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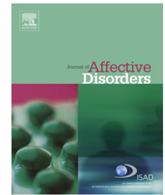

Research report

Reasons and determinants of help-seeking in people with a subclinical depression

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ABSTRACT

Background: Subclinical depression is common. Although interventions have proven to be effective, participation rates are low. This study first aimed to get more insight in help-seeking and reasons for (not) seeking care. The second aim was to identify characteristics that distinguish people who receive help, those with an unmet need, or no perceived need for care.
Methods: Respondents with a subclinical depression ($n=162$) were recruited from the general population. They were eligible for participation if they were aged 18 years or older, scored 20 or higher on the K10 screening instrument for depression, and did not meet the criteria for major depression.
Results: Of all participants, 27% received help, 33% had an unmet need, and 40% had no perceived need for care. Participants with no perceived need reported not to experience symptoms, were able to solve problems on their own, and could mobilize their own support. They were characterized by lower scores on neuroticism and an older age than those who received care.
Limitations: The response rate in this study was relatively low which may have caused a selection bias.
Conclusion: Not all people with subclinical depression may need help for their symptoms, some are able to deal with problems on their own. However, others experience a need for care but do not receive any. Gaining insight into potential barriers for help seeking and receiving in people with an unmet need is important so appropriate measures can be taken to ensure that those who need care get the help they want.

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1. Introduction

Subclinical depression is common and has a significant impact on daily functioning (Cuijpers et al., 2004; Rapaport and Judd, 1998) while at the same time creating a large burden for the society (Broadhead et al., 1990). Subclinical depression can be defined in different ways such as (1) a score above a threshold on a screening instrument without meeting the full criteria for major depression according to the DSM-V or (2) having a depressed mood accompanied with additional symptoms, but not as severe or as many as the DSM-V criteria for major depression (American Psychiatric Association, 2013; Cuijpers and Smit, 2004; Eaton et al., 1995). The definitions proposed in the DSM-V of clinical and subclinical depression suggest a qualitative difference between the two; however, research indicates that depression is best viewed on a continuum from no symptoms to many symptoms (Geiselman and Bauer, 2000; Goldberg, 2000; Rodríguez et al., 2012). Subclinical depression is considered part of the prodromal phase of depression and is one of the best predictors of major depression (MDD) (Cuijpers et al., 2004; Eaton et al., 1995).

The incidence and prevalence rates of subclinical depression vary widely depending on the definition, population, and instruments that are used. Estimates of the incidence rates range from 2.3% to 12.9% (Goldney et al., 2004; Rivas et al., 2011; Rucci et al., 2003) and prevalence rates vary from 2.2% to 24% in community samples (Kessler et al., 1997; Rucci et al., 2003). Compared to the prevalence of full blown depressive disorders these prevalence rates are equal or higher (Rucci et al., 2003). It is estimated that, in the Netherlands, approximately 7.5% of the general population meets the criteria for a subclinical depression (Cuijpers et al., 2004). Although research has shown that effective interventions are available to ameliorate symptoms in individuals with a subclinical depression and to prevent the onset of major depression (van Zoonen et al., 2014), only few people who could benefit from these treatments actually participate in these interventions. Help-

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receiving rates in individuals with a subclinical depression range between 1% and 32% (Andrews et al., 2001). Since preventive treatments have shown to be effective, it is important to know what the reasons are for people with subclinical depression not to seek help, and what kind of people do or do not seek help for their symptoms.

Research on help seeking behavior is often guided by Andersen and Newman's model for health services utilization that distinguishes three interrelated factors; need factors, predisposing factors, and enabling factors (Anderson, 1973). According to this model need factors include both the individual's own judgment of their health and symptoms (perceived need) and the professional assessment of the individual's symptoms and health based on a clinical instrument (actual need) (Anderson, 1973; Babitsch et al., 2012; Parslow and Jorm, 2000).

Predisposing factors consist of personal, social, and cultural characteristics of individuals such as demographic factors (e.g. gender), social structure (e.g. education and relationship status), and belief factors towards the health care system and symptoms (e.g. expectations of treatment outcome and/or their health) (Andersen and Newman, 2005). Enabling factors relate to organizational factors which affect the availability and affordability of mental health care (e.g. individual's financial situation, location and distribution of health care facilities) (Bartels, 2003).

The model of Andersen and Newman contains feedback loops between the various factors, illustrating the interrelations between those factors. For example, the ability to recognize symptoms (a need factor) is closely related to age and the level of education (both predisposing factors), health related quality of life (e.g. when people do not experience a burden of disease they might not seek help) and the severity of symptoms (actual need) (Andersen and Newman, 2005; Sherwood et al., 2007).

Furthermore, looking at (actual) need factors, research in the general population has shown that depressive disorders are often accompanied by alcohol use disorders, with depressed individuals having a 2-to-3-fold increased risk of alcohol use disorders (Burns and Teesson, 2002; Hasin et al., 2007; Pirkola et al., 2005). Research on help-seeking in people with and without an alcohol disorder is contradictory with some studies showing no difference in help-receiving (Ten Have et al., 2004) and others showing a reduced tendency to seek care in people with an alcohol disorder (Alonso et al., 2004; Ten Have et al., 2010). Also, previous episodes of depression tend to make people with recent depressive episodes seek help more quickly (Farmer et al., 2012).

Research on age is not clear cut with some research indicating that increasing age is related to a greater need for and receiving of professional help (Bristow and Patten, 2002; Gallo et al., 1995; Mackenzie et al., 2006) and other studies showing that young people, people with more positive experiences of their mental health care, and people who acknowledge their mental problems receive more mental health treatment (Andrews et al., 2001; Bland et al., 1997; Sherwood et al., 2007; Verhaak et al., 2009). Research on gender and help-seeking showed that men are less likely than women to seek help, which might be due to gender-role differences and what is viewed as masculine (Mackenzie et al., 2006; Oliver et al., 2005). Furthermore, research on stigma and help-seeking in depression is contradictory, with some research showing a relation between stigma and help-seeking (Barney et al., 2006; Gulliver et al., 2010; Schomerus et al., 2009) and others not finding a relation (Endicott, 1996). Further research has shown that people with higher scores on neuroticism, a higher education, and those who are in a relationship with a significant other tend to seek more help for their mental health problems (Andrews et al., 2001; Bristow and Patten, 2002; Oliver et al., 2005; Parslow and Jorm, 2000; Ten Have et al., 2005). However, research in people with affective symptoms has shown that people who have a partner are less likely to seek professional help (Burns et al., 2003). Above literature shows that there is a lot of information on help-seeking in mental health care and full-blown depressive disorders. However, not many studies have focused on help-seeking in populations with subclinical depression. In the Netherlands preventive care is easily accessible and mostly free of charge to everyone which will minimize the influence of enabling factors.

In the current study we recruited a sample with subclinical depression from the general population in order to get more insight in help-seeking and the reasons for (not) seeking help. In order to do so, we distinguished between people who had: (1) no perceived need for professional help, (2) an unmet need (i.e. they did not receive professional help, but perceived a need for help), and (3) received professional help (people who received care for their symptoms). Furthermore, we examined what type of professional help was used by people who received care.

The second aim was to examine if we could identify characteristics that distinguished people with an unmet need, no perceived need, and those who received professional help. We examined differences in predisposing factors such as, sex, age, education, marital status, mastery, neuroticism, and need factors such as, health related quality of life (HRQoL), alcohol use, duration of symptoms, severity of depression and anxiety symptoms, and comorbid anxiety disorder.

2. Methods

2.1. Participants and procedure

Subjects with subclinical depression were recruited from the general population between September 2012 and February 2013 in collaboration with Municipal Public Health Services (GGD) in three different areas in the Netherlands: Amsterdam, Zuid-Holland West, and Zuid-Holland Zuid. In collaboration with several mental health institutions, the availability of preventive interventions in these areas was optimized and widely advertised (i.e. extensive advertisement through local newspapers, flyers and leaflets with information on the preventive interventions and mental health institutions prevention these were delivered to GPs and individual's homes to make health care professionals as well as the general population aware of the preventive interventions). In each area the preventive interventions were well distributed, however with the optimization the emphasize was on five preventive interventions; two web-based interventions and three group interventions: mindfulness training, a coping with depression course, and exercise therapy. Advertisement was focused on people with symptoms of depression such as low mood or feelings of sadness and who wanted to do something about them. We specifically asked about these five interventions, because they form a good representation of the broad range in available preventive interventions throughout the Netherlands and provide enough diversity for people to choose from. Since the focus of these interventions is to prevent (or at least delay) the onset of depressive disorders they are considered preventive interventions. Subjects were also able to indicate if they preferred other interventions.

GGD in the Netherlands are obliged by law to gain insight into the health situation of their citizens and a Health Survey among a random sample of the population is one way of doing so. The current study joined this survey in 2012. This survey is usually conducted every four years by the GGD and contains questions about physical, mental, and social health and lifestyle. A screening instrument for depression, the Kessler-10 (K10) was included in the 2012 survey (Kessler et al., 2002). Subjects who scored 20 or higher on the K10 screening instrument for depression (Donker et al., 2010), who were 18 years or older, and who had given

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