

Presenting Problems and Treatment Expectations Among Service Users Accessing Psychiatric Outpatient Care: Are There Gender Differences?

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ABSTRACT

Background: Community-based studies have documented gender differences in mental health problems and service utilization. This mixed methods study explored gender differences in severity of emotional distress, referral paths, presenting problems and care expectations among service users upon accessing outpatient psychiatric care.

Methods: Consecutive service users (N=284, 64% women) who presented for a new or repeated episode of care in adult outpatient clinics completed questionnaires on a measure of emotional distress, treatment history and referral path. These variables were quantitatively analyzed. Also, users completed two open-ended questionnaires on reasons for seeking care and expectations from the services. These variables were qualitatively analyzed using thematic analyses.

Results: No significant gender differences emerged on any of the variables examined among new and repeated users. The main reasons for seeking care were psychiatric symptoms as well as non-specific psychopathology. The most frequent expectations from the services were receiving psychotherapy and specific tools to better manage life problems.

Limitations: The sample of new male service users was relatively small.

Conclusions: Once care is initiated, men and women showed similar clinical presentation and care expectations.

INTRODUCTION

While the term “sex” designates a biological trait, “gender” refers to socially constructed attributes and behaviors applied to men and women within a given culture (1). These may differentially affect their health care status and behaviors. For example, epidemiological surveys found higher rates of internalizing disorders among women than men, and conversely for externalizing disorders (2-6). Several explanations were raised to account for these differences that included both biological (e.g., genetic vulnerability, pubertal hormones, pubertal timing and development; 7-9); and psychosocial factors (e.g., emotional reactivity, rumination, cognitive style; 10-12) (for integrative models see 13-16). The “gender role” hypothesis which received considerable support in the literature, proposes that gender differences in emotional distress result from the types of stressors and coping mechanisms to meet them, as well as from opportunity structures for expressing psychological predicaments (2, 17, 18).

Gender differences were also documented in help-seeking behaviors for mental health problems, e.g., women were more likely than men to seek care for mental health problems (e.g., 19-21). Community studies suggest that such a behavior is partly due to their higher likelihood to recognize a mental health problem compared to men (22, 23). The differential expectations associated with gender roles were proposed as a possible explanation for these findings (21). For example, many of the tasks associated with help-seeking for a mental health problem, such as relying on others, admitting need for help, or recognizing and labeling an emotional problem, conflict with the messages men receive about the importance of self-reliance, physical toughness, and emotional control (21, 24, 25).

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Relatively less research examined gender differences in the process of help-seeking. In a study on referral patterns among students and faculty in universities in the U.S., the gender of the source was significantly associated with referrals (i.e., women compared to men were more likely to refer to mental health services) while the gender of the referral recipient was not significant (26).

OBJECTIVES

In this study we investigated gender differences in variables related to the process of help-seeking once individuals traverse the clinic threshold. More specifically, we examined gender differences in 1) socio-demographic (e.g., education), degree of emotional distress and service-related factors (e.g., referral path), and 2) service users' reports of reasons to seek care and expectations from the mental health service.

METHODS

SAMPLE AND PROCEDURE

The sample included Jewish service users (N=284, 64% women), who presented consecutively for a new (N=78, 28%) or repeated (N= 206, 72%) episode of care in four adult public outpatient mental health clinics in two large Israeli cities. All repeated users were in treatment before (32.1% received treatment in the same clinic while 67.9% received treatment in other clinics in the past) and returned for a new episode of care. The study took place between June 2011 and April 2012 and data were collected consecutively in the four clinics (two month in each clinic).

All participating clinics offer free mental health services (including psychotherapy and psychopharmacology) to a diverse adult service user population in the catchment area of the clinic. Access to specialized care does not necessitate medical referral (27). Participants filled out self-administered questionnaires in their native language (Hebrew or Russian), that were handed out by the administrative personnel upon their first contact with the clinic (n=13 declined participation). Completion of measures took approximately 15 minutes.

The study was approved by the Institutional Ethics Committees at Shalvata Mental Health Center, Abarbanel Mental Health Center, and Eitanim – Kfar Shaul Mental Health Center in Israel. Data collection was in compliance with human subject protocols at all participating clinics.

MEASURES

Demographic and treatment-experience questionnaire. The questionnaire included information on: age, gender, years of education, income (below average, average, above average), employment status (employed, unemployed), country of birth, family status (married, single, divorced, widowed), degree of religiosity (secular, traditional, religious). In addition, it included questions about history of mental health treatment, and satisfaction with past treatment. Service-users were also asked about the referral source for the present episode of care. Lastly, participants completed two open-ended questions: (1) "describe in your own words what brought you to the clinic today?" (2) "what do you hope to receive from the clinic that would help you?"

The General Health Questionnaire (GHQ-12) (28). This 12-item scale is a well-documented screening measure for common psychiatric disorders and assesses emotional distress in the last month. It has been used in many countries (29), including Israel (30). Items are rated on a 4-point Likert scale. Final score was computed as the summary for all items, where higher scores indicate increased emotional distress. The overall internal consistency reliability for the scale was high (Cronbach's $\alpha = .88$).

ANALYSIS

Quantitative analysis. Independent samples t-tests and chi-square analyses were performed to identify gender differences in socio-demographic and service-related factors, for continuous and categorical variables, respectively. Analysis was performed using the SPSS version 20.0 (SPSS Inc., Chicago, IL).

Qualitative analysis. The two open questions were qualitatively analyzed based on thematic analysis, using ATLAS.ti version 7 (Scientific Software Development, Berlin). Analyses procedures were conducted by the first two authors following Braun and Clarke's recommendations (31), and comprised of three steps: 1) independent open coding (32); 2) grouping and labeling key categories to organize them into themes; and 3) integration of the information of each theme to draw a coherent representation. Throughout the process, the team met to discuss coding challenges as well as disagreements. When disagreement arose, the team attempted to identify the source of the discrepancy and coded sections which were reviewed again until consensus was reached (32, 33). Lastly, Chi-square tests of independence were performed to identify gender differences in frequencies of the identified thematic cat-

egories. The mean number of words participants included in their answers to the open question about the presenting problem was 18.3 words (SD=14.0) and about expectations from care 10.1 words (SD=9.0).

RESULTS

SOCIO-DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF THE SAMPLE

The majority of the new and repeated service users were secular Israel-born females. Table 1 presents their characteristics. There were significant gender differences among repeated service users in years of formal education (men: $M=12.2$ $SD=3.10$ women: $M=13.5$ $SD=3.4$; $t=-2.51$, $p=.01$) and family status (significantly more men were single, 53% compared with women 34.7%; $\chi^2=6.87$, $p=.03$)

Men and women who were either new or repeat users reported similar mean level of emotional distress upon accessing services. The majority of all users reported being referred

by a family/friend/neighbor or other mental health providers. Among returning service users, women compared to men reported lower utilization of psychotropic medications in the past (68.1%, 84% respectively; $\chi^2=6.4$, $p=.01$) and lower satisfaction with past treatment ($M=2.6$ $SD=1.2$, $M=3.0$ $SD=1.4$, respectively; $t=2.06$, $p=.04$). There were no significant gender differences in referral paths and other clinical variables among new and repeated service users (Table 2).

REASONS FOR SEEKING CARE AND EXPECTATIONS FROM THE MENTAL HEALTH SERVICE

Table 3 presents the main reasons for seeking care and expectations for mental health services. The most common reported reason to seek care included specific psychiatric symptoms or disorders (e.g., suicidal thoughts or previous attempts) and recent stressors (e.g., car accident) (repeated users: men: 34.7% women: 31.4%; $\chi^2=0.23$ n.s.; new users: men: 30% women: 26.4%; $\chi^2=0.09$ n.s.); and non-specific psychopathology such as general emotional distress (repeated users:

Table 1. Socio-demographic characteristics of new and repeated service users by gender (N=284)

	Repeated service users (n=206)								New service users (n=78)							
	Men (n=82)		Women (n=124)		Statistic	P	Men (n=20)		Women (n=58)		Statistic	P				
	N	%	N	%			N	%	N	%						
Age (years); mean (SD)	82	38.2 (14.7)	124	41.2 (15.8)	$t=-1.42$	n.s.	20	39.2 (13.0)	58	42.9 (16.2)	$t=0.92$	n.s.				
Country of birth																
Israel	63	77.8%	81	66.9%	$\chi^2=2.78$	n.s.	17	85%	39	70.9%	$\chi^2=1.54$	n.s.				
Other	18	22.2%	40	33.1%			3	15%	16	29.1%						
Employment																
Yes	33	40.7%	50	41%	$\chi^2=0.00$	n.s.	13	68.4%	29	50%	$\chi^2=1.96$	n.s.				
No	48	59.3%	72	59%			6	31.6%	29	50%						
Family status																
Married	18	21.9%	38	30.6%	$\chi^2=6.87$	$p=.03$	9	45%	23	39.7%	$\chi^2=2.05$	n.s.				
Single	44	53.7%	43	34.7%			8	40%	17	29.3%						
Separated/ Divorced	20	24.4%	43	34.7%			3	15%	18	31%						
Religiosity																
Secular	34	43.6%	51	44%	$\chi^2=0.74$	n.s.	5	25%	15	27.3%	$\chi^2=0.12$	n.s.				
Traditional	22	28.2%	38	32.8%			8	40%	23	41.8%						
Religious	22	28.2%	27	23.2%			7	35%	17	30.9%						
Formal education: mean (years) (SD)	76	12.2 (3.1)	117	13.5 (3.4)	$t=-2.51$	$p=.01$	19	12.6 (2.5)	53	12.9 (2.5)	$t=-0.55$	n.s.				
Income																
Much below average	41	51.9%	53	48.6%	$\chi^2=2.23$	n.s.	5	27.8%	22	44.9%	$\chi^2=2.12$	n.s.				
Below average	12	15.2%	25	22.9%			2	11.1%	6	12.2%						
Average	14	17.7%	14	12.8%			7	38.9%	15	30.6%						
Above average	12	15.2%	17	15.6%			4	22.2%	6	12.2%						

Table 2. Emotional distress, referral path and history of mental health treatment among new and repeated service users by gender (N=284)

		Repeated service users						New service users					
		Men		Women		Statistic	P	Men		Women		Statistic	P
		N		N				N		N			
Emotional distress;	mean (SD)	81	30.5 (9.0)	121	31.0 (7.5)	t=-0.48	n.s.	20	30.7 (6.9)	56	28.2 (7.2)	t=1.35	n.s.
Referral path													
Family/friend/neighbor		20	25%	39	32%	$\chi^2=4.78$	n.s.	7	35%	22	39.3%	$\chi^2=3.28$	n.s.
Rabbi		1	1.2%	0	0%			1	5%	2	3.6%		
Police/judge		0	0%	2	1.6%			0	0%	1	1.8%		
Medical doctors		15	18.8%	23	18.9%			4	20%	12	21.4%		
Mental health providers		31	38.8%	37	30.3%			4	20%	10	17.9%		
Self		8	10%	14	11.5%			2	10%	8	14.3%		
Other		5	6.2%	7	5.7%			2	10%	1	1.8%		
Past treatment satisfaction;	mean (SD)	80	3.0 (1.4)	118	2.6 (1.2)	t=2.06	p=.04						
Past psychotropic medication use													
Yes		68	84%	81	68.1%	$\chi^2=6.40$	p=.01						
No		13	16%	38	31.9%								

men: 34.7% women: 31.4%; $\chi^2= 0.23$ n.s.; new users: men: 50% women: 26.4%; $\chi^2= 3.66$ n.s). Other reasons for coming for care included interpersonal and work- related problems, distress related to physical illness, help with eligibility for social security benefits and following referral from primary care doctor or other professionals. There were no significant gender differences in any of the categories of reasons for seeking care among both new and repeated users (Table 3).

The most frequently reported expectations from the mental health services among men and women were receiving psychotherapy (repeated users: men: 35.3% women: 37.5%; $\chi^2= 0.09$ n.s.; new users: men: 29.4% women: 23.9%; $\chi^2= 0.2$ n.s) and specific tools to manage life problems (repeated users: men: 32.4% women: 31.2%; $\chi^2= 0.02$ n.s.; new users: men: 52.9% women: 50%; $\chi^2= 0.04$ n.s). Other expectations included receiving psychotropic medications, general support, and help regarding eligibility for social security benefits. There were no significant gender differences in any of the categories of expectations from the services among both new and repeated users (Table 3).

DISCUSSION

In this study we explored gender differences with regard to selected clinical and service-related variables as well as expectations from the service among a consecutive sample of new and repeated service users upon accessing specialized care. In contrast to gender differences in

service utilization patterns found in most community studies (3, 34), our findings based on the quantitative study component, suggest that once care was initiated significant gender differences are no longer present with regard to 1) socio-demographic variables associated with access to care (e.g., employment, religiosity), 2) referral pathways, and 3) degree of emotional distress.

The single difference we found referred to satisfaction with previous treatment; men more often than women reported higher satisfaction from past treatment. Patient satisfaction is an important measure of service-users' experiences with the health care system. It is also recognized as a measure of effectiveness of provider-patient communication and quality of care (35). In addition, patient satisfaction is associated with better compliance with medical advice (36). Other research, mostly from general health fields, has shown that more women compared to men change doctors due to dissatisfaction (37). Women and men may have different expectations about the course and process of care, which may affect their satisfaction with services (38). For example, studies have shown that women place a higher value on time and explanations from their doctors compared to men (39). Other research suggests that factors such as general quality of life that is not directly under the control of professionals may influence an individual's satisfaction with the mental health care (40).

Congruent with previous research, our findings show that most often men and women that start care are referred

Table 3. Thematic analysis of self-reported reasons to seek care and expectations from mental health services by gender among new and repeated service users upon accessing specialized care (N=284)

Description of thematic categories	Repeated service users			New service users			Verbatim examples
	Men N (%)	Women N (%)	Statistic	Men N (%)	Women N (%)	Statistic	
Reasons to seek care							
Specific psychiatric symptoms/disorders* and recent stressors	25 (34.7)	46 (39)	$\chi^2(1)=0.35$ n.s.	6 (30)	14 (26.4)	$\chi^2(1)=0.09$ n.s.	"I had panic attacks last week, low energy to do things, fatigue, difficulty sleeping" (1001)
Non-specific psychopathology	25 (34.7)	37 (31.4)	$\chi^2(1)=0.23$ n.s.	10 (50)	14 (26.4)	$\chi^2(1)=3.66$ n.s.	"I need help, my soul aches, I feel bad in life" (1006)
Interpersonal difficulties	8 (11.1)	21 (17.8)	$\chi^2(1)=1.55$ n.s.	6 (30)	21 (39.6)	$\chi^2(1)=0.58$ n.s.	"Two weeks after the birth of my oldest son I discovered that my husband is addicted to sex. It has been six months since then, and I am afraid to take the move of divorcing him, and on the other hand I have a lot of anger toward him, I cry a lot, and sometimes feel I hate him and other time pity on him" (1020)
Work-related problems	6 (8.3)	14 (11.9)	$\chi^2(1)=0.59$ n.s.	5 (25)	5 (9.4)	$\chi^2(1)=2.98$ n.s.	"I'm in a crisis as a result of being laid off from work" (1024)
Distress related to physical illness	3 (4.2)	4 (3.4)	$\chi^2(1)=0.08$ n.s.	2 (10)	4 (7.5)	$\chi^2(1)=0.12$ n.s.	"I have many fears and worries about my medical problems, my blood pressure, diabetes and other physical problems" (1074)
Social security eligibility	2 (2.8)	2 (1.7)	$\chi^2(1)=0.25$ n.s.				"Social security office referred me here for the evaluation process to determine my disability" (1002)
Referral (from primary care doctor or other professionals)	13 (18.1)	16 (13.6)	$\chi^2(1)=0.70$ n.s.	2 (10)	2 (3.8)	$\chi^2(1)=1.09$ n.s.	"My primary care doctor referred me" (2025)
Expectations from services provided at the psychiatric clinic							
Psychotherapy and group therapy	24 (35.3)	42 (37.5)	$\chi^2(1)=0.09$ n.s.	5 (29.4)	11 (23.9)	$\chi^2(1)=0.20$ n.s.	"Psychotherapy twice a week to help me get back to myself" (2078)
Specific tools to manage life problems	22 (32.4)	35 (31.2)	$\chi^2(1)=0.02$ n.s.	9 (52.9)	23 (50)	$\chi^2(1)=0.04$ n.s.	"Get guidance and tools to manage better with the kids and improve my self-esteem" (1068)
Medications	19 (27.9)	20 (17.9)	$\chi^2(1)=2.54$ n.s.	1 (5.9)	1 (2.2)	$\chi^2(1)=0.56$ n.s.	"To be balanced again with my medications" (2051)
Support/ talk to someone	6 (8.8)	19 (17)	$\chi^2(1)=2.35$ n.s.	2 (11.8)	9 (19.6)	$\chi^2(1)=0.52$ n.s.	"Get help, support, talking with someone who will listen to my problems" (1090)
Help receiving social benefits	3 (4.4)	5 (4.5)	$\chi^2(1)=0.00$ n.s.	---	3 (6.5)	$\chi^2(1)=1.16$ n.s.	"Help with approving my disability and receive social benefits" (1069)
Don't know/general help	1 (1.5)	4 (3.6)	$\chi^2(1)=0.69$ n.s.	---	2 (4.3)	$\chi^2(1)=0.76$ n.s.	"I don't know what they offer so I don't know what to expect" (2113)
Diagnostic assessment	3 (4.4)	1 (0.9)	$\chi^2(1)=2.41$ n.s.	---	1 (2.2)	$\chi^2(1)=0.38$ n.s.	"Someone who can help tell me if I have ADHD" (3005)

*Specific self-reported psychiatric symptoms/disorders included: suicidality (including thoughts plans or previous attempts; men=3.3%, women=5.8%); OCD (men=3.3%, women=2.3%); depression (men=15.2%, women=12.9%); anxiety (men=1.1%, women=3.5%); ADHD (men=0%, women=0.6%); trauma (men=2.2%, women=5.8%); substance use (men=0%, women=0.6%) and eating disorders (men=0%, women=1.2%).

by a friend, relative or other confidant (41). Our findings support other research that found little evidence for gender bias with regard to the referral recipient (i.e., the gender of alleged service user did not affect the likelihood of referral to services) as a possible explanation to women's higher utilization of services (20).

The results from the qualitative analyses in the study showed that approximately only a third of service users

among both men and women reported accessing care for specific psychiatric symptoms or disorders and/or following a recent stressful event. The remaining users reported coming to care for a more general sense of emotional distress and/or interpersonal and work related problems. These findings are congruent with other research documenting that approximately two-thirds of patients presenting for psychotherapy report significant

personality problems or interpersonal difficulty which are not always diagnosable under current psychiatric classification systems (42). Our findings expand on this research to show that both men and women approach mental health services with either presenting general-nonspecific problem, or with a wider range of problems related to their social and interpersonal functioning.

Our findings suggest that no significant gender differences emerged on any of the presenting problems and expectations from care among new and repeated service users. These findings diverge from studies conducted in the community, and from predictions made by the gender role theory. These predictions suggest that gender differences in emotional distress are due to the types of stressors and opportunity structures for expressing psychological distress that differ for men and women (2, 17). Although it is plausible that the relatively low sample size of new male service users precluded the power to detect differences that may exist, our findings may support the notion that gender role orientations are socially constructed (15, 18, 21) and as such may present within person and across situation variability (i.e., some men/women under some conditions, will seek help for some problems but not for others). Therefore, among those persons who seek care, within gender variability may overshadow possible differences between men and women that are more visible among community respondents.

The study has several limitations. First, although we included a consecutive client sample in the current naturalistic study, the relatively high percentage of repeated users may have resulted in a conservative estimation of the gender differences in the outcome variables. It is plausible that among new users this association would be different. In addition, it is plausible that examining referral paths and expectations from care among repeated users reflects in part actual previous experiences with the care system. Future studies that include only novel clients may shed light on these questions. Second, although the study was conducted in four public mental health clinics the findings may not generalize to all clinics. Future replication studies are needed. Third, although we collected information on emotional distress, it is possible that the diagnoses of the users who were not included in the current study may affect the relationship between gender and service utilization patterns. Finally, although we attempted to present the richness of themes that emerged from the qualitative data, the number of participants in some of the themes is small and may have precluded statistical strength to detect gender differences when they may

have existed. Future studies should include additional qualitative sources of data such as in depth interviews.

Our findings suggest that gender is a critical determinant of mental health (3), including for help-seeking behaviors that can partly affect the probability of accessing care. As in other community studies, in our consecutive sample more women compared to men turned to care (22, 43). However, among those who do seek care the presenting problems and care expectations are generally similar between men and women. Clinicians, thus, should be wary of gender bias, insofar as treating gender roles as stable, internal, trait-like constructs (25), rather than being sensitive to within gender and situational variability among those seeking help.

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