Seeking psychological help: A comparison of individual and group treatment

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Abstract

The study examined public and self-stigma and their association with attitudes and intentions to seek psychological help in regard to both individual and group treatment as well as to various subgroups, including gender, ethnicity, educational orientation, level of religion, and age. Undergraduate students ($N = 307$) in three universities in Israel participated in the study. Results partly confirmed the model for both individual and group therapy: Self-stigma was related to attitudes and intentions to seek help. However, public stigma was not related to self-stigma. Importantly, some differences were also found among the various subgroups, and the model, which takes into account the different subgroups, looks somewhat different for individual and group therapy.

Keywords: help seeking; stigma; attitudes; group therapy

Concerns about stigma can prevent people from seeking psychological services. Past research has demonstrated the link among stigma, attitudes, and intentions to seek individual counseling (Vogel, Wade, & Hackler, 2007). However, although group therapy is also underutilized, we know very little about the role of stigma on attitudes and intentions to seek group treatment (Piper, 2008). Stigma may be an important factor in potential clients' attitudes toward group therapy, because concerns about the stigmatizing reactions of others may be particularly salient in a group setting. The goal of the current study is to fill in this gap in the literature by examining the relationships among stigma, attitudes, and intentions to seek treatment for both individual and group treatment.

Stigma of Seeking Therapy

Many people who experience psychological stress or interpersonal concerns never pursue treatment (Andrews, Issakidis, & Carter, 2001). The most common reason for not seeking services is the stigma associated with mental illness and help seeking (Corrigan, 2004). Stigma has been defined as a mask or flaw resulting from a personal or physical characteristic that is viewed as socially unacceptable (Blaine, 2000). "The stigma associated with seeking mental health services is the perception that a person who seeks treatment is undesirable or socially unacceptable" (Vogel, Wade, & Haake, 2006, p. 325). There are at least two separate types of stigma affecting an individual's decision to seek treatment. The first is public stigma, or the perception held by others (i.e., society) that an individual is socially unacceptable. The second is self-stigma, or the perception held by the individual that he or she is socially unacceptable (Vogel et al., 2006). In other words, the negative perceptions expressed by society toward those who seek mental health services may be internalized and lead people to perceive themselves as inadequate or inferior (Corrigan, 2004). In a series of studies, Vogel and colleagues established that among U.S. samples public stigma is internalized as self-stigma, and self-stigma then inhibits intentions to seek individual treatment by attenuating positive attitudes toward seeking psychological help. Specifically, Vogel et al. (2007) reported the results of a structural model in which public stigma was positively related to self-stigma, self-stigma was

then negatively associated with attitudes, and these attitudes were positively related to intentions to seek help for psychological concerns. Although the relationship of perceived public stigma with one's intentions to seek treatment in an individual setting is well established, little is known about whether the same factors are related to seeking help in a group setting.

Given the evidence for the efficacy, applicability, and efficiency of group therapies (Burlingame, McKenzie, & Strauss, 2004) and the growing need for mental health services (Taylor et al., 2001), it is quite surprising that group therapy is underutilized (Piper, 2008). In an attempt to understand potential clients' resistance to group therapy, Piper (2008) suggested several concerns, including the fear of losing control, a diminished sense of individuality, less privacy, exposure to others, lack of safety, and fear of criticism. All these factors are present in individual treatment but are amplified in a group setting. This amplification may increase clients' concerns about stigma. On the other hand, self-stigma could be lessened in a group setting because it may normalize the behavior of help seeking. As such, research is needed to empirically examine whether the relationships between the different types of stigma and attitudes are similar or different than has been shown for individual counseling.

Drawing from the research on individual treatment, we replicated the model suggested by Vogel and colleagues (2007) on stigma to test whether it also applies to group treatment. Moreover, because stigma may be influenced by cultural factors, we also looked at the role of several subcultures, including gender, ethnicity, religion, and educational orientation. Vogel et al. (2007) reported gender differences related to stigma, with men internalizing public stigma as self-stigma more strongly than women. As such, men may experience heightened stigma upon admitting that they need help from a group. Group psychotherapy also requires members to share personal thoughts and feelings, disclose private events among a group of strangers, and provide honest and direct feedback (Yalom & Leszcz, 2005), all behaviors that may be embarrassing to non-Western participants. For example, individuals from more collectivistic (vs. individualistic) cultures would be less likely to seek help from a professional because of perceptions of greater shame associated with disclosing personal information to nonfamily members (Kim & Omizo, 2003). Such may be the case for Arabs in Israel (Al-Krenawi & Graham, 2001) as well as for highly religious individuals. Examining the role of public and self-stigma on attitudes and intentions to seek treatment within a culture with both strong

individualistic and collectivistic orientations would allow for a clearer examination of these ideas.

Moreover, career tendencies and choice of educational major may make a difference because the subject in which one majors may be linked with stigma and help-seeking intentions. Initially, career choices are in part based on personal preferences (Holland, 1997). These initial preferences may then be reinforced by the influence of those around the individuals with similar dispositions. For example, those completing liberal arts majors may have more positive attitudes toward help seeking than those in the natural sciences (Wu, 1994). Because many of the studies on stigma have only used psychology students, it is important to look at other majors to examine their potential link with stigma and help-seeking intentions.

We asked two questions. First, would the basic model suggested by Vogel and colleagues for individual treatment (public stigma → self-stigma → attitudes → intention), apply to group treatment? In this study, we report the findings of the model for both individual and group treatment. Second, to what extent are cultural factors associated with the model? We hypothesized that (a) for individual and group treatment, public stigma will be positively related to self-stigma, self-stigma will be negatively related to attitudes toward help seeking, and attitudes will then be positively related to intention to seek help; (b) compared with individual therapy, participants would express greater concern about self-stigma as well as less positive attitudes and intention to seek help in the context of group therapy; and (c) differences would be found between subpopulations in the study. Women, Jewish students, humanistic majors, and secular students will score lower on public and self-stigma and higher on attitudes and intention to seek help compared with men, Arab students, science majors, and religious students.

Method

Participants

The study population was composed of 307 undergraduate students—153 men and 154 women—from three universities in the north of Israel. The majority of the students ($n=235$; 76.5%) were Jewish, and the rest ($n=72$; 23.5%) were Arabs, representing the normal ratio of students at these universities. Ages ranged from 18 to 42 years ($M=24$, $SD=3.92$). The majority of the students (89%) were born in Israel. About half of the students (52.4%) majored in science and the rest (47.6%) in humanities. Just over

half of all the students (54%) reported being secular and the rest reported being religious.

Measures

Public stigma was measured with the 12-item perceived Devaluation–Discrimination scale (DD; Link, Mirotznik, & Cullen, 1997). Participants rated, on a scale ranging from 1 (*strongly agree*) to 6 (*strongly disagree*), the degree to which they believed statements about how most people view current or former psychiatric patients (e.g., "Most people wouldn't hire a former mental patient to take care of their children, even if he or she had been well for some time"). Estimates of internal consistency range from .76 to .88 among clinical and community samples (Link et al., 1989; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), and in the current study the internal consistency was .81. Validity has been demonstrated through relationships with internal experiences of demoralization and lower self-esteem 6 and 24 months later (Link et al., 2001).

Self-stigma was measured with the 10-item Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). The SSOSH is rated on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). To assess the self-stigma associated with individual and group therapy, the word "individual" or "group" was inserted into the items (e.g., "I would feel inadequate if I went to [individual/group therapy] for psychological help"). Estimates of the internal consistency range from .86 to .90, and the 2-week test–retest reliability was .72 (Vogel et al., 2006). The internal consistency obtained in the current sample was .80 and .78 for individual and group treatment, respectively. Evidence of validity has been shown through correlations with attitudes toward seeking professional help (rs = −.53 to −.63) and intention to seek counseling (rs = −.32 to −.38). The SSOSH also differentiates students who sought psychological services from those who did not across a 2-month period (Vogel et al., 2006).

Attitudes toward seeking professional help were measured with the 10-item Attitudes Towards Seeking Professional Psychological Help Scale–short version (ATSPPHS-S; Fischer & Farina, 1995). To assess individual and group therapy, the word "individual" or "group" was inserted into the items (e.g., "If I believed I was having a mental breakdown, my first indication would be to go to [individual/group therapy]"). Items are rated from 1 (*disagree*) to 4 (*agree*). The short version of the scale correlated with the longer version ($r = .87$) and with prior use of professional help for a problem ($r = .39$; Fischer & Farina, 1995) and intentions to seek help ($r = .50$; Vogel et al., 2007). Internal

consistency was found to be .84, and test–retest reliability over a 1-month interval was reported to be .80. The internal consistency of the scores obtained in the current sample was .80 and .74 for individual and group treatment, respectively.

Intention to seek counseling was measured with the Intention to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). The ISCI is a 17-item measure wherein respondents rate, on a scale ranging from 1 (*very unlikely*) to 4 (*very likely*), how likely they would be to seek counseling if they were experiencing the problem listed. To assess individual and group therapy, participants were asked to report their likelihood of seeking both individual and group therapy for the problems listed. Factor analysis of the ISCI supports the existence of three subscales, labeled Psychological and Interpersonal Concerns (11 items; $\alpha = .90$), Academic Concerns (four items; $\alpha = .71$), and Drug Use Concerns (two items; $\alpha = .86$), with correlations among the subscale ranging from .18 to .50. In the present study, we used only the first subscale (Psychological and Interpersonal Concerns). The internal consistency obtained in the current study was .86 and .89 for individual and group treatment, respectively.

Procedure

Students were recruited from three different institutions, including (a) a university that focuses on social and humanistic studies, (b) a technical university that teaches science and engineering, and (c) a teacher college for Orthodox students. One of the researchers visited classrooms to ask people to participate in a study about attitudes and perceptions. Each scale was translated by two independent researchers to Hebrew and then back-translated to English by the same researchers. In case of discrepancies, a third researcher discussed the discrepancy with them until complete agreement was achieved. Questionnaires were submitted in random order and completed anonymously in the classroom; only a few declined participation (5%). The package included two forms (one for individual therapy, one for group therapy) for SSOSH, ATSPPHS-S, and ISCI and just a single form for DD (not specified as to whether it related to any type of psychotherapy). Participants, who all spoke Hebrew, completed the scales in Hebrew.

Results

Testing the General Model

Means, standard deviations, and correlations among all variables are presented in Table I. Means centered on the middle of the range for each of the scales, and

4   *A. Shechtman et al.*

Table I. Means, Standard Deviations, and Correlations among the Study Variables ($N = 307$)

Variable	Range	M (SD)	1	2	3	4	5	6	7
1. Self-stigma, individual therapy	10–50	24.89 (6.56)[a]	—	.82★★	−.02	−.51★★	−.33★★	−.24★★	−.13★
2. Self-stigma, group therapy	10–50	25.95 (6.53)		—	.03	−.40★★	−.42★★	−.24★★	−.23★★
3. Public stigma	12–72	50.13 (8.73)[b]			—	.08	−.11	.04	−.06
4. Attitudes toward individual therapy	10–40	27.08 (6.00)				—	.61★★	.48★★	.21★★
5. Attitudes toward group therapy	10–40	23.35 (5.29)					—	.38★★	.42★★
6. Intention to seek individual therapy	17–68	39.79 (10.42)						—	.59★★
7. Intention to seek group therapy	17–68	32.70 (9.90)							—

[a]The mean for self-stigma in Vogel et al. (2007) was 28.5 ($SD = 7.4$). [b]The mean for public stigma in Vogel et al. (2007) was 46.9 ($SD = 9.4$).
★$p < .05$. ★★$p < .001$.

significant correlations ranged from moderate to high. Figures I and II present the results of a path analysis conducted for the basic model for individual and group treatment, respectively. Both models fit the data: Chi-square was nonsignificant, normed fit index (NFI) and nonnormed fit index (NNFI) were close to 1, and root-mean-square error of approximation (RMSEA) was lower than 0.05—individual

treatment model: $\chi^2(3, N = X) = 1.86$, $p = .60$, NFI $= 0.99$, NNFI $= 1.02$, RMSEA $= 0.00$; group treatment model: $\chi^2(3, N = X) = 4.92$, $p = .18$, NFI $= 0.96$, NNFI $= 0.94$, RMSEA $= 0.046$—and the results supported the predicted relationships between self-stigma and attitudes and between attitudes and intentions to seek help for both individual and group therapy. Interestingly, though, the expected relationship between public stigma and self-stigma was not present for either individual or group treatment (see Figures I and II), and public stigma did not correlate with any of the variables (see Table I). Hence, for Israeli participants, public stigma was a less important factor than self-stigma regardless of treatment type.

Differences between the Two Models

Repeated measure analyses of covariance were used for this analysis, controlling for age, ethnicity, and religiosity. First, for self-stigma, the difference in the means (see Table I) were not significant, $F(1, 302) = 0.70$, $\eta^2 = .002$, $p = ns$. However, the differences in the means for attitudes, $F(1, 302) = 10.27$, $\eta^2 = .03$, $p < .01$, and intentions, $F(1, 302) = 15.78$, $\eta^2 = .05$, $p < .001$ (see Table I) between individual and group therapy were significant. Thus, the second hypothesis was supported for attitudes and intentions (less

positive attitudes and intentions to seek group therapy) but not for self-stigma (participants were equally self-stigmatized).

Testing the Role of Subcultures

Because of the large age range, scores were first correlated with age, before the analyses of differences between the subpopulations. Three significant correlations were found: self-stigma regarding individual and group therapy (rs $= .18$ and $.17$, respectively, $p < .01$) and attitudes toward individual treatment ($r = .24$, $p < .001$). The higher the age, the lower the scores on self-stigma and the higher the scores on attitudes. Because of these correlations, the analyses of subcultural differences were performed using multivariate analysis of covariance (MANCOVA) to control for age.

The MANCOVA included the study variables (public stigma, self-stigma, attitudes, and intentions) and the four demographic variables (gender, ethnicity, education, and religiosity). Main effects and second-order interactions were introduced (third- and fourth-order interactions resulted in prohibitively small cell sizes). Gender, $F(7, 284) = 2.75$, $p < .01$, $\eta^2 = .06$, ethnicity, $F(7, 284) = 2.44$, $p < .05$, $\eta^2 = .06$, and religiosity, $F(14, 566) = 1.72$, $p < .05$, $\eta^2 = .04$, were significant, yet education, $F(7, 284) = 1.72$, ns, $\eta^2 = .04$, was not. All second-order interactions were nonsignificant. For gender, differences were found on attitudes and intentions toward individual ($p < .001$) and group ($p < .01$) therapy; women scored higher on these variables. No differences were found on public stigma and self-stigma (ps $> .05$). For ethnicity, differences were revealed for self-stigma toward individual therapy ($p < .05$) and intention to seek individual ($p < .01$) and group
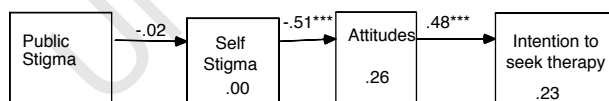

Figure I. The basic model for individual treatment: $\chi^2(3, N = X) = 1.86$, $p = .60$, NFI $= 0.99$, NNFI $= 1.02$, RMSEA $= 0.00$.

Figure II. The basic model for group treatment: $\chi^2(3, N = X) = 4.92$, $p = .18$, NFI $= 0.96$, NNFI $= 0.94$, RMSEA $= 0.046$.

($p <.001$) therapy; Arabs scored higher on self-stigma and intentions to seek help. No differences were found in public stigma and attitudes (ps $>.05$). Finally, for religiosity, two specific differences were found in self-stigma toward individual treatment ($p <.05$) and intentions to seek group therapy ($p <.01$). Post hoc analysis revealed that the Orthodox scored higher than the secular group on both self-stigma ($p <.01$) and intentions to seek group therapy ($p <.01$).

Given the significant differences between these subgroups, we conducted the path analyses again while including these demographic variables. For individual therapy, the expanded model (including all subpopulations; see Figure III) was found to fit the data, $\chi^2(8, N=X) =9.54$, $p =.30$, NFI $=0.97$, NNFI $=0.98$, RMSEA $=0.025$, because the chi-square was nonsignificant, NFI and NNFI were close to 1, and RMSEA was lower than 0.05. The model suggests that self-stigma was associated with age, gender, and religion. The older participants, the less religious, and women had lower self-stigma. Self-stigma was negatively related to attitudes, but age and gender also related directly to attitudes; older participants and women reported more positive attitudes. Finally, attitudes were positively related to intention to seek therapy, but gender and ethnicity also related directly; women and religious students scored higher on intention to seek help. For group therapy, the expanded model (Figure IV) was also found to fit the data, $\chi^2(18, N=X) =23.02$, $p =.19$, NFI $=0.90$, NNFI $=0.95$, RMSEA $=0.03$, because the chi-square was nonsignificant, NFI and NNFI were close to 1, and RMSEA was lower than 0.05. Public and self-stigma were negatively associated with attitudes. In addition, age is negatively related to self-stigma and education was negatively related to attitudes. Finally, as previously, gender and ethnicity were positively related with intentions to seek group therapy.

Discussion

Results of this study confirmed Vogel et al.'s (2007) model regarding individual and group treatment, with the exception of the association between public stigma and self-stigma. The models supported the links among self-stigma, attitudes, and intentions (Vogel et al., 2007), proposing that help-seeking intentions are directly based on attitudes toward a behavior, which are, in turn, based on the expectations the individual has about the outcome of the behavior. However, in contrast to Vogel et al.'s (2007) findings, public stigma was not related to self-stigma in either the individual or group treatment models. This occurred despite the fact that the means of public and self-stigma were similar in this study as in Vogel et al.'s study (see Table I). Although these results were initially unexpected, they suggest that public stigma may not be an important factor in the underutilization of individual or group treatment in Israel. One possible explanation for this finding may be that, in the current sample, people formed their own opinion about help seeking regardless of the opinions of others. This may be a result of living among a less conformist group of people or, alternatively, a lack of clear social norms. In a highly immigrant society such as Israel, such explanations are plausible. For example, there may be considerable diversity in the perceptions and attitudes among those who have emigrated from different societies (e.g., Western countries and those who come from Middle Eastern countries). These represent considerably different cultures that may have very different attitudes about seeking psychological help. Alternatively, in a country traumatized by frequent wars and political tension, the perceptions of public stigma regarding people in need of mental help may be very different from those in the United States.

If these explanations hold, then the explanation suggested by Vogel and others that public stigma affects attitudes and intentions through its relationship with self-stigma (Vogel et al, 2007) may be
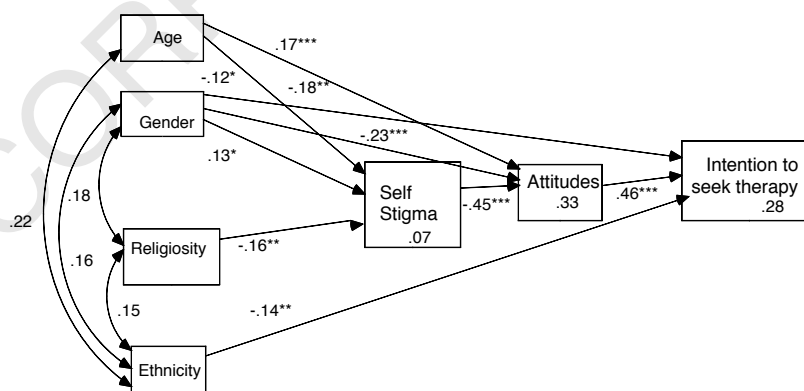

Figure III. The expanded model for individual treatment: $\chi^2(8, N=X) =9.54$, $p =.30$, NFI $=0.97$, NNFI $=0.98$, RMSEA $=0.025$.
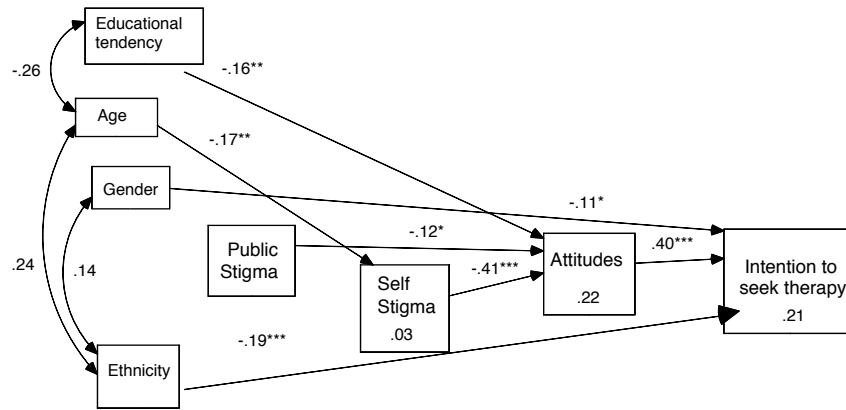
Figure IV. The expanded model for group treatment: $\chi^2(18, N = X) = 23.02$, $p = .19$, NFI $= 0.90$, NNFI $= 0.95$, RMSEA $= 0.03$.

incorrect. Self-stigma may develop and subsequently influence attitudes and help-seeking intentions, even in the absence of public stigma's influence. Self-stigma may be a result of internal dynamics, such as a person's sense of inefficacy, incompetence, and dependence, which make one feel stigmatized when in need of psychological help.

The current results suggest that internal factors (e.g., shame) may be more important than external factors (public views). Moreover, the differences in the two extended models are interesting because in individual treatment age, gender, religion, and ethnicity were all associated with self-stigma, but public stigma was unrelated. In contrast, in the group treatment model, only age was related to self-stigma, whereas public stigma was associated with attitudes. Perhaps public stigma is stronger in the context of group treatment than in the context of individual treatment, when other factors are accounted for. Nevertheless, public stigma was not related to self-stigma, which challenges the explanation that public stigma operates through a reduction of self-esteem (Vogel et al., 2007).

The differences by demographic subculture are interesting. In contrast to our expectations, public stigma was not higher in the collectivistic societies (e.g., Arab, Orthodox Jews). However, these two subgroups scored higher on self-stigma, which casts additional doubt on the supposition that self-stigma arises from the internalization of public stigma (Vogel et al., 2007) and strengthens the explanation that public stigma may measure different constructs in different cultures. Moreover, intentions to seek help were higher in these two subgroups despite concomitant higher self-stigma.

The age and gender differences are interesting although not surprising. The fact that older participants scored lower on self-stigma regarding both individual and group therapy may be attributed to their maturity level. Mature people may be more realistic about their needs and less defensive about getting psychological help. Indeed, older participants also show more positive attitudes toward therapy (Mackenzie, Gekoski, & Knox, 2006).

Gender was associated with several variables: Women scored lower on self-stigma, expressed more positive attitudes toward therapy, and showed higher intentions to seek help within both models. These results are congruent with Vogel et al.'s (2007) findings and with the general help-seeking literature showing that women report more positive attitudes toward seeking help (Fischer & Farina, 1995) and are more likely to seek help for emotional issues (Moller-Leimkuhler, 2002).

Finally, pertaining specifically to group therapy, students majoring in the humanities were more open to therapy than those majoring in the sciences. Students in the humanities may tend a priori to be interested in emotions and people's lives and, therefore, may be more likely to want to hear about other group members' experiences than science students (Holland, 1997; Wu, 1994). These results regarding the impact of age, gender, and subject of study need further exploration.

Thus, it seems that people may form attitudes and intentions to seek help regardless of or despite the presence of stigma. Indeed, past studies with an Arab population in Israel have demonstrated that participants show positive attitudes and function constructively in groups, despite the collectivistic norms of their society (Shechtman, Goldberg, & Cariani, 2008). No information is yet available for Orthodox Jews.

The study is not without limitations. First, because we intended to replicate the Vogel studies, we too investigated a student population. Even though we did not use psychology students, who might be biased in regards to psychological help seeking, we did study a student population that certainly does not represent the general population.

Thus, our results may not present an accurate picture of stigma for all individuals. Second, the study focused on intentions to seek help rather than actual help-seeking behavior. Although the relationship between intentions and behavior is recognized in the literature (see Webb & Sheeran, 2006), there might also be differences between the two in regard to help seeking. All measures were also self-report. Although attitudes and intentions can only be examined via self-report measures, assessing actual use of mental health services would provide a more convincing result. Third, we used a public stigma questionnaire that may not retain validity across diverse cultures; questionnaires must be developed that are valid for the unique culture studied. Despite these limitations, this study is an important step in understanding the role of stigma, particularly public stigma, in cultures other than the United States. Moreover, this was the first time the role of stigma in the context of group treatment has been studied. It may be of interest to explore the role of stigma in group treatment within a U.S. sample where the model regarding individual treatment was initially established.

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