British Journal of Medicine & Medical Research
5(6): 794-801, 2015, Article no.BJMMR.2015.084
ISSN: 2231-0614

SCIENCEDOMAIN *international*
www.sciencedomain.org

Psychosocial Characteristics of Subjects Who Hoped to Receive Psychotherapy as Part of a Research Study in Japan

Chieko Hasui[1*]

[1]*Department of Human and Sociology, Tokyo International University, 2509 Matoba, Kawagoeshi, Saitama 350-1198, Japan.*

Author's contribution

The sole author designed, analyzed and interpreted and prepared the manuscript.

Article Information

DOI: 10.9734/BJMMR/2015/11178
Editor(s):
(1) Kishore Kumar Hotha, Novel Laboratories, Inc., Somerset, NJ 08873, USA.
(2) Costas Fourtounas, Faculty of Medicine, School of Health Sciences, University of Thessaly, Greece.
Reviewers:
(1) Ram Lakhan, Department of Epidemiology, Jackson State University, USA.
(2) Anonymous, SKN Medical College, India.
(3) Anonymous, São Paulo University, Brazil.
Complete Peer review History: http://www.sciencedomain.org/review-history.php?iid=696&id=12&aid=6418

Original Research Article

Received 1st May 2014
Accepted 15th September 2014
Published 9th October 2014

ABSTRACT

Aims: This study examined the psychosocial characteristics of subjects who hoped to receive psychotherapy, but were not receiving psychiatric medication as part of a research study using quantitative methods to measure psychometric properties in Japan.
Methods: Subjects were examined using the Structured Clinical Interview for DSM-IV Axis I disorders, Global Assessment of Functioning, a questionnaire (including the resilience scale, social desirability scale, and the State Trait Anger Expression Inventory (STAXI)) and psychological assessments.
Results: Of the 67 people who initially volunteered, 22 came to the clinical centre at Tokyo International University. Of these, 16 completed a psychiatric diagnostic interview. They all had a fair IQ and were highly resilient and functioning well. Nine subjects had an Axis I disorder that could be classified as a life-long prevalence or 12-month prevalence. The subjects were diagnosed as follows: depressive episode group (N=7), manic episode group (N=1), anxiety disorder group (N=7), and eating disorder group (N =2). There were no significant differences between the subjects with (N=9) and without (N=6) a psychiatric diagnosis except for GAF. The results of a Mann-Whitney test between subjects with or without a desire to seek psychotherapy revealed that the former (N=7)

**Corresponding author: Email: chasui@tiu.ac.jp;*

had significantly lower GAF scores as well as lower Perceptual Organization scores than the latter (N=7).
Conclusion: Regardless of whether or not they had a psychiatric diagnosis and were motivated to receive psychotherapy, the subjects intended to participate in a study on the psychotherapeutic process. The results suggested that the subjects in this study were a mix of people who had mistaken opinions about their psychological problems and those who truly hoped to receive psychotherapy. Since little is known about reluctant subjects, further larger studies using diagnostic, quantitative, and qualitative methods will be needed.

Keywords: Psychiatric disorder; diagnosis; psychotherapy; resilience.

1. INTRODUCTION

In Japan, epidemiological studies have reported a life-long prevalence of 6.16% and a 12-month prevalence of 2.13% for Major depressive episode, and a life-long prevalence of 0.72% and a 12-month prevalence of 0.32% for Dysthymic disorder [1]. Moreover, there is a 12-month prevalence of 22% for Major depressive episodes for which the subject sought professional help (including psychiatric and general professionals). Of people who suffered from a mental disorder, about 80% did not seek professional help, and there was a lower level of help-seeking behavior in Japan than in the U.S. [1]. Many people in Japan thought that they could treat their mental problems by themselves [2]. Of the 80% of people who suffered from psychiatric disorders but did not receive professional help, only about 10% used psychiatric services. The remaining people used psychological treatment, a physician, the welfare system, or folk remedies instead of psychiatric medications [3]. Socio demographic variables that may significantly affect the use of psychiatric services were not identified, and there were no clear findings to explain why people who suffered from psychiatric illness escaped psychiatric help. Thus, while many people in Japan suffer from mental disorders, we still do not understand why they do not seek professional help.

Worldwide, epidemiological studies have reported that there are differences between countries with respect to the prevalence of psychiatric disorders, and cultural differences contribute to help-seeking behaviors. Most people who suffer from psychiatric disease do not receive professional medical help [4]. However, subjects who also suffer from comorbidities such as painful physical symptoms and anxiety disorder do not delay in seeking professional medical help [5]. In contrast, in Belgium, most people who suffer from mental disorders, except for those with alcohol disorders, receive treatment [6]. The medical care systems in Belgium and the U.S. were compared, and the results showed that factors other than the availability and accessibility of treatment facilities were related to this delay in seeking professional help.

Obsessive compulsive phenomena are much more prevalent in the community than obsessive compulsive disorder, and subjects who suffer from obsessive-compulsive syndromes are quite heterogeneous [7]. In Europe, 3.1% of adults had an unmet need for mental healthcare [8]. The authors in the research insisted that the 'mere' presence of a mental disorder might not suggest a need for care by medical professionals. The result suggests that there are differences between general and clinical populations, even when they suffer from mental disorders.

Various reasons have been proposed to explain why people in the general population who suffer from mental disorders delay or avoid seeking medical help. For example, the stigmatization of psychiatric treatment or psychiatric hospitals may contribute to these phenomena [9,10]. There has been very little research on this subject.

This study examined subjects who desired to participate in a study on the psychotherapeutic process. About half of them satisfied a psychiatric diagnosis, but were not receiving psychiatric medication. The characteristics of these subjects with and without psychiatric diagnoses were examined.

2. METHODS

2.1 Subjects

The subjects were recruited through the Internet to participate as clients in a study on the psychotherapeutic process. A homepage was made to explain both this research and how to participate in the study. Moreover, an

advertisement to attract participants was presented on the Internet (Yahoo) from the end of April to the beginning of August in 2013. The total number of clicks on the advertisement was 2871, and the keywords were clinical trial, part-time job, psychology, counseling, free of charge, psychotherapy, and so on.

This study was designed so that subjects came to the clinical centre at Tokyo International University weekly for 30 weeks to participate in psychotherapy with students who were studying for their Master's degree. Subjects were paid 10 USD (1000 JPY) and the cost of transportation (10 USD; up to 1000 JPY) every time they came to the university. This compensation was almost equal to the minimum wage for a part-time job in the university's surroundings.

Due to university regulations, subjects had to come to the university on a weekday.

2.2 Measurements

At the first interview, participants were asked to describe the aim of their participation, the reason why they were interested in the study, and their life and family history. Since there were no medical doctors at the university and the subjects were to be treated by students, subjects with psychiatric disorders, manic episodes, and suicide attempts were excluded at the time of their application through the Internet or at their first interview. These policies were explained and a checklist using DSM 4th was presented on the homepage [11]. At the first interview, if a participant was shown to satisfy these exclusion criteria, the participant was asked to not participate in this study.

At the second interview, the participants' psychiatric states were diagnosed using the Structured Clinical Interview for DSM-IV Axis I disorders, 4th edition and the Global Assessment of Functioning (GAF) [12]. A GAF score of 91-100 means no symptoms, 81-90 means the absence of or only minor symptoms, 71-80 means that symptoms are transient and expected reactions to psychosocial stress, 61-70 means some mild symptoms, and less than 60 means moderate to severe symptoms. People with GAF scores below 60 were excluded from further psychotherapeutic study.

At the third and fourth interviews, the subjects underwent psychological assessments (including the Rorschach test, drawing, Wechsler Intelligence Scale (WAIS-III) [13], and Sentence Completion Test (SCT)). The subjects were presented with a questionnaire (including are resilience scale [14-20], a social desirability scale [21], an assessment of curiosity (This was an original assessment prepared for this research. Participants were asked whether they'd been told that they are curious or whether they believed that they were curious using a 5-point Likert scale.) and the State Trait Anger Expression Inventory (STAXI) [22,23].

2.3 Statistical Analysis

Descriptive statistics are given as mean values with the standard deviation. Statistical analyses were performed by appropriate non-parametric tests (Mann-Whitney test) with SPSS 22.0 for Windows.

2.4 Ethical Considerations

Written informed consent was obtained from the participants prior to the start of the study (at the first interview) and before the psychological assessments. The study protocol was approved in June, October and December 2012 by the Tokyo International University Committee for Research Ethics. The study protocol was carried out in accordance with the Declaration of Research Ethics for Epidemiological Studies by the Ministry of Health, Labour and Welfare of Japan.

3. RESULTS

Of the 67 people who initially volunteered, 22 came to the clinical centre at Tokyo International University. Of these, 16 completed a psychiatric diagnostic interview. Fourteen completed the psychological assessment process. None of the subjects were undergoing psychotherapy or receiving psychiatric medication during the study period.

Table 1 shows the socio-demographic characteristics, psychiatric diagnoses and GAF scores of the 16 subjects included in the study. Nine subjects had an Axis I disorder that could be classified as either life-long prevalence or 12-month prevalence. The subjects were diagnosed as follows: depressive episode group (N=7), manic episode group (N=1), anxiety disorder group (N=7), and eating disorder group (N =2).

Next, we considered the subjects' stated purpose for participating in this study at the first interview.

All subjects are divided into two groups; those who claimed that they had some psychological problems and thus sought psychotherapy, and those who said that they had some other motivation, such as a desire to participate in a clinical trial, to obtain a part-time job, and so on. When a subject's response could have placed them in either group, if they referred to their psychological or psychiatric problems, they were considered to be seeking psychotherapy. Of the total 16 subjects, 9 sought psychotherapy and 7 did not (subjects 1, 6, 9, 10, 12, 13, and 14).

One subject had an extremely low IQ, and their data were excluded from further statistical analyses. Descriptive data indicated that the remaining subjects were highly resilient, had a fair IQ, and functioned well (Table 2).

Table 1. Demographic variables, diagnosis, and experience with receiving medical treatment

ID	Gender	Marital status/ age	Employment	GAF	Diagnosis	Experience with receiving medical treatment
1	Male	Never married/22	Working/student	87	none	none
2	Female	Never married/26	Working/student	65	Depressive episode (lifetime) Dysthymia, Social Phobia, eating disorder	none (had experience with counseling)
3	Female	Married/ cohabitating/67	homemaker	82	none	none
4	Male	Never married/25	none	75	none	none
5	Male	Never married/58	Working/student	68	Social Phobia, Obsessive-compulsive disorder	none
6	Female	Never married/25	Working/student	92	none	none
7	Female	Never married/42	Working/student	68	Depressive episode (12-month)	none (seeking help when she participated)
8	Male	Married/ cohabitating/52	Working/student	55	Depressive episode (lifetime) Dysthymia	none
9	Female	Never married/20	Working/student	85	none	none
10	Male	Never married/28	Working/student	82	none	none
11	Female	Married/ cohabitating/52	Working/student	68	Dysthymia	none
12	Male	Married/ cohabitating/24	Working/student	74	Depressive episode (lifetime)	none
13	Female	Married/ cohabitating/39	homemaker	65	Social Phobia	Several times (over 10 years ago)
14	Female	Married/ cohabitating/63	homemaker	73	none	One time (over 10 years ago)
15	Male	Never married/25	Working/student	49	Hypomanic episode (12-month), Obsessive-Compulsive disorder	Several times (this subject had used a psychiatric service one month before he participated)
16	Male	Married/ cohabitating/49	Working/student	79	Depressive episode (lifetime) Obsessive-Compulsive disorder	None (seeking help when he participated)

Table 2. Descriptive data regarding the scores on all scales

	N	Mean	SD
Age	15	39.33	16.44
Global assessment of functioning (GAF)	15	72.80	11.95
Resilience	13	85.69	16.38
Social desirability	13	26.69	4.42
State Anger	13	14.23	6.57
Trait Anger	13	20.30	4.34
Anger Temperament	13	7.76	2.89
Anger Reaction	13	8.30	1.60
Anger In	13	17.46	4.29
Anger Out	13	14.76	3.81
Anger Control	13	22.84	4.25
Anger Expression	13	25.38	6.83
Curiosity	13	3.23	.725
Verbal Intelligent Quality (VIQ)	14	110.36	10.93
Performance Intelligent Quality (PIQ)	14	104.36	16.41
Full-scale Intelligent Quality (FIQ)	14	108.57	14.10
Verbal Comprehension (VC)	14	111.36	11.72
Perceptual Organization (PO)	14	103.50	16.15
Working Memory (WM)	14	101.14	13.85
Processing Speed (PS)	14	104.57	15.47

Since the sample size is very small, non-parametric statistics were used in this study. A Mann-Whitney test indicated that the score for anger control in females was lower than that in males (U=4.50, P=0.14), and thus male subjects tended to control their anger. This may be associated with the fact that most of the males worked outside the home.

Subjects with a psychiatric diagnosis (N=9) had lower GAF scores than those without a psychiatric diagnosis (N=6) (U=2.00, P=0.02). Subjects who sought psychotherapy (N=8) had significantly lower GAF scores than those who were not seeking psychotherapy (N=7) (U=10.00, P=0.40). In addition, subjects who sought psychotherapy (N=7) had significantly lower Perceptual Organization scores than those who were not seeking psychotherapy (N=7) (U=6.00, P=0.17).

Most subjects who suffered from a psychiatric disorder did not know their diagnosis or disorder before the diagnostic interview and their desire to participate in this study. Even after they learned of their disorder, most subjects did not want to go to a hospital. Subjects who suffered from obsessive compulsive disorder thought that their disorders were not severe enough to warrant going to a hospital.

4. DISCUSSION

Over half of the total subjects who participated in this study on the psychotherapy process satisfied some psychiatric diagnoses. Only the GAF score differed between subjects with and without a psychiatric diagnosis. One subject (No. 15, Table 1) did not know his diagnosis, but had gone to a hospital for the treatment of insomnia one month before he participated in this study. His GAF score was the lowest among all of the subjects. Unless his psychiatric symptoms disturbed his daily life or work, although he may have had some problems, he would not require treatment with psychiatric medications. There were no significant differences in other scales between subjects with and without a diagnosis. The fact that there was almost no difference between the two groups may be considered a characteristic of these subjects with respect to a diagnosis. Even though these subjects had troubles, they were able to maintain their daily lives without medical help, in contrast to a clinical population. Moreover, they could manage their symptoms so as not to disturb their daily lives. The subjects in this study did not know their diagnosis before the diagnostic interview. This may have been an obstacle for them to seek professional psychiatric help. However, the knowledge of a diagnosis does not necessarily mean that a subject will seek professional psychiatric help. Most of the subjects who satisfied a psychiatric diagnosis in this study thought that their symptoms were not severe enough to warrant seeking professional psychiatric help. Especially, subjects who had obsessive compulsive symptoms did not think that they needed to seek professional help because of these symptoms. A study in people suffering from obsessive compulsive disorder showed that there was some tension between their denial of their problems and self-confidence about their ability to control their problems. These people sought help if their symptoms were beyond their ability to control [24].

In France, people who suffered from a psychiatric disorder preferred to consult their GP and preferred psychotherapy to psychopharmacological therapy [25]. In the U. S., many people suffering from a psychiatric illness also consult with clergy [26]. Such a preference for a type of treatment should influence help-seeking and -choosing behavior. There may be some reasons other than demographic

characteristics to explain why subjects who suffer from psychiatric illness do not seek professional psychiatric help. A study examined the prevalence of psychological distress among students, people receiving psychiatric care and people in a counseling center. The psychiatric population had the highest level of distress, followed by people in a counseling center [27]. The results showed that people with mild symptoms do not prefer to consult with psychiatric professionals. These studies means that people who suffered from a psychiatric illness but did not seek help had their own ideas regarding their psychiatric symptoms and the reasons for their onset [28].

It is interesting that people who did not feel that they had any psychological problems wanted to participate in a study on the psychotherapeutic process. It seemed that subjects either with or without psychiatric diagnosis or subjective psychological problems had an internal desire to participate in this study. Since subjects who sought a part-time job were in their early 20's, and thus were likely inexperienced with self-assessment, it is possible that subjects who did not seek psychotherapy were not consciously aware of their psychological problems. It is also possible that some people did not want to admit that they wanted psychotherapy.

The high score on the resilience scale might mean that the subjects became highly resilient because they suffered from a psychiatric illness. Resilience is thought to be effectively utilized when an individual experiences adversity [17]. The results in this study may reflect the characteristics of subjects with this trait. On the other hand, the resilience score might correspond to the subjective cognition regarding psychological problems. If an individual is not consciously aware of their psychological troubles, they may have a high score on the resilience scale. There is a question of whether or not simply asking subjects if they are resilient can actually be used to identify individuals who are resilient [29]. This study suggests that the resilience scale might mistakenly identify individuals with considerable psychological problems. Subjects who did not hope to receive psychotherapy, but who still intended to participate in this study, may be in denial of their psychological problems.

In this study, the GAF score and Perceptual Organization scores of the subjects who sought psychotherapy were significantly lower than those in subjects who did not seek psychotherapy. A lower Perceptual Organization score reflects a tendency for decreased attentiveness, and is associated with many careless mistakes. Since people with this characteristic cannot take an overall view of things, it is difficult for them to speculate or deal with things based on information which they have obtained [13]. The subjects who sought psychotherapy seemed to think that they had psychological and interpersonal problems even though they did not know why or whether they had a psychiatric diagnosis. This awareness of individual problems could have contributed to their seeking psychotherapy. In Japan, information that encouraged mental health literacy, such as information on resources for support, had a greater influence than information on the stigma associated with help-seeking behavior among university students [30]. Such information could be useful for the subjects who truly hoped for psychotherapy.

4.1 Weakness and Strengths

First, the subjects desired to participate in this study. Therefore, the data had to be interpreted with the understanding that there was a sampling bias. Second, since the subjects desired to participate in this study, they may have unintentionally distorted their responses to the questionnaire and interviews. The use of psychotherapy and psychological treatment has recently been spreading in Japan. However, since a license to work as a clinical psychologist cannot be granted by a national examination for various reasons, many people without a license provide psychological treatment. Since this study was supported by Grants-in Aid for Scientific Research, people who hoped to receive psychological treatment were eager to participate. Third, since there were few subjects, it may be difficult to generalize. This kind of a small, non- randomized sample drawn from a vast population will not give valid conclusions. People who suffer from a psychiatric illness in general, but who do not seek help, are heterogeneous [4,7]. This preliminary study reflects some of that heterogeneity. Further studies with a large sample size and a control group will be needed. Finally, since we cannot identify people who can manage their disorders, it is possible that we might not have chosen suitable scales.

Despite its limitations, this study still had some notable findings. The subjects in this study

showed contradicting responses to the evaluations. This showed that people who hoped to receive psychotherapy as part of a research study tended to have mistaken opinions about their psychological problems, regardless of whether or not they were conscious of, and sufficiently intelligent to understand, their psychological problems. Further follow-up studies will be needed for subjects who do not complain about their psychological problems. There are quite a few studies on how to treat these people [31]. The information we gain should help to clarify what kind of information is needed to help these people.

5. CONCLUSION

Regardless of whether or not they had a psychiatric diagnosis and a high score on a resilience scale and were motivated to receive psychotherapy, the subjects intended to participate in a study on the psychotherapeutic process. The presence of a psychiatric diagnosis was independent of a motivation to receive psychotherapy. The subjects who were motivated to receive psychotherapy had lower scores for the Global Assessment of Functioning and Perceptual Organization in the WAIS-III. The result suggested that the subjects in this study were a mix of people who had mistaken opinions about their psychological problems and those who truly hoped to receive psychotherapy. Since little is known about reluctant subjects, further larger studies using diagnostic, quantitative, and qualitative methods will be needed.

ACKNOWLEDGEMENTS

This study was supported by a Grant–in-Aid for JSPS (Japan Society for the Promotion of Science) Fellows.

COMPETING INTERESTS

Author has declared that no competing interests exist.

REFERENCES

1 Kawakami N. Epidemiology of depressive disorder in Japan and the world. Nippon Rinsho. 2007;65:1578-1584. Japanese

2 Tachimori H, Naganuma Y, Koyama T, Koyama A, Kawakami N. The epidemiological study of mental health. 2006; Accessed 10 April 2014. Japanese. Available:http://www.ncnp.go.jp/nimh/keikaku/epi/Reports/Summary20070510.pdf

3 Naganuma Y, Tachimori H, Kawakami N, Takeshima T, Ono Y, Uda H, et al. Twelve-month use of mental health services in four areas in Japan: Findings from the World Mental Health Japan Survey 2002-2003. Psychiatry Clin Neurosci. 2006;60:240-248.

4 Demyttenaere K, Bruffaerts R, Posada-villa J, Kovessv G, Lepine JP, Angermeyer MC, et al. Prevalence, severity and unmet need for treatment of mental disorders in the World Health organization World Mental Health (WMH) Surveys. JAMA. 2004;291:2581-2590.

5 Demyttenaere K, Bonnewyn A, Bruffaerts R, De Graaf R, Haro JM, Alonso J. Comorbid painful physical symptoms and anxiety: Prevalence, work loss, and help seeking. J Affect Dis. 2008;109:264-272.

6 Bruffaerts R, Bonnewyn A, Demyttenaere K. Delays in seeking treatment for mental disorders in Belgian general population. Soc Psychiatry Psychiatr Epidemiol. 2007;42:937-944.

7 Fullana MA, Vilagut G, Rojas-Farreras S, Mataix-Cols D, de Graaf R, Demyttenaere K, et al. Obsessive-compulsive symptom dimensions in the general population: Results from an epidemiological study in six European countries. J Affect Dis. 2010;124:291-299.

8 Alonso J, Codony M, Kovess M, Angermer MC, Katz SJ, Haro JM, et al. Population level of unmet need for mental health care in Europe. Br J Psychiatry. 2007;190:299-306.

9 Hasui C, Sakamoto S, Sugiura T, Kitamura T. Stigmatization of mental illness in Japan: Images and frequency of encounter with mental illness diagnostic categories reported by medical and non-medical university students. J Psychiatry Law. 2000;28:253-266.

10 Hasui C, Sakamoto S, Sugiura T, Tomoda T, Kitamura F, Kitamura T. The negative attitudes towards psychiatric diagnoses-preliminary study of the relationship between stigmatization and media. Seishinshindangaku Zasshi. 1999;10:319-328. Japanese.

11 American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 4th edn. Washington DC: American Psychiatric Association; 1994.

12 First MB, Spitzer RL, Gibbon M, Williams

JNW. Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-IV). Washington DC: American Psychiatric Publishing; 1997.
13 Fujita K, Maekawa H, Dairoku K, Yamanaka K, editors. Nihon ban WAIS-III no Kaishakujirei to RishoKenkyu. Tokyo: Nihon Bunka Kagakusha; 2011. Japanese
14 William R, Beardslee MD. The role of self-understanding in resilient individuals: the development of a perspective. Am J Orthopsychiatry. 1989;59:266-278.
15 Chambers E, Belicki K. Using sleep dysfunction to explore the nature of resilience in adult survivors of childhood abuse or trauma. Child Abuse Negl. 1998;22:753-758.
16 Garmezy N. Children in poverty: Resilience despite risk. Psychiatry. 1993;56:127-136.
17 Masten AS, Best KM, Garmezy N. Resilience and development: Contributions from the study of children who maltreatment on social competence and behavior problems. Dev Psychopathology. 1990;2:425-444.
18 Rutter M. Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. Br J Psychiatry. 1985;147:598-611.
19 Wagnild GM, Young HM. Development and psychometric evaluation of the resilience scale. Journal of Nurs Meas. 1993;1:165-178.
20 Hasui C, Nagata T, Kitamura T. Resilience and guilty feeling: predicting factors of suicidal ideation. Risho Shinrigaku Zasshi. 2008;25:625-635. Japanese.
21 Kitamura T, Suzuki S. The validity and reliability of social desirability scale in Japan. Shakai SeishinIgaku. 1986;9:173-180. Japanese
22 Spielberger CD. State-trait anger inventory. Sampler set. Manual, Text booklet, Scoring key. Mind Garden, Psychological Assessment Resources; 1979.
23 Suzuki T, Haruki Y. The relationship between anger and circulatory disease. Jap J Health Psychology. 1994;7:1-13. Japanese.
24 Belloch A, del Valle G, Morillo C, Carrio C, Cabed E. To seek advice or not to seek advice about the problem: the help-seeking dilemma for obsessive-compulsive disorder. Soc Psychiatry Psychiatr Epidemiol. 2009;44:257-264.
25 Kovess-Masfety V, Saragoussi D, Sevilla-Dedieu C, Cilbert F, Suchocka A, Arveille N, et al. What makes people decide who to turn to when faced with amental health problem? Results from a French survey. BMC Public Health. 2007;7:118.
26 Wang PS, Berglund PA, Kessler RC. Patterns and correlates of contacting clergy for mental disorders in the United States. Health Serv Res. 2003;38:647-673.
27 Mechanic D, Greenley R. The prevalence of psychological distress and help-seeking in a college student population. Soc Psychiatry. 1976;11:1-14.
28 Carta MG, Angermeyer MC, Matschinger H, Holzinger A, Floris F, Moro MF. Perception of depressive symptoms by the Sardinian public: results of a population study. BMC Psychiatry. 2013;13:57.
29 Oshio A. Measurement of resilience: From the perspective of validity. Rinsho-SeishinIgaku. 2012;41:151-156. Japanese.
30 Koike H, Ito Y. Effect of providing information about mental health literacy for intention of seeking psychiatry. Jpn J Counsel Sci. 2012;45:155-164. Japanese.
31 Versaevel C, Samama D, Jeanson R, Lajugie C, Dufeutrel L, Defromont L, et al. Determiner la position du patient envers les soins psychiatriques avec le questionnaire Touriste-Plaignant-Client: un outil simple pour evaluerl' alliace et la motivation. L'Encephale. 2013;39:284-291. French.

Peer-review history:
The peer review history for this paper can be accessed here:
http://www.sciencedomain.org/review-history.php?iid=696&id=12&aid=6418