Mental Health Literacy in Caregivers of Sundarban Estuary Area of West Bengal

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Objectives: National Institute of Behavioural Sciences (NIBS) has been working ceaselessly for more than five years doing a longitudinal study by visiting every month in the core area of Sundarban. Most studies done there are either sporadic or peripheral in nature and lack the potentiality to identify the intricacies of the native problems. Sundarban – the Gangetic delta of mangrove forest and the land of Royal Bengal tigers has also been inhabited by people who are dependent on the forest for their livelihood. In most areas critical medical assistance is not available within hundred kilometers. Mental patients are often confronted with stigma and prejudice. Mental health literacy (MHL; Jorm, 1997) is the idea of knowledge and belief about mental disorders that are cognizant for recognition, management and prevention of these disarray. Higher mental health literacy is vital in controlling the prevalence of mental disorders which are going to be the second cause of mortality after cardiovascular diseases in next 15 years (WHO, 2000). In India dearth of knowledge about mental health even in urban areas can be alarming.
Present study aims to assess the MHL in a population of a remotely located village area near mangrove forest inhabited by mainly people of lower socio-economic status.

Methods: The study included 180 subjects at the Rangaberia block of Sundarban (south 24 Parganas). They are the caregivers of the patients who visited the local primary care hospital for the last 3 years. The tools used were a narrative interview, Duke Mental Health Inventory, Social belief Questionnaire and Locus of Control (LOC). The data was analyzed by using standard statistical procedure.

Results: Increased public knowledge is required to empower the understanding of mental health as in these remote areas of Sundarban professional help is not easily available. The recognition of the disorders was much below the expected level (<0.5%) as mostly the mental disorders are assumed as manifestation of physical illness

(anxiety, depression) or some witchcraft (psychotic). Knowledge of symptomology was scanty and insignificant (<0.4%) and thus communication with health professionals become problem even when professional help is available. Locus of control indicates significant (p=0.05) emphasis on chance factors. Scores of Duke Health profile indicated poorer health status among these caregivers.

Discussion: Detection of mental disorders become easier when exact symptom presentation happens and lack of MHL is a setback. Belief systems as possession by evil spirits, witchcraft were predominant (>60%). Traditional healers and poor compliance to medication were other major areas of setback. While scarcity of professional help emphasize the importance of self-help interventions in this type of remote areas, knowledge and belief about self-help interventions were found to be feeble and inappropriate. It was implicit that many milder forms of mental disarray can well be managed by physical exercise, Yoga, simple cognitive exercises, behaviour reinforcements, seeking support from family and friends and engaging in plausible activities. Thus improved MHL status can immensely help to curb on the cost and distress caused by the highly multiplying disorders of mental illnesses.

Conclusion: It is unfortunate that people of Sundarban are yet to experience the light of mental health awareness while rest of the modern world is having better exposure of that. It is beyond doubt that above type of study can facilitate and encourage other way of promoting mental health in these remote areas and thus improve the quality of life in general.

References:

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