

Stigma and help-seeking

David L. Vogel and Nathaniel G. Wade explain that it's not just about what others think

The fear of being stigmatised by others often leads people to avoid professional help. This stigma can also be internalised, further reducing the likelihood of seeking help. Understanding these different forms of stigma can help psychologists target interventions at different levels to help people overcome the barriers to seeking help.

One of the most common reasons for people to not seek treatment is concern about stigma. In the psychotherapy literature, stigma has generally referred to the public stigma of having a mental illness, with the clearest example being schizophrenia. Public stigma is society's rejection of a person due to certain behaviours or physical appearances that are deemed unacceptable, dangerous or frightening. Although in most industrialised societies today the mentally ill are no longer overtly persecuted, there are clear indications of the presence of public stigma towards individuals with a mental illness. These perceptions of the mentally ill are not lost on those needing treatment and can lead to the hiding of mental health concerns and avoidance of treatment in an attempt to reduce the negative consequences associated with stigma (Corrigan, 2004).

But what other forms of stigma might prevent people from seeking psychological services, and what can be done about them?

Public stigma over help-seeking

The public stigma attached to having a mental illness is not the only type of stigma that inhibits the decision to seek therapy. There is also a public stigma associated with seeking professional services, separate from the public stigma associated with mental illness. With this stigma, what one suffers from is less important than the simple behaviour of seeking psychological help, whether that

is for a chronic, diagnosable mental disorder or for processing the death of a loved one. Simply seeking professional psychological help appears to carry its own mark of disgrace. Research indicates that people tend to stigmatise clients more than they stigmatise non-clients. In scenario-based research, individuals described as depressed and having sought help were rated more emotionally unstable, less interesting, and less confident than those described as depressed and not seeking help (Ben-Porath, 2002). In addition, those who have sought help are more likely to report being stigmatised by others than those who have not (Jorm & Wright, 2008).

Self-stigma

These are compelling findings. Public stigma regarding mental illness and seeking professional help has a significant impact on those who suffer from problems that could be treated. However, there is a growing awareness of a potent stigma that might be more directly related to negative experiences with mental illness and help-seeking.

In contrast to the outward, other-oriented focus of public stigma, self-stigma has been described as an internal form of stigma, wherein one labels oneself as unacceptable because of having a mental health concern (Corrigan, 2004; Vogel et al., 2006). We originally conceived of self-stigma as the specific threat to one's sense of self, including esteem, regard and confidence, that seeking psychological help might pose. We hypothesised that the more a person saw psychological help as a threat to their sense of worth, confidence or self-regard, the less likely they would be to seek out that help.

The distinction between the public and self-stigma associated with seeking professional help allows for a more nuanced assessment of what people feel about their own psychological concerns and their treatment. Although perception of public stigma is likely to be related to self-stigma for many individuals, this does

questions

What happens when public stigma is internalised?

Why do people choose to continue to suffer from psychological problems even if professional help is readily available?

What is the perceived impact of seeking psychological help on the potential client?

resource

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not have to be the case for everyone. Individuals might perceive the possibility of public stigma for seeking help (perhaps accurately), and yet have little or no internalisation of that stigma. For example, people might have less self-stigma due to previous experiences with therapy or knowing someone who benefited from therapy. Thus, they might perceive a general public stigma toward help-seeking, but know from personal experience that seeking help is beneficial and have less concern about it personally. This distinction is important, as it allows psychologists to intervene at either individual (i.e. self-stigma) or more global levels (i.e. public stigma).

Most of the focus by researchers has been on the self-stigma associated with having a mental illness. Findings indicate that negative interactions from others, along with largely negative portrayals of mental illness in the media, lower an individual's self-esteem and self-efficacy (Corrigan, 2004). Internalised negative perceptions of mental health issues also appear have a negative impact on mental

health and 'adjustment and growth' (Mak et al., 2007).

However, we believe that for many people a separate self-stigmatisation process exists, specifically associated with seeking help. One reason for this is that in the case of the self-stigma associated with a mental illness, the label of mental illness to which the stigma is attached is often externally given and then the person decides whether to accept it. In contrast, seeking therapy, which is often a voluntary activity, may result in an internally driven label (or self-label). This may be particularly true in situations where the symptoms are troubling yet not so severe that the counselling is perceived as mandatory. In this case, we argue that the role of self-stigma in the decision to seek help might be even more pronounced because it is difficult for many to both acknowledge the need for professional help and not feel

"self-stigma uniquely predicts attitudes towards seeking psychological help"

Vogel et al., 2006). Based on Corrigan's (2004) discussion of self-stigma, the items 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. We have found that self-stigma is conceptually different from other potentially related constructs such as self-esteem and public stigma, and that self-stigma uniquely predicts attitudes towards seeking psychological help and willingness to seek counselling over and

above previously identified factors, such as gender or the perceived risk of counselling (Vogel et al., 2006). Furthermore, supporting our notion that self-stigma is

particularly important in the help-seeking process, in a second study we found that the self-stigma of seeking therapy fully mediated the relationship between the public stigma associated with mental illness and attitudes towards seeking help as well as willingness to seek help (Vogel et al., 2007). In other words, perceptions of public stigma initially contributed to the experience of self-stigma, but then self-stigma and not public stigma influenced help-seeking attitudes and eventually help-seeking willingness. We argue from these results that public stigma's effect on help-seeking is indirect, by influencing the tendency to internalise stigma. The flip-side of this finding is that lower self-stigma (i.e. less internalisation of public stigma) might act to buffer the effects of public stigma on help-seeking.

Our research, as well as others', is starting to identify how self-stigma may be related to cultural and gender-role norms (i.e. external expectations about how we should behave). Among many other prescriptions and proscriptions, these norms teach us who is an appropriate person to ask for assistance. For example, scholars in the area of psychotherapy for men have written of the personal risks (e.g. sense of failure, loss of control, perception of weakness) experienced by men when admitting the need for and



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If psychological help is seen as a threat to someone's self-regard, they may avoid seeking that help

a sense of failure or loss as our society portrays needing help as a weakness. In an attempt to further explore the self-stigma associated with seeking professional help, we have recently developed the Self-Stigma of Seeking Help Scale (SSOSH:

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seeking mental health services (Addis & Mahalik, 2003). Self-stigma may be particularly salient for men because the traditional male gender role's prescription that men should be independent, controlled and self-sufficient may lead to increased concerns about seeking help, as seeking help may mean admitting an inability to handle things on one's own. Therefore, a man who believed that he needed counselling may feel a strong sense of failure, which could make the act of asking for help particularly difficult. Consistent with this, Pederson and Vogel (2007) found that men who endorsed more traditionally masculine gender roles were more likely to self-stigmatise for seeking professional help. Specifically, they found that although the relationship between perceived public stigma and self-stigma is present for both women and men, the relationship was stronger for men than for women.

Interventions

A number of efforts have been implemented to try to reduce public and self-stigma, though most of these have been directed towards reducing the

stigma associated with having a mental illness – less attention has been spent on reducing the stigma surrounding seeking treatment. Although efforts to reduce the stigma associated with a mental illness are clearly important, ignoring the stigma associated with seeking professional help does nothing to reduce the difficulty for many individuals who might consider therapy as an option, particularly if they are not exhibiting severe symptoms. Next, borrowing from the literature on stigma reduction for mental illness, we will discuss some strategies to potentially reduce the public and self-stigmas associated with seeking professional help.

Reducing public stigma

Corrigan and Penn (1999) have suggested three approaches to reducing public stigma: protest, education and contact.

Firstly, protest. Psychologists and other mental health providers should be vocal in their objection to inaccurate portrayals of psychotherapy and clients in popular media and other sources. Psychologists have a right to object. The media's portrayals of therapy are often negative, which is particularly problematic because most people have little contact with actual

therapists (Orchowski et al., 2006). Recent research supports this media effect; the more people watch comedy and drama shows on television the more stigmatisation they perceive for seeking therapy (Vogel et al., 2008). Thus, psychologists have a responsibility to protest the stereotyped and often inaccurate portrayals of therapy. If those of us who know therapy and its effectiveness do not speak out, who will?

In terms of education, there is a need for accurate information about psychotherapy to help reduce public stigma. Education efforts can take many forms including books, videos, audiotapes, posters, advertisements and even commercials. Even brief educational programmes have been shown to have at least short-term effects on people's attitudes (Pinfold et al., 2003). A number of larger-scale public education campaigns have been implemented around the globe. One current example is the National Institute of Mental Health (NIMH) 'Real Men, Real Depression' campaign, which uses broad-based advertisements (print, radio and television) to educate the public about men and depression. This campaign is attempting to reach men who might not

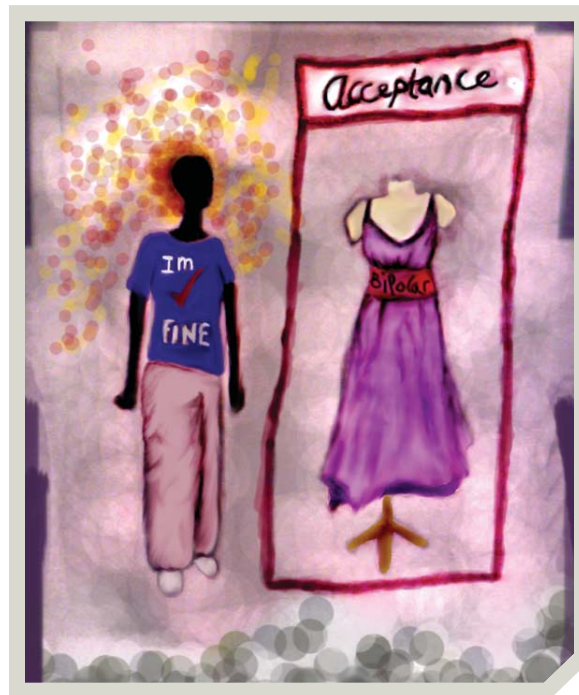
seek help for depression by reducing the public and self-stigma related to psychological treatment.

Finally, contact. This is one of the most effective ways to change individuals' endorsement of stigma towards others. Those who have more contact with people who have experienced a mental illness tend to stigmatise them less (Angermeyer et al., 2004). Personal contact can also be incorporated into educational efforts by having individuals not only learn about counselling but also interact with individuals who have sought treatment (Pinfold et al., 2003). Contact with people who have been in counseling can also be elicited through reading stories about individuals who have sought treatment and through public service announcements. In general, contact seems to have the most effect when the person is (a) of at least equal status, (b) perceived as an in-group member, and (c) likeable (Corrigan & Penn, 1999). Thus, having famous individuals such as sports or movie stars come out as having sought counselling is one way that help seeking can be normalised.

Reducing self-stigma

In trying to change the self-stigma associated with seeking professional help a number of lessons can also be learned from the studies on mental illness stigma. Specifically, a number of researchers have suggested cognitive-behavioural (C-B) strategies to build the necessary skills to manage stigma. Hayward and Bright (1997) for example, suggested C-B strategies focusing on changing inaccurate beliefs, providing accurate information, describing health and illness as a continuum with no clear cutoff, and fostering self-acceptance. Corrigan and Calabrese (2005) also suggested that C-B interventions including desensitisation of feared stimulus and cognitive reframing of negative beliefs could have a positive impact on self-stigmatisation. Cognitive-behavioural interventions to reduce self-stigma can be implemented through a number of modalities including in person and via computer or web-based programmes (e.g. see tinyurl.com/6abeqo; Griffiths et al., 2004).

Some evidence also suggests that people may feel less self-stigma (i.e. less shame and guilt) if their symptoms are normalised and if they are given an explanation for their symptoms that suggests that their problems are not their fault and are reversible (Rosen, 2003). This normalising of the therapeutic process may be a key component. Recently, Addis and Mahalik (2003) noted how 'any strategy that increases the normativeness for



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Cognitive-behavioural strategies focus on changing inaccurate beliefs

particular problems should be effective in facilitating help seeking' (p.12). Thus, help-seeking is increased when people see the problem they are dealing with as common. Normalising issues may make seeking treatment less threatening and more typical. Outreach interventions and public marketing could, therefore, discuss the commonness of mental illness and therapy.

Empowerment may also help reduce self-stigmatisation (Corrigan, 2004). Framing therapy as a type of empowerment ('it takes courage to face one's problems'), rather than something that is perceived as a weakness ('I could not handle this on my own'), may increase service use. The depression campaign in the US noted above, for example, describes seeking treatment as taking courage ('It takes courage to ask for help: These men did'). NIMH has a website where this statement is followed by pictures of men who sought treatment and links to their stories as well as information about depression (see tinyurl.com/6ben7o).

Another major implication for mental health professionals is the awareness that clients are evaluating their decisions to seek professional help even after they have made the initial decision to seek help. Although outreach programmes may be able to acknowledge this, a major benefit may come from examining with actual clients how stigma affects them even after they enter therapy (Vogel et al., 2007). The number of clients who drop out of treatment suggests that concerns about

seeking help do not vanish after the initial visit, and that for some these concerns may intensify after seeking treatment. Therapists may need to acknowledge and address the stigmas some clients perceive about therapy in order to increase service utilisation and decrease premature termination.

Conclusion

The decision to seek professional help is typically not an easy one. Understanding this difficult and complex process can help facilitate the use of mental health services by those who can truly benefit.

Understanding the unique roles of public and self-stigma associated with professional help will allow

psychologists to develop interventions designed to overcome these stigmas. Importantly, the discussion offers different possible routes of intervention, rather than restricting intervention only to those individuals who actually sit in our offices.

We can intervene at the individual, community, family, and societal levels to help people make the most informed and healthy choices for themselves. We believe that psychologists will be more effective at helping people overcome the barriers to seeking professional help if they are able to focus their efforts at these different levels. Although reducing the hesitancy to seek professional help is a large task, psychologists can help by using interventions that focus specifically on the stigmas associated with seeking help.



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