An-Najah National University

Faculty of Graduate Studies

SELF-REPORTED CAUSES OF MENTAL ILLNESS AND THEIR ASSOCIATION WITH PATHWAYS TO HEALTHCARE AMONG PEOPLE WITH PSYCHOLOGICAL DISORDERS IN PALESTINE

By
Zaynab Hinnawi

Supervisors
Dr. Fayez Mahamid
Dr. Samah Jabr

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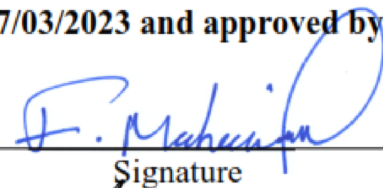
Dr. Fawaz Aqel
Supervisor


Signature

Dr. Sameh Jaber
Co-Supervisor

Signature

Dr. Wael Abu-Alhasan
External Examiner

Signature

Dr. Mohammad Merie
Internal Examiner

Signature

Dedication

I would like to dedicate this thesis to my parents, Sameera Salameh and Saher Hinnawi, who passed away when I was a child. You are in my heart… I will be always longing for our eternal reunion someday….

Zaynab Hinnawi

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There are number of people to whom I owe thanks for encouraging or helping me with my Master degree study in general, my thesis in particular.

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Declaration

I, the undersigned, declare that I submitted the thesis entitled:

SELF-REPORTED CAUSES OF MENTAL ILLNESS AND THEIR ASSOCIATION WITH PATHWAYS TO HEALTHCARE AMONG PEOPLE WITH PSYCHOLOGICAL DISORDERS IN PALESTINE

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: **Zaynab Hinnawi**

Signature: Zaynab Hinnawi

Date: **20123/03/27**

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Abstract

Background: Mental illness affects every segment of population, in every country including Palestine. The beliefs held by patients regarding the causes of mental illness impact their treatment-seeking behavior. No doubt that understanding the context of the beliefs held by the patients and their family members with respect to the causation and treatment of various psychiatric disorders may help seeking behavior of mentally ill subjects and their adherence to treatment.

Previous studies revealed many different attributions stated by mentally-ill people. Those attributions were relevant to the culture they belong to. The aim of this study was to find out the attributions of the Palestinian patients, and the pathways followed by them to seek healthcare.

Methodology: The sample of this study consisted of thirty-one stable patients who attend private clinics. The participants were with different diagnoses, and from different cities of the West Bank in addition to Jerusalem. Semi-structured interviews using an adapted version of the McGill illness Narrative interview were conducted in order to illicit illness narratives.

Results: The findings of this study showed three main attributions: supranatural, psychosocial, and biomedical causes. Participants sought help through two main pathways; psychiatrists and sheikhs. Other pathways were followed but with less countable frequency.

Conclusion: An important number of patients attribute their psychiatric symptoms to supranatural causes. In regard to help-seeking behaviors, many patients seek help from nonmedical pathways.

Keywords: Mental health; Attribution theory; Supranatural causes; Psychosocial causes; Biomedical causes; Treatment pathways; Psychiatrists, Sheikhs.

Chapter One
Introduction and Theoretical Background

1.1 Mental illness in Palestine

Mental illness affects every segment of the population, in every country including Palestine. Previously, there were very few reliable mental health data, such as incidence and prevalence, for Palestine (Road et al., 2006), however, in the past few years, many studies were conducted resulting in a clearer overview of mental health statistics in Palestine.

Mental health disorders may be considered one of the largest – and least acknowledged health problems in the occupied Palestinian territory (OPT). Around a third of Palestinians need mental health interventions, yet mental health services are among the most under-resourced areas of health provision (Afana et al., 2004). Compared to the global level, nearly all Eastern Mediterranean Region countries had a higher mental disorder burden. Among those countries, Palestine had the largest burden of mental disorders (Charara et al., 2017). In Gaza, based on WHO projections of mental disorders in populations affected by emergencies, it is estimated that, approximately 10,400 people will have severe mental health problems and 41,700 will have mild to moderate problems requiring MHPSS (Child Protection Working Group, 2019). In 2019 the Lancet medical journal published the WHO's paper which declaring that 22% of people living in conflict areas have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia (Boseley, 2019). In Palestine, this means that more than 250,000 individuals require essential mental health and psychosocial interventions (WHO, 2020).

To make a closer look at the prevalence of mental disorders among youths, a representative household survey of 2481 Palestinian youth was conducted in 2014, showed that the proportion of elevated symptoms of global distress (46%), depression (55%), and (37%) anxiety was high (Wagner et al., 2020). Another study that targeted Palestinian youths conducted by Médecins du Monde Switzerland in 2019 found that young Palestinians aged 16 to 25 years were at highest risk of self-harm, accounting for 52% of all cases of attempted suicide (WHO, 2020).

Talking about which disorders are more prevalent in Palestine, Canetti et al., (2014) estimated the expected population prevalence of post-conflict PTSD and major depression to be close to 30% for Palestinians in the West Bank and Gaza. And due to the continuous exposure to political violence, prolonged displacement, and other limitation on professional, educational, financial opportunities, and mental health services, Palestinians are particularly at a higher risk for developing anxiety disorders and PTSD (Marie, SaadAdeen, et al., 2020). According to the Palestinian Health Information Center (PHIC 2016), schizophrenia was the highest in the treatment with 30,008 cases, and the third-highest incidence rate for newly reported cases in the West Bank (Marie, Shaabna, et al., 2020). Another Research suggested that upwards of 40% of Palestinians suffer from depression. The same study found that 54% of boys and 46.5% of girls ages 6-12 had emotional or behavioral disorders (Brady, 2020). Knowing that the overall Palestinian population is predominantly young: nearly 40% of Palestinians are aged 0–14 years (WHO, 2020), those numbers are crucial.

1.2 Stigma and help-seeking

Previous mentioned numbers are significant; however, it is suggested that the extent of mental illness is being under-reported, because of the stigma which follows mentally ill people, who tend to present their psychological distress in the form of physical symptoms such as colic, headaches and back pain (Afana et al., 2004). One of the important barriers to mental health service utilization, research found out, is stigma towards, and discrimination against people with mental disorders. It contributes to delays in seeking care, obstructs timely diagnosis and treatment for mental disorders, clogs recovery and rehabilitation, and ultimately reduces the opportunity for patients to fully participate in life (Shidhaye & Kermode, 2013). Moreover, societal rejection stemmed from stigma results in retracted self-esteem, fear of endeavoring one's goals, and deprivation of social opportunities (Corrigan, 1998).

One of the most important negative properties of stigma that pursues people with mental issues is lessened health care seeking behavior (Rüsch et al., 2005). That includes whether persons with mental illness, like depression, will seek treatment, what kind of treatment

they will seek, and whether they will abide by certain treatment protocols (Nieuwsma et al., 2011). For example, ex-detainees may avoid seeking mental health treatment because of the belief that potential stigma would undermine the public view of them as heroes (Jabr, S., Morse, M., Awidi, B., & Berger, 2014). Not surprisingly, the frequency of help-seeking is low, although mental illness rates are high, especially among those from lower socioeconomic backgrounds (Ibrahim et al., 2019).

The way in which people represent mental disorders affects their behavior (Mehta & Farina, 1997), including of course help seeking behavior. That behavior is affected by Beliefs and attitudes of individuals suffering from mental disorders towards various sociocultural and environmental factors relevant to these disorders (Balhara & Yadav, 2012), and also impacted by the community's beliefs about the causes of mental illness (Boldero & Fallon, 1995; Jenkins et al., 2013; Muga & Jenkins, 2008; Musyimi et al., 2016). So, it is believed that the perception of the cause of distress is one of the Determinants of help-seeking recommendations, which are highly affected by both social network's attitudes and beliefs of the person suffering from mental distress, and the person's attitude (M. Angermeyer et al., 1999).

Conrad & Pacquiao (2005) stated that religion, family solidarity, age, and gender make up the context for thoughts and behaviors associated with expression, attribution, and meanings of mental illness. Furthermore, somatic expression and attitudes of denial of illness by mentally ill patients and family members are conditioned by stigma. In India, for example, people believe that diet, possession, smoking cannabis, and traumatic shock are different causes of madness, which they describe by talking insanely or behaving in a hostile, aggressive manner. people seek help from magico-religious healers, homeopaths, and allopaths.

This belief in evil spirits and stigma of mental health problems affect the acceptance of help with mental health issues, and commitment to services in developing countries (Ndetei et al., 2011). Hence, people seek help from faith healers as a first step as a management of their mental disorder which leads to under-reporting of the extent of

mental illness (Zafar et al., 2008). Therefore, the mindset that leads people to do so should be more investigated in the following section.

1.3 Irrational thinking and its roots

Cultural and religious backgrounds significantly influence the way people interact with mental illnesses (Guthrie et al., 2016). Religion – as part of culture - plays a key role in the understanding, cause and treatment of mental illness and mental illness-like symptoms (Ally & Laher, 2008). That created misconceptions about mental health held by many people, e.g. believing that mental illness is due to moral failures such as insufficient religious faith (Jabr, S., Morse, M., Awidi, B., & Berger, 2014).

Cultural interpretation of mental illness symptoms is changeable, differ from belief in evil, to poisoning, to magic or even posession (World Psychiatric Association, 2010). others may attribute thoses symptoms to mental shock, and unhappiness with the spouse, stressful life events, drug use, personal traits and heredity (Chowdhury et al., 2001; Kadri et al., 2004). Palestinians, for example, have their own traditional explanations for mental disorders. They believe that possession by supernatural forces is the cause of mental illness. This belief has religious roots and can't be explained by psychiatric or psychological terms (Afana et al., 2004).

Beliefs in evil, jinn and witchcraft are prevalent, especially among less educate and older individuals, higher prevalence is noticed among women who were less educated (Ahmad, 2016). Some Muslim communities believe that mental illness is caused by possession by jinn, which are supernatural entities (Ally & Laher, 2008), hallucinations and other psychotic symptoms in particular (Lim et al., 2014). They may explain it that way, in the absence of outward physical signs of those illnesses (Islam & Campbell, 2014). Not only madness is directly linked to spirit possession, in these religious and philosophical texts, but also many symptoms that we associate with mental illness, such as depression, self-harm, disinhibition, homicidal thoughts, delusions and mania (Islam & Campbell, 2014).

In order to investigate how often Muslim patients attributed their mental health problems to jinn, a study was conducted in Netherlands that resulted in the following: 43% were

positive that their psychiatric symptoms were caused by jinn, 27% refused that thought, and 31% were in doubt (Lim et al., 2018). Earlier, a clinical population of psychotic patients was investigated of this attribution model, resulted in 80% (Blom et al., 2010). That attribution affects the diagnosis, treatment, and the pathway in which biomedical practitioners consider psychiatric disorders (Lim et al., 2014). This attribution was well constructed that no considerable difference in its pattern of endorsement was made by neither religious denomination nor educational status (Ikwuka et al., 2014).

To understand more the religious role, it is worth mentioning that treatments in South Africa for example, were based within religious doctrine, despite the fact that causes of mental illness were believed as originating from dualistic points; spiritual and biological (Ally & Laher, 2008).

On the other hand, Islamic medicine used to treat mental illness as a somatic illness, most patients sought treatment in both the spiritual realm as well as the medical. They sought amulets, charms, and perfumed, as well as massage, baths, bloodletting, cupping, music and drug therapies such as emetics, purgatives and opium (Dols, 1987).

In the area of Islamic perspective about mental health, Muhammad Liwaudeen Ahmad (2016) carried out a case study, in which he treated a 45-year-old lady from Ghana, who showed psychiatric symptoms and didn't get any benefit from Psychiatrists, by conducting the Ruqyah therapy (method for healing by recitation of Qur`an, seeking of refuge in Allah (SWT), remembrance and supplications) for a couple of weeks. Assuming that she was under the influence of Jinn, an entity which has its affects when it reacts with Humans. From this case study and based on Islamic evidences, he concluded that the Jinn possession and its disorders cannot be denied, and Ruqya is its remedy. But belief in such supernatural beings should not prevent people from seeking help from medical professionals. Mental health professionals should be aware of the explanatory models adopted by their patients (Ahmad, 2016).

In an opposing opinion, Dr. Tariq Sweidan, one of the most prominent Islamic thinkers, denies the existence of any effect of jinn or magic on humans, and says that this is one of the misconceptions that are inserted in people's minds in the name of religion, and that

God says that Jinn has no authority over believers nor infidels, except in whispering in their minds (Sweidan, 2022). A thematic analysis which was carried out on the Qur'an to explore if the connection between jinn-possession and insanity exists, showed no correlation. (Islam & Campbell, 2014)

In Christianity, people believe that immorality and sinfulness result in mental illness, which has spiritual causes and treatments (Wesselmann et al., 2015). That notion of sin prevalent in American Christianity leads to blaming attributions toward mental illness, especially in more conservative groups (Dain, 1992). But it is found in the scripture of both the Christians and Jews that there is a direct linkage between madness and spirit possession (Islam & Campbell, 2014). However, people of any religion faith or no faith at all can embrace the belief in possession (Guthrie et al., 2016).

Mental distress association solely with demonic origins – among other causes - seemed to create a climate of shame and stigma (Lloyd, 2021). Also blame is generated from the idea that through lack of faith and sin, the person let the devil possess his soul (Islam & Campbell, 2014). Sufferer's weakness and sinful life, some Muslims believe, to bring mental illness caused by metaphysical forces like jinn (Ally & Laher, 2008).

Such feelings (blame and shame) are important to be addressed because they affect patients attitude towards treatment; a study conducted among migrant British Muslims of South Asian origin showed that shame was a considerable predictor that patients are not willing to seek professional mental healthcare (Pilkington et al., 2012). Shame and stigma, other studies showed, lead to failure of Muslims to seek mental healthcare treatment, or to significantly underutilize that-much needed services (Cinnirella & Loewenthal, 1999; Haque, 2004; RETHINK, 2007; Weatherhead & Daiches, 2010; Youssef & Deane, 2006).

Stigma and religious belief in suffering, underlain by the concept of karma, as a natural consequence of past deeds, were made the barriers to early recognition and treatment of symptoms, diagnosis of the main problem, and adherence with prescribed treatment (Conrad & Pacquiao, 2005). Stoicism is believed to be important in the face of illness in many cultures, so good Muslims should embrace this kind of fatalism, accept God's will,

and don’t seek treatment (Islam & Campbell, 2014). Sometimes, persons with mental illness are discouraged from taking their psychiatric medications by members of religious communities, and instead asked to seek treatment that favors scripture study and payer (Malony, 1998; M. S. Stanford, 2007).

1.4 Pathways to treatment choices

Delays in professional medical treatment and seeking variable treatment modalities are affected by these beliefs about the causation of some mental disorders, and therefore the outcome of those illnesses is altered (Jorm et al., 1997). As a measurement of help seeking behavior, researches were conducted to measure lost time before initiation of treatment at a psychiatric department or clinic, after the onset or first symptom of mental illness manifested, the delay in treatment is labelled as Duration of Untreated mental illness (DUM). If the disease is not recognized, fundamental amount of time is lost (H. Naqvi et al., 2009; Nishio et al., 2018). A common cause of delay was unawareness about the mental illness, it’s causes and treatment (Hasan & Musleh, 2017; Nallapaneni, 2015).

Family doctors were the initial destination to be addressed to seek help in many cases, other prominent components of care pathways were emergency rooms in hospitals (H. Naqvi et al., 2009). Those community and general practitioners refer to specialized mental health services, but other pathways like referral from native faith healers are also frequent (Saeed et al., 2000). Those faith healers were the initial help-seeking destination in some comuniteies because of the cultural beleifs of black magic, evil eye, etc., as a causative factor of mental illness (H. A. Naqvi et al., 2009).

In Pakistan, for example, psychiatrists featured prominently as initial care providers in the pathway to care. 43% of patients were initially taken to psychiatrists in the first attempt at help-seeking. After the initial consultation, 45% were prescribed psychotropic drugs while 7% were admitted to hospital (H. Naqvi et al., 2009).

Mentally ill patients differ in their tendency to the treatmets they are seeking. In western contexts, people attribute their mental illness to biological causes, and increasingly seek medicines (Ikwuka et al., 2014; Muga & Jenkins, 2008; Samouilhan & Seabi, 2010).

While in other communities people consider the psychiatric treatments (antipsychotics, antidepressants, admission to psychiatric hospitals and electroconvulsive therapy) as harmful and less helpful than other treatments such as vitamins and minerals and special diets (Jorm et al., 1997). But the treatment will be rated as unhelpful at all if it was completely unrelated to causal belief people hold (Furnham et al., 2000). Some patients with mental disorders tend to seek professional medical and psychosocial help, as well as to try other different remedies (Mbuthia et al., 2018).

1.5 Role of family members in the help-seeking process

Family members of the mentally ill individuals have a significant role in the option of seeking help, kind of help sought, and adherence to treatment. In some societies, families have little faith in the treatment potential, and therefore they abandon "mad persons" in their families, if the symptoms did not quickly respond to treatment (Chowdhury et al., 2001). Almost always, family members were the first people consulted, and the most influential people in the process of making the decision of help-seeking (Nishio et al., 2018). Research shows that the adherence to treatment in chronic mental patients raise from 55% to 80% when they are accompanied by their family members (Sweeney et al., 1984)

But as we mentioned before, people's interaction with mental illness is affected by culture, studies found out that when people believe that they can relate to the distress source, they seek help from their families, but when they are unable to understand that distress, they seek help from an external source. The interplay between dissatisfaction of family ideals, intergenerational variations in distress understanding and seeking help stigma influence professional help-seeking (Gunputh, 2015). In respect to magico-religious beliefs and supernatural elements, there is a positive correlation between mentally ill individuals and their care givers (Balhara & Yadav, 2012). According to parental attributions, one can predict whether parents will seek treatment for their child or not (Morrissey-Kane & Prinz, 1999). Marked delay in seeking professional help by family members may be a manifestation of the conflict between individual advocacy and traditional family organization and status hierarchy (Conrad & Pacquiao, 2005).

1.6 A problem statement

Since Palestinian patients' attributions of mental illness are not well-researched; we know very little about their manners of help-seeking attitude or their commonly used description of distress. Our study is an exploratory step towards understanding Palestinian patients' attributions associated with mental illness, and factors that prevent or contribute to management of mental disorders. By gathering mental illness-related attributions held by the Palestinian patients, we made it possible to extrapolate aspects of their psychotherapy care which need further reinforcement. Exploring the beliefs Palestinians hold about their illness and pathways to treatment are important steps to facilitating early access to mental health services and improving psychological wellbeing.

1.7 Aims of study

The objective of this qualitative research project is:

1. To explore the ways in which persons with mental disorders (e.g., Bipolar, schizophrenia) perceive their mental health problems with a particular focus on casual attribution.
2. To gain an in-depth understanding of local explanatory models and the ways in which these might be linked to help- and health- seeking behavior as well as the construction of health care pathways and therapeutic pathways.
3. To investigate differences of causal beliefs according to patients' primary diagnoses.

1.8 The importance of study

The importance of this study lies in its objective to explore the causes of mental illness as perceived by the patients themselves and how these attributions influence their pathways to healthcare. By focusing on the patient's perspective, the research addresses a gap in existing studies and offers valuable insights into the lived experiences and beliefs of individuals with mental illness. Furthermore, as there has been a lack of research conducted on this topic in Palestine, this study contributes to the understanding of mental

health within the context of the region and provides a foundation for future interventions and support strategies tailored to the unique needs of the population.

1.9 Attribution theory

Help-seeking behaviors, treatment recommendations, and stigma views towards people with mental illness are affected by causal beliefs (Compton et al., 2006), and there is also a strong correlation between help-seeking behaviors of caregivers regarding supernatural influences and causal role of these influences in mental disorders (Balhara & Yadav, 2012). For example, non-biomedical beliefs about the cause of schizophrenia are held by vast majority of people in Pakistan, and their help-seeking behavior is improper and damaging to schizophrenic patient's health (Zafar et al., 2008). Based on what has been just mentioned, we should investigate the theory that underlies that notion, which is the Attribution theory.

Attribution theory refers to the internal (thought) and external (behavior) process understanding of is beyond our own and others' behaviors. It explains occurrence and defines the cause of the behavior, as well as the outcome of such understanding on their future behavior (Mbuthia et al., 2018; Schmitt, 2015). Weiner defined three dimensions of attribution theory; locus of causality which refers to cause's location (internal or external to the subject), stability which describes whether the cause is stable or temporary, and controllability which refers to whether the cause can be controlled by the individual or not (Weiner, 1985).

Regarding the first dimension, the locus of causality, a person is apt to overvalue the significance of internal causes in case of success to build confidence and pride, and to overvalue the significance of external causes in case of failure to protect the self-esteem. This is called, which is done to defend the ego, "self-serving bias" (Schmitt, 2015). Considering stability, when the causal attribution is viewed to be stable, this implies that the person will be less inclined to believe in the improvement of his problems. Contrary when it's viewed as unstable, in which expectations of successful results will appear (Försterling, 2001). In other words, stability may result in hopelessness and not seeking help, while instability may motivate to work in treatment (Mbuthia et al., 2018). While

controllability dimension discusses whether the situation can be influenced, guided or prevented by the individual personally, then it's considered controllable (Mbuthia et al., 2018). Noticing that the event will elicit blame and responsibility if viewed as controllable (Corrigan, 2000). Conclusions about stable attribution or instable one, depends on how controllable the individual experiences an event or not, it's also conditioned by the individual's perspective about the locus of control, and the way he views the event whether internal or external (Mbuthia et al., 2018).

Mentally ill people are identified to be responsible for causing their disabilities and in control of them (Weiner et al., 1988). There are two paths of attribution- affect- action; the first is whether the causes are considered controllable, this will evoke anger and neglect, the second one is whether the cause in uncontrollable, this will elicit pity and help (Schmidt & Weiner, 1988). Mental health disorders which are perceived to be controllable, and therefore unstable, don't elicit pity and the tendency to offer help, like physical illnesses do (Donaldson et al., 2015). Promoting a biomedical model of mental illness may thought to decrease the stigma and blame towards mentally ill people; while the cause of the illness (biology) may have an internal locus, it remains out of patient's control. But that model gives an impression that mental illness Is stable over time (Ryan, 2008).

Regarding controllability, some patients attribute their madness to devil (uncontrollable cause), and therefore, they free themselves from the burden of responsibility (Islam & Campbell, 2014), while others will seek therapy and commit themselves to it, in order to be in a higher position of controlling (Mbuthia et al., 2018). Considering locus of control, people are likely to frame their difficulty concerning social distress to external forces such as jinn, envy and magic. It is understandable that those people with many psychiatric problems sought help from traditional healers to get rid of malevolent spirit (Al Riyami et al., 2009). On the other hand, the sense of internal locus of control was one of the factors which assisted UK military individuals with Post-traumatic stress disorder to hold in help-seeking behaviors (Murphy et al., 2014).

1.10 Labeling

Another theory that explored understanding the stigma of mental illness is labeling, which suggests that social interactions and media created stereotypes about mental illness at an early age, which - in the case of mental illness - are then internalized and applied to self. According to this theory, a new identity of a "psychiatric patient" and a social status is created for that individual once he or she is diagnosed with mental illness, and that identity excludes the person from daily interactions (Zorba, 2015).

Link (1987) opposed this theory by conducting an experiment in which he manipulated aberrant behavior and label, results showed that – even in the absence of the aberrant behavior - people were likely to stigmatize mentally ill individuals (Link et al., 1987)

1.11 Literature Review

Mentally ill people's attributions of their sickness are not well researched; hence, very little is known about their help-seeking behavior (Mbuthia et al., 2018). More researches were conducted in regard to people's attribution towards mentally ill people. Following is the literature review of the related researches to the topic:

Conrad (2005) found out that expression of symptoms, attribution of illness, help-seeking behaviors, and connections patterns are highly affected by social and cultural context. Stigma and religious beliefs participated in extended denial, difficulty in sharing sentimental problems with professional caregivers, and delay in professional intervention. The hierarchy of the traditional family conflicted with help-seeking behaviors and commitment to treatment. That was thorough interviewing 23 multidisciplinary mental health professionals and review of 20 patients' records retrospectively (Conrad & Pacquiao, 2005).

In investigating the medical literature on Jinn as a clarification model in the context of psychotic disorders, systemic research for 105 scientific texts on Jinn and psychosis was conducted. This research indicated that psychiatric symptoms attribution to jinn is common among Islamic patients, although it is rarely documented in the biomedical

literature. This attribution has an important effect on the diagnosis, treatment and prognosis of the mental illness (Lim et al., 2014).

In an attempt to explore the nature of Muslim community beliefs in Glasgow about a phenomenon such as spirit possession, jinn, and black magic, and to investigate whether such beliefs can be harmful to women's mental health, research was conducted including 23 Muslim women from Glasgow. Among other findings, this research showed that Glasgow Muslim women strongly believe in the idea of 'spirit possession' can cause illness, and that suitable help can be delivered through other ways other than medical services. It also showed that 'lack of fit' between spirit possession language and western medical approach in dealing with mental illness, adversely affected the mental health of some Muslin women. Most participants believed in the validity of this phenomenon, but didn't consider these as poor mental health's main cause, instead assured psychosocial causes. Stigma and concerns to be seen as having weak faith because of seeking medical help, influenced their help-seeking behavior, whether to initially seek help from medical practitioner or from faith healer. Most participants favored a mix of both (Gunson et al., 2019).

In Johannesburg, six Muslim healers were interviewed for the purpose of their perceptions of mental and spiritual illness, regarding their understanding of the distinctions between etiologies and treatment. This study emphasized that those healers can differentiate between mental and spiritual illness, and that Islam has an obvious taxonomy to distinguish illness and their causes. They advise the treatments accordingly (Ally & Laher, 2008).

Child and Adolescent psychiatry and mental health journal has published an article titled by "Attributions and private theories of mental illness among young adults seeking psychiatric treatment in Nairobi: an interpretive phenomenological analysis". In this article, the researchers carried out interviews with ten young adults of ages 18–25 years about their mental health condition for which they were undergoing treatment. The research provided subjective explanations of Kenyan youths' perceptions of their mental illness. Three key themes emerged: psychosocial triggers of distress, biological

conditions and psychopathologies limiting interventions, and subjective views on treatment. Certain aspects of their participants' lives originated from uncontrollable events that shaped their locus of control to be externalized (Mbuthia et al., 2018).

With Regards to Magico-religious and Supernatural Influences on Beliefs, Attitudes and Behavior of Psychiatric Patients and their Care givers, Balhara and Yadav (2012) conducted a study by Applying questionnaires to 100 patients and caregivers seeking consultation at Out-patient Psychiatry Department of a tertiary care multispecialty hospital. The questionnaire inquired into the sample's beliefs in magico-religious and supernatural influences. Additionally, it explored the help seeking behavior of patient based on these attitudes and beliefs. The findings of this study suggest a significant positive correlation between the attitudes and beliefs of care givers and patients about role of magico-religious and supernatural influences in causation of mental disorders. Help seeking from faith healers was found to be correlated (Balhara & Yadav, 2012).

Another research fulfilled in Nigeria, done by Ikwuka et al (2014), aimed to investigate the causal beliefs about schizophrenia, and to determine the extent to which the population makes psychosocial, biological and supernatural attributions. Questionnaires were administered to 200 participants. The results revealed a significant endorsement of supernatural causation, and a significant contributions of old age and female gender to supernatural attribution (Ikwuka et al., 2014).

When Magaard, Schuts and Brutt (2017) asked 678 patients from Germany with different mental disorders about their three most important Causal beliefs about their mental illness, most frequently mentioned answers were Causal beliefs referring to 'problems at work' (47%) and 'problems in social environment' (46%). And 35% of patients indicate causal beliefs related to 'self/internal states' (Magaard et al., 2017).

In order to determine attitude of patients and relatives with respect to magico-religious beliefs and its influence on psychopathology, and to examine the relationship between psychopathology and major sociodemographic variables, Sapkota et al (2017) from Nepal conducted research about Magico-religious Beliefs in Schizophrenia. They applied the supernatural attitude questionnaire for 50 patients with schizophrenia. The results were

68% consulted faith healer and 42% performed religious treatment during the illness period; 60% acknowledged personal belief in sorcery, 58% in ghosts, and 52% in spirit intrusion. And that shows that there is a common belief in the relationship between supernatural influences and mental illness among the relatives of the patients (Sapkota et al., 2017)

For the purpose of investigating the attitudes and perceptions of Baptist clergy towards mental illness, and potential treatments, 168 senior pastors completed the questionnaire. Participants' age, who were all male, ranged from 25 to 72 years. More than half of them held master degree. Three consistent causal factors of mental illness emerged: biological causes (chemical imbalances in the brain and inherited genes), psychosocial causes (social pressure and inconsistent parenting), and spiritual causes (personal sin, lack of faith, Domenic oppression and spiritual poverty). Perceiving the biological cause as the most important. Respondents rated pastoral counselling and medical intervention to be effective in mental illness treatment, in addition to psychotherapy but to a less extent (M. Stanford & Philpott, 2011).

Samouilhan and Seabi (2010) endeavored to investigate beliefs of university students about the causes and treatments of mental illness. A questionnaire was administered to 112 students of a large South African university. The results showed different etiologies for different disorders; stressful events are thought to be the cause of drug abuse and depression, chemical imbalance as causing schizophrenia, and negative social factors as a cause of anorexia nervosa. Almost half of the participants chose professional psychological intervention to be overall top-rated treatment (Samouilhan & Seabi, 2010).

In the examination of attributions of controllability and stability, among other goals, 107 undergraduate students were recruited in a study conducted by Ryan (2007). Results showed that participants tend to believe that mental illnesses are uncontrollable and unstable. But according to biological cause model, Schizophrenia was believed to be controllable, and depression to be stable (Ryan, 2008).

Zafar (2008) conducted a cross-sectional survey in order to investigate the perceptions of schizophrenia's cause, and the following help-seeking behavior in Pakistan. The sample

comprised 404 sample in outpatient departments. A self-administered questionnaire was submitted to the participants. Among the participants, only 30% attributed 'mental illness' as the main cause of psychotic symptoms. A substantial portion of them considered other factors as the primary causes, such as 'God's will' (32.3%), 'superstitious ideas' (33.1%), 'loneliness' (24.8%), and 'unemployment' (19.3%). The report of 'mental illness' as the single most important cause was limited to only 22% of the respondents. Psychiatric consultation was reported by 40% to be the single most important management stride. Other answers included socio-changes and spiritual healing, while some suggested to do nothing (Zafar et al., 2008).

In order to examine explanations of voice-hearing affect public's attitudes, attributions, and intentions towards voice-hearers, an online survey which was submitted to 1004 participants, included vignettes, attribution questionnaire, and behavioral outcome measure. Results of this study indicated identification of mediated pathways between attributions and intention; participants viewed the behaviors of voice-hearers as dangerous, within their responsibility, and linked to more compulsory intentions. These were interposed by feelings of anger, fear and pity (Kingston et al., 2016).

In order to assess the attitudes and beliefs held by mentally ill Christians they encountered on their way to seek counsel from church, as study was carried out through submitting an online survey to 293 participants. Thirty percent of the participants reported negative interaction, which included suggesting that their mental illness was due to individual's personal sins, dealing with mental illness and demon's work as equivalents, and abandonment by church. Another finding was women were significantly more likely to be told to quit their psychiatric medications, given that religious support can play an important role in serious mental illness treatment (M. S. Stanford, 2007).

To explore the correlation attitudes and beliefs of mentally ill patients and their caregivers for role of supernatural and magico-religious influences on mental illness, Balhara (2012) presented a questionnaire to 100 sequential patients and caregivers, who attend psychiatry outpatient department. Results showed that 46% of caregivers believed in supernatural and magico-religious influences, 61% of them had favorable attitudes towards those

influences as cause of mental illness. Care givers' help-seeking behavior with regards to those influences was more strongly correlated with caregivers' attitude towards their causal role in mental illness. This study manifested a positive correlation between attitudes, beliefs and behaviors of psychiatric patients and their caregivers regarding supernatural and magico-religious factors (Balhara & Yadav, 2012).

A cross sectional survey took place in Germany to specify nature and impact of socio-cultural factors on shaping help-seeking behavior. Structured interviews with a presentation of a patient with Depression or Schizophrenia, were carried out with 1564 lay people. Results of this study suggested help-seeking behavior is highly impacted by attitudes and belief systems of the society, both through social network interacting with the person suffering from mental distress, and through individual's attitudes formed in the process of socialization (Angermeyer et al., 1999).

In an attempt to examine factors that affect help-seeking attitude among university students, multiple relevant questionnaires were submitted to 202 participants. This study which took place in Malaysia showed that attitude of mental help-seeking had an important relationship with self-stigma which was the strongest predictor, general help-seeking attitude, and age (Ibrahim et al., 2019).

Quantitative and qualitative measures were used to elicit beliefs about stigma, symptoms, causes and treatments related to depression, through a study conducted by Nieuwsma and his colleagues (2011). The sample included 92 university students in an Indian university, and 97 university students in an American university. Results of this study indicated that Indian students were more likely to describe symptoms of depression as troubled manifestations (anxiety, irritation, difficulty thinking), viewing the disorder to have a personally controllable cause. They suggested spiritual reflection, relaxation and social support to be helpful means for dealing with depression (Nieuwsma et al., 2011).

Systemic random sample of 300 university students was included in a study to test causal attribution to interpret temporary emotional problems as emerging from inside. Results of the study indicated individuals with greater psychiatric contact tend minimally but consistently to interpret personal problems as dispositional, that consistency is associated

with psychiatric and psychological services. They also indicated a positive connection between the use of those services and psychiatric contact and sophistication. It is concluded that emotional inaccurate interpretation may induce one to avoid needed treatment or seek unneeded treatment (Robbins, 1981).

In the examination of the effect of cultural orientation on the way college students cope with stress, and whether cultural orientation is mediated by causal attribution, researchers manipulated cultural orientation of 96 students who were randomly assigned to individualistic or collective condition. Participants were asked to evaluate the scope to which they attribute the cause of a presumptive academic stressor to dimensions of attribution theory, and to suggest coping strategies to handle that stressor. Results showed more tendency of individualistic condition participants to use active coping strategies and their inclination to stability and controllability. They were also more likely to attribute the cause of the stressor to temporary factors, and therefore, these unstable factors were linked to more active coping. The relationship between cultural orientation and active and avoidant coping is mediated by stability attributions, and controllability attributions (Tilley et al., 2019).

A research aimed to investigate whether misconceptions such as attributing epilepsy to demonic possession (Jinns) still persist among educated Saudis. The study targeted university-educated school teachers and undergraduate students, employing a structured questionnaire to assess their familiarity with epilepsy, information sources, and depth of knowledge about specific aspects of the condition. The analysis encompassed responses from 398 participants, many of whom had firsthand experience with epileptic seizures. Approximately two-thirds of the participants indicated that they had acquired knowledge about epilepsy through friends and family. Notably, 172 participants (43.1%) regarded epilepsy as a psychiatric disorder. Within the study cohort, 62 school teachers (40.3%) and 123 students (50.4%) believed that possession by supernatural entities could be a cause of epilepsy. While the majority acknowledged the availability of medical treatments for epilepsy, a noteworthy portion still entertained the notion that faith healers and traditional medicine might also play a role in addressing the condition. Remarkably, the

belief in Jinn possession as a cause of epilepsy persisted in Saudi society, even among individuals with relatively advanced education (Obeid et al., 2012).

Since there was a significant research gap regarding causal attributions concerning mental illness within developing nations of the Caribbean, including Jamaica, and because of the importance of the exploration of these causal attributions in providing insights into the perception of the illness experience, and impacting mental health service utilization and engagement, a study delved into the realm of causal attributions concerning mental illness in Jamaica. Through a comprehensive approach involving 20 focus groups, encompassing 16 community-based cohorts, 2 groups of individuals receiving patient care, and 2 groups consisting of caregivers of patients, a total of 159 participants were engaged. This investigation sheds light on the five most frequently endorsed causal attributions attributed to mental illness: (a) factors linked to substance abuse, particularly marijuana; (b) biological triggers encompassing chemical imbalances, hereditary transmission, and the cultural concept of "blood"; (c) psychological determinants such as stress and excessive rumination; (d) societal influences including interpersonal conflicts and job instability; and finally, (e) spiritual and religious influences, which encompass belief (Arthur & Whitley, 2014).

The comprehension of mental health attributions within ethnic minority communities bears considerable significance, as it can facilitate the encouragement of seeking appropriate treatments and contribute to the development of culturally sensitive, community-oriented mental health services. So that, in order to gain insights into the attributions regarding mental health within diverse ethnic contexts, a study engaged in focus group discussions involving participants from African American (n = 8; 24%), Asian American (n = 6; 18%), Latino/Hispanic (n = 9; 26%), and White (n = 11; 32%) backgrounds. The research aimed to elicit attributions concerning 19 mental health disorders, each representative of major sub-categories in the DSM-IV. Employing a grounded theory approach, participant responses were systematically classified into 12 distinct themes: Biological, Normalization, Personal Characteristic, Personal Choice, Just World, Spiritual, Family, Social Other, Environment, Trauma, Stress, and Diagnosis. The findings underscore that ethnic minority participants are notably more inclined to

reference causes related to spirituality and normalization, in contrast to their White counterparts (Bignall et al., 2015).

A cross-sectional research aimed to examine the attributions related to depression and identify the psychosocial factors linked to these perceptions among Latino immigrants. The study involved interviews with 177 individuals receiving primary care, utilizing assessment tools to gauge causal beliefs, depressive and somatic symptoms, ethnic identity, and stigma. Through an exploratory factor analysis of the Causal Beliefs scale, three distinct factors emerged: "Balance," "Psychosocial," and "Malevolent Spirituality/Transgressions." These factors were subsequently utilized as dependent variables in the context of multivariate analyses. Notably, depressive symptoms, age, country of origin, and religiosity displayed significant associations with specific aspects of causal beliefs (Caplan et al., 2011).

In regard to assess changes in public perceptions of the causes of mental disorders in Australia over time, a study was conducted using case vignettes. Beliefs about causes and risk factors were examined in two national surveys conducted in 1995 and 2003-2004. The results revealed shifts in beliefs, with increased acceptance of genetic causes for depression and schizophrenia. Beliefs in childhood problems and bereavement as causes for depression grew, while the perception of "weakness of character" as a cause for schizophrenia decreased. These findings highlight evolving mental health perceptions in Australia, emphasizing genetic influences and broadening the recognition of external factors influencing mental disorders (Jorm et al., 2005).

Another study examined the causal attributions of schizophrenia among 30 Chinese American caregivers residing in the Los Angeles area. The research delves into the factors that these caregivers attribute to the development of schizophrenia. Among the attributions, stress-related and biological explanations garnered the highest endorsements. Notably, attributions related to interpersonal and familial stress reflect the sociocentric nature of Chinese culture and the significant role of family dynamics within it. The research also establishes a positive association between higher levels of acculturation and biological attributions of the illness. Additionally, it reveals that

supernatural attributions are significantly linked to caregivers' objective and overall burden (Kung, 2004).

In the purpose of exploring how patients' explanatory models of psychosis relate to their engagement with psychiatric services in South India, a comprehensive study was conducted among a representative cohort of first-episode schizophrenia patients there. The assessment encompassed 131 consecutively presenting schizophrenic patients' explanatory models, as well as clinician evaluations of insight, psychosis symptoms, and functional status using established measurement scales. A significant proportion of patients (70%) attributed their condition to spiritual and mystical factors. Moreover, 22% held multiple models of illness. An intriguing finding emerged, where patients subscribing to a biomedical understanding of disease demonstrated higher insight scores in comparison to those endorsing non-medical beliefs. The outcomes of multivariate analyses spotlighted three factors linked to embracing spiritual/mystical models, specifically being female, having lower educational attainment, and seeking assistance from traditional healers. Additionally, a solitary factor, higher levels of insight, was associated with endorsing the biological model (Saravanan et al., 2007).

In the examination of the influence of various beliefs regarding the causes of illness, such as 'physical causes,' 'general social causes,' and 'indigenous Chinese beliefs,' on the recognition of mental illness, a study was carried out involving 49 relatives of Chinese-immigrant individuals with psychosis. The results revealed that a stronger belief in 'physical causes' was connected to the perception of mental illness. Among non-biomedical causal beliefs, the belief in 'general social causes' showed no correlation with the recognition of mental illness. Interestingly, endorsing 'indigenous Chinese beliefs' was linked to a decreased tendency to identify mental illness (Yang & Wonpat-Borja, 2012).

Trying to assess personal beliefs, attributional models and help-seeking behavior of 73 schizophrenic patients by using self-rated questionnaire, a study was conducted by Kate and colleagues (2012). Results showed that 62% of participants emphasized their community beliefs in magico-religious phenomenon. Two-third patients thought that

mental illness can be caused by either spirit intrusion, sorcery, divine visitation, astrological influences, or evil spirits and past bad deeds. 46.6% of patients believed that only fulfilling prayers was adequate to recover from their mental illness. Few patients thought that magico-religious rituals were enough to get better, hence, 24.7% confessed that either they or their caregivers did magico-religious rituals during recent episode (Grover et al., 2012).

Fifty 20 schizophrenic patients who attend psychiatric services were evaluated in order to determine patients' attitude and their relatives regarding magico-religious beliefs and their effect on psychopathology, and to investigate psychopathology sociodemographic variables relationship. Majority of patients went through magico-religious therapy. Among the sample, 68% counselled faith healer, 42% fulfilled religious treatment during the period of illness, 60% admitted belief in sorcery, 52% in spirit intrusion, and 58% in ghosts. Among them, 20% thought there is a connection between sorcery and mental illness, and 20% thought spirit could be a reason of mental illness. There was a statistically significant association between local belief in supernatural influences and belief that rituals can improve patients behavior (Sapkota et al., 2017).

Regarding the rate and type of treatment for mental disorders in Arab countries from the Middle Eastern Mediterranean region, a thorough literature review was carried out. The outcome of this review highlighted the inclusion of a total of 23 articles, providing valuable insights into the subject matter. Results showed that individuals who took the initiative to seek treatment predominantly turned to general medical practitioners rather than specialized mental health services individuals who took the initiative to seek treatment predominantly turned to general medical practitioners rather than specialized mental health services (Nasser & Salamoun, 2011).

In an attempt to ascertain the prevalence, demographic factors, and clinical attributes related to the utilization of traditional healers (T.H.) as an alternative therapeutic approach among psychiatric outpatients in the Al-Khobar region of Saudi Arabia, this research aimed to shed light on the subject. A randomized sample of 227 individuals was selected from the pool of patients attending the psychiatric outpatient services at King Fahd

Hospital of the University in AlKhobar. For each participant, a structured questionnaire comprising 32 items was administered, covering socio-demographic details, clinical profiles, and encounters with traditional healers. Results indicated that 70% of the participants had, at some point during their ongoing mental health condition, sought assistance from traditional healers. Among these cases, 60% had consulted a traditional healer prior to seeking conventional psychiatric treatment. Notably, the frequency of engagement with traditional healers exhibited significant correlations with factors such as female gender, higher age bracket, lower maternal educational attainment, history of psychiatric hospitalization, and a diagnosis of schizophrenia. This underscores the considerable influence that traditional healers exert on the management of psychiatric ailments and the utilization of psychiatric services within the local community (Sayed et al., 1999).

A Cross-sectional study was conducted at the adult psychiatry clinic, Maudsley Health, Abu Dhabi, with the aim of examining the patterns and potential factors influencing the utilization of traditional healers (THs) among psychiatric patients. A total of 214 patients were included in the analysis, comprising 58 males and 156 females. The majority of participants (43.5%) were diagnosed with depressive disorders. Prior to seeking assistance from a mental health professional, 28% of patients had sought care from a traditional healer. Among this group, 36.7% had engaged in just a single visit to a TH, while 60% had exclusively consulted a single TH. The primary motivation for seeking the services of THs was the advice provided by friends or family members (81.7%). Notably, THs most frequently attributed symptoms to feelings of envy (26.7%). Further analysis revealed that being female and having a high school education or lower were significant predictors of seeking care from traditional healers (Adel et al., 2023).

A cross-sectional study design was used in a study that aimed to analyze the routes individuals with mental illness take to access psychiatric care and identify factors linked to delayed help-seeking in Northern Ethiopia. This investigation utilized the WHO Pathway Study Encounter Form for data collection. Collected through face-to-face interviews, data were obtained from patients with various mental illness diagnoses who were attending outpatient treatment at Ayder Comprehensive Specialized Hospital in

Mekelle City, Tigray, Northern Ethiopia. The study's participants consisted of individuals who sought outpatient treatment during the study period, selected using a consecutive sampling technique. Results showed a significant delay in seeking modern psychiatric treatment in the studied region. Initial help-seeking often involves religious healers, and a majority of respondents attributed mental illness to supernatural causes. Barriers to appropriate care included stigma surrounding mental health and a lack of awareness about available treatment options (Teshager et al., 2020).

An exploratory cross-sectional study aimed to analyze the health-care seeking patterns among newly diagnosed psychiatry patients, as per the WHO pathways of care proforma. The study also intended to investigate the influence of social and cultural factors on their health-care seeking behavior. The research focused on patients newly diagnosed with psychiatric disorders according to ICD-10 criteria, who were attending the psychiatry outpatient department (OPD) at a private medical college in India. To ensure adequate representation, the sample size was determined to be approximately 350 individuals using proportion-based calculations. The data collection involves using the WHO pathways to care proforma to gather information about the patients' health-care seeking journeys. During the preliminary phase of the study, it was observed that around 32% of the patients initially sought assistance from general medical practitioners, followed by consultations with psychiatrists and faith healers. The study also revealed an average delay of 24 months before patients accessed psychiatric services (Khan et al., 2022).

For the purpose of examining Indian research help-seeking behavior for problems of mental health in adults, a review of 52 original Indian research studies published from 2001-2019 was conducted using a set of relevant key words. Results showed, among other indications, that in the Indian context seeking help is oftentimes is a decision-making process that’s based on family (Sanghvi & Mehrotra, 2022).

With the aim of comprehending the referral pathways undertaken by 1554 patients directed to mental health services in 11 diverse countries, and of documenting the factors contributing to delays in the referral process, this research paper delved into the findings. The pathways observed in well-staffed psychiatric centers were predominantly influenced

by general practitioners and, to a lesser degree, hospital doctors. In centers with fewer resources, a diverse range of pathways emerged, often involving the participation of native healers. Interestingly, despite the variance in psychiatric resources, the study found consistently short delays in all centers. However, in certain instances, longer delays were identified when native healers were part of the referral pathway. The prevalence of somatic complaints was evident across all centers, with some locations showing that patients presenting somatic issues experienced lengthier delays compared to those exhibiting symptoms of depression or anxiety (Gater et al., 1991).

With the aim of enhancing comprehension regarding the history of care-seeking and treatment of novel patients attending mental health services in Eastern Europe, diagrams depicting care pathways were created, outlining the trajectories of 50 individuals across eight centers. Comparative analysis of care-seeking patterns, durations, and preceding interventions was conducted among ICD–10 diagnostic categories, which displayed variability influenced by service organization. Predominant routes encompassed general practitioners, direct self-referral, and hospital physicians. The role of general practitioners as 'gatekeepers' was limited in Albania, Croatia, Macedonia, Romania, and Serbia–Montenegro centers, with infrequent prescription of mental disorder treatments, barring sedatives (Gater et al., 2005).

A study conducted in 2008 in Bangladesh aimed to investigate referral patterns, delays in accessing mental health professionals (MHPs), diagnoses, and prior treatments sought by patients before reaching psychiatric care. The research involved interviews with 50 consecutive new patients at a tertiary hospital's Psychiatry outpatient department, utilizing a translated WHO pathway encounter form. Results revealed that 84% of patients had consulted other caregivers before reaching an MHP, requiring 2.5–3.1 steps to do so, with delays ranging from 8 to 78 weeks along the indirect pathway. Conversely, 16% of patients took a direct pathway to an MHP, experiencing an average delay of 10.5 weeks from the onset of mental illness. Among those who followed the indirect pathway, 44% initially visited Individual Private Practitioners (PP), 22% consulted native or religious healers (NRH), and 12% engaged rural medical practitioners (RMP). The patients consulting NRH or RMP experienced the shortest delays (2–2.5 weeks) and the briefest

route to MHP (4.5–7 weeks). The most substantial delay occurred between visits to PP and MHP/General Hospital (22–31 weeks). Notably, approximately one-third of patients received a diagnosis with limited concordance with the MHP's assessment. Additionally, 70% and 40% of patients with mental illness attending General Hospitals and PPs, respectively, were referred to MHPs (Giasuddin et al., 2012).

With the purpose of Examining the pathways that patients follow when seeking psychiatric care, a study involving 159 patients directed to a tertiary psychiatric facility in Nigeria was conducted. It became with an evidence that a significant number of individuals with mental health concerns initially consult traditional and religious healers. These alternative caregivers serve as the primary point of contact for a considerable portion of these patients. Remarkably, there are no notable distinctions between these patients and those who initially consult conventional medical practitioners in terms of demographic attributes, presenting issues, or proximity to healthcare services. However, those who initially seek assistance from traditional healers tend to reach the tertiary psychiatric facility significantly later than those who engage with other types of caregivers. These findings underscore the importance of refining the referral capabilities of traditional medical practitioners, should efforts be made to integrate traditional healing approaches into the broader healthcare system (Gureje et al., 1995).

A study in Bali found that traditional healers were the most common source of care for mental patients, with 87% of patients consulting a healer before visiting a mental hospital. However, consultation with traditional healers was associated with treatment delay. Some traditional healers recommended that patients seek psychiatric care, and all 11 patients who received this advice followed it immediately. Additionally, 29.8% of patients reported that their symptoms had improved significantly after receiving treatment from a traditional healer. The study concluded that traditional healers can play a dual role in the treatment of mental illness in Bali. They can act as a barrier to care, by delaying patients from seeking psychiatric help. However, they can also be an effective provider of care, or a decision-making support for patients who are considering seeking psychiatric help. The study also found that traditional healers are more likely to be effective for patients with non-psychotic symptoms (KURIHARA et al., 2006).

In the purpose of describing the pathways that patients take to reach psychiatric services in Ankara, a paper presented the results of a study of 582 patients who were seen in a calendar month in seven centers, two of them being child psychiatric clinics. The study found that the pathway in Ankara is dominated by direct referrals, with only 4% of patients contacting their general practitioner (GP) first. In contrast, 42% of patients first saw hospital doctors and 53% came direct. Religious healers appeared in the pathway of only 1% of patients, and the delay associated with them was longer.

The study also found that male patients had longer delays than female patients, and delays were also longer for patients presenting with somatic symptoms. However, the median time taken to be seen by the psychiatric services after contacting any carer was only 1 week. The patients presenting with somatic symptoms consulted hospital doctors more frequently and were delayed more (Kiliç et al., 1994).

Research in Japan, similar to a World Health Organization study from 1991, investigated how people in Japan access psychiatric care for mental health issues. Thirteen psychiatric facilities across the country were enlisted for participation, focusing on 84 patients who were seeking psychiatric assistance for the first time out of the 228 individuals grappling with psychiatric issues. The study rigorously examined the routes patients took to access care and the time intervals spanning from the onset of their illnesses to the point of receiving treatment from psychiatrists. The findings of the study revealed that 39.4% of patients directly sought the expertise of mental health professionals, while 38.1% reached them through general hospitals, and 15.5% opted for care via private practitioners. Notably, patients who initially consulted mental health professionals experienced more extended intervals before subsequently seeking psychiatrists, in contrast to those who initially sought assistance from non-mental health professionals, who encountered shorter delays. Additionally, patients primarily presenting somatic symptoms faced lengthier delays in accessing psychiatric care compared to those who reported complaints related to depressive or anxiety symptoms (Fujisawa et al., 2008).

Goldberg and Huxley had outlined a psychiatric care pathway with five distinct levels and four filtering stages. To apply this pathway to elderly individuals dealing with

depression, they conducted a comprehensive literature review. Their goal was to determine the median annual rates of moderate to severe depression at each level of the pathway. Among a sample of 27 elderly individuals per thousand each year who were experiencing depression, 22 of them sought help from a family physician, leading to the detection of the disorder in 5.3 cases. Out of these, 2.8 individuals were subsequently referred to psychiatric services, and 1.3 were ultimately admitted to psychiatric units. As a result, only 10% of elderly individuals with moderate to severe depression received assessment or treatment from a Psychiatrists (Cole & Yaffe, 1996).

In the purpose of examining the pathways taken by newly referred patients to mental health services in different health areas of Spain, and exploring the influence of sociodemographic, medical, and service-related factors on referral delays, this study was conducted. The investigation revealed that in a rural health area, the majority of newly referred patients initially established contact with their general practitioner, with fewer opting to consult a hospital doctor. Subsequently, they progressed directly to psychiatric services. Conversely, in urban health areas, there was a greater inclination to reach out to specialized medical and psychiatric services right away. Remarkably, the delays in these health areas were notably short and comparable to those observed in other European centers (Vázquez-Barquero et al., 1993).

In order to compare the pathways leading to psychiatric care for individuals reaching out to the Community Psychiatric Service (CPS) in Italy with those documented in various other countries, a study -included 116 residents from South-Verona who initiated new episodes of care- was conducted. It was observed that for 92% of the patients, their initial point of contact was a medical doctor. Interestingly, over one-third of the patients directly accessed the CPS without being referred by other healthcare providers, while another third initially consulted a general practitioner (GP) before proceeding directly to the CPS. Both the median duration of time from the onset of symptoms to seeking care and the median interval between the emergence of the issue and the initial care-seeking event were found to be approximately 8 weeks. Moreover, it was noted that individuals who initially sought care from the two primary points of contact had similar waiting periods before seeking assistance. The most commonly reported problems among these patients

were primarily related to depression and anxiety. More than half of the sample received a diagnosis of affective disorders, followed by neurotic and somatoform disorders, as well as schizophrenia and related disorders (Balestrieri et al., 1994).

The objective of a study -which took place at Pantang Psychiatric Hospital in Ghana- was to explore the routes that individuals with mental health conditions follow when seeking psychiatric services, with a specific focus on where they initially seek treatment and the factors influencing this decision. The research was conducted as a cross-sectional study involving 107 patients aged 18 and older, along with their family members. To collect data on patients' initial points of contact for psychiatric care, the study employed the World Health Organization's (WHO) pathway encounter form. Statistical analyses, including the Chi-Square test, were performed to identify the first point of contact for patients and any potential associations between independent variables (such as clinical diagnosis and socio-demographic factors) and their initial pathway to mental health care. Additionally, multiple regression analyses were conducted to estimate the likelihood of patients' first pathway contact. Overall, the findings revealed that nearly 48% of patients initially reached out to non-psychiatric treatment centers, including faith-based institutions, traditional healers, and general medical practitioners, as their first choice for mental health treatment. Just over half of the patients directly sought care at the formal public psychiatric facility as their initial point of contact. Notably, patients' occupation showed a significant association with their first point of contact for psychiatric care. Furthermore, individuals with a secondary education were less likely to seek initial care from the formal public psychiatric hospital compared to those with no formal education (Ibrahim et al., 2016).

With the aim of shedding light on the utilization of services and mapping the patient pathways to psychiatric care in Singapore, this study focused on 323 outpatients recruited from a psychiatric tertiary hospital. Utilizing the Pathways to Psychiatric Care form, researchers collected comprehensive data on the sources of care sought, reasons prompting help-seeking, and the temporal sequence of each contact made during their journey to psychiatric care. The investigation meticulously mapped the diverse routes patients took to access psychiatric care and conducted a detailed analysis of their

motivations for seeking assistance. Employing quantile regression, researchers probed for associations between sociodemographic and clinical factors and the duration between the onset of their issues and receiving psychiatric care. The study revealed that the foremost reason for seeking help was the need to manage symptoms, and prior to psychiatric care, participants typically engaged with an average of 1.2 other care providers. The primary pathway to psychiatric services predominantly involved primary care and community services (37.2%), with a median duration of approximately 6 months between the onset of problems and psychiatric care receipt, where age emerged as a significant factor influencing a shorter duration (Chang et al., 2021).

1.12 Summary of Literature Review

Reviewing of related literature emphasized that people's beliefs and attitudes towards mental illness are highly affected by their attribution to the cause of that illness, and those beliefs influence their help-seeking behavior, and pathways to care they approach. Related literature highlighted that the idea of supernatural factors as causes of mental illness is widespread in many cultures, no matter what their religion is.

This study intended to test causes of mental illness as attributed by patients themselves, and how these attributions are associated to pathways to health care. This study differs from the previous studies in that it explores the attribution of mental illness from the perspective of the patient himself and not the perspective of others, that is an area of research which is not enough conducted. It also differs in the place it's carried out in, since here in Palestine, as far as we know, no research was conducted having these objectives.

Chapter Two
Methods

2.1 Study design

This study uses a qualitative research design as an appropriate methodology to inquire into patients' beliefs, experiences and views with regards to their mental illness and the ways in which they connect these to broader contextual factors including cultural beliefs and values as well as political and social determinants of health.

To illicit illness narratives, we collected demographic and diagnostic information. We administered a survey specifying where possible gender, age, educational level, place of residence, diagnostic category, estimated date of the onset of symptoms, previous attempts of treatment, extent of awareness of mental affliction and degree of insight into its nature.

Second, we conducted in-depth semi-structured interviews using an adapted version of the McGill illness Narrative interview (MINI) (Groleau, Young, & Kirmayer, 2006).

It was planned for the interviews to be tape recorded, then the researcher found it more suitable to be written and transcribed, so as not to elicit paranoia in patients. The data then are coded and analyzed following thematic analysis.

When data are collected through notes and transcription of interviews, the researchers attempted to correlate the patients' attribution of their pathology to certain causes with the factors established by the questionnaire.

2.2 Study population

Study participants were recruited by employing a criterion sampling approach, a useful method for identifying and understanding cases that are information rich. The research team recruited about 30 adults (18+ years) who receive treatment in private clinics in West Bank and Jerusalem. All were sufficiently eligible to speak in Arabic to finalize the research tasks. The interviews were designed to gather information about patients'

perspectives about the attribution of their symptoms, and pathways they had while they were seeking help.

To guarantee the participants privacy and confidentiality, we recruited them in a non-intrusive manner by introducing ourselves and our research project to them, asking whether they would be willing to participate in the study, and making sure that they understand from the very beginning that their participation is entirely voluntary. We excluded agitated, instable patients, and patients with severe cognitive impairment.

2.3 Study sample

Out of 34 patients approached, three patients declined the invitation to participate in this research, without declaring any reasons. The participants in the study were thirty-one (31) Palestinian patients from different cities of the West Bank in Palestine (Jerusalem 16, Nablus 3, Ramallah 7, Tulkarem 1, Qalqilya 1, Jenin 1, Salfeet 1, Bethlehem 1). They were (21) females and (10) males, aged between (19-56) years (Mean age 29.8). They were of different educational statuses, ranging from no high school degree to master degree holders. About the marital status, 13 of the participants were married, 17 unmarried, and one divorced. They worked in different professions; for example, as a translator, nurse, journalist, driver, paramedic and others.

2.4 Instruments of study

The MINI is a theoretically driven, semi-structured, qualitative interview protocol which is structured into three sections:

1. A basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events.

2. Salient prototypes related to current health problems, based on the previous experience of the interviewee, family members or friends and mass media or other popular representations

3. Any explanatory models, including labels, casual attributions expectations for treatment, course and outcome.

The supplementary sections of the MINI explore help seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception and relationships with others.

2.5 Ethical Approval and Consideration

The participants were notified verbally and also offered a written consent document about the aim of study. Participants were informed that participation or refusal to take part in the study would not affect services they have in the clinic. No rewards were given for participation. It was made clear to participants that their participation is voluntary, they can withdraw from the research anytime they need to, their private data will be kept confidential.

Chapter Three

Results

The shortest interview lasted for twenty (20) minutes while the longest interview lasted for thirty-five (35) minutes; however, most interviews were around twenty-five (25) minutes. Duration of untreated mental illness (DUM) ranged from zero to 8 years (Mean DUM 1.46 years). Number of attempts to seek help ranged from 1 to 9 (Mean 2.29 attempts). 16 participants had same attributions as their families, while 15 had different attributions.

Different pathways were followed by our study participants; psychiatrists, psychologists, general doctors, sheikhs (clergies), and family traditional healing.

Participants main diagnosises were as follow:

- Bipolar disorder (10) participants.
- Psychosis Not Otherwise Specified (6) participants.
- Depression (4) participants.
- Drug abuse (2) participants.
- Conversion disorder (1) participant.
- OCD (1) participant.
- Anxiety (2) participants.
- Schizophrenia (2) participants.
- Borderline Personality Disorder (1) participant.
- Schizoaffective Disorder (2) participants.

3.1 Data analysis

All interviews were transcribed in Arabic by a native speaking researcher. Written interviews were analyzed following a thematic content analysis methodology to identify the main themes manifesting from the written material.

About half of the participants declared one single attribution to their psychiatric symptoms, others stated two or more attributions.

The thematic content analysis of the interview transcripts brought out the identification of three major themes (Supra-natural causes, Socio-relational causes, and Biomedical causes):

3.2 Supra-natural causes

Participants differed in terms of their attribution of the symptoms as supranatural causes. Interviews results demonstrate that beliefs in supranatural powers as causes to mental illness are common. Below is the description in greater detail their responses to attributions with supranatural causes.

Supranatural causes -that were mentioned by 11 participants as a main cause- included evil eye, magic, hasad (envy) and Jinn possession. A 22-year-old university female student stated “after my uncle’s wedding, my beautiful long hair started to fall down because of evil eye. Soon I became ill (Lymphoma), and started to hear and see things which are not real. My family took me first to a sheikha from Dora and another sheikh from Hebron, without a noticeable benefit”. A 25-year-old medical student claimed “I belong to a family which attribute every bad event to hasad (envy)”. A 56-year-old woman stated “there was a big gathering of family members in my house after the death of one of my relatives, they noticed how clean and tidy my house was, and I believed that their evil eye was the cause of my symptoms”. A 31year old security man mentioned “I and my family believed that magic was the reason why I’m ill, so we went to the sheikh who validated that belief, and asked me to drink water that has been Quran read on it (treated with Quran readings)”.

A bipolar patient declared “My family and I believed that I was under the effect of Seher (magic), so we went to a sheikh who recited some Quran Infront of me, but I didn’t get better”.

On the other hand, an anxiety patient mentioned “I thought that hasad might be the cause of my anxiety symptoms, and I can overcome it by reading Quran”.

Another sub-theme emerged from the analysis of supranatural attribution -which was mentioned twice- was sinful deeds. A 29year old depressed woman stated “I felt that God was punishing me for sinful deeds I have done earlier, that’s why I became depressed”.

3.3 Psycho-social causes

Many participants realized the role of psychosocial adversity and relationships difficulties in mental illness. Several subthemes emerged from the analysis. Below is the description in greater detail the subthemes that emerged from content analysis as they respond to attributions with socio-relational causes. Psychosocial causes were a common attribution of mental illness between the research sample, many of them believed how psychological and social factors can negatively affect their wellbeing.

3.4 Family relational problems

Several studies have verified that problematic social relationships, especially family ones, can have both, short- and long-term negative effects on mental health (Mental Health Center, 2016), and it was clear that many of our participants realized this fact. A 19-year-old nurse who suffers from borderline personality disorder declared “My parents hate me, and I believe this was the cause of my psychological suffer. My family thought it was Jinn possession or seher, and in spite of that I didn’t have the same attribution, I accepted to go with them to the sheikh, who said there was nothing wrong with me. I didn’t know there were psychiatrists”.

A 31-year-old schizophrenic patient reported “My father -who is a doctor- suggested to go to a Khouri to handle my psychiatric symptoms, but I didn’t agree, I believed that my brother’s conspiracy against me was the reason, and the Khouri will not be able to relieve me”.

Another interviewee commented “I believed that pressure put on me by my family was the cause of my symptoms”.

“I believed the agitation and restlessness I was suffering from, were because of the refusal of the family of the girl I love to our relationship, although my family suggested it to be a neurological problem. I surrendered to their explanation and went to a neurologist who assured that I am not ill. My aunt also has almost same symptoms I am having, I think it is because of her loneliness”. And when researcher asked him if he went to a sheikh, he responded with a shrug “why should I go to a sheikh?!”.

A 28-year-old Bipolar woman reported “I have problems with my family, they used to provoke my anger, I thought they were planning to give me psychiatric medications which belonged to my brother who recently fell down and his psychological wellbeing deteriorated. But my husband believed those are delusions and I have to consult a psychiatrist”.

A 32-year-old schizophrenic driver reported “My family thought I was possessed by Jinn, because I had some strange behaviors. So, I went to the sheikh who declared that I was not possessed by Jinn. Then I realized that family’s breakup was the reason of my suffering”.

“The day I had my engagement party, I thought my family is very angry of me for being in a relationship with a man, I was obsessed with the idea that they are going to beat me, that’s when my symptoms appeared”. A depressed divorced woman stated “I had many complications in my marital life, we had arguments all the time, and I believe these problems caused the depression symptoms I’m having now”.

A psychotic patient who works in a supermarket declared “My family suggested for me to go to an Internist who advised me to be on a certain food diet to overcome the

symptoms I suffered from. But I didn't have any benefit from that diet, I think the problems in my family relationships were the cause".

Bullying

some of our participants thought that bullying has serious and lasting negative effect on mental health, and believed that some individuals can develop psychiatric disorders as a result. One of our study sample commented "girls at school bullied me for being so quiet and a little isolated, I believed that was an important reason why I became sick".

Arrest

Psychopathology triggered by imprisonment is documented by a study done by Jabr (2007). One of the participants had linked between the brutal way he was arrested with, and psychiatric symptoms he suffered from. He believes in the profound damaging effect of the imprisonment and investigation techniques which were used against him. The 33-year-old media man stated "every night at 2:30 I have that feeling of distress and fear. This is the time of me being arrested by Israeli armies". He continued "At the beginning, all what I was thinking about: when I'm going to die? In the period of investigation, I was overwhelmed with negative thoughts which I thought I overcame in the past".

Greif

A 28-year-old anxious woman stated "I came from Jordan where I live, to Palestine to attend my brother's wedding, but I attended my father's death instead". A 54-year-old woman mentioned "all my distressing symptoms started the time my father died, I used to spend a lot of time taking care of him".

Khawfeh (sudden stress)

Some of our participants believed that extreme and sudden fear can cause mental illness. A 34-year-old electrician stated "My nephew got a car accident, I was very distressed, that's when my symptoms started".

Stress

It is proven by research that chronic stress can result in or worsen many mental illnesses. A 25-year-old schizoaffective patient reported "stress was, beside other reasons, the cause of many symptoms that I noticed about myself".

3.5 Biomedical causes

Some of our participants were concerned about different biomedical causes that adversely affected their lives. Below is a number of experiences and thoughts as being the prominent causes of their distress and worries.

Personality traits

Psychopathology and personality can relate to one another in many different ways, which may cause confusion to some individuals and their families. "I and my family believed that my symptoms were because of my picky (obsessive) personality. For example, I used to refuse to eat in plastic dishes, and spend a lot of time in the shower doing rituals to wash myself, then it turned out that I have OCD" declared by 25-year-old medical student.

A mid-thirties journalist stated "My family thought evil eye was the cause of my Bipolar symptoms, but I believe that it's my biological composition, which affected my personality traits and mood swings. So, I didn't go for any Khouri as they suggested, I went to a psychologist".

"My suffering is because of my genetic composition, that's why I should consult a psychiatrist, not a sheikh or a general doctor" reported by 21-year-old Bipolar waiter.

Corona Virus

Since covid 19 was a new experience for everyone, some got confused about it and attributed their psychiatric symptoms to the infection they had. "I remember my symptoms started once I got Corona virus, so I think it was the cause of my sadness", reported by a postpartum depressed woman.

Physical problem

Since physical and mental wellbeing is fundamentally linked, and since some mental illnesses have physical symptoms, some individuals attribute their mental illness to physical cause. A woman with post-partum depression declared "I believed I have heart problem, and I'm going to die because of it, so I investigated a lot about this issue with the general (non-psychiatric) doctors and cardiologists. I realized that I have a psychiatric problem when I talked to my relative who also had Post-Partum Depression, and then I went to a psychiatrist".

A Jerusalemite depressed woman reported "I believed my depression symptoms were due to vitamin deficiency, I consulted a general doctor who referred me to a psychiatrist".

Substance abuse

Recreational Drug abuse and withdrawal has many symptoms that resembles mental illness ones, such as confusion, paranoia and disorientation. However, the presence of these symptoms does not mean that the individual is suffering from a psychiatric illness.

"My friends put me a Trip pill in my juice I was drinking because they wanted to take revenge on me, that pill was the cause of the auditory and visual hallucination I fell victim to" reported by a psychotic student. A 28-year-old boucher stated "I used to misuse some substances for some time, and when I started to cut them off, some psychological symptoms hit me. I believe that withdrawal was the reason. But I went to a sheikh who attributed my symptoms to seher and did Ruqyah for me".

Medications

Pharmacological treatment of physical diseases can induce psychiatric side effects, and thus, the clinical presentation often mimics psychiatric disorders (Casagrande Tango, 2003). "I used to take some psychiatric medications which I believed they were the reasons of me becoming psychologically not well, in addition to other reasons" declared by a 25-year-old schizophrenic restaurant owner.

In regard to the effect of the attribution of the mental illness on the pathway the patient follows to seek help, some patients were coherent about it, for example, a 19-year-old

schizophrenic patient reported "At the beginning, I thought seher was the cause of my unusual voices I hear, so I went to a sheikh who confirmed my perception. But when things didn't get better, I thought it was a problem in my endocrine function, so I consulted an endocrinologist. Recently, I believed that it could be a psychiatric problem, so I came to the psychiatric clinic". Another patient who is a 31-year-old schizoaffective male declared "I knew that my symptoms had no relation with clergies, if my arm was broken, I'm not going to go to the clergy to fix it".

On the other hand, some patients were not that reasonable; as we can tell from the 33-year-old male statement "Although I believed my anxiety symptoms were because of sudden death of my father, I agreed to go with my brother to sheikh to recite some Quran in front of me. We believed that we have nothing to lose".

Chapter Four

Discussions and Conclusions

4.1 Discussions

Understanding beliefs held by the patients and their families can better clarify help-seeking behaviors and their adherence to treatment, in regard to the causation and treatment of different psychiatric disorders (Grover et al., 2012). Few studies have investigated the causal beliefs held by mentally ill people themselves, fewer studies with same objective are conducted in the Islamic or Arab world, hence, to researcher's knowledge, this is the first study to be done in Palestine. As well as that this study focuses on the patient perspective about his mental illness, not others perspectives, which is more researched.

The aim of this study was to explore the ways in which persons with severe mental disorders perceive their mental health problems, to understand local explanatory models and the ways in which these might be linked to help-seeking behavior, and to investigate differences of causal beliefs according to patients' primary diagnoses.

Half of the participants mentioned psychosocial causes as their attribution, this result is in line with a study conducted in Turkey to test causal attributions of a group of patients, which showed that the most mentioned attributions was conflicts with family which is part of psychosocial domain (Karanci, 1993). One third of the participants mentioned supranatural causes as the main attribution to their psychological symptoms, while the least mentioned attribution was the biomedical one.

Our results were harmonious with another study which focused on how caregivers perceive the causes of their relatives' mental illnesses. Researchers gathered data from 350 primary caregivers of psychiatric outpatients in an Asian setting. They used interviews to explore caregivers' explanations for the mental illness. The study aimed to understand how sociodemographic factors and diagnoses influenced different categories of causal explanations, including psychosocial, biological, substance use-related, and supernatural causes. Majority of caregivers identified psychosocial factors as the primary cause of their relatives' mental illnesses, followed by biological factors. Supernatural

explanations ranked third, while drug and substance use-related causes were identified the least frequently (Sagayadevan et al., 2020).

Psychosocial causes were also the most frequently endorsed attributions across various mental illness vignettes, in a study that investigated prevalent causal beliefs about mental illnesses in a multi-ethnic Southeast Asian community. The research aimed to understand the associations between these beliefs and sociodemographic factors. Through the analysis of a nationwide study involving 3006 participants, three primary categories of causal beliefs emerged: physical causes, psychosocial causes, and personality causes (Pang et al., 2018).

Unlike researcher's expectations, Patients with psychotic symptoms (psychosis, bipolar disorder, schizoaffective disorder, schizophrenia) were not more likely to attribute their illness to supranatural causes than others. The most common attribution for psychotic patients was psychosocial causes; their number was more than patients who attributed their symptoms to supranatural and biomedical causes combined. A convergent result was found in a study conducted in Mexico, where most of the participants attributed psychosis for social factors (Gómez-de-Regil, 2014).

Patients who suffer from neurotic disorders (Anxiety, BPD, Hysteria, Depression, OCD, Drug abuse) attributed their illnesses to biomedical and supranatural causes equally and slightly more to psychosocial ones.

Regarding Duration of untreated mental illness (DUM) according to different attributions, patients with supranatural attribution had the longest DUM (Mean 1.85 years), while those with biomedical attribution had the shortest (Mean 1.1 years).

Regarding pathways followed to seek help, Patients with supranatural attribution had "sheikh" pathway with highest frequency (more than the half), followed by "psychiatrist" pathway. Patients with psychosocial attribution had almost equal frequencies for both "sheikh" and "psychiatrist" pathways. While patients with biomedical attribution had more frequency for "psychiatrist" pathway than for "sheikh" one. Other pathways (Neurologists, Cardiologists, Internists, and general doctors) were also followed but with

less frequencies. There were results closely resembling our findings regarding treatment-seeking pathways in a study conducted in Singapore, which aimed to investigate the utilization pattern of services and the factors influencing help-seeking behavior among individuals with mental disorders within Singapore's diverse multi-ethnic Asian population. The methodology involved conducting a household survey on a nationally representative sample of adult residents (aged 18 and above). The results were based on data from 6616 completed respondents, forming a representative sample of Singapore's adult resident population. Notably, only 31.7% of individuals with mental disorders had actively sought help. This assistance-seeking behavior included seeking help from mental health providers (15.7%), general practitioners (8.4%), and religious/spiritual advisors or other healers (7.6%) (Chong et al., 2012)

Concerning the marital status, unmarried participants were found to have almost equal percentages of attributions to supranatural and psychosocial causes, while much less extent to biomedical ones. Moreover, about half of the married participants had psychosocial attributions, and one third of them had supranatural attributions, and the rest had biomedical ones.

In regard to sex, half of men participated in the study attributed their symptoms to psychosocial causes, one third of them had supranatural causes as their attribution, and biomedical causes were the least to be attributed to. While women had equal results concerning supranatural and psychosocial causes, with least tendency to attribute to biomedical causes.

We can interpret these results using the Attribution theory, more participants attributed their psychiatric symptoms to supranatural and psychosocial causes, because – regarding the first domain of the theory- these are external causes, and thus, they will free themselves from the burden of responsibility. Moreover, attribution to external causes will defend their egos and protect their self-esteem. While few participants attributed their symptoms to biomedical ones, because they are internal causes, which makes them feel responsible for what they suffer from. Considering the second domain of the theory (stability), All participants may have considered the cause of their symptoms to be

instable, because they sought help, no matter what kind of help it was. They believed it can be affected and changed. Biomedical approach supporters may give the impression their mental illness is stable overtime, this might be another reason why the least percentage of attributions was for them. In regard to the third domain (controllability), all participants might consider the cause of their illnesses can be controlled, and they sought help in order to be in a higher position of controllability. We can conclude how crucial role family has in determining the pathway which the patient follows, even if they had different attributions, in many cases the patient followed the pathway which the family suggested.

Finally, our research appears to have effectively achieved its goals by providing a comprehensive understanding of how individuals with severe mental disorders perceive the causes of their conditions, how these perceptions impact their help-seeking behaviors, and how these factors might vary based on different diagnoses and sociodemographic factors. The study contributes valuable insights to the field of mental health research, particularly in the context of the Islamic or Arab world and within the specific setting of Palestine.

4.2 Summary

Our study which was conducted in Palestine aimed to explore how individuals with different mental disorders perceive the causes of their conditions and how these beliefs affect their choices in seeking help. Participants attributed their mental health issues to psychosocial, supranatural, and biomedical factors. Those with psychotic symptoms linked their illness more to psychosocial causes, while those with neurotic disorders attributed it more equally to biomedical and supranatural causes. Duration of untreated mental illness (DUM) varied based on attribution, with longer DUM for supranatural attributions and shorter DUM for biomedical attributions. Seeking help patterns differed; those with supranatural beliefs sought assistance from traditional healers and psychiatrists, psychosocial believers balanced both, and biomedical believers leaned towards psychiatrists. Attribution Theory suggests supranatural and psychosocial attributions may protect self-esteem, while biomedical attributions were rarer but motivated seeking help for control. Family significantly influenced help-seeking

regardless of attribution. The study underscores the intricate interplay of cultural beliefs, family dynamics, and personal attributions in shaping help-seeking and understanding of severe mental disorders.

4.3 Recommendations

- It is important to address patients' attributional beliefs and considering them in clinical practice and not dismiss it, this improves therapist-patient relationship, and could improve their recovery. We don't argue patients' attribution, but we should use it for the patient benefit, in other words, we should roll with the resistance and the denial of the patient.

- This research guides clinical work, and shows the importance of providing psychoeducation to patient and family.

- Future research might focus on the impact of attribution theory on adherence, and DUM, using a bigger sample of patients and more variant diagnosis.

4.4 Limitations

- All participants were clients at a private clinic, which is not accessible to many patients who cannot afford private fees.

- Not all the participants were de novo patients, many of them have already received treatment and psychoeducation that have raised their awareness and influenced their attribution, which caused recall bias.

- Some patients seem to be in distress and refused to share much information or not in a stable mental health to give reliable answers.

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Appendices

Appendix A

Table of terms

Terms	Explanation
Stable patients	Patients who are not agitated, psychotic, or with severe cognitive impairment
Khawfeh	this idiom stands locally for extreme fear because of a traumatic event
seher	Magic
sheikh	Clergy in Islam
khoury	Clergy in Christianity
Trip pill	A pill that is thought to cause permanent brain loss, which is not scientifically true. It is used recently as a replacement of the attribution of the jinn possession
Ruqyah therapy	method for healing by recitation of Qur`an, seeking of refuge in Allah (SWT), remembrance and supplications

Appendix B

استمارة الموافقة

استمارة موافقة على شروط الدراسة البحثية المتعلقة في الأسباب التي يعزو لها الناس المرض النفسي وسبل العلاج التي تم اتباعها وفقا لذلك

التاريخ:

لقد تمت دعوتي للمقابلة التي سيقوم بها الطبيب أو الأخصائي النفسي للتعرف على فهمي الخاص لأسباب مرضي.

هذه المقابلة لن تفصح عن أية معلومات تعريفية بهويتي، حيث سيقوم الباحثون بجمع عدة معلومات مني ومن أشخاص آخرين بغرض الحصول على نتائج مفيدة، بشرط أن لا يتم الإفصاح عن أي معلومات تعريفية بأي شخص تجرى معه المقابلة، وفي حال رغبتي بالاطلاع على النتائج البحثية سيتم إرسال نسخة لي عندما يتم نشرها.

يحق لك الاستفسار عن أن أي بند خاص بالمقابلة قبل البدء بها

يحق لك الانسحاب إن أردت ذلك

أقرّ بالفهم الكامل لبنود المقابلة والموافقة عليها

الاسم:

التوقيع:

Appendix C

أسئلة المقابلة

Semi-structured Interview for Eliciting Patient's Understanding as to what they attribute their illness

- منذ متى بدأت تشعر بتغير أو أنك لست بخير أو أنك تواجه صعوبات؟

- هل مررت بهذه المشاعر أو الأفكار من قبل؟

- نحن نعلم أن البعض عندما يواجهون أعراضا مشابهة، يشعرون بأن شيئا أو قوى معينة أو أشخاصا معينين كانوا سببا بطريقة أو بأخرى في الأعراض التي يشعرون بها، هل راودتك أفكار كهذه؟

- هل حصلت أحداث في حياتك في تلك الفترة والتي كان من الممكن أن تفسر هذه الأفكار؟

- هل تحدثت لأشخاص آخرين؟

- هل قاموا بتقديم أي اقتراحات؟

- هل غيرت رأيك نتيجة لذلك؟

- عندما ذهبت لاستشارة (طبيب/شيخ/غيره) هل قاموا بتقديم أية مساعدة؟ كيف؟

- هل أبدوا اقتراحات لما قد يكون سبب المرض؟

- هل اختلف ذلك عن تفسيرات الشخصية؟

- أو عن تفسير عائلتك؟

- هل اعتقدت أن تفسيراتهم كانت أفضل من تفسيرك السابق؟

- هل ساعدك فهم الأسباب وراء حالتك على التخفيف عنك بأي طريقة؟

- هل أعطاك ذلك الفهم أملا أكثر أم أقل؟

- لأي درجة أثر تفسيرك للمرض على طلبك للمساعدة؟

- هل تملك فكرة حول تفسير من عانوا نفس أعراض مرضك لوضعهم؟

جامعة النَّجاح الوطنيَّة

كليَّة الدّراسات العليا

التقارير الذاتية لأسباب المرض النفسي وعلاقتها بمسارات الرعاية الصحية لدى الأفراد من ذوي الاضطرابات النفسية في فلسطين

إعداد

زينب ساهر عبد الله حناوي

إشراف

د. فايز محاميد

د. سماح جبر

قدمت هذه الرسالة استكمالا لمتطلبات الحصول على درجة الماجستير في علم النفس الإكلينيكي من كلية الدراسات العليا، جامعة النجاح الوطنية، نابلس – فلسطين.

2023

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إعداد

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إشراف

د. فايز محاميد

د. سماح جبر

الملخص

الخلفية: تؤثر الأمراض النفسية على كل شرائح المجتمعات في كل الدول بما فيها فلسطين. تؤثر المعتقدات التي يتبناها المرضى فيما يتعلق بأسباب المرض النفسي على سلوكهم في البحث عن العلاج. لا شك في أن فهم سياق المعتقدات التي يتبناها المرضى وأفراد أسرهم فيما يتعلق بالسببية والعلاج من الاضطرابات النفسية المختلفة سيساعد الأشخاص المصابين بأمراض نفسية في بحثهم عن العلاج والتزامهم به.

كشفت الدراسات السابقة عن العديد من الأسباب المختلفة التي ذكرها الأشخاص المصابون بأمراض نفسية، وكانت تلك الأسباب ذات صلة بالثقافة التي ينتمون إليها. كان الهدف من هذه الدراسة هو معرفة التفسيرات الخاصة التي يعتقد المرضى النفسيون في فلسطين بأنها سبب مرضهم، كما هدفت إلى التعرف على المسارات التي يتبعونها للحصول على الرعاية الصحية.

المنهجية: تكونت عينة هذه الدراسة من واحد وثلاثين مريضاً يتلقون العلاج في عيادات خاصة. كان المشاركون من ذوي التشخيصات المختلفة، ومن مدن مختلفة في الضفة الغربية بالإضافة إلى القدس. أجريت المقابلات شبه المنظمة باستخدام نسخة معدلة من مقابلة سرد المرضى الخاصة بماكغيل من أجل حث المريض على الحديث عن مرضه.

النتـائج: أظهـرت نتـائج الدراسـة ثـلاث مسـببات رئيسـية ذكرها المرضـى: الأسـباب الغيبيـة، والـنفس- اجتماعيـة، والطبيـة الحيويـة. اتجـه المشـاركون طلبـا للمسـاعدة مـن خـلال مسـارين رئيسـيين؛ الأطبـاء النفسيين والشيوخ. تم اتباع مسارات أخرى ولكن بمعدل تكرار أقل.

الخاتمـة: ينسـب عـدد كبيـر مـن المرضـى أعراضـهم النفسـية إلـى أسـباب غيبيـة. كمـا أن هنـاك عـددا كبيرا من المرضى النفسيين يسلكون مسارات غير طبية طلبا للمساعدة.

الكلمـات المفتاحيـة: الصـحة النفسـية، نظريـة العـزو، أسـباب خارجـة عـن الطبيعـة، أسـباب نفسـية اجتماعية، أسباب طبية حيوية، مسارات العلاج، أطباء نفسيون، شيوخ.