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REASONS FOR DELAY IN SEEKING PROFESSIONAL CARE FOR MENTAL HEALTH PROBLEMS IN LAHORE

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Abstract:
Aims*: Pakistan has a literacy rate of 58%. Mental health issues are widely stigmatized and are thought to be caused by supernatural causes. There is social disapproval of mentally ill individuals which leads to issues regarding marriage & divorce. This research was conducted to find reasons as to why people delay in seeking professional care for their mental health issues and the duration of delay present.*
Methodology*: The cross-sectional study on 50 patients was conducted in three hospitals with mental health care centers accessible to both rural and urban population. Non-probability convenient sampling technique was used to select the study sample. The data collection tool was a questionnaire. The completed questionnaire data was entered into computer for data analysis on SPSS-23.*
Results*: The results showed that the duration of delay ranged from one month till six years. Not considering mental health issues as a problem was the most common reason for delay. The number of female participants were greater than male participants.*
Conclusion*: Our study concluded that main reason for delay in seeking professional care was never considering their mental health state a problem. The largest time gap between onset of symptoms and seeking help was of six years.*
Keywords*: Delay in treatment, mental health care, depression.*

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INTRODUCTION:

Mental health as defined by World Health Organization (WHO) is " a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community"1. More than 300 million people are affected with mental health issues making them one of the commonest worldwide health problems. Depression is different from short term emotional responses to everyday challenges or mood fluctuations experienced on day to day basis.2 Anxiety and mood disorders are the most common psychiatric conditions which make up for more than half of the total mental health issues globally.3 WHO has asserted that socioeconomic burden caused by mental health issues will exceed that of cardiovascular disorders and cancer.4

Epidemiological studies have shown that failure at school or failure in seeking job is one of the contributors behind mental illnesses. Other factors contributing are teenage child bearing- early pregnancies when there was no financial stability. Early violent and unstable marriages are also associated with early onset of mental disorders which go untreated.5 6 7 The rising use of social media where everyone displays the good parts of their lives often leads others to think negative of their own or the display of wealth puts one under society's pressure to match them leads to depression.8 Low self-esteem is also reported to play a role as one of the reasons behind depression.9 However, if the mental illness goes untreated it results in the following severe consequences which range from Suicide, Drug and substance abuse, self-injury, reckless behavior, relationship problems, health issues and homicides. Around 800,000 people die due to suicide each year. It is said to be second leading cause of death in 15-29-year-olds around the world.10

Majority of people with mental health issues didn't get any treatment11. Those who did seek treatment went for it in later stages. The median delays ranged from 1-14 years for mood disorders, 3-30 years for anxiety disorder and 6-18 years for substance abuse.12 Almost 28% people went to seek help within first year of onset at special anxiety clinics in Australia.13 All over the world the median rate for untreated patients is said to be 56.3%.14 The percentage difference between number of people needing treatment for major depression and the number of people which are currently seeking help ranged between 15.9% (12 month, Florence)15 16and 83.9% (current, UK).17 According to a recent study conducted in Pakistan 61% of delay was contributed to lack of awareness and false beliefs in consultations for psychosis.18 Clinical trials have shown that if the disorder is picked up on time and treated the suicidal tendency decreases. A few delays that have been known were caused by person not accepting the state they are in and tend to try it make it better on their own.19 Another factor that contributes is if the age of onset is early and they have to rely on adults to help them get the treatments needed. and also the stigma associated with mental health problems which causes them to feel ashamed and embarrassed while seeking help for such issues. 20 21

Pakistan is a developing country where mental illnesses are thought to be caused by supernatural powers22 and even educated people are stigmatized.23 The number of suicides in Pakistan have been 0.43 per 100,000 in Peshawar to 2.86 per 100,000 in Rawalpindi. The rates for men have been higher in Larkana, Sindh with 7.06 per 100,000 in age group of 20-40 years. .24 The male percent of the population affected by depression is 25.5% and female perfect affected is 57.5%.25 Overall prevalence of anxiety and depression is Pakistan was 34%.26. There has not been any significant study done regarding why people delay in seeking treatment after realization of their condition and the duration for how long this delay lasted in Lahore, Pakistan. This research will highlight those reasons which are causing delays in seeking treatment for mental health issues and will then suggest different ways which will help in reducing these delays.

MATERIALS AND METHODS:

Study design: Cross sectional descriptive study
Setting: Among three public hospitals in Lahore, which are accessible to both urban and rural population.

Duration of Study: Study was conducted from 9th July 2018 till 20th August 2018

Study Population: All the patients presenting to psychiatry wards during the duration of study
Sample Size: 50 Patients
Sampling Technique: Non-probability convenient sampling technique was used to select the study sample.

Sample Selection:
Inclusion Criteria: Patients presenting with delay in seeking help. Delay will be found out by time gap between first onset of symptoms till first contact for help made.

Exclusion Criteria: Refusal to participate

Data collection procedure: Jinnah Hospital, Lahore General Hospital & Mayo Hospital were selected on convenience basis after seeking approval from the authority. The questionnaire was translated into Urdu for easy understanding, consent was taken from the patient and the verbal responses written down.

Data Collection Tool: Self-administered Questionnaire designed by investigators after extensive literature search was used. Pre-testing was done on 5 patients, data was discarded and not made part of this study. The questionnaire has two parts. One consisting of the biodata and second consisting of questions related to the problem. The questionnaire was shown to the experts at Azra Naheed Medical College to verify the clarity of the questions as content validity.the experts indicated that the surveys are suitable for both patients and doctors and could answer the intended research questions in details.

Data analysis Procedure: The completed questionnaire data was entered into computer for data analysis on SPSS v23.0. Descriptive stats are applied.

RESULTS:

Here 55 patients participated in this study out of which 50 were chosen as the information was complete. From the patients 18 were from Jinnah Hospital Lahore, 16 were from General Hospital Lahore and 16 from Mayo Hospital Lahore. (Table 1) shows the number of males and females in this study out of which 38% were male and 62% were females. The sample distribution was 22% from rural areas and 78% from urban areas (Fig 1). The age distribution is shown in (Fig 2). Family setting is shown in (Fig 3) in which 64% were from joint family system and 36% were from separate family system. History of past emotional trauma in family was present in 58% of the patients (Table 2). The Marital status was 42% unmarried and 58% married. Number of family members per person is shown in the (Fig 4). Previous Consultations made by the patient are shown is (Fig 5). 72% of the patients were referred by someone else to the professional whereas 28% went on their own. The occupational percentages were 6% Landlords, 38% Office Going, 14% Outside Workers, 20% Students, 22% Housewives. The different reasons for delay were reported to be 6% Financial constraints, 4% transport issues, 28% considering the problem not big enough, 12% stigma in society & 50% never considering it a problem as shown in (Fig 6). The durations of delay can be seen in (Table 3) which ranges from one month to six years. The duration of delay correlated with gender is shown in (Fig 7). In (Table 7) the chi-square value is 0.124 which means there is no statistically significant association between them.

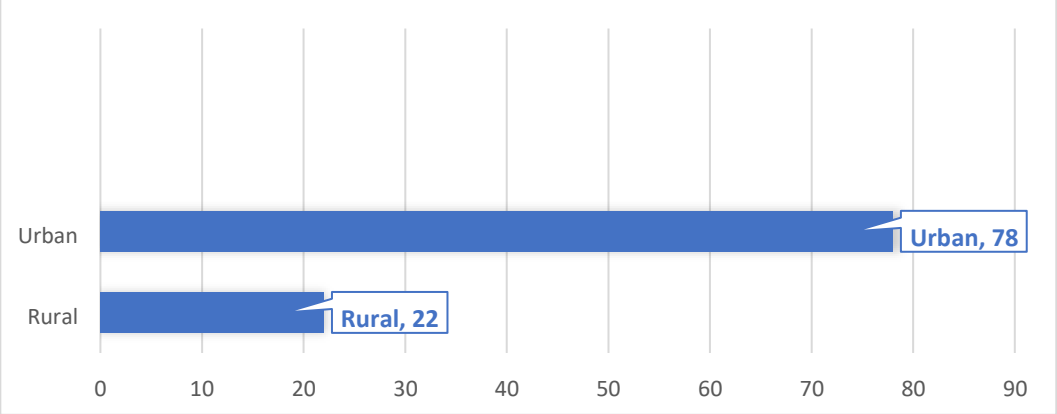

Figure 1 Location of the Patients

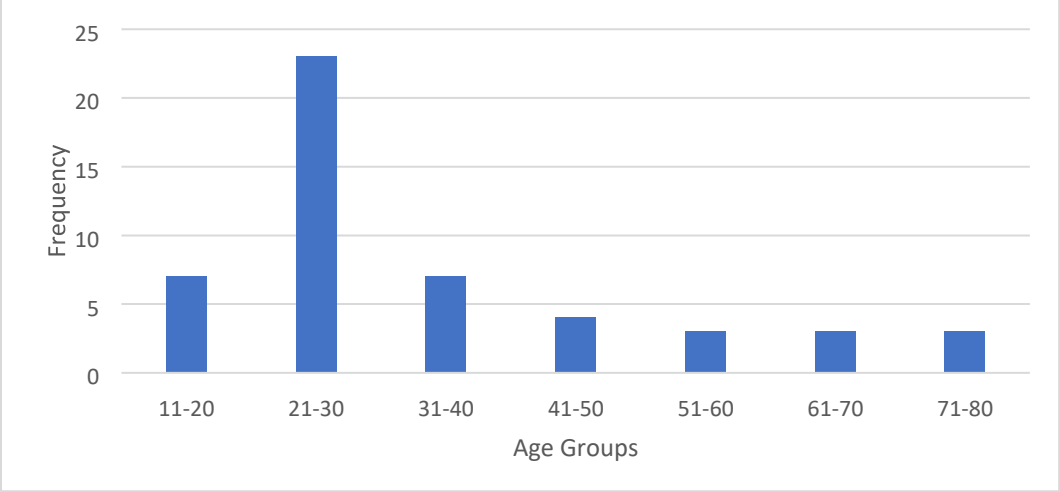

Figure 2 Age of the patients participating

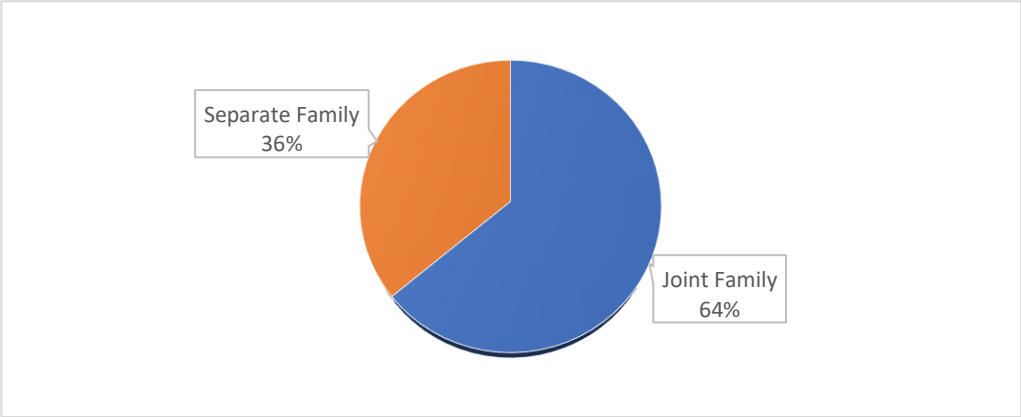

Figure 3 Family setting of the patients

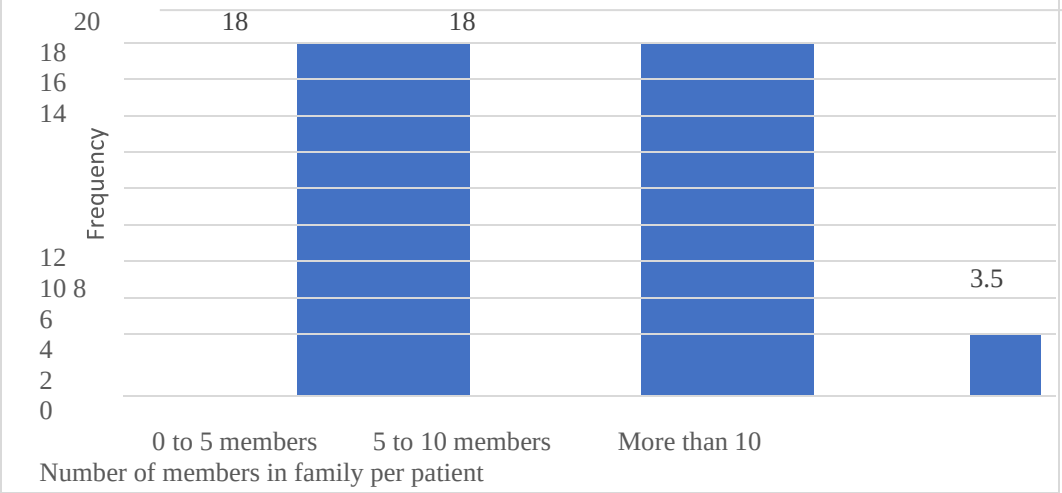

Figure 4 Family Members per Patient

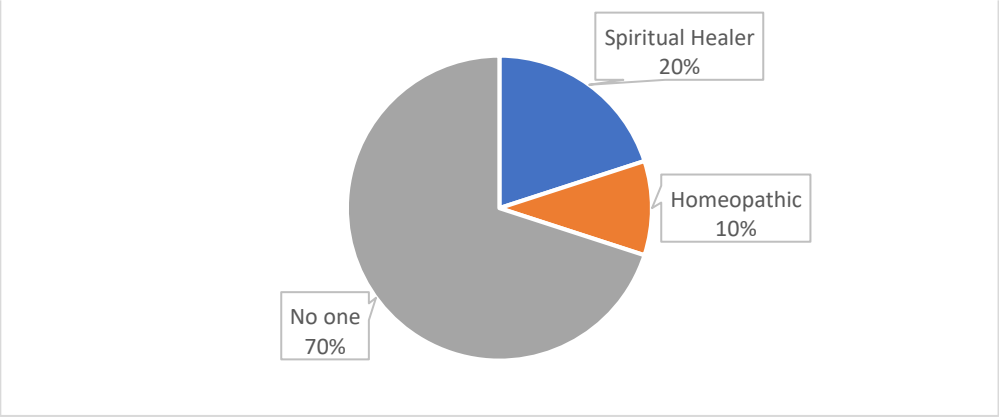

Figure 5 Previous Consultations

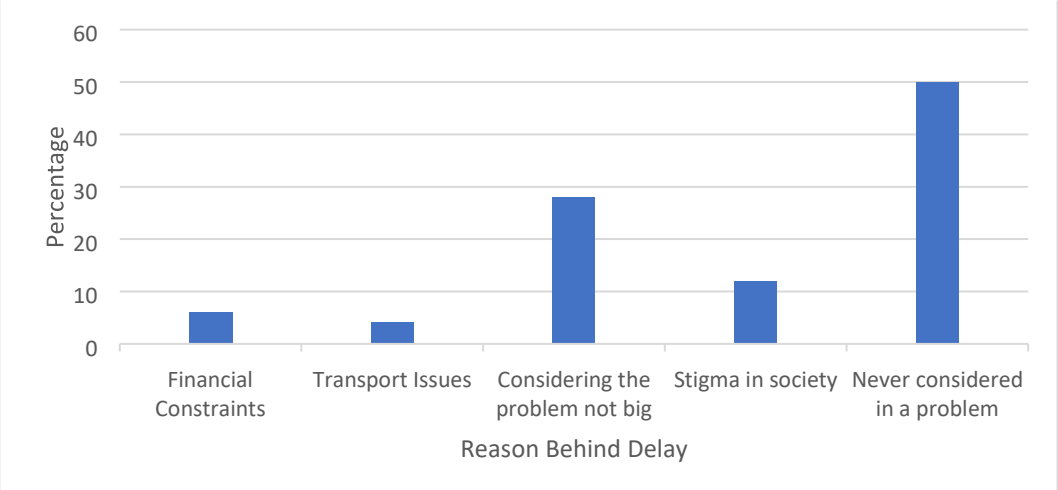

Figure 6 Reasons Behind Delay

Table 1 Gender of Participants

Gender	Frequency	Percent
Male	19	38
Female	31	62
Total	50	100

Table 1 Presence of emotional trauma in family

	Frequency	Percent
Yes	29	58
No	21	42
Total	50	100

Table 2 Duration of Delays

Delay	Frequency	Percent
Less than 6 months	21	42
6 months to 1 year	23	46
More than 1 year	6	12
Total	50	100

Table 4 Gender and Marital status of participant

Gender	Marital status of patient		Total
	Unmarried	Married	
Male	11	8	19
Female	10	21	31
Total	21	29	50

Table 5 Gender and Family setting of participant

Gender	Family setting of patient		Total
	Joint Family	Seperate Family	
Male	13	6	19
Female	19	12	31
Total	32	18	50

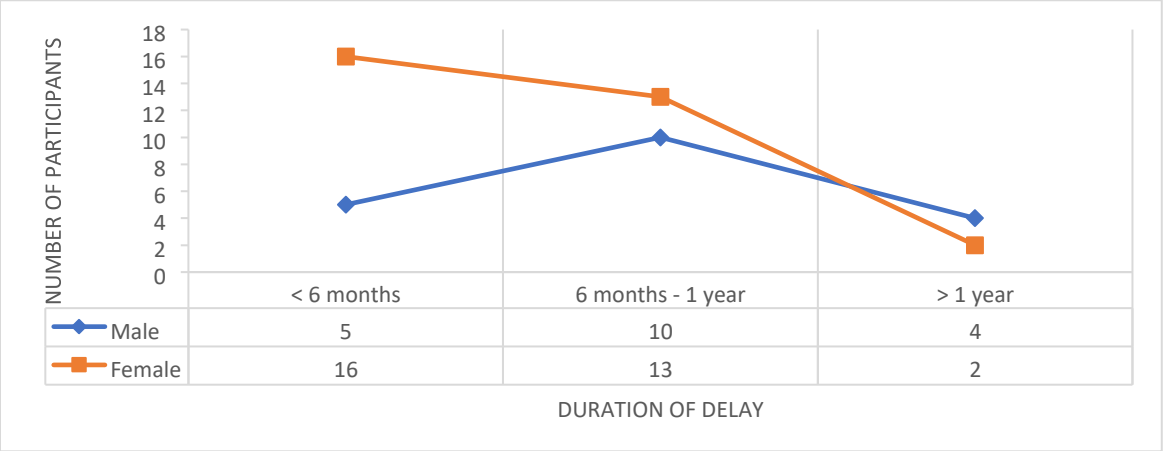

Figure 7 Association of duration of delay with gender of participants.

Table 6 Chi-Square test for Correlation between delay duration and gender.

	Value	df	Asymptotic Significance (2-sided)

Pearson Chi-Square	4.181a	2	.124
Likelihood Ratio	4.223	2	.121
Linear-by-Linear Association	4.084	1	.043
N of Valid Cases	50		
a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.28**.**			

DISCUSSION:

In this study 62% (31) of the subjects were females and 38% (19) were males. A similar Study conducted in Hindukush mountains of north west frontier showed that more prevalent depression and anxiety was in females with 46% and males had 15%.45 A study conducted in UK showed that married women with no jobs outside home were more likely to suffer from mental health issues46, this was supported by our findings as 22% of the patients were housewives. According to our study 64% of patients were from joint family systems and 36% were from separate family systems. This finding goes along the study conducted on females living in joint family systems which reported that role of interference by in-laws in daily life had greater impact of stress and anxiety.47 On the other hand it is opposed by a study conducted on elderly patients who were more prone to depression in separate household systems.48 About 72% of the subjects in this study were married females which is in favor of the previous study conducted on married females, which reported that they are usually burdened with child care along with household chores alone which makes them more susceptive to depression.49 Also conflict with husband 80% and conflict with in laws 43% lead women to have more suicidal thoughts.50 Here 50% of the patients in this study reported that they never considered their current state a problem and 28% considered it a problem but not big enough to seek help. 12% were afraid of stigma in society. Only 6% had financial constraints and 4% had transport issues. In Japan low perceived need for seeking treatment was reported to be a reason for delay in 63.9% patient. Considering the problem small and trying to resolve on own was also present as a factor in 68.8% patients. Also, women and younger age patients had more issues in seeking professional care at the right time because both are dependent on others.51 Many people reported that they would be embarrassed if their friends got to know about their use of mental health services which led them to avoid getting treated as per the study conducted in USA & Canada.52.

CONCLUSIONS:

Our study concluded that main reason for delay in seeking professional care was the lack of awareness among people as half of the patients never considered their mental state a problem and tried to live on their life. Others who did recognize it a problem didn't seem to pay much attention as they thought it wasn't big enough and tried to solve it on their own. They do not realize due to the lack of knowledge that this kind of problem is treated by a psychiatrist or a psychologist. The largest gap between onset of symptoms and seeking professional care was of six years.

REFERENCES:

1. WHO. Mental Health: a state of well-being [Internet]. 2014. Available from http://www.who.int/features/factfiles/mental_health/en/
2. 2. WHO. Depression [Internet]. 2018. Available from http://www.who.int/news-room/factsheets/detail/depression Andrews G, Henderson S, Hall W Prevalence, comorbidity, disability and service utilization: An overview of the Australian national mental health survey. Br J Psychiatry. (2001a) 178:145–153.
3. Jenkins R, Lewis G, Bebbington PE, Brugha T, Farrell M, Gill B, Meltzer H. The National Psychiatric Morbidity Surveys of Great Britain—initial findings from the household survey. Psych Med (1997) . 27:765–790.
4. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, Wittchen H, Kendler KS Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the US: Results from the National Comorbidity Survey. Arch Gen Psychiatry. (1994) 51:8–19
5. Roh S, Lee S-U, Soh M, et al. Mental health services and R&D in South Korea. International

Journal of Mental Health Systems. 2016;10:45. doi:10.1186/s13033-016-0077-3
6. Kessler RC, Bergland PA, Foster Cl et ad. Social consequences of psychiatric disorders, II: Teenage parenthood. Am J Psychiatry 1997; 154:1405-141
7. Kessler RC, Foster CL. Saunders WB, et al. Social consequences of psychiatric disorders, I: Educational attainment. Am J Psychiatry 1995; 152:1026-1032
8. Kessler RC, Walter EE, Forthofer MS. The social consequences of psychiatric disorders, III: probability of marital stability. Am J Psychiatry 1998; 155:1092-1096.
9. Mark W. Becker, Reem Alzahabi, and Christopher J. Hopwood. Media Multitasking Is Associated with Symptoms of Depression and Social Anxiety.Cyberpsychology, Behavior, and Social Networking 2012 16:2, 132-135
10. Vaughan, G. and Hansen, C. 'Like Minds, Like Mine': a New Zealand project to counter the stigma and discrimination associated with mental illness. Australasian Psychiatry . (2004), 12: 113-117. doi:10.1111/j.1039-8562.2004.02083.x
11. WHO Website, Factsheet Depression, 22 March 2018.
12. Wang PS. Aguilar-Gaxiola E. Alonso J, et al. Worldwide use of mental health services for anxiety, mood, and substance disorders: results from 17 countries in the WHO World Mental Health (WMH) Surveys. Lancet. 2007; 370:841–850
13. S Wang, Philip & Angermeyer, Matthias & Borges, Guilherme & Bruffaerts, Ronny & Tat Chiu, Wai & de Girolamo, Giovanni & Fayyad, John & Gureje, Oye & Haro, Josep Maria & Huang, Yueqin & Kessler, Ronald & Kovess, Viviane & Levinson, Daphna & Nakane,
14. Yoshibumi & Oakley Browne, Mark & Ormel, Johan & Posada-Villa, Jose & Aguilar-Gaxiola, Sergio & Alonso, Jordi & Ustun, Tevfik. . Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey

Initiative. World psychiatry: official journal of the World Psychiatric Association (WPA). (2007). 6. 177-85.

15. Thompson, A., Issakidis, C., & Hunt, C. Delay to Seek Treatment for Anxiety and Mood Disorders in an Australian Clinical Sample. Behaviour Change, (2008). 25(2), 71-84. doi:10.1375/bech.25.2.71
16. Kohn R, Saxena S, Levav I, Saraceno B. The treatment gap in mental health care. Bulletin of the World Health Organization. 2004;82(11):858–66.
17. Faravelli C, Degl'Innocenti BG, Aiazzi L, Incerpi G, Pallanti S. Epidemiology of mood disorders: a community survey in Florence. Journal of Affective Disorders. 1990;20(2):135–41.
18. Faravelli C, Degl'Innocenti BG, Biardinelli L. Epidemiology of anxiety disorders in Florence. Acta Psychiatrica Scandinavica. 1989;79(4):308–12.
19. Ohayon MM, Priest RG, Guilleminault C, Caulet M. The prevalence of depressive disorders in the United Kingdom. Biological Psychiatry. 1999;45(3):300–7.
20. Sultan SM: Factors delaying psychiatric consultation in first episode psychosis – A retrospective cross-sectional study. J Med Sci. 2006, 14: 21-25
21. Gulliver, A., Griffiths, K. M., & Christensen, H.Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. BMC Psychiatry, . (2010). 10, 113.
22. Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., & Ustun, T. B.Age of onset of mental disorders: A review of recent literature. Current Opinion in Psychiatry, (2007). 20(4), 359–364.
23. Pedersen, E. R., & Paves, A. P. Comparing perceived public stigma and personal stigma of mental health treatment seeking in a young adult sample. Psychiatry Research, (2014). 219(1), 143–150. http://doi.org/10.1016/j.psychres.2014.05.017
24. Karim S, Saeed K, Rana MH, Mubbashar MH, Jenkins R: Pakistan mental health country profile. Int Rev Psychiatry. 2004, 16: 83-92.
25. Javed Z, Naeem F, Kingdon D, Irfan M, Izhar N, Ayub M: Attitude of the university students and teachers towards mentally ill, in Lahore, Pakistan. J Ayub Med Coll Abbottabad. 2006, 18: 55-58.
26. Murad M. Khan, Haider Naqvi, Durrane Thaver & Martin Prince. Epidemiology of Suicide in Pakistan: Determining Rates in Six Cities, Archives of Suicide Research. (2008) .12:2, 155-160
27. N. Husain , F.Creed ,B.Tomenson. Depression and social stress in Pakistan. Psychological medicine journal, Volume 30; Issue 2 March 2000:395-402
28. Mirza I, Jenkins R. Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. BMJ 2004;328(7443): 794.
29. Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E.

J., … Wells, J. E. Worldwide Use of Mental Health Services for Anxiety, Mood, and Substance Disorders: Results from 17 Countries in the WHO

World Mental Health (WMH) Surveys. Lancet, (2007). 370(9590), 841–850.
30. Edlund, M. J., Wang, P. S., Berglund, P. A., Katz, S. J., Lin, E., & Kessler, R. C.Dropping out of mental health treatment: Patterns and predictors among epidemiological survey respondents in the United States and Ontario. The American Journal of Psychiatry. (2002). 159(5), 845-851.
31. Olfson M, Mojtabai R, Sampson NA, Hwang I, Druss B, Wang PS, Wells KB, Pincus HA, Kessler RC. Dropout from outpatient mental health care in the United States.. Psychiatr Serv. 2009 Jul; 60(7):898-907. DOI: 10.1176/ps.2009.60.7.898
32. Sayers, J. The world health report 2001 — Mental health: new understanding, new hope. Bulletin of the World Health Organization, (2001). 79(11), 1085.
33. Mental health: massive scale-up of resources needed if global targets are to be met http://www.who.int/mental_health/evidence/atlas/atlas_2017_web_note/en/
34. Gadit A, Khalid N .State of Mental Health in Pakistan: service, education and research, Hamdard Foundation, Karachi. Pakistan, (2002) 36–58
35. Knapp M. Hidden costs of mental illness. Br J Psychiatry. 2003 Dec; 183():477-8.
36. Mechanic D. Removing barriers to care among persons with psychiatric symptoms.Health Aff (Millwood). 2002 May-Jun; 21(3):137-47.
37. Jagdeo A, Cox BJ, Stein MB, Sareen J. Negative attitudes toward help seeking for mental illness in 2 population-based surveys from the United States and Canada. Can J Psychiatry. 2009 Nov; 54(11):757-66. DOI: 10.1177/070674370905401106
38. Prins MA, Verhaak PF, Bensing JM, van der Meer K. Health beliefs and perceived need for mental health care of anxiety and depression--the patients' perspective explored. Clin Psychol Rev. 2008 Jul; 28(6):1038-58. DOI: 10.1016/j.cpr.2008.02.009
39. Ten Have, M., de Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J., & the ESEMeD/MHEDEA 2000 Investigators.Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. Social Psychiatry and Psychiatric Epidemiology, . (2010). 45(2), 153–163.
40. Alegría M, Bijl RV, Lin E, Walters EE, Kessler RC. Income Differences in Persons Seeking Outpatient Treatment for Mental Disorders. A Comparison of the United States With Ontario and the Netherlands. Arch Gen Psychiatry. 2000;57(4):383–391. doi:10.1001/archpsyc.57.4.383
41. Ten Have, M., de Graaf, R., Ormel, J., Vilagut, G., Kovess, V., Alonso, J., & the ESEMeD/MHEDEA 2000 Investigators. Are attitudes towards mental health help-seeking associated with service use? Results from the European Study of Epidemiology of Mental Disorders. Social Psychiatry and Psychiatric Epidemiology, . (2010). 45(2), 153–163.
42. Mojtabai, R., Olfson, M., Sampson, N.A., Jin, R., Druss, B., Wang, P.S. et al, Kessler, R.C. Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. Psychological Medicine. 2011; 41:1751–1761 DOI: https://doi.org/10.1017/S0033291710002291
43. Shah, S., Van den Bergh, R., Van Bellinghen, B., Severy, N., Sadiq, S., Afridi, S. A., … Zachariah, R. Offering Mental Health Services in a Conflict Affected Region of Pakistan: Who Comes, and Why? PLoS ONE, (2014). 9(6), e97939.
44. S. Clement1, O. Schauman1, T. Graham, F. Maggioni, S. Evans-Lacko, N. Bezborodovs, C. Morgan, N. Rüsch, J. S. L. Brown and G. Thornicroft: Cambridge University Press 2014: What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies, Psychological Medicine 7, 1-17
45. Westerman T. Engagement of indigenous clients in mental health services: what role do cultural differences play [editorial]? Aust E J Adv Ment Health [Internet] 2004; 3 (3). http://www.auseinet.com/journal/vol3iss3/ westermaneditorial.pdf (accessed Jul 2007).
46. Lincoln C, McGorry PD. Pathways to care in early psychosis: clinical and consumer perspectives. In: McGorry PD, Jackson HJ, editors. The recognition and management of early psychosis: a preventative approach. Cambridge, UK: Cambridge University Press, 1999: 5179.
47. Mumford DB, Nazir M, Jilani FU, Baig IY. Stress and psychiatric disorder in the Hindu Kush: a community survey of mountain villages in Chitral, Pakistan.Br J Psychiatry. 1996 Mar; 168(3):299-307.
48. Brown GW, Harris TO: Social Origins of Depression: A Study of Psychiatric Disorder in Women. London, Tavistock, 1978.
49. Niaz, U. Women's mental health in Pakistan. World Psychiatry, (2004). 3(1), 60–62.

50. Taqui, A. M., Itrat, A., Qidwai, W., & Qadri, Z. Depression in the elderly: Does family system play a role? A cross-sectional study. BMC Psychiatry (2007)., 7, 57.http://doi.org/10.1186/1471-244X-7-57
51. Brown GW, Harris TO: Social Origins of Depression: A Study of Psychiatric Disorder in Women. London, Tavistock, 1978.
52. Niaz U. Human rights abuse in family. Journal of Pakistan Association of Women's Studies. 1994;3:33–41
53. Kanehara, A., Umeda, M., Kawakami, N., & on behalf of the World Mental Health Japan Survey Collaborators. Barriers to mental health care in Japan: results from the World Mental Health Japan Survey. Psychiatry and Clinical Neurosciences, (2015). 69(9), 523–533.
54. Jagdeo A., Cox B. J., Stein M. B., & Sareen J. Negative attitudes toward help seeking for mental illness in 2 population—Based surveys from the USA and Canada. The Canadian Journal of Psychiatry, (2009). 54, 757–766.