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Help - seeking, stigma and attitudes of people with and without a suicidal past. A comparison between a low and a high suicide rate country.

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Background: A significant proportion of suicidal persons do not seek help for their psychological problems. Psychological help-seeking is assumed to be a protective factor for suicide. However, different studies showed that negative attitudes and stigma related to help-seeking are major barriers to psychological help-seeking. These attitudes and stigma are not merely individual characteristics but they are also developed by and within society. The aim of this study is twofold. First, we investigate if persons with a suicidal past differ from people without a suicidal past with respect to help-seeking intentions, attitudes toward help-seeking, stigma and attitudes toward suicide. The second aim is to investigate if these attitudinal factors differ between people living in two regions with similar socio-economic characteristics but deviating suicide rates.

Method: We defined high (Flemish Community of Belgium) and low (the Netherlands) suicide regions and drew a representative sample of the general Flemish and Dutch population between 18 and 65 years. Data were gathered by means of a postal questionnaire. Descriptive statistics are presented to compare people with and without suicidal past. Multiple logistic regression was used to compare Flemish and Dutch participants with a suicidal past.

Results: Compared to people without a suicidal past, people with a suicidal past are less likely to seek professional and informal help, perceive more stigma, experience more self-stigma (only men) and shame (only women) when seeking help and have more accepting attitudes toward suicide. In comparison to their Dutch counterparts, Flemish people with a suicidal past have less often positive attitudes toward help-

seeking, less intentions to seek professional and informal (only women) help and have less often received help for psychological problems (only men).

Limitations: The main limitations are the relatively low response rate; suicidal ideation was measured by retrospective self-report; and the research sample includes only participants between 18 and 65 years old.

Conclusions: Having a suicidal past is associated with attitudinal and stigmatizing barriers toward help seeking and accepting attitudes toward suicide. Prevention strategies should therefore address this target people with a suicidal history with special attention for attitudes, self-stigma and feelings of shame related to help-seeking.

Introduction

Research shows that nine out of ten suicide victims suffered from at least one severe psychological problem (Nock et al 2008). As a consequence, receiving psychological help is a assumed to be a protective factor of suicide. Not receiving adequate help increases the risk for psychological problems to deteriorate and thus increasing the risk of suicide (Suominen et al 2004). A number of researches showed that persons with suicidal thoughts were less likely to seek psychological help compared to those who have psychological problems but no suicidal thoughts (Calear et al 2014; Carlton & Deane 2000; Gould et al 2004; Rancans et al 2003; Rickwood et al 2005). Not seeking psychological help is associated with negative attitudes and stigma in relation to help-seeking (Vogel, 2007). Furthermore, research found that the majority of people experience stigma and shame if they would receive psychological help (Reynders et al 2014).

According to psychological health models, having a negative attitude toward a behavior (e.g. help-seeking) will decrease the intention to actually conduct this behavior (Ajzen & Fishbein 2000). Stigma is a negative stereotype about people because of their characteristics or behavior. When believed by a substantial part of the general public these stereotypes can lead to prejudice and discrimination (Corrigan

& Rao 2012). In this study we distinguish between two kinds of stigma. First, perceived stigma refers to the stigmatizing attitudes toward people who receive psychological help one observes in his environment (Link et al 1989). Perceived stigma implies that people are convinced that they will be discriminated against if they would seek help for psychological problems. Second, self-stigma for psychological help-seeking is the internalization of the stigmatizing attitudes (Rüsch et al 2005). People who experience self-stigma will apply the stigmatizing attitudes on themselves, resulting in low self-esteem and low self-efficacy. A way to prevent being stigmatized is not to disclose psychological problems and not to seek help (Vogel et al 2007). Furthermore, research found that people without a suicidal past have more disapproving attitudes toward suicide than people with a suicidal past (Arnautovska & Grad 2010; Colucci & Martin 2007; Gibb et al 2006; Joe et al 2007; Kocmur & Dernovsek 2003; O'connor et al 2006). The disapproving attitudes of others could create feelings of shame in seeking psychological help among people with suicidal problems (Kageyama, 2012).

Important to notice within the scope of cross-national analysis is that stigma and attitudes are not just individual features. They are social conceptions rooted in a cultural context (Rüsch et al 2005). They can vary across regions and therefore possibly explain regional differences in help-seeking behavior and suicide rates. For this reason, it would be of interest to compare two regions which resemble with respect to socio-economic indicators, language, geographic and demographic characteristics but have strongly deviating suicide rates. Two regions who satisfy these conditions are Flanders and the Netherlands. For example in 2012, the fertility rate is 1.75 and 1.72, the percentage of students in all levels of education is 25.3 and 25.2, the populations density is 478.2 and 496.9/km², the employment rate is 4.5% and 5.3% and the percentage of people at risk of poverty 15.0 and 15.7 for Flanders and the Netherlands respectively (Eurostat 2014). However, there are also significant differences in suicide rates between the two Dutch speaking regions (Reynders et al 2014). The Flemish suicide rates are almost 80 percent higher (15.4/100.000 inhabitants) than in the Netherlands (8.8/100.000 inhabitants). Despite these differences in suicide rates, cross-national research did not find significant differences between the two regions with respect to the incidence of life time suicidal ideation (8.2% in the Netherlands and 8.4% in Belgium) and

suicide attempts (2.3% and 2.5%) (Bernal et al., 2007). Although suicidal ideation and behavior are assumed to be important antecedents of suicide on an individual level, on the cross-national level the association between both is unclear (Bernal et al 2007; Bertolote et al 2005; Casey et al 2008). It is argued that from an epidemiological point of view, the suicidal process is not a clear-cut transition from ideation to attempt to suicide. Possibly, Dutch people cope differently and more effectively with psychological and suicidal problems than Flemish people resulting in higher suicide rates among the latter.

The aim of this study is to investigate if people with a suicidal past differ from people without a suicidal past with respect to intentions, attitudes and stigma associated with help-seeking and attitudes toward suicide. We hypothesize that, compared to people without a suicidal past, people with a suicidal past have weaker intentions to seek psychological help, perceive more stigma, experience more self-stigma and shame related to help - seeking and have more approving attitudes toward suicide. In addition, we expect that these differences are more apparent in Flanders than in the Netherlands.

METHOD

Study sample

The target population for this study is the general population of Flanders and the Netherlands with a Belgian and Dutch nationality respectively. Because of methodological and ethical reasons, only data within the age group 18 through 65 years were gathered. Even though data are available on French speaking Belgium as well, we have chosen to compare two Dutch speaking geographical entities. Evidently, also comparisons between Belgium as a whole and the Netherlands on the one hand, and between Flanders and the French Community on the other is of interest; this is outside of the scope of this paper. For the selection of the sample units, we made use of a combination of a cluster sample and systematic sample. Multi – stage cluster sample means that we started at the provincial level, out of each province we selected the regions. In the Netherlands, these were so called ‘COROP-regions’ and in Flanders ‘care regions’. These regions are defined by the authorities with the purpose of conducting long

term cross-regional research (the Netherlands) or evaluate and adjust health policy (Flanders). Out of these regions we further selected municipalities and out of the municipalities, we finally selected the individual respondents. For the selection of the units at each stage we made use of a systematic sampling technique. The result is a random, geographically well spread and representative sample. The Dutch sample contains 4550 individuals out 38 of the 403 municipalities, out 8 COROP regions and 7 provinces. In Flanders the outcome of this procedure was 4550 individuals, out of 52 of the 306 municipalities, out of 12 care regions and 5 provinces. The systematic sample of individuals was selected out of the official population register by the authorities.

Procedure

The procedure for both countries was identical. The selected individuals received a structured postal questionnaire together with a guided letter. The letter informed the participants about the goal of the research, the voluntariness of participation and the anonymity of the study. Beside this, a telephone number and website of a free and anonymous crisis line was mentioned for those who may need it. Finally, participants were informed that they had the chance to win an incentive in the form of two film tickets or a gift voucher. Non-respondents received reminders after two weeks and after five weeks. This research procedure was evaluated by the Belgian Privacy Commission and the Dutch Ethical Commission. The data collection took place during the months of October and November 2009 (Flanders) and 2010 (The Netherlands). The response rate was 27.4% (The Netherlands) and 41.4% (Flanders). In study we analyzed data of 2978 Dutch and Flemish participants.

Instruments

The Self-Stigma of Seeking Help –Scale, Attitudes toward Seeking Professional Psychological Help- scale (Short form) and Perceived Devaluation- Discrimination –scale, discussed below, were independently translated into Dutch by two researchers focusing on the meaning of the items rather than literally

translating the wording. Both translations were brought together and discussed by the two translating researchers and a third researcher. Cronbach's Alpha for the translated scales are presented.

Demographic variables. The survey included questions about age, years of schooling, civil state and employment.

Suicidality. Participants were asked for their personal life time experience with suicidality. Three questions were asked, each measuring a phase of the suicidal process: death wish, suicide plan and suicide attempt. In our analysis, people who indicated that during their lifetime they ever had a death wish, suicide plan or attempted suicide, are defined as having a 'history of suicidality'.

Mental health. This was measured by the five item mental health summary scale of the SF-36. The SF-36 was constructed to satisfy minimum psychometric standards necessary for group comparison. The SF-36 is suitable for self-administrated surveys within the general population. Reliability and validity are well established. Scores ranged from 0 to100. A score $\leq$ 52 indicates emotional problems with possibly a psychiatric disorder (Ware et al 1994).

Intention to seek help. The respondents were asked yes or no if they would seek help if they were confronted with psychological problems in the future. Three types of help are distinguished. First, professional help includes help from a general practitioner, a psychotherapist or a psychiatrist. Second, informal help refers to help from friends and family. The third type is not seeking help or passive coping, meaning that respondents would do nothing and hope that the psychological problems would disappear out of their own.

History of professional help seeking. Respondents were asked yes or no if they had ever received help for psychological problems from a general practitioner, a psychotherapist or a psychiatrist.

The concept ‘psychological problems’ was explained by two vignettes describing a man and woman with depressive symptoms such as feeling fatigue, helpless, worthless, down, feeble, and sad during several weeks. They had little energy for fulfilling daily tasks or doing sports, they had diminished interests, sleeping problems and they had suicidal thoughts.

Self-stigma was measured by the Self-Stigma of Seeking Help –Scale (SSOSH). The scale has a uni-dimensional factor structure and consists of 10 items such as "Seeking psychological help would make me feel less intelligent" (Vogel et al 2006). The internal consistency of the original scale ranged between .86 to .90 (Vogel et al 2007). In our sample Cronbach's Alfa was .85. Correlation with the intention to seek counseling and attitudes toward help seeking proves its construct validity (Vogel et al 2006). Higher scores represent higher self-stigma. Scores went from 0 to 100. Percentage of people with a score of > 50 were calculated. Translation of the instrument was conducted by

Shame for help - seeking: We developed three six – point Likert items. The items were: 'I would prefer that my neighbors did not know if I would receive help for psychological problems', 'I would be ashamed if I needed help for psychological problems' and 'I would keep it to myself if I would receive help for psychological problems'. The internal consistency of the three items was .80.Previous analysis showed good construct validity with Attitudes toward Seeking Professional Psychological Help- scale (Short form) and discriminant validity with Self-Stigma of Seeking Help –Scale (Reynders et al 2014). Scores went from 0 to 100. Percentage of people with a score of > 50 were calculated.

Perceived stigma was measured by the Perceived Devaluation- Discrimination –scale (Link et al 1987). The scale was developed as a one-dimensional scale containing 12 items such as "Most people feel that entering a mental hospital is a sign of personal failure". The average internal consistency is .78 and the scale shows good construct validity through a relationship with internal experience of demoralization and lower self-esteem (Link & Phelan 2001). The internal consistency obtained in our sample was .85. Higher scores on a scale from 0- 100 reflect higher perceived stigma. Percentage of people with a score of > 50 were calculated.

Attitudes toward help seeking was measured by Attitudes toward Seeking Professional Psychological Help- scale (Short form) and it was developed to measure mental health treatment attitudes. This widely used scale was designed as a one-dimensional 10 item scale (Fischer & Farina 1995). Test –retest reliability (.80), and internal consistency (.84) were good. In our sample internal consistency was .81. In our sample internal consistency was .81.Validity was proved to be good through a negative relation with

stigma and positive relations with emotional disclosure and intention to seek help (Elhai et al 2008). Higher scores represent more positive attitudes toward help-seeking. Percentages that had a score of > 50 were calculated.

Attitudes toward suicide. Six items with a six point - Lickert scale were developed for this study. Approving attitudes were measured by the next three items: 1) there are situations in which suicide is the only way out; 2) if I suffer from a sever and incurable disease and 3) I would consider suicide; everybody has the right to commit suicide. The Cronbach's Alpha for these three items were .655 for the Dutch population and .638 for the Flemish population. Although rather low, an Cronbach's Alpha value of $\geq .60$ for new scales and scales with few items is acceptable (Nunnally 1988). Three items measured disapproving attitudes toward suicide: 1) suicide means that one is walking away from his daily responsibilities;. 2) people who consider suicide, would feel better if they would not let themselves go and show some strength instead and 3) suicide is a cowardly act. The internal consistency for the Dutch population was .724 and .738 for the Flemish population. The scores were recalculated on a scale from 0 to 100 with a cut-off score of 50.

Analysis

First, we present the incidences of lifetime death wishes, suicide plans and suicide attempts for Dutch and Flemish men and women (Table 1). Next we presented percentages and 95% confidence intervals to compare men and women with a suicidal past (Table 2). Logistic regression was used to analyze the differences between people with and without a suicidal past (table 3) and differences between Dutch and Flemish participants with a suicidal past (Table4). Adjusted odds ratios are presented together with 95% confidence intervals and p-value. The first model includes the all the demographic variables. Next we included all other variables separately using the 'enter' method in Model 1, thus adjusting for the demographic variables age, education level, marital status and employment status. This was done because the help-seeking intentions and attitudinal variables correlates significantly. As a result, they would

neutralize each other's effect when including them all together in the regression equation. Because of differences between men and women with respect to the prevalence of suicidal ideation, intentions to seek help and attitudinal factors (Reynders, 2014), all analyses are split by gender. For the analysis we used the statistical package SPSS.

RESULTS

Table 1 indicates that lifetime suicidality in our sample does not differ between Flanders and the Netherlands, with the exception of lifetime death wish among women (OR = 1.26, p = 0.044).

Table 1 about here

Table 2 shows that among people with a suicidal history, compared to men, women received more often professional psychological help and have more often the intention to seek informal and professional help. Men reported more often that they would cope passively with psychological problems and that they would more often experience self-stigmatization when seeking help. Furthermore, compared to women, the proportion of men having disapproving as well as accepting attitudes toward suicide is higher.

Table 2 about here

Table 3 shows that compared to people without a suicidal past, those with a suicidal past are less often married and men are more often unemployed. We notice also that people with a suicidal past had less often a good mental health during the last four weeks and they had more often received psychological help but they were also less likely to seek help in the future compared to people without suicidal past. Furthermore, although no differences were found with respect to attitudes toward help - seeking between people without and with suicidal past, the latter perceived more stigma and experienced more self - stigma

(men only) and shame (women only). Finally, having a suicidal past was associated with more accepting and less disapproving attitudes toward suicide.

Table 3 about here

The comparison between Dutch and Flemish men with a history of suicidality is presented in table 4. After controlling for demographic factors, we noticed that compared to Dutch men, Flemish men are less inclined to seek professional help for psychological problems (OR = 0.44, p = 0.000), have less often received professional help in the past (OR = 0.64, p = 0.037), and have less positive attitudes toward professional help seeking (OR = 0.68, p = 0.016). More Dutch than Flemish women have the intention to seek professional (OR =0.56, p = 0.009), and informal help (OR = 0.58, p = 0.015) for psychological problems. Moreover, Dutch women have more often positive attitudes toward professional help seeking than their Flemish counterparts (OR = 0.43, p = 0.002) and experience more shame related to help-seeking (OR1.64, p = .007). When reanalyzing the data with people that only had a suicide plan or only have attempted suicide, the direction and effect size of the association remained the same. However, due to a lower number of units and thus a decrease in the statistical power, less associations showed statistical significance.

Nagelkerkes R^2 for the logistic regression including all variables presented in Table 3 was .40 (men) and .31 (women) and for the logistic regression presented in Table 4 it was .12 (men) and .08 (women). Although these are small values, caution needs to be used because this quantity does not have the same interpretational ease as the corresponding R^2 in linear models. The main reason is that the mean and variance structures are functionally and statistically separable for normally distributed outcomes, while they are not for non-Gaussian outcomes.

Table 4 about here

DISCUSSION

The aim of this study was to investigate how people with a suicidal past differ from people without a suicidal past with respect to their attitudes, intentions and stigma in relation to help-seeking. We examined if suicidal ideation and suicidal behavior occur more often in Flanders than in the Netherlands. Despite the 80% higher suicide rates in Flanders compared to the Netherlands, a significantly higher score for the lifetime prevalence of death wishes was found for Flemish women only. Previous suicide plans and suicide attempts did not differ significantly between the two regions. One could assume that in some countries people, are more inclined to seek help because of the more favorable belief systems concerning suicide, psychological problems and help seeking. In these countries, as a result, suicidal ideations and behavior are possibly less likely to evolve in suicide. Our data show that in Flanders, where the suicide rates are higher than in the Netherlands, people with a suicidal past were less inclined to seek help for psychological problems and fewer have positive attitudes toward professional help seeking. Among Flemish men we noticed that they have less frequently received professional help. Flemish women less often have the intention to seek informal help and more often experience shame compared to their Dutch counterparts. In general, a trend becomes apparent in which Dutch participants with a suicidal history are characterized by more protective factors of suicide than the Flemish participants. This could partly explain the differences in suicide rates between the two regions.

Looking at the differences between people with and without suicidal past, we observed that the former are characterized by more risk factors of suicide such as a weaker mental health, not being married and being unemployed (only men). Because people with a suicidal past had more often psychological problems, they received more often psychological help than those without suicidal past. Nevertheless, people with a suicidal past are less willing to seek help for psychological problems in the future. Studies found that one of the greatest barriers for seeking help among suicidal persons is that they less often perceive a need for help (Pagura et al 2009). Other studies pointed out that persons with a history of suicidality less often have effective coping strategies such as avoidance, emotional coping, self-blame, not seeking help and a

preference to solve problems on their own (Mathew & Nanoo 2013; McMahon et al 2013; Svensson et al 2014). These findings are in line with our results. We found that people with a suicidal past were more likely to cope passively in case of psychological problems, they would experience more shame (women) and more self-stigma (men) when seeking psychological help. With respect to self-stigma and shame, studies show that they not only result in lower self-esteem and self-efficacy, which are risk factors of suicide. They also inhibit help -seeking intentions (Reynders et al 2014).

Furthermore, we found that people with a suicidal past more often had accepting and less often disapproving attitudes toward suicide. Therefore, we would expect that Flemish people had more tolerable attitudes toward suicide than Dutch people. Although not significant, we observed an opposite tendency. Possibly, the less accepting attitude towards suicide makes it for Flemish people more difficult to disclose suicidal problems making them less likely to seek help.

Even though our research design includes people with at least a death wish during their life and no more strict inclusion criteria such as for example severe suicide plans or attempts during the past 12 months, the differences with people without suicidal past are significant with respect to help seeking intentions, experiencing stigma and attitudes toward suicide. Therefore, we believe that for the prevention of suicide it is important to invest in a positive image of mental health care, making it as accessible as possible for those in need of professional help. Hereby, it is of importance to acknowledge that even people with limited suicidal thoughts during their life time are already more vulnerable for stigmatizing attitudes and feelings of shame with respect to help-seeking. Self-stigma and shame can result in low self-esteem and low self-efficacy, which could further increase the risk of suicide. In addition, having a suicidal past is associated with lower intentions to seek informal help from family and friends. Furthermore, although stigmatizing attitudes toward suicide could result in more negative attitudes towards help-seeking (Calear et al 2014), policy makers and care givers should be reticent in promoting tolerable and accepting attitudes toward suicide to prevent that suicide is seen as a normal way to cope with psychological and suicidal problems. On the other hand, more longitudinal research is needed to understand the direction of the

relationship between attitudes toward suicide and suicidal behavior on an individual level as well on a macro-level.

LIMITATIONS

Some limitations should be considered when interpreting the results of this study. First, the response rate is rather low. A review of response rates in academic studies using mail surveys found an average of 55.6% and a standard deviation of 19.7 (Baruch 1999). This can be explained both by the strong emotional connotation of the research subject, as well as by the use of a postal questionnaire for collecting data. Despite of the reminders and incentives, subjects are less compelled and encouraged to participate when contacted by mail than in the case of face-to-face contact. On the other hand, a postal survey creates more security and anonymity, making participants less restrained to answer more sincere. Second, closely related with the first point, the response rate in the Netherlands was lower than in Flanders. The research project was an initiative of a Belgian research team and this was communicated to all potential participants. Possibly, participating and resending their personal and delicate information across the border could be a barrier for the Dutch population. Third, suicidal ideation was measured by retrospective self-report. Therefore, data can be biased. Fourth, analysis was done using data on lifetime suicidal ideation. Comparisons with the general population were not done for suicidal plans and attempts during the last 12 months because of a lack of statistical power. Fifth, the research sample includes only participants between 18 and 65 years old. Therefore, our results cannot be generalized for teenagers and the elderly.

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Conflict of Interest

None

References

Ajzen, I., Fishbein, M. 2000. Attitudes and the attitude-behavior relation: reasoned and automatic processes. Eur. Rev. Soc. Psychol. 11, 1-33.

Arnautovska, U., Grad, O.T. 2010. Attitudes toward suicide in the adolescent population. *Crisis* 31,22-29.

Baruch,Y. 1999. Response rate in academic studies - a comparative analysis. Hum. Relat. 52, 421-438.

Bernal, M., Haro, J.M., Bernert, S., Brugha, S., de Graaf, R., et al. 2007. Risk factors for suicidality in Europe: Results from the ESEMeD study. J. affect. Disorders. 101, 27-34.

Bertolote, J.M., Fleischmann, A., De Leo, D., Bolhari, J. 2005. Suicide attempts, plans, and ideation in culturally diverse sites: WHO SUPRE-MISS community survey. Psychol. Med. 35, 1457-1465.

Calear, A., Batterham, P., Christensen, H. 2014. Predictors of help - seeking for suicidal ideation in the community: Risks and opportunities for public suicide prevention campaigns. Psychiatry. Res. http://dx.doi.org/10.1016/j.psychres.2014.06.027i.

Carlton, P.A., Deane, F.P. 2000. Impact of suicidal ideation on adolescent's intention to seek professional psychological help. J. Adolescence. 23, 35-45.

Casey, P., Dunn, G., Kelly, B.D,, Lehtinen, V., Dalgard, O.S., et al. 2008. The prevalence of suicidal ideation in the general population: results from the Outcome of Depression International Network (ODIN) study. Soc. Psychiatry. Psychiatr. Epidemiol. 43, 299-304.

Colucci, E., Martin, G. 2007. Ethnocultural aspects of suicide in young people: a systematic literature review. Part2: risk factors, precipitating agents, and attitudes towards suicide. Suicide Life. Threat. Behav. 37, 222-237.

Corrigan, P., Rao, D. 2012. On the self-stigma of mental illness: stages, disclosure, and strategies for change. Can. J. Psychiatry. 57, 464-469.

Elhai, J., Schweinle, W., Anderson, S. 2008. Reliability and validity of the attitudes toward seeking professional psychological help scale - short form. Psychiatry Res. 159, 20-329.

Eurostat. 2014. Regional statistics. European Commission

Fischer, E.,H., Farina, A. 1995. Attitudes toward seeking professional psychological help: A shortened form and considerations for research. J. Coll. Student Dev. 36, 368-373.

Gibb, B.E., Andover, M.S., Beach, S.R.H. 2006. Suicidal ideation and attitudes towards suicide. Suicide Life. Threat. Behav. 36,12-18.

Gould, M.S., Velting, D., Kleinman, M., Lucas, C. 2004. Teenagers' attitudes about coping strategies and help-seeking behavior for suicidality. *J. Am. Acad. Child. Psy.* 43, 1124-1132.

Joe, S., Romer, D., Jamieson, P.E. 2007. Suicide acceptability is related to suicide planning in U.S. adolescents and young adults. Suicide Life. Threat. Behav.37, 165-178.

Kageyama, T. 2012 Views on suicide among middle-aged and elderly populations in Japan: their associations with demographic variables and feeling shame in seeking help. *Psychiatry Clin Neurosci* . 66, 105-112.

Kocmur, M., Dernovsek, M.Z. 2003. Attitudes towards suicide in Slovenia: a cross-sectional survey. Int. J. Soc. Psychiatr. 49, 8-16.

Link, B.G., Cullen, F.T., Frank, J., Wozniak, J.F. 1987. The social rejection of former mental patients: understanding why labels matter. Am. J. Sociol. 62, 1461-1500.

Link, B.G., Cullen, F.T., Struening, E., Shrout, P.E., Dohrenwend, B.P. 1989. A modified labeling theory approach to mental disorders: an empirical assessment. *Am. Sociol. Rev.* 54, 400-423.

Link, B.G., Phelan, J.C. 2001. Conceptualizing stigma. Annu. Rev. Sociol. 27, 363-385.

Mathew, A., Nanoo, S. 2013. Psychosocial stressors and patterns of coping in adolescent suicide attempters. *Indian J Psychol Med* 35,39-46.

McMahon, E., Corcoran, P., McAuliffe, C., Keeley, H., Perry, I., Arensman, E. 2013. Mediating effects of coping style on associations between mental health factors and self-harm among adolescents. *Crisis* 34,242-250.

Nock, M., Borges, G., Bromet, E., Chal, C., Kessler, R., Lee, S. 2008. Suicide and Suicidal Behavior. *Epidemiol. Rev.*,133-154.

Nunnally, J.C. 1988. *Psychometric Theory*. New Jersey: McGraw-Hill

O'connor, R.C., Armitage, C.J., Gray, L. 2006. The role of clinical and social cognitive variables in parasuïcide. Br. J. Clin. Psychol. 45, 465-481.

Pagura J, Fotti S, Katz L, Sareen J. 2009. Help seeking and perceived need for mental health care among individuals in Canada with suicidal behaviors. *Psychiatr Serv.* 60, 943-949

Rancans, E., Lapins, J., Renberg, E.S., Jacobsson, L. 2003. Self-reported suicidal and help seeking behaviours in the general population in Latvia. Soc. Psychiatry Psychiatr Epidemiol. 38, 18-26.

Reynders, A., Kerkhof, A., Molenberghs, G., Van Audenhove, C. 2014. Attitudes and stigma in relation to help - seeking intentions for psychological problems in low and high suicide rate regions. Soc. Psychiatry Psychiatr. Epidemiol. 49, 231-239.

Rickwood, D., Deane, F.P., Wilson, C.J., Ciarrochi, J. 2005. Young people's help-seeking for mental health problems. Australian e-Journal for the Advancement of Mental Health. 4, 34.

Rüsch, N., Angermeyer, M., Corrigan, P. 2005. Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. Eur. Psychiatry. 20, 529-539.

Suominen, K., Isometsä, E., Suokas, J., Haukka, J., Achte, K., Lonnqvist, J. 2004. Completed suicide after a suicide attempt: a 37-year follow -up study. Am. J. Psychiatr. 161, 562-563.

Svensson, T., Inoue, M., Charvat, H., Sawada, N., Iwasaki, M., Sasazuki, S. 2014. Coping behaviors and suicide in the middle-aged and older Japanese general population: the Japan Public Health Center-based Prospective Study. Ann. Epidemiol. 24, 199-205.

Vogel, D.L., Wade, N.G., Haake, S. 2006. Measuring the self-stigma associated with seeking psychological help. J Couns. Psychol . 53, 325-337.

Vogel, D.L., Wade, N.G., Hackler, A.H. 2007. Perceived public stigma and the willingness to seek counseling: the mediating roles of self-stigma and attitudes toward counseling. J. Couns. Psychol. 54, 40-50.

Ware, J., Kosinski, M., Keller, S. 1994. *SF. SF-36 Physical and Mental Health Summary Scales: A User's Manual*. Boston: The Health Institute.

Table 1 Lifetime suicidal ideation, plans and attempts in the Netherlands and Flanders for men and women

		Men (N = 1204)				Women (N = 1774)			
		%	Adj.OR*	95% CI	P	%	Adj.OR*	95% CI	P
Death wish	Netherlands	28.7	1.00			33.6	1.00		
	Flanders	31.6	1.26	(0.99-1.61)	0.056	38.0	1.26	(1.01-1.59)	**0.044**
Suicide plans	Netherlands	12.5	1.00			12.9	1.00		
	Flanders	13.4	1.25	(0.89-1.74)	0.202	14.0	1.20	(0.87-1.67)	0.268
Suicide attempt	Netherlands	4.9	1.00			4.8	1.00		
	Flanders	4.5	1.11	(0.65-1.92)	0.696	5.9	1.61	(0.96-2.70)	0.070

*OR adjusted for age, education, civil state and employment status

Table 2 Comparison between men and women with a life time history of suicidal thoughts.

	Men N = 368		Women N = 641	
	%	95% C.I.	%	95% C.I.
Age				
18-34	30.3	(25.6-35.0)	32.0	(28.4-35.6)
35-49	32.0	(27.2-36.7)	35.9	(32.2-39.6)
50-64	37.7	(32.7-42.7)	32.1	(28.5-35.8)
Married	40.3	(35.3-45.3)	48.8	(44.9-52.6)
Education				
lower secondary	17.7	(13.8-21.6)	19.2	(16.1-22.2)
upper secondary	41.4	(36.4-46.5)	39.9	(36.1-43.7)
Superior or +	40.9	(35.8-45.9)	40.9	(37.1-44.7)
Unemployed	8.2	(**5.3-11.0**)	3.4	(**2.0-4.9**)
Good mental health	73.5	(69.0-78.1)	71.1	(67.6-74.7)
Previous professional help	55.8	(**50.7-60.9**)	69.7	(**66.1-73.2**)
Intention to seek help				
Professional	56.8	(**51.8-61.9**)	68.2	(**64.6-71.9**)
Informal	57.8	(**52.7-62.9**)	67.2	(**63.5-70.8**)
Passive coping	34.7	(**29.8-39.6**)	21.3	(**18.2-24.5**)
Stigma & attitudes				
Self-stigma	30.8	(**26.0-35.6**)	21.4	(**18.2-24.7**)
Shame	68.1	(63.3-73.0)	62.3	(58.5-66.1)
Perceived stigma	75.2	(70.7-79.7)	76.1	(72.8-79.5)
Positive attitudes help seeking	69.7	(64.9-74.5)	80.8	(77.7-83.9)
Attitudes toward suicide				
Disapproving	27.9	(**23.3-32.5**)	17.6	(**14.6-20.6**)
Accepting	67.0	(**62.2-71.9**)	51.4	(**47.4-55.3**)

Significant differences between people with and without suicidal past are in bold

Table 3 Comparison between people with and without a life time history of suicidal ideation for men and women.

	Men			Women		
	OR[a]	CI 95%	p	OR[b]	CI 95%	p
Model 1						
Age						
18-34	1	***	***	1	***	***
35-49	0.86	(0.58-1.27)	.441	0.95	(0.70-1.29)	.297
50-64	1.07	(0.74-1.56)	.718	1.17	(0.88-1.55)	.742
Married	0.44	(0.32-0.61)	**<.001**	0.60	(0.47-0.76)	**<.001**
Education						
lower secondary	1	***	***	1	***	***
upper secondary	0.91	(0.64-1.52)	.966	.78	(0.56-1.01)	.152
Superior or +	0.99	(0.64-1.52)	.955	.87	(0.62-1.21)	.403
Unemployed	2.94	(1.50-5.76)	**.002**	0.98	(0.52-1.88)	.961
Model 2[a]						
Mental health	0,13	(0,08-0,21)	**<,001**	0,15	(0,11-0,21)	**<.001**
Intention to seek help						
Professional	0.68	(0.52-0.90)	**.006**	0.71	(0.57-0.88)	**.002**
Informal	0.30	(0.22-0.41)	**<.001**	0.42	(0.33-0.55)	**<.001**
Passive coping	2.44	(1.81-3.28)	**<.001**	1.40	(1.08-1.82)	**.011**
history of professional help	5.64	(4.19-7.59)	**<.001**	4.98	(3.97-6.24)	**<.001**
Stigma & attitudes						
Self-stigma	1.81	(1.34-2.44)	**<.001**	1.21	(0.93-1.57)	.158
Shame	1.24	(0.94-1.64)	.128	1.93	(1.12-1.71)	**.002**
Perceived stigma	1.57	(1.16-2.12)	**.003**	1.36	(1.07-1.72)	**.011**
Positive attitudes help seeking	1.21	(0.91-1.61)	.200	1.15	(0.89-1.50)	.278
Attitudes toward suicide						
Disapproving	0.43	(0.33-0.58)	**<.001**	0.43	(0.34-0.54)	**<.001**
Accepting	2.78	(2.10-3.68)	**<.001**	2.11	(1.71-2.60)	**<.001**

[a] Model 2: all variables were separately included in Model 1

Table 4 Comparison between Dutch and Flemish men and women with lifetime history of suicidal ideation.

	Men			Women		
	OR[a]	CI 95%	p	OR[b]	CI 95%	p
Model 1						
Age						
18-34	1	***	***	1	***	***
35-49	1.61	(0.99-2.61)	.053	1.09	(0.70-1.69)	.706
50-64	1.89	(1.09-3.27)	**.023**	1.01	(0.62-1.67)	.960
Married	1.39	(0.89-2.16)	.149	0.93	(0.63-1.37)	.695
Education						
lower secondary	1	***	***	1	***	***
upper secondary	1.38	(0.77-2.50)	.278	1.02	(0.61-1.71)	.944
Superior or +	1.03	(0.57-1.85)	.926	0.83	(0.49-1.4)	.479
Unemployed	1.05	(0.51-2.16)	.149	0.73	(0.27-1.99)	.535
Model 2[a]						
Mental health	0.73	(0.45-1.18)	.192	0.93	(0.61-1.41)	.730
Intention to seek help						
Professional	0.44	(0.29-0.67)	**<.001**	0.56	(0.37-0.87)	**.009**
Informal	0.95	(0.62-1.45)	.817	0.58	(0.37-0.90)	**.015**
Passive coping	0.93	(0.61-1.42)	.740	1.35	(0.85-2.16)	.205
history of professional help	0.64	(0.42-0.97)	**.037**	0.69	(0.46-1.04)	.079
Stigma & attitudes						
Self-stigma	1.41	(0.84-2.36)	.199	1.41	(0.91-2.21)	.128
Shame	1.52	(0.94-2.48)	.088	1.64	(1.15-2.33)	**.007**
Perceived stigma	0.84	(0.52-1.36)	.470	1.27	(0.82-1.97)	.284
Positive attitudes help seeking	0.68	(0.36-0.90)	**.016**	0.43	(0.25-0.73)	**.002**
Attitudes toward suicide						
Disapproving	1.48	(0.85-2.57)	.116	1.30	(0.81-2.09)	.273
Accepting	0.82	(0.47-1.41)	.469	0.82	(0.55-1.24)	.267

[a] Model 2: all variables were separately included in Model 1