

Assessing Reluctance in Consulting a Psychiatrist among the People Residing in Urban and Rural Areas of Pimpri

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ABSTRACT

Background: Stigma towards psychiatry acts as a hindrance to overall well-being. **Aim:** This study was aimed to assess the multifactorial causation for reluctance in consulting a psychiatrist when it concerns mental health. **Methodology:** 579 participants residing in the rural and urban areas of Pimpri were assessed using a self-made questionnaire and the Attitudes Towards Mental Health Problems Scale was applied to them. **Results:** A marked negative correlation was present with higher levels of education, income and socioeconomic status with stigma. There exists a difference between the distribution of all domains of shame and stigma vis-a-vis sex and location. Males showed higher levels of shame and stigma than females. Rural residents had higher levels of shame and stigma than urban residents. **Conclusion:** Psychiatric disorders are associated with widespread prevalence of stigma and shame.

Keywords: Attitudes, Stigma, Mental Illness

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Introduction

While it is well known that majority of people avoid going to a psychiatrist, or approach them with fear and trepidation, the extent of the problem is not well known. About 30 to 80% of people with psychiatric problems were never treated, according to a World Health Organization evaluation of the rates of use of psychiatric care across 37 research studies. The following disorders had the highest average non-treatment rates: Bipolar Disorder (50%), Schizophrenia (32%), Panic Disorder (55%), Depression (56%), Obsessive-Compulsive Disorder (59%), Generalized Anxiety Disorder (57%) and Alcohol Dependence Syndrome (78%). The report also mentioned that rates underestimated the actual number of people not receiving treatment. Obviously, the majority of persons with psychiatric disorders do not get the treatment

that they need. The reasons for this are varied and include lack of awareness, feeling of inadequacy or failure, distrust, lack of availability and cost of therapy but probably most important is the stigma of mental illnesses [1]. A significant deterrent to obtaining mental health care is the stigma associated with mental illness [2]. There are two forms of stigmas: personal stigma (people's own stigmatizing attitudes) and perceived public stigma. Public stigma is how society views those who have mental illness. The stigma that individuals suffering from mental illness hold against themselves is known as self-stigma. Stereotypes, prejudices and discrimination are the three elements that make up both public and self-stigma. The four kinds of prejudice brought on by public stigma include withholding assistance, avoiding people, coercive treatment, and isolated institutions [3].

A large multicentric study on perception of Indians of mental illness revealed three major groups of people based on their perception and attitudes of mental illnesses: 47% had a negative attitude; 26% were afraid of the mentally ill, while 27% felt that the mentally ill need support from people. Although 87% of the participants had some awareness about psychiatric disorders, the majority (71%) described mental illness with terms associated with stigma. Persons with psychiatric disorders try their best to hide their illness and avoid expressing their mental health problems openly, due to the fear of being labelled as a psychiatric case. Moreover, many are under the wrong impression that psychiatric disorders occur only in the mentally weak. Therefore, seeking psychiatric consultation is an admission of mental weakness [4]. Stigmatization of people with psychiatric disorders is widespread in Asia, due to the prevalence of supernatural, religious and magical remedies to mental disease as well as the widespread somatization of psychiatric problems. The most pressing issue with psychiatric services in Asia is a paucity of financial and personal resources. As a result, the majority of mental health experts are found in metropolitan regions, which makes it harder for those in need of assistance to get it and fuels stigma against those with mental illnesses. [5]

Public stigma is the general public's response to those with mental illness. The stigmatization of oneself is something that persons with mental problems do. [3] Literature suggests that one-third of young people in India exhibit poor awareness of psychiatric disorders and bad attitudes toward people with psychiatric disorders and one in five actually engage in stigmatization behavior. Youth fail to identify the reasons and signs of mental health issues and think that healing is improbable. People's misconceptions and a lack of awareness of mental health issues have led them to feel that recovery is unlikely and to view those who are struggling with them as dangerous. Due to lack of information and understanding of mental health problems people believe that recovery is impossible and perceive those with mental health problems as dangerous [6]. The current study was done to investigate the factors impacting people's reluctance to consult a psychiatrist among those living in urban and rural areas due to the dearth of Indian studies in this topic.

Materials and Methods

This cross-sectional, comparative study was done in the department of psychiatry of a tertiary care hospital in a semi-urban center of Western Maharashtra.

Sample for the Study

By convenience sampling people living in the vicinity of the Medical College at Pimpri and

Rural Health Centre at Pimpri were approached and those

meeting the inclusion and exclusion criteria and willing to give consent were included in the study. The minimum total sample size was 385, calculated using Fisher's formula.

Inclusion Criteria

1. Men and women residing in urban/rural areas of Pimpri.
2. People in the age group 18-65yrs.

Exclusion Criteria

1. People unwilling to give consent.
2. People with existing major medical/psychiatric disorders.

Study Tools

Self made questionnaire

The self-made questionnaire will have demographic details like age, address, domicile, religion, education, occupation, marital status, number of children, and socio-economic status based on the Modified Kuppaswamy Scale 2021.

Attitudes Towards Mental Health Problems Scale (ATMHP)

A 35-item scale called ATMHP was developed to examine several facets of shame in relation to a mental health issue. Previous studies had shed light on a variety of Asian women's shame-related issues [7]. These had to do with individual, family, and social views. Some of these are manifestations of external shame [8]. Additionally, this measure investigates individual attitudes of shame for a mental health issue. Some people have a strong worry for the idea of reflected shame, which states that one can bring shame to others like one's family. To address this, these questions have been created.

Procedure

All men and women eligible for the study belonging to Rural and Urban areas were explained the aim of the study and an informed consent was taken maintaining complete confidentiality. All demographic details were recorded after which Attitudes toward mental health problem scale was administered.

Statistical Analysis

By using IBM SPSS v 26, the data collected was tabulated and analysed with Pearson's Correlation, Mann Whitney U test with the domains and relevant factors.

Results

The study included 579 subjects comprising of 335 females and 244 males. The mean age was 27.2 with a standard deviation of 8.79. About 380 participants were from the urban areas of Pimpri among which 250 were female and 130 were

male. The Rural areas of Pimpri, Chinchwad and Alandi had 199 participants with 85 female and 114 male participants. Socio-demographic characteristics of the sample are given in Table 1. The Domains measuring the attitudes, external stigma, internal stigma and reflected stigma in seeking psychiatric help were categorized and measured in Table 2.

The binarized values in the factor of sex were analyzed comparing the means and standard deviation between males and females (Table 3); males showed higher mean scores in all the domains. Thus, implying that males showed higher levels of stigma across the domains of shame. The Mann Whitney U test values indicate that there is a difference between the distribution of all domains and sex.

Table 4 compares the means and standard deviations between Urban and rural population depicting higher scores for residents of rural Pimpri in all domains. Implications of a strong correlation of stigma in all domains with Rural location. The Mann Whitney U test values across all domains implies a rejection of the null hypothesis that the distribution of both groups being equal and hence we conclude that there is a difference between the distribution of all domains and location.

Table 5 depicts the correlation between domains of stigma and age, sex and location.

A medium correlation between age and stigma in the domains of attitude and reflected shame is observed using Pearson's correlation and it is statistically significant. The domains of external shame and internal shame show a small correlation. There is statistically significant medium inverse correlation between sex and stigma in almost all domains of shame observed using Pearson's correlation. The reflected shame on family showed a low inverse correlation to sex. Statistically significant correlation between location and stigma in the domains of shame is observed using Pearson's correlation. The domain of internal shame showed a medium correlation while all other domains indicated a strong correlation.

Table 1: Demographic data collected in the year 2021 in Urban and Rural areas

Factors	Categories	N
Age	18-27	405
	27-45	136
	45	37
Sex	Male	244
	Female	335
Location	Urban	380
	Rural	199
Education	Illiterate	60
	Primary	117
	Middle-school	86
	High school	189
	Intermediate	62
	Graduate	64
Occupation	Unemployed	201
	Unskilled	21
	Semi skilled	118
	Skilled labor	146
	Professional	91
Income	<20,000	310
	21-50,000	141
	>50,000	127
Socioeconomic Status	Lower class	46
	Upper Lower	221
	Lower Middle class	94
	Upper middle class	161
	Upper class	56
Marital Status	Married	231
	Unmarried	347
Type of Family	Joint	194
	Nuclear	384
Religion	Hindu	467
	Muslim	69
	Buddhist	18
	Christian	18
	Others	6

Table 2: Domain severity of Stigma based on scores tabulated

Domain	Mean±SD	High	Moderate	Low
Attitude	15.826±5.48903	305	212	62
External Shame	15.96712803±6.8893678	224	269	88
Internal Shame	7.430795848±4.3118738	202	179	196
Reflected Shame on Family	12.08304498±5.0980020	247	237	95
Reflected Shame on Self	9.008650519±4.3249621	274	223	82

Table 3: Comparisons of Domain scores of stigma with Sex

Domain	Male Mean±SD	Female Mean±SD	p value
Attitude	17.683±4.677	14.006±5.566	0.001
External Shame	18.206±5.986	13.828±6.956	0.001
Internal Shame	9.587±3.011	5.549±3.279	0.001
Reflected Shame on Family	13.197±4.788	10.961±5.183	0.001
Reflected Shame on Self	11.553±3.618	6.961±3.849	0.001

Table 4: Comparisons of Domain Scores of stigma in Urban and Rural areas of Pimpri, Pune

Domain	Urban Mean [SD]	Rural Mean [SD]	p value
Attitude	13.415±4.988	20.109±3.342	0.001
External Shame	13.229±6.431	20.802±4.745	0.001
Internal Shame	5.945±4.253	9.526±3.458	0.001
Reflected Shame on Family	10.030±4.460	16.494±3.325	0.001
Reflected Shame on Self	7.161±3.827	12.166±3.385	0.001

Table 5: Correlation between domain scores of stigma and Age, sex and location.

Factor	Domains	Pearson's coefficient: r	p value
Age	Attitude	0.353**	< 0.001
	External shame	0.247**	< 0.001
	Internal shame	0.215**	< 0.001
	Reflected shame 1	0.337**	< 0.001
	Reflected shame 2	0.335**	< 0.001
Sex: Male, Female	Attitude	- 0.316**	< 0.00001
	External shame	- 0.305**	< 0.00001
	Internal shame	- 0.462**	< 0.00001
	Reflected shame 1	- 0.177**	< 0.000018
	Reflected shame 2	- 0.498**	< 0.00001
Location: Urban, Rural	Attitude	0.576**	< 0.00001
	External shame	0.516**	< 0.00001
	Internal shame	0.376**	< 0.00001
	Reflected shame 1	0.594**	< 0.00001
	Reflected shame 2	0.526**	< 0.00001

** correlation is significant at the 0.01 level

Table 6: Correlation between domain scores of stigma and Education levels

Factor	Domains	Pearson's coefficient: r	p value
Education	Attitude	-.726**	<.00001
	External shame	-.654**	<.00001
	Internal shame	-.538**	<.00001
	Reflected shame 1	-.612**	<.00001
	Reflected shame 2	-.635**	<.00001
Occupation	Attitude	-.322**	<.00001
	External shame	-.240**	<.00001
	Internal shame	-.250**	<.00001
	Reflected shame 1	-.310**	<.00001
	Reflected shame 2	-.292**	<.00001
Income	Attitude	-.681**	<.00001
	External shame	-.568**	<.00001
	Internal shame	-.551**	<.00001
	Reflected shame 1	-.482**	<.00001
	Reflected shame 2	-.596**	<.00001
Socioeconomic status	Attitude	-.685**	<.00001
	External shame	-.569**	<.00001
	Internal shame	-.542**	<.00001
	Reflected shame 1	-.536**	<.00001
	Reflected shame 2	-.604**	<.00001

** correlation is significant at the 0.01 level

Table 6, Statistically, significant strong inverse correlation between education and stigma in the domains of shame is observed using Pearson's correlation. Higher levels of education were related to lower stigma in all the domains of shame. Statistically significant correlation between occupation and stigma in the domains of shame is observed using Pearson's correlation. The domains of external shame and internal shame depict mild inverse correlation with occupation and the domains of attitude and reflected shame have a medium inverse correlation. The occupation was classified using the modified Kuppuswamy scale.

Statistically significant inverse correlation between income and stigma in the domains of shame is observed using Pearson's correlation, almost all domains show a strong inverse correlation with income and the domain of reflected shame on family shows a medium inverse correlation. Statistically significant strong inverse correlation between socioeconomic status and stigma in the domains of shame is observed using Pearson's correlation. Higher socioeconomic status is related to lower levels of stigma.

Discussion

The study highlighted several factors contributing to the various domains of shame related to stigma. Significant correlation between age and stigma in the domains of shame is observed using Pearson's correlation, implying that the

older aged population showed more shame and stigma about seeking psychiatric help, which acts as a major barrier to availing treatment. This agrees with earlier studies [9,10]. Lack of knowledge about mental health and stigma or bad attitudes toward mental illness have been cited as reasons why older persons may refuse receiving mental health care. Ageism may not be as much of a barrier to elderly people using psychiatric services as their personal prejudices and anxieties regarding mental illnesses and mental health professionals.

The younger population has access to better mental health resources and the universal awareness of mental health in recent years has helped bridge biases and stigma. This is in contrast to a previous study which showed that one third of their young population displayed poor knowledge and negative attitudes towards mental health problems [6]. A significant inverse correlation between males and females with all the domains implies that females have lesser levels of stigma and shame for consultation with a psychiatrist. Males with higher levels of shame in the domains of stigma acts as a barrier to access a psychiatrist leading to higher rates under-diagnosed mental health conditions. A few studies have found that mental illness stigma is lower in women than in men, but the degree to which mental illness symptoms map onto gender expectations was not taken into account [11]. This finding is different from previous studies done in India.

Boge et. al. and Trani et. al. found in their studies in an Indian Population that women had a more negative attitude towards mental illness due to the high presence of stigma [12,13]. According to them, women faced the brunt of discrimination compared to their male counterparts. However, in a recent study in Jharkand by Shankar et. al. showed a similar finding as ours [14].

Significant correlation between urban and rural residents with shame in the domains of stigma in all domains implies that residents in rural areas have higher levels of stigma and shame associated with visiting a psychiatrist. There is a limitation in accessibility, lack of awareness, communication gap in the rural areas leading to barriers in accessing psychiatric help when needed. Cultural beliefs pertaining to mental illness are also widespread in the rural communities where they ascribe symptoms to black magic and visit religious healers. This leads to increased duration of untreated illness and increased sequelae. Significant inverse correlation between education and shame in the domains of stigma implies that higher education levels lead to lower levels of stigma and shame in psychiatric consultation. Education sheds light on the depth and scope of mental health which empowers individuals to seek help when needed. Previous research has shown that those with lower levels of education tend to have more stigmatizing attitudes [15]. But it can also have a contradictory effect wherein educated populace may view mental illness as a hindrance and refuse acknowledging it fearing discrimination [16].

Significant inverse correlation between occupation and shame implies that occupations with higher skill levels have lesser stigma and shame attached to psychiatric resources. Several companies in India have direct access to mental health at the workplace which makes accessibility easier. For those with psychosis, stigma and discrimination are substantial roadblocks to employment. Research that is currently being done on the subject of disclosing a mental health illness to an employer supports the existence of stigma and discrimination in the workplace [17]. According to research by Perkins et. al. [18] and Corrigan and Penn [19], integrating people with mental health issues into profitable employment can significantly influence social views and lessen the stigma attached to these conditions. According to Hamilton et. al. [17], employment may function as a buffer against the overall amount of discrimination endured by those utilizing mental health services in England. In comparison to those without mental problems, those with severe and common mental disorders had a 7:3 increase in likelihood of being unemployed, respectively [20]. In general, it has been demonstrated that losing a job causes health decline, while finding work again after being unemployed promotes improvement of health. People who suffer from mental illness in particular may benefit from advantages of employment

but may find it challenging to land and hold a job. According to clinical research, stigma is a result of mental illness, and its biological treatment will lessen the stigma that goes along with it.

Significant inverse correlation between income and shame implies higher income individuals show lesser shame and stigma attached to visit a psychiatrist. Higher income makes accessibility easier whereas low income means getting basic necessities met becomes a priority and mental health is relegated to a luxury. Despite the emerging literature on poverty, poor mental health, and disability, there is a paucity of research examining the relationships between experienced stigma, mental illness, and poverty, especially in developing countries. Income inequality is a significant risk factor for people with mental health problems, including those with common mental disorders, in high-income countries [24]. Discrimination due to stigma towards PSMI persists in India. Although the dynamics of poverty, prejudice, and mental health have not been thoroughly addressed, the variables that contribute to these issues may possibly deprive people of numerous resources [25]. According to the clinical literature, stigma is a result of mental illness, and its medical treatment will lessen the stigma that goes along with it [26]. Significant inverse correlation between socioeconomic status and shame is seen implying that lower socioeconomic status leads to higher levels of shame and stigma with visiting a psychiatrist. The difference in stigma between lower and upper socioeconomic strata may be due to a lack of awareness or lower levels of education. According to studies, people with lower SES have more pessimistic beliefs about their capacity to recover and the value of treatment, which suggests that low-income groups experience inferior treatment outcomes. This could be as a result of increased exposure to socioeconomic determinants of mental illness, like material deprivation and job security.

Although, a few contradictory studies do exist. Holman reported that higher socioeconomic status was related to greater levels of stigma [27]. Similar findings related to diminished empathy and understanding of mental illness were reported by a study, however they used subjective rather than objective SES measures to support their conclusions [28]. Higher SES individuals are more inclined to credit external, uncontrollable forces rather than internal ones as the source of diverse outcomes [29]. Factors affecting more marginalized communities were beyond the scope of the study. A binarization of gender was done. The study found significant correlation between sex, location, income, occupation, socioeconomic status with stigma associated with consulting a psychiatrist. The lack of awareness and access to proper mental health in rural Pimpri sheds light on the lacunae in many such parts of rural India. A marked negative correlation with higher levels of education, income

and socioeconomic status with stigma highlights the need for a more multifaceted approach to help narrow the differences in society at large. The comparative analysis of sex and location using Mann Whitney U-test implies that there is a difference between the distribution of all domains of shame and stigma with sex and location. Males showed higher levels of shame and stigma than females. Rural residents had a higher level of shame and stigma than urban residents.

Conclusion

Psychiatric disorders and consulting a psychiatrist are associated with shame and stigma in society. Males, rural residents, less educated and lower socioeconomic status was associated with higher prevalence of stigma.

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Ethics:	There is no ethical violation as it is based on voluntary anonymous interviews
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