Recognition and Stigma in Depression and Anxiety

Presented by: Courtney Cuthbertson and Scott Loveridge

Acknowledgments

- This presentation is based on a draft paper by Scott Loveridge, Mark Skidmore, Robert Shupp, Courtney Cuthbertson (Michigan State University) Paula Miller (Ohio University) and Stephan Goetz (Pennsylvania State University).
- Partial funding for the work was provided by the Substance Abuse and Mental Health Services Administration.
- The USDA’s National Institute for Food and Agriculture is providing grant administration services.
Outline

• Regional nature of mental health issues
• Role of recognition and stigma in mental health recovery
• Survey design
• Survey results
• Possible community responses

Mental health as a community & economic development issue

• Mental health varies by place.
• Poor mental health creates direct costs (e.g., healthcare) and indirect costs (e.g., days off of work)
• Poor mental health costs US society as much as $53B annually (Davlasheridze et al., 2018)

Recognition, Stigma, and Mental Health

• Mental illness is treatable
• People who don’t recognize they are mentally ill are unlikely to seek treatment, or treatment may be delayed (Johnson and Coles 2013)
• Stigma may cause delays in treatment, or people not to seek treatment at all (Shrivastava et al. 2012)
• Delaying treatment allows progression of frequency and severity of mental health issues and impacts ability to carry out activities related to school, work, or satisfying relationships (Wang et al. 2004)
Scenario & 2 webinar polls

Michael is 30 years old and he is often worried. He has a great deal of concern about his job performance, his children’s well-being, and his relationships. In addition, he is troubled by a variety of minor matters such as getting to appointments on time, keeping his house clean, and maintaining regular contact with family and friends. It takes Michael longer than necessary to accomplish tasks because he worries about making decisions. Michael has trouble sleeping at night and finds that he is exhausted during the day and irritable with his family.

Two national online surveys

• Anxiety (n=627)
• Depression (n=2,514)

• Key activity was response to a vignette. You just read the anxiety vignette. A similar vignette was produced for depression.

• The sample for depression was higher because we experimented with several different first names to see whether it influenced responses.

What is Wrong with X? Proportion of responses

<table>
<thead>
<tr>
<th>Survey Response Option</th>
<th>Survey 1: Anxiety Vignette</th>
<th>Survey 2: Depression Vignette</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0.30</td>
<td>0.68</td>
</tr>
<tr>
<td>Nervous Breakdown</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Personality Problems/Social Anxiety</td>
<td>0.02</td>
<td>0.01</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>0.10</td>
<td>0.13</td>
</tr>
<tr>
<td>Mental Disorders</td>
<td>0.19</td>
<td>0.27</td>
</tr>
<tr>
<td>Nervous Disorder</td>
<td>0.36</td>
<td>0.36</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>0.16</td>
<td>0.21</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>Smoking</td>
<td>0.05</td>
<td>0.04</td>
</tr>
<tr>
<td>Diet</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Sleep disorder</td>
<td>0.09</td>
<td>0.10</td>
</tr>
<tr>
<td>Stress</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Prescription Drug Abuse</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Physical Injury</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>0.46</td>
<td>0.16</td>
</tr>
</tbody>
</table>

N 627 2,514
Exploring determinants of anxiety & depression recognition

- Logit regression on whether or not the respondent clicked appropriate condition [1-0]
- Control variables are respondent socio-economic characteristics and conditions in their county of residence
- Main findings:
  - Males less likely to recognize either condition than females
  - 18-34 year olds and 55+ are less likely to recognize depression than middle aged people
  - People in the $75K-$100K income range are less likely to recognize either condition than people in the $50K-$75K income range.
  - Respondents from rural counties are more likely to recognize both conditions.
  - Respondents from counties with high mental health provider access are less likely to recognize either condition than those from counties with low access.
Stigma analysis

- Basic approach: multinomial regression.
- In multinomial regression, you compare other responses to a “base” category. We used “neither agree nor disagree” as the base. The output then tells you whether the control variable is associated with more or fewer people not choosing the base.
- To simplify comparisons, we combined “agree/strongly agree” into one category; we also combined strongly disagree and disagree.
- We used respondent and county of residence controls for all 12 forms of stigma and both conditions, resulting in 24 equations, each with two columns of results.

Results

- For both anxiety and depression, the stigma question, “A problem like Michael's is a sign of personal weakness” provided the best fit of the twelve measures.
- For both conditions, the respondent’s choice of the “correct” condition was strongly associated with less stigma. (Less likely to agree, more likely to disagree).
- In terms of age, 55+ was less likely to agree to stigma on anxiety; 55+ was also less likely to agree and more likely to disagree on depression.
- The other variables were less important.

Conclusions from the analysis

- Recognition seems to be key to addressing the mental health issues of anxiety and depression.
- If you educate people to recognize the condition, the issue of stigma may also decline.
- It is worth exploring further:
  - Why rural people can recognize these conditions more easily than others
  - Why status as mental health provider seems not to improve recognition
Community responses

- **CAPE Project:**
  - Engage Extension staff to improve mental health literacy (MHL), equip them to enhance MHL in communities they serve, and increase their capacity to initiate and sustain local coalitions focused on community mental health challenges.
  - Series of webinars in conjunction with Mental Health First Aid training
    - Community action planning
    - Community needs assessment and making sense of data
    - Assessing community preparedness
    - Engaging the community and building consensus
    - Creating a strategic action plan
    - Keeping the drive alive

- **Community responses**
  - Michigan State University Extension
    - Newly formed Community Behavioral Health team
    - Goal of improving behavioral health literacy and community responses to emerging mental health and substance use issues
    - Mental Health First Aid trainings across the state
    - Opioid film documentary screenings and panel discussions

References

Questions?
Contact Information:
  Courtney Cuthbertson (cuthbe16@msu.edu)
  Scott Loveridge (loverid2@msu.edu)