Associations between stigma and help-seeking intentions and beliefs: Findings from an Australian national survey of young people

Marie Bee Hui Yap [a,b,*], Nicola J. Reavley [a,b], Anthony Francis Jorm [a,b]

[a] Orygen Youth Health Research Centre, Centre for Youth Mental Health, University of Melbourne, Australia
[b] Melbourne School of Population and Global Health, University of Melbourne, Australia

ARTICLE INFO

ABSTRACT

To reduce stigma and improve help seeking by young people for mental illness, we need a better understanding of the associations between various dimensions of stigma and young people's help-seeking intentions and helpfulness beliefs for various sources of help and for different disorders. This study assessed stigmatizing attitudes and help-seeking intentions and helpfulness beliefs via a national telephone survey of 3021 youths aged 15–25. Five stigma scales were used: social distance, personally held weak-not-sick and dangerousness beliefs, and weak-not-sick and dangerousness beliefs perceived in others. Respondents were presented with a vignette of a young person portraying depression, depression with suicidal thoughts, depression with alcohol abuse, post-traumatic stress disorder, social phobia, or psychosis. Beliefs that mental illness is a sign of personal weakness and preference for social distance were associated with less intention to seek professional help and less endorsement of their helpfulness. In contrast, dangerousness/unpredictability beliefs were associated with more intention to seek professional help and more endorsement of their helpfulness. Findings highlight the importance of examining the associations between different dimensions of stigma with different sources of help, specifically for various mental disorders, to better inform future efforts to reduce stigma and increase help seeking in young people.

© 2013 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Mental disorders are the largest contributors to disability in young people (Mathews et al., 2011). In particular, the long-term sequelae of mental disorders are often exacerbated by delayed help seeking or the lack thereof (Harris et al., 2005; de Girolamo et al., 2012). The stigma attached to having a mental disorder is one important impediment to help seeking by young people (Andrews et al., 2001; Penn et al., 2005; Fröjd et al., 2007; Pescosolido et al., 2008; Gulliver et al., 2010). Young people's stigmatizing attitudes have been found to influence their intentions to seek help for mental health problems (Yap et al., 2011), which in turn influence their subsequent help-seeking behaviours (Reavley et al., 2011). Beliefs about the helpfulness of interventions for mental disorders have also been found to influence help seeking (Komiti et al., 2006; ten Have et al., 2010), and limited evidence to-date suggests that stigma may influence these beliefs (Yap et al., 2011). In order to increase appropriate help seeking by young people, we need a better understanding of how stigmatizing attitudes influence their help-seeking intentions and beliefs.

Whilst extant evidence is unequivocal about the associations between stigma and help seeking, several key questions remain unanswered. Firstly, given the multifaceted nature of stigma, it is important to elucidate how different dimensions of stigma influence help-seeking intentions and helpfulness beliefs differentially. Studies have varied in the dimensions of stigma examined. These have included '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, 2006b); 'personal stigma', which refers to one's own discriminating perceptions of others (Griffiths et al., 2004, 2006b); '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).

The diverse stigma literature suggests that different dimensions of stigma may indeed influence help seeking differentially. For example, perceived stigma has been found to be unrelated to help seeking in some studies (Komiti et al., 2006; Golberstein et al., 2009; Schomerus et al., 2009; Yap et al., 2011); and dangerousness has been found to be unrelated to (Cooper et al., 2003) or even to increase willingness to seek help (Mojtabai, 2010; Yap et al., 2011; Jorm et al., 2012). Few studies have examined the association between social distance and help seeking, but preliminary evidence suggests that greater preference for social distance is associated with less willingness to seek

* Corresponding author at: Population Mental Health Group, Melbourne School of Population and Global Health, Level 3, 207 Bouverie Street, Victoria 3010, Australia. Tel.: +61 4 11989022; fax: +61 3 9349 5815.
E-mail address: mbhy@unimelb.edu.au (M.B.H. Yap).

help from a psychiatrist (Schomerus et al., 2009), less intention to seek any help (for young adults aged 18–25 years) or from a teacher (for adolescents aged 12–15 years; Yap et al., 2011), and less favourable beliefs about the helpfulness of informal sources of help (Yap et al., 2011).

Emerging evidence of the association between personal stigma and help seeking is somewhat equivocal. A recent national survey of Australian youth (Yap et al., 2011) and a survey of the general population in four European countries (Coppens et al., 2013) found that greater personal stigma, in the form of believing that mental disorders are a sign of personal weakness rather than an illness, was associated with less favourable attitudes towards professional help seeking. Similarly, in a small sample of currently depressed persons in the general population, personal stigma was found to be associated with lower perceived need for treatment, an association which was partially mediated by lower appraisal of their depressive symptoms as a mental health problem (Schomerus et al., 2012). However, a survey of adults with depression in the general population of Finland found that personal stigma was not associated with mental health service use in the last 12 months (Aromaa et al., 2011). One major limitation of evidence to date is that most studies have examined a limited number of stigma dimensions, hence it remains unclear if differences in findings may be partly due to different measures of help seeking or differences in the sample (e.g. hypothetical help seeking in the general population versus actual help seeking by individuals with mental disorders). One way to address this limitation is to examine a wider range of stigma dimensions within one large study.

A second key question for this field of research is related to the fact that most studies have focussed primarily on professional help seeking; hence little is known about the effects of stigma on help seeking from informal or non-professional sources. Although professionals are the ideal source of help for mental disorders, they are often not the first port of call for young people, who prefer to turn to family or friends for help (Rickwood and Braithwaite, 1994; Rickwood et al., 2007). Hence it is important to examine how stigma might stop young people from seeking help even from close others like family and friends, especially if they can become conduits to appropriate professional treatment (Rickwood et al., 2007).

Finally, many studies to date have failed to examine the stigma-help seeking associations specifically for different mental disorders, although there is clear evidence that some disorders are more stigmatized than others (Dinos et al., 2004; Corrigan et al., 2005; Griffiths et al., 2006a), and that certain disorders which are more stigmatized in one component may not necessarily be more stigmatized in another (Jorm and Wright, 2008b). To facilitate stigma reduction efforts and increase help seeking for specific disorders, research examining the influence of stigma specifically on different disorders is required.

The current study seeks to address the above questions by examining the associations between young people's stigmatizing attitudes and their help-seeking intentions and beliefs for a range of mental disorders and from various formal and informal sources, using data from a 2011 national survey of Australian youth. Specifically, this study examined stigma-help seeking associations separately for six vignettes: depression, depression with alcohol abuse, psychosis, social phobia, depression with suicidal thoughts, and post-traumatic stress disorder (PTSD).

2. Methods

2.1. Participants

The survey involved computer-assisted telephone interviews with 3021 young people aged between 15 and 25. The survey was carried out by the survey company Social Research Centre using random-digit dialling of both landlines and mobile phones covering the whole of Australia from January to May 2011. 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 confirmed as in scope (6306). Interviewers ascertained whether there were residents in the household within the age range and, if there were multiple, selected one for interview using the nearest-birthday method.

2.2. Survey interview

The interview was based on a case vignette of a young person (John or Jenny) with a mental disorder. On a random basis, respondents were read one of six vignettes – depression, depression with suicidal thoughts, depression with alcohol abuse, social phobia, PTSD, or psychosis (early schizophrenia) – portraying a person aged 15 years (for participants aged 15–17 years) or 21 years (for participants aged 18–25 years) of the same sex as the respondent (Reavley and Jorm, 2011).

All respondents were then asked a series of questions that assessed socio-demographic characteristics, mental health literacy, stigma, exposure to mental disorders, beliefs about interventions and prevention for the mental disorder in the vignette, psychological distress (using the K6 screening scale; Kessler et al., 2002), and exposure to mental health media campaigns.

Here, we report only on stigma and help-seeking intentions and beliefs.

2.2.1. Stigmatizing attitudes

Stigma was assessed using 19 questions. Five scales were created based on exploratory structural equation modelling analysis (Yap et al., in press): these were parallel personal and perceived stigma: weak not sick (henceforth referred to as personal-weak-not-sick and perceived-weak-not-sick respectively), parallel personal and perceived stigma: dangerous-unpredictable (henceforth referred to as personal-dangerousness and perceived-dangerousness respectively), and social distance. A model in which personal and perceived structures were constrained to have the same loadings had a comparative fit index (CFI)=0.98, the Tucker–Lewis fit index (TLI)=0.97, and RMSEA=0.045. These values indicate a good, parsimonious fit to the data. This means that personal and perceived stigma can be measured validly on comparable scales.

The first four factors were assessed with two sets of statements, one evaluating the respondent's personal attitudes towards the person described in the vignette (personal stigma) and the other evaluating the respondent's beliefs about other people's attitudes towards the person in the vignette (perceived stigma; Griffiths et al., 2004). The personal stigma items were: (1) (John/Jenny) could snap out of it if (he/she) wanted; (2) (John/Jenny)'s problem is a sign of personal weakness; (3) (John/Jenny)'s problem is not a real medical illness; (4) (John/Jenny) is dangerous; (5) it is best to avoid (John/Jenny) so that you don't develop this problem yourself; (6) (John/Jenny)'s problem makes (him/her) unpredictable; (7) you would not tell anyone if you had a problem like (John/Jenny)'s. The perceived stigma items presented the same statements but were designed to elicit the respondent's belief about the stigmatizing beliefs held by others using the stem 'Most other people believe that…'. Ratings were made on a 5-point Likert scale ranging from 1='strongly agree' to 5='strongly disagree'.

Personal and perceived stigma formed distinct dimensions with each having 'weak not sick' (comprising items 1, 2, 3 and 5) and 'dangerous/unpredictable' (comprising items 4, 5, and 6) factors. Item 7 did not load on any of the stigma factors and was excluded from analyses in this study.

The 'social distance' factor comprised responses to five questions which were adapted for young people (Jorm and Wright, 2008b) from the Link et al. (1999) scale. The items were rated according to the respondent's willingness to (1) go out with (John/Jenny) on the weekend; (2) invite (John/Jenny) around to your house; (3) go to (John/Jenny's) house; (4) work closely with (John/Jenny) on a project; (5) develop a close friendship with (John/Jenny). Each item was rated on a 4-point scale ranging from 1='Yes, definitely' to 4='Definitely not'. Means of items comprising each stigma factor were calculated such that higher scores indicated more stigmatizing attitudes. The scores on social distance ranged from 1 to 4, whereas scores ranged from 1 to 5 for the other four factor scales.

2.2.2. Help-seeking intentions

Respondents were asked: "If you had a problem right now like (John/Jenny), would you go for help? Where would you go?". Verbatim-recorded responses were coded based on categories identified from an earlier survey (2007), with additional categories formed that were relevant to the different mental disorders studied (Yap et al., 2013). Responses were coded with a 'yes' or 'no' in each category, so that multiple categories were possible. Categories included family, such as parents, spouse, or relative, general practitioner (GP)/doctor, psychologist, psychiatrist, mental health specialist/service, counsellor, helpline, teacher/lecturer, and friend.

2.2.3. Help-seeking beliefs

Beliefs about helpfulness were measured by providing respondents with a list of different people who could possibly help John/Jenny and asking if they thought each person would be helpful, harmful, or neither. The list included: a GP/family doctor, a lecturer/teacher, a counsellor, a telephone counselling service, a