

Barrier to Treatment in Patients with Neurotic, Stress Related and Somatoform Disorders: Study from A Tertiary Centre of North India

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ABSTRACT

Background: Psychiatric disorders are highly prevalent and also the leading causes of disability worldwide. Because of multiple factors playing as barriers in help seeking many people who might benefit from the treatment do not obtain it. Data regarding common mental disorders is even more lacking. **Methods:** Present study was undertaken to assess various treatment barriers affecting help seeking behavior in 156 patients of “neurotic, stress related and somatoform disorders” who were assessed on various tools. The study sample was divided in Aware and Unaware group on the basis of their awareness about psychiatric disorder at the time of onset/initial stages of illness. **Results:** Inability to recognize patient’s behavioral problem by family members and lack of treatment facility/ resource were important barrier to care. Prevalent nonscientific etiological belief (e.g. supernatural phenomenon, a form of worry or tension) in society also delayed treatment seeking.

The observations of present study have helped in revealing the barriers in treatment seeking for patients of neurotic and stress related disorders. Raising awareness about these disorders in community and making psychiatric easily accessible to general population will be helpful in overcoming these barriers.

Key words: barrier to treatment, pathway of care, awareness.

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INTRODUCTION

Psychiatric disorders are highly prevalent with estimated rates of lifetime prevalence in adults ranging from 12.2% to 48.6%.^[1] Findings from recent meta-analysis from 174 surveys across 63 countries indicate that on average one in five adults (17.6%) experienced a common mental disorder within the past 12 months and 29.2% across their lifetime.^[2] Apart from being highly prevalent these disorders are also the leading causes of disability worldwide, accounting for

37% of all healthy life years lost from disease.^[3] What compounds the problem is that despite availability of effective treatment many people who might benefit from the treatment do not obtain treatment. Study showed that even less than 30% -40% of people with psychiatric disorders seek treatment.^[4,5] This delay in treatment not only cause prolonged suffering but also cause untreated disorders to become more frequent, spontaneous, severe, and treatment refractory due to neural “kindling”.^[6]

There are multiple factors playing as barriers in the pathway of care, because of these many are left untreated, many partially treated and only a small fraction get access to appropriate place of treatment. These factors may be cultural belief regarding mental illness, stigma, and lack of

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knowledge regarding psychiatric disorders and lack of appropriate place of treatment, poor availability of psychiatric services.^[7]

Most of the work has been done to assess barriers to treatment in psychotic disorders.^[8,9] However common mental disorders like depression, anxiety disorders, somatoform disorder, etc are also associated with high disability in multiple domains and there is dearth of research material concerning treatment gap associated to them. The findings from this study may be useful in future planning of mental health care keeping in view of removing barriers in pathway of care and taking appropriate measures to treat “neurotic, stress related and somatoform disorders” at early stages which will be described in further text as N.S.S. Disorders.

METHODS

The present study was a single point cross-sectional study. Written informed consent was taken from all the patients after giving them given a full description of the study and study was approved by the IEC. Sample of the study was patients of N.S.S. Disorders^[10] of age group 17-60 years presenting for the first time in the Adult Psychiatry OPD of Department of Psychiatry at K.G. Medical University, UP, Lucknow during August 2010 to August 2011. Schedules for Clinical Assessment in Neuropsychiatry (SCAN) was applied to exclude Subjects with any other Axis I disorders. Neurotic disorder co-morbid with severe physical illness requiring active interventions and patients with substance abuse (except nicotine) and subjects with underlying organic pathology were excluded.

A semi-structured proforma was used to collect information about the socio-demographic profile of the patients and help seeking behavior. In preparation of this proforma basic idea has been taken from the encounter form developed for the WHO by Gater et al^{11, 12} and from the study by Chiang et al.^[13]

The study sample was divided in two groups on the basis of knowledge about psychiatric disorder at the time of onset/initial stage of illness. The subjects/family members were asked about general information regarding psychiatric disorders and whether they knew at the time of onset/initial stage of illness that symptoms present in their patient could also be due to psychiatric disorders and if yes then whether they knew that treatment was available for these disorders. Those who answered in affirmative to both the questions were put into the “**Aware**” group while those who gave negative answer to any of the two or both the questions were put in the “**Unaware**” group.

Appropriate statistical tests were applied for data analysis.

RESULTS

Screening of study sample

Out of 207 patients screened during the study, 51 patients (24.64%) were excluded and 156 (75.36%) patients were included in the study. Presence of other Axis I psychiatric disorders was the most common reason (8.21%) of exclusion

of subjects. Substance abuse other than tobacco (5.31%), not fulfilling age criteria (3.86%), not turning up for follow up(3.38%), not giving consent (2.90%) and presence of organic brain lesion (focal lesions in Brain Parenchyma) (0.97%) were other reasons of exclusion.

Awareness regarding psychiatric disorder

The sample was sub grouped into ‘aware’ and ‘unaware’ groups based on information obtained from semi structured Performa regarding knowledge about psychiatric disorders. Only 44 patients (28.21%) were found to have awareness regarding psychiatric disorders and constituted ‘aware’ group and rest 112 patients (71.79%) were kept in the ‘unaware’ group. Most of the respondent became aware due to exposure of psychiatric illness in the family (11 i.e. 07.05%), in the neighborhood (20 i.e.12.82%) or both (04 i.e.02.56%) while others got awareness from media or advertisements (09 i.e. 5.77%).

First care provider

In the ‘*aware*’ group local practitioners were the most common first care provider followed by General Medical Practitioners, Psychiatrists and faith healers. In the ‘*unaware*’ group faith healers were the most common first care providers, followed by local practitioners, General Medical Practitioners, (17.86%) and lastly psychiatrist, (11.61%). Significant statistical difference was found between ‘*aware*’ and ‘*unaware*’ group in making first contact to the faith healers ($p=0.0251$). (Table 2)

Reasons of treatment delay

Important beliefs and myths which affected help seeking behavior are enumerated in Table 3.

DISCUSSION

Majority of the study sample (71.8%) were unaware about psychiatric disorders. This finding is in line with the finding of other studies which showed that mental health literacy is low, regardless of the population considered.^[14,15] Further among aware participants (28.2%), most of the respondent (79.5%) in present study became aware due to exposure of psychiatric illness in the family or in the neighborhood while others (20.5%) got awareness from media or advertisements. These sources of information about mental illness in study group is different from sources of information in western countries where prime source of information is through newspaper, media, or pamphlets and various agencies raising awareness in community.^[16,17] This highlights the need of increasing illness awareness through media and other sources in our country. Our suggestion is in line with the view put up by *H. Leventhal et al* that Public information campaigns have to more clearly explain the action plans regarding psychiatric disorders in the community.^[18]

Most of the participants were female (62.18%), unmarried (59.62%), Hindu (87.12%), educated up to high school or less (67.95%) and belong to the age group of 17-25 years (56.41%) followed by the age group of 26-40 years (32.05%). Further sample is mostly consisting of participants from rural background (65.38%), joint families (60.26%) and from families with monthly income <5000

Table-01: Socio demographic variables of patients (n=156)

Variables	Participants (n=156)	"Aware" group (n=44)	"Unaware" group (n=112)	Chi square test
Age (In years)				
17-25	88(56.41%)	22 (50.00%)	66 (58.93%)	$\chi^2 = 1.277$, d.f.=2 , p= 0.5280
26-40	50(32.05%)	17 (38.64%)	33 (29.46%)	
40-60	18(11.54%)	05 (11.36%)	13 (11.61%)	
Gender				
Male	59(37.82%)	23 (52.27%)	36 (32.14%)	$\chi^2 = 4.621$, d.f.= 1, p=0.0316
Female	97(62.18%)	21 (47.73%)	76(67.86%)	
Marital status				
Married	63(40.38%)	20 (45.45%)	43 (38.39%)	$\chi^2 = 0.3939$, d.f.= 1, p=0.5303
Unmarried	93(59.62%)	24 (54.55%)	69 (61.61%)	
Religion				
Hindu	137(87.12%)	40 (90.91%)	97 (86.61%)	$\chi^2 = 0.2184$, d.f.= 1, p=0.6403
Muslim	19(12.18%)	04 (9.09%)	15 (13.39%)	
Domicile				
Rural	102(65.38%)	22 (50%)	80 (71.43%)	$\chi^2 = 5.497$, d.f.= 1, p=0.0190
Urban	54(34.62%)	22 (50%)	32 (28.57%)	
Type of family				
Nuclear	62(39.74%)	21(47.73%)	41 (36.61%)	$\chi^2 = 1.200$, d.f.= 1, p=0.2733
Joint	94(60.26%)	23(52.27%)	71 (63.39%)	
Socio-economic status (Family income in Rupees per Month)				
<5000	97(62.18%)	22 (50.00%)	75 (66.96%)	$\chi^2 = 3.901$, d.f.= 2, p=0.1422
5000-<10000	34(21.78%)	13 (29.55%)	21 (18.75%)	
≥ 10000	25(16.02%)	09 (20.45%)	16 (14.29%)	
Education status				
Illiterate	24(16.02%)	4 (9.09%)	20 (17.86%)	$\chi^2 = 4.141$, d.f.= 4, p=0.3873
Up to primary	42(26.92%)	12(27.27%)	30 (26.79%)	
Vi - high school	40(25.64%)	14 (31.82%)	26 (23.21%)	
Intermediate	32(20.51%)	7 (15.91%)	25 (22.32%)	
Graduate and above	18(11.54%)	7 (15.91%)	11 (9.82%)	

Table-02: First Care Provider

Type of First Care Provider	Participants (n=156)	"AWARE" GROUP (n=44)	"UNAWARE" GROUP (n=112)	Chi square test
'Faith Healer'	55 (35.26%)	9 (20.45%)	46 (41.07%)	$\chi^2 = 5.014$, d.f.= 1, p=0.0251
'Local Practitioner'	48 (30.77%)	15 (34.10%)	33 (29.46%)	$\chi^2 = 0.1374$, D.f.= 1, p=0.7109
'General Medical Practitioner'	31(19.87%)	11 (25.00%)	20 (17.86%)	$\chi^2 = 0.6133$, d.f.= 1, p=0.4335
'Psychiatrist'	22(14.10%)	9 (20.45%)	13 (11.61%)	$\chi^2 = 1.376$, D.f.= 1, p=0.2407

INR (62.18%). As Neurotic and stress related disorders are more common between late adolescence and mid adult, so maximum numbers of our patients were in the age group of 17-25 years in both the groups followed by the age group of 26-40 years.^[19] Female preponderance of such disorders is clearly reflected in our study sample (female 62.18%, male 37.82%).^[20,21] More prevalence of Hindus, people from rural background and joint families echoed the demographic pattern of the study area. Awareness was found significantly

more in male (p=0.0316) and participants from urban background (p=0.0190) In a study by Pradhan *SC et al*, it was found that approximately only one-third of the subjects had contacted a psychiatrist as their first care provider.^[22] Another study by *Lahariya et al*, revealed that only 9.2% patients consulted a psychiatrist as the first helping agency.^[23] In our study only 14.10% participant contacted psychiatrist as their first care provider.

Table-03: Myths/belief and reasons which affect 'HELP SEEKING BEHAVIOR' and 'PATHWAY OF CARE'

Reasons (Information given by family member/patient)	Participants (n=156)	Aware (n=44)	Unaware (n=112)	Chi square test
Assumption that symptoms may be due to supernatural phenomenon and hence need faith healing	114 (73.07%)	24 (54.54%)	90 (80.30%)	$\chi^2 = 9.426$, df= 1, p=0.0021
Concern of stigma	96 (61.54%)	21 (47.72%)	75 (66.96%)	$\chi^2 = 4.160$, df= 1, p=0.0414
Lack of facility/resource from where to and how to seek proper help for such kind of behavioural symptoms	89 (57.05%)	18 (40.90%)	71 (63.39%)	$\chi^2 = 5.632$, df= 1, p=0.0176
Assumption that this may be a common form of worry/tension and may resolve on its own	84 (53.85%)	26 (59.09%)	58 (51.78%)	$\chi^2 = 0.4162$, df= 1, p=0.5188
Conflicting opinion between family members	78 (50%)	22 (50.00%)	56 (50%)	$\chi^2 = 0.000$, df= 1, p=1.0000
Ignorance of patient's behavioural problem by family Member	69 (44.23%)	17 (38.63%)	52 (46.42%)	$\chi^2 = 0.4938$, df= 1, p=0.4822
Think having a physical illness	64 (41.02%)	12 (27.27%)	52 (46.42%)	$\chi^2 = 4.032$, df= 1, p=0.0446
Considered that patient is dramatizing/feigning	55 (35.25%)	10 (22.72%)	45 (40.17%)	$\chi^2 = 3.485$, df= 1, p=0.0619

This is a cause for concern as the majority of the non-psychiatric caregivers are poorly trained and ill equipped to handle the psychiatric disorders presenting to them at an early stage. They might aggravate the sufferings of the patients by prolonging the pathway and thus increasing the burden of care on family members.^[24]

One of the major observations of the present study was that 73.07% of patients/their family member were having assumption that the behavioral problems of patient may be due to supernatural phenomenon and hence this needs faith healing. This finding is similar to the view of a study by *Trivedi et al* who reported that in developing countries of the world, belief prevails that mental illness is due to supernatural or evil forces like angry deities, intrusion by noxious elements, witchcrafts or sorcery.^[25] Our finding is in line with the *Razali et al*, which reported that in non-Western cultures, supernatural phenomena, such as witchcraft and possession by evil spirits, are seen as an important cause of mental disorders.^[26]

Another etiological model was the Assumption that this may be a common form of worry/tension and may resolve on its own. 53.85% of respondent were found to have such assumptions. These were more frequent in aware group (59.09%) than unaware (51.78%) participants. In a study by *Chakraborty et al*, 80% of respondents with OCD and anxiety disorders and 61 % of somatization and dissociative disorders viewed the problem arising out of too much worrying/thinking.^[27]

This denotes that still majority of population have belief in non-biological causation of mental illnesses. Belief about causation of psychiatric disorder determines help seeking behavior. A more traditional belief (i.e. 'non-medical disease' model for mental disorders) regarding causation of illness will promote help seeking from traditional means while a more biological causation about psychiatric disorder

will favour help seeking behavior from a professional care provider.^[28,29,30]

The other major observation of present study was 'Concern of stigma' (61.54%) of patient/their family had stigmatizing attitude because of mental illness at one or other point during pathway of care, and which had significantly affected their help seeking behavior. Boey et al found in urban china that stigmatization associated with psychiatric illness was major deterring factors in seeking psychiatric treatments.^[31] Stigma toward people with a mental illness in particular in India has been shown to be high.^[32,33] Mental illness stigma may present as a preference of distancing oneself from people with mental illness^[33,34] or the belief that people with mental illness are different and inferior^[35], dangerous^[36,37], or violent.^[36,38]

Another important reason was 'Lack of facility/resources from where to and how to seek proper help for such kind of behavioral problems which was present in 57.05% of patients. Important reasons could be poor accessibility and availability of psychiatric services. These findings are expected as majority of our study sample belonged to rural background, where there is scarcity of qualified physicians, and psychiatrists are almost absent. It has been reported that the mental health facilities are nearly non-existent in rural areas of our country, with the prevalence of psychiatric disorders being almost same in rural and urban areas.³⁹ According to world health organisation, there are 0.33 mental health outpatient facilities, 0.30 psychiatrists, and 0.05 psychologists per 100,000 people in India whereas in the USA these figures were 1.95, 7.79, and 29.0, respectively.^[40,41] Further these are mostly based in urban areas while close to 75% of the Indian population resides in rural area.^[42]

Jorm AF has reported that many members of the public cannot correctly recognize mental disorders and do not

understand the meaning of psychiatric terms.^[30] It could be said that there is urgent need of raising awareness in community. Present study also revealed 44.23% of participants didn't have knowledge about patient's behavioral problems. Further 35.25% of participants had the opinion that patient is dramatizing/feigning. Thus lack of knowledge regarding behavioral symptoms and consequent misinterpretation of symptoms is an important reason of delayed help seeking from psychiatrist. If mental disorders are to be recognized early in the community and appropriate intervention sought, the level of mental health literacy needs to be raised.^[43,44]

41.02% of the patients had assumption that they are *having a physical illness*. This number is expected because of nature of disorders included in this group. Patients of somatoform disorders and dissociative disorder were more in this group. *Bebbington et al*, found that of people with neurotic disorder vast majority had undergone check-ups or treatments for physical complaints.^[45]

The other factor which also influenced the help seeking behavior at one or other point of time during pathway of care of 50% family members/patients was conflict between different family member regarding attitude towards patient or choice of care provider for treatment. Possible explanation could be that different family member may have conflicting belief about benefits and harms from different modality of treatment or about causation of psychiatric disorder, which may affect help seeking behavior. This is because in our society, patient is taken for treatment to different type of care provider by their family members and decision to take treatment is based on advices of different family members, and it may be even influenced by advices of relatives and close ones. Various studies performed across many countries report that when the public was asked about various treatment modalities, a strikingly consistent finding was negative beliefs about medications for a range of mental disorders.^[46] Previously other studies have reported various reasons of conflict between family member regarding professional help as perceived side-effects, such as dependence, lethargy or brain damage by psychotropic medication, and the belief that the treatment deals only with the symptoms and not the causes of psychiatric disorders.⁴⁷ Thus we summarize by our work that availability of mental health services is already scares overall in the world and more so in our setup and most importantly its utilization is affected by many interacting factors, such as individual and help-seeking preferences, access and referral practice as previous studies have also pointed out.^[48]

CONCLUSION

The observations of present study have helped in revealing the barriers in treatment seeking for patients of neurotic and stress related disorders in the form of various myths and belief, influence of which affects in determining choice of care providers, causes delay in initiating early treatment, leads to ignorant attitude toward patient, perpetuates stigma and misbelieve regarding causation of mental illness. All of

this ultimately causes delay in engagement with psychiatric services. The author views awareness about psychiatric disorder as one of the important factors that could modify cultural myths regarding psychiatric disorders, consequently reaching to a favorable help seeking behavior. It makes the attitude of the family members/significant ones to be more concerned and less ignorant towards their patient. There is also need to improve accessibility and availability of psychiatric services in our country so that needy persons may avail them.

Limitation:

Retrospective information could have led to recall bias. There was no structured tool to assess awareness for psychiatric disorders in the patients and family members. The severity of the disorders was not assessed which could have affected the patients'/family members' help seeking behaviour and modified their misbelieves.

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