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Views and Perceptions toward Mental Illness: A Qualitative Study from a Rural, Agricultural Community in Anuradhapura, Sri Lanka

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Abstract

Community's perception toward mental illness is a major determinant of stigma and discrimination toward mental illness, ignorance, delayed help-seeking attitude, and treatment options. Conceptions of mental illness are often influenced by sociocultural structures and health literacy among communities. Despite the increased burden of mental health problems, little is known about knowledge and perception of the public toward mental illness in rural communities in Sri Lanka. A community-based qualitative study was conducted in a rural, agricultural community in the district of Anuradhapura, in North-Central province of Sri Lanka to explore perception and attitudes toward mental illness. Eight individual, in-depth, semi-structured interviews and one group interview were conducted among a convenient sample of 15 lay community members. The data were analyzed using qualitative content analysis method. Participants described their views and perceptions toward conceptualizing mental illness under four themes, namely, causes of mental illness, complementary treatment methods, stigma and social discrimination, and supporting factors for mental well-being. Poverty, bad relationships, and beliefs influenced by sociocultural and religious background were considered as the main causes of mental illness. Misconceptions, stigma, and discrimination of mentally ill people and their families delayed help-seeking behavior and caused barriers to mental health-care provision. There is a strong need for increasing mental health literacy and awareness among people in rural communities. People's sociocultural and religious beliefs should take into account when caring for mentally ill people and their family members.

Keywords: Community, Culture, Mental illness, Perceptions, Religion

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Introduction

Mental health problems may exist across the globe, regardless of age, gender, or income levels or living arrangements of people, for example, rural or urban communities, high-income or low-income setting. Mental disorders are generally characterized by a combination of abnormal thoughts, perceptions, emotions, behavior, and relationships with others.[1] According to facts and figures reported by the WHO Mental Health Gap Action Programme[2] in 2008, mental, neurological, and substance use disorders were common especially in the low- and middle-income countries. Lifetime prevalence of mental illness around the world ranged from 12.2% to 48.6% and 12-month prevalence between 8.25% and 29.1%.[2] For example, worldwide, an estimated 264 million people are affected by depression, about 45 million people are affected by bipolar affective disorder, 20 million people are affected by schizophrenia, and approximately 50 million people have dementia.[3] In Sri Lanka, 4.1% and 3.4% of the total population have been found with depression and anxiety, respectively.[4]

People have various perceptions, myths, and beliefs toward mental illnesses and these are influenced by their health literacy, knowledge, culture, and religious backgrounds.[5] The conceptualization of illness and perceived causes of mental illnesses can vary from community to community. Some communities can hold misconceptions toward mental illness that is sometimes deviant from evidence-based, scientific view causing difficulties in home-based, long-term care provision.[6] This may also negatively affect help seeking, adherence to treatments, and providing care for people living with mental health problems.

Stigmatization and labeling against people with mental illness remain a significant barrier to positive outcomes across cultures and nations over years. The way people with mental health problems and their family members respond to stigma may impact whether people with mental illness recover or become marginalized. Stigma has a profound effect on mentally ill people and their family members' lives and also on their chances of recovery[7] and studies from other LMIC settings have found that stigma is associated with barriers to care.[8] Fernando *et al*. found

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in a study from Sri Lanka that attitudes stigmatizing mental illness were also prevalent among doctors and medical undergraduates.[9]

Sri Lanka being a multi-ethnic, Asian country where both Western medicine and alternative treatment methods are widely practiced,[7] sociocultural views, beliefs, and attitudes on health and recovery are salient. However, sociocultural influence on mental illness and community-based management of mental health is less researched in Sri Lanka generally. Therefore, it is a timely need for more high-quality research, with robust methodologies, which would inform policy and service provision in Sri Lanka for people with mental illness and their family caregivers.[10]

The current study intended to explore how a group of people living in a rural community conceptualize "mental illness" in general, its causes and living with a mental illness and how that affects help seeking of a group of lay community members in a rural village in Anuradhapura district, Sri Lanka.

Methods

An exploratory study was carried out among a group of lay community members using in-depth, semi-structured interviews (eight individual interviews and one group interview). Data were analyzed using content analysis method.

Study Setting

Our study setting is a rural, agricultural community with low-income households in the district of Anuradhapura, in the north-central part of Sri Lanka. According to the census of population and housing in 2012,[11] a total of 860,575 people resides in Anuradhapura district. More than 90% of the population is Sinhala Buddhists, and the rest consists of Hindu, Muslim, Roman Catholic, and other ethnic groups.

Sampling and Sample Size

A convenient sample of 15 participants consisted of a group of lay community members of ages 19–67 was recruited. The broad age range was useful to obtain diverse views regarding mental health across age groups. Among them, four had experiences as an informal caregiver for a family member with some kind of major mental illness such as depression, bipolar affective disorder, or schizophrenia. Others did not engage in any caregiving activity for a person with mental illness.

Consent Procedure

All participations were voluntary, and participants were told that they could withdraw from the study at any time and signed written informed consent. Participants were provided with a copy of the informed consent form in English or Sinhala with the contact information of the principal investigator and supervisors for the project. The informed consent form was guided by the WHO guidelines for qualitative research.

Data Collection and Analysis

Data collection was carried out over 3 months using a semi-structured interview guide that explored views and perception of people relating to mental illness. Questions included the conceptualization of mental illness, how to name or label any such conditions, sociocultural beliefs or myths relating to mental illness, aspects of stigma, and help-seeking attitudes. Questions also explored how culture affected health behavior, for example, how a person perceives mental health or illness, what and how something affects the person and his/her behavior, and what/who can influence the health behaviors of others.[12] The interview guide was developed in English and then translated to the Sinhala language.

Eight individual interviews and one group interview were conducted. The duration of the individual interviews was approximately 40 min and the group interview was about 2 h. No monetary compensation was given to the participants, but refreshments were provided in some of the interviews. Individual interviews were done in settings chosen by the participants, often in their homes or gardens. The group interview was carried out among seven women at a home of one of the participants.

Two interviews were conducted in English, and the rest in Sinhala, the mother tongue of the participants. Communications were audio recorded with participants' permission and transcribed verbatim. Most interviews were conducted in Sinhala to establish a better flow in the participants' narratives. All interviews were translated and transcribed into English by the same persons who conducted the interviews. The material that was translated from Sinhala was read by the interviewers together to ensure that the meaning of the material was not lost. Pseudonyms instead of the actual names of study participants were used to maintain the confidentiality and anonymity of the data.[13]

The transcripts were analyzed using the process of deductive manifest content analysis.[12,13] All data were read through and divided into units of meaning, after which the meaning units were condensed into codes categories, and finally, these were labeled as different themes. Themes were compared across the data set, reviewed by the supervisors, and finalized.

Results

Demographic Information of the Participants

A total of eight individual, in-depth interviews and one group interview were conducted. The age of the participants ranged between 19 and 67 years. Among the participants, there were four informal caregivers for a family member with some kind of mental illness. All were female. One informal caregiver who took part in the interview was under treatment for major depression. The group interview was conducted among a group of women (seven) who did not have any formal or informal caregiving experience for a person with a mental illness. All participants were Sinhalese. Table 1 illustrates socio-demographic information.

Themes

Views and perceptions of conceptualizing mental illness can be described under four major themes emerged: Causes of

Table 1: Sociodemographic characteristics of the persons with dementia

Characteristics	*n (%)*
Individual interviews (total = 8, age range 19–67 years)	
Informal caregivers	4 (50)
Lay members without any caregiving experience	4 (50)
Group interview (total = 7, age range 35–40 years)	
Lay members without any caregiving experience	7 (100)

mental illness, complementary treatments, stigma and social discrimination, and supporting factors for mental well-being in the community.

Theme 1: Causes of mental illness

The majority of participants identified poverty, poor relationships, alcohol, and drug addiction as common causes of mental illness. Some interpreted certain misconceptions influenced by sociocultural and religious beliefs as causes of mental illness. None of the participants referred to mental illness as a "brain disorder."

The vicious cycle of poverty: Participants believed mental illness as a cause of poverty as it was associated with their livelihood, socioeconomic, or educational backgrounds.

"We get these diseases as we are poor. Hard life we go through causes mental issues." (P 01, 43 Y)

Poverty, low level of education, lack of awareness, and help-seeking attitude were closely connected to each other. Some reported "*not knowing where to go for help," "having no money for treatment and medications"* as challenges when caring for a person with mental illness. A mother said that the loans she had to take to treat her mentally ill child dragged the entire family into poverty.

"I have tried everything, mortgaged our paddy fields to treat him. Though we don't have anything to eat, the money I saved by farming spent on medicine. I even get loans, Son." (P 02, Mother of a Child with mental illness)

Bad relationships

Another cause for mental health problems stated by the majority of participants was "*bad relationships"* with family members, partners, or neighbors. Family disputes caused by alcohol use, quarrels between parents, and in-laws were seen as a risk for mental health problems among children and housewives.

"Parents quarrelling in front of the children could create anxiety for children. If a father had been drinking alcohol, he might quarrel with the mother" (P 01, 43 Y)

"Bad neighbors bring stress" (P 05, 57 Y)

Having "*poor sexual relationships"* in the marriage was also mentioned as a risk for developing mental illness. Some older adults mentioned that "*having love affairs before marriage could result in mental illness*." According to some participants, parents pressuring their children to choose suitable partners could affect the mental health of young adults. Long-term ill treatment by others or suffering from many problems also seen as common causes for mental health issues at the late stage of life.

"Those who have many problems and cannot tolerate those will eventually get mental illnesses." (P 01, 43 Y)

"Elderly people who haven't received good care from their children will end up there [the mental ward]." (*P 04, 46 Y*)

Addiction to illegal drugs or alcohol was another reported cause of mental illness.

Sociocultural and religious beliefs

Some participants held certain misconceptions influenced by their sociocultural and religious beliefs. For example, they believed spells, evil eye and evil tongue cause mental illness. Receiving a curse by someone or put under a spell called "*Gurukam*" was mentioned as a common cause for mental health problems which were not limited to an individual but to a wider group such as the entire village.

"Some people are jealous of clever children or beautiful girls. Their evil eye/ evil tongue could cause mental issues to [clever or beautiful person]" (P 06, 45 Y)

The participants said that beliefs and myths about evil spirits or gods are common in their village. One myth concerned young unmarried girls:

"If a young girl walked alone outside their house [especially near streams] in the evening, [an evil spirit] could descend upon them and make them mentally ill." (P 08, 67 Y)

Uncertainty if the mental illness was an illness

Uncertainty in the identification of illness was expressed by the majority in various ways. One caregiver of a child with severe mental illness explained that;

"the illness was not defined as a disease at first. I had never before seen or heard about a disease like that."

Furthermore, the participants in the focus group interview discussed reasons for a girl to commit suicide, and they had very divergent views of what could cause mental illness. "*Ragging at university"* was one probable cause that could result in mental illness but no conclusion on associations was clarified. Symptoms of mental illness were generally unclear for the participants, and they had experienced that health-care staff also sometimes failed to identify mental illness. Conditions such as feeling excessively sad (depression) or compulsively washing hands (obsessive-compulsive disorder) were not regarded as mental illnesses by lay community members, and therefore, they did not seek treatment or medical help in advance. It was seen as "severe mental illness" only when people received mental health care, which happened to diagnose accidentally such as after being hospitalized due to self-harm or a suicide attempt, or after the person had damaged the properties of others.

They are a good couple. There are no problems among them. We don't know, we didn't understand how she got it (P 05, 57 Y)

Theme 02: Complementary treatments and healing rituals

People often practiced traditional or complementary therapies as a remedy for mental illness instead of seeking medical treatments from the hospital. For example, "*Bali Thovil"* are the most common healing rituals. These rituals include drumming, dancing, the use of wooden masks, and shamans chanting. There was a strong conviction among the participants that these techniques are effective, yet they were not practiced by the participants in this study.

"People go to sacred places and get blessings... Sometimes they get cured. Sometimes, we have traditional dances that can cure mental illnesses. They have... psychological transformation. Sometimes the dance going on all night... with drums... dancing... blessing... praying... all night." (P 06, 45 Y)

The Buddhist participants had certain practices based on their religious beliefs. A participant said;

"Religious acts and ceremonies could improve mental health and reward relatives with better karma in their next lives. Doing good deeds is important to all aspects of mental health."

Good deeds included going to the temples and worshipping Lord Buddha or religious symbols such as "*Sri Maha Bo Tree*." "*Observing sil on poya days*" was mentioned as being extra important. This is a practice that Buddhists do on full moon days, when a monk gives "*sil*" to people and, by repeating the monk's chant, they change their behaviors concerning the body, as well as speaking and thinking.

"When I encounter a new problem, I go to temple or worship Lord Buddha by offering flowers or lighting oil lamps." (P 07, 28 Y)

The majority of participants expressed that they use Ayurvedic medicine, also referred to as *"Sinhala medicine,"* as a complement to Western medicine. One mother said that she paid to go to see an Ayurvedic doctor to treat and medicate her child, despite the treatment and medicine being expensive:

"We did both Sinhala and Western medicine. Doctors (referring to western medicine) even asked me to take Sinhala medicine." (P 02, Mother of a Child with mental illness)

"I also took [her child] treatments from Ayurvedic doctors" (P 03, Mother of a Child with mental illness)

Theme 03: Stigma and discrimination

Stigma and discrimination concerning mental illness were a clear theme emerged in the analyses. All the participants consistently reported that persons with mental illness and their families were being stigmatized, and neglected by others.

Exclusion

The notion of "*kon kireema"* or exclusion which was based on stigma in Sinhalese was mentioned often. Participants pointed to stigma manifested in acts of exposure or exclusion. Acts of exposure included people scolding others or saying things such as "*you are mad*" or using Sinhalese words such as "*manasika"* (mental), "*manasika aya" (*mental person), or "*pissuwa"* (schizophrenia) when addressing others. People also made sick people uncomfortable and threatened them with violence or inflicted it upon them.

The participants stated that some people in the community teased people with mental illness in order to engage them in quarrels. Mentally ill persons were also excluded, for example, by not being allowed to participate in community events or not being made welcome in public places. It was also stated that *"people did not like to talk to or associate with mentally ill,"* and they showed this by *"closing their doors"* when such people passed their homes.

"People try to stay away from them. They tend to close doors on them. So, it may be difficult for them even to talk to people" (P 02, Mother of a Child with mental illness)

It was believed that *"mentally ill persons did not understand"* this discrimination due to their illness.

"They cannot understand anything. Isn't it? So, he may not think much about it [stigma]." (P01, 43 Y)

However, this stigma resulted in people with mental illness having to hide that they were on medication, lest they be mistrusted and lose their jobs. If a mentally ill person took drugs, it was not looked upon favorably in the village, since it was believed that it could influence children negatively.

Fear of others people's views – guilt by association

There was a fear in the community that interacting with mentally ill persons was risky because one could be "infected" by them or that others might think those interacting with mentally ill persons to also be "mad" or to have mental problems. It was compelling that it was through talking to villagers that people got information about other person's illnesses and that many feared themselves also being the subject of such gossip. Furthermore, early interruption of treatment could be due to fear of being associated with persons with more severe illnesses.

"If I talk to someone having a mental disease, an onlooker will say; 'Ah, look… she also seems to be 'mental'... because I am talking to 'someone that is mental' " (P 04, 46 Y)

Theme 04: Supporting factors for mental well-being in the community

Despite stigma and discrimination people also discussed enhancing mental health well-being. All participants in the group interview were invited to discuss how they can support mentally ill people in the community.

Relieving the mind

They all agreed that *"having a clear mind or relieving the mind from problems"* as a preventive measure against mental illness. It was believed that one could suppress or share burdens and thus feel better by *"letting go."* Suggestions for how to suppress burdens included *"ignoring problems and not thinking about them."*

"Thinking about the same problems repeatedly resulted in a negative mental state, which was bad. One way to prevent mental illness is refraining from over thinking" (P 04, 46 Y)

Some stated that *"not talking about those feelings would also result in mental illness"* and therefore highlighted the importance of good communication.

"Relief of the mind could also be achieved by sharing one's burdens with others and interacting with others. To have someone close to share worries with and to get advice from is essential for mental health." (P 01, 43 Y)

However, sometimes talking to family was not enough, or not successful and it was necessary, or at least potentially beneficial, for others outside the family to help. To be friendly and talk to people with mental health problems was a joint responsibility in the community. Participants identified the importance of social interactions when treating severe mental illnesses:

"We can help by talking to them. We have to be friendly with him. We have to form a good relationship with him." (P 01, 43 Y)

The importance of family support

It was taken for granted that family members should take care of each other, and the family was often the only supportive network for a mentally ill person. If one family member incurred any mental problem, it was perceived as a burden for the whole family. Participants highlighted the importance of teamwork for securing income, caregiving and suggested that extended family would also help.

"I look after her well, like the apple of my eye. More than a father, a mother can find out why it is so. Because fathers are not paying attention much" (P 03, Mother of a child with mental illness)

Participants stated that mentally ill persons do not have insight into their state of mind and thus needed someone close to them to help them understand that they needed help and that they should seek help.

"Hospital refused to have him without a 'responsible person' to be with him. It was a must that [the person with mental illness] was accompanied by someone"

However, this dependency created stress among family members as they worried about who should take care of the family member, and who would provide food, medicine, and social support if they were unable to do it longer. The people with mental illnesses in this study were all economically dependent on their family caregivers. Caregivers to persons who, in addition

to mental illness also had physical impairments, felt even more responsible since they had to be physically available at all times. Caregivers also stated that they were sometimes exposed to acts of violence from the mentally ill person, which created additional stress.

"…don't stay a moment without me, while he is sleeping, I quickly run to the lake to take a bath before he wakes up." (Mother of a child with mental illness)

"I worry a lot it hurts… Who will look after her in the future? I think a lot about what will happen to her. I am thinking about her day and night, who will take care of her?" (P 03, Mother of a child with mental illness)

Having a good relationship with the villagers

Participants stated that as nurturers there was a clear distinction between family and others, as well as neighbors and villagers, and there was a distinction between "good and bad people." Good relationships with neighbors were viewed as being important to one staying mentally healthy. People generally had someone in the village to talk to if they needed advice: Persons of good character, the elderly, the well-educated, and religious leaders.

Some said that to stay mentally healthy *"a person should seek to live without being blamed by others, to live without social or economic burdens, and to not having quarrels with neighbors." "Talking to good friends was in some cases better than attending a hospital to get medicine."* Provided that relations were good, neighbors were also highly supportive if one was ill. On the other hand, it was a mental health risk in being alone and not interacting with neighbors.

"We have good relations with neighbors; we don't quarrel with them. We maintain good relations with them. So, they also treat us well. There are no bad people here, they are sympathetic towards her (the child)." (Mother of a child with mental illness)

Discussion

The primary aim of this qualitative study was to explore how people living in a rural community in Sri Lanka conceptualized mental illness and its causes, and how that affects the lives of people living with a mental illness and their family members. This study identified that socioeconomic, cultural, and religious concepts had a strong association for conceptualization of mental illness and it affected their help-seeking attitudes. A significant proportion of a lay community in Gimbi town in West Ethiopia reports similar findings. People were found to have a poor perception of mental illness, especially among old aged, less educated, private workers, those unable to access mental health information, and those with no family history of mental illness.[14]

Poverty, Stigma, and Discrimination

Some community members had negative views toward mental illness and people suffering from mental illness which resulted in stigma and discrimination. Since mental illness is seen as something shameful, it affected relationships and marriage prospects of affected families. Furthermore, it created difficulties for finding a job as well as more expenses which, in turn, created a negative cycle of poverty and alienation. Among poor caregivers, it was difficult to distinguish feelings related to poverty from feelings related to the mental health situation, since they were closely related. Mental illness in the family entails a high cost of care (transport and medication) and decreases the opportunities to gain income for both the sick person and the caretakers.[15-17] Poverty is a known risk factor for marginalization and mental illness so to focus on improving living conditions in general for the poorest in the community is essential when developing strategies to improve mental health.[17-19]

Stigmatizing opinions were uttered in different ways and had an obvious role in the perceptions of mental illness. Most of the findings in this study showed that people understood mental illness as something self-chosen or self-inflicted, such as being alone, due to drinking alcohol, having bad relations within the family, outside spells, or having bad karma. This is in line with a study by Ratnayake and Links (2009)[20] that found little knowledge about mental illness among young adults in Sri Lanka. They identified alcohol and misuse of drugs as important problems affecting suicidal behavior, similar to our study where alcohol was perceived as causing mental illness. To withdraw, be single or to be alone, was seen as negative, which is more accepted in countries with more individualistic cultures. This self-chosen isolation may be interpreted in two ways: It could be voluntary withdrawnness but also the person could be suffering from mental illness such as depression or anxiety and therefore hide from the public eye due to the illness or fear of consequences.[21] Also, to drink alcohol may be a way of self-medication if there is no care available.[22]

Increase Support for Caregivers

It appeared that mental illnesses often are not detected and recognized as conditions that required proper medical treatments. Mostly, it was women who involved in long-term caregiving for a mentally ill family member and they had less awareness about the nature of the illness. Lack of mental health literacy and stigma were the main barriers to accessing health-care facilities. Caregivers of mentally ill persons expressed that it was a major change in life to have a member become mentally ill and they felt helpless and worried since the person was dependent on them. This strain on caregivers has also been identified by Rodrigo *et al*.[23] who found a high prevalence of depression and low life satisfaction among caregivers of patients with severe mental illness in Sri Lanka. Furthermore, among caregivers to children with cerebral palsy rural residence and low income were associated with higher caregiver burden, in another study from Sri Lanka.[17] Our findings suggest that the situation for caregivers needs to be improved and supported to avoid a downward social and economic drift affecting the whole family. Findings also highlight that lack of knowledge, misconceptions, and stigma can be overcome through health promotion interventions to raise awareness within the community. Interventions, including local health workers and social workers visiting the families, and support networks for caregivers, could be one way to go.[15,21] The WHO's Mental Health Action Plan 2013–2020, endorsed by the World Health Assembly in 2013, recognizes the essential role of mental health in achieving health for all people. The plan includes four major objectives including more effective leadership and governance for mental health, the provision of comprehensive, integrated mental health and social care services in community-based settings, the implementation of strategies for promotion and prevention, and strengthened information systems, evidence, and research.

Health Systems Strengthening

Since this study was conducted, improvements have been made in the mental health-care system in Sri Lanka. There are now designated medical officers entitled MO/Mental Health in each district who are appointed to coordinate mental health-care services in that district. A postgraduate diploma in mental health was introduced so that interested doctors can take it up. Postgraduate education on any specialty is provided free for Sri Lankan doctors, and they also receive paid leave for the duration of the course. Mental health clinics are also now established in each district in which MO/mental health provides their services. They also conduct outreach clinics with regular frequency, for instance, monthly clinics in rural hospitals. Those clinics are often manned by trained professionals, including a psychiatrist. The number of psychiatrists has also increased remarkably during the past few years as the Post Graduate Institute of Medicine (the institute responsible in producing specialists in Sri Lanka) increased the number of postgrads recruited for training as psychiatrists. Sub-specialties such as child psychiatry have also emerged. Thus, services related to mental health have improved dramatically in quantitative terms during the past decade. Furthermore, in relation to medicine, changes in drug policies in Sri Lanka in 2016 prevented overly expensive and not readily available drugs from entering the market. However, this study also showed that social and cultural factors very much affected rural people's conceptions about mental illness as well as their help-seeking behavior. Culture in this study is understood as "…shared values, norms, and codes that collectively shape a group's beliefs, attitudes, and behavior through their interaction in and with their environments."[10,22] Religious places, traditional rituals, and Ayurvedic medicine were commonly used together with governmental health-care services. To increase knowledge and improve attitudes toward people with mental illness in the local communities, there is still room for improvement and the development of health interventions. The interventions should be developed in collaboration with the community members using a participatory approach.[24] Engaging rural communities in health promotive projects have a long tradition in Sri Lanka and show successful results. In a recent health promotive community project in Sri Lanka, community members identified determinants for low birth weight and thereby contributed to improving child health in the village.[25] The same participatory design can be used also to improve mental health in local communities.

The availability of clinics to seek help, how access to health care and information, whether people accept the treatments and care provided and whether they trust the health systems are to be investigated further.[26]

Conclusion and Recommendations

How mental health is viewed and its acceptability in a society are very much determined by the culture people inhabit, and health planners need to understand how culturally relevant factors influence both the risk of mental illness as well as the help-seeking process when suffering from mental illness.

Conflicts of Interest

The authors declare no potential conflicts of interest with respect to research, authorship, and/or publication of this article.

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