Special Articles

Stigma and its impact on help-seeking for mental disorders: what do we know?

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SUMMARY. **Aims** – Many people suffering from serious mental illness do not seek appropriate medical help. The stigma of mental illness has often been considered a potential cause for reluctance in seeking help. We review recent evidence on this topic. **Methods** – Narrative review of the recent literature on stigma and help-seeking for psychiatric disorders. **Results** – There is proof of a particular stigma attached to seeking help for a mental problem. Anticipated individual discrimination and discrimination qua self-stigmatisation are associated with a reduced readiness to seek professional help for mental disorders. Intervention studies show that destigmatisation may lead to increased readiness to seek professional help, but other aspects like knowledge about mental diseases seem to be at least as important. The belief that seeking help for a mental health problem is actually helpful has been shown to be at the core of help-seeking intentions and thus offers a promising target for information programmes. Population based time-trend studies show that public attitudes towards help-seeking have improved over the last decade. **Discussion** – The relationship between help-seeking intentions and actual help-seeking needs further exploration. While many studies have been able to relate attitudes to intentions, predicting actual help-seeking has proved more difficult.

Declaration of Interest: None.

Targeting "help-seeking" for mental disorders in empirical research is a difficult undertaking, since help-seeking does not constitute a singular decision or act (like "seeing a psychiatrist" or "taking antidepressants"), but an individual pathway, shaped by a sequence of interactions between available resources and personal beliefs and attitudes (Rogler & Cortes, 1993). Help-seeking pathways may meander between resources of lay- and professional spheres. They may, quickly or with delays, lead to appropriate help, but may also constitute failed or insufficient treatment. The need to understand the hindrances of the public's help-seeking is pressing: although highly prevalent, mental disorders frequently remain untreated. Population based studies in several countries have examined the unmet need for healthcare and have found an annual incidence between 3% and 15% of severe untreated mental illness (Alonso *et al.*, 2007; Demyttenaere *et al.*, 2004; Grabe *et al.*, 2005; Regier *et al.*, 1993; Wittchen & Jacobi, 2001). A large European survey using a conservative estimate of need found half of those needing treatment for mental disorders not getting any medical help for their problem (Alonso *et al.*, 2007). Use of services is generally lower in developing than in developed countries (Wang *et al.*, 2007). Help-seeking behaviour differs for different mental disorders: people with substance abuse disorders more frequently fail to seek help than those with anxiety or mood disorders (Wang *et al.*, 2005; Wittchen & Jacobi, 2001). Those seeking help often do so after a considerable delay of many years (Wang *et al.*, 2005).

This "service use problem" (Corrigan & Rüsch, 2003) has frequently been attributed to the stigma of mental illness. The potential exposure to stigma is referred to as a cause of the reluctance of those with mental disorders to seek help (Gaebel *et al.*, 2004; Sartorius, 2007). It seems to be a truism that stigma inhibits optimal treatment for mental disorders – although, a closer look reveals that very few studies have in fact examined the impact of stig-

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ma on help-seeking. In this article, we review recent evidence on this topic, thereby sketching a theoretical framework of how stigma could affect help-seeking. We aim to put this evidence in context with additional research on other beliefs and attitudes that might influence help-seeking for mental disorders.

STIGMA AND HELP-SEEKING FOR MENTAL DISORDERS

Stigmatisation of those with mental illness has been conceptualised as a process ultimately resulting in status loss and discrimination (Link *et al.*, 2001). When considering the impact of stigma on help-seeking, it is helpful to contemplate how discrimination may affect those seeking help for mental disorders on their help-seeking pathway and to distinguish three levels of discrimination: individual, structural, and discrimination qua self-stigmatisation. Individual discrimination refers to the behaviour of individuals that is intended to have a differential or harmful effect on the members of a stigmatised group (Pincus, 1996), whereas structural discrimination describes the negative consequences for the members of such a group that result from the imbalances and injustice inherent in social structures, political decisions and legal regulations (Link & Phelan, 2001). Self-stigmatisation occurs when members of a minority group internalise the stigmatising ideas of their social environment and start to believe that they are of less value and will be rejected by most people.

Structural discrimination of those seeking help for mental illness would include a lack of available mental health services, difficult access to services, or insufficient coverage of mental health care by health insurances (Kluge *et al.*, 2007). Whereas at first glance this does not seem to be a major problem in Western European countries with well established public mental health services, it certainly is at issue in many, if not most other countries (Becker & Vazquez-Barquero, 2001; Saxena *et al.*, 2007). But even in rich industrialized countries, private health insurance plans often provide insufficient coverage for mental health problems (Hanson, 1998). Attitudes among the public favouring structural discrimination of psychiatric patients have been found in population-based surveys in Germany. When asked to prioritise funding for selected medical and mental diseases during a period of financial restraint, respondents showed a clear preference for medical diseases (Beck *et al.*, 2003; Schomerus *et al.*, 2006), thus potentially putting mentally ill patients at a disadvantage. However, whether increasing the availability of services will result in better service use is under debate. In an Australian survey, 65% of those who did not receive treatment for a serious mental disorder stated that they had no need for treatment (Andrews *et al.*, 2001), pointing to the importance of intra-personal attitudes and considerations for under-utilization of mental health care.

Discrimination at the individual level has been researched extensively for mental diseases. There is evidence of stigmatisation of mentally ill patients by those entrusted with helping them. Family doctors and psychiatrists have more pessimistic views about the outcomes for mental illnesses than the general public (Jorm *et al.*, 1999), and mental health professionals hold more negative stereotypes about mentally ill patients, but, reassuringly, they are less accepting of restrictions towards them (Nordt *et al.*, 2006). So far, studies on discrimination have focused predominantly on persons that have been hospitalised or have a longstanding history of mental illness – as in Link's classic *Perceived Discrimination and Devaluation Scale*, that refers to "a former mental patient" or to "a person that has been in a mental hospital" (Link, 1987). With help-seeking, the focus is on pre-treatment cases, a population which may be less severely affected. While it is well established that the stigma of mental illness varies according to diagnosis (Crisp *et al.*, 2000), a person considering seeing a psychiatrist often does not yet have a diagnosis. Discrimination of those seeking help could thus be the result of the *stigma attached to help-seeking*, i.e. the stigma of seeing a psychiatrist, visiting a mental health centre, or talking to a GP about a mental health problem. An experimental study targeting stigma of help-seeking examined how college students judged a person described in a case vignette. In fact, a depressed person seeking help was judged as more emotionally unstable than an identical person that did not seek help for the disease (Ben-Porath, 2002).

However, the decision to seek help for a mental problem often occurs *prior to overt discrimination*: a person considering seeking help for a mental health problem for the first time has not yet been labelled as mentally ill, hence the person does not yet belong to the discriminated group of "those" with mental illness. However, when considering seeing a psychiatrist, the person might anticipate being diagnosed as mentally ill and, as a result, fear potential discrimination. Factual discrimination is thus preceded by *anticipated discrimination*. Admitting a psychological problem was anticipated as much more stigmatising than admitting a physical health problem among soldiers returning from Bosnia (Britt, 2000). Barney and her colleagues examined the influence of anticipated stigmatisation on help-seeking preferences. They used a

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labelled depression vignette to ask a population sample of 1,312 Australians how likely they were to seek help from a list of different professional helpers if they were depressed like the person described (Barney *et al.*, 2006). They found a significant minority of people expected professionals to respond negatively to them, and this attitude was associated with a decreased readiness to seek help. In a smaller study of 142 Australians from a rural town, higher anticipated stigmatisation was equally associated with more negative attitudes towards seeking professional psychological help but not with past help-seeking behaviour (Wrigley *et al.*, 2005). Other studies also failed to demonstrate a relationship between anticipated stigmatisation and real help-seeking. A study examining 300 Australians from rural areas also did not find an association between perceived stigmatisation and past help-seeking from a GP for mental health problems (Komiti *et al.*, 2006). Employing a quite sophisticated design, Jorm and his group examined how attitudes towards people with depression translated into future help-seeking behaviour in a small population based sample of depressed persons. In an initial survey, they asked 3,109 adults whether they thought a depressed person was likely to experience discrimination. Additionally, they recorded beliefs about long-term outcomes, drawing on a list stereotypes of mentally ill people like "to be violent", "to have poor friendship" or, positively, "to be understanding of other people's feelings" and "to be a caring parent". After six months, they re-interviewed a sub-sample of 422 people that were found to be depressed at baseline about their actions to relieve their symptoms. Neither negative nor positive beliefs about outcomes and anticipated discrimination predicted help-seeking actions. This held true for both actions that involved someone else having to know that the person had psychiatric symptoms and for actions which did not (Jorm *et al.*, 2000b). In a study of 92 depressed persons seeking treatment from a psychiatric outpatient clinic for the first time, however, anticipated individual discrimination did predict treatment discontinuation in older but not in younger patients (Sirey *et al.*, 2001).

Similar to anticipated discrimination, the third level of discrimination again lies within the help-seeking person himself/herself. Corrigan & Rüsch (2003) have pointed to the particular importance of *self-stigma* on help-seeking. The negative attitudes someone entertains towards those with mental illness turn against himself when he is forced to consider himself as a member of the stigmatised group, possibly resulting in lowered self esteem or lowered self-efficacy. Negative attitudes towards those seeking help for a mental health problem could thus translate into reluctance to seek help in order to avoid identification with the disliked group. Discrimination qua self-stigmatisation is the least researched part of stigma and help-seeking. Barney and colleagues have subsumed self-stigma to "feeling embarrassed" when seeking help and found this feeling to be significantly associated with decreased readiness to consult professional helpers (Barney *et al.*, 2006). In an examination of beliefs associated with potential help-seeking, Cooper and her colleagues found a reduced readiness to seek help for psychological problems in those respondents who attributed high responsibility to those affected and had feelings of anger towards them (Cooper *et al.*, 2003).

So far, we have seen that there is evidence for a particular stigma attached to help-seeking for mental disorders and that anticipated individual discrimination and discrimination qua self-stigmatisation are associated with a reduced readiness to seek professional help for mental disorders. Most studies have failed, however, to demonstrate variations in actual help-seeking behaviour corresponding to these attitudes. The translation of attitudes and intentions into actual help-seeking thus seems not to be as straight forward as expected – either because the time frame of the studies was too short to depict significant decisions on the help-seeking pathway, or because other attitudes and beliefs besides stigma shape the intention whether or not to seek professional help for mental problems.

MENTAL HEALTH LITERACY AND HELP-SEEKING

Other beliefs or attitudes may be of potential relevance in help-seeking individuals. Combining various beliefs, attitudes and abilities that promote mental well-being and aid appropriate use of mental health services, Jorm introduced the concept of mental health literacy (Jorm *et al.*, 1997; Jorm, 2000). Some studies have examined the impact of mental health literacy on help-seeking preferences. Examining a population based sample of 1,207 young people from Australia, Wright and her colleagues demonstrated that, compared to socio-demographic variables and previous contact with the disease, recognition and accurate labelling of a depression or psychosis vignette was the variable associated most frequently with recommendation of appropriate help and treatment for both diseases (Wright *et al.*, 2007). In the case of depression, for example, those who recognized the disease were more likely to recommend seeking help quickly, taking antidepressants, calling on a psychologist, seeing a social

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worker, or using counselling. Recommending a particular treatment for another person, however, is different from considering the same measure for oneself. In their above cited study, Jorm *et al.* (2000a) evaluated whether, in their general population based sub-sample of 422 depressed persons, beliefs about treatment influenced help-seeking behaviour after six months. They asked respondents to rate various medicines, activities, and people whether they considered them as helpful, harmful or neither for a depressed person. Six months later, they questioned respondents about actions they had actually taken in order to relieve their own symptoms. It turned out that the rankings of interventions according to their perceived helpfulness was considerably different from the rankings of actual use. While most respondents thought counselling or seeing a counsellor were helpful, the rank order of used interventions was headed by having an occasional drink and taking pain relievers. Only for a minority of actions did rating them as helpful predict their actual use, among them the use of antidepressants, turning to close friends, and reading about the problem. Other actions, like seeing a GP, were unrelated to their prior rating. A limitation of that study was the short time frame of six months, which could have contributed to the fact that "helpful" interventions involving mental health services were rarely used.

HELP-SEEKING INTENTIONS AND THE THEORY OF REASONED ACTION

Another methodological approach to help-seeking is employing an established theory of social psychology to beliefs and attitudes on help-seeking intentions, for example the Theory of Reasoned Action (Fishbein & Ajzen, 1975). This theory is based on the assumption that behaviour is most precisely predicted by the intention to perform the behaviour. Intention in turn is determined by two factors: attitude towards the behaviour, which represents an individual's general positive or negative evaluation of performing the behaviour, and subjective norm, which represents an individual's general belief about whether important others would approve or disapprove of him or her performing the behaviour. Bayer & Peay (1997) have first employed this theory for help-seeking for mental problems in a study with 142 patients in a community based general practice. They asked them how likely they would be to seek help from a mental health professional if they were experiencing a persistent personal problem in their life. Attitude towards the behaviour was a stronger predictor than subjective norm, indicating that personal attitudes are more important than the disapproval of others in predicting intentions to seek help form mental health professionals. Specifically, likely help-seekers more often believed that they would receive help from a mental health professional and that they would experience acceptance, understanding and confidentiality from mental health professionals than did unlikely help-seekers. Similarly, in a post-hoc adaptation to the Theory of Reasoned Action, a survey among 10,962 internet users who screened positively for depressive symptoms showed that personal attitudes were more important determinants both for the intention not to accept the diagnosis of depression, and for low perceived need for treatment than subjective social norms (Van Voorhees *et al.*, 2005; 2006). The most influential personal belief about treatment in this study was the notion that medication is effective. The cited studies did not explicitly refer to stigma, but the limited influence of social norms could point to a limited influence of anticipated discrimination by others. However, whether stigmatising attitudes shape subjective evaluation of the helpfulness of professional help for mental problems could be worth further exploration. By using the established framework of the Theory of Reasoned Action, these studies are helpful in weighting different influences on help-seeking intentions, and thus suggest promising targets for future interventions. They show that expectations about the helpfulness of seeing a mental health professional or receiving medication are particularly important to those considering seeking professional help for an emotional problem. Ajzen's successor theory, the Theory of Planned Behaviour (Ajzen, 1991), also includes perceived difficulty of performing a behaviour (perceived behavioural control) as a predictor of behavioural intention, which could be helpful to target structural discrimination, as well as perceptions of self-efficacy as potential hindrances to help-seeking (Schomerus *et al.*, 2008).

INTERVENTIONS TO IMPROVE HELP-SEEKING ATTITUDES

In order to improve attitudes towards help-seeking for mental disorders, interventions have been designed and evaluated. Providing knowledge about mental disorders and their treatment has been shown to be a promising way to increase readiness to seek help (Esters *et al.*, 1998; Han *et al.*, 2006; Jorm *et al.*, 2003). An evidence based consumer guide about depression and its treatment produced changes in some beliefs about treatments. Participants from a population based sample of depressed

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persons who were provided a consumer guide rated effective treatments more frequently as helpful than a control group who received a general brochure on depression. In particular, ratings for cognitive behavioural therapy, electro-convulsive therapy and St. John's Wort increased significantly, while no changes could be observed for the ratings of other interventions or health professionals (Jorm *et al.*, 2003). In a small controlled study of adolescents, a unit of instructions informing about sources of help for mental problems in the community and the reality of stigma improved opinion about mental illness and attitudes towards seeking professional help (Esters *et al.*, 1998). There seems to be a differential effect of information about the biological causes of depression and information focussing on destigmatisation of help-seeking. In a sample of Taiwanese college-students, Han and colleagues demonstrated that biological attribution increased students' willingness to seek help, while destigmatising information did not alter attitudes towards help-seeking (Han *et al.*, 2006). Beyond providing information, contact with mental patients has consistently been shown to be a powerful predictor of less stigmatising attitudes (Angermeyer & Dietrich, 2006). A school-based intervention delivered by people who had personally experienced mental illness, either by having a mental illness themselves or by having cared for someone with mental illness, was evaluated by Rickwood *et al.* (2004). This intervention combined information on mental illness and help-seeking with contact with affected persons or caregivers. It had strong impact on increasing knowledge and a moderate impact on reducing stigma. The intervention did change some help-seeking intentions: those participating in the intervention were slightly more inclined to seek help from professional sources than those having regular classes instead.

TIME TRENDS IN ATTITUDES TOWARDS HELP-SEEKING

From a population perspective, efforts to enhance public understanding of mental illness and improve their attitudes towards help-seeking seem to have succeeded, since public attitudes towards help-seeking have positively changed over the last decade. Interestingly, time-trend analyses from the United States, Australia and Germany, all covering about the last decade, found very similar changes in all three countries. In Germany, a comparison of data from two representative population surveys found both seeing a psychiatrist and psychotherapist more readily recommended in 2001 than in 1990 for someone suffering from schizophrenia or depression (Angermeyer & Matschinger, 2005). Psychotropic drugs became more popular for both disorders having been recommended for schizophrenia by 57.3% of respondents in 2001, compared to 30.7% in 1990 (Angermeyer & Matschinger, 2005). Health professionals were more often ranked as first choice recommendation for both disorders in eastern German states in 2001 compared to an earlier survey in 1993 (Riedel-Heller *et al.*, 2005). Similar findings come from two Australian surveys in 1995 and 2003-2004, where considerably more positive beliefs about a range of appropriate medical and psychosocial interventions surfaced in the later survey. The perception that a person should deal with a mental disorder alone decreased markedly (Jorm *et al.*, 2006). Participants of a large representative US survey 2003 were also more willing to seek professional help for an emotional problem than respondents of a similar survey in 1990. They felt more comfortable talking about personal problems with a professional and felt less embarrassed to talk with friends about it (Mojtabai, 2007). The study also analysed changes in attitudes of different age groups ("generations"). While younger adults generally had the most critical attitudes about seeking professional help, attitudes in this generation also increased most, pointing towards positive effects of mental health education and media coverage of mental illness.

CONCLUSION

The relationship between stigma and help-seeking for mental disorders is complex. While stigma is intuitively regarded as one of the main obstacles to effective help-seeking, pinpointing its influence proves difficult, since the individual may encounter many situations on the help-seeking pathway where stigma becomes relevant. We have related previous research on stigma and help-seeking to three levels of potential discrimination of help-seekers: individual, structural, and discrimination qua self-stigmatisation. Self-stigmatisation and anticipated individual discrimination have been identified as important cognitive processes within the help-seeking subject that need further exploration. Intervention studies show that destigmatisation may lead to increased readiness to seek professional help, but other aspects like knowledge about mental diseases may be equally important. The belief that seeking help for a mental health problem is actually helpful has been shown to be at the core of help-seeking intentions and thus offers a promising target for information programmes. However, the relationship of

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help-seeking intentions and actual help-seeking needs further exploration – while many studies were able to relate attitudes to intentions, predicting actual help-seeking proved much more difficult.

The last decade has seen an improvement of attitudes towards help-seeking, and this could result in an increased demand for mental health services. Given the well-established under-utilisation of mental health care, this would be a welcome development, but the question remains whether health services are prepared to meet an increased demand for mental health care.

Most studies dealing with determinants of help-seeking for mental diseases chose to investigate help-seeking for depression. There are many good reasons to investigate this disorder, not least is its high incidence and the assumption that healthy study participants can reasonably well relate to its common symptoms. However, since help-seeking is evidently more problematic for other diseases like substance abuse disorders, it is worth considering whether research on help-seeking itself may reflect stigmatising attitudes by neglecting certain diseases. Attitudes towards help-seeking for early schizophrenia would be a particularly promising field of research, since there is substantial international interest in early interventions for this disease (Marshall & Lockwood, 2004). Finally, apart from help-seeking for mental disorders, recent work on the possibilities of mental health prevention gives relevance to attitudes of healthy people towards prevention of mental diseases (Riedel-Heller, 2006; Schomerus *et al.*, 2008). Help-seeking for mental disorders is an area where huge improvements seem possible – but more research still seems necessary to outline how reducing the stigma of mental illness may contribute to this goal.

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