

# Help-seeking for mental health concerns: review of Indian research and emergent insights

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428

Received 19 February 2020

Revised 25 April 2020

4 June 2020

Accepted 29 June 2020

## Abstract

**Purpose** – The purpose of this review was to examine Indian research on help-seeking for mental health problems in adults.

**Design/methodology/approach** – Original Indian research studies on help-seeking for mental health, published from the year 2001–2019 were searched on PubMed, EBSCO, ProQuest and OVID using a set of relevant keywords. After applying exclusion criteria, 52 relevant research studies were identified.

**Findings** – The reviewed studies spanned a variety of themes such as barriers and facilitators to help-seeking, sources of help-seeking, causal attributions as well as other correlates of help-seeking, process of help-seeking and interventions to increase help-seeking. The majority of these studies were carried out in general community samples or treatment-seeking samples. Very few studies incorporated non-treatment seeking distressed samples. There is a severe dearth of studies on interventions to improve help-seeking. Studies indicate multiple barriers to seeking professional help and highlight that mere knowledge about illness and availability of professional services may be insufficient to minimize delays in professional help-seeking.

**Originality/value** – Help-seeking in the Indian context is often a family-based decision-making process. Multi-pronged help-seeking interventions that include components aimed at reducing barriers experienced by non-treatment seeking distressed persons and empowering informal support providers with knowledge and skills for encouraging professional help-seeking in their significant others may be useful.

**Keywords** Barriers, Help-seeking, Help-seeking intervention, Mental health, India

**Paper type** Review

## Introduction

Despite the availability of evidence-based cost-effective interventions, the treatment gap for mental disorders is very high, leading to increased burden and disability. The widespread treatment gap has been attributed to various demand- and supply-related barriers. According to the National Mental Health Survey 2015–16 conducted in India, the main demand-side barriers consisted of low help-seeking inclination, low perceived need, inadequate awareness and socio-cultural beliefs and stigma, whereas, the supply-side barriers included inadequate, unevenly disseminated and inefficiently used resources [1]. In the past, the focus on increasing access to mental health care to reduce the treatment gap has been more on the supply-side, while the demand-side factors, such as help-seeking inclinations and behaviors have been given less important due to their complex nature [2].

In the context of mental health, help-seeking has been defined as, “an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern”

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The author gratefully acknowledges support from the Indian Council of Medical Research, Delhi, India for the fellowship support for her doctoral research on help-seeking among young adults.



[3]. Appropriate help-seeking has the potential to reduce psychological distress and improve mental health [4]. It involves communication with various help-seeking sources including professional ones to understand, seek advice, inform, treat and support for one's disturbing life events [5]. Various theories have been introduced to understand help-seeking. The health-belief model [6] helps to understand how beliefs about health problems explain health-related behaviors. The theory of planned behavior [7] suggests that behavior is influenced by the intention to perform which is in turn dependent on one's attitude toward the behavior, perceived subjective norms and behavior control. Cramer's help-seeking model [8] proposed that help-seeking behavior is associated with attitudes toward seeking counseling in addition to factors such as social support, level of distress and the tendency toward concealing personally distressing information. While there are several generic models of help-seeking, a few have focused on youth, and the factors likely to be of the highest relevance in this segment of the population [9, 10]. Across theories, attitudes toward seeking help and perceived norms regarding help-seeking in one's community or peers emerge as some of the most common factors that influence help-seeking intention and behaviors.

Among the empirical studies conducted across the globe on help-seeking, a high prevalence and wide treatment gap for common mental health problems have been noted [11] along with negative attitudes and low inclination to seek professional help [12]. Among those who do seek help, informal sources are preferred more than the professionals [13]. Systematic reviews have identified cognitive, affective and structural barriers that hinder professional help-seeking [14]. The facilitators of help-seeking identified in various studies include mental health literacy, positive past experiences, social support and encouragement from significant others in the help-seeking process [15]. Interventions have been developed to reduce these barriers to help-seeking and increase the uptake of health services, using various health behavior models including those specific to mental health-related help-seeking. These focus on changing help-seeking attitudes, inclinations and behaviors. Interventions targeted at behavior change have been most successful in altering health behavior [16]. Examples of help-seeking interventions include mental health literacy and de-stigmatization programs [17], screening and linkage [18], contact with the researcher and gatekeeper and peer training [19] among others. Both universal and targeted interventions have been tried out. Universal interventions directed at everyone in a given population have not shown consistent improvements in help-seeking behaviors. Therefore, the need to take into consideration those populations which are at risk or are already suffering from mental health problems (targeted interventions) has been highlighted [15].

This study aimed to provide a review of Indian research on the factors and processes related to help-seeking for mental health problems in adults, utilization and experiences of services during the help-seeking process as well as interventions that aim to enhance professional help-seeking for mental health issues in the Indian context.

## Methodology

The databases used to search for studies included PubMed, EBSCO, ProQuest and OVID. Google Scholar was used as a supplementary tool to aid the search. The search was initially carried out in March 2019 using the following combination of keywords: "Help-seeking AND mental AND India; Help-seeking AND Inclination AND India; Mental Health AND Help-seeking AND India; Help-seeking AND Intervention AND India," anywhere in the text from 2001 to 2019. Only those studies focusing on original research articles that assessed or documented help-seeking variables (e.g. attitude, inclination, behaviors, pattern, pathways, process, facilitators and barriers) in the adult samples were included. The following types of articles were excluded: general and conceptual articles, editorials, letters to the editor, review articles, case studies, monographs, commentaries, poster presentations and research proposals. The

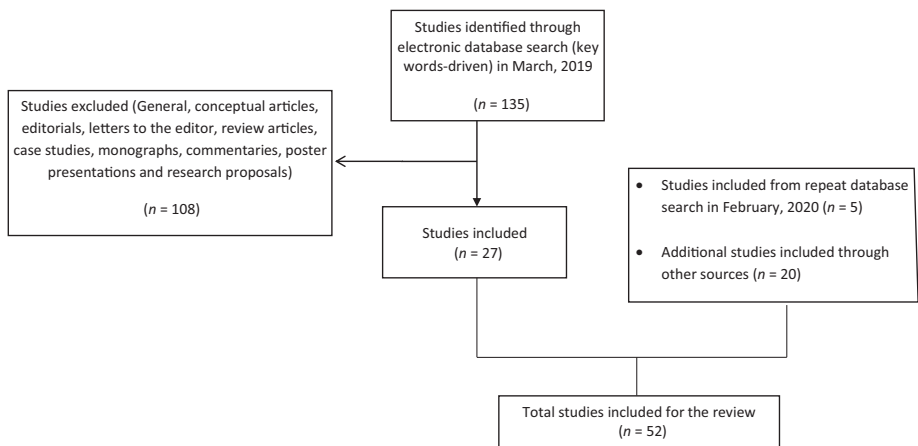
studies that did not assess mental health-related help-seeking and studies using non-Indian samples were also excluded. A repeat search was also subsequently carried out in March 2020 for additional articles published between March and December 2019. After applying exclusion criteria and removal of duplicate studies, 52 relevant primary research studies were identified (Figure 1). The studies during the review period spanned a variety of themes related to help-seeking such as barriers and facilitators to help-seeking, sources of help-seeking, causal attributions for mental illness as well as other correlates to help-seeking, the process of help-seeking, service utilization and interventions to increase help-seeking. The following sections present the summary findings from these studies. The sections have been organized based on the nature of the target population focused upon studies on general community samples, treatment-seeking samples and those on non-treatment seeking distressed samples. The last section summarizes the intervention studies on help-seeking in the Indian context. There is no ethical consideration for this review paper.

### Findings

#### *Studies on community samples*

Various segments of the community population have been studied concerning help-seeking including college-going adolescents, medical students, community health workers and adults in the general community [20–23]. Several studies have highlighted poor identification of mental illness, even in young adults pursuing higher education. For example, only 15% of the college-going youth were able to identify depression correctly in a vignette when depressive symptoms were described as preceded by a negative life event. Thirty-three percent correctly identified depression only if it was not preceded by a negative life event [24]. Similarly, another study found that only 13% of medical students identified depression correctly [25]. Not being able to correctly identify the signs of depression indicates low mental health literacy leading to hesitation in seeking professional help. Also, not being able to identify depression correctly when preceded by a life event again points to the distress being normalized and being considered as a passing phase instead of a mental health condition, resulting in a delay in help-seeking.

The decision to seek professional help is likely to be influenced by perceived causal factors. Depressive symptoms preceded by negative life events may be normalized as a life event that would pass in due course and therefore not necessitate professional help [24].



**Figure 1.**  
Study selection flow diagram

Similarly, when mental illness is believed to be caused by black magic or evil spirits, this may lead to the belief that medical help would not be beneficial [26].

Barriers to professional help-seeking that delay early identification and treatment have been the focus of multiple studies. Some of the common barriers found across these community samples were negative attitudes and poor knowledge of mental health, social- and self-stigma, confidentiality concerns, misconceptions and perceived ineffectiveness of mental health services, apprehension of unwanted intervention, lack of time and finances, worries about risking a future in academics by seeking professional help and lack of availability of mental health services in the vicinity [18, 21–24, 27]. Beliefs about the causal factors and barriers to professional help-seeking may lead to a preference for informal sources of help like family and faith healers for conditions such as depression and schizophrenia and to consider professional consultation only if traditional healing did not improve the condition [17, 21–24].

A few studies have also reported enabling factors for higher inclination to seek professional help. Parasocial interaction has been considered as a facilitator with regard to intentions and efficacy perceptions to seek professional help [20]. Parasocial interaction refers to “an illusion of a ‘face-to-face’ relationship with a media celebrity where the conditions of response to the performer are similar to those in a primary group” [28]. Individuals also report preferring professional help if they felt out of control [29] or if the problem was correctly identified as a mental health condition when symptoms were not preceded by a negative life event [24]. In a study that elicited perceptions of the participants themselves on improving help-seeking, members of a rural community recommended creating awareness regarding mental illness and the need to receive support and treatment through the use of social networking and group meetings, door-to-door campaigns and involvement of various stakeholders in the treatment process [30].

To summarize, the studies on community samples highlight the role of poor mental health literacy, perceived causal attributions, barriers and facilitators of professional help-seeking and the preference for informal sources to seek help for mental health concerns.

#### *Studies on treatment-seeking samples*

This section consists of studies on individuals and their caregivers who were already seeking mental health services. These studies have been mostly conducted among newly registered patients with various psychiatric disorders and their caregivers. Several of these were conducted in tertiary care settings and mainly on persons with severe mental illnesses (SMIs). The average duration of an untreated illness varied widely, e.g. from 21 days for bipolar disorder-I (BPD-I) [31] to two years for Dhat syndrome [32]. For psychoses, it ranged from six months to around four years [33, 34]. These data highlight variable levels of delays in help-seeking across mental health conditions.

Delay in help-seeking as a variable was extensively examined in a study among persons with psychosis and their caregivers [35]. The authors categorized the reasons into (1) illness-related (stigma, poor awareness, attributions to supernatural and physical causes); (2) patient-related (pre-morbid personality, negative symptoms, significant life events, poor insight, uncooperativeness and impaired functioning); (3) treatment-related (poor knowledge of general practitioners about the disorders, delayed referrals and misconceptions regarding medication side-effects) and (4) family-related (shared societal beliefs, magico-religious attributions, cultural and financial restraints and poor social support). Some of these factors have also been noted in other studies [36].

The utilization of mental health services has been linked not just to patients’ but also to caregivers’ causal attributions. In almost all the studies reviewed, patients and their caregivers reported a combination of psychological, biological and sociocultural factors as perceived

causation of mental illness [37]. Attribution to supernatural forces or patient's traits was commonly seen in cases of SMIs among individuals from lower socioeconomic statuses [38], rural background and lower education [39]. Choosing traditional or faith healers as the first contact to seek help were noted across several studies that mainly sampled persons with SMIs or their caregivers and rural backgrounds [32, 35–37, 40]. These causal attributions were culturally meaningful and seemed to propel help-seeking from non-professional sources, delayed identification and timely management of SMIs.

In cases of BPD-I [31] and neurotic disorders [41, 42], patients and caregivers emphasized external or biopsychosocial factors as causal attributions and were likely to seek help from sources such as general practitioners or psychiatric services. Also, a significant proportion of patients and their caregivers hailing from an urban background and having formal education up to intermediate level and higher reported psychiatrists as their first contact for treatment [43–47]. This shows that awareness about the causality as well as treatment options for mental illnesses and sociodemographic factors play an important role in the decision-making process for help-seeking. This decision is also heavily influenced by significant others. Studies have shown that recommendations to seek help mostly came from relatives or friends ranging from 26% to 87% [31, 42, 46–48] or other patients and their families [45, 49]. The reasons related to preference for a particular source ranged from the ease of accessibility, causal match, belief in a particular medicine system, the reputation of the source, recommendations from significant others, time given for consultation and awareness about the appropriateness of a treatment to cost and distance factors [45, 46, 48, 50]. Although some patients and caregivers had less conviction in faith healing, initial help was still sought from these sources owing to their significant others' wishes and fear of stigma and isolation in their society. This highlights that help-seeking is not a purely individual decision, but is often a shared decision or a decision influenced by the perspectives of significant others [43].

Past professional help-seeking was negatively linked to illness-related stigma, whereas previous informal help-seeking was positively related. Informal help-seeking signaled an unwillingness to disclose symptoms of the illness, whereas positive encounters during professional help-seeking were likely to reduce such hesitations [51]. Similarly, stigma interfered significantly with the treatment and utilization of the available facilities [48, 52]. On the other hand, support from family and well-wishers proved beneficial in sustaining engagement with professional help-seeking [53]. Education of the decision-maker significantly influenced help-seeking behaviors [54]. Patients and caregivers having higher awareness about mental illness sought help from mental health professionals sooner, whereas, those with lower awareness contacted faith healers first [49].

Persons with schizophrenia who believed in supernatural explanations of the illness had poor insight, whereas those with an awareness of the consequences of illness showed higher levels of insight and early help-seeking. A pattern suggesting self-serving bias and the role of stigma was also observed in this sample, wherein the hypothetical person in the vignette was readily recognized as suffering from a mental illness, but such identification was rarely used by patients for themselves [55]. The reviewed studies indicate that when faith healing did not provide any improvement or provided only short-term improvement, patients and their caregivers progressed to medical management as a last resort [37, 39, 48]. On an average, two to four transitions from one source to another ensued before finally reaching a mental health professional [32, 47, 50]. On ultimately reaching the tertiary care setup, patients and their caregivers reported being satisfied with the illness-related information and with the management of symptoms [36]. Treatment was continued for a longer duration with more visits than other sources of help [46]. Caregivers experienced a wide range of feelings from despair, frustration, lost opportunities and loneliness to hope of recovery and fear of the future while seeking professional help. They also had expectations for understanding and

acceptance of their situation from their community. They helped others by guiding them into treatments by mental health professionals, expressed interest in increasing awareness and reducing stigma related to mental illness [38]. However, the continuation of faith healing alongside medical treatment has also been noted in a few studies highlighting the significance of culturally approved ways of dealing with mental illness [31, 56]. Despite availability of mental health services and awareness about the same, urban context and higher education levels, sources of help other than mental health services may be initially chosen due to multiple factors such as apprehensions and misconceptions about treatment as well as stigma [39, 47].

In sum, there is an abundance of studies on treatment-seeking samples that have examined variables such as duration of untreated illness, reasons for the delay in help-seeking, causal attributions associated with different sources of help, pathways to psychiatric care, factors influencing help-seeking behaviors and caregiving experiences. Recommendation of significant others plays an important role in help-seeking often resulting in a shared decision-making process. Furthermore, the review reiterates that pathways to care are complex and multifaceted without a fixed direction [49].

#### *Studies on non-treatment seeking distressed samples*

There is a dearth of studies conducted exclusively on non-treatment seeking distressed individuals in the community. However, the majority of the studies in this section have identified a sub-sample of distressed participants using screening or diagnostic instruments for conditions like problem alcohol use [57], suicidality [58], depression [59, 60], severe and stress or distress [61, 62]. These studies have used diverse samples such as adults in the general community, college-going youth, or trainee resident doctors and identified a significant proportion of their sampled participants with elevated levels of distress/symptoms.

Experience of subjective distress may not go hand-in-hand with the identification of the same as a mental health concern as noted in the previous section. Similarly, elevated symptoms/distress does not necessarily result in professional help-seeking. As part of the National Mental Health Survey, a 91% treatment gap was found for mental health conditions in the community sample of Madhya Pradesh [50]. Out of approximately 60% of pre-university students who reported significant emotional problems, only 3 to 9% had undertaken professional consultation [58]. Also, a few studies highlight that even when professional services are accessed, this may not necessarily reflect access to all kinds of interventions. For example, those who were screened positive for depression, 79% had visited either a private or a government general medical practitioner in the past three months. But, only 3.3% were prescribed medications and none of them were offered counseling or psychotherapy [59]. Similarly, a World Health Organization-World Mental Health (WHO-WMH) survey found that only 17% from lower middle-income countries including India received treatment for suicidality mostly from general practitioners (22%), followed by a psychiatrist (15%) [63].

Among 25% of the pre-university students who reported suicidal ideation or attempts in the past three months, only 13% expressed a need for seeking help and only a minimal proportion had sought professional help [58]. Even though around half of the stressed trainee medical residents felt the need to consult a mental health professional, only 13% did so indicating a large disparity [62]. Similar results were obtained in other studies [60]. This demonstrates that recognition of a mental health concern alone is not enough to seek help and even when the need is high, individuals may not seek professional help. Instead, their preferences may often center around informal sources like friends [61, 62].

Various internal and external barriers to help-seeking in distressed non-treatment seeking sub-samples have been observed in these studies. For example, although students with

moderate to severe self-reported depression had a higher need for psychological help, they were least likely to do so due to stigma-related beliefs. They believed that help-seeking would imply inadequacy to deal with stress, inadequate coping and reflect poorly on one's intelligence [60]. Similarly, the stigma of being labeled as mentally ill, being perceived as weak among peers and a lack of time were also found to be some of the barriers to seeking professional help among trainee resident doctors [62]. Most of the problem alcohol users reported shame (27%) and perceived ineffectiveness of treatment (23%) as barriers for not seeking professional help [57]. In another study, among suicidal individuals who had not sought treatment, stigma was not found to be an important barrier (7%). Instead, it was a low perceived need (58%), followed by a preference for self-reliance (40%) and financial constraints (15%) [63].

In a large-scale study to understand the barriers to mental health treatment, WHO-WMH surveys were conducted in 24 countries including India, where household representative samples were recruited ( $N = 2992$ ). Barriers were analyzed separately in a sub-sample of participants who acknowledged the need for treatment based on the severity of the problem. Women, young and middle-aged adults with moderate-to-severe disorders had a higher likelihood of acknowledging the need for treatment as well as reported more structural barriers to seeking help. Among persons with mild-to-moderate severity, the low perceived need for treatment was the commonest barrier followed by attitudinal barriers. Self-reliance was another important barrier identified among those who recognized a need for treatment. Structural barriers and negative experiences with the professionals played a key role in persons with severe problems. The most common reasons for drop-out from professional services included perceived ineffectiveness of treatment and negative experiences with treatment providers [64]. Negative experiences with healthcare providers, exorbitant costs of services in private settings, loss of hope and resultant discontinuation of help-seeking have also been described in another study among persons with disabling mental stress in rural Uttar Pradesh [65].

In a nutshell, studies focusing solely on non-treatment seeking distressed samples are scarce. The available studies have focused on the treatment gap along with the needs and barriers to seeking professional help.

#### *Interventions promoting help-seeking*

While there are multiple studies on help-seeking processes and related factors, only a handful of Indian studies have described the development or evaluation of interventions to improve help-seeking inclinations and/or behaviors for mental health concerns (help-seeking interventions). For instance, the impact of a 24-h telephonic helpline set up by the psychiatry department in a government medical college hospital in delivering mental health care for the prevention of suicide was examined in a study [66]. Almost 73% of the callers had not contacted any kind of mental health service earlier. They were unaware if they had any mental illness, where to seek treatment and if the disorder was treatable. Interventions carried out by the helpline varied based on the need in a given case ranging from counseling, referral to psychiatric outpatient services, other healthcare facility or crisis intervention team and hospital admissions to home visits. Only 16% of the callers who were referred to psychiatric outpatient services visited the concerned department for consultation.

Another study examined the effects of a structured educational intervention on explanatory models of illness and help-seeking behavior among family members of patients with schizophrenia using a randomized controlled design [67]. The baseline assessment elucidated that the relatives of patients held multiple, diverse and contradictory explanatory models of the illness. The intervention explored participants' explanations for illness, provided psychoeducation without challenging the indigenous beliefs and focused on coping methods. At a two-week follow-up, some reduction in non-medical explanations was

seen in the intervention group as compared to the control; however, several indigenous beliefs models persisted.

Systematic medical appraisal referral and treatment mental health project provided mental health care for common mental disorders in a rural community of Andhra Pradesh. It employed a task-shifting approach through training accredited social health activists and primary healthcare center doctors for screening, diagnosis and management using an electronic decision support system and conducting an anti-stigma campaign to raise awareness for mental health and help-seeking which included printed information, education and communication materials, indirect social contact and a promotional video and drama. Indirect social contact and drama were found to be most helpful [68]. Information obtained through the intervention helped the participants to approach the activists, share their concerns and increased their perceived need for help-seeking [69]. Participants became aware of the available services and utilization increased from 0.8% to 12.6%. Mobile-based technology for mental health service delivery using government resources was found to be feasible [70]. The longitudinal assessment showed improvement in knowledge, attitude and behaviors related to mental health along with a tenfold drop in perception of stigma related to help-seeking and service use [71].

Similarly, VISHRAM (the Vidarbha Stress and Health ProgRAM), a multi-component grass-root community-based mental health program was developed to tackle risk factors for suicide and increase contact coverage for depression among rural community members by improving mental health literacy and increasing the provision of evidence-based interventions by community workers and lay counselors and teaming up with the general practitioners and psychiatrists. There was a significant increase in mental health literacy and help-seeking inclination post-intervention and contact coverage increased from 4.3% to 27.2% [72].

A handful of studies conducted on help-seeking interventions have shown that significant improvement could be achieved in knowledge, attitude and behaviors related to help-seeking and utilization of services along with a reduction in perceived barriers and stigma. However, there is a need for more studies in this area.

### Implications

There is a need for large-scale studies, particularly on samples of distressed non-treatment seekers from varied backgrounds that comprehensively assess the role of various barriers to help-seeking and examine mediators and moderators in the professional help-seeking process. There is a need for further studies that can help in a systematic examination of any differences in factors related to help-seeking between different psychiatric disorders as well as between psychiatric disorders and non-communicable diseases in general. Findings from such studies can provide important leads for fine-tuning the interventions to promote help-seeking for various disorders. There have been very few studies in India that have explored preferences for medical and psychological interventions for various common mental disorders. The paucity of studies on interventions to improve help-seeking inclinations and behaviors highlights that addressing demand-side barriers requires as much attention as managing supply-side barriers for reducing the treatment gap for mental health problems in the Indian context.

Less than a handful of studies have demonstrated the potential utility of integrating technology in healthcare delivery systems, but its role in improving help-seeking remains to be sufficiently explored. The available studies on correlates of help-seeking also provide several leads in developing help-seeking interventions. There is a need for developing and testing the utility of help-seeking intervention components that target and enable informal sources of support such as family and friends and equip them with knowledge and skills to motivate professional help-seeking to someone in their family or social circle as and when



appropriate. Rather than a mere focus on improving knowledge and attitudes toward mental illnesses, an emphasis on the complementary roles of informal and formal sources of support may be helpful during mass campaigns. Multi-pronged help-seeking interventions that are theoretically grounded and address awareness and attitudinal shifts in the larger community while simultaneously targeting distressed non-treatment seekers, and their significant others can aid in negotiating barriers to appropriate help-seeking and go a long way in addressing the mental health treatment gap.

### Conclusion

While there are several Indian studies on variables related to help-seeking, most of these pertain to individuals who are currently utilizing professional help (treatment seekers) or to general community samples. Fewer studies have focused on distressed persons in the community who are not availing professional services for their mental health concerns. Among the studies on treatment-seeking samples, severe mental illnesses have been taken into consideration. There is a serious dearth of Indian studies on interventions to improve help-seeking. Studies across sections reveal that help-seeking is a complex process, influenced by multiple interacting factors ranging from education, socioeconomic status and background, to perceived causal attributions, beliefs related to treatment effectiveness along with a preference for self-reliance and informal sources, perceptions of the severity of one's problem and perceived social consequences of seeking professional help. Such factors are in addition to instrumental barriers such as cost and ease of access. Across studies, it repeatedly emerges that mere knowledge about the illness and availability of professional services is insufficient to minimize the delays in professional help-seeking. Moreover, the review suggests that the help-seeking often involves a shared family-based decision-making process or that the process of help-seeking is often influenced by the recommendations of one's social networks [47]. This seems to be a reflection of a predominantly collectivistic orientation that characterizes the Indian culture and places a higher value on interdependence and social harmony [73]. These patterns are in line with the previous observations that cultural differences in professional help-seeking exist and may be partially mediated by the use of support-seeking among close others that are prominent in more collectivistic cultures [74]. The review has highlighted several implications for further studies in India on interventions to promote help-seeking and thereby reducing the treatment gap for psychiatric disorders.

Conflict of Interest: None

### References

1. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, *et al*. National mental health survey of India, 2015-16: prevalence, pattern and outcomes. Bengaluru: National Institute of Mental Health and Neuro Sciences; 2016.
2. Gask L, Bower P, Lamb J, Burroughs H, Chew-Graham C, Edwards S, *et al*. Improving access to psychosocial interventions for common mental health problems in the United Kingdom: narrative review and development of a conceptual model for complex interventions. *BMC Health Serv Res*. 2012; 12: 249. doi: [10.1186/1472-6963-12-249](https://doi.org/10.1186/1472-6963-12-249).
3. Rickwood D, Thomas K, Bradford S. Help-seeking measures in mental health: a rapid review. Haymarket, NSW: Sax Institute; 2012.
4. Wilson CJ, Deane FP, Ciarrochi J, Rickwood D. Measuring help-seeking intentions: properties of the general help-seeking questionnaire. *Can J Couns*. 2005; 39(1): 15-28.

5. Batten L, Dutton J. Young tertiary students and help-seeking for health advice. *Nurs Prax N Z*. 2011; 27(3): 31-42.
6. Rosenstock IM. Why people use health services. *Milbank Mem Fund Q*. 1966; 44(3): 94-127. doi: [10.2307/3348967](https://doi.org/10.2307/3348967).
7. Ajzen I. The theory of planned behavior. *Organ Behav Hum Decis Process*. 1991; 50(2): 179-211. doi: [10.1016/0749-5978\(91\)90020-T](https://doi.org/10.1016/0749-5978(91)90020-T).
8. Cramer KM. Psychological antecedents to help-seeking behavior: a reanalysis using path modeling structures. *J Couns Psychol*. 1999; 46(3): 381-7. doi: [10.1037/0022-0167.46.3.381](https://doi.org/10.1037/0022-0167.46.3.381).
9. Biddle L, Donovan J, Sharp D, Gunnell D. Explaining non-help-seeking amongst young adults with mental distress: a dynamic interpretive model of illness behaviour. *Sociol Health Illn*. 2007; 29(7): 983-1002. doi: [10.1111/j.1467-9566.2007.01030.x](https://doi.org/10.1111/j.1467-9566.2007.01030.x).
10. Martínez-Hernaez A, DiGiacomo SM, Carceller-Maicas N, Correa-Urquiza M, Martorell-Poveda MA. Non-professional-help-seeking among young people with depression: a qualitative study. *BMC Psychiatry*. 2014; 14: 124. doi: [10.1186/1471-244X-14-124](https://doi.org/10.1186/1471-244X-14-124).
11. Jorm AF, Patten SB, Brugha TS, Mojtabai R. Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry*. 2017; 16(1): 90-9. doi: [10.1002/wps.20388](https://doi.org/10.1002/wps.20388).
12. Eisenberg D, Hunt J, Speer N. Help seeking for mental health on college campuses: review of evidence and next steps for research and practice. *Harv Rev Psychiatry*. 2012; 20(4): 222-32. doi: [10.3109/10673229.2012.712839](https://doi.org/10.3109/10673229.2012.712839).
13. Gulliver A, Griffiths KM, Christensen H, Brewer JL. A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry*. 2012; 12: 81. doi: [10.1186/1471-244X-12-81](https://doi.org/10.1186/1471-244X-12-81).
14. Leong FT, Lau AS. Barriers to providing effective mental health services to Asian Americans. *Ment Health Serv Res*. 2001; 3(4): 201-14. doi: [10.1023/a:1013177014788](https://doi.org/10.1023/a:1013177014788).
15. Gulliver A, Griffiths KM, Christensen H. Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*. 2010; 10: 113. doi: [10.1186/1471-244X-10-113](https://doi.org/10.1186/1471-244X-10-113).
16. Gould MS, Marrocco FA, Hoagwood K, Kleinman M, Amakawa L, Altschuler E. Service use by at-risk youths after school-based suicide screening. *J Am Acad Child Adolesc Psychiatry*. 2009; 48(12): 1193-201. doi: [10.1097/CHI.0b013e3181bef6d5](https://doi.org/10.1097/CHI.0b013e3181bef6d5).
17. Chan JY, Mak WW, Law LS. Combining education and video-based contact to reduce stigma of mental illness: "The Same or Not the Same" anti-stigma program for secondary schools in Hong Kong. *Soc Sci Med*. 2009; 68(8): 1521-6. doi: [10.1016/j.socscimed.2009.02.016](https://doi.org/10.1016/j.socscimed.2009.02.016).
18. Haas A, Koestner B, Rosenberg J, Moore D, Garlow SJ, Sedway J, *et al*. An interactive web-based method of outreach to college students at risk for suicide. *J Am Coll Health*. 2008; 57(1): 15-22. doi: [10.3200/JACH57.1.15-22](https://doi.org/10.3200/JACH57.1.15-22).
19. Lipson SK, Speer N, Brunwasser S, Hahn E, Eisenberg D. Gatekeeper training and access to mental health care at universities and colleges. *J Adolesc Health*. 2014; 55(5): 612-9. doi: [10.1016/j.jadohealth.2014.05.009](https://doi.org/10.1016/j.jadohealth.2014.05.009).
20. Jain P, Pandey US, Roy E. Perceived efficacy and intentions regarding seeking mental healthcare: impact of Deepika Padukone, a bollywood celebrity's public announcement of struggle with depression. *J Health Commun*. 2017; 22(8): 713-20. doi: [10.1080/10810730.2017.1343878](https://doi.org/10.1080/10810730.2017.1343878).
21. Joel D, Sathyaseelan M, Jayakaran R, Vijayakumar C, Muthurathnam S, Jacob KS. Explanatory models of psychosis among community health workers in South India. *Acta Psychiatr Scand*. 2003; 108(1): 66-9. doi: [10.1034/j.1600-0447.2003.01327.x](https://doi.org/10.1034/j.1600-0447.2003.01327.x).
22. Ogorchukwu JM, Sekaran VC, Nair S, Ashok L. Mental health literacy among late adolescents in South India: what they know and what attitudes drive them. *Indian J Psychol Med*. 2016; 38(3): 234-41. doi: [10.4103/0253-7176.183092](https://doi.org/10.4103/0253-7176.183092).

23. Menon V, Sarkar S, Kumar S. A cross-sectional analysis of barriers to health-care seeking among medical students across training period. *J Ment Health Hum Behav.* 2017; 22(2): 97-103. doi: [10.4103/jmhbb.jmhbb\\_34\\_17](https://doi.org/10.4103/jmhbb.jmhbb_34_17).
24. Fathima M, Mehrotra S, Sudhir P. Depression with and without preceding life event: differential recognition and professional help-seeking inclination in youth? *Indian J Soc Psychiatry.* 2018; 34(2): 116-9. doi: [10.4103/ijsp.ijsp\\_30\\_17](https://doi.org/10.4103/ijsp.ijsp_30_17).
25. Sameed S, Karkal R, Mendonsa R, Shriyan S, Thomas AM, Chandran VM. Help-seeking attitudes for depression among first year medical undergraduates. *Indian J Basic Appl Med Res.* 2016; 5(2): 839-44.
26. Gaiha SM, Sunil GA, Kumar R, Menon S. Enhancing mental health literacy in India to reduce stigma: the fountainhead to improve help-seeking behaviour. *J Public Ment Health.* 2014; 13(3): 146-58. doi: [10.1108/jpmh-06-2013-0043](https://doi.org/10.1108/jpmh-06-2013-0043).
27. Menon V, Sarkar S, Kumar S. Barriers to healthcare seeking among medical students: a cross sectional study from South India. *Postgrad Med J.* 2015; 91(1079): 477-82.
28. Horton D, Wohl RR. Mass communication and para-social interaction; observations on intimacy at a distance. *Psychiatry.* 1956; 19(3): 215-29. doi: [10.1080/00332747.1956.11023049](https://doi.org/10.1080/00332747.1956.11023049).
29. Kishore J, Gupta A, Jiloha RC, Bantman P. Myths, beliefs and perceptions about mental disorders and health-seeking behavior in Delhi, India. *Indian J Psychiatry.* 2011; 53(4): 324-9. doi: [10.4103/0019-5545.91906](https://doi.org/10.4103/0019-5545.91906).
30. Maulik PK, Tewari A, Devarapalli S, Kallakuri S, Patel A. The Systematic Medical Appraisal, Referral and Treatment (SMART) mental health project: development and testing of electronic decision support system and formative research to understand perceptions about mental health in rural India. *PLoS One.* 2016; 11(10): e0164404. doi: [10.1371/journal.pone.0164404](https://doi.org/10.1371/journal.pone.0164404).
31. Sahu A, Patil V, Purkayastha S, Pattanayak RD, Sagar R. Pathways to care for patients with Bipolar-I disorder: an exploratory study from a tertiary care centre of North India. *Indian J Psychol Med.* 2019; 41(1): 68-74. doi: [10.4103/IJPSYM.IJPSYM\\_201\\_18](https://doi.org/10.4103/IJPSYM.IJPSYM_201_18).
32. Singh A, Tripathi A, Gupta B, Agarwal V. Pathways to care for dhat (Semen loss anxiety) syndrome: a study from North India. *Int J Ment Health.* 2016; 45(4): 253-61. doi: [10.1080/00207411.2016.1238741](https://doi.org/10.1080/00207411.2016.1238741).
33. Jain N, Gautam S, Jain S, Gupta ID, Batra L, Sharma R, *et al*. Pathway to psychiatric care in a tertiary mental health facility in Jaipur, India. *Asian J Psychiatr [Internet].* 2012; 5(4): 303-8. doi: [10.1016/j.ajp.2012.04.003](https://doi.org/10.1016/j.ajp.2012.04.003).
34. Morgan C, John S, Esan O, Hibben M, Patel V, Weiss H, *et al*. The incidence of psychoses in diverse settings, INTREPID (2): a feasibility study in India, Nigeria, and Trinidad. *Psychol Med.* 2016; 46(9): 1923-33.
35. Dutta M, Spoorthy MS, Patel S, Agarwala N. Factors responsible for delay in treatment seeking in patients with psychosis: a qualitative study. *Indian J Psychiatry.* 2019; 61(1): 53-9. doi: [10.4103/psychiatry.IndianJPsychiatry\\_234\\_17](https://doi.org/10.4103/psychiatry.IndianJPsychiatry_234_17).
36. Hossien SA, Loganathan S, Kolar Sridara Murthy M, Palanimuthu Thangaraju S, Bharath S, Varghese M. Pathways to care among persons with dementia: study from a tertiary care center. *Asian J Psychiatr.* 2017; 30: 59-64. doi: [10.1016/j.ajp.2017.07.002](https://doi.org/10.1016/j.ajp.2017.07.002).
37. Cohen A, Padmavati R, Hibben M, Oyewusi S, John S, Esan O, *et al*. Concepts of madness in diverse settings: a qualitative study from the INTREPID project. *BMC Psychiatry.* 2016; 16(1): 388. doi: [10.1186/s12888-016-1090-4](https://doi.org/10.1186/s12888-016-1090-4).
38. Dijkxhoorn MA, Padmakar A, Jude N, Bunders J, Regeer B. Understanding caregiver burden from a long-term perspective: the Banyan model of caregiver experiences. *Perspect Psychiatr Care.* 2019; 55(1): 61-71. doi: [10.1111/ppc.12299](https://doi.org/10.1111/ppc.12299).
39. Naik SK, Pattanayak S, Gupta CS, Pattanayak RD. Help-seeking behaviors among caregivers of schizophrenia and other psychotic patients: a hospital-based study in two geographically and culturally distinct Indian cities. *Indian J Psychol Med.* 2012; 34(4): 338-45. doi: [10.4103/0253-7176.108214](https://doi.org/10.4103/0253-7176.108214).

40. Kumar V, Kiran M. Pathways of psychiatric treatment in rural patients with psychosis. *East J Psychiatry*. 2019; 22: 11-24.
41. Chakraborty K, Das G, Dan A, Bandyopadhyay G, Chatterjee M. Perceptions about the cause of psychiatric disorders and subsequent help seeking patterns among psychiatric outpatients in a tertiary care centre in eastern India. *Ger J Psychiatry*. 2013; 16(1): 7-14.
42. Hashimoto N, Fujisawa D, Giasuddin NA, Kenchaiah BK, Narmandakh A, Dugerragchaa K, *et al*. Pathways to mental health care in Bangladesh, India, Japan, Mongolia, and Nepal. *Asia-Pacific J Public Heal*. 2015; 27(2): NP1847-57.
43. Pattanayak RD, Sagar R. A qualitative study of perceptions related to family risk of bipolar disorder among patients and family members from India. *Int J Soc Psychiatry*. 2012; 58(5): 463-9. doi: [10.1177/0020764011408543](https://doi.org/10.1177/0020764011408543).
44. Srinivasan TN, Thara R. Beliefs about causation of schizophrenia: do Indian families believe in supernatural causes? *Soc Psychiatry Psychiatr Epidemiol*. 2001; 36(3): 134-40. doi: [10.1007/s001270050302](https://doi.org/10.1007/s001270050302).
45. Behari M, Gupta DK, Singh V, Verma K, Sengupta S, Sidana R, *et al*. Help seeking behaviour and pathways to care among patients seeking care at a community mental health clinic and psychiatry outpatient department of a medical college: a study from North Rajasthan. *J Ment Health Hum Behav*. 2013; 18(1): 18-33.
46. Mishra N, Nagpal SS, Chadda RK, Sood M. Help-seeking behavior of patients with mental health problems visiting a tertiary care center in north India. *Indian J Psychiatry*. 2011; 53(3): 234-8. doi: [10.4103/0019-5545.86814](https://doi.org/10.4103/0019-5545.86814).
47. Prabhu A, Vishnu Vardhan G, Pandit LV. Pathways to tertiary care adopted by individuals with psychiatric illness. *Asian J Psychiatr*. 2015; 16: 32-5. doi: [10.1016/j.ajp.2015.06.005](https://doi.org/10.1016/j.ajp.2015.06.005).
48. Lahariya C, Singhal S, Gupta S, Mishra A. Pathway of care among psychiatric patients attending a mental health institution in central India. *Indian J Psychiatry*. 2010; 52(4): 333-8. doi: [10.4103/0019-5545.74308](https://doi.org/10.4103/0019-5545.74308).
49. Jilani AQ, Saha R, Dalal PK, Kallivayalil RA, Tiwari A, Kar SK. The impact of awareness of psychotic disorder on pathways to psychiatric care for first episode psychosis in India. *Int J Cult Ment Health*. 2018; 11(3): 295-310. doi: [10.1080/17542863.2017.1376104](https://doi.org/10.1080/17542863.2017.1376104).
50. Kokane A, Pakhare A, Gururaj G, Varghese M, Benegal V, Rao GN, *et al*. Mental health issues in Madhya Pradesh: insights from national mental health survey of India 2016. *Healthcare (Basel)*. 2019; 7(2): 53. doi: [10.3390/healthcare7020053](https://doi.org/10.3390/healthcare7020053).
51. Raguram R, Raghu TM, Vounatsou P, Weiss MG. Schizophrenia and the cultural epidemiology of stigma in Bangalore, India. *J Nerv Ment Dis*. 2004; 192(11): 734-44. doi: [10.1097/01.nmd.0000144692.24993.1b](https://doi.org/10.1097/01.nmd.0000144692.24993.1b).
52. Chadda RK, Agarwal V, Singh MC, Raheja D. Help seeking behaviour of psychiatric patients before seeking care at a mental hospital. *Int J Soc Psychiatry*. 2001; 47(4): 71-8. doi: [10.1177/002076400104700406](https://doi.org/10.1177/002076400104700406).
53. Yamarthi P, Kannuri NK. Enabling factors for behavior change among people with alcohol dependency: an exploratory study in a mental health-care facility. *Indian J Public Health*. 2019; 63(3): 233-8. doi: [10.4103/ijph.IJPH\\_364\\_18](https://doi.org/10.4103/ijph.IJPH_364_18).
54. Upadhyaya SK, Raval CM, Sharma DK. The sociocultural factors and patterns of help-seeking among patients with mental illness in the sub-Himalayan region. *Ind Psychiatry J*. 2018; 27(2): 279-84. doi: [10.4103/ipj.ipj\\_95\\_14](https://doi.org/10.4103/ipj.ipj_95_14).
55. Saravanan B, Jacob KS, Johnson S, Prince M, Bhugra D, David AS. Assessing insight in schizophrenia: East meets West. *Br J Psychiatry*. 2007; 190: 243-7. doi: [10.1192/bjp.bp.106.029363](https://doi.org/10.1192/bjp.bp.106.029363).
56. Housen T, Ara S, Shah A, Shah S, Lenglet A, Pintaldi G. Dua Ti Dawa Ti: understanding psychological distress in the ten districts of the Kashmir Valley and community mental health service needs. *Confl Health*. 2019; 13: 59. doi: [10.1186/s13031-019-0243-8](https://doi.org/10.1186/s13031-019-0243-8).

57. Pal HR, Yadav S, Joy PS, Mehta S, Ray R. Treatment nonseeking in alcohol users: a community-based study from North India. *J Stud Alcohol*. 2003; 64(5): 631-3. doi: [10.15288/jsa.2003.64.631](https://doi.org/10.15288/jsa.2003.64.631).
58. Bholra P, Rekha DP, Sathyanarayanan V, Daniel S, Thomas T. Self-reported suicidality and its predictors among adolescents from a pre-university college in Bangalore, India. *Asian J Psychiatr*. 2014; 7(1): 38-45. doi: [10.1016/j.ajp.2013.10.003](https://doi.org/10.1016/j.ajp.2013.10.003).
59. Mathias K, Goicolea I, Kermodé M, Singh L, Shidhaye R, Sebastian MS. Cross-sectional study of depression and help-seeking in Uttarakhand, North India. *BMJ Open*. 2015; 5(11): e008992. doi: [10.1136/bmjopen-2015-008992](https://doi.org/10.1136/bmjopen-2015-008992).
60. Vankar JR, Prabhakaran A, Sharma H. Depression and stigma in medical students at a private medical college. *Indian J Psychol Med*. 2014; 36(3): 246-54. doi: [10.4103/0253-7176.135372](https://doi.org/10.4103/0253-7176.135372).
61. Fathima M. Help seeking for psychological distress and its correlates in college going youth. Bangalore: National Institute of Mental Health and Neuro Sciences; 2017.
62. Grover S, Dua D, Shouan A, Nehra R, Avasthi A. Perceived stress and barriers to seeking help from mental health professionals among trainee doctors at a tertiary care centre in North India. *Asian J Psychiatr*. 2019; 39: 143-9. doi: [10.1016/j.ajp.2018.12.020](https://doi.org/10.1016/j.ajp.2018.12.020).
63. Bruffaerts R, Demyttenaere K, Hwang I, Chiu WT, Sampson N, Kessler RC, *et al*. Treatment of suicidal people around the world. *Br J Psychiatry*. 2011; 199(1): 64-70. doi: [10.1192/bjp.bp.110.084129](https://doi.org/10.1192/bjp.bp.110.084129).
64. Andrade LH, Alonso J, Mneimneh Z, Wells JE, Al-Hamzawi A, Borges G, *et al*. Barriers to mental health treatment: results from the WHO World Mental Health surveys. *Psychol Med*. 2014; 44(6): 1303-17. doi: [10.1017/S0033291713001943](https://doi.org/10.1017/S0033291713001943).
65. Mathias K, Jacob KS, Shukla A. "We sold the buffalo to pay for a brain scan" - a qualitative study of rural experiences with private mental healthcare providers in Uttar Pradesh, India. *Indian J Med Ethics*. 2019; 4(4): 282-7. doi: [10.20529/IJME.2019.057](https://doi.org/10.20529/IJME.2019.057).
66. Chavan BS, Garg R, Bhargava R. Role of 24 hour telephonic helpline in delivery of mental health services. *Indian J Med Sci*. 2012; 66(5-6): 116-25. doi: [10.4103/0019-5359.114196](https://doi.org/10.4103/0019-5359.114196).
67. Das S, Saravanan B, Karunakaran KP, Manoranjitham S, Ezhilarasu P, Jacob KS. Effect of a structured educational intervention on explanatory models of relatives of patients with schizophrenia: randomised controlled trial. *Br J Psychiatry*. 2006; 188: 286-7. doi: [10.1192/bjp.bp.104.007245](https://doi.org/10.1192/bjp.bp.104.007245).
68. Maulik PK, Devarapalli S, Kallakuri S, Tewari A, Chilappagari S, Koschorke M, *et al*. Evaluation of an anti-stigma campaign related to common mental disorders in rural India: a mixed methods approach. *Psychol Med*. 2017; 47(3): 565-75. doi: [10.1017/S0033291716002804](https://doi.org/10.1017/S0033291716002804).
69. Tewari A, Kallakuri S, Devarapalli S, Jha V, Patel A, Maulik PK. Process evaluation of the systematic medical appraisal, referral and treatment (SMART) mental health project in rural India. *BMC Psychiatry*. 2017; 17(1): 385. doi: [10.1186/s12888-017-1525-6](https://doi.org/10.1186/s12888-017-1525-6).
70. Maulik PK, Kallakuri S, Devarapalli S, Vadlamani VK, Jha V, Patel A. Increasing use of mental health services in remote areas using mobile technology: a pre-post evaluation of the SMART Mental Health project in rural India. *J Glob Health*. 2017; 7(1): 010408. doi: [10.7189/jogh.07.010408](https://doi.org/10.7189/jogh.07.010408).
71. Maulik PK, Devarapalli S, Kallakuri S, Tripathi AP, Koschorke M, Thornicroft G. Longitudinal assessment of an anti-stigma campaign related to common mental disorders in rural India. *Br J Psychiatry*. 2019; 214(2): 90-5. doi: [10.1192/bjp.2018.190v](https://doi.org/10.1192/bjp.2018.190v).
72. Shidhaye R, Murhar V, Gangale S, Aldridge L, Shastri R, Parikh R, *et al*. The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: a population-based study. *Lancet Psychiatry*. 2017; 4(2): 128-35. doi: [10.1016/S2215-0366\(16\)30424-2](https://doi.org/10.1016/S2215-0366(16)30424-2).
73. Chadda RK, Deb KS. Indian family systems, collectivistic society and psychotherapy. *Indian J Psychiatry*. 2013; 55(6): 299-309. doi: [10.4103/0019-5545.105555](https://doi.org/10.4103/0019-5545.105555).

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74. Mojaverian T, Hashimoto T, Kim HS. Cultural differences in professional help seeking: a comparison of Japan and the U.S. *Front Psychol.* 2012; 3: 615. doi: [10.3389/fpsyg.2012.00615](https://doi.org/10.3389/fpsyg.2012.00615).

Help-seeking  
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