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Beliefs about the causes of and treatments for depression and bipolar disorder among South Koreans

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ABSTRACT

Public beliefs about psychiatric disorders are important for understanding help-seeking behaviours. We investigated factors that affect South Koreans' beliefs about the causes and treatment of depression and bipolar disorder. We recruited 654 participants aged 15–54 years using an online panel survey. Participants completed two questionnaires: 34 possible causes of and 33 possible treatments for depression and bipolar disorder. For both disorders, the questionnaires about causes revealed four factors: social-environmental, God/fate, heath/lifestyle, and biological; the questionnaires about treatments revealed five factors: self-help/stress management, physical treatment/health management, seeking mental health services, religious help, and resting. Causes of depression were more recognized as social-environmental, religious, and health/lifestyle compared to bipolar disorder. Participants expressed more beliefs in self-help/stress management, physical treatment/health management, seeking mental health services, and resting for depression, compared to bipolar disorder. Participants' beliefs about the causes of the disorders and their demographic and psychiatric characteristics were closely associated with beliefs about treatment validity. Participants' beliefs about the causes of depression and bipolar disorder significantly affected their beliefs about treatment. Therefore, strategies to improve mental health literacy should provide the aetiology of specific mental disorders. Further research using a representative community sample is needed to generalize our findings.

1. Introduction

A study addressing a nationwide sample of Korean adults reported that the lifetime and 12-month prevalence rates for major mental disorders (as listed in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders) were 27.6% and 16.0%, respectively (Cho et al., 2015). However, among respondents who met the criteria for the 12-month diagnosis of a psychiatric disorder, only 6.1% said that they received mental health care (Cho et al., 2009). This rate is relatively low compared to that of Western patients, where approximately one-quarter of the patients with psychiatric problems were seen in multiple mental service sectors (Kessler et al., 1999). Stigmatization of mental illness (Choi, 2013) and the wish to handle the problem on their own (Cho et al., 2009) have been suggested as reasons for the low consultation rate among those with psychiatric disorders in Korea. Treatment delay due to non-consultation is associated with a more adverse course of illness in patients with major psychiatric disorders such as depression (Kupfer et al., 1989) and bipolar disorder (Post et al., 2010). Therefore, improving access and raising awareness for specialized mental health services are critical in lessening the burden of psychiatric disorders and improving the overall mental health of the general population.

Previous studies on mental health services use have mainly focused on socio-demographic factors (Andersen, 2008; Park et al., 2012); specifically, ethnic minorities (Grace et al., 2016; Hunt et al., 2015), men (Mackenzie et al., 2006), and those with low educational attainment (Goodwin et al., 2002) were reported to underutilize mental health services. Moreover, several studies have shown that beliefs and knowledge about mental illness could affect treatment-seeking behaviours. For instance, the stigma (Ng, 1997) and misconceptions (Jang et al., 2009) related to mental illness lead to negative attitudes toward mental health services and treatment delay. To assess public beliefs about mental disorders, several studies have investigated the factor structure of questionnaires assessing beliefs about the causes of and treatments for major psychiatric disorders (mainly depression) among the general population (Furnham et al., 2016; Loo and Furnham, 2012;

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Swami et al., 2010). In a study by Furnham et al. (2016), for instance, the questionnaires on depression causes and treatment yielded seven factors named God/fate, environmental, health, self-obsession, brain, genetics, and parents. The same study further showed that demographic characteristics and experience with mental illnesses predicted different beliefs about depression causes and treatment. These results imply that people hold detailed, multidimensional beliefs about the causes of and treatments for psychiatric disorders.

This study had two main goals. First, we compared beliefs about the causes of and treatments for depression and bipolar disorder, which, to our knowledge, has not been accomplished in any study before. Although depression and bipolar disorder are both categorized under affective disorders and have some overlapping symptoms, the causative factors leading to these disorders are different. Family, twin, and adoption studies have suggested the importance of genetic determinants of susceptibility to bipolar disorder (Craddock et al., 2005), whereas environmental factors such as stressful life events are considered more critical at the onset of depression (Kendler et al., 1999). Therefore, comparing beliefs about depression and bipolar disorder could reveal meaningful findings that could be useful for the implementation of mental health literacy campaigns in South Korea. Second, we replicated previous analyses of beliefs about the causes of and treatments for both disorders in a South Korean population. Direct application of the findings obtained from other populations may not be applicable to the Korean population, since socio-cultural factors influence attitudes toward mental illness and subsequent health service utilization (Nguyen, 2012; Office of the Surgeon et al., 2001). Therefore, in this study, we examined multifaceted public beliefs about the causes of and treatments for depression and bipolar disorder in the South Korean population.

2. Methods

2.1. Participants

An online panel survey was conducted from October to November 2016 with a sample of South Koreans (N = 654) aged 15–54 years**.** An online research service that operates its own consumer panel site (www.esurvey.kr) was used to recruit participants. Quotas were imposed to reflect the age distribution of the population. The research service sent email invitations requesting participation from a random sample of potential respondents who had responded to another survey at least one time within the last 12 months. Of the 9631 individuals who received the invitation email, 654 completed the questionnaires. Information about the study was presented on the survey webpage. After reading the instructions, participants started the survey by clicking the 'participate' button, which was regarded as consent to participate. Personal identification data were not collected. This study was reviewed and approved by the Institutional Review Board of the National Center for Mental Health (No. 116271-2016-44).

2.2. Materials

Information on age, sex, socioeconomic status, and religion were collected. Religious and supernatural beliefs have been reported to influence help seeking and treatment in some psychiatric disorders such as bipolar disorder (Grover et al., 2016). Before answering the questions about the diseases' causes and treatments, short descriptions on depression and bipolar disorder were given. Questionnaires asking how strongly the respondent agrees or disagrees with each of the 34 possible causes ('How strongly do you agree that the following example will cause depression/bipolar disorder?') and 33 possible treatments ('How strongly do you agree that the following example will treat depression/bipolar disorder?') of depression and bipolar disorder were given. Each question was answered using a 7-point Likert scale (1 = *strongly disagree* to 7 = *strongly agree*.). The lists of possible causes and treatments of the psychiatric disorders were derived from questionnaires used by Furnham et al. (2016), which were informed by anthropological, psychological, and sociological literature (Angermeyer and Matschinger, 1999). The lists were slightly adapted to fit the sociocultural context of South Korea. Questions on the lifetime diagnosis of psychiatric disorders and whether respondents have a relative or an acquaintance with a psychiatric disorder sought to assess how experiences related to psychiatric disorders influence beliefs about the causes of and treatments for depression and bipolar disorder.

2.3. Statistical analysis

Factor analyses using Varimax rotation were conducted to investigate the underlying structure of respondents' beliefs about the causes of (34-item questionnaire) and treatments (33-item questionnaire) for depression and bipolar disorder. Factors with an eigenvalue greater than 1 were retained (Kaiser, 1960). We then compared whether the mean scores of the items included in each of the cause and treatment factors differed between depression and bipolar disorder. A paired samples *t*-test was used to compare the mean differences, since each participant completed all questionnaires. Next, we examined whether respondents' socio-demographic characteristics and experiences related to psychiatric disorders affected their ratings, using a multiple linear regression model. Factor scores for causes and treatments were entered as dependent variables and age (per 10 years), sex (male = 0, female = 1), religion (no = 0, yes = 1), family income (per 1000,000 Korean won), any lifetime psychiatric diagnosis (no = 0, yes = 1), and having relatives with any psychiatric disorders (no = 0, yes = 1) were concurrently entered as independent variables (Model 1). We additionally regressed each treatment factor on the cause factors after entering the independent variables to determine whether beliefs about the causes influenced respondents' beliefs on valid treatments for the disorders (Model 2). All statistical analyses were performed with SPSS 21.0 (SPSS Inc. Chicago, IL), with statistical significance defined as $\alpha = 0.05$.

3. Results

3.1. Demographic characteristics

Among the 654 respondents, 340 (52%) were men and 314 (48%) were women. Respondents aged 15–19, 20–29, 30–39, 40–49, and 50–54 years constituted subsamples of 75 (11.5%), 144 (22%), 160 (24.5%), 182 (27.8%), and 93 (14.2%) of the total sample, respectively. Regarding family monthly income, 5.2% of participants earned less than one million Korean won (about 900 USD), 8.9% earned 1–2 million won, 16.1% earned 2–3 million won, 15.7% earned 4–5 million won, 17.9% earned 5–6 million won, 14.8% earned 6–7 million won, and 11.6% earned more than 7 million won. With regard to religion, 63.1% of participants reported no religion.

3.2. Beliefs about causes of depression and bipolar disorder

Table 1 shows the results of the Varimax-rotated factor analysis for the supposedly causative items for depression and bipolar disorder, respectively. The eigenvalue and accounted variance for each factor as well as the factor loading, mean, and standard deviation of each item are shown. The analysis yielded four factors for the causes of depression and bipolar disorder: social/environmental, God/fate, health/lifestyle, and biological. The order (descending eigenvalues) of causes was the same for the two disorders. The list of items included in each of the four factors were similar, but not the same, for depression and bipolar disorder. The four causal factors for depression and bipolar disorder accounted for 62.62% and 68.08% of the total variances, respectively.

Of note, some items appeared to have double loadings on two factors or did not seem to perfectly fit the factor showing the highest