CHAPTER: ONE

INTRODUCTION

1.1 Background of the Study

Nepal is situated in the heart of Asia, between its two big neighbors China and India. Nepal is home to several ethnic groups. The majority of the 23 million populations reside in the countryside. Although figures on many of the health and socio-economic indicators are non-existing, some existing ones show gradual improvement over the years. However the figures for illiteracy and infant mortality are still one of the highest in the world. As per GDP, and population living below the poverty line and per capita income, Nepal still remains one of the poorest countries in the world. Less than 3 percent of the national budget is allocated to the health sector. Mental health receives insignificant attention. The Government spends about 1 percent of the health budget on mental health. There is no mental health act and the National Mental Health Policy formulated in 1997 is yet to be fully operational. Mental ill health is not much talked about because of the stigma attached. The traditional/religious healing methods still remain actively practiced, specifically in the field of mental health. The service, comprising little more than two-dozen psychiatrists along with a few psychiatric nurses and clinical psychologists (mainly practicing in modern health care facilities) has started showing its impact--however this is limited to specific urban areas. The majority of the modern health care facilities across the country are devoid of a mental health facility. The main contextual challenges for mental health in Nepal are the provision of adequate manpower, spreading the services across the country, increasing public awareness and formulating and implementing an adequate policy (WHO, 1959).

Health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. A sound mind in a sound body has been recognized as a social ideal for many centuries. Mental health is thus the balance development of the individual's personality and emotional attitudes which enable him to live harmoniously with his fellow-men (WHO, 1959).

Mental health is defined as "A state of complete physical, mental and social well-being in which the individual realizes his or her own abilities, can cope with the

normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2007) In other words, mental health involves finding a balance in all aspects of life: physically, mentally, emotionally and spiritually (Haque, Ansari, Noraini et.al., 2005). Although mental well-being is believed to be instrumental to quality living and personal growth, people often take mental health for granted and may not notice the components of mental well-being until problems and stresses surface (Mental Health America, 2010).

The Mental Health is a positive state of being in its own right and is much more than the absence of diagnosis of mental illness; low-level symptoms and unhappiness, not reaching diagnostic criteria, are associated with poorer quality of life (Thomas, Evans, Gately et.al., 2002).

Mental health is more than the absence of disease or disorder. It is a state of complete mental wellbeing including social, cognitive, spiritual and emotional aspects. Mental wellbeing is part of an individual's capacity to lead a fulfilling life, which includes the ability to study, engage in gainful work or pursue leisure interest, and to make day-to-day personal or household decisions and choices. On the other hand, mental disorders relate to symptoms that affect thinking and emotions, as well as those that relate to the relationships of individuals with family and society, often resulting in an inability to cope with the ordinary demands of life. Disturbances to one's mental wellbeing therefore compromise one's capacities in a fundamental and enduring manner (Barneys, 2006).

Mental health and mental illness can be thought of as a continuum, rather than a polarized dichotomy, with people positioned at various points depending on life events (external factors), genetic inheritance and stages of development (internal factors) (Angermeryer and Dietrich, 2006).

Studies aimed at mental health promotion and prevention have identified many strategies to maximize the public's mental health, such as increasing public awareness, improving public knowledge about mental health problems (Jarm, Barney, Christensen et.al., 2006), reducing the stigmatization and discrimination of individuals with mental health problems,(Bourget and Chenier, 2007) and enhancing public attitude towards seeking help from mental health professionals. However, any strategy intended to initiate change will have to take into consideration the range of

people's knowledge and perceptions (Mohit, 2011). In order to devise an effective mental health promotion campaign, assessing the public's knowledge and prevailing attitude would be the pre-requisites. As many of the previously-publishes studies were conducted in the west, it is important for a local study to be conducted.

Previous work has strongly supported the idea that childhood and adolescent psychopathology are predictive of poor adjustment and psychopathology in adulthood (Hofstra, Van der Ende and Verhulst 2002; Heijmens, Van der Ende, Koot et.al., 2000). Knowledge about the magnitude, expression, and course of psychiatric illness among children and adolescents is therefore important. Regarding prevalence, previous studies using psychiatric interviews reported that the rates of all disorders varied from 4.6 percent (Vikan, 1985) to 50.4 percent (Shaffer, Fisher, Dulcan et.al., 1996) with an overall rate of around 20% (Robert, Attkisson and Rosinblatt 1998; Angold and Costello, 1995).

Mental illness continues to be regarded as a unique illness that is highly stigmatized. The stigma attached to mental illness was found to be mostly associated with belief systems regarding the causes of mental illness (Karter, 2008) Many poor and unemployed people, especially the uneducated, attempt to cope with their frustrations and social problems by resorting to alcohol and other illicit drugs, making them more susceptible to mental health problems (Bhugra and Leff, 1993).

The Magnitude of mental health problem and its consequent burden upon human society is enormous. The problem is particularly troublesome in developing countries like Nepal where in the ratio of mental health professional to the population is extremely low viz. 25 psychiatrists for the population of 23 million. Apart from this, general public's view about mental illness remains largely unfavorable. The topic of mental illness itself evokes a feeling of fear, embarrassment or even disgust fostering negative attitudes towards mental illness and mentally ill people (Bhugra and Leff, 1993).

The consequence is the low psychiatric service utilization rate despite a large body of literature points towards high rate of psychiatric problem in the community as well as in hospitals (Lipwosky, 1968). Knowledge and attitude is a complex and interrelated construct. While the knowledge refers to the fact that a person knows about a subject through personal experiences, cultural practices or from others, the attitude

encompasses knowledge, experiences, personal variables and emotions related to particular topics (Hollingshed and Redlich, 1958).

1.2. Statement of the Problem

Globally 500 million people are believed to suffer from neurotic, stress-related and somatoform (psychological problem which present themselves as physical complaints). A further 200 million suffer from mood disorders, such as chronic and manic depression, mental retardation affects about 83 million, epilepsy 30 million, dementia 22 million and schizophrenia 16 million (WHO,1995).

High rates of physical illness in developing countries such as Nepal have been recognized for years and health services have emphasized the control and treatment of physical illness (World Bank, 1993). Psychological disorders, however, are also a part of the disease burden (Desjarlais, Eisenberg, Good and Kleinman, 1995).

The World Health Organization estimates that disability-adjusted life years attributed to mental illness account for 10 percent of all disability adjusted life years and that behavior-related illnesses associated with psychological disorder account for an additional 34 percent of disability years (World Bank, 1993). Despite the high prevalence of mental illness, health services largely ignore these disorders (Cohen, Kleinman and Saraceno, 2002). Health planners have little or no reliable data about the community prevalence of psychological disorders and hence no real basis for planning treatment (WHO, 2010).

People with mental disorders in Uganda experience some of the worst forms of stigma and discrimination, linked to lack of awareness, misinformation and stereotyping about their condition. Consequently, they are denied the chance to participate fully in community activities or enjoy basic social services. A belief that mental illness is contagious exacerbates and intensifies stigma and exclusion (Sujenman, 2010).

According to some respondents, members of the public often consider mentally ill people to be possessed by evil spirits or paying a price for their bad deeds. The entrenched nature of stigma against mental illness was reflected in the responses by some of the presumably well informed participants (Saraceno, 2002).

People mostly visit faith healers to seek help for their problems. People with severe mental disorders and their family members are targets of stigma and discrimination in the society. Due to the stigma attached with their problem, they hesitate to come forward for appropriate treatment even when services are accessible. According to various reports, 25-30 percent of the general population has one or more mental disorders. Very few epidemiological studies have been done so far to find out the incidence and prevalence of mental disorders in Nepal. It is estimated that the total prevalence rate of all psychiatric disorders put together exceeds more than 20 % of the total population (Cohen, 2002).

According to the Uganda Bureau of Statistics (2006), of all households with disabled members 58 percent had at least one person with a mental disorder (UNHS, 2005). Similarly, according to the teachers who were interviewed, children with mental illness are less likely to attend and continue with school. If they are already in school at the time of onset of the mental illness, chances are high that they will be forced to drop out. This was attributed to two reasons. Firstly, such children often fall victims of stigma by schoolmates and teachers, prompting them to abandon school. Secondly, the parents might not only look at them as a disgrace but have very little hope in them and believe it is a waste of money to keep them in school (Chiu, 2010).

Majority of the people in Nepal take mental disorders not as disorders or problems which could be solved or treated but as a moral weakness caused by supernatural forces like Bhoot (ghost), Boksi (witches), Mohini (black magic), Paap (sins of previous lives) or as a result of celibacy. There is an utter lack of awareness that mental disorders are treatable. There is a concept that once; a person becomes mad, her/his condition will remain the same for the rest of the life. The patients, who have recovered fully from mental disorders, also continue to be stigmatized and discriminated in their society and work places on the basis of their history. Today there are more innocent mentally ill people in the jails of Nepal, than there are in the psychiatric ward (Bhugra and Leff, 1993).

Mental illness touches on the lives of everyone. Many of us will have some kind of mental health problem at some time in our lives and we will all know someone affected by such illness. Mental illness accounts for 28 percent of the years lived with a disability in most world regions, and for 10.5 percent of the total global burden of

disease (WHO-AIMS, 2010). At a national level, antidepressants account for 7 percent of the UK's primary care drug budget; the total cost to the economy of treating people with mental health problems is greater than that for ischaemic heart disease, breast cancer and diabetes combined (Shretha, 2005).

Mental illness is a diseased condition, which is deemed undesirable for both the affected individual and the society because it affects adversely the normal functioning of the mental, psychological and emotional make-up of the individual and so it makes the capacity for insight, orientation, judgment, thought, mood and perception blurred (WHO 2001; WPA, 2002).Economic factors are one of the major problem to decrease in education and mental health so it is necessary to find out the economic factors that help to improvement in the education and mental health of the higher secondary school students.

1.3 Rationale/Significance of the Study

Mental illness touches on the lives of everyone. Many of us will have some kind of mental health problem at some time in our lives and we will all know someone affected by such illness. As the living standard of people is modernized and changing, the prevalence of mental illness has been found in increasing trend.

Majority of the people in Nepal take mental disorders not as disorders or problems which could be solved or treated but as a moral weakness caused by supernatural forces like Bhoot (ghost), Boksi (witches), Mohini (black magic), Paap (sins of previous lives) or as a result of celibacy. There is an utter lack of awareness that mental disorders are treatable. There is a concept that once; a person becomes mad, her/his condition will remain the same for the rest of the life. The patients, who have recovered fully from mental disorders, also continue to be stigmatized and discriminated in their society and work places on the basis of their history.

Not surprisingly, therefore, there is a lack of community level mechanisms to cater for the needs of people with mental disorders, and initiatives to support households affected by mental illness to cope with the socio-economic challenges they face are limited to self-help. In 1978, at the Alma Ata Conference, the "promotion of mental health" was said to be one of the eight essential parts of primary health care.

Mental health concerns everyone. It affects our ability to cope with and manage change, life events and transitions such as bereavement or retirement. All human beings have mental health needs, no matter what the state of their psyche. Mental health needs can be met in a variety of settings including acute hospital settings, primary care settings, self-help groups, through social services and of course through counseling and psychotherapy. Today there are more innocent mentally ill people in the jails of Nepal, than there are in the psychiatric wards.

Hence, a study to determine the awareness on education and mental health among higher secondary school students is very much essential as they are the future of our nation and to determine what can be done to give them correct information on mental health to prevent further increasing of mental illness and misconceptions on mental illness.

1.4 Objectives of the Study

1.4.1 General Objectives

- To find out Economic factors affecting on education level and mental health among higher secondary school students.

1.4.2 Specific Objectives

- to find out demographical relationship between education and mental health
- to find out causes and treatment of mental illness
- to find out sources of information of mental health of students
- to find out types and prevention of mental health
- to find out economic factors of students

1.5 Research Questions/Hypothesis

Economic factors effect on education level and mental health among higher secondary school students?

1.6 Limitations of the Study

Only two colleges of Kathmandu districts will be taken due to short duration of time.

Data will be collected by self-administered questionnaire and reliability fully depends upon the respondent's honesty.

Purposive sampling will be taken according to methodology.

1.7 Organization of the Study

This dissertation consists of five different chapters and those are all in sequence. The first chapter is an Introductory chapter of the Study which provides the Background of the Study, Statements of the Problems, Objectives of the Study, Rationale/Significance of the Study, Limitation of the study, Organization of the Study and Operational Definitions of Terms and Variables.

The second chapter focuses on Literature review. It describes previous studies about Theoretical and Conceptual Framework Likewise, the chapter third contains Research Method used in this Study including different Data Collection Tools.

The chapter four focuses on Analysis and Interpretation of the Result and chapter five also focus on Conclusion and Recommendations of the Study.

1.8 Operational Definitions of Terms and Variables

Level of awareness: Level of awareness means absence or presence of knowledge on mental health. For this study, level of awareness is categorized on the basis of score received by the respondents as adequate and inadequate level.

Mental health: Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects.

Mental illness: Mental illness is a disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems.

Mentally ill people: Those people who are suffering from mental illness are termed as mentally ill people.

Exposed to mass media: Those students who use any basic or common communication media like radio, TV, newspaper are exposed to mass media.

Social and traditional belief: The concept of people in beliefs like mental illness as a consequence of sins, evil spirits, witchcrafts, etc operationally included in social and traditional belief.

Occupation of parents/ guardians: It is defined as the work or activity that the student parents or guardians do for income to run the family.

Parents Education: It is defined as the academic education received by the parents

CHAPTER: TWO

REVIEW OF RELATED LITERATURE AND CONCEPTUAL FRAMEWORK

2.1 Review of Related Literature

Pandey et al. (2003) studied relationship between socio economic status and academic achievement of adolescents and found significant relationship between academic achievement and socio economic status; significant difference between academic achievement of adolescents studying in different types of school depending upon the socio economic status of parents. Varma (2003) examined the type of child rearing practices, personality and academic achievement of advantaged and disadvantaged students with the objective to find out the difference between groups with regard to personality traits, adjustment and academic achievement by taking a sample of 200 Hindu male students and found that students of advantaged and disadvantaged groups did not differ significantly on Cattell's 14 personality factors, but there was significant difference between both the groups with respect to their academic achievement; negative relationship exists between anxiety and academic achievement; intelligence was a positive predictor variable of academic achievement; feeling of security and adjustment was related to academic achievement. Kumaran (2003) studied organisational climate and academic performance with reference to the school, age, management and sex, and found that younger schools were better in academic performance; unaided private schools had better position than government corporation and aided private schools in all aspects of organizational climate and academic performance; mixed schools had better organizational climate aspects than unisex schools and also the academic performance was good in these schools**.**

Panigrahi (2005) studied academic achievement in relation to intelligence and socioeconomic status of high school students with the objective to examine the influence of intelligence and socioeconomic status on academic achievement of high school students by taking a sample of 100 students from Bhubaneshwar city of Orissa and found that there was significant and positive correlation between academic achievement and intelligence; high intelligence leads to better academic success; a low positive correlation between academic achievement and socioeconomic status;

there was no significant difference between boys and girls with respect to academic achievement. Oyesoji (2005) studied correlates of learning styles on academic performance of secondary schools adolescents and found that there existed a significant relationship between learning styles and academic performance of secondary school adolescents; three senses of learning viz. auditory, visual and kinesthetic significantly contributed to academic performance.

Sukhia (1972) studied the adjustment of students as a determinant of academic achievement with the objective to study the relationship between adjustment, socio economic status and academic achievement by taking a sample of 450 senior secondary school students and found that adjustment scores of children having high socio-economic status was highly significant with academic achievement. Pathak (1972) studied gender difference among school children in the area of adjustment by taking boys and girls of 14-16 years of age. The number of boys and girls were 200 in each group and found that boys were emotionally better adjusted than girls; overall adjustment of high achievers was significantly better than the low achievers. Tiwari et al. (1976) studied aspect of adjustment as a function of value orientation of supernormal and normal adolescents and found that adjustment among females was significant with the low economic, high aesthetic and religious value orientation; there existed no significant difference between supernormal and normal adolescents with regard to their adjustment in the field of home, health and emotional adjustment. Pandey (l977) studied the adjustment of bright and average students and found that bright and average students differed significantly in social, health, emotional and home adjustment; bright students had more social problems than average students. Dutt (1978) found that boys and girls were equally adjusted in their environment irrespective of their academic achievement; boys and girls were emotionally equally adjusted; high achievers boys and girls were better adjusted emotionally than low achiever boys and girls; there was significant effect of gender on educational adjustment; girls were better adjusted educationally as compared to boys and also high achiever boys and girls were better adjusted educationally as compared to low achiever boys and girls.

Aruna et al. (2009) studied academic achievement in relation to social phobia and socio economic status and found that there was no significant difference in the achievement of social studies for the students paired as government and private

school; management of school and social phobia were not the factors influencing the achievement in mathematics; significant difference in achievement in social studies was observed for the students paired as boys and girls, rural and urban students, and high and low socio economic status groups. This indicates that factors like gender and socio economic status were the factors influencing the achievement in social studies. Mohanty (2009) studied social correlates of academic achievement of rural underprivileged primary school girls and found that socio economic status was a potential social correlate of academic achievement; home environment had positive correlation with academic achievement in case of low achievers only; school environment failed to establish any relationship with the achievement level of high and low achievers

A research conducted by G Wolff, S Pathare, T Craig and J Leff, London showed that Most respondents (80%) knew of somebody who had a mental illness but a substantial proportion of respondents had little knowledge about mental illness. Social Control showed an association with knowledge of mental illness. Groups who showed more socially controlling attitudes (especially those over 50 years old, those of lower social class, and those of non-Caucasian ethnic origin) had less knowledge about mental illness. About two-thirds of respondents thought that other people would treat psychiatric patients negatively (usually by being wary or avoiding them). People could treat them differently, especially if children were involved Children would most probably be told to keep well away disease (Wiley, 2010).

In two identical UK public opinion surveys, little change was recorded over 10 years, with over 80 percent endorsing the statement that "most people are embarrassed by mentally ill people", and about 30 percent agreeing "I am embarrassed by mentally ill persons" (Huxley, 1993).

Family and friends may endure a stigma by association, the so-called "courtesy stigma" (Goffman, 1963). In one study of 156 parents and spouses of first-admission patients, half reported making efforts to conceal the illness from others (Phelan et al, 1998). Professionals are no different in this regard, and hide psychiatric illness in themselves or a family member.

In spite of the increased prevalence and incidence of mental health problems, mental illness is still surrounded by fear and misunderstanding and remains even now deeply

taboo. (Tudor, 1996) notes that the history of mental illness is one of exclusion, separation, distinction and otherness. It is well known that the stigma and discrimination that is associated with mental health issues add to this experience of isolation, exclusion and distress (Mental Health Foundation, 2000). The Department of Health (2003) publication Attitudes to Mental Illness observed that attitudes towards people with mental health problems are often inconsistent and contradictory. Stereotyping, that is the belief that all people in a certain group conform to an unjustifiably fixed mental picture, is widespread and often leads to prejudice expressed through intolerance and ignorance. This is compounded by media stereotypes of individuals with mental illness, who are often portrayed as violent criminals (Wiley, 2010).

In cinema and television, mental illness is the substrate for comedy, more usually laughing at than laughing with the characters (Byrne, 1997). According to the Uganda Bureau of Statistics (2006), of all households with disabled members 58% had at least one person with a mental disorder28. Similarly, physical and psychological war-related trauma accounts for major depressive disorders among 71 percent of refugees and Internally Displaced Persons. The proportions of common mental disorders among the general population are post-traumatic stress disorders (PTSD) (9%), common depression (20%), manic depression (3%), anxiety (4%), Epilepsy (3%) and Schizophrenia (1%); and these account for 20-30% of all hospital outpatient attendance (MoH Uganda, 2005). At least one in five people with mental health problems has “suicidal tendencies” and nearly one in four engage in substance abuse (Musisi, 2005). In absolute terms, an estimated 35 percent of Ugandans suffer from some form of psychiatric (mental) disorders; at least 15 percent of which require treatment (Basangwa, 2004).

The UNHS 2005 / 06 showed that in Uganda, 66.6 percent of people with mental disorders aged between six and twenty four years had their school attendance either fully or partially negatively affected by their situation, while 80.7 percent of people with mental disorders aged between 14 and 16 years have their work / employment negatively affected (UBS, 2006).

Negative attitudes to people with mental illness start at playschool and endure into early adulthood: one cohort confirmed the same prejudices on reexamination eight

years later (Weiss, 1994 Adorno et a.,l 1950) have hypothesized about the likely make-up of prejudiced people: they have an intolerance of ambiguity, rigid authoritarian beliefs and hostility towards other groups (ethnocentricity). Other studies of the attributes of those who are more likely to produce negative evaluations of stigmatized people found no relation to "conventionalism", but did report an association with a "cynical world view" (Repsy, 2010).

In a research among adolescents in Taiwan on the prevalence and changing trend of mental disorder for 3 consecutive years for overall psychiatric the most prevalent psychiatric condition was attention deficit hyperactivity disorder (ADHD) in the first 2 years and substance use disorders in the third. During the 3 years, the rates for attention deficit hyperactivity disorder (ADHD) specific phobia, and social phobia decreased, and the rates for major depression and substance use disorders, conversely, increased. Although conduct disorder, ADHD, and substance use disorders were more prevalent among boys, the rates for major depression, social phobia, specific phobia, and adjustment disorder were higher among girls (Wrasky, 2010).

Prevalence rates for attention deficit hyperactivity disorder (ADHD), specific phobia, social phobia, and separation anxiety disorder were in the range of 3%–10%, 0.3%–21.6%, 0.2%–9.3% , and 0.2%–7.2% , respectively. These childhood-onset disorders were reported to decline in rates over time during adolescence. Conversely, the rates for conduct disorder/oppositional defiant disorder (3%–5%), substance use disorders, major depression (1.3%–7.0%), and dysthymia (0.4%–8.0%) were found to increase with age during adolescence The magnitudes of conduct disorder/oppositional defiant disorder and substance use disorders have differed considerably across countries and ethnicity (Springer, 2010).

These data suggest that stigma and misinformation regarding mental illness exists, influencing preferred treatment modality and help-seeking behavior. More work need to be done to educate the public about the psychobiological underpinnings of psychiatric disorders and about the value of effective treatments. A better understanding of these disorders amongst the public would presumably lessen stigmatization and encourage the use of currently available and effective interventions (Springer, 2010).

A research conducted by Lauber G., Vladeta A.G., Fritschi N., Stulz N., and Rössler W. in Switzerland showed that most participants recognized the specific symptoms of depression. The symptoms of schizophrenia were acknowledged to a lower extent. Delusions of control and hallucinations of taste were not identified as symptoms of schizophrenia. Repeated revival of a trauma for depression and split personality for schizophrenia were frequently mistaken as symptoms of the respective disorders. Bivariate analyses demonstrated that previous interest in and a side job related to mental disorders, as well as previous personal treatment experience had a positive influence on symptom recognition. The correspondence analysis showed that male students of natural science, economics and philosophy are illiterate in recognizing the symptoms depression and schizophrenia (Lauber G., Vladeta A.G., Fritschi N., Stulz N., and Rössler W., 2005) .

A study showed that in Ethopia, Nearly three quarters of the parents identified genetic factors while approximately 20 % of them mentioned neuro-chemical disturbance as possible causes of their children's mental health problems. On the other hand, magic, curse, and sin were mentioned as causes of mental health problems by 93.2, 81.8 and 73.9 % of the parents, respectively. Externalizing behavioral symptoms like "stealing from home, school or elsewhere" and internalizing symptoms like "being nervous in new situations and easily loses confidence" were perceived by 60.9 and 38.2 % of the parents, respectively. The majority (92.7 %) of parents agreed that they would seek treatment either from religious or spiritual healers if their children developed mental illness (Abera1,M. Jeffrey, M. and Markos, T.,2015).

Similar study in China showed that correct response rates for the 20 Mental Health Knowledge Questionnaire items ranged from 19 percent to 94 percent, with a mean rate of 58%. Younger age ($r=-0.02$, $p<0.01$), higher education (r: 1.38–2.69, $p<0.01$) and higher income ($r=0.41$, $p<0.01$), were independently associated with higher Mental Health Literacy (MHL). MHL was independently associated with self-rated general health ($r=2.31$, $p<0.01$), depression ($r=-0.09$, $p<0.01$) and anxiety ($r=-0.07$, $p<0.05$) (Yu, Y. Zi-wei, L. et.al 2015).

A study was conducted in Iran showed that the mean (±SD) age was 23.5±2.8. The participants were 188 (58.1%) females and 136(41.9%) males. In response to the recognition of the disorder 115 (35.6%) students mentioned the correct answer. In

help-seeking area, 208 (64.3%) gave positive answer. The majority of affected students sought for help from their friends and parents. Stigma was the greatest barrier for seeking help. Television and Internet were the most common sources of information related to mental health (Sayarifard A, Ghadirian L, Mohit A,et.al. 2015).

A research was conducted in U.S.A. showed that the present study assessed college students' perceived benefits and barriers to obtaining mental health treatment and stigma-related attitudes via a four-page survey. A total of 682 students at one Midwestern university participated in the study. Findings indicated that females perceived a greater number of benefits to having participated in mental health services and held significantly lower stigma-related attitudes than did males. Students who had ever received mental health services reported significantly more barriers to treatment than did students who had never received services. Health professionals should target students with educational programs about positive outcomes related to receiving mental health services and work with treatment centers to reduce barriers for receiving services (Rebecca, A. V., Keith, A. Kinga, L. A., et. 2014).

2.2 Review of Theoretical Literature

The relationship between mental health and education has been explored in both the psychological literature and the economic literature. There are many small-scale studies in the psychological literature looking at the relationship between indicators of mental health and educational outcomes. The first study to examine the educational consequences of mental disorders in a national sample for the US was by Berslau et al. (2008). They find strong associations between child-adolescent mood, anxiety, substance use and conduct disorders with termination of schooling prior to each of three educational milestones (high school graduation, college entry among school graduates and completion of four years of college among college entrants). A more recent study also finding large effects(though among a broader set of disorders) is by Berslau et al. (2008). They find that the proportion of school terminations attributable to mental disorders was largest for high school graduation (10.2%) but also meaningful for primary school graduation, college entry, and college graduation. A disadvantage of these studies is that they are cross-sectional and rely on retrospective questions of 'early onset' mental health indicators. Within the psychological literature, longitudinal studies are rare. An example is the study by Fergusson and

Woodward (2002). They are find that the relationship between adolescent depression and subsequent educational underachievement could be fully explained by a range of social, familial and personal factors. Johnson, Cohen, and Dohrenwend (1999) come to a similar conclusion with regard to the association between depression/anxiety disorders and subsequent staying on decisions. The economic literature has only fairly recently begun to consider the relationship between mental health and educational outcomes. However, there are other mental health problems that become more prevalent in early adolescence such as depression. An interesting observation is that the sex difference in mental health problems is reversed in childhood and in early adolescence. For example, depression and other types of mental health problems are more prevalent in males in childhood whereas the opposite is true among adolescents and adults (Peterson et al. 1993).Globally 500 million people are believed to suffer from neurotic, stress-related and somatoform (psychological problem which present themselves as physical complaints). A further 200 million suffer from mood disorders, such as chronic and manic depression, mental retardation affects about 83 million, epilepsy 30 million, dementia 22 million and schizophrenia 16 million (WHO, 1995).

The Global Burden of Disease study estimated that the burden of disease from mental and behavioral disorders such as depression, bipolar disorder, psychosis, schizophrenia, and substance abuse would increase from 12 percent in 1990 (WHO, 2001), to close to 15 percent by 2020 (De Jong, 2002). This estimate was based in part on the projection that violent conflicts would shift from the 16th to the 8th leading cause of disease by 2020 (Baingana, 2010).

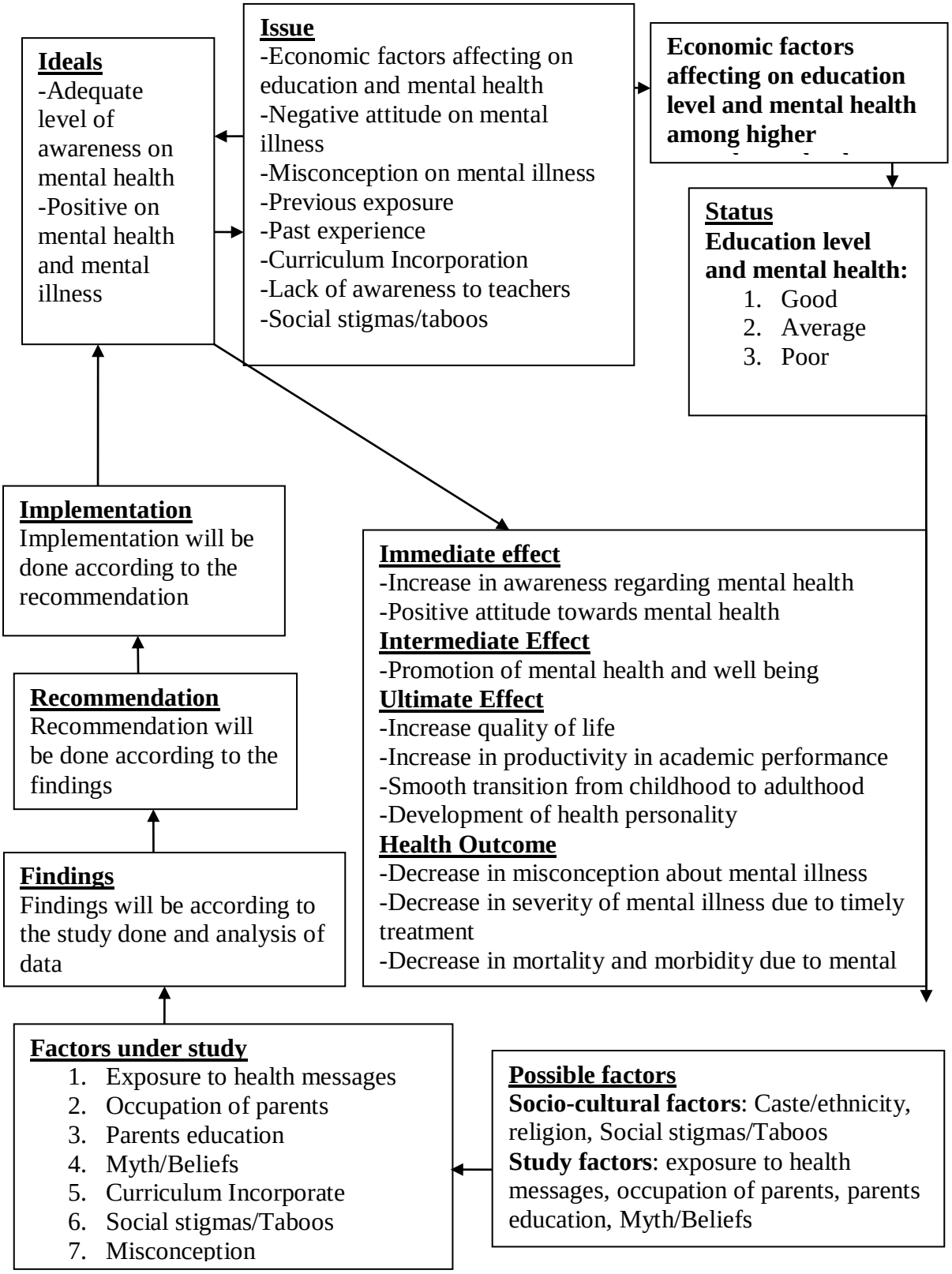
About 450 million people suffer from mental or behavioral disorder. 33 percent of the years lived with disability are due to neuropsychiatric disorders. Four of the six leading causes of years lived with disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder). Nearly 1 million people commit suicide every year. About 25 million suffer from schizophrenia. 50 million suffer from epilepsy. About 40 million or 80 percent are assumed to live in developing countries. More than 90 million suffer from an alcohol or drug-use disorder. One in four families has at least one member with a mental disorder (Mususu, 2005).

Mental illness accounts for 28 percent of the years lived with a disability in most world regions, and for 10.5 percent of the total global burden of disease (Sayce and Morris, 1999). At a national level, antidepressants account for 7 percent of the UK's primary care drug budget; the total cost to the economy of treating people with mental health problems is greater than that for ischaemic heart disease, breast cancer and diabetes combined (Dawson and Tylee, 200).

Data from the 2001 Minnesota Student Survey indicates that many students in Dakota County report feeling or experiencing circumstances that places them at high risk for depression and suicide. Thirteen percent of male 9th graders and 16 percent of female 9th graders reported feeling "extremely or quite a bit discouraged or hopeless in the past month." (Saycee and Morris, 1999)

Mental disorders are common in the United States and internationally. An estimated 26.2 percent of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year (Kessler, Chiu, Demler et.al. 2005). When applied to the 2004 U.S. Census residential population estimate for ages 18 and older, this figure translates to 57.7 million people (U.S.Census Bureau, 2005). Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 who suffer from a serious mental illness (WHO, 1995). In addition, mental disorders are the leading cause of disability in the U.S. and Canada (WHO, 2008). Many people suffer from more than one mental disorder at a given time. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to comorbidity (WHO, 1995).

2.3 Conceptual Framework of the Study



2.4 Implications of the Review for the Research

As whole in above reviewed literature a large number of studies revealed that low academic achievers were comparatively less emotionally mature, less calm, less placid, less prone to getting into difficulties, less able to face reality and possessed less ego strength than over achievers. Most part of these studies revealed positive correlation between field independent and academic achievement and a negative correlation between field dependent and academic achievement. A few studies revealed no significant relation between these variables. It should be noted that population of these studies were different such as gifted, student with specific subject and specific area. Regarding the relationship between academic achievement and adjustment, most of the researches disclosed that home, educational, emotional, health and overall adjustment was positively correlated with academic achievement. Regarding the relationship of social adjustment and academic achievement the findings were inconsistent.

Few researches showed the significant influence of gender on academic achievement without any direction and some studies showed significant gender difference regarding emotional adjustment, overall adjustment as indicating that boys showed better adjustment than girls. The influence of different types of schools was assessed on academic achievement in previous literature. Majority of studies showed that academic achievement of students studying in government schools was poor. Few studies reported a significant influence of type of school on academic achievement without any direction.

The literature showed that students studying in urban schools performed better in academic achievement than students studying in rural schools. Some studies reported significant difference in academic performance between adolescents residing in rural and urban area without any direction. A few studies reported no difference on the basis of location. Only few studies were conducted to assess the location difference for cognitive style with inconsistent results.

There are 18 outpatient mental health facilities available in the country, of which none are for children and adolescents only. These facilities treat 297.9 users per 100,000 general populations. A users treated in mental health outpatient facilities, 46 percent

are female. The percentage of children and adolescent is not known. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (21%) and neurotic disorders (56%) (WHO-AIMS, 2007).

Neurotic, stress related and somatoform disorders (47%) and Mood [affective] disorders (26%). Few patients (1-20%) in community-based psychiatric inpatient units received one or more psychosocial interventions in the past year, while 100% percent of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) available in the facility (WHO-AIMS, 2010). All of the outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic) (WHO-AIMS, 2010).

According to Dr. Shrestha, about 30 per cent of the general population of the country usually suffers from one or other kind of psychiatric problems at any point of time. Despite such a high prevalence of mental illness in Nepal, mental health sector seems to be the most neglected by the government. Out of five per cent of total national budget that is allocated for the health sector, less than 0.2 per cent is allocated to the hospital. This is mainly because of the misconceptions and lack of knowledge about mental health among the planners and policy makers. Also the basic understanding among them is that unlike physiological illnesses or diseases, mental illnesses rarely take one's life. This also contributes to the negligence of the mental health sector by the government.

The general public lacks information and economy about important mental health benefits, and this lack of information and economy may represent a barrier in their seeking care when needed. Given the overriding preference for primary care providers to treat mental health problems, particularly among older adults, mental health issues should be given more [attention] at all levels of primary care education. Different factors of economics are directly affect education and mental health of the people so study of economic factors is an important to improvement of education and mental health.

CHAPTER: THREE

METHODS AND PROCEDURES OF THE STUDY

3.1 Design and Methods of the Study

3.1.1 Design of the Study

The research involves both quantitative and qualitative components in order to explore economic factors affecting education and mental health among higher secondary school students. However, within the constructivist approach and when the problem has not been examined before, it is recommended that the qualitative component is to be the larger so more realties are to be exposed and constructed. Such realities need to be uncovered from the internal perspective of individuals rather than by a pre-established highly structured method as is the case with previous work (Dickinson and Bhatt 1994, McBride, 1995).

However, eliciting some quantitative data about a multifaceted problem, allows a more robust evidence based implication to be drawn (Polit et al, 2001). In this study it was felt that using a quantitative method (questionnaire) would overcome the weakness of the qualitative methods (e.g. focus group discussions) such as the complexity of establishing its validity and reliability. Statistical data from the questionnaire in this work could enable the generalization of certain themes /constructs found in qualitative materials. On the other hand, qualitative materials would add breadth and depth to the constructions of the reality of education and mental health of higher secondary school students. Driven by the above arguments, the study used a model of exploring qualitatively the social construct of the reality of economics factors affecting on education and mental health among higher secondary school students and then testing them quantitatively by the questionnaire.

3.1.2 Methods of the Study

Subjects aged 14 to 20 were drawn from the two colleges' study that contains data from three separate parts. First parts were contains demographic information of respondents such as faculty, level of education, age, sex, marital status, religious, ethnicity, occupation etc. of respondents. Second parts were contains source of

information, causes and treatment of mental health and third parts were contains types and prevention measures of mental illness of respondents. Education and mental health were dependents variable whereas economic factors was independent variable.

3.2 Population, Sample Size and Sample Strategy

3.2.1 Population

For this research private higher secondary school of Kathmandu Metropolitan City had been selected. Altogether 180 respondents were selected from these two schools. So the population of the study indicates the total number of students of this school. The respondents of higher secondary School are taken as population. Similarly one case study of moderate mentally retardation child was included.

3.2.2 Sample Size

The sample size was students of two higher secondary schools who were interested to participate in this research. Due to non-probabilistic purposive sampling techniques sample size was not determine any mathematical formulae.

3.2.3 Sample Strategy

The study populations were higher secondary school students from different colleges of Kathmandu Districts. Sample strategy was purposive sampling.

3.3 Study Area

Kathmandu, the capital city of Nepal was chose as study area in this descriptive study. The main reason for this selection was accessibility & convenience. With no doubt economic plays a vital role for the overall development of country and the students are the foremost determinant for the quality education. It is absolutely impossible even to achieve of effective education in absence of economic and mental well-being. This study was conducted to find out economic factors affecting on education and mental health of higher secondary school students. The study covered only the Private higher secondary school students. The study aimed to indicate the economic factors affecting on education and mental health among higher secondary school students of Kathmandu.

3.4 Data Collection Tools (Research Tools)

3.4.1 Questionnaire

A set of open ended questions was prepared to obtain quantitative data on personal history of the respondents, their past economic situation, present demographic information, education, employment, causes, types, source of information, prevention, treatment, etc. of mental health. The questionnaires were collected from person interviewed. Standard questionnaire was administered to the students with quantitative information. These questions deal with economic factors that effect of students on education and mental health.

3.4.2 Interview

Interview is fundamentally a process of economic interaction. It plays a significant role in economic research. In this study, a well-designed questionnaire was used to ascertain the different independent variables such as age, sex, education, causes, source of information, types, prevention and treatment of mental health in relation to the dependent variable i.e. economic factors of students of higher secondary school of Kathmandu.

3.4.3. Observation

Observation is the only way to examine a phenomenon in practice (Gillis and Jackson, 2002). Although their contributions are appreciated, earlier studies have been criticized due to the failure of using observation methods that capture what students do in the name of health promotion (McBride 1994, Maidwell, 1996, Cross, 2005, Irvine, 2007, Whitehead et al, 2008).

Employing observation in this study attempts to evaluate the economics factors that affecting on education and mental health.

The literature offers three types of observations which have been evaluated for this work. This includes complete observer, complete participant and non-participant observation (Miles and Huberman, 1994). The first two types were judged as unsuitable. This is due to the fact that it would not be possible in a college setting to be completely detached from what is being observed and document observational data

without both researcher's and student's awareness. This could raise ethical issues (e.g. permission to undertake the observation). Whilst complete participant observation could minimize the Hawthorne effect (see below regarding this problem), it has been considered as unsuitable. For its full success, the current author needs to conceal his identity (McPherson and Leydon, 2002). Thus, once again, more ethical issues would emerge particularly when it comes to patients' privacy and confidentiality. Culturally speaking, "hidden identities" in Jordan are often associated with "spying".

This could lead to misunderstanding the whole aim of the current author's presence at the college. Thus, participants' willingness to take part in the research will be in doubt. Finally, as the study involves different stages, it was unwise to conceal his identity in one stage and then reveal it in another (e.g. distributing the questionnaires).

Three forms of non-participant observation were identified in the literature – structured, semi-structured and unstructured (Turnok et al, 2001). Thus, it is difficult to construct a standardized checklist to score and examine certain behavior. Indeed, following a checklist, guided by pre-determined items, could constrain the emergence of the whole picture of practice in a natural setting (Mulhall, 2003).

Likewise, unstructured observation might be too broad to address the research questions and its data are complex to analyze. In this study semi-structured observation was used to collect data. In this study, mentally retarded child was taken and detail information was taken from him parent. Case study was done by using different materials and to draw picture of flower and child was able to learning.

3.5 Sources of Data

3.5.1 Primary Sources

Primary data collection tools were questionnaire, focus group discussion ad interview. These tools were contains demographic information of respondents, causes, source of information, types, prevention and treatment of mental health and economic factors that effects on education and mental health.

3.5.2 Secondary Sources

Secondary data were obtained from books, journals, internet and different official and non-officials site.

3.6 Data Collection Procedures

A well-developed questionnaire was distributed to respondents as mentioned of the above. Besides, this structured interview and uncontrolled focus group discussion was also taken to collect the data.

3.6.1 Focus Group Discussion

Data was collected by means of focus group discussions (FGDs). FGDs with a purposive sample of 8 to 12 participants for each FGD were conducted in two higher secondary schools. The focus groups were conducted from 30–40 minutes. The purposive sampling aimed to compose groups representing the range of gender, age, and study results and respondents characteristics. Head teachers invited students of grade 11 to 12 students to participate in each FGD, according to the researcher's instructions on wide representation with regard to gender, age, sources, types, treatment of mental health and economic factors etc. The pupils were selected on the basis of the researcher's request for wide representation with regard to gender and to a range from high to low school performance

3.6.2 Questionnaire

A set of open ended questions was prepared to obtain quantitative data on personal history of the respondents, their past economic situation, present demographic information, education, employment, causes, types, source of information, prevention, treatment, etc. of mental health. The questionnaires were collected from person interviewed. Standard questionnaire was administered to the students with quantitative information. These questions deal with economic factors that effect of students on education and mental health.

3.6.3 Interview

Interview is fundamentally a process of economic interaction. It plays a significant role in economic research. In this study, a well-designed questionnaire was used to ascertain the different independent variables such as age, sex, education, causes, source of information, types, prevention and treatment of mental health in relation to

the dependent variable i.e. economic factors of students of higher secondary school of Kathmandu.

3.7 Data Analysis and Interpretation

The collected data was entered in the computer programs in epi-data and then was processed and analyzed in the form of percentage and tables by the help of SPSS version 22. The data processing and analysis is divided into three parts to collect the data. Part I included a demographic response section, Part II included source of information and treatment of mental illness and part III included causes and prevention of mental illness. First part contained 14 questions which were focused to derive general information related to student's demographic characteristics such as age, gender, education level etc. of the respondents. Second part contained 4 questions which were focused on source of information and causes of mental illness and third part contained 6 questions which were also focused on types and treatment of mental illness.

3.8 Ethical Considerations

Approved from Angles Heart Higher Secondary School Manamaiju, Kathmandu and Pasang lhamu College, Samakhusi, Kathmandu and Permission from the concerned authorities will take before the study. Written consent was taken from the students for the study. The identity of the students and any information which causes harm to student's reputation was not disclose.

CHAPTER: FOUR

ANALYSIS AND INTERPRETATION OF DATA

4.1 Introduction to the Study Area

4.1.1 Brief Introduction of Kathmandu Metropolitan City

Kathmandu Metropolitan City (KMC) is the capital and largest city of Nepal. It is the cosmopolitan heart of the Himalayan Region. It is the gateway to Nepal. It has a glorious history going back two thousand years, and a refined culture that ranks among the highest in Asia. It is also a modern financial and business hub, exotic tourist destination, and a sacred goal for pilgrims. Kathmandu is situated in a bowl-shaped valley in central Nepal.

The city is believed to be founded in tenth century by Gunakamdeva (Kathmandu existed as two settlements Yamby and Yamgal prior to that). It is situated in Kathmandu Valley that also contains two other cities - Patan and Bhaktapur. Nepali is the lingua franca of the valley and is the most widely spoken language. Nepal Bhasa/Newari is the language spoken by native people, the Newars. The city stands at an elevation of approximately 4,500 ft (1,400 m) and is inhabited by about 700,000 people. Kathmandu is the most developed city in Nepal.

4.1.2 Present

Kathmandu is home to most of the government offices, embassies, corporate houses, and the palace. The old palace of Newar kings, Kathmandu Durbar Square, which is listed as UNESCO world heritage site, is in Basantapur, next to Freak Street, which was the popular hippie spot during the seventies. The King's Palace (now converted to National Museum) stands right next to Thamel - the tourist hub of the country. The palace is at the head of Durbar Marg, a street lined with various shops. Most of the streets in Kathmandu are named from Nepal Bhasa, owing its origin to the rich Newari Culture and heritage.

The "old" city is noted for its many Buddhist and Hindu temples and palaces, most dating to the 17th century. Many of these landmarks have been damaged by earthquakes and pollution. This valley hosts an UNESCO World Heritage Sites

composed by seven different Monument Zones: The two most important Buddhist stupas, Swayambhunath and Boudhanath and two famous Hindu shrines, Pashupatinath temple and Changu Narayan are located in the three primary cities, Kathmandu, Lalitpur and Bhaktapur (*Kathmandu Metropolitan City Office).*

4.1.3 History

As the story goes, the Kathmandu Valley was a lake surrounded by hills in ancient time. Blessed by the visits of various primordial Buddhas during various eons, the lake attracted pilgrims. Then a saint named Manjushree arrived, and created the valley by letting out the water with a sword cut on the southern rim of the valley at Chobhar gorge. And civilization began on the fertile lake bed.

Archeological digs show that Kathmandu, along with the other towns in the valley, ranks among the oldest human settlements in the central Himalaya. Excavations in the suburb of Hadigaon have shown up brick walls belonging to the period between 167 BC and 1 AD. Stone Age tools have been unearthed in Lubhu village, in the southern part of the valley.

Kathmandu existed during the time of the Lichhavi dynasty (300-879 AD) as two adjoining settlements-Yambu and Yangal. Yambu, also known as Koligram signified the northern half of Kathmandu that is the area north of present-day Makhan Tole, next to the Durbar Square. (Yamby means "northern land" in Newari language.) The southern sector was called Yangal. It was also known as Dakshin Koligram. Yangal endures in the name of a locality in this part of the city.

Tradition has it that in the late 900's AD, the King named Gunakama Deva established Kathmandu at the sacred confluence of the Bagmati and Bishnumati rivers by absorbing the first settlements of Yambu and Yangal. The town was laid out in theshape of Manjushree's sword-with the tip pointing north and the hilt in the south. The temples of the eight mother goddesses defined its perimeter. The temples stand to this day.

Old Kathmandu (Kasthamandap) corresponds to the current City core a compact network of charming temple squares and narrow streets lined with multi-storey houses. Most of Kathmandu's opulent cultural heritage-represented by soaring

pagodas, houses decorated with carved windows, exquisite open-air shrines and courtyards filled with brilliant sculptures were put together during the Malla period (1200-1768 Ad). By then, Kathmandu was already a relatively large city. Father Giuseppe, a Capuchin missionary living here during the 1760's, wrote that 'Catmandu' contained about 18,000 houses.

The Great Earthquake of 1934 destructed parts of Kathmandu city to the ground, but they were rebuilt almost like the original. Since the 1980's, the city has been spreading out on the surrounding farmland in an unprecedented building frenzy. And fringing form the traditional city core, the capital consists of new settlements of high-rise business, wide boulevards and posh residential suburbs *(Kathmandu Metropolitan City Office).*

4.1.4 Culture and Heritage

Kathmandu's ancient and refined culture has been inspired by the convergence of the Hindu and Buddhist devotion of its inhabitants. The traditional customs, festivals, art and literature are all religious in character. Kathmandu's location on a key Asian trade route has exposed it to varied influences form ancient times, and they have further enriched local artistic traditions.

High level craftsmanship can be seen in the exquisite artworks that ornament the ancient temples, palace buildings and domestic houses. Local artisans excelled in wood carving, stone carving, metal casting, weaving, pottery and other crafts. Street side images of gods and goddesses and sunken water spouts illustrate the level of skill in stone carving.

From 1400's to late 1700's AD, Kathmandu experienced a cultural flowering under the Malla Kings. This was a creative period for the other cities in the Kathmandu valley as well (known as Nepal Mandal from historical times). These great patrons of the arts embellished the city with sculptures, pagodas, stupas and palace buildings of exceptional beauty. Amazed by the artistic prolificacy, a British visitor more than two hundred years ago, made the often-quoted observation, "There are as many temples as there are houses and as many idols as there are men."

Indeed, Kathmandu possesses one of the greatest concentrations of architectural treasures in the world. There are not only hundreds of temples, stupas and open shrines, but also 106 monastic courtyards (known as baha or bahi). UNESCO has listed four of the temple complexes as World Heritage Sites. They are the Hanuman Dhoka Durbar Square, Swayambhunath, Pashupatinath and Bouddhanath. Rivers that flow in this holy valley are Bagmati, Bishnumati, Dhobi Khola, Samakhusi, tukucha, Bhaucha-Khusi, Balkhu, Manamati (*Kathmandu Metropolitan City Office site).*

4.1.5 Population

Kathmandu has been a densely inhabited urban centre from historical times. The indigenous people and the creator of its unique are the Newars. They still make up a large segment of the population. Over the centuries various peoples have come to settle here, and the present demography is very cosmopolitan in makeup. Kathmandu, thus, offers a delightful array of different traditions and cultural practices.

Attracted by the economic opportunities, modern comforts and the bright light of the city, the capital has in recent years experienced a flood of migrants. The population, as a result, has been swelling rapidly. According to the National Census Report 2012, following data can give good insight.

Table 1: Population of Kathmandu

Male	576,010.00
Female	545,835.00
Total	**11,11,845.00**

Source: National Census Report, 2012

4.1.6 Geography

Kathmandu City lies at an altitude of 1,300 meters above sea level. Lalitpur Sub-metropolitan City is in its south, Kirtipur Metropolitan City is in south-west, Madyapur Thimi Municipality in east and different Village Development Committees of Kathmandu in north, west and north-east. The snow peaks rise behind the green hills in the north to provide an awe-inspiring backdrop. Eight rivers meander through the city. It has a temperate climate and it experiences all four seasons a year. Temperature ranges between 1 degree C and 35 degree C. The annual rainfall is 1,407

millimeters, with most of it occurring during the three months from June to August. Metropolitan Kathmandu is spread over an area of 50.8 sq. km, and it can be divided into five sectors- i.e. Central Sector, East Sector, North Sector, City Core and the West Sector. Administratively, the city is divided into 35 Wards (*Kathmandu Metropolitan City Office).*

4.1.7 Government

The city is looked after by Kathmandu metropolitan office located at Bagdarbar. The city hosts Singha Durbar, the government seat of Nepal (with office of Prime Minister, Supreme Court and Senate). Most of the ministries are present in the Singha Durbar premises.

4.1.8 Economy

Kathmandu is the nation's main business center and largest market. The city's economic output is worth more than NRs. 170 billion per year. Trade accounts for 21% of its finances. Manufacturing comes next in importance with 19%. Kathmandu is a major manufacturer and exporter of garments and woolen carpets, other money making sectors are agriculture, education, transport, and hotels and restaurants.

Tourism is a key component of the city's economy, thanks to the plentiful sightseeing and shopping opportunities available here. Kathmandu is Nepal's tourist gateway with almost 90 percent of the foreign visitors arriving by air at the Tribhuvan International Airport. The capital also occupies the hub of the national transport system, with road connections to various parts of the country. There are direct air links to all neighboring countries and East Asia, the Middle East and Europe.

Kathmandu has been a trading city from time immemorial. Because of it’s in between position on the ancient trade route between India and Tibet, commerce has always been important in the lives of the inhabitants. Until not so long ago, Kathmandu's merchants used to travel in caravans across the Himalaya to run business in Lhasa of China pursuing an institutionalized tradition going back to centuries. Farming, metal casting, woodcarving, painting, waving and pottery are other popular traditional occupations.

4.1.9 Educational Entrance Age of Kathmandu Metropolitan City

Educational aspect of the city is also praise worthy having literature rate of over 83 percent which is comparatively higher that of the other cities of the country.

Table: 2 Educational Entrance Age of Kathmandu Metropolitan City

Education Level	Entrance Age
Primary	5
Secondary	10
Higher secondary	15

Source: UNESCO, 2014/2015

4.2 Analysis and Interpretation of Data

4.2.1 Demographic Characteristics

Several articles in this issue association between socio-demographic factors and health related conditions. Recent issues have reported associations between socioeconomic status and life expectancy, infant mortality. Several researches will find studies focused on problems such as the relationship of socioeconomic status to health and age and sex variations in the prevalence and onset of mental illness. From one point of view, this repeated documentation of the association between socio-demographic factors and health belies a distinct lack of progress and indicates a major problem in the field of metal health. From this perspective, knowledge about socio-demographic patterns of disease is considered useful insofar as it helps us to pinpoint the medically relevant risk factors that explain these associations and economic factors that effect on education and mental health However, progress is indicated when we are able to move our attention away from the social conditions and toward identifying and intervening on the more proximate risk factor. Our continuing focus on socio-demographic patterns thus suggests that we are stuck in a primitive stage of scientific development. Socio-demographic factors can be expected to elicit a long gaping.

But there is not an important principle of social epidemiology that suggests that we will never be able to, nor should we try to, tum our attention away from the socio-demographic factors themselves. Put simply, this principle states that societies shape

patterns of disease. These are bold and broad statements because they are not bound by time or place. They imply that sociocultural factors are at work in all societies-past, present, and future-and that a direct focus on them is essential. From this perspective, our continued attention to socio-demographic factors is not a sign of stalled progress, but rather a simple reflection of the fact that societies continue to shape patterns of disease. Linking socioeconomic status to economic factor had been addressed, and one might have expected the association to weaken and perhaps disappear altogether. The respondents chose for this study are divided into different groups such as age, sex, educational attainment, marital status, family size, level of education etc. Table given below depicts the demographic characteristics of the students.

Table: 3 Demographic Characteristics of Study Population

Demographic Characteristics	Number of Respondents (n=180)	Percent
Faculty of Respondents		
Science	94	52.2
Commerce	86	47.8
Levels of Respondents		
Class XI	41	22.9
Class XII	139	77.1
Age of Respondents		
14-15	3	1.7
15-16	26	14.5
16-17	67	37.4
17-18	55	30.7
18-19	26	14.0
19-20	3	1.7
Sex of Respondents		
Male	103	57.2
Female	77	42.8

Source: Field Survey, 2016

Table 3 shows that, Out of 180 respondents, 52.2 percent of the respondents were from science faculty and rest 47.8 percent were from commerce faculty. Out of 180 respondents, 77.1 percent were from grade twelve and 22.9 percent were from grade eleven. Majority of the respondents belonged to age group 16-17 years of age with 37.4% followed by 17-18, 15-16, 18-19 and 14-15 & 19-20 with the percent of 30.7 percent, 14.5 percent, 14.0 percent and 1.7 percent respectively. 57.2 percent were male and 42.8 percent were female.

Table: 4 Demographic Characteristics of Study Population

Demographic Characteristics	Number of Respondents (n=180)	Percent
Marital Status of Respondents		
Married	2	1.1
Unmarried	178	98.9
Religion of Respondents		
Hindu	146	81.6
Buddhist	26	14.0
Christian	8	4.5
Ethnicity of Respondents		
Brahmin	53	29.5
Chhetri	58	32.4
Janajati	65	36.1
Dalit	1	0.6
Others	3	1.7

Source: Field Survey, 2016

Table 4 shows that, Out of 180 respondents 98.9 percent of the respondents were unmarried. Majority of the respondents were Hindu (81.6%) followed by Buddhist (14.0%) and Christian (4.5). 36.1 percent of the respondents belonged to Janajati followed by Chhetri (32.4 %,) Brahmin (29.5%), Dalit (0.6%) and others (1.7%). On the basis of religion highest numbers of respondents were Hindu because of Nepal is one of the Hindu states so there is large numbers of respondents to be found. According to ethnicity, large numbers of respondents were found to be Janajati

because Kathmandu is Newar dominance district and it is bound by other districts these are domicile of large number of Janajati includes so large number of Janajati to be found.

Table: 5 Parent's Occupation

Demographic Characteristics	Number of Respondents (n=180)	Percent
Father's Occupation		
Farmer	17	9.4
Service	54	30
Business	76	42.2
Others	33	18.3
Mother's Occupation		
Farmer	34	18.9
Service	29	16.1
Business	38	21.1
Household	72	40.0
Others	7	3.9

Source: Field Survey, 2016

According to Table 5, majority of the respondents father's occupation was Business (42.2%) followed by others (18.3%); Service (30%) and Farmer (9.4%). Majority of the respondent's mother's occupation was Household (40%) followed by Business (21.1%), Farmer (18.9%), Service (16.1%) and others (3.9%). Above results shows that majority of father's occupation was found to be business due to the Nepal is patriarchal country so male were free than female so they are exposed different occupation than female. Some father's occupation was services and farmer because most of the male were participated in different types of services and rest was participated in farmer. Similarly majority of mother's occupation was household. In Nepal household is one of the female custom that's why number of respondents was high and rest was business, farmer and services respectively.

Table: 6 Parent's Education Status

Demographic Characteristics	Number of Respondents (n=180)	Percent
Education Status of Father		
Literate	164	91.1
Illiterate	16	8.9
Education Level of Father		
Primary Level	12	6.7
Secondary Level	50	30.5
Higher Secondary Level	6o	36.6
Bachelor's Level	25	15.3
Master's Level	15	9.1
Higher Study	2	1.2
Education Status of Mother		
Literate	130	72.2
Illiterate	50	27.8
Education Level of Mother		
Primary Level	28	21.5
Secondary Level	48	36.9
Higher Secondary Level	42	32.3
Bachelor's Level	8	6.1
Master's Level	3	2.3
Higher Study	1	0.8

Source: Field Survey, 2016

Table 6 shows that, Out of 180 respondents, 91.1 percent of the respondents Father were literate and 72.2 percent of the mothers were literate. Majority of the respondents Father had received higher secondary level of education (36.6%) and majority of the mother received secondary level of education (36.9%).

Table: 7 Family Characteristics

Demographic Characteristics	Number of Respondents (n=180)	Percent
Family Types of Respondents		
Nuclear Family	138	76.5
Joint Family	32	17.9
Extended Family	10	5.6
Family Income (Per Month)		
Below 10,000	14	7.8
10,000-20,000	87	48.3
20,000-30,000	25	13.8
30,000-40,000	10	5.6
40,000-50,000	22	12.2
50,000 and above	23	12.7

Source: Field Survey, 2016

Table 7 shows that, majority of the respondents had nuclear type of family (76.5%) followed by Joint family (17.9%) and Extended family (5.6%). Most of the respondent's family had a gross monthly income in between ten thousand to twenty thousand (48.3%) whereas only 5.6 percent had a family income per month in between thirty one thousand to forty thousand. In this study, nuclear family was highest due to the effect of modernization and independents of people. Similarly joint and extended family was second and third of respondents due to the traditional customs of people which is 17.9 and 5.6 percent respectively. On the basis of the family income highest numbers of respondents were 10,000-20,000 due to the foreign remittance may effect on the income of the respondents so it could be directly effect on the education and mental health of the respondents. Highest amount of income could provide high quality of education and high knowledge on mental health. Therefore, the family income is one of the major economic factors that effect on education and mental health.

Table: 8 Family Characteristics

Demographic Characteristics	Number of Respondents (n=180)	Percent
Number of Family Members		
3	12	6.7
4	39	21.7
5	59	32.8
6	31	17.2
7	10	5.6
8	8	4.4
9	6	3.3
10	7	3.9
11	2	1.1
12	2	1.1
13	1	0.6
14	2	1.1
15	1	0.6

Source: Field Survey, 2016

Table 8 shows that, majority of the respondent's family size belonged to number 5 with the percentage of 32.8 percent and the mean size of the family was 5.8 percent. Numbers of families determines the size of family. The size of family directly related with the economic condition and it also effects on quality of education and mental health.

4.3 Causes and Treatment of Mental Illness

Commonly divided into biological, social and psychological causes, there are also interactions between these three categories such that psychological and social factors can cause biological changes to brain structure and neuro-endocrine function. The new field of epigenetics points to gene-environment interaction; some people are more susceptible to developing mental health conditions and are therefore more vulnerable to adverse environment. Biological factors: include genetic predisposition, brain injury and the effect of illicit drugs. Social factors: include fragmented and

unsupportive communities, poor housing, inadequate health care, poverty and racial or sexual discrimination. Psychological factors: include insecure attachments to parents in infancy, sexual and physical abuse in childhood, poor parenting, bullying or harassment, the absence of one or more confiding relationships, family breakdown and bereavement. Causes of mental illness is way that cause mental illness or causes mean triggering factors that cause disease. Causes of mental illness are also known as pathophysiology of disease in which disease occurrence.

There are many causes of mental illness that cause mental illness. Clinically mental illness is occurrence during imbalance of neurotransmitter like adrenaline, acetylcholine, dopamine, prostaglandin etc. Mental health problems can have a wide range of causes. In most cases, no one is sure precisely what the cause of a particular problem is. We can often point to things that trigger a period of poor mental health but some people tend to be more deeply affected by these things than others. There are different methods of treatment such as Assess suicide risk, Liaise with relevant parties, Consider the need to hospitalize, Form a contract with the patient, Treat mental disorder, Provide emergency contacts, Refer to relevant professionals and Regular follow-up. Some people find complementary and alternative therapies such as hypnotherapy, massage and acupuncture helpful to manage stress and other common symptoms of mental health problems. The clinical evidence for these therapies is not always as robust as it is for other treatment. But in this research following types of causes and treatment are included.

Table: 9 Causes and Treatment of Mental Illness

Heard About Mental Illness	Number of Respondents (n=180)	Percent
Yes	169	93.9
No	11	6.1
Causes of Mental Illness		
Misuse of Drug	91	50.6
Physical Abuse	40	22.2
Stress	30	16.7
Evil Spirit	13	7.2
God's Punishment	6	3.3
Perceived Place of Treatment for Mental Illness		
Hospital	97	54
Yoga and Meditation Centre	45	25
Home	12	6.7
Faith Healers	11	6.1
Others	15	8.3

Source: Field Survey, 2016

Table 9 shows that, Out of 180 respondents, 93.9 percent of the respondents had heard about mental illness out of which majority of the respondent perceived misuse of drugs (50.6%) as the cause of mental illness followed by Physical abuse (22.2%), Stress (16.7%), Evil Spirit (7.2%) and God's punishment (3.30%). The major perceived place of treatment for mental illness was hospital (54%) followed by Yoga and meditation center (25%), Home (6.7%), Faith healers (6.1%) and others (8.3%).

4.4 Source of Information of Mental Health

Information on recognizing mental health problems, local sources of treatment and support, and self-help approaches that promote wellbeing or alleviate psychological distress should be readily available to both practitioners and clients. Sources of information and resources are provided in the Useful Resources section of mental health and education. Fact sheets on many aspects of mental illness can be downloaded from a range of websites as provided. Source of information also provide

the economic factors that effect on education and mental health. In this research following source of information of mental health was included.

Table: 10 Source of Information of Mental Health

Sources of Information	Number of Respondents (n=180)	Percent
Media	105	58.3
By seeing mentally ill people	53	29.4
Family/Friends	10	5.5
Health	9	5
Others	3	1.7

Source: Field Survey, 2016

Table 10 shows that, majority of the respondent's source of information was media (58.3%) followed by seeing mentally ill people (29.6%), Family/friends (5.5%), Health workers (5%) and others (1.7%). In 2001, the Australian government published a large-scale literature review examining portrayals of mental health in the media (Francis, Pirkis, Dunt, & Blood, 2001). Many other studies have found a definite connection between negative media portrayals of mental illness and the public's negative attitudes toward people with mental health issues (Coverdale, Nairn, & Claasen, 2002; Cutcliffe & Hannigan, 2001; Diefenbach, 1997; Olstead, 2002; Rose, 1998; Wahl, 1995; Wahl & Roth, 1982; Wilson, Nairn, Coverdale, & Panapa, 1999). These are similar to my findings.

4.4.1 Exposure to Health Message

Table: 11 Exposures to Health Message

Received Mental Health Promotional Message	Number of Respondents (n=169)	Percent
Yes	121	71.6
No	48	28.4
Source	**Number of Respondents(n=121)**	**Percentage**
TV	93	76.9
Radio	18	14.9
Pamphlets	7	5.8
Posters	1	0.8
Others	2	1.7

Source: Field Survey, 2016

Table 11 shows that, majority of the respondents (71.6%) had received mental health promotional message. The source of mental health promotional message for majority of the respondent was TV (76.9%) followed by Radio (14.9%), Pamphlets (5.8%), Posters (0.8%) and others (1.7%). Source of information is an important element in mental health so above results shows that majority of the respondents were get information of mental health through T.V. due to it is accessible source of information and it is one of the common source for respondents so numbers of respondents were higher than others. Next one is a radio, it also provides information for respondents which was 14.9 percent due to audio aid so it is prefer less numbers of respondents than T.V. Rest of others source of information was pamphlets, posters and others which were 5.8, 0.8 and 1.7 percent respectively. Similar research has concluded that the media are the public's most significant source of information about mental illness (Coverdale et al., 2002 [citing Borinstein, 1992; Kalafatelis & Dowden, 1997; Philo, 1994]). Fiske (1987, cited in Rose, 1998) argues that television is the most powerful medium for framing public consciousness. Cutcliffe and Hannigan (2001) further state that rarely does a week go by without a reference to mental illness in the mass media.

4.5 Types and Prevention of Mental Illness

In this section, deal with the types and prevention ways of mental illness. Many different classification systems for mental disorders exist, but some general categories include: Schizophrenia, Major depressive disorder, Bipolar disorder/manic-depressive disorder, Anxiety disorders, Substance-use disorders, Organic disorders (e.g., Alzheimer's disease) Personality disorders, psychosis, hysteria etc. Prevention is way of reduce illness through provides awareness towards illness. In this study different types and prevention of mental illness were discuss. These are as follows:

Table: 12 Past Exposures

Seen Anyone with Mental Illness	**Number of Respondents(n=168)**	**Percent**
Yes	138	82.1
No	30	17.9
Anyone with Mental Illness in Family	**Number of Respondents(n=137)**	**Percent**
No	116	84.7
Yes	21	15.3
Type of Mental Illness Seen	**Number of Respondents(n=168)**	**Percent**
Depression	68	40.5
Psychosis	30	17.9
Anxiety	17	10.1
Schizophrenia	12	6.5
Hysteria	11	6.5
Don't Know	26	15.5
Others	4	2.4

Source: Field Survey, 2016

Table 12 shows that, majority of the respondents (82.1%) has seen someone with mental illness and among them 15.3% had seen someone in their own family i.e. their family members. Depression (40.5%) was the most common type of mental illness seen by the respondents followed by Psychosis (17.9%), Anxiety (10.1%), Schizophrenia (6.5%), Hysteria (6.5%) and others (2.4%).

4.5.1 Depression

Table: 13 Depressions

Heard About Depression	Number of Respondents (n=169)	Percent
Yes	153	90.5
No	16	9.5
Causes of Depression	**Number of Respondents (n=153)**	**Percent**
Loss of Loved Ones	53	34.6
Economic Problem	25	16.3
Exam Failure	23	15
Relationship Problem	5	3.2
Social Life	22	14.4
Loss of Job	17	11.1
Others	8	5.2

Source: Field Survey, 2016

Table 13 shows that, majority of the respondents i.e. 90.5 percent of the respondents had heard about depression. The major perceived cause of depression according to the respondents were loss of loved ones (34.6%) followed by economic problem (16.3%), exam failure (15%), relationship problem (3.2%), social life (14.4%), loss of job (11.1%) and other (5.2%).

Table: 14 Perceived Ways of Prevention of Depression

Perceived Ways of Prevention	Number of Respondents (n=153)	Percent
Sharing with a Close Friend	83	54.2
Reduce Factors Causing Stress	27	17.6
Engage on ECA	13	8.5
Maintain Healthy Daily Routine	11	7.2
Seeking Counseling	12	7.8
Others	7	4.6

Source: Field Survey, 2016

Result of Table 14 shows that, majority of the respondents thought that sharing with a close friend can prevent depression with a percent of 54.2 percent followed by reduce factors causing stress (17.6%), engage on ECA (8.5%), maintain health daily routine (7.2%) etc. Depression is one of the major mental diseases in the World so there is different methods and way to prevent the causes of depression. Depression is mostly found in the developed countries than developing countries so in above result shows that sharing with close friends was front way to prevent the depression. Similarly reduce factors that cause tress, engage on extracurricular activities, and maintain healthy daily routine and needs of counseling were 17.6, 8.5, 7.2, and 7.8 percent respectively.

4.5.2 Schizophrenia

Table: 15 Schizophrenia

Heard About Schizophrenia	**Number of Respondents (n=98)**	**Percent**
Yes	71	72.4
No	27	27.6
Causes of Schizophrenia	**Number of Respondents (n=89)**	**Percent**
Genetic	26	29.2
Stress	25	28
Poor Family Relationship	20	22.5
Economic Problem	7	7.9
Social Isolation	6	6.7
Others	5	5.6

Source: Field Survey, 2016

Table 15 shows that, majority of the respondents i.e. 72.4 percent of the respondents had heard about schizophrenia. The major perceived cause of schizophrenia according to the respondents were genetic (29.2%) followed by stress (28%), poor family relationship (22.5%), economic problem (7.9%), social isolation (6.7%) and other (5.6%). There are different causes of schizophrenia. It is one of the most common mental illnesses of people. Most of the respondents was heard about schizophrenia due the common mental illness so there is many ways to perceived the causes of schizophrenia in which genetic causes is most common causes of schizophrenia which

is 29.2 percent and rest of the causes are stress, poor family relationship, economic problem, social isolation and others.

Table: 16 Perceived Ways of Prevention of Schizophrenia

Perceived Ways of Respondents	Number of Respondents (n=107)	Percent
Sharing with a Close Friend	27	25.2
Reduce Factors Causing Stress	20	18.7
Engage on ECA	20	18.7
Maintain Healthy Daily Routine	19	17.8
Seeking Counseling	18	16.8
Others	3	2.8

Source: Field Survey, 2016

Table 16 shows that, majority of the respondents thought that sharing with a close friend can prevent schizophrenia with a percent of 25.2 percent followed by reduce factors causing stress & maintain healthy daily routine (17.8%), engage on ECA (18.7%), seeking counseling (16.8%) and others (2.8%). Prevention is better than care. Most of the mental illness has not any treatment but they are only prevention of sign and symptoms of illness. That's why schizophrenia has different ways of prevention. Most predominance way of prevention of respondents was sharing with a close friend because every person sharing their own problem to their close friend that provide relief for her or him so there is easily express their all problem with friends. so sharing with a close friend is most common way to prevention of schizophrenia and rest of others are reduce factors causing stress, engage on extra-curricular activities, maintain healthy daily routine and seeking counseling are others ways that prevention of mental illness.

4.5.3. Cost of Treatment of Mental Illness

Cost of treatment of mental illness also included all types of costs like cost of medication, cost of psychotherapy etc. cost of treatment play an important role in the treatment of mental illness so we were know that how cost of treatment effect on education and mental health. Mental illness and cost of its treatment also impact in education. If there is highest cost of treatment no one are ready to treatment of that types of disease that's why cost of treatment and mental illness directly effect on the

education. So to achieve good mental health and education we should be properly know about the cost of treatment. In my research following cost of treatment of mental illness were found which were shown in table 16.

Table: 17 Cost of Treatment of Mental Illness

Mental Illness	Number of Respondents(n= 180)	Cost of Treatment	Percent
Depression	40	30,000-40,000	22.22
Psychosis	70	Above 40,000	38.88
Anxiety	30	20,000-30,000	16.66
Schizophrenia	30	10,000-20,000	16.66
Hysteria	10	0-10,000	5.55

Source: Field Survey, 2016

Table 17 shows that, out of 180 respondents, Psychosis is the most costly mental illness of the respondents followed by depression, anxiety, schizophrenia and hysteria. In this research the cost of treatment of psychosis is 40,000 and more which is 38.88 percent and the cost of treatment of depression, anxiety, schizophrenia and hysteria were 30,000-40,000, 20,000-30,000, 10,000-20,000 and 0-10,000 respectively.

4.5. Economic Factors Affecting on Education and Mental Health

The current economic factors could have a significant influence on Europeans' health and well-being. Economic hardship, unemployment, job insecurity, and the lack of a regular living wage all have important effects on health and demand for health care. The economic downturn has a potential for both negative (loss of income, insecurity) and positive (reduced work load, less traffic) effects on health, but the pooled effects in Europe are likely to be negative.

The data on the impact of unemployment on mortality rates is conflicting. There is evidence from the European Union for a link between unemployment and mortality rates: i.e. the higher unemployment, the higher is all-cause mortality. A 1percent increase in a national unemployment rate increases the standardized mortality rate substantially, i.e. by 1, 5 per 100 000 people. On the other hand, the evidence across the European Union that all-cause mortality increases when unemployment rises is

not consistent. Populations vary substantially in how sensitive mortality is to economic crises, depending partly on level of social protection.

The increased risk of death due to suicide after redundancy and financial problems is greater among men than among women, perhaps because men are taught to believe more often than women that there is no appropriate source of support and help for them when things go wrong.

Times of economic instability cause psychological stress, which is linked to both the onset and course of mental illnesses. Unwelcome changes in life circumstances, such as unemployment, are strongly linked to depression, anxiety disorders, and suicide. The effects are modified by experiences like shame at losing one's job and financial hardship.

To some extent, the economic growth has been on the expense of the mental well-being of the population. Thus, the economic factors may also bring along welcome changes, such as increase in spare time leading to increases in time spent with family members. How people deal with difficulties like unemployment in times of economic crisis depends on the individual's coping mechanism. The crisis may offer possibilities to strengthen social capital and to shift our value base from money to non-monetary components of life, provided that social protection is sufficient. The economic crisis offers a chance for re-orientation. So in my study similar results would be found. These are shown in table below:

Table: 18 Economic Factors Affecting on Education and Mental Health

Economic Factors	Percent
Family income	48.3
Psychosis	38.88
Economic problem	16.3
Loss of job (unemployment)	11.1

Source: Field Survey, 2016

Table 18 shows that, out of 180 respondents, highest economic factors of family income is 10,000-20,00 which is 48.3 percent, in cost of treatment of mental illness psychosis is highest cost which is 38.88 percent, economic problem take place 16.3 percent from total numbers of causes of mental illness followed by loss of job which

is 11.1 percent. Most of the research showed that unemployment, economic problem also effect on the education and mental health because unemployment creates many problem like lack of money, crisis in family, loss of family relationship as a result it should be effect on quality of education and mental health so economic problem and loss of job is one of the major factors that effect on education and mental health. Similarly size of family income and types of mental illness also effect on education and mental health. Due to types of disease the cost of treatment also increase so it could be also effect on education and mental health. Size of family income also indicates life style of students so if greater the family income there is regular care of mental health and vice-versa so it also impact on education and mental health.

4.6 Observed Case Analysis

4.6.1. Condition of the Observed Case

Seven years old Bimal was residence of Nuwakot. His Father Name is Himal Tamang and Mother Name is Sita Tamang live in Kathmandu since 10 year. Father's occupation was driver and Mother's occupation was household. His parent's education level was secondary level. His parent's income is not sufficient to treat the disease. He is a male student with special needs, born on 02.01.2009. According to the Patan Psychiatric Hospital on 05.12.2014, Bimal is defined as "Mildly Mentally Retarded". Taking this report as basis, Bimal can be identified as an individual who has intellectual special needs. According to the said report prepared by the rehabilitation team (1 speech and language therapist, 1 psychologist and 1 physiotherapist) who have worked with Bimal since 2015;

a) In terms of social communication skills: the child can adapt to the environment within the framework of the social rules his age requires, he gets excited in spontaneous changes and contracts and he has behavioral problems such as waving his right hand for a long period, but; he does not have any behavioral problems that would prevent him from learning and even though he cannot clearly communicate verbally, he tries to communicate and he can use his body language correctly, he obeys the rules in the class, he can adapt to new environments, he can queue in games,

b) In terms of cognitive skills: he is deficient in concepts of place/location, shape, form, color, opposites (small-large, thin-thick, short-long, thin-fat... etc.), numbers but; the student is able to hold the pencil and use it and with a systematic effort he may be able to draw meaningful lines as a preparation to writing, he can accomplish instructions that include two actions; he can imitate actions, he reacts to auditory and visual stimulus,

c) In terms of speech and language skills; he has receptive language (he understand what is being told) but he lacks expressive language and the ability to differentiate between homonyms, he can articulate some sounds (a, e, o, b .. etc. -those that are labial and laryngeal-) but fails to articulate some others (s, ş, ç, ğ, r, z, v, j... etc. -those that require breath and tongue movements-), he cannot combine sounds, he can accomplish two and three staged instructions, he can imitate words,

d) In terms of motor skills: he does not have any physical problems that may prevent him from acting.

e) Daily life skills: he can use a fork and a spoon age appropriately, he can fill his glass with water from the bottle and drink it, he can clean the floor, the table, the chair…etc. with a wipe, he can spread jam, honey, chocolate spread etc. on bread.

f) Personal care skills: he can wash his hands and face age appropriately, he can dress and undress, he can put on and take off his valorize shoes, he can use the toilet, he can brush his teeth and he abides by the hygienic rules.

4.6.2. Cost Analysis of the Case

Mental retardation is an irreversible condition. Treatments for this condition focus on improving the patient's ability to live a full life. To that end, special education and training, including for social skills, may begin even in infancy. Cost is one of the major factors that is responsible for the treatment of disease. Sufficient cost is need for the prevention and treatment of mentally retarded disease because it is an irreversible condition so there is need of huge amount of cost for prolong time. So there is significant relationship between cost and treatment of mentally retarded disease. There is certain parameters that need to maintain mentally retarded child and their costs are describe in table below:

Table:-19. Cost of Treatment of Case Study

Sources of Cost	Cost per Month (Rs)
Laboratory Test	3,000
Medical Treatment	5,000
Psychological Treatment	2,000
Speech Therapy	3,000
Educational Guidance	2,000
Counseling	1,000
Home Training	1,000
Total	17,000

Source: Field Survey 2016

The highest cost of treatment is Medical treatment because it includes the charge of doctors and cost of total drugs these are used for disease of child. Laboratory test and Speech therapy are second highest cost of treatment followed by psychological treatment, educational guidance, counseling, and home training. In my case study, cost of treatment is highest than the income of family so the economic factors are major elements to affect the mental retardation. The poverty is ply vital role in the treatment of mental disease so economic factors can directly effect on the mental disease.

4.6.3. Result and Discussion

In this case study, mentally retarded child was able to draw flower and to shows the cost of treatment such cost of laboratory test, cost of medical treatment, cost of speech therapy, cost of counseling etc. were studied. The cost of treatment and income of family was analytically compared. This case-study research was carried out to identify functional teaching stages, cost of treatment and methods for use with a person with moderate mental retardation. It presents a structured and sequenced teaching programmed which has analyzed the stages needed to produce a flower-drawing and has created a tested and approved practical example in which a person with moderate mental retardation was enabled to carry out a flower-drawing independently. To this end, Bimal a seven year old child with moderate mental retardation was used as an

example for the case study research. Thus the chronological progress and performance of Bimal during the structured teaching programmed, cost of treatment was observed and evaluated as an example.

The study took place over ten days, comprising 20 sessions of 15 minutes each in total. An observation form, developed by the researcher, was used in each of the sessions to record the results. As shown on the observation form, the programmed used with Bimal was structured in sequential stages, ordered from simple to more difficult where each step was taught separately. The visual clues included an indication of the onset points of lines, reminder points at regular intervals and the direction of lines and cost of treatment data was collected from on the basis of his parent's interview. At the end of the teaching programmed used with Bimal, it was noted that he had accomplished the task within the stages provided and succeeded in the outcome of drawing a flower using the method outlined and total cost of treatment was greater than family income and analytically cost of treatment was calculate in this study.

Consequently, mildly mentally retarded Bimal acquired the ability to draw a flower independently after the 13th session using the visual clues provided and cost of treatment was greater than family income.

CHAPTER: FIVE

FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of Findings

Out of 180 respondents, highest economic factors affecting on education and mental health among higher secondary school students of Kathmandu were family income is 10,000-20,000 which is 48.3 percent, in cost of treatment of mental illness psychosis is highest cost which is 38.88 percent, economic problem take place 16.3 percent from total numbers of causes of mental illness followed by loss of job which is 11.1 percent.

Majority of the respondents were unmarried, Hindu and occupation of Parent's were business. Majority of the respondents had heard about mental illness i.e. 93.9% (180 respondents). Misuse of drug ranked highest among the respondents as the perceived cause of mental illness than other factors (50.6% of the respondents) which is similar to the findings of the study conducted in Karfi village, Northern Nigeria by Mohammad Kabir et al, 2004.

Belief in demons as the cause of mental illness is a well-known phenomenon in many cultures of the world according to the study conducted in Switzerland by Pfeifer S but in my study this factor was ranked 4th by the respondents (7.7% of the respondents).

The findings regarding the past exposure to mental illness is similar to the study conducted in London by G Wolff, S Pathare, T Craig and J Leff, i.e. most respondents (82.1%) knew somebody who had mental illness out of which 15.3% had someone in their family.

The finding regarding the statement that "mentally ill people are often violent and dangerous" is contrast to the findings of the study conducted in Klang Valley, Malaysia by Yeap R. & Low, W. Y.s, 2009. The study shows that majority of the people strongly disagree with this statement in my study (48.6%).

Most students received information about mental health from internet and TV, which shows the potential role of these media in promoting mental health in students. %). Similar study showed that, there is a complex relationship between mass media

depictions of mental illness and the public understands. McKeown and Clancy (1995, cited in Cutcliffe & Hannigan, 2001) state that this link is circular: negative media images promote negative attitudes, and ensuing media coverage feeds off an already negative public perception. The media must play a role in changing such negative perceptions. In the past, people with physical disabilities were depicted in the media only when the story was about their disability. Today, it is becoming more common to see television characters whose physical disability has nothing to do with the storyline they are characters like any other, and their disability is not significant to the story. This is far from the case with mental illness. In popular media, mental illness is most commonly portrayed as deviant and dangerous, and is also frequently the only noteworthy trait about the character.

5.2 Conclusion

Out of 180 respondents, highest economic factors affecting on education and mental health among higher secondary school students of Kathmandu were of family income is 10,000-20,000 which is 48.3 percent, in cost of treatment of mental illness psychosis is highest cost which is 38.88 percent, economic problem take place 16.3 percent from total numbers of causes of mental illness followed by loss of job which is 11.1 percent.

Majority of the respondent were from science faculty (52.2%) and rest (47.8%) were from commerce faculty. Majority of the respondents were from grade twelve and 22.9% were from grade eleven. The results showed that higher education students had higher awareness towards the mental health.

Majority of the respondents had heard about mental illness (93.9%). The misuse of drug was ranked first among all the causes of mental illness where as the cause for mental illness was only 7.2% and 3.3% by evil spirit and god's punishment respectively.

Majority of the respondents preferred Hospital for the treatment for mental illness (54.1%) followed by Yoga and Meditation Centre (25%).

Majority of the respondents i.e. 58.3% knew about mental illness through Media (Electronic and Print media) followed by seeing mentally ill people (29.4%).There is

a complex relationship between mass media depictions of mental illness and the public's understanding. McKeown and Clancy (1995, cited in Cutcliffe & Hannigan, 2001) state that this link is circular: negative media images promote negative attitudes, and ensuing media coverage feeds off an already negative public perception. The media must play a role in changing such negative perceptions. In the past, people with physical disabilities were depicted in the media only when the story was about their disability. Today, it is becoming more common to see television characters whose physical disability has nothing to do with the storyline they are characters like any other, and their disability is not significant to the story. This is far from the case with mental illness. In popular media, mental illness is most commonly portrayed as deviant and dangerous, and is also frequently the only noteworthy trait about the character.

Majority of the respondents had seen someone with mental illness (82.1%) among which 15.3% were within the family. The most common type of mental illness seen by the respondent was depression (40.5%). Majority of the respondents had heard about depression (90.5%) and schizophrenia (72.4%).

A case-study research was carried out to identify functional teaching stages, cost of treatment and methods for use with a person with moderate mental retardation. It presents a structured and sequenced teaching programmed which has analyzed the stages needed to produce a flower-drawing and has created a tested and approved practical example in which a person with moderate mental retardation was enabled to carry out a flower-drawing independently. To this end, Bimal a seven year old child with moderate mental retardation was used as an example for the case study research. Thus the chronological progress and performance of Bimal during the structured teaching programmed, cost of treatment was observed and evaluated as an example.

The study took place over ten days, comprising 20 sessions of 15 minutes each in total. An observation form, developed by the researcher, was used in each of the sessions to record the results. As shown on the observation form, the programmed used with Bimal was structured in sequential stages, ordered from simple to more difficult where each step was taught separately. The visual clues included an indication of the onset points of lines, reminder points at regular intervals and the direction of lines and cost of treatment data was collected from on the basis of his

parent's interview. At the end of the teaching programmed used with Bimal, it was noted that he had accomplished the task within the stages provided and succeeded in the outcome of drawing a flower using the method outlined and total cost of treatment was calculate in this study.

Consequently mildly mentally retarded Bimal acquired the ability to draw a flower independently after the 13th session using the visual clues provided and cost of treatment was greater than family income.

5.3 Recommendations

5.3.1 Policy Related Recommendations

Developing and implementing mental health policy, plans and programs in a country or region is a complex process. Many factors have to be considered and the needs of various stakeholders have to be taken into consideration.

In this study, policy-makers and public health professionals can find a method for organizing actions at different stages and for facing challenges and barrier. It is hoped that the information given will help to lighten the required tasks and provide guidance in decision-making.

The process requires moving between theory and practice, while interacting with real people and their circumstances. The specific circumstances of developing and implementing mental health policy, plans and programs can vary enormously from one country to another. The steps for developing policy, plans and programs in this study have to be adapted to the particular conditions of the countries concerned.

Although there is variation between countries it is essential that countries develop policy, plans and programs for mental health. Equipped with a policy, plan and programs, a higher school is well placed to systematically improve the mental health of its students.

Implementing the steps in this study may be a slow process requiring the mobilization of political will. Nevertheless, the experiences of several countries or regions show that these steps are feasible for the development and implementation of mental health policies, plans and programs. The whole process can produce positive mental health

outcomes and the population of a country or higher school can receive the following benefits:

- alleviation of symptoms associated with mental disorders;
- improved functioning in various areas (e.g. family, social, education, work);
- improvement in the quality of life of persons with mental disorders and their families;
- Prevention of psychological and social disability.
- Increase of Investment in treatment of mental illness in higher secondary schools.

5.3.2 Practice Related Recommendations

As most of the respondent heard about mental health through the media like radio, TV, etc. the advertisement through media should be encouraged. Mental health counseling unit should be established in colleges to give mental health education like information on treatment centers and existing mental health services. Celebration of various mental health days should be encouraged (World Mental Health Day – 10th October, Children Mental Health Day – 4th May) as they helps to raise public awareness about mental health issues. Various mental health programs should be designed and implemented to invest sufficient invest in higher school students.

5.3.3 Further Research Related Recommendations

Results of this study could be useful for future planning in order to promote the mental health literacy of higher school students. In future studies, it may be beneficial to use qualitative methods to determine the basis for positive views as well as determine whether other variables, such as contact with peers who have benefited from mental health services, are influencing positive perceptions of those with mental health problems. It may beneficial for economist to invest in higher secondary school students to improvement of education and mental health and also study correlation between socio-economics and mental health of the students.

At the end of the case study research, suggestions based on the results of the study were stated regarding application and further studies.

- A similar study can be carried out to cover students with attention deficit.
- A similar study can be carried out to cover dyslexia cases which include reverse perception.
- A similar study can be carried out in a way to cover various drawing structures (such as houses, trees, flowers ... etc.) together and analytical study of overall cost of disease.

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ANNEX I- RESEARCH QUESTIONS

Trihbuwan University

Kritipur, Kathmandu

Department of Economics of Education

Master Degree

2015

"Economic factors affecting on education level and mental health among higher secondary school students of Kathmandu, Nepal"

Questionnaire for higher school students Date: -

Namaste, I am Bir Bahadur Gharti a student of Master of Economics of Education from Tribhuwan University. I am doing a research on "Economic factors affecting on education level and mental health among higher secondary school students of Kathmandu, Nepal". This research is done as it is one of the requirements for the partial fulfillment of the degree of Master of Education.

It will take about 30 minute to fill out this form. Your participation in this research is very valuable & the information will be kept confidential. There is no right or wrong answer, the most important thing is that with your help I achieve an insight in the situation of mental health which could be helpful for future in program and policy formation.

You are not obliged to answer any question you don't want to and you may withdraw your participation at any time. The results obtained from this study will be used only for the study.

If you have any queries, please ask me now. Thank you for your valuable participation and kind co-operation.

You may proceed to following questions now.

Thank you!

Note: Please put tick (√) for the chosen answer and or fill in the spaces below.
Q.S.N._____

Section I- Demographic information:

S.N	Questions	Answers	Remarks
1.	Faculty:	☐ [1] Science ☐ [2] Commerce	
2.	Level:	☐ [1] 11 ☐ [2] 12	
3.	Age:	☐ [1] 13-14 ☐ [2] 14-15 ☐ [3] 15-16 ☐ [4] 16-17 ☐ [5] 17-18 ☐ [6] 18-19 ☐ [7] 19-20 ☐ [8] Others(specify) _____	
4.	Sex:	☐ [M] Male ☐ [F] Female	
5.	Marital Status:	☐ [1] Married ☐ [0] Unmarried	
6.	What is your religion?	☐ [1] Hindu	

		☐ [2] Buddhist ☐ [3] Christian ☐ [4] Islam ☐ [5] Others (specify) _____	
7.	Ethnicity (specify) : (Brahmin, Chhetri, Newar, Tamang, Gurung, Lama, Etc)	Specify: _____	
8.	Father's occupation:	☐ [1] Farmer ☐ [2] Service ☐ [3] Business ☐ [4] Others (specify) _____	
9.	Mother's occupation	☐ [1] Farmer ☐ [2] Service ☐ [3] Business ☐ [4] Others (specify) _____	

S.N	Questions	Answers	Remarks
10.	Education status of Father:	☐ [0] Illiterate ☐ [1] Literate	If [0], then go to 11
10.1	IF [1] THEN CLASSIFY:	☐ [1] Primary Level ☐ [2] Secondary Level ☐ [3] High School/ Higher Secondary Level ☐ [4] Bachelors Level ☐ [5] Masters Level ☐ [6] Others (specify) _____	
11.	Education status of Mother	☐ [0] Illiterate ☐ [1] Literate	If [0], then go to 12
11.1	IF [1] THEN CLASSIFY:	☐ [1] Primary Level ☐ [2] Secondary Level ☐ [3] High School/ Higher Secondary Level ☐ [4] Bachelors Level ☐ [5] Masters Level ☐ [6] Others (specify) _____	

12.	Family type Note: Nuclear- A family that consists of only parents and unmarried children Joint- A family that consists of parents and married children Extended- A family that consists of parents, married children and other relatives (uncle, aunt, etc)	☐ [1] Nuclear ☐ [2] Joint ☐ [E] Extended	
13.	Number of family members	_____	
14.	Family income (Gross monthly income in Rupees)	Rs. _____ per month	

Please read the following items very carefully & consider how you feel about each of the statement. There is no any right/ wrong answers to any of these statements, please give your honest reactions.

Section – II Source of information based question

S.N	Questions	Answers	Remarks
General			
1.	Have you heard of mental illness?	☐ [1] Yes ☐ [0] No	If [0], then go to __
1.1	If yes, then what may be the possible causes of mental illness?(one or more answers)	☐ [1] Possession by evil spirits ☐ [2] God's punishment ☐ [3] Physical abuse ☐ [4] Drug or alcohol misuse ☐ [5] Stress ☐ [6] Others (specify) _____	
1.2	If yes, then where do you suggest people to visit for treatment of mental illness?	☐ [1] Faith healers/Dhami/Jhakris/Vaidyas/Lamas ☐ [2] General Doctor/Physician ☐ [3] Yoga and meditation centre	

		☐ [4] Treatment at home ☐ [5] Others (specify) _____	
Source of information			
2.	From where did you know about the mental illness? (one or more answers) Note: Electronic media- TV, Radio, Internet, Print Media- Posters, Pamphlets, Hoarding boards, magazines, newspapers, books, journals,	☐ [1] By seeing mentally ill people ☐ [2] Print media ☐ [3] Electronic media ☐ [4] Doctors/ Health Workerss ☐ [5] Family/Friends ☐ [6] Others (specify) _____	If [0], then go to 3
Exposure to health message			
3.	Have you ever received any mental health promotional information?	☐ [1] Yes ☐ [0] No	If [0], then go to 4
3.1	If yes, from where did you get mental health promotional messages? (one or more answers)	☐ [1] TV ☐ [2] Posters ☐ [3] Radio ☐ [4] Pamphlets ☐ [5] others(Specify):	

		_____	
Past exposure			
4.	Have you seen anyone with mental illness?	☐ [1] Yes ☐ [0] No	If [0], then go to 5
4.1	If yes, then please specify the type of illness: Note: - Depression- is considered an illness when the change in mood occurs more than normal. The most important is that patient becomes sad. AnxietyNeurosis- people experience severe feelings of anxiety, beyond that expected for the stress of his situation. This prevents him from carrying out his usual daily life. Hysteria- People with hysteria may have 'fits', have weakness, unable to speak and faith in crowds. Psychosis- People have experiences and thoughts which other people do not have, and usually their behavior is abnormal. Schizophrenia- a mental disorder characterized by a disintegration of the process of thinking and of	☐ [1] Depression ☐ [2] Anxiety Neurosis ☐ [3] Hysteria ☐ [4] Psychosis ☐ [5] Schizophrenia ☐ [6] Don't know ☐ [7] Others (specify) _____	

	emotional responsiveness.		
4.2	Where were they treated?	☐ [1] Kept at home ☐ [2] Visited to Faith healers ☐ [3] Hospital ☐ [4] Yoga/meditation Centre ☐ [5] Don't know ☐ [6] Others (specify) _____	
4.3	Is there anyone in your family who has mental illness?	☐ [1] Yes ☐ [0] No	

DISEASES BASED QUESTION

S.N	Questions	Answers	Remarks
Depression			
5.	Have you heard of Depression?	☐ [1] Yes	If [0], then go

		☐ [0] No	to 7
5.1	If yes then, what might be the possible cause for depression? Note: * Social life- staying alone or far from family, no friends circle,	☐ [1] Lost of loved ones/ Bereavement ☐ [2] Exam failure ☐ [3] Loss of job ☐ [4] Economic Problem ☐ [5] Relationship problems ☐ [6] Social life * ☐ [7] Others (specify) _____	
5.2	In your opinion what can be done to prevent causing depression? Note: *ECA- Extra Curricular Activities * maintain healthy daily routine – wake up on time, eat well, sleep well, no workload	☐ [1] Sharing with a close person ☐ [2] Seek counselling ☐ [3] Engage on ECA* ☐ [4] Reduce factors causing stress ☐ [5] Maintain health daily routine * ☐ [6] Others (specify) _____	
Schizophrenia			

6	Have you heard of Schizophrenia?	☐ [1] Yes ☐ [0] No	If [0], then go to 7
6.1	If yes then, from where did you hear about it? Note: *Print Media- Posters, Pamphlets, Hoarding boards, magazines, newspapers, books, journals,	☐ [1] Movies ☐ [2] TV/Radio ☐ [3] Print media* ☐ [4] Friends ☐ [5] Health workers ☐ [6] Family ☐ [7] Others (specify) _____	
6.2	If yes then, what might be the possible cause for Schizophrenia?	☐ [1] Economic problem ☐ [2] Social isolation ☐ [3] Poor Family relationship ☐ [4] Genetic ☐ [5] Stress ☐ [6] Others (specify) _____	

6.3	In your opinion what can be done for the people to prevent suffering from schizophrenia? Note: *ECA- Extra Curricular Activities * maintain healthy daily routine – wake up on time, eat well, sleep well, no workload	☐ [1] Sharing with close friend ☐ [2] Seeking counseling ☐ [3] Engage in ECA* ☐ [4] Reduce factors causing stress ☐ [5] Maintain health daily routine* ☐ [6] Others (specify) _____	

ANNEX: -II.

A Case Study on Moderate Mentally Retardation Child: - How Able to Draw a Flower by Means of the Visual Clues and Calculate the Cost of Treatment

Information about child

Name: - Bimal Tamang

Permanent Address: - Nuwakot

Temporary Address: - Kathmandu

Age: - 7 years old

Class: - 3

Disease: - Moderate Mentally Retardation

Information about Parents

Father's Name: - Himal Tamang

Education Level: - S.L.C.

Occupation: - Driver

Religion: - Buddhist

Income: - Rs 10,000/ month

Mother's Name: - Sita Tamang

Education Level: - 8 class

Occupation: - Household

Religion: - Buddhist

Income: - X

Introduction

"At the base of learning structures of children, lies the skill to imitate. Children correlate between what they see and hear and the level of their ability to do and they try, experience and as a result, at the end of this process, they learn" (Morrow, 2005). Apart from children being able to do what they see, it is important to reflect what they see. The skill to reflect constitutes one of the fundamental criterion of visual arts education (Özsoy, 2003).

Generally, visual arts education is perceived by educators as an area where visual perception is intensely experienced and reflected. Accordingly, visual arts education is a type of education that adapts and puts emphasis on children's visual perception and visual structuring criteria (Kırışoğlu, 2002). It is known that children are introduced to visual arts education in early childhood. Examples of their experiences include; learning to hold a pen, creating marks on the paper, scribbling, drawing meaningful lines, using colors in lines among others.

Many children who develop normally explore linear trials involved in visual arts education by themselves within their normal process of development and implement them. More clearly, it can be said that most children who develop normally are able to observe people, houses, trees, flowers and similar objects and living creatures within their development process by observing their own environment and are able to reflect them on paper (implantation field). Therefore, children who develop normally do not

need special teaching techniques to learn to draw during childhood. However, this is not the case for mentally retarded children who are among individuals with special needs. Mentally disabled children need special education to acquire skills in the area of visual arts just as they need special education to acquire the skills necessary in other areas (Kellogg and O'Dell, 1967; Salderay, 2008).

A child who develops normally can reflect a flower drawing on paper, even if schematically, with looking at a flower or an illustration of a flower. However, it does not seem very probable that a mentally retarded child can analyze the steps of drawing flowers and practice it on paper step by step by looking at a flower or from an illustration he has created. For that very reason, it would seem necessary that when teaching a mentally retarded child how to draw a flower, the steps must be sequenced from simple to more difficult, with each step being taught separately. This would include explicitly showing the onset points of lines, interval points and the direction of the lines.

Based on this hypothesis, the researcher wanted find out, "how the ability to draw a flower by a person with moderate mental retardation could be facilitated using structured visual clues" This issue has been explored and analyzed from a variety of perspectives.

Method

This case study research is an observation using qualitative data. According to Karasar (1994: 156-158), an observation-based qualitative research comprises: participation in an observation process with a view to gather information about a certain person, place, event, object, situation and condition, to make observations intended for specific purposes.

The dependent variable of this research is the student's ability to perceive and draw the illustrations on the visually ordered flash cards that will be shown to her/him, on the paper, in the same order and cost of treatment. The student himself/herself is the independent variable of the research.

In this case study research, the observation form (Table 1) method, which is a data collection technique in qualitative research, was used to record the outcome of the performance the of the mentally disabled seven-year-old child using visually

sequenced illustration cards, in order to determine whether he had learnt to draw a flower and collect the detail data about disease from him parent.

Background of the Sample

The universe of the case study research is Bimal who is a seven year old mildly mentally retarded child. Accordingly, the universe of the research has been implemented within the defined universe.

The Student Who Participated in the Case Study Research:

Bimal is a male student with special needs, born on 02.01.2009. According to the Patan Psychiatric Hospital on 05.12.2014, Bimal is defined as "Mildly Mentally Retarded". Taking this report as basis, Bimal can be identified as an individual who has intellectual special needs. According to the said report prepared by the rehabilitation team (1 speech and language therapist, 1 psychologist and 1 physiotherapist) who have worked with Bimal since 2015;

a) In terms of social communication skills: the child can adapt to the environment within the framework of the social rules his age requires, he gets excited in spontaneous changes and contracts and he has behavioral problems such as waving his right hand for a long period, but; he does not have any behavioral problems that would prevent him from learning and even though he cannot clearly communicate verbally, he tries to communicate and he can use his body language correctly, he obeys the rules in the class, he can adapt to new environments, he can queue in games,

b) In terms of cognitive skills: he is deficient in concepts of place/location, shape, form, color, opposites (small-large, thin-thick, short-long, thin-fat... etc.), numbers but; the student is able to hold the pencil and use it and with a systematic effort he may be able to draw meaningful lines as a preparation to writing, he can accomplish instructions that include two actions; he can imitate actions, he reacts to auditory and visual stimulus,

c) In terms of speech and language skills; he has receptive language (he understand what is being told) but he lacks expressive language and the ability to differentiate between homonyms, he can articulate some sounds (a, e, o, b .. etc. -those that are

labial and laryngeal-) but fails to articulate some others (s, ş, ç, ğ, r, z, v, j... etc. -those that require breath and tongue movements-), he cannot combine sounds, he can accomplish two and three staged instructions, he can imitate words,

d) In terms of motor skills: he does not have any physical problems that may prevent him from acting.

e) Daily life skills: he can use a fork and a spoon age appropriately, he can fill his glass with water from the bottle and drink it, he can clean the floor, the table, the chair…etc. with a wipe, he can spread jam, honey, chocolate spread etc. on bread.

f) Personal care skills: he can wash his hands and face age appropriately, he can dress and undress, he can put on and take off his valorize shoes, he can use the toilet, he can brush his teeth and he abides by the hygienic rules.

Developing the Data Collection Tool

Before starting the case study research, the researcher collected some information about the general performance of the student by interviewing the rehabilitation team that worked with the student (1 language and speech therapist, 1 psychologist and 1 physiotherapist) and the student's parents. In light of the information he gathered, the researcher discovered that the student experiences some difficulties in looking carefully at a sample shown (such as a photo or a picture), in reflecting what he sees on paper correctly; in drawing pictorially meaningful figures (drawing an object or a living creature schematically), in concentrating on what he does and in working in a focused manner. Having gathered the information, a visual arts task (drawing a flower) was designed to serve the purpose of the study. The visual arts task was selected according to the student's preference. After the task had been selected, the researcher developed an observation form (Table 1) of 15 criteria to judge the performance of the child. Subsequently, the draft observation form was shown to the rehabilitation team (1 language and speech therapist, 1 psychologist and 1 physiotherapist) and three arts teachers for evaluation and was modified in line with their feedback. The revised observation form was sent to a specialist of Nepalese Language and Literature for review of the terms used. In accordance with the expert views, it was decided that the observation form was well-designed and functional.

For the evaluation of the 15 questions included in the form, a grading scale consisting of two options was used. Accordingly, for each question, there were two options: 1) can do the action when shown the card (+), and 2) fails to do the action when shown the card (–). The researcher ticked the appropriate symbol on the observation form.

Collecting the Data

Prior to the researcher starting to teach the drawing task, he collected baseline data to ascertain the student's performance at the task without input. To do this, he observed the reactions of the student (his level of ability to draw flowers) three days in a row, by means of single opportunity technique and recorded data he obtained on the performance level form. The flower drawings which possessed schematic features and scribbles were then used determine the student's baseline performance level (Appx 1) using the observation form. The application of the observation form process lasted 20 days and included 20 sessions of 15 minutes each. Within this process, visually sequenced and ranked drawing cards that reflected the questions in the observation form (Appx 2) were shown to the student in sequence and the performance of the student (his level of ability to know and do) was observed and put down in the form. Furthermore, the researcher took care to ensure that each session within study (within the observation form process) was carried out within the same external conditions (same venue, table, chair, time of day, pencil, paper, period etc.). Under these conditions, the data obtained in 20 sessions were recorded on the observation form, and constituted the data of the research.

Introduction of Disease

In each country approximately 1% of the population have mental retardation. Mental Retardation is a disability, which starts before adulthood, and has a lasting effect on development producing:

Reduced ability to cope independently (impaired social functioning) due to Reduced ability to understand new information and to learn new skills (impaired intelligence) The essential features of mental retardation are a significantly sub-average general intellectual function, accompanied by significant deficits in social functioning in areas such as social skills, communication and in addition difficulties in attaining personal independence and social responsibility. The onset of mental retardation

must be before the age of 18. Traditionally, intellectual functioning has been measured by IQ tests and a significantly sub-average intellectual functioning was defined as an IQ of 70 or below. However IQ tests are now treated with some flexibility that might permit the exclusion from the diagnosis of mental retardation of some people with IQ's lower than 70. This is the case if it is felt that there are no significant deficits in adaptive function (the person's effectiveness in areas such as social skills, communication, daily living skills, etc) Mental retardation can be further broken down into borderline, mild, moderate, severe and profound according to IQ. The IQ level gives an approximate guide to the individual's general level of functioning.

Borderline / Mild Mental Retardation

They represent about 80% of people with mental retardation and their appearance is usually unremarkable and any sensory or motor deficits are slight. In adult life most of these people are never diagnosed. Most of these people can live independently in ordinary surroundings, although they may need help with housing and employment or when under some unusual stress.

Moderate Mental Retardation

People in this group account for about 12% of the learning disabled population. Most of them can talk or at least learn to communicate and they take 3 care of themselves with some supervision. As adults they can usually undertake simple or routine work and find their way about.

Severe Mental Retardation

This group accounts for about 7% of the learning disabled population. In preschool years their development is usually greatly slowed. Eventually they may acquire some skills to look after themselves although under close supervision. They may also be able to communicate in a simple way. Association adults they can undertake simple tasks and engage in limited social activities.

Profound Mental Retardation

People in this group account for less than 1% of the learning disabled group. Few of them learn to care for themselves although some eventually acquire some simple speech and social behavior.

Etiology

The causes of mental retardation can be divided into genetic and environmental, although these

Categories may overlap.

Genetic causes originate prior to conception or during the very early development of the fetus. Environmental causes include those that affect the developing fetus or those that occur in the perinatal, neonatal or childhood period.

Why is it important that we should know the causes of mental retardation?

It is important for a number of reasons such as:

1. The need for the parents, careers and individuals to understand why mental retardation has occurred

2. The individual and family's basic right to know

3. Relief from uncertainty regarding the cause of the disabilities

4. Relief from the guilt that family and/or social factors were the cause of the mental retardation or developmental or behavioral disturbance

5. Facilitation of grief resolution

6. Focusing towards the future

7. Instigations of interventions relevant to strengths and needs

8. Potential for identifying with and belonging to a support group

9. Essential genetic counseling where appropriate for the entire extended family

10. Risks for other family members of the condition re-occurring in their offspring

11. Possible treatment of specific conditions

12. Identification of complications of the disorder understanding of how the disorder may develop over time

Are there common syndromes associated with mental retardation?

The interest in specific syndromes in mental retardation has increased in recent years as it is recognized that, apart from similarities in physical features, there are identifiable behaviors that occur more commonly in certain syndromes.

Examples of these are:

• Down syndrome

• Fragile-X syndrome

• Prader-Willi syndrome

• Lesch-Nyhan syndrome

• Tuberous sclerosis

Signs and Symptoms

Generally speaking, the symptoms of mental retardation include delays in oral language development, deficits in memory skills, difficulty learning social roles, difficulty with problems solving skills, decreased learning ability or an inability to meet education demands at school, failure to achieve the markers of intellectual development and a lack of social inhibition.

However, symptoms of mental retardation will vary depending on the condition's severity. For instance, while signs of mild retardation (i.e., those with IQs of about 52 to 79) may include a lack of curiosity and quiet behavior, signs of severe mental retardation (i.e., those with IQs of about 20 to 35) may include infant-like behavior throughout the patient's life, and those with profound mental retardation (i.e., IQs of 19 or below) are likely to have limited motor and communication skills and require lifelong nursing care.

The symptoms of mental retardation are broken out by the level of the condition below.

Mild intellectual disability: From birth to age six, these children are able to develop social and communication skills, but their motor skills are slightly impaired. In late adolescence, they can usually read at a sixth-grade level. They are typically able to develop appropriate social skills, and adults can often work and support themselves, though some of these individuals may require assistance during times of social or financial stress.

Moderate intellectual disability: Children with this condition who are six years old or younger can talk and communicate, but usually have poor social awareness. Their motor coordination is fair, and adolescents can learn some occupational and social skills. Adults can sometimes support themselves and hold down a job, though they often require guidance and assistance during stressful periods.

Severe intellectual disability: Young children with this condition have limited speech abilities, though they can usually say a few words. Their motor coordination is mostly poor. While adolescents can communication with others and can learn simple habits, they typically require lifelong guidance and assistance with daily activities.

Profound intellectual disability: Young children with this level of mental retardation have very little motor coordination of often require nursing care, which can last a lifetime. Adolescents have limited motor and communication skills.

Diagnosis

Diagnosing mental retardation can only be done by a certified psychologist capable of administering, scoring and interpreting an intelligence or cognition test. Screening for this condition involves tests to analyze the child's intellectual and adaptive development, including the abnormal Denver developmental screening test and IQ testing. (These tests are done of children and adolescents because mental retardation's limitations are apparent before age 18.) Children with IQs below 70 and those with limitations in two or more areas of adaptive behavior (e.g., motor skills, communication abilities, self-help and independent living skills, and other everyday skills) may generally be considered intellectually disabled

Treatment

Mental retardation is an irreversible condition. Treatments for this condition focus on improving the patient's ability to live a full life. To that end, special education and training, including for social skills, may begin even in infancy

Table:-1. Cost of Treatment

Sources of Cost	Cost per Month (Rs)
Laboratory Test	3,000
Medical Treatment	5,000
Psychological Treatment	2,000
Speech Therapy	3,000
Educational Guidance	2,000
Counseling	1,000
Home Training	1,000
Total	17,000

Source: Field Survey 2016

The highest cost of treatment is Medical treatment because it includes the charge of doctors and cost of total drugs these are used for disease of child. Laboratory test and Speech therapy are second highest cost of treatment followed by psychological treatment, educational guidance, counseling, and home training. In my case study, cost of treatment is highest than the income of family so the economic factors are major elements to affect the mental retardation. The poverty is ply vital role in the treatment of mental disease so economic factors can directly effect on the mental disease.

Findings and Comments

This section the question was analyzed and findings and comments regarding the analysis are stated. Table:-2. The records of the Observation Form regarding Flower Drawing Using Visual Clues (Visually Staged and Ranked Drawing Cards)

Meanings of the symbols used: +: Can do the action when shown

-: Fails to do the action when shown

Questions		Session No:																			
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
		SYMBOLS USED IN THE SESSIONS																			
1	Can the student place an A4 page vertically on the table?	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	++	+	+
2	Can the student draw a circle with 3cm diameter in the middle of the paper?	_	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
3	Can the student put a dot on the upper end of the circle?	_	_	_	+	_	+	+	+	+	+	+	+	_	+	+	+	+	+	+	+
4	Can the student put a dot on the lower end of the circle?	_	_	_	_	_	_	_	+	+	+	+	+	+	+	+	+	+	+	+	+
5	Can the student put a dot on the right hand side of the circle?	_	_	_	_	_	_	_	_	_	+	+	+	+	+	+	+	+	+	+	+
6	Can the student put a dot on the left hand side of the circle?	_	_		_	_	_	_	+	_	+	+	+	+	+	+	+	+	+	+	+
7	Can the student draw an oval line from the right hand side of the circle towards the upper end of the circle?	_	_	_	_	_	_	_	_	_	_	_	+		+	+	+	+	+	+	+
8	Can the student draw an oval line from the upper end of the circle towards the left hand side of the circle?	_	_	_	_	_	_	_	_	_	_	_	_	_	+	+	+	+	+	+	+
9	Can the student draw an oval line from the left hand side of the circle towards the lower end of the circle?	_	_	+	+	_	_	_	_	_	_	_	_	_	+	+	+	+	+	+	+

10	Can the student draw an oval line from the lower end of the circle towards the right hand side of the circle?	–	–	+	–	–	–	–	–	–	–	–	–	–	+	+	+	+	+	+	+
11	Can the student draw a long downward line from the right hand side petal at the bottom of the circle?	–	–	–	–	–	–	–	–	+	+	+	+	+	+	+	+	+	+	+	+
12	Can the student draw a long downward line from the left hand side petal at the bottom of the circle, which is parallel to the line on the right, with some space in between the two?	–	–	–	–	–	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
13	Can the student put a dot in the middle of the downward line on the right?	–	–	–	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
14	Can the student put another dot 1 cm below the other dot?	–	–	–	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+
15	Can the student draw half an oval line that connects the two dots?	–	–	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+

As can be seen in Table 2, the student can draw a flower when exposed to the visually staged and ranked drawing cards technique after the 13th session onwards. It can be seen that the student could accomplish only the 1st point in the 1st session. In the 2nd session, he could accomplish the 1st and the 2nd stages. In the 3rd session he could accomplish the 1st, 2nd, 9th, 10th and 15th stages. In the 4th session he could accomplish the 1st, 2nd, 3rd, 9th, 13th, 14th and 15th stages. In the 5th session he could accomplish the 1st, 2nd and 13th stages. In the 6th session he could accomplish

the 1st, 2nd, 3rd, 12th, 13th and 15th stages. In the 7th session, he could accomplish the 1st, 2nd, 3rd, 12th and 13th stages. In the 8th session, he could accomplish the 1st, 2nd, 3rd, 4th, 6th, 12th, 13th and 15th stages. In the 9th session, he could accomplish the 1st, 2nd, 3rd, 4th, 11th, 12th, 13th and 15th stages. In the 10th 11th and 13th sessions he could accomplish the 1st , 2nd , 3rd , 4th , 5th , 6th , 11th , 12th , 13th , 14th and 15th stages. However, in the 14th, 15th, 16th, 17th, 18th, 19th and 20th sessions, he accomplished all 15 stages.

In addition to the student's positive performance that emerged after the use of the visually sequenced and ranked drawing cards technique, corresponding conclusions were reached upon the analysis of similar studies. Kalmanowitz and Kasabova (2004; 6, 7), which deals with the same subject, states that drawing studies that are realized in early childhood result in the child interacting with the work and help the child to give meaning to his environment and therefore help him participate in the adult world. Also, it is stated that, as the student individually closely interacts with the work in drawing studies, he gains experience and this helps them give meaning to symbolic expression and reflect them. However, Levorse (2008), states that mentally disabled children cannot learn to draw meaningful lines by way of this technique. Accordingly, he states that although mentally disabled children are eager to scribble and draw lines like children that present with normal development, they have difficulties in differentiating between linear symbols and writing and understanding them. He emphasizes that the student needs guidance to differentiate between linear structures and to give meaning to them. Arts Education Partnership (2002), USA national coalition, on the other hand mentions that guiding children properly during their first drawing attempts is a strategy that can be used. More clearly, this can be seen as utilizing techniques that will help children see the things they are looking at more accurately, give meaning to them and reflect them on paper more accurately. Selfe (1983: 202) on the other hand, mentions that it is the responsibility of visual arts instructors (arts teachers) to intervene in children's drawing attempts.

Accordingly he emphasizes that the initial basic information to be given to children and the teaching techniques to be used should tailored to the children's needs. Therefore it can be said that the way in which the student perceives, attributes meanings to what he sees, and the way in which he applies what he attributes meanings to, is highly significant. Similarly, Kellogg and O'Dell (1967) mention that

mentally disabled children need special teaching techniques to be able to draw linear expressions. It can be stated here that the special teaching technique to be used to teach the linear expression should be determined according to the needs of the child and his readiness. In light of all of the above, the positive performance that emerged at the end of the study where visually sequenced and ranked drawing cards were used to teach the student how to draw a flower correspond to other studies in the field. Moreover, it can also be said that the intense eagerness and motivation of the student towards the study had a positive effect on his performance. Furthermore, it can be said that the fact that the linear structures were concrete and were sequenced in order of difficult, had a positive effect on the student's ability to perceive and to reflect. It should also be mentioned that the fact that the student clearly saw that he could accomplish the task and succeed in the assignment using the technique played a role in his performance. The fact that the instructor was passive and the student was active during the study benefited the student's performance. Finally, it can be said that the fact that the study was novel to the student had a positive impact on his performance.

Conclusıon

This case-study research was carried out to identify functional teaching stages, cost of treatment and methods for use with a person with moderate mental retardation. It presents a structured and sequenced teaching programmed which has analyzed the stages needed to produce a flower-drawing and has created a tested and approved practical example in which a person with moderate mental retardation was enabled to carry out a flower-drawing independently. To this end, Bimal a seven year old child with moderate mental retardation was used as an example for the case study research. Thus the chronological progress and performance of Bimal during the structured teaching programmed, cost of treatment was observed and evaluated as an example.

The study took place over ten days, comprising 20 sessions of 15 minutes each in total. An observation form, developed by the researcher, was used in each of the sessions to record the results. As shown on the observation form, the programmed used with Bimal was structured in sequential stages, ordered from simple to more difficult where each step was taught separately. The visual clues included an indication of the onset points of lines, reminder points at regular intervals and the direction of lines and cost of treatment data was collected from on the basis of his

parent's interview. At the end of the teaching programmed used with Bimal, it was noted that he had accomplished the task within the stages provided and succeeded in the outcome of drawing a flower using the method outlined and total cost of treatment was calculate in this study.

Consequently mildly mentally retarded Bimal acquired the ability to draw a flower independently after the 13th session using the visual clues provided and cost of treatment was greater than family income. Also, at the end of the case study research, suggestions based on the results of the study were stated regarding application and further studies.

Suggestions regarding application:

- Visually staged and ranked drawing cards technique can be used to teach mentally disabled individuals how to draw human figures, plants and animals, objects and structures.
- Visually staged and ranked drawing cards technique can be used to help individuals who have difficulties in perceiving what they see and linearly reflecting them, to overcome these problems.
- Visually staged and ranked drawing cards technique can be used to help students who are learning how to read and write, to perceive linear symbols and imitate them and to improve their skill to generalize.
- Large amount of cost may be need to prevent and treatment of mentally retarded child

Suggestions regarding further studies:

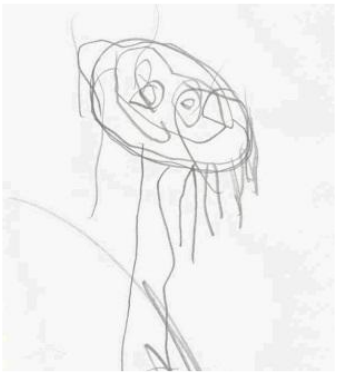
- A similar study can be carried out to cover students with attention deficit.
- A similar study can be carried out to cover dyslexia cases which include reverse perception.
- A similar study can be carried out in a way to cover various drawing structures (such as houses, trees, flowers ... etc.) together.

Appendices

Appendix 1

Flower drawings by Bimal which were used to evaluate his level of performance before the teaching technique was used.

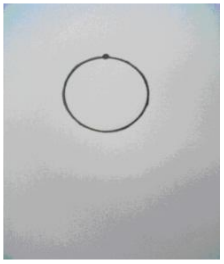




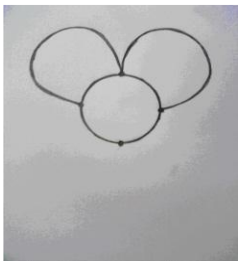
Appendix 2

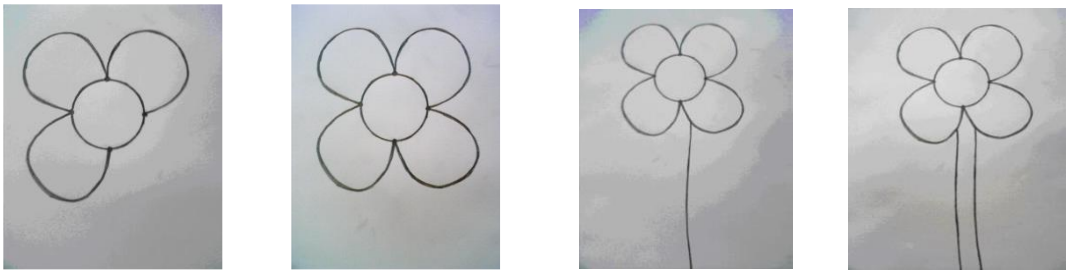
Visually staged and ranked drawing cards

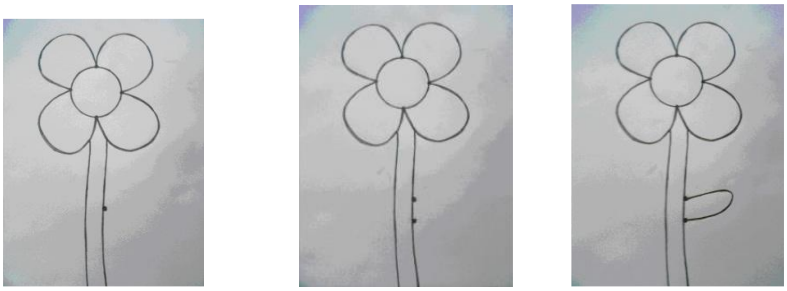










Appendix 3

The flower drawing Bimal did at the 20th session