# Exploring barriers in seeking mental health services

*Thesis submitted in partial fulfillment of the requirements for the Degree of M.Phil. in Clinical Psychology awarded by the University of Dhaka*


Submitted by

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## Approval of the Thesis

This is to certify that the study "**Exploring barriers in seeking mental health services**" submitted by **Fahmida Shultana** to fulfill the requirements for the degree of M. Phil in Clinical Psychology is an original study. The research was carried out by her under my guidance and supervision. I have read the thesis and believe this to be an important work in the field of clinical psychology.

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**Declaration by the Researcher**

I declare that the thesis has been written by and it is based on findings from original research conducted by me under supervision from Prof. M. Kamruzzaman Mozumder. No plagiarism has been done in this write up. Use of any ideas or contents from previously published material has been duly cited.

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Fahmida Shultana

## Abstract

Prevalence of mental health condition in Bangladesh indicates a huge need for psychological sufferer. However, many of inidviduals with the disorders do not seek psychiatric treatment. In the context of high treatment gap (92.3%) in our country it is important to explore the barriers to seek treatment for mental illness in Bangladesh, which was the objective of the present study. Qualitative research design using grounded theory approach was used for the aimed exploration. Eleven participants were interviewed including three groups which were patient group, non patient group and caregiver group. In the patient group there are two sub divisions; non treatment-seeker and delay treatment-seeker. Non seekers are those who go through the problem but did not receive any treatment and delay seeker reeived service after suffering a long time. For screening purpose SRQ-20 was administer. In-depth face to face interview was conducted by the researcher using a topic guide. Data analysis was done with support from qualitative reserach software.

Analysis though open and axial coding identified twenty themes which were organized under eighteen sub-categorizes from four broad categories. The four categories were socio cultural barrier, perceptual barrier, experiential barrier and structural barrier. It was found that stigma and mental health are strongly connected with each other and different cultural beliefs make the condition worse. When a person goes for treatment, it becomes a part of social gossip. That reduces the social acceptance of a patient and his/her caregiver and they would be victimized by different types of discrimination. Perceptual barriers also play an important role, mostly of which is due to poor mental health literacy for which they do not perceive the need treatment. Patient and care giver do not give enough importance in mental health issue and also discourage patient to go for treatment.

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Experiences around support around psychological problems also contribute towards the choice of seeking or not seeking treatment. Individuals adopt different types of alternative coping when they have psychological problems, and by giving some transient relief, these in turn creats a barrier to seek formal treatment. Additionally in our country there are limited resources, thus lack of availability and access act as a structural barrier for seeking treatment. Concerns about the inapropriate professional practices such as hasty interaction, judgmental approach, and violation of confidentiality among the mental health service providers also create a barrier for access.

Finding of this study indicates that services seeking for mental health problems are contributed by factors from multiple dimensions. This research may contribute in planning and implementing intervention related to increasing access and thus help policy makers become more effective in ensureing quality service for patients with mental health conditions.

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# Dedication

This paper is dedicated to my respected parents, Zillur Rahman and Taslima Begum.

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# Chapter 1

# INTRODUCTION

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# Introduction

The 2018-2019 prevalence survey of mental health problems in Bangladesh indicated 16.8% of adults and 13.6% child have a mental disorder where only 7.7% receives service (WHO, 2020). With a huge treatment gap of 92.3% (WHO, 2020) the scenario causes huge concerns among the policy makers. With support from WHO, the government of Bangladesh has initiation comprehensive training for professionals to reduce the treatment gap in mental health area. Although this initiative focused on availability of and access to services, it is well known that these are not the only barriers in seeking treatment (Nuri et al, 2018). The effectively reduce treatment gap, it is therefore, essential to understand the treatment seeking behavior and the associated barriers.

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004). In this definition, it is very clear that good mental health is necessary not only for a person but also for the community and the nation. Thus, untreated mental illness is a major concern for the individual wellbeing as well as the greater society and the country.

## 1.1. Impact of Untreated Mental Illness

Mental illness affects individuals, families and society at large. It has direct implication to the quality of life and well-being of the person. Close connection between mental and physical health problems are increasingly raising concerns among health service providers. Different types of physical diseases and psychological diseases are closely link, such as, pulmonary disease, diabetics, asthmas. Mental health and pulmonary disease are associated (Ohayon, 2012). It was found that mentally sick people do not

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maintain their daily activities. As a result, they cannot take proper care about diabetics (Robinson, Coons, Haensel, Vales & Yale, 2018). Asthma is another physical disease that is connected with mental illness. The patient with asthma with mental illness has higher functional impairment than patient without mental illness (Goodwin, Pagura, Cox & Sareen, 2010). Individuals with serious mental illness have been shown to have higher mortality compared to general population (Colton & Manderscheid, 2006).

It has also been shown that the suicidal risk for a mental health patient is higher than the general population (Bolton, Gunnell & Turecki, 2015). Sometimes people are not taking their mental illness very seriously and the subsequent delays results in poor prognosis and worsening of problems (Large, Nielssen, Ryan & Hayes, 2008). This impacts productivity of the person and increases school dropout, irregularity of school and work, and unemployment (Ngui, Khasakhala, Ndetei & Roberts, 2021).

Untreated parental depression effect on child's developmental stage and also has risk of future psychiatric disorders (Gentile & Fusco, 2017). Besides that, it was also shown that people with untreated mental illness have higher prevalence of domestic violence, and relationship breakdown (Walker, 2010). People with poor mental health have a risk of social exclusion (Walker, 2010).

The cost of untreated mental illness has a huge impact on the economy of any nation. An estimate from the United States of America suggests that in every year, untreated mental illness costs them $300 billion (NAMI, 2018).

### 1.2. Mental Health Services

There are different professionals in the mental health area. Each professional has different trainings and they have different roles and address the mental health problems

from different perspectives and strategies. The following section presents a summary of the different mental health professionals in Bangladesh.

**1.2.1. Psychiatrist**. A psychiatrist has medical degree along with postgraduate specialized training in psychiatry. They work from medical model of mental illness and rely on diagnosing the condition for prescribing medication. Due to huge patient's loads, the time for psychiatric consultation is usually limited and may range from a couple of minutes to 15 minutes with some exceptions. Psychiatric services are available across the district headquarters and are almost nonexistent in rural areas.

**1.2.2. Clinical psychologist.** Clinical psychologists have one year intensive training on mental health area. They are assessing the problem and formulating a treatment plan. The consultant time of a clinical psychologist is approximately one hour. They are working in district headquarters level. But they are not available in rural or native area. Clinical psychologists mainly practice cognitive behavior therapy.

**1.2.3. Counseling psychologist.** Counseling psychologist mainly work on humanistic approach based therapy. They are mainly practicing on major cities in our country. Counseling psychologist generally works with healthy people or those with less serious psychological problems.

**1.2.4. Occupational therapist.** Occupational therapy is an emerging field in our country. They are available only in major cities. They mainly help patients to regain functionality and to maintain daily activities. They also help to rehabilitee the people with mental and physical disability.

**1.2.5. Social worker.** They work for case management such as linking the person or family with referral resources, housing for homeless people, etc. Social workers have

been part of the health system for a long time in Bangladesh. In recent time, there is a new branch named, clinical social workers who are showing some progress enhancing quality of treatment for patients with mental illness.

**1.2.6. Psychiatric nurse**. They help patients and their caregivers to assess their mental health needs and make a plan for nursing care. There are only a handful of psychiatric nurses' working in our country but there is no professional training course on becoming psychiatric nurse.

## 1.3. Help-seeking Behavior

According to Cornally & Geraldine McCarthy, (2011) help-seeking behavior was shown to be a complex decision-making process instigated by a problem that challenges personal abilities. As per research literature, the process is characterized by being problem-focused, rooted in intentional action and connected with interpersonal interaction. According to the definition, for a health problem, help-seeking behavior will be problem focused, to solve the problem behaviors will be planned and involved different types of interaction with some selected professional (Cornally & Geraldine McCarthy, 2011). Generally, there are three types of help-seeking behavior

**1.3.1. Formal help-seeking.** Formal help-seeking means people search for any type of legitimate professional service. This type of help-seeking is considered an adaptive and problem focus coping.

**1.3.2. Informal help-seeking.** Informal help-seeking means people search for help from those who have no legitimate professional role. It can be friends, family, relatives, acquaintances who have no professional expertise. People often seek services from quakes and faith healers which also falls under informal help seeking.

**1.3.3. Self-help.** Recently self-help behavior emerges as a significant modality to cope with mental illness (Musiat, Goldstone & Tarrier, 2014). In this type of help-seeking behavior, people do not go for external sources of support and they try to cope with the problems and alleviate the sufferings by using their own coping resource. With the advancement in IT, self-help has now becoming increasingly popular among youths with mental health conditions (Musiat et al., 2014).

### 1.4. Theoretical Perspective of Help-seeking Behavior

Different psychological theories try to explain help-seeking behavior, these include reactance theory, attribution theory, equity theory, and threat-to self-esteem theory.

According to reactance theory (Brehm, 1966), people have certain value states like freedom of choice and autonomy. If these states get threatened the reactance occurs. In this situation, people try to restore the state again. The degree of reactance depends on the perceived threat of the recipient. The more threat to freedom is perceived by the person, the more negatively he/she reacts to seek aid or assistance. A very closely connected to reluctance theory is the threats-to-self-esteem model (Nadler & Jeffrey, 1986). According to this model, help-seeking behavior depends on the positive and negative characteristics of the four components which are aid, helper, recipient, and context. The recipient feels self-threaten when the aid (i.e., treatment) focuses on their inferiority; on the other hand, the recipient becomes positive about the aid when he/she feels supported.

Equity theory (Walster, Berscheid & Walster's, 1973) came from social exchange theory where it is expressed that, people want equity in their relationships. They feel distressed when there is inequity. For ensuring seeking service, the role of recipient and provider need to be equitable. Otherwise, the discomfort of inequity will prevent help-seeking process.

Prochaska, DiClemente and Norcross (1992) propose the stages of change model with five stages which are precontemplation, contemplation, preparation, action and maintenance. In precontemplation stage people are not aware of his disease, so he does not feel any need for treatment. In contemplation stage people recognize that they have a problem but do not understand what they need to do for recovery. In preparation stage are getting ready and gathering information to go for treatment. In action stage people take action to make some change, i.e., they go for treatment. In maintenance stage, people maintain the change, i.e., they continue treatment regimen.

A popular model for understanding health behavior is the Health Belief Model (Champion & Skinner, 2008). This model mainly discusses the perception about the disease and the perceived threat of the disease creating a belief pattern to adopt a recommended health behavior. This model discusses six components. These are - 1) Perceived Susceptibility- people take treatment when they think they are at risk; 2) Perceived Severity- the perception of the seriousness of the illness or its consequence contribute towards taking action; 3) Perceived Benefit- the person need to see the benefits from cost-benefit analysis in choosing treatment; 4) Perceived Barrier- individuals check for barrier (e.g., cost, time, discomfort, etc.) before going for treatment; 5) Cue to action- this is the stimulation that triggers the person to take a decision for recommended treatment; and 6) Self-efficacy- the belief and confidence about self to make the change.

### 1.5. Help-seeking Process for Mental Illness

Help-seeking behavior has multiple stages. Saunder and Bowersox (2007) proposed seven steps for the help-seeking process for mental illness and also discuss the barriers to each step. This is a sequential process and the parson needs to go through the

earlier steps to reach the next steps. The following section presents the details of the seven steps.

***Step 1. Problem recognition.*** Problem recognition is the first step for voluntary treatment-seeking. Denial and lack of knowledge is therefore the first barrier in seeking treatment.

***Step 2. Concluding the problem is related to mental health.*** One the person recognizes the problem the next step is to decide whether the problem is related to mental health or not. This is a difficult process because the person needs to exclude alternative explanations such as physical or situational causation. Lack of knowledge on mental illness and social or self-stigma can impede progression to this step.

***Step 3. Deciding change is necessary.*** This step involves taking personal responsibility to make a decision for making change. The barriers of this stage are denying the importance of the change or minimizing the seriousness of the problem.

***Step 4. Self-help efforts.*** After deciding on change, the initiation is not so easy to step. At the primary level, the person tries self-help to solve the problem all by him-herself. Self-help approach may include reading materials, or talking with nonprofessionals. Waiting or delaying the change effort is the main barrier to seek processional support in this step.

***Step 5. Deciding professional treatment is necessary to accomplish change.*** When the person realizes that self-help is not sufficient and further support may be required for improvement. Resistance generated from shame and stigma makes it difficult for the person to make the decision. The attitude about mental health treatment plays a major role in this step.

***Step 6. Deciding to seek professional treatment.*** When the person can overcome the barriers after realizing the need to professional treatment, they make decision to do so. Knowledge about and access to sources of services and uncertainty about the mode of service delivery can be the main barriers in this step.

***Step 7. Seeking treatment.*** The final step is seeking treatment. This step is completed by getting an appointment with a professional. Accessibility and affordability are the major barriers in this step.

## 1.6. Barrier in Mental Health Service Seeking

The detailed discussion presented in the earlier sections clearly indicates the presence of numerous barriers in seeking mental health services. Published literature on mental health services indicates numerous barriers ranging from stigma, knowledge, accessibility, etc. These findings are discussed below-

Stigma is the common barrier in seeking mental health services across the world. From literature, there are two types of stigma such as, “social stigma” and “self-stigma” (Velasco, Cruz, Billings, Jimenez & Rowe, 2020).

Poor mental health literacy is another barrier in mental health service seeking. People have lack of knowledge about mental health problem. There is also a knowledge gap about the service (Gulliver, Griffiths & Christensen, 2010).

Many people suffer from mental illness but they think they can solve their problems on their own. The perceived need among the mental health patient is very low (Bonabi et al., 2016; Pagura, 2007). For that reason they do not go for service.

Lack of affordability is a strong barrier in help seeking (Byrow, Pajak, Specker & Nickerson, 2020). As mental health service needs multi-dimensional and long term treatment, it is expensive for many. Most of the time insurance do not cover all expense. At a result, it is difficult for many patients to continue treatment.

Lack of access is a strong barrier in help seeking (Gulliver et al., 2010). In rural area the facility of mental health service is very limited and sometime absent. In that case distance (Tomczyk, Schmidt & Muehlan, 2020) and time (Hom, Stanley & Joiner, 2015) adds up as barrier.

From literature, it was found that different types of negative emotions such as shame (Tomczyk et al, 2019) and helplessness (Staiger, Waldmann, Rüsch & Krumm, 2017) are associated with not seeking service.

People have some concerns about the service which barrier to service initiation. Among them confidentiality and trust is an important issue (Gulliver et al., 2010). Beside this people are also concern about communication pattern of service provider. Sometime patients have concern that the practitioner would not understand his/her problem (Staiger et al., 1017). As a result, patient loss interest to go for treatment.

### 1.7. Barriers in Seeking Mental Health Services in Bangladesh

Bangladesh is a densely populated poorly resourced country. For a large population of approximately 160 million there are only 260 psychiatrists, 565 psychologists and 700 nurses (WHO, 2020) are providing service. It is obvious that availability of service is a major barrier in seeking treatment in our country. Additionally, lack of public mental health facilities, scarcity of skilled workforce, inadequate financial resource allocation, and social stigma also complicates the treatment seeking process

(Islam & Biswas, 2015). From our social-cultural perspective, stigma is strongly connected with mental health services. People fear social isolation and discrimination (Hasan et al, 2021).

Lack of knowledge and social influence is another barrier in our country. It was found that there is a positive association between knowledge and service use. People in Bangladesh often do not perceive mental health problems as serious issues (Nuri et al, 2018). Social influence plays an important role in seeking mental health services (Sifat et al, 2022).

Along with general populations, mental health professionals also face difficulties in seeking service. A study indicated that among 40 mental health professionals 38 felt the need for the service, but only 20 of them receive service (Gayen, Fatema, Tasnim, Shaha & Rahman 2018). Reasons for not seeking service were fear of being judged, lack of structured service in place, issues of confidentiality and difficulty in reaching a competent service provider (Gayen et al, 2018).

**1.8. Knowledge Gap**

There is very limited research around treatment seeking behavior in mental health area in Bangladesh. Being an emerging field the, studies in mental health is more focused on the prevalence and disease characteristics in Bangladesh. A few studies have done in understanding the help seeking barriers however, most of them are done using quantitative confirmatory approach. Top-down theorizing and implementation of strategies are mostly used by the experts and policy makers in minimizing the numerous challenges faced in mental health services. A qualitative exploration may contribute to findings informed planning and intervention delivery which may in a bottom-up approach address the challenges in a more adequate and effective manner. Unfortunately, such exploratory

studies are scares. To curb the treatment gap, it is necessary to understand the barriers of seeking mental health services in Bangladesh. The present study was therefore necessary for addressing the research question - why people with mental illness are not seeking professional services in Bangladesh?

### 1.9. Objective of the Present Study

With the overarching goal to explore the reasons behind mental health patients for not seeking formal treatment, the present study aimed at exploring the barriers in seeking mental health services in Bangladesh.

# Chapter 2

# METHOD

# Method

The objective of this research was to explore the barriers to seeking treatment for a mental health problem in Bangladesh. Due to limited published research on this matter in the Bangladesh context, the qualitative approach of exploration seemed more suitable and hence chosen for the study.

## 2.1. Study Design

In the qualitative approach, there are different types of designs such as grounded theory, phenomenological study, and case study design. For the present research, the grounded theory approach seemed best suited as it involved exploration of factors and connecting them with a specific behavior.

Although in ideal sense this is not generating theory which grounded theory is aimed to do, however, connecting factors and behaviors are precursor to generate hypothesis leading to theory development.

In the tradition of grounded theory approaches the present research explored process, action, and interaction involving multiple factors and individuals.

## 2.2. Participants

To ensure the richness of data in this exploratory research, wide variation among participants was needed. Therefore, maximum variation sampling using the purposing selection technique was used. The concept of theoretical sampling was used to decide the type of participants to be interviewed. Details on the categories and characteristics of the participants are presented in the following subsections.

**2.2.1. Categories of participants.** Three groups of participants namely patient, caregiver of patients, and non-patient.

**a. Patient.** Individuals with experience of mental health problems were included as participants to infuse the first-person perspective around treatment seeking in this research. The patient participant group was formed of two categories of patient namely non treatment seeker and delayed treatment seeker. To examine their mental state SRQ 20 was used. The person whose SRQ 20 score was above the cut-off point was selected for this group.

***Non-treatment-seeker***. Many individuals with mental health problems never seek professional treatment for their condition at all and are considered non-treatment-seeker. The perspective of these participants is important to understand the reason for seeking or not seeking treatment for a mental health problem and hence was included in this research.

***Delayed treatment-seeker.*** People often delay in seeking treatment despite suffering from mental health problems. Such delay can account for a few weeks to a few years before taking any professional service. For the present research, any individual who failed to seek treatment for the first six months of developing mental health problem was considered delayed treatment seeker.

**b. Caregiver of patients.** The family members of diagnosed psychiatric patients were also included in an interview. In Bangladesh, the decision to seek treatment often depends on the family members of the patients and hence their perspective around treatment seeking seemed to be a useful addition to understanding the phenomenon. The diagnosis of the patient was done by the psychiatrist and to examine the mental state of the patient’s caregiver SRQ 20 was applied. To include in interview SRQ 20 score must be below cut off point.

**c. Non-patient.** People from the general community often have extended observation regarding mental health problems, treatment options and factors associated with seeking treatment despite not directing experiencing mental health problems themselves. Their perspective was therefore deemed important for the present exploratory study. SRQ 20 was used to make sure that their mental state is normal. The participants whose score was below the cut-off point were selected for this group.

**2.2.2. Inclusion and exclusion criteria.** Additional to the defining feature of the specific group of participants as mentioned in the participant section, several generic inclusion and exclusion criteria were used for selection. As inclusion criteria, the participants needed to be adults (i.e., age above 18 years) and communicable while poor or lack of insight was used as exclusion criteria.

**2.2.3. Characteristics of participants.** Eleven individuals participated in the interview in this study. Participants were selected from different socio-demographic statuses with the age range of 25-49 years (see Table 2.1 for detailed characteristics of participants).

Table 2.1 Details of participants

| | | Sex | Age | Socio-economic status | Marital status |
|---|---|---|---|---|---|
| Non-patient | 1 | Female | 27 | Higher-middle | Married |
| | 2 | Female | 31 | Higher-middle | Married |
| | 3 | Male | 29 | Lower-middle | Married |
| Patient | 1 | Female | 25 | Middle-middle | Unmarried |
| | 2 | Female | 25 | Lower-middle | Unmarried |
| | 3 | Female | 28 | Lower-middle | Unmarried |
| | 4 | Male | 25 | Middle-middle | Unmarried |
| | 5 | Female | 27 | Middle-middle | Unmarried |

| | | Sex | Age | Socio-economic status | Marital status |
|---|---|---|---|---|---|
| Caregiver of the patient | 1 | Male | 25 | Middle-middle | Unmarried |
| | 2 | Female | 38 | Middle-middle | Married |
| | 3 | Female | 49 | Higher-middle | Married |

**2.3. Tools**

Several tools are used in the process of selecting participants and collecting data. Details of the tools used are discussed below.

**2.3.1. Socio-demographic questionnaire.** Some demographic information of the participants such as age, occupation, gender, religion, and socio-economic status were collected using a socio-demographic questionnaire (see appendix: C). These data supported the process of maximum variation sampling.

**2.3.2. The Self-Reporting Questionnaire (SRQ-20; World Health Organization, 1994).** The SRQ-20 has been validated in Bangladesh (Islam, Ali, Ferroni, Underwood, & Alam, 2000), and is widely used for screening. It has 20 summated rating items with a Yes-No response option. A cut off score ≥ 8 was used for screening. The scale has been reported to have acceptable sensitivity (81%-90%) and specificity (58%-95.2%) in screening people with and without psychological morbidity across populations from different countries, including Italy, Brazil, Nicaragua and Kenya (World Health Organization, 1994) (see appendix :F).

**2.3.3. Topic guide.** A topic guide was used to conduct the in-depth interviews. It helped to maintain a structure and sequence of interviews. The topic guide was prepared through a thorough mind map (brainstorming) exercise carried out by the research team. Piloting was done to refine and finalize the topic guide before its use for collecting data.

Necessary further probes were used during the interview using the topic guide (see appendix: A).

**2.3.4. Voice recorder.** Voice recorder was used to record the interview. It helped to collect complete data and to prepare a verbatim written transcript at a later time.

## 2.4. Data Collection Procedure

In this research, more than 20 individuals were approached for an interview among them eleven agreed to participate. The in-depth interviews were conducted face-to-face by the researcher in a suitable location chosen by the respondent. The selection procedures for the participants in three groups were different.

In the patient group, there were five participants. Among them four were non-treatment-seeker and one was delayed treatment-seeker. Snowball sampling was used to select participants in this group. First, the researcher informed her friends and colleagues about the participants. The researcher cleared them about inclusion and exclusion criteria. The first participant of this group was collected by referral system. Then the participant was referred to the next participant. For the interview, the referral person communicated with the participant. When he/she became agreed, the researcher communicated with them over the phone and set a convenient place and time for an interview. The researcher verbally explained the total procedure of the research and also provided the explanatory statement paper. When they agreed the consent paper was signed and filled up the SRQ 20. Then the interview was taken.

The next group was the caregiver of the patient. In this group, there were three participants. Among them, one was selected by referral system and the other two were selected from beacon point. The researcher took permission from the authority of the

mental health service center. A psychiatrist visits the patient in the outpatient department on Friday. Some patients come here for their regular follow up and they waited in the waiting room. The researcher wanted permission from the caregiver to see their prescription. The caregiver of the persons whose psychiatric features were diagnosed was requested to participate in the interview. Among them, two people agreed and they were interviewed.

In the non-patient group, there were three participants. One participant was selected from the Dhaka University area, one participant was selected from the school waiting room and another participant was selected by referral. At first, the researcher approached the participant to participate in the research and briefly described the procedure of the research. When they agreed for participating the researcher selected a place where both participant and the researcher felt comfortable. Then researcher provided an explanatory statement and consent form. SRQ-20 was filled up by the participants and started the interview.

### 2.5. Data Analysis

In the grounded theory approach data analysis started at an early stage of data collection. Data collection and data analysis were conducted simultaneously. As an aid to data analysis, N vivo software (QSR International, 2012) was used.

**2.5.1. Transcribing interview.** Interviewing data was transcribed verbatim in Microsoft word. All the data were transcribed by the researcher and the electronic written transcript was imported into the N vivo project file.

**2.5.2. Memo writing.** Memo writing is a cognitive map of the researcher, it helped in analyzing data by creating a link between analysis and field observation.

**2.5.3. Coding.** Coding is the first major analytic part of grounded theory. It helped in identifying and narrowing down the data into themes and categories. The coding started with open coding and moved to axial coding after substantial categories and themes were identified.

***2.5.3.1. Open Coding***. Open coding is the first step of coding for data analysis. In this stage, the researcher revisited the entire transcripts several times to identify and locate a significant chunk of information and themes. This review process contributed to understanding participants' meaning of the identified factors and themes. In this way, coding was done by adding a descriptive name. The researcher coded the transcript line by line. The purpose of the open coding was to break down the data regarding knowledge, emotion, behavior, etc. The researcher makes a list of codes which helps in the next stage of coding to categorize a different theme.

***2.5.3.2. Axial Coding.*** In axial coding core concepts identified through open coding were categorized into broader themes. It helps to make a relationship among the codes and data. While the data were fractured in open coding; they become meaningfully organized during the axial coding phase.

## 2.6. Ethical Consideration

This study maintained the guideline of research ethics in collecting data. The research was approved by the ethical review committee of the Department of Clinical Psychology, Dhaka University. The approval (project # MP-191001, 9$^{th}$ October 2019 to 8$^{th}$ October 2021) was collected before initiating the data collection. The following section discussed the major ethical aspect addressed in this study.

**2.6.1. Informed consent.** All the participants were given printed explanatory statements (see appendix: D) containing detailed information on the research purpose, procedures, costs and benefits of participation, confidentiality, and other rights and

responsibilities of the participants and the researcher. They made their understood choice regarding participation after going through that explanatory information along with responses to their queries. Signed written informed consent was taken from the participants where they agreed to give an interview and permitted audio recording (see appendix: E).

**2.6.2. Confidentiality.** All the identifiable data from participants collected during the interviews were treated as confidential and was de-identified during transcription. No identification data was used in reporting.

**2.6.3. Right to withdraw from the study.** The participants were informed that they had the freedom to withdraw from the interview at any time they wish.

**2.6.4. Right to know the research findings.** The participants' right to know the research findings was kept under consideration. The researcher's contact number and email address were provided to the participants for further correspondence if in case they want to know the findings.

**2.6.5. Well-being of participants.** SRQ 20 was administered to the participants for measuring their mental state possibility of having psychological illness. The researcher provided them with information about the available service providers so that they can access appropriate treatment if they need to.

**2.6.6. Safety of the participants and researcher.** The covid-19 pandemic situation created added risk for both the participants and the researcher. To minimize the risk of infection transmission precautionary measures such as physical distance and a face mask was used.

# CHAPTER 3

# FINDINGS

## Findings

Data from eleven interviews were transcribed and analyzed using Nvivo (QSR International, 2012) software for qualitative data analysis. Open and axial coding was done during the content analysis of data. Four broad categories comprised of several subcategories and themes were found. Table 3.1 presents the overall organization of these categories and themes, while these are described in detail with relevant quotations from the participants in the subsequent sections.

Table 3.1 Organization of broad and subcategories of barriers on treatment-seeking

| Category | Subcategory | Theme |
|---|---|---|
| Socio cultural barrier | Contrasting cultural belief | |
| | Stigma | |
| | Lack of acceptance | Diminished respect |
| | | Social isolation |
| | Social gossiping | |
| | Discrimination | |
| Perceptual barrier | Limited mental health literacy | |
| | Unimportance | |
| | Maintaining status quo | |
| | Treatment induced worsening of condition | |
| | Disapproval by other | |
| | Lack of preparedness | |

| Category | Subcategory | Theme |
|---|---|---|
| Experiential barrier | Disease characteristics | Symptom itself<br>Invisibility |
| | Treatment characteristics | Adverse effect<br>Slow progress |
| | Lack of positive example | |
| | Alternative coping | Seeking informal treatment<br>Engaging in self-damaging practices |
| Structural barrier | Resource | Financial constraints<br>Need for Multi-dimensional resources<br>Limited availability<br>Limited sources of information<br>Lack of human resources<br>Time constrains and business |
| | Lack of professionalism among practitioners | Lack of warmth<br>Hasty interaction<br>Limited or no explanation<br>Judgmental approach<br>Breach of confidentiality |

### 3.1. Socio-cultural Barriers

Every culture has some uniqueness, they differ from one another. The interview revealed some socio-cultural barriers to seeking treatment for psychiatric illness. The following sections present these in detail.

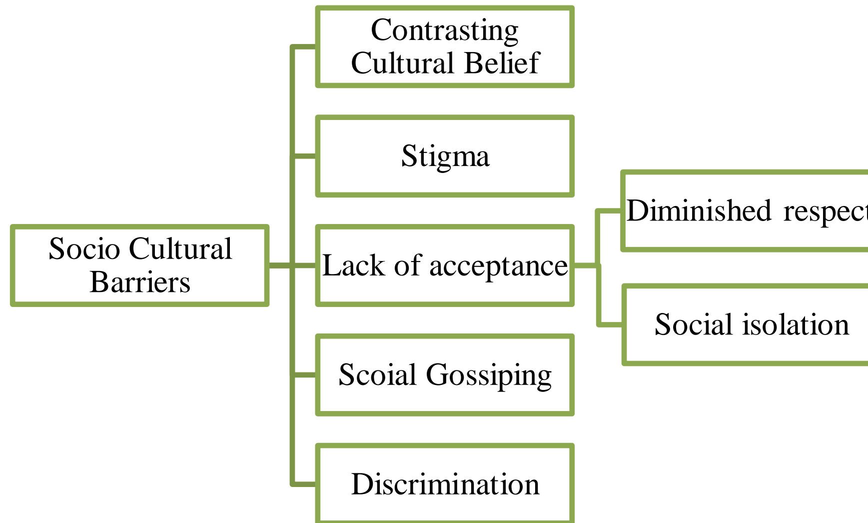


**Figure 3.1:** Theme and sub-theme of socio-cultural barriers.

**3.1.1. Contrasting cultural belief.** In our country, people have some preconceptions about mental health conditions, their etiology and treatment. Faith in traditional healing of mental health problems is part of that and hence people generally go for a traditional healer rather than seeking scientific treatment. The following quotation from a female caregiver reflects this.

> *"Blind faith. This is blind faith that comes for ages. People believe that traditional healer will cure the problem."*
>
> \- *Female, Caregiver of patient*

**3.1.2. Stigma**. Unscientific cultural beliefs around mental illness give rise to one of the most important socio-cultural barriers i.e., stigma. Different stigmas associated with mental health problems prevent people from seeking proper help. The stigma associated

with mental illness causes distress in people and families suffering from mental health problems. The 'mad' is strongly associated with stigma and subsequent discrimination. Affected individuals often feel **frightened** to seek treatment due to these stigmas. The following quotation reflects these.

> *"This is a problem. It will be a public knowledge that [my] daughter is mad. This is a matter of shame."*
>
> *-Female, Caregiver of patient*

> *"Probably he will be proven incapable or mad. These are the tag lines [for mental illness]. People do not seek treatment due to the possibility of being labeled with such tag lines."*
>
> *-Female, Patient (Non treatment seeker))*

Societal stigma causes ***anxiety*** among the patients and family members about being exposed and labeled by the community. This often leads the sufferer towards wanting to hide their problem. In an attempt to avoid exposure they often are reluctant to seek treatment. The burden of having a mental illness can be observed in the following quotation.

> *"There is panic, there is fear that these should not happen to anyone… then I will be sick. No one considers a human being. Everyone will look at it with hatred."*
>
> *-Female, Non-patient*

**3.1.3. Lack of acceptance.** People are afraid of losing acceptance in society due to their mental illness. The interviews reflected concerns about losing two forms of

acceptance which were ***social acceptance*** and ***professional acceptance***. They think that other people in the society won't get along with them; they did not share with them anything if they inform about their diseases.

> *"Actually, the main fear is acceptance. In reality, society does not prevent anyone from seeking help. We wonder if others will say something for my situation – this is the fear"*
>
> *-Male, Non-patient*

In the professional field, people accept physical illness very easily but they can't accept mental illness. Some people are afraid that their professional growth may decrease or they may be deprived of opportunities such as promotion if their history of mental illness is known by their colleagues.

> *"[It] affects your professionalism. When you gave an excuse that you could not come [to the office] due to headache or fever, that is readily acceptable than when you say you were absent or couldn't communicate for a couple of days because of depression"*
>
> *-Male, Patient (Non treatment seeker)*

From the fear of lack of acceptance, there are two types of other barriers are arise. In the following section, these barriers are discussed.

***3.1.3.1. Diminished respect.*** Discloser of the disease often results in losing a role and position in the family and society. In one word he has no position or respect in the family. People have also lost respect from society. Society discarded the mentally ill people. The following quotation beautifully reflects this in a family context.

*"If I am the eldest daughter or eldest daughter-in-law in a family, I would have a position, some weights. But if for some reason I get a psychological disease ...they will not address me from my [usual] position when they talk with me; will not respect me as a senior; will try to humiliate me."*

*-Female, Caregiver of patient*

***3.1.3.2. Social isolation.*** Human is a social beings, so they are frightened about isolation. People often have a limited understanding of mental health conditions and are afraid of possible bizarre behavior from the patients which led them to keep their distance from patients with mental illness. Thus the patients become isolated from society. Such societal isolation often extends to the family members of the patients as well. For that reason, people do not want to reveal their disease.

*"Will call me a mental case, shun me in the society and mark me an outcast. This fear prevents many from wanting or taking [treatment]*

*-Male, Patient (Non treatment seeker)*

**3.1.4. Social gossiping.** When a person goes for treatment in mental health hospital it's become open. People make gossip about mental health. The family members and patient are afraid of what people said behind him. This may destroy the social image of a person.

*"Everyone will notice that he/she is going to that hospital; His/her relative is mentally sick. . . . . . . . . . . . . In our society, mentally sick people are addressed as mad. It has been observed that everyone says - his/her son or brother become mad. Hey, how do you know? Hm, I have seen [him/her] going to that hospital. This thing is common in our society."*

*-Male, Caregiver of patient*

**3.1.5. Discrimination.** Mental health patients and their family members are faced with different types of discrimination in our country. They are bullied by their neighbor and peer groups and loses opportunities due to such discrimination.

> *"I will not get help from my colleagues; my working field becomes narrow. I will have fewer promotions. The growth of my carrier will decrease. The growth in my job may start to cease."*
>
> *-Female, Patient (Non treatment seeker)*

People often get bullied when they try to disclose their condition. Others often do not consider depression as an illness, they think it is fake and the person is trying to get attention.

> *"Now people say depression is fashionable. If someone says he/she is depressed then other will directly tag the person as he/she trying to get attention or something like that. I think this is a social bothering issue"*
>
> *-Female, Patient (Non treatment seeker)*

## 3.2. Perceptual Barriers

Perception is a process that makes sense of information. Perception has an impact on a person's help-seeking behavior. Six broad perceptual barriers were found from the data which are presented in Figure 3.2.

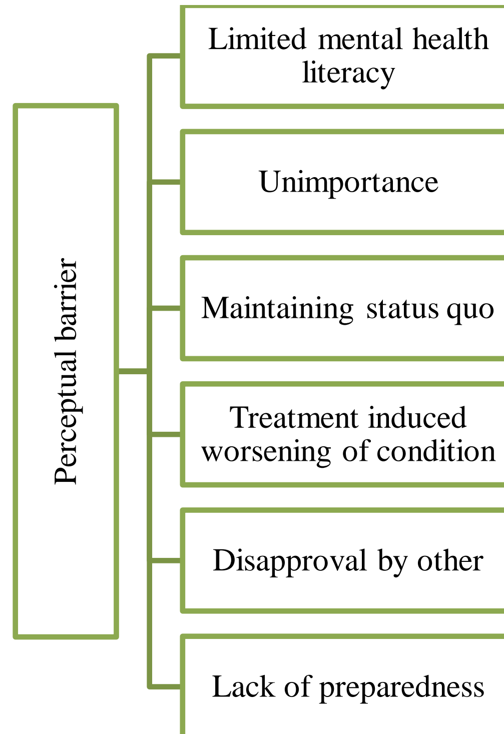


**Figure 3.2:** Theme and sub-theme of perceptual barriers

**3.2.1. Limited mental health literacy.** People demonstrate some general understanding when they are asked about their *knowledge of the mental illness*. However, it was observed that the participants generally mentioned the overt observable symptoms of mental illness (as reflected in the quotation below). Only a few talked about covert or internal feelings associated with mental illness. This lack of awareness around unobservable symptoms can be associated with limited treatment seeking.

> *"Mentally ill are those who are very bad-tempered, do not know how to handle situations, do whatever they want when they are angry, break things".*
>
> *-Female, Caregiver of patient*

Despite the general understanding of symptoms, participants demonstrate a poor understanding of the causation of mental illness. It is commonly perceived that mental illness only occurs in impoverished conditions.

> *"The family thinks how come he is depressed, what is his /her anxiety I am already providing him with everything."*
>
> *-Male, Patient (Non treatment seeker)*

When asked about their *knowledge regarding mental health services*, they demonstrate an acceptable level of understanding regarding the differential roles of different types of mental health professionals.

> *"I know about two, for mental illness both psychiatrist and psychologist can work. Psychiatrists prescribe medicine based on stage while the psychologists provide therapy or work on behavioral or habit development to reduce mental stress".*
>
> *-Male, Non-patient*

The participants also demonstrate a fair amount of *Knowledge about available mental health facilities,* especially medical hospitals. Many of them were also informed about private setups for psychological support.

**3.2.2. Unimportance.** In our country, people often perceive mental illness as a problem, not a disease, so it is always kept aside. People do not give enough importance to mental health problems. As they do not give importance, they do not want to expense money, time, and energy on this issue.

> *"Spending money on mental health treatment! It is not necessary. It will be fine automatically. No need to spend money."*
>
> *-Female, Non-patient*

**3.2.3. Maintaining status quo.** Due to a lack of seriousness, people often are reluctant to make effort in changing their situation. They want something magical or an auto solution that needs less effort. The quotation below reflects this aspect.

> *"People, who go for faith healing, are mainly indolent. They do not want a solution from acting out. They want things to come from God. I will be sitting and it [solution] will come to me automatically."*
>
> *-Female, Caregiver of patient*

**3.2.4. Treatment induced worsening of condition.** People are afraid of the perceived negative consequence of treatment. They fear if they go for treatment, the situation may get worse. Their cost-benefit analysis indicates a higher cost of seeking treatment in the form of the person losing respect, becoming more depressed, or reduction in confidence.

> *"It will harm [him/her], it will worsen the condition. He/she might have had one problem; it will add more to that."*
>
> *-Female, Patient (Non treatment seeker)*

**3.2.5. Disapproval by others.** Lack of positivism about treatment in support networks is a common experience among the patients and caregivers. When people around us are positive about a treatment option, it is easier and more likely for us to go for that option. Negative comments or disapproval from others demotivate the person to go for treatment. These create negative thoughts among the persons about the treatment process.

> *[They] said, Damn it…… there is no need for this [treatment]. You are overthinking, Go for a trip or let's go for a tour.*
>
> *-Male, Patient (Non treatment seeker)*

*"Everyone will ask why? Who told you to visit there? Is there any benefit to visiting them? It means [they are] demotivated a person [to go for treatment]. It will develop insecurity in me, I won't know what they are saying behind me. Maybe they will paint an exaggerated story and communicate that to others."*

*-Female, Patient (Non treatment seeker)*

**3.2.6. Lack of preparedness.** Some people have negative thoughts that they need self-preparation to go for treatment. A person needs time to think about his/her readiness to disclose or what and how much change to make.

*"I am not sure, if I am mentally prepare to deal the matter? I am not sure how much I will be able to trust worth the person. Yes, I know if I don't take any chance, I won't be able to move forward - but I am not ready to take the chance yet".*

*-Male, Patient (Non treatment seeker)*

### 3.3. Experiential Barriers

When people go through unpleasant experiences it creates negative impressions of the treatment. Such experiences create an obstacle to seeking treatment. Several themes were observed as part of the experiential barriers which are presented in Figure 3.3 and are discussed in the following.

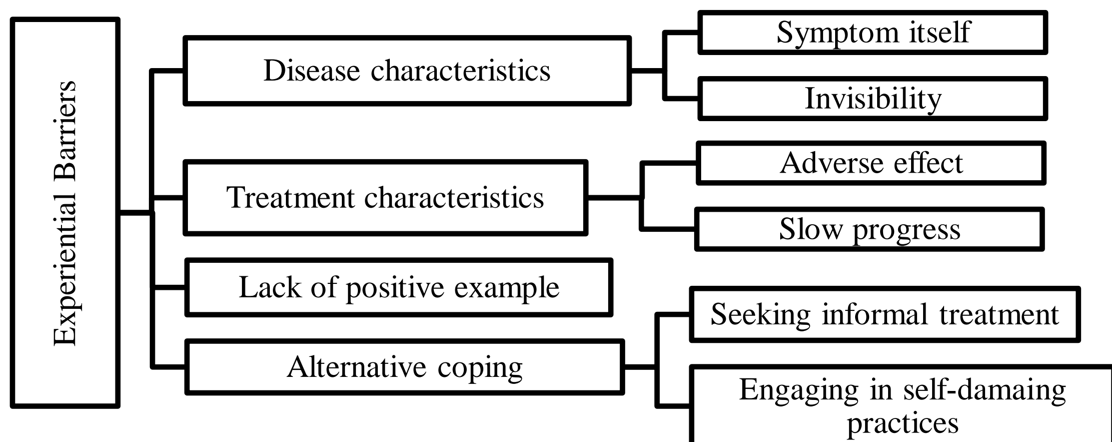


**Figure 3.3:** Theme and sub-theme of experiential barriers

**3.3.1. Diseases Characteristics.** Characteristics of an illness are the first aspects that draw attention and trigger treatment seeking among the patients or caregivers. These characteristics differ categorically for mental and physical health problems. Characteristics associated with mental health conditions often serve as a barrier to seeking treatment.

***3.3.1.1. Symptom itself.*** Symptoms associated with a mental health problem often resist treatment seeking. For example, in psychotic conditions patients with impaired insight are generally seen to deny treatment and are unlikely to comply with the treatment which is reflected in the following quotation from a caregiver.

> *"If a person does not understand that he/she has got a problem, it is difficult to take him/her to treatment. You can't tie him/her up and bring him/her to treatment"*
>
> *-Male, Caregiver of patient*

A person who failed to get treatment despite his willingness explained how his disease character disrupt his treatment seeking in the following quotation.

*"I can't get the motivation to go out and talk with anyone, so I missed the appointment."*

*-Male, Patient (Non treatment seeker)*

***3.3.1.2. Invisibility.*** Unlike many physical health problems, psychological diseases are not visible. In most cases, the psychological conditions are hidden inside the brain. The person can't provide any absolute proof to make others believe that the person needs support or treatment.

*"One thing, when someone gets physically hurt, it is visible, and therefore, people immediately go for treatment. But mental diseases are not visible, so we don't understand, and we do not go."*

*-Male, Non-patient*

**3.3.2. Treatment characteristic.** Psychiatric treatment has some characteristics which make a barrier to seeking help. The following section is discussed in detail.

***3.3.2.1. Adverse effect.*** Psychiatric medicines have some adverse effects such as excessive sleep. These adverse effects interrupt people's daily functioning. Therefore, those who have occupational responsibilities often are not interested to take medicine.

*"Anything [Medicine] has an adverse effect such as excessive sleep, I didn't feel good that's why [I] did not continue [treatment]."*

*-Female, Patient (Delayed treatment seeker)*

***3.3.2.2. Slow progress.*** Another barrier to psychiatric treatment is that it requires more time compared to physical treatment. For that reason, patients and caregivers feel

reluctant to consider or seek scientific interventions and they often go for other convenient non-scientific approaches.

> *"It takes time to get benefit from this [psychiatric treatment]. . . . . . . For depression it takes time to bring some changes with antidepressant [medicine]. We also say, many medicines do not work until it is taken for [at least] one month. In such case those who know or doesn't know [this] face difficulty to keep patience".*
>
> *-Female, Patient (Delayed treatment seeker)*

**3.3.3. Lack of positive example.** In our society, mental health problems and treatment are stigmatized, so people try to keep these hidden from others. Therefore, it is likely that success stories of mental health treatment will not be disclosed to others. For that reason, in our country, we have very few known examples of recovery from psychiatric illness after receiving treatment.

> *"We have very little examples where someone got cured of a mental health problem through treatment."*
>
> *-Male, General People*

**3.3.4. Alternative coping.** People try to cope with their mental health conditions in different ways. As they try these coping, it inadvertently delays or sometimes prevents the person from seeking treatment. The types of coping reported in the interviews are discussed below.

***3.3.4.1. Seeking informal treatment.*** Some people go to a pharmacy and take sleeping pills at the advice of the seller. Some others distract themselves by increasing their workload, talking with friends, or engaging in prayers.

*"I think, at first people did not seek out for doctor or counselor. They [follow the advice of] people around them - go for a tour, talk to friends - you will feel better. They try to manage in this way."*

*-Male, Patient (Non treatment seeker)*

It was also found that they search for other patients for help or sharing. They think only another patient will understand the pain. Sometimes they find out some unknown people with similar condition, ventilate with the person and get disconnected from them when the need is over.

*"I reach out to the people who are like me [have similar problems]. I think they are more sensible, and they understand the matter and treat people in that way."*

*-Female, Patient (Non treatment seeker)*

***3.3.4.2. Engaging in self-damaging practices.*** Individuals with mental health conditions often engage in harmful behaviors (such as drugs, smoking, or self-harm) to cope with their mental health problems as an alternate to seek professional treatment.

*"I do not have a clear idea of how they cope [when they don't go for treatment] . . . . . . . he may get involved in drug. If the person has a habit of smoking, he may try to smoke to get rid of the negative thoughts – [these] are injurious for health"*

*-Male, Patient (Non treatment seeker)*

### 3.4. Structural Barriers

The structural barriers are the external aspect that prevents a person from seeking help. There are two broad types of structural barriers. We have discussed these in detail in the following section.

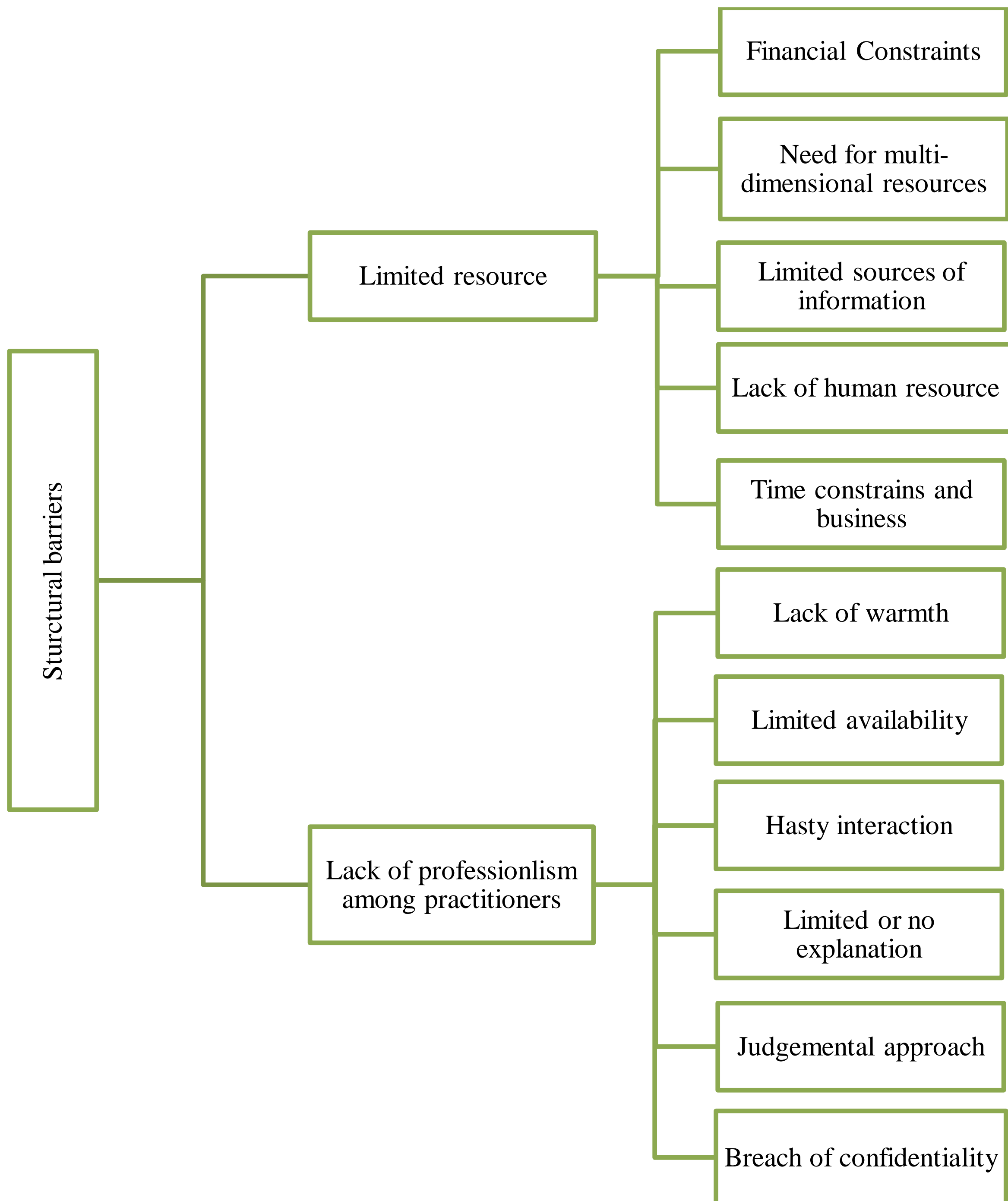


**Figure 3.4:** Theme and sub-theme of structural barriers

**3.4.1. Limited resource.** The fewer resources we have the fewer people go for treatment. The interviews indicated how lack of resources creates barrier to seek treatment.

***3.4.1.1. Financial constraints.*** As mental health treatment is a specialized form of treatment, it is costly. Most of the people in our country are poor and uneducated. They often do not have enough money to bear the cost of treatment. For this reason, people are demotivated to take treatment which is clear by the following statement of a female caregiver of the patient.

> *"Treatment mental health requires multiple sessions. Obviously there is transport cost. These cost of session [fees], transport cost, doctor's fee – [the family member] perceive these as an extra cost. [They] are not willing to spend this extra cost."*
>
> *-Female, Caregiver of patient*

Another barrier is financial dependency. Many of the patients especially the women and children are financially dependent on others. Therefore, the decision to seek specialized treatment for mental health problems is often beyond their own choice. The following quotation from a female caregiver reflects this concern.

> *In our country, most of the females are dependent on others. Other meaning - father or husband. We have no income. So, we can't take our own decision. As we are dependent on them, we have to accept their decision. If they say we can't spend money on this matter then there is no treatment, and the situation gets stuck.*
>
> *-Female, Caregiver of patient*

***3.4.1.2. Limited availability.*** Availability of mental health services is limited and mostly concentrated in the major citifies. This makes it difficult for people in need to seek appropriate treatment for their mental health conditions.

> *"If we saw people going to get service very easily, the help seeker and help provider both are available then we will go easily for service. We see the doctor's chambers at the corner, but we do not see the psychiatric chamber at the corners."*
>
> *-Female, Patient (Non treatment seeker)*

***3.4.1.2. Need for multi-dimensional resources.*** Psychiatric treatment is a process. It is not as simple as just taking medicine and overcome the disease. For ensuring uptake of service, it requires support from multiple individuals and coordination between systems. It's hard to manage all of these resources. The following statement represents this difficulty.

> *"Really, it's difficult because it needs multi-system involvement, needs multiple person involvement. If I need to go to the psychiatrist, it's not like that only I need to know this, I have to inform my parent or others who are involved with this."*
>
> *-Female, Patient (Delayed treatment seeker)*

***3.4.1.3. Limited sources of information.*** Awareness on mental health condition and treatment is limited in Bangladesh. Thus the lack of information makes it difficult for people to seek service even in cases where they want to. They do not understand what the problem is or where they need to go for proper treatment. The following quotation reflects this.

> *"The numbers of times I have face this problem; I have had money, human resource but didn't find anyone who has expertise or knowledge on the matter."*
>
> *-Male, Caregiver of patient*

***3.4.1.4. Lack of human resource.*** Because of poor insight some patients are noncompliant with treatment. In such cases forced treatment are often required at the initial stage. However, this requires human resources. The caregivers find it difficult to bring the patient to hospital as they do not have anyone who will persuade or to use force to make the patient to visit to doctors.

> *"[To take him to hospital] it requires ten persons to give him an injection . . . . . I may not have the human resource when need that, it is a barrier"*
>
> *-Male, Caregiver of patient*

***3.4.1.5. Time constrains and business.*** Time is a big factor to get treatment. Many people do not take treatment because they can't manage their time. Sometimes patients' regular activities overlap with doctor's appointment especially for those who have jobs or study. In other cases, the caregivers who are supposed to take them to the doctors are busy with their own engagement. Additionally, the long que at the clinics and hospitals and huge road traffic creates additional burden for the service seekers making the treatment a time-consuming business.

> *"It seems treatment is extremely needed but I couldn't go because of my business".*
>
> *-Female, Patient (Non treatment seeker)*

**3.4.2. Lack of professionalism among practitioners.** Experienced or perceived professional skills of the practitioners play an important role in treatment seeking. Nature of interaction with the treatment providers may increase or decrease access to treatment.

***3.4.2.1. Lack of warmth.*** Patients and caregivers expect that the practitioner will be warm, cordial, and respectful with the patient. Sometimes, doctors and nurses do not

treat the psychiatric patient as other patients, which is very disheartening for the patient and caregiver.

> *"We do not respect the mental health patient as like a normal people. This type of behavior is not expected from a psychiatrist. He has to respect his patient. So that patient relies on a psychiatrist."*
>
> *-Female, Caregiver of patient*

***3.4.2.2. Hasty interaction.*** Some caregivers and patients complain that doctor did not give adequate time required for proper intervention. They become disappointed with the doctors behavior where they prescribes medicine with a very brief interaction without listening or interviewing patients thoroughly. They seem not to have much time for the patient.

> *"He didn't talk too much ... they said they understand everything by looking at her face".*
>
> *-Female, Caregiver of patient*

***3.4.2.3. Limited or no explanations.*** Explanation is vital for any treatment especially for mental health problems where there is huge stigmas and lack of awareness. Often the doctors do not explain about the disease and medicine to the patients and caregivers. This can create confusion and lack of faith in the intervention among the service recipients which may ultimately prevent treatment seeking or continuity of care. The following quotation reflects this concern.

> *"He [Doctor] is totally unwilling to disclose anything. Didn't tell me anything. I think it should be more cordial. When someone go of her own, wanting to understand her situation – she should be informed about the state – your condition*

*is this and you should do this and that. It should be like [saying] that you take medicine, and everything will be fine.”*

*-Female, Patient (Non treatment Seeker)*

***3.4.2.4. Judgmental approach.*** Sometimes patients have a fear that the practitioner may make some judgmental comment. This is particularly important in case of mental health problems as there is a high prevalence of societal stigma around mental illness. The following quotation reflects such fear can prevent treatment seeking.

*“Sometimes I felt, what if I went there and got judged [by him/her] and return [home] with the worst feeling. I do not want to have this type of feeling.”*

*-Female, Patient (Non treatment seeker)*

***3.4.2.5. Breach of confidentiality.*** Concern about confidentiality and trust on the providers regarding these is an important aspect in mental health treatment. Sometimes patients feel afraid that their information and identity will be disclosed. This feeling is more intense when someone experience that the practitioner disclosed the identity of the patient.

*“We do not have much of that [protection from disclosure] in our society. Those who treat, talk about or train [encourage] other to receive therapy, they themselves also have gaps in this aspect [disclosure] . . . . . . . . . . I mean, these information are disclosed by them [the service providers] – this person [patient] went to that person [provider]; – he [that patient] has this problem.”*

*-Female, Patient (Non treatment seeker)*

# CHAPTER 4

# DISCUSSION

# Discussion

The present study attempted to explore the barriers to seeking mental health services. Findings were organized into four main categories of the barrier which were comprised of several sub-categories. The broad categories were socio-cultural barriers, perceptual barriers, experiential barriers and structural barriers. The first three are mainly internal aspects and the fourth one is an external aspect. It was also seen that the perceptual barrier is created by socio-cultural barriers and experiential barriers. Knowledge is not only the contributory factor in seeking service. Other factors play a big role in treatment seeking. Comprehensive discussions of all these categories are discussed in the following section.

## 4.1. Socio-cultural Barriers

From our socio-cultural perspective, there are different types of barriers in seeking mental health services cultural belief is an important one among them. People believe that the main cause of mental illness is an evil spirit. Such belief pattern was also found in other studies by (Mantovani, Pizzolati & Edge, 2016). When people believe in possession by evil spirit, their first choice of treatment become traditional healing instead of formal medical treatment. Many of them choose religious healing (Brenman, Luitel, Mall & Jordans, 2014). People also have strong stigma around mental illness for which individuals with mental illness are perceived as mad, crazy (Mantovani et al., 2016; Brenman et al., 2014; Golberstein, Eisenberg & Gollus, 2008). The stigmas trigger emotional reactions such as fear and anxiety that act as a barrier to seek treatment. People have the fear that if they go for treatment their disease state will be revealed which will in turn result in losing acceptance in the society (Lynch, Long & Moorhead, 2018). Gradually they will be isolated and lose their respect from others and will be deprived of facilities available for

everyone else in the society (Thornicroft, 2008). Eventually people lose interest to seek service. The socio-cultural barriers are playing an important role in preventing treatment-seeking not only in our country but also worldwide (Chilale, Silungwe, Gondwe & Masulani-Mwale, 2017). Programs such as awareness campaign are well regarded for their ability to reduce socio-cultural barriers (e.g., faulty beliefs, stigma) and therefore can be useful in improving treatment seeking in Bangladesh. It is important to create awareness that mental illness is an illness similar to other physical illnesses and there are scientific treatments available to treat such illness.

### 4.2. Perceptual Barriers

The present research found six types of perceptual barriers where lack knowledge about the symptoms of psychiatric diseases and services is a major one. Poor mental health literacy is a barrier found not only in our country, but is also regarded globally as a major barrier (Gulliver et al., 2010). As people have limited knowledge about mental health problems and services, they do not understand the seriousness or importance of psychiatric treatment. Literature indicates that, mental illness is considered as an unimportant issue in Bangladesh and therefore, the spending on its treatment is also considered unessential (Hossain et al., 2014). Their perceived need of seeking help for mental illness is very low (Bonabi et al., 2016; Pagura, 2007). Many of them think that mental illness will be cured automatically, so the cost of psychiatric treatment is unnecessary. Additionally, influences by others play a big role in treatment-seeking (Martinez, Co, Lau & Brown, 2020). The family members and relatives often demotivate them by expressing negative ideas and comments about psychiatric treatment. Such negative comments create negative thoughts within prospective service recipients and prevent them from seeking treatment due to anticipated negative impacts and outcomes (Clement et al., 2014). The fear of isolation

and disapproval from others (Salaheddin and Mason, 2016) make the condition worse. As a consequence, they try to find a more convenient way (e.g., faith healer) which requires less effort and are also socially approved. As suggested in research literature, action towards removal of perceptual barriers by improving mental health literacy, increasing social support and encouragement from others may contribute heavily in increasing help seeking behavior for mental illness (Gulliver et al., 2010).

### 4.3. Experiential Barriers

Disease character, treatment character, lack of positive example and altered coping constitute an experiential field which often prevent individuals with mental illness from seeking treatment. Psychiatric illness has some specific characteristics which serve as a direct barrier in seeking service (Wang et al., 2019). For example, a person with depressive disorder has lack of energy and motivation which prevent them to seek service. Similarly, patients with poor insight do not perceive that they have the illness and hence refuse to seek or comply with the treatment. Another important feature of most of the psychiatric illness is invisibility i.e., it happens inside the mind of the person and cannot be seen, this is a major barrier to treatment across the world (Tobin, Napoli & Beck, 2017). Due to this invisibility, the family members do not understand or feel alarmed that the patient needs treatment which results in adoption of alternative options by the patients including harmful coping such as self-medication or substance use (Lynch et al., 2018) or informal treatment (Martinez et al., 2020).

People have a negative attitude toward mental health treatment because of many reasons. The common reason is psychiatric medicines have some adverse effects (Karthik, Kulhara, & Chakrabarti, 2013) and the prognosis of the illness is very slow (Pardo & Khizroev, 2022). This serves as an important barrier for seeking treatment. Practitioner

can play a strong role in reducing this barrier by educating patients and caregivers about the treatment process and the adverse effect of the medicine. This education will help the patient and caregiver be prepared for the process of change and the effects. Positive experience or anecdotal evidences of successful recovery form mental illness can play a facilitating role for help seeking (Martinez et al. 2020). However, due to stigma and other factors, people in Bangladesh hide the problems treatment history from others and thus, successful treatments are rarely known by common people. Strategies on bringing forth such examples of successful treatment for mental illness can be devised which may motivate others to seek similar treatment for their illness.

### 4.4. Structural Barriers

In past research, it has been found that structural barriers have a poor contribution to help-seeking behavior (Rice et al., 2020). But in low and middle income country like Bangladesh, it has an important role in seeking mental health services. Because of as far demand, the resource is not enough to provide service sufficiently. For mental health services need a multi-disciplinary team such as psychiatrists, psychologists, social workers, etc. In the service provider side they are very few in number and most of them work in Dhaka city (Hossain et al., 2014). So in rural areas, the service is not available. From the service receiver side, the service is so expensive. In most cases, it is very hard to continue the service. Financial strain is a strong barrier to seeking service (Byrow et al., 2020). So it is clear that lack of accessibility is an important barrier to help-seeking (Gulliver et al., 2010). Another thing is that because of the stigma the publicity of the service is very poor. So people do not have proper or exact information about the service. Our government should give more attention to the mental health sector. The service should be carried over to the community label.

Practitioner characteristics have a great role in service seeking. From previous research, it is found that confidentiality is a big issue for patients (Gulliver et al., 2010). Not only that people also want someone who is warm and also feels comfortable talking. It is expected that the practitioner will give proper time and listen to his/her problem properly (Staiger et al., 2017). He will understand the patient and also help the patient to make clear about the problem. In this process, the practitioner will be non-judgmental. The professionalism has an important impact on treatment seeking. If professional follow their professional code of conduct and ethics it will help to encourage patient to go for treatment.

## 4.5. Strengths of the Study

From the above discussion, it is clear that mental health services always get less propriety because of different types of barriers. Research in this area is very few, so for better exploration qualitative research was essential which was used in this research. In this study, face to face in-depth interview was used to find out the barrier from different perspectives. Another strength is that maximum variation of sampling is used according to the preplanned study.

## 4.6. Limitation of the Study

Despite an effort to generate in-depth insights grounded in rich data, there are several limitations which could not be addressed in the present research. These are discussed below for future researchers to understand and explore ways to eliminate these.

- The data do not represent perspective of people from poor socio-economic status. Despite several attempts, the researcher could not find anyone interested or agreeing to take part in the interview.

- Snowball sampling was used for the patient group. It is likely, that they have some similarity based on what they are connected. Therefore, it might have undermined the ethos of maximum variation sampling needed for this research.
- The research data did not include any interview from patients who are currently receiving services. It would be useful to understand how they overcome the barriers of seeking treatment. Although the research was not focused on exploring ways people overcome the barriers, however, such exploration might have had added an additional perspective to better understand the barriers and the way they work.

### 4.7. Implication of the Study

The help-seeking barriers found through this research are expected to expand understanding of the large treatment gap (92%) in mental illness in Bangladesh (WHO, 2020). Lack of services and resources are generally perceived as the reason for this gap. However, the present research clearly indicates that individuals and families with mental illness have other barriers which prevent them seeking treatment despite having access to services. Thus, the findings are orienting the policy makers to have an additional focus to reduce treatment gap in Bangladesh. It may contribute in designing and adopting a multipronged approach necessary for effectively increase treatment seeking and reduce treatment gap for mental health illness in Bangladesh.

# CHAPTER 5

# CONCLUSION AND RECOMMENDATION

## Conclusion and Recommandation

The present study explored the barriers in seeking mental health services. There are limited studies in Bangladesh and exploration is absent. To explore service seeking barrier; socio-cultural, perceptual, experiential and structural barriers are need to explore. For this purpose, data are collected from three group of participants including patient group, non patient group and care giver group. For exploration grounded theory approach of qualitative design is used and total eleven in depth interview was conducted.

This qualitative study nineteen themes and seventeen sub categorizes are found under four broad categories. The present study revealed four important aspects to understand the barrier in Bangladesh context. From the finding it is clear that service availability is not only barrier for mental health service. Stigma, cultural belief and other perceptual barrier are playing a strong role. In our cultural context people have some culture and spiritual belief. Moreover, stigma is highly associated with psychiatric service. Still now in our country mental health is neglected. People do not consider mental illness as an illness and it need treatment.

Another important finding is that the disease and treatment have some characteristics that loss a person's interest in service receiving. The interest is also lost because the positive example is not published or highlighted in our society. For that reason patient and care giver prefer alter coping mechanism. At a consequence service is not receive in proper time.

Mental health service needs multi-dimensional approach and the treatment needs long time. Therefore, finance is a big factor for not seeking service. It is also found that the lack of professionalism among our practitioner is a barrier. For that reason service receiver does not feel confident to go for a professional.

The present study has some important value in Bangladesh context. In Bangladesh, help-seeking barriers are not explored. To overcome from barrier, barriers identification is so much important. This research is an attempt to reveal the barrier. That helps the policy maker to make policies to overcome barriers and promote mental health service.

## Recommendation

There are some recommendations for further study, which added the research more value.

1. For further research need more sample size including different group such as expert interview, service receiving patient etc. That will add the research different view.
2. This study conduct in broad spectrum, all types of psychiatric diseases. It will be more helpful if the research will conduct on specific disease oriented barrier.
3. This study is found out the factors that make the barriers in treatment seeking. The interconnection of these factors will give a different dimension, which can conduct in futher study.

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# Appendix A

## Topic guide

ক) মানসিক রোগ বলতে আপনি কি বোঝেন ?

খ) কারো মানসিক রোগ হলে সে কি করে ?

গ) মানসিক রোগের চিকিৎসা সম্পর্কে আপনি কি জানেন ?

ঘ) মানসিক রোগের চিকিৎসা গ্রহণের ক্ষেত্রে মানুষ কি কি বাঁধা বোধ করে বলে আপনি মনে করেন ?

১) ব্যক্তির দিক থেকে কি কি বাধা থাকতে পারে ?

২) পারিবারিক দিক থেকে কি কি বাধা থাকতে পারে ?

৩) সামাজিক দিক থেকে কি কি বাধা থাকতে পারে ?

৪) সেবাপ্রদানকারীর দিক থেকে কি কি বাধা থাকতে পারে ?

৫) চিকিৎসা প্রতিষ্ঠানের দিক থেকে কি কি বাধা থাকতে পারে ?

চ) মানসিক চিকিৎসা সেবা শব্দটি শুনলে কেমন বোধ করেন ?

ছ) আমাদের দেশে কি কি মানসিক চিকিৎসা সেবা রয়েছে ?

১। কারা দিয়ে থাকে ?

২। কোথায় গেলে পাবেন ?

**Appendix B**

**CONFIDENTIAL**

**Contact Details**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Code: | B | G | y | m | d | s | l |
| Code: | B | P | y | m | d | s | l |
| Code: | B | C | y | m | d | s | l |

| |
|---|
| Name: |
| Address: |
| Note: |

Dhaka University Institutional Repository

# Appendix C

## Demographic Information

| Date | | | | | | |
|---|---|---|---|---|---|---|

Code | | | | | | | | | |

| ১)লিঙ্গঃ ☐ছেলে ☐মেয়ে ☐অন্যান্য | ২)বয়স: |
|---|---|
| ৩)বৈবাহিক অবস্থা: | ৪)ধর্ম: |
| ৫)পেশা: | ৬)শিক্ষাগত যোগ্যতা: |
| ৭)পরিবারের সদস্য সংখ্যা: | ৮)পারিবারিক আয়: |
| ৯)ভাই বোন সংখ্যা : | ১০)জন্মক্রম: |
| ১১)আবাসনঃ | |

১২)আপনার কোন মানসিক সমস্যা আছে বলে কি মনে করেন ? ☐হ্যাঁ ☐না

হ্যাঁ ক্ষেত্রে প্রযোজ্য

১২.১)প্রথম সমস্যাটি বুঝতে পেরেছেন কতদিন আগে?.........

১২.২)তার জন্য কোন চিকিৎসা নিয়েছেন কিনা?..................

১২.৩)সমস্যাটি বোঝার কতদিন পর চিকিৎসা নিয়েছেন?.........

১৩)আপনার পরিবারের কারো মানসিক সমস্যা আছে কিনা?

Field Note:

# Appendiz D

## Explanatory Statement Form

### গবেষণায় অংশগ্রহণকারীর জন্য ব্যাখ্যামূলক বিবৃতি

তারিখঃ..../..../ ২০১৯

গবেষণার শিরোনামঃ Exploring barriers in seeking mental health services. (**মানসিক চিকিৎসা গ্রহণের বাধাসমূহ অনুসন্ধান)**

| এই ব্যাখ্যামূলক তথ্যসমূহ, আপনার কাছে রাখার জন্য |
|---|

আমি ফাহমিদা সুলতানা, আমার এম. ফিল. ডিগ্রির অংশ হিসাবে ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগ এর সহযোগী অধ্যাপক, ড. মুহাম্মদ কামরুজ্জামান মজুমদার এর তত্ত্বাবধানে একটি গবেষণা করছি।

*গবেষণার লক্ষ্যঃ*

আমাদের সমাজের অনেকেই আছেন যারা মানসিক ভুগছেন। কিন্তু চিকিৎসা গ্রহণের ক্ষেত্রে দেখা যায় তারা অনেক ধরনের সামাজিক, আচরণগত, আবেগীয়, চিন্তাগত এবং কাঠামোগত বাধার সম্মুখীন হন। যার ফলে তারা হয়ত চিকিৎসা নিচ্ছে না অথবা চিকিৎসা নিলেও তা দেরিতে নিচ্ছে। এই গবেষণার লক্ষ্য হচ্ছে সেই বাধাগুলো কি কি তা খুঁজে বের করা ।

*কেন আপনাকে এই গবেষণায় অংশগ্রহনের জন্য অনুরোধ করা হচ্ছে?*

এই গবেষণায়, মানসিক চিকিৎসা গ্রহণের ক্ষেত্রে বাধার সমূহ জানার জন্য আমি কিছু ব্যক্তির সাক্ষাৎকার নিতে চাই। আমি আপনার কাছে এসেছি কারন আমার মনে হয়েছে যে আপনি এই গবেষণায় মূল্যবান তথ্য দিতে পারবেন। কিন্তু এই গবেষণায় অংশগ্রহনের পূর্বে আমার জানা দরকার যে, আপনার বয়স ১৮ বছরের কম নয়, আপনি কথা বলতে পারেন ও বুঝতে পারেন, আপনি এই মুহূর্তে মাদকগ্রস্থ নন এবং আপনার স্মৃতিশক্তি স্বাভাবিক। কারন, সেক্ষেত্রে এই গবেষণায় অংশগ্রহন করা আপনার জন্য কষ্টকর হতে পারে এবং আপনার দেওয়া তথ্য গবেষণায় গুরুত্বপূর্ণ ভুমিকা রাখতে সক্ষম হবে না।

*গবেষণায় যা করা হবে?*

প্রথমত, গবেষণায় অন্তর্ভুক্তি বিষয়ক প্রশ্নমালা ব্যবহার করে দেখা হবে যে আপনি এ গবেষণায় অংশগ্রহনের জন্য যথাযথ ব্যক্তি কিনা। যদি তা হয়ে থাকেন তাহলে, একক সাক্ষাৎকার এর মাধ্যমে আপনার কাছ থেকে তথ্য নিয়ে, তা অডিও ক্যাসেট ও লিখিতভাবে সংরক্ষণ করা হবে।

*গবেষণায় অংশগ্রহন করলে যে পরিমান সময় দিতে হবে?*

প্রথমত, গবেষণায় অন্তর্ভুক্তি বিষয়ক প্রশ্নমালা ব্যবহার করতে সময় লাগবে ৫ মিনিট। আপনি গবেষণায় অংশগ্রহনের উপযুক্ত হলে, তারপর একক সাক্ষাৎকার এর জন্য আপনাকে ৩০-৫০ মিনিট সময় দিতে হতে পারে। পরবর্তীতে প্রয়োজন অনুসারে এক বা একাধিক বার আপনাকে সাক্ষাৎকার দিতে হতে পারে। তার সময় ও তারিখ আপনার সাথে আলোচনা সাপেক্ষে নির্ধারণ করা হবে।

*সাম্ভাব্য সুবিধা ঃ*

বর্তমান গবেষণা, মানসিক চিকিৎসা গ্রহণের ক্ষেত্রে কি কি বাধা রয়েছে সেগুলো খোঁজে বের করতে গুরুত্বপূর্ণ ভূমিকা রাখবে বলে আশা করা যায়। যা কিনা যথাযথ এবং দ্রুত চিকিৎসা গ্রহণের ক্ষেত্রে প্রধান অন্তরায়। বর্তমান গবেষণায় অংশগ্রহন আপনাকে সরাসরি কোন সুবিধা না দিলেও, এ গবেষণার ফলাফল আমাদের দেশে মানসিক চিকিৎসার বাধাগুলো চিহ্নিত করতে সাহায্য করবে। যা আমাদের দেশের মানুষের সচেতনতা বৃদ্ধি এবং প্রকল্প প্রণয়নে সাহায্য করবে বলে আশা করা যায়।

*গবেষণায় অংশগ্রহনে সাম্ভাব্য অসুবিধা ঃ*

আমি যে বিষয়ে কথা বলবো তা আপনাকে সাময়িকভাবে আবেগীয় করতে পারে বা কিছু বাস্তব সমস্যার কথা মনে করিয়ে মন খারাপ বা অস্বস্তির কারন হতে পারে। কিন্তু এই বিষয়ের জন্য আপনার দীর্ঘস্থায়ী বা মারাত্মক কোন অসুবিধা হবে না বলে মনে করা হয়। প্রয়োজনে আপনি বিএসএমএমইউ অথবা জাতীয় মানসিক স্বাস্থ্য ইনসটিটিউট এ মানসিক স্বাস্থ্য সেবা নিতে পারবেন।

*গবেষণায় অংশগ্রহন প্রত্যাহার ঃ*

এ গবেষণায় আপনার অংশগ্রহন বাধ্যতামূলক নয় বা আপনি অংশগ্রহনের ক্ষেত্রে কোন প্রকারের দায়বদ্ধ নন। আপনার অংশগ্রহন সম্পূর্ণ স্বেচ্ছাধীন। এমন কি অংশগ্রহনের সিদ্ধান্ত নেয়ার পরও একক সাক্ষাৎকার থেকে প্রাপ্ত তথ্যের অনুলিপি অনুমোদনের পূর্ব পর্যন্ত আপনি আপনার অংশগ্রহন প্রত্যাহার করতে পারেন।

*গোপনীয়তা ঃ*

এ গবেষণায় আপনার গোপনীয়তা সম্পূর্ণরূপে রক্ষা করা হবে এবং এ বিষয়ে সর্বাধিক গুরুত্ব দেওয়া হবে। আপনাকে চেনা যায় এমন সব তথ্য ( যেমন আপনার নাম, ঠিকানা) আলাদা একটি কাগজে লেখা থাকবে এবং আপনার দেয়া সাক্ষাৎকার এর তথ্য থেকে আলাদা ভাবে রাখা হবে। যা একটি সাংকেতিক চিহ্ন এর মাধ্যমে একত্রিত করা যাবে এবং এই

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চিহ্ন আমি ছাড়া কেউ জানবে না। আপনার দেয়া তথ্য বা রিপোর্ট এমন ভাবে প্রকাশ করা হবে যেন আপনাকে কোন ভাবেই চিহ্নিত করা না যায়।

*সংগৃহীত তথ্যের সংরক্ষন ঃ*

গবেষণায় সংগৃহীত সকল তথ্য গবেষকের কাছে নিরাপদ স্থানে ৫ বছর সংরক্ষিত থাকবে। গবেষণা থেকে আহরিত তথ্য থিসিস লেখার ক্ষেত্রে এবং এক বা একাধিক মৌখিক উপস্থাপনার ক্ষেত্রে ব্যবহার করা হবে। গবেষণার রিপোর্ট প্রকাশের ক্ষেত্রেও এ তথ্য ব্যবহার করা হতে পারে। এক্ষেত্রে অংশগ্রহনকারীদের গোপনীয়তা সম্পূর্ণরূপে রক্ষা করা হবে যাতে তাদের চিহ্নিত করা না যায়।

*গবেষণার ফলাফল ঃ*

আপনি যদি এ গবেষণার ফলাফল জানতে চান তবে আমার সাথে (01914045210) এ নম্বরে অথবা fahmidashultana26@gmail.com এর মধ্যমে যোগাযোগ করবেন।

আপনার সহযোগিতার জন্য ধন্যবাদ ।

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ফাহমিদা সুলতানা

# Appendix E

## Consent Form

### সম্মতি পত্র

**গবেষণার শিরোনামঃ** মানসিক চিকিৎসা গ্রহণের বাধাসমূহ অনুসন্ধান।

এই সম্মতি পত্রটি গবেষণার রেকর্ড হিসাবে ঢাকা বিশ্ববিদ্যালয়ের গবেষকের কাছে জমা থাকবে।

আমি ঢাকা বিশ্ববিদ্যালয়ের উপরোলেখিত গবেষণায় অংশগ্রহনের জন্য সম্মতি দিচ্ছি। আমাকে গবেষণাটি সম্পর্কে বিস্ড়ারিত বুঝিয়ে বলা হয়েছে এবং আমি এই সংক্রান্ড় ব্যাখ্যামূলক বিবৃতি পড়েছি (বা আমাকে পড়ে শুনানো হয়েছে) যা আমার কাছে রেকর্ড হিসাবে রাখা আছে। আমি বুঝতে পারছি যে, সম্মতি প্রদানের মানে হচ্ছে যে-

| | | |
|---|---|---|
| আমি গবেষকের কাছে সাক্ষাৎকার প্রদানের সম্মতি দিচ্ছি, | হ্যাঁ | না |
| আমি সাক্ষাৎকারটি ক্যাসেটে রেকর্ড করার অনুমতি দিচ্ছি, | হ্যাঁ | না |
| আমি প্রয়োজনে পরবর্তীতে আবারো সাক্ষাৎকার প্রদানের সম্মতি দিচ্ছি, | হ্যাঁ | না |

আমি বুঝতে পারছি যে, গবেষণায় অংশগ্রহন করা আমার স্বেচ্ছামূলক, আমি চাইলেই আংশিক বা সম্পূর্ণ অংশগ্রহন করা থেকে বিরত থাকতে পারব এবং গবেষণার যে কোন পর্যায়ে আমার অংশগ্রহন প্রত্যাহার করতে পারব। এতে আমাকে কোনোরকম ক্ষতিগ্রস্থ করা হবে না।

আমি আরও বুঝতে পারছি যে, গবেষণায় প্রাপ্ত সকল তথ্য গোপন থাকবে এবং এমন কোন তথ্য কারো কাছে বা কোন রিপোর্টে প্রকাশ করা হবে না, যা থেকে আমাকে চেনা সম্ভব।

সাক্ষাৎকারের রেকর্ড এবং তা থেকে প্রাপ্ত তথ্যের লিখিত অনুলিপি সমূহ একটি নিরাপদ স্থানে সংরক্ষিত থাকবে এবং তা শুধু গবেষক ছাড়া অন্য কারো কাছে সহজলভ্য হবে না। এছাড়াও ৫ বছর সংরক্ষণের পর এসব তথ্য ধ্বংস করে ফেলা হবে, যদি এই তথ্য অন্য কোন গবেষণায় ব্যবহারের জন্য আমার পূর্বানুমতি না নেয়া হয়।

অংশগ্রহনকারীর নামঃ ....................................................................................

স্বাক্ষরঃ ..........................................বা টিপসই.....................................

তারিখঃ...........................................................................................

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# Appendix F

## SRQ-20

এস, আর, কিউ, (SRQ)

আপনার জন্য প্রযোজ্য

নিম্নের প্রশ্নাবলীর উত্তর প্রশ্নের পার্শ্বে লিখিত হ্যাঁ ও না জবাবে টিক চিহ্ন দ্বারা প্রকাশ করুন।

নন-সাইকোটিক

১. আপনার কি ঘনঘন মাথা ব্যথা হয়? হ্যাঁ ☐ না ☐

২. আপনার কি ক্ষুধা মন্দা আছে? হ্যাঁ ☐ না ☐

৩. আপনার কি ঘুমের সমস্যা হচ্ছে? হ্যাঁ ☐ না ☐

৪. আপনি কি অল্প কিছুতেই আতংকিত হচ্ছেন? হ্যাঁ ☐ না ☐

৫. আপনার কি হাত কাঁপে? হ্যাঁ ☐ না ☐

৬. আপনি কি বিচলিত, স্নায়ুবিকভাবে উত্তেজিত অথবা উদ্বিগ্নিত হচ্ছেন? হ্যাঁ ☐ না ☐

৭. আপনার কি হজমে অসুবিধা আছে (হজম কম হয়)? হ্যাঁ ☐ না ☐

৮. পরিস্কারভাবে চিন্তাভাবনা করতে কোন অসুবিধা হচ্ছে কি? হ্যাঁ ☐ না ☐

৯. আপনার নিরানন্দ বোধ হয় কি? হ্যাঁ ☐ না ☐

১০. আপনার কি অতি সহজেই কান্না পায়? হ্যাঁ ☐ না ☐

১১. আপনার প্রতিদিনের কাজ করে তৃপ্তি পান কি? হ্যাঁ ☐ না ☐

১২. আপনার কি সিদ্ধান্ত নিতে অসুবিধা হয়? হ্যাঁ ☐ না ☐

১৩. আপনার দৈনন্দিন কাজ কি ব্যাহত হচ্ছে? হ্যাঁ ☐ না ☐

১৪. আপনি কি জীবনের ক্ষেত্রে অবদান রাখতে অসমর্থ হচ্ছেন? হ্যাঁ ☐ না ☐

১৫. আপনি কি বৈষয়িক বিষয়ে আগ্রহ হারিয়ে ফেলেছেন? হ্যাঁ ☐ না ☐

১৬. আপনার কি অনুভূতি হচ্ছে যে, আপনি একজন মূল্যহীন ব্যক্তি? হ্যাঁ ☐ না ☐

১৭. আপনার নিজের জীবন শেষ করে দেওয়ার চিন্তা কি আপনার মনে আসছে? হ্যাঁ ☐ না ☐

১৮. আপনার কি সারাক্ষণ ক্লান্তি বোধ হয়? হ্যাঁ ☐ না ☐

১৯. আপনার পাকস্থলিতে কি আপনি অস্বস্থি (গোলপাক খায়) বোধ করেন? হ্যাঁ ☐ না ☐

২০. আপনি কি অতি সহজেই উদ্বিগ্ন হন? হ্যাঁ ☐ না ☐

মোট হ্যাঁ উত্তর ☐ টি

**ICD-10 (DCR) diagnosis: Cut off point : 8 ≥**

**DSM III-R diagnosis: Non case :**

**Possible case :**

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## Appendix G: Ethical Approval Letter

চিকিৎসা মনোবিজ্ঞান বিভাগ
ঢাকা বিশ্ববিদ্যালয়
কলা ভবন (৫ম তলা)
ঢাকা–১০০০, বাংলাদেশ

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### Certificate of Ethical Approval

Project Number : **MP191001**

Project Title : **Exploring Barriers in Seeking Mental Health Services**

Investigators : **Fahmida Shultana** and **Muhammad Kamruzzaman Mozumder**

Approval Period : **09 October 2019** to **08 October 2021**

Terms of Approval

1. Any changes made to the details submitted for ethical approval should be notified and sought approval by the investigator(s) to the Department of Clinical Psychology Ethics Committee before incorporating the change.
2. The investigator(s) should inform the committee immediately in case of occurrence of any adverse unexpected events that hampers wellbeing of the participants or affect the ethical acceptability of the research.
3. The research project is subject to monitoring or audit by the Department of Clinical Psychology Ethics Committee.
4. The committee can cancel approval if ethical conduction of the research is found to be compromised.
5. If the research cannot be completed within the approved period, the investigator must submit application for an extension.
6. The investigator must submit a research completion report.

. . . . . . . . . . . . . . .

Chairperson
Ethics Committee
Department of Clinical Psychology
University of Dhaka

**Appendix H:**

**Original Quotation and Translated Quotation**

| Theme/Sub theme | English | Bangla |
|---|---|---|
| Contrasting cultural belief | *"Blind faith. This is blind faith which comes for ages. People believe that traditional healer will cure the problem."* | অন্ধ বিশ্বাস। এটা অন্ধ বিশ্বাস থেকে হয় যুগ যুগ ধরে চলে আসছে মানুষ মনে করে ঝাড় ফুঁক করলে ভাল হয়ে যাবে। |
| Stigma | *"This is a problem. It will be a public knowledge that [my] daughter is mad. This is a matter of shame."* | এই একটা সমস্যা লোক জানাজানি হয়ে যাবে মেয়ে পাগল। এই একটা লজ্জা। |
| Stigma | *"Probably he will be proven incapable or mad. These are the tag lines [for mental illness]. People do not seek treatment due to the possibility of being labeled with such tag lines."* | সে হয়ত ইন্সাফিসিয়েন্ট বা ইনকেপাল্ল জিনিসটা প্রমানিত হবে বা পাগল। এই ধরণের বিভিন্ন টেগ লাইন থাকে যা আমার গায়ে লেগে যাবে সেই রকম ভীতি থেকেও মানুষ আসলে যায় না। |
| Stigma | *"There is panic, there is fear that these should not happen to anyone… then I will be sick. No one consider as a human being. Everyone will look at it with hatred."* | আতঙ্ক লাগে, ভয় লাগে এগুলো কারো যেন না হয় --- হলে অসুস্থ থাকব, আমাকে কেউ মানুষ বলে মনে করবে না। সবাই ঘৃণার চোখে দেখবে। |

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| Theme/Sub theme | English | Bangla |
| --- | --- | --- |
| Lack of acceptance | *"Actually, the main fear is acceptance. In reality, society does prevent anyone from seeking help. We wonder if others will say something for my situation – this is the fear"* | এক্সেপ্টে করে নেয়াটাই আসলে মানুষজনের ভয়। সমাজত আসলে বাঁধা দেয় না বা কারো কাছে হেল্প সিক করতে গেলে কিন্তু কেউ বাঁধা দেয় না। আমাদের আসলে মনে হয় ওরা কি আমাকে কিছু বলবে আমার এই সিচুয়েশন এর জন্য। এইটাকে মানুষ ভয় পায়। |
| Lack of acceptance | *"[It] affects your professionalism. When you gave excuse that you could not come [to office] due to headache or fever, that is readily acceptable than when you say you were absent or couldn't communicate for a couple of days because of depression"* | আরেকটা চাকরির ক্ষেত্রে, আপনার প্রফেসনালিজম অনেকটা ক্ষুন্ন হয় যখন আপনি এই এক্সকিউজ দিচ্ছেন আপনার মাথা ব্যাথা বা আপনার জ্বর সেটা অনেকটা রেডিলি এক্সেপটেড দেন যে আপনি ডিপ্রেশনের এর জন্য দুই দিন এবসেন্স ছিলাম অথবা এই সমস্ত কারনে আসতে পারি নাই বা কমিনিকেশন করতে পারি নাই। এগুলো প্রফেসনালিজমকে খারাপ করে। |

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| Theme/Sub theme | English | Bangla |
|---|---|---|
| *Diminished respect* | *"If I am the eldest daughter or eldest daughter in law in a family, I would have a position, some weights. But if for some reason I get a psychological disease . . . . . . . They will not address me from my [usual] position when they talk with me; will not respect me as a senior; will try to humiliate me."* | পরিবারে যদি আমি বড় মেয়ে হই বা বড় বউ হই আমার একটা অবস্থান থাকবে, একটা ওয়েট থাকবে। কিন্তু আমি যদি কোন কারণে মানসিক রোগে আক্রান্ত হই ---------এখন আমাকে ঐ জায়গায় রেখে কথা বলবে না। বড় হিসেবে সম্মান দিবে না। আমাকে হেয় প্রতিপন্য করার চেষ্টা করবে। |
| Social Isolation | *"Will call me a mental case, shun me in the society and mark me an outcast. This fear prevents many from wanting or taking [treatment]* | আমাকে মেন্টাল কেস বলবে আমাকে সোসাইটি থেকে সান করে রাখবে, আমাকে আউট কাষ্ট করে রাখবে, এই ভয়ে অনেকে হয়ত নিতে চায় না বা নিতে পারে না। |
| Social gossiping | *"Everyone will notice that he/she is going to that hospital; His/her relative is mentally sick. . . . . . . . . . . . . In our society mentally sick people are addressed as mad. It has been observed that everyone says - his/her son or brother become mad. Hey how do you know? Hm, I have seen [him/her] going to that hospital. This thing is common in our society"* | যেতে গেলে সবাই দেখবে অমুক ঐ হাসপাতালে যাচ্ছে। অমুকের আত্নীয় মানসিকভাবে অসুস্থ। ---------সমাজের মানুষ মানসিকভাবে অসুস্থ হলে তাকে পাগল বলে এড্রেস করে। দেখা যায় যে সবাই বলবে অমুকের ছেলে বা অমুকের ভাই পাগল হয়ে গেছে। এই মিঞা তুমি কিভাবে জানলা। এই মিঞা দেখলাম অমুক হাসপাতালে গেল । এই জিনিসটা খুব প্রচলিত। |

| Theme/Sub theme | English | Bangla |
| --- | --- | --- |
| Discrimination | *"I will not get help from my colleagues; my working field becomes narrow. I will have fewer promotions. The growth of my carrier will decrease. The growth in my job may start to cease."* | আমি আমার কলিগদের সাহায্য পাব না, আমার কাজের জায়গা কমে যাবে, আমার প্রমোশ্ন কমে যাবে। আমার কেরিয়ারের গ্রোথ কমে যাবে, আমার জবের গ্রোথ বন্ধ হয়ে যেতে থাকবে। |
| Discrimination | *"Now people say depression is fashionable. If someone says he/she is depressed then other will directly tag the person as he/she trying to get attention or something like that. I think this is a social bothering issue"* | এখন আবার দেখা যায় যে মানুষ এ রকমও বলে মানুষ depression এ দেখান হচ্ছে। depression হচ্ছে fasionable, কেউ যদি বলে যে আমি depressed তাহলে সরাসরি টেগ লাগিয়ে দেয়া হবে যে সে মানূষকে দেখানোর জন্য করতেছে বা এই ধরণের কিছু। আমি মনে করি এই জিনিসটা একটা bother সামাজিক দিক থেকে। |
| Mental health literacy | *Mentally ill are those who are very bad tempered, do not know how to handle situations, do whatever they want when they are angry, break things".* | মানসিক রোগ বলতে আমি এখন পর্যন্ত যা বুঝি যারা খুব বদমেজাজী, সিচুয়েশন হেন্ডেল করতে জানে না, রেগে গেলে যা ইচ্ছা তা করে, ভাংগচুর করে এই কেটাগরির মানুষকে আমি মানসিক রোগী মনে করি। |
| Mental health literacy | *"The family think, how come he is depressed, what is his/her anxiety, I am already providing him with everything."* | ফ্যামিলি থেকে এমন হয় যে ওকে তো আমি খাওয়াচ্ছি পড়াচ্ছি ওর এত কিসের ডিপ্রেশন। কিসের দুঃশ্চিন্তা, |

| Theme/Sub theme | English | Bangla |
|---|---|---|
| Mental health literacy | *"I know about two, for mental illness both psychiatrist and psychologist can work. Psychiatrists prescribe medicine based on stage while the psychologists provide therapy or work on behavioral or habit development to reduce mental stress".* | আমি মোটামুটি দুইটা জানি যদি বুঝা যায় যে মানসিক রোগ তাহলে সাইক্রিয়াট্রিস্ট ও সাইকোলজিস্ট এই দুই জন কাজ করে। সাইক্রিয়াট্রিস্ট রা পর্যায়গুলো বুঝে ঔষধ দেয় আর সাইকোলজিস্ট যারা তারা থেরাপি দেয় বা বিহেভিয়ার ডেভেলাপমেন্টের মাধ্যমে বা একটা হেভিট ডেভেলাপমেন্টের মাধ্যমে কিভাবে সেই একই মেন্টাল সেস্টটা কমাতে পারে সেটা নিয়ে কাজ করে। |
| Unimportance | *"Spending money on mental health treatment! It is not necessary. It will be fine automatically. No need to spend money."* | মানসিক রোগের জন্য চিকিৎসার টাকা খরচ করব, এটার মনে হয় প্রয়োজন নাই, এমনি ভাল হয়ে যাবে। টাকা খরচ করতে হবে না। |
| Maintaining status quo | *"People who go for faith healing, are mainly indolent. They do not want solution from acting out. They want things to come from God. I will be sitting and it [solution] will come to me automatically."* | যারা ঝাড় ফুকে বিশ্বাসী তারা কর্ম বিমুখ হয়। কাজের মাধ্যমে তারা সফলতা পেতে চায় না। তারা গায়েবী ভাবে সেটা চায়। আমি এখানে বসে থাকব অটো এটা আমার কাছে চলে আসবে। |
| Treatment induced worsening in condition | *"It will harm [him/her], it will worsen the condition. He'/she might have had one problem; it will add more to that."* | ক্ষতি হবে সে আরো খারাপ হতে থাকবে, তার হয়ত একটা মানসিক সমস্যা ছিল আরো একটা মানসিক সমস্যা হতে থাকবে, মানে সমস্যা এডিশন হবে। |

| Theme/Sub theme | English | Bangla |
|---|---|---|
| Disapproval by other | *"Everyone will ask why? Who told you to visit there? Is there any benefit to visit them? It means [they are] demotivating a person [to go for treatment]. It will develop an insecurity in me, I won't know what they are saying behind me. Maybe they will paint an exaggerated story and communicate that to others."* | সবাই বলবে কেন? কে তোমাকে এগুলা দেখাতে বলছে? এদের কাছে গিয়ে কি লাভ হচ্ছে? মানে একটা মানুষকে ডিমুটিভেটেট করে ফেলতেছি। আমার মধ্যে একটা ইনসিকিউরিটি আসবে। আমি জানব না সে আমাকে নিয়ে পিছনে কি কি বলবে? আমার আত্নীয় স্বজনরা হয়ত তারা সেটাকে রঙ চঙ দিয়ে আরো বাড়ায়ে বলবে? |
| Lack of preparedness | *"I am not sure, if I am mentally prepare to deal the matter? I am not sure how much I will be able to trust worth the person. Yes, I know if I don't take any chance, I won't be able to move forward - but I am not ready to take the chance yet".* | আমি ব্যাপারটা ডিল করার জন্য মানসিকভাবে প্রস্তুত কিনা সেটা নিয়ে আমি শিঊর না। আমি যার কাছে যাব আমি তাকে কতটুকু বিশ্বাস করব এই ব্যাপারটাতে আমার একটু সমস্যা আছে। হ্যাঁ চান্স না নিলে আমি কখনো আগাতে পারব না আমি জানি। কিন্তু চান্স নেয়ার জন্য আমি এখনও প্রস্তুত না। |
| Symptom itself | *"If a person does not understand that he/she has got a problem, it is difficult to take him/her to treatment. You can't tie him/her up and bring to treatment"* | একটা বিষয় যদি পেশেন্ট না বুঝে তার সমস্যা তাহলেত তাকে নিয়ে যাওয়া একটা সমস্যা, তাকেত আপনি বেধেও নিয়ে যেতে পারবেন না। |

| Theme/Sub theme | English | Bangla |
|---|---|---|
| Symptom itself | *“I can’t get the motivation to go out and talk with anyone, so I missed the appointment.”* | আমাকে বাসা থেকে বের হয়ে কারো সাথে কথা বলতে হবে এই মটিভেশন আমি নাও পেতে পারি। এই কারনে আমি হয়ত এপ্যায়েন্টমেন্ট মিস দিতে পারি |
| Invisibility | *“One thing, when someone gets physically hurt, it is visible, and therefore, people immediately go for treatment. But mental diseases are not visible, so we don’t understand, and we do not go.”* | একটা জিনিস হচ্ছে কেউ যখন ফিজিক্যালি হার্ট হয় তখন সেই জিনিসটা ভিজিব্যাল সেইক্ষেত্রে মানুষ ইমিডিয়েট সিক করে আমার চিকিৎসা দরকার। কিন্তু মানসিক ব্যাপারটা ভিজিব্যাল না। সেজন্য আমরা বুঝিও না যার জন্য আমরা যাই না। |
| Adverse effect | *“Anything [Medicine] has adverse effect such as excessive sleep, I didn’t feel good that’s why did not continue [treatment].”* | যে কোন জিনিস এর এডভার্স ইফেক্ট যেমন ঘুম বেশি হওয়া ইত্যাদি কারণে আর ভাল ফিল করছিলাম সে জন্য আর কনটিনিউ করা হয় নাই। |

| Theme/Sub theme | English | Bangla |
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| Slow progress | *"It takes time to get benefit from this [psychiatric treatment]. . . . . . . For depression it takes time to bring some changes with antidepressant [medicine]. We also say, many medicine do not work until it is taken for [at least] one month. In such case those who knows or doesn't know [this] face difficulty to keep patience".* | এটার বেনিফিট আসতেও অনেক সময় লাগে।---------একটা ডিপ্রেশন এর ক্ষেত্রে তাকে এন্টিডিপ্রেশন দিয়ে মোটামুটি একটা জায়গায় আনতে সময় লাগে। আমরা নিজেরাই বলি অনেক ঔষধ এক মাসের আগে কাজই করে না। সেক্ষেত্রে যারা জানে না বা জানেও তাদের ধৈর্য্য ধরে রাখাটা ডিফিকাল্ট। |
| Lack of positive example | *"We have very little examples where someone got cured of mental health problem through treatment."* | আমাদের কিন্তু এই রকম এক্সামপল খুব কম যে কেউ মানসিক চিকিৎসা নিয়ে ভাল হয়ে গেছে। |
| Seeking informal treatment | *"I think at first people did not seek out for doctor or counselor. They [follow advice of] people around them - go for a tour, talk to friends - you will feel better. They try to manage in this way."* | প্রথমে যেটা করে বলে আমার মনে হয়, মানুষ প্রথমেই ডাক্তার সিক আউট বা কাউন্সিলর সিক আউট করে না। তারা মানে আশে পাশে যারা বলে এখান থেকে ঘুরে আস, ওর সাথে কথা বলে আস, বন্ধুদের সাথে আড্ডা দেও তাহলে হয়ত তোমার ভাল লাগবে। এভাবে মেনেজ করার চেষ্টা করে। |

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| Theme/Sub theme | English | Bangla |
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| Seeking informal treatment | *"I reach out to the people who are like me [have similar problems]. I think they are more sensible, and they understand the matter and treat people in that way."* | আমি যাদের কাছে রিচ আউট করছি তারা আমার মত মানুষ। আমি মনে করি তারা অনেক সেন্সসেবল এবং তারা বিষয়গুলো বুঝে এবং সে রকমভাবে মানুষকে ট্রিট করে। |
| Engaging in self-damaging practices | *"I do not have a clear idea of how they cope [when they don't go for treatment] . . . . . . . he may get involved in drug. If the person has a habit of smoking, he may try to smoke to get rid of the negative thoughts – [these] are injurious for health"* | সে হয়ত ড্রাগের মধ্যে ইনভ্লভ হয়ে যেতে পারে। কেউ হয়ত যারা স্মোকার তারা যখন স্মোক করে ঐ সময়টাতে তাদের মধ্যে বাজে চিন্তা আসে না দেখে সে চিন্তা করে, তার হেলথ এর জন্য ইঞ্জুরিয়াস। |
| Financial constraints | *"Treatment mental health requires multiple sessions. Obviously there is transport cost. These cost of session [fees],. transport cost, doctor's fee – [the family member] perceive these as an extra cost. [They] are not willing to spend this extra cost."* | মানসিক রোগের চিকিৎসা নিতে গেলে কয়েকটা সিটিং এর প্রয়োজন হয়। যাওয়া আসার খরচত আছেই। এই যে কয়েকটা সেটিং এর খরচ, যাওয়া আসার খরচ, ডাক্তারের খরচ এই খরচটাকেত এক্সট্রা খরচ মনে করে। এই খরচটা করতে রাজি হয় না। |

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| Theme/Sub theme | English | Bangla |
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| Financial constraints | *In our country, most of the females are dependent on others. Other meaning - father or husband. We have no income. So, we can't take our own decision. As we are dependent on them, we have to accept their decision. If they say we can't spend money on this matter then there is no treatment, and the situation gets stuck.* | আমাদের দেশের বেশির ভাগ মেয়েরাই অন্যের উপর নির্ভরশীল। অন্যের মানে হয় বাবার উপর না হয় স্বামীর উপর। আমাদের নিজেদের কোন ইনকাম নাই। যাতে আমরা নিজেরা সিদ্ধান্ত নিতে পারি। যেহেতু তাদের উপর নির্ভরশীল আমরা তাদের সিদ্ধান্তটাই আমাদের মেনে নিতে হয়। তারা যদি বলে না আমরা এই ব্যাপারে কোন রকম পয়সা খরচ করতে পারব না চিকিৎসা হয়ও না ব্যাপারটা আগায়ও না। |
| Need for multi-dimensional resources | *"Really, it's difficult because it need multi-system involvement, need multiple person involvement. If I need to go to the psychiatrist, it's not like that only I need to know this, I have to inform my parent or others who are involved with this."* | এটা আসলেই ডিফিকাল্ট কারণ এখানে মাল্টি সিস্টেম ইনভল্ভমেন্ট লাগে, মাল্টি পার্সন এর ইনভল্ভমেন্ট লাগে, আমি ডাক্তারের কাছে যাচ্ছি সেটা শুধু আমি জানলে হচ্ছে না আমার পেরেন্ট কে ও জানতে হচ্ছে অথবা অন্য কেউ যদি ইনভল্ভ থাকে তাকেও জানতে হচ্ছে। |
| Limited sources information | *"The number of times I have face this problem, I have had money, human resource but didn't find anyone who has expertise or knowledge on the matter."* | আমি যে কয়বার প্রবলেমটা ফেস করছি আমার কাছে টাকা ছিল, মানুষ ছিল কিন্তু এই বিষয়টা সম্পর্কে এক্সপার্ট বা জানে এই রকম কোন লোক ছিল না। |

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| Theme/Sub theme | English | Bangla |
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| Lack of human resources | *"[To take him to hospital] it requires ten person to give him an injection . . . . . I may not have the human resource when need that, it is a barrier"* | দশ জন মানুষ মিলে তাকে ইনজেকশন দিতে হবে -------প্রয়োজনের সময় আমার কাছে জনবল নাও থাকতে পারে এটা একটা বাঁধা। |
| Time constrains and business | *"It seems treatment is extremely needed but I couldn't go because of my business".* | আমার মনে হয়েছিল আমার জিনিসটা এক্সট্রির্মলি দরকার এবং আমি হচ্ছে ঐ সময় ব্যস্ততার কারনে যেতে পারি নাই। |
| Limited availability | *"If we saw people going to get service very easily, the help seeker and help provider both are available then we will go easily for service. We see the doctor's chambers at the corner, but we do not see the psychiatric chamber at the corners. This type of practice is not usually seen."* | আমরা যদি দেখতাম মানুষ খুব সহজেই যাচ্ছে মানে হেল্প সিকার এবং হেল্প প্রভাইডার দুই জনই এভেলেভেল তখন কিন্তু আমরা খুব সহজেই চিকিৎসা সেবাটা নিতে যেতাম। যেমন আমরা মোড়ে মোড়ে ডাক্তারের চেম্বার দেখছি কিন্তু মোড়ে মোড়ে মানসিক চিকিৎসার চেম্বার দেখি না। এই ধরণের প্রক্টিস আমরা সচরাচর দেখি না। |

| Theme/Sub theme | English | Bangla |
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| Lack of warmth | *"We do not respect the mental health patient as like a normal people. This type of behavior is not expected from a psychiatrist. He has to respect his patient. So that patient relies on psychiatrist."* | আমরা একজন স্বাভাবিক মানুষের সাথে যেভাবে সম্মান দিয়ে কথা বলব, মানসিক বিকার গ্রস্ত মানুষের সাথে আমরা সেভাবে কথা বলি না। একজন চিকিৎসকেরত সেটা করলে হবে না। তার পেশেন্টকে আরো সম্মান দিয়ে কথা বলতে হবে। যাতে পেশেন্ট চিকিৎসকের উপর ভরসা করতে পারে। |
| Hasty interaction | *"He didn't talk too much;………… they said they understand everything by looking at her face".* | কিন্তু কথা বলল না বেশি একটা।---------ত কথা বলল না বেশি একটা ওনারা বলে চেহারা দেখেই সব বুঝে ফেলে। |
| Limited or no explanation | *"He [Doctor] is totally unwilling to disclose anything. Didn't tell me anything. I think it should be more cordial. When someone go of her own, wanting to understand her situation – she should be informed about the state – your condition is this and you should do this and that. It should be like [saying] that you take medicine, and everything will be fine."* | হি ইজ টোটালি আনঅয়েলিং টু ডিজক্লোজ এনিথিং। কিছুই বলে নাই আমাকে। আমার কাছে মনে হয়েছে এই ব্যাপারটাতে আরো অন্তরিকতা থাকা উচিৎ। কেউ যখন নিজে যাচ্ছে, নিজের সিচুয়েশন টা বুঝতে চাচ্ছে এট লিষ্ট তাকে ব্যাপারটা জানান উচিৎ। আপনার অবস্থা হচ্ছে এটা এবং আপনার এই অবস্থার জন্য এই এই করা উচিৎ। মানে এই রকম না যে শুধু ঔষধ খাও ঠিক হয়ে যাবে। |

| Theme/Sub theme | English | Bangla |
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| Judgmental approach | *"I have said something, but he did not take it seriously. Sometimes I felt, what if I went there and got judged [by him/her] and return [home] with the worst feeling. I do not want to have this type of feeling."* | আমি কিছু একটা বললাম সে আমার কথাটা সিরিয়াসলি নিল না। মাঝে মাঝে মনে হইছে যদি এমন ঘটে আমি যাই আর আমাকে জাজ করে, আমি আরো খারাপ লাগা নিয়ে ফিরে আসলাম। ঐ ফিলিং টা আমি চাই না। |
| Breach of confidentiality | *"We do not have much of that [protection from disclosure] in our society. Those who treat, talk about or train [encourage] other to receive therapy, they themselves also have gaps in this aspect [disclosure] . . . . . . . . . . I mean, these information are disclosed by them [the service providers] – this person [patient] went to that person [provider]; – he [that patient] has this problem."* | আমাদের সমাজে ভাল একটা ইয়ে নাই। যারা দেখছেন, যারা কথা বলছেন যারা ট্রেন করছেন এখানে আসার জন্য তাদেরও এই জায়গাটাতে ঘাটতি আছে তারা এটাতে empress করতে পারছে না, মানে এটাতে stigma নাই। মানে এই কথা গুলো তাদের মাধ্যমে ছড়ায়। অমুকে তার কাছে যায়, অমুকে তাকে দেখায়, এই সমস্যা। এই ব্যাপারে আরো সচেতন হওয়া উচিত। |