For the past 40 years, researchers have attempted to explain why some people with mental illness seek services while others do not. Researchers have hypothesized that the negative effects of stigmatizing attitudes may dissuade people from seeking care because they do not want to suffer the corresponding label of “mental patient.” Fairly compelling literature shows that people who may benefit from mental health services do not seek them. Research from two nationwide epidemiologic studies suggested that 50% to 60% of people who would benefit from treatment do not seek it (Kessler et al., 2001; Regier et al., 1993). Subsequent analyses of these data have shown that respondents with psychiatric diagnoses were more likely to avoid services if they were unreceptive to treatment (e.g., agreeing that people should not seek care if they have a mental or emotional problem) or believed that family members and others would have a negative reaction to these services (Leaf et al., 1986, 1987; Kessler et al., 2001).

The negative attitudes regarding mental health that were assessed in the aforementioned studies, however, are not necessarily equivalent to stigma. Subsequent studies have shown a direct relationship between stigmatizing attitudes and treatment adherence (Deane and Todd, 1996; Kelly and Achter, 1995; Sirey et al., 2001). In a prototypic example of this ilk (Sirey et al., 2001), stigma was measured using the Scale of Perceived Stigma (Link et al., 1989); scores on the Scale of Perceived Stigma were associated with the compliance of 134 adults with their antidepressant medication regimen 3 months later. Link and colleagues’ (1989) measure of perceived stigma provides a one-dimensional model of stigma. Other studies have examined the component attitudes that compose stigma. Two models, in particular, have strong empirical support. The first examines the public perspective of people with mental illness as responsible for their disorder (Corrigan et al., in press; Weiner et al., 1988). Members of the general public who blame people for their psychiatric disorders are likely to react to them angrily and to withhold help. A second model of mental illness stigma that highlights dangerousness has similar empirical support (Angermeyer and Matschinger, 1995; Corrigan et al., in press; Link et al., 1999; Penn et al., 1999). Members of the general public who view people with mental illness as dangerous report fear of them, try to avoid them, and endorse coercive services for them. Given the inverse relationship between causal
attributions and help, we expect people who endorse responsibility to be less likely to seek care when in need.

Care seeking should be viewed as a multidimensional concept because domains of care providers vary significantly. As indicated by other research, people may alternatively seek care from members of the medical profession (including primary care physicians, nurses, and mental health specialists, such as psychiatrists, psychologists, or mental health counselors) or from a generic group of community mentors (including the clergy, elder friends, and teachers; Cockerham, 1996). Hence, proxies of these two constructs will be included in our analyses. We expect to show that stigma predicts care seeking across the various domains of care.

Methods

Research participants were drawn from the at-large student body of a local community college. Seventy-nine individuals were informed of the study and asked to participate; all agreed and completed measures. The sample had an average age of 30.7 years (SD = 11.1) and was 66.7% female. In terms of marital status, 55.1% were single; 34.6% were married; and 10.2% were separated, divorced, or widowed. The sample was 41.0% white, 50.0% black, 7.7% Latino, and 1.3% other races, including Asian and Native American. In terms of education, 16.7% had completed high school; 82.0% had received some college training or an associates degree; and 1.3% had earned a bachelor’s degree.

Measures.

Two broad constructs were assessed in this study: seeking care and mental illness stigma. Care seeking was measured, in part, through self-administration of the short scale for assessing Attitudes Toward Seeking Professional Psychological Help (ATSPPH; Fischer and Farina, 1995; Fischer and Turner, 1970). The short version of the ATSPPH includes 10 items regarding willingness to seek psychological help (e.g., “If I believed I was having a mental breakdown, my first inclination would be to get professional attention”) that respondents answer on a 0- to 3-point agreement scale (3 = disagree). The measure yields a single reliable and valid index; the higher the ATSPPH score, the less likely the person is to seek care. Respondents also completed a yes-no item asking whether they had previously sought assistance for a mental illness or similar personal problem from 14 possible categories of helpers: a teacher or coach, school counselor, parent, older sibling, another adult relative, physician, nurse, social worker, psychologist, psychiatrist, clergy member, friend of the same age, or crisis hotline worker. Results from this item led to two codes per person: yes or no for whether they had ever sought help from medical personnel or community mentors. A total of 34.6% of participants reported that they had spoken to at least one of the professionals in the medical personnel category and 56.4% acknowledged that they had spoken to a community mentor. Respondents also answered a yes-no question regarding whether they had ever experienced some type of mental illness or similar personal problem; 35.4% of respondents answered yes to the question.
Stigma was assessed using the Attribution Questionnaire. This measure directs respondents to answer 27 Likert Scale items representing various stigmatizing statements regarding Harry, who is described as a 30-year-old single man with schizophrenia (e.g., “I would feel unsafe around Harry”). The scale has nine points that vary from not at all to very much. Based on findings from previous research (Corrigan et al., in press), items were summed to create eight factors relevant to the model outlined above: responsibility, pity, anger, help, danger, fear, social avoidance, and treatment coercion.

Results

Pearson product-moment correlations summarizing the relationship among the three indicators of care seeking or use are listed in the top half of Table 1. Potential care seeking as assessed on the ATSPPH was significantly associated with previous help received from medical professionals and from community mentors. Moreover, previous mental health problems were significantly related to potential care seeking in the future. A significant relationship was also found between obtaining help from medical professionals and from community mentors. Self-reporting of previous mental health problems was significantly associated with previous help from medical professionals but not community mentors.

TABLE 1 Pearson product moment correlations between proxies of service use seeking and measures of stigma*p < .05;**p < .01;***p < .001

The bottom half of Table 1 lists the relationships between stigmatizing attitudes and the various proxies of care seeking. Several stigma measures were significantly related to potential care seeking on the ATSPPH, but no significant relationships were found between stigma factors and previous help from medical professionals or community mentors. In terms of the ATSPPH findings, respondents were less likely to seek services if they viewed people with mental illness as responsible for their disorder, did not pity them, reacted to them with anger, and were likely to withhold help. Consistent with our predictions, danger, fear, and coercion were not significantly associated with care seeking; a significant relationship was found between ATSPPH care seeking and social avoidance.

Discussion

The purpose of this study was to examine the relationship between a multidimensional model of stigma and care seeking. Results showed that some dimensions of stigma were associated with potential care seeking and others were not. In particular, individuals were less likely to consider future care seeking if they viewed people with mental illness as responsible for their disorders, reacted to them angrily because of this attribution, and withheld pity and helping behaviors. Conversely, viewing people with mental illness as
dangerous, fearing them, and endorsing coercive treatments were not found to be
significantly related to care seeking.

This differential pattern of correlations is noteworthy for several reasons. First, finding a
significant association between care seeking and the attribution model, but not the
dangerousness model, is contrary to other trends in stigma research (Corrigan et al., in
press). Namely, dangerousness-related attitudes have been shown to be a robust predictor
of public stigma of mental illness, whereas responsibility-related attitudes have been a
lesser predictor. The relationship between help seeking and responsibility makes sense
when one considers the fundamental assertion of Weiner’s (1995) attribution model.
Namely, people who are blamed for a condition (e.g., mental illness) are not deserving of
help; they should overcome the difficulty using their own resources. Hence, by applying
this relation to the individual’s decision regarding seeking care for his or her mental
illness, people who blame themselves for their mental illness are likely to believe they
should struggle alone with their problems and do not deserve help.

Another noteworthy finding was the absence of a significant relationship between
endorsing various stigmatizing attitudes and reporting previous use of medical
professionals or community mentors because of a mental illness or other personal
problems. The absence of a significant finding here may have resulted from a restricted
range of the service use variables, which were binary, thereby decreasing the power of
the correlational analyses. Alternatively, the relationship between actual service use and
stigmatizing attitudes may be mediated by care-seeking intentions. Although there was no
significant relationship between service use and stigma, care seeking on the ATSPPH
was significantly associated with several stigmatizing attitudes and with service use.
Whether this kind of relationship is better described by a path analysis could be addressed
by structural equation models. This is a goal for future research because the sample size
for this study was too small to conduct these kinds of analyses.

If supported in future research, our findings would suggest that changing attitudes
regarding personal responsibility for mental illness may increase the public’s openness to
seeking mental health services when in need. Several programs are attempting to
accomplish this goal by educating the public that mental illness is a brain disorder.
Research by our group has shown that educating people about responsibility attributions
reduces the tendency to blame others for their mental illness (Corrigan et al., 2002). This
kind of antistigma effort is markedly enhanced when contact with people with mental
illness is added to the education program. Future research must further examine these
kinds of programs and their specific effects on care-seeking behavior.

References

   suffering from psychiatric disorders: Their effect on the social distance towards the
   mentally ill. Eur Arch Psychiatry Clin Neurosci 245: 159–164. [Context Link]


