



MSc in Clinical Psychology

Impact of mental illness diagnosis on the course of mental health treatment: Thematic analysis of service users' experience

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This thesis, and all my academic achievements and endeavors, are dedicated to
the loving memory of my father
Sæmundur Hafsteinsson (1954-2010)

Forewords and acknowledgements

This thesis, presented as an article for publication in a peer-reviewed journal, is submitted in partial fulfilment of requirements for the MSc degree in Clinical Psychology at Reykjavik University. The study presented here is the culmination of work over three semesters. In the first one, a thorough literature review was written, containing detailed theoretical background. During the second semester, a formal application was prepared and submitted to the clinical ethics committee of Landspítali for permission to conduct this study and sample data through medical records. Furthermore, the method was outlined in detail and written as a chapter for the thesis. The third semester involved data collection, analysis and writing.

This is a qualitative study that aimed to analyze the impact of a mental diagnosis on the process of mental healthcare service. It is conducted at the psychiatric outpatient unit of Landspítali as part of a larger research project. The other part is a quantitative study that analyzed service processes at the outpatient unit, irrespective of diagnosis, through the documentation in medical records of 193 patients all of whom had received a new diagnosis between 2010 and 2012. For this study, a total of 11 people who were diagnosed with depression or anxiety were interviewed and responses processed with a thematic framework analysis. The main purpose was twofold. Firstly, to gain understanding of how the process of seeking care is experienced by service users and secondly, to analyze their personal experience of being diagnosed. In terms of methodology, by focusing on the perspective of the service users themselves, a new point of view is provided. This kind of study has never been conducted in Iceland before, making it a valuable contribution to the existing body of knowledge of the quality of secondary mental healthcare in Iceland. Additionally, this study was conducted as a part of the doctoral project of my principal supervisor, Magnús Blöndahl Sighvatsson. One of his advisors, professor Jón Friðrik Sigurðsson, also served as a

supervisor for this thesis. The present study will be submitted to a peer-reviewed journal and Magnús and Jón will be co-authors of the article.

I would like to take this opportunity to express my gratitude to my supervisors. To Magnús for his availability, his skilled and constructive guidance and to professor Jón Friðrik for his insightful supervision and for repeatedly, during the past two years, taking the time to listen and help me to keep things in perspective at times when I dropped the ball and the weight of my studies and the distance from my family really took a toll. I was received with not only sincere understanding but also encouragement, one memorably summed up in the question “you’re not quitting, are you?” Working under the guidance of my two supervisors has been a privilege. I’m inspired by their exceptional scientific knowledge, devotion and human qualities. Having been their student, I feel extremely lucky.

Heartfelt thanks go out to my classmates for solidarity and unity from day one and for their ever lasting sources of refreshing (and often much needed) sense of humor. In particular, I thank Inga Guðlaug Helgadóttir, my research partner, for a fantastic collaboration.

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Abstract

The objective of this study was to analyze how a diagnosis of depression and/or anxiety impacts the course of mental healthcare at the outpatient unit of Landspítali-The National University Hospital of Iceland. The aim was twofold. Firstly, to gain understanding of how service users experienced various aspects of the assessment process and the course of treatment and secondly, their personal experience of getting a diagnosis in terms of attitude, emotional reaction and behavior. Data was collected through medical records and audio recorded, semi-structured interviews were conducted with 11 participants individually, all of whom had been diagnosed with anxiety or depression (or co-occurrence of both) between 2010 and 2012. Responses were investigated by applying an in-depth thematic framework analysis to the interview transcripts. In total, 26 themes were identified, including four main themes, seven overarching sub-themes and 15 sub-themes, all presented in a descriptive framework. A particularly pervasive theme was *postponement of seeking care* and among other important themes in service users' experience were *barriers*, *stigma* and *validation*. Lastly, clinical implications of the results are discussed.

Key words: Thematic framework analysis, mental healthcare, depression, anxiety

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Depression and anxiety are among the most prevalent psychiatric disorders. They are known to cause substantial levels of distress and impairment in the general population, burdening not only the patients themselves but also their families and ultimately society at large (Kristjánsdóttir, 2007; Wittchen and Jacobi, 2005). In Iceland, access to specialized mental healthcare and dissemination of evidence-based treatment has been questioned and criticized (Agnarsdóttir and Halldórsdóttir, 2004; Sighvatsson, Kristjánsdóttir, Sigurðsson and Sigurðsson, 2011). Research has shown that detection of depression and anxiety remains significantly low with many patients not receiving any care (Locke and Kamo, 2016). Moreover, only 1/3 of treatment that is provided meets minimal standards of adequacy according to evidence-based treatment guidelines meaning that many patients in routine clinical care are not receiving empirically supported services (Kessler, Demler, Frank, Olfson, Pincus and Walters, 2005; Kristjánsdóttir, 2007). Cognitive behavioral therapy (CBT) and anti-depressive medications are strongly advocated as the treatment of anxiety and depression according to research, but only one of them, i.e., medication is made readily available to people (Sighvatsson et al., 2011; Shafran, Clark, Fairburn, Arntz, Barlow, Ehlers, ... and Wilson, 2009; Sigurðsson, Ólafsdóttir and Gottfreðsson, 2009). Furthermore, a lot of research has been dedicated to treatment but unfortunately the research field has somewhat overlooked the clinical area of diagnosis (APA, 2006; Rogers, Agius and Zaman, 2012).

The main objective of all treatment interventions should be ensuring effective care but when resources are limited and waiting lists are long it is also expected that healthcare should be efficient from an economical standpoint. In the outpatient unit at Landspítali and in general, psychologists and other healthcare professionals face financial restrictions that ought to be addressed here as they heavily impact possibilities and policies. Expanding care and

improving aspects such as early detection, assessment accuracy and treatment initiation is shaped by emphasis on minimizing cost in every possible way. Therefore, pressure to control healthcare costs has inevitably resulted in increased restrictions on the care that's provided (Sigurðsson, 2010). This is the challenging reality of the outpatient unit, a challenge that has remained constant for many years (Agnarsdóttir and Halldórsdóttir, 2004; Kristjánsdóttir, 2007). One solution to optimize that the best possible evidence-based care is provided, while still maintaining the least possible amount of risk and cost, is to make professionals utilize official clinical guidelines. Those would be a set of instructions meant to aid healthcare professionals in conducting diagnosis and in treatment planning (e.g., Agnarsdóttir, Eypórsdóttir, Einarsson, Daníelsdóttir, Kristjánsdóttir, Sverrisdóttir, Tyrfingsson, Jónsdóttir, Heiðarsdóttir, Sigurðsson, Ársælsdóttir, Ólafsdóttir, 2011). To what extent these guidelines are followed in patient assessment process remains unknown. This is especially worrisome and leads to the first of the two main topics of this study, the question as to how the process of seeking mental healthcare at the outpatient unit is experienced by service users. In other words, how is the process described and explained by patients battling the aforementioned disorders?

Depression and anxiety

Lifetime prevalence of anxiety disorders in Iceland is estimated to be around 14-15% and any mood disorder i.e. depression, around 13% (Stefánsson and Línadal, 2009; Kristjánsdóttir, 2007) and this prevalence is parallel to results of studies elsewhere (Tyrer, 2014).

In this study, the classification and definition of depression and anxiety is built on ICD-10 which is a leading classification system, containing globally accepted diagnostic guidelines both in clinical practice and research (Tyrer, 2014), and its official manual is used as an assessment and treatment guide in Iceland. By definition, depression is a broad and

heterogeneous mood disorder in which the predominant feelings are of sadness, depressed mood and/or loss of pleasure in most activities. These symptoms can take a variety of forms and are typically accompanied by a change in the overall level of function and activity (NICE, 2009; NICE, 2016; Stefánsson and Línadal, 2009). Out of the prevalence of mental disorders in Europe, anxiety disorders are estimated to be the most prevalent (Wittchen, 2002). The three most common anxiety disorders are generalized anxiety disorder (GAD), panic disorder and social anxiety disorder (SAD) (Kroenke et al. 2007).

Anxiety is one of the most frequently seen mental disorders, both in primary and secondary care (Ansseau et al., 2004; Ormel, VonKorff, Ustun, Pini, Korten and Oldehinkel, 1994) yet, it has received less attention than depression (Kroenke et al., 2007). What we do know however is that depression and anxiety, untreated or undetected, have major implications for general function and well-being (Guðmundsson, Gíslason, Janson, Lindberg, Ulrik, Brøndum and Bakke, 2006). Not only is it associated with poor quality of life but it leads to increased disability and significantly increased social cost (Kristjánsdóttir, 2007; Maurer, Rebbapragada, Borson, Goldstein, Kunik, Yohannes and Hanania, 2008; Wittchen, 2002). Interestingly, research on disability due to mental disorders in Iceland suggest that the prevalence of anxiety has been rising and is in excess of what is to be expected from the prevalence of mental disorders in general (Thorlaciús and Stefánsson, 2004) This needs to be addressed by improving early detection rates and ensuring that diagnosis and treatment reaches patients before a disorder becomes severe. Improving detection rates and assessment accuracy serves to increase the proportion of patients receiving adequate and specialized care and thereby reduce the cost and burden of mental disorders and improving general public health (Thorlaciús and Stefánsson, 2004; Katon, Roy-Byrne, Russo and Cowley, 2002). This makes the course of treatment in healthcare especially interesting and important to investigate, particularly possible obstacles to psychological treatment.

This brings us to the second main topic of this study, to explore the patient's personal experience of getting a mental diagnosis. Research findings suggest that prejudice and discrimination continue to complicate people's lives even as treatment improves their symptoms and functioning. Rejection due to psychiatric status and being exposed to devaluation is a common experience that undermines patients' mental health. For example, in some places, official policies marginalize people with mental disorders. This is referred to as structural discrimination, making participation in one's society more difficult and undermining in terms of personal value (Erickson, 2006; Wahl, 2012). It has also been widely hypothesized that prejudice and discrimination experience is a major factor that hinders people in seeking care (Brohan Elgie, Sartorius and Thornicroft, 2010). Below, conceptualization of stigma and other possible treatment barriers, such as prejudice and discrimination, is outlined.

Barriers to service use

One well known obstacle to seeking care is the perception of stigma which is defined as a feeling of being marked by a label that sets a person apart from others and links the marked person to undesirable characteristics. That can ultimately impact people's behavior, leading them typically to withdrawal themselves socially which often results in isolation. (Link, Sturueing, Rahav, Pehelan and Nuttbrock, 1997).

Depression and anxiety have had an increasing public interest in recent years and yet still seem to remain associated with negative stereotypes such as laziness, dangerousness, unreliability, unreasonable thinking, less intelligence and lack of self-control (Cox, Abramson, Devine, and Hollon 2012; Link et al., 1997). What makes this so important in terms of psychological care is that stigmatization is a dimension of suffering added to the illness experience and has been found to lead to social isolation, limited life chances and delayed help-seeking behavior (Brohan et al., 2010). However, to our current knowledge this

topic is almost entirely in form of attitude surveys and thus of limited value which makes it important to investigate from a patient's standpoint, analyzing the experiences of those who utilize the service (Schulze and Angermeyer, 2003).

Summing this up, there is a clear connection between the experience of stigma and well-being and the effect is relatively strong and enduring (Link et al., 1997; Schulze and Angermeyer, 2003). Furthermore, previous research has in general been drawing on theories and concepts that are uninformed by the lived experience of the group under study. It is important to take account of the perspective of those living the illnesses and receiving the care (Corney, 1990; Schulze. and Angermeyer, 2003). Involvement of patients is essential and imperative if attempts to combat stigma or improve quality of care are to be successful.

Summary and goal of research

The aim of this study was to explore the course of healthcare at the outpatient unit, following a depression and/or anxiety diagnosis, from the standpoint of service users. On one hand, how they experienced various aspects of the assessment process and the course of treatment. On the other hand, what was their personal experience of getting a diagnosis in terms of attitude, emotional reaction and behavior? These research questions stem from assumptions about well known treatment barriers that can weaken people's motivation to seek specialized psychiatric care as well as from the evident need to enhance treatment initiation, quality of assessment, early detection and dissemination of evidence-based care for people with depression and anxiety, a group that has remained underserved by the healthcare system.

Method

Sample

This is a qualitative study that was conducted alongside a quantitative research that analyzed service processes at the outpatient unit through the documentation in medical records of 193 patients. All of them had received a new diagnosis at the outpatient unit

between 2010 and 2012. The present study builds on this sample, classifying by disorders. Namely, those who had been diagnosed with the following: 1) major depressive disorder, current and/or recurrent (F-32.0-32.9); 2) An anxiety disorder from the anxiety section in ICD-10 (F-41.0-41.9); 3) Co-occurrence of two disorders or more. A total of 11 people participated in this study. The group consisted of seven women and four men within the age range of 27-58 years, all residing in the capital district. One participant was married, three were in a relationship and seven divorced or separated.

Instruments

Interview - A semi-structured interview was designed for the purpose of the study. In total, the interview consists of 29 open-ended questions. The former half is about how the service at the outpatient unit was experienced including questions about the process of seeking care (antecedents and aftermath), the assessment process and attitude towards treatment resources. The latter half is about the experience of being diagnosed including questions about the perception of stigmatization, prejudice and discrimination. In sum, the interviewer encouraged narrative accounts about a variety of components with the intention to elicit contextualized information and perceptions from the participants.

The Perceived Devaluation and Discrimination Scale (PDD) is a 12-item unidimensional scale which assesses the extent to which a person believes that most people will devalue or discriminate against those who are known to have a mental illness..This scale has been widely used and has excellent psychometric properties (Brohan et al., 2010).

Internal Stigma of Mental Illness 9 (ISMI-9) is a nine-item scale that assesses mental health service user's experience of internalized stigma. The scale is a unidimensional instrument, reflecting a numerical quantification of stigma which refers to the overall degree to which a person experiences the five themes of the construct: alienation, stereotype

endorsement, perceived discrimination, social withdrawal, and stigma resistance. Hammer and Toland (2017) found that this scale has sufficient psychometric properties.

Procedure

The application to conduct this study was approved in January 2018 by the Clinical ethics committee of Landspítali (referral number: 56/2017). Subsequently, data was collected from medical records and 17 people in total were chosen by convenience and invited to participate. First they were contacted by a letter in which they were presented with the characteristics and goals of the study. Then, by telephone, they were contacted again and invited to participate. If they accepted participation, a time was booked for the interview, which had priorly been pilot studied with three people. The interviews were conducted in February and March of 2018 with each interview lasting between 45 and 75 minutes. Every interview started with a brief summary of previously stated study objectives. All participants received promotional letter about the study and were asked to sign an informed consent. They were then given the opportunity to ask questions and informed that they could decline or cancel participation without any conditions at any time. The interviewer encouraged participants to elaborate their answers and used prompts if answers were incomplete. When data had been collected, audio recordings of the interviews were transcribed verbatim and the transcripts systematically analyzed according to study design, described below.

Analysis and research design

Thematic framework analysis (TFA) was used to process and analyze the interview transcriptions aiming to develop a coding framework by identifying and combining themes emerging from the data. TFA is a systematic and flexible approach to analyzing and processing qualitative data in health research (Braun and Clarke, 2006). It is about detecting themes in responses and identify commonalities and differences in the data to draw descriptive and explanatory conclusions clustered around themes (Gale, Heath, Cameron,

Rashid and Redwood, 2013). By using this research design, a more comprehensive information and deeper understanding is gained that wouldn't be accessible using a traditional group design (Davidson and Fosgerau, 2014).

The systematic assessment, according to the TFA protocol and guidelines, is executed in seven steps: (1) Transcription is made of the audio recording of each interview by writing the transcript of the conversation, verbatim. (2) Gain familiarization with the interview by listening and reading repeatedly and carefully to participant's responses. (3) Coding all responses, which means finding similarities and differences between participants and identify patterns with a matching or appropriate code. (4) Developing a working analytical framework, creating a classification or orderly representation of the coding results. (5) Applying the analytical framework by calculating the results of the coding with the usage of specific software. (6) Data is represented graphically by charting the data into the framework matrix. This means a clear presentation of the main characteristics and findings. (7) Interpreting the findings by summarizing what the data reveal and describing the conclusions and discussing the assumptions and suggestions that can be drawn from the results (Gale et al., 2013).

Results

Thematic analysis

All themes emerging from the thematic framework analysis are presented visually in a thematic map shown in Fig. 1. Twenty six themes emerged from the thematic analysis. Four main themes are presented in grey boxes and capital letters; *motives for seeking specialized care*, *postponement*, *confidence in treatment options* and *overall experience*. The 22 sub-themes are divided into seven overarching sub-themes (grey boxes) and 15 sub-themes (white boxes). In the following sections, these themes are described in details with specific examples from the transcripts.

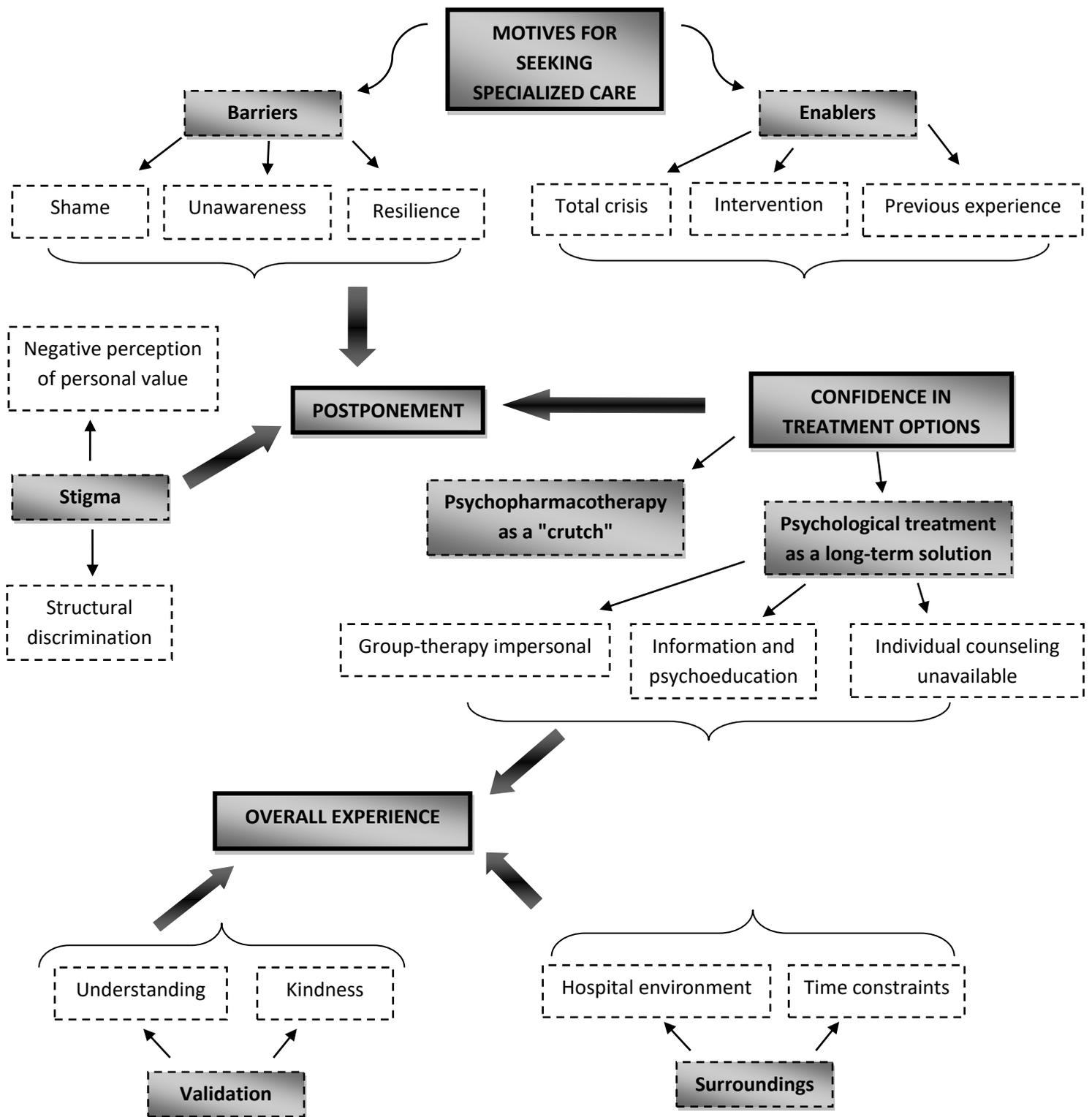


Figure 1. Thematic map of service users' experience at the outpatient unit. The main themes and the overarching sub-themes are represented in gray colored boxes and arrows link each of them to descriptive sub-themes.

Motives for seeking specialized care

People's initiative and reason for seeking help was investigated through a discussion about how participants came into contact with the outpatient unit and how much time had passed since the problem was evident until help was sought. Two overarching sub-themes emerged, *enablers* and *barriers* that either drive or hinder people to seek specialized care.

Enablers. This overarching sub-theme refers to the motive and drive behind a person taking the step of seeking care. The three enabling sub-themes are, firstly *Total crisis* manifesting in responses such as „*I was at point of a total meltdown and was at the end of my tether*“ (participant 1) and „*I had reached the bottom and didn't see any way out*“ (participant 9). Secondly, *Intervention* meaning that participants usually didn't take initiative themselves to seeking care, others intervened. „*It was my sister who pulled up her sleeves and helped me to get there*“ (participant 7) and „*I was tricked into going, actually*“ (participant 11). Thirdly, *Previous experience* referring entirely to those who sought help on their own, saying for example „*Because I had been down that road before*“ (participant 4) and „*The second time around, when I starting feeling like this again, I just got dressed, packed my bag and made the phone call [...] I just felt like I was losing my mind*“ (participant 9).

Barriers, the overarching sub-theme, referring to obstacles to seeking care. The three defining sub-themes for barriers were firstly, *Shame*. Many described having been hesitant, ashamed or apologetic about seeking specialized mental healthcare, for example „*First of all it's the shame [...] this intense shame that somehow is always linked with mental illnesses. That's my notion at least*“ (participant 8). Secondly, *Unawareness*, meaning lack of mental health literacy, not recognizing that their symptoms call for specialized care, for instance „*I had no idea that my thoughts and feelings were due to a disorder, I just thought this was life, I had always been this way*“ (participant 4) or not knowing where to turn to for help. Thirdly, *Resilience* or the attitude of perseverance and willingness to cope. This was a particularly

dominant theme, described by most participants in one way or another. For example, *“I have a tendency to keep driving, even on an empty tank [...] and continue until it's impossible to carry on. This has happened repeatedly”* (participant 1) and *“I was raised the way that you solve your problems on your own and you don't burden others with them”* (participant 5).

Postponement

According to responses, people often find themselves in a loop of delaying help-seeking. This tendency to postpone is largely explained by barriers, lack of confidence in treatment and by stigma. The time that had passed since participants first felt that there was something wrong until help was sought was typically several months but for others it took years. Three participants talked about decades (20 years), two mentioned five and twelve years, four participants talked about a few months and two said it took less than a week. Some described not having confidence in the treatment resources and therefore ignored the outpatient unit as an option. One participant said *„I didn't really want to go because I was afraid of this whole system. My experience when I was a teenagers just wasn't good, mainly because of the medicine I was given, I was just scared“* (participant 10). Additionally, the overarching sub-theme of *Resilience* seemed to explain postponement in part. One participant explained this by saying *“It's hard to admit you have a problem you can't handle. Because you always want to take care of yourself and be able to pull your own weight”* (participant 6).

In terms of postponement, participants were also burdened by the overarching sub-theme of *Stigma*. One participant discussed in this context how she felt in the waiting room at the outpatient unit. She reacted emotionally just to being seen in there. She said *“The waiting room at the outpatient unit is a window covered room right next to a parking lot and anybody entering the building passes the waiting room. You're exposed in a way and to be sitting in a waiting room of a psychiatric unit is a lot to take in”* (participant 7).

Both sub-themes of *Stigma* were manifested in the data, seemingly impacting postponement tendencies. Firstly, *Negative perception of personal value*, which was manifested in prejudice felt strongly by participants towards themselves. Two described this by saying “*you are your own worst enemy*” (participants 5 and 8). Furthermore, a lot of prejudice was experienced at home or in the closest social circle. “*Very little understanding or tolerance [at home]. I would just get told that I was a loser and to get my act together*” (participant 11). Furthermore, participants perceived and reacted emotionally to a certain mentality in society in which, according to their description, evil is automatically paired with mental illness. For example, three participants described emotional reaction to media coverage of violent crimes in which, typically, the perpetrator is referred to as mentally ill without furtherer explanation. This was a shared experience that can be summed up in the following explanation “*I’m not violent and I hate to be lumped with such behavior*” (participant 2). The second sub-theme of *Stigma* was *Structural discrimination* which refers to perception of discrimination in society. Three participants described difficulties in obtaining life -and critical illness insurance due to their depression diagnosis because of the premium rates being unaffordable. Then there was one female participant, who had been diagnosed with dysthymia at the outpatient unit. She described her experience at a fertility clinic, where she intended to become an egg donor, as strikingly discriminatory as she was declined because “[their policy is that] *if you have ever been diagnosed with any kind of mental disorder or taken medication for it, then you can't be an egg donor due to genetics. I have never felt more like a second-class citizen*” (participant 5).

Regarding personal experience of a diagnosis, the scores on questionnaires, showed in table 2 below, indicate that most participants experienced mild or no internalized stigma. However, nearly half of participants perceived a certain degree of devaluation and discrimination due to their mental illness.

Table 2. Scores on ISMI and PDD

	ISMI-9	PDD
Mean score	8,8	17,9
Cut-off score	13	18
Ratio above cut-off	9%	45,5%

A score above cut-off measures as high perception of stigma (ISMI9) or devaluation/discrimination (PDD)

Interestingly, all participants, with one exception, agreed to one statement in particular. Namely, question 9 in the PDD scale about admission to a hospital due to mental illness being a *personal defeat* which corresponds with the barrier sub-theme of *Resilience*.

Confidence in treatment options

Psychopharmacotherapy as a “crutch” was a pervasive overarching sub-theme, characterized by the notion of it being effective and important as a last resort or for acute situations, not as a long-term solution. Many described excessive side-effects and one participant stated “*My body just responds very badly to the drugs and I feel that the side-effects disturb me more than any of the symptoms that they alleviate*” (participant 2) and another said “*Drugs can help but it’s never enough*” (participant 6).

Another overarching sub-theme in this context was *Psychological treatment as a long-term solution*, characterized by a strong preference across the group for one-on-one therapy. The sub-themes identified were *Group therapy impersonal* and *Individual counseling unavailable*. One participant said in this context “*I found it hard to relate to group therapy, it’s too impersonal*” (participant 9). Not surprisingly, most were offered group therapy and a few participants were told that individual counseling wouldn’t be possible due to staff shortage. Concerning accessibility to treatment, cost was also mentioned frequently. Almost all participants said that they would utilize psychological treatment if it was subsidized. Another meaningful theme regarding psychological treatment was *Information and psychoeducation* which is closely related to diagnostic procedures and assessment. Most

participants valued information and felt relieved at the normalization about their problem having a name and that it wasn't uncommon. However, strikingly, it was dominant in responses that participants were largely unaware of any diagnosis being made, not recalling anybody defining the problem or explaining it from a personalized standpoint. One participant even said "*I wasn't diagnosed with anything, I was just told I was having a nervous breakdown*" (participant 9).

Overall experience

Impacting the whole experience in general, two overarching sub-themes emerged, *Validation* and *Surroundings*. The two validating sub-themes were *Kindness* and *Understanding* and the two sub-themes attached to surroundings were *Hospital environment* and *Time constraints*. A positive outlook on the overall experience was typically described by referring to the staff being friendly "*They showed understanding and gave me a chance to talk and explain*" (participant 8) and another said as she explained what was most helpful "[the doctor] *was compassionate and just really took the time to listen*" (participant 9). Also regarding details in the surroundings, many found the environment to be cold and depressing with old, worn out furniture and dominantly, people would compare the outpatient unit to other sectors of the hospital where they found surroundings to be warmer and more hospitable. Then, various aspects of financial constraints manifested in people's overall experience such as pressure, emphasis on productivity and patient throughput rather than accuracy and time with patients. Time constraints was a particularly pervasive theme. One woman said "*You can just feel that the staff is under pressure*" (participant 2). In sum, a positive overall experience was largely characterized by friendly impression. However, for those who had experienced the opposite, an unfriendly impression and devaluation impacted heavily their future delaying tendencies. Negative impression kept some participants away from mental healthcare for years and even decades.

Discussion

Principal findings and practical implications

The help-seeking barriers that emerged in this study indicate that people often seem to come into contact with specialized care at a point of desperation where they feel they have nothing left and nowhere else to go. What people need more than anything at that point when they arrive at the outpatient unit is fairly simple. It is kindness, compassion and validation in the face of shame and distress making a warm welcome imperative to all service providers and should not be underestimated by professionals.

Interestingly, in terms of why people make their way to the outpatient unit, *the idea of getting better* does not seem to be an enabler in the process. This was somewhat surprising because from the perspective of a healthcare professional, it seems tempting to assume that the idea of recovery would attract people to seek care. And moreover, people often don't seek specialized care on their own, others interfere and most commonly that would be the family. It ought to be kept in mind also, in terms of barriers to seeking specialized care that for patients who are impacted by the distress and impairment of a mental illness, possibly also perceiving stigma and not knowing where to turn, that is understandably challenging. Therefore, it is perhaps not surprising that *Postponement* and *Intervention* are such dominant themes. There are of course some who take initiative on their own to seeking care but that generally seems to be the case when people have already sought care before and are familiar with the outpatient unit. However, outlook and attitude towards psychological treatment was generally positive and people would utilize it if it was accessible.

Regarding the perception of prejudice and discrimination, the themes of *Structural discrimination* and *Negative perception of personal value*, tell us that living with a mental illness is not limited to symptoms. It is strongly felt in various forms such as negative self-image and concrete experience of opportunities and rights in society being inferior to others

not battling mental illnesses. It follows, as previous research has suggested, that if healthcare professionals want to maximize the well-being of the people they treat, the perception of stigma and other barriers should be addressed as separate and important factors in their own right (Link et al., 1997).

Limitations

An obvious limitation to a qualitative research design and small sample size is the generalizability of the findings. The themes that extracted in this study should be interpreted with caution as they may not fit a broader group of patients. Also, reliability is a concern due to subjective interpretations of the researcher (Halldórsson, Salkovskis, Kobori and Pagdin, 2016; Nowell, Norris, White and Moules, 2017).

Future research

What might explain the postponement of seeking care other than the barriers described here? The first thing that might be an explanation is that commonly, symptoms of both depression and anxiety are mild in the beginning before they start to impact functioning and disturb daily life. However, detecting these symptoms on early stages can be preventive and hinder the condition to develop into a severe state, saving a lot of hardship and economical cost in the long run (Nolen-Hoeksema, 2014; Zhang, Xiong, Huang, Wu, Leach and Barnes, 2015). Other possible explanation for postponement is that research has shown that people battling mental illness don't typically begin seeking specialized care with a specialist, but in primary care (Kroenke et al. 2007; Nordström and Bodlund, 2008; Þórisdóttir and Sveinsdóttir, 2012). It has been suggested in previous research that people generally find it stigmatizing to seek medical attention in a specialized mental illness facility and are more comfortable seeking medical attention in primary care (Wang, Lane, Olfson, Pincus, Wells and Kessler, 2005). What is interesting in this context is that most participants in this study had been at their GP's office before because of depression or anxiety but none of them came

the outpatient unit after being referred from primary care. It would therefore be interesting to analyze the linkage between the primary and secondary sectors, which needs to be intact and efficient, because previous research has also shown that a large portion of those who have mental problems are diagnosed and treated exclusively in primary care and only a few are referred to a specialist (approximately 16%) (Kristjánsdóttir, 2007). This raises questions and concerns and suggests a few areas where future research is needed. For example, how can people be encouraged to come into contact with specialized care units earlier? To what extent are patients turned away when they seek help at the outpatient unit if their condition is not considered severe enough?

Conclusion

On a practical level, this study emphasizes the importance of early detection, increased access to psychological service, dissemination of empirically supported care and reduction of treatment barriers. These are all key elements in quality healthcare. And on the most basic level, these results certainly yield insight into how improvements can be wrought in mental healthcare and is also an important reminder for mental health professionals about the obligation to mitigate misperceptions of mental disorders and the damage caused by stigmatization. Thus, like previous findings, this study stresses the importance and need of ensuring effective dissemination of evidence-based mental healthcare and provides new viewpoints and insights into the quality of care provided at the psychiatric outpatient unit of Landspítali.

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