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Measuring the Self-Stigma Associated With Seeking Psychological Help

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Self-stigma is an important factor in people's decisions not to engage in therapy. To measure this construct, the authors developed the 10-item Self-Stigma of Seeking Help (SSOSH) scale. In Study 1 (n = 583), the SSOSH had a unidimensional factor structure and good reliability (.91) among participants. Study 2 (n = 470) confirmed the factor structure. Studies 2, 3 (n = 546), and 4 (n = 217) cross-validated the reliability (.86 to .90; test–retest, .72) and showed evidence of validity (construct, criterion, and predictive) across the study samples. The SSOSH uniquely predicted attitudes toward and intent to seek psychological help. Finally, in Study 5 (n = 655) the SSOSH differentiated those who sought psychological services from those who did not across a 2-month period.

Keywords: self-stigma, public stigma, help seeking, psychological services

An unsettling paradox exists in counseling psychology and related mental health fields. Decades of psychotherapy research have revealed that psychological treatments are effective for a broad range of concerns (Wampold, 2001). However, many people who are experiencing mental health concerns never seek psychological help. In fact, large-scale epidemiological studies have found that less than 40% of individuals with a mental health concern seek any type of professional help (e.g., Andrews, Issakidis, & Carter, 2001; Kessler et al., 2001; Regier et al., 1993). The percentage of those with a mental health concern who actually seek help from a counselor or mental health professional is noticeably smaller (i.e., 11%), particularly for those who struggle with problems that do not meet diagnosable criteria (i.e., <2%, Andrews et al., 2001). As a result, it is important to understand what factors keep people from seeking psychological services when they are experiencing a significant problem.

Researchers have identified some factors that inhibit individuals from seeking professional psychological help, such as the desire to avoid discussing distressing or personal information (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003) and the desire to avoid experiencing painful feelings (Komiya, Good, & Sherrod, 2000). However, the most cited reason is the stigma of seeking treatment (see Corrigan, 2004, and Corrigan & Penn, 1999, for reviews). Stigma is the perception of being flawed because of a personal or physical characteristic that is regarded as socially unacceptable (Blaine, 2000). According to Corrigan, two types of stigma exist: public stigma and self-stigma. Public stigma is the perception held by a group or society that an individual is socially unacceptable and often leads to negative reactions toward them. The public stigma associated with seeking mental health services, therefore, is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable. These perceptions are often harmful because they lead to stereotyping, prejudice, and discrimination of individuals who seek psychological care (Corrigan, 2004). Thus, researchers hypothesize that people hide psychological concerns and avoid treatment to limit the harmful consequences associated with public stigma (Corrigan & Matthews, 2003). Corrigan calls this *label avoidance,* which he defines as the tendency to deny mental health concerns and not seek the treatment that can cause one to be negatively labeled. Consistent with this, the public stigma associated with mental health issues has been linked to negative attitudes about seeking psychological help (Komiya et al., 2000; Vogel, Wester, Wei, & Boysen, 2005), a decrease in treatment adherence (Sirey, Bruce, Alexopoulos, Perlick, Friedman, et al., 2001), and the early termination of treatment (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001). Laboratory studies have also shown that those who endorse public stigmas of the mentally ill are less likely to seek psychological help for themselves (Cooper, Corrigan, & Watson, 2003).

Although the public stigma associated with seeking psychological services is one potentially important factor in the decision to seek treatment, an equally important barrier might be the stigmatizing beliefs of mental illness on one's self-esteem (Corrigan, 2004). Self-stigma is the reduction of an individual's self-esteem or self-worth caused by the individual self-labeling herself or himself as someone who is socially unacceptable. In the case of seeking psychological help for a personal problem, the largely negative images in western culture of mental illness and psychological services could lower an individual's internalized self-concept, self-esteem, and self-efficacy if they were to seek treatment (Corrigan, 1998, 2004; Holmes & River, 1998). Consistent with this perspective, Fisher, Nadler, and Whitcher-Alagna (1982) described help seeking as a potential threat to one's self-esteem because seeking help from another is often internalized by the individual as meaning they are inferior or inadequate. Therefore, a person may decide not to seek help, even when they are experiencing emotional pain, because of the belief that it would be a sign of weakness or an acknowledgment of failure (see Fisher et al., 1982; Fisher, Nadler, & Whitcher-Alagna, 1983; Nadler & Fisher, 1986). This admission of needing help may be seen as worse than

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the current suffering. Thus, a person may decide not to seek help in order to maintain a positive self-image (Ames, 1983; Miller, 1985).

Research has shown that people do internalize negative perceptions when dealing with mental health issues (Link, 1987; Link & Phelan, 2001) and that being labeled mentally ill can lead to lower self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). A number of studies on nonprofessional help seeking have also found evidence consistent with the importance of protecting one's self-esteem by not asking for help (see Nadler, 1986; Wills & DePaulo, 1991). For example, laboratory studies have found that participants are less likely to seek help when they fear embarrassment (Mayer & Timms, 1970; Shapiro, 1983; Sweetser, 1960) or believe that seeking help will result in feelings of inferiority or incompetence (Nadler, 1991; Wills, 1983). Concerns about the impact of asking for help on an individual's self-esteem may also be an important barrier to seeking help from nonprofessional sources such as family and friends (Nadler, 1991) and teachers (Karabenick & Knapp, 1991).

Although some attempts to measure perceptions of public stigma in relation to help seeking exist (e.g., Komiya et al., 2000), there is no direct measure of self-stigma related to seeking psychological help. Development of a self-stigma measure will make it possible to examine whether avoidance of professional help is related to the desire to avoid self-stigma or to other factors. Furthermore, development of such a measure will facilitate assessment of interventions designed to reduce the effects of self-stigmatization on those considering seeking psychological services. Therefore, the goals of this investigation were (a) to develop a scale of self-stigma that directly measures the perception that seeking help from a psychologist or other mental health professional would threaten one's self-regard, satisfaction with oneself, self-confidence, and overall worth as a person; (b) to examine the reliability, factor structure, and validity of this new scale; and (c) to begin to examine the role that self-stigma plays in the psychological help-seeking process. To meet these goals, we created the Self-Stigma of Seeking Help Scale (SSOSH) over the course of five studies. In Study 1, we developed the 10-item scale and examined the initial reliability and factor structure. In Study 2, we used confirmatory factor analysis to confirm the factor structure and provided additional reliability and initial validity estimates for the scale, including evidence that the SSOSH added unique information to our understanding of psychological help-seeking attitudes and intentions. In Study 3, we replicated and further examined the construct and criterion validity and explored the test–retest reliability of the scale. Study 4 replicated and cross-validated the scale with a new sample and provided expanded evidence that the SSOSH added unique information to our understanding of psychological help-seeking attitudes and intentions. Finally, in Study 5 we examined the ability of the SSOSH to predict those who sought psychological services and those who did not across a 2-month period.

Study 1: Scale Construction

The purposes of Study 1 were (a) to develop items reflecting the content domain of the self-stigma associated with seeking psychological help (see Corrigan, 2004), (b) to evaluate the internal reliability of the new SSOSH scale, and (c) to examine the initial factor structure of the SSOSH.

Method

Participants

Participants were 583 college students, of whom 53% were female and 47% were male. Among the sample, 48% were first-year students, 32% were sophomores, 13% were juniors, and 7% were seniors. Most of the participants were European American (86%), followed by African American (4%), Latino/Latina American (3%), Asian American (3%), multiracial American (2%), and international (2%).

Procedure

Before data collection began on this study (and all of the following studies), approval was obtained from the university Institutional Review Board. Across studies, participants were informed that participation was voluntary; they completed an informed consent form and then responded to the study questions, which included no self-identifiable information. After finishing the study questions, participants in each study were debriefed and received extra credit in their psychology class for their participation.

Participants were contacted through classes and informed that by participating they would be eligible to take part in research later in the semester (see Study 5). For purposes of linking their data with the future data collection, participants provided an ID number (a nine-digit number that was a subset of numbers from their university ID). Participants completed the SSOSH and responded to some demographic questions (i.e., gender, year in school, and ethnic/racial status).

Item Development

Twenty-eight items were created to measure the self-stigma associated with seeking psychological help. On the basis of Corrigan's (2004) discussion of self-stigma as negatively impacting one's self-esteem, we developed the items to assess concerns about the loss in self-esteem a person would feel if they decided to seek help from a psychologist or other mental health professional. The feelings and thoughts about oneself were based on the different aspects that have been identified in the literature to make up an individual's self-esteem (i.e., self-regard, self-confidence, satisfaction with oneself and one's abilities, and overall sense of worth as a person; see Guindon, 2002; Rosenberg, 1965; Street & Isaacs, 1998). We created the items to reflect how these aspects of one's self-esteem might change if a person considered seeking psychological help. Items were discussed and refined over several meetings to clarify wording, to adequately cover the domains, and to reduce item similarity. At the end of this process, 28 items were given to a group of 54 college students to assess the clarity and readability of the items. All items were considered intelligible to college students. On the basis of this feedback, however, we altered the wording of some items for further clarity.

Subsequently, two professional counselors (employed at a university counseling center) assessed the content validity of the 28 items. Both counselors had PhD's in counseling psychology, at least 5 years of therapy experience postlicensure, and experience with the recruitment and retention of clients. The counselors were provided with a definition of the self-stigma associated with seeking psychological help:

> [The self-stigma associated with seeking psychological help] is the fear that by seeking help or going to therapy, a person will reduce their *self-regard*, their *satisfaction with themselves*, their confidence in themselves and their abilities, and that their overall worth as a person will be diminished. [Self-stigma] is distinct from what others might think of me if I went to therapy (public stigma) and from the perceived risks or benefits of going to therapy (except the risk that I might feel worse about myself).

Table 1
Corrected Item–Total Correlations for Items of the Self-Stigma of Seeking Help Scale

Item	Corrected item–total correlation
Nonreverse-keyed items	
23. If I went to a therapist, I would be less satisfied with myself.	**.823**
9. I would feel inadequate if I went to a therapist for psychological help.	**.808**
6. It would make me feel inferior to ask a therapist for help.	**.802**
19. I would feel worse about myself if I could not solve my own problems.	**.771**
22. Seeking psychological help would make me feel less intelligent.	**.769**
14. My view of myself would be more negative if I asked for psychological help.	.762
21. If I could not solve a personal problem on my own, I would feel less worthy as a person.	.758
8. I would not ask for help from a therapist because my view of myself would be threatened.	.757
3. My self-image would feel threatened by seeking professional help.	.748
11. By making the choice to seek therapy, I would be admitting that I am incompetent to solve my problems.	.739
24. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.	.700
2. Asking for help from a therapist would make me feel like there was something wrong with me.	.687
20. People who go to therapy are weaker than I am.	.676
5. If I started therapy, it would mean that there was something wrong with who I am.	.652
7. By asking for help, I am admitting that my coping skills are inadequate.	.635
26. I would feel self-conscious asking for professional help.	.596
18. Seeking help from a professional therapist would make me too dependent on them.	.490
13. I would worry about becoming dependent on therapy if I sought professional help.	.277
Reversed-keyed items	
12. My self-confidence would NOT be threatened if I sought professional help.	**.707**
4. I would feel okay about myself if I made the choice to seek professional help.	**.647**
10. My self-confidence would remain the same if I sought professional help for a problem I could not solve.	**.616**
15. My view of myself would not change just because I made the choice to see a therapist.	**.588**
16. My self-esteem would increase if I talked to a therapist.	**.510**
25. Seeking professional help would mean I could handle things.	.447
17. Getting professional help for my problems would have no effect on my self-image.	.420

Note. $N = 577$. Numbers represent the order in which the original items were presented. Items in boldface type are those that were retained for the final scale. The order of items in the final 10-item scale is 9, 12, 22, 16, 15, 6, 4, 23, 10, and 19.

The counselors were then asked to rate each item on a scale ranging from 1 (*not at all*) to 5 (*extremely well*) on the degree to which it assessed the concept. We retained any item that both content raters scored at least a 3 (*adequate*) and dropped those items that at least one of the raters rated as less than adequate. Analysis of the raters' responses showed adequate consistency across the 28 items (*kappa* = .78). This resulted in the elimination of three items. The resulting 25 items (see Table 1) were retained in the initial item development pool.

Study participants responded to these items using a five-point, partly anchored Likert-type scale ranging from 1 (*strongly disagree*) to 3 (*agree and disagree equally*) to 5 (*strongly agree*). Of the 25 items, 7 were reverse keyed. Participants rated the degree to which each item described how they might react if they faced problems for which they were considering seeking help. Higher scores indicated a greater concern that seeking help from a psychologist or other mental health professional would negatively affect one's self-regard, satisfaction with oneself, self-confidence, and overall worth as a person.

Results and Discussion

Item Selection

Our goal was to develop a unidimensional measure that adequately assessed the domains of interest. The self-stigma associated with seeking psychological help was considered a concept similar to self-esteem (see Rosenberg, 1965), which, though having several possible domains, was a unified construct. As is recommended in classical test theory (see Nunnally, 1978), we selected items for inclusion on the basis of their correlation with the total score (i.e., the item–total correlation). Items that correlate highest with the total scale score are considered most representative of the underlying dimension being measured (Nunnally, 1978). This is in contrast to exploratory factor analysis, which attempts to organize data into as many factors as might be represented by the items. Because we had an a priori unidimensional construct based on the theory that we were attempting to measure, we chose the former strategy over the latter.

In selecting items, we also wanted to be able to lessen the effects of response sets on the total score of the measure and thus decided to retain an equal number of reverse-keyed items (Holden, Fekken, & Jackson, 1985; Kelloway & Barling, 1990; Nunnally, 1978; Paulhus, 1991; Spector, 1992). Response sets are methods of responding to survey questions (i.e., tendency to acquiesce or to respond with extreme categories) that can lead to results that do not reflect actual perceptions but instead measure how the person tends to respond (Cheung & Rensvold, 2000). Having a balance of positively and negatively worded items can reduce these effects (Holden et al., 1985; Kelloway & Barling, 1990).[1] Finally, in selecting items, we wanted to create a measure that would be

[1] Whereas traditionally, it has been recommended that scales contain an equal number of positively and negatively worded items to reduce a variety of response biases, such as acquiescence, researchers have also noted some potential drawbacks to including reverse-keyed items (see Ibrahim, 2001; Messick, 1962; Motl, Conroy, & Horan, 2000; Schmitt & Stults, 1985; Weems, Onwuegbuzie, Eggers, & Schreiber, 2003). The main problem is that reverse-keyed item themselves can be responded to in a biased manner (e.g., paid less attention to) than nonreverse-keyed items, and thus the potential advantage of including reverse-keyed items may be offset by equally problematic issues in responding. However, this issue is less problematic when one factor is expected (and found) because all items are measuring the same underlying construct. In addition, our inclusion of an

useful to researchers and clinicians. A measure that is too long would not be as useful in survey research or as likely to be used by clinicians. In turn, a measure that was too short could miss the domains of interest. We therefore examined the corrected item–total correlation of each item and chose the five highest positively worded items and the five highest reverse-keyed items (see Table 1 for item–total correlations). Although some of the reversed-keyed items were not the highest loading items, overall all of the retained items had what we deemed to be acceptable corrected item–total correlations (all .50). In addition, in examining the face validity of the selected items, we deemed that the 10 items adequately covered the breadth of the domains we originally developed.

Reliability and Factor Structure

The internal consistency of the new 10-item SSOSH was .91 ($N = 583$). The mean of the SSOSH in this sample was 27.1 ($SD = 7.7$). To examine the factor structure, we conducted a principal axis factor analysis on the 10 items that comprised the SSOSH. As expected, this resulted in the extraction of one factor with an eigenvalue 1.0 (eigenvalue = 5.31), accounting for 53% of the total variance. The factor loadings are presented on Table 2. All items loaded >.50. In summary, these results indicated that the 10-item SSOSH has adequate reliability and has a unidimensional factor solution suggesting that it is measuring a single construct.

Table 2
Results of the Principal Axis Factor Analysis in Study 1 and the Confirmatory Factor Analysis in Study 2

Item	Study 1 factor loading	Study 2 factor loading
1. I would feel inadequate if I went to a therapist for psychological help.	.79	.76
2. My self-confidence would NOT be threatened if I sought professional help.	.75	.73
3. Seeking psychological help would make me feel less intelligent.	.75	.80
4. My self-esteem would increase if I talked to a therapist.	.54	.79
5. My view of myself would not change just because I made the choice to see a therapist.	.63	.68
6. It would make me feel inferior to ask a therapist for help.	.80	.70
7. I would feel okay about myself if I made the choice to seek professional help.	.68	.45
8. If I went to a therapist, I would be less satisfied with myself.	.84	.44
9. My self-confidence would remain the same if I sought help for a problem I could not solve.	.66	.74
10. I would feel worse about myself if I could not solve my own problems.	.79	.53

Note. Items are listed in the order in which they appear on the scale.

Study 2: Confirmatory Factor Analysis and Construct and Criterion Validity

The purposes of Study 2 were (a) to replicate in a new sample the reliability and factor structure from Study 1, (b) to examine the construct and criterion validity of the new measure, and (c) to examine the predictive validity of the SSOSH to add unique information to our understanding of psychological help-seeking attitudes and intentions. For construct validity, theory suggests that the self-stigma associated with seeking psychological help should negatively affect one's perceptions of seeking treatment. Therefore, we expected that the SSOSH would be positively associated with the anticipated risks of talking to a counselor and negatively associated with the anticipated benefits of talking to a counselor. We also expected that those who experience higher self-stigma associated with seeking psychological help would be sensitive to the public stigma associated with seeking psychological help; thus, we expected that the SSOSH would be positively associated with the perceived public stigma associated with seeing a counselor. With regard to criterion validity, the self-stigma associated with seeking psychological help was expected to relate to one's general attitudes toward seeking psychological help and one's direct willingness to seek help for a psychological concern. Therefore, we predicted that the SSOSH would be negatively associated with attitudes toward, and intent to seek, psychological services. Finally, consistent with the idea that the self-stigma associated with seeking psychological help leads to the avoidance of psychological services, we hypothesized that the SSOSH would uniquely predict help-seeking attitudes and help-seeking intentions over and above other measured factors.

Method

Participants

Participants were 470 college students, of whom 52% percent were female and 48% were male. Among the sample, 52% were first-year students, 30% were sophomores, 13% were juniors, and 5% were seniors. Most of the participants were European American (92%), followed by African American (2%), international (2%), Asian American (1%), Latino/Latina American (1%), and multiracial American (1%).

Procedure

The procedures used in Study 2 were the same as those used in Study 1.

Measures

Self-Stigma of Seeking Help (SSOSH) scale. The 10-item SSOSH scale, developed in Study 1, was used to assess the self-stigma associated with seeking psychological help.

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). A shortened, 10-item revision (Fischer & Farina, 1995) of the original 29-item ATSPPHS (Fischer & Turner, 1970) was used. Items are rated from 1 (*disagree*) to 4 (*agree*), with five items reversed scored so that higher scores reflect more positive attitudes. A sample item is, "If I believed I was having a mental breakdown, my first inclination would be to get professional attention." The revised scale strongly correlated with the longer version (.87), suggesting that the two are measuring the same construct (Fischer & Farina, 1995). The revised scale also correlated with previous use of professional help for a problem ($r = .39$, $p < .001$). The 1-month test–retest (.80) and internal consistency (.84) reliabilities were also adequate. In our study, the internal consistency of the measure was .82.

equal number of reverse and nonreverse items allowed for a direct test of the potential adverse effects of reverse-keyed items (see Study 2).

Intentions to Seek Counseling Inventory (ISCI). The ISCI (Cash, Begley, McCown, & Weise, 1975) is a 17-item scale measuring on a scale ranging from 1 (*very unlikely*) to 4 (*very likely*) the intent to seek psychological services for a list of specific problems. The problems include relationship difficulties, depression, personal worries, and drug problems. For brevity, only the 10-item Psychological and Interpersonal Concerns subscale of the ISCI was used to rate how likely participants would be to seek psychological services if they were experiencing a psychological or interpersonal problem. Responses on the ISCI are summed such that higher scores indicate a greater likelihood of seeking services for that issue. The measure has been found to detect differences in college students' intentions to seek psychological services when therapists were presented as more or less attractive (Cash et al., 1975). The ISCI Psychological and Interpersonal Concerns subscale has adequate internal consistency estimates (.90). In our study, the internal consistency of the subscale was .89.

Disclosure Expectations Scale (DES). The DES (Vogel & Wester, 2003) is an eight-item questionnaire that assesses the perceptions of risks and benefits associated with disclosing an emotional problem to a therapist. Each of the two subscales (Anticipated Risks and Anticipated Benefits) consists of four items rated on a Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Responses are summed for each subscale such that higher scores reflect greater anticipated risks or benefits. A sample item for anticipated risks is, "How risky would it feel to disclose your hidden feelings to a counselor?" A sample item for anticipated benefits is, "How likely would you be to get a useful response if you disclosed an emotional problem you were struggling with to a counselor?" The two subscales have been identified in factor analysis and have been correlated with measures of self-disclosure and self-concealment as well as with social support and psychological distress (Vogel & Wester, 2003). Internal consistency was previously found to be .74 for anticipated risks and .83 for anticipated benefits (Vogel & Wester, 2003). In our study, the internal consistency of the measure was .83 for anticipated risks and .85 for anticipated benefits.

Social Stigma for Seeking Psychological Help (SSRPH) scale. The SSRPH scale (Komiya et al., 2000) was designed to assess perceptions of the public stigma associated with seeking professional help. It contains five Likert-type questions rated on a scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). The items are summed so that higher scores reflect greater perceptions of public stigma. A sample item is, "People tend to like less those who are receiving professional psychological help." The SSRPH scale has been correlated with attitudes toward seeking professional help ($r = -.40$, $p < .001$; Komiya et al., 2000). The internal consistency for the measure was originally found to be .73. In our study, the internal consistency of the measure was .76.

Results and Discussion

Reliability and Confirmation of the Factor Structure

The internal consistency (.89, $N = 470$) was very similar to that in Study 1. To confirm the factor structure, we conducted a confirmatory factor analysis using the maximum likelihood method in LISREL (Version 8.54). As suggested by Hu and Bentler (1999), we used three indices to assess the goodness of fit of the models: the comparative fit index (CFI; values of .95 or greater indicate a model that fits the data well), the root mean square error of approximation (RMSEA; a value of .06 or less indicates a model that fits well), and the standardized root mean square residual (SRMR; values of .08 or less indicate a good fitting model). As expected, the results indicated a good fit of the data to the factor model found in Study 1, $\chi^2(35, N = 470) = 103.3$, $p < .001$, CFI = .98, RMSEA = .04, SRMR = .04. The factor loadings are presented in Table 2. All items loaded >.50. The results, therefore, confirm the unidimensional factor structure found in Study 1.

Examining the Effects of Including Reverse-Keyed Items

Although researchers have traditionally suggested the inclusion of reverse-keyed items in a scale to reduce the effects of certain response sets, some researchers have noted that the reverse-keyed items themselves can be responded to in a biased manner. On the basis of this concern, we directly examined the potential adverse effects of our inclusion of reverse-keyed items. First, we conducted a principal axis analysis with oblimin rotation, directly specifying two factors. If the items were being responded to differently, we would expect the nonreverse- and reverse-keyed items to separate out. Yet, even with specifying two factors, no items loaded on the second factor before rotation, and after rotation the majority of both the nonreverse- and reverse-keyed items (i.e., 8) still loaded cleanly on the first factor. Only Items 5 and 9 loaded on the second factor. Second, we examined this issue by directly testing the worst-case scenario. We conducted a confirmatory model analysis in which we forced the five nonreverse-keyed items and the five reverse-keyed items to each make up a separate construct in order to see how this model fit the data and the degree to which the two subscales correlated. The new model, $\chi^2(34, N = 470) = 90.7$, $p < .001$, CFI = .99, RMSEA = .04, SRMR = .04, did fit the data well; however, the fit indices were almost exactly the same (CFI = .98 vs. .99, RMSEA = .04 vs. .04 and SRMR = .04 vs. .04) as when all 10 items were used as indicators of a single construct, $\chi^2(35, N = 470) = 105.5$, $p < .001$, CFI = .98, RMSEA = .04, SRMR = .04. Furthermore, the correlation between the nonreverse-keyed and reverse-keyed scales in the second model was extremely high (.94), suggesting that the two scales were measuring the same underlying construct. These data suggest that in this sample, the differences in responding on the basis of item wording was small. Thus, the benefits of including the reverse-keyed items appear to outweigh the potential problems in this case.

Construct and Criterion Validity

Next, we examined the correlations between the SSOSH total score and scores on the DES Anticipated Risks and Anticipated Benefits scales and the SSRPH (public stigma) scale (for construct validity) and scores on the ATSPPHS and the ISCI scales (for criterion validity; see Table 3). As expected, scores on the SSOSH were positively associated with scores on the DES Anticipated Risks and the SSRPH (public stigma) scales and negatively associated with scores on the DES Anticipated Benefits, ATSPPHS, and ISCI scales. These results provide initial support for the validity of this measure.

Predicting Attitudes Toward Seeking Professional Help

Next, we examined the role of the self-stigma associated with seeking psychological help in predicting psychological help-seeking attitudes. Participants' sex (1 = male, 2 = female), anticipated risks, anticipated benefits, public stigma, and self-stigma were used as predictors of attitudes toward seeking professional help in a hierarchical multiple regression analysis (see Table 4).

Table 3
Correlations Between the Self-Stigma of Seeking Help Scale and Validity Criteria Measures Across Studies 2–4

Validity criteria	Study 2	Study 3	Study 4
N	470	227	271
M (SD)	27.2 (7.2)	27.3 (7.0)	27.3 (6.6)
Attitudes Toward Seeking Professional Psychological Help Scale	−.63***	−.60***	−.53***
Intentions to Seek Counseling Inventory	−.38***	−.32***	−.34***
Disclosure Expectations Scale—Anticipated Risks	.47***	.37***	.30***
Disclosure Expectations Scale—Anticipated Benefits	−.45***	−.40***	−.32***
Social Stigma for Seeking Psychological Help Scale	.48***		.46***
Rosenberg Self-Esteem Scale			.06
Hopkins Symptom Checklist–21			−.00
Distress Disclosure Index			−.25***
Self-Concealment Scale			.15***
Marlowe–Crowne Social Desirability Scale		−.13	

*** $p < .001$.

All of the variables except self-stigma were entered in the first step; self-stigma was entered in the second step to show its predictive ability above the other measures. The initial model was significant, $F(4, 436) = 99.8$, $p < .001$, $R = .65$, $R^2 = .43$, adjusted $R^2 = .42$, as was the full model with self-stigma included, $F(5, 436) = 91.8$, $p < .001$, $R = .72$, $R^2 = .52$, *adjusted* $R^2 = .51$. Notably, the addition of self-stigma resulted in a significant improvement over the original model (R^2 change $= .09$, $p < .001$). As hypothesized, scores on the SSOSH uniquely predicted help-seeking attitudes over and above the other variables included in the model ($\beta = -.40$) such that those participants' who perceived a greater self-stigma associated with seeking psychological help had less positive attitudes toward seeking treatment. These results suggest that the self-stigma associated with seeking psychological help may be an inhibiting factor in people's help-seeking decisions.

Predicting Intent to Seek Counseling for Psychological and Interpersonal Problems

To examine the role of the SSOSH in predicting the intent to seek psychological help, we conducted another hierarchical multiple regression analysis, including participants' sex (1 = male, 2 = female), anticipated risks, anticipated benefits, public stigma, and self-stigma as predictors of the intent to seek psychological services for psychological and interpersonal concerns (see Table 5). As before, all of the variables except self-stigma were entered in the first step; self-stigma was entered in the second step to assess its unique predictive ability above the other measures. The initial model was significant, $F(4, 439) = 26.6$, $p < .001$, $R = .44$, $R^2 = .20$, adjusted $R^2 = .19$, as was the full model with self-stigma included, $F(5, 439) = 26.9$, $p < .001$, $R = .49$, $R^2 = .24$, adjusted $R^2 = .23$. Notably, the addition of self-stigma again showed a significant improvement over the original model (R^2 change $= .04$, $p < .001$). The self-stigma associated with seeking psychological help ($\beta = -.27$) was a unique predictor of help seeking intent beyond public stigma and anticipated risks and benefits. Specifically, those participants' reporting a greater self-stigma associated with seeking psychological help had less intention to seek treatment for psychological and interpersonal concerns. These results further support our hypothesis that the self-stigma associated with seeking psychological help can be an inhibiting factor in people's decisions to seek treatment.

Study 3: Test–Retest Reliability and Cross-Validation

The purposes of Study 3 were (a) to examine the test–retest reliability of the SSOSH, (b) to replicate the criterion validity and further cross-validate the construct in a different sample, and (c) to

Table 4
Summary of Hierarchical Multiple Regression Predicting Attitudes Towards Seeking Professional Help in Study 2

Variable	*b*	*SE b*	β	*t* (436)
Step 1				
Sex of Participant	−2.0	.44	−.18	−4.7***
Anticipated Risks (DES)	−0.3	.06	−.20	−5.1***
Anticipated Benefits (DES)	0.8	.06	.47	12.1***
Public stigma (SSRPH)	−0.2	.07	.10	2.6*
Step 2				
Sex of Participant	−1.6	.40	−.14	−4.0***
Anticipated Risks (DES)	−0.1	.06	−.07	−1.8
Anticipated Benefits (DES)	0.6	.06	.35	9.2***
Public stigma (SSRPH)	0.0	.07	.02	0.4
Self-stigma (SSOSH)	−0.3	.04	−.40	−9.0***

Note. DES = Disclosure Expectations Scale; SSRPH = Social Stigma for Seeking Psychological Help; SSOSH = Self-Stigma of Seeking Help scale. Step 1: $F(4, 436) = 79.8$***, $R^2 = .43$; Step 2: $F(5, 436) = 91.9$***, $R^2 = .52$, change in $R^2 = .09$***.
* $p < .05$. *** $p < .001$.

Table 5
Summary of Hierarchical Multiple Regression Predicting Intentions to Seek Psychological Help for Psychological and Interpersonal Concerns in Study 2

Variable	*b*	*SE b*	β	*t* (439)
Step 1				
Sex of participant	−1.0	.55	−.08	−1.7
Anticipated risks (DES)	−0.1	.07	−.06	−1.4
Anticipated benefits (DES)	0.7	.08	.41	8.9***
Public stigma (SSRPH)	−0.0	.09	.02	0.5
Step 2				
Sex of participant	−0.6	.54	−.05	−1.1
Anticipated risks	0.0	.08	−.03	0.5
Anticipated benefits	0.6	.08	.33	6.9***
Public stigma (SSRPH)	0.2	.10	.10	2.1*
Self-stigma (SSOSH)	−0.2	.05	−.27	−4.8***

Note. DES = Disclosure Expectations Scale; SSRPH = Social Stigma for Seeking Psychological Help Scale; SSOSH = Self-Stigma of Seeking Help Scale. Step 1: $F(4, 439) = 26.6$***, $R^2 = .20$; Step 2: $F(5, 439) = 26.9$***, $R^2 = .24$, change $R^2 = .04$***.
* $p < .05$. *** $p < .001$.

examine discriminant validity by examining the relationship between the SSOSH and social desirability.

Method

Participants

Participants were 546 college students who had not participated in the previous studies. Of these, 58% were female and 42% were male. Among the sample, 45% were first-year students, 30% were sophomores, 16% were juniors, and 9% were seniors. Most of the participants were European American (89%), followed by African American (3%), Asian American (3%), Latino/Latina American (2%), international (2%), and multiracial American (1%).

Procedure

At Time 1, participants filled out the SSOSH, the ATSPPHS, the ISCI, the DES, and the Marlowe-Crowne Social Desirability Scale, Form XI (MCSDS; see *Measures* below). Participants were also asked to provide their ID number so that their Time 1 data could be linked with their Time 2 data. Then, after 2 months (Time 2), participants were recontacted through their psychology classes (i.e., announcements were again made in classes regarding where and when they could participate in the study). At these new sessions, participants were asked to fill out the SSOSH again. At Time 1, a total of 546 individuals participated; at the second time period, 227 participated (42% retention rate).

Measures

Marlowe–Crowne Social Desirability Scale, Form XI. The Form XI version of the MCSDS (Strahan & Gerbasi, 1972) is a shortened 10-item revision of the original 33-item scale (Crowne & Marlowe, 1960). The short version has been found to correlate .91 with the full version (Fischer & Fick, 1993). A sample item is, "I am always courteous, even to people that are disagreeable." Items are responded to as either true or false, with statements indicating a greater tendency to generate socially desirable responses rated 1 and statements indicating less of a tendency to generate socially desirable responses rated 0 (i.e., scores ranged from 0 to 10). Kuder–Richardson (K-R) formula 20 reliability coefficients of the 10-item MCSDS ranged from .59 to .88 (Fischer & Fick, 1993; Strahan & Gerbasi, 1972). In our study, the K-R 20 reliability was .61.

Previously used measures. As in Studies 1 and 2, the SSOSH and the ATSPPHS were administered. The internal consistency of the ATSPPHS measure in this study was .81. In addition, the full 17-item ISCI measure (Cash et al., 1975) was used in this study to determine whether the correlation between the SSOSH and the full version of this scale would replicate the correlation found with the shorter version. The internal consistency of the full measure in this study was .80. Finally, the DES was administered, as in the previous studies. The internal consistency for the DES (Vogel & Wester, 2003) in this study was .77 for the Anticipated Risks subscale and .83 for the Anticipated Benefits subscale.

Results and Discussion

Reliability

The internal consistency of the 10-item SSOSH was very similar to that obtained in the previous studies (.90 at Time 1 [$N = 546$] and .88 at Time 2 [$N = 227$]). The correlation between participants' Time 1 SSOSH total score and their total SSOSH score 2 months later was .72 ($N = 226$), suggesting that the measure has good test–retest reliability over a 2-month period.

Construct and Criterion Validity

Next, we attempted to replicate and cross-validate the findings of Study 2 by examining the correlations of the Time 1 SSOSH total score with the Anticipated Risks and the Anticipated Benefits scale scores (for construct validity) and with the ATSPPHS and ICSI scale scores (for criterion validity). We also looked at the relationships between social desirability and the SSOSH total score to examine discriminant validity. As expected, the SSOSH total score was positively associated with scores on the Anticipated Risks scale and negatively associated with scores on the Anticipated Benefits, ATSPPHS, and ICSI scales. In addition, the SSOSH total score was not significantly associated with social desirability (see Table 3). These results provide further support for the validity of the SSOSH.

Study 4: Further Cross-Validation

The first purpose of Study 4 was to further cross-validate the SSOSH with a new sample by replicating the previous findings with anticipated risks and benefits of disclosing to a counselor (for construct validity) and attitudes toward seeking professional help and intent to seek psychological services (for criterion validity). We were also interested in exploring the convergent validity of the SSOSH by examining its relationship with the tendency to self-disclose distress information, the tendency to self-conceal personal information, and perceptions of public stigma. Specifically, we expected the SSOSH to be negatively related to self-disclosure and positively related to self-concealment and public stigma. To explore the discriminant validity, we examined the relationship of the SSOSH to measures of global self-esteem and overall psychological distress. The SSOSH should be domain specific (i.e., measuring the self-stigma associated with help seeking) and thus should not be related to global self-esteem or general distress.

The second purpose of this study was to examine the predictive validity of the SSOSH by examining whether differences existed between those who have not sought psychological help and those who have, and to assess concurrent validity by examining whether differences exist between women and men. Because the self-stigma associated with seeking psychological help was hypothesized to keep people from seeking treatment, those who had sought help should have lower SSOSH scores than those who had not. Furthermore, the SSOSH should show differences between men and women because research indicates that traditional gender roles affect the level of concern women and men have about seeking help (see Addis & Mahalik, 2003, for a review). The male gender role, with its emphasis on being independent and in control, for example, may increase concerns about the loss of self-esteem, as it may mean admitting the inability to handle things on their own (Addis & Mahalik, 2003; Blazina, & Watkins, 1996; Wisch, Mahalik, Hayes, & Nutt, 1995). Therefore, men should experience greater self-stigma associated with seeking psychological help than women.

The final purpose of Study 4 was to further examine the role of the SSOSH in predicting help-seeking attitudes and intent to seek psychological services over and above variables that have been previously identified as possible predictors (i.e., participants' biological sex, previous counseling experience, psychological distress, global self-esteem, anticipated risks, anticipated benefits,

tendency to self-disclose, tendency to self-conceal, and public stigma). Consistent with the theory that the self-stigma associated with seeking psychological help leads to the avoidance of psychological services, and with the results from Study 2, we hypothesized that the SSOSH would uniquely predict help-seeking attitudes and help-seeking intentions over and above other important variables identified in previous research.

Method

Participants

A new set of 271 college students participated in this study. Of the participants, 61% were female and 39% were male. Among the sample, 44% were first-year students, 32% were sophomores, 14% were juniors, 8% were seniors, and 2% described themselves as other. Most of the participants were European American (88%), followed by Asian American (7%), Latino/Latina American (3%), and African American (2%).

Procedure

The research project was listed as a study that would involve answering questions regarding oneself and one's thoughts about seeking professional help. Participants completed a packet containing the study measures (see below) as well as some demographic questions (i.e., gender, year in school, and ethnic/racial status).

Measures

Rosenberg Self-Esteem Scale (RSES). The RSES (Rosenberg, 1965) was used to measure global self-esteem. Items are rated on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). A sample item is. "On the whole, I am satisfied with myself." Five items are reverse scored, and item ratings are summed to yield a total score that ranges from 10 to 40, with higher scores indicating higher self-esteem (Wylie, 1989). Wylie reported alphas ranging from .74 to .87 and test–retest reliabilities ranging from .63 to .91. RSES scores have been linked negatively to depressive affect, anxiety, psychosomatic symptoms, and interpersonal insecurity (Wylie, 1989). The internal consistency of this measure in our study was .91.

Hopkins Symptoms Checklist–21 (HSCL-21). The HSCL-21 (Green, Walkey, McCormick, & Taylor, 1988) is an abbreviated form of the Hopkins Symptom Checklist (Derogatis, Lipman, Richels, Uhlenhuth, & Covi, 1974) and is a widely used measure of psychological distress. Items, such as "feeling lonely," are rated on a scale ranging from 1 (*not at all*) to 4 (*extremely*). This scale has been shown to have a replicable three-factor structure (i.e., general, somatic, and performance distress), although it is generally used as a single-factor scale reflecting 'total distress.' The HSCL-21 is able to detect changes across therapy and has been related to other counseling outcome measures (Deane, Leathem, & Spicer, 1992). The measure has a corrected split-half reliability of .91 and an internal consistency alpha of .90. In our study, the internal consistency of the measure was .90.

Distress Disclosure Index (DDI). The DDI (Kahn & Hessling, 2001) is a 12-item Likert-type scale assessing the tendency to disclose distressing information to others. Each response ranges from 1 (*strongly disagree*) to 5 (*strongly agree*). Sample items include "When I feel upset, I usually confide in my friends" and "I prefer not to talk about my problems" (reverse scored). The DDI positively correlates (.43) with the Self-Disclosure Index (Miller, Berg, & Archer, 1983) and negatively correlates (.35) with the Self-Concealment Scale (Larson & Chastain, 1990), suggesting adequate convergent validity (Kahn & Hessling, 2001). Furthermore, Kahn, Lamb, Champion, Eberle, and Schoen (2002) demonstrated the predictive validity of the DDI through the correlation with an individual's actual number of later disclosures as well as observer and interviewer ratings of the levels of disclosure. DDI scores showed stable test–retest correlations across 2- and 3-month periods of .80 and .81, respectively (Kahn & Hessling, 2001). Internal consistency is also very high across studies ranging from .92 to .95 (Kahn et al., 2002). In our study, the internal consistency of the measure was .92.

Self-Concealment Scale (SCS). The SCS (Larson & Chastain, 1990) is a 10-item measure designed to assess a person's tendency to actively conceal distressing information from others. Self-concealment is related to, but conceptually different from, self-disclosure, as one might not actively attempt to conceal something but might not be actively attempting to disclose it either (Larson & Chastain, 1990). A sample item is, "I have an important secret that I haven't shared with anyone." The SCS asks respondents to respond on a 5-point scale their level of agreement with each item, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The responses are summed such that higher responses reflect greater self-concealment. The SCS correlates with self-reported measures of anxiety, depression, and physical symptoms (Larson & Chastain, 1990). The internal consistency for this measure has been reported to be adequate (.83), as has the test–retest reliability (.81; Larson & Chastain, 1990). In our study, the internal consistency of the measure was .88.

Use of psychological services. Whether a person had used psychological services was determined through self-report by asking participants the following yes–no question: "Have you ever sought help from a mental health professional?"

Previously used measures. The target instrument, the SSOSH, was administered to participants, with an internal consistency of .86 in this study. The ATSPPHS (Fischer & Farina, 1995) was also administered. The internal consistency of the measure in this study was .83. The full ISCI measure (Cash et al., 1975) was administered, with an internal consistency of .88. The DES (Vogel & Wester, 2003) was also given to participants. The internal consistency in this study was .82 for the Anticipated Risks subscale and .85 for the Anticipated Benefits subscale. Finally, theSSRPH scale (Komiya et al., 2000) was administered, with an internal consistency in this study of .75.

Results and Discussion

Construct and Criterion Validity

To examine the construct validity of the SSOSH for this sample, we examined the correlations of the SSOSH total score with scores on the DES Anticipated Risks and Anticipated Benefits scales, the SSRPH scale, the DDI, and the SCS. All of these correlations were significant in the expected directions (see Table 3). For criterion validity, we explored the relationship between the SSOSH total score and scores on the ATSPPHS and the ISCI scales, both of which were significant (see Table 3). In order to assess the discriminant validity of the scale, we examined the correlation between the SSOSH total score and two measures of current functioning with which it should be unrelated (i.e., global self-esteem and overall psychological distress). The SSOSH total score was not correlated with either of the scores of these scales (see Table 3). These results provide further support for the validity of this measure.

To further assess the predictive validity of the SSOSH scale, we examined the differences in reported self-stigma between those who had sought psychological services and those who had not. However, our sample was potentially limited in that over 50% of participants were first-year students and thus their opportunity to have independently sought psychological treatment in the past may have been limited. Therefore, we included year in school in the

analysis. This 4 × 2 analysis of variance (ANOVA) showed that despite the potential concern, there were no differences in means across years in school, $F(3, 266) = 1.1$, $p = .37$, partial eta$^2 = .01$, or a significant interaction between year in school and having sought help or not, $F(3, 266) = 1.50$, $p = .22$, partial eta$^2 = .02$. There was, however, as predicted a significant mean difference between those who had sought help ($n = 64$, $M = 25.0$, $SD = 6.2$) and those who had not ($n = 202$, $M = 28.1$, $SD = 6.7$), $F(1, 266) = 15.7$, $p < .001$, partial eta$^2 = .06$.

Finally, we expected that the self-stigma associated with seeking psychological services would be different for men and women. A t test of the mean differences between men and women indicated that men reported more self-stigma associated with seeking psychological services ($M = 29.1$, $SD = 6.7$) than did women ($M = 26.2$, $SD = 6.4$), $t(266) = 3.65$, $p < .001$, partial eta$^2 = .05$.

Predicting Attitudes Toward Seeking Professional Help

One of the main goals in developing the SSOSH scale was to develop a new measure that assesses an aspect of help seeking that previously has not been identified. Therefore, we wanted to examine the role of self-stigma in predicting psychological help-seeking attitudes over and above several of the factors previously identified as influential in this process (i.e., participants' biological sex, previous counseling experience [1 = yes, 2 = no], psychological distress, global self-esteem, anticipated risks, anticipated benefits, tendency to self-disclose, tendency to self-conceal, and public stigma). These factors were used as predictors of attitudes toward seeking professional help in a hierarchical multiple regression analysis (see Table 6). All of the variables except self-stigma were entered in the first step and then self-stigma was entered in the second step to show its predictive ability above the other measures. The initial model was significant, $F(9, 252) = 30.3$, $p < .001$, $R = .73$, $R^2 = .53$, adjusted $R^2 = .51$, as was the full model with self-stigma included, $F(10, 252) = 34.8$, $p < .001$, $R = .77$, $R^2 = .59$, adjusted $R^2 = .57$. Notably, the addition of self-stigma showed a significant improvement over the original model (R^2 change $= .06$, $p < .001$). As hypothesized, scores on the SSOSH scale uniquely predicted help-seeking attitudes over and above the other factors included in the model ($\beta = -.30$), such that those participants' who perceived greater self-stigma associated with seeking psychological help had less positive attitudes toward seeking treatment. These results suggest that the self-stigma associated with seeking psychological help may be an inhibiting factor in people's help-seeking decisions.

Table 6
Summary of Hierarchical Multiple Regression Predicting Attitudes Towards Seeking Professional Help in Study 4

Variable	*b*	*SE b*	β	*t* (252)
Step 1				
Sex of participant	0.9	.56	.08	1.6
Previous use of counseling	−3.4	.61	−.25	−5.5***
Psychological distress (HSCL-21)	0.0	.02	.09	1.8
Public stigma (SSRPH)	−0.3	.10	−.15	−3.0**
Global self-esteem (RSES)	0.0	.04	.07	1.5
Anticipated risks (DES)	−0.3	.08	−.17	−3.5**
Anticipated benefits (DES)	0.7	.08	.43	8.6***
Self-disclosure (DDI)	0.0	.03	.10	1.9
Self-concealment (SCS)	0.0	.04	.00	0.0
Step 2				
Sex of participant	0.4	.53	.03	0.7
Previous use of counseling	−2.8	.57	−.21	−4.9***
Psychological distress (HSCL-21)	0.0	.02	.08	1.8
Public stigma (SSRPH)	−0.1	.10	−.05	−1.0
Global self-esteem (RSES)	0.0	.03	.07	1.5
Anticipated risks (DES)	−0.2	.07	−.12	−2.7**
Anticipated benefits (DES)	0.6	.08	.39	8.1***
Self-disclosure (DDI)	0.0	.03	.10	1.9
Self-concealment (SCS)	0.0	.04	.02	0.3
Self-stigma (SSOSH)	−.26	.04	−.30	−6.0***

Note. HSCL-21 = Hopkins Symptom Checklist–21; SSRPH = Social Stigma for Seeking Psychological Help scale; RSES = Rosenberg Self-Esteem Scale; DES = Disclosure Expectations Scale; DDI = Distress Disclosure Index; SCS = Self-Concealment Scale; SSOSH = Self-Stigma of Seeking Help scale. Step 1: $F(9, 252) = 30.3$***, $R^2 = .52$; Step 2: $F(10, 252) = 34.8$***, $R^2 = .59$, change $R^2 = .06$***.
** $p < .01$. *** $p < .001$.

Predicting Intent to Seek Counseling

Next, we included the variables listed above (and in Table 7) in a hierarchical multiple regression model predicting intent to seek psychological services. As before, all of the variables except self-stigma were entered in the first step, and self-stigma was entered in the second step. The initial model was significant, $F(9, 252) = 10.2$, $p < .001$, $R = .52$, $R^2 = .27$, *adjusted* $R^2 = .25$, as was the full model with self-stigma included, $F(10, 252) = 11.7$, $p < .001$, $R = .57$, $R^2 = .32$, *adjusted* $R^2 = .30$. It is noteworthy that the addition of self-stigma led to a significant improvement over the original model (R^2 change $= .05$, $p < .001$). The self-stigma associated with seeking psychological help ($\beta = -.27$) was a unique predictor of help-seeking intent, along with psychological distress ($\beta = .18$), anticipated benefits ($\beta = .32$), and public stigma ($\beta = .14$). Specifically, those participants' reporting more self-stigma associated with seeking psychological help had less intention to seek treatment. These results again support our hypothesis that self-stigma can be a unique inhibiting factor in people's decisions to seek treatment, beyond many important factors established in previous research.

Study 5: Predicting Help-Seeking Behavior

As with Study 4, most studies examining the factors influencing help-seeking decisions have used cross-sectional designs and assessed the relationship of a measure with current attitudes, current intentions, or past behavior. Although this is an important step, the true measure of the validity of a self-stigma scale is its ability to predict future help-seeking behavior. Therefore, the purpose of Study 5 was to examine the predictive validity of the SSOSH scale by examining whether scores on the SSOSH scale would actually differentiate those who sought psychological services from those who did not across a 2-month period.

Method

Participants

Participants were 655 college students who had participated in Studies 1, 2, or 3, reported above. Of these, 54% were female and 46% were male. A total of 50% of the participants were first-year students, 29% were soph-

Table 7
Summary of Hierarchical Multiple Regression Predicting Intentions to Seek Professional Help in Study 4

Variable	*b*	*SE b*	β	*t* (255)
Step 1				
Sex of participant	1.5	1.1	.08	1.4
Previous counseling	−2.4	1.2	−.11	−2.0*
Psychological distress (HSCL-21)	0.2	0.1	.19	3.2**
Public stigma (SSRPH)	0.2	0.2	.05	0.9
Global self-esteem (RSES)	0.0	0.1	.01	0.2
Anticipated risks (DES)	−0.2	0.2	−.07	−1.1
Anticipated benefits (DES)	0.9	0.2	.36	5.8***
Self-disclosure (DDI)	0.0	0.1	.10	1.5
Self-concealment (SCS)	0.0	0.1	.05	0.8
Step 2				
Sex of participant	0.7	1.1	.04	0.6
Previous counseling	−1.7	1.2	−.08	−1.4
Psychological distress (HSCL-21)	0.2	0.1	.18	3.2***
Public stigma (SSRPH)	0.4	0.2	.14	2.2*
Global self-esteem (RSES)	0.0	0.1	.01	0.2
Anticipated risks (DES)	−0.0	0.1	−.03	−0.4
Anticipated benefits (DES)	0.8	0.2	.32	5.2***
Self-disclosure (DDI)	0.0	0.1	.10	1.5
Self-concealment (SCS)	0.0	0.1	.07	1.1
Self-stigma (SSOSH)	−0.4	0.1	−.27	−4.3***

Note. HSCL-21 = Hopkins Symptom Checklist-21; SSRPH = Social Stigma for Seeking Psychological Help scale; RSES = Rosenberg Self-Esteem Scale; DES = Disclosure Expectations Scale; DDI = Distress Disclosure Index; SCS = Self-Concealment Scale; SSOSH = Self-Stigma of Seeking Help scale. Step 1: $F(9, 255) = 10.2$***, $R^2 = .27$; Step 2: $F(10, 255) = 11.7$***, $R^2 = .32$, change $R^2 = .05$***.
* $p < .05$. ** $p < .01$ *** $p < .001$.

omores, 13% were juniors, and 6% were seniors. Most of the participants were European American (91%), followed by Latino/Latina American (3%), African American (2%), Asian American (2%), international (1%), and multiracial American (1%).

Procedure

To have a large enough sample of participants who had completed the SSOSH scale prior to seeking psychological help, participants from Studies 1, 2, and 3 were recontacted 2 months after they first completed the SSOSH scale (the follow-up data from Studies 1, 2, and 3 are presented here for simplicity). Participants were recontacted through an announcement made in their classes. At the time of the study, participants answered on a piece of paper the following question, "Have you sought help from a mental health professional over the past 2 months?" (i.e., a yes or no response option). As mentioned, participants' data were matched according to their nine-digit ID number. Of the total 1,599 potential participants, 655 (41%) participated in this study. Participants received extra credit in their psychology class for their participation.

Results and Discussion

Thirty-one participants (5%) reported that they had sought psychological help over the 2-month period after they completed the SSOSH scale. First, we conducted a *t* test to compare the average perceived self-stigma (measured prior to seeking help) between those who eventually sought psychological services and those who did not. Because the cell sizes were unequal, we could not assume prior to the analysis that variances would be equal; thus, we examined the results of the *t* test assuming the variances were unequal. Supporting the validity of the SSOSH scale, those who had sought psychological services reported significantly less self-stigma before seeking help ($M = 24.3$, $SD = 6.1$) than those who had not sought services ($M = 27.3$, $SD = 6.6$), $t(33) = -2.24$, $p = .032$, partial eta^2 = .01. Next, to examine whether the SSOSH could differentiate those who sought psychological services from those who did not, we conducted a discriminant analysis. We used self-stigma to predict the categorical criterion variable, having sought help or not over the 2-month period following the initial assessment with the SSOSH scale. Consistent with our hypothesis, the SSOSH scale significantly differentiated between those who eventually sought psychological services and those who had not, $\chi^2(1, 654) = 5.05$, $p = .025$, canonical correlation = .09.

General Discussion

This project involved five studies examining the reliability and validity of a measure of the self-stigma associated with seeking psychological services. Findings across these studies suggest that the psychometric properties of the 10-item SSOSH scale are adequate for research purposes. Specifically, the 10-item SSOSH scale exhibited strong internal consistency reliability and good 2-month test–retest reliability. Confirmatory factor analyses indicated that a unidimensional factor model provided a good fit to the data.

As expected, the positive association between the SSOSH scale and anticipated risks, public stigma, and the tendency to conceal personal information, as well as the negative associations with anticipated benefits and the tendency to disclose distressing emotions, supported the construct validity of the scale. The nonsignificant associations between the SSOSH scale and measures of social desirability, global self-esteem, and psychological distress further supported the construct validity of the scale. Criterion validity was supported by the negative associations of the SSOSH scale with attitudes toward seeking professional help and intent to seek counseling. Consistent with these findings and the role of stigma in internal self-evaluations (Corrigan, 2004), the SSOSH scale also uniquely predicted attitudes toward and intentions to seek psychological services. Self-stigma associated with seeking psychological services was also different between those who had sought help in the past and those who had not as well as between women and men. Similarly, the SSOSH scale differentiated those who sought psychological services from those who did not seek services over a 2-month period. In sum, these results support the validity of the new scale.

Implications and Directions for Future Research

The primary implication of this research is the creation of a psychometrically sound measure of the self-stigma associated with seeking psychological help. Before the development of this scale, there existed no adequate conceptual or measurement tool for exploring the unique contributions of internalized self-stigma on the tendency to eschew psychological help. The first of its kind, this measure will allow researchers to better address why individuals with significant life problems are hesitant to seek professional help. Future research can now explore the relationship of the self-stigma associated with seeking psychological help with other factors known to facilitate or hinder help seeking. Although we

present some evidence in this article that the self-stigma associated with seeking psychological help predicts psychological help-seeking attitudes and intent beyond other known factors, the research in this area is just beginning. For example, understanding and modeling the relationships among these variables and examining potential mediating or moderating effects of different factors, such as personality, attachment style, and type and severity of a psychological disorder could help focus intervention efforts. Future investigations could also examine the results of treatment, educational programs, and other interventions targeted toward reducing self-stigma (e.g., large-scale media efforts). This would be an important step for research in this area, as efforts to understand and mitigate the effects of both public and self-stigma are likely to have a direct effect on getting more people the help they need (Corrigan, 2004).

This research also has direct implications for mental health delivery. Even if only a portion of those who avoid therapy could be reached, a significant number of people would be helped. This would benefit not only the troubled individuals and their families and communities but could have a potentially broader impact at a societal level (e.g., greater work productivity and lower health care costs and crime rates). Yet, how do psychologists and other health care providers reach individuals who typically avoid psychological treatment? One excellent example is the National Institute of Mental Health (NIMH) "Real Men, Real Depression" campaign, which uses broad-based advertisements (print, radio, and TV) to educate the public about men and depression (NIMH, 2005). This campaign is attempting to reach men who might not seek help for depression, by reducing the public and self-stigma related to psychological treatment. Guided by future research on self-stigma, broad campaigns and more focused educational efforts might be able to address the concerns of individuals who avoid needed treatment for fear of negative consequences.

Limitations

Despite the robust findings across five different studies, some important methodological limitations of this work should be noted. Although it appears that the 10-item SSOSH scale is an adequate measure in terms of the scores' reliability, factor structure, construct validity, and criterion validity, researchers should note that participants in the present studies were predominantly Caucasian undergraduate students from the same midwestern university. Therefore, it is not fully known what the psychometric properties of the measure are for people residing in other regions of the country or of different cultures. Similarly, our data do not assess the reliability or validity of the SSOSH scale with people of varying age, economic or educational backgrounds, and clinical problems. Until future research can establish the reliability and validity of the SSOSH scale in these ways, we recommend that caution be used in interpreting data collected on these groups. This is particularly important given our decision to include reverse-keyed items. Although we found no negative effect of reverse-keyed items in a college sample (Study 2), it is important to note that the size of the effect of reverse-keyed items is related to reading ability and age (Marsh, 1986), and thus effects could be larger in samples that read at a level lower than college students or who are older than college-age students. It should also be noted that participants self-selected to participate in the studies and that in Study 4 they were explicitly told that the questions would be about help seeking before they elected to participate. This self-selection may have led to some biases in who decided to participate. This problem is somewhat mitigated by the consistent means, standard deviations, and internal consistencies across studies, but it should be noted those who chose to volunteer may have been different than those who did not. Furthermore, although the SSOSH scale was not found to correlate with social desirability, the reliability of the Marlowe–Crowne measure was not very high in Study 3 and thus may have limited the possibility of a relationship between the two measures. Future studies may need to further examine this issue. Finally, our validity data is based on self-report measures and a self-reported question about help-seeking behavior (examined in Study 5). Thus, in future research, the validity of the SSOSH scale needs to be corroborated by other assessment methods (e.g., peer reports, observational/behavioral data, and physiological measures).

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