“To seek help or not to seek help for mental illness, that seems to be the question.

To be judged or not to be judged for mental illness, that is the real question.”
Holding up a sociological mirror to the mental health treatment gap

Elise Pattyn

Dissertation submitted to the Faculty of Political and Social Sciences of Ghent University in partial fulfillment of the requirements for the degree of Doctor in Sociology

Supervisor: Prof. Dr. Piet Bracke

Co-supervisor: Dr. Mieke Verhaeghe

October 2013
# Table of Contents

Table of Contents.................................................................v

Tables..........................................................................................ix

Part I. General Introduction.................................................................1
  1 Introduction................................................................................3
  2 Social construct of mental illness .................................................6
  3 Approaches on help-seeking for mental illness .............................8
    3.1 State of the art approach in utilization studies .........................8
    3.2 Sociological approach toward utilization of (mental) health services ........................................10
  4 Social Network Perspective ........................................................12
    4.1 Social network recommendations depend on beliefs about mental illness ..................................12
    4.2 Social network content depends on social network structure ..............................................14
  5 Bringing culture back in ..............................................................16
    5.1 How stigma might constitute a barrier toward help-seeking ..........17
    5.2 Stigma as gendered phenomenon ............................................20
    5.3 Tackling stigma by means of contact .........................................22
  6 Empirical research questions .........................................................26
    6.1 Association between the conceptualization of mental illness and coping strategies and stigmatizing attitudes ..................................................................................26
    6.2 Impact of the social network content on beliefs toward professional mental health care 28
    6.3 Association between stigma and help-seeking: Stereotype awareness versus stereotype internalization ........................................................................................................29
    6.4 Stigma as a gendered phenomenon ............................................30
    6.5 The potential negative side-effect of contact on stigmatizing attitudes .....................................31
  7 Research design .............................................................................34
    7.1 Public opinion research ...........................................................34
    7.2 Vignette technique ....................................................................35
  8 Belgian Context ............................................................................41
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>Methods</td>
<td>114</td>
</tr>
<tr>
<td>3.3.1</td>
<td>Sample and data</td>
<td>114</td>
</tr>
<tr>
<td>3.3.2</td>
<td>Variables</td>
<td>115</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Analysis</td>
<td>117</td>
</tr>
<tr>
<td>3.4</td>
<td>Results</td>
<td>118</td>
</tr>
<tr>
<td>3.5</td>
<td>Discussion</td>
<td>126</td>
</tr>
<tr>
<td>3.6</td>
<td>Reference list</td>
<td>132</td>
</tr>
<tr>
<td>4</td>
<td>Lay attitudes toward care provided in psychiatric hospitals: the role of social network composition</td>
<td>138</td>
</tr>
<tr>
<td>4.1</td>
<td>Abstract</td>
<td>138</td>
</tr>
<tr>
<td>4.2</td>
<td>Introduction</td>
<td>139</td>
</tr>
<tr>
<td>4.3</td>
<td>Methods</td>
<td>142</td>
</tr>
<tr>
<td>4.3.1</td>
<td>Sample and data</td>
<td>142</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Variables</td>
<td>143</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Analysis</td>
<td>146</td>
</tr>
<tr>
<td>4.4</td>
<td>Results</td>
<td>147</td>
</tr>
<tr>
<td>4.5</td>
<td>Discussion</td>
<td>151</td>
</tr>
<tr>
<td>4.6</td>
<td>Reference list</td>
<td>154</td>
</tr>
<tr>
<td>5</td>
<td>The gender gap in mental health service use</td>
<td>158</td>
</tr>
<tr>
<td>5.1</td>
<td>Abstract</td>
<td>158</td>
</tr>
<tr>
<td>5.2</td>
<td>Introduction</td>
<td>159</td>
</tr>
<tr>
<td>5.3</td>
<td>Methods</td>
<td>162</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Sample and data</td>
<td>162</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Variables</td>
<td>163</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Analysis</td>
<td>165</td>
</tr>
<tr>
<td>5.4</td>
<td>Results</td>
<td>166</td>
</tr>
<tr>
<td>5.5</td>
<td>Discussion</td>
<td>169</td>
</tr>
<tr>
<td>5.6</td>
<td>Reference list</td>
<td>172</td>
</tr>
<tr>
<td>Part III</td>
<td>GENERAL CONCLUSION</td>
<td>176</td>
</tr>
<tr>
<td>1</td>
<td>Implications for sociological theory and empirical research</td>
<td>178</td>
</tr>
</tbody>
</table>
Tables

Table 1: Reasons of non-response.........................................................................................................................49
Table 2: Study samples........................................................................................................................................52
Table 3: Descriptives conceptualization of mental illness.... Fout! Bladwijzer niet gedefinieerd.
Table 4: Descriptives public perceived stigma................. Fout! Bladwijzer niet gedefinieerd.
Table 5: Descriptives self-stigma. ................................................. Fout! Bladwijzer niet gedefinieerd.
Table 6: Descriptives contact conditions...........................................................................................................59
Table 7: Descriptives spontaneous treatment suggestions.....................................................................................61
Table 8: Comparison help-seeking rates..............................................................................................................62
Table 9: Descriptives rating of importance of care-providers................................................................................63
Table 10: Descriptives rating of helpfulness of treatment options...........................................................................63
Table 11: Descriptives treatment stigma ................................................................................................................64
Table 12: Descriptives negative perceptions about the (institutional) mental health care.............65
Table 13: Descriptives of the attitudes toward community care ...........................................................................68
Table 14: Descriptives study population and (in)dependent variables (N=381, weighted data, SGC-BMHS, 2009). ........................................................................................................................................68
Table 15: The association between medicalizing versus psychologizing mental illness and formal help-seeking suggestions (N=381, weighted data, SGC-BMHS, 2009). ........................................................................................................................................80
Table 16: The association between the medicalizing versus psychologizing mental illness and informal help-seeking suggestions (N=381, weighted data, SGC-BMHS, 2009)........................................83
Table 17: The association between medicalizing versus psychologizing mental illness and social exclusion after treatment (N=381, weighted data, SGC-BMHS, 2009). ........................................................................................................................................84
Table 18: Characteristics of the study population (N=728, weighted data, SGC-BMHS, 2009)... 100
Table 19: The association between perceived stigma and anticipated self-stigma and the rating of importance of (in)formal care-providers (N=728, weighted data, SGC-BMHS, 2009).......... 101
Table 20: Descriptives Study Population (weighted data, SGC-BMHS, 2009)......................................................... 119
Table 21: Community Mental Health Ideology scale..................................................................................................120
Table 22: The association between contact variables and the attitude toward community mental health care among all respondents, controlled for socio-demographic variables (N=1104, weighted data, SGC-BMHS, 2009). ........................................................................................................................................121
Table 23: The association between contact variables and the attitude toward community mental health care among the respondents who had public contact, controlled for socio-demographic variables (N=787, weighted data, SGC-BMHS, 2009)........................................................................................................................................123
Table 24: The associations between contact variables and the attitude toward community mental health care among the respondents who had interpersonal contact, controlled for socio-demographic variables (N=626, weighted data, SGC-BMHS, 2009). ................................................................. 125

Table 25: Descriptives study population and (in)dependent variables (N=750, weighted data, SGC-BMHS, 2009)........................................................................................................................................................................ 147

Table 26: Descriptives service stigma (N=750, weighted data, SGC-BMHS, 2009).............................. 148

Table 27: The association between social network composition and institutional service stigma (N=750, weighted data, SGC-BMHS, 2009)........................................................................................................................................................................ 150

Table 28: Descriptives of the study population and the independent variables (N=743, weighted data, SGC-BMHS, 2009)......................................................................................................................................................................... 166

Table 29: Gendered interactions related to treatment recommendations (weighted data, SGC-BMHS, 2009)......................................................................................................................................................................... 167

Table 30: Gendered interactions related to stigmatizing attitudes (N=738, weighted data, SGC-BMHS, 2009)......................................................................................................................................................................... 168
Part I.

General Introduction
1 Introduction

As a sociologist, your main goal is to try to unravel why people behave the way they do. People are not completely free to act as they please, nor are they puppets on a string that are controlled by structure. The difficult task of sociologists is to study the interplay between individual agency and social structure. I infiltrated as a sociologist in a field that has been dominated by social psychologists, psychiatrists and epidemiologists. Their utilization studies mainly focus on the choices that individuals make. This rational actor perspective is useful, but has its limitations, particularly in the context of studying help-seeking for mental illness.

Applying a sociological approach to the theme of mental health care use means shifting the focus from the individual in a social vacuum to the individual that is embedded in a social network, surrounded by a cultural context. The cultural context may define which definition people apply to the deviant behavior. This cultural definition or label may trigger a range of associations which can be positive or negative. In case negative attributions dominate, the social construction of stigma comes into play and might constitute a barrier toward help-seeking. Furthermore, the social circle of people also harbors specific beliefs about the origin of mental illness and the utility of different treatment options. Depending on those beliefs, people are pushed toward or pulled away from the professional mental health care sector through social interaction.

The image on the cover depicts the core sociological research question of this dissertation. How do other people’s beliefs influence the decision-making of individuals? People are able to imagine how other people perceive the image of themselves. Other people might form different impressions of the Self, depending on a range of factors. For instance, if people have yet encountered someone with mental illness, they will be able to build on that experience. Others who lack that experience have to rely on the cultural images of someone with mental illness that have been transmitted through
socialization. Also the characteristics of the person who is being judged play a role. People will respond differently to a female person who is suffering from mental illness compared to a male person. When a female person expresses emotional difficulties, this is conform with the feminine role. However, when a male person discloses mental health problems, the reaction might be more severe as it can trigger a role conflict.
2 Social construct of mental illness

The conceptualization of mental illness has changed over time (Foucault, 1965; Hacking, 1999). Symptoms of mental illness were seen as unique traits at a certain point in time. They were linked to positive characteristics such as wisdom and insight. At another point in time, symptoms of mental illness became categorized as abnormal. As a consequence, they needed to be controlled. For instance, when people perceived mental illness as resulting from some demonic possession, it was placed under the control of religion. Another example is that when people perceived mental illness as badness, the criminal justice system was engaged to provide sanctions. Furthermore, at present, the conceptualization of mental illness still varies within subcultures (Foucault, 1965; Hacking, 1999). Symptoms of mental illness are considered to be diseases in the Western world, while indigenous people of Latin-America perceive it as ‘soul loss’ (Eaton, 2001).

The medical view upon mental illness has been imposed by the profession of psychiatry. By focusing more on biological causes and psychopharmacological treatment options, the professionals lent legitimacy to the concept of mental illness (Scull, 1977). This medicalization movement occurred partly as a reaction to the anti-psychiatry movement that was popular in the 1960s and early 70s (Szasz, 1961; Foucault, 1973). Psychiatry wanted to defend and professionalize its position. This phenomenon is referred to as the ‘medicalization of deviance’ (Conrad & Schneider, 1980; Conrad, 2007; Horwitz, 2007; Horwitz & Wakefield, 2007). The professional power of medicine expanded over wider spheres of life and reframed previously nonmedical problems into medical problems.

The locus of responsibility for control shifted from informal to more formal organizations (Foucault, 1973). Deviance was removed from the realm of public discussion and medical experts took the position of agents of social control based on medical knowledge. By using diagnoses as classification
tools (Jutel & Nettleton, 2011) and by regulating symptom behavior by means of medical interventions (Kirk & Kutchings, 1992; Lane, 2007), medical professionals exerted power.

However, not only professionals exerted power (Conrad, 2005). Pharmaceutical companies also stimulated the medicalization of deviance by direct-to-consumer advertising (Payton & Thoits, 2011). For example, social anxiety was a little used diagnosis, until a company started advertising, presenting social anxiety as a biologically based condition that was treatable with the compounds they sold. Beside the professionals and the pharmaceutical companies, the private consumers also stimulated the medicalization process. For instance, Attention Deficit Hyperactivity Disorder was initially perceived as a childhood disorder, but consumers themselves pushed to drop the age limit in order to make it applicable to adults too.

In sum, society is undergoing a process of medicalization. Deviance is increasingly defined as disease-like with biogenetic causes. This process can be discerned in the expansion of the number of disorders and the lowering of the diagnostic thresholds in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (Judd et al., 1994). As a result, the definition of what is considered to be normal is further restricted while the medicalization of mental illnesses is strengthened (Conrad & Schneider, 1980; Conrad & Leiter, 2004).
3 Approaches on help-seeking for mental illness

3.1 State of the art approach in utilization studies

In the field of medical sociology, Parsons is one of the founding fathers. In his structuralist-functionalist approach, medical care seeking is seen as a sort of normative control in order to restore normal functioning (Parsons, 1951). He was the first to apply social role theory to interactional relations between sick people and others. According to Parsons, sickness is not only a biological state, but a matter of social significance. He argues that social roles govern the behavior of ill people. When confirming to the sick role, people are obliged to seek professional help and to comply with the advice of medical professionals. As a result, they are not perceived as responsible for their condition, which in turn validates a withdrawal from their normal work and family roles.

In traditional utilization studies, the sick role is analogous with the patient role. It is examined which people do and which people do not make contact with the formal care system. Classic utilization models are the Socio-behavioral model of Andersen (1995), the Health Belief Model (Rosenstock, 1966) and the Theory of Reasoned Action (Fishbein & Ajzen, 1975). The Socio-behavioral model of Andersen (1995) distinguishes between need, predisposing and enabling factors. The need factor reflects that some need for care must be defined in order for people to seek care. Enabling factors refer to the ability to act on a desire to receive care, for instance geographical availability of care or financial ability (through income and insurance). Examples of predisposing characteristics are age, level of education, gender and race. These socio-demographic characteristics are associated with an individual’s tendency to seek care. In sum, the socio-behavioral model is structurally oriented, focusing on access and need for care, while incorporating a range of predisposing characteristics. The
The question is whether people’s needs can be met, depending on the resources to which people have access to.

The Health Belief Model (Rosenstock, 1966) originates from social psychology and focuses primarily on the role of motivations, beliefs and perceptions on individual’s decisions to seek formal care. The question is whether health beliefs (for instance the perceived severity of the illness) and preferences (the way the benefit of seeking treatment is being perceived) influence the health care decision, beyond the impact of experience with and knowledge about the mental health care sector. Furthermore, the Theory of Reasoned Action (Ajzen & Fishbein, 1975) stresses the assessment of risks and avoidance of negative outcomes. Expectancy becomes key as individuals rate how current and alternative actions can reduce their health problems and accordingly, evaluate whether or not to seek help. Moreover, the subjective norm is taken into account, referring to the influence of people’s significant others. The core question is whether the risk of illness can be offset by the health care system.

In general, the aforementioned models consider help-seeking as an individual process. They perceive individuals as active, rational decision makers who weigh the costs and benefits of help-seeking and make voluntary choices. Yet the explanatory value of these models seems to be limited (Pescosolido, Gardner & Lubell 1998). An individual’s cost-benefit assessment does not adequately reflect the processes that people go through when considering help-seeking. The nature of mental illness calls into question people’s ability to engage in complicated cognitive processes. Symptoms of mental illness such as confused thinking, cognitive disorganization, delusions and deficits in affect make a rational choice approach a poor candidate for understanding the mechanisms underlying the use of mental health services.
Empirical findings strengthen this critique on the rational choice perspective. Less than half of the reports on how people entered the mental health care sector reflect a cost-benefit assessment (Pescosolido, Gardner & Lubell, 1998). Among those who ended up in treatment, a big part of them did this only after a substantial delay of many years (Wang et al., 2005; Thompson, Hunt & Issakidis, 2004). Moreover, the majority of the population suffering from symptoms of mental illness do not enter professional care (Kessler et al., 2005; Wang et al., 2005). This is the case for almost two thirds of those who suffer from mental illness (Wang et al., 2005, 2007; Dua et al., 2011; Mc Alpine & Mechanic, 2000; Kessler et al., 1996; Alonso et al., 2007, Kohn et al., 2004) and in Belgium the rate is similar (Bruffaerts et al., 2004).

3.2 Sociological approach toward utilization of (mental) health services

Sociology starts out from the idea that social interaction is the basis of society (Simmel, 1955). Accordingly, action is composed of organized episodes of social interaction rather than discrete individual acts (Granovetter, 1985; Simmel, 1955). It is through interaction that individuals understand and attempt to handle difficulties (Kulka, Veroff & Douvan, 1979). In brief, interaction with others forms an essential element in the dynamics of decision making (Pescosolido, 1992). The mechanism of social interaction is provided by the structure of social networks. Social networks are built by social interaction, whether those interactions are routinized and regular, or spontaneous and fleeting (Pescosolido, 1992).

As the rational choice perspective ignores this aspect of interaction, we rely on a different theoretical framework. The Social Organization Strategy (SOS) (Pescosolido, 1991) expands the perspective from sole reliance on rational, cost-benefit analysis to socially constructed patterns of decisions. This framework offers a network- and event-centered counterpart to the dominant individually
focused rational choice perspectives on social action. In accordance with the SOS, the Network Episode Model (1992) puts forward that social networks constitute the dynamic upon which help-seeking decisions are based. This will be elaborated upon in the next chapter.

Furthermore, the Network Episode Model (NEM) brings culture back in (Olafsdottir & Pescosolido, 2009). Whereas in traditional utilization models, the role of culture is downplayed, the NEM draws attention to cultural factors. Particularly in the case of mental illness, the influence of culture on health behavior is pronounced (Angemeyer, Matschinger, Riedel-Heller, 1999; Furnham & Malik, 1994; Kurihara et al., 2000; Kleinman, 1988; Lopez & Guarnaccia, 2000; Rogler, 1999). When mental health problems occur, people base themselves on common sense knowledge and cultural routines. Culture is seen as offering a toolbox from which individuals can draw. Culture provides a framework for meaning and suggests avenues for solving problems (Dimaggio, 1997).

In sum, the NEM laid out the limits of dominant models and began to elaborate the roles played by other people. NEM conceptualized responses to illness as resulting from the process of social-influence, and as such refocused attention on the dynamic nature of health decision-making. The NEM responds to, but does not reject the rational choice theory approach to utilization. It does not ignore individuals’ purposive action, it just gives them a different priority in determining action. People’s actions cannot only be conceptualized as being rationally pursued. We also have to consider that social structure defines the boundaries of what is possible. Individuals are neither calculating individualists nor puppets of some abstract structure. Both agency and structure play a role in decision making and we study this combination by focusing on social interaction in social networks (Pescosolido & Boyer, 1999).
4 Social Network Perspective

In the following paragraphs, we will zoom in on the social network perspective. Individuals face illness in the course of their day-to-day lives by interacting with others who may recognize or deny a problem, or who may report positive or negative beliefs about the mental health care sector and may send them to formal care or provide informal care themselves. In other words, they might push people toward or pull people away from professional treatment, depending on whether they acknowledge that something is wrong and depending on their perceptions of what should and can be done about it. Individuals in social networks are more than just an influence on help seeking, they are caregivers and advisors themselves, as treatment is rarely sought in isolation (Clausen & Yarrow, 1955; Freidson, 1970).

More specific, we will zoom in on two characteristics of the social network. First, we question how the lay population conceptualizes symptoms of mental illness. Do they recognize mental health symptoms as underlying symptoms of mental illness? To which causal factors do they attribute the situation? Second, we study the opinion of the lay population about the treatment effectiveness of the professional mental health care sector. These two aspects reflect the level of mental health literacy of people’s social networks. Jorm (2000) defined mental health literacy as knowledge and beliefs about mental disorders that aid their recognition, prevention, and management.

4.1 Social network recommendations depend on beliefs about mental illness

Durkheim (1895) was the first who moved the object of analysis in studies of deviance from individual behavior to cultural definitions of deviance. The same behavior can be defined in multiple ways, depending on the system of classification that is being employed. Acts are not deviant until
they are so defined by other people’s reactions (Becker, 1963; Kitsuse, 1961). So deviant behavior has no reality apart from the cultural rules that define its existence. This is the core idea of social constructionism (Berger & Luckman, 1966).

The key element in this whole process is labeling. Labeling occurs when people cannot make sense out of a certain social situation. In order to attach meaning to the otherwise incomprehensible behavior, they apply a certain label. Only when people perform behavior that is highly visible and in violation of social norms and role expectations on a regular basis, they are at risk of being labeled. The latter is referred to as ‘residual rule breaking’ (Scheff, 1966). Yet not all deviant behavior is being labeled. Some deviant behavior is tolerated when it only occurs rarely, referred to as ‘primary deviance’.

In this dissertation, we argue that the way people define symptoms of mental illness matters for their help-seeking attitudes. The cultural definition they apply influences their responses toward deviant behavior. Depending on the label that people apply, different coping strategies are triggered, as the need for care is something subjective or relative. While the professionals state that the ill person fits the diagnosis of, for instance, depression (if his or her score matches the minimum score on the symptoms scales), it is possible that the social network of the ill person does not perceive him/her as ill. They might rather say that he or she is suffering from a life crisis. Social networks can support or discourage the framing of mental health problems as real diseases or as temporary states of mind (Pescosolido & Levy, 2002). So not every one of the lay public is medicalizing deviant symptoms. Haslam (2005) mentioned different folk models of psychiatry. Psychologizing mental illness is one of them. As social networks differ in whether they “see” a disease, they also differ in whether they adopt a medical solution for mental health symptoms (Pescosolido, Brooks-Gardner, and Lubell 1998).
4.2 Social network content depends on social network structure

Next to beliefs about the conceptualization of mental illness, people also differ in their beliefs regarding the effectiveness of treatment provided by the mental health care sector. Responses to mental illness vary considerably, depending on whether people support professional treatment or whether they criticize treatment options. The norms of the group to which he or she belongs may determine an individual's orientation toward health behavior. Interaction in social networks creates cultures of information, beliefs, and action scripts. The content of the network seems to depend on the structure of the social network. Social networks can both facilitate or restrict access to certain health related resources.

Simmel (1955), the father of the social network perspective in sociology, was the first to play with the geometry of social circles and to highlight that social circles are a substitute of subcultures with specific values. Suchman (1965) posited that cosmopolitan (higher educated) networks lead people toward medical care, while parochial (lower educated) networks lead people away from medical care. Kadushin (1969) labeled those social networks that facilitate entry into mental health care as the ‘friends and supporters of psychotherapy’. Also Freidson (1970) developed a framework for understanding the effect of network structure and content on the type of care-provider likely to be sought, namely the ‘lay referral system’. In addition, McKinlay (1972), and Horwitz (1977) underlined that referrals to medical care depend on people in the social network and whether their beliefs are skeptical about the efficacy of modern medicine.

These ideas are further elaborated upon in the Health Lifestyle Paradigm (Abel et al., 2008). In medical sociology, it is widely recognized that health related attitudes and behavior differ significantly between various social groups (Blaxter, 1990), as different groups have varying opportunities for access to resources that sustain and develop health (Robert & House, 2000; Abel et
al., 1991; Cockerham, 1995). Health lifestyles are patterns of voluntary health behavior based on choices from options that are available to people according to their life situations (Cockerham, 1995), linking agency and structure together in a theoretically meaningful way (Williams, 1995).

The concept of ‘habitus’ of Bourdieu (1977) is central to the Health Lifestyle Paradigm, as it explains the balance between the determining power of social fields and the creativity of social action. Habitus is defined as “systems of durable, transposable dispositions, structured structures predisposed to operate as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of operations necessary in order to attain them” (Bourdieu, 1977, pp 73). Bourdieu posited that dispositions to act are constructed through socialization and experience, with class position providing the social conditions for this process. The merit of this concept is that it points out that health-related behavior is not always the result of well thought-out, conscious reasoning, but might proceed through cultural routines which provide a practical and habitual logic.

With regard to ‘healthy’ lifestyles, the upper and middle classes are regarded as taking better care of their health than the working and lower classes (Abel et al., 1999; Blaxter, 1990; Cockerham, 2000, 2005; Korp, 2008). Bourdieu (1984) explains this by the theory of distance of necessity. This distance of necessity allows people from the higher social strata leisure time, resources to learn about appropriate health behavior and access to sources of authoritative knowledge. Another potential explanation is the Learning Generalization Hypothesis (Kohn & Schooler, 1983), which states that the lessons learned in the work domain can be carried over into other areas of life such as the health domain. For instance, the job conditions of members of the (upper) middle class tend to strengthen the emphasis on self-direction and self-control, leading to more positive health lifestyles in which they take greater personal responsibility for controlling their health status. In
contrast, the emphasis on conformity among manual workers triggers a more constrained and less optimistic world view, leading to less positive health lifestyles such as not engaging in preventive care due to a more passive or even fatalistic attitude (Cockerham, 2005; Williams, 1995; Stringhini et al., 2010).

In sum, we draw attention to the social network perspective in this dissertation by taking the lay population’s beliefs about the origin of mental illness and the treatment effectiveness of professional care into account.

5 Bringing culture back in

Next to focusing on the social network perspective, another advantage of the Network Episode Model (Pescosolido, 1992) is that cultural beliefs are highlighted. Hence, in the context of mental illness, we cannot ignore the stigma research tradition. Goffman (1963) defined stigma as an attribute that is socially defined as deeply discrediting, reducing the bearer from a whole and normal person to a tainted, discounted one. Jones (1984) underlined that ‘marked’ people get set apart from others and that their ‘mark’ links them to undesirable attributes that discredit him/her in the eyes of others. Crocker et al. (1998) proposed that stigma occurs when a person possesses some attribute or characteristic that conveys a social identity that is devalued in a particular social context. Finally, Thornicroft (2006) indicated that stigma is used as a form of social control against those whose characteristics are perceived to threaten the effective functioning of social groups.

The sociological definition of stigma by Link and Phelan (2001) highlights the importance of labeling issues and power differentials. Differences between persons have to be noticed, to be regarded as relevant and to be labeled accordingly. Also power is a necessary condition for stigma to unfold its
detrimental consequences. The labeler has to have the social, cultural, economic or political power to imbue his or her cognitions. This definition goes a step further than the social-psychological definition of Corrigan (2000) by defining stigma as the co-occurrence of the components of labeling and power differentials, next to the ‘classic’ components of stereotyping, emotional reactions and discrimination. Stereotyping refers to negative beliefs about a group such as perceiving people with mental illness as dangerous. Prejudice is the result of endorsing those negative beliefs, which leads to negative emotional evaluation. People for instance are afraid of people with mental illness. Finally, the behavioral response to prejudice is discrimination. For example, because people are afraid of people with mental illness, they do not want them to be a babysitter for their children.

5.1 How stigma might constitute a barrier toward help-seeking

In a first step, we will describe the underlying process of how stigma might serve as a barrier toward treatment.

Secondary deviance

Labeling not only has consequences in the sense that the labeler might stigmatize, also the person who is being labeled changes his/her behavior eventually. This is emphasized by the original labeling theory of Scheff (1966). The stereotypes associated with the label may guide the ill person’s behavior and may become crucial for its self-identity. This phenomenon is referred to as ‘secondary deviance’ (Lemert, 1951). In contrast to primary deviance, the behavior is no longer transitory, but it becomes perceived as a typical characteristic or even the master status of one’s identity. When persons around the deviant person react to him/her uniformly in terms of the stereotypes attached to people with mental illness, the ill person might conform to these expectations, as he/she may be rewarded
when confirming to the expectations and may be punished when attempting to return to their customary roles. In other words, a stable pattern of deviance or a deviant career might emerge due to labeling. In brief, a label tends to exacerbate the behavior that prompted the label in the first place. In other words, a self-fulfilling prophecy takes place (Merton, 1948).

**Modified labeling theory**

The modified labeling theory has been developed by Link et al. (1987, 1989) as a reaction to the debate between Scheff’s original labeling theory and Gove’s critique. While Scheff (1966) considered labeling as prime cause of deviant careers, Gove (1970) uttered that continued symptoms and social outcomes were merely consequences of, and inherent to mental disorders. Also labels were according to Gove merely reactions toward the bizarre, aberrant behavior that people with mental illness displayed. This “either-or” debate regarding the importance of labels versus behavior set the stage for the modified labeling theory. Instead of underlining either labeling or behavior, the modified labeling theory argued that both labeling and behavior matter. Behavior matters in the sense that more severely disturbed behavior influences the severity of social reactions. Also labeling has a range of consequences, which are described in more detail in the following paragraph. In brief, the modified labeling theory states that the social consequences of mental illness are driven by others’ responses to the mental illness label rather than by individual pathology.

Conceptions about people with mental illness are learned early in life through socialization (Wahl, 1997). People form expectations about how other people will react toward an individual with mental illness. These cultural conceptions become personally relevant in case people report mental health symptoms themselves. Accordingly, people fear the discrimination and devaluation that might come along with the label. As a consequence, people may develop (maladaptive) coping strategies in order to avoid being labeled, such as secrecy and social withdrawal. The latter coping strategies can
hamper a range of life circumstances, as acting more defensively and with less self-confidence might result in less employment chances, strained social networks and reduced self-esteem. All these negative outcomes might put the person at greater risk of reoccurrence or prolongation of mental illness symptoms. Hence, the mental illness label leads to social network instability both directly through rejection and avoidance, and indirectly through anticipation of others’ negative reactions.

One of the biggest contributions of the modified labeling theory is that people with mental illness are not portrayed as passive recipients of the label (which is the case in Scheff’s theory), but as people who react and respond to the label in various ways. In order to conceal the discreditable stigma of mental illness, they can engage in coping strategies, of which not seeking professional care is an example. As people know through role-taking that the label of mental illness is associated with undesirable characteristics, they will avoid official labeling through treatment contact in order to avoid discrimination and devaluation. Also Goffman (1959) underlined in his notions regarding impression management that life is a theatre and that people are actors on a stage. People try to avoid embarrassment and keep their troubles ‘off-stage’.

Self-stigma paradox

The internal process of reacting toward labeling is explained by the self-stigma paradox (Corrigan & Watson, 2002). As said before, people are not passive victims of stigma. Being aware of stigmatizing beliefs held by other people does not automatically lead to secondary deviance or the internalization of stigmatizing beliefs. It is also possible that people will not identify with the labeled group or will not perceive the negative attributes attached to the label as legitimate. People who do not identify are likely to remain indifferent to stigma, because they do not feel that the prejudices actually refer to them. Even if people identify themselves with the stigmatized group, it is also possible that they regard stigma as illegitimate and unfair. In this case, they rather react with righteous anger. Only
when people both identify themselves as part of the stigmatized group and perceive the public stigma beliefs to be legitimate, they will endorse the public stigma and will apply the stigmatizing beliefs to themselves, resulting in feelings of self-stigma (Corrigan, Watson & Barr, 2006). Self-stigma is defined as the reduction in a person’s self-esteem or sense of self-worth and self-efficacy due to the perception held by the individual that he or she is socially unacceptable (Vogel et al., 2007). Accordingly, sentiments such as ‘why try to seek out a job? I am not competent’ arise. In terms of Mead, self-stigma occurs when the I and Me aspect of the Self coincide; the social categories that individuals have learned in social interaction become self-defining. In brief, this self-stigma paradox stresses that people can choose other coping strategies instead of automatically internalizing cultural beliefs.

5.2 Stigma as gendered phenomenon

In a second step, we zoom in on how the characteristics of the person you are interacting with might influence the stigma process.

*Expectation-States Theory*

The Expectation-States Theory has been utilized by the sociologist Ridgeway (1991) to explain the influence of beliefs about the status of different social groups. Drawing on social role theory (Eagly, 1987) and the stereotype content model (Fiske et al., 2002), expectation-states theory argues that people rely on the content of culturally embedded stereotypes. With regard to gender, the theory states that greater social status is attributed to men in comparison to women (Mast, 2004). These widely held cultural beliefs are very powerful. They are so powerful that individual accomplishments cannot overcome the disadvantages that come with being in a lower status group.
So we make a case that gender norms carry a lot of potential to determine the behavior of both men and women in mixed gender settings (Sabo & Gordon, 1995). Gender influences the performance expectations held by both the one who is observing and the one who is being judged. Even if the one who is being judged is not personally endorsing gender norms, he or she will still be likely to take them into account when performing behavior (Sechrist & Stangor, 2001). Because people know that they will be judged based on whether they succeed or fail to meet gendered expectations (Reczek & Umberson, 2012; Springer, Hankivsky, & Bates, 2012; West & Fenstermaker, 1995; Olson, Roese and Zanna, 1996). In sum, we follow the ‘Doing Gender’ theory of West & Zimmerman (1987), which acknowledges that people are constantly engaged in (re)creating a sense of gender difference (Gerson & Peiss, 1985; Connell, 1995).

**Help-seeking as constituting a role conflict among men**

Gender norms also influence coping strategies used to deal with mental illness. Emotional expressiveness, caring for one’s health and asking for help are constructed as forms of idealized femininity (Courtenay, 2000; O’Brien, Hunt & Hart, 2005; Phillips & Segal, 1969; van Wijk & Kolk, 1997; Schofield et al., 2000). Women use emotion-focused coping strategies which change their perceptions about the stressor (Matud, 2004). They cope with mental health problems by talking about them in order to solicit social support (Thoits, 1995; Ross & Mirowsky, 1989). Masculinity norms, on the contrary, strongly emphasize emotional control, independency and self-reliance (Addis & Mahalik, 2003; Williams & Best, 1990; Golombok & Fivush, 1994). As a consequence, the coping strategies of men reflect a high sense of mastery. Men prefer problem focused coping strategies which change the stressor itself. They will try to reduce or divert stressors by engaging in self-care strategies (Kessler et al., 1985). They do not want to be part of a subordinated relationship with a health care-provider (Courtenay, 2000; Springer & Mouzon, 2011). Therefore, it is argued in this
dissertation that men are at risk of a role conflict when seeking help for mental illness, as the latter is culturally more acceptable for women (Vogel et al., 2013; Angermeyer & Matschinger, 1999; Gouwy, 2008; Koopmans & Lamers, 2007; Biddle et al., 2004; O’Neil, Good, & Holmes, 1995; O’Brien, et al., 2005). As a consequence, we expect that help-seeking is stigmatized to a higher degree among men (Vogel et al., 2006; Pederson & Vogel, 2007; Ng & Chan, 2000; Addis & Mahalik, 2003).

5.3 Tackling stigma by means of contact

Next, we focus on how the characteristics of the person who is judging someone with mental illness might play a role.

Intergroup contact has long been social psychology’s and sociology’s most promising strategy for changing stigmatizing attitudes (Corrigan & Penn, 1999; Corrigan, River, et al., 2001; Pinfold et al., 2003). Being confronted with people that contradict the content of cultural beliefs is a powerful tool to change stereotypes. The basic rationale is that prejudice may be reduced as one learns more about a category of people and no longer relies on generalizations and oversimplifications. The following theoretical frameworks underline this reasoning. First, according to the Theory of Cognitive Dissonance (Festinger, 1957), people change their stereotypes when they encounter information that is inconsistent with the stereotypes they hold. Second, following the Recategorization Theory (Gaertner et al., 1990), contact with an out-group member results in changes in the classification of that person. Instead of viewing the person with an out-group status as one of ‘them’, he or she becomes one of ‘us’. Furthermore, the attribution theory (Weiner, 1995; Corrigan, 2000) argues that due to contact with people with an out-group status, people will change their perceptions regarding responsibility and controllability.
Contact hypothesis

The contact hypothesis or Intergroup Contact Theory of Allport (1954) refines the idea that contact is one of the best ways to improve relations among in- and out-groups. Its contribution is that it underlined that contact only reduces prejudice toward minority groups under specific conditions. More specifically, contact has the most positive effect if it is personal, voluntary, intimate, and repeated over time. Contact situations need to be long enough to allow for the members of the conflicting groups to feel comfortable with one another and to decrease feelings of anxiety. Other beneficial circumstances are similar social statuses of the interaction partners, a collaborative task, and institutional support (Gaertner et al., 1990; Kolodziej & Johnson, 1996; Sigelman & Welch, 1993; Pettigrew & Tropp, 2006; Pettigrew, 1998; Pettigrew et al., 2011). In other words, to obtain beneficial effects, the situation must include positive contact.

In brief, in this dissertation we consider cultural factors by paying attention to stigmatizing attitudes which might deter care-seeking. Next to different dimensions of stigma (public stigma and self-stigma), we also take into account the characteristics of the one who gets labeled and the labeler. On the one hand, we study whether the gender of the person who is reporting symptoms of mental illness does matter. On the other, we examine whether the level of contact of the labeler with people with mental illness has an impact.

In conclusion, this dissertation starts out from the Network Episode Model of Pescosolido (1992). We focus our attention on two aspects of the NEM. On the one hand, we acknowledge that the social network is the mechanism that constitutes decision-making. On the other, we emphasize that more attention should be paid to cultural beliefs when studying help-seeking for mental illness. With regard to the social network, we highlight the importance of the social network content. Depending on the composition of the social network, different conceptualizations of mental illness arise and
different perceptions about the effectiveness of professional treatment are present. As concerns cultural beliefs, we underline the importance of taking stigma into account. Next to stigmatizing attitudes, we also consider how characteristics of the labeler and characteristics of the one who gets labeled play a role in the stigma process.
6 Empirical research questions

In the following section, we deduce some empirical research questions based on the theoretical framework that has been outlined above. For each research question, we start with outlining the state of the art of previous empirical studies. Next, we highlight the contribution of our research and finally, we utter some hypotheses.

6.1 Association between the conceptualization of mental illness and coping strategies and stigmatizing attitudes

A range of longitudinal studies have indicated that over time, people have become more ‘literate’ regarding mental health. They have become better able to recognize mental illness (Angermeyer, Holzinger & Matschinger, 2009; Jorm, Christensen & Griffiths, 2006) and are more likely to attribute the situation, at least partly, to biogenetic factors (Jorm, 2000; Angermeyer & Matschinger, 2005; Mojtabai, 2007; Schomerus et al., 2012; Paykel, Hart & Priest, 1998; Jorm et al., 2005). Yet empirical studies also revealed that not all of the lay public have adopted the medical model (Angermeyer & Matschinger, 1996; Jorm, et al., 1997; Magliano et al., 2004). Many people still prefer psychosocial to biogenetic explanations (Jorm, Christensen & Griffiths, 2005; Rogers & Pilgrim, 1997; Furnham & Bower, 1992; Schomerus et al., 2012). However, in previous studies, the association between labeling issues and causal attributions on the one hand and coping strategies on the other is merely studied departing from the medical framework.

As said before, most previous studies focused only on the impact of attributing the situation to biogenetic factors. Yet it is unclear whether the impact of biogenetic explanations differs depending on whether people also hold psychosocial explanations. Little is known about how psychosocial
attributions interact with biogenetic ones. The contribution of our study is that we focus also on the role that psychosocial factors play in etiology. Moreover, we addressed a ‘bottom-up’ operationalization of both the conceptualization of mental illness as well as the help-seeking strategies, as a reaction toward the ‘top-down’ approach of many previous studies regarding this topic. We contrast the medicalized conceptualization with the psychologizing model. We hypothesize that the former will be associated with a greater likeliness to recommend professional care, while the latter will be related to a preference for informal or self-care.

Next to linking the conceptualization of mental illness with help seeking strategies, we also consider the relationship with stigma. Concerning this topic, longitudinal studies revealed that although people have become more knowledgeable, the level of stigma has remained stable or even increased (Phelan et al., 2000). This phenomenon is considered as ‘the package deal’ (Rosenfield, 1997; Link et al. 1997). Rosenfield (1997) pointed out that labeling has both positive and negative consequences. She showed that both receipt of services and stigma are related in opposite directions to multiple dimensions of quality of life. Furthermore, Link et al. (1997) performed a longitudinal study among men who were dually diagnosed with mental disorder and substance abuse. The researchers followed those men from entry into treatment to follow up one year later. It appeared that symptoms improved thanks to treatment, but that the perceptions and experiences of stigma had an enduring effect on people’s self-esteem. In brief, the package deal reflects a double-edged sword. On the one hand, a medical conceptualization of mental illness might facilitate help-seeking, but on the other, it might also induce fear of stigma (Jorm, 2012). So the contribution of our study is that we take both the potential advantages and disadvantages of medicalization into account. Moreover, we examine a specific dimension of stigma, namely stigmatizing attitudes toward someone who has been in treatment, as we expect those attitudes to be more negative compared to attitudes toward someone who merely reported symptoms of mental illness.
This study questions the ‘genes paradox’. Genetic optimism expected that the medicalization movement would reduce stigma by reducing people’s tendency to blame people with mental illness. By attributing the illness to causes located beyond the individual’s control, the individual’s responsibility is lessened following the attribution theory (Angermeyer, Holzinger & Matschinger, 2009; Read et al., 2006; Jorm & Oh, 2009; Weiner, 1995). On the contrary, the genetic essentialist thinking defines a group of individuals as having a deep-seated, unchangeable essence that makes them fundamentally different from others (Phelan, 2005; Schnittker, 2008; Haslam, 2011). The genetic essentialist hypothesis argues that the decontextualized nature of biogenetic factors of mental disorders might encourage the lay public to perceive mental illness as unchangeable and uncontrollable. This seems to lead to pessimism about change and recovery and desire for separation. Furthermore, labeling might also strengthen stigma, as it strengthens perceptions of homogeneity and stability (Corrigan, 2007). We expect that we will find empirical support for the genetic essentialist hypothesis.

6.2 Impact of the social network content on beliefs toward professional mental health care

How people’s socio-economic status predicts their health behavior is an often researched question (Minkin, Stoline & Sharfstein, 1994). Particularly those who obtained a higher level of education seem to be more likely to contact specialist mental health care (Howard et al., 1996; Olfson & Pincus, 1994). Yet more knowledge may also reflect more skeptical views of medical services (Angermeyer, Matschinger & Riedel-Heller, 1999; Furnham & Wardley, 1991). They may not always translate their knowledge into more positive views of medical services. However, personal income as such is not consistently related to help-seeking behavior (Kessler et al., 2005). The limitation of those previous studies is that they only take the position of the individual into account, without considering the influence of his/her social network.
Our research, on the contrary, will also take the social network structure into account, as beliefs about the efficacy of the mental health care sector seem to differ between social groups according to the health lifestyle paradigm (Cockerham, 2000, 2005; Abel & Frohlich, 2012; Cockerham, Abel & Rutten, 1997). The contribution is that we consider the potential buffering effect of belonging to a certain social circle. For instance, for people from the lower strata, belonging to a heterogeneous network might imply that people have access to differential cultural resources. This might trigger healthier lifestyles (Abel et al., 1999; Blaxter, 1990; Cockerham, 2005; Cockerham, Rutten & Abel, 1997). In other words, we hypothesize that knowing many people from the middle or upper class—as representing the social classes with the most positive health lifestyles—will report more positive attitudes toward the mental health care sector. We expect that this association will appear beyond the impact of people’s personal socio-economic position on attitudes.

6.3 Association between stigma and help-seeking: Stereotype awareness versus stereotype internalization

Previous empirical studies that examined the association between stigma and help-seeking operationalized stigma by means of the stigma dimensions social distance and dangerousness. They showed that a desire for greater social distance was associated with considering formal treatment options as helpful (Lauber, Carlos & Wulf, 2005) and that dangerousness appeared to facilitate the willingness to seek formal care (Mojtabai, 2010; Jorm, 2012) and the application of coerced treatment (Angermeyer & Matschinger 1995; Corrigan et al., 2002). So the lay public seems to draw a clear line when they hold an expectation of dangerousness. Perceptions of dangerousness seem to trigger a greater desire for social distance and lead people to believe that people with mental illness should be institutionalized (Corrigan et al., 2001). Those studies, however, did not capture the process of stereotype threat that we are aiming at.
The idea of stereotype threat (Steele & Aronson, 1995) is that people want to avoid being labeled as someone with a mental illness in order to avoid the stigma that is attached to that label. Since mental illness is not readily visible, the biggest cue of being labeled is entering treatment. Therefore, we argue that stigma might constitute a barrier toward professional help-seeking. The contribution of our study is that we do not consider people as passive recipients of stigma. Instead, we underline that the impact of cultural stigmatizing beliefs depends on whether people internalize those beliefs or not. We hypothesize that only people who internalize stigmatizing beliefs will be less likely to be in favor of professional care-seeking. Moreover, we expect that the association will differ depending on the source of care that is considered.

6.4 Stigma as a gendered phenomenon

When in current research gender is linked to help-seeking issues, the focus is usually on women’s health in current research (Bayne-Smith, 1996). Women are generally portrayed as the ‘sicker’ gender, resulting in greater utilization of mental health services (Courtenay, 2000; Sabo & Gordon, 1995; Addis & Mahalik, 2003). Men’s underutilization of mental health services, is on the contrary, often taken for granted (Annandale & Clark, 1996; Courtenay, 2000) and no effort is being made to explain the gendered treatment gap with regard to mental health services in current research.

In our study, we follow the doing gender perspective (West & Zimmerman, 1987) and examine how gender is being created in social interactions (Bohan, 1993; Connell, 1995; Courtenay, 2000). We know that gender norms somehow serve as a structuring framework when people interact. As concerns health related issues, norms of masculinity and femininity are also determining people’s reactions. Salonstall (1993) yet reasoned that people use health practices to demonstrate gender.
People are somehow encouraged to define men as the opposite of women, since they know that they will be judged upon their conformity with those gendered expectations. Hence, our contribution is that we do not consider gender as an innate characteristic, but that we study how the gender of both the labeler and the labeled person influence people’s responses to mental illness symptoms.

We hypothesize that men will be less likely to be recommended to seek professional care and that men who deal with mental illness will be stigmatized to a higher degree, based on our argument that seeking professional care for mental illness is not in accordance with masculinity norms and accordingly might cause a role conflict and status loss.

6.5 The potential negative side-effect of contact on stigmatizing attitudes

The level of familiarity with mental health services – either through personal experience or through knowing someone who has been treated - is considered in every one of our empirical studies, since contact is a crucial indicator of help-seeking beliefs. In the last empirical study, we zoom in on the association between contact and stigmatizing attitudes. This is a relevant research question in times of deinstitutionalized or community based care.

Although it was expected that contact would reduce stigmatizing attitudes, previous empirical studies regarding the association between contact and stigma delivered inconsistent findings. As a consequence, Brunton (1997) and Callaghan et al. (1997) introduced the term ‘contact paradox’. Some studies indeed found that contact with people with mental illness decreased the desired social distance from people with mental illness (Angermeyer & Matschinger, 1996; Hall et al., 1993; Ingamells, Goodwin & John, 1996; McKeon & Carrick, 1991; Vezzoli et al., 2001). Yet other studies reported that contact with people with mental illness encouraged the desire for social distance due
to perceiving them as dangerous (Phelan & Link, 2004). Additionally, a range of studies did not find any significant effect of contact on social distance (Arkar & Eker, 1992; Stuart & Arboleda-Florez, 2001).

We argue that these inconsistent findings are due to the rather crude measures of contact that are used in previous studies. Therefore, we apply a more nuanced operationalization of contact, inspired by the contact hypothesis of Allport (1954). The contribution of our approach is that we consider the level of intimacy of the contact relationship, potential outcomes of the relationship and emotional reactions that reflect the intensity of the encounter.

We hypothesize that a personal relationship with a high level of intimacy is better in modifying prejudice. Furthermore, we expect that the outcome of the treatment matters too. Finally, we hypothesize that negative emotions such as fear might have a powerful detrimental impact on stigmatizing attitudes. Those contact conditions are linked to the preferred social distance toward people with mental illness, conceptualized as how opposed or how positive people’s beliefs are toward community care initiatives.
7 Research design

7.1 Public opinion research

In this dissertation, we used public opinion research to question the lay public’s attitudes toward people with mental illness and mental health services. Using survey research among a representative sample of the general population is a valuable approach, since many empirical studies are limited in the sense that they study selective samples such as student (Vogel, Wade, & Hackler, 2007; Golberstein, Eisenberg, & Gollust, 2008, 2009) or rural samples (Wrigley et al., 2005; Komiti, Judd, & Jackson, 2006). In Belgium, this is the first survey that studies the attitudes of the general population toward people with mental illness and mental health services. Previous studies were limited to specific research samples such as service users (Verhaeghe & Bracke, 2011), community and health professionals (Scheerder et al., 2011), and medical students (Scheerder & Van Audenhove, 2011).

The disadvantage is that if you want to study people’s personal experience with mental illness and their actual help-seeking behavior, the number of participants of the survey has to be substantial in order to have a sufficient number of participants that would have reported psychiatric symptoms and who would report some variability in treatment contact. Given that in general, merely a small percentage (10-15%) of the general population are (former) mental health service-users (Alonso et al., 2004), extensive datasets studying this topic are needed, particularly when the research aim involves the comparison of different sources of care. Therefore, some studies focus on patient samples (Sirey et al., 2001). However, the pitfall of patient samples is that information is missing about those people who did not end up in care, despite their (subjective) need of it. So a key variable is then eliminated.
The advantages of public opinion research are that cultural beliefs can be questioned on the one hand, as stigma originates in the cultural beliefs held by the general public. Also gender norms are based on the stereotypes regarding masculinity and femininity that are taken for granted in society. On the other hand, the lay referral system can be studied, as we acknowledge that mental health complaints are almost always identified first by members of the social network and that people are influenced by their significant others when considering the decision to seek care or not (Dew et al., 1991; Pescosolido et al., 1998; Cusack et al., 2004).

The limitations that come along with applying public opinion research, more specific regarding the attitudes versus behavior debate and social desirability issues will be more elaborately discussed upon in the discussion part.

7.2 Vignette technique

An important criticism on survey research is that the judgments required of respondents are often too abstract. When posing vague questions, there is a risk that each respondent will answer in terms of his own mental picture of the question. So ambiguity arises when respondents are asked to make judgments based on limited information, since they then are required to impute information themselves.

A methodological approach that can be used to alleviate the aforementioned problem is the vignette technique. The solution is to make the stimulus presented as concrete and detailed as possible in order to approximate a real-life decision-making situation.
The advantage in case of applying the vignette technique is that the additional details are provided by the researcher. By holding the stimulus constant, the researcher gains a degree of control over the stimulus situation, comparable to the use of experimental designs (Alexander & Becker, 1978).

A vignette is a fictional story that provides concrete information about people’s behavior in certain situations. They contain precise references to what are thought to be the most important factors in decision-making processes (Alexander & Becker, 1978). Vignettes are used as a stimulus to explore participants’ perceptions and beliefs in relation to a specific situation (Barter & Renold, 2000). In psychiatric attitude research, the vignette technique has a long tradition with Starr as the pioneer (1955). Particularly in stigma research, the vignette methodology is widely employed (Ben-Porath, 2002; Corrigan et al., 2005; Mcbride, 1998; Schumacher, Corrigan & Dejong, 2003; Schwartz, Weiss & Lennon, 2000; Walkup, Cramer & Years, 2004; Hazel, 1995; Hughes, 1998; Barter & Renold, 1999; Schoenberg & Ravdal, 2000).

The technique has also been used as narrative in health promotion research to improve knowledge, change attitudes and motivate health behavior change. Furthermore, the vignette technique was used to examine decision making among clinicians (Shulman et al., 1999; Green et al., 2007) and literature suggested that assessment made on basis of vignette case descriptions correlated highly with those made after examination of patients with equivalent symptoms seen in person (Kirwan et al., 1983).

According to Shulman et al. (1999), vignettes have emerged as a viable method. Applying the vignette technique has the following advantages. First, to be able study mental illness in a cross-cultural comparative perspective, one has to be sure that one is studying the same type of mental illness across different countries. In this case, fundamental classification tools such as the DSM-IV are
essential. The diagnostic ‘bible’ of the DSM IV, although heavily criticized, has been developed in order to guarantee reliable communication among clinicians, researchers and policy makers (Reed et al. 2011; Soydan, 1996).

Second, studying mental illness in general is too broad, too amorphous to be useful. The blanket term of ‘the mental patient’, which has dominated research on stigma related to mental illness, is not useful (Mann & Himmelein, 2004). People have different ideas about what the meaning of mental illness is, and thus one would be studying different conceptualizations of mental illness, as people interpret mental illness differently. Some people would think about subclinical mental health problems, while others would only consider the most severe mental disorders. Some would regard internalizing disorders to be the subject, while others would make the connection with externalizing disorders such as substance abuse. Instead of being dependent on the imagination of the respondents, we chose to fix the ‘need’ factor by focusing upon two particular types of mental disorders: one that is common (depression) and one that is considered as very severe (schizophrenia). Presenting a fixed range of symptoms rules out the possibility that the misunderstanding of the concept of mental illness guides people their responses. Moreover, applying the vignette techniques creates the opportunity of comparing the attitudes toward different types of mental disorder.

Third, another advantage is that the respondent is not as likely to consciously bias his report. As the respondent does not know which factors are being compared, he or she will be less likely to answer in a socially desirable way. Fourth, the vignette technique makes it possible to analyze the effect of systematically varying certain characteristics of the vignette description. As long as there is an approximately equal distribution of the different vignette versions across the sample population, group differences in attitudes can be measured. So the vignette technique allows the researcher to develop specific research questions related to the characteristics of the vignette person (Lapatin et
al., 2012). For instance, much attention has been devoted to the theme of ‘double stigma’ (Gary, 2005) by examining people’s reactions toward someone with an out-group status who also suffers from a disorder that is taboo. In our case, we took the opportunity to study how responses differ depending on the gender of the vignette person in interaction with the gender of the respondent. Both cases of same-gender or cross-gender interaction can be studied as a consequence.

Finally, another opportunity that is provided by applying the vignette technique is that the mental health literacy of the respondent can be questioned. The fact that the case histories are unlabeled offers a way to examine whether people are able to recognize the mental disorder, while not implying a medical interpretation. Last but not least, taking into account the sensitivity of the research theme, vignettes provide a non-threatening and impersonal approach for people who themselves have dealt with mental illness in the past (Hazel, 1995; Hughes, 1998; Barter & Renold, 1999; Schoenberg & Ravdal, 2000).

The biggest critique on the vignette technique is that some researchers argue that there might be a significant gap between what people say they are going to do in response to a hypothetical story and how they react in reality (Hughes, 1998; Barter & Renold, 1999, 2000). This debate will be elaborated upon in the discussion section.

More specific, in this dissertation, we used two different vignettes to draw conclusions about the attitudes of lay people towards someone who is suffering from a certain mental disorder and toward the use of mental health care services. The judgments that are evoked are for instance opinions about what that person should do, or their willingness to engage in a working relationship with that person (Hazel, 1995; Hughes, 1998; Barter & Renold, 1999, 2000; Schoenberg & Ravdal, 2000). The vignettes, used in this PhD, refer to major depressive disorder and schizophrenia. Major depressive disorder is a rather common mental disorder. Its relatively high prevalence (lifetime prevalence...
approximates around 20% (Kessler et al. 2005, 2007) makes it a ‘known’ disorder. The symptom description refers to changes in mood or affect. People have to suffer from some of the following clusters of symptoms: changes in weight or appetite, changes in sleep, decreased energy, feelings of worthlessness and difficulties to concentrate. Schizophrenia belongs to the category of psychotic disorders. It is defined as a disturbance lasting at least six months and in its active phase, it includes some of the following symptom groups: delusions, hallucinations, disorganized speech, negative symptoms. Studying that kind of relatively rare type of mental disorder (approximately 1% of the population is affected by it (Linscott & Van Os, 2010), as it is categorized as a ‘severe mental illness’, because people can be hampered to complete education, maintain a job or in general, function as expected in society.

The vignettes, used in this survey, are taken from the 1996 U.S. General Social Survey, and were rewritten during a meeting in Madrid, with all the country teams’ representatives and a cross-cultural psychiatrist who was involved in the WHO studies present. The vignettes are in accordance with the DSM IV-definitions, which itself was revised for cross-cultural applicability (Thakker & Ward, 1998). The vignettes were randomly varied and referred either to someone suffering from major depression, schizophrenia or asthma, either to a man or a woman and either to someone with an in-group or an out-group status. The out-group status refers to the Turkish nationality, as the Turkish community is one of the largest ethnic minority groups in Belgium (Federal Public Service Employment, Labour and Social Dialogue, 2013).

The depression vignette was as follows:

Jan/Marie/Ahmed/Fatima is a Belgian/Turkish men/women. For the last several weeks NAME has been feeling really down. She/he wakes up in the morning with a sad mood and heavy feeling that sticks with her/him during the rest of the day. She/he isn’t enjoying things the way she/he normally would. In fact, nothing seems to give him/her pleasure. Even when good things happen, they don’t
The psychosis vignette was as follows:

Jan/Marie/Ahmed/Fatima is a Belgian/Turkish man/woman. Up until a year ago, life was pretty okay for NAME. But then, things started to change. He thought that people around him/her were making disapproving comments, and talking behind his/her back. NAME was convinced that people were spying on him/her and that they could hear what she/he was thinking. NAME lost his/her drive to participate in his/her usual work and family activities and retreated to his/her home, eventually spending most of his/her time on his/her own. NAME became so preoccupied with what she/he was thinking that she/he skipped meals and stopped bathing regularly. At night, when everyone else was sleeping, she/he was walking back and forth at home. NAME was hearing voices even though no one else was around. These voices told him/her what to do and what to think. She/he has been living this way for six months.

In sum, using the vignette technique is a promising research method for investigating respondents’ beliefs and attitudes. Vignette studies combine ideas from classical experiments and survey methodology to counterbalance each approach’s weakness. On the one hand, traditional surveys show a high external validity due to their claim of representativeness and their multivariate measurements. On the other hand, classical experimental designs derive their high internal validity enabled by the controlled intervention. The combination of the vignette technique with a representative sampling of respondents and supplemented with a traditional questionnaire allows the investigation of conditional vignette effects (conditional on respondent characteristics) and the
generalization to a well-defined target population (Atzmüller & Steiner, 2010). For Sniderman and Grob (1996) this combination of the traditional representative survey and the vignette analysis with their different strengths in external and internal validity was one of the innovational breakthroughs in the design of public opinion surveys.

8 Belgian Context
The relevance of the Belgian context for an international audience is the peculiar position of Belgium. Studying help-seeking for mental illness in Belgium is interesting for the following reasons. First, cultural factors play an important role in Belgium, as there are only limited structural barriers toward medical treatment. Accessibility factors play a minor role due to the high number of care-providers in Belgium and the fact that medical care is reimbursed. Second, Belgium has no gatekeeper-system, so people can immediately approach specialist care to cope with mental health problems if they themselves consider it necessary. Third, the deinstitutionalization movement started rather late in Belgium. We explain these arguments into more detail in the following paragraphs.

In Belgium, there is a relatively high supply of (mental) health professionals. There are 177 general practitioners (HOPE, 2013) and approximately 18 psychiatrists per 100,000 inhabitants (WHO, 2005). There are no official numbers of clinical psychologists and psychotherapists available, since their title was not legally acknowledged previously. Moreover, mental health visits to medically trained professionals are relatively affordable thanks to the insurance system based on the solidarity principle (Bruffaerts, Bonnewyn & Demyttenaere, 2007; Hermans et al., 2012; Kovess-Masfety et al., 2007). Furthermore, access to specialized care is unrestricted, since Belgium has no gatekeeper-system which forces people to go to their general practitioner first in order to get a referral to specialist care.

The deinstitutionalization process is still in transition in Belgium. Nevertheless, a range of reforms have occurred over the years to reduce hospital-based care and to establish more community-based care. In the seventies, large outpatient community health centers were established. In Flanders, there are twenty large centers for mental health care and in the Walloon region, there are 61 smaller centers. They are funded by the regional governments. In the nineties, another important reform took place. There was a cutback of psychiatric hospitals. Alternative forms of residential care were
provided by psychiatric nursing homes, sheltered accommodation and home care instead. Psychiatric
nursing homes (42 in total, providing 3,265 beds) take care of stabilized, chronic patients. For people
with mental illness who need daily help in order to live independently, there are psychiatric sheltered
living facilities (88 in total, providing 3,917 beds). Home care can be traced back to the city of Geel,
which was the first city worldwide where people with mental illness were looked after in foster
families 700 years ago (Goldstein & Godemont, 2003). Nowadays, there are still 890 host families,
particularly in the Flemish region. Subsequently, in 1999, the number of psychiatric nursing home
beds and places of sheltered living were increased, and care in psychiatric hospitals was reserved for
intensive and specialized treatment. In addition, a better cooperation between intramural and
extramural services was established.

As of 2010, article 107 of the hospital law allows psychiatric hospitals to close beds (an additional
decline of 11% psychiatric hospital beds is the aim) so that those resources can be used to develop
outpatient outreach multidisciplinary teams. Recently, 19 pilot projects have been approved by the
government, and will be evaluated in 2014. These outreach teams will be able to handle crisis
situations in order to lower the number of collocations and to provide less restrictive alternatives of
care. This is only one aspect of article 107 of the hospital law. In general, its aim is to bring mental
health care as close as possible to the needs and demands of people with mental illness by
guaranteeing continuity of care through the development of care circuits and care networks in well-
deﬁned regions. Next to the provision of homecare services for people with acute and chronic
mental illness, article 107 also includes the promotion and prevention of mental illness and the
social reintegration of former service-users by helping them to find housing, employment and
leisure activities (Hermans et al., 2012; www.psy107.be)

Yet Belgium still has an extensive supply of available psychiatric hospital beds (Bruffaerts, Sabbe, &
Demyttenaere, 2004). Institutional care is still an important aspect of mental health care, as
Belgium has the second highest number of psychiatric hospital beds in the world after Japan. The number of psychiatric hospital beds per 100,000 inhabitants amounts to 161 (WHO, 2011), while the mean number of beds per country remains around 100. The majority of those beds (15,790) are located in one of the 68 psychiatric hospitals and a minority (3,975 beds) are situated in psychiatric wards of general hospitals (Hermans et al., 2012). So the on-going deinstitutionalization movement in Belgium is far from completed. Article 107 is a step in the right direction, but remains a pilot project, highly dependent on initiatives taken by psychiatric hospitals and merely covering about two thirds of the Belgian territory nowadays.
9 Methodology
9.1 Stigma in a Global Context – Mental Health Study

The international project ‘Stigma in a Global Context – Mental Health Study’ has been initiated by Bernice Pescosolido of Indiana University, in collaboration with J. Martin, J. Long and T. Smith. The general aim of this survey was to test a multilevel theoretical explanatory model of discrimination and exclusion of people with mental illness, using an international comparative approach. In total, nineteen countries are involved in this project: USA, New-Zealand, Argentina, Brazil, Bangladesh, South-Korea, the Philippines, Japan, China, Nepal, South-Africa, Iceland, Germany, United Kingdom, Spain, Cyprus, Hungary, Bulgaria and Belgium. In each country, between 1000 and 1500 respondents of the non-institutionalized adult population are questioned by means of face-to-face interviews. A lot of attention has been paid to the cross-cultural comparability of the survey (Pescosolido et al., 2013).

The Belgian part of the survey ‘Stigma in a Global Context - Belgian Mental Health Study’ has been established thanks to a grant from the Research Foundation (FWO) Flanders and a grant from the Special Research Fund of Ghent University (BOF). In the Belgian survey, the original questionnaire of 35 minutes was expanded to an interview of 60 minutes. In addition, a drop-off questionnaire of 10 pages was given to the respondents to be filled in and to be returned later.

9.2 Fieldwork of the Belgian survey
The sampling frame was a multi-stage probability sample, which was based on data from the Belgian population census. To obtain those data, permission was obtained from the Privacy Commission. For the sampling frame, firstly, the municipalities were weighted according to their number of inhabitants. Subsequently, 140 municipalities were selected randomly (with the possibility of being selected more than once). Finally, from each selected municipality, 15 inhabitants were selected randomly (18+). This resulted in a total sampling frame of 2100 potential respondents (without the possibility of providing substituting addresses).

I was responsible for the coordination of the fieldwork. The company ‘GFK Significant’ from Heverlee was chosen to undertake the fieldwork. The preparations of the fieldwork involved a pilot study with 20 respondents from different gender, age and education levels. In addition, a training session for the 108 interviewers took place. When presenting the study, I emphasized that they could not mention that the survey involved the theme of mental illness or mental health care utilization or stigmatization. Instead, the survey had to be presented as studying health and medical care in general.

The fieldwork started on the 5th of October 2009 and ended on the 18th of January 2010. The response was maximized through a minimum of 5 contact moments, of which at least one contact took place after 6 p.m. during the week and at least one contact took place during the weekend. Moreover, all contact moments had to be spread over 2 weeks. In addition, a reconversion-procedure took place during the last weeks of the fieldwork. This procedure involved revisiting addresses where nobody was found at home and revisiting those who uttered a soft refusal by other interviewers who obtained a high response rate. By means of this procedure, 95 extra interviews were obtained from the 387 addresses which were set aside in reconversion. A response rate of 25% in a reconversion procedure is relatively high. To maximize the response rate of the drop-off questionnaire, several reminders took place. Some respondents were reminded of returning the drop-off questionnaire
when they received a phone call with regard to the fraud control. The other respondents who did not receive a phone call regarding the fraud control, received a phone call 15 days after the date on which the interview took place. When they could not be reached by phone, a new drop-off questionnaire was sent as standard procedure.

The quality of the interviews has been controlled by me. When the interviewer completed his/her first three interviews, the interviews were controlled along the lines of duration, answers on open-ended questions, number of refusals to answers and ‘do not know’-answers, and the congruence between years of education and level of education attained. This occurred again after completing a set of 15 addresses. In the end, 23 interviews have been deleted due to lack of quality. In addition, a fraud control took place by again contacting the respondents with a brief questionnaire regarding whether a man or woman came by to do the interview, whether that person used a computer and how long the duration of the interview was among other things. The fraud control which has been executed by ‘GFK Significant’ by means of phone calls (at least one respondent per interviewer and 237 in total) and the fraud control that was carried out by us by means of the answer-cards which were sent together with the thank you letter, revealed no additional unusable interviews.

Response rate

In total, 1166 validated interviews were obtained. To calculate the response rates, we followed the guidelines of the American Association of Public Opinion Research (http://www.aapor.org/Response_Rates_An_Overview1.htm). The cooperation rate, excluding those who were incapable of cooperating due to for instance a language barrier, illness or being on holiday or having moved, amounts to 66.9% and the Response rate, calculating response in a traditional way by dividing the total number of interviews by the total number of available addresses, amounts to
55.5%. With regard to the drop-off questionnaire, it was returned by 841 respondents which is a response rate of 72%. In the table below, we mention the reasons for non-response.

<table>
<thead>
<tr>
<th>Reasons of non-response</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit refusal</td>
<td>469</td>
</tr>
<tr>
<td>Refusal by excuse</td>
<td>78</td>
</tr>
<tr>
<td>Refusal by third person (not the respondent)</td>
<td>31</td>
</tr>
<tr>
<td>No contact (respondent not at home)</td>
<td>12</td>
</tr>
<tr>
<td>Nobody at home</td>
<td>83</td>
</tr>
<tr>
<td>Respondent on holiday or on business trip during the time of the fieldwork</td>
<td>55</td>
</tr>
<tr>
<td>Changed address (respondent has moved and new address is not known)</td>
<td>55</td>
</tr>
<tr>
<td>Unknown address</td>
<td>34</td>
</tr>
<tr>
<td>Respondent has died</td>
<td>2</td>
</tr>
<tr>
<td>Language barrier</td>
<td>23</td>
</tr>
<tr>
<td>Disabled, demented or chronically ill</td>
<td>91</td>
</tr>
</tbody>
</table>

Table 1: Reasons of non-response.

9.3 Study samples

Regarding the study population of the interview, women, older people and higher educated people are slightly overrepresented. Next to this, we have to mention that Flanders (62.71% response rate) is somehow overrepresented, while the Walloon region (47.19% response rate) and particularly Brussels (36% response rate) are underrepresented. Despite the fact that we asked the interviewers to mention that this survey has been organized by Ghent University in collaboration with the university of Liège, we received many explicit refusals from French speaking participants, among
others through the telephone line that was mentioned on the introduction letter. Furthermore, we notice that the amount of inhabitants without the Belgian nationality is 5.6%, but this lower number in comparison to the actual migrant population of 12.6% (Federal Public Service Employment, Labor and Social Dialogue, 2013) is probably due to the language barrier. In addition, the number of unemployed people is slightly underrepresented (5.8% versus 7.9% (Federal Public Service Employment, Labor and Social Dialogue, 2009), while the number of retired people is overrepresented (23.2% versus 17%) (Berghman et al., 2010). In the study population of the drop-off questionnaire, women, older people and higher educated people are again overrepresented. Furthermore, single people, unemployed people and those with a lower household income are underrepresented.

In order to partly address this selective non-response bias and to give appropriate relative importance to the answers of certain subgroups which are over- or underrepresented, we created a weighting factor (Winship, Christopher & Radbill, 1994). By lack of population data regarding the education level of the general population, we used the socio-economic Labor Force Survey from 2009 as the most valid source of information providing information about gender, age and education level of the general Belgian population upon which to base the weighting procedure. This survey includes information about the working, unemployed and non-active population among 90,000 Belgian people. The response of this survey approximates 80% from which merely 3% is caused by explicit refusal to participate. Two different weighting factors were created, one for the interview sample and one for the drop-off sample. The weighted interview sample consists of 1116 cases and the weighted drop-off sample of 750 cases. The number of cases is reduced due to the fact that the maximum weight factor has been restricted to three and due to the fact that some categories were not represented in the study population, so that they could not be overrepresented. As a consequence of the weighting procedure, the number of men and women becomes more balanced, the mean age is slightly reduced and the mean level of education approximates 12 years instead of 12 years and a
half. We were not able to take into account the regional variation, since this would make the weighting procedure too complex.

In the table mentioned below, the descriptives of the study samples are given. In study 1, we only addressed the respondents who received the schizophrenia-vignette (N= 381), since the genetic base of schizophrenia is more pronounced than that of major depression. In study 2, we assessed both vignettes (N=728), as stigma also constitutes a barrier toward less severe mental disorders. Study 3 examined the whole study population (N= 1104), but we distinguished two subsamples. One focused on the respondents with public contact (N= 787) and the other subsample excluded those who did not have interpersonal contact (N= 626), because specific characteristics of public and interpersonal contact are questioned. Study 4 addressed the respondents who filled in the drop-off questionnaire (N=750), since the questions regarding social network resources were only included in the drop-off. Finally, study 5 studied both mental disorder vignettes (N= 743).
Table 2: Study samples.

9.4 Core Variables

In this section, we add some information about the core variables of this dissertation. The descriptives mentioned below are based on the weighted study samples. We start with the determinants of help-seeking attitudes that are addressed in this dissertation, namely the conceptualization of mental illness, the composition of the social network, the stigma dimensions of public stigma and self-stigma, gendered interactions and contact conditions.
**Conceptualization of mental illness**

Labeling is measured in two ways. Next to asking for prompted identification, we also questioned labeling in a more spontaneous way. First, a question was asked which indicated prompted identification: “How likely is it that the vignette person is experiencing a mental illness?”. This is the most common method to question labeling issues (Link et al., 1999; Martin, Pescosolido & Tuch, 2000; Perry et al., 2007; Pescosolido et al., 2010; Phillips, 1967). This item was originally scored on a 4-point Likert scale, but we dichotomized the scores so that the score of 1 referred to defining the situation as a mental illness.

Second, respondents were asked what they would say was wrong with the vignette person. They could choose from the following categories: depression, schizophrenia, asthma, or stress, or they could suggest another option. The responses of the latter open-ended answering option were subject to content analysis. Subsequently, all labels involving the adequate recognition of schizophrenia were pooled, following Angermeyer and Matschinger (2003, 2005). This resulted into three categories: (1) applying a medical label (in this case those who accurately apply the schizophrenia-label), (2) applying a non-medical label (referring to stress, psychological problem, traumatic event, etc.), and (3) giving an inaccurate diagnosis (for example labeling schizophrenia as depression) (54.6%).

As concerns etiology, our intention was to draw attention to the relative importance of two types of causal attributions, namely biogenetic and psychosocial factors. As it was not literally asked in the questionnaire to mention the cause with the greatest significance and the second most significant one (see Schomerus, Matschinger and Angermeyer, 2006), we developed the following measure in order to give an indication about the ranking of the two factors under study. We make the distinction between adhering to both psychosocial and biogenetic factors (biopsychosocial model), or adhering
to one of both (bio-bio-bio model or psychosocial model). This is a step forward, compared to the studies that merely examine the impact of psychosocial and biogenetic factors next to each other.

Causal attributions refer to three categories which are based on the following questions. Respondents were asked to rate the likeliness of the situation being caused by on the one hand biogenetic factors, namely (a) a brain disorder and/or (b) genes and psychosocial factors, respectively (c) social problems and/or (d) economic problems on the other. We dichotomized the original scores (‘very or somewhat likely (1)’ versus ‘not very or not at all likely (0)’ and created three categories ourselves to take into account the relative importance of both biogenetic and psychosocial factors. This resulted in the following three categories: (1) adhering to the biopsychosocial model (believing that both biogenetic and psychosocial causes are involved), (2) adhering to the psychosocial model (merely attributing the situation to a psychosocial cause) and (3) adhering to the bio-bio-bio model (only attributing the situation to a biogenetic cause). The respondents who believed in neither biogenetic nor psychosocial factors were deleted from the sample, as only 2 respondents (0.4%) belonged to this category.

**Composition of the social network**

Since health lifestyles are class dependent, we use a class-based indicator to sketch the composition of the social network. This measure is based on the position generator, which questions whether the respondent knows people in his or her social network who practice certain professions (Lin, 2001; Lin, Fu & Hsung, 2001; Van der Gaag, 2005). Respondents were presented with a list of 15 professions, which are all salient in Belgium, ranging from cleaning worker to physician. The response categories are ‘a family member has this occupation’, ‘a friend has this occupation’, and ‘an acquaintance has this occupation’. A definition of an acquaintance was added for conceptual clarity. An acquaintance refers to someone whose prename you know and with whom you make a short conversation when
meeting him/her. There was also an answering category reflecting ‘I do not know anyone who has this occupation’ to be able to distinguish people their lack of network resources from missing answers.

In this particular study, both strong and weak ties are taken into account. Strong ties are an important source of social support, but weak ties are also important in the sense that they provide more diffuse health information, reaching people from more diverse social positions (Granovetter, 1973).

Subsequently, the occupations are divided into different social classes, following Goldthorpe’s (1987) class scheme. We distinguish the manual working class (cleaning worker, assembly line worker, truck driver, policeman/woman, electrician), the middle class (clerical worker, owner of a small factory/firm, nurse, journalist, teacher) and the upper-middle class (division head and manager of a large factory/firm, owner of a large factory/firm, lawyer, physician) (see Verhaeghe et al., 2012 for more information). The number of occupations from whom you know somebody are added up, with five as the maximum (manual working class: Mean (SD): 2.82 (1.54); middle class: 3.19 (1.34); upper-middle class: 2.47 (1.64).

Public stigma and self-stigma

We pay attention to two stigma dimensions that are attached to being in treatment, namely public stigma and self-stigma. Public perceived stigma or Link’s perceived devaluation and discrimination scale refers to people’s perception of to which extent most other people stigmatize someone who has been in psychiatric treatment (Link et al., 1987). The advantage of this approach is that social desirability issues are reduced (Link et al., 1989). In this dissertation, we changed the formulation of the statements slightly to make reference to people who have been treated for mental illness in general, instead of someone who has been in a mental hospital (Link et al., 2002). The response
categories are situated on a 4-point Likert scale and range from fully disagree (1) to fully agree (4), instead of the original 6-point Likert scale.

<table>
<thead>
<tr>
<th>How do most people think about people who have been treated for mental illness according to you?</th>
<th>Totally disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Totally agree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people would willingly accept a former mental patient as a close friend (reverse scored)</td>
<td>2.9</td>
<td>37</td>
<td>49.1</td>
<td>11</td>
<td>2.68</td>
<td>0.70</td>
</tr>
<tr>
<td>Most people believe that a former mental patient is just as intelligent as the average person (reverse scored)</td>
<td>5.7</td>
<td>46.4</td>
<td>41.9</td>
<td>6.0</td>
<td>2.48</td>
<td>0.70</td>
</tr>
<tr>
<td>Most people believe that a former mental patient is just as trustworthy as the average citizen (reverse scored)</td>
<td>3.6</td>
<td>32.7</td>
<td>55.1</td>
<td>8.7</td>
<td>2.69</td>
<td>0.68</td>
</tr>
<tr>
<td>Most people would accept a fully recovered former mental patient as a teacher of young children in a public school (reverse scored)</td>
<td>5.9</td>
<td>44.1</td>
<td>39.1</td>
<td>10.9</td>
<td>2.55</td>
<td>0.76</td>
</tr>
<tr>
<td>Most people feel that seeking treatment is a sign of personal failure</td>
<td>7.6</td>
<td>43.9</td>
<td>40.3</td>
<td>8.2</td>
<td>2.49</td>
<td>0.75</td>
</tr>
<tr>
<td>Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time</td>
<td>4.8</td>
<td>19.9</td>
<td>56.9</td>
<td>18.4</td>
<td>2.89</td>
<td>0.75</td>
</tr>
<tr>
<td>Most people think less of a former mental patient</td>
<td>2.5</td>
<td>31</td>
<td>52.9</td>
<td>13.6</td>
<td>2.78</td>
<td>0.70</td>
</tr>
<tr>
<td>Most employers will hire a former mental patient if he or she is qualified for the job (reverse scored)</td>
<td>5</td>
<td>47.3</td>
<td>39</td>
<td>8.7</td>
<td>2.51</td>
<td>0.72</td>
</tr>
<tr>
<td>Most employers will pass over the application of a former mental patient in favor of another applicant</td>
<td>1.4</td>
<td>15</td>
<td>62.1</td>
<td>21.5</td>
<td>3.04</td>
<td>0.65</td>
</tr>
<tr>
<td>Most people in my community would treat a former mental patient just as they would treat anyone (reverse scored)</td>
<td>6.1</td>
<td>56.4</td>
<td>34.7</td>
<td>2.7</td>
<td>2.34</td>
<td>0.63</td>
</tr>
<tr>
<td>Most young women would be reluctant to date a man who is a former mental patient</td>
<td>2.2</td>
<td>16.4</td>
<td>66.6</td>
<td>14.8</td>
<td>2.94</td>
<td>0.63</td>
</tr>
<tr>
<td>Most people will take the opinions of a former mental patient less seriously</td>
<td>0.9</td>
<td>22.1</td>
<td>69</td>
<td>8.1</td>
<td>2.84</td>
<td>0.59</td>
</tr>
<tr>
<td>Full scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.68</td>
<td>0.40</td>
</tr>
</tbody>
</table>

Table 3: Descriptives public perceived stigma.
Anticipated self-stigma refers to negative reactions toward oneself if one would be in psychiatric treatment. It is also referred to as the internalization of stigmatizing beliefs. The scale is developed by Verhaeghe (2008), based on the Social Isolation subscale and the Internalized Shame subscale of Fife and Wright (2000). The original scores on the 5 point Likert scale were reversed so that higher scores would represent higher levels of anticipated self-stigma.

<table>
<thead>
<tr>
<th></th>
<th>Totally disagree</th>
<th>Rather disagree</th>
<th>Undecided</th>
<th>Rather agree</th>
<th>Totally agree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would feel ashamed when I would be in psychiatric treatment</td>
<td>33.2</td>
<td>28.0</td>
<td>14.1</td>
<td>18.5</td>
<td>6.1</td>
<td>2.36</td>
<td>1.28</td>
</tr>
<tr>
<td>I would feel inferior when I would be in psychiatric treatment</td>
<td>26.6</td>
<td>24.7</td>
<td>12.6</td>
<td>28.0</td>
<td>8.0</td>
<td>2.66</td>
<td>1.34</td>
</tr>
<tr>
<td>Psychiatric treatment would make me feel incapable</td>
<td>26.0</td>
<td>32.4</td>
<td>13.5</td>
<td>21.5</td>
<td>6.5</td>
<td>2.50</td>
<td>1.26</td>
</tr>
<tr>
<td>Psychiatric treatment would make me doubt myself</td>
<td>17.5</td>
<td>24.9</td>
<td>14.3</td>
<td>32.6</td>
<td>10.7</td>
<td>2.94</td>
<td>1.30</td>
</tr>
<tr>
<td>Psychiatric treatment would make me feel useless</td>
<td>23.5</td>
<td>30.6</td>
<td>13.3</td>
<td>25.1</td>
<td>7.5</td>
<td>2.63</td>
<td>1.29</td>
</tr>
<tr>
<td>Full scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.62</td>
<td>1.09</td>
<td></td>
</tr>
</tbody>
</table>

Table 4: Descriptives self-stigma.

Gendered interactions

The gender of the respondent and the vignette person are considered in interaction, since we made the distinction between a male respondent who judges a male vignette, a female respondent who judges a female vignette (same gender) and a male respondent who judges a female vignette and a female respondent who judges a male vignette (cross-gender).
Contact

Contact refers to contact with people who have been treated for mental illness. Instead using crude measures of contact, we refined the conceptualization of contact by drawing attention to the level of intimacy of the contact relationship and to some other characteristics of the contact relationship.

To assess the level of intimacy, the respondents were asked a range of questions. Have you personally ever received treatment for a mental health problem? Has a relative of yours ever received treatment for a mental health problem? Has anyone within your circle of friends and acquaintances ever received treatment for a mental health problem? Have you ever seen someone who seems to have a serious mental health problem in a public space? If the respondent did not answer any of the aforementioned questions in the affirmative, he or she was assigned to the category ‘no contact at all’. If several categories applied to the respondent, the one representing the highest degree of intimacy was chosen. In sum, we established five hierarchical categories: (1) personal experience; (2) having a family member who has been undergoing psychiatric treatment; (3) knowing someone within their circle of friends and acquaintances who has been undergoing psychiatric treatment; (4) public contact; (5) no contact at all.

To address some characteristics of the contact relationship, the following questions were asked. If the respondents mentioned that they had met someone in public who seemed to have a mental illness, they were asked about the frequency of that public contact and about the emotional reactions that arose due to that public contact. The frequency of the public contact that had occurred ranged from ‘rarely’(1) and ‘occasionally’(2) through ‘frequently’(3). The questions related to emotional reactions included ‘How frightening do you find people that you see in public places that seem to have a serious mental health problem?’ and ‘How much sympathy do you feel for people that you see in public spaces that seem to have a serious mental health problem?’ The response categories were
situated on a 4-point Likert scale ranging from 1 (not at all frightening/no sympathy at all) to 4 (very frightening/a great deal of sympathy).

Furthermore, the respondents who mentioned that they had known someone (family member, friend or acquaintance) who received treatment for a mental health problem were asked what the closeness of the relationship was, whether the received treatment was perceived as effective and how much distress this person’s mental health problem caused them. The closeness of the relationship ranged from 1 (not at all close) to 4 (extremely close). The answering categories related to the perceived effectiveness of the treatment were dichotomized and the answering categories of the level of distress were the following: ‘not at all’(1), ‘a little’(2), ‘quite a bit’(3), and ‘a great deal’(4).

<table>
<thead>
<tr>
<th>Level of intimacy of the contact relationship</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personally received treatment</td>
<td>15.2%</td>
</tr>
<tr>
<td>Family member received treatment</td>
<td>26.4%</td>
</tr>
<tr>
<td>Friend received treatment</td>
<td>19.7%</td>
</tr>
<tr>
<td>Public contact</td>
<td>22.8%</td>
</tr>
<tr>
<td>No contact at all</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristic of the contact relationship</th>
<th>Mean±SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of public contact</td>
<td>1.63±0.72</td>
</tr>
<tr>
<td>Feelings of fear arising from public contact</td>
<td>1.96±0.73</td>
</tr>
<tr>
<td>Feelings of pity arising from public contact</td>
<td>2.97±0.71</td>
</tr>
<tr>
<td>Closeness of the relationship</td>
<td>2.79±0.93</td>
</tr>
<tr>
<td>Level of distress caused by the relationship</td>
<td>2.68±0.98</td>
</tr>
<tr>
<td>Perceived effectiveness of the treatment of the contact relationship</td>
<td>0.56±0.50</td>
</tr>
</tbody>
</table>

Table 5: Descriptives contact conditions
Following the operationalization of the different determinants of help-seeking, we go further by providing more details about the different help-seeking attitudes that are used in this dissertation. On the one hand, we operationalized help-seeking by means of spontaneous help-seeking recommendations, the rating of importance of a range of care-providers and the rating of helpfulness of treatment options. On the other, we examined the (negative) attitudes of the public toward professional treatment by studying treatment stigma, the stigma dimensions of blame and shame, the perceptions about the mental health care sector and finally the attitudes toward community mental health care initiatives.

*Spontaneous help-seeking recommendations*

The contribution of operationalizing help-seeking attitudes by means of spontaneous treatment recommendations is that we study people’s cultural toolbox. These help-seeking attitudes reflect the ideas that people have at their disposal regarding suggestions for potential healing strategies (Dimaggio and Swindler 2001; Pescosolido, 1992). The spontaneous treatment suggestions were asked at the very beginning of the interview after that the vignette scenario has been read (more specific as the third question in the survey). So they require an active approach of the respondent since no clues were offered.

Help-seeking suggestions were assessed by means of the following open-ended question: “What should the vignette person do if he or she needs to do something?”. Respondents were allowed to offer three suggestions at the most. The responses were assigned to a range of predefined categories by the interviewers and if the responses did not correspond with one of the predefined categories, they were coded as verbatim. Those verbatim responses were recoded independently by two raters through a content analysis procedure and were reconsidered if the raters disagreed. For this
particular study, six (dichotomous) help-seeking options were considered: (1) general practitioner, (2) psychiatrist, (3) psychologist, (4) family, (5) friends, and (6) self-care.

<table>
<thead>
<tr>
<th></th>
<th>Depression</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>69.2%</td>
<td>52.0%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>21.8%</td>
<td>43.8%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>14.8%</td>
<td>21.3%</td>
</tr>
<tr>
<td>Family</td>
<td>30.8%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Friends</td>
<td>23.9%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Self-care</td>
<td>21.7%</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

Table 6: Descriptives spontaneous treatment suggestions.

If we compare prompted endorsements with spontaneous suggestions, we notice that the latter are better aligned with actual utilization rates than the former (Pescosolido & Olafsdottir, 2010). This is illustrated in the table below. Prompted endorsements are more susceptible for issues of social desirability. The acceptance of a prompted option simply takes less effort than its rejection (Gilbert, 1991). Furthermore, the medical framework might be triggered by previous items in the questionnaire referring to for example labeling and etiology. As individuals do ‘learn’ during the process of an interview, they may alter their responses accordingly, resulting in unrealistically high endorsements of medical care (Regier et al., 1998). Endorsements are perceived to rather reflect the dominant cultural values regarding the perceived efficacy of modern medicine, rather than referring to the willingness to actually do something about the situation.
Spontaneous treatment suggestions
Prompted endorsements
Actual life-time help-seeking rates in the SGC-BMHS survey
Actual help-seeking rates Belgium in ESEMED-study

<table>
<thead>
<tr>
<th>Provider</th>
<th>Spontaneous treatment suggestions</th>
<th>Prompted endorsements</th>
<th>Actual life-time help-seeking rates in SGC-BMHS survey</th>
<th>Actual help-seeking rates Belgium in ESEMED-study</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>60.2%</td>
<td>93.8%</td>
<td>66.6%</td>
<td>60%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>33.3%</td>
<td>75.5%</td>
<td>38.6%</td>
<td>36%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>18.2%</td>
<td>77.9%</td>
<td>46.4%</td>
<td>19%</td>
</tr>
</tbody>
</table>

*: source: Bruffaerts et al., 2004

Table 7: Comparison help-seeking rates.

Rating of importance of care-providers

The rating of importance of a range of care-providers is a continuous measure. The advantage of this measure is that it is not merely the question whether people do or do not endorse a certain care-provider (yes or no). Instead, respondents were asked to rate the importance on a scale from 1 to 10, with the latter reflecting ‘very important’. This measure offers more nuanced information than simply endorsing or rejecting a specific care-provider.

This measure is used to be able to compare people’s help-seeking attitudes toward a range of formal and informal care-providers. The care-providers assessed are a general practitioner, psychiatrist, psychologist, family, and friends. In the table below, the original scores are presented. In the analytical model in study 2, a logarithmical transformation of these variables was used in order to
approach the normal distribution and to render the estimations of the ordinary least squares regression analyses more accurate (Moore & McCabe, 1999).

<table>
<thead>
<tr>
<th></th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td>General practitioner</td>
<td>8.85 (1.39)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7.95 (2.23)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>7.98 (2.10)</td>
</tr>
<tr>
<td>Family</td>
<td>8.09 (2.03)</td>
</tr>
<tr>
<td>Friends</td>
<td>7.74 (1.99)</td>
</tr>
</tbody>
</table>

Table 8: Descriptives rating of importance of care-providers.

**Rating of helpfulness of treatment options**

Rating of helpfulness of treatment options is a continuous measure. Respondents were asked whether they thought that certain treatment options were helpful. The answering categories were situated on a 7 point Likert scale, ranging from very harmful (1) to very helpful (2). Again, this measurement brings more nuance to the picture than merely endorsing or rejecting a certain treatment option. In study 3, we compared the help-seeking attitudes toward the use of psychotherapy and the use of tranquilizers.

<table>
<thead>
<tr>
<th></th>
<th>Very harmful</th>
<th>Harmful</th>
<th>Rather harmful</th>
<th>Neither harmful, neither helpful</th>
<th>Rather helpful</th>
<th>Helpful</th>
<th>Very helpful</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychotherapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>0</td>
<td>0.4</td>
<td>0</td>
<td>9.0</td>
<td>24.1</td>
<td>40.5</td>
<td>25.9</td>
<td>5.82</td>
<td>0.95</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>0</td>
<td>1.5</td>
<td>0.7</td>
<td>6.0</td>
<td>22.7</td>
<td>36.5</td>
<td>32.6</td>
<td>5.90</td>
<td>1.04</td>
</tr>
<tr>
<td><strong>Tranquilizers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>2.9</td>
<td>10.0</td>
<td>11.3</td>
<td>11.1</td>
<td>33.7</td>
<td>25.1</td>
<td>5.9</td>
<td>4.62</td>
<td>1.51</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1.6</td>
<td>4.4</td>
<td>16.7</td>
<td>12.9</td>
<td>32.8</td>
<td>23.7</td>
<td>7.8</td>
<td>4.73</td>
<td>1.39</td>
</tr>
</tbody>
</table>

Table 9: Descriptives rating of helpfulness of treatment options.
**Treatment stigma**

Treatment stigma reflects the idea that people who have been in psychiatric treatment might experience social exclusion in a range of situations. The three items are illustrated in the table below. Each item was scored on a 4-point Likert scale with a higher score expressing more treatment stigma.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Totally disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Totally agree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) After receiving treatment, the vignette person will be considered an outsider in his or her community</td>
<td>19.8</td>
<td>44.1</td>
<td>29</td>
<td>7.1</td>
<td>2.23</td>
<td>0.85</td>
</tr>
<tr>
<td>(b) If the vignette person mentions that he or she has been in treatment, that person will lose some of their friends</td>
<td>9.1</td>
<td>39</td>
<td>44.3</td>
<td>7.7</td>
<td>2.51</td>
<td>0.77</td>
</tr>
<tr>
<td>(c) Whatever the vignette person accomplishes in the future, his or her chances will always be limited when people discover that he or she has been in treatment</td>
<td>11.6</td>
<td>40.2</td>
<td>38.3</td>
<td>9.9</td>
<td>2.46</td>
<td>0.83</td>
</tr>
<tr>
<td>Full scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.40</td>
<td>0.60</td>
</tr>
</tbody>
</table>

**Table 10: Descriptives treatment stigma.**

**Negative perceptions about the professional mental health care sector**

The perceptions about the mental health care sector are measured in two ways. Next to a five-item scale, we also examined these lay beliefs by means of an open-ended question. The 5-item scale is developed by Verhaeghe (2010), reflecting people’s attitudes toward the institutional mental health care sector. Each item is scored on a 5-point Likert scale and one item has been reversed. Subsequently, the mean score for all items is calculated and higher scores reflect stronger negative attitudes toward institutional mental health care. The reliability of this scale is high (Cronbach’s Alpha
= 0.861). Principal component analysis reveals only one factor with an eigenvalue of 3.236, which explains 64.7% of the variance. All items load highly on that factor, respectively (a) 0.862, (b) 0.864, (c) 0.716, (d) 0.759, and (e) 0.810. Furthermore, we also controlled whether the mean score of the scale in the subsample, referring to those respondents who filled in the drop-off questionnaire, differed significantly from the mean score of the scale in the full sample (referring to all respondents who were interviewed).

<table>
<thead>
<tr>
<th></th>
<th>Fully disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Fully agree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional mental health care makes mental health problems worse</td>
<td>12.0</td>
<td>44.0</td>
<td>25.0</td>
<td>13.5</td>
<td>5.5</td>
<td>2.56</td>
<td>1.04</td>
</tr>
<tr>
<td>Institutional mental health care does more harm than good</td>
<td>11.4</td>
<td>49.5</td>
<td>21.1</td>
<td>12.7</td>
<td>5.4</td>
<td>2.51</td>
<td>1.03</td>
</tr>
<tr>
<td>Institutional mental health care currently achieves good results (reversely scored)</td>
<td>8.1</td>
<td>52.6</td>
<td>31.1</td>
<td>7.0</td>
<td>1.2</td>
<td>2.40</td>
<td>0.78</td>
</tr>
<tr>
<td>Once you are institutionalized in a psychiatric hospital, it is difficult to find a way out</td>
<td>8.7</td>
<td>40.5</td>
<td>21.5</td>
<td>23.5</td>
<td>5.8</td>
<td>2.77</td>
<td>1.08</td>
</tr>
<tr>
<td>Once you suffer from mental health complaints, it is better to stay away from psychiatric hospitals</td>
<td>15.6</td>
<td>50.2</td>
<td>17.0</td>
<td>12.5</td>
<td>4.6</td>
<td>2.40</td>
<td>1.04</td>
</tr>
<tr>
<td>Full scale</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.53</td>
<td>0.80</td>
</tr>
</tbody>
</table>

Table 11: Descriptives negative perceptions about the (institutional) mental health care
The open-ended question was the following: ‘What do you think about the mental health care provided in psychiatric hospitals?’ By means of content analysis, we distinguished 200 responses (26.6%) referring to negative attitudes toward the mental health care sector, and accordingly a dichotomous variable was created. Examples of negative perceptions were ‘they knock patients out with sedatives’, ‘I think of straightjackets and padded cells’, ‘it is like being in prison’, ‘crazy people all together’, ‘it is harmful that people are surrounded by people with other mental disorders, often more serious cases’, ‘inhumane treatment’, ‘there are too few health care providers and they do not have enough time to carefully treat the patients’, ‘they leave patients to their own devices’, ‘taboo’, and ‘should only be considered as last resort’.

*Stigma dimensions blame and shame*

The stigma dimension ‘blame’ refers to attributing the situation to a weak character or lack of willpower. The original 4 point Likert scale has been dichotomized and 38.8% of the respondents did utter that they thought that the illness situation of the vignette person was his/her own fault.

The stigma dimension ‘shame’ refers to the opinion that the vignette person should be embarrassed about his/her situation. The original 4 point Likert scale is dichotomized and more than half of the respondents (58.1%) expressed that they agreed with this statement.
Attitudes toward community care

The Community Mental Health Ideology (CMHI)-scale (Sévigny et al., 1999) is a subscale of the CAMI-scale (Community Attitudes toward the Mentally ill) (Taylor & Dear, 1981). The CAMI-scale is based on the OMI scale (Opinions About Mental Illness) of Cohen and Struening (1962), but the number of items has been reduced and the scale has been adjusted to target the general population instead of professional care providers. The CMHI-subscale questions the acceptance of community mental health facilities and contrasts the therapeutic value of community care with the potential risks to local residents. For each of the 10 items, the respondents were asked to indicate the extent to which they agreed with the statement on a 5-point Likert scale. Some items have been reversed so that a higher mean score is indicative of a more positive attitude toward community mental health care. In our sample, the internal consistency was very good (Cronbach’s Alpha = 0.86) and the principal components analysis revealed only one component (eigenvalue = 4.545, which explained 45.45% of the variance).
<table>
<thead>
<tr>
<th>Statement</th>
<th>Fully agree</th>
<th>Agree</th>
<th>Neither agree, nor disagree</th>
<th>Disagree</th>
<th>Fully disagree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community</td>
<td>2.2</td>
<td>8.9</td>
<td>11.9</td>
<td>55.1</td>
<td>21.8</td>
<td>3.85</td>
<td>0.93</td>
</tr>
<tr>
<td>The best therapy for many mental patients is to be part of a normal community</td>
<td>0.5</td>
<td>6.7</td>
<td>12.4</td>
<td>56</td>
<td>22.4</td>
<td>3.95</td>
<td>0.81</td>
</tr>
<tr>
<td>As far as possible, mental health services should be provided through community based facilities</td>
<td>0.7</td>
<td>7.5</td>
<td>14.8</td>
<td>63.8</td>
<td>13.2</td>
<td>3.81</td>
<td>0.78</td>
</tr>
<tr>
<td>Locating mental health services in residential neighborhoods does not endanger local residents</td>
<td>2.0</td>
<td>14.2</td>
<td>18.4</td>
<td>52.3</td>
<td>13.1</td>
<td>3.60</td>
<td>0.95</td>
</tr>
<tr>
<td>Residents have nothing to fear from people coming into their neighborhood to obtain mental health services</td>
<td>1.3</td>
<td>9.6</td>
<td>18.2</td>
<td>56</td>
<td>14.9</td>
<td>3.74</td>
<td>0.87</td>
</tr>
<tr>
<td>Mental health facilities should be kept out of residential neighborhoods (reversely scored)</td>
<td>2.5</td>
<td>13.5</td>
<td>18.9</td>
<td>55.3</td>
<td>9.8</td>
<td>3.56</td>
<td>0.93</td>
</tr>
<tr>
<td>Local residents have good reason to resist the location of mental health services in their neighborhood (reversely scored)</td>
<td>2.6</td>
<td>16.3</td>
<td>21.3</td>
<td>49.5</td>
<td>10.3</td>
<td>3.49</td>
<td>0.97</td>
</tr>
<tr>
<td>Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great (reversely scored)</td>
<td>3.4</td>
<td>22.4</td>
<td>30.5</td>
<td>39.2</td>
<td>4.4</td>
<td>3.19</td>
<td>0.95</td>
</tr>
<tr>
<td>It is frightening to think of people with mental problems living in residential neighborhoods (reversely scored)</td>
<td>2.2</td>
<td>16.1</td>
<td>18.1</td>
<td>54</td>
<td>9.5</td>
<td>3.53</td>
<td>0.95</td>
</tr>
<tr>
<td>Locating mental health facilities in a residential area downgrades the neighborhood (reversely scored)</td>
<td>3.4</td>
<td>19.8</td>
<td>17.5</td>
<td>50</td>
<td>9.2</td>
<td>3.42</td>
<td>1.02</td>
</tr>
</tbody>
</table>

**Table 12: Descriptives of the attitudes toward community care**
Part II.

EMPIRICAL STUDIES
Medicalizing versus psychologizing mental illness: What are the implications for help seeking and stigma. A general population study.


1.1 Abstract

Objective: This study contrasts the medicalized conceptualization of mental illness with psychologizing mental illness and examines what the consequences are of adhering to one model versus the other for help seeking and stigma.

Methods: The survey “Stigma in a Global Context–Belgian Mental Health Study” (2009) conducted face-to-face interviews among a representative sample of the general Belgian population using the vignette technique to depict schizophrenia (N=381). Causal attributions, labeling processes, and the disease view are addressed. Help seeking refers to open-ended help-seeking suggestions (general practitioner, psychiatrist, psychologist, family, friends, and self-care options). Stigma refers to social exclusion after treatment. The data are analyzed by means of logistic and linear regression models in SPSS Statistics 19.

Results: People who adhere to the biopsychosocial (versus psychosocial) model are more likely to recommend general medical care and people who apply the disease view are more likely to recommend specialized medical care. Regarding informal help, those who prefer the biopsychosocial model are less likely to recommend consulting friends than those who adhere to the psychosocial model. Respondents who apply a medical compared to a non-medical label are less inclined to recommend self-care. As concerns treatment stigma, respondents who apply a medical instead of a non-medical label are more likely to socially exclude someone who has been in psychiatric treatment.
Conclusions: Medicalizing mental illness involves a package deal: biopsychosocial causal attributions and applying the disease view facilitate medical treatment recommendations, while labeling seems to trigger stigmatizing attitudes.

1.2 Introduction

The mental illness is an illness like any other position is promoted by medical professionals in an attempt to ameliorate the mental health literacy of the lay public [1]. They emphasize that mental illness is equivalent to any physical disease, as it has a known biogenetic cause (which needs to be triggered by a social stressor) and as there are effective ways to treat it. In other words, emotions that were once perceived as ‘badness’ have been reconceptualized as ‘sickness’ or the moral has turned into the medical [2].

The aim of this medicalization movement was to create an optimistic therapeutic ideology and to remove the blame attached to mental illness by reducing perceptions of personal responsibility [3]. Empirical studies showed that on the one hand, people have become more positive toward psychiatric treatment over the years [4]. Yet on the other hand, stigmatizing attitudes have not diminished over the years; they remained stable or even increased [5-6]. So medicalizing mental illness seems to facilitate formal care seeking [7]. Biogenetic attributions might trigger benevolent attitudes according to the attribution theory [8] and a medical label may activate a schema of how to cope with the illness [9]. However, the disadvantage of medicalizing mental illness is that it seems to be associated with a greater amount of stigmatizing attitudes [5, 10-11]. A biogenetic cause implies perceptions of stability and uncontrollability [12] and a medical label emphasizes the separation between “them” and “us” [13], resulting in harsher reactions [14].
Yet this medicalized conceptualization of mental illness is not adopted by all of the lay public. Many of them rather psychologize mental illness [15], viewing mental illness as a life crisis, caused by environmental stressors [10]. The advantage of this point of view is that the psychosocial model seems to be linked with less stigmatizing attitudes [16-18]; when the illness is attributed to environmental stressors, the ill are considered not responsible and are relieved of blame. The disadvantage is that it seems to incite informal help-seeking [19] or self-care [20], which is not always appropriate in cases of severe mental disorders. Because reliance on nonprofessional sources of care may delay or even may substitute formal care seeking.

When studying help seeking, three things should be considered. First, it is crucial to capture people's "cultural toolbox" for action by questioning unprompted suggestions rather than prompted endorsements [21]. Since prompted endorsements are known to trigger the medical framework, they result in high rates of endorsement [22]. Second, it is important to consider help seeking as a process involving different steps, conceptualized by the term "pathway to care", rather than as a single event. Third, as nonprofessional help often precedes formal care seeking, consideration of informal help should not be neglected. Jorm et al.'s model of "overlapping waves of action" [23] illustrates that people have often already pursued self-care options or sought support among family and friends before they took the step of consulting formal care.

When studying stigma, different dimensions of stigma may be considered. We specifically focus on treatment stigma, as this stigma dimension catches the core meaning of the modified labeling theory [24]. Central to this modified labeling theory is the proposition that stigmatizing attitudes toward people with mental illness are not directly linked to the person's actual aberrant behavior. Yet stigma is attached to the label, which is triggered once people enter psychiatric treatment. In other words, former service users are still at risk of being stigmatized, even in the absence of aberrant behavior, due to the label that is attached to them.
When addressing help seeking and stigma, some potential confounders should be controlled for. First, women are more likely to recommend formal care and to endorse psychosocial conceptualizations of mental illness. The findings of previous studies regarding whether there are gender differences in stigmatizing attitudes are rather inconsistent [25]. Regarding age, older people are more inclined to consult general care [26] and also seem to report more stigmatizing attitudes [27]. Furthermore, people who have obtained a higher level of education are more likely to contact mental health specialists [28] and are less likely to stigmatize people with mental illness [29]. Next to these socio-demographic characteristics, it is important to consider whether the respondents report mental health complaints themselves and whether they are familiar with mental health services, as this might influence treatment recommendations [30] and stigmatizing attitudes [31] too.

In sum, the aim of this paper is to study what the implications are of medicalizing or psychologizing mental illness. In contrast to previous studies, we will not study their effects side by side, but we will contrast them. We hypothesize that the relative importance of adhering to one or the other model will reveal clearer associations with both help seeking and stigma.

### 1.3 Methods

#### 1.3.1 Sample and data

This study is based on data from the survey “Stigma in a Global Context—Belgian Mental Health Study” (2009), which examined the attitudes of the lay public toward mental health care services and people with mental illness. The fully structured, face-to-face computer-assisted personal interviews were implemented among a representative sample of the noninstitutionalized adult Belgian population. Part of the interview consisted of questions referring to a hypothetical
vignette person. The vignette specifically selected for this study was taken from the 1996 U.S. General Social Survey [32], and was rewritten during a meeting in Madrid of all of the country teams’ representatives and a cross-cultural psychiatrist who had been involved in the WHO studies [33].

To define the target population, we used a multistage cluster sampling design, based on data from the Belgian National Register. In stage 1, municipalities were weighted according to their number of inhabitants and 140 of them were selected randomly (with the possibility of being selected more than once), using the statistical program SPSS 19. In stage 2, the Belgian National Register provided us with a random sample of 15 respondents within each of the 140 selected municipalities. This resulted in a target sample of 2,100 people. In total, 1,166 respondents participated. We followed the guidelines of the American Association of Public Opinion Research [34]. The response rate was 55.5% (AAPOR Response Rate 1) and the cooperation rate was 66.9% (AAPOR Cooperation Rate 3). As this paper focuses only on the attitudes toward people with a very severe mental disorder, only the vignette consisting of an unlabeled psychiatric case history with symptoms that fulfill the criteria of the DSM-IV of schizophrenia was included (see appendix). Additionally, a post-stratification weight procedure was applied in SPSS 19 in order to approximate the cross-classification of the census population count within gender, age, and education. As a result, our weighted sample consisted of 381 respondents.

1.3.2 Variables

DEPENDENT VARIABLES

Help-seeking suggestions were assessed by means of the following open-ended question: “What should the vignette person do if he or she needs to do something?” This was asked immediately
after the description of the vignette person was read; no clues for responding were offered. Respondents were allowed to offer three suggestions at the most. The responses were assigned to a range of predefined categories by the interviewers and if the responses did not correspond with one of the predefined categories, they were coded as verbatim. Those verbatim responses were recoded independently by two raters through a content analysis procedure and were reconsidered if the raters disagreed. For this particular study, six help-seeking options were considered: (1) general practitioner, (2) psychiatrist, (3) psychologist, (4) family, (5) friends, and (6) self-care. Respondents received the score of 1 if they mentioned a particular help-seeking option and 0 if they did not mention that option.

_Treatment stigma_ is measured by means of a three-item scale that refers to the exclusion of the vignette person in different social situations after he or she had been in psychiatric treatment. The three items are (a) “After receiving treatment, the vignette person will be considered an outsider in his or her community,” (b) “If the vignette person mentions that he or she has been in treatment, that person will lose some of their friends,” and (c) “Whatever the vignette person accomplishes in the future, his or her chances will always be limited when people discover that he or she has been in treatment.” Each item was scored on a 4-point Likert scale and the mean score was taken. A higher score expresses that people more strongly agree that the label associated with having received psychiatric treatment leads to social exclusion.

**INDEPENDENT VARIABLES**

First, to assess _causal attributions_, respondents were asked to rate the likeliness of the situation being caused by on the one hand biogenetic factors, namely (a) a brain disorder and/or (b) genes and on the other hand psychosocial factors, respectively (c) social problems and/or (d) economic problems. We dichotomized the original scores (‘very or somewhat likely (1)’ versus ‘not very or not at all likely (0)’ and created three categories ourselves: (1) adhering to the biopsychosocial model (believing that both biogenetic and psychosocial causes are involved), (2)
adhering to the psychosocial model (merely attributing the situation to a psychosocial cause), and (3) adhering to the bio-bio-bio model (only attributing the situation to a biogenetic cause). The respondents who believe in neither biogenetic nor psychosocial factors were deleted from the sample, as only 2 respondents (0.4%) belonged to this category.

Second, to assess the disease view, the following question was asked: “How likely is it that the vignette person is experiencing a mental illness?”. This item was originally scored on a 4-point Likert scale, but we dichotomized the scores so that the score of 1 refers to defining the situation as a mental illness, whereas 0 refers to not applying a disease view.

Third, to assess labeling, respondents were asked what they would say, if anything, was wrong with the vignette person. They could choose from the following categories: depression, schizophrenia, asthma, or stress, or they could suggest another option themselves. When they chose the latter open-ended answering option, their responses were subject to content analysis. This resulted into three categories: (1) applying a medical label (those who accurately apply the schizophrenia-label), (2) applying a non-medical label (referring to stress, psychological problem, traumatic event, etc.), and (3) giving an inaccurate diagnosis (for example labeling schizophrenia as depression).

**CONTROL VARIABLES**

Education was measured as the number of years of education people have attained. Marital status refers to either being married/cohabiting or being separated, divorced, widowed, or single. Employment status distinguishes the employed, the unemployed, the retired, students and those who are homemakers. To assess mental health status, we used the shortened version of the General Health Questionnaire (GHQ-12). The validity of this scale has been shown by Goldberg et al. [35]. The original answering categories were scored on a 4 point Likert scale and were added up so that higher scores represent more mental health complaints. Additionally, the level of
contact is addressed by the following categories: (1) personal experience (respondents have undergone psychiatric treatment themselves), (2) interpersonal contact (respondents know a family member, friend, or acquaintance who has received psychiatric treatment), and (3) no contact. Finally, the vignette person was presented as either a male or as a female person, and as someone with a Belgian or Turkish nationality.

1.3.3 Analysis

First, the descriptives of the study population and the (in)dependent variables are illustrated in Table 9. Second, the bivariate correlations of the core independent variables are calculated. Because these variables are all categorical variables, we check the crosstabulations and the Pearson Chi-square statistic to test whether they are significantly correlated with each other. Third, the association between medicalizing (versus psychologizing) mental illness and (in)formal help-seeking suggestions is studied using multiple logistic models. The odds ratios, their 95% confidence intervals and the corresponding p-values are reported in Table 10 and 11. Fourth, the association between the medicalized (versus psychosocial) conceptualization of mental illness and treatment stigma is estimated with multiple linear regression models. The unstandardized coefficients, their standard errors, the 95% confidence intervals and the p-values are reported in Table 12. All analyses have been done in the statistical program SPSS 19.

1.4 Results

The descriptives of the study population and the (in)dependent variables are presented in Table 13. The dependent variable treatment stigma or social exclusion after treatment deserves some extra attention. First of all, the internal consistency of the scale is satisfying, as Cronbach’s alpha amounts to 0.6, which is reasonable for a three-item scale, and the principal component analysis revealed only one factor. The eigenvalue of that factor was 1.67, which explained 55.5% of the
variance. All three items have a high loading on this factor: (a) 0.64, (b) 0.81, and (c) 0.78, respectively. Furthermore, to give a clearer interpretation of the mean score of treatment stigma, we add that 36.1% of our respondents agree that the vignette person will be considered an outsider in the community after treatment; 52% support the statement that the vignette person’s opportunities will be limited when people discover that he or she has been in treatment. Besides, 48.2% hold the opinion that the vignette person will lose friends if he or she mentions their history of psychiatric treatment.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>191</td>
<td>50.1</td>
</tr>
<tr>
<td>Women</td>
<td>190</td>
<td>49.9</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>246</td>
<td>64.5</td>
</tr>
<tr>
<td>Separated/divorced/widowed/single</td>
<td>135</td>
<td>35.5</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>224</td>
<td>58.8</td>
</tr>
<tr>
<td>Unemployed/retired/students/homemakers</td>
<td>157</td>
<td>41.2</td>
</tr>
<tr>
<td>Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>51</td>
<td>13.4</td>
</tr>
<tr>
<td>Interpersonal contact</td>
<td>197</td>
<td>51.8</td>
</tr>
<tr>
<td>No contact</td>
<td>133</td>
<td>34.8</td>
</tr>
<tr>
<td>Labeling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applying a medical label</td>
<td>99</td>
<td>26</td>
</tr>
<tr>
<td>Applying a non-medical label</td>
<td>74</td>
<td>19.4</td>
</tr>
<tr>
<td>Applying an inaccurate label</td>
<td>208</td>
<td>54.6</td>
</tr>
<tr>
<td>Disease view</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defining as mental illness</td>
<td>286</td>
<td>75</td>
</tr>
<tr>
<td>Not defining as mental illness</td>
<td>95</td>
<td>25</td>
</tr>
<tr>
<td>Causal attributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adhering to the biopsychosocial model</td>
<td>257</td>
<td>67.4</td>
</tr>
<tr>
<td>Adhering to the psychosocial model</td>
<td>90</td>
<td>23.7</td>
</tr>
<tr>
<td>Adhering to the bio-bio model</td>
<td>34</td>
<td>8.9</td>
</tr>
<tr>
<td>Spontaneous help-seeking recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General practitioner</td>
<td>196</td>
<td>51.5</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>168</td>
<td>44</td>
</tr>
<tr>
<td>Psychologist</td>
<td>82</td>
<td>21.4</td>
</tr>
<tr>
<td>Family</td>
<td>107</td>
<td>28.1</td>
</tr>
<tr>
<td>Friends</td>
<td>79</td>
<td>20.6</td>
</tr>
<tr>
<td>Self-care</td>
<td>74</td>
<td>19.3</td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>Min.-Max.</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>46.22 (17.06)</td>
<td>18-90</td>
</tr>
<tr>
<td>Education</td>
<td>11.97 (3.61)</td>
<td>0-22</td>
</tr>
<tr>
<td>Mental health complaints</td>
<td>14.54 (4.96)</td>
<td>1-34</td>
</tr>
<tr>
<td>Social exclusion after treatment</td>
<td>2.40 (0.60)</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Table 13: Descriptives study population and (in)dependent variables (N=381, weighted data, SGC-BMHS, 2009).
The mutual correlations of the core independent variables reveal that they are all significantly correlated with each other. Causal attributions are correlated with whether or not people apply the disease view ($X^2=33.72$, df=2, $p<0.001$). Defining the situation as a mental illness is also linked to how people label the situation ($X^2=21.35$, df=2, $p<0.001$) and labeling processes are related to the perceived causes of the situation ($X^2=17.54$, df=4, $p<0.01$) (crosstabulations not tabulated).

Table 14 and Table 15 show the results of the association between the conceptualization of the situation of the vignette person and (in)formal help-seeking recommendations. People who define the situation as a mental illness seem to be more inclined to recommend help from a psychiatrist. The respondents who apply a medical label or an inaccurate label are less likely to recommend self-care than those who use a non-medical label. Concerning causal attributions, people who adhere to the biopsychosocial instead of the psychosocial model are more likely to recommend help from a general practitioner and less likely to recommend consulting friends.

The control variables reveal that female respondents are more likely to recommend general care. Older respondents less tend to recommend help from a psychologist and are less likely to recommend self-care. Higher educated people report a stronger predisposition to recommend help from a psychologist, whereas those who report more mental health complaints are less predisposed to recommend help from a psychologist. Additionally, the working population is more inclined to recommend help from family members compared to those who are unemployed, retired, students or homemakers. Respondents who indirectly came into contact with mental health services are less likely to recommend help from a general practitioner. Finally, when the respondents had to give advice to a vignette person with a Turkish instead of a Belgian nationality, they were also more reluctant to recommend self-care.
<table>
<thead>
<tr>
<th></th>
<th>General Practitioner</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR (95% CIs)</td>
<td>OR (95% CIs)</td>
<td>OR (95% CIs)</td>
</tr>
<tr>
<td>Applying a medical label</td>
<td>0.82 (0.42-1.61)</td>
<td>1.66 (0.85-3.27)</td>
<td>1.43 (0.63-3.24)</td>
</tr>
<tr>
<td>Applying an inaccurate label</td>
<td>0.98 (0.56-1.72)</td>
<td>1.22 (0.68-2.18)</td>
<td>1.15 (0.55-2.40)</td>
</tr>
<tr>
<td>Defining as mental illness</td>
<td>1.32 (0.77-2.26)</td>
<td>2.57 (1.45-4.56)</td>
<td>** 1.56 (0.75-3.25)</td>
</tr>
<tr>
<td>Adhering to the biopsychosocial model</td>
<td>1.84 (1.07-3.14) *</td>
<td>1.34 (0.77-2.33)</td>
<td>1.44 (0.70-2.96)</td>
</tr>
<tr>
<td>Adhering to the bio-bio-bio model</td>
<td>1.73 (0.72-4.15)</td>
<td>1.26 (0.52-3.05)</td>
<td>1.63 (0.58-4.62)</td>
</tr>
<tr>
<td>Female</td>
<td>2.59 (1.64-4.08) ***</td>
<td>0.87 (0.55-1.38)</td>
<td>1.15 (0.66-1.99)</td>
</tr>
<tr>
<td>Age</td>
<td>1.01 (1.00-1.03)</td>
<td>0.99 (0.98-1.01)</td>
<td>0.98 (0.96-0.99) **</td>
</tr>
<tr>
<td>Years of education</td>
<td>1.03 (0.96-1.10)</td>
<td>0.95 (0.89-1.02)</td>
<td>1.12 (1.03-1.22) *</td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>1.03 (0.64-1.67)</td>
<td>0.67 (0.41-1.09)</td>
<td>1.18 (0.65-2.16)</td>
</tr>
<tr>
<td>Employed</td>
<td>1.52 (0.89-2.60)</td>
<td>1.00 (0.58-1.72)</td>
<td>0.61 (0.32-1.15)</td>
</tr>
<tr>
<td>Mental health complaints</td>
<td>1.00 (0.96-1.04)</td>
<td>1.02 (0.98-1.07)</td>
<td>0.93 (0.88-0.98) *</td>
</tr>
<tr>
<td>Personal experience</td>
<td>0.54 (0.27-1.10)</td>
<td>1.66 (0.81-3.42)</td>
<td>1.18 (0.50-2.79)</td>
</tr>
<tr>
<td>Interpersonal contact</td>
<td>0.56 (0.35-0.91) *</td>
<td>1.48 (0.90-2.42)</td>
<td>0.99 (0.55-1.78)</td>
</tr>
<tr>
<td>Female vignette</td>
<td>1.02 (0.66-1.58)</td>
<td>1.23 (0.79-1.92)</td>
<td>0.79 (0.47-1.34)</td>
</tr>
<tr>
<td>Outgroup vignette</td>
<td>1.55 (1.00-2.42)</td>
<td>0.67 (0.43-1.04)</td>
<td>0.94 (0.55-1.61)</td>
</tr>
</tbody>
</table>

*: p<0.05, **: p<0.01, ***: p<0.001

| ref.cat.          | non-medical label, b: ref.cat.: adhering to the psychosocial model, c: ref.cat.: men, d: ref.cat.: separated/divorced/widowed/single, e: ref.cat.: unemployed/retired/students/housewives/housemen, f: ref.cat.: no contact, g: ref.cat.: male vignette, h: ref.cat.: ingroup vignette |

Table 14: The association between medicalizing versus psychologizing mental illness and formal help-seeking suggestions (N=381, weighted data, SGC-BMHS, 2009).
<table>
<thead>
<tr>
<th></th>
<th>Family</th>
<th>Friends</th>
<th>Self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR  (95% CIs)</td>
<td>OR  (95% CIs)</td>
<td>OR  (95% CIs)</td>
</tr>
<tr>
<td>Applying a medical label</td>
<td>0.67 (0.33-1.39)</td>
<td>0.64 (0.26-1.55)</td>
<td>0.17 (0.07-0.45)</td>
</tr>
<tr>
<td>Applying an inaccurate label</td>
<td>0.81 (0.44-1.46)</td>
<td>1.37 (0.70-2.68)</td>
<td>0.42 (0.22-0.78)</td>
</tr>
<tr>
<td>Defining as mental illness</td>
<td>0.79 (0.45-1.40)</td>
<td>0.58 (0.31-1.06)</td>
<td>0.76 (0.40-1.43)</td>
</tr>
<tr>
<td>Adhering to the biopsychosocial model</td>
<td>0.67 (0.38-1.18)</td>
<td>0.52 (0.29-0.94) *</td>
<td>0.80 (0.42-1.54)</td>
</tr>
<tr>
<td>Adhering to the bio-bio-bio model</td>
<td>0.84 (0.32-2.16)</td>
<td>0.59 (0.21-1.66)</td>
<td>0.77 (0.22-2.71)</td>
</tr>
<tr>
<td>Female</td>
<td>1.37 (0.84-2.23)</td>
<td>1.01 (0.58-1.76)</td>
<td>0.70 (0.39-1.26)</td>
</tr>
<tr>
<td>Age</td>
<td>1.00 (0.98-1.02)</td>
<td>1.00 (0.98-1.02)</td>
<td>0.97 (0.95-0.99) *</td>
</tr>
<tr>
<td>Years of education</td>
<td>0.96 (0.89-1.04)</td>
<td>1.06 (0.97-1.16)</td>
<td>0.93 (0.85-1.02)</td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>1.01 (0.60-1.70)</td>
<td>1.02 (0.57-1.84)</td>
<td>1.07 (0.57-2.02)</td>
</tr>
<tr>
<td>Employed</td>
<td>2.21 (1.20-4.06)</td>
<td>1.29 (0.65-2.54)</td>
<td>0.60 (0.31-1.18)</td>
</tr>
<tr>
<td>Mental health complaints</td>
<td>1.00 (0.96-1.05)</td>
<td>0.95 (0.90-1.01)</td>
<td>0.97 (0.92-1.03)</td>
</tr>
<tr>
<td>Personal experience</td>
<td>1.16 (0.53-2.53)</td>
<td>0.72 (0.27-1.93)</td>
<td>1.35 (0.50-3.65)</td>
</tr>
<tr>
<td>Interpersonal contact</td>
<td>1.04 (0.62-1.76)</td>
<td>0.96 (0.54-1.71)</td>
<td>1.45 (0.78-2.68)</td>
</tr>
<tr>
<td>Female vignette</td>
<td>1.61 (1.00-2.60)</td>
<td>0.90 (0.53-1.54)</td>
<td>0.73 (0.42-1.29)</td>
</tr>
<tr>
<td>Outgroup vignette</td>
<td>0.70 (0.44-1.13)</td>
<td>1.24 (0.72-2.12)</td>
<td>0.52 (0.29-0.92) *</td>
</tr>
</tbody>
</table>

*: p<0.05, **: p<0.01, ***: p<0.001

*: ref.cat.: non-medical label, #: ref.cat.: adhering to the psychosocial model, #: ref.cat.: men.

Table 15: The association between the medicalizing versus psychologizing mental illness and informal help-seeking suggestions (N=381, weighted data, SGC-BMHS, 2009)
Table 16 focuses on the association between medicalizing versus psychologizing the situation of the vignette person and treatment stigma. The results reveal that labeling processes are associated with stigmatizing attitudes toward someone who has been in psychiatric treatment, while causal attributions are not. If people apply a medical label, they seem to be more likely to socially exclude the vignette person after treatment compared to those who use a non-medical label. The control variables show that older people tend to report more stigmatizing attitudes toward someone who has been in psychiatric treatment. Furthermore, respondents express more social exclusion toward someone who has been in psychiatric treatment when the vignette person referred to someone with a Turkish nationality.

<table>
<thead>
<tr>
<th>Treatment stigma</th>
<th>B</th>
<th>SE</th>
<th>(95% CIs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applying a medical label&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.19</td>
<td>0.10</td>
<td>(0.01-0.38)</td>
</tr>
<tr>
<td>Applying an inaccurate label&lt;sup&gt;b&lt;/sup&gt;</td>
<td>0.02</td>
<td>0.08</td>
<td>(-0.14-0.18)</td>
</tr>
<tr>
<td>Defining as mental illness</td>
<td>0.05</td>
<td>0.08</td>
<td>(0.10-0.20)</td>
</tr>
<tr>
<td>Adhering to the biopsychosocial model&lt;sup&gt;c&lt;/sup&gt;</td>
<td>0.02</td>
<td>0.08</td>
<td>(-0.12-0.10)</td>
</tr>
<tr>
<td>Adhering to the bio-bio-bio model&lt;sup&gt;d&lt;/sup&gt;</td>
<td>0.12</td>
<td>0.13</td>
<td>(-0.13-0.37)</td>
</tr>
<tr>
<td>Female &lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.10</td>
<td>0.07</td>
<td>(-0.03-0.23)</td>
</tr>
<tr>
<td>Age</td>
<td>0.00</td>
<td>0.00</td>
<td>(0.00-0.01)</td>
</tr>
<tr>
<td>Years of education</td>
<td>-0.01</td>
<td>0.01</td>
<td>(-0.03-0.01)</td>
</tr>
<tr>
<td>Married or cohabiting&lt;sup&gt;e&lt;/sup&gt;</td>
<td>0.00</td>
<td>0.07</td>
<td>(-0.14-0.14)</td>
</tr>
<tr>
<td>Employed&lt;sup&gt;e&lt;/sup&gt;</td>
<td>0.14</td>
<td>0.08</td>
<td>(-0.02-0.29)</td>
</tr>
<tr>
<td>Mental health complaints</td>
<td>0.01</td>
<td>0.01</td>
<td>(-0.00-0.02)</td>
</tr>
<tr>
<td>Personal experience&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.12</td>
<td>0.10</td>
<td>(-0.08-0.33)</td>
</tr>
<tr>
<td>Interpersonal contact&lt;sup&gt;f&lt;/sup&gt;</td>
<td>0.07</td>
<td>0.07</td>
<td>(-0.07-0.20)</td>
</tr>
<tr>
<td>Female vignette&lt;sup&gt;g&lt;/sup&gt;</td>
<td>0.03</td>
<td>0.06</td>
<td>(-0.09-0.15)</td>
</tr>
<tr>
<td>Outgroup vignette&lt;sup&gt;h&lt;/sup&gt;</td>
<td>0.16</td>
<td>0.06</td>
<td>(0.04-0.28)</td>
</tr>
</tbody>
</table>

<sup>a</sup>: ref.cat.: non-medical label, <sup>b</sup>: ref.cat.: adhering to the psychosocial model, <sup>c</sup>: ref.cat.: men, <sup>d</sup>: ref.cat.: separated/divorced/widowed/single, <sup>e</sup>: ref.cat.: unemployed/retired/students/housewives/housemen, <sup>f</sup>: ref.cat.: no contact, <sup>g</sup>: ref.cat.: male vignette, <sup>h</sup>: ref.cat.: ingroup vignette

Table 16: The association between medicalizing versus psychologizing mental illness and social exclusion after treatment (N=381, weighted data, SGC-BMHS, 2009).
1.5 Discussion

This empirical study examines the implications of the lay conceptualizations of mental illness. In contrast to previous studies who merely studied the effects of the different conceptualizations of mental illness side by side, we contrast the medicalized conceptualization of mental illness with psychologizing mental illness and study what the consequences are of adhering to one model versus the other for help seeking and stigma. The data are derived from the “Stigma in a Global Context–Belgian Mental Health Survey,” using the vignette technique which depicts an unlabeled case history of a very severe mental disorder, namely schizophrenia.

Before we draw attention to the main findings of the current study, we first acknowledge some limitations and strengths. The first limitation refers to the cross-sectional nature of the data, which does not allow a strict causal interpretation of the results. Nevertheless, we partially control for the selection hypothesis—which suggests that familiarity with mental health services influences the ability to recognize specific mental disorders and improves knowledge about the causes of them—by considering whether the respondents had direct or indirect contact with mental health care services. Second, the vignette technique has been criticized for its limited generalizability, as it refers to a hypothetical situation. Yet, we argue that the help-seeking process is subjected to social influence. The recognition of psychiatric symptoms most often occurs in the community and social network members serve as a lay referral system, providing treatment recommendations that may lead people to seek formal care [36]. Third, the scale of treatment stigma consists of only three items and has not yet been cross-validated in other countries. Nevertheless, the internal consistency of the scale is satisfactory among the Belgian population. Moreover, it is interesting to study this stigma dimension, as it catches the core meaning of the modified labeling theory, which has received too little research attention to date [37].
Despite these limitations, this study makes a contribution to the research field in the following ways. First, this is the first Belgian survey that has studied stigmatizing attitudes among the general population by means of face-to-face interviews. Previous research in Belgium was limited to service users [38], community and health professionals [39], and medical students [40]. Furthermore, there are no important structural barriers to accessing mental health services in Belgium. There is a sufficient supply of (mental) health professionals and access to specialized care is unrestricted. Moreover, up to 80% of all mental health visits to medically trained professionals are covered by health insurance [41]. Second, we went beyond the premise of the medicalized conceptualization of mental illness by comparing it with the psychosocial model. We contrasted both models, instead of merely studying the impact of both conceptualizations of mental illness side by side. Because the relative importance of adhering to one model versus the other is crucial. Third, our dependent variables address both the positive (help seeking) as well as the negative (stigma) implications of lay conceptualizations of mental illness.

The main finding of this study is that medicalizing mental illness has a brighter and darker side [2] or involves a ‘package deal’ [42]. As concerns help-seeking, a medicalized conceptualization of the situation of the vignette person seems to facilitate professional care-seeking. Defining the situation as a mental illness leads people to recommend help from a medical specialist. This finding is in accordance with the results of Lauber et al. [43] and Riedel-Heller, Matschinger, and Angermeyer [44]. People who attribute the situation to both biogenetic and psychosocial causes are more likely to recommend help from a general practitioner. This is consistent with the findings of Angermeyer et al. [19]. Phelan, Yang, and Cruz-Rojas [45], however, found that biogenetic attributions were linked to more extreme treatment options, such as hospitalization, and not to consultations with medical professionals. Regarding informal help seeking, people who adhere to the biopsychosocial model seem to be less inclined to recommend lay care from friends than those who prefer the psychosocial model. This again corresponds with the results of
the study of Angermeyer, Matschinger, and Riedel-Heller [19]. Also, those who apply a medical rather than a nonmedical label are less inclined to recommend self-care. This result is in line with the findings of Wright, Jorm, and Mackinnon [46] and Jorm et al. [47], which state that broad, nonspecific labels such as stress indicate that a person will seek less help from professional care providers. Nevertheless, although self-care and informal care are not considered to be adequate coping strategies to counter symptoms of schizophrenia, they are relevant to deal with less severe mental health complaints. Self-care has shown to be effective to deal with subclinical mental health symptoms [23] and informal care is crucial in the way that it often facilitates professional care seeking as family or close friends provide information and support to access formal care services [36].

Regarding stigma, our results show that applying a medical label is associated with more stigma toward someone who has been in psychiatric treatment. These findings are in line with the studies of Taskin et al. [48] and Lauber et al. [27] that also addressed a schizophrenia vignette, but studied another stigma dimension. Those studies indicated that a mental illness conceptualization is related to a greater desire for social distance. Szeto et al. [49] differentiated that a specific label, in their case they studied a depression vignette, was associated with more negative attitudes than applying a more general label such as mental illness. Additionally, we are not able to give a verdict on the association between adhering to the biopsychosocial model and stigmatizing attitudes toward someone who has been in psychiatric treatment, as the relationship was not significant. So we cannot support the assumption that also attributing the situation to biogenetic factors seems to trigger stigmatizing attitudes [10], while attributing it to merely psychosocial factors seems to be related to more tolerant attitudes [16-18]. This might be due to the fact that the association between biological attributions and stigma is primarily pronounced with regard to other stigma dimensions such as perceptions of unpredictability and dangerousness and desire for social distance [10-11].
We conclude that treatment stigma or the social exclusion of people who have been in psychiatric treatment seems to be particularly triggered by labeling processes. Treatment stigma is a crucial stigma dimension, as the danger for former service-users is that they will perceive the label that is attached to them as a key aspect of their identity and secondary deviance will occur. This self-stigmatization will interfere with their life opportunities and social skills. For example, they will develop self-sabotaging coping strategies such as not attempting to find a job or withdrawing from social contact and as such, it might become a self-fulfilling prophecy. In order to tackle this stigma dimension, mental distress should be viewed in a dimensional rather than a categorical way, including normalcy on its continuum, so that the gap between “them” and “us” diminishes. A call for replacing the label ‘schizophrenia’ by the term ‘psychosis’ might be appropriate too. A Japanese case study revealed that the strategy of renaming holds considerable promise for tempering negative attitudes toward schizophrenia [50].

1.6 Reference list


http://www.aapor.org/Response_Rates_An_Overview1.htm


90


2 The Differential Association Between Stigma Dimensions and (In)formal Help Seeking


2.1 Abstract

Objective: People in need of psychiatric treatment often avoid help seeking because of stigma. This study questions how two different stigma dimensions have an impact on help seeking attitudes. Perceived public stigma reflects how people fear anticipated discrimination and devaluation by others, while anticipated self-stigma reflects how people internalize stereotypes about people who seek help and apply them to themselves.

Methods: Data are derived from the survey “Stigma in a Global Context–Belgian Mental Health Study” (2009), which conducted face-to-face interviews among a representative sample of the general Belgian population, using the vignette technique to depict major depression or schizophrenia (N = 728). The stigma dimensions under study are perceived public stigma and anticipated self-stigma. Help seeking attitudes are measured by the rating of importance of a range of formal and informal care-providers (general practitioner, psychiatrist, psychologist, family, or friends). Multiple linear regression models are estimated in SPSS Statistics 19.

Results: People with higher levels of anticipated self-stigma seem to attach less importance to care provided by a general practitioner or a psychiatrist, while those with higher levels of perceived public stigma are less likely to consider informal help seeking as important.

Conclusions: Anticipated self-stigma and perceived public stigma seem to have a differential impact on formal and informal help seeking attitudes. The self-concurrence of stereotypes is negatively associated with the perceived importance of medical care-providers, even general care-providers. The awareness of stereotypes held by others deters people from acknowledging the importance of informal care.
2.2 Introduction

There is a high level of unmet need regarding mental illness [1-2]. Unmet need refers to a situation in which an individual who is in need of psychiatric treatment does not seek care. As mental illness is not readily visible, entering psychiatric treatment is the biggest cue that a person will be labeled as mentally ill. This label is associated with a range of culturally agreed-upon beliefs or stereotypes transmitted through socialization [3]. So the threat of being associated with those stereotypes [4] or the fear of stigmatization is one of the reasons why people avoid help seeking behavior [5-7].

Stigma is a multidimensional phenomenon. Corrigan and Watson [8] underlined the theoretical difference between perceived public stigma and anticipated self-stigma. Perceived public stigma refers to the awareness of stereotypes held by the general public about former service users [9], while anticipated self-stigma refers to the application of stereotypes regarding people who are in psychiatric treatment to oneself leading to feelings of internalized devaluation and disempowerment [10]. Yet being aware of stereotypes held by others does not automatically lead to the self-concurrence of those stereotypes [8; 11]. Therefore, we consider perceived public stigma and anticipated self-stigma as two different stigma dimensions in contrast to Vogel et al. [12].

Perceived public stigma may lead people to avoid seeking help, if people expect that others will discriminate against and devaluate service users [7]. Before people perform a certain behavior, they adopt the perspective of the generalized other through the process of role taking [13]. So out of fear of negative reactions of others, they will adapt their behavior and might not seek help. Empirical studies have shown that perceived stigma is related to a more negative attitude towards help seeking [14] and to less willingness to seek formal care [15].
Anticipated self-stigma may also lead people to avoid help seeking, as self-stigma affects feelings of self-esteem and self-efficacy [16-18]. When people endorse, for example, the stereotype of blame (people with mental illness are responsible for their condition), this may trigger feelings of guilt and shame [19]. To avoid those feelings, people choose coping strategies such as secrecy or social withdrawal instead of seeking help [11]. There is empirical evidence that people with a higher level of anticipated self-stigma are more reluctant to seek help [15, 20-21].

When studying help seeking, we focus on both formal and informal sources of care. First, it is important to distinguish different types of formal care providers, because the impact of stigma depends on the source of care that is considered [15;22]. We expect that the negative association between stigma and formal help seeking will be more pronounced for specialist than for general care. Second, it is crucial to take informal care into account. Informal support might facilitate entering the formal care sector [23], and also might encourage treatment adherence. Furthermore, informal support is meaningful in preventing relapse after treatment [24-25]. This has been acknowledged by Jorm and colleagues [26] in his model of overlapping waves of action, by Pescosolido et al. [27-28] in her Network-Episode Model and by Milstein et al. in their COPE continuum [29]. We hypothesize that the negative association between stigma and informal help seeking will be more pronounced for help from friends than from family members. As stigma has less effect on close ties, since family members feel obliged to help following the hierarchy of responsibility [30].

Additionally, some potential confounders should be controlled for. Women are more predisposed to seek external help [31-33], whereas men are more inclined to manage their emotional problems on their own [34]. Regarding age, young people are more likely to turn to nonprofessional sources of care [35], while older people choose general care more often [36]. Furthermore, people who obtained a higher level of education are more likely to contact specialist care [37]. Concerning marital status, the divorced and separated are more likely to rely
on professional care than the married and cohabiting [38]. Employment status also correlates with formal help seeking [39]. Finally, it is important to consider whether respondents report mental health complaints themselves and whether they are familiar with mental health services [40-41].

In sum, we expect a negative association between stigma and help seeking, yet we hypothesize that perceived public stigma and anticipated self-stigma will have a differential impact on various sources of formal and informal care, since they reflect different mechanisms. Furthermore, we hypothesize that the strength of the association will be more pronounced for specialist care, compared to general care, and for help from friends, compared to help from family members.

2.3 Methods

2.3.1 Sample and data

This study is based on data from the survey “Stigma in a Global Context–Belgian Mental Health Study” (2009), which examined the attitudes of the general public toward mental health care services and people with mental illness. Fully structured, face-to-face computer-assisted personal interviews were implemented among a representative sample of the non-institutionalized adult Belgian population. Part of the interview consisted of questions referring to a randomly chosen hypothetical vignette person, including unlabeled psychiatric case histories describing symptoms that fulfill the criteria of the DSM-IV. This vignette technique is often applied in general population research about mental illness [42-48]. The vignettes were taken from the 1996 U.S. General Social Survey [49] and were rewritten during a meeting with representatives from all country teams and a cross-cultural psychiatrist who had been involved in the WHO studies [50].
To define the target population, we used a multistage cluster sampling design based on data from the Belgian National Register. In stage 1, municipalities were weighted according to their number of inhabitants. Subsequently, 140 municipalities were randomly selected; selection included the possibility of being selected more than once. In stage 2, 15 respondents were randomly selected within each municipality. This resulted in a target sample of 2,100 people. After complete description of the study to the participants, written informed consent was obtained from 1,166 respondents in total. The response rate was 55.5% and the cooperation rate, excluding those who were incapable to cooperate due to for instance a language barrier, illness or being on holiday or having moved, was 66.9% [51].

For this particular study, we only included the vignettes that depict major depression or schizophrenia (see appendix), so one third of the respondents, those who received the asthma vignette, were excluded from the research sample, resulting in a sample of 755 respondents. Furthermore, a post-stratification weight procedure was applied in order to approximate the cross-classification of the census population count within gender, age, and education. Accordingly, our weighted sample consisted of 728 cases.

2.3.2 Variables

Help seeking attitudes are assessed by presenting the respondents with a list of potential care-providers that the vignette person could consult to cope with his/her situation, namely general practitioner, psychiatrist, psychologist, family, and friends. The respondents are literally asked how important they think it is that the person in the vignette consults each of those care-providers to deal with his/her health problems. This rating of importance occurs on a scale from
1 (not important at all) to 10 (very important). This measure is comparable to the rating of helpfulness of diverse treatment options, which is often applied in vignette studies [22; 43-46].

INDEPENDENT VARIABLES

*Perceived public stigma* is measured using Link's Perceived Devaluation and Discrimination Scale [9]. In this study, we refer to former service users in general, instead of someone who has been in a mental hospital. The response categories are situated on a 4-point Likert scale and range from *totally agree* to *absolutely disagree*. The scores of some items were reversed, so that a higher value represents more anticipated discrimination and devaluation. The construct validity has been proven in other studies [52]. In this study, Cronbach's alpha amounts to 0.82.

*Anticipated self-stigma* is derived from the Social Isolation subscale of Fife and Wright [53] and has been applied in other studies too [15; 54]. It consists of five items that assess the negative reactions toward oneself if one would be in psychiatric treatment. Examples are “I would feel ashamed if I had received psychiatric care,” and “Receiving psychiatric care would make me feel useless.” The response categories are scored on a five point Likert scale and ranged from *totally agree* to *totally disagree*. The original scores were reversed so that the mean score would represent a higher level of anticipated self-stigma. The internal consistency of the scale is very good (Cronbach's alpha = .90) and the exploratory principal component analysis revealed a one-factor solution with component loadings ranging from 0.76 to 0.88 (eigenvalue = 3.55, explaining 70.97% of the variance).

CONTROL VARIABLES

*Education* is measured as the number of years of education that people have attained [55]. To assess *mental health status*, the shortened General Health Questionnaire (GHQ-12) is used [56]. The original answering categories were coded on a 4 point Likert-scale and varied between *not*
at all, not more than usual, a little more than usual, and a lot more than usual. The scores of the positive items were first reversed and, subsequently, all items were added up, so that the scale ranged from 0 to 36. Cronbach’s alpha was 0.791. Furthermore, to assess contact with mental health services, respondents were asked whether they ever underwent psychiatric treatment themselves and whether they knew a family member, friend, or acquaintance who had received psychiatric treatment. They were assigned to the category representing the most direct form of contact. Finally, the characteristics of the person in the vignette are controlled for, namely gender, type of disorder and in-group versus out-group status. The latter refers to the Belgian nationality as in-group status and to the Turkish nationality as out-group status, as the Turkish community is one of the largest ethnic minority groups in Belgium.

2.3.3 Analysis

This study focuses on the association between perceived public stigma and anticipated self-stigma and formal and informal help seeking attitudes. In a first step, the descriptives of the (in)dependent variables are presented in Table . In a second step, the analytical models were performed by means of the statistical program SPSS Statistics 19. Multiple linear regression models were estimated, since a separate model was estimated for each type of care-provider. The dependent variables have a skewed distribution and therefore we performed a logarithmical transformation in order to approach a normal distribution and to render the estimations of the ordinary least squares regression analyses more accurate [57]. Subsequently, all independent variables were entered as a block. We also checked whether there were problems of multicollinearity for the two stigma variables, but the VIF-scores revealed that this was not the case. In Table 19 the unstandardized coefficients are reported, accompanied by their standard errors and the test statistic values.
2.4 Results

Table 19 illustrates the descriptives of the study population. To give a more interpretable description of the mean scores of the two stigma dimensions, we add that 66.5% of the respondents state that other people look down on former service users and almost half of the respondents (48.5%) agree that other people think that receiving psychiatric treatment is a sign of personal failure (perceived public stigma). As concerns anticipated self-stigma, it seems that one fifth (24.7%) of the respondents agree that they would feel ashamed of being in psychiatric treatment and even 43.3% states that they would start to doubt themselves when following psychiatric treatment.

The results shown in Table 19 indicate that perceived public stigma is negatively associated with the rating of importance of informal care-providers. People who report a higher level of perceived public stigma are less likely to rate help from family (B = -.111, p < 0.01) and friends (B = -.113, p<.01) as important. Perceived public stigma does not seem to have a significant impact on formal help-seeking options. Anticipated self-stigma is associated with rating help provided by a general practitioner (B = -.022, p < .05) or a psychiatrist (B = -.032, p < .05) as less important. Anticipated self-stigma is not significantly associated with rating help provided by a psychologist as important, neither with informal help.
Independent variables

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>354</td>
<td>48.6</td>
</tr>
<tr>
<td>Women</td>
<td>374</td>
<td>51.4</td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>464</td>
<td>63.8</td>
</tr>
<tr>
<td>Divorced</td>
<td>65</td>
<td>8.9</td>
</tr>
<tr>
<td>Widowed</td>
<td>59</td>
<td>8.1</td>
</tr>
<tr>
<td>Single</td>
<td>140</td>
<td>19.2</td>
</tr>
<tr>
<td>Employed</td>
<td>392</td>
<td>53.9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>46</td>
<td>6.3</td>
</tr>
<tr>
<td>Retired</td>
<td>171</td>
<td>23.5</td>
</tr>
<tr>
<td>Other (student/housework)</td>
<td>119</td>
<td>16.3</td>
</tr>
<tr>
<td>Urban</td>
<td>544</td>
<td>74.8</td>
</tr>
<tr>
<td>Rural</td>
<td>184</td>
<td>25.2</td>
</tr>
<tr>
<td>No contact</td>
<td>261</td>
<td>36</td>
</tr>
<tr>
<td>Personal experience</td>
<td>113</td>
<td>15.5</td>
</tr>
<tr>
<td>Interpersonal contact</td>
<td>354</td>
<td>48.5</td>
</tr>
</tbody>
</table>

Age (M+SD)  48.11+17.82  
Education (M+SD)  11.94+3.69  
Mental health status (M+SD)  14.34+4.80  
Perceived stigma (M+SD)  2.68+.40  
Anticipated self-stigma (M+SD)  2.62+1.09

Dependent variables

<table>
<thead>
<tr>
<th></th>
<th>(M+SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>8.80+1.54</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>8.30+2.12</td>
</tr>
<tr>
<td>Psychologist</td>
<td>8.51+5.45</td>
</tr>
<tr>
<td>Family</td>
<td>8.11+2.01</td>
</tr>
<tr>
<td>Friends</td>
<td>7.69+2.04</td>
</tr>
</tbody>
</table>

a: Age ranges from 18 to 94  
b: Years of education range from 0 to 24  
c: Mental health status ranges from 0 to 34, and a higher score represents a worse mental health status with more complaints  
d: Perceived stigma ranges from 1 to 4 in which a higher score represents more perceived stigma  
e: Self stigma ranges from 1 to 5, in which a higher score represents more self-stigma  
f: The importance of a particular care-provider is rated on a scale from 1 to 10, with higher scores indicating a higher importance

Table 18: Characteristics of the study population (N=728, weighted data, SGC-BMHS, 2009).
<table>
<thead>
<tr>
<th></th>
<th>General Practitioner</th>
<th>Psychiatrist</th>
<th>Psychologist</th>
<th>Family</th>
<th>Friends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>SE</td>
<td>t</td>
<td>B (SE)</td>
<td>t</td>
</tr>
<tr>
<td>Perceived stigma</td>
<td>.017</td>
<td>.023</td>
<td>.71</td>
<td>.013</td>
<td>.041</td>
</tr>
<tr>
<td>Anticipated self-stigma</td>
<td>-.022</td>
<td>.009</td>
<td>-.256*</td>
<td>-.032</td>
<td>.015</td>
</tr>
<tr>
<td>Female (ref.cat.: Male)</td>
<td>.027</td>
<td>.019</td>
<td>1.42</td>
<td>.013</td>
<td>.033</td>
</tr>
<tr>
<td>Age</td>
<td>.001</td>
<td>.001</td>
<td>.76</td>
<td>.000</td>
<td>.002</td>
</tr>
<tr>
<td>Education</td>
<td>.005</td>
<td>.003</td>
<td>1.72</td>
<td>.007</td>
<td>.005</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: Married/Cohabiting)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>.055</td>
<td>.032</td>
<td>1.72</td>
<td>-.045</td>
<td>.057</td>
</tr>
<tr>
<td>Widowed</td>
<td>.023</td>
<td>.036</td>
<td>.62</td>
<td>.057</td>
<td>.065</td>
</tr>
<tr>
<td>Single</td>
<td>.012</td>
<td>.028</td>
<td>.42</td>
<td>.052</td>
<td>.049</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: Employed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>.003</td>
<td>.039</td>
<td>.08</td>
<td>.041</td>
<td>.069</td>
</tr>
<tr>
<td>Retired</td>
<td>.005</td>
<td>.034</td>
<td>.14</td>
<td>-.007</td>
<td>.060</td>
</tr>
<tr>
<td>Other (Student/ Housework)</td>
<td>-.018</td>
<td>.028</td>
<td>-.64</td>
<td>.054</td>
<td>.049</td>
</tr>
<tr>
<td>Urbanicity (ref.cat.: Rural)</td>
<td>-.024</td>
<td>.006</td>
<td>.036</td>
<td>-.006</td>
<td>.036</td>
</tr>
<tr>
<td>Mental health status</td>
<td>.000</td>
<td>.002</td>
<td>-.13</td>
<td>.002</td>
<td>.004</td>
</tr>
<tr>
<td>Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: No contact)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>.053</td>
<td>.029</td>
<td>1.83</td>
<td>.050</td>
<td>.052</td>
</tr>
<tr>
<td>Interpersonal contact</td>
<td>.002</td>
<td>.020</td>
<td>.11</td>
<td>-.015</td>
<td>.035</td>
</tr>
<tr>
<td>Schizophrenia vignette</td>
<td>-.017</td>
<td>.018</td>
<td>-.95</td>
<td>.100</td>
<td>.032</td>
</tr>
<tr>
<td>(ref.cat.: Depression vignette)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female vignette</td>
<td>.024</td>
<td>.018</td>
<td>1.35</td>
<td>.056</td>
<td>.032</td>
</tr>
<tr>
<td>(ref.cat.: Male vignette)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outgroup status vignette (ref.cat.: ingroup status)</td>
<td>-.022</td>
<td>.018</td>
<td>-.123</td>
<td>.013</td>
<td>.032</td>
</tr>
</tbody>
</table>

Table 17: The association between perceived stigma and anticipated self-stigma and the rating of importance of (in)formal care-providers (N=728, weighted data, SGC-BMHS, 2009).
2.5 Discussion

The main finding of this study is that the two stigma dimensions under study have a differential impact on the perceived importance of formal and informal care. Anticipated self-stigma is negatively associated with rating help from medical care providers as important. Perceived public stigma is negatively related to acknowledging the helpfulness of informal care.

Regarding the negative association between anticipated self-stigma and formal help seeking attitudes, it is striking that we found this association only for medical care sources and not for help provided by a non-medical specialist. Furthermore, if we compare the two medical care sources, we notice that the effect size of anticipated self-stigma is most pronounced for the importance of help provided by a psychiatrist, which is in accordance with the results of Barney et al. [15]. This finding is not surprising, since many people have doubts about the quality and effectiveness of specialized psychiatric treatment [58-63].

Concerning the negative association between perceived public stigma and informal help seeking attitudes, it is remarkable that fear of anticipated discrimination and devaluation by others constitutes a barrier towards perceiving informal care as an important coping strategy. Our finding is in line with the few research studies that linked stigma and informal help seeking and that report that informal help seeking is impaired when people fear devaluation in the sense of being perceived as inferior or incompetent [64] and when (young) people fear social discrimination [23]. Next to this, our results take the edge off the argument of Perry [30] regarding the differential impact of stigma on close versus weaker ties, since perceived public stigma is negatively related to both help from friends as well as help from family members. Remarkable is also that the gender and the ethnicity of the person in the vignette almost have no impact on help seeking attitudes, which adds credence to the strength of the main effects.
Moreover, the impact of the socio-demographic characteristics of the respondents themselves on help seeking attitudes is very limited too in our study, which is a common finding [65-66].

The policy implication of these findings is threefold. First, the structural stigma that is surrounding the mental health care sector and psychiatrists in particular should be tackled. Second, it is worrying that anticipated self-stigma is also negatively linked to the perceived helpfulness of consulting a general practitioner, which is considered to be a familiar and accessible source of care. If patients experience barriers to disclosing mental health problems to their general practitioner, the general practitioners should take the initiative and should screen their patients for psychiatric symptoms and should refer them if necessary to specialist care. So Belgium might benefit from officially moving toward a gatekeeper system. Because research revealed that at the moment, patients make few psychological requests in general care and general practitioners in turn make few psychiatric diagnoses [67]. Third, it is remarkable that anticipated self-stigma does not constitute a barrier toward acknowledging the helpfulness of a psychologist. Therefore, the Belgian public might benefit from the reimbursement of non-medical specialist care.

Our findings should, however, be viewed within the confines of the used data and measures. First, our data do not allow a strict causal interpretation of the results. Nevertheless, we partially control for the selection hypothesis, which suggests that previous negative experiences within the mental health care sector might trigger stigmatizing attitudes, by considering whether respondents have had direct or indirect contact with mental health services. Second, this study captured the association between stigma and help seeking attitudes, more specifically the perceived importance of different types of care-providers. One disadvantage of this approach is that the rating of importance might be confounded by the level of mental health literacy of the respondent [68]. A better strategy would have been to study actual help-seeking behavior, but this was not possible, since analyzing the small amount of actual service users (15.5%) within
our general population sample would lack statistical power. Nevertheless, it is interesting to grasp the help seeking attitudes of the general public, as their advice reflects the lay referral system [69], which at the same time serves as a reference system, reflecting the social norms about how stigmatized help-seeking is [70-71]. Third, the stigma measures refer to attitudes toward former service users without providing information about the severity of the psychiatric symptoms. Yet this is not a problem as the rejection associated with having been in psychiatric treatment is independent of the severity of the symptoms [9]. People with a relatively minor mental disorder are not more likely to participate in treatment than those with more severe disorders [72].

Nevertheless, within the confines of these limitations, this study extends the research field in several ways. First, our study examines the association between stigma and help seeking attitudes among a sample that is representative for the general population. Other research has been limited to student samples [12; 73-79] or rural samples [14; 79-80]. Furthermore, there are only limited structural barriers to mental health care seeking in Belgium, as there is a high density of (mental) health professionals, access to specialist care is unrestricted and mental health visits to medically trained professionals are covered by public insurance [81]. Second, we draw attention to stigma dimensions that are related to being in psychiatric treatment instead of relying on a general scale about professional help seeking such as the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) [82]. Third, this study distinguishes different sources of care, including informal care-providers, as little is known about the impact of stigma on informal help seeking attitudes [22].
In brief, we conclude that anticipated self-stigma and perceived public stigma have a differential impact on the perceived importance of formal and informal care. The self-concurrence of stereotypes about being in psychiatric treatment is negatively related to the perceived helpfulness of medical sources of formal care. Furthermore, being aware that other people hold stereotypes about former service users deters people from acknowledging the helpfulness of informal care.

2.6 Reference list

13. Mead GH: Mind, Self and Society. Chicago, IL, University of Chicago, 1934


55. Schneider SL: Measuring educational attainment in crossnational surveys: The case of the European Social Survey; in EDUC Research Group Workshop of the EQUALSOC network, 1997
[http://www.nuffield.ox.ac.uk/users/Schneider/pdfs/schn07.pdf]


3 Attitudes Toward Community Mental Health Care: The Contact Paradox Revisited


3.1 Abstract

Objective: Contact with people with mental illness is considered to be a promising strategy to change stigmatizing attitudes. This study examines the underlying mechanisms of the association between contact and attitudes toward community mental health care.

Methods: Data are derived from the 2009 survey “Stigma in a Global Context—Belgian Mental Health Study”, using the Community Mental Health Ideology-scale.

Results: Results show that people who received mental health treatment themselves or have a family member who has been treated for mental health problems report more tolerant attitudes toward community mental health care than people with public contact with people with mental illness. Besides, the perception of the effectiveness of the treatment seems to matter too. Furthermore, emotions arising from public contact are associated with attitudes toward community mental health care.

Conclusion: The degree of intimacy and the characteristics of the contact relationship clarify the association between contact and attitudes toward community mental health care.
3.2 Introduction

Intergroup contact has long been social psychology's and sociology's most promising strategy for changing stigmatizing attitudes (Corrigan & Penn, 1999; Corrigan, River, et al., 2001; Pinfold et al., 2003). When members of the general population have direct interaction with people with mental illness, they might experience people with mental illness as no different from other people. Accordingly, prejudices about people with mental illness are challenged (Holmes, Corrigan, Willimans, Canar, & Kubiak, 1999; Penn et al., 1994). Several divergent theoretical frameworks provide an explanation for this phenomenon. First, the theory of cognitive dissonance assumes that individuals alter their beliefs when they encounter information that is inconsistent with the stereotypes they hold (Festinger, 1957). Second, the recategorization theory (Gaertner, Mann, Dovidio, Murrell, & Pomare, 1990) claims that contact with an out-group member results in changes in the classification of that person. Instead of viewing the person with mental illness as one of 'them', he or she becomes one of 'us'. Third, the attribution theory states that interpersonal contact might change perceptions of controllability and inferences about personal responsibility (Corrigan, 2000).

However, this theoretical reasoning is not supported by sufficient empirical research (Desforges et al., 1991). The findings of empirical studies have been inconsistent. Some studies found that contact with people with mental illness decreases the desired amount of social distance from people with mental illness (Angermeyer & Matschinger, 1996; Hall, Brockington, Levings & Murphy, 1993; Ingamells, Goodwin & John, 1996; McKeon & Carrick, 1991; Vezzoli et al., 2001). Whereas, Phelan and Link (2004) reported that contact with people with mental illness might encourage a desire for greater social distance, if the public perceives people with mental illness as dangerous. Additionally, a range of prospective studies did not find any significant effect of contact on social distance (Arkar & Eker, 1992; Stuart & Arboleda-Florez, 2001). Consequently,
Brunton (1997) and Callaghan, Chan, Yu, Ching, and Kwan (1997) introduced the term ‘contact paradox’. Farina (1982) and Huxley (1993) put forward that the mere presence of contact is not sufficient to alter negative attitudes. Therefore, it is needed to examine which contact characteristics are associated with a desire for less social distance toward people with mental illness.

This study applies the concept of social distance to the context of the deinstitutionalization movement. Due to this movement, inpatient stays have been reduced and community mental health care facilities have been established, since community-based care is assumed to be intrinsically more humane, more therapeutic and more cost-effective than hospital-based care (Thornicroft & Bebbington, 1989). In Belgium, community mental health care refers to initiatives of sheltered living, psychiatric nursing homes and host families which are supported by professional services (Belgian Health Care Knowledge Centre, 2010). The theoretical rationale underlying this movement assumes that intensifying the public’s contact with people with mental illness provides an opportunity to facilitate social reintegration of people with mental illness into the community (Novella, 2008). Therefore, we will study the association between contact and the attitude toward community mental health care into more detail, by focusing on potential mechanisms that might modify this association.

First, it is crucial to take the type of contact into account (Angermeyer & Matschinger, 1996; Wolff, Pathare, Craig, & Leff, 1996). The contact hypothesis, originally developed by Allport (1954), suggests that contact will only reduce prejudice under certain conditions; contact has the best effect if it is personal, voluntary, intimate, and repeated over time (Gaertner et al., 1990; Kolodziej & Johnson, 1996; Sigelman & Welch, 1993). Ellison and Powers (1994) agree that the effect of contact is dependent on the level of intimacy of the relationship; only very close relationships are able to modify the prejudices that generate discrimination against people with mental illness. In sum, we distinguish between different types of contact and hypothesize that
contact with a higher degree of intimacy will be related to more positive attitudes toward community mental health care (H1).

Second, the characteristics of the contact relationship should be considered (Kolodziej and Johnson, 1996; Jorm & Oh, 2009; Martin, Pescosolido, Olafsdottir, & McLeod, 2007), since not every type of contact with people with mental illness has a positive outcome. A first example is a threatening public encounter with a stranger who appears to be mentally ill. The exposure to people who have mental health problems might activate emotional reactions such as fear, anger, or pity due to the incomprehensibility of mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003; Horwitz, 1982). Those emotional reactions are persistent and yield behavioral outcomes (Weiner, 1995); fear seems to lead to a desire for greater social distance (Angermeyer & Matschinger, 1996; Levey & Howells, 1995; Link & Cullen, 1986; Wolff et al., 1996), while pity is more likely to result in a preference for less social distance (Angermeyer & Matschinger, 1997; Corrigan et al., 2003; Martin, Pescosolido, & Tuch, 2000). A second example is having a family member who has a mental health problem, but in which case the mental illness has casted a cloud upon your relationship. Martin et al. (2007) emphasized that contact reduces the desired social distance, only if the outcome of the relationship is rewarding instead of causing distress. A third example is a friend with mental illness who relapses from time to time. Huxley (1993) noted that contact with someone who has been treated effectively for his or her mental illness is more likely to be associated with improved attitudes. In brief, we expect that the association between contact and the attitude toward community mental health care will depend on the characteristics of the contact relationship (H2).

In addition to contact, previous research has found a range of socio-demographic characteristics that determine the attitude toward community mental health care. Taylor and Dear (1981) pointed out that women, young people, more highly educated people, and people with a higher occupational status all seem to be more tolerant toward community mental health care. The
study of Song, Chang, Shih, Lin, and Yang (2005), confirmed the negative relationship between age and attitudes toward community mental health care, while Brockington, Hall, Levings, and Murphy (1993) validated the association between occupational status and attitudes toward community mental health care.

3.3 Methods

3.3.1 Sample and data

This study is based on data from the survey "Stigma in a Global Context—Belgian Mental Health Study" (2009). The survey was implemented by means of fully structured, face-to-face Computer Assisted Personal Interviews and questioned the attitudes toward people with mental illness and mental health care services among the general public. We used a multistage cluster sampling design to define a representative sample of the Belgian population. In stage 1, municipalities were weighted according to their number of inhabitants and 140 municipalities were selected, including the possibility of being selected more than once. In stage 2, 15 respondents were selected randomly within each municipality, based on data from the Belgian national register, representing the adult, non-institutionalized population. Of the target sample of 2100 people, 1166 respondents gave their informed consent and participated. Following the guidelines of the American Association of Public Opinion Research, the response rate is 56.1% (AAPOR Response Rate 1) and the cooperation rate amounts to 67.7% (AAPOR Cooperation Rate 3). A post-stratification weight factor was created to compensate for the effects of the sample design and non-response and to approximate the cross-classification of the census population count within gender, age and education.
3.3.2 Variables

DEPENDENT VARIABLE

When studying attitudes toward people with mental illness, many studies have adopted the CAMI scale (Community Attitudes toward the Mentally Ill) of Taylor and Dear (1981). The CAMI scale is based on the OMI scale (Opinions About Mental Illness) of Cohen and Struening (1962), but the number of items has been reduced and the scale has been adjusted to target the general population instead of professional care providers. This study used one specific subscale of the CAMI scale, namely the Community Mental Health Ideology-scale (CMHI) (Sévigny et al., 1999). This scale questions the acceptance of community mental health facilities and contrasts the therapeutic value of community care with the potential risks to local residents. For each of the 10 items, the respondents were asked to indicate the extent to which they agreed with the statement. The response format was a 5-point Likert scale with the following answer categories: strongly disagree / disagree / neutral / agree/strongly agree. A higher score is indicative of a more positive attitude toward community mental health care. In order to ensure the reliability and validity of the scale, the Cronbach’s Alpha was measured and we conducted an exploratory factor analysis. The internal consistency was very good (Cronbach’s Alpha = 0.86) and the principal components analysis revealed only one component (eigenvalue = 4.545).

INDEPENDENT VARIABLES

To distinguish between different types of contact, the respondents were asked a range of questions. Have you personally ever received treatment for a mental health problem? Has a relative of yours ever received treatment for a mental health problem? Has anyone within your circle of friends and acquaintances ever received treatment for a mental health problem? Have you ever seen someone who seems to have a serious mental health problem in a public space? If the respondent did not answer any of the aforementioned questions in the affirmative, he or she was assigned to the category ‘no contact at all’. In sum, we established five hierarchical
categories representing the type of contact with people with mental illness: (1) personal experience; (2) having a family member who has been undergoing psychiatric treatment; (3) knowing someone within their circle of friends and acquaintances who has been undergoing psychiatric treatment; (4) public contact; (5) no contact at all. If several categories applied to the respondent, the one representing the highest degree of intimacy was chosen.

To clarify the association between contact and the attitude toward community mental health care, we included a range of characteristics of public contact and interpersonal contact. If the respondents mentioned that they had met someone in public who seemed to have a mental illness, they were asked some additional questions regarding the characteristics of that contact: frequency and emotional reactions. The frequency of the public contact that had occurred ranged from ‘rarely’ and ‘occasionally’ through ‘frequently’. The questions related to emotional reactions included ‘How frightening do you find people that you see in public places that seem to have a serious mental health problem?’ and ‘How much sympathy do you feel for people that you see in public spaces that seem to have a serious mental health problem?’ The response categories were situated on a 4-point Likert scale ranging from 1 (not at all frightening/no sympathy at all) to 4 (very frightening/a great deal of sympathy). The respondents who mentioned that they had known someone (family member, friend or acquaintance) who received treatment for a mental health problem were asked subsequently what the closeness of the relationship was, whether the received treatment was perceived as effective and how much distress this person's mental health problem caused them. The closeness of the relationship ranged from 1 (not at all close) to 4 (extremely close). The questions related to the perceived effectiveness of the treatment and the level of distress had the following answer categories: ‘not at all’, ‘a little’, ‘quite a bit’, and ‘a great deal’. The perceived effectiveness of the treatment was recoded into two categories; if participants responded with ‘a great deal’ or ‘quite a bit’, they received the score of 1 , while those who replied with ‘a little’ or ‘not at all’ served as the
reference category. The level of distress was scored according to the aforementioned 4-point Likert scale.

**CONTROL VARIABLES**

As concerns *gender*, women received the score of 1 and men served as the reference category. *Age* was measured in years. *Education* was measured as the number of years of education people had completed. This is often used as a proxy variable for educational attainment (Schneider, 2007). *Employment status* is a categorical variable: people with a job (reference category) were compared with people who are unemployed, retired, or in another position (chronically ill or disabled, househusband/housewife, student, etc.).

3.3.3 Analysis

First, two descriptive analyses have been done to describe the study population (Table 20) and the different items of the dependent variable, the CAMI scale (Table 19).

To study the association between *type of contact* and attitudes toward community mental health care, we use the full sample which consists of all the respondents, whether they have had personal, interpersonal, public or no contact at all. After having deleted the missing cases list wise, the weighted full sample is comprised of 1104 respondents. We compare those with public contact with people with mental illness with more intense types of contact (interpersonal contact and personal experience) and with those with no contact at all (Table 20).

To study how the *characteristics of contact relationships* are related to the attitude toward community mental health care, we extracted two nested subsamples of the full sample. Subsample A zooms in on people with public contact. Those who have never met someone with mental illness in public are excluded from the sample, even if they personally received mental
health treatment or had interpersonal contact with someone who received mental health care. As a result, subsample A consists of 787 respondents. We study whether the attitude toward community mental health care depends on the emotional reactions that arise due to public contact with people with mental illness, controlled for the frequency of that public contact and the type of contact (only public contact serves as the reference category) (Table 21). Subsample B focuses on people who have someone in their family or circle of friends and acquaintances who has been treated for mental illness and amounts to 626 respondents. We examine whether the attitude toward community mental health care is dependent of the perceived effectiveness of the received treatment or the level of distress caused by the contact relationship, controlled for the closeness of the relationship and the type of contact (Table 22).

All models mentioned above were estimated in IBM SPSS Statistics 19 by means of linear regression models (Ordinary Least Squares), controlled for a range of demographics. The results of the weighted samples are presented. We report the unstandardized coefficients and the standard errors of the independent variables. The total explained variance of the model is mentioned at the bottom of the table.

The study was approved by the Privacy Commission for the ethical aspects related to the research. Furthermore, there are no known conflicts of interest and all authors certify responsibility for the manuscript.

### 3.4 Results

Table 20 presents the descriptives of the study population of the full sample and the nested subsamples A and B.
<table>
<thead>
<tr>
<th>Full sample (N=1104)</th>
<th>Sample of people who had public contact (N=787)</th>
<th>Sample of people who had interpersonal contact (N=626)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Dependent variable</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Independent variables |
|-----------------------|-----------------------------------------------|
| Control variables     |                                |          |          |                      |                                |          |          |                      |                                |          |          |
| Gender                |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Men                   |                                | 543       | 49.2     | 383                   | 48.7                             | 283       | 45.3     |
| Women                 |                                | 560       | 50.8     | 403                   | 51.3                             | 342       | 54.7     |
| Age                   |                                | 47.99 (17.869) | 18-94    | 45.97 (16.745) | 18-89    | 46.317 (16.585) | 18-93    |
| Years of education    |                                | 11.991 (3.600) | 0-24     | 12.335 (3.597) | 0-24    | 12.634 (3.562) | 0-24     |
| Employment status     |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Employed (ref.cat.)   |                                | 598       | 54.2     | 460                   | 58.5                             | 365       | 58.3     |
| Unemployed            |                                | 64        | 5.8      | 49                    | 6.2                              | 34        | 5.5      |
| Retired               |                                | 256       | 23.2     | 146                   | 18.6                             | 119       | 19.0     |
| Other                 |                                | 185       | 16.7     | 131                   | 16.7                             | 108       | 17.3     |
| Contact types         |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Personal experience   |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Interpersonal contact |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Family member received treatment | 291 26.4 | 233 29.6 | 281 44.8 |
| Friend or acquaintance received treatment | 217 19.7 | 169 21.4 | 207 33.1 |
| Public contact        |                                | 252       | 22.8     | 252                   | 32                                | /         | /         |
| No contact at all     |                                | 176       | 15.9     | /                     | /                                 | /         | /         |
| Contact conditions    |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Public contact        |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Frequency             |                                |           |          |                      |                                |          |          | 1.634 (0.715) | 1 - 3                        |
| Arising feelings of fear | 1.964 (0.726) | 1 - 4     |
| Arising feelings of pity | 2.968 (0.708) | 1 - 4    |
| Interpersonal contact |                                |           |          |                      |                                |          |          |                      |                                |          |          |
| Closeness             |                                |           |          |                      |                                |          |          | 2.788 (0.929) | 1 - 4                        |
| Level of distress     |                                |           |          |                      |                                |          |          | 2.675 (0.983) | 1 - 4                        |
| Perceived effectiveness of treatment | 0.564 (0.496) | 1 - 4 |

Table 18: Descriptives Study Population (weighted data, SGC-BMHS, 2009).
Table 19 illustrates the different items of the Community Mental Health Ideology-scale. We can conclude that around one fifth of our respondents hold the opinion that local residents may resist the location of mental health services in their neighborhood. One out of four respondents agrees that having mental patients living within residential neighborhoods might be good therapy but that the risks to residents are too great.

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree, neither disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community</td>
<td>21.8%</td>
<td>55.1%</td>
<td>11.9%</td>
<td>8.9%</td>
<td>2.2%</td>
</tr>
<tr>
<td>The best therapy for many mental patients is to be part of a normal community</td>
<td>22.4%</td>
<td>58%</td>
<td>12.4%</td>
<td>6.7%</td>
<td>0.5%</td>
</tr>
<tr>
<td>As far as possible, mental health services should be provided through community based facilities</td>
<td>13.2%</td>
<td>63.8%</td>
<td>14.8%</td>
<td>7.5%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Locating mental health services in residential neighborhoods does not endanger local residents</td>
<td>13.1%</td>
<td>52.3%</td>
<td>18.4%</td>
<td>14.2%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Residents have nothing to fear from people coming into their neighborhood to obtain mental health services</td>
<td>14.9%</td>
<td>56%</td>
<td>18.2%</td>
<td>9.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Mental health facilities should be kept out of residential neighborhoods</td>
<td>2.5%</td>
<td>13.5%</td>
<td>18.9%</td>
<td>55.3%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Local residents have good reason to resist the location of mental health services in their neighborhood</td>
<td>2.6%</td>
<td>16.3%</td>
<td>21.3%</td>
<td>49.5%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Having mental patients living within residential neighborhoods might be good therapy but the risks to residents are too great</td>
<td>3.4%</td>
<td>22.4%</td>
<td>30.5%</td>
<td>39.2%</td>
<td>4.4%</td>
</tr>
<tr>
<td>It is frightening to think of people with mental problems living in residential neighborhoods</td>
<td>2.2%</td>
<td>16.1%</td>
<td>18.1%</td>
<td>54%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Locating mental health facilities in a residential area downgrades the neighborhood</td>
<td>3.4%</td>
<td>19.8%</td>
<td>17.5%</td>
<td>50.0%</td>
<td>9.2%</td>
</tr>
</tbody>
</table>

Table 19: Community Mental Health Ideology scale.

The first research question refers to Table 20. We question whether the attitude toward community mental health care depends on the type of contact one has with people with mental
illness. The results in Table 20 indicate that those with personal experience (B= 1.377, SE= 0.608, p<0.05) and those who have a family member (B= 1.198, SE= 0.524, p< 0.05) who has been treated for mental health problems report more positive attitudes toward community mental health care, compared to those with only public contact. The attitudes of people who have a friend or acquaintance who received mental health treatment and people without contact do not seem to differ significantly from the attitudes of people with public contact with people with mental illness. In brief, the impact of contact on the attitude toward community mental health care depends on the degree of intimacy of the contact relationship.

<table>
<thead>
<tr>
<th>(Constant)</th>
<th>B</th>
<th>S.E.</th>
<th>***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (ref.cat.: Men)</td>
<td>-0.727</td>
<td>0.372</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.018</td>
<td>0.015</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>0.209</td>
<td>0.055</td>
<td>***</td>
</tr>
<tr>
<td>Employment status (ref.cat.: Employed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>-0.422</td>
<td>0.806</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>-1.191</td>
<td>0.645</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.234</td>
<td>0.528</td>
<td></td>
</tr>
<tr>
<td>Contact types (ref.cat.: Public contact)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>1.377</td>
<td>0.608</td>
<td>*</td>
</tr>
<tr>
<td>Family member received treatment</td>
<td>1.198</td>
<td>0.524</td>
<td>*</td>
</tr>
<tr>
<td>Friend or acquaintance received treatment</td>
<td>0.742</td>
<td>0.559</td>
<td></td>
</tr>
<tr>
<td>No contact at all</td>
<td>-1.124</td>
<td>0.601</td>
<td></td>
</tr>
</tbody>
</table>

R²= 0.051

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

Table 20: The association between contact variables and the attitude toward community mental health care among all respondents, controlled for socio-demographic variables (N=1104, weighted data, SGC-BMHS, 2009).
The second research question refers to Table 21 and Table 22. We question whether the characteristics of contact are associated with the attitude toward community mental health care. Table 21 shows that some characteristics of public contact do matter. Emotions that arise when meeting someone in public who seems to have a mental illness are significantly linked to the attitude toward community mental health care. The more people fear people with mental illness whom they have met in public, the more negative their attitudes appear to be (B = -1.641, SE= 0.282, p<0.001). On the contrary, the more people feel pity for people with mental illness, the more positive their attitudes toward community mental health care becomes (B = 1.796, SE= 0.290, p<0.001). The association between the frequency of public contact and the attitude toward community mental health care is not significant.
Table 21: The association between contact variables and the attitude toward community mental health care among the respondents who had public contact, controlled for socio-demographic variables (N=787, weighted data, SGC-BMHS, 2009).

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S.E.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Constant)</strong></td>
<td>29.421</td>
<td>1.59</td>
<td>***</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: Men)</td>
<td>−1.207</td>
<td>0.41</td>
<td>**</td>
</tr>
<tr>
<td>Age</td>
<td>0.027</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>0.272</td>
<td>0.06</td>
<td>***</td>
</tr>
<tr>
<td><strong>Employment status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: Employed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>−0.418</td>
<td>0.87</td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td>−2.141</td>
<td>0.74</td>
<td>**</td>
</tr>
<tr>
<td>Other</td>
<td>0.511</td>
<td>0.57</td>
<td></td>
</tr>
<tr>
<td><strong>Contact types</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ref.cat.: Only public contact)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>0.744</td>
<td>0.61</td>
<td></td>
</tr>
<tr>
<td>Family member received treatment</td>
<td>0.695</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>Friend or acquaintance received treatment</td>
<td>0.524</td>
<td>0.56</td>
<td></td>
</tr>
<tr>
<td><strong>Contact conditions of public contact</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency</td>
<td>0.521</td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Arising feelings of fear</td>
<td>−1.641</td>
<td>0.28</td>
<td>***</td>
</tr>
<tr>
<td>Arising feelings of pity</td>
<td>1.796</td>
<td>0.29</td>
<td>***</td>
</tr>
</tbody>
</table>

R²= 0.136

*: p < .05; *: p < .05; **: p < .01; ***: p < .001
Table 22 illustrates the association between the characteristics of interpersonal contact and the attitude toward community mental health care. The results show that if people perceive the received treatment as effective, they report a more positive attitude toward community mental health care \((B = 1.211, \ SE = 0.468, p<0.05)\). The level of distress that the relationship causes does not seem to make any difference and neither does the closeness of the relationship. In brief, our results indicate that the association between contact and attitudes toward community mental health care is dependent on the characteristics of that contact relationship.
<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>S.E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>34.394</td>
<td>1.54</td>
</tr>
<tr>
<td>Gender (ref.cat.: Men)</td>
<td>-1.220</td>
<td>0.47</td>
</tr>
<tr>
<td>Age</td>
<td>0.002</td>
<td>0.02</td>
</tr>
<tr>
<td>Education</td>
<td>0.197</td>
<td>0.06</td>
</tr>
<tr>
<td>Employment status (ref.cat.: Employed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>-0.725</td>
<td>1.04</td>
</tr>
<tr>
<td>Retired</td>
<td>-0.732</td>
<td>0.84</td>
</tr>
<tr>
<td>Other</td>
<td>0.986</td>
<td>0.64</td>
</tr>
<tr>
<td>Contact types (ref.cat.: Friend or acquaintance received treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>1.648</td>
<td>0.68</td>
</tr>
<tr>
<td>Family member received treatment</td>
<td>0.980</td>
<td>0.56</td>
</tr>
<tr>
<td>Contact conditions of interpersonal contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Closeness</td>
<td>0.194</td>
<td>0.30</td>
</tr>
<tr>
<td>Level of distress</td>
<td>-0.519</td>
<td>0.29</td>
</tr>
<tr>
<td>Perceived effectiveness of treatment</td>
<td>1.211</td>
<td>0.46</td>
</tr>
</tbody>
</table>

R²=0.063

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

Table 22: The associations between contact variables and the attitude toward community mental health care among the respondents who had interpersonal contact, controlled for socio-demographic variables (N=626, weighted data, SGC-BMHS, 2009).
In reference to the control variables, the results reveal that women seem to report more negative attitudes than men among the subsample of respondents with public contact (Table 21: $B = -1.207, SE = 0.417, p<0.01$) and among the subsample of respondents with interpersonal contact (Table 22: $B = -1.220, SE = 0.475, p<0.05$). The attainment of more years of education corresponds with more tolerant attitudes in all three samples (Table 20: $B = 0.209, SE = 0.055, p<0.001$; Table 21: $B = 0.272, SE = 0.061, p<0.001$; Table 22: $B = 0.197, SE = 0.069, p<0.01$).

Furthermore, among the subsample of respondents with public contact, the retired seem to report a less tolerant attitude toward community mental health care compared to the working population (Table 21: $B = -2.141, SE = 0.742, p<0.01$).

### 3.5 Discussion

As the success of the deinstitutionalization movement is dependent on an accepting host community, public opinion about community mental health care should receive greater scientific attention. Using data from the 2009 survey “Stigma in a Global Context—Belgian Mental Health Study”, we consider the attitude of the general Belgian population. Our study specifies the association between contact and attitudes toward community mental health care by means of comparing several types of contact with a different degree of intimacy and by means of considering characteristics of the contact relationship.

Before we discuss the main findings, we want to draw attention to the limitations and strengths of this study. First, due to the cross-sectional nature of the data, we cannot make any judgment about the causality of the association between contact and attitude change. Selection mechanisms may be at play; for example, people with stigmatizing attitudes will be less likely
to be friends with people with mental illness. Second, research has suggested that people who come into contact with people with mental illness within the scope of their professional or voluntary work report more positive attitudes toward them (Roth, Antony, Kerr, & Downie, 2000; Rousseau & de Man, 1998; Song et al., 2005; Alexander & Link, 2003). Nevertheless, this type of contact was not included in our study. Third, although research often considers emotions as moderators of the relationship between contact and attitudes (Angermeyer & Matschinger, 1997; Brockington et al., 1993; Corrigan et al., 2003; Rössler, Salize, & Voges, 1995), we only examined the independent effects of emotions on the attitude toward community mental health care. Fourth, the study of attitudes has often been criticized because of its tenuous link with behaviour (Fazzio & Zanna, 1981; Weiner, 1995). However, the meta-analysis of Kraus (1995) refuted this assumption. Petty and Cacioppo (1996) also defended attitudinal research, especially if the attitudes are based on direct experiences, which is the case with contact. Besides, Pinfold et al. (2003) emphasized that the attitude toward community psychiatry can be considered as a proxy measure of planned behavior. Fifth, according to the NIMBY-phenomenon (not-in-my-backyard), people might be tolerant toward community mental health care as long as those mental health care facilities are not located in their own neighborhood (Dear, 1992). Nevertheless, we did not control for the presence of a community mental health facility in the respondent’s neighborhood, as previous studies found that more than half of the residents were unaware of the presence of a mental health facility in their neighborhood (Dear & Taylor, 1982; Rabkin, Muhlin, & Cohen, 1984; Repper & Brooker, 2007).

Despite these limitations, our findings contribute to the study of attitudes toward community mental health care in several ways. First, compared with the amount of current research
linking contact with the general attitude toward people with mental illness (Addison & Thorpe, 2004; Hannigan, 1999; Kobau, Dilorio, Chapman, & Delvecchio, 2010; Kolodziej & Johnson, 1996; Papadopoulos, Leavy, & Vincent, 2002; Read & Law, 1999; Bruenton, 1997), the number of studies that applied the contact hypothesis to the theme of community mental health care is rather limited (Brockington et al., 1993; Lauber, Nordt, Haker, Falcato & Rössler, 2006; Reda, 1995; Song et al., 2005; Wolff et al., 1996; Taylor & Dear, 1981). Moreover, the generalizability of those studies’ findings has been restrained by their small and selective samples (e.g., Malvern & Bromsgrove, Brockington et al., 1993; North London, Reda, 1995; South London, Wolff et al., 1996). Second, Belgium is an interesting case to study, considering the fact that the deinstitutionalization movement is advancing at different paces in different countries. Belgium is occupying an intermediate position on the continuum of hospital-based care versus community-based care; the deinstitutionalization process has been implemented in the ‘90ies, but the country still counts one of the highest numbers of psychiatric hospital beds per 100,000 inhabitants within Europe (Bruffaerts, Sabbe, & Demyttenaere, 2004). While a range of countries already provide advanced community mental health care programs (such as the USA, UK and Germany), some 38% of the countries worldwide have no community based mental health services at all and still rely on large tertiary institutions as the common form of psychiatric care (Fakhoury & Priebe, 2002). Third, the Community Mental Health Ideology-scale is reliable and valid; several studies have extracted a factor related to community mental health ideology when using the CAMI scale (Brockington et al., 1993). Wolff et al. (1996) defined that factor as ‘fear and exclusion’, while Song et al. (2005) defined it as ‘rehabilitation in the community’. Fourth, several studies have mentioned that more attention should be devoted to contact characteristics (Alexander & Link, 2003; Couture & Penn, 2003; Jorm & Oh, 2009; Repper & Brooker, 2007). To fill this gap, our study compares several types of contact
with a different degree of intimacy and considers a range of characteristics of public and interpersonal contact. Although the amount of explained variance of the models was rather small, this is not uncommon (Alexander and Link, 2003).

The first main finding of this study is that the level of tolerance of people who had contact with people with mental illness depends on the degree of intimacy of that contact relationship. People who personally received mental health treatment and people who have a family member who has been treated for mental health problems report more positive attitudes toward community mental health care than people with only public contact with people with mental illness. The history of mental health service use is a common predictor of attitudes toward help seeking, as it is obvious that help seeking beliefs change after having received mental health treatment themselves. Furthermore, the fact that stigma processes are less powerful among family members of people with mental illness has been recognized by labeling theorists (Link et al. 1989). On the contrary, friends or acquaintances may be more apt to accept the negative stereotypes applied to people with mental illness due to their lower degree of intimacy of contact, since they are peripheral network members or have weaker ties (Alexander & Link, 2003; Couture & Penn, 2003; Perry, 2011). Next to this, no difference is found between people with public contact and people without contact. A possible explanation might be that public contact does not fulfill the preconditions of the contact hypothesis; public contact is neither personal, nor voluntary, nor intimate or repeated over time. We conclude that contact with a high degree of intimacy is necessary to disconfirm the negative stereotypes associated with people with mental illness. In other words, our results support the causation-hypothesis that contact has an impact on stigmatizing attitudes. As involuntary types of contact (public contact and having a family member who received mental health treatment) are also
associated with the attitude toward community mental health care, the selection-hypothesis, stating that people with stigmatizing attitudes are less likely to have contact with people with mental illness, does not hold. Besides, a range of experimental studies adhere to this line of thinking (Link & Cullen, 1986; Desforges et al., 1991; Reinke, Corrigan, Leonhard, Lundin, Kubiak, 2004), next to two studies using path analysis (Corrigan, Edwards, Green, Diwan & Penn, 2001; Corrigan, Green, Lundin, Kubiak & Penn, 2001) and a literature review of Kolodziej and Johnson (1996).

The second main finding of this study is that taking the characteristics of the contact relationship into account is important to develop a deeper understanding of the association between contact and attitudes toward community mental health care. On the one hand, a threatening encounter with a stranger who appears to have a mental health problem, is associated with a more hostile attitude toward community mental health care. As the frequency of public contact does not seem to have an impact on the attitude toward community mental health care, it appears that even one encounter with a stranger can have detrimental consequences, as stated by Wallach (2004). This finding is in accordance with the research of Corrigan, Green, et al. (2001) that demonstrated that the perception of dangerousness leads to the belief that people with mental illness should be institutionalized. On the other hand, we found that some contact characteristics are related to more positive attitudes toward community mental health care. Pity appears to be associated with more tolerant attitude toward community mental health care. We explain this finding by the fact that people who assume that a person with a mental illness has little control over his or her illness adopt a more sympathetic orientation toward community mental health care (Corrigan et al., 2003). Nevertheless, this finding is in contrast with the research of Addison and Thorpe (2004), who
dispute the finding that feelings of pity are indicative of a positive attitude toward people with mental illness. Next to this, our results state that people who experienced that a mental illness can be treated effectively are more tolerant toward community mental health care. This finding supports the proposition of Monahan (1992) who stated that emphasizing the efficiency of mental health care alleviates public anxiety.

In sum, this study underlines that the assumption that intergroup contact leads to more positive attitudes toward people with mental illness should not be taken for granted. This study reveals that not the mere presence of contact is associated with less stigmatizing attitudes, but that only contact relationships with a high degree of intimacy, contact relationships associated with positive emotions and contact relationships with a good prognosis are associated with more tolerant attitudes toward community mental health care.

Finally, it would be interesting to study the association between contact and social distance toward people with mental illness in a cross-national perspective, since the deinstitutionalization process has been implemented in various ways. A wave of criticism appeared in the literature regarding the deinstitutionalization movement, as people with mental illness who do live in the community, often live in sheltered environments with limited social contacts (Fakhoury & Priebe, 2007). Bitter, Entenfellner, Matschnig, Frottier and Fruhwald (2009) speak about de-hospitalization and Kelly and McKenna (2004) claim that trans-institutionalization or re-institutionalizations has occurred in some countries. The former refers to the fact that the decline in institutional care is not always complemented by the establishment of sufficient alternative community mental health care facilities. As a result, people with mental illness might end up without treatment, homeless or even imprisoned
(Eikelmann, 2000; Lamb & Bachrach, 2001). The latter term illustrates that the placement of people with mental illness merely shifts from one isolated context to another instead of facilitating social inclusion; the decrease in conventional psychiatric beds is supplemented with an increase in supported housing or forensic beds as worst-case scenario. In countries in which the afore-mentioned scenarios have occurred, the visibility of people with mental illness might lead to more social distance instead of social reintegration. Future research should investigate this hypothesis to inform mental health policy.

3.6 Reference list


4 Lay attitudes toward care provided in psychiatric hospitals: the role of social network composition


4.1 Abstract

**Background:** Not only is health behavior determined by agency, it is also subject to the influence of structural factors. By considering the composition of social networks, this study addresses one particular structural factor. We hypothesize that the health lifestyles of people in one’s social network, particularly the positive lifestyles of the (upper) middle class, may have a spillover effect on health attitudes, particularly toward mental health care provided in psychiatric hospitals.

**Methods:** Our data are derived from the survey Stigma in a Global Context–Belgian Mental Health Study (2009), which was conducted using face-to-face interviews among a representative sample of the general Belgian population and supplemented with a drop-off questionnaire (weighted N = 750). Social network composition is measured by means of a position generator, and service stigma refers to negative attitudes toward care provided in psychiatric hospitals (scale indicator and open-ended question). Linear and logistic regression models are estimated in SPSS.

**Results:** Someone who knows more people from the middle class express fewer negative attitudes toward care provided in psychiatric hospitals, beyond the impact of that person’s personal socioeconomic position.

**Conclusion:** For people from the lower social strata, having access to a heterogeneous network may serve as an enabling structural factor. From a health-promoting perspective, therefore, selective interventions should be targeted toward lower educated people who are situated in a
homogenous network, since service stigma constitutes an attitudinal barrier toward seeking psychiatric treatment among this group.

4.2 Introduction

Research that investigates health-related behavior is dominated by studies that concentrate on agency. However, people's choices with regard to health practices may be constrained or enabled by structural factors. This dialectic interplay between agency and structure is highlighted in the health lifestyle paradigm [1-4]. The centerpiece of this health lifestyle paradigm is Bourdieu's concept of habitus [5], which refers to cultural codes or routines which provide a practical, habitual, intuitively followed logic or system of dispositions, and stresses that health behavior is not always the result of rational, well-thought-out, conscious reasoning.

The social network in which one is embedded is one of those structural factors. Social networks can constrain health-related behavior by deterring people from consulting medical care; they can also enable health-related behavior by directing people toward certain treatment options. Suchman [6], for instance, posited that “cosmopolitan” networks, which incorporate a scientific belief system about health, led people toward medical care. “Parochial” networks led those people who prefer to rely on informal care away from medical care. Furthermore, Kadushin [7] stated that if people belonged to a social circle of “friends and supporters of psychotherapy,” it would facilitate their entry into mental health care. In addition, Freidson [8], McKinlay [9], and Horwitz [10] emphasized that beliefs held by social network members, who may or may not be skeptical about the efficacy of modern medicine, shape referrals to medical care. Several more recent studies have also indicated that social networks play a role in people's health behavior [11-13].
Therefore, in this study we take the social network composition into account. We argue that health lifestyles are socially stratified, since people who share similar positions in the social stratification system share similar sociocultural and economic conditions [14]. Following the learning generalization hypothesis [15], we reason that the lessons learned in the work domain can be carried over into other areas of life such as the health domain. For instance, members of the (upper) middle class tend to be intellectually challenged at work; they can be required to be creative and asked to direct the activities of subordinates. These job conditions strengthen the emphasis on self-direction and self-control, leading to more positive health lifestyles in which they take greater personal responsibility for controlling their health status [2,4,16-17]. In contrast, manual workers are often faced with narrow, repetitive tasks under close supervision. Consequently, the emphasis on conformity is strengthened and a more constrained and less optimistic view of the world is instilled, leading to less positive health lifestyles such as not engaging in preventive care due to a more passive or even fatalistic attitude [2,4,18-19].

The health norms of the (upper) middle class not only promote positive health lifestyles in their own stratum, but also set the tone for society as a whole. Specifically, they are able to expand their class-specific lifestyles across class boundaries [20]. In other words, the cultural health capital to which people have access to through their network resources may enable more positive health lifestyles. Particularly for people from the lower strata, bridging ties can be of relevance. Therefore, we hypothesize that people who know more people from the (upper) middle class may report more positive health attitudes.
The health behavior related attitudes this study examines are lay attitudes toward care provided in psychiatric hospitals. We focus on these particular attitudes since Belgium still has an extensive supply of available psychiatric hospital beds [21]. With 161 psychiatric hospital beds per 100,000 inhabitants, Belgium has the second highest number of psychiatric hospital beds in the world, after Japan. Based on the literature, we suggest that people may report negative attitudes toward care provided in psychiatric hospitals because they doubt the quality and effectiveness of psychiatric treatment [22-25]. These doubts may arise because of concerns about the heavy reliance on psychotropic drugs [26-30] or because of a perception that a psychiatric hospital is merely an institution of social control [31-32].

In addition to taking the social network composition into account, a range of sociodemographic characteristics need to be controlled for. First, the socioeconomic position of the respondent should be considered. Von dem Knesebeck et al. [33] indicated that education is the most crucial indicator of socioeconomic status in influencing attitudes toward psychiatric treatment. Furthermore, gender and age may influence attitudes toward the mental health care sector [34]. We also control for marital status. Finally, it is important to consider whether respondents are familiar with mental health services [35].

In sum, we consider social network composition to be a structuring factor, influencing lay attitudes toward care provided in psychiatric hospitals. We expect that individuals who know more people from the (upper) middle class will report less service stigma, net of their personal socioeconomic position. This research question will be addressed empirically by analyzing data derived from the survey Stigma in a Global Context–Belgian Mental Health Study.
4.3 Methods

4.3.1 Sample and data

Data are derived from the survey Stigma in a Global Context–Belgian Mental Health Study (2009), which examined the attitudes of the general public toward mental health care services and people with mental illness. Fully structured, face-to-face computer-assisted personal interviews were implemented among a representative sample of the non-institutionalized adult Belgian population. We obtained approval for the ethical aspects related to our research from the Privacy Commission.

To define the target population, a multistage cluster sampling design based on data from the Belgian National Register was used. In the first stage, municipalities were weighted according to their number of inhabitants. Subsequently, 140 municipalities were randomly selected. This process included the possibility of being selected more than once. In the second stage, 15 respondents were randomly selected from each municipality. This resulted in a target sample of 2,100 people. After providing a complete description of the study to the participants, written informed consent was obtained from a total of 1,166 respondents. Following the guidelines of the American Association of Public Opinion Research (AAPOR) [36], the response rate was calculated at 55.5% (AAPOR Response Rate 1); the cooperation rate was 66.9% (AAPOR Cooperation Rate 3).
After the interview, each respondent was asked to fill in a drop-off questionnaire and return it. In total, 841 people (72% of those who had been interviewed) did this. Since the questions referring to network resources were included in the drop-off questionnaire, we had to restrict our study sample to this final group. Additional analyses revealed that those who did not return the drop-off questionnaire were more likely to be lower educated, to be younger, single, retired or unemployed, and to have a lower income. Therefore, a post-stratification weighting procedure was applied in order to partly compensate for the effects of this selective non-response and to better approximate the cross-classification of the census population count with regard to gender, age, and education. The weighted sample consisted of 750 cases.

4.3.2 Variables

**INDEPENDENT VARIABLES**

The social network composition is measured by means of the position generator [37-40]. The position generator asks whether the respondent knows people in his or her social network who practice certain professions. Respondents were presented with a list of 15 professions that are salient in Belgium, ranging from house cleaner to physician. People could tick off one or more of the following response categories: “a family member has this occupation,” “a friend has this occupation,” and “an acquaintance has this occupation.” The definition of an acquaintance was added for conceptual clarity: an acquaintance is someone whose given name one knows and with whom one would have a short conversation when meeting him/her. The answering category “I do not know anyone who has this occupation” distinguishes people who lack network resources from missing answers. In this particular study, we included both strong and weak ties in the analyses, since strong ties are an important source of social support [41].
and weak ties are important in providing more diffuse health information, reaching people from more diverse social positions [38,42-43].

We began with Goldthorpe's scheme with 11 classes (EGP 11) [44], but we simplified this scheme into a threefold division (see Verhaeghe et al. [45] for more information). Manual labor, or the working class, is represented by knowing someone who is a house cleaner, assembly line worker, truck driver, police(wo)man, or electrician. The middle class refers to jobs such as clerical worker, owner of a small factory/firm, nurse, journalist, or teacher. The upper middle class involves jobs such as division head, manager of a large factory/firm, owner of a large factory/firm, lawyer, or physician. Finally, from each social class, the total number of occupations that one knows people from is added up, with five as the maximum.

The socioeconomic position of the respondent is assessed by means of education, occupational class, and income. Education is measured as the number of years of education completed, which is often used as a proxy variable for educational attainment [46]. Occupational class is assessed by asking respondents to describe their current or last main job in detail. Following Goldthorpe's [44] social class schema, we make the distinction between the working class (skilled, semi-skilled, or unskilled), the middle class (proprietors of small businesses, routine non-manual workers, higher grade technicians and lower grade professionals, administrators, and officials), and the upper middle class (proprietors of large businesses, managers and higher grade professionals, administrators, and officials). In addition, we include a category of non-active people (unemployed, retired, chronically ill, students, homemakers). Information about the net household income equivalent is created by adopting the OECD (Organization for Economic Co-operation and Development) scale, which gives a weight of 1 to the first adult in a
household, 0.5 to all other adults (> 14 years old), and 0.3 to children. Five categories are created for monthly income, including a missing category due to the high number (17.8%) of missing cases: less than €1000; €1000–€1500; €1500–€2000; more than €2000; and income missing.

DEPENDENT VARIABLES

Service stigma refers to the stigma that is attached to care provided in psychiatric hospitals. It is measured using two indicators: a 5-item scale and an open-ended question. The scale was developed by Verhaeghe [47] and the items are presented in Table 23. Each item is scored on a 5-point Likert scale and the original score of item (c) is reversed. The mean score for all items is calculated, so that higher scores reflect more negative attitudes toward care provided in psychiatric hospitals. The reliability of this scale is high (Cronbach’s Alpha = 0.861). Principal component analysis reveals only one factor with an eigenvalue of 3.236, which explains 64.7% of the variance. All items load highly on that factor: (a) 0.862, (b) 0.864, (c) 0.716, (d) 0.759, and (e) 0.810.

The open-ended question we used is “What do you think about the mental health care provided in psychiatric hospitals?” By means of content analysis, we have distinguished 200 responses that refer to negative attitudes toward care provided in psychiatric hospitals (26.6%), resulting in a dichotomous variable. Examples of negative attitudes are ‘they knock patients out with sedatives,’ ‘I think of straightjackets and padded cells,’ ‘it is like being in prison,’ ‘crazy people all in one place,’ ‘it is harmful that people are surrounded by people with other mental disorders, often more serious cases,’ ‘inhumane treatment,’ ‘there are too few health care
providers and they do not have enough time to carefully treat the patients; ‘they leave patients to their own devices; ‘taboo; and ‘should only be considered as last resort.’

**CONTROL VARIABLES**

We control for gender and age, which is measured as a continuous variable. Further, by considering marital status, we compare those who are married or cohabiting with those who are separated, divorced, widowed, or single. Finally, the level of familiarity with mental health services is controlled for. Familiarity is represented by the following categories: (1) personal experience (respondents have undergone psychiatric treatment themselves); (2) interpersonal contact (respondents know a family member, friend, or acquaintance who has received psychiatric treatment); and (3) no (inter)personal contact.

4.3.3 Analysis

The associations between people’s social network composition and service stigma are examined using two analytical models. We estimated a linear regression model to study the association between the social network composition and the scale indicator of service stigma. In Table 25, the unstandardized regression coefficients are given, accompanied by their standard errors and p-values. We estimated a logistic regression model to study the association between the social network composition and the open-ended indicator of service stigma. The odds ratios are also shown in Table 22, accompanied by their 95% confidence interval and p-values. All analyses are carried out using the statistical program SPSS Statistics 19.
4.4 Results

The descriptive statistics of the study population and the core dependent and independent variables are presented in Table 23.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>382</td>
<td>51</td>
</tr>
<tr>
<td>Male</td>
<td>367</td>
<td>49</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>510</td>
<td>68</td>
</tr>
<tr>
<td>Separated, divorced, widowed or single</td>
<td>240</td>
<td>32</td>
</tr>
<tr>
<td><strong>Familiarity with mental health services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal experience</td>
<td>110</td>
<td>14.7</td>
</tr>
<tr>
<td>Indirect contact</td>
<td>397</td>
<td>52.9</td>
</tr>
<tr>
<td>No (inter)personal contact</td>
<td>245</td>
<td>32.3</td>
</tr>
<tr>
<td><strong>Personal occupational status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manual working class</td>
<td>220</td>
<td>29.3</td>
</tr>
<tr>
<td>Middle class</td>
<td>349</td>
<td>46.6</td>
</tr>
<tr>
<td>Upper middle class</td>
<td>98</td>
<td>13.1</td>
</tr>
<tr>
<td>Unemployed</td>
<td>83</td>
<td>11</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1000 \leq x)</td>
<td>155</td>
<td>20.7</td>
</tr>
<tr>
<td>(1500 \leq x &gt; 1000)</td>
<td>217</td>
<td>29</td>
</tr>
<tr>
<td>(2000 \leq x &gt; 1500)</td>
<td>136</td>
<td>18.1</td>
</tr>
<tr>
<td>(x &gt; 2000)</td>
<td>130</td>
<td>17.3</td>
</tr>
<tr>
<td>Missing</td>
<td>112</td>
<td>14.9</td>
</tr>
<tr>
<td><strong>Institutional service stigma (open-ended)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>200</td>
<td>26.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mean +/S.D.</th>
<th>Min.-Max.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>49.31+17.49</td>
<td>18 - 93</td>
</tr>
<tr>
<td>Education</td>
<td>12.24+3.66</td>
<td>0 - 24</td>
</tr>
<tr>
<td>Social network composition</td>
<td>Number of people known from the Manual working class</td>
<td>2.82+1.54</td>
</tr>
<tr>
<td></td>
<td>Middle class</td>
<td>3.19+1.34</td>
</tr>
<tr>
<td></td>
<td>Upper-middle class</td>
<td>2.47+1.64</td>
</tr>
<tr>
<td><strong>Institutional service stigma (scale)</strong></td>
<td>2.53+0.80</td>
<td>1 - 5</td>
</tr>
</tbody>
</table>

Table 23: Descriptives study population and (in)dependent variables (N=750, weighted data, SGC-BMHS, 2009).
Furthermore, we added the descriptives of the service stigma scale in order to illustrate the attitudes of the general Belgian population toward care provided in psychiatric hospitals (Table 24). One out of twelve (8.2%) agrees that admission into a psychiatric hospital does not achieve good treatment outcomes (the statement is reversely scored). One in five (19%) confirms that admission into a psychiatric hospital makes mental health problems worse. Almost one third of the lay population (29.3%) does agree with the statement that once you are admitted into a psychiatric hospital, it is difficult to find your way out.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Fully disagree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Fully agree</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Admission into a psychiatric hospital makes mental health problems worse</td>
<td>12.0</td>
<td>44.0</td>
<td>25.0</td>
<td>13.5</td>
<td>5.5</td>
<td>2.56</td>
<td>1.04</td>
</tr>
<tr>
<td>(b) Admission into a psychiatric hospital does more harm than good</td>
<td>11.4</td>
<td>49.5</td>
<td>21.1</td>
<td>12.7</td>
<td>5.4</td>
<td>2.51</td>
<td>1.03</td>
</tr>
<tr>
<td>(c) Admission into a psychiatric hospital currently achieves good outcomes*</td>
<td>8.1</td>
<td>52.6</td>
<td>31.1</td>
<td>7.0</td>
<td>1.2</td>
<td>2.40</td>
<td>0.78</td>
</tr>
<tr>
<td>(d) Once you are admitted into a psychiatric hospital, it is difficult to find a way out</td>
<td>8.7</td>
<td>40.5</td>
<td>21.5</td>
<td>23.5</td>
<td>5.8</td>
<td>2.77</td>
<td>1.08</td>
</tr>
<tr>
<td>(e) Once you suffer from mental health complaints, it is better to stay away from psychiatric hospitals</td>
<td>15.6</td>
<td>50.2</td>
<td>17.0</td>
<td>12.5</td>
<td>4.6</td>
<td>2.40</td>
<td>1.04</td>
</tr>
</tbody>
</table>

*: reversely scored

Table 24: Descriptives service stigma (N=750, weighted data, SGC-BMHS, 2009).

The question whether the social network composition matters for people’s attitudes toward care provided in psychiatric hospitals is answered by Table 25. The results reveal that people who have more relatives, friends, or acquaintances from the middle class report less service stigma. The association is significant for both the scale indicator (B = -0.080, SE = 0.030, p < 0.01) and the open-ended indicator of service stigma (OR = 0.818, CI = 0.687–0.975, p < 0.05).
In addition to considering the social network composition, we also took the impact of people's personal socio-economic status into account to control for the mediator hypothesis. The findings show that the association between the social network composition and service stigma holds, beyond the effect of people's personal socioeconomic position. Finally, a striking result regarding the control variables is that people who have been in psychiatric treatment themselves report more negative attitudes toward care provided in psychiatric hospitals (scale: $B = 0.193$, $SE = 0.092$, $p < 0.05$; open-ended: $OR = 1.954$, $CI = 1.164–3.281$, $p < 0.05$). Older people also seem to express more service stigma (scale: $B = 0.008$, $SE = 0.002$, $p < 0.001$; open-ended: $OR = 1.014$, $CI = 1.003–1.025$, $p < 0.05$).
Table 25: The association between social network composition and institutional service stigma (N=750, weighted data, SGC-BMHS, 2009).
4.5 Discussion

Research that investigates health-related behavior is dominated by studies that concentrate on agency while neglecting structural factors. This article contributes to the research field by focusing on the role of structure by drawing attention to social network composition. Based on data derived from the survey Stigma in a Global Context—Belgian Mental Health Study, we examined the association between knowing people from different social classes and negative attitudes toward care provided in psychiatric hospitals (or service stigma), net of the impact of the respondent's personal socioeconomic position.

The current study makes several contributions to the research field. First, this study focuses on social networks in which an individual is embedded, whereas classical utilization models such as the Health Belief Model [48] or the SocioBehavioral Model [49] merely focus on individual characteristics (agency). By considering the social network composition, we take into account one example of a structural factor involved in shaping health behavior. Second, the position generator is a promising measure of network social capital. Moreover, the class division is relevant to the study of health lifestyles because of the socially stratified nature of habitus [2]. Third, service stigma is a crucial stigma dimension, since it might constitute an attitudinal barrier toward professional care-seeking. Nevertheless, it received little attention in previous research. The two different measurements of service stigma were significantly correlated (Pearson correlation: 0.481, p < 0.01) and the correlation between the scale-measure of service stigma and people's help-seeking intentions was relatively high (willingness to consult a psychiatrist: Pearson correlation: -0.400, p<0.01; willingness to be admitted in a psychiatric
hospital: Pearson correlation: -0.492, p<0.01). So we argue that service stigma is a good indicators of people's perceptions about specialist mental health care.

The main finding of this study is that a person knowing more people from the middle class is negatively associated with service stigma, net of the impact of that person's level of education. Thus it seems that middle class values are related to more positive attitudes toward care provided in psychiatric hospitals. This finding confirms that the deepest social class division is between the working class and the middle class [44]. Bourdieu [2] attributed this to the "distance from necessity," from people from a higher social stratum having the leisure time, the access to sources of authoritative knowledge, and the normative forms of consumption and resources needed to learn about appropriate health behavior. Recently, the gap between the working and the middle class has actually increased, due to job polarization [50] and greater job insecurity among the lower social strata because of the current economic crisis [51]. That the association with upper middle class resources is not significant may be explained by the two processes counterbalancing each other. On the one hand, some subgroups may report more positive health lifestyles due to greater mental health literacy; on the other hand, some subgroups may be more skeptical about the mental health care sector or may fear the loss of status that comes with stigmatization [52].

Our findings should, however, be viewed within the confines of the used data and measures. First, the study sample is selective in the sense that those who did return the drop-off questionnaire were more likely to be higher educated, to be employed, or to have a higher income. This could have an impact on our findings. Therefore, we did an additional control to check whether the mean score of the scale in the subsample, referring to those respondents
who filled in the drop-off questionnaire, differed significantly from the mean score of the scale in the full sample, referring to all those who were interviewed. This was not the case. Moreover, we weighted the data according to educational level. Second, our measure of social network composition, operationalized by means of the position generator, captures only one aspect of the influence of the social network on health-related behavior. Social support might also be of relevance. A study of Verhaeghe et al. [44], based on the same survey data, indicated that both social network resources and social support influence people’s subjective health status independent of each other.

From a health promoting perspective, the advantage of a social network perspective is that specific risk groups can be identified. In this context, lower educated people with a homogenous network should be targeted, as this vulnerable group seems to experience attitudinal barriers toward accessing specialist mental health care. Moreover, since general awareness is not high among this subgroup and prevention campaigns do not easily reach them, interventions targeting health empowerment should for example take place at work. However, currently, initiatives such as serving healthy food in the cafeteria, fitness clubs at work, or courses for life coaching or stress management are reserved (almost exclusively) for higher end jobs. Unemployed people should be reached by a better collaboration between public employment services and social services.
4.6 Reference list


36. AAPOR [http://www.aapor.org/Response_Rates_An_Overview1.htm]


155
5 The gender gap in mental health service use


5.1 Abstract

**Objective:** This study examines why men engage less in mental health service use, by studying how gender is performed in interactions, following the doing gender perspective. We hypothesize that seeking help for mental illness may constitute a gendered role conflict among men since help-seeking is associated with femininity. Therefore, we expect that men will recommend reliance on self-care options to other men, and in cases in which professional treatment is recommended, they will prefer medication to psychotherapy. We also expect that men will report greater stigmatizing attitudes.

**Methods:** The survey Stigma in a Global Context–Belgian Mental Health Study (2009) conducted interviews of a representative sample of the Belgian general population (N = 743). The vignette technique, depicting depressive and schizophrenic symptoms, was used. Multiple linear and logistic models were estimated in SPSS.

**Results:** In male vignettes, self-care is more likely to be recommended, both by male and female respondents. Men are less likely to acknowledge the helpfulness of psychotherapy and women rate psychotherapy as less helpful when judging a man compared to a woman. Men rate tranquilizers as more helpful for other males than that women do for other females. Furthermore, male respondents seem to ascribe more shame and blame to the situation.

**Conclusion:** The gender gap in mental health service use is due not only to men and their negative attitudes toward help-seeking, but also to structured social norms that are
reconstructed in interactions. Women also contribute to the maintenance of masculinity norms.

5.2 Introduction

There is a gender gap in mental health service use. Men make fewer visits to mental health professionals than women [1-6]. These gender differences are particularly pronounced with regard to general care, but decrease when it comes to specialist or residential care [7-8]. This gender gap in mental health service use cannot be explained by need [9]. There are no gender differences in the overall rates of psychopathology [10], yet men and women differ in types of symptoms. Women are more likely to internalize [11]; men are more likely to report externalizing disorders [12]. This study therefore will examine why men engage less in the use of mental health services. Explanations for gender differences have often been posited, but seldom tested empirically [4,9,13-14].

Following the doing gender perspective [15], we will look for an explanation by studying how gender is shaped in dyadic interactions. This social constructionist perspective emphasizes that gender differences do not reside in the individual, but are actively (re)produced in social transactions [16]. Men and women think and act in the ways they do not because of role identities or psychological traits but because of the adopted cultural conceptions about femininity and masculinity. People share common values about what behavior is considered appropriate for men and women [17]. During social interactions, people constantly engage in (re)creating a sense of gender difference. People know they will be judged in terms of their success or failure in meeting gendered societal expectations [15, 18]; therefore they try to match those expectations. In other words, gender is negotiated [19].
In the context of help-seeking for mental illness, the normative expectations guiding female and male behavior are of crucial importance [20]. Doing health is a form of doing gender [21]. Emotional expressiveness, caring for one's health, and asking for help are constructed as forms of idealized femininity [22-24]. Men are expected to be in emotional control and to appear strong, independent, and self-reliant [4, 9]. Consequently, to conform to the socially prescribed male role, men are encouraged to define themselves in opposition to women by suppressing their own health needs and by not seeking help [24-25]. Otherwise, a gendered role conflict might arise if men behave in a way that is not in accordance with the (hegemonic) idea of masculinity [22-26].

Because of this gendered role conflict, men may be reluctant to seek professional care and may fear greater stigma if they do seek help. With regard to treatment, men are more likely than women to choose to deal with mental illness on their own and to rely on self-care options [27], in part because they do not want to end up in a subordinate relationship to a health care provider [24,28]. If they do seek professional treatment, men seem to prefer a quick solution, one that is not time-consuming [29]. Consequently, we suggest that men more often opt for medical treatment instead of psychotherapy than women do. Men also report greater stigmatizing attitudes because of the role conflict between the male gender role and the patient role [30-33]. Stigma can be related to viewing personal weakness as the cause of mental illness [34]. Hence, when men disclose mental health problems, they may feel that they have failed and feel ashamed of their so-called weakness [35]. We suggest that men therefore attribute more blame and shame to mental illness.
We control for a range of other socio-demographic variables. Older people are more inclined to use general medical care [36] and to report more stigmatizing attitudes [37]. People with a higher level of education are more likely to contact mental health specialists [38], and are less likely to stigmatize people with mental illness [39]. Further, we control for marital status and employment status. In addition, it is important to consider whether respondents are familiar with mental health services, as this might influence treatment recommendations [40] and stigmatizing attitudes [41]. Last, but most important, we control for labeling, since women are known to have higher levels of mental health literacy and are also more likely to be labeled as deviant [42-43].

In sum, we will examine why men engage less in mental health service use by studying how gender is performed in interactions, following the doing gender perspective. We hypothesize that seeking help for mental illness might constitute a role conflict among men. We expect that men will recommend reliance on self-care to other males. And when they do prefer professional treatment, we assume that they will opt for medication to deal with it rather than discussing their problems in psychotherapy. Moreover, we hypothesize that men will report greater stigmatizing attitudes toward people in general and males in particular who suffer from mental illness.
5.3 Methods

5.3.1 Sample and data

Our data are derived from the survey Stigma in a Global Context–Mental Health Study (SGC-MHS), the first cross-national survey designed to examine attitudes toward mental health services and people with mental illness. Fully structured, face-to-face computer-assisted personal interviews were implemented among representative samples of non-institutionalized adult populations. Part of the interview consisted of questions referring to a vignette about a hypothetical person. The vignettes specifically selected for this study consist of unlabeled psychiatric case histories with symptoms that fulfill the criteria of the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association) regarding major depression or schizophrenia. In addition, socio-demographic variables are assessed by means of the ISSP indicators (International Social Survey Program).

To define the target population, we used a multistage cluster sampling design based on the data from the Belgian National Register. In stage 1, municipalities were weighted according to their number of inhabitants and 140 of them were selected randomly (with the possibility of being selected more than once), using the statistical program SPSS 19. In stage 2, the Belgian National Register data provided us with a random sample of 15 respondents within each of the 140 selected municipalities. This resulted in a target sample of 2,100 people. In total, 1,166 respondents participated. We followed the guidelines of the American Association of Public Opinion Research [44]. The response rate was 55.5% (AAPOR Response Rate 1) and the cooperation rate was 66.9% (AAPOR Cooperation Rate 3). Additionally, a post-stratification weight procedure was applied in SPSS 19 to approximate the cross-classification of the census
population count within gender, age, and education. As a result, our weighted sample consisted of 743 respondents.

5.3.2 Variables

**INDEPENDENT VARIABLES**

The gender of the respondent and the vignette person are considered in interaction, since we made the distinction between a male respondent who judges a male vignette, a female respondent who judges a female vignette (same gender), and a male respondent who judges a female vignette and a female respondent who judges a male vignette (cross-gender).

**DEPENDENT VARIABLES**

Attitudes toward self-care were assessed by asking for spontaneous treatment suggestions immediately after the description of the vignette had been read out. 'What should the vignette person do if he or she needs to do something?' Answers were open-ended, with three suggestions at the most. The responses were assigned to a range of predefined categories by the interviewers and if a response did not correspond with one of the predefined categories, it was coded verbatim. The verbatim responses were subsequently recoded independently by two raters through a content analysis procedure and were reconsidered if the raters disagreed. Accordingly, dichotomous variables were created. For this study, only the self-care option was considered. Attitudes toward psychotherapy and tranquilizers were assessed by asking the respondent whether they thought that certain treatment options were helpful. The answering categories were situated on a 7-point Likert scale, ranging from very harmful to very helpful.
Stigmatizing attitudes were assessed by means of the stigma dimensions ‘blame’ and ‘shame’. Blame refers to a person attributing the situation of the vignette subject to a weak character or lack of willpower. The original 4-point Likert scale was dichotomized. Shame refers to the opinion that the vignette person should be embarrassed about his/her situation. This original 4-point Likert scale was also dichotomized.

**CONTROL VARIABLES**

‘Age’ is measured as a continuous variable. ‘Education’ is measured as a categorical variable, referring to either primary, lower secondary, higher secondary, or tertiary education. ‘Marital status’ refers to being married or cohabiting, separated, divorced, widowed, or single. ‘Employment status’ compares the employed population with those who are unemployed, retired, or who are students or homemakers. The ‘level of familiarity’ with mental health services is categorized as follows: (1) personal experience (respondents have had psychiatric treatment themselves), (2) interpersonal contact (respondents know a family member, friend, or acquaintance who has received psychiatric treatment), and (3) no (inter)personal contact. Furthermore, to assess labeling, the following question is used: ‘How likely is it that the vignette person is experiencing a mental illness?’ This item is scored on a 4-point Likert scale. In addition, we also control for the in-group/out-group status of the vignette. For example, in Belgium and Germany, the out-group status was given the Turkish nationality, as they represent one of the largest ethnic minority groups. If the vignette subject suffered from major depression, he/she receives the score 1; symptoms of schizophrenia constitute the reference category.
5.3.3 Analysis

First, the descriptives of the whole study population and the dependent variables are illustrated in Table 26. Second, in Table 27, the gendered interactions between the respondent and the vignette person are linked to treatment recommendations. Finally, the gendered interactions are associated with stigmatizing attitudes in Table 28. With regard to self-care options and the stigma dimensions blame and shame, logistic regression models are estimated. The odds ratios are shown, accompanied by their 95% confidence interval and p-values. Concerning the helpfulness of psychotherapy and tranquilizers, linear regression models are estimated and the unstandardized regression coefficients are reported, accompanied by their standard errors and p-values. All analyses are carried out using the statistical program SPSS Statistics 19.
5.4 Results

The descriptives of the study population and independent variables are presented in Table 26.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>363</td>
<td>48.8</td>
</tr>
<tr>
<td>Women</td>
<td>380</td>
<td>51.2</td>
</tr>
<tr>
<td>Married or Cohabiting</td>
<td>470</td>
<td>63.2</td>
</tr>
<tr>
<td>Divorced, separated, widowed or single</td>
<td>273</td>
<td>36.8</td>
</tr>
<tr>
<td>Employed</td>
<td>393</td>
<td>52.9</td>
</tr>
<tr>
<td>Unemployed, retired, disabled, student or homemaker</td>
<td>350</td>
<td>47.1</td>
</tr>
<tr>
<td>Personal experience</td>
<td>115</td>
<td>15.5</td>
</tr>
<tr>
<td>Indirect contact</td>
<td>399</td>
<td>53.7</td>
</tr>
<tr>
<td>No contact</td>
<td>229</td>
<td>30.8</td>
</tr>
<tr>
<td>Recommending self-care</td>
<td>152</td>
<td>20.4</td>
</tr>
<tr>
<td>Blame</td>
<td>294</td>
<td>39.5</td>
</tr>
<tr>
<td>Shame</td>
<td>429</td>
<td>57.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Mean+SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>48.51+-18.05</td>
<td>18-94</td>
</tr>
<tr>
<td>Education</td>
<td>11.93+-3.70</td>
<td>0-24</td>
</tr>
<tr>
<td>Helpfulness of psychotherapy</td>
<td>5.86+-1.00</td>
<td>2-7</td>
</tr>
<tr>
<td>Helpfulness of tranquilizers</td>
<td>4.68+-1.45</td>
<td>1-7</td>
</tr>
</tbody>
</table>

Table 26: Descriptives of the study population and the independent variables  (N=743, weighted data, SGC-BMHS, 2009).

A first potential explanation of why men engage less in mental health service use is that they prefer self-care options. The results in Table 27 regarding treatment recommendations show that the subjects of the male vignettes are more likely to be advised to rely on self-care options, both by male and female respondents. A second hypothesis regarding help-seeking attitudes was that if professional treatment would be preferred, men would opt for medication rather than psychotherapy. Our findings indicate that male respondents are less likely to
acknowledge the helpfulness of psychotherapy, both for male and female vignettes. Moreover, female respondents are less inclined to rate psychotherapy as a helpful treatment option when considering a male vignette versus a female vignette. Additionally, male respondents are more likely to rate tranquilizers as helpful when making recommendations for a male vignette, compared to female respondents making a similar recommendation for a female vignette.

<table>
<thead>
<tr>
<th></th>
<th>Self-care (N=743)</th>
<th>Psychotherapy (N=741)</th>
<th>Tranquilizers (N=741)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>B</td>
</tr>
<tr>
<td>Male respondent &amp; Male vignette</td>
<td>2.375</td>
<td>1.357-4.155</td>
<td>** -0.211</td>
</tr>
<tr>
<td>Female respondent &amp; Male vignette</td>
<td>2.152</td>
<td>1.247-3.714</td>
<td>** -0.207</td>
</tr>
<tr>
<td>Male respondent &amp; Female vignette</td>
<td>1.262</td>
<td>0.691-2.305</td>
<td>-0.341</td>
</tr>
<tr>
<td>Age</td>
<td>0.998</td>
<td>0.987-1.010</td>
<td>-0.004</td>
</tr>
<tr>
<td>Education</td>
<td>0.923</td>
<td>0.873-0.976</td>
<td>** 0.019</td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>0.699</td>
<td>0.468-1.045</td>
<td>0.031</td>
</tr>
<tr>
<td>Employed</td>
<td>1.005</td>
<td>0.639-1.579</td>
<td>-0.012</td>
</tr>
<tr>
<td>Personal experience</td>
<td>0.907</td>
<td>0.484-1.701</td>
<td>0.157</td>
</tr>
<tr>
<td>Indirect contact</td>
<td>1.331</td>
<td>0.865-2.049</td>
<td>-0.098</td>
</tr>
<tr>
<td>Labeling as mental illness</td>
<td>0.746</td>
<td>0.595-0.937</td>
<td>* 0.236</td>
</tr>
<tr>
<td>Depression vignette</td>
<td>0.934</td>
<td>0.637-1.368</td>
<td>-0.005</td>
</tr>
<tr>
<td>Out-group status vignette</td>
<td>0.656</td>
<td>0.451-0.955</td>
<td>* 0.02</td>
</tr>
</tbody>
</table>

*: p<.05. **: p<.01. ***: p<.001
a: ref.cat.: Female respondent & Female vignette
b: ref.cat.: Single or divorced or widowed
c: ref.cat.: Unemployed or retired or disabled or student or homemaker
d: ref.cat.: No (inter)personal contact
e: ref.cat.: Schizophrenia vignette
f: ref.cat.: In-group status

Table 27: Gendered interactions related to treatment recommendations (weighted data, SGC-BMHS, 2009).

Furthermore, we examined men’s stigmatizing attitudes. Table 28 shows that male respondents seem to consider the situation of male vignettes more shameful than female
respondents considering the situation of female vignettes. Also, male respondents seem to attribute more blame to female vignettes than female respondents attribute to female vignettes.

<table>
<thead>
<tr>
<th></th>
<th>Shame OR</th>
<th>95%CI</th>
<th>Blame OR</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male respondent &amp; Male vignette</td>
<td>1.57</td>
<td>1.010-2.441</td>
<td>1.338</td>
<td>0.851-2.104</td>
</tr>
<tr>
<td>Female respondent &amp; Male vignette</td>
<td>1.157</td>
<td>0.758-1.764</td>
<td>1.270</td>
<td>0.816-1.978</td>
</tr>
<tr>
<td>Male respondent &amp; Female vignette</td>
<td>1.326</td>
<td>0.855-2.057</td>
<td>1.680</td>
<td>1.071-2.635</td>
</tr>
<tr>
<td>Age</td>
<td>1.006</td>
<td>0.996-1.016</td>
<td>1.009</td>
<td>0.998-1.019</td>
</tr>
<tr>
<td>Education</td>
<td>1.046</td>
<td>0.999-1.096</td>
<td>0.898</td>
<td>0.856-0.942</td>
</tr>
<tr>
<td>Married or cohabiting</td>
<td>1.231</td>
<td>0.884-1.713</td>
<td>0.973</td>
<td>0.692-1.368</td>
</tr>
<tr>
<td>Employed</td>
<td>0.968</td>
<td>0.666-1.406</td>
<td>1.053</td>
<td>0.718-1.544</td>
</tr>
<tr>
<td>Personal experience</td>
<td>0.603</td>
<td>0.374-0.973</td>
<td>0.489</td>
<td>0.286-0.834</td>
</tr>
<tr>
<td>Indirect contact</td>
<td>1.186</td>
<td>0.833-1.687</td>
<td>1.249</td>
<td>0.875-1.783</td>
</tr>
<tr>
<td>Labeling as mental illness</td>
<td>1.459</td>
<td>1.206-1.764</td>
<td>0.902</td>
<td>0.746-1.091</td>
</tr>
<tr>
<td>Depression vignette</td>
<td>1.135</td>
<td>0.830-1.551</td>
<td>0.955</td>
<td>0.693-1.315</td>
</tr>
<tr>
<td>Out-group status vignette</td>
<td>0.944</td>
<td>0.696-1.280</td>
<td>1.067</td>
<td>0.783-1.456</td>
</tr>
</tbody>
</table>

*: p<.05. **: p<.01. ***: p<.001

\( ^{a} \): ref.cat.: Female respondent & Female vignette

\( ^{b} \): ref.cat.: Single or divorced or widowed

\( ^{c} \): ref.cat.: Unemployed or retired or disabled or student or homemaker

\( ^{d} \): ref.cat.: No (in)direct contact

\( ^{e} \): ref.cat.: Schizophrenia vignette

\( ^{f} \): ref.cat.: In-group status

Table 28: Gendered interactions related to stigmatizing attitudes (N=738, weighted data, SGC-BMHS, 2009).

In addition, the control variables reveal that older people are more inclined to rate tranquilizers as helpful and that higher educated people are less predisposed to recommend self-care options. People who have been in psychiatric treatment perceive tranquilizers to be more helpful and report less stigmatizing attitudes than those who have not. Next to this, people who label the situation of the vignette subject as mental illness are less likely to
recommend self-care, while they are more likely to acknowledge the helpfulness of psychotherapy and to agree that the vignette person should be embarrassed. Finally, when people have to judge someone with an out-group instead of an in-group status, they seem to be less inclined to recommend self-care.

5.5 Discussion

Research has consistently found that men report less mental health service use [1-6]. However, the reasons for this gender gap remain unclear. This study makes a contribution to the research field by empirically testing a range of potential explanations. We start out from the doing gender perspective [15] and suggest that gender differences are due to the role conflict that men may experience when seeking help for mental illness, resulting in differences in treatment recommendations and stigmatizing attitudes. This study is carried out using data from the SGC-MHS survey, which questioned a representative sample of the general population in Belgium.

The first strength of this study is that a representative sample of the Belgian sample is examined; other research examining the theme of gender differences in mental health service use often relies on selective samples, such as a student sample [45-46]. Second, although the interaction between the respondent and the vignette subject is not a real social interaction, the advantage of this approach is that many cases can be questioned through randomly varying the gender of the vignette subject. Third, in particular, gender differences in stigmatizing attitudes have received relatively little attention. When they were studied, stigma dimensions such as social distance tended to be the focus [13], which measures the perception that men exhibit
more dangerous behavior and therefore explains why men experience stronger rejection [14], but does not capture the gendered role conflict.

The main finding of the current study is that not only men ‘perform’ gender in the sense that they report more negative attitudes toward professional help-seeking, but that also women (re)construct masculinity norms by giving different treatment advice to a man compared to another woman. Men report less positive attitudes toward the helpfulness of psychotherapy and advise male vignettes to rely on self-care options. Yet women also contribute to the maintenance of the role conflict between the male role and the patient role by rating psychotherapy as less helpful for men and by recommending self-care to men. It is striking that although women are more psychologically minded [47-50], their acknowledgment of the helpfulness of psychotherapy depends on the gender of the person they are giving advice to.

Furthermore, men seem more likely to rate tranquilizers as a helpful option for other men in comparison to women who gave advice to other women. This finding is in line with the study by Ettorre, Klaukka, and Riska [51] that showed that the lay referral system was an important channel of introduction to psychotropic drug use, especially for men. One potential explanation is that men just want to be able to continue in their work role, so drugs may provide a quick solution [21,29].

Additionally, our results concerning stigma indicate that men seem to attribute more shame and blame to mental illness than women do. Men consider suffering from mental illness as more shameful than women do, particularly when a male vignette subject is dealing with mental illness. This is consistent with the finding of an older study by Phillips [52] that
indicated that people more strongly rejected cases that had to do with men rather than women. Shame can also be perceived as a proxy for self-stigma [53]; thus this finding is consistent with the study by Pederson and Vogel [30]. Additionally, male respondents seem to ascribe more blame to female vignette subjects, compared to women judging other female vignettes.

This has implications for both informal and formal care. Women in general pay attention to not only their own health, but also to the health of their partner and children [54]. They are a crucial source of lay referral. Yet our findings show that masculinity norms also seem to influence women’s mental health treatment recommendations in a detrimental way. Regarding formal care, empirical research has shown that the gender of the patient influences the amount and type of treatment provided by physicians, independent of objective symptoms [55]. Clinicians were less likely to identify the presence of depression in men [56], resulting in fewer prescriptions for psychotropic drugs for men compared to women [57-59].

Finally, we address a limitation of the study and give a suggestion for future research regarding this theme. We acknowledge that we did not explicitly consider people’s adherence to traditional masculinity norms. Multiple beliefs about masculinity exist [60] that depend, among other things, on socio-economic status [61] and ethnicity [62]. Previous research pointed out that those who score higher on measures of traditional masculinity ideology seem to have more negative attitudes toward help-seeking for mental illness [63]. We argue that future research should link this research question to substance abuse, such as alcohol disorder or drug use, since Rosenfield [64] suggested that men experience less rejection when suffering from externalizing disorders that are more in line with stereotypical masculine behavior.
5.6 Reference list


44. AAPOR [http://www.aapor.org/Response_Rates_An_Overview1.htm]


Part III.

GENERAL CONCLUSION
1 Implications for sociological theory and empirical research

In the following section, we discuss the implications of our research findings for sociological theory and empirical research.

1.1 Redefining unmet need

The psychiatric profession describes the phenomenon that people who meet a diagnosis of mental illness do not seek appropriate professional help as ‘unmet need’ (Kessler et al., 1999). However, this reflects a medical model bias (Gold, 1977). Conceptualizing help-seeking as seeking or not seeking professional care is based on notions of superiority of medical care over other sources of care. The problem is that other non-professional sources of care are lumped together. No distinction is being made between those who do seek any non-professional source of care (such as informal care, self-care or alternative healing) and those who do nothing to cope with the mental illness symptoms.

Therefore, by studying the spontaneous treatment recommendations, we acknowledge that a part of the lay people recommends non-professional sources of care. In other words, our empirical research shows that the absence of professional treatment does not necessarily imply the absence of care. Part of help-seeking activities take place outside the professional care sector. As Jorm (2004) highlights in the ‘overlapping waves of action’ model, the first of three waves of action involves the use of self-help interventions and the reliance on informal support from family and friends. The Network Episode Model of Pescosolido (1992) also underlined the help-seeking options outside the field of modern medicine. In conclusion, informal care and self-care should be brought much more into the picture in future research.
1.2 Measuring the impact of cultural beliefs

In traditional research, using prompted endorsements of certain treatment options, the impact of cultural beliefs has been underestimated. Once need has been controlled for, cultural predispositions did not consistently show to have an impact on the use of mental health services. Yet this standard approach—in terms of placement and format of questions—may not be adequate to capture the impact of cultural beliefs on help-seeking attitudes.

We have tried to capture the impact of cultural beliefs on utilization by reconsidering measures and methods. Instead of prompted endorsements, we relied on spontaneous help-seeking recommendations. The latter refers to open-ended questions that are better able to capture people’s cultural toolbox. This approach resulted in preference rates that were better aligned with actual utilization rates. In sum, we argue that utilization research needs a specific methodological approach in order to reveal the role of culture.

1.3 Labeling theory

With this dissertation, we can contribute to the labeling theory in three ways.

First, our results reveal that also informal labeling has an impact on people’s help-seeking attitudes. Whereas in the labeling theory the emphasis lies on official labeling through treatment.
However, it seems that people who fear being labeled by people from their social network, avoid talking about those problems with family and friends. This is a crucial problem, since people usually enter professional care through the preliminary labeling of ‘unofficial’ labelers such as family and friends. This is the core idea of the ‘lay referral system’ of Freidson (1970). The mental health literacy of this lay population has risen. This occurred partly due to the e-health movement by which medical knowledge has become more available and is no longer limited to the professional scene (Nettleton, 2004). Therefore, the association between informal labeling by lay people and stigma should receive more attention in future research.

Secondly, our findings draw attention to the fact that someone who is or has been in treatment suffers from stigma. Our measures of treatment stigma, public stigma and self-stigma indicate that the label of being a former mental patient has detrimental consequences. Goffman (1961) already acknowledged that an individual’s social position after (institutional) treatment would never be quite what it was prior to treatment. He argued that inpatient care could stigmatize individuals and prevented their return to society. He considered asylums as ‘total’ institutions with an unfavorable status. In addition, Sibicky and Dovidio (1986) showed that people who were labeled as having received counseling services were rated less favorably than those who were not treated. Also more recent research findings confirmed that being in treatment is particularly associated with stigmatized reactions (Reynders et al., 2009). Ben-Porath (2002) indicated that individuals described as seeking help for depression were rated as more emotionally unstable, less interesting, and less confident than those individuals seeking help for physical problems. Therefore, future research should devote more attention to stigma toward people who are or have been in psychiatric treatment instead of using only stigma dimensions that refer to people who merely report mental illness symptoms.
Thirdly, our findings confirm the assumption that the impact of stigma depends on the source of care that is considered (Barney et al., 2006; Yap, Wright & Jorm, 2011). Our results reveal that care provided by a psychiatrist seems to be highly associated with self-stigma. Care provided by a general-care provider appears to be also related to self-stigma, but to a lesser extent. Care provided by a non-medical specialist appears not to be linked to self-stigma.

Phillips (1963) was the first to indicate that seeking help from a psychiatrist was more rejected than seeking help from a general physician for the same symptoms. The differential impact of self-stigma depending on the source of care might be explained by the differential risk of being labeled as someone in treatment. Seeking help from a psychiatrist is less ‘anonymous’ than consulting a general practitioner. These findings are in line with a study by Verhaeghe and Bruynooghe (2007), which indicated that service users who were treated in a psychiatric hospital expected to experience more social rejection and stigma expectations compared with those being treated in psychiatric wards of general hospitals. In sum, these findings add an important nuance to the labeling theory. We have found that stigma through labeling can occur to a different degree and that it depends on the type of care.

1.4 Network theory

Network theorists have documented the importance of social relationships that take place outside bounded social groups. They underline that people their social characteristics are only good proxies for social networks under conditions of network homogeneity (Coleman, 1990). When
heterogeneous networks occur, the importance of weak ties is crucial as weak ties are potential bridging ties. Through weak ties people get access to more diverse and more unique information (Granovetter, 1973; Lin, 2001). Accordingly, we did not only rely on personal characteristics of the respondent, but we also took the composition of the social network into account. Our results reveal that having access to more resources of the middle class is beneficial for people’s attitudes toward professional mental health care. So we stress that people’s personal socio-economic position is not too deterministic. There is room for variation by accumulating different types of capital (Cockerham et al., 1997; Williams, 1995; Bourdieu, 1986).

The fact that only middle class-resources and not upper-middle class resources seem to be significantly related to help-seeking attitudes is in accordance with Bourdieu’s distinction between different types of capital (1986). He argued that the space of social positions is organized by two crosscutting principles of differentiation, namely economic and cultural capital. The latter term refers to non-financial social assets that promote social mobility beyond economic means. Cultural capital serves as a toolkit of resources that can be used to construct strategies of action (Swidler, 1986). Contemporary medical sociologists have defined the values, behavioral norms, knowledge and operational skills that are available to people for acting in favor of their health as cultural health capital (Abel, 2008; Shim, 2010). The upper-middle class seems to possess much economic capital but fewer cultural assets. The capital of the middle class appears to be preeminently cultural and has the biggest impact on help-seeking attitudes, as our empirical study indicated. This nuance adds something to the health lifestyle paradigm, which considers both the middle as well as the upper-middle class as representing the healthiest lifestyles.
With regard to empirical research, it is interesting to remember that we did not use the position generator as merely an indicator of size of social network. Instead, we focused upon the resources available in the network through distinguishing different social classes. The link between health lifestyles and social class structure fits Bourdieu’s (1977) idea that dispositions to act are constructed through socialization and experience, with class position providing the social conditions for this process. The class-oriented nature of the habitus underlines that many forms of health behavior are unconsciously transmitted and reproduced.

1.5 Gender theory

Gender norms are absolutely not fixed. For example, over time women have moved into fields and jobs that were previously dominated by men. However, men have been much slower to pursue jobs in the fields where women were predominantly active. Following the expectations states theory (Ridgeway, 1991), we argue that men are not stimulated to endorse female traits, since the latter appears to be associated with lower status. Our results confirm that men are recommended less to seek professional help. Instead, they are stimulated to cope with the situation on their own, honoring their sense of mastery. Also men who express mental illness symptoms seem to be stigmatized to a higher degree, in contrast to being in emotional control, which is highly valued among men. In general, it seems that male traits still seem to incorporate more symbolic capital than female traits. Men who perform behavior that is seen as feminine suffer from enduring stigma.

Translating this to empirical research, it seems interesting to put gender in a relational perspective. The same gender or mixed gender settings provide additional information about how gender is being
performed in certain situations. The vignette technique that we applied has the advantage that many cases of same-gender or cross-gender interaction can be studied. This approach stresses that gender norms are not innate characteristics, but are (re)created both by male and female respondents. Women for instance also help to maintain masculinity norms by recommending self-care instead of professional care to deal with mental health symptoms. An experiment of Loring and Powell (1988) regarding a patient-practitioner interaction revealed that female vignette subjects were more likely to be diagnosed with depressive disorder by male than by female psychiatrists, indicating that a mixed gender setting does lead to different outcomes.

1.6 Contact hypothesis

Our research findings confirm that negative intergroup contact can be a more powerful predictor of prejudice than positive contact, because it makes people’s beliefs about out-group members more salient during the encounter. Our results reveal that people who encounter a stranger who seems to report mental illness symptoms and who arouses emotions of fear appear to report more prejudice, even if the encounter occurs only rarely. Also people who personally know someone who has been in treatment seem to report more prejudice in case the treatment did not help. This finding is in line with the research of Paolini, Harwood, and Rubin (2010) and Barlow et al. (2012). So the potential negative side-effect of contact should not be ignored, particularly in the case of people with mental illness. In case of the latter group, the risk remains of showing bizarre behavior due to their pathology.
2. Limitations

In the following paragraphs, we will elaborate on the potential limitations of the empirical studies in this dissertation.

2.1 Cross-sectional design

This dissertation studied cross-sectional data. As a consequence, we are unable to make any claims about causality. With regard to the study on the conceptualization of mental illness and help-seeking attitudes, we can confirm that the medical model is associated with a greater likelihood to recommend professional care, but we cannot state that medicalization causes more professional help-seeking. We controlled for selection mechanisms that might be at play by taking the familiarity with mental health services into account. Considering the latter helped us to rule out the impact of people’s (negative) experiences on people’s beliefs. However, the only way to clearly outline the causal relationship between medicalization and people’s attitudes is to measure people’s attitudes before and after the implementation of a public health campaign promoting the medicalization movement. By comparing the attitudes of those who were aware of the campaign with those who were not, clearer associations could be revealed.

Our findings also revealed that the labeling aspect of medicalization is associated with more treatment stigma. However, if we want to make clear statements about the package deal, another research approach is necessary, particularly since the balance between the impact of treatment (in the sense of improving symptoms) and the impact of stigma (in the sense of harming quality of life)
might shift as people continue their illness career. Qualitative research among a chronic patient population might reveal interesting and nuanced findings regarding this topic.

Another example of a potential selection mechanism that might interfere with our results, is that we could not take into account whether people lived in a neighborhood in which a community care facility was present or not. A better option to capture the causal link between deinstitutionalization and stigma is to compare neighborhoods in which a community care facility has been implemented with neighborhoods in which this is not the case. The literature describes that people’s attitudes might be positive when community care is a hypothetical scenario. However when people are confronted with the implementation of a community care facility in their own neighborhood, their attitudes might become more negative due to concerns about personal security and about property values (Dear, 1992; Belcher, 1990). This phenomenon is referred to as ‘Not In My BackYard’ (Lauber et al., 2004).

2.2 Public opinion research

In this dissertation, help-seeking attitudes of the general public are addressed. In the literature, there is a lot of debate regarding whether people’s (positive) beliefs toward help-seeking are translated into actual help-seeking behavior (Swindle et al., 2000; Jorm et al., 2000; Hughes, 1998; Barter & Renold, 1999; Weiner, 1995; Kraus, 1995). We acknowledge that the link between attitudes and behavior might be questionable with regard to people’s personal help-seeking behavior. However, in our dissertation, we do not use treatment recommendations as a proxy for people’s own help-seeking behavior. If we chose to do so, then we would ask what the respondents
themselves would do when being confronted with a similar situation as the vignette person (Yap, Wright & Jorm, 2011).

Instead, we use treatment recommendations as an indicator of the cultural context. Cultural conceptions constitute what the lay public thinks about what mental illness is, what causes mental illness, how people with mental illness are like and finally, what should be done when a person develops symptoms of mental illness. These cultural conceptions somehow become an external reality. It is something that individuals must take into account when they make decisions, no matter what their personal attitudes and beliefs are (Angermeyer, Matschinger & Schomerus, 2013). In terms of the Theory of Reasoned Action of Fishbein and Ajzen (1975), we zoom in on the ‘subjective norm’. The subjective norm refers to how other people think the individual should act when dealing with a health problem. Moreover, some research studies have indicated that the social norms describing other people’s health behavior is significantly correlated with one’s own behavior (Borsari & Carey, 2003; Perkins, Haines & Rice, 2005; Weiss & Garbanati, 2006; Rüsch et al., 2013).

Furthermore, we tried to limit the overestimation of people’s help-seeking recommendations by using spontaneous suggestions instead of prompted endorsements. Prompted endorsements are more susceptible for issues of social desirability, resulting in unrealistically high endorsements (Regier et al., 1998). The acceptance of prompted treatment options simply takes less effort than its rejection (Gilbert, 1991), particularly when the medical framework is triggered by previous items in the questionnaire. Suggestions on the contrary are better aligned with actual utilization rates (Pescosolido & Olafsdottir, 2010), as has been shown in the methodology section.
With regard to stigmatizing attitudes, social desirability issues are also at play. Henderson et al. (2012) indicated that face-to-face interviews generated more socially desirable answers than self-completing questionnaires. We were aware of this, so we let people answer by means of numbers instead of verbal accounts of agreement. Next to this, we tried to limit the impact of social desirability by measuring stigma by means of the public stigma scale and by measuring negative attitudes toward the mental health care sector by means of open-ended questions. Asking people about how most other people would react (public stigma) generates more rejecting responses as has been shown by Link and Cullen (1983). If we compared some agreement percentages of personal stigma and public stigma in our survey, we also noticed a huge discrepancy between personal stigmatizing attitudes and public stigmatizing attitudes. For example, one out of three agreed that they would not accept the vignette person as a friend, while 60% agreed that most others would not accept the ill person as a friend. Regarding an issue of devaluation, the numbers were even more extreme. Only one in ten mentioned that they considered the vignette person as less intelligent, while half of them agreed that other people would think less of the level of intelligence of the ill person.

2.3 Vignettetechnique

On the one hand, the vignette technique can be criticized for being too stringent in depicting mental disorders. The descriptions are based on the symptom profiles of the DSM-IV. However, episodes of a certain mental disorder differ in onset, course, duration and severity. For instance, no two major depressions have exactly the same symptom profile. Some aspects are shared, other aspects are
differentiated. Ross and Mirowsky (2002) criticize the fact that phenomena that are continuous in nature are being reduced to dichotomous diagnostic categories.

Furthermore, our findings cannot be extrapolated to other mental disorders. For instance, it is possible that biogenetic explanations are associated with less stigmatizing attitudes when substance abuse is the object of study (Angermeyer et al., 2011). People who suffer from substance abuse are held more responsible for their condition compared to substance-unrelated mental disorders (Schomerus et al., 2011). In addition, studying substance abuse might also reveal other findings with regard to the gendered hypothesis. Rosenfield (1982) suggested that men experience less stigma when suffering from externalizing mental disorders, as the latter are more in line with stereotypical masculine behavior. Substance abuse is seen as the gender equivalent of depression (Aneshensel, Rutter & Lachenbruch, 1991). So it can be that men who suffer from alcoholism provoke less severe reactions.

On the other hand, the vignette technique can be criticized for having a questionable link with actual behavior due to the hypothetical context of the vignette. Social network theorists suggest that core networks and more peripheral networks may have divergent responses when someone reports symptoms of mental illness. Yet the strength of the tie between the respondent and the vignette person is not expressed.

As concerns labeling, people seem to be more willing to interpret symptoms within a psychiatric framework when the behavior is performed by a more distant relative in comparison to when their spouse is reporting similar symptoms (Horwitz, 1982; Clausen & Yarrow, 1955). Families are less
likely to acknowledge the occurrence of a mental disorder, as they often deny and normalize symptoms in their effort to manage difficult behavior (Link, Mirotznik & Cullen, 1991). Yet once the illness is identified, close ties are more likely to increase involvement rather than ending the relationship (Perry, 2011; Perry & Pescosolido, 2012). Because norms of kinship and close friendship override the impact of stigma, stigma might have less impact on close ties (Couture & Penn, 2003; Link et al., 1989; Perry, 2011). On the contrary, weaker relationships may be more susceptible to stigma, since those relationships lack the sense of obligation, reciprocity, and shared history that helps to preserve social bonds when relationships are strained (Wellman, 2000). Peripheral network members may be more likely to increase social distance between themselves and the person with mental illness.

Finally, we argue that the mode and form of the vignette presentation might influence respondents’ judgments. For future research regarding the theme of mental illness, we suggest that video vignettes might also be a good option (Atzmüller & Steiner, 2010). A video vignette appears to be more in accordance with real life situations in which you encounter people with mental illness. In addition, non-verbal communication in a video vignette may be less biased by how people interpret certain concepts that are mentioned in the text vignette.

2.4 Conceptualization of help-seeking

Our measures of help-seeking are limited in the sense that they do not capture the whole help-seeking process. Help-seeking does not refer to one type of care-practitioner nor to one moment in time. These ideas are elaborated upon in the following paragraphs.
First of all, people generally do not make a single choice. Instead, they continue to ask advice and seek help from a wide variety of lay and professional care-providers. These potential combinations of help-seeking strategies are not addressed in this dissertation. Future research should focus upon analytic techniques that allow researchers to compare the different strategies that people employ. Some people prefer one type of care-provider over another, while others endorse several types of care-provider. One way to do this is to use clustering techniques. Another way to do it is to use multinomial logistic regression, comparing the reliance on none or both or one out of two treatment options. Both approaches refer to the technique of ‘cultural mapping’ (Gieryn, 1999; Dimaggio 1997), drawing from recent innovations in sociology of culture. Linking determinants with combinations of help-seeking options might reveal a more nuanced cultural scheme than studying the simple endorsement of different treatment options (Olafsdottir & Pescosolido, 2009). This technique refers to outlining the conditions based on which people discriminate between different care options or ‘cultural maps’.

Secondly, the complete illness career deserves more attention in future research, rather than focusing on a one-time decision to seek help. Help-seeking consists of different sequences or episodes that create patterns or pathways of care. Inspiration can be sought in the life course approach in sociology (Pavalko, 1997) and the illness career conceptualizations (Zola, 1973, Davis, 1963, Roth, 1963). Not only the entry into the treatment sector is important- as we discussed in this dissertation-but also the adherence to treatment should be focus of attention, since research showed that one out of three who enter professional treatment do not adhere till the end (Sirey et al., 2001). Next to this, the likelihood of following through with aftercare in the community after being institutionalized is quite low (Boyer & Mechanic, 1994).
3 Policy implications

Last but not least, we highlight a range of policy implications, based on the results of this dissertation. In a first step, we question how stigma can be tackled. Second, we outline some risk groups and in a final step, we zoom in on the implications of our findings for the mental health care sector.

3.1 Tackling stigma

Contact and education have been suggested as powerful strategies to tackle stigma (Rüscher, Angermeyer & Corrigan, 2005). However, our research findings indicate that both have side-effects.

3.1.1 Impact of contact

The deinstitutionalization movement has been implemented to facilitate the social reintegration of people with mental illness by reducing social distance (Novella, 2008). Community-based care does not only take place in the community, but also by the community (Bhugra, 1989; Thornicroft & Bebbington, 1989; Pescosolido & Kronenfeld, 1995). The question is whether this aim has been realized. Are people, living in countries where community care has (partly) replaced institutionalized care, more tolerant toward people with mental illness? The research of Kurihara et al. (2000) indicated that more tolerant attitudes appeared in countries where community care has been more strongly established than in countries that are still relying on hospital care. However, the research of
Schomerus et al. (2006) and Rössler, Salize and Voges (1995) did not find significant differences in stigmatizing attitudes between regions with a different stage of deinstitutionalization.

Based on our findings we argue that the inconsistent findings – referred to as the contact paradox – depend on the way community care has been implemented. It often occurs that people with mental illness living in the community, live in sheltered environments with limited social contacts (Fakhoury & Priebe, 2007). Then trans-institutionalization is a better description than deinstitutionalization (Kelly & McKenna, 2004). Another scenario is that the decline in institutional care is not complemented by the establishment of sufficient alternative community mental health care facilities. In that case, deinstitutionalization rather refers to de-hospitalization (Bitter et al., 2009). As a result, people with mental illness might end up without treatment or even homeless or imprisoned (Eikelmann, 2000; Lamb & Bachrach, 2001). And prejudice might be triggered by, arising emotions of fear when meeting someone who seems to deal with mental illness in public, such as a homeless person. Also, encountering people who have not been helped by treatment seems to trigger stigmatizing attitudes.

Therefore, we conclude that the deinstitutionalization process in Belgium must be further implemented with caution. Enough guidance is needed to facilitate that people really reintegrate in society. And next to this, intensive hospital care for people with severe and complex disorders should be guaranteed (Van Hecke et al., 2011; Fitzgerald, 2010; Trieman & Leff, 2002). Furthermore, in order to avoid that people slip through the net and end up without treatment (Bitter et al., 2009; Lamb & Bachrach, 2001), the mental health care sector should put a lot of effort in making clear agreements between the different partners who are involved in the care of the person with mental illness.
Finally, after-care and eventually coerced care, for those who are again in need of professional care, but do not want to be cared for, is a shared responsibility of all mental health care organizations.

3.1.2 Impact of mental health literacy

When using education as a strategy to tackle stigma, improving mental health literacy is aimed at (Jorm, 2000). However, the results regarding the association between a medical conceptualization of mental illness and stigma were inconsistent. A recent meta-study indicated that biogenetic explanations for mental health problems reduced blame, but strengthened perceptions of dangerousness and induced prognostic pessimism (Kvaale, Gottdiener & Haslam, 2013). Our study did not reveal a significant association between causal attributions and stigma. Consequently, public health campaigns with the ‘mental illness is an illness like any other’-message seem to lack the power to tackle stigma. Moreover, a review study of anti-stigma programs in 14 European countries showed that the effects of those campaigns were generally sporadic, small and short-lasting (Beldie et al., 2012).

Also for specific subgroups, the strategy of promoting a medical conceptualization of mental illness is not without side-effects. Family members, for instance, may be relieved from blame by the shift of attributing mental illness to biology instead of to bad parenting (Meiser et al., 2005). Yet the idea that family members transmit bad genes can also increase the public’s desire for distance from family members of the ill person (Phelan, 2005). Furthermore, the ill people themselves may become more pessimistic about change due to biogenetic explanations (Lam & Salkovskis, 2007) and this might trigger more negative implicit attitudes toward the Self (Rüsch et al., 2010). Finally, you would expect
that professionals’ sophisticated knowledge of the neurobiology of mental disorders would reduce their stigmatizing attitudes. Yet professionals do not report lower levels of stigmatization compared to the lay public (Jorm et al., 1999).

Next to the link between the medical model of mental illness and stigma, we want to emphasize that other current constructs of mental illness are also not relieved from stigma. For instance, in Asian countries they currently adhere to psychosocial factors, but stigma or ‘face loss’ is a severe problem over there too. The onset of mental illness brings shame to the whole family (Lauber & Rössler, 2007). So culture-specific effects also play a role. If we consider the shift of conceptualizations of mental illness over time, we also notice that other constructs of mental illness were not relieved from stigma. Comte (1855 in: Pasternak, 1981) argued that the interpretation of mental illness has evolved from the religious model toward the scientific model, and Weber (1958; in Pasternak, 1981) stressed that the former superstitious forms of prejudice have been replaced by newer forms based on economic considerations. Accordingly, some authors argue that stigma has evolutionary roots (Kurzban & Leary, 2001).

We conclude that biogenetic explanations are not a primary determinant of stigma. We encourage future research to identify factors that are more strongly predictive of stigmatizing attitudes.

3.1.3 How can stigma be tackled?

Based on our findings on the association between self-stigma and help-seeking attitudes, we argue that the most powerful destigmatizing message could come from the mental health service users
themselves. Their empowerment can show people that individuals who have been in treatment are not merely service users, but that they are also mothers, employees, husbands, neighbors, volunteers,... If people show their other social roles, beside the sick role, we imagine that feelings of self-stigma would diminish. Broadening the self-concept beyond the illness by identifying and emphasizing personal strengths and positive qualities is a way to reinforce the inaccuracy of the stereotypes attached to people in treatment. Therefore, secrecy as a coping strategy should be tackled. We already noticed that famous Belgians who reported their history of mental health service use (such as the TV and radio presenter Otto Jan Ham) paved the way for more open discussion about the theme. We need more testimonials of people who have been helped by treatment and who were able to return to their societal roles in order to break the vicious circle of secrecy which maintains the existence of stereotypes due to a lack of counter-information.

Regarding the association between contact and stigma, we argue that not only face-to-face contact plays a role, but also contact through the media. Schiappa, Gregg and Hewes (2005) proposed the Parasocial Contact Hypothesis, analogue to Allport’s (1954) Contact Hypothesis. Television and movies give the illusion of face-to-face relationships and are cognitively processed in a matter similar to interpersonal interactions. As a consequence, they may also carry the potential to shape change or to reinforce stereotypes about people with mental illness. Therefore, we stress that the way people with mental illness are being portrayed in the media has a huge impact on stigmatizing attitudes, particularly since not everyone has personal contact with someone who suffers from mental illness. Sensational messages regarding violent events may have helped creating the misperception of the actual risk of violence (Wahl, 1997). These messages are highly emotion-arousing and are way more powerful than didactic messages regarding the onset of mental illness. For that reason, we
recommend that non-fiction reports as well as fiction series should address the theme of mental illness more consciously. The way suicide is being addressed in the media nowadays is a good example. The media addresses this theme with more caution and always mentions the number of a telephone help line. Yet it is necessary that this approach is extended to mental illness in general. Sensational messages regarding someone with mental illness who committed a crime still reach a big audience. The frequency and intensity of negatively stereotyped images about people with mental illness in the media should be reduced.

3.2 Particular risk groups

Based on our findings, we deduce two specific risk groups of people who experience attitudinal barriers toward help-seeking for mental illness. People from the lower social strata who are embedded in a homogeneous network constitute a risk group, next to men.

3.2.1 People from the lower social strata embedded in homogenous networks

Considering the composition of the social network in one of our studies has the advantage that a specific risk group can be identified. Lower educated people with a homogenous network should be targeted, as this vulnerable group seems to experience attitudinal barriers toward accessing specialist mental health care. Since (mental) health awareness in general is not high among this subgroup and prevention campaigns do not easily reach them, interventions targeting health empowerment should for example take place at work. We question why initiatives at work such as
serving healthy food in the cafeteria, access to fitness clubs, or life coaching and stress management courses are reserved (almost exclusively) for employees in higher end jobs. Those initiatives are particularly needed among the groups who do not address similar health issues on their own initiative. Unemployed people should be reached by a better collaboration between public employment services and social services.

3.2.2 Men

Men are an important risk group, particularly since suicide rates among men are very high (Reynders et al., 2009). Our results indicate that men are less likely to be recommended to seek professional care. Even within the mental health care sector, men are addressed differently than women. Research has shown that the gender of the patient influences the amount and type of treatment independently of objective symptoms (Loring & Powell, 1988). Clinicians were less likely to identify the presence of depression in men (Potss, Burnam & Wells, 1991), resulting in fewer drug prescriptions (Weyerer & Dilling, 1991; Van der Waahls, Mohrs & Foets, 1993; Morabia, Fabre & Dunand, 1992). We argue that the mental health care sector should be more aware of this gender bias. Furthermore, as talking might not be the best option for men (Ross & Mirowsky, 1989), the mental health care sector should offer alternative treatment options for men that are more in accordance with masculine norms. Life coaching workshops are a possible example of a more proactive approach.
3.3 Implications for the mental health care sector

When describing the implications for the mental health care sector, we distinguish between different types of care-providers along the lines of general versus specialist care and medical versus non-medical care. Last but not least, tackling self-stigma is posited as a crucial intervention in order to lower the barrier toward help-seeking and promote treatment adherence.

3.3.1 General practitioner

Based on the fact that many lay people recommend to consult a general practitioner to deal with mental disorders, and that seeking help from a general practitioner is less stigmatized than help from a medical specialist, we argue that general practitioners should occupy a more central position in the help-seeking process. This idea is in accordance with the principle of stepped care (Thornicroft & Tansella, 2004; Dezetter et al., 2013). Mental health problems that can be treated by primary care, should be treated by a primary care practitioner. To accomplish this, general practitioners need to be supported and guided to deal with mental health complaints.

Since Belgium does not have the gatekeeper-system, general practitioners should be encouraged to screen proactively for mental health symptoms. A possible way to do this is to complement the fee-for-service system partly with a fixed salary. Otherwise, general practitioners will be less eager to pursue time consuming visits of patients (Boerma & Verhaak, 1999; Astin et al., 2006). In addition, further guidance is needed so that general practitioners do not only prescribe medication. General practitioners seem to be partly responsible for medication-only treatment (Anthierens et al., 2007). A
promising initiative regarding the treatment of mental health problems in primary care is the first line psychologist who is linked to a group practice and who can offer psychotherapy sessions (Van Audenhove & Scheerder, 2010).

3.3.2 Psychiatrist

To strengthen the use of medical specialist care, we believe that more funding is needed for scientific research that is addressing evidence-based medicine. The sector suffers from an image of ‘soft’ science (Schulze, 2007). In our opinion, when effectiveness of treatment is proven, the attitude of people toward the professional mental health care sector will improve too. As a consequence, the barrier toward seeking professional care will be lowered. Yet this goal can only be reached with additional funding, and herein lies the underlying problem of the situation. Psychiatry clearly suffers from a structural stigma (Corrigan et al., 2003). From the 10.2% of the gross domestic product that is spent on health care, only 6.2% goes to mental health care (Hermans et al., 2012). Furthermore, compared with investments in research into cancer or cardiovascular disease, fewer resources are obtained for psychiatric research (Rusch, Angermeyer & Corrigan, 2005; Sobocki et al., 2006).

3.3.3 Psychologist

Due to the fact that psychotherapy provided by non-medical practitioners seems to be less stigmatized, we argue that the acknowledgment of psychotherapy is a step forward (the legal criteria have been recently recognized by the government). Such quality indicators will help to get hold of
the scattered landscape of non-medical mental health specialists and will probably lower the barrier to mental health care. This might also pave the way for the extension of reimbursement of psychotherapy sessions (nowadays limited to children and young adults younger than 25 depending on the private health insurance company). Moreover, other research indicates that in countries where psychotherapy plays a more crucial role in the provision of mental health care, there seems to be less taboo surrounding mental health care (Reynders et al., 2009) and lower suicide rates are reported (Van Deurzen, 2010).

3.3.4 Tackling self-stigma

Personal negative attitudes toward seeking professional help seem a much stronger hindrance to help-seeking than worries about how other people might react. Whereas public stigma is based on societal factors that can be difficult to change, interventions at the individual level could be developed in order to interrupt the process of self-stigma (Vogel et al., 2013). Individuals who experience self-stigma not only suffer from more negative attitudes toward psychological treatment, but also report lower treatment compliance (Fung et al., 2007; Wade et al., 2011; Zartaloudi & Madianos, 2010).

This could be done by developing interventions that can be applied in clinical settings or by the individuals themselves (for example through online self-help materials) in order to address disclosure and identity. The Coming Out Proud program has been developed, based on the coming out movement of the gay, lesbian, bisexual, transgender and questioning (GLBTQ) community. The program encompasses weighing the costs and benefits of disclosure in deciding whether to come
out, considering different strategies for coming out, and obtaining peer support through the disclosure process. The aim of the peer support is threefold. Peer support encourages those who are just coming out. Secondly, peer support fosters a sense of community through shared experiences. Finally, group pride is further promoted (Corrigan et al., 2013). Research has shown that public disclosure may promote empowerment and feelings of self-esteem (Corrigan et al., 2010).
Part IV.

REFERENCE LIST
AAPOR [http://www.aapor.org/Response_Rates_AnOverview1.htm]


230


Parsons, T., & Bales, R. F. (1955). *Family, socialization and interaction process*.


Walkup, J., Cramer, L. J., & Yeras, J. (2004). How is stigmatization affected by the “layering” of stigmatized conditions, such as serious mental illness and hiv? Psychological Reports, 95, 771.


[www.psy107.be] Official website of the Belgian government about Article 107