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Predictors of help-seeking for suicidal ideation in the community: Risks and opportunities for public suicide prevention campaigns

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ABSTRACT

Help-seeking behaviour for suicidality is low and the reasons for this have not systematically been examined. The aim of the current study was to examine the relationship between suicide stigma, suicide literacy and help-seeking attitudes and intentions. One thousand two hundred seventy-four Australian adults recruited via Facebook completed an online survey assessing a range of mental health outcomes. High suicide literacy and low suicide stigma were significantly associated with more positive help-seeking attitudes and, among a subsample of 534, greater intentions to seek help. Attribution of suicide to isolation was associated with more positive attitudes toward help-seeking and greater intentions to seek help, while respondents experiencing suicidal ideation had more negative attitudes toward help-seeking and lower intentions to seek help. Lower depressive symptoms, older age and female gender were associated with more positive help-seeking attitudes and higher help-seeking intentions. However, there were differential associations of specific suicide knowledge items and specific stigmatising attitudes with help-seeking outcomes; suggesting a nuanced approach may be required to promote help seeking for suicidality. Suicide knowledge and attitudes play an important role in the help-seeking process for suicide and should be carefully considered in the development of public awareness campaigns.

1. Introduction

Suicide is a major public health problem, with a high disease burden. The World Health Organisation's World Mental Health Surveys estimate that the 12-month prevalence rate of suicide ideation and attempts in developed countries is 2.0% and 0.3% respectively (Borges et al., 2010). Evidence suggests that help-seeking for suicidality is low, with 55% of people who complete suicide having no contact with a primary care provider in the month before suicide and 68% having no contact with mental health services in the year before suicide (Luoma et al., 2002). Currently, we know little about why those at risk of suicide do not seek help.

In contrast, much research has been conducted about help-seeking for mental disorders, such as depression and anxiety, which may shed some light on the processes of help-seeking for suicide. In particular, the importance of mental health literacy (knowledge of the symptoms, causes and treatment of a disorder) and stigma (negative attitudes towards individuals with a disorder) in the help-seeking process has been highlighted. Research in this area has developed from Azjen's theory of planned behaviour, which emphasises the direct links between knowledge, attitudes and beliefs to intentions and behaviours (Ajzen, 1991). This theory has been applied directly to models of help-seeking for mental disorders. For example, for social anxiety (Griffiths, 2013), it is proposed that an individual's knowledge (e.g., symptoms, causes, prevalence) and beliefs (e.g., diagnosis applicable, benefits of treatment) about the disorder can influence their attitudes (e.g., stigma, positive to help-seeking) towards the condition and subsequent willingness to seek help for it.

The purported relationship between mental health literacy, stigma and help-seeking behaviour highlighted in this model is supported by community-based research that has found low mental health literacy and high stigma to be associated with an unwillingness to accept help from a mental health professional, a lack of treatment adherence and a tendency towards inappropriate service use (Jorm et al., 1997; Jorm, 2000; Jorm et al., 2003; Barney et al., 2006; Reynders et al., 2014). However, no research has

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examined the roles of suicide stigma and suicide literacy in help-seeking for suicidality. With the development of new measures to directly assess personal stigma toward people who die by suicide (Batterham et al., 2013) and suicide literacy (Calear et al., 2014), it has become possible to evaluate whether these constructs influence an individual's propensity to seek help.

Other factors identified as positively affecting help-seeking attitudes and intentions for mental disorders have included female gender, older age, and greater symptom severity (Rickwood and Braithwaite, 1994; Deane et al., 2001; Sheffield et al., 2004; Barney et al., 2006; Reynders et al., 2014). Suicide ideation is another factor that needs to be considered in the help-seeking process for suicide, as high suicide ideation has been associated with lower intentions to seek help (Deane et al., 2001). The term 'help-negation' has been used to describe this process of refusing to access or accept available help as symptoms increase (Rudd et al., 1995). Help-negation for suicidal ideation has been reported in a number of studies (Rudd et al., 1995; Carlton and Deane, 2000; Deane et al., 2001) and is considered to be a significant barrier to help-seeking for suicide.

The primary aim of the present study was to examine the relationships between suicide stigma, literacy and help-seeking attitudes and intentions. These relationships were investigated using the short forms of the Stigma of Suicide Scale (SOSS; Batterham et al., 2013) and the Literacy of Suicide Scale (LOSS; Calear et al., 2014). The SOSS is the first scale designed specifically to evaluate personal (public) stigma toward individuals who die by suicide, rather than self-stigma, the stigma of suicidal behaviours, or the stigma of seeking help for suicidality, which are likely to reflect distinct constructs. Likewise, the LOSS is the first scale designed to assess all aspects of the literacy framework proposed by Jorm (2000). Scores on the LOSS and the three subscales of the SOSS (stigma, attribution to isolation and normalisation/glorification) were tested as predictors of help-seeking. For a more nuanced understanding of the specific attitudes and knowledge areas that may drive help-seeking outcomes, the association of individual items of the SOSS and LOSS with help-seeking was also examined. Such analyses could be used to directly inform public awareness campaigns and activities, by identifying the specific messages that are most likely to increase help-seeking in the community, albeit recognising that these examined relationships are correlational.

2. Methods

2.1. Participants and procedure

An online survey was developed to examine a range of mental health outcomes. The survey lasted approximately 30 min, and included measures assessing suicide literacy (LOSS), suicide stigma (SOSS), help-seeking attitudes, help-seeking intentions, depression stigma, psychological distress, depression, anxiety disorders, alcohol use, sleep problems, suicidal ideation, exposure to suicide, interpersonal risk factors for suicide and a range of demographics. Participants were recruited through online advertising on the social network site Facebook. Advertisements were targeted to individuals aged 18 years and older living in Australia. Details of the advertising strategy are provided by Batterham (2014), with an example advertisement reading, 'Mental Health Survey: Participate in a study examining your mental health by completing a 30 min survey now'. From 12,773 clicks on the advertisements, 1283 participants completed the survey, of which nine participants refused to respond to one or more demographic variables. Two versions of the survey were administered, with one reverse-ordered and only one of these versions including help-seeking intention items. Consequently, 1274 participants were included in the analyses of help-seeking attitudes. Of these, a sub-group of 534 who also received the help-seeking intentions scale were included in the analyses of help-seeking intentions. The sub-sample who completed the intentions scale were more likely to have reported suicidal ideation [χ^2 (1)=20.2, $p<0.001$] and trended older [χ^2 (6)=19.8, $p=0.003$] than those who did not complete the scale, with no other significant differences observed.

All participants were provided with written information about the study aims prior to commencing the survey and informed consent was given. A brief list of state-based mental health service contacts was provided to individuals at the consent stage. Participants who completed the survey were provided with an additional list of mental health resources, including physician directory information, help lines, crisis care services, informational resources and online services. The study received ethics approval from the Human Research Ethics Committee at the Australian National University.

2.2. Measures

Five help-seeking outcomes were assessed: attitudes towards help-seeking and intentions to seek help from four sources, namely psychologist or psychiatrist, general practitioner (family physician), family or friend, or nobody. The help-seeking attitudes measure was an updated version of the 10-item Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS-SF; Fischer and Farina, 1995). The scale was originally developed in the 1970s and includes dated terminology that poorly represents mental health problems (e.g., "mental breakdown") and may require high literacy levels. The first four items of the scale were rewritten, with revised versions compared to their original counterparts. The rewritten items included: "If I was having personal or emotional problems, the first thing I would do is seek professional help", "Talking with a professional about my personal or emotional problems is not the best way to resolve them", "If I was having personal or emotional problems, I am sure that seeing a professional would be helpful", and "I would admire a person who dealt with their problems without getting professional help".

Items on this scale assess a range of attitudes towards seeking help from professional psychological services, including need for help, stigma tolerance, interpersonal openness, and confidence in mental health professionals (Fischer and Turner, 1970). Each item is rated on a four-point scale from 0 "Agree" to 3 "Disagree", with agreement indicating a positive attitude for five items and a negative attitude for the other five items, which are reverse scored. Scores on the help-seeking attitudes scale were assessed as the sum of responses to all items, ranging from 0 to 30, with higher scores indicating more positive attitudes towards seeking professional psychological help. There were strong correlations between the original first four items of the ATSPPHS-SF and their revised versions ($r=0.42$–0.56). Factor loadings were similar on both versions, with a single factor accounting for 43% of total variance for the original scale and 42% of total variance for the revised scale. Cronbach alphas were similar at 0.85 (original) and 0.84 (revised), and were also similar to those reported in previous studies (Fischer and Farina, 1995; Woodward and Pachana, 2009). The Flesch–Kincaid reading level was 12.7 for the four original items and 10.1 for the revised versions of these items. Considering the similarities in items, variance explained and internal reliability, combined with the updated terminology and lower literacy demands of the revised items, the updated version of the ATSPPHS-SF scale was used in subsequent analyses.

The help seeking intentions items were based on the General Help-Seeking Questionnaire (GHSQ; Wilson et al., 2005) adapted to help-seeking for thoughts of suicide. Intentions to seek help from five sources (psychologist/psychiatrist, general practitioner, family/friend, the internet, nobody) in response to hypothetical thoughts of suicide were rated on a four-point scale from 1 "Highly unlikely" to 4 "Highly likely". Each of these sources were treated as a separate outcomes in the analyses, although the internet was excluded due to inconsistent ratings that may reflect the range of both reliable and unreliable resources available on the internet.

The short forms of the SOSS (Batterham et al., 2013) and LOSS (Calear et al., 2014) were used to assess suicide stigma and literacy respectively. These scales have previously been validated in a university-based sample. The SOSS was shown to have a three-factor structure, with the primary factor assessing stigma towards people who die by suicide, a factor of attributing suicide to isolation or depression and a normalisation or glorification factor (Batterham et al., 2013). Given the strong internal consistency of the 16-item short form of the SOSS (Batterham et al., 2013), the short form was used in the present study, with eight items assessing stigma and four items each assessing isolation and glorification. Each item is a one- or two-word descriptor of a person who dies by suicide (e.g., cowardly, noble, lonely), rated on a 5-point Likert scale from "strongly disagree" (1) to "strongly agree" (5). The subscales of the SOSS are summarised by calculating the mean response to all items on the subscale, ranging from 1 to 5. In the present study, each of the 16 items had loadings >0.60 on a single factor and <0.25 on the other factors, while Cronbach alphas of 0.89, 0.78 and 0.82 for the stigma, isolation and glorification factors respectively indicated satisfactory internal consistency.

The LOSS assesses the four domains of suicide literacy: (i) signs and symptoms, (ii) causes or the nature of suicidality, (iii) risk factors, and (iv) treatment and prevention. Each of the items on the LOSS is responded to on a 3-point scale ("True", "False", or "I don't know"), with correct responses allocated a score of 1 and incorrect or "I don't know" responses assigned a score of 0. Total scale scores are calculated by summing item scores. Example LOSS items include "Men are more likely to commit suicide than women" and "People who have thoughts about suicide should not tell others about it". The LOSS has been validated by using Item Response Theory to identify items that had the strongest discrimination of the underlying literacy construct (Calear et al., 2014). A 12-item short form of the LOSS (Calear et al., 2014) was used in the present study, which provides a total literacy score (per cent correct).

Additional measures were included as predictors in the study, including mental health status and background characteristics. The Patient Health Questionnaire-9 (PHQ-9; Spitzer et al., 1999) and Generalised Anxiety Disorder-7 (GAD-7; Spitzer et al., 2006) were used to assess presence of depression or generalised anxiety disorder,