The Role of Public and Self-Stigma in Predicting Attitudes Toward Group Counseling

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Abstract

Public and self-stigmas have been implicated as factors in the underutilization of individual counseling. However, group counseling is also underutilized, and yet scholars know very little about the role of different types of stigma on attitudes toward seeking group counseling. Therefore, the current study examined the relationships between public and self-stigma and attitudes toward group counseling among a sample of 491 U.S. college students. Results of structural equation modeling analyses indicated that public stigma is internalized as self-stigma and self-stigma is then negatively related to attitudes toward group counseling. Furthermore, public stigma and self-stigma explained 52% of the variance in attitudes toward seeking help.

Keywords

attitudes, help seeking, stigma, group therapy, group counseling

A person who is stigmatized is perceived by society as belonging to a social group or category that is viewed as undesirable (Crocker, Major, & Steele, 1998).

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Researchers have found that both having a mental illness and the act of seeking individual counseling are stigmatized (Vogel, Wade, & Hackler, 2007) and, therefore, it has been suggested that individuals may decide to forego counseling to avoid being labeled as a member of a stigmatized group (Corrigan, 2004). This barrier to seeking appropriate services has led to increasing calls for research into the role of stigma in the decision to seek help for different types of counseling so that targeted interventions can be developed (Ludwikowski, Vogel, & Armstrong, 2009; Shechtman, Vogel, & Maman, 2010). However, although concerns about stigmatization have been clearly linked with negative attitudes toward individual counseling (Vogel et al., 2007), we know little about the role of stigma on decisions to seek other forms of counseling such as group counseling. Group counseling is utilized even less than individual counseling (Abraham, Lepisto, & Schultz, 1995); thus, the goal of this study is to fill in this gap in the research by examining the role of stigma on attitudes toward seeking group counseling.

Stigma and Help Seeking

Stigma may be a significant barrier to seeking counseling. One explanation for the effects of stigma is based on modified labeling theory (MLT; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). MLT posits that for those experiencing mental health issues, negative external perceptions (i.e., public stigmatization) can negatively affect their internal sense of self (i.e., self-stigmatization) if they are labeled by themselves or others as having a mental health concern. Because of this process, people may avoid seeking services to avoid being labeled (Corrigan, 2004). Consistent with this theory, people have been found to internalize external perceptions of mental illness (Link, 1987; Link & Phelan, 2001) and to report lower self-esteem after being labeled as mentally ill (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001).

Originally, MLT (Link et al., 1989) was developed in relation to perceptions of mental illness. However, more recently, MLT has been applied to decisions to seek counseling. Specifically, researchers have started to examine the relationships between the public stigma and self-stigma associated with seeking help for a psychological problem (e.g., Vogel, Wade, & Haake, 2006). Public stigma has been defined as the negative reactions that the general population has toward a stigmatized group (Corrigan, 2004). Past research has clearly shown the existence of public stigma associated with individual counseling (Komiya, Good, & Sherrod, 2000). For example, Sibicky and Dovidio (1986) found that people described as having used counseling services are viewed more negatively than those not described as

having used services. Similarly, those seeking help for depression are viewed as less stable, less interesting, and less confident than those seeking help for physical concerns (Ben-Porath, 2002). In contrast, self-stigma has been defined as the reduction of an individual's self-esteem or self-worth caused by the individual labeling herself or himself as socially unacceptable (Vogel et al., 2006). In other words, people may perceive themselves as inferior, inadequate, or weak if they were to seek counseling services (Fisher, Nadler, & Whitcher-Alagna, 1982; Nadler & Fisher, 1986).

Directly examining the hypothesized relationships of MLT between public and self-stigma, researchers have started to find evidence that public stigma is, in fact, internalized as self-stigma (Vogel et al., 2007). Specifically, researchers have found not only that was public stigma positively related to self-stigma but also that self-stigma fully mediated the relationship between public stigma and attitudes toward seeking individual counseling (Ludwikowski et al., 2009; Vogel et al., 2007). In other words, public stigma was negatively associated with attitudes about individual counseling only through its relationship with self-stigma. Thus, the data support MLT assertions that perceptions of public stigma are related to help-seeking decisions through the internalization of those beliefs. This focus on self-stigma provides some important guidance for interventions as counselors can readily focus on reducing internal (i.e., self-stigmatization) as opposed to just external (i.e., public stigma) factors. Examples of internal interventions have included use of narrative therapy to change negative personal narratives to reduce self-stigma via empowerment of the individual (see Kondrat & Teater, 2009).

The relationship between public and self-stigma is important in understanding help-seeking decisions and developing targeted interventions to increase the use of specific types of counseling services. However, despite the fact that group counseling is underutilized at least as much as individual counseling (Piper, 2008), the role of stigma on the decision to seek group counseling is less well known than it is for individual counseling. This is an important omission in the literature as group counseling has been shown to be an effective form of treatment (Burlingame, MacKenzie, & Strauss, 2004; McRoberts, Burlingame, & Hoag, 1998; Shechtman, 2004). Furthermore, group counseling has a number of unique strengths including time efficiency, cost-effectiveness, and being particularly well suited for certain types of issues (e.g., interpersonal skills) for which individuals often seek help (Kincade & Kalodner, 2004; Yalom & Leszcz, 2005). Yet despite the potential benefits of group counseling, individuals seem to prefer individual to group counseling (Abraham et al., 1995). For example, although 92% of college counseling centers offer groups, only about one in five clients are willing to participate (Golden, Corazzini, & Grady, 1993).

One reason for the increased reluctance to seek group counseling may be a strong sense of stigma associated with this type of treatment. For example, researchers have noted the common belief that group counseling is only for highly disturbed individuals (Parcover, Dunton, Gehlert, & Mitchell, 2006). This perception may exacerbate concerns about stigmatization for seeking group counseling (i.e., "I will be viewed as highly disturbed if I seek group therapy"). Some support for this assertion may be found in that clinicians have discussed the high levels of anxiety present early on for individuals involved in groups (Yalom & Leszcz, 2005). Similarly, concerns about self-disclosing personal issues may be enhanced in a group setting, in particular, fearing that disclosure will lead to rejection by other group members (Parcover et al., 2006). However, despite these assertions, little is actually known about the role that stigma plays in the decision to seek group counseling. Theoretically, public stigma may play a particularly important role in potential clients' decisions to seek group counseling as many external concerns are central factors in a group setting. For example, there may be strong fears about how other group members will react to them including concerns about being rejected and criticized. In addition, there may be a fear that other group members could break confidences and that other people (i.e., coworkers, family) would find out about their seeking group therapy. In turn, self-stigma may also be a central factor. Apprehension about others reactions could lead to self-stigmatizing beliefs by reinforcing negative perceptions people have about themselves. In other words, believing that other group members would not be accepting of their problems could lead to decreased self-acceptance. Similarly, people may feel worse about themselves if they believed they have problems severe enough to be considering group treatment. Therefore, although exposure to others in a group setting may have a positive benefit of normalizing experiences once one is in counseling (i.e., universality; Yalom & Leszcz, 2005), thinking about this exposure, particularly before seeking treatment, may increase self-stigma by bringing into focus aspects of the self that are perceived negatively (i.e., "I am unable to handle things without help from others").

Yet despite the logical connections between public and self-stigma and the decision to seek group counseling, the relationships between these constructs are not fully clear. Recent evidence has questioned whether stigma is equally as important in decisions to seek group counseling as it is for individual counseling. For example, a study by Shechtman et al. (2009) examining decisions to seek counseling in an Israeli college population found support for the link between self-stigma and attitudes toward seeking group counseling. However, in contrast to the research with U.S. samples investigating individual

counseling (i.e., Vogel et al., 2007), self-stigma did not mediate the relationship between public stigma and attitudes. In fact, public stigma was not significantly related to attitudes toward group counseling. These findings call into question whether public stigma is actually a salient factor in the decision to seek group counseling. However, before this conclusion can be reached, it is important to note that this is the only study we are aware of examining the potential roles of public and self-stigma and attitudes for group counseling, and therefore it is not fully known if these results are because of cultural differences in the perceptions of stigma between the samples assessed (Israeli vs. U.S.) or something about perceptions of stigma related to group counseling, specifically. Therefore, the goal of the current study is to shed light on this question by building on these recent findings and examining the specific roles of public and self-stigma on attitudes toward group counseling among a U.S. sample.

Drawing from the research on individual counseling, we applied the model suggested by Vogel and colleagues (2007), in which public stigma is related to attitudes toward group counseling through the mediator of self-stigma. Better understanding the role that public and self-stigma play in people's choices about group counseling would have important implications for group counselors. Improving our understanding of how stigma relates to the decision to seek group counseling could be used to enhance the use of group services through outreach and educational programs that specifically target the aspects of stigma that inhibit the decision to seek group counseling.

Sex Differences in Perceptions of Stigma

Sex differences may be present in the relationships between public and self-stigma and attitudes (Addis & Mahalik, 2003). Vogel et al. (2007) found differences in the strength of the relationship between public and self-stigma for women and men. Public stigma was internalized as self-stigma to a greater degree for men than for women. Vogel and colleagues explained these results by citing gender role expectations. In other words, men may feel extra pressure to be self-reliant and in control of their emotions whereas women are expected to be expressive and in touch with their emotions. As such, women may be more accepted by others and in turn more accepting of themselves if they were to feel the need to express distressing emotions to a therapist (Vogel et al., 2006). Consistent with this, women are more likely to seek help for emotional issues compared to men (Andrews, Issakidis, & Carter, 2001). Yet researchers have rarely examined whether these sex differences are present across different types of counseling. In terms of group counseling, Shechtman

et al. (2009) found that men feel a stronger sense of self-stigma toward group counseling, possibly as a result of their sense of self-reliance being more threatened because more people would know about their concerns (i.e., not just a therapist but all group members). Therefore, building on these findings this study examines the potential moderating role of sex on the relationships between public and self-stigma and attitudes toward seeking group counseling.

Current Study

Structural equation modeling (SEM) analyses were used to examine the relationships among public stigma, self-stigma, and attitudes toward seeking group counseling. It is expected that the model suggested by Vogel et al. (2007) would be largely replicated. Specifically, self-stigma will fully mediate the relationship between public stigma and attitudes toward group counseling. In particular, we hypothesize that public stigma will be positively linked with self-stigma and that self-stigma will then be negatively related to positive attitudes toward seeking group counseling. Also, given the need to examine potential differences across sex, we examine the invariance of the model paths by sex (women vs. men). Because of gender role expectations suggesting that men should be able to handle emotional issues on their own, we expect that for group counseling men will internalize public stigma as self-stigma to a greater degree than women.

Method

Participants and Procedure

Before data collection began, university institutional review board approval was obtained. Participation was voluntary and questionnaires were completed anonymously. Participants were 491 college students (males = 238, females = 253) all attending a university in the Midwest and enrolled in a 100- or 200-level psychology class. Participants received extra credit for their participation.

Measures

Public stigma was measured with the 12-item perceived Devaluation-Discrimination Scale (Link et al., 1989). Participants rated from 1 (*strongly agree*) to 6 (*strongly disagree*) the degree to which they believed statements

about how most people view current or former mental health patients. An example item is "Most people would willingly accept a former mental patient as a close friend." Higher scores represent greater perceived stigma. Estimates of internal consistency range from .76 to .88 among clinical and community samples (Link et al., 1989; Link et al., 2001). The internal consistency estimate obtained in the current sample was .83. Validity has been shown through a relationship between this scale and the internal experience of demoralization and lower self-esteem among a community sample 6 months and 24 months later (Link et al., 2001).

Self-stigma was measured with Shechtman et al.'s (2010) modified version the Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). The SSOSH is a 10-item scale consisting of items assessing internal reactions (e.g., feeling inadequate) for seeking psychological help. To assess the self-stigma associated with group counseling, Shetchman et al. changed the words *therapist* and *therapy* to *group counseling*. Example items are "I would feel inadequate if I went to group counseling for psychological help" and "My view of myself would not change just because I made the choice to be in group counseling." Items are rated on a 5-point partly anchored scale ranging from 1 (*strongly disagree*) to 5 *(strongly agree)*, with 5 items reverse scored so that higher scores reflect greater self-stigma. Shechtman et al. reported internal consistency estimates with college students for both the individual (.80) and group (.78) versions of the scale. The internal consistency of the scores obtained in the current sample was .85. Shechtman et al. reported the correlation between the individual and group versions of the scale to be .82. The group version of the scale was also reported to be negatively associated with attitudes toward group counseling ($r = -.42$, $p < .001$) and intentions to seek group counseling ($r = -.23$, $p < .001$).

Attitudes toward seeking group counseling were measured with Shechtman et al.'s (2009) modified version of the Attitudes Toward Seeking Professional Psychological Help Scale–Short Form (Fisher & Farina, 1995). Items are rated from 1 (*disagree*) to 4 (*agree*), with higher scores reflecting positive attitudes. The 10-item scale was modified by Shechtman et al. (2009) by changing the wording to reflect a group setting (e.g., "individual counseling" was changed to "group counseling" and "psychologist" was changed to "therapy group" or "group setting"). Example items are "If I believe I was having a mental breakdown, my first inclination would be to go to group therapy," "The idea of talking about problems in a group setting strikes me as a poor way to get rid of emotional conflicts," and "A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with the help of a therapy group." Shechtman et al. reported the reliabilities of both the

original individual (.80) and the modified group (.74) versions in their sample of college students. The internal consistency of the scores obtained in the current sample was .78. Shechtman et al. reported the correlation between the individual and group attitude scales to be .61. The attitudes toward group counseling scale was also linked to intentions to seek group counseling ($r = .42$, $p < .001$).

Results

The maximum likelihood method in the LISREL 8.8 program was used to examine the measurement and hypothesized structural models. Three observed indicators of each of our latent constructs (public stigma, self-stigma, and attitudes) were included in each model. The observed indicators for the latent variables were three parcels created from the original scales following the recommendation of Russell, Kahn, Spoth, and Altmaier (1998). The parcels were created by separately fitting a one-factor model using exploratory factor analyses with the maximum likelihood method on the items from each scale. Each scale's items were then rank ordered based on the magnitude of their factor loadings. To equalize the average loadings of each parcel on its respective factor, we assigned the highest and lowest ranking items in pairs to a parcel. We chose to parcel these variables to reduce the number of parameters that would result from using the individual items, thereby improving the estimation of the effects (see Russell et al., 1998). Furthermore, parcels were used rather than including additional measures of each construct because some of the constructs (e.g., self-stigma) had only one validated scale and because using fewer measures reduced participant burden. We chose this method of parceling because, as Russell and colleagues stated, "when this procedure is used, the resulting item parcels should reflect the underlying construct . . . to an equal degree" (p. 22). Having equal loadings across the parcels should maximize the benefits of parceling.

Because the maximum likelihood procedure assumes normality, we first examined the multivariate normality of the observed variables. The result indicated that the multivariate data were not normal: $\chi^2(2, N = 491) = 84.9$, $p < .001$. Therefore, the scaled chi-square is reported in subsequent analyses. We also report four additional indices to assess the goodness-of-fit of the models: the comparative fit index (CFI; .95 or greater), the incremental fit index (IFI; .95 or greater), the standardized root mean square residual (SRMR; .08 or less), and the root mean square error of approximation (RMSEA; .06 or less; Hu & Bentler, 1999).

Table 1. Factor Loadings for the Measurement Model

Measured variable	Unstandardized factor loading	SE	Z	Standardized factor loading
Public-stigma				
Public stigma parcel 1	2.37	0.13	17.61	0.77***
Public stigma parcel 2	2.67	0.13	21.03	0.88***
Public stigma parcel 3	2.62	0.12	21.98	0.84***
Self-stigma				
Self-stigma parcel 1	2.43	0.11	23.23	0.89***
Self-stigma parcel 2	1.97	0.09	22.12	0.84***
Self-stigma parcel 3	2.08	0.09	22.22	0.85***
Attitude toward counseling				
Attitude 1	1.66	0.09	18.02	0.78***
Attitude 2	1.41	0.07	20.57	0.85***
Attitude 3	1.52	0.07	20.86	0.82***

Note: $N = 491$.
***$p < .001$.

Stigma and Group Counseling

In testing a latent model, Anderson and Gerbing (1988) suggest following a two-step procedure: (a) conducting a confirmatory factor analysis to develop a measurement model with an acceptable fit to the data and then (b) conducting a structural model to test the hypothesized relationships. A test of our measurement model resulted in an excellent fit to the data, scaled $\chi^2(24, N = 491) = 44.22$, $p = .007$, CFI = .99, IFI = .99, SRMR = .025, RMSEA = .041 (90% confidence interval [CI] = .021, .060). All of the measured variables significantly loaded on the latent variables (all ps < .001, see Table 1). Therefore, the latent variables appear to have been adequately measured by their respective indicators. Furthermore, the expected correlations between public stigma and self-stigma ($r = .33$, $p < .01$), public stigma and attitudes ($r = -.25$, $p < .01$), and self-stigma and attitudes ($r = -.63$, $p < .001$) were present. The correlations between each of the observed variables are presented in Table 2.

Next, we examined our hypothesized model in which self-stigma fully mediates the relationship between public stigma and attitudes toward group counseling. The structural model showed an excellent fit to the data: scaled $\chi^2(24, N = 491) = 44.41$, $p = .009$, CFI = .99, IFI = .99, SRMR = .026, RMSEA = .040 (90% CI = .019, .059). Public stigma was related to self-stigma,

**Table 2.** Zero-Order Correlations Among Nine Observed Variables

	2	3	4	5	6	7	8	9
1. Public stigma 1	.68	.66	.22	.24	.28	−.22	−.22	−.13
2. Public stigma 2	—	.76	.27	.27	.27	−.18	−.20	−.12
3. Public stigma 3		—	.21	.19	.25	−.18	−.20	−.16
4. Self-stigma 1			—	.76	.75	−.52	−.54	−.55
5. Self-stigma 2				—	.72	−.45	−.47	−.41
6. Self-stigma 3					—	−.55	−.53	−.53
7. Attitude 1						—	.67	.63
8. Attitude 2							—	.71
9. Attitude 3								—

Note: Public stigma 1, 2, 3 = the three parcels created from Perceived Devaluation Discrimination; self-stigma 1, 2, 3 = the three parcels created from the Self-Stigma of Seeking Help Scale; attitude 1, 2, 3 = the three created parcels from the Attitudes Toward Seeking Professional Psychological Help Scale.
Absolute values of correlations greater than or equal to |.16| were significant at $p < .001$;
Absolute values of correlations less than .16 were significant at $p < .01$.

and then self-stigma was related to attitudes toward seeking group counseling (see Figure 1). Next, we tested an alternative partially mediated model in which we added the direct path from public stigma to attitudes. We used the Satorra–Bentler scaled chi-square difference test (Satorra & Bentler, 2001) to compare these two nested models to determine which model was a better fit to our data. The result of this partially mediated model also indicated an excellent fit to the data: scaled $\chi^2(25, N = 491) = 44.22$, $p = .007$, CFI = .99, IFI = .99, SRMR = .025, RMSEA = .041 (90% CI = .021, .060). However, when these two models were compared, there was no significant corrected chi-square difference, indicating no difference between these two models, $\Delta\chi^2(1, N = 491) = .22$, $p = .63$, suggesting that the added path from public stigma to attitudes did not add to the model. We also tested two alternative models: one in which self-stigma predicted public stigma and then public stigma predicted attitudes and one in which public stigma predicted attitudes and then attitudes predicted self-stigma. Neither model fit the data as well as the hypothesized model. The first alternative model did not fit the data, scaled $\chi^2(25, N = 491) = 193.45$, $p < .001$, CFI = .96, IFI = .96, SRMR = .19, RMSEA = .12 (90% CI = .10, .13). The second alternative model, scaled $\chi^2(25, N = 491) = 60.98$, $p = .007$, CFI = .99, IFI = .99, SRMR = .055, RMSEA = .054 (90% CI = .037, .072), showed some fit with the data, but three of the fit indices were worse than the hypothesized model (i.e., scaled χ^2, SRMR, and RMSEA). Therefore, for group counseling a fully mediated model was selected as the best fitting model (see Figure 1).
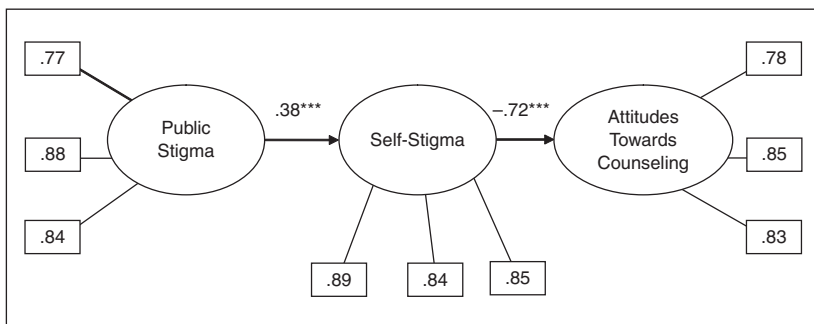
Figure 1. Final mediated model
**p < .01. ***p < .001.

Bootstrapping

The bootstrap procedure recommended by Shrout and Bolger (2002) was used to examine the significant levels of indirect effect for the hypothesized mediated model. Bootstrap procedures offer an empirical means for determining statistical significance that circumvents the need to assume normality as the bootstrapping results provide asymmetric confidence limits. If the 95% CI for the estimate of asymmetric indirect effect does not include zero, it can be concluded that the indirect effect is statistically significant at the .05 level (Shrout & Bolger, 2002). In the first step of the bootstrap procedure we created 2,000 bootstrap samples from the original data set ($N = 491$) by random sampling with replacement. In the second step we ran the hypothesized structural model 2,000 times with the 2,000 bootstrap samples to yield 2,000 estimations of each path coefficient. In the third step we used LISREL's saved output of the 2,000 estimations of each path coefficient to calculate an estimate of the indirect effect. The bootstrap results confirmed that the direct pathway from public stigma to self-stigma ($\beta = .38$, *B* mean = –.97, *SE* of mean = .002, 95% CI = –1.26, –1.16), the direct pathway from self-stigma to attitudes ($\beta = –.72$, *B* mean = 1.01, *SE* of mean = .001, 95% CI = 0.90, 0.93), and the mediated pathway from public stigma through self-stigma to attitudes ($\beta = .38 \times –.72 = –.27$, *B* mean = .98, *SE* of mean = .002, 95% CI = –1.25, –1.15) were all significant.

Sex Comparison

The invariance of structural path coefficients for the female ($n = 253$) and male ($n = 238$) participants was also examined by conducting SEM multiple

group comparison analysis. A freely estimated model was compared to a model in which the relations between variables were set to be equal for women and men. The corrected scaled chi-square difference test was used to determine whether these models were equivalent. When these two models were compared, the corrected chi-square differences test was not significant, $\Delta\chi^2(2, N = 490) = 2.23$, $p = .33$. Thus, the relations between the variables were not different for women and men. Thus, although in past research the relationship between perceived public stigma and self-stigma was found to differ for women and men in regard to individual counseling (Vogel et al., 2007), the relationships were similar for men and women with regard to group counseling.

Discussion

The purpose of the study was to examine the role of public and self-stigma on attitudes toward group counseling in a U.S. sample. Using SEM, we built on our understanding of the ways in which stigma influences one's decision to seek group counseling by replicating Vogel et al.'s (2007) model in which public stigma is linked to self-stigma and then self-stigma is linked to attitudes toward group treatment. These findings also further support some assertions of MLT (Link et al., 1989). MLT asserts that societal perceptions of stigma toward the mentally ill (i.e., public stigma) can lead to negative consequences for people's sense of self (i.e., self-stigma) if they are labeled (by themselves or others) as having a mental health concern. It is believed then that people avoid seeking help to avoid this label (Corrigan, 2004). Our findings extend this idea to group counseling in that public stigma might lead to internalization of the stigma and decreased positive attitudes toward seeking help. Thus, for U.S. populations, the present results add to the help-seeking literature by providing empirical evidence that the effect of perceived public stigma on attitudes toward seeking group counseling is mediated by one's internalization of that stigma.

Moreover, comparing the current finding with a U.S. sample to the findings found by Shechtman et al. (2009) with an Israeli sample, the results support the previous authors' assertion that this internalization process may be culture specific. Shechtman and colleagues suggested that different cultures might have more or less clearly defined public stigmas regarding seeking help. When the messages present in society are consistent (i.e., in the United States people who go to counseling are consistently presented in negative ways on TV and in movies), people may be more likely to internalize these views and thus feel worse about themselves (i.e., "I must be crazy").

In cultures where these norms are less well defined, individuals may be able to rely more on their own evaluations. This hypothesis is promising in that as societal or public stigmas change they may have less of an influence on our feelings of self-worth. Future researchers may want to further examine these issues by directly examining the perceptions of stigma across different cultures.

We also examined the potential moderation of the model by sex. Interestingly, unlike the previous findings pointing to sex differences in the internalization of stigma for individual counseling, sex differences were not present in the current sample (Vogel et al., 2007). Although these results were unexpected, they are consistent with one other study examining stigma and career counseling (Ludwikowski et al., 2009). The results suggest that group counseling may be perceived differently than individual counseling in terms of its stigmatizing nature (i.e., either more or less stigmatizing). For example, although individual counseling may be perceived as something men are not supposed to need (i.e., they should be self-reliant), group counseling may be perceived as something both women and men should not need. In other words, gender roles may not be as strong a factor as other more salient concerns are present. Specifically, concerns about privacy and exposure to others could play a role in self-stigmatizing beliefs to a greater degree than sex. Given these findings, future research should continue to examine the role of sex on stigma and help seeking, with particular emphasis on the effect of gender roles on perceptions of public and self-stigma and help-seeking decisions.

Implications

Several important clinical implications arise from the findings of this study. First, this work supports the growing body of research noting the importance of self-stigma in the decision to seek help by extending it to group counseling. This is a significant step. Although it has been discussed for a number of years that public stigma interferes with seeking help, public stigma is based on society-level beliefs and therefore can be difficult and slow to change. Although this change may be the ultimate goal, intermediate goals might also be worthwhile. Self-stigma is an individual factor that can be addressed both on larger scale interventions and in work with clients at the individual and small group level. Furthermore, the knowledge that self-stigma fully mediates the relationship between public stigma and attitudes toward seeking counseling stresses the direct importance of focusing on this issue in the United States. Recent work has started to suggest the use of specific interventions (i.e., based on social constructivism and personal narratives) to reduce

self-stigma (see Kondrat & Teater, 2009). For example, from a social constructivist perspective self-stigma may be reduced through the process of changing from a socially constructed view of self to a new empowered self-constructed view of self (Kondrat & Teater, 2009). Narrative therapy offers a set of interventions designed to assist in this process by having clients create an "account of themselves and the world around them . . . a self-narrative" (White & Epston, 1990, p. 10). Initially, these narratives may be filled with stigmatizing messages internalized by the individual while other positive aspects of their narrative are given less attention (Kondrat & Teater, 2009). The focus of counseling is to have the client "re-author, their personal stories to account for the [other positive] . . . alternatives" (Kondrat & Teater, 2009, p. 41). Doing so could empower a potential client to view herself or himself in a more positive light (for further discussion, see Kondrat & Teater, 2009).

As such, training programs may start to work with graduate students to develop interventions, skills, and confidence in working with clients to reduce self-stigmatizing beliefs. Future researchers may also want to focus on specific group interventions that may affect stigma. For example, a number of characteristics specific to group work (i.e., universality, social learning; Yalom & Leszcz, 2005) may be particularly powerful in combating self-stigmatizing beliefs once a person has the experience of being in a group. Thus, focusing on interventions and strategies to change self-stigma can be both practical and efficient ways to encourage college students to enter group counseling.

Consistent with the previous discussion, Sirey and colleagues (2001) suggested that psychologists work with potential clients to reduce stigma. One approach may be to offer student outreach programs on campus or to add information to college counseling center Web sites that acknowledges the presence of stigma and provides information to counteract the negative messages associated with counseling. For example, the belief that "seeking counseling is a sign of weakness" could be reframed as evidence of strength as it takes courage to acknowledge a problem and discuss it in a group setting. Similarly, self-stigma may also be decreased when symptoms are normalized (Schreiber & Hartrick, 2002) and problems are presented as resolvable (Mann & Himelein, 2004). Some efforts to provide these types of messages have been started. For example Griffiths, Christensen, Jorm, Evans, and Groves (2004) developed a Web site for those experiencing depression to help reduce stigma (see http://www.bluepages.anu.edu.au). However, more interventions specific to group counseling are needed. Group counseling is particularly well suited to provide feelings of normalization and hope (Yalom & Leszcz, 2005), and so counseling centers and counseling programs interested

in having their students engage in social justice–oriented outreach may want to develop "single session groups" where college students can experience what it is like to be in a group setting and thus lessen potential fears if they were to need group services in the future. In all, helping different groups understand stigma and its effects, and providing options for addressing it might help to promote the use of psychological services for underserved populations.

Limitations and Future Research

There are limitations to the present research that should be noted. First, we studied only a college student population that may not represent the general population and may not present an accurate picture of stigma for all people. Given the limited demographic information collected, we were not able to examine the potential of role certain potentially important demographic factor such as culture. Both public and self-stigma may be different depending on certain cultural factors (i.e., individualistic vs. collectivistic cultures), and examining stigma across cultures is an important future direction (see Shechtman et al., 2009). Similarly, this study was conducted at a single college campus in the Midwest that had limited variation in terms of race or ethnicity. Certain ethnic and racial minority groups tend to avoid traditional psychological help, possibly because of concerns about stigma (see Leong, Wagner, & Tata, 1995), and so future studies might be conducted to further address this issue.

Another potential limitation is the measures used. The original versions of the stigma measures have been reported to have excellent reliability and validity. However, we adapted the measures from the original focus on individual counseling to a focus on group counseling, and the reliability and validity of these adapted scales have been reported in only one previous study. As such, the findings of this study should be considered in light of this knowledge until additional studies can verify the construct validity of the use of these scales for this purpose.

The present results are also correlational and do not show causation. Longitudinal studies or experimental designs are needed to show that one's beliefs about public or self-stigma actually directly cause or inhibit help seeking. Similarly, the study focused on attitudes toward seeking help rather than actual help-seeking behaviors. Although attitudes have been shown to be a good predictor of intentions in regard to seeking help (Vogel et al., 2007), they are different from actual help seeking. Future investigations could explore actual help-seeking behaviors. In addition, our sample was not chosen based on psychological distress. However, studies have shown that those who are

not distressed report similar help-seeking attitudes and decisions as those currently distressed (Vogel et al., 2007). Still, this was the first study to explore the mediating effect of different stigmas for group counseling, and so future studies might be conducted to validate this model with a clinically distressed sample. For example, future studies could include a global symptom measure and then examine the analyses separately for the portion of the sample that scores greater than the clinical cutoff. Related to this, future research should also examine models that include the relationships among these variables and other potential mediating factors, such as personality and attachment style. These investigations could help to focus interventions and would be important in efforts to understand and mitigate the effects of both public and self-stigma (Corrigan, 2004).

Conclusion

In all, this study provides an important step in understanding the role of stigma on the decision to seek group counseling for U.S. college students. Specifically, this study underscores the importance of self-stigma in mediating the effects of public stigma on attitudes toward group counseling. As such, researchers and clinicians should continue to explore the role of self-stigma for group counseling and continue to examine ways to mitigate the potential negative effects of stigma.

Declaration of Conflicting Interests

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