The long and complex road in the search for treatment for mental disorders: An analysis of the process in five groups of patients

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ABSTRACT

Seeking treatment for mental-health problems is a complex process, with different underlying motives in each stage. However, the entire process and these motives have hardly been investigated. This study aims to analyze the different stages of the help-seeking process and their underlying motives in five groups of patients with different mental disorders.

In all, 156 patients seeking treatment in outpatient mental health clinics were individually interviewed: 71 had Obsessive-Compulsive Disorder (OCD), 21 had Agoraphobia (AGO), 18 had Major Depressive Disorder (MDD), 20 had Anorexia Nervosa (AN), and 22 had Cocaine Dependence (COC). The AGO and MDD patients delayed significantly less time in recognizing their mental health symptoms. Moreover, MDD patients disclosed their symptoms and searched for professional help faster than the other groups. The most relevant variables in the recognition of disorders were the loss of control over the symptoms, the interference produced by these symptoms, and their negative impact on the person's emotional state. The most frequent barriers to seeking treatment were related to minimizing the symptoms and fear of stigma. Finally, the most important motivator for seeking treatment was the awareness that minimizing the symptoms did not help to reduce them, lessen their interference, or make them disappear.

1. Introduction

The search for professional help for mental health problems is a complex process that includes different consecutive stages, such as recognizing that the problem exists, disclosing the problem to others, and deciding to seek professional help. These different phases and their corresponding components should be assessed in depth in order to better understand the nature of the process itself and then implement strategies to improve mental health in our societies and reduce the stigma associated with mental disorders.

The insight that one has a mental health problem is undoubtedly the first step in initiating the help-seeking process. Nonetheless, few instruments have been designed to evaluate this step. The Mental Health Problem Appraisal Scale (Schomerus et al., 2012), with only 5 items, is one of the most widely used instruments. Another strategy is to describe a case and ask the person whether he/she might have a similar problem (Mond et al., 2006).

Although the effective search for treatment does not necessarily coincide with the first time patients disclose their problems or symptoms, this seems to be an important stage that has received little attention from researchers. As far as we know, only one study (Becker et al., 2005) has examined the disclosure of Eating Disorder symptoms in a group of subclinical participants using a brief structured interview. By contrast, a large number of studies have examined the last step, that is, the search for professional treatment. Some of these studies ask whether the patient has received treatment before (e.g., Bebbington et al., 2000; Mayerovitch et al., 2003; Roness et al., 2005; Subramaniam et al., 2012; Wallerblad et al., 2012), others explore the age of the first formal contact with a healthcare provider and/or the time the patient took to consult one (e.g., Chong et al., 2012; Christiana et al., 2000; Demyttenaere et al., 2008; The ESEMeD/MHEDEA 2004 investigators, 2004; Wang et al., 2007), and still others analyze what formal and informal resources patients have used in the past to cope with their mental-health problems (e.g., Carragher et al., 2010; Keel et al., 2003).
et al., 2002; Mond et al., 2007; Ramirez et al., 2009).

Other researchers have examined patients’ reasons for delaying the search for treatment (Christiana et al., 2000) or not seeking treatment, using open-ended questions (Goodwin et al., 2002; Lorant and Grisham, 2011; Meltzer et al., 2003) or self-report questionnaires. Some examples are the Barriers to Help Seeking Scale (Mansfield et al., 2005), the Barriers to Treatment Questionnaire (Marques et al., 2010), and the Online Survey about Obstacles to Treatment for Anxiety Disorders (Chartier-Ottis et al., 2010). However, to the best of our knowledge, no studies have examined what motives contribute to the effective search for treatment.

In sum, most of the published studies and evaluation instruments are specifically designed for one of the stages in the help-seeking process, whereas only a limited number address the whole process in its different phases. Some of these studies have used an interview (Belloch et al., 2009; Blumenthal and Endicott, 1996; Pagura et al., 2009), and others have applied self-report questionnaires (The ESEMeD/MHEDEA 2004 investigators, 2004; Saunders, 1993; Thompson et al., 2004). The different assessment instruments used in these studies make it difficult to compare the results and reach conclusions that can help to improve the understanding of the help-seeking process for mental-health problems. Additionally, most research focuses on the help-seeking process for one specific group of mental disorders and/or one of the stages in the process (e.g., Andrews et al., 2001a; Andrews et al., 2001b; Bijl and Ravelli, 2000), whereas as far as we know there are no studies designed to compare the entire process in different mental disorders.

The aims of this study were, first, to examine the whole process of seeking help for mental health problems using a structured interview, and second, to compare this process in five groups of individuals with different mental disorders that have a high impact on healthcare resources: Obsessive-Compulsive Disorder (OCD), Agoraphobia (AGO), Major Depressive Disorder (MDD), Anorexia Nervosa (AN), and Cocaine Dependence (COC).

2. Material and methods

2.1. Participants

In all, 152 patients with five different diagnoses participated in the study. The main diagnoses (Axis I, DSM-IV-TR) (American Psychiatric Association, APA, 2002) at the time of the study were the following: Obsessive-Compulsive Disorder (OCD, 71 patients), Agoraphobia (AGO, 21 patients), Major Depressive Disorder (MDD, 18 patients), Anorexia Nervosa (AN, 20 patients), and Cocaine Dependence (COC, 22 patients). Demographic and clinical data for each patient group appear in Table 1. As Table 1 shows, the five groups differed on demographic data. Post-hoc tests (Bonferroni) indicate that in the COC group, the majority of the patients were men. MDD patients were older than the other groups, and they were also older when they had their first depressive symptoms (age at onset). By contrast, AN patients were younger than the other groups, and, consequently, their disorder appeared early. Regarding clinical data, MDD patients differed from the other groups in the duration of the disorder and in their current comorbidity rate. On both variables, the MDD patients showed the lowest scores. All the groups showed high scores on their respective measures assessing severity (see below for a description of the different measurement instruments). Finally, MDD patients showed the poorest health-related quality of life, but no differences were observed among the other groups.

The participants were consecutively recruited in three outpatient mental health clinics included in the network of the public National Health System and in the Research and Treatment Unit for Obsessive-Compulsive Disorder at the University, during one-year period. They were either self-referrals or referred to one of the authors for psychological treatment by the psychiatrist-in-chief at each of these clinics. The inclusion criteria were as follows: a primary diagnosis of OCD, AGO, MDD, AN, or COC (DSM-IV-TR, Axis I), age range between 18 and 65 years, absence of any organic mental disorder or mental retardation, and not having begun psychological treatment, in order to avoid severity biases. Additionally, all the patients who were undergoing pharmacotherapy were required to have maintained stable doses for a period of 3 weeks before being included in the assessment protocol. Severity of the disorder, its duration in years, comorbidity with other psychological disorders, and concurrence with psychopharmacotherapy were not considered non-inclusion criteria.

2.2. Instruments

2.2.1. Severity assessment

Disorder severity was evaluated with a different instrument for each disorder. OCD severity was assessed with the Yale-Brown Obsessive-Compulsive Scale (YBOCS) (Goodman et al., 1989a, 1989b). Scores range from 0 to 40, and lower scores indicate less severe OCD. The internal consistency in this study was α=0.772. Agoraphobia severity was assessed with the Agoraphobia Inventory (Echeburúa et al., 1992), a self-report questionnaire containing 69 items with a response range from 0 to 5, distributed in three dimensional symptom domains: avoidance, physical, and cognitive and emotional. A total score ≥176 is used as the cut-off point to differentiate between the presence versus absence of clinically significant symptoms. The internal consistency in the current study was α=0.747. MDD severity was assessed with the Spanish version (Sanz et al., 2003) of the Beck Depression Inventory-II (Beck et al., 1996). This is a widely used and validated self-report

### Table 1

<table>
<thead>
<tr>
<th>Study Variables</th>
<th>OCD (n=71)</th>
<th>AGO (n=21)</th>
<th>MDD (n=18)</th>
<th>AN (n=20)</th>
<th>COC (n=22)</th>
<th>F (4148) or chi²</th>
<th>η²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Men / Women (%)</td>
<td>39.4 / 60.6</td>
<td>23.8 / 76.2</td>
<td>38.9 / 61.1</td>
<td>0 / 100</td>
<td>81.8 / 18.2</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Age (years)</td>
<td>34.17 (11.38)</td>
<td>35.62 (11.63)</td>
<td>42.94 (11.35)</td>
<td>24.46 (6.92)</td>
<td>34.50 (8.53)</td>
<td>8.46**</td>
<td>0.188</td>
</tr>
<tr>
<td>Age at onset (years)</td>
<td>24.59 (9.95)</td>
<td>28.62 (10.58)</td>
<td>41.50 (10.85)</td>
<td>17.92 (3.01)</td>
<td>27.45 (9.41)</td>
<td>17.67**</td>
<td>0.322</td>
</tr>
<tr>
<td>Duration of disorder (years)</td>
<td>9.58 (9.75)</td>
<td>7 (9.73)</td>
<td>1.44 (1.62)</td>
<td>6.54 (5.79)</td>
<td>7.95 (4.17)</td>
<td>3.87*</td>
<td>0.094</td>
</tr>
<tr>
<td>Comorbidity (%)</td>
<td>32.4</td>
<td>33.3</td>
<td>11.1</td>
<td>25.0</td>
<td>36.4</td>
<td>4.09</td>
<td>–</td>
</tr>
<tr>
<td>Disorder Severity</td>
<td>27.01 (5.33)</td>
<td>267.71 (63.58)</td>
<td>35.22 (7.57)</td>
<td>83.77 (41.04)</td>
<td>16.45 (22.05)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>GHQ-28, Total</td>
<td>34.75 (10.96)</td>
<td>38.81 (15.26)</td>
<td>56.61 (10.99)</td>
<td>38.18 (19.16)</td>
<td>26.18 (17.26)</td>
<td>9.24***</td>
<td>0.296</td>
</tr>
</tbody>
</table>

Data are Means (SD)

OCD: Obsessive-Compulsive Disorder; AGO: Agoraphobia; MDD: Major Depressive Disorder; AN: Anorexia Nervosa; COC: Cocaine Dependence.


* p < 0.05; ** p < 0.01; *** p < 0.001.

a,b,c indicate between-group differences (same superscript, no differences).
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