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ORIGINAL PAPER

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To seek advice or not to seek advice about the problem: the help-seeking dilemma for obsessive-compulsive disorder

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Abstract *Background* Although obsessive-compulsive disorder (OCD) is associated with considerable distress, it has been reported that OCD patients delay considerably in seeking treatment for their problem. The present study aimed to explore some variables hypothetically involved in the help-seeking process among OCD patients. *Methods* Twenty-six OCD patients without comorbid conditions completed the Interview of Help-Seeking, specifically designed for this study, which assesses to what extent patients delay seeking treatment for their problem, and three group of variables: factors influencing the recognition of the problem, reasons for delaying the treatment-seeking, and reasons for finally seeking treatment. Participants also completed OCD measures, as well as a questionnaire on thought control strategies. *Results* The mean length of delay in seeking treatment was 39.38 (SD = 50.95) months, and a great variety of reasons for delaying were observed. The OCD patients who delayed consultation longer, in comparison with patients who delayed less time, used fever social control strategies, and they were less aware of the interference and behavioral changes associated with the problem. *Conclusions* To gain more insight about the problem and to experience greater interference from the symptoms were determinants in the active search for help. Conversely, the main barriers to the help-seeking were the fears of stigma and the meaning of the thought contents. Additionally, the fact that patients are willing to disclose their obsessions to other people may favor an adequate representation of the problem and the need to seek mental health treatment.

Key words obsessive-compulsive disorder – obsessions – help-seeking – insight

Introduction

Epidemiological studies on mental disorders report that a substantive percentage of mentally disabled people do not receive adequate treatment in spite of having adequate access to the mental health resources [13, 25, 32].

The Obsessive-Compulsive Disorder (OCD) is a chronic and disabling mental health condition associated with considerable distress and interference in daily functioning. Nevertheless, it has been reported that only a reduced rate of subjects suffering OCD seek psychological and/or psychiatric treatment. Data from different community-based survey studies suggest that only 34 to 40% of the subjects that meet screening criteria for OCD have ever received mental health treatment [11, 15]. Moreover, the Epidemiologic Catchment Study [23] indicated that the OCD

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compared to other mental disorders, is in the middle range with regard to the likelihood of treatment seeking. For example, patients suffering panic disorder or depression, have higher rates of treatment seeking than OCD sufferers, whereas specific phobias or drug/alcohol abuse disorders are associated with lower treatment-seeking rates.

One related problem is the delay in seeking help in OCD patients. In routine clinical practice, it is frequently observed that OCD patients do not seek mental health treatment until a considerable amount of time after the initial onset of symptoms. This observation received some support in a study [22] reporting an average delay of 7.6 years from the onset of symptoms to the search for professional help in the OCD patients. Some authors have examined to what extent the socio-demographic characteristics and illness-related variables influence the search for mental health resources among OCD patients [8, 11, 15]. It has been reported that the "help-seeker" OCD individuals had a higher total number of OCD symptoms and more comorbid diagnoses, such as panic disorder, generalized anxiety disorder, and post-traumatic stress disorder, than the "non help-seeker" ones. Similarly, depressive disorders are a frequent reason for seeking treatment among OCD patients [37]. By contrast, only 13.9% of pure OCD subjects (i.e., without comorbid conditions), compared with 55.6% of comorbid OCD patients, received treatment as a consequence of their help-seeking [33].

Several reasons for delaying the search for treatment among OCD patients have been pointed out. It has been reported that people suffering from OCD tend to be secretive about their problems for many years, and they may be confronted with many fears about revealing the content of the obsessions to other people. It has been suggested [17] that the tendency to deliberately conceal the content and frequency of obsessions could be considered an overlooked safety-behavior in OCD, playing an important role in the maintenance of the disorder because the person is never exposed to alternative interpretations about the nature and meaning of their thoughts. The factors that could be influencing the concealment of obsessions are the fear of negative reactions from others (e.g. social rejection, to regarding the person as being bad or malicious, mentally ill or dangerous), the feelings of shame or guilt associated with the obsessions, and the fear that the obsessions could be used against the subject [17]. Several obsession-related beliefs (need to control the thoughts, thought-action fusion beliefs) are also proposed as being related to the concealing of obsessions. From this perspective, the disclosure of the obsessions to a therapist could be a very stressful experience for many OCD patients [17]. On the opposite extreme, some variables that influence the disclosure of obsessions and the active involvement of patients in help-seeking for their disorder could be the need for reassurance (for instance, asking another person to ensure the thought will not come true), the need to unburden and obtain relief and liberation, and the awareness that the problem interferes with one's social relationships or daily activities.

Nevertheless, the above-mentioned assumptions mainly refer to the obsessions which include repugnant thoughts, images or impulses concerning sex, violence, aggression or blasphemy, usually without overt compulsions and/or rituals. Consequently, doubt remains about whether the concealment of obsessions is or is not associated to a greater extent with the "pure obsessions" than with other OCD manifestations (i.e., contamination fears, checking, ordering). To explore this possibility, it would be helpful to characterize different patterns of help-seeking or, alternatively, different reasons for help-seeking delay, depending on the modality of obsessions that are being experienced. However, there are no empirical data about this question.

From an experimental perspective, the attitudes toward the obsessive-compulsive problems have been investigated in a non-clinical sample [31]. The results indicate that the content of obsessions influences both the attitudes towards the obsessions and the active search for treatment. Moreover, it is suggested that the help-seeking influencing variables may vary across different OCD subtypes (harming, checking, aggression, and blasphemy obsessions are the OCD manifestations investigated). For example, the aggression and blasphemy obsessions received the most negative evaluations followed by the washing compulsions and then by checking compulsions [31]. Even though the checking problems were less readily identified as problematic, it may be easier for the person to disclose and seek help. Conversely, although the aggressive/blasphemous contents and washing were the worst rated, and recognized as the most problematic mental problems, it may be harder to disclose and seek help. Another scarcely examined issue regarding the possible differences among OCD presentations is the age at symptom onset. One study [25] compared adult OCD with an early symptom onset to OCD subjects with a later symptom onset, and a worse treatment response, higher severity, and higher comorbidity in the early onset group was found.

In summary, there are some suggestions indicating that OCD patients and specially those without comorbid conditions associated with the OCD, are reluctant to seek advice about their problems, and so they delay seeking mental health treatment. However, the reasons that could explain these delays have not been empirically explored from the point of view of the patients themselves. In our opinion, achieving a deeper understanding of the barriers to and motivators of help-seeking among OCD patients could have remarkable implications, both at a psychopathological and from the perspective of public health policies:

early detection and intervention, epidemiological surveys, and efficacy of therapeutic interventions, among others.

The present paper aims to explore the aforementioned issues. To that end, a structured interview for help-seeking was designed and applied to a group of OCD patients without comorbid disorders ("pure OCD patients"). The specific goals of this study were: first, to examine the extent to which pure OCD patients delay help-seeking, and the extent to which they initially recognize the existence of a problem (that is, insight from the onset of noticeable symptoms); second, to explore the reasons reported by OCD patients to help seek for their disorder; third, to identify the differences between short and long delayers in the help-seeking process; and finally, to analyze the associations among the delay rates and questionnaire measures on obsessionality and thought control strategies.

Methods

Participants

In order to avoid interference with comorbid diagnoses other than OCD, only those patients who received a principal Axis I DSM-IV [2] diagnosis of OCD without current comorbid diagnoses participated in the study. From the 50 patients initially interviewed, only 26 meet the aforementioned criteria and were then included in the study. A total of 61.5% of participants were women. The mean age of patients was 32.85 (SD = 9.39) years (range from 21 to 60 years). At the time of the study, all the participants were outpatients who visited a mental-health clinic looking for professional help.

The patients were recruited during a one-year period in two outpatient mental health clinics included in the network of the public National Health System and located in the outskirts of the city of Valencia (Spain). Both of these clinics serve a population of approximately 160,000 people, and the number of patients who visited both centers for the first time during the year of the study was 1,081. All the patients were referred for psychological evaluation and treatment by the psychiatrist-in-chief of each of the two clinics on the basis of the usual organization of these clinical settings. Patients who had the following features were not included in the study: borderline intelligence or less, illiteracy, and age under 18 years or over 60 years. To be included in the current study, the patients must fulfill two requirements: first, a principal OCD diagnosis without comorbid conditions, and second, to be the first time that the patients were seeking for help due to their OCD symptoms.

Measures

Structured interviews

The *Interview on Help-Seeking (IH-S)* was developed by the authors for this study and was conceived as a questionnaire to be administered by the clinician. It was designed on the basis of the patients' information about their help-seeking process throughout our routine clinical practice. Help-seeking was defined as the first voluntary contact with a formal health provider (GP or other physician, psychiatrist, clinical psychologist, or social worker). The IH-S starts with two questions: the first deals with how much time, in months, the consultant has delayed his/her search for help for the OCD problem after the onset of noticeable symptoms. Delays due to reasons other than the self-determination to seek help were explicitly excluded: for example, the waiting list in the Outpatient Clinic, difficulties related to work or personal duties, etcetera. The second question is addressed to delineate to what extent there was insight about the disorder from the beginning of the noticeable symptoms: "Did you realize from the beginning that your problems/thoughts/behaviors were not normal?" (Response format: Yes/Not). After these two initial questions, the patients were invited to answer three set of questions: (1) the patient's reasons for recognizing the problem, (2) the patient's reasons for delaying treatment seeking (that is, barriers to help-seeking), and (3) the patient's reasons for seeking treatment (that is, motivators of help-seeking). Each question was presented in the form of an open question: "How did you recognize you had a problem?"; "Why did you delay in seeking treatment for your problem?"; and, "Why are you currently seeking treatment for your problem?". After every question a list of possible answers was presented, and the subjects were asked to mark all those that they considered applicable to themselves: the first question was followed by six possible answers, and questions two and three were presented with ten possible answers each. Moreover, at the end of each section an open answer ("other reasons you consider") was also offered. The time required to complete the IH-S was around ten minutes.

The *Yale-Brown Obsessive-Compulsive Severity Scale* (YBOCS) [6, 9, 10] was applied to measure OCD severity. It yields three scores: severity of obsession, severity of compulsions, and a total score obtained by adding the obsession and compulsion subscores together (ranging from 0 to 40). The YBOCS items assess the frequency, interference, distress, resistance, and perceived control of both obsessions and compulsions, using a scale from 0 (none) to 4 (extreme).

Self-report questionnaires

The Spanish validated versions of the following questionnaires were completed by the participants:

Maudsley Obsessive Compulsive Inventory (MOCI) [3, 12, 21]. Is a self-report questionnaire designed to evaluate obsessive-compulsive symptoms. It consists of 30 true/false items in four subscales: washing, checking, slowness, and doubting. The MOCI mainly assesses overt compulsive symptoms.

Thought Control Questionnaire (TCQ) [14, 36]. This 30-item self-report instrument assesses the frequency of the use of different strategies to control negative unwanted thoughts. The instrument includes five empirically derived subscales: distraction, punishment, reappraisal, social control and worry. The items are scored on a 4-point Likert scale from 1 = "Never" to 4 = "Almost always". In a confirmatory factor analysis [14], the five-factor structure of the TCQ was confirmed, but the length of the instrument was reduced in order to preserve good psychometric properties. A new 16-item TCQ version, was postulated in order to improve the interpretation of the factor contents. This reduced version of the TCQ has been applied in the current study.

Procedure

All potential participants were individually screened with a full history and examination by a licensed clinical psychologist (Doctoral level). The intake assessment consisted of a diagnostic interview using the Anxiety Disorders Interview Schedule for DSM-IV: Lifetime version (ADIS-IV-L) [7] in a session lasting 120–150 min. Information about basic demographic data (age, gender, occupation, educational level, socio-economic status), medical conditions and current/past psychological or pharmacological treatments was also recorded. The evaluator also completed the YBOCS to assess the OCD severity. The patients were informed about the purpose and assessment procedure of the study, and they gave their explicit consent to participate. Once the explicit consent was given, the Interview of Help-seeking was administered. After this assessment session, each patient was then given a questionnaire packet containing the self-report questionnaires described in the instruments section (MOCI and TCQ). A half of patients were administered the IH-S one week after the first administration.

Statistical analyses

The temporal stability of the IH-S was examined by using the Intraclass Correlation Coefficient (ICC; 95%). Differences between the study groups were examined by using Student's *t* test (for quantitative data with normal distribution), or non-parametric tests (Chi square test, χ^2, for qualitative data and/or not normal data distribution). The differences between the subjects with an early-onset and those with late-onset of OCD symptoms was analyzed dividing the subjects into two groups, taking as a cut-off point the median age at onset of symptoms. The differences between short and long delayers' subjects were examined by dividing the patients into two groups: patients who made formal contact due to their symptoms in the first year of initial onset (short-delay group) and those who delayed more than one year (long-delay group). The associations among the delay rate and the questionnaire measures were analyzed applying zero order correlations. All reported *P* values are two-tailed. The significance level was set at $P \leq 0.05$. Effect sizes (ES) and Cohen's *d* were also estimated. Descriptive data are expressed as Mean (SD) or percentages (%).

Results

Demographic data and OCD severity

A total of 38.5% of patients had compulsory studies, 30.8% had high-school studies (typically 3 years after compulsory), and 30.8% had university or college educations. The 61.5% of the subjects were married.

Regarding the OCD severity (YBOCS, total score), 8 patients were moderate (YBOCS = 16 to 23), and the remaining 18 were severe (YBOCS = 24–40). The mean age at OCD symptom onset was 24.3 (SD = 9.0) years (Median = 22.5 years; range = 9–50 years).

Help-seeking variables: reliability and descriptive data

The temporal stability of the IH-S was excellent. The following values were obtained for each set of questions: How did you recognize you had a problem?: ICC = 0.90 (range: 0.88–0.91); Why did you delay in seeking treatment for your problem?: ICC = 0.93 (range: 0.90–0.95); and, Why are you currently seeking treatment for your problem?: ICC = 0.92 (range 0.89–0.92).

The time that patients delay in seeking professional help was 39.38 (SD = 50.85) months (range: 2–228 months; Median delay = 24 months). The proportion of patients who made treatment contact in the year of the initial onset of the disorder was 38.46%, and the median delay among people who made treatment contact after the year of initial onset was 45 months. In spite of this fact, 53.8% of patients recognized they had a problem soon after the early symptoms began, whereas 46.2% did not present early insight.

Table 1 shows the percentage of responses to each answer selected by the subjects, ordered from the most to the least reported. A high rate of patients indicated difficulties in controlling the obsessions and/or compulsions and the interference that these symptoms had on their daily activities as reasons for seeking treatment. Changes in mood state (dysphoria) and being aware of changes in their own behavior were also selected by a large number of patients. Six patients also decided to consult with a professional following the advice of others (close relatives in all cases), and only one patient reported having some information about OCD.

As for the most reported barriers to treatment-seeking (second section of the IH-S), four were related to a denial of the problem, together with self-confidence about its control. However, it is interesting to note that the other most reported reasons were related to fears about the stigma associated with a mental disorder. The least reported reasons by patients were related to fears about disclosing their thought contents and some form of thought action-fusion appraisals. Two patients also selected non-interference of symptoms as a reason for their delay in contacting mental-health resources.

Finally, the most frequently selected answers to the question about the reasons for seeking help (third section) can be clustered in four types: the interference caused by the disorder was too high; mood changes (dysphoria); dysfunctional beliefs attached to the thoughts; and having increasing insight about the illness basis of the problem.

As a great variability in the age at the onset of the disorder was observed, we explored the possibility that an early onset was associated with a longer delay in seeking professional help. This assumption was confirmed, as a significant relationship was obtained between early age of OCD onset and delay in help-seeking ($r = -0.51$; $P = 0.007$). Given this result, the differences in the IH-S between the subjects with an early-onset and those with late-onset of OCD symptoms, was then analyzed. The 13 subjects included in the early onset group had a mean age at the onset of their symptoms of 17 (SD = 3) years, whereas the mean age of the not-early onset group at the symptoms onset was 31 (SD = 7) years. The two groups did not differ on any demographic or questionnaire measures and they were also comparable on their OCD severity (YBOCS). However, the patients in the early-onset group reported significantly worse insight that the subjects in the late-onset group, as was revealed by a low percentage of responses to some of the questions on the IH-S: they did not notice changes in their behaviour ($\chi^2_{(1,\ 24)} = -2.69$; $P = 0.007$); they needed others to tell them that their behaviour was

Table 1 Interview of Help-Seeking (IH-S). Percentage of reported responses (26 OCD patients)

	%
Section I. How did you realize you had a problem?	
I couldn't control (my behavior and/or thoughts)	84.6
It interrupted what I was doing	80.8
I felt sad	65.4
I noticed changes in my behavior	61.5
Someone told me that my behaviors (and/or concerns) were unusual or strange	23.1
I have information about the disorder	3.8
Section II. Why did you delay in seeking treatment for your problem?	
I was convinced that the problem was temporary (it would pass over the time)	50
I felt I could control the problem	34.6
I believed my behaviors and/or thoughts were not serious	34.6
I felt ashamed by the thought contents	34.6
I feared being considered a mentally ill person	30.8
I thought it was not a problem requiring professional help or treatment	23.1
I was afraid (of the thought contents)	19.2
The problem did not interfere in my daily activities	7.69
I was afraid someone would tell me I was a bad person for having these thoughts	3.8
I feared that if I disclosed the thoughts to someone, the thoughts could come true	3.8
Section III. Why did you seek treatment for your problem?	
The problem didn't disappear, I couldn't control it	77
The problem (thoughts and/or behaviors) interfered with what I was doing	77
The problem (thoughts and/or behaviors) became more and more disturbing	73.1
The problem (thoughts and/or behaviors) became more frequent	65.4
I felt sad	65.4
I was afraid of what was happening to me	57.7
I believed that my thoughts could come true	57.7
I thought I had a serious problem (an illness)	46.2
Someone advised me to seek treatment	38.5
I thought I was a bad person for having these thoughts	30.8

unusual ($\chi^2_{(1,\ 24)} = -2.62$; $P = 0.009$); they experienced fewer fears associated with their obsessions ($\chi^2_{(1,\ 24)} = -3.01$; $P = 0.003$) and less insight about their symptoms indicating an illness ($\chi^2_{(1,\ 24)} = -2.07$; $P = 0.03$).

Differences between short and long delayers on the help-seeking process, demographic characteristics, and OCD severity

Regarding the time that patients delayed on the help-seeking process, there were 10 patients included in the short-delay group and 16 subjects included in the long-delay group. On the first section of the IH-S (*How did you recognize you had a problem?)*, the short-delay group was shown to have more insight from the beginning about their symptoms ($\chi^2_{(1,\ 24)} = 2.07$; $P = 0.03$); they experienced the symptoms as interfering more in their daily activities ($\chi^2_{(1,\ 24)} = 2.01$; $P = 0.05$), and they were aware of the changes in their behavior as a consequence of having the symptoms ($\chi^2_{(1,\ 24)} = 2.31$; $P = 0.02$). As for the second section of the Interview (*Why did you delay in seeking treatment for your problem?)*, the long-delay group reported more frequently feeling ashamed of the symptoms ($\chi^2_{(1,\ 24)} = 2.04$; $P = 0.04$) and fearing the stigma associated with a mental disorder ($\chi^2_{(1,\ 24)} = 2.05$; $P = 0.04$). There were no differences between the two groups on the questions related to the third section of the interview (*Why did you seek treatment?)*.

Taking into account the socio-demographic data, the short-delay group had a lower educational level ($\chi^2_{(1,\ 24)} = 2.01$; $P = 0.04$), but no other difference was found. The two groups do not differ on their OCD severity either: short-delayers YBOCS = 28.30 (SD = 4.52); long-delayers YBOCS = 26.63 (SD = 5.89); $t_{24} = 0.76$. However, the long-delayers obtained higher scores on the MOCI slowness/repetition subscale: 2.5 (SD = 1.46) versus 1.20 (SD = 1.03); $t_{24} = 2.44$; $P = 0.02$.

Relationships among the help-seeking delay and thought control strategies

The time that patients delayed in searching for help was only related to low scores on two TCQ subscales: social control ($r = -0.41$; $P < 0.001$; Cohen's $d = 0.78$; ES = 0.36), and reappraisal ($r = -0.48$; $P < 0.001$; Cohen's $d = 0.69$; ES = 0.32). When the age of OCD onset was partialled out, these associations remained significant ($r = -0.40$; $P = 0.02$; $r = -0.54$; $P = 0.005$, for social control and reappraisal respectively).

Discussion

This study was designed to explore the variables involved in the help-seeking decision among clinical OCD patients. To that purpose, a structured interview of Help-Seeking was specifically designed and applied to OCD outpatients without comorbid conditions and seeking for help for the first time, in the context of a routine clinical practice in two public-mental health services included in the National Health System. It is important to say that these services are community-based and universally available.

Our first objective was to assess the extent to which OCD patients delay help-seeking from the initial onset of the symptoms to the first contact with a formal health provider. The OCD patients delayed, on average, slightly more than 3 years in seeking help, although a remarkable dispersion among delay rates was also observed. Interestingly, we also observed that an early onset of OCD symptoms is associated with a longer delay in help-seeking. Even though there are few data on the amount of delay in help-seeking among OCD patients without comorbid conditions, the figure obtained in the present study is lower than what was reported by other studies [22, 30]. We cannot provide explanations for these data, because the design study does not allow us to make cross-cultural comparisons. So, we can only hypothesize that perhaps the universal access to the public health services in our context, or other socio-cultural factors involved, such as the existence of strong and extended social support networks, underlie the relatively short delay rates found. The positive role of the social support network as a source of help-seeking has been reported in a study on help-seeking for anxiety disorders and depression [24].

The process of help-seeking has several stages [16]. Our second goal was to explore the factors that might have some influence on these stages, which we have operationalized as reasons reported by OCD patients on three sets of variables related to the help-seeking process: first, what the OCD patients base their illness insight on; second, the barriers to help-seeking or reasons for delay in searching for professional help; and third, the motivators of help-seeking. Our data suggest a relative homogeneity among the first and third set of reasons, since a greater variability was observed in relation to the barriers to help-seeking. The results suggest that almost all OCD patients recognized the symptoms early and searched for help when the problem had negative consequences in their daily lives. In other words, the problem is easy to recognize, and the patients are ready to consult a professional when the symptoms are beyond their self-control, which suggests that the patients make sustained efforts to keep their thoughts and/or associated behaviors under control before looking for help. The effort to keep the obsessions under control, and the failure to achieve this, has been consistently argued by the cognitive approaches to OCD as a main factor in explaining the genesis and the maintenance of the disorder [5, 18, 19, 20, 26, 27]. Although this study was not designed to find support for this assumption, the fact that failure to control the thoughts and behaviors was selected by a large percentage of patients as a warning sign of having a mental-health problem, as well as a motivator of help-seeking, indirectly provides support for the cognitive explanation of the disorder.

The interference, unpleasantness, recurrence, and behavioral and mood changes (sadness, fear) associated with the symptoms were also reported as main reasons for the awareness of the problem and the search for help among obsessive patients. These results support the role of the interference caused by the symptoms as a motivator of help-seeking [1, 17]. The seeking mental health treatment is a process that begins when the person initially recognizes s/he has a problem and finishes when s/he initiates contact with mental-health services. In fact, it has been found that people with different disorders seeking psychotherapy reported that the recognition of the problem was the most difficult step to achieve [28]. From this perspective, the interference experienced by the patients in this study could be the main warning signal that motivates the active help-seeking. Additionally, our data indicate an impaired quality of life in OCD patients, as was found in other study [33] when comparing the impact of symptoms interference in OCD subjects with that observed in other neurotic disorders. However, it was also noticeable that several patients decided to consult a professional following advice from close others, which suggests that, in spite of the interference caused by the symptoms, some patients need help from others to acquire some insight into their problems. On the other hand, the fact that "to believe that the thoughts could come true" was selected by more than half of the patients could be considered a way to obtain reassurance from others, as has been suggested [17]. Finally, it must be remembered that only one patient decided to consult a professional because s/he had information about the disorder. This indicates the lack of information about OCD among the general population, which, in our opinion, suggests the need to implement active policies to disseminate knowledge about early symptoms of this disorder as a way to reduce the associated functional impairment and personal suffering and enhance the possibilities that current treatments can be offered to OCD patients.

Regarding the reasons for the delay in help-seeking, we observed a great heterogeneity, which could be due to the very different attitudes patients have with regard to mental disorders and mental health treatments. In this sense, as some authors have pointed out [29, 31], the role that the social concept of the disorder plays in the treatment-seeking process must be taken into account. Denial of the problem, fears of the stigma associated with mental-health problems, and lack of knowledge about the disorder, again indicates the necessity of actively disseminating information about this disorder. On the other hand, some suggested reasons for the concealment of obsessions, such as being considered evil for having the thoughts, or thought fusion-action beliefs [17], were only marginally selected by the patients.

Our third objective was to examine the differences between OCD patients with long and short delay rates, on socio-demographic variables, symptom measures, control strategies and patterns of help-seeking. The long and short delay groups were comparable on age, gender distribution, marital status and economic level. These results are not consistent with some community-based survey studies that found a greater proportion of women among help-seekers for anxiety and depressive disorders in comparison with non-help-seekers [24, 34, 35]. However, it must be noted that in the former study, the gender differences disappeared when the load of age was controlled. Additionally, in the third report, there were no gender differences in the overall help-seeking, and when the severity of depression was controlled, depressed women required a higher threshold of symptom severity before deciding to seek help.

A low educational level among the short-delayers was observed, which suggests that OCD is more concealed among highly-educated people. This result coincides with others studies [24, 34] reporting a higher rate of help-seeking among persons with the lowest level of studies for their anxiety or depressive problems. We can only speculate about this data, and more detailed studies must be planned to ascertain the possibility that higher-educational levels could be associated, for instance, with higher fears of the stigma for having a mental-health problem. As for the OCD related data, the long-delayers did not differ from the short-delayers on severity, but they scored higher on the slowness/repetition subscale of the MOCI. This result could indicate that in this modality of obsession the tendency to conceal the problem increases, and, subsequently, the risk of chronicity and functional impairment may also be increased.

Concerning the differences between long and short delayers on the IH-S, some interesting differences were observed. As for the reasons to consult a professional, having more insight about the problem and experiencing greater interference by the symptoms were determinants in the active search for help. Conversely, the main barriers to the help-seeking were fears of stigma and the meaning of the thought contents, which supports some suggestions about the reasons behind the concealment of obsessions [17].

On the whole, the time delay in seeking help was shown to be associated with few variables, with the most relevant being the age at onset of symptoms and the use of two thought-control strategies: reappraisal and social control. The relationship between an early onset of symptoms and more time needed to seek professional help could reveal that the subject has become used to these obsessions and/or rituals over time, and has more difficulties in achieving adequate insight about the symptoms. Additionally, the significant others might also consider the behavior and concerns of the patient to be normal. Perhaps only when the subject experiences changes in her/his network of social relationships, as a result of increasing age, does she/he acquire the necessary insight about the disorder and feel motivated to search for help. This possibility could explain why the only differences on the IH-S among the subjects with an early age of OCD onset and the patients with a late onset were on the answers indicating low insight and low concern about the disorder.

An interesting result emerged on the general thought control strategies as measured by the TCQ: the long delay group scored lower on reappraisal and on social control. As a result, this group of patients seems to be more reluctant to disclose their negative unwanted thoughts to other people and compare them, thus contributing to maintaining the disorder [17]. In a recent study [4], a non-dysfunctional characterization of these control strategies was postulated in the following terms: the disclosure of the obsessions to close others could be considered a non-dysfunctional way to cope with the obsessions, as it opens up the possibility of obtaining a non-threatening explanation about the presence and/or content of these thoughts. Consequently, the fact that patients are willing to disclose their obsessions to other people may favor an adequate representation of the problem and the need to seek mental health treatment.

A number of limitations must be considered when interpreting the findings of this study. The study sample was reduced, and this fact limits the generalizability of the results. However, given the low prevalence of pure OCD patients (that is, without comorbid conditions), our sample can be considered reasonably representative of the disorder. The use of a new instrument, the IH-S, which requires further refinements, is another methodological limitation. Moreover, we cannot discard the memory effects with regard to the correct estimation of the delay rates and reasons related to the help-seeking, given that these data were only obtained from the reports of the patients themselves. We tried to dismiss these effects by means of the Intraclass Correlation Coefficient of the IH-S, which offers an estimation of the temporal stability of a measure. We are aware that a period of only a week between the first and second assessment is too short a period to obtain a correct estimation about the stability of the IH-S. However, in order not to delay the treatment process (which started after the patients completed the evaluation protocol), we consider that more than a week would be inappropriate (and most important, unethical) for our patients. It must be kept in mind that in order to analyse the stability of a measure, the conditions of assessment must be the same across time. Undoubtedly, the introduction of the patients into a treatment protocol presents a new scenario that could influence the stability of a measure.

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