Journal of Affective Disorders 178 (2015) 5–11

Contents lists available at ScienceDirect

Journal of Affective Disorders

journal homepage: www.elsevier.com/locate/jad

Research report

Help-seeking, stigma and attitudes of people with and without a suicidal past. A comparison between a low and a high suicide rate country

Alexandre Reynders [a,*], Ad J.F.M. Kerkhof [b], Geert Molenberghs [c], Chantal Van Audenhove [a]

[a] LUCAS KU Leuven, Leuven, Belgium
[b] Department of Clinical Psychology, VU University and EMGO Institute, Amsterdam, The Netherlands
[c] Interuniversity Institute for Biostatistics and Statistical Bioinformatics (I-BioStat), KU Leuven–UHasselt, Belgium

ARTICLE INFO

Article history:
Received 31 August 2014
Received in revised form
13 February 2015
Accepted 14 February 2015
Available online 21 February 2015

Keywords:
Suicidal past
Attitudes
Stigma
Help-seeking
Cross-national

ABSTRACT

Background: A significant proportion of suicidal persons do not seek help for their psychological problems. Psychological help-seeking is assumed to be a protective factor for suicide. However, different studies showed that negative attitudes and stigma related to help-seeking are major barriers to psychological help-seeking. These attitudes and stigma are not merely individual characteristics but they are also developed by and within society. The aim of this study is twofold. First, we investigate if persons with a suicidal past differ from people without a suicidal past with respect to help-seeking intentions, attitudes toward help-seeking, stigma and attitudes toward suicide. The second aim is to investigate if these attitudinal factors differ between people living in two regions with similar socio-economic characteristics but deviating suicide rates.
Method: We defined high (Flemish Community of Belgium) and low (The Netherlands) suicide regions and drew a representative sample of the general Flemish and Dutch population between 18 and 65 years. Data were gathered by means of a postal questionnaire. Descriptive statistics are presented to compare people with and without suicidal past. Multiple logistic regressions were used to compare Flemish and Dutch participants with a suicidal past.
Results: Compared to people without a suicidal past, people with a suicidal past are less likely to seek professional and informal help, perceive more stigma, experience more self-stigma (only men) and shame (only women) when seeking help and have more accepting attitudes toward suicide. In comparison to their Dutch counterparts, Flemish people with a suicidal past have less often positive attitudes toward help-seeking, less intentions to seek professional and informal (only women) help and have less often received help for psychological problems (only men).
Limitations: The main limitations are: the relatively low response rate; suicidal ideation was measured by retrospective self-report; and the research sample includes only participants between 18 and 65 years old.
Conclusions: Having a suicidal past is associated with attitudinal and stigmatizing barriers toward help seeking and accepting attitudes toward suicide. Prevention strategies should therefore target people with a suicidal history with special attention for attitudes, self-stigma and feelings of shame related to help-seeking.

1. Introduction

Research shows that nine out of 10 suicide victims suffered from at least one severe psychological problem (Nock et al., 2008). As a consequence, receiving psychological help is assumed to be a protective factor of suicide. Not receiving adequate help increases the risk for psychological problems to deteriorate and thus increasing the risk of suicide (Suominen et al., 2004). A number of researches showed that persons with suicidal thoughts were less likely to seek psychological help compared to those who have psychological problems but no suicidal thoughts (Calear et al., 2014; Carlton and Deane, 2000; Gould et al., 2004; Rancans et al., 2003; Rickwood et al., 2005). Not seeking psychological help is associated with negative attitudes and stigma in relation to help-seeking (Vogel et al., 2007). Furthermore, research found that the majority of people experience stigma and shame if they would receive psychological help (Reynders et al., 2014).

According to psychological health models, having a negative attitude toward a behavior (e.g. help-seeking) will decrease the intention to actually conduct this behavior (Ajzen and Fishbein, 2000). Stigma refers to behavior that is often perceived by the general

* Corresponding author. Tel.: +32 2 240 68 40.
E-mail address: alexandre.reynders@odisee.be (A. Reynders).

http://dx.doi.org/10.1016/j.jad.2015.02.013
0165-0327/

public as disgraceful or shameful. In this study we distinguish between two kinds of stigma in relation to help-seeking, and thus not stigma in relation to suicidal behavior. First, perceived stigma refers to the stigmatizing attitudes toward people who receive psychological help one observes in his environment (Link et al., 1989). Perceived stigma implies that people are convinced that they will be discriminated if they would seek help for psychological problems. Second, self-stigma for psychological help-seeking is the internalization of the stigmatizing attitudes (Rüsch et al., 2005). People who experience self-stigma will apply the stigmatizing attitudes on themselves, resulting in low self-esteem and low self-efficacy. A way to prevent being stigmatized is not to disclose psychological problems and not to seek help (Vogel et al., 2007). Furthermore, research found that people without a suicidal past have more disapproving attitudes toward suicide than people with a suicidal past (Arnautovska and Grad, 2010; Colucci and Martin, 2007; Gibb et al., 2006; Joe et al., 2007; Kocmur and Dernovsek, 2003; O'connor et al., 2006). The disapproving attitudes of others could create feelings of shame for seeking psychological help among people with suicidal problems (Kageyama, 2012).

Important to notice within the scope of cross-national analysis is that stigma and attitudes are not just individual features. They are social conceptions rooted in a cultural context (Rüsch et al., 2005). They can vary across regions and therefore possibly explain regional differences in help-seeking behavior and suicide rates. For this reason, it would be of interest to compare two regions which resemble with respect to socio-economic indicators, language, geographic and demographic characteristics but have strongly deviating suicide rates. Two regions that satisfy these conditions are Flanders and The Netherlands. For example in 2012, the fertility rate is 1.75 and 1.72; the percentage of students in all levels of education is 25.3 and 25.2; the populations density is 478.2 and 496.9/km^2; the employment rate is 4.5% and 5.3% and the percentage of people at risk of poverty 15.0 and 15.7 for Flanders and The Netherlands respectively (Eurostat, 2014). However, there are also significant differences in suicide rates between the two Dutch speaking regions (Reynders et al., 2014). The Flemish suicide rates are almost 80 percent higher (15.4/100.000 inhabitants) than in The Netherlands (8.8/100.000 inhabitants). Despite these differences in suicide rates, cross-national research did not find significant differences between the two regions with respect to the incidence of life time suicidal ideation (8.2% in The Netherlands and 8.4% in Belgium) and suicide attempts (2.3% and 2.5%) (Bernal et al., 2007). Although suicidal ideation and behavior are assumed to be important antecedents of suicide on an individual level, on the cross-national level the association between both is unclear (Bernal et al., 2007; Bertolote et al., 2005; Casey et al., 2008). It is argued that from an epidemiological point of view, the suicidal process is not a clear-cut transition from ideation to attempt to suicide. Possibly, Dutch people cope differently and more effectively with psychological and suicidal problems than Flemish people resulting in higher suicide rates among the latter.

The aim of this study is to investigate if people with a suicidal past differ from people without a suicidal past with respect to intentions, attitudes and stigma associated with help-seeking and attitudes toward suicide. We hypothesize that, compared to people without a suicidal past, people with a suicidal past have weaker intentions to seek psychological help, perceive more stigma, experience more self-stigma and shame related to help-seeking and have more approving attitudes toward suicide. In addition, we expect that these differences are more apparent in Flanders than in The Netherlands.

2. Method

2.1. Study sample

The target population for this study is the general population of Flanders and The Netherlands with a Belgian and Dutch nationality respectively. Because of methodological and ethical reasons, only data within the age group 18 through 65 years were gathered. Even though data are available on French speaking Belgium as well, we have chosen to compare two Dutch speaking geographical entities. Evidently, also comparisons between Belgium as a whole and The Netherlands on the one hand, and between Flanders and the French Community on the other is of interest; this is outside of the scope of this paper. For the selection of the sample units, we made use of a combination of a cluster sample and systematic sample. Multi-stage cluster sample means that we started at the provincial level. Out of each province we selected the regions. In The Netherlands, these were so called 'COROP-regions' and in Flanders 'care regions'. These regions are defined by the authorities with the purpose of conducting long term cross-regional research (The Netherlands) or evaluate and adjust health policy (Flanders). Out of these regions we further selected municipalities and out of the municipalities, we finally selected the individual respondents. For the selection of the units at each stage we made use of a systematic sampling technique. The result is a random, geographically well spread and representative sample. The Dutch sample contains 4550 individuals out of 38 of the 403 municipalities, out of 8 COROP regions and 7 provinces. In Flanders the outcome of this procedure was 4550 individuals, out of 52 of the 306 municipalities, out of 12 care regions and 5 provinces. The systematic sample of individuals was selected out of the official population register by the authorities.

2.2. Procedure

The procedure for both countries was identical. The selected individuals received a structured postal questionnaire together with a guided letter. The letter informed the participants about the goal of the research, the voluntariness of participation and the anonymity of the study. Beside this, a telephone number and website of a free and anonymous crisis line was mentioned for those who may need it. Finally, participants were informed that they had the chance to win an incentive in the form of two movie tickets or a gift voucher. Non-respondents received reminders after two weeks and after five weeks. This research procedure was evaluated by the Belgian Privacy Commission and the Dutch Ethical Commission. The data collection took place during the months of October and November 2009 (Flanders) and 2010 (The Netherlands). The response rate was 27.4% (The Netherlands) and 41.4% (Flanders). In this study we analyzed data of 2978 Dutch and Flemish participants.

2.3. Instruments

The Self-Stigma of Seeking Help-Scale, Attitudes toward Seeking Professional Psychological Help-scale (Short form) and Perceived Devaluation–Discrimination-scale, discussed below, were independently translated into Dutch by two researchers focusing on the meaning of the items rather than literally translating the wording. Both translations were brought together and discussed by the two translating researchers and a third researcher. Cronbach's Alpha for the translated scales is presented.

2.3.1. Demographic variables

The survey included questions about age, years of schooling, civil state and employment.

2.3.2. Suicidality

Participants were asked for their personal life time experience with suicidality. Three questions were asked, each referring to a phase of the suicidal process: death wish, suicide plan and suicide attempt. In our analysis, people who indicated that during their