



Students' Attitudes to Mental Health; Measuring Stigma and Help Seeking Behaviour.

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### ABSTRACT

Previous literature has demonstrated the barrier that mental health stigma is to seeking mental health services. This research aimed to provide an insight into the attitudes towards mental health held by students and measured levels of stigmatising attitudes and help seeking propensity (one's willingness and perceived ability to seek help for psychological problems). Adopting a quantitative, correlational survey design, the study aimed to establish the effect between the two variables stigma and help seeking. Furthermore, establish whether ethnic/cultural backgrounds and gender has a significant effect on attitudes to mental health. Multiple linear regression analysis revealed stigma did not significantly predict help seeking propensity among students. In accordance with the hypotheses, gender and ethnicity were found to be significant predictors of help seeking propensity. Whilst displaying evidence that mental health stigma is not a formidable barrier to help seeking among students, the findings confirm the varying experience of mental health stigma felt across cultures and gender.

<b>KEY WORDS:</b>	<b>MENTAL HEALTH</b>	<b>STIGMA</b>	<b>HELP- SEEKING PROPENSITY</b>	<b>GENDER</b>	<b>ETHNICITY</b>
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## Introduction

“Mental illness is a condition that impacts a person’s thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis” (#IAmStigmaFree and Balance, 2015). Current figures states that each year 1 in 4 adults in the UK will experience at least one diagnosable mental health problem, although, only 230 out of every 300 who need help will actually visit their GP (Counselling-directory.org.uk, 2015). Globally, it is estimated more than 70% of people will receive no treatment for their mental health issues (Henderson, Evans-Lacko& Thornicroft, 2013). Frequently, people with a mental illness struggle with a double problem; coping with symptoms of the disease itself and dealing with the misunderstandings of society about mental disorders (Rüsch, Angermeyer& Corrigan, 2005). The most often cited reason why people do not seek help for mental health problems is the stigma associated with mental illness (Corrigan, 2004).

Mental health stigma can be defined as the display of negative attitudes (based on prejudice and misinformation), in response to a marker of illness - for example, a negative response at the mention of psychiatric treatment in a person’s curriculum vitae (Sartorius, 2007). Link and Phelan (2001) defined stigma in terms of four characteristics that distinguishes it from other social phenomena: (1) it is fundamentally a label of an out-group; (2) the labelled differences are negative; (3) the differences separate the ‘normal’ from the out-group and (4) label and separation leads to discrimination. Stigma creates mental distress for individuals, which furthers stigmatising attitudes, thereby making it a relentless force (Seeman et al., 2016). Nevertheless, it is widely acknowledged that psychiatric diagnoses are stigmatised and associated with negative public attitudes (Angermeyer& Matschinger, 2003).

Social cognitive models pin point stigma as a relationship between stigma signals (cues), stereotypes (attitudes) and behaviours (discrimination) (Corrigan 2000), stemming from socialisation that occurs with members of the public (Abdullah& Brown, 2011). Damaging stereotypes about people with mental illness includes them perceived as dangerous and unpredictable, to be at blame for their illness and as incompetent in achieving life goals such as living independently or having a good job (Angermeyer & Dietrich, 2006). Prejudice arises when people endorse such

stereotypes, and discrimination is the behavioural result of prejudice (Corrigan, Druss & Perlick., 2014).

On a macrosocial level, policies of private and governmental institutions can be said to endorse mental health stigma by restricting the opportunities of people with mental illness (Corrigan, Markowitz & Watson, 2004). For example, the media's often negative portrayal of mental illness has engendered common misconceptions of those with mental health issues (Rüsch et al., 2005). Continuously presenting those with a mental health issue as a threat to society or as irresponsible and childlike who need caring for (Rüsch et al., 2005), has perpetuated the stigma surrounding mental illness (Benbow, 2007). Therefore, both social cognitive processes (Corrigan, 2004) and structural discrimination (Corrigan et al., 2004) contribute to the development and reinforcement of stigma, unjustly impeding those with a mental illness from attaining work, independent living, health and relationship goals (Sartorius, 2005).

There is a continued effort to reduce the stigma surrounding mental illness. In January 2009, campaign programme 'Time to Change' launched in England hoping to implement changes in attitudes and behaviour around mental health (Evans-Lacko, Henderson & Thornicroft, 2013a). By utilising mass-media advertising and public relations exercises, the national campaign emphasises social contact between people with and without mental health problems as a solution to reduce stigma and discrimination (Evans-Lacko et al., 2013b). Literature has demonstrated the importance of contact and education in reducing the stigma surrounding mental health. Corrigan et al., (2012) conducted a meta-analysis examining anti-stigma approaches and found both education and contact had positive effects on reducing stigma for adults and adolescences. Interestingly, contact was reported to better reduce stigma amongst adults. Conversely, education was more effective for adolescents, a difference which may be because adolescents' beliefs about mental illness are not as firmly developed as adults, hence, are more likely to be responsive to education effects (Corrigan et al., 2012).

However, stigma still acts as a barrier to many who wish to pursue mental health services, as they face the threat of diminished self-esteem and public identification when labelled 'mentally ill' (Corrigan, 2004). Nearly nine out of ten people with mental health problems state stigma and discrimination has a negative effect on their lives

(Mentalhealth.org.uk). Therefore, given the negative perceptions attached to those who seek psychological services, it is not surprising that individuals hide their psychological concerns and choose to avoid treatment to limit the damaging consequences attached with being stigmatised (Corrigan & Matthews 2003).

### **Help Seeking**

Corrigan (2004) distinguishes between the two separate types of stigma; public stigma and self-stigma. The first, public stigma, is the perception held by others that an individual is socially unacceptable (Vogel, Wade & Hackler, 2007). It refers to the negative stereotypes and prejudice held by a collective of people or society. Public stigma affects an individual's help seeking behaviour as they wish to avoid being labelled 'mentally ill' (Corrigan, 2004). Hence, in an effort to evade the loss of opportunity that comes with stigmatising labels, individuals refrain from going to clinics or interacting with mental health providers with whom the prejudice is associated (Corrigan, 2004). The latter, self-stigma, occurs when an individual identifies themselves with the stigmatised group and applies corresponding stereotypes and prejudices to the self (Eisenberg et al., 2009). For example, those who strongly endorse mental health stigma may believe that seeking services from a psychological professional is a sign of being unpredictable or permanently damaged (Thompson, Bazile & Akbar, 2004). According to Corrigan (2004), self-stigma may hinder an individual's help seeking behaviour if the use of services means acknowledging their own mental health problems and if the individual's negative attitudes about people with mental health problems would harm their own self-esteem.

Numerous studies have explored how public stigma relates to help-seeking attitudes and behaviour. Cooper, Corrigan and Watson (2003) found adults were less likely to consider seeking mental health services if they held public stigmatising beliefs, such as; those with mental illnesses are personally responsible for their disorders or did not feel a desire to help them. Similarly, Eisenberg et al., (2009) found public stigma to be significantly associated with help seeking behaviour, however, proposes that the causality may run in both directions. Yet, the large negative association found between public stigma and help seeking behaviour suggests public stigma is a formidable barrier to help seeking (Eisenberg et al., 2009). In support of this, Kessler et al., (2001) community based study found one in four people who perceived a need for help did

not seek help services in part because of what others might think. The stigma, prejudice and discrimination towards those with mental health issues in society means individuals create “personal-level barriers” (Corrigan et al., 2014, p.37), whereby, behaviours and attitudes influence an individual’s health decisions. Hence, demonstrating the dangerous consequences of negative stereotypes and prejudice towards mental illness in society.

### **Ethnicity**

Although anyone can be a victim of mental health stigma, numerous studies document the differences in the stigma felt across cultures. Culture refers to the shared beliefs systems, norms and practices of a given racial or ethnic group (Abdullah& Brown, 2011). Since stigma is a social construction, it is influenced by socially important categories such as culture and ethnicity (Corrigan et al., 2014). Thus, our beliefs about mental health are culturally informed, as are our stigmatising beliefs about those with mental illness (Abdullah& Brown, 2011). Corrigan et al., (2015) states minority groups are more likely to be sensitive to and be the object of stigma. Studies conducted within United States suggest the experience of mental illness stigma can be more complicated for those from racial and ethnic minority groups. Masuda et al., (2009) found African American students to display less favourable help-seeking attitudes and greater mental health stigma. Psychosocial factors such as poverty, lack of access to services or transport and mistrust of provider have been shown to relate to underuse of mental health services among African Americans (Dobalian& Rivers, 2007). Yet, it is the attitudes towards seeking mental health services among African American students that is particularly relevant (Obasi& Leong, 2009). Masuda, Anderson& Edmonds, (2012) concludes stigma is a major obstacle of mental health service use among African Americans. In contrast, other studies have found African Americans to have the most positive beliefs about the benefits and expectations associated with mental health treatment and recovery (Evans-Lacko et al., 2011).

Within Asian cultures, mental illness can be seen as a shame to the family (Lauber& Rössler, 2007). Endorsement of Asian cultural values has been found to negatively correlate with help seeking behaviour and positively correlate with help seeking stigma (Miville& Constantine, 2007). Shea and Yeh (2008) found support for a positive association between Asian cultural values and stigma among Asian American

students, however, there was no association found between cultural values and help seeking behaviour. Research has shown, that in Muslim communities, stigma is the most significant barrier to accessing mental health services and due to family values, disclosure of mental illness is considered shameful (Youssef& Deane, 2006). Hence, there is evidence to suggest a relationship between cultural/ethnic background, mental health stigma and help seeking behaviour, however, the link remains unclear. In addition, much of the research in this area is limited to minority groups in the US, with little research examining the minority communities in the UK. Therefore, although differences in attitudes and norms may influence levels of stigma across cultures, it is important that new stereotypes are not created by assuming that a person of a specific ethnic group will act consistently with values of that group (Corrigan et al., 2014).

## **Gender**

As well as cultural and ethnic backgrounds reportedly having an effect upon mental health stigma, research has documented gender differences in stigmatising attitudes and help seeking behaviour. As mentioned, different communities and cultures have their own norms by which they behave. Similarly, there are gender-role norms, which are external expectations on how one should behave in accordance to their sex (Vogel& Wade, 2009). Consequently, men may feel that there is pressure for them to be self-reliant and in control of their emotions, whereas women are expected to be expressive and in touch with their emotions (Vogel, Shechtman and Wade, 2010). Therefore, help seeking and mental health problems are more self-threatening for men than women (Magovcevic& Addis, 2005). After finding men had a stronger relationship between perceived public stigma and self-stigma than women, Vogel et al., (2007) suggested men may seek help for mental health problems less often than women because they internalise public stigma more strongly than women. Thus, a man may feel a sense of failure if he believes he needs to access mental health services (Vogel& Wade, 2009). Females are consistently reported more likely to seek help for emotional issues (Moller-Leimkuhler, 2002) and young men tend to have greater negative attitudes about mental health and less willingness to seek counselling than their female peers (Chandra& Minkovitz 2006). Gonzalez, Alegria and Prihoda (2005) found young males (18-24) were 50% less likely to be willing to seek mental health treatment,

as compared to females, interestingly, this percentage decreased as males grew older.

On the other hand, Magovcevic and Addis (2005) study measured 120 undergraduate student's levels of gender role conflict and perceptions towards mental health issues, both males and females who endorsed norms that are more masculine had increased negative perceptions of mental health issues. The researchers suggests that adherence to more 'masculine' socially valued norms (e.g., restricted emotional expression, success) for behaviour determines mental health attitudes rather than the sex of individual. Hence, women who endorse characteristics associated with more traditional masculine roles, may have similar help seeking behaviour to men (Magovcevic& Addis, 2005). Yet, this study examined attitudes towards mental health issues within the framework of alcohol and depression, even though more extreme disorders such as schizophrenia are associated with the most negative stereotypes (Wood et al., 2014). Therefore, different attitudes towards mental illness may have been recorded had the issue been approached in a broader spectrum.

Additionally, education may be an influential factor in the endorsement of dominant masculine norms and the internalisation of stigma associated with help seeking behaviour (Hammer, Vogel& Heimerdinger-Edwards, 2013). Myers and Booth (2002) suggest those with a higher level of education tend to be less gender-typified, potentially due to the University environment which exposes individuals to different perspectives, possibly changing how males think about gender-role norms and opening up choices about how they subscribe to these norms (Calvo-Salguero, García-Martínez and Monteoliva, 2008). Therefore, although there is evidence to suggest males inhibit greater negative attitudes to mental health, the association is complex and any research contributing to the area is beneficial.

### **Students and mental health attitudes**

Mental health problems occurring in early life are associated with adverse occupational, health, academic and social outcomes (Breslau, Sampson& Kessler, 2008). Given the onset of a mental illness typically occurs in adolescence, with approximately three quarters of lifetime mental disorders having first onset by the age of 24 (Kessler et al., 2005). It is important to understand late adolescents/ young adults



approach to mental health and help seeking behaviour, as they represent an age range vulnerable to the first onset of mental illness. Furthermore, this age range is typically undergoing various developmental processes, such as identity formation, which involves evolving views on issues such as mental health (Eisenberg et al., 2009). Therefore, student's attitudes towards mental health are important as they provide an insight into the emerging generation's understanding of mental health.

### **The current study**

This research aimed to establish student's attitudes to mental health by measuring levels of stigmatising attitudes and help seeking propensity (one's willingness and perceived ability to seek help for psychological problems). This research examined public stigma rather than self-stigma as it applies to everyone, regardless of whether an individual acknowledges having a mental health problem (Eisenberg et al., 2009). Hence, providing insight into the attitudes and help-seeking propensity of a typical student.

By looking at levels of stigmatising attitudes as a predictor of help seeking behaviour, the research hoped to understand the effect mental health stigma can have on help seeking behaviour in a vulnerable age group. Since stigma is the most cited reason why people do not seek help for mental health problems (Corrigan, 2004), it was hypothesised that higher levels of stigmatising attitudes would be associated with lower help-seeking propensity (H1). In addition, stigmatising attitudes would have a significant effect on help seeking propensity (H2).

After reviewing the literature, ethnic/cultural differences in attitudes towards mental health are not always clear and a vast proportion of the research is only applicable to American college students. This study intended to explore the relationship between ethnicity and mental health attitudes whilst providing research from a UK sample. It was hypothesised there would be an association between ethnicity and help seeking behaviour (H3). As well as an association between ethnicity and stigmatising attitudes (H4).

The existing literature demonstrates that in general, males are less likely to seek mental health treatment than females. This research examined the relationship between gender and attitudes to mental health, to see whether similar findings would be replicated. It was hypothesised that there would be an association between gender

and help seeking propensity (H5). Furthermore, an association between gender and stigmatising attitudes (H6).

### **Research Aims:**

1. Provide an insight into student's attitudes towards mental health by measuring stigmatising attitudes and help seeking behaviour.
2. Establish whether there is a significant relationship between stigmatising attitudes and help seeking behaviour.
3. Establish whether ethnicity has an effect on attitudes to mental health.
4. Establish whether gender has an effect on attitudes to mental health.

## **Methodology**

### **Design**

This present cross-sectional study, adopted a quantitative, correlational survey design. The research consisted of four variables; the criterion variable was help seeking propensity, predictor variables were stigmatising attitudes, gender and ethnicity.

### **Participants**

An online (Soper, 2011), A-priori sample size calculator for multiple regression (Cohen et al., 2003) indicated that a minimum number of 76 participants were required. The final sample comprised 130 students: 54 males and 76 females from a mixture of ethnic backgrounds. Ethnic backgrounds were described as White or non-White. Participants who identified themselves as 'White-British' or 'White-Irish' were classified into the 'White' category, those who identified as any other ethnicity were classified into the 'Non-White' category.

The current research utilised a volunteer sample, recruiting participants via internet social network website Facebook, asking participants for their involvement in the study. Further participants were recruited through Manchester Metropolitan University's psychology participation pool. Each participant completed an anonymous web-based questionnaire that contained the self-report measures of interest between

22<sup>nd</sup> January 2016 and 4<sup>th</sup> March 2016. Participants were aged between 18-25 years of age, anyone outside of this age range was not included in the study. Further exclusion criteria was not being a student and participants must not have accessed mental health services in the past or present, in order to limit any harm coming to participants.

## **Materials**

The questionnaire comprised of 15 questions, measured student's levels of stigmatising attitudes and their help-seeking propensity. The Stigmatising Attitudes-Believability Questionnaire (SABQ) (Masuda et al., 2012), measured student's levels of stigmatising attitudes. The SABQ is a seven-item self-report questionnaire to measure stigma towards people with psychological disorders. The questionnaire asks participants to rate a series of negative statements about individuals with a mental health problem on a 7-point Likert-scale. (e.g. "A person with a psychological disorder is unpredictable"). Scores ranged from 1 (not at all believable) to 7 (completely believable), hence, a high score represented high levels of stigmatising attitudes. Since the SABQ is subject to copyright, permission was granted by Aki Masuda to use his questionnaire (appendix 3). The scale displays an acceptable internal consistency with a Cronbach's alpha of 0.78 (Masuda et al., 2009). Example of the SABQ can be found in appendix 2

The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) (Mackenzie et al., 2004) measured student's help seeking behaviour. The IASMHS devised by Mackenzie et al., (2004) originally consisted of 24 items, however, for the purpose of this research, only eight questions measuring help seeking propensity were selected for use. Participants were required to score statements relating to help seeking behaviour on a 5-point Likert-scale ranging from 0 (disagree) to 4 (agree) (e.g. I would want to get psychological help if I was upset or worried for a long period of time). A high score represented high help seeking propensity. Internal consistency coefficients for the IASMHS display acceptable levels with a Cronbach's alpha of 0.76 for the help seeking propensity questions (Mackenzie et al., 2004). It was not necessary to obtain permission to use the IASMHS. Example of the IASMHS can be found in appendix 4.

A further, three demographic questions were asked; requiring participants to state their age, sex and ethnicity. The ethnicity of participants was recorded using a question obtained from the UK census. Example of the demographic questions can be found in appendix 5.

Once all data had been collected, the questionnaire responses were analysed using Statistical Package for the Social Sciences (SPSS) and a multiple regression analysis was conducted. All graphs and tables in this study were derived from SPSS outputs (appendix 10). This method of analysis predicts a criterion variable from several predictor variables and is an incredibly useful method because it allows the researcher to go a step beyond the data that was collected (Field, 2005). Within this research, it permitted the researcher to predict help-seeking propensity among students based on several variables (stigmatising attitudes, gender, and ethnicity) and demonstrated how these variables interact with each other.

## **Procedure**

Before gathering data for this research, ethical approval was granted by Manchester Metropolitan University to ensure the protection of participants (appendix 1). Once approval had been granted, a link to the questionnaire was posted on Facebook and Manchester Metropolitan University's psychology participation pool, which requested 18-25 year old students to take part. The link was first posted on the 22<sup>nd</sup> January 2016 and again on 16<sup>th</sup> February 2016 to maximise the number of participants. There are many advantages and disadvantages noted on web-based data collection, with the main advantages relating to time efficiency and money saving (e.g. Skikta & Sargis, 2006). Due to time constraints, the present study made use of a web-based survey.

Prior to completing the questionnaire, participants had the opportunity to read an invitation letter (appendix 6) and an information sheet (appendix 7), briefing participants on the purpose of the research and its aims. Students were informed they were taking part in research on mental health attitudes and were made aware of the exclusion criteria. In an effort to limit the effect of demand characteristics, the aims of the study were not disclosed in their entirety, as participants were not informed that

the research aimed to measure their levels of stigmatising attitudes and help seeking propensity.

Once participants had the opportunity to read about the research, they provided their consent to participate (appendix 8). The questionnaire took approximately 5 minutes to complete. Upon completion of the study, participants were fully debriefed on the aims of the study and were given the opportunity to create themselves a unique anonymous personal code had they wished to withdraw their results (appendix 9). Relevant contact information was provided if they had further queries about the research, as well as a contact for counselling if they felt they needed to speak to someone after completing the questionnaire.

When all responses had been collected, raw data for the 130 participants was entered into Statistical Package for the Social Sciences (SPSS). Mean values were calculated, providing participants with a level of stigmatising attitudes score and a help seeking propensity score. For the SABQ individual means scores ranged from 1-7 and mean scores ranged 0-5 for the IASMHS. In order to examine the relationship between variables, a multiple regression was conducted using the forced entry method. Stigmatising attitudes, gender and ethnicity were the predictor variables and help seeking propensity was the criterion variable.

## **Results**

A total of 130 students completed the questionnaire, 76 females and 54 males. 24.6% of the sample represented the non-white category. Table 1 displays the range and frequencies of participants' ethnicities. Two participants listed as 'other' included; one participant who identified as white and Arabic mixed and another who identified as white and Lithuanian.

**Table 1****Range of Participant's Ethnicities and Frequencies**

<u>Ethnicity</u>	<u>Frequency</u>
White-British	88
White-Irish	10
White &Black Caribbean	2
White &Asian	13
Indian	5
Pakistani	5
Bangladeshi	1
African	1
Chinese	3
Other	2
Total	130

**Descriptive statistics****Table 2****Overall Means and Standard Deviations for Level of Stigmatising Attitudes and Help Seeking Propensity**

	<u>M</u>	<u>SD</u>
<u>Help seeking</u>	3.00	1.07
<u>Stigmatising Attitudes</u>	2.74	.96

Table 2 provides the overall means and standard deviations for all measures in the student sample (N=130). Table 3 provides descriptive statistics according to gender and ethnicity. Descriptive statistics revealed non-white males displayed the highest levels of stigmatising attitudes (M = 3.73, SD = .78) and lowest help seeking propensity (M = 2.01, SD = .61). Whilst, white females displayed the lowest level of stigmatising

attitudes ( $M = 2.24$ ,  $SD = .67$ ) and highest level of help seeking propensity ( $M = 3.65$ ,  $SD = .74$ ). Relative to white students, non-white students had higher levels of stigmatising attitudes and lower help seeking propensity. Non-white females displayed higher levels of stigmatising attitudes ( $M = 3.40$ ,  $SD = 1.16$ ) than white males ( $M = 2.82$ ,  $SD = .78$ ) and lower help seeking propensity ( $M = 2.67$ ,  $SD = .87$ ) than white males ( $M = 2.39$ ,  $SD = 1.05$ ).

**Table 3**  
**Mean scores and Standard Deviations of Participants' Levels of Stigmatising Attitudes and Help Seeking Propensity**

<u>Gender</u>	<u>Ethnicity</u>	<u>N</u>	<u>Stigmatising Attitudes</u> (1-7)		<u>Help Seeking</u> (0-4)	
			<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>
Male	White	39	2.82	.78	2.39	1.05
	Non-White	15	3.73	.82	2.01	.61
Female	White	59	2.24	.67	3.65	.74
	Non-White	17	3.40	1.16	2.67	.87

### Correlation Analyses

Pearson's correlation coefficients between all variables are provided in table 4.

**Table 4**  
**Pearson Correlation Matrix among all variables (N=130)**

Variable	1	2	3	4
1.Help Seeking Propensity – (IASMHS)		-.35*	.53*	.32*
2.Stigmatising Attitudes (SABQ)			-.30*	-.49*
3.Gender				0.62
4.Ethnicity				

Note: N=130. IASMHS= Inventory of Attitudes toward Seeking Mental Health Services (Mackenzie et al. 2004);

SABQ= Stigmatising Attitudes Believability Questionnaire (Masuda et al., 2009).

\* $p < .001$

As expected, stigmatising attitudes, gender and ethnicity had significant associations with help seeking propensity at  $p < .001$ . Levels of stigmatising attitudes was found to negatively correlate with help seeking propensity. All correlations, except for the association between gender and ethnicity were statistically significant.

### Multiple linear regression analyses

Stigmatising attitudes, gender and ethnicity were used in a standard multiple linear regression analysis to predict help seeking propensity. Using the forced entry method, the prediction model was statistically significant  $F(3,129) = 24.72$ ,  $p < .001$ . Stigmatising attitudes, gender and ethnicity accounted for 35.5% of the variance in the criterion variable help-seeking propensity  $R^2 = .370$  (adjusted  $R^2 = .355$ ).

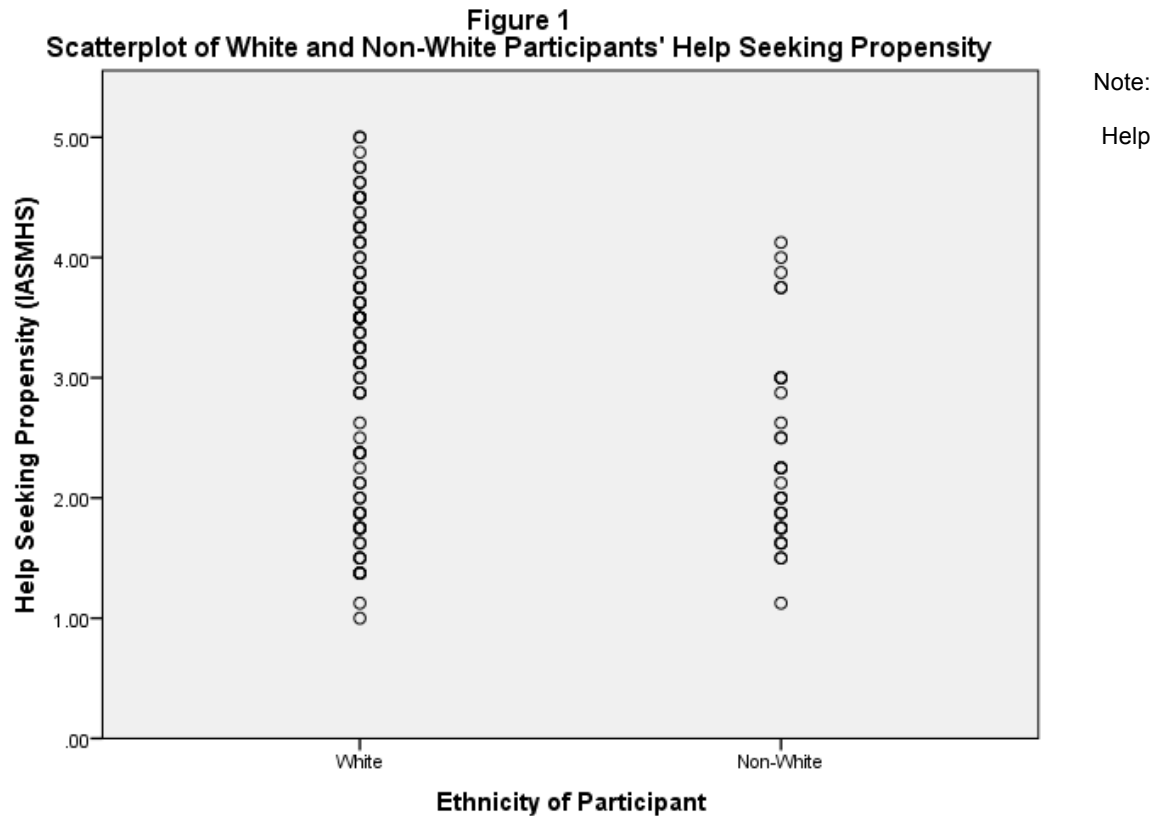
Table 5 provides a summary of the regression model, with predictor variables: stigmatising attitudes, gender and ethnicity and criterion variable help seeking propensity. The results of the regression indicated levels of stigmatising attitudes did not significantly predict help seeking propensity among participants ( $p = n.s$ ). Gender was found to significantly predict help seeking propensity ( $p < .001$ ). Ethnicity



significantly predicted help seeking propensity ( $p = < .05$ ). Figure 1 displays the higher help seeking propensity demonstrated by participants in the White category in comparison to the Non-White category.

**Table 5**  
**Investigations of Stigmatising Attitudes, Gender and Ethnicity as Unique Predictors of Help-Seeking Propensity: Summary of Regression Analysis**

Variable	$\beta$	B	<i>SE B</i>	<i>t</i>	<i>p</i>
Stigmatising Attitudes (SABQ)	-.080	-.013	.014	-.932	.353
Gender	.493	1.06	.161	6.62	.000
Ethnicity	-.251	-.619	.201	-3.07	.003



Seeking Propensity values indicate participants' scores on the IASMHS questionnaire. IASMHS= Inventory of Attitudes toward Seeking Mental Health Services (Mackenzie et al. 2004)

## Discussion

The current study aimed to gain insight into student's attitudes towards mental health by measuring stigmatising attitudes and help seeking behaviour. Furthermore, to examine how stigmatising attitudes, ethnic/cultural background and gender can affect students' help seeking behaviour. The regression model was significant and all findings support the hypotheses, except stigmatising attitudes, which did not significantly predict help seeking propensity. The hypotheses are discussed in detail below.

### Stigma and help seeking (H1&H2)

In accordance with the hypothesis 1, there was a significant negative association found between levels of stigmatising attitudes and help seeking propensity, suggesting higher levels of stigmatising attitudes relates to lower help seeking propensity. However, multiple regression analysis revealed that stigmatising attitudes did not significantly predict help seeking propensity, rejecting hypothesis 2.

Since, this study measured levels of public stigma and help seeking behaviour, this finding suggests the stigma surrounding mental health does not act as a significant barrier to help seeking among students. Corrigan et al., (2014) states stigmatising attitudes create “personal-level barriers” (p.37), whereby stereotypes, prejudice and discrimination in society influence an individual’s health decisions. However, this research found no support for the effect stigmatising attitudes has on help seeking behaviour.

This finding may be due to the increased awareness of mental health and the promotion of a more positive approach to the issue in recent years. Campaigns such as ‘Time to Change’ have been implemented in the UK since 2013, in an effort to target the stigma surrounding mental health and change people’s attitudes towards it (Evans-Lacko et al., 2013a). Since the stigma surrounding health did not predict help seeking behaviour, it suggests that such campaign programmes have been successful in their aim to challenge behaviours and attitudes towards mental health and reduce the public stigma surrounding it. Whilst, previous literature states stigma is a barrier to seeking mental health care (Corrigan, 2004), this research indicates that stigma is not a main concern for help seeking behaviour among students.

A further reason for this finding may be due to the student sample used within the study. Previous literature has demonstrated how education and contact have positive effects on reducing the stigma surrounding mental health (Corrigan et al., 2012). Many of the participants who took part in the research were psychology students whereby education about mental health is a fundamental part of their study. Thus, their knowledge on the issue may explain the non-significant effect stigma had on help seeking propensity.

However, it is worth noting that the overall mean scores for stigmatising attitudes and help seeking propensity indicate generally positive views towards mental health from the student sample. The age range used within the sample is at a period when typically views on issues such as mental health are evolving (Eisenberg et al., 2009), therefore, it is encouraging that mostly low stigmatising attitudes and high levels help seeking propensity were recorded.

**Ethnicity (H3&H4)**

Ethnicity had a significant association with both stigmatising attitudes and help seeking behaviour, satisfying hypothesis 3 and 4. Furthermore, ethnicity was found to significantly predict help seeking propensity.

Although grouping a wide range of ethnicities into a single 'non-White' category appears coarse, it allowed the important distinction between majority and minority groups to be made, as minority groups are more likely to be sensitive to and be the object of stigma (Corrigan et al., 2015).

Taking into account previous and current findings, it is argued that there is a difference in the stigma felt across cultures. Previous literature has demonstrated that stigma is an obstacle for African American people (Masuda et al., 2012) and within Muslim communities stigma is the most significant barrier to accessing mental health services (Youssef & Deane, 2006). Within this study, the non-white category (across both genders) displayed the highest level of stigmatising attitudes and lowest level of help seeking propensity. This finding supports the link between ethnic minority groups, stigma and help seeking behaviour. Furthermore, provides evidence on minority groups' attitudes towards mental health from a UK sample. The current findings could be enhanced with qualitative data, asking participants to report their hesitations in seeking mental health services.

**Gender (H5 &H6)**

In line with hypothesis 5 and 6, gender was found to have an association with both stigma and help seeking propensity. Gender was also a significant predictor of help seeking propensity. Females in the white category exhibited the lowest stigmatising attitudes and highest level of help seeking propensity, demonstrating support in the claim females are more likely to seek help for psychological problems. (Moller-Leimkuhler, 2002).

Whilst white females exhibited the most positive attitudes to mental health, white males displayed the second highest positive attitudes, higher than females in the non-white category. This finding disputes research by Gonzalez et al., (2005) who reported males were 50% less likely to seek mental health treatment than females. Previous

research has endorsed the idea that males display less willingness to seek mental health services due to gender-role norms (Vogel & Wade, 2009). Within this research, white males generally displayed positive attitudes to mental health. This finding may be because of the high level of education students have and the university experience that has exposed them to new perspectives and choices on how they subscribe to these gender norms (Calvo-Salguero et al., 2008). Further investigations, with samples consisting of students and non-students are needed, in order to gain an understanding of the potential role education may play in assigning to gender-role norms and mental health attitudes.

### **Limitations and future directions**

In addition to recommendations already discussed in relation to the hypotheses, suggestions and general limitations of the research are also considered below.

Firstly, the 'non-white' category only represented 24.6% of the sample, with only 32 out of the 130 participants representing this group. Inferences from a limited sample should be carefully made, as it is important new stereotypes are not created by assuming that a person of a specific ethnic group will act consistently with values of that group (Corrigan et al., 2014). Future research should make use of a wider sample to give the findings increased validity, as they would be more representative of the minority population.

Secondly, the use of quantitative data. Although quantitative data gives rise to more reliable and internally valid data (Coolican, 2004), it limited participants attitudes to a number with no capacity for elaboration. Since this research intended to measure attitudes to mental health, qualitative research could have been gathered alongside quantitative data to form a more holistic understanding of the issue. Future research should make use of qualitative research, to establish themes in the potential barriers for help seeking.

Lastly, the research examining the interaction between gender, ethnicity and attitudes to mental health is still premature. The findings from this study suggest females in minority groups display less positive attitudes to mental health than males from a majority group. Future research should measure individuals' level of identification with

values of a minority group, as well as their subscription to gender-role norms, in relation to mental health attitudes

### **Implications of the findings**

The findings of the current research enhanced knowledge of the varying levels of stigma felt across different cultures. Minority groups are more likely to be sensitive to and be the object of stigma (Corrigan et al., 2015), thus, future campaigns should attempt to target those in minority groups, in an effort to reduce the stigma felt in these communities and increase their willingness to seek mental health services

### **Conclusions**

Although students' level of stigmatising attitudes did not significantly predict help seeking propensity within this study, it is important efforts targeting the stigma surrounding mental health continue. The findings serve as a foundation for future research aiming to examine gender and ethnicity in relation to mental health attitudes. Furthermore, the study enhanced literature on ethnicity and mental health attitudes, providing research from minority groups in the UK.

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