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Perceptions About the Cause of Psychiatric Disorders and Subsequent Help Seeking Patterns Among Psychiatric Outpatients in a Tertiary Care Centre in Eastern India

Kaustav Chakraborty[1], Gautam Das[2], Amitava Dan[3], Gautam Bandyopadhyay[4], and Moumita Chatterjee[5]

[1]Department of Psychiatry, College of Medicine and J. N. M. Hospital, WBUHS, Kalyani, Nadia, West Bengal, India
[2]Department of Neurology, NRS Medical College and Hospital, Kolkata, West Bengal, India
[3] Department of Psychiatry, NRS Medical College and Hospital, Kolkata, West Bengal, India
[4]Department of Psychiatry, North Bengal Medical College and Hospital, West Bengal, India
[5]Department of Microbiology, College of Medicine and J. N. M. Hospital, WBUHS, Kalyani, Nadia, West Bengal, India

Corresponding author: Kaustav Chakraborty, Assistant Professor, Department of Psychiatry, College of Medicine and J.N.M. Hospital, WBUHS, Kalyani, Nadia, E-mail: drkaustav2003@yahoo.co.in

Abstract

Background: The lay public across different cultures hold highly variable beliefs regarding the cause of different psychiatric disorders. In developing countries, a vast majority of people attributed psychiatric symptoms to supernatural phenomena, drug use, stressful life events, heredity or personality deficiencies and accordingly sought treatment from various avenues.

Methods: One hundred twenty consecutive consenting patients accompanied by a reliable informant/family member fulfilling the ICD-10 criteria of schizophrenia or related psychotic disorders, mood disorders, obsessive–compulsive disorder (OCD), anxiety disorders, somatization and dissociative disorders were included in the study. Sociodemographic and clinical proforma of all the eligible subjects was filled in. Perceived causes of illness and help seeking pattern were explored from the informant by administering proper instrument.

Results: Respondents identified a mean of 2.78 (± 0.87 SD) causes of psychiatric disorders in their relatives and explored a mean of 2.8 (± 1.51 SD) help seeking options before reaching tertiary care center. The majority (96.8%) of the relatives of patients' with schizophrenia or related psychotic disorders believed in supernatural causation whereas, majority of the relatives of subjects with depressive disorder (34.6%), OCD and other anxiety disorders (80%), somatization or dissociative disorders (61.5%) attributed their relatives' symptom to excessive worrying/thinking. Majority of the subjects across all four diagnostic categories sought non-professional medical help. Preference for religious remedies (54.8% of subjects with schizophrenia and 100% of subjects with OCD-anxiety disorders) and alternative medicine (80% of the subjects with OCD-anxiety disorders) were also noticed. Across all four diagnostic categories belief in causes other than bodily pathology predicted help seeking from various quarters except for professional medical help whereas symptom attribution to bodily pathology predicted professional help seeking in OCD-anxiety disorder group. In the schizophrenia group, people who believed in psychological causation were more likely to be from higher income group; whereas those who sought professional medical help were more likely to be educated.

Conclusion: A wide variety of indigenous beliefs exist in Indo-Pak subcontinent which is in conflict with biomedical models of these psychiatric disorders. Such beliefs result in non-professional medical help seeking which could be detrimental to the health of patients suffering from these psychiatric disorders (German J Psychiatry 2013; 16(1): 7-14).

Keywords: perception; help seeking; psychiatric disorders

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Introduction

Since antiquity researchers have attempted to explain the causation of psychiatric disorders both at micro-levels and macro-levels, that act within and outside of the individual, and that involve processes best understood from biological, psychological, and sociocultural perspectives (Kendler, 2008). Lay public across different cultures hold highly variable beliefs regarding the cause of different psychiatric disorders (Zafar et al., 2008). In developing countries a vast majority of people attributed the schizophrenic symptoms to supernatural phenomena, drug use, stressful life events, heredity or personality deficiencies which contradict the biomedical model of schizophrenia as envisaged by modern psychiatrists (Banerjee & Roy, 1998; Joel et al., 2003; Kadri et al., 2004; Kulhara et al., 2004; Philips et al., 2004; Srinivasan & Thara, 2001; Zafar et al., 2008). Significant cultural variations also occur in clinical presentation of depressive disorder which influences the source of distress, the interpretation of symptoms, mode of coping with the distress, help seeking behavior, the social response to distress, disability, doctor-patient interactions, the likelihood of outcomes such as suicide, and the practices of professionals (Dejman et al., 2008; Kleinman, 2004; Okello, 2006; Pachter, 1994). Although not much work have been done in the field of obsessive compulsive disorder, other anxiety disorders and somatoform disorder, available evidence suggests similar kind of explanatory model governing the causation of these (Jacob et al., 1998; Ng et al., 2008).

Persons suffering from psychiatric disorders often do not seek professional help (Bebbington et al., 2000; Ng et al., 2008; Walters et al., 2008). The reasons for this include negative attitudes towards seeking help generally, as well as concerns about cost, transportation or inconvenience, confidentiality, other people finding out, feeling like they can handle the problem on their own, and the belief that the treatment will not help (Gulliver et al., 2010). Among those who seek professional help, psychiatrists and psychologists are rated less highly than general practitioners for disorder such as depression, whereas for schizophrenia the former is perceived to be more helpful (Angermeyer et al., 1999; Jorm et al., 1997). In Indo-Pak subcontinent, traditional healers along with psychiatric services are the main mental health service providers and most of those who believed in supernatural causation of psychiatric disorders, consult indigenous healers first (Banerjee & Roy, 1998; Kulhara et al., 2000; Zafar et al., 2008).

In view of this, it becomes imperative to generate more data regarding perception about the causes of psychiatric disorders and subsequent help seeking behavior in Indian population. The index study aims to explore the explanatory model of illness and patterns of help seeking behavior from the families of patients with four categories of psychiatric disorders viz. schizophrenia and related psychotic disorders; mood disorders; obsessive compulsive disorder and other anxiety disorders; somatization and dissociative disorders attending the outpatient of a tertiary care hospital in Eastern India.

Methods

Setting and sample

The study was carried out at the Psychiatry Department of a multi-speciality teaching tertiary care hospital in West Bengal, India. The above-mentioned hospital provides services to a major area of southern part of West Bengal. This department is a general hospital psychiatric unit with inpatient and outpatient facilities in a tertiary care, multi-disciplinary teaching hospital. Patients have to pay a nominal fee (2 rupees) at the first visit and then the subsequent visits are free of charges. Hospital has its dispensary, which provides most of the drugs free of cost to the patients and those patients who take medications from the hospital have to visit the hospital monthly for the refills.

One hundred twenty consecutive patients accompanied by a reliable informant/family member fulfilling the ICD-10 criteria of schizophrenia or related psychotic disorders; mood disorders; obsessive compulsive disorder (OCD) and other anxiety disorders; somatization and dissociative disorders were approached for consent; all the subjects consented to participate in the study. Sociodemographic and clinical proforma of all the eligible subjects was filled in. Perceived cause of illness and help seeking pattern were explored from the informant by administering proper instrument.

Instruments

The following instruments, as required, were used:

1. *Sociodemographic profile sheet.* Specially developed for this study, it was used to record the relevant sociodemographic data on age, gender, education, occupation, income, and marital status.
2. *Clinical profile sheet.* Specifically developed for this study, it was used to record the following clinical details: diagnosis, duration of illness, most prominent symptoms etc.
3. *Questionnaire for exploring perceived causes of illness.* This was specifically designed for the study. The questionnaire was designed by the investigators after an extensive literature search (Angermeyer & Matschinger, 1994; Srinivasan & Thara, 2001; Zafar et al., 2008). Prior to the study it was pretested on a sample of twenty individuals. No major changes were required and this data was discarded. Perceived causes were divided into two broad categories: causes inside the body and causes outside the body. The former was further subdivided into bodily pathology, habits/practices, and psycholog-

ical causes while the later consisted of supernatural causes. Only one response was permitted for each of the four subcategories.

4. *Questionnaire for assessing pattern of help seeking.* This was also specifically designed for the study after extensive literature search. This included 14 types of help seeking behaviour. For tabulation and analysis purposes these responses were divided into five categories: professional medical help, non-professional medical help, religious remedies, alternative medicine and others.

Statistical analysis

The statistical analysis was done using the SPSS software package for windows, version 13.0 (SPSS Inc., Chicago, IL, USA). Descriptive analysis was computed in terms of mean and standard deviation with range for continuous variables and frequency with percentage for ordinal and nominal variables.

Results

Sociodemographic profile

The mean age of the sample was 32.82 ± 12.82 SD years (a range of 11-70 years). The majority of the sample were educated up to matric (56.6%), married (66.7%), housewife or managing households (36.7%), belonged to Hindu religion (60%), came from rural background (80.83%) and staying in joint/extended family set up (72.5%). The mean income of the sample was 1530.33 rupees per month.

Table 1: Sociodemographic profile of the participants (N=120)

Variables		Mean ± SD/ N (%)
Age (ANOVA: F=2.27; p=0.08)	Whole sample	32.82 ± 12.82
	Schizophrenia and related psychoses	35.52 ± 14.80
	Depressive disorders	29.27 ± 9.26
	OCD and other anxiety disorders	27.20 ± 7.34
	Somatization and dissociative disorders	31.54 ± 10.62
Gender	Male	66 (55)
	Female	54 (45)
Education	Illiterate	38 (31.7)
	Upto matric	68 (56.6)
	Beyond matric	14 (11.7)
Occupation	Employed	42 (35)
	Unemployed	24 (20)
	Housewife	44 (36.7)
	Retired	2 (1.7)
	Student	8 (6.6)
Marital status	Single	40 (33.3)
	Ever married	80 (66.7)
Religion	Hindu	72 (60)
	Muslim	48 (40)
Family type	Nuclear	33 (27.5)
	Joint/Extended	87 (72.5)
Background	Rural	97 (80.83)
	Urban	23 (19.17)

Clinical profile

The majority (51.7%) of the sample fulfilled the ICD-10 diagnostic criteria for schizophrenia or related psychotic disorders. The rest of the sample consisted of subjects with somatization and dissociative disorders (21.7%), depressive disorders (18.3%), and OCD and other anxiety disorders (8.3%). The mean duration of illness was 9.33 ± 10.95 SD months (a range of 1-60 months).

Perceived causes of illness

The participants gave highly variable responses to the question that assessed their opinion about the cause of psychiatric disorders. The mean number of responses endorsed by the respondents was 2.78 ± 0.87 SD (a range of 1-4). These responses are shown in table 2 and have been divided for tabulation and analysis purposes into four categories namely bodily pathology, habits and practices, psychological cause, and supernatural cause.

Nearly all (96.8%) the family members of subjects with schizophrenia had belief in supernatural causation. Near about half (48.4%) of the respondents attributed their family member's illness to excessive worrying/thinking as the single most important cause. Three fourth (77.4%) of the respondents endorsed some bodily pathology as the cause of schizophrenia while only a minority (22.6%) attributed it to habits and practices.

In case of depressive disorder, the single most important cause of the illness was excessive worrying/thinking and bad fortune reported by one third of the respondents (34.6%) each. Near about one quarter of the respondents attributed the illness to black magic/witchcraft (27.3%), relational problems (27.3%) and medical illness (27.3%).

As would be expected, the majority (80%) of respondents with OCD and anxiety disorders viewed the problem arising out of too much worrying/thinking. Less than half of the subjects thought it was a kind of medical illness (40%), or because of dysfunction of specific organ system (40%), or blackmagic (40%).

In case of somatization and dissociative disorders, the majority (61.5%) of the respondents were of view that it developed because of too much worrying/thinking. Only a minority were of opinion that it was a medical illness (30.8%) or caused by excessive masturbation (23.1%).

Help seeking behavior

The mean number of helps sought by families before reaching the tertiary care center was 2.8 ± 1.51 SD (a range of 1-6). In majority (31.7%) of the cases first degree relatives

accompanied the patients to the treatment center, whereas in minority of the cases they either presented themselves alone (20%) or along with their spouses (16.7%). As far as first help seeking type is concerned more than half (58.3%) of the families sought professional medical help in preference to non-professional medical help (23.3), religious remedies (15%) and alternative medicine (3.3%).

Table 3 shows the help seeking pattern of the families of persons with psychiatric disorders. From the table it can be seen that, all the families of patients with OCD and anxiety disorders took recourse to non-professional medical help before coming to tertiary center, whereas more than half of the families each in the psychotic disorder (67.8%), depressive disorder (54.6%) and somatization & dissociative disorder (53.9%) group sought such treatment. A very high percentage of families in the OCD and other anxiety disorders group sought some sort of religious remedies; a similar trend was noticed for these families seeking alternative medical treatment as well. A substantial proportion of subjects in all the four psychiatry disorder categories were referred by other branches of medicine. An encouraging fact was near about half of the families in all these four psychiatric disorder categories sought treatment from primary health center, subdivisional hospital or district hospital before reaching tertiary center.

Table 2: Participant's beliefs concerning the cause of psychiatric disorders (divided into four categories; n = 120)

		Schizophrenia or related psychotic disorders (N=62)	Depressive disorders (N=22)	OCD and other anxiety disorders (N=10)	Somatization and dissociative disorders (N=26)
A. Causes inside the body					
Bodily pathology	Malfunctioning or dysfunction of specific organ system or organ	6 (9.7)	2 (9.1)	4 (40)	4 (15.4)
	Physical trauma	12 (19.4)	02 (9.1)	0 (0)	4 (15.4)
	Medical illness	8 (12.9)	6 (27.3)	4 (40)	8 (30.8)
	Operation	0 (0)	0 (0)	0 (0)	2 (7.7)
	Accidents	4 (6.5)	2 (9.1)	0 (0)	0 (0)
	Ingestion of poisoned food or drink	2 (3.2)	2 (9.1)	0 (0)	0 (0)
	Illness/accident or any event (of mother) during pregnancy	0 (0)	0 (0)	0 (0)	0 (0)
	Birth trauma/distress	2 (3.2)	2 (9.1)	0 (0)	0 (0)
	Childhood illness/stress	8 (12.9)	0 (0)	0 (0)	2 (7.7)
	Hereditary	6 (9.7)	0 (0)	0 (0)	4 (15.4)
	Total	48 (77.4)	16 (72.8)	08 (80)	24 (92.4)
Habits and practices	Masturbation	4 (6.5)	2 (9.1)	2 (20)	6 (23.1)
	Drugs and alcohol	8 (12.9)	4 (18.2)	0 (0)	4 (15.4)
	Prostitute visit	0 (00)	0 (0)	0 (0)	0 (0)
	Intake of any particular food	0 (00)	0 (0)	0 (0)	0 (0)
	Bad association/peer group	0 (00)	2 (9.1)	0 (0)	0 (0)
	Pressure of study	2 (3.2)	0 (0)	0 (0)	4 (15.4)
	Total	14 (22.6)	8 (36.4)	2 (20)	14 (53.9)
Psychological	Too much worry/thinking	30 (48.4)	8 (36.4)	8 (80)	16 (61.5)
	Too much mental pressure	2 (3.2)	0 (0)	0 (0)	0 (0)
	Problems due to love affair	0 (0)	0 (0)	0 (0)	0 (0)
	Relational problems	14 (22.6)	6 (27.3)	0 (0)	4 (15.4)
	Major accident/illness/bereavement of family member	2 (3.2)	2 (9.1)	0 (0)	2 (7.7)
	Total	48 (77.4)	16 (72.8)	8 (80)	22 (84.6)
B. Causes outside the body					
Supernatural cause	Gods and Goddesses	4 (6.5)	0 (0)	0 (0)	0 (0)
	Spirit	4 (6.5)	0 (0)	2 (20)	2 (7.7)
	Stars and astronomy	2 (3.2)	2 (9.1)	0 (0)	4 (15.4)
	Black magic and witchcraft	18 (29)	6 (27.3)	4 (40)	4 (15.4)
	Harm caused by envious neighbour	8 (12.9)	0 (0)	2 (20)	4 (15.4)
	Karma/deeds of previous birth	16 (25.8)	2 (9.1)	0 (0)	2 (7.7)
	Bad fortune	8 (12.9)	8 (36.4)	0 (0)	4 (15.4)
	Total	60 (96.8)	18 (81.9)	08 (80)	20 (77)

Correlation analysis

A significant positive correlation (Spearman's rank correlation 0.403, $p < 0.01$) was found between illness attribution to habits/practices and seeking religious remedies in schizophrenia or related psychotic disorders group. In the same group professional medical help seeking was negatively correlated (Spearman's rank correlation -0.251, $p < 0.05$) with psychological causation of illness.

In patients with depressive disorders, a significant positive correlation was found between illness attribution to habits/practices and non-professional medical ((Spearman's rank correlation 0.449, $p < 0.05$) or alternative medical (Spearman's rank correlation 0.624, $p < 0.01$) help seeking. In the same patient population a significant positive and negative correlation was found between psychological causation of illness and non-professional medical help seeking (Spearman's rank correlation 0.559, $p < 0.01$), religious remedies (Spearman's rank correlation -0.542, $p < 0.01$) respectively.

Table 3: Help seeking behavior of participants towards a relative with psychiatric disorder (n = 120)

Type of help seeking	Schizophrenia or related psychotic disorders (N=62)	Depressive disorders (N=22)	OCD and other anxiety disorders (N=10)	Somatization and dissociative disorders (N=26)
Professional medical help				
PHC, Subdivisional Hospital, District Hospital	35 (56.5)	14 (63.6)	4 (40)	12 (46.2)
Referral consultant	22 (35.5)	10 (45.5)	8 (80)	18 (69.2)
Private GP, clinic, nursing home	22 (35.5)	8 (36.4)	2 (20)	4 (15.4)
Mental Health Speciality	2 (3.2)	0 (0)	0 (0)	0 (0)
NGO health clinic	0 (0)	4 (18.2)	0 (0)	2 (7.7)
Sex Clinic	0 (0)	0 (0)	0 (0)	2 (7.7)
Non-professional medical help				
Faith healer (gunin, ojha)	22 (35.5)	4 (18.2)	8 (80)	4 (15.4)
Quack/LMP	20 (32.3)	8 (36.4)	2 (20)	10 (38.5)
Religious remedies				
Healing temple, Dargah	18 (29)	2 (9.1)	4 (40)	4 (15.4)
Priest or Maulavi	10 (16.1)	4 (18.2)	6 (60)	2 (7.7)
Astrologer	6 (9.7)	0 (0)	0 (00)	2 (7.7)
Alternative medicine				
Homeopath, Kabiraj, Ayurveda, Unani	4 (6.5)	4 (18.2)	6 (60)	8 (30.8)
Local herbal healer	2 (3.2)	0 (0)	2 (20)	2 (7.7)
Others				
Yoga, physical exercise, Meditation	2 (3.2)	0 (0)	0 (0)	0 (0)

*PHC, Primary Health Center, GP, General Practitioner; NGO; Non-Governmental Organisation; LMP, Lay Medical Practitioner; Dargah, Sufi Islamic shrine built over the grave of a revered religious figure; Kabiraj, People practicing Ayurveda in ancient India; Unani, a form of traditional medicine widely practiced in South Asia; Maulavi, is an honorific Islamic religious title given to Sunni Muslim religious scholars

In OCD and anxiety disorder group, a belief in having some bodily pathology prompted the relatives to seek professional medical help (Spearman's rank correlation 1.0, $p < 0.01$) whereas, belief in psychological (Spearman's rank correlation 1.0, $p < 0.01$) and supernatural causation (Spearman's rank correlation 1.0, $p < 0.01$) drove them towards religious remedies.

A significant positive correlation was found between illness attribution to habits/practices and non-professional medical help seeking (Spearman's rank correlation 0.548, $p < 0.01$) in somatization and dissociative disorders group. A belief in psychological causation (Spearman's rank correlation 0.395, $p < 0.05$) also guided the family members in similar kind of help seeking.

Regression analysis

In binary logistic regression, in the schizophrenia or related psychotic disorder group, people who were from lower occupational class/unemployed were more likely to attribute their illness to habits and practices [OR = 2.31, CI = 1.24 - 4.32] whereas, those having higher income [OR = 1.002, CI = 1.000 – 1.004] and ever married [OR = 11.49, CI = 1.01 - 129.97] were more likely to give a psychological causation. Also noteworthy was participants who were more educated were more likely to seek professional medical help [OR = 4.93, CI = 1.47-16.45] in the schizophrenia group. On the contrary, females in the somatization and dissociative disorders group were more likely to seek non-professional medical help [OR = 134.9, CI = 1.45 - 12534.56].

Furthermore, a belief in having bodily pathology [OR = 6.35, CI = 1.15 – 35.19] and illness attribution to habits/practices [OR = 13.97, CI = 2.11 - 92.32] separately predicted seeking religious remedies in schizophrenia or related psychotic disorder group.

Discussion

Studies from developing as well as developed countries have suggested that general population attributes a wide range of non-biomedical beliefs to the cause of psychiatric disorders (Angermeyer & Matschinger, 1994; Joel et al., 2003; Kulhara et al., 2000; Magliano et al., 2004; Shibre et al., 2001). Therefore it is of little surprise that our sample also held a wide variety of beliefs regarding causation of psychiatric disorders. There are very few studies (mostly conducted on patients with schizophrenia) from India regarding perceptions about the cause of psychiatric disorders and subsequent help seeking pattern to serve as a benchmark (Banerjee & Roy, 1998; Joel et al., 2003; Kapur, 1975; Kulhara et al., 2000). A similar study was conducted in patients with schizophrenia in Pakistan, India's neighbouring country and similar in terms of cultural, social and traditional values which found that despite majority of the study population being well educated,

only a few recognized schizophrenia as a mental illness and many held superstitious beliefs (Zafar et al., 2008). The strength of the index study lies in the fact that it attempted to explore the perceptions regarding cause of four categories of psychiatric disorders and subsequent help seeking pattern in Indian psychiatric outpatients which has not been attempted till date.

In index study, respondents identified a mean of 2.78 causes of psychiatric disorders in their relatives. In a study from China, respondents who identified a mean of 2.5 causes, attributed 84% of the cause of schizophrenia to social, interpersonal and psychological problems (Philips et al., 2000). In our sample, an overwhelming 96.8% of the relatives attributed schizophrenia to supernatural causation whereas near about three fourth (77.4%) believed in bodily pathology. Two Indian studies also reported a variety of indigenous beliefs regarding schizophrenia and related psychosis in patients and health workers (Joel et al., 2003; Kulhara et al., 2000). In the study from neighbouring Pakistan, 65.1% of the participants attributed psychotic symptoms to supernatural causes (Zafar et al., 2008).

With regard to depressive disorder, near about one-third (34.6%) of the subjects attributed their relatives' condition to excessive worrying and bad fortune each. These beliefs were closely followed by belief in relational problem (27.3%), black magic or witchcraft (27.3%) and medical cause (27.3%). Data regarding explanatory model of depression is relatively sparse. In Western countries, depression is most often seen by public as caused by social environment, particularly recent stressors (McKeon & Karrick, 1991; Priest et al., 1996). In a study from Uganda, depression without psychotic features was regarded as 'illness of thoughts' whereas depression with psychotic features was believed to be arising from poor relationships between the living and the dead (Okello, 2006).

In OCD and anxiety disorder group, four fifth of the respondents had belief in bodily pathology, psychological and supernatural causation each. Excessive worrying (80%) emerged as the single most important cause. The novelty of this data precludes us from comparing it with similar data from this subcontinent or western world. A related study from Singapore found that, out of 10% of the subjects with depressive or anxiety disorders, 3% acknowledged having mental problems (Ng et al., 2008).

As per relatives of subjects with somatization and dissociative disorders, excessive worrying or thinking was the predominant cause (61.5%) leading to such condition. Very little research has been done in this field to make any meaningful comparison.

In index study, the mean number of helps sought by families before reaching the tertiary care center was 2.8 $\pm$ 1.51 SD (a range of 1-6). In majority (48.4%) of the cases, either first degree relatives or spouses accompanied the patients to the treatment center suggesting substantial family support for the ill. As far as first help seeking type is concerned more than half (58.3%) of the families sought professional medical help in preference to other modes of treatment. Regarding help seeking by families of patients with schizophrenia one Indian study found that, over 27% of families took more than five years to report to the referral centre (Banerjee & Roy, 1998). In a survey conducted by World Health Organisation, median delays among cases eventually making therapeutic contact ranged from 3 to 30 years for anxiety disorders, from 1 to 14 years for mood disorders (Wang et al., 2007).

In index study, more than half of the subjects with schizophrenia and related psychotic disorders sought non-professional medical help (67.8%) and religious remedies (54.8%). Another Indian study by Kulhara et al. (2000) lends support to the result of index study with 57.5% of their subjects undergoing magico-religious treatment. The study conducted by Zafar et al. (2008) revealed that, 52.2% and 19.3% of their subjects were in favour of professional medical help and religious remedies respectively for treatment of schizophrenia. In Ethiopia, traditional sources of help, such as witchcraft, holy water and herbalists, were preferred over medical help for a range of mental health problems (Alem et al., 1999).

Near about half of the families each in the depressive disorder (54.6%) and somatization & dissociative disorder (53.9%) group sought non-professional medical help. A very high percentage of subjects suffering from OCD and other anxiety disorders sought non-professional medical help (100%), religious remedies (100%) and help from alternative medicine (80%). In studies involving subjects with depression and psychological distress, preference towards informal sources of help (e.g. alternative care providers and traditional healers) and those involving human contact were noticed (Dejman et al., 2008; Walters et al., 2008). In a postal questionnaire survey Oliver et al. (2005) found that, 63.1% of the respondents preferred friends or relatives for seeking help for common mental health problems. Only 28% of respondents with high psychological distress as measured by GHQ-12 scores sought help from their general practitioner. In Western countries, among medical help providers, general practitioners (GPs) are rated very highly, particularly for depression (Jorm et al., 1997; Priest et al., 1996; Wolff et al., 1996). For depression, psychiatrists and psychologists are rated less highly than GPs, but are more likely to be seen as helpful for schizophrenia (Angermeyer et al., 1999).

In correlation analysis, in schizophrenia and related psychotic disorders group, symptom attribution to habits and practices was positively correlated with seeking religious remedies. Banerjee & Roy (1998) found that, most of the families of patients with schizophrenia who believed in supernatural causation, consulted indigenous healers first and those who identified schizophrenia as a medical problem consulted practitioners of modern medicine. Another study by Kulhara et al. (2000) reported that, 74% of the patients who had symptoms coloured by cultural influences such as delusional explanation in terms of paranormal phenomena had undergone magico-religious treatment. Study by Zafar et al. (2008) demonstrated that people who gave a biological cause for the disease were almost 13 times more likely to seek professional medical help for a relative with schizophrenia than those who gave other reasons for the disease. In depressive disorder and somatization & dissociative disorder categories belief in illness causation due to habit and practices led to non-professional medical help seeking. Similar was the case

for those who believed in psychological causation in subjects with depressive disorders. On the other hand, in patients with OCD and anxiety disorders, belief in having bodily pathology led to professional medical help seeking. This amply demonstrates that perceptions about the cause of psychiatric disorders largely determine the pattern of help seeking by the families. If a person believes that the cause is a supernatural or religious one then one tends to seek faith healing as a remedy for the illness. Thus seeking such help then becomes the first step in the management of most mental disorders Padmavati et al., 2005). This causes substantial delays in seeking professional treatment, and subsequently leads to a poorer prognosis, higher burden on society and a higher cost of the disease (Zafar et al., 2008)

In regression analysis, in the schizophrenia or related psychotic disorders group, people who were more educated were more likely to seek professional medical help for their relatives' illness. Income status also influenced perception about the cause of schizophrenia with subjects from lower income group attributing it to habits or practices while those who were from higher income group believed in psychological causation. Furthermore, illness attribution to habits or practices and bodily pathology separately predicted seeking religious remedies by the families. In the study conducted by Zafar et al. (2008) subjects who were living in a nuclear family, were moderately religious, females and those who gave the cause of schizophrenia to be biological or being a personality issue were more likely to seek professional medical help. On the contrary, people more likely to seek a religious remedy were very religious, less educated, living in a joint family system and those who had given a religious cause for schizophrenia. Kulhara et al. (2000) found that, belief in supernatural influences is common in schizophrenia patients' relatives from urban background and with adequate education, and treatment based upon such beliefs is sought to a considerable extent in such cases. In index study, in the somatization and dissociative disorder group, females were more likely to seek non-professional medical help. Considering that majority of the subjects in index study come from rural background where professional medical help is sparse most of them go to non-professional medical healers for their problems.

Limitations

As with many other studies, our study has limitations, which include small sample size (particularly in OCD and anxiety disorder group), outpatients only, not studying other host of factors (example, mental health delivery system of that particular area, availability of free of cost medicine in primary health center), use of self designed proforma for exploring perceived cause of illness and pattern of help seeking. No multivariate analyses were performed and thus potential confounding factors were not eliminated. Future studies are required in large sample to understand the indigenous health belief system and how they influence help seeking in patients with psychiatric disorders. This has enormous public health importance particularly for those who are involved with policy formulation.

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