

Explanatory Models and Help-Seeking Behavior: Pathways to Psychiatric Care Among Patients Admitted for Depression in Mulago Hospital, Kampala, Uganda

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In this article, the authors present findings from a qualitative study exploring how people diagnosed with depression conceptualize their condition and how their conceptualization shaped their efforts to seek help. They used an interview guide based on an explanatory model framework for data collection. Four major themes emerged from the analysis: (a) somatization, social meaning of illness, and help seeking; (b) meaning and perceived consequences of illness; (c) How did I get here? Making sense of psychiatric admission; and (d) variations in the causal attribution and the role of significant others in help seeking. Somatization of emotional problems, variations in causal attribution between patients and their significant others, the nature of the available health care system, and burden of infectious disease complicate access to care. These findings suggest the need to raise the awareness of primary care providers on how to recognize and help people with depression appropriately in this setting.

Keywords: *depression; explanatory model; pathway to care; help seeking; qualitative research*

Depressive disorders are the most prevalent of all psychiatric disorders, accounting for up to 30% of primary care service utilization in developing countries (Desjarlais, Eisenberg, Good, & Kleinman, 1992; Raguram, Weiss, Keval, & Channabasavanna, 2001). These disorders have substantial effects on the individual, family, and society and are associated with more functional disabilities than chronic medical illness is (Broadhead, Blazer, George, & Tse, 1990; Wells, Stewart, & Hays, 1989).

Despite their frequency and magnitude, depressive disorders are said to have significant cultural variation in clinical presentation (Manson, 1995), making them less likely than many other health problems to be recognized and treated by clinicians (Eisenberg, 1992; Raguram et al., 2001). Delays, misdiagnosis, and unspecific treatments have been typical pathways to care for people with depression (Cooper et al., 1997; Mechanic, McAlpine, Rosenfield, & Davis, 1994).

According to a World Health Organization (WHO, 2001) annual report, depression is one of the disorders causing increased costs of health care due to unnecessary investigations and inappropriate or nonspecific treatment. Individuals with depression use health care

services in the general medical and mental health care sector three times as often as nondepressed individuals, even after controlling for medical comorbidity (Shapiro et al., 1984). Undiagnosed depression places a significant socioeconomic burden on individuals, families, and communities in terms of increased service needs, lost employment, reduced productivity, poor parental care with the risk of transgenerational effects, and, thus, as a whole an increased burden on caregivers (WHO, 2001).

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Population, Context, and Culture

Buganda is located in the south-central region of the country known today as Uganda. This is right in the heart of Africa, astride the equator and at the source of the great river Nile, the watershed of which takes in the largest part of south-central Uganda (Nzita & Mbaga-Niwampa, 1998).

The people of Buganda are referred to as *Baganda*; their language is called *Luganda*, a Bantu dialect that uses prefixes, infixes, and suffixes in classifying both living and nonliving things. Human beings are classified under the *Mu-ba* class; hence, the people are called *Muganda* and *Baganda* (singular and plural forms, respectively) (Muliira, 1967). They refer to their customs as *Kiganda* customs. Sometimes the generic term *Ganda* is used for all of the above.

Spirits are regarded as an important aspect of health and illness. There are two main categories of spirits: family and community ancestors, and alien and evil spirits. The Baganda, like many other ethnic groups in Africa (Good & Kamani, 1980; Patel, 1995), believe that after the body dies and decomposes, the soul still exists as *omuzimu* (singular of *Mizimu*). Family and community ancestors are usually involved in the maintenance of good health, although if they are upset, they might cause illness and misfortune. The alien and evil spirits are more likely to cause illness maliciously (Okello & Ekblad, 2006). The Baganda believe in superhuman spirits in the forms of *mizimu*, *Misambwa*, and *Balubaale* (sing. *Lubaale*). These beliefs are referred to as traditional religion (Nzita & Mbaga-Niwampa, 1998).

However, with the coming of missionaries in the 19th century and advent of Christianity in Buganda, beliefs became more ambiguous, following the Christian teaching, which considered African belief systems as satanic or pagan. In the past generation, however, the new order represented by imported religions and political systems has been found to be wanting, not only in the poor cohesiveness and function of the community but even in the personal conduct of religious and community leaders. Thus, the traditional ways are once again treated with respect, even to the extent that the traditional terms for such things as a shrine (*ekiggwa*) or a prayer (*okusamira*) are now being used to describe Christian churches and services. This combination has given rise to its own dilemmas, with many people indicating that the combination of two systems might be responsible for ill health in the society.

It has also been shown that the Baganda have two groups of illnesses, the “Kiganda illnesses” and the “non-Kiganda illness” (Orley, 1970). In general, the Kiganda illnesses are those that Baganda believe to have been afflicting them before the Arabs and Europeans came to their country. Such illnesses are also thought to be strong, and there are traditional forms of therapies for them. Western medicine is not considered to be particularly effective in treating such illnesses (Okello & Musisi, 2006; Orley, 1970).

Besides the causative agents, beliefs about body and body functioning have been found to be important in explaining ill health. The Baganda think of their illnesses in terms of the part of the body affected; thus, a cough might be referred to as *ekifuba*, literally translated as “affecting the chest” (Bennett, 1963; Orley & Wing, 1979). Nonpsychotic depression is seen as an illness of thoughts (*Ebirowoozolo/okweralikirira*) and as having its etiology from psychosocial problems, such as marital conflicts and poverty. On the other hand, psychotic depression seems to be associated with poor relations between the living and the dead (Okello & Ekblad, 2006; Okello & Musisi, 2006).

This distinction has implications for help-seeking behavior. If a person is ill and he or she and his or her significant others consider it to be a kiganda illness, that person will be encouraged to seek help from a traditional healer. If it is deemed a non-kiganda illness, he or she will most likely seek help from a Western-type medical facility. Although witchcraft is occasionally mentioned in reference to the etiology of depression, psychosocial problems and poor relations between the living and the dead seem to be important in the etiology of nonpsychotic and psychotic depression, respectively.

Depression in Uganda

The few available prevalence studies in Uganda estimate depression at 10% to 25% in the general population (Bolton, Wilk, & Ndongoni, 2004; German, 1987; Orley & Wing, 1979; Ovuga, Boardman, & Wasserman, 2005). However, the difficulty with depressive illness in Uganda, as in many other parts of the world, is in recognition and differentiation from other psychological symptoms, such as trauma from wars and emotional problems related to the burden of physical disorders, particularly infectious diseases such as malaria, tuberculosis (TB), and HIV/AIDS (Nakasujja, 2002).

It has been noted that the encounter between patient and doctor is a transaction between the explanatory models of each party (Kleinman, 1980). It has been well demonstrated that patients' explanatory models can provide insight into lay beliefs about illness; the historical, personal, and social meaning of the illness; expectations about what will happen as a result of illness; and how and when a healer is expected to intervene and can identify the short- and long-term therapeutic goals. Such knowledge is said to facilitate communication in a clinical encounter and, consequently, diagnostic acumen.

The biomedical models of depression are generally available through educational pamphlets, usually written in local languages, and through health education sessions during consultation with psychiatrists. However, the patients' understandings of depression are less readily available to the clinicians.

The objective of this part of the study was to examine the perception of depression, as defined by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994)*, among people receiving treatment for depression, with the aim of describing patients' personal and social meaning of the illness, their beliefs related to the cause and consequences of depression, and what triggered their seeking psychiatric help.

Method

Study Design

We conducted this qualitative interview study with the aim of developing an understanding of depression from the patients' point of view by exploring how people diagnosed with depression conceptualized their illness and how the conceptualization shaped courses of action in the search for help. Our intention was to capture the complexity of the decision to seek help for depression. A qualitative research design was chosen because it facilitated our obtaining in-depth knowledge of human realities and meanings (Morse & Field, 1995).

The Site

Mulago Hospital, located in Kampala, the capital city of Uganda, where this part of the study was conducted, serves as both the national referral hospital and regional hospital for the central region in the hierarchical structure of health care service organizations in Uganda. As a regional hospital, Mulago serves the

people of Kampala and surrounding districts, most of whom belong to the Ganda cultural group. As a national referral hospital, Mulago receives patients referred from all regions of Uganda.

Sample and Sampling Procedure

The sample was purposively selected with the aim of identifying informants who would enable exploration relevant to the study. Sampling was made by referral from local psychiatrists running the mental health clinic. Inclusion criteria were having depression as an Axis I diagnosis (American Psychiatric Association, 1994), being 18 years and older, and belonging to the Ganda cultural group. The participants were recruited between May 2003 and December 2004.

Data Collection Procedure and Methods

Patients were identified and referred to our research team by the attending psychiatrists in the unit. The first author (EO), with the help of trained research assistants (a clinical psychologist and a psychiatric nurse), conducted diagnostic interviews using the MINI-Mini International Neuropsychiatry Interview (Sheehan & Lecrubier, 1998) for Axis I diagnosis to confirm the psychiatric assessment of the clinician. We administered the Montgomery-Åsberg Depression Rating Scale (MADRS; Montgomery & Åsberg, 1979) to gauge the severity of the symptoms. These standard instruments were used only to ascertain the biomedical explanation of the symptoms. After this had been ascertained, we asked the respondents to participate in the follow-up explanatory interview, which was the main focus of the study.

The interview explanatory model (EM) protocol was used as an interview guide to collect data. EM protocols were intended for collection of information concerning the informants' perception about their illness. The central question was how individuals explain their illness. The subquestions were the following: What did they consider helpful? At what stage was that help sought, and what triggered their seeking help? Although there was an interview guide, the researchers tried to achieve a good balance between structure and flexibility. The interview lasted 60 to 90 minutes.

Of those who were approached, all except two participated in the study, and their material is involved in the analysis. The two who did not participate, although they had initially agreed to do so and actually participated in the MINI interview, left the ward without discharge notes before the day of interview.

Given the unreliability of the physical addresses in our setting, following up on them proved difficult. Hence, no information about them is included in the analysis.

Respondents' Characteristics

Consenting participants included 19 women and 6 men ranging from 18 to 75 years with a median age of 45 years. Regarding education level, 47% of the participants had 7 years or less of primary education, 43% had secondary school education, and 10% reported some years of college education.

Twenty-two of 25 participants met the criteria for major depression current episode. Thirteen of these had recurrent depression, 3 had chronic symptoms, and 7 had been admitted for their first episode. Two participants met the criteria for dysthymia, and 1 fulfilled the criteria for adjustment disorder with depressed mood (American Psychiatric Association, 1994). The 3 participants who did not meet the criteria for major depression were referred from the outpatient clinic.

The MADRS was used to assess the severity of the symptoms. The severity of the symptoms was determined using Mueller and others' score of 31 as a cut-off point between severe and moderate symptoms (Mueller, Himmerich, Kienzle, & Szegedi, 2003). A score of 31 or less was interpreted as moderate, whereas one greater than 31 was regarded as severe. Fifteen participants had severe symptoms, ranging from 32 to 51 points. Ten participants were moderately depressed, with scores ranging from 19 to 31 at the time of the interview.

EO, with help of an interpreter, conducted 60% of the interviews; two trained research assistants (a clinical psychologist and a psychiatric nurse) conducted the remaining 40%. All of the interviews were conducted in a private, comfortable, and quiet room located within the hospital that was usually used as a seminar room for training medical students.

Ethical Issues

Ethical approval for the study was gained from Makerere University ethics committee (Uganda), Uganda National Council for Science and Technology, and the Regional Research Ethics Committee at Karolinska Institutet (Sweden). Individual informed consent was gained from informants. Informants were assured of confidentiality and their right to withdraw from the study at any time. Permission to audiotape the interview sessions was sought from each informant. Sometimes during the interview, strong emotions about

illness experiences were evoked. Under such circumstances, sufficient time was allowed for the informants to air their feelings, and they were then asked if they were willing and able to continue. Participants who required emotional support were referred as appropriate to a clinical psychologist who was not part of the study team. With the permission of the participants, all the interviews were tape-recorded. To conceal the identity of participants, no names or other form of identifier is used in this article. Although it was not possible to share the findings with all the participants, EO made individual follow-up visits to share the interpretations of participants' transcripts after analysis.

Theoretical Framework

The analysis of material for this article was informed by symbolic interaction theory (Blumer, 1969), a basic principle of which is that all objects, events, and situations acquire their meaning through the process of human interpretation. The meanings attached to objects, events, or situations are not built into them. Instead, they are products of human responses to them. In this regard, all human experience is an ongoing exercise in sense making of those experiences. However, some social situations are more ambiguous than others, requiring more extensive interpretation; depressive illness is one of those human experiences that have proven to be ambiguous in symptoms as well as in care experiences (Karp, 1996; Nelson, Rosenfeld, Breitbart, & Galietta, 2002).

The material regarding respondents' efforts to conceptualize depressive symptoms is interpreted with the following assumptions in mind: First, people individually and collectively act based on the meaning that circumstances or experience has for them. Second, meaning arises in the process of interaction among individuals. Subsequently, behavior is based on these meanings, which emerge from within the context of social life and are modified and dealt with through an interpretative process that occurs as persons respond to the circumstances they are in (Stryker, 1980). Meaning is sought as an object of cognitive struggle that is directed toward providing a sense of purpose for the crisis situation and enables the individual to place the event in the context of other aspects of his or her life (O'Connor, Wicker, & Germino, 1990). Third, meanings are assigned and modified through an interpretative process that is ever changing, subject to redefinition, relocation, and realignment. Fourth, the individual and the context in which he or she exists are inseparable from this process (Blumer, 1969).

Data Analysis

The analysis was conducted both manually and with the help of a computer program.

A bilingual speaker transcribed the recorded interviews verbatim. We began the analysis process by gaining familiarity with the data by reading the transcripts several times, followed by open coding. The open coding involved initial fracture of the data into expressions, lines, or paragraphs (Jeon, 2004) to explore all possible aspect of the ideas. Then descriptive codes were developed as labels for meaning of issues and ideas. We used NVivo 2.0, a qualitative software program, when coding and organizing the data. The second level of analysis entailed moving from codes to interpretation and reconstruction. This process allowed us to make links and connections between different codes and patterns and between categories. This involved putting data together for new understanding; however, this was possible only with reference to the raw data (Strauss & Corbin, 1990). The two authors (EO and SN) continually discussed codes and interpretations during the analysis process.

The NVivo program facilitated the process of rethinking with the data, recoding, reorganizing, testing, and checking the interpretation. In the last level of analysis, we focused on the integration with the literature and construction of theoretical understanding.

Criteria for Rigor

Verification of scientific data is assessed in relation to trustworthiness. Trustworthiness is the term used to describe rigor and validity in qualitative research (Crabtree & Miller, 1992). In this study, we followed the criteria for rigor of credibility, conformability, recurrent patterning, and saturation (Leininger, 1991; Muhlbauer, 2002). Credibility refers to truth, accuracy, and believability of findings; and accuracy, credibility, and believability of informants. The accuracy was supported by similarity of the findings from varied sources of data, and credibility was supported by the repetition of similar experiences by the majority of the participants.

Confirmation was evidenced by the frequency of cited experiences. For example, 22 out of 25 respondents interviewed came into contact with psychiatry only when others defined their behaviors as socially disruptive. Recurrent patterning refers to repeated instances, sequences that occur over time in designated ways and contexts. This became readily evident

as informants described their pathway to seeking help for their symptoms.

Findings

The findings are presented in four themes: (a) somatization, social meaning of illness, and help seeking; (b) meaning and perceived consequences of illness, whereby patients tried to make sense of illness by attempting to answer questions such as What is it? What caused it? and What effect does it have?—that is, the assessment of the effect the illness has on the individual and his or her family; (c) How did I get here? Making sense of psychiatric admission, a theme that reflects the efforts of the patients to assess the effect of their contact with psychiatric services on their identity; and (d) variations in the causal attribution and the role of significant others in help seeking. This theme assesses the role of significant others in the help-seeking process, whereby patients tried to answer questions such as What did others think about my problem? What was their role in making the current choice? and Was the choice appropriate considering the symptoms? In other words, how have their beliefs affected the process of seeking help?

Somatization, Social Meaning of Depression, and Help Seeking

Somatic complaints were spontaneously volunteered by a majority of the respondents as the reason for the first help seeking. Somatization has been variously described as functional, biomedically unexplained, somatic symptoms, somatic preoccupation, or worry about illness or undue emphasis on the somatic concomitants of psychiatric disorders (Kirmayer, Robbins, Dworkind, & Yaffe, 1993). It is also regarded as an important reason for underutilization of mental health services in non-Western societies (White, 1982). Informants mentioned somatic symptoms such as headache, body weakness, fever, malaria, and general body pains as some of the complaints that were presented to health care providers. One woman said,

I have a problem with my stomach here. Something attacks from within and hurts so much . . . and my legs are also hurting a lot.

However, when she was asked to describe the origin of her pain, the informant had this to say:

I am unhappy; I do not feel I am what I should be. I pray to God to save me from this misery. . . . My people leave me home alone without any one to help me. I used to have a servant, she used to help me but she went. My son used to help me unfortunately he died recently. (75-year-old woman with recurring depression)

Another informant said this:

I have had this headache for a long time; however, it got worse in 1999 when my husband got another woman. I could no longer stay with him and that is when my condition worsened. (42-year-old woman with depression)

Although somatic symptoms are reported initially, on further inquiry, the patient began talking about the condition that brings about the somatic distress. With probing, it became apparent that the pains in their bodies were anchored in the contexts of their everyday lives, as participants expanded the explanations of physical pains to include social circumstances relating to their distress. Some of the social circumstances included conflicts in the family, difficulties in marriage, and perceived neglect of the elderly. Although the pains are located inside the individual body, they reflect the events and constraints of the social space of which they are part. The physical experience of the body is always modified by the social categories through which it is known and sustained in a particular view of the society. The body in pain might contain within it an image as well as a message.

Consequently, a patient's narrative of his or her illness included statements linking his or her physical distress to social predicaments, moral sentiments, and otherwise unexpressed emotions. Hence, complaints that seem (to the medical practitioner) to be evidence of a syndrome of somatic symptoms might, in reality, encode an ethnomedical theory. This might explain in part the fact that the treatment focus in the earlier consultation was on the somatic complaints, making entry into psychiatry possible only when there was emotional breakdown.

Although there was clear gender imbalance in the sample, it was noticeable that female and older informants related their physical distress to social circumstances more often than younger and male informants did.

Informants' stories made apparent the fact that general health care providers attended to somatic symptoms and did not make efforts to explore possible underlying psychological distress, although this cannot be interpreted as neglect on the part of the care

providers, given the burden of infectious diseases. However, the patients' problems were not sufficiently attended to; hence, they continued with the search for help.

Meaning and Perceived Consequences of Illness

Informants made efforts to give meanings to their symptoms and assess effects that the symptoms had on their life in general and their identity in particular. The meaning making was an ongoing process whereby informants tried to make sense of their suffering. The stories carried descriptions of causal attribution as well as constant reevaluation of earlier ideas and the process of actively seeking new knowledge about the explanatory process. Causal explanation patterns were characterized by presentation of more than one attribution, as the narrative in the following extract suggests:

My head has a problem. (*Would you please elaborate?*) My head has a problem it gets chaotic. Sometimes is like there bells ringing in it. I got fever, but you see in the village I am active. I have been involving myself in a number of activities. Even the local leader in our area had promise to take me a course in modern agriculture. People may not be very happy about my progress. They become jealous because I am successful; I think they are bewitching me. I think they are doing certain things to hinder my progress. (20-year-old man)

For some informants, the symptoms' attribution continuum began with adverse life events, but as the illness worsened the explanations changed or incorporated several other explanations, including the failure to perform rituals, as custom requires, to witchcraft, as the quote below illustrates:

My problem started when my father died. I was made an heir, my stepmother was not happy. When I fell sick for the first time I consulted a traditional Healer and he told me that it was witchcraft, but the clan issues were also there. I had not done what was required by the customs since my father died. I am the heir in the family, but because of lack of support from my elder brothers I have not been able to perform the necessary rituals. (39-year-old man with recurring psychotic depression)

Participants' meanings of the symptoms had two dimensions: self- and contextual dimensions. Self-meaning pertains to the perceived effect of illness on

the various part of the identity, whereas contextual meaning pertains to perceived characteristics of illness as well as social circumstances surrounding it.

The perceived consequence that the illness had for individuals' lives, as well as their relevance of self-perception in their plans and their expectations based on meaning constructed about life, was an important issue. Informants in the study cited changes that had occurred in their identity and relationships due to the illness:

Since I started falling sick, my friends are no longer close, they keep away. Even those who use to invite me for social activities like wedding and funeral rites do not do so any more. (43-year-old woman with recurring depression)

When the symptoms come I worry that they may not go away and I will become insane and walk naked like mad people that walk along the roads. (36-year-old woman with recurring depression)

The illness negatively affected the informants' lives and threatened the assumptions they had made about life and the attainment of future goals. The following extracts illustrate worries informants had about future plans, failure to meet societal expectations, and loss of position in the societal hierarchy:

I worry about my plans for the future, like my plan to go back to school. If the illness does not go away then my hope to go back to school is shattered. Because, you know the opportunity cannot wait for you. (20-year-old man with first episode of depression)

I have wasted a lot of money in trying to treat myself. My life has completely changed. I have no control over my financial situation any more because of the illness. I can no longer grow vanilla to make money so my children cannot rely on me for support any more. It is difficult. (33-year-old man with depression)

The informants presented a continuous process of making sense of illness and its consequences. Hence, the idioms of distress were formed through more than one way of reasoning, as patients interpreted their current condition through memories of salient experiences. This could be interpreted as an indication that patients do not have a systematic, worked-out theory of sickness and its manifestation but, rather, continually try to make sense of their illness.

How Did I Get Here? Making Sense of Psychiatric Admission

Pattern of resort has been described as the logic by which individual and family navigate the medical traditions and available resources (Kirmayer, Galbaud du Fort, Young, Weinfeld, & Lasry, 1996; Kirmayer et al., 1993; Kirmayer & Young, 1998; Okulate, Olayinka, & Jones, 2004).

In the process of seeking help, for many respondents, the journey started with their feeling unwell. These feelings were expressed to significant others, and the individual and significant others interpreted the illness using a combination of lay and biomedical theories. Depending on the interpretation, help was sought. When no improvement was registered, new explanations were developed, and new help was sought. This circle continued, sometimes involving multiple sources of care or multiple levels of one source of care. The process involved multiple visits to health care facilities at various levels in the health care system. Most evident in relation to psychiatric admission was the effort by the patients to answer the question, How did I get here? Frequently, psychiatric admission was described as an end to a long pathway that had taken the patient and significant others a substantial amount of resources to accomplish, as this young man described his journey in search of help:

I felt fever; I went to the clinic in our village. They gave me some tablets, which I took for one week. I did not feel any better so after two weeks they took me to the health center in Bukomero (subcounty health center). They checked my blood but they could not find anything. However, they gave me a drip and some tablets. I took the tablets for another week. It reduced a little but it increased again after two weeks. This time my head became chaotic. I started saying things that people could not understand. I was referred to Mulago and my brother brought me. (18-year-old man with first episode of depression)

Participants needed to evaluate the consequences of illness to their identity and future life, and the assessment of psychiatric admission was an important part of the process, given the stigma attached to mental psychiatric facilities in general and to mental illness in particular. This finding is similar to what is referred to as the social construction of the illness identity (Karp, 1996).

Contact with psychiatric experts forced patients to reformulate their identity, go through reconstruction of the past in terms of the current experiences, look for causes of their situation, construct theories about the nature of illness, and establish modes of coping.

After the acute period, patients realized that they had a condition that is conventionally defined as mental illness. In Buganda, as in many other societies, mental illness is highly stigmatized, and therefore having mental illness has significant implications for one's identity. The acquisition of mental illness identity creates a challenge; after one has acquired such an identity, it becomes difficult to change. Hence, most participants whose admission to a psychiatric facility was an index found it hard to relate to the identity, as the following extract reflects:

I was feeling very bad. I did not want people to disturb me. For three months I would not talk to any one. Then my sister and my friend said that I must go to the hospital. They told me we were going to Mulago. They did not tell me they were bringing me to a ward of mentally ill patients. (42-year-old woman with recurring depression)

Participants' stories indicated that symptoms that were considered by others as socially disruptive were important triggers that led to psychiatric attention. Disruptive behavior included attempting suicide and bizarre behavior, such as hearing voices, talking to oneself, refusing to talk/being mute, and extreme social withdrawal.

Variations in the Causal Attribution and the Role of Significant Others in Help Seeking

The participants' stories were full of the roles that significant others had played in the whole process of illness definition, treatment choices, and courses of action during the acute phase of illness.

Patients' stories involved an assessment of how the beliefs of their significant others had influenced the definition of illness and definition of appropriate therapy. Respondents indicated at times that there were disagreements within the families regarding symptom definition and the appropriate help that should be sought. The main source of these differences was religious beliefs. People who believed in traditional religion defined illness in terms of relationship between the living and the ancestral spirits, as this quotation illustrates:

At home, they have started telling me that it is spirits making me sick because I displease them by becoming saved (Born Again Christian). The people at home, especially my aunt, think it is a grave mistake to get saved when I know that my father was in charge of the clan shrine . . . but for me I am saved, I do not believe in spirit things. I do not think clan things have anything to do with this illness. (20-year-old man with depression)

Sometimes patients and their significant others agreed on the causal attribution but disagreed on appropriate therapy on the basis of religion. The typical example here is when both thought the illness was due to witchcraft. The born-again Christians did not agree with the choice of traditional healing as appropriate help, so even when the attribution was witchcraft, they preferred to seek help from the church. The following extract illustrate this:

My mother does not believe in traditional healers, she says they are satanic. She thinks prayer and drugs are capable of removing the witchcraft from my head. However, I believe that if they had taken me to a traditional healer the illness would have been cured. (18-year-old woman with first episode of depression)

Even my parents believe that it is the man who is bewitching me. However, my parents are saved and they do not believe in fighting the evil powers with evil. Before I was admitted my mother told me, they will take me to church so that they could pray for me. (23-year-old woman admitted after attempting suicide)

Under normal circumstances, an illness caused by witchcraft would require an intervention of a traditional healer. However, the Christian doctrine regards traditional healing as satanic. Although Christians agreed that witchcraft might have caused an illness, they considered going to a traditional healer as against the religious principle "do not fight evil with evil." However, as it is with many other aspects of culture, many people who converted to Christianity retained many aspects of their traditional beliefs. Hence, traditional beliefs on illness causation and treatment coexist with the new belief system. Witchcraft, angry ancestors, and other supernatural forces are still considered causes of ill health and other misfortunes, but how to treat illness caused by witchcraft, for example, has changed with Christian influence.

Some participants seemed to appreciate and agree with choices made for them by their significant others, but others disagreed with the choices and expressed dissatisfaction. Divergent views between the patients and their significant others complicated the help-seeking process. These variations sometimes resulted in long processes of negotiation between family members (the therapy-managing group) and the patient. Sometimes these disagreements were the major precursor to patients' dissatisfaction, as illustrated by the quote below:

They brought me here but my illness is due to witchcraft. My head is bewitched. People from my father's side are bewitching me because they do not like me. . . . The illness started one day when I was going home and two particles of sand fell on my head. I tried to remove them I could not. I don't see how hospital drugs are going to help me unless they say they are going to operate my head to remove the particles. (18-year-old woman with depression)

Looking at the above extract, what we see is a rejection of not only the choice and methods of treatment. According to the medical model, rejection of psychiatric illness and refusal of admission are caused by lack of insight produced by cognitive deficits common to major mental disorders. Care for a patient is geared toward symptom relief, functional stability, and rapid return to the community. This clinical approach reinforces the denial of the personal reality and meaning of mental illness. As a result, patients often find that hospitalization has not helped them to understand what has happened (Sayre, 2000). The altered sense of self and the unusual experiences that occur, especially if depression is associated with psychotic features, place the individual in what has been termed an undifferentiated predicament (Barham & Hayward, 1995), which the individual must then interpret and manage. The above model fails to recognize the significance of the meaning attached to the illness in the process of coping

Discussion

The focus of the study was to explore how depression, as defined in *DSM-IV* (American Psychiatric Association, 1994), is conceptualized by people diagnosed with it and how their conceptualization might have shaped their pathways to care. With regard to conceptualization of depression, we found out that

the majority of informants presented their problems in term of somatic symptoms. This is consistent with findings of research conducted elsewhere (Kirmayer, 1992; Kirmayer et al. 1993; Kirmayer & Young, 1998; Kleinman, 1977; Kleinman & Good, 1985; Okulate et al., 2004). With more discussion, however, the informants expanded their explanations to include psychosocial dimensions of their illness. The implication of this is that if health care providers, particularly those in primary care settings, are to help people with emotional problems, they need to devise ways that allow them to get access to information regarding the relationship between somatic complaints being presented to them and emotional problems. Failure to address emotional problems places a burden not only on the patient and his or her family but also on the scarce resources. This has implications not only for clinical care for people with depression but also regarding the use of scarce resources.

The findings also indicated that patients, even after admission to psychiatric services, continued to define their illness, evaluate and reevaluate what has been done about it, and reevaluate theories that had been made about the illness. Such findings challenge the assumption that patients make choices of therapeutic options with clearly developed theories about their symptoms. This finding is consistent with findings of studies conducted elsewhere that have recommended the use of exploratory maps instead of explanatory models (Williams & Healey, 2001). Preliminary explanation, or prototype, is another concept developed to explain the fluidity of lay explanations of illness (Young, 1982).

The findings also point to the important role played by significant people in the lives of patients in the help-seeking process and how disagreement can complicate the definition process and the agreement on the appropriate help. These findings are consistent with what had been suggested earlier, that help seeking is a social action involving complex interactions between the patient and his or her significant others (Fabrega, 1973; Igun, 1979; Janzen, 1978; Mechanic et al., 1994; Segall, 1976; Shapiro et al., 1984). This draws attention to the fact that help seeking is not merely an individual but also a social action that concerns and involves other members of the individual's social unit.

Socially disruptive behavior on the part of the patient was the trigger that necessitated the attention of psychiatrists. Other studies conducted in this setting have come up with similar observations about help seeking for emotional problems (Orley, 1970).

It was evident that it is only when a patient exhibited what was defined as socially disruptive behavior that psychiatric care was sought. This finding contributes from a different perspective to existing knowledge about access to psychiatric care by people with emotional problems, pointing to the fact that people with less severe and less drastic symptoms, which equally impair social functioning, might never receive the attention of psychiatrists. This study highlights the need for care providers to provide holistic care to patients who seek help, owing to the fact that a bigger burden of infectious diseases, such as TB, HIV, and malaria, will result in higher rates of emotional problems.

The important questions that arise from these findings regarding the care of depressed individuals in the community are What are the mechanisms available in the community to help people with less severe symptoms? and How effective are they in helping people deal with depressive symptoms? These are areas that require further exploration to contribute to efforts geared toward improving care for people with depression.

Limitations

One might argue that the findings of this study are subject to limitations due to the methods used and the limits on verification of scientific data. In qualitative methods, a researcher becomes an instrument of data collection, and the ability to communicate with the respondents becomes an important issue (Britten, 1995; Britten, Jones, Murphy, & Stacy, 1995). The study was conducted in Luganda, the local language, thus requiring translation into English, which brought with it issues of equivalency. The complexity and challenges involved for conceptual equivalence in this process have been noted (Marshall & While, 1994). In trying to address this challenge, we had two bilingual translators translate the transcripts independently. One translator and the first author (EO) discussed small differences that appeared in the two versions of the translations that could have influenced the interpretation during analysis.

As regards sample selection, the study setting was an admission unit, and so it might be argued that the participants for the study came from a highly selected population. The sample constituted mainly what would be defined as severe cases of depression according to *DSM-IV* criteria (American Psychiatric Association, 1994). However, the primary intention of the study was to capture the perspective of people affected by the illness, thus necessitating a clear definition of the illness using accepted criteria.

Conclusion

The diagnosis of mental illness and early intervention are recognized in the literature as critical to treatment and recovery (Bagder, McNiece, & Gagan, 2000). Failure to facilitate the access of patients who suffer from mental illness to the mental health care system not only increases the risk of hospitalization and poor clinical prognosis but also diminishes the quality of life of people affected by mental illnesses such as depression.

The current data also indicate that the help-seeking process of those participants who sought mental health services involved multiple stages. The way in which symptoms were expressed, the nature of the health care system, and the burden of disease in this setting, particularly infectious diseases, caused general physicians to pay little attention to the underlying emotional problems. Appropriate care for emotional problems was therefore delayed. In the process, resources are wasted because of nonspecific treatments, and productivity is lost because of impaired social functioning, resulting in greater poverty in a population that is already poor.

The implication of these findings is that depression contributes significantly to the burden of disease, and therefore primary care providers need to be made more aware of how to recognize emotional problems and address them appropriately.

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