HEALTH CARE SEEKING BEHAVIOURS: CONTRIBUTING FACTORS- A REVIEW

M.Megha
(MA student, Department of Psychology, University of Delhi, North Campus, New Delhi, India)

Maria Zafar
(MA student, Department of Psychology, Jamia Millia Islamia, New Delhi, India)

Dr. Neera Pant
(Associate Professor, Department of Psychology, Gargi College, University of Delhi, New Delhi, India)

Abstract

Health care seeking behaviours can be defined as incidences wherein an unhealthy/sick individual seeks help to cure his/her illness. These are different from health seeking behaviours - activities healthy individuals engage in to maintain or promote their health. Both kinds of behaviours do not exist in isolation but involve biological, sociological and psychological considerations. The present paper is a critical review of literature devoted to health care seeking behaviours. It reveals various contributing factors such as an individual’s gender, belief system, ethnicity, socio-economic status, role of internet, etc. Moreover, the reviewers focus on the type of health issue (mental/physical), knowledge about its symptoms and severity, awareness about available treatment options which could further influence the possibility of seeking help. In this paper, we categorise the major themes observed in regard to health care seeking behaviours. With critical evaluation, we identify certain gaps in the existing literature and suggest subsequent recommendations for future researchers.

Keywords: Health, Health care seeking behaviours (HCSB), Health seeking behaviours (HSB).

INTRODUCTION
The World Health Organization (1948) has defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. By understanding that health is more than just the absence of illness, one can classify ‘health seeking’ behaviours (HSB) as activities healthy individuals engage in to maintain or promote their health. These activities may involve information seeking or making lifestyle changes (such as maintaining a healthy diet, exercising regularly, meditating, etc.). HSB can be differentiated from ‘health care seeking’ behaviours (HCSB). The latter can be defined as incidences wherein an unhealthy/sick individual seeks help to cure his/her illness. This “help” can involve either seeking treatment from medical professionals or through information which can be obtained from different sources (MacKian, 2003). The difference between the two lies in the health condition of the person before seeking help. Having differentiated the two, it is important to note that such behaviours (both HSB and HCSB) don’t exist in isolation but involve biological, sociological and psychological considerations. Sometimes these terms (HSB and HCSB) are used interchangeably. However we feel that HCSB should be studied separately, as from the psychological point of view, care is more important.

The definition of health given by WHO emphasizes both physical and mental well-being of an individual. It is therefore important to study the attitudes people exhibit towards physical and mental illnesses, and the subsequent healthcare seeking behaviours shown for these different kinds of issues. The present review, thus, focuses on differences in health care seeking behaviours for mental and physical health problems.

METHOD

A number of databases were used in the search for published articles including PsycNET, PsycINFO, PubMed, ScienceDirect. Articles for the review were drawn from published papers, articles, reports, and reviews. The terms used for search purposes included, but were not restricted to: ‘health seeking behaviour’, ‘health care seeking behaviour’, ‘health seeking behaviour for mental problems’. Due to the breadth of subjects covered, the literature review concentrates more on recent researches published majorly from 2000 to 2016. Most researches have used the term HSB to signify seeking medical help due to the presence of illness. However, as suggested by MacKian (2013) our paper outlines the subtle differences between HSB and HCSB, we have thus modified the terms to mean the latter wherever necessary.

After reviewing information regarding healthcare seeking behaviours for physical and mental illnesses, we have identified the following areas as having maximal research backing: gender (Doherty & Doherty, 2011; Nakagawa, et al, 2001; Pronyk et al, 2001; Rosenstock et al, 2015, etc), education (Abdulraheem&Parakoyi, 2009; Mashreky et al., 2010; Peng et al., 2010; Yadav, 2010; Zhang, Liu, Bromley & Tang, 2007, etc), culture (Ghosh, Chakrabarti, Chakraborty & Biswas, 2013; Hashimoto & Kim, 2012; Jang, Chiriboga& Okazaki 2009; Thaker, 2008, etc), age (Jacobsen et al., 1993; Macfarlane, Blinkhorn, Davies, Kincey&Worthington, 2003; Yadav, 2010; Yerpude, Joggand&Joggand, 2014, etc), beliefs/perceptions (Domininc, Shashidhara&Nayak, 2013; Girma&Tesfaye, 2011; Jack-Ide &Uys, 2013; Maneze et al, 2015; Pradhan, 2013, etc), severity of illness (Burton et al., 2011; Jimba, Poudyal&Wakai, 2003; Plowden& Miller, 2000; Webair& Bin-Gouth, 2013, etc), and the role of technology/internet (Basoglu, Daim, Atesok&Pamuk, 2010; Burns et al, 2010; Farmer, 2014; Horgan & Sweeney, 2010; Jensen, King, Davis &Guntzviller, 2010; Weaver et al, 2010, etc). We have discussed and compared these in the following sections. Other factors such as stigma (Atre et al., 2008; Davies et al., 2010; Möller-Leimkühler, 2002; Rao et al., 2012, etc), SES (Abebe et
al., 2010; Ahmed, Haque, Haque & Hossain, 2009; Mashreky et al., 2010; Yadav, 2010; Zhang, Liu, Bromley & Tang, 2007), and place of residence (Mashreky et al., 2010; Okeke & Okeibunor, 2010) have also been mentioned and explained briefly.

DISCUSSION

GENDER DIFFERENCES

PHYSICAL HEALTH PROBLEMS. The review has clearly indicated that the incidence of HCSB is largely dependent on the gender of the individual. Many studies have shown that gender does influence the incidence of health care seeking behaviour (Ahmed, Adams, Chowdhury, Bhuiya, 2000; Pronyk et al, 2001; Rosenstock et al, 2015). Delay in the occurrence of HCSB has been found to be attributed to different factors for males and females. Yamasaki-Nakagawa, et al (2001) focused on a particular type of disease, TB and the gender differences involved in the related health care seeking behaviours. In the case of TB, women were found to have a longer total delay before diagnosis than men. Also, more women visited traditional healers before diagnosis than men, and were more likely to receive more complicated charms from traditional healers. Men tended to visit the government medical establishment first if they knew that free TB treatment was available, but women did not. Johansson, Long, Diwan&Winkvist (2000) found that for males, it is due to the fear of individual costs of diagnosis and treatment. Men have also been found to disregard symptoms until the disease reached a crucial stage which results in them heading directly for public health services. For women, the delay for seeking help was often due to fear of social isolation, be it from the family or the community. In contrast to men, they tend to seek out private services and indulge in self-medication before seeking public services. However it is important to note here that this study was based in Vietnam, thus cultural factors will also come into play which shape gender roles.

There may be instances wherein gender, which is a by-product of societal norms, influences the health care professional’s attitude. Adamson, Ben-Shlomo, Chaturvedi, Donovan (2003) reported that gender, socioeconomic status and race were not a factor when it came to reporting immediate health care seeking in response to the clinical vignettes.

In the case of sexually transmitted diseases, shame is a very prevalent factor which influences one’s health seeking behaviour or lack thereof. Mercer et al., (2003) on a study based in Britain found that more women sought help for sexually transmitted diseases, but men were more likely to than women to seek help at a genitourinary clinic. In a draft protocol submitted by WHO in 1995 it was found that in some populations it may be easier for a man with an STD to go and ask for help whereas in certain population, it may be inappropriate for a woman to discuss genital problems with another man.

MENTAL HEALTH PROBLEMS. Research has shown that gender differences exist within the subset of mental health problems too. Doherty & Doherty (2010) attempted to examine the socio-demographic and health status factors that predict help seeking for self-reported mental health problems for males and females from a general practitioner. The findings showed more factors (socio demographic, psychological) influencing attendance at the general practitioner for males than for females (social limitations, accessibility). Nam et al (2010) who examined gender differences in attitudes toward seeking professional psychological help. Female students were found to have more positive attitudes toward seeking help than their male counterparts. Nonye & Oseloka (2009) studied the health seeking behaviour of mentally ill patients in Enugu, Nigeria. They found that socio-cultural practices such as male dominance and
the stigmatizing nature of mental illness could explain the observed gender difference in health-seeking behaviour of mentally ill patients. Rickwood, Deane & Wilson (2007) found that young men and young people from indigenous and ethnic minority groups tend to be those most reluctant to seek help. Another study by Mackenzie, Gekoski & Knox (2006) found similar results. Their research revealed that older age and female gender were associated with more positive help-seeking attitudes. Moreover, they found that women exhibited more favourable intentions to seek help from mental health professionals than men, likely as they hold a more positive attitude concerning psychological openness. Oliver et al. (2005) found that males, young people and people living in affluent areas were least likely to seek help for mental health problems.

As is obvious from the review, when it comes to consciously seeking treatment for physical problems, men seem to be driven by internal factors such as fear of being seen as weak, unfit, whereas women are influenced by social factors such as isolation by the family, being ousted from society, etc. Moreover, men tend to benefit more from health care facilities when it comes to physical illness. For mental health problems, it is observed that women are more likely to demonstrate HCSB as they are more emotional beings and have more positive attitudes when it comes to psychological openness. For men on the other hand, seeking help for mental health problems such as anxiety and depression is probably viewed as a question to their masculinity.

**EDUCATION**

**PHYSICAL HEALTH PROBLEMS.** Education levels of individuals have been found to be significantly related to their likelihood of engaging in HCSB. An individual’s level of education influences his/her choice of treatment sought (home remedies vs. professional help) and time gap between occurrence of first symptom and seeking of help. Peng et al. (2010), for example, found education levels to be significantly associated with the HCSB of Chinese migrant workers, with higher educated workers more likely to go see a doctor when they fell sick. Zhang, Liu, Bromley & Tang (2007), studying the poor rural communities of Inner Mongolia, too found that less educated people were less likely to seek care for tuberculosis.

Numerous researchers have found that in case of HCSB for children, higher parental (mostly maternal) education is associated with a greater likelihood of getting professional treatment for the children (Abdulraheem & Parakoyi, 2009; Mashreky et al., 2010; Webair & Bin-Gouth, 2013; Yadav, 2010). Probable reasons for this may be that the literacy and numeracy skills that women acquire in school enhance their ability to recognize illness and seek treatment for their children, or the increased number of years in school make them more receptive to modern medicine (Abura, Ciera & Kimani-Murage, 2012). Ogunlesi & Ogunlesi (2011) too found that low maternal education has a significant relationship with delayed health care seeking and the use of home remedies, while immunization coverage rates for immigrants have been found to increase with mother’s educational attainment (Kusuma, Kumari, Pandav & Gupta, 2010).

However, in rural communities, cultural beliefs and practices often overshadow other factors like education, and lead to self-care, home remedies and consultations with traditional healers. These factors result in delay in treatment seeking and more common amongst women, not only for their own health, but for their children’s illnesses too (Nakagawa et al., 2001, as cited in Shaikh & Hatcher, 2004).

**MENTAL HEALTH PROBLEMS.** Unlike in the case of physical health issues, where higher education levels mostly lead to a greater likelihood of engagement in HCSB, the review for mental health problems shows an unclear pattern. Fortney et al. (2016) found that a
substantial gap exists between the prevalence of probable mental health disorders and treatment seeking among community college students. Knipscheer & Kleber (2005) found that lower educated respondents reported a more negative attitude towards consulting mental health services. Such findings follow the expected pattern as one generally assumes that people with higher levels of education would be more open to seeking help for psychological problems. However, the issue of stigma attached with mental health can be a strong barrier to HCSB even among educated individuals. To avoid the label of mental illness and the harm it brings, people decide not to seek or fully participate in care (Corrigan, 2004). Chew-Graham, Rogers & Yassin (2003) also found perceptions of stigma associated with mental health to lead to avoidance of appropriate HCSB among medical students.

Thus, education levels of an individual seem to be quite important in determining whether they engage in health care seeking behaviours for physical problems. Individuals having higher education often are more aware of illnesses and the various treatment options available to them. Even for health care seeking behaviours for their children, parental education levels determine the kind of help sought. For mental health problem, however, the issue of stigma associated with mental illnesses becomes more salient, and hinders even the educated individuals from seeking help for their illness.

CULTURE

PHYSICAL HEALTH PROBLEMS. Culture has been found to play a monumental role in the manifestation of health care seeking behaviours. We have viewed the studies highlighting culture from two perspectives, that being individualistic and collectivistic cultures. Within the collectivist cultures factors such as family attitudes and opinions and relationships matter a lot. Factors such as joint family structure, role of other family members do influence health care seeking behaviours among individuals (Ghosh, Chakrabarti, Chakraborty & Biswas, 2013; Shaikh & Hatcher, 2004). Thaker (2008) attempted to understand the role of culture in the health related behaviours of older Asian Indian immigrants. An analysis of the findings also addressed three cultural values that influenced these immigrants’ health behaviours: Establishing a personal relationship with their health care professional, high level of family involvement during treatment and also daily maintenance of health, and valuing alternative medicine.

There haven’t been many researches that focus specifically on the individualistic aspects that may influence health care seeking behaviours. But having discussed the collectivistic values involved in such behaviours we could say that in the individualistic cultures, health care seeking would probably not be as heavily dependent on the views of other family members. Instead it may eventually come down to the individual deciding himself/herself whether s/he should seek health care. In such a scenario, other factors such as convenience, stigma, knowledge about treatment, etc. would have greater weight and influence.

MENTAL HEALTH PROBLEMS. Within the realm of mental health problems, there too are differences among people from individualistic and collectivistic cultures in seeking health care. It has been found that individuals belonging to collectivistic cultures rely more on social support and are thus more reluctant to seek professional help as compared to individuals belonging to individualistic culture (Lee et al, 2009; Mojaverian, Hashimoto & Kim, 2012). Jang, Chiriboga & Okazaki (2009) studied the age-group differences in Korean American adults in their attitudes toward mental health services. This study, though focused on age differences
still helps demonstrate the influence of culture. For example, older adults were observed to view a mental illness as bringing shame to the entire family.

We can hence say that a culture can influence HCSB to a high degree. The influence of culture across both physical and mental health problems is quite similar except it’s slightly more enhanced in the case of the latter. For collectivistic cultures, health care seeking in the context of physical health problems are almost always determined by other family members, whereas individualistic cultures may not see as much involvement of the family in making such decisions. For mental health problems, where stigma is anyway a very strong factor, collectivistic cultures often see less of HCSB as a problem with one family member is viewed as a problem with the whole family which brings in a lot of shame. Conversely, collectivistic cultures emphasize social support and familial ties which may also reduce the incidence of going to a professional.

AGE

PHYSICAL HEALTH PROBLEMS.Age as a factor influencing HCSB of individuals shows mixed patterns. Studying the aged population of South India, Yerpude, Jogdand & Jogdand (2014) found that though the majority of the older population seeks treatment for their physical health problems, compliance to treatment generally was low, while Abebe et al. (2010) established that age was not a contributing factor to HCSB of individuals. Macfarlane, Blinkhorn, Davies, Kincey & Worthington (2003) also found the likelihood of seeking treatment to increase linearly with age. Jacobsen et al. (1993) found that after adjusting for symptom severity and sociodemographic characteristics, older men were likely to seek treatment than middle aged men for urinary symptoms experienced in the past year. This trend of increased HCSB with increase in age could be attributed to the fact that physical deterioration generally is accepted as an outcome of aging. Thus, older individuals may be more open to seeking treatment as, unlike the younger individuals, they are not ‘expected’ to be physically fit. Also, younger individuals who are the working population, may give their work more priority than their health, leading to less HCSB.

Regarding the HCSB of parents for their children, mothers were, in a study, found to be more likely to seek treatment for their malaria-infected children who were younger in age (Yadav, 2010). This could be because of mother’s perceptions regarding their younger children being more vulnerable to developing the disease more seriously than older children, who might be believed to be stronger physically and thus have higher immunity. Besides the child’s age, the age of mothers too may be related to HCSB for their ill children, as was found by Kusuma, Kumari, Pandav & Gupta (2010) when immunization coverage rates, which were lower for immigrant children, increased with mother’s age.

MENTAL HEALTH PROBLEMS.Unlike for physical health problems, the review on HCSB for mental health issues shows a clearer relationship between individual’s age and their likelihood of engaging in HSB: age has been found to be positively correlated to mental health help-seeking (Mackenzie, Gekoski & Knox, 2006; Mojtabai, Olfson & Mechanic, 2002; Oliver, Pearson, Coe & Gunnell, 2005; Stead, Shanahan, Neufeld, 2010). This trend may be explained by the fact that younger people often feel that they have their entire lives ahead of them: they are starting out in their careers, will soon be starting a family, etc. Thus, they are more likely to brush off their symptoms and not seek help. Again, the associated stigma may be another barrier to their seeking treatment. People who suffer from or have suffered from some mental illness, are discriminated against in different walks of life: job, education, marriage prospects etc. Older individuals, on the other hand, do not have the pressures of jobs and careers, making them more
open to seeking help with mental professionals. They are also more likely to be married and thus experience greater support from their spouse than younger, unmarried individuals might get from their friends.

As can be seen from the review, older individuals are more likely to engage in health care seeking behaviour for both physical as well as mental health problems, as compared to their younger counterparts. A probable reason for this trend could be the fact that older individuals do not have to face the pressures of jobs and taking care of their families, making them more open to the prospect of seeking help for both the kinds of problems.

BELIEFS/PERCEPTIONS

PHYSICAL HEALTH PROBLEMS. Beliefs, attitudes and perceptions are shaped by society and culture. The way individuals perceive a health problem does influence their likelihood of seeking health care. Perceptions may also be shaped due to experiences of others or due to societal views and opinions. Cultural beliefs and practices can work both as a facilitator and as well as a barrier (Maneze et al, 2015). In the case of deciding whether to opt for public or private health care, such perceptions do play a big role (Domininc, Shashidhara & Nayak, 2013). Pradhan (2013) explored the health and healthcare seeking behaviour among tribals in Sundargarh district of Orissa. The study found that the cause of illness and healing system was found to be associated with the magicoreligious beliefs. Treatment options were also influenced by factors such as illness type, severity, beliefs regarding the causes, etc. Zhang, Liu, Bromley & Tang (2007) found that perceptions of TB were associated with their gender, socio-economic status, gender, age, education level. These factors then influenced their likelihood of seeking professional health care. Scheppers et al (2006) studied the potential barriers to the use of health services among ethnic minorities. They found that cultural perceptions about symptoms may act as a barrier, as needs may be differently expressed. Presentation of classical symptoms may also be different which could result in a misdiagnosis. Perceptions may also be influenced by gender. For example, men in the United States are more likely than women to adopt risky beliefs and behaviours, and are less likely to engage in healthy behaviours (Courtenay, 2000). Specific physical diseases such as STDs, TB, also have various perceptions attached to them. These perceptions too affect individuals’ health care seeking behaviours.

MENTAL HEALTH PROBLEMS. In the context of mental health problems, perceptions play a comparatively bigger role as the aspects of stigma and shame are associated with them. In addition to such factors, there is less information and clarity about mental health problems as compared to physical health problems. This ambiguity may result in the fostering of skewed perceptions. Jack-Ide & Uys (2013) too found that culture among other factors was a major barrier in the occurrence of health care seeking behaviours. Within the realm of culture, aspects such as stigma, discrimination, and shame were also at play. Individuals may also believe that mental health problems are not as important as physical health problems. They might even attribute causes for mental illnesses as being natural or supernatural, spiritual possession, evil eye (Girma & Tesfaye, 2011). In the case of young people who are quite susceptible to external perceptions and beliefs, factors such as stigma, shame, poor knowledge about mental health, and preference for self-reliance are some of the major hurdles to help seeking. Positive past experiences, social support and encouragement were found to be facilitators (Gulliver, Griffiths & Christensen, 2010). The belief that mental health professionals may not be able to help is also a factor that reduces the likelihood of seeking health care (Bayer & Peay, 1997).
We can thus observe that when it comes to physical illnesses, most of the perceptions regarding the symptoms are culture or society based. Also, treatment practices are also influenced by culture as doctors and health professionals need to be sensitive to the cultural practices and beliefs of individuals. In the context of mental health, cultural beliefs play a role in deciding whether a problem can or cannot be helped/cured. Natural and supernatural ideas regarding mental health problems also stem from culture. Also, the major aspect surrounding all mental health problems, that is stigma, shame and the resultant discrimination is also a product of one’s perceptions and beliefs about the disorder.

SEVERITY OF ILLNESS

PHYSICAL HEALTH PROBLEMS. Illness severity is one of the most significant factors that dictates whether an individual seeks help or treatment for their problem or not. Webair& Bin-Gouth (2013) found that seeking medical care was frequently initiated for illnesses that did not improve or worsened; the caretakers sought medical care significantly more when the illness was perceived as severe. Studying health care seeking behaviour in rural Nepal, Jimba, Poudyal&Wakai (2003) found that the people would treat mild illnesses at home; even when moderately or severely ill, they seek health care from traditional healers first. Plowden& Miller (2000) found that among urban African-American men, for most, seeking care was done after all other measures failed to relieve symptoms; perceived disability and death from an illness, unrelieved symptoms, were internal motivators to seek help.

Even in cases of parents seeking treatment for their children, seeking health care at health facilities was more likely for children with more symptoms of severe illness (Burton et al., 2011); mothers were more likely to seek treatment for their malaria-infected children when they perceived their condition to be severe and showing no improvement (Yadav, 2010); parents were more likely to seek emergency help even for non-urgent issues when they perceived their child’s condition to range from moderate to very serious (Williams, O’Rourke & Keogh, 2009). Abdulraheem&Parakoyi (2009) too found that care seeking for child depends on illness severity and number of symptoms exhibited.

For illnesses that are perceived to be less severe, self-medication or home remedies are often preferred, while professional help is only sought when symptoms start getting worse. This was seen by Abebe et al. (2010), who found that some reasons for not seeking treatment for TB among the people studied included the perception that the disease will improve and considering disease to be harmless. Not seeking treatment for less severe illnesses may also be related to factors such as non-availability of health services (if such services are not easily available to people, they would only go for these when the ill individual’s condition badly deteriorates) or the high cost of treatment (again, people would be open to incurring high treatment costs only when they know that the illness is serious).

MENTAL HEALTH PROBLEMS. In case of mental health problems too, illness severity to a large extent determines whether individuals seek help or not. On being asked when it is appropriate to seek professional help for mental health issues, people suggested that patients should seek care in a psychiatric hospital or mental institution only for the most severe symptoms (van der Ham, Wright, vo Van, Doan &Broerse, 2011). Satyanarayana, Enn, Cox &Sareen (2009) found that individuals suffering from chronic depression are more likely to go for health service use. Beşiroğlu, Çilli&Aşkıın (2004) studied why some people with obsessive-compulsive disorder do not seek treatment while others do. They found that non-health care seekers scored significantly lower on a measure of illness severity than did health care seekers.
This belief of seeking treatment only when the condition becomes severe may be due to certain factors such as the financial burden incurred by the patient’s family for the person’s treatment, along with the emotional burden of taking care of a patient, when often one family member always has to stay with the patient.

Thus, as the review shows, severity of illness as a determinant of health care seeking behaviour has shown a clear trend over time: positively related to seeking help for both physical and mental problems. Individuals often start out with brushing off their minor symptoms as not serious, engaging in self-medication, etc. However, as gradually the symptoms begin to worsen, they become more likely to seek professional help for both their physical and/or mental problems.

ROLE OF INTERNET/TECHNOLOGY

PHYSICAL HEALTH PROBLEMS. Various researches have attempted to study the influence of technology on health information seeking behaviour (Basoglu, Daim, Atesok & Pamuk, 2010; Jensen, King, Davis & Guntzviller, 2010; Weaver et al, 2010). Often individuals with health issues search for their symptoms and treatment options online before deciding to visit a doctor. There are also cases wherein individuals who are not suffering from any health problem still use the internet to look for health related information. Farmer (2013) studied the issues in teen technology use to find health information. The results of her study indicated that teen health information interests vary by age, gender, social situation, and motivation. Moreover, her paper refers other studies that have found that the most popular topics deal with sexual health or drugs and teens tend to seek information out of need or fear, such as having a personal problem, rather than as a proactive effort to be healthy, such as eating nutritionally. Atkinson, Saperstein & Pleis (2009) found that those seeking health information were more likely to be women, have cable or satellite Internet connections or DSL connections, have Internet access from work or from home and work, and report more hours of weekday Internet use. Educated individuals were less likely to search for health information. Older individuals and married individuals were more likely to purchase medicine or vitamins online. Gray et al (2005) aimed to study the role of the internet in health information-seeking behaviour in adolescence. They found that internet health information was regarded generally as significant. Its relevance was increased through active searching and personalization. However perceived credibility varied as expertise and trustworthiness were often tough to determine. Cline & Haynes (2001) elucidate diverse purposes of using the internet to access health related information. They claim that the internet is useful as it provides health web pages, online support groups, and online interaction with health professionals. They also list out various benefits such as widespread access to health information, interactivity, potential for anonymity, etc. with benefits come certain costs. The disadvantages according to them are information overload, disorganization, searching difficulties, overly technical language, etc.

MENTAL HEALTH PROBLEMS. Among the youth, the internet is seen as a big source of information for mental disorders. Young people will seek information online even if they are not suffering from a mental health problem themselves (Burns et al (2010). It has been found that young people are willing to use the Internet for mental health information and it represents a viable source of support for this age group (Horgan & Sweeney, 2010). A study by Powell & Clarke (2006) revealed that eighteen per cent of all internet users (in their study) had used the internet for information related to mental health. The likelihood of using the internet for health information increases if the individual is suffering from psychological distress or has a
past history of mental health problems. Being able to access reliable disease information online has been found to reduce anxiety, increase feelings of self-efficacy, and decrease utilization of ambulatory care. Moreover, studies report that Internet health information seekers are more likely to have health concerns, see themselves as having poor health, or demonstrate actual symptoms of clinical impairment as compared to non-seekers (Ybarra & Suman, 2006).

From the review we can hence understand that in the scenario of physical health problems, the internet is seen as an important source of health information. It is advantageous in the sense that it allows complete anonymity, thus preventing shame or stigma in case there is any. It also has a host of online communities which can help the individual having the physical problem. This could probably be helpful for patients with chronic illnesses and also reduce the physical act of seeking health care. In the context of mental health problems, it is observed that being able to access the internet for health related information in itself reduces anxiety. Moreover, those who do seek health information on the internet may already have had or are currently experiencing clinical symptoms, depression, anxiety, etc. They are thus merely seeking further information about their symptoms. Also, many individuals tend to seek information related to mental health despite not having any mental illnesses themselves.

OTHER FACTORS: STIGMA, SES, RESIDENCE

Besides the above mentioned factors, the literature review also highlighted certain other factors such as stigma associated with illness, socioeconomic status/income and place of residence. Be it a physical or mental illness, the stigma associated with the illness has always been shown to be a barrier to individuals seeking help. In case of physical health issues, a lot of stigma is often attached to sexually transmitted infections (STIs) which stops people from taking modern medicine, even after they acknowledge that it is the best treatment against STIs (Rao et al., 2012). Even with diseases like TB, the associated stigma hinders people suffering from the disease to start treatment (Atre et al., 2009). With mental illnesses, the issue of stigma is even more prominent, and acts as a great barrier to help seeking, as was studied by Verger et al. (2010), who found that less than half of the university students with a psychiatric disorder sought professional help.

Stigma is an even more significant barrier for health care seeking among men than women. Galdas, Cheater & Marshall (2005) too found ‘traditional masculine behaviour’ as an explanation for delays in seeking help among men who experience illness. Möller-Leimkühler (2002) found that for emotional, depressive problems, social norms of traditional masculinity make help-seeking more difficult for men. Davies et al. (2000) found that men have important health needs but take little action to address them because of their socialization to be independent and conceal vulnerability.

An individual’s socioeconomic status becomes an important determinant of their HSBs, as it addresses the issues of whether the health care services are available to people or not, whether they can afford the services or not. Invariably, it has been found that individuals from lower SESs are less likely to engage in health care seeking behaviour(s (Ahmed, Haque, Haque& Hossain, 2009; Zhang, Liu, Bromley & Tang, 2007). Even for health care seeking behaviour for children, parental income is an important factor. Yadav (2010) found that mothers from high income families were more likely to seek treatment for their malaria-infected children. Similarly, for parents seeking treatment for their child with burn injuries, higher income parents are likely to go for qualified service providers over unqualified ones (Mashreky et al., 2010). Abebe et al. (2010), in their study, found that one reason participants cited for not seeking treatment of TB
was the lack of money for transportation, highlighting income as a factor that influences behaviour s people show to deal with illnesses.

Lastly, the place of residence (rural/urban) can also influence the kind of help people seek when they are sick. For example, Shah, Patel & Shah (2013) explored the differences in health care seeking behaviour in rural and urban Ahmedabad. They found a significant difference in the place of residence for the kind of treatment sought: more rural people took treatment from faith healers than urban; majority of the rural people took treatment for chronic illness from private practitioner than urban. Okeke & Okeibunor (2010), on the other hand, found that majority of urban residents seek private or government health facilities for treatment, while majority of rural residents go for self-treatment, going to hospitals only when problems persist or worsen. Similarly, for parents seeking treatment for their child with burn injuries, parents residing in urban areas are likely to go for qualified service providers over unqualified ones (Mashreky et al., 2010).

This factor could be related to that of accessibility or convenience. Studies have shown that convenience/ accessibility to resources is a factor that does influence HSB (Grundy & Annear, 2010; MacKian, 2003; Selvam et al, 2007, etc.). For example, Nsereko et al. (2011) studied perceptions of help-seeking behaviour among people with mental health problems in Uganda. Results revealed that the accessibility of health facilities and financial costs associated with care influenced help-seeking behaviour. Kaushal et al. (2005) evaluated the knowledge of mothers and grandmothers regarding breastfeeding and health seeking behaviour for neonatal sickness in a rural community in India. They found that most respondents preferred to try home based remedies before seeking medical attention. In scenarios where medical attention was crucial, they favoured unqualified village practitioners over government hospitals. Reasons included distant location of hospital, long queues, and impolite and callous behaviour of the staff. Tipping (2000) found that individuals usually go to nearby private drug sellers or to the local drugstore. This behaviour is more common with women who have less time and income to spend on searching for a place.

CONCLUSION

Through this review, we observe that various factors such as gender, age, culture, severity of illness, beliefs/perception, education level, and role of technology/internet, stigma, SES and place of residence, all influence the occurrence of health care seeking behaviours. Moreover such behaviours do differ to some extent on the various dimensions depending on the kind of problem the individual is suffering from (physical or mental). Having gone through various papers, articles, reports and reviews, we have come to the conclusion that there is a substantial amount of literature on HCSB in the context of physical illnesses, however mental illnesses have not been given much focus/importance. Within the Indian context we observed that culture plays a major role in effecting the likelihood of individuals engaging in HCSB. Our suggestions for future researchers would be to attempt to fill this gap by exploring the various HCSB, patterns and trends among mental health problems. Moreover, we feel it is important to delve further into the psychological aspects of each factor that is seen to be influencing such behaviour. For example, focusing on the individual’s mental processes, thoughts, and emotions that go into seeking health care and how they in turn are related to self-esteem, self-image might be one area that future researchers could concentrate on studying. Moreover, since culture influences all such psychological factors, it should also be studied in detail and its relation to HCSB must be explored.
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