FACTORS AFFECTING HELP-SEEKING BEHAVIORS IN MENTAL HEALTH SERVICE OF PEOPLE WITH DEPRESSION IN THUA THIEN HUE

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Abstract

Objectives: To identify factors contribute to help seeking behavior of and understand the perception and attitude of patients with depression, and their service utilisation of people with depression in mental health service. **Methodology:** Both qualitative and quantitative methods were used in the study. 50 clients who were diagnosed with depression by (ICD-10) and recruited by convenient sampling method. Questionnaires were built in addition to references of similar previous research. Descriptive statistic method were used for data analysis in quantitative research. Thematic analysis of the data in qualitative research was conducted using a framework analysis method. **Results:** Quantitative research shows that first help-seeking behavior at specialized health service were only 28%, meanwhile 24% pursuits general local health service. The role of religious source of help (traditional healers, fortune-tellers) as first help-seeking behavior was significant at 26%, its ranked as the second choice for clients when first symptoms occur. Most patients with depression have appropriate attitude towards their illness, in particular, not being stigmatized and not isolated from others, the need of long-treatment and the avoidant of stressful responsibility and career. Qualitative research displays common patterns from themes emerged from the analysis: (1) First symptoms of depression, first contact to source of help; (2) Major obstacles accessing to professional mental health care; (3) Perception on the cause of depression; and (4) Change of attitude and practice of help-seeking behavior after being diagnosed as depression. **Conclusions:** People with depression in Thua Thien Hue province are less likely to access professional care as source of help for their first episode. Factors found to contribute to help seeking behavior include knowledge of health service and mental health problems, social-economic status, and service availability.

Key words: *help seeking behavior, depression, contributing factors*

1. INTRODUCTION

There was concern that many people with mental disorders often delay seeking help from professional health service. In Viet Nam, as other developing countries around the world, the mental health care resources are scarce and insuficient; the service accessibility is also limited [1]. Nevertheless, research associated with service seeking behaviour in the community would help consumers accessing the better care of service. Meanwhile, research toward mental health service model are not completely understood and are still rare. Previous studies show that limited help-seeking behaviour are associated with lacking of knowledge and perception of traditional health care and also the traditional mental health care practice in the community.

In general, people with mental illness and particularly people with depression tend to delay their treatment due to different reasons. Rickwood et al. have studied on factors affecting help-seeking process of young adults with mental health problems [2]. The research found main obstacles toward help-seeking process were low emotional capacity due to mental health problems, negative attitude and belief during the seeking help and the afraid of discrimination. Factors that foster the help-seeking behaviors were previous positive experience, the perception of mental health and also effects from social support [2].

In Viet Nam, other researchers evaluated patients' perception, knowledge and attitude toward mental illnesses [3] [4]. There are also behavior models to explain how patients decide

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to utilise a certain health service. Wacker et al. [5] analysed the social behavior on health service consumption, showing that it is a process containing prerequisite factors, to fostering or harnnessing factors and the neccessity of health service utilisation.

Previous studies in Viet Nam so far have not considered the help-seeking behavior in mental health care, especially mental health service for people with depression. This research focuses on description of service usage among people with depression, and therefore would help to understand the mental health service usage model for people with depression in general.

2. METHOD

2.1. Setting

The study was conducted in Thua Thien Hue province from June-July, 2012. The study recruited patients from mental health care facilities in Thua Thien Hue including Psychiatric hospitals and Primary health centres which have national mental health program on depression.

2.2. Participants

Of 50 eligible patients recruited for the study with diagnosis of depression, consecutive recruitment at the out-patient clinics from Hue psychiatric hospital and the Department of Psychiatry – Hue Central hospital. Other patients were from the commune health centre of Thuy Thanh – Huong Thuy District – Thua Thien Hue province who had been diagnosed as depression disorder The participants answered questionnaire when information was processed in quantitative analysis. A part from quantitative method, 18 participants agreed to attend three the focus-group discussions after interviews.

2.3. Study design

A mix-method of quantitative and qualitative study was implemented. 50 participants were recruited through a convenience sampling from a pool of diagnostic depression patients in different mental health care facilities.

The participants were recruited based on the available inpatients and outpatients book-list at Hue psychiatric hospital and the Department of Psychiatry – Hue Central hospital and 1 local community health centers (Participants in local were listed from BASIC NEED Project). Inclusionary criteria included: (1) diagnosis of schizophrenia, (2) aged between 21-65 years and (3) stable overall functioning over the previous 30 daysAll participants were double-checked through clinical psychiatric interview by experienced psychiatrist to confirm the diagnosis. Following the diagnostic guideline for depression, all participants have had clinical depression at least the last 2 weeks. The ICD 10- (International Classification of Diseases 10) was used to define the diagnosis. Only participants who had good insight and sound cognitive function were included in the interviews and focus-group discussions.

2.4. Instruments and data collection Instrucments

Patient's perception scale

To survey the patient's perception of the impact of depression on social relationships, research used scale with multiple indicators from previous studies. The questionnaire was designed with five questions related to the ability to influence others to suffer from depression, guilty feelings when the risk of infection and limit the ability dealings with others. The scale was a 6 point Likert rating ranging from (1) Totally disagree, to (6) Totally agree .

Data collection

The questionnaire was constructed with the reference of previous information from related studies on mental health service delivery. The quantitative questionnaire included three parts: (1) Demography and social economic status; (2) Factors in associaton with depression treatment; and (3) Mental health service. The guideline for discussion in qualitative study was a compilation of open-ended questions which based on similar studies of help-seeking behavior of people with mental health problems; in the reference of raw data in quantitative study.

2.5. Data processing and analysis

Data analysis was made by using descriptive statistic method using statistic sofware Stata 11.0. Qualitative data was collected by tape recording and analyzed following thematic analysis method.

2.6. Study ethical

The study was approved by Ethics Committee at the Hue University of Medicine and Pharmacy. All participants were voluntered to attend the interviews and signed in the consent form. The research team explained the study's goals and method to all participants following the research guidelines of WHO.

3. RESULTS

3.1. Sample characteristics

50 patients were screening and including in research sample. All patients were confirmed as depression followed by psychiatric interview. Sex ratios were 58% female and 42 % male. Most of patients were married (66%), single (24%), others with 10%.

All participants were Kinh ethnic group. Literacy level were high school at 28%, secondary school - 26%, undergraduate and graduate 22%, primary school-16%. 16% of patients were unemployed. Others were part-time employee (24%), full-time employee (32%) or household self-employed (20%). Average age of patients was 44 years, oldest patient was 70, youngest one was 16.

3.2. Help-seeking behaviour

3.2.1. Access for mental health care of patients suffering from first depressive episode

Table 1. First access for mental health service when having first episode of depression

First access for mental health service	Facillities where patients approach treatments			
	Psychiatric hospital (%)	General hospital (%)	Commune Health Centre (%)	Total (%)
Fortune-tellers, with or without worship	38.5	22.2	6.4	26.0
Worship in pagoda	3.8	-	6.7	4.0
Telephone counseling	3.8	-	.0	2.0
Traditional medicine	-	-	6.7	2.0
Private GPs	7.7	11.1	-	6.0
Private psychiatrists	3.8	-	-	2.0
Psychiatric hospital clinic	26.9	66.7	6.7	28.0
Commune health centre	15.4	-	53.3	24.0
No access/self-medicated	-	-	20.0	6.0

The role of religious source of help (Fortune-tellers, with or without worship) as first help-seeking behavior was significant at 26%. Psychiatric hospital clinic and Commune health centre was accounted for 52%. In particular, in the group of patients being treated in psychiatry department of a general hospital and provincial psychiatric hospital, the proportion who sought help with spiritual healing were 22.2% (2 of 8 patients) and 38.5% (10 cases), respectively. This suggests that the initial resources were diversed , not prioritizing for specialist mental health services.

There is common pattern that patients access many other support resources before treatment as present. 49 year-old male patient stated, *"... first I used traditional medicine with herbs as drinks ... , I got exessive heart rate, took advice by my friend who was a doctor to see Mr. M., a cardiologist, and then Dr. V.-another cardiologist saw me in his clinic... I asked Dr. V whether psychiatrist can help with the insomnia? Dr. V said psychiatry only cure crazy people, .. you are not the case ....* ". Another female stated that " *I was 17, first symptoms were insomnia, loss of appetite , get bored, I didn't like socialising with anyone , I visited doctor T but medication didn't help, my supervisor at work gave advice for me to have treatment in psychiatric hospital"* (said a 17 y/o female, FGD).

3.2.2 . The main obstacles of depression when seeking mental health services

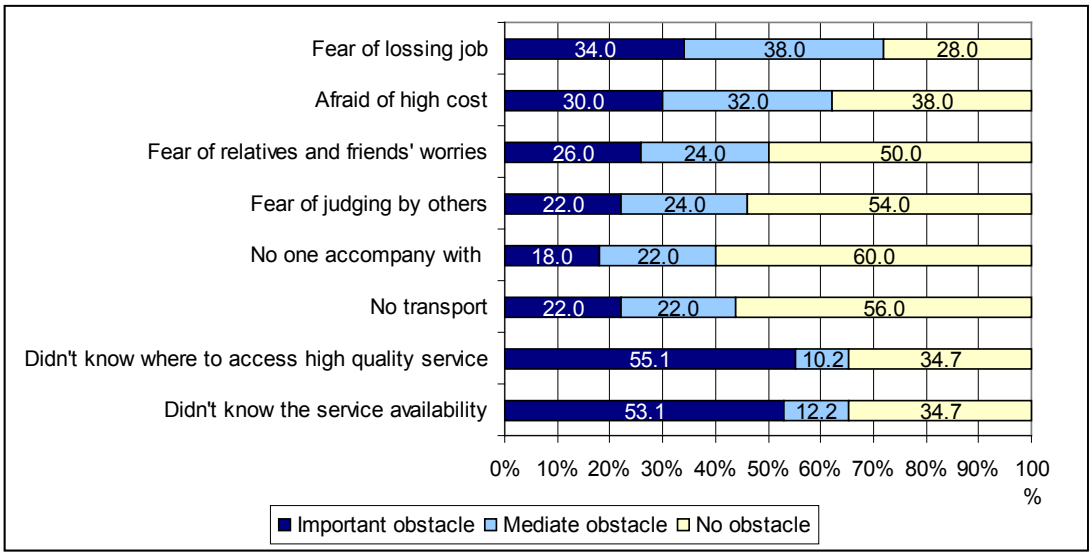

Chart 1. Main obstacles of depression when seeking mental health services

The main obstacle was the lack of knowledge about available mental health services (52 %) and good mental health professional (54%). Other obstacle were fear of job loss or loss of income (34%) and expensive treatment (30%). When asked about the knowledge of locations of psychiatric treatment, there was significant difference between the groups of patients being treated in a specialist psychiatric facility with patients in commune health centre (CHC). Patients in CHC thought it was difficult to approach mental health care service (average value for this criterion was 4), but patients in mental health care facilities didn't mean the same. One patient said "at CHC we don't have counseling sevice, only interview and medication were provided; if I sufferd severe mental health problems, medical staff then referred me to a general hospital ..., we didn't know where to receive treatment for depression ." (43 y/o woman, FGD)

3.3. Perception of depression

This study surveyed aspects of patients' perception related to depression. These aspects include: perception of the impact of the disease to the social relationships , the impact of the illness on marriage and family relations in the future, the impact of depression on professional competence and the belief about specialist treatment.

3.3.1 . Perception of the impact of depression with social relationships

Table 2. Perception of the impact of depression with social relationships

Survey criteria	Min	Max	Mean	SD
Inferiority risk of harm to others while suffering from depression	1	6	2.92	1.68
Feel ashamed by depression diagnosis	1	6	2.60	1.69
Fear of potentially dangerous for relatives and friends as depression	1	6	2.74	1.70
Fear of the employer /colleagues thinking negatively about myself	1	6	3.22	1.86
Fear of isolated by friends	1	6	2.14	1.34

The descriptive statistics showed that the majority of patients have less negative perception about the impact of depression to their social relationships. This is reflected by the average index in the range of 2.14 to 3.22 on Likert scale such as "Inferiority risk of harm to others while suffering from depression" (2.92); feel ashamed by depression diagnosis" (2.6); fear of potentially

dangerous for relatives and friends as depression (2.74), " fear of the employer/colleagues thinking negatively about myself" (2:22) and "fear of isolated by friends" (2.14). Nevertheless, in FGD, patients stated that *"I am afraid that someone know and imply that I am mentally ill, crazy; parents fear about me roaming the streets .. "* or *"not many friends of mine know (I suffered from depression) , just know that I have sleep disorder"*. (Female , 25 y/o, FGD)

3.3.2. Perception of the impact of depression on marriage and family in the future

Survey criteria	Min	Max	Mean	SD
People with depression couldn't be a good parent	1	6	2.66	1.479
People with depression shouldn't get married and have children	1	6	2.85	1.660

Result showed that most patients do not think that depression negatively affects the ability to get married and raise their children . The average value at 2.66 and 2.85 (< 3).

3.3.3. Perception of the impact of the disorder on professional competence

The impact on jobs, most patients tend to accept that the depression, they should work work with less stress and less responsibility with trauma. The index reached statistical average 4.7 respectively .

3.3.4. Perception of specialist treatment

Descriptive statistics showed that most patients had appropriate knowledge about the treatment of depression. The patient aware that depression disorder need long-term treatment but depression is not untreatable. Statistics averaged 4.68 for criteria "continuous treatment" and 2.42 for criteria "can not be treated even with whatever measures". One patient also stated that *"I thought it will be expensive here (psychiatric hospital), after that I feel better and less expensive for treatment"* (Female, 28 y/o - FGD)

4. DISCUSSION

The study explores the behavior seeking mental health care through understanding of services approach, the obstacles when seeking specialist treatment, the patient's attitude during receiving services.

Survey of first source of help brought suprsising results about the role of religious belief when having a mental health problem. Patients tend to seek resources from religious help and other health service rather than professional mental health services. This result is also reflected in similar studies of Nsereko in Uganda [6] and Kishore et al in India [7]. This is one of the factors hindering the process aware search specialist services. Comparison to other studies, patients with mental disorders often have access rate to specialist treatment services as low as 25% of young people seeking help in Canada [8].

In term of the obstacles in the process of seeking for services, lack of information about the availability of specialist treatment services stands out as a leading factor causing obstacles that delay access to services. This result is consistent with a study in Australian Chinese population [9], which share some characteristics religious beliefs as the study group. This is also confirmed in the later qualitative results of this study. The cause might be the availability of information from service providers toward health education and communications for populations as other health care services. On the other hand, the qualitative results also show that GPs does not have sufficient referral skills causing lack information about mental health services.

In addition, qualitative research also indicated problem related to patients' use of insurance and referral system complexity, patients waiting take time and fear of stigma, discrimination. All of these contributed to the cost of treatment, which is an obstacle in seeking specialist services, this also was showed in quantitative results. Qualitative results contributed to explain the barriers in seeking help fron mental health services.

After accessing mental health services, overall perception of the patient to the treatment is positive. Patients admitted that treatment was cost-effective, in particular changing beliefs about spiritual treatments. Comparison between the two

groups of patients interviewed at the specialist services and at CHCs, we found that knowledge of services differ significantly, when patients might have change their attitude after using specialist service.

In addition, this study also explored patients' perceptions related to depression. The perceptions nclude: perception of the impact of the disease to the social relationships, the impact of the disease on marriage and family relations in the future, the impact of depression on professional competence and belief in specialist treatment. Patient's perception of the impact of depression on social networks showed the majority of patients have positive perception about the impact of depression on the relationship of their society. People with depression often withdrawn from the world around them , including family relationships and society. Many members of the community do not recognize specific disorders or different types of depression [10]. Family and friend who do not understand about depression, might let depresion worse and make patients more isolated, affect all aspects of the patient's life, especially social relationships[11]. Moreover, the negative understanding of depression reduces the willingness of patients to participate in social relationships [12], [13]

Limitations of the study :

This research is an exploratory study, descriptive and cross-sectional data collection method in a convenient sampling relatively in a short time. Therefore, It might be difficult to avoid some limitations. Firstly, because of the characteristics of the pathology of depression, patients with severe depression did not have the opportunity to participate in the study would affect the results. Patients with depression mainly have had a long term treatment and the study was conducted in patients that have been diagnosed and given treatment, this sample would not represent for the community. Secondly, methodology of research with small size sampling would limit the examination of relationship of the statistical variables. The questionnaire only had purpose to describe the help-seeking behavior but assessment what model of factors affecting seeking behaviour to mental health service.

5. CONCLUSIONS AND RECOMMENDATIONS

Patients with first depressive episode have little access to metnal health care specialists. This make patient wasting of time and missing opportunities for early treatment of depressive disorders. Besides the issue of the cost of treatment, an important factor hinders treatment is lack of information about services and professional treatment availability.

This conclusion led to recommendations for health management agencies to raise perception of the community about the availability of treatment services in psychiatry, including mental health care for depression. The health care providers, health insurance agencies in general and psychiatric specialist hospitals should establish and develop appropriate referral system for people with mental disorders and depression in particular.

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