BJPsych | The British Journal of Psychiatry (2008) 192, 144–149. doi: 10.1192/bjp.bp.107.039404

Influences on young people's stigmatising attitudes towards peers with mental disorders: national survey of young Australians and their parents

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Background
Little is known about the development of stigma towards people with mental disorders.

Aims
To investigate stigma in young Australians and the influence of exposure to mental disorders, parental attitudes and information campaigns.

Method
A national telephone survey was carried out with 3746 people aged 12–25 years and 2005 co-resident parents. Stigmatising attitudes were assessed in relation to four vignettes (depression, depression with alcohol misuse, social phobia and psychosis).

Results
Stigma was found to have multiple components labelled 'social distance', 'dangerous/unpredictable', 'weak not sick', 'stigma perceived in others' and 'reluctance to disclose'. Exposure to mental disorders and help-seeking in oneself or others was associated with lower scores on some components of stigma but not on others. Young people's attitudes showed specific associations with those of parents. Exposure to campaigns was associated with reductions in beliefs that the person is 'weak not sick'.

Conclusions
Personal experiences, parental attitudes and campaigns all affect stigmatising attitudes.

Declaration of interest
None.

Stigma has been identified as a major concern for many people with mental disorders.[1,2] Stigma is known to be present early in life[3] but little is known about its development. Exposure to people with mental disorders is known to reduce stigma in adults;[4,5] however, one study found that exposure increased stigma in adolescents.[6] Parents are an obvious potential model for stigmatising attitudes, but this influence has received only limited research.[3] There are interventions to reduce stigma that appear to have a small effect in young people,[7,8] although it is not known whether these have a detectable population impact. Our study was designed to examine the role of these influences on the development of stigma in a population sample.

Method

Sample

A national computer-assisted telephone survey was conducted of young Australians aged 12–25 years by the survey company The Social Research Centre. The sample was contacted by random-digit dialling covering the whole country during May to August 2006. Up to nine calls were made to establish contact. Interviewers ascertained whether there were residents in the household within the age range and, if there was more than one, selected the individual who had the most recent birthday. If the young person lived with a parent, then one parent was also invited to be interviewed using the last-birthday method. The response rate was 61.5%, defined as completed interviews (3746) out of sample members who could be contacted and were confirmed as in scope (6087). There were 835 males and 798 females in the 12–17 year age group, and 958 males and 1155 females in the 18–25 year age group. There were 2925 youth respondents with a parent in the household, of whom 2005 completed interviews, giving a response rate of 68.5%. Mothers comprised 68.9% of the parent sample. The sub-sample which had a parent interview was younger than the sample as a whole (mean age 16.56 years *v.* 18.23 years). Comparison with population data showed that young men aged 18–25 years were slightly underrepresented. There was also a bias in the parent sample, with fathers underrepresented. This was particularly the case with fathers of young people aged 18–25 years. To reduce any bias in the sample due to greater refusal by those with negative attitudes towards mental disorders, the survey was introduced as 'a major study of people's attitudes to some public health issues facing Australians today to gain a better understanding of what people know and understand about some health problems'. Mental health was not explicitly mentioned until late in the interview.

Interview

The interview was based on a vignette of a young person with a mental disorder. On a random basis, respondents were read one of four vignettes: depression, depression with alcohol misuse, social phobia and psychosis (schizophrenia). The vignettes were written to satisfy DSM–IV criteria and were validated by surveys of mental health professionals asking what was wrong with the person described.[9] Respondents were shown a vignette of the same gender as their own. The male vignettes referred to 'John' and the female ones to 'Jenny'. The respondents aged 12–17 years were read a version of the vignette portraying a person aged 15 years; those aged 18–25 years were read one portraying a person aged 21 years. The details of the vignettes were altered slightly to be age-appropriate (e.g. reference to functioning at school *v.* on a course). Parents who were interviewed were read the same vignette

as their child. Text of all the vignettes is available elsewhere.[10] The four male adolescent vignettes are given here as examples. The depression vignette was:

'John is a 15-year-old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.'

The depression with alcohol misuse vignette was:

'John is a 15-year-old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. John has been drinking a lot of alcohol over the last year, and recently lost his weekend job because of his hangovers. His parents and friends are very concerned about him.'

The social phobia vignette was:

'John is a 15-year-old living at home with his parents. Since starting his new school last year he has become even more shy than usual and has made only one friend. He would really like to make more friends but is scared that he'll do or say something embarrassing when he's around others. Although John's work is OK he rarely says a word in class and becomes incredibly nervous, trembles, blushes and seems like he might vomit if he has to answer a question or speak in front of the class. At home, John is quite talkative with his family, but becomes quiet if anyone he doesn't know well comes over. He never answers the phone and he refuses to attend social gatherings. He knows his fears are unreasonable but he can't seem to control them and this really upsets him.'

The psychosis vignette was:

'John is a 15-year-old who lives at home with his parents. He has been attending school irregularly over the past year and has recently stopped attending altogether. Over the past 6 months he has stopped seeing his friends and begun locking himself in his bedroom and refusing to eat with the family or to have a bath. His parents also hear him walking about in his bedroom at night while they are in bed. Even though they know he is alone, they have heard him shouting and arguing as if someone else is there. When they try to encourage him to do more things, he whispers that he won't leave home because he is being spied upon by the neighbour. They realise he is not taking drugs because he never sees anyone or goes anywhere.'

After being presented with the vignette, respondents were asked a series of questions to assess their recognition of the disorder in the vignette, what they would do to seek help if they had the problem, beliefs and intentions about first aid, beliefs about interventions, beliefs about prevention, stigmatising attitudes and social distance, exposure to mental disorders, the six-item version of the Kessler Psychological Distress Scale, exposure to campaigns and media items about mental health, and socio-demographic characteristics. Parents were asked a subset of the same questions as their child, with changes in the wording to reflect the parent's perspective.

Assessment of stigma

Young people were given questions to assess personal and perceived stigma based on those developed by Griffiths *et al*.[11,12] Data on the psychometric properties and validity of these items have been reported.[13] The questions were modified to be suitable for a younger age group: questions on voting for a politician were dropped and the wording of some questions was simplified. The personal stigma questions were as follows:

'The next few questions contain statements about John's/Jenny's problem. Please indicate how strongly *you personally* agree or disagree with each statement. John/Jenny could snap out of it if he/she wanted. John's/Jenny's problem is a sign of personal weakness. John's/Jenny's problem is not a real medical illness. John/Jenny is dangerous. It is best to avoid John/Jenny so that you don't develop this problem yourself. John's/Jenny's problem makes him/her unpredictable. You would not tell anyone if you had a problem like John's/Jenny's.'

These statements were rated on a scale of: strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. The perceived stigma questions involved the same items, but concerned what the respondent thought others would believe. They were told:

'Now we would like you to tell us what you think *most other people* believe. Please indicate how strongly you agree or disagree with the following statements.'

Each statement was of the form 'Most other people believe that'. Next, respondents were given a social distance scale based on one for adults,[14] but modified to be age-appropriate. It has been shown that social distance scores differ greatly between different types of vignettes, with substance misuse rating higher than schizophrenia, which in turn rated higher than major depression.[14] The social distance scale used in this study covered interactions of various degrees of closeness that could occur with a young person. The respondent was told:

'The following questions ask how you would feel about spending time with John/Jenny. Would you be happy to go out with John/Jenny on the weekend? To work on a project with John/Jenny? To invite John/Jenny around to your house? Would you be happy to develop a close friendship with John/Jenny?'

The response options were: 'yes, definitely', 'yes, probably', 'probably not' or 'definitely not'. Parents were asked the same questions, except that the social distance questions were asked in relation to their child, e.g. 'Would you be happy for your child [name of child] to go out with John/Jenny on the weekend?'

Assessment of variables associated with stigma

To measure exposure to mental disorders and professional help-seeking, the young people were asked the following questions in relation to the particular vignette presented:

'Has anyone in your family or close circle of friends ever had a problem similar to John's/Jenny's? (If yes) Have they received any professional help or treatment for these problems? Have you ever had a problem similar to John's/Jenny's? Have you received any professional help or treatment for these problems?'

Respondents were scored as 'exposed' if they knew someone who had received help and if they had themselves received help.

The impact of campaigns was assessed by asking those at school, 'In the past 12 months, have you received any information about mental health problems from your teachers?' and asking those not at school, 'In the past 12 months, have you had any information about mental health problems at your workplace/TAFE [technical college]/university?'. Specific awareness of Australia's national depression initiative was assessed by asking: 'Which organisations related to mental health problems, if any, can you think of?' and 'Have you heard of *beyondblue* – the national depression initiative?' Awareness of this initiative was scored as being present if *beyondblue* was either recalled or recognised.[15]

Statistical method

The items on social distance and stigma were reduced using principal components analysis with varimax rotation. A scree plot was used to determine the number of components to retain. Separate analyses were carried out for youths and parents. The resulting components were compared between the two samples using coefficients of congruence. Items were scored into scales by summing items, based on the component on which they loaded most highly. The resulting stigma scales were used as the dependent variables in regression analyses examining the predictors of the various components of stigma. Because some of the scales ('social distance' and 'weak not sick') had skewed distributions, the dependent variables were dichotomised at the median and binary logistic regression was used. The data were also checked with linear regression analysis of the continuous measures, but the findings were substantially the same so only the logistic regressions are reported here. Two sets of regression analyses were carried out. The first involved the full youth sample and examined the following predictors: type of vignette (depression, psychosis, social phobia, depression with alcohol misuse), socio-demographic characteristics (age, gender), exposure to help-seeking for mental disorders (in self, in family or in friends) and exposure to campaigns (aware of national depression initiative, received information at educational institution or workplace). In these regression analyses, type of vignette was dummy coded with participants receiving the depression vignette selected to be the

https://doi.org/10.1192/bjp.bp.107.039404 Published online by Cambridge University Press

reference group. The second set of regressions involved the subset of youths who also had a co-resident parent interviewed. The predictors included all those above, plus the parent's scores on the stigma scales (also dichotomised at the median). All analyses were carried out using the Statistical Package for the Social Sciences version 14.0.

Results

Principal components analysis

For both youth and parent samples the scree plot indicated that four components should be retained. The eigenvalues for the first eight components were (for youth) 3.80, 2.57, 2.06, 1.50, 1.05, 0.87, 0.80 and 0.75, and (for parents) 4.14, 2.97, 1.84, 1.47, 1.10, 0.94, 0.84 and 0.76. The results of these analyses are given in a data supplement to the online version of this paper. The component loadings were similar across the youth and parent samples, with coefficients of congruence for the corresponding components ranging from 0.97 to 0.99. The first component had high loadings on all the social distance items and was labelled 'social distance'. The second had high loadings from items concerning stigma in others and was labelled 'stigma perceived in others'. The third had high loadings on items concerned with dangerousness or unpredictability, covering both personal attitudes and perception of others, and was labelled 'dangerous/unpredictable'. The fourth involved personal stigma items concerning a belief that the person was weak, not ill, could control their behaviour, and should be avoided. This component was labelled 'weak not sick'. Attitude scales were constructed by summing the items with loadings greater than 0.5. One item, 'You would not tell anyone if you had a problem like John's', did not load on any of the components and was consequently scored as a single item covering 'reluctance to disclose'. Cronbach's alphas for the resulting scales were: social distance, youths 0.86, parents 0.88; dangerous/unpredictable, youths 0.68, parents 0.65; weak not sick, youths 0.68, parents 0.61; stigma perceived in others, youths 0.67, parents 0.80.

Factors associated with stigma

Table 1 shows the predictors of the attitude scales in the full youth sample. It can be seen that type of vignette is an important determinant of stigma, but the effects vary across scales. Relative to depression, psychosis was associated with higher scores on 'dangerous/unpredictable' and 'social distance'. Social phobia was associated with lower scores than depression on 'dangerous/unpredictable' and higher scores on 'weak not sick' and 'stigma perceived in others'. Compared with depression alone, depression with alcohol misuse was associated with higher scores on 'social distance', 'dangerous/unpredictable' and 'stigma perceived in others'.

Socio-demographic characteristics were found to be associated with the various scales in different ways. 'Social distance' and 'weak not sick' decreased with age, whereas belief in 'dangerous/unpredictable', 'stigma perceived in others' and 'reluctance to disclose' increased. All aspects of stigma were lower in female respondents, except for 'stigma perceived in others'. Having personally had help for a mental disorder was associated with lower scores on 'social distance' and 'weak not sick', but higher on 'stigma perceived in others'. Having a family member or friend who had received help for a mental disorder was associated with lower scores on 'social distance', 'weak not sick' and 'reluctance to disclose'. Those who were aware of the national depression initiative or who had received information at their educational institution or workplace scored lower on 'weak not sick'. However, campaign exposure was unrelated to other components of stigma.

Table 2 shows the predictors where data from parents were also available. The major interest in these analyses is the associations with parental attitudes. All attitude scales showed quite specific associations between the young person and the parent, apart from 'stigma perceived in others'. There were only two cross-associations between scales: 'weak not sick' in the young person was predicted by lower 'stigma perceived in others' in the parent, as well as by the parent's 'weak not sick' beliefs; similarly, 'stigma perceived in others' was predicted by the parent's 'dangerous/unpredictable' beliefs.

Discussion

Components of stigma

Although stigma is often written about as though it were a unitary characteristic, our findings agree with earlier studies that the construct is multidimensional.[16,17] However, the actual dimensions found will depend on the pool of items used and the types of

Table 1 Predictors of different components of stigma in youth: odds ratios and probability values from simultaneous logistic regressions

Predictor variable	Social distance OR (*P*)	Dangerous/ unpredictable OR (*P*)	Weak not sick OR (*P*)	Stigma perceived in others OR (*P*)	Reluctance to disclose OR (*P*)
Type of vignette[a]					
Psychosis	1.39* (0.001)	2.58* (<0.001)	0.86 (0.16)	1.07 (0.48)	1.07 (0.53)
Social phobia	0.95 (0.62)	0.45* (<0.001)	1.28* (0.02)	1.49* (<0.001)	1.16 (0.17)
Depression and alcohol misuse	1.34* (0.002)	1.53* (<0.001)	1.14 (0.21)	1.29* (0.009)	0.87 (0.18)
Socio-demographic characteristics					
Age, years	0.93* (<0.001)	1.03* (0.001)	0.90* (<0.001)	1.02* (0.02)	1.02 (0.05)
Female gender	0.65* (<0.001)	0.78* (0.001)	0.68* (<0.001)	1.13 (0.08)	0.84* (0.02)
Exposure to mental disorders and help-seeking					
Personal history	0.72* (0.009)	0.87 (0.25)	0.67* (0.01)	1.59* (<0.001)	0.90 (0.40)
Family or friend history	0.68* (<0.001)	1.10 (0.27)	0.47* (<0.001)	1.08 (0.34)	0.83* (0.03)
Campaign exposure					
Aware of national depression initiative	1.01 (0.84)	1.06 (0.39)	0.37* (<0.001)	1.02 (0.75)	1.01 (0.88)
Received information at educational institution or workplace	1.01 (0.89)	0.97 (0.65)	0.69* (<0.001)	1.02 (0.80)	1.01 (0.92)
Nagelkerke R^2	0.08	0.12	0.21	0.02	0.01

a. Depression vignette was reference group.
*$P<0.05$.

https://doi.org/10.1192/bjp.bp.107.039404 Published online by Cambridge University Press

Table 2 Predictors of different components of stigma in young people who live with a parent: odds ratios and probability values from simultaneous logistic regressions

Predictor variable	Social distance OR (*P*)	Dangerous/ unpredictable OR (*P*)	Weak not sick OR (*P*)	Stigma perceived in others OR (*P*)	Reluctance to disclose OR (*P*)
Type of vignette[a]					
Psychosis	1.54* (0.001)	2.67* (<0.001)	0.84 (0.23)	0.91 (0.48)	1.06 (0.69)
Social phobia	1.13 (0.38)	0.50* (<0.001)	1.28 (0.09)	1.51* (0.003)	1.17 (0.31)
Depression and alcohol misuse	1.44* (0.008)	1.80* (<0.001)	1.06 (0.68)	1.15 (0.31)	0.87 (0.36)
Socio-demographic characteristics					
Age, years	0.92* (<0.001)	1.06* (0.001)	0.85* (<0.001)	1.03* (0.04)	1.05* (0.009)
Female gender	0.61* (<0.001)	0.87 (0.16)	0.72* (0.002)	1.08 (0.43)	0.76* (0.009)
Exposure to mental disorders and help-seeking					
Personal history	0.66* (0.03)	0.91 (0.62)	0.72 (0.17)	1.87* (0.001)	0.96 (0.84)
Family or friend history	0.70* (0.003)	1.12 (0.35)	0.52* (<0.001)	1.07 (0.56)	0.96 (0.79)
Campaign exposure					
Aware of national depression initiative	1.06 (0.56)	1.03 (0.78)	0.42* (<0.001)	0.93 (0.44)	0.96 (0.71)
Received information at educational institution or workplace	0.92 (0.40)	0.94 (0.56)	0.69* (0.001)	1.02 (0.82)	0.99 (0.94)
Parent stigma					
Social distance	1.21 (0.06)	1.05 (0.64)	0.85 (0.13)	1.00 (0.99)	1.17 (0.15)
Dangerous/unpredictable	0.92 (0.46)	1.25* (0.04)	1.22 (0.08)	1.32* (0.009)	0.83 (0.11)
Weak-willed	1.16 (0.15)	1.01 (0.90)	1.48* (<0.001)	0.87 (0.18)	1.00 (0.96)
Stigma perceived in others	1.06 (0.59)	1.05 (0.65)	0.68* (<0.001)	1.02 (0.85)	0.98 (0.89)
Reluctance to disclose	1.06 (0.56)	0.98 (0.87)	0.14 (0.28)	1.00 (0.99)	1.50* (0.001)
Nagelkerke R^2	0.09	0.14	0.22	0.03	0.01

a. Depression vignette was reference group.
*$P<0.05$.

disorders covered (with most previous studies focusing on severe mental disorders). For these reasons, it is not surprising that there is no generally agreed set of factors. In this study we found four dimensions labelled 'social distance', 'dangerous/unpredictable', 'weak not sick' and 'stigma perceived in others'. One item, involving reluctance to disclose, stood on its own and probably represents another construct not well represented in the item pool. The fact that social distance items reduced to a single dimension separate from other components of stigma supports the appropriateness of existing social distance scales. The remaining items were adapted from the Personal and Perceived Stigma scales of Griffiths *et al*, which have been scored as involving two independent dimensions.[11,12] However, our results support the existence of three dimensions in these scales: 'weak not sick' (largely corresponding to personal stigma), 'stigma perceived in others' (largely corresponding to perceived stigma) and 'dangerous/unpredictable' (which involves items from both personal and perceived stigma scales). The principal components analyses of these scales reported by Griffiths *et al* supported either a two- or a three-component interpretation, although they preferred the two-component interpretation for simplicity.[13] Nevertheless, the different pattern of correlates found here for each of the components supports the idea that these are indeed distinct constructs.

Differences between disorders

Most previous research on stigma has examined either severe mental disorders or 'mental illness' that has not been defined. Where specific disorders have been investigated, it has been found that some disorders are more stigmatised than others, in particular people with psychotic disorders or substance misuse.[1,6,12] However, our results show a more complex pattern, with disorders that are more stigmatised on one component not necessarily being more stigmatised on another. Consistent with previous research, psychosis and depression with alcohol misuse were seen as more dangerous and unpredictable, and elicited greater social distance. However, social phobia was more likely to be seen as a weakness rather than a sickness and was perceived as being more stigmatised by others in society. These findings are consistent with the reports of people with phobias about the reactions of others to their behaviour.[18]

Socio-demographic differences

Age differences in stigma showed complex trends. Social distance and belief that the person is weak rather than sick decreased with age, whereas there were increases in the belief in dangerousness and unpredictability, stigma perceived in others and reluctance to disclose. Similarly, gender differences were complex. Most aspects of stigma were higher in male respondents, consistent with previous research.[3,19] However, male respondents tended to be less likely to perceive stigma in others, which might relate to their lower awareness and knowledge about mental health problems in general.[20] These age and gender differences were present in a multivariate analysis which controlled for a number of variables relating to exposure to mental disorders and campaigns. These findings show that age and gender differences are not simply due to differential exposure and that other factors must be partly responsible.

Experiences affecting stigma

Research with adults has consistently shown that stigma is reduced through contact with people affected by mental disorders,[4,5] but the opposite was found in one study of adolescents.[6] This latter study used a scale of 'familiarity with mental illness' which included a broad range of experiences such as being personally affected and having family and friends who are affected. However, the findings reported here show that a personal history of mental disorder and seeking professional help can have a different impact from contact with family or friends who have sought help. The findings also show that such contact can have different effects on various components of stigma. Both types of contact reduced

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social distance and the belief that the person is weak rather than sick. However, only personal history increased the perception of stigma in others, whereas only contact through family and friends decreased reluctance to disclose. These results show that although contact is generally a good thing, it does not reduce all aspects of stigma. As Corrigan *et al* pointed out, contact can worsen a stereotype if the type of person interacted with reinforces it.[6]

The findings also show that campaigns can have an effect that is detectable at the population level. Awareness of Australia's national depression initiative, *beyondblue*, was associated with less belief that the person is weak rather than sick. A similar association was found for reported exposure to mental health information at an educational institution or workplace. However, neither of these exposures was associated with other aspects of stigma. A previous analysis of the impact of *beyondblue* on youth showed no association with social distance, but positive associations with recognition of depression and beliefs about treatment.[15] From the cross-sectional data in this study it is impossible to determine the direction of causality. However, it seems plausible that campaign exposure did lead to the reduction in stigma, rather than the other way around, because exposure to information in schools or workplaces is not under the control of the individual. It is also hard to imagine how belief that a mental disorder is an illness rather than a weakness would lead to differential exposure to campaign information, whereas other stigma variables (such as social distance) would not.

This study is the first to measure stigmatising attitudes in both youths and parents. The data show quite specific associations between the pattern of attitudes in the young person and in the parent. Again, it is impossible to be sure of the causal direction with cross-sectional data. However, it seems more plausible that the influence would be from parent to child, or because of common experiences of both parent and child, rather than from child to parent. Efforts to reduce stigma in young people do not typically involve parents, although it has recently been suggested that they should be actively involved.[3] Our findings support this suggestion.

Limitations

As discussed above, the causal interpretation of the findings is limited by the cross-sectional nature of the data. Longitudinal and experimental studies are needed to better understand causality. There may be additional components of stigma (e.g. self-stigma, discriminatory behaviour and experiences of being stigmatised) that were not measured. There needs to be more systematic coverage of potential stigma items based on initial qualitative research into the many aspects of stigma. Because questionnaires that ask explicitly about stigma may be affected by the social desirability of responses, future work needs to examine implicit and behavioural measures.[21] A limitation of the sampling is that parents were not interviewed for those living away from their family and that only one co-resident parent was surveyed for each child. Furthermore, there was a bias in the parent sampling towards mothers, despite the use of a random selection method. Finally, the regression models predicting components of stigma accounted for only small percentages of the variance.

Implications of the study

This study is one of the few to look at stigma early in life and the influences on its development. Stigma is clearly multidimensional and each dimension is affected by different influences. The pattern of stigma varies across different mental disorders. Similarly, experiences that affect one component of stigma do not necessarily affect others. We have shown that personal experience of a mental disorder, contact with others who are affected and have sought professional help, exposure to campaigns and parental attitudes all have an influence on some aspects of stigma. Our findings support current efforts to reduce stigma through school and workplace campaigns and for young people to have organised contact with people who have experienced mental disorders and sought help. However, no single approach is likely to reduce all aspects of stigma. The findings also show the need for stigma reduction efforts that are aimed at young people to incorporate parents as a potential target.

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First received 23 Apr 2007, final revision 31 Oct 2007 accepted 4 Dec 2007

Acknowledgements

Amy Morgan assisted with the organisation of the survey. Claire Kelly, Robyn Langlands, Betty Kitchener and Len Kanowski had input into the survey content. Darren Pennay and Graham Challice from the Social Research Centre provided advice on survey methodology. Funding was provided by the National Health and Medical Research Council, the Colonial Foundation and '*beyondblue*: the national depression initiative'.

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EXTRA CONTENT ONLINE

I am by John Clare (1793–1864)

Chosen by Robert Howard

I am was written in 1844 or 1845 by John Clare in the Northampton General Lunatic Asylum (now St Andrew's Hospital). Now regarded as one of the 19th century's most important poets, Clare's rural working class origins led to his being dubbed 'the Northamptonshire Peasant Poet'. Overtaken by poverty and a chronic psychotic illness he was incarcerated in mental hospitals from 1837 until his death. In the poem Clare struggles to conquer the effects of his illness through assertion of his individuality and faith that he will ultimately find a spiritual peace.

I am: yet what I am none cares or knows,
My friends forsake me like a memory lost;
I am the self-consumer of my woes,
They rise and vanish in oblivious host,
Like shades in love and death's oblivion lost;
And yet I am! and live with shadows tost

Into the nothingness of scorn and noise,
Into the living sea of waking dreams,
Where there is neither sense of life nor joys,
But the vast shipwreck of my life's esteems;
And e'en the dearest – that I loved the best –
Are strange – nay, rather stranger than the rest.

I long for scenes where man has never trod;
A place where woman never smil'd or wept;
There to abide with my creator, God,
And sleep as I in childhood sweetly slept:
Untroubling and untroubled where I lie;
The grass below – above the vaulted sky.

The British Journal of Psychiatry (2008) 192, 123. doi: 10.1192/bjp.192.2.123

https://doi.org/10.1192/bjp.bp.107.039404 Published online by Cambridge University Press