

From
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PSYCHIATRIC TABOO?

Mental health problems and help-seeking

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**Karolinska
Institutet**

Stockholm 2008

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ISBN 978-91-7357-569-0

ABSTRACT

Mental health disorders are common conditions in the general population, yet only about half of those with mental health problems have health care contacts for their problems. The pathway for help-seeking is complex, and may be influenced by socio-demographic factors, as well as more complex characteristics such as personality, attitudes and personal preferences. This thesis aimed to improve knowledge of factors associated with help-seeking for mental health problems. One focus was on lay people's opinions and expectations of mental health care.

The present study was conducted in two stages. An initial postal questionnaire was distributed to a random sample of the general population aged 20-64 in Skaraborg, Sweden, to assess mental health status and history of treatment contact. Data from Skaraborg (n=3 538) was compared to questionnaire data from the PART study, Stockholm (n=10 441). Information from the questionnaire also served as basis for a stratified selection of subsamples. In stage II a total of 358 participants, 125 persons with symptoms of mental disorders with healthcare contact, 105 persons with symptoms of mental disorders without health care contact, and 128 mentally healthy participated in a face-to-face interview. The interview included a semi structured diagnostic interview (SCAN), a personality inventory (SSP), a vignette to assess mental health literacy, and open-ended questions about expectations concerning a hypothetical contact with mental health care.

Data from the questionnaire stage showed that mental health problems were common in both the rural and urban area. Harmful alcohol use, however, was less common among rural women compared to their urban counterparts. Overall contact with health care was more often reported by urban residents, regardless of age, gender, or presence of mental health problems.

Results from the interview stage: Personality traits such as Somatic Trait Anxiety and Stress Susceptibility were associated with help-seeking for mental health problems. Mental health literacy was poor among the respondents; only one third could correctly recognise depression from a vignette. A majority of the respondents were positive about counselling and psychotherapy. Persons with a history of mental health care contacts were more positive to medical interventions such as antidepressants, hypnotics, and admission to a psychiatric ward. Non help-seekers were more optimistic than help-seekers concerning the prognosis of depression without professional help. The quality of interaction between patient and provider was by far the most important theme when the respondents expressed their wishes concerning a hypothetical contact with health care for mental health problems. Only a minority expressed wishes for specific treatments.

Urbanity was associated with overall utilisation of health care during the last year. Personality traits were associated with help-seeking. Persons with health care contact for mental health problems were more in tune with the professional point of view with rating interventions. The quality of interaction between patient and provider is highly important in health care contacts for mental health problems.

Key-words: mental disorder, depression, help-seeking, rural, urban, personality, mental health literacy, attitudes, patients' preferences and expectations

LIST OF PUBLICATIONS

- I. **Dahlberg K.,** Forsell Y., Damström-Thakker K., Runeson B.
Mental health problems and healthcare contacts in an urban and a rural area.
Comparisons of two Swedish counties.
Nordic Journal of Psychiatry, 2007, Vol 61, 1, 40-46

- II. **Dahlberg K. M.,** Gustavsson P., Runeson B.
Personality traits in people seeking help for common mental health problems.
submitted

- III. **Dahlberg K. M.,** Waern M., Runeson B.
Mental health literacy and attitudes in a Swedish community sample
-Investigating the role of personal experience of mental health care.
BMC, Public Health 2008, 8:8

- IV. **Dahlberg K. M.,** Lundqvist-Persson C., Runeson B.
People's expectations on the health care system when seeking for mental health problems.
submitted

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LIST OF ABBREVIATIONS

ANOVA	Analysis of Variance
AS	Adventure Seeking
AUDIT	Alcohol Use Disorder Identification Test
D	Detachment
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders 4 th edition
E	Embitterment
GP	General Practitioner
Imp	Impulsiveness
KSP	Karolinska Scales of Personality
LA	Lack of Assertiveness
M	Mistrust
MDI	Major Depressive Inventory
PhTA	Physical Trait Aggressiveness
PsTA	Psychic Trait Anxiety
SCAN	The Schedule of Clinical Assessment in Neuropsychiatry
SD	Social Desirability
SRH-5	Self Rated Health (Five step response model)
SPSS	Statistical Package of Social Science
SS	Stress Susceptibility
SSP	Swedish Universities Scales of Personality
STA	Somatic Trait Anxiety
TI	Trait Irritability
VTA	Verbal Trait Aggression
WHO	World Health Organization

1 INTRODUCTION

Even in the 21st century, mental health problems and psychiatric treatments are surrounded by prejudices and taboos. This is manifested in newspapers, literature, film, art and in everyday discussions. There is often a distinct disparity between attitudes towards somatic and mental health problems. It seems that Cartesian dualism is still alive. Does it matter; what are the consequences of this dichotomy?

Mental disorders such as depression, anxiety and substance abuse are widespread in society. The magnitude is of public health concern, with substantial effects on individual suffering, work, costs for society and survival. One key to improve mental health is through health care contacts. Unfortunately, the unmet need for psychiatric care is still a problem. In some cases today's society and health care system do not have the resources to meet the demand. The grim reality is that almost half of the persons with symptoms of mental disorders never ask for help. Obstacles for help-seeking occur on many levels, such as cultural, organisational and interpersonal.

My interest was to learn more about factors which could be associated with help-seeking for mental health problems. In this work I focused on personality traits, attitudes and the user's personal expectations. People with symptoms of mental disorders both with and without health care contacts were then identified. In an effort to cover the cultural context concerning attitudes, we found it important to also include persons without significant symptoms of mental disorders. Our focus was not on particular diagnostic entities, but rather on mental health problems as a broader concept.

Through a questionnaire sent to a random sample of the general population, information was gathered about mental health problems and eventual health care contacts for these problems. Since addressing factors such as attitudes, personality and expectations, we found it appropriate to conduct face-to-face interviews at a second stage of the survey.

2 BACKGROUND

2.1 COMMON MENTAL DISORDERS

Affective, anxiety and addictive disorders are common and associated with a wide range of disabilities and functional impairments. National surveys of psychiatric disorders point to a lifetime prevalence in the magnitude of 40-50 per cent [1, 2]. The pan European Study of the Epidemiology of Mental Disorders (ESEMeD) showed that one in four respondents reported symptoms of any mental disorder at some point in life [3]. The presence of mental disorders is a problem of great dignity concerning public health, involving both the suffering of individuals and their families and significant costs for society [4, 5]. The World Health Organization (WHO) estimates major depression to be the second most burdensome disease in the world by 2030 [6]. However, the situation is even more severe as mental disorders interact with other health conditions, both communicable (e.g. HIV/AIDS) [7] and non-communicable diseases (e.g. heart diseases) [8]. The impact of mental disorders on other health conditions is significant, a reason why some researchers argue “No health without mental health” [9]. A life time prevalence of mental disorder were reported by 50 per cent among Oslo residents [10]. The cumulative probability for developing a depression in Sweden, is revealed to be 22 per cent for men and 31 per cent for women [11].

In Sweden, mental ill-health makes up a remarkable part of the burden of diseases measured in Disability-Adjusted Life Years [12]. Among the new disability pensions in Sweden 2006, forty per cent were due to psychiatric ill health [13]. However, the consequences of mental disorders are at some times even more extreme with premature death through suicide as an end-point [14]. For example, untreated depressions may be a common cause of suicide in the population [15, 16].

2.1.1 Measures

There are different ways of defining mental disorders. The criteria used to define cases might be broad or narrow, and more or less operationalised [17]. Narrow criteria include only the most clear-cut and severe cases. Internationally, there exist two widely used criteria based systems; The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [18] and the International Classification of Diseases (ICD -10) [19]. The DSM-IV is a descriptive, free of etiological aspects and criteria-based system with strictly operationalised and narrow criteria for psychiatric disorders.

Concerning affective disorders, major depression according to DSM-IV is very similar to severe depressive episode in ICD-10. The criteria for major depression according to DSM is either depressed mood most of the time or loss of interest or pleasure in most activities with at least four of eight additional (criterion B) symptoms. The additional symptoms include; appetite disturbance, sleep disturbance, psychomotor agitation or retardation, fatigue, feelings of worthless or guilt, difficulties concentrating and recurrent thoughts of death or death wish or suicidal thoughts. For diagnosis of major depression the symptoms need to be present for a period of at least two weeks as well as causing significant stress or impairment. Further, the symptoms should not be better

accounted for by bereavement or psychological effects of substance use or a general medical condition.

There are likewise well defined, narrow criteria for anxiety and addictive disorders described in DSM-IV. Social phobia, for instance, is characterised by anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behaviour, and according to DSM-IV the problems need to be clinically significant [18]. Substance disorders are divided into dependence and abuse. Alcohol abuse is defined by significant impairment and distress, as manifested by one or more of the following; drinking resulting in failure to fulfil major role obligation, recurrent drinking in situations in which it is physically hazardous, recurrent legal problems due to drinking or continuing drinking despite having persistent or recurrent social or interpersonal problems. Alcohol dependence is manifested by three or more of the following problems during a 12-month period; tolerance, withdrawal, larger amounts than was intended, persistent desire, great deal of time spent in obtaining, using or recovering from drinking, reduction of important activities, and continuing drinking despite knowledge of having persistent or recurrent physical or psychological problems [18].

In epidemiological research self-rating scales are often used as an approximation [17]. The use of scales with broader definitions is probably more valuable in studying the impact of common mental health problems on health care use, since broader definitions are more likely to mirror the situation in the community. These can be global scales, such as the General Health Questionnaire (GHQ) [20], which has validated cut points for identification of cases with common mental disorder. Another approach is to use separate scales in assessing separate condition. Concerning depression, MDI [21], MADRS [22] and HAM-D [23] are commonly used scales. The construct of several of these scales are made to fit the criteria in DSM-IV. The Alcohol Use Disorder Identification Test score (AUDIT) [24] is today well established in screening for the spectrum of alcohol use disorders [25].

2.1.2 Risk factors

Well established risk factors for mental disorders are age, gender, employment status and level of education [1, 26-28]. Recent studies show higher rates of mental disorders in younger ages and declining prevalence at later age [1, 27]. Women have higher prevalence of affective and anxiety disorders, while men have higher rates of substance abuse disorders. The degree of urbanity has long been considered to have a certain influence on psychiatric morbidity [29, 30]. Most studies point to a higher prevalence in larger cities, especially for depression, but the findings are by no means concordant [26, 29-33]. Recent research from Norway, Britain and the Netherlands show higher prevalence of psychiatric disorders in more urbanised areas [34-36]. A Swedish register study shows a linear association between increasing population density and first admission rate for depression [37]. Other studies point at the influence of different socio-demographic characteristics associated with rural and urban areas [38-40].

2.2 HELP-SEEKING

Many people with apparent mental disorders never ask for help. Less than fifty per cent have health care contact for their mental health problems [41-43]. Even recent results from the WHO mental health surveys on the use of mental health services are discouraging; barely half of those with severe disorders receive treatment [44]. In the European part of the study, only one fourth among the participants with a mental disorder in the last year had consulted a formal health service during this period [45]. In a population-based study in Stockholm, 37 per cent among persons with a meetable need for care for mental health problems had actually requested care [46]. The unmet need for mental health care is high in Europe [47].

The pathway to help-seeking may be influenced by socio-demographic factors, personality and attitudes. Women, middle-aged people, whites and people with higher education have the highest levels of treatment contact [41, 46, 48, 49]. Urbanity is also associated with help-seeking, with rural residents being less likely to have contacted health care for mental health problems [33, 50].

The rate of service use is related to the type of symptomatology as well as to the severity of the problems. The WHO world mental health surveys showed a relationship between health service use and disorder severity in most countries [44]. There is a variance in contact rates also concerning different types of diagnostic entities. People with addictive disorders have the lowest rate of treatment contact while people with panic and mood disorder have the highest rate of treatment contact among common mental disorders [51, 52]. Delay in help-seeking is a worldwide problem, and the treatment seeking can be delayed for years or even decades [53].

Several obstacles exist in the process of applying for mental health care. Canadian researchers have proposed three types of self-reported barriers. The first category, *accessibility* includes e.g. cost, lack of transportation, or lack of childcare. The second category is *acceptability*; “not getting around” to treatment seeking, preferring to manage it themselves, thinking it could not help, being afraid to ask for help, or having language barriers or other responsibilities that prevent help-seeking. The last category is *availability*; no professionals available in the area, long waiting times for services, or no professionals available at the time of required services. Acceptability barriers were by far the most common reason for unmet needs [54] and are probably influenced both by individual factors as well as common factors, such as the risk for stigmatisation in society, strengths and limitations of the social network etc. Another possible obstacle is, of course, scepticism concerning available interventions. Individual factors that might influence acceptability are coping strategies, attitudes and personality.

2.3 PERSONALITY

2.3.1 Definition

The word “personality” originates from the Etruscan *phersu* through the Greek *persona*, which means mask. It is noteworthy, that in the ancient theatre of the Latin-speaking world, the mask was not used to camouflage the identity, but was rather a convention employed to represent or typify that character.

For a scientific and more recent definition of personality we turn to Pervin [55].

“Personality refers to those characteristics of the person that account for consistent patterns of feeling, thinking and behaving “

2.3.2 Personality traits; theories and inventories

Allport and Odbert defined personality traits as “generalized and personalized determining tendencies – consistent and stable models of an individual’s adjustment to his environment” [56]. In his research on personality traits, Eysenck focused on biological correlates. He described three major factors, namely extraversion, neuroticism, and psychoticism [57]. A person scoring high on extraversion is lively, sociable, active, and sensation seeking. The typical neuroticism high scorer tends to be moody, emotional, tense, and to have low self-esteem. Solitary, cold, aggressive, and unempathic traits finally describe a person who scores high on psychoticism.

The fundamental lexical hypothesis states that “the most important individual differences in human transaction will become encoded as single terms in some or all of the world’s languages” [58]. According to this theory, personality can be described in five broad dimensions, the Big Five. The five bipolar dimensions are neuroticism, extraversion, openness, agreeableness, and conscientiousness [59]. Each dimension consists of six facets. Neuroticism, for instance, is composed of the facets of anxiety, self-consciousness, depression, vulnerability, impulsiveness, and angry hostility [60].

The Swedish psychologist Daisy Schalling incorporated concepts from psychopathological theories and research, and psychological theories of temperament [61-63] in the creation of the Karolinska Scales of Personality (KSP). The inventory consists of 135 items grouped in 15 different scales. The KSP was developed to cover specific areas of importance for research projects in healthy subjects and in certain groups of psychiatric patients. The KSP was later revised to improve psychometric qualities and to reduce the number of items. The revised inventory, Swedish university Scales of Personality (SSP) has a simple and timeless language, and includes 91 items divided into 13 scales [64]. Factor analysis on normative material yields three factors, Neuroticism, Aggressiveness and Extraversion. For more details on SSP, see Method section.

2.3.3 Personality and health

Interest in the relationship between personality and health is not a modern phenomenon. In the pre-scientific era, Hippocrates proposed the existence of four basic personality types, the humoral theory [65]. A person could gain health by achieving balance in all four humours.

Today we are aware that the linkages between personality and health are complex, with various pathways and feedback loops [66]. One connection is via psychophysiological impact, which involves the effects of psychological events on physiological, neuroendocrine, and metabolic processes [67, 68]. The effects of stress and emotion on cardiovascular functioning are for instance well documented [8].

Other pathways are behavioural mechanisms, which involve actions (e.g. use of tobacco, dietary practice, and unprotected sexual intercourse) [67, 68]. Personality is also known to affect the way a person perceives, experiences, and acts upon different symptoms known as the illness behaviour model [69]. Research shows support for a linkage between personality and important life outcomes, such as disease process, subjective well-being, risk-taking, the ability to cope with symptoms and longevity [70].

2.4 MENTAL HEALTH LITERACY AND ATTITUDES

Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of causes and risk factors of both self-help and professional treatments; and attitudes that promote recognition and appropriate help-seeking [71].

2.4.1 Recognition

One crucial step in the pathway towards help-seeking is the ability to recognise the problems as a mental disorder. Does the individual interpret the signs of illness as symptoms of mental disorder? One important aspect is the often gradual onset of symptoms. Early onset is common in anxiety disorders, and the symptoms can be interpreted as personality traits. There is also, of course, a risk of denial, especially concerning substance abuse. From international research we know that correct recognition of mental disorders is still a problem for the majority of lay people [72].

2.4.2 Attitudes towards interventions

Depending on how the individual interprets the signs of illness, different actions could be taken towards an eventual change. Research shows that lay people often attribute mental illness to psychosocial stress rather than a medical condition [73-76], which probably affects the demand for treatment. The public clearly favours the lay support system, and as a second choice the general practitioner [77].

Concerning attitudes towards specific interventions for mental disorders, there is an apparent discrepancy between the general population and the treatment providers [78]. A majority of depressed primary care patients preferred counselling or psychotherapy as treatment for depression [79]; only one third were positive to antidepressants. Actual reviews on the subject reveal that most lay people hold negative attitudes towards antidepressants [72, 79].

2.4.3 Long-term outcome

Jorm et al have studied attitudes towards people with mental disorder, and indicated some interesting differences between the public and the health professionals. Concerning the long-term prognosis after treatment, the public was more optimistic than the professionals [78]. The public held an optimistic view of the person described in the vignette; they tended to rate them as more likely than other people to experience positive outcomes (such as being a productive worker) and less likely to experience negative out-come (such as abusing alcohol or committing suicide) [80]. The professionals, on the other hand, rated long-term outcomes more negatively [78], and believed discrimination to be more likely [80].

2.4.4 Stigmatisation

German research reveals that people with mental illness, such as depression and alcohol dependence, still encounter substantial stigma and discrimination [81]. The public expresses negative reactions, such as fear, anger and social distance [81]. Interviewing depressed patients showed that a majority anticipated stigmatisation concerning interpersonal interaction and access to social roles (job/occupation) [82]. The fear of stigmatisation might lead to avoidance of help-seeking for mental health problems. The linkage between the perceived norms of viewing mental health problems as a weakness, and avoiding appropriate help-seeking has been shown for medical students [83].

2.5 EXPECTATIONS - THE USER'S PERSPECTIVE

It is important to focus on the presumptive care user when investigating factors that affect help-seeking. In some European countries (e.g. The Netherlands) demand oriented and demand driven health care have been a research focus [84, 85]. The results revealed that the way in which the decision making process was carried out was more important to the clients, than who made the decisions [84]. The possibility of being heard and being involved as a serious party was especially valuable. A Swedish study of therapeutic relationship in psychiatric settings revealed that "being understood" by the therapist/staff is one of the most central aspects of good care [86].

2.5.1 Responsiveness

WHO has put focus on the non-health enhancing, non-financial aspect of the health system [87]. "Responsiveness in the context of a system can be defined as the outcome that can be achieved when institutions and institutional relationships are designed in such a way that they are cognisant and respond appropriately to the universally legitimate expectations of individuals." The concept of responsiveness includes several domains; dignity, autonomy, confidentiality, prompt attention, quality of basic amenities, access to social support networks during care and choice of care provider. German researchers have tested WHO's concept of responsiveness for appropriateness in mental health care through focus groups [88]. Some alterations were made in order to assess mental health service from the user's point of view. A new domain; continuity was created, and the domain of prompt attention was extended and renamed attention [88].

2.5.2 Trust

In our attempt to understand trust we can study the concept as defined by Mayer et al. "*The willingness of a party to be vulnerable to the action of another party based on the expectations that the other party will perform a particular action important to the trustor, irrespectively of the ability to monitor or control that other party*" [89]. In an effort to conceptualise interpersonal trust, Hall et al [90] describe five overlapping domains as follows:

1. Fidelity, which is caring and advocating the patient's interests or welfare and avoiding conflict of interest.
2. Competence, which is having good practice and interpersonal skills, making correct decisions, and avoiding mistakes.
3. Honesty, which is telling the truth and avoiding intentional falsehood.
4. Confidentiality, which is proper use of sensitive information.
5. Global trust, which is the irreducible soul of trust, or aspects that combine elements from some or all of the separate dimensions.

One should not confound trust with satisfaction. Satisfaction is based on experience, while trust is primarily future oriented. Quantitative studies on trust have mainly been conducted on patients attending their family doctor, and show that trust in general health clinicians was high [91], and is increased by continuity [92].

2.5.3 Choice

There are cultural changes in today's society, including a more consumerist attitude among patients. This change requires more focus on choice. An actual choice may be limited by resources. Patient may have the full possibility to choose between different clinics, but where all offer the same approach. The issue of choice is important in mental health care settings. However, it is important to differentiate between desire for information and desire for treatment choice. Choice can be described within a broad spectrum, with paternalism at one end, where the doctor knows what is best for the patient, and autonomy at the other of the spectrum end with right of self-determination. Coulter describes three different approaches [93].

1. Professional choice – the clinicians decides and the patient contents.
2. Shared decision making – information is shared and both decide together.
3. Consumer choice – the clinician informs and the patient makes the decision

Shared decision is often preferred, shown by a growing body of research in this area [94]. Furthermore, it is often a desire that the treating doctor expresses an opinion. The application of shared decision making in psychiatry is still at the initial stage, depending on the relatively scant research that has been performed in this field [94]. One important issue is whether or not the treatments offered by the health care system harmonise with the person's own beliefs.

A recent Swedish thesis on recovery from dysthymia and panic disorders indicated the importance of shared understanding for reaching collaboration [95]. The author suggested a combination of diagnostic assessment with attention to patients' understanding of illness, goals and treatment preferences [95].

3 AIM

The overall aim of this thesis was to improve knowledge of factors associated with help-seeking for mental health problems. One focus was on lay people's opinions and expectations of mental health care. This thesis builds on four papers from a cross-sectional study of the general population in a rural area (Skaraborg).

Paper I is based on questionnaire data from the rural area and from an urban survey (PART).

Aim: To study the level of mental health problems and the level of overall health care contact during the last year in the rural area (Skaraborg), comparing with an urban population.

Hypothesis: Symptoms of mental health disorders are less prevalent in the rural population and persons residing in a rural environment are less likely to consult health care.

Papers II-IV are based on interview data examining three different groups, namely
A, persons with symptoms of mental disorders with healthcare contact (n=125)
B, persons with symptoms of mental disorders without health care contact (n=105)
C, mentally healthy (n=128).

Paper II: To compare personality traits in the three interview groups.

Hypothesis: Personality traits are associated with help-seeking for mental health problems.

Paper III: To examine mental health literacy in the three interview groups.

Hypothesis: We hypothesised that persons with mental health contact would have better knowledge and more positive attitudes towards professional interventions.

Paper IV: To investigate the expectations in a hypothetical health care contact for mental health problems and their relationship with mental health status and treatment contact.

Hypothesis: People have different expectation on a hypothetical contact with mental health care, depending on whether they have had symptoms for which they had consulted a professional; have had symptoms but had not consulted or have had no symptoms at all.

4 METHODS

4.1 DESIGN

Paper I is a comparative study based on cross-sectional questionnaire surveys in the former County of Skaraborg (n=3 538) and in Stockholm (n=10 441). The survey in Skaraborg was used to obtain information about mental health status and history of health care contacts. Based on these data, three stratified subsamples were invited to participate in a face-to-face interview. The subsamples were A, persons with symptoms of mental disorders with healthcare contact (n=125), B, persons with symptoms of mental disorders without health care contact (n=105), and C, mentally healthy (n=128). Papers II, III and IV are based on interview data from these three subsamples (n=358).

4.2 SETTING

4.2.1 Skaraborg

The former county of Skaraborg (below referred to as Skaraborg) comprises 15 municipalities and is nowadays a part of Västra Götaland. Skaraborg is situated between the two great lakes Vänern and Vättern. It is historically a rich agricultural area; today 5% of the working population is involved in agriculture. In 2001, 79% of the inhabitants were employed. The main occupational branches are manufacturing industry, trading and healthcare/social services. Three military regiments are situated in the region. Since 1977, Skaraborg has a university in Skövde with 48 study programmes and 8 300 students.

Skaraborg has 250 000 inhabitants. The largest centre, Skövde, has a population of 32 000. During the time of the study, 125 900 people in Skaraborg were between 20-64 years old, 29.0% aged 20-34, 35.6% aged 35-49 and 35.2% aged 50-64. Forty-nine per cent were women, and 6.9% of the total population was of foreign origin.

4.2.2 Mental health care in the county

Specialised mental health care in Skaraborg was concentrated to one psychiatric clinic in 2001. The in-patient facilities were situated in the southern part of the county (Falköping) and included 160 beds (data from 2001) divided in sub-specialised wards. The psychiatric out-patient care was structured in six different geographical sectors, with out-patient facilities in every sector. Some of the sectors comprised one municipality; in others, several municipalities were merged. There were about 20 professionals (psychiatrists, psychologists, social workers/counsellors, psychiatric nurses and physiotherapists) in each sector. Clinics were understaffed due to vacancies for both psychiatrists and psychiatric nurses.

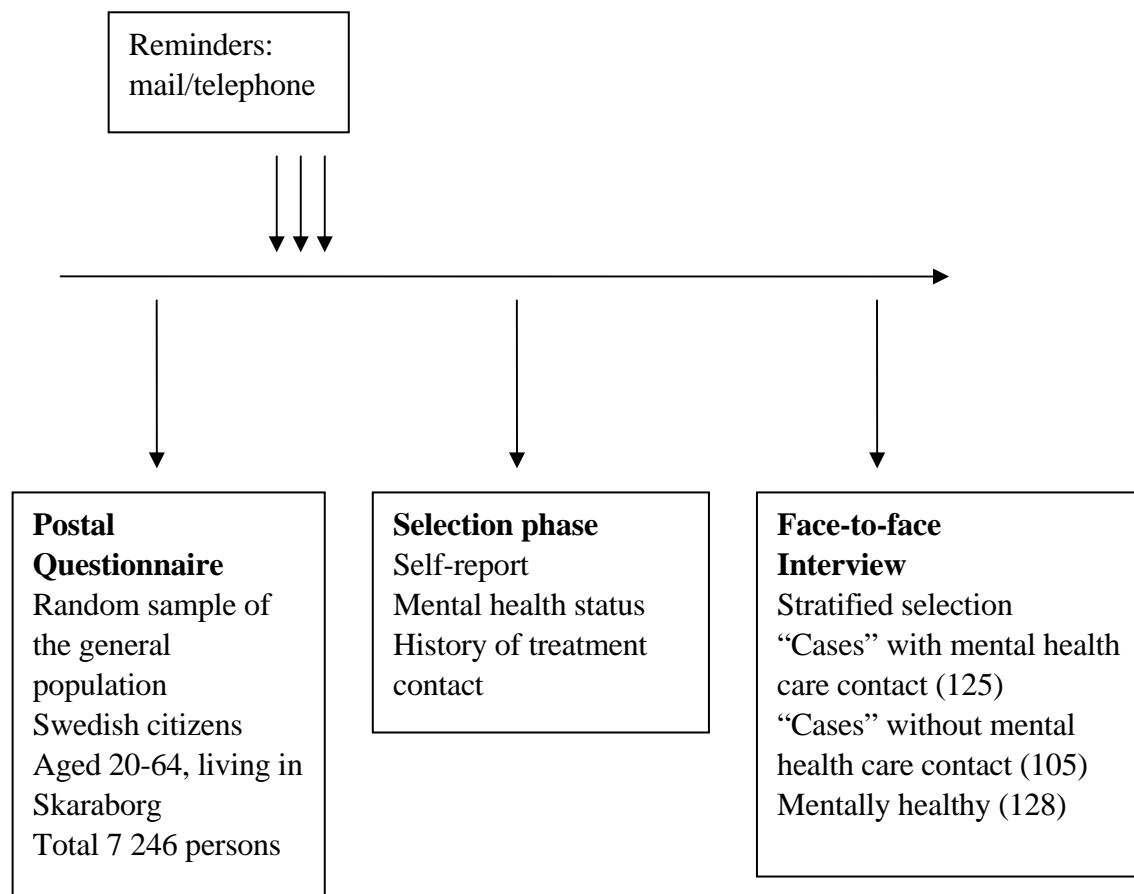
Primary health care is well organised in Skaraborg, with one or more community health centres in each municipality. The access to general practitioners differed between the municipalities during the study period. For some health centres vacancies for physicians has been a continuous problem, sometimes resolved with "rented doctors". This, of course, affects continuity. Primary health care "psychosocial" teams are found in every municipality, they are often shared between several health care centres.

Staffing differed between these teams, in some cases several professions were represented (psychiatric nurses, counsellors and psychologists). In other cases, the work was performed by district nurses.

4.3 SAMPLING

Data was collected between March 2000 and May 2003. The primary survey population consisted of all Swedish residents aged 20-64 in the former county of Skaraborg. For the purpose of the study, a randomly selected sample of 7 500 subjects was chosen from the general population register (by VM-data); 254 could not be reached. The response rate for the postal questionnaire was 49% (3 538/7 246). Among the respondents, 55% were women, 26.6% aged 20-34, 34.5% aged 35-49 and 38.9% aged 50-64. Four per cent of the respondents were of foreign origin. Reminders were distributed through mail, and additional telephone call.

Fig 1. Flowchart over sampling



4.4 COMPARATIVE URBAN POPULATION (PAPER I)

In 1998–2000, a population based study of mental health (PART) was conducted in the county of Stockholm [96]. Stockholm is the capital of Sweden with approximately 1 860 000 inhabitants. Most people are engaged in service and industrial occupations. During the time of the study, 1 098 400 people in Stockholm were 20-64 years old, with skewness towards the younger age groups with 37.0% aged 20-34, 34.4% aged 35-49, and 28.5% aged 50-64. Fifty per cent were women. Eighteen per cent of the total population was of foreign origin. The response rate in the Stockholm sample was 53%. Non-participants were more often male, younger, less educated and had a lower income, lived alone and were more often born in a non-Nordic country [96].

4.5 MEASURES

4.5.1 Variables

Table 1 Variables included in papers I, II, III and IV.

	Paper I	Paper II	Paper III	Paper IV
Socio-demographic data				
Age and gender	X	X	X	X
Educational level	X	X	X	
Questionnaire data				
The Major Depression Inventory	X	*	*	*
Sheehan Patient-Rated (Panic) Scale	X	*	*	*
Marks & Mathews Brief Standard Rating for phobic patients	X	*	*	*
Obsessive compulsive symptom	X	*	*	*
Use of illicit drugs	X	*	*	*
The Alcohol Use Disorder Identification Test	X	*	*	*
Checklist of ongoing disorders		*	*	*
WHO's brief Disability Assessment Schedule	X	*	*	*
Self-Rated Health-5	X			
Sick-leave last 30 days	X			
Current use of prescribed drugs	X			
Current use of psychoactive drugs		*	*	*
Overall contact with health care last 12 months	X			
Help-seeking for mental health problems		*	*	*
Interview data				
The Swedish universities Scales of Personality		X		
The Schedule of Clinical Assessment in Neuropsychiatry		X	X	
Vignette assessing mental health literacy			X	
Open ended questions about expectations				X

* Questionnaire data were used to ascertain mental health status and history of health care contact which served as a basis for the selection of stratified subsamples for the interview stage. The cut-off used for each variable is presented in the next section.

4.5.2 Common mental health problems

Data from the questionnaire was used as a basis for dividing the respondents into three different groups: A, persons with symptoms of mental disorders with health care contact, B, persons with symptoms of mental disorders without health care contact, and C, mentally healthy. Criteria for definition of “caseness” (e.g. symptoms of mental disorder), presented by self-report instruments are described below.

4.5.2.1 *Depressive symptoms*

- A slightly modified Major Depression Inventory (MDI) (4 point-scale [97] instead of the usual 6 point-scale [98, 99]) was used to record depressive symptoms. Five or more symptoms lasting more than two weeks, causing disability as well as significant distress during the last 14 days, was required for caseness.
- Presence of suicidal thoughts some of the time or more often during the last two weeks, according to the MDI was defined as caseness.

4.5.2.2 *Symptoms of anxiety*

- Panic attacks with anticipatory fear of future attacks and /or six or more symptoms of anxiety according to Sheehan Patient-Rated (Panic) Scale [100].
- Questions from Marks and Mathews brief standard rating for phobic patients [101] was used to define symptoms of avoidance of agoraphobic or social phobic situations due to fear or anxiety. Indicating the presence of symptoms often or always in one or more of the situations described below was considered as caseness. Three agoraphobia questions included avoidance of transport vehicles, shops or cinemas, and open public places. Avoidance of social situations due to fear or anxiety was investigated for the following circumstances: eating, drinking or writing in public, being in the centre of attention, and avoiding being with other people due to a high level of self-criticism.
- Three screening questions recommended by the Swedish Psychiatric Association [102] and the Swedish Institute for Health Service Development was used to gain information about obsessive compulsive symptoms. These concerned obsessional washing and checking, as well as intrusive unpleasant thoughts. A question concerning marked distress was added, in accordance with DSM-IV criteria. At least one obsessive-compulsive symptom during the last 30 days and suffering due to this was required for caseness.

4.5.2.3 *Alcohol and illicit drug use*

- The Alcohol Use Disorder Identification Test (AUDIT) score [24] was used to measure alcohol use. The AUDIT was used as a one-dimensional construct, using a summary measure of 10 items (ranging from 0 to 40). Several different cut-offs are described for AUDIT, for instance, the cut-off concerning hazardous drinking is 8 for men and 5-6 for women [25]. For the purpose of this study, with the focus on mental health problems, a value of eleven or more labelled harmful drinking was considered as caseness.
- Individuals who indicated any use of illicit drugs during last year were considered to be cases.

4.5.2.4 *Social disability due to psychological problems*

- To investigate possible impact on social life due to psychological problems WHO's brief Disability Assessment Schedule (WHO-DAS-S) [103, 104] was used. The fulfilment of one item was sufficient for caseness.

4.5.2.5 *Self-reported medical conditions and use of prescribed drugs.*

- From a checklist, the respondents were asked to indicate if they had been treated for a number of specific medical conditions. Self-report of an ongoing life-crisis, depression, "burn-out", or other mental disorder was concerned as caseness.
- The respondents were asked about current use of any prescribed drug. In case of a positive answer, they were asked to name all their medications and dosages. The lists were manually checked and indication of current use of prescribed psychoactive drugs was considered as caseness with health care contact (group A).

In addition to the self-report instruments used as a basis for defining caseness, the questionnaire included supplementary health related items.

4.5.2.6 *Global health and sick-leave*

- Self-Rated Health-5 (SRH-5) [105] was used to assess global health. For Paper I the five point Likert scale was dichotomized - very good, good, neither good nor poor (1-3) at one end, and poor and very poor (4-5) at the other end.
- The questionnaire included one question about sick-leave, full or part-time during the last thirty days.

4.5.3 Health care contact

4.5.3.1 *Overall healthcare contact*

For Paper I, data was obtained on overall contact with health care during the last 12 months. The kind of health care was not specified.

4.5.3.2 *Mental health care contact (Papers II-IV)*

To gain information on whether the persons with symptoms of mental disorders had contacted health care for their problems we asked: "Have you had health care contact for sleep disturbance, personal problems, or mental health problems?" From a checklist of professions, the respondents were asked to indicate present (last three months) or former contact. The sources of care which could be indicated included specialised mental health care (psychiatric inpatient care, psychiatric outpatient facilities, psychiatrist in private practice, psychologist or psychotherapist) and primary care (general practitioner, company physician, and non-psychiatric physicians in private practice). All respondents with present contact with health care, as well as those with a history of contact with specialised mental health care were considered as having health care contact for symptoms of mental disorder. As mentioned above, current use of psychoactive drugs was coded as health care contact for symptoms of mental disorder.

4.5.4 Stratified samples (Papers II, III and IV)

Questionnaire respondents were divided into three groups, according to the definitions above. In total, 353 individuals had symptoms of mental disorder with health care contact, 292 had symptoms of mental disorder without healthcare contact, and 2 893 were mentally healthy. A random sample from each group was invited to participate in the interviews. Among cases with contact, 89% (125/141) of the approached agreed to participate. In total, 160 individual cases without contact were invited to the interview, 66% (105) accepted. Among the mentally healthy, 252 respondents were randomly selected for the interview, 128 (51%) agreed to participate.

Table 2 Distribution of socio-demographic characteristics among interview groups.

	A Cases with contact N=125 n (%)	B Cases without contact N=105 n (%)	C Mentally healthy N=128 n (%)	Total N=358 n (%)	p-value
Male	48 (38%)	48 (46%)	52 (41%)	148 (41%)	n.s.
Female	77 (62%)	57 (54%)	76 (59%)	210 (59%)	n.s.
20-34 years	24 (19%)	46 (44%)	29 (23%)	99 (28%)	B>A, p<0.001 B>C, p=0.001
35-49 years	42 (34%)	30 (28%)	42 (33%)	114 (32%)	n.s.
50-64 years	59 (47%)	29 (28%)	57 (44%)	145 (40%)	A>B, p=0.02 C>B, p=0.008
Born in Sweden	120 (96%)	100 (95%)	119 (93%)	339 (95%)	n.s.
Education >12 years	54 (43%)	40 (38%)	51 (40%)	145 (41%)	n.s.
Employment	72 (58%)	83 (78%)	90 (70%)	245 (68%)	B>A, p<0.01 C>A, p=0.01
Married/cohabiting	77 (62%)	63 (60%)	112 (88%)	252 (70%)	C>A, p<0.01 C>B, p<0.01

Among the cases with contact, 67% were recruited on the basis of self-report instruments (symptoms of depression, anxiety, suicidal thoughts, alcohol use, and illicit drug use). Twelve per cent were selected by indicating social impairment, seven per cent by indicating ongoing mental disorder, and fourteen per cent were selected merely on the basis of current use of prescribed psychoactive drugs.

Among the cases without contact, a total of 86% were selected on the basis of self-report instruments. Eleven per cent were selected by indicating social impairment and the remaining three per cent by reporting ongoing mental disorder.

Depressive symptoms were equally common in the two groups, 37% among cases with contact and 36% among cases without contact. Symptoms of anxiety were also evenly distributed in the two groups of cases; 42 per cent (A) and 40 per cent (B). Harmful alcohol use was more common among cases without contact compared to cases with contact (28% vs 14%, p=0.01).

4.5.5 Instruments incorporated in the interview

4.5.5.1 Personality inventory

Personality traits were assessed with self-report inventory, the Swedish universities Scales of Personality (SSP) [64], based on the Karolinska Scales of Personality (KSP) inventory [63, 106, 107]. The KSP are conceived to be a quantification of some crucial personality or temperament dimensions. They represent qualities of the information processing and arousal system of the individual, using concepts from psychopathological theories and research, and psychobiological theories of temperament. The SSP inventory comprises 91 items, presented as statements, with a four-point response format, ranging from “does not apply at all” (=1) to “applies completely” (=4). The items are grouped in 13 scales, with seven items in each scale.

Table 3 Examples of items in each scale in accordance with Gustavsson et al, 2006, “SSP: construction, internal consistency and normative data”.

SSP-scale	Example of item
Somatic Trait Anxiety (STA)	<i>My body often feels stiff and tense</i>
Psychic Trait Anxiety (PsTA)	<i>I'm the kind of person who is excessively sensitive and easily hurt</i>
Stress Susceptibility (SS)	<i>I get tired and hurried too easy</i>
Lack of Assertiveness (LA)	<i>Even though I know I'm right I often have great difficulty getting my point across</i>
Embitterment (E)	<i>I have often got into trouble even when it is not my fault</i>
Social Desirability (SD)	<i>No matter who I'm talking to, I'm always polite and courteous</i>
Trait Irritability (TI)	<i>I don't have so much patience</i>
Mistrust (M)	<i>I tend to be on my guard with people who are somewhat more friendly than I expected</i>
Verbal Trait Aggression (VTA)	<i>When I get angry, I often express myself ironically or sarcastically</i>
Physical Trait Aggression (PhTA)	<i>If someone hits me, I hit back</i>
Impulsiveness (Imp)	<i>I have a tendency to act on the spur of the moment without really thinking ahead</i>
Adventure Seeking (AS)	<i>I have an unusually great need for change</i>
Detachment (D)	<i>I feel best when I keep people at a certain distance</i>

The sub-scales correspond mainly to three personality factors, namely Neuroticism, Aggressiveness and Extraversion [64], derived from factor analysis on normative data. The Neuroticism-related personality traits include the scales of STA, PsTA, SS, LA and E. The Aggressiveness-related personality traits comprise SD (negatively loaded), TI, M, VTA and PhTA. Finally, the Extraversion-related personality traits include Imp, AS and D (negatively loaded).

Principal axis factoring with Oblimin rotation has been conducted on the study material, with a similar result as presented above. The main disparity is due to the Detachment scale, which loads positively on Neuroticism (0.396) and Aggressiveness (0.469) and negatively on Extraversion (-0.270). The results in this thesis are mainly presented on scale level. However, when factors are given, they are derived from the normative data.

The internal consistency for each of the SSP-scales in our material was estimated with the Cronbach's alpha coefficient, and was generally found to be acceptable (range 0.74 and 0.83), except for the scale of Social Desirability with a coefficient of 0.57. The scales were approximately normally distributed. Scale raw scores were transformed to standardised T-scores (with M=50 and SD=10) using normative data [64]. To be able to test the influence of both low and high levels of the personality scales, they were trichotomised with the reference value 45-55. For data on reliability and validity see reference [64].

4.5.5.2 *Mental health literacy*

The interview began with a vignette developed by Jorm and colleagues [108], designed to determine mental health literacy. The vignette depicted a diagnostically unlabelled case with major depressive disorder. Either a female (Anna) or a male (Magnus) version was presented, depending on the respondent's gender.

“Anna is 30 years old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping almost every night. Anna doesn't feel like eating and has lost weight. She can't keep her mind on her work and puts off making decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Anna's boss who is concerned about her lowered productivity.”

After being presented with the vignette, respondents were questioned about what was wrong and how the person could be helped. Recognition was examined using an open-ended question: “What, if anything, do you think is wrong with Anna?” If multiple responses were given, only the label closest to the correct diagnosis (depression) was registered. Optimal form of help was assessed by asking the respondents how Anna/Magnus best could be helped.

After responding to these open-ended questions, participants were shown a list of interventions (professionals and other potential helpers, medications and a variety of other treatments) and asked to rate each intervention as helpful, harmful or neither. Respondents were then asked about the prognosis (full recovery, full recovery with risk of relapse, partial recovery, partial recovery with risk of relapse, no improvement, or progression), were the person to receive the preferred intervention. Finally, they were asked to assess prognosis in a similar manner, were the person described in the vignette to receive no treatment at all.

The instrument including the vignette and the questions were translated to Swedish by the investigators and checked and edited by colleagues.

4.5.5.3 Diagnostic interview

The Schedule of Clinical Assessment in Neuropsychiatry (SCAN) version 2.1, PART 1, chapter 1-8 and 11 [109, 110] was used to generate past month diagnoses in accordance with DSM-IV [18].

Table 4 DSM-IV diagnosis according to SCAN

	Cases with contact (N=125) n	Cases without contact (N=105) n	Mentally healthy (N=128) n
Alcohol dependence	5	1	0
Alcohol abuse	3	8	3
Major depressive episode	17	6	0
<i>Mild</i>	8	4	
<i>Moderate</i>	5	1	
<i>Severe</i>	3	0	
Dysthymia	3	0	0
Brief psychotic disorder	0	1	0
Panic disorder without agoraphobia	8	2	0
Panic disorder with agoraphobia	3	0	0
Agoraphobia without history of panic disorder	7	6	4
Specific phobia	3	0	1
Social phobia	5	3	2
Obsessive-compulsive disorder	4	2	0
Generalised anxiety disorder	8	1	0
Somatisation disorder	1	0	0
Any sleeping disorder	21	7	2
Any disorder according to SCAN	49	32	10
> 2 diagnoses	11	1	1

Even if symptoms of depression and anxiety were equally common among subjects with and without health care contact based on questionnaire data, the diagnostic assessment based on the clinical interview showed significant differences. Anxiety disorders were found in 21% of subjects with contact, who accepted to be interviewed. The corresponding figure among subjects without contact was 11% ($p=0.05$). The same trend could be seen for depressive disorders, with 13% among subjects with contact and 6% among subjects without contact. Any kind of sleeping disorder was more common among subjects with contact (17% vs 7%, $p=0.02$). Adding these multiple diagnoses, 39% of the subjects with contact and 30% of subjects without contact were diagnosed with any disorder (ns). However, multiple diagnoses were more common among subjects with contact (9% vs 1%, $p=0.02$).

4.5.5.4 *Expectations*

In order to capture the respondents' own conceptions concerning a potential health care contact, a hypothetical situation was proposed to them:

“If you experience difficult psychological problems that you cannot manage on your own but decide to seek care: What is the most important thing you would like to experience when you contact the mental health system and what is it that you most want to avoid?”

During the interview, the responses were written down verbatim by the interviewers.

4.5.6 Socio-demographics

4.5.6.1 *Age and gender*

The subjects were divided into three age groups, 20-34 years, 35-49 years, and 50-64 years. The classification of males and females was done on the basis of the personal identification number.

4.5.6.2 *Educational level*

Information about education was obtained through the questionnaire. We used three educational levels for the analysis, 0-9 years (compulsory school), 10-12 years (upper secondary school) and more than 12 years of education.

4.5.7 Interviews

The interviews were carried out by two psychiatrists Karin Dahlberg (KD) and Håkan Andersson (HA), one psychiatric nurse Ing-Britt Eriksson (IBE), and one occupational therapist Eva Marie Sjöberg (EMS), all with broad experience of psychiatric care. Before the project started, all four interviewers participated in a one-week WHO certified SCAN training. Joint ratings were performed both within the research group and in cooperation with PART, Stockholm. Furthermore, two interviewers were present at the same time on some occasions. Additionally, all interviewers had conducted test interviews before the start of the project. Continuous consensus discussions took place within the group concerning the administration of the interview throughout the project.

Age, gender and group among the respondents were evenly distributed among the four interviewers. Fifty per cent of the interviews were conducted at the respondents' home; the remainders were conducted at the research centre in Skövde. The respondents were compensated for travel costs and parking fees. There were no additional compensations for participating.

The mean time between the postal questionnaire and the interview was 4 months (range 1-18 months); ninety per cent of the interviews were conducted within seven months.

4.6 ANALYSIS

4.6.1 Statistics

SPPS version 12.0 was used for statistical analyses in Papers I-IV. The use of methods is shown in table 5. When logistic regressions are applied the dependent variable is given in parenthesis.

Table 5 Statistical methods

	Statistical methods used
Paper I	Chi ² -test Logistic regression (Overall contact with health care)
Paper II	Chi ² -test (socio-demographics) Factor analysis (SSP) ANOVA (SSP) Logistic regression (Caseness, Mental health care contact)
Paper III	Chi ² -test Logistic regression (Correct recognition)
Paper IV	Chi ² -test

4.6.2 Qualitative interpretive description

The data in Paper IV were analysed with a mixed methods approach. The qualitative approach was based on interpretative description [111]. We acknowledge the influence of our clinical experiences as psychiatrist (KD) and psychologist Cristina Lundqvist-Persson (CL-P) on the interpretative part of the work. Our effort was to conduct interdisciplinary research. The information collected throughout the interviews was juxtaposed into one text document, with each respondent indicated only by research number. For an initial comprehensive reading, three of the interviewers (KD, IBE and EMS) gathered for a thorough reading of the text material. This session was supervised by a senior researcher in qualitative analysis. The identification of open codes and possible key words started at this session and possible meanings were discussed. Two of the authors (CL-P and KD) worked with the further analytic process. Through repeated reading and reflection, both together and independently, the work with identification of keywords and phrases continued. The agreement was satisfactory. In case of disagreement thorough discussions and rereading were carried out and new options were considered. The two authors CL-P and KD had shared right of interpretation. In addition to reading all answers in one cohesive document, further reading was carried out with the answers divided by (1) age-groups, (2) gender, and (3) interview groups. The purpose of this process was to explore possible qualitative differences in the answers among these groups. After defining the themes, the material was reread to identifying new meanings and possible associations across themes. The findings were discussed and reflected upon with other researchers; an epidemiologist, a sociologist and a GP.

The themes derived from this process were used in quantitative analysis, examining possible differences between age-groups, gender, and interview groups.

4.7 ETHICAL CONSIDERATIONS

The Ethical Committee at Karolinska Institutet (99-293) and the University of Gothenburg (126-99) approved the study.

The authors have no competing interest.

The study focused on delicate questions; for instance if the subjects were affected by anxiety, depression, substance abuse and suicidal ideation. We were aware of the probability of meeting people in crisis; hence, we found it important that all the interviewers had broad experience in psychiatric work. Plenty of time was reserved for each interview in case the respondents were in need of dialogue and support after completing the interview. In general, the interviewer was blind to which group the respondent belonged. However, when the respondent had indicated suicidal thoughts or ideation in the questionnaire we found it important for the interviewers to be aware of this particular circumstance. More than one hundred persons in the interview stage had symptoms of mental disorders but were without health care contacts. Hence, we could expect to meet people with unmet needs. For this reason we listed possible resources for help within the health care sectors in Skaraborg, including names, telephone hours and locations. As a part of the introduction we informed the participants of the opportunity to ask questions after the interview, and we offered appropriate referral in case of evident unmet need of care. However, it was clearly stated that the interviewer could not supply the health care contact.

5 RESULTS

5.1 PAPER I. MENTAL HEALTH PROBLEMS AND HEALTHCARE CONTACTS IN AN URBAN AND A RURAL AREA. COMPARISONS OF TWO SWEDISH COUNTIES.

This is a descriptive study of the level of mental health problems and health care contacts in two Swedish areas. The results are based on questionnaire data, from a survey of Swedish citizens, aged 20-64. The studies were conducted during 1998-2000 (Stockholm) and 2000-2003 (Skaraborg). The response rate was 53% (n=10 441) in Stockholm and 49% (n=3 538) in Skaraborg.

In accordance with the age distribution of the investigated areas, the urban sample contained a larger proportion of younger respondents, whereas the proportion of older respondents was larger in the rural sample. The gender composition was equal in the two samples, with 55% of the respondents being women. More people in the urban area lived alone; there were also more people with a higher level of education in the urban sample. Subjects in the rural sample were more often born in Sweden and raised within the county. In both samples, a majority indicated high affinity to the area they lived in, 83% in the rural area and 75% in the urban area ($p<0.001$).

Over ninety per cent of the respondents rated their health as good. Stratified for age groups there were significant differences between sites, with the oldest age group (both women and men) in the rural site more often rating their health as good compared to their urban counterparts ($p=0.02$ for both gender). Symptoms of mental disorder including substance abuse were common in both samples. The rate of self-reported mental health problems ranged from 13% in rural women to 17% in urban women, and from 15% in rural men to 20% in urban men. Adjusting for the uneven age distribution, the urban-rural differences disappeared in the two youngest age groups (20-34 and 35-49). However, in the oldest age group (50-64) the difference remained statistically significant, with higher prevalence of symptoms of mental disorder for both genders in the urban area. In both sites, the youngest age group had the highest rates of symptoms of mental disorder.

The prevalence of anxiety symptoms had an equal distribution in the two samples. However, there were differences between the two samples concerning female depression. The urban women had an even distribution of depressive symptoms over the three age groups (7%, 7% and 6% respectively). Among rural women, the rate of depressive symptoms had an almost linear decreasing association with age (10%, 8% and 4%). Harmful alcohol use were more common in the urban (7%) than the rural population (5%), ($p<0.001$). The differences could be attributed to a higher rate of harmful alcohol use among urban women (all ages) and among the oldest age group in urban men.

The urban sample had more often during the last year consulted health care on an overall basis, 77% compared to 52% ($p<0.001$). This difference remained after adjusting for age, gender, self-rated health and various symptoms of mental ill health.

5.2 PAPER II. PERSONALITY TRAITS IN PEOPLE SEEKING HELP FOR COMMON MENTAL HEALTH PROBLEMS.

This is a cross-sectional descriptive study on three stratified subsamples. Based on the answers from the questionnaire the respondents were divided into three different groups, a sample from every group was invited to participate in an interview.

- A. Persons with symptoms of mental disorders with health care contacts (n=125).
- B. Persons with symptoms of mental disorder without health care contact (n=105).
- C. Mentally healthy persons (n=128).

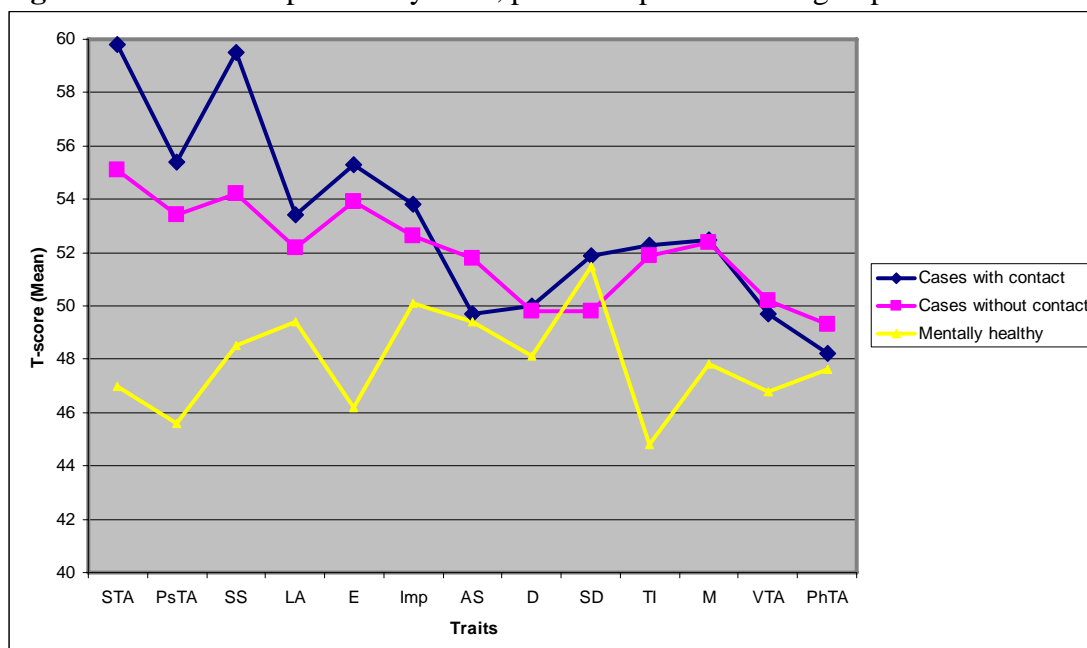
The aim was to investigate the association between personality traits and (1) symptoms of mental disorders and (2) help-seeking behaviour for such symptoms. Additionally we wanted to investigate if a possible association between personality traits and help-seeking was merely mediated by a concurrent episode of mental disorder, e.g. major depression.

The personality traits STA, PsTA, SS, LA and E (all part of the Neuroticism factor) were all associated with symptoms of mental disorder. In addition, two of the personality traits that make up the factor of Aggressiveness, namely TI and M were also associated with symptoms of mental disorders. Higher levels of the above mentioned personality traits predicted symptoms. These results were robust after adjusting for socio-demographic factors.

High levels of STA and SS were associated with help-seeking for symptoms of mental disorders; the results remained significant after adjusting for socio-demographic factors. Low levels of AS were additionally found to be associated with having a mental health care contact for mental health problems.

On factor level, only Neuroticism was a significant predictor for help-seeking for symptom of mental disorders (OR 1.95, p=0.03). This result was robust after adjusting for a concurrent episode of major depression.

Fig 2. Mean values of personality traits, presented per interview group.



5.3 PAPER III. MENTAL HEALTH LITERACY AND ATTITUDES IN A SWEDISH COMMUNITY SAMPLE - INVESTIGATING THE ROLE OF PERSONAL EXPERIENCE OF MENTAL HEALTH CARE.

This is a cross-sectional study based on interview data (see Paper II), with the objective of investigating a possible association between mental health literacy and personal experience of mental health care. Mental health literacy and attitudes towards interventions were assessed through a vignette (depicting a depressed person) and residing questions.

The ability of recognition was modest, only one third correctly labelled the case as depression. The results were equally poor in all three interview groups. Younger women were best at recognition; over fifty per cent correctly identified depression. However, 60% of the respondents correctly identified the problems as dealing with mental illness in a broader context.

Unprompted answers concerning best form of help showed that one third suggested counselling and only one per cent proposed antidepressant treatments. Work-related interventions were suggested by 15 per cent. No differences were found between interview groups. Mentally healthy persons and persons with symptoms of mental disorders without health care contact more often suggested help from family or close friends. Persons with symptoms of mental disorder with health care contact on the other hand were more prone to suggest contact with a GP.

In judging the helpfulness of different interventions, those with a history of mental health care contacts were more positive to medical interventions, such as antidepressants, hypnotics, and inpatient psychiatric treatment. This was even more evident concerning respondents with present use of antidepressants; nine out of ten of these rated antidepressants as helpful. The situation was corresponding for persons in psychotherapeutic interventions; where nine out of ten likewise rated psychotherapy as helpful.

A majority believed in full recovery with appropriate help. Concerning prognosis without help, persons with symptoms of mental disorder without health care contact were more optimistic than persons with symptoms of mental disorders with health care contacts.

5.4 PAPER IV. PEOPLE'S EXPECTATIONS ON THE HEALTH CARE SYSTEM WHEN SEEKING HELP FOR MENTAL HEALTH PROBLEMS.

In this qualitative study the aim was to establish what people expect from the health care system in managing symptoms of mental disorder. Our assumption was that people would express different expectations depending on whether they had symptoms for which they had consulted a professional, had symptoms but had not consulted, or had no symptoms at all.

In analysing the participants' statements, we interpreted four themes:

- A. *The Quality of interaction between the patient and provider*, expressed as attention, engagement, enough time, being listened to, being treated with respect, being believed, meeting on an equal level, common kindness etc.
- B. *Competence*, expressed as yearning for explanations, information, substantial medical diagnosis, correct treatment and the wish for cure and treatment.
- C. *Organisation*, expressed by continuity, given access to the correct authority, and the wish to avoid waiting lists.
- D. *Specific treatments*, including both pharmacological and psychological treatments, both as desirable and undesirable.

We also found the term trust to be relevant, often expressed as a desire to get a good *quality of interaction between patient and provider* and a wish for professional *competence*.

“To get someone I can really trust and believe in – someone I can talk to and who knows what I’m talking about.”

Quality of interaction between patient and provider was by far the most common theme, mentioned by three quarters of all the respondents. One quarter mentioned competence, nineteen per cent organisation, and less than six per cent mentioned a specific treatment. No major differences could be detected among interview groups.

There were quantitative differences between genders concerning treatments the respondents wanted to avoid. More men than women wished to avoid psychological interventions. On the other hand more women than men expressed a wish to avoid medication.

6 DISCUSSION

6.1 METHODOLOGICAL ISSUES

We found it valuable to conduct a population based survey with a public health approach. Our focus was on common mental disorders such as depression, anxiety, and alcohol abuse, obviously conditions prevalent in the society. We have not included conditions with low prevalence, for instance psychotic disorders. The postal questionnaire approach is probably less suitable for reaching people with psychotic problems. The focus on mental health problems within a broader context, rather than investigating specific disorders probably better reflects the situation in society. Yet it presents difficulties when it comes to comparisons with other studies. Our main goal was not, however, to study prevalence of mental disorders, but rather to examine different phenomena which could be associated with the process of help-seeking for mental health problems. The major part of the analyses has been made on differences between three groups, namely A, persons with symptoms of mental disorder with health care contact, B, persons with symptom of mental disorder without health care contact and C, mentally healthy persons.

6.1.1 The problem of non-responders

The present study has a response rate of 49%. It is important to address the issue of selection bias. Do the persons who agree to participate differ from non-participants? This question is often raised in epidemiological research, but it is difficult to gain information about bias related to non-response. Socio-demographic characteristics such as age, gender, and social class are some of the factors that can actually be studied [112]. Response rates are often lower among men and younger persons [96, 113, 114]. This was the case in our study, with fewer responders among males, and in the youngest age group. Hence, the main part of our analyses was made separately for men and women, and on the three different age groups.

Information on whether non-responders differ from responders in terms of health is scarce [112]. However, some facts are available, demonstrating that responders more often report better health [115] and more health-related behaviour [115], for instance concerning smoking habits [116]. A Norwegian research group states that self-selection had little impact on prevalence estimates such as Self-Rated Health, smoking, Body Mass Index, and mental health [113]. However, they base their analysis on the assumption that attendees and non-attendees are similar within each stratum of socio-demographic variables.

The PART study in Stockholm has compared the databases of responders and non-responders with several population registers. Concerning socio-demographic factors they found that non-participants were more often men, younger, had lower income, and a lower degree of education, lived alone more often, and were more often born in a non-Nordic country [96]. Additionally, non-participants more often had a psychiatric disability pension or a hospital discharge for psychiatric diagnosis [96]. However, when related to age, gender, income, residential status, education, and country of origin the odds ratio for all hospital discharge psychiatric diagnoses were remarkably similar among participants and non-participants [96]. Concerning the present study, we have not compared register data in responders and non-responders. Our questionnaire is,

however, based on modules from the PART questionnaire. We do not have any strong reason to believe that motives for non-participation would differ significantly between Skaraborg and Stockholm. One possible distinction may be differences in attitudes related to differences in availability and the supply of psychiatric services between Skaraborg and Stockholm.

Available data on differences in health care utilisation between responders and non-responders to surveys is limited. A Dutch study reveals that utilisation of all types of care, except hospital care, was lower among non-responders [117]. They also state that background characteristics differ only slightly for most risk estimates of utilisation [117].

We are aware of several obstacles to answering the present questionnaire. Severe mental health problems most probably decrease the ability of answering a questionnaire. As the study concerned mental health problems which are personal and delicate issues, some persons may have lacked trust in the warrant of anonymity. Today, in our society with a wealth and intensity of information, there may also be a sense of exhaustion of surveys.

There are several aspects to consider in questionnaire design; some efforts might improve the response rate. A more narrowly defined patient population would most certainly influence the response rate in a positive way. This was not an option as we wished to reach also those who did not seek help, and thus had to address the general population. The response rate of questionnaires are related to length, appearance, way of delivery, content, and the use of incentives [118]. Questions of sensitive nature reduce the response rate [118]. The present questionnaire was primarily elaborated for the PART study in Stockholm. In our study we shortened the questionnaire in some parts, mainly concerning working conditions, whilst keeping the main part of the questionnaire in order to enable comparisons. As we were investigating help-seeking for mental health problems, the majority of our questions dealt with sensitive issues. The responders in the present study were not offered any incentive.

6.1.2 Strength and limitations

The data on help-seeking is based solely on the subjective information reported by the respondents. In the present study we have abstained from register control, hence, we do not have the corresponding data on help-seeking from the health care system.

The main part of the analysis is made on dichotomous variables. Using several self-report instruments instead of one global instrument, we found it convenient to use dichotomous variables in comparing the two study sites, as well in dividing the respondents into three different groups. We are aware of that some information, for instance associations between help-seeking and the level and degree of symptoms have been lost in this way.

The time between the questionnaire stage and the interview was in some cases long. This was mainly due to practical difficulties, for instance respondents rescheduling appointments. We found it important to offer flexibility and compliance towards the respondents' requests concerning appointments. However, we believe that factors such as personality and attitudes have rather a high stability over the present time period.

The self-report instruments in the questionnaire stage differ concerning their psychometric properties; some of them are well established with good diagnostic validity, for instance MDI [21] and AUDIT [25], while others are not. However, the instruments used in the questionnaire were chosen to facilitate a comparison between the two study sites in Paper I.

The use of face-to-face interviews is a strength in the present study. Symptoms of mental disorders have been registered both with self-report instruments in the questionnaire stage, and with a semi-structured interview in the second stage. However, comparison between data from the questionnaire and the diagnostic interview to validate self-report data was not a purpose of this study. The questionnaire was mainly used as a screening to identify interview subjects. The time interval between the questionnaire and the personal interview is one reason for refraining from comparison. The study has diverseness of methods; with both a qualitative and quantitative approach. The participants' opinions and expectations on mental health care have been assessed, both with a case vignette with open and structured questions as well with open question within a hypothetical situation. A self-reporting inventory has been used for assessing personality. Dealing with delicate issues we found the personal meeting offered by the interview situation invaluable. It enabled us to offer the participants the possibility of consultation at the end of the interview. It also offered a possibility to evaluate the need for help and make appropriate referrals.

We have gathered data from interviews with more than one hundred persons with symptoms of mental disorder but without health care contacts. This is valuable in investigating factors associated with help-seeking.

6.2 COMPARISON BETWEEN THE RURAL AND THE URBAN AREA

The level of mental health problems was relatively high in both sites. Depressive and anxiety symptoms were equally common in both samples. These findings diverge from the overall results from the European Study of the Epidemiology of Mental Disorders (ESEMED) which shows a higher risk for mental health disorders in urban residents [31]. However, the urban-rural pattern differs between the attendance countries in ESEMED. The European Outcome of Depression International Network (ODIN) revealed a higher prevalence of female depression in the urban sites in Ireland and the UK, whereas the Scandinavian countries Norway and Finland showed few urban-rural differences [119].

Regarding harmful alcohol use, there was a distinct difference, with higher rates in the urban area. Our result is in line with Norwegian research, which shows higher prevalence of alcohol abuse and dependence in Oslo [10] compared to the rural area Sogn and Fjordane [36]. Likewise in The Netherlands the rates of substance disorders showed a significant urban-rural trend, with higher levels in the more urbanised areas [35]. In contrast to these results, there are findings from ESEMED which could show no link between urbanity and alcohol disorders [31].

A majority of the respondents had been in contact with health care, on an overall basis, during the last year. However, the overall healthcare utilisation was more frequently reported among urban residents, regardless of age, gender, or presence of mental health problems. Living in a big city has previously been reported as a major predictor of help-seeking among those with a perceived need for mental health assistance [120].

6.3 PERSONALITY

We found an association between symptoms of mental disorders and personality traits; STA, PsTA, SS, LA and E. These five scales make up the factor of Neuroticism. Our results are in accordance with other research, which shows Neuroticism (Big Five) to be associated with higher rates of mental disorders [121], and to covariate with depression and anxiety disorders [122]. There was also an association between two of the personality traits making up Aggressiveness (TI and M) and symptoms of mental disorders. Within the Big Five concept, high levels of Aggressiveness might be interpreted as low levels of Agreeableness. It has previously been shown that psychiatric out-patients have higher levels of Neuroticism and lower levels of Agreeableness than the general population [123].

Comparing the two groups of cases, the help-seekers had higher levels of two Neuroticism-related traits, STA and SS. Specific personality traits, such as Neuroticism are known to be associated with overall consultation with a general practitioner [124] and with utilisation of primary care for mental health problems [125]. Neuroticism is also found to be a significant predictor of increased use of mental health services [125, 126]. Even after the adjustment for the influence of social support, education, emotional disorder and functional impairment, Neuroticism was revealed to be associated with use of both primary care and specialised mental health care [127].

There is always the question of whether we assessed proper personality traits or merely signs of mental disorders. In an effort to distinguish between trait and state, we investigated the association of personality factors and help-seeking under the influence of an ongoing episode of major depression. High levels of neuroticism predicted health care contact for mental health problems, regardless of depression status.

6.4 MENTAL HEALTH LITERACY AND ATTITUDES

Less than one third correctly labelled the case vignette as a depression. This should be compared with data from Australia, where recognition of depression has been improved. Recognition using the same vignette method increased from 39% in 1997 to 76% in 2003-2004 [128]. Recent research from Canada showed that three quarters of the respondents could recognise a depression [129]. However, sixty per cent of our participants interpreted the case vignette within a broader context of mental illness. This is in line with results from Germany [130] and Japan [131], where 62% and 75% respectively identified the depression vignette as mental illness.

One third of participants in our study suggested counselling as the best form of help for the person in the vignette. Only 13% of the total sample recommended the person to see a GP, a result which diverges from reports from other parts of the world. In Japan [131], one third recommended the person to see a physician, in Canada [129] 45% suggested a GP, and in Australia [132] fifty per cent suggested contact with a GP. While this may reflect cultural differences in attitudes, it is possible that problems with primary care are at play. In Skaraborg it is not always easy to obtain an appointment with your GP, and the lack of physician continuity might influence people's willingness so to seek help for mental health problems. Among our respondents, fifteen per cent suggested a work-related intervention, an alternative not recorded in the other studies.

This may be a result of the current discussion of work-related problems, such as “burn-out”, often presumed to be highly prevalent today.

A large majority of the participants favoured psychotherapy. Other population based studies using case vignettes [72] also shows a preference for psychotherapy. A review article stated that a majority of depressed patients in primary care likewise preferred counselling or psychotherapy [79]. Concerning interventions, help-seekers were significantly more positive to medical interventions, such as antidepressants and admission to a psychiatric ward compared to the two other groups. The help-seekers were, so to speak, more in tune with the professional point of view. The investigation of the subgroups receiving specific treatments showed that as many as ninety per cent rated their own intervention as helpful. This may reflect the respondents having received their preferred treatment. Another possible interpretation is that the respondents have experienced the benefit of the offered treatment, regardless of their first preferences.

We found that our participants were more optimistic about the prognosis of depression with appropriate help than without any help, an attitude found in several general population studies [72]. The non-help seekers were significantly more optimistic about the prognosis without help; more than twenty per cent believed in full recovery, compared to eight per cent among help-seekers. This optimism may be based on own experiences or it could merely be an underestimation of the problems. Population studies from Europe, Asia and Australia show that only five per cent believe in full recovery without help [133, 134].

The participants in our study were optimistic about the long-term outcome for the person described in the case vignette (depression). They tended to rate the person in the vignette as more likely than people in general to experience a positive outcome (such as understanding other peoples feelings and being a good parent). The participants probably believed that an experience of depression could improve the empathic ability. They also rated the person in the vignette to be less likely than others to experience negative out-comes (such as using drugs and being violent). These findings are in accordance with earlier research from Australia [80].

6.5 THE USER'S PERSPECTIVE

When faced with a hypothetical consultation for mental health problems an explicit majority of the participants in our study gave priority to the quality of interaction between patient and provider. Concerning users' expectations within the concept of responsiveness, a German study reveals that most statements refer to attention, dignity and autonomy [88], which could be seen as important aspects of interaction. British research points to the importance of good communication for quality of care in depression [135], and that patients experience barriers in talking about mental health problems with their GPs.

Among our 358 participants, only twenty persons expressed a wish for a specific treatment. On the other hand, issues like being listened to, be believed and met on equal level were frequently mentioned. We believe these aspects to be important components in the decision-making process of choosing intervention. These results are in line with previous known facts, that shared decision is often preferred, shown by a growing body of research [94].

We also noticed that respondents mentioned trust, often as a combination of the quality of interaction and competence. Concerning mental health settings, the research on trust has mainly been qualitative. Trust has been revealed to be important in building positive relationships [136], and central for good quality service [91]. The therapeutic relationship has mainly been studied in psychotherapeutic settings [137], and shows a positive relationship to better outcome. Quantitative studies of trust in mental health settings are rare.

6.6 AGE

In both study sites, symptoms of mental disorder were most common among the youngest age group (20-34); this is mainly due to a higher rate of harmful alcohol use in this group. This corresponds with earlier research which shows high prevalence of substance abuse among young adults [1, 138]. Kessler and co-workers also point to the important fact that many mental disorders begin in childhood or adolescence [139]. In the rural site, female depression had an uneven age distribution, with higher rates of depressive symptoms in younger age, declining with age. The same pattern with higher rates of female depression in younger age has been shown in the Stirling County study [28].

Among respondents who screened positive for symptoms of mental disorders, the rate of mental health care contact differed by age group. In the youngest age group (20-34), 47% of the cases had mental health care contact; the corresponding numbers for the two other age groups were 66% (35-49) and 70% (50-64). This may be due to a delay in treatment seeking [53].

The youngest age group was the best at recognising depression from the vignette. More than 50 per cent among the youngest women recognised depression, compared to only one fourth among all the other respondents. This is in accordance with Australian studies, which reveal young people (15-24) to be better at recognising mental health problems from a vignette than older people (65-74) [140]. The young respondents were more negative towards some interventions; they rated both admissions to a psychiatric ward and Electro Convulsive Therapy as harmful more often than the rest of the participants. The oldest age group (50-64) were, on the other hand, less prone to rate a psychologist as helpful, which is in line with results from the Australian study [140].

6.7 GENDER

We found the prevalence of harmful alcohol use to be more common among men than among women. Comparison of cross-cultural research shows that male drinkers drink more frequently, larger amounts, and with higher rates of adverse consequences compared to female drinkers [141]. However, a recent study points to the fact that the gender gap in alcohol use, abuse, and dependence is probably decreasing [142]. We report a closer gender-gap in the urban area (data on harmful alcohol use) than in the rural site.

More women than men reported anxiety symptoms (9% vs 7%, $p=0.01$). Regarding depression there was a clear gender difference, with more women than men being affected with depressive symptoms. It is well known that depression is more common

among females [3, 143]. Some studies even point to an increase of chronicity of depressive disorders among females [144]. The presence of suicidal thoughts during the last two weeks showed a similar level for both genders.

Indirect signs of illness, defined by current use of prescribed drugs and sick-leave during the last 30 days, were more often reported among women. However, when it came to rating their own health, as many women as men stated their own health to be good. Previous Swedish research on twins could not show any significant gender differences concerning Self-Rated Health [145].

With regard to help-seeking behaviour, we could detect the expected differences between the genders. Among women, 54% had some form of health care contact last year, compared to 49% among men ($p=0.002$). More than two thirds (69%) of the women who screened positive in the questionnaire had a health care contact for their mental health problems, the corresponding number for men was 53%. Many studies report higher levels of health care utilisation [146] and more specific help-seeking for mental health problems [41, 46] among women.

It may not be surprising that women were better than men in recognising depression in a vignette. One reason might be that psychological matters are more often discussed and reflected upon among women, reflected for instance in women's magazines compared to their male equivalents. More women than men also suggested a GP as the best form of help, in line with more women being in contact with health care for their own mental health problems. Studies from Canada [129] and Japan [131] show gender differences with poorer mental health literacy among men.

When it came to the expectations on the health care contact, more women than men emphasised the quality of the interaction between patient and provider. It has previously been shown that women value listening skills [147], which was confirmed in the present study with more women than men stating the importance of being listened to.

6.8 CONCLUSION

The aim of the present study was to improve knowledge about factors associated with help-seeking for mental health problems. Some of the findings confirmed earlier knowledge, for instance the influence of age and gender, urbanity and severity of the mental disorder. We have tried to elucidate the associations between attitudes, personality, expectations and help-seeking for mental health problems.

- The level of overall health care contact during last year was higher in Stockholm, compared to Skaraborg, regardless of age, gender, or symptoms of mental health problems.
- More than fifty per cent of cases in the Skaraborg study had health care contacts for their mental health problems.
- Among cases, women and the oldest age group (50-64) had the highest rate of health care contact for mental health problems.
- The level of self-reported symptoms of depression and anxiety was similar in those who had applied for help and those who had not. Harmful alcohol use, however, was more common among non-help seekers.
- Help-seekers had higher rates of sleeping disorders (DSM-IV). Comorbidity (DSM-IV) was likewise more common among help-seekers.
- Higher levels of the personality traits Somatic Trait Anxiety and Stress Susceptibility were associated with help-seeking for mental health problems. The association between neuroticism and help-seeking was robust even after adjusting for an ongoing episode of major depression.
- Very few of the respondents could recognise depression from a vignette.
- The ability to recognise a depression from a vignette was neither associated with presence of mental health problems nor with help-seeking for such problems.
- Mentally healthy and cases without mental health care contact were more positive towards help from the lay support system, while help-seekers more often suggested help from a GP.
- Help-seekers were more positive about medical interventions such as antidepressants, hypnotics, and admission to a psychiatric ward than those without health care contact.
- Non help-seekers were more optimistic than help-seekers concerning the prognosis of depression without professional help.
- The quality of interaction between patient and provider was the most important issue for a great majority of the respondents when encountering mental health care. The wish for specific treatments was less pronounced among the respondents.

6.9 IMPLICATIONS

With a response rate of 49% one has to be cautious when it comes to making generalisations concerning the general population. We are aware of the fact that there are other possible factors related to help-seeking, which are not covered by this research. Even concerning associations between help-seeking and the studied factors, it is possible that we have missed specific circumstances. However, results presented in this thesis may be valuable for generating hypotheses for further research. We will also consider some possible implications based on the results presented in this thesis.

Possible implications could be directed at the general population, as well as towards the health care system. With the public as a target, efforts could be put on educational programmes, improving the mental health literacy. With the intention to improve public understanding of depression and its treatment, countries such as the United Kingdom and Australia have implemented national awareness campaigns [148, 149]. Positive changes have been shown both regarding attitudes towards depression and some interventions [148, 149] such as counselling and medication, but also towards a more positive attitude to help-seeking in general [148]. In Australia, the public's ability to recognise depression has improved since the 1990's [128, 150]. However, it is difficult to attribute these changes to any one factor, as a number of approaches have been employed to improve mental health literacy, especially concerning depression [132]. Despite the positive effects on recognition in Australia, it is still difficult to show effects on the prevalence of depression [151]. Yet there has been no such national campaign in Sweden. However, Swedish mass media has in recent years put more focus on mental illness and mental health care. A cooperation between the profession and the media may well be a way of expanding the understanding of mental health issues. Offering high quality coverage of available treatment options within the health care system will hopefully give a positive picture of the health care system.

Likewise, it would be valuable to increase the awareness among health care providers about the user's perspective. Knowledge about the importance of the quality of interaction will hopefully improve contact with health care users, from the first telephone call to long-term treatment contacts. We believe that a good quality of interaction between patient and provider, including a positive decision-making process, would enhance the possibility of trying different evidence based treatment options. This will hopefully lead to positive experiences of the specific intervention. It would also be beneficial for caregivers to gain knowledge about the association between certain personality traits and help-seeking behaviour for mental health problems.

On a health care planning level, it may be beneficial to balance the needs and wishes of the users with allocations of health care resources, for instance by expanding the availability of psychotherapeutic interventions.

6.10 FUTURE RESEARCH

Valuable baseline information was gathered from 105 persons with symptoms of mental disorder but without health care contact for these symptoms. Following these 105 individuals may add important information in the present research field. How do the symptoms develop? How many of the individuals self-heal? Do some of them, eventually, over time, take contact with health care for their mental health problems? It may be valuable to investigate possible associations between prognosis and baseline factors, such as personality, attitudes, and expectations.

Other possible future projects where we have already gathered data would be to study the association between stress, expressed as life events, and help-seeking for mental health problems. Additional interesting associations with help-seeking for mental health problems also include the link between access to support (social network) and well-being.

Another possibility to evaluate the present data would be to scrutinise official registers concerning e.g. sick-leave or inpatient care among our samples, both during the study period but also in years to come.

6.11 SOME PERSONAL IMPRESSIONS FROM THE INTERVIEWS

Conducting almost one hundred interviews has of course left me with important impressions and experiences. I have travelled to parts of Skaraborg which I didn't even know by name. A lot of people have welcomed me into their homes; some even found it difficult to let me leave. I have tasted cakes and buns from most of the bakeries and drunk strong boiled coffee.

After a presentation and introduction with questions about socio-demographic factors, the interview proper started with the case vignette depicting a depressed person. Even though many respondents failed to recognise the depression, many of them could easily identify themselves with the situation, either directly or via the experience of someone close. The short case story initiated a lot of ideas concerning the respondent's own situation. One older gentleman could easily understand the boss's situation and told me about people he had encountered during his own work as a manager. Another respondent was a woman in her thirties who could very well understand the background of the person in the vignette. She talked about Anna having a tough time with the children, lacking support from her husband. It is worth noting that the vignette says nothing about family.

Quite early in the interviews it became apparent whether or not the person had symptoms of mental disorder, and whether he or she had health care contact for these problems. Many of the persons with symptoms of mental disorders but without health care contacts took up the offer of consultation at the end of the interview. There was a need for conversation, mutual speculations, and a wish for confirmation and to test their own thoughts and ideas. Some of the respondents clearly expressed their gratitude for such dialogue. I especially remember one woman in her late thirties with social phobia. Her problems had started in her teens, but she had never asked for help. The interview finished with quite a long discussion concerning possible interventions; psychotherapy as well as pharmacological treatment. Since she had some doubts about health care contact, no referral was made. However, two years later she telephoned the research office asking for information about treatment and where to turn for help.

There was also a middle-aged man, who had indicated suicidal thoughts when answering the questionnaire. Twice, I made the one-hour journey to his home, but no-one opened the door. After a new telephone call to his work (the number he had reported), we schedule a third time for an interview - this time at the research office. He did not appear. Maybe his barriers to health care contact were too big, despite an initial wish for a meeting.

7 SVENSK SAMMANFATTNING

Psykisk ohälsa som depression, ångestillstånd och missbruk är idag folkhälsoproblem. Internationell forskning visar att fyrtio till femtio procent drabbas någon gång under sin livstid. Svenska resultat från Lundby studien visar att var tredje kvinna och var fjärde man utvecklar en depression någon gång under livet. Med psykisk ohälsa följer lidande och ekonomisk påverkan såväl för individen som för samhället. Bland nybeviljade sjukersättningar i Sverige 2006 utgjordes fyrtio procent av psykisk sjukdom. Nedslående fakta är att många med psykisk ohälsa aldrig söker hjälp. Internationella studier visar att mindre än femtio procent har sjukvårdskontakt för sina psykiska problem. Nyligen publicerade data från WHO visar att även bland de med svåra tillstånd är många utan sjukvårdskontakt. Orsaker kan finnas på många olika nivåer, kulturella, organisatoriska och personliga. Identifierar man inte sina bekymmer som psykisk sjukdom? Vilka förväntningar har man på den hjälp sjukvården kan erbjuda? Spelar personligheten in för om man söker eller inte? Finns det skillnader mellan storstad och landsbygd?

Målet med avhandlingen var att öka kunskapen om faktorer som är associerade med hjälpsökande för psykisk ohälsa. Vi har speciellt uppmärksammat lekmäns attityder och förväntningar kring sjukvårdskontakter vid psykisk ohälsa.

Samtliga arbeten bygger på data från en befolkningsundersökning genomförd i forna Skaraborg, åren 2000-2003, inkluderande svenska medborgare i åldern 20-64 år. I steg ett besvarade 3538 (49%) en postenkät innehållande självskattningsinstrument om psykisk ohälsa och sjukvårdskontakter. Utifrån utfallet i enkäten bjöds tre olika grupper in för att delta i en personlig intervju.

A. Personer med symptom på psykisk ohälsa med sjukvårdskontakt, n=125 (89%).

B. Personer med symptom på psykisk ohälsa utan sjukvårdskontakt, n=105 (66%).

C. Psykiskt friska personer, n= 128 (51%).

Intervjun innehöll en fallberättelse som beskrev en deprimerad person, ett personlighetsinventarium, en strukturerad diagnostisk intervju och öppna frågor kring förväntningar vid en eventuell sjukvårdskontakt.

I artikel I jämförs enkätdata med motsvarande data från PART:s undersökning i Stockholm. Symptom på psykisk ohälsa var vanligt i båda studiebefolkningarna. I Stockholm hade 17% av kvinnorna och 20% av männen symptom på psykisk ohälsa. Motsvarande siffror i Skaraborg är 13% bland kvinnorna och 15% bland männen. Skillnaden beror till stora delar på att Stockholm har en yngre befolkning. När det gäller skadligt alkoholbruk är detta vanligare bland kvinnorna i storstaden och bland männen i den äldsta åldersgruppen (50-64 år). I Stockholmsstudien hade mer än två tredjedelar haft sjukvårdskontakt det senaste året, jämfört med varannan person i Skaraborgsstudien.

I artikel II undersöker vi personlighetsdrag hos de tre intervjugrupperna. Vi fann en association mellan psykisk ohälsa och neuroticismrelaterade personlighetsskalor. Två

av dessa skalor, som gäller kroppslig ångest och stress känslighet visade högre värden hos de personer som hade sökt sjukvårdshjälp för sina psykiska symptom.

I artikel III, undersöker vi personernas förmåga att känna igen en depression via en fallbeskrivning, vad man tyckte om olika behandlingar och hur man skattar prognosen. Endast en tredjedel kände igen en depression. Totalt 60 procent definierar problemet som någon form av psykisk ohälsa. På en öppen fråga om vad som skulle vara bäst hjälp föreslår en tredjedel samtalskontakt, femton procent föreslår arbetsrelaterade insatser och endast en procent föreslog antidepressiva läkemedel. När man fick skatta en rad olika interventioner var personerna ur grupp A (symptom på psykisk ohälsa med sjukvårdskontakt) mer positiva till medicinska interventioner såsom antidepressiva läkemedel, sömnmedel och inläggning på en psykiatrisk avdelning. De flesta i studien trodde på full återhämtning med rätt typ av hjälp.

I artikel IV använder vi oss av en kvalitativt tolkande beskrivning angående vad som är viktigast vid en eventuell sjukvårdskontakt för psykiska besvär och vad man helst vill slippa. Merparten av svaren handlar om kvalitén på mötet mellan patienten och vårdgivaren. Andra tema är organisation, kompetens och specifika behandlingar. Som ett andra steg har vi analyserat dessa fyra teman kvantitativt, tre fjärdedelar handlar om kvalitén i mötet mellan patient och vårdgivare, endast 20 individer tar upp önskemål om specifik behandling.

Sammanfattande resultat från avhandlingen:

1. Under det gångna året hade betydligt fler i Stockholm än Skaraborg haft sjukvårdskontakt, oberoende av kön, ålder och symptom på psykisk ohälsa.
2. Mer än hälften av dem som hade symptom på psykisk ohälsa hade också sjukvårdskontakt. Störst var andelen bland kvinnor och den äldsta åldersgruppen (50-64 år).
3. Höga nivåer av personlighetsdrag med kroppslig ångest och stresskänslighet var associerade till sjukvårdskontakt för psykiska problem.
4. En minoritet av dem som deltog i intervjun kände igen en depression.
5. De som själva hade sjukvårdskontakt för sina psykiska problem var mer positiva till medicinska interventioner som antidepressiva, sömnmedel och inläggning på psykiatrisk avdelning jämfört med dem som inte hade kontakt för sina problem.
6. En klar majoritet betonade kvalitén i mötet mellan patient och vårdgivare som det viktigaste vid en eventuell sjukvårdskontakt för psykiska problem. Endast en liten andel uttryckte önskemål om en specifik behandling.

Förslag till åtgärder: Via utbildningskampanjer riktade till allmänheten öka kunskapen om hur man känner igen depressioner och andra vanliga psykiska symptom. Sjukvården kan i samarbete med massmedia tillhandahålla mer information om de behandlingar som finns att tillgå vid psykisk ohälsa. Våra resultat visar att merparten (9/10) skattade den behandling som de själva fått som hjälpsam, detta gällde såväl antidepressiva läkemedel som psykoterapi. Vidare är det viktigt att för vårdgivare belysa vikten av ett gott bemötande och att olika personlighetsdrag påverkar om man söker vård eller inte. Organisatoriskt kunde man öka utbudet av interventioner för att på så sätt tillmötesgå individers olika önskemål.

8 ACKNOWLEDGEMENTS

The research presented in this thesis was carried out in the former county of Skaraborg. I would like to express my sincere gratitude to everyone who has contributed to this work. In particular I wish to thank the following:

All the participants, who made this research possible.

My most sincere gratitude goes to my supervisor Bo Runeson, for inviting me into the world of science. Thank you for your guidance throughout this project, and your generous support and encouragement during the different stages. Thank you for keeping an open mind during our discussions and for offering an environment of progress. But most of all, my deepest thanks for being such a good friend, always available and fully aware of the impact of everyday life.

Yvonne Forsell and Kerstin Damström-Thakker, for your valuable feedback during my first tentative endeavours in scientific writing. I am also grateful for letting me use sections of your PART data.

Petter Gustavsson, thank you for sharing your great knowledge about personality. I am grateful for the opportunity you gave me to go over the analysis and results, over and over again.

Margda Waern, with your curiosity, vitality and positive attitude, you encouraged me to improve our joint work a little bit further after every discussion.

Cristina Lundqvist-Persson, for an intense and close collaboration filled with possibilities but completely without prestige. I look forward to seeing you at first tee at the end of May.

Ingela Krantz, Beth Maina Ahlberg, Anneli Darheden and all my fellow researchers at the Skaraborg Institute for Research and Development. I am grateful for the financial support and for the physical as well as mental research environment. But, above all, my sincere thanks to Bo Eriksson for his infinite patience during our discussions concerning design and analysis throughout the project.

I express my gratitude to the Department of Psychiatry at Skaraborg Hospital for generously providing me with precious time during the main part of the project, and leave of absence for my research work in the final stage. I am also grateful to the valuable support from the Research and Development Unit at Skaraborg Hospital in, Skövde, including premises, finance and encouragement. A special thanks to Anna-Lena and Lisbeth, our coffee breaks saved my day on many occasions.

The three additional interviewers; Håkan Andersson, Ing-Britt Eriksson and Eva Marie Sjöberg for lively discussions, crazy ideas and most of all for your thorough and stringent work with the interviews. Special thanks to Eva Marie for sharing sushi and doubts with me at some specific critical moments.

It would not have been possible to conduct a study of this magnitude without good logistics and skilful coordinators. Thanks to Christina for contagious enthusiasm during

the first phase of the project, to Lena for keeping up the middle phase, and to Carina for persistence and strictness during the finish.

Thanks to Ingela Malmsjö and Marie Dahlin for their social support during my visits at S:t Görans Hospital.

Maria Morris, for efficient reviewing and adjustments to my written English. Any mistakes are my own, and have occurred after Maria's efforts.

My sincere gratitude for generous financial support also goes to the Vardal Foundation for Health Care Sciences and Allergy Research, The Dahréns Foundation, R&D Centre Skaraborg Primary Care, the Foundation for Psychiatric Research at S:t Görans hospital and the Bror Gadelius Foundation.

The members of my book club; Karin, Magnus, Gunnar, Anna and Sari for sharing my joy in reading and discussing literature. And of course, thanks for all the lovely Sunday dinners during all these years.

Per-Åke and Siv Pettersson, my dear parents, for their love and support and for letting me know that everything is possible. Marcus, my bonus son, thanks for your catching curiosity and spontaneity.

Stig, my dearest husband, thanks for your love and warmth and for your generous support, both practical and emotional. Thank you for your endless belief in me and in this work throughout all my doubts.

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