

Attitude towards seeking psychological help regarding psychiatric symptoms and stigma in patients with fibromyalgia

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Abstract. – OBJECTIVE: The current study aimed to examine the psychiatric symptoms that can be seen in fibromyalgia (FM) patients, their attitudes toward seeking psychological help, and their concerns about stigma. Besides, it was investigated whether the stigma concerns that they may experience about receiving psychiatric treatment constitute an obstacle for patients to receive psychiatric treatment.

SUBJECTS AND METHODS: This cross-sectional descriptive study was conducted between February and July 2020. Various seeking help were measured with Attitude Towards Seeking Psychological Help Scale-Short Form (ATSPPH-SF), Self-Stigma in the Process of Seeking Psychological Help Scale (SSPSPHS), Intention to Seek Psychological Help Inventory (ISPFI), and Social Stigma Due to Seeking Psychological Help Scale (SSDSPHS). FM symptoms of patients were measured with The Symptom Screening Questionnaire, Revised 90 Items (SCL-90-R). Quality-of-life parameters were measured with Fibromyalgia Impact Questionnaire (FIQ).

RESULTS: Fibromyalgia patients had higher somatization ($p=0.001$), psychoticism ($p=0.045$) and phobic anxiety ($p=0.015$) scores than controls. The ATSPPH-SF ($p=0.002$) and SSPSPHS ($p=0.043$) scale scores of the FM patients were higher than the controls. There was a significant positive correlation between FIQ and SSPSPHS ($r=0.288$, $p=0.043$) and SCL-90 overall ($r=0.602$, $p<0.001$) and all subscales scores. Patients with high active psychotic symptom levels had higher FM exposure scale scores and SCL-90 overall scores than those with low active psychotic symptom levels ($p<0.001$).

CONCLUSIONS: The findings of this study showed that fibromyalgia patients have more so-

matization symptoms than healthy individuals, and as psychiatric symptoms increase in these individuals, their level of being affected by FM increases.

Key Words:

Fibromyalgia, Social stigma, Seeking-help, Attitude, Quality of life.

Introduction

Fibromyalgia (FM) is a chronic musculoskeletal disease in which many psychosomatic symptoms, such as pain, fatigue and sleep problems, can be seen together. Although the etiopathogenesis has not been fully explained yet, it has been suggested that various factors such as sleep disorder, neuroendocrine dysfunction, regional blood flow changes, metabolic and immunological disorders may play a role in the emergence of the disease¹. Many studies¹⁻³ in the literature emphasized that psychosocial stress factors are associated with the onset and persistence of the symptoms of the disease. The relationship between FM and psychiatric diseases is bidirectional. As psychological factors play a role in the etiology of the disease, many psychiatric symptoms occur during the chronic course of the disease and adversely affect the treatment⁴. Scholars⁵ have shown that many psychiatric symptoms, especially depression, anxiety and somatoform disorders, are increased in patients with FM. Previous studies have reported that the lifetime prevalence of depressive symp-

toms in people with FM is as high as 90%, and the rates of major depression range from 62% to 86%. The association of depression and pain was associated with greater pain medication consumption, treatment failure, higher emotional dysregulation, limited use of adaptive pain coping mechanisms, and higher suicidal ideation frequency and intensity^{6,7}. In light of this information, the identification and treatment of the accompanying psychological factors in the follow-up of patients with FM gain particular importance. There is good quality evidence to support the use of a variety of pharmacological (i.e., antidepressants and anti-seizure medications) and non-pharmacological treatment (i.e., Cognitive Behavioral Therapy, CBT) options for FM⁸. Considering the positive effects of antidepressant drugs on pain and sleep, it is evident that getting psychiatric help in patients with FM is important in treatment and symptom control. Despite this, our clinical experience has shown that although FM patients apply to branches other than psychiatry, the rate of admission to psychiatry outpatient clinics for treatment is much lower. We predicted that this may be a result of fear and anxiety that individuals may experience stigma when diagnosed with a psychiatric illness. Therefore, in our study, we aimed to examine whether patients' attitudes towards seeking psychological help and their concerns about stigmatization constitute an obstacle to receiving psychiatric treatment in FM patients.

Subjects and Methods

Study Design and Population

This prospective cross-sectional study was conducted in the psychiatry and rheumatology departments of a tertiary university hospital between February 2020 and July 2020. The research was approved by the Firat University Non-Interventional Research Ethics Committee (Ethics Committee approval date: 02.01.2020 number: 2020/01-13). Written informed consent was obtained from all participants included in the study. Fifty patients diagnosed with FM over the age of 18, who stated that they volunteered to participate in the study, and 50 healthy controls matched for age and gender were included. The diagnosis of FM was made by two rheumatologists working in the rheumatology clinic and responsible for the follow-up and treatment of patients with FM. It was confirmed by considering the 2016 FM diagnostic criteria⁹.

Exclusion criteria of the study: physical, mental, and neurological disease, active psychiatric disease, cancer, and substance use that would prevent them from responding to the questionnaires.

Data Collection

Research data were obtained by using questionnaires and scales. All questionnaires and scales applied throughout the research were applied face to face by the researchers in the interview rooms prepared for the purpose of obtaining the research data. The sociodemographic characteristics of the participants (age, gender, education level, economic status, smoking and alcohol use, etc.) were obtained with a questionnaire. The Fibromyalgia Impact Questionnaire (FIQ) was applied only for the patient group in order to evaluate the quality of life specific to FM. Attitude Towards Seeking Psychological Help Scale-Short Form (ATSPPH-SF), Self-Stigma in the Process of Seeking Psychological Help Scale (SSPSPHS), Intention to Seek Psychological Help Inventory (ISPHI), Social Stigma Due to Seeking Psychological Help Scale (SSDSPHS) and Symptom Screening Questionnaire (SSQ) for both patients and control group 90-item Revised Passed Version (SCL-90-R) was applied.

Attitude Scale Towards Seeking Psychological Help-Short Form (ATSPPH-SF)

Developed by Fischer and Turner in 1970¹⁰, the 29-item scale was later shortened to 10 items by Fischer and Farina¹¹. The items of the scale are answered in a 4-point Likert style, ranging from 1 strongly disagree to 4 strongly agree. The lowest score that can be obtained from the scale is 10, and the highest score is 30. Whether the person has a positive attitude towards seeking psychological help is evaluated in direct proportion to the total score to be obtained from the scale.

Self Stigma Scale in the Process of Seeking Psychological Help (SSPSPHS)

It is a 10-item scale developed by Vogel et al¹². The items of the scale are answered in a 5-point Likert style, ranging from 1 strongly disagree to 5 strongly agree. The total score that can be obtained from the scale varies between 10 and 50. As the scores obtained from the scale increase, the person's self-stigma is higher when he receives help from an expert who provides psychological help. The low score obtained indicates that the person's self-stigmatization is low when

help is received from a specialist who provides psychological help. The Cronbach Alpha value of the scale was reported as 0.87. The Turkish validity and reliability of the scale was performed by Kapikiran and Kapikiran¹³. The Cronbach Alpha value of the Turkish version of the scale was reported as 0.71.

Inventory of Intention to Seek Psychological Help (ISPHI)

Attitudes toward seeking professional psychological help-seeking attitudes of participants were measured using the Inventory of Intention to Seek Psychological Help (ISPHI). The scale consists of 12 items using a 4-point Likert-scale. The scale contains three sub-factors, including relational problems, traumatic problems, and affective and behavioral problems. The lowest score that can be obtained from the inventory is 12, and the highest score is 48. The highest score that the individual gets from the inventory indicates that the intention to seek psychological help is high. The Cronbach Alpha coefficient calculated for the scale is 0.84¹⁴.

Scale of Social Stigma Due to Seeking Psychological Help (SSDSPHS)

SSDSPHS is a 5-item scale developed by Komiya, Good, and Sherrod (2000)¹⁵ to evaluate the individual's perception of social stigma due to psychological help. The items of the scale are answered in a 4-point Likert style, ranging from 1 strongly disagree to 4 strongly agree. The lowest score that can be obtained from the scale is 5, and the highest score is 20. The high score that the individual gets from the scale means that the person has a high perception of being stigmatized by society if he receives help from a specialist who provides psychological help. The lowest score obtained indicates that the perception that the person will be stigmatized by society is low if help is received from a specialist who provides psychological help.

Revised 90-item Symptom Screening Questionnaire (SCL-90-R)

The presence of ongoing mental symptoms in participants was measured using the Revised 90-item Symptom Screening Questionnaire (SCL-90-R). The scale consists of 90 items using a 4-point Likert scale. Each of the 90 items is rated on a five-point Likert scale of distress, ranging from "not at all" (0) to "extremely" (4). The scale contains nine sub-factors, including so-

matization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid thought, and psychoticism. The statements in the scale consist of self-report questions about the status of individuals in the last 15 days¹⁶.

Fibromyalgia Impact Questionnaire (FIQ)

The functional status of FM patients was measured using the Turkish version of the Fibromyalgia Impact Questionnaire (FIQ). This scale measures 10 different features: physical function, well-being, absenteeism, difficulty at work, pain, fatigue, morning fatigue, stiffness, anxiety, and depression. Low scores, except for the feeling of well-being, indicate recovery or less affliction. The maximum score for each title is 10. Thus, the total maximum score is 100. The median FM patient scored 50, while the more severely affected patients usually scored above 70. Test-retest reliability and internal consistency were good at 0.81 and 0.72, respectively¹⁷.

Statistical Analysis

SPSS version 22 (IBM Corp., Armonk, NY, USA) package program was used for statistical analysis. Study data were presented as numbers and percentages for categorical variables, mean/standard deviation for normally distributed continuous variables, and median (Q1-Q3) for non-normally distributed data. Pearson Chi-square and Fischer Exact tests were used in the analysis of categorical data. Student *t*-test was used for the analysis of normally distributed continuous variables, and Mann Whitney U test was used for the analysis of non-normally distributed variables. Spearman or Pearson correlation analyses were used according to the distribution of the data in the analysis of the relationship between continuous variables. $p < 0.05$ was considered statistically significant.

Results

The patient group and control group were similar in terms of age ($p=0.864$) and gender ($p=0.525$). The sociodemographic characteristics of the participants are presented in Table I (Table I).

The FM affect scale score of the patients was 46.01 ± 15.92 . In the comparison of the patient and control groups, the ATSPPH-SF ($p=0.002$) and SSPSPHS ($p=0.043$) scale scores of the patient

Table I. Comparison of demographic characteristics of patient and control groups.

Variables	Patient group n (%)	Control group n (%)	p-value
Age (mean \pm sd)	44.01 \pm 01	43.70 \pm 8.95	0.864 ^a
Gender			0.525 ^b
Female	46 (92.0)	43 (86.0)	
Male	4 (8.0)	7 (14.0)	
Marital status			0.026 ^b
Married	42 (84.0)	36 (72.0)	
Single/widowed/Divorced	8 (16.0)	14 (28.0)	
Education level			< 0.001 ^b
Under high school	38 (76.0)	10 (20.0)	
High school and above	12 (24.0)	40 (80.0)	
Income perception			0.095 ^c
Low	10 (20.0)	3 (6.0)	
Middle	36 (72.0)	44 (88.0)	
High	4 (8.0)	3 (6.0)	
Smoking			0.668 ^b
Yes	17 (34.0)	15 (30.0)	
No	33 (66.0)	35 (70.0)	

^aStudent *t*-test, ^bPearson's Chi square test, ^cFisher exact test.

group were found to be statistically higher than the controls. There was no statistically significant difference between the two groups in terms of ISPHI and SSDSPHS scale scores ($p > 0.05$). There was no statistically significant difference between the two groups in terms of SCL-90 inventory total score ($p = 0.799$), SCL-90 somatization ($p = 0.001$), SCL-90 psychoticism ($p = 0.045$) and SCL-90 phobic anxiety ($p = 0.015$) scores of the patients were significantly higher than the controls (Table II).

The relationship between the scale scores of the patient group and the fibromyalgia exposure scale score was examined. A positive and significant correlation was found between the SSPSPHS scale score and the fibromyalgia exposure scale score ($r = 0.288$, $p = 0.043$). In addition, a positive significant correlation was found between the general score of the SCL-90 scale and all subscale scores and the fibromyalgia affect scale (Table III).

Table II. Comparison of the scale scores of the patient and control groups.

Scales	Patient group (n = 50)	Control group (n = 50)	p-value
ATSPPH-SF (ATTITUDE SCALE)	16.74 \pm 2.52	14.96 \pm 3.02	0.002^a
SSPSPHS (SELF-STAMPING)	29.78 \pm 5.15	27.60 \pm 5.49	0.043^a
ISPHI (INTENTION INVENTORY)	33.40 \pm 6.37	34.90 \pm 5.01	0.194 ^a
SSDSPHS (SOCIAL STIGMA)	10.00 (7.00-11.25)	10.00 (6.00-11.00)	0.270 ^b
SCL-SOMATIC	1.76 \pm 0.81	1.20 \pm 0.85	0.001^a
SCL-ANX	0.70 (0.38-0.93)	0.80 (0.38-1.30)	0.490 ^b
SCL-OBSESSION	1.05 (0.40-1.43)	1.00 (0.50-1.73)	0.844 ^b
SCL-DEPRESSION	0.69 (0.30-1.44)	1.07 (0.44-1.75)	0.265 ^b
SCL-PERSONAL SENSITIVITY	0.55 (0.22-1.47)	0.88 (0.33-1.57)	0.169 ^b
SCL-PSYCHOTIC	0.20 (0.00-1.16)	0.40 (0.10-1.00)	0.045^b
SCL-PARANOID	0.66 (0.00-1.16)	0.75 (0.33-1.50)	0.118 ^b
SCL-ANGER	0.50 (0.16-1.16)	0.75 (0.33-1.20)	0.162 ^b
SCL-PHOBIA	0.21 (0.00-0.57)	0.42 (0.25-1.04)	0.015^b
SCL-ADDITIONAL	1.14 (0.57-1.71)	1.00 (0.42-1.84)	0.631 ^b
SCL-GENERAL	0.89 (0.44-1.21)	0.87 (0.43-1.40)	0.799 ^b

ATSPPH-SF: Attitude scale towards seeking psychological help-short form SSPSPHS: Self-stigmatization scale in the process of seeking psychological help. ISPHI: Intention to seek psychological help inventory, SSDSPHS: Social stigma scale in the process of seeking psychological help. ^aStudent *t*-test, ^bMann-Whitney U test.

Table III. Correlation analysis between fibromyalgia affect scale and other scales.

	FIQ		FIQ
ATSPPH-SF	$r = 0.138, p = 0.338$	SCL-90 obsession	$r = 0.417, p = \mathbf{0.003}$
SSSPHS	$r = 0.288, p = \mathbf{0.043}$	SCL-90 depression	$r = 0.575, p < \mathbf{0.001}$
ISPHI	$r = 0.021, p = 0.886$	SCL-90 personality	$r = 0.382, p = \mathbf{0.006}$
SSDSPHS	$r = 0.131, p = 0.366$	SCL-90 psychoticism	$r = 0.467, p < \mathbf{0.001}$
SCL-90 general	$r = 0.602, p < \mathbf{0.001}$	SCL-90 paranoid	$r = 0.434, p = \mathbf{0.002}$
SCL-90 additional	$r = 0.573, p < \mathbf{0.001}$	SCL-90 anger	$r = 0.374, p = \mathbf{0.008}$
SCL-90 somatization	$r = 0.670, p < \mathbf{0.001}$	SCL-90 phobic	$r = 0.457, p < \mathbf{0.001}$
SCL-90 anxiety	$r = 0.580, p < \mathbf{0.001}$		

ATSPPH-SF: Attitude scale towards seeking psychological help-short form SSPSPHS: Self-stigmatization scale in the process of seeking psychological help. ISPHI: Intention to seek psychological help inventory, SSDSPHS: Social stigma scale in the process of seeking psychological help; SCL-90-R: Revised 90-item Symptom Screening Questionnaire; FIQ: Fibromyalgia Impact Questionnaire.

In the patient group, those with a score less than 1 according to the SCL-90 scale total score were considered as low active psychotic symptom levels. The number of patients with low active psychotic symptom level was 30 (60.0%), while the number of patients with high or very high active psychotic symptom level was 20 (40.0%). Fibromyalgia impact scale scores of patients with low active psychotic symptom level were found to be significantly lower than patients with high active psychotic symptom level ($p < 0.001$). While 25% ($n=5$) of the patients with high active psychotic symptom levels had a suicide attempt at transition, the participants with low active psychotic symptom levels did not have a history of suicide attempt ($p=0.007$). Participants with high active psychotic symptom levels had statistically higher scores on FIQ ($p < 0.001$), SSPSPHS ($p=0.016$) and SSDSPHS ($p=0.013$) (Table IV).

Discussion

In the current study, it was determined that somatization symptoms were more common in FM patients than in healthy individuals, and as the psychiatric symptoms increased in these individuals, their level of being affected by FM increased. Again, it was observed that 25% of FM patients with a high or very high active psychotic symptom level in terms of psychological disorder had a suicide attempt at transition and only 50% of these patients sought psychiatric treatment.

In general, it was determined that all patients participating in the study had positive attitudes towards getting psychiatric help. However, it was determined that the self-stigmatization scores of seeking psychiatric help were higher than the control group. In addition, it was determined that as the scores of being affected by fibromyalgia increased, the self-stigmatization scores increased in direct proportion.

Table IV. Comparison of the patient group by symptom level.

Variables	Low active psychotic symptom (n = 30)	High active psychotic symptom (n = 20)	p-value
FIQ mean ± sd	39.84 ± 15.15	55.28 ± 12.32	< 0.001
SCL-90 overall score	0.50 (0.34-0.80)	1.34 (1.15-1.62)	< 0.001
ATSPPH-SF	16.63 ± 2.68	16.90 ± 2.32	0.718
SSSPHS	28.37 ± 5.11	31.90 ± 4.54	0.016
ISPHI	33.77 ± 6.52	32.85 ± 6.27	0.623
SSDSPHS	10.00 (6.75-11.00)	11.50 (8.25-14.00)	0.013
Suicide attempt n (%)	0 (0.0)	5 (25.0)	0.007

ATSPPH-SF: Attitude scale towards seeking psychological help-short form SSPSPHS: Self-stigmatization scale in the process of seeking psychological help. ISPHI: Intention to seek psychological help inventory, SSDSPHS: Social stigma scale in the process of seeking psychological help; SCL-90-R: Revised 90-item Symptom Screening Questionnaire; FIQ: Fibromyalgia Impact Questionnaire.

Considering the literature, many data have been published showing that psychiatric comorbidities may be increased in patients with FM¹⁸⁻²⁰. In a study conducted in Turkey, it was reported that the patient group with FM and rheumatoid arthritis had depression and anxiety as well as high pain scores and somatic symptoms frequently accompanied the clinic of the disease²¹. Pain-like somatic complaints that occur at specific points of the body in FM are already among the main symptoms of the disease. However, sometimes, in addition to these complaints, some somatic symptoms that occur in different parts of the body and can be evaluated as exaggeration or misinterpretation of typical somatic symptoms can also be seen. These somatic complaints can negatively affect the prognosis of the disease by reducing the quality of life of the person^{22,23}.

In many studies comparing fibromyalgia patients with a healthy control group, it has been reported that social and psychological support should be provided in addition to biological support in this patient group in order to eliminate the adverse effects of psychiatric symptoms on the prognosis of the disease and the quality of life of the patients²⁴. In addition, it is known that antidepressant drugs used in this patient group reduce the symptoms of the disease by acting on neurotransmitters, such as serotonin and noradrenaline, which are responsible for pain transmission and central sensitization of pain²⁵. For this reason, patients receiving psychological help in addition to their current treatment and psychiatric treatment when necessary may contribute significantly to the follow-up and continuation of the treatment. In our study, it was observed that the patient group with FM had quite a lot of somatic complaints and, as these somatic complaints increased, the rate of being affected by FM increased. Again, it was determined that 40% of the patients had a high or very high level of active psychotic symptoms in terms of psychological symptoms, although only half of these patients received psychiatric treatment. Psychological help-seeking behavior is when the individual is faced with a psychosocial stressor and seeks help and support from professional or non-professional individuals in order to cope with them^{26,27}. There may be many reasons that may prevent seeking psychiatric treatment in individuals with mental illness or in individuals with a chronic illness accompanied by psychiatric symptoms. One of the most important reasons why these individuals do not seek psychologi-

cal help is stigma anxiety²⁸. Self-stigmatization, which is a type of stigma, is defined as negative perceptions or beliefs that an individual develops based on seeking or receiving psychological help²⁹. In the literature, it has been determined that patients followed up with the diagnosis of FM or chronic fatigue syndrome have higher stigma levels than healthy individuals and even other chronic diseases such as rheumatoid arthritis, osteoarthritis, and multiple sclerosis³⁰.

In a study, the question of whether chronic fatigue syndrome and FM diseases are stigmatizing was investigated through interviews with 25 women with these diseases. It has been determined that women primarily experience stigma before being diagnosed, and the common symptomatology associated with the disease is important for stigma³¹. In our study, it was observed that the self-stigmatization scores of patients with FM were much higher than healthy individuals, according with the literature. Negative prejudices towards individuals with mental disorders may cause them to feel stigmatized and be exposed to discrimination³². As the self-stigmatization score increases, the behavior of seeking psychological help also decreases. It is known that this increasing self-stigmatization behavior increases the burden of disease in patients with FM and leads to a lower level of well-being³³. Both the stigma they feel due to FM and the anxiety they feel about being diagnosed with a mental illness may be an obstacle for these individuals to receive psychiatric treatment. More comprehensive studies to be conducted in this patient group in the future may guide clinicians in this regard.

Limitations

The current study has some limitations. Increasing the number of patients, although sufficient, may help to better understand the relationship with stigma and other clinical variables. Therefore, the relatively small number of patients can be considered as one of the limitations of our study. In addition, in our study, the SCL 90 symptom screening inventory was applied to all participants in order to evaluate the general psychiatric symptoms.

The severity of depression or the severity of anxiety can be determined by using the scales for the disease itself, not for the symptoms. Thus, the relationship between stigma and psychiatric diseases that may accompany FM can be determined more specifically, depending on the type of disease.

Conclusions

It has been determined that fibromyalgia patients have more somatization symptoms than healthy individuals, and as psychiatric symptoms increase in these individuals, their level of being affected by FM increases. It has been determined that FM patients have a positive attitude toward getting psychiatric help, but their self-stigmatization scores are high in getting psychiatric help. Self-stigmatization behavior may be one of the barriers to getting psychiatric help in this patient group.

Conflict of Interest

The authors declare that they have no conflict of interests.

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Ethics Approval

The research was approved by the Firat University Non-Interventional Research Ethics Committee (Ethics Committee approval date: 02.01.2020 number: 2020/01-13).

Informed Consent

Written informed consent was obtained from all patients. The study was conducted in accordance with the principles of the Declaration of Helsinki.

Authors' Contribution

AB, EO, SK: Data collection, design, Led and conceived the project, and authored the manuscript. TG, HA, TKK: Data collection, compiling, and discussion. BY: Contributed to collecting and analysis data, discussion ED, AK, SSK: Supervision, writing, review, and editing.

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