Journal of Counseling Psychology

© 2013 American Psychological Association
0022-0167/13/$12.00 DOI: 10.1037/a0033555

Disentangling Self-Stigma: Are Mental Illness and Help-Seeking Self-Stigmas Different?

Jeritt R. Tucker, Joseph H. Hammer, David L. Vogel, Rachel L. Bitman, Nathaniel G. Wade, and Emily J. Maier
Iowa State University

Two established but disparate lines of research exist: studies examining the self-stigma associated with mental illness and studies examining the self-stigma associated with seeking psychological help. Whereas some researchers have implicitly treated these 2 constructs as synonymous, others have made the argument that they are theoretically and empirically distinct. To help clarify this debate, we examined in the present investigation the overlap and uniqueness of the self-stigmas associated with mental illness and with seeking psychological help. Data were collected from a sample of college undergraduates experiencing clinical levels of psychological distress ($N = 217$) and a second sample of community members with a self-reported history of mental illness ($N = 324$). Confirmatory factor analyses provide strong evidence for the factorial independence of the 2 types of self-stigma. Additionally, results of regression analyses in both samples suggest that the 2 self-stigmas uniquely predict variations in stigma-related constructs (i.e., shame, self-blame, and social inadequacy) and attitudes and intentions to seek help. Implications for researchers and clinicians interested in understanding stigma and enhancing mental health service utilization are discussed.

Keywords: self-stigma, mental illness, help-seeking, counseling

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Self-stigma is defined as the reduction in a person's self-esteem or sense of self-worth due to the perception that he or she is socially unacceptable (Corrigan, 2004). Self-stigma occurs when individuals internalize stereotypes and apply negative public attitudes to their own self-concept (Corrigan & Shapiro, 2010; Vogel, Bitman, Hammer, & Wade, 2013). Previous research has shown that individuals who experience self-stigma associated with mental illness experience lowered self-esteem (Link & Phelan, 2001) and increased depression (Manos, Rüsch, Kanter, & Clifford, 2009). Common expressions of self-stigma include feelings of shame, limiting one's social interactions, and reluctance to seek employment and other rightful life opportunities (Kranke, Floersch, Townsend, & Munson, 2010). Furthermore, those who endorse greater self-stigma also endorse negative attitudes toward psychological treatment (Conner et al., 2010), have lower treatment compliance (Fung & Tsang, 2010), and are less willing to return for subsequent counseling sessions (Wade, Post, Cornish, Vogel, & Tucker, 2011). In other words, self-stigma has been found to play a powerful role in seeking psychological services, in the effectiveness of psychological treatment, and in the recovery from mental illness (Corrigan & Roa, 2012). The potentially devastating effect of self-stigma on the individual has compelled researchers to attempt to better understand its role in individuals' help-seeking decisions and mental health outcomes. However, researchers have not always clearly described or operationalized self-stigma, leading to some contradictory results and confusion in the literature. One important distinction in the stigma literature that has begun to emerge but still remains largely unexamined is the difference between the self-stigma associated with *having a mental illness* and the self-stigma associated with *seeking psychological help*.

Jeritt R. Tucker, Joseph H. Hammer, David L. Vogel, Rachel L. Bitman, Nathaniel G. Wade, and Emily J. Maier, Department of Psychology, Iowa State University.

Correspondence concerning this article should be addressed to Jeritt R. Tucker, Department of Psychology, Iowa State University, W112 Lagomarcino Hall, Ames, IA 50011-3180. E-mail: jrtucker@iastate.edu

Differences Between Mental-Illness Self-Stigma and Help-Seeking Self-Stigma

Much of the self-stigma literature has followed from Link's (1987) groundbreaking work on the negative impact of receiving the label of "mental patient" (p. 101). In this work, Link defined *mental patients* as those who have both symptoms of mental illness and have made contact with a psychiatrist, psychologist, or social worker (Link, 1987). It should be noted that Link subsumed the stigma associated with receiving psychological services under the broader construct of mental illness stigma. Much of the subsequent theory and measurement in the area of mental illness stigma has incorporated items or factors related to seeking psychological services. This may be due in part to the perception that help seeking is a behavioral cue linking one to mental illness rather than as an act with its own unique stigmatization. Thus, although there is a compelling body of literature suggesting that people avoid mental health services in order to avoid the self-stigma of mental illness, the relationship may be more nuanced. More specifically, the self-stigma of mental illness and the self-stigma of seeking psychological help may have independent influences on help-seeking behaviors.

Making this distinction not only influences the way in which researchers understand the stigmatization process but also influ-

ences the types of interventions used to decrease the negative impacts of stigma and increase the use of psychological services. For example, interventions focused on reducing the self-stigma of mental illness might focus on normalizing symptoms, providing information about the neurobiological basis of mental illness (Rüsch, Angermeyer, & Corrigan, 2005), using cognitive behavioral strategies to change self-stigmatizing thinking (Lucksted et al., 2011), and providing methods to cope with discrimination and stereotypes (Corrigan & Roa, 2012). Alternatively, interventions focused on reducing help-seeking self-stigma might focus on normalizing the act of seeking help, discussing the benefits of therapy, and challenging the myths about therapy (Schomerus & Angermeyer, 2008). Although these interventions may not be at odds with one another, the self-stigmas that they target may differentially relate to help-seeking attitudes and intentions as well as components of well-being. Determining if the two self-stigmas are indeed distinct may help determine the aim and content of future stigma-reduction initiatives; consistent with calls for greater clarity from stigma scholars (e.g., Schomerus & Angermeyer, 2008).

The notion that these two types of stigma are unique is theoretically plausible. Link's (1987) Modified Labeling Theory proposes that when a person is labeled as having a mental illness, he or she applies negative external perceptions, stereotypes, and biases related to mental illness to his or her self-concept. Some researchers have argued that a parallel process can occur for help seeking. When an individual makes the decision to seek help—meaning that for that individual, the approach factors outweigh the avoidance factors for treatment—he or she may self-identify as being a "help seeker" (Vogel & Wade, 2009). The internalization of these two stigmatizing attributes appears independent. For example, people who seek outpatient counseling or psychotherapy but do not endorse a diagnosis for themselves, such as those receiving counseling for marital problems or life transitions, may not see themselves as "mentally ill." Conversely, those who accept the label of having a mental illness might not consider themselves help seekers (or psychotherapy patients) and may in fact avoid counseling in order to avoid receiving a second stigmatizing label.

There is also empirical support for the difference between the self-stigma of mental illness and the self-stigma of help seeking. In Freeman's early (1961) survey of relatives of formerly hospitalized patients, public attitudes toward psychiatric treatment were seen to differ from attitudes toward mental disorders. This finding is supported in a more recent study examining student ratings of vignettes of depressed individuals as well as vignettes of depressed individuals who were also receiving psychotherapy. Students evaluated the individuals on measures of emotional stability, interest, and confidence. Results indicated that depressed individuals who were *also* receiving help were rated as less emotionally stable and less confident than those who were depressed but *not* seeking treatment (Ben-Porath, 2002). Indeed, those who have sought mental health treatment report higher levels of perceived discrimination than those who have not received treatment (Jorm & Wright, 2008). Furthermore, utilization of psychological treatment is associated with labels such as *awkward*, *cold*, *defensive*, *dependent*, *insecure*, *unsociable* (Sibicky & Dovidio, 1986), *not in control of one's emotions* (Oppenheimer & Miller, 1988), and *weak* or *disturbed* (King, Newton, Osterlund, & Baber, 1973). Thus, the finding that being a consumer of mental health care is linked with lower self-esteem, difficulty securing job opportunities, and difficulties in maintaining close relationships (Wahl & Harman, 1989) may result not only from the stigma of mental illness but also from the stigma related to seeking psychological help. For this reason, it is important to assess whether the two self-stigmas are empirically distinct constructs that independently relate to components of self-concept and key help-seeking factors.

The Present Study

If mental illness and help-seeking stigmas are distinct constructs, one would expect that the process by which the stigmatization of individuals occurs to also differ for each type of stigma. Such a difference would imply that beliefs about those who are mentally ill are experienced and internalized independently from beliefs about those who seek psychological help. To examine this possibility, we first conducted confirmatory factor analysis to examine whether the two potential types of self-stigma were empirically distinct. Confirmatory factor analysis is a strategy that has been used to distinguish between constructs such as hope and optimism (Bryant & Cvengros, 2004) and anxiety and depression (Feldman, 1993). We then examined whether the two types of self-stigma account for unique variance in related stigma constructs (i.e., the public stigma of mental illness, the public stigma associated with seeking help, self-blame, shame, and social inadequacy). Last, we examined whether both forms of self-stigma are uniquely associated with help-seeking attitudes and intentions. We hypothesized that items operationalizing the self-stigma of seeking help and items operationalizing the self-stigma of mental illness would (a) load on two distinct factors in confirmatory factor analyses and that each factor would (b) account for unique variance in theoretically related stigma constructs and (c) account for unique variance in help-seeking attitudes and intentions. These hypotheses were examined across two independently sampled groups: undergraduate students with clinical levels of psychological distress and community members with a self-reported history of mental illness.

Method

Participants

Sample 1: Undergraduate students experiencing psychological distress. Sample 1 consisted of undergraduate students at a large, Midwestern university. Initially, 729 students were surveyed. Of these, 30% ($n = 217$) met the clinical cutoff score on the General Population Clinical Outcomes in Routine Evaluation measure (GP-CORE; Evans, Connell, Audin, Sinclair, & Barkham, 2005; described later in the Instruments section) and were included in further analysis. Of the remaining students, 63% were female and 37% were male. The majority of students were first year students (53%), followed by second year (26%), third year (14%), fourth year (6%), and graduate students (1%). Most participants were European American (85%), followed by Asian American (5%), African American/Black (3%), international (2%), multiracial American (2%), Latino American (2%), and Native American (1%).

Sample 2: Community sample with a reported history of mental illness. Sample 2 consisted of 330 participants recruited from online web sites, forums, or listservs focusing on mental

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

illness. Of the initial sample, 324 (98%) indicated having experienced one or more mental illnesses and were included in further analyses. Of these, the majority (92%) indicated experiencing depression and (93%) anxiety. Participants also indicated experiencing abuse or trauma (69%), having an eating disorder or body image problem (33%), experiencing alcohol or drug abuse or addiction (33%), and/or having schizophrenia (6%). Fourteen percent of the sample identified as male, 81% as female, 1% as "other," and 4% did not report their biological sex. The mean age of the sample was 41 years ($SD = 13$). Two percent of the sample held less than a high school degree, 6% had a high school diploma or general educational development (GED) credential, 9% held an associate's degree, 30% had completed some college, 31% had received their bachelor's degree, and 22% had a graduate degree. The sample was largely European American (86%), followed by African American/Black (4%), Asian American (2%), Hispanic/Latino/a (2%), Native American (2%), and 3% identified as "other."

Procedures

The university Institutional Review Board approved all study procedures. For Sample 1, data were collected during a 3-month period. Students were recruited to participate in the study through announcements in their psychology and communication studies classes. Participants volunteered and received extra credit for their involvement. For Sample 2, we contacted moderators of mental illness support group listservs and forums and asked permission to distribute an electronic announcement about the study. Respondents participated voluntarily and did not receive compensation. For both samples, participants completed online questionnaires that included measures of the self-stigma of seeking psychological help and of mental illness, the public stigma of mental illness, the public stigma of seeking psychological help, and help-seeking attitudes and intentions. Sample 1 also completed measures of psychological distress, and shame, self-blame, and social-inadequacy associated with mental illness.

Instruments

Psychological symptoms. The General Population Clinical Outcomes in Routine Evaluation measure (GP-CORE; Evans et al., 2005) was used in Sample 1 to distinguish between clinical and nonclinical levels of distress. The GP-CORE is a 14-item measure derived from the larger 25-item Clinical Outcomes in Routine Evaluation–Outcome Measure (CORE-OM; Evans et al., 2000; Barkham et al., 1998). The GP-CORE was developed to improve upon the CORE-OM in its use with the general public and college student populations by removing risk items and all but two high-intensity items. Remaining items include statements such as "I have felt tense, anxious, or nervous" and "I have felt warmth or affection for someone" (reverse scored). Responses are rated on a 5-point Likert scale from 0 (*not at all*) to 4 (*most or all of the time*; Evans et al., 2005). The 14 items composing the GP-CORE demonstrate high internal reliability ($\alpha = .83$), and high test–retest reliability ($r = .91$). In the present study, Cronbach's alpha for Sample 1 was .86.

The initial authors of the scale derived clinical cutoff scores for both men and women based on the means and standard deviations of two independently sampled groups: a broad sample of undergraduates ($n = 772$) and a second sample of those presenting for counseling at university counseling centers ($n = 633$; Evans et al., 2005). From these, the authors derived a single cutoff score to differentiate between clinical and nonclinical populations: 1.49 for men and 1.63 for women. These cutoff scores were used in the current sample to select for those with clinical levels of psychological distress.

Self-stigma of seeking psychological help. The Self-Stigma of Seeking Help (SSOSH; Vogel, Wade, & Haake, 2006) Scale was utilized in both samples to measure reductions in self-esteem and self-efficacy that result from receiving the label of a seeker of psychological help (Vogel & Wade, 2009). The SSOSH is a 10-item questionnaire, and includes items such as "If I went to a therapist, I would be less satisfied with myself." Items are rated from 1 (*strongly disagree*) to 5 (*strongly agree*) with half of the items reverse-scored such that higher scores represent greater self-stigma of seeking psychological help. Evidence for the construct validity of the SSOSH includes correlations with attitudes toward counseling ($r = -.63$), intentions to seek counseling ($r = -.38$), and the public stigma for seeking help ($r = .48$; Vogel et al., 2006). Additionally, the SSOSH has been shown to distinguish between those who seek help and those who do not (Vogel et al., 2006). The SSOSH has demonstrated adequate test–retest reliability over a period of 2 months ($\alpha = .72$) and adequate internal consistency ($\alpha = .89$). In the present study, Cronbach's alpha was .90 for Sample 1 and .92 for Sample 2.

Self-stigma of mental illness. The Self-Stigma of Mental Illness (SSOMI) Scale is a 10-item scale developed for the present study to parallel the Self-Stigma of Seeking Help (SSOSH) Scale. It was utilized in both samples to measure the reduction in self-esteem and self-efficacy that results from receiving the label of *mental illness*. Items were generated by replacing references to seeking psychological help on the SSOSH with references to having a mental illness. Because of the minimal syntax difference between the scales, separate factor loadings of their respective items and differential prediction of outcome variables were thought to communicate a large effect (Prentice & Miller, 1992). Items include such statements as "If I had a mental illness, I would be less satisfied with myself." Items are rated from 1 (*strongly disagree*) to 5 (*strongly agree*), with half of the items reverse-scored such that higher scores represent greater self-stigma associated with mental illness. In the present analysis, convergent validity of the SSOMI was demonstrated through its strong, positive correlation with the modified Self-Stigma of Depression (SSD) Scale ($r = .73$, $p < .001$; Barney, Griffiths, Christensen, & Jorm, 2010). Additionally, the SSOMI and the SSD were similarly correlated with other variables in the model. In the present study, Cronbach's alpha for the SSOMI was .91 for Sample 1 and .92 for Sample 2.

Public stigma of mental illness. The Beliefs about Devaluation–Discrimination (BDD) Scale is a 12-item scale that measures the extent to which a person believes the general public devalues and discriminates against those with a mental illness (Link, 1987). It was utilized to measure the public stigma of mental illness in the present study. The BDD includes statements such as "Most people would not hire a former mental patient to take care of their children, even if he or she had been well for some time." Items are rated on a 6-point Likert scale from 1 (*strongly*

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

disagree) to 6 (*strongly agree*). Half of the items are reverse-scored such that a higher total score indicates greater public stigma toward mental illness. The internal consistency of the measure has been demonstrated (α = .76; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Evidence of convergent validity comes from the measure's moderate correlation with demoralization in mental health patients (r = .48; Link, 1987). In the present study, Cronbach's alpha was .86 for Sample 1 and .89 for Sample 2.

Public stigma of seeking psychological help. The Social Stigma of Receiving Psychological Help (SSRPH; Komiya, Good, & Sherod, 2000) Scale assesses perceptions of the public stigma associated with seeking professional help and was utilized in both samples. It is a five-question measure, with items rated on a Likert-scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). The items are summed so that higher scores connote greater perceptions of social stigma associated with receiving psychological help. Items include questions such as "People will see a person in a less favorable way if they come to know that he or she has seen a psychologist." As evidence of construct validity, the SSRPH Scale has been correlated with attitudes toward seeking professional help (r = –.40, $p < .001$; Komiya et al., 2000). The internal consistency has also been demonstrated (α = .72; Komiya et al., 2000). In the present study, Cronbach's alpha was .76 for Sample 1 and .82 for Sample 2.

Dimensions of self-stigma. In the present study, a modified version of the Self-Stigma of Depression (SSD) Scale (Barney et al., 2010) was used in Sample 1 to examine domains of self-stigma. This 16-item scale consists of four factors: Shame, Self-Blame, Social Inadequacy, and Help-Seeking Inhibition. Only the Shame, Self-Blame, and Social Inadequacy subscales were used in the present study. Questions begin with the stem "If I were depressed, I would . . ." and include items such as "feel inferior to others" (Shame), "think I should be able to cope with things" (Self-Blame), and "feel I couldn't contribute much socially" (Social Inadequacy). Items were developed for the SSD based on six dimensions of stigma as outlined by Jones et al. (1984). Through factor analytic strategies, the authors of the SSD found a four-factor structure to provide an optimal fit to the data (Barney et al., 2010).

In the present study, references to depression were replaced with the term *mental illness*. This was done in order to assess for the convergent validity of the author-developed SSOMI as well as to examine the unique relationship of the SSOMI and SSOSH with dimensions of broader self-stigma as opposed to depression stigma specifically. The scale demonstrates internal consistency (Cronbach's α = .87) and shows moderate test–retest reliability across and within subscales (SSDS Total p^ = .63; Shame p^ = .56; Self-Blame p^ = .54; Help-Seeking Inhibition p^ = .63; and Social Inadequacy p^ = .49). The scale demonstrates convergent validity through its moderate association with perceived social distance from those with depression (r = .23; Barney et al., 2010). An indication of the scale's discriminant validity is its weak, negative correlation with self-esteem (r = –.14; Barney et al., 2010). In the present study, Cronbach's alphas for the modified SSD subscales in Sample 1 were: .87 for the Shame subscale, .79 for the Self-blame subscale, and .90 overall.

Help-seeking attitudes. The Attitudes Toward Seeking Professional Psychological Help–Short Form (ATSPPH–SF; Fischer & Farina, 1995) is a 10-item revision of the original 29-item ATSPPH (Fischer & Turner, 1970) and was utilized to measure attitudes toward seeking help in both samples. The revised scale strongly correlates with the full version (r = .87), suggesting that the two are measuring the same construct (Fischer & Farina, 1995). Items are rated on a 4-point Likert-scale from 0 (*disagree*) to 3 (*agree*). Five items are reversed scored so that higher scores reflect more positive attitudes toward seeking psychological help. Items include such statements as "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts." Evidence of convergent validity comes from the correlation of the revised scale with use of professional psychological help (r = .39). The scale has demonstrated 1-month test–retest (r = .80) and internal consistencies (r = .84; Fischer & Farina, 1995). In the present study, Cronbach's alpha was .79 for Sample 1 and .84 for Sample 2.

Help-seeking intentions. The Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975) is a 17-item scale measuring how likely respondents would be to seek psychological services if they were to experience any of the specific problems listed. The ISCI was collected in both Samples 1 and 2. Items are rated on a 6-point Likert scale from 1 (*very unlikely*) to 6 (*very likely*). Responses on the ISCI are summed such that higher scores indicate a greater likelihood of seeking services for the given issues. In Cepeda-Benito and Short's (1998) factor analysis of the ISCI, three factors were revealed: Psychological and Interpersonal Concerns, Academic Concerns, and Drug Use concerns (α = .71). For Sample 1, the 14 items from the Psychological and Interpersonal Concerns and Academic Concerns subscales were included. For Sample 2, the nine items from the Psychological and Interpersonal Concerns were used. Evidence of the convergent validity of the ISCI comes from the measure's ability to detect differences in college students' intentions to seek psychological services when therapists are presented as more or less attractive (Cash et al., 1975). Additionally, the ISCI relates to the perceived significance of a current problem and to general attitudes toward seeking help (r = .36; Kelly & Achter, 1995). In the present study, Cronbach's alpha was .89 for Sample 1 and .88 for Sample 2.

Results

Confirmatory Factor Analysis

We sought first to examine whether the self-stigmas of mental illness and help seeking are empirically distinct through confirmatory factor analyses (CFA) conducted separately in Samples 1 and 2 using the maximum likelihood method in LISREL (Version 8.8; Jöreskog & Sörbom, 1999). As recommended by Martens (2005), we sought to examine the fit of both the hypothesized two-factor model and the competing model of a single-factor self-stigma construct. The results of the two-factor model for Sample 1, using criterion established by Hu and Bentler (1999), suggested a good model fit, scaled $\chi^2(169, N = 217) = 387.53$, $p = .001$, comparative fit index (CFI) = .97, root-mean-square error of approximation (RMSEA) = .077, 90% confidence interval (CI) [.067, .088], and standardized root-mean-square residual (SRMR) = .078. The factor loadings are presented in Table 1. All estimated factor loadings were significant, ranging from .52 to .86. The correlation between the two latent factors was .67.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 1
Summary of Confirmatory Factor Analyses Results Across Two Samples

Item	Factor loading			
	Sample 1		Sample 2	
	1	2	1	2
SSOSH1	.86		.78	
SSOSH2	.55		.62	
SSOSH3	.70		.64	
SSOSH4	.53		.79	
SSOSH5	.46		.62	
SSOSH6	.83		.76	
SSOSH7	.77		.70	
SSOSH8	.86		.75	
SSOSH9	.52		.74	
SSOSH10	.66		.86	
SSOMI1		.71		.75
SSOMI2		.68		.70
SSOMI3		.62		.63
SSOMI4		.70		.74
SSOMI5		.54		.44
SSOMI6		.66		.45
SSOMI7		.78		.84
SSOMI8		.71		.75
SSOMI9		.81		.74
SSOMI10		.75		.42
Factor correlations	.67		.57	

Note. SSOSH = Self-Stigma of Seeking Help Scale; SSOMI = Self-Stigma of Mental Illness Scale.

Next, we compared the fit of the two-factor model to the competing single-factor model. The single-factor model provided a poor fit for the data, scaled χ^2 (170, N = 217) = 926.54, $p <$ .001; RMSEA = .14, 90% CI [.13, .15]; CFI = .90; SRMR = .097. A scaled chi-square difference test was then used to examine if the models were equivalent. Results of this analysis indicated a significant difference, scaled $\Delta\chi^2(1) = 17.79$, $p < .001$, suggesting that the two-factor model provided a better fit to the data than the single-factor model.

Next, to confirm whether the public and self-stigmas of mental illness and help seeking are empirically distinct in a community sample with a self-reported history of mental illness, we replicated the CFA with Sample 2. The results of the two-factor model suggested a good model fit, scaled $\chi^2(169, N = 324) = 342.31$, $p = .001$, CFI = .98, RMSEA = .056, 90% CI [.048, .065], and SRMR = .063. The factor loadings are presented in Table 1. All estimated factor loadings were significant, ranging from .42 to .84. The correlation between the two latent factors was .57.

Next, we compared the fit of the two-factor model to the competing single-factor model. The single-factor model again provided a poor fit for the data, scaled χ^2 (170, N = 324) = 1,601.64, $p < .001$; RMSEA = .16, 90% CI [.15, .17]; CFI = .85; SRMR = .11. A scaled chi-square difference test was then used to examine if the models were equivalent. Results of this analysis indicated a significant difference, scaled $\Delta\chi^2(1) = 33.76$, $p <$ .001, suggesting that the two-factor model provided a better fit to the data than the single-factor model. Thus, in regards to our first hypothesis, the CFA findings support the distinction between the two self-stigma constructs for both undergraduate students experiencing clinical levels of psychological distress and community members who self-identify as having experienced a mental illness.

Multiple Regression Analyses

Given the empirical distinctness of the two stigma constructs, we were interested in further examining whether the two types of self-stigma accounted for unique variance in stigma-related constructs and help-seeking factors. We were also interested in determining the relative strength of the relationships between both forms of self-stigma with these outcomes. To answer these questions, we conducted simultaneous multiple regressions that included both stigmas as predictors of each construct. Means, standard deviations, possible scale ranges, and bivariate correlations for the main variables are presented in Table 2 (Sample 1) and Table 3 (Sample 2). Notably, the SSOMI and the SSOSH showed significant bivariate correlations with all study variables across both samples, except for the nonsignificant correlation between SSOMI and intentions to seek help in Sample 2.

Given the large correlations between the self-stigma of mental illness and the self-stigma of seeking psychological help in Sample 1 (r = .65, p < .001) and Sample 2 (r = .54, p < .001), multicollinearity was considered as a potential concern in any regression analysis in which both measures were entered as predictor variables. Thus, we paid careful attention to the variance inflation factor (VIF), the standard errors of regression coefficients in each analysis, and condition indexes (see Tabachnick & Fidell, 2001). VIF for all of the analyses were between 1.42 and 1.74 across both samples, meaning that the highest standard error for the coefficients for the self-stigma of mental illness and the self-stigma of seeking help was 1.74 times larger than if the two had been completely uncorrelated (O'Brien, 2007). This is below the typical cutoff value of 5 considered to be cause for concern (Menard, 1995). Standard errors of the regression coefficients were also small (.03–.10; see Tables 4 & 5). Additionally, no condition index was above 30, consistent with the data screening procedures recommended by Tabachnick and Fidell (2001). Because multicollinearity tends to inflate the standard errors of the coefficients but does not impact the bias or efficiency of least-squares regression and because standard errors in these two samples were not large, regression was considered appropriate in the present analysis, and the significance of regression coefficients was considered interpretable (O'Brien, 2007).

Because multiple outcome variables were examined, a Bonferroni correction (.05/7 = .007 for Sample 1 and .05/4 = .013 for Sample 2) was applied to the overall regression analyses. Although this has been cited as a very strict post hoc correction, it helps guard against the risk of Type 1 errors that result from conducting multiple comparisons (Heppner, Wampold, & Kivlighan, 2008).

Sample 1. In Sample 1, we examined the links between the two types of self-stigma and stigma-related concepts (public stigma of mental illness, public stigma of seeking psychological help, shame, self-blame, and social inadequacy) and attitudes and intentions to seek help. The results of the seven regression analyses are reported in Table 4. The R^2s for all of the overall regression equations were significant ($p < .007$). Together, the SSOMI and the SSOSH explained between 5% (devaluation–discrimination) and 42% (Shame and Social Inadequacy) of the variance in out-

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 2
Bivariate Correlations, Means, Standard Deviations, and Ranges for Sample 1

Variable	1	2	3	4	5	6	7	8	9
1. SSOMI	—								
2. SSOSH	.65***	—							
3. BDD	.23***	.17**	—						
4. SSRPH	.31***	.48***	.24***	—					
5. SSD–Sh	.60***	.57***	.23***	.41***	—				
6. SSD–SB	.38***	.45***	.18***	.26***	.49***	—			
7. SSD–SI	.65***	.47***	.15***	.37***	.60***	.30***	—		
8. ATSPPH–SF	−.25***	−.53***	−.01	−.31***	−.30***	−.30***	−.13	—	
9. ISCI	−.19***	−.31***	−.07	−.12	−.15*	−.12	−.06	.43***	—
M	35.88	30.53	47.36	14.16	13.3	14.31	13.19	15.68	30.71
SD	6.95	6.87	8.52	3.05	3.99	3.16	3.18	4.04	8.08
Possible range	10–50	10–50	12–72	5–25	4–20	4–20	4–20	0–30	14–84
Sample range	13–50	14–50	20–72	6–24	4–20	4–20	4–20	4–27	14–55

Note. *N*s = 214–217. SSOMI = Self-Stigma of Mental Illness; SSOSH = Self-Stigma of Seeking Help; BDD = Beliefs about Devaluation–Discrimination; SSRPH = Stigma Scale for Receiving Psychological Help; SSD–Sh = Self-Stigma of Depression (modified for mental illness)–Shame subscale; SSD–SB = Self-Blame subscale; SSD–SI = Social Inadequacy subscale; ATTSPPH–SF = Attitudes Toward Seeking Professional Psychological Help–Short Form; ISCI = Intentions to Seek Counseling Inventory.
* $p < .05$. ** $p < .01$. *** $p < .001$.

comes. The SSOMI (β = .20, p = .02) but not the SSOSH (β = .04, p = .64) was an independent predictor of the public stigma of mental illness, while the SSOSH (β = .47, $p < .001$) was the only significant predictor of the public stigma of seeking psychological help. Both the SSOMI (β = .41) and the SSOSH (β = .30) were independent predictors of shame ($p < .001$), while the SSOSH was the only significant predictor of self-blame (β = .36, $p < .001$) and the SSOMI was the only significant predictor of social inadequacy (β = .60, $p < .001$). Both the SSOMI and the SSOSH were unique predictors of attitudes toward seeking help (β = .16, p = .04, and β = –.37, $p < .001$, respectively), while the SSOSH was the only significant predictor of intentions to seek help (β = –.32, $p <$ .001).

Overall, the magnitude of the effects for the SSOSH and the SSOMI in predicting these outcomes showed important differences. For example, treating the standardized betas as if they were correlation coefficients (D. Bonet, personal communication, October 11, 2010), the self-stigma of seeking help accounted for 22% of the variance in the public stigma of seeking help, while the self-stigma of mental illness accounted for negligible variance. In turn, the self-stigma of mental illness accounted for around 4% of the variance in the public stigma of mental illness compared with .1% of the variance accounted for by the self-stigma of help seeking. These differences indicate distinctions in the relative contribution of the two stigmas to perceived public stigma, domains of self-stigma, and help-seeking attitudes and intentions.

Sample 2. In Sample 2, we examined the links between the two types of self-stigma and two types of public stigma as well as links with attitudes and intentions to seek help. The results of the four regression analyses are reported in Table 5. The R^2s for all of

Table 3
Bivariate Correlations, Means, Standard Deviations, and Ranges for Sample 2

Variable	1	2	3	4	5	6	7	8	9
1. SSOMI	—								
2. SSOSH	.54***	—							
3. BDD	.50***	.41***	—						
4. SSRPH	.50***	.62***	.55***	—					
5. SSD-Sh	.70***	.61***	.49***	.58***	—				
6. SSD-SB	.48***	.50***	.32***	.48***	.64***	—			
7. SSD-SI	.60***	.51***	.48***	.45***	.59***	.47***	—		
8. ATSPPH-SF	−.28***	−.55***	−.21***	−.39***	−.30***	−.31***	−.31***	—	
9. ISCI	−.05	−.21***	−.12*	−.12*	−.018	−.08	−.12*	−.47***	—
M	36.57	26.90	45.46	25.94	35.22	33.07	35.15	19.86	24.00
SD	8.54	7.95	8.31	5.76	11.16	11.04	9.89	5.15	6.98
Possible range	10–50	10–50	12–72	5–20	4–20	4–20	4–20	0–30	9–54
Sample range	10–50	10–50	12–72	5–20	4–20	4–20	4–20	4–30	9–36

Note. *N*s = 308–324. SSOMI = Self-Stigma of Mental Illness; SSOSH = Self-Stigma of Seeking Help; BDD = Beliefs about Devaluation–Discrimination; SSRPH = Stigma Scale for Receiving Psychological Help; SSD–Sh = Self-Stigma of Depression (modified for mental illness)–Shame subscale; SSD–SB = Self-Blame subscale; SSD–SI = Social Inadequacy subscale; ATTSPPH–SF = Attitudes Toward Seeking Professional Psychological Help–Short Form; ISCI = Intentions to Seek Counseling Inventory.
* $p < .05$. *** $p < .001$.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 4
Stigma-Related Constructs and Help-Seeking Factors Simultaneously Regressed on the Self-Stigma of Seeking Help and the Self-Stigma of Mental Illness in Sample 1

Variable	B	SE_b	95% CI	β	R^2	F (df)
BDD					.05	6.12* (2, 213)
SSOMI	0.25	0.11	[.04, .61]	.20*		
SSOSH	0.05	0.11	[−.16, .27]	.04		
SSRPH					.23	30.76* (2, 211)
SSOMI	0.00	0.04	[−.07, .07]	.01		
SSOSH	0.21	0.04	[.14, .28]	.47*		
SSD–Sh					.42	76.57* (2, 212)
SSOMI	0.24	0.04	[.16, .31]	.41*		
SSOSH	0.17	0.04	[.10, .25]	.30*		
SSD–SB					.22	29.79* (2, 212)
SSOMI	0.07	0.04	[−.00, .14]	.15		
SSOSH	0.16	0.04	[.10, .24]	.36*		
SSD–SI					.42	77.96* (2, 212)
SSOMI	0.28	0.03	[.21, .34]	.60*		
SSOSH	0.04	0.03	[−.03, .10]	.08		
ATSPPH–SF					.30	44.65* (2, 213)
SSOMI	0.09	0.04	[.00, .18]	.16*		
SSOSH	−0.37	0.05	[−.46, −.29]	−.63*		
ISCI (14-item)					.09	10.88* (2, 210)
SSOMI	0.02	0.10	[−.17, .22]	.02		
SSOSH	−0.38	0.10	[−.58, −.18]	−.32*		

Note. CI = confidence interval; BDD = Beliefs about Devaluation–Discrimination; SSOMI = Self-Stigma of Mental Illness; SSOSH = Self-Stigma of Seeking Help; SSRPH = Stigma Scale for Receiving Psychological Help; SSD–Sh = Self-Stigma of Depression–Shame subscale (modified for mental illness); SSD–SB = Self-Stigma of Depression–Self-Blame subscale; SSD–SI = Self-Stigma of Depression–Social Inadequacy subscale; ATTSPPH–SF = Attitudes Toward Seeking Professional Psychological Help–Short Form; ISCI = Intentions to Seek Counseling Inventory.
* $p < .007$ (Bonferroni correction $\alpha/\kappa = .05/7 = .007$).

the regression equations were significant at $p < .013$. Together, the SSOSH and SSOMI explained between 5% (Intentions to Seek Help) and 42% (Public Stigma of Seeking Help) of the variance in outcomes. Specifically, the SSOSH independently predicted attitudes to seek help (β = –.60, $p < .001$), whereas the SSOMI did not (β = .10, p = .09). In turn, the SSOSH also independently predicted intentions to seek help (β = –.27, $p < .001$), whereas the SSOMI did not (β = .09, p = .16).

Also in Sample 2, the SSOMI and the SSOSH were both independent predictors of the public stigma of mental illness, (β = .40 and β = .20, respectively, *ps* < .001) and the public stigma of seeking psychological help (β = .24. and β = .49, respectively, *ps* < .001). These differences again indicate some distinctions in the two stigmas' relative contribution to other help-seeking factors. Perhaps most interesting is that the pattern of relative strengths of the beta weights for Sample 2 appears largely consistent with the

Table 5
Stigma-Related Constructs and Help-Seeking Factors Simultaneously Regressed on the Self-Stigma of Seeking Help and the Self-Stigma of Mental Illness in Sample 2

	B	SE_b	95% CI	β	R^2	F (df)
BDD					.28	57.48* (2, 296)
SSOMI	0.39	0.06	[.25, .47]	.40*		
SSOSH	0.20	0.06	[.13, .37]	.20*		
SSRPH					.42	108.06* (2, 297)
SSOMI	0.16	0.04	[.08, .22]	.24*		
SSOSH	0.35	0.04	[.29, .45]	.49*		
ATSPPH-SF					.31	67.33* (2, 307)
SSOMI	0.06	0.03	[−.02, .12]	.10		
SSOSH	−0.39	0.04	[−.47, −.31]	−.60*		
ISCI (9-item)					.05	8.12* (2, 299)
SSOMI	0.08	0.06	[−.04, .18]	.09		
SSOSH	−0.23	0.06	[−.36, −.12]	−.27*		

Note. CI = confidence interval; BDD = Beliefs about Devaluation–Discrimination; SSOMI = Self-Stigma of Mental Illness; SSOSH = Self-Stigma of Seeking Help; SSRPH = Stigma Scale for Receiving Psychological Help; ATTSPPH–SF = Attitudes Toward Seeking Professional Psychological Help–Short Form; ISCI = Intentions to Seek Counseling Inventory.
* $p < .005$ (Bonferroni correction $\alpha/\kappa = .05/4 = .013$).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

results of Sample 1. Again, the self-stigma constructs explained the greatest variance in their corresponding public stigmas. The SSOMI explained around four times the amount of variance in the public stigma of mental illness (16% vs. 4%) while the SSOSH explained approximately four times the amount variance in the public stigma of seeking help (24% vs. 6%). Moreover, the SSOSH explained approximately 36% of the variance in attitudes toward seeking help, whereas the SSOMI explained negligible variance in these attitudes.

Discussion

Foremost, the results of the present study provide empirical evidence for making a conceptual distinction between the self-stigma of mental illness and the self-stigma of seeking psychological help. CFAs across two samples confirmed a two-factor solution as opposed to a single, broad self-stigma construct that encompasses mental illness and seeking psychological help. This finding suggests that the two self-stigma constructs are distinct concepts for those with clinical levels of psychological distress as well as those with a self-reported history of mental illness. Moreover, the magnitude of the distinction between the two stigmas was likely minimized in the present study. Because the self-stigma of mental illness was measured with an instrument that was methodologically identical to the instrument used to measure the self-stigma of seeking help, method invariance in assessing both constructs likely artificially increased the detected correlation between the two constructs. Because this would make it more difficult to detect latent differences between the constructs, the present results are noteworthy.

Additionally, both self-stigma constructs were found to differentially relate to shame, self-blame, and social inadequacy among a sample of individuals experiencing clinical levels of psychological distress. This result suggests that there may be differences between the two self-stigmas in how they impact an individual's self-concept. First, both self-stigmas were found to predict shame. Shame is a "non-specific component of stigma" (Corrigan & Miller, 2004, p. 540) that does not relate to specific attitudes but encompasses general feelings of embarrassment and wishing to hide oneself (Corrigan et al., 2010). It is perhaps thus not surprising that both stigmas explained approximately equal variance in this construct. With regards to self-blame, however, the self-stigma of seeking help was found to be the only significant predictor. This result may be consistent with research examining perceived controllability. Possessing a mental illness may be perceived as less of a "choice" than being a mental health patient. Seeking help represents an active decision to engage in a set behavior and may be seen as more controllable (Vogel & Wade, 2009). Consistent with this idea, mental illnesses that are perceived to have a higher degree of controllability (e.g., drug abuse) have been found to be more stigmatizing than those that are less controllable (Corrigan et al., 2000). Thus, help seeking may be found to explain greater variability in self-blaming attitudes than mental illness. Finally, mental illness self-stigma was the only significant predictor of social inadequacy. Research has demonstrated that persons with internalized stigma for their mental illness see themselves as less valuable than others (Link & Phelan, 2001), whereas seeking help may be seen as posing less interference to interpersonal relationships. In Ben-Porath's (2002) study, for example, those who were experiencing depression and sought help were seen as no less interpersonally interesting than those who were experiencing depression but did not seek help. Together, these findings may suggest that the behavior of seeking psychological help is perceived as an act for which one is blameworthy but that feelings of social inadequacy are more highly related to having a mental illness.

The two self-stigmas were also found to differentially relate to perceived public stigma. For undergraduates who reported currently experiencing clinical levels of psychological distress, each self-stigma was the only significant predictor of variance in its corresponding public stigma. In turn, for community members who self-reported having experienced a mental illness, the self-stigma of seeking help explained approximately four times the amount of variance in the public stigma of seeking help than that of mental illness self-stigma. In a parallel fashion, the self-stigma of mental illness explained approximately four times the amount of variance in the public stigma of mental illness than that of help-seeking self-stigma. Overall, these findings provide strong support for the idea that the two self-stigmas are more highly associated with their corresponding public stigmas. This may mean that the process of awareness, endorsement, and application of publically stigmatizing attitudes to oneself occurs independently for both stigmas, consistent with Modified Labeling Theory (Link, 1987) and the work of Corrigan et al. (2000).

Finally, in both samples, the self-stigma of seeking psychological help explained a larger amount of variance in attitudes and intentions to seek help than the self-stigma of mental illness. In Sample 1, the SSOSH explained 40% of the variance in attitudes and 10% of the variance in intentions, whereas the SSOMI explained 4% and 0.04%, respectively. For Sample 2, the SSOSH explained 36% of the variance in attitudes and 7% of the variance in intentions, while the SSOMI explained approximately 1% in each. These findings are consistent with Schomerus & Angermeyer's (2008) suggestion that help-seeking stigma may be more relevant than mental illness stigma in decisions to seek help. Fears of discrimination and loss of esteem for those considering seeking treatment may thus be the result of the specific stigma attached to help seeking. Although a person might anticipate being labeled mentally ill for seeing a mental health professional and thus avoid seeking treatment, it appears that the stigma associated with seeing a mental health professional is itself the more proximal deterrent.

Implications

The present findings have important implications for stigma research, mental health advocacy and prevention, and clinical practice. For researchers, the present study suggests that measures that include items assessing help-seeking stigma and mental illness stigma may be measuring two related but independent stigma constructs. In particular, measures such as the Beliefs about Devaluation-Discrimination Scale (Link, 1987), Self-Reported Experiences of Rejection Scale (Link, Struening, Rahev, Phelan, & Nuttbrock, 1997), Self-Stigma Scale (Moses, 2009), Consumer Experiences of Stigma Questionnaire (Wahl, 1999), Depression Self-Stigma Scale (Kanter, Rüsch, & Brondino, 2008), Stigma Scale (King et al., 2007), Self-Esteem and Stigma Questionnaire (Hayward, Wong, Bright, & Lam, 2002), and Self-Stigma of Depression Scale (Barney et al., 2010), which include items that

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

utilize help-seeking terminology or include subscales that measure treatment stigma, might best be conceptualized as sampling from the content domains of both help-seeking and mental illness stigma. While this practice has precedent in the large body of literature on mental illness stigma, it may overlook the unique perceptions of those who seek help. In particular, the present findings suggest that in addition to being perceived as mentally ill, being perceived as a help-seeker (or mental health client or patient) is an additional threat to one's self-concept, is internalized separately from mental illness stigma, and is a stronger predictor of help-seeking attitudes and intentions. If researchers continue to subsume help-seeking stigma under mental illness stigma—theoretically and empirically—they may miss what most strongly discourages people from seeking help and subsequently design interventions that target less-salient obstacles to needed psychological treatment.

With respect to improving the utilization of mental health care, mental health literacy has been the focus of many interventions aimed at increasing help-seeking behavior. It is often suggested that by improving the general public's attitudes toward those with mental illness through education and contact, attitudes toward seeking help will improve (Hayward & Bright, 1997). Generally, such interventions have been found to be effective (Rüsch et al., 2005). Other researchers, however, have pointed to the importance of normalizing seeking psychological help as well (Gonzalez, Tinsley, & Kreuder, 2002; Jorm, et al., 2003). The present investigation adds to this conceptualization by suggesting that it may be important for interventions to address both mental illness and help-seeking processes. Because the two are conceptually distinct and the internalization of public messages about the two attributes appears independent, attending to mental-illness stigma alone may not adequately address stigmatizing attitudes toward seeking psychological help or vice versa. Thus, addressing both components of self-stigma may offer considerable gains in improving self-concept and help-seeking attitudes over attending to one component alone. In addition to education about mental illness, effective prevention efforts may benefit from designs that outline the efficacy of counseling, the professional standards of training and conduct, and clinical practice guidelines to decrease help-seeking stigma (see Jorm & Wright, 2008).

For clinicians, knowing which components of mental health care stigma to address may help increase treatment adherence and reduce drop-out rates. Because help-seeking self-stigma appears to be the stronger predictor of help-seeking attitudes, clinicians may find greater utility in incorporating in-session stigma interventions that address help seeking itself. As Wade et al. (2011) have suggested, the self-stigma of seeking help can persist even after the decision to see a counselor has been made and treatment has begun. As such, counselors might work to reduce the stigma of being seen by a mental health provider through methods consistent with strategies to reduce help-seeking stigma. These include using phrasing to describe counseling that is compatible with gender norms (Hammer & Vogel, 2010), challenging the idea that seeking help is a sign of weakness (Wade et al., 2011), and discussing the benefits of psychotherapy (Vogel et al., 2006).

Limitations and Future Research

Perhaps the largest limitation in the present study is the multicollinearity of the two measures used to analyze the self-stigma of seeking help and that of mental illness. Although multicollinearity was an anticipated issue, it may have engendered difficulties for the multiple regression analyses. Analysis of common measures of multicollinearity and model comparisons did not indicate violation of the assumptions of multiple regression, which provides support for the analytic strategy used and the conceptual distinctness of the two constructs. Still, future research might seek to replicate the present findings through discriminant validity analyses of the two self-stigma concepts as in Campbell and Fiske's (1959) multitrait–multimethod matrix (Watson, 2012).

Another important limitation in the present study is the restriction of the samples to those reporting clinical levels of psychological distress and those with a self-reported history of mental illness. These groups were sampled because concerns about seeking psychological help and having a mental illness are likely relevant, and thus the stigma associated with seeking help is likely to be more important in their self-concept than in those not experiencing clinical distress or mental illness (see Schomerus & Angermeyer, 2008). While the present samples have much to say about these populations, researchers may wish to replicate the present findings in a sample of those with very severe and persistent mental illness or those who have received a formal clinical diagnosis. Indeed, research with individuals with serious mental illnesses indicates the use of both clinical and highly personal labels for one's mental health concerns (Ritsher & Lucksted, 2000). It is unclear how such personal and clinical self-labels might influence the differences between mental illness and help-seeking self-stigma observed in the present investigation.

In the present study, we examined distinctions between seeking professional psychological help and mental illness stigma. Given the uniqueness of these constructs, future researchers may wish to explore nuances within the help-seeking stigma construct as has been done in the mental illness literature (e.g., Corrigan et al., 2000). In particular, researchers may wish to examine whether different sources of psychological help (e.g., seeing a pastor, a general practitioner, or a psychotherapist) or different interventions (e.g., requesting medication, receiving cognitive behavioral therapy) are more or less stigmatizing. Such differences would be consistent with research indicating variation in the perceived helpfulness and acceptability of different interventions (Jorm et al., 2000).

Additionally, given the differences in the patterns of relationship between the SSOSH and the SSOMI across different domains of stigma (i.e., shame, self-blame, and social inadequacy), it may be important for researchers to examine mental-illness and help-seeking stigmas across other stigma dimensions. These may include concealability, disruptiveness, or aesthetic qualities as outlined by researchers such as Jones et al. (1984); Weiner, Perry, and Magnusson (1988); or Bresnahan and Zhuang (2010). This may provide better understanding of the ways in which help-seeking stigma and mental-illness stigma differ.

Finally, in the present study we utilized a cross-sectional, descriptive design. It will be important for future studies of the stigma related to help seeking and mental illness to use experi-

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

mental or analogue studies. Research designs such as Ben-Porath's (2002) work can be used to examine more direct responses to stigmatized persons and how these might differ for both mental illness stigma and help-seeking stigma. Additionally, use of structural equation modeling and cluster analysis can be used to better capture the essence of the two variables and increase the precision of measurement. Although the present study provides evidence that each stigma is more strongly associated with its corresponding public stigma and that the two uniquely predict variation in attitudes and intentions to seek help, future researchers may wish to examine structural models in which both mental illness and help-seeking stigma are included. This will help to better illuminate the ways in which persons who seek psychological help or experience a mental illness internalize public messages, interact with others in marked relationships, and pursue rightful life opportunities and needed psychological healthcare.

Conclusion

The present study provides empirical evidence that the self-stigma of mental illness is conceptually distinct from the self-stigma of seeking psychological help. Further, it finds that help-seeking and mental-illness self-stigma explain unique variance in related stigma constructs and components of self-concept, suggesting that the stigmatization process and stigmatizing attributes of each construct may differ. Finally, the present study suggests that help-seeking self-stigma may be more proximal to attitudes and intentions to seek help than mental illness self-stigma.

Mental health services continue to be perceived by many as uncomfortable, risky, and unhelpful. As a result, these services carry a unique set of personally stigmatizing beliefs that interfere with persons receiving needed psychological treatment. It will be important for researchers and clinicians to understand how to address the unique stigma related to psychological treatment and to mental illness in order to increase help-seeking behavior. For this to happen, however, researchers must intentionally disentangle the self-stigma of seeking help from the self-stigma of mental illness.

References

Barkham, M., Evans, C., Margison, F., McGrath, G., Mellor-Clark, J., Milne, D., & Connell, J. (1998). The rationale for developing and implementing core outcome batteries for routine use in service settings and psychotherapy outcome research. *Journal of Mental Health, 7,* 35-47. doi: 10.1080/09638239818328

Barney, L. J., Griffiths, K. M., Christensen, A., & Jorm, H. (2010). The Self-Stigma of Depression Scale (SSDS): Development and psychometric evaluation of a new instrument. *International Journal of Methods in Psychiatric Research, 19,* 243–254. doi:10.1002/mpr.325

Ben-Porath, D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behavior and the presence of depression. *Journal of Social and Clinical Psychology, 21,* 400–413. doi:10.1521/jscp.21.4.400.22594

Bresnahan, M. I., & Zhuang, J. (2010). Towards a theory of stigma. *Journal of Health Psychology, 15,* 231–243.

Bryant, F. B., & Cvengros, J. A. (2004). Distinguishing hope and optimism: Two sides of a coin or two separate coins? *Journal of Social and Clinical Psychology, 23,* 273–302. doi:10.1521/jscp.23.2.273.31018

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait–multimethod matrix. *Psychological Bulletin, 56,* 81–105. doi:10.1037/h0046016

Cash, T., Begley, P., McCown, D., & Weise, B. (1975). When counselors are heard but not seen: Initial impact of physical attractiveness. *Journal of Counseling Psychology, 22,* 273–279. doi:10.1037/h0076730

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology, 45,* 58–64. doi:10.1037/0022-0167.45.1.58

Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., 3rd, & Brown, C. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *The American Journal of Geriatric Psychiatry, 18,* 531–543. doi:10.1097/JGP.0b013e3181cc0366

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59,* 614–625. doi:10.1037/0003-066X.59.7.614

Corrigan, P. W., & Miller, F. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health, 13,* 537–548. doi:10.1080/09638230400017004

Corrigan, P. W., Morris, S., Larson, J., Rafacz, J., Wassel, A., Michaels, P., . . . Rüsch, N. (2010). Self-stigma and coming out about one's mental illness. *Journal of Community Psychology, 38,* 259–275. doi:10.1002/jcop.20363

Corrigan, P. W., River, L. P., Lundin, R. K., Wasowski, K. U., Campoin, J., Mathisen, J., . . . Gagnon, C. (2000). Stigmatizing attributions about mental illness. *Journal of Community Psychology, 28,* 91–102. doi:10.1002/(SICI)1520-6629(200001)28:1<91::AID-JCOP9>3.0.CO;2-M

Corrigan, P. W., & Roa, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry/Revue canadienne de psychiatrie, 57,* 464–469.

Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review, 30,* 907–922. doi: 10.1016/j.cpr.2010.06.004

Corrigan, P. W., Watson, A., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology, 25,* 875–884. doi:10.1521/jscp.2006.25.8.875

Evans, C., Connell, J., Audin, K., Sinclair, A., & Barkham, M., & (2005). Rationale and development of a general population well-being measure: Psychometric status of the GP-CORE in a student sample. *British Journal of Guidance & Counselling, 33,* 153–173. doi:10.1080/03069880500132581

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical Outcomes in Routine Evaluation. *Journal of Mental Health, 9,* 247–255.

Feldman, L. A. (1993). Distinguishing depression and anxiety in self-report: Evidence from confirmatory factor analysis in nonclinical and clinical samples. *Journal of Consulting and Clinical Psychology, 61,* 631–638. doi:10.1037/0022-006X.61.4.631

Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36,* 368–373.

Fischer, E. H., & Turner, J. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35,* 79–90. doi:10.1037/h0029636

Freeman, H. E. (1961). Attitudes toward mental illness among relatives of former patients. *American Sociological Review, 26,* 59–66. doi:10.2307/2090513

Fung, K., & Tsang, H. (2010). Self-stigma, stages of change, and psychosocial treatment adherence among Chinese people with schizophrenia: A path analysis. *Social Psychiatry and Psychiatric Epidemiology, 45,* 561–568. doi:10.1007/s00127-009-0098-1

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Gonzalez, J., Tinsley, H., & Kreuder, K. (2002). Effects of psychoeducational interventions on opinions of mental illness, attitudes towards help seeking and expectations about psychotherapy in college students. *Journal of College Student Development, 43,* 51–63.

Hammer, J., & Vogel, D. (2010). Men's help seeking for depression: The efficacy of a male-sensitive brochure about counseling. *The Counseling Psychologist, 38,* 296–313. doi:10.1177/0011000009351937

Hayward, P., & Bright, J. A. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health, 6,* 345–354. doi:10.1080/09638239718671

Hayward, P., Wong, G., Bright, J. A., & Lam, D. (2002). Stigma and self-esteem in manic depression: An exploratory study. *Journal of Affective Disorders, 69,* 61–67. doi:10.1016/S0165-0327(00)00380-3

Heppner, P. P., Wampold, B. E., & Kivlighan, D. M. (2008). *Research design in counseling*. Pacific Grove, CA: Brooks Cole.

Hu, L., & Bentler, P. M. (1999). Cutoff criteria for fit indexes in covariance structure analysis: Conventional criteria versus new alternatives, *Structural Equation Modeling, 6,* 1–55. doi:10.1080/10705519909540118

Jones, E., Farina, A., Hastorf, A., Markus, H., Miller, D., & Scott, R. (1984). *Social stigma: The psychology of marked relationships*. New York, NY: Freeman.

Jöreskog, K. G., & Sörbom, D. (1999). *Lisrel: New statistical features*. Lincolnwood, IL: Scientific Software International.

Jorm, A. F., Griffiths, K. M., Christensen, H., Korten, A. E., Parslow, R. A., & Rodgers, B. (2003). Providing information about the effectiveness of treatment options to depressed people in the community: A randomized, controlled trial of effects on mental health literacy, help-seeking and symptoms. *Psychological Medicine, 33,* 1071–1079. doi:10.1017/S0033291703008079

Jorm, A. F., Medway, J., Christensen, H., Korten, A. E., Jacomb, P. A., & Rodgers, B. (2000). Public beliefs about the helpfulness of interventions for depression: Effects on actions taken when experiencing anxiety and depression symptoms. *Australian and New Zealand Journal of Psychiatry, 34,* 619–626.

Jorm, A. F., & Wright, A. (2008). Influences on young people's stigmatizing attitudes toward peers with mental disorders: National survey of young Australians and their parents. *British Journal of Psychiatry, 192,* 144–149. doi:10.1192/bjp.bp.107.039404

Kanter, J. W., Rüsch, L. C., & Brondino, M. J. (2008). Depression self-stigma: A new measure and preliminary findings. *Journal of Nervous and Mental Disease, 196,* 663–670. doi:10.1097/NMD.0b013e318183f8af

Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology, 42,* 40–46. doi:10.1037/0022-0167.42.1.40

King, M., Sokratis, D., Shaw, J., Watson, R., Stevens, S., Passetti, F., . . . Serfaty, M. (2007). The Stigma Scale: Development of a standardized measure of the stigma of mental illness. *The British Journal of Psychiatry, 190,* 248–254. doi:10.1192/bjp.bp.106.024638

King, P., Newton, F., Osterlund, B., & Baber, B. (1973). A counseling center studies itself. *Journal of College Student Personnel, 14,* 338–344.

Komiya, N., Good, G., & Sherod, N. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47,* 138–143. doi:10.1037/0022-0167.47.1.138

Kranke, D., Floersch, J., Townsend, L., & Munson, M. (2010). Stigma experience among adolescents taking psychiatric medication. *Children and Youth Services Review, 32,* 496–505. doi:10.1016/j.childyouth.2009.11.002

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52,* 96–112. doi:10.2307/2095395

Link, B. G., Cullen, F., Struening, E., Shrout, P., & Dohrenwend, B. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54,* 400–423. doi:10.2307/2095613

Link, B. G., & Phelan, J. (2001). Conceptualizing stigma. *Annual Reviews of Sociology, 27,* 363–385. doi:10.1146/annurev.soc.27.1.363

Link, B. G.., Struening, E. L., Rahav, M., Phelan, J. C., & Nuttbrock, L. (1997). On stigma and its consequences: Evidence from a longitudinal study of men with dual diagnosis of mental illness and substance abuse. *Journal of Health and Social Behavior, 38,* 177–190. doi:10.2307/2955424

Lucksted, A., Drapalski, A., Calmes, C., DeForge, B., & Boyd, J. (2011). Ending self-stigma: Pilot evaluation of a new intervention to reduce internalized stigma among people with mental illnesses. *Psychiatric Rehabilitation Journal, 35,* 51–54. doi:10.2975/35.1.2011.51.54

Manos, R. C., Rusch, L. C., Kanter, J. W., & Clifford, L. M. (2009). Depression self-stigma as a mediator of the relationship between depression severity and avoidance. *Journal of Social and Clinical Psychology, 28,* 1128–1143. doi:10.1521/jscp.2009.28.9.1128

Martens, M. P. (2005). The use of structural equation modeling in counseling psychology research. *The Counseling Psychologist, 33,* 269–298. doi:10.1177/0011000004272260

Menard, S. (1995). *Applied logistic regression analysis:* [Sage University Paper Series on Quantitative Applications in the Social Sciences Series No. 07-106]. Thousand Oaks, CA: Sage.

Moses, T. (2009). Stigma and self-concept among adolescents receiving mental health treatment. *American Journal of Orthopsychiatry, 79,* 261–274. doi:10.1037/a0015696

O'Brien, R. M. (2007). A caution regarding rules of thumb for variance inflation factors. *Quality & Quantity, 41,* 673–690. doi:10.1007/s11135-006-9018-6

Oppenheimer, K., & Miller, M. (1988). Stereotypic views of medical educators toward students with a history of psychological counseling. *Journal of Counseling Psychology, 35,* 311–314. doi:10.1037/0022-0167.35.3.311

Prentice, D. A., & Miller, D. T. (1992). When small effects are impressive. *Psychological Bulletin, 112,* 160–164. doi:10.1037/0033-2909.112.1.160

Ritsher, J. E., & Lucksted, A. (2000). What do you call your problem? Labels for mental illness in four samples in the United States and Russia. *Psychiatric Rehabilitation Journal, 23,* 393–395. doi:10.1037/h0095139

Rüsch, N., Angermeyer, M., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20,* 529–539. doi:10.1016/j.eurpsy.2005.04.004

Schomerus, G., & Angermeyer, M. C. (2008). Stigma and its impact on help-seeking for mental disorders: What do we know? *Epidemiologia e Psichiatria Sociale, 17,* 31–37. doi:10.1017/S1121189X00002669

Sibicky, M., & Dovidio, J. (1986). Stigma of psychological therapy: Stereotypes, interpersonal reactions, and the self-fulfilling prophecy. *Journal of Counseling Psychology, 33,* 148–154. doi:10.1037/0022-0167.33.2.148

Tabachnick, B., & Fidell, L. (2001). *Using multivariate statistics*. Boston, MA: Allyn & Bacon.

Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N. G. (2013). Is Stigma Internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology*. Advance online publication. doi:10.1037/a0031889

Vogel, D., & Wade, N. G. (2009). Stigma and help-seeking. *The Psychologist, 22,* 20–23.

Vogel, D., Wade, N., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53,* 325–337. doi:10.1037/0022-0167.53.3.325

Wade, N., Post, B., Cornish, M., Vogel, D., & Tucker, J. (2011). Predictors of the change in self-stigma following a single session of group counseling. *Journal of Counseling Psychology, 58,* 170–182. doi:10.1037/a0022630

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin, 25,* 467–478. doi:10.1093/oxfordjournals.schbul.a033394

Wahl, O. F., & Harman, C. R. (1989). Family views of stigma. *Schizophrenia Bulletin, 15,* 131–139. doi:10.1093/schbul/15.1.131

Watson, D. (2012). Objective tests as instruments of psychological theory and research. In H. Cooper (Ed.), *APA handbook of research methods in psychology*: *Vol. 1. Foundations, planning, measures, and psychometrics* (pp. 349–369). Washington, DC: American Psychological Association.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology, 55,* 738–748. doi:10.1037/0022-3514.55.5.738

Received November 30, 2012
Revision received April 9, 2013
Accepted May 13, 2013 ■

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.