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Research report

Psychiatric labels and other influences on young people's stigmatizing attitudes: Findings from an Australian national survey

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ABSTRACT

Background: Stigma is a major impediment to help seeking for mental disorders by young people. To reduce stigma and improve help seeking, a better understanding of the influences on different components of stigma for different disorders is required.
Methods: In 2011, a telephone interview was conducted with a national sample of 2522 Australians aged 15–25 years. Participants were presented with a vignette of a young person portraying either depression, depression with suicidal thoughts, social phobia, post-traumatic stress disorder or psychosis. They were then asked what they thought was wrong with the person, exposure to mental health problems in themselves and in family or friends, stigmatizing attitudes, and their awareness of *beyondblue*.
Results: Accurate psychiatric labeling of the mental disorder presented in the vignette and *beyondblue* awareness were the best predictors of less stigmatizing attitudes, followed closely by exposure to family or friends with mental health problems. Across vignettes, the personally held stigmatizing perception of mental health problems as a weakness rather than an illness was most strongly associated with these predictors.
Limitations: Stigma and labeling were assessed with reference to a vignette character and may not reflect actual experience or behaviors. Other limitations include the cross-sectional design and potential for social desirability bias in the stigma measure.
Conclusions: Findings suggest that community awareness campaigns (such as those by *beyondblue*) that encourage appropriate close contact with others affected by mental health problems and improved accurate psychiatric label use may have potential to counter various aspects of stigma, especially personal beliefs that mental illness is a weakness.

1. Introduction

Affective disorders have a high lifetime prevalence (29% and 25% for anxiety and depressive disorders respectively), and often have their first onset in the first few decades of life (Kessler et al., 2005). However, rates of professional help seeking by young people are low (Slade et al., 2009), so it is hardly surprising that mental disorders are the largest contributors to disability in this age group (Mathews et al., 2011). The stigma attached to having a mental disorder is an important impediment to appropriate help seeking (Andrews et al., 2001; Penn et al., 2005; Pescosolido et al., 2008). To improve help seeking and reduce the burden of mental illness on young people and society, researchers for many decades have tried to better understand the factors that influence the development and maintenance of stigmatizing attitudes (Corrigan and Penn, 1999; Mukolo et al., 2010; Pescosolido et al., 2008).

A challenge to understanding stigma is that it has multiple components which are influenced differently by various factors and have different effects on help seeking (Yap et al., 2011a). Of interest in this study, some common stigma components include 'perceived or public stigma' which refers to one's belief that others (i.e., the public) perceive an individual as socially unacceptable (Corrigan, 2004; Griffiths et al., 2004, 2006); 'personal stigma' which refers to one's own discriminating perceptions of others (Griffiths et al., 2004, 2006); 'social distance' which refers to one's desire to maintain distance from the stigmatised individual (Jorm and Griffiths, 2008); and 'dangerousness' which refers to one's belief that the individual is dangerous (Jorm and Griffiths, 2008; Mojtabai, 2010). Some potential influences

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of stigmatizing attitudes in young people include their exposure to mental health problems either in themselves (Jorm and Wright, 2008) or in others (sometimes known as 'contact'; Angermeyer et al., 2004; Corrigan et al., 2001; Jorm and Wright, 2008), exposure to mental health campaigns and organizations (Jorm and Wright, 2008; Pinfold et al., 2003; Schulze et al., 2003), and the use of psychiatric terms to label mental disorders (Angermeyer and Matschinger, 2005; Penn and Nowlin-Drummond, 2001; Wright et al., 2011).

It is well established through research with adults that positive contact with people affected by mental illness can reduce stigmatizing attitudes (Angermeyer et al., 2004; Corrigan et al., 2001). The evidence from research with young people is more equivocal. For example, one study of adolescents finding an opposite effect when a broader measure of 'familiarity with mental illness' was used, which assessed a range of experiences including being personally affected and knowing people who were affected by mental illness (Corrigan et al., 2005). Nonetheless, a subsequent national survey of Australian young people highlighted the importance of assessing 'contact' with others affected by mental illness separately from a personal history of mental illness because these two types of experiences were found to have different associations with different components of stigma (Jorm and Wright, 2008). In particular, while they were both associated with less social distance and reduced belief that the affected person is weak rather than sick (similar to personal stigma), only personal history was associated with perceptions of more stigmatizing attitudes in others, and only contact with family or friends affected by mental illness was associated with less reluctance to disclose if they were experiencing a mental health problem. One limitation of many studies to date is their failure to examine the contact–stigma associations specifically for different mental disorders, although there is clear evidence that some disorders are more stigmatized than others (Corrigan et al., 2005; Dinos et al., 2004; Griffiths et al., 2006), and that certain disorders which are more stigmatized in one component may not necessarily be more stigmatized in another (Jorm and Wright, 2008).

Several school-based interventions to reduce stigma towards mental illness have found small positive effects (Pinfold et al., 2003; Schulze et al., 2003), and school-based campaigns in Australia seem to have a detectable population impact (Jorm and Wright, 2008). Of interest in the current study, Australia's national depression initiative, *beyondblue*, was first established in 2000 and has focused on promoting awareness and an effective response to depression and anxiety disorders in the community, through population-wide campaigns and the provision of other resources. Young people's awareness of *beyondblue* has been found to be associated with reduced belief that someone with mental health problems is weak rather than sick (Jorm and Wright, 2008), but was unrelated to a desire for social distance (Morgan and Jorm, 2007). However, a recent report found that *beyondblue* awareness was associated with better mental health literacy for psychosis as well as depression and anxiety disorders, suggesting that it may have generalized effects across disorders (Yap et al., 2012a). It remains to be ascertained whether the associations between *beyondblue* awareness and various stigma components are specific to particular mental disorders.

The association between stigma and the use of psychiatric terms by the public to label mental disorders has been the subject of continuing debate (Jorm and Griffiths, 2008; Read et al., 2006, 2009), mainly due to concerns that labeling may fuel stigma (Gove, 1975; Jorm and Griffiths, 2008; Link et al., 1989; Scheff, 1966). On the other hand, labeling a mental disorder as it emerges may be an important part of the process of help seeking (Biddle et al., 2007; Vogel et al., 2006). Various methodologies have been used to assess labeling to date, but the method of eliciting distinct labels to describe a mental disorder without prompting is arguably most comparable to the real-life process of recognizing and labeling a disorder as it emerges in the course of help seeking (Biddle et al., 2007; Vogel et al., 2006; Wright et al., 2011). To date, we are aware of only one study that has examined the association between unprompted label use and stigma in young people (Wright et al., 2011). Using data from a national telephone survey of 2802 Australians aged 12–25 years, this study assessed label use and stigmatizing beliefs in response to vignettes of a young person experiencing depression, psychosis or social phobia. The study found that, compared to other common or lay labels, accurate 'psychiatric' labels were associated with reduced belief that the disorder is a sign of personal weakness rather than an illness. However, use of psychiatric labels for psychosis was associated with increased belief in its dangerousness and unpredictability.

1.1. The current study

Using data from a 2011 national survey of Australian youth, the current study aimed to replicate and extend Wright et al. (2011) study in several ways. Firstly, the current study included the same social distance and stigma inventories used in the 2006 survey by Wright and colleagues, but the structure of responses was investigated using novel exploratory structural equation modeling (ESEM) methods which yield slightly different and more empirically defensible stigma scales (Yap et al., submitted for publication). In particular, personal stigma and stigma perceived in others formed distinct but structurally parallel dimensions with each comprising a 'weak not sick' and a 'dangerous/unpredictable' factor. Social distance items formed a distinct dimension from these factors. Based on this work, the current study sought to examine the associations between label use and these empirically-derived stigma scales.

Secondly, the 2011 survey included two additional vignettes—depression with suicidal thoughts and post-traumatic stress disorder (PTSD)—which have not been included in previous national surveys examining predictors of stigma. Thirdly, in addition to label use, we also examined other potentially important predictors of stigma, including exposure to mental health problems in oneself and others and awareness of *beyondblue*, taken as an indicator of exposure to mental health campaigns. Importantly, we examined the associations between these predictors and stigma separately for each of the five vignettes.

Finally, there is an emerging evidence suggesting that landline-only versus landline and mobile phone samples may differ in some important characteristics (Newman, 2011), including levels of psychological distress and recognition of depression in a vignette (Holborn et al., 2012), reported levels of substance use (Hu et al., 2011; Pennay, 2010), and attitudes towards substance use (Yap et al., 2012b). In this study, we examined whether stigmatizing attitudes in young people differed according to type of phone contact (mobile or landline).

2. Methods

2.1. Participants

The survey involved computer-assisted telephone interviews with 3021 young people aged between 15 and 25 years. The survey was carried out by the survey company Social Research Centre from January 2011 to May 2011 using random-digit dialing of both landlines and mobile phones covering the whole of Australia. Up to six calls were made to establish contact. The response rate was 47.9%, defined as completed interviews (3021) out of sample members who could be contacted and were