Part I: Introduction
Chapter 1

General Introduction
These famous words are also known as the more common saying; “Prevention is better than cure”, meaning it is better to stop something bad from happening before it occurs than it is to deal with it after it has happened. But is this true? Natural instincts and many diverse situations might incline you to say yes. However, there is a certain complexity to prevention and, therefore, this saying when you look at mental health prevention. In mental health it is difficult to predict if a certain disorder will develop or not, what happens when you try to prevent something of which you cannot predict it will happen? Is prevention better or feasible when it is uncertain what can be done to prevent an illness from developing? For example, there are several mental health disorders in which the outcome (e.g. a full-blown disorder) is unpredictable, even for people who are diagnosed as ‘at risk’.

One of the most prevalent and disabling mental health disorders is depression. Unfortunately, it is unknown which people will develop a depressive disorder and which people will not. However, we do know that certain people are at high(er) risk of developing depression, such as people with a subclinical depression. People with subclinical depression report depressive symptoms, but fail to meet the criteria of major depression according to the Diagnostic and Statistical Manual of Mental Disorders V (DSM-V) (1). Although it is known that preventive interventions for depression can prevent or, at the very least, delay the onset of depression, it is unknown which people with subclinical depression will develop a depressive disorder and which people will not (2). In other words, it is unknown which people might benefit from preventive interventions. Another important shortcoming in the literature is that we do not know if the people that might benefit from preventive care receive or seek this care or how people view their symptoms and how they feel about (preventive) care. This leads to the following research questions;

1. Can people benefit from preventive interventions?
2. Which people with subclinical depression (are willing to) participate in preventive interventions for depression?
3. How do people view their symptoms?
4. What are their attitudes towards care?
5. Which people with subclinical depression develop depressive disorders?

This thesis aims to answer these questions and provide more insight into the onset of depression and reasons for (not) seeking help in people with subclinical depression. This chapter will introduce the general background and provide an overview of the chapters.
Prevention of depression

Depression is a worldwide health concern and affects one in every eight men and one in every five women (3, 4). It is associated with considerable morbidity and mortality (5-7). Moreover, depression impacts the ability to function at home, affecting marital and parenting behaviour, as well as the ability to function at work, resulting in absenteeism and reduced productivity (8). Depression can be best viewed on a continuum ranging from no symptoms to many symptoms (9-11). Prevalence rates of major depression range from 14.6% in high-income countries to 5.9% in low- to middle-income countries (12). The incidence rates are around 2% in the general population (13).

As the saying suggests, treatment and prevention are two different things (Figure 1). Treatment, even under optimal conditions, cannot reduce the burden of disease associated with depression sufficiently (14, 15). A way to further reduce the burden is to reduce the incidence. This is the focus of prevention rather than treatment. However, it is more difficult to convince people, health care professionals and government agencies of the advantages of prevention compared to treatment, as people are not sure a bad event will happen and there is no direct benefit for taking action. Therefore, the urgency to deal with symptoms is less pronounced. This is the area of prevention and there are three levels of prevention;

1) Universal preventive strategies or interventions targeting the entire population.
2) Selective preventive interventions focusing on specific subgroups within the population who are considered at high risk due to common characteristics (e.g. traumatic events, poverty, etc).
3) Indicated prevention targeting people who suffer from early stages or symptoms of depression (e.g. people with subclinical depression).

The model in Figure 1 also describes “promotion” and “recovery”. Promotion is not necessarily focused on preventing depression. However, due to the focus of promotion on producing healthy and resilient mood states, it is likely to also prevent depression. Recovery focuses more on curing during treatment or after treatment has ended and as such is not part of prevention.
From a clinical perspective early detection of a mental illness is important (16) and focusing on people who are at risk of developing depression (e.g. people with subclinical depression) is an effective way of doing this. In the past 2 decades more and more research has demonstrated that preventive interventions can be effective in delaying and preventing the onset of major depression by 22% (17, 18). Therefore, the current thesis will focus on people with subclinical depression and indicated prevention, since these people are at high risk of developing depression and subclinical depression has been consistently found to be one of the best predictors of major depression (2, 19, 20).

In the Netherlands, an infrastructure that structurally embeds prevention in mental health care has been implemented in the past 30 years, which makes the Dutch health care system unique. Depression prevention is freely available to the general public, including people with subclinical depression, in about forty specialized mental health facilities at little to no costs. However, despite the wide availability of depression prevention in the Netherlands, participation rates in preventive interventions for depression are low, which is similar to participation rates in other countries (21-23).

Subclinical depression

Subclinical depression is part of the depression continuum and is considered a prodromal phase. It is well known that subclinical depression is one of the best predictors of major depression, but there is also an increased risk of developing other mood and anxiety
disorders as well as an increased risk of suicidal ideation and attempts (2, 19, 20, 24).
Subclinical depression has a significant impact on daily functioning and is associated
with great economic costs (19, 25).

There are several ways of operationalizing subclinical depression, such as (1) a score
above a threshold on a screening instrument, but failing to meet the criteria for major
depression according to the Diagnostic and Statistical manual of Mental Disorders
(DSM-V) or (2) having a depressed mood accompanied with additional symptoms, but
not as severe or as many as the DSM-V criteria for major depression (1, 2, 20). In the
current thesis we mostly used the first definition; depressive symptoms that do not yet
meet the diagnostic criteria of a full-blown depression (26).

Incidence and prevalence rates vary widely due to differences in population,
definition and instruments that are used, with incidence rates ranging from 2% to
13% and prevalence rates varying from 2% to 32% (27-30). These prevalence rates are
equal or higher than those for full-blown depressive disorders (29). The prevalence in a
population-based study in the US was 12% (24), in the Netherlands approximately 7.5%
of the general population suffers from subclinical depression (19).

As stated before, it is well known that people who suffer from subclinical depression
have an increased risk of developing major depression and research has shown
that between 20% to 34% of people with subclinical depression will develop a major
depression (31, 32). Other research has indicated that a considerable proportion of adults
and older people with subclinical depression experience recurrent episodes or develop a
chronic form of subclinical depression (33). However, little is known about which people
with subclinical depression will develop a depressive disorder, which people will not,
and which people will recover or, in other words, the individual course of subclinical
depression (2, 24).

The few studies that have examined the onset of depressive disorders in people
with subclinical depression have identified several factors that influence the onset
of depressive disorders (20, 31, 34, 35). Some of these factors can be categorized as
characteristics of depression, such as feelings of worthlessness and severity of depressive
symptoms, other factors can be categorized as individual characteristics, such as family
history of depression, suffering from a chronic illness, and mastery.

Help-seeking

Since we know that not everyone with subclinical depression will develop a depressive
disorder, it is imperative to know who will need (professional) care in order to prevent
the onset of major depression (e.g. which people do not naturally recover from subclinical
depression). A good and necessary first step is to examine help-seeking behaviour and
identify reasons for (not) seeking help in people with subclinical depression, regardless of the onset of depression.

Literature on help-seeking in (mental) health care is often guided by the Behavioural Model of Health Service Use by Andersen and Newman (36). This model, as presented in Figure 2, explains the use of health care by looking at three interrelating factors: need, predisposing, and enabling factors (37). Need factors can be described as both perceived (e.g. how people view and experience their own health and illness symptoms) and actual need (e.g. defined by professional assessment and objective measurement of the symptoms a person experiences or their health status) for health care (38-41). Help-seeking in depression has shown that need factors, such as recognizing symptoms and severity of symptoms, determine whether someone is more likely to seek help (42, 43).

Predisposing factors consist of demographic factors, social structure and belief factors (e.g. attitudes, values, and health beliefs) (37). Some research has shown that young people, people with more positive experiences in mental health care and people who acknowledge their mental problems were more likely to receive mental health treatment (44, 45). However, other research indicates that increasing age is related to greater need for mental health care (46-48). Also, research has shown that people with higher scores on neuroticism, higher education, female gender, and who are in a relationship with a significant other tend to seek more care for their mental health problems (48-52). Furthermore, research indicates that stigma and embarrassment are related to help-seeking in young people (53).

![Figure 2. Andersen's model of health care utilization (36)](image-url)
Enabling factors relate to organisational factors which affect the availability and affordability of mental health care. These can be individual factors, such as a person’s financial situation (54), organizational factors, such as location and distribution of health care facilities, or contextual factors, such as resources that are available to a person (23). Due to the infrastructure in the Netherlands, mental health care is available and mostly free to everyone who needs it, however not everyone might know of this type of care or feel it is applicable to them.

The Behavioural Model of Health Service Use, however, fails to explain what happens with these three factors and their influence on help-seeking when need factors are less important or pronounced (e.g. lower severity of symptoms), which is the case in people with subclinical depression. Research has indicated that many people with mental health problems do not perceive a need for help, because they do not perceive they have mental health problems, they feel symptoms are temporary or not serious enough (55, 56). This, combined with the natural recovery rate in people with subclinical depression, indicates that people might be correct not to seek help for their symptoms.

Summary

Preventive interventions for depression can help prevent or delay the onset of depression in people who are at high risk of developing depression, such as people with subclinical depression. Although there is no consensus on the definition of subclinical depression, researchers have agreed that depression exists on a continuum and subclinical depression is considered a prodromal phase of depression (2). Furthermore, it is considered the best predictor of major depression. However, the individual course of subclinical depression is unknown which makes it impossible to tell who will benefit from preventive interventions and who will not or, in other words, who should seek-help in order to prevent depressive symptoms converting into a depressive disorder (2).

Research on help-seeking in people with subclinical depression is scarce, however existing research indicates that people’s (poor) self-identification of their symptoms and the judgment of their ability to deal with the symptoms on their own are reported most often as reasons for not seeking help. On the other hand, practical reasons (e.g. lack of time or money) are reported less often as barriers to seeking care (56). These barriers could be categorized, according to the Andersen and Newman model of health care utilization, into need, predisposing and enabling factors, which interrelate to one another.

Although people could benefit from preventive care, participation rates across the world are low. This is also the case in the Netherlands, despite its unique infrastructure which makes mental health care available to everyone at little to no costs. It is not yet clear which of the discussed factors might explain the low participation rates in preventive
interventions for depression or what people with subclinical depression report as reasons for not seeking preventive care. A possible explanation might be the severity of symptoms or the natural recovery rate of subclinical depression. It is imperative to gain better insight into help-seeking and the onset of depression in people with subclinical depression and this thesis provides a first step by examining if preventive interventions are (still) effective, what reasons people with subclinical depression have for (not) seeking help and what predicts the onset of a depressive disorder in people with subclinical depression.

Overview of the chapters

This thesis will examine the reasons of people with subclinical depression to (not) seek help and the onset of depression in this high risk group. Chapter 2 will focus on answering the first research question and includes a meta-analysis examining the effectiveness of preventive interventions for depression. Chapters 3 to 5 examine the second research question by investigating reasons and determinants for (not) seeking help in people with subclinical depression, whether the patient perspective corresponds to the professional perspective (Chapter 4), and how people with subclinical depression view professional mental health care, informal care (e.g. help from friends and/or family) or being self-reliant (Chapter 5). Finally, this thesis will examine the third research question by providing insight into the onset of a depressive disorder within a one year period in people with subclinical depression and examine characteristics that predict the onset of depression (Chapter 6). Chapter 7 will provide a general discussion on the findings discussed in the previous chapters. As a final note to the reader I would like to draw attention to the fact that chapters 2, 3, 4, 5, and 6 are separate journal articles and can be read independently.
References
