

## Research Article

# Pattern of Help Seeking Behavior for Common Mental Disorders among Urban Residents in Southwest Ethiopia

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### ABSTRACT

**Background:** Worldwide evidences showed that the magnitude of mental health such as common mental disorders is very high. It is also indicated that only a small proportion of people with common mental disorders seek help from different sources. Assessing pattern of help seeking behavior among people with common mental disorders is crucial in order to provide appropriate mental health service. Therefore, this study assessed the pattern of help seeking behavior for common mental disorders among urban residents.

**Methodology:** Community based cross sectional study was conducted in March, 2015 in Jimma town using interviewer administered structured questionnaire. A total of 745 residents were selected using multi stage probability sampling technique. Self Reporting Questionnaire (SRQ) was used to determine the prevalence of common mental disorders. The mental help seeking behaviors was assessed using Actual Help Seeking Questionnaire (AHSQ). Data was analyzed with SPSS version 20. Simple and multiple logistic regression analysis were done to identify associated factors. Strength of association of the variables was determined using odds ratio and 95% confidence level.

**Results:** Among residents 245 (33.6%) had Common Mental Disorders (CMD). From residents with CMD, 121 (49.4%) of them had sought help for their problems. The most frequently visited source of help was the informal help sources, 306 (82.7%). Being 48 year old and above, female gender, married, divorced/separated and widowed in marital status, not using khat and alcohol during the past one month, cigarette smoking and having chronic physical illness were significantly associated with increased help seeking behavior for common mental disorders among residents

**Conclusion:** Only half of the residents sought help for common mental disorders and the sources of help for 83% of the residents were the informal help sources. Future intervention is needed targeting factors negatively affecting help seeking behavior and promoting use of formal help sources is essential for improved mental health of residents

**Keywords:** Help seeking behavior; Common mental disorders; Urban residents; Ethiopia

### Background

Mental disorders are highly prevalent and cause considerable suffering and disease burden [1]. Mental and behavioral disorders are estimated to account for 12% of the global burden of disease and in 2020 the burden of these disorders is projected to increase by 15% [2]. Among the mental disorders depression, anxiety disorders and medically unexplained somatic symptoms referred to as common mental disorders (CMD) contribute for the global burden of mental health problems. The global prevalence of CMD has shown that about 29.2% of people are affected during their life time [3]. Studies consistently showed that a large number of people, from different regions of the world, are affected by common mental disorders. In the United States of America, about 30% of the population was reported to be affected by mood disorders, anxiety disorders and substance use disorders [4]. Community based surveys in Feira de Santana, Northeastern Brazil among adult population indicated

that 29.9% of residents were affected by CMD [5]. Similarly, Population based survey conducted in South Africa reported 34.9% of CMD among the general population [6]. In Ethiopia, up to 32.4% prevalence rate of CMD among the community was reported [7].

However, various studies reported that a large proportion of people with mental health problems did not seek professional help and remain untreated despite there are effective treatments [1,2]. It was shown that only one third of adults with diagnosable mental disorders seek professional help [8,9]. Help-seeking is defined as an active and adaptive process of attempting to cope with problems or symptoms by using external resources for assistance. Help can be sought from a wide range of external sources, including people who occupy different roles and who vary in terms of their relationship with the person seeking help. Two main types of help-seeking have been delineated, formal and informal: Formal help-seeking is assistance from professionals who have a legitimate and recognized professional role in

providing relevant advice, support and/or treatment. Informal help-seeking is assistance from informal social networks, such as friends, relatives, traditional healers, religious leaders and family. Other form of seeking help is self – help such as reading books, watching TV and reading on internets [10,11].

Regardless of the sources consulted help seeking behavior for mental health problems is generally low. In the United States of America the use of formal and informal source of help among elderly African-American public house residents showed that only 47% needed help among them 38.5% of the residents used formal while 18.6% used informal help sources [12]. A community psychiatric morbidity survey in south London indicated that 40.1% of participants had sought formal help, 33.6% had sought informal help, 29% had sought both formal and informal help and only 26.3% had sought no help [13]. In another study only 28% of people with CMD had sought help from their general practitioner but most, 78% had sought some form of help from informal help sources [14]. A study on mental health service utilization in Singapore reported that only 31.7% of those with mental disorders had sought help: 15.7% from mental health providers, 8.4% from general practitioners and 7.6% from religious/spiritual advisors or other healers [15].

The main reasons mentioned for low professional treatment seeking behaviors were fear of being stigmatized for having mental illness, believing in informal help sources, lack of mental health literacy, negative experience of past help seeking and being unaware of services among others [16-19]. Help seeking was also found to vary among socio-demographic characteristics of respondents. Being female, having lower education, higher social health, higher mental health knowledge and physical causal attribution for depression were positive predictors of help-seeking intention [20]. Another study also similarly showed that being female, holding a lower rank, having functional impairment, and having co-morbid mental disorders were increased predictors of help seeking [21]. Whereas, being male, young age and people living in affluent areas were reported to be the least likely to seek help [14]. Therefore, it is vital to take these factors into consideration and design a mechanism in order to bring positive mental health seeking behavior.

However, in Ethiopia, a country where there are high prevalence of mental health problems with limited mental health service access due to low number of trained mental health professionals and mental health facilities, the help seeking behavior of the community with commonly occurring mental conditions was not known [22]. Thus, a community based study was conducted among urban residents of Jimma town, Southwest Ethiopia to assess the pattern of help seeking behavior for common mental disorders and associated factors.

## Methods

### Study design and settings

A community based cross-sectional study was conducted in Jimma town, south west Ethiopia, from February-March, 2015. Jimma Town is located 352 km south-west of Addis Ababa, the capital city of Ethiopia. The town has 17 administrative units

(kebeles). According to 2007 central statistical agency (CSA) census the town has 32,191 households with total population of 120, 960 [23]. Jimma University Teaching Hospital is found in the town providing health service to the people of southwest Ethiopia. Mental health service, both outpatient and inpatient, is given in the hospital.

### Population

The Source populations of the study were residents of Jimma town age  $\geq 18$  years during the data collection period. The study population was a sample of adult residents living in Jimma town. Individual residents with hearing impairment and cognitively impaired to consent and unable to recall events were excluded.

### Sampling

Taking prevalence rate of 32.4% for common mental disorders from Northeast Ethiopia, at 95% certainty and  $\pm 5\%$  margin of error, considering design effect and adding 10% non response rate the final sample size was 745. Two-stage sampling technique was employed for the study. The study unit was housing units with the assumption that each housing unit would have a sampling subject. Using simple random sampling technique, 5 kebeles were selected from the 17 and the number of participants that were selected from each kebele for the study, were determined using proportional allocation of the sample size to the total number of households in each of the selected kebeles. Systematic random sampling technique was employed to select study units. The first study unit was selected randomly between 1<sup>st</sup> and k<sup>th</sup> and study subjects in every k<sup>th</sup> household were interviewed. When more than one study subjects were found in one household, a lottery method was used to select a participant.

### Measurements

A structured interviewer-administered questionnaire was used which has four sub sections: a socio-demographic questionnaire to assess the resident's background information. Self reported questionnaire (SRQ-20), which was developed by WHO, was used to assess the prevalence and presence of CMD. The SRQ was originally designed as self administered scale but was also found to be suitable for interviewer administered questionnaire because of the low literacy rate in developing countries [24]. Each of the 20 items is scored 0 or 1. A score of 1 indicate that the symptom was present during the past month, a score of 0 indicate that the symptom was absent. A cut-off point of 7/8 (7 'yes's' a non-case, 8 'yes's' a case) was used which is the most commonly used cut off point in developing countries [25]. In the current study respondents with SRQ-20 score of 8 and above were asked about their help seeking pattern in the past two weeks for CMD. To assess help seeking behavior, the Actual help seeking questionnaire (AHSQ) was used to assess the pattern mental health seeking behavior among residents. AHSQ assesses recent help-seeking behavior previously utilized to measure pattern of help seeking behavior for mental health problems [26,27]. The scale assesses the formal and informal sources of help.

The final section was questionnaire to assess current substance use (the past one month) such as khat, alcohol and cigarette together with a questionnaire to assess the presence of chronic physical illnesses, such as tuberculosis, cardiovascular diseases, HIV/AIDS, cancer, diabetes, asthma and hypertension. The Amharic version of the questionnaires was used to collect data.

**Data collection**

Questionnaire was pre-tested on 5% residents which were not included in the study to check for applicability and understandability of the instruments. The data collectors and supervisors were trained about the instruments and the process of proper data collection and handling procedures. The supervisors were trained to check for completeness of the questionnaire. Regular supportive supervision was made by the principal investigator. There was cross checking of the data for completeness and for missing value every day among the data collectors and the supervisors.

**Data processing and analysis**

After data was collected, it was coded and entered into a computer using Epi-data version 3.1 programs. Then it was exported to statistical package for social sciences (SPSS version 20). Descriptive statistics: frequency and percentages were calculated and presented in tables. Binary logistic regression analysis was used to explore associated variables with pattern of help seeking for CMD. This was done by entering each independent variable separately into simple logistic regression analysis. Then, variables with statistical significant association including those variables with p-value of less than 0.25 on simple logistic regression were entered into multiple logistic regression analysis once. Then, variables having p-value of less than 0.05 on multiple logistic regressions were finally considered as significantly associated with pattern of help seeking behavior for CMD. The strength of association of the variables was determined using odds ratio and 95% confidence level.

**Results**

**Background characteristics of respondents**

From a total of 745 study participants, 729 completed the study, yielding 97.8% response rate. From all respondents completing the study, 245 (33.6%) of them had common mental disorders. The respondents' background characteristics with common mental disorder indicated that the majority 163 (67%) were female in the age groups of 28-37 years 111 (45.3%). The majority, 80 (32.7%) of the respondents were from Oromo ethnicity and were followers of orthodox Christianity 102 (42%) and Muslim 85 (35%). Married respondents 107 (44%), attending Secondary school 70 (29%), who are self employed 86 (35%) and whose gross monthly family income was in the range of 100-800 ETB constituted the majority of the respondents. Regarding social support, more than half, 137 (56%) of the respondents reported as having poor social support.

Reported substance use among respondents showed that about half, 111 (45%) of them used khat followed by alcohol

64 (26%) and cigarette 39 (16%). About one third 76 (31%) of the respondents also reported having known chronic physical illness (Table 1).

**Table 1:** Background characteristics of study participants in Jimma town, March, 2015.

Characteristics (n=245)	Frequency	%	
<b>Sex</b>	Male	82	33.5
	Female	163	66.5
<b>Age</b>	18-27	51	20.8
	28-37	111	45.3
	38-47	61	24.9
	≥ 48	22	9.0
	Muslim	85	34.7
<b>Religion</b>	Orthodox	102	41.6
	Protestant	43	17.6
	Others*	15	6.1
<b>Marital status</b>	Single	63	25.7
	Married	107	43.7
	Divorced and separated	54	22.0
	Widowed	21	8.6
<b>Ethnicity</b>	Oromo	80	32.7
	Amhara	68	27.8
	Keffa	54	22.0
	Guragie	23	9.4
	Others **	20	8.2
	Unable to read and write	32	13.1
<b>Educational status</b>	Able to read and write	47	19.2
	Primary school	53	21.6
	Secondary school	70	28.6
	College and above	43	17.6
<b>Occupational status</b>	Employed	70	28.6
	Self employed	86	35.1
	Student	11	4.5
	Housewife	30	12.2
	Unemployed	27	11.0
<b>Gross monthly family income(ETB)</b>	Others***	21	8.6
	100-800	86	35.1
	801-1500	47	19.2
	1501-3000	53	21.6
<b>Family size</b>	>3000	59	24.1
	<3.6	112	45.7
<b>Level of social support</b>	>3.6	133	54.3
	Poor	137	55.9
	Moderate	101	41.2
<b>Current Khat use</b>	Strong	7	2.9
	yes	111	45.3
<b>Current Alcohol</b>	No	134	54.7
	Yes	64	26.1
<b>Current Cigarette</b>	No	181	73.9
	Yes	39	15.9
<b>Chronic physical illness</b>	No	206	84.1
	Yes	76	31.0
	No	169	69.0

Note: - \*=Catholic, Jehovah witness, Pagan, \*\* =Tigre, Wolayita, Yem, Hadiya, kulo and \*\*\* =Pensioner, Farmer, Daily laborer; House servant

### Pattern of help-seeking behavior among common mental disorders cases

Among respondents with current CMD cases 245 (33.6%); 121 (49.4%) of them had sought help for their problems. The remaining 124 (50.6%) had not sought help for their problems within two weeks period prior to the study. The most frequently visited source of help was the informal help sources, these were visited by 306 (82.7%) of respondents who had sought help, on contrary those who seek help from formal help sources accounted for only 64 (17.3%) of the total respondents who seek help for their current problem. From the informal help source majority (34.3%) of respondents sought help from intimate partners followed by other relatives (22.4%) and friends (18%). General health care providers (12.2%) were more utilized as formal source of help than mental health professionals (6.9%) (Table 2).

Pattern of past history of help seeking indicated that 61 (29%) of the respondents with current CMD had history of seeking help previously, of which 52 (85%) seek help from informal sources. Regarding the frequency of visit most 45 (38%) has  $\leq 2$  contacts with the consulted source. Majority 50 (82%) of those who had history of previous consultation reported that the consultations were unhelpful (Table 3).

### Pattern of help-seeking behavior for CMD and associated factors

More than half of the respondents with age greater than 28 years seek more help than respondents with age less than 27 years. The highest prevalence of help seeking was found in female respondents, 109 (56.5%). Help seeking by marital and

educational status showed that majority of married respondents, 63 (58.9%) and respondents who were unable to read and write, 18 (56.2%) seek more help. Most students, 8 (72.7%) seek help for their CMD than those who are employed workers, 33 (47.1%), housewives, 14 (46.7%) and unemployed respondents, 12 (44.4%). Majority of respondents with family size of greater than 3.6, 70 (52.6%) seek more help than respondents with family size less than 3.6, 51 (45.5%). Respondents who did not use khat 85 (63.4%), alcohol, 105 (58.0%) and those who reported to have strong social support seek more help than their counterparts. The majority of respondents who have had known chronic physical illness 61 (80.3%), those who had history of previous help seeking behavior with a frequency visit of  $\leq 2$  times, 41 (91.1%) and those who reported that the previous visit was helpful 10 (90.9%) had sought more help.

The binary logistic regression analysis of help seeking behavior for CMD indicated that sex, ethnicity, marital status, gross monthly family income, current use of khat and alcohol, level of social support, presence of chronic physical health conditions, previous history of help-seeking and frequency of visit made for previous help seeking were significantly associated ( $P < 0.05$ ). The other variables listed were not associated with help seeking behavior for CMD (Table 4).

### Predictors of help seeking behavior for common mental disorders

Multiple logistic regression analysis indicated that residents of ages 48 years and above sought help for CMD 10 times (AOR=10.18; 95% CI (1.45-71.49) more than residents with age 18-27 years. Females sought 6 times (AOR=6.23, 95% CI (2.41-16.12) more help for CMD than males. Residents

**Table 2:** Pattern of help-seeking behavior among CMD case residents of Jimma town, March, 2015.

Help-source	Frequency	%	Total	
Informal	Parent	42	17.1	
	Intimate partner	84	34.3	
	Minister/religious leaders	38	15.5	
	Friends	44	18.0	
	Other relatives/family members	55	22.4	306 (82.7%)
	Traditional healers	42	17.1	
	Praying	1	0.4	
Formal	Teacher	17	6.9	
	Doctor/GP/any Health care provider	30	12.2	64 (17.3%)
	Mental health professionals	17	6.9	

**Table 3:** Previous history of help seeking for CMD among residents of Jimma town, March, 2015.

Characteristics	Frequency	%	
Previous history of seeking help	Yes	61	24.9
	No	184	75.1
Types of sources visited	Formal	9	14.7
	Informal	52	85.3
Frequency of visit	$\leq 2$ visits	45	73.8
	$\geq 3$ visits	16	26.2
Helpfulness of the sources visited	Helpful	11	18.0
	Unhelpful	50	82.0

**Table 4:** Help-seeking behavior for CMD and associated factors among residents of Jimma town, March, 2015.

Variables	Help-seeking for common mental disorders		COR (95% CI)	P-Value	
	No n (%)	Yes n (%)			
Age	18-27	32 (62.7%)	19 (37.3%)	1.00	
	28-37	54 (48.6%)	57 (51.4%)	1.78 (0.90-3.51)	0.097
	38-47	28 (45.9%)	33 (54.1%)	1.98 (0.93-4.24)	0.077
	≥ 48	10 (45.5%)	12 (54.5%)	2.02 (0.73-5.57)	0.173
Sex	Male	62 (75.6%)	20 (24.4%)	1.00	
	Female	62 (38.0%)	101 (62.0%)	5.05 (2.78-9.16)	<0.001*
Religion	Muslim	42 (49.4%)	43 (50.6%)	1.29 (0.62-2.70)	0.494
	Orthodox	48 (47.1%)	54 (52.9%)	1.42 (0.69-2.91)	0.336
	Protestant	24 (55.8%)	19 (44.2%)	1.00	
	Others *	10 (66.7%)	5 (33.3%)	0.63 (0.18-2.16)	0.464
Ethnicity	Oromo	32 (40.0%)	48 (60.0%)	4.25 (1.51-11.94)	0.006*
	Amhara	30 (44.1%)	38 (55.9%)	3.59 (1.26-10.22)	0.017*
	Keffa	30 (55.6%)	24 (44.4%)	2.27 (0.770-6.64)	0.135
	Gurage	17 (73.9%)	6 (26.1%)	1.00	
	Others**	15 (75.0%)	5 (25.0%)	0.94 (0.24-3.74)	0.935
Marital status	Single	46 (73.0%)	17 (27.0%)	1.00	
	Married	44 (41.1%)	63 (58.9%)	3.87 (1.97-7.62)	<0.001*
	Divorced and separated	24 (44.4%)	30 (55.6%)	3.38 (1.56-7.33)	0.002*
	Widowed	10 (47.6%)	11 (52.4%)	2.98 (1.07-8.26)	0.036*
Educational status	Unable to read and write	14 (43.8%)	18 (56.2%)	1.97 (0.78-4.97)	0.153
	Able to read and write	25 (53.2%)	22 (46.8%)	1.35 (0.58-3.11)	0.487
	Primary school	28 (52.8%)	25 (47.2%)	1.37 (0.60-3.09)	0.454
	Secondary school	31 (44.3%)	39 (55.7%)	1.92 (0.89-4.16)	0.097
	College and above	26 (60.5%)	17 (39.5%)	1.00	
Occupational status	Employed	37 (52.9%)	33 (47.1%)	1.12 (0.46-2.72)	0.811
	Self-employed	43 (50.0%)	43 (50.0%)	1.25 (0.52-2.98)	0.615
	Student	3 (27.3%)	8 (72.7%)	3.33 (0.38-3.12)	0.123
	Housewife	16 (53.3%)	14 (46.7%)	1.09 (0.38-3.12)	0.866
	Unemployed	15 (55.6%)	12 (44.4%)	1.00	
	Others ***	10 (47.6%)	11 (52.4%)	1.37 (0.44-4.32)	0.585
Gross monthly family income (ETB)	100-800	50 (58.1%)	36 (41.9%)	1.00	
	801-1500	22 (46.8%)	25 (53.2%)	1.58 (0.77-3.23)	0.211
	1501-3000	29 (54.7%)	24 (45.3%)	1.15 (0.58-2.29)	0.692
	>3000	23 (39.0%)	24 (45.3%)	2.17 (1.11-4.27)	0.024*
Family size	<3.6	61 (54.5%)	51 (45.5%)	1.00	
	>3.6	63 (47.4%)	70 (52.6%)	1.33 (0.80-2.20)	0.269
Current Khat use	Yes	75 (67.6%)	36 (32.4%)	1.00	
	No	49 (36.6%)	85 (63.4%)	3.61 (2.13-6.14)	<0.001*
Current Alcohol use	Yes	48 (75.0%)	16 (25.0%)	1.00	
	No	76 (42.0%)	105 (58.0%)	4.14 (2.19-7.85)	<0.001*
Current Cigarette smoking	Yes	16 (41.0%)	23 (59.0%)	1.58 (0.79-3.17)	0.194
	No	108 (52.4%)	98 (47.6%)	1.00	
Level of social support	Poor	63 (46.0%)	74 (54.0%)	1.72 (1.02-2.89)	0.041*
	Moderate	60 (59.4%)	41 (40.6%)	1.00	
	Strong	1 (14.3%)	6 (85.7%)	8.78 (1.02-75.68)	0.048

<b>Chronic physical illness</b>	Yes	15 (19.7%)	61 (80.3%)	7.39 (3.87-14.11)	<0.001*
	No	109 (64.5%)	60 (35.5%)	1.00	
<b>Previous history of seeking help</b>	Yes	12 (19.7%)	49 (30.1%)	6.35 (3.16-12.76)	<0.001*
	No	112 (60.9%)	72 (39.1)	1.00	
<b>Frequency of visit for previous help seeking</b>	≤ 2 visits	4 (8.9%)	41 (91.1%)	10.3 (2.48-42.38)	0.001*
	≥ 3 visits	8 (50.0%)	8 (50.0%)	1.00	
<b>Helpfulness of the sources visited</b>	Helpful	1 (9.1%)	10 (90.9%)	2.82 (0.32-24.50)	0.347
	Unhelpful	11 (22.0%)	39 (78.0%)	1.00	

1=Reference, p<0.05=significantly associated

from Amhara (AOR=10.02, 95% CI (1.81-55.34) and Keffa (AOR=10.23, 95% CI (1.73-60.36) ethnicity sought 10 times while residents of Oromo ethnicity sought 5 times (AOR=5.21, 95% CI (1.00-27.23) more help than residents from Gurage ethnicity. Residents who were married in marital status sought 4 times (AOR=4.17, 95% CI (1.44-12.08) more help than singles. Similarly divorced or separated residents sought 7 times (AOR=7.35, 95% CI (2.00-27.03) and widowed sought 5 times (AOR=4.91, 95% CI (0.98-24.64) more help than singles for CMD.

Substance use and help seeking for CMD indicated that residents who did not used khat for the last one month sought 3 times (AOR=3.12, 95% CI (1.28-7.51) more than current khat users. Similarly current alcohol nondrinkers sought 5 times (AOR=5.02, 95% CI (1.55-16.20) more help than current alcohol drinkers. On the other hand current cigarette smokers

had sought 5 times (AOR=5.24, 95% CI (1.45-18.95) more help than current cigarette smokers. Residents who reported of having known chronic physical illness had sought 10 times (AOR=10.23, 95% CI (3.68-28.48) more help than residents with no reported chronic physical illness (Table 5).

## Discussion

This study aimed to assess pattern of help seeking behavior for Common mental disorders among residents of Jimma town and factors affecting help seeking behavior. Using cut off point of 7/8 of the SRQ-20, the prevalence of CMD was 33.6% among urban residents. Among them 49.4% had reported that they had sought help for CMD. The remaining 50.6% of residents had not sought any form help for CMD. From those who had sought help, the majority of them, 82.7% had visited informal help sources. Formal source of help was sought by only 17.3% of

**Table 5:** Multiple logistic regression analysis of factors associated with help seeking among residents with current CMD, Jimma town, March, 2015.

Variables		COR (95% CI)	AOR (95% CI)	P-Value
<b>Age</b>	18-27	1.00	1.00	
	28-37	1.78 (0.90-3.51)	2.33 (0.68-7.97)	0.176
	38-47	1.98 (0.93-4.24)	2.78 (0.70-10.97)	0.145
	≥ 48	2.02 (0.73-5.57)	10.18 (1.45-71.49)	0.02 *
<b>Sex</b>	Male	1.00	1.00	
	Female	5.05 (2.78-9.16)	6.23 (2.41-16.12)	<0.001*
	Oromo	4.25 (1.51-11.94)	5.21 (1.00-27.23)	0.05*
<b>Ethnicity</b>	Amhara	3.59 (1.26-10.22)	10.02 (1.81-55.34)	0.008*
	Keffa	2.27 (0.770-6.64)	10.23 (1.73-60.36)	0.01*
	Gurage	1.00	1.00	
	Others**	0.94 (0.24-3.74)	1.77 (0.18-17.52)	0.624
<b>Marital status</b>	Single	1.00	1.00	
	Married	3.87 (1.97-7.62)	4.17 (1.44-12.08)	0.009*
	Divorced and separated	3.38 (1.56-7.33)	7.35 (2.00-27.03)	0.003*
	Widowed	2.98 (1.07-8.26)	4.91 (0.98-24.64)	0.053*
<b>Current Khat use</b>	Yes	1.00	1.00	
	No	3.61 (2.13-6.14)	3.12 (1.28-7.51)	0.012*
<b>Current Alcohol use</b>	Yes	1.00	1.00	
	No	4.14 (2.19-7.85)	5.02 (1.55-16.20)	0.007*
<b>Current Cigarette smoking</b>	Yes	1.58 (0.79-3.17)	5.24 (1.45-18.95)	0.012*
	No	1.00	1.00	
<b>Chronic physical illness</b>	Yes	7.39 (3.87-14.11)	10.23 (3.68-28.48)	<0.001*
	No	1.00	1.00	

P<0.05=significantly associated

the residents with CMD. The proportion of residents who had sought help for CMD was similar with a study from USA where 47% of elderly African-American public house residents had sought help for their mental health problems and from a study from south London. However, the use of formal help source in this study (17.3%) is much lower than the study from USA (38.5%) and south London (40.1%). In the current study a large proportion of participants (82.7%) of residents with CMD used the informal sources while only 18.6% of informal source of help alone was reported in the USA and about 33.6% in south London studies [12,13]. The reasons could be the accessibility of formal help sources and availability of health facilities and professional man power in USA and England than in Ethiopia where there is an imbalance between disease burden and availability of mental health service resources and facilities [22]. The other reason could be the belief held by most Ethiopians regarding the cause of mental illness as spiritual possession, God's will and evil spirit compared to the more psycho-social attribution in developed countries [28-30]. The belief might lead people to utilize traditional and religious help sources than seeking modern treatment. In another study from England, about 20% of the respondents with score in the General Health Questionnaire ( $\text{GHQ} \geq 8$ ) had not sought any form of help from anyone which is a much lower rate than the current study [14]. This indicated that 80% had sought help among them; a large number of (28%) had sought formal help sources from the general practitioners than the current study while about 78% had sought some form of help from informal help sources which is in agreement with our study. But the proportion of residents sought help in the current study was higher from a study result from Singapore where only 31.7% were reported seeking help for their mental health problems [15]. The probable reasons for the difference could be differences in socio-cultural difference between the study population and use of different assessment tools to screen mental health problems and help seeking in the current study (SRQ-20 and AHSQ) versus use Composite International Diagnostic Interview (CIDI) in the Singapore study to establish diagnosis of mental disorders and the service sought. Conversely, large proportion (24.1%) of people from Singapore study sought formal help sources than informal help sources 7.6% when compared with the current study. This could be due to the number of mental health professional and the available mental health services in the general hospitals or specialized settings to population ratio in Singapore is much better than that in Ethiopia [15,22].

Regarding predictors of help seeking behavior for common mental disorders, older age was significantly associated with increased help seeking behavior for CMD. This is in agreement with previous study results which reported that younger people has less tendency of help seeking behavior for mental health concerns [14,31]. But it is against to a study done in Malaysia which reported increased help seeking intention among younger respondents for mental health [23]. The result of the current study in indicated that, females were more likely to seek help for CMD than males. This is a consistent finding compared with previous study results [14,20,21,32]. Residents with married divorced or separated and who were widowed in marital status

had significantly positive help seeking behavior for CMD than singles. Similar results were obtained in previous studies [21,33]. However, in one of the previous studies mentioned [23], divorced and separated people were found to seek more help in reference to the married people while the reference in the current study was being single in marital status.

The association between current substance use such as khat and alcohol showed that non-khat chewers and non alcohol drinkers during the last month from the commencement of this study had sought significantly more help than those who reported chewing khat and drinking alcohol. It is indicated that people with mental illness such as depression and anxiety use substance in order to self medicate the symptoms and get out of the feeling of discomfort [34]. This kind of maladaptive coping strategy might be the reason why current khat chewers and alcohol drinkers had sought less help for CMD. In the contrary, cigarette smokers had significantly higher help seeking behavior than non-smokers for CMD. The reasons why smokers had sought more help than non-smokers for their mental health problems needs further investigations. Residents who reported of having known chronic physical illness had sought significantly more help than respondents without the illness. This is due to the reason that people tend to seek more help when they do have accompanying physical symptoms and when they attribute the symptoms of mental health problems to physical cause [20,28]. Having one or two previous history of seeking help in the past was associated with seeking more help for current CMD than having three and above past history of seeking help. The decreased need for seeking help after subsequent visits of the help sources might be related to participants' level of satisfaction of the first or second visits. In this study the majority (82%) of residents who had past history of seeking help reported that the help sources visited were unhelpful.

The results of this study can be used taking in to consideration the following limitations. Recall biases and social desirability biases since residents need to remember the CMD symptoms during the past one month and their help seeking behavior for CMD in the last two week using interviewer administered questionnaire. It is a community based study conducted in urban area focused on CMD and the findings may not be generalized to people living in rural areas and people with severe mental disorders

## Conclusion

Only half of the residents sought help for common mental disorders and the sources of help for 83% of the residents were the informal help sources. Being 48 year old and above, female gender, married, divorced/separated and widowed in marital status, not using khat and alcohol during the past one month, cigarette smoking, having chronic physical illness and having one or two past history of help seeking were significantly associated with increased help seeking behavior for common mental disorders among residents. Future intervention is needed targeting factors negatively affecting help seeking behavior and promoting use of formal help sources is essential for improved mental health of residents.

## ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The Ethics committee of College of health science, Jimma University has approved the study. All participants gave verbal informed consent.

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## AUTHORS' CONTRIBUTION

HK and MS design the study, coordinated the data collection process, analyzed the data and write the manuscript. MA involved in data analysis and write up of the manuscripts.

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