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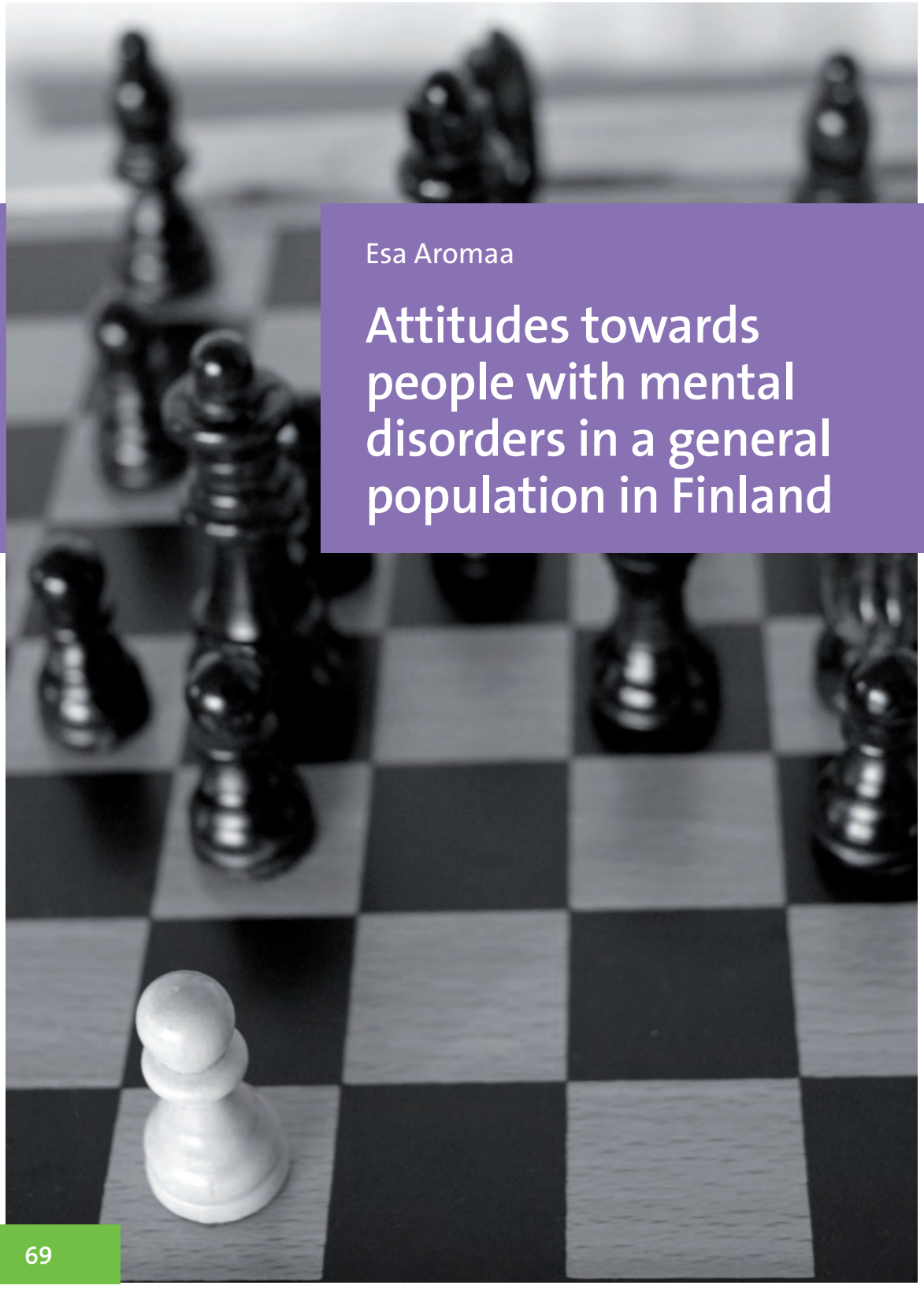

RESEARCH

Esa Aromaa

Attitudes towards people with mental disorders in a general population in Finland

RESEARCH NR 69

Esa Aromaa

Attitudes Towards People with Mental Disorders in a General Population in Finland

ACADEMIC DISSERTATION

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‘To prevent an effect from occurring at all requires a force equal to the cause of that effect, but to give it a new direction often requires only something very trivial’

(Georg C. Lichtenberg : The Waste Book, 2000)

To my family

Abstract

Esa Aromaa. Attitudes towards people with mental disorders in a general population in Finland. National Institute for Health and Welfare (THL). Research 69. 118 pages. Helsinki, Finland 2011.
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Stigma is common toward persons with mental health problems and can be defined as a label that sets a person apart from others, links her or him with undesirable characteristics and leads to avoidance by others in society. To aid in the planning of effective and well-targeted initiatives to reduce stigma I examined in my dissertation the prevalence of stigmatizing attitudes of a general population and the factors associated with stigmatizing of people with mental disorders in western Finland. Further, because only a minority of persons with depression are actually treated for their disorder it was also highly interesting to identify the role stigma might have on the use of mental health services. The statistical analyses made use of two large cross-sectional data sets from a Finnish population survey.

The results showed that although the majority of respondents believed that people with depression are not responsible for their illness, a majority still believed that they were responsible for their recovery. A lot of negative characteristics were linked with people with mental disorders and negative consequences were linked with the disclosure of the disorders. Women were less likely to hold negative stereotypes towards people with depression as were those with a higher education and people with Swedish as their mother language. A stronger sense of mastery and higher perceived social support predicted more positive attitudes. In addition, a person's own depressive symptoms and knowing someone who has had mental health problems were also related to more favourable attitudes towards people with depression.

Factors which significantly predicted a stronger desire for social distance included higher age, the female gender, having Swedish as ones native language, lower sense of mastery, milder depression, less familiarity with people with mental health problems and most strongly negative stereotypical beliefs held.

People with depression showed more social tolerance toward people with mental problems; they also carried more positive views about antidepressants. Those with depression were more pessimistic about the usefulness of care and the prognosis for mental problems on the whole. They were afraid of becoming stigmatized in the health care system and agreed with a stereotype that said depression can be seen as a stigmatizing and shameful disease. Among those with depression, users of mental health services carried less desire for social distance to people with mental health problems as compared to non-users and had more positive views about the effects of antidepressants. More severe depression predicted more active use of services. Among those with depression, users of mental health services, as

compared to non-users, were more pessimistic about recovery. Personal agreement with seeing depression as a stigmatizing disease was associated with use of mental health services. Personal agreement with the stereotype that people with mental health problems are unpredictable was linked to less use of mental health services.

These results suggest that the message "Depression is a real medical condition" is insufficient in anti-stigma campaigns. It is important to emphasize that depression is not one's own fault, and that people do not have to manage depression on their own. The results also suggest that older people and those who are unfamiliar with mental health problems are potential target groups for reducing stigma. When planning interventions to eliminate negative stereotypes, one potential target group could be men with low sense of life control and poor social networks. Although those with depression are afraid of becoming stigmatized within the health care system and may stigmatize themselves, this does not necessarily prevent professional service use if depression is serious and views about antidepressant medication are realistic.

Key words: Attitudes, stigma, mental disorders, depression, general population, stereotypes, service use, anti-stigma campaign

Tiivistelmä

Esa Aromaa. Attitudes towards people with mental disorders in a general population in Finland [Suomalaisen väestön asenteet mielenterveyden häiriöistä kärsiviä kohtaan]. Terveyden ja hyvinvoinnin laitos (THL). Tutkimus 69. 118 sivua. Helsinki, Finland 2011.
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Mielenterveyden häiriöistä kärsiviin henkilöihin kohdistuva häpeäleima (stigma) on yleistä. Leimaamisessa henkilö määritellään toisenlaiseksi, häneen liitetään ei-toivottuja ominaisuuksia ja häntä vältellään. Jotta voisimme suunnitella tehokkaita ja oikein kohdennettuja toimenpiteitä tämän leimaamisen vähentämiseksi, tutkin väitöstyössäni leimaavien asenteiden esiintymistä länsisuomalaisessa väestössä sekä niitä tekijöitä, jotka vaikuttavat tähän leimaamiseen. Koska ainoastaan vähemmistö masennuksesta kärsivistä saa ammatillista hoitoa ongelmiinsa, halusin myös selvittää häpeäleiman yhteyttä mielenterveyspalveluiden käyttöön. Tilastotieteelliset analyysit pohjautuvat kahteen länsisuomalaisen väestökyselyn poikkileikkausaineistoon.

Tulosten mukaan selvä enemmistö vastaajista ei pitänyt masennuksesta kärsiviä henkilöitä syyllisinä sairastumiseensa, mutta toisaalta enemmistö piti heitä vastuullisina omasta toipumisestaan. Mielenterveyden häiriöistä kärsiviin henkilöihin liitettiin monia kielteisiä ominaisuuksia ja häiriöiden paljastumiseen monia kielteisiä seuraamuksia. Naisilla, korkeammin koulutetuilla ja ruotsia äidinkielenään puhuvilla oli vähemmän masennukseen liittyviä kielteisiä kaavamaisia ajatuksia. Vahvempi elämän hallinta ja mahdollisuus sosiaaliseen tukeen yhdistyi myönteisempään asennoitumiseen masentuneita kohtaan. Kokemus omasta masennuksesta ja jonkun mielenterveyden ongelmista kärsivän tunteminen näkyi niin ikään myönteisempinä asenteina.

Suurempaa halukkuutta sosiaalisen etäisyyden ottamiseen ennusti tilastollisesti merkitsevästi vastaajan korkeampi ikä, nais-sukupuoli, ruotsi äidinkielenä, heikompi elämänhallinnan kokemus, lievempi masennus ja vähäisempi kokemus läheisen mielenterveysongelmista, sekä kaikkein merkittävimmin kaavamaiset kielteiset uskomukset.

Masentuneet henkilöt osoittivat suurempaa suvaitsevaisuutta mielenterveyden ongelmista kärsiviä kohtaan ja heidän suhtautumisensa masennuslääkkeisiin oli myönteisempää. Toisaalta he olivat pessimistisempiä hoidon tulosten ja häiriöistä toipumisen suhteen. Masentuneet myös pelkäsivät useammin tulevansa terveydenhuollon henkilökunnan leimaamiksi ja jakoivat kaavamaisen käsityksen masennuksesta leimaavana ja häpeällisenä sairautena.

Mielenterveyspalveluita käyttäneet masentuneet henkilöt välttelivät harvemmin mielenterveyden ongelmista kärsiviä ja heidän käsityksensä masennuslääkkeistä olivat myönteisempiä. Mitä vakavampi masennus, sitä aktiivisemmin hoitopalve-

palveluita oli käytetty. Palveluita käyttäneiden masentuneiden toiveikkuus toipumisesta oli vähäisempää kuin hoitoon hakeutumattomien. Masennuksen pitäminen leimaavana ja häpeällisenä liittyi aktiivisempaan palveluiden käyttöön. Jos masentunut vastaaja sen sijaan jakoi käsityksen mielenterveyspotilaan arvaamattomuudesta, oli hän käyttänyt harvemmin palveluita.

Näiden tulosten perusteella viesti masennuksesta oikeana sairautena ei ole riittävä stigman vähentämiseen tähtäävissä hankkeissa. On tärkeää korostaa, ettei masennus ole sairastuneen omaa syytä, eikä hänen tarvitse toipua siitä omin voimin. Tulokset viittaavat myös siihen, että vanhemmat ikäluokat ja ne, joilla ei ole omakohtaista kosketusta mielenterveyden ongelmiin, olisivat otollisia kohderyhmiä leimaamisen vähentämiseen tähtäävässä työssä. Silloin kun pyritään muuttamaan kaavamaista kielteistä ajattelua, toimenpiteet kannattaa suunnata miehiin, joiden elämänhallinta on puutteellista ja joiden sosiaaliset verkostot ovat heikkoja. Vaikka masentuneet henkilöt pelkäävätkin tulevansa leimatuiksi hoitojärjestelmässä ja leimaavat myös itseään herkästi, ei tämä välttämättä johda hoitopalveluiden vieroksumiseen, jos masennus on vakavaa ja masennuslääkkeitä koskevat käsitykset ovat realistisia.

Avainsanat: Asenteet, stigma, mielenterveyden häiriöt, masennus, väestö, stereotypiat, palveluiden käyttö, stigman vastaiset kampanjat

Sammandrag

Esa Aromaa. Attitudes towards people with mental disorders in a general population in Finland [Den finska befolkningens attityder mot personer med psykiska störningar]. Institutet för hälsa och välfärd (THL). Forskning 69. 118 sidor. Helsingfors, Finland 2011.
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Stigma som ofta riktas mot personer med psykisk ohälsa kan definieras som en stämpel som urskiljer en person från andra, förknippar honom eller henne med icke-önskvärda egenskaper och som leder till att andra undviker personen. För att bidra till planeringen av effektiva och välriktade initiativ för att minska stigmatisering, studerades i min avhandling förekomsten av stigmatiserande attityder och faktorer som är förknippade med stigmatisering av personer med psykisk ohälsa. Eftersom endast en minoritet av personer med depression får professionell vård var det också intressant att identifiera stigmans roll i användningen av mentalvårdstjänster. Datamaterial baserade på två stora tvärsnittsstudier från en befolkningsundersökning i västra Finland användes för de statistiska analyserna.

Resultaten visade att fastän majoriteten av de tillfrågade ansåg att personer med depression inte är ansvariga för sin sjukdom, ansåg ändå en majoritet att de var ansvariga för sitt tillfrisknande. Många negativa egenskaper var förknippade med personer med psykisk ohälsa och negativa följder var förknippade med avslöjande av psykisk ohälsa. Kvinnor, personer med högre utbildning och respondenter med svenska som modersmål hade färre negativa stereotyper om depression. Starkare bemästring av livet och möjlighet till socialt stöd korrelerade med mer tolerans mot människor med depression. Egen depression och kännande av någon person med mental ohälsa var också förknippade med mer toleranta attityder.

Statistiskt signifikant samband uppvisades mellan önskan om att hålla social distans till personer med psykisk ohälsa och kvinnliga respondenter samt högre ålder och svenska som modersmål. Vidare fann man samband med svagare bemästring av livet, mildare depression, mindre kontakt med någon person med mental ohälsa och stereotypiska övertygelser, varav den senaste var den starkaste indikatorn.

Personer med depression visade mer social tolerans mot människor med psykisk ohälsa och de hade även en mer positiv syn på antidepressiva läkemedel. Personer med depression var mera pessimistiska mot nyttan av vård och prognosen för psykisk ohälsa i sin helhet. De var rädda för att bli stigmatiserade i sjukvården och höll med påståendet om att depression kan ses som en stigmatiserande och skamlig sjukdom. Bland personerna med depression hade användare av mentalvårdstjänster ett mindre behov av att ta ett socialt avstånd från personer med psykisk ohälsa jämfört med icke-användare. De hade mera positiva åsikter om

effekterna av antidepressiva läkemedel. Svårare depression korrelerade med aktivare användning av tjänster. Användare av mentalvårdstjänster var mera pessimistiska om återhämtning bland respondenter med depression, jämfört med icke-användare. Personliga övertygelser med stereotypen att personer med psykisk ohälsa är oförutsägbara korrelerade med mindre användning av mentalvårdstjänster.

Dessa resultat tyder på att budskapet "Depression är en riktig sjukdom" är otillräckligt i antistigmakampanjer. Det är viktigt att betona att depression inte är ens eget fel och att personer inte behöver hantera sin depression på egen hand. Resultaten tyder också på att äldre människor och de som är inte är bekanta med psykisk ohälsa kan vara potentiella målgrupper för att minska stigmatisering. Vid planering av interventioner för att eliminera negativa stereotyper kunde en potentiell målgrupp vara män med svag känsla av kontroll i livet och bristfälliga sociala nätverk. Även om personer med depression är rädda för att bli stigmatiserade inom sjukvården och kan stigmatisera sig själva, förhindrar det inte nödvändigtvis användningen av professionella tjänster om depressionen är allvarlig och om åsikter om antidepressiva läkemedel är realistiska.

Nyckelord: Attityder, stigma, psykiska ohälsa, depression, allmän befolkning, stereotyper, användning av tjänster, antistigmakampanj

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List of original papers

I. Esa Aromaa, Asko Tolvanen, Jyrki Tuulari & Kristian Wahlbeck (2010) Attitudes towards people with mental disorders: the psychometric characteristics of a Finnish questionnaire. Social Psychiatry and Psychiatric Epidemiology, 45,265-273.

II. Esa Aromaa, Asko Tolvanen, Jyrki Tuulari & Kristian Wahlbeck (2011) Predictors of stigmatizing attitudes towards people with mental disorders in a general population in Finland. Nordic Journal of Psychiatry, 65,125-132.

III. Esa Aromaa, Asko Tolvanen, Jyrki Tuulari & Kristian Wahlbeck (2011) Personal stigma and use of mental health services among people with depression in a general population in Finland. BMC Psychiatry, 11:52.

Abbreviations

ADSP	Anticipated Discrimination when Seeing a Psychiatrist scale
ASPEN	European Anti Stigma Programme
AQ	Attribution Questionnaire
CAMI	Community Attitudes toward the Mentally Ill
CIDI-SF	Composite International Diagnostic Interview Short Form
DISC	Discrimination and Stigma scale
DSS	Depression Stigma Scale
DSSS	Depression Self-Stigma Scale
GHQ-12	Global Health Questionnaire
ISMI	Internalized Stigma of Mental Illness
OMI	Opinions about Mental Illness
PCA	Principal Component Analysis
PDD	Perceived Devaluation-Discrimination scale
SDS	Social Discrimination Scale
SSMIS	Self-Stigma of Mental Illness Scale
SSOSH	Self-Stigma of Seeking Help scale
SPSS	Statistical Package for the Social Sciences for Windows

1 Introduction

1.1 Mental illness stigma

There is growing evidence of stigmatization of people with mental disorders all over the world (Alonso et al., 2008; Sartorius & Schulze, 2005; Thornicroft et al, 2009). Research has established that mental illness is more stigmatizing than physical illnesses (Lai et al., 2001; Lee et al.. 2005) and that more stigmatizing attitudes are directed toward people diagnosed with schizophrenia compared with depression (Mann & Himelein, 2004) and eating disorders (Corrigan et al., 2000) , demonstrating not only that mental illness is more stigmatizing than physical illness, but also the existence of a hierarchy of stigma within psychiatric diagnoses.

Research also suggests that public attitudes toward people with mental illness seem to have become more stigmatizing over the last decades in the US and in Germany (Phelan et al. 2000; Angermeyer & Matschinger, 2005). Also in Finland stigma is prevalent, but the situation may be better here than in many other European countries (Wahlbeck & Aromaa, 2011). There also seems to be considerable cross-cultural variation. In particular, perceived stigma is more common in developing countries (Alonso et al., 2008).

Persons with mental disorders must not only cope with the psychological, cognitive and biological symptoms of their psychiatric condition but also with many negative consequences that go along with highly prevalent stigma. Examples would be social exclusion, unsatisfactory housing, restricted opportunities for employment and education, which impair the quality of life (Rüsch et al., 2005). Many people hesitate to use mental health services because they do not want to be labeled as a "mental patient" and want to avoid the negative consequences connected with stigma (Corrigan & Rusch 2002). It has also been shown that stigma is significantly related to mental health (Mak et al., 2007). Across stigmatized conditions, stigma was found to have a stronger relationship with positive mental health indicators than with negative ones. Given mental health is not merely the absence of mental illness or distress, this pattern of relationships suggested that stigma has a stronger negative effect on adjustment and growth than an exacerbating effect on psychological distress (Mak et al., 2007).

1.1.1 The concept of stigma

Stigma is a term originating with the ancient Greeks, denoting a visible mark placed or branded on members of tainted groups such as traitors or slaves (Goffman, 1963). All members of society therefore knew instantly of the degraded status of the stigmatized individual. The modern starting point for defining the stigma of mental illness is Goffman's "an attribute that is deeply discrediting" and

that reduces the bearer "from a whole and usual person to a tainted, discounted one" (Goffman, 1963).

Several alternative or elaborated definitions were put forward following Goffman, though they varied considerably. Elliot and colleagues emphasize the social interaction in stigma (Elliot et al., 1982). In their definition, stigma is a form of deviance that leads others to judge an individual as not having legitimacy to participate in a social interaction. This occurs because of a perception that they lack the skills or abilities to carry out such an interaction, and is also influenced by judgments about the dangerousness and unpredictability of the person. Once the person is considered as lacking legitimacy then they are beyond the rules of normal social behavior and may be ignored or excluded by the group.

Goffman categorized the attributes of the stigmatized into three main groups: 1) abominations of the body, 2) blemishes of individual character e.g. mental illness, criminal conviction or 3) tribal stigmas e.g. race, gender, age. The work of Jones and colleagues built on these categorizations with a focus on the study of "marked relationships" (Jones et al., 1984). In this definition, stigma occurs when the mark links the identified person via attributional processes to undesirable characteristics which discredit him or her. They propose six dimensions of stigma:

1. Concealability: how obvious or detectable a characteristic is to others
2. Course: whether the difference is life-long or reversible over time
3. Disruptiveness: the impact of the difference on interpersonal relationships
4. Aesthetics: whether the difference elicits a reaction of disgust or is perceived as unattractive
5. Origin: the causes of the difference, particularly whether the individual is perceived as responsible for this difference
6. Peril: the degree to which the difference induces feelings of threat or danger in others

Stafford and Scott propose that stigma "is a characteristic of persons that is contrary to a norm of a social unit" where a "norm" is defined as a "shared belief that a person ought to behave in a certain way at a certain time" (Stafford & Scott, 1986).

Current stigma models often represent mental illness stigma as cognitive-behavioral constructs. Crocker et al. indicate that "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context" (Crocker et al., 1998). As a broad theory, cognitive-behavioral models define the process of human behavior in three parts:

1. Situational cues signal a specific setting for which behavioral responses may be indicated.
2. Cognition makes sense out of these cues.
3. Behavior results from these cognitions.

Over the last 15 years there has been a substantial increase in research on mental illness stigma. Link and Phelan developed a conceptualization (Link & Phelan, 2001) in response to criticisms that the stigma concept locates the "problem" in the individual and tend to focus on the cognitive processing of information rather than on the discrimination and exclusion that a stigmatized person experiences (Sayce, 1998). They define stigma as "the co-occurrence of its components – labeling, stereotyping, separation, status loss, and discrimination" and further indicate that for stigmatization to occur, power must be exercised. Although focusing on mental illness stigma, Link and colleagues deal with various stigmata while stressing that no definition of stigma can be universally applicable. Therefore they emphasize that definitions of stigma should always be made transparent by the respective researchers.

Writing from a sociological perspective, Link and Phelan put more stress on two societal aspects: First, as a precondition of stigma differences between persons have to be noticed, to be regarded as relevant and to be labeled accordingly. This labeling process is at the core of Link's modified labeling theory (Link et al., 1989). Phelan and colleagues have recently investigated the possible intersection of conceptual models of stigma and prejudice, and concluded that the two approaches have much in common with most differences being a matter of emphasis and focus. They argue that stigma and prejudice have three functions: exploitation and domination (keeping people down); disease avoidance (keeping people away) and norm enforcement (keeping people in) (Phelan et al., 2008).

Corrigan has proposed a framework in which stigma is categorized as either public stigma or self-stigma. Within each of these two areas, stigma is further broken down into three cognitive and behavioral core features: stereotypes (cognitive knowledge structures), prejudice (cognitive and emotional consequence of stereotypes) and discrimination (behavioral consequence of prejudice) (Corrigan, 2000) (see Table 1).

Table 1. Components of public and self stigma

Public stigma	**Self-stigma**
Stereotype: Negative belief about a group such as incompetence, character weakness, dangerousness	Stereotype: Negative belief about the self such as incompetence, character weakness, dangerousness
Prejudice: Agreement with belief and/or negative emotional reaction such as anger or fear	Prejudice: Agreement with belief, negative emotional reaction such as low self-esteem or low self-efficacy
Discrimination: Behavior response to prejudice such as: Avoidance of work and housing opportunities, with-holding help	Discrimination: Behavior response to prejudice such as: Fails to pursue work and housing opportunities, does not seek help

Building on Corrigan's foundation, Thornicroft et al. have recently defined stigma to include three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behavior (discrimination) (Thornicroft et al., 2007). Thornicroft and colleagues criticize that most stigma research so far has been based on attitude surveys and on media representations of mental illness and violence, and that it has only focused upon schizophrenia, has excluded direct participation by service users, and has included few intervention studies. The authors argue that the time has come to shift the focus of research and action from stigma to discrimination. This means sharpening the focus upon human rights, injustice and discrimination as actually experienced by people with mental illness.

1.2 Measuring stigma

There exist at least two comprehensive reviews of the measurement of mental illness stigma (Link et al., 2004; Brohan et al., 2010). Link et al.'s review considers the measurement from multiple perspectives, including mental health service users, professional groups, the general population, families or carers of those with a mental illness and children and adolescents. The recent review from Brohan et al. focuses only on measures appropriate to people with personal experience of mental illness and includes several measures which have been published since the previous review.

Link's review showed the number and overall percentage of each of several design types employed in the 109 stigma studies from 1995 to 2003. Most of the research involved nonexperimental survey research (60.1%), with another sizable component involving survey research with a vignette component (7.3%). Experimental research with vignettes was the second most popular method (16.2%). Qualitative research in this review was relatively rare (13.8%).

The studies were also categorized by the stigma components identified by Link and Phelan (Link & Phelan, 2001) and the results showed that each of the stigma components was assessed by more than 10 percent of the studies which can be interpreted as underscoring the need for a multicomponent conceptualization of stigma. There was only one exception, "structural discrimination", which was coded as present in only two studies. It was also interesting that measurement of stereotyping (62.4%) and expectations of status loss and discrimination (58.7%) were much more common than were experiences of status loss and discrimination (13.8%) and behavioral responses (15.6%) to stigma.

1.2.1 Measures applicable to members of the general population

1.2.1.1 Measures of social distance

Measures of social distance seek to assess a respondent's willingness to interact with a target person in different types of relationships. Measures frequently in-

clude items that differ in the closeness of an association a respondent is asked to accept or decline. The first social distance scale in the context of a vignette experiment designed to assess responses to a described individual, was used in 1963 (Phillips, 1963). Since then, variants of the scale have been used with great frequency in research on stigma but particularly in the context of studies employing vignettes (Jorm & Oh, 2009). Link himself has developed a 7-item Social Discrimination Scale (SDS) (Link et al., 1987) which has been widely used since then. The SDS has also been translated into Finnish and used in an international comparison study analysing mental health stigma and its determinants among pharmacy students in Finland, Australia, Belgium, Estonia, India and Latvia (Bell et al., 2008).

Social distance scales tend to show good to excellent internal-consistency reliability (Link et al., 2004). There are two main limitations to the validity of social distance scales. The first of these is a social desirability bias. Because of social desirability people are likely to underreport their stigmatizing stereotypes compared with their real-life behavior (Tourangeau et al., 2002). This contamination makes it difficult to know whether predictors of reported social distance are due to willingness to report social distance or to true social distancing responses.

Another important limitation is the difference between behavioral responses and reported intentions. Although behavioral intention items like social distance items are often good predictors of behavior, the connection can be mitigated by situational circumstances, competing attitudes, and other such factors. If the target concept is in fact a specific behavior, then the relevant behaviors need to be measured directly. In his review paper, Jorm has criticized the fact that there is not a single piece of evidence that social distance scales predict discriminatory behavior (Jorm & Oh, 2009). Thus he recommends using the more accurate term “desire for social distance”.

1.2.1.2 Semantic differential

The semantic differential is a measurement approach that provides a direct assessment of stereotyping – that is, the tendency to link a label like “mental patient” with negative attributes. It was developed by Osgood et al. (Osgood et al., 1957) as a general technique for measuring the psychological meaning that concepts hold for people. Crisp et al. (Crisp et al., 2000) applied the semantic differential to the question of public conceptions of people with mental illnesses and the professionals who treat them. This measure presents respondents with labels, or concepts (e.g.”mental patient”), and asks them to evaluate the extent to which those labels are associated with various characteristics. Specifically, respondents are asked to rate the concept on a number of 7-point rating scales, each bounded by a pair of polar adjectives such as “insincere-sincere”.

The semantic differential has several features to recommend it. It provides a direct measure of stereotyping and it can be flexibly applied to different concepts

and evaluative dimensions. It has good reliability and construct validity (Link et al., 2004; Crisp et al., 2000). A shortcoming of this approach, shared by many other stigma instruments, is its vulnerability to social-desirability bias.

1.2.1.3 Multidimensional attitude scales

Struening and Cohen sought the "adequate conception and objective measurement of attitudes toward mental illness" through a multidimensional scale (Struening & Cohen, 1963). The Opinions About Mental Illness Scale (OMI) is a 51-item instrument with 5 dimensions: authoritarianism, benevolence, mental hygiene ideology, social restrictiveness and interpersonal etiology. In this instrument respondents are asked to react on such statements as "People who were once patients in mental hospitals are no more dangerous than the average citizen".

OMI has several important strengths. Its items are closely scrutinized and compared with items in other scales and it includes items assessing many of the components that Jones et al. (Jones et al., 1984) and Link and Phelan (Link & Phelan, 2001) identify. Moreover, OMI has such long history that it gives the possibility to assess changes in attitudes over time. A disadvantage of the OMI is that new issues have arisen since it was developed. The social policy of deinstitutionalization and the increased salience of genetic factors in the etiology of mental illnesses are examples of domains that might be represented in a new formulation of the OMI.

Because OMI did not cover issues of deinstitutionalization and the community treatment, Taylor and Dear (Taylor & Dear, 1981) created The Community Attitudes Toward the Mentally Ill (CAMI). This measure recycled three of the five OMI factors (authoritarism, benevolence, and social restrictiveness) and created a fourth factor assessing community mental health ideology. The CAMI measure has been translated into Finnish and used in an international survey analyzing attitudes of registered nurses working in Finland, Lithuania, Ireland, Italy and Portugal (Chambers et al., 2010).

A measurement stemming from Weiner's attribution theory (Weiner, 1986) focuses on a subject's emotional reaction e.g. (pity, anger), a subject's behavioral intentions, and the perceived controllability of a stigmatizing condition. According to this theory the target's perceived responsibility for the stigmatizing circumstance predicts anger and punishing actions (if believed to be controllable) or pity and helping behaviors toward the target (if believed to be uncontrollable). Weiner et al.'s (Weiner et al., 1988) attribution measure included eight questions about ten illnesses: 1) three questions using nine-point scales to assess the responsibility, blame, and changeability of each illness; and 2) five questions about the subject's liking, pity, anger, charitable donations, and personal assistance toward each of the ten conditions.

The Attribution Questionnaire (AQ) was developed by Corrigan (Corrigan, 2003) to measure key constructs defined in his social cognitive models. He used

Weiner et al.'s (Weiner et al, 1988) measure and 11 questions from Reisenzein (Reisenzein, 1986) that measured controllability, sympathy, anger, and helping behavior. Corrigan's AQ consists of 27 items measuring nine constructs. There is also a short 9-item version of this scale.

Angermeyer and Matchinger (Angermeyer & Matschinger, 1996) developed a scale to measure emotional reactions toward people with mental illnesses**.** The first version of this measure consisted of 18 five-point Likert scale items, with each item assessing a single emotional response. Factor analysis yielded three dimensions: (1) aggressive emotions; (2) prosocial reactions; and (3) feelings of anxiety. The final version of the instrument included the four items that loaded highest on each factor. This instrument's strengths are its assessment of affective experiences of the stigmatizer, which have previously been under-assessed, its demonstrated reliability, and its validity in demonstrating a predicted pattern of relationships with the construct of previous contact with mentally ill people.

Link (Link et al., 1989) constructed a perceived devaluation-discrimination measure (PDD) to test hypotheses associated with the "modified labeling theory". The measure assesses a respondent's perception of what most other people believe – a key feature of modified labeling theory. This 12-item instrument asks respondents the extent to which they agree or disagree with statements indicating that most people devalue current or former psychiatric patients by seeing them as failures, as less intelligent than other persons, or as individuals whose opinions need to be taken seriously. The scale also includes items that assess perceived discrimination by most people in jobs, friendships, and romantic relationships. The scale has been used mainly among people in treatment for mental illnesses but can be administered to members of the general public.

Griffiths and her colleagues have developed a Depression Stigma Scale (DSS) consisting of two parts with 9 items each (Griffiths et al., 2006, Griffiths et al., 2008). The first part assesses the respondent's personal attitudes toward the person described in the vignette (personal stigma). The second part assesses the respondent's beliefs about other people's attitudes toward the person described in the vignette (perceived stigma). Both parts contain essentially the same statements, but differ in terms of whether they were aimed at personal attitudes or the perceived attitudes of others. An example of a statement from the personal stigma part is: "John's problem is not a real medical illness". The corresponding statement in the perceived stigma part is "Most people believe that John's problem is not a real medical illness".

1.2.1.4 Use of vignettes in research on stigma

One of the most common methodological approaches employed in the study of the stigma of mental illness is the use of a vignette. This approach was first time used in stigma context by Star in 1955 (Star, 1955). A vignette can be perceived as a form of stimulus that researchers can ask people to react to. Following a vignette

description many types of measures can be applied. There are three major reasons for the popularity of the vignette approach. First, vignettes allow the researcher to present a more elaborate stimulus to respondents than is afforded in measurement approaches that simply ask people about "mental problems", "a psychiatric patient" or "a mental health consumer". Second, by using vignettes, the researcher can avoid the stigmatizing effect of using psychiatric language and third, vignettes allow for the use of random assignment and bring the power of the experimental method to hypothesis testing (Link et al., 2004). There is at least one limitation too. Vignettes are hypothetical and abstracted from "real life" experience. Thus people rely on cognitive schemas or scripts when reacting to this type of stimulus. There is no evidence that this reaction fits with their actual behavior.

1.2.2 Measures appropriate to people with personal experience of mental illness

A strongly increasing trend in the development of stigma measures in the last 15 years has been closely related to the need to evaluate anti-stigma interventions. Personal stigma of mental illness is often the key outcome in these interventions (Henderson & Thornicroft, 2009). The personal stigma can be considered in three main ways: perceived stigma, experienced stigma and self-stigma (Brohan et al., 2010).

Van Brakel and colleagues provide a definition of perceived stigma research as that in which "people with a (potentially) stigmatized health condition are interviewed about stigma and discrimination they fear or perceive to be present in the community or society" (Van Brakel et al., 2006). Le Bell suggests that perceived stigma can include both a) what an individual thinks most people believe about the stigmatized group in general and b) how the individual thinks society views him/her personally as a member of the stigmatized group (LeBel, 2008). Van Brakel and colleagues define experienced stigma as the "experience of actual discrimination and/or participation restrictions on the part of the person affected" (Van Brakel et al., 2006).

Corrigan uses the term public stigma to describe the ways in which the general public stigmatize people with mental illnesses (Corrigan 2000). He describes self-stigma as the internalization of this public stigma; "self-stigma refers to the reactions of individuals who belong to a stigmatized group and turn the stigmatizing attitudes against themselves" (Corrigan, 2000).

Brohan et al.'s review identified 14 measures appropriate to people with personal experience of mental illness (Brohan et al., 2010). Seven of the located measures addressed aspects of perceived stigma, 10 addressed aspects of experienced stigma and 5 addressed aspects of self-stigma. Of the identified studies, 79 percent used one of the measures of perceived stigma, 46 percent one of the measures of experienced stigma and 33 percent one of the measures of self-stigma. The

psychometric properties of these scales, of which many are quite new, have not been thoroughly examined and reported (Brohan et al., 2010).

In Brohan et al.'s review Links PDD was the most commonly used measure (82% of studies) appropriate to people with personal experience of mental illness (Brohan et al., 2010). Corrigan and Watson have built a measure, Self-Stigma of Mental Illness Scale (SSMIS), which consists of 40 items and four subscales: awareness of stereotypes, agreement of stereotypes, application of stereotypes to themselves, and decreased self-esteem or self-efficacy (Corrigan et al., 2006). Of those subscales, the first one "awareness of stereotypes" is a popular measure of perceived stigma and is similar to the "perceived stigma" of Link (Link et al., 1989). This scale also measures self-stigma.

As stereotype awareness is only one aspect of perceived stigma, there are also scales that focus on personal expectations or fears of encountering stigma (Brohan et al., 2010). One example of such scales is the Discrimination and Stigma Scale (DISC) constructed by Thornicroft et al. (Thornicroft et al., 2009). The DISC contains 4 items that address anticipated discrimination, or the expectation of being stigmatized in various aspects of life. The DISC can also be used as a measure of experienced stigma with its 32 items that address experiences of stigma in various areas of life including work, family and mental health service use (Thornicroft et al., 2009). The DISC has also been translated into Finnish and used in the international Indigo Study (Thornicroft et al., 2009) and in the European Anti Stigma Programme (ASPEN) which targets the reduction of stigma and discrimination against people with depression.

Another scale that operates with both perceived and experienced stigma is the Depression Self-stigma Scale (DSSS) by Kanter et al. (Kanter et al., 2008). In this scale perceived stigma is called public stigma, while it also measures self-stigma and treatment stigma. Another example of scales that measure both experienced stigma and self-stigma is the Internalized Stigma of Mental Illness (ISMI) by Ritscher et al. (Ritsher et al., 2003). This 29-item measure has 5 subscales: Alienation, Stereotype Endorsement, Perceived Discrimination, Social Withdrawal and Stigma Resistance. It has also been translated into Finnish and used in the European ASPEN project[1].

1.2.3 Scales measuring stigma associated with seeking mental health treatment

Vogel and colleagues have defined one important aspect of stigma as follows: "Stigma associated with seeking mental health services, therefore, is the perception that a person who seeks psychological treatment is undesirable or socially

[1] http://groups.stakes.fi/MTR/FI/projektit/Aspen.htm

unacceptable" (Vogel et al., 2006). Vogel and colleagues have also created the Self-Stigma of Seeking Help Scale (SSOSH) (Vogel et al., 2006). The SSOSH is a 10-item scale consisting of items such as "I would feel inadequate if I went to a therapist for psychological help". The internal consistency and structural validity of SSOSH seem to be good. Another commonly used measure for this aspect of stigma is the Attitudes Towards Seeking Professional Psychological Help Scale, developed originally as a 29-items version by Fischer and Turner (Fischer &Turner, 1970). Later a shorter form of 10 items was also developed (Fischer & Farina, 1995). The psychometrical qualities of both these scale forms have proved to be good. Schomerus et al. have recently developed the Anticipated Discrimination when Seeing a Psychiatrist scale (ADSP) (Schomerus et al., 2009). This scale has good internal consistency and factor analysis revealed a construct of three components: 1) anticipated discrimination, 2) anticipated job problems and, 3) anticipated shame.

1.2.4 Measures of actual interaction and implicit processes

Hebl and Dovidio have recommended that research into the actual interaction between stigmatizers and targets should be conducted (Hebl & Dovidio, 2005) to improve the understanding of the dynamics of stigma. The increased reliance on interactive paradigms would enable researchers to learn different sorts of information, to ask different types of questions and to observe different sets of dependent measures (e.g. verbal vs. nonverbal, self-reports vs. actual behavior). A reliance primarily on self-report responses may systematically distort conclusions about the dynamics of stigma. People are often not aware of their biases (Greenwald & Banaji, 1995) and they are usually not conscious of the actual sources that influence their decisions (Wilson & Nisbett, 1978).

Dovidio identified three waves of research in the study of prejudice (Dovidio, 2001). In the first wave, prejudice was assumed to reflect psychopathology. In the second wave it was viewed as rooted in normal processes. The third wave emphasized the multidimensional aspect of prejudice and took advantage of new technologies to study implicit (i.e. automatic and unconscious) attitudes and beliefs (Dovidio & Fazio, 1992; Greenwald et al., 1998).

1.3 Predictors of mental illness stigma

Previous research has contributed to a multifaceted comprehension of the stigma process and construction (Crocker et al., 1998; Link & Phelan, 2001; Corrigan, 2000) and of the typical stereotypical beliefs about mental illnesses (Brockington et al., 1993; Taylor & Dear, 1980). Forms of discrimination have also been investigated (Thornicroft et al., 2009; Angermeyer & Matschinger, 2005). However, for planning effective and well-targeted initiatives to reduce stigma, we need to identify factors that are related to it.

1.3.1 Sociodemographic variables

Many studies have reported on the influence of sociodemographic background variables on stigmatization. In the review article of Angermeyer and Dietrich, higher age and lower level of education most consistently predicted negative attitudes (Angermeyer & Dietrich, 2006). Results on the influence of gender are more conflicting. Statistically significant differences are rarely found, but if significant differences are revealed, women will usually show more positive attitudes (Angermeyer & Dietrich, 2006).

Also in Finnish population surveys, the attitudes of older people have been more negative than attitudes of younger people, which has been interpreted as a generational effect (Laine & Lehtinen, 1973; Lehtinen & Väisänen, 1977; Ojanen, 1992). In earlier studies women had more negative attitudes (Laine & Lehtinen, 1973; Lehtinen & Väisänen, 1977) but later men had more negative attitudes (Ojanen, 1992). Education has consistently been linked to more favourable attitudes. Studies dealing with urban rural differences come up with quite contradictory results (Angermeyer & Dietrich, 2006). A good example of this is two Finnish population surveys where in the first study (Laine & Lehtinen, 1973), no connection between place of residence and attitudes toward mental illness was found, but in the second study four years later, attitudes tended to be more negative in rural areas (Lehtinen & Väisänen, 1977).

Overall, the findings regarding the significance of socio-demographic variables is inconsistent and the predictive power of these variables on stereotypical thinking and discriminating behavior is relatively low (Van´t Veer et al., 2006; Phelan et al., 2000).

1.3.2 Personal experience

Whether a respondent is familiar with mental disorder, i.e. having personally experienced a mental disorder or having had personal contact with people suffering from mental disorder, has been used as an explanatory variable in many population surveys. Results usually indicate that familiarity with mental disorders is associated with more positive attitudes and a readiness to make social contacts with patients (Angermeyer & Dietrich, 2006).

Current psychological distress and depression have also been investigated as explanatory variables (Griffiths et al., 2008). Results revealed that current psychological distress was positively correlated with personal and perceived stigma. Personal stigma, perceived stigma and intention to maintain social distance were lower in people with a self-reported history of depression. However, family members and members of the general community with higher levels of contact with depression reported higher levels of perceived stigma (Griffiths et al., 2008). Also, knowledge about psychiatric illness seems to be a determinant for stigma.

Griffiths et al. found that personal stigma was higher among those with lower depression literacy (Griffiths et al., 2008).

In Finland Räty found in his qualitative analysis of a student population two quite independent determinants of the mental illness attitude: one's behavioural history and one's values. A subject's own behavioural history – or more precisely, her retrospective account of it – correlated strongly with her attitude: the more negative the experience concerning the mentally ill, the more rejective the attitude. Expressed values also correlated with attitudes: a person with an optimistic view emphasized democracy, morality and "soft values" such as a humane, anti-bureaucratic and ecologically-sound society. Based on a detailed analysis of accounts the following features appeared typical of a consistently positive attitude: (a) a tendency to minimize and counter-balance the negative characteristics of mental illness, (b) a questioning of taken-for-granted thinking, (c) a tendency to consider mental illness rather a social problem than a form of pathology, and (d) symbolic "we-categorization", i.e. the mentally ill person is a victim of unjust conditions and deserves our sympathy (Räty, 1987).

1.3.3 Stereotypical negative characteristics

Population studies have usually revealed that negative stereotypical characteristics are associated with mental disorders. First of all, people suffering from mental disorders are considered to be unpredictable and dangerous. Secondly, they are considered to be irresponsible. Thirdly, they are seen as child-like and finally the fourth stereotype is of a person who is incapable, which is associated with a self-inflicted weakness of character (Brockington et al., 1993). At least the first and fourth stereotypes have been used as explanatory variables in studies exploring social rejection (Van´t Veer et al., 2006; Phelan et al., 2000).

There is particularly strong evidence of significant relationships between wishing to maintain greater social distance toward those with mental illness and beliefs about their dangerousness (Brockington et al., 1993; Angermeyer & Matschinger, 2004) and the unpredictability or the inappropriateness of their social behavior (Angermeyer & Matschinger, 2004; Socall & Holtgraves, 1992). In Finland too, social distance among pharmacy students was linked to perceived dangerousness (Bell, et al., 2010). Also positive stereotypes such as "highly skilled", "creative", "healthy", "intelligent", and "trustworthy" have been measured in population studies (Brockington et al., 1993; Lauber et al., 2006). If people believed a mental health service user to be intelligent or trustworthy, they expressed less intention to take social distance (Brockington et al., 1993).

1.3.4 Causal beliefs

The idea of a self-inflicted weakness of personality refers also to causality. Results on the influence of causal beliefs on discriminative attitudes are inconsistent.

Some studies suggest (Brockington et al., 1993; Martin et al., 2000) that willingness to interact with mental patients is lower if people consider that they are responsible for their condition. It has been argued (Read, 2007) that biogenetic causal explanations are increasing prejudices and are connected with intentions toward keeping social distance. However, it has also been claimed (Jorm & Griffiths, 2008) that biomedical conceptualizations are not as important a cause of stigma as the behavior associated with mental illness and the belief that this is because of personal weakness. In this view personal weakness is primarily connected with the control of behavior not with the responsibility for the mental health problem.

1.3.5 Social norms

There are also suggestions in the literature on prejudice and stigma that stereotyped beliefs may have been overemphasized as determinants of behavioral intentions or actual behavior (Park & Judd, 2005). Goffman's writings on stigma even as early as the 1960s emphasized the importance of a perceived social consensus or norms concerning behavioral responses to stigmatized individuals (Goffman, 1963; Kusow, 2004). In a recent study Norman et al. examined the importance of perceived social norms in improving the prediction of social distance preferences toward those with depression and schizophrenia (Norman et al., 2008). They found that perceived norms were the most important predictor for an individual with either illness.

1.3.6 Other determinants

Researchers have most often assessed stigma associated with mental illness by surveying the public about attitudes toward "mental patients" or "persons with mental illness", vague terms that likely evoke images of chronic illness. A substantial part of the public cannot recognize specific mental disorders. Thus, when researchers have examined the differences in beliefs and attitudes toward different mental disorders, they often prefer to use vignettes (Link et al., 2004). The result has been that people with schizophrenia or alcoholism are more frequently considered as unpredictable and violent than people with depression and anxiety disorders. Rejection is most pronounced toward people with drug abuse and alcoholism, followed by those with schizophrenia, and is less pronounced toward people with depression and anxiety disorder (Corrigan et al., 2001; Link et al., 1999).

Also diagnostic labels themselves may induce prejudice (Penn & Nowlin-Drummond, 2001, Kulmala, 2006) but this result has not been affirmed in every study. Mann and Himelein for example found that stigmatization of schizophrenia diagnosis was significantly higher than stigmatization of depression diahgnosis. However, psychiatric terminology had no impact on attitudes toward mental illness in a student population (Mann & Himelein, 2004).

Some of the conflicting results in findings may result from the use of different populations. Researchers have mostly used national representative public population samples, student samples and clinical samples comprising people with different psychiatric disorders. Moscovici developed a theory of social representations (Moscovici, 1961). Social representations are "a system of values, ideas and practices with a twofold function; first, to establish an order which will enable individuals to orientate themselves in their material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them with a code for social exchange and a code for naming and classifying unambiguously the various aspects of their world and their individual and group history" (Moscovici, 1973).

This theory deliberately allows for the co-existence of competing and sometimes contradictory versions of reality in the same community, culture and individual (Howarth et al., 2004). Also, stereotypes (cognitive knowledge structures) about mental illnesses can be defined as social representations made by lay people (population), people with mental health problems or professionals, to orientate to people with mental disorders. This theory suggests that the elementary facts influencing stereotypes and discrimination depend on the history of an individual and group. The above mentioned results of Räty fit well with this theory too (Räty, 1987).

Also the use of different instruments measuring different stigma components may partly explain the inconsistencies of predictor studies. The scale (PDD) developed by Link et al. (Link et al., 1989) measures respondents' beliefs about other people's negative attitudes (perceived stigma), whereas Corrigan (Corrigan, 2000) studies the respondents' own personal views of, for example, depression (stereotypic agreement). Griffiths and colleagues have developed the Depression Stigma Scale (DSS) consisting of two parts, the first measuring respondents' personal attitudes (personal stigma, stereotypic agreement) and the second the respondents' assessment of other people's attitudes (perceived stigma). The results from these two subscales have varied significantly even within the same samples (Griffiths et al., 2006; Griffiths et al., 2008).

1.4 Mental illness stigma and use of mental health services

1.4.1 Use of mental health services

The psychiatric symptoms and disabilities of many people living with mental illness can be significantly improved by various psychiatric and psychosocial treatments. Unfortunately, although each year approaching 30 percent of the population worldwide has some form of mental illness, at most only one third of them receive mental health treatment (Kessler et al., 2003; Alonso et al., 2004; Kohn et al., 2004; Kessler et al., 2005; Wittchen & Jacobi, 2005). Only 34 percent of peo-

ple with major depression in Finland seek professional help (Hämäläinen et al., 2008). This treatment gap exists not only in minor mental illness, such as adjustment disorders, but also results in less than two thirds of people with schizophrenia taking part in treatment (Kohn et al., 2004); generally, people with serious mental illness do not participate in treatment more often than those with minor disorders (World Health Organization 2005).

The reasons proposed for this treatment gap include social support (Burns et al., 2003), access to health care (Amaddeo & Jones, 2007), severity of the disorder (Hämäläinen et al., 2008) and health belief systems (Leaf et al., 1988).

Descriptive models, which try to explain service use in terms of the combined effects of socio-demographics (age, gender, education), access (income, insurance, availability of services) and severity of illness, have only modest power to predict the help-seeking of people with mental conditions (Leaf et al., 1988).

1.4.2 Stigma associated with mental health disorders and the use of mental health services

There is conflicting empirical data about the effects of stigmatizing beliefs on seeking help for mental disorders from professionals. Some studies have found a connection (Barney et al., 2006; Mojtabai et al., 2002; Cooper-Patrik et al., 1997; Schomerus et al., 2009), while others have not (Ng et al., 2008; Jorm et al., 2000; Blumenthal & Endicott, 1996).

One explanation for the conflicting results could be the complexity of the concept of stigma and thus differences in measuring it. It has been demonstrated that some dimensions of stigma connected with mental illness were associated with potential care-seeking while others were not (Schomerus et al., 2009; Cooper et al., 2003). Schomerus et al. found that anticipated discrimination from others was unrelated to help-seeking intentions, while personal discriminatory attitudes seemed to hinder help-seeking for depression (Schomerus et al., 2009).

In another study of the relationship between the multidimensional model of stigma and care seeking, results show that in a student sample, respondents were less likely to seek services if they viewed people with mental illness as responsible for their disorder, did not pity them, reacted to them with anger, and were likely to withhold help. Unexpectedly, viewing people with mental illness as dangerous, fearing them, and endorsing coercive treatments were not found to be significantly related to care seeking (Cooper et al., 2003). In particular, perceived stigma and self-stigma have relevance in the context of help-seeking. In many cases, they seem to interact (Corrigan & Rusch, 2002; Vogel et al., 2007).

1.4.3 Theoretical models of help-seeking

Theoretical models for help-seeking behavior suggest that an individual progresses through several stages before seeking mental health treatment. They experience

symptoms, try to evaluate their significance, assess if they can manage by themselves or if treatment is required, asses the feasibility of and options for treatment, and decide whether to seek treatment (Goldberg & Huxley, 1980). Health belief theorists have shown that a rational consideration of the costs and benefits of participating in specific treatments may be an important factor when an individual decides to use services (Satcher, 1999). One such perceived cost to engaging in mental health services may be the risk of stigma. It has been suggested that many people hesitate to use mental health services because they do not want to be labeled a "mental patient" and want to avoid the negative consequences connected with stigma (Corrigan & Rusch, 2002). Among people who perceived a need for help with serious mental illnesses as well as nonpsychotic mental disorders, the most commonly reported reason both for failing to seek treatment (72%) and for treatment dropout (58%) was wanting to solve the problem on their own (Kessler et al. 2001). In a later study, Sareen's group reported similar results (Sareen et al. 2007).

Kohn's group has analyzed that there are two factors that contribute toward a low degree of mental health service use (Kohn et al., 2004). First, the reluctance of many people to seek help for mental - related problems because of their anticipation of stigma should they be diagnosed, and second, the reluctance of many people who do have a diagnosis of mental illness to advocate for better mental health care for fear of shame and rejection if they disclose their condition. In a recent literature review Thornicroft (Thornicroft, 2008) lists four potent factors that increase the likelihood of treatment avoidance, or long delays before presenting for care: (i) lack of knowledge about the features and treatability of mental illnesses; (ii) ignorance about how to access assessment and treatment; (iii) prejudice against people who have mental illness, and (iv) expectations of discrimination against people who have a diagnosis of mental illness.

In Corrigan's two-factor theory of stigma (Table 1) stereotypes, prejudice, and discrimination comprise the specific experiences of both public and self-stigma (Corrigan, & Rusch, 2002). Personal awareness of stereotypes does not necessarily mean agreement with them. But if people agree with negative stereotypes they have prejudices, with discrimination a possible behavioral consequence of prejudices. The experiences of people who wish to avoid stigma by not pursuing psychiatric services partially dovetail both elements of this theory. Corrigan names this group "potential consumers" (Corrigan, & Rusch, 2002). Potential consumers are members of the "public" who do not identify themselves as a part of "the mentally ill" minority. They are aware of the various stereotypes and may endorse part or all of the corresponding prejudices. Potential consumers also know the negative outcomes that result from being part of the minority group labeled mentally ill and wish to avoid the discriminatory results: the loss of opportunity that would other-

wise be provided by others and diminished self-esteem/self-efficacy applied to one's self (Corrigan, & Rusch, 2002).

Vogel et al. have presented a mediated model where they hypothesize that the effect of public stigma on help-seeking attitudes will be fully mediated through self-stigma (Vogel et al., 2007). In particular, public stigma is positively related to self-stigma, self-stigma is then negatively related to attitudes toward counseling, and attitudes, in turn, are positively related to the willingness to seek counseling. The results of their study gave a lot of support to this model (Vogel et al., 2007). These authors differentiate a perceived public stigma associated with seeking professional services from the perceived public stigma associated with mental illness (Vogel et al., 2006) and have developed scales to specifically measure this stigma component (Vogel et al., 2007).

1.4.4 Mental health literacy

An issue closely related to attitudes toward people with psychiatric conditions, mental health professionals and the service system, is people's knowledge about mental disorders, remedies and services. In a review of public beliefs regarding treatment for depression as well as on other psychiatric conditions, psychosocial interventions were predominantly perceived as favorable, while negative views prevailed about pharmacological treatments (Angermeyer & Dietrich, 2006). In general, without psychiatric treatment, the course of schizophrenia is seen more pessimistically than in the case of depression. Conversely, as long as appropriate treatment is provided, the prognosis for both disorders is assessed as quite optimistic (Angermeyer & Dietrich, 2006). Given that evidence exists of possibilities to improve people's awareness and knowledge about depression, public beliefs may over time move closer to those of health professionals (Highet et al., 2006). Nevertheless, it is still an open question if this would lead to an increase in actual help-seeking on a population level.

1.5 Aims of the study

To begin with my dissertation aimed at examining the prevalence of stigmatizing attitudes of a general population in western Finland. Secondly, I also tried to identify which factors are associated with stigmatizing of people with mental disorders for the purpose of planning effective and well-targeted initiatives to reduce stigma. My third interest was to examine the connection between personal stigma and help-seeking among people with depression. Up to 5 percent of people suffer from a clinically significant depressive disorder in Finland, while depressive symptoms are much more common (Aromaa & Koskinen, 2002). At the same time, only one third of persons suffering from depression are actually being treated for their disorder (Hämäläinen et al., 2008). Thus it is highly important to identify those factors that might have an influence in under-treatment. All these aims are closely

connected with the targets of the large-scale development project for the mental health and substance abuse services, the Ostrobothnia Project (Forsman et al., 2008).

The research questions were:

1. What are the underlying dimensions of survey items covering attitudes to mental health in the western Finland general population?
2. Are those identified dimensions in line with previous theoretical constructs and studies that have established links between attitudes and age, gender, educational level and familiarity with people suffering from mental illness?
3. What kinds of stereotypes about mental health problems are prevalent in a general population in western Finland and what are the negative consequences attached to mental health problems?
4. How well does a combination of potential variables predict stigmatizing attitudes and desire for social distance in a general population?
5. Do people with depressive symptoms in a general population carry different kinds of stigmatizing attitudes compared with non-depressive respondents?
6. Is there any connection between negative stigmatizing attitudes and the actual use of mental health services among those with depression?

2 Methods

2.1 Samples

A large-scale development project for mental health and substance abuse services, the Ostrobothnia Project, is being implemented in 2005-2014 by the hospital districts of Vaasa, South Ostrobothnia and Central Ostrobothnia regions. In addition, the regional depression project "Pohjalaiset masennustalkoot", established by the Vaasa and South Ostrobothnia hospital districts, was active in the area from 2004-2007. To lay the basis for an evaluation of the outcome and effectiveness of these projects, a population survey was performed in the spring 2005 in the Ostrobothnia Project area that aimed to define the situation before the project was to be conducted in 2011. The random population sample constituted of 5000 persons aged 15 to 80 from the intervention area and another 5000 persons of same age distribution from the Hospital District of Southwest Finland, which was the control area. A follow-up was conducted in spring 2008 and a further follow-demography of the Southwest Finland region can be considered similar to the intervention area.

In this dissertation two datasets were used. The first dataset originates from the 2005 survey, which had an overall response rate of 55.2 percent. Overall, females had a 65 percent response rate compared to 48 percent among males, while the response rate was highest in the 50-70 year age group. The average age of the respondents was 46.9 (SD 17.3) years. Overall, 15 percent of the respondents were Swedish-speakers. The lowest response rate was among Finnish-speaking men (42.1%) and the highest among Swedish-speaking women (79%). The data were weighted in the analyses according to age, gender, language and region to ensure representativeness of the general population in the research region. This dataset was used in Study I "Attitudes towards people with mental disorders: The psychometric characteristics of a Finnish questionnaire" (Aromaa et al., 2010).

The second dataset originated from the 2008 survey, which had an overall response rate of 51.6 percent. Overall, females had a 60 percent response rate compared to 43 percent among males, while the response rate was highest in the 50-70 age group. The average age of the respondents was 50.6 (SD 17.3) years. Overall, 16.5 percent of the respondents were Swedish-speakers. The lowest response rate was among Finnish-speaking men (42.1%) and the highest among Swedish-speaking women (68.8%). The data were weighted in the analyses according to age, gender, language and region to ensure representativeness of the general population in the research region. This dataset was used in Study II "Predictors of stigmatizing attitudes towards people with mental disorders in a general population in Finland" (Aromaa et al., 2011a) and in Study III "Personal stigma and use of men-

tal health services among people with depression in a general population in Finland"(Aromaa et al., 2011b).

2.2 Population survey

The survey was set up to collect information about mental health, attitudes towards mental disorders and the use of mental health and substance abuse services. The postal survey questionnaire was 8 pages long with 36 questions, many of which included several parts. In total, the survey yielded over 140 variables. The questionnaire in its entirety is presented in Appendix 1 (in English) and Appendix 2 (in Finnish).

In this dissertation I applied the following variables: Sociodemographic background variables were age, gender, native language (Finnish or Swedish), basic education (measured with an ordinal-level variable ranging from 1 (low level) to 3 (grammar/high school education) and vocational training (measured with an ordinal level variable ranging from 1 (no vocational training) to 6 (university degree).

The following standardized survey instruments were used to define different indicators related to mental health: Pearlin's Sense of Mastery Scale (Pearlin & Schooler, 1978) was used as an indicator for positive mental health and coping abilities. Pearlin and Schooler define mastery as "the extent to which one regards one's life changes as being under one's own control in contrast to being fatalistically ruled"(Appendix 1, question 12). In Study II the Cronbach's alpha for this scale was 0.81.

In Study II the OSLO-3 instrument was used (Brevik & Dalgard, 1996) to define the amount of social support. This scale consists of three items dealing with the number of confidants, the feeling of interest and concern from others, and the possibility for practical help from neighbors. The instrument's internal consistency in earlier studies has been poor (Korkeila et al., 2003) and it has not been properly validated and I therefore chose to use only one of its three items in Study II. Respondents answered the question "How many people are so close to you that you can count on them if you have serious personal problems? (Appendix 1, question 13).

Respondent's psychological distress was measured in Study II with the General Health Questionnaire (GHQ-12) scale (Goldberg & Hillier, 1979). Although this is not a diagnostic instrument, it identifies psychiatric problems with a 95 percent probability (Goldberg 2000). This version of the scale consisted of 12 items and the Cronbach's alpha for this scale in sample 2008 was 0.90 (Appendix 1, question 17).

Questions based on the Composite International Diagnostic Interview Short Form (CIDI-SF) (Kessler et al., 1998) were used to assess the prevalence and degree of severity of major depressive disorder within the last twelve months in Study II and Study III. The scale's internal consistency in the 2008 sample was 0.7

(Cronbach's alpha). (Appendix 1, questions 24 and 25). The familiarity with mental disorders was measured in Study II by asking if the respondent "knows someone who suffers from mental health problems?" (Appendix 1, question 18).

In Study III professional help-seeking was ascertained by asking: "Have you during the past 12 months used any health services because of mental problems?" and the use of different types of mental health services was investigated by asking: "During the last 12 months, did you seek help from any of the following service institutions in respect of a mental health problem" giving respondents 12 alternatives (Appendix 1, questions 19 and 20).

For this survey, sixteen statements exploring attitudes to and stereotypes of mental health were developed based on earlier studies measuring public attitudes toward mental health problems and also on researchers' clinical experience (Table 2, Appendix 1, questions 33 and 34). Eight of the statements related to mental health problems in general and eight to depression only. Three of the statements referred to perceived public stigma/stereotype awareness and the rest to personal stigma/stereotype agreement.

Table 2. The 16 questionnaire items on beliefs and attitudes towards people with mental problems, as well as the instructions used

Instruction: 'Below are some statements on general attitudes towards mental problems. Choose the alternative which you think suits best'.
1. Mental health problems are a sign of weakness and sensibility.[2]
2. You don't recover from mental problems.[2]
3. Patients suffering from mental illnesses are unpredictable.[2]
4. Society should invest more in community care instead of hospital care.[2]
5. If one tells about his/her mental problems, all one's friends will leave him/her.[1]
6. The professionals in health care do not take mental problems seriously.[1]
7. It is difficult to talk with a person who suffers from mental illness.[2]
8. If the employer finds out that the employee is suffering from mental illness, the employment will be in jeopardy.[1]
Instruction: 'Below are some statements on general attitudes towards depression. Choose the alternative which you think suits best'.
9. Depression can't be treated.[2]
10. Depression is not a real disorder.[2]
11. Depression is a sign of failure.[2]
12. Antidepressants are not addictive.[2]
13. Depressed people should pull themselves together.[2]
14. Antidepressants have plenty of side-effects.[2]
15. People with depression have caused their problems by themselves.[2]
16. Depression can be considered as a shameful and stigmatizing disease.[2]

[1] Statements refer to perceived public stigma/stereotype awareness.
[2] Statements refer to personal stigma / stereotype agreement

The scale "Depression is a matter of will", used in Study II and Study III, measures negative stereotypes about people with depression and the belief that people with depression are responsible for their illness and their recovery. It was built from the following five statements measuring personal stigma:

1. "Depression is a sign of failure"
2. "People with depression have caused their problems by themselves"
3. "Depressed people should pull themselves together"
4. "Mental health problems are a sign of weakness and sensibility"
5. "Depression is not a real disorder"

These statements were extracted by principal component analysis (PCA) (Tabachnick & Fidell, 2001) from the dataset originating from the 2005 survey. Prior to performing the PCA the suitability of the data for factor analysis was assessed.

The PCA revealed the presence of four components with eigenvalues exceeding 1, explaining 21.7 percent, 9.3 percent, 8.1 percent and 6.6 percent of the variance respectively (Table 3). This model accounted for 45.7 percent of the total variance. To aid in the interpretation of these four components, a Varimax rotation was performed. An identical PCA was performed three years later in a similar population survey and it identified exactly the same structure of four components. The main component, here called "*Depression is a matter of will",* consisted of eight items and accounted for 21.7 percent of the variance. If the three items with low loadings ("Patients suffering from mental illness are unpredictable","Depression can't be treated" and "You don't recover from mental health problems") were excluded, I had a feasible five-item-scale with an internal consistency of 0.70 (Cronbach's alpha) and inter-item correlations from 0.38-0.50. A high score on this scale indicates a belief that a person is responsible for the cause and course of his or her depression, and also capable of recovering from the illness if sufficiently strong-willed.

Table 3. Results of the Principal Components Analysis (followed by Varimax rotation) applied to the 16 items data collected in 5504 population sample (only the 14 significant items are listed)

	Component loadings			
Items	**I**	**II**	**III**	**IV**
Depression is a sign of failure	0.69			
People with depression have caused their problems by themselves	0.65			
Depressed persons should pull themselves together	0.65			
Mental health problems are a sign of weakness and sensibility	0.64			
Depression is not a real disorder	0.59			
If one tells about her mental problems, all friends will leave her		0.70		
If the employer finds out that the employee is suffering from mental problems, the employment will be in jeopardy		0.64		
The professionals in health care do not take mental problems seriously		0.62		
Depression can be considered as a shameful and stigmatizing disease		0.52		
It is difficult to talk with a person who suffers from mental illness		0.48		
Antidepressants are not addictive			-0.76	
Antidepressants have plenty of side-effects			0.67	
You don't recover from mental problems				0.47
Depression can't be treated				0.46

The second attitude scale in this dissertation study called "Antidepressant attitudes" consisted of the two items: "Antidepressants are not addictive" and "Antidepressants have plenty of side-effects". This 2-item scale has a very low internal consistency of 0.42 but because these items are highly correlated, they are used as a measure of antidepressant attitudes/knowledge in Study III. A higher score on this scale indicates a belief that antidepressants are addictive and have plenty of side effects.

The third attitude scale in Study II and Study III, called "Desire for Social Distance", reflects personal desire for social distance. This scale was constructed from a different set of items contained in the survey questionnaire (Appendix 1, question 35) and is based on respondents' expressed willingness in four different imaginary situations to be in contact with a person who has mental problems:

1. "Would you be willing to marry or be in a common law marriage with someone who has mental problems?"
2. "Would you be willing to give your child into the care of someone who has mental problems?"
3. "Would you be willing to choose someone who has mental problems as your work colleague?"
4. "You find out that a rehabilitation centre for patients with mental illnesses is being planned in your neighborhood. Would you object to the plans?"

The fifth question "A person you know is committed to psychiatric hospital care. Would you be willing to visit him there?" was not included in the scale to strengthen the internal consistency and because of its poor ability to differentiate. A higher total score means less willingness to be in contact with a person who has mental problems. The internal consistency of this scale was 0.70 (Cronbach's alpha).

Six individual stereotypical statements were used as predictive variables in the most comprehensive model in Study II where imaginary discriminative choices were the dependent variable. Three of these stereotypical statements measured perceived stigma: "If one tells about her mental problems, all friends will leave her", "If the employer finds out that the employee is suffering mental illness, the employment will be in jeopardy" and "The professionals in health care do not take mental problems seriously". Three statements measured personal stigma/stereotype agreement: "Depression can be considered as a shameful and stigmatizing disease", "It is difficult to talk with a person who suffers from mental illness" and "Patients suffering from mental illnesses are unpredictable".

2.3 Statistical analyses

In Study I the sixteen attitude items were subjected to principal components analysis (PCA). The principal components analysis is a widely used and validated tool for identifying the underlying dimensions in a set of variables (Tabachnick &

Fidell, 2001). After the factor extraction, Varimax rotation was performed because orthogonal rotation results in solutions that are easier to interpret. The internal consistency of the new scales was assessed using Cronbach's alpha coefficient. In Study I the preliminary examination of the construct validity was performed by investigating the relationship between the formulated scales and respondents' age, gender, educational background and familiarity with someone who has experienced mental illness himself, using the Pearson correlation coefficient.

In Study II the relative effects of predicting variables on stigma components and discriminative choices were analyzed with a series of hierarchical regression analyses. Analyses composed of three or four blocks, with the changes in explanatory power of these blocks tested statistically. The standardized coefficients were presented in different columns (model 1 – model 4).

In Study III the connections between depression and components of personal stigma were analyzed using logistic regressions. Age and gender were entered in this model simultaneously with attitude components. The relative effects of three attitude scales on 12-month help-seeking among persons with depression were also analyzed using logistic regressions. Age and gender as well as the degree of depression were entered in this model simultaneously with attitude components. All analyses in these three dissertation studies were carried out with SPSS 16 software (SPSS Inc, Chicago, IL, 2006).

3 Summary of the three studies

3.1 Study I

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2010). Attitudes towards people with mental disorders: the psychometric characteristics of a Finnish questionnaire. *Social Psychiatry and Psychiatric Epidemiology, 45,*265-273.

Study I investigated the background dimensions of the survey items covering attitudes to mental health, and their connection to stigma theories and earlier studies. The construct validity of the questionnaire statements was also assessed. An 8-page health survey questionnaire with 16-items on attitudes to mental health and depression was sent to a randomly selected sample of 10000 persons aged 15-80. Seven of these items related to mental health problems in general and nine to depression only. The items were based on earlier studies measuring public attitudes toward mental health problems and also on researchers' clinical experience. The overall response rate was 55.2 percent. The data were submitted to a principal components analysis (PCA).

The PCA identified four components: (1) "Depression is a matter of will", (2) "Mental problems have negative consequences" (3) "One should be careful with antidepressants " and (4) "You never recover from mental problems". The internal consistencies of the first two components were assessed sufficiently to build dimension scales for future analyses.

The preliminary examination of the construct validity was performed by investigating the relationship between the formulated scales and respondents' age, gender, educational background and familiarity with someone who has experienced mental illness himself, using the Pearson correlation coefficient. Further, an analysis was made of the consistency between the formulated scales and results from earlier population mental health awareness studies. The extracted components fit consistently with the leading stigma theories and earlier studies measuring public attitudes.

3.2 Study II

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2011). Predictors of stigmatizing attitudes towards people with mental disorders in a general population in Finland. *Nordic Journal of Psychiatry, 65*,125-132.

The first aim of Study II was to get a general picture of the prevailing beliefs on mental health problems and attitudes toward persons with mental illness in western Finland. Secondly this study examined how well a combination of variables predicts stigmatizing attitudes and desire for social distance.

The 8-page mental health survey questionnaire with 16 items on attitudes to mental health and depression was sent to a randomly selected sample of 10000 persons aged 15-80 years in 2008. The overall response rate was 51.6 percent. Attitudes were measured using a scale consisting of negative stereotypes about people with depression and stereotypical beliefs connected with mental problems, while desire for social distance was also measured by a scale. Potential predictors included demographic variables (age, gender, education, native language), sense of mastery and perceived personal social support, familiarity with someone who has experienced mental health problems himself, personal experience of depression or psychological distress and negative stereotypical beliefs. The relative effects of these variables were examined with hierarchical linear regression analyses.

Although 86 percent of the general population thought that depression is a real medical condition and 83 percent opposed the idea that those with depression are responsible for causing their illness, 58 percent reported that persons with depression should "pull themselves together". In other words, a clear majority of respondents felt that people with depression are not responsible for their illness; however, simultaneously a majority believed that they were responsible for their recovery. A lot of negative characteristics were linked with people with mental disorders and negative consequences were linked with the disclosure of the disorders.

Negative stereotypes associated with depression were most powerfully predicted by gender. Women were less likely to hold negative attitudes towards people with depression as were those with a higher education and people with Swedish as their mother language. A stronger sense of mastery and higher perceived social support predicted more positive attitudes. In addition, a person's own depressive symptoms and knowing someone who has had mental health problems were related to more favourable attitudes towards people with depression.

Factors which significantly predicted a stronger desire for social distance included higher age, the female gender, having Swedish ones native language, lower sense of mastery, milder depression, less familiarity with people with mental health problems and most strongly negative stereotypical beliefs held. The explanative power of the predictive variables was 23.6 percent in this comprehensive model.

These results suggest that he message "Depression is a real medical condition" is insufficient in anti-stigma campaigns. We must also emphasize that depression is not one's own fault, and that people do not have to manage depression on their own. The results also suggest that older people and those without familiarity with mental problems are potential target groups for reducing stigma. When planning interventions for shaping stereotypes, one potential target group could be men with a low sense of life control and poor social networks. Direct interactions with persons who have mental problems may change the stereotypical beliefs and discriminative behavior of those who do not have familiarity with mental problems.

3.3 Study III

Aromaa, E., Tolvanen, A., Tuulari, J., & Wahlbeck, K. (2011). Personal stigma and use of mental health services among people with depression in a general population in Finland. *BMC Psychiatry,* 11:52.

Study III examined whether people with depressive symptoms in a general population carry different kinds of stigmatizing attitudes compared with non-depressive respondents and if there is any connection between attitudes and the actual use of mental health services among those with depression. The survey questionnaire was mailed to 10000 persons aged 15-80 who were randomly selected from the Finnish Population Register and resided in four hospital catchment areas in western Finland. The overall response rate was 51.6 percent. Attitudes were determined by scales which measured the belief that people with depression are responsible for their illness and their recovery and also measured attitudes toward antidepressants. Desire for social distance was measured by a scale and depression with the Composite International Diagnostic Interview Short Form (CIDI-SF) instrument. Use of mental health services was measured by self-report.

On the "Desire for Social Distance" scale, people with depression showed more social tolerance toward people with mental problems. They also carried more positive views about antidepressants. Among those with depression, users of mental health services, as compared to non-users, carried less desire for social distance to people with mental health problems and more positive views about the effects of antidepressants. More severe depression predicted more active use of services.

Although stronger discriminative social intentions can reduce the use of mental health services, this does not necessarily prevent professional service use if depression is serious and views about antidepressant medication are realistic. One important target in public health campaigns should be to improve people's knowledge about anti-depressant medication. The beliefs about plentiful side effects and a high risk of becoming addicted to antidepressants needs clarification in people's minds, because those ideas may have a connection with professional help seeking. The impact of addressing these topics in public campaigns should be evaluated in future research.

The individual attitude items outside of the scales were left out of the regression models in the published article "Personal stigma and use of mental health services among people with depression in a general population in Finland" (Aromaa et al., 2011b). However, I entered the individual items to those analyses simultaneously with stigma-scales, age and gender and found interesting connections between individual items and depression (not reported in published Study III). Agreement with the following statements statistically significantly predicted depression: "Depression can't be treated", "Depression can be considered as a shameful and stigmatizing disease", "The professionals in health care do not take

mental problems seriously", "If one tells about his/her mental problems, all friends will leave him/her" and "You don't recover from mental problems". Agreement with the following statement statistically significantly predicted an absence of depression: "It is difficult to talk with a person who suffers from mental illness".

Also the connections of individual attitude statements with the use of mental health services after age and gender, depression severity and stigma-scales were controlled for showed that agreement with the following statements statistically significantly predicted active service use:"You don't recover from mental problems", "Depression can be considered as a shameful and stigmatizing disease". Disagreement with the statement "Patients suffering from mental illnesses are unpredictable" also predicted active service use.

Those with depression were more pessimistic about the usefulness of care and the prognosis for mental problems on the whole. They were afraid of becoming stigmatized in the health care system and agreed with a stigmatizing stereotype about depression as a shameful disease. Among those with depression, users of mental health services, as compared to non-users, expressed more pessimism about recovery. Personal agreement with seeing depression as a stigmatizing disease was associated with use of mental health services. Personal agreement with the stereotype that people with mental health problems are unpredictable was linked to less use of mental health services.

4 Discussion

Overall, the results suggest that the attitude items used in this survey questionnaire cover many of the general stereotypes about mental illnesses. Four components were extracted: (1) "Depression is a matter of will" (2), "Mental problems have negative consequences" (3), "One should be careful with antidepressants " and (4) "You never recover from mental problems". The results also showed that people perceive a lot of negative consequences to be associated with mental problems. When all variables were included into the predictive model, the desire for social distance was significantly associated with respondents' age, gender, native language, sense of mastery, depression, familiarity with mental problems and most strongly with stereotypical beliefs. On the "Desire for Social Distance"- scale, people with depression showed more social tolerance toward people with mental problems. They also carried more positive views about antidepressants. The results suggested that among those with depression, users of mental health services, as compared to non-users, carried less desire for social distance to people with mental health problems and more positive views about the effects of antidepressants. More severe depression predicted more active use of services.

4.1 The stigma measures in the population survey

The measurement of mental illness stigma in this dissertation was based on two kinds of instruments. First, the thirteen items referring to negative stereotypes about people with mental problems measure stereotype agreement as conceptualized by Corrigan (Corrigan, 2000) or personal stigma as Griffiths has conceptualized it (Griffiths et al., 2008). The two scales called "depression is a matter of will" and "antidepressant attitudes" were built from these statements and used in Study II and Study III. Three statements referred to perceived stigma as conceptualized by Link (Link et al., 1989) or stereotype awareness by Corrigan (Corrigan, 2000). These statements were used as predictor variables in Study II. Second, a scale to measure desire for social distance was built and used in Study II and III. This four item scale was based on respondents' expressed willingness in four different imaginary situations to be in contact with a person who has mental problems. This type of measure has been very popular in population stigma research especially combined with vignettes (Jorm, A.F. & Oh, 2009).

Study I made clear that there were four dimensions that underlay the questionnaire items on attitudes to mental health problems, of which two were assessed as sufficiently reliable to be used to formulate scales with adequate psychometric validity. The findings of this study confirm the results of earlier studies that have shown stigma to be a multidimensional construction (Wolf et al., 1996; Watson et

al., 2005; Jorm & Wright, 2008). The dimensions found are dependent, at least, on what kind of attitude survey items are used and also on the type of mental disorder targeted. In Study I the statements referred on the one hand to ‘‘mental health problems,’’ in general and to depression specifically on the other. The statements selected were primarily chosen to serve a research interest in public attitudes toward the use of health services, and secondly, to aid the planning of a public awareness campaign. Two of the dimensions found applied to depression: the first is ‘‘depression is a matter of will’’ and the second ‘‘one should be careful with antidepressants’’. The dimensions ‘‘mental problems have negative consequences’’ and ‘‘you never recover from mental problems’’ consisted of items that referred to both depression and mental health problems. An identical structure to these four dimensions was found by principal component analysis on a data set from 2008.

The first dimension ‘‘depression is a matter of will’’ challenges the respondent to consider the nature of depression. Does the respondent see depression as a real medical condition, and if not, is depression a matter of personal weakness and laziness? This latter viewpoint would indicate the view that persons are responsible for their illness and for their recovery. This is a common stereotypical belief, identified in many studies (Griffiths et al., 2006; Brockington et al., 1993; Taylor & Dear, 1980; Crisp et al., 2000). Jorm and Wright’s (Jorm & Wright, 2008) study among young Australians identified a survey component they labeled as ‘‘weak not sick.’’ This component seems to correspond conceptually to the controllability dimension identified in Study I. Jorm and Wright also found that respondents’ exposure to ongoing awareness campaigns reduces the stigma effect among young people particularly in this dimension (Jorm & Wright, 2008).

Analysis of the answers to individual items on this dimension revealed some interesting findings in Study II. Although 86 percent of the general population thought that depression is a real medical condition and 83 percent opposed the idea that those with depression are responsible for causing their mental health problems, 58 percent believed that persons with depression should “pull themselves together”.

Brickman et al. presented a model where a distinction between attribution of responsibility for a problem and attribution of responsibility for a solution was drawn (Brickman et al., 1982). They derived four general models that specified what form people’s behavior will take when they try to help either others or themselves. In the first model, the moral model, actors are held responsible for both problems and solutions and are thought to need proper motivation. In the compensatory model, people are seen as not responsible for problems but responsible for solutions and are believed to need power. In the medical model, individuals are seen as responsible for neither problems nor solutions and are believed to need

treatment. In the enlightenment model, actors are seen as responsible for problems but as unable or unwilling to provide solutions and are thought to need discipline.

The compensatory model explains the stereotypes found in this study well. A clear majority of respondents thought that people with depression are not responsible for their illness and simultaneously a majority believed that they were responsible for recovery and advised them to gain strenght by "pulling themselves together". Advice along the lines of ''pull yourself together'' from a lay person given to a person with depression does not necessarily reflect negative attitudes. Also, in professional psychotherapies one of the aims is to encourage people to take more responsibility for their life choices, problem solving and welfare. The self-responsibility approach is most commonly applied to substance abuse and eating disorders, but also to depression, which in turn is more strongly associated with self-responsibility than schizophrenia (Griffiths et al., 2006; Angermeyer & Matschinger, 2004; Taylor, & Dear, 1980). Brockman's model can also be used to analyze these differences. Perhaps people with schizophrenia are usually not seen as responsible for their illness or recovery and needing treatment, while people who misuse alcohol and have eating disorders are perceived as being responsible for their problems as well as their recovery.

The second dimension ''mental problems have negative consequences'' indicates those various negative consequences a person might face if other people know about his or her mental illness. The statements forming this dimension challenge the respondents to think about whether the risk of telling someone about a mental problem is worth taking. A high score on a scale consisting of the items of this dimension was thought to reveal that the respondent is aware of the common manifestations of discrimination and of the risk of being stigmatized. However, this dimension was not used as a scale in Studies II and III because some of its items referred to perceived stigma and others to personal stigma. Perhaps this mixture also explains the low internal consistency (Cronbach's alpha 0.6) of this scale. Some of the single items of this dimension were however used as predictive variables in Study II.

Statements about the risks connected to antidepressants constitute the third dimension in both data. This dimension was used in Study III as a two-item scale and renamed as "antidepressant attitudes". Studies have shown that the public easily confuse antidepressants with anxiolytics and therefore are afraid of their addictive nature and adverse effects (Priest et al., 1996). On a behavioral level, this can be seen as an unwillingness to seek or adhere to treatment that uses medication as a primary or sole option. There is also evidence that earlier experiences of adverse effects while taking medication diminish adherence to treatment (Dwight-Johnson et al., 2001). However, it is important to remember that antidepressants, although they are not addictive, do have adverse effects (Hollon et al., 2005). Well-informed people may be aware of adverse effects and therefore be

critical of the use of antidepressants. Thus, this dimension does not necessarily reflect stigmatizing beliefs, but may also reflect a lack of knowledge or appropriate skepticism.

The dimension ‘‘you never recover from mental problems’’ reveals not only respondents’ conceptions about mental illnesses, but also the levels of optimism associated with treatment. Studies have shown that the public are even more optimistic in relation to recovery from schizophrenia and severe depression than professionals, especially if the treatment programme includes psychotherapy. The public are more suspicious, however, of medication (Angermeyer & Dietrich, 2006; Jorm et al., 1997; Lauber et al., 2001; Paykel et al., 1998). The most common stereotype that the public share is the unpredictability and dangerousness of mentally ill patients (Angermeyer & Matschinger, 2004; Martin et al., 2000; Crisp et al., 2000). In our questionnaire, the statement ‘‘people suffering from mental illness are unpredictable’’ was dealt with as a separate item to the formulated scales because of its weak loading to two dimensions at the same time. This item was used in Study II as a predictor variable.

4.2 The preliminary construct validity of the scales

Construct validity refers to the ability of a measurement tool (e.g., a survey, test, etc) to actually measure the psychological concept being studied. In other words, does it properly measure what it is supposed to measure (Everitt, 1996).

The preliminary examination of the construct validity in Study I supported the factor solution chosen. If the dimensions found in the PCA were valid, the results would be expected to correspond with earlier studies. The results gained are in line with previous studies that establish links between attitudes and the three sociodemographic variables (age, gender, education). These three variables were chosen because their significance has been the most consistent in previous research (Angermeyer & Dietrich, 2006). However, sociodemographic variables explain only a small part of the total variance of the attitude measurements while previous studies are also inconsistent in their results (Griffiths et al., 2008; Van´t Veer et al., 2006). The effect of sociodemographic variables may be determined through several mediating variables. Such mediating variables could be, for example, personal familiarity with people suffering from mental illness, susceptibility to depression, psychological distress, knowledge about mental illnesses, conceptions of causes of mental illness or stereotypical attitudes (Griffiths et al., 2008; Van´t Veer et al., 2006). This result was also supported by results in Study II.

The scales measuring "Depression is a matter of will" and "Mental problems have negative consequences" varied somewhat in their associations to sociodemographic variables. The age -variable correlated more clearly with the consequences –component, with older people seeing more negative consequences. This may be because older people have more experiences of mental illnesses and with

the negative consequences linked to them. In Finland the educational level of older generations is also notably lower, which can have a covariate effect on age associations in both dimensions. There were also differences between the genders: women were more optimistic in their assessments than men and women did not blame the mentally ill for being responsible for their illness as much as men did.

It seems that persons who are familiar with people suffering from mental problems can more easily understand that people with depression are not responsible for their illness. On the other hand, these people who have familiarity probably also have experiences of the negative consequences linked with mental illnesses, with close family ties to persons with mental health problems implying more realistic views about the discriminating reactions of others. If a respondent was familiar with a mentally ill person from his work or friendship, the responses on the consequences dimension were slightly more positive than those of respondents who were not familiar.

The construct validity of the dimensions is also strongly supported by the fact that same structure of four components was found three years later in another independent data set used in Study II.

4.3 The negative consequences attached to mental health problems

In Study II, a lot of negative consequences were connected with the disclosure of mental health problems, such as perceived and personal stigma and discrimination in social relationships, work, and health care. Similar results have been reported around the world (Griffiths et al., 2006; Crisp et al., 2000; Schomerus et al., 2006). Further, the findings in relation to the desire for social distance are also consistent with earlier studies (Angermeyer & Matschinger, 2005; Van´t Veer et al., 2006; Link et al., 1999; Lauber et al., 2004). It is much easier to choose someone who has had mental problems as your work colleague than to trust him as a nurse for your children. The more intimate the relationship, the more wary people are.

4.4 Predictors of stigmatizing attitudes toward people with mental disorders

Although many of the predicting variables used in earlier studies was included and native language and indicators of positive mental health were added among the predictors, the predicting power of the models was relatively modest in Study II. Even in the most comprehensive model it was only 23.6 percent of the total variance of the desire for social distance. The result corresponds well with results from The Netherlands (Van´t Veer et al., 2006) and Australia (Griffiths et al., 2008). This may indicate that the elementary facts influencing social discrimination are highly individual and dependent on situational facts. Haghigat has suggested that the origins of stigmatization can be divided into four elements - consti-

tutional, psychological, economic and evolutionary - and argues that the fundamental basis of all stigmatization is the pursuit of self-interest (Haghigat, 2001).

Of the sociodemographic predictive variables that were used, gender and age turned out to have the strongest significance in relation to dependent stigma variables. Women show statistically significantly more tolerant attitudes on the depression scale, but interestingly, when the scale of stereotypical beliefs is added as a predictive variable in the most comprehensive model, women seem to be more cautious than men in their social distance choices. Perhaps women are more inclined toward safety and weigh candidates for marriage or babysitting more carefully than men. In the data age does not have any connection with beliefs about depression, although younger generations seem to be more ready to have contacts with persons suffering from mental problems. Lower education was clearly associated with the idea that people with depression are responsible for their illness but had no connection with social distance taking. Language has a connection with beliefs about depression and distance choices. The Swedish speaking minority holds more tolerant beliefs on depression than the Finnish speaking majority, but in social choices they seem to be more restrictive than Finnish speakers.

To my knowledge, this dissertation is the first piece of research to examine a sense of mastery and perceived social support as determinants of stereotypical beliefs and desire for social distance toward people with mental problems. Mental health resources measured as a sense of mastery and having many friends to rely on predicted more positive beliefs on the depression scale. It might be that trust in one's own life control and in social support gives self-confidence and lessens worries about negative consequences. The concept of social capital may also be relevant to explain this finding because trust in social support is one main component of social capital. There is evidence about a positive correlation between mental health and social capital (Almedon, 2005). But interestingly, in the most comprehensive model, where the desire for social distance is the dependent variable, a stronger sense of mastery correlates positively with distance keeping. This may indicate that people with high life control also strive to control external circumstances by creating distance to people with mental disorders.

Familiarity with someone suffering from a mental problem turned out to be a predictor for more positive beliefs on depression and predicted also a lower desire for social distance, a result that supports earlier findings (Link & Phelan, 2001; Paykel et al., 1998). The explanatory power of one's own depressive symptoms was statistically significant but relatively weak in regard to the depression scale and stronger in regard to the desire for social distance scale. One might expect depressed people to even be strongly aware that they are not responsible for their problems, but these results suggest that they also share the stereotypes prevailing in society and maybe stigmatize themselves.

The scale for stereotypical beliefs "Depression is a matter of will" and the six negative stereotypical statements of mental problems showed the strongest predictive power on discriminative choices in the most comprehensive model. This result supports earlier findings (Van´t Veer et al., 2006; Phelan et al., 2000; Link et al., 1999; Crisp et al., 2000), where negative stereotypical beliefs were strongly connected with discriminative intentions. However, these models also indicate how important it is to understand that stigmatization is a process. Good knowledge or positive beliefs do not necessarily mean less discrimination in practical situations. For example although women and Swedish speakers hold more optimistic and tolerant beliefs, they begin to hesitate when faced with intimate social choices.

In Study II statements measuring personal stigma had a much stronger connection with discriminative intentions compared with statements measuring perceived stigma. Awareness of negative attitudes among the public may link to feelings of empathy and a willingness to help, but personal stigma may link to fear and a feeling of inconvenience. And often the latter feelings seem to make people cautious and may manifest as discrimination. It could also be that those who carry stereotypical beliefs about people with a mental disorder are afraid to be identified with what is perceived as a stigmatized group and so want to keep a distance, as Corrigan et al. suggests (Corrigan & Rusch, 2002).

That those who think depression is self-inflicted are more careful in making contact with people with mental problems corroborates the results of Martin et al. (Martin et al., 2000). They found that people who attribute mental health problems to individual causes such as "bad character" or the "way the person was raised" are less willing to interact with people with mental health problems than those who believe in structural causes (e.g., stress or genetic/biological causes). Also Jorm and Griffiths (Jorm & Griffiths, 2008) found that attribution to weakness of character was associated with more social distance.

That familiarity with someone suffering from a mental problem makes people more ready to engage in social contacts is an endorsement of the idea of many anti-stigma campaigns to invite people to become acquainted with people suffering from mental health problems (Penn & Martin, 1998; Pinfold et al., 2003, Angermeyer et al., 2004; Corrigan & Wassel, 2008). In Finland Räty (Räty, 1987) also found a connection between students experiences and mental illness attitudes in his qualitative analysis.

4.5 Personal stigma and use of mental health services among people with depression

To my knowledge Study III is the first large population study in Europe that investigates the connection between stigmatizing attitudes and actual use of mental health services among those with depression. Study II revealed that the belief that people with depression are responsible for their illness is common in Finland. This

result fits well with a recent international comparison study which analysed mental health stigma and its determinants among pharmacy students in six countries (Bell et al., 2008) and found that the largest share (44%) of students in Finland agreed that people with severe depression have themselves to blame. Study II also showed that people commonly believe in negative consequences if mental problems are disclosed.

Kessler et al. (Kessler et al., 2003) have investigated why people with serious mental illnesses failed to seek treatment or dropped out of their treatment. The most common reason for this was their intention to solve the problem on their own. Therefore recognizing one's disease does not help very much if we at the same time share the typical cultural belief that we must solve our problems by ourselves. The results of a descriptive study from data 2005 (Aromaa et al., 2007) appeared similar to the results of Kessler. Almost 90 percent of the respondents reported themselves willing to seek help from their family and relatives if affected by depression, while 68 percent would contact a psychiatric outpatient clinic and 58 percent a primary health care clinic. Accordingly, the three most popular ways to treat one's depression were physical exercise, going on holiday and relaxation exercises. Only 19 percent thought antidepressant drugs to be a very suitable form of treatment and 55 percent thought them to be somewhat suitable.

In Finland, Tontti analyzed the causal explanations of people who had sought psychotherapy for their depression (Tontti, 2000). In his qualitative analysis he found that 21 percent of explanations were connected with interpersonal relationships, 14 percent were connected with cognitive problems, 13 percent with childhood history, 11 percent with working life and economy, 8 percent with personality and only 3 percent were connected with body and illness. Thus, it seems logical that these people primarily trust in self-help and social support and only secondarily in antidepressant medication and other professional help.

In Study III the occurrence of depression and personal beliefs about one's own responsibility for depression did not correlate. One might expect people with depression to be aware that they are not responsible for their problems, but our results suggest that many of them also share the stereotypes prevailing in society and maybe stigmatize themselves. An alternative explanation for this result is depression itself. Self-accusation is one of the typical symptoms in depression and it may counteract the personal knowledge about the nature of the origins of depression. On the social discrimination scale, people with depression showed more social tolerance toward people with mental problems. This replicates results from previous studies (Angermeyer et al., 2004; Corrigan et al., 2001). The greater the knowledge of or experience with mental illness, the less frequently people express the desire to keep social distance from people with mental conditions. Perhaps experiencing the burden of depression helps one empathize with the suffering of other people. Those with depression seem to know more about the non-addictive

nature of antidepressants, possibly because of their own experiences of those medicines.

In Study III almost 40 percent of persons with questionnaire scores indicating major depressive disorder had had contact with health care professionals during the last year. Internationally this is a rather positive result but far from optimal. Another result was also alarming: the prevalence of depression was higher among younger people, but older people used services more actively. In Study III, respondents with more serious depression had used mental health services more actively. This connection has likewise been found in previous studies too (Hämäläinen et al., 2004; Burns et al., 2003).

It can be assumed that if a person believes that he is responsible for his depression, he bears more feelings of guilt and shame and hesitates to seek professional help. In my data this hypothesis was not confirmed. The scale "Depression is a matter of will" was not connected to service use.

If respondents with depression say they are willing to have close social contact with people with mental problems, their probability of using mental health services was higher. This connection has been found in at least one earlier study (Cooper et al., 2003). Perhaps people with depression are not worried about the perceived public stigma associated with seeking professional services if they have had contact with someone who has experienced mental problems.

Attitudes toward antidepressant drugs seem to be an important differentiating factor between those who use mental health services for their depression and those who do not. Knowledge or belief about the adverse effects of antidepressants is relevant but even more so is the worry about addiction. This worry may connect with the idea of "self management" and that many people are afraid of all kinds of dependence - also in therapeutic relationships. On a primary health care level, the role of attitudes toward antidepressants is especially important because psychotherapy is often unavailable.

4.6 Individual attitude items and use of mental health services

Those with depression have a more pessimistic view about the prognosis for mental problems and depression and many members of this group seemed to agree with the statement "depression can be considered as a shameful and stigmatizing disease". People with depression also seemed to be aware of the risks of being discriminated against by health care services, i.e., that professionals in health care do not take mental problems seriously.

Putting these pieces of information together gives some ideas about the possible reasons people might have for not seeking professional help for depression. People with depression seem to be more pessimistic about the usefulness of care and at the same time they are afraid of becoming stigmatized by the health care

system (perceived public stigma) and personally agree with the stigmatizing stereotype of depression as a shameful disease, leading to self-stigma. It can thus be hypothesized that people who agree with these stereotypes probably do not seek mental health services.

Those with depression indeed agreed more often with the statement "depression can be considered as a shameful and stigmatizing disease". Agreement with this stereotype had a connection also with help-seeking from professionals, but not in the way I supposed. Stronger agreement did not prevent help-seeking. On the contrary, if the depressed respondent shared this stereotype, she had used mental health services more often. This seemingly paradoxical result can be explained in several ways.

One alternative is the seriousness of a respondent's condition. If symptoms are serious enough, she perhaps prefers all possible ways to relieve her condition although there is a risk of becoming stigmatized. In my data this explanation receives support from the finding that people with more severe depression indeed had used more mental health services and there was also a positive correlation ($r=.16$, $n=219$, $p<.05$) between severity of depression and the statement "depression can be considered as a shameful and stigmatizing disease".

On the other hand, people's views of their illness and feelings of shame may in part be a symptom of their depression. A third explanation is that stigma experiences are aroused or strengthened by seeing the way mental health services are organized or through having contacts with mental health professionals. It is interesting to note that although those with depression agreed with the view in the statement on perceived stigma "the professionals in health care do not take mental problems seriously", agreement with this statement did not have a connection with actual service use. Anticipated stigmatizing reactions from health care professionals did not put people off seeking their help. In a recent German study (Schomerus et al., 2009) anticipated discrimination from others was unrelated to help-seeking intention, while personal discriminatory attitudes seemed to hinder help-seeking. The conclusion was that self-stigmatization is an important mechanism that decreases the willingness to seek psychiatric help. Likewise, in this study, the attitude statements that had a statistically significant connection with service use were all measuring personal stigma.

Here again the seriousness of depression can play an important role. There was a positive correlation between severity of depression and the statement "the professionals in health care do not take mental problems seriously" ($r=.19$ $n= 221$ $p<.01$) and of course we must remember that the direction of causality is an open question. Perhaps those who have used mental health services have experienced that health care professionals do take patients seriously. Many other elements in mental health treatment can also affect service users' knowledge and attitudes. If there are psychoeducational and/or case management elements in therapeutic dis-

cussions, this can change peoples' knowledge and concerns about stigma (Sirey et al., 2005; Gilbody et al., 2003).

Agreement with the pessimistic statement "You don't recover from mental problems" was positively connected with the use of mental health services. This result is compatible with a previous study (Burns et al., 2003) where a connection was found between "hopelessness" and help-seeking among those with affective disorders. Hopelessness often occurs in serious depression and in our data severity of depression was positively correlated with the use of services. There was also a positive correlation between severity of depression and the statement "You don't recover from mental problems" ($r=.17$, $n=215$, $p<.05$). Thus again the seriousness of depression may interact with our stigma items.

In the whole general population sample, people with depression symptoms held to the stereotype" patients suffering from mental illnesses are unpredictable" less often. Those people with depression and agreeing with this stereotype made less use of mental health services. This result can be interpreted as an expression of people's worry of being identified as a stigmatized mental patient by using the same services. The idea that people with mental illness are unpredictable is logically closely connected with another usual stereotype about dangerousness. Members of the general public who hold to this stereotype have reported fear of those with mental illness, want to keep their distance and prefer coercive services for them (Link et al., 1999; Penn et al., 1999).

4.7 Strengths, limitations and ethics of this study

To my knowledge this is the first large population study in Europe that has investigated the connection between stigmatizing attitudes and actual use of mental health services among people with depression. The findings of this dissertation can be generalized in Finland given the use of a large representative general population sample.

However, one should be very careful to generalize these results internationally because the Finnish population is highly educated and the degree of general knowledge and social capital is high.

Second, because I constructed my own attitude and social discrimination measures we must be careful when comparing these results with the results of other studies and in any attempt to generalize the results of this dissertation. This methodological solution was adopted because this study used data from a large cross-sectional postal survey with wide research interests. However, many of the individual statements were identical with previous stigma studies.

There are two ideal ways to build up a new stigma scale. The first one is to do it from a theoretical basis, such as done by for example Link et al. (Link et al., 1989) or Corrigan (Corrigan, 2000). The other way is to start from earlier qualitative research into patients' or the public's experiences and views of mental illness.

The work of Michael King's group (King et al., 2007) is a good example of this kind of approach. In this dissertation the point of view was pragmatic. I wanted simply to find out in Study I what these statements really measure and are they a good enough tool for evaluating future population-level interventions. One problem in these kinds of statements is that one cannot know if the answer to the individual item tells about a stigmatizing belief or a lack of knowledge or perhaps of negative experiences. The statements on antidepressants are a good example of this and also some of the items in the negative consequences dimension in Study I. Before the latter dimension can be used as a scale all the five items must be revised so that they refer either to personal stigma or to perceived stigma.

Third, in some attitude items such vague expressions are used as "mental health problem" or "mental illness" which can be perceived in different ways by respondents. It is possible that a person with depression does not think that he or she has a "mental health problem". We also know that stereotypes connected with different mental conditions can vary a lot (Crisp et al., 2000).

Fourth, a problem with these scales is that they measure only cognitions and intentions, not feelings or actual behavior toward people with mental disorders. However, most of the instruments intended to measure attitudes and stigma can be criticized for this same reason (Thornicroft et al., 2009; Jorm & Oh, 2009; Lauber et al., 2004).

Fifth, the survey response rates were 55.2 percent (dataset 2005) and 51.6 percent (dataset 2008). However, nowadays a response rate over 50 percent is acceptable and even in some cases can be considered good (Bishop, 2005). In these data the risk of non-response bias is highest among the young, with the response rate under 40 percent for those aged 16-23 and also among men, with a response rate of 48 percent (2005) and 43 percent (2008) compared with women's 65 percent (2005) and 60 percent (2008). It is known that non-respondents to the GHQ-12 have a higher prevalence of psychiatric morbidity (Williams & MacDonald, 1986) and we might suspect that the postal questionnaire version of CIDI-SF may suffer a similar problem.

Sixth, social desirability may always have an effect on attitude questionnaires (Link et al., 2004). People are likely to underreport their stigmatizing stereotypes compared with their real-life behavior.

Seventh, in Study III actual service use among those with depression was measured with respondents' self-reports. The true percentage of service users may be higher because of its association with shame and social desirability. Further, non-response bias is possible. Those with more severe depression may choose not to complete the survey. On the other hand, in this study 40 percent of those with depression reported that they had used professional services. In another recent Finnish study this percentage was 34 (Hämäläinen et al., 2008).

Finally, these studies are cross-sectional and we cannot be sure that there is a causal relationship between these variables.

This kind of population postal survey contains many sensitive questions about mental health, use of alcohol, attitudes and use of health services. These may have an influence on the response rate but also provoke psychological distress among receivers. According to Finnish legislation ethical approval is needed only for medical research, which is defined as research involving interventions. Thus, ethical approval is not needed for e.g. register-based research, opinion polls or anonymous general population postal surveys.

In the research questionnaire we advised the receiver to contact his/her own primary health care centre if the questions arouse worries about their own mental health. The respondents could also contact the research team for additional information. In addition, the questionnaire included an open question for possible comments. In both surveys a lot of comments were provided. A great majority were highly positive reflecting that people felt grateful for the interest in mental health issues. Critical comments regarding the inclusion of certain questions were rare.

4.8 Implications and conclusions

My results support the usefulness of the scales "depression is a matter of will", "antidepressant attitudes" and "desire for social distance" in future follow-up surveys to assess the effectiveness of the anti-stigma projects. The short scales I extracted are however nothing but a starting point for a standardized stigma scale. For example, many of the statements were presented in the negative, emphasizing perhaps the stigmatizing attitudes. For future purposes it could be relevant to reverse some of the statements and see if there is any difference in the results. The internal consistency of the scales could also become stronger with some additional items.

The analysis of public attitudes in Finland can support the planning and evaluation of future public awareness campaigns. In particular, people's views about how responsible mental patients are for their condition can be addressed. Another important target in public health campaigns should be to improve people's knowledge about anti-depressant medication. The beliefs about plentiful side effects and a high risk of becoming addicted to antidepressants needs clarification in people's minds, as those ideas may have a connection with professional help seeking.

The inconsistence between disease concept and controllability suggests that perhaps the message "Depression is a real disease" is not enough in public awareness campaigns in Finland to encourage people to seek help early. It is also important to be aware that people link the revealing of mental disorders with negative consequences. One such consequence may be that those with serious mental illnesses will decide not to seek professional treatment for fear of the stigma that

will come if such a move were to become publicly known. The mediating role of stereotypical beliefs seems to be important in stigma processes and this must be taken into consideration when planning anti-stigma interventions.

In future research it may be useful to include other negative as well as positive stereotypes and the connection between positive indicators of mental health and stigma need to be verified in other samples and also with other mental health resources. The impact of addressing these topics in public campaigns should be evaluated in future research.

This dissertation offers a general picture of the prevailing beliefs on mental health problems and attitudes toward persons suffering from mental illnesses in Finland. The results suggest that future statistical analyses can make use of not only responses to the individual questionnaire statements, but also the two scales built up by means of principal components analysis and the scale measuring the desire for social distance. The results suggest that among older people and those without familiarity with mental problems the need for anti-stigma interventions is highest. The connections I found suggest that especially when planning interventions to counter negative stereotypes, one potential target group could be men with a low sense of life control and poor social networks. Although a stronger desire for social distance can reduce the use of mental health services among those with depression, these data suggest that this does not necessarily prevent professional service use if depression is serious and views about antidepressant medication are realistic.

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Appendix 1. Mental health population survey 2008

1. Year of birth: **19**_____

2. Gender: ☐ *male* ☐ *female*

3. Municipality of residence:_____

4. Civil status: ☐ *Living alone* (*unmarried, divorced, widower/widow*)
☐ *Common-law marriage* ☐ *Married*

5. How many people belong to your household (yourself included)? _____

6. Your basic educational status: ☐ *Elementary school* ☐ *Middle school*
☐ *Comprehensive school* ☐ *Matriculation*

7. Which of the following is the highest educational level that you have completed?

☐ No *vocational training* ☐ *Vocational course or on the job –training*
☐ *Vocational school/Vocational training* ☐ *Vocational college level training*
☐ *Higher vocational diploma* ☐ *University degree*

*If you are uncertain, please write down your degree*_____

8. Which of the following describes best your present and main activity? (With main activity, we mean activities that take most of your time or which constitute your main incomes.)

☐ *Fulltime employed* ☐ *Part-time employed (also part-time retirement)*
☐ *Still in training (fulltime student)* ☐ *Retired* ☐ *Unemployed or temporarily dismissed*
☐ *Stay at home parent* ☐ *Military service/non-military service*
☐ *Other, what?*_____

9. How active are you when it comes to association activities?

☐ *Very active* ☐ *Fairly active* ☐ *Not very active* ☐ *Not active at all*

10. Have you at any time before this survey heard about the Ostrobothnia Project, which targets mental health and substance abuse services?

☐ *Yes* ☐ *No*

11. Have you at any time heard about the regional depression project 'Pohjalaiset masennustalkoot'?

☐ *Yes* ☐ *No*

12. In the following we will present you statements about your experience of your ability to control and master things in your life. We would like you to tell whether *you strongly agree, agree, disagree or strongly disagree* with the statements.

	Strongly Agree	*Agree*	*Disagree*	*Strongly Disagree*
a. I have little control over the things that happen to me.	☐	☐	☐	☐
b. There is really no way I can solve some of the problems I have.	☐	☐	☐	☐
c. There is little I can do to change many of the important things in my life.	☐	☐	☐	☐
d. I often feel helpless in dealing with the problems of life.	☐	☐	☐	☐
e. Sometimes I feel that I'm being pushed around in life.	☐	☐	☐	☐
f. What happens to me in the future mostly depends on me.	☐	☐	☐	☐
g. I can do just about anything I really set my mind to.	☐	☐	☐	☐

13. In the following we will make questions about how your experience your social relationships. Choose one of the options given for each question.

a. How many people are so close to you that you can count on them if you have serious personal problems? ☐ *None* ☐ *1 or 2* ☐ *3 – 5* ☐ *More than 5*

b. How much concern do people show in what you are doing?

☐ *A lot of concern and interest* ☐ *Some concern and interest* ☐ *Uncertain*
☐ *Little concern and interest* ☐ *No concern and interest*

c. How easy is it to get practical help from neighbours if you should need it?

☐ *Very easy* ☐ *Easy* ☐ *Possible* ☐ *Difficult* ☐ *Very difficult*

14. Do you feel lonely?

☐ *Often* ☐ *Sometimes* ☐ *Seldom* ☐ *Never*

15. Choose the alternative which you think suits best.

	Fully correct	*Quite correct*	*Quite incorrect*	*Fully incorrect*
a. I feel I belong and am part of my neighbourhood.	☐	☐	☐	☐
b. Most people in my neighbourhood can be trusted.	☐	☐	☐	☐
c. It is better not to trust anyone.	☐	☐	☐	☐

16. During the past 4 weeks, have you had any of the following problems in your work or in other daily activities caused by emotional problems (for example depression or anxiety)?

	Yes	*No*

a. Cut down the amount of time you spent on work or other activities. ☐ ☐

b. Accomplished less than you would like. ☐ ☐

c. Didn't do work or other activities as carefully as usual. ☐ ☐

17. We would like to know how your health has been in general, over the past few weeks. Have you recently....

a. ... been able to concentrate on your work?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

b. ... lost much sleep over worry?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

c. ... felt that were playing a useful part in things?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

d. ... been capable of making decisions about things?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

e. ... felt constantly under strain?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

f. ... felt, like you couldn't overcome your difficulties?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

g. ... been able to enjoy your normal day to day activities?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

h. ... been able to face up to your problems?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

i. ... been feeling unhappy and depressed?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

j. ... been losing self confidence in yourself?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

k. ... been thinking yourself as worthless person?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

l. ... been feeling reasonably happy all things considered?

☐ *much less than usual* ☐ *same as usual* ☐ *more than usual* ☐ *much more than usual*

18. Do you know someone who has a mental illness? *You may choose several alternatives.*

☐ *within the family or relatives* ☐ *friends* ☐ *from work* ☐ *someone from hobbies*

☐ *elsewhere. From where?* _____

☐ *I don't know anybody*

19. Have you during the past 12 months used any health services because of mental problems? ☐ *Yes* ☐ *No If you answered "no", please go to question number 22.*

20. During the last 12 months, did you seek help from any of the following service institutions in respect of a mental health problem? *You may choose several alternatives.*

☐ *From the primary health care centre* ☐ *From the occupational health care*
☐ *From the student health care* ☐ *From the mental health clinic or a psychiatric clinic*
☐ *From the substance misuse services* ☐ *From family counselling*
☐ *From a private physician or psychologist clinic* ☐ *From a psychiatric hospital*
☐ *From other hospital* ☐ *From a rehabilitation institution*
☐ *From the emergency room* ☐ *From elsewhere, where?*_____

21. a. Did your treatment help you?

☐ *Very much* ☐ *Quite a lot* ☐ *Somewhat* ☐ *Rather little* ☐ *Rather little or not at all*

b. Did your treatment include medical treatment? ☐ *Yes* ☐ *No*

22. There are different ways of treating depression. How suitable do you think that following treatment methods are?

	Very suitable	***Somewhat suitable***	***Not at all suitable***
Pull yourself together	☐	☐	☐
Light therapy	☐	☐	☐
Relaxation exercises	☐	☐	☐
Physical exercise	☐	☐	☐
Take antidepressants	☐	☐	☐
Take sedatives or sleeping medicine	☐	☐	☐
Take alternative medicine	☐	☐	☐
Take alcohol	☐	☐	☐
Treat oneself to something	☐	☐	☐
Group discussions with others who suffer from depression	☐	☐	☐
Individual discussion therapy (e.g. psychotherapy)	☐	☐	☐
Discussion forums on the internet	☐	☐	☐

23. Where would you seek help for depression?

	Certainly	***Probably***	***Hardly***	***Never***
from the health centre	☐	☐	☐	☐
from a private doctor	☐	☐	☐	☐
from a private professional who offer discussion therapy	☐	☐	☐	☐

from the occupational/student health care	☐	☐	☐	☐
from the mental health clinic or psychiatric clinic	☐	☐	☐	☐
from a priest or a healer	☐	☐	☐	☐
from my friends	☐	☐	☐	☐
from my family and relatives	☐	☐	☐	☐
I would not seek help	☐	☐	☐	☐

24. a. During the past 12 months, was there ever a time when you felt sad, blue or depressed for two weeks or more in a row? ☐ *Yes* ☐ *No*

b. During the past 12 months, was there ever a time when you lost interest in most things like hobbies, work, or activities that usually give you pleasure for two weeks or more in a row? ☐ *Yes* ☐ *No*

If you answered "no" for both questions, please go to question number 26.

25. For the next few questions, please think of the two week period during the past 12 months when these feelings were worst.

a. During that time did the feelings of being sad, blue, or depressed usually last all day long, most of the day, about half the day or less than half the day?

☐ *All day long* ☐ *Most of the day* ☐ *About half the day* ☐ *Less than half the day*

b. During those two weeks, did you feel this way every day, almost every day or less often?

☐ *Every day* ☐ *Almost every day* ☐ *Less often*

Thinking about those same two weeks, what problems did you encounter	***Yes***	***No***
c. Did you feel more tired out or low on energy than is usual for you?	☐	☐
d. Did you gain or lose weight without trying, or did you stay about the same?	☐	☐
e. Did you have more trouble falling asleep than you usually do during those two weeks?	☐	☐
f. Did that happen every night or nearly every night?	☐	☐
g. Did you have a lot more trouble concentrating than usual?	☐	☐
h. People sometimes feel down on themselves, no good or worthless. During that two week period, did you feel this way?	☐	☐
i. Did you think a lot about death – either your own, someone else's, or death in general during those two weeks?	☐	☐

	Yes	***No***
26. a. During the past 12 months, have you had suicidal thoughts?	☐	☐
b. During the past 12 months, have you tried to commit a suicide?	☐	☐

27. Have you ever drunk alcohol?

☐ *Yes, during the past 12 months* ☐ *Yes, but not during the past 12 months*

☐ *No, never. If you have answered 'no, never', please go to question number 32.*

28. The following questions are about your alcohol use	***Yes***	***No***
a. Have you ever felt you should cut down on your drinking?	☐	☐
b. Have people annoyed you by criticizing your drinking?	☐	☐
c. Have you ever felt bad or guilty about your drinking?	☐	☐
d. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	☐	☐

29. In the last 12 months, did you seek professional help for an alcohol problem?

☐ *Yes* ☐ *No* *If you answered "no", please go to question number 32.*

30. In the last 12 months, did you seek help from any of the following service institutions in respect of an alcohol problem? *You may choose several alternatives*

☐ *From the primary health care centre* ☐ *From the occupational health care*

☐ *From the student health care* ☐ *From the mental health clinic or a psychiatric clinic*

☐ *From the substance misuse services* ☐ *From family counselling*

☐ *From a private physician or psychologist clinic* ☐ *From a psychiatric hospital*

☐ *From other hospital* ☐ *From a rehabilitation institution*

☐ *From the emergency room* ☐ *From elsewhere, where?*_____

31. Did your treatment help you?

☐ *Very much* ☐ *Quite much* ☐ *Somewhat* ☐ *Rather little* ☐ *Little or not at all*

32. Choose the alternative which you think suits best.

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***
a. Alcoholism is a real medical illness	☐	☐	☐	☐
b. Health care professionals do not take alcohol problems seriously	☐	☐	☐	☐
c. Alcohol problems can't be treated	☐	☐	☐	☐
d. Alcohol problems can be considered as shameful and stigmatizing	☐	☐	☐	☐

33. Below are some statements on general attitudes towards mental illness. Choose the alternative which you think suits best.

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***
a. Mental health problems are a sign of weakness and sensitivity.	☐	☐	☐	☐
b. You don't recover from mental problems.	☐	☐	☐	☐

c. Patients suffering from mental illnesses are unpredictable.	☐	☐	☐	☐
d. The society should invest more in community care instead of hospital care.	☐	☐	☐	☐
e. If one tells about his/hers mental problems, all friends will leave him/her.	☐	☐	☐	☐
f. The professionals in health care do not take mental problems seriously.	☐	☐	☐	☐
g. It is difficult to talk with a person who suffers from mental illness.	☐	☐	☐	☐
h. If the employer finds out that the employee is suffering from mental illness, the employment will be in jeopardy.	☐	☐	☐	☐

34. Below are some statements on general attitudes towards depression. Choose the alternative which you think suits best.

	Strongly Agree	***Agree***	***Disagree***	***Strongly Disagree***
a. Depression can't be treated.	☐	☐	☐	☐
b. Depression is not a real disorder.	☐	☐	☐	☐
c. Depression is sign of failure.	☐	☐	☐	☐
d. Antidepressants are not addictive.	☐	☐	☐	☐
e. Depressed persons should pull themselves together.	☐	☐	☐	☐
f. Antidepressants have side effects.	☐	☐	☐	☐
g. Depressed persons have caused their problems by themselves.	☐	☐	☐	☐
h. Depression can be considered as a shameful and stigmatizing disease.	☐	☐	☐	☐

35. Please answer the following imaginary questions as you find best.

	Yes	***Probably***	***Probably not***	***No***
a. Would you be willing to marry or be in a common law marriage with someone, who has mental problems?	☐	☐	☐	☐
b. Would you be willing to give your child for care for someone who has mental problems?	☐	☐	☐	☐
c. Would you be willing to choose someone who has had mental problems as your work colleague?	☐	☐	☐	☐
d. You find out, that a rehabilitation centre for patients	☐	☐	☐	☐

with mental illnesses is being planned in your neighbourhood. Would you object to the plans?

e. A friend of yours is committed to hospital caused by mental illness. Would you be willing to visit him/her in the hospital? ☐ ☐ ☐ ☐

36. Please feel free to write down your thoughts and experiences of the connection between your well-being and other people.

_____

_____

YOUR COMMENTS.

Please feel welcome to write down your comments and opinions about this questionnaire:

_____

_____

THANK YOU!

Appendix 2. Mielenterveyttä koskeva kyselytutkimus 2008

1. Syntymävuotesi: **19_____**

2. Sukupuolesi: ☐ *mies* ☐ *nainen*

3. Missä kunnassa asut? _____

4. Mikä on siviilisäätysi? ☐ *yksinasuja (naimaton, eronnut, leski)*
☐ *avoliitossa* ☐ *avioliitossa*

5. Kuinka monta henkilöä kuuluu kotitalouteesi tällä hetkellä itsesi mukaan luettuna? _____

6. Peruskoulutuksesi: ☐ *kansakoulu* ☐ *keskikoulu*
☐ *peruskoulu* ☐ *ylioppilastutkinto*

7. Mikä on korkein peruskoulutuksen jälkeen suorittamasi koulutus tai tutkinto?

☐ *ei mitään ammattikoulutusta* ☐ *ammatillinen kurssi tai työpaikkakoulutus*
☐ *ammattikoulu/ammatillinen koulu* ☐ *ammatillinen opistotutkinto*
☐ *ammattikorkeakoulututkinto* ☐ *korkeakoulututkinto*
Jos olet epävarma, kirjoita tutkintosi tähän: _____

8. Mikä seuraavista vaihtoehdoista kuvaa parhaiten tämänhetkistä pääasiallista toimintaasi?
(Pääasiallinen on se toiminta, johon käyttää eniten aikaa tai josta saa eniten tuloja.)

☐ *kokopäivätyössä* ☐ *osa-aikatyössä (myös osa-aikaeläkeläiset)*
☐ *opiskelija* ☐ *eläkkeellä* ☐ *työtön tai lomautettu*
☐ *hoitamassa omaa kotitaloutta tai perheenjäseniä* ☐ *varusmies- tai siviilipalvelussa*
☐ *muu, mikä? _____*

9. Kuinka aktiivisesti osallistut yhdistystoimintaan?

☐ *erittäin aktiivisesti* ☐ *melko aktiivisesti* ☐ *melko vähän* ☐ *en ollenkaan*

10. Oletko joskus ennen tätä kyselyä kuullut mielenterveys- ja päihdetyön *Pohjanmaa-hankkeesta*?

☐ *Kyllä* ☐ *Ei*

11. Oletko joskus kuullut *Pohjalaiset masennustalkoot* -hankkeesta?

☐ *Kyllä* ☐ *Ei*

12. Esitämme Sinulle seuraavaksi elämän hallintaan liittyviä väitteitä. Voit olla väitteen kanssa joko *täysin samaa mieltä, osittain samaa mieltä, osittain eri mieltä tai täysin eri mieltä.* Valitse Sinua parhaiten kuvaava vaihtoehto.

	Täysin	***Osittain***	***Osittain***	***Täysin***

	samaa mieltä	*samaa mieltä*	*eri mieltä*	*eri mieltä*
a. Voin vaikuttaa vain vähän minulle tapahtuviin asioihin.				
b. En pysty millään ratkaisemaan joitain ongelmiani.	☐	☐	☐	☐
c. En voi tehdä paljoakaan muuttaakseni asioita elämässäni.	☐	☐	☐	☐
d. Tunnen usein avuttomuutta elämän ongelmien edessä.	☐	☐	☐	☐
e. Joskus minusta tuntuu että elämä kohtelee minua miten tahtoo.	☐	☐	☐	☐
f. Se mitä minulle tulevaisuudessa tapahtuu riippuu lähinnä minusta itsestäni.	☐	☐	☐	☐
g. Kykenen tekemään lähes kaiken sen minkä todella päätän tehdä.	☐	☐	☐	☐

13. Seuraavaksi esitämme kysymyksiä ihmissuhteistasi.

a. Kuinka monta sellaista läheistä Sinulla on, joihin voit luottaa kun Sinulla on vakavia henkilökohtaisia vaikeuksia? ☐ *ei yhtään* ☐ *1 – 2* ☐ *3 – 5* ☐ *enemmän kuin 5*

b. Kuinka paljon ihmiset osoittavat mielenkiintoa siihen, mitä teet?

☐ *paljon mielenkiintoa* ☐ *jonkin verran mielenkiintoa*
☐ *olen epävarma* ☐ *vähän mielenkiintoa* ☐ *ei lainkaan*

c. Kuinka helppoa Sinun on tarvittaessa saada naapureiltasi käytännön apua?

☐ *erittäin helppoa* ☐ *helppoa* ☐ *mahdollista* ☐ *vaikeaa* ☐ *erittäin vaikeaa*

14. Tunnetko itsesi yksinäiseksi?

☐ *Usein* ☐ *Joskus* ☐ *Harvoin* ☐ *En koskaan*

15. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista mielestäsi sopivin

	Pitää täysin paikkansa	*Pitää melko lailla paikkansa*	*Ei juuri pidä paikkansa*	*Ei lainkaan pidä paikkansa*
a. Tunnen kuuluvani naapurustooni ja olevani osa sitä.	☐	☐	☐	☐
b. Useimmat ihmiset naapurustossani ovat luotettavia.	☐	☐	☐	☐
c. On parasta olla luottamatta kehenkään.	☐	☐	☐	☐

16. Onko Sinulla viimeksi kuluneiden neljän viikon aikana ollut tunne-elämään liittyvien ongelmien johdosta (esimerkiksi masennus tai ahdistuneisuus) mitään seuraavista ongelmista työssäsi tai muissa päivittäisissä toiminnoissasi?

	Kyllä	*Ei*
a. Olen vähentänyt työhön tai muuhun toimintaan käyttämääni aikaa.	☐	☐
b. Olen saanut aikaan vähemmän kuin mitä olisin halunnut.	☐	☐
c. En ole pystynyt suorittamaan töitäni tai muita toimintojani yhtä huolellisesti kuin tavallisesti.	☐	☐

17. Haluaisimme tietää millainen vointisi on yleensä ollut viime viikkoina. Oletko viime aikoina….

a. … pystynyt keskittymään töihisi?

☐ *paremmin kuin tavallisesti*
☐ *yhtä hyvin kuin tavallisesti*
☐ *huonommin kuin tavallisesti*
☐ *paljon huonommin kuin tavallisesti*

b. … valvonut paljon huolien vuoksi?

☐ *en ollenkaan*
☐ *en enempää kuin tavallisesti*
☐ *jonkin verran enemmän kuin tavallisesti*
☐ *paljon enemmän kuin tavallisesti*

c. … tuntenut, että mukana olosi asioiden hoidossa on hyödyllistä?

☐ *tavallista hyödyllisempää*
☐ *yhtä hyödyllistä kuin tavallisesti*
☐ *vähemmän hyödyllistä kuin tavallisesti*
☐ *paljon vähemmän hyödyllistä kuin tavallisesti*

d. … tuntenut kykeneväsi päättämään asioista?

☐ *paremmin kuin tavallisesti*
☐ *yhtä hyvin kuin tavallisesti*
☐ *huonommin kuin tavallisesti*
☐ *paljon huonommin kuin tavallisesti*

e. … tuntenut olevasi jatkuvasti rasituksen alaisena?

☐ *en ollenkaan*
☐ *en enempää kuin tavallisesti*
☐ *jonkin verran enemmän kuin tavallisesti*
☐ *paljon enemmän kuin tavallisesti*

f. … tuntenut, ettet voisi selviytyä vaikeuksistasi?

☐ *ei ollenkaan*
☐ *ei enempää kuin tavallisesti*
☐ *jonkin verran enemmän kuin tavallisesti*
☐ *paljon enemmän kuin tavallisesti*

g. … kyennyt nauttimaan tavallisista päivittäisistä toimistasi?

☐ *enemmän kuin tavallisesti*
☐ *yhtä paljon kuin tavallisesti*
☐ *vähemmän kuin tavallisesti*
☐ *paljon vähemmän kuin tavallisesti*

h. … kyennyt kohtaamaan vaikeutesi?

☐ *paremmin kuin tavallisesti*
☐ *yhtä hyvin kuin tavallisesti*
☐ *huonommin kuin tavallisesti*
☐ *paljon huonommin kuin tavallisesti*

i. … tuntenut itsesi onnettomaksi ja masentuneeksi?

☐ *en ollenkaan* ☐ *en enempää kuin tavallisesti*

☐ *jonkin verran enemmän kuin tavallisesti* ☐ *paljon enemmän kuin tavallisesti*

j. … kadottanut itseluottamuksesi?

☐ *en ollenkaan* ☐ *en enempää kuin tavallisesti*

☐ *jonkin verran enemmän kuin tavallisesti* ☐ *paljon enemmän kuin tavallisesti*

k. … tuntenut itsesi ihmisenä arvottomaksi?

☐ *en ollenkaan* ☐ *en enempää kuin tavallisesti*

☐ *jonkin verran enemmän kuin tavallisesti* ☐ *paljon enemmän kuin tavallisesti*

l. … tuntenut itsesi kaiken kaikkiaan kohtalaisen onnelliseksi?

☐ *enemmän kuin tavallisesti* ☐ *yhtä paljon kuin tavallisesti*

☐ *vähemmän kuin tavallisesti* ☐ *paljon vähemmän kuin tavallisesti*

18. Tunnetko jonkun mielenterveysongelmista kärsivän henkilön?

Voit valita useamman vaihtoehdon.

☐ *perhe- tai sukulaispiiristä* ☐ *ystäväpiiristä* ☐ *työn kautta* ☐ *harrastusten kautta*

☐ *muuta kautta. Kuinka?*_____

☐ *en tunne ketään*

19. Oletko viimeksi kuluneiden 12 kk aikana käyttänyt mielenterveydellisten ongelmien takia jotain terveyspalvelua? ☐ *Kyllä* ☐ *Ei*

Jos vastasit EI, siirry kysymykseen 22.

20. Oletko käynyt mielenterveysongelmien takia terveyspalveluissa viimeksi kuluneiden 12 kk aikana? *Voit valita useamman vaihtoehdon.*

☐ *terveyskeskuksessa*

☐ *työterveyshuollossa*

☐ *oppilas/opiskelijaterveydenhuollossa*

☐ *mielenterveystoimistossa tai psykiatrisella poliklinikalla*

☐ *A-klinikalla*

☐ *perhe- tai kasvatusneuvolassa*

☐ *yksityisvastaanotolla (lääkäri, psykologi tai muu*)

☐ *psykiatrisessa sairaalassa*

☐ *muussa sairaalassa*

☐ *kuntoutuslaitoksessa*

☐ *muualla, missä?* _____

21. a. Onko saamastasi hoidosta ollut Sinulle apua?

☐ *erittäin paljon* ☐ *melko paljon* ☐ *jonkin verran*

☐ *melko vähän* ☐ *hyvin vähän tai ei lainkaan*

b. Sisälsikö hoitosi lääkehoitoa? ☐ *Kyllä* ☐ *Ei*

22. Masennusta voidaan hoitaa eri tavoilla. Miten sopivia seuraavat hoitomuodot ovat mielestäsi?

	Erittäin sopiva	***Jokseenkin sopiva***	***Sopimaton***
lomanvietto	☐	☐	☐
ryhdistäytyminen	☐	☐	☐
valohoito	☐	☐	☐
rentoutusharjoitukset	☐	☐	☐
liikunta	☐	☐	☐
masennuslääkkeet	☐	☐	☐
rauhoittavat lääkkeet tai unilääkkeet	☐	☐	☐
luontaislääkkeet	☐	☐	☐
alkoholi	☐	☐	☐
itsensä hemmottelu	☐	☐	☐
ryhmäkeskustelut masennuksesta kärsivien kanssa	☐	☐	☐
yksilöllinen keskusteluhoito (esim. psykoterapia)	☐	☐	☐
keskusteluryhmä internetissä	☐	☐	☐

23. Mistä hakisit itse apua masennukseen?

	Varmasti	***Todennäköisesti***	***Tuskin***	***En koskaan***
terveyskeskuksesta	☐	☐	☐	☐
yksityiseltä lääkäriltä	☐	☐	☐	☐
yksityiseltä keskusteluhoitoa tarjoavalta ammattilaiselta	☐	☐	☐	☐
työterveys-/opiskelijaterveydenhuollosta	☐	☐	☐	☐
mielenterveystoimistosta tai psykiatriselta poliklinikalta	☐	☐	☐	☐
papilta tai sielunhoitajalta	☐	☐	☐	☐
ystäviltäni	☐	☐	☐	☐
perheeltä tai sukulaisilta	☐	☐	☐	☐
En hakisi apua	☐	☐	☐	☐

24. a. Onko Sinulla viimeksi kuluneen vuoden aikana ollut 2 viikkoa tai pitempään kestänyt jakso, jolloin olit surullinen, alakuloinen tai masentunut?

☐ *Kyllä* ☐ *Ei*

b. Onko Sinulla viimeksi kuluneen vuoden aikana ollut vähintään 2 viikkoa tai pitempään kestänyt jakso, jonka aikana menetit mielihyvän kokemuksen tai kiinnostuksesi melkein kaikkeen, kuten työhön, harrastuksiin tai muihin Sinulle tavallisesti mieluisiin tekemisiin? ☐ *Kyllä* ☐ *Ei*

Jos vastasit EI molempiin kysymyksiin, siirry kysymykseen 26.

25. Seuraavien muutaman kysymyksen aikana, ajattele tuota kahden viikon jaksoa viimeisen 12 kuukauden aikana, jolloin mielihyväsi menetys oli suurimmillaan tai masennus pahimmillaan.

a. Kestikö mielihyväsi tai mielenkiintosi menetys…

☐ *koko päivän* ☐ *suurimman osan päivästä*

☐ *suunnilleen puolet päivästä* ☐ *vähemmän aikaa?*

b. Tuntuiko Sinusta tuon kahden viikon aikana tällaiselta…

☐ *joka päivä* ☐ *miltei joka päivä* ☐ *harvemmin?*

Tuon kahden viikon aikana, mitä ongelmia esiintyi?	***Kyllä***	***Ei***
c. Olitko voimattomampi tai väsyneempi kuin tavallisesti?	☐	☐
d. Nousiko painosi tai laihduitko tahtomattasi (5 kiloa tai enemmän)?	☐	☐
e. Oliko Sinun tavallista vaikeampaa saada unta?	☐	☐
f. Oliko Sinun tuon kahden viikon aikana vaikea saada unta joka yö tai lähes joka yö?	☐	☐
g. Oliko Sinun selvästi vaikeampaa keskittyä asioihin kuin tavallisesti?	☐	☐
h. Jotkut voivat tuntea toisinaan itsensä arvottomiksi, hyödyttömiksi tai arvostella itseään. Tuntuiko Sinusta tällaiselta?	☐	☐
i. Ajattelitko kuolemaa – joko omaasi tai jonkun muun, tai kuolemaa ylipäänsä?	☐	☐

26. a. Onko Sinulla viimeisen 12 kuukauden aikana ollut itsemurha-ajatuksia? ☐ ☐

b. Oletko viimeisen 12 kuukauden aikana yrittänyt itsemurhaa? ☐ ☐

27. Oletko <u>joskus</u> nauttinut jotain alkoholia?

☐ *Kyllä, viimeisten 12 kuukauden aikana* ☐ *Kyllä, mutta en viimeisten 12 kuukauden aikana* ☐ *En koskaan. Jos vastasit En koskaan, siirry kysymykseen 32.*

28. Seuraavat kysymykset koskevat alkoholin käyttöäsi.	***Kyllä***	***Ei***
a. Oletko koskaan ajatellut, että Sinun täytyisi vähentää juomistasi?	☐	☐
b. Ovatko ihmiset ärsyttäneet Sinua kriittisillä huomautuksillaan juomisestasi?	☐	☐

c. Oletko koskaan tuntenut syyllisyyttä juomisesi takia? ☐ ☐

d. Oletko koskaan ottanut krapularyyppyjä aamulla? ☐ ☐

29. Oletko käynyt alkoholin käyttöösi liittyen terveys- ja sosiaalipalveluissa viimeksi kuluneiden 12 kk aikana? ☐ *Kyllä* ☐ *Ei* *Jos vastasit EI, siirry kysymykseen 32*

30. Oletko käyttänyt seuraavia terveys- ja sosiaalipalveluja viimeksi kuluneiden 12 kuukauden aikana alkoholin käyttöösi liittyen? *Voit valita useamman vaihtoehdon*

☐ *terveyskeskuksessa*
☐ *työterveyshuollossa*
☐ *oppilas/opiskelijaterveydenhuollossa*
☐ *mielenterveystoimistossa tai psykiatrisella poliklinikalla*
☐ *A-klinikalla*
☐ *perhe- tai kasvatusneuvolassa*
☐ *yksityisvastaanotolla (lääkäri, psykologi tai muu)*
☐ *psykiatrisessa sairaalassa*
☐ *muussa sairaalassa*
☐ *kuntoutuslaitoksessa*
☐ *päivystyksessä*
☐ *muualla, missä?* _____

31. Onko saamastasi hoidosta ollut Sinulle apua?

☐ *erittäin paljon* ☐ *melko paljon* ☐ *jonkin verran*
☐ *melko vähän* ☐ *hyvin vähän tai ei lainkaan*

32. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista sopivin.

	Täysin eri mieltä	***Osittain eri mieltä***	***Osittain samaa mieltä***	***Täysin samaa mieltä***
a. Alkoholiongelma ei ole oikea sairaus	☐	☐	☐	☐
b. Terveydenhuollon henkilökunta ei ota alkoholiongelmaa vakavasti	☐	☐	☐	☐
c. Alkoholiongelmaa ei voida hoitaa	☐	☐	☐	☐
d. Alkoholiongelmaa pidetään häpeällisenä ja leimaavana	☐	☐	☐	☐

33. Alla on väittämiä yleisestä suhtautumisesta mielenterveysongelmiin. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista sopivin.

	Täysin eri mieltä	***Osittain eri mieltä***	***Osittain samaa mieltä***	***Täysin samaa mieltä***
a. Mielenterveysongelma on merkki ihmisen heikkoudesta ja yliherkkyydestä.	☐	☐	☐	☐
b. Mielenterveysongelmat eivät koskaan parane.	☐	☐	☐	☐
c. Mielenterveyspotilaat ovat arvaamattomia.	☐	☐	☐	☐
d. Yhteiskunnan tulisi panostaa enemmän mielenterveysongelmaisten avohoitoon (ei	☐	☐	☐	☐

sairaalahoitoon).

e. Jos kertoo omista mielenterveysongelmista, ystävät jättävät.	☐	☐	☐	☐
f. Terveydenhuollon henkilökunta ei ota vakavasti mielenterveysoireita.	☐	☐	☐	☐
g. On vaikeaa puhua henkilön kanssa, joka kärsii mielenterveysongelmista.	☐	☐	☐	☐
h. Jos työnantaja saa tietää työntekijän mielenterveysongelmista, työsuhde vaarantuu.	☐	☐	☐	☐

34. Alla on väittämiä masennuksesta. Valitse väittämien paikkansapitävyyttä kuvaavista vaihtoehdoista mielestäsi sopivin.

	Täysin eri mieltä	***Osittain eri mieltä***	***Osittain samaa mieltä***	***Täysin samaa mieltä***
a. Masennusta ei voida hoitaa.	☐	☐	☐	☐
b. Masennus ei ole oikea sairaus.	☐	☐	☐	☐
c. Masennus on merkki epäonnistumisesta.	☐	☐	☐	☐
d. Masennuslääkkeet eivät ole riippuvuutta aiheuttavia.	☐	☐	☐	☐
e. Masentuneen pitäisi ottaa itseään niskasta kiinni.	☐	☐	☐	☐
f. Masennuslääkkeillä on paljon sivuvaikutuksia.	☐	☐	☐	☐
g. Masennuksesta kärsivät henkilöt ovat itse aiheuttaneet ongelmansa.	☐	☐	☐	☐
h. Masennusta pidetään häpeällisenä ja leimaavana.	☐	☐	☐	☐

35. Lopuksi pyydämme Sinua vastaamaan seuraaviin kysymyksiin, joissa Sinun tulisi kuvitella eri tilanteita.

	Kyllä	***Luultavasti***	***Luultavasti ei***	***Ei***
a. Olisitko valmis solmimaan avio-/avoliiton henkilön kanssa, jolla on mielenterveysongelmia?	☐	☐	☐	☐
b. Antaisitko lapsesi hoidettavaksi henkilölle, jolla on mielenterveysongelmia?	☐	☐	☐	☐
c. Olisitko valmis valitsemaan työtoveriksi mielenterveysongelmista kärsineen henkilön?	☐	☐	☐	☐
d. Kuulet että naapurustoosi ollaan suunnittelemassa mielenterveyskuntoutujien tuettua asumisyksikköä. Herättäisikö suunnitelma Sinussa vastustusta?	☐	☐	☐	☐
e. Tuttavasi joutuu mielenterveysongelmien vuoksi	☐	☐	☐	☐

sairaalahoitoon. Kävisitkö katsomassa häntä siellä?

36. Toivomme Sinun kirjoittavan ajatuksistasi ja kokemuksistasi siitä, miten muut ihmiset liittyvät hyvinvointiisi.

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_____

KOMMENTTEJA.

Toivomme Sinun vielä kirjoittavan ajatuksiasi ja mielipiteitäsi tästä kyselytutkimuksesta.

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KIITOS!