

A study on nonpsychiatric management of psychiatric patients in Minia governorate, Egypt

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Received 12 August 2012

Accepted 27 December 2012

Egyptian Journal of Psychiatry
2013, 34:128–133

Background

The world is suffering from an increasing burden of mental disorders and a widening gap in treatment. About 450 million people suffer from mental or behavioral disorders; yet, only a small minority receives even the most basic treatment.

Objectives

The objective of the study was to assess nonpsychiatric treatments and traditional and folklore management of psychiatric disorders and examine the nature of communication between psychiatric and nonpsychiatric care providers in Minia Governorate, Egypt.

Participants and methods

A total of 1134 patients [638 male (56.2%) and 496 female (43.8%)] were recruited from the outpatient psychiatric clinic of Minia University Hospital. They were interviewed using an unstructured open-ended technique to assess the previous methods by which their psychiatric illness was handled.

Results

The number of patients who reported that they had undergone nonpsychiatric medical and cultural traditional treatment methods was 985 (82% of the sample). Nonpsychiatric medical management techniques used by the patients (530, 53.8%) included medical treatment and investigations advised by general practitioners in primary healthcare units (231 patients, 43.5%), internal medicine (123, 23.2%), pediatric services (101, 19.1%), neurosurgery (25, 4.8%), and others including emergency room services (50, 9.4%). Nonpsychiatric cultural traditional interventions (455 patients, 46.2%) included following the Holy Koran (274 patients, 60.2%), using herbs and plants (91, 20%), Hegab (written words on a piece of paper, 55, 12.1%), Hegama (23, 5.4%), and physical interactions (12, 2.3%). The rate of referral of these patients from nonpsychiatric to psychiatric attention was limited (119 patients, 12%).

Conclusion

Our results highlighted the need to enhance communication between psychiatrists and providers of nonpsychiatric care to psychiatric patients.

Keywords:

Egypt, Minia governorate, nonpsychiatric management

Egypt J Psychiatr 34:128–133
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1110-1105

Introduction

In our country, psychiatric diagnosis started very early in time. Pharaonic medicine considered psychiatric disease as a medical problem needing a physician's service. A case of senile dementia was reported on a papyrus in 1500 BC – that is, earlier than the Hippocrates doctrine. A case of hysteria was also reported on a Kahun papyrus (Shaheen and Rakhaw, 1971). These disorders carried no stigma, as in those days there was no demarcation between psyche and soma (Okasha, 2001). Egypt is currently suffering from serious problems such as illiteracy (especially among women), lack of job opportunities (especially for young people), and slow economic growth because of loss of traditional economies, low productivity, and lack of innovation and competitiveness (Okasha, 2004). Despite the rapid social change in Egypt,

the majority of people, especially in rural areas, belong to an extended family hierarchy. It is considered shameful to care for psychiatric patients away from family surroundings. Traditional and religious healers have a major role in primary psychiatric care in Egypt (Okasha, 1966). At any time, almost half of the patients consulting traditional religious healers in an Egyptian rural community have diagnosable psychiatric disorders. In contrast, many psychiatric patients tend to seek nonpsychiatric medical help, particularly those with minor neurotic and psychosomatic symptoms (El-Amin and Refaat, 1997).

Participants and methods

The population of the sample was recruited from the Psychiatry and Neurology outpatient clinic of Minia

University Hospital during the period from 1 March 2011 to 31 August 2011. The total number of patients who attended the clinic during these 6 months was 1791, ranging between 285 and 312 patients per month (mean \pm SD = 298.5 \pm 9.81). The age range of the patients was 6–70 years; patients belonging to both genders, whether referred or visiting on their own, with a diagnosis of any psychiatric disorder based on the Diagnostic Research Criteria of the ICD-10 were included. Patient's consent to participate in the study procedures was a prerequisite.

Patients who came with neurological disorders including epilepsy ($n = 542$, 30.8% of the primary sample) or who were referred to other departments of the hospital (68 patients, 3.7% of the primary sample), as well as those who refused to participate in the study procedures (47 patients, 2.5% of the primary sample), were excluded from the final study sample.

The final studied sample included 1134 patients who had had psychiatric manifestations (secondary sample). The results of the study are confined to this secondary sample with psychiatric illness. Patients were interviewed by the researchers after explaining the purpose of the study and after obtaining their consent to participate. Interviews were carried out in an open-ended manner to assess patients' awareness of psychiatric services, treatment-seeking behavior, and experiences with traditional or religious healers. Special emphasis was placed on their current reasons for seeking psychiatric help.

Diagnosis was carried out according to the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems, Diagnostic Criteria for Research (ICD-10) (World Health Organization, 1993). The criteria for each patient were revised independently by the research team members to reach a consensus on diagnosis. However, the diagnoses of 27 patients were still deferred after revision and joint discussion (2.4% of the secondary sample).

The total secondary sample was divided into two groups:

Group A consisted of patients who were referred by nonpsychiatric medical or traditional providers and/or had a history of previous nonpsychiatric care ($n = 895$, 87% of the secondary sample).

Group B consisted of patients who came for psychiatric help without a history of seeking nonpsychiatric management ($n = 149$, 13% of the secondary sample).

Statistical methods

The data were collected, checked, and finally analyzed using SPSS (version 20; SPSS Inc., Chicago, Illinois, USA). Descriptive statistics were used to determine the demographic and clinical variables. The tests used were the χ^2 -test, the unpaired t -test, and the Mann-Whitney test, where appropriate. Pearson's correlation coefficient was used to find different correlations between the studied variables. A P -value of less than 0.05 was considered statistically significant.

Results

Sociodemographic characteristics

The sample consisted of 1134 patients, of whom 638 (56.2%) were men and 496 (43.8%) were women. Thirty-eight percent of the patients belonged to the age group of 18–30 years, whereas 27.3% were in the age group of 31–40 years. The age group below 18 years was the least in number (96 patients, 8.4% of the sample).

Forty-two percent of the patients were single. A total of 827 (72.9% of the sample) patients came from rural areas, whereas the rest of the patients were urban. Illiteracy and unemployment were prevalent in our sample (56 and 46%, respectively) (Table 1).

Patient diagnoses

The most common diagnoses included in our sample were neurotic, stress-related, and somatoform disorders (58.3%), followed by schizophrenia and related disorders (15.2%). Mental and behavioral disorders due to psychoactive substance use (1.3%) were the least prevalent. In 2.3% of the cases, the diagnosis was deferred (Table 2). The duration of psychiatric illness ranged from 2 days to 9 years (Table 3).

Treatment seeking as a first contact and reasons

A total of 530 patients (53.8%) consulted nonpsychiatric physicians and 455 patients (46.2%) consulted nonpsychiatric traditional healers as their first contact before coming to our clinic. In contrast, 149 patients (13.2%) attended our outpatient psychiatric clinic as their first contact. Of the group of patients who sought nonpsychiatric care, general practitioners were chosen by 231 patients (43.5%), followed by internal medicine (123 patients, 23.2%), pediatric services (101 patients, 19.1%), emergency room services (50 patients, 9.4%), and neurosurgical services (25 patients, 4.8%; Table 4).

As regards the nonpsychiatric traditional care techniques, the majority of patients in this sector (274, 60.4%) reported following the Holy Koran for treatment, followed by use of herbs and plants (91 patients, 20%), Hegab (55 patients, 12.1%), Hegama (23 patients, 5.4%), and finally physical methods (12 patients, 2.5%).

The most important reason for choosing nonpsychiatric therapeutic services was easy accessibility (34.3% of the patients; Table 5).

Psychiatric care was selected as a first contact for reasons such as visiting the specialist (64.4%), recommendation by someone else and belief system (20.1%), and popularity of the service or its providers (15.5%; Table 6). The reasons for seeking psychiatric help after consulting nonpsychiatric care providers were progression of symptoms (58.9%), non-improvement of symptoms (15.2%), recurrence of symptoms (13.9%), and finally referral (12%; Table 7).

Discussion

Information about culture and tradition and the treatment-seeking behavior of psychiatric patients could

Table 1 The relationship between age, gender, and marital status and the selected type of management

Variables	Number (n=1134)	TH [n (%)]	NPP [n (%)]	PP [n (%)]	P-value
Age (years)					NS
<18	96	62 (64.5)	32 (33.1)	2 (2.4)	
18–30	432	232 (53.7)	188 (43.5)	12 (2.8)	
31–40	310	85 (27.5)	102 (32.9)	123 (39.6)	
41–50	197	73 (35.5)	113 (58.3)	11 (6.2)	
>50	99	9 (9)	89 (89.8)	1 (1.2)	
Gender					0.001**
Male	638	353 (55.3)	161 (25.2)	124 (19.5)	
Female	496	102 (20.5)	369 (74.3)	25 (5.2)	
Marital status					0.05*
Single	484	255 (52.6)	150 (30.1)	84 (17.3)	
Married	463	117 (25.2)	298 (64.4)	48 (10.4)	
Divorced	86	21 (24.4)	58 (67.4)	7 (8.2)	
Widow	101	67 (53.4)	24 (23.7)	10 (22.9)	

NPP, nonpsychiatric physician; PP, psychiatric physician; TH, traditional healers.

*Statistically significant.

**Highly statistically significant.

Table 2 The relationship between residence, occupation and the selected type of management

Variables	Number (n=1134)	TH [n (%)]	NPP [n (%)]	PP [n (%)]	P-value
Residence					NS
Rural	827	404 (48.8)	411 (49.7)	12 (1.5)	
Urban	307	51 (17.3)	119 (38.1)	137 (44.6)	
Occupation					NS
Unemployed	637	312 (48.9)	323 (50.7)	2 (0.4)	
Part-time work	269	123 (45.7)	134 (49.8)	12 (4.5)	
Full-time work	228	20 (8.7)	73 (32.1)	135 (59.2)	
Education level					NS
Illiterate	523	267 (51.5)	232 (44.3)	24 (4.2)	
Can read and write	279	120 (43.1)	141 (50.5)	18 (6.4)	
Scholastic education	232	59 (25.4)	129 (55.6)	44 (19)	
Higher education	100	9 (9)	28 (28)	63 (63)	

NPP, nonpsychiatric physician; PP, psychiatric physician; TH, traditional healers.

Table 3 The relationship between patient diagnoses according to ICD-10 and the selected type of management

Diagnoses	Number (n=1134)	TH [n (%)]	NPP [n (%)]	PP [n (%)]	P-value
F42.1 generalized anxiety disorder	51	10 (19.7)	19 (37.2)	22 (43.1)	NS
F41.0 panic disorder	170	52 (30.5)	115 (67.4)	3 (1.7)	NS
F42 obsessive-compulsive disorder	126	89 (70.3)	30 (23.8)	7 (5.5)	NS
F43.1 posttraumatic stress disorder	18	8 (44.5)	1 (5.5)	9 (50)	NS
F45.0 somatization disorder	198	9 (4.5)	188 (94.9)	1 (0.6)	NS
F44 dissociative (conversion) disorder	99	79 (79.7)	19 (19.1)	1 (1.2)	0.01**
F32 depressive episode	82	20 (24.3)	25 (30.4)	37 (45.1)	NS
F30 manic episode	27	9 (33.3)	3 (11.1)	15 (55.6)	0.05*
F20 schizophrenia	100	50 (50)	25 (25)	25 (25)	NS
F23 acute and transient psychotic disorder	73	59 (80.8)	1 (1.3)	13 (17.9)	NS
F00–F09 organic, including symptomatic and mental disorders	60	22 (36.6)	32 (53.3)	6 (10.1)	NS
F66.2 sexual relationship disorder	48	34 (70.8)	14 (29.2)	0 (0)	NS
F20 mental retardation	22	6 (23)	12 (54.5)	4 (22.5)	NS
F90 hyperkinetic disorder	18	4 (22.2)	12 (66.6)	2 (11.2)	NS
F10–F19 mental and behavioral disorder caused by psychoactive substance use	15	2 (13.3)	10 (66.6)	3 (20.1)	NS
Diagnosis was deferred	27	2 (7.4)	24 (88.8)	1 (3.8)	NS
Total	1134	455 (40.1)	530 (46.7)	149 (13.2)	

NPP, nonpsychiatric physician; PP, psychiatric physician; TH, traditional healers.

*Statistically significant.

**Highly statistically significant.

reflect the status of knowledge and attitudes toward mental illness. According to Dien (1998), each culture provides its members with ways of explaining mental illness. He added that, in the west, emphasis is placed on psychological factors, life events, and effects of stress, but in many parts of the east explanation of mental illness takes into account wider social and religious factors.

The majority of our patients (86.8%) were treated by nonpsychiatric medical and traditional services before they sought psychiatric care. This finding is concordant with that reported by El-defrawy *et al.* (2000), who reported that 77.5% of psychiatric patients in Ismailia, Egypt, had attended nonpsychiatric care providers as a first step in seeking help. A possible explanation for this

Table 4 Duration of current illness when seeking outpatient psychiatric treatment

Duration of illness (months)	n (%)
< 1 month	453 (39.9)
1–6 months	283 (24.9)
7–12 months	204 (17.8)
> 12 months	194 (17.4)

Duration of illness: 2 days to 9 years; median = 1 year.

Table 5 Patients' reasons for going to nonpsychiatric physicians and traditional healers first (n = 985)

Reasons	n (%)
Easy accessibility	338 (34.3)
Recommendation by someone and belief systems	242 (24.5)
Popularity of care providers and the effect of media	205 (20.8)
Fear of stigma associated with psychiatric services	200 (20.4)
Total	985 (100)

Table 6 Patients' reasons for attending psychiatric services as a first visit (n = 149)

Reasons	n (%)
Being a specialist	96 (64.4)
Recommendation by someone else and belief system	30 (20.1)
Popularity of care providers and the effect of media	23 (15.5)
Total	149 (100)

Table 7 Patients' reasons for attending psychiatric outpatient clinics after consulting nonpsychiatric services (n = 985)

Reasons	n (%)
Symptom progression	581 (58.9)
Symptoms did not change	148 (15.2)
Symptom recurrence after improvement	137 (13.9)
Referral by nonpsychiatric care providers	119 (12)
Total	985 (100)

finding could be that traditional and nonpsychiatric medical care providers offer a culturally accepted explanation more often than do psychiatric care providers who rely on medications and/or investigation (Patel *et al.*, 1997). According to Rakhawy (1996), most psychiatrists rarely encountered a patient who did not consult, in one way or another, a traditional healer.

In the present study, a large proportion of our patients with psychiatric problems had consulted nonpsychiatric medical care providers as the first contact for their problems (46.1%). This finding was in agreement with the work of Nagpal *et al.* (2011), who found that 44% of their patients had first chosen nonpsychiatric physicians for relief from their symptoms. General practitioners remain an important resource of help for psychiatric patients in our study. They represent 43.5% of nonpsychiatric healthcare providers attended by patients of the study. This finding is consistent with the figure reported by Richared *et al.* (2005), who found that about 40% of their patients first sought care from a doctor, usually a general practitioner.

Forty-one percent of the patients in our study consulted the nonpsychiatric traditional healers first. This result is

similar to that reported by Razali and Mohd Yasin (2008). They stated that 44.2% of their patient sample with mental illness in Malay (Singapore) consulted traditional healers as the first contact. Our findings showed that many psychiatric patients consulted sheikhs or other local religious figures for treatment of mental illnesses. This finding could be explained on the grounds that, in Arabic countries, social and religious beliefs have a powerful influence that is stronger than civilization. Patients who go to sheikhs believe that their symptoms are due to evil spirits or a jinn and that sheikhs may be able to cure them by controlling the jinn and forcing it to leave their bodies. This also could explain why the majority of patients who sought help from traditional healers were treated by following the prescriptions in the Koran (60.2%).

Psychiatric services were chosen as the first step in seeking help by 13.2% of our patients. Our finding is comparable to that of Chong *et al.* (2012), who reported that 15.7% of the patients with mental illnesses in the multiethnic Asian population in Singapore had sought help from psychiatric healthcare providers from the beginning of onset.

Factors affecting health-seeking behavior: we do not have an exact explanation for the selective tendency to choose a psychiatrist or a nonpsychiatric physician to begin with, but a probable one could be that, if the health problem was conceptualized in physical terms, medical services would be sought; however, if the problem was conceptualized in emotional or psychological terms, traditional healers would be consulted (Tables 8 and 9). This probable explanation is partially supported by the results of the study on immigrant Chinese-American women suffering from major depression (Ying, 1990).

In our study female patients were significantly more prevalent than male patients in the group that sought help from nonpsychiatric medical care providers (369, 74.3%, $P = 0.001$). This finding has been supported by many studies. The Australian National Survey of Mental Health and Wellbeing found that being female was associated with the use of healthcare services and female patients were also more likely than male patients to use services provided by other healthcare professionals rather than by mental healthcare professionals (Parslow and Jorm, 2000); Leaf and Livingston Bruce (1987) similarly found that women were more likely to consult general practitioners but not psychiatrists or psychologists. In addition, Chong *et al.* (2012) found that the women in their sample were more likely to seek help from professionals who were not in the mental healthcare sector but in the medical sector.

Marital status also contributed to the predilection to take on a more active help-seeking role. Single patients in our study were more likely to seek help from nonpsychiatric traditional healers than were married, divorced, and widowed patients ($P = 0.05$). Thus, being female and being single were associated with higher rates of seeking nonpsychiatric traditional and medical care.

Table 8 Types of reported nonpsychiatric traditional management (n=455)

Traditional managements	n (%)
Holy Koran	274 (60.2)
Plants and herbs	91 (20)
Hegab	55 (12.1)
Hegama	23 (5.4)
Physical methods (including Zar and beating)	12 (2.3)
Total	455 (100)

Table 9 Types of reported nonpsychiatric medical services (n=530)

Nonpsychiatric medical services	n (%)
General practitioners	231 (43.5)
Internal medicine	123 (23.2)
Pediatrics	101 (19.1)
Emergency room	50 (9.4)
Neurosurgery	25 (4.8)
Total	530 (100)

This finding could be explained by the fear of stigma associated with mental illness. Female patients, especially those single, would fear that their chances of getting married might be threatened if they were known to have a psychiatric illness and to have attended psychiatric care services. In contrast, in our native culture of upper Egypt it is not very stigmatizing to be a victim of envy, witchcraft, or a Jinn. Two-hundred patients (20.4%) of our sample reported that fear of stigma was the reason for not consulting psychiatric providers. This is in concordance with the results of Kenneth *et al.* (1996), who suggested that little was known about alternative routes to recovery from mental illnesses because stigma on mental treatment continued to be a substantial barrier for seeking treatment. They reported that fear of what others might think was a common barrier.

We found no other sociodemographic correlates (including place of residence and education levels) with seeking help from nonpsychiatric traditional and medical care providers. This finding is in agreement with the results previously reported by Kua *et al.* (1993).

People may tolerate many psychological symptoms for some time without seeking psychiatric help until it causes distress and impairment in their relationship or work (Galbaud Du Fort *et al.*, 1999). This seems to be the case in our study, as we found a significant association between help seeking and the type and severity of the presenting symptoms or psychiatric condition. Those presenting with manic episodes were significantly more likely to seek psychiatric help from the start rather than visiting nonpsychiatric care providers ($P = 0.05$). In contrast, a significant proportion of patients presenting with dissociation (conversion) disorders started with visiting traditional healers rather than psychiatric and nonpsychiatric physicians ($P = 0.01$).

In the present study, only 119 (12%) of the 985 patients seeking psychiatric help after nonpsychiatric services were referred to psychiatric attention. This finding

suggests that the tendency of nonpsychiatric care providers to consult or refer psychiatric patients to psychiatrists is inadequate. This inadequacy of referral may be partially because of insufficient recognition of psychiatric disorders by general practitioners in primary care units (Blacker and Clare, 1987). In contrast, the psychiatrists' attitude, in general, may tend to devalue, warn, and/or condemn all such nonpsychiatric consultations (Rakhawy, 1996). Psychiatrists tend to view traditional healers and their practices as being distinctly unhelpful (Parker *et al.*, 2000). This conservative attitude of psychiatrists may be one reason for the lack of communication between nonpsychiatrist care providers and psychiatrists and the low rates of referral of psychiatric patients to psychiatric care.

Conclusion

The majority of people with mental illness in Minia governorate tend to seek nonpsychiatric services as a first step in seeking help. Nonpsychiatric medical care was found to be provided mostly by general practitioners, whereas sheikhs were the most common nonpsychiatric traditional service providers. Female gender, being single, and suffering from dissociation (conversion) were significantly associated with seeking help from nonpsychiatric traditional healers. Having a manic episode was significantly associated with seeking psychiatric care at first contact. The rate of referral of psychiatric patients to psychiatric services seems to be inadequate.

Recommendations

- (1) To closely identify our social and cultural norms and tendencies and their effect on healthcare-seeking behavior.
- (2) To update and review the current undergraduate and postgraduate courses in different departments of the Faculty of Medicine to equip graduates with the necessary knowledge and drive to identify and refer psychiatric patients.
- (3) To establish communication with nonpsychiatric medical and traditional care providers. Community healthcare providers should be encouraged to have knowledge, skills, and the ability to detect, manage, or refer those with mental illness to specialists whenever indicated.

Limitations

- (1) The image of psychiatry in the minds of patients and their expectations and impressions about psychiatrists and psychiatric services were not explored in this study.
- (2) The attitudes and opinions of nonpsychiatric medical care providers toward psychiatry and psychiatric practice were not directly approached in the study design.

- (3) The use of traditional cultural interventions among patients with medical illness in the same culture was not studied, and thus a comparison could not be made between the attitudes of psychiatric patients and those of medical patients regarding this issue.
- (4) The reported rate of referral was relatively low; however, some psychiatric patients may have been referred by nonpsychiatric physicians or traditional healers and they may have refused to comply with the advice of seeking psychiatric help.

Acknowledgements

Conflicts of interest

There are no conflicts of interest.

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