The sociocultural factors and patterns of help-seeking among patients with mental illness in the sub-Himalayan region

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ABSTRACT

Context: Selection of first help in psychiatric illnesses depends on various sociodemographic and environmental factors. In integrated societies like India careers also contribute in deciding help-seeking behavior of psychiatric patients. In this study, we explored these factors and the role of education of decision maker, i.e., person who is final authority in deciding the course of management. Aims: This study aims to study sociocultural factors and patterns of help-seeking behavior of psychiatric patients in rural sub-Himalayan region. Settings and Design: A cross-sectional study conducted in a tertiary care teaching hospital. Subjects and Methods: Factors affecting help-seeking behavior such as age, sex, education, occupation, income, accessibility to psychiatric treatment, expenses on faith healers and general practitioners, and education of “decision maker” were assessed. Statistical Analysis Used: Data were analyzed with GraphPad InStat, using appropriate statistical tests. Results: In this study of 250 patients, psychiatrists were chosen as first help by 98 (39%), faith healers by 84 (34%), and general medical practitioners (GMPs) by 68 (27%) patients. Mean “years of education” of patients in psychiatrist group, faith healer group, and GMP group were 9.98, 8.81, and 7.99, respectively (P = 0.08). Mean “years of education” of decision makers for these groups were 11.64, 8.36, and 10.93, respectively (P < 0.001). Time required in reaching psychiatric facility from the residence of patient was maximum in those who consulted faith healers first compared to those who consulted psychiatrist (P < 0.001) or GMP (P < 0.01). Expenses on faith healers were significantly high compared to GMPs (P < 0.001). Conclusions: Psychiatrists, faith healers, and GMPs were equally chosen as first help for psychiatric illness. Education of decision maker and accessibility affect help-seeking behavior significantly. Faith healers were more expensive than GMPs.

Keywords: Decision maker, education, pathway, psychiatric illness

The understanding of help-seeking behavior of patients with psychiatric illnesses may play an important role in quality and provision of psychiatric services. Psychiatric care providers may include psychiatrists, general medical practitioner (GMP), ayurvedic, homeopathic and alternate stream practitioners, and faith healers. Decision of selecting health-care provider is influenced by socioeconomic factors, availability, awareness, cultural beliefs, and social stigma. Complex interactions of these factors lead to selection of the first help for psychiatric illnesses. Belief systems of society has been found to have a major impact on this. Understanding of help-seeking behavior is further complicated in integrated societies like in India where help-seeking behavior is significantly influenced by careers, sometimes superseding patient’s own opinion.

Worldwide, there are numerous studies regarding various aspects of help-seeking behavior in psychiatric illnesses. Many studies have observed that psychiatrists were not consulted as first help. Patients reach mental health...
service after consulting GMPs\textsuperscript{[11,12]} or faith healers.\textsuperscript{[13,14]} Giasuddin \textit{et al.}\textsuperscript{[9]} found in their study in Bangladesh that only 16% of cases reach mental health professionals directly. Studies of help-seeking behavior in India have found predominance of specialist consultation\textsuperscript{[13]} in some while of faith healers\textsuperscript{[10]} in others. In a Jaipur-based study Jain \textit{et al.}\textsuperscript{[5]} observed that 40% of patients visited to faith healer first while only 28% consulted to psychiatrist as first help. This study demonstrated that referral pathways relied heavily on faith healers.

There are many studies which explored factors related to selection of first help. Coton \textit{et al.}\textsuperscript{[17]} found that those who have higher than primary education or from high income families are more prone to seek help from western medicine. Some authors\textsuperscript{[15]} concluded that accessibility is the determining factor for help-seeking behavior while some\textsuperscript{[18]} considered that it is the cultural beliefs which determine selection of first help.

Most of these studies are from urban or mixed populations of plain geographical areas. We could not find any study from a hilly area or from an entirely rural population. Our study was conducted in sub-Himalayan region where because of geographical constraints patients find difficulty in accessing required health facility. Because of unemployment earning members of family migrate to neighboring plain areas in search of livelihood, thus the number of the careers are reduced. This study was planned to understand help-seeking behavior of psychiatric patients and sociocultural factors affecting it in an entirely rural hilly area. Furthermore, this is the first Indian study exploring the role of education of decision maker.

**SUBJECTS AND METHODS**

The study was conducted in a Tertiary Care Teaching Hospital of Uttarakhand, India. This tertiary care center has a large catchment area as it caters to four districts of hilly sub-Himalayan region. In this catchment area, no psychiatrist is available other than at the study center. Daily OPD is about 10–15 patients of which 4–5 are new patients. The study was conducted from February 2012 to June 2012, after obtaining permission of Institutional Ethics Committee.

Using convenient sampling, we selected 300 patients who had no history of psychiatric consultation. Patients and accompanying attendant were explained the motive of study and a written informed consent was obtained. Those who refused to give consent or who had earlier consultation with a psychiatrist were excluded from the study. Earlier consultation with psychiatrist was kept as an exclusion criterion because such patients were less likely to have consulted faith healers or GMPs later. Cases with memory impairments such as amnesia or dementia were excluded as data collection relied heavily on memory. In case of minor and psychotic patients, consent was obtained from accompanying attendant. All cases were subjected to a semi-structured questionnaire which included sociodemographic details in addition to details of illness and earlier managements. Information obtained included details of various types of healers consulted earlier, reason for choosing a specific service, number of visits, and expenditures on each of these services. Expenditure included those on consultation, in patient care, investigations, medications, travel, religious rituals, and animals sacrificed in rituals. We also enquired about the educational status of the “decision maker,” the person who was final authority to decide on treatment options of the patient. Educational status was calculated as years of education, i.e., secondary means 10 years, senior secondary means 12 years, graduate means 15 or 16 years, and postgraduate means 17 or 18 years depending on their courses.

We categorized healers as psychiatrists, faith healers, and GMPs. GMPs included all practitioners having a medical qualification from Allopathy, Ayurveda, Homeopathy, or any other stream which is not specialized in psychiatry. Faith healers were the people who did not have any medical qualification and treated patients using magico-religious practices.

Psychiatric disorders were diagnosed as per International Classification of Diseases 10\textsuperscript{th} version and managed accordingly.

Data were tabulated and analyzed using GraphPad InStat package (version 3, GraphPad Software, San Diego, USA). Data were expressed as proportions, and Chi-square test, Mann–Whitney test, and Kruskal–Wallis analysis of variance were applied where ever appropriate.

**RESULTS**

A total of 300 patients were considered for study. Four patients refused to participate in the study, eight patients were excluded because during the study, they were found to have consulted psychiatrist earlier, and 38 patients were excluded because of inadequate information or unreliability of informant. Final analysis was done for 250 patients, 123 males and 127 females.

Psychiatrists were chosen for first consultation by 39.2% ($n = 98$) patients while 33.6% ($n = 84$) patients went
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There was a statistically significant difference between mean expenditure on faith healers and GMPs ($P < 0.01$). Major part of faith healing expenses were on animal sacrificing rituals. We found that 98 cases who went to faith healers had sacrificed 246 animals (138 cocks, 108 male goats) for religious rituals with an average of 2.51 animals per patient. In addition, five cases reported that they were physically tortured by red hot iron rods during rituals.

Table 1 shows sociodemographic variables of patients. Majority of the subjects were in 20–40 years of age group, and mean age of sample was $36.05 \pm 13.75$ years with a range of 4–82 years. Mean age of patients consulting psychiatrist, faith healer, and GMPs was not statistically different ($P = 0.36$). Male to female ratio was almost 1:1 in all the groups. Among 250 patients, 58% had studied up to secondary or more, and 62.4% belonged to joint family. Only 10.4% ($n = 26$) cases were unemployed at the time of psychiatric consultation. Entire sample belonged to rural area. Per capita per month income of those consulting first to psychiatrists was $(4639.09 \pm 3566.7$ INR) similar to those consulting faith healers $(4398.88 \pm 3248.5$ INR) and GMPs $(4522.05 \pm 3142.7$ INR). The duration of psychiatric illness ranged from 1 day to 17 years. None of these factors had significant impact.

Table 2 shows that mean number of visits paid to faith healers was comparable to those for GMP ($P = 0.56$), but there was statistically significant difference between mean expenditure on faith healers and GMPs ($P < 0.01$). Major part of faith healing expenses were on animal sacrificing rituals. We found that 98 cases who went to faith healers had sacrificed 246 animals (138 cocks, 108 male goats) for religious rituals with an average of 2.51 animals per patient. In addition, five cases reported that they were physically tortured by red hot iron rods during rituals.

The most common diagnosis [Table 3] was mood disorders, followed by “schizophrenia, schizotypal, and psychotic disorders.” Majority of the patients were suffering from moderate to severe psychiatric illnesses. Diagnoses did not show any difference in relation to the source of first help.

Table 4 shows that patient’s educational status in three groups was not different although showing a trend ($P = 0.08$). However, decision maker’s education

| Variable | Psychiatrist ($n=98; 39.2\%$), $n$ (%) | Faith healer ($n=84; 33.6\%$), $n$ (%) | General med practitioner ($n=68; 27.2\%$) $n$ (%) | Total 250 ($P$) |
|----------|----------------------------------------|----------------------------------------|----------------------------------------|----------------|
| Age | | | | |
| <20 (18) | 11 (61) | 3 (16.6) | 4 (22.2) | 0.09* |
| 20-40 (156) | 54 (34.6) | 61 (39.1) | 42 (26.2) | |
| >40 (76) | 33 (43.4) | 20 (26.3) | 23 (30.3) | |
| Sex | | | | |
| Males (123) | 49 (39.8) | 42 (34.1) | 32 (26) | 0.48* |
| Females (127) | 49 (38.58) | 42 (33.07) | 36 (28.35) | |
| Religion | | | | |
| Hindu (248) | 98 (39.5) | 84 (33.8) | 66 (26.6) | 0.06* |
| Muslims (2) | 0 | 0 | 2 (100) | |
| Marital status | | | | |
| Married (167) | 67 (40.12) | 57 (34.3) | 43 (25.75) | 0.46* |
| Unmarried (69) | 23 (33.4) | 23 (33.4) | 23 (33.4) | |
| Widowed/separated (14) | 8 (57.14) | 4 (28.57) | 2 (14.29) | |
| Occupation | | | | |
| Homemakers (93) | 32 (34.4) | 30 (32.1) | 31 (33.3) | 0.10* |
| Students (39) | 22 (56.4) | 10 (25.6) | 7 (17.9) | |
| Employed (92) | 35 (38.0) | 31 (33.6) | 26 (28.2) | |
| Unemployed (26) | 9 (34.6) | 13 (50) | 4 (15.3) | |
| Family type | | | | |
| Nuclear (94) | 37 (39.36) | 34 (36.17) | 23 (24.47) | 0.70* |
| Joint (156) | 61 (39.10) | 50 (32.05) | 45 (28.85) | |
| Per capita income/month (Indian national rupees) mean (SD) | 4639.09 (3566.7) | 4398.88 (3248.5) | 4522.05 (3142.7) | 0.88† |

*Chi-squared test, †Kruskal-Wallis test. SD – Standard deviation
was significantly lower in faith healers group compared to psychiatrist \( (P < 0.001) \) or GMP \( (P < 0.05) \) groups. Patients themselves were decision makers in 141 cases.

Accessibility was quoted as most important determinant in selection of faith healer or GMP as first contact [Table 5]. Non-belief in faith healers was quoted as the most common reason for consulting psychiatrists first. Second-most common reason for consulting psychiatrists was need of specialist consultation, while for faith healers, it was the belief that illness is nonpsychiatric.

Those who consulted psychiatrist as second or third service provider revealed that most common reasons were failure of other treatments (72\%), recommendation by relatives or friends (32\%), and less expensive treatment (24\%) (data not in table).

### DISCUSSION

Most of the subjects were in the age group of 20–40 years. In our study, male to female ratio was almost 1:1; and surprisingly, cases were almost equally divided in all three

#### Table 2: Analysis of number of visits, total expenditure, and time required to reach hospital

|                   | Psychiatrist \((n=98)\) | Faith healer \((n=84)\) | GMPs \((n=68)\) | Total 250 \((P)\) |
|-------------------|-------------------------|-------------------------|----------------|-----------------|
| Number of visits  | Median 2                | Median 2                |                | 0.56\(^1\)      |
| Total expenditure (INR) | Range 1-12               | Range 1-6               |                |                 |
|                    | Median 10000             | Median 3500             |                | \(<0.001\)      |
| Time required to reach psychiatric facility (min) | Range 800-70,000         | Range 500-30,000        |                |                 |

\(^1\)Kruskal-Wallis test, \(^2\)Mann-Whitney test, \(^3\)Earlier consultation with psychiatrist was an exclusion criterion. GMPs – General medical practitioners; INR – Indian rupees

#### Table 3: Diagnostic distribution of cases according to international classification of diseases-10\(^{th}\) version

| Diagnostic group | Psychiatrists \((n=98)\) | Faith healers \((n=84)\) | GMPs \((n=68)\) | \(P\) |
|------------------|--------------------------|--------------------------|----------------|------|
| Schizophrenia, schizotypal, and psychotic disorders (57) | 22 (39.60) | 17 (29.82) | 18 (31.58) | 0.78* |
| Mood disorders (138) | 50 (36.23) | 51 (36.96) | 37 (26.81) |      |
| Neurotic, stress related, and somatoform (26) | 12 (46.15) | 7 (26.92) | 7 (26.92) |      |
| Others (29) | 14 (48.28) | 9 (31.03) | 6 (20.69) |      |

*Chi-squared test. GMPs – General medical practitioners

#### Table 4: Educational profile of patients and decision makers

| Years of education | Psychiatrist \((n=98)\) | Faith healer \((n=84)\) | GMP \((n=68)\) | \(P\) |
|--------------------|-------------------------|-------------------------|----------------|------|
| Patient’s years of education | Mean (SD) | 9.98 (6.32) | 8.81 (6.02) | 7.99 (6.46) | 0.08 |
|                      | Median (range) | 12 (0-17) | 12 (0-17) | 10.5 (0-17) |      |
| Decision maker’s years of education | Mean (SD) | 11.64 (5.4) | 8.36 (6.18) | 10.93 (5.09) | \(P<0.001^{**}\) |
|                      | Median (range) | 12 (0-20) | 10 (0-17) | 12 (0-17) |      |

**Post hoc (Dunn’s multiple comparison test) revealed psychiatrist versus faith healer \(P<0.001\), Faith healer versus GMP \(P<0.05\), psychiatrist versus GMP \(P>0.05\). GMP – General medical practitioners; SD – Standard deviation

#### Table 5: Reasons for visiting a treatment facility as first contact

| Reason for first consultation | Psychiatrist \((n=98)\) | Faith healer \((n=84)\) | GMP \((n=68)\) | Total |
|------------------------------|-------------------------|-------------------------|----------------|-------|
| Easily accessible             | 23                      | 77                      | 35             | 135   |
| Belief in system              | 13                      | 22                      | 5              | 40    |
| Less expensive                | 17                      | 3                       | 16             | 36    |
| Belief that illness is nonpsychiatric | 17             | 38                      | 11             | 49    |
| Supernatural causation of disease (5) | -           | 5                       | -              | 5     |
| Should consult specialist for this | 21                      | -                       | 8              | 29    |
| Do not believe in faith healers | 43                      | -                       | 3              | 47    |
| Recommendation by friend/relative | 18                      | 22                      | 25             | 65    |
| Stigma of psychiatric illness | -                       | 5                       | 6              | 11    |

GMP – General medical practitioners
groups. This is in contrast to earlier observations which found distribution to be highly skewed toward males.\[23\]

It was observed that selection of first help was not skewed to psychiatrist or faith healer which is in contrast to earlier studies. It has been perceived in some studies that subjects from rural area prefer faith healers while those from urban areas prefer psychiatrists as first help. In a study which had 70% urban population, majority of the patients consulted a psychiatrist first\[15\] while another study in central India with two-thirds of patients from rural area showed that psychiatrists were preferred as first help in only 9% of cases.\[19\] It is important to note that in our study, all cases were from rural areas and it was observed that people from rural background prefered psychiatrist, faith healers, and GMPs equally. This is not an unusual observation as our findings are consistent with a multicentric study\[24\] which observed psychiatrists as first help in 34% cases and faith healer in 26%. In this multicentric study, subjects from rural areas preferred psychiatrists for first help.

On analysis of educational status, it was seen that patients in three groups did not have significant difference. Earlier studies have placed different opinions on this issue. Coton et al.\[17\] reported that cases with lower educational status are more prone to magico-religious treatments and patients with higher education seek western medicine. In contrast, Kishore et al.\[21\] found that for unknown reasons even university graduates consult faith healers in spite of their disbelief in supernatural causation of mental illness. We observed that educational status of “decision maker” had significant impact on selection of the first help. We could not find any study for comparison as no previous study has assessed the role of decision maker. We feel it is a very important issue especially in Indian scenario as our society is more integrated and relatives play a key role in the management of any illness including psychiatric ones. Patient’s own opinion is often not adequately valued irrespective of their educational status and relatives and close friends consider it as their responsibility to provide the best care to the patient.

Time required for reaching psychiatric facility from patient’s residence was maximum in case of faith healers group and minimum for psychiatrist group. Instead of distance, we considered time taken to reach psychiatric facility because in hilly regions accessibility is not related to distance. It depends on presence or absence of roads, altitude, development, and transport facility. It is important to note that study center is the only psychiatric facility in a wide catchment area. Our finding indicates that accessibility is an important issue in selection of first help. On enquiring, it was found that the most common reason behind considering faith healers as first choice was easy accessibility, followed by trust in faith healers. These observations are in line with Chadda et al.\[18\] who observed that accessibility and belief in supernatural causation of mental illness are most important reason for consulting faith healers. In contrast, Trivedi and Jilani\[18\] believe that it is cultural belief, not lack of medical facility which forces the patients to seek help from the traditional health providers. It has been observed that mere availability of mental health services may not be enough to change the help-seeking pattern of society.\[22\]

Those who first consulted psychiatrists revealed that non-belief in faith healers and felt need of specialist consultation were most common reasons for consulting psychiatrist. Most of them were postgraduates. This observation is in sharp contrast to earlier research in which psychiatrists were consulted due to recommendations by others, or failure of response to other managements.\[15\] None of the earlier studies reported that non-belief in faith healers or felt need of specialist consultation may have a role in psychiatrist consultation.

We found that expenditure on faith healers was significantly high compared to GMPs. Expenses could not be compared to psychiatrists because history of consultation with psychiatrist was an exclusion criterion. One study\[23\] revealed that management by faith healers is more expensive than public health services, while another study\[18\] found that low cost of treatment was reason for consulting faith healers in 36% of cases. In our study, major part of expenses on faith healers was due to ritual slaughters. In a North Indian study Mishra et al. found that expenses on non-psychiatric physicians were significantly higher than those on faith healers, a finding opposite to our study.\[24\] We found that 98 cases who went to faith healers sacrificed a total of 246 animals for religious rituals with an average of 2.51 animals per patient. We emphasize that the benefits of faith healing practices for psychiatric patients are not only questionable but also expensive, highly unethical and cruel for the animals. Ritual slaughter is a centuries old concept in Uttarakhand and many other Indian states which is gradually declining due to judicial orders.\[25\] Complete ban on these practices may save a lot of money of psychiatric patients.

Our observation of physical torture on patients is in line with earlier research. Trivedi and Sethi observed that 9% of patients visiting faith healers were subjected to unethical and inhuman treatment modalities such as beating, flogging, and physical torture.\[26\]

The most common psychiatric illness was mood disorder, followed by “schizophrenia, schizotypal and psychotic disorders” and all the three groups were comparable. Only 10% of patients were of neurotic, stress related, and
somatoform disorders [Table 3]. Majority of the patients were suffering from severe psychiatric illnesses. This is a well-known fact that patients with minor mental ailments do not seek treatment. Majority of patients in a study said that they will go to psychiatrist only when feeling mentally out of control, not when feeling sad, anxious, or fearful. This difference was more marked in urban population. In a study of help-seeking behavior in central India, it was found that 96% patients belonged to psychotic or affective disorders category.

CONCLUSIONS

Psychiatrists, faith healers, and GMPs were equally chosen as first help for psychiatric illness. Education of decision maker and accessibility affect help-seeking behavior significantly. Faith healers were more expensive than GMPs.

A complex interaction of various factors such as education, socioeconomic status, beliefs, and accessibility influences help-seeking behavior for psychiatric illnesses. This is the first study in a hilly region with entirely rural population. This is the only study which assessed role of decision maker’s education in help-seeking behavior.

Limitations

This study has some limitations. First, it is a single center study so represents one population sample which may not be applicable to other populations. Second, this study relied heavily on memory so possibility of biased information and retrospective falsification cannot be ruled out. Third, this is a hospital-based study. There can be significant number of patients who never reach to psychiatrist, and there can be many patients who never seek any treatment for psychiatric illness. Fourth, we could not establish duration of untreated psychosis (DUP). It would have been interesting to find out the association between the independent variables and DUP as the dependent variable.

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Conflicts of interest

There are no conflicts of interest.

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