Brief Reports

Mental Illness Stigma and Care Seeking

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

TABLE 1
Pearson product moment correlations between proxies of service use seeking and measures of stigma

	Care Seeking from the ATSPPH	Previous Medical Professional Help	Previous Help from Community Mentors	Previous Mental Illness
Previous medical professional help	−.20*			
Previous help from community mentors	−.28**	.31**		
Previous mental illness	−.18*	.47***	.12	
Responsibility	.22*	.01	.10	−.01
Pity	−.26*	.01	.07	.01
Anger	.29**	−.11	.00	−.08
Help	−.41***	.11	.14	.23*
Danger	.13	.03	.14	−.24
Fear	.16	.10	.09	−.10
Avoidance	−.21*	.04	−.06	.06
Coercion	.16	.00	.05	−.02

*$p < .05$; **$p < .01$; ***$p < .001$

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.

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

Angermeyer MC, Matschinger H (1995) Violent attacks on public figures by persons suffering from psychiatric disorders: Their effect on the social distance towards the mentally ill. *Eur Arch Psychiatry Clin Neurosci* 245:159–164.

Cockerham WC (1996) *Sociology of mental disorder*. Upper Saddle River, NJ: Prentice Hall.

Corrigan PW, Markowitz FE, Watson A, Rowan D, Kubiak MA (in press) An attribution model of public discrimination towards persons with mental illness. *J Health Soc Behav*

Corrigan PW, Rowan D, Green A, Lundin R, River P, Uphoff-Wasowski K, White K, Kubiak MA (2002) Challenging two mental illness stigmas: Personal responsibility and dangerousness. *Schizophr Bull* 28:293–310.

Deane FP, Todd DM (1996) Attitudes and intentions to seek professional psychological help for personal problems or suicidal thinking. *J College Student Psychotherapy* 10:45–59.

Fischer EH, Turner JL (1970) Orientations to seeking professional help: Development and research utility of an attitude scale. *J Consult Clin Psychol* 35:79–90.

Fischer EH, Farina A (1995) Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *J College Student Development* 36:368–373.

Kelly AE, Achter JA (1995) Self-concealment and attitudes toward counseling in university students. J Couns Psychol 42:40–46.

Kessler RC, Berglund PA, Bruce ML, Koch JR, Laska EM, Leaf PJ, Manderscheid RW, Rosenheck RA, Walters EE, Wang PS (2001) The prevalence and correlates of untreated serious mental illness. *Health Serv Res* 36:987–1007.

Leaf PJ, Bruce ML, Tischler GL (1986) The differential effect of attitudes on the use of mental health services. *Soc Psychiatry* 21:187–192.

Leaf PJ, Bruce ML, Tischler GL, Holzer CE (1987) The relationship between demographic factors and attitudes toward mental health services. *J Community Psychol* 15:275–284.

Link BG, Phelan JC, Bresnahan M, Stueve A, Pescosolido BA (1999) Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *Am J Public Health* 8:1328–1333.

Link BG, Struening E, Cullen FT, Shrout PE, Dohrenwend BP (1989) A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review* 54:400–423.

Penn DL, Kommana S, Mansfield M, Link BG (1999) Dispelling the stigma of schizophrenia II: The impact of information on dangerousness. *Schizophr Bull* 25:437–446.

Regier DA, Narrow WE, Rae DS, Manderscheid RW, Locke BZ, Goodwin FK (1993) The de facto US mental and addictive disorders service system: Epidemiological catchment area prospective 1-year prevalence rates of disorders and services. *Arch Rev Psychiatry* 50:85–94.

Sirey JA, Bruce ML, Alexopoulos GS, Perlick DA, Raue P, Friedman SJ, Meyers BS (2001) Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *Am J Psychiatry* 158:479–481.

Weiner B (1995) *Judgments of responsibility: A foundation for a theory of social conduct*. New York: Guilford Press.

Weiner B, Perry RP, Magnusson J (1988) An attributional analysis of reactions to stigmas. *J Pers Soc Psychol* 55:738–748.

Amy E. Cooper, A.M.,[1]
Patrick W. Corrigan, Psy.D.,[1]
Amy C. Watson, Ph.D.[1]

[1]University of Chicago Center for Psychiatric Rehabilitation, 7230 Arbor Drive, Tinley Park, IL 60477. Send reprint requests to Dr. Corrigan.

The Concordance Between Self-Ratings of Childhood and Current Symptoms of Attention Deficit Hyperactivity Disorder

Attention deficit hyperactivity disorder (ADHD) is no longer considered to be exclusively a childhood disorder. Research now indicates that adults can be severely affected (Gittelman et al., 1985; af Klinteberg et al., 1989; Mannuzza et al., 1991; Shekim et al., 1990). Although the diagnosis of ADHD in adults is permitted by DSM-IV, ADHD is not diagnosed if clinically significant symptoms began only in adulthood. Symptoms must have been evident in childhood (American Psychiatric Association, 1994). For a diagnosis of ADHD to be made in an adult, it must be established during assessment that the individual met criteria for the disorder in childhood and continues to suffer from significant symptoms causing impairment.

Attention deficit hyperactivity disorder is now being studied extensively in adults, and a significant number of adults are now consulting psychiatrists and psychologists regarding their own perceived symptoms of ADHD. Knowing the correlation between childhood and current symptoms would aid in diagnosis and assessment for research purposes.

The purpose of this study was to determine the concordance between self-ratings of childhood and current ADHD symptoms. A low concordance between childhood and current symptoms would underline the necessity of obtaining a thorough account of childhood and current behavior in making a diagnosis of ADHD in an adult.

Methods

Research Design. Adults were asked to assess their own childhood and current ADHD symptoms. Participants were asked to complete one questionnaire rating the severity of childhood symptoms (before the age of 12 years) and one questionnaire rating the severity of current symptoms. Scores were obtained for inattentive symptoms, hyperactive-impulsive symptoms, and total symptoms. The concordance between scores on the childhood and current behavior questionnaires was measured. The Childhood Behavior Questionnaire and the Current Behavior Questionnaire were administered in random order. After completing one of the behavior questionnaires, it was taken away from the subjects, who were then asked to complete the other questionnaire. The subjects were not allowed to refer to the first questionnaire while completing the second.