Attitude towards Psychiatric Medication among the Providers and Recipients of Mental Health Services

Thesis submitted in partial fulfillment of the requirements for the Degree of M.Phil. in Clinical Psychology awarded by the University of Dhaka

Submitted by

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Dedication

"Dedicated to my beloved and respected parents, Md. Abul Hossain (late) and Noorjahan Begum" For their unconditional love, constant prayers, and sacrifices

Approval of the Thesis

This is to certify that the study **"Attitude towards Psychiatric Medication among the Providers and Recipients of Mental Health Services"** submitted by **Kaniz Fatema** to fulfill the requirements for the degree of M. Phil in Clinical Psychology is an original study. The research was carried out by her under my guidance and supervision. I have read the thesis and believe this to be an important work in the field of clinical psychology.

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Abstract

People often do not seek or adhere to psychiatric treatment for mental health problem. Among many factors including accessibility, stigma and side effects, attitudinal barriers toward psychiatric medication is one of the major reasons behind this. The attitudinal aspect of both the service providers and recipients can contribute to this. However, study findings on attitude towards psychiatric medication are limited in the worldwide context and almost nonexistent in the Bangladesh context. This study was therefore designed to explore the attitude towards psychiatric medication among the providers and recipients of mental health services.

Qualitative exploration using grounded theory approach was used in this study. 18 individuals from different categories of providers and recipients participated in this study. The recipients were selected purposively from mental health service centers (National Institute of Mental Health, Bangabandhu Sheikh Mujib Medical University, Nasirullah Psychotherapy Unit) and from community to ensure maximum variation. Ethical approval was taken before starting data collection. Data collection involved in-depth interview done face to face using a predesigned topic guide to cover the research objectives. The topic guide was developed through mind-map exercise and was pilot tested before starting the interview. Written consent was obtained from the participants before the interview except for one illiterate participant. All the interviews were audio recorded with participants' permission. Recorded interviews were transcribed in the form of text document. Data was analyzed using computer based qualitative analysis program NVivo-10. Data collection, coding and analysis were carried out simultaneously.

The data from the interview revealed several distinct themes which were classified into six broad categories namely, pre-conceived ideas, experience, attitude, behavior,

facilitators of behavior and burden. Although the primary concern was the attitude towards medication, the other categories seem to contribute in widening the context in which attitude towards psychiatric medication develops and interact. Data revealed presence of several pre-conceived ideas among the participants, which include equating psychiatric medicine with psychiatric illness, reliance on medical model, low priority of mental health problem and misconceptions. They also reported personal and vicarious experiences of using psychiatric medication that have exposed them to direct and indirect impacts of psychiatric medication. The pre-conceived ideas and experiences seemed to contribute to the formation of attitude towards psychiatric medication. Attitude was conceptualized with a bi-factorial cognitive-affective model, which leads towards medication related behavior. The findings also indicated six distinct themes namely knowledge, psycho-education, communication, faith on expertise, multidisciplinary teamwork, and family influence that seemed to facilitate behavior related to psychiatric medication. Several types of burdens also revealed, which thought to be associated with behavior related to psychiatric medication.

The findings have enhanced understanding of the connections between attitude and practice around the use of psychiatric medication. This may be useful in increasing early uptake of psychiatric intervention and in reducing non-compliance to medical treatment. Overall, findings of this study may contribute in policymaking and devising strategies to reduce mental health service gap in Bangladesh.

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CHAPTER 1

INTRODUCTION

Introduction

Psychiatric medication is a major option in the treatment of mental health problems, it is often consider as a crucial for many cases and occasionally the only available option in some resource-constrained context. Despite its vital role in psychiatry and mental health service delivery, people's attitude towards psychiatric medication is not always very positive. Presence of negative attitude towards psychiatric medication can act as a barrier for access to treatment and impose a detrimental impact in mental health service delivery. Considering the limited number of qualified non-medical practitioner and high burden [prevalence of 16.8% among adult and 13.6% among child (National Institute of Mental Health, 2019)] of mental health problem in Bangladesh, negative attitude towards medication can be serious. This research aimed at exploring the attitude towards psychiatric medication.

1.1 Conceptualizing of Attitude

Attitude can be defined as "a mental and neural state of readiness, organized through experience, exerting directive or dynamic influence upon the individual's response to all objects and situations with which it is related" (Fishbein, 1967). It can be conceptualize as evaluations regarding ideas, events, objects, or people (Ajzen & Fishbein, 1977). Attitudes are generally positive or negative, but they can also lack valance at times. Researchers tried to theorize attitude in different ways, some tried to divide it into components and talked about affective attitude and cognitive attitude (Edwards, 1990; Thurstone, 1928). However, the most common theorizing involves a three component model of attitude also known as ABC model of attitude (Eagly & Chaiken, 1993). The ABC model proposes that attitude is comprised of affective, behavioral and cognitive components as indicated consequently by the A, B and C. Despite this multi-component theorizing, it has believed

that any particular attitude can be based and demonstrated by any one component more than another.

The affective component refers to the emotional reaction one has towards an attitude object. An attitude that is stemmed from or originally created by an emotion is called an affectively-based attitude. Attitude about hot-button issues such as politics, sex, and religion-tend to be affectively-based, as they usually come from a person's values. This type of attitude used to express and validate our moral belief or value systems. The behavioral component refers to the way one behaves when exposed to an attitude object. The third component of an attitude is the cognitive component, and it refers to the thoughts and beliefs one has about an attitude object.

A closer look at the conceptualization of each component indicates that the behavioral component of the attitude may actually be a reflection or outcome of attitude rather than its component. Researchers interested to study relation between attitude and argued on affective and cognitive components of attitude (Millar & Tesser, 1986). Therefore, a bi-factor model has used to conceptualize attitude in this research (Figure 1b) instead of the tri-factor model (Figure 1a). Similar two dimensional affective-cognitive model of attitude has also been used by other researchers (Moon et al., 2017).

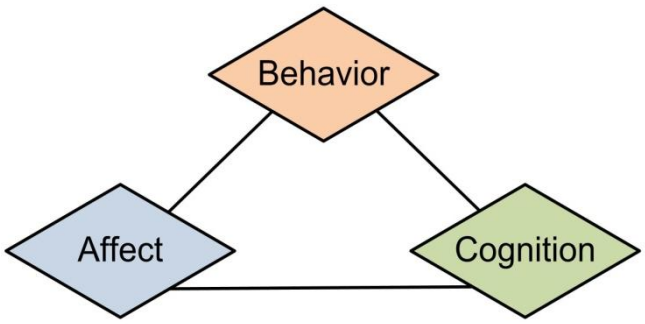

Figure 1a. Tri-factor model (Existing Conceptualization of Attitude)

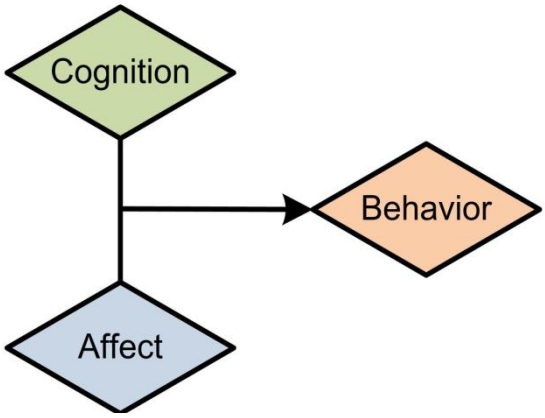

Figure 1b. Bi-factor model (Proposed Conceptualization of Attitude)

1.2 Applicability of Attitude in Treatment Seeking

Attitude intricately related to human behaviors and responses. Thus, understanding of attitude has endorsed in understanding treatment related behavior. There are several models that explains health behavior and treatment seeking such as, the Theory of Reasoned Action (Fishbein & Ajzen, 1975), the Theory of Planned Behavior (Ajzen, 1985), the Health Belief Model (Rosenstock, 1990), the Protection Motivation Theory (Rogers, 1983) and the Stages of Change Model (Prochaska & DiClemente, 1983). Attitude, either explicitly or implicitly, is an integral part of most of these models.

Both the Theory of Reasoned Action (Fishbein & Ajzen, 1975) and the Theory of Planned Behavior (Ajzen, 1985) consider attitude as a key factor in determining our health behavior. The Theory of Reasoned Action (TRA) proposes a connection between peoples' behavior, their intention to perform the behavior, their attitude toward the behavior and subjective norms regarding it. Delineated by (Ajzen, 1985), the Theory of Planned Behavior (TPB) originated as an expansion of the Theory of Reasoned Action. The TPB proposes behavioral control as an additional factor that work with attitude in determining

health behavior. The TPB model is well researched and has been used in many health programs.

Strating, van Schuur, and Suurmeijer (2006) have shown to demonstrated predictive capacity of the TPB based model focusing on attitude, social support, self-efficacy and intention on self-management of arthritis. Researchers have further worked on these two models (TRA and TPB) and integrated them into the Integrated Behavioral Model (IBM), which also incorporate attitude as a key component.

The Health Belief Model suggest that, people's engagement in health-related behavior depends on their belief on the possibility of serious consequences arising from the problem and the possibility of effectiveness of the intervention, and when they perceive few barriers to taking action (Henshaw & Freedman-Doan, 2009). Attitude towards intervention can interfere with and contribute to perception of efficacy of intervention as well as perception of barriers. Attitude along with personality traits and health beliefs has been demonstrated to predict help-seeking behavior for mental health problems among adolescents (O'connor, Martin, Weeks, & Ong, 2014).

The crucial role of attitude in understanding health behavior has particularly reflected in the studies conducted in the KAP (knowledge, attitude and practice) model. The knowledge, attitude and practice (KAP) model is one of the widely used models in the health research. The KAP model suggests that any practices (behaviors) are determinate by the person's attitude and knowledge towards the behaviors. Although strength of knowledge in changing or ensuring a specific practice is often questioned, the role of attitude in practice i.e., health behavior is well recognized.

1.3 Attitude around Mental Health and Illness

Mental health is an integral part of health, without it, health is incomplete. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2004). Mental health is the state where people can understand and utilize their ability, able to solve their problem and can be functional in everywhere (World Health Organization, 2004). These definitions refer to mental health as a sense of wellbeing, functional and confident. Mental health may affects on mind body relationship such as thought, emotion, physical reaction and activities. Physical and mental health affect each other, one cannot be well without another.

Mental illness is a compact disorder where thought, emotion and related other factors are negatively affected El magd and Al Zamil (2013). Although mental illness comes from people's complex interactions between thinking pattern, feeling, and environment, it also affect on person's mind, body and behavior in a cycling way. Mental illness diagnosed significantly according to standardized criteria proposed in Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Statistical Classification of Diseases and Related Health Problems (ICD). Diagnosed mental disorder is serious concerned issue in mental health problems. There are different types of psychiatric diseases; those classified depending on symptoms, pattern and degrees of severity. Psychiatric disorder broadly classified in to two categories psychotic and neurotic. Schizophrenia, bipolar mood disorder etc. are in psychotic group and depression, anxiety, phobia, obsessive-compulsive disorder, learning disabilities, personality disorders etc. are under neurotic group. Psychiatric disorder treated and controlled through psychiatric treatment, combination of psychiatric medication and psychotherapy. Some neurotic disorders go in

to remission and can be manage within short time however, in other cases especially the psychotic disorders, need long-term treatment. Psychiatric disorder may disrupt patient's entire life by affecting their personal, occupational, and social activities.

People with mental illness may be label and treated as a stereotyped group. Thornicroft, Rose, Kassam, and Sartorius (2007) reported that, lack of knowledge, negative attitudes and discrimination are associated with stigma. Psychiatric disorder may affect patient's life in many ways. Patient struggle with their illness and stigmatized behavior too. It has known from many studies that, people with mental illness suffered from stigmatized behavior in worldwide. Corker et al. (2013) reported that, people with psychiatric disorder struggle with stigma and discriminative behavior in England, they deprived of good facilities of quality life too. Lauber and Rössler (2007) reported that, Asian people maintain long distance with the mentally ill patient and isolate them. Patient's personal and marriage life also destroyed by stigmatized behavior. Even patient are deprived of receiving psychiatric treatment due to supernatural belief, religious view, magical approaches. Stigma negatively impact on psychiatric treatment (Sickel, Seacat, & Nabors, 2019). Negative attitude connected with stigma and treatment seeking behavior. Kim, Britt, Klocko, Riviere, and Adler (2011) reported that negative attitude of psychiatric illness is the barrier of psychiatric treatment. Stigma and discrimination are also the barrier of psychiatric treatment (Sartorius, 1998).

1.4 Mental Health Status in Worldwide and Bangladesh

Mental disorder contribute to 13% of the global burden of diseases measured as disabilities adjusted life years and thus it constitute a major public health concern (World Health Organization, 2008). Mental disorder inflict terrible morbidity, mortality, and impairment worldwide (Demyttenaere et al., 2004). Overall, prevalence of psychiatric

illness from different countries of the world is mentioned here. Approximately 26% people of United States suffer from any kind of mental illness among which, 22.3% are severe; 37.3%, moderate; and 40.4%, mild. Half of them found with two or more co-occurring diagnoses (Kessler, Chiu, Demler, & Walters, 2005). The prevalence of psychiatric illness varied from 16.7% to 19.7% respectively one month to six months in adult population of Chile (Vicente et al., 2004). In Australia the prevalence of mental illness was 17.7% among the adults, who were suffering from one or more common mental disorders (Henderson, Andrews, & Hall, 2000). 2.4 million people suffer from mental illness among 24.3 million people of Ghana in 2011 (Roberts, Mogan, & Asare, 2014). In China, the prevalence of mental disorder was 17·5%. Among them 6.1% was mood disorder, 5·6% was anxiety disorder, 5·9% was substance abuse disorder and 1·0% was psychotic disorder (Phillips et al., 2009). Psychiatric illness was 18% among adult in Nepal (Subedi, Tausig, Subedi, Broughton, & Williams-Blangero, 2004).

It has been mentioned earlier about the prevalence of psychiatric illness in Bangladesh, which is 16.8% among adult and 13.6% among child, (National Institute of Mental Health, 2019). It seemed that prevalence of mental illness is increasing day by day. It was 12.2%, among them female were higher (13.9%) than male (10.2%) and among the mental disorder, neurotic disorder was 7.0%, major depressive disorder was 4.0% and psychotic disorder was 1.2% (Karim et al., 2006). Hossain, Ahmed, Chowdhury, Niessen, and Alam (2014), reported after reviewing 32 articles that, the prevalence of mental disorders in Bangladesh varied from 6.5 to 31.0% among adults and from 13.4 to 22.9% among children. The prevalence of mental disorder was 16.5%, among them one-half suffered from depressive disorders and one-third suffered from anxiety disorders, it was found based on a rural community study (Hosain, Chatterjee, Ara, & Islam, 2007).

Although mental disorders are notable among the leading causes of disability worldwide, this is especially true for the case of low and middle-income countries where people are least resourced to bear the burdens arising from mental health conditions. Individual characteristics such as less-education, age and low income are known associates of under-treatment in mental illness (Wang, Aguilar-Gaxiola, et al., 2007). Treatment of mental illness is a burden issue in worldwide. Wang, Angermeyer, et al. (2007) reported from an analysis of data on 15 countries concluded that failures and delays in seeking help at the onset or early stage of illness is a pervasive and worldwide problems. Interventions to ensure prompt access to treatment needed to reduce the global burden of untreated mental disorders. Low perceived need and attitudinal barriers are among the major challenges in seeking and continuing treatment among individuals with common mental disorders worldwide (Andrade et al., 2014). The awareness of psychiatric problem and care for its treatment is poor in everywhere in the world, similar in Bangladesh. Beside this, there is social stigma concept attached to mental illness, which may affect negatively in help seeking behavior. (Nuri et al., 2018) reported that, patient do not go for mental health treatment earlier due to lack of knowledge of mental illness and treatment, and give less priority on mental health problem. People showed negative attitude towards taking psychiatric treatment despite of some awareness at community level (Hossain et al., 2014). People of rural community believe that mental illness happens supernaturally and is incurable; this believe interrupt their treatment seeking behavior (Selim & Satalkar, 2008).

1.5 Mental Health Service Providers in Bangladesh

Mental health service refers to, “any one of a group of government, professional or lay organizations operating at a community, state, national, or international level to aid in the prevention and treatment of mental disorders” (Myers, 2009). Depending on the state

of development of service, a range of services is available across the world for treating and preventing the mental health conditions. They may range from institutionalized service vs. community-based care, semiprofessional vs. professional service, or medical vs. non-medical service. Irrespective of the nature, all these varied forms of services target to assist an individual or group in alleviating mental health problems and its burden. In the context of Bangladesh, there are psychiatrists, clinical psychologists, counseling psychologist, educational and school psychologists, counselors, clinical social workers, substance abuse treatment practitioner, who are working on improving mental health condition. These professionals work at different model of intervention and are at different levels of development in Bangladesh. They broadly classified into two groups, non-medical service providers and medical service providers.

1.5.1 Providers of non-medical service. Non-medical service providers are those who mostly use a psychological or social model of intervention to ameliorate mental health condition. Non-medical service providers usually refer to clinical psychologist, counseling psychologist, clinical social worker, counselor, and other partially trained mental health service providers.

Clinical Psychologists. Professionals with postgraduate qualification in clinical psychology. Clinical psychologist is a mental health professional with highly specialized training in the diagnosis and psychological treatment of mental, behavioral and emotional problems and disorders. Clinical psychologists tend to work more with complex cases with mental illness but trained and engaged in intensive assessment and intervention techniques.

Educational and School Psychologist. Professionals with postgraduate qualification in educational and counseling psychology. They work mostly in educational setup but are also equipped with mental health services delivery skills.

Counseling Psychologists. Professionals with postgraduate qualification in counseling psychology having long training mostly on humanistic approach based therapy. Counseling psychologists tend to work more with healthy patients who have fewer serious psychological problems.

Clinical Social worker. Trained in social and psychological model of intervention, this includes a diverse group of individuals. They especially trained to use the social work model in the care of mental health condition.

Counselors and partially trained mental health service providers. Apart from the professionals, mentioned above, there are a group of individuals who received different levels of training on mental health and services delivery.

Non-medical service providers provide psychotherapy. Psychotherapy is an interpersonal intervention, which employs with some specific psychological techniques without medication. Among the common psychological interventions practiced in Bangladesh are Cognitive Behavior Therapy (CBT), Client Centered Therapy, Eye Movement Desensitization and Reprocessing therapy (EMDR), Transitional Analysis (TA), Dialectical Behavior Therapy (DBT), Systemic Family Therapy (SFT). Most of the work has done individual mode however, there are also group mode and family mode of intervention available in Bangladesh. Systemic Family Therapy addresses and modifies the problem through work with network of relationship and communication among the systems (most commonly family members'). Some other group modes of interventions are available which mostly focus on skill building. Mental health professionals especially those having professional qualifications often use integrative approach tailored to needs of the individual client.

1.5.2 Providers of medical service. Providers of medical service uses medical model to treat mental health condition. Medical interventions are an essential part of mental health service. Medical service provider use diagnostic model and treatment provided subsequent to it. Treatment mode involves psychiatric medication, psychosurgery and electroconvulsive therapy (ECT). Many of the medically trained service providers often provide psychological counseling when required. There are two groups of providers who uses medical intervention with psychological illness in Bangladesh, these are, i) psychiatrists and ii) medical professionals with partial training on psychiatric medication.

Psychiatrists. Professionals with post-graduate qualification i.e., FCPS, MD, MCPS or MPhil. in psychiatry. They are the expert practitioner for the diagnosis and treatment of psychiatric diseases. They provide psychiatric medication according to the particular diseases. Usually they work following integrating treatment approach which may comprised of clinical psychologists, social workers, occupational therapists and nursing staff. Psychiatrists trained by intense bio-psycho-social approach to assessment and management of mental illness but they tend to work and contribute mostly on the biological intervention.

Medical professional with partial training on psychiatric medication. Due to scarcity of psychiatrist in Bangladesh, to serve the huge population in need, there are groups of medical professionals who do not have qualification in psychiatry but have received training on psychiatric medication. They also provide medical intervention to patients with psychiatric illness.

1.6 Psychiatric Medication as a Treatment Modality

Psychiatric medication is uses for the treatment of psychiatric disorder. It also called psychotropic medication. Psychiatrist usually prescribes this medication; however, other physicians and neurologists also can prescribe this. Psychiatric medication works on brain and nervous system for reducing the psychiatric diseases and symptoms. Among the mental health services, psychiatric medication has a vital role on psychiatric treatment. For the management of some severe diseases psychiatric medication is much essential.

1.6.1 Types of psychiatric medication. There are many types of psychiatric medication for treating different types of mental illness. Some major types of psychiatric medications are mentioned here.

Antipsychotics. Antipsychotics medication used for the treatment of psychotic diseases especially for schizophrenia and bipolar mood disorder. This medication also used for the management of other psychotic symptoms such as delusions, hallucinations, paranoia and some non-psychotic disorders. This medicine usually reduces the psychosis's symptoms within short time. Some adverse effect also may happen after using this type of medicine. The common adverse effect are dizziness, drowsiness, blurred vision, rapid heartbeat, skin rashes, burning sensation, menstrual problems for women, rigidity in physical movement, muscle spasms, tremors, restlessness, weight gain and metabolic problem.

Anxiolytics (Anti-anxiety). For the management of several anxiety related disorders anxiolytics drugs needed. This category drug also used for the prevention and treatment of psychological and physical symptoms reduce. These can work fast and reduce the problematic symptoms quickly. Anxiolytics drug can be habit-forming, so it is usually

prescribe for short time uses. These medicines usually not prescribed for those people who have history of drug abuses.

Antidepressants and mood stabilizers. Antidepressants drug mainly used for the treatment of major depressive disorder. It is also used to treat other disorder such as, dysthymia, agitation, bipolar disorder, social anxiety, obsessive-compulsive disorder, chronic pain, insomnia etc. These medicines are sometimes prescribed singly and sometimes in combination with other medicine. Some common adverse effects of antidepressants medication are weight gain, drowsiness, nausea, vomiting, diarrhea, sexual problem etc.

Mood stabilizer drugs used to control mood disorders such as intense and sustained mood swing, bipolar mood disorder, abnormal activities in brain, borderline personality disorder and to manage schizoaffective disorder. There are several adverse effects of mood stabilizer drugs such as tremor, nausea, vomiting, slurred speech, irregular heartbeat, blackouts, changes in vision, seizures, hallucinations, loss of coordination, and swelling, itching, rash on skin, excessive thirst and frequent urination. Some side effects may be serious and need to manage those following psychiatrist's advice.

1.6.2 Course of action of psychiatric medication. Course of action means any sequence of activities to achieve the goal. Every medication has specific formula for its course of action. Some work rapidly and some work slowly. It may effective for short or long duration. Psychiatric medication mostly has delayed onset. Therefore, its effectiveness can be measure, only when medication uses following the instructions.

Onset of action. Onset of action is the duration of time from drug administration to its specific action or response. Generally, almost each psychiatric medication has a delayed

onset. It may take a few days to weeks to be fully effective. Some symptoms may decrease within few days and for full remission, it may need six weeks or more days. Medicine's onset of action or effectiveness depends on patient's response and the problem's severity and pattern. So its need to provide the proper information about the medicine's function and treatment process towards the patient.

Duration of action. The duration of action is the length of time, a drug remain active in the person's body. Different types of medicine have varieties duration of actions. Some medicine has long duration of action such as some specific injections. These usually used for those who are reluctant of taking medicine regularly.

1.6.3 Effect of psychiatric medication. Psychiatric medication has an important role in treating several mental disorders especially for severe psychiatric illnesses such as schizophrenia, psychotic disorders. On the other hand, psychiatric medication also has some adverse effects as other medication. All medication has positive and negative effect. It has said that, there is no effect without side effect. Usually people may have uncomfortable feelings towards any medication. Psychiatric medication is not different from that. Moreover, people seemed more concerned about this. Some people misuse some psychiatric medication for their recreation, which produce pleasurable effect. Excessive use or misuse this medicine may give wrong message and can effect negatively.

1.6.3.1 Positive effect of psychiatric medication. Medication uses in the treatment for reducing and managing the diseases. Psychiatric medication can change and save patient's life. It helps many people with mental disorders to live better life. They might suffer from serious and disabling symptoms without these medications. Especially in psychotic cases without antipsychotic medication, it is not possible to manage psychotic

problems. Antipsychotic medication usually used to treat schizophrenia, schizophrenia-related disorders and some other psychotic diseases.

1.6.3.2 Adverse effect of psychiatric medication. Adverse effect is an unexpected harmful effect that results from using medication in a treatment. The adverse effect is an additional bad function of a drug, which is undesirable. Some adverse effects may go away after a few days and some can be manage using other medication. Adverse effects may occur at the beginning of the treatment when starting the medication. Patient often discontinue the treatment when adverse effects increase. Although adverse effects are manageable but this may the common reason of discontinuation of psychiatric treatment.

1.6.3.3 Drug interaction of psychiatric medication. There is another additional effect beside the adverse effect, which called drug interaction. Drug interaction also may happen in psychiatric medication. Drug interaction can impede drug's effectiveness. It may reduce or increase the action of a drug and can cause unwanted negative effects. Antipsychotic medication may produce drug interaction when other specific drugs use simultaneously. There are three types of drug interactions such as drug-drug interaction, drug-food interaction and drug-condition interaction. Drug-drug interaction occurs between two or more drugs, with the presence of a co-prescribed drug. When co-prescribed drug alters the nature, magnitude or duration of the effect of prescribed drug, it called drug-drug interaction. Drug-food interaction interacts between a drug and a food or beverage while taking those together. Drug-condition interaction is the reaction that happens while taking a drug, having a certain medical condition.

1.6.4 Uses of psychiatric medication. Psychiatric medication used for the treatment of psychiatric illness. Medication may not fully cure all the diseases, i.e., some chronic or long-term psychotic conditions. However, it can minimize the problematic symptoms,

makes the patient feel better and functional. Some medicines relieve pain and reduce restlessness. Medication can help to control the negative thought and unusual behavior. Using psychiatric medication sometimes may feels like burden but medicine is the most effective treatment for many psychiatric illness.

Psychiatric medication works differently for different people. No medicine is equally suitable for everyone. People's age, health condition, gender etc also considered for prescribing these medications. Some peoples need small dosage or some people may need large dosage of medicine. Some patients get rid of early from the diseases; some peoples need long time and may suffer from the adverse effect of medicine. Psychiatric medication's need and effectiveness also may depend on disease's pattern and degrees of severity. Usually this medication can be use for all types of people. However, some people need to be extra attention for providing psychiatric medication such as pregnant women, children, elderly people and it should be conscious for the people with sensitive or vulnerable health condition.

1.7 Attitude towards Psychiatric Treatment and Medication

People's attitude towards psychiatric illness, mental health service and psychotropic i.e., psychiatric medication closely relates to their experience and knowledge about the concept of mental disorders, causation and treatment. Similar to any behavior, adherence to psychiatric treatment or psychiatric medication largely depends on people's attitude. Attitude towards psychiatric problem and medication may affect the treatment related behavior and in the same way, it may affect mental health professionals' prescribing and referral behavior in psychiatric illness. In general, very limited scientific attention has given on attitude towards medication. Which has been pointed out by Wahl and

Aroesty-Cohen (2010) where they found only 19 published studies on attitude towards medication over a five years publication span.

People who are connected or familiar with psychiatric medication have comparatively positive view towards the medication. Which can explain relatively positive attitude toward medication found among the mental health professionals and staffs (Basson, Julie, & Adejumo, 2014; Waddell & Taylor, 2009). Perception of the prospect of improvement and recovery has also been found to be associated with attitude (Björkman, Angelman, & Jönsson, 2008).

A cross-sectional study done to investigate the attitude towards the illness and antipsychotic medication among the patients with schizophrenia and medical and non-medical professionals involved in their treatment found that, patients were not much interested to suggest their relatives to take the antipsychotic medication (Rettenbacher, Burns, Kemmler, & Fleischhacker, 2004). However, acceptance of medication was reported among the professionals where 71.4 % of psychiatrists and 35 % of non-medical professionals reported their willingness to take antipsychotic medication themselves, if they were to suffer from schizophrenia (Rettenbacher et al., 2004). This finding indicates remarkably difference in attitude between the recipients and the professionals as well as between medical and non-medical professionals.

Patient's attitude towards psychiatric medication may influence in many ways on taking psychiatric treatment. Low insight, coerced admission and poor relationship with the provider were contributed on negative attitude towards antipsychotic medication (Day et al., 2005). Similarly, Adewuya et al. (2006) reported that, negative attitude towards medication is associated with the presence of symptoms, presence of side effects and lack of insight. However, they also mentioned that patients with schizophrenia generally have

positive attitude towards antipsychotic medications (Adewuya, Ola, Mosaku, Fatoye, & Eegunranti, 2006). Positive attitude has found towards psychotropic medication among patients with chronic psychiatric disorders and their family caregivers (Grover, Chakrabarti, Sharma, & Tyagi, 2014). Psychiatric patients have more positive attitude towards the psychotropic medication than general population which may be due to the supportive role of psychiatric medication in reducing symptoms experienced and perceived by the patients (De las Cuevas & Sanz, 2007). Many people in American population, perceive psychiatric medications as effective but they are not interested to take those due to potential problems (Croghan et al., 2003). .

Pharmacotherapy treatment using psychiatric medication is influenced by patients' as well as doctors' beliefs (Mączka, Siwek, Skalski, Grabski, & Dudek, 2010). Many psychiatrists were reluctant to prescribe clozapine, which may be due to their lack of experience and knowledge on clozapine (Nielsen, Dahm, Lublin, & Taylor, 2010). Physicians' perception and attitude, influence on prescribing psychotropic medication (Damestoy, Collin, & Lalande, 1999).

Attitude towards psychiatry can be different due to different background's knowledge. Medical students have comparatively positive attitude towards people with mental illness and psychiatry treatment than general students of different disciplines (Chung, Chen, & Liu, 2001; De las Cuevas et al., 2011; Risal, Sharma, & Sanjel, 2013; Tork & Abdel-Fattah, 2015). People's negative attitude towards psychiatry not only on psychiatric medicine, it also extends to choice of career. Despite of knowledge and positive attitude towards psychiatry, students are not much interested to choose psychiatry as career (Lyons, 2013, 2014; Niaz, Hassan, Hussain, & Saeed, 2003). Although these findings does not indicate direct negative attitude towards psychiatric medication but it is

partially expressed their negative attitude towards psychiatry by avoiding of career development in this area.

In the context of the worldwide lack of attention on researching attitude and psychiatric medication, Bangladesh is not exception of that. A few studies have done with a focus on attitude, mental illness and non-compliance with medication. Mental health is the most neglected and stigmatized branch of medical science in Bangladesh (Sarker et al., 2014). They also added that, very few amount of students want to be specialized in psychiatry. Giasuddin, Levav, and Gal (2015) showed that, upper medical student, elderly people, mother's lower academic level, upper and lower socioeconomic status and self-consultation for mental or neurological complaints are associated with increased stigma towards persons with mental disorders. More positive attitude has found in upper medical students and that was significantly associated with female gender and middle socioeconomic level affiliation. Jahan et al. (2017) reported that, patients with mentally ill have good family support but they have stigmatized beliefs about mental illness and psychiatric medicine. There are some factors associating with non-compliance of psychiatric medication and some reasons of relapse of psychiatric illness. Less education, unemployment, inadequate knowledge and thought about illness, unavailability of psychiatric services, smoking and substance using are related with non-compliance in medication among patients with schizophrenia (Akter, Mali, & Arafat, 2019). Lack of knowledge and family support, negative attitude of relatives and neighbors, non-compliance with medicine, adverse effect of medicine, unavailability of psychiatric treatment and financial crisis were found as the reasons of relapse of psychiatric illness (Akhtar, 2014).

Khan (2011) urged for carryout survey to understand attitude and knowledge towards psychotropic. He mentioned that, knowledge of mental health has an important role on people's psychiatric treatment seeking behavior. People give more priority on social issues than their biological need of medicine, in the treatment of psychiatric diseases. Due to their stigmatized behavior, they do not receive psychiatric treatment as well medication.

1.8 Impact of Attitude on Treatment Related Behavior

Attitude is associated with some treatment related behavior such as treatment seeking, compliance to treatment, referral and prescribing behavior.

1.8.1 Treatment seeking. Attitude influences on people's treatment seeking behavior along some other factors. There are some factors associated with negative attitude, which obstruct the treatment seeking such as fear of stigma, age, gender, and perceived knowledge of treatment prediction (Yamawaki, Pulsipher, Moses, Rasmuse, & Ringger, 2011). Senior citizen and female have more positive attitude towards treatment seeking (Mackenzie, Gekoski, & Knox, 2006). Women and younger people seemed to have positive attitude towards help seeking of mental health service in Japan (Yamawaki et al., 2011).

1.8.2 Compliance. Generally, treatment compliance means a person's agreement with treatment following the prescribed medication, advice and follow-up visiting with physician. Compliance may influence by person's attitude, belief, decision, personal and social circumstances etc. Attitude may have a connection with compliance of psychoactive medication. Compliance with medication is associated with the outcome of treatment and non-compliance may be one of the reasons of relapse. Thus, attitude connected with

adherence to treatment. Awad (2004), reported after reviewing a number of selected published reports during one year (from 2002); there is a significant contribution of attitude on adherence and outcome of psychiatric treatment. Awareness and distrust about illness and antipsychotic medication have negative association with adherence to psychiatric treatment (Beck, Cavelti, Kvrgic, Kleim, & Vauth, 2011).

Side effects, different belief system, poor insight, ineffectiveness of some medication, lack of care and family support are the reasons of non-compliance of treatment. Additionally, social stigma and religious view linked with non-compliance (Sharif, Ogunbanjo, & Malete, 2003). Taj and Khan (2005) reported that, lack of awareness of treatment, financial crisis, adverse effects of drugs, careless about doctor's advice and unfriendly attitude of doctors are the reasons for non-compliance with psychiatric treatment among the patients with psychiatric illness. Chandra, Kumar, Reddy, and Reddy (2014) identified the similar attitude and some factors of non-compliance of medication such as lack of knowledge of importance of medicine, denial of illness, financial burden, adverse effect of medicine, less access to treatment facilities and substance abuse. Lower educational status, living in rural area, family problem, previous history of non-compliance and poor insight, are also the reasons of non-compliance of treatment (Baby, Gupta, & Sagar, 2009). Patients' concern about prescribed medication, experience of side effects, beliefs, doubts of medication's need and negative perceptions are associated with adherence to psychiatric treatment (Clatworthy, Bowskill, Rank, Parham, & Horne, 2007). Non-adherence of medication is a common and complex barrier to effective long-term treatment of chronic psychiatric disorders. Non-adherence to treatment is the main reason of relapse in the cases of schizophrenia, among many other factors such as poor family support, stressful life events and substance use (Sariah, Outwater, & Malima, 2014).

1.8.3 Referral behavior. The referral system is a vital component in psychiatric treatment. People usually go to general physician at first for any kind of health problem. Many psychological problems exposed through somatic complain. Patient with somatoform disorders usually go to general physician for their primary care (Kisely, Goldberg, & Simon, 1997). Then physician may refer the patient according to their needs to a specialist as well psychiatrist. General physician's attitude towards mental health problem influence on their referral process to mental health services (Ross & Hardy, 1999). Psychiatrists may refer the patient to a non-medical professional of mental health service when patient needs psychotherapy. Non-medical professional also may refer the patient to psychiatrist for medication as needed. In some cases, both medicine and psychotherapy may need together for better outcome of the treatment. Therefore, physician, psychiatrist and non-medical professionals need a strong referral system for the betterment of patient. General physician may significantly contribute on referral system of mental health service (Tanielian et al., 2000). Family physicians can collaborate with mental health services by referring patient (Kates et al., 1997). Good referral system can help to make easy, to access the appropriate treatment process. People waste time by going here and there which delay or missing the appropriate treatment (Nuri et al., 2018). Appropriate referral needed for ensuring early intervention in mental health problems. In Bangladesh, direct referral system towards psychiatric treatment is often through private practitioners, general hospitals and traditional or religious healers (Giasuddin, Chowdhury, Hashimoto, Fujisawa, & Waheed, 2012). Referral behavior may influenced by people's attitude, as person's inner traits influence their behavior (Heinström, 2003). However, its need to give more attention and effort on appropriate referral system that may enhances the better treatment process.

1.8.4 Prescribing behavior. Attitude of medicine providers also influence their prescribing behavior. (Patel, Nikolaou, & David, 2003) reported that, psychiatrist's attitude towards depot medication are strongly associated with their knowledge and prescribing behavior. Patel, Haddad, Chaudhry, McLoughlin, and David (2010) showed that, psychiatrist's attitude and knowledge about antipsychotic long-acting injections, influence on prescribing this medication. Despite of effectiveness psychiatrists prescribe depot antipsychotics in a conservative way due to their attitude towards this medicine (Jaeger & Rossler, 2010). Psychiatrist's skepticism towards the outcome of treatment also associated with multiple medications prescribing and excessive doses (Ito, Koyama, & Higuchi, 2005). To improve the effectiveness of treatment, its need to inform the patients and care giver about different forms of medication and treatment process beside the medicine prescribe.

1.9 Knowledge Gap

Studies on attitude in the area of mental health treatment are limited in number. Few studies have been conducted focusing on prevalence of mental illness, experience and perception of mental health care service, beliefs on supernaturalism, referral source of psychiatric treatment service, attitudes towards psychiatry, treatment seeking, psychosocial factors of relapse, attitude towards persons with mental disorders etc. These studies conducted among general population, students, rural community, patients, and caregivers. Lack of knowledge on attitude towards psychiatric medication seemed evident. The importance of carrying out studies to understand attitude towards psychiatric medication has been mentioned by researchers in mental health field (Khan, 2011). This kind of tasks usually addressed using a quantitative perspective where structured questioner used to check fitness of ideas from international context. However, it has generally known that

when lack of knowledge exists is a form where little or no information is available on a topic, qualitative exploration serves best. To know detailed information by direct conversation with people in natural setting qualitative study is required (Creswell, 2007). Quantitative confirmatory study can be design and done afterwards based on the findings from the exploration. Therefore, the need to explore the attitude of the service recipients and the providers towards psychiatric medication afresh from the participants is essential.

High prevalence of psychiatric illness among adults and children has been reported in Bangladesh (Hossain et al., 2014; National Institute of Mental Health, 2019; World Health Organization, 2007) however, the qualified professional to provide support for them are limited. Only 0.49 mental health professionals per 100,000 people, provide mental health support. Among them 0.072 psychiatrist, 0.182 other medical doctors (not specialized in psychiatry), 0.196 nurses, 0.007 psychologists, 0.002 social workers, 0.002 occupational therapists, 0.028 other health or mental health workers (World Health Organization, 2007). Increasing access and accessibility of psychiatric medication can be a useful idea to reduce the treatment gap. Beside this, its need to increase medical service as well qualified professional. It is essential to engage the patient in psychiatric treatment and make them understand about medications' importance. Because patients' attitude is associated with health related behavior and adherence to medication (Richardson, McCabe, & Priebe, 2013). Overall, it may keep contribution for reducing treatment gap, by planning and providing suitable treatment. It may possible by understanding providers and recipients' attitude towards psychiatric medication. Therefore, exploring attitude is a current demanding issue in psychiatric treatment domain.

1.10 Research Question

The present study addressed the research question, "What the recipients and providers of mental health services think about psychiatric medication?"

1.11 Objectives of the Present Study

This study aimed at exploring attitudes of the mental health service providers and the service recipients regarding psychiatric medication. The following specific objectives drafted in line with the research question to achieve the overall objective of the study.

1. To explore attitude towards psychiatric medication among the current and prospective recipients of mental health services.
2. To explore attitude towards psychiatric medication among the multidisciplinary mental health services providers.
3. To explore similarities and differences in attitude between the providers and recipients of mental health services.

CHAPTER 2

METHOD

Method

2.1 Research Design

Present study was designed in qualitative research design. Among the different qualitative approaches, grounded theory approach seemed most suitable and useful for the present study. This approach was considered appropriate for the present study because it focuses on understanding human beliefs, experiences, behavior as they arise in their natural settings (Marshall & Lloyd, 1996). The present study was the first investigation of understanding the attitude towards psychiatric medication in Bangladesh. Therefore, grounded theory approach seemed most appropriate for this study. Grounded theory approach enabled exploration of attitudes through understanding of thoughts, feelings, knowledge, experience, practice, and other contextual aspects associated with psychiatric medication.

This study was conducted following the systematic procedures of Corbin and Strauss (2008) suggested for conduction and data analysis of grounded theory research. Grounded theory is a structured method to address current theory from a new and inductive perspective. It was hoped that the findings might help to generate a model about the process of attitude formation towards psychiatric medication among the participants.

2.2 Participants

Participants of this study comprised of mental health service providers as well as current and prospective recipients of mental health services. Maximum variation of sampling was planned to ensure inclusion of perspectives and ideas from participants with different socio-demographic and experiential characteristics. The recipient group varied in terms of age, gender, socio-economic status and types of problem. General population was

also included to include perspective of the prospective recipient for ensuring maximum variation. The providers group varied in terms of educational qualification, length of experience of dealing patient, professional background and service differentials.

2.2.1 Inclusion and exclusion criteria. The inclusion and exclusion criteria for the participants of this study have summarized below.

Inclusion criteria. Any individual who fulfils either of the following two criteria, considered eligible for inclusion as a participant.

1. Mental health service providers
2. Mental health service recipients (current or prospective)

Exclusion criteria. Exclusion criteria were set up in order to get relevant and appropriate data. Exclusion criteria for participation were as follows:

1. Age bellow 18
2. Inability to communicate
3. Lack of insight

An additional exclusion criteria was set for the provider group which was

1. Not in clinical practice for more than six months

2.2.2 Characteristics of participants. The mental health service providers group included clinical psychologist, educational and counseling psychologist, psychiatrist, general physician and partially trained professional. The recipient group included patients with neurotic condition, caregiver of patient with both neurotic and psychotic condition

and general population. Age range of participants was 18-68 years and they were from different socio-demographic status. Details on the categories of participants of this study have been presented in Table 2.1.

Table 2.1 Details of participants (N=18)

Mental health service providers (n=10)	**Mental health service recipients (n=08)**
Psychiatrist: 03 Clinical Psychologist: 02 Educational and Counselling Psychologist: 02 Partially trained mental health service providers: 02 General physician: 01 (working experience in mental health service)	Patients with neurotic condition : 03 Caregiver of patients with neurotic condition: 01 Caregiver of patients with psychotic condition: 02 General Population: 02

2.3 Sampling Procedure

Maximum variation purposive sampling technique used to enroll participants for this study. Individuals with characteristics suggested in the Section 2.2.2 were approached and invited to share their ideas, emotion, knowledge, experience and behavior related to

psychiatric medication. The service recipients were selected from mental health service centers and community. Among the mental health service centers National Institute of Mental Health (NIMH), Bangabandhu Sheikh Mujib Medical University (BSMMU) and Nasirullah Psychotherapy Unit (NPU, Project of the Dept of Clinical Psychology, University of Dhaka) were included. Mental health service recipients were selected from the service centers NIMH, BSMMU and NPU. Number of interview (i.e., participant) were decided based on the principle of maximum variation and saturation.

2.3.1 Maximum variation. To achieve a complete understanding of the topic of a study, maximum variation sampling used for including a comprehensive variation of participants (Vitcu, Lungu, Vitcu, & Marcu, 2007). For maximum variation, researchers select a small number of samples that maximize the variety of the research finding relevant to the objectives.

2.3.2 Saturation. Saturation is the particular state of data, where participants do not provide any new information about the topic, additional to those, which already provided by others. Another important level of saturation is theoretical saturation, that is obtained in the certain level where new category of concepts and their interrelation stops to emerge during analysis of data (Strauss & Corbin, 1998). Saturation can ensure the researcher about the completeness of data.

2.4 Data Collection Method

In the present study, data obtained through in-depth interview with the participants which is considered as the most common method of data collection used in grounded theory research (Corbin & Strauss, 2008; Creswell, 2007). Some additional data also collected by observation. Researcher observed participant's behavior while conducting

interview and took the note as memo. However, observation was unstructured and used as supplementary data to in-depth interview.

In-depth interview was conducted with the participants using a topic guide. Interview was conducted face to face and individually. All interviews were recorded on voice recorder to facilitate the flow of the conversation and to ensure accuracy of information for analysis the data.

2.5 Instruments

Topic guide was applied to conduct the interview. Demographic information sheet, written consent form and explanatory statement were also included for conducting the interview. Voice recorder was used to record the data.

2.5.1 Topic guide. A topic guide was developed through mind map of the topic and following the objectives of the study (sees Appendix A). Researcher then discussed with supervisor and received feedback to build the initial topic guide. The topic guide covered the main areas of exploration. It contained the broad thematic questions with necessary probes to reach in depth.

The topic guide was used for field-testing before applying for data collection. Three interviews were conducted as field-testing. Among the participants, one was professional, one was caregiver of patient with psychotic condition and another participant was from general population. Researcher then transcribed the interviews and carried out initial coding to check if the topic is being covered by the topic guide. Then researcher again received feedback from supervisor and modified the topic guide. The detailed procedure for developing the topic guide is presented below (Figure 2.1).

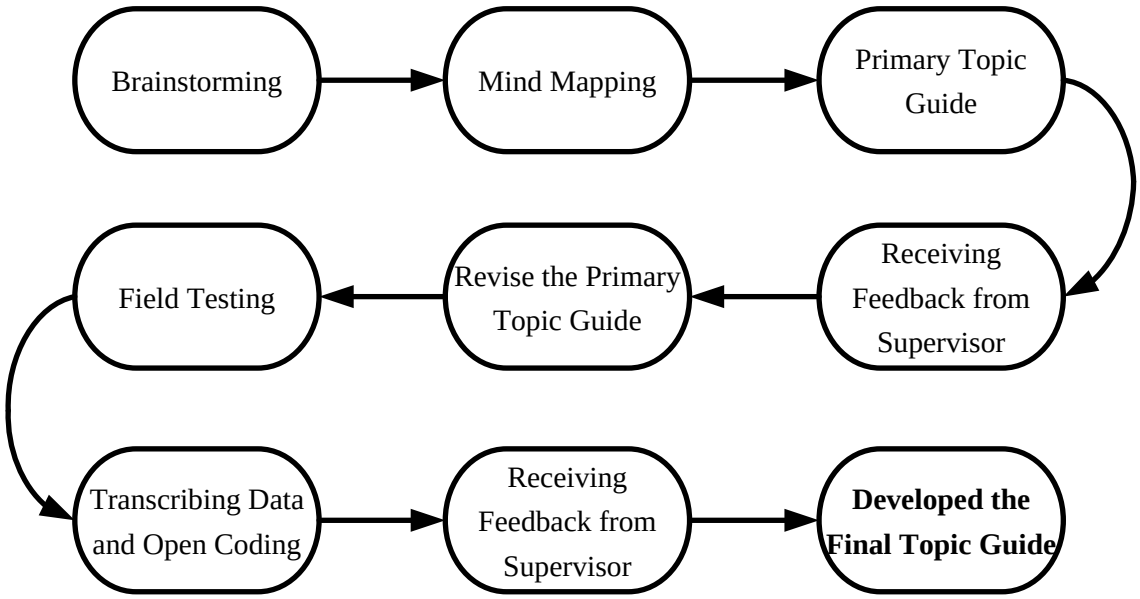

Figure 2.1 Development of the topic guide.

The questions were organized orderly in the topic guide. However, presentation of questions was, based on flow of discussion with interviewees. The question style of interview varied slightly for interview with the providers and recipients of mental health services. For recipients group interview was starts by asking some general questions regarding psychiatric problem to know their orientation about mental health issues and its treatment, which was mostly absent in providers group. They asked comparable direct and basic questions in their interview.

2.5.2 Demographic information sheet. A demographic information sheet was used to collect the basic socio demographic information such as age, education, residence, occupation, duration of attachment with mental health service, socio economical status etc. There was difference in demographic information sheet between recipient group and provider group (See Appendix B). There was also used a contact details sheet, where researcher took note the personal information of participants and other necessary thing (See Appendix C).

2.5.3 Explanatory statements. Explanatory statements prepared and provided to the participants of the present study before conducting the interview. The explanatory statements contained detailed about the nature and procedure of the present study. There mentioned some issues about the study like the goal of the study, its advantage and disadvantage, confidentiality, storage of data and uses of data for future research. The participants could understand about the research and decided to participate in the study. They were clearly informed that the participation is voluntary and they has right to stop the interview or withdraw from interview anytime they want. It was mentioned in the explanatory statements to make sure that the participants' all information will be remain confidential. Researcher's contact details was provided so that the participants could contact her to know further information about the research and findings (See Appendix D).

2.5.4 Consent form. Consent form provided to the participants to ensure that they were informed detail about the study and consented to participate in the study. Participant informed detail about voluntary involvement, confidentiality maintaining and ethical consideration issues, so that they could make an informed decision where or not to enroll in the study to continue participation. To ensure these issues participants provided the consent form (See Appendix E).

2.5.5 Voice recorder. A digital voice recorder (Sony ICD UX-533F) was used for recording the interviews and all the interviews were transcribed later in textual data.

2.6 Data Collection Procedures

Data were collected through in-depth interview with 18 participants. Mental health service recipients were selected from service centers and general populations were selected from community. Providers were contacted and invited to participate through personal

communication. Necessary permission was taken from the study sites (NIMH, BSMMU & NPU) before the start of data collection.

Participants were selected purposively based on the inclusion and exclusion criteria. Suitable participants were approached and briefly explained verbally about the purpose of the present study. Socio-demographic information sheet was provided to the interested individual for collecting demographic information, which was also used as screening form. Researcher then selected participants based on demographic information bearing in mind the concept of maximum variation. This screening was essential especially for some professionals to assess their practice experience.

Interviews were scheduled according to participants' convenience. Before conducting the interview researcher established a trustworthy relationship with the interviewee. Informed consent was obtained from the participants both verbal and written format. Except for one participant, where only verbal consent was taken due to her illiteracy. The consent form organized the issue of informed choice for participation in the present study, approval to record the interview, assurance of confidentiality and consent for second interview if needed. Each participant has provided a written explanatory statement report containing essential details. Essential socio demographic variables recorded in the data information sheet.

All the interviews were conducted face to face with the participants. The interview was conducted in mental health service centers and some other places in community. Places were selected based on participant's convenience. Interviewer tried to select comparatively suitable places in hospital area while conducting interview with mental health service recipients.

In-depth interview was conducted with the participants using the topic guide. Most interviews lasted around 30 to 50 minutes. All the interviews were recorded on digital recording equipment i.e. digital voice recorder with the permission of participants. Before recording the interview, the participants were oriented with the voice recorder. As it was an unfamiliar tool to few of them, the purpose of the record was explained to them, which reduced their hesitation towards it. Two of the participants were unwilling to allow recording their voice and withdraw their participation. Interview concluded when information was saturated. Recorded interviews were then transcribed in the form of text document. The overall data collection procedure is presented in the following flowchart (Figure 2.2).

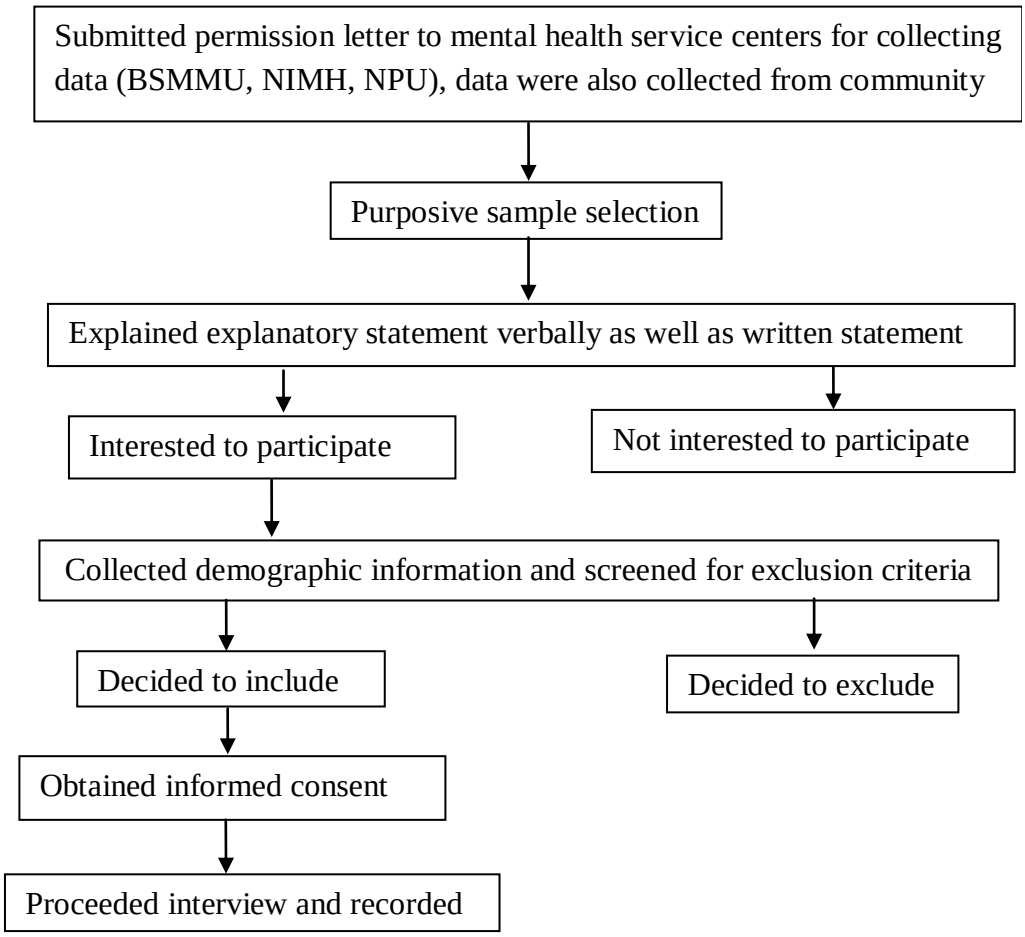

Figure 2.2 Data collection flowchart

2.7 Time Frame

Data were collected for the present study between May 2017 and August 2019. Data collection and analysis process were conducted simultaneously.

2.8 Data Analysis Procedures

In line with principles of grounded theory suggested by Corbin and Strauss (2008), data collection and analysis were done simultaneously in this research. Collection of data, coding, and memo writing were done parallel to each other. Data were analyzed using a specialized computer based program NVivo-10 (QSR International, 2012) suitable for managing qualitative data and aiding its analysis. Data collection, coding and analysis have done simultaneously.

2.8.1 Data transcription. Recorded interviews were transcribed in verbatim form. Researcher herself transcribed the interviews. To ensure adequate understanding and appropriateness of the coding the researcher repeatedly checked back and listened to the interviews from audio record.

2.8.2 Memo writing. Researcher maintained a written record i.e., memos while conducting interview and analysis the data. Memos helped in understanding and making sense of the findings.

2.8.3 Data coding. The first step of data analysis is coding, which helps to move forward from a particular statements to more abstract explanations (Charmaz, 2006). Open coding, axial coding and selective coding are the three phases of coding in grounded theory analysis (Strauss & Corbin, 1998). According to Strauss and Corbin (1998), researchers begin analysis in grounded theory with open coding, which carries categories of information, develops axial coding by interconnecting the categories and finally build a

story that connects the categories by selective coding. Data analysis in this research involved open and axial coding.

2.8.3.1 Open coding. The purpose of the open coding is to start the process of breaking down the data into concepts, which is the representation of object or events. Strauss and Corbin (1998) explained the open coding as the first step of theory building process. In open coding phase the researcher broken the data by coding primarily line-by-line, examine and review deeply, and compare with each other. The codes were compared and contrasted with each other to check overlap and repetitions of concepts (Corbin & Strauss, 2008). The researcher continued this process with between the participants and categories. Researcher carried out the open coding using analytic techniques suggested by Corbin and Strauss (2008). The goal of this present open coding phase was to generate a list of categories regarding the knowledge, affect, experience, practices etc. Data were broken down into phrases and sentences, which represented participants' main ideas. Open coding helped to identify overall phenomena and produced a list of themes, which were later organized into broader categories in the axial coding phase.

2.8.3.2 Axial coding. The aim of axial coding is to structure and more deeply connect the existing categories. To understand the situation, action and their connection researchers use the axial coding in data analysis (Strauss & Corbin, 1998). Axial coding emerges from the open coding helping the researcher recognize the connection more easily. During the data analysis in the research, axial coding was started after substantial amount of open codes were generated. The goal of this phase was to relate categories and their features to one another to understand the interconnection of the different themes and associated with the core phenomenon. The researcher moved backward and forward

among the transcripts for connecting the open coding and axial coding to redefine categories to create specific relationship among them.

2.9 Ethical Considerations

The guidelines of the research ethics was maintained for conducting this study. Confidentiality of the information was ensured properly and the respondents assured about that while taking their verbal informed consent. Ethical approval were collected from the ethical review committee of the Department of Clinical Psychology University of Dhaka, bearing the project number: MP-170202 (see Appendix F) before conduction of the study. Additional ethics approvals were collected from study sites as well where necessary.

2.9.1 Informed consent. Interviewer provided the detail information verbally about the purpose and nature of the research. In addition, a written consent paper also was provided.

2.9.2 Wellbeing of the participants. Researcher was concerned about the participants' wellbeing. So, that they did not get hurt by interview process. Referral was planned to address the possibility of triggered disturbance among the participants, however, no such referrals was required.

2.9.3 Right to withdraw. Participants were informed about their right to withdraw from research interview whenever they wish. Interviewer did not insist him for interviewing. Two of the participants used this to withdraw from participation when they felt uncomfortable with voice recording.

2.9.4 Confidentiality and privacy. Participants were ensured before interview that their all information will be remain confidential which they will provide in interview for research purpose.

2.9.5 Participants' right to know the findings. Participants were informed that they have the right to know the research findings. Researchers' contact phone number was provided to them for future correspondence if they wish to know the findings.

CHAPTER 3

FINDINGS

Findings

The findings presented here are based on transcribed data from 18 in-depth interviews analyzed using NVivo-10, a computer based software program exclusively designed for qualitative data analysis. Open and axial coding were used to explore and identify the emerging themes. The findings have been organized into six broad categories and associated sub-categories (see Table 3.1).

Table 3.1 Organization of the broad categories and sub-categories of attitude towards psychiatric medication

	Broad categories	Sub-categories	Themes
1	Pre-conceived Ideas		Equating psychiatric medicine with psychiatric illness
			Medical model
			Low priority of mental health problem
			Misconceptions
2	Experience	Direct impact of medicine	Experience of effectiveness
			Experience of adverse effect
		Indirect impact of medication	Discriminatory
			Decapacitating
			Humiliating

	Broad categories	Sub-categories	Themes
3	Attitude	Emotion	Helplessness
			Reliance towards medicine
			Fear
		Cognition	Interference with non-medical treatment
			Unavoidable adverse effect
			Short-lived nature of effect
			Relative importance of medication
			Medicine second
4	Behavior	Treatment seeking	
		Compliance to treatment	
		Referral practice	
5	Facilitators of Behavior		Knowledge
			Psycho-education
			Communication
			Faith on expertise
			Multidisciplinary team
			Family influence
6	Burden		Financial burden
			Burden associated with accessibility
			Burden of adverse effect

3.1 Pre-conceived Ideas

Participants of this study reported some ideas about psychiatric medication, which commonly held in the society irrespective of their personal experience on psychiatric medication. These have been categorized and presented as pre-conceived ideas. These ideas came into four broader themes, which were equating psychiatric medicine with psychiatric illness, medical model, low priority of mental health problem and misconceptions. These pre-conceived ideas largely reflects cognitive portion of people's attitudes and are supposed to have influence on people's emotional part of attitudes towards psychiatric medication.

3.1.1 Equating psychiatric medicine with psychiatric illness. Participants reported several experience associated with stigma in psychiatric illness and they further mentioned that they feel uneasy to take medicine because of the association of medicine with psychiatric illness. This association therefore equates psychiatric medication with mental illness and the stigma associated with that. Participants reported their feeling of shame and fear of discrimination associated with psychiatric medication.

> *"When others see me taking medicine, they get confused why an apparently fit person is taking medicine; [requires to] explaining the reason [psychiatric illness] . . . . . that's why people want to get rid of medicine as soon as possible. This is a matter of shame" [Male, Patient, Neurotic]*

Association between medicine and psychiatric illness has been further demonstrated in participants' responses where the stigma of mental illness extended on the taking of medication, which is reflected in the following quotation,

> *"If I know a person is on medication, I will not go for any marital relation [for me and my family] with that person" [Female, Provider, Non-medical]*

3.1.2 Medical model. Participants' responses indicated that many people perceive medical treatment as the only treatment for mental illness. They believe only on medication and doubt on other psychological therapy process, which has expressed in the following participant's statement.

> *"Our mental illness; the caregiver family thinks that there is no other option than this [medicine]. . . . . have to be on medication, nothing can be done by lip service. . . ." [Female, Caregiver, Neurotic]*

However, some participants also expressed rejection towards medical model and unwillingness to take psychiatric medicine as reflected in the following quotation.

> *"They never opt to give medicine [for child]. Even if she talk about giving medicine, others forbid, no, do not give medicine, Follow the advices and procedures first [counseling], do not give medicine to child" [Female, General population]*

3.1.3 Low priority of mental health problem. Participants explained that the idea of mental health is nonexistence in people's mind. They cannot realize it, as it is mostly invisible, so they do not care about it much. One participant's statement expressed this message.

> *"When [we] have accident – bleeding occurs from limb, must to go to treatment. However, mental diseases are not visible, it has to feel. Therefore, people delay to go to treatment, they think to wait for ten days or five days, and then see later. I think they neglect it."[Female, General population]*

3.1.4 Misconceptions. There are some myths about psychiatric medication, which work as deterrent in taking psychiatric treatment as well psychiatric medication. People have these misconceptions regarding long-term damage, dependence etc. The service providers also confirmed the presence of this misconception from their experience. Few quotations reflecting these misconceptions are given bellow.

> *"Once started, the medicine should be continued [forever]" Female, Caregiver, Psychotic]*

Providers mentioned from their experience on the service recipients' misconception are as follows,

> *"[Patients believe] - If I take medicine, I'll be addicted on it; my sleeping hour will be increased; my behavior will be influenced; I'll be having irritable mood; I may face lack of appetite; I can't concentrate on any work; I'll be crazy; my brain will totally be damaged; I even can't recognize others; all these negative ideas people have."[Female, Provider, Non-medical]*

> *"[Patients believe] - If I start medicine for once, never can stop it. Brain will be damaged by taking mad's medicine" [Male, Medical provider]*

3.2 Experience

Participants shared their experience, which was comprised of two sub-categories direct impact and indirect impact of medicine. These two categories also included another two contents.

3.2.1 Direct impact of medicine. This sub-category revealed the information, which participants experienced directly with the medicine. Two types of direct impact of medicine were reported. One was experience of effectiveness and another one was experience of adverse effect. All providers and caregivers of patients shared from their experience that medicine has a strong effective role on overcoming the mental illness and informed about some adverse effect of medicine.

3.2.1.1 Experience of effectiveness. Participants reported about the effectiveness of psychiatric medication, which they experienced. It has the effectiveness that ensures the recipients to continue medication for psychiatric illness.

> *"I would like to stop the medicine forever; I did stop [once] and realized that there is no benefit in stopping the medicine" [Female, Caregiver, Psychotic]*

In this study, participants stated the effectiveness of the psychiatric medication in two ways. Those were labeled by speed of action and magnitude of outcome.

Speed of action. It refers to the time of starting the action of medication. Participants reported that, medicine works fast for reducing the problematic symptom. This message was revealed in the following statement.

> *"After taking medicine his unusual negative thought associated with mania went away, these issue were solved within three to four days" [Male, Provider, Non-medical]*

Few participants also reported that medicine did not work so fast for them. Among the participants, few patients with neurotic condition experienced differently.

"Actually I did not get any significant change from medicine.... In my case medicine did not work so fast" [Male, Patient, Neurotic]

Magnitude of outcome. Participants also mentioned about the magnitude of outcome of psychiatric medication. They reported that psychological problem not fully cured by medication only. According to some participants, medicine helps to overcome the psychotic problem for about fifty percent. Magnitude of outcome of psychiatric medication in psychotic cases, reflected in the following quotation.

"Improvement was seventy five percent" [Female, Caregiver, Psychotic]

Medical provider provided the information about the outcome of psychiatric medication in psychotic case and added the message of importance of psychological intervention. That was reflected in the following statement.

"In case of schizophrenia, majority - two third do not get cured. One third of them completely recover after taking medicine. For the remaining two third diseases continues to return even if they are on medication."[Male, Provider, Medical]

Some other participants of the recipient group reported that they did not get the psychiatric medication as effective. That is reflected in the following statement.

"I did not get benefit like that" [Female, Patient, Neurotic]

3.2.1.2 Experience of adverse effect. Participants shared their experiences about the adverse effect of psychiatric medication. They mentioned two types of changes due to taking psychiatric medication. Those were behavioral change and somatic change.

Behavioral change. Participants reported about some observable behavioral changes that occurred after taking psychiatric medication. These included, decreasing activity level,

slow movement, inactivity, irritation and lack of concentration. These changes are reflex in the following statement.

> *"Because of these medicines he is always inactive. [Previously] he was always a jolly, cheerful person and used to interact with everyone. But now what we see in him is persistent inactivity . . . ."[Male, Provider, Non-medical]*

Somatic symptoms. Participants also reported about some somatic symptoms of adverse effect. Those were tremor, muscle twist, dullness, lethargic, insomnia, irregular menstruation, oversleep, overweight, blurred vision and dizziness. Participants complained about these somatic changes of adverse effect, which is reflected in the following quotation.

> *"Once I took a medicine, then seemed that tremor happened on hand-leg or leg twisted" [Female, Patient, Neurotic]*

Medical providers also confirmed the idea of adverse effect of psychiatric medicine, which is reflected in the following quotation,

> *"Among the side effects extra pyramidal side effect, tremor, rigidity of hand-leg which called dystonia and some sexual problem may happen." [Male, Provider, Medical]*

3.2.2 Indirect impact of medication. Indirect impacts of the medicine as reported by the participants presented in three categories namely discriminatory, decapacitating and humiliating.

3.2.2.1 Discriminatory. The person, who takes psychiatric medication often deprived from their right. Stigmatized beliefs causes' discrimination towards them. Some of the

participants expressed about the discriminatory behaviors towards the people taking psychiatric medication, which has been reflected in their behavior that is presented in the following statement.

> *"I've been instructed to hide this information that I'm going to a psychologist, because no good person would marry me if I am seen mad" [Female, Patient, Neurotic]*

This has also been mentioned by providers that people are judged by discriminatory behavior if take psychiatric medication.

> *"There are cultural, social and family pressures. For example, even the siblings referred to this during quarrel that – you are mad, you are on medication. They also are deprived from family assets. [Female, Provider, Non-medical]*

3.2.2.2 Decapacitating. Participants talked about decapacitating belief towards taking psychiatric medication. They reported that, psychiatric medication effect on normal behavior, which decreases the level of activities and increase psychological problems. This belief reflected in the following quotation.

> *"More sleep, can't be awake, can't go to school…then I noticed much more side effect, parents would say that she/he has been quite lazy having no motivation in work."[Female, Provider, Non-medical]*

It has been found that, these beliefs also prevailed among the medical and non-medical provider before their enrolment into professional training. Their belief has changed after being educated with psychiatric knowledge. This message has been explored in the following assertion.

> *"I also used to think the same as the common people that these are dangerous kind of medicine. It cases heavy sleep, reduces speed of work, decrease intellectual ability, make people robotic, decrease capacity to think, cause inability to maintain usual social activities"[Male, Provider, Medical]*

3.2.2.3 Humiliating. This message has been found that taking psychiatric medication treated in society is a humiliating activity. Participants shared their observation in the following statement.

> *"People don't want to go to [psychiatry treatment] in our social context, the main reason is that people would say him as bad, they would criticize him….hey you are a crazy, you are going to the psychiatrist" [Female, General population]*

3.3 Attitude

What people think and how they feel about psychiatric medication that was found in attitude. Attitude was a major category in this study, which is built by two sub-category emotion and cognition. Emotion and cognition develop people's attitude, which reflects on their behavior. Three themes were found in emotion and five themes were found under the cognition.

3.3.1 Emotion. Emotion grows from one's circumstances, experience or mood. Negative emotion or affect is the experience of negative feeling such as shame, fear, threat, anger, frustration etc. The emotional responses to medicine that have found in this study include helplessness, reliance towards medicine and fear of uncontrollability.

3.3.1.1 Helplessness. People feel helplessness in using psychiatric medication. As psychiatric medication is important to treat psychiatric illness, it cannot be stopped and at

the same time, it is cumbersome to continue its use. This make them feel bounded to take psychiatric medication especially in psychotic cases. Caregiver of patient with psychotic condition expressed their feeling of helplessness in the following quotation.

> *"There is no peace whether taking medicine or not taking medicine . . . . . This pain, so much medicine, how long he will continue? It has been so long, it has been ten years. [Female, Caregiver, Psychotic]*

3.3.1.2 Reliance towards medicine. Participants mentioned about the reliance on medication in two ways, firstly they mentioned their reliance in terms of its usefulness and secondly in terms of its dependability.

Usefulness. Psychiatric medication is much effective for psychotic diseases. Without medication, psychotic illness cannot be manageable. Patient can live a better life with the help of psychiatric medication, which is reflected in the following quotation.

> *"I'm okay with it because I've observed when he doesn't take psychiatric medicine for one to two days, then he shows different behavior…what a restless condition! Totally agitated!....." [Female, Caregiver, Psychotic]*

*Dependability***.** Some patients rely on psychiatric medication as if they are dependent on it. They do not want to stop it. This message is indicated in the following quotation,

> *"My father also became addicted on medicine. He thinks he is well due to taking medicine, so he does not want to go to visit doctor. He is worried that doctor may stop the medicine. He believes that, he is only fine as long as he is taking medicine" [Male, Caregiver, Neurotic]*

3.3.1.3 Fear. Participants reported about their fear regarding uncontrollability and adverse consequences of using psychiatric medication. This is reflected in the following quotations.

> *"Do not want to take medicine due to the fear of the unknown consequences, deterioration of child's condition, initiation of additional problem" [Female, General population]*

The providers mentioned about the patients' fear on medicine as reflected in the following quotation,

> *"[Patients believe] - I will become dependent on it if I continue [the medicine] regularly" [Female, Provider, Non-medical]*

One of the providers mentioned about her fear regarding using psychiatric medication in relation to losing control over medicine.

> *"I personally [believe] that it's better not to take medicine. I meant, being okay without taking it . . . . What if I get used to – I become dependent on it!" [Female, Provider, Non-medical]*

3.3.2 Cognition. People's knowledge comes from both of preconceived ideas and experience, which helps to develop their attitude. Interference with non-medical treatment, unavoidable adverse effect, short-lived nature of effect, relative importance of medication, medicine second all these five concepts were found in cognition component of attitude.

3.3.2.1 Interference with non-medical treatment. Using psychiatric medication can affect negatively on people's thought. Medicines can hampers on psychotherapeutic process. Non-medical providers felt discomfort while patients take medicine

simultaneously with psychotherapy. There were three specific ideas regarding this interference, which were, patient's expectation regarding quick recovery, perceived challenge in responding to queries on medication. However, the providers also expressed positive impact of this associated with suppression of symptoms due to medication.

When patients are on psychiatric medication, they experience quick recovery for dominant symptoms, and that often creates expectation for quick recovery in psychological intervention as well. This message expressed in the following quotation of non-medical service provider.

> *"Sometimes it feels threatening. I mean I start feeling bad due to over-expectation from the client. [The client] expects from me that, my treatment also will be completed as quickly as the medicine [treatment]". [Female, Provider, Non-medical]*

One of the non-medical providers mentioned his uneasiness due to lack of adequate knowledge on medication and this uneasiness extend to patients on medication. When patients quarry something about medicine it is difficult to respond which reflected in the following quotation.

> *"I felt obstacle to work with them initially. Because sometimes they show me the medicine list and want to know the reason of uses that medicine. So in that case I feel that it's my barrier, I have poor knowledge on this" [Male, Provider, Non-medical]*

The providers also expressed idea that the medication expedites the psycho-therapeutic process by suppressing the symptoms due to using medication. Medication stabilizes the patients for therapeutic session. It gives comfortable feeling to non-medical

provider to work with the patient who takes medicine. This is reflected in the following quotation.

> *"Depression, if that is very long term [severe] - if it'd PTSD or any acute stress - going through some severe stress - in that case if the person becomes a bit normal after taking medicine we can communicate better with them." [Female, Provider, Non-medical]*

3.3.2.2 Unavoidable adverse effect. Participants discussed about some unavoidable adverse effect of using psychiatric medication from their experience and knowledge. Participants expressed their negative thought towards unavoidable adverse effect of using psychiatric medication. Some participants' thoughts of unavoidable adverse effect reflected in this following quotation.

> *"I used one medication – [it] started tremor in my limbs" [Female, Patient, Neurotic]*

> *"These medicines causes weight gain, increased sleep" [Male, Patient, Neurotic]*

Providers also reported about the adverse effect of the psychiatric medication.

> *"As far as we know – there are some common issues, weight gain, increased appetite, disturbances in sleep, dryness in mouth, burning sensation on skin, hot flashes and many other issues. [Male, Provider, Non-medical]*

3.3.2.3 Short-lived nature of effect. Participants talked about the short-lived nature of effect of psychiatric medication. They said that, this medicine works as short-term relief. It does not cure; it should be maintained long time otherwise problematic symptoms may relapse. When patients continue the medicine they feel well and when they

discontinue, they feel unwell. Both recipients and providers reported similar message. Some selected quotation presented bellow, where short-lived nature of psychiatric medication reflected.

> "*She was well as long as she took medicine. Whenever she stopped medicine she felt bad again."[Female, Caregiver, Neurotic]*

Both of medical and non-medical providers also mentioned about the short-lived nature of effect of psychiatric medication. Few selected examples as follows:

> *"There are the severe illnesses – they rarely get completely cured. They stay well for some time when they are on medication and then it returns. [The symptoms] may even return while they are on medication" [Male, Provider, Medical]*

3.3.2.4 Relative importance of medication. Participants' belief regarding patients' need for medicine depends on the nature and severity of disorder. Providers and caregivers of patients with psychotic condition reported about the relative importance of medicine (for e.g., schizophrenia).

> *"Medicine is needed for whole life in the cases of schizophrenia and bipolar mood disorder. Medicine also needed for severe OCD, depression, anxiety and suicidal attempt" [Female, Provider, Non-medical]*

However, participants also think that, there is no need to medical treatment for some psychological problem. One of the participants of provider group shared her thought in the following statement.

> *"Medicine is not required for all kind of disorder. For example, phobia, panic attack does not need it. It can overcome by therapeutic process" [Female, Provider, Non-medical]*

3.3.2.5 Medicine second. As mentioned earlier, participants reported about relative importance of medicine according to severity of disease, however, a perception for choosing non-medical treatment at the first place also mentioned. Although this does not reflect a direct negative attitude towards medication, it may however, be considered as a likely outcome of it.

> *"If anyone says about mental problem, I'd rather suggest him to go to psychological service center first, not for medication." [Female, Patient, Neurotic]*

Some participants think that only psychological intervention is enough for mental health problems, they also mentioned the ineffectiveness of psychiatric medication. Their thought reflected in the following quotation.

> *"The medicine that is used for mental [illness] is a temporary remedy, this is not a solution. It just keeps [the person] weak . . . . he/she does not need any medicine [Female, Caregiver, Neurotic]*

3.4 Behavior

This category was comprised of three sub-categories those were treatment seeking behavior, referral practice and compliance behavior towards medicine. People behave, according to their emotion and cognition towards the thing. Attitude influences on their treatment seeking behavior as well treatment compliance behavior.

3.4.1 Treatment seeking. Participants reported that mental health awareness did not develop due to lack of adequate information. They do not know where the service available or where to go for the treatment. Therefore, people do not seek the treatment or receive mental health service. These mentioned in the following quotations.

> *"When information will be available to people then they will go to treatment, they will seek that they need treatment. Many people do not know that psychiatry treatment is available" [Male, Provider, Medical]*

Even they do not think about mental illness seriously. People usually neglect mental health issue and ignore its treatment, as mental health problem is not visible. Their neglected behavior reflected in the following statement towards seeking treatment.

> *"We do not want to take medicine because of our social context. We want to wait and seen for six months – one year then we think it will be recovered automatically with age [Female, General population]*

3.4.2 Compliance to treatment. Compliance is a behavior in which patient follow the treatment instructions from the doctor. In this study, participants informed that due to outcome of medicine, psychological dependency and belief on provider they comply with the psychiatric medication. For example,

> *"Those who got adjusted to the medicine, getting positive outcome and becoming functional are one who continue medicine" [Female, Provider, Non-medical]*

Faith on provider was also mentioned as a contributor to compliance, which reflected in the following quotation.

> *"I kept my faith, as [the doctor] said - the benefit would not be observed until six months and it should not be stopped for a single day in this time. As it's not been six-months I am keeping my faith on doctor" [Male, Patient, Neurotic]*

Another thing also was found which is connected with compliance behavior. Due to adverse effect, people do not want to comply with psychiatric medicine. It has revealed in some participant's statement, which is reflected in the following quotation.

> *"One of my patient who is a doctor, but he did not take medicine, cause he said that medicine has side effects, so he will not take medicine" [Female, Provider, Non-medical]*

3.4.3 Referral practice. When, where and how to refer a patient for mental health service, depends on one's belief, experience and choice of priority which came from their knowledge. Many non-medical providers and service recipients (neurotic patient) prefer non-medical service for mental health problems. It has been expressed on one of the participant's following quotation.

> *"When a person comes for support for mental health problems, I will send him/her for psychological consultation first. If the psychologist thinks he/she needs medicine, he/she will refer to psychiatrist [Female, Provider, Non-medical]*

However, the doctors and some caregivers of psychotic patient and general population prefer medical service. It was reflected in one caregiver of patient with psychotic condition's statement, who used to go to hospital for medical service.

> *"I will refer people to come here. Here is mental hospital, doctor will give you medicine, you will feel better" [Female, Caregiver, Psychotic]*

Participants also consider the nature and severity of the problem for referring the people for taking mental health service. It was found in the following statement.

> *"I'll refer for counseling first, if the person has neurotic symptoms and if s/he has the condition to handle own self….if not very severe, then I'll refer to counseling but if the person is psychotic, then I must refer to the psychiatrist, again if it's a case of severe neurotic having suicidal ideation, then I'll refer to psychiatrist first." [Female, Provider, Non-medical]*

3.5 Facilitators of Behavior

Six themes have been included in this category. Those were knowledge, psycho-education, communication, faith on expert, multidisciplinary team, and family influence. These themes contribute to the compliance towards psychiatric medication.

3.5.1 Knowledge. Lack of factual knowledge prevents people from taking and continuing psychiatric medication. Almost all participants said similarly in this content. Improper knowledge may result from misconception, lack of psycho-education, misinterpretation, and fear of adverse effect. The following quotations reflect some of these issues.

> *"I thought that I became well, so I stopped taking medicine. Now I can realize that I did wrong." [Male, Provider, Non-medical]*

> *"Although [medicine] reduces symptoms, slight increase in weight and sleep occurs. [they] stop taking medication due to these side effects. They think the disease is gone; actually, the recovery is not achieved rather it was in control. When the illness reappears, they go for different doctor, different medicine" [Male, Provider, Medical]*

3.5.2 Psycho-education. Lack of knowledge can be managed with use of psycho-education. Almost all providers and recipients reported that education from providers i.e., psycho-education has an important role on compliance of medicine which is reflected in the following quotation.

> *"When psychologists provide psycho-education to the patient, it works well to continue the medicine and reduce the fear" [Female, Provider, Non-medical]*

3.5.3 Communication. Several participants mentioned apparently the same thing that, communication between providers and recipients is another valuable factor, which facilitates the compliance towards medication. This message was found from their following assertion.

> *". . . . explains the medicine, discuss the advantage-disadvantage of the medicine. In that case patients continue the medicine." [Female, Provider, Non-medical]*

3.5.4 Faith on expertise. Patient's faith on expertise has an important role in continuing to take medicine. Some participants shared that they complied with the medicine because of doctor's advice despite feeling disturbance in taking the medicine. They belief doctors know better as they are the expert on this area.

> ***"****Totally I cannot rely 100% on medicine yet. I rely mostly on counseling. I view the medicine as an issue that I should not outsmart the doctor in understanding. As they are the expert on it, they said that medicine would work after long-term use so I should follow their advice and have to continue the medicine. I am doing this totally following doctor's advice." [Male, Patient, Neurotic]*

3.5.5 Multidisciplinary team. Psychiatric treatment works based on multidisciplinary team. Medical provider and non-medical provider both have important role for the success of treatment. Psychological treatment such as psychotherapy is a long treatment process. In this treatment process, rapport building between therapist and client is an important part. So patient can be motivated by the therapist comply with the psychiatric medication. Therapist's strong role towards compliance with medication has been reflected in the following quotation.

> *"Therapist [non-medical service provider] has a strong role; otherwise I would never take medicine" [Female, Patient, Neurotic]*

A non-medical provider strongly resonate the idea by stating that the therapists has strong influential role on the patients medicine related behavior as they have good relationship with the patients.

3.5.6 Family influence. Family has a strong contribution to continue or discontinue the medicine. Family member's support helps the patient to comply with medicine, which was reflex in the following report.

> *"Family has an influence [for taking medicine], some people have a tendency to follow the rules-regulation." [Female, Provider, Non-medical]*

In the same way, some participants also informed that, patients do not comply with the medicine due to lack of proper guidance and care of family members. This was reflected in the participant's statement.

> *"It involves helping to take medicine, taking care, is taking [medicine] being helped and monitored? Does s/he know? If treatment is needed? In case of no insight… [Male, Provider, Medical]*

3.6 Burden

All participants reported about the feeling of burden towards taking psychiatric medication. Sometimes medication taking is like a burden to the patient and their caregiver. Both providers and recipients of mental health service reported from their experience and observation that, some patients feel burden to take psychiatric medication for long time and regularly. Perception of burden associated with medication has been manifested in three distinct categories, namely financial burden, burden associated with accessibility and burden of adverse effect.

3.6.1 Financial burden. Participants talked about financial burden. They reported that some people feel burden because of extra expenditure to taking medicine for a long time.

> *"Whenever feel little bit well, think that it's totally wastage to spend money behind this. No need to do this anymore, I can use this money for another purpose" [Male, Patient, Neurotic]*

Medical providers also mentioned about the financial issue stating that the price of psychiatric medication is often higher than the medication of other health problems.

3.6.2 Burden associated with accessibility. Burden associated with accessibility has much influence on taking psychiatric treatment as well as medication. Participants explained about some factors, which are associated with the burden to receive the mental health service.

> *"My health condition is not good; still I come [with him]. Who will take care if [him], day by day I am getting sick due to this" [Female, Care giver, Psychotic]*

3.6.3 Burden of adverse effect. Adverse effects make the use of psychiatric medication burdensome for the users and care givers.

> *"I felt bad thinking that why I'm feeling like this! Why I can't walk? Why am I having this tremor in the limbs? Why am I becoming bed ridden?" [Female, Patient, Neurotic]*

Due to adverse effect, patients sometimes become dependent on others for their routine work, which is often burdensome for the family members. This message has been reflected in the following quotation.

> *"Even she did not want to brush her teeth after awaken. She used to say that she has no energy, she requested others to help her brush her teeth" [Female, Caregiver, Neurotic]*

CHAPTER 4

DISCUSSION

Discussion

4.1 Overall Attitude towards Medication and Related aspects

This study explored the participant's attitude towards psychiatric medication. It has been found from the findings that, attitude was a broad category which was connected with other five broad categories. These six broad categories were comprised of multiple sub-categories and themes. Among the six categories, two categories such as pre-conceived ideas and experience contributed in the formation of attitude, which in turn contributed to the behavior related to psychiatric medication. The findings also indicated two categories namely facilitators and burden, which seems to be indirect contributors of medication related behavior. The visual model was portrayed in Figure 4.1 displays the connection of attitude with other components. (See figure 4.1).

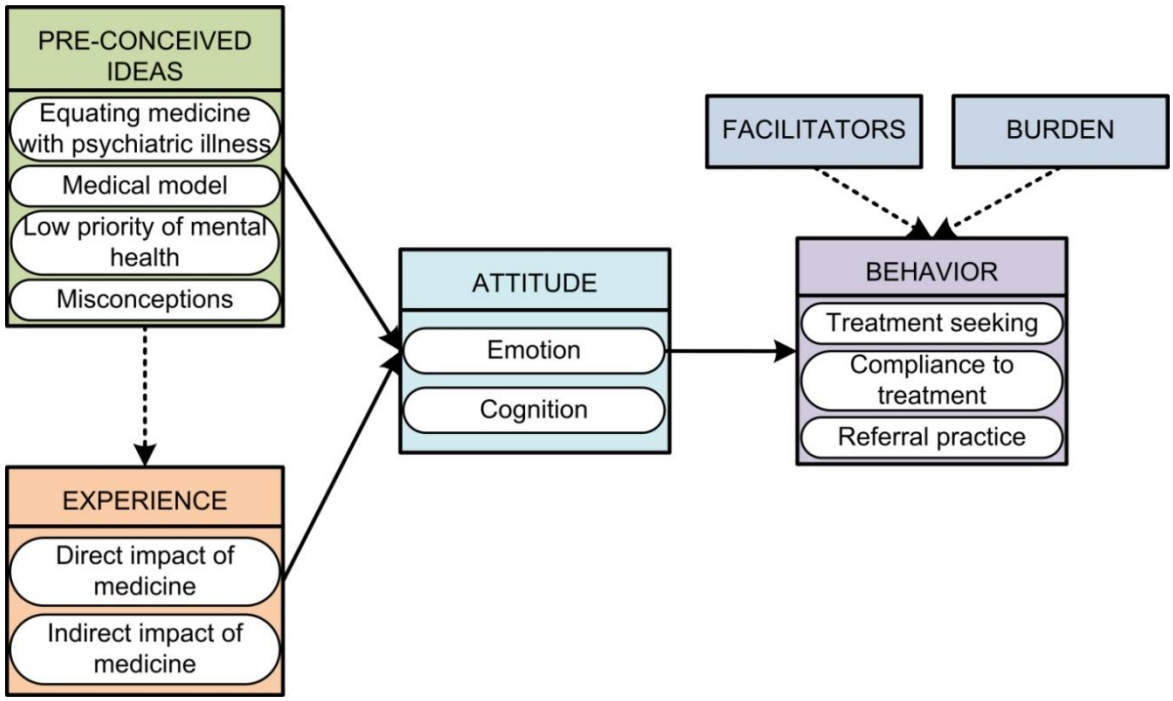

Figure 4.1. Attitude towards psychiatric medication and related factors.

Attitude has been conceptualized with a bi-factor cognitive-affective model. The findings revealed multiple other aspects associated with attitude towards psychiatric medication. People have some pre-conceived ideas including equating psychiatric medicine with psychiatric illness, reliance on medical model, low priority of mental health problem and misconceptions. Additional to these, people have personal and vicarious experiences of using psychiatric medication. These experiences expose them to direct and indirect impacts of psychiatric medication. Pre-conceived ideas and experiences initiate cognition, and produce emotional reactions and thus contribute to the formation of attitude towards psychiatric medication. Once attitude towards medication is formed i.e., specific thoughts, beliefs appears and emotions develops, the person starts to demonstrate behavioral response towards psychiatric medication. Six factors namely knowledge, psycho-education, communication, faith on expertise, multidisciplinary teamwork, and family influence have been found as the facilitators of behavior, related with psychiatric medication. Financial burden, accessibility burden and burden of adverse effect also influences the behavior associated with psychiatric medication.

The findings of the present study have been discussed in the following six broad categories namely pre-conceived ideas, experience, attitude, behavior, facilitators of behavior and burden.

4.1.1 Pre-conceived ideas. People have ideas conceived from their early experience and interaction with environment. Equating medicine with psychiatric illness, belief on medical model, low priority of mental health and misconceptions about psychiatric medication have been found as pre-conceived idea in this study. These concepts about psychiatric medication influence their medicine related behavior.

People perceive psychiatric medication in the same light with psychiatric illness. They mix up two concepts equally such as psychiatric medicine and psychiatric illness. Stigma attached with the psychiatric illness, therefore becomes associated with medication. Thus, they felt ashamed to take psychiatric medicine in front of others. They were afraid of questioning by others about taking medicine. Removal of stigma about mental illness may thus contribute to removal of stigma from psychiatric medication.

Belief on medical model, is the another pre-conceived idea where people belief only on medical treatment for mental health problems. Although non-medical treatment especially those uses psychological principles have well known for their effectiveness, people often rely on medical model. Such beliefs may contribute to positive attitude towards psychiatric medication. Studies suggests that combination of medicine and psychotherapy are effective (Lenroot, Bustillo, Lauriello, & Keith, 2003), in this context, belief in medical model can also be useful in continuing medication along with psychotherapy. Medical model is often considered among the professionals as more favorable as a treatment method for many psychiatric diseases (Beecher, 2009). Lower importance on mental health problem has been reported in the present study which is common in other places of the world despite the evidence of burden of the diseases (Herrman, 2001; Mojtabai et al., 2011). The lower concern for mental health problem may be due to the lack of visible symptoms and thus may delay treatment seeking. Various misconceptions regarding psychiatric treatment prevail among the recipients as well as among the providers. These misconceptions often shed negative ideas towards psychiatric medicine and may contribute to development of stigma around it. Stigma influence the people's attitude towards psychiatric illness and treatment (Sickel et al., 2019). Saporito, Ryan, and Teachman (2011) reported about the effectiveness of psycho-education in

reducing negative attitude towards mental illness which can be also useful to reduce negative attitude towards psychiatric treatment.

4.1.2 Experience. Participants' experiences with psychiatric medication contribute into the formation of attitude towards medication. Experience of direct impact of medicine relates to its effectiveness and adverse effect. Psychiatric medication manages the psychotic illness and improves patients' outcome. Mixed experiences were reported on the effectiveness of psychiatric medicine, which depends on the type of disorder and other contextual factors. Experiences of positive effects were especially reported for the cases of schizophrenia which was also supported by findings from international context Hunter, Kennedy, Song, Gadon, and Irving (2003). Effectiveness of medicine is well known for psychotic cases (Tandon et al., 2008) and neurotic cases (Davis, Frazier, Williford, & Newell, 2006). As patients with psychotic disorder are benefited from psychiatric treatment they seemed to have more positive attitude toward medication than other people (De las Cuevas & Sanz, 2007). Thus, the effectiveness of psychiatric medication is connected with the attitude towards medication. In the same way, adverse effects of medicine are also associated with the negative attitude and non-compliant with the medicine. However, non-compliance can be minimized by properly identifying the problem and by effectively reducing medication-induced adverse effects (DiBonaventura, Gabriel, Dupclay, Gupta, & Kim, 2012).

Apart from direct biological impacts, psychiatric medications have secondary indirect impact from interaction with family and society. Discriminatory, humiliating and decreased capacity are commonly associated with consumption of psychiatric medication (Piliavin, Rodin, & Piliavin, 1969; Weiner, Perry, & Magnusson, 1988). These indirect impacts of medicine can led to discontinuation of the treatment and can result in relapse of

the disorder (Adhikari, Pradhan, & Sharma, 2008; Sartorius, 1998). Affected individuals often have fear of being stigmatized and such self-stigma is highly associated with discontinuation of psychiatric medication (Kamaradova et al., 2016).

4.1.3 Attitude. People's attitude towards psychiatric medication is comprised of their feeling and thought towards it. These feelings and thoughts arise from the combined effects of their experiences and pre-conceived ideas.

Emotion towards medication. Helplessness, fear and reliance towards medicine have been reported by the participants. Helplessness in the form of be bounded by the unmanageability of psychiatric medicine was a concern among the participants. This concern creates worry regarding the medication. Patient's fear of becoming addicted on medicine has been found to be associated with their denial to psychiatric treatment (Vargas-Huicochea, Huicochea, Berlanga, & Fresán, 2014). Negative feeling such as fear, shame, humiliation, worthlessness and helplessness resulted from electroconvulsive therapy lead to distrust towards psychiatric staff (Johnstone, 1999). Interestingly, fear of uncontrollability of medicine has also been reported by the providers who wanted to avoid medicine in their personal life. Unnecessary fear needs to be reduced by proper knowledge and guideline. On the contrary, some participants reported their reliance on psychiatric medication due to its usefulness and dependability. Medication reduces psychotic symptoms within few days, and people rely on psychiatric medicine and continue for long time due to this immediate relief. This often becomes dependency on psychiatric medication for some patients. They continue the prescribed medicine for long days, even year after year

Cognition towards medication. Cognition is one of the key components of attitude towards psychiatric medication. Five patterns of thoughts namely interference with non-

medical treatment, unavoidable adverse effect, short-lived nature of effect, relative importance of medication and medicine second have found among the providers and recipients. Non-medical providers verbalized that, psychiatric medication interfere the therapeutic process in three ways. Those are patient's expectation regarding quick recovery, perceived challenge in responding to quarries on medication, and suppression of symptoms due to medication. Patient's expectation regarding quick recovery as medicine may hamper the natural process of therapy. Sometimes therapist perceives challenge in responding to patients' quarries regarding medication, contrary to this, medicine also can expedite the therapeutic process by suppressing the problematic symptoms in short time. The combination of medication with intensive psychotherapy has been found to be more effective in the long term than using either these separately (Cuijpers et al., 2014). Participants have mentioned about some unavoidable adverse effect of psychiatric medicine, which contribute to the development of negative attitude towards medication. All antipsychotic medications have some possible adverse effect (Muench & Hamer, 2010). Adverse effects of psychiatric medication are highly correlated with negative attitude of patients towards medicine (Karthik, Kulhara, & Chakrabarti, 2013). Participants perceived the effectiveness of psychiatric medication as short-lived as a result need to use for long days. They also have concern regarding the return of diseases or symptoms whenever they stop medicine. Perceiving medicine as the second choice is another cognition, which needs to paid careful attention. This has also been observed and reported by other (Angermeyer, van der Auwera, Carta, & Schomerus, 2017). Mostly the neurotic patient and non-medical providers reported about this. Although, selecting medicine as second choice does not indicate direct negative attitude towards medication, but it may need to consider about the outcome of medicine. They may think medicine as second choice due to adverse effect, past experience, ineffective outcome, and short-lived nature.

People's preference for non-medical treatment intervention, over medication can often be problematic and can leads to delay in accessing appropriate treatment.

Participants' attitude towards medication plays an important role in shaping their treatment related behavior. There is a significant relationship between patient's positive attitude and compliance with antipsychotic treatment (Schennach-Wolff et al., 2009). Previous research also reported that, peoples' beliefs and knowledge about mental illness and stigma influence on individuals' attitude towards mental health services (Jang, Kim, Hansen, & Chiriboga, 2007). Persons' attitude contribute more strongly on adherence to medication compared to the contribution of side effects (Mutsatsa et al., 2003).

4.1.4 Behavior. At the outset of this research medication, related behavior has conceptualized as outcome of attitude. Psychiatric treatment seeking is highly influenced by peoples' attitude towards mental illness (Angermeyer et al., 2017). The findings revealed distinct pattern of medication and treatment related behavior, which has organized under three broad themes namely, treatment seeking, compliance to treatment, and referral practice. Psychiatric treatment seeking is associated with the realization of treatment's need and appropriate information of mental health service informed by participants. Delay in seeking treatment has been connected with the lack of knowledge about mental health problems, lack of information about the place for appropriate care and lack of seriousness about mental health problem (Nuri et al., 2018). People with severe mental disorders often seek treatment from traditional healer due to easy availability and accessibility, belief on supernatural influence and socio-cultural influences (Chadda, Agarwal, Singh, & Raheja, 2001).

Some patients comply with the medicine due to psychological dependency on medicine and belief on providers' advice, which is associated with their attitude.

Compliance towards medicine has determinate by complex interplay of cost-benefit analysis around treatment, knowledge, beliefs, and surrounding circumstances. Compliance is strongly influenced by attitude towards psychiatric medication (Day et al., 2005). People, including the service providers, refuses psychiatric medicine due to concern of adverse effect about the prescribed medication which may influenced by their negative attitude towards medication. This has been supported by Clatworthy et al. (2007), who reported that intentional non-adherence is associated with patients' concerns about the prescribed medication, experience of side effects, misconception of using medication, doubts of diagnosis and need for medication. Referral practice is also associated with people's attitude, which has been explored in this study. Other researchers also found that patient referral practice among the general physicians, is associated with their attitude towards mental illness and treatment (Ross & Hardy, 1999).

4.1.5 Facilitators of behavior. Knowledge, psycho-education about psychiatric illness and medication, communication with provider, faith on expertise, role of multidisciplinary team and family influence have been found as the facilitators of treatment compliance. Similar findings was reported by Karthik et al. (2013), awareness and knowledge of illness, social support, relatives' positive attitudes towards antipsychotic medicine and treatment satisfaction are associated with positive attitudes towards treatment. Improper knowledge about using medication misleads the patient and it is one of the reasons of discontinuation of medication. Supported study by Zarea, Fereidooni-Moghadam, and Hakim (2016), improper knowledge leads patient with schizophrenia to stop medicine when they feel asymptomatic. Those, who have adequate knowledge of medicine usually are more compliant with medicine (Barnas, Hummer, & Fleischhacker, 1998; Rettenbacher et al., 2004). Psycho-education is an important phenomenon in psychiatric treatment. Psycho-education has strong contributions in the continuation of

medication, reducing unnecessary fear and reducing misconceptions of psychiatric medication, reported by participants. The role of psycho-education on improving of adherence to antipsychotic medication has also been found from another study (Eticha, Teklu, Ali, Solomon, & Alemayehu, 2015). By providing adequate psycho-education about medication, peoples' attitude towards medication can be improve, thus compliance with medication also may be enhance gradually.

Good communication between service providers and recipients, expedites the treatment process, which also increase patient's adherence to the medication. Proper communication helps to understand each other's expectations and help to enhance the compliance with the treatment (Fleischhacker, Meise, Günther, & Kurz, 1994; Oehl, Hummer, & Fleischhacker, 2000). Bahall (2019) reported that, poor patient-physician communication, language barriers and insufficient time to explanation of medication regimens influence on non-adherence to medication. Therefore, relationship between patient and physician is much important in treatment process (Meise, Günther, & Gritsch, 1992). Peoples' belief on experts facilitates their decision towards taking treatment and compliance with the medication. Some patients comply with the medication due to faith on experts' advice. There is a positive relationship between trusting on medicine provider and adherence to medicine (Hamrin, McCarthy, & Tyson, 2010). Multidisciplinary team as well non-medical service providers can contribute strongly on psychiatric treatment as well medication adherence that has been exposed in this study. Multidisciplinary team can efforts in enhancing regular follow-up, informal social support system and increasing awareness for the adherence to treatment (Tesfay, Girma, Negash, Tesfaye, & Dehning, 2013). Another strong facilitator of treatment behavior is family. Family members have a significant role on patients receiving psychiatric medication and compliance with medication. Parental attitudes have a strong contribution towards using psychiatric

medication for children (Stevens et al., 2009). Family's attitude, belief and perception about psychiatric illness and treatment, can strongly influence the decision regarding psychiatric medication (Hamrin et al., 2010).

4.1.6 Burden. Financial crisis, difficulty of treatment accessibility, and adverse effect were mentioned as burden of psychiatric treatment, in this study. Higashi et al. (2013) supported that lack of insight, attitude towards illness and medication, past experiences, substance abuse, adverse effect and lack of social support are the burden to comply with the treatment in schizophrenia.

Participants reported the psychiatric medicine as comparatively costly, which need to continue for long time. Many people cannot bear this cost and financial burden is one of the main barrier to comply with the psychiatric medication (Shoib et al., 2014). Other factors such as lack of family support, social stigma, and belief in alternative treatment also act along with the financial burden and contribute towards non-adherence (Bahall, 2019). There were some burdens of treatment accessibility found, which cause the discontinuation of psychiatric treatment such as care the patient, take their responsibility and continue treatment for long days. Treatment compliance is significantly associated with treatment access related factors, along with some other factors such as medicine related aspects, quality of interaction with therapeutic team, family support, and also their attitude towards mental illness (Lama, Lakshmi, Shyangwa, & Parajuli, 2012). Adverse effect of medicine has been found as an additional burden to the treatment recipients and the family members, which is also supported by (Taj & Khan, 2005). Adverse effect is one of the important factors associated with non-adherence (Teferra, Hanlon, Beyero, Jacobsson, & Shibre, 2013). Despite the effectiveness, some people do not want to take antipsychotic medication due to their adverse effect (Oehl et al., 2000). Management and

awareness of the adverse effect is an important concerned issue for the treatment of psychiatric medication. Providers can help by preparing and providing proper guideline, psycho-education on medication, and proper management of adverse effect.

4.2 Attitude among the Current and Prospective Recipients

The recipient group represented almost all the themes presented in the findings. They revealed the existence of the four pre-conceived ideas namely, equating psychiatric medicine with illness, belief on medical model, low priority of mental health and misconceptions about psychiatric medication.

Variations were observed among the participants regarding experience, attitude, and behavior towards medication. Medical model was preferred by caregiver of patient with psychotic condition while the patients with neurotic condition mostly preferred the non-medical treatment. Some patients and caregivers with neurotic condition equate psychiatric medicine with illness, they have misconceptions too, and few of them talked about the prevailing low priority of the mental health problems. All recipients reported on adverse effect of medicine, including some indirect impact of medication such as discriminatory, decapacitating and humiliating impact. Caregiver of patient with psychotic condition feels helplessness about continuing medicine. Fear of negative consequences and reliance towards medicine were also found among them. Short-lived nature of effect and unavoidable adverse effect were found in recipients group. Medicine is considered as second choice among most patients especially those with neurotic condition. Treatment related behavior such as, treatment seeking, compliance with treatment and referral practice were also reported by the recipients. Communication, multidisciplinary team, faith on expertise and family influence have been found as the facilitators of treatment related behavior in recipients group. Three types of burdens (financial, accessibility, and adverse

effect) have also been mentioned in their report that interfere the treatment related behavior.

4.3 Attitude among the Multidisciplinary Mental Health Services Providers

Participants of provider group reported about three pre-conceived ideas (equating psychiatric medicine with illness, low priority of mental health problem and misconceptions). Equating psychiatric medicine with illness concept was found on few providers' interview and even few of them mentioned their reluctance to make personal relation with those who takes psychiatric medicine. Some providers reported having misconceptions before being educated on psychiatry. Interference with non-medical treatment, unavoidable adverse effect, short-lived nature of effect, relative importance of medication, and medicine second concepts have also been found in their report.

4.4 Similarities and Differences in Attitude between the Providers and Recipients

Both of providers and recipients of mental health services presented similar contents regarding attitude towards medication. Among the 26 themes, most were similar except for eight themes. Four themes, which were only reported by the providers group. Those were, interference with non-medical treatment, relative importance of medication, knowledge and psycho-education. Four other themes namely medical model, helplessness, reliance towards medicine, and faith on expertise were exclusively reported by the recipient group.

There were few more themes which were primarily mentioned by the recipients from their personal experience, however, were also mentioned by the providers as their observation of the recipients. Providers mentioned that they received this knowledge from their working experience with the recipients. In this manner, the providers also shared their knowledge that the direct impacts of medicine such as experience of effectiveness and

experience of adverse effect are related with recipients' attitude and behavior towards medication. Indirect impacts of medicine (discriminatory, decapacitating, and humiliating) and the burdens (financial burden, burden associated with accessibility, burden of adverse effect) were also reported by them as related to behavior towards psychiatric treatment.

4.5 Strengths of the Study

This study properly followed the pre-planned methodological design. It has two major strengths, which are as follows.

This study explored in detailed the knowledge and attitude towards psychiatric medication using an inductive process i.e., understanding the phenomena from participants' perspective. This is unique approach considering the general practice of conducting confirmatory study without carrying out exploration indigenous ideas about the phenomenon. Use of maximum variation of sampling to incorporate wider perspectives and ideas in the data is another strength of this research. This study marks the beginning of a new but important area of research in Bangladesh.

4.6 Limitation of the Study

Although attempted, but this study could not cover the full spectrum (i.e., all variations) in participants groups particularly due to complex patterns of variation among the provider and recipient groups. One way of dealing this could be exploring attitude of only one group at a time i.e., psychiatrist, psychotherapist, or caregiver of patient with neurotic condition and then combine all the findings together to form wider understanding of the topic. However, this would be time consume and resource exhaustive.

4.7 Implication of the Study

This finding will help the providers and the current and prospective recipients of mental health services, to understand the connection and gap between knowledge and practice. It has been identified that, only knowledge cannot motivate the people for seeking psychiatric treatment and increase the adherence to medicine. Attitude towards medication is an important factor that interferes with choice and behavior related to psychiatric medication. Some other factors have been found, which are connected with attitude and thus can facilitate access to treatment. Thus, the finding of the present study may contribute in devising strategy to increase access to treatment. It may help to change the response towards psychiatric medication, which may reduce delay in accessing psychiatric intervention. Overall, this finding may be useful in further enrichment of mental health service and its access among the service recipients in Bangladesh.

Chapter 5

Conclusion and Recommendations

Conclusion and Recommendations

The present study explored attitude towards psychiatric medication among the providers and recipients of mental health services. Data on attitude towards psychiatric medication is limited in worldwide and almost nonexistent in Bangladesh. To understand the reason of treatment gap and non-adherence to psychiatric medication, this study explored the attitude from multiple stakeholders of mental health services. Psychiatrist, clinical psychologist, educational and counseling psychologist, partially trained mental health service providers, patient with neurotic condition, care giver of patient with neurotic and psychotic condition and general population were included. Grounded theory method used in qualitative design and 18 participants were interviewed in this study.

The findings were organized into 26 themes under six broad categories and seven sub-categories. Apart from understanding of cognitive and emotional components of attitude, data revealed two broad aspects namely pre-conceived ideas, and experience which were thought to contribute in the development of attitude. Behavior towards medication was separated from attitude as a consequence or manifestation of attitude. Findings revealed some facilitators of behavior as well as perceived burden that were seemingly contributing to behavior.

The findings of the present study revealed a detailed understanding of attitude towards psychiatric medication and several additional factors that are important in understanding attitude. The findings may help the mental health service providers to understand patients' attitude and need, and thus enhance accessibility to psychiatric medication. Patients' treatment seeking behavior and adherence to medication may be increased if their attitudinal factors can be addressed. The themes generated from the data may be utilized in developing strategy in the development for mental health services. This

research can consider as an initial exploration of the attitude about psychiatric medication. The findings provided several aspects of attitude towards medication that can utilize in policy making towards increasing access and utilization of medication for mental health problems, which may reduce mental health service gap in Bangladesh.

Following recommendations can be made in relation to scientific and applied utilization of the finding of this research,

1. Attention needs to be given to develop strategies to prevent people from equating medicine with mental illness. People equalize the medicine as psychiatric illness. They perceive that, medicine-taking mean becoming mad. Therefore, people avoid psychiatric medicine or discontinue the medicine even in serious illness that often results in increased burden and relapse among the patients. Future research can be designed aiming at developing strategies to minimize stigma.

2. The concept of "medicine second" which was found in this study, has the potentiality to delay referral and treatment. Further exploration is required to identify its underlying reason and ways to minimize this. People usually do not want to take psychiatric medicine at first; rather they prefer non-medical treatment such as psychotherapy or counseling. However, the prevalence of mental illness is high in Bangladesh. On the contrary, the quantity of qualified mental health service provider is very poor. It is impossible to manage the large number of patient by providing non-medical service for long days. Moreover, medicine works fast for reducing problem symptoms and its essential for the management of severe psychiatric illness, where non-medical service is secondary. Without medication, it is not possible to manage the psychotic diseases and some other severe disorders. Besides this, medicine is relatively less expensive and easier to access compared to psychological intervention. Therefore,

works need to be done to change the concept of ‘medicine second’ to effectively reduce the treatment gap.

3. Need to consider planning ways for changing perception of medicine from unsafe to sate. Careful treatment planning and ensuring proper management to reduce adverse effects of medicine is crucial.

4. The findings necessitate further confirmatory studies with specific groups of providers and recipients (i.e., psychiatrist or patient with neurotic condition) so that powerful data can be generated to contribute in policymaking.

5. Researchers, practitioner and policymakers may use the findings for designing further study to understand and address the attitude and its associated factors, which will be useful in further developing the mental health services delivery and access.

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APPENDICES

APPENDIX A

Topic Guide on the Exploration of "Attitude towards Psychiatric Medication"

1. What is mental health problem?

    What do you mean by mental illness?

    How does it recover?

2. What do you know about psychiatric treatment?

    What is your thought about psychiatric medication?

    How much it is important?

    When and for whom it need?

    How much it is essential for reducing restlessness, tension, fear etc?

    What is the advantage and disadvantage of medication?

3. Tell about the outcome of psychiatric medication.

    What is the effectiveness and adverse effect of medication?

    How do you manage the side effect of psychiatric medication?

4. How do you evaluate between psychiatric medication and physical medication?

    Is there any difference between two types of medication?

5. Share your experience of psychiatric medication.

    Self-experience or experience from observation.

    How does it effect on physical and psychological heath?

6. How do you feel (when you think of using) about psychiatric medication?

    What is your feeling towards them (people who takes medication)?

    How do you feel to communicate with them?

7. What is your opinion about using psychiatric medication?

What will be your suggestion to those people, who suffers from mental health problem?

Where do you will refer them?

Where do you will go if it is in your case?

8. Why people do not take psychiatric treatment?

   Why people do not comply with psychiatric medication?

   Why people take medicine for long time?

9. What is the experience of mental health service?

   Is there any influence of service providers' attitude on the recipients towards taking treatment?

APPENDIX B

Demographic Information Sheet

Date:		Code:				Y	M	M	D	D			

Gender: ( ) Male ( ) Female	Age:
Religion:	Monthly Family Income:
Habited: ( ) Urban ( ) Semi-Urban ( ) Rural	
Family history of mental illness: ( ) Yes ( ) No	Experience of mental illness:
Educational status of parents: Father : Mother :	
Mental health service centre: ( ) BSMMU ( ) NIMH ( ) NPU ( ) Others	
Category of participants:	
( ) Mental health service provider	( ) Mental health service recipient
Occupation: Educational Status: Professional training/degree on mental health: Duration of practice experience:	Occupation: Educational Status: Source of information about mental illness: Referred by:

Type of mostly dealing client:	Duration of problem: Types of problem: Severity of problem (0%-10%): Experience of receiving therapy: ( )Yes ( )No Type of therapy: Relation with caregiver:

APPENDIX C

Contact Details

CONFIDENTIAL

Code:				**Y**	**M**	**M**	**D**	**D**			

Name of Participants:
Mobile number:
Address:
Note:

APPENDIX D

Explanatory Statement Report

গবেষণায় অংশগ্রহনের জন্য ব্যাখ্যামূলক বিবৃতি

তারিখঃ .....

গবেষণার শিরোনামঃ মানসিক রোগের ঔষধ এর প্রতি মানসিক স্বাস্থ্য সেবা প্রদানকারী এবং গ্রহণকারীর মনোভাব।

আমি কানিজ ফাতেমা, আমার এম.ফিল. ডিগ্রীর অংশ হিসাবে ঢাকা বিশ্ববিদ্যালয়ের ক্লিনিক্যাল সাইকোলজি বিভাগের সহযোগী অধ্যাপক ডঃ মুহাম্মদ কামরুজ্জামান মজুমদার এর তত্ত্বাবধানে আমি একটি গবেষণা করছি। গবেষণার উপর ভিত্তি করে আমাকে একটি থিসিস লিখতে হবে।

গবেষণার লক্ষ্যঃ মানসিক রোগের ঔষধ এর প্রতি মানসিক স্বাস্থ্য সেবা প্রদানকারী এবং মানসিক স্বাস্থ্য সেবা গ্রহণকারীর মনোভাব কি সেটা জানা এবং এই মনোভাবের উপর যেসব উপাদান প্রভাব ফেলে তা বের করা।

কেন আপনাকে এই গবেষণায় অংশগ্রহন করতে অনুরোধ করা হচ্ছেঃ আমার জানা মতে, আপনি মানসিক স্বাস্থ্য সেবা প্রদানকারী/সেবা গ্রহণকারী, তাই মানসিক স্বাস্থ্য সেবার সাথে আপনি অতিপরিচিত। রোগীর মেডিকেল চিকিৎসা নেয়ার ব্যাপারে তথা মানসিক রোগের ঔষধ সেবন করার ব্যাপারেও আপনি গুরুত্বপূর্ণ তথ্য দিতে পারবেন বলেই আপনাকে সাক্ষাৎকারের জন্য বেছে নেয়া হয়েছে। এতে মেডিকেল চিকিৎসার বিষয়েও নানারকম তথ্য জানা যাবে এবং যা পরবর্তীতে মানসিক স্বাস্থ্য সেবার উন্নতির জন্য প্রথমিকভাবে গুরুত্বপূর্ণ অবদান রাখবে বলে আশা করা যায়।

আপনার অংশগ্রহনের আগে আমার জানা দরকার যে, আপনার বয়স ১৮ বছরের বেশী, আপনি সুস্থভাবে কথা বলতে বা তথ্য দিতে স্বক্ষম। আপনার স্মরণশক্তি স্বাভাবিক এবং আপনি এই মূহুর্তে মাদকগ্রস্থ অবস্থায় নেই। কারন তবেই আপনার দেয়া তথ্য গবেষণায় গুরুত্বপূর্ণ ভূমিকা রাখবে।

গবেষণায় যা করা হবেঃ একক সাক্ষাৎকারের মাধ্যমে আপনার কাছ থেকে তথ্য আহরন করা হবে। প্রাপ্ত তথ্য অডিও ক্যাসেট এর মাধ্যমে রেকর্ড করা হবে এবং লিখিত ভাবে সংরক্ষন করা হবে।

গবেষণায় অংশগ্রহন করলে যে পরিমান সময় দিতে হবেঃ একক সাক্ষাৎকারের জন্য আপনাকে ৩০-৬০ মিনিট সময় দিতে হবে। আপনার দেয়া তথ্যের গুরুত্ব অনুসারে পরবর্তীতে আরও এক বা একাধিক বার সাক্ষাৎকার দেয়ার প্রয়োজন হতে পারে। সেটা আপনার সাথে আলোচনা করে সময় নির্ধারণ করা হবে।

সম্ভাব্য সুবিধাঃ এই গবেষণায় অংশগ্রহন আপনাকে ব্যাক্তিগত ভাবে কোন প্রত্যক্ষ সুবিধা না দিলেও আপনার দেয়া তথ্য বাংলাদেশের মানসিক স্বাস্থ্য সেবার উন্নতির জন্য প্রাথমিক ভাবে গুরুত্বপূর্ণ অবদান রাখতে পারবে বলে আশা করা যায়।

গবেষণায় অংশগ্রহনের সম্ভাব্য অসুবিধাঃ আমি যে বিষয়ে কথা বলবো তা আপনাকে সাময়িকভাবে আবেগীয় করতে পারে বা কিছু বাস্তব সমস্যার কথা মনে করিয়ে মন খারাপ বা অস্বস্তির কারন হতে পারে। কিন্তু এই বিষয়ের জন্য আপনার দীর্ঘস্থায়ী বা মারাত্মক কোন অসুবিধা হবে না বলে মনে করা হয়। প্রয়োজনে আপনি বিএসএমএমইউ অথবা জাতীয় মানসিক স্বাস্থ্য ইনসটিটিউট এ মানসিক স্বাস্থ্য সেবা নিতে পারবেন।

গবেষণায় অংশগ্রহণ প্রত্যাহারঃ এই গবেষণায় অংশগ্রহন সম্পূর্ণরূপে আপনার ইচ্ছাধীন। গবেষণায় অংশগ্রহন করতেই হবে এমন কোন দায়বদ্ধতা নাই। আপনার যখন খুশী আপনি গবেষণায় অংশগ্রহন প্রত্যাহার করতে পারবেন। এমন কি প্রাপ্ত তথ্যের লিখিত অনুলিপি অনুমোদনের পূর্ব পর্যন্ত আপনার অংশগ্রহন প্রত্যাহার করতে পারবেন।

গোপনীয়তাঃ আপনার গোপনীয়তা রক্ষা করার বিষয়টি সর্বোচ্চ গুরুত্ব সহকারে দেখা হবে। আপনার নাম, ঠিকানা ইত্যাদি অর্থাৎ যা থেকে আপনাকে চেনা যাবে এমন তথ্য একটি আলাদা কাগজে লেখা থাকবে। এবং সেটা আপানার দেয়া সাক্ষাৎকারের তথ্য থেকে আলাদা থাকবে। কেবলমাত্র একটি সাংকেতিক চিহ্নের মাধ্যমে এদুটোকে একত্রে চেনা যাবে যা আমি ছাড়া আর কেউ জানবে না। এমন কোন তথ্য কারো কাছে যাবে না বা কোন রিপোর্টে প্রকাশ হবে না যা থেকে আপনাকে চেনা যাবে।

সংগৃহীত তথ্যের সংরক্ষনঃ সংগৃহীত তথ্যগুলো ঢাকা বিশ্ববিদ্যালয়ের নিয়মাবলী অনুযায়ী সংরক্ষণ করা হবে। প্রাপ্ত তথ্যগুলো পাঁচ বছর সংরক্ষন করা হবে। গবেষণার প্রাপ্ত তথ্য থেকে একটি থিসিস লেখা হবে, গবেষণার রিপোর্ট প্রকাশনার জন্য দেয়া হতে পারে। এক বা একাধিক মৌখিক উপস্থাপনা করা হতে পারে। কিন্তু কোনোক্ষেত্রেই অংশগ্রহণকারীর পরিচয় প্রকাশ করা হবে না।

গবেষণার ফলাফলঃ যদি আপনি গবেষণার ফলাফল সম্পর্কে জানতে চান তাহলে আমার সাথে ফোনে (০১৯২১৩৪৮১০৭) অথবা ইমেইল (kanizf22@gmail.com) এ যোগাযোগ করতে পারবেন।

আপনার সহযোগীতার জন্য ধন্যবাদ।

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কানিজ ফাতেমা

APPENDIX E

Consent Form

গবেষণায় অংশগ্রহনের জন্য সম্মতি পত্র

গবেষণার শিরোনামঃ মানসিক রোগের ঔষধ এর প্রতি মানসিক স্বাস্থ্য সেবা প্রদানকারী এবং গ্রহণকারীর মনোভাব।

এই সম্মতি পত্রটি গবেষণার রেকর্ড হিসাবে ঢাকা বিশ্ববিদ্যালয়ের গবেষকের কাছে জমা থাকবে।

আমি ঢাকা বিশ্ববিদ্যালয়ের উপরোলেখিত গবেষণায় অংশগ্রহনের জন্য সম্মতি দিচ্ছি। আমাকে গবেষণাটি সম্পর্কে বিস্তারিত বুঝিয়ে বলা হয়েছে এবং আমি এই সংক্রান্ত ব্যাখ্যামূলক বিবৃতি পড়েছি (বা আমাকে পড়ে শুনানো হয়েছে) যা আমার কাছে রেকর্ড হিসাবে রাখা আছে। আমি বুঝতে পারছি যে, সম্মতি প্রদানের মানে হচ্ছে যে-

আমি গবেষকের কাছে সাক্ষাৎকার প্রদানের সম্মতি দিচ্ছি, ☐ হ্যাঁ ☐ না

আমি সাক্ষাৎকার টি ক্যাসেটে রেকর্ড করার অনুমতি দিচ্ছি, ☐ হ্যাঁ ☐ না

আমি প্রয়োজনে পরবর্তীতে আবারো সাক্ষাৎকার প্রদানের সম্মতি দিচ্ছি, ☐ হ্যাঁ ☐ না

আমি বুঝতে পারছি যে, গবেষণায় অংশগ্রহন করা আমার স্বেচ্ছামূলক, আমি চাইলেই আংশিক বা সম্পূর্ণ অংশগ্রহন করা থেকে বিরত থাকতে পারবো। এবং গবেষণার যেকোনো পর্যায়ে আমার অংশগ্রহন প্রত্যাহার করতে পারবো। এতে আমাকে কোনোরকম ক্ষতিগ্রস্থ করা হবে না।

আমি আরও বুঝতে পারছি যে, গবেষণায় প্রাপ্ত সকল তথ্য গোপন থাকবে। এবং এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না, যা থেকে আমাকে চেনা সম্ভব।

সাক্ষাৎকারের রেকর্ড এবং তা থেকে আহরিত তথ্যের লিখিত অনুলিপি সমূহ একটি নিরাপদ স্থানে সংরক্ষিত থাকবে এবং তা কেবল মাত্র গবেষক ছাড়া অন্য কারো কাছে সহজলভ্য হবে না। এছাড়াও ৫ বছর সংরক্ষণের পর এসব তথ্য ধ্বংস করে ফেলা হবে, যদি এই তথ্য অন্য কোন গবেষণায় ব্যবহারের জন্য আমার পূর্বানুমতি না নেয়া হয়।

অংশগ্রহনকারীর নামঃ .....

স্বাক্ষরঃ .....বা টিপসই.....

তারিখঃ.....

APPENDIX F

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা-১০০০, বাংলাদেশ

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Certificate of Ethical Approval

Project Number : **MP170202**

Project Title : **Attitude towards Psychiatric Medication among the Providers and Recipients of Mental Health Services**

Investigators : **Kaniz Fatema** and **Muhammad Kamruzzaman Mozumder**

Approval Period : **16 April 2017** to **15 April 2019**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka