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Taboo Topics: Depression, Anxiety, Sexual Assault, and PTSD; the Influence of Stigma on Help Seeking

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The Influence of Stigma on Help Seeking

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Abstract

This review analyzes investigations into the stigma associated with depression, anxiety, sexual assault, and post-traumatic stress disorder (PTSD) and how stigma affects patients seeking treatment. The three disorders and the experience of sexual assault are examined for; prevalence, past and present stigma, and the history of the diagnosis. Each of the three disorders and sexual assault carry social stigma. Stigma can be described as a negative belief towards one group of people and stigma likely prevents people from seeking treatment for disorders and sexual assault. Researchers have found that one way to reduce stigma and the barrier that it has on help seeking is to educate people about stigma. Educating future health care professionals about the impact of mental health stigma and the negative perception correlated with having a mental health diagnoses or sexual assault will diminish the influence of stigma. The hope is that an upward “ripple effect” of understanding will eliminate the mental health stigmas and encourage more people to speak up and seek treatment as future health professionals are educated on the influence that stigma has against help seeking.

Keywords: mental health, stigma, stereotype, anxiety, depression, sexual assault, rape, post-traumatic stress disorder

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It has never been a secret that people often fear what they do not know or do not understand. It's the unfamiliar that causes us to wonder what is going on and creates a sense of mystery around the intended subject. Because of this mystery there is often a tendency for people to develop opinions based on what they have been told or what they can infer based on what they think they know. This often causes stereotypes to spread like wild fire with little to do to stop them. Over time, these stereotypes, which typically have a negative connotation, can create a stigma. Stigma has been defined a multitude of ways: "the negative attitude (based on prejudice and misinformation) that is triggered by a marker of illness," (Sartorius, 2007, p. 810) or "a sign of disgrace or discredit, which sets a person apart from others" (Byrne, 2000, p. 65). No matter how it is defined, stigma represents a negative attitude that separates one population from another; in this case, people that fall within the mental health spectrum and those that do not.

Batterham, Griffiths, Barney, and Parsons (2013) recognized a few different classifications of stigma: perceived stigma, personal stigma, and self-stigma (para. 3). Perceived stigma is "the level of stigma that [people] believe is held by the greater community towards a certain group of people;" personal stigma is the person's "own attitude towards a certain group of people;" and self-stigma is "the stigma or shame a person feels about their own condition" (para. 3). In each classification of stigma, those that have mental health differently compared to the "normal" American tend to experience separation from the rest of society.

Through this study there will be four areas of mental health that will be observed: depression, anxiety, sexual assault, and post-traumatic stress disorder (PTSD). It is not uncommon for people with any of these disorders to have hesitations about speaking with their

healthcare professional about their symptoms or experiences. Many refrain from seeking treatment strictly based on the backlash that they fear they will receive from their family, their friends, and healthcare professionals. This fear has been established, encouraged, and passed down over centuries and has stopped people from getting the help that they need. Peter Bryne (2000) explains that there is a sequence of feelings and emotions that go along with stigma and mental illness. He believes that stigma goes across eight different areas: shame, blame, secrecy, the “black sheep of the family” role, isolation, social exclusion, stereotypes, and discrimination (p. 65). He even reports that shame can “override even the most extreme of symptoms” to the point where people become embarrassed by their illness and they move into a time of secrecy. They will hide their symptoms from their friends, family, coworkers, etc. and it is not uncommon for family members to hide symptoms from the outside world or even from other family members in order to escape the stigma.

Why is there that separation and the feelings of inadequacy and failure? Why do people feel that they have to hide what is going on in their minds and in their bodies because they think they will be ostracized and judged?

Literature Review

Although it is not often talked about in mainstream society, mental illness affects many people on a daily basis. According to the National Alliance on Mental Health (2013), 26.2% adults over the age of 18, 20% of those ages 13 to 18, and 13% of those ages 8 to 15 will experience a mental illness in a given year. In addition, 60% of adults over the age of 18 and roughly one half of those ages 8 to 15 that have a mental illness did not receive any mental health services in the last year. It is believed that stigma is a major contributor to people not seeking the adequate treatment that they need for, in many cases, a manageable disorder.

Depression is often overlooked as just being sad or unhappy, however when those feelings don't go away for weeks or months at a time the person is likely suffering from depression. Penny Louch (2009) wrote an article about diagnosing and treating those with depression in order to challenge healthcare professionals to reach more patients with undiagnosed or untreated depression. She reports that "just under half of depressed patients seek help from a doctor... [and] only half of those who are diagnosed receive treatment..." (p. 43). Louch suggests that fear, stigma, and ignorance may be to blame for a person struggling with depression to not seek help.

In a study about anxiety disorder stigma by Griffiths, Batterham, Barney, and Parsons (2011), they believed that "stigma can be associated with increased psychological distress, demoralization and isolation and reduced employment and accommodation opportunities." To support their beliefs they sent out a quantitative survey to 5000 residents between the ages of 18 and 65 years old entitled "Community Attitudes on Mental Health Questionnaire." The study found that more than half of those surveyed perceived that people held negative stigma against those with an anxiety disorder compared to less than 20% of them who personally believed in the same negative stigmas (2011).

Although sexual assault is not considered a mental illness, it is often a contributor to a person's mental health diagnosis in regards to depression, anxiety, and PTSD. According to a study by Miller et al. (2011), 22% of the research participants feared retaliation based on the social stigma (p. 122). The participants reported believing they "figured people wouldn't believe [them]," they "would have felt ashamed," and they often believed it was their "fault." The researchers sought out to determine why many sexual assault victims choose to not report their assault; of the 144 undergraduate women that they individually interviewed, only one had reported her experience to the police (p.119). Because of stigma, the researchers have concluded that many of those affected by sexual assault will never seek treatment or report their attack and by doing so, they increase their risk for a repeated assault.

In the years since 9-11, more research has been conducted on post-traumatic stress disorder and how stigma affects a person's ability to seek help. Mittal et al. (2013) explored this topic with sixteen Operation Enduring Freedom and Operation Iraqi Freedom veterans who were currently seeking treatment. They found that many of the reasons that veterans avoid treatment is because they didn't want the mental illness label. In the author's opinion, a PTSD diagnosis was a stamp that denoted a veteran or soldier as "crazy," "violent," "unreliable," and "unstable" (p. 88). Throughout the study, the veterans were very candid about the stigma that was attached to PTSD and how that hindered them from getting help (Mittal et al. 2013).

The National Alliance on Mental Health (2013) found that more than 90% of those who die by suicide had one or more mental disorders. Although mental health is often a difficult topic to talk about, it needs to be addressed so that people can get the help they need. Perhaps then those affected by mental illness can stop feeling trapped and limited by the stigma that society has cultivated around them. It is believed that by talking about mental illness and by welcoming

those around us instead of making them feel ashamed, it will no longer be considered a “taboo topic.”

Part I: Depression

In May 2013, Kevin Breel recorded a TED Talk about depression entitled: “Confessions of a depressed comic.” It went viral and for a moment, people started to talk about mental health and the stigma that comes with the declaration of suffering from depression. At the age of 19 he was standing on a national stage admitting to struggling with depression and announcing to the world that this was a topic that should no longer be overlooked, something that many people fighting depression could never even dream of doing. His TED Talk has since been viewed over 1.2 million times and he’s currently touring college campuses across the United States to talk to people about the stigma that goes alongside with depression. He notes that “It’s the stigma inside of others, it’s the shame, it’s the embarrassment, it’s the disapproving look on a friend’s face, [and] it’s the whispers in the hallway that you’re weak, it’s the comments that you’re crazy. That’s what keeps you from getting help” (Breel, 2013).

The Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used by clinicians and psychiatrists to diagnose psychiatric illnesses, was not originally published until 1952 however, depression has been tracked throughout history. Originally it was known as “melancholia” and can be referenced as far back as ancient Mesopotamian texts which date roughly 6000 years ago (Nemade, Reiss & Dombeck, 2014). As time progressed there was a discrepancy as to whether melancholia was caused by demonic possession or biological/psychological disease and there were many ways that people believed they could be “freed” from depression.

According to the Centers for Disease Control and Prevention, an estimated 1 in 10 Americans report suffering from depression and they predict that by the year 2020 it will be the second most common health problem in the world (Division of Adult and Community Health,

2011). They also found that persons between the ages of 45-64, persons without a high school diploma, and women were more likely to meet criteria for major depression than others.

The National Institute of Mental Health (2009) states that Depression “interferes with daily life” and symptoms for include:

- Persistent sad, anxious, or “empty” feelings
- Feelings of hopelessness, helplessness, guilt, worthlessness
- Irritability
- Loss of interest in activities that once were pleasurable
- Fatigue/decreased energy
- Insomnia
- Overeating or loss of appetite
- Thoughts or attempted suicide

Depression varies from patient to patient and can be difficult to diagnose. There are other medical conditions that may mimic depression symptoms so there is often a physical examination, interview, and perhaps lab tests to determine if the individuals would be referred to a mental health professional (National Institute of Mental Health, 2009). Individuals should receive a complete evaluation including a thorough mental health history including if any family members have been diagnosed with depression. There are many effective ways to treat depression including the use of medications (antidepressants), speaking with a therapist, peer support groups, etc.

Those that receive a depression diagnosis are typically seen as weak, lazy, and some may believe that the individual should “suck it up” (Depression, 2014). People have the view that those suffering with depression are hiding in their bedroom wearing dark colored clothing and listening to angry music but that’s not necessarily the case; it’s just what people think depression looks like. In Kevin Breel’s case, he is very involved, lives an active lifestyle, and doesn’t fit the “mold” that people have about depression (2013). This skewed viewpoint causes those struggling

with depression to not speak up, to not seek treatment, and to not get the help that would benefit them the most.

Studies show that education can be associated with decreased personal stigma towards depression (Batterham et al., 2013). This means that as a person becomes more aware of what a depression diagnosis really encompasses, they are less likely to develop stigma against those with depression.

Part II: Anxiety

Anxiety first began to be separated from depression in the 17th century, however it would not be considered as a standalone diagnosis until the late 1800s (Makari, 2012). Today, symptoms of anxiety disorders vary however they each last at least 6 months and “all [of] the symptoms cluster around excessive, irrational fear and dread” (NIMH, 2014a). Similar to depression there are several anxiety disorders that each have associated stigma. In order to be diagnosed with an anxiety disorder, “a doctor must conduct a careful diagnostic evaluation to determine whether a person’s symptoms are caused by an anxiety disorder or a physical problem” (NIMH, 2014a). From there, the individual can decide to seek varying forms of psychotherapy with a mental health professional, medication, or a combination of both. Many times a person stops participating because they feel that they have “failed” their treatment (2014a). In reality, they often times have not given the chosen type of therapy enough time or the treatment was administered incorrectly.

Currently 18.1% of the adult population affected by some type of anxiety disorder and only about a third of those are seeking treatment (NIMH, 2014a). If 18.1% of the population is affected by an anxiety disorder, why are only a third of them seeking treatment? In a study conducted by Griffiths et al. (2011), researchers found that people viewed those with anxiety as poor employees, a danger to others, and that their condition was shameful/embarrassing (p. 2). These beliefs may inhibit people from furthering their careers, going to public places, and may decrease their overall quality of life. It is likely that someone experiencing symptoms of an anxiety disorder would dismiss them and not seek treatment in order to avoid the stereotype that society has against them.

Griffiths et al. (2011) were also able to identify and organize “themes” of stigma that people tend to hold against those diagnosed with an anxiety disorder. These include the belief that “anxiety was not a real medical illness, that it was [a] sign of weakness, laziness, instability and self-absorption, that people could ‘snap out of’ anxiety if they wished, [and] that the condition was the fault of the person” (p. 2). This causes people to hesitate or deny treatment because they would have to also fight against the stigma along with the disorder. Persons with anxiety disorders often face complicated situations. On one hand, they know and understand how debilitating an anxiety disorder can be. For example, panic disorder which can cause panic attacks in which the individual reports “sudden feelings or terror when there is no real danger... [or the feeling of] losing control” are unpredictable and can happen at any time (NIMH, 2014a). On the other hand though, they may face questioning or doubt by others whether they are really having/ a panic attack or if the person is a hypochondriac or lying for attention.

Part III: Sexual Assault

According to the Rape, Abuse, and Incest National Network (RAINN), “the FBI ranks rape as the second-most violent crime, behind only murder” (2009). When it is learned that someone has been sexually assaulted, it is not uncommon for the first thought to be “what did you do?” In other words, implying that the victim was “asking” to be assaulted, “asking” to be raped. The Office on Women’s Health (2012) states that sexual assault is “any type of sexual activity that you do not agree to, including inappropriate touching, vaginal, anal, or oral penetration...rape, attempted rape, [or] child molestation.” It is estimated that 1 in 4 women in college have or will experience sexual assault; worldwide it is estimated that 1 in 6 women will be sexually assaulted in her lifetime (Miller, Canales, Amacker, Backstrom, & Gidycz, 2011). In comparison, roughly 1 in 33 men will be sexually assaulted within their lifetime. It is thought that less than half of ALL sexually assaulted persons are reporting the crime (RAINN, 2009).

Many victims do not report their sexual assault because they don’t want to be judged. If they pursue legal action against their attacker, they are likely to obtain the title of being “dirty” or “tainted” and at times even derogatory terms are applied such as “whore” or “slut.” The director of St. Vincent Hospital’s emergency department, Jennifer Balthazor states that “people still question if the victim ‘should have been THERE,’ ‘should have done THIS’ or ‘should have worn THAT.’ And [the stigma] impacts the victim, the victim’s family and even the providers who care for the victim in the hospital” (Glaser-Martin & Malak, 2013). Social stigma is often a determinant from reporting and studies show that 16% of victims say they fear reprisal from others (RAINN, 2009). On one hand, the victim has already been violated and on the other, they fear that people will blame them for what happened to them.

Those currently serving in the military also face sexual assault at a similar rate, however it's referred to as Military Sexual Trauma. A woman currently enlisted in the US military is nearly 180 times more likely to have become a victim of military sexual trauma in the past year than to have died while deployed during the last 11 years of combat in Iraq and Afghanistan (O'Toole, 2012). This statistic brings attention to the frequency of sexual assault in all settings. Sexual assault is not limited to any age, gender, lifestyle, or location. According to RAINN (2014), "approximately 2/3 of assaults are committed by someone known to the victim." Sexual assault is not exclusive to just strangers and acquaintances even though that is the perceived idea.

Women in the military are unlikely to report their experiences because they fear being ostracized by their peers or may face having to report the attack to the same person that perpetrated it (Mattocks et al. 2012).). The comic listed in Appendix A was found in the Chicago Tribune on December 19, 2013 (Trudeau, 2013); it depicts a female soldier following procedure to report a sexual assault to her commanding officer. The soldier explains to him that she was assaulted and he responds with satire; the case is "Not credible. Dismissed" (2013). This encourages a perception that the very people put into place to respond to the victims of sexual assault don't care and will not. In the United States, a victim of sexual assault has a few options to report their assault. They can choose to call 911 and report it to the police or they can visit a hospital emergency room or their own doctor (RAINN, 2009). The hospital will advise that you receive a "sexual assault forensic exam" which involves collecting evidence of the attack.

Although sexual assault is not necessarily a mental health "diagnosis," research shows that sexual assault can be "associated with depression, PTSD, [and] generalized anxiety disorder..." (Gibson & Leitenberg, 2001, p. 1344) and studies continue to better understand the psychological effects of sexual assault and rape. The Rain Abuse & Incest National Network has

calculated that victims of sexual assault are 3 times more likely to suffer from depression and 6 times more likely to suffer from PTSD (2009). Even though sexual assault is not labeled as a mental health disorder, it has a tendency to impact the victim's mental health.

Part IV: Post-Traumatic Stress Disorder

Post-traumatic stress disorder can be traced back as far as Homer's Iliad but was not officially classified in the DSM as a mental disorder until the 1980s (Garske, 2011). Throughout history it has been referenced as many different disorders and has almost always had a negative viewpoint. It is currently defined as a "debilitating condition that can affect every aspect of a patient's life due to its multifaceted composition of mental, physical and social symptoms" (Eagen Chamberlin, 2012, p. 363). The symptoms of PTSD have the ability to drastically change the individual's life, occupation, and relationships. Symptoms include flashbacks, feeling emotionally numb, feeling guilty, losing interest in activities that were previously enjoyed, being easily startled, feeling tense or "on edge," etc. (NIMH, 2014b). Although it is not exclusive to military personnel, there has recently been an influx in research on PTSD in post 9/11 military veterans and there have been many new developments.

Of those returning from Operation Iraqi Freedom or Operation Enduring Freedom (OIF/OEF), it is estimated that 15-17% suffer from symptoms of PTSD (Garske, 2011). The US Department of Veteran's Affairs determined that men in the military are almost four times more likely to develop PTSD than civilians and military women are twice as likely to develop PTSD compared to civilian counterparts (2014). This prevalence presents a new set of obstacles for current and future health professionals. As more and more military personnel continue to return to the United States, they will need more help readjusting to civilian life and with that comes a greater need for understanding and support throughout society.

Historically, military personnel do not usually seek out treatment due to the fear that they will be labeled or stereotyped as "crazy" (Lande et al., 2011). This is a common belief among those with a mental health diagnosis however people tend to have an added fear with this area of

mental health due to the fact that military veterans are seen as strong, competent, and skilled in how to kill if need be.

In a study conducted by Mittel et al. (2013), the veterans that participated felt that the public saw them as responsible for “causing their own illness” because they “volunteered” for military duty (p. 90). There are many reasons that a person enlists in the military; financial stability, chosen career path, family profession, etc. but it is not probable that individuals join the military with the expectation of returning to the United States with a mental illness. Since 9-11, there has been an increase in research on how to best prevent PTSD and many “soldier to civilian transition programs” have been implemented. As more research is being conducted, perhaps a better understanding of how PTSD can be prevented will arise but until then there needs to be support systems put into place so more people can get help.

Part V: Health Professionals Impact on Mental Health

Throughout history there have been various campaigns, rallies, and events used to motivate people to change a belief about something: racism, sexism, ageism, etc. but what about for those that have a mental health diagnosis? As a healthcare professional who may work in the mental health field, it is important to be educated and be an advocate for those fighting mental health stigma. Through involvement, advocacy, and education, there is the possibility of changing others' perspectives on mental health disorders and sexual assault.

It has been found that one of the best ways to stand up against mental health stigma is to educate people on what the disorder entails. Not all people fit the mold that society has developed for each mental illness; just as every person is different, with a different story, every mental illness diagnosis is different. Corrigan (2004) wrote that "education provides information so the public can make more informed decisions about mental illness" (p. 621). In this nature it is no longer an uneducated guess about how someone might be affected by mental illness but rather a new understanding of what is actually going on in their life.

Norman Sartorius (2007) found that it is not uncommon for healthcare workers to use words that are stigmatizing or derogatory towards those with a mental illness diagnosis (p. 810). He even notes that some healthcare professionals may refuse treatment for other medical illness/injury if the patient has a mental illness diagnosis. These stigmas may prevent patients from speaking up about the symptoms and feelings that they are experiencing. A patient may have come in with the intention of speaking honestly with their healthcare professional but they may feel the person is indifferent or biased against mental health. One common misconception about persons with a mental health diagnosis is that they are violent, uncontrollable, and in essence, a walking time bomb that could go off at any moment.

It has been found that “many people may avoid mental health services because they fear that confidential information about their psychiatric history may become known to groups whom they would opt to not disclose” (Corrigan, 2004, p. 621). As a healthcare professional, it is expected that information should not be shared to others without the permission of the patient, however the patient may still fear that their information will get out. It is important that the patient be affirmed in the fact that their personal information will remain confidential between themselves and the healthcare professional to encourage the patient to continue to receive treatment.

Conclusion

One researcher proposed that there be an adopted term to describe those who are prejudice against people with mental illness known as “psychophobic” (Byrne, 2000, p. 67). The researcher also believes that using “politically correct” language helps to fight discrimination. Across the board it has been found that those who fear mental illness are often uneducated about what the diagnosis even means. Then due to the fear of judgment, shame, and guilt, there are family members who feel they have to hide their loved one’s diagnosis.

Mental health effects a lot of people; 26.2% of adults, 20% of adolescents ages 13 to 18, and 13% of younger adolescents ages 8 to 15 (NAMI, 2013). Those percentages represent a portion of the population that are dealing with something mental health specific. Researchers estimate that there are almost 238,000 sexual assaults each year (RAINN, 2014). Although each addressed area has a different set of stigmas and stereotypes, individuals are forced to either confront the stigma and seek help or let the stigma suppress them. For some that choose to seek help, they may face stigmatized perceptions from the healthcare professional that they report to.

Stigma has impacted people’s outlook on mental health for centuries and will continue to do so until there is a change in society. Every year, future health professionals attend classes and clinical experiences to become educated on how to treat patients but how many more patients could be helped if we were to create an inviting and non-judgmental atmosphere at all times? It is not easy to be aware of the entire mental health stigma that you grew up with and then realize that you are now part of that spectrum. It would be very beneficial if future health professionals recognized stigma as an issue and made strides to erase it from their community as a means to encourage more people to seek help. Researchers have found that one of the best ways to address stigma and reduce the effects of stigma in society is to educate people (Corrigan, 2004). They

have found that it is important to not only address the stigmas of mental health, but also the success of participating in treatment programs. It is important for health care professionals to be aware of their perceptions of those with a mental illness or of those who have been sexually assaulted so that they do not convey negative feelings towards the individual. By being aware of their thoughts and attitudes, perhaps then they will be able to develop an understanding of mental illness and sexual assault that does not inhibit help seeking.

Bryne (2000) quoted a woman in his study who had developed her own ideas of stigma what it means, what it entails, and what it hinders

For me stigma means fear, resulting in a lack of confidence. Stigma is loss, resulting in unresolved mourning issues. Stigma is not having access to resources...stigma is being invisible or being reviled, resulting in conflict. Stigma is lowered family esteem and intense shame, resulting in decreased self-worth. Stigma is secrecy...stigma is anger, resulting in distance. Most importantly, stigma is hopelessness, resulting in helplessness. (p. 66)

When handled correctly, there is no need for people affected by these four areas to live separate from the rest of the world, no need for them to live in fear, no need to see life as hopeless. There needs to be a break in stigma so that more people can get help and live full functioning lives.

As researcher Allison Abrams (2013) said, "to change others' minds, we must first change our own." If we continue to treat mental health stigma as something that someone else is responsible for, there will never be any change; there will never be freedom for those currently shackled to the stigmas they are currently restrained by.

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Appendix A



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