Cultural self-constructs and help-seeking behavior in mental illness: The Mardin example

Cemile Hazan Tunalı[1], Mustafa Akan[2], Suheyla Unal[3]
[1]M.D., [3]Prof., University of Health Sciences, Bursa Medical School, Department of Psychiatry Bursa, Turkey
https://orcid.org/0000-0002-6498-8973-https://orcid.org/0000-0002-1442-3093
[2]M.D., Gemlik State Hospital, Psychiatry Clinic, Bursa Turkey https://orcid.org/0000-0002-9252-8341

SUMMARY

Objective: This study examines the impact of cultural self-construals in the context of autonomy and relatedness on help-seeking behavior for non-psychotic mental illnesses. Cultural factors shape individuals' perceptions of mental illness and the treatment methods they pursue. Individuals with an independent-autonomous self-construal tend to seek medical assistance, whereas those with an interdependent-relational self-construal are more inclined toward traditional and non-medical methods.

Method: The study was conducted with 80 patients who applied to the psychiatry outpatient clinic of our hospital. Participants completed the Autonomous-Relational Self Scale (ARSS) and the Illness Perception Questionnaire (IPQ). They were categorized into three groups: "medical help-seekers," "non-medical help-seekers," and "those using mixed methods." Data were analyzed using ANOVA and Chi-square tests.

Results: Among participants, 46.2% sought medical help, 36.2% used non-medical methods, and 17.5% used both. The medical group had significantly higher autonomy scores (29.2±4.4) compared to the non-medical (23.3±5.7; $p<0.001$) and combined groups (23.6±7.9; $p=0.002$). In contrast, relational self-construal was higher in the non-medical group (32.2±5.7) than in the medical group (28.0±5.7; $p=0.006$). The main reasons for choosing non-medical approaches were despair (48.8%), personal beliefs (41.9%), and influence from close others (39.5%).

Discussion: Cultural self-construals play a crucial role in help-seeking processes for mental illnesses. Individuals with a relational self-construal tend to be influenced by their social environment and are more likely to turn to non-medical methods. As autonomy levels increase, the likelihood of seeking professional psychiatric support also rises. The findings highlight the importance of cultural psychology in access to mental health services and emphasize the need for healthcare policies to consider cultural sensitivities.

Key Words: Self-construals, autonomous self, relational self, help-seeking behavior

INTRODUCTION

Individuals spend their lives in interaction with social, psychological, and biological events (1). Human behavior is a physical and social function of both the individual and the environment. People, however, vary in the degree of integration with others and the social environment (2). As long as there is open communication between individuals, cultural evolution accelerates. This is because the number of ideas that can be changed or adhered to increases. People are constantly finding out and being influenced by shared ideas. Therefore, understanding human psychology requires taking into account the cultural information that people encounter in their daily lives (3).

Personal, familial, and cultural factors impact the emotions people experience, the meaning of these emotions, and their expression throughout life. Distress is experienced alongside other emotions within a cultural environment. Culture also provides guidance for individuals in experiencing, expressing, and coping with distress. The labeling of the meanings attributed to emotional experiences and their associated physical symptoms as

DOI: 10.5505/kpd.2025.01328

Cite this article as: Tunali CH, Akan M, Unal S. Cultural self-constructs and help-seeking behavior in mental illness: The Mardin example. Turkish J Clin Psych 2025; 28:

The arrival date of article: 15.02.2025, **Acceptance date publication:** 04.06.2025

Turkish J Clinical Psychiatry 2025;28:

"illness" occurs within a sociocultural context (4). Culture affects all aspects of health and mental disorders. This includes perceptions of disorder, explanations, and behaviors aimed at relieving illness or alleviating suffering (5). Help-seeking behavior for mental illness is influenced by factors such as the severity and duration of the disorder, ease of access to healthcare, gender, age, marital status, educational background, an individual's cognitive schemas, cultural background, and religious belief systems (6,7,8).

Throughout generations, human societies worldwide have sought solutions to various health problems through trial and error. In this historical process, malpractices and misbehaviors have given way to more rational and healthy methods through cultural evolution (4). In recent years, societal attitudes toward mental health help-seeking and mental health treatments have shown some evidence to become more positive. Studies of societal attitudes have denoted increasing approval of both psychiatric medications and psychotherapy in Western industrialized countries (9). Nevertheless, there are also studies suggesting that supernatural powers are already being attributed to mental illnesses in various cultures (10, 11). In Anatolia, various beliefs adopted at different periods were widely perceived and applied as traditional remedies for treating mental health problems. The effects of this historically persistent attitude on help-seeking behavior can still be seen today. In our country, patients seeking help from non-medical healers or priests, particularly for psychiatric illnesses, are often observed. In rural areas, patients primarily seek non-medical methods (12).

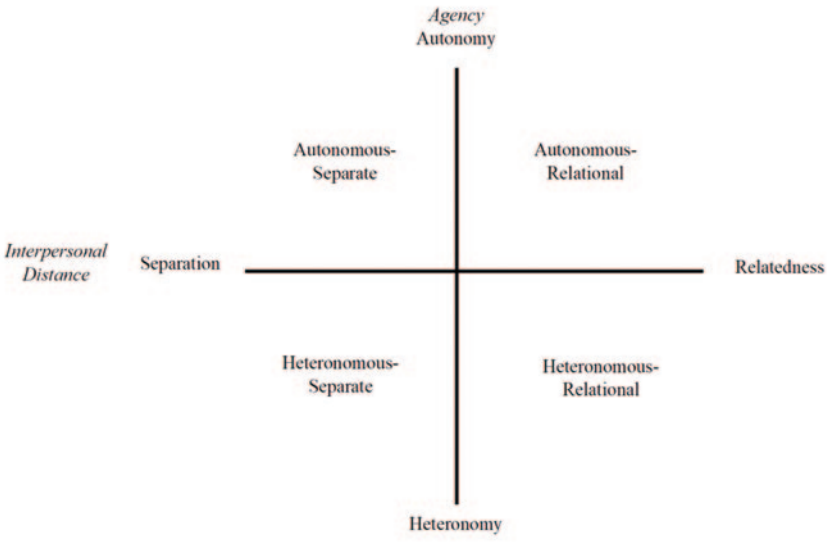
"Self" can generally be considered as a "structure" that is effective in the regulation of behavior and the organization of affective and cognitive processes, and as a dynamic "process" shaped by the interaction of the individual with his or her social environment (13). Cultural psychology argues that the process of becoming a self develops as people interact with their cultural environment and derive meaning from this environment. This process leads to differences in self-concepts across cultures (3). However, with the increasing impact of globalization, cultures are also beginning to resemble each other. Different response patterns in self-descriptions suggest that there are at least two different ways in which people conceptualize their self (3). According to this dual perspective, the development of self-construal in a culture develops either in the direction of individualism or collectivism (14). In the "individualistic culture" individual development, freedom, individual success, individual expectations, and individual happiness play a crucial role in the formation of the "autonomous" self-construal; in the "collectivistic culture" the group's perspective, group continuity, dependence on the group, group support, group happiness, and how one's own roles affect the group play an important role in the formation of the "relational" self-construal (3, 13,15,16).

Today, in many Western countries, it is assumed that individuals should detach themselves from relationships with other people as much as possible to maintain their independence and self-discovery. In Eastern cultures, however, the crucial factor is maintaining interpersonal connectedness. In these cultures, individuals must play appropriate social roles within society, act in a way that meets the expectations of the group they belong to, and be able to understand the perspectives of individuals within the group (13).

Kağıtçıbaşı's Autonomous-Relational Self-Model, which addresses this theoretical dichotomy more flexibly, argues that an individual can possess both autonomous and relational orientations simultaneously. According to Kağıtçıbaşı, the self has two distinct yet related dimensions: agency and interpersonal distance. As the interpersonal distance dimension varies between relatedness and separation, the dimension of agency varies between autonomy and heteronomy. These two dimensions cannot be completely separated from one another; rather, their combination results in four different self-styles. These are autonomous-separate, autonomous-relational, heteronomous-separate, and heteronomous-relational self-construals (Figure 1) (14,17,18).

In the autonomous-separate self-model, autonomy and self-sufficiency are at the forefront. However, the need for relatedness is not sufficiently met in this model. Individuals with a heteronomous-rela-

Figure 1. Self-styles in the context of agency and interpersonal distance



tional self-model have grown up in traditional families with a focus on the utilitarian value of the child. In this model, the need for autonomy is not sufficiently met. The heteronomous-separate self is pathological because neither the needs for autonomy nor relatedness are met. The self-construal that appears to be the most psychologically healthy is the autonomous-relational self-construal. In regions with high socioeconomic status, the autonomous-relational self emerges in a family model where intergenerational ties are diminished yet emotional attachments persist (14,19,20).

This study aims to understand how self-construals, a key determinant of culture, shape the help-seeking behaviors of individuals experiencing mental distress. In the Mardin sample, where the local cultural structure is thought to have more collectivistic characteristics, we investigated the distribution of individuals' self-construals between professional medical help and traditional help-seeking. We hypothesize that as the autonomous self increases, the likelihood of seeking psychiatric support increases, while as the relational self increases, the likelihood of seeking non-medical methods increases.

METHODS

Research Group

The study included 80 literate volunteer patients, presented to our hospital's psychiatric outpatient clinic between October 1, 2024, and January 1, 2025. Patients presenting to the outpatient clinic were consecutively enrolled as long as they met the inclusion criteria. No patient refused to participate. In the planning stage of the study, the autonomy score of the medical group was anticipated to be higher than that of the other groups, and the medical group's autonomy score was predicted to be 4 points higher than the other two groups. A power analysis based on these data showed that a minimum of 14 subjects in each group was required to achieve a 4-point difference between the medical group and the other groups, assuming alpha =0.09 and power (1-beta) =0.80.

The patients participating in the study were diagnosed by a psychiatrist using the SCID-5, adapted to the DSM-5 diagnostic criteria. Patients with psychiatric disorders due to general medical conditions, alcohol and/or substance abuse, mental retardation, and dementia were excluded from the study. Individuals with chronic illnesses that impair judgment, such as bipolar disorder, schizophrenia, and schizoaffective disorder, were excluded from the research since their illness perception, explanation, and help-seeking behaviors may differ. Comorbid cases were excluded as they were thought to alter the meanings attributed to the illness. Participants were divided into groups based on their responses to the fourth question of the Illness Explanatory Model Questionnaire, which is "What practices have you previously used for your

complaints?". Those who selected either a psychiatrist or other non-psychiatric doctors were included in the "medical" group whereas the groups were assigned by including those who chose the options "I convinced myself, I did not seek a cure, I went to a healer (hodja, shrine, amulet, entombed saint), I resorted to herbal medicine, I used folk medicine practices (lead casting, leech therapy), I did not seek a cure, I meditated" and others in the "non-medical" group, and those who chose both options in the "mixed" group. Ethics committee approval was obtained from Mardin Artuklu University Non-Interventional Research Ethics Committee with decision number 2024/9-3.

Data Collection Tools

Sociodemographic Data Form: Information on demographic characteristics such as age, gender, and socioeconomic status of the participants in the study was obtained through the sociodemographic data form.

Autonomous-Relational Self-Scale (ARSS): This scale, developed by Kağıtçıbaşı to measure self-construals, consists of 27 items, with nine items in each scale measuring relational self, autonomous self, and autonomous-relational self. Participants are asked to evaluate the items on a scale of 1 to 5, from 1 (Strongly Disagree) to 5 (Strongly Agree). Some items are reversed to increase the precision of the results (14). The scale can be used in different ways depending on the researchers' purpose. The total score obtained from each scale provides information about a person's relational self, autonomous self, and autonomous-relational self. On the other hand, by considering the relational self and autonomous self scales separately, insights can be gained into four self-characteristics: autonomous-relational, autonomous-separate, heteronomous-relational self, and heteronomous-separate based on scores above and below the average. In this study, the method most appropriate for answering the research questions was used.

Illness Explanatory Model Questionnaire (IEMQ): The IEMQ was developed by Ünal and colleagues using Kleinman's Illness Explanatory Model (21). The questionnaire includes 10 questions that explore the patient's recommendation for seeking psychiatry, the causative factor for the mental illness, the reason for the current onset of the illness, the procedures the patient has previously applied to, how she/he would seek treatment if a family member were ill, what other members of their circle would do if someone in their circle were ill, what treatment they desired, their expectations from treatment, their fears about the outcome of the illness, and, if so, why they sought non-medical interventions. Patients were informed that they could choose one or more answers for each question. Each question in the questionnaire includes an "other" option for answers other than those listed. In our study, we included the fourth question of the survey, which practices the patient had previously consulted, and the tenth question, the reason for seeking non-medical care, if so, for non-medical care.

Data Analysis

Data analysis was conducted using SPSS 22.0. Quantitative variables were presented as mean ± standard deviation, while qualitative variables were presented as numbers and percentages. Data normality was tested using the Kolmogorov-Smirnov test. Age, gender, marital status, education, employment status, socioeconomic status, psychiatric medication use, history of psychiatric illness, family history of psychiatric illness, and autonomous-relational scale scores were compared among participants in the Medical, Non-Medical, and Mixed groups. The Chi-square test was used for qualitative variables, and both ANOVA and Kruskal-Wallis tests were used for quantitative variables. Tukey and Bonferroni analyses were used for pairwise comparisons to assess significant results between groups. Descriptive statistical analysis was conducted for the reasons for seeking non-medical care. A p-value of <0.050 was considered statistically significant.

RESULTS

Of the participants in our study, 37 (46.2%) were in the medical group, 29 (36.2%) in the non-medical group, and 14 (17.5%) in the mixed group. Fifty-five (68.7%) of the participants were female, and

Table 1: Comparison of groups in terms of clinical and sociodemographic characteristics

	Non-medical	Medical	Mixed	p
	n (%)			
Gender				
Female	16 (55.2)	28 (75.7)	11 (78.6)	0.139
Male	13 (44.8)	9 (24.3)	3 (21.4)	
Marital Status				
Married	19 (65.5)	21 (56.8)	4 (28.6)	0.071
Single	10 (34.5)	16 (43.2)	10 (71.4)	
Educational Status				
Primary School	9 (31.0)	16 (43.2)	3 (21.4)	-
High School	11 (38.0)	14 (37.8)	5 (35.7)	
University	9 (31.0)	7 (18.9)	6 (42.9)	
Socioeconomic Level				
Below 17,000 TL	16 (55.2)	18 (48.6)	7 (50.0)	-
17,000 TL and above	13 (44.8)	19 (51.4)	7 (50.0)	
Employment Status				
Employed	12 (41.4)	15 (40.5)	6 (42.9)	-
Unemployed	17 (58.6)	22 (59.5)	8 (57.1)	
Psychiatric Disorders				
Depression	14 (48.2)	10 (27.0)	8 (57.1)	
GAD	11 (38.0)	16 (43.2)	3 (21.4)	
OCD	0 (0.0)	1 (2.7)	1 (7.1)	
Social phobia	0 (0.0)	1 (2.7)	0 (0.0)	-
Panic disorder	2 (6.9)	3 (8.1)	1 (7.1)	
Conversion disorder	2 (6.9)	3 (8.1)	1 (7.1)	
Hypochondriasis	0 (0.0)	3 (8.1)	0 (0.0)	
Psychiatric medical use				
Yes	15 (51.7)	28 (75.7)	8 (57.1)	0.113
No	14 (48.3)	9 (24.3)	6 (42.9)	
Previous psychiatric history				
Yes	11 (62.0)	22 (59.5)	7 (50.0)	0.222
No	18 (38.0)	15 (40.5)	7 (50.0)	
Psychiatric history in the family				
Yes	10 (34.5)	19 (51.4)	8 (57.1)	0.263
No	19 (65.5)	18 (48.6)	6 (42.9)	

p<0.050

twenty-five (31.2%) were male. No statistically significant differences were found between the non-medical, medical, and mixed groups in terms of gender, marital status, psychiatric medication use, previous psychiatric history, and family history of psychiatric illness (p=0.139, p=0.071, p=0.113, p=0.222, p=0.263, respectively) (Table 1).

The mean age was 35.2 years for the non-medical group, 37.6 years for the medical group, and 28.7 years for the mixed group; no statistically significant differences were found. Considering comparisons of the groups' autonomy, relatedness, and autonomous-relational characteristics, the medical group was found to have a more autonomous self-concept than both the non-medical group (p<0.001) and the mixed group (p=0.002). Similarly, the medical group was found to have a less relational self-concept than the non-medical group (p=0.006) and the mixed group (p=0.012). No difference was detected between the non-medical and mixed groups in terms of autonomous (p=0.973) and relational (p=0.902) self-concepts. The medical group also had a higher autonomous-relational self-concept than the non-medical group (p<0.001) and the mixed group (p=0.001) (Table 2).

Table 2: Comparison of groups in terms of age and scale scores

	Non-Medical[1]	Medical[2]	Mixed[3]	p[a]	Pairwise Comparisons
	Mean (SS)				
Age	35.2 (13.5)	37.6 (13.5)	28.7 (8.2)	0.093	-
Autonomy	23.3 (5.7)	29.2 (4.4)	23.6 (7.9)	<0.001	1;2 p<0.001 1;3 p=0.973 2;3 p=0.002
Relatedness	32.2 (5.7)	28 (5.7)	33 (5.1)	0.002	1;2 p=0.006 1;3 p=0.902 2;3 p=0.012
	Median (Min-Max)			p[b]	
Autonomous-Relational	27 (20-44)	37 (26-41)	32 (24-44)	<0.001	1;2 p<0.001 1;3 p=0.107 2;3 p=0.001

SD: Standard Deviation; [a]: p value for ANOVA test; [b]: p value for Kruskal-Wallis test; p<0.050. Tukey and Bonferroni analyses were performed in pairwise comparisons to evaluate significant results between groups.

Table 3: Descriptive statistical analyses for reasons to apply to non-medical practices

	n (%)
Helplessness and hope	21 (48.8)
Personal belief	18 (41.9)
Guidance from relatives	17 (39.5)
Traditions	12 (27.9)
Curiosity	7 (16.3)
Media guidance	3 (7.0)
Economic reasons	3 (7.0)
Difficulty accessing healthcare	3 (7.0)
Attitudes of healthcare professionals	1 (2.3)
Distrust of doctors	1 (2.3)
Failure of medical treatment	0 (0.0)
Benefits from non-medical practices	0 (0.0)

Regarding the reasons for applying for non-medical practices, participants were determined to resort to these practices mostly out of helplessness and hope (48.8%), followed by personal belief (41.9%), guidance from relatives (39.5%), and traditions (27.9%). As none of the participants selected the options of benefiting from non-medical practices and the ineffectiveness of medical treatments, one participant each chose the options of distrust of doctors and the attitude of healthcare professionals (Table 3).

DISCUSSION

The process of "understanding" is crucial for providing psychiatric assistance to individuals' various biopsychosocial problems, distress, and suffering. Due to the dominance of biological paradigms in the psychiatric field, the social factors that influence the pathogenesis, course, and chronicity of mental illness, as well as the social, cultural, and economic context of the illness, are often overlooked (4). An individual who recognizes their mental distress goes through several stages before seeking psychiatric help. During this period, they first develop a causal explanation to gain control over the process. They may externalize the symptom they are experiencing by attributing it to causes outside of themselves, or internalize it by thinking something is wrong with their body. They may mentalize the symptom by attributing it to a psychological process, such as boredom or anger at someone. Based on their explanation, they begin to seek a solution for their complaints and, after several attempts, consult a mental health professional (21).

In this study, conducted to reveal how cultural self-construals shape individuals' help-seeking behaviors for mental illnesses, individuals with an autonomous self-construal were found to tend to seek medical help more, while those with a relational self-construal preferred non-medical interventions. Socioeconomic factors had no significant effect on help-seeking behavior. This demonstrates the influence of social and cultural values on help-seeking processes. A study conducted in India found that more than half of patients, regardless of socioeconomic status, sought help from religious healers for mental illnesses (22). Considering a study conducted in the Himalayas, 39% of patients preferred a psychiatrist as their first choice, while 34% preferred religious healers (23). A study conducted in 2001 found that less than 40% of individuals sought any professional help within the first year after the onset of a mental illness, and the number of those seeking help from a mental health professional was around 11% (24). Regarding a study carried out in 2001 in our country, 32.5% of patients were initially determined to seek professional help for their mental health problems (21). Based on our study, regardless of the duration, 46.2% of participants initially sought professional help following their mental health complaints. There are, nevertheless, studies indicating that public attitudes toward mental health treatments have become more positive in recent years (9), but seeking professional help for mental health is not yet at the expected level.

The social influence of an individual's immediate circle can be a significant factor in the decision to seek professional help. Regarding people's decisions to seek medical help, 50% of those applying for medical services have been determined to do so upon the recommendation of a relative. Similarly, researchers have asserted that those closest to an individual play an influential role in whether or not they seek mental health care when experiencing distressing symptoms (25).

Culture influences many aspects of professional help-seeking, including problem description and attribution, help-seeking decisions, and evaluation of various coping resources. In particular, disparities in relationship patterns across cultures influence the likelihood of seeking help from professionals. Numerous studies on professional help-seeking suggest systematic differences in the fre-

quency of help-seeking among people from various cultural contexts. Ethnicity and modernity, which are both elements of culture, have a significant impact on help-seeking behaviors (26, 27).

Culture-influenced self-construal also influences help-seeking behavior. Research indicates that communal cultures generally exhibit stronger stigmatizing attitudes toward mental disorders than individualistic cultures. A study of 305 individuals from four different cultural groups living in the United Kingdom found that stigma toward mental disorders was higher in collectivistic cultures, as positive attitudes toward mental disorders were higher in individualistic cultures (28). Similarly, a study of African Americans found that an individual with a higher sense of community was associated with greater fear of stigma and a tendency to conceal oneself (29).

According to Kim and Omizo, traditional Asian Americans have a negative attitude toward professional mental health treatment since they believe that expressing psychological problems brings shame to the family (30). The fact that people of East Asian descent are less likely than Americans to perceive their personal problems as significant enough to seek professional help suggests that this may be related to the prevalence of individualism in the United States and collectivism in East Asia (31). Similarly, a study of 88 American and 95 South Korean university students detected that individuals with individualistic self-construals were associated with more positive attitudes toward seeking professional help (32).

Considering a study conducted in the Philippines, cultural factors such as shame, stigma, and collectivist beliefs were identified to prevent individuals from seeking help from mental health professionals, and these factors lead to a preference for folk healers for the treatment of mental illness (33). Considering our study, those with a high autonomous self-construal were more likely to seek medical help. In contrast, those with a relational self-construal were more likely to seek non-medical treatment.

In communal cultures, health is considered a consequence and a resource of a well-functioning group, rather than merely an individual entity (5). Seeking help from an external source, such as mental health professionals, can be viewed as disrupting the harmony within the group or disrupting family balance. Given the relatively strong values placed on family obligations, a family member's illness is viewed as a potential disruption to family stability, leading to the individual's decision to seek help becoming a family decision. Furthermore, in communal cultures, disclosing problems to professionals can be interpreted as a result of dysfunction in the internal group, which can discourage individuals from seeking professional mental health help (26). As individuals with strong family ties may take longer to seek medical help, they trust their support systems and are more open to family members' guidance. Those with an autonomous self-construal may be more likely to seek professional help because they view their own health as an individual responsibility.

Regarding our study, helplessness and hope (48.8%), and personal beliefs (41.9%) were cited as reasons for seeking non-medical methods. A study conducted in Nepal indicates that individuals primarily prefer to seek help from religious healers due to their widespread trust in religious healers, their accessibility, and the persistent belief that mental illnesses are rooted in supernatural causes (34). In the research carried out in 2011 with 135 psychiatric patients on help-seeking behavior, similar to ours, the most common reasons for seeking non-medical help were helplessness, followed by hope, followed by personal belief. In the same study, 7.4% of patients cited distrust of doctors as the reason for seeking non-medical help; however, this rate remained at 2.3% (35). This may indicate that patients' trust in doctors has increased over the past 15 years. Patients may be "seeking non-medical solutions for problems that modern medicine cannot solve". In some psychiatric disorders (e.g., depression, anxiety disorders), patients may seek alternative methods since their symptoms do not immediately improve with medical treatment. As patients tend to explain their symptoms within a spiritual/religious framework, non-medical methods may be sought.

As well as the current study is one of the few stud-

ies to examine how self-construals, along the axis of individualism and collectivism, relate to psychiatric referral processes using a local sample, it does have some limitations. First, due to the relatively small sample size, the generalizability of the findings is limited. Conducting future studies in larger and more diverse sociocultural contexts will help to more comprehensively evaluate the results. Second, the data collection method used in the study is predominantly quantitative, and it would be beneficial to also utilize qualitative research methods to more deeply examine participants' individual experiences and motivations during the help-seeking process. The cross-sectional design of the study precludes tracking changes in help-seeking behaviors over time.

In further studies, it may be recommended to comparatively study the relationship between self-construals and help-seeking behaviors in various sociocultural contexts and to investigate the psychological and social mechanisms behind help-seeking behaviors through detailed narratives of individuals' help-seeking processes using qualitative research methods. Longitudinal studies could also be conducted to observe changes over time, exploring how cultural influences evolve in individuals' mental health care referral processes.

Ultimately, help-seeking behavior for mental disorders is a complex process that combines cultural, social, and psychological factors. Our study investigated that individuals with a relational self-concept tend to turn to non-medical methods under the influence of family and the environment, and that as their level of autonomy increases, their likelihood of seeking professional psychiatric support increases. The findings of this study further underscore the significance of designing health policies and mental health services that consider cultural differences.

Correspondence address: M.D., Cemile Hazan Tunalı, University of Health Sciences, Bursa Medical School, Department of Psychiatry Bursa, Turkey
hzancitlak@gmail.com

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