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Socio - Religious Influences on Mental Health Associated Myths and Misconceptions among Rural People

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Abstract:
Social and religious background of people influences the myths and misconceptions associated with mental health. The present study examines the beliefs about the causes and treatment of mental illnesses among different caste and religious groups in rural areas of Dakshina Kannada district of Karnataka, India. The sample consisted of 140 women from 3 main religious groups, i.e. Hindus (Caste groups: Bunts, Gowdas, Brahmins, Gowda Saraswat Brahmins and Schedule Tribes), Muslims and Christians. Based on education levels of participants two following categories were formed. Participants with the qualification of Pre-University and above were considered as the highly educated group and participants with the qualification of 10th standard or below were considered as the low educated group. A structured questionnaire used to measure the myths and misconceptions among participants. Brahmins and Christians had reported fewer myths and misconceptions compared to Scheduled Tribes (ST), Gowdas, Muslims, Bunts and Gowda Saraswat Brahmins (GSB). Educated participants of all sections of society had fewer myths and misconceptions compared to less educated participants. This study recommends creating awareness on mental health among marginalized, vulnerable and less educated populations.

Keywords: *Myths and Misconceptions, Mental Health, Socio - Religious Background.*

1. Introduction

Many studies have reported the influence of myths and misconceptions about mental health (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Chadda, Agarwal, Singh, & Raheja, 2000; Charles, Manoranjitham, & Jacob, 2007) adversely affected the treatment seeking behavior of families with mental illnesses (Saeed, Gater, Hussain, & Mubbashar, 2000; Raguram, Venkateswaran, Ramakrishna, & Weiss, 2002; Shankar, Saravanan, & Jacob, 2006; Kurihara, Kato, Reverger, & Tirta, 2006). Religious and caste groups play a role in socializing belief system among people in Indian society. Hence, it is important to know how people from various religions and/or caste groups perceive the reasons, nature and possible treatment options for mental health problems (Razali, Khan, & Hasanah, 1996; Saeed, Gater, Hussain, & Mubbashar, 2000; Borras, Mohr, Brandt, Gilliéron, Eytan, & Huguelet, 2007). Recent studies (Almanzar, Shah, Vithalani, Shah, Squires, Appasani, & Katz, 2014; Parikh, Parikh, Vankar, Solanki, Banwari, & Sharma, 2016) have reported that even educated people do not possess awareness on mental illnesses. While revamping the national mental health service system, policy makers have to be sensitive towards the influences of religions and caste groups.

People inherit belief system and knowledge from their parents naturally in the absence of proper scientific information. Such knowledge may not be sufficient to take the informed decision in preventing and treating mental illnesses. An understanding of various myths and misconceptions gives an opportunity to address the mental health needs of the community in a culturally sensitive modus (Kermode, Bowen, Arole, Joag, & Jorm, 2009; Lauber, & Rossler, 2007). When studies explore the reason for the delay in accessing treatment for mental illnesses and challenges faced by people with mentally illnesses in the society have also pinpointed how myths and misconceptions contribute towards delay in seeking treatment from mental health professionals and how people blindly trust faith healers (Vijayalakshmi, Ramachandra, Reddemma, & Math, 2013; Liu, Tirth, Appasani, Shah, & Katz, 2014; Almanzar, Shah, Vithalani, Shah, Squires, Appasani, & Katz, 2014). This study aims to understand myths and misconceptions among people from their viewpoint, which is significant (Ng, 1997) and that, would help to address the need for mental health literacy (Jorm, 2000).

2. Methods

The descriptive study collected data from 140 villagers who lived in Belthangady region of Dakshina Kannada, district of Karnataka, India. The study used purposive sampling and selected samples from three major religions, Hindu, Muslim and Christian. Since Hindu religion has major caste groups, to represent those caste groups, 20 samples each from Bunts, Gowdas, Brahmins, Gowda Saraswat Brahmins (GSB) and Schedule Tribes (ST) were selected for the study. Similarly, 20 samples each from Muslims and Christians were selected. Researchers used an interview schedule to collect data. The interview schedule has been framed with the support of existing literature and experts of community mental health. A comparative analysis was used to describe the influence of religion on myths and misconceptions about mental health. Among 20 samples of each group 10 of them were highly educated and the other 10 of them were low educated. The researcher visited the people at their home and collected data through personal interview using structured questionnaire. Higher the score means higher the myths and misconceptions.

3. Results

Caste/ Religions	Mean	SD	N	t	df	SIG.
Highly educated Bunts	10.5	3.03	10	2.99	18	P< 0.01**
Low educated Bunts	16.7	5.81	10			
Highly educated Gowdas	14.5	4.38	10	1.78	1.8	P> 0.05
Low educated Gowdas	19.1	6.87	10			
Highly educated Brahmins	8.7	3.71	10	2.23	18	P< 0.05*
Low educated Brahmins	13	4.83	10			
Highly educated GSBs	10.5	3.89	10	1.25	18	P> 0.05
Low educated GSBs	13.7	7.07	10			
Highly educated STs	13.4	4.005	10	9.06	18	P< 0.01**
Low educated STs	26.9	2.47	10			
Highly educated Muslims	10	5.06	10	4.45	18	P< 0.01**
Low educated Muslims	19.3	4.27	10			
Highly educated Christians	8.3	4.72	10	2.56	18	P< 0.05*
Low educated Christians	12.8	2.97	10			

Table 1: Education levels and Myths and Misconception
**Significant difference, **Highly significant difference*

The table.1 shows that highly and low educated groups of Bunts, STs, and Muslims differ from each other significantly (P<0.01) in the level of myths and misconceptions within the group. The Mean for highly educated Bunts is 10.5 and for low educated is 16.7 which shows that the low educated Bunts have the high level of myths and misconceptions about causes and treatment of mental illnesses. The Mean for highly educated STs is 13.4 and for low educated is 26.9 which shows that the low educated STs have the high level of the myths and misconceptions. The Mean for highly educated Muslims is 10 and for low educated is 19.3 which shows that the low educated Muslims have the high level of the myths and misconceptions.

Highly and low educated groups of Brahmins and Christians differ from each other significantly (P<0.05) in the level of myths and misconceptions within the group. The Mean for highly educated Brahmins is 8.7 and for low educated is 13 which shows that the low educated Brahmins have the high level of myths and misconceptions about causes and treatment of mental illnesses. The Mean for highly educated Christians is 8.3 and for low educated is 12.8 which shows that the low educated Christians have the high level of the myths and misconceptions.

Highly and low educated groups of Gowdas and GSBs do not differ from each other significantly (P>0.05) within the group. The Mean for highly educated Gowdas is 14.5 and for low educated is 19.1 which shows that the low educated and highly educated Gowdas do not differ significantly (P>0.05) in their beliefs about causes and treatment of mental illnesses. The Mean for highly educated GSBs is 10.5 and for low educated is 13.7 which shows that the low educated and highly educated GSBs do not differ significantly (P>0.05) in their beliefs about causes and treatment of mental illnesses.

Religions	Mean	SD	N	Degrees of freedom	F	Sig.
Hindus	14.7	6.81	100	(2, 137)	3.47	P<0.05*
Muslims	14.65	6.59	20			
Christians	10.6	4.48	20			

Table 2: Religions and Myths and Misconception
**Significant difference*

One-way analysis of variance was calculated to find out the significance of the difference in the level of myths and misconceptions among the Hindu, the Muslim, and the Christian religions. Three religious groups differ from each other in myths and misconceptions about the causes and treatment of mental illnesses significantly (P<0.05). Examination of table 2 shows that Hindus and Muslims do

not differ significantly from each other in their beliefs. Hindus and Muslims reported the high level of myths and misconceptions compared to Christians.

4. Discussion

As findings indicate low educated people in the society possess the high level of myths and misconceptions associated with mental health irrespective of their religious or caste background. Another significant finding is people who belonged to marginalized sections of Hindu and Muslim religion have the high level of myths and misconceptions. Interestingly their vulnerability increases with low-level of education. Low social status and low education are a threat, that deprives the access to modern treatment (Mishra, Nagpal, Chadda, & Sood, 2011; Jain, Gautam, Jain, Gupta, Batra, Sharma, & Singh, 2012; Nortje, Oladeji, Gureje, & Seedat, 2016). They become victims of their ignorance. Similarly, fewer myths and misconceptions among Christians compared to other groups indicate that how their access to quality education, empower them from vulnerable positions in the society. Since the Christian community is closely associated with medical and educational institutions, these opportunities help them to be aware about mental health issues.

This study proposes to meet the need for understanding the belief system of the Indian society and to address their knowledge gap through the culturally sensitive way. Education is a solution for many social evils. But mere education alone may not be enough to address this service gaps. Partnership with leaders of religious and caste groups may enhance the momentum of awareness creation in the rural community. Faith healers are another group of people who can be trained to identify severe mental illnesses and to facilitate the treatment as early as possible. A threat of social exclusion faced by people with mental illnesses is confirmed by the prevalence of high level of myths and misconceptions among people in the rural community. Hence, district mental health team has to work closely with community-based organizations to promote community-based rehabilitation of people with mental illnesses.

5. Conclusion

The present study was designed to assess the myths and misconceptions about causes and treatment associated with mental health among different caste and/or religious groups and aimed at comparing the level of myths and misconceptions associated with mental health between the highly and low educated groups in each of the caste and/or religious groups. As a summary, the social status and the level of education influence the awareness on mental illnesses. Hence, a psychosocial model with the focus on community development is required to enhance the awareness among people from marginalized sections of Indian society.

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