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What to do about mental disorder — help-seeking recommendations of the lay public

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Objective: Sociocultural factors have been recognized as an important predictor in shaping help-seeking behaviour.
Method: We investigated attitudes of the lay public toward help-seeking for mental disorders in a population survey ($n = 1564$) conducted in the new *Laender* of Germany. After presenting a vignette depicting a person either with major depression or with schizophrenia (DSM-III-R), we inquired about help-seeking recommendations. employing a qualitative approach.
Results: The lay support system plays an significant role in initially dealing with mental disorders. However, help-seeking recommendation differed for depression and schizophrenia. In depression, support from the lay system was more often considered. In schizophrenia, public opinion favoured the expert system. If primary suggestions fail the expert system is clearly favoured regardless of the disorder in question.
Conclusion: Lay public's opinion has to be taken into account of in mental health care planning to make services more acceptable to the consumer and their social network.

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Introduction

Past empirical work on help-seeking behaviour among the mentally ill has focused mainly on the examination of individual and structural determinants (1). The impact of the sociocultural context has been largely neglected. However, attitudes and belief systems, transmitted by family, kinship and friendship networks, influence the manner in which an individual defines and acts upon symptoms and life crises. Few attempts have been made to investigate the nature of attitudes and belief systems prevalent in society and their impact on help-seeking decisions. Ajzen's theory of planned behaviour may serve as a theoretical background to determine how attitudes and beliefs function in the help-seeking process (2). At the most basic level of explanation the theory postulates that behaviour is a function of salient beliefs, relevant to the behaviour in question. Salient beliefs are the antecedents of attitudes, subjective norms and perceived behavioural control — three conceptually independent determinants of intention — which, in turn, may result in concrete behaviour or action. Subjective norms are composed of normative expectations and the motivation to comply with these expectations. Normative expectations of patients are orientated to the ideas currently prevalent in the society. According to this assumption attitudes of the lay public should play a central part in the patient's decision about possible sources of support in the event of experiencing mental distress. This study investigates explicitly the lay public's attitudes toward help-seeking for psychiatric disorders in the eastern part of Germany. The following questions are addressed: to what extent does the lay public consider to seek professional help? In the eyes of the public, how does professional help differ from informal support systems and resources of the lay support system? Which agents and institutions are recommended primarily? What are the suggestions if the help considered in the first place fails? So far, very few studies have focused on the public attitudes toward help-seeking regarding psychiatric disorders (3–6). With the exception of a field study conducted in the old German *Laender*,

quantitative study designs were used. Respondents mainly rated or ranked a preselected set of agents regarding their perceived helpfulness. Thus, these studies measured a reaction to an offer of help-seeking channels rather than exploring the respondents own conceptions. To avoid this limitation, a qualitative approach seems more suitable. The assessment of spontaneously offered help-seeking recommendations might be a better reflection of sources of help considered in the decision-making process in real-life situations.

Material and methods

Sample

During March and April of 1993, a representative survey was conducted in the new *Laender* of the Federal Republic of Germany among people of German nationality who were at least 18 years old living in private households. The sample was drawn using a three-stage random sampling procedure with electoral wards at the first stage, households in the second and individuals within the target households in the third stage. Target households within the sample points were determined according to the random route method, the selection of target people according to random digits. Since two subsamples were needed, electoral wards were assigned randomly to the subsamples. Subsamples ($n=1063$, $n=501$) do not differ significantly regarding age ($t=0.2245$, $P=0.5888$), gender ($\chi^2=0.2447$, df$=1$, $P=0.621$) and education ($\chi^2=3.2841$, df$=3$, $P=0.350$). In all, $n=1564$ interviews were conducted, which reflects an response rate of 71.2%. Regarding age and gender, the sample is comparable to the whole population aged 18 years and older in 1993 living in the new *Laender* (see Table 1).

Table 1. Sociodemographic characteristics of the population and the sample

	Population[1]			Sample		
	Male $n=5795500$ %	Female $n=6428400$ %	All $n=122239000$ %	Male $n=738$ %	Female $n=825$ %	All $n=1564$ %
18–24	11.46	9.21	10.3	9.89	10.67	10.3
25–44	42.96	36.44	39.4	37.40	37.09	37.2
45–59	26.28	24.24	25.2	29.54	24.73	27.0
60–64	6.88	6.99	6.9	8.94	7.88	8.4
65+	12.41	23.11	18.0	14.23	19.64	17.1

[1] Population 31.12.1993, resource: *Statistisches Jahrbuch* 1995/Official Registry Report 1995.

Interview

A fully structured face-to-face interview was carried out, which began with the representation of a vignette describing a diagnostically unlabelled psychiatric case history. The case history either depicted a person suffering from schizophrenia or major depressive disorder, according to DSM-III-R criteria. Before being included in the survey, the texts of the vignettes had been presented to five psychiatrists or psychologists for the purpose of a blind diagnostic allocation. For each of the two disorders, all experts were able to provide the correct diagnosis based on the case histories described in the vignettes. Subsamples were presented with only one case history (schizophrenia $n=1063$; depression $n=501$). Following the presentation of the vignette, respondents were asked if they would seek help in a situation as described in the vignette. If the respondents felt that help was needed they were asked the following open questions: 'What would you recommend to do first in such a situation?/ From whom should one seek help?' Rather than there being one single answer, a variety of suggestions were given in response to this question, ranging up to five recommendations per respondent. Afterwards, the respondents were asked: 'If this fails, what should happen next?' Again, those questioned gave multiple responses (maximum three suggestions). All answers to these questions were noted verbatim by the interviewers.

Analysis

The answers to the open questions were coded using an elaborated coding system. The coding system, comprising a list of 32 categories, was developed in a prior study and will be described briefly (6). The categories were arrived at by means of an empirical inductive process. The categories were conceptualized according to the research question. On a very basic level, lay people and lay organizations (lay support system) were differentiated from experts and expert organizations (expert system). These broad categories were further subdivided with regard to agents and organizations, as well as specific interventions (e.g. talk it over with someone). This paper focuses specifically on agents and organizations. Within the lay support system, the following recommended agents were differentiated: friends, family, self-help groups, colleagues, the respondent (few respondents offered their help) and the affected people themselves in a sense of self-help without involving others. The expert system comprises the following categories: the family physician, the psychiatrist, the psychologist, the psychological counselling service centre, the hospital (not further specified), the psychiatric hospital, clergy men, other experts and other institutions.

For a subsample ($n=100$) the primary, i.e. spontaneously offered, suggestions and the secondary recommendations were coded independently by two raters. A satisfying reliability could be demonstrated (Cohen's kappa of 0.85 and 0.90 for primary recommendation and 0.86 and 0.95 for secondary recommendation, respectively).

Since for both primary and secondary recommendations multiple responses were given, statistical testing of differences between recommendations for schizophrenia and depression is not possible, because vital assumptions are violated. For conclusions on the basis of respondents the assumption of independent observations is violated, since each respondent may (and actually does) contribute more than once for both recommendations. If we regard the total of responses, these 'observations' are not independent either, since they are stochastically dependent within each respondent.

Results

In cases of major depression and schizophrenia the great majority of respondents, 80.2% and 86.2%, respectively, felt that help is needed. Figure 1 shows the percentage of respondents who were recommended to seek help either from various agents of the lay support system or the expert system, in cases of depression and schizophrenia. Due to multiple recommendations, respondent percentages do not add up to 100%. As can be seen at first glance, the lay support system plays a remarkable role as the primarily recommended source of help. This is more pronounced in depression (67%), but still substantial (47.3%) in schizophrenia; whereas in depression almost the same proportion (65.3%) considered the expert system as primary recommendation, in schizophrenia the great majority decided for the expert system (86.4%). In the case that primary suggestions fail, the expert system is clearly favoured regardless of the disorder in question (87.4% in depression, 86.4% in schizophrenia).

Focusing on the *primary recommendations,* it was advised to contact the following agents and organizations: within the lay support system friends are the main source of help, followed by family and self-help groups. Colleagues were mentioned very seldom. The family physician is cited most frequently as the best source of help among the expert system, followed by psychiatrist and psychologist. The help of clergymen, on the other hand, does not play a role in this situation. This holds true for both disorders. However, help-seeking recommendations for both disorders differed in several respects. In depression, support from the lay system was suggested by the majority of the respondents. Friends were the most frequently mentioned source of help. It is remarkable that in the case of major depression psychiatrists are considered as a primary source of help by only 12.2% of the respondents. Not a single respondent conceived a general hospital or psychiatric hospital as a primary source of help in major depression. In the case of a full-blown psychosis, as depicted in the schizophrenia vignette, one-fourth (26.2%) recommended seeing a psychiatrist. The family physician, as a representative of the expert system, was considered to be the most effective source of advice in schizophrenia. Table 2 shows the five most frequently mentioned primary sources of help regarding depression and schizophrenia, respectively.

When respondents were asked what to do in case primary help-seeking suggestions failed, roughly a quarter (28% in depression, 27% in schizophrenia) did not give a secondary advice. Either the respondents could not think about any other sources than they had already recommended spontaneously, or they simply did not want to give further advice. Considering primary and corresponding *secondary recommendations* (Table 2), it becomes obvious that

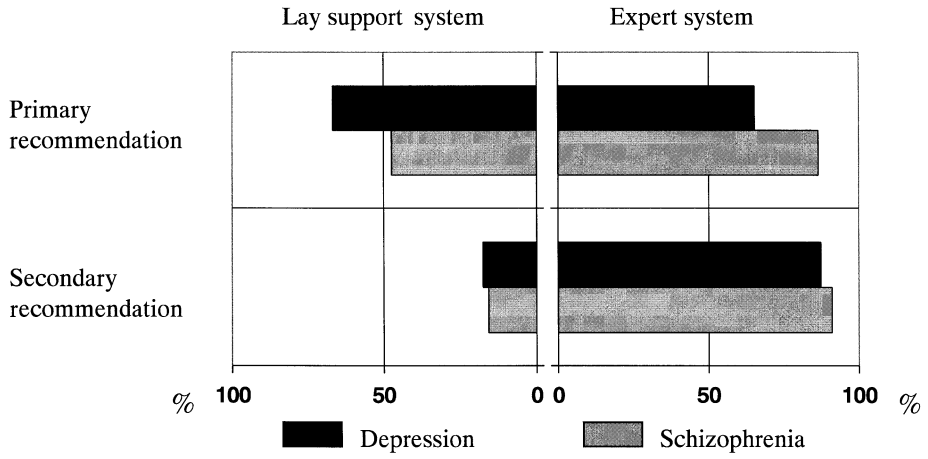

Fig. 1. Lay public's attitudes toward help-seeking (percentages do not add up to 100% due to multiple responses per question).

Table 2. Help-seeking in case of depression and schizophrenia — first and second recommendation, depression: percentage of $n=287$[a], schizophrenia: percentage of $n=667$[a] (percentages do not add up to 100% due to multiple responses per question), [a] respondents offering a first and a second recommendation

Depression recommendation				Schizophrenia recommendation			
%	First	%	Second	%	First	%	Second
41.8	Friends	45.0	Family physician	34.2	Family physician	26.8	Psychiatric hospital
		21.7	Psychiatrist			26.3	Psychiatrist
		12.5	Psychologist			12.7	General hospital
		10.8	Themselves			10.5	Family physician
30.0	Family physician	22.1	Psychiatrist	31.8	Friends	37.7	Family physician
		11.6	Family physician			23.1	Psychiatrist
		9.3	Psychologist			11.3	Psychiatric hospital
		9.3	General hospital			8.5	Psychologist/self-help group
12.2	Psychiatrist	42.9	Psychiatric hospital	26.2	Psychiatrist	49.1	Psychiatric hospital
		8.6	Psychiatric hospital			18.3	General hospital
		8.6	Friends			8.6	Family physician
		8.6	Family			8.0	Psychiatrist
11.8	Family	44.1	Family physician	10.0	Psychologist	26.9	Psychiatrist
		23.5	Psychiatrist			25.4	Psychiatric hospital
		17.6	Psychologist			11.9	Family physician
		11.8	Themselves			9.0	General hospital
9.8	Self-help group	50.0	Family physician	8.1	Family	33.3	Family physician
		25.0	Psychologist			31.5	Psychiatrist
		14.3	Psychiatric hospital			11.1	Psychologist
		10.7	General hospital			9.3	General hospital

those who endorse the lay support system in the first place suggest seeking expert help if the lay support system as a source of help is exhausted. Respondents who consider seeking help from the expert system suggest primarily either more specialized out-patient care, or in-patient care in the case that initial professional advice has failed.

Discussion

The lay support system plays a significant role as an initially recommended source of help for mental disorders. However, help-seeking recommendations differed for depression and schizophrenia. In depression, support from the lay system was more often considered. Friends were the most frequently mentioned source of help. In schizophrenia, the expert system was favoured as a source of help in which family physicians were most frequently mentioned. Although psychiatrists were considered as a source of help in schizophrenia by one-quarter of the respondents, only a few recommended seeing a psychiatrist for major depression. These differences could be explained by a different perception of symptom quality regarding the disorders in question. While depression might be conceived as an extension of normal feelings that most people experience at some point in time, symptoms of schizophrenia might appear incomprehensible and thus be seen as requiring professional help. This different perception of symptom quality in depression and schizophrenia may be accompanied by a different appreciation of its seriousness, resulting in advice for either more familiar or more distant helpers to the person in need. However, if primary suggestions fail the expert system is clearly favoured, regardless of the disorder in question. In this context it has to be pointed out that within the German health system access to specialists is open to everybody and used routinely. The number of psychiatrists in private practice is substantial, with only few shortages in rural areas.

There are two different ways in which public attitudes may have an impact on help-seeking behaviour.

First, the public's opinion may shape the attitudes of those in direct contact with individuals suffering from mental disorder. This refers to a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant and authoritative laymen. Social networks can influence the help-seeking behaviour of people suffering from mental disorder as a communication system providing information, as a reference system formulating normative expectations, and as a support system (7, 8). Empirical evidence regarding the impact of social networks on help-seeking behaviour of the mentally ill shows that larger social networks may be associated with the wider use of non-hospital services, suggesting the informal communication, advice and support function of social networks (9–11). McKinlay (12) and Birkel and Reppucci (13) emphasized the impact of the normative expectations. They reported that resentment against psychiatric services or networks afraid of stigmatization delay the contact of ill

people with psychiatric services. Studies looking into family patterns of help-seeking revealed that professional help was found to be more likely to be used in depression when there is previous experience of major depression in the family (14, 15).

The second method, of which opinion of the lay public influences help-seeking behaviour, is that individuals suffering from mental disorder themselves have incorporated these beliefs into the course of their socialization. This realization is reflected in findings from population-based studies identifying individuals suffering from mental disorders and assessing their help-seeking as well as studies investigating the utilization of health services. Epidemiological studies on depression revealed that only a minority of depressed individuals, about one-fourth to one-third, seek professional help for their distress (16–19). This underlines the magnitude of distress dealt with by the lay support system. If professional help for depression is sought most turn to general care providers (16, 19–21). Hence, it is not surprising that depression is the most common psychiatric disorder in general practice. The largest study of psychiatric disorders in general health-care involving study centres in 14 countries indicates that 10.4% of all practice attendees suffer from depression, as diagnosed according to ICD-10 (22). Reflecting the lay public's inclination to recommend mainly the expert system in dealing with schizophrenia, it has been shown that the majority of individuals suffering from schizophrenia appear in the mental health system at some point in time (23). However, a substantial delay in obtaining effective care for first-episode schizophrenia patients is claimed (24–26).

Attitudes prevalent in society, transmitted both through expectations of the social network and incorporated in the person's attitudes acquired in the process of socialization, may influence the manner in which a person suffering from mental distress acts upon symptoms. Therefore, the lay public's opinion has to be taken into account in mental health care planning to make services more acceptable to the consumer and their social network. Co-operation between family physicians and mental health specialists should be enhanced to reach those in need.

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