SOCIOCULTURAL BELIEFS AND TREATMENT ACCEPTANCE

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SUMMARY

The beliefs of patients attending walk-in clinic and outpatient section, Department of Psychiatry, NIMHANS, Bangalore were studied separately. The Walk-in Clinic and Outpatient population were divided into three groups by systematic randomization. The beliefs of Group I, II and III were left untouched, contradicted and supported respectively. The follow up attendance pattern of the patients was taken as an indicator of treatment acceptance and according to the regularity of follow up in each group patients were categorised as good, fair and poor attenders.

The significance of these findings is discussed and it is inferred that supporting scientifically tenable beliefs and keeping a neutral attitude towards unscientific beliefs may be the best policy for a clinician.

Any branch of medical science which tends to divorce itself from the prevalent socio-cultural beliefs is doomed to stagnate itself within the four walls of hospitals without reaching the doors of general community because the naive minds of general public are more likely to understand and accept even an illogical explanation which conforms to their deep rooted cultural beliefs than a rational explanation which invalidates the same.

Thus, while making a comparison between Western medical practitioners and indigenous medical practitioners, Marriott (1955) found that the latter were more popular and enjoyed the confidence of people whereas the former were regarded as a socially separate class.

Despite the importance of the subject, there have been few systematic studies about prevalent socio-cultural beliefs about diseases (Garstairs, 1955; Opler, 1963; Khare, 1963; Hassan, 1964; Gould, 1965; Valunjkar and Chaturvedi, 1967; Verghese and Beig, 1974) and none about the relationship of the attitude of clinician towards beliefs and patient’s treatment compliance.

AIMS

(1) To explore socio-cultural beliefs about the causation of mental illness in patients and their relatives.

(2) To find out if there are any differences between the beliefs of those who come for the first time in contact with psychiatric services and those who have remained in contact with psychiatric services for some time.

(3) To find out if there are any differences between socio-cultural beliefs of those who attend out-patient department very regularly and those who attend it irregularly.

(4) To find out if contradicting or supporting these socio-cultural beliefs has any effect on future treatment acceptance.

METHODOLOGY

Population studied:

The following two populations were studied—

(1) Patients attending Walk-in Clinic, Department of Psychiatry, NIMHANS, Bangalore, on certain specified days of a week.
(2) Patients attending out-patient section of Department of Psychiatry, NIMHANS, Bangalore, on certain specified days of a week.

The patients attending Walk-in-Clinic were those who had come to our psychiatric services for the first time and those attending the out-patient section were the ones who had come to our psychiatric services previously and were being followed up on an out-patient basis. Patients from Walk-in Clinic and Outpatient Departments were studied separately.

Selection of Patients

Inclusion criteria for Walk-in Population—

(1) Age above 15 yrs.
(2) A diagnosis of mental illness (according to ICD-8) by a psychiatrist.
(3) Availability of key informant in case of a psychotic, mentally retarded or uncooperative patient.

Inclusion criteria for outpatient population—same as for Walk-in population and—

(1) A follow up of more than 3 months duration.
(2) Patients getting free drugs.

A key informant was defined as—

(1) An informant who had been living with the patient throughout the duration of illness.
(2) One who had some degree of emotional attachment with the patient (e.g., the informant had brought the patient on his own or was anxious about patient’s recovery or was prepared to pay for patient’s treatment.)

METHOD

Since the majority (96.15%) of the patients were psychotic, mentally retarded or uncooperative, the information about socio-cultural beliefs had to be gathered from a key informant. Where more than one key informant was available, information was collected from that key informant with whom the patient was more closely attached.

The informants were first asked what, in their opinion, had caused mental illness in the patient. They were encouraged to reply and were given some time to think. Their reply was categorised as “spontaneous response.”

After getting the spontaneous response, a list of possible socio-cultural beliefs were read to them and they were asked to pick up the most likely cause for mental illness in the patient. The response thus obtained was categorised as “opted response.”

After getting the opted response, direct questions were asked about a given cause being responsible for illness in the patient (e.g., ‘Is it possible that the illness has been caused because someone has cast a magic spell on you?’). The response thus obtained was categorised as “acceptable” cause for mental illness. Whenever an informant believed in more than one cause as being responsible, all his beliefs were taken into consideration.

The spontaneous, opted and acceptable causes of mental illness when added together were designated as “global belief pattern” of the informant.

After such evaluation, by systematic randomization, the Walk-in Clinic and outpatient population were separately divided into three groups.

In Group I, the global belief patterns of the informant were not touched and a neutral attitude was kept towards them.

In Group II, the global belief patterns of the informant were contradicted in very clear terms whenever such beliefs were inconsistent with scientific assessment of the patient’s illness.

In Group III, the global belief pattern of the informant was reinforced by supporting them even if their beliefs were scientifically untenable.
The patients included in the study were given free drugs and were asked to come for follow up after every seven days.

The attendance of patients on four subsequent follow up dates (in case of outpatient population, also the attendance on last four follow up dates as mentioned in hospital records) were taken into consideration to infer the pattern of treatment acceptances. Regularity of follow up was taken as an indicator of treatment acceptance.

If the attendance of patients was 100% (i.e., four out of four follow up dates) it was rated as good, if 25 to 75% (i.e., 1 to 3 out of 4 follow up dates) it was rated as fair and 0% (i.e., nil out of 4 follow up dates) it was rated as poor.

OBSERVATION

Socio-cultural Beliefs (Table 1)

All the respondents included in the study, cited one or other factor as being responsible for mental illness. Many of the respondents gave multiple responses. The spontaneous responses far exceeded opted and acceptable responses in number. The three commonest responses were—(1) Physical causes; (2) Sins/wrong deeds of previous life; and (3) Sins/wrong deeds of present life. Few people believed that social and psychological factors were responsible for mental illness.

Comparison of belief patterns of Walk-in/Outpatient Population:

The belief patterns of Walk-in and Outpatient population were similar except in the following respects—

1. The outpatient population more often responded that sins and wrong deeds in a previous life were the cause of mental illness ($p<.05$).

### Table 1—Comparison of Beliefs of Outpatient and Walk-in Population

|                         | Spontaneous Responses | Opted Responses | Accepted Responses | Global Belief pattern |
|-------------------------|-----------------------|-----------------|---------------------|-----------------------|
|                         | O.P. Wk. in n=99      | O.P. Wk. in n=99 | O.P. Wk. in n=99   | O.P. Wk. in n=99     |
| Sins/wrong deeds of previous life | 16 18 N.S. | 4 2 N.S. | 12 3 $p<.05$ | 32 23 N.S. |
| Sins/wrong deeds of present life | 13 14 N.S. | 2 3 N.S. | 11 3 $p<.05$ | 26 20 N.S. |
| Faulty diet             | 9 1 $p<.05$          | 1 N.S.          | 1 N.S.             | 10 1 $p<.01$        |
| Changes in physical state of body (Heat, cold, dryness, etc.) | 6 1 N.S. | ... N.S. | ... N.S. | 6 1 N.S. |
| Displeasure/curse of ghosts/spirits/diety/God etc. | 12 6 N.S. | 2 1 N.S. | 1 1 N.S. | 15 8 N.S. |
| Physical causes (somatic including infection) | 37 24 N.S. | 8 6 N.S. | 6 4 N.S. | 51 34 N.S. |
| Social and Psychological causes | 16 8 N.S. | 3 4 N.S. | 3 ... N.S. | 22 12 N.S. |
| Magic and Sorcery       | 6 1 N.S.             | 1 1 N.S.       | ... N.S.          | 7 2 N.S.          |
(2) The outpatient population more often believed that sins and wrong deeds committed during present life were the cause of mental illness (p<.05).

(3) The outpatient population significantly more often responded spontaneously (p<.05) and globally (p<.01) that the faulty diet was the cause of mental illness.

Comparison of Belief patterns of good and poor attenders in outpatient population (Table 2).

Table 2—Comparison of Beliefs of Good and Poor Attenders in Outpatient Population

| Global Belief Pattern | Attendance Pattern |
|-----------------------|--------------------|
|                       | Poor (n=17) | Good (n=21) |
| Sins/Wrong deeds of a previous life | 11  | 3** |
| Sins/Wrong deeds of past life | 8  | 2** |
| Faulty diet | 1  |  |
| Changes in physical state of body |  |  |
| Curse/displeasure of God/deities etc. | 8  | 3* |
| Curse/displeasure of Ghost/spirits etc. | 10  | 3* |
| Physical cause | 4  | 16* |
| Social and Psychological causes | 6  | 1* |
| Magic and Sorcery |  |  |

p Co 05, **p>0.01

(1) The good attenders more often believed that mental illness was due to physical causes (p<.01).

(2) The poor attenders more often believed sins/wrong acts of present life (p<.01), sins/wrong acts of previous life (p<.01), displeasure/curse of Gods/deities (p<.01) and social and psychological factors (p<.05) were the cause of mental illness.

Comparison of the regularity of follow up in walk-in sample before and after study (Table 4)

Table 4—Follow-up Patterns in Outpatient samples before and after study

| Follow-up pattern | Before study | After Study |
|-------------------|--------------|-------------|
| Gr. I (n=33)      | 6 21 6 5 22 6 |
| Gr. II (n=33)     | 4 20 9 9 15 9 |
| Gr. III (n=33)    | 7 20 6 5 22 6 |

N.S.

There was no statistically significant difference in follow up pattern of any of the groups before and after the study. However, a trend (p<.10) was seen in group II (beliefs contradicted) where the number of poor attenders increased after the study.

DISCUSSION

Socio-cultural beliefs

1. In the present study all respondents gave at least one response whereas in previous study (Verghese & Beig, 1974) only
60% had responded. The differences can be due to either difference in sample or method of data collection.

The spontaneous and opted responses far exceeded acceptable responses showing that these beliefs are relatively fixed and even with suggestion from an authoritarian figure, there is little tendency to add any new belief to the already existing belief pattern.

Physical diseases were most often believed to be the cause of mental illness. This may be explained in two ways—

(a) Popular concept of illness—
People have a tendency to think of illness in terms of something being wrong with the body. Thinking in terms of such a closed equation, they tend to attribute physical causes as being responsible for mental illnesses also.

(b) Traditional concept of hospital—
By their traditional status, hospitals are considered to be the places where physical illnesses are treated. Hence those who believe that mental illness is due to something being wrong with the body commonly bring their patients to the hospital. In this respect, it is interesting to note that in the Vellore study (Verghese & Beig, 1974) the commonest response relating to the causation of the illness (29%) was “emotional factors.”

Sins of the present and a previous life were the next most frequent response. This may be due to belief in doctrine of Karma and Punarjanma according to which all our sufferings are due to sins and wrong deeds of the previous and present life. Relatively few people believed in socio- and psycho-genesis of mental illness. This shows lack of psychological and social orientation. Unless such an awareness is brought about, psychological and social therapies will continue to be relatively unacceptable to the close relatives of our patients.

Differences between the beliefs of informants at the Walk-in Clinic and Outpatient Department:

The informants seen at the outpatient clinic when compared with those seen at the walk-in clinic significantly more often expressed belief in the idea that sins of the present and of previous life and faulty diet are largely responsible for the onset of mental illness. These findings cannot be logically explained.

Difference between the beliefs of good and poor attenders in outpatient population:

The good attenders of outpatient population significantly more often believed in somatogenesis of mental illness whereas the poor attenders significantly more often believed in sociogenesis, psychogenesis and superhuman causation of mental illness. It is possible that the former come more regularly to hospitals because they think of hospitals as being the centre for treatment of somatic diseases and their illness being somatic, they too can be benefited; whereas, the latter come irregularly because they think that hospitals cannot help them because their illness is not physical.

Difference between follow up pattern of Walk-in sample:

The statistically significant (p<.05) increase in number of non-attenders in Gr. II (beliefs contradicted) as compared to Gr. III (beliefs supported) suggests that if the informant’s belief pattern is supported rather than contradicted, then treatment acceptance improves.

Comparison of follow-up pattern in outpatient population:

A tendency towards increase in the number of non-attenders (p<.1) was seen in Gr. II (beliefs contradicted) suggesting that contradiction of beliefs tends to decrease treatment acceptance. However, there is no significant change in follow up
pattern whether the beliefs are supported or one remains neutral towards them. It suggests that a neutral attitude towards an irrational belief may be a more logical approach than either supporting or contradicting it.

The faith-healers offer patients and their relatives supernatural explanations of the cause and cure of mental illness which are more readily accepted by patients and their relatives because the healers themselves share these traditional ideas. One finding which emerges from this study is that Western-trained psychiatrists should take care not to challenge or dismiss as mere superstition, beliefs in which the patients, their friends and relatives and the traditional healer all have implicit faith. It is possible to offer a different kind of treatment without denigrating that of their traditional healers. The study shows that non-acceptance of psychiatric treatment by patients can be lessened if the psychiatrist avoids directly challenging the community's own beliefs.

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