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Barriers to Treatment-Seeking Behavior Among Adolescents With Anxiety in Indonesia

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Abstract

This study aims to identify factors related to treatment-seeking behavior in people with anxiety disorders in Indonesia. The research was conducted in 3 (three) regions ie Bogor City, Jombang and Tojo Una-Una Regency. The study population was men and women aged 15 years and above. The total sample survey was 2,283 respondents. This research was a cross-sectional design with a quantitative approach. Selection of research location based on the village with a variety of mental disorder conditions. Bogor City in West Java Province was chosen to represent the urban areas of Java with a high prevalence of the mental disorder. Tojo Una-Una District in Central Sulawesi was selected to represent rural areas outside Java with a high prevalence of the mental-emotional disorder. Jombang District in East Java Province also elected to represent the area of low mental disorder with a well-known mental health program. Results show 16.6% of respondents are suffering from anxiety disorders, while others have only complained about 1 or more symptoms of anxiety. Of the total people with such anxious symptoms, only 46.2% of people are seeking treatment, while 36.3% with anxiety disorders doing the same. There is a relationship between age and sex with help-seeking behaviors (p = 0.00). Adolescents who suffer from anxiety at risk of no treatment 6.6 times (Adjusted OR=6.6; 95% CI= 3.4-23.9) compared to the elderly. Men with anxiety disorders are likely 1.97 times (Adjusted OR=0.5; 95% CI= 0.4-0.7) at no treatment than women. People who have an anxiety disorder at risk of 1.7 times (Adjusted OR=1.7; 95% CI= 1.1-2.4) for having no treatment than people with anxiety symptoms. It is essential to improve knowledge about anxiety and how important to find treatment through counseling and health education on mental health.

Keywords: anxiety disorders, seeking treatment, treatment gap, mental health, adolescents, gender

1. Introduction

Anxiety disorders such as panic, agoraphobia, social anxiety disorder, and specific phobias are the most common mental disorders associated with enormous health care costs and high disease burden (Davis, 2015). An individual acquires, develops, or first experiences an age-of-onset condition of an anxiety disorder, usually in childhood or adolescence and is often chronic or recurrent (Kessler et al., 2011). Childhood and adolescence is a critical risk phase for the development of symptoms of anxiety syndrome, ranging from mild symptoms to anxiety disorders (Beesdo et al., 2011). Many mental disorders begin in childhood and adolescence and have a significant effect on adulthood (Kessler et al., 2011).

The problem of mental health in Indonesia is assessed to increase and cause a significant health burden. Mental disorders produce a burden to the family because the patient's productivity decreases and ultimately creates a huge cost burden for patients and families. From the government's point of view, these disruptions cost a great deal of health care. From 2013 Basic Health Research (Riskesdas) report, the prevalence of mental disorders (symptoms of depression and anxiety) are 6% for the age of 15 years and above. This means more than 14 million people suffer from mental disorders in Indonesia. As for severe mental disorders such as psychosis, the prevalence is 1.7 per 1000 inhabitants. More than 400,000 people suffer from severe psychiatric disorders (NIHRD, 2013). The mental health services that have been run so far are still focused on curative services for mental health patients rather than preventive and promotive efforts (Indonesian Ministry of Health, 2014).

Another problem is that the gap in the treatment of mental disorders in Indonesia reaches more than 90 percent. The treatment gap is the proportion of people who require specific treatment but did not receive it (Indonesian

Ministry of Health, 2017). This means that only about 10 percent of people with mental disorders are receiving mental health services due to a lack of mental health facilities (Indonesian Ministry of Health 2014). Currently, health facilities that provide mental health services remain uncommon. There are only 50 mental hospitals and 1 hospital of drug addiction in 34 provinces in Indonesia Also, only 151 of 445 general hospitals with mental services (33%) and 1,934 of 9005 (21.47%) "*puskesmas*" serving mental health care (Indonesian Ministry of Health 2014). These treatment gaps caused by the limited number of mental health services in Indonesia, with uneven distribution, and varies in quality. Several previous studies have shown a tendency for a relationship between treatment-seeking behavior and treatment gap (Mathias et al., 2015; Azale et al., 2016; Kristina et al., 2008; Hidayat et al., 2017).

Seekles (2012) stated that people seek help depending on their personality trait and personal need, while Thorstensson reported that disability is the main problem which prohibited to find help among adults aged 35 years old above (Thorstensson et al., 2009). Since there is no study previously about the socio-economic and demography in relationship with seeing medication and anxiety in Indonesia, therefore, this study may find the factors associated with seeking treatment behavior regarding characteristic social and economy, demography, health care facilities and activity in anxiety problem. The purpose of this study is to identify factors related to treatment-seeking behavior in people with symptoms and anxiety disorders in three districts and cities in Indonesia that is Bogor City, Jombang and Tojo Una-Una Regency.

2. Method

2.1 Design and Sample

This research was a cross-sectional design with a quantitative approach. Selection of research location based on the village with a variety of mental disorder conditions. Bogor City in West Java Province was chosen to represent the urban areas of Java with a high prevalence of the mental disorder. Tojo Una-Una District in Central Sulawesi was selected to represent rural areas outside Java with a high prevalence of the mental-emotional disorder. Jombang District in East Java Province also elected to represent the area of low mental disorder with a well-known mental health program. This research took place during the period of year 2017.

Population and sample were people aged 15 years and above at each one village in Bogor City (West Java Province), Jombang Regency (East Java Province), and Tojo Una-Una Regency (Central Sulawesi Province). If the respondents had severe memory and communication difficulties and were unable to provide accurately representative information or answers, they were not included in the study. This study involved 2,273 samples from three districts, with 880 samples had experienced 1 or more symptoms of anxiety during the last 6 months.

2.2 Variables

2.2.1 Seeking Treatment

Health Seeking Behavior is what physically and emotionally compromised individuals people do to get health and recovery. It is also called curative and rehabilitative behavior which includes activities: 1) Recognizing the symptoms of the disease, 2) Efforts to obtain healing and recovery by treating themselves or seeking services (traditional, professional), 3) Complying with the healing and recovery process (Notoatmodjo 2007). In this study what is meant by seeking treatment is if the respondent has an anxious complaint and takes medication or undergoes medical treatment.

2.2.2 Socio Demography

The variables analyzed in this study were symptoms of anxiety, sex, age, marital status, education, occupation, and economic status. Age was grouped into 15-18 years, 19-58 years, and 59 years and above. This age grouping is based on the assumption that the 15-18 year age group is considered to represent the age of adolescence where adolescent problems are considered more specific and complex than adulthood. The second group, between the ages of 19-58 years, is considered to represent the productive age group that is actively working with relatively simpler problems because they are more able to control emotions. The third group, aged 59 years and over, is considered to represent the elderly group who are generally retired and are no longer active at work and are assumed to be more relaxed in dealing with problems. Married status was divided into unmarried/single, married, and divorced. Education level was categorized as college-level (high level), junior high school (middle level), an elementary school or never been studied at school (low level). Occupation status was consists of formal employees, non-formal employees and, un-employment. Meanwhile, economic status was composed of several variables of some goods owned by the respondent. Economic status was calculated by Principal Component Analysis (PCA) (Ariawan, 2006) and it was grouped into a high, middle and low level.

2.2.3 Anxiety Disorder

The anxious condition was obtained from the interviews of respondents using the structured instrument "The Mini-International Neuropsychiatric Interview" (M.I.N.I), which consists of 23 questions that had been translated in Bahasa (Indonesian language). Anxiety symptoms were asked within the last 6 months until the interview. An anxiety disorder was assumed as if the answer to question number 1 was "yes" and at least there were 4 "yes" answers from question number 2 to 23, however, there must be at least 1 "yes" answer to question number 2 to 5 (Sheehan et al., 2004).

2.3 Data Collection Procedure

Data Collecting

Data is collected by interviews using structured instruments. The data collection period is from October to November 2017. Interviews were conducted by enumerators who had nursing education backgrounds and were trained by psychiatrists. Data analyzed were anxiety as the dependent variable. Independent variables are gender, age, marital status, education, employment, economic level measured by ownership with the PCA method.

2.4 Research Ethics

Ethical clearance of this study was approved by the Health Research Ethics Commission, National Institute of Health Research and Development, Indonesian Ministry of Health in the year 2017.

3. Results

Total respondents aged 15 years and above who suffer anxiety disorders and also experienced 1 or more symptoms of anxiety during the last 6 months was 880 people from three selected districts. As can be seen, in general, 83.4 percent of respondents showed anxiety symptoms and 16.6 percent had suffered anxiety disorders (Figure 1).

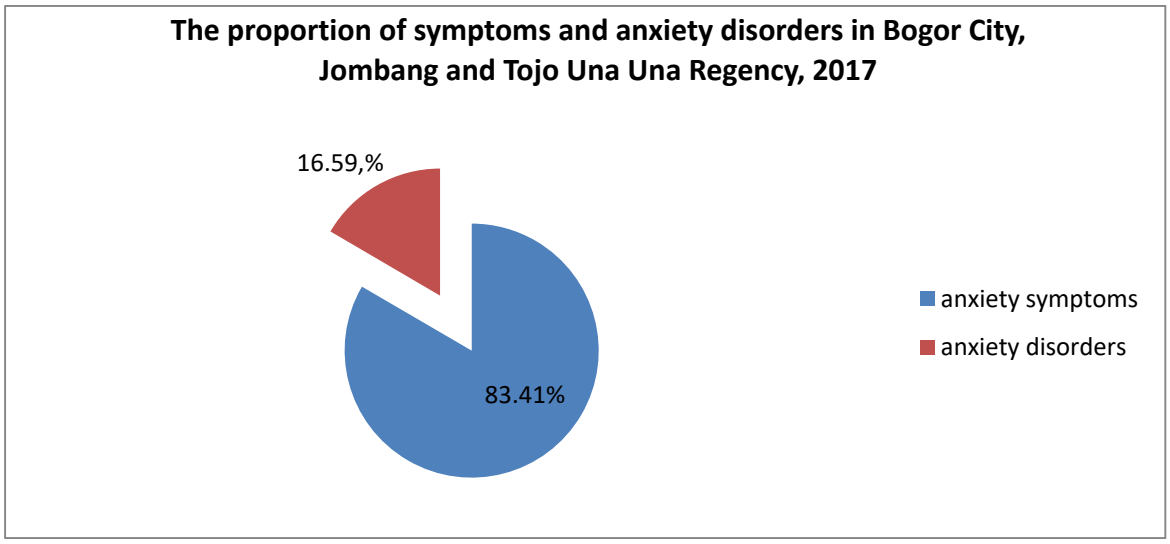

Figure 1. The proportion of symptoms and disorders of anxiety

Table 1 below presents the percentage of anxiety disorder was high in the adult age group compared to the younger age group. More anxious disorders experienced by women. People who were less educated and unemployed were more anxious. People in the middle-economic status and married had the highest percentage to experience anxiety.

Table 1. The proportion of Anxiety Symptoms and Anxiety Disorders based on Characteristics in the Bogor, Jombang and Tojo Una Una District, 2017

Characteristics	Anxiety Symptoms		Anxiety Disorders		Total
	n	%	n	%	
Age					
59+	119	16.21	23	15.75	142
15-18	60	8.17	9	6.16	69
19-58	555	75.61	114	78.08	669
Sex					
Male	283	38.56	44	30.14	327
Female	451	61.44	102	69.86	553
Education					
College	35	4.77	6	4.11	41
High school	349	47.55	58	39.73	407
Elementary	350	47.68	82	56.16	432
Employment					
Formal	71	9.67	8	5.48	79
Informal	263	35.83	68	46.58	331
Unemployment	400	54.50	70	47.95	470
Marital status					
Single	134	18.26	11	7.53	145
Married	527	71.80	114	78.08	641
Divorce	73	9.95	21	14.38	94
Economic status					
High	7	0.95	2	1.37	9
Middle	418	56.95	75	51.37	493
Low	309	42.10	69	47.26	378
Total	**734**	**100.00**	**146**	**100.00**	**880**

Figure 2 below shows that the proportion of people with 1 or more anxiety symptoms is more likely to seek treatment compared to those who have been diagnosed with anxiety.

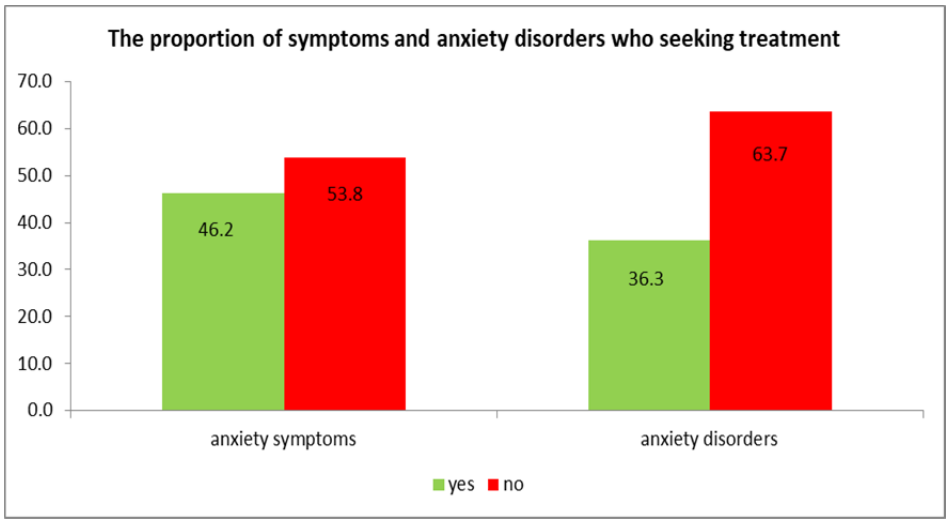

Figure 2. The proportion of symptoms and disorders of anxiety who seek treatment

Table 2 shows that in groups of people with 1 or more anxious symptoms, most of those who seek treatment, are working in the informal sector, divorced and have low economic status.

Table 2. The proportion of Anxiety Symptoms and Anxiety Disorders Whom Seeking Treatment based on Population Characteristics in the City of Bogor, Jombang and Tojo Una Una District, 2017

Characteristics	**Anxiety**				**Total**
	Symptoms		**Disorders**		
	n	**%**	**n**	**%**	
Age					
59+	79	66.4	15	65.2	94
15-18	15	25.0	1	11.1	16
19-58	245	44.1	37	32.5	282
Education					
College	11	31.4	2	33.3	13
High school	142	40.7	19	32.8	161
Elementary	186	53.1	32	39.0	218
Employment					
Formal	28	39.4	4	50.0	32
Informal	126	47.9	24	35.3	150
Unemployment	185	46.3	25	35.7	210
Marital status					
Single	40	29.9	1	9.1	41
Married	253	48.0	43	37.7	296
Divorce	46	63.0	9	42.9	55
Economic status					
High	3	42.9	2	100	5
Middle	191	45.7	31	41.3	222
Low	145	46.9	20	29.0	165
Total	**339**	**100.00**	**53**	**100.00**	**392**

In each group of people with anxiety symptoms and those has been diagnosed with anxiety, more than 50% do not seek treatment. The reasons they do not seek treatment were vary. Most of the groups who experienced anxiety symptoms reasoned they did not need treatment (76%). The same reason was stated by those who had been diagnosed with anxiety (Table 3).

Table 3. The proportion of Anxiety Symptoms and Anxiety Disorders based on Reason for Untreated in the Bogor City, Jombang and Tojo Una Una District, 2017

Reasons	Anxiety				Total
	Symptoms		Disorders		
	n	%	n	%	
Uncomfortable procedure treatment					
No	371	93.97	87	93.55	458
Yes	24	6.03	6	6.45	30
Difficult in transportation					
No	373	94.46	83	89.25	456
Yes	22	5.54	10	10.75	32
Assuming no need treatment					
No	95	24.24	30	32.26	125
Yes	300	75.76	63	67.74	363
Assuming it's not a disease					
No	279	70.71	51	54.84	330
Yes	116	29.29	42	45.16	158
Prefer to tradisional treatment					
No	349	88.38	84	90.32	433
Yes	46	11.62	9	9.68	55
Ashamed to seek treatment					
No	369	93.43	80	86.02	449
Yes	26	6.57	13	13.98	39
Ignorance of the existence of MHS					
No	364	92.17	79	84.95	443
Yes	31	7.83	14	15.05	45
Others					
No	323	81.57	77	82.80	400
Yes	72	18.18	16	17.20	88
Total	**395**	**100.00**	**93**	**100.00**	**488**

From the final model in table 4, it was found out that people in the 15-18 years age group who suffered anxiety were at risk to did not seek treatment by 6.6 times compared to the elderly group (59 years and above). In the group of people with aged 19-58 years who experienced anxiety had a risk of no seeking help 2.9 times compared to the elderly (59 years and over). This shows that adolescents at risk of not seeking treatment compared to the elderly group.

Table 4. Model of factors associated with anxiety and treatment-seeking

	Seeking treatment				Adjusted OR	95% CI	P value
	Yes (n=392)		No (n=488)				
	n	%	n	%			
Age							
59+	94	66.20	48	33.80	1.00	Reference	
15-18	69	23.19	53	76.81	6.60	3.39-12.86	0.000
19-58	282	42.15	387	57.85	2.97	2.01-4.38	0.000
Sex							
Male	116	35.47	211	64.53	1.00	Reference	
Female	276	49.91	277	50.09	0.51	0.38-0.68	0.000
Anxiety							
Symptoms	339	46.19	395	53.81	1.00	Reference	
Disorders	53	36.30	93	63.70	1.65	1.13-2.42	0.010

4. Discussion

This result is in line with some research that found that adolescents do not access treatment because of several reasons (Gulliver et al., 2010; Cummings et al., 2013). In general, young people perceived stigma and embarrassment, problems in recognizing symptoms (poor mental health literacy), and a preference for self-reliance as the most important barriers to help-seeking.

Meanwhile, Rickwood argued that significant obstacles teenagers did not seek treatment was their difficulty in finding information about mental health-related to their problems (Rickwood et al., 2007). This is in line with Boldero and Fallon (1995 in Cohen 2009) who found that young people prefer friends, family, and teachers to mental health professionals as a source of help. Adolescents prefer the help obtained from people who have close relationships with them rather than professionals. Besides, Wright et al., (2005 in Cohen 2009) also found that teenagers' and family's beliefs may hamper their behavior in seeking care, such as a negative view or stigma about drug treatment, as well as their limited or wrong knowledge of the type of mental illness. However, difficulties in the identification of mental illness are not the main cause of the lack of seeking treatment, as most adolescents are now able to identify problems within themselves (Hickie, Luscombe et al., 2007, in Cohen 2009). Thus the obstacles cause adolescents not to seek treatment or professional help lie in the interpersonal understanding of the factors that influence them in interacting with professionals, i.e., the encouragement of friends and family (Cohen et al., 2009).

On the contrary, the above findings are somewhat different from Shai et al., (2012) who reported that people seek the professional help of mental disorders in South Africa is primarily determined by the public's view of the causes of disease that are influenced by the local culture. It is also reported that patients move to treatment if they feel their symptoms worsen. Traditional healers are usually the first source of care that people look for when faced with mental health problems, and are often the only source of care sought (Shai et al., 2012). To overcome this negative issue, Kauer et al., (2014) conducted a systematic review on efforts to improve seeking help in adolescents and concluded that online care is assumed to be one way to improve adolescent access to mental health services (Kauer et al., 2014). Wisdom and colleagues also reported that one way for teenagers to treat symptoms of mental disorders is when service providers or health workers are actively building rapport, providing information about adolescent diseases, treatment methods, helping teenagers make decisions about their care, and feel normal, independent, then adolescents will be more likely to receive treatment (Wisdom et al., 2006).

The dominant influence during adolescence is family and will change significantly as they mature when they can decide on their own. In adolescents, the influence of friends was very low on the decision to seek treatment. Parents and families need to be more involved to encourage the use of health services, while online health services are still needed to ensure that teen groups can more easily obtain appropriate services (Rickwood et al., 2015).

Another result is that men who undergone anxiety were 1.97 times more at risk than women for not seeking care. The results showed that men with symptoms and anxiety disorders were less likely to seek treatment than women.

This is consistent to Doherty et al., (2010), who reported that men also do not go for treatment with some reasons, among others, because they feel embarrassed for treatment, do not feel there is a problem with physical activity, have no health insurance or have to pay the full cost of health services, and living in urban areas (Doherty & Doherty, 2010). Males tend to be less likely to reveal common mental health problems such as depression due to social stigma and are constrained to seek help because of their stereotypical role (World Health Organization, 2009) (Lynch et al., 2018; Oliver et al., 2005). This is in line with the research conducted by Liddon et al., in the United Kingdom that men are less inclined than women to seek help for psychological issues (Liddon et al., 2018).

Different outcomes related to gender and treatment-seeking issues have also been studied by Mackenzie et al., that indicate the negative attitudes related to psychological openness may contribute to a lack of male mental health services. Women showed better intentions to seek help from mental health professionals than men, possibly because of women's positive attitudes about psychological openness. These findings suggest the need for education and counseling to improve the attitude of seeking help and treatment in men (Mackenzie et al., 2006). While, other studies report the current health care system does not seem to be adapted to meet the health needs of men, because providers unable to deal with male health problems appropriately (Smith et al., 2006; Oliver et al., 2005) This study suggests that healthcare providers should be properly trained to meet the specific health needs of men. Need to understand better how to deliver preventive health messages and provide health care in an appropriately gendered way (Smith et al., 2006; Oliver et al., 2005).

Likewise, there is an assumption that seeking professional help is like expressing weakness, thus allowing men not to seek treatment (Wendt & Shafer, 2016). Another possibility of men not being treated because of symptom complaints is still mild (Parent et al., 2018). Other findings also provide an interesting point of fear for psychiatric drugs, self-medication, and alcohol use as a barrier to men not seeking professional help (Lynch et al., 2018) (Oliver et al., 2005).

Moreover, the result shows that people with anxiety disorders are 1.65 times less likely to seek health care than those who acquired symptoms of anxiety after controlling for age and sex factors. It means that people who experienced symptoms of anxiety were more likely to seek treatment than those who already suffered from an anxiety disorder. This is due to several reasons, i.e., because they think this complaint may be treated traditionally (84%). Likewise, research has been undertaken by Mwaka et al., and Thirthalli et al suggested traditional treatment is still considered as a chosen treatment method by majority community in Asia and Africa (Thirthalli et al., 2016; Mwaka et al., 2016) As a result, collaboration and synchronization of health programs between modern and traditional medicine are needed to get effective and efficient services and optimal recovery.

In Indonesia, this traditional treatment has been known that 30.4% of households still use traditional medicine. Traditional medicine is also widely known in Indonesia as "*Jamu*" and empirically used in promotive and preventive action, even further develop into curative and palliative directions. Philosophically, the traditional complementary approach emphasizes a holistic approach (mind-body-spirit). Regulations governing traditional medicine in Indonesia already exist, including referring to the 2014-2023 WHO Traditional Medicine Strategy, in addition to policies at the ASEAN level and also APEC (Aditama, 2015).

Added to this reason for people do not seek treatment because they feel embarrassed (33%) and it may be because of the negative stigma about mental illness. It is similar to Sharp and Murphy who found what makes people ashamed to go for treatment (Sharp et al., 2015; Murphy et al., 2016). Finally, they do not know where the health facilities which provide mental health services. This is in line with research conducted on adult groups in rural China (Yu et al., 2015).

There are some reasons not to seek help in adolescents, they feel uncomfortable procedure, difficulties in transportation, feel no need treatment, and they assure this symptom may be treated traditionally without any help from health providers (Table 1). These findings are lined up with the results that have been published in previous studies on the reasons why people do not go to health services. Some of the reasons stated are comforted when treated (Green et al., 2014), feeling embarrassment (Gulliver et al., 2010), more believing traditional treatment (Thirthalli et al., 2016; Mwaka et al., 2016). All are the cause of someone not using or delaying medical treatment.

5. Conclusion

The percentage of treatment-seeking due to symptom or anxiety disorder in 3 districts in Indonesia is still far from expectations. People who have already suffered from anxiety disorders are less likely to find treatment than those who only have symptoms of anxiety. Factors associated with treatment-seeking behavior in anxiety disorder were age and sex. Young men who had anxiety disorders were more likely to un-seeking treatment. Most of them prefer to traditional treatment, feel embarrassed to find treatment, do not know whether the availability of the mental

health service facility in the neighborhood. They also refuse to find treatment because feel uncomfortable procedure treatment and transportation difficulties. It is recommended to provide mental health services that would meet the needs of people especially for adolescents, as well as counseling in schools. It is also essential to train young people to be as a counselor for their peers.

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Informed Consent

All procedures followed were by the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000 (5). Informed consent was obtained from all patients for being included in the study.

Ethics Approval

Ethics approval was obtained from the Health Research Ethics Committee of the National Institute of Health Research and Development, Ministry of Health (Number: LB.02.01/2/KE.200/2017) on 24 May 2017. As well as the amendment to the protocol, numbered LB.01.02/2/KE.351/2017.

Conflict of Interest

Author Dwi Hapsari Tjandrarini, Author Puti Sari Hidayangsih, and Author Rofingatul Mubasyiroh declare that they have no conflict of interest.

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