

General Self-efficacy and Its Relationship to Self-reported Mental Illness and Barriers to Care: A General Population Study

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Abstract Given the prevalence of mental illness worldwide, it is important to better understand the dynamics of mental health help-seeking behavior to improve access to care. The aim of this study was to investigate if general self-efficacy (GSE) was associated with self-reported mental illness and help-seeking behavior and barriers to care in a randomized population. This study utilized a mailed questionnaire completed by 3,981 persons aged 19–64 years who resided in Western Sweden. GSE was measured and logistic regression models calculated, controlling for various sociodemographic variables. Results showed that 25 % of men and 43 % of women reported a lifetime prevalence of mental illness that they felt could have benefitted from treatment. Of those, 37 % of the men and 27 % of the women reported barriers to care. Men and women with low GSE were more likely to suffer from mental illness compared with persons high in GSE, but GSE did not enhance help-seeking behavior or perceived barriers to

care. The most prevalent barriers to care for both sexes were beliefs that the illness will pass by itself, doubt whether treatment works, lack of knowledge of where to go and feelings of shame. Overall, GSE scores did not differ among those who experienced various barriers to care with the exception of two barriers only among women.

Keywords General self-efficacy · Mental illness · Barriers to care · Unmet need

Introduction

Globally, mental illness is an increasing problem, and the World Health Organization estimates that depression will be the second most common disease contributing to disability adjusted life years in 2020 (WHO 2001). In the European Union, it is estimated that every fourth citizen is currently affected by some form of mental illness (European Commission 2005), and common mental disorders significantly contribute to sick leave and receipt of disability pension (Hensing et al. 2006). Several risk factors for mental illness have been identified including sex, age, marital status and educational level (Tsuang and Tohen 2002) as well as a lack of social networks, social isolation (Kawachi and Berkman 2001) and experienced loneliness (Cacioppo et al. 2006). Alcohol problems are also associated with mental illness, both as a risk factor and as a method to self-medicate (Dawson et al. 2005). In addition to these more commonly discussed risk factors is self-efficacy, which in the few studies performed, is associated both with fewer depressive symptoms (Maciejewski et al. 2000) and lower rates of experienced loneliness (Blazer 2002). Self-efficacy has been found to be a mediator between social relations and depressive symptoms (Fiori

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et al. 2006) but little is known about how self-efficacy relates to help-seeking behavior for mental illness (Jackson et al. 2007). Bandura (1994) defines self-efficacy as "... people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective and selection processes" (Bandura 1994). Therefore, self-efficacy may be important to emotional well-being as well as in help-seeking, which often demands that the sick person have motivation and power to act although mental health is impaired. To acknowledge the problem, to be motivated to obtain help, to know where to go and how to get there, and also believe that one's attempt to obtain assistance will be successful are all important factors in help seeking, thus self-efficacy is vital in this process. Since self-efficacy is determined by both social and psychological factors, it is amenable to change. One's feelings of efficacy can be altered by performance successes (or failures) and the concomitant cognitive appraisal of the attempt and its outcome (Bandura 1997). Therefore, efficacious help-seeking behavior for mental illness is not only influenced by previous successes in seeking help, but also by the meaning one attaches to those previous attempts and their successes or failures.

One's perceptions and evaluations of the barriers to care may influence these cognitive appraisals of help-seeking attempts and their resulting personal meanings and feelings of self-efficacy. In their review of the literature on mental health and help-seeking behavioral in rural contexts, Jackson et al. (2007) found some evidence that self-efficacy may be a factor in predicting help-seeking, and conclude the construct is "under researched." Judd et al. (2006) found that among people in rural settings in Australia, low self-efficacy and low levels of stoicism were associated with higher likelihood of help-seeking. Other findings have also been reported; one study revealed that lower self-efficacy was related to fewer cardiovascular health-promoting behaviors (Leas and McCabe 2007) and decreased attempts to seek medical care for physical symptoms (Schmutte et al. 2009). Specifically related to mental illness, lower self-efficacy is related to increased perceived stigma about mental illness and poorer overall coping (Kleim et al. 2008); furthermore, Corrigan (2004) found that perceived stigma is a factor in thwarting help-seeking for mental health issues. Given these mixed findings, the role of self-efficacy in help-seeking behavior deserves further attention.

Although efficient evidence-based treatments exist for mental health problems (Gloaguen et al. 1998; Joffe et al. 1996), research shows that only a small proportion of

individuals in the general population with mental illness seek health care (Alonso et al. 2004; Andersson et al. 2013; Bebbington et al. 2000, Hämäläinen et al. 2009; Kessler et al. 1994; Svensson et al. 2009). Previous studies have found several reasons for not seeking health care including: beliefs that no one can help, the idea that the problem will get better by itself (Meltzer et al. 2003), a wish to deal with the problem without the involvement of others (Issakidis and Andrews 2002), feelings of shame (Forsell 2006), negative attitudes from the community and a fear of being considered dangerous by others (Link et al. 2001), and low social support (Andersson et al. 2013). Furthermore, results from focus groups studies with Latinos in the US identified nine themes as barriers to care for depression: vulnerability, social connections and engagement, language, culture, insurance/money, stigma, disengagement, information and family (Uebelacker et al. 2012). To our knowledge there are no population-based studies that have investigated if self-efficacy is associated with specific barriers to care for mental illness, which may be useful information in developing strategies to improve access to care. Given the prevalence of mental illness worldwide and the need for those with such illnesses to be treated expeditiously, it is important to better understand the factors associated with help-seeking for mental health issues in order to improve access to care. Early detection and treatment improves possibilities for recovery and decreases the risk of long-standing illness, sick leave and social exclusion. Self-efficacy is an individual characteristic amenable to change, and if related to help-seeking behavior, could be addressed in education and health promotion strategies. The aim of this study is twofold: to investigate if general self-efficacy (GSE) is associated with self-reported mental illness and to examine if GSE is associated with help-seeking behavior and barriers to care.

Methods

This cross-sectional study was based on data from the Health Assets Project implemented in 2008 in the Vastra Gotaland region in Western Sweden and full details of the study are described in Holmgren et al. (2010). The region has approximately 1.5 million inhabitants (corresponding to 17 % of Sweden's population) living in both urban and rural areas, mirroring the overall population in Sweden.

Sample and Data Collection

A randomized general population sample of 7,984 individuals aged 19–64 years was approached. Of these, 4,027 individuals (1,793 men and 2,234 women) answered the questionnaire resulting in a response rate of 50.4 % (42 %

among men and 58 % among women). Excluded from this group were 46 persons due to misinterpretation of some questions on barriers to care—some had checked *No* to the question if they have suffered of mental illness, but subsequently indicated they had experienced one or more barriers to care. Thus, the final study population consisted of 3,981 participants: 1,770 (44.5 %) men and 2,211 (55.5 %) women. A drop-out analysis of the total study population showed a significantly higher non-response rate for women and men in the youngest age group, in the lowest income level, $\leq 149,000$ SEK/21,900 USD, and among those born outside Sweden and the other Nordic countries. Furthermore, the dropout rate was higher among women and men living alone, compared to those married or cohabiting. Women, but not men, living in urban areas had a significantly higher dropout rate than women living in rural areas. The data collection was initiated and funded by the research team and collected by Statistics Sweden between April and June 2008. Sampling was done by the use of the unique Swedish personal identification numbers. An extensive questionnaire was sent out by ordinary/surface mail. It included questions on socio-demographic factors, physical and mental health, self-reported symptoms, work and family conditions, and life-style. Two reminders were sent out. Additional information on sex, age, and civil status, country of birth, citizenship, municipality and income was collected from national registers via linkage by Statistics Sweden by the use of the respondent's identification number.

Measurement of Mental Illness and Description of Dependent Variables

In this study, mental illness was defined as one's self-assessed need to seek mental health care. Thus, the definition used in this study is likely to reflect common mental disorders and psychological distress. The respondents answered the question "Have you at any time felt so mentally ill that you felt a need to seek care?" Three response options were given: "Yes," "Yes, but I didn't seek care," and "No." In the first logistic regression model, the first two "Yes" answers were merged into one category called "Yes" and the other "No" which provided a dichotomy. "No" was used as a reference in the analyses and associations between mental illness and GSE were investigated. A second logistic regression model was calculated in order to investigate if GSE was associated with the choice to seek help among those persons that reported they had experienced mental illness. We compared persons that did seek care ("Yes, I did seek care") with persons that did not seek care ("Yes, but I didn't seek care"). The first group that did seek care was the reference group in the analysis.

Independent Variable: General Self-efficacy

The GSE scale developed by Schwarzer and Jerusalem (1995) was used as an independent variable. The scale is widely used, has been validated in a number of languages including Swedish (Löve et al. 2012). The purpose of the scale is to evaluate a person's sense of capacity to handle everyday events and stressful situations. The scale consists of ten statements. All individuals answering at least seven of the ten questions were included in the analysis. All questions had four response options: *exactly true*, *moderately true*, *hardly true*, *not at all true*. Each option was given a score from four for *exactly true* to one for *not at all true*. A mean scale score was calculated for each individual. The mean scores were divided into quartiles. In the statistical analyses, GSE was dichotomized into a 25/75 % distribution, where mean scores 1.00–2.70 represented low self-efficacy (the lowest 25 %) and mean scores 2.71–4.00 represented medium/high self-efficacy (representing 26–100 %). Medium/high self-efficacy was the reference in the analyses.

Predictor Variables

Possible confounding variables were sex, age, civil status, monthly household income, education, employment status, alcohol consumption and feelings of loneliness. Alcohol consumption was measured by using the AUDIT instrument (Babor et al. 2001); no risky consumption was defined as scoring 0–5 on the AUDIT scale, and risky consumption was defined as scoring 6–40 points. The question on experienced loneliness was phrased, "Do you sometimes feel alone?" with options to answer: "Yes, frequently", "Yes, sometimes", "No, rarely", "No, never/almost never". The first two answers were merged into one category called "Yes" and the latter two into one category called "No." Reasons for not seeking care were constructed based on findings from the literature (Forsell 2006; Kessler et al. 2001; Meadows et al. 2000; Meltzer et al. 2003) as well as new items constructed for this study. If for the main question: "Have you at any time felt so mentally ill that you felt a need to seek care?" a respondent answered "Yes, but I did not seek care," the next question was "Which were the reasons that you did not seek care?" Respondents could choose more than one barrier; the response alternatives were to tick boxes with "Yes" or "No."

Statistical Analyses

All analyses were stratified by sex. Chi square tests were performed to identify statistically significant differences between GSE and barriers to care. Bivariate analyses were

done on all explanatory variables. Two logistic regression models [95 % confidence intervals (CI)] were used in order to calculate odds ratios (OR) with 95 % CI. Only variables that had one or more sub-groups that were statistically significant in the bivariate analyses were introduced in the multivariate logistic regression models. The confounding variables were included in the models step-wise, first age, then further adjusted for marital status, household income, employment status, alcohol consumption, and experienced loneliness. The study was approved by the Regional Ethical Review Board in Gothenburg, Sweden. The authors have no known conflicts of interests and all authors certify responsibility for the manuscript.

Results

A total of 3,941 answered the mental health question (40 missing), and of those 442 men (25 %) and 950 women (43 %) reported a lifetime prevalence of mental illness that they felt could have benefitted from treatment. Of these, 163 men (37 %) and 254 women (27 %) reported that they did not seek care. The distribution of GSE scores in the total sample (74 missing) showed that 980 individuals (25 %) had low GSE scores. A higher proportion of women, 632 (30 %), presented low scores compared to the men, 348 (20 %).

The socioeconomic profile of the sample is presented in detail elsewhere (Holmgren et al. 2010). In short, 20 % was 19–29 years, 34 % was 30–44 years and 47 % was 45–60 years old with almost identical proportions of men and women. The majority was married or cohabiting (78 %—of these, 76 % were men and 80 % were women). The monthly income was distributed according the following: 36 % had 6,618 USD, 28 % 4,411–6,618 USD, 28 %, 2,205–4,412 USD, 26 and 10 % had 0–2,205 USD. Thirty-eight percent had a university degree, 44 % a secondary high school degree, 18 % a primary school degree. The majority (72 %) of the individuals were employed, 8 % self employed, 8 % studying, 3 % on sick leave or having a disability pension, 3 % on parental leave and 3 % unemployed, 1 % homemaker (1 %), and 1 % other. Age distribution was similar among men and women, the proportion of married was somewhat higher among women, women had higher education levels than men, but men had higher income than women. More women than men experienced loneliness and more men than women had risk an alcohol consumption.

Logistic Regression Investigating GSE and Its Association with Self-reported Mental Illness and Help-Seeking

The logistic regression analysis showed that there was an association between GSE and self-reported mental illness.

The crude odds ratio for men with low GSE was OR 3.7 (95 % CI 2.89–4.76). When adjusted for age, civil status, household income, employment status and alcohol consumption, the odds decreased to OR 3.26 (95 % CI 2.45–4.34). In the last model, experienced loneliness was introduced and decreased the odds ratio to 2.80 (95 % CI 2.08–3.77). Among women, the regression analysis revealed that the crude odds ratios for women with low GSE to report mental illness was 2.36 (95 % CI 1.95–2.85) compared to women with medium/high GSE. Further adjustment for civil status, household income, employment status and alcohol consumption attenuated the rates only slightly (OR 2.18; CI 1.75–2.72); and when the variable experienced loneliness was added to the model, the odds decreased to OR 1.99 (95 % CI 1.59–2.49). A second logistic regression analysis was done including only individuals that had reported they had suffered from mental illness ($n = 1,373$) in order to investigate if GSE differed between those that did seek help when they felt mentally ill and those that did not. The results showed that there were no statistically significant differences in crude GSE scores, neither among men (OR 1.04; CI 0.65–1.68) nor women (OR 0.74; 95 % CI 0.52–1.06).

Description of Barriers to Care Among Person with Self-reported Mental Illness and Its Association with GSE

As mentioned above, we found that 442 men (25 % of the men in the sample) and 950 women (43 % of the women in the sample) reported a lifetime prevalence of mental illness that they felt could have benefitted from treatment. However many did not seek help: 163 (37 %) of the men and 254 (27 %) of the women reported barriers to care. There were no differences in GSE scores among the endorsed barriers to care with two exceptions for women: *I did not know where to turn for help* (p value 0.02) and *I felt ashamed because I felt ill* (p value 0.01), where those with low GSE were more likely to endorse these barriers compared to women with high GSE. The majority of the sample endorsed one or two barriers to care regardless of gender or self-efficacy scores. The barriers had the following ranking among men: *It will pass by itself*, 59 % among men with medium/high GSE versus 50 % among men with low GSE; *I did not believe that care would help*, 42 versus 33 %; *I did not know where to turn for help*, 20 versus 27 %; *I felt ashamed because I felt ill*, 24 versus 17 %; *I was afraid someone would see me when I sought care*, 7 versus 7 %; *I was afraid to be enrolled against my will*, 2 versus 5 %; *It was too expensive*, 9 versus 8 %; *The health care provider was closed*, 4 versus 0 %. The statements, *It was too far to travel* and *There were no transports so I could get to the caregiver* were not endorsed by any of

men. The same ranking of barriers was found among women as found with men: *It will pass by itself*: 58 % among women with medium/high GSE versus 61 % among women with low GSE; *I did not believe that care would help*, 28 versus 28 %; *I did not know where to turn for help*, 27 versus 42 %*; *I felt ashamed because I felt ill*, 15 versus 30 %*; *I was afraid someone should see me when I sought care*, 4 versus 9 %; *I was afraid to be enrolled against my will*, 1 versus 1 %; *It was too expensive*, 10 versus 16 %; *The health care provider was closed*; 0 versus 2 %; and *There were no transport so I could get to the caregiver*: 0 versus 1 %. The statement *It was too far to travel* was not endorsed by any participant (* Difference was statistically significant).

Discussion

In this population-based study we found that 25 % of men and 43 % of women reported a mental illness they felt could have benefitted from treatment and of those, 37 % of the men and 27 % of the women reported barriers to care. This is a lower proportion of unmet need that is found in other studies (57–79 %) (Andersson et al. 2013; Bebbington et al. 2000; Forsell 2006; Lehtinen et al. 1990; Reiger et al. 1993) which could be explained by a milder severity of illness reported here than in studies investigating diagnostic criteria of psychiatric disorders. We found that men and women with low GSE were more likely to self-report mental illness compared to individuals with high GSE. This association was stronger among men than among women. Secondly, we found that GSE did not affect help-seeking behavior among people with mental illness, however some barriers to care differed relative to GSE scores.

The risk for self-reporting mental illness was almost four times higher among men with low GSE compared to those with higher scores and among women this ratio was 2.5 times higher. After adjusting for marital status, the odds ratios for self-reporting mental illness decreased among men but not among women. Having a close confidant is associated with several types of social support; emotional, informative and practical, all important for mental health (Kawachi and Berkman 2001). Why this effect is not seen among women in our study is unclear. Education, income, and employment status affected the association among men, but again not among women. This gender difference is intriguing since these socioeconomic factors are all known risk factors for mental illness (Tsuang and Tohen 2002). High alcohol consumption did not affect the association, however experienced loneliness did. Lack of social support and social ties have been found to have a negative effect on mental health in many previous studies (Cohen and Willis 1985; Hyypää and Mäki 2001; Kawachi and

Berkman 2001), and to have social support can have an overall positive impact on mental health and may serve as a stress-buffering effect (Cohen and Willis 1985). After final adjustment, the odds ratios for having mental illness among men with low GSE was OR 2.80 (95 % CI 2.08–3.77) and among women OR 1.99 (95 % CI 1.59–2.49). Although socioeconomic factors did explain some of the association between self-efficacy and mental illness, it was feelings of loneliness that had the highest impact on the association between the two variables. Those with low GSE scores were still approximately twice as likely to report mental illness compared to those with high GSE scores after controlling for these confounding variables. Socioeconomic factors were not predictors for mental illness in the UK study by Meltzer et al. (2003) either; however alcohol problems were, which was not found in our study. It may be that one's sense of self-efficacy, based on individual subjective beliefs, may be less influenced by external factors such as economy, work and social status and more by cognitive appraisals of such objective realities.

Self-efficacy may be enhanced through appropriate support. Weak self-efficacy expectancies may have several causes, including a history of failures, minimal supportive feedback, a negative attributional style of an individual's successes and failures by significant others which may lead to a tendency to view situations and demands as threatening and result in dysfunctional coping strategies (Jerusalem and Mittag 1999). Through support and attempts at altering negative attributional styles, one's ability to cope with challenging situations and complex demands may increase. Self-efficacy can be enhanced by one's own experience of mastery, as well as the vicarious experience of the outcomes of other's actions and the verbal persuasion or encouragement of others (Bandura 1997). Previous research indicates health outcomes can be improved when self-efficacy is involved in behavioral change strategies, including physical activity and fatigue in breast cancer survivors (Phillips and McAuley 2013), medication adherence (Spruill et al. 2014), and cardiovascular diseases and depression (Greco et al. 2013). Given this evidence coupled with the mechanisms associated with self-efficacy promotion, improvement of self-efficacy could be an explicit goal in mental health self-management groups, mental health-promotion strategies, and therapeutic and counseling sessions. A focus on one's own successful outcomes as well as others' in coping with and decreasing the symptoms associated with common mental illness and strategies to identify and change negative attributional styles could be instrumental in bolstering self-efficacy. Social networks, including family and peers support are vital to include in these strategies, especially for younger persons.

When investigating help-seeking behavior we did not find that GSE had any impact on people's choices to seek

help when they felt emotionally troubled. However, the confidence interval for women approached significance and suggested that women with low GSE scores were less likely to seek help than those with high GSE scores. This is opposite the findings of Judd et al. (Judd et al. 2006) in their study on rural residents in which they found that low self-efficacy was positively associated with help-seeking for mental health problems, but similar in relation to help-seeking for physical health problems in a qualitative study by Schmutte et al. (2009) where men and women with low self-efficacy were more likely to experience barriers to care. These inconsistent findings are intriguing, and more research is necessary to fully understand the role of GSE in help-seeking, particularly for mental health issues. One variable that should be considered in future research on this topic is stigma, since mental illness is associated with both individual and community stigma (Corrigan et al. 2006), both demonstrated barriers to care (Corrigan 2004). It could be that stigma associated with mental illness has decreased in Sweden during the last 20 years through a decentralized mental health reform and an increase in health promotion discussions in media. It is also possible that participants may have had contact with the telephone health care information service, often used in Sweden, where people can call and be guided into health care which may help people with low self efficacy to access care.

There were no statistically significant differences in what barriers to care people had depending on their self-efficacy, except for two barriers among women: *I did not know where to turn for help* and *I felt ashamed because I felt ill*. It is possible that low GSE among women leads to cognitive appraisals that discourage behaviors aimed at actively searching for information as to where to get help. This may also be related to the primary health care system not successfully reaching out with information detailing where to get assistance with mental health problems. Furthermore, our findings indicate that women with low GSE feel more ashamed when suffering from mental health problems. This could increase self-stigma which leads women to condemn and shame themselves for having problems; therefore, decreasing the likelihood of women locating proper treatment (Corrigan 2004; Kleim et al. 2008). Regardless of GSE scores, personal beliefs about the nature of mental illness were the prime reasons for not seeking help among both men and women. The most common barrier was *a belief that the mental illness would pass by itself*. This barrier was the fourth mentioned by the individuals in a UK study (Meltzer et al. 2003). It is true that many mild mental health problems may disappear on their own, for example, the US Epidemiological Catchment Area study showed that most episodes of mental illness were neither severe nor longstanding (Robins and Reiger 1991). However, this statement may also indicate a wish

not to acknowledge the severity of the mental health problem due to the stigma of mental illness (Eisenberg et al. 2009). The second most prevalent barrier to care was *a belief that care does not help*. Doubt whether treatment is beneficial has long been identified as a hindrance for people seeking treatment (Angermeyer and Matschinger 1996; Jorm et al. 1997). Since good evidence-based treatment exists for both milder and severe mental health problems (Gloaguen et al. 1998; Joffe et al. 1996), public health information is needed to inform the population about the quality of care offered. Only one structural barrier emerged as a concern for women in the study: *too expensive*. In Sweden, although health care is universally available, a co-pay needs to be paid for each visit, amounting to 14 USD. This fee is not high but may differentially impact people with lower income. The other barriers: *it was closed, it was too far to travel and there was no transport*, were not seen as barriers to care in our study. The densely populated area could explain it with high access to public transports and health clinics, as several private health care providers. Why we did not see many differences in GSE scores in relation to barriers to care may be that this population-based study identified people with less severe mental health problems, thus help-seeking was not seen as urgent, regardless of people's self-efficacy. Another explanation maybe that the study was done in a country with a well-developed welfare system around health care with structures that may be available and accessible for all regardless of socioeconomic status and self-efficacy, such as a universal health care coverage, many out-patient clinics, sickness compensation, occupational health services and mental health discussions in work places and the media which may decrease barriers to care.

This study utilizes a general population of over four thousand men and women performed in a country with broad social insurance coverage. The area included is representative of both urban and rural areas in Sweden and represents almost a fifth of the Swedish population. The epidemiological design is strength since we identify common mental illness that burden populations in both high and low-income countries. We used a validated instrument to measure self-efficacy with high psychometric standards (Löve et al. 2012). The cross-sectional design is a limitation since reversed causality cannot be excluded and recall bias may be affecting rates since the question on mental illness was phrased as lifetime prevalence. The results may also be biased due to a higher dropout rates in the study among people with low income. A higher drop out rate was also found among those born outside Europe and among this group, socioeconomic status may be low and therefore introducing bias in this association. Our results may also be affected by the self-efficacy scale we have used which measures a general construct of self-efficacy. Bandura

argued that self-efficacy is domain-specific; one may feel efficacious in one area yet not feel capable in another, and that when measuring self-efficacy the scale items should be specific to the outcome, in this case help-seeking for mental illness (Bandura 1994). However, at the time this study was implemented, there was no such scale to use. The GSE items are quite broad, and participants may have considered other behavioral domains when answering the questions instead of focusing on their capacities to deal with mental health problems specifically. Further research utilizing a mental-health seeking self-efficacy measure should be considered. Finally, the question that explained most of the associations, “Do you sometimes feel alone?” could be interpreted as being physically alone and not feeling emotionally alone, which may have overestimated this variable’s influence on the outcomes. Future research should examine the influence of loneliness using an alternative operational definition of the construct.

Conclusion

This study provides results on how self-efficacy is associated with self-rated mental illness and help-seeking behavior in a large randomized population sample. People with low GSE were more likely to report mental illness compared to individuals high in GSE. However, GSE did not enhance help-seeking behavior or perceived barriers to care, except for two barriers among women: knowledge about where to go to get help and feelings of shame. Self-efficacy is an individual characteristic amenable to change. However, more studies are needed to disentangle the causal relationship between mental illness and self-efficacy. Regardless of self-efficacy, we found several barriers that decreased the likelihood of people seeking care for their mental health problems, and based on our findings, we suggest that health planners improve information about where to go to seek help and address strategies on how to decrease stigma in society as well as improve mental health literacy. Special attention should be given to people with low self-efficacy and strategies should include a gender perspective.

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