TAJ December 2011; Volume 24 Number 2
Published on 2016

ISSN 1019-8555
The Journal of
Teachers Association
RMC, Rajshahi

Original Article

Study of the Santal-Psychiatric Patients and their Belief Towards Mental Illness

A A Mamun Hussain[1], Shahana Qais[2], Khan M M R[3]

Abstract

This study aims at finding the presence of psychiatric illness of the santals, an ethnic minorities of the northern part of Bangladesh and their belief towards mental illness. Among the 77 patients, 39 (50.64%) were male and 38 (49.35%) were female. The majority of the respondents were in between the age of 16-35 years. Most (80%) believed that possession by Bonga/Kali caused the illness. In the present study, 45 (59.74%) had major mental disorder, 18 (23.37%) had minor mental disorders and 13 (16.88%) had psychotic disorder due to general medical condition (viz. Epilepsy). Observations suggest that change of awareness and perception regarding mental disorder, should be a high priority, as right mental health is one of the key component of total delivery of health care.

TAJ 2011; 24(2): 76-81

Introduction

Some 400 million people in the world suffer from mental disorders[1]. Of every four people who turn to the health services for help, at least one is troubled by mental disorder, often not even correctly diagnosed. World Health Report (2001)[2] illustrated that, "at any one point of 10-15% of the population suffer from one or other mental disorder. Mental disorders are commonly affecting 20-25% of all 12.3% of the total DALYs (Disability Adjusted Life Year). It is projected that the burden will have increase to 15% of the mental disorders, when unipolar depression would be the biggest contribution to DALYs burden by 2020. The WHO sponsored global Burden of disease, study lists five psychiatric illness among the ten leading causes of disability in the world[3]. So, their impact on psychological, social and economic well being is also very high. Keeping this axiom in mind, the present study is proposed to measure the miseries of the Santals, who are the minorities among the marginalized people. The Santals inhabit widely varying ecological and geo-climatic environment and at the same time, they are distinct biological isolates with district cultural and socio-economic background. Ahsan[4] noted that the transformation of tribal culture in Bangladesh has been facing a good deal of opposition, conflict, and disbelief due to many socio-economic and political factors that stand in the way of the progress of the country. Commenting on the Santals, Tone Bleie[5], noted their increasing underemployment and disruption of the Adivasi World View, which were making them more vulnerable to exploitation, to frenetic alcohol consumption, to abuse and to downward mobility towards extreme poverty. As such, the ethnic minorities are subjected to mental health strains[6].

[1] Associate Professor, Department of Psychiatry, Rajshahi Medical College, Rajshahi.
[2] Associate Professor, Department of Crop Science & Technology, University of Rajshahi.
[3] Associate Professor, Department of Medicine, Rajshahi Medical College, Rajshahi.

On the other hand, in the arena of psychiatry today, the search for ethno-medical perspective[7] has become an important paradigm of attention. 'Mental Health in a Changing World: The Impact of Culture and Diversity' was the theme of World Mental Health Day of 2007. This theme mostly concentrated on the suffering of migrant and marginalized people, causing social isolation and acculturative stress, leading to further trauma. So, considering all these background information, the present study renders an adequate explanation for carrying out such exploration.

Aims and Objectives

- The specific concern in this research is to explore the different pattern of psychiatric illness among the Santals.
- It will provide an essential insight into the behaviour and mental processes of the Santals, so that right management of the patients could be ensured.
- It will provide the essence to form a comprehensive approach in understanding and managing the psychopathology of the Santals by minimising culture and psycholinguistic barriers, which often is experienced by the psychiatrist of different culture.

Justification of the Study

This study, would bring psychiatry with essential insights into the behaviour of Santals in their natural habitats, the interactions with their environment, native views on health and illness, descriptions of indigenous healing system, and the role of the healer and rituals of healing.

Secondly, since psychiatrists of urban-settings are increasingly called upon to evaluate and treat patients in the many cultural and linguistic group that constitute today's multicultural society, this study would help in the formulation of technically correct and culturally competent service.

Finally, this study, would be the first of this kind in our country, when 'WHO' has long advocated implementation at the local level of a policy of close collaboration between the conventional health system and traditional medicine, between individual health professionals and traditional practitioners.

Materials and Methods

Research Approach

This work was a cross-sectional retrospective study, done on the Santal psychiatric patients, attending the department of psychiatry of Rajshahi Medical College, Rajshahi, Bangladesh.

Study Design

The researcher, firstly had necessary permission from the attending patients. Then taking into account the proposed 'inclusion criteria', the patient had psychiatric interview by SCID (Structured Clinical Interviews for Diagnosis), proposed by WHO and NIMH (National Institute of Mental Health, Dhaka). Finally, the diagnosis was assigned, according to DSM-IV (Diagnostic and Statistical Manual, Proposed by American Psychiatric Association).

Inclusion Criteria: The Santal patients attending the department of psychiatry.

Exclusion Criteria: The Santal patients with serious general medical condition, cognitive impairment and distress.

Sample Size: A consecutive series of seventy seven patients – thirty nine male and thirty eight female patients are taken.

Duration of the Study: 2006 January – 2008 July

Procedure of Data Collection and Analysis

As per study deign, the socio-demographic variables were noted, along with the 'psychiatric' diagnosis. These data were than compiled, edited and grouped in order to have analysis by using computer software statistical package for social survey (SPSS) for windows.

Results and Observation

Table 1: Distribution of the psychiatric Santal patients.

Age	Number of the patients (n=77)	Percentage (%)
08-15 years	06	07.79
16-25 years	26	33.76
26-35 years	22	28.57
36-45 years	09	11.68
46-55 years	06	07.79
56-65 years	03	03.89
66 – Above	05	06.49
Total	**77**	**99.96**

Table 1 shows that among 77 respondents most of the patients (33.76%) were in the age group of 16-25 years, 28.57% were in the group of 26-35 years. About 8% were in the age group of 08-15 years. 11.68% represented 36-45 years, 7.79% belongs to 46-55 years, 3.89% were in the group of 56-65 years and 6.49% were in the group of 66 year and above.

Table 2: Occupations of the patients.

Occupation	Number of the patients (n=77)	Percentage (%)
Housewife	34	44.15
Students	11	14.28
Landless farmer	62	80.51
School Teacher	01	01.29
Retired School Teacher	01	01.29
Retired Official (Caritas)	01	01.29
Sister (Nun)	01	01.29

Table 2 represents occupational status, when mostly they are landless farmer (80.51%) and housewife (44.15%); 14.28% are students and each 1.29% represented school teachers, retired official and Nun, respectively.

Table 3: Educations of the patients.

Education	Number of the patients (n=77)	Percentage (%)
Primary	02	2.59
Class VI	03	3.89
Class VIII	06	7.79
SSC	01	1.29
SSC with PTI	01	1.29
HSC	02	2.59
Drop out	15	19.48
Illiterate	47	61.03

Table 3, illustrates 61.03% as illiterate respondents. 7.79% were in Class VIII, 3.89% in Class VI and 2.59% in primary. Each of 1.29% had SSC and PTI and only 2.59% completed HSC. About 19.48% were drop-out.

Table 4: Sexual distribution of the patients.

Sex	Number of the patients (n=77)	Percentage (%)
Male	39	50.64
Female	38	49.35
Total	77	99.99

Table 4, shows that of 39 were male (50.64%) and 38 were female (49.35%).

Table 5: Marital status of the patients.

Marital status	Number of the patients (n=77)	Percentage (%)
Unmarried	41	53.24
Married	34	44.15
Widow	01	1.29
Divorcee	01	1.29

Table 5 presents marital status among the respondents, when 44.15% are married, 53.24% were unmarried and each 1.29% represented widow and divorcee respondents, respectively.

Table 6: Economic background of the patients.

Monthly income	Number of the patients (n=77)	Percentage (%)
Low income group (<5000)	73	94.81
Middle income group (>5000-10000)	04	5.19
High income group (10000 and Above)	Nil	Nil

Table 6, shows 94.80% are in low income group, 5.19% represented middle income group and none was in high income group.

Table 7: Beliefs toward mental illness of the patients.

Pattern of beliefs toward mental illness	Number of the patients (n=77)	Percentage (%)
Annoyance of Bonga	63	81.81
Possession by Bonga/Kali	61	79.22
Bad Air	48	62.33
Being unclean, during menstruation and after labour	32	41.55
Loss of Semen	27	35.06
Bad Water	09	11.68

Table 7, elucidates pattern of beliefs among Santal patients toward mental illness. Most of them considered it to be the effect of Bonga, viz. the annoyance of Bonga (81.81%) and the possession by *Kali/Bonga** (79.22%). 62.33% thought it due to bad air, 41% women considered uncleanliness

following menstruation and labour. Loss of Semen was considered as contributing factor among 35.06% patients and 11.68% believed its causation due to bad water.

[**Kali* is the deity of Hindus; *Bonga* is the deity or supernatural forces of Santals.]

Table 8. Psychiatric diagnosis of the patients (N=77).

Psychiatric disorders	Number of patients
1. Childhood depression	01
2. Dhat syndrome (culture bound sexual neurosis with mixed anxiety depression	09
3. Mixed anxiety depression with migraine	02
4. Obsessive compulsive disorder	01
5. Panic disorder with agoraphobia	01
6. Somatization disorder	03
7. Hypochondriasis	02
8. Major depressive disorder	07
9. Brief psychotic disorder (without stressor)	05
10. Brief psychotic disorder (with postpartum onset)	02
11. Schizophrenia (Pararoid type)	08
12. Schizo-affective disorder (Bipolar types)	02
13. Substance induced psychotic disorder	05
14. Substance induced psychotic disorder with delusional disorder (Jealous type)	02
15. Delusional disorder (somatic type)	01
16. Conversion disorder	04
17. Dissociative trance disorder	04
18. Dementia	05
19. Psychotic disorder due to general medical condition, viz. Epilepsy	13

Table 8, represents psychiatric diagnosis among the Santal patients. 13 had epilepsy, 09 had Dhat syndrome with mixed anxiety depression, 08 had schizophrenia and 02 had major depressive disorder. Each 05 had dementia, substance induced psychotic disorder and brief psychotic disorder. Each 4 had conversion disorder with dissociative trance disorder, 3 had somatization disorder. Each 2 had hypochondriasis and mixed anxiety depression with migraine, schizoaffective disorder and delusional disorder (Jealous type). Lastly each 1 had childhood depression, obsessive compulsive disorder, panic disorder with agoraphobia and delusional disorder (Somatic type).

Discussion

The study was carried out during January 2006 to July 2008, comparing 77 respondent's, when 39 were male and 38 were female. It was a cross-sectional retrospective study, where by employing the 'research instruments', necessary diagnosis was established. Among the respondents, about 1/3 rd (33.76%) were in the age group of 16-25 years and another 1/3rd (28.57%) were in the age group of 26-35 years. The rest were in other age group and among them 6.49% was only in the age group of 66 and above. In the present study 50.64% were male and 49.35% were females. Around 61% were illiterate, 1.29% passed secondary school certificate, 2.59% passed Higher Secondary and almost 19.48% were 'dropout' from different classes. Marital status revealed that 44.15% were married, 53.24% unmarried and each 1.29% was widow and divorce. The respondents, mostly (94.80%) were in low income group. Among them 5.198% represented middle income group. And there was none in high income group. Study[8] among tribals of Bihar, found that, they had also certain misconception about mental illness. They were loss of semen (94%), disorder of menstruation (82%) and evil spirit (82%). Coid[9] while studying the case of Amok in Malaysia noted the causes in three level: At one level are those causes, which originate or have their effects within the individual, like wind, blood, germs, trauma, or poison. At a second level are causes, which originate from sources outside the body, such as magic, spirits, God, and natural pathogen. At a third level are found causes, which are the consequences of behaviour or result from traits of the individual, e.g. unethical or inappropriate behaviour. Schwab[10] studying the concept of mental illness among indigenous people of Malaysia classified it in three broad categories: serious threatening status, chronic nonthreatening status, and acute nonthreatening status. Murphy[11] by examining 189 different cultures believed that most illness is supernaturally caused, with supernatural causation including mystical retribution (punishment by the God or other forces for violating rules), animistic causation (soul loss or spirit aggression against the individual for violating rules), and magical causation (witchcraft,

sorcery, and the evil eyes used against the individual by other persons for violating rule. The pattern of psychiatric disorder, in this study, was almost the same like those of other cultural and ethnic groups; but had certain differences in their presentation. In a recent study[12] among Manipuri ethnic people of Bangladesh, the psychiatric disorders were higher (20%) in comparison to main-stream population (16.1%). Among 300 Manipuri ethnic people major depressive disorder, generalized anxiety disorder, and schizophrenia, were 9%, 6% and 1.3% respectively. Each bipolar disorder, panic disorder and somatoform disorder was 0.7% and 0.3% was obsessive compulsive disorder. In Bangladesh, although there was never a study among the Santal patients, but some community study revealed significant psychiatric morbidity among the primary care attenders. The point prevalence of psychiatric disorder[13] in Spain, Nepal, India and Chile was respectively 31.5%, 25%, 46.5%. Khan LR found in his study it to be 23.1%.[14] A recent study[15] carried out in Bangladesh by NIMH and WHO (2007), reported prevalence rate to be 16.1%, when prevalence rate of neurotic disorder, major depressive disorder, psychiatric disorder and generalized anxiety disorder was respectively 8.4%, 4.6%, 1.1% and 2.9%. Wittkower and Hsien Rin[16], on discussing transcultural psychiatry, found that acute anxiety reaction are more common in primitive societies and hysterical reactions are much more common in less developed countries. Laurence J Kirmayer[17], discussing cultural variation on psychiatric disorder and emotional distress, found that culture influences the experience and expression of distress. He further added that, in non-western societies, psychosocial conflict is frequently presented to both western and traditional healers in the form of somatic distress. Paul K Benedict and Irving Jacks[18] in their article 'Mental illness in primitive societies made some important observation. They are as such –

- The Hawaiians had the lowest relative incidence of schizophrenia.
- The incidence of psychosis is likely to be higher where the cultural group is struggling to work out a satisfactory adaptation to western patterns of culture.
- In Kenya, paranoid forms of schizophrenia appeared to be relatively uncommon on the Gold Coast.
- Depressions with agitation are hardly ever seen among the natives.
- Schizophrenia among primitive peoples as reported in our sources, tend to be poorly defined in terms of western nosology.
- The Japanese show significantly more disturbance of thinking. Such terms as 'preocuupied', 'confused' and 'obsessed' are applied much more frequently to Japanese patients then Filipino.

Summary

The purpose of this research was to examine the different pattern of mental disorders of the Santals, who are one of the ethnic minorities and their belief towards mental illness. Considering these finding and observation, it so appears that a significant 'social suffering' exists among the Santal, or in other word, among the indigenous and aborigin-people. To Kleinman[19], this is the kind of long term, institutionalized, and ultimately invisible suffering that has been referred to as a 'soft knife' or long term oppression. So, the subject of ethnicity and health today, holds an unmet challenges, when social, economic and cultural profiles vary between and within ethnic population. Again, most ethnic minority communities live in such remote places that right access of health-service is quite different. Addressing gaps in information needs foresight and commitment from government to implement linkage of physicians and hospital records, or to make a thriving strategy we need to form a tripartite partnership between health authorities, local authorities and local communities.

References

1. Chaudhuri U: Mental Health – stop exclusion dare to care, Souvenir, 54th An. National. Conference of Ind. Psych. Society. 2002, 55-58.
2. WHO, World health report 2001: Health systems – improving performance, Geneva, 2001.
3. WHO, Mental Health Care in Developing Counties: a critical appraisal of research findings. Technical Report Series, WHO, Geneva. 1984, 698.

4. Ahsan A: Social Change among, the Santals of Bangladesh: A study of cultural Isolation, Department of Anthropology, Calcutta Universtiy, India. 1989.
5. Tone Bleie: Tribal peoples, Nationalism and the Human Rights Cahllenge – the Adivasi of Bangladesh, UPL, Dhaka, 2006.
6. Varma VK: Social Disadvantage, Mental and Social Justice. Ind. J. Soc. Psychiatry. 1992, **8:** 8-12.
7. Neurotale: www.squarepharma.com.bd.2007.
8. Basu SK: Health status of tribal women in India. Social Change. 1993, **23(4):** 1-20.
9. Coid JW, Kahtan N, Gault S: Ethnic differences in admissions to secure forensic psychiatry services. British Journal of Psychiatry, 2000, **177:** 241-247.
10. Schwab ME: A study of reported hallucinations in a south eastern country. Mental Health and Society. 1977, **4:** 34. 43, 54.
11. Murphy HBM: Comparative psychiatry: The international & intercultural distribution of mental illness, New York, Springer-Verlag. 1982.
12. Singha RK: Psychiatric disorders among ethnic minorities – unpublished thesis, BSMMU, Dhaka, 2006.
13. Vazquez – Barquero JL, Simon JA, Garcia J., et al. Mental health in primary care. Br. J. Psychiatry 1997, **170:** 529-535.
14. Khan LR: Summary and Conclusion, In psychiatric morbidity among patients attending primary health care centers of Bangladesh (Thesis – Unpublished), Dept. of Psychiatry, BSMMU. 1999: 69-70.
15. WHO-AIMS (Assessment Instrument for Mental Health Systems) Report on Mental Health System in Bangladesh. WHO, Dhaka, Bangladesh, 2007.
16. Wittkower ED & Hsien Rin: Transcultural psychiatry. Arch Gen. Psychiat. 1965, **13:** 387-394.
17. Laurence J Kirmayer: Cultural variations in the response to psychiatric disorder and emotional distress. Soc. Sci. Med. 1989, **29(3):** 327-339.
18. Paul K. Benedict & Irving Jacks: Mental illness in primitive societies. Amer. J. Psychiatry. 1942, **98:** 703-707.
19. Kleinman A.: Anthropology and psychiatry – the role of culture in cross-cultural research on illness Br. J Psych. 1987, **151:** 447-454.

All correspondence to:
A A Mamun Hussain
Associate Professor
Department of Psychiatry
Rajshahi Medical College
Rajshahi, Bangladesh