

## ORIGINAL PAPER

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# The influence of stigma and attitudes on seeking help from a GP for mental health problems

## A rural context

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**Abstract** *Background* Lack of mental health specialists in rural and remote communities suggest that rural communities depend more on general practitioners (GPs) for mental health care. Residents of rural communities are less likely than urban residents to seek help from their GPs for mental health issues. The aim of the current study was to examine whether attitudinal factors including perceived stigma, influenced rural residents seeking help from GPs. *Method* Help-seeking for psychological issues was retrospectively reported by 300 community residents in rural north-west Victoria. Current distress levels, functional disability, and current or lifetime syndromal disorder were recorded. Attitudes towards seeking professional psychological help, perceptions of stigma about mental illness, and belief in helpfulness of GPs, were also measured. *Results* Having a positive attitude towards seeking professional help, and believing that a GP would be helpful, were significant predictors of ever having sought help from a GP for mental health problems. Other independent predictors of help-seeking included having a mood, anxiety or substance use disorder, higher distress levels, and greater functional disability due to physical problems. *Conclusions* Seeking help from a GP for psychological problems was predicted by having a positive attitude towards seeking professional psychological help as

well as believing a GP would be helpful in treating psychological problems. Illness variables were also strong predictors of help-seeking behaviour. Contrary to expectations, perceived stigma did not influence help-seeking. The findings of this study highlight the important role of GPs in the treatment of mental health problems in the rural community.

**Key words** stigma – mental health – attitudes – help-seeking – rural

## Introduction

There is increasing evidence for the important contribution of attitudinal and belief variables in explaining help-seeking behaviours for mental health problems [1–5]. The most studied to date have been attitudes and beliefs people have about mental illness-termed mental health literacy. In addition there are a variety of less studied variables such as perceived stigma, and personality characteristics such as stoicism and self-reliance. It has been suggested that perceived stigma and a propensity for self-reliance are more prevalent amongst rural than urban residents [6–8]. A variety of factors may contribute to these attitudes such as the culture of avoiding overt expressions of feelings and display of emotion, and the traditional sex role stereotyping and ideology of self reliance which is characteristic of the ‘Aussie male’ [8]. Furthermore, these attributes may be reinforced by a lack of readily available and accessible services in rural areas. It should be noted however, that the number of studies comparing rural and urban communities on these attributes are limited.

Individuals who experience mental illness are often confronted by stigma, fear, discrimination and rejection in the wider community. It is commonly believed that the fear of stigma may deter persons with symp-

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toms of mental illness from acknowledging that something is wrong, seeking help, and continuing with any recommended treatment [9, 10]. Although this is not a universal finding [11, 12]. Stigma and discrimination may be particular problems in rural and remote regions where communities are smaller, social networks are closely enmeshed and privacy is lacking [9]. Consistent with these observations, stigmatizing attitudes towards mental illness are often quoted as a barrier to help-seeking from formal services in rural communities [13–15]. Furthermore, it has been reported that the stigma of accessing care for mental health problems can be a greater barrier to seeking help than the stigma attached to the problem itself [16].

It has been suggested that the level of stigma varies according to town size with one study [17] reporting that persons living in the most rural environments (populations under 2,500) were more likely to hold stigmatized attitudes towards mental health care than residents of larger town sizes. It is proposed that there is greater ‘visibility’ in smaller rural towns where residents are more aware of others’ problems and the options of dealing with them. This may contribute to a lessened sense of confidentiality. Consistent with this notion, Hoyt et al. [17] found that such attitudes were strongly predictive of willingness to seek help.

Help-seeking may also be seen as a sign of personal weakness and some individuals will only seek help as a last resort, preferring to cope themselves or rely on informal (i.e. family and friends) over formal (e.g., GPs, mental health services) help. While such attitudes are prevalent throughout the general community [18], such “stoic” attitudes are believed to be more pronounced in rural communities, and may act as barriers to help-seeking behaviours for mental health problems [13, 14].

Another factor which has been found to influence help-seeking from formal health services is believing that professionals can help. Most people who seek help for a mental health problem do so from a GP [19]. In rural areas, there are few specialist mental health providers so residents rely more on GPs for assessment and treatment of mental health problems. Believing that GPs can assist in the treatment of mental health problems may be of particular importance in rural areas. It has been found that individuals who believed a GP would be helpful in treating mental health problems were more likely to have sought help for mental health problems [5, 20].

The aims of the current study were three-fold. First, to explore whether certain attitudes and beliefs thought to be particularly characteristic of rural communities (e.g., high perceived stigma and a preference for self-reliance), were prevalent in this sample of rural residents. Second, to explore whether there were differences between males and females and participants from different town sizes. Third, to examine whether attitudinal factors (i.e., perceived stigma, attitudes towards seeking professional psy-

chological help, and belief in the helpfulness of a GP), predicted help-seeking from GPs for psychological problems while controlling for illness and socio-demographic variables.

The following hypotheses were made about the outcomes of the study: (1) Females would report more positive attitudes towards seeking professional help than males and that perceived stigma of mental illness would be greater in smaller towns compared to a large regional centre, and (2) Significant predictors of help-seeking from a GP would include: need variables such as severity of symptoms and functional disability, being female, more positive attitudes towards seeking professional psychological help, less perceived stigma, and believing that a GP will be helpful.

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## Method

### ■ Sample

Participants were recruited from a sample of 400 adults from rural north-west Victoria who had participated in two earlier phases of an ongoing research project investigating mental health and well-being in rural residents [21]. In the first phase of the project [21], 7,615 individuals participated in a mail-out survey of mental health and well-being. These individuals were a sub-sample of 20,000 individuals whose names had been randomly drawn from the electoral roll in rural Victoria and NSW. In the second phase of the project, 400 individuals from the 7,615 original pool participated in face-to face interviews with trained Research Assistants to determine whether they met criteria for a diagnosis of a mental disorder. Participants had been randomly drawn from three categories of town size populations: a large regional centre (population size >20,000), medium sized rural towns (populations 1,000–20,000), and small rural towns (populations < 1,000). The current study formed the third phase of the research project.

### ■ Procedure

In this study, packs of self-report questionnaires were mailed to the 400 individuals who had participated in the two earlier phases of the research project as described above. After 4 weeks, a reminder letter was sent out to those who had not responded. Return of a completed questionnaire was taken as consent to participate in the study. Approval for the current study was obtained from the Human Research Ethics Committees of the Bendigo HealthCare Group and Monash University.

### ■ Measures

#### Socio-demographic variables

Socio-demographic information (age, gender, marital status, education level, employment status, annual household income) which was obtained by self-report in the first phase [21], was used in this study.

#### Syndromal disorder

Diagnosis of a mental disorder was obtained in the second phase of the project. Trained research assistants, using the Structured Clinical Interview for DSM-IV (SCID-IV; [22]) obtained current and or lifetime diagnosis of mental disorder. Only the high prevalence disorders (i.e., mood, anxiety and substance use disorder) diagnoses were recorded.

### Psychological distress

The Kessler Psychological Distress Scale (K-10; [23]) is a brief self-report measure designed for use in health surveys as an indication of morbidity level. Participants indicate whether they have experienced symptoms in the past one week. Higher scores indicate greater distress. Normative data for the K-10 for the Australian population has been reported with a mean score of 14.2 and a Cronbach's  $\alpha$  of 0.92 [24]. For this study, the Cronbach's  $\alpha$  was 0.89.

### Functional disability

The Medical Outcomes Short Form 12 (SF-12; [25]) is a self-rated inventory of 12 items designed to assess disability due to both physical and mental health issues, and is scored to produce two weighted subscales: Physical Component Summary (PCS) and Mental Component Summary (MCS). Lower scores indicate greater disability. Australian norms have been reported with a MCS mean of 52.0 and a PCS means of 49.1 [26]. Ware et al. [25] report good test-retest reliability for the two subscales (MCS  $r = 0.76$ ; PCS  $r = 0.89$ ). In this study, the Cronbach's  $\alpha$  for the MCS and PCS were 0.66 and 0.76, respectively.

### Experience of help-seeking

Respondents were asked "Have you ever sought help for psychological or mental health problems?". Respondents answered "yes" or "no". Respondents were also asked "Have you ever sought help from a General Practitioner for psychological or mental health problems"? Respondents answered "yes" or "no".

### Belief in helpfulness of GP

Respondents were asked "How helpful would a GP be in the treatment of mental health problems?". Responses were recorded on a four-point Likert scale which ranged from 1 = very helpful to 4 = very unhelpful. Due to low numbers in some cells, this was later collapsed to form two categories: helpful (very helpful and helpful) and unhelpful (unhelpful and very unhelpful).

### Attitudes towards mental illness

The Perceived Stigma Scale (PSS) was used to assess perceived stigma in the community about individuals with mental illness. The PSS was developed by Wrigley et al. [5] and is based on the Devaluation and Discrimination Scale (DDS; [27, 28]), a 12-item measure designed to assess the extent to which respondents believe that most people will devalue or discriminate against a person with a history of mental illness. The PSS differs from the DSS in two ways: (1) Modification of American wording in the DSS and, (2) Addition of four items. The extra four items were added to gauge perceptions about stigma towards mental illness within respondents' specific communities. These items are listed in Table 2 below. The 16 items on the PSS are scored on a four-point Likert scale ranging from 1 = strongly agree to 4 = strongly disagree. Two of the items (6, 14) are reverse scored. Total scores range from 16–64 with higher scores indicative of *less* perceived stigma. Wrigley et al. [5] reported good internal reliability for the PSS (Cronbach's  $\alpha = 0.80$ ). In the current study, the Cronbach's  $\alpha$  was 0.84.

### Help-seeking attitudes

The Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH; [29]) is a 29-item instrument designed to assess the multi-factorial nature of individuals' attitudes towards seeking help for mental health issues. The possible ranges of scores are 0–87 with higher scores indicative of more positive attitudes towards

**Table 1** Comparing respondents and non-respondents socio-demographic characteristics

	Respondents ( <i>n</i> = 300)	Non-respondents ( <i>n</i> = 86)	<i>t</i> value/ $\chi^2$
Mean age $\pm$ SD (years)	56.59 $\pm$ 14.18	52.57 $\pm$ 16.71	2.23*
Gender (%)			
Males	50.6	55.5	1.01
Females	49.4	44.5	
Marital status (%)			
Married/defacto	76.6	73.6	2.51
Previously married	16.1	13.8	
Single/never married	7.4	12.6	
Employment status (%)			
Full-time employed	33.2	41.2	4.0
Part-time employed	20.5	24.7	
Economically inactive	46.3	34.1	
Education level (%)			
12 years or less	53.9	53.0	0.02
13 + years	46.1	47.0	
Annual income			
\$0–\$17,719	21.7	25.0	0.33
\$17,720–\$33,335	32.0	30.9	
\$33,336–\$55,918	25.0	23.5	
>\$55,918	21.3	20.6	

\*  $p < 0.05$

getting professional help. Fischer and Turner [29] reported good test-retest reliability of the scale of 0.84 over a 2-month period. The authors recommend the use of the total score as a uni-dimensional measure of attitudes towards help-seeking.

For the purposes of this study, responses to six items (see Table 3 below) selected from the 29 items on the scale, which might be particularly applicable in rural settings, and which might vary according to rurality, were also examined individually. In their study, Fischer and Turner [29] reported good internal reliability for the ATSPPH (Cronbach's  $\alpha = 0.86$ ). In the present study, the Cronbach's  $\alpha$  was 0.85.

### Data analysis

Pearson chi-square analyses and independent samples *t*-tests and ANOVAs were performed to determine if there were any gender and town size differences on measures of distress, disability and syndromal disorder, and attitudinal variables, including the four community items on the PSS and the six items on the ATSPPH as described in the Measures section above. Results were considered significant at the 0.05 level.

A bivariate logistic regression analysis was then performed to predict having ever sought help from a GP for psychological problems. Predictor variables included measures of need (K-10, SCID diagnosis, MCS, PCS), socio-demographic variables (gender, age, income, marital status, education level), and attitudinal variables (total PSS score, total ATSPPH scale score, belief in helpfulness of GP). Predictors were entered into the equation simultaneously to determine the influence of predictor variables in the presence of other variables. All data analysis was conducted using the SPSS 12.0.1 [30] statistical package.

## Results

Of the initial 400 individuals contacted, 14 were identified as ineligible (changed addresses). Three hundred individuals responded to the survey, a response rate of 77.7%. The response rate was calculated using the following formula: (*n* returned)/

**Table 2** Percentage of participants agreeing with PSS items on stigma

PSS item	% of sample agreeing with item
1. People would be treated poorly in this community if people found out about it.	34.4%
2. This community would be supportive and caring towards someone who experienced a mental illness.	72.2%
3. People would gossip about a person who had a mental illness.	72.1%
4. Many people would be wary of someone who had been hospitalized for a mental illness.	72.3%

**Table 3** Percentage of participants agreeing with ATSPPH items on stigma, interpersonal openness, recognition of need for psychotherapeutic help, and preference for informal help

ATSPPH item	% of sample agreeing with item
1. I would feel uneasy about going to a psychiatrist because of what some people would think.	88.0%
2. A person with a strong character can get over mental conflicts by him/herself, and would have little need for a mental health practitioner.	79.6%
3. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without resorting to professional help	88.1%
4. A person should work out his/her own problems, getting psychological counseling would be a last resort.	88.5%
5. There are certain problems which should not be discussed outside one's immediate family.	87.6%
6. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	87.6%

(*n* mailed–*n* ineligible). Respondents were compared with non-respondents using the socio-demographic data that were obtained in the first study (Murray et al. 21). Respondents were significantly older ( $p < 0.05$ ) than non-respondents by a mean of 4 years. There were no significant differences between the two groups on any other socio-demographic characteristics (see Table 1). There was little difference between the response rates from the three different town size categories: > 20,000 (85.4%), 1,000–20,000 (73.2%), < 1,000 (76.3%).

### ■ Assumptions

Prior to commencing data analysis, the dataset was examined for normality, multicollinearity, and multivariate outliers. To assess for possible multicollinearity amongst the scale, Pearson product-moment correlations were performed between all scales. The MCS and K-10 scales were highly correlated ( $r > 0.80$ ). To avoid problems of multicollinearity, the decision was made to remove the MCS from the logistic regression analysis.

### ■ Descriptive of need variables

Ninety-eight individuals (32.8%) of the study sample met SCID criteria for a current or lifetime diagnosis of a mood, anxiety or substance use disorder. The mean K-10 (untransformed) score  $\pm$  SD of the study sample was  $15.09 \pm 5.77$ . The mean (untransformed) MCS and PCS scores  $\pm$  SD were  $50.99 \pm 9.82$  and

$45.82 \pm 11.36$ , respectively. Independent samples *t*-tests comparisons between males and females and ANOVA for comparing the three town sizes, showed no significant differences between the groups on any of the need variables.

### ■ Help-seeking experience

Approximately a third ( $n = 97$ ) of the study sample reported having sought some form of help in their lifetime for psychological problems or mental health issues. Seventy-eight individuals had sought help from a GP. This group comprised the majority (80.4%) of the 97 individuals who reported having sought some form of help for psychological problems or mental health issues. There was no statistical difference between the proportion of females (30.5%) and males (21.1%), seeking help from GPs for mental health problems ( $\chi^2 (1) = 2.91, p > 0.05$ ). Comparisons between participants from the three town sizes showed no significant differences on the rate of help-seeking ( $\chi^2 (2) = 0.14, p > 0.05$ ).

### ■ Attitudinal variables

For the current study, the mean  $\pm$  SD, PSS and ATSPPH scores were  $42.18 \pm 6.28$  and  $44.54 \pm 7.13$ , respectively. Around 86% ( $n = 259$ ) of the study sample considered GPs to be helpful in the treatment of psychological or mental health problems.

An independent samples *t*-test was performed to determine if there were any gender differences on the



**Table 4** Summary of the bivariate logistic regression equation predicting help-seeking from a general practitioner for psychological problems

Predictors	Logit	SE	Wald	Exp(B) (95% CI)
Has a SCID diagnosis				
No				1.0 (reference)
Yes	1.07	0.35	9.09	2.91 (1.45–5.82)**
δ K-10 score	0.70	0.27	6.78	2.02 (1.19–3.43)*
δ PCS score	−0.46	0.19	5.94	0.63 (0.44–0.92)*
Gender				
Male				1.0 (reference)
Female	0.54	0.34	2.54	1.72 (0.88–3.36)
Age	−0.01	0.02	0.64	0.99 (0.96–1.02)
Education				
13 years or more				1.0 (reference)
12 years or less	−0.31	0.36	0.74	0.73 (0.36–1.49)
Gross household income (per year)				
\$0–\$17,719	−0.68	0.66	1.08	0.51 (0.14–1.83)
\$17,720–\$33,335	0.34	0.51	0.51	1.41 (0.55–3.60)
\$33,336–\$55,918	0.09	0.49	0.04	1.10 (0.43–2.84)
\$55,918 or more				1.0 (reference)
Marital status				
Married/defacto				1.0 (reference)
Previously married	0.67	0.51	1.72	1.96 (0.72–5.32)
Single/never married	0.25	0.64	0.15	1.28 (0.36–4.50)
Belief in helpfulness of GP				
Unhelpful				1.0 (reference)
Helpful	1.73	0.86	4.04	5.66 (1.05–30.63)*
Attitudes towards help-seeking (ATSPPH scores)	0.06	0.03	4.75	1.06 (1.01–1.11)*
Perceived stigma (PSS score)†	−0.04	0.03	2.24	0.96 (0.90–1.01)

\*  $p < 0.05$ , \*\* $p < 0.01$ ; δ-transformed scale was used;  
 K-10 – Kessler-10 scale; PCS – Physical Component Score;  
 ATSPPH – Attitudes Towards Seeking Professional Psychological Help;  
 PSS – Perceived Stigma Scale † – higher score means less perceived stigma

PSS and ATSPPH scores. There was no significant difference on PSS scores between males ( $M = 41.76$ ,  $SD = 6.42$ ) and females ( $M = 42.52$ ,  $SD = 6.17$ ),  $t(295) = 1.03$ ,  $p > 0.05$ . Males ( $M = 43.58$ ,  $SD = 7.10$ ) had lower ATSPPH scores than females ( $M = 45.33$ ,  $SD = 7.07$ ). Although this reached statistical significance,  $t(286) = 2.09$ ,  $p < 0.05$ , the effect size was small ( $\eta^2 = 0.015$ ). ANOVA Comparisons between the three town sizes showed no differences on the PSS and ATSPPH total scores.

Responses to the four Items from the PSS scale used to gauge perceived stigma within participants' specific communities, were explored. The items and percentage of participants in agreement with the items are described in Table 2.

Chi-square analysis performed to determine if there were any differences based on gender and town size, indicated there were no differences between the groups on any of the items.

Responses to six items taken from the ATSPPH scale, which might capture attitudes purportedly attributed to rural residents were also explored. The items and percentage of participants agreeing with the items are described in Table 3.

Chi-square analysis used to determine whether there were any differences between males and females on the items, showed that more males (85.6%) agreed with item 3 than females (74.7%),  $\chi^2(1) = 4.68$ ,  $p < 0.05$ . There were no other gender differences on

the remaining items. Nor were there any town size differences on any of the items.

### ■ Predicting help-seeking from a GP

A simultaneous logistic regression analysis was performed to examine the influence of need, socio-demographic, attitudinal variables and town size on seeking help from a GP for psychological problems.

Predictors were entered into the logistic regression equation which was set up to predict membership in the “yes” category in answer to the question “*Have you ever sought help for psychological problems from a GP?*”. Table 4 displays the Logit coefficient, standard errors, Wald statistics and odds ratios (95% CI), of the simultaneous regression analysis.

The logistic regression model was significant, indicating that the predictor variables were linearly related to the log odds of the criterion variable  $\chi^2(14, n = 267) = 69.31$ ,  $p < 0.001$ . The model accounted for 33.2% (Nagelkerke  $R^2$ ) of the total variance, and correctly predicted 82.4% of all cases. The factors that were independent predictors of help-seeking from a GP were: having a syndromal level disorder (SCID diagnosis), higher distress (K-10 score), greater physical dysfunction, belief that a GP would be helpful in treating psychological problems, and more positive attitudes towards seeking professional help.

## Discussion

There were three aims of this study. The first was to explore the prevalence, in a sample of rural residents, of perceived stigma and preference for self-reliance. The second aim was to examine gender and town size differences on various attitudinal variables. The third aim was to determine whether attitudinal factors predicted help-seeking from GPs for psychological problems.

Examination of certain items on the PSS and ATSPPH scales indicated attitudes generally regarded as barriers to help-seeking, were quite prevalent in this sample of rural residents. Firstly, participants generally reported high levels of perceived stigma as demonstrated by responses to specific items on the PSS scale. For example, the majority (over 70%) of participants believed that people in their respective communities would gossip about a person who had a mental illness, and that many people would be wary of someone who had been hospitalized for a mental illness. It is curious though that at the same time, most individuals also believed that their respective communities would be supportive and caring towards someone with a mental illness. This somewhat contradictory set of beliefs might be reflective of a “not in my backyard” community response to the presence of individuals with mental illness residing in one’s community [27]. However this would need to be clarified by further studies. Second, consistent with previous reports (e.g., [31]), the majority (87%) of respondents endorsed the item on the ATSPPH scale indicating a preference for informal over formal help. Responses to selected items on the ATSPPH scale supported the view that rural residents may see help-seeking from professionals as a sign of personal weakness. Over 80% agreed that a person should work out their own problems and getting professional help would be a last resort, and that there is something admirable about a person who is willing to cope with their problems without resorting to professional help. This last item was particularly endorsed by more males than females.

Contrary to previous studies (e.g., [4, 29]), females did not have more positive attitudes towards seeking professional psychological help (as indicated by higher ATSPPH scores) than males. There were no gender differences either on perceived stigma scores, or on the items selected from the PSS and ATSPPH scales described in Tables 2 and 3 respectively, with the exception that significantly more males believed that there was something admirable about a person who was willing to cope by himself/herself, without resorting to professional help.

Of note, contrary to previous research (e.g., [17]), perceived stigma levels did not differ according to town size in this study. This result may mean two

things: (1) There is no relationship between town size and stigma in this study, or (2) There might be other moderating variables acting on the relationship between town size and stigma level.

As expected, illness variables were significant predictors of having sought help from a GP, and this finding supports result of earlier studies [24, 32, 33]. Believing that a GP would be helpful in treating mental health problems was also a predictor of help-seeking from GPs, in this study sample. This result was consistent with other studies [5, 20]. Having more positive attitudes towards seeking professional psychological help was also significantly predictive of having sought help from a GP. This finding is consistent with previous research [1–5]. It should be noted though that having a positive attitude towards help-seeking could have been a consequence of previous help-seeking from a GP, rather than a determinant of help-seeking. This issue would need to be clarified by further research.

Perceived stigma score was not a significant predictor of help-seeking from a GP, in this study, a finding which was consistent with an earlier study by this group [5], and other research (e.g., [11, 12], but in contrast to existing literature (e.g., [13, 14]) that suggests stigma is a barrier to seeking help for mental health problems in small rural communities.

Contrary to expectations, being female was not a significant predictor of help-seeking. While this finding is in contrast to the generally robust finding in the literature that females seek help more often than males [24, 34, 35], again it supports the findings of Wrigley et al. [5], which also did not find an effect of gender on help-seeking. This finding is perhaps not surprising given there was little difference in this study sample between males and females on their attitudes towards seeking professional help, as measured by the ATSPPH scale.

The findings of this study support the importance of exploring the role of attitudes as facilitators or barriers to help-seeking for mental health problems. In this sample of rural residents, there was a high prevalence of perceived stigma and also of purported “rural” attitudes of self reliance and preference for informal help.

The finding of high levels of perceived stigma but lack of effect of perceived stigma on seeking help for mental health problems is of note. Participants in this study were assessed for the “high prevalence disorders” of anxiety, depression and substance use disorders, which have been the focus of community education campaigns in Australia such as *beyondblue* [36]. Individuals who experience these disorders are also “less visible” than those with other forms of mental illness such as schizophrenia which tend to receive more media coverage. It is possible that these disorders are associated with lower levels of stigma than other mental illness (e.g., schizophrenia) and so

the effect of perceived stigma on help-seeking for these conditions is less potent.

The findings of this study also highlight the important role GPs play in the delivery of mental health care in the community, and support current initiatives in Australian mental health policy such as assisting GPs to deliver such care (e.g., Commonwealth Government's Better Outcomes in Mental Health Care Initiative). Consistent with existing data [19], the majority of individuals in this sample who had sought help for psychological difficulties, had seen a GP for help. The finding in this study that people who believed GPs would be helpful in treating mental illness were five times more likely to seek help than those who did not believe they were helpful, also lends support to developing and sustaining programs to strengthen public confidence in the role of GPs in the treatment of mental illness.

The results have practical implications in terms of improving community attitudes towards seeking help through, for instance, public campaigns and could be incorporated in existing initiatives such as *beyond-blue* [36]. In addition to work that is currently being done such as improving mental health literacy, education of rural communities could also focus on changing attitudes such as self-reliance and preference for informal help. It should be noted though that considering the current paucity of studies comparing rural and urban settings on these attributes, and the lack of a control urban group in the current study, it is possible that self-reliance and preference for informal help are not primarily rural attributes and that these issues should also be addressed in urban settings.

While the strengths of this study include a large sample size, and recruitment of participants from different rural communities, the results reported here must be considered within certain methodological limitations. First, the cross-sectional nature of the study implies association of variables and precludes making causal links between help-seeking behaviour and the predictor variables. For example, it is possible that people who have had prior experience of help-seeking from GPs for psychological problems are more inclined to have more positive attitudes and more inclined to view GPs as helpful, rather than the other way around.

Second, apart from the diagnostic data obtained from the structured clinical interview, all other information obtained was by self-report, and given the retrospective nature of that self-report, the data could have been subject to problems inherent to retrospective reporting such as recall bias and poor recall. Third, it would have been informative to have included a measure of perceived need by the participants by asking if they felt that they needed professional help for their psychological problems, rather than inferred need by symptom severity and disability as we have done in this study. Fourth, the information

obtained was not verified by independent sources. Fifth, temporal relationships between the onset of psychological problems and the act of seeking help from GPs were not established. In addition, this sample of study participants was highly self-selected as they had already participated in two earlier phases of the research project, and there was a greater representation of middle-aged individuals. Given these limitations, caution must be exercised when extending the findings of the study to the wider rural community.

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## Conclusion

Attitudes and beliefs that might be discouraging of help-seeking behaviour, such as perceived stigma, self-reliance, and preference for informal help, were quite prevalent in this study sample. In this study, illness variables and attitudinal factors played a significant role in predicting help-seeking for mental health problems from GPs. Gender, previously shown to be a strong predictor of help-seeking was not significant in this study. Contrary to expectations perceived stigma was not a predictor of help-seeking behaviour. Further studies will be needed to explore the specific influences of attitudinal factors such as stoicism and self-reliance, features traditionally attributed to the culture of rural communities.

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