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Which Depressive Symptoms are Associated with Help-Seeking Behavior?

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Objective The purpose of this study is to understand the effect of perceived need and help-seeking behaviors on mental health problems in Korea and investigate which depressive symptoms are associated with help-seeking behavior.

Methods Participants were selected from a random sample of 365 people in 3 different Korean cities. A self-reported survey assessing the effect of perceived need and help-seeking behavior on mental health problems and the Beck Depression Inventory (BDI) were performed. Participants were divided into 3 groups, 1) those with perceived need and help-seeking behavior (PN with HS) 2) those with only perceived need (only PN) 3) those without perceived need (no PN). The intergroup differences in each specific symptom (affective, cognitive, neurovegetative) of the BDI were analyzed by analysis of variance (ANOVA) and Bonferroni's post hoc test.

Results 139 (40.9%) of the respondents exhibited perceived need, while only 40 (28.7%) demonstrated help-seeking behavior. The mean score of neurovegetative symptoms was significantly higher in the subjects with help-seeking behaviors (PN with HS) than in those without help-seeking behaviors (only PN, no PN).

Conclusion Only a small proportion (11.8%) of the sample ever sought help for mental problems, in spite of the high lifetime prevalence of depression. Lack of understanding of psychiatric problems is one of the major barriers to seeking help for mental health problems, indicating that widespread psychoeducation is needed to solve the disparity between the unmet needs and receipt of mental health services.

KEY WORDS: Depression, Help-seeking, Community.

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Introduction

The majority of persons with mental disorders do not get professional help.[1-3] Although 80 to 90% of people with depression can be treated successfully, most people with potentially remediable depression do not receive treatment.[4] Depressive disorders often impair social and occupational functions.[5] Understanding the factors that determine the unmet need for treatment of depression would allow professionals and policy-makers to close the gap between the need for, and receipt of, mental health services. Such information is pivotal for determining optimal referral patterns, planning mental health services, and effectively allocating human and financial resources.[6]

Within health care, the concept of need has been used to determine service provision, which has to be defined by experts. However, increased attention has also recently been paid to the self-perceived need for mental health treatment in the community.[7] This concept takes into account theoretical models of help-seeking. These models posit that individuals suffering from emotional problems pass through several stages prior to seeking help for their emotional symptoms: 1) they experience symptoms, 2) they evaluate the severity and consequences of the symptoms, 3) they assess whether treatment is re-

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quired, 4) they assess treatment feasibility and options, 5) they seek or do not seek treatment.[8-10]

In previous studies, many factors have been found to be associated with help-seeking behavior concerning mental health problems. Females, older people and better-educated people are known to be more likely to exhibit help-seeking behaviors.[11,12] People with physical problems or a maternal history of mental illness, and who experienced divorce or separation were reported to have higher perceived need.[13-16] However, demographic factors such as sex, age, and education level in the prediction of help seeking behavior for mental health problems remain controversial.[13,15]

In depression, Have et al. reported that vegetative symptoms, more complex or dangerous symptoms (suicidal ideation) were more likely to have received specialized treatment as opposed to primary care only.[17] It is not yet known whether it is possible to predict help-seeking behaviors according to the various symptoms of depression.

The purpose of this study is to understand perceived need and help-seeking behaviors regarding mental health problems in Korea and investigate which depressive symptoms are associated with help-seeking behavior.

Methods

Subjects and design

The participants were chosen from a random sample of 365 people in 3 different Korean cities (Osan, Suwon, and Pyeongtaek). Surveys on perceived need and help-seeking behavior were performed by researchers, in April, 2006. 340 (93.1%) of the participants gave valid responses to the perceived need and help-seeking questionnaire and 293 (80.3%) completed the Beck Depression Inventory (BDI). The following questions were posed; 'Have you ever perceived the need for the treatment of mental health problems in the last 12 months?', 'Have you ever sought help for mental health problems in the last 12 months?' The responses to these two questions were recorded as dichotomous variables (yes or no). Additional questions were 'What were the reasons for not seeking help despite the need to do so?', 'What types of help seeking behavior were used? These questions were asked in the form of multiple choices allowing multiple answers. The BDI[18] and basic demographic data were also included in the survey.

The BDI was categorized into subscales consisting of affective, cognitive and neurovegetative symptoms. The affective symptoms corresponded to item numbers 1, 10, and 11, the cognitive symptoms to item numbers 2, 3, 5, 8, 9, and 13 and the neurovegetative symptoms to item numbers 16, 17, 18, 19, and 21. To evaluate the differences of the BDI subscale scores according to the perceived need and help-seeking behavior, the participants were divided into 3 groups, viz. 1) those with perceived need and with help-seeking behavior (PN with HS), 2) those with only perceived need (only PN), 3) those without perceived need (no PN).

Statistics

We first calculated summary statistics (percentages) to describe the sample between the 3 groups (PN with HS, only PN, no PN). To analyze the mean differences between the three groups in each specific subscale of symptoms (affective, cognitive, neurovegetative) of the BDI we performed analysis of variance (ANOVA) and post hoc pairwise comparisons using Bonferroni's significant difference test. Statistical Package for Social Science (SPSS) 12.0 for Windows was used to perform all of the statistical analyses. All of the significance tests were performed using two-tailed probabilities with an alpha level of 0.05.

Results

Description of the sample

139 (40.9%) of the respondents had perceived the need for help for mental health problems, while only 40 (28.7%) respondents exhibited help-seeking behavior. There were no differences in the sex, age, marital status or education level between the three groups (PN with HS, only PN, no PN) (Table 1).

Among the 40 respondents who sought help, 14 (26.9%) exhibited help seeking behavior through their religion, 11 (21.2%) went to a psychiatrist and 10 (19.2%) sought help through traditional medicine. The total number of

TABLE 1. Sociodemographic data

		A	B	C	χ^2
Sex	Male	11 (27.5)	26 (26.3)	68 (33.8)	<.05
	Female	29 (72.5)	73 (73.7)	133 (66.2)	
Age	Under 20	8 (20.0)	23 (23.2)	63 (31.3)	
	21–30	12 (30.0)	41 (41.4)	78 (38.8)	
	31–40	7 (17.5)	14 (14.1)	29 (14.4)	
	41–50	7 (17.5)	8 (8.1)	7 (3.5)	
	51–60	3 (7.5)	5 (5.1)	11 (5.5)	
	Over 60	3 (7.5)	8 (8.1)	13 (6.4)	
Marital status	Single	27 (67.5)	72 (72.0)	146 (72.6)	
	Married	13 (32.5)	27 (27.0)	55 (27.4)	
Education level	<High school	32 (80.0)	69 (70.0)	150 (74.6)	
	College	8 (20.0)	30 (30.0)	51 (25.4)	
Total N (%)		40 (100)	99 (100)	201 (100)	

A: group who perceived need and exhibited help seeking behavior, B: group who only perceived need, C: group who did not perceive need

responses was 52 because multiple answers were allowed (Table 2).

99 respondents felt they needed some kind of help for their mental health problems but had not sought help. They gave a total of 180 answers concerning their reasons for not seeking help. The 3 most common reasons were "preferred to manage by self" (26.1%), "had no time" (19.4%), and "afraid of visiting" (14.5%) (Table 3).

Which depressive symptoms are associated with the use of mental health services?

50 (17.1%) respondents out of the 293 who completed the BDI, were self-diagnosed with depression by a cutoff score of 16[19]. 29 respondents had a perceived need and help-seeking behavior, 87 had only perceived need and 177 did not have perceived need. On the ANOVA, the average scores of the 3 specific symptoms (affective, cognitive, neurovegetative) were significantly different ($p<0.000$) in all three groups; PN with HS, only PN and no PN. The mean score of the affective symptoms was significantly higher in those with perceived needs (PN with HS, only PN) than in those without perceived needs (no PN), implying that those with perceived needs for mental health services have severe affective symptoms of depression. The mean score of the cognitive symptoms was also significantly higher in those with perceived needs (PN with HS, only PN) than in those without perceived needs. However, the mean score of the neurovegetative symptoms was significantly higher in those with help-seeking behaviors (PN with HS) than in those without help-seeking behaviors (only PN, no PN).

TABLE 2. Types of help-seeking behavior

	N (%)
Religious counseling	14 (26.9)
Psychiatrist	11 (21.2)
Traditional medicine	10 (19.2)
Internet counseling	9 (17.3)
Non-psychiatrist (Medical Doctor.)	4 (7.7)
Mental Health specialist (Social worker, Nurse)	4 (7.7)
Total	52 (100)

TABLE 3. Reasons for not seeking help

	N (%)
Manage by self	47 (26.1)
No time	35 (19.4)
Afraid of visiting	26 (14.5)
Unrecognized psychiatric problem	22 (12.2)
No recommendation	15 (8.3)
Cost	15 (8.3)
Others	12 (6.7)
Unavailability of psychiatrist	4 (2.2)
Discontent with prior use	4 (2.2)
Total	180 (100)

Discussion

The purpose of this study was to understand the help-seeking behavior, perceived need and specific symptoms of depression as regards the mental health problems of the general population in Korea. 17.1% of the participants had depression at the time of the survey. This is consistent with other population-based epidemiological surveys of mental disorder.[3,20,21] Only a small proportion (11.8%) of the sample reported ever having sought help for mental problems, in spite of the high lifetime prevalence of depression. In summary, many people who have a perceived need for mental health services are not receiving appropriate treatments that would improve their health, well-being and functioning.

The most preferred source for help seeking turned out to be religion (35%) rather than psychiatrists (27.5%). In general, people prefer to manage their mental health problems by themselves, have no time to seek treatment, are afraid of visiting psychiatrists or do not consider their problems as needing treatment. Compared to western societies, the Asian and minority groups prefer to seek help from informal resources rather than obtaining specialized mental health treatment. According to the research conducted by A.F. Jorm on the public belief in treatment and the outcome of mental disorders in Australia and Japan, there are obvious cultural differences between these two countries. The Japanese prefer to obtain help from their close family and deal with their problems on their own and have a tendency to consider mental disorder to be a private issue.[22] Korean culture is similar to that of Japan, in that mental health issues are considered to be a

TABLE 4. ANOVA of depressive symptoms in each group

	A (N=29)	B (N=87)	C (N=177)	p	Post hoc test
Affective symptoms	2.38 (1.84)	1.89 (1.81)	0.98 (1.43)	.000*	A, B>C
Cognitive symptoms	3.92 (2.74)	3.72 (2.67)	2.4 (2.44)	.000*	A, B>C
Neurovegetative symptoms	2.94 (2.54)	2.00 (1.72)	1.71 (1.60)	.000*	A>B, C

*p<0.05. A: group who had perceived need with help seeking behavior, B: group who only had perceived need, C: group who did not have perceived need. ANOVA: analysis of variance

private matter, to be dealt with by oneself, and Korean people are therefore less positive about receiving treatment.

The results of this study show that severe neurovegetative symptoms are associated with help-seeking behavior. The major barriers to seeking help were ignorance and stigma surrounding mental health problems. On account of this stigma, as a result of which all mental health problems are labeled as major psychiatric illnesses, people prefer to seek moral or religious counseling and neurovegetative symptoms tend to be socially accepted help-seeking behavior.[23] From a cross-cultural perspective, Asians are more likely to consider depression as a physical or somatic problem, whereas, on the other hand, Americans have a cultural tendency to consider it as a psychological problem. Therefore, when Asians experience depression, they naturally shape it into a physical experience.[24]

We showed that only a small part of this population admits that they have sought help. Connecting the perceived need for professional help to the actual receipt of treatment is one of the fundamental tasks in the arrangement and organization of mental health services in Korea. Perceiving the need for treatment is now recognized as playing a pivotal role in initial help seeking behavior therefore a reduced threshold for help-seeking behavior is needed. Also, symptom pattern and severity determines the timing of treatment seeking. For those individuals who do perceive such a need, public information on mental health, specifically the affective and cognitive symptoms of depression, concerns about cultural discrepancies and a more accepting attitude toward professional help may facilitate help-seeking behavior. Psychiatric knowledge of both mental health professionals and non-psychiatric doctors would allow more referrals to professional treatment and, thus, education on the management and treatment of psychiatric problems should be included in planning policies for mental health.

The under-reporting of help-seeking, consciously or unconsciously, and recall bias may contribute to the low prevalence of help-seeking. We presume that the risk of false negative responses to the help seeking question is far higher than the risk of false positive ones, due to the general attitude towards mental illness in the population. The influence of age on the perceived need and various patterns of help-seeking behavior was excluded from the discussion, because most of the participants were between their 20's and 40's and far too few were in their 50's and 60's to represent the help-seeking behaviors of older people. Future studies of help-seeking behavior should be conducted with a larger sample population for the sake of the generalizability of the results.

REFERENCES

1. Katz SJ, Kessler RC, Frank RG, Leaf P, Lin E, Edlund M. The use of outpatient mental health services in the United States and Ontario: the impact of mental morbidity and perceived need for care. Am J Public Health 1997;87:1136-1143.
2. Regier DA, Farmer ME, Rae DS. One-month prevalence of mental disorders in the United States and sociodemographic characteristics: the Epidemiologic Catchment Area Study. Acta Psychiatr Scand 1993;88:35-47.
3. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the national comorbidity survey. Arch Gen Psychiatry 1994;51: 8-19.
4. Regier DA, Hirschfeld RM, Goodwin FK, Burke JD Jr, Lazar JB, Judd LL. The NIMH Depression Awareness, Recognition and Treatment Program: structure, aims and scientific basis. Am J Psychiatry 1988;145:1351-1357.
5. Spitzer RL, Kroenke K, Linzer M, Hahn SR, Williams JB, deGruy FV 3rd, et al. Health-related quality of life in primary care patients with mental disorders. Results from the PRIME-MD 1000 Study. JAMA 1995;274:1511-1517.
6. Regier DA, Goldberg ID, Taube CA. The de facto US mental health services system: a public health perspective. Arch Gen Psychiatry 1978;35:685-693.
7. Spitzer RL. Diagnosis and need for treatment are not the same. Arch Gen Psychiatry 1998;55:120.
8. Sareen J, Stein MB, Campbell DW, Hassard T, Menec V. The relation between perceived need for mental health treatment, DSM diagnosis and quality of life: a Canadian population-based survey. Can J psychiatry 2005;50:87-94.
9. Mojtabai R, Olfson M, Mechanic D. Perceived need and help-seeking in adults with mood, anxiety or substance use disorders. Arch Gen Psychiatry 2002;59:77-84.
10. Goldberg D. Mental health in the community: the pathways to psychiatric care. London: Tavistock Publications; 1980.
11. O'Neil MK, Lancee WJ, Freeman SJ. Help-seeking behaviour of depressed students. Soc Sci Med 1984;18:511-514.
12. Kendler KS. Is seeking treatment for depression predicted by a history of depression in relatives? Implications for family studies of affective disorder. Psychol Med 1995;25:807-814.
13. Veroff F, Kulka RA, Douvan E. Mental health in America: Patterns of help-seeking from 1957 to 1976. New York: NY Basic Books; 1981.
14. Lehtinen V, Joukamaa M, Jyrkinen E, Lahtela K, Raitasalo R, Maatela J, et al. Need for mental health services of the adult population in Finland: results from the Mini Finland Health Survey. Acta Psychiatr Scand 1990;81:426-431.
15. Rabinowitz J, Gross R, Feldman D. Correlates of a perceived need for mental health assistance and differences between those who do and do not seek help. Soc Psychiatry Psychiatr Epidemiol 1999;34:141-146.
16. Gurin G, Veroff J, Feld S. Americans View their mental Health. New York: NY Basic Books; 1960.
17. ten Have M, de Graaf R, Vollebergh W, Beekman A. What depressive symptoms are associated with the use of care services? Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS). J Affect Disord 2004;80:239-248.
18. Lee YH, Song JY. A study of the reliability and the validity of the BDI, SDS, and MMPI-D scales. Korean J Clin Psychology 1991;10:98-113.
19. Park KB, Kim JS, Shin MS. The cut-off score for the Korean version of Beck Depression Inventory. Korean J Clin Psychology 1993;12:71-81.
20. Kringlen E, Torgersen S, Cramer V. A Norwegian psychiatric epidemiologic study. Am J Psychiatry 2001;158:1091-1098.
21. Wittchen HU, Essau CA, von Zerssen DV, Krieg JC, Zaudig M. Life-

time and six-month prevalence of mental disorders in the Munich Follow-Up Study. Eur Arch Psychiatr Clin Neurosci 1992;241:247-258.
22. Jorm AF, Nakane Y, Christensen H, Yoshioka K, Griffiths KM, Wata Y. Public beliefs about treatment and outcome of mental disorders: a comparison of Australia and Japan. BMC Med 2005;3:12.
23. Yoon CH, Kim KI. Attitude toward help-seeking behavior. J Korean Neuropsychiatric Assoc 1991;23:1091-1110.
24. Kleinman A. Patients and Healers in the context of Culture. Berkeley: University of California express; 1980.