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Intentions to Seek Therapy, Attitudes, and Stigma: An Analysis of the Theory of

Reasoned Action

by

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Doctoral Dissertation

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Abstract

The relatively low utilization of mental health care is a concern for psychology, as only 32% of individuals with a psychological disorder receive treatment (Andrews, Issakidis, & Carter, 2001). It is typically attitudinal rather than structural barriers that influence individuals when deciding to pursue treatment (Outram, Murphy, & Cockburn, 2004). This study utilized the theory of reasoned action as a model to test the relationship among variables hypothesized to contribute to the intention to seek therapy: public stigma, self-stigma, social support, self-efficacy, attitudes toward seeking therapy, and psychological distress. Both quantitative and qualitative methods were used to evaluate barriers to seeking therapy. Structural equation modeling was used to show that the theory of reasoned action provided a good fit to the data, as positive attitudes toward therapy was a stronger predictor of intentions to seek therapy than self-stigma. The statistical model that included all of the variables demonstrated that positive attitudes toward therapy and higher levels of social support were both direct predictors of higher intentions to seek therapy. In the qualitative interviews, the majority of barriers described by participants were attitudinal rather than structural. These individuals related experiences of shame, prejudice, and stigma related to seeking psychological treatment. However, participants described critically significant support and encouragement from their social network. Based on the results, recommendations are made for future studies and mental health advocacy efforts.

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Introduction

When a person encounters stress and personal difficulties, he or she faces a conflict between the wish to be independent and the desire for support and guidance (Nadler, 1997). Seeking help from others can be a threatening experience for individuals in Western cultures because, within these cultures, independence is associated with a positive view of oneself. Most individuals are aware of this conflict on some level and will seek protection from it by avoiding help from others (Nadler, 1997). Andrews, Issakidis, and Carter (2001) explain it in this way: “independence or stoicism is a laudable trait unless it interferes with relief of a disabling disorder” (p. 421). Disclosure of personal and sensitive information to a stranger in an unfamiliar setting is truly difficult. Seeking help for a mental health concern is a difficult process involving four steps: recognizing that a problem exists, deciding that seeking services would be an appropriate method of solving the problem, deciding to obtain professional mental health services, and contacting these services (Saunders, 1996). A person thinking about seeking help encounters a conflict between approach tendencies (e.g., distress, life disruptions) and avoidance tendencies (e.g., stigma, treatment fears; Kushner & Sher, 1991).

It seems that avoidance largely prevails in regard to mental health treatment, as there is consistently low utilization of these services in Western countries. For example, Andrews and his colleagues (2001) reported that, in their population study of Australia, only 32% of individuals with a psychological disorder consulted a mental health practitioner. This problem is more severe in the United States, as population studies comparing the USA, Canada, and The Netherlands found that the lowest consulting rate (22%) of individuals with a mental disorder with any health professional (physician, psychiatrist, nurse, psychologist,

or social worker) was in the USA (Alegria, Bijl, Lin, Walters, & Kessler, 2000). Further, there are no differences in mental health care utilization based on severity of mental illness (Narrow et al., 2000). The tendency to avoid health care is more severe in men, as the literature reveals that women are more likely than men to seek medical and psychological help and are more likely to have favorable attitudes toward treatment (Addis & Mahalik, 2003; Kessler, Brown, & Broman, 1981; Nadler, 1997). The data concerning low mental health care utilization is disturbing, especially for the male population who are also more likely to commit suicide (Landers, 1989). On the positive side, there is research that shows that changing societal and individual attitudes toward seeking therapy increases the use of psychological services by individuals experiencing a psychological disorder (Nelson & Barbaro, 1985).

There are many factors that prevent individuals from seeking treatment (e.g., cost, time), and they are difficult to modify and vary greatly among populations. Indeed, many individuals (83%) perceive at least one barrier to accessing mental health services (Leaf, Bruce, Tischler, & Holzer, 1987). Barriers are divided into structural factors (e.g., cost) and attitudinal factors (e.g., perceived stigma). One may hypothesize that cost is a significant barrier to treatment attendance; however, population studies suggest that level of income does not significantly affect mental health care utilization (Alegria et al., 2000). It seems that attitudinal barriers are more likely to prevent mental health care utilization than structural barriers (Outram, Murphy, & Cockburn, 2004). Indeed, these authors found that the most frequently cited barriers to treatment were attitudinal, and structural barriers such as cost were rarely mentioned. These barriers were associated with attitudes toward seeking therapy or stigma and included thinking they should cope alone, thinking the problem would improve

on its own, embarrassment, and fear of what other people would think. Wells, Robins, Bushnell, Jarosz, and Oakley-Browne (1994) found that the two most common reasons provided for not seeking mental health services were attitudinal: beliefs that the problem would resolve itself and that they could remedy the concern on their own. In an Australian community sample, the most cited reason (43% of the sample) for not seeking therapy in the past was embarrassment (Wrigley, Jackson, Judd, & Komiti, 2005). It seems that individuals suffering from a psychological problem often avoid treatment because of unfavorable attitudes concerning the utility of therapy and apprehension about the societal stigma associated with mental health.

Importantly, favorable attitudes toward therapy significantly predict a greater likelihood of seeking psychological help (e.g., Cepeda-Benito & Short, 1998; Leaf et al., 1987). Individuals who believe that seeking therapy will be more beneficial than “risky” are more likely to have a positive attitude toward psychological treatment (Shaffer, Vogel, & Wei, 2006). In other words, individuals who have a positive attitude toward therapy believe that therapy is effective (Bayer & Peay, 1997). Fortunately, attitudes may be changeable both within a population and on an individual basis (Petty & Cacioppo, 1986). In support of this idea, several studies found that attitudes toward therapy and mental illness improve following a psychoeducational intervention (Battaglia, Coverdale, & Bushong, 1990; Esters, Cooker, & Ittenbach, 1998; Nelson & Barbaro, 1985). The interventions presented in the literature to alter attitudes toward therapy are few, yet effective; however, there is room for further investigation. “Interventions to improve attitudes might focus on two levels: improving attitudes about the personal experience of seeking mental health treatment and improving social norms and related stigma” (Gonzalez, Alegria, & Prihoda, 2005, p. 625).

Indeed, development of these interventions is essential, as is expanding the knowledge base of how attitudinal barriers prevent individuals from seeking psychological treatment. Many of the issues with low mental health care utilization may originate from negative societal beliefs toward mental illness and its treatment.

Stigma

Stigma can be defined as an “attribute that is deeply discrediting,” which reduces a person to a “tainted” individual (Goffman, 1963, p. 3). Goffman explains that stigma is a relationship between an internal attribute and a social stereotype. Link and Phelan (2001) add that stigma with mental illness includes some type of prejudice towards these individuals when their attributes are linked to a negative stereotype. Further, there is significant “status loss” for the stigmatized individual as their position in the social hierarchy lowers after the identification of the socially negative attributes (Link & Phelan, 2001, p. 371). The “stigma associated with seeking mental health services...is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). When an individual seeks therapy, it leads to the inference that the person has some type of psychological problem and is incapable of dealing with the problem on his or her own, which is viewed as negative in Western cultures (Nadler, 1997). “Thus, a possible consequence for seeking professional psychological aid may be negative evaluation and rejection from others” (Sibicky & Dovidio, 1986, p. 148). The informal labeling of individuals with a mental illness is a form of stigmatization that leads to diminished self-concept and identity in these individuals (Goffman, 1963). The public is certainly aware of this stigma, as 90% of respondents in a study believe that “some people who want to go for counseling don’t, because they’re afraid that people might think they’re crazy” (Nelson &

Barbaro, 1985, p. 94). Unfortunately, the stigmatizing stereotypes are not constricted to the general public, as mental health professionals also subscribe to the stereotypes (Corrigan & Watson, 2002). Indeed, many psychological theories blame the individual's internal functioning for pathology rather than external conflicts. Therefore, the message is that psychological disorders are stigmatizing because a stronger person would not be afflicted with the pathology in a similar context (Scheff, 1999).

Social support is valued as individuals are more likely to seek therapy if they receive encouragement from a friend or family member (Vogel, Wade, Wester, Larson, & Hackler, 2007). Conversely, friends and family members' attitudes may be a significant barrier to seeking services, as 24% of individuals surveyed believed that a loved one would be upset if they sought psychotherapy (Leaf, Bruce, & Tischler, 1986). The stigma of mental illness includes public stigma, the general population prejudice toward people with psychological disorders, and self-stigma, an individual's internalization of the public stigma (Corrigan, Watson, & Barr, 2006). In other words, public stigma is the perception of others as socially unacceptable and self-stigma is the perception held by an individual that he or she is socially unacceptable (Vogel et al., 2006). Before receiving a mental illness label, individuals internalize the stereotypes of mental illness (e.g., they believe they are incompetent and to blame for the problem; Link, 1987). When they begin to experience the symptoms of a mental illness, these stereotypes become personally relevant (Watson, Corrigan, Larson, & Sells, 2007). "Persons with mental illness, living in a culture steeped in stigmatizing images, may accept these (images) and suffer diminished self-esteem and self-efficacy as a result" (Corrigan & Watson, 2002).

Public stigma and self-stigma are both likely to affect attitudes and intentions to seek therapy (Ajzen & Fishbein, 1980). Public stigma toward individuals seeking treatment for a psychological problem is prevalent in American culture. Sibicky and Dovidio (1986) found that college students who believed they were interacting with an individual who was attending therapy reported more negative impressions (e.g., boring, awkward, insecure) of their conversation partner than did participants who believed they were interacting with individuals who were not clients. Further, judges viewed videos of these interactions and reported that participants behaved more negatively towards the “clients” than the “nonclients.” Seeking treatment for psychological problems has also been found to be more stigmatizing than seeking treatment for physical problems (Ben-Porath, 2002; Corrigan, 2004). Ben-Porath found that undergraduate students enrolled in a psychology course rated individuals with a psychological problem as less interpersonally interesting, competent, and confident than individuals with a physical problem. She also found that these students viewed individuals who sought help for a psychological problem as more emotionally unstable than individuals who did not seek help for a similar problem. This is evidence to support the presence of stigma for individuals seeking psychological treatment, which is likely to lead to an avoidance of treatment (Komiya, Good, & Sherrod, 2000; Wrigley et al., 2005).

According to Corrigan (2004), the stigma process involves four factors: cues, stereotypes, prejudice, and discrimination. In the first process, cues, the author explains that the general public infers the presence of mental illness in others based on four different cues: *psychiatric symptoms*, *social skill deficits*, *physical appearance*, and *labels*. The first three cues produce stigmatizing reactions because people are likely to perceive these qualities

(e.g., poor physical appearance) as indicators of a psychological disorder. The final cue, labeling, can lead to stigma when an individual receives a label from a mental health professional or obtains it by association (e.g., observation of the individual leaving a psychologist's office). These cues lead individuals to experience negative stereotypes associated with individuals with a psychological disorder. However, knowledge of these stereotypes does not insure that the individual will endorse these negative perceptions. In the third step, people who are prejudiced and do endorse these stereotypes form negative reactions to individuals with a psychological disorder. Finally, these individuals display discriminatory behavior towards individuals with a mental illness (e.g., not hiring an individual with a psychological disorder). All of these factors are likely to lead to significant harm for individuals who are publicly identified as "mentally ill." This in turn may lead individuals to deny their group status, thereby not seeking beneficial mental health care (self-stigma). Corrigan explains that self-stigma is influenced by public stigma, so they are best understood in interaction with each other. "Hence, the potential of self-stigma can yield label avoidance and decreased treatment participation" (Corrigan, 2004, p. 618).

Although public stigma, which predicts self-stigma, is important to the formation of attitudes toward seeking therapy, self-stigma is a more personal belief and may exert a larger influence in the formation of attitudes. Indeed, the greater self-stigma related to seeking psychological help has been found to be associated with less positive attitudes toward seeking psychological treatment than individuals perceiving less self-stigma (Vogel et al., 2006). In addition, Vogel and his colleagues found that individuals reporting greater self-stigma had less intention to seek therapy for psychological concerns. In a later study of undergraduate psychology students, Vogel and his colleagues (2007) found that self-stigma is

a better predictor of attitudes toward seeking therapy than public stigma and, as they expected, attitudes toward therapy is the best predictor of intentions to seek therapy (see Figure 1).

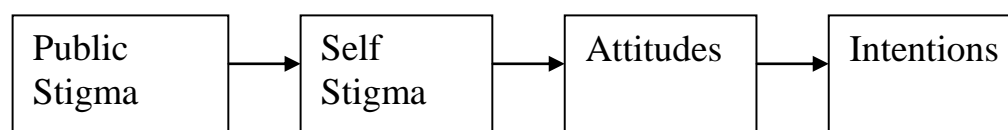


Figure 1. Relationship of Stigma, Attitudes, and Behavioral Intentions (Vogel et al., 2007)

Vogel and his colleagues (2007) present support for an interesting model of the relationships among these important attitudinal barriers to seeking therapy. However, a significant limitation of their model is their exclusion of an assessment of psychological distress. According to Corrigan and his colleagues (2006), self-stigma begins with an individual's endorsement of common negative stereotypes (e.g., "people with a psychological disorder are morally weak"). The process becomes harmful when an individual with a psychological disorder internalizes these cultural beliefs (e.g., "I am morally weak because I have a psychological disorder"). Clearly, an individual cannot reach this step if they are not experiencing any psychological distress. It is possible that Vogel and his colleagues' (2007) omission of a psychological distress measure impose limitations on their model. It is difficult to see how an individual can experience self-stigma, as defined by Corrigan and his colleagues (2006), for something that is personally irrelevant. For example, a Caucasian individual can recognize the negative stereotypes directed toward African-Americans, but he cannot experience internalized prejudice. At the very least, the Vogel

model is measuring a different construct than self-stigma because it is unknown how many of their participants were experiencing psychological distress at the time of the study. Perhaps the authors' measure of "self-stigma" assessed the first process of self-stigma, *stereotype agreement*, but, without a measurement of psychological distress, one cannot determine the next, integral process, *self-concurrence* (Corrigan et al., 2006). Vogel and his colleagues (2007) admit that an assessment of psychological distress could contribute to their model, but they did not mention the problems with including a measure of self-stigma in a sample without significant psychological distress. The addition of a psychological distress measure would be a significant contribution to this model and the literature.

Psychological Distress

Unsurprisingly, psychological distress is an integral factor in the decision to seek therapy because individuals with a psychiatric diagnosis are five times more likely to seek mental health services (Leaf et al., 1986). Rickwood and Braithwaite (1994) analyzed several possible barriers to help-seeking for emotional problems (e.g., social support) and found that greater psychological distress was the only significant predictor of treatment utilization. In addition, a recent literature review corroborates these findings (Jackson et al., 2007). Several studies analyze the relationship between psychological distress and attitudes toward seeking therapy. Cramer (1999) provided support for a model that showed that individuals are more likely to seek therapy when psychological distress is high *and* attitudes toward seeking therapy are positive. However, conflicting theories concerning the relationship between psychological distress and attitudes toward seeking therapy existed before Cramer's model. These largely focused on how self-concealment fit in modeling barriers to seeking therapy.

There is some evidence that self-concealment or secret-keeping is associated with increased risk for psychopathology (Kelly & Achter, 1995). Kelly and Achter discovered that individuals who were more likely to conceal personal information tended to have less favorable attitudes toward therapy but had greater intentions to seek therapy. Surprisingly, in this study self-concealment was a better predictor of intentions to seek therapy than depression or social support. The authors explain their seemingly contradictory findings by suggesting that high self-concealers have poor attitudes toward therapy because they fear that they will have to disclose personal information. However, they are more likely to seek therapy because these “secret keepers” are likely to have an inadequate social support network and may rely on a therapist for support. Indeed, Kelly and Achter reported that the high self-concealers were significantly more likely to have sought psychological help in the past than had the low self-concealers.

Cepeda-Benito and Short’s (1998) findings challenge the results from the previous study (Kelly & Achter, 1995) because, in their study, high self-concealers were not more likely to seek therapy. Further, level of distress *and* social support were better predictors of intention of seeking help than self-concealment. Cramer (1999) addressed the inconsistencies in these two studies by reanalyzing their results with a path analysis (see Figure 2). As previously described, he explained that individuals are more likely to seek therapy when distress is high and attitudes toward seeking therapy are positive. Further, distress is likely to be high when social support networks are inadequate and individuals are likely to conceal personal information from others, and that people who conceal information are likely to have negative attitudes toward therapy and inadequate social networks. Cramer explained the apparent inconsistencies in his model with a two-tiered system for self-

concealers' decision to seek help. On the first and strongest level, self-concealment leads to greater distress, which is associated with increased intentions to seek psychological help. On the second and weaker level, the tendency to keep secrets is associated with negative attitudes toward seeking therapy, which decreases the likelihood of seeking help. Therefore, high self-concealers struggle with an approach-avoidance conflict, as they are skeptical of the benefits of therapy even though it could be helpful for the distressing symptoms they have not revealed to others.

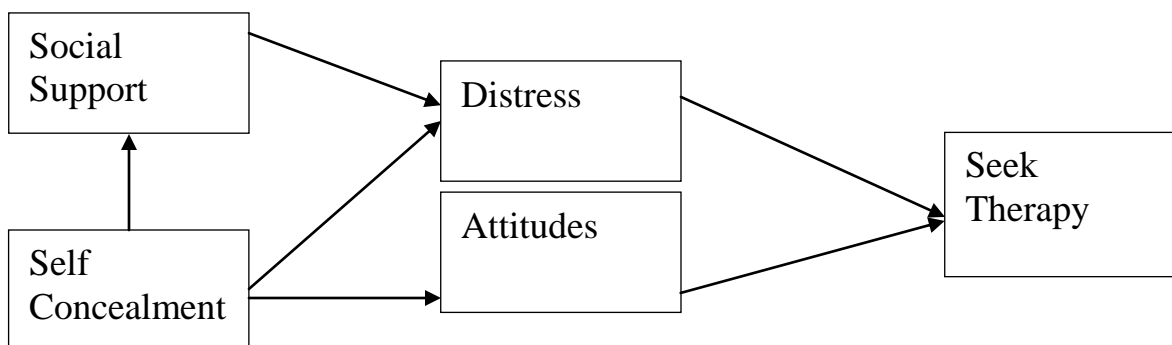


Figure 2. Psychological Antecedents to Help Seeking (Cramer, 1999).

Cramer's (1999) model is important in determining the relationship of psychological distress and attitudes toward seeking therapy with intentions to seek therapy, but it does not explain the relationship between the first two variables. There are few studies that examine the direct relationship between psychological distress and attitudes toward seeking therapy. Fortunately, Yoo, Goh, and Yoon (2005) studied this relationship in a sample of Korean residents. However, their results were puzzling because in their study psychological distress was negatively related to attitudes toward seeking therapy. The authors hypothesize that negative attitudes do not portend avoidance of therapy, which may be the case, but this finding is surprising. Further, African American adolescent males with a history of

psychiatric disorders reported significantly less favorable attitudes toward seeking therapy than did individuals without a disorder (Scott & Davis, 2006). It is likely these adolescents experience pressure from their peers to avoid therapy, and those who do seek therapy are likely to experience feelings of shame and embarrassment. However, firm conclusions cannot be made because there were no measures of perceived stigma or self-stigma to allow an examination of any of these relationships (Lindsey, Korr, Broitman, Bone, Green, & Leaf, 2006).

There are clearly conflicting results concerning the relationship between attitudes toward therapy and psychological distress. For example, it has been also shown that biracial women with favorable attitudes toward therapy were *more* likely to seek therapy. In addition, higher scores on a depression measure were associated with an increase in the likelihood that these women sought psychological treatment (Constantine & Gainor, 2004). It is possible that the positive results in this study are related to the findings that women report more favorable attitudes toward therapy and are more likely to attend treatment than men (e.g., Fischer & Turner, 1970; Jackson et al., 2007; Yeh, 2002). Morgan, Ness, and Robinson (2003) replicated Cramer's (1999) findings and found that women with higher levels of distress were more likely to report favorable attitudes than men with high levels of distress. However, the findings regarding gender differences in attitudes toward seeking therapy is not consistent, as Yi and Tidwell (2005) found that there were no gender differences in their sample of Korean-Americans. In a diverse sample of college students, Cellucci et al. (2006) found that depression distress was positively related to attitudes toward therapy, which conflicts with the results from previous studies (Scott & Davis, 2006; Yoo et al., 2005). Further, they reported that less perceived stigma increased the likelihood of

having favorable perceptions of treatment for alcohol problems. However, the authors used a measure of public stigma rather than an assessment of self-stigma. Although there is not a consistent relationship between psychological distress and attitudes toward seeking therapy, the addition of a self-stigma measure is likely to be a significant contribution to the theory. Further, the different cultural groups sampled in each study may explain the conflicting findings in this section. Therefore, a study that includes all of the relevant variables (e.g., stigma) is likely to help explain some of the inconsistencies within the literature.

Social Support

When an individual seeks social support for a psychological problem, he or she has the options of informal (e.g., friends) and formal (e.g., healthcare professional) support. However, the relationship between informal and formal help is complex. The majority of individuals prefer the informal support of family and friends before engaging in formal mental health services (Narikiyo & Kameoka, 1992; Saunders, 1996). In addition, it has been well-documented that social support from friends or family members effectively reduces psychological distress (e.g., Fleming, Baum, Gisriel, & Gatchel, 1982). Thus, informal support may reduce the likelihood of formal help-seeking in many individuals (Briones, Heller, Chalfant, Roberts, Aguirre-Hauchbaum, & Fair, 1990; Thoits, 1986). Further, informal support may influence poor attitudes toward mental health treatment, as about 25% of participants perceive that their family would be upset if they entered this form of treatment (Leaf et al., 1987). However, Saunders (1996) found that more than 90% of study participants indicated that they discussed their psychological problem with a family member or friend who encouraged therapy attendance at some point during the help-seeking process. Therefore, one may expect that social support predicts attitudes and intentions to

seek therapy to alleviate psychological suffering. Indeed, Kelly and Achter (1995) found that social support is positively correlated with attitudes toward seeking therapy.

As mentioned above, the relationship between social support and intentions to seek therapy is not clear. Kelly and Achter (1995) concluded that social support is a poor predictor of intentions to seek therapy, whereas Cepeda-Benito and Short (1998) found that social support is a good predictor of this variable. Cepeda-Benito and Short (1998) discovered that low levels of social support increased intention to seek therapy for psychological and interpersonal reasons. Cramer (1999) attended to these inconsistencies by conducting a path analysis on these two study samples. He found that social support is not a direct predictor of intentions to seek therapy. As shown in Figure 2, psychological distress and attitudes toward therapy are direct predictors of this variable. Social support fits in the model because psychological distress is high when social support is low. Other studies found that the relationship between social support and intentions to seek therapy is not direct but is mediated by psychological distress (Briones et al., 1990; Rickwood & Braithwaite, 1994). It seems that the majority of studies find that social support is generally a poor predictor of help-seeking for a mental illness, especially in young adults (e.g., Bergeron, Poirier, Fournier, Roberge, & Barrette, 2005).

Self-Efficacy

The stigma towards mental illness and its treatment is often damaging to an individual's self-esteem and self-efficacy (Link, 1987). Self-efficacy is a particular problem for individuals with a mental illness because they often feel that they are ruled by forces outside of their control (Rosenfield, 1997). Perception of societal stigma by individuals with psychological distress is associated with lower levels of self-efficacy (Corrigan et al., 2006;

Rosenfield, 1997). However, Corrigan and his colleagues (2006) found that self-stigma was not significantly associated with self-efficacy. In other words, an individual may recognize societal stigma toward mental illness, but this does not necessitate that the person internalizes the stigma and suffers diminished self-efficacy. The authors of this study were puzzled by this finding, as one would expect that internalization of a negative stereotype would lead to low feelings of self-worth. Fortunately, if an individual does experience lower levels of self-efficacy, he or she is more likely to seek help for a mental health concern (Judd et al., 2006). Conversely, higher levels of self-efficacy are positively predictive of help seeking for an alcohol problem (Cellucci, Krogh, & Vik, 2006). It seems that firm conclusions cannot be made because self-efficacy has rarely been included in research studies to determine its relationship with help-seeking (Jackson et al., 2007).

Theory of Reasoned Action

Throughout nearly the entirety of social psychology's young history, researchers have analyzed the connection between an individual's attitude and the performance of a related behavior (for review see Ajzen & Fishbein, 1980). The definition of "attitude" is a "learned predisposition to respond in a consistently favorable or unfavorable manner with respect to a given object" (Fishbein & Ajzen, 1975, p. 6). The relationship between attitude and behavior is, simply that, people who believe that a behavior will lead to a positive outcome will have a positive attitude concerning the behavior and vice versa (Ajzen & Fishbein, 1980). The attitude-behavior connection is important because attitudes toward seeking therapy are likely to be an integral piece in the decision to attend therapy (Fisher & Turner, 1970). However, Ajzen and Fishbein remind us that, despite the assertion of many social psychologists, there

is not a predictable or direct path between an individual's attitude and the performance of the expected behavior.

Individuals who have sought psychological treatment in the past have more positive attitudes toward therapy than do individuals who have not attended therapy, but this does not establish a direct connection between attitude and behavior (Fisher & Turner, 1970). Further, attitudes are one of many factors that influence behavior (e.g., personality characteristics, intellectual abilities). One cannot be sure that an individual with a positive attitude toward seeking psychological services will attend therapy when experiencing distress or vice versa (Miville & Constantine, 2006). However, Ajzen and Fishbein (1980) developed a model, the *theory of reasoned action*, which models how attitudes influence behavior. This theory is based on the assumption that humans are rational and that they make systematic use of the information available to them, as they consider the implications of their actions before deciding whether or not to engage in a behavior. Ajzen and Fishbein (1980) explain that their "theory views a person's *intent* to perform (or not to perform) a behavior as the immediate determinant of the action" (p. 5, italics added). The authors explicate that an individual's intention (e.g., "I am 100% certain that I will vote for X presidential candidate") is not a perfect determinant of behavior, but it is the most effective at predicting behavior that has not occurred in the past.

According to the theory of reasoned action, an individual's intention is a function of two determinants, one personal and the other social (Ajzen & Fishbein, 1980). The personal determinant is an individual's attitude toward the behavior and the social determinant is his/her perception of social pressure to perform or not perform the behavior, which the authors call the *subjective norm*. An assessment of these variables is presented in the therapy

literature as *attitudes toward seeking therapy* and *perception of stigma toward seeking treatment*, respectively. Although personal attitudes and social pressures are both important in the formation of intent to perform a behavior, Ajzen and Fishbein believe that the literature in this area is incomplete because it does not consider how an individual weighs the importance of personal attitude versus societal demands (if there is conflict between them). For example, they suggest that an individual who favors his/her own personal attitude over societal demands is more likely to emphasize that factor in determining his/her intent to perform a behavior. Figure 3 provides a visual presentation of the theory of reasoned action.

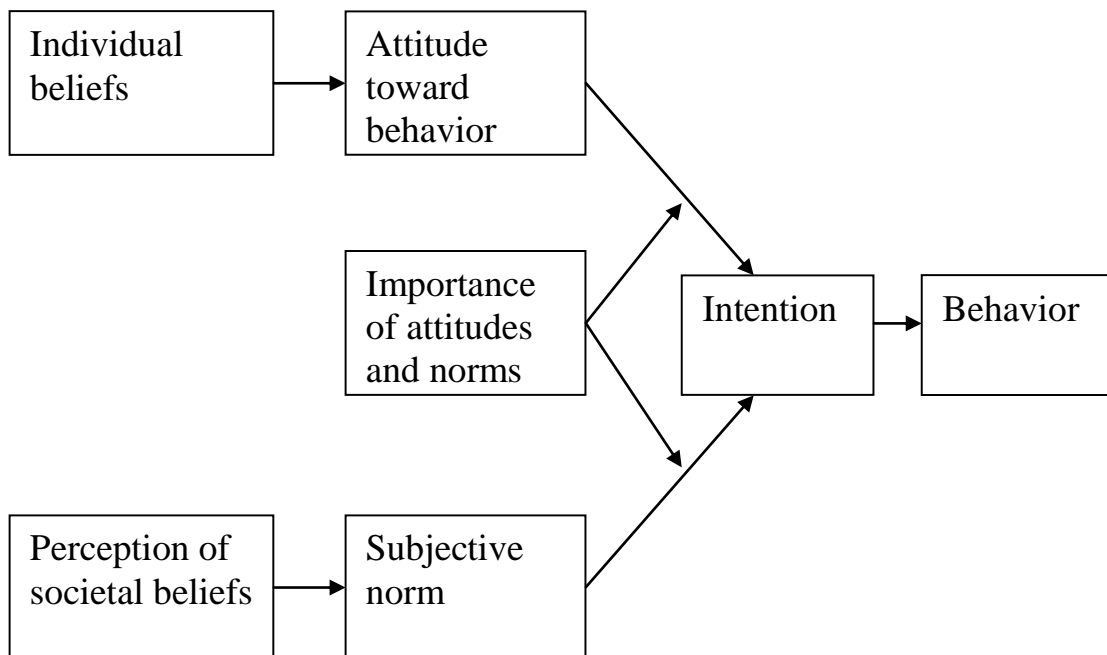


Figure 3. Theory of Reasoned Action (Ajzen & Fishbein, 1980).

There are several possible theoretical challenges to the theory of reasoned action. First, it does not consider the weight of factors outside the model (e.g., personality) or the

possibility of behavior influencing the formation of attitudes. Second, Festinger's (1957) theory of cognitive dissonance seems to be in conflict with the theory of reasoned action, as it predicts that dissonance that occurs from the inconsistency between cognitive elements (beliefs, attitudes, or behavior) will lead an individual to change either his/her attitude or behavior. However, Ajzen and Fishbein (1980) argue that tests of Festinger's theory show that people tend to coordinate their beliefs and attitudes with their actions, but they do not provide any information concerning the extent to which attitudes influence behavior. It should be noted however, that Festinger did not make a distinction between beliefs and attitudes, and most of his research focuses on beliefs rather than attitudes (Fishbein & Ajzen, 1975). In this respect, Ajzen and Fishbein (1980) created a model to show how attitudes influence behavior where Festinger did not.

Other challenges to the theory of reasoned action are contributions from factors outside of the model such as personality, gender, and age. It is clear that these factors could affect the model at several integral points. For example, an individual who is introverted will believe that attending a party will not lead to positive circumstances. In other words, the individual's personality will lead to a negative attitude toward the behavior (attending a party). Ajzen and Fishbein (1980) recognize that external factors will influence their model, but because these factors will change over time and across populations, a model that includes external factors will be unstable and lack significant predictive power. These external factors may mediate the attitude-behavior link in some situations, but because of the dynamics of such variables they chose not to make it a focus of their global model. They find that their model is stable because the influences of external factors have little bearing on the validity of the theory of reasoned action.

There have been varying levels of success in determining the nature of the attitude-behavior connection, but the theory of reasoned action seems to be an effective model for the process of entering therapy. The model examines the interaction of an individual's attitudes and his or her adherence to societal beliefs in determining the likelihood of actually attending therapy (Ajzen & Fishbein, 1980). There has been some success applying the theory of reasoned action to psychological therapy. For example, Codd and Cohen (2003) conducted a study to test the ability of the theory of reasoned action to predict college student intentions to seek therapy for alcohol abuse. In support of the theory of reasoned action, they found that attitudes and subjective norms (stigma) accounted for 12% of the variance predicting intentions of seeking therapy for this disorder. Cellucci and his colleagues (2006) replicated these findings and found that favorable attitudes toward therapy increased the likelihood of seeking help for alcohol problems and that stigma negatively predicted help-seeking.

Other Models of Behavioral Prediction

Theory of Planned Behavior. The theory of planned behavior is an extension of the theory of reasoned action. It includes *control beliefs* in addition to personal beliefs and perception of societal beliefs for the prediction of the performance of a particular behavior. Control beliefs are an individual's perception of factors that may facilitate or impede performance of the behavior referred to as *perceived behavioral control* (Ajzen, 1991). Ajzen explains that both the theory of reasoned action and the theory of planned behavior are sufficient to predict particular behaviors, but the addition of control beliefs may account for more variance in the model. There are only a few studies in the mental health literature that test the theory of planned behavior (e.g., Skogstad, Deane, & Spicer, 2006). The control belief variable in this model may include either internal factors (self-efficacy) or external

factors (structural barriers such as cost). This creates difficulty in conceptualizing the control belief variable, as it can include several different factors related to the decision to seek treatment for a psychological problem. Therefore, the theory of reasoned action is more parsimonious than the theory of planned behavior in predicting intentions to seek therapy.

Health Belief Model. Another behavioral prediction model specifically related to health behaviors is the health belief model (see Figure 4; Becker, 1974). The health belief model focuses on the beliefs and attitudes of individuals and includes four dimensions. The first, *perceived susceptibility*, is the individual's perception of their likelihood of contracting a certain illness or disorder. The second, *perceived severity*, is the individual's perception of the severity of the current condition. The third factor is *perceived benefits*, which is the individual's perception of the effectiveness of treatment to improve their condition. Finally, *perceived barriers* are an individual's perception of any barriers or costs to seeking any form of treatment. The health belief model is frequently used in health psychology studies (for review see Harrison, Mullen, & Green, 1992) but was originally designed to examine preventative behaviors for medical problems (e.g., breast examination; Becker, 1974). Further, the problem of control beliefs with the theory of planned behavior also plagues this model. The perceived barriers to treatment can be psychological, physical, and others, which creates difficulty when trying to conceptualize this dimension (Ogden, 2003). In addition, perceived susceptibility has little relevancy to conceptualizing decisions to seek treatment for a psychological problem.

Behavioral Model of Health. The final theory, the behavioral model of health, is a linear model. The behavioral model of health includes a combination of three variables to determine the likelihood of service use (Andersen, 1995). The factors are: (1) *predisposing*

variables such as personal history or beliefs about treatment prior to developing a condition, (2) *enabling variables* such as availability of resources, and (3) *illness/need variables* such as the severity of the individual's condition. In studies assessing individuals with a mental illness, this model has failed to garner support as it predicted help-seeking in only two out of the five studies (Elhai, Reeves, & Frueh, 2004; Goodwin & Andersen, 2002; Goodwin, Koenen, Hellman, Guardino, & Struening, 2002; Koenen, Goodwin, Struening, Hellman, & Guardino, 2003; Pickard, 2006). It is possible that these differences are due to the various populations studied with this model, but the general lack of support does not suggest that this model is promising in predicting help-seeking for psychological problems.

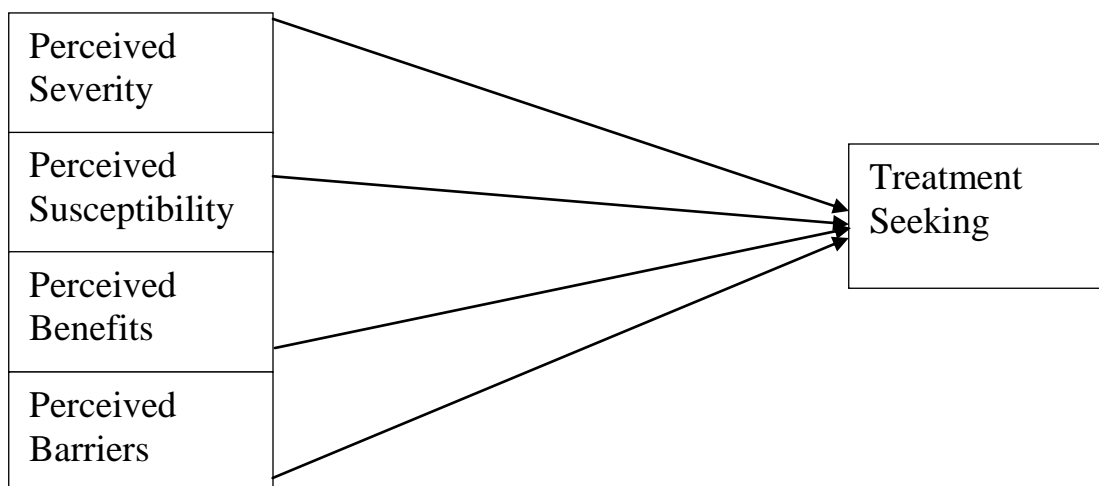


Figure 4. Health Belief Model (Becker, 1974).

Rationale for the Theory of Reasoned Action

The theory of reasoned action (Ajzen & Fishbein, 1980) was used to test the relationships among the variables of interest in this study. This theory includes the attitudinal barriers (attitudes and stigma) relevant to the decision-making process for therapy

attendance. In addition, the theory of reasoned action has been recently and effectively used in the social psychology literature (e.g., Eves & Cheng, 2007) and mental health literature (e.g., Perkins, Jensen, Jaccard, Gollwitzer, Oettingen, Pappadopoulos, et al., 2007). Other similar models (e.g., health belief model; Becker 1974) combine attitudinal and structural barriers and assume that the individual is experiencing some type of disorder rather than measuring distress on a continuum. The theory of reasoned action was used instead of other theories (e.g., health belief model) because the focus of the study was to assess the affect of attitudinal barriers (stigma and attitudes) to therapy rather than structural barriers (e.g., cost). As previously mentioned, the analysis of the relationships between attitudinal barriers and intentions to seek therapy was the focus of this study because these barriers are more likely to prevent individuals from seeking treatment than structural barriers (e.g., Outram et al., 2004) and are more easily changed in the population (e.g., Esters et al., 1998).

The aim of the current study was to evaluate the barriers associated with seeking professional psychological treatment with the theory of reasoned action. Vogel and his colleagues (2007) implemented this theory for the same purpose; however, the current study addressed several limitations from their research. For example, the current study included a measure of psychological distress and comprehensively tested the theory of reasoned action by including the weight of the relative importance of attitudes versus stigma in the decision to seek treatment. Vogel et al's model utilized the theory of reasoned action to describe the relationship between stigma and attitudes toward therapy with intentions to seek therapy; however, Vogel's model is linear and the theory of reasoned action is not (Ajzen & Fishbein, 1980).

The authors of the theory of reasoned action conceptualize stigma and attitudes as separate factors. On one path are an individual's personal beliefs and attitudes toward a particular behavior. Attitudes include an individual's beliefs about a certain behavior, which includes personal beliefs about the costs and benefits of this behavior. The other path of the theory of reasoned action consists of society's beliefs and the individual's interpretation of the pressures to perform or not perform the behavior. In the theory of reasoned action, attitudes and societal pressures have separate and unequally weighted influences depending on the intention being measured (e.g., birth control use). For example, in predicting intentions to pursue a career outside of the home, the attitude path was weighted .67 and the societal pressure path was weighted .29 (Ajzen & Fishbein, 1980). Vogel et al.'s (2007) linear model assumes that perception of public stigma leads to self-stigma and so forth rather than considering stigma and attitudes as related *and* separate processes. One cannot deny that people do not form their attitudes toward a behavior in a vacuum, so it is likely that societal pressures will affect an individual throughout the attitude development process. Indeed, as Vogel and his colleagues found, if participants adhered to the general societal pressure not to attend therapy, they were more likely to have negative attitudes toward therapy. Although this is within the theoretical boundaries of the theory of reasoned action, the authors did not assess participants' evaluation of the relative importance of their attitudes versus perceived societal norms. Therefore, their study was not a comprehensive assessment of the theory of reasoned action in relation to intentions to seek therapy.

Current Study

A large amount of research on societal stigma and attitudes toward seeking therapy has been implemented in the last decade. Fortunately, awareness of these factors in the

therapeutic process continues to grow, and mental health organizations have introduced initiatives to dispel stigma and improve the attitudes toward therapy (e.g., NIMH, 2003), making it even more important that we should continue to gather data in order to understand the attitudinal barriers associated with seeking mental health treatment. The current study implemented quantitative and qualitative methods to analyze the effect that stigma and attitudes toward seeking therapy have as barriers to seeking psychological treatment.

The current study aimed to determine if the theory of reasoned action can be successfully applied to intentions to seek treatment for psychological distress. The theory of reasoned action was tested instead of other theories (e.g., health belief model) because the focus of the study was to assess the effect of attitudinal barriers (stigma and attitudes) to therapy rather than structural barriers (e.g., cost). Vogel and his colleagues (2007) claim their model is a direct test of the theory of reasoned action. However, as previously argued, their model is linear where the theory of reasoned action is not, which makes it one of many studies that did not test the theory in its entirety (Ogden, 2003). The same self-report instruments (with slight modifications) were used in this study to allow a complete analysis of the variables in their model. The proposed model, with the inclusion of the relative importance of the two pathways of the theory of reasoned action, is portrayed in Figure 5.

This study included a measure of psychological distress because this variable was proposed to significantly effect the Vogel (2007) model. The aim of the current study was to analyze the entirety of theory of reasoned action in relation to intentions to seek therapy, and determine the contribution of psychological distress to the model. The inclusion of a measure of psychological distress is likely to reconcile the inconsistent findings concerning the relationships between psychological distress, stigma, and attitudes (Cellucci et al., 2006;

Constantine & Gainor, 2004; Cramer, 1999; & Yoo et al., 2005). Most important, psychological distress provided valuable data to help determine whether self-stigma toward psychological treatment can be experienced only by individuals who are experiencing significant distress, similar to the theories of internalized homophobia and internalized racism (Ritsher, Otilingam, & Grajales, 2003).

Quantitative Hypotheses. Given the arguments presented, the purpose of this study was to test the theory of reasoned action in its entirety by including an analysis with public stigma, self-stigma, attitudes toward seeking therapy, psychological distress, and intentions to seek therapy. Further, we tested the strength of the relationships among these variables and their ability to predict intentions to seek therapy. Another goal of the study was to clarify the relationships of perceived social support and self-efficacy among the other variables. The following hypotheses were examined:

1. In this sample, men were expected to experience significantly more stigma (public and self) and report significantly more negative attitudes toward seeking therapy than women (e.g., Fischer & Turner, 1970).
2. There was expected to be a significant positive relationship between public stigma and self-stigma, as found in previous research (e.g., Vogel et al., 2007).
3. There was expected to be a significant positive relationship between self-stigma and psychological distress. That is, the expectation was that distressed individuals are more likely to experience self-stigma related to psychological distress because one cannot internalize these negative associations related to psychological distress unless he or she is experiencing this distress (Corrigan, 2004).

4. The analysis of the relationship between attitudes toward seeking therapy and psychological distress was exploratory rather than predictive because of the previous conflicting findings concerning this relationship (Cellucci et al., 2006; Constantine & Gainor, 2004; Scott & Davis, 2006; Yoo et al., 2005).
5. There was expected to be a significant positive relationship between psychological distress and intentions to seek therapy. That is, we expect the experience of psychological distress to be a motivating factor to forming an intention to attend therapy.
6. The analysis of the relative importance variable was expected to be revealing. This variable measured the weight of each of the paths (attitudes and stigma), therefore providing the relative strength of the influence of each path on intentions to seek therapy (see Figure 5). In the previously cited research by Ajzen and Fishbein (1980), the personal attitude path had a higher weighting than the subjective norm path. Therefore, it was expected that this would also occur in the current study (a stronger weighting for the attitudes path and a weaker one for the stigma path). Consequently, the relative importance variable would mediate the relationship between attitudes toward seeking therapy and intentions to seek therapy and moderate or weaken the relationship between stigma and intentions to seek therapy.
7. The best fit model was to be determined with the inclusion of psychological distress. Psychological distress has not been included in a model with these variables in past studies, so it was not known how this variable would interact with the other study variables.

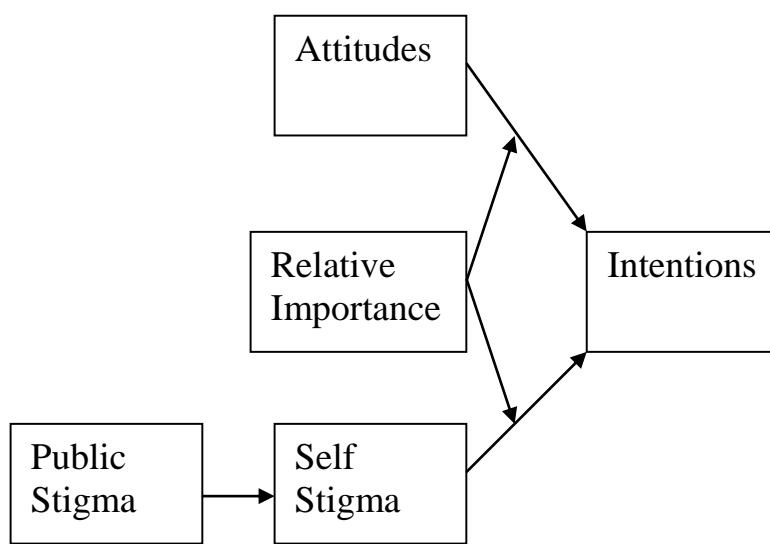


Figure 5. Hypothesized Model Based on the Theory of Reasoned Action.

Qualitative Hypotheses. To further explore the effect that attitudes and stigma have on help-seeking behavior, the qualitative section of this research gathered additional information from individuals who are currently attending therapy. The focus of this portion of the study was on their struggles with having psychological distress and the factors that influenced their utilization of mental health treatment. Further, this data assessed the theory that attitudinal barriers are more likely to prevent individuals from immediately seeking treatment to alleviate psychological suffering. Qualitative data on stigma and attitudes toward seeking therapy contributes information that is unattainable when the analysis is restricted to a set of questions in a self-report assessment. While also self-report, when participants provide a descriptive narrative of their struggles with a psychological problem, factors and concerns that might otherwise be overlooked emerge, contributing to the

understanding of the processes involved in the decision to seek or not to seek help for a psychological problem.

Both qualitative and quantitative data are useful for the generation and verification of theories. As Glaser and Strauss (1973) state, “In many instances, both forms of data are necessary, not quantitative used to test qualitative, but both used as supplements, as mutual verification and, most important to us, as different forms of data on the same subject, which, when compared will generate theory” (p. 18). The list of questions used to guide this semi-structured interview is in Appendix H. The questions were constructed to gather information about the experience of attending therapy in general, past barriers to treatment, experiences with stigma, and the effect of psychological distress on the decision to seek treatment. This information supplemented the knowledge gained from the quantitative portion of this research, informed the proposed model, and added to the growing literature of qualitative studies on the experience of therapy and psychological disorders (e.g., Kai & Crosland, 2001; Link, Yang, Phelan, & Collins, 2004). The following hypotheses were proposed for this portion of the study:

1. It was expected that men would report more attitudinal barriers to treatment than women.
2. It was expected that participants would cite more attitudinal barriers (e.g., stigma) as preventing them from seeking treatment sooner than structural barriers (e.g., cost).
3. It was expected that the majority of participants would have experienced stigma and its effects in relation to having a psychological disorder and/or attending therapy.

Method

Participants

Quantitative Study. The experimenter surveyed students ($N = 259$) in psychology courses at a Midwestern university. All students received extra credit from their psychology instructors as an incentive for participation in the study. This is a convenience sample, but this sample allows direct comparison to previous studies that also surveyed undergraduate psychology students (e.g., Vogel et al., 2007). There were more women (67.3%) than men (32.7%) in this sample, predominantly 1st-year (33.9%) or 4th-year (27.6%) students. The remaining participants were 2nd year (16%), 3rd year (20.2%), and graduate level (2.3%). Participants were predominantly European American (64.6%; African Americans = 24.5%; Asian American = 5.1%; Other = 4.3%; Hispanic = 1.2%; Native American = .4%). Some of the participants (20.5%) were either currently taking or had taken medications for a psychological problem, whereas more participants (37.5%) were either currently receiving or had received professional counseling. A slightly higher percentage of men (39.3%) in this sample have received professional psychological services than women (37.0%), but this is not a significant difference.

Qualitative Study. For the qualitative portion of the study, six women and four men were interviewed. These participants were seeking treatment at a low-fee community training clinic at a Midwestern university for psychological services. All participants were interviewed within six months of starting counseling at this clinic with seven participants interviewed after their first session and before a follow-up appointment. Age of participants ranged from 19 to 53 years old with a mean of 32.9. Seven participants had been in therapy previously before their current attendance with a range of one to six years in the past.

Measures

Perceived Devaluation-Discrimination Scale (Link, 1987; Appendix A)

This measure assesses perceived public stigma. The author constructed this scale to assess the extent to which an individual believes that people will devalue or discriminate against an individual with a psychiatric disorder. Participants rated the 12 items on a 6-point Likert scale (1 = *strongly agree*, 6 = *strongly disagree*) to determine how they view individuals in treatment for psychological or personal problems. Higher scores represent greater perceived stigma. This measure has been validated on psychiatric and non-psychiatric populations with an adequate internal consistency of .84. The wording of the items was developed in a way to reduce the effect of social desirability (e.g., “Most people think less of a person ...”) because it removes the pressure of presenting personal stigmatizing thoughts while expressing their beliefs about society's viewpoints (Link, 1987).

The original scale uses the terms “mental patient” and “mental hospital” to describe people and the treatment setting, respectively. Further, statements described the individuals as “former” or “fully recovered” mental patients. The aim of this study was to determine participants’ perception of societal stigma towards individuals *currently* having a psychological problem and/or who are *currently* attending therapy. Therefore, “therapy client” replaced “mental patient,” “therapy” replaced “mental hospital,” and “former” or “fully recovered” were removed from the statements. Vogel et al. (2007) admits that a limitation of this assessment is the inclusion of mental patients rather than individuals attending therapy. Although altering the original language of the scale may affect the internal validity of this measure, the changes are made to incorporate this study’s objective

and do not significantly change the goal of this assessment in calculating a rating of public stigma.

Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Hackler, 2006; Appendix B)

This scale measures the self-stigma associated with seeking psychological help (Vogel et al., 2006). The scale contains 10 items rated on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). The authors report good internal consistency (ranges from .86 to .90) and adequate test-retest reliability ability (.72). Higher scores indicate greater self-stigma related to utilizing psychological services. The original authors found that scores on the scale were negatively correlated with attitudes (-.63) and intentions toward therapy (-.38). Further, they found positive associations between the scale and anticipated risks, public stigma, and self-concealment.

Attitudes Toward Seeking Professional Psychological Help Scale: Shortened Form (ATSPPHS; Fischer & Farina, 1995; Appendix C)

The full version of the measure was the first designed to assess attitudes toward seeking therapy, and it is the most widely used instrument for this construct (Fischer & Turner, 1970). In the development of the original measure, Fischer and Turner (1970) described numerous decisions that can affect an individual's decision to seek therapy such as his/her own beliefs about treatment, support from friends and family, public stigma, and ability to self-disclose personal issues. They reported that the goal of their measure was to sample these factors as they relate to the attitude domain.

There were some inadequacies in the subscales of the original measure, so Fischer and Farina (1995) developed a shortened form of the original scale. The authors' goal was to

increase the stability of the underlying structure of the measure. They believed that a briefer, more valid scale would accomplish this goal. The shortened version is 10 items on a 4-point Likert scale (0 = *disagree*, 3 = *agree*). Higher scores suggest more favorable attitudes toward therapy. The shortened version has adequate internal consistency of .84 and a good test-retest reliability of .80. Fischer and Farina discovered significant overlap between the two measures ($r = .87$), so they suggest using the shortened version because the questionnaires are assessing similar constructs, and its brevity is more user friendly.

Hopkins Symptom Checklist-21 (HSCL; Green, Walkey, McCormick, & Taylor, 1988; Appendix D)

This measure is included in this study as the assessment of psychological distress. It is a shortened version (21 items) of the original 58-item Hopkins Symptom Checklist (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). Higher scores suggest higher levels of distress. Participants respond to the questions based on how distressing symptoms were during the last 7 days on a 4-point Likert scale (1 = *not at all*, 4 = *extremely*). This questionnaire has a three-factor structure: General Feelings of Distress (GFD), Somatic Distress (SD), and Performance Difficulty (PD; Green et al., 1988). Internal consistency is adequate for the full scale (.90) and its subscales (range from .75-.86). This instrument is able to distinguish between clinical and non-clinical populations and is able to identify changes in distress level during therapy (Deane, Leathem, & Spicer, 1992)

Intentions to Seek Therapy

Several researchers use the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975) to assess an individual's intentions to seek psychological support for various concerns. However, Cash and his colleagues did not develop this

“measure” to assess this construct. They used the original scale to “determine the degree of confidence the subjects placed in the counselor’s effectiveness with 15 particular types of personal problems” (p. 275). Furthermore, the authors developed the questionnaire to determine the effect a counselor’s physical attractiveness had on his effectiveness. They found that the measure distinguished between attractive and unattractive counselors, which supports the idea that this is not a direct measure of intention to seek professional help. For intentions to seek therapy, it seems more valid to ask individuals a question similar to the one in Deane and Todd’s (1996) study: “If you did have a personal-emotional problem, how likely is it that you would seek professional psychological help from a psychologist or counselor?” (p. 50). The current study used a modified version of this question to assess for intentions of seeking therapy: “If you did or do have a personal or psychological problem, how likely is it that you would seek professional psychological help from a psychologist or counselor?” Participants will answer this question on a 7-point Likert scale (1 = *not at all likely*, 7 = *extremely likely*; See Appendix E). To increase the validity of this question, participants answered this question with different professionals listed in each query (psychologist, psychiatrist, physician, social worker, and religious leader).

The New General Self-Efficacy Scale (NGSE; Chen, Gully, & Eden, 2001; Appendix E)

This measure is designed to assess self-efficacy, which is the view of oneself as capable or incapable of performing successfully in a variety of situations. An example item is “I believe I can succeed at most any endeavor to which I set my mind.” Participants record responses on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*)

with higher scores reflecting a greater sense of self-efficacy. This measure shows an adequate internal consistency with 0.85 (Chen et al., 2001).

Sense of Support Scale (SSS; Dolbier & Steinhardt, 2000; Appendix F)

This assessment is a global measure of perceived quantitative and qualitative levels of social support. This scale has been validated on community and college student samples (Dolbier & Steinhardt, 2000). This measure contains 21 items on a 4-point Likert scale (0 = *not true at all*, 3 = *completely true*). Higher scores suggest higher levels of perceived social support. These authors reported that the internal consistency of the final measure was .86, and the test-retest reliability was .91. This measure was significantly related to two other measures of social support. Further, it has significant positive relationships with measures of hardiness and approach-coping and significant negative relationships with avoidance-coping, perceived stress, and symptoms of illness.

Additional Questions (Appendix G)

There was an assessment of current and past utilization of therapy. The final open-ended question is to assess potential barriers to treatment. This question was adapted from a similar query in Cellucci et al's (2006) study. Finally, each participant will provide general demographics (e.g., gender).

Procedure

Quantitative Study. In the quantitative portion of the study, the experimenter recruited participants from undergraduate psychology classes. Psychology instructors were contacted in person or by E-mail to explain the study and request a short amount of time (about 5 minutes) at the beginning or end of the class to explain the study to prospective participants. The experimenter made brief presentations about the study to the selected

classes and provided sign-up sheets for a set day and time to complete the study in another room. Further, these sign-up sheets were available for students on the research participation board in the psychology department. Participants completed questionnaires during a set day and time in a testing room. The experimenter was available at every data collection session to answer questions and assist participants.

After signing the informed consent form (see Appendix I), to provide consent to participate in the study and inform these individuals of any risks associated with participation, participants completed the study questionnaires in a random order. Participants were given the experimenter's contact information and the information for the college counseling center. Participants received extra credit in their course, at the discretion of the instructor, as an incentive for participation in the study.

Qualitative Study. In the qualitative portion of the study, the experimenter recruited participants through the student therapists at the community clinic. Participants were included in the study if the interview was conducted *within six months* of their initial therapy session at the clinic. Further, only participants who had not attended formal therapy (psychiatrist, psychologist, or social worker) in the past year before beginning treatment at the community clinic were included in the study.

Student therapists described the study to individuals who met the above criteria. After the client expressed interest in study participation, the student therapist obtained a signed consent from the individual. The experimenter conducted the semi-structured interviews (see Appendix F) over the phone or in person when possible. Participants gave verbal consent before beginning the interview and were solicited for any questions or concerns about the study. The experimenter took written notes during the interviews. Most

of the interviews lasted about 30 minutes with a range of 15-45 minutes in duration.

Participants were assured that the interviews are confidential and not shared with others.

Participants were offered a free therapy session at this clinic as an incentive for participation.

Analyses

Quantitative Data. For Hypothesis 1, three separate independent *t*-tests were conducted to analyze gender differences on the three dependent variables of interest (public stigma, self-stigma, and attitudes toward seeking therapy). For Hypotheses 2, 3, 4, and 5, bivariate correlations were performed to test the relationships among the variables of interest (public and self-stigma; stigma and distress; distress and intent; attitudes and distress). Hypotheses 6 and 7 require analyses of proposed mediating and moderating relationships among the variables in the proposed models in Figure 5 (relative importance, public stigma, self stigma, attitudes toward therapy, psychological distress, and intentions to seek therapy). A mediating variable accounts for the relationship between the predictor and the criterion variables, thereby strengthening this relationship. A moderating variable affects the strength of the relationship between the predictor and the criterion variables, in this case weakening the relationship (Baron & Kenny, 1986). Baron and Kenny indicate that researchers should test mediator and moderator effects with regression equations rather than an ANOVA. In the current study, structural equation modeling (SEM) was used because it is similar to multiple regression but is a more robust test of mediation and moderation (MacKinnon, Lockwood, Hoffman, West, & Sheets, 2002). In addition, Weinstein (1993) suggests using SEM to test the theory of reasoned action. SEM was used with the analysis of moment structures program (AMOS). A baseline fit index will be used because it compares a baseline model with the hypothesized model (see Figures 5). This procedure allowed an evaluation of the

significance and strength of the hypothesized relationships, the variance accounted for in prediction of intentions to seek therapy, and the degree to which the overall model fits the observed data (Kline, 2005).

Qualitative Data. The qualitative data were coded and analyzed with procedures outlined by Glaser and Strauss (1973). These authors recommend reviewing each new interview as it is obtained to help inform the interviewing strategy for each subsequent participant. The experimenter reviewed each interview as it was gathered and coded the responses into similar categories. The data were coded into similar emergent themes (e.g., stigma), and each concept was grouped into a distinct category.

Results

Gender Comparisons

All statistical analyses were conducted with SPSS 15.0 and AMOS 7.0. Two participants were excluded from some analyses due to missing demographic information. As an evaluation of the first hypothesis, independent samples t-tests were conducted to determine if there were any significant gender differences in the study variables. The first hypothesis stated that men will report significantly more stigma (public and self) and have significantly more negative attitudes than women toward seeking therapy. This hypothesis was partially supported. There was not a significant difference between male and female recognition of public stigma toward individuals with a psychological disorder. However, there was a significant gender difference on self-stigma toward seeking help for a psychological problem $t(254) = 3.04, p < .01$. This suggests that men ($M = 26.68, SD = 6.62$) are more likely than women ($M = 24.04, SD = 6.48$) to experience self-stigma. In addition, there was a significant gender difference for attitudes toward seeking therapy $t(255) = -3.73,$

$p < .001$. In this sample, men ($M = 15.89$, $SD = 5.09$) reported less favorable attitudes toward seeking therapy than women ($M = 18.54$, $SD = 5.45$).

Additional independent samples t-tests were conducted to determine if there were any other significant gender differences among the study variables. There were no significant differences between the men and women surveyed for psychological distress, self-efficacy, and perceived social support. Among the subscales on the Hopkins Symptom Checklist, there was a significant gender difference for the General Feelings of Distress subscale $t(255) = -2.67$, $p < .01$. This suggests that the men ($M = 11.48$, $SD = 3.80$) in this sample were experiencing less general feelings of distress than the women ($M = 13.01$, $SD = 4.56$). There was also a significant gender difference for intentions to seek therapy $t(254) = -2.05$, $p < .05$. This finding suggests that men ($M = 17.62$, $SD = 4.81$) are less likely than women ($M = 19.11$, $SD = 5.75$) to plan on seeking help for a psychological problem.

Racial Comparisons

Multiple independent samples t-tests were conducted to determine if there were any racial differences among the study variables. All United States minority cultures surveyed in this study were combined into one group and compared to European Americans. Of note, there were no significant differences among these cultures for attitudes and intentions toward seeking therapy. The only significant differences between these two groups were on the General Feelings of Distress subscale of the Hopkins Symptom Checklist $t(255) = -2.42$, $p < .05$ and perceived social support $t(255) = -2.40$, $p < .05$. This suggests that the participants representing the majority culture ($M = 13.0$, $SD = 4.90$) experience more general feelings of distress than those individuals representing the minority cultures ($M = 11.63$, $SD = 3.06$). This is despite the finding that individuals of the majority culture ($M = 46.76$, $SD = 9.14$)

perceived higher levels of social support than participants from the minority cultures ($M = 43.89$, $SD = 9.24$).

Treatment

Independent samples t-tests were conducted to determine if there were any differences between individuals who have and have not received professional psychological treatment. There was not a significant difference in recognition of public stigma, but there was a significant difference between these two groups on self-stigma $t(256) = -3.94$, $p < .001$. This finding suggests that individuals who have received psychological treatment ($M = 22.91$, $SD = 6.49$) experience less self-stigma than individuals who have not received these services ($M = 26.18$, $SD = 6.43$). There was a significant difference between these two groups for attitudes toward therapy $t(257) = 6.68$, $p < .001$. This suggests that the individuals who have attended therapy ($M = 20.35$, $SD = 5.18$) have more favorable attitudes toward treatment than the individuals who have not attended these services ($M = 16.01$, $SD = 5.00$). Further, there was a significant difference between these two groups for intentions to seek therapy $t(256) = 2.85$, $p < .01$. This finding suggests that individuals who have received therapy ($M = 19.82$, $SD = 5.66$) are more likely than individuals who have not received therapy ($M = 17.82$, $SD = 5.35$) to plan on seeking help in the future for a psychological problem. Finally, there was a significant difference between these groups for psychological distress $t(257) = 4.28$, $p < .001$. This suggests that individuals who have attended therapy ($M = 40.12$, $SD = 10.86$) were experiencing higher levels of psychological distress than individuals who have not attended these services ($M = 34.91$, $SD = 8.59$).

Independent samples t-tests were conducted to determine if there were any differences between individuals who identified past barriers to seeking treatment and those

who did not identify any barriers. There were not any significant differences between these groups for public stigma, self-efficacy, social support, and intentions to seek therapy. There was a significant difference between these two groups for self stigma $t(256) = -2.52, p < .05$. This suggests that individuals who identified past barriers to treatment ($M = 23.34, SD = 5.99$) experience less self-stigma than individuals who did not identify these barriers ($M = 25.61, SD = 6.78$). Further, there was a significant difference between these two groups for attitudes toward therapy $t(257) = 5.82, p < .001$. This suggests that individuals who identified past barriers to treatment ($M = 20.58, SD = 4.85$) have more positive attitudes toward therapy than individuals who did not identify these barriers ($M = 16.45, SD = 5.28$). Finally, there was a significant difference between these two groups on psychological distress $t(257) = 2.65, p < .01$. This suggests that individuals who identified past barriers to treatment ($M = 39.39, SD = 9.66$) experience more psychological distress than individuals who did not identify these barriers ($M = 35.85, SD = 9.72$).

Stigma

Bivariate correlations were conducted to evaluate the second hypothesis. The second hypothesis stated that there will be a significant positive relationship between public stigma and self-stigma. This hypothesis was supported with a modest positive correlation, $r = .18, p < .01$ (Cohen, 1988). This finding suggests that higher levels of perceived societal stigma toward mental illness were related to higher levels of self or internalized stigma for seeking help for a psychological problem. Of note, public stigma was not significantly related with any other variable in this study. Bivariate correlations were used to test the third hypothesis. This hypothesis predicted a significant positive relationship between self-stigma and psychological distress. There were not any significant correlations between self-stigma and

the total level of distress or subscales on the Hopkins Symptom Inventory and the hypothesis was not supported. However, although not predicted, self-stigma was negatively correlated with attitudes towards seeking psychological treatment, $r = -.51, p < .001$ and intentions to seek help for a psychological problem, $r = -.25, p < .001$. This indicates that higher levels of self-stigma were associated with less favorable attitudes toward seeking therapy and lower intentions to seek treatment.

Attitudes toward Therapy

Bivariate correlations were conducted to evaluate the fourth hypothesis. This hypothesis focused on the relationship between attitudes toward seeking therapy and psychological distress. There was a small positive correlation between these two variables, $r = .18, p < .01$. This suggests that higher levels of psychological distress are associated with more favorable attitudes toward seeking therapy. There was only one other significant relationship between attitudes toward seeking therapy and the other variables. There was a significant positive correlation between attitudes and intentions to seek therapy, $r = .41, p < .001$. This finding suggests that more favorable attitudes toward seeking therapy are associated with higher intentions to seek help for a psychological problem.

Intentions to Seek Therapy

Bivariate correlations were used to evaluate the fifth hypothesis. This hypothesis stated that there will be a significant positive relationship between psychological distress and intentions to seek therapy. This hypothesis was not supported, as there were not any significant correlations between intentions to seek therapy and the total level of distress or subscales on the Hopkins Symptom Inventory.

Social Support & Self-Efficacy

Bivariate correlations were conducted to determine if there were any significant relationships between perceived social support and other study variables. There was a small significant negative relationship between perceived social support and self-stigma, $r = -.13$, $p < .05$ suggesting that higher levels of social support are related to lower levels of self-stigma. Further, there was a significant negative relationship between perceived social support and psychological distress, $r = -.33$, $p < .001$, suggesting that higher levels of social support are associated with fewer symptoms of psychological distress. Perceived social support was positively correlated with intentions to seek therapy, $r = .30$, $p < .001$ and self-efficacy, $r = .31$, $p < .001$. This suggests that higher levels of perceived social support are related to higher intentions to seek treatment for a psychological problem. Further, it appears that higher levels of social support are associated with higher levels of self-efficacy. The only significant correlation not already mentioned was a negative relationship between self-efficacy and psychological distress, $r = -.31$, $p < .001$. This suggests that higher levels of self-efficacy are associated with fewer symptoms of psychological distress.

Structural Equation Modeling

Structural equation modeling (SEM) with AMOS 7.0 (Analysis of Moment Structures) was used to analyze the interactions among the study variables (Kline, 2005). SEM is similar to multiple regression, as they both are extensions of the general linear model. However, SEM is a more robust test of mediation and moderation relationships than multiple regression procedures (MacKinnon et al., 2002). Further, SEM provides several distinct advantages relevant to this data analysis (Kline, 2005):

- SEM has more flexible assumptions particularly in regard to the presence of multicollinearity.
- SEM provides the ability to model error terms.
- SEM allows the testing of complete models rather than only focusing on individual relationships.
- Mediating variables can be included in a single model as predictors.
- The ability to compare multiple models without succumbing to statistical error.
- The inclusion of “modification indices,” which suggest changes that lead to a more powerful model.

AMOS provides several goodness of fit indices for evaluating model fit. However, there is little agreement on which of these indices should be used (Hu & Bentler, 1999; Kline, 2005). Kline suggests using at least four indices to evaluate goodness of fit, which must include chi-square, the only statistical test of absolute fit, and three tests of relative fit. Based on the suggestions of these researchers, the following four goodness of fit indices were used to examine the proposed models: chi-square (should *not* be significant for good model fit), Tucker Lewis fit index (TLI; .95 or greater), comparative fit index (CFI; .95 or greater), and the root mean square error of approximation (RMSEA; .06 or less). All models were tested for gender differences and discrepancies in individuals experiencing low (N = 133) and high (N = 126) levels of psychological distress (separated near median distress level). In the following sections, each figure with a statistically significant model has unstandardized regression weights for each path.

Original Models. The test models in this section are a test of Vogel and his colleagues' (2007) theory, and therefore, include only the original variables (public stigma,

self-stigma, attitudes toward therapy, and intentions to seek therapy) analyzed in this study. Their structural model was successfully replicated with the data from the current study (see Figure 6). This structural model showed an excellent fit to the data, $\chi^2(3, 259) = 1.80, p = .62$ (TLI = 1.03; CFI = 1.00; RMSEA = .00). This suggests that perceived public stigma predicts self-stigma, and self-stigma predicts attitudes toward therapy, which, in turn, predicts intentions to seek therapy. Public stigma accounted for 3% of the variance for self-stigma, self-stigma accounted for 26% of the variance for attitudes toward therapy, and attitudes toward therapy accounted for 17% of the variance for intentions to seek therapy.

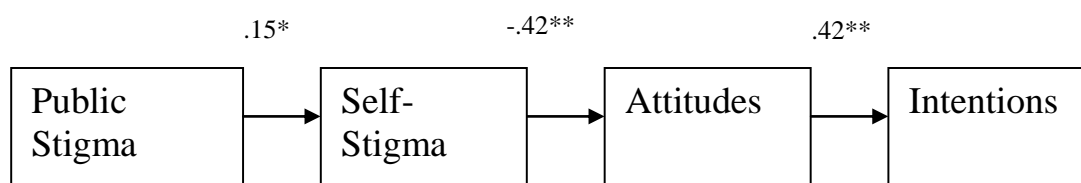


Figure 6. Replication of Vogel et al's (2007) Model. * $p < .01$, ** $p < .001$

It was hypothesized that the model in Figure 7 would be a good fit for the data because it directly adhered to the theory of reasoned action (Ajzen & Fishbein, 1980). Vogel's model differs from the theory of reasoned action because it implicates that there is one direct path in the prediction of intentions to seek therapy, whereas the theory of reasoned action proposes that two separate paths (personal attitudes and societal influences) predict intentions to engage in a behavior. However, the model depicted in Figure 7 was not an adequate fit for the data $\chi^2(3, 259) = 79.21, p = .00$ (TLI = -1.01; CFI = .40; RMSEA = .31),

because attitudes toward therapy had a significantly stronger beta weight ($\beta = .39$) than self-stigma ($\beta = -.04$) in predicting intentions to seek therapy.

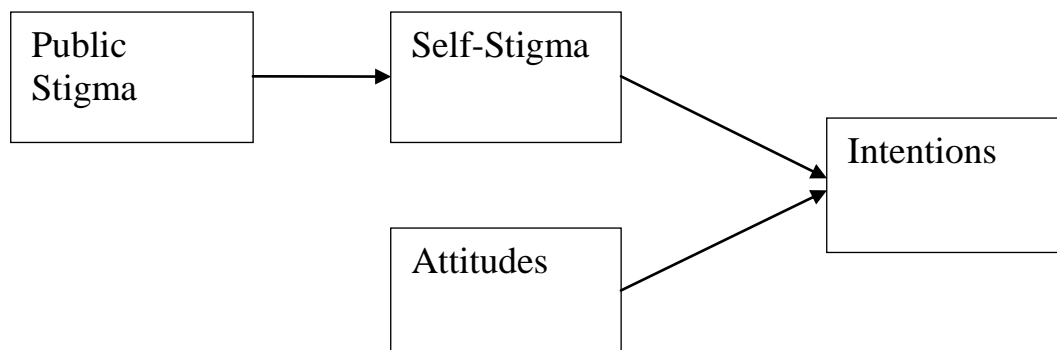


Figure 7. Hypothesized Theory of Reasoned Action Model.

Distress Models. The test models included in this section evaluate the addition of the psychological distress variable in relation to the variables included in the preceding section (public stigma, self-stigma, attitudes toward therapy, and intentions to seek therapy). As stated in hypothesis 7, there were no firm a priori models for psychological distress because it has not been included in any studies with all of these variables. However, based on the results from the preceding section, it was expected that a linear model with psychological distress would be the most parsimonious and provide the best fit for the study data. In addition, as cited earlier, the absence of a measure of psychological distress in Vogel et al.'s (2007) study seemed to be a significant confounding factor in the conceptualization of self-stigma for a mental illness. Therefore, the initial model with the inclusion of psychological distress (see Figure 8) suggested that psychological distress would mediate the relationship between perception of public stigma and self-stigma. This was hypothesized because the

relationship between both types of stigma is likely to be partially dependent on the personal internalization of societal stigma for individuals experiencing psychological distress.

However, the model in Figure 8 was not an adequate fit for the entire data set, $\chi^2(6, 259) = 25.29, p = .00$ (TLI = .65; CFI = .86; RMSEA = .11). This model was analyzed to determine if there were any significant differences between the two levels of distress (low and high).

Interestingly, the structural model showed a good fit to the data for individuals experiencing high levels of distress, $\chi^2(6, 124) = 7.35, p = .29$ (TLI = .95; CFI = .98; RMSEA = .04). This model demonstrates the same predictive relationships as the preceding “Vogel model” (Figure 6). Further, when psychological distress is high, it mediates the relationship between public stigma and self-stigma. However, upon review of the regression coefficients, the relationships between both public stigma and psychological distress and distress and self-stigma were both not significant at $p < .05$. Further, these relationships accounted for little of the variance within the model. Therefore, this model should be rejected on the basis of these findings.



Figure 8. Initial Proposed Mediation Model for Psychological Distress.

Several other proposed models were tested to determine the best fit model including psychological distress. The most parsimonious model is shown in Figure 9. This structural model exhibited an excellent fit to the data, $\chi^2(6, 259) = 3.24, p = .78$ (TLI = 1.05; CFI =

1.00; RMSEA = .00). In this model, attitudes toward therapy are predicted by two distinct paths. On one path are both of the stigma variables, where public stigma predicts self-stigma and self-stigma contributes to the prediction of attitudes toward therapy. On the other path, psychological distress contributes to the prediction of attitudes toward therapy. This model suggests that attitudes toward therapy is the best direct predictor of intentions to seek therapy. Public stigma accounted for 3% of the variance for self-stigma, self-stigma and psychological distress accounted for 31% of the variance for attitudes toward therapy, and attitudes toward therapy accounted for 17% of the variance for intentions to seek therapy.

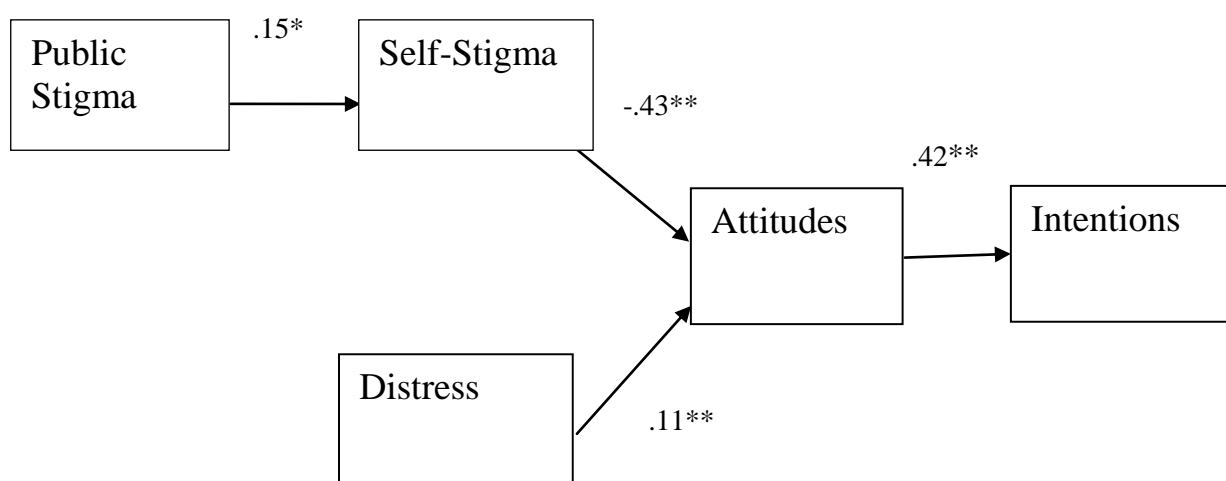


Figure 9. Mediation Model with Psychological Distress. * $p < .01$, ** $p < .001$

Social Support Models. The test models in this section evaluate the addition of the social support variable in relation to variables included in the preceding sections (public stigma, self-stigma, psychological distress, attitudes toward therapy, and intentions to seek therapy). The first model tested was similar to Cramer's (1999) model (see Figure 2) to determine if there were any similarities to the two data sets. Cramer did not incorporate

measures of stigma, so they were not included in this data analysis. On the other hand, the “self-concealment” variable was included in his model but not the current study. The rationale for testing this model is that Cramer’s model provided a theoretical basis to assess the inclusion of social support within a model evaluating barriers to psychological treatment. The model tested with the current data is shown in Figure 10. Unsurprisingly, this model was not a good fit to the data, which is likely explained by the absence of self-concealment, $\chi^2(3, 259) = 36.26, p = .00$ (TLI = -.06; CFI = .68; RMSEA = .21). The other possible reason for the failure of this model was the absence of a significant relationship between psychological distress and intentions to seek therapy.

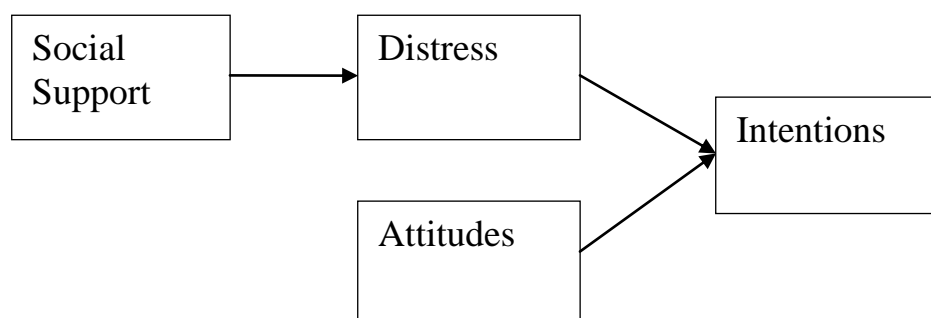


Figure 10. Initial Proposed Mediation Model for Social Support.

Based on Cramer’s (1999) model and the mediated model in Figure 9, it was expected that social support would directly influence psychological distress (see Figure 11). However, this model was not a good fit to the entire data set. It was an excellent fit for the male sample in this study, $\chi^2(10, 84) = 4.10, p = .94$ (TLI = 1.19; CFI = 1.00; RMSEA = .00). Social support is added to beginning of the psychological distress path in order to predict this

variable. All of the other predictions are the same as the mediation model shown in Figure 9. In the model below, public stigma accounts for 8% of the variance in self-stigma and social support accounts for 12% of the variance in psychological distress. The combination of self-stigma and psychological distress account for 28% of the variance in attitudes toward seeking therapy. Finally, attitudes toward seeking therapy accounts for 16% of the variance in intentions to seeking therapy.

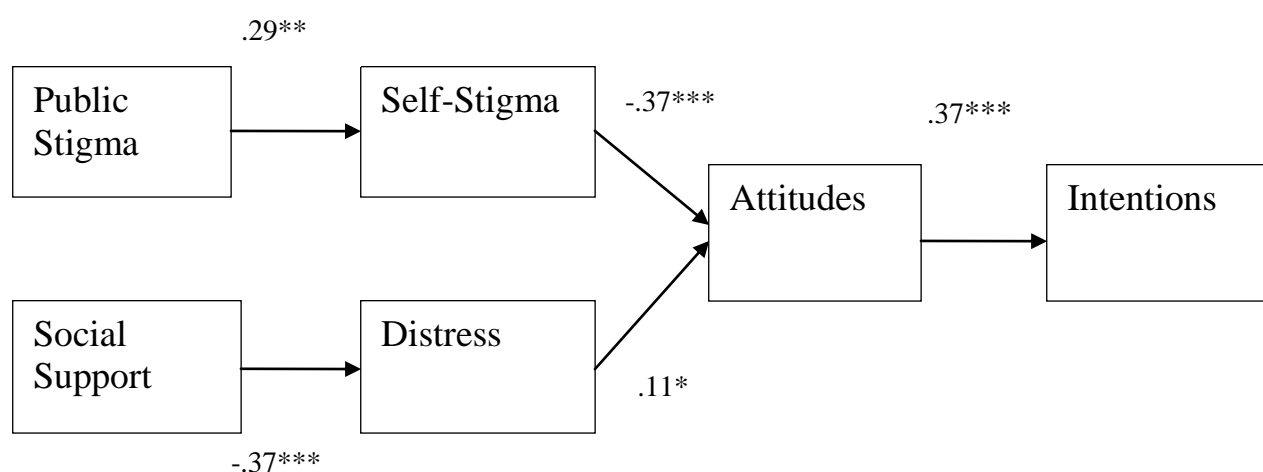


Figure 11. Mediation Model for the Male Sample. * $p < .05$, ** $p < .01$, *** $p < .001$

Despite the excellent fit to the data of the male sample in Figure 11, this model does not explain the role of social support for the entire data set. It seemed that maintaining the position of social support as seen in the above model was theoretically supported by the findings in Cramer's (1999) study. Further, availability and quality of social support is likely to directly affect an individual's decision to seek help for a psychological problem. However, there are inconsistent findings in the literature for the relationship between social support and attitudes and intentions to seek therapy (Begeron et al., 2005; Briones et al.,

1990; Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Narikiyo & Kameoka, 1992; Rickwood & Braithwaite, 1994; Saunders, 1996; Thoits, 1986). The most compelling finding from these studies was that 90% of individuals who attended therapy were encouraged to seek treatment by a loved one (Saunders, 1996). Therefore, it was predicted that there would be a direct, positive relationship between social support and intentions to seek therapy in the model. Indeed, this structural model was an excellent fit to the data (see Figure 12), $\chi^2(9, 259) = 10.40, p = .32$ (TLI = .98; CFI = .99; RMSEA = .02). This model has the same predictive paths as the model seen in Figure 11 with the inclusion social support as another predictor of intentions to seek therapy. In this model, public stigma accounts for 3% of the variance in self-stigma and social support accounts for 11% of the variance in psychological distress. The combination of self-stigma and psychological distress account for 31% of the variance in attitudes toward seeking therapy. Finally, the combination of social support and attitudes toward seeking therapy accounts for 22% of the variance in intentions to seek therapy.

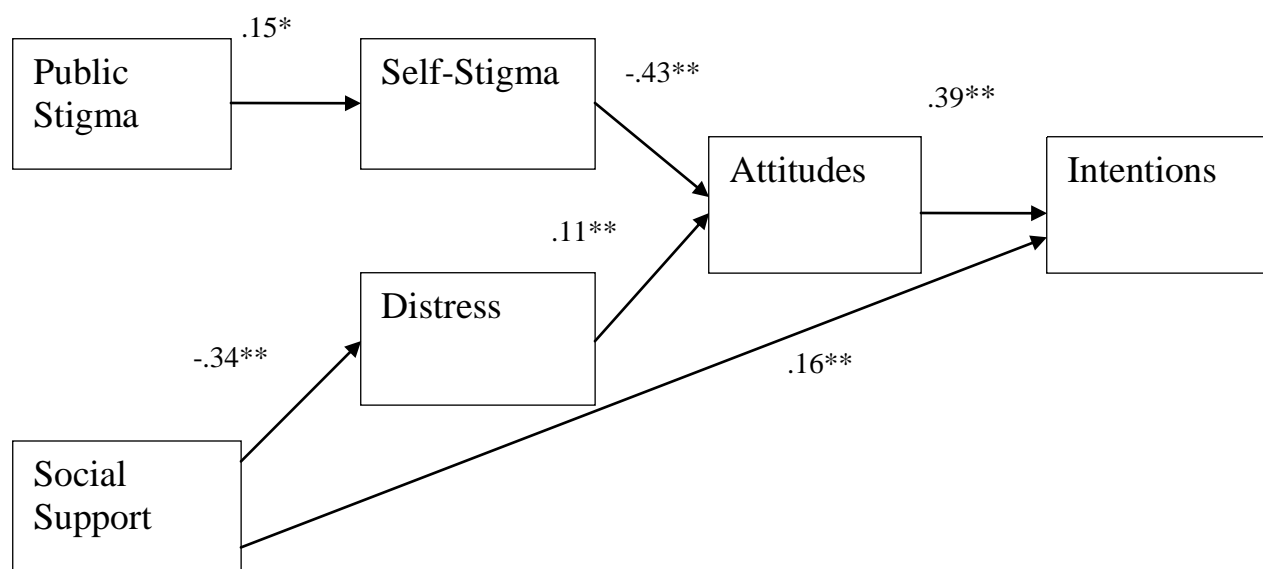


Figure 12. Social Support Mediation Model for the Entire Sample. * $p < .01$, ** $p < .001$

Self-Efficacy Model. The model in this section focused on the addition of the self-efficacy variable in relation to variables included in the preceding sections (public stigma, self-stigma, social support, psychological distress, attitudes toward therapy, and intentions to seek therapy). Unfortunately, there was no theoretical guide for inclusion of self-efficacy among the other study variables because this construct has rarely been included in studies of barriers to seeking therapy (Jackson et al., 2007). Further, the relationship between self-efficacy and the two different types of stigma is unclear (Corrigan et al., 2006). Indeed, bivariate correlations in the current data analysis show no significant relationships between stigma and self-efficacy. There was a model including self-efficacy (see Figure 13) that was a good fit to the data, $\chi^2(13, 259) = 16.12, p = .24$ (TLI = .97; CFI = .99; RMSEA = .03). This model has the same predictive paths as the model seen in Figure 12 with the inclusion of self-efficacy as a predictor of social support and psychological distress. In this model, public stigma accounts for 3% of the variance in self-stigma, and self-efficacy accounts for 10% of the variance in social support. Further, self-efficacy and social support account for 16% of the variance in psychological distress. The combination of self-stigma and psychological distress account for 31% of the variance in attitudes toward seeking therapy. Finally, the combination of social support and attitudes toward seeking therapy accounts for 21% of the variance in intentions to seeking therapy.

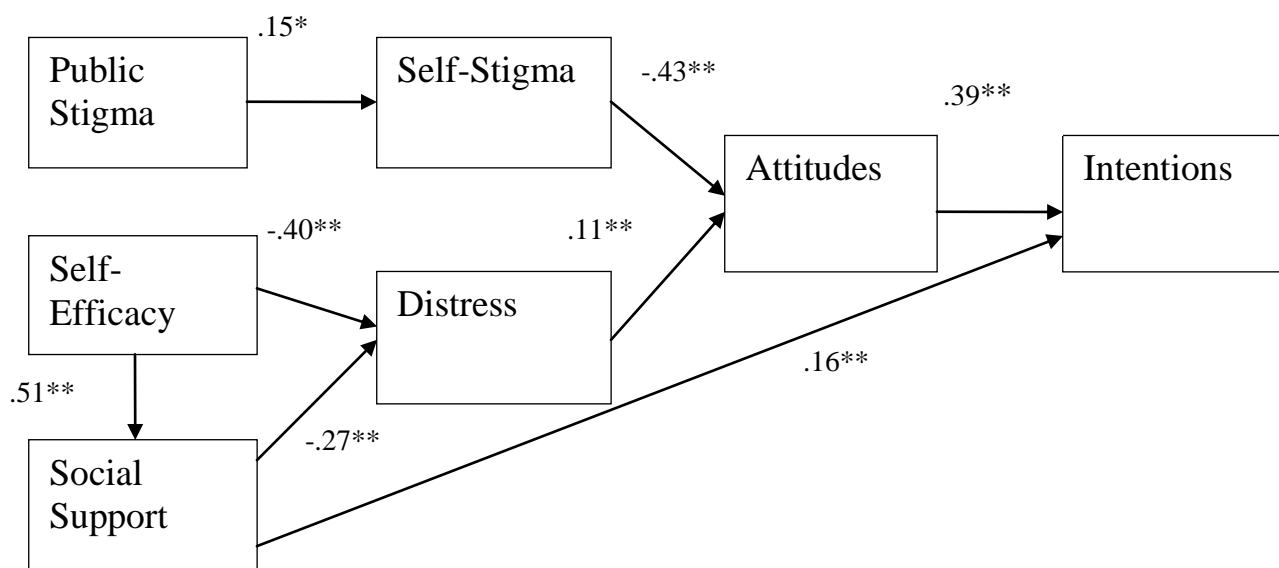


Figure 13. Self-Efficacy Mediation Model. * $p < .01$, ** $p < .001$

Past Barriers to Treatment

Participants were provided with the opportunity to list any past barriers to seeking professional psychological treatment. They responded to the following question: “Have you ever felt you may have benefited from professional psychological help in the past for a personal problem but did not seek such help?” If participants answered “yes” to this query, they were requested to qualitatively provide the specific barrier. There were 74 participants (28.6%) who indicated that they encountered past barriers to seeking psychological treatment. The majority of the participants who endorsed this statement were female (81.1%) and Caucasian (78.4%). There were three participants (4.0%) who did not provide a qualitative response, and eight participants (10.8%) who seemed to misunderstand the question. Based on the responses of the latter set of individuals, it seems that they were currently in psychotherapy and were describing the purpose of their treatment (e.g., “issues

with substance abuse, court ordered to seek therapy” or “anger management”). The remaining responses (N = 80) were separated into structural (e.g., money) and attitudinal (e.g., shame) barriers. There were more responses than participants who endorsed barriers because some individuals provided multiple responses which were coded into more than one category. More participants listed attitudinal barriers (54.0%) than structural barriers (21.6%), with seven individuals (9.4%) providing at least one response in both categories.

Structural barriers. Within this category, there were 29 responses coded into three separate subcategories: knowledge, monetary concerns, and time. Structural barriers are obstacles primarily created by the system, in this case, the institution of psychotherapy. Although individuals can overcome these barriers on their own, the “system” of psychotherapy can significantly modify structural barriers to increase client access. For example, an individual can seek more information on psychotherapy if interested, but the “system” of psychotherapy can increase general knowledge of treatment through public education. This is also relevant for the other two subcategories (money and time), as mental health professionals could decrease access issues by offering reduced rates and evening/weekend appointments. However, structural barriers continue to be prevalent within the mental health system, which in turn restricts admission for possible consumers.

There were six individuals who reported that a lack of knowledge about professional psychological services was a significant barrier to seeking treatment in the past. It is obvious that if an individual is not knowledgeable about the location of services or the process of seeking psychological help, it is likely to be a significant barrier. Indeed, mental health services are not as visible as physical health services, evidenced by the statement of a female participant: “(I) didn’t really know where to start looking for help.” This was corroborated

by another female participant who explained that she “didn’t know the steps to take.” The knowledge barrier seemed to be significant for these participants as one woman stated, “I didn’t know where to go for help!” (emphasis in original statement).

There were 17 participants who indicated that insufficient money was a past barrier to seeking psychological services. It seems that several participants would have sought treatment if psychological help were more affordable. Mental health services are often expensive, which was iterated by a male participant, “It’s (treatment) quite costly.” These participants related to the stereotypical role of the “poor college student”: “didn’t have the resources or money,” “no insurance, too expensive,” and “never had the money.” Further, a female student was not aware, yet worried of the cost of treatment, “I was afraid it would cost too much.” It is likely that many of these college students did not possess the financial resources or have appropriate health insurance to help cover the high price of therapy.

There were six participants who reported that insufficient time was a past barrier to seeking psychological services. Attaining psychological services requires significant time and effort, which may not be available for individuals with a hectic life (e.g., “No time...I have a very busy schedule” or “I didn’t have the time or energy”). A male participant stated that he “never got around to it (seeking treatment),” which suggests that attending psychotherapy was not an important consideration in his busy schedule. These participants seemed to be describing the lack of time available in their own day rather than discussing unavailability of clinicians for extended hours. However, it is possible that increased availability of evening and weekend clinic hours would reduce the effects of this barrier.

Attitudinal Barriers. Within this category, there were 51 responses coded into four separate subcategories of barriers: lack of awareness concerning the severity of their

problem, belief that they did not need help to overcome problem, family, and fear and shame. Attitudinal barriers to seeking psychological services are often obstacles outside the control of the actual system. These barriers are primarily regulated to the personal beliefs of individuals or the general societal viewpoint (including family members and friends) of the system of mental health treatment and disorders. For example, feelings of shame related to seeking psychological treatment arise from the negative stereotypes pervading, in this case, American society. It should be noted that psychological services can directly affect these personal and societal viewpoints, as these services are not residing inside of a vacuum. Further, mental health organizations could make subtle changes to alleviate some of these attitudinal barriers with advocacy campaigns (e.g., *Real Men, Real Depression*; National Institute of Mental Health, 2003). However, it is likely that reduction of stigma and poor attitudes toward psychological problems and treatment are more difficult to alter than structural barriers.

There were four participants who indicated that their lack of awareness concerning the severity of their problem prevented them from seeking psychological help in the past. Indeed, a female participant seemed to be truly unsure that her problem warranted treatment, saying “I didn’t know if it was a big enough problem to actually seek help.” There is likely to be a pervading thought that professional psychological treatment is for “people with more severe problems than my own.” The remaining three participants in this category seemed to dismiss their problems. For example, a female student stated that “(she) didn’t see how bad things really were.” Individuals contemplating seeking psychological services may believe that their problem is not significant and different than the “norm.” It was easier for the last two individuals to view their past problem as significant in hindsight than it was when they

were in the midst of their struggle. “(I) felt like what I was going through did not matter at the time.” Further, a female participant explained that “I didn’t realize it was a problem until after. I was depressed in high school but I thought everyone felt that way.” She seemed to express the hope that the difficulty she was experiencing was no different than the personal struggles of others.

There were 15 individuals who identified with the belief that they did not require professional help to overcome their emotional struggles. The popular sentiment among these participants was that they preferred to tackle the problem on their own. “I felt I could overcome it on my own,” “I wanted to get through the problem on my own,” “Because I felt like I was capable of dealing with the problem myself,” “I tried to deal with it alone, I felt I could do it alone,” and “It was a situation that only I, myself, could answer.” Indeed, some individuals discovered that the issue was alleviated without professional aid, “it worked itself out, I made permanent changes to fix the issue” and “I didn’t really think of it at the time, the issue has since worked itself out.” A female participant did not seek therapy despite encouragement from a family member, “I figured I would get over it, just a ‘bump in the road’ in my life even though my mom told me to seek help... wasn’t motivated to look.” It is not surprising that this desire for independence was a barrier to treatment for several individuals (Nadler, 1997). Unfortunately, there are still misconceptions about professional treatment that may prevent some individuals from attaining possibly beneficial help. This is exhibited by the statement of a female participant, “I guess I hate being told how to feel.”

There were seven participants who reported that their family was a significant past barrier to seeking treatment. It seems that some participants learned early lessons about the value of psychological services. As one female participant explained, “I was young and my

parents did not think highly of psychologists... and they told me things would get resolved on their own and with time.” This is certainly an example of other individuals shaping the development of attitudes toward therapy. Psychotherapy often requires an individual to be forthcoming with personal information, which may be in conflict with a person’s upbringing. Two female participants identified this as a barrier to seeking psychological services, saying “it (therapy) was not spoken of in my family” and referring to “(my) family’s stoic upbringing.” It seems that one female participant continues to experience the pressure from her family to avoid psychological treatment “because my family thinks it’s not suitable for me to seek professional psychological help.” It is possible that the feelings of shame that may be associated with the experience of an emotional problem originated from their familial belief system.

There were 25 participants who stated that feelings of fear and shame prevented them from seeking psychological services. The largest number of responses was coded into this subcategory. It seems that the potential of attending psychological services produced feelings of fear and anxiety in several individuals. Two participants simply expressed these feelings with one word responses, “afraid” and “anxiety.” An individual would be certainly hesitant to seek these services if just the thought of it led to anxiety. A female participant expressed her apprehensiveness towards therapy, saying “it’s (therapy) a change, and I would probably be scared at first.” Indeed, a male participant was fearful of scheduling for an appointment at the time of the current study, stating “I’m afraid to make an appointment.” Some participants were afraid to reveal their internal struggles to others (e.g., “fear of sharing myself” and “I didn’t want to tell anyone about my issues”). This was also exhibited by a female participant who said, “I was very hesitant and did not want to admit to an issue.” In

particular, a male participant was afraid to reveal his emotions to others, admitting that he was “scared to express feelings or unsure how to do so.” A female participant was afraid of the feedback she may receive from a mental health professional, as she explained that she was “afraid of what (she) might hear.” Finally, a female participant was concerned about the implications on her future as a mental health professional if she were to utilize services, stating “I was/am worried it will affect my career in psychology.” It seems that even future mental health professionals are affected by the stigma associated with psychological disorders and its treatment.

Several participants indicated that feelings of shame prevented them from seeking therapy in the past (e.g., they were “too embarrassed to seek help” or “too ashamed to ask for help”). For two female participants, this shame was regulated to their specific problems, “embarrassment for eating disorders” and “I was too embarrassed at the prospect of admitting I was depressed.” A female participant indicated that “it felt uncomfortable to seek help,” but she did not report the source of this discomfort. However, another female participant was able to identify the source of her discomfort. “I didn’t feel comfortable going and I didn’t know what others would perceive me as.” Some participants were concerned about how others would perceive them if they sought psychological help (e.g., “afraid of what others would think”). A female participant’s shame and desire to hide her problem was evident from her statement “I didn’t want help, and I didn’t want anyone to know.”

It is possible that individuals view attending professional psychological services as a personal failure. For example, a female participant indicated that she would be “embarrassed about how (she) couldn’t solve (her) own problems and cope with them.” Two participants, one male and one female, suggested that they would be a “tainted” person if they attended

therapy. “Because I don’t feel like talking with someone I barely know. If I did I would feel less of myself.” “Because although I see it as a good solution for many, I somehow feel as though I would be ‘defeated’ or failed if I were to do the same” (emphasis in original statement). It seems that the sense of shame and failure was a significant barrier for several individuals. Indeed, it appears that one female participant continued to struggle with feelings of shame. “I didn’t seek help because of the feeling of being ashamed. I do regret it; however, (I am) unsure if I should seek help now.”

Qualitative Data

The purpose of this portion of the study was to supplement and enrich the quantitative analysis with interviews from a clinical sample. This data collection was also focused on gathering information on barriers to seeking therapy and the stigma associated with psychological treatment but used a qualitative approach. The sample differs from the sample of the quantitative analysis in that these participants were all attending therapy at the time of the interviews. These individuals provided a narrative of their thought processes as they made the decision to attend professional mental health treatment. The questions that were used to guide the interviews are listed below:

1. Tell me about your experience with seeking counseling.
2. Tell me the ways you have used to deal with your problem.
3. Tell me the reason that you are seeking treatment now.
4. Tell me about what prevented you from seeking counseling earlier than you did.
5. Tell me about any problems you have experienced in relation to having a mental or behavioral problem.
6. Have you told anyone that you are seeking counseling, and if so, how did they react?

Each interview was evaluated for themes as they were completed in compliance with grounded theory methods (Glaser & Strauss, 1973). The general themes that emerged from analyses were: *coping strategies implemented before beginning treatment, structural barriers to therapy, attitudinal barriers to therapy, experiences with stigma and prejudice, and social support*. Participants described the coping strategies, other than therapy, that they had implemented to reduce their suffering. This often led to a discussion of their initial realization that therapy might be beneficial. However, every individual encountered more than one type of barrier related to seeking therapy. Many of these barriers were similar to the ones described in the previous section but there were two interesting exceptions, language and negative attitudes toward therapy. Because all of the participants were currently in therapy, they were able to describe actual experiences of prejudice and stigma that were related to their psychological problem and their therapy attendance. Finally, individuals described the positive support received from others throughout the process of therapy-seeking.

Coping Strategies. Every participant viewed therapy as a possible aid in improving their condition, but it was just one of many strategies that they implemented to further this goal. Some participants were able to identify more coping mechanisms than others. Some form of exercise was the most frequently listed coping strategy, as seven participants listed physical activity as a beneficial tool. Indeed, a female participant reported that her use of yoga was her most effective coping mechanism. Another important coping skill mentioned by five participants was discussion of their problems with friends and family members. A male participant indicated that he used “creative expression” (writing, art, and music), martial arts, and spirituality to cope with his depression. Conversely, three other participants

described a few activities but felt that “nothing really helped.” They felt that their repertoire of coping mechanisms was inadequate in improving their psychological functioning.

Participants described therapy as a “last resort” to help with coping when all else failed.

Some participants were able to consider their past use of therapy when making a decision to return to treatment. Seven out of the ten participants had attended therapy in the past before beginning their current treatment, so they were also able to discuss their past experiences with therapy. One would expect that past experiences with therapy would make it easier to return to treatment. Further, it would be less difficult to overcome the barriers associated with therapy. This was the case for some of the participants, as two individuals remarked that it was easier to return to therapy than it was to go for the first time because their initial treatment had been helpful. “I found it (therapy) to be a useful tool.”

Unfortunately, some individuals had ineffective and sometimes uncomfortable professional treatment. Indeed, two participants described poor therapy experiences (e.g., “pretty unpleasant and uncomfortable”) in the past. As one would expect, it was more difficult for these individuals to return to treatment in order to improve their psychological functioning.

Participants did not view therapy as an initially intriguing option, and some individuals described dealing with several years of struggles before seeking professional treatment. For example, a male participant expressed his regrets about avoiding counseling: “I maybe waited too long for therapy.” Each individual had to reach a “turning point” when they viewed therapy as a viable option. They discussed their realization that therapy would be likely to reduce some of their suffering. A male participant felt that his short time in therapy has been the most beneficial method of improving his condition. A female participant described her positive view of therapy in detail. “I view counseling as beneficial

because I've already done the things I know to do to recover and they're not as effective as I need them to be. So, it's time for me to seek outside assistance. I see it as a resource." One man described his interest in therapy for relationship issues. "I can't solve this (relationship problem) on my own." One female participant stated that she is now seeking therapy because she "started realizing how (she) was acting... it (anger) was causing problems... (she) wanted to get some help." Another participant explained that he had experienced several significant changes in his life recently and was interested in assistance in coping with these changes. Therapy eventually signified a symbol of guidance for positive change. Indeed, a female participant suggested that therapy would help facilitate a life transition. "I felt like it was time to get some help. It's time to grow up; I am trying to be an adult now."

Structural Barriers. There were nine structural barriers to seeking therapy reported by seven participants. Four of the six female participants and three of the four male participants described structural barriers that prevented them from attending therapy sooner. The majority of these structural barriers were organized into the same subcategories as were used in the quantitative data: knowledge, monetary concerns, and time. There was one exception described by a male participant. He said that language has been a barrier because he had met with a therapist for whom English was a second language. He felt that the therapist did not understand his perspective, and the participant regretted seeking therapy because of this uncomfortable situation. Therefore, he avoided returning to therapy for some time because he feared that he would encounter a similar situation.

The most frequently cited structural barrier to psychological treatment was monetary concerns. Four participants briefly described their "financial issues" related to the current economic crisis and cited these as barriers to seeking therapy (e.g., "I don't have a lot of

money laying around” or “money has been tight”). The high cost of psychotherapy even prevented one man from continuing with a favored psychologist. He indicated that he found a psychologist that he liked, but this practitioner reportedly charged \$225 per session. Indeed, the struggle to find affordable psychological care is a serious problem for many individuals. A male participant explained that most psychological services cater to more affluent individuals. He reported that he did not have insurance, so it was difficult to find reasonably priced mental health services. Some participants did not directly mention monetary issues as a barrier to treatment but expressed their belief that therapy was an expensive treatment modality. They did not realize that there are low fee treatment options until someone mentioned the clinic they were attending at the time of the interviews. If it is not well-known that low fee therapy is available, individuals may feel that psychological treatment is financially inaccessible.

Inadequate time was a structural barrier mentioned by two participants. Seeking therapy certainly requires adequate time to research different treatment options and practitioners and to schedule initial sessions. Further, a client must invest a significant amount of time in attending appointments when therapy is initiated. Indeed, two female participants stated that they were always too busy to seek out therapy. “I had no time to sit down to talk to anyone.” They were able to start therapy as soon as they were able to remove an obligation from their life. “I have more time now to go to therapy.” Both of these participants seemed to refer to a personal barrier rather than a limitation set by the mental health field. In other words, it is important to offer evening and weekend appointments for potential psychological consumers, but some individuals may still be too busy to utilize services.

Even if a person has available time to seek therapy, he/she may not possess adequate knowledge of the mental health system. A male participant described his lack of information simply, saying “I did not know where to go for help.” He believed that psychiatrists are the only available option for counseling. Another male participant struggled to make sense of the confusing mental health landscape. He wished for a simpler method of gathering information about available treatment options. “It is not obvious where to go for help like it is for a physician.” Indeed, people are likely to ask for referrals from coworkers, neighbors, friends, and family members when searching for a medical professional. As explained by the same participant, “You can’t really ask people, ‘who is your therapist?’ like you can with a mechanic.” Unfortunately, it is likely that people either do not possess that information or are not forthcoming with it. In addition, it seems that the mental health field is not providing consumers with easy access to this knowledge.

Attitudinal Barriers. As expected, there was more discussion of attitudinal barriers than structural barriers by individuals currently attending therapy. Almost every participant (nine) mentioned at least one attitudinal barrier to seeking therapy. A female participant was the only individual who did not report a past attitudinal barrier to treatment. There were 16 different attitudinal barriers listed by these individuals, which were coded into similar subcategories as the quantitative data. Participants in this part of the study described a lack of awareness concerning the severity of their problem, the belief that they did not need help to overcome their problem, and fear and shame related to attending psychological treatment. The one difference in themes between the quantitative and qualitative data was that none of the participants in this portion of the study said that their family provided barriers to therapy. However, a novel subcategory arose from the qualitative interviews, as four participants

indicated that their negative attitudes about psychotherapy prevented them from seeking treatment sooner than they did.

For some, negative attitudes were based on unpleasant past interactions with counselors. One woman reported that she would have sought therapy sooner if she had not had poor past experiences. Another man stated that his difficult experiences with therapy in the past led him to the following belief: “I don’t believe in the art of psychology.” Some individuals view therapy as a personally threatening experience that should be avoided. For people belonging to an individualistic and stoic culture, they do not approve of discussing their personal issues with others, especially a therapist who is unknown to them. As explained by one woman, she “didn’t want to talk about (her) problems with a complete stranger.” The threatening thought of discussing problems with a stranger is likely to lead individuals to develop negative attitudes to seeking therapy. It is certainly difficult to utilize services that one views as unfavorable. This same woman also admitted that she should have sought therapy earlier, but she had focused on the negative aspects of psychological treatment rather than considering any possible benefits. Another woman reflected on the transition from a negative to a positive attitude. “I was thinking that it (therapy) doesn’t make a difference, but I hit a point when I felt I finally needed to get help.”

Initially, some individuals are unaware that they have a significant problem or simply do not recognize the severity of their suffering. As stated by one woman, “I did not realize that I had a problem, so I did not consider therapy to be an option.” It is easy for some individuals to ignore their problem, thereby denying the potential need for treatment. A male participant clearly described his transition from ignorance of his problem, to lack of awareness of the severity of his problem, and finally to the present uncertainty he felt about

the value of continuing treatment. He explained that the initial barrier for him in seeking therapy was that he “didn’t know (he) had a problem... (he) didn’t realize (he) was depressed and anxious.” He finally recognized that he struggled with symptoms of depression and anxiety, but he did not view these issues as significant or severe. “I thought therapy was only for the very severe.” Many people believe that therapy is an appropriate treatment modality for others but not for them (e.g., Narikyo & Kameoka, 1992). Despite the fact that he is now in therapy, he continues to question his decision because he “does not perceive (himself) as crazy.” “I still think it (therapy) is for severe people... sometimes I think that I’m wasting the therapist’s time because my problem is not that bad.”

The independent and stoic personality traits so revered by Western culture often produce a significant barrier to seeking professional psychological help. When an individual encounters a serious problem, the first step is often to attempt to solve the issue without help from others. One man expressed this idea succinctly: “Most problems can be solved on their own.” This attitude can be problematic when those holding it are afflicted with a psychological problem, and it was the most frequently listed attitudinal barrier to seeking therapy. “I would prefer to work out problems on my own.” “I felt like I could deal with the problem on my own.” “I thought I could handle it on my own... I didn’t think I needed it.” “I thought I could do it on my own... I thought I could ignore it and it would go away.” This last statement was made by a young woman who struggled with grief related to the death of her mother for over a year until she admitted to herself that she required assistance. Understandably, professional counseling is not the first, second, or even third step for most individuals suffering with a psychological problem. Indeed, this woman indicated that therapy was her last resort after discussing her issues with her family, friends, pastor, and

college academic advisor. “I would not go to therapy until it got really bad... I had to hit rock bottom.”

The fear, embarrassment, and shame associated with “talking to a stranger” and discussing personal issues with a professional may fuel the desire to avoid treatment until all other possibilities are exhausted. One woman indicated that she considered seeking therapy sooner than she did, but that she feared discussing her problems with others and was afraid that she would be viewed by others as “crazy.” Participants reported that they preferred to hide their psychological problems from others because they were afraid that other people would discover their perceived deficiencies. A male participant stated that he would be “embarrassed” if his loved ones discovered that he was in therapy. Psychological problems and their treatment are often viewed in a negative light in American culture. Rather than being encouraged by others to seek help for their problems, many people struggling with psychological issues are made to feel ashamed or weak. Unfortunately, some of these individuals internalize this stigma, believing that they are deficient individuals because they requested help. One man reported that the internalization of the stigma associated with mental health treatment became “the single biggest hurdle” to overcome in order to attend therapy. “I believed that seeking therapy would be a weakness or a defect in myself.” He did not want to admit to a personal weakness; therefore, he avoided therapy for several years. Fortunately, he was able to overcome this barrier and is currently benefitting from therapy, but he feels that this internalized stigma led him to avoid treatment for too long.

Stigma. The majority of participants reported experiencing internalization of the stigma associated with mental health treatment and/or prejudice from others. The internalization of this stigma led several participants to believe that it was important to hide

the fact they were attending therapy in order to avoid embarrassment. "I'm very selective about who I tell... I wouldn't want other people to know." "I would prefer that other people do not know... I don't want to tell anyone." "I don't tell most people, it is a hidden thing... People don't share this sort of thing (therapy attendance)." There is a fear associated with revealing this personal, stigmatizing information to others. They may believe that other people will interact with them differently. "I'm afraid that my coworkers would act differently around me if they found out (I was in therapy)." One woman admitted that she used humor to cope with the uncomfortable reality that she is utilizing therapy. "I joke about going to therapy, so people will blow it off." She believed that her friends would ignore the fact that she was in therapy if she made it seem like it "was no big deal." This was certainly a unique tactic to avoid potentially embarrassing interactions.

Biomedical treatments are generally more accepted in society than psychological treatment modalities. It has less potential to be personally damaging if sessions are described as a "doctor appointment" rather than a "therapy appointment." Further, it may even be difficult to discuss the truth with loved ones. For example, one man reported that it has always been difficult, uncomfortable, and embarrassing to discuss his psychological problems with his family. In addition, he expressed his feeling that "it is easier to tell people that (he) is taking antidepressants." This participant and many other individuals in general may find it is easier to blame issues on physical concerns rather than psychological concerns. He explained that when he was struggling with depression and missing work, he would blame his truancy on his own or his wife's medical problems rather than his own psychological struggles ("you don't divulge that kind of stuff").

When it is divulged to other people that an individual is attending therapy, that individual sometimes encounters prejudice. The general consensus from participants was that society views individuals attending therapy as "weak." As explained by one woman, she noticed that other people viewed her in a "negative light" and "flawed in some way" when they discovered that she was seeking professional help. She stated that the primary message these individuals conveyed was that "therapy is for the crazy people." Indeed, an acquaintance of hers, who was coping with a similar issue, implied that she was "weak" because she needed therapy while this individual avoided it. Another female participant experienced institutional discrimination based on her psychological problem. She explained that her previous employer declined her short-term disability because of her severe depression. In addition, when applying for health insurance, companies either refused her coverage or required higher rates because of her preexisting psychological condition. One man seemed fully aware of the stigma associated with treatment and the related prejudice. He was not afraid to tell his friends that he was in therapy, but he recognized that "people altered their behavior when they found out." He noticed that people were "more cautious" around him in the "short-term" (i.e., they appeared to be more careful with their words around him). He believed that these people viewed him as "different" or "flawed" in some way; therefore, it was wise to be careful around him. In a blatant form of prejudice, some of his friends "completely removed themselves from (his) life" when they discovered that he was attending therapy. Based on these unfortunate experiences of prejudice, the fear of another male participant may be warranted. "I have always thought to myself, 'what if I tell my friends' (that I am in therapy)."

Support. Despite the experiences of stigma reported by these individuals, almost every participant (nine out of 10) indicated that a friend and/or family member encouraged therapy attendance (e.g., “a lot of people encouraged me to go to therapy”). Although this portion of the study is based on a small sample, it replicates another study in which 90% of individuals indicated that a loved one had encouraged them to seek professional psychological treatment (Saunders, 1996). Two participants explained that it was family members who had benefited from therapy who were able to effectively encourage these participants to seek professional help. It seems that people often benefit from the support of a loved one to “take the next step” in seeking therapy. Fortunately, support networks also influence continued participation in treatment, as all participants reported that they had family and friends who were accepting and supportive upon discovering that he/she was in therapy. One woman corroborated this: “They’re (mom and close friends) pretty happy, all positive reactions.” According to the findings from both methods of data collection, it is clear that social support is integral throughout the help-seeking process.

Despite the significant struggles associated with seeking therapy, every participant viewed his or her decision to attend treatment positively. Therapy was seen as a strategy that helped to improve their functioning by either supplementing other coping mechanisms or by helping them when everything else had failed. Many of these individuals may have been able to attend therapy sooner if it were not for the multitude of barriers associated with psychological treatment. While it is true that individuals must overcome the knowledge, time, and monetary barriers associated with any treatment (e.g., dental, medical), in the mental health field they are likely to also encounter negative attitudes and the stigma that is associated with it. It is unlikely that an adult individual asks “What will my mother think if I

go to the dentist for a cleaning?" However, many individuals have this concern and the related shame and embarrassment when they are considering psychological therapy. Fortunately, for the participants in this portion of the study, they found individuals in their social network that provided encouragement and support throughout the therapy seeking process. They may continue to experience the stigma associated with their treatment, but they are no longer alone in their suffering.

Discussion

The purpose of this study was to analyze the attitudinal barriers related to seeking psychological treatment. Frequently cited attitudinal barriers preventing therapy attendance are often associated with personal attitudes toward therapy and the societal stigma associated with mental illness and its treatment (Outram et al., 2004; Wells et al., 1994; Wrigley et al., 2005). The use of the theory of reasoned action as the theoretical underpinning for the process of seeking psychological treatment led to interesting results. Vogel and his colleagues' (2007) results were replicated in the current study (see Figure 6) even though it had been considered an inadequate test of the theory of reasoned action. The inclusion of psychological distress, social support, and self-efficacy provided some unexpected results and several models leading to the prediction of intentions to seek help for a psychological concern. Further, the results from the current study provide some insight into the reasons for conflicting results in past studies that utilized some of the key variables (e.g., Cellucci et al., 2006; Cepeda-Benito & Short, 1998; Constantine & Gainor, 2004; Cramer, 1999; Kelly & Achter, 1995; Scott & Davis, 2006; & Yoo et al., 2005). Finally, the participants' responses in the quantitative and qualitative portions of the study to questions about barriers to seeking therapy provided interesting results.

Demographic Comparisons

It was expected that there would be significant differences between men and women for barriers to seeking therapy because women have been shown to be more likely to seek psychological help than men (e.g., Kessler et al., 1981). Further, past studies consistently find that women have more positive attitudes toward therapy than men (e.g., Addis & Mahalik, 2003; Fischer & Turner, 1970). Therefore, it was hypothesized that men would have higher perceptions of public and self-stigma and more negative attitudes toward seeking therapy than women. This hypothesis was partially supported, as the men in this sample did report significantly higher levels of self-stigma and less favorable attitudes toward seeking therapy, but there was not a gender discrepancy for the measure of public stigma. These findings certainly help explain the lower mental health care utilization by men. First, less favorable attitudes toward therapy predict a lower likelihood of seeking psychological help (Cepeda-Benito & Short, 1998; Leaf et al., 1987). Further, internalization of the negative stereotypes related to psychological problems and their treatment (self-stigma) is likely to lead to avoidance of these services (Komiya et al., 2000; Wrigley et al., 2005). This is supported by the finding that the men in this sample had fewer intentions to seek therapy in the future than the women did. This difference existed despite only minimal gender differences in the experience of psychological distress, as men rated significantly lower than women on only one subscale of the Hopkins Symptom Checklist, General Feelings of Distress. In addition, the men (39.3%) in this sample were just as likely as women (37.0%) to have received professional psychological services at some point in their lives. This suggests that men are impacted more than women by the stigma toward seeking therapy even if they have utilized such services. It is perhaps not surprising then, that there was not a

significant difference for the perceptions of public stigma between men and women. Based on the current results, men and women are likely to be equally aware of the stigma related to psychological disorders (public stigma), but men are more likely to internalize this stigma (self-stigma).

Additional analyses were conducted on the demographic data to determine if there were relevant differences among the study variables. There were significant differences between individuals representing United States minority cultures and European American individuals. It was found that individuals belonging to minority cultures were significantly less likely to experience *general* feelings of distress and perceived lower levels of social support than European American participants. However, there were no significant differences between these groups for self-stigma, attitudes toward therapy, or intentions to seek therapy.

There were also differences between individuals in this sample who had and had not previously attended professional psychological services. Participants who had received previous psychological treatment reported less self-stigma than participants who had not received these services. This lends additional support to those researchers who theorize that internalization of the stigma related to psychological problems is likely to lead to avoidance of mental health treatment (e.g., Corrigan, 2004; Komiya et al., 2000). Further, the findings that individuals who have attended therapy have more favorable attitudes toward treatment and are more likely to resume treatment in the future than individuals who have not attended these services supports results from past studies (e.g., Fischer & Turner, 1970). Participants who had attended therapy reported higher levels of psychological distress at the time of this study than the participants who had not. This is in conflict with the epidemiological survey

finding that mental health care utilization is not based on the severity of the psychological concern (Narrow et al., 2000). However, design differences limit any direct comparisons between these two studies.

There were several unexpected results from the comparisons between individuals who reported past barriers to seeking treatment and those who did not. Participants who identified past barriers to treatment reported lower levels of self-stigma and more favorable attitudes toward therapy than participants who did not identify these barriers. This finding is in conflict with studies reporting that attitudinal barriers are more likely to prevent therapy attendance than structural barriers (e.g., Outram et al., 2004). However, it is possible that some of the individuals in the current study who conquered past barriers to treatment suffered less internalization of stigma, which, in turn, formed more positive attitudes toward treatment. Indeed, exactly 50% of the participants who identified past barriers had attended therapy compared to 32% of the individuals who did not identify past barriers. Further, the participants who identified past barriers to treatment were experiencing higher levels of psychological distress at the time of the study, so psychological treatment may have eventually seemed like a more attractive option. As described below, this explanation is supported by the significant positive relationship between psychological distress and attitudes toward therapy.

Stigma

Perception of public stigma towards psychological disorders and self-stigma demonstrated a significant positive relationship. In other words, higher levels of perceived public stigma were associated with higher levels of self-stigma. This supports the theory that self-stigma is influenced by public stigma. This theory explains that the first step towards

self-stigma occurs with the endorsement of negative stereotypes toward individuals with a psychological problem (Corrigan, 2004; Corrigan et al., 2006). It was notable that public stigma was not related to any other study variable. The reason for this finding is not clear, as Vogel and his colleagues (2007) found a significant relationship between public stigma and both attitudes and intentions toward seeking therapy. However, in their results, public stigma was only weakly correlated with attitudes (-.12) and intentions (-.09) in a sample nearly three times as large as the current study ($N = 680$). It is possible that similar relationships would have been found in the current study if there had been a larger sample size.

As opposed to the findings for public stigma, there were unexpected findings for self-stigma. It was expected that there would be a significant positive relationship between self-stigma and psychological distress. However, there was not a significant relationship between these two variables. This is surprising because self-stigma toward psychological disorders was expected to be similar to the theories of internalized homophobia and internalized racism (Ritsher et al., 2003). In other words, it was expected that one would have to experience a psychological problem in order to internalize the related negative stereotypes (Corrigan, 2004). For example, people may recognize the negative stereotypes directed toward African-Americans in the United States, but a Caucasian individual cannot internalize the stigma related to these stereotypes. However, there are integral differences between these two characteristics (psychological disorders and race). Race, from a societal perspective, is determined from birth and cannot change; however, an individual can develop psychological distress at any time. It is possible that self-stigma concerning a psychological disorder and its treatment represents both actual and hypothetical feelings about having a psychological

problem and receiving treatment for it. That is to say, it is much easier to hypothesize about one's belief about something that may happen in one's future (receiving treatment for psychological distress) than it is to contemplate the distress one may experience as a member of a different race. Indeed, the wording in the Self-Stigma of Seeking Help Scale administered in the present study is in the future tense (e.g., "If I went to a therapist, I would be less satisfied with myself"). Simply put, in the present study, public stigma is "what I believe *other people* think about individuals who seek help for a psychological problem" and self-stigma is "what I would (or do) think of myself if I had to use (or have used) psychological services."

Self-stigma demonstrated significant relationships with other study variables as well. Although not directly hypothesized, self-stigma was negatively correlated with attitudes toward seeking therapy and intentions to seek help for a psychological problem. Higher levels of self-stigma were associated with less favorable attitudes toward therapy and lower intentions to seek psychological treatment. These results support findings from previous studies (Komiya et al., 2000; Vogel et al., 2006; Vogel et al., 2007; Wrigley et al., 2005). This is not surprising, as an individual who internalizes the societal stigma toward psychological problems is more likely to avoid potentially beneficial treatment (Corrigan, 2004). These individuals would view themselves as weak if they were to seek treatment, which would lead to poor attitudes toward therapy.

Attitudes and Intentions

The analysis of the relationship between attitudes toward therapy and psychological distress was of particular interest because of conflicting research findings (Cellucci et al., 2006; Constantine & Gainor, 2004; Scott & Davis, 2006; Yoo et al., 2005). Two of these

studies (Cellucci et al., 2006; Constantine & Gainor, 2004) found a positive relationship between attitudes toward therapy and psychological distress while the other two (Scott & Davis, 2006; Yoo et al., 2005) reported a negative relationship between these two variables. The samples these studies used were quite different and included a diverse group of college students (Cellucci et al., 2006), biracial women (Constantine & Gainor, 2004), African-American adolescent males (Scott & Davis, 2006), and Korean residents (Yoo et al., 2005). One might expect that the results from the current study would support those of Cellucci and his colleagues (2006) because the samples were similar. Indeed the current study supported the findings of Cellucci and his colleagues (2006) and Constantine and Gainor (2004), as there was a significant positive relationship between attitudes toward therapy and psychological distress. This suggests that higher levels of psychological distress are associated with more favorable attitudes toward seeking therapy. This finding is welcome because one would hope that an individual suffering with psychological distress would have favorable attitudes about seeking help to alleviate his or her problem. Perhaps the opposite findings from the other studies (Scott & Davis, 2006; Yoo et al., 2005) can be explained by the generally unfavorable attitudes toward therapy in the cultures they sampled, African-Americans (e.g., Thurston & Phares, 2008) and Koreans (e.g., Ahn Toupin, 1980).

There was only one other significant relationship between attitudes toward seeking therapy and the other study variables. There was a significant positive relationship between attitudes toward therapy and intentions to seek therapy. This suggests that more favorable attitudes are associated with more favorable intentions to seek therapy for a psychological problem. This finding is supported by past studies (e.g., Cepeda-Benito & Short, 1998; Leaf et al., 1987). This finding in combination with the negative relationship between self-stigma

and intentions to seek therapy is promising because these attitudinal barriers are easier to influence on a population level (e.g., Battaglia et al., 1990; Esters et al., 1998; Nelson & Barbaro, 1985). The influence of these variables (attitudes and stigma) on the decision to seek therapy supports the idea that interventions to improve mental health care utilization should focus on improving attitudes towards therapy and reducing stigma (Gonzalez et al., 2005).

It was expected that psychological distress would be a significant factor in the decision to seek therapy. However, there was not a significant relationship between psychological distress and intentions to seek therapy. This is in conflict with several past studies that suggest that psychological distress is a significant predictor of mental health care utilization (Cepeda-Benito & Short, 1998; Cramer, 1999; Jackson et al., 2007; Leaf et al., 1986; Rickwood & Braithwaite, 1994). Indeed, Rickwood and Braithwaite (1994) analyzed possible barriers (e.g., social support) to seeking therapy and found that psychological distress was the *only* significant predictor of treatment utilization. A few of these studies measured actual treatment utilization as opposed to intentions to seek treatment, which helps to interpret the contrasting findings (Jackson et al., 2007; Leaf et al., 1986; Rickwood & Braithwaite, 1994). That is, participants in this study who have been in therapy in the past were experiencing significantly higher levels of psychological distress. Perhaps this difference in measures of psychological distress is due to the distinction between a hypothetical and an actual situation. However, this does not explain the significant relationship between psychological distress and intentions to seek therapy in other studies (Cepeda-Benito & Short, 1998; Cramer, 1999). A possible explanation for this discrepancy is that these two studies used a different measure of intentions to seek therapy than the

current study. Certainly, future study will be required before concrete conclusions can be reached.

Social Support and Self-Efficacy

There were several interesting relationships between perceived social support, self-efficacy, and the other study variables. There was a small negative relationship between social support and self-stigma, which suggests that higher levels of support relate to lower levels of self-stigma. It seems that social support may buffer the internalization of negative stereotypes concerning psychotherapy. There was also a negative relationship between social support and psychological distress, which suggests that higher levels of social support are associated with lower levels of psychological distress. This lends additional support to the well-documented finding that social support effectively reduces psychological distress (e.g., Fleming et al., 1982), and replicates the findings in Cramer's (1999) study.

The relationship between social support and psychological distress is well-established, but there are conflicting results for the relationship between social support and intentions to seek therapy. Several studies indicate that there is not a direct relationship between social support and intentions to seek therapy (Beregeron et al., 2005; Briones et al., 1990; Cramer, 1999; Kelly & Achter, 1995; Rickwood & Braithwaite, 1994). However, Cepeda-Benito and Short (1998) found that lower levels of social support were related to more favorable intentions to seek therapy. This could lead to the assumption that individuals do not require the support of a professional counselor if they possess adequate social support. Conversely, in the current study, there was a *positive* relationship between these variables, as higher levels of perceived social support were significantly related to more favorable intentions to seek treatment for a psychological problem. This finding was certainly

unexpected based on the results from the aforementioned studies. However, the current findings between social support and intentions to seek therapy are supported by a study where the large majority (90%) of participants reported that a friend or family member encouraged them to seek professional help (Saunders, 1996). The influence of social support in the decision to seek psychological treatment is certainly ambiguous. Perhaps the models described below may shed some light on this issue.

Self-efficacy has rarely been included in studies of psychological help-seeking (Jackson et al., 2007). Although several studies have found significant relationships between stigma and self-efficacy (Corrigan et al., 2006; Rosenfield, 1997), there was not a significant relationship between either type of stigma and self-efficacy in the current study. Further, studies have found that low (Judd et al., 2006) and high (Cellucci et al., 2006) levels of self-efficacy are predictive of help-seeking for a psychological concern. However, self-efficacy was not related to attitudes or intentions to seek therapy in the present research. Higher levels of self-efficacy were related to higher levels of social support and lower levels of psychological distress. These findings are not surprising, as many studies reported similar relationships between self-efficacy and these two variables (e.g., Rosenfield, 1997). Based on the current study and the few studies that included self-efficacy, there are no consistent relationships between this construct and some of the other study variables (public stigma, self-stigma, attitudes toward therapy, and intentions to seek therapy). Therefore, additional studies with self-efficacy could help to decipher its role in help-seeking for a psychological problem.

Structural Models

Several interesting models were constructed using structural equation modeling. The models were tested using established theory wherever possible. The main focus was to construct a model to explain the factors that influence the decision to attend psychological treatment. The goal was to begin with a direct test of the theory of reasoned action and then to expand the models by adding each new variable individually based on theories from past research. Therefore, the first model contained only the variables related to the theory of reasoned action (perception of societal stigma, internalize of this stigma, attitudes toward a behavior, and intentions to engage in this behavior; Ajzen & Fishbein, 1980).

Theory of Reasoned Action Model. The original theory of reasoned action suggests two distinct paths to predict intentions to engage in a behavior. On one path is the perception of the social pressure to perform or not perform the behavior, and the other path focuses on the individual's personal attitudes toward the proposed behavior. They clearly explain that there are two paths in the decision-making process that are weighed by an individual. One individual may be more influenced by personal attitudes while another individual may be more affected by societal perceptions. However, the weights of these two paths can also be analyzed on a population level to determine which path is more likely to influence intentions to perform a certain behavior (Ajzen & Fishbein, 1980). Vogel and his colleagues (2007) evaluated the variables related to intentions to seek therapy from the perspective of the theory of reasoned action. However, the model with the best fit to their data was a linear one rather than one that reflects the dual paths described in the original theory. Therefore, the first step in the current analyses was to determine if the core variables are better explained using a linear or a dual path model.

The first test models included only public stigma, self-stigma, attitudes toward therapy, and intentions to seek therapy. The linear structural model (see Figure 6) from Vogel and his colleagues' (2007) study was successfully replicated. This model was an excellent fit to the data and accounted for 17% of the variance in intentions to seek therapy. Public stigma significantly predicted self-stigma, self-stigma predicted attitudes toward therapy, and attitudes toward therapy predicted intentions to seek therapy. This is an interesting and positive finding, but it was hypothesized that the dual path model of the theory of reasoned action would be a better fit to the data. However, the theory of reasoned action model (see Figure 7) was not an adequate fit to the data, so it should be rejected as a model to describe the factors that influence intentions to seek therapy.

Vogel and his colleagues' model (2007), as replicated in the current study, may actually support the theory of reasoned action in its entirety. Unfortunately, these researchers were not clear, as they did not mention any consideration of the weighted importance of the two paths (societal stigma and personal attitudes) that Ajzen and Fishbein (1980) assert to be an integral portion of the theory of reasoned action. However, it is now seems that Vogel and his colleagues did conduct an adequate analysis of the theory of reasoned action. Ajzen and Fishbein did not use complex statistical procedures such as structural equation modeling to test their theory. With analyses in the current study, it seems that both paths influence intentions to seek therapy because of the significant correlations between both paths (stigma and attitudes) and intentions to seek therapy. Nevertheless, the theory of reasoned action as originally constructed is not an adequate fit to the data because attitudes toward therapy was found to mediate the relationship between self-stigma and intentions. This mediation demonstrates that, in the current research, the attitudes path is more heavily weighted than

the stigma path. Therefore, the linear model is the best fit as explained by Vogel and his colleagues (2007) and is an adequate representation of the theory of reasoned action. As in the theory of reasoned action, societal stigma and attitudes toward therapy both influence intentions to seek therapy but attitudes is the stronger predictor, thereby reducing the influence of self-stigma through mediation. This suggests that individuals consider both personal attitudes and societal stigma as proposed by Ajzen and Fishbein (1980), but that personal attitudes were more likely to influence the decision to seek therapy than societal beliefs in this sample.

Psychological Distress Model. Due to previous conflicting findings for psychological distress (e.g., Cellucci et al., 2006; Constantine & Gainor, 2004; Scott & Davis, 2006; Yoo et al., 2005), there were no firm a priori assumptions about the placement of this variable within the model. Based on the best fit model among the other variables and the expectation that psychological distress would mediate the relationship between public stigma and self-stigma, the model in Figure 8 was the first to be analyzed. This model was proposed to be linear, and it was expected that public stigma would directly predict psychological distress, that psychological distress would directly predict self-stigma, that self-stigma would directly predict attitudes toward therapy, and that attitudes toward therapy would predict intentions to seek therapy. This model was expected to be a good fit because the presence of psychological distress is thought to make an individual susceptible to internalizing the negative stereotypes related to psychological problems and its treatment. However, this model was not a good fit to the data and was rejected. It is likely that psychological distress did not significantly contribute to this model because of the differences between internalized racism or homophobia and self-stigma as described previously.

The correlational analysis showed that psychological distress was related to attitudes toward therapy, so the model in Figure 9 was analyzed for goodness of fit. In this model, public stigma predicted self-stigma and both self-stigma and psychological distress predicted attitudes toward therapy, and attitudes predicted intentions to seek therapy. This model was an excellent fit to the data and was the most parsimonious model when including the measure of psychological distress. This model presents an interesting description of two separate, distinct paths predicting attitudes toward therapy. The first path contains both stigma variables, where public stigma predicts self-stigma and self-stigma contributes to the prediction of attitudes toward therapy. On the other path, psychological distress also contributes to the prediction of attitudes toward therapy. The combination of self-stigma and psychological distress accounts for 31% of the variance in attitudes toward therapy. In this model, attitudes toward therapy continues to be the best predictor of intentions to seek therapy.

Social Support Model. The only model that includes social support in conjunction with some of the other variables examined in this study was Cramer's (1999) model. However, the current study did not include a measure of self-concealment and Cramer did not incorporate measures of stigma. Therefore, it is not surprising that a model similar to Cramer's (see Figure 10) was not a good fit to the data. Cramer's model and the previous mediation model (see Figure 9) was the basis for the model tested in Figure 11. In Cramer's model, social support directly influenced psychological distress, so this variable was tested by adding it to the beginning of the psychological distress path in Figure 10. This model was not a good fit to the data for the entire sample, but it was an excellent fit for males in the sample. For the men in the current study, lower levels of social support were predictive of

higher levels of psychological distress. It is possible that men are affected more negatively by inadequate social support than women. It is also possible that men are more likely to seek professional help in the absence of informal support, whereas women may seek formal support regardless of the adequacy of their support network.

Despite the excellent fit to the data in the male sample shown in Figure 11, this model does not explain the role of social support for the entire data set. There are many studies that cite social support as a major influence in seeking psychological help, but the results are mostly conflicting (Begeron et al., 2005; Briones et al., 1990; Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Narikiyo & Kameoka, 1992; Rickwood & Braithwaite, 1994; Saunders, 1996; Thoits, 1986). Saunders (1996) provided the most conclusive finding, as he found that 90% of individuals who attended therapy were encouraged to seek treatment by a loved one. Therefore, it was expected that there would be a direct, positive relationship between social support and intentions to seek therapy. Indeed, the model seen in Figure 12 was an excellent fit to the data. Higher levels of perceived social support were predictive of more favorable intentions to seek therapy. The combination of perceived social support and attitudes toward seeking therapy accounts for 22% of the variance in intentions to seek therapy. The best fit model continues to contain two paths predicting attitudes toward therapy with another direct path from social support to intentions. These findings help to reduce some of the confusion regarding the importance of social support in the decision to seek psychological treatment. According to the best fit model, social support predicts the level of psychological distress and also directly influences intentions to seek treatment.

Self-Efficacy Model. The final piece to the puzzle was perhaps the most difficult to predict due to the lack of studies using self-efficacy and the other study variables (Jackson et

al., 2007). Some studies found significant relationships between public stigma and self-efficacy (Link, 1987; Rosenfield, 1997), and self-stigma and self-efficacy (Corrigan et al., 2006), but these relationships were not found in the current study. Corrigan and Watson (2002) propose that problems with self-efficacy are more likely related to a psychological problem rather than to perceptions of stigma. Therefore, it was expected that self-efficacy would be a better fit in the distress path than in the stigma path. Indeed, the model including self-efficacy in Figure 13 was a good fit to the data. In addition to the predictive paths from Figure 12, self-efficacy helped to predict perceived social support and psychological distress. Higher levels of self-efficacy were associated with higher levels of social support and lower levels of psychological distress. However, structural equation modeling relies on theory for model construction, and there are no theories that bear on the role of self-efficacy in psychotherapy attendance. Therefore, this model should be considered with caution because of the lack of theory to interpret the analyses.

The final structural model provides important information for predicting intentions to seek therapy. The influence of societal stigma related to psychological treatment and the personal experience of psychological distress are two integral factors that affect the decision-making process. On one hand, ignorance of this stigma decreases the likelihood that an individual will internalize the negative stereotypes. On the other hand, lower levels of self-efficacy are likely to lead to less perceived social support. Further, individuals with less self-efficacy and social support are more likely to be experiencing higher levels of psychological distress. Both of these paths (stigma and distress) play a role in predicting attitudes toward seeking therapy. Individuals who are less likely to internalize the negative stereotypes about psychological treatment and are experiencing more psychological distress are more likely to

have favorable attitudes toward seeking therapy. These personal attitudes and an individual's social support system play a significant and direct role in the formation of intentions to seek therapy. An individual with more favorable attitudes toward seeking therapy and higher levels of perceived social support is more likely to have positive intentions to seek therapy for a psychological problem. Therefore, individuals are more likely to consider their own personal attitudes and the influence of their support network when considering therapy attendance.

Past Barriers to Treatment

A small percentage (28.6%) of participants in the college sample indicated that they encountered past barriers to seeking professional psychological treatment. The majority of these participants described attitudinal barriers (e.g., shame) rather than structural barriers (e.g., money) to seeking treatment. These findings substantiate the results from past studies suggesting that attitudinal barriers are more frequently cited by individuals as factors that prevent them from attending mental health treatment (Outram et al., 2004; Wells et al., 1994; Wrigley et al., 2005). Despite these findings, mental health practitioners should not discount the structural barriers. Several participants (31%) listed monetary issues, time, and/or lack of knowledge as significant barriers to seeking treatment. These barriers are powerful and are likely to affect individuals when initially considering the possible utility of mental health treatment, and fortunately these barriers are modifiable.

Currently, there are some measures that reduce structural barriers to seeking mental health treatment. The monetary concerns have been reduced for individuals on Medicaid or Medicare, as they are able to utilize mental health services in some states (Moyer, 2006). Further, there are clinics and individual practitioners offering sliding fee scales and extended

hours. However, the Community Mental Health Clinics (CMHC) movement enacted by President Kennedy to eliminate financial barriers to treatment was stalled during the Reagan administration due to budget cuts. Indeed, only 750 of the initially proposed 2,000 clinics opened their doors (Humphreys & Rappaport, 1993). In addition, many of these clinics restrict access to only individuals with schizophrenia, major depressive disorder, and bipolar disorder. Although participants may have identified barriers that were present for them before becoming a college student, it is surprising that some listed structural barriers because the majority of these barriers are eliminated on this college campus. The counseling services are free to students and are located in the center of campus, thereby eliminating monetary (the most frequently cited structural barrier) and transportation concerns if a student is taking classes on campus. Lack of available time to attend services may continue to be a barrier within this population due the lack of evening and weekend hours. Further, lack of knowledge could also continue to be a barrier as an informal paper survey of a student sample suggested that a large proportion of individuals were unaware of free counseling services on campus (Scott Brown, personal communication, 2006). These two barriers could be eliminated by extending clinic hours and increasing campus wide informational sessions and fliers on counseling services.

The majority of the participants in the college student sample who cited past barriers to seeking treatment listed attitudinal obstacles. These attitudinal barriers fell into four categories: lack of awareness concerning the severity of their problem, belief that they did not need help to overcome their problem, familial influence, and fear and shame. Based on participant responses, many of these individuals have been affected by the societal stigma related to psychological disorders and its treatment. They had experienced significant

personal struggles but did not seek support for their problems. Several individuals believed that their problem was not severe enough for treatment or that they could overcome their problem on their own. Certainly, professional treatment is not necessary for everyone, and many people successfully cope with their problems without formal help. Indeed, several participants explicitly stated that their problems were resolved on their own. However, it seems that fear and shame were significant barriers to seeking treatment, making it difficult for some participants to attend potentially beneficial treatment.

For seven participants in the college student sample, the shame associated with seeking psychological treatment was reported to originate from familial beliefs about therapy. These participants were influenced by their family's disapproval of psychological services. Leaf and his colleagues (1987) also found that a subset of their sample reported that their family would be disappointed if they entered therapy. Fortunately, this was not a concern listed by anyone in the clinical sample, as they indicated that family and friends supported and encouraged their therapy attendance. As seen in the structural model in the current study, higher levels of perceived social support predicted higher intentions to seek therapy. Based on the quantitative and the qualitative results, social support was shown to influence treatment attendance rarely in negative but mostly positive ways. However, both the quantitative and qualitative data suggest that stigma, in the form of negative societal stereotypes toward psychological problems and its treatment, is a factor that often prevents treatment attendance.

Twenty-five participants in the college sample stated that feelings of fear and shame prevented them from attending therapy. These participants were afraid that seeking treatment would portray them in a negative light. They were afraid to learn about the

implications of their psychological problem. Further, they expressed their concerns about others' perceptions of them if they sought treatment or were discovered to be in therapy. Entrance into psychological treatment would be considered by some of these individuals to be shameful, embarrassing, a failure, and a "defeat." These attitudes are obviously not conducive to help-seeking. It certainly does not help that American culture encourages stoicism, independence, and self-reliance (Nadler, 1997). There is help available for many individuals suffering with a psychological disorder, but, according to the current study, the influence of the negative attitudes toward this treatment prevalent in our society leads these individuals to avoid treatment for fear of being viewed as weak. It is unfortunate that many of these individuals internalize these perceptions into personal feelings of inadequacy, which is likely to increase their suffering.

Qualitative Data

The qualitative section of this study allowed narratives from individuals who had surmounted past barriers to therapy in order to receive professional help. There were several limitations to the procedure for this data collection, listed below, that prevented more descriptive accounts of the process of seeking therapy. However, this piece provided additional information unattainable from the quantitative data collection. Although a wealth of information was gathered from the quantitative section, it was important to solicit data from a sample currently utilizing treatment even though many of the findings coincide with the results from the college student sample. The qualitative analysis was also beneficial because each participant described past barriers to therapy, where only a small proportion of college student listed barriers. It is difficult to make firm conclusions from the barriers listed in the quantitative section because they were heterogeneous in regard to therapy attendance

and listed by only a small portion of this sample. However, with the inclusion of the qualitative data, the similarities between the barriers described in both sections reinforce the findings from the quantitative data. The qualitative data also helped to delineate the role of social support in seeking therapy. The reports from the participants in the qualitative section showed that the stigma towards therapy does not disappear after treatment begins. Indeed, participants seemed initially unsure if therapy was the correct choice for them, and three participants mentioned that they were considering ending treatment prematurely. Their statements are a reminder to the profession that initiating therapy is a difficult process but maintaining treatment is also a struggle because of the continued influences of the same structural and attitudinal barriers described by participants.

The individuals participating in the qualitative data portion of the study had to overcome several different types of barriers before seeking therapy. Many of them viewed therapy as a last resort, as they initially possessed unfavorable attitudes toward this method of treatment. These individuals reported similar barriers to therapy and more attitudinal than structural barriers, as was described by the college students in the quantitative section. The attitudinal barriers of the lack of awareness concerning the severity of their problem, the belief that they did not need help to overcome their problem, poor attitudes toward therapy, and fear and shame were similar to the themes from the quantitative data. The structural barriers, however, should not be discounted because the knowledge, money, and time barriers listed by participants can be partially removed with the strategies listed previously.

Most of the structural barriers discussed by these individuals related to financial issues, but the knowledge barrier was the most striking. The knowledge barrier could be attributed to ignorance of where to look for mental health services. However, in this age of

information, it is likely that most people recognize that counselors can be found in the phone book or through an Internet search. As explained by one man, knowledge is more likely to become a barrier when an individual is wondering about *who* to see for services, not where to search for treatment. “You can’t really ask people, ‘who is your therapist?’ like you can with a mechanic.” When people search for a new family doctor, dentist, or mechanic, they want someone they can trust to take care of them or a loved one. They want personal recommendations from others, “go to this doctor, she is the best” or “this mechanic will not cheat you.” It is a more threatening experience to meet with a psychologist without any personal recommendations. Unfortunately, due to the stigma related to psychological treatment, it is difficult and possibly personally damaging to ask others if they know a good therapist. This factor can be added to the growing number of barriers to therapy.

A theme for many of the participants from the qualitative sample was the strong desire to hide their problems and treatment from others. They believed the unstated “rule” that one does not discuss psychological treatment attendance with others because it will possibly lead to embarrassment and prejudice [e.g., “people don't share this sort of thing (therapy attendance)"]. There is the fear, perhaps warranted in some cases, that they will be treated differently after others discover they are utilizing psychological treatment. There are some medical conditions that are stigmatized, but overall, individuals dealing with a psychological condition are more likely to be negatively evaluated (Ben-Porath, 2002; Corrigan, 2004; Sibicky & Dovidio, 1986). For this reason, shame is often a barrier that needs to be considered before seeking therapy, and an individual *in therapy* will continue to encounter this shame throughout treatment as he/she tries to hide this part of his/her life. Although overcoming the barriers to seeking treatment is an accomplishment, the social

forces that created the barriers do not disappear after therapy commences. This is something that therapists should be aware of at all times because it seems that, for many individuals, seeking therapy is a difficult and humbling experience.

Fortunately, the process of seeking therapy is not entirely barriers and hardships. In the quantitative sample, higher levels of social support predicted higher intentions to seek therapy, and nearly all of the participants in the qualitative sample described experiences of support and encouragement from their support network. Further, all of these participants described positive reactions from loved ones upon discovering that they were in therapy. These friends and family members were pleased that these individuals were engaging in a process to reduce their personal suffering. Individuals rely on their social network for support, which may also provide the relationships necessary to facilitate entrance into formal psychological treatment. This provides some evidence that the stigma toward therapy is not completely paralyzing. For better or worse, psychological issues are now a part of the public consciousness with Dr. Phil, Prozac commercials, and Tony Soprano's therapist all in the "public eye." Perhaps there will eventually be less restrictive barriers to seeking professional psychological treatment. However, it is still important for the mental health field to be vigilant in enacting changes to reduce structural and attitudinal barriers towards therapy.

Limitations

There are several limitations that may affect the results in the current study. In the quantitative data collection, data were gathered from a convenience sample of college student in psychology courses. While students were surveyed from a variety of psychology courses and were not limited to freshmen in introductory classes, the present results cannot be generalized to a broader population. It is possible that gathering data from a more

heterogeneous sample would have led to significantly different results. An interesting future study would be to compare a clinical (i.e., meet criteria for a psychological disorder) and a non-clinical sample that have never attended treatment. This would require a formal diagnostic interview or measure, but such a study would help to shed additional light on the low mental health care utilization among individuals with a psychological problem. The measures implemented for public stigma and intentions to seek therapy may have also led to limitations in interpretation. The Perceived Devaluation-Discrimination Scale (Link, 1987) is a valid measure of public stigma, but it uses the terms “mental patient” and “mental hospital.” Because the goal of this study was to assess the stigma associated with attending counseling rather than admission into a psychiatric ward, these terms were altered. These changes may explain the lower scores for public stigma than were found in previous studies (e.g., Vogel et al., 2007) because it is likely that therapy attendance is less stigmatizing than an inpatient admission. The author also chose not to use the measure of intentions to seek therapy that was implemented in similar past studies (Cash et al., 1975). An explanation of the rationale for using a shorter questionnaire with better face validity is in the Method section. Therefore, the results with public stigma and intentions to seek therapy should be evaluated with caution due to the lack of validity studies with the changes to these two measures.

Intentions to seek therapy as the dependent variable in this study caused another significant limitation. In other words, the structural model in the current study predicts intentions to perform a behavior, but there is no assurance that any of the participants would seek therapy if they experienced significant psychological stress without direct behavioral observation. Obviously, there is no replacement for evaluating the factors that predict actual

behavior, but this is difficult in cross-sectional research. As stated earlier, Ajzen and Fishbein (1980) assert that measuring intentions to perform a behavior is the best substitute to actual observation of the behavior. The ideal study to assess barriers to seeking professional psychological treatment would be to follow a sample of participants who have never attended therapy over time (probably several years) to determine the differences between the individuals who eventually seek treatment and those who do not. Besides the obvious problems with longitudinal studies such as financial support and participant attrition, it is difficult to predict the amount of time individuals would need to be followed to receive an adequate number of participants who attended psychological treatment. This type of study may solve many of the mysteries related to mental health care utilization, but would be too costly and time-consuming for most researchers.

As for the qualitative data collection, it would have been ideal to interview individuals as close as possible to when they made the initial decision to seek professional support. This would increase the likelihood that the past barriers and the factors that led to the initiation of treatment would be fresh in their mind. Certainly, a larger sample of participants would provide more information on potential barriers to seeking treatment and would lead to additional information on the personal struggles and barriers associated with seeking psychological help. All participants should be interviewed in person with the option for audio taping to allow for inclusion of longer, more informative quotations and analysis of verbatim dialogues. In addition, it seemed that the interviews conducted in person led to more information on these individuals than the phone interviews. Many of the individuals completing the phone interviews were distracted during the discussion by other stimuli (e.g., children), making it difficult to focus and provide more elaborate responses. Increasing the

overall uniformity in the methodology of the qualitative section would improve the validity of the data and ability to make comparisons.

Conclusions

While difficult, it is important to reduce the effects of stigma within psychotherapy. Counselors can be involved in the advocacy process by empowering clients to challenge stigma in their social networks, neighborhoods, and even on governmental levels. Indeed, some individuals suffering with a psychological problem react to the stigma initially with anger and eventually with advocacy (Boyd et al., 2008). They are empowered to challenge societal stereotypes and fight for better formal and informal treatment (Corrigan & Watson, 2002). Mental health practitioners can also be involved in organizing advocacy efforts within their community. It may be more effective to reduce stigma by targeting specific situations such as educating employers on biases related to hiring individuals suffering with a psychological disorder (Link & Phelan, 2001). Psychology's organizing bodies (e.g., American Psychological Association) should continue to design and support programs to help dispel the myths of psychological problems and its treatment. In addition, based on the present results, more anti-stigma and attitude improvement interventions (e.g., Real Men, Real Depression) should target men. Fortunately, the U.S. military, a male-dominated culture, is paying special attention to anti-stigma activism with a recent \$2.7 million campaign (Dingfelder, 2009).

The findings from the current study provide some direction in reducing barriers to seeking psychological treatment. Despite the finding that attitudinal barriers to psychological treatment are more likely to be cited as barriers, structural barriers are significant and should not be ignored. For example, individuals in lower SES ranges experience structural and

attitudinal barriers, so mental health practitioners should attend to both areas (Leaf et al., 1987). Additional funding and support for mental health services for individuals in poverty is certainly necessary. Also, education on the value of services, the process of seeking treatment, the different types of treatment (e.g. different theoretical orientations), and what to expect in treatment would be extremely valuable for high school students and young adults regardless of socio-economic status. Most people learn at an early age about the process of seeking help for a medical problem, but it is much more uncommon for people to possess this knowledge for psychological issues. In many ways, professional psychological treatment remains sheltered from mainstream society.

The societal stigma and the general negative attitudes toward seeking help for a psychological problem may facilitate the avoidance of mental health treatment. Individuals with a psychological diagnosis continue to experience considerable prejudice. For example, the media continues to report acts of violence committed by people with psychological disorders but rarely include opposite stories (e.g., individual suffering with depression is elected mayor; Scheff, 1999). It does not help that advocacy for mental illness is lagging behind the efforts for other discriminated groups (e.g., ethnic minorities, individuals with physical disabilities). As stated above, further efforts to dispel stigma and improve attitudes toward treatment are likely to be beneficial in increasing mental health care utilization for individuals who would otherwise avoid potentially beneficial treatment. The contributions of self-efficacy and perceived social support in the structural model predicting intentions to seek therapy are interesting but difficult to improve on a population level. Therefore, future studies should focus on evaluating potential population based interventions to improve attitudes toward therapy and reduce the stigma in order to increase mental health care

utilization. The direct path between social support and intentions to seek therapy actually emphasizes the importance of interventions focused on reducing stigma. If the general public is more accepting of treatment of people with psychological problems, an individual's support network is more likely to provide positive encouragement towards seeking help for a problem.

As stated above, improvement of social support networks is difficult to facilitate. However, the current finding that suggests that social support encourages therapy attendance may be a signal of change. Indeed, individuals suffering with a psychological disorder may require an outside observer to help recognize the need for professional assistance. The most apparent relationship between the quantitative and qualitative results was the positive influence of social support on mental health help-seeking. It is certainly desirable for people to have a support network that promotes therapy attendance when it could be possibly beneficial, just as social support facilitates scheduling an initial appointment with a trusted primary care physician or dentist when called for. However, the stigma associated with psychological treatment can lead an individual to feel alone with his/her struggles. This person may feel like there is no one else struggling with the same problem. Indeed, a male participant from the clinical sample asked the experimenter about the prevalence of major depressive disorder (~ 8% lifetime prevalence; American Psychological Association, 2000). He was very surprised that there are many other people who struggle with severe depression. He explained: "I know there must be other people at work that are depressed, but I don't know other people with the same problems... I feel alone." Certainly, professional psychological treatment is not for everyone, but there are many others like this man,

struggling alone with their hidden problem due to the poor attitudes and stigma toward the mental health field.

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Appendix A

Perceived Devaluation-Discrimination Scale

Answer these questions based on general society's beliefs. Use the following scale to answer each question:

- 1 = strongly agree
- 2 = agree
- 3 = slightly agree
- 4 = slightly disagree
- 5 = disagree
- 6 = strongly disagree

- ___ 1. Most people would willingly accept a therapy client as a close friend.
- ___ 2. Most people believe that a person who has been in therapy is just as intelligent as the average person.
- ___ 3. Most people believe that a therapy client is just as trustworthy as the average citizen.
- ___ 4. Most people would accept a therapy client as a teacher of young children in a public school.
- ___ 5. Most people feel that entering therapy is a sign of personal failure.
- ___ 6. Most people would not hire a therapy client to take care of their children, even if he or she had been well for some time.
- ___ 7. Most people think less of a person who has been in therapy.
- ___ 8. Most employers will hire a therapy client if he or she is qualified for the job.
- ___ 9. Most employers will pass over the application of a therapy client in favor of another applicant.
- ___ 10. Most people in my community would treat a therapy client just as they would treat anyone.
- ___ 11. Most young women would be reluctant to date a man who has been in therapy for a serious mental disorder.
- ___ 12. Once they know a person is in therapy, most people will take his or her opinions less seriously.

Appendix B

Self-Stigma of Seeking Help Scale

Answer these questions based on your personal beliefs. Use the following scale to answer each question:

- 1 = strongly disagree
- 2 = disagree
- 3 = agree and disagree equally
- 4 = agree
- 5 = strongly agree

- ___ 1. I would feel inadequate if I went to a therapist for psychological help.
- ___ 2. My self-confidence would NOT be threatened if I sought professional help.
- ___ 3. Seeking psychological help would make me feel less intelligent.
- ___ 4. My self-esteem would increase if I talked to a therapist.
- ___ 5. My view of myself would not change just because I made the choice to see a therapist.
- ___ 6. It would make me feel inferior to ask a therapist for help.
- ___ 7. I would feel okay about myself if I made the choice to seek professional help.
- ___ 8. If I went to a therapist, I would be less satisfied with myself.
- ___ 9. My self-confidence would remain the same if I sought help for a problem I could not solve.
- ___ 10. I would feel worse about myself if I could not solve my own problems.

Appendix C

Attitudes Toward Seeking Professional Psychological Help Scale-Shortened Form

Answer these questions based on your personal beliefs. Use the following scale to answer each question:

- 0 = disagree
- 1 = partly disagree
- 2 = partly agree
- 3 = agree

- ___ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
- ___ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
- ___ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
- ___ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.
- ___ 5. I would want to get psychological help if I were worried or upset for a long period of time.
- ___ 6. I might want to have psychological counseling in the future.
- ___ 7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.
- ___ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
- ___ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.
- ___ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

Appendix D

Hopkins Symptom Inventory

INSTRUCTIONS: How have you felt during the past seven days including today? Use the following scale to describe how distressing you have found these things over this time.

- 1 = Not at all
- 2 = A little
- 3 = Quite a bit
- 4 = Extremely

- ___ 1. Difficulty in speaking when you are excited
- ___ 2. Trouble remembering things
- ___ 3. Worried about sloppiness or carelessness
- ___ 4. Blaming yourself for things
- ___ 5. Pains in the lower part of your back
- ___ 6. Feeling lonely
- ___ 7. Feeling blue
- ___ 8. Your feelings being easily hurt
- ___ 9. Feeling others do not understand you or are unsympathetic
- ___ 10. Feeling that people are unfriendly or dislike you
- ___ 11. Having to do things very slowly in order to be sure you are doing them right
- ___ 12. Feeling inferior to others
- ___ 13. Soreness of your muscles
- ___ 14. Having to check and double-check what you do
- ___ 15. Hot or cold spells
- ___ 16. Your mind going blank
- ___ 17. Numbness or tingling in parts of your body

- ___ 18. A lump in your throat
- ___ 19. Trouble concentrating
- ___ 20. Weakness in parts of your body
- ___ 21. Heavy feelings in your arms and your legs

Appendix E

The New General Self-Efficacy Scale

Instructions: Please select the response that most closely indicates the degree to which you agree or disagree with the following statements. Use the following scale to indicate your opinion:

1	2	3	4	5
Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree

- ___ 1. I will able to achieve most of the goals I have set for myself.
- ___ 2. When facing difficult tasks, I am certain that I will accomplish them.
- ___ 3. In general, I think I can obtain outcomes that are important to me.
- ___ 4. I believe I can succeed at most any endeavor to which I set my mind.
- ___ 5. I will be able to successfully overcome many challenges.
- ___ 6. I am confident that I can perform effectively on many different tasks.
- ___ 7. Compared to other people, I can do most tasks very well.
- ___ 8. Even when things are tough, I can perform quite well.

Appendix F

Sense of Support Scale

Instructions: Read each item carefully and write the number that best describes what is generally true for you. Use the following scale to complete each item:

0 = not true at all

1 = slightly true

2 = mostly true

3 = completely true

- ___ 1. I participate in volunteer/service projects.
- ___ 2. I have meaningful conversations with my parents and/or siblings.
- ___ 3. I have a mentor(s) in my life I can go to for support/advice.
- ___ 4. I seldom invite others to join me in my social and/or recreational activities.
- ___ 5. There is at least one person I feel a strong emotional tie with.
- ___ 6. There is no one I can trust to help solve my problems.
- ___ 7. I take time to visit with my neighbors.
- ___ 8. If a crisis arose in my life, I would have the support I need from family and/or friends.
- ___ 9. I belong to a club (eg, sports, hobbies, support group, special interests).
- ___ 10. I have friends from work that I see socially (eg, movie, dinner, sports, etc).
- ___ 11. I have friendships that are mutually fulfilling.
- ___ 12. There is no one I can talk to when making important decisions in my life.
- ___ 13. I make an effort to keep in touch with friends.
- ___ 14. My friends and family feel comfortable asking me for help.
- ___ 15. I find it difficult to make new friends.
- ___ 16. I look for opportunities to help and support others.
- ___ 17. I have a close friend(s) whom I feel comfortable sharing deeply about myself.

- ___ 18. I seldom get invited to do things with others.
- ___ 19. I feel well supported by my friends and/or family.
- ___ 20. I wish I had more people in my life that enjoy the same interests and activities as I do.
- ___ 21. There is no one that shares my beliefs and attitudes.

Appendix G

Additional Questions/Demographics

Directions: Circle one answer for each question.

1. If you did or do have a personal or psychological problem, how likely is it that you would seek help from a *psychologist or counselor*?

Not at all likely	Very unlikely	Somewhat unlikely	Unsure
Somewhat likely	Very likely	Extremely likely	

2. If you did or do have a personal or psychological problem, how likely is it that you seek help from a *psychiatrist*?

Not at all likely	Very unlikely	Somewhat unlikely	Unsure
Somewhat likely	Very likely	Extremely likely	

3. If you did or do have a personal or psychological problem, how likely is it that you seek help from a *physician*?

Not at all likely	Very unlikely	Somewhat unlikely	Unsure
Somewhat likely	Very likely	Extremely likely	

4. If you did or do have a personal or psychological problem, how likely is it that you seek help from a *social worker*?

Not at all likely	Very unlikely	Somewhat unlikely	Unsure
Somewhat likely	Very likely	Extremely likely	

5. If you did or do have a personal or psychological problem, how likely is it that you seek help from a *religious leader*?

Not at all likely	Very unlikely	Somewhat unlikely	Unsure
Somewhat likely	Very likely	Extremely likely	

6. Are you currently taking medications for a psychological problem? Yes No

a. If not, have you ever taken medications for a psychological problem? Yes No

7. Are you currently in psychological treatment? Yes No

a. If not, have you attended psychological treatment in the past? Yes No

8. Have you ever felt you may have benefited from professional psychological help in the past for a personal problem but did not seek such help? Yes No

a. If yes, why did you not seek help? (Please write your response)

What is your ethnicity? (circle one)

African-American

Asian/Pacific Islander

Latino/Latina

Native American

Caucasian

Other (please describe) _____

What is your gender?

Male

Female

What year of college are you in? _____

Appendix H
Semi-Structured Interview

1. Tell me about your experience with seeking counseling.
2. Tell me the ways you have used to deal with your problem.
3. Tell me the reason that you are seeking treatment now.
4. Tell me about what prevented you from seeking counseling earlier than you did.
5. Tell me about any problems you have experienced in relation to having a mental or behavioral problem.
6. Have you told anyone that you are seeking counseling, and if so, how did they react?

Appendix I

Informed Consent

1. **Purpose of the Study:** The purpose is to examine the relationships of stigma, attitudes toward therapy, and psychological distress on intentions to seek psychotherapy as part of a doctoral dissertation study.
2. **Participation Withdrawal or Refusal to Participate:** Taking part in this study is voluntary. You may refuse to participate, decline to answer particular questions, or withdraw from the research at any time without any penalty.
3. **Description of the Procedures:** You will fill out seven short questionnaires. The questionnaires will ask about your perception of stigma and personal attitudes toward therapy and your current level of distress. The entire process will take about 20-30 minutes.
4. **Anonymity:** Please do not put your name anywhere on the questionnaires, so your answers remain anonymous. This will allow the results of the questionnaire to be kept confidential because there will be no identifying information attached to the questionnaires. You will sign a form separate from the study questionnaires to note that you participated in the study, so your name can be provided to your instructor if extra credit is offered for study participation.
5. **Expected Risks of the Study:** There are no known risks for participating in the study. Some of the questions may be troubling to you because there are questions about your level of distress. If you would like to talk to someone about uncomfortable reactions you have from completing the questionnaires, please contact Snow Counseling Center (734-487-1118).
6. **Expected Benefits of the Study:** Your participation in the research may provide key information about stigma and attitudes as barriers to seeking professional psychological help. The aim is to gain more understanding of these variables to increase use of psychological services for those in need.
7. **Use of Research Results:** The research in this study will be published in psychological journals and presented at psychology conferences. The data published will not be individual results so the data cannot be linked back to individual participants' identities. You can contact the Principal Investigator Matthew Altieri (maltiere@emich.edu) to receive a copy of the results of the study. You can also contact Matthew Altieri's supervisor, Dr. Silvia von Kluge if you have any questions or comments concerning the research at svonkluge@emich.edu.
8. **If You Have Questions or Comments:** Please contact the researcher, Matthew Altieri, at maltiere@emich.edu.
9. **This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee for use from _____ to _____ (date). If you have questions about the approval process, please contact Dr. Deb de Laski-Smith (734.487.0042, Interim Dean of the Graduate School and Administrative Co-chair of UHSRC, human.subjects@emich.edu).**

I understand my rights as a research participant and I voluntarily consent to participate in this study. I have received a copy of this informed consent form, and I understand what the study is about and how and why it is being conducted.

Participant's Signature

Date

Signature of Principal Investigator

Date

Appendix J

Informed Consent

1. **Purpose of the Study:** The purpose is to examine the relationships of stigma, attitudes toward therapy, and psychological distress on intentions to seek psychotherapy.
2. **Participation Withdrawal or Refusal to Participate:** Taking part in this study is voluntary. You may refuse to participate, decline to answer particular questions, or withdraw from the research at any time without any penalty. Your decision to participate or not participate in this study will in no way impact the quality or type of services offered by EMU Psychology Clinic.
3. **Description of the Procedures:** You will be interviewed over the phone about experiences with stigma and past barriers to seeking psychological treatment. The interview should take about 30-45 minutes.
4. **Confidentiality:** Your responses in the interview will not be shared with your therapist and any notes of these responses will not contain any identifying information. The notes of your interview will be stored in a locked cabinet.
5. **Expected Risks of the Study:** There are no known risks for participating in the study. Some of the questions may be troubling to you, but not more so than normal discussion of these issues. Your therapist is aware of your involvement in this study and will be prepared to discuss any concerns that arise from the interview.
6. **Expected Benefits of the Study:** Your participation in the research may provide key information about stigma and attitudes as barriers to seeking professional psychological help. The aim is to gain more understanding of these variables to increase use of psychological services for those in need.
7. **Incentive for Participation in the Study:** The EMU Psychology Clinic will waive your fee for one therapy session.
8. **Use of Research Results:** The research in this study will be published in psychological journals and presented at a dissertation meeting and psychology conferences. The data published will not be individual results so the data cannot be linked back to individual participants' identities. You can contact the Principal Investigator Matthew Altieri (maltiere@emich.edu) to receive a copy of the results of the study. You can also contact Matthew Altieri's supervisor, Dr. Silvia von Kluge if you have any questions or comments concerning the research at svonkluge@emich.edu.
9. **If You Have Questions or Comments:** Please contact the researcher, Matthew Altieri, at maltiere@emich.edu.
10. **This research protocol and informed consent document has been reviewed and approved by the Eastern Michigan University Human Subjects Review Committee for use from 2/14/08 to _____.** If you have questions about the approval process, please contact Dr. Deb de Laski-Smith (734.487.0042, Interim Dean of the Graduate School and Administrative Co-chair of UHSRC, human.subjects@emich.edu).

I understand my rights as a research participant and I voluntarily consent to participate in this study. I have received a copy of this informed consent form, and I understand what the study is about and how and why it is being conducted.

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