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ORIGINAL PAPER

Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions

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Abstract
Purpose Accessibility and availability of mental health care services are necessary but not sufficient for people to seek help for psychological problems. Attitudes and stigma related to help seeking also determine help seeking intentions. The aim of this study is to investigate how cross-national differences in attitudes and stigma within the general population are related to professional and informal help seeking intentions in low and high suicide rate regions.
Methods By means of a postal structured questionnaire, data of 2999 Dutch and Flemish respondents between 18 and 65 years were gathered. Attitudes toward help seeking, perceived stigma, self-stigma, shame and intention to seek help were assessed.
Results People in the Netherlands, where suicide rates are low, have more positive attitudes toward help seeking and experience less self stigma and shame compared to the people in Flanders, where suicide rates are relatively high. These attitudinal factors predicted professional as well as informal help seeking intentions. Perceived stigma was negatively associated with informal help seeking. Shame was positively associated with higher intention to use psychotropic drugs and perceived stigma was negatively associated with the intention to seek help from a psychotherapist in Flanders but not in the Netherlands.
Conclusion Help seeking for psychological problems prevent these problems to aggravate and it is assumed to be a protective factor for suicide. Our results stress the importance of the promotion of positive attitudes and the reduction of stigma within the general population to facilitate help seeking from professional providers and informal networks. Focusing on these attitudinal factors is believed to be a key aspect of universal mental health and suicide prevention policies.

Keywords Attitudes · Stigma · Help-seeking · Suicide · Cross-national research

Introduction

People with psychological problems often experience many barriers for seeking help, resulting in high rates of unmet need [1, 2]. Seeking help is important to prevent psychological problems to aggravate and even to reduce the risk of suicide [3]. Structural factors, such as the organization of mental health care, are important determinants for seeking psychological help. However, accessibility and availability are necessary but not sufficient for people to actually seek help. The attitudes and stigma people hold in relation to mental health and help seeking are also important barriers [4]. Therefore, the aim of this study is to investigate how cross-national differences in attitudes and stigma within the general population are related to professional and informal help seeking intentions in low and high suicide rate regions.

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A positive attitude toward a behavior such as help seeking is associated with a stronger intention to act upon this attitude. According to behavioral theories, intentions are immediate antecedents of actual behavior [5]. Various studies found an association between positive attitudes and help seeking intentions [6–8] and actual service use [9]. Stigma comprises a negative reaction of a substantial part of the general public toward a group of people because of their characteristics (e.g., a psychological problem) or behavior (e.g. help seeking). Stigma contains three essential aspects. The first aspect is negative beliefs or stereotypes such as 'people with psychological problems are incompetent'. Second, there is the aspect of prejudice. This is the agreement of most of the people with these stereotypes and/or the experience of negative emotional reactions such as fear or anger toward the stigmatized group. Third, there is the behavioral response to prejudice resulting in discrimination and thus the need for social distance [10]. A key concept in the process of stigmatization is labeling. From the moment one is labeled and thus identified as a member of the stigmatized group, he risks being prejudged and discriminated. Furthermore, research found that depressed people were more often stigmatized when they seek help than those who did not [11]. A way for people with psychological problems to prevent being labeled is secrecy or not seeking help.

In this article, we distinguish between two types of stigma. First, perceived stigma refers to the stigmatizing attitudes and discriminating behavior one observes in his environment toward people who have received psychological help [12]. A review of studies among young people found a relation between perceived stigma and a weaker intention to seek help [13]. Nevertheless, recent studies found no direct relation between perceived stigma and professional help seeking [6, 8, 14, 15]. One explanation is that perceived stigma was not directly related to help seeking intentions because it was mediated by attitudes toward help seeking and self-stigma [6, 8]. Second, there is the belief of people that seeking help can be kept secret to others. If so, they should not fear being stigmatized if they did [15]. However, secrecy is not a valid coping strategy to avoid labeling by others when seeking help within the informal network. In a qualitative study, stigma was the most commonly mentioned disadvantage of seeking help from family and friends [16]. Therefore we will include informal help seeking in our analysis.

Self-stigma, the second type of stigma in this article, is the internalizing of the stigmatizing attitudes toward people who seek help for psychological problems [10]. People who experience self-stigma will turn the stigmatizing attitudes, such as incompetence, against themselves resulting in a loss of self-efficacy, self-esteem and non-participation in society [17]. Many studies found a negative correlation between self-stigma and help-seeking intentions [6, 8]. Although closely related to self-stigma, few studies investigated the relation of shame for help seeking for psychological problems and willingness to seek help. Barney and colleagues found that embarrassment was associated with lower help-seeking intentions [18]. Besides the indirect relation between stigma and shame and suicide via help seeking intentions and behavior, it has been suggested that stigma and shame create distress which people, who already have psychological problems, must overcome. Therefore stigma is not only an important barrier for help seeking but it is also a more direct risk factor for suicide [19, 20].

The above mentioned attitudes and stigma are not merely individual constructs. Research found not only that attitudes differ between regions, but also that there is an association between the individual attitudes and the societal attitudes of the region [21]. Furthermore, research found that in countries characterized by less stigmatizing attitudes and more help seeking intentions, people with a mental illness experienced less self-stigma and perceived less discrimination [22]. Therefore, socio-cultural factors such as attitudes and belief systems prevalent in a society, determine the way people think about and cope with psychological problems [23].

These attitudinal factors are possibly even more important for understanding differences in help seeking between populations of regions where structural barriers to help seeking are comparable. This is illustrated by the case of the Netherlands and Flanders. Although historical, religious and cultural differences are noticeable, both neighboring regions do also resemble with respect to their socio-demographic, economic, linguistic and geographic features. Moreover, the prevalence of mental disorders is comparable in both regions [24]. Furthermore, both regions are known for their well-developed mental health care and social security systems although the mental health care is organized differently. For example the number of general practitioners, psychiatrists and psychologists per 100,000 population is higher in Belgium than in the Netherlands [25]. The number of beds in mental health hospitals is higher in Belgium but the number of outpatient facilities is higher in the Netherlands [26]. In the Netherlands, people are obliged to have a private basic care insurance but in return specialized mental health care is better reimbursed. In contrast to their Flemish counterparts, Dutch general practitioners have a gate keeping function and there are explicit directives for a multidisciplinary mental health care approach resulting in higher rates of referral from general practitioners to mental health specialists in the Netherlands [25]. The Flemish government has a suicide prevention action plan including initiatives for reducing stigma of mental illness while the Netherlands is lacking a

comparable nation wide policy [27]. In addition, both regions differ remarkably with respect to the way people cope with psychological problems. The suicide rates are about 80 % higher in Flanders. Over the period 2005–2010, the age standardized suicide rate for Flemish men is 22.9/100.000 inhabitants and for women 8.7 [28]. In the Netherlands, the suicide rates for the same period are 12.0 and 5.2 respectively [29]. Furthermore, a previous study on seeking help for psychological problems found that Dutch people were more inclined to seek specialized help for psychological problems than Belgian people. Although the differences in help seeking could partially be explained by organizational factors, it is also suggested that attitudinal factors too could play a prominent role [25].

Building further on these observations, the aim of this study is to investigate (1) if there are differences in help seeking related attitudes and stigma between the general populations of low and high suicide rate regions and (2) if there is an association within the general population between these attitudinal factors on the one hand and the intention to seek professional and informal help when confronted with psychological problems on the other hand. We hypothesize that in the Netherlands, where suicide rates are lower, attitudes toward help seeking are more positive and perceived stigma, self-stigma and shame related to help seeking are less prevalent than in Flanders. Furthermore, we hypothesize that positive attitudes toward help seeking are positively related to the intention to seek professional and informal help and perceived stigma, self-stigma and shame are negatively related to the intention to seek professional and informal help. In addition, research found that being female and higher education was associated with more positive attitudes toward help seeking [9], less perceived stigma [14, 30] and less self-stigma [22]. Being unemployed was associated with more perceived stigma [30] and more self- stigma [22]. Having psychological problems and previously received help was associated with more positive attitudes toward help seeking [9, 31] while psychological problems was also found to be related to more perceived stigma [14]. Because of these associations, we will also include these variables in our analysis.

Methods

Study sample

The target population for this study is the general population of Flanders and the Netherlands between 18 and 65 years old with the Belgian and the Dutch nationality, respectively. For the selection of the sample units, we made use of a cluster sample combined with systematic sampling [32]. The result is a random, geographically well spread and representative sample. The Dutch sample contains 4550 individuals out of 38 municipalities, out of eight COROP regions and seven provinces. In Flanders the outcome of this procedure was 4550 individuals, out of 52 municipalities, out of 12 care regions and five provinces.

Procedure

The systematic sample of individuals was selected out of the official population registered by the authorities. The selected individuals received a structured postal questionnaire together with a guided letter. The letter informed the participants about the goal of the research, the voluntariness of participation and the anonymity of the study. The response rate was 27.4 % (The Netherlands) and 41.4 % (Flanders). In total, we gathered data of 2999 Dutch and Flemish participants. The sample was weighted for age, gender, and marital status based on demographic data from the Netherlands and Flanders to match population distributions and to compensate for the moderate response rate.

Instruments

Demographic variables

The survey included questions about age, gender, years of schooling, civil state and employment.

Mental health

This was measured by the five item mental health summary scale (MH) from the 36-Item Short-Form Health Survey (SF-36) [33]. Scores range from 0 to 100. High scores indicate better mental health. In the SF-36 MH, scores $\leq$52 indicate emotional problems probably of any psychiatric disorder [33]. Reliability and validity are well established. Reliability for MH scores usually exceed 0.90 [33]. In our sample, Cronbach's alpha was 0.85. The five items were: how much of the time during the past 4 weeks have you been a very nervous person? Have you felt so down in the dumps that nothing could cheer you up? Have you felt calm and peaceful? Have you felt downhearted and blue? Have you been a happy person? The six response choices were: all of the time, most of the time, a good bit of the time, some of the time, a little of the time, none of the time.

Intention to seek help

This was measured by six items which were created for this study. The respondents were asked whether they would seek help from a general practitioner, psychiatrist,

psychotherapist, friends or family if they were confronted with psychological problems.

Furthermore, the respondents were asked whether they are willing to use psychotropic drugs.

Passive coping

Respondents were asked if they would do nothing hoping that the psychological problems would disappear out of their own. This item was based on the Utrecht Coping scale [34].

History of professional help seeking

By means of a single yes/no item, respondents were asked whether they had ever received help for psychological problems from a general practitioner, a psychotherapist or a psychiatrist.

Self-stigma

It was measured by the Self-Stigma of Seeking Help-Scale (SSOSH) [35]. The scale has a uni-dimensional factor structure and consists of ten items such as "Seeking psychological help would make me feel less intelligent". The internal consistency of the scale ranged between 0.86 and 0.90. In our sample, Cronbach's alpha was 0.85. The instrument was dichotomized by expressing the scores on a scale from 0 to 100. A score higher than 50 indicates that the respondent agreed that they would experience self-stigma for seeking psychological help.

For shame for seeking help

We developed three six-point Likert items. The items were: 'I would prefer that my neighbors did not know if I would receive help for psychological problems', 'I would be ashamed if I needed help for psychological problems' and 'I would keep it for myself if I would receive help for psychological problems'. The internal consistency of the three items was 0.80. The instrument was dichotomized by expressing the scores on a scale from 0 to 100. A score higher than 50 indicates that the respondent agreed that they would feel ashamed if they would sought psychological help.

Perceived stigma

It was measured by the Perceived Devaluation- Discrimination-scale [36]. The scale was developed as a one-dimensional scale containing 12 items such as "Most people feel that entering a mental hospital is a sign of personal failure". The average internal consistency is 0.78 and the scale shows good construct validity through a relationship with internal experience of demoralization and lower self-esteem [37]. In this study, the internal consistency was 0.85. The instrument was dichotomized by expressing the scores on a scale from 0 to 100. Scores higher than 50 indicate respondents who in general agreed that most people had stigmatizing attitudes toward psychiatric patients.

Attitudes toward help seeking

It was measured by Attitudes toward Seeking Professional Psychological Help- scale (Short form) and it was developed to measure mental health treatment attitudes. This scale was designed as a one-dimensional ten item scale [38]. Test-retest reliability (0.80), and internal consistency (0.84) were good [39]. In our sample, Cronbach's alpha was 0.81. The instrument was dichotomized by expressing the scores on a scale from 0 to 100. Scores higher than 50 indicate that the respondents had overall positive attitudes.

Analysis

First, weighted percentages and 95 % confidence intervals were presented. Next, associations between the attitudinal variables are presented by the zero-order correlations together with the level of significance. Multiple logistic regression was used to analyze the association between on the one hand socio-demographic variables, previously received help and mental well-being and on the other hand the attitudinal variables. Adjusted odds ratios and level of significance are presented. Finally, the relations between attitudinal factors and variables measuring professional and informal help seeking intentions were calculated by means of multiple logistic regression analysis. The odds ratios were adjusted for the demographic variables age, education level, marital status and employment status and for previously received help and mental well-being. For the analysis SPSS 16.02.2 was used.

Results

Table 1 shows that the majority of people have positive attitudes toward help seeking. Dutch people have more often positive attitudes toward help-seeking and they would be less often ashamed for seeking-help than Flemish people. Between 13 and 28 % of the respondents would experience self-stigma if they would seek professional help for psychological problems. About seven out of then perceive stigmatizing attitudes by others.

Table 2 gives the zero-order correlates between the different attitudinal variables. Positive attitudes correlates

Table 1 Percentage of Dutch and Flemish men and women who have positive attitudes toward professional help seeking, perceived stigma, experience self-stigma and shame for professional help seeking (weighted percentages and 95 % CI)

	Men				Women			
	The Netherlands, $N = 471$		Flanders, $N = 778$		The Netherlands, $N = 760$		Flanders, $N = 1075$	
	%	95 % CI	%	95 % CI	%	95 % CI	%	95 % CI
Positive attitudes toward help seeking	73.9	**70.9–77.4**	62.9	**59.7–66.0**	85.2	**82.1–88.0**	75.4	**72.5–78.2**
Self-stigma for help seeking	21.5	21.7–28.7	27.7	24.8–30.7	13.3	**10.7–16.2**	23.3	**20.7–26.3**
Shame for help seeking	59.6	**55.4–63.4**	68.2	**65.1–71.1**	47.0	**43.0–51.1**	65.2	**62.3–68.7**
Perceived stigma	70.3	66.5–73.9	68.9	65.7–71.8	70.2	66.4–73.9	73.2	70.2–76.0

CI's in bold indicate significant differences between the regions

Table 2 Zero-order correlations between the attitudinal variables

Variable	1		2		3		4	
			r	*P*	*r*	*P*	*r*	*P*
1 Positive attitudes toward help seeking	–	–	−0.543	<0.001	−0.328	<0.001	−0.006	0.737
2 Self-stigma for help seeking			–	–	0.586	<0.001	0.146	<0.001
3 Shame for help seeking					–	–	0.205	<0.001
4 Perceived stigma							–	–

negatively with self-stigma and shame. A strong correlation was found between self-stigma and shame. These two variables correlated weakly but significantly with perceived stigma.

Table 3 shows that women, unmarried and higher educated people, and people who previously received professional help have more positive attitudes toward help seeking. Self-stigma and shame was more often experienced by men, younger adults, people with lower self-ratings of mental health and those who have never received help for psychological problems. Public stigma were more often observed by younger adults, higher educated people and people with lower self-ratings of mental health. Dutch people are characterized by more positive attitudes, less self-stigma and shame compared to Flemish people.

Positive attitudes toward help seeking was positively related to the intention of seeking help from a general practitioner, psychiatrist, psychotherapist and family Table 4. Self-stigma and shame were negatively related to the intention to seek help from these providers.

Perceived stigma was associated with less willingness to seek help from a psychotherapist (in Flanders) and informal help from family members. We performed an additional analysis to find out if the relation between perceived stigma and the intention to seek help was mediated by self-stigma, shame and attitudes toward help seeking. The result was that the relation remained significant for informal help seeking from family in Flanders (OR 0.72, $P = 0.024$) but not in the Netherlands (OR 0.72, $P = 0.091$) nor for the intent to seek help from a therapist in Flanders (OR 0.96, $P = 0.741$). A passive coping style was negatively related to positive attitudes toward help seeking and positively with self-stigma and shame. Shame for seeking professional help decreases the intention to seek help from family or friends. Finally, shame was positively related to the intention to use psychotropic drugs, but only in Flanders.

Limitations

Some limitations should be considered when interpreting the results of this study. The response rate is moderate. A review of response rates in academic studies using mail surveys found an average of 55.6 % and a standard deviation of 19.7 [40]. This can be explained by the strong emotional connotation of the research subject. Furthermore, subjects are less compelled and encouraged to participate when contacted by mail than in the case of for example a telephone survey. On the other hand, a postal survey creates more security and anonymity, making participants less restrained to respond more sincerely [41]. Closely related with the previous point, the response rate in the Netherlands was lower than in Flanders. The research project was an initiative of a Belgian research team and this was communicated to all potential participants. Participating and resending personal and delicate information

Table 3 Socio-demographic factors, mental health and help seeking in relation to socio-cognitive factors within the Netherlands and Flanders

	Attitudes prof. help-seeking			Self-stigma			Shame			Perceived stigma		
	OR	95 % CI	*P*	OR	95 % CI	*P*	OR	95 % CI	*P*	OR	95 % CI	*P*
Gender												
Men	1.00		–	1.00		–	1.00		–	1.00		–
Women	1.66	1.38–1.98	**<0.001**	0.73	0.60–0.88	**0.001**	0.82	0.70–0.96	**0.014**	1.09	0.92–1.29	0.345
Age category												
18–34	1.00		–	1.00		–	1.00		–	1.00		–
35–49	0.86	0.68–1.08	0.190	0.71	0.56–0.90	**0.004**	0.71	0.58–0.87	**0.001**	1.06	0.84–1.32	0.637
50–64	0.87	0.68–1.13	0.311	0.54	0.41–0.71	**<0.001**	0.55	0.44–0.69	**<0.001**	0.65	0.51–0.82	**<0.001**
Married	0.76	0.62–0.93	**0.008**	0.95	0.77–1.17	0.600	1.02	0.86–1.22	0.819	1.04	0.86–1.26	0.691
Education												
Low (secondary school)	1.00		–	1.00		–	1.00		–	1.00		–
Medium (high school)	0.99	0.77–1.28	0.938	1.05	0.80–1.39	0.709	0.90	0.71–1.13	0.350	1.34	1.05–1.70	**0.017**
High (college or university)	1.60	1.23–2.08	**<0.001**	0.87	0.66–1.15	0.332	0.86	0.68–1.08	0.198	1.40	1.10–1.78	**0.006**
Unemployed	1.01	0.62–1.62	0.984	0.69	0.40–1.19	0.184	0.84	0.55–1.28	0.410	1.10	0.69–1.76	0.679
Region												
The Netherlands	1.00		–	1.00		–	1.00		–	1.00		–
Flanders	0.58	0.48–0.70	**<0.001**	1.56	1.28–1.91	**<0.001**	1.73	1.47–2.03	**<0.001**	1.06	0.89–1.26	0.501
Mental health and help seeking												
Lower self-ratings of mental health (SF-36 < 52)	0.98	0.73–1.32	0.894	1.67	1.26–2.22	**<0.001**	1.73	1.33–2.26	**<0.001**	1.65	1.22–2.23	**0.001**
Previously received any help from a GP, psychiatrist or psychotherapist	2.32	1.87–2.87	**<0.001**	0.65	0.53–0.81	**<0.001**	0.69	0.58–0.82	**<0.001**	1.20	1.00–1.45	0.53

Odds ratios are adjusted for all the variables in the left column

P values in bold indicate significance at <0.05

across the border could be a barrier for the Dutch population. To obviate these limitations, weighted adjustments were done to represent population distributions. Third, the research sample includes only participants between 18 and 65 years old. Therefore, our results cannot be generalized to teenagers and the elderly. Moreover, we added a three-item scale for shame for help seeking which was developed for this study. Although internal consistency was good, and there was a moderate correlation with the self-stigma scale suggesting discriminant validity, more validity tests should be conducted. Furthermore, the authors acknowledged the importance of cultural factors and structural characteristics of the mental health organization of both regions, but our study design did not allow us to incorporate these variables in our analysis. Therefore, future research should be undertaken to investigate the role of structural and cultural factors on help seeking for psychological problems. Next, the data in our research are cross-sectional. As a result, we could not investigate causal relations between the dependent and independent variables, but only associations. In addition, our dependent variables were intentions to seek help. Although, intentions are close antecedents of actual help seeking behavior, considerable variability in correlations between intentions and actual behavior were observed.

Discussion

In general, we can conclude that all hypotheses were confirmed. In the Netherlands where people were more inclined to consult a general practitioner, a psychiatrist or a psychotherapist, positive attitudes were more prevalent and self-stigma and shame less prevalent in comparison to Flemish people. Furthermore, we found a clear relation between attitudes and stigma on the one hand and intention to seek help on the other hand. These results indicate that besides organizational factors such as availability and accessibility of mental health care services, also attitudinal factors play a key role in help seeking intentions. People

Table 4 Association between socio-cognitive factors and intention to seek help for psychological problems

		GP			Psychiatrist			Therapist			Psychotropic drugs		
		OR	95 % CI	*P*	OR	95 % CI	*P*	OR	95 % CI	*P*	OR	95 % CI	*P*
Positive attitudes toward professional help seeking	NL	2.56	1.74–3.75	**<0.001**	4.17	3.00–5.99	**<0.001**	5.56	3.94–7.93	**<0.001**	2.50	1.81–3.53	**<0.001**
	FL	1.75	1.36–2.31	**<0.001**	4.00	3.11–5.00	**<0.001**	5.00	4.00–6.37	**<0.001**	2.33	1.85–2.25	**<0.001**
Self-stigma for professional help seeking	NL	0.44	0.32–0.65	**<0.001**	0.52	0.37–0.72	**<0.001**	0.43	0.30–0.61	**<0.001**	0.93	0.66–1.29	0.646
	FL	0.53	0.41–0.89	**<0.001**	0.47	0.37–0.59	**<0.001**	0.34	0.27–0.43	**<0.001**	0.98	0.78–1.25	0.902
Shame for professional help seeking	NL	0.46	0.32–0.65	**0.001**	0.64	0.49–0.82	**0.001**	0.39	0.28–0.54	**<0.001**	1.11	0.86–1.41	0.416
	FL	0.68	0.51–0.89	**<0.001**	0.60	0.49–0.74	**<0.001**	0.44	0.35–0.55	**<0.001**	1.43	1.15–1.78	**0.001**
Perceived stigma	NL	0.81	0.55–1.17	0.258	0.79	0.60–1.04	0.095	0.78	0.84–1.09	0.146	0.86	0.65–1.13	0.283
	FL	0.97	0.73–1.28	0.823	0.81	0.65–1.01	0.065	0.75	0.59–0.94	**0.013**	0.87	0.70–1.09	0.228
Region													
The Netherlands		1.00		***	1.00		***	1.00		***	1.00		***
Flanders		0.81	0.67–0.10	**0.045**	0.66	0.57–0.78	**<0.001**	0.48	0.40–0.57	**<0.001**	0.76	0.65–0.89	**0.004**

		Passive coping			Family			Friends		
		OR	95 % CI	*P*	OR	95 % CI	*P*	OR	95 % CI	*P*
Positive attitudes toward professional help seeking	NL	0.50	0.34–0.73	**<0.001**	1.49	1.02–2.16	**<0.040**	1.05	0.68–1.63	0.826
	FL	0.70	0.54–0.91	**0.007**	1.59	1.23–2.03	**<0.001**	1.08	0.81–1.43	0.623
Self-stigma for professional help seeking	NL	2.27	1.56–3.33	**<0.001**	0.51	0.35–0.75	**0.001**	0.58	0.38–0.90	0.014
	FL	1.45	1.12–1.88	**0.006**	0.67	0.52–0.87	**0.003**	0.85	0.63–1.15	0.311
Shame for professional help seeking	NL	2.27	1.62–3.25	**<0.001**	0.58	0.43–0.81	**0.001**	0.46	0.32–0.66	**<0.001**
	FL	2.44	1.84–3.32	**<0.001**	0.63	0.49–0.81	**<0.001**	0.65	0.49–0.87	**0.002**
Perceived stigma	NL	1.18	0.82–1.69	0.373	0.63	0.44–0.91	**0.013**	0.86	0.58–1.27	0.447
	FL	1.09	0.83–1.43	0.529	0.65	0.50–0.86	**0.002**	0.94	0.70–1.26	0.679
Region										
The Netherlands		1.00		***	1.00		***	1.00		***
Flanders		1.16	0.95–1.41	0.137	0.80	0.66–0.96	**0.018**	0.82	0.66–1.01	0.062

Odds ratios are adjusted for all the variables include in Table 3

P values in bold indicate significance at <0.05

are inclined to adopt the predominant attitudes and belief systems of the community resulting in a mentality more or less prone to seek help for psychological problems [21, 22]. However, it is also plausible that there is an interaction between the organization of the mental health care and attitudinal factors. The organization of the Dutch mental health care differs in some respects from the Flemish health care. For example, compared with the Flemish situation, Dutch general practitioners have a more pronounced gate keeping function, resulting in more references to specialized mental health care. Furthermore, Dutch general practitioners cooperate more closely with psychologists and social workers. Additionally, psychotherapy is better reimbursed in the Netherlands than in Flanders [25]. These structural factors facilitate specialized help seeking, making Dutch people more acquainted with specialized health care and help seeking for psychological problems. This could translate itself in a more open attitude toward help seeking, less self-stigma, less shame and at the end, stronger intentions to seek help for psychological problems.

With regard to perceived stigma we found no difference between the two populations but in contrast to some recent studies [6, 8, 15], we did find a relation between perceived stigma and the intention to seek help from a psychotherapist but only in Flanders. Interestingly, we found also a negative relation between perceived stigma and the intention to seek help from family members. Perceived stigma implies that people fear being labeled as mentally ill and as a result fear discrimination. However, it is assumed that if people believe they can keep their help seeking secret to others, there is no reason to fear discrimination and thus is perceived stigma no longer a barrier to seek help. But in the case of informal help seeking, the ones seeking help from

and those having stigmatizing attitudes, coincide. Keeping help seeking a secret becomes difficult if not impossible. This relation was not found for seeking help among friends. Possibly, one can choose the friends to whom it is safe to disclose one's problems without fearing being stigmatized. As in other studies [6, 8], we did not find an association between perceived stigma and attitudes toward the intention to seek help. This suggests that what one thinks about help seeking and what is believed others think about people who need help, is not per se related. We did find a correlation between perceived stigma and self-stigma and shame. This is in line with the modified labeling theory which states that perceived stigma can result in self-stigma when people are felt being labeled as mentally ill [12]. Our results suggest that this process is also anticipated by the general population without having psychological problems or being labeled as such.

Although our data show that there is a moderate correlation between self-stigma and shame, we also ascertain that shame is two to three times more common than self-stigma. Furthermore, our data indicate also that people being ashamed for others to know that they sought professional help, are also more reluctant to seek help from friends and family. It is therefore believed that shame is a strong emotional reaction to stigma and that it is an important barrier for seeking professional as well as informal help. Moreover, shame, although associated with less intention to seek help, was found to be positively associated with the intention to consume psychotropic drug among Flemish people. Possibly, shame is mainly associated with consulting mental health providers but not with treatment itself. At least, if it can be undergone in a discrete way, which is the case for psychotropic drug treatment but less for psychotherapy. This is in line with our observation that perceived stigma is only in Flanders negatively associated with willingness to seek counseling from a psychotherapist. This possibly adds to the explanation why in Flanders the consumption of psychotropic drugs is higher [42] and the intention to seek help weaker than in the Netherlands [25].

Another interesting observation is that attitudes toward help seeking, self-stigma and shame are not only associated with help seeking intentions but also with a passive coping style.

Finally, the regions subject to our study, although resembling in many aspects, do differ with respect to help seeking intentions and attitudinal factors but they differ also with respect to their respective suicide rates. Stigma and shame do not only inhibit help seeking for psychological problems with the risk that these problems aggravate and thus increasing the risk of suicidal behavior [3]. In itself, stigma and shame create distress which people, who already have psychological problems, must overcome. Therefore stigma is not only an important barrier for help seeking but it is also a risk factor for suicide [19, 20].

Although it is often assumed that the taboo regarding psychological help seeking is diminishing in recent years, our results indicate that still a considerable part of the people have negative attitudes and experience stigma related to psychological help seeking. Given the evidence of the inhibiting effect on professional and informal help seeking and thus on the prevention of psychological problems and suicide, sensitizing campaigns within the general population remain necessary [43]. As pointed out before, these attitudinal factors are in part culturally determined and they can vary regionally between but also within countries [21–23]. Further research should investigate the relation between these attitudinal factors, help seeking and regional suicide rates. Insight in these regional determinants is of interest for the development of mental health and suicide prevention policies.

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