Help Seeking Preferences to Informal and Formal Source of Care for Depression: a Community Based Study in Northwest Ethiopia

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Abstract

**Background:** Depression is the leading cause of disability at a population level and globally 350 million people are suffering from depression. Many people suffer from depression use different sources of help for their mental health problems. People with different mental health problems seek help from formal and/or informal sources. This gives crucial information on community’s beliefs and perception regarding their preference for help if they faced depression. This study helps to guide effective planning and provision of mental health services and health policy of the country to explore the community’s preferences of help-seeking.

**Objective:** The aim of this community based cross-sectional study was to contrast patterns of formal and informal help-seeking preferences for depression among residents of Aykel town, Northwest Ethiopia.

**Methods:** This cross-sectional population based study included 832 participants. We used a major depressive disorder case vignette and general help-seeking questionnaire (GHSQ) to assess the preferences to seek help. Study participants were selected by multistage cluster sampling technique. Data were collected by face-to-face interviews. An independent-sample t-test and analysis of variance test (ANOVA) was performed to determine mean score difference in socio-demographic characteristics of the participants for informal sources of help.

**Results:** A total of 656 subjects (78.8%) showed high propensity to intimate partner, and 655 (78.7%) of the study subjects had high propensity to mental health professional. The mean score of the residents’ preference to seek help from informal sources was 3.41±0.60. The mean score of preference to seek help from formal sources was 3.18±0.75. A total of 276 (33.2%) subjects showed high propensity to both informal and formal sources of help. The result also showed that there was mean score difference in preferences to informal help between subjects with strong social support and low and/ moderate social support (P<0.001).

**Conclusion:** The result suggests that the majority of the residents had a higher preference to seek help from informal sources compared to formal sources of care. Mean score difference was observed in degree of social support and occupational status (student, housewife and jobless) for informal sources of help. Providing and strengthening both formal and informal sources of help in conjunction is crucial to get a more qualified and effective care of depressed patients.

Introduction

Mental disorders are a major public health concern that affects more than 340 million people worldwide. Five of the mental disorders are in the top 10 leading causes of disability(1, 2). Depression is one of the common mental disorders with an average prevalence of 12% globally (2). In the past 15 years, the magnitude of depression has been increasing to 18.4% (1) and 40.5 % of DALYs caused by mental illness accounted for depression (3). It affects all people in all age groups worldwide(4). Depression has high impact at the individuals’, family members’, and at the country level(2, 5, 6). At the individual level,
depression causes social and occupational functioning impairment (7-9). Indeed, it increases the burden of other chronic medical illnesses such as HIV/AIDS, cardiac failure, diabetes mellitus, tuberculosis and surgical illness (9, 10). Its’ impact on the cause of life threatening illnesses is unbearable in low income countries including Ethiopia (11, 12) with the estimated magnitude ranging from 2.4% to 60% (13-17). The other trajectory consequence of depression is suicide (8, 18, 19) and substance use (20, 21).

Help-seeking preference and behavior for depression have received increasing attention due to their effect on long-term prognosis. Early identification and intervention of depression can reduce the suffering of affected individuals and prevent the morbidity and mortality rates (22, 23). It can reduce long-term costs of mental health care during the rehabilitation process. Despite the benefits of early intervention, studies have reported that there are variations among individuals in the utilization and preferences of mental health services (23-28). To design appropriate planning and strengthening mental health services, it is important to determine the communities’ preferences for help-seeking and barriers that occur in the process.

Evidence based treatment modalities like antidepressant drugs, psychotherapies and psycho-educations are available for the treatment of depression. Different literatures revealed that only approximately to one-half’s of individuals with depression seek a formal help from health care professionals (1, 2), despite the availability of these treatment modalities (29-31). Earlier researches reported that the prevalence of formal help seeking behavior for depression ranged from 33% to 55.6% (15, 32, 33). Different epidemiological evidences showed that socio-demographic variables such as females and younger age (6, 34); clinical variables including co-morbid illnesses, perceived need, functional impairment, higher level of depression (35, 36); accessibility of the treatment (6, 37); and white Americans (38) were more frequently associated with help-seeking from different treatment areas.

Informal help usually offered by friends, family, religious leaders (priests), or other non-health professionals. Individuals in the community have been found higher support from informal help providers than formal help providers (5, 39). It is more difficult and a challenge to explore informal help as informal help occurs frequently and studies are limited (40). The World Health Organization (WHO) believes confidently that informal community services are crucial at the initial as a primary health care services (2). The role of informal help from friends, families or other non-medical sources has been researched less frequent.

A number of researches on informal and formal help preferences have studied while they were focused on specific population groups such as pregnant women, adolescents, youth people (41), students, and ethnic minority groups (42, 43). Those studies indicated that individuals were seeking help from different sources (39, 40). Earlier community based studies in England conducted on formal and informal help preferences among adults (36, 40) found that 55.6-63.1% of the participants commonly preferred to seek help from informal treatment sources such as friends and family when they were feeling ‘stress and depressed’. Both studies were using the General Health Questionnaire (GHQ) (44) to examine the severity, they reported no differences in problem severity amongst those seeking informal help, but found
differences with formal help, with 14% with less severe problems having sought formal help compared to 28% with more severe problems (40).

Therefore, studying the help seeking preferences helps to understand and discover people's dynamics in their preferences of formal and informal help seeking for depression from different service providers. Additionally, it gives crucial information on communities' beliefs and perception regarding their preference for help if they faced depression. This study helps to guide the effective planning and provision of mental health services and health policy of the country to explore the communities' preferences of help-seeking treatment areas. In Ethiopia, there are studies regarding formal help seeking behavior about depression from health care providers (14, 16, 21, 45), but, there is no a community survey on formal and informal help seeking preferences. Thus, the purpose of this community survey was to assess the magnitude of formal and informal help seeking preferences for depression in northwest Ethiopia.

**Methods**

**Study design and setting**

Community-based cross-sectional survey was employed between April and May 2015 at Aykel town, northwest Ethiopia. In this town, around 18507 residents were living. During the survey, there were two health posts, one health center and one primary hospital that provide health care service for the community in the town.

**Study participants and sampling procedure**

A total of 832 participants were interviewed. Multi-stage cluster sampling technique was used to sample the participants. There are two kebeles in the town. The residents are huge in number with similar socio-demographic indicators in each Kebele (an administrative unit of Ethiopia, similar to a ward and consists 5000 people). So simple random sampling (lottery method) technique was used to select one kebele. Inside this kebele, there are subdivisions of kebele to Ketena. Twelve ketenas were included using lottery method. From the catchment area 832 households were interviewed. Adult residents whose age 18 years and above living in the catchment area were included for this study. Individuals with severe illness, and unable to communicate were excluded from the study (16).

**Data collection procedure and tools**

A structured questionnaire was used to determine the residents informal and formal help-seeking preference if they have depression. It was designed through adopting from previously conducted study among young people's help-seeking for mental health problems in Australia (46). The questionnaire was prepared by the authors in English language; then forward translation to Amharic language was done which is a local language of the residents and back translated to English by language experts to check its consistency. Data were collected by trained data collectors via face-to face interview technique. Four
trained public health professionals were the data collectors using the Amharic version of the questionnaire. The training was given for data collectors regarding how to interview and explain unclear questions for the participants. Furthermore, they have been given awareness about ethical principles including confidentiality/ anonymity/ and data management, secure subjects’ informed consent for participation. All collected data were checked for completeness and consistency.

Socio demographic variables (sex, age, religion, marital status, ethnicity, educational status, and occupational status) which were adopted from different literatures.

Social support was measured using the Oslo 3-items social support scale with scores ranging from 3 to 14: 3–8=poor social support; 9–11=intermediatesocial support; and 12–14=strongsocial support(47).

General help seeking questionnaire (GHSQ) with major depressive disorder case vignette to measure preference to seek informal and formal source of help. GHSQ is measured with five point likert type scale ranging from (1) “very unlikely” to (5) “very likely”. Participants were asked: “If you were feeling like symptoms described in the vignette how likely it is, you would seek help from a list of people?” High scores (score of 4 or 5) for each source of care shows that a person had highest propensity to ask help; low score (≤3) indicates that the participant had low propensity to ask specific source of help (41). The mean scores of high and low propensity of each source of help were calculated. The sources of help were divided in to three groups: formal help, close informal help, and broad informal help. This category was adapted from Italian study (39). The formal help group included any health professional (doctor, nurse, public health professional), mental health professional (psychiatrist, psychologist, social worker, counselor) and traditional healer. Under the close informal help groups were boyfriend, girlfriend, friend, father or mother, other relatives/family members/. Religious related sources of help (holly water, priest), sorcerer were under the broad informal help category. In this study close informal and broad informal help category were considered as informal help source. The sum of each source of help in the formal and informal category have computed and then divided by the number of sources of help in each category which resulted in the total score ranging from 1 to 5. The higher the score in each scale the higher the likelihood that the participant prefers to seek this source of care. We have computed Cronbach’s Alpha to test the internal consistency of the scale, obtaining a score of 0.55. Cronbach Alpha indexes were also computed for each variable to test the internal consistency, and values ranged from 0.56 for the close informal help group to 0.69 for the formal help group.

Data processing and analysis

Data were entered in to EPI INFO 3.5.3 and then analyzed via STATA-14. Descriptive statistics (frequency, percent mean and standard deviation) were used to summarize the data. Mean scores and percentage estimate for specific informal and formal help preference were described. An independent- sample T-test and Analysis variance test (ANOVA) were performed to determine whether there was a difference in informal help scores between participants socio demographic characteristics.
Ethical consideration

Ethical clearance and approval was not sought for this study since a secondary data analysis was employed that have collected and used before(16). The initial study had received ethical approval from the University of Gondar and Amanuel Mental Specialized Hospital Ethical Review Committee. A Formal letter of permission was also received from Aykel town administration. The aim of the study and the confidentiality issue was explained for the participants’. Written informed consent was obtained from participants. Personal identification was omitted to maintain confidentiality.

Results

Personal and socio-economic characteristics of the residents

A total of 832 residents took part in the study with a response rate of 98.3%. More than half (58.8%) of the participants were males with the median age of 32 years (interquartile range= 10). Majority of the respondents (83.9%) were Orthodox Christians; 365 (43.9%) had attended secondary education, and two hundred forty three (29.2%) of the participants were government employed workers. Nearly half,(48.9%) the respondents were not married, and 389 (46.8%) of the participants had moderate social support (Table 1).

Community preference to seek help from different sources of care

The higher the score in each source of help the higher the likelihood that the study subjects prefer to seek this source of care. Among informal sources of care, participants reported higher preference to seek help from intimate partner, parents, friends and a religious source of help than from other family members and sorcerer. Among formal sources of care, participants reported higher propensity to seek help from mental health professionals (e.g., psychiatrist, psychologist, social worker, and counselor) than from general medical professionals or traditional healers.

Depending on the major depression case vignette, a total of 656 subjects (78.8%) showed high propensity to intimate partner source of help with the mean score of 3.96 (SD=1.14) followed by parents with mean score of 3.86±1.14, friends (mean score of 3.76±1.07) and religious sources (mean sore of 3.86±1.30). 97.6% of the participants had low propensity to seek help from sorcerer in broad informal help with mean score of 1.34±0.71. Six hundred fifty five (78.7%) of the study subjects had high propensity to mental health professional with a mean score of 4.00±1.09. (Table 2).

The mean total score of informal source of help was 3.41 (SD=± 0.60). The participants’ preference was higher for close informal help (3.67±0.78) than formal sources of help (3.18 ±0.75). The mean score of broad informal source of help (religious leaders, sorcerer) was 2.6±0.76; this implies the subjects had a lower propensity than formal sources of help (Table 3).

A total of 276(33.2%) subjects showed high propensity (mean score of nearly 4 or more) to both informal and formal sources of help. Ninety two (11.1%) of the participants showed high propensity to informal
help and low to formal help whereas 62 (6.5%) of the subjects had low preferences to informal help and high to formal help. Indeed, 85 (10.2%) of subjects had little propensity (mean score of nearly 2 or lower) to both informal and formal sources of help.

In this study we found a significant difference in preference of informal sources of help scores between students and house-wife or jobless subjects. Students had lower propensity of help from informal sources when they would encounter depression than house-wife and jobless individuals (P=0.045). Also, the result demonstrated a significant mean score difference in preferences of informal help between subjects with strong social support and low and moderate social support (P<0.001). On the contrary, there was no a mean score difference for informal help between sex, age, marital status, educational level of the study participants (Table4).

**Discussion**

Previous literatures showed more than one in five of the community residents (20.5%) had depression in Ethiopia (21). We examined communities’ preference to seek help for depression by presenting them a vignette depicting an individual experiencing a major depressive disorder and asking them to report their preferences to seek help from formal and informal sources if they were having a similar situation.

More than three-fourth of the residents tended to prefer informal sources of help such as an intimate partner, friend, parents (father or mother), religious sources of help, while less likely to prefer sorcerer and other family members. The main reason could be these sources of help are usually available in nearby as required, and persons used easily for less severe of the problem (48). They might also use those sources of help as a bridge to formal and other broad sources of help such that in case of serious problems and need for professional help intimate partner, friends might facilitate the linkage to formal source of help (49). Peoples propensity to source of help might also be related with illness casual belief. If people perceive depressive symptom is due to adverse life events they might not prefer professional help (formal and informal).

The fourth most preferred source of help was a mental health professional (psychiatrist, psychologist, social worker, counselor) indicating that professional help was considered an important source by more than 65% of the residents. Persons usually preferred the formal sources of help particularly for severe problems (40). This finding is in contrary to previous studies (39-41) in which for young adults, family was relatively less important (21%–31%) and GPs relatively more so (19%–34%). People with physical illness causal belief might prefer professional help because they may think the problem could not improve by itself spontaneously. Though preference to informal help is its leading component, help-seeking should be promoted as a general attitude. Professional help is trusted if people know what trust in people and if they are aware of their feelings and can handle and communicate them [3, 13]. Therefore, indicating professional help as the real or best source of help can prove counterproductive. On the other hand, professional help needs to be publicized, and made more accessible to everyone and everywhere.
when needed. Professional help and reliable information about it should be more readily accessible in all settings for the community [14].

Other relative/family members and sorcerer were substantially less preferred help-seeking sources by the residents. As study shows (50) if individuals have high support from friends and parents, they might have low preference for other family members.

Regarding religious source of help (Holly water, priest, chaplain or rabbi), 70% of the study participants have high propensity to seek help if they have confronted similar situations in the vignette. This finding is opposite with other studies (40, 41). The possible reason for this difference might be socio-cultural, and population differences. People have understood depressive symptoms as less serious and not requiring treatment and therefore those suffering from depression might prefer religious sources of help rather than professional help. Most people in Ethiopia use traditional and religious methods for treating mental illness and look for modern treatment after they tried the local means. The other reason might be in developing countries like Ethiopia people might not afford the cost of modern treatment.

Concerning occupational status of the participants, students had lower propensity to seek help from informal sources if they would encounter depression than house-wife and/ jobless individuals (P=0.045). Majority of the students are young and they may consider depression is simple. As a result, they might cope up with the problem on their own. For example; a study conducted in Australia (preference, rural and remot) showed that participants reported that they do not like when people judged them or they feel that they are being judged. They prefer it when others think they are confident and in control. Preference to informal source of help by jobless participants might be related to un able to afford costs for professional help because this group of population might not have income for their health need. House wife also might prefer from their intimate partner/couple to get any kinds of help before they tried to other options.

Also, the result demonstrated a significant mean score difference in informal help preferences among subjects with strong social support and low and/ moderate social support (P<0.001).

On the contrary, we observed no mean score differences to informal source of help between males and females; age groups, marital status and educational level categories.

**Limitation Of The Study**

We did not consider whether or not the participants have depression. Because participants’ preference to seek help might be different when they have depression or do not have depression.

The other limitation was we did not know the formal and informal help relation. Participants might seek help to formal help after talking to their family, parent, partner and other informal sources of help or in case of serious disorders.
Social desirability and recall biases might be the limitation of this study. Since data collection method was face-to-face interview which might lead individuals to respond socially acceptable answer during the interview process especially in case of sorcerer sources of help.

Conclusion

This study has revealed that majority of the residents had a higher preference to seek help from informal sources of care such as intimate partner, father or mother, friends and religious leaders compared to formal sources of care. There was mean score difference for informal source across occupational status (student, housewife and jobless), and degree of social support.

Though preference to informal help is its leading component, formal and informal help seeking should be promoted as a general attitude to get a more qualified and effective care for depressed patients. Because it is not clear whether informal and formal help are mutually exclusive or whether they are part of the same overall propensity to help-seeking. Although help seeking preference and attitude is not an actual behavior, it is an important issue in mental health for designing strategies to support the community.

Declarations

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Authors contribution: SS developed the proposal, supervised the data collection, analyzed the data and wrote the draft manuscript. TK revised the proposal and assist the data analysis. TA, DA, GA, GT, MW revised the proposal, and revised and approved the manuscript. Finally, all authors have read and approved the manuscript.

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Competing interests

The authors declare that they have no competing interest

Ethical approval and consent to participate: Ethical clearance and approval was not sought for this study since a secondary data analysis was employed that have collected and used before. The initial study had received ethical approval from the University of Gondar and Amanuel Mental Specialized Hospital Ethical Review Committee. A Formal letter of permission was also received from Aykel town administration. The aim of the study and the confidentiality issue was explained for the participants’.
consent was obtained from the participants. Personal identification was omitted to maintain confidentiality.

**Consent for publication**

Not applicable

**Availability of data and material**

All the data are included in the manuscript

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Tables

Table 2: Residents preferences for different informal and formal sources of help to depression in Aykel town, Northwest Ethiopia, 2015 (n=832)
| Preferences to seek depression care | Mean(SD) | Score ≤3 (low propensity) | Score4 (high propensity) |
|------------------------------------|----------|---------------------------|-------------------------|
|                                    |          | Freq  | Percent  | Freq  | Percent  |
| **Informal sources of care**       |          |       |          |       |          |
| Intimate partner(girlfriend, boyfriend, husband, wife) | 3.96(1.14) | 176   | 21.2     | 656   | 78.8     |
| Friends                            | 3.76(1.07) | 206   | 24.8     | 626   | 75.2     |
| Parent (Mother/Father)             | 3.86(1.14) | 228   | 27.4     | 604   | 72.6     |
| Other relative/family members      | 3.07(1.21) | 474   | 57       | 358   | 43       |
| Religious sources (Holly water, priest, chaplain or rabbi) | 3.86(1.30) | 232   | 27.9     | 600   | 72.1     |
| Sorcerer                           | 1.34(0.71) | 812   | 97.6     | 20    | 2.4      |
| **Formal sources of care**         |          |       |          |       |          |
| Any health professionals (e.g. doctor, nurse, HO, etc.) | 3.72(1.23) | 240   | 28.8     | 592   | 71.2     |
| Mental health professionals (psychologist, social worker, counselor) | 4.00(1.09) | 177   | 21.3     | 655   | 78.7     |
| Traditional healer                 | 1.82(1.08) | 748   | 89.9     | 84    | 10.1     |

Table 3: Summary of measures of preferences to informal and formal sources of help for depression

| Sources of help        | Mean (standard deviation) |
|------------------------|---------------------------|
| Close informal         | 3.67 (0.78)               |
| Broad informal         | 2.6 (0.76)                |
| Informal total         | 3.41 (0.60)               |
| Formal                 | 3.18 (0.75)               |

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Table 4: Comparison of socio demographic characteristics of participants and mean scores of preference to informal sources of help, northwest Ethiopia, 2015 (N=832)
| Variables               | Frequency (%) | Mean ±SD | Test of significance | p-value |
|-------------------------|---------------|----------|----------------------|---------|
| **Sex**                 |               |          |                      |         |
| Male                    | 489 (58.8)    | 3.30±0.62 | t= -0.17             | 0.202   |
| Female                  | 343 (41.2)    | 3.31±0.57 |                      |         |
| **Age in years**        |               |          |                      |         |
| 18-25 years             | 215 (25.8)    | 3.30±0.61 | F=1.37               | 0.192   |
| 26-35 years             | 375 (45.1)    | 3.2±0.59  |                      |         |
| 36-45 years             | 163 (19.6)    | 3.32±0.61 |                      |         |
| >45 years               | 79 (9.5)      | 3.34±0.54 |                      |         |
| **Ethnicity**           |               |          |                      |         |
| Amhara                  | 486 (58.4)    | 3.27±0.60 | F=2.41               | 0.09    |
| Kimant                  | 326 (39.2)    | 3.36±0.59 |                      |         |
| Tigre                   | 20 (2.4)      | 3.4±0.40  |                      |         |
| **Religion**            |               |          |                      |         |
| Orthodox                | 698 (83.9)    | 3.31±0.60 | F=0.47               | 0.62    |
| Muslim                  | 124 (14.9)    | 3.27±0.55 |                      |         |
| Protestant              | 10 (1.2)      | 3.43±0.91 |                      |         |
| **Educational status**  |               |          |                      |         |
| Unable to read and write| 65 (7.8)      | 3.34±0.57 | F=0.64               | 0.51    |
| Primary school          | 98 (11.8)     | 3.28±0.63 |                      |         |
| Secondary school        | 365 (43.9)    | 3.31±0.59 |                      |         |
| Diploma and above       | 304 (36.5)    | 3.31±0.61 |                      |         |
| **Occupational status** |               |          |                      |         |
| Government employee     | 298 (35.8)    | 3.33±0.59 | F=7.54               | 0.045   |
| Private business        | 244 (29.3)    | 3.30±0.57 |                      |         |
| House wife              | 102 (12.3)    | 3.50±0.55 |                      |         |
| Student                 | 115 (13.8)    | 3.02±0.70 |                      |         |
| Jobless                 | 73 (8.8)      | 3.46±0.55 |                      |         |
| **Marital status**      |               |          |                      |         |
| Unmarried               | 407 (48.9)    | 3.30±0.59 | F=0.64               | 0.48    |
| Married                 | 387 (46.5)    | 3.32±0.61 |                      |         |
| Divorced/ Widow         | 38 (4.6)      | 3.30±0.70 |                      |         |
| **Social support**      |               |          |                      |         |
| Poor                    | 363 (43.5)    | 3.18±0.64 | F=18.47              | <0.001  |
| Moderate                | 389 (46.8)    | 3.38±0.55 |                      |         |
| Strong                  | 81 (9.7)      | 3.55±0.50 |                      |         |
