

**EXAMINING MENTAL ILLNESS STIGMA, HELP-SEEKING AMONG TAIWANESE YOUTHS: PERPETUATED BY CONVENTIONAL PUBLIC VIEWS AND TRANSFORMED BY CHANGING SOCIAL VALUES**

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**ABSTRACT**

To protect youths with mental distress, it is important to understand their help-seeking behaviors, explore potential help sources, and examine factors that deter them from seeking help, such as negative perceptions towards mental illness. In the current study, quantitative data was collected to examine mental illness stigma of Taiwanese college students. Students' help-seeking behaviors were also assessed both quantitatively and qualitatively. A psychoeducational program on mental illness stigma reduction was implemented. The results showed that the participants had a moderately low level of mental illness stigma. The proposed intervention did not significantly reduce overall mental illness stigma. However, the intervention significantly decreased participants' inclination to avoid people with mental illness. Generally, the participants scored moderate on willingness to seek help. The qualitative analysis indicated that although subscribing to the conventional stigmatizing belief of avoiding the mentally ill, Taiwanese youths have gradually abandoned the Chinese tradition of associating shame with counselling.

**Key Words:** Help-seeking, Mental Illness Stigma, Psychoeducational Program.

**1. INTRODUCTION**

Suicide has been one of the leading causes of youth mortality in many parts of the world, a problem which has gradually increased in magnitude in Taiwan during the last decade (Gau et al., 2008; Madge, 1999; Pelkonen & Marttunen, 2003). By the end of 2004, suicide death rose to become the second leading cause of mortality among adolescents in Taiwan (Chiang, et al., 2013). In their investigation of risk factors for suicide among Taiwanese college students, Gau and colleagues (2008) identified a positive correlation between suicidal risk and psychiatric symptoms.

A big obstacle in intervening problems related to mental health is the fact that people affected tend to avoid seeking professional help. In the United States, only 15% out of those with mental health problems sought professional help, and among them, only 6% used specialty mental health services (Chen & Mak, 2008; Kessler et al., 1996; Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993). Earlier studies have also found a disparity between treatment need and mental health service usage among Chinese in Hong Kong, mainland China, and Taiwan (Boey, 1999; Chen, 1987; Chen & Mak, 2008). Based on statistics issued by both Hong Kong Health and Welfare Bureau and Hong Kong Government Information Center in 2001, around 95,000 individuals had mental health problems; however, less than 20% of them had received necessary services (Mo & Mok, 2009). In the studies conducted on 63,004 Chinese adults, around 24% of them were diagnosed with moderate or severe mental disorder; nonetheless, only 8% had sought

professional help (Phillips et al., 2009). As pointed out by Lin (2002), very few Taiwanese have ever resorted to formal psychological help service. For instance, one survey showed that only 3.8% of Taiwanese students had sought psychological help when confronted with severe mental health problems (Chang & Kuo, 1984)

One primary reason for an underuse of mental health service is the perceived stigma associated with mental illness both for the affected and among the general public (Teh, King, Watson, & Liu, 2014). As argued by Corrigan and Penn (1999), mental illness stigma can be so harsh to be worse than the disease itself. Among young patients, mental illness stigma interferes with their willingness to seek help (Romer & Bock, 2008). Therefore, in the current study, efforts were made to explore Taiwanese college students' general perceptions of mental health problems and examine help-seeking communication among depressed college students in Taiwan. The ultimate goal was to enhance help-seeking for Taiwanese youths suffering from mental health problems.

## 2. UNDERLYING THEORETICAL CONCEPTS

### 2.1 Mental illness stigma

In Erving Goffman's (1963) seminal book, stigma was defined as an "attribute that is deeply discrediting" which reduces the stigmatized individual "from a whole and usual person to a tainted, discounted one" (p. 3). Mental-health-related stigmatization was found in the United States (Cullen, Frank, & Wozniak, 1987; Roman & Floyd, 1981), and in most Western nations (Brockington, Hall, Levings, & Murphy, 1993; Corrigan & Penn, 2015). Similarly, societal stigma against psychiatric disorders is pervasive in Asia (Fancher, Lee, Cheng, & Yang, 2014). It has been reported that stigma against mental illness is particularly severe in Chinese groups (Yang & Kleinman, 2008; Yang et al., 2013) and prevalent among Koreans (Han, Cha, Lee & Lee, 2017). In a study conducted by Griffiths and colleagues (2006), negative attitudes against the mentally ill were observed to be stronger among Japanese than their counterparts in Australia. In spite of the talk on political correctness and advancement in medical technology, attitudes among the general public about people with mental illness have become more stigmatizing during the past thirty years (Phelan, Link, Stueve, & Pescosolido, 2000).

#### 2.1.1 Types of mental illness stigmas

In general, there are three stigma types related to mental illness – public stigma, anticipated stigma, and self-stigma (Rüsch et al., 2005; Teh et al., 2014). *Public stigma* refers to reactions of the general public towards a stigmatized group (Rüsch, et al., 2005, p. 530). *Anticipated stigma* describes how people with mental illness anticipate others' perceptions of them as carrying some negative attributes (Chadoir, Earnshaw, & Andel, 2013). *Self-stigma* happens when people with mental illness internalize the negative evaluations of others and succumb to the label of being socially unacceptable (Ben-Zeev, Young, & Corrigan, 2010).

There is a lack of information on different effects stigma may exert on various mental disorders (Rüsch, et al., 2005). In the current study, this researcher has adopted the definition of mental illness stigma by Corrigan and Penn (2015). Based on the *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed. *DSM-IV*; American Psychiatric Association, 1994), Corrigan and Penn explained mental illness as the categories of "schizophrenia and other psychotic disorders, mood disorders, anxiety disorders, and personality disorders," a mental illness group which stigma researchers generally distinguished from other mental illness categories such as

“developmental disabilities and substance abuse disorders” (Corrigan & Penn, p. 3). Accordingly, mental illness in the current study refers to those in the former category.

### **2.1.2 Three components of stigma**

Similar to stereotypes, stigma is based on some knowledge structures. The knowledge structures are collective opinions about members of a social group (Corrigan & Penn, 2015; Hamilton & Sherman, 1994; Hilton & Von Hippel, 1996). However, stigma is more pernicious than stereotype because it is prejudice and negative stereotyping (Corrigan & Penn, 2015; p. 3). Stigma is when individuals use the *knowledge* structures to generate negative judgments and form a prejudiced *attitude* towards the stigmatized or to engage in *discriminatory behaviors* by acting on the misinformation (Ando et al., 2013; Janoušková et al., 2017; Thornicroft, 2006). Conceivably, among the three components of stigma, knowledge, attitudes and discrimination, it is the outward expression of discriminatory behavior which is most likely to remind people with mental illness of their stigmatized status.

According to the modified labeling theory, people labeled as mentally ill are aware of the devalued status conferred upon them (Ray & Dollar, 2014). Shunning and alienation has left most mentally ill with low self-esteem, aptly expressed by a patient’s self-description of being “the social garbage heap” (Gallo, 1994, p. 407). Once labeled as mentally ill, an individual may adopt any of the potential stigma management strategies, including *education* in which one discloses information and hopes to deflect negative reactions from others; *withdrawal*, when an individual limits contact with those aware of his or her illness; and *secrecy* which involves withholding information from others to avoid discrimination (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Ray & Dollar).

### **2.1.3 Mental illness stigma and help-seeking communication**

People with mental illness tend to hide their illness and avoid seeking help to prevent themselves from being labelled as mentally ill (Teh et al., 2014). In most cases, people with mental illness can be effectively treated and lead quite productive living if they follow therapeutic regimes (Corrigan & Lundin, 2001; Romer & Bock, 2008). Therefore, it is of particular significance that people with mental illness are willing to engage in help-seeking communication. For instance, several epidemiological studies have found an association between good communication with family members and a lower rate of suicidal cases among adolescents (Evans et al., 2005; Shaffer, Gould, Fisher, Trautman, Moreau, et al., 1996). Ultimately, it is crucial to reduce stigma surrounding mental illness and create an environment conducive to help-seeking among those affected by related illness.

## **2.2 Destigmatization: approaches and effectiveness**

Fundamentally, there are three strategies to combat mental illness stigma. They are *protest*, *education*, and *contact* (Corrigan & Penn, 2015; Rüscher et al., 2005). Reactive anti-stigma campaign or protests are initiated by advocacy and service groups to sanction any public statements that contain negative representations of mental illness. However, the efforts to correct the media behavior of promoting stigmatizing advertisements or messages often achieved limited success due to the “suppression rebound effect” (Corrigan et al., 2002, p.295). That is, attempts to suppress negative attitudes towards psychiatric disorder may in fact prime these stereotypes and

lead to greater attitude recollection (Corrigan & Penn, 2015; Macrae, Bodenhausen, Milne, & Jentzen, 1994).

Psychoeducation programs, such as brief courses or lectures, provide information that contradicts stereotypical or prejudiced beliefs about the mentally ill (Rüsch et al., 2005). In a meta-analysis on anti-stigma interventions, Xu, Huang, Kösters & Rüsch (2017a) concluded that psychoeducation was the most commonly used strategy. Education built on stigma-countering facts has been shown to lead to significant improvement in stigmatizing attitudes (Corrigan et al., 2002; Link et al., 1987). Nonetheless, the efficacy of psychoeducational interventions has been mixed according to reviews of different scholars. In a meta-analysis on efforts to reduce stigma against mental disorders, Griffiths and colleagues (2014) found no support for stigma intervention in reducing perceived or self-stigma. Xu, Rüsch, Huang & Kösters (2017b) reviewed nine studies and concluded that the interventions yielded only a small effect on both stereotypes reduction and enhancement of mental health literacy. Inconsistent results were also observed in efficacy of school-based educational interventions to fight mental illness stigma (Mellor, 2014; Schachter et al., 2008). Based on the review conducted by Mehta and colleagues (2015), some interventions may possibly lead to worsened mental-health-related stigma.

Contact or personal interactions with the mentally ill have been acknowledged as one of the most promising strategies to reduce associated stigma (Corrigan & Penn, 1999; Yang, et al., 2012). Interventions containing social contact were found to be more effective than others in reducing stigma (Drew et al., 2011; Mehta et al., 2015; Thornicroft, Rose, & Kassam, 2007), and the decreased stigmatizing attitudes seemed to be lasting (Reinke, Corrigan, Leonhard, Lundin, & Kubiak, 2004; Yang et al., 2012). Nonetheless, some study results did not confirm the effectiveness of introducing contact in mental illness stigma interventions. For example, two studies reviewed by Xu and colleagues (2017b) concluded that there were no significant differences in post-intervention stereotypes between programs that included education alone or programs that combined education with contact (Chan, Mak, & Law, 2009; Rong et al., 2011). In the review conducted by Mehta et al. (2015), interventions containing social contact, either direct or indirect, were said to have no more efficacy than those without. Based on the literature reviewed above, it is reasonable to conclude that attempts to reduce mental illness stigma, regardless of intervention format, have not produced definitive results.

According to the above review, efforts to destigmatize mental illness have yielded mixed results. However, there is no denial regarding the deleterious effects of stigma on mental health. Indeed, researchers have called for continued interventions in different contexts. When examining mental illness stigma in the Korean American community, Han, Cha, Lee and Lee (2017) mentioned that the need for anti-stigma programs was widely acknowledged. One of the participants in their study commented that unlike discrimination against race or gender which is a subject of discussion in the general curriculum, discrimination against the mentally ill has commanded relatively less attention (p. 138). As pointed out by Botha and Dozois (2015), when launching a 10-year initiative to reduce mental illness stigmatization in Canada, the Mental Health Commission of Canada (2008) admitted the inadequacy in research related to stigma reduction. In their meta-analysis of efficacy of anti-stigma interventions among people with mental illness in mainland China, Hong Kong, Taiwan and Macau, Xu and colleagues (2017) called for more and

high-quality intervention research. In an effort to understand the characteristics of mental health-related stigma in Japan, Ando et al. (2013) pointed out a lack of national campaigns in reducing mental illness stigma. Thornicroft and colleagues (2016) reviewed the research on mental health-related stigma globally and explained that literature related to mental illness stigma has mostly focused on the attitudes component of stigma rather than on interventions to reduce discrimination. Similarly, in their study comparing attitudes toward psychological counseling between Caucasian and South Asian college students, Loya, Reddy, and Hinshaw (2010) emphasized the importance of interventions targeting at reducing the discriminatory behavior of distancing from people with mental illness.

With a strong belief in the need for continued mental illness destigmatization efforts and the hope of contributing to related endeavors in Taiwan, in the current study, an attempt was made to explore degree of stigma against mental health problems and willingness to seek help for college students in Taiwan. In addition, a stigma reduction intervention program was introduced to test its potential in reducing negative perceptions and discriminatory acts towards mental illness (i.e., the three components of knowledge, attitude, and discrimination in mental illness stigma). Finally, students were interviewed to understand in-depth their attitudes towards possible help sources. The purpose was to identify “gatekeeper candidates” who may serve as a buffer for high risk individuals (Yakushi et al., 2017). To better illustrate the concept of “gatekeeper,” Yakushi and colleagues cited the example of the *Nuremberg Alliance against Depression*, a two-year four-level community based suicide intervention program implemented in Nuremberg, Germany during 2001 and 2002 (Hegerl et al., 2013). Through trainings and awareness raising campaigns, the program included sources at four levels (primary care practitioners, general public, community facilitators, and patients and relatives), resulting in a 24% reduction in suicidal acts. The non-medical community facilitators such as religious personnel, police, teachers, and media workers may well serve as potential gatekeepers.

Based on the literature reviewed, the following research questions were posited.

RQ1: Do Taiwanese college students hold mental health stigma, measured by negative mental illness attributes and endorsement of discrimination toward mental illness?

RQ2: What is participants’ level of willingness to seek help from different sources when encountering mental health problems?

RQ3: Does the invented psychoeducational program lower mental health stigma among the participants, in knowledge, attitudes, and discrimination of mental illness?

RQ4: How might certain help sources qualify to be gatekeepers for the participants?

### 3. METHOD

#### 3.1 Designing the psychoeducational program

The current project adopted a psychoeducational initiative, the most commonly used intervention strategy (Xu, et al., 2017a), which included destigmatizing information about the mentally ill. As pointed out by Han and colleagues (2006) in their experimental study on diminishing depression-related stigma among Taiwanese college students, oftentimes,

destigmatization education contained abstract information taken from psychological theories or clinical observation which apparently was less effective. Therefore, the current study resorted to counter-stereotypical information believed to be more readily comprehensible than the biological health information. Moreover, rather than reading printed material as in the study of Han and colleagues, this researcher decided to have the student participants in the experimental group view photo sets depicting positive attributes about depressed<sup>1</sup> people. Photos were believed to convey intended meaning with more clarity. Also, it was likely that college students would find images more appealing than words.

Creation of the stimulus material was adapted from the study of Mazziotta, Mummendy, and Wright (2011). According to Mazziotta et al., for vicarious contact to take effect, it requires participant exposure to an episode which is both positive and interactive and depicts an outgroup member (a person with depression) engaging in positive interactions with an ingroup model (a person without symptoms of depression). Specifically, the student participants in the experimental group were exposed to positive intergroup interaction illustrations along with brief descriptions of the scenarios to avoid misinterpretations. The depictions were in three-frame photo sequences. The process of designing current photo stimuli closely followed that in an earlier study (Hsu, 2011), with each photo highlighting a specific social trait of the protagonist in interaction. An example of the interaction episode is shown below.



The above illustration was accompanied by a short description, “Hsiao-yu (the girl in pony tail, a college student) was carrying loads of material. Ting-wen (in black cap, a college student suffering from depression) saw Hsiao-yu and offered to help her. The specific photo set is an example of a depiction that contradicts the commonly held stigmatized attribute about depressed people as being dangerous. All images portrayed were meant to sensitize the participants to information contrary to mental health stigma.

### 3.2 Measures

#### 3.2.1 The Beck Depression Inventory-II (BDI-II)

The BDI-II (Beck, Steer, Ball, & Ranieri, 1996; Brouwer, Meijer, & Zevalkink, 2013) is widely used around the world to assess severity of depressive symptoms. The BDI-II was used to screen all participants for involvement in the interviews<sup>2</sup>, and the qualitative data collection was

<sup>1</sup> Within the photo depictions, to designate protagonists as being depressed rather than mentally ill individuals was based on the following concerns. For Taiwanese college students, the term mentally ill maybe abstract because it covers a wide range of symptoms related to mental health problems and psychological disorders (Lin, 2002).

Moreover, in college population, depression and anxiety are the most widespread mental health problems (Chang, 2007; Oliver et al., 1999). Therefore, it was hoped that by using depression as a reference point, participants found it easier to identify with the depicted individuals.

<sup>2</sup> The reason for using the BDI-II to finalize the interview sample was to maximize the interviewee number, knowing that depression and anxiety are the most widespread mental health problems among college students.

intended to identify “gatekeepers.” The measure consists of 21 items asking participants to report how they have been feeling for the past two weeks on items such as sadness, self-dislike, or suicidal thoughts. Every item is rated on a scale from 0, indicating “absence of symptom”, to 3, indicating “severe symptom.” Any participant’s BDI-II score is the sum of the 21 scores, the higher the score the more severe one’s depression.

In examining the psychometric properties of the BDI-II, Storch and colleagues (2004) were able to replicate prior research and confirmed the validity and reliability of the BDI-II in a college sample. Wilson VanVoorhis and Blumentritt (2007) found solid convergent and divergent validity of the BDI-II and provided support for BDI-II as a measure of depression among Mexican American youths. Finally, Hall and colleagues (2013) performed a confirmatory factor analysis of the BID-II and concluded that the BDI-II was a reliable and valid measure of depression for bariatric surgery candidates. For measuring depression of the sample in the current study, the BDI-II demonstrated good internal consistency reliability,  $\alpha = 0.82$ .

### 3.2.2 Mental Illness stigma

The measure to assess stigma perception towards mental health problems included statements that conveyed stereotypical attributes about the mentally ill held by the public. It is believed that public stigma towards the mentally ill contains the three aspects of stereotypes, prejudice, and discrimination (Corrigan & Watson, 2002; Xu, Rüscher, Huang, & Kösters); that is, knowledge, attitudes, and behavior (Ando et al., 2013). Therefore, the stigma perception measure used in the current study included items that reflected negative mental illness attributes in the three aspects. The items were based on the Attribution Questionnaire developed by Corrigan and colleagues (2002, 2003). Various articles were also referenced to replace questions in the Attribution Questionnaire with items that described mental illness stigma upheld in Chinese communities (Kao, et al., 2016; Seigny, et al., 1999; Teh et al., 2014).

Participants were asked to what extent they agreed with a list of sixteen five-point statements containing sixteen mental illness stigma attributes and projected discrimination, anchoring on 1 = strongly disagree and 5 = strongly agree. Example statements are as follows. People with emotional or behavioral problems (e.g. depression) are *unpredictable*; most people would feel *unsafe* around people with emotional or behavioral problems (e.g. depression); and most people would try to *avoid* people with emotional or behavioral problems (e.g. depression). Adopted from the study of Evans et al. (2005), the statement stem “people with emotional or behavioral problems” was used with the hope of capturing a wider spectrum of mental illness.

In a meta-analysis of different empirical articles assessing mental illness stigma measures, Link and colleagues concluded that the Attribution Questionnaire showed evidence of construct validity (2004, p. 522). Evaluating the psychometric properties of the Attribution Questionnaire, Brown (2008) concluded that the questionnaire provided reliable and valid measurement of stigmatizing attitudes towards mental illness. The mental illness stigma measure used in the current study demonstrated a good internal consistency reliability at different points of measure (i.e., pre-intervention, post-intervention #1, and post-intervention#2 to check longer-term effect),  $\alpha = 0.829$ ,  $\alpha = 0.894$ , and  $\alpha = 0.893$  respectively.

### 3.2.3 Help-seeking communication

The measure to explore willingness to seek help was adapted from three studies (Evans et al., 2005; Lienemann, Siegel, & Crano, 2013; Romer & Bock, 2008). All student participants were asked to indicate how likely or unlikely would they seek help from each of the listed six sources if they were experiencing mental health issues. The six sources included family members, close friends, medical professionals, school counsellors, teachers, and strangers in self-help groups. The options ranged from 1 = very unlikely to 5 = very likely. It is worth mentioning that including teachers in the list is significant because studies show that mentally troubled students rarely turn to teachers for help. For instance, in the study of Evans et al. (2005), teachers were the least likely candidates from whom students with thoughts of self-harm would seek help. The internal consistency reliability of the measure (i.e., pre-intervention) was good,  $\alpha = 0.79$ .

### 3.3 Interview guide

Development of the interview guide was informed by related studies examining help-seeking behaviors (Evans et al., 2005; Kao, et al., 2016; Teh et al., 2014). Participants were asked whether and why they would resort to certain help sources when encountering mental-health-related issues. The qualitative data collection regarding students' help-seeking behavior was conducted some time after post-intervention test #1 was completed. Before the start of all study procedures, individual participants were provided with informed consent forms. Also, the study protocol was approved by the Research Ethics Office of the National Taiwan University.

### 3.4 Procedures

The student participants were recruited from a university in northern Taiwan. There were a total of 81 students in the experimental group and 90 in the control group initially. Since participation was voluntary and the study was longitudinal spanning over two semesters, the current study encountered the inevitable problem of sample size fluctuation during the process. Consequently, there were 169 students in the pre-intervention survey (79 in the experimental, 90 in the control group); 171 students in the post-intervention survey (81 in the experimental and 90 in the control group); and 157 students in the third survey (80 in the experimental and 77 in the control group). Participant characteristics were fairly homogeneous between the experimental and control groups and among the members in the same group. Each group was composed of two intact sophomore classes in which the ratio between male and female students was approximately 20% to 80%. The ratio matched with the overall gender ratio in their department of study.

At Time 1, students in both experimental and control groups underwent depression diagnosis using the BDI-II scale, with the purpose of locating potential participants in planned interviews. All of them took a pre-intervention mental illness stigma measurement, and indicated their willingness to seek help from the six help sources when experiencing mental health issues. Sometime later, the counterstereotype education initiative was conducted. The initiative exposed the experimental group participants to twelve photo sets depicting positive attributes about people with depression. Half of the episodes were performed by male actors and the other half by female actors. Participants were asked to view the photo sets and indicate on a scale of 1 to 5 whether they believed each photo set adequately depicted the intended scenario as described in the short story accompanied each photo set. The photo evaluation task purposefully required students to examine the photos attentively, and consequently would sensitize students to information which contradicted the stereotypical beliefs about mental illness. A cover story ostensibly informed the



participants that by viewing the photos, the students were assisting the school counsellor's office to select good material for campaign promotion. In fact, the cover story was used to prevent students from associating the counterstereotype education initiative (i.e., viewing of the photo sets) with the current study to avoid social desirability in the following post-intervention measurements of mental illness stigma levels.

After an arbitrary two-week period, the first post-intervention test was conducted. Students in both the experimental and control groups were measured their mental illness stigma levels again. Around the same time, qualitative data collection (interviews) and analysis started.

The purposive sampling strategy (Luborsky & Rubinstein, 1995; Vasileiou et al., 2018) was used to determine the participants in the interview on help-seeking behavior in the current study. Rather than following the principle of saturation and continued interviewing until saturation was reached, the sample of interview participants were determined a priori due to pragmatic considerations. Specifically, there was a fixed size of participant pool to sample from. The current interview participants were chosen from those who had taken the BDI-II and assessed to be suffering from depression. Considering the BDI-II scoring interpretation (Beck, Steer, & Brown, 1996), the frequencies and percentiles of the current BDI-II scores, a cutoff point of 26 was determined. Fifteen out of a total of 21 participants who had scored 26 or above had agreed to participate in the interviews. The participants were designated a participant code respectively, from A to O. All interviews were conducted at this researcher's office and by this researcher only to maintain consistency. Every interviewee had the right to skip any questions he or she found uncomfortable with. Each interview was recorded with the consent of the participant.

Finally, to test possible enduring effects of the invented counterstereotype psychoeducation initiative, at one point during the mid-second semester, the second *post-intervention test* was administered on both student groups to assess their perceived stigma against mental illness.

### 3.5 Statistical analyses

To assess the level of mental health stigma of the participants at three measuring points, descriptive statistics were performed to calculate the mean scores of participants' agreement levels to negative attributes describing people with emotional and behavioral problems. Independent t-tests were conducted to assess the effectiveness of the invented psychoeducational program. To further detect possible changes in pre-and post-interventions #1 and #2 among the experimental group participants regarding the three components (i.e., knowledge, attitude, and discrimination) of mental illness stigma, more t-tests were performed on levels of agreement to individual stigma attributes (see Tables 3, 4). In addition, descriptive statistics were performed to understand willingness to seek help among the Taiwanese college students in the current study. All numerical analyses were carried out using SPSS Version 18.0 (SPSS, Chicago, IL).

Finally, as emphasized earlier, the ultimate goal of this study was to identify "gatekeepers" through understanding help-seeking behavior among Taiwanese college students with mental distress. To that end, interviews were conducted to examine participants' willingness to approach a list of potential help sources and their reasons for turning to those sources. The audio-tape-recorded interviews were transcribed verbatim and kept as an audit trail. This researcher read the interview material multiple times and reviewed contents line by line in detail. The purpose was to

identity a well-integrated set of concepts through constant comparing and categorizing (Corbin & Strauss, 1990). With iterative assessment of the data, a set of recurring patterns or themes emerged which explained the participants’ interpretations and experiences with the phenomenon of interest (McDonald, Schoenebeck, & Forte, 2019), help-seeking behaviors in the current study. Besides analyzing the data with several readings, this researcher, being the sole investigator of the current study, resorted to additional strategies to enhance credibility of the findings, such as creating an audit trail detailing the data analysis process and participant validation (Diamond, et al., 2008; Miles & Huberman, 1994; Pope & Mays, 1995).

**4. RESULTS and DISCUSSIONS**

The low baseline scores (i.e., during the pre-intervention phase) summarized in Table 1 indicated that the surveyed college students held a moderately low level of stigma towards mentally ill individuals, with the mean scores of both the experimental and control groups standing below the midpoint of the scale, ranging from 1 to 5 ( $M = 2.69$  for the experimental group;  $M = 2.71$  for the control group). Nonetheless, it is worth mentioning that among the 16 attributes of the stigma measure, the participants scored the highest on *perceived difference*, *feeling unsafe*, *unpredictability*, and *an intention to avoid* (see Table 2). To the students in the current study, people with mental illness were unpredictable and should be feared and avoided, which coincided with the results of most research on stigmatizing attitudes towards mental illness and conformed to the prototypical stigma of mental illness in the West (Corrigan et al., 2002; Rüsçh et al., 2005) and in Chinese communities; that is, the stereotypes of abnormality, danger and unpredictability (Chen, Lai, & Yang, 2013; Han et al., 2017; Yang et al., 2013).

Table 1  
**Mean ratings (SD) of all participants on mental illness attributes**

	Experimental Group	Control Group
Pre-intervention	2.69 (.49)	2.71 (.63)
Post-Intervention	2.57 (.57)	2.75 (.70)
Longitudinal	2.70 (.54)	2.78 (.75)

**Note:** The higher the score, the grater the mental illness stigma level. The measurement was on a scale of 1 to 5.

Table 2

**Mean ratings of mental illness attributes for all participants (n =169) in pre-intervention survey**

Attribute	Mean	SD
different	3.15	1.097
cannot handle things	2.42	.992
people feel unsafe	3.25	1.041
weak	2.24	1.166
unpredictable	3.57	1.078
need to be treated as child	2.38	1.16
responsible for their condition	2.33	1.062
not trustworthy	1.91	.885
not treatable	3.07	1.053
pose a risk to others	2.79	.971
less able to contribute	2.01	.994
uncomfortable to be with	2.20	1.003
try to avoid	3.15	1.102
not rent apartment	2.94	1.184
not hire	3.05	1.176
look down on	2.71	1.125

Note: The higher the score, the greater the mental illness stigma level. The measurement was on a scale of 1 to 5.

The above findings were significant and worth exploring further. First, it corroborated some earlier research which suggested that compared to Western participants Chinese individuals were more inclined to maintain social distance from people with mental illness (Corrigan et al., 2010; Yang et al., 2013; Xu et al., 2017a). Second, the endorsed discriminatory behavior of distancing or avoiding was dictated by the stigmatized beliefs of mentally ill being dangerous or unpredictable (Han et al., 2017) and the emotion of fear (Corrigan et al., 2002). Third, the finding of the current study was concerning because it implied that Taiwanese students might avoid or isolate people with mental illness due to the negative judgment of danger and unpredictability. Consequently, it was important to find out whether the intervention in the current study could potentially reduce mental illness stigma along the three individual components, knowledge about mental illness (e.g., weak), attitudes toward people with mental illness (e.g., feeling unsafe), and discrimination of people with mental illness (e.g., social distance).

The independent t-tests results indicated no significant differences between the experimental and control groups or within the experimental group across all three phases. As a result, the invented intervention did not significantly reduce the overall stigma levels among the participants in the experimental group. Arguably, the low baseline levels of stigma made it difficult to produce significant reductions. The argument that final stigmatizing attitude was strongly dependent on baseline level scores was similarly reported in related studies (Cheng, 2015; Griffiths et al., 2006).

More t-tests were performed to assess the effectiveness of the invented psychoeducational program in modifying participants' ratings on some key attributes along the three components of

stigma (i.e., knowledge, attitude, and discrimination). A more positive picture had emerged in this regard (see Tables 3, 4). The participants who received the intervention were significantly less prone to *avoid* people with emotional or behavioral problems ( $p < 0.05$ ) and were trending to register lower on *feeling unsafe* around them ( $p = 0.096$ ). Similarly, there was a lasting significant effect on avoidance of people with mental or behavioral problems ( $p < 0.05$ ; see Table 4); that is, participants felt less compelled to avoid people with mental or behavioral problems. Significantly, the current intervention had the potential of altering the stigmatizing behaviors of the participants; specifically, the inclination to avoid people with mental issues. It is worth reiterating that arguably, it is more meaningful to change discriminatory behaviors than to modify negative cognitive and attitudinal responses about mental illness. An outer act serves as a direct indicator of aversion towards the mentally ill, which is readily picked up by the stigmatized and conceivably more deleterious than stigmatizing attitudes or knowledge assumed by an individual.

Table 3

**Mean ratings of mental illness attributes for experimental group participants in pre-intervention (n = 79) and post-intervention surveys (n = 81)**

Attribute	Mean (SD)	Mean (SD)	t	p-value
different	3.18 (1.059)	3.00 (.975)	1.102	.272
cannot handle things	2.28 (.973)	2.19 (.868)	.640	.523
people feel unsafe	3.20 (1.030)	2.94 (.966)	1.674	.096
weak	2.27 (1.151)	2.14 (1.034)	.752	.453
unpredictable	3.57 (1.082)	3.48 (.976)	.541	.589
need to be treated as child	2.22 (1.106)	2.14 (1.009)	.475	.636
responsible for their condition	2.47 (.985)	2.49 (1.108)	-.154	.878
not trustworthy	1.86 (.858)	1.90 (.875)	-.295	.768
not treatable	3.09 (1.064)	2.93 (1.070)	.964	.336
pose a risk to others	2.68 (.927)	2.47 (.963)	1.434	.154
less able to contribute	1.91 (.865)	1.90 (.903)	.073	.942
uncomfortable to be with	2.14 (.957)	2.10 (.957)	.267	.789
try to avoid	3.43 (.957)	3.11 (1.049)	2.010*	.046
not rent apartment	2.89 (1.177)	2.70 (1.112)	1.008	.315
not hire	2.92 (1.152)	2.79 (1.033)	.774	.440
look down on	2.97 (1.086)	2.83 (1.127)	.843	.401

**Note:** \*  $p < .05$ . The higher the score, the greater the mental illness stigma level. The measurement was on a scale of 1 to 5.

Table 4

**Mean ratings of mental illness attributes for experimental group participants in pre-intervention (n = 79) and post-intervention #2 surveys (n = 80)**

Attribute	Mean ( <i>SD</i> )	Mean ( <i>SD</i> )	<i>t</i>	<i>p-value</i>
different	3.18 (1.059)	3.25 (.893)	-.469	.640
cannot handle things	2.28 (.973)	2.35 (.858)	-.492	.624
people feel unsafe	3.20 (1.030)	3.26 (.882)	-.394	.694
weak	2.27 (1.151)	2.14 (.924)	.775	.439
unpredictable	3.57 (1.082)	3.58 (.925)	-.034	.973
need to be treated as child	2.22 (1.106)	2.16 (.947)	.323	.747
responsible for their condition	2.47 (.985)	2.74 (1.145)	-1.588	.114
not trustworthy	1.86 (.858)	2.09 (.944)	-1.584	.115
not treatable	3.09 (1.064)	2.85 (1.045)	1.427	.156
pose a risk to others	2.68 (.927)	2.78 (.914)	-.626	.532
less able to contribute	1.91 (.865)	1.98 (.871)	-.462	.645
uncomfortable to be with	2.14 (.957)	2.29 (.944)	-.983	.327
try to avoid	3.43 (.957)	3.06 (1.035)	2.326*	.021
not rent apartment	2.89 (1.177)	2.95 (1.179)	-.342	.733
not hire	2.92 (1.152)	2.86 (1.088)	.346	.730
look down on	2.97 (1.086)	2.85 (1.069)	.730	.467

**Note:** \* $p < .05$ . The higher the score, the greater the mental illness stigma level. The measurement was on a scale of 1 to 5.

The computed descriptive statistics showed a moderate level of help-seeking willingness ( $M = 3.09$ ,  $SD = 0.927$  on a scale of 1 to 5). The mean ratings on the six help sources are listed in Table 5. Based on the item ratings, close friends are the first help source the participants would resort to when encountering mental health issues, a result which complies with findings in the past research (Teh et al., 2014; Yakushi et al., 2017). Unexpectedly, instead of family, professional medical personnel and school counsellors were next in line on the willingness ratings. Disappointing but endorsing the findings of past research on students in other parts of the world (Boulton et al., 2017; Evans et al., 2005; Williams, 2012), the study showed that teachers, receiving almost identical ratings as support group strangers, came in the last on the list of help sources for Taiwanese college students.

Table 5

**Mean ratings on help sources for all participants (n =169) in pre-intervention survey**

Help Sources	Mean	SD
School counsellor	3.41	1.429
Professional medical personnel	3.42	1.421
Family	3.31	1.336
Good friends	3.74	1.156
Teachers	2.34	1.262
Support group strangers	2.33	1.340

**Note:** The higher the score, the greater the inclination to seek help from the sources. The measurement was on a scale of 1 to 5.

Considering that teachers are one of the few adults with whom students interact on a regular basis, the above findings can be concerning. In related literature, some reasons were commonly cited to have deterred students from seeking help from teachers. For instance, students suffered from mental distress due to bullying but perceived it ineffective or counterproductive to resort to teachers (Boulton et al., 2017; Shaw et al., 2019); students believed seeking help for psychological problems was futile (Williams, 2012); or students did not perceive a close and responsive teacher-student relationship (Halladay, 2020).

The quantitative data findings regarding students' help-seeking were intriguing on another front. As pointed out by previous research, compared to Caucasian students, Asian American college students tended to use counseling services less frequently besides holding relatively less positive attitudes toward the service (Eisenberg et al., 2007; Loya et al., 2010; Masuda et al., 2009). In the current study, college students ranked professional medical personnel and school counsellors second on a list of potential help sources for resolving mental health issues. This result went contrary to the established knowledge about Asians of being reluctant about counseling for fear of bringing shame and stigma to families and communities (Yang et al., 2008).

Thus, the findings called for a deeper assessment of help-seeking among college students in contemporary Taiwanese society. Such an attempt would be better achieved with qualitative interview studies, which allowed for extraction of rich data to explain possible sociocultural change behind the students' help-seeking behaviors (Bradley, Curry, & Devers, 2007; Marshall et al., 2003). Rather than merely knowing how willing students were to seek help from their social networks, this researcher believed it would be more informative to explore students' rationale about why and with whom to divulge their mental health problems.

#### 4.1 Results in conceptualizing help-seeking communication

Indeed, mental illness is not a condition to be communicated freely with anyone. As commented repeatedly by the Taiwanese college student participants, concealment was common among those with mental distress.

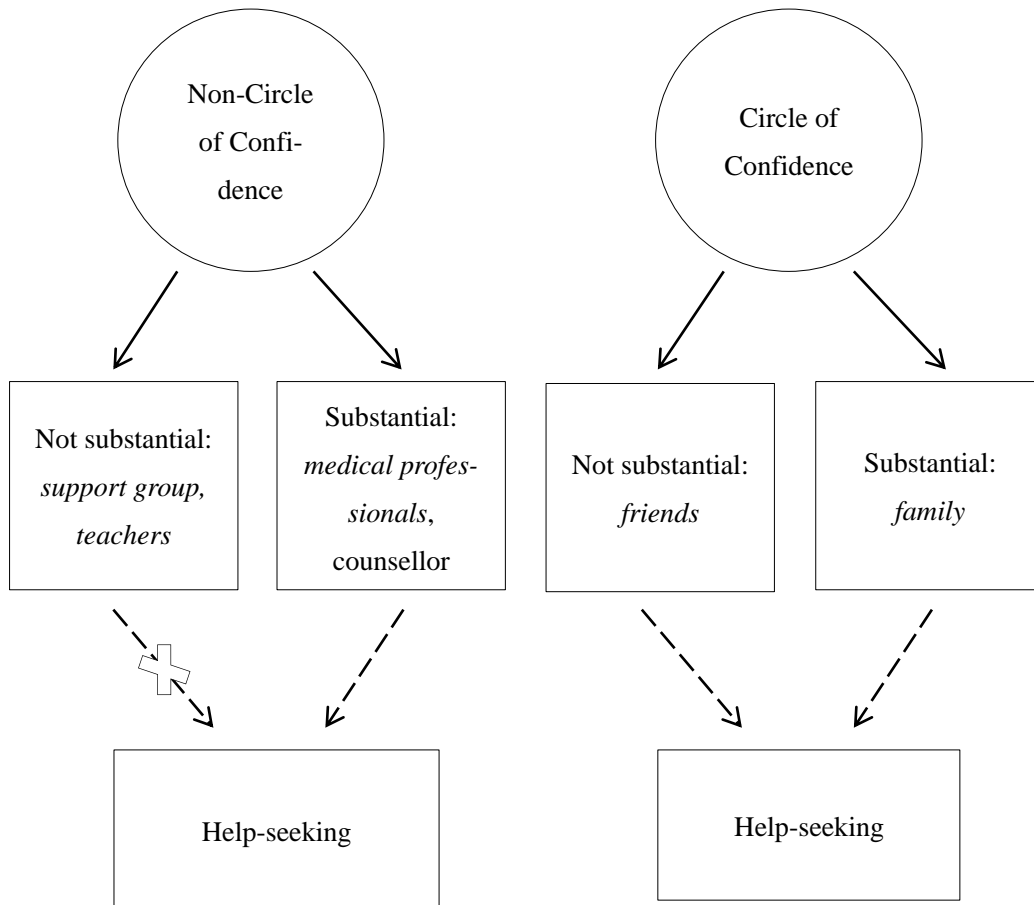
"I did not want to tell anyone about my emotional issues because I could not afford worsening relations with my classmates." (B)

“Mental illness is after all a disease that incurs disgust or fear, therefore, to cover up is only natural, to avoid being seen in a negative light.” (G)

Based on the participants’ comments in the interviews, an attempt was made to identify potential “gatekeepers” and examine students’ help-seeking behaviors. The help sources can be divided into *circle of confidence* (i.e., those with whom participants spend much time), and *non-circle of confidence*. Each category can be further divided into the sub-categories of *offering substantial assistance* (i.e., those who offer constructive advice and concrete solutions) and *not offering substantial assistance* (see Figure 1).

Figure 1

Conceptual map of help-seeking behaviors among Taiwanese college students



**4.1.1 Circle of confidence and offering substantial assistance -- Friends**

Almost all participants (14 out of 15) mentioned *friends*, as their top choice to talk about mental health problems. Nonetheless, they acknowledged that friends could offer only non-substantial assistance.

“I talk about my emotional issues with those friends who are very close to me; friends lend an ear to your trouble but cannot give you any substantial help.” (J)

Consistent with the quantitative data analysis results regarding willingness to seek help, the interview data shows that medical professionals and counsellors rank the second on the list of potential help sources for the participants (10 out of 15). As demonstrated by the comments below, participants believed medical personnel were capable of offering professional and substantial assistance to better solve problems for those in need.

**4.1.2 Circle of confidence but not offering substantial assistance -- Parents**

“I never tell my parents because I don’t think they can bear up with the fact that I am suffering from depression.” (A)

“I worry I might bring pain to them, making their lives miserable by talking about my emotional problems.” (L)

“I have been seeing psychiatrist since senior high school; I briefly mentioned my problems to my father, but he was not able to understand even the slightest; he dismissed the whole thing and believed that I was only trying to get attention.” (E)

Counterintuitively, *teachers*, situated in the non-circle of confidence along with medical professionals, were considered by the interview participants as sources who were unable to provide substantial assistance to students. In fact, only one out of fifteen students mentioned teachers to be potential help sources. Coincidentally, the students’ accounts of their help-seeking experiences with teachers comply with the findings in literature on help-seeking between students and teachers cited and explained earlier in the current study.

**4.1.3 Non-circle of confidence but offering substantial assistance -- Medical professionals**

“I am used to conversing with psychiatrist. I go to hospital every month and I have been receiving counselling from the very first week I attended the university.” (C)

“Compared to friends, doctors are trained academically to provide prognosis, offering assistance different from the mere attention rendered by ordinary friends.” (O)

Although capable of providing substantial assistance and situating within the circle of confidence, *parents* were behind medical professionals as help sources for the student participants. In fact, participants cited multiple reasons for refusing to discuss with parents about emotional problems.

**4.1.4 Non-circle of confidence and not offering substantial assistance -- Teachers**

“Teachers were not helpful; a lot of them simply paid lip service without taking me seriously.” (G)



“When I was in elementary school, I reported a bullying case to my teacher; he believed nothing should be done about the little bickering among students; therefore, nobody did anything to rescue the sufferer; no further actions taken was equal to pushing away the hands extending out for help.” (M)

“I believe most college students would not talk with teachers; I don’t tell college teachers about my emotional condition because we don’t feel close to them; the bond is very weak.” (B)

Along with teachers, *support groups* were also ranked at the bottom of the help source list. In fact, only one student was receptive to the idea of speaking her mind with total strangers.

## 5. CONCLUSION

In a meta-analysis of 13 studies, Too and colleagues detected a strong association between mental disorders and suicide (Too, et al., 2019). Although help-seeking serves as a buffer to mental distress, mental illness stigma has been found to strongly correlate with decreased willingness to seek help (Reichert, 2012). As such, the current study was conducted with the goal of enhancing help-seeking communication of Taiwanese college students through examining mental illness stigma and possibly reducing the stigma among the students with an intervention attempt. The results showed that overall, Taiwanese youths rated moderately low on mental illness attributes. However, the ratings were relatively high on such attributes as *feeling unsafe* around people with emotional and behavioral problems, who were perceived as *unpredictable* and should be *avoided*, which reflected the contents of conventional public stigma against mental illness.

The intervention implemented in the current study was not able to reduce the overall mental illness stigma, a result which could have been attributed to the low baseline score. Further studies may be conducted by using different measuring instruments to reach better assessment of mental illness stigma among Taiwanese youths. Nonetheless, the intervention significantly reduced participants’ inclination to avoid the mentally ill. Arguably, the finding is meaningful because it is believed that a discriminatory act, one component of mental illness stigma, such as avoidance, is more powerful than the other two components, knowledge or attitude of mental illness, in conveying disdain towards people with mental health problems. It is all the more significant that the current study results show that through implementation of a well-designed psychoeducational intervention, reduction in behavioral stigmatizing expression is possible.

Conforming to earlier research on help-seeking behaviors among younger people with mental health problems, the student participants in the current study also cited *friends* as their first choice to talk about their life problems (Evans et al., 2005; Griffiths et al., 2006). Therefore, it is highly encouraged that schools provide mental-health-related psychoeducational programs to train peer friends into gatekeepers. It is expected that these primary help sources can play an important role in identifying high risk individuals to reduce potential suicidal acts (Yakushi et al., 2017).

The fact that teachers came in the last in participants’ choice of help sources is worthy of attention from teachers and educators respectful of their jobs. Arguably, teachers in Taiwan care much about their students, a claim which can be attested to by the fact that homeroom teachers are positioned even at the college level. However, as revealed in the qualitative interview data,

teachers, especially college instructors, were distant and inaccessible in the minds of the participants in the current study. It is suggested that certain mechanism may be introduced to allow teachers to work in tandem with school counsellors to render needed assistance to students. Fundamentally, it is possible for teachers to take part in school-based mental health initiatives by integrating psychoeducational information into normal classes. Correct and relevant knowledge embedded in regular curriculum is believed to be effective because it can reach a huge number of students at once.

Informed by the qualitative data findings, the students in the current study did not abide by the traditional Chinese values of attaching shame to counseling service. Instead, they valued the substantial assistance medical professionals and school counsellors were able to offer compared to parents or teachers. Therefore, it is viable to expand the capacity of counselling personnel on campus, and to increase the visibility of campus counselling service among the student population. Moreover, parents and teachers should prioritize provision of substantial help to their children and students so as to become successful help sources for the youths.

### 5.1 Study limitations and future directions

The study examined the degree and contents of mental illness stigma among members of a specific cultural community, the college students in contemporary Taiwanese society. However, due to a relatively small sample, generalizability of the findings might be limited. Nonetheless, the participants were college students from a general university and were considered representative of the youth population in Taiwan. Their responses were presumably indicative of the values and thoughts of Taiwanese young people nowadays. Understandably, mental illness includes a range of mental health conditions. As such, special attention was taken to prompt participants to think more broadly about their feelings towards mental illness by using the question stem in the stigma perception measure (i.e., “emotional and behavioral problems”). Moreover, the stigma perception measure used was composed of mental illness attributes cited from related literature. The stigma perception result showed that the Taiwanese college students scored only moderately low on mental illness stigma, which was somewhat unexpected because it did not comply with the results of related literature. A follow-up qualitative study such as interviews may be conducted to triangulate the validity and reliability of the quantitative data in the current study. Finally, the current study have yielded some conflicting results that young Taiwanese college students were generally low on mental illness stigma; nonetheless, they were quite conventional in their beliefs about mental ill people being unsafe, unpredictable and to be avoided; and in addition, Taiwanese college students were relatively open to psychological counselling. These major findings have pointed out the value of reexamining how stigma works across different social contexts with the passing of time and changing of cultural norms.

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