

# A Comparative Study to Assess Knowledge and Attitude Towards Mental Illness Among Rural and Urban Population of Udaipur District, Rajasthan.

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## ABSTRACT

**Background:** Mental illness remains a major public health concern, and misconceptions and stigma often delay help-seeking and social acceptance. Rural and urban populations may differ in their knowledge and attitude towards mental illness due to differences in education, exposure to health information, and access to healthcare services. **Objective:** To assess and compare knowledge and attitude towards mental illness among rural and urban populations of Udaipur district, Rajasthan. **Methods:** A non-experimental cross-sectional survey design was used. A total of 40 participants were selected from selected rural and urban community areas using a non-probability convenience sampling technique, with 20 participants from rural areas and 20 from urban areas. Data were collected using a structured questionnaire consisting of socio-demographic variables, a knowledge questionnaire, and an attitude scale. Data were analyzed using descriptive statistics, independent t-test, and correlation analysis. **Results:** Among rural participants, 45% had average knowledge, 30% had poor knowledge, and 25% had good knowledge. Among urban participants, 55% had good knowledge, 35% had average knowledge, and 10% had poor knowledge. The mean knowledge score was significantly higher among urban participants than rural participants ( $19.40 \pm 3.85$  vs.  $16.20 \pm 4.32$ ;  $t = 2.47$ ,  $p = 0.018$ ). Regarding attitude, 60% of urban participants had a positive attitude compared with 20% of rural participants. The mean attitude score was also significantly higher among urban participants than rural participants ( $77.10 \pm 10.95$  vs.  $64.35 \pm 12.84$ ;  $t = 3.38$ ,  $p = 0.002$ ). A significant positive correlation was found between knowledge and attitude among both rural ( $r = 0.46$ ,  $p = 0.041$ ) and urban participants ( $r = 0.52$ ,  $p = 0.019$ ). **Conclusion:** Urban participants demonstrated significantly better knowledge and more favorable attitudes towards mental illness than rural participants. The findings highlight the need for targeted community-based mental health awareness programmes, particularly in rural areas, to improve mental health literacy and reduce stigma.

**Keywords:** Mental illness, knowledge, attitude, rural population, urban population, mental health literacy, stigma.

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## INTRODUCTION

Mental illness is a major public health concern that affects individuals, families, and communities across all regions of the world. According to the World Health Organization, mental disorders contribute substantially to global disability and are commonly associated with impaired functioning, reduced quality of life, social exclusion, and increased risk of premature mortality<sup>(1)</sup>. Despite

the availability of effective treatment and rehabilitation services, many people with mental illness do not receive timely care because of poor awareness, stigma, negative attitudes, and limited access to mental health services<sup>(2)</sup>. In India, mental health problems represent a significant but often under-recognized burden. The National Mental Health Survey of India reported a high treatment gap for mental morbidity, indicating that a large proportion of affected individuals remain untreated or inadequately

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treated. This gap is influenced not only by shortage of mental health professionals and service availability but also by community-level factors such as misconceptions, fear, social stigma, and lack of mental health literacy<sup>(3)</sup>.

Knowledge and attitude toward mental illness play an important role in early identification, help-seeking behavior, treatment adherence, and social acceptance of people living with mental disorders. Adequate knowledge helps individuals understand that mental illness is a health condition that can be treated, whereas poor knowledge may lead to supernatural explanations, blame, neglect, discrimination, or delayed treatment<sup>(4)</sup>. Similarly, a positive attitude promotes empathy, support, and inclusion, while a negative attitude may increase stigma and social distance from affected individuals. Studies from the Indian context have shown that stigma surrounding mental illness continues to influence the experiences of patients, caregivers, and community members<sup>(5)</sup>.

Rural and urban populations may differ in their understanding and perception of mental illness because of variations in education, socioeconomic status, cultural beliefs, exposure to media, access to healthcare facilities, and availability of psychiatric services. Urban populations may have comparatively better exposure to health information and specialized services, while rural populations may face barriers such as limited awareness, dependence on traditional beliefs, poor accessibility, and greater stigma<sup>(6)</sup>. However, negative attitudes toward mental illness may exist in both settings, making it important to assess and compare knowledge and attitude across rural and urban communities. Rajasthan, with its diverse cultural, social, and geographical characteristics, provides an important setting for examining community perceptions regarding mental illness. Udaipur district includes both rural and urban populations with differences in lifestyle, education, healthcare access, and sociocultural practices<sup>(7)</sup>. Understanding the level of knowledge and attitude toward mental illness among these populations can help identify existing gaps and guide the development of community-based mental health education programmes.

### NEED OF THE STUDY

Mental illness is a growing public health concern in India, yet awareness and help-seeking remain limited because of stigma, misconceptions, and poor mental health literacy. The National Mental Health Survey reported that 13.7% of Indians had lifetime mental morbidity and 10.6% had current mental morbidity, while the overall treatment gap was about 84.5%, showing that many affected people do not receive timely care<sup>(8)</sup>. The need for this study is

further supported by rural–urban differences. National data show that current prevalence of mental disorders was higher in urban metro areas at 14.71% compared with rural areas 9.57%, but rural populations may face stronger barriers such as limited services, traditional beliefs, low awareness, and stigma. Therefore, comparing knowledge and attitude in rural and urban populations is important for planning targeted mental health education<sup>(9)</sup>.

In Rajasthan, mental health remains a relevant concern. The NMHS data highlighted Rajasthan among surveyed states and reported a very high rate of tobacco abuse/dependence at 39.6%, which is important because substance-use-related conditions contribute significantly to mental morbidity. Recently, Rajasthan also constituted the Rajasthan State Mental Health Authority in September 2024 under the Mental Healthcare Act, 2017, indicating renewed state-level focus on mental health services and regulation<sup>(10)</sup>. Despite these developments, community-level evidence from districts such as Udaipur is limited. Hence, this study is needed to assess and compare the knowledge and attitude toward mental illness among rural and urban populations of Udaipur district. The findings may help identify awareness gaps, reduce stigma, and support the development of culturally appropriate mental health awareness programmes in Rajasthan.

### OBJECTIVES OF THE STUDY

- To assess the knowledge regarding mental illness among rural and urban population.
- To assess attitude regarding mental illness among rural and urban population.
- To compare the knowledge and attitude regarding mental illness among rural and urban population.
- To determine the correlation between Knowledge and attitude regarding mental illness among rural and urban population

### MATERIAL AND METHOD

#### Study Design and Variables

A descriptive cross-sectional survey design was adopted to assess knowledge and attitude towards mental illness. The study variables were knowledge regarding mental illness and attitude towards mental illness, while selected socio-demographic characteristics were considered demographic variables.

#### Research Tool and Sampling

A total of 40 participants were selected using a non-probability convenience sampling technique. Data was collected using a structured questionnaire. The tool consisted of three sections: Section A included socio-demographic data, Section B consisted of 30 questions to assess knowledge regarding mental illness, and

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Section C consisted of 20 items to assess attitude towards mental illness.

## Data Collection and Data Analysis

Ethical permission for the study was obtained from the Pacific University Ethical Committee. Permission for research data collection was obtained from the respective authorities. Written informed consent was obtained from each participant before data collection. Confidentiality and anonymity of the participants were maintained throughout the study. The collected data was coded, organized, and analyzed using descriptive and inferential statistics. Frequency, percentage, mean, and standard deviation were used to summarize the data, while appropriate statistical tests were applied to compare knowledge and attitude between rural and urban populations and to determine their association with selected socio-demographic variables.

## RESULT

A total of 40 participants were included in the study to assess and compare knowledge and attitude towards mental illness. The collected data were organized and analyzed using descriptive statistics such as frequency and percentage. Table 1 shows the frequency and percentage distribution of socio-demographic variables of the participants. The total sample size was 40. An equal number of participants were selected from rural and urban areas, with 20 (50%) participants from each area.

**Table 1; Description of samples based on their personal characteristics in terms of frequency and percentage. (N=40 = N<sub>1</sub>=20 & N<sub>2</sub>=20)**

| S. N o. | Demographic Variable | Category       | Ru ral, f (%) | Ur ban , f (%) |
|---------|----------------------|----------------|---------------|----------------|
| 1       | Age                  | 18–30 years    | 6 (30 %)      | 6 (30 %)       |
|         |                      | 31–45 years    | 7 (35 %)      | 7 (35 %)       |
|         |                      | 46–60 years    | 5 (25 %)      | 4 (20 %)       |
|         |                      | Above 60 years | 2 (10 %)      | 3 (15 %)       |
| 2       | Gender               | Male           | 9 (45 %)      | 10 (50 %)      |

|   |                       |                           |           |           |
|---|-----------------------|---------------------------|-----------|-----------|
|   |                       | Female                    | 11 (55 %) | 10 (50 %) |
| 3 | Marital Status        | Married                   | 13 (65 %) | 11 (55 %) |
|   |                       | Unmarried                 | 5 (25 %)  | 6 (30 %)  |
|   |                       | Widow/Widower             | 1 (5%)    | 2 (10 %)  |
|   |                       | Divorced/Separated        | 1 (5%)    | 1 (5%)    |
| 4 | Education Level       | Primary education         | 5 (25 %)  | 2 (10 %)  |
|   |                       | Secondary education       | 5 (25 %)  | 4 (20 %)  |
|   |                       | Higher secondary          | 5 (25 %)  | 5 (25 %)  |
|   |                       | Graduate                  | 4 (20 %)  | 5 (25 %)  |
|   |                       | Postgraduate and above    | 1 (5%)    | 4 (20 %)  |
| 5 | Occupation            | Government employee       | 2 (10 %)  | 3 (15 %)  |
|   |                       | Private employee          | 3 (15 %)  | 5 (25 %)  |
|   |                       | Self-employed/Business    | 4 (20 %)  | 3 (15 %)  |
|   |                       | Farmer/Daily wages worker | 6 (30 %)  | 2 (10 %)  |
|   |                       | Homemaker                 | 3 (15 %)  | 4 (20 %)  |
|   |                       | Unemployed/Student        | 2 (10 %)  | 3 (15 %)  |
| 6 | Monthly Family Income | Below Rs. 10,000          | 5 (25 %)  | 3 (15 %)  |
|   |                       | Rs. 10,001–20,000         | 8 (40 %)  | 5 (25 %)  |

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|   |                                     |                       |                 |                 |
|---|-------------------------------------|-----------------------|-----------------|-----------------|
|   |                                     | Rs. 20,001–40,000     | 5<br>(25<br>%)  | 7<br>(35<br>%)  |
|   |                                     | Above Rs. 40,000      | 2<br>(10<br>%)  | 5<br>(25<br>%)  |
|   |                                     |                       |                 |                 |
| 7 | Type of Family                      | Nuclear family        | 7<br>(35<br>%)  | 11<br>(55<br>%) |
|   |                                     | Joint family          | 10<br>(50<br>%) | 7<br>(35<br>%)  |
|   |                                     | Extended family       | 3<br>(15<br>%)  | 2<br>(10<br>%)  |
| 8 | Source of Mental Health Information | Television            | 5<br>(25<br>%)  | 3<br>(15<br>%)  |
|   |                                     | Social media/Internet | 4<br>(20<br>%)  | 8<br>(40<br>%)  |
|   |                                     | Newspaper/Magazine    | 3<br>(15<br>%)  | 3<br>(15<br>%)  |
|   |                                     | Health personnel      | 5<br>(25<br>%)  | 4<br>(20<br>%)  |
|   |                                     | Friends/Relatives     | 3<br>(15<br>%)  | 2<br>(10<br>%)  |

The demographic characteristics of the rural and urban participants showed some variation between the two groups. In both rural and urban groups, the highest proportion of participants belonged to the age group of 31–45 years, accounting for 35% in each group. Females constituted 55% of the rural participants and 50% of the urban participants, while males represented 45% and 50%, respectively. With regard to marital status, the majority of participants were married in both groups, comprising 65% of the rural participants and 55% of the urban participants. Educational status indicated that rural participants were more frequently represented in the primary, secondary, and higher-secondary categories, whereas the urban group had a higher proportion of graduates and postgraduates. In terms of occupation, farmer/daily-wage workers constituted the largest occupational group among rural participants (30%), whereas private employees were comparatively more common among urban participants (25%). Regarding monthly family income, 40% of rural participants had an income of Rs. 10,001–20,000, while 35% of urban participants had an income of Rs. 20,001–40,000. With respect to family type, half of the rural participants belonged to joint families (50%), whereas

more than half of the urban participants belonged to nuclear families (55%). Television and health personnel were the most commonly reported sources of mental health information among rural participants, each accounting for 25%, while social media/Internet was the major source among urban participants, reported by 40%. Overall, the demographic profile revealed noticeable differences between rural and urban participants, particularly in educational level, occupation, family income, type of family, and source of mental health information.

**Knowledge Regarding Mental Illness Among Rural and Urban Population**

The findings show that among the rural population, the majority of participants, 9 (45%), had average knowledge, followed by 6 (30%) with poor knowledge and 5 (25%) with good knowledge regarding mental illness. Among the urban population, the majority of participants, 11 (55%), had good knowledge, followed by 7 (35%) with average knowledge and 2 (10%) with poor knowledge.

**Table 2; Comparison of Level of Knowledge Regarding Mental Illness Among Rural and Urban Population. (N=40 = N1=20 & N2=20)**

| Knowledge Category | Rural f (%) | Urban f (%) |
|--------------------|-------------|-------------|
| Good Knowledge     | 5 (25.0%)   | 11 (55.0%)  |
| Average Knowledge  | 9 (45.0%)   | 7 (35.0%)   |
| Poor Knowledge     | 6 (30.0%)   | 2 (10.0%)   |
| Total              | 20 (100%)   | 20 (100%)   |

Overall, out of 40 participants, 16 (40%) had good knowledge, 16 (40%) had average knowledge, and 8 (20%) had poor knowledge regarding mental illness. The results indicate that the urban population had comparatively better knowledge regarding mental illness than the rural population.

**Attitude Toward Mental Illness Among Rural and Urban Population.**

The findings show that among the rural population, the majority of participants, 11 (55%), had a neutral/average attitude, followed by 5 (25%) with negative attitude and 4 (20%) with positive attitude towards mental illness. Among the urban population, the majority of participants, 12 (60%), had a positive attitude, followed by 6 (30%) with neutral attitude and 2 (10%) with negative attitude.

**Table 3; Comparison of Level of Attitude Regarding Mental Illness Among Rural and Urban Population. (N=40 = N1=20 & N2=20)**

| Attitude Category | Rural f (%) | Urban f (%) |
|-------------------|-------------|-------------|
|-------------------|-------------|-------------|

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|                          |            |            |
|--------------------------|------------|------------|
| <b>Positive Attitude</b> | 4 (20.0%)  | 12 (60.0%) |
| <b>Neutral Attitude</b>  | 11 (55.0%) | 6 (30.0%)  |
| <b>Negative Attitude</b> | 5 (25.0%)  | 2 (10.0%)  |
| <b>Total</b>             | 20 (100%)  | 20 (100%)  |

Overall, out of 40 participants, 17 (42.5%) had neutral/average attitude, 16 (40%) had positive attitude, and 7 (17.5%) had negative attitude towards mental illness. The results indicate that the urban population had a more favorable attitude towards mental illness compared to the rural population.

**Comparison of Knowledge and Attitude Scores Between Rural and Urban Population.**

The mean knowledge score was higher among urban participants ( $19.40 \pm 3.85$ ) than rural participants ( $16.20 \pm 4.32$ ), with a mean difference of 3.20. An independent t-test demonstrated a statistically significant difference in knowledge scores between rural and urban groups,  $t(38) = 2.47$ ,  $p = 0.018$ .

**Table 4. Independent Samples t-test Comparing Knowledge Level Regarding Mental Illness Between Rural and Urban Groups.**

| G<br>r<br>o<br>u<br>p | N  | Mean<br>Knowl<br>edge<br>Score | S<br>D | Mea<br>n<br>Diffe<br>rence | t-<br>v<br>al<br>ue | d<br>f | p-<br>va<br>lu<br>e | Inte<br>rpre<br>tatio<br>n |
|-----------------------|----|--------------------------------|--------|----------------------------|---------------------|--------|---------------------|----------------------------|
| R<br>u<br>r<br>al     | 20 | 16.2                           | 4.32   | 3.2                        | 2.47                | 38     | 0.018               | Sign<br>ifica<br>nt        |
| U<br>r<br>b<br>a<br>n | 20 | 19.4                           | 3.85   |                            |                     |        |                     |                            |

These findings indicate that urban participants had significantly better knowledge regarding mental illness compared with rural participants.

**Comparison of Attitude Scores Between Rural and Urban Population.**

The mean attitude score was higher among urban participants ( $77.10 \pm 10.95$ ) than rural participants ( $64.35 \pm 12.84$ ), with a mean difference of 12.75. An independent t-test showed a statistically significant difference in attitude scores between rural and urban groups,  $t(38) = 3.38$ ,  $p = 0.002$ .

**Table 5. Independent Samples t-test Comparing Attitude Level Regarding Mental Illness Between Rural and Urban Groups.**

| G<br>r<br>o<br>u<br>p | N | Mean<br>Attitu<br>de | S<br>D | Mea<br>n | t-<br>v<br>al<br>ue | d<br>f | p-<br>va<br>lu<br>e | Inte<br>rpre |
|-----------------------|---|----------------------|--------|----------|---------------------|--------|---------------------|--------------|
|-----------------------|---|----------------------|--------|----------|---------------------|--------|---------------------|--------------|

| u<br>p                |    | de<br>Score |       | Diffe<br>rence | al<br>ue |    | lu<br>e | tatio<br>n          |
|-----------------------|----|-------------|-------|----------------|----------|----|---------|---------------------|
| R<br>u<br>r<br>al     | 20 | 64.35       | 12.84 | 12.75          | 3.38     | 38 | 0.002   | Sign<br>ifica<br>nt |
| U<br>r<br>b<br>a<br>n | 20 | 77.1        | 10.95 |                |          |    |         |                     |

These findings indicate that urban participants had a significantly more favourable attitude towards mental illness compared with rural participants.

**Correlation Between Knowledge and Attitude Regarding Mental Illness.**

A residence-wise correlation analysis was performed to examine the relationship between knowledge and attitude scores regarding mental illness among rural and urban participants separately. Among rural participants, knowledge showed a significant positive correlation with attitude,  $r = 0.46$ ,  $p = 0.041$ . Similarly, among urban participants, a significant positive correlation was observed between knowledge and attitude scores,  $r = 0.52$ ,  $p = 0.019$ . These findings suggest that higher knowledge regarding mental illness was associated with a more favorable attitude in both rural and urban populations.

**Table 6. Correlation Between Knowledge and Attitude Scores Regarding Mental Illness Stratified by Rural and Urban Population**

| G<br>r<br>o<br>u<br>p | N  | Mean<br>Knowl<br>edge<br>Score | Mean<br>Attit<br>ude<br>Score | Correl<br>ation<br>coeffici<br>ent (r) | p-<br>v<br>al<br>ue | Interpr<br>etation                             |
|-----------------------|----|--------------------------------|-------------------------------|----------------------------------------|---------------------|------------------------------------------------|
| R<br>u<br>r<br>al     | 20 | 16.2                           | 64.35                         | 0.46                                   | 0.041               | Signific<br>ant<br>positive<br>correlati<br>on |
| U<br>r<br>b<br>a<br>n | 20 | 19.4                           | 77.1                          | 0.52                                   | 0.019               | Signific<br>ant<br>positive<br>correlati<br>on |

The strength of correlation was slightly higher among urban participants compared with rural participants, indicating that improved knowledge may be more strongly associated with favourable attitudes in the urban group; however, both groups

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demonstrated a positive relationship between knowledge and attitude.

### DISCUSSION

The present study demonstrated a clear rural–urban difference in knowledge and attitude regarding mental illness among participants from Udaipur district. Urban participants had significantly higher knowledge scores than rural participants ( $19.40 \pm 3.85$  vs.  $16.20 \pm 4.32$ ;  $p = 0.018$ ) and also reported more favourable attitude scores ( $77.10 \pm 10.95$  vs.  $64.35 \pm 12.84$ ;  $p = 0.002$ ). Category-wise findings supported this pattern, as 55% of urban participants had good knowledge compared with 25% of rural participants, while positive attitude was reported by 60% of urban participants compared with 20% of rural participants. These findings suggest that urban residence may be associated with better mental health literacy and lower stigmatizing attitudes, possibly due to greater exposure to education, media, healthcare services, and mental health information.

The findings are consistent with a comparative study from Chhattisgarh, where urban adults had higher mean knowledge scores than rural adults (6.66 vs. 5.20) and higher attitude scores (5.66 vs. 3.33). That study also reported that 30% of urban adults had good knowledge, whereas 23.33% of rural adults had poor knowledge, supporting the rural–urban disparity observed in the present study<sup>(11)</sup>. Similarly, Ahmed and Nikita reported more positive community attitudes among urban participants and found higher social restrictiveness among rural participants ( $31.86 \pm 6.87$ ) than urban participants ( $19.23 \pm 3.15$ ), indicating stronger restrictive beliefs in rural settings<sup>(12)</sup>.

The significant positive correlation between knowledge and attitude in both rural ( $r = 0.46$ ,  $p = 0.041$ ) and urban participants ( $r = 0.52$ ,  $p = 0.019$ ) further indicates that higher knowledge was associated with more favorable attitudes towards mental illness. This relationship suggests that mental health literacy may play an important role in reducing misconceptions, stigma, and social distance. However, because of the cross-sectional design and small sample size, causal interpretation should be avoided. Overall, the findings support the need for targeted, community-based mental health awareness interventions, particularly in rural areas, to improve knowledge, reduce stigma, and promote early help-seeking behavior.

### LIMITATIONS OF THE STUDY

The present study has certain limitations. The study was conducted among a small sample from selected rural and urban community areas of Udaipur district, which may limit the generalizability of the findings to wider populations. The use of a non-probability convenience sampling technique may have

introduced selection bias. As the data were collected through a self-reported questionnaire, responses may have been influenced by recall bias or social desirability bias. In addition, the cross-sectional design assessed knowledge and attitude at a single point in time; therefore, causal relationships between knowledge and attitude could not be established.

### RECOMMENDATION

Future studies should be conducted with a larger and more representative sample across multiple rural and urban community settings to improve the generalizability of the findings. Probability sampling methods may be used to reduce selection bias and strengthen methodological rigor. Longitudinal or interventional studies are recommended to evaluate whether structured mental health awareness programmes can improve knowledge and reduce negative attitudes over time. Further research may also include qualitative approaches to explore community beliefs, stigma, misconceptions, and barriers to mental health help-seeking in greater depth. Community-based mental health education activities should be planned, particularly in rural areas, to promote early identification, reduce stigma, and encourage timely use of mental health services.

### Nursing Implications

The findings of the study have important implications for nursing practice, education, administration, and research. In nursing practice, nurses can play a key role in improving mental health literacy, reducing stigma, and promoting early identification of mental illness at the community level, especially in rural areas where knowledge and attitude were comparatively lower. Community health nurses should provide health education, counselling, and referral support to individuals and families regarding mental illness and available treatment services. In nursing education, the study highlights the need to strengthen mental health awareness, stigma reduction, and community-based psychiatric nursing components in the nursing curriculum. Student nurses should be trained to identify misconceptions, communicate therapeutically, and promote positive attitudes toward persons with mental illness. In nursing administration, nurse administrators can organize community mental health awareness programmes, training sessions, and outreach activities in collaboration with primary health centres, schools, local leaders, and community organizations. Special emphasis should be given to rural communities to improve access to mental health information and services. In nursing research, the findings provide a basis for conducting further studies with larger samples and interventional designs to assess the effectiveness of structured mental health education programmes. Future research may also explore cultural beliefs, stigma, and barriers to mental

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health help-seeking among rural and urban populations.

## CONCLUSION

The study concluded that there was a significant rural–urban difference in knowledge and attitude regarding mental illness among the study participants. Urban participants demonstrated significantly higher knowledge and more favourable attitudes compared with rural participants. A significant positive correlation was also found between knowledge and attitude in both rural and urban groups, indicating that better knowledge was associated with more positive attitudes towards mental illness. These findings highlight the need for targeted community-based mental health awareness programmes, particularly in rural areas, to improve mental health literacy, reduce stigma, and promote timely help-seeking behaviour.

**Conflict of Interest-** None to declare

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