The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 9, Issue 3, July- September, 2021
DIP: 18.01.040.20210903, DOI: 10.25215/0903.040
http://www.ijip.in

Research Paper

# A Comparative Study of Common Factors Restricting Seeking Professional Psychiatric Help in Mental Illness in Rural and Urban Area

Durga Yadav[1], Sweta[2], Upendra Singh[3]*

## ABSTRACT

***Background:*** Mental illness is a condition that affects a person's thinking, feeling or mood. Having mental illness affects how family and society changes its perception towards that individual, thus there are several factors that could hinder seeking professional help. ***Aim:*** The aim of the study was to compare the common factors restricting seeking professional psychiatric help in mental illness in rural and urban area. ***Methodology:*** Sample size of 50 rural and urban areas from psychiatric institute was selected and purposive sampling method was used. Self-prepared Socio-demographic data sheet and clinical data sheet, Stigma scale and Self-prepared checklist on Faith healing was used for the data collection. It was a cross sectional study. ***Result:*** It was found that stigma related to mental illness was one of the factors restricting seeking professional help in mental illness. Families and patient from rural area were seeking less professional help when compared with their urban counterparts. ***Conclusion:*** Concluding one can easily frame that it is very import to conduct community awareness programs to increase acceptance of mental illness in the society and to reduce the factors restricting seeking professional psychiatric in both the rural and urban areas.

***Keywords:*** *Psychiatric Professional, Mental Illness, Restricting Factors, Stigma*

Mental illness is common and can affect anyone or everyone irrespective of age, gender, residence, cast and creed. Mental illness may present itself in varying particular condition or in as a group of conditions from acute illness to chronic mental ill conditions, mild to severe symptoms, multiple disorders to single illness, morbid and co-morbid conditions, co-occurrence with physical diseases and still in many other ways. Few examples of psychiatric disorder like schizophrenia, depression, anxiety spectrum disorders, eating disorders and behavioral addiction. Conditions of mental illness can make life of the sufferer and his family miserable with causing problems in daily life, such as at school or work or interpersonal relationships (Ziedonis & Brady, 1997; De et al., 2011).

[1]Clinical Psychologist, Asray Child Guidance and Neuro-psychiatric Point, Kidwai Nagar, Kanpur, UP, India
[2]Assistant Professor, Dept of Clinical Psychology, Institute of Mental Health & Hospital, Agra, UP, India
[3]Lecturer, Dept of Psychiatric Social Work, ABVIMS &Dr RML Hospital, New Delhi, India
*Corresponding Author

**Received: June 24, 2021; Revision Received: July 21, 2021; Accepted: August 03, 2021**

According to National Mental Health Survey of India, 2015-16, Media referred to the findings of the report as follows: "India needs to talk about mental illness;" "Every sixth Indian needs psychiatric help;" Between age 40 to 49 years age group was mostly pretentious with psychotic illness, bipolar disorders, depressive disorders and neurotic-stress related disorder. The prevalence of substance use disorders was highest in the 50–59 years age group (29.4%). The gender prevalence of psychotic disorders was near similar (lifetime: male: 1.5%; female: 1.3%; current: male: 0.5%; female: 0.4%). While there was a male predominance in alcohol use disorders (9.1% vs. 0.5%) and for BPAD (0.6% vs. 0.4%), a female predominance was observed for depressive disorders (both current [female: 3.0%; male: 2.4%] and lifetime [female: 5.7%; male: 4.8%]) for neurotic and stress-related disorders (Murthy, 2017).

The weighted prevalence across diagnostic categories in urban metros was higher than in rural and urban non-metro areas (with less than 10 million populations). However, differences exist across diagnostic categories. The prevalence of schizophrenia and other psychoses (0.64%), mood disorders (5.6%) and neurotic or stress related disorders (6.93%) was nearly 2-3 times more in urban metros (Gururaj et al., 2016).

Treatment gap for mental disorders ranged between 70% and 92% for different disorders: common mental disorder - 85.0%; severe mental disorder - 73.6%; psychosis - 75.5%; BPAD - 70.4%; alcohol use disorder - 86.3%; and tobacco use - 91.8% (Murthy, 2017).

Also several studies found that factors like stigma and discrimination inherent belief that nothing could help, seeking help being a sign of weakness, denial, embarrassment to seek help, poor awareness, economic policies, lack of resources, unequal distribution of resources, insufficient facilities, poor allocation of funds, lack of availability and accessibility of treatment, lower socio-economic status, low education, poorly developed services and beliefs in supernatural powers develop barriers and treatment gap. A study from India has highlighted the limited access, inadequate knowledge, lack of family support, and continued dependence by the family on the service provider as the factors for treatment gap in mental illness (Kohrt et al., 2018)

Literature suggested that most of the individuals adapt different path ways, like approaching faith healers, traditional practitioners, before seeking a professional psychiatric care. People who have not previously received mental health services may be particularly reluctant to recognize their need for treatment and establish treatment contact. In India with its cultural diversity, and a mix of rural and urban environment, the discriminating attitude towards mentally ill patients causes stigma to consult a psychiatric professional (Kumar et al., 2011). Thus, there was a need for assessing the factors like stigma and faith healing that could contribute in both urban and rural population to prevent individuals from seeking professional help.

## RESEARCH MATHODOLOGY

***Aim:*** The aim of the study was to compare the common factors restricting seeking professional psychiatric help in mental illness in rural and urban area.

### *Objectives*

To study the common factors restricting seeking professional psychiatric help in mental illness in rural area.

To study the common factors restricting seeking professional psychiatric help in mental illness in urban area.

***Research Design***

**Research Design: -** The study was a cross sectional study.

**Sample**: - A sample of 50 participants male and female was selected from the family ward and OPD for the current study. The total number of individuals was purposively assigned for the comprised study. Data collection done in Pandeypur Mental Hospital, Varanasi.

**Inclusion Criteria: (For sample from Mental Hospital)**

- Literate and illiterate both
- Patient and care giver both.
- Any psychiatric illness.
- Both male and female.
- Rural and urban area

**Exclusion Criteria: (For sample from mental hospital)**

- Age range criteria
- Uncooperative patient
- Individuals not giving written consent for the study
- Any Physical or organic illness

**Tools used in the collection of data**

- Socio Demographic and Clinical Data Sheet
- Stigma scale by M. King.et.al (2007)
- Self-prepared checklist for faith healing

***Procedure***

Ethical Permission was taken from the authorities for conducting the study. After getting written consent from the participants, day and time was fixed according to their convenience for administering the scales. Sample was selected purposively. Those people who were selected on the basis of purposive sampling technique were requested to fill up clinical data sheet, socio demographic data sheet and then stigma scale and faith healing scale was administered. Stigma scale 28-item stigma scale has a three-factor structure: the first concerns discrimination, the second disclosure and the third potential positive aspects of mental illness. 20 item Self prepared check for assessing faith healing among the family. The procedure followed for administration of test was essentially identical in case of all the participants.

**Statistical Analysis:** Statistical analyses of the quantitative scores were done using Statistical Package for Social Sciences (SPSS 21). Descriptive statistics, t-test and pearson correlation test used in study.

## RESULTS

*Table 1: Socio-demographic characteristics of the participants*

| Variable | | Frequency (%) |
|---|---|---|
| **Gender** | **Male** | **60** |
| | **Female** | **40** |
| **Education** | Illiterate | 16 |
| | Primary | 14 |
| | Secondary | 12 |
| | Higher-Secondary | 44 |
| | Graduation | 4 |
| | Post-Graduation | 8 |
| **Marital Status** | Married | 74 |
| | Unmarried | 26 |
| **Diagnosis** | Psychosis | 60 |
| | Neurosis | 40 |
| | | **Mean ± SD** |
| **Age** | | 32.74±13.59 |
| **Age of onset** | | 2.76±0.65 |
| **Duration of illness** | | 59.90±65.81 |

*Table2: Showing that Correlation between Residence, Stigma and Faith Healing*

| Correlation | Residence | Stigma | Faith Healing |
|---|---|---|---|
| Pearson Correlation | 1 | .255 | .088 |
| Sig(2.tailed) | | .074 | .543 |
| N | 50 | 50 | 50 |

*Table3: Showing Comparison between rural and urban participants score on Faith healing and Stigma*

| Variable | Residence | N | Mean | S.D | t-Value | p-Value |
|---|---|---|---|---|---|---|
| Total Sigma | RURAL | 25 | 69.64 | 9.77 | 1.828 | 0.074 |
| | URBAN | 25 | 74.96 | 10.77 | | |
| Total Faith healing | RURAL | 25 | 21.96 | 3.91 | 0.612 | 0.543 |
| | URBAN | 25 | 22.72 | 4.81 | | |

## DISCUSSION

In this study we have calculated mean to find out the average of the data and SD is calculated to assess the scatter in the data or in other words the variance in the data. In this study, the results of the present findings indicate mean value of age is 32.74and Standard deviation of age13.59. The mean value of age of onset of mental illness 2.76 and standard deviation is 0.65. The mean value of Duration of illness is 59.90 and standard deviation is 65.81. 44% of the participants were educated up to 8 to 12th standard; 14% up to 5th standard; 12% up to 8th standard and only 16% were illiterate.

In this study, the results of the present findings indicate mean value of age is 32.74and Standard deviation of age13.59. The mean value of age of onset 2.76 and standard deviation is 0.65. The mean value of Duration of illness is 59.90 and standard deviation is 65.81. 44%

of the participants were educated up to 8 to 12th standard; 14% up to 5th standard; 12% up to 8th standard and only 16% were illiterate.

Sample consists of 60% of male and 32% of female. Out of which 74% were married and 26% unmarried.

From the results it is clear the 60% participants were suffering from psychosis and 40% were diagnosed with neurotic disorders.

Pearson bivariate Correlation was used to check the relationship between residence, stigma total and faith healing has not been significant. Thus, the null hypotheses1and 2 are accepted. However, not significant but the correlation to each other is in the same direction. So, we can say that stigma and attitude towards faith healing are prevails in the participants from rural and urban areas which hinders seeking professional helps. The reason could be that the study sample was too small to establish a relationship and association between the cause and effect.

The analysis of table no.5 shows that mean and SD of stigma in rural area is 69.64±9.77 and the mean and SD of stigma in urban area is 74.96±10.77. The mean and SD of faith healing in rural area is 21.96±3.91 and the mean and SD of faith healing in urban area is 22.72±4.81. The t value of stigma in rural and urban area is 1.82 and t value of faith healing is .612. On 48 degree of freedom tabulated value of stigma is 0.074 and tabulated value of faith healing is 0.543. Which is greater than calculated value it indicates that there is no significant difference found in the level of stigma and attitude towards faith healing in rural and urban area.

## CONCLUSION

The current finding of the research indicates that stigma and faith healing are common factors for restricting professional help in psychiatric illness in rural and urban area. It is concluded that there is no significant difference found in the level of stigma and attitude towards faith healing in rural and urban area. Therefore, we can say that cultural biasness, upbringing and environmental factor is one the reasons for result of the study.

### *Future Directions*

- To conduct similar study on a large population.
- To include education and family and social support as variables.
- To include psycho educational approach in the future studies.

## REFERENCES

Amesia, Gulliver, Kathleen, Griffiths, & Helen Christensen et al. (2010) Perceived Barriers & facilitating to mental health help seeking in young people: A systematic review. BMC Psychiatrist. 10113

Factors influencing access to psychiatric treatment in persons with schizophrenia: A qualitative study in a rural community (2014), Indian journal of psychiatry, Volume - 56(1), P-54-60.

Kumar. P, Kumar. L et al. (2011) Delay in first psychiatrist consultation and its reasons AP Journal of Psychiatry. Volume -12, P-79-83

Murthy, R.S. National Mental Health Survey of India 2015–2016 Indian J Psychiatry. 2017 Jan-Mar; 59(1): 21–26.

Perception & attitudes towards mental illness in urban community in south Delhi, A community Based study (2013), Indian journal of psychological medicine, Volume - 35, (2) P-154-158.

Ziedonis, D., & Brady, K. (1997). Dual diagnosis in primary care: detecting and treating both the addiction and mental illness. Medical Clinics of North America, 81(4), 1017-1036.

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D. A. N., Asai, I., ...& Newcomer, J. W. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. World psychiatry, 10(1), 52.

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., &Misra, R. (2016). National mental health survey of India, 2015-16: Summary. Bengaluru: National Institute of Mental Health and Neurosciences.

Murthy, R. S. (2017). National mental health survey of India 2015–2016. Indian journal of psychiatry, 59(1), 21.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., ...&Serfaty, M. (2007). The Stigma Scale: development of a standardised measure of the stigma of mental illness. The British Journal of Psychiatry, 190(3), 248-254.

Kohrt, B. A., Asher, L., Bhardwaj, A., Fazel, M., Jordans, M. J., Mutamba, B. B., ...& Patel, V. (2018). The role of communities in mental health care in low-and middle-income countries: a meta-review of components and competencies. International journal of environmental research and public health, 15(6), 1279.

Kumar, L., Reddy, P., &Babu, R. (2011). Delay in first psychiatric consultation and its reasons. Archives of Mental Health, 12(2), 79-79.

***Acknowledgement***

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

***Conflict of Interest***

The author(s) declared no conflict of interest.

***How to cite this article:*** Yadav D., Sweta & Singh U. (2021). A Comparative Study of Common Factors Restricting Seeking Professional Psychiatric Help in Mental Illness in Rural and Urban Area. *International Journal of Indian Psychology*, *9*(3), 397-402. DIP:18.01.040.20210903, DOI:10.25215/0903.040