disorders than those who lived in urban areas. One possible explanation for this evidence is that rural communities may be more tolerant of unusual behaviors, typical of people with mental disorders. However, evidence from previous studies provided rather mixed results. Girma et al. [20] found that living in rural places was the strongest predictor of families holding stigmatizing attitudes toward their mentally ill relatives. Authors reported that rural

Table 3 The correct response rate of MHKQ (n = 1087)

Item	n	Percent (%)
1. Mental health is a component of health. (true)	1047	96.3
2. Mental disorders are caused by incorrect thinking. (false)	596	54.8
3. Many people have mental problems but do not realise it. (true)	1052	96.8
4. All mental disorders are caused by external stressors. (false)	653	60.1
5. Components of mental health include normal intelligence, stable mood, a positive attitude, quality interpersonal relationship and adaptability. (true)	1035	95.2
6. Most mental disorders cannot be cured. (false)	742	68.3
7. Psychological or psychiatric services should be sought if one suspects the presence of psychological problems or a mental disorder. (true)	969	89.1
8. Psychological problems can occur at almost any age. (true)	1049	96.5
9. Mental disorders and psychological problems cannot be prevented. (false)	825	75.9
10. Even for severe mental disorders (eg, schizophrenia), medications should be taken for a given period of time only; there is no need to take them for a long time. (false)	887	81.6
11. Positive attitudes, good interpersonal relationships and healthy life style can help maintain mental health. (true)	1046	96.2
12. Individuals with a family history of mental disorders are at a higher risk for psychological problems and mental disorders. (true)	981	90.2
13. Psychological problems in adolescents do not influence academic grades. (false)	964	88.7
14. Middle-aged or elderly individuals are unlikely to develop psychological problems and mental disorders. (false)	957	88.0
15. Individuals with a bad temperament are more likely to have mental problems. (true)	838	77.1
16. Mental problems or disorders may occur when an individual is under psychological stress facing major life events (eg, death of family members). (true)	1031	94.8
17. Have you heard about International Mental Health Day? (yes)	613	56.4
18. Have you heard about the International Day against Drug Abuse and Illicit Drug Trafficking? (yes)	947	87.1
19. Have you heard about the International Suicide Prevention Day? (yes)	345	31.7
20. Have you heard about World Sleep Day? (yes)	694	63.8

residents showed significantly higher stigmatizing attitudes than urban residents, perhaps because of lower mental health literacy. However, we didn't find a significant relationship between mental health literacy and discriminatory attitudes.

Our analyses did not yield any significant relationship between educational level and discrimination, but we found that participants with higher levels of education were more likely to have greater mental health knowledge. Some studies reported that lower education levels were more strongly associated with negative attitudes toward mental disorders [31, 32], but others found the inverse to be also true [33, 34]. These studies indicated that highly educated people had higher expectations of social responsibility and functioning than those with less education, and that they associated people with mental disorders with lower levels of responsibility and functioning.

Today, more and more educational initiatives and informational campaigns have been implemented to improve the public's mental health knowledge, in order to change negative opinions toward people with mental disorders. Some of the interventions yielded positive results, as expected [35, 36]. But in our study, we didn't find any relationship between mental health knowledge and stigmatizing attitudes. In accordance with other studies, our data tend to support the idea that the public's mental health knowledge might not represent a highly effective remedy against discrimination [37]. As some studies have shown, health care staff with supposedly greater knowledge about mental health issues are likely to hold more negative attitudes toward mental disorders than the general population [21, 22]. Moreover, many people with mental disorders have been unfairly treated by health professionals when they have sought help for medical diseases [23]. Altogether, these findings suggest that other ways to decrease stigma against mental disorders are still to be pursued.

Exposing the general public to people with mental disorders has been a method used by many anti-stigma campaigns as an effective way to improve attitudes towards mental disorders among the target group [36, 38–40]. However, in our survey we didn't find any significant difference in the attitudes of subgroups who had or had no previous contact with people with mental disorders. Participants who reported having had contact with people with mental disorders also showed greater mental health knowledge. Once again, such findings are in line with the idea that there is no correlation between knowledge of mental disorders and positive attitudes towards them.

In our study, while 64.9% of participants reported having had direct contact with people with mental disorders, most of our respondents (59.7%) acquired their understanding of mental disorders from portrayals in mass media. For people who had no direct contact with people suffering from mental disorders, mass media may be a relevant source of information which may strongly influence their perceptions and attitudes about mental disorders. However, mass media often portray people with mental disorders as dangerous, strange, unpredictable, and violent [9], which could further lead the general public to fear people with mental disorders, cause

Table 4 Associations between PDD and demographic variables

Item	n	Mean score	t/F	P
Gender			0.67	0.500
Male	394	33.96 ± 7.24		
Female	693	33.66 ± 6.31		
Age (years)			5.37	0.001
16–24 25–	114	35.11 ± 5.48		
34 35–44	558	34.03 ± 6.69		
45 and above	235	32.37 ± 7.11		
Education	180	33.92 ± 6.39		
Junior high school or less			0.13	0.942
Senior high school	97	33.90 ± 6.76		
College/undergraduate	160	33.82 ± 6.77		
Postgraduate or above	608	33.83 ± 6.58		
Place of residence	222	33.52 ± 6.79		
Urban area			−2.42	0.016
Rural area	901	33.56 ± 6.74		
Sources of information about mental disorders	186	34.78 ± 6.20		
Mass media			1.31	0.192
Personal encounters	649	33.99 ± 6.44		
Contact level	438	33.44 ± 6.97		
No			1.40	0.161
Yes	381	34.15 ± 6.54		
	706	33.56 ± 6.72		

people with mental disorders to feel isolated and rejected, create greater discrimination and prevent people with mental disorders from fully integrating into society [41]. Interventions aimed at changing portrayals of mental disorders in mass media might represent a valid means to induce a significant positive change in public attitudes toward people with mental disorders.

Finally, we didn't find an increased risk for stigmatizing attitudes except for the age and place of residence factors. A German study found that gender, age, education level, and place of residence only accounted for 1.4% of the variance [42].

There are some limitations to our study. First, the survey was based on a cross-sectional sampling strategy and on self-reported measures, so it might be difficult to make reliable inferences about the correlations or causal relationships between attitudes and knowledge. Second, since our study was a web-based survey, we couldn't provide the participants with in-person explanations of the questions and this might influence their responses. On the other hand, using a web-based strategy allowed participants to participate in the study without feeling socially pressured or guided to respond in one way or another. Finally, since included participants represented a convenience sample, it could not fully represent the Chinese population. The latter consideration coupled with some imbalance in terms of socio-demographic characteristics of our sample (e.g., greater ratio of female respondents) might imply that our study should be replicated in a larger and more representative sample of the Chinese population.

Conclusions

Our findings suggested that overall mental health knowledge may have improved in the Chinese population over the years, but that most Chinese people still hold negative attitudes toward mental disorders. According to our data, this tendency seems to be more relevant in urban areas. It is important to carry out anti-stigma campaigns for the future progress of mental health in China. Although some campaigns aim to improve the public's mental health knowledge, it is still a matter of open debate whether increasing mental health knowledge may actually decrease people's discriminatory attitudes toward people with mental disorders or not. Finally, although we did not find a positive correlation between participants' levels of

Table 5 Associations between MHKQ and demographic variables

Item	n	Mean score	t/F	P
Gender			−1.02	0.310
Male	394	15.78 ± 2.80		
Female	693	15.95 ± 2.63		
Age (years)			4.56	0.003
16–24	114	15.82 ± 2.16		
25–34	558	15.93 ± 2.86		
35–44	235	16.27 ± 2.52		
45 and above	180	15.30 ± 2.61		
Education			65.72	< 0.001
Junior high school or less	97	13.36 ± 2.28		
Senior high school	160	14.69 ± 2.36		
College/undergraduate	608	16.17 ± 2.51		
Postgraduate or above	222	17.08 ± 2.58		
Place of residence			7.32	< 0.001
Urban area	901	16.15 ± 2.62		
Rural area	186	14.60 ± 2.65		
Sources of information about mental disorders			−2.10	0.036
Mass media	649	15.74 ± 2.54		
Personal encounters	438	16.10 ± 2.89		
Contact level			−4.85	< 0.001
No	381	15.35 ± 2.56		
Yes	706	16.18 ± 2.72		

contact with people with mental illness and their attitudes toward people with mental disorders, we did find similar evidence in other studies. Thus, we should further explore the hypothesis that more frequent contact with people with mental disorders may change negative attitudes towards mental disorders.

Abbreviations
MHKQ: The Mental Health Knowledge Questionnaire (MHKQ); MOH: Ministry of Health; PDD: Perceived Devaluation and Discrimination Scale; WHO: World Health Organization

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Availability of data and materials
All the data supporting our findings have been presented in the manuscript; however, the datasets analyzed during the current study are available from the corresponding author on reasonable request.

Authors' contributions
JL designed and led the study, drafted the manuscript. MMZ and LZ contributed to the study design, helped with data collection and conducted the main analysis. WQL and JLM contributed to the study design and critically appraised the manuscript. ZHZ was involved in the data collection and editing the manuscript. All authors read and approved the final manuscript.

Ethics approval and consent to participate
The study protocol was approved by Research Ethics Committee of the Second Affiliated Hospital of Xinxiang Medical University. All the participants informed the purpose of the study and gave their oral consent before the investigation.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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Dr. P C Sen Memorial Award

For Rural Based Original Research Article

A Study on Knowledge, Attitude, and Practice Regarding Mental Health Illnesses in Amdanga Block, West Bengal

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Abstract

Background: The discourse of mental health is getting its due attention after all these years in India. A major threat to the mental health system is the demand side factors, namely, knowledge, attitude, and practice (KAP) of the general population toward this. In spite of growing concern regarding mental health in India, this kind of study to assess the mental health status has been very few in India, more so in West Bengal. **Objectives:** With this background, this study was carried out with the objectives to validate the Community Attitude to Mental Illness (CAMI), to assess the different sociodemographic factors among the study population, to assess the KAP regarding mental illness among the study population. **Methods:** It was an observational, descriptive study with cross-sectional design done at Amdanga Community Development Block, North 24 Parganas, West Bengal, India, in 2015-16. Questionnaire validation to assess the KAP was the primary objective with obtaining the descriptive data were the second one. CAMI questionnaire was used which was validated for the given area by validation methods such as Cronbach's alpha and structural equation modeling. The resultant questionnaire was used in the field on adult population after a single-stage survey design to collect 730 samples. **Results:** The test statistics showed that the questionnaire was reasonably valid after a few tweakings. SEM identified well-define domains in the attitude part. 94.9% says that they are willing to live with a people with mental illness. 14.9% has actually done so. Health-care seeking behavior shows that 19.2% will go to a GP in case of any mental illness. Furthermore, attitude toward mental illness showed mixed picture as also knowledge. This study correlated with various studies of developing countries and it was seen that these population showed markedly different attitudes for probability of the patients getting cured than many other countries. Furthermore, stigma was gradually decreasing, as evident from various other studies. **Conclusion:** This study will provide valuable insights into the cognitive and affective aspect of mental illness among these population and thus help in implementing better policies in this regard, as this is fast becoming the talk of the day.

Key words: Attitude toward mental illness, Community Attitudes to Mentally Illness, structural equation model

Introduction

The WHO defines health as "Health is a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity."[1]

From the above widely accepted definition of health, it is quite evident that it encompasses physical as well as mental health. The human mind is a set of cognitive faculties including consciousness, perception, thinking, judgment, and memory. It holds the power of imagination, recognition, and appreciation, and the same time is responsible for processing feelings and emotions, resulting in attitudes and actions.

With a sound mental health, a person can be logical and judgmental and has the ability to distinguish between the good and the evil of the society, so that, appropriate rewards and recognition of the good things of the society and at the same time punishment and derecognition of the evil matters are quite rightly taken care of to establish a state of equilibrium and harmony among the people of the society, a place where human beings can live in peace and at the same time perform certain responsibilities. A mentally ill person not only becomes a burden of the society but also at the same time becomes a potential threat for the society as they are quite often prone to indulge in antisocial activities.

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Public stigma against mental health problems is damaging to people with mental illness and is associated with significant societal burden. It is a global phenomenon which is prevalent over time and place. A recent systematic review and meta-analysis of public attitudes have shown that despite improvements in mental health literacy, public attitudes and desire for social distance have remained stable over time.[2] Moreover, literature suggests that there is an association between public attitudes toward mental health and the individual stigma felt.[3] In spite of growing concern regarding mental health in India, this kind of study to assess the mental health status has been very few in India, more so in West Bengal. With this background, the study is being carried out with the objectives to validate the Community Attitude to Mental Illness (CAMI), to assess the different sociodemographic factors among the study population, and to assess the knowledge, attitude, and practice (KAP) regarding mental illness among the study population.

Materials and Methods

It was an observational, descriptive study with cross-sectional design done at Amdanga Community Development Block, North 24 Parganas, West Bengal, India. It is the rural field practice area of the Department of Community Medicine, R. G. Kar Medical College and Hospital, Kolkata, West Bengal, India. Data were collected from December 1, 2015, to January 31, 2016.

Adult population (>18 years) of 81 villages of the Amdanga Community Development Block were the study population. The schedule that was applied stays valid for the adult populations only. As per record available from the Block Development Office at Amdanga, there were total 41,184 adult populations at that block in July 1, 2015. Individuals who were not able to comprehend the study schedule due to illness were excluded from the study. Those who expressed unwillingness to become a study participant were also excluded from the study. Pilot testing was done on one question only in October 2015, with 28 people, as there were no background data on prevalence, also questionnaires needed much important feedback for validity. "Consulting a general practitioner (GP) about a mental health problem" came out to be 22.8%, which was considered to be a major behavioral outcome of the study. With an allowable absolute error of 1% design effect of 1.4, the sample size came out to be 653. A 10% dropout rate raised the required sample size to 718. It was decided by the study team that all the villages should be included for better representation. Hence, a probability proportional to size strategy was adopted from villages. However, the numbers came as fractions. Thus, around nine persons were targeted to be obtained from each of the 81 villages in random order. The individual was selected by going to the center of a village and finding out the direction to start survey by lottery method. Going door to door in the direction ascertained by the lottery, nine adults for a village were interviewed consecutively. Seven hundred and thirty adults responded completely altogether.

A predesigned and pretested schedule was used for this study. The schedule had two sections. The first section comprised questions related to KAP about mental illness and the second part comprised sociodemographic information. The first part, Attitudes to Mental Illness Questionnaire was developed by the Department of Health, the United Kingdom, for this series of surveys, based on previous research in Toronto, Canada, and the West Midlands, UK. It included 26 items based on the 40-item CAMI scale and the opinions about Mental Illness Scale and an added item on employment-related attitudes. The questions covered a wide range of issues, from attitudes toward people with mental illness to opinions on services provided for people with mental health problems. The questionnaire was translated into Bengali and again retranslated and checked for consistency. A group of experts of Community Medicine and Psychiatrists from Medical College, Kolkata, gave their inputs on these questions and ascertaining face validity. The conceptual, cultural, and semantic equivalence were well judged as these questions may mean differently in different contexts. Kaiser–Meyer–Olkin (KMO) and Bartlett's test, Scree plot, factor loadings, correlation matrix, and structural equation modeling were done to ascertain discriminant validity on the attitude part only. Cronbach's alpha was done to ascertain convergent validity. Content validity (concurrent and predictive) could not be done due to paucity of the previous gold standard instruments in the area. Taking all these into account, some questions were dropped and some modified. There were five interviewers chosen to work in two different teams. They were trained to ensure reliability. A work plan was developed to cover the block in around 2 months. Supervisors from the Department of Community Medicine visited the sites regularly to check progress and assure quality.

Data were assembled in Microsoft Excel 2010 software. Results were described in terms of absolute numbers and percentage.

Results

Scree plot corresponded with the idea that there are probably four domains in the attitude questionnaire. Domain-wise Cronbach's alpha revealed that fear and exclusion of persons living with mental illness has a value of 0.721, integration with health services (0.426), tolerance toward patients having mental illness (0.531), and causes of mental illness (0.61). Furthermore, knowledge and practice part had a value of 0.73 KMO and Bartlett's test. Figure 1 shows the structural equation model of the variables. This showed that the domains have poor correlation and the goodness of fit index as 0.935 (acceptable). In Table 1, it can be seen that out of the total 730 study population, 345 (47.3%) were male and 385 (52.7%) were female. Highest number of respondents belonged to age group of 20–40 years were 389 (53.29%). Most of them had primary education 283 (38.8%) and majority of them were unskilled workers 340 (46.6%). Table 2 shows the distribution of the study population according to the knowledge regarding mental illness. A substantial population (73.3%) still feels that the mental health

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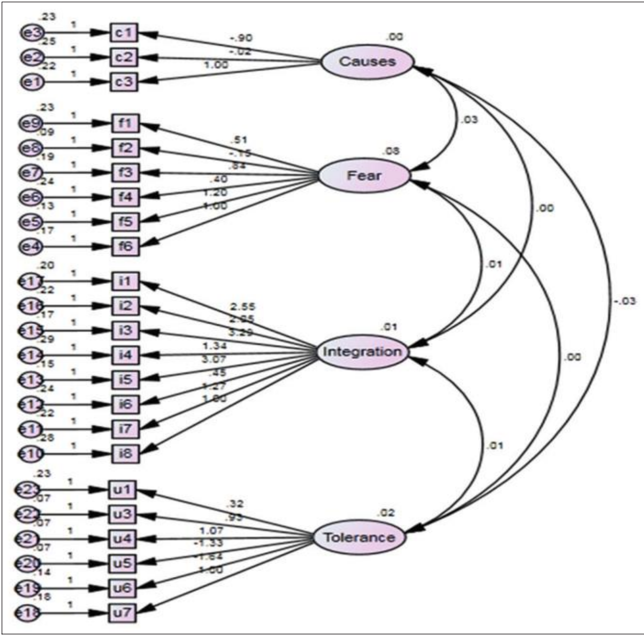

Figure 1: Structural equation model of attitude part of the questionnaire.

Table 1: Distribution of the study population according to sociodemographic characteristics (*n*=730)

Variables	*n* (%)
Education	
Illiterate	91 (12.47)
Just literate	117 (16.3)
Primary	283 (38.77)
Middle school	126 (17.3)
Above middle school	113 (15.5)
Occupation	
Unemployed	40 (5.48)
Unskilled	340 (46.6)
Semi-skilled	259 (35.5)
Skilled	52 (7.1)
Professional	39 (5.3)
Per capita income	
≤900	194 (26.6)
901-1200	228 (31.2)
1201-1571	123 (16.8)
≥1572	181 (24.8)
Not reported	4 (0.5)

patients should be kept in mental hospitals. 78.1% feels that they are prone to violence. However, 71% believes that it can be cured through medication. Table 3 shows distribution of the study population according to attitude regarding mental illness. Regarding fear about mental illness, 52.5% of population still believes that a woman would be foolish to marry a man who has suffered from mental illness even though he seems fully recovered. However, tolerability seems to be better with 90% supporting that mentally ill patients need to be responsibly looked on, and need to adopt a far more tolerant attitude toward people with mental illness in our society. Integration showed a good response with 77.4% saying that residents have nothing to fear from people coming into their neighborhood to obtain mental health services. However, 62.1% still believe that mental illness is caused due to the lack of willpower.

About the reported and intended behavior of persons toward mental illness [Table 4], 94.9% says that they are willing to live with a people with mental illness. 14.9% has actually done so. Health-care seeking behavior shows that 19.2% will go to a GP in case of any mental illness [Table 5].

Table 2: The knowledge regarding mental health among the study population (*n*=730)

	n (%)
Statements that usually describe someone who is mentally ill	
Has to be kept in a psychiatric or mental hospital	535 (73.3)
Has serious bouts of depression	349 (47.8)
Is born with some abnormality affecting how the brain works	266 (36.4)
Cannot be held responsible for his or her own actions	229 (31.3)
Is incapable of making simple decisions about his or her own life	319 (43.7)
Is prone to violence	571 (78.1)
Stigma-related mental health knowledge	
If a friend had a mental health problem, I know what advice to give them to get professional help	210 (28.8)
Medication can be an effective treatment for people with mental health problems	518 (71)
Psychotherapy (e.g., talking therapy or counseling) can be an effective treatment for people with mental health problems	478 (65.5)
People with severe mental health problems can fully recover	374 (51.2)

Discussion

The KAP regarding metal health illness among adult population in rural area in the Amdanga Block, West Bengal, were studied by us. In our study, we did not focus any particular type of mental illness rather we considered every kind of mental illnesses in general. A large-scale, community-based study had been done regarding mental health so that any appropriate policy can be prepared for promotion attitude, knowledge, and practice of community toward the mental illnesses.

In our study, it was found that there was a positive participation of community regarding socially acceptance of mentally ill patients, about treatment outcome and also modest attitude toward mentally ill patients. Most of the participants agreed that mental illnesses were similar like other diseases and it can be treated by proper medicine and normal day-to-day involvement. They also considered the need of mental health care to be a community-based service. There were different studies in different countries such as South Africa and also in India showing similar type of result.[4] A study in India showing that almost 40.2% of participants in rural area, 33.3% of participant in urban area believed that mental illnesses were

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Table 3: Distribution of the study population according to attitude regarding mental illness (*n*=730)

Questions	*n* (%)
Fear about mental illness (% agreeing)	
I would not want to live next door to someone who has been mentally ill	342 (46.8)
A woman would be foolish to marry a man who has suffered from mental illness even though he seems fully recovered	383 (52.5)
Anyone with a history of mental problems should be excluded from taking public office	364 (49.9)
People with mental illness should not be given any responsibility	372 (50.9)
People with mental illness are a burden on society	78 (10.7)
As soon as a person shows signs of mental disturbance, he should be hospitalized	333 (45.6)
Understanding and tolerance of mental illness (% agreeing)	
We have a responsibility to provide the best possible care for people with mental illness	657 (90)
Virtually anyone can become mentally ill	470 (64.4)
Increased spending on mental health services is a waste of money (% disagreeing)	175 (23.9)
People with mental illness do not deserve our sympathy (% disagreeing)	88 (12)
We need to adopt a far more tolerant attitude toward people with mental illness in our society	657 (90)
As far as possible, mental health services should be provided through community-based facilities	525 (71.9)
Integrating people with mental illness into the community (% agreeing)	
People with mental illness are far less of a danger than most people suppose	508 (69.6)
Less emphasis should be placed on protecting the public from people with mental illness	408 (55.9)
The best therapy for many people with mental illness is to be part of a normal community	469 (64.2)
Residents have nothing to fear from people coming into their neighborhood to obtain mental health services	565 (77.4)
Most women who were once patients in a mental hospital can be trusted as babysitters	443 (40.7)
Mental illness is an illness like any other	409 (56)
No one has the right to exclude people with mental illness from their neighborhood	552 (75.6)
Mental hospitals are an outdated means of treating people with mental illness	442 (60.5)
Causes of mental illness and the need for special services (% agreeing)	
There are sufficient existing services for people with mental illness	233 (31.9)
One of the main causes of mental illness is a lack of self-discipline and willpower	457 (62.1)
There is something about people with mental illness that makes it easy to tell them from normal people	327 (44.8)

untreatable.[5] However, in our study, it is showing that the condition is different. Almost 70.96% people were accepting the fact that mental diseases can be curable. Different studies in India were showing that there was stigmatic attitude of community toward mentally ill patients. The people of community think that mentally ill patients were dangerous, harmful, unpredictable,

Table 4: The reported and intended behavior of persons toward mental illness (*n*=730)

Question	*n* (%)
Reported	
Lived with someone with a mental health problem (% agreeing)	109 (14.9)
Worked with someone with a mental health problem (% agreeing)	121 (16.6)
Had a neighbor with a mental health problem (% agreeing)	101 (13.8)
Had a close friend with a mental health problem (% agreeing)	105 (15.4)
Intended	
"In the future, I would be willing to…"	
Live with someone with a mental health problem (% agreeing)	693 (94.9)
Work with someone with a mental health problem (% agreeing)	508 (69.6)
Live nearby to someone with a mental health problem (% agreeing)	401 (54.9)
Continue a relationship with a friend who developed a mental health problem (% agreeing)	462 (63.3)

and worthless.[6-8] Another study in India reflecting that 36.9% of rural participate and 43.2% of urban participate unwilling to marriage with a person recovered from mental illness.[5] Many study showing that mentally ill patients were ignored and neglected and considered as social burden.[9] However, in our study, it is showing that social stigma among community toward mentally ill patients is gradually decreasing. Almost 90% of participants considered that mentally ill patients should be accepted cordially in society. Our study findings tally with some study in India showing the decreasing trends of community stigma toward mentally ill patients.[10] However, still some stigma were present in our study participants also. Almost 10% of participants still believe that mentally ill patients are burden of society, and almost half of the participants (50.96) do not want to give any responsible work to mentally ill patients. Almost 73.15% of participants feel uncomfortable about discussing their mental health problems if ever occur. However, by comparing with various previous studies which showing many stigmatic attitude of community toward mentally ill patients,[11,12] we can say that our study definitely showing some improving conditions regarding the acceptance of mentally in patients in society.

Conclusion

We had a large sample size and covered a block extensively; thus, the representation of this block has been done extensively. However, a multi-centric study can give a better external validity. The schedule used was validated previously, we checked for judgmental validity of the Bengali version, but not the validity metrices. Furthermore, a detailed look at the covariates could have been done, but this kind of KAP studies, often these factors are of less importance.

This study will provide valuable insights into the cognitive and affective aspect of mental illness among these population

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Table 5: Healthcare seeking behavior of participants (*n*=730)

Question	*n* (% agreeing)
Consulting a GP about a mental health problem	140 (19.2)
Talking to a friend or family member about your mental health, for example, telling them you have a mental health diagnosis and how it affects you?	119 (16.3)
Talking to a current or prospective employer about your mental health, for example, telling them you have a mental health diagnosis and how it affects you?	54 (7.4)
Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?	2 (0.3)

GP: General practitioner

and thus help in implementing better policies in this regard, as this is fast becoming the talk of the day.

Financial support and sponsorship Nil.

Conflicts of interest

The first author is a member of Editorial Board of the Indian Journal of Public Health.

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Exploring the knowledge and attitude of public about mental health problems: A pilot intervention for effective mental health promotion

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Abstract:

CONTEXT: The knowledge about mental health problems among the general public is comparatively quite low. The pilot study was conducted with an aim to increase the knowledge of the day-to-day mental health problems which people can have among the mass.

AIMS: The aims of this study are (1) to assess the knowledge and attitude about mental health problems of the selected sample and (2) to build the capacity in providing first aid for mental health to the selected sample through training.

SETTINGS AND DESIGN: A cross-sectional study was used in assessing the knowledge and skills of the participants of the first aid for mental health problems. It was conducted in the institute itself.

SUBJECTS AND METHODS: A total of 89 participants were taken to participate in the cross-sectional study. Using a semi-structured self-administered questionnaire, a brief training, and a feedback form, capacity building for first aid for mental health problems was provided.

STATISTICAL ANALYSIS USED: The questionnaires were analyzed using descriptive statistics.

RESULTS: The capacity building program for first aid for mental health problems appears to be effective in improving the knowledge and attitude with regard to the mental health problems. The findings from the program indicated lack of knowledge in understanding of mental health, knowledge of causation, and treatment of mental health problems. Feedback of the training program indicated that it improved the ability of the participants in recognizing persons undergoing mental health problems and brought about a change in their beliefs about mental health, attitudes, and need for prompt referral.

CONCLUSIONS: The program was successful in increasing the confidence of the participants in providing help to someone with a mental health problem and referring to appropriate mental health professional. This shows that there is an immediate need for empowering general public with knowledge and skills to provide support to people with mental health problems.

Keywords:

Attitude, capacity building, first aid, knowledge, mental health

Introduction

Mental and behavioral disorders account for about 12% of the global burden of diseases. This is likely to increase to 15% by 2020.[1] As the numbers are spiraling, the community continues to lack awareness when it comes to identifying and intervening when a person is affected with mental health problems.

Studies have shown that not all are able to receive adequate consultations with professional mental health-care services and that there is a long delay between

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the recognition of the mental disorders and the help provided for those who received a consultation.[2,3]

Although people widely accept the public knowledge imparted about physical health problems, there is negligence of knowledge acceptance when it comes to mental health literacy.[4] This ignorance adds to the stigma of mental health problems and prevents people from talking and seeking help early, as well as providing help for mental health problems. To address this issue, attempts have been made by some countries to conduct programs at the community level for providing first aid for people having mental illnesses. A typical first-aid program consists of sessions for identifying symptoms of mental health disorders such as acute suicidal thoughts, depressive, anxiety, or psychotic behavior, their possible risk factors, and how to get professional help. One such program which deserves a mention is the young Mental Health First Aid (MHFA) program, conducted in Australia with an aim to help adults learn skills required to recognize early signs of mental illness of adolescents and provide help as and when required.[5] With respect to mental health disorders, mention should be made of training in MHFA which was conducted yet again in Australia, specifically planned for eating disorders. The program yielded quite positive results, thereby facilitating early intervention of the disorder.[6] Based on the positive feedback on these training programs, similar training programs were conducted for the Chinese as well as Vietnamese communities in Melbourne, Australia, to help members of these communities to identify persons with mental illness (depression and schizophrenia) and help in seeking treatment.[7,8] As culture plays an important part when it comes to disseminating mental health literacy, such training programs were conducted, specifically for various cultural groups within Australia, like for the Australian Aboriginals and Torres Strait Islander people.[9] Such MHFA training programs for identifying mental disorders, after gaining such positive results, have begun to roll out in other countries as they are being accepted world-wide as an excellent method of empowering people at a community level as well as increasing mental health literacy.[10] However, what is crucial to notice is that all these programs concentrate on mental health illness in particular, and not mental health problems faced by almost everyone on a day-to-day basis. To bring out the differences between mental health illness and mental health problems, it can be said that mental health illnesses are those, which are diagnosable as forms of clinical disorders by a psychiatrist, while mental health problems arise out of social, psychological, and physical effects which are not intense enough to be diagnosed as disorders. Mental health problems can occur on a day-to-day basis and should be addressed adequately so that it does not turn into any form of full-blown disorder. In order to be a responsible member of a community, one should not remain ignorant of the signs and symptoms of these mental health problems a person may face community. Efforts should be made in identifying these, as they can act as a predisposing factor to a forthcoming mental illness in an individual. It is thus of utmost importance and need of the hour to find ways for empowering general public with knowledge and skills to provide support to people with mental health problems.

Based on our objective of assessing and increasing knowledge and skills of identifying general mental health problems that an individual can face, we developed a first of its kind, a 3-h capacity building program on first aid for mental health problems for the community. This initiative is quite different from the other first-aid training programs where mental illness is emphasized in particular. The objective of the program was to assess and increase the knowledge of mental health problems and build the skills needed to intervene, assist, and refer individuals experiencing a mental health issue.

Subjects and Methods

Ethics

The study was approved by the Institutional Ethics Committee with the ethical code of National Institute of Mental Health and Neuro Sciences (NIMHANS)/EC (BEH.SC.DIV.)/16th MEETING/2018/5.06.

Design

A cross-sectional study was used in assessing the knowledge and skills of the participants of the first aid for mental health problems.

Participants

The program was advertised in the institute website, and participants comprised of college students, lay counselors, and teachers enrolled for it. Eighty-nine participants participated in the program.

Tools

Everybody who got registered were given a 19-item semi-structured self-administered questionnaire developed for the program in order to assess the knowledge and attitude with regard to mental health with ratings of (1) agree, (2) disagree, and (3) not sure. A feedback form was given after the completion of the training. The items were given to the five subject experts for validation. Once validated, the final questionnaire was prepared.

Setting

The program was conducted at the Department of Mental Health Education, NIMHANS, Bengaluru, India.

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Intervention

The faculty from the Department of Mental Health Education, Clinical Psychology, and Psychiatry implemented the program. The faculty are experienced and qualified in providing the capacity building programs. Fulfilling the aims of the program and the following steps cited above, the training was implemented. After the registration, the participants were given a 19-item semi-structured questionnaire. The training lasted for 3 h. Using various methodologies such as brainstorming, interactive sessions, role plays, and group activities, the participants were asked to list of crises which could trigger a mental health problem. The participants were split into four groups each and were asked to brainstorm. The group cited sexual assault, bullying, migration, separation from family, health issues, avoiding school, death, loss of any kind, issues related to elderly, accident, etc., The participants were further asked to list how these crises which people experience could manifest as behavioral and emotional issues. The participants through group activities reported manifestations such as being easily tearful; worry and anxious; aggressive and irritated; social withdrawal; refusal to go to school/college/workplace; thoughts of self-blame; and feeling of hopelessness, feeling of helplessness, and many more. Role play was used as an effective medium to know how one can approach the person undergoing mental health problem without being judgmental and communicate effectively. Referring the person to mental health professional and self-help strategies that the participants can implement was discussed and stressed on. The participants were also asked to take care of their mental well-being and health in the process of facing the challenges. After the training, a feedback form was given to all the participants for feedback.

Procedure

As mentioned, 89 participants registered themselves for the training program through the institute website as well as advertisements in department's bulletin board and in social media platforms. As a part of the pilot study, the participants were given the initial assessment questionnaire for the assessment of knowledge and attitude that the public commonly hold toward mental health problems. It was an easy to follow, simple, and self-administered questionnaire which was collected back once filled. Following this, the 3-h training intervention was given to the participants, for a better understanding of the mental health problems, helping them build skills to assist people facing a mental health crisis, as well as referring them to proper channels, thereby fostering treatment procedures. The brief 3-h capacity building program included the following steps [Table 1].

Table 1: Steps to provide first aid for mental health problems

Identify the signs of a mental health problems
Avoid being judgmental
Encourage professional help
Build up coping strategies

The above criteria were met with the help of training using techniques of role play, video demonstration, brainstorming sessions, and group discussions. The steps are applied to various mental health problems that might surface when a person faces crisis such as bullying, ragging, low mood, anxiety, migration, violence, trauma, and death of a near one to name a few. Majority of the studies have focused on providing MHFA focusing on identifying a person at risk for developing psychosis, depression, anxiety disorders, and substance dependence. This training is unique and one of its kind wherein we take a step backward and help participants to identify day-to-day issues that can lead to mental health problems and provide immediate intervention, thereby minimizing the risk of developing mental disorders. The effectiveness of the training program was assessed through the written feedback forms collected from the participants at the end of the program. Initial evaluation questionnaires were assessed to explore the level of knowledge and attitude the participants had before the training program.

Results

The mean (standard deviation) age of the participants was 28 years. Half of the participants were students pursuing their undergraduate or graduate degree and had an experience of either having or knowing someone with mental illness. Majority of the participants were female (73%).

Table 2 is just not problems that "the other" could have but that it could affect them too. Most of the participants (73%) expressed that being mentally healthy means overcoming difficulties and stressful events that we can face at some point.

They did not hold (56%) the idea that is quite commonly found in the community that people with mental health problems are violent and unpredictable. Majority (48%) of them held the attitude that mental health problems are more like a weakness than a real illness. Most (58%) of the participants indicated that there is hope for people with mental health problems, but then they were ambiguous on whether people with mental health problems can snap out of it if they try hard enough, with 33% indicating that they were not sure.

Table 3 indicates that majority (44%) of the participants think that personality weakness or character flaws cause mental health problems. Majority (87%) indicated that

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identifying the early signs of distress in a person can be helpful in providing help. The utility of talking about mental health challenges as well as the effectiveness of therapy or counseling in helping someone with mental health problems was endorsed by most (70% and 80%, respectively). There was a greater degree of ambiguity on whether people can treat themselves with positive thought and prayer with 44% agreeing to it.

Table 4 indicates that majority (62%) of the participants think that mental health problems can be prevented. Most also indicated that they could be of assistance to a person with a mental health problem (65%) as well as that listening is very important when providing help to a person with mental health problems (94%).

Discussion

The aim of the program was to assess and increase knowledge and skills through a 3-h training program on first aid for mental health problems. Participants' responses toward understanding mental health clearly show that the majority of participants possessed the attitude that mental health problems are more like a weakness and the person does not have a real problem. Most (58%) of the participants indicated that there is hope for people with mental health problems, but then they were ambiguous on whether people with mental health problems can snap out of it if they try hard enough, with 26% agreeing and 33% indicating that they were not sure [Figure 1].

Participants' responses toward knowledge of causation and treatment of mental health problems clearly demonstrate that 29% of the participants think that personality weakness or character flaws can cause mental health problems. A majority (87%) of the participants clearly indicated that identifying the early signs of distress in a person is crucial in identifying the mental health problem arising and in seeking timely help. This clearly goes with the objectives for which the training is based on. The results indicated that 44% of participants considered that people can treat themselves with positive thought and prayer [Figure 2].

Participants' attitude toward psychological first aid reveals that a majority (62%) of the participants think that mental health problems are preventable. Most of the participants also indicated that they could be of help and source of support to a person undergoing a mental health problem (65%) as well as certain skills such as listening is very important when providing first aid to a person with mental health problems (94%). These results could be partially due to the fact that a majority of the participants were working as lay counselors and teachers who were at sometimes exposed to curriculum pertaining to mental health briefly [Figure 3].

The feedback responses obtained from the participants indicated that they benefitted from the training program in terms of improvement in their knowledge and skills:

- *"Very unique program and knowledge gained"*
- *"Best part is the understanding obtained regarding the meaning of First Aid for Mental Health issues"*

Table 2: Responses indicating understanding of mental health

Item	Agree (%)	Disagree (%)	Not sure (%)
Mental health problems cannot affect me	11	56	33
Being mentally healthy means overcoming difficulties and stressful events that we can all face at some point	73	16	11
People with mental health problems are violent and unpredictable	23	56	21
Mental health problems are more like a weakness than a real illness	23	48	29
There is very little hope for people with mental health problems	14	58	28
People with mental health problems can snap out of it if they try hard enough	26	41	33

Table 3: Responses indicating knowledge of causation and treatment of mental health problems

Item	Agree (%)	Disagree (%)	Not sure (%)
Personality weakness or character flaws cause mental health problems	29	44	27
Identifying the early signs of distress in a person can be helpful in providing help	87	4	9
Talking about your mental health challenges is a waste of time	7	70	23
Therapy or counseling is always effective in helping someone with mental health problems	80	11	9
People can treat themselves with positive thought and prayer	44	32	24

Table 4: Responses indicating attitude toward Mental Health First Aid

Item	Agree (%)	Disagree (%)	Not sure (%)
Prevention doesn't work. It is difficult to prevent mental health problems	6	62	32
I can't do anything for a person with a mental health problem. Only a doctor can	7	65	28
Listening is very important when we are providing help to a person with mental health problems	94	3	3

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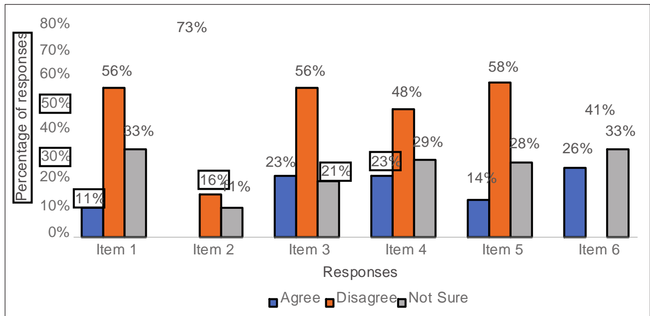

Figure 1: Graphical representation of responses indicating understanding mental health

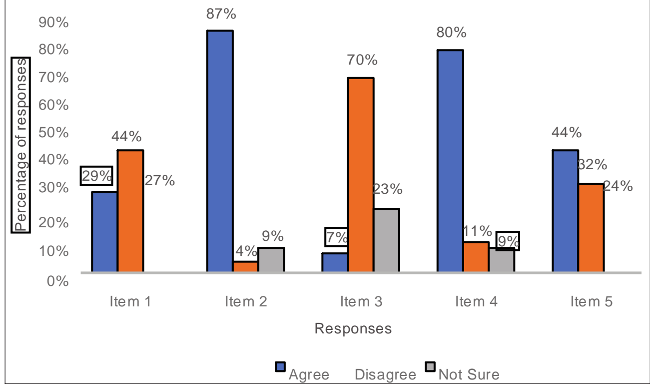

Figure 2: Graphical representation of responses indicating knowledge of causation and treatment of mental health problems

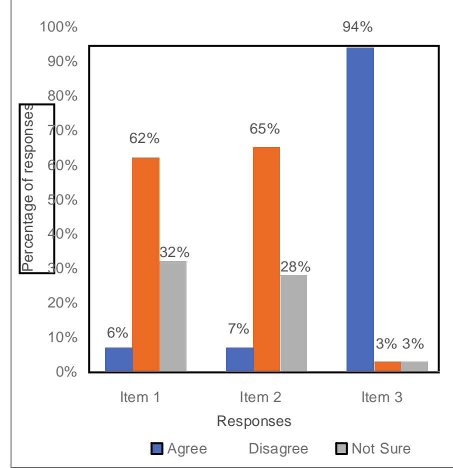

Figure 3: Graphical representation of responses indicating attitude toward Mental Health First Aid

- *"The training helped me in developing skills in identifying persons with mental health problems"*
- *"This training was very useful for me for my career and day to day life"*
- *"It strengthened my skills in dealing with Persons with mental health problems."*

Participants also expressed that the design of the program was useful and concepts were clearly explained with role play and group activities. Suggestions for improving the capacity building program were to make it for a longer duration, organize a follow-up session, and have it online for participants who are unable to physically attend.

Conclusions

The capacity building program for first aid for mental health problems appears to be effective in improving the knowledge and skills with regard to the mental health problems. The findings from the program indicated lack of knowledge in understanding of mental health, knowledge of causation, and treatment of mental health problems. Feedback from the training program indicated that it improved the ability of the participants in recognizing persons undergoing mental health problems and brought about a change in their beliefs about mental health, attitudes, and need for prompt referral. It also was successful in increasing the confidence of the participants in providing help to someone with a mental health problem and referring to appropriate mental health professional. The limitation of the program was that it was carried out with a small group. The same can be replicated onto a larger population with diverse group, and the study appears recommendable for the community at large. Based on the positive results of this interventional study conducted, future plans to conduct training of teachers programs have been thought of. Such programs will be aimed to be beneficial for teachers as they will be able to provide first aid to their students who may be facing a mental health crisis.

Future suggestions

This pilot study was considered effective based on the feedback received from the participants, for increasing knowledge about mental health and building skills to assist people facing a mental health crisis. Based on this finding, the following points for further research are suggested:

- Use of standardized questionnaires for assessing the initial knowledge and attitude about mental health and mental health problems in the community
- Building of a brief and effective intervention training program, based on the steps used in this pilot study, exclusively for the community with an aim of promoting knowledge with respect to mental health, and skills to assist people facing mental health crisis
- Use of standardized questionnaire for objectively assessing the effectiveness of the training program.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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RESEARCH ARTICLE

Knowledge, attitude and behaviors towards patients with mental illness: Results from a national Lebanese study

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Abstract

Objectives

Patients with mental health disorders often have to endure the burdens of the condition itself and the stigma that follows. Since no study has been conducted in Lebanon on this topic, our objective was to assess the knowledge, attitude and behaviors towards public stigma of mental health diseases, among a sample of the Lebanese population.

Methods

A cross-sectional study, conducted between November 2017 and May 2018, enrolled 2289 participants. The Mental Health Knowledge Schedule (MAKS), the Community Attitudes toward Mental Illness (CAMI) and the Reported and Intended Behavior Scale (RIBS) were used to assess knowledge, attitude and behaviors toward mental illness respectively. The 25th, 50th and 75th percentile of the MAKS, CAMI and RIBS scales scores were considered as cutoff points for low, medium and high scores respectively.

Results

A high knowledge score was found in 33.0% of the participants, whereas a high attitude score and a higher behavior score were found in 32.2% and 26.9% of the participants respectively. Living in North Lebanon (Beta = 1.331) and being familiar with a non-close person with mental illness (Beta = 0.811) were associated with higher knowledge of mental illness (higher MAKS score), whereas living in Bekaa (Beta = -8.693) and being 70 years old and above (Beta = -5.060) were associated with lower knowledge toward mental illness (lower MAKS score). Higher knowledge of mental illness (higher MAKS score) (Beta =

0.670), having a high level of education (university (Beta = 8.785), secondary (Beta = 6.084) and technical (Beta = 5.677)) were associated with less stigmatizing attitudes (higher CAMI scale). Being familiar with close people with mental illness (Beta = 0.577), less stigmatizing attitudes (higher CAMI scale) (Beta = 0.077) and higher knowledge of mental illness (higher MAKS score) (Beta = 0.115) were associated with higher favorable behaviors (higher RIBS score), whereas knowing a non-close person who have a mental illness (Beta = -0.720) was associated with lower favorable behaviors (lower RIBS score).

Conclusion

A mass media awareness campaigns that could transmit health messages to a wide public audience in the country to fight stigma toward mental illness, seems warranted.

Introduction

Patients with mental health disorders do not only have to endure the burden of having the condition but also the stigma that results from it, and that is classified into: public stigma, institutional stigma, and self-stigma. In this paper, we will address public stigma and refer to it as stigma. Stigma is defined as "a set of negative attitudes and beliefs that motivate individuals to fear, reject, avoid, and discriminate against people with mental illness" [1, 2]. It results in reduced autonomy and self-efficacy [3]. Stigma is mainly manifested in three ways: stereotype, prejudice and discrimination [2]. Many nations have taken steps forward to fight this social phenomenon. An example would be the United Kingdom and its "Time to Change" campaign [4]. Similar campaigns have been launched in New Zealand (Like Minds Like Mine) [5], Denmark (One of Us) [6], and Canada (Opening Minds) [7]. These anti-stigma initiatives targeted not only the general population but also specific groups through social media.

Studies have shown that low rates of seeking psychiatric help are mainly due to poor knowledge of mental health disorders (MHD) [8], that includes information about mental disorders, symptoms, and psychiatric treatments [9]. Many studies have also shown that more knowledge leads to fewer stigma [10, 11]. Moreover, attitudes range from acceptance [12] and tolerance [13] to negativity and fear [14]. When a positive attitude is portrayed, a supportive and open-minded behavior follows such as hiring a person suffering from MHD. Conversely, when attitudes are negative, it results in avoidance, social exclusion and discrimination [15].

Previous findings have shown that being in contact with a person having MHD influences behaviors, emotions and attitudes [16, 17]. In some cases, having experience with mental illnesses generated a positive and an understanding attitude, while in other cases, there has been rejection and negativity [18]. Interpersonal contact with patients with mental illness could develop understanding attitudes, change the beliefs, and reduce misconceptions toward these patients [19]. However, people may hold some negative views about the dangerousness of people with MHD and would prefer to keep a social distance despite their regular contact with them [20]. A study conducted by Angermeyer et al. showed that a large part of the public cannot recognize a specific mental disorder and the majority of the public consider people with mental disorders to be in need of help [21]. However, a substantial part perceives them as dangerous and unpredictable and reacts with fear [21]. In addition, several studies have shown that the general public perceives individuals with mental illness to be dangerous to themselves

and others [22–25]. A worldwide study conducted in 229 countries showed that in developed countries such as the USA and Canada, only 7% to 8% of respondents had stigma towards patients with MHD, compared to 15% or 16% in developing countries [26], where people stigmatize, fear and distance themselves from patients with MHD; they also show prejudices and stereotypes as they think that patients with mental illnesses tend to be more violent.

In most Arab countries stigma toward mental illness is still prevalent and people with MHD still experience the disadvantages of poverty and illness stigma [27]. Arab countries, have shared set of values, traditions and beliefs that are different from those of the western countries [28]. In Arab countries, patients with MHD have a negative attitude toward mental health services and tend to avoid the use these services; they express their psychological problems in the form of physical symptoms [27]. In Arab countries, symptoms of psychiatric disorders are associated to religious beliefs [29]. Most of mentally ill patients of the Arab world are first examined by the religious or spiritual healer whose task is to free the patient from the "evil" [29]. A large number of Arabs-speaking persons in Australia believes that mental illness is an experience of God because it is the result of sin or wrongdoing [30]. Consequently, sociocultural, religious and political aspects of the Arab world have an impact on psychiatric care. A study conducted in Egypt among 208 participants recruited through their places of work showed that the majority of respondents (70.2%) do not accept a person with MHD as a teacher for their children, 53.7% do not accept him as a family member, 32.7% do not accept him as a friend and 25.1% do not accept him as a neighbor. In this study, patients with psychiatric disorders are stigmatized and often face social rejection [31]. Another study conducted in the United Arab Emirates among parents of children with MHD showed that the majority of parents (62%) often do not seek help from mental health specialists [32].

Lebanon is an Arab country located in the Eastern Mediterranean region, with high religiosity among its eighteen various religious communities. A Lebanese study of a sample of 203 undergraduates revealed that stigma differs considerably according to various cultural misconceptions, for example 158 (77.8%) they think that evil eye might cause mental illness and 95 (46.8%) think that mental illness is a punishment from God [33]. The Arab World has its distinctive sociocultural beliefs about mental illness; Arabs profoundly believe in the reality of paranormal entities such as evil eye, Jinn (the devil), Sehr (Black Magic). They associate the symptoms of psychiatric disorders to the workings of these paranormal entities [33]. In 2010, a report of the WHO (World Health Organization) showed the existence of 3 mental hospitals and 5 community-based psychiatric inpatient units in Lebanon [34]. A total of 42 psychiatric beds are available per 10,000 inhabitants, and 2 psychiatrists per 100,000 inhabitants. Patients admitted to a hospital for mental illnesses mainly belong to the following two diagnostic groups: schizophrenia, schizotypal and delusional disorders (47%) and mood disorders (12%) [35]. A study done by Karam et al. among a representative sample of the Lebanese population (n = 2857) had showed that 25.8% of the sample met at least one of the criteria of the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders—fourth edition) at some point in their lives [36]. In Lebanon, stigma is still widespread with regard to mental illness, and people diagnosed with MHD still hide their disease: instead of seeking medical help, they refuse it because of cultural stigma [33].

To our knowledge two studies had been done in Lebanon that evaluated knowledge, attitudes and beliefs regarding mental illness [33, 37]. The first one was done among undergraduate people and the second among Catholic clerics [33, 37]. However, no studies had been done among the general population that evaluate knowledge, attitude and behaviors towards the stigmatization of MHD. Therefore, the objective of this study is to assess these parameters among a sample of the Lebanese population.

Methods

Ethical approval

In accordance with the hospital's Regulatory Research Protocol, the Ethics and Research Committee of the Psychiatric Hospital of the Cross, Jal Eddib, Lebanon approved this study protocol (HPC-023-2018) based on the fact that the autonomy and confidentiality of participants were respected and that it was an observational study with no prejudice to them. The purpose and requirements of the study were communicated to each participant. Consent was obtained in the form of written approval of the ethical consent form.

Study design and sample

This cross-sectional study was conducted between November 2017 and May 2018; it enrolled 2289 community dwelling participants using a proportionate random sample from all Lebanese governorates (Beirut, Mount Lebanon, North, South and Bekaa). Each governorate is divided into Caza (stratum). In the first stage of the random sampling technique, two villages were randomly selected from each Caza, based on the list of villages provided by the Central Agency of Statistics in Lebanon. In the second stage, in each selected village, the questionnaire was distributed randomly to the households, based on random sampling technique to select the included house. All persons living inside the selected house were invited to participate, if eligible. After eligibility criteria were determined, subjects were assigned identification numbers and randomized according to an online software, Research Randomizer (www.randomizer.org). The stratified randomization method was used since it allows to control and balance the influence of covariates. Prior to participation, individual subjects were briefed on the study objectives and methodology, and were assured of the anonymity of their participation. Individuals agreeing to participate in the study were then asked to read through and sign off a written informed consent form. Those who accepted to participate in the study were invited to fill out the questionnaire via a face-to-face interview. All participants above 18 years of age were eligible to participate. Excluded were the persons with self-reported psychiatric problems or those who refused to participate. No resources/helpline brochures were given to participants.

Questionnaire

The questionnaire included 102 questions and was in Arabic (the native language in Lebanon). The first part covered socio-economic and demographic characteristics, including age, gender, marital status and the level of education. The level of education was divided into four categories: primary, secondary, university and technical education–the technical education system in Lebanon is defined as a curriculum (combination of theoretical and practical studies) that prepares skilled technicians [38]. The household crowding index was calculated by dividing the number of persons living in the house by the number of rooms in the house excluding the bathroom(s) and the kitchen. The higher the score the more the house is crowded. Overcrowded households are often households with few economic resources [39].

The second part, included three scales: the Mental Health Knowledge Schedule (MAKS), the Community Attitudes toward Mental Illness (CAMI), and the Reported and Intended Behaviour Scale (RIBS). All three scales were not validated in Arabic. Therefore, all scales were translated from English to Arabic through an initial translation and back translation process. The English version was translated into Arabic by a mental health specialist, then back-translated into English by another specialist. Upon completion of this process, the translators compared the English versions of all the scales to determine whether the variables had the same meaning. An expert committee formed by healthcare professionals and a language professiona
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verified the Arabic translated version. The expert committee aimed at discerning discrepancies and to solve any inconsistencies between the two versions. The process of forward-back translation was repeated until all ambiguities disappeared.

The Mental Health Knowledge Schedule (MAKS). This twelve-item scale comprises domains of relevant evidence-based knowledge in relation to stigma toward mental illness. Items are coded on an ordinal scale (1–5). Items which the respondent strongly agrees with score 5 points; 1 point reflects a response to which the respondent strongly disagrees. The total score is calculated by adding the points obtained for each of the 12 items. Higher total scores correspond to greater knowledge [40]. The Cronbach's alpha for the MAKS scale was 0.749.

The Community Attitudes toward Mental Illness (CAMI). The forty-item CAMI scale was developed by two researchers at a Canadian university [41] and was used in this study to measure public stigma attitudes towards mental illness. All items are rated according to a five-point Likert scale (1 = strongly agree to 5 = strongly disagree). Negatively stated items were reversely recoded for analysis. The scale has four subscales, each with 10 items: Authoritarianism (AU), Benevolence (BE), Social Restrictiveness (SR), and Community Mental Health Ideology (CMHI). AU is a "view of the mentally ill person as someone who is inferior and requires supervision and coercion." BE corresponds to "a humanistic and sympathetic view of mentally ill persons"; SR means "the belief that mentally ill patients are a threat to society and should be avoided." Community Mental Health Ideology (CMHI) is "the acceptance of mental health services and the integration of mentally ill patients in the community" [41]. Higher AU scores, lower BE scores, lower SR scores and higher CMHI scores would indicate higher stigma. Overall stigma against patients with mental illness was computed by summing up the subscales. Higher scores indicated less stigma attitudes against patients with mental illness. The Cronbach's alpha for the total scale and subscales were as follows: CAMI (0.876), AU (0.555), BE (0.637), SR (0.690) and CMHI (0.804).

The Reported and Intended Behavior Scale (RIBS). The RIBS (eight-item scale) comes in two groups of four items each. The first group focuses on behavior reported in past or present experiences regarding the following areas: live with, work with, live nearby, or have a relationship with a person with a mental health problem. The second group focuses on future intentions to establish contact with people with a mental health problem in the same areas as described above. Each item is coded on an ordinal scale (1 = strongly disagreed to 5 = strongly agreed). "Do not know" is coded as neutral. High values correspond to more favorable expected behaviors [42]. The Cronbach's alpha for the CAMI scale was 0.766.

Data collection

Data collection was performed by study-independent clinical psychologists who had received a thorough training prior to data collection, and whose role was to evaluate participants' level of mental illness to exclude those with psychiatric problems. No resources/helpline brochures were given to participants. The questionnaire was completed within 45 minutes approximately. During the data collection process, the anonymity of the participants was assured. Individual participants had the right to accept or refuse participation in the study, with no financial compensation provided in exchange for individual participation.

Statistical analysis

Data analysis was conducted using SPSS software version 23. The independent-sample t-test was used when comparing two means, whereas the ANOVA test was used to compare 3 means or more. The Pearson's correlation coefficient was used between 2 quantitative variables. Since better knowledge would lead to better attitudes, which would lead to better behaviors, three

hierarchical stepwise linear regressions were conducted; in the first one, we took the MAKS score (knowledge score) as the dependent variable and sociodemographic variables as independent variables. In the second one, we took the CAMI score (attitude score) as the dependent variable, with the sociodemographic variables and the knowledge score as independent variables. Finally, in the third regression, we considered the RIBS score (behaviors score) as the dependent variable and the sociodemographic variables, knowledge and attitude scores as independent variables. All variables that showed a p<0.1 in the bivariate analysis were taken as independent variables in the regression model in order to eliminate the potential confounding factors. Moreover, Cronbach's alpha was recorded for reliability analysis for all the scales. A p-value less than 0.05 was considered significant.

Results

Overall, 2289 persons out of 3000 completed the interviews and 711 refused to participate; thus, the response rate was 76.3%. More than half of the participants were females (53.0%), unemployed (60.9%), between 18 and 24 years old (61.0%), and university graduates (62.4%) (Table 1).

Based on the total scores of CAMI, MAKS and RIBS scales, 25th, 50th and 75th percentile were considered as cut off points for low, medium and high score. A higher score of public stigma toward mental illness was found in 67.8% of the participants. The higher score of knowledge toward mental illness was 61.9% and 66.6% had more favorable behaviors. The mean scores for all the scales and subscales were as follows: CAMI (136.84 ± 17.55), AU (32.74 ± 5.05), BE (36.75 ± 5.25), SR (34.34 ± 5.50), CMHI (33.19 ± 6.25), MAKS (39.00 ± 6.84) and RIBS (15.58 ± 4.10).

Bivariate analysis

The bivariate analysis of factors associated with the total CAMI scale score showed a significantly higher mean CAMI score (less stigma) in females compared to males (138.62 vs. 135.58,

Table 1. Sociodemographic characteristics of the participants.

		Frequency (%)
Age	18–24 years	1342 (61.0%)
	30–49 years	580 (26.4%)
	50–69 years	255 (11.6%)
	>70 years	22 (1.0%)
Sex	Male	1032 (47.0%)
	Female	1163 (53.0%)
Education level	Primary	105 (4.7%)
	Secondary	541 (24.2%)
	University	1393 (62.4%)
	Technical education	194 (8.7%)
Employment status	Employed	862 (39.1%)
	Unemployed	1347 (60.9%)
Region	Beirut	441 (20.2%)
	Mont Lebanon	979 (44.8%)
	North	278 (12.7%)
	South	348 (15.9%)
	Bekaa	141 (6.4%)
		Mean ± SD
The household crowding index		0.64 ± 0.35

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p<0.001), in those with a university level of education compared to a primary one (138.74 vs. 127.96, p<0.001), and in those aged between 18–24 years compared to those above 70 years (138.25 vs. 126.77, p<0.001). Also, people who live in Beirut had a significantly higher mean CAMI scale than people who live in Bekaa (137.31 vs. 131.34, p<0.001). A higher CAMI score was significantly associated with higher MAKS (r = 0.689) and RIBS scores (r = 0.778).

The bivariate analysis taking the MAKS score as the dependent variable, showed a significantly higher mean MAKS score in females compared to males (39.41 vs. 38.62, p = 0.007), in those with a university level of education compared to a primary one (39.30 vs. 37.34, p = 0.001), in those aged between 18–24 years compared to those above 70 years (39.51 vs. 34.45, p = 0.005) and in those living in Mount Lebanon compared to those living in Bekaa (39.66 vs. 30.65, p<0.001). A higher MAKS score was significantly associated with a higher household crowding index (r = 0.055), CAMI scale (r = 0.689), RIBS scale (r = 0.709), the number of family/friends (close people) (r = 0.077) and non-close people (r = 0.082) with mental illness the person knows.

The bivariate analysis taking the RIBS score as the dependent variable showed a significantly higher mean RIBS score in people living in Beirut compared to those living in Bekaa (16.40 vs. 13.81, p<0.001). A higher RIBS score was also significantly associated with the number of family/friends (close people) (r = 0.143) and non-close people (r = 0.087) with mental illness the person knows (Tables 2 and 3).

Multivariable analysis

A first linear regression, taking the MAKS scale as the dependent variable, showed that living in North Lebanon (Beta = 1.331) and knowing non-close people with mental illness (Beta = 0.811) were associated with higher knowledge of mental illness (higher MAKS scores), whereas living in Bekaa (Beta = -8.693) and being 70 years old and above (Beta = -5.060) were associated with lower knowledge toward mental illness (lower MAKS scores).

A second linear regression, taking the CAMI scale as the dependent variable, showed that higher knowledge of mental illness (higher MAKS score) (Beta = 0.670) and having a high level of education (university (Beta = 8.785), secondary (Beta = 6.084) and technical (Beta = 5.677)) were associated with less stigmatizing attitudes (higher CAMI scores).

A third linear regression, taking the RIBS scale as the dependent variable, showed that knowing close people with mental illness (Beta = 0.577), less stigmatizing attitudes (higher CAMI scores) (Beta = 0.077) and higher knowledge of mental illness (higher MAKS scores) (Beta = 0.115) were associated with higher favorable behaviors (higher RIBS scores), whereas knowing a non-close person who have a mental illness (Beta = -0.720) was associated with lower favorable behaviors (lower RIBS score) (Table 4).

Discussion

To the best of our knowledge, this is the first study that assesses knowledge, attitude and behavior towards mentally ill patients in a Lebanese sample. The results obtained are in line with other studies [31, 32, 43, 44] showing a high prevalence of stigma toward mental illness in our sample. A study done by Abolfotouh et al. among the Saudi public had found that the majority of the sample (87.5%) reported lack of knowledge of mental illness, 66.5% had negative perception and 54.5% had negative attitudes to mental illness [45]. In a Moroccan study, most families (76%) reported having no knowledge about mental illness [46]. A study done by Coker et al. had found that 85.5% of the sample would not accept a psychotic person [31]. Other findings showed that only 38% of parents of children having mental illness in the United Arab Emirates would seek medical help [32]. Lebanese families are still denying the presence

Table 2. Bivariate analysis of sociodemographic factors associated with each subscale of the CAMI score.

Variable	Total CAMI score	AU	BE	SR	CMHI	MAKS	RIBS
Age categories							
18–29 years	138.25 ± 16.91	33.17 ± 4.93	37.06 ± 5.18	34.89 ± 5.51	33.45 ± 6.06	38.96 ± 6.99	15.65 ± 3.91
30–49 years	135.58 ± 18.54	32.28 ± 5.47	36.54 ± 5.36	33.80 ± 5.53	33.03 ± 6.50	39.51 ± 6.52	15.52 ± 4.38
50–69 years	134.65 ± 17.75	32.03 ± 4.58	36.42 ± 5.01	33.25 ± 5.09	32.78 ± 6.62	38.32 ± 7.01	15.35 ± 4.22
70 years and above	126.77 ± 19.50	29.95 ± 6.27	36.84 ± 5.21	30.95 ± 6.78	29.50 ± 6.58	34.45 ± 7.10	14.09 ± 4.70
p-value	**<0.001**	**<0.001**	0.095	**<0.001**	**0.01**	**0.005**	0.438
Gender							
Male	135.58 ± 17.93	32.33 ± 5.10	36.50 ± 5.41	33.74 ± 5.54	33.12 ± 6.32	38.62 ± 7.08	15.43 ±3.97
Female	138.62 ± 16.85	33.29 ± 4.93	37.19 ± 4.94	35.05 ± 5.41	33.39 ± 6.17	39.41 ± 6.51	15.67 ±4.12
p-value	**<0.001**	**<0.001**	**0.002**	**<0.001**	0.307	**0.007**	0.18
District							
Beirut	137.31 ± 16.65	32.58 ± 4.88	36.71 ± 5.36	34.63 ± 5.66	33.77 ± 5.44	39.54 ± 6.01	16.40 ± 4.26
Mount Lebanon	137.11 ± 16.82	32.86 ± 5.22	36.88 ± 4.86	34.44 ± 5.46	33.05 ± 6.25	39.66 ± 6.23	15.55 ± 3.97
North	137.08 ± 19.66	32.64 ± 5.24	37.10 ± 5.10	34.11 ± 5.95	33.26 ± 7.63	39.90 ± 6.06	15.30 ± 4.69
South	135.43 ± 17.70	32.62 ± 4.48	36.07 ± 5.68	34.29 ± 5.35	32.88 ± 5.94	39.43 ± 5.79	15.58 ± 3.81
Bekaa	131.34 ± 11.36	31.39 ± 2.62	36.47 ± 4.58	31.80 ± 3.51	31.26 ± 4.63	30.65 ± 10.35	13.81 ± 3.08
p-value	**0.002**	**<0.001**	0.078	**<0.001**	**0.001**	**<0.001**	**<0.001**
Education level							
Primary	127.96 ± 19.72	30.07 ± 5.58	35.11 ± 5.56	31.57 ± 5.35	31.17 ± 7.38	37.34 ± 6.86	14.87 ± 5.12
Secondary	135.63 ± 16.84	32.51 ± 4.88	36.32 ± 5.07	33.72 ± 5.34	33.13 ± 5.98	39.10 ± 6.20	15.42 ± 4.25
University	138.74 ± 17.15	33.22 ± 4.88	37.26 ± 5.11	35.00 ± 5.40	33.57 ± 6.23	39.30 ± 6.91	15.74 ± 3.91
Technical	134.57 ± 16.60	32.31 ± 5.06	36.26 ± 5.20	33.35 ± 5.64	32.65 ± 5.72	38.00 ± 7.31	15.28 ± 4.11
p-value		**<0.001**	**<0.001**	**<0.001**	**0.001**	**0.001**	0.114
Knowing someone with a mental illness							
Yes	137.01 ± 16.91	32.43 ± 4.99	36.79 ± 5.03	34.46 ± 5.61	33.49 ± 6.17	39.94 ± 6.05	16.18 ± 4.33
No	137.88 ± 17.18	32.23 ± 5.07	37.19 ± 4.94	34.41 ± 5.31	33.13 ± 6.32	38.31 ± 7.31	14.97 ± 3.79
p-value	0.273	**0.001**	0.084	0.842	0.214	**<0.001**	**<0.001**

Authoritarianism (AU), Benevolence (BE), Social Restrictiveness (SR), and Community Mental Health Ideology (CMHI); MAKS: Mental Health Knowledge Schedule; RIBS: reported and Intended Behavior Scale. Lower scores on "Authoritarian" and "Social Restrictiveness" signify greater amounts of stigma, while lower on "Benevolence" signifies higher stigma and a higher score on "Community Mental Health Ideology" signifies higher acceptance of the mentally ill.

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of mental illness and many individuals choose not to seek professional help out of fear of their communities' reactions. There are still misconceptions and stigma associated with mental illness in the Lebanese population, similar to other Arab countries. Al-Krenawi et al. (2005) found that Arab patients with mental illness avoid the negative reactions of the public towards their illness by not disclosing their psychiatric symptoms to others [27].

In fact, the Lebanese society where religion plays an important role, pays special attention to beliefs about sin and causes and treatment of mental illness. Lower scores on public stigma against mental illness were associated with the belief that evil eye, magic and punishment from God might cause mental illness [33]. The theological view of mentally illness in the Arab culture considers that the illness is related to evil eye or a result from a sin or wrongdoing, with mental illness being a consequence of God punishment and a demonic possession [47]. The primary treatment is spiritual healing (exorcism to eradicate the demon or evil eye), miraculous healing through prayer and reading the holy book (Bible or Koran) [47]. In the Arab culture, the care of the ill person is the responsibility of the family [48]; Arab families tend to hold negative attitudes toward psychiatric services; it takes them months and even years to accept

Table 3. Correlation between continuous variables and the CAMI subscales, MAKS and RIBS scores.

Variable	AU	BE	SR	CMHI	MAKS	RIBS
AU						
r	1	0.517	0.603	0.522	0.663	0.687
p-value	-	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**
BE						
r	0.517	1	0.528	0.475	0.669	0.673
p-value	**<0.001**	-	**<0.001**	**<0.001**	**<0.001**	**<0.001**
SR						
r	0.603	0.528	1	0.547	0.596	0.546
p-value	**<0.001**	**<0.001**	-	**<0.001**	**<0.001**	**<0.001**
CMHI						
r	0.522	0.475	0.547	1	0.609	0.594
p-value	**<0.001**	**<0.001**	**<0.001**	-	**<0.001**	**<0.001**
MAKS						
r	0.663	0.669	0.596	0.609	1	0.609
p-value	**<0.001**	**<0.001**	**<0.001**	**<0.001**	-	**<0.001**
RIBS						
r	0.687	0.673	0.546	0.594	0.609	1
p-value	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**	-
Familiarity with close PWMI						
r	-0.019	-0.053	-0.014	-0.006	0.041	0.143
p-value	0.359	**0.011**	0.5	0.764	0.054	**<0.001**
Familiarity with non-close PWMI						
r	-0.018	0.001	0.033	0.041	0.082	0.087
p-value	0.386	0.944	0.121	**0.049**	**<0.001**	**<0.001**
House crowding index						
r	-0.1	-0.071	-0.081	-0.027	-0.125	-0.028
p-value	**<0.001**	**0.001**	**<0.001**	0.206	**<0.001**	0.179

Authoritarianism (AU), Benevolence (BE), Social Restrictiveness (SR), and Community Mental Health Ideology (CMHI); MAKS: Mental Health Knowledge Schedule; RIBS: reported and Intended Behavior Scale, **PWMI: person with mental illness.** Higher scores on "Authoritarian" and "Social Restrictiveness" signify greater amounts of stigma, while higher scores on "Benevolence" signifies lower stigma and a higher score on "Community Mental Health Ideology" signifies higher acceptance of the mentally ill.

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that the person with mental illness needs professional psychiatric care [28]. Nevertheless, the majority of Arab families still hold restrictive cultural and social beliefs that consider the mentally ill patients as a shame [49]. A study done by Dalky in 2012 found that Arab families perceived the experience of caring for a family member with a mental illness with fear, loss, embarrassment, and disgrace of family reputations [50]. Another study done by Kadri et al. among a sample of 100 Moroccan family members accompanying patients with schizophrenia showed that 86.7% of family members reported having hard/difficult lives and 72% reported psychological suffering and poor quality of life [46].

Knowledge

Stigma has been associated with low knowledge about mental health disorders. There are two types of knowledge; the first refers to the people's familiarity with various disorders such as depression and schizophrenia; this shows that they consider them as disorders so it is more likely for them to suggest help or care from a physician. The second refers to the high

Table 4. Multivariable analysis.

Model 1: Linear regression taking the MAKS scale (knowledge score) as the dependent variable.

	Unstandardized Beta	Standardized Beta	p-value	Confidence interval	
				Lower Bound	Upper Bound
Bekaa	-8.693	-0.314	<0.001	-9.894	-7.492
Familiarity with non-close people with mental illness (yes vs no◆)	0.811	0.063	0.010	0.190	1.432
Age 70 years and above compared to 18–29 years◆	-5.060	-0.069	0.002	-8.221	-1.900
North compared to Beirut◆	1.331	0.063	0.004	0.418	2.243

Variables entered: Sex, Age, the household crowding index, Familiarity close people, Region, education level, familiarity non-close people who have mental illness.

Model 2: Linear regression taking the total CAMI scale (attitude score) as the dependent variable.

	Unstandardized Beta	Standardized Beta	p-value	Confidence interval	
				Lower Bound	Upper Bound
Knowledge toward mental illness score (MAKS scale)	0.670	0.266	<0.001	0.570	0
University education compared to primary◆	8.785	0.253	<0.001	6.154	11.416
Secondary education compared to primary◆	6.084	0.152	<0.001	3.264	8.904
Technical education compared to primary◆	5.677	0.094	0.001	2.373	8.981

Variables entered: Sex, the household crowding index MAKS scale, Familiarity with close people who have mental illness, Age categories, Region, education level.

Model 3: Linear regression taking the RIBS scale (behaviors score) as dependent variable.

	Unstandardized Beta	Standardized Beta	p-value	Confidence interval	
				Lower Bound	Upper Bound
Attitudes toward Mental Illness (CAMI scale)	0.077	0.320	<0.001	0.067	0.087
Knowledge toward mental illness (MAKS scale)	0.115	0.193	<0.001	0.090	0.139
Familiarity with close people (yes vs no◆)	0.577	0.119	<0.001	0.366	0.788
Familiarity with non-close person who have mental illness (yes vs no◆)	-0.720	-0.087	<0.001	-1.082	-0.358

Variables entered: MAKS scale, CAMI scale, Familiarity with close people who have mental illness, Region, education level, familiarity with close people who have mental illness, familiarity with non-close person who have mental illness.

◆Reference group

CAMI: Community Attitudes toward Mental Illness; MAKS: Mental Health Knowledge Schedule; RIBS: reported and Intended Behavior Scale

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educational level being correlated to less prejudice and segregation towards mentally ill patients [51].

Moreover, our study has shown that people over 70 years old had less knowledge towards mental illness; our findings are consistent with those reported in an Indian study [52] but are in opposite to other studies that showed that older people have more knowledge because as they grow older, they are exposed to more experience and therefore more knowledge [53]. In addition, no correlation between age and knowledge was found according to a more recent study [54]. The association between age and knowledge towards mental illness is still controversial, with more in-depth research needed for a better understanding.

Knowing non-close people with mental illness was associated with higher knowledge according to the results of this study. These findings are in agreement with previous ones that showed that persons who are in contact with mentally-ill patients possess an adequate overall information about mental illness since they experience with those patients some of the signs, symptoms and treatments of the disease [53].

Finally, our results indicate that living in North Lebanon was associated with higher knowledge scores of mental illness, whereas living in Bekaa was associated with lower knowledge. In view of these results, awareness campaigns to increase knowledge of mental disorders should target the Bekaa region most importantly, but also the other regions since a lack of knowledge of mental illness apparently exists in all Lebanese governorates.

Attitudes and behaviors

Attitudes and behaviors vary from positive and understanding to negative and repulsive. In our study, a positive correlation was established between the CAMI score and knowledge, so better attitudes are associated with more knowledge. Similar results were found in some studies [10, 11, 55–59] whereas others showed opposing results with no significant correlation between knowledge and attitude [60, 61]. One theory states that individuals with a higher level of knowledge have had the chance to get educated on the topic and are as a result more understanding and have better attitudes. Other studies showed that having higher level of knowledge of mental illness has forced people to be more distant from the mentally ill as they know their actual symptoms and behaviors [62, 63].

Gender is also a significant variable when it comes to stigma. Our results showed that females had a better attitude towards the mentally ill in the bivariate but not in the multivariable analysis. This is in concordance with previous studies as it was shown that females are more empathetic and open-minded [54, 64] and positive [21] showing less stigma [65]. No significant correlation was established between gender and behavior in our study; however, in a Swedish study, females showed fear and social distance as opposed to men [66]. Other studies demonstrated that women have less social restrictiveness and prejudice and misconceptions [67]. A study done by Elkington et al. (2012) demonstrated that a male's stigma focuses on the diagnosis itself, while a female's stigma depends on how the patients are perceived by society, so males have a realistic view while a female's view is more subjective [68]. Additional research is necessary to clarify this association.

Familiarity and experience with people suffering from a mental illness have shown to be one the most crucial criteria that determine attitudes and behaviors [54]. Our questionnaire assessed familiarity with friends, close and distant people, in relation to attitudes and behaviors. A positive correlation was established in all cases. Previous studies have shown that having experienced mental illness with others leads to more positive attitudes [64]. In fact, those having mental illnesses in the family induced more benevolence and higher CAMI score than those without mentally ill family members. In other cases however, having experience with someone suffering from mental illnesses establishes negative attitudes [18]. According to Arkar and Eker, experienced individuals become realistic and sense the danger along with mental illnesses, which is why their attitude shifts negatively [69].

The results revealed that higher mean of knowledge, positive behaviors and positive attitudes scores toward mental illness was seen in persons living mostly in Beirut and Mount Lebanon. In these areas the majority of activities (economic, political, education and industrial) are concentrated [70]. The higher education institutes are located mainly in the center of the country along with the three main mental health hospitals in Lebanon [35]. Education may provide information about mental illness that might reduce the blame placed on mentally ill people and could change the stigmatizing attitudes toward them [71]. Also regular contact with mentally ill patients that occur in the overcrowded areas may reduce the social distance (discomfort fear and distrust emotions) toward mentally ill persons [71].

Limitations and strengths

This study used a large sample, which included measures specifically targeted for the evaluation of stigma. It provides a first description of the level of stigma in the Lebanese population. Despite these strengths, there are some limitations associated with this study. The study is cross-sectional with a low level of evidence. The instruments used to assess the attitude, knowledge and behaviors toward mental illness had not yet been validated in the Lebanese context. An information bias could exist since the participants provide us with information using a

self-reported questionnaire. The results could not be generalized to the entire population, since the group of 18–24 years, with university education, and unemployed was more represented. Our data could not be weighted to account for the multi-level sampling design in the absence of official numbers from the Lebanese government in terms of total population per governorate and subcategories by age and gender. Future research using alternative methods, such as stratified random sampling, might obtain a more complete view of level of stigma.

Conclusion

In a country where mental health disorders and stigma prevail, it was important to assess the factors that contribute to public stigma. Knowledge, attitudes and behaviors were differently associated among different members of the Lebanese society. Our main finding was that more knowledge is associated with better behaviors and attitudes and therefore less stigma, which is why it is important to initiate awareness campaigns all over the country and especially in schools to prepare a more knowledgeable and open-minded society. As a result, people suffering from mental health disorders will not feel ashamed to seek the professional help that they need.

Supporting information

S1 Table. Questionnaire in Arabic.
(DOCX)

S2 Table. Questionnaire in English.
(DOCX)

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Knowledge Of Mental Health And Mental Illnesses Among Community Members In Bungoma County, Kenya

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Abstract: *Objective. The objective of the study was to determine the knowledge of mental health and mental illness by the community in Bungoma county Kenya. Design. The study was a descriptive cross-sectional study and Quantitative methods were adopted. Setting. The study was carried out in Bungoma County Sample. Five Sub-Counties in Bungoma County were purposively sampled to increase the representation. The household's heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling (n = 396) Analysis. Data wasanalyzed through descriptive statistics, chi-square test of independence and logistic regression. Main outcome measures. Knowledge of mental health and mental illness Results. 67.7% (268) disagreed that mental illness is an illness like any other. 60.6% (240) disagreed that one of the main causes of mental illness is lack of self-discipline and will power. Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. Of the 396 respondents, 300 (75.8%) of respondents agreed that people with mental illness have a lower intelligent quotient. Chi square analysis showed that there was no statistically significant relationship between the knowledge of mental illness and gender X^2 (1, N=369) =0.22. Logistic regression was done and respondents who were single were 0.4 times more likely (OR=0.42, 95% C.I, 0.06-2.84) to belong to the 'poor knowledge 'group than the 'good knowledge' group compared to the widowed Conclusion. That sensitization of the community/ public on mental illnesses is important. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.*

Keywords: *Mental health, Mental illness, Knowledge of mental illness, public knowledge, sensitization, stigma, myths about mental illness.*

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I. Background

The World Health Organization (WHO) recognized the importance of psychological wellbeing, defining health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" WHO-AIMS, (2005). For all individuals, mental, physical and social health are vital elements of life that are closely interwoven and deeply interdependent (WHO report, 2011). Today mental health problems are recognized as a public health problem in developed as well as developing countries Pinfold et al. (2008).A 2011, study in United States (U.S) found out that 5 to 6 million U.S workers aged 16 to 54 years "lost, failed to seek, or could not find employment" due to mental illness (Cohen &Struening, 2013). Reduced earnings and decreased employment potential put mentally ill individuals at an increased risk of poverty Pinfold et al. (2008). As Lund et al. (2013) explained, mental illness and poverty "interact in a negative cycle", in which poverty acts as a risk factor for mental illness, and mental illness increases the risk that individuals will drift into or remain in poverty". This negative cycle contributed to high rates of homelessness among individuals with mental illnesses Mas & Hatim (2009). The notion that mental health problems were less common in low-income countries than in developed countries was disputed by Morgan, (2010).

In a typical African context, mental health disorders and mental illness were normally associated with witchcraft and sorcery Issa et al. (2008), Gikonyo (2009) & Hugo (2011). Most families/communities perceived it as a punishment from "gods" for a wrong act committed by a family member, most especially the clan Reid et al. (2014). Usually the blame would be shifted to the mother of the person with mental illness, thereby initiating and causing family and marriage breakdown. A good sense of self-esteem was therefore required to cope effectively and promote good mental health for the family/community (Gikonyo, 2009). Evidence suggested that there was considerable variation in how families and community adapted to the demands of the affected individual and family (Kitchener &Jorm, 2013). Contextual factors such as socio-economic status, severity of

mental disorder and behavioral problems of the affected, social support and coping strategies were associated with psychological distress and depression (Muga& Jenkins, 2012).

Several studies have found out that many members of the community lack knowledge about mental illness, especially with respect to beliefs and myths about causes of the disorders (Trainer, 2008). Some believed that psychiatric illness was not a disease, but a curse that was caused by witchcraft and evil spirits. (Watson & Corrigan, 2002; Sadok&Sadok, 2015) agreed that traditional communities believed that mental illnesses are caused by spirits and curses, with influences by the moon, or that it is a divine punishment. Trainer & Pierre (2014) reiterated that beliefs of this nature keep the stigma and discrimination alive.Studies have shown that beliefs about causes may alter patterns of help seeking and responses to treatment (Abbey et al., 2011). For example, in Malaysia beliefs by psychiatric patients in supernatural causes were associated with great use of traditional healers and poor compliance with modern medication (Jorm, 2010). Therefore, negative beliefs about causes and lack of adequate knowledge have been found to sustain deep seated negative attitudes about mental illness (Gureje et al., 2005). Conversely, better knowledge has often been reported to result in improved attitudes towards people with mental illness and a belief that mental illnesses were treatable, can encourage early help seeking and promote better outcomes (Ephraim-Oluwanuga& Kola., 2010). However, in practice professional help was often not sought at all or only sought after a delay (Barney et al., 2008). Early recognition and appropriate help seeking only occurred if mentally ill patients and their "supporters" (e.g. their family, teachers, employers and friends) know about the early changes produced by mental disorders, the best types of help available, and how to access this help (Dahlberg et al., 2008).

The National Development plan report on statistics (GOK, 2002) further indicated that approximately 1.8 million people in Kenya aged between 0-19 have mental health disorders. The taskforce established that there were 998 persons enrolled in special schools and units in other major towns (KDHS, 2008). Out of these 225 had mental health disorders comprising of autism, mental retardation among other conditions (Livingstone & Boyd, 2010). As per the census report by Kenya National Bureau of Statistics (GOK, 2009), there are no statistics on the number of persons with mental illness since some have been hidden from the public and the number registered does not give the true picture of the target population (Becker &Klumman, 2013). Studies have shown that in the Western world, mental illnesses are generally thought to be caused by psychological factors, such as environmental stressors, or childhood events (Krifton et al., 2012). Biochemical and genetic influences, although recognized as causal factors, are not considered as important as environmental ones (Jorm, 2011). Some studies suggested that serious mental illnesses such as schizophrenia are more likely to be linked to genetic causal factors, compared to common mental disorders such as depression (Krifton et al., 2012). Over the last 50 years, philosophies of service delivery to people with mental health problems have changed considerably (Ephraim-Oluwanuga& Kola, 2007). More particularly, in the last few decades the focus has changed from medical and therapeutic needs only to an approach that included the needs of the whole family.

In the developed world, these changes have coincided with the de-institutionalization of people with mental illness and children with an intellectual disability, legislation mandating a range of advocacy, educational and intervention policies, and the increasing entry of these children into mainstream schools (Stuart, 2008). For example, in the 1970"s in the United States, legislation was passed that mandated early intervention programs for families with a person with mental health problem, recognizing the important role of the family in maximizing the life outcomes especially for the children and people with mental health conditions (Trainer & Pierre, 2014).According to Modest (2008), causes of mental illness is not synonymous, but vary widely, from inherited chemical imbalances responsible for the development of such illnesses as depression, bipolar disorder, and schizophrenia, to brain diseases, to causes that are more immediately under our control. Improved knowledge about causes may lead to improved overall knowledge about mental illness and promote supportive attitudes to the mentally ill (Mehta et al. 2010). Inarguably, ignorance and stigma prevent the mentally ill from seeking appropriate help (Kabir et al. 2009). Researchers have often assessed stigma, associated with mental illness, by surveying the community"s attitudes and perceptions towards "mental patients", or "persons with mental illness", and in using these terms, evoking images of chronic psychopathology (Corrigan et al. 2011).

The researcher therefore, sought to fill exiting knowledge gaps in the study area. Past studies on causes of mental illnesses were done in different geographical regions and differently Krifton*et al.* (2012). This is the knowledge gap that the study attempted to address Modest (2008). This study also sought to understand the local contexts of perception in order to develop effective programs to change such attitudes in the community where the mentally affected lives Mehta et al (2010). Therefore, the researcher found it necessary to conduct this study. The objective of the study was to determine the knowledge of mental health and mental illness by the community in Bungoma County, Kenya.

II. Methods

The study was conducted in Bungoma county and ethics approval was obtained from Masinde Muliro University of Science and Technology ethics board, National commission for science and technology. No further approval was needed since the project did not require access to patients or personal data.

Research Design

The study designs adopted for this study was descriptive cross-sectional and evaluation because they employ quantitative approaches, where self-administered questionnaires were used for data collection. This particular designs were ideal since the research entailed collecting and comparing data from the phenomena at the same time of study (Basavanthappa, 2011). A descriptive research design determines and reports the way things are (Mugenda & Mugenda, 2008). Polit & Hungler (2010) observed that a descriptive research design was used when data was collected to describe persons, organizations, settings or phenomena. The purpose of the design was to gather data at a particular point in time with the intention of describing the nature of the existing conditions (Burns and Grove, 2011). Descriptive study design was also ideal as the study was carried out in a limited geographical scope and hence it was logistically easier and simpler to conduct considering the limitations of this study (Mugenda& Mugenda, 2008). It helped make judgments about values or worth of developing mental health campaigns and other rehabilitation programs like half-way home centers for the mentally ill (Wisner *et al.* 2014). Therefore, the descriptive survey was deemed the best strategy to fulfill the objectives of this study.

Study setting

The study was carried out in Bungoma County, Kenya. Bungoma town is the Headquarter of Bungoma County and the third largest County in Western Kenya (Maphill, 2011). It was the Mount Elgon region in the former larger Western Province and it lies 102 kilometers North West from Kisumu City on an altitude of 4,400ft (1,340 m) (Kenya Mpya, 2013). According to the Government of Kenya Census (2012), it has a population of 1,375,063 (1.38m) and the County covers an area of 2,206.9 km^2 (852.1 sq mi). There are 67,358 households within the County (Kombo &Delmo, 2015).

Participants

Mugenda and Mugenda (2008) defined population as all elements (individuals, objects and events) that meet the sample criteria for inclusion in a study. In this study the target population were people who resided in Bungoma County and met the criteria of interest to the researcher (Burns & Grove, 2011). The researcher then randomly sampled the units of the study from the accessible population (Polit & Hungler, 2010). The researcher focused on community households heads aged 18 years and above. The research used a sample size of 398.

Bungoma was purposively selected because of the post-election violence in 2008, 2009 and 2013 in Kenya, which caused closure of most factories and industries, thereby increasing violence related mental illnesses and exacerbating existing ones (Inyanji, 2014). It recorded the highest cases of depression and other mental health disorders (Kenya Red Cross, 2015). Like in the Mt Elgon region, there were a lot of animosity resulting in people torching houses and hacking one another to death (UNHCR, 2012). Five Sub-Counties in Bungoma County were purposively sampled to increase the representation (KDHS, 2008/9). The household"s heads were sampled by stratified sampling; the researcher divided the population into strata and drew a predetermined number using simple random sampling. The sample size was determined using Cochran equation (1963):

$$n = \frac{z^2 pq}{d^2}$$

Where:
n = the desired sample size (when the target population is greater than 10,000)
z = standard normal deviation set at 1.96 which corresponds to 95% confidence interval
p = proportion of the target population estimated to have a characteristic that is being measured (at 50%) to maximize sample size.
q = 1 – p (1 – 0.5) = 0.5
d = degree of accuracy desired set at 0.05
Therefore,

$$n = \frac{1.96^2 x\ 0.5\ x\ 0.5}{0.05^2} = 384 \text{ respondents}$$

In order to take care of any losses due to spoilage and lack of response, a 10% attrition was added to the sample size making it 422.

Questionnaire

Questionnaires were selected as data collection instruments. A questionnaire is a printed self-report form designed to elicit information that can be obtained through the written responses of subjects. The information obtained through a questionnaire is similar to that obtained by an interview, but questions to have less depth (Denzin, 1970). The instrument comprised of the following sections: In section one, the information that was collected was the demographic characteristics and included age, gender , marital status, education level and religion. In section two, nine questions sought to determinemental health knowledge levels (Bloom, 1998).this questions were modified from a validated tool used by (Ng & Chan 2004). The questions were ranked on a 2-point likert scale with the anchors being disagree=0 to agree=1. To increase the validity and reliability of the instruments, the questionnaire was evaluated by experts. Then based on the feedback the final questionnaire was prepared for pre-test. The pretest study was conducted in one Sub-County in Bungoma County.The reliability of the scale of the 9 items was found to be: Internal consistency = (Cronbach"s $\alpha = 0.79$).Deleting selected items would not increase the alpha.

Data Analysis

Data analysis was done using the statistical program for social sciences (SPSS) version 23. Inferential and descriptive statistics were used to analyze data. Descriptive analysis of data was done using the mean, frequencies and percentages. In this study association between the study variables was assessed by a two-tailed probability value of $p<0.05$ for significance. Visual inspection of the data illustrated that missing data appeared to be missing at random. After visual inspection, in order to further examine the pattern of missing data, the researcher evaluated whether the data was missing completely at random (MCAR). The researcher utilized Little"s MCAR test (Schlomer *et al.*, 2010) which employs a chi-square statistical analysis and assumes the null hypothesis, that missing data is missing completely due to randomness. In this case, failing to reject the null hypothesis indicates that the data was most likely not missing in a random way. For this study, Little"s MCAR test results showed that Knowledge (χ^2 [112] = 86.447, p = .965) was not significant indicating that the variables were missing completely at random, the researcher proceeded to address the missing data. To avoid reducing the variances of the scores by replacing missing items using subscale means, the missing data items were instead imputed using the Expectation- Maximization (EM) algorithm within SPSS 23; EM is considered a superior method for conducting missing data imputation when one has MCAR data (Schlomer *et al.,* 2010). Their guidelines were considered when reviewing the missing data for the current research study. Each question was coded and entered in SPSS (Barohn et al, 2012). The findings were entered in the variable view of the Statistical Package for Social Sciences (SPSS) version 20.0 screen, each questionnaire at a time, starting with first to last questionnaire (Cohen, 2011). The researcher conducted analyses of normality, for the outcome variable, prior to hypothesis testing by examining kurtosis and skewness of the data. In order to test and identify possible outliers in the data, graphical assessment visuals, including scatter and box plots were used. Elimination of observed outliers was based on a case by case basis, dependent on standard deviations, and on normality and homogeneity of variance assessments. Normality was assessed using examination of the histograms by seeing how they related or deviate against a normal bell curve distribution and observing the levels of kurtosis and skewness present.

Univariate analysis was used to describe the distribution of each of the variables in the study objective, appropriate descriptive analysis was used to generate frequency distributions, tables and other illustrations used to analyze community knowledge. Bivariate and multivariate analysis was used to investigate the strength of the association and check differences between the outcome variable and other independent variables. One-way analysis of variance (ANOVA) at 0.05 level of significance was used to determine if there is differences in Knowledge among levels of the demographic characteristics. The knowledge questions were to be indexed for each household head member and an index score was to be computed and was recorded on a new variable. Alpha level for all the computations was considered $p <0.05$.

III. Results

Out of the 422 questionnaires distributed, 396 were correctly filled and returned which represented a response rate of 87 percent. According to Mugenda and Mugenda (2003) a response rate of 50 percent is adequate, a response rate of 60 percent is good, and a response rate of 70 percent is very good. Therefore, the 87 percent response rate reported for this study formed an acceptable basis for drawing conclusions. While we should not expect full response in studies where responding is voluntary, scholars utilizing questionnaires should aim for a high response rate (Baruch &Holtom, 2008). Firstly,the study asked the respondents to indicate their background characteristics based on the gender, religion, marital status; age-bracket and education level. The summary of their responses is given in Table 1.

Table 1. *Background characteristics of respondents*

Demographics		**Frequency**	**Percent**
Gender	Male	172	43.4%
	Female	224	56.6%
	Total	**396**	**100.0**
Religion	Christian	220	55.6%
	Muslim	164	41.4%
	Hindu	8	3%
	Total	**396**	**100.0**
Marital Status	Single	148	37.4%
	Married	216	54.5%
	Separated	12	3%
	Divorced	8	2%
	Widowed	12	3%
	Total	**396**	**100.0**
Education level	No education	4	1.0%
	Primary education	220	55.6%
	Secondary education	120	30.3%
	College	28	7.1%
	University	24	6.1%
	Total	**396**	**100.0**
Age Bracket	18-24 years	200	1.0%
	25-34 years	128	55.6%
	35-45 years	48	30.3%
	Over 45 years	16	7.1%
	Total	**396**	**100.0**

Findings in Table 1 revealed that, most 224 (56.6 %) were females while 172 (43.4%) were males. Distribution of age bracket showed that 200 (50.5%) were aged between 18-24 years, 128 (32.3%) were 25-34 years, 48 (12.1%) were 35-45 years, and 16 (4%) were over 45 years. Results on their level of education revealed that 220 (55.6%) had primary school education, 120 (30.3%) had secondary school education, 28 (7.1%) had college education and 4 (1%) had a no education at all. Findings in Table 1 revealed that, 268 (67.7%) disagreed that mental illness is an illness like any other. Results showed that 240 (60.6%) disagreed that one of the main causes of mental illness is lack of self-discipline and will power. Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. Of the 396 respondents, 300 (75.8%) of respondents agreed that people with mental illness have a lower intelligent quotient. Majority of the respondents 352 (88.9%) agreed that mental illness and mental retardation are the same thing. Figure 1 below summarizes the responses on the knowledge items.

Figure 1: Knowledge of Mental Health and Mental illnesses

Knowledge of Mental health and Mental illnesses (n=396)

	K1	K2	K3	K4	K5	K6	K7
Agree	128	148	292	300	188	352	280
Disagree	268	240	100	96	208	44	116

Key
K1-Mental illness is an illness like any other
K2-One of the main causes of mental illness is to lack self-discipline and will power
K3- If people become mentally ill, they will easily become ill again
K4-People with mental illness have a low intelligence quotient
K5-The best therapy for mental patients is to be part of a normal community
K6-Mentall illness and mental retardation are the same thing
K7-Virtually anyone can become mentally ill

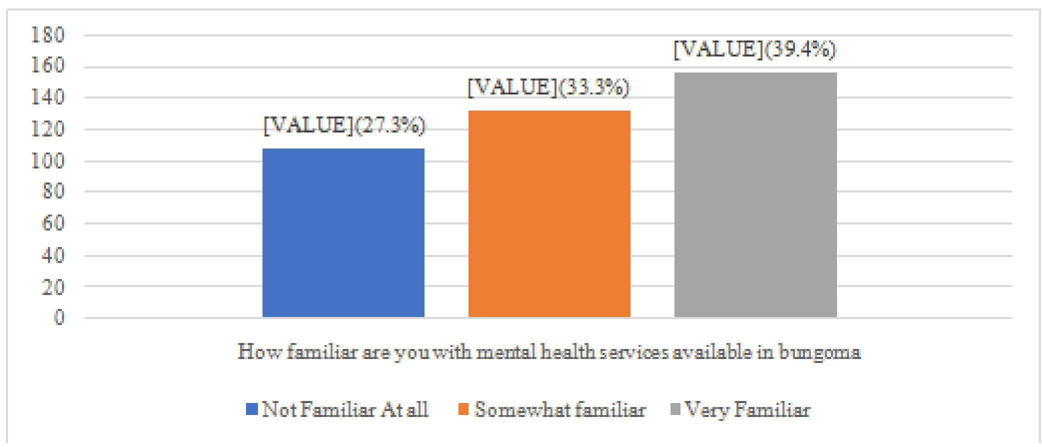

Figure 2.Familiarity with mental health services available in Bungoma County.

With regard to mental health services in the County, only 156 (39.4%) said that they were very familiar with mental health services available in Bungoma County, 132 (33.3%) said they were somewhat familiar with the mental health services offered in the county. However, 108 (27.3%) said they were not at all familiar with the mental health services available in the County

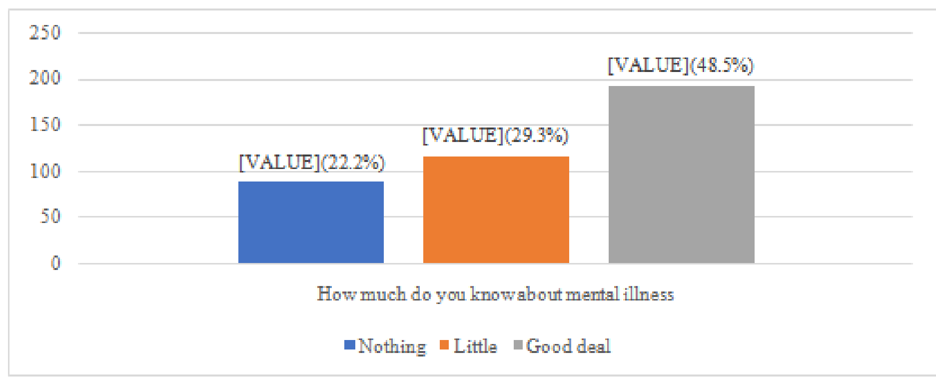

Figure 3.How much respondents know about mental illness.

Almost half 192 (48.5%) of the respondents reported to have a good deal of knowledge about mental illness, 116 (29.3%) reported to have little knowledge about mental illness, while 88 (22.2%) said they had no knowledge about mental illness.

Respondents answered a total of seven closed ended questions. Scale scores were computed by adding responses to the seven questions. The score varied from 7 - 21 points and was classified into 2 levels according to the Blooms' (1956) cut off point as follows:

- High Knowledge (above 60%) 13 or more score.
- Poor Knowledge (below 60%) 12 or less score.

Table 2. *Knowledge of mental illness*

Sources	**Frequency**
Poor Knowledge	199
Good Knowledge	197
Total	**396**

With regards to Knowledge of mental illness 50.3% of the respondents scored less than 60 percent in the knowledge items and were categorized as having poor knowledge in mental illness (Bloom, 1998). However, 49.7% had over 60 percent score in the knowledge items and hence were categorized as having good knowledge

Bivariate analysis of the relationship between Client characteristics and Knowledge of mental illness

Results from table 3 show that the knowledge of mental illness among females was higher 52.7% compared to males 48.8% however chi square analysis showed that there was no statistically significant relationship between the knowledge of mental illness and gender X^2 *(1, N=369) =0.22, p>0.05*. Respondents in the age bracket 35-45 years had the highest knowledge (72.7%) of mental illness, while those in the age bracket 34-45 years had the poorest knowledge of mental illness (38.7%). Results from the chi square showed that there was a statistically significant relationship between knowledge of mental illness and age X^2 *(3, N=369) =32.722, $p<0.05$.*

Multinomial logistic regression was done, and the results showed people in the age group 18-24 were 1.7 times more likely (OR=1.17, 95% C.I, 0.4-3.8) to belong to the „poor knowledge‟ group than the „good knowledge‟ group compared to respondents over 45 years. With regards to marital status, respondents who were separated from their spouses had the highest knowledge (66.7%) of mental illness, while majority of the single people had poor knowledge of mental illness (55.6). Results from chi square test showed that there was a statistically significant relationship between marital status and knowledge of mental illness X^2 *(4, N=369) =39.109, $p<0.05$.*

Logistic regression was done and respondents who were single were 0.4 times more likely (OR=0.42, 95% C.I, 0.06-2.84) to belong to the „poor knowledge ‟group than the „good knowledge‟ group compared to the widowed. Table 3 is a bivariate analysis of client characteristics and knowledge of mental illness.

Table 3: Bivariate analysis of Client characteristics and Knowledge of mental illness

	Poor Knowledge (60%>)	**Good Knowledge (60%<)**	**O.R(95% C.I)**	**χ^2(p value)**
Gender				0.882
Male	84 (51.2%)	80 (48.8%)	-	
Female	104 (47.3%)	116 (52.7%)	-	
Age Bracket				**0.001**
18-24years	92 (46.9%)	104 (53.1%)	1.171 (0.359-3.825)	
25-34 years	76 (61.3%)	48 (38.7%)	2.098 (0.636-6.920)	
35-45 years	12 (27.3%)	32 (72.7%)	0.110 (0.022-0.544)	
Over 45	8 (50%)	8 (50%)	*	
Religion				0.983
Catholic	104 (49.1%)	108 (50.9)		
Muslims	80 (50%)	80 (50%)		
Hindu	4 (50%)	4 (50%)		
Marital Status				**0.05**
Single	80 (55.6%)	64 (44.4%)	0.419 (0.062-2.835)	
Married	92 (43.4%)	120 (56.6%)	0.209 (0.33-1.344)	
Separated	4 (33.3%)	8 (66.7%)	0.500 (0.05-4.957)	
Divorced	8 (100%)	0 (0.0%)		
Widowed	4 (50%)	4 (50%)	*	
Educational Level				0.069
Primary Education	11 6(54.7%)	96 (45.3%)		
Secondary Education	48 (40%)	72 (60%)		
College	12 (42.9%)	12 (50%)		
University	12 (50%)	12 (50%)		
***Reference category**				

IV. Discussion

The objective of the study was to find out knowledge of mental illness by the community in Bungoma county. The study revealed that the respondents were fairly educated though they did not have any other training skills on how to manage and cope with to identify signs of mental illness. This finding concur with Tierney *et al*. (2011) who pointed out that education level influences general view on matters of mental health. The findings also showed that 268 (67.7%) disagreed that mental illness is an illness like any other. The possible explanation could be due to the myths associated with mental illness (Mehta *et al.* 2010). Studies in the

developed world also show that, there has been de-institutionalization of people with mental illnesses and children with intellectual disability. Legislation has mandated a range of advocacy, educational and intervention policies and the increased entry of these children into mainstream schools (Stuart, 2011).

Results showed that 240 (60.6%) disagreed that one of the main causes of mental illness is lack of self-discipline. Lack of knowledge on causes of mental illness in the public has been documented in other studies elsewhere. Some believed that psychiatric illness was not a disease, but a curse that was caused by witchcraft and evil spirits (Watson & Corrigan, 2002). Sadok&Sadok, (2015) agreed that traditional communities believed that mental illnesses are caused by spirits and curses, with influences by the moon, or that it is a divine punishment. Trainer & Pierre (2014) reiterated that beliefs of this nature keep the stigma and discrimination alive. In addition, 108 (27.3%) said they were not at all familiar with the mental health services available in the County. This explains findings from other studies that reported only a small percentage of people with mental disorders generally received treatment (Viklud, 2010). The incidence is likely to be higher due to inadequacy of health services, specialized medical personnel and facilities (Regier et al., 2012). Similar studies carried out in Asia revealed that about 70% of individuals that suffered from mental illness did not seek help (Mati, 2012).

From the findings half 192 (48.5%) of the respondents reported to have a good deal of knowledge about mental illness. The findings are interesting because they are inconsistent with findings from literature, where majority of the respondents had low perceived knowledge of mental illness (Trainer, 2008, Watson & Corrigan, 2002 and Sadok&Sadok, 2015). Majority of the respondents 292 (73.7%) agreed that, if people become mentally ill, they would easily become ill again. The reason behind could be due to the limited knowledge on mental illness and its causes. Studies have reported that the community views mental illness as a strange occurrence and is associated with curses and bad omen (Sadok&Sadok, 2015). 75.8% of respondents agreed that people with mental illness have a lower intelligent quotient. This implies that the study population was unaware of other possible causes of mental illness and couldn"t differentiate the various mental health problems a similar observation was reported by a study done by (Sangeeta & Mathew, 2017). 88.9% of the respondents agreed that mental illness and mental retardation are the same thing. The findings show that the community was able to detect a case of mental retardation which may be beneficial for an early intervention. A study done in Ethiopia found that, the community would be able to recognize a person in remission or less severe phases of mental illness and majority of the community (60%) reported that abnormal behavior was a sign of mental illness (Deribew&Tamirat 2005).

Limitations

Findings from this study are also based on a small, geographical sample and thus, may not represent other populations. Last, due to the nonrandomization of the sample, response bias may also be a limitation. Moreover, there may be selectivity bias such that only those nurses who were interested in the topic of antenatal physical activity agreed to participate in the study.

V. Conclusion& Recommendation

The study established that residents of Bungoma County had little to no knowledge about mental illness hence more should be done to increase awareness of mental health problems in the community through informal education, public awareness campaigns, and formal school intervention. The following recommendations were made based on the findings of the conclusions of the study.

i. The study recommends that sensitization of the community/ public on mental illnesses is important in Bungoma County. Scaling up public awareness campaigns to reach more people by diversifying the approaches targeting specific group of family members having mentally ill persons.
ii. Stimulate further research regarding mental health knowledge and perceptions in order to improve knowledge and a change in attitude and perceptions of the Bungoma Community as well as the health seeking behavior of mentally ill individuals. With increased awareness of mental illness, stigma will be reduced as well as stereotype mentality that negatively affect the mentally ill in the community.
iii. By training more of community health workers towards positive perceptions for mental illness, in order to change the behavior and perceptions of the community as well as health seeking behavior of mentally ill. This will empower the Bungoma County community members regarding knowledge of mental illness and as a result increase community members" interaction with the mentally ill in the community.

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Gambaran Pengetahuan dan Sikap Masyarakat Terhadap Pasien Gangguan Jiwa Dengan Perilaku Kekerasan di Wilayah Upt Puskesmas Sukajadi

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ABSTRAK

Pada tahun 2030 gangguan diperkirakan meningkat dari 13% menjadi 25%. Penderita gangguan jiwa di Jawa Barat pada tahun pada tahun 2013 sekitar 465.975. Angka kunjungan gangguan jiwa tertinggi di Kota Bandung berada di UPT Puskesmas Sukajadi yakni sebanyak 1.222 orang. Salah satu gangguan jiwa berat adalah perilaku kekerasan. Tujuan penelitian ini adalah untuk mengetahui bagaimana gambaran pengetahuan dan sikap masyarakat terhadap pasien gangguan jiwa dengan perilaku kekerasan di Wilayah UPT Puskesmas Sukajadi. Desain penelitian adalah deskriptif yaitu menggambarkan sikap dan perilaku responden. Sampel penelitian adalah 60 orang dengan *accidental sampling*. Pengumpulan data dengan kuesioner pengetahuan dan sikap. Hasil penelitian menunjukkan Hampir setengahnya responden (46,7%) memiliki pengetahuan yang baik tentang perilaku kekerasan dan Sebagian besar responden (61,7%) memiliki sikap yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan. Kesimpulannya mayoritas responden memiliki pengetahuan baik dan sikap mendukung. Saran penelitia, masih terdapat responden yang berpengetahuan rendah dan sikap tidak mendukung sehingga dapat dilakukan intervensi keperawatan untuk meningkatkannya. Penelitian ini diharapkan dapat dijadikan referensi serta dapat melakukan penelitian terkait dengan faktor-faktor mendukung pengetahuan dan sikap masyarakat terhadap pasien gangguan jiwa dengan perilaku kekerasan.
Kata Kunci: Gangguan Jiwa, Pengetahuan, Perilaku Kekerasan, Sikap

ABSTRACT

In 2030 mental disorders are expected to increase from 13% to 25%. People with mental disorders in West Java in 2013 were around 465,975. The highest number of visits to mental disorders in the city of Bandung was in the Public Health Unit of Sukajadi, which was 1,222 people. One of the severe mental disorders is violent behavior. The purpose of this study was to find out how the description of community knowledge and attitudes towards mental patients with violent behavior in the UPT Puskesmas Sukajadi Region. The research design is descriptive, which describes the attitudes and behavior of respondents. The study sample was 60 people with accidental sampling. Collecting data with a knowledge and attitude questionnaire. The results showed that almost half of the respondents (46.7%) had good knowledge about violent behavior and most of the respondents (61.7%) had a supportive attitude towards mental patients with violent behavior. In conclusion, the majority of respondents have good knowledge and supportive attitudes. Suggestion of researchers, there are still respondents who are low knowledgeable and not supportive attitude so nursing intervention can be carried out to improve it. This research is expected to be used as a reference and can conduct research related to the factors supporting the knowledge and attitudes of the community towards mental patients with violent behavior.
Keywords: Attitudes, Knowledge, Mental Disorders,Violent Behavior

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PENDAHULUAN

Prevalensi orang gangguan jiwa meningkat. WHO (2015) sekitar 450 juta orang di dunia menderita gangguan jiwa. Menurut *National institute of mental health* pada tahun 2030 gangguan jiwa akan meningkat menjadi jumlah 25% dari awalnya 13%, sehingga prevalensi gangguan jiwa di berbagai negara akan mengalami peningkatan (Lestari, 2014). Di indonesia sendiri berdasarkan data RisKesDas (2013) menyatakan bahwa prevalensi gangguan jiwa berat, seperti *schizophrenia* adalah 1,7 per 1000 penduduk atau sekitar 400.000 orang. Provinsi Jawa Barat termasuk urutan ke tiga dengan prevalensi gangguan jiwa berat tertinggi yakni 20,0% .

Data RisKesDas (2013) menyebutkan jumlah penderita gangguan jiwa di Jawa Barat pada tahun 2012 sebesar 296.943 orang, sedangkan pada tahun 2013 mengalami kenaikan sekitar 465.975 orang pasien gangguan jiwa ringan hingga berat. Data dari Profil Kesehatan Kota Bandung tahun 2012 urutan pertama angka kunjungan gangguan jiwa di Kota Bandung berada di UPT Puskesmas Sukajadi yakni sebanyak 1.222 orang, kedua di UPT Puskesmas Cetarip sebanyak 1.191 orang dan ketiga di UPT Puskesmas Pagarsih yaitu sebanyak 662 orang.

Orang Dengan Gangguan Jiwa (ODGJ) adalah orang yang mengalami gangguan dalam pikiran, perilaku, dan perasaan yang termanifestasi dalam bentuk sekumpulan gejala atau perubahan perilaku yang bermakna, serta dapat menimbulkan penderitaan dan hambatan dalam menjalankan fungsi sebagai manusia (Undang-Undang RI Nomor 36, 2014). Salah satu gangguan jiwa berat adalah perilaku kekerasan. Masyarakat merasa ketakutan jika ada penderita perilaku kekerasan di lingkungan, karena mereka berpikir penderita perilaku kekerasan suka mengamuk dan mencelakai orang lain (Mestdagh, 2013). Perilaku kekerasan dianggap paling meresahkan dan harus dihindari karena mereka berbahaya (Yulianti & Wijayanti, 2016). Perilaku kekerasan beresiko menciderai diri, orang lain dan lingkungan, perilaku kekerasan dipandang sebagai tindakan yang bersifat destruktif (Dalami, et al. 2009). Sehingga masyarakat merasa ketakutan jika ada penderita perilaku kekerasan di lingkungan, karena mereka berpikir penderita perilaku kekerasan suka mengamuk dan mencelakai orang lain (Mestdagh, 2013).

Selama ini masih banyak ditemukan respon dan pemahaman yang belum benar terhadap pasien perilaku kekerasan di masyarakat atau keluarga, padahal peran mereka sangat penting terhadap kesembuhan pasien perilaku kekerasan (Yulianti & Wijayanti, 2016). Perilaku kekerasan adalah salah satu respon terhadap stresor yang dihadapi oleh seseorang yang ditunjukkan dengan perilaku kekerasan baik pada diri sendiri atau orang lain dan lingkungan baik secara verbal maupun non verbal (Stuart & Laraia, 2009). Perilaku kekerasan dilakukan karena ketidakmampuan dalam melakukan koping terhadap stres, ketidakpahaman terhadap situasi sosial, tidak mampu untuk mengidentifikasi stimulus yang dihadapi, dan tidak mampu mengontrol dorongan untuk melakukan perilaku kekerasan (Volavka & Citrome, 2011).

Dari hasil studi pendahuluan yang dilakukan terhadap 10 warga di Puskesmas Sukajadi Kecamatan Sukabungah RW 01, diperoleh hasil bahwa 7 orang mengatakan perilaku kekerasan adalah tindakan yang dapat meresahkan, merusak, mengganggu ketentraman dan membahayakan secara fisik baik kepada diri sendiri maupun orang lain, 3 orang lainya mengatakan bahwa orang dengan perilaku kekerasan adalah orang yang dirasuki roh jahat. Sedangkan sikap masyarakat terhadap perilaku kekerasan diperoleh 8 orang mengatakan harus dijauhi, ditiadakan dari lingkungan dari 8 orang tersebut lainnya mengatakan sebaiknya tidak dijauhi karena individu tersebut juga manusia yang harus dihargai dan didukung kesembuhannya. Tujuan penelitian ini adalah untuk mengetahui bagaimana gambaran

pengetahuan dan sikap masyarakat terhadap pasien gangguan jiwa dengan perilaku kekerasan di Wilayah UPT Puskesmas Sukajadi

KAJIAN LITERATUR

Perilaku kekerasan merupakan salah satu respon marah yang diekspresikan dengan melakukan ancaman, mencederai orang lain, atau merusak lingkungan. Respon tersebut biasanya muncul akibat adanya stresor. Respon ini dapat menimbulkan kerugian baik pada diri sendiri, orang lain, maupun lingkungan (Keliat et al, 2012). Faktor predisposisi perilaku kekerasan; Yosep (2014), Muhith (2015), Yusuf (2015) dan Stuart dan Laraia (2009) yaitu sebagai berikut:faktor psikologi, faktor sosial budaya dan faktor biologis.

Pengetahuan masyarakat adalah organisasi terstruktur manusia berdasarkan pengetahuan yang dikembangkan kontemporer dan mewakili kualitas baru sistem pendukung kehidupan. Pengetahuan masyarakat didasarkan pada kebutuhan untuk distribusi pengetahuan (Afgan & Carvalho, 2010). Faktor yang mempengaruhi pengetahuan menurut Wawan & Dewi (2011), Notoatmodjo (2010) dan meliputi : faktor internal ada pendidikan dan usia. Faktor eksternal ada pekerjaan.

Menurut Sarwono (2012) sikap (*attitude*) adalah istilah yang mencerminkan rasa senang, tidak senang, atau perasaan biasa-biasa saja (netral) dari seseorang terhadap sesuatu. Menurut Rahayuningsih (2008), Friedman (2008), Notoatmodjo (2008), Mubarak (2011), Yosep (2014) dan Azwar (2013) ada beberapa faktor yang mempengaruhi sikap yakni meliputi pengalaman pribadi, lingkungan, pengaruh orang yang dianggap penting, pengaruh kebudayaan, media masa, pekerjaan dan faktor emosional.

Peran perawat kesehatan jiwa mempunyai peran yang bervariasi dan spesifik (Dalami, 2010). Aspek dari peran tersebut meliputi kemandirian dan kolaborasi

METODE PENELITIAN

Desain penelitian adalah deskriptif yang menggambarkan variable pengetahuan dan sikap masyarakat. Populasi adalah seluruh warga di wilayah binaan UPT Puskesmas Sukajadi Kecamatan CIpedes RW 05. Teknik sampling dengan accidental sampling selam 2 minggu sehingga sampel berjumlah 60 orang. Kuesioner pengetahuan merupakan modifikasi Dafli, Annis & Karim (2018) dan Simatupang (2010). Uji validitas rata-rata 0,70 dan realiabilitas 0,78 Kuesioner sikap ini merupakan modifikasi dari Sari, Nauli & Sabrian (2018). Uji validitas rata-rata 0,82 dan reliabilitas 0,87.

PEMBAHASAN

Tabel 1 Karakteristik Responden

Karakteristik	Frekuensi	Persentase %
Pendidikan		
SD	5	8,3
SMP	9	15,0
SMA/SMK	34	56,7
Perguruan Tinggi	12	20,0
Total	60	100
Usia		
17-25 tahun (Masa Remaja Akhir)	21	35,0
26-35 tahun (Masa Dewasa Awal)	8	13,3
36-45 tahun (Masa Dewasa Akhir)	11	18,3
46-55 tahun (Masa Lansia Awal)	12	20,0
≥ 56 tahun (Masa Lansia Akhir)	8	13,3
Total	60	100
Jenis Kelamin		
Laki-laki	28	46,7
Perempuan	32	53,3
Total	60	100
Pekerjaan		
Tidak bekerja	5	8,3
IRT	23	38,3
Pelajar	1	1,7
Buruh	7	11,7
Wirausaha	1	1,7
Karyawan Swasta	20	33,3
PNS	3	5,0
Total	60	100

Dari Tabel 1 Menunjukkan hampir setengahnya responden (35,0%) 21 orang berumur 17-25 tahun, sebagian besar responden (53,5%) 32 orang merupakan perempuan, sebagian besar responden (56,7%) 34 orang berpendidikan SMA/SMK dan hampir setengahnya responden (38,3%) 23 orang merupakan seorang ibu rumah tangga.

Tabel 2 Gambaran Pengetahuan Responden

Variabel	Frekuensi	Persnetase %
Pengetahuan		
Baik	28	46,7
Cukup	13	21,7
Kurang	17	31,7
Total	60	100

Tabel 2 Menunjukan hampir setengahnya responden (46,7%) 28 orang memiliki pengetahuan yang baik, hampir setengahnya responden (31,7%) 17 orang memiliki pengetahuan yang kurang dan sebagian kecil responden (21,7%) 13 orang memiliki pengetahuan yang cukup.

Tabel 3 Gambaran Pengetahuan Responden

Variabel	Frekuensi	Persentase %
Sikap		
Mendukung	37	61,7
Tidak Mendukung	23	38,3
Total	60	100

Tabel 3 menunjukan sebagian besar responden (61,7%) 37 orang memiliki sikap mendukung dan hampir setengahnya responden (38,3%) 23 orang memiliki sikap tidak mendukung.

Pengetahuan Masyarakat Terhadap Pasien Gangguan Jiwa (Perilaku Kekerasan)

Hasil penelitian menunjukan 28 orang (46,7%) memiliki pengetahuan yang baik. Kategori pengetahuan baik adalah responden mampu menjawab dengan benar ≥76% dari seluruh pertanyaan tentang perilaku kekerasan. Menurut pendapat peneliti, pengetahuan seseorang dipengaruhi oleh beberapa hal yaitu pendidikan yang diterima dengan baik dari lingkungan sekolah, keluarga maupun dari orang lain bisa diperoleh melalui media informasi seperti buku, internet dan media masa yang lainnya. hal ini dimungkinkan karena hasil karakteristik pendidikan responden sebagian besar yakni 34 responden (20,0%) tamatan SMA/SMK. Berdasarkan hasil penelitian peneliti mengenalisa bahwa melalui pendidikan seseorang akan mempelajari banyak hal, menyerap informasi, mengubah persepsi dan membentuk pemahaman yang benar. Hal tersebut senada dengan paparan yang disampaikan Hasbullah (2009) bahwa pendidikan merupakan usaha manusia untuk membina kepribadiannya sesuai dengan nilai-nilai di dalam masyarakat dan kebudayaan. Menurut Arikunto (2010) kategori pendidikan tinggi yaitu SMA/SMK dan perguruan tinggi. Pendidikan berarti bimbingan yang diberikan seseorang pada orang lain terhadap suatu hal agar mereka dapat memahami dan seseorang memiliki tingkat pendidikan tinggi akan berdampak pada pengetahuan (Mubarak, 2012).

Pengetahuan juga dipengaruhi oleh usia dari hasil penelitian karakteristik usia menunjukan bahwa sebagian besar responden berada pada kategori remaja akhir usia 17-25 tahun sebanyak 21 orang (35,0%). Peneliti menganalisa bahwa, sebagian besar usia responden berada pada rentang kategori remaja akhir, tahap usia remaja akhir kapasitas kognitif sepenuhnya berkembang, tetapi dengan kematangan, mereka terus mengakumulasi pengetahuan dan keterampilan baru dari berbagai sumber pengalaman baik informal maupun formal, sehingga pengalaman ini menambah persepsi mereka.karena semakin tinggi usia seseorang diharapkan semakin tinggi pula tingkat pengetahuan yang dimiliki. Semakin bertambah usia dan pengetahuan seseorang juga mempengaruhi pola pikir yang semakin berkembang.

Hal tersebut didukung oleh Notoatmodjo (2010) bahwa usia dianggap optimal dalam mengambil keputusan adalah usia yang diatas 20 tahun. Semakin bertambah usia seseorang maka semakin mampu seseorang menunjukan kematangan jiwa, semakin bijaksana dalam mengambil keputusan, mampu berpikir rasional dan mampu mengendalikan emosi dan makin toleran terhadap orang lain. Menurut Nursalam (2012) usia merupakan tingkat kedewasaan karena semakin tinggi usia seseorang maka pengetahuan merekapun bertambah, karena pengetahuan yang mereka dapatkan bukan

hanya berasal dari lingkungan tingkat pendidikan, tetapi pengalaman mereka menghadapi realita kehidupan yang menuju kematangan pemikiran.

Hasil penelitian ini sejalan dengan penelitian yang dilakukan oleh Yulianti & Wijayanti (2016). Hubungan Tingkat Pendidikan dan Tingkat Pengetahuan Tentang Kesehatan Jiwa dengan Sikap Masyarakat Terhadap Pasien Gangguan JiwaI Di Rw xx Desa Duwet Kidul, Baturetno, Wonogiri kepada 102 responden hampir seluruh responden yaitu 94 orang (87%) memiliki tingkat pengetahuan yang tinggi tentang kesehatan jiwa. Dilihat dari karakteristik usia sebagian besar responden berada pada kategori remaja akhir usia 26-35 tahun sebanyak 49 orang (48%), karakteristik jenis kelamin responden sebagian besar adalah perempuan sebanyak 59 orang responden (57,8%) dan karakteristik pendidikan sebagian besar responden adalah tamatan SMA yaitu 39 responden (38,2%). Namun hasil tersebut tidak sejalan dengan hasil penelitian Dafli, Annis & Karim (2018). Hubungan Tingkat Pengetahuan Masyarakat Tentang Gangguan Jiwa Terhadap Sikap Memberikan Pertolongan Kesehatan Jiwa di Desa Kualu Kecamatan Tambang Kabupaten Kampar. Berdasarkan hasil penelitian yang dilakukan pada 102 responden didapatkan data bahwa sebagian besar pengetahuan responden adalah cukup dengan jumlah 56 responden (54,9%). Dilihat dari karakteristik usia sebagian besar responden berada pada kategori usia 36-45 tahun sebanyak 50 orang (50,0%), karakteristik jenis kelamin responden sebagian besar adalah perempuan sebanyak 59 orang responden (57,8%) dan karakteristik pendidikan sebagian besar responden adalah tamatan SMP yaitu 41 responden (40,2%).

Sikap Masyarakat Terhadap Pasien Gangguan Jiwa (Perilaku Kekerasan)

Berdasarkan hasil penelitian yang dilakukan pada 60 responden didapatkan hasil bahwa sebagian besar responden mempunyai sikap positif yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan yaitu sebanyak 37 responden (61,7%). Dalam penelitian ini sebagian besar responden mempunyai sikap positif atau mendukung pada pasien gangguan jiwa dengan perilaku kekerasan. Hal ini dimungkinkan karena responden mempunyai pemahaman yang benar terkait dengan perilaku kekerasan dan hal tersebut tidak mengganggu atau bertentangan dengan nilai-nilai pribadinya. Sikap positif juga dipengaruhi oleh jenis kelamin dan pekerjaan.

Dalam penelitian ini jenis kelamin sebagian besar responden (53,3%) 32 orang adalah perempuan. Dalam penelitian ini jumlah responden perempuan mengungguli jumlah responden laki-laki walaupun tidak terdapat perbedaan yang cukup jauh. Menurut pendapat peneliti perempuan cendrung lebih rajin dalam hal belajar maupun mencari sumber informasi dan perempuan lebih mengutamakan perasaan dalam bersikap dan lebih sensitif.

Menurut Friedman (2010), menjelaskan bahwa karakteristik perempuan lebih lembut dalam bersikap, lebih pintar membaca emosi dan lebih peka terhadap situasi dan perasaan orang lain. Perempuan lebih cenderung mentaati aturan normatif yang berlaku di masyarakat dibandingkan laki-laki serta cenderung mencari rasa aman sehingga ia akan lebih banyak bertanya dan berhati-hati dalam bertindak. Sedangkan menurut Sofni (2015) perempuan secara psikologi lebih termotivasi dan lebih rajin dalam hal belajar dan bekerja dari pada laki-laki sehingga perempuan lebih tahu bagaimana harus bersikap terhadap apa yang dihadapinya termasuk memberikan pertolongan pertama pada orang dengan gangguan jiwa, meskipun hal tersebut juga membutuhkan keberanian yang cukup.

Hasil penelitian karakteristik pekerjaan hampir setengahnya responden (38,3%) 23 orang memiliki pekerjaan sebagai ibu rumah tangga. Peneliti menganalisa bahwa seorang ibu rumah tangga rata-rata menghabiskan waktunya di rumah dan dilingkungan jadi

kemungkinan untuk bertemu dan memperoleh sumber informasi tentang pasien gangguan jiwa dengan perilaku kekerasan lebih sering dibandingkan dengan masyarakat yang sibuk bekerja hanya memiliki waktu sedikit untuk memperoleh sumber informasi karena waktu yang dimiliki masyarakat tersebut akan habis dilahan kerja. Hal tersebut didukung oleh Mubarak (2012) dan Yulianti & Wijayanti (2016).

PENUTUPAN

Hampir setengahnya responden (46,7%) memiliki pengetahuan yang baik tentang perilaku kekerasan dan Sebagian besar responden (61,7%) memiliki sikap yang mendukung terhadap pasien gangguan jiwa dengan perilaku kekerasan. Masih terdapat responden yang berpengetahuan rendah dan sikap tidak mendukung sehingga dapat dilakukan intervensi keperawatan untuk meningkatkannya. Penelitian ini diharapkan dapat dijadikan referensi serta dapat melakukan penelitian terkait dengan faktor-faktor mendukung pengetahuan dan sikap masyarakat terhadap pasien gangguan jiwa dengan perilaku kekerasan.

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HUBUNGAN TINGKAT PENGETAHUAN DENGAN PERSEPSI MASYARAKAT TERHADAP ORANG DENGAN GANGGUAN JIWA DI DUSUN KETINGAN TIRTOADI SLEMAN YOGYAKARTA

Dwi Ari Astanti[2], Deasti Nurmaguphita[3]

ABSTRAK

Latar Belakang: Prevalensi gangguan jiwa di Indonesia sangat tinggi yaitu mencapai 236 juta penduduk mengalami gangguan kejiwaan. Gangguan jiwa tersebut menimbulkan persepsi negatif dan positif di masyarakat sehingga sikap masyarakat dapat mempengaruhi perlakuan terhadap individu yang mengalami gangguan jiwa

Tujuan: Mengetahui hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakata.

Metode Penelitian: Penelitian ini menggunakan metode *Correlation Study* dengan pendekatan *Cross Sectional*. Variabel bebasnya yaitu yaitu pengetahuan dan variabel terikatnya adalah persepsi masyarakat terhadap orang dengan gangguan jiwa. Pengambilan sampel dengan tehnik *Total Sampling* berjumlah 50 orang. Tehnik analisis yang digunakan yaitu uji *Kendall Tau*.

Hasil: Hasil penelitian dianalisis dengan uji *Kendall Tau*, diperoleh nilai signifikan ($p = 0,031 < 0.05$) dengan keeratan hubungan sebesar 0,289 yang artinya memiliki keeratan hubungan sedang.

Simpulan dan Saran: Terdapat hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman Yogyakarta. Diharapkan masyarakat mampu memberikan motivasi kepada penderita dengan gangguan jiwa maupun keluarga yang memiliki kerabat dengan gangguan jiwa.

Kata Kunci	: Tingkat pengetahuan, Persepsi masyarakat, Orang dengan gangguan jiwa
Daftar Pustaka	: 18 Buku (2007-2010), 4 Skripsi (2013-2016) 3 Jurnal (2009-2016) 1 Web (2013)
Jumlah Halaman	: i-xii halaman depan, 79 halaman, 9 tabel, 2 gambar, 16 lampiran

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THE CORRELATION BETWEEN KNOWLEDGE AND PUBLIC PERCEPTION TOWARDS PEOPLE WITH MENTAL DISORDERS IN KETINGAN VILLAGE SLEMAN YOGYAKARTA

Dwi Ari Astanti[2], Deasti Nurmaguphita[3]

ABSTRACT

Background: The prevalence of mental disorders in Indonesia is very high, reaching 236 million people experiencing mental disorders. These mental disorders cause negative and positive perceptions in the public so that their attitude can affect the treatment of individuals who experience mental disorders.
Objective: The objective of the study was to determine the correlation between the level of knowledge and public perception towards people with mental disorders in Ketingan Village, Tirtoadi, Sleman, Yogyakata.
Method: This study applied correlation study method with a cross sectional approach. The independent variable was the knowledge, and the dependent variable was public perception towards people with mental disorders. The samples were taken by a total sampling technique with as many as 50 people. The analysis technique used Kendall Tau test.
Result: The results of the study were analyzed by Kendall Tau test and obtained the significant value ($p = 0.031 < 0.05$) with the correlation of 0.289 which means having a moderate correlation.
Conclusion and Suggestion: There was a correlation between the level of knowledge with public perception towards people with mental disorders in Ketingan Village, Tirtoadi, Sleman Yogyakarta. It is expected that the public can provide motivation to patients with mental disorders and families who have relatives with mental disorders.

Keywords : Level of knowledge, public perception, people with mental disorders
References : 18 books (2007-2010), 4 thesis (2013-2016) 3 journals (2009-2010) 1 website (2013)
Pages : xii front pages, 79 pages, 9 tables, 2 figures, 16 appendices

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PENDAHULUAN

Kesehatan jiwa adalah kondisi dimana seorang individu dapat berkembang secara fisik, mental, spiritual, dan sosial sehingga individu tersebut menyadari kemampuan sendiri, dapat mengatasi tekanan, dapat bekerja secara produktif, dan mampu memberikan kontribusi untuk komunitasnya. (Undang-Undang Kesehatan Jiwa No. 18 Tahun 2014 dalam Depkes RI). Indikator sehat jiwa meliputi sikap yang positif terhadap diri sendiri, tumbuh, berkembang, memiliki aktualisasi diri, keutuhan, kebebasan diri, memiliki persepsi sesuai kenyataan dan kecakapan dalam beradaptasi dengan lingkungannya (Stuart & Laraia, 2007). Kesehatan jiwa meliputi kemampuan individu dan kelompok lingkungannya untuk berinteraksi dengan yang lain sebagai cara untuk mencapai kesejahteraan, perkembangan yang optimal, dengan menggunakan kemampuan mentalnya (kognisi, afeksi, dan relasi) memiliki prestasi individu serta kelompoknya konsisten dengan hukum yang sedang berlaku (Yosep, 2007). Jumlah penderita gangguan jiwa menurut badan Kesehatan Dunia (WHO, 2016), terdapat sekitar 35 juta orang terkena depresi, 60 juta orang terkena bipolar, 21 juta orang terkena skizofrenia, 7,5 juta terkena dimensia. Jumlah penderita gangguan jiwa di Indonesia adalah 236 juta orang, dengan kategori gangguan jiwa ringan 6% dari populasi dan 0,17% menderita gangguan jiwa berat, 14,3% diantaranya mengalami pasung. tercatat sebanyak 6% penduduk berusia 15-24 tahun mengalami gangguan jiwa. Peningkatan gangguan jiwa yang terjadi saat ini akan menimbulkan masalah baru yang disebabkan ketidakmampuan dan gejala-gejala yang ditimbulkan oleh penderita. Sedangkan prevalensi penderita gangguan jiwa di wilayah Yogyakarta yaitu 18,2% di wilayah pedesaan dan 10,7% di wilayah kota (Riskesdas, 2013). Data pemkab kabupaten sleman tahun 2016 tercatat sebanyak 543 orang menderita gangguan jiwa, Data tersebut menunjukan banyaknya penderita gangguan jiwa atau masalah psikososial di Indonesia. Persepsi adalah sebuah proses saat individu mengatur dan menginterpretasikan kesan-kesan sensoris mereka guna memberikan arti bagi lingkungan mereka (Robin, 2007).

Hasil observasi dan wawancara yang dilakukan pada tanggal 12 Oktober 2017 di Rt 02 / Rw 20, Dusun Ketingan, Desa Tirtoadi, Sleman, Yogyakarta bahwa didapatkan hasil terdapat 3 orang yang menderita gangguan jiwa jiwa dan telah mengikuti pengobatan di Puskesmas

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setempat, serta dulu pernah terjadi tindakan pemasungan pada salah satu penderita gangguan jiwa dikarenakan dinilai membahayakan lingkungan setempat. berdasarkan tingkat pengetahuan 7 dari 13 warga mengatakan tidak begitu tahu tentang orang dengan gangguan jiwa, yang mereka tahu bahwa orang yang menderita gangguan jiwa adalah orang yang sulit untuk disembuhkan secara total dan mereka juga mengatakan bahwa biasanya gangguan jiwa merupakan sebuah penyakit keturunan. Persepsi masyarakat terhadap orang dengan gangguan jiwa 9 dari 13 warga mengatakan mereka merasa takut dan menghindari apabila melihat orang dengan gangguan jiwa dan mereka beranggapan bahwa orang dengan gangguan jiwa merupakan seseorang yang menyeramkan. sedangkan 4 warga mengatakan bahwa merasa kasihan dan iba akan tetapi mereka tidak terlalu memperdulikan hal tersebut.

METODE PENELITIAN

Penelitian ini menggunakan desain penelitian *correlation study* Dilakukan dengan mengidentifikasi semua variabel yang ada, kemudian dilakukan uji statistik dengan analisis korelasi. Pendekatan pada penelitian ini adalah *cross sectional* yaitu suatu penelitian yang mana data menyangkut variabel bebas yaitu tingkat pengetahuan dan variabel terikatnya yaitu persepsi masyarakat terhadap orang dengan gangguan jiwa, yang dikumpulan dalam waktu bersamaan dengan menggunakan instrumen yang telah ditentukan. Metode pengambilan sampel yang digunakan dalam penelitian ini adalah dengan menggunakan *total sampling* yaitu dengan cara keseluruhan dari pada populasi dijadikan sampel. Sampel dalam penelitian ini adalah warga Rt 02 / Rw 20 Dusun Ketingan Tirtoadi Sleman Yogyakarta dengan jumlah 50 orangMetode pengumpulan data dilakukan oleh peneliti yang dibantu oleh asisten penelitian yang sebelumnya telah melakukan diskusi untuk menyamakan persepsi terkait pengisian kuesioner. Pengisian data dilakukan dengan cara pembagian kuesioner yang dilakukan dengan cara berkeliling dari rumah satu ke rumah yang lainnya dengan durasi waktu tiga hari.

HASIL DAN PEMBAHASAN

Penelitian ini dilakukan di wilayah Dusun Ketingan Tirtoadi Sleman Yogyakarta yaitu di Rt 02 / Rw 20. Pada tanggal 10 Mei 2018 dengan kriteria responden usia 18 sampai 65 tahun. Karakteristik responden yang diteliti meliputi jenis kelamin, usia, dan pendidikan yang dijelaskan pada tabel berikut:

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Tabel 1 Karakteristik Tingkat Pengetahuan Masyarakat Terhadap Orang Dengan Gangguan Jiwa Berdasarkan Jenis Kelamin di Dusun Ketingan Tirtoadi Sleman Yogyakarta

Tingkat Pengetahuan	Frekuensi (f)		Prosentase (%)	
	Laki-Laki	Perempuan	Laki-Laki	Perempuan
Baik	13	18	26.0	36.0
Cukup	6	7	12.0	14.0
Kurang	4	2	8.0	4.0
Total	23	27	46.0	54.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 1 hasil penelitian tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa berdasarkan karakteristik responden jenis kelamin, tingkat pengetahuan baik adalah responden berjenis kelamin perempuan 18 responden (36%), tingkat pengetahuan cukup adalah responden berjenis kelamin perempuan 7 responden (14%), sedangkan tingkat pengetahuan kurang adalah responden berjenis kelamin laki-laki 4 responden (8%).

Tabel 2 Karakteristik Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa Berdasarkan Jenis Kelamin di Dusun Ketingan Tirtoadi Sleman Yogyakarta

Persepsi	Frekuensi (f)		Prosentase (%)	
	Laki-Laki	Perempuan	Laki-laki	Perempuan
Persepsi Negatif	12	14	24.0	28.0
Persepsi Positif	10	14	20.0	28.0
Total	22	28	44.0	56.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 2 hasil penelitian persepsi masyarakat terhadap orang dengan gangguan jiwa berdasarkan karakteristik responden jenis kelamin, persepsi negatif paling banyak adalah responden berjenis kelamin perempuan 14 responden (28%), sedangkan persepsi positif paling banyak adalah responden berjenis kelamin perempuan 14 responden (14%).

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Tabel 3 Karakteristik Responden Berdasarkan Usia Periode bulan Mei 2018 di Dusun Ketingan Tirtoadi Sleman Yogyakarta

Umur	Frekuensi (f)	Prosentase (%)
20-25 Tahun	8	16.0
26-35 Tahun	15	30.0
36-45 Tahun	12	24.0
46-55 Tahun	11	22.0
56-65 Tahun	4	8.0
Total	50	100.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 3 hasil penelitian tentang karakteristik responden usia paling banyak berusia 26-35 Tahun sebanyak 15 responden (33,3%) sedangkan paling sedikit berusia di atas 56-65 Tahun sebanyak 4 responden (8%).

Tabel 4 Karakteristik Responden Berdasarkan Pendidikan Periode bulan Mei 2018 di Dusun Ketingan Tirtoadi Sleman Yogyakarta

Pengetahuan	Frekuensi (f)	Prosentase (%)
Baik	31	62.0
Cukup	13	26.0
Kurang	6	12.0
Total	50	100.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 4 hasil penelitian tentang karakteristik responden pendidikan paling banyak memiliki pendidikan sampai SMA sebanyak 22 responden (44%) sedangkan paling sedikit tidak sekolah sebanyak 5 responden (10%).

Tingkat Pengetahuan Masyarakat Terhadap Orang Dengan Gangguan Jiwa.

Hasil penelitian pada tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa dapat dilihat pada tabel berikut ini:

Tabel 5 Distribusi Frekuensi Tingkat Pengetahuan Masyarakat Terhadap Orang Dengan Gangguan Jiwa Periode bulan Mei 2018 di Dusun Ketingan Tirtoadi Sleman Yogyakarta

Pendidikan	Frekuensi (f)	Prosentase (%)
Tidak sekolah	5	10.0
SD	6	12.0
SMP	11	22.0
SMA	22	44.0
Perguruan Tinggi	6	12.0
Total	50	100.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 5 hasil penelitian tentang tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki tingkat pengetahuan dalam kategori baik sebanyak 31 responden (62%), sedangkan paling sedikit tingkat pengetahuan dalam

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kategori kurang sebanyak 6 responden (12%).

Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa

Hasil penelitian pada persepsi masyarakat terhadap orang dengan gangguan jiwa dapat dilihat pada tabel berikut ini:

Tabel 6 Distribusi Frekuensi Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa Periode bulan Mei 2018 di Dusun Ketingan Tirtoadi Sleman Yogyakarta

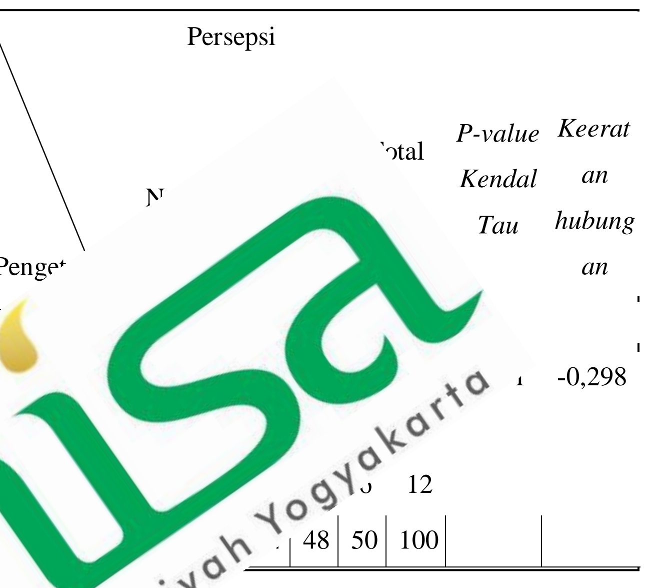
Persepsi	Frekuensi (f)	Prosentase (%)
Persepsi negatif	26	52.0
Persepsi positif	24	48.0
Total	50	100.0

Sumber: *Data Primer, 2018*

Berdasarkan tabel 6 hasil penelitian tentang persepsi masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki persepsi positif terhadap orang dengan gangguan jiwa sebanyak 26 responden (52%), sedangkan sebagian kecil memiliki persepsi negatif sebanyak 24 responden (48%) .

Hasil penelitian pada hubungan tingkat pengetahuan dengan persepsi terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta dapat dilihat pada tabulasi silang berikut:

Tabel 7 Tabulasi Silang Hubungan Tingkat Pengetahuan Dengan Persepsi Masyarakat Terhadap Orang Dengan Gangguan Jiwa Periode bulan Mei 2018 di Dusun Ketingan Tirtoadi Sleman Yogyakarta


Persepsi
Total
P-value Kendal Tau
Keeratan hubungan
-0,298
12
48
50
100

Sumber: *Data Primer, 2018*

Berdasarkan tabel di atas dapat dilihat bahwa paling banyak responden memiliki pengetahuan baik dengan kecenderungan memiliki persepsi kategori positif berjumlah 18 (36%) responden. Penguji hipotesis dilakukan dengan menggunakan analisis korelasi *Kendal Tau* Berdasarkan hasil penelitian ini diperoleh harga koefisien pengetahuan baik dengan kecenderungan memiliki persepsi kategori positif nilai *p-value* sebesar 0,031 <0,05. Dari hasil tersebut dapat disimpulkan bahwa terdapat hubungan tingkat pengetahuan dengan persepsi

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masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta memiliki keeratan hubungan sebesar 0,298 yang artinya memiliki keeratan hubungan sedang

Tingkat Pengetahuan Masyarakat Terhadap Orang Dengan Gangguan Jiwa.

Hasil penelitian tentang tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki tingkat pengetahuan dalam kategori baik sebanyak 31 responden. Hasil penelitian menunjukkan masyarakat memiliki pengetahuan baik terhadap orang dengan gangguan jiwa. Hasil ini digambarkan dalam hasil kuisoner pada butir 1 sebanyak (98%) responden menjawab benar pada pengertian gangguan jiwa, dan pada butir 2 sebanyak (92%) responden juga menyatakan definisi gangguan jiwa merupakan suatu gejala pola perilaku seseorang yang ditandai dengan adanya stres.

Pengetahuan baik responden juga tergambar pada butir kuisioner nomor 6 bahwa responden menjawab benar pada pernyataan bahwa penderita gangguan jiwa berhak mendapatkan perlindungan yang sama seperti orang sehat pada umumnya. Pada butir kuisioner nomor 9 responden menyatakan bahwa gangguan jiwa dapat diatasi/dicegah apabila diatasi dari awal mula munculnya tanda dan gejala. Pada butir kuisioner nomor 10 responden menyatakan penyebab awal gangguan jiwa yaitu karena adanya faktor stres.

Pengetahuan baik responden dapat juga dilihat dari butir 11 bahwa seluruh responden menyatakan untuk penderita gangguan jiwa sesegara mungkin ditangani dengan membawa ke pelayanan medis. Pada butir kuisioner nomor 13 responden menyatakan bahwa dukungan dari lingkungan sekitar sanga dibutuhkan yaitu berupa motivasi dan peran kader masyarakat untuk dapat membimbing ke sarana pelayanan kesehatan setempat.

Pengetahuan yang dimiliki responden dalam kategori baik, hal ini menggambarkan bahwa responden sudah memiliki informasi tentang gangguan jiwa, dengan pengertian bahwa gangguan jiwa adalah sindrom pola perilaku seseorang yang secara khas berkaitan dengan suatu gejala penderitaan (*distress*) atau hendaya (*impairment*) di dalam satu atau lebih fungsi yang penting dari manusia, yaitu fungsi psikologik, perilaku, biologic, dan gangguan itu tidak hanya terletak dalam hubungan antara orang itu tetapi juga dengan masyarakat.

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Ada beberapa faktor yang mempengaruhi pengetahuan, antara lain pendidikan dan sumber informasi. Dalam penelitian karakteristik responden dapat dilihat sebagian responden pendidikan SMA sebanyak 22 (44%), tingkat pendidikan tersebut termasuk dalam pendidikan tinggi. Pendidikan mempengaruhi proses belajar, makin tinggi pendidikan seseorang makin mudah orang tersebut untuk menerima informasi. Hal ini diperkuat oleh teori milik Notoadmojo (2010) yang menyatakan bahwa pendidikan mempengaruhi proses belajar, makin tinggi pendidikan seseorang makin mudah orang tersebut untuk menerima informasi.

Tingkat pengetahuan juga didapat dari paparan informasi yang semakin lama akan semakin baik dan semakin mudah diperoleh, akan mempengaruhi tingkat pengetahuan seseorang. Informasi tersebut dapat diperoleh dari buku, media massa seperti majalah, koran, ataupun televisi, saling bertukar informasi atau pengalaman, dan juga dari internet. Dari sumber informasi tersebut, responden memperoleh informasi lebih banyak sehingga pengetahuannya akan bertambah. Hal ini sesuai dengan pendapat teori Notoatmodjo, yaitu pengetahuan terjadi setelah orang melakukan penginderaan terhadap objek tertentu yang diperoleh dari proses belajar yang membentuk keyakinan sehingga berperilaku sesuai dengan keyakinan tersebut.

Hasil penelitian ini sejalan dengan penelitian Yulianti, (2016) dengan judul Hubungan Tingkat Pendidikan dan Tingkat Pengetahuan Tentang Kesehatan Jiwa Dengan Sikap Masyarakat Terhadap Pasien Gangguan Jiwa di RW XX Desa Duwet Kidul, Baturetno, Wonogiri Hasil penelitian Ada hubungan tingkat pendidikan dengan sikap masyarakat terhadap pasien gangguan jiwa di RW XX Desa Duwet Kidul, Kecamatan Baturetno, Kabupaten Wonogiri yang ditunjukkan dengan nilai signifikan..

Hasil penelitian ini dikuatkan oleh penelitian Wardana daan Suharto (2017) hasil penelitian menyatakan terdapat hubungan yang bermakna secara signifikan antara pendidikan dan pengetahuan (rendah,tinggi) peserta BPJS di Kelurahan Rowosari dengan Pemanfaatan Pelayanan Kesehatan di Puskesmas Rowosari. Dengan analisa bivariat, secara statistik terdapat hubungan yang signifikan antara tingkat pendidikan (p=0,017) dan pengetahuan (p=0,00) peserta BPJS dengan pemanfaatan pelayanan kesehatan di puskesmas.

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Persepsi masyarakat terhadap orang dengan gangguan jiwa.

Hasil penelitian tentang persepsi masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki persepsi positif terhadap orang dengan gangguan jiwa sebanyak 26 responden (52%). Responden dengan persepsi positif dapat digambarkan pada hasil kuisoner butir kuisioner nomor 1 bahwa sekitar (66%) responden memahami apa itu gangguan jiwa merupakan perilaku yang tidak normal yang dilakukan oleh seseorang seperti berbicara sendiri, berbicara kacau, emosinya mudah berubah tiba-tiba menangis kemudian tertawa, menarik diri dari lingkungan keluarga dan sosial.

Persepsi positif yang dimiliki responden dapat digambarkan pada butir kuisioner nomor 2 yang menyatakan bahwa gangguan jiwa terjadi karena seseorang yang tidak dapat menyelesaikan masalah yang sedang dialami. Pada butir kuisioner nomor 4 menyatakan setuju bahwa Orang yang mengalami gangguan jiwa itu dapat disembuhkan walaupun sudah dirawat di rumah sakit jiwa dan dinyatakan sembuh.

Persepsi positif juga tergambar dalam hasil kuisoner butir kuisioner nomor 6 bahwa responden tidak setuju bahwa gangguan jiwa adalah penyakit yang tidak disadari dan timbul dengan sendirinya. Pada butir kuisioner nomor 7 menyatakan setuju bahwa Gangguan jiwa dapat menyerang siapa saja. Pada butir kuisioner nomor 11 responden menyatakan setuju bahwa penderita gangguan jiwa dapat sembuh jika lingkungan sekitar membantu dan mendukungnya. Pada butir 12 juga menyatakan responden setuju bahwa Penderita gangguan jiwa adalah manusia yang haknya berhak dilindungi.

Persepsi positif responden juga dapat dilihat pada butir 19 bahwa responden setuju jika ada anggota keluarga atau orang-orang disekitar sudah menunjukan perilaku lain di luar kebiasaan, misal suka menyendiri, melamun, dan menunjukkan perilaku diluar batas kewajaran. maka perlu dicurigai dan harus segera mendapat pertolongan. diperkuat juga pada butir 21 responden setuju bahwa orang dengan gangguan jiwa adalah dapat melakukan kekerasan pada orang lain.

Persepsi positif yang dimiliki responden disebabkan karena cara pandang masyarakat terhadap orang dengan gangguan jiwa. Dapat dilihat pada hasil kuisoner bahwa responden dalam pengamatannya telah

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mengetahui seseorang dengan gangguan jiwa memiliki perilaku yang tidak normal yang dilakukan oleh seseorang seperti ngomong sendiri, bicara kacau, emosinya mudah berubah tiba-tiba menangis kemudian tertawa, menarik diri dari lingkungan keluarga dan sosial. Responden meyakini bahwa penderita gangguan jiwa dapat sembuh jika lingkungan sekitar membantu dan mendukungnya.

Hasil penelitian ini sesuai teori Sarwoto (2012) menyatakan pembentukan persepsi berlangsung ketika seseorang dapat menerima stimulus dari lingkungannya. Stimulus diterima melalui panca indra dan diolah melalui proses berpikir oleh otak, untuk kemudian dapat membentuk suatu pemahaman. Persepsi masyarakat dapat mempengaruhi sikap dan perlakuan terhadap individu yang mengalami gangguan jiwa. Dukungan atau penerimaan masyarakat tentunya akan menjadi *treatment* tersendiri untuk penderita gangguan jiwa dalam proses penyembuhannya.

Menurut pengamatan peneliti responden setuju jika ada anggota keluarga atau orang-orang disekitar sudah menunjukan perilaku lain di luar kebiasaan, misal suka menyendiri, melamun, dan menunjukkan perilaku diluar batas kewajaran. Maka perlu dicurigai dan harus segera mendapat pertolongan. tindakan yang demikian menggambarkan perngamatan yang nantinya akan menjadi persepsi positif.

Hasil penelitian ini sesuai dengan teori Yue (2010) bahwa faktor-faktor yang mempengaruhi persepsi yaitu pengamatan dengan penginterpretasian dari apa yang seseorang lihat bergantung pada karakteristik pribadi orang tersebut. Faktor lain seperti pengalaman yang merupakan kejadian atau pengetahuan yang pernah dialami. Dalam hal ini kejadian bertemunya responden dengan penderita gangguan jiwa.

Hasil penelitian ini sejalan dengan penelitian Suci Alfiana, (2015) dengan judul Persepsi Masyarakat Terhadap Individu Yang Mengalami Gangguan jiwa di Kelurahan Poris Plawad Cipondoh Tangerang menyatakan bahwa masyarakat berpersepsi baik terhadap orang yang mengalami gangguan jiwa

Hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta

Hasil penelitian ini diperoleh harga koefisien pengetahuan baik dengan kecenderungan memiliki

persepsi kategori positif nilai *p-value* sebesar 0,031 <0,05. memiliki keeratan hubungan sebesar 0,298 yang artinya memiliki keeratan hubungan sedang. Dari hasil tersebut dapat disimpulkan bahwa terdapat hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta.

Adanya hubungan antara tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa didapatkan dari latar belakang pendidikan responden. Menurut pengamatan peneliti pendidikan responden dalam kategori tinggi akan mempengaruhi persepsi responden terhadap orang dengan gangguan jiwa. Dalam penelitian karakteristik responden dapat dilihat sebagian responden pendidikan SMA sebanyak 22 (44%), tingkat pendidikan tersebut termasuk dalam pendidikan tinggi.

Pendidikan mempengaruhi proses belajar, makin tinggi pendidikan seseorang makin mudah orang tersebut untuk menerima informasi. Hal ini diperkuat oleh teori milik Notoadmojo (2010) yang menyatakan bahwa pendidikan mempengaruhi proses belajar, makin tinggi pendidikan seseorang makin mudah orang tersebut untuk menerima informasi. Persepsi positif yang dimiliki responden disebabkan karena faktor pengamatan, pengalaman, dan informasi responden terhadap orang dengan gangguan jiwa.

Menurut hasil penelitian sebagian besar responden setuju jika ada anggota keluarga atau orang-orang disekitar sudah menunjukan perilaku lain di luar kebiasaan, misal suka menyendiri, melamun, dan menunjukkan perilaku diluar batas kewajaran, maka perlu dicurigai dan harus segera mendapat pertolongan. Tindakan yang demikian merupakan gambaran persepsi positif dimasyarakat.

Hal ini menunjukkan bahwa responden melakukan pengamatan yang akhirnya timbul menjadi persepsi positif. Hasil penelitian ini sesuai dengan teori Yue (2010) bahwa faktor-faktor yang mempengaruhi persepsi yaitu pengamatan dengan penginterpretasian dari apa yang seseorang lihat bergantung pada karakteristik pribadi orang tersebut. Karakteristik pribadi yang mengakibatkan timbulnya persepsi positif dapat muncul karena pengetahuan yang dimiliki. Dengan adanya pengetahuan yang baik maka akan juga menimbulkan persepsi yang positif.

Hasil penelitian ini sejalan dengan penelitian Hasil penelitian ini sejalan dengan penelitian Suci Alfiana, (2015) dengan judul Persepsi Masyarakat Terhadap Individu Yang Mengalami Gangguan jiwa di Kelurahan Poris Plawad Cipondoh Tangerang menyatakan bahwa berpersepsi baik pada masyarakat yang terkena gangguan jiwa

Hasil penelitian ini relevan dengan penelitian Haniva (2013) dengan judul Analisis Faktor-Faktor yang Mempengaruhi Penerimaan Masyarakat Terhadap Penderita Gangguan Jiwa di Desa Kedondong Kecamatan Sokaraja Kabupaten Banyumas. bachelor thesis, universitas muhammadiyah purwokerto dalam hasil penelitian menyatakan bahwa terdapat hubungan antara tingkat pengetahuan, persepsi, dan sikap masyarakat desa kedondong tentang gangguan jiwa dengan penerimaan masyarakat terhadap penderita gangguan jiwa. sikap merupakan faktor yang paling dominan dibanding faktor lainnya.

SIMPULAN DAN SARAN

Simpulan

Berdasarkan hasil penelitian dapat disimpulkan bahwa:

1. Tingkat pengetahuan masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki tingkat pengetahuan dalam kategori baik sebanyak 31 responden.
2. Persepsi masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa sebagian besar responden memiliki persepsi positif terhadap orang dengan gangguan jiwa sebanyak 26 responden.
3. Hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa di Dusun Ketingan, Tirtoadi, Sleman, Yogyakarta memiliki keeratan hubungan sebesar 0,298 yang artinya memiliki keeratan hubungan sedang. memiliki harga koefisien pengetahuan baik dengan kecenderungan memiliki persepsi kategori positif nilai *p-value* sebesar 0,031 <0,05.

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Saran

1. Bagi Masyarakat

   Hasil penelitian ini hendaknya dapat dijadikan sebagai bahan acuan di dalam melakukan upaca preventif atau pencegahan terhadap terjadinya persepsi negatif masyarakat serta memberikan motivasi terhadap penderita dan keluarga yang mempunyai kerabat dengan gangguan jiwa dengan tujuan untuk meningkatkan kepercayaan diri mereka di dalam bersosialisasi di masyarakat.

2. Bagi Mahasiswa Universitas 'Aisyiyah Yogyakarta

   Mahasiswa hendaknya dapat memanfaatkan hasil penelitian sebagai sumber pengetahuan, masukan dan informasi agar dapat digunakan sebagai bahan kepustakaan mengenai hubungan tingkat pengetahuan dengan persepsi masyarakat terhadap orang dengan gangguan jiwa.

3. Peneliti selanjutnya

   Diharapkan dapat digunakan sebagai salah satu sumber atau acuan untuk melakukan penelitan selanjutnya dengan mengembangkan penelitian ini dengan desain, variabel dan teknik pengumpulan data yang lain serta dapat mengendalikan variabel penganggu sehingga tidak mempengaruhi hasil penelitian nantinya.

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STUDI TINGKAT PENGETAHUAN MASYARAKAT TENTANG GANGGUAN JIWA DI DESA BANJAR KEMANTREN BUDURAN SIDOARJO

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Abstrak: the study of public knowledge level about mental illness in the village of Banjar Kemantren Buduran Sidoarjo. Mental disorders are a deviation from the ideal state of a mental health. An understanding of the condition of mental illness characterized myths often makes the family often treat people with mental disorders unfairly. Problems with mental disorders has long been ignored, therefore the purpose of this study was to determine the level of public knowledge about mental disorders in the village of Banjar Kemantren Buduran Sidoarjo. This research used descriptive design with cross sectional method, a population of 300 families living in the village of Banjar Kemantren Buduran Sidoarjo, sampling technique used was Non-Probability Sampling method purposive sampling approach, the sample consisted of 171 families living in the village of Banjar Kemantren Buduran Sidoarjo. The variable in this study was the level of public knowledge about mental disorders in the village of Banjar Kemantren Buduran Sidoarjo. Data were collected by questionnaires and were analised with descriptive design. The results showed the level of public knowledge in the village of Banjar Kemantren Buduran Sidoarjo about mental illness was pretty average. Looking at the data above that need to improve the quality of human resources both from their families and from the health workers in an effort to increase public knowledge about mental disorders.

Abstrak studi tingkat pengetahuan masyarakat tentang gangguan jiwa di Desa Banjar Kementren Buduran Sidoarjo: Gangguan jiwa adalah penyimpangan dari keadaan ideal dari suatu kesehatan mental. Pemahaman tentang kondisi sakit jiwa yang diwarnai mitos acap kali membuat keluarga sering memperlakukan penderita gangguan jiwa secara tidak adil. Masalah gangguan jiwa memang telah lama di abaikan, oleh karena itu tujuan dari penelitian ini adalah untuk mengetahui tingkat pengetahuan masyarakat tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo. Jenis penelitian ini menggunakan desain deskriptif dengan metode *cross sectional*, populasi 300 kepala keluarga di Desa Banjar Kemantren Buduran Sidoarjo, teknik sampling yang digunakan adalah *Non Probability Sampling* dengan metode pendekatan *Purposive Sampling*, sampel terdiri dari 171 kepala keluarga di Desa Banjar Kemantren Buduran Sidoarjo. Variabel dalam penelitian ini adalah tingkat pengetahuan masyarakat tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo. Pengambilan data dilakukan dengan penyebaran kuesioner. Data dianalisa secara deskriptif untuk melihat distribusi frekuensi yang dihasilkan. Hasil penelitian menunjukkan tingkat pengetahuan masyarakat di Desa Banjar Kemantren Buduran Sidoarjo tentang gangguan jiwa adalah rata-rata cukup. Melihat data diatas maka perlu ditingkatkan kualitas sumber daya manusia baik dari keluarga maupun dari tenaga kesehatan dalam upaya meningkatkan pengetahuan masyarakat tentang gangguan jiwa.

Kata Kunci : Tingkat Pengetahuan, gangguan jiwa

PENDAHULUAN

Gangguan jiwa telah dikenal sejak zaman purba ada kepercayaan yang sedikit menghambat perkembangan kedokteran jiwa secara ilmiah, yaitu kepercayaan bahwa gangguan jiwa mempunyai penyebab supernaturistik spiritistik (Maramis, 2004 : 28), tanda dan gejala gangguan jiwa diantaranya adalah penurunan kesadaran dan sulit tidur (Maramis, 2004 :122). Fenomena yang ada, masyarakat terkadang tidak mengetahui secara pasti tentang gangguan jiwa, mereka memperlakukan penderita gangguan jiwa secara tidak adil diantaranya mengurung penderita dalam rumah. Kondisi demikian peneliti temukan pada studi pendahuluan di Desa Banjar Kemantren Buduran Sidoarjo didapatkan penderita gangguan jiwa yang di isolasi dalam rumah dan tidak boleh berinteraksi dengan orang lain dan lingkungan sekitar.

Data di seluruh rumah sakit jiwa di Indonesia tahun 2008 menyebutkan bahwa jumlah penderita gangguan jiwa mencapai 2,5 juta orang. Sementara menurut hasil survey kesehatan mental rumah tangga (SKMRT) menunjukkan sebanyak 185 orang dari 1000 penduduk dewasa mengalami gejala gangguan jiwa (Depkes tahun 2008). Studi pendahuluan pada tahun 2014 dengan cara wawancara kepada 10 masyarakat di Desa Banjar Kemantren Buduran Sidoarjo didapatkan 2 orang (20%) tingkat pengetahuannya baik, 2 orang (20 %) tingkat pengetahuan cukup dan 6 orang (60 %) tingkat pengetahuannya kurang.

Menurut Maramis (2004, 122) gangguan jiwa mempunyai tanda dan gejala diantaranya penurunan kesadaran, kesadaran yang tinggi, insomia, berjalan waktu tidur, gangguan ingatan, gangguan disorientasi, gangguan afek dan emosi, gangguan psikomotor, gangguan inteligensi, gangguan proses berpikir, gangguan persepsi, gangguan penampilan, gangguan kepribadian dan gangguan pola hidup. Dengan adanya tanda dan gejala gangguan jiwa tersebut dapat mempengaruhi kesehatan fisik penderita dan menyebabkan resiko terjadinya mencederai diri sendiri dan orang lain, apabila pengetahuan masyarakat tentang gangguan jiwa kurang, maka hal tersebut akan dapat mengancam jiwa penderita sendiri jika masyarakat terlambat untuk mengetahuinya.

Masyarakat merupakan kesatuan hidup manusia yang berinteraksi menurut suatu sistem adat istiadat tertentu yang bersifat kontinyu dan yang terikat oleh suatu rasa identitas bersama (Koentjoroningrat, 1980 :160). Keluarga merupakan sistem pendukung utama yang memberikan perawatan dasar langsung pada setiap keadaan (sehat-sakit) yang merupakan bagian terkecil dalam masyarakat. Ada beberapa upaya yang dapat dilaksanakan oleh keluarga di dalam masyarakat untuk mencegah gangguan jiwa diantaranya menciptakan lingkungan keluarga yang sehat, saling mencintai dan menghargai antar anggota keluarga, saling terbuka dan tidak ada diskriminasi, menghadapi ketegangan dengan tenang serta menyelesaikan masalah secara tuntas dan wajar (Suliswati,2005 :144). Adapun peran perawat yang dapat dilakukan yaitu memberikan *health education* tentang gangguan jiwa dengan bantuan tokoh-tokoh masyarakat antara lain ketua RW, ketua RT, pemuka agama dan orang yang yang mempunyai kedudukan tinggi di masyarakat. Berdasarkan latar belakang diatas, peneliti perlu melakukan penelitian mengenai studi tingkat pengetahuan masyarakat tentang tanda dan gejala gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo.

METODE

Metode penelitian ini diuraikan dalam desain penelitian, tempat dan waktu penelitian, kerangka penelitian, sampling penelitian, identifikasi variabel, definisi operasional, pengumpulan data

dan analisa data, etika penelitian dan keterbatasan.

Pada penelitian ini menggunakan desain penelitian deskriptif yang bertujuan untuk mendeskripsikan (memaparkan) peristiwa-peristiwa urgen yang terjadi pada masa kini dengan menggunakan pendekatan *cross sectional* dimana variabel-variabel yang termasuk faktor resiko dan variabel-variabel yang termasuk efek diobservasi sekaligus pada waktu yang sama.

Penelitian dilakukan pada bulan 6-12 April 2015 di Desa Banjar Kemantren Buduran Sidoarjo.

Populasi dalam penelitian ini adalah masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo. Sampel pada penelitian ini yaitu masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo yang memenuhi kriteria dengan pendekatan *non probability sampling "purposive sampling.* Dalam penelitian ini variabelnya adalah tingkat pengetahuan masyarakat tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo.

HASIL & PEMBAHASAN

a. Hasil

1. Jenis Kelamin

Tabel 5.1 : Karakteristik Responden Berdasarkan Jenis Kelamin Pada Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 – 12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	Laki-laki	141	82.5
2	Perempuan	30	17.5
		171	100

Tabel 5.1 diatas terlihat bahwa responden penelitian ini berjumlah 171 responden, yang berjenis kelamin laki – laki sebanyak 141 orang (82.5 %), sedangkan yang berjenis kelamin perempuan sebanyak 30 orang (17.5 %).

2. Umur Responden

Tabel 5.2 : Karakteristik Responden Berdasarkan Umur Pada Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 – 12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	17 – <26 tahun	35	20.5
2	26 – <35 tahun	68	39.8
3	35-< 45 tahun	46	26.9
4	> 45 tahun	22	12.9
		171	100

Tabel 5.2 diatas dapat diketahui bahwa dari 171 responden, dimana yang berusia 17-<26 tahun sebanyak 35 orang (20,5%), yang berusia 26-< 35 tahun sebanyak 68 orang (39,8 %), berusia 35 – <45 tahun 46 orang (26,9 %) dan yang berusia > 45 tahun 22 orang (12,9 %).

3. Pendidikan

Tabel 5.3 : Karakteristik Responden Berdasarkan Pendidikan Pada Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6–12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	Tidak Sekolah	0	0
2	SD	28	16.4
3	SLTP	65	38
4	SMA	57	33.3
5	Perguruan Tinggi	21	12.3
		171	100

Tabel 5.3 diatas diketahui bahwa responden yang tidak sekolah tidak ada, berpendidikan SD sebanyak 28 responden (16,4 %), SLTP 65 orang (38 %), SMA 57 orang (33,3 %), dan Perguruan Tinggi 21 orang (12,3%).

4. Pekerjaaan

Tabel 5.4 : Karakteristik Responden Berdasarkan Pekerjaan Pada Masyarakat

(Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 – 12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	Tidak Bekerja	3	1,8
2	Wiraswasta	18	10,5
3	Pegawai	116	67,8
4	Swasta	19	11,1
5	PNS TNI / POLRI	15	8,8
		171	100

Tabel 5.4 terlihat bahwa dari 171 responden didapatkan tidak bekerja 3 orang (1,8 %), wiraswasta sebanyak 18 orang (10,5 %), Pegawai Swasta 116 orang (67,8 %), PNS 19 orang (11,1 %), TNI / POLRI 15 orang (8,8%)

5. Status Pernikahan

Tabel 5.5 : Karakteristik Responden Berdasarkan Status Pernikahan Pada Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 – 12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	Menikah	122	71,3
2	Janda	30	17,5
3	Duda	19	11,1
		171	100

Tabel 5.5 diatas terlihat responden dalam penelitian ini sejumlah 171 responden, dimana yang berstatus menikah sebanyak 122 orang (71,3 %), janda sebanyak 30 orang (17,5 %) dan duda sebanyak 19 orang (11,1 %)

6. Agama

Tabel 5.6 : Karakteristik Responden Berdasarkan Agama Pada Masyarakat (Kepala Keluarga) di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 – 12 April 2015

No	Karakteristik	Frekuensi	Prosentase (%)
1	Islam	165	96,5
2	Kristen	6	3.5
3	Hindu	0	0
4	Budha	0	0
		171	100

Tabel 5.6 diatas terlihat responden yang beragama Islam sebanyak 165 orang (96,5 %), Kristen 6 orang (3,5 %) dan tidak ada yang beragama Hindu dan Budha.

7. Tingkat Pengetahuan Masyarakat Tentang Gangguan Jiwa

Tabel 5.7 Tingkat Pengetahuan Masyarakat Tentang Gangguan Jiwa di Desa Banjar Kemantren Buduran Sidoarjo Tanggal 6 - 12 April 2015.

Tingkat Pengetahuan	Frekuensi	Prosentase (%)
Kurang	36 orang	21,1
Cukup	105 orang	61,4
Baik	30 orang	17,5
	171	100

Tabel 5.7 dapat diketahui bahwa masyarakat (Kepala Keluarga) memiliki tingkat pengetahuan kurang 36 orang (21,1 %), cukup 105 orang (61,4 %), dan baik 30 orang (17,5 %).

b. Pembahasan

Hasil penelitian diperoleh tingkat pengetahuan kurang 36 orang (21,1 %), cukup 105 orang (61,4 %), dan baik 30 orang (17,5 %). Angka ini menunjukkan bahwa rata–rata masyarakat (kepala keluarga) Desa Banjar Kemantren Buduran Sidoarjo mempunyai tingkat pengetahuan yang cukup mengenai gangguan jiwa.

Pengetahuan atau kognitif merupakan domain yang sangat penting untuk terbentuknya tindakan seseorang *(overt behavior).* Karena dalam pengalaman dan penelitian ternyata perilaku yang didasarkan oleh

pengetahuan akan lebih langgeng dari pada prilaku yang tidak didasari oleh pengetahuan, (Notoatmodjo, 2003 : 127)

Tingkat Pengetahuan dipengaruhi oleh beberapa faktor diantaranya Pendidikan, Pekerjaan, Usia, Informasi, dan Pengalaman (Wahid Iqbal Mubarak, 2007 : 30). Dari data di atas ditemukan bahwa masih ada masyarakat dengan pengetahuan kurang sebanyak 36 orang (21,1 %). Hal tersebut dapat disebabkan oleh tingkat pendidikan. Hasil crosstabulasi, tingkat pengetahuan kurang didukung oleh tingkat pendidikan sekolah dasar dan sekolah menengah. Pendidikan adalah usaha sadar untuk mengembangkan kepribadian dan kemampuan didalam dan diluar sekolah yang berlangsung seumur hidup (Gunawan, 2000 : 108). Pendidikan berarti bimbingan yang diberikan seseorang pada orang lain terhadap sesuatu hal agar mereka dapat memahami (Mubarok, 2007 : 30).

Pengetahuan juga dipengaruhi oleh usia karena semakin tinggi usia seseorang diharapkan semakin tinggi pula tingkat pengetahuan yang dimiliki. Usia merupakan tingkat kedewasaan karena semakin tinggi usia seseorang maka pengetahuan merekapun bertambah, karena pengetahuan yang mereka dapatkan bukan hanya berasal dari lingkungan tingkat pendidikan, tetapi pengalaman mereka menghadapi realita kehidupan yang menuju kematangan pemikiran (Nursalam, 2001 : 88). Sedangkan jika dilihat dari hasil crosstabulasi, usia responden yang berpengetahuan kurang didominasi oleh usia 26-<35 tahun dan usia 35-<45 tahun. Hal tersebut disebabkan oleh kebanyakan masyarakat menjadi ibu rumah tangga dan bekerja menjadi buruh pabrik (swasta) sehingga mereka kurang mendapat informasi atau penyuluhan dari pihak terkait. Seseorang yang berumur lebih juga belum tentu memiliki tingkat pengetahuan yang tinggi pula, pada beberapa orang yang lebih tua kadang mereka justru tidak begitu memperhatikan hal–hal yang cukup penting. tetapi memiliki pengetahuan yang kurang karena pada usia tersebut

Pengetahuan kurang pada masyarakat Desa Banjar Kemantren juga disebabkan oleh jenis pekerjaan. Hasil crosstabulasi tingkat pengetahuan kurang didukung oleh pekerjaan responden yang didominasi oleh jenis pekerjaan swasta sebanyak 61 %. Hal ini sesuai dengan pendapat (Notoatmojo 2003 : 100) yaitu masyarakat yang sibuk bekerja hanya memiliki waktu sedikit untuk memperoleh informasi karena waktu yang di miliki masyarakat tersebut akan habis di lahan kerja, sedangkan masyarakat yang tidak bekerja memiliki waktu untuk memperoleh informasi.

Hasil analisa setiap pertanyaan pada kuesioner tingkat pengetahuan, yang mendukung pengetahuan masyarakat kurang adalah masyarakat kurang mengetahui tentang gejala gangguan jiwa antara lain 1) gejala psikis gangguan jiwa yaitu suka melamun dan suka bicara sendiri, melihat benda yang orang lain tidak melihatnya 2) gejala lain dari gangggguan jiwa adalah kecurigaan yang berlebihan, gembira yang berlebihan 3) tanda dan gejala perubahan tidur pada klien gangguan jiwa yaitu insomia atau sulit tidur, gerjalan waktu tidur 4) perubahan proses pikir adalah pikiran untuk bunuh diri, merasa terasing dari lingkungan sekitar 5) perubahan emosi merasa kesepian, marah–marah dan permusuhan 6) gejala psikomotor gaduh gelisah, bersikap aneh 7) tanda dan gejala perubahan kepribadian yaitu kepribadian paranoid atau ketakutan yang berlebihan dan kepribadian anti sosial 8) perubahan ingatan yaitu amnesia dan 9) perubahan afek emosi adalah depresi dan kecemasan yang berlebihan

Tabel 5.7 menunjukkan bahwa tingkat pengetahuan masyarakat sudah ada yang baik sebanyak 30 orang (17,5 %), meskipun pengetahuan seseorang juga berkaitan erat dengan pengalaman

yang mereka miliki. Sehingga dapat ditarik kesimpulan, makin banyak seseorang memperoleh pengalaman maka pengetahuan mereka semakin baik. Sebaliknya makin sedikit seseorang memiliki pengalaman maka semakin rendah pula pengetahuan yang dimlikinya. Dengan demikian, baik buruk pengalaman seseorang dapat mempengaruhi tingkat pengetahuan.

Hasil penelitian, tingkat pengetahuan masyarakat Desa Banjar Kemantren rata-rata cukup sebanyak 105 orang (61,4 %). Hal ini dapat didukung oleh usia responden mayoritas di bawah 45 tahun dimana tingkat kemampuan untuk menerima informasi dan mengingat mudah dan cepat apalagi untuk saat ini berbagai informasi mudah sekali didapatkan melalui media cetak, elektronika bahkan internet. Menurut Wahid Iqbal Mubarak (2007 : 30) bahwa pengetahuan secara internal dipengaruhi oleh pengalaman dimana seseorang mengalami berbagai kejadian dalam berinteraksi dengan lingkungannya, selain itu pengetahuan juga dipengaruhi secara eksternal oleh informasi dimana seseorang mendapatkan kemudahan untuk memperoleh suatu informasi dan dapat membantu mempercepat untuk memperoleh pengetahuan yang baru.

Pengetahuan responden yang cukup juga didukung oleh jenis pekerjaan responden, dimana didominasi oleh pekerjaan swasta sebanya 72 %. Hal ini sesuai dengan Wahid Iqbal Mubarak (2007 : 30) bahwa pengetahuan dipengaruhi oleh pekerjaan seseorang dimana lingkungan pekerjaan dapat menjadikan seseorang memperoleh pengalaman dan pengetahuan baik secara langsung maupun tidak langsung.

Selain itu pengetahuan masyarakat Desa Banjar Kemantren cukup didukung oleh status responden menikah sebanyak 73 %. Pasangan dalam keluarga juga mendukung keluarga melaksanaan fungsi sosialisasi dimana saling memberikan informasi antar anggota keluarga, saling berinteraksi dan saling berkomunikasi dan didukung oleh kehidupan di masyarakat desa. Menurut Soerjono Soekanto (1986) yang dikutip oleh Basrowi (2005 : 40) menyatakan bahwa masyarakat sebagai suatu pengalaman hidup atau suatu bentuk kehidupan bersama manusia yang mempunyai ciri-ciri pokok yaitu sebagai berikut:

1. Manusia yang hidup bersama.
2. Bercampur dalam waktu yang cukup lama
3. Mereka sadar bahwa mereka merupakan satu kesatuan
4. Mereka merupakan suatu sistem hidup bersama.

Sedangkan masyarakat desa mempunyai ciri-ciri :

1. Warga memiliki hubungan lebih erat
2. Sistem kehidupan biasanya berkelompok atas dasar kekeluargaan
3. Umumnya hidup dari pertanian
4. Golongan orang tua memegang peranan penting
5. Dari sudut pemerintahan, hubungan antara penguasa dan rakyat bersifat informal
6. Perhatian masyarakat lebih pada keperluan utama kehidupan
7. Kehidupan keagamaan lebih kental
8. Banyak berurbanisasi ke kota karena ada faktor yang menarik dari kota.

SIMPULAN

Berdasarkan analisa data dalam penelitian yang telah dilakukan maka dapat ditarik simpulan :
Tingkat pengetahuan masyarakat (kepala keluarga) tentang gangguan jiwa di Desa Banjar Kemantren Buduran Sidoarjo rata- rata adalah cukup

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www. Depkes .go.id *Data Orang yang Mengalami Gangguan Jiwa diseluruh Indonesia Tahun 2*

TINGKAT PENGETAHUAN, PERSEPSI DAN SIKAP MASYARAKAT TERHADAP ORANG DENGAN GANGGUAN JIWA (ODGJ)

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Abstrak

Gangguan jiwa merupakan psikologi, pola perilaku yang ditunjukkan oleh individu yang dapat menyebabkan distress. Pengetahuan merupakan hasil tahu dan terjadi setelah orang mengadakan penginderaan terhadap suatu objek tertentu. Persepsi merupakan sebuah rangsangan yang di terima melalui panca indera yang diawali dengan perhatian, sehingga seseorang dapat memahami hal yang diamati. Sikap ialah respon yang masih tertutup dari seseorang terhadap suatu stimulus atau objek. Pengetahuan dan persepsi masyarakat terhadap orang dengan gangguan jiwa diharapkan bisa membentuk sikap masyarakat baik itu berupa sikap positif ataupun negatif. Tujuan penelitian ini adalah menganalisis hubungan tingkat pengetahuan, persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang. Jenis penelitian ini adalah *Deskriptif Korelasional* dengan menggunakan desain *Cross Sectional*. Proses penelitian pada Oktober 2017 di Kelurahan Rowosari Kota Semarang dengan teknik *Proportional Stratified Random Sampling*. Jumlah sampel penelitian ini adalah 82 responden, masyarakat yang dekat dengan orang dengan gangguan jiwa. Hasil penelitian menunjukkan bahwa pengetahuan masyarakat terhadap ODGJ Cukup baik (53,7%), persepsi masyarakat terhadap ODGJ Baik (63,4%), sikap masyarakat terhadap ODGJ positif (61,0%). Ada hubungan yang signifikan antara tingkat pengetahuan dan sikap masyarakat terhadap ODGJ dengan *p value* 0,000 (<0,05) dan Ada hubungan yang signifikan antara persepsi dan sikap masyarakat terhadap ODGJ dengan *p value* 0,000 (<0,05). Berdasarkan hasil tersebut diharapkan tenaga kesehatan selalu memberikan pendidikan kesehatan serta pengetahuan atau informasi tentang ODGJ pada masyarakat, pentingnya masyarakat membangun dukungan lingkungan yang baik dalam proses penyembuhan ODGJ agar pengetahuan, perhatian atau pengamatan dan sikap masyarakat lebih baik lagi terhadap ODGJ di sekitarnya.

Kata kunci :Tingkat Pengetahuan masyarakat, Persepsi masyarakat, sikap masyarakat, Orang Dengan Gangguan Jiwa.
Pustaka : 64 (2004-2017)

Abstract

Mental disorder was pshycology, behavioural system that showed by individual and causing distress. Knowledge was originated from knowing which happened after sensing certain object. Perception was a stimulation from sensing and began with attention, so that human can understand what they observed. An atitude was a closed respond from the person to the stimulus or object. Society's Knowledge and perseption to mentally disorders person hopped to manage their positive or negative attitude. The purposes of

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this research was to analyzed relation between society degree of knowledge, perception and attitude toward person with mental disorder on Rowosari, Semarang. The type of research was a Descriptive Corelational research with Cross Sectional design. The research process was conducted in 19 October 2017 in Rowosari Semarang using Proportional Stratified Random sampling technique. The sample were 82 respondent, people who near person with mental disorder. The ressult showed that people knowledge to ODGJ were good enough (53,7%), while society's perseptions to ODGJ were good (63,4%), and their attitude to ODGJ were positive (61, 0%). There was a significance relation among society's knowledge and attitude to ODGJ with p value 0,000 (<0, 05) and the significance relation between society's perception and attitude to ODGJ with p value 0,000 (<0,05). Based on the research's result hopped that the medical workers always give health education and knwoledge or information about ODGJ to the society, about the importance of society built up a good environment support in a process of ODGJ recovery, so that the knowledge, attention or observation and attitude from society to the ODGJ person would give better environment in their surronding.

Keywords : *Knowledge level of society, the public perception, the attitude of society, People With Mental Disorders.*
References : *64 (2004-2017)*

PENDAHULUAN

Kesehatan jiwa adalah kondisi sehat emosional psikologis, konsep diri yang positif, kestabilan emosional, sosial yang terlihat dari hubungan perilaku yang afektif dan hubungan interpersonal yang memuaskan (Videbeck, 2008). Kesehatan manusia tidak hanya dilihat dari fisiknya saja, namun kondisi manusia yang mempunyai jiwa sehat sangat diperlukan pada seseorang. Seseorang yang dikatakan memiliki jiwa yang sehat apabila seseorang memiliki sikap yang positif terhadap diri sendiri, penguasaan lingkungan seorang merasa berhasil diterima oleh masyarakat, mempunyai persepsi realitas individu mampu menguji asumsi tentang dunia, otonomi yang melibatkan kemandirian, pertumbuhan, aktualisasi diri dan ketahanan diri (Stuart, 2013).

Kesehatan jiwa masih menjadi salah satu permasalahan kesehatan yang signifikan di dunia, termasuk pada Indonesia (Kemenkes RI, 2016). Salah satunya adalah gangguan jiwa kondisi ini merupakan keadaan-keadaan yang abnormal baik berhubungan dengan fisik atau mental. Keabnormalan tersebut terbagi dalam dua golongan diantaranya gangguan jiwa (*Neurosa*) dan sakit jiwa (*Psikosa*) (Yosep, 2013).

Word Health Organization (WHO) memperkirakan pada tahun 2016, jumlah penderita depresi terdapat sekitar 35 juta, 21 juta terkena skizofrenia, 60

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juta orang terkena bipolar (Kemenkes RI, 2016). Di Indonesia jumlah kasus orang dengan gangguan jiwa terus bertambah. Berdasarkan data Riskesdas tahun 2013, prevelensi pada gangguan mental emosional dengan gejala anxietas dan depresi usia ≥15 tahun ke atas mencapai 14 juta orang (6% dari jumlah penduduk Indonesia). Sedangkan pada prevelensi gangguan jiwa berat seperti skizofrenia sebanyak 1,7 per 1000 penduduk atau sekitar 400.000 orang. Gangguan jiwa terbanyak berada di DI Yogyakarta, Aceh, Sulawesi Selatan, Bali dan Jawa Tengah. Berdasarkan data proporti RT yang pernah memasung ART (Anggota Rumah Tangga) tersebut diantaranya 14,3% sekitar 57.000 orang yang sedang atau pernah dipasung. Angka pemasungan lebih tinggi dilakukan dipedesaan 18,2% dibandingkan dengan angka pemasungan di kota sebesar 10,7% (Riset Kesehatan Dasar, 2013).

Pada tahun 2015 jumlah penderita ODGJ yang tercatat berobat di Rumah sakit dan Puskesmas di Provinsi Jawa Tengah sebanyak 317.504, dari tahun ke tahun jumlah penderita gangguan jiwa semakin meningkat (Dinas Kesehatan Provinsi Jawa Tengah, 2015). Berdasarkan Profil Kesehatan Semarang tahun 2015 jumlah penderita ODGJ yang berobat di Rumah Sakit dan Puskesmas di Kota Semarang sebanyak 50.965 jiwa (Dinkes Semarang, 2015). Jumlah ini mengalami penurunan pada tahun 2016 yaitu sebanyak 33.248 jiwa (Dinkes Semarang, 2016). Menurut data statistik Dinas Kesehatan Kota Semarang (DKK) pada tahun 2016 diperoleh data yang terkena Skizofrenia sebanyak 511 jiwa, gangguan cemas atau anxietas 549 jiwa, gangguan neurotik 104 jiwa, gangguan Psikotik akut dan sementara 1.021 jiwa, retardasi mental 10 jiwa, gangguan mental dan perilaku akibat zat multi dan psikoaktif lain 18 jiwa, gangguan Skizoafektif 10 jiwa, episode depresif 47 jiwa dan gangguan depresi berulang 22 jiwa (Dinas Kesehatan Kota Semarang, 2016).

Angka tersebut menunjukkan jumlah penderita gangguan jiwa di masyarakat masih sangat tinggi. Ada beberapa penyebab masalah kesehatan orang dengan gangguan jiwa berupa kekerasan fisik dan emosional dikarenakan masyarakat kurang peduli terhadap orang dengan gangguan jiwa (Kemenkes RI, 2015). Pada penderita gangguan jiwa dinyatakan sembuh kemudian dikembalikan

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ke keluarganya, namun sering kambuh lagi karena terdapatnya stigma masyarakat beranggapan jika mereka tidak dapat sembuh, mereka sering dikucilkan di lingkungannya, tidak diberi peran dan dukungan sosial kemudian di bully (Noorkasiani., Heryati & Ismail, 2009). Hingga kini, kesehatan jiwa masih memprihatinkan karena kurangnya kepedulian masyarakat, masih adanya diskriminasi dan stigma pada orang dengan gangguan jiwa (ODGJ) dan ketidaktahuan masyarakat dalam menjaga kesehatan jiwa (Kemenkes RI, 2016).

Hasil penelitian Asti, (2016) menyatakan bahwa masyarakat masih memberikan prasangka dan diskriminasi terhadap orang dengan gangguan jiwa mereka sering mendapat cemooh, dijauhi, diabaikan, dikucilkan dan dianggap aib di masyarakat. Masyarakat masih banyak yang beranggapan buruk terhadap orang dengan gangguan jiwa, masyarakat menganggap ODGJ adalah orang yang mengerikan, memalukan, menakutkan, dan aib yang harus disembunyikan. Sebagian warga juga masih ada yang melakukan diskriminasi seperti isolasi sosial (pengasingan), kekerasan dan bullying. Salah satu penyebabnya karena rendahnya pendidikan serta pengetahuan masyarakat tentang kesehatan jiwa. Masyarakat perlu memiliki pengetahuan, persepsi dan sikap dalam meningkatkan kepedulian serta respon yang baik masyarakat terhadap orang dengan gangguan jiwa yang ada di lingkungan sekitarnya. Pengetahuan, persepsi dan sikap yang baik perlu dimiliki oleh masyarakat, dengan memiliki pengetahuan dan persepsi yang baik diharapkan sikap masyarakat tersebut dapat memiliki sikap yang baik terhadap Orang dengan gangguan jiwa (Azwar, 2016). Berdasarkan data di Puskesmas Rowosari Kota Semarang ditemukan sebanyak 21 kasus Orang dengan gangguan jiwa, sementara hasil penelitian pendahuluan yang dilakukan pada bulan Agustus 2017 terdapat kasus orang dengan gangguan jiwa dikelurahan Rowosari sebanyak 14 orang.

METODE

Jenis penelitian yang digunakan adalah *Deskriptif Korelasional* dengan desain *cross sectional.* Dalam penelitian ini Populasi adalah masyarakat di Kelurahan Rowosari Kota Semarang pada RW 02, RW03, RW 06 dan RW 07. Cara pengambilan sampel ini adalah dengan metode *Probability sampling* dengan

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pendekatan *Proportional Stratified random sampling* sehingga menjadi 82 responden. Penelitian dilakukan pada masyarakat Kelurahan Rowosari Kota Semarang. Alat pengumpulan data menggunakan lembar observasi atau kuesioner penelitian. Proses Penelitian berlanggsung dari bulan juni-januari 2018. Data dianalisis secara univariat dan bivariat (diuji menggunakan statistik non parametrik *Rang spearman*).

HASIL DAN PEMBAHASAN

Karakteristik responden sebagian besar berjenis kelamin perempuan yaitu sebanyak 46 responden (56,1%), sebagian besar usia rata-rata dalam kategori usia dewasa tengah (31-65 tahun) sebanyak 66 responden (80,5%), pendidikan sebagian besar responden berpendidikan SMA sebanyak 31 responden (37,8%), dan sebagian responden bekerja sebagai buruh (seperti buruh bangunan, buruh pabrik, asisten rumah tangga (ART) dan lain sebagainya) sebanyak 49 responden (59,8%).

Tabel 1

Distribusi Frekuensi Reponden Berdasarkan Jenis Kelamin Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Jenis Kelamin	Frekuensi (n)	Persentase (%)
Laki – Laki	36	43,9
Perempuan	46	56,1
Total	82	100,0

Tabel 2

Distribusi Frekuensi Responden Berdasarkan Umur Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Umur	Frekuensi (n)	Persentase (%)
Dewasa Awal (21 – 30 th)	16	19,5
Dewasa Tengah (31 – 65 th)	66	80,5
Total	82	100,0

Tabel 3

Distribusi Frekuensi Responden Berdasarkan Pendidikan Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Pendidikan	Frekuensi (n)	Persentase (%)
TS	4	4,9
SD	12	14,6
SMP	29	35,4
SMA	31	37,8
S1/D3	6	7,3
Total	82	100,0

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Tabel 4
Distribusi Frekuensi Responden Berdasarkan Pekerjaan Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Pekerjaan	Frekuensi (n)	Persentase (%)
IRT	10	12,2
Swasta	5	6,1
Buruh	49	59,8
Pedagang	13	15,9
PNS	5	6,1
Total	82	100,0

Tabel 5
Distribusi frekuensi respoden berdasarkan kategori Pengetahuan Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Pengetahuan	Frekuensi (n)	Persentase (%)
Kurang Baik	10	12,2
Cukup Baik	44	53,7
Baik	28	34,1
Total	82	100,0

Tabel 6
Distribusi Frekuensi Reponden Berdasarkan kategori Persepsi Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Persepsi	Frekuensi (n)	Persentase (%)
Tidak Baik	30	36,6
Baik	52	63,4
Total	82	100,0

Tabel 7
Distribusi Frekuensi Responden Berdasarkan kategori Sikap Masyarakat di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober 2017 n = 82

Sikap	Frekuensi (n)	Persentase (%)
Negatif	32	39,0
Positif	50	61,0
Total	82	100,0

Tabel 8
Tingkat Pengetahuan dan Sikap Masyarakat terhadap Orang Dengan Gangguan Jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober n = 82

Tingkat Pengetahuan Masyarakat	Sikap Masyarakat Negatif n (f)	%	Positif n (f)	%	Total n (f)	%	Spearman's Rho (sig)	P value
Kurang Baik	8	9,8	2	2,4	10	12,2		
Cukup Baik	19	23,2	25	30,5	44	53,7	0,382	0,000
Baik	5	6,1	23	28,0	28	34,1		
Total	32	39,0	50	61,0	82	100		

Tabel 8 bahwa dari 82 responden peneliti memperoleh 44 responden (48,8%) pengetahuan cukup baik, yang mempunyai pengetahuan cukup baik dan sikap negatif terhadap orang dengan gangguan jiwa sebanyak 19 responden (23,2%), sedangkan 25 responden (30,5%) mempunyai pengetahuan cukup baik dan sikap positif. Kemudia 28 responden (34,1%) pengetahuan baik, yang mempunyai

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pengetahuan baik dan sikap negatif sebanyak 5 reponden (6,1%), sedangkan sebanyak 23 responden (28,0%) mempunyai pengetahuan baik dan sikap positif. Dan 10 responden (12,2%) pengetahuan kurang baik, sebanyak 8 responden (9,8%) mempunyai pengetahuan kurang baik dan sikap negatif, sedangkan 2 responden (2,4%) mempunyai pengetahuan kurang baik dan sikap positif. Berdasarkan hasil uji korelasi *rank spearman rho* diperoleh nilai *p value* sebesar 0,000 ($p<0,05$). Maka H_o ditolak yang artinya ada hubungan secara signifikan antara tingkat pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ). Hasil analisis data dengan menggunakan uji statistik korelasri *rank spearman* diketahui $r_{hit} =$ 0,382. Karena koefisien korelasi nilainya positif, maka berarti tingkat pengetahuan berhubungan positif dan signifikan terhadap sikap masyarakat. Jadi dalam penelitian ini dapat disimpulkan bahwa ada hubungan tingkat pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang.

Tabel 9

Persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang tanggal 19 Oktober n = 82

Persepsi Masyarakat	Sikap Masyarakat						Spearman's Rho (sig)	P value
	Negatif		Positif		Total			
	n (f)	%	n (f)	%	n (f)	%		
Tidak Baik	24	29,3	6	7,3	30	36,6	0,638	0,000
Baik	8	9,8	44	53,7	52	63,4		
Total	32	39,0	50	61,0	82	100		

Tabel 9 bahwa dari 82 responden peneliti memperoleh 52 responden (63,4%) persepsi baik, yang mempunyai persepsi baik dan sikap negatif terhadap orang dengan gangguan jiwa sebanyak 8 responden (9,8%), sedangkan 44 responden (53,7%) mempunyai persepsi baik dan sikap positif. Dan 30 responden (36,6%) persepsi tidak baik, yang mempunyai persepsi tidak baik dan sikap negatif sebanyak 24 responden (29,3%), sedangkan 6 responden (7,3%) mempunyai persepsi tidak baik dan sikap positif. Berdasarkan hasil uji korelasi *rank spearman rho* diperoleh nilai *p value* sebesar 0,000 ($p<0,05$). Maka H_o ditolak yang artinya ada hubungan secara signifikan antara persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ). Hasil analisis data dengan menggunakan uji statistik korelasi *rank spearman* diketahui r_{hit}=0,638. Karena koefisien korelasi nilainya positif, maka berarti persepsi berhubungan positif dan signifikan terhadap sikap masyarakat. Jadi dalam penelitian ini dapat disimpulkan bahwa ada

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hubungan persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang.

PEMBAHASAN

Hasil Karakteristik responden sebagian besar berjenis kelamin perempuan yaitu sebanyak 46 responden (56,1%), sebagian besar rata-rata dalam kategori usia dewasa tengah (31-65 tahun) sebanyak 66 responden (80,5%), pendidikan sebagian besar responden berpendidikan SMA sebanyak 31 responden (37,8%), dan sebagian responden bekerja sebagai buruh (seperti buruh bangunan, buruh pabrik, asisten rumah tangga (ART) dan lain sebagainya) sebanyak 49 responden (59,8%).

Berdasarkan hasil penelitian, gambaran pengetahuan masyarakat terhadap orang dengan gangguan jiwa (ODGJ) didapatkan bahwa sebagian besar masyarakat memiliki pengetahuan cukup baik yaitu sebanyak 44 (53,7%), sedangkan 28 (34,1%) memiliki pengetahuan baik dan 10 (12,2%) memiliki pengetahuan kurang baik. Pengetahuan memiliki pengaruh yang sangat besar terhadap orang dengan gangguan jiwa untuk individu, keluarga dan masyarakat. Pengetahuan seseorang dengan objek mempunyai intensitas tingkah laku yang berbeda-beda. Pengetahuan seseorang tentang objek bisa menimbulkan dua aspek, yang pertama aspek positif kedua aspek negatif (Notoatmodjo, 2010). Hasil Penelitian ini sejalan dengan penelitian Yulianti, (2016) diperoleh bahwa tingkat pengetahuan masyarakat tentang kesehatan jiwa di RW XX Desa Duwet Kidul, Kecamatan Baturetno, Kabupaten Wonogiri ialah tingkat pengetahuan tinggi sebanyak 94 orang dan tingkat pengetahuan yang rendah sebanyak 14 orang. Hal tersebut dikarenakan sebagian besar responden berpendidikan setingkat minimal SMA. Penelitian ini juga di perkuat oleh Riza (2009), mengatakan Kejadian stres lebih banyak terjadi pada keluarga yang memiliki pengetahuan tentang stres dengan kategori rendah dibandingkan dengan keluarga yang memiliki pengetahuan tentang stres dengan kategori tinggi. Ada Hubungan antara pengetahuan keluarga tentang stres dengan kejadian stres di keluarga tersebut, peneliti menyatakan kejadian stres disuatu keluarga berbeda antara keluarga yang

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memiliki pengetahuan tentang stres yang tinggi dengan keluarga yang memiliki pengetahuan tentang stres yang rendah.

Berdasarkan hasil penelitian, gambaran persepsi masyarakat terhadap orang dengan gangguan jiwa (ODGJ) didapatkan bahwa sebagian besar masyarakat memiliki persepsi baik sebanyak 52 orang (63,3%) dan 30 orang (36,6%) masyarakat memiliki persepsi tidak baik. Adanya persepsi yang baik dan tidak baik tersebut, masyarakat terhadap orang dengan gangguan jiwa dapat dipengaruhi oleh faktor pengetahuan dan penglihatan. Persepsi diawali adanya objek yang telah dipersepsikan, individu dapat menyadari kemudian memahami keadaan pada sekitar lingkungan mereka, kemudian dapat menyadari, memahami keadaan diri individu yang bersangkutan. Tidak semua stimulus selalu direspon oleh individu, respon yang diberikan pada individu terhadap stimulus yang ada penyesuaian dan yang menarik perhatian individu. Dengan demikian bisa dikemukakan bahwa yang dipersepsikan pada individu selain bergantung pada stimulus tetapi bergantung pada keadaan individu yang bersangkutan (Walgito, 2010).

Hasil peneliti yang dilakukan oleh Suryani, (2014) diperoleh bahwa keluarga memiliki persepsi yang positif sebanyak 50 responden dan sisanya memiliki persepsi negatif sebanyak 30 responden. Dapat disimpulkan bahwa pada umumnya keluarga memiliki persepsi yang positif terhadap skizofrenia. Hal tersebut menunjukkan ada kecenderungan keluarga akan berperilaku positif dalam merawat klien, tetapi masih terdapat beberapa responden yang mempunyai persepsi negatif pada skizofrenia. Persepsi positif ini disebabkan dukungan keluarga yang berobat secara rutin, sehingga memperoleh informasi yang cukup tentang skizofrenia. Hasil peneliti ini di perkuat oleh Wiharjo, (2014) mengatakan persepsi setiap masyarakat terhadap orang dengan gangguan jiwa atau penderita skizofrenia sangat bervariasi, ada yang memiliki persepsi positif dengan mempersepsikan bahwa penderita skizofrenia atau orang dengan gangguan jiwa merupakan bagian dari masyarakat, akan tetapi masih ada juga yang memiliki persepi negatif pada orang dengan gangguan jiwa atau penderita skizofrenia

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dikarenakan sudah pernah mendapatkan pengalaman yang tidak menyenangkan seperti pernah dikasari atau pernah diganggu.

Berdasarkan hasil penelitian, gambaran sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) didapatkan bahwa sebagian besar masyarakat memiliki sikap positif sebanyak 50 orang (61,0%) dan 32 orang (39,0%) memiliki sikap negatif. Sesuai teori Wawan, (2010) bahwa sikap mempunyai sikap positif dan sikap negatif. Melalui sikap kita bisa memahami proses kesadaran yang menentukan tindakan nyata dan tindakan yang mungkin bukan individu dalam kehidupan sosialnya.

Penelitian ini di perkuat oleh oleh Riza, (2009) mengatakan kejadian stres lebih banyak terjadi pada keluarga yang memiliki sikap terhadap stres dengan kategori negatif sebanyak (93,8%), dibandingkan dengan keluarga yang memiliki sikap terhadap stres dengan kategori positif sebanyak (72,7%). Ada hubungan bermakna antara sikap keluarga terhadap stres dengan kejadian stres pada anggota keluarganya. Sedangkan hasil peneliti Setiawati, (2012) menunjukkan sikap masyarakat terhadap pasien gangguan jiwa ialah menerima, mengucilkan, membicarakan dan memandang pasien berbeda dengan masyarakat. Keluarga yang menerima keadaan pasien dan bersikap positif dengan mengajak pasien berbicara dan mengobrol ketika pasien berbicara sendiri dan berjalan mondar mandir, mengikat pasien ketika mengamuk, melepas pasien ketika sudah tenang.

Berdasarkan hasil penelitian hubungan pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa ada hubungan yang signifikan antara pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) (p value <0,05). Pada hasil penelitian yang dilakukan oleh peneliti dengan 82 responden didapatkan hasil bahwa dari 82 responden peneliti memperoleh 44 responden (48,8%) pengetahuan cukup baik, yang mempunyai pengetahuan cukup baik dan sikap negatif terhadap orang dengan gangguan jiwa sebanyak 19 responden (23,2%), sedangkan 25 responden (30,5%) mempunyai pengetahuan cukup baik dan sikap positif (Dapat dilihat pada tabel 8). Hal tersebut menandakan bahwa pengetahuan sangat mempengaruhi dalam pembentukan sikap. Apabila masyarakat yang memiliki pengetahuan terhadap

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orang dengan gangguan jiwa baik, maka sikap masyarakat yang diberikan masyarakat akan positif seperti sikap memberi dukungan dalam proses penyembuhannya, sikap simpati atau kepeduliannya kepada orang dengan gangguan jiwa, tidak menjauhi atau mengucilkan pada lingkungannya dan tidak berperilaku negatif kepada orang dengan gangguan jiwa. Hasil tersebut sesuai dengan yang disampaiakan oleh Wawan, (2010) pengetahuan seseorang tentang suatu objek tergantung pada dua aspek yaitu aspek positif dan negatif. Kedua aspek tersebut yang akan menentukan sikap seseorang, semakin banyak aspek positif dan objek yang diketahui maka akan menimbulkan sikap makin positif terhadap objek tertentu.

Penelitian ini sejalan dengan Sulistyorini (2013), terdapat hubungan pengetahuan tentang gangguan jiwa terhadap sikap masyarakat kepada penderita gangguan jiwa di wilayah kerja Puskesmas Colomadu 1, di dapatkan nilai p value=0,000. Berarti semakin baik pengetahuan masyarakat tentang gangguan jiwa, maka akan positif sikap masyarakat kepada penderita gangguan jiwa. Sedangkan hasil penelitian lain ada hubungan antara tingkat pengetahuan dengan sikap masyarakat terhadap pasien gangguan jiwa (ODGJ) di RW XX Desa Duwet Kidul, Kecamatan Baturetno, Kabupaten Wonogiri (Yulianti, Meilina, & Wijayanti, 2016). Sedangkan peneliti ini diperkuat oleh penelitian yang berjudul pengaruh pendidikan kesehatan terhadap perubahan tingkat pengetahuan dan sikap masyarakat pada penderita gangguan jiwa di Desa Nguter Kabupaten Sukoharjo, di dapatkan hasil bahwa terdapat pengaruh pendidikan kesehatan terhadap perubahan tingkat pengetahuan dan sikap masyarakat pada penderita gangguan jiwa (Pratomo, Aji Galih Nur & Teguh, 2015).

Berdasarkan hasil penelitian hubungan persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa menunjukkan bahwa ada hubungan yang signifikan antara persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) (p value <0,05). Pada hasil penelitian yang dilakukan oleh peneliti dengan 82 responden didapatkan hasil bahwa dari 82 responden peneliti memperoleh 52 responden (63,4%) persepsi baik, yang mempunyai persepsi baik dan sikap negatif terhadap orang dengan gangguan jiwa sebanyak 8 responden

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(9,8%), sedangkan 44 responden (53,7%) mempunyai persepsi baik dan sikap positif (Dapat dilihat pada tabel 9). Hasil tersebut menunjukkan bahwa persepsi sangat mempengaruhi pembentukan sikap seseorang, apabila masyarakat mempersepsikan orang dengan gangguan jiwa (ODGJ) dengan baik, maka sikap yang telah diberikan pada orang dengan gangguan jiwa akan positif. Seperti masyarakat tidak akan mengucilkan orang dengan gangguan jiwa di dekatnya, mereka mau tolong menolong atau merasa simpati, tidak akan melakukan hal seperti kekerasan akan tetapi memberikan bantuan kepadanya. Memberikan dukungan dalam proses penyembuhan, tidak akan saling mengucilkan akan tetapi saling menghargai satu sama lain. Hasil tersebut sesuai dengan yang disampaikan oleh Sunaryo, (2013) persepsi ialah proses diterimanya rangsangan oleh indra kemudian individu memiliki menyadari tentang sesuatu yang diamati dengan persepsi individu bisa menyadari dan memahami keadaan lingkungan yang ada di sekitarnya. Persepsi dapat mengubah sikap pada seseorang, setiap individu kadang-kadang memiliki persepsi yang berbeda-beda walaupun mengamati objek yang sama.

Peneliti ini sejalan dengan peneliti yang dilakukan oleh Wiharjo, (2014) didapatkan p value=0,000 sehingga dapat disimpulkan bahwa ada hubungan positif yang sangat signifikan antara persepsi masyarakat terhadap penderita skizofrenia dengan sikap masyarakat terhadap penderita skizofrenia. Hasil peneliti lain yang dilakukan oleh Lestari, (2012) didapatkan ada hubungan persepsi tentang gangguan jiwa dengan sikap keluarga yang mempunyai anggota keluarga gangguan jiwa di RSJD Surakarta.

KESIMPULAN

Hasil penelitian di masyarakat Kelurahan Rowosari Kota Semarang dengan responden sebanyak 82 didapatkan, sebagian besar responden dengan pengetahuan cukup sebanyak 44 orang (53,7%), sedangkan 28 orang (34,1%) memiliki pengetahuan baik dan yang terendah 10 orang (12,2%) mepunyai pengetahuan kurang baik. Sebagian besar responden dengan persepsi baik sebanyak 52 orang (63,4%), sedangkan yang terendah memiliki persepsi tidak baik sebanyak 30 orang (36,6%). Sebagian besar responden sikap positif sebanyak

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50 orang (61,0%), sedangkan yang terendah memiliki sikap negatif sebanyak 32 orang (39,0%). Hasil ini menunjukkan ada hubungan yang signifikan antara tingkat pengetahuan dan sikap masyarakat terhadap orang dengan gangguan jiwa (ODGJ) di Kelurahan Rowosari Kota Semarang dan ada hubungan yang signifikan antara persepsi dan sikap masyarakat terhadap orang dengan gangguan jiwa di Kelurahan Rowosari Kota Semarang.

SARAN

Diharapkan masyarakat mampu memperbaiki pengetahuan, persepsi atau penilaian yang tidak baik (buruk) terhadap orang dengan gangguan jiwa. Pengetahuan dan persepsi yang baik dapat menjadikan masyarakat memiliki sikap yang baik pula terhadap ODGJ. Bagi Institusi Pendidikan hasil penelitian ini diharapkan dapat menciptakan generasi penerus yang dapat mengembangkan ilmu dalam hal penelitian tentang tentang pengetahuan dan persepsi masyarakat terhadap sikap masyarakat pada ODGJ. Serta bagi tenaga kesehatan hasil tersebut diharapkan tenaga kesehatan selalu memberikan pendidikan kesehatan serta pengetahuan atau informasi tentang ODGJ pada masyarakat, pentingnya masyarakat membangun dukungan lingkungan yang baik dalam proses penyembuhan ODGJ agar pengetahuan, perhatian atau pengamatan dan sikap masyarakat lebih baik lagi terhadap ODGJ di sekitarnya. Dan bagi instansi pemerintah diharapkan pemerintah serta kepala desa bisa mengoptimalkan dalam pelayanan kesehatan jiwa, pada rumah sakit ataupun puskesmas. Orang dengan gangguan jiwa akan sembuh jika mereka rutin dalam berobat, masyarakat tidak perlu takut ataupun berperilaku negatif terhadap orang dengan gangguan jiwa. Bagi peneliti selanjutnya, apabila ada peneliti yang tertarik untuk meneliti topik ini, peneliti selanjutnya sebaiknya melakukan penelitian lebih mendalam mengenai pengetahuan, persepsi dan sikap masyarakat terhadap ODGJ dengan metode kualitatif melalui interview mendalam sehingga dapat mengetahui pengetahuan, persepsi dan sikap masyarakat lebih jelas.

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RIWAYAT PENDIDIKAN

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2. SMP Negeri 02 Salatiga	: 2005 – 2008
3. SMA Negeri 02 Salatiga	: 2008 – 2011
4. Akademi Keperawatan Widya Husada Semarang	: 2011 – 2014
5. Universitas Muhammadiyah Semarang	: 2016 – Sekarang

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