World Journal of Pharmaceutical and Life Sciences
WJPLS
www.wjpls.org
SJIF Impact Factor: 6.129

A STUDY TO ASSESS SELF EFFICACY FOR SOCIAL PARTICIPATION AMONG MENTALLY ILL PATIENTS IN SELECTED HOSPITALS AT BENGALURU"

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Article Received on 28/12/2022 **Article Revised on 17/01/2023** **Article Accepted on 06/02/2023**

ABSTRACT

Self-efficacy affects every area of human endeavor. By determining the beliefs, a person holds regarding his or her power to affect situations, it strongly influences both the power a person, actually has to face challenges competently and the choices a person is most likely to make. These effects are particularly apparent, and compelling, with regard to behaviors' affecting health. People identified as having mental health problems are one of the most marginalized groups in society. Equal citizenship and active community participation remains highly desired but elusive goals. Stigma is a major barrier and people feel its sting in terms of lost relationships, opportunities denied or their own unwillingness to pursue life's goals for fear of rejection or failure. Hence this study has been conducted to assess the self efficacy for social participation among mentally ill patients at selected hospital.

Objectives of Study

- To assess the self efficacy for social participation among mentally ill patients.
- To find the association between self efficacy for social participation among mentally ill patients and selected personal variables

Methods: The study involved non experimental approach, descriptive survey research design with purposive sampling technique. To collect the data from respondents, modified scale to assess self efficacy for social participation among mentally ill patients was used and administered to 60 mentally ill patients following inclusion and exclusion criteria. The tool consisted 39 items regarding assessment of self efficacy for social participation among mentally ill patients. The results were described by using descriptive and inferential statistics. **Results:** The study clearly showed that majority, 76.66% of respondents were having low self efficacy and remaining 23.33% were having moderate level of self efficacy for social participation. The mean score of participants was 90.13 with mean percentage 57.77% and standard deviation 10.1. With regard association between self efficacy for social participation among mentally ill patients and selected personal variables, there is a significant association between demographic variable such as age ($\chi 2$ =17.26*), education ($\chi 2$ =16.98*) type of family (($\chi 2$ =23.80*), employment ($\chi 2$ =27.08*), duration of illness in years ($\chi 2$ =14.29*), family history of illness($\chi 2$= 15.97*), monthly income of family in rupees ($\chi 2$ =28.11*) treatment receiving ($\chi 2$ =22.63*) at 5% level and there is no significant association between gender ($\chi 2$= 0.30NS) marital status ($\chi 2$ = 3.85 NS) , religion ($\chi 2$= 0.017 NS) and diagnosis ($\chi 2$ = 2.51 NS) with self efficacy for social participation among mentally ill patient. **Interpretation and Conclusion:** The overall findings of the study clearly showed that majority, 76.66% of respondents were having low self efficacy and remaining 23.33% were having moderate level of self efficacy for social participation, and personal variables like, age, education, type of family, employment, duration of illness, family history of mental illness monthly income of family and treatment receiving influences the self efficacy for social participation among mentally ill patient.

INTRODUCTION

Self-efficacy is the measure of one's own ability to complete tasks and reach goals. Psychologists have been studied self-efficacy from several perspectives, noting various paths in the development of self-efficacy; the dynamics of self-efficacy, and lack thereof, in different settings; interactions between self-efficacy and self-concept; and habits of attribution that contribute to, or detract from, self-efficacy.[1]

Self-efficacy affects every area of human endeavor. By determining the beliefs of a person holds regarding his or

her power to affect situations, it strongly influences both the power, a person actually has to face challenges competently and the choices a person is most likely to make. These effects are particularly apparent, and compelling, with regard to behaviors affecting health.[1]

People generally avoid tasks where self-efficacy is low, but undertake tasks where self-efficacy is high. Self-efficacy significantly beyond actual ability leads to over estimation of the ability to complete tasks. On the other hand, self-efficacy significantly lower the ability, discourages growth and skill development. Research shows that the optimum level of self-efficacy is slightly above ability; in this situation, people are most encouraged to tackle challenging tasks and gain experience.[2]

Mental health issues are very common. We are in daily contact with people affected by mental health problems. They run our banks, police our communities, and teach our children they are our friends, neighbors and family. The stigma attached to mental ill-health, however, prevents most people from disclosing. Fear of discrimination prevents people speaking of their experience and seeking support from work colleagues, friends or family. The later people leave seeking help, the more significant is their ultimate call on health and social service. The discrimination against people with mental illness remains high and that fear of discrimination is a key reason to people do not seek help early.[3]

NEED FOR THE STUDY

People identified as having mental health problems are one of the most marginalised groups in society. Equal citizenship and active community participation remains highly desired but elusive goals. Stigma is a major barrier and people feel its sting in terms of lost relationships, opportunities denied or their own unwillingness to pursue life's goals for fear of rejection or failure. Discrimination is experienced when support is withdrawn by family and friends, by being shunned, shamed, through name calling, being denied employment or having one's rights abused. It is a problem borne of ignorance and bred by fear.[4]

Mental health issues are very common; people's willingness to share their experience is exceedingly rare. Positive personal contact is a critical means of changing negative beliefs. Ironically, we are in daily contact with people affected by mental health problems. What we don't have is disclosure. The result of this secrecy is that the myths of violence and incompetence go unchallenged, slights go unchecked, and people won't seek out the support they accept a reduced share of resources, suffer the loss of their rights, and live a diminished life often without protest. Creating a dialogue between those who have experienced mental problems and the broader community plants the seeds of change.[5]

A successful social inclusion program challenges every citizen to rethink their assumptions and take steps to create an inclusive social quilt where rights are respected, differences are valued, and we all belong. However, contact alone is not enough. There are also powerful systemic, social, attitudinal and institutional barriers that need to be simultaneously untangled. A broader lens is required beyond seeing this as a health based issue. Multi-sectorial planning across government and stakeholder groups is also needed to transform policies and practices, improve services and to enhance legislative protections to stop discrimination. Affirm equal rights and support full citizenship.[5]

The world health organisation estimates that one in four people experience a mental health disorder during their lifetime. The Australian bureau of statistics estimates it as being higher with 45.5% of population experiencing a mental illness and/or substance misuse in their lifetime. The leading cause of healthy life lost due to disability is mental illness. Conservative estimate of the economic cost of poor mental health is 3% to 4%of GDP in developing nations. The WHO recognises psychiatric disability as the fastest growing cost sector for occupational disability.[6]

Economic modelling done by Freidle and Parsonage in England highlighted the enormous cost of treating mental health problems and the woeful underfunding of mental health promotion and mental illness prevention within the National Health Services and by local health authority. Relative to other health conditions the cost of mental illness is very high in terms of disability adjusted life years (20%) exceeding cardio vascular disease (17.2%) and cancer (15.5%). Yet relative to their importance as a health problem funding is disproportionally low.[7]

The high price of mental ill-health is borne by individuals and their families (lost income for both), by employers (lost productivity, rising health, disability and benefit costs) and by society (welfare payments, lost taxes, lost opportunity) making this an important policy issue for government and industry to address.[8, 9]

Over the past 30 years US and other westernized countries, including Israel, have witnessed major changes in the form of residential care provided to people with mental illness. Deinstitutionalization and the development of supported residences have resulted in growing numbers of individuals with persistent mental health problems returning to the community.[10]

Despite concerted attempts by mental health Professionals to guide these people and place them in suitable living and employment settings, many of them still find life within the community a constant struggle. Research conducted among persons with severe mental illness living in the community has revealed that more than half of them complain of loneliness. An

understanding of the factors that contribute to loneliness among these residents is important for improving their quality of life.[11]

People need to feel part of an active environment in order to feel less lonely. Recreational and other social activities in the community are or particular importance as they are meeting points where people interacts and share common activities and concerns. Taking part in social club, sitting in a cafe or simply food shopping naturally involve interaction with other people with mental illness. Furthermore, through social participation in the community people also learn social skills and receive feedback.[12]

Self efficacy theory asserts that functional capacity alone is insufficient to generate a desired behaviour. An individual's thoughts, emotions and actions before and during a particular event are influenced by the person's judgement of his or her abilities, whether or not that judgement is correct. Judgements of self efficacy also influences the amount of energy that individual are willing to invest in overcoming certain obstacles. Those with a strong sense of self efficacy will often try harder than those with doubts. Furthermore, research has shown that higher levels of perceived self efficacy lead to a progressive increase in performance.[13]

Unfortunately, many of the effects of mental illness, such as cognitive deficiencies, poor assertive and interpersonal relational skills, or a limited sense of direction in one's life, all contribute to reduced feelings of efficiency and competence and measures of self-efficacy among people with mental illness. It should be noted, however, that because causality could not be established, even if negative symptoms might have led to reduced self-efficacy, it is also possible that reduced self-efficacy was what led to the negative symptoms. People with mental illness are likely to feel that they lack control not only over the illness but over their environment, as well. This is yet another factor that can cause individuals to abandon attempts to improve negative aspects of their lives, including poor interpersonal relations. By contrast, deinstitutionalization and incorporation into various living arrangements within the community may encourage individuals to become more active within their own communities.[14]

Loneliness has been generally associated with negative feelings about interpersonal relationships. Lonely people are judged to be less interpersonally competent than people who are not lonely, and research has consistently shown a negative correlation between social skills and loneliness. Therefore, it appears that if people with mental illness living in the community can enhance their social self-efficacy, they may mitigate their feelings of loneliness.[15]

People with mental health problems experience social exclusion in a multiplicity of domains including: high rates of unemployment; lower educational achievement; persistent poverty; the loss of friendships; kinship; denial of housing; and all contribute to worsening in mental health. Increasing the self efficacy for social participation among people with mental illness and educating the care givers regarding social inclusion will reduce stigma and discrimination of mental ill people and it will strengthen and support the people with mental illness improve their general health and quality of life.

MATERIALS AND METHODS

Research Approach

In order to accomplish the main objectives of the study a non-experimental research approach was considered the best to assess self efficacy for social participation among mentally ill patients in selected hospitals at Bengaluru.

Research design

Descriptive survey design was adopted for the study.

Research setting

This study was conducted in Psychiatric OPD at Victoria Hospital in Bengaluru district.

Population

In the present study, the population consisted of psychiatric patients who were attending OPD at Victoria hospital Bengaluru.

Sample

In the present study psychiatric patients who were attending OPD at Victoria hospital Bengaluru and having insight of score 4 and above are selected as target population or samples of the study.

Sample size

The total sample size of the study consists of 60 psychiatric patients.

Sampling technique

Subjects were selected by Non probability- Purposive sampling technique.[43]

Criteria for selection of sampling

The criteria for sample selection are mainly depicted under two headings, which includes the inclusive and the exclusive criteria.

Inclusion Criteria

(i) Mentally ill patients who are present at the time of data collection.
(ii) Mentally ill patients whose care givers give the consent on patient's behalf to participate in the study.
(iii) Mentally ill patients whose insight is score 4 or more which is certified by psychiatrist

Exclusion Criteria

(i) Mentally ill patients who are physically, critically ill and not Cooperative.

Research variables

1. **Independent variable**: Mental illness
2. **Dependent variables:** Self efficacy for social participation
3. **Personal variable:** Age, gender, religion, educational status, occupation, marital status, type of family, Family monthly income, diagnosis, duration of mental illness, family history of mental illness and treatment receiving.

Tool of Research

Based on the objectives of the study, a structured interview schedule was prepared in order to assess self efficacy for social participation among mentally ill patients.

Selection and Development of the Tool

The data was collected by using modified scale to assess Self efficacy for social participation among people with mental illness. The tool was selected and developed based on the research problem, review of the related literature and with suggestions and guidance of the experts in the field of psychiatric Nursing, The tool consisted of 2 Sections.

Section I: Consists of questions on socio personal data such as Age, gender, religion, educational status, occupation, marital status, type of family, diagnosis, duration of mental illness, family history of mental illness, family income and type of treatment.

Section II: It Consists 39 items to assess self efficacy for social participation among people with mental illness which are divided into 4 aspects.

1. Trust for social self
2. Self management
3. Social adaptability
4. Mutual support

Scoring Interpretation

The number of items in modified scale to assess Self efficacy for social participation among people with mental illness included 39 and each item is rated 0, 1, 2, 3,4 that is never, rarely, can't say, sometimes, always. In this a response carries one score and maximum score of 4 and total maximum score of 39 items is 156.

Interpretation of score and level of self efficacy for social participation

Degree of self efficacy	Low	Moderate	High
Percentage	Below 50%	50%-75%	More than 75%
Score	Less than 78	79-117	More than 118

Data Collection

The total samples of the main study consisted of 60 psychiatric patient. After obtaining consent from participants, data was collected from the samples by administrating modified scale to assess Self efficacy for social participation among people with mental illness. It has taken 40 minutes to complete the modified scale to assess Self efficacy for social participation among people with mental illness and it took four weeks to complete the study. It was found that the items were simple and comprehensive.

Plan for data analysis

The data obtained was planned to be analyzed on the basis of the objectives and assumptions of the study by using descriptive and inferential statistics.

- Frequency and percentage distribution were used to study the demographic variables.
- Mean & standard deviation were used to assess Self efficacy for social participation among people with mental illness.
- Chi- square test was used to find the association between levels of Self efficacy for social participation among people with mental illness with selected personal variables.

RESULTS

This section presents the analysis and interpretation of the data collected from 60 mentally ill patients from Victoria hospital Bengaluru. The data collected through modified self efficacy scale for social participation among mentally ill patient was organized, analyzed and interpreted by using descriptive and inferential statistics.

Section - I: Personal Characteristics of Respondents.

Section - II: Assessment self efficacy for social participation among mentally ill patients.

Section - III: Association between self efficacy for social participation among mentally ill Patients and selected personal variables.

Classification of Respondents by Gender

Characteristics	Category	Number	Percentage
Gender	Male	38	63.33
	Female	22	36.66

N=60

Classification of Respondents by Religion

Characteristics	Category	Number	Percentage
Religion	Hindu	35	58.33
	Muslim	17	28.33
	Christian	08	13.33
	Other	0	0

N=60

Classifications of Respondents by Education

Characteristics	Category	Number	Percentage
Education	No formal education	12	20
	Primary Education	16	26.66
	High School	15	25
	P.U.C	14	23.33
	Degree and above	03	05

N=60

Classification of Respondents by Marital status

Characteristics	Category	Number	Percentage
Marital status	Married	35	58.33
	Unmarried	18	30
	Separated	0	0
	Widow/ widower	07	11.66

N=60

Classification of Respondents by Type of Family

Characteristics	Category	Number	Percentage
Type of the family	Joint family	15	25
	Nuclear family	45	75

N=60

Classification of Respondents by Employment

Characteristics	Category	Number	Percentage
Employment	Self employment	10	16.66
	Daily wages	15	25
	Unemployed	35	58.33

N=60

Classification of Respondents by Diagnosis

Characteristics	Category	Numbers	Percentage
Diagnosis	Schizophrenia	25	41.66
	Mood disorder	15	25
	ADS	20	33.33

N=60

Classification of Respondents by duration of illness

Characteristics	Category	Number	Percentage
Duration of illness	Less than 1 year	16	26.66
	1-4 years	28	46.66
	5-9 years	14	23.33
	10 or more years	02	3.33

N=60

Classification of Respondents by Family History of Mental Illness

Characteristics	\Category	Number	Percentage
Family history of illness	Yes	28	46.66
	No	32	53.33

N=60

lassifications of Respondents by Family Income

Characteristics	Category	Number	Percentage
Monthly income of family (in rupees)	Below 5000	46	76.66
	5001-10,000	10	16.66
	10,001-15,000	4	6.66

N=60

Classifications of Respondents by Type of Treatment Receiving

Sl.No.	Characteristic	Category	Number	Percentage
1	Treatment receiving	Rehabilitation therapy	03	5
		Occupation therapy	0	0
		Group therapy	12	20
		Pharmacotherapy	45	75
		Others	0	0

N =60

Assessment self efficacy for social participation among mentally ill patients.
Classification of mentally ill patients on level of self efficacy for social participation

Level of self efficacy for social participation	Score Category	Number	Percent
Low	Less than 56 **(**Below 50%**)**	46	76.66
Moderate	57-82 (50%-75%)	14	23.33
High	More than 83 (More than 75%)	0	0

N=60

Classification of mentally ill patients on level of self efficacy for social participation
Aspect wise mean response scores of respondents on self efficacy for social participation

No.	Aspects	Statements	Max score	Response			
				Mean	SD	Mean(%)	SD(%)
I	**Trust for social self**	11	44	37.40	8.20	85.02	13.2
II	**Self management**	11	44	27.31	3.44	62.07	15.6
III	**Social adaptability**	10	40	13.83	1.44	34.59	16.2
IV	**Mutual support**	07	28	11.57	1.92	41.33	12.5
	Combined	39	156	90.13	11.84	57.77	7.58

Association between self efficacy for social participation among mentally ill Patients and selected personal variables

Demographic Variables	Category	Sample	Level of self efficacy for social participation					χ^2 Value	P Value
			Low		Moderate		High		
			N	%	N	%			
Age (years)	20-29	18	08	4.8	10	06	0	17.26*	P<0.05
	30-39	20	16	9.6	04	2.4	0		
	40-49	12	12	7.2	0	0	0		
	50-59	10	10	06	0	0	0		
Gender	Male	38	30	18	08	4.8	0	0.30NS	P>0.05
	Female	22	16	9.6	06	3.6	0		
Religion	Hindu	35	27	16.2	08	4.8	0	0.017NS	P>0.05
	Muslim	17	13	7.8	04	2.4	0		
	Christian	08	06	3.6	2	1.2	0		
	Other	0	0	0	0	0	0		

N= 60
* Significant at 5% level, NS: Non-significant

Association between self efficacy for social participation among mentally ill Patients and selected personal variables.

Demographic Variables	Category	Sample	Level of self efficacy for social participation					χ^2 Value	P Value
			Low		Moderate		High		
			N	%	N	%			
Education	No formal education	9	12	7.2	0	0	0	16.98*	P<0.05
	Primary Education	18	15	09	1	0.6	0		
	High School	15	7	4.2	8	4.8	0		
	P.U.C	18	11	6.6	03	1.8	0		
	Degree and above	0	0	0	0	0	0		
Marital status	Married	35	24	14.4	11	6.6	0	3.85NS	P>0.05
	Unmarried	18	15	09	03	1.8	0		
	Separated	0	0	0	0	0	0		
	Widow/ widower	07	07	4.2	0	0	0		
Type of the family	Joint family	15	03	1.8	12	7.2	0	23.80*	P<0.05
	Nuclear family	45	39	23.4	6	3.6	0		

* Significant at 5% level, NS: Non-significant

Association between self efficacy for social participation among mentally ill Patients and selected personal variables.

Demographic Variables	Category	Sample	Level of self efficacy for social participation					χ^2 Value	P Value
			Low		Moderate		High		
			N	%	N	%			
Employment	Private	0	0	0	00	0	0	27.08*	P<0.05
	Government	0	0	0	00	0	0		
	Self employment	10	02	1.2	08	4.8	0		
	Daily wages	15	10	06	05	03	0		
	Unemployed	35	34	20.4	01	0.6	0		
Diagnosis	Schizophrenia	25	20	12	05	03	0	2.51NS	P>0.05
	Mood disorder	15	13	7.8	02	1.2	0		
	ADS	20	13	7.8	07	4.2	0		
	Others	0	0	0	0	0	0		

* Significant at 5% level, NS: Non-significant

Association between self efficacy for social participation among mentally ill Patients and selected personal variables.

Demographic Variables	Category	Sample	Level of self efficacy for social participation					χ^2 Value	P Value
			Low		Moderate		High		
			N	%	N	%			
Duration of illness(in years)	Less than 1	15	16	9.6	0	0	0	14.29*	P<0.05
	1-4	28	14	8.4	14	8.4	0		
	5-9	14	12	7.2	2	1.2	0		
	10 or more	03	03	1.8	0	0	0		
Family history of illness	Yes	28	28	16.8	0	0	0	15.97*	P<0.05
	No	32	18	10.8	14	8.4	0		
Monthly income of family (in rupees)	Below 5000	46	39	23.4	6	3.6	0	28.11*	P<0.05
	5001-10,000	10	01	0.6	9	5.6	0		
	10,001-15,000	04	01	0.6	4	2.4	0		
	15,001-20,000	0	0	0	0	0	0		

* Significant at 5% Level, NS: Non-significant

Association between Levels of Social Phobia among urban respondents with demographic variables

Demographic Variables	Category	Sample	Social Phobia Level					χ^2 Value	P Value
			None		Mild		High		
			N	%	N	%			
Treatment receiving	Rehabilitation therapy	03	01	47.3	02	52.7	0	22.63*	P<0.05
	Occupation therapy	0	0	0.0	0	100	0		
	Group therapy	17	7	35.7	10	64.3	0		
	Pharmacotherapy	40	38	48.4	02	51.6	0		
	Others	00	0	50.0	0	50.0	0		

* Significant at 5% Level, NS: Non-significant

1: Personal Characteristics of Respondents

Age (years)

Among 60 participants 30% were between 20-29years, 33.33% belonged to 30-39years, 20% were belongs to 40-49 years and 16.66% belongs to 50-59 years of age.

Similar findings were supported by a study conducted to development of an instrument to measure self-efficacy for social participation of people with mental illness. In this study the respondent's age group was 27.3% between 34-44 years, 22.8% between 25-34 years, 22.2% between 55-85 years, 21.6% between 45-54 years and 6.1% between 18-24 years.[17]

Gender

Among 60 participants majority, 63.33% were males, and 36.66% were females.

Similar findings were supported by a study conducted to assess the role of Self-Esteem, Self-Efficacy, and the Balance of Peer Support among Persons with Chronic Mental Health Problems: The data contain information on 628 clients of 51 service organizations. After excluding the samples remaining 63% were men, 26.3%. The study concluded that both self-esteem and self-efficacy were linked to the amount of support received and the amount of support provided. Two related pathways from support to well-being were identified: Support balance leads to enhanced feelings of self-esteem and self-efficacy.[34]

Education

Among 60 respondents 20% respondents were not having formal education 26.66% had primary education 25% had high school 23.33% PUC and remaining 5% degree and above.

Similar findings were supported Similar findings were supported by a study conducted to assess the role of Self-Esteem, Self-Efficacy, and the Balance of Peer Support among Persons with Chronic Mental Health Problems: The data contain information on 628 clients of 51 service organizations. Among those 26.3% earned a primary degree, 61% finished high school, and 11% finished higher education.**[34]**

Marital status

Among 60 respondents majority of respondents, 58.33% were married, 30% were unmarried and 7% were widow/widower.

Similar findings were supported by study conducted to assess the role of Self-Esteem, Self-Efficacy, and the Balance of Peer Support among Persons with Chronic Mental Health Problems .The majority (54%) was single, 20%were married, 22% were divorced, and 3% were widowed. Results show that both self-esteem and self-efficacy were linked to the amount of support received and the amount of support provided.[34]

Type of family

Among 60 respondents majority, 75% of participants were belongs to nuclear family and remaining 25% belongs to joint family Similar findings were supported by study conducted to assess the role of Self-Esteem, Self-Efficacy, and the Balance of Peer Support among Persons with Chronic Mental Health Problems. Most (32%) of the respondents lived in supported housing, 24% lived alone, 20% lived with a partner, 16% lived with their parents, and the remaining 8% lived with their children or with other family members.[34]

Employment

Among 60 participants majority, 58.33% participants were unemployed, 25% were daily wages and 16.66% self employed.

Similar findings were supported by a study conducted to development of an instrument to measure self-efficacy for social participation of people with mental illness. 22.8% were unemployed and remaining were working in rehabilitation centers.[17]

Diagnosis

Among 60 participants majority, 41.66 % of participants were diagnosed as schizophrenia, 25% were diagnosed as having mood disorder and 33.33% were having ADS Similar findings were supported by a study conducted to development of an instrument to measure self-efficacy for social participation of people with mental illness. 67% were diagnosed as schizophrenia, 15.4% were diagnosed as mood disorder, and remaining were diagnosed as other psychiatric disorder.[17]

Duration of illness
Among 60 participants 26.66% participants were suffering from mental illness for less than a year, 46.66% were suffering for 1-4 years, 23.33% were suffering for 5-9 years and 3.33% of respondents were suffering from 10 0r more years.

Family history of mental illness
Among 60 participants 46.66% of participants were having family history of illness and remaining 53.33% were not having the family history of illness.

Family income/monthly
Among 60 participants 76.66% participant's family income was below 5000 rupees, 16.66% participant's family income was 5001-10000 rupees and remaining 6.66% participant's family income was 10001 to 15000 rupees.

Type of treatment receiving
Among 60 participants majority, 75% of Respondents were receiving only pharmacotherapy, 20% of respondents were receiving group therapy and remaining 5% were receiving rehabilitation therapy.

2: Assessment of self efficacy for social participation among mentally ill patients
Among 60 participants majority, 76.66% of respondents were having low self efficacy and remaining 23.33% were having moderate level of self efficacy for social participation.

3: Association between self efficacy for social participation among mentally ill
Patients and selected personal variables
With regard to association between self efficacy for social participation among mentally ill patients and selected personal variables there is a significant association between demographic variable such as age (χ^2 =17.26*), education (χ^2 =16.98*) type of family ((χ^2 =23.80*), employment (χ^2 =27.08*), duration of illness in years (χ^2 =14.29*), family history of illness(χ^2= 15.97*), monthly income of family in rupees (χ^2 =28.11*) treatment receiving (χ^2 =22.63*) at 5% level and there is no significant association between gender (χ^2= 0.30NS) marital status (χ^2 = 3.85 NS) , religion (χ^2= 0.017 NS) and diagnosis (χ^2 = 2.51 NS) with self efficacy for social participation among mentally ill patient.

Similar findings were supported by a study conducted to find factors related to self-efficacy for social participation of people with mental illness. A study was conducted to investigate factors related to self-efficacy for social participation of individuals with severe mental illness (SMI). A total of 142 people with SMI recruited from a variety of rehabilitation programs completed an anonymous self-report questionnaire that assessed self-efficacy for social participation, general self-efficacy, self-esteem, general mental health, social support, and life satisfaction. Employed participants reported significantly greater self-efficacy for social participation, general self-efficacy, and life satisfaction than those who did not work. Participants using a day service reported having significantly fewer people providing social support than those not using one.[17]

CONCLUSION

This chapter presents the conclusions drawn, implications, limitations, suggestions and recommendations. The present study is focused on to assess the self efficacy for social participation among mentally ill patient in selected hospital at Bengaluru.

In this study descriptive survey research design was used to conduct the study which is a type of non-experimental approach. 60 (mentally ill patients) sample were drawn from population using purposive sampling technique. The data was collected by using modified scale of self efficacy for social participation among mentally ill patients. Data was analyzed and interpreted by applying statistical methods.

The 60 mentally ill patients in Psychiatric OPD at Victoria hospital have willingly participated in the study. The study was based on the Health Belief Model by Becker, Drachman RH and Kircht JP. It provides a comprehensive systematic framework to assess the self efficacy for social participation among mentally ill patients. The major findings of the study were as follows.

- Among 60 participants 30% were between 20-29years, 33.33% belonged to 30-39years, 20% were belongs to 40-49 years and 16.66% belongs to 50-59 years of age.
- Majority, 63.33% of the participants were males, and 36.66% were females.
- Majority, 58.33% of the participants were Hindus, 28.33% were Muslims and remaining 13.33% were Christians.
- Among 60 respondents 20% respondents were not having formal education 26.66% had primary education 25% had high school 23.33% PUC and remaining 5% degree and above.
- Majority, 58.33% of the participants, were married, 30% were unmarried and 7% were widow/widower.
- Majority, 75% of the participants were belongs to nuclear family and remaining 25% belongs to joint family.
- Majority, 58.33% of the participants were unemployed, 25% were daily wages and 16.66% self employed.
- Majority, 41.66 % of the participants were diagnosed as schizophrenia, 25% were diagnosed as having mood disorder and 33.33% were having ADS.
- Among 60 participants 26.66% participants were suffering from mental illness for less than a year, 46.66% were suffering for 1-4 years, 23.33% were suffering for 5-9 years and 3.33% of respondents were suffering from 10 0r more years.

- Among 60 participants 46.66% of participants were having family history of illness and remaining 53.33% were not having the family history of illness.
- Among 60 participants 76.66% participants family income was below 5000 rupees, 16.66% participants family income was 5001-10000 rupees and remaining 6.66% participants family income was 10001 to 15000 rupees.
- Majority, 75% of the participants were receiving only pharmacotherapy, 20% of respondents were receiving group therapy and remaining 5% were receiving rehabilitation therapy.
- Majority, 76.66% of the participants were having low self efficacy and remaining 23.33% were having moderate level of self efficacy for social participation.

Aspect wise mean response scores of respondents on self efficacy for social participation. The highest mean percentage score of participants found in the aspect of trust for social self (85.02%), self management 62.07%, mutual support 41.33% followed by social adaptability34.59. it is evident from overall mean score of participants found to be 90.13, mean % 57.77 and SD value 11.84, SD% 7.58.

With regard to association between self efficacy for social participation among mentally ill patients and selected personal variables there is a significant association between demographic variable such as age (χ^2 =17.26*), education (χ^2 =16.98*) type of family ((χ^2 =23.80*), employment (χ^2 =27.08*), duration of illness in years (χ^2 =14.29*), family history of illness(χ^2= 15.97*), monthly income of family in rupees (χ^2 =28.11*) treatment receiving (χ^2 =22.63*)with self efficacy for social participation among mentally ill patient and there is no significant association between gender (χ^2= 0.30NS) marital status (χ^2 = 3.85 NS), religion (χ^2= 0.017 NS) and diagnosis (χ^2 = 2.51 NS) with self efficacy for social participation among mentally ill patient.

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