

Original Research Article

Practices causing time delay in seeking care for mental illness

Sunitha Kandasamy¹, M. Vijayalakshmi^{2*}, Abdulrahuman Mohamed Buhari³

¹Department of Community Medicine, ³Department of Psychiatry, Tirunelveli Medical College, Tirunelveli, Tamil Nadu, India

²Institute of Community Medicine, Madras Medical College, Chennai, Tamil Nadu, India

Received: 20 March 2019

Revised: 03 June 2019

Accepted: 08 June 2019

*Correspondence:

Dr. M. Vijayalakshmi,

E-mail: drvijivijay@yahoo.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Mental health is the foundation for wellbeing and effective functioning for an individual. When people consult clinicians to determine the cause and treatment for such illness, they may also seek answers to questions that medical science can't answer. Many patients rely on a religious or traditional framework to help answer these questions that often hinder medical treatment and affect its prognosis. This study aim to estimate the practices adopted by the community for cure of mental illness and estimates the time delay that occurred to initiate medical treatment because of these practices.

Methods: A cross sectional study was conducted among 103 patients and their caretakers undergoing treatment in the Psychiatry Department of a tertiary care hospital using a semi structured questionnaire. The data collected was analyzed for mean and statistical significance between proportions.

Results: Among the 103 patients, 54.4% were males and 45.6% females. 54.3% of patients suffered from psychosis and 45.6% from neurotic illness. About 60.1% of the patients had experienced some form of traditional and religious practices for treating their illness before approaching medical treatment causing an average time delay of 2.6 years to initiate regular medical treatment.

Conclusions: The high rate of religious and traditional practices followed by the community for psychiatric illness leads to significant time delay in initiating evidence based management of illness resulting in significant reduction in the quality of life of these patients. Hence mental health awareness initiative at community level and strengthening mental health services at primary care level is the need of the hour.

Keywords: Mental illness, Time delay, Practices

INTRODUCTION

The definition of health includes mental health along with its physical and social components.¹ Mental health is the foundation for wellbeing and effective functioning for an individual. Mental illness makes persons vulnerable and makes individuals susceptible to human rights violations. Mental Health is vital for the growth and productivity of every society and for a healthy and happy life.

Mental illnesses are responsible for nearly 13% of the global burden of disease.² Nearly 80% of people with mental disorders live in low- and middle-income countries, which account for more than 10% of total burden of disease in these countries.³ According to Global Burden of Disease Report, mental health problems are among the first twenty leading causes of disease burden.⁴ The WHO study conducted for the NCMH (National Care of Mental Health), states that at least 6.5 per cent of the Indian population suffers from some form of the

serious mental disorder, with no discernible rural-urban difference.⁵ Also there is inadequate care seeking as well as poor service delivery for mental health disorders. There are sparse structured and organized mental health services available at primary and even at secondary health care level.

India has a long history of mental health understanding and practices, good, bad and harmless. The community, family and individual perceptions, various social and cultural factors often determine and influences their help seeking behavior. The pathway of psychiatric care is defined as the sequence of contacts with individuals and organizations, initiated by the distressed person's efforts and those of his significant others to seek appropriate help as well as the help that is supplied in response to such efforts.⁶ The quality and the seriousness of the distress provide impedus to the pathway, but the duration and direction are shaped by the psychosocial and cultural factors.

When people consult clinicians to determine the cause and to treat an illness, they may also seek answers to questions that medical science cannot answer such as, "why is this illness happening to me?" When confronted with severe distress, suffering, and personal limitation, individuals with mental illness may have exhausted other resources and consequently find solace in looking beyond themselves for hope and power.⁷

Many patients rely on religious or spiritual framework and call on religious or spiritual care providers to help answer these questions.⁸ In a secular country like India, it is widely common. Religious beliefs can provide support through the following ways: Enhancing acceptance, endurance and resilience. They generate peace, self-confidence, purpose, forgiveness to the individuals own failures, self-giving and positive self-image. On the other hand, they can bring guilt, doubts, anxiety and depression through an enhanced self-criticism.⁹

Many claim mental illness as a state of being possessed by someone. They still believe that mental illnesses as acts of God or as an evil spell. So they turn towards faith healers who outnumber the psychiatrists.¹⁰ These beliefs are common especially in rural population and people with low literary rates. Women are more prone to develop psychiatric disorders are more neglected than males in receiving care.¹¹ They end up going to a black magician or a faith healer who give amulets and perform black magic. Just as mental health professional have not valued the role of religious practices so they too have developed negative attitudes towards psychologists and psychiatrists.¹²

Malediction and exorcism are commonly practiced in India, Malediction refers to the utterance of a curse against someone. While malediction and its associated practices may be considered superstitious, they are still considered real, dangerous, and not to be dismissed or

taken lightly.¹³ Exorcism is the religious or spiritual practice of evicting demons other spiritual entities from a person, or an area, that are believed to be possessed.¹⁴ Depending on the spiritual beliefs of the exorcist, this may be done by causing the entity to swear an oath, performing an elaborate ritual, or simply by commanding it to depart in the name of a higher power. The practice is ancient and part of the belief system of many cultures and religion

In the 1980s, the Government of India felt the need to evolve a plan of action aimed at the mental health component of the national health programme. The National Mental Health Programme (NMHP) was formulated in 1982 to develop a national-level initiative for mental healthcare based on the community psychiatry approach. The objectives of the NMHP were: (i) to ensure the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population, in the foreseeable future; (ii) to encourage the application of mental health knowledge in general healthcare and in social development; and (iii) to promote community participation in the development of mental health services and to stimulate efforts towards self-help in the community The most important progress has been in the integration of mental health with primary healthcare, in the form of the district mental health programme.¹⁵

Though mental health services are taken to primary care level, utilization of these services largely depend on the knowledge, cultural and social beliefs and attitude of the people. The reasons for non-utilization need to be explored. Help-seeking pathways provide the critical link between the onset of psychiatric problems and the provision of help, which does not necessarily culminate in an involvement with a health care provider.

An understanding of the way people seek care for mental disorders is increasingly recognized as important for planning mental health services. This study primarily aims to determine the practices adopted for care in mental illness and to estimate the time delay caused by these practices to seek evidence based management

Aim

- To determine the various practices adopted by patients with mental illness that cause time delay in seeking health care in a tertiary care hospital
- To estimate the time delay caused by such practices among them.

METHODS

This cross sectional study was conducted after obtaining approval from the Institutional Ethics Committee at the psychiatry Department of Tirunelveli Medical College Hospital. During the month of July 2018, from the

Department OPD register (includes both old and new cases), every fifth patient was selected and approached to participate in the study. This sampling technique was adopted to eliminate selection bias by the interviewer. Patients and care givers who consent were included in the study. Non consenters were excluded from the study. Data was collected from 103 patients using a semi structured questionnaire on basic demographic information, the duration of illness and the various practices adopted for curing the illness. Information on the social or economic disadvantage they faced due to the illness was also elicited. A detailed history was elicited from relatives also to ensure completion of data. All the data collected were categorized in percentage and mean. Chi-square test was used to calculate statistical significance.

RESULTS

Among the 103 patients with mental illness 54.4% were males and 45.6% females. The mean age of the patients is about 38.6 years and 43.6% of them belonged to the age group of 31-45 years (Table 1). About 30.1% of the patients were from urban areas whereas 69.9% of the patients from rural areas (Figure 1).

Clinically, about 54.4% of patients suffered from psychosis and 45.6% from neurosis. Among patients with psychotic illness, 80% of them suffered from schizophrenia. Among the neurotic patients, sleep disorder (33.9%) dominates followed by anxiety disorder and substance abuse (8.7%). The most common substance abused was alcohol, the next being marijuana (Table 2).

Table 1: Age and sex wise classification of psychiatric patients.

S. No	Age in years	Males(No)	Males (%)	Females	Females (%)
1	<18	4	3.9	2	1.9
2	19-25	7	6.8	9	8.7
3	26-30	4	3.9	2	1.9
4	31-35	11	10.7	7	6.8
5	36-40	8	7.7	5	4.8
6	41-45	7	6.8	7	6.8
7	46-50	6	5.6	7	6.8
8	51-55	4	3.9	3	2.9
9	56-60	2	1.9	3	2.9
10	>60	3	2.9	2	1.9
	Total	56	54.4	47	45.6

Table 2: Classification of patients based on the illness.

S no	Type of illness	No of males	No of females	Total	%
Neurosis					
1	Sleep disorder	9	10	19	18.4
2	Anxiety disorder	4	6	10	9.7
3	Severe depression	2	1	3	2.9
4	Behavioural disorder	6	0	6	5.8
5	OCD	3	0	3	2.9
6	Phobic disorder	2	4	6	5.8
Psychosis					
1	Schizophrenia	21	24	45	43.7
2	Substance induced psychosis	9	0	9	8.7
3	Bipolar disorder	0	2	2	1.9
	Total	56	47	103	100

Table 3: Time gap to initiate medical treatment.

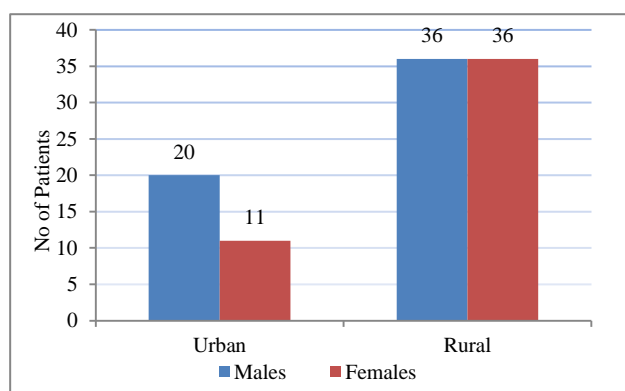
S. No	Time gap	No of males	No of females	Total	%
1	Within a month	10	3	13	12.6
2	1 to 6 months	12	15	27	26.2
3	6 months to 1 year	11	2	13	12.6
4	1 to 2 years	20	12	32	31.1
5	More than 2 years	3	15	18	17.4
	Total	56	47	103	100

(p<0.05)

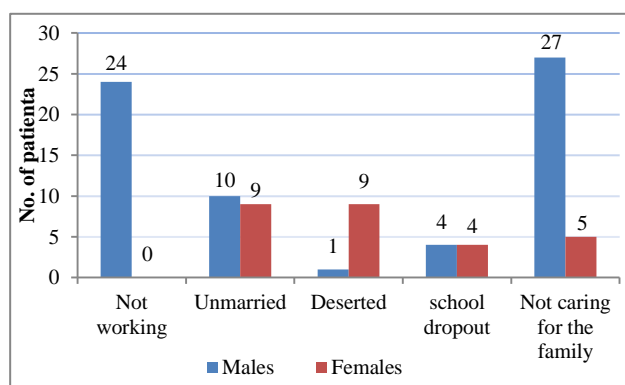
Table 4: Common practices adopted for mental illness.

Sl. no	Practices	No of males	No of females	Total	%
Harmful practices					
1	Malediction / exorcism	9	9	18	33.9
2	Black magic	8	5	13	24.7
3	Tying to tree	6	2	8	15.2
4	Hands or legs tied	3	4	7	13.3
5	Locked in a room	3	3	6	11.4
6	Beating	0	1	1	1.9
	Total	29	24	53	100
Harmless practices					
1	Special prayers / poojas	9	17	26	46.8
2	Splashing holy water/ powder	11	10	21	37.8
3	Tying amulet	11	8	19	34.2
	Total	31	25	56	100

(Some patients were subjected to more than one practice)

**Figure 1: Distribution based on the residential area of the patients.**

Based on the duration of the illness, it is found that 6.9% of the patients had illness for less than a year (57.7% males and 42.3% females), 54.3% of the patients had illness between 1-5 years and 38.8% of them had been with the illness for more than 5 years. 82.5% said that they were regular on their treatment.

**Figure 2: Impact of illness on the patients.**

The impact of the illness is that, about 31.1% of the patients couldn't support their family after being affected by the illness, 23.3% of the patients (all males) were left unemployed, and 18.4% couldn't get married and among married 9.7% were deserted by their life partners. 7.8% had stopped their education because of the illness (Figure 2).

Practices adopted for mental health care

60.1% of the patients had experienced either traditional or religious practices or both before they initiated evidence based management for their mental illness. This includes 54.3% harmless and 51.5% harmful practices, though a few patients were subjected to both practices one after the other. Based on sex, it was found that 50% of males and 72.3% of female had sought religious practices. In 54.8%, these practices were suggested by the neighbors and in 30.6% by relatives.

The most common harmful practice adopted was malediction and exorcism among 33.9% patients equally distributed in both sex. Black magic was practiced among 24.7% of the patients. Almost half of the patients were subjected to the harmless practice of performing poojas and special prayers either at home / religious places (Table 4).

The harmful practices were more among psychotic patients than neurotic and the association is statistically significant ($p < 0.05$), but there was no statistical association between the sex of the patient and the harmful practices ($p > 0.05$).

Time delay

The average time delay to initiate regular medical treatment was 2.6 years and women with mental illness

take 3.4 years to initiate psychiatric treatment while for men it was 10 months.

More than half of the patients (54.3%) had a time interval of more than 1 year from the onset of symptoms to initiate Evidence based management is. Only 12.6% of the patients resorted to scientific management within a month and this is more among patients with neurotic disorders. (Table 3). This may be attributed to the severity with which the neurotic disorders manifest that affects the day to day activities (usually sleep) to a large extent when compared to the slow and progressive manifestation of psychosis over a long period.

Early initiation of treatment is more among males (55%). This may be attributed to the role of man as the earning member and any deterioration to his health may lead to financial crisis in the family.

DISCUSSION

In this study, the sex wise distribution of the patients was 54.4% males and 45.6% females. In a study conducted by Tepper et al, among 406 psychiatric patients, 59% were men and 41% were females.⁷ Also the mean age of the patients in the above study was 40.9 ± 10.7 years which are very much comparable with this study of 38.67 ± 13.5 years.

In this study, it was found that more patients are from rural area 69.9%. But the studies conducted by Kroll et al, 2% were from urban area and the rest from rural areas. This might be a reflection of lack of mental health care facility at primary care level or lack of affordability of the rural poor for private consultation than the affluent urban. Also the study states that about 93% of them were taking regular treatment on a daily basis.¹⁶ In this study only 82.5% take regular treatment.

In a study conducted in Bangladesh, the major psychiatric illness encountered was anxiety disorder and about 59% resorted to prayer as to treat psychiatric illness.¹⁷ But in this study the major illness was schizophrenia (43.7%) and 46.8% of the patients resorted to prayer.

In a study in China, Yang showed that 74.3% of schizophrenic patients had consulted healers providing superstitious or religious therapy.¹⁸ In the study by Ghaffari, 60% of the patients had followed religious or traditional practices similar to this study (60.1%).¹⁹ In the same study 71.1% of males and 48.9% of females had sought religious practices but in this study 50% of males and 72.3% of female had sought religious practices. This is mainly attributable to the common notion in our country that usually females are bewitched.

In a study conducted by Bukhari in Pakistan, 20% resorted to traditional and religious practices because of their relatives.²⁰ In this study, 30.6% of the patients'

treatment seeking behavior had been influenced by their relatives.

In the study of pathway to psychiatric care, in Australia, Lincoln had reported a mean treatment delay of 16 weeks, but in this study the mean time delay for treatment is 2.6 years.²¹ Epidemiological studies had shown that women with mental illness present about five years later than men with the disorder. In this study, time delay for woman was 3.4 years, while for men it was 10 months. This might be the reflection of gender bias existing in Indian community and neglecting of women's health in the family.

CONCLUSION

Traditional and religious practices are widely adopted for treating mental illness in this region, leading to significant time gap between the onset of illness and approaching scientific management. There is a need to widen the scope of mental health interventions, increasing the involvement of all available community resources, and basing the interventions on the historical, social and cultural roots of India. Creating community level awareness and strengthening mental health care services at primary care level can bring change in the societal approach towards mental illness.

ACKNOWLEDGEMENTS

We sincerely acknowledge the patients and caregivers for their cooperation and participation in this study. Authors' also thank Dr. Aishwarya, the then intern for helping in data collection.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES

1. Park K. Textbook of Preventive and Social medicine 24th edition. Banarsidas Bhanot Publishers; 2017.
2. World Health Organization. The global burden of disease: 2004.
3. Jacob KS, Patel V. Classification of mental disorders: a global mental health perspective. *The Lancet*. 2014;383(9926):1433-5.
4. Vos T, Barber RM, Bell B, Bertozzi-Villa A, Biryukov S, Bolliger I, et al. Global Burden of Disease Study 2013 Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet*. 2015;386(9995):743-800.
5. Murthy RS. National mental health survey of India 2015-2016. *Indian J Psychiatry*. 2017;59(1):21.

6. Rogler LH, Cortes DE. Help-seeking pathways: a unifying concept in mental health care. *The American J Psychiatry*. 1993;150(4):554.
7. Tepper L, Rogers SA, Coleman EM, Malony HN. The prevalence of religious coping among persons with persistent mental illness. *Psychiatric Services*. 2001;52(5):660-5.
8. Mueller PS, Plevak DJ, Rummans TA. Religious involvement, spirituality, and medicine: implications for clinical practice. In *Mayo clinic proceedings*. Elsevier. 2001;76(12):1225-35.
9. Moreira-Almeida A, Lotufo Neto F, Koenig HG. Religiousness and mental health: a review. *Brazilian J Psychiatry*. 2006;28(3):242-50.
10. Carson V, Huss K. Prayer-an effective therapeutic and teaching tool. *J Psychosocial Nursing Mental Health Services*. 1979;17(3):34-7.
11. Koenig HG. Religion, spirituality and psychotic disorders. *Arch Clin Psychiatry (São Paulo)*. 2007;34:95-104.
12. Armstrong RG, Larsen GL, Mourer SA. Religious attitudes and emotional adjustment. *J Psychological Studies*. 1962;13(1):35-47.
13. Available at: <https://tif.ssrc.org/2014/11/17/malediction-exorcism-and-evil>. Accessed on 6 March 2018.
14. Jacobs, Louis. "Exorcism". *Oxford Reference Online* (Oxford University Press). 1999.
15. Available at: http://dghs.gov.in/content/1350_3_NationalMentalHealthProgramme.aspx. Accessed on 7 March 2018.
16. Kroll J, Sheehan W. Religious beliefs and practices among. *Am J Psychiatry*. 1989;146(1):67-72.
17. Hossain MD, Ahmed HU, Chowdhury WA, Niessen LW, Alam DS. Mental disorders in Bangladesh: a systematic review. *BMC Psychiatry*. 2014;14(1):216.
18. Yang D. The patterns of the health care seeking behavior and related factors in the schizophrenic patients (in Chinese). *Zhonghua Shen Jing Jing Shen, Ke Za Zhi*. 1992;25:215-53.
19. Ghaffari-Nejad A, Pouya F, Kashani MR. Superstitious beliefs among psychiatric patients in Kerman, Iran. *Arch Iranian Med*. 2003;6(3):184-8.
20. Bukhari SS, Pardhan A, Khan AS. Superstitions regarding health problems in different ethnic groups in Karachi. *J Pak Med Assoc*. 2002;52:38
21. Lincoln C, Harrigan S, McGorry PD. Understanding the topography of the early psychosis pathways. An opportunity to reduce delays in treatment. *Br J Psychiatry*. 1998;Suppl172:21-5.

Cite this article as: Kandasamy S, Vijayalakshmi M, Buhari AM. Practices causing time delay in seeking care for mental illness. *Int J Community Med Public Health* 2019;6:2879-84.