



Predictors of Generalized Anxiety Disorder stigma

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ABSTRACT

The stigma associated with mental illness can lead to a range of negative outcomes, including delaying or avoiding help seeking. Identifying the characteristics of people who are more likely to hold stigmatizing attitudes enables the development of targeted stigma reduction programs. However, no previous research has systematically examined the predictors of anxiety stigma. This study used the Generalized Anxiety Stigma Scale (GASS) to assess the predictors of personal stigma and perceived stigma associated with Generalized Anxiety Disorder. A community sample of 617 Australian adults completed a survey that included the GASS, the Depression Stigma Scale, exposure to anxiety disorders, emotional distress and a range of demographic characteristics. Linear regression models indicated that women, people with greater exposure to anxiety disorders and people reporting a previous anxiety diagnosis had lower personal stigma toward anxiety. Higher exposure to anxiety disorders and rurality were significantly associated with higher perceived anxiety stigma. Results also suggested that respondents who had only been exposed to anxiety disorders through the media tended to be no more stigmatizing than respondents who had direct contact with people with an anxiety disorder. Media campaigns may be an effective vehicle for decreasing stigmatizing views in the community.

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1. Introduction

Stigmatization of people with mental illness leads to detrimental outcomes, including delay or avoidance of help seeking and treatment non-adherence, along with indirect negative outcomes such as strained social interactions, poorer quality of life or decreased self-esteem (Link and Phelan, 2006). Identifying the characteristics that are associated with stigmatizing viewpoints may enable researchers and health professionals to target stigma reduction interventions in the community. Previous studies have examined predictors of stigma in the general population (Link et al., 2004), with studies examining stigma associated with depression (Crisp et al., 2000; Angermeyer and Matschinger, 2003; Lauber et al., 2004; Pyne et al., 2004; Griffiths et al., 2006; Wang et al., 2007) and psychosis (Corrigan et al., 2000; Crisp et al., 2000; Angermeyer and Matschinger, 2003; Lauber et al., 2004). Crisp et al. (2000) examined stigma toward people with a range of mental disorders, and reported that the stigma around schizophrenia, drug and alcohol disorders tended to be higher than for panic disorder, major depression and eating disorders. However, to our knowledge, there have been no systematic investigations of stigmatizing viewpoints towards people with generalized anxiety specifically and the characteristics of people who might have such

viewpoints. The high prevalence, chronicity and burden of anxiety disorders (Kessler and Greenberg, 2002), particularly Generalized Anxiety Disorder, necessitates research into the predictors of anxiety stigma.

Most previous community-based research has examined personal stigma (sometimes referred to as public stigma), which is concerned with the respondent's own attitudes toward a certain group of people, such as people with depression or anxiety. However, it is also important to examine perceived stigma, that is, the level of stigma that respondents perceive is held by the greater community towards a certain group of people. Other forms of stigma have also been examined, including self-stigma, which is the stigma or shame a person feels about their own condition, and stigma associated with seeking help for mental health problems.

Although there have been no studies of the predictors of the stigma associated with Generalized Anxiety Disorder, there has been some investigation of the factors that are associated with the stigma associated with mental illness or depression (Lauber et al., 2004; Pyne et al., 2004; Anglin et al., 2006; Griffiths et al., 2008). There is mixed evidence for the effects of demographic characteristics such as gender and age on mental illness stigma, (Crisp et al., 2000; Lauber et al., 2004; Pyne et al., 2004; Wang et al., 2007; Griffiths et al., 2008), which may be attributable to the variety of stigma measures and the heterogeneity of samples. Only one study (Griffiths et al., 2008) has systematically examined a range of potential predictors of stigma and compared the

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predictors of personal stigma and perceived stigma using parallel stigma scales. In this study, which focused on the stigma associated with depression, differences in the pattern of predictors for personal compared to perceived stigma were found. In particular, female gender and greater exposure to depression were associated with higher perceived stigma but lower personal stigma. Having lower depression literacy or being born overseas was found to be associated with increased personal stigma alone (Griffiths et al., 2008). However, higher psychological distress predicted both higher personal and perceived stigma (Griffiths et al., 2008).

The present study employed a similar approach to that described by Griffiths et al. (2008), to investigate and compare the predictors of personal and perceived stigma associated with Generalized Anxiety Disorder among members of the community. In addition, the study sought to compare the predictors of generalized anxiety stigma with the predictors of depression stigma in the same cohort. By examining whether the predictors of depression and anxiety stigma are similar, the generalizability of other depression stigma research to anxiety stigma may be assessed, while differences in predictors might be indicative of divergent public attitudes towards depression and Generalized Anxiety Disorder. Based on previous research on depression stigma (Griffiths et al., 2008), it was hypothesized that exposure to people with anxiety disorders and increased education would be associated with lower personal anxiety stigma. Similarly, previous diagnosis of anxiety and higher current anxiety symptoms were predicted to be associated with lower personal stigma but higher perceived stigma based on previous findings (Pyne et al., 2004; Griffiths et al., 2008).

2. Methods

Data were collected by means of a brief survey sent by mail to randomly selected members of two regions of Australia. Details of the survey have previously been reported by Griffiths et al. (2011).

2.1. Participants

Participants were randomly sampled from the community using the electoral rolls for two Australian electorates. The electorates selected were Banks, an urban electorate in Western Sydney in the state of New South Wales (NSW) and Calare, a rural electorate which included the towns of Orange, Parkes, Cowra and Forbes in NSW. Registration on the electoral roll is compulsory for Australian citizens. In each electorate, 2500 residents aged 18–65 were sent surveys. Of these 5000 surveys, 617 (12.3%) were completed and returned. The study received approval from the Human Research Ethics Committee of the Australian National University.

2.2. Measures

The outcome measures were the Generalized Anxiety Stigma Survey (GASS, Griffiths et al., 2011) and the Depression Stigma Survey (DSS, Griffiths et al., 2004). Both personal stigma and perceived stigma are assessed by each measure. The GASS-Personal and GASS-Perceived each consist of 10 items (nine items in the DSS) rated on a five-point Likert scale from “strongly disagree” (1) to “strongly agree” (5). These items are rated for personal stigma (e.g., “An anxiety disorder is a sign of personal weakness”) and perceived stigma (e.g., “Most people think that an anxiety disorder is a sign of personal weakness”). A vignette of a typical case of Generalized Anxiety Disorder (or Depression) is presented before the scale, with the characterization based on DSM-IV criteria. The GASS vignette and items are presented in Griffiths et al. (2011), while the DSS items are presented in Griffiths et al. (2008). The GASS has previously been demonstrated to have good internal consistency, construct validity and test–retest reliability over a four-month follow-up in the present sample (Griffiths et al., 2011). The GASS-Perceived and DSS-Perceived have been found to correlate with the Devaluation-Discrimination Scale (Link et al., 1989) at 0.42 and 0.37 respectively (Griffiths et al., 2011). GASS scores range from 0 to 40 and DSS scores range from 0 to 36 for both personal and perceived forms, with higher scores indicating greater stigma.

Demographic measures included as independent variables in the analyses were gender, age group, years of education (based on four items assessing previous and current educational attainment) and employment status. Location (rural or urban electorate) was only collected for the subgroup of respondents who

agreed to participate in a follow-up survey. Specifically, participants who agreed to participate in the follow-up survey wrote their identification number in a space allocated in the initial survey, which was then matched to their name and address for the mailing of the follow-up survey. Participants who did not agree to participate in the follow-up survey did not have their identification number printed on the survey, so that it remained anonymous and their location could not be ascertained. Level of exposure to anxiety disorders was based the highest endorsed item chosen from a scale based on the Level of Contact Report (Holmes et al., 1999). Exposure was rated from 0 (no experience of people with anxiety disorders) to 10 (have personally experienced an anxiety disorder), with intermediate scores indicating exposure to anxiety disorders through a television character, a documentary, observation, a colleague, providing services to people with anxiety disorders, an acquaintance, a relative, a close friend, or a member of the household. Self-reported lifetime diagnosis of an anxiety disorder was assessed using a single yes/no item. The K10 scale (Kessler et al., 2003) was included to measure emotional distress, with scores ranging from 0 to 40 where high scores indicate high distress. The Goldberg Depression and Anxiety scales (Goldberg et al., 1988) assessed the core symptoms of depression and anxiety, with scores reflecting symptom counts ranging from 0 to 9.

2.3. Analysis

Predictors of personal and perceived stigma for both anxiety and depression were assessed using linear regression models. Separate models examined the effects of rural/urban setting on stigma, as this information was only collected for a subsample. All analyses were conducted using SPSS v20.

3. Results

The characteristics of the sample are shown in Table 1, including demographic characteristics, stigma measures and symptom scales. The mean age of the respondents was 46.6 years (S.D. = 13.3 years) and 62% were female. On average, the sample was well-educated, with approximately two years post-secondary education, 75% were in the workforce, and 76% were married or in a de-facto relationship. As already reported by Griffiths et al. (2011), personal stigma levels were relatively low (see Table 1) both for GAD and depression. In addition, there were similar levels of personal and perceived stigma associated with depression and GAD adjusting for the differences in total items in the GASS and the DSS.

Table 2 shows the linear regression models predicting personal stigma for both generalized anxiety disorder and depression, with significant p values identified in bold ($p < 0.05$). Females reported significantly less personal stigma than males for both generalized anxiety disorder ($t_1 = -3.20$, $p = 0.002$) and depression ($t_1 = -3.56$, $p < 0.001$). Participants reporting a previous diagnosis of anxiety/depression had less personal stigma (anxiety: $t_1 = -3.12$, $p = 0.002$; depression: $t_1 = -3.87$, $p < 0.001$). Although each additional year of education was associated with a 0.26 decrease in personal depression stigma ($t_1 = -2.68$, $p = 0.008$), there was no such association for personal anxiety stigma ($t_1 = -1.18$, $p = 0.237$). Participants with more exposure to anxiety disorders had significantly less personal stigma (anxiety: $t_1 = -6.17$, $p < 0.001$; depression: $t_1 = -4.68$, $p < 0.001$), such that each additional level of exposure to people with anxiety was associated with a 0.52 point decrease in anxiety stigma and a 0.36 point decrease in depression stigma. This relationship is shown for the GASS personal scale in Fig. 1. In a separate univariate analysis to further explore this effect, it was found that all forms of exposure were significantly associated with lower levels of personal stigma compared to no exposure, except having observed a person with an anxiety disorder or having a colleague with an anxiety disorder. Furthermore, compared to having a household member with an anxiety disorder, there were no differences in levels of personal stigma for participants who reported having seen a documentary about anxiety disorders, providing services to people with anxiety disorders, having a close friend with an anxiety disorder or having a history of an anxiety disorder themselves (see Fig. 1).

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