Summer 8-20-2021

Stigma Towards Treatment Amongst People with Mental Illness

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Abstract

There is evidence for the persistence of stigma towards people diagnosed with mental illness, as well as that endorsement of stigma is associated with reluctance to seek treatment. However, the process by which self-stigma impacts treatment choice amongst people with mental illness is not well understood. This study examined the impact of self-stigma on one's decision to take medication or undergo psychotherapy; as well as the impact of stigma on choice of individual or group therapy. Surveys were administered through CloudResearch to 128 participants from the U.S, who reported a disorder diagnosed by a professional. The *SSMIS-SF* and *ISMI-9* estimated self-stigma. The *MHSAS* and *ATSPPH-SF* distinguished attitudes towards help-seeking. Demographics were collected along with data related to treatment preference. Data were analyzed using correlations and ANOVA's. Self-stigma was not related to treatment choice (medication, psychotherapy, or both). Men and women preferred psychotherapy and medication conjointly. Stigma didn't have an impact on attending psychotherapy but there was a significant difference between the attitudes scales and attendance of psychotherapy variable. Those who attended psychotherapy expressed more favorable attitudes. Men and women preferred individual therapy to group therapy. Negative correlations existed between self-stigma and attitudes. A significant difference appeared between the agree subscale and choices of psychotherapy. There was a statistically significant difference between the +/- treatment variable and ISMI-9 as well as with this variable and the MHSAS. Those with more negative views endorsed more stigma and less favorable attitudes. Generalizability was limited, therefore future studies should encompass a more diverse population.

Keywords: medication, psychotherapy, mental illness, self-stigma, survey

Stigma Towards Treatment Amongst People with Mental Illness

Medication and psychotherapy are commonly used methods amongst mental health professionals to treat mental illness. A certified professional may prescribe antidepressants, anti-anxiety, stimulants, antipsychotics or mood stabilizing drugs depending on one's diagnosis (The National Institute of Mental Health [NAMI], 2016). Psychotherapy involves a collaborative relationship between an individual and a professional, who helps to build a supportive environment where the patient can speak openly to someone who is nonjudgmental and objective (American Psychological Association [APA], n.d.). For those who experience mental illness, psychotherapy is frequently a key component in treatment.

Despite the effectiveness of treatment, many may choose not to seek therapy because of the stigma associated with it (Sanders-Thompson, Brazile, & Akbar, 2004). Stigma has been defined as "a mark or flaw resulting from a personal or physical characteristic that is viewed as socially unacceptable" (Blaine, 2000). It also encompasses processes such as "labelling, separation, stereotype awareness, stereotype endorsement, prejudice and discrimination" (Link & Phelan, 2001). In a review, Clement et al. (2015) verified that stigma was a barrier to help-seeking. The shame and embarrassment associated with stigma acted as a barrier to help-seeking (Sanders-Thompson et al., 2004). According to Vogel et al. (2007), the best predictor of help-seeking is a person's attitude towards it, with attitudes are defined as the positive or negative perceptions towards seeking counseling.

In addition to community stigma, people diagnosed with mental illness may also experience internalized or self-stigma, which occurs when an individual endorses "stereotypes about mental illness, anticipates social rejection, considers stereotypes to be self-relevant, and

believes they are devalued members of society" (Livingston & Boyd, 2010). In other words, internalized stigma can be understood as incorporating society's negative thoughts into one's own beliefs about oneself. The literature indicates that self-stigma impacts willingness and attitudes towards seeking treatment. Most research (Bathje & Pryor, 2011; Held & Owens, 2013; Nam et al., 2013; Pattyn et al., 2014; Shechtman et al., 2018; Topkaya, 2014; Vogel et al., 2007; Vogel et al., 2017) has noted a relationship between these variables in the general population such as college students, older adults etc. These factors have also been studied among persons diagnosed with mental illness in a number of studies (Clement et al., 2015; Conner, 2010; Komiti et al., 2006; Livingston & Boyd, 2010; Szczesniak et al., 2018), with findings generally supporting that self-stigma is associated with decreased willingness to seek help among people diagnosed with mental illness.

The current study sought to understand the extent to which self-stigma impacts people's decision of what *type* of treatment method to choose: psychotherapy (individual or group) or medication. It is plausible that individuals who perceive more self-stigma would be less inclined to enroll in psychotherapy because of its personal nature. It also attempted to uncover a relationship between self-stigma and attitudes towards help-seeking. A better understanding of self-stigma and how it may impact treatment seeking will help clinicians decide the best way to approach treatment and improve the daily lives of those with mental illness.

Literature Review

Self-Stigma, Attitudes, Help-seeking, and the general population

Many studies have examined the relationship between self-stigma and attitudes towards help- seeking (see Bathje & Pryor, 2011; Held & Owens, 2013; Nam et al., 2013; Pattyn et

al.,2014; Shechtman et al., 2018; Topkaya, 2014; Vogel et al., 2007; Vogel et al., 2017). Bathje & Pryor (2011), investigated the influence of awareness and endorsement of public stigma on self-stigma. They also evaluated the connection between stigma and attitudes towards seeking counseling as well as intentions. They found that help-seeking attitudes fully mediated the connection between self-stigma and intention to seek help.

Another piece of literature analyzed the relationships between public stigma, self-stigma, and attitudes toward seeking mental health treatment (Held & Owens, 2013). An online survey was used to obtain a sample of 126 active and retired U.S. military service members. The authors determined that self-stigma had a direct effect on an individuals' attitudes toward seeking treatment for mental health issues.

Similarly, Nam et al. (2013) examined the relationship between attitudes towards help-seeking and various psychological variables which included self-stigma. The number of studies were narrowed down to 19 which comprised a total of 7,397 participants. The researchers then used the Meta-analysis with the Interactive eXplanations (MIX) program to analyze the data. The findings reported that self-stigma had a negative relationship with attitudes towards help-seeking, and had the largest negative effect size.

Research by Pattyn et al. (2014) evaluated the impact of perceived public stigma and anticipated self-stigma on help-seeking attitudes. Data was obtained from the Belgian Mental Health Study-2009 Stigma in a Global Context. Online interviews were conducted with a representative sample of the Belgian population where participants were assigned random vignettes. The results indicated that those who had higher levels of anticipated self-stigma had negative attitudes towards help-seeking from a medical professional.

Another study conducted a path analysis, to understand how self-stigma towards help-seeking influences Israeli adolescents 'decision to seek engage in therapy (Shechtman et al., 2018). They found that higher levels of self-stigma were consistently related to negative help-seeking attitudes. If a person held a certain amount of internal stigma, they would have an unfavorable attitude towards help-seeking which would influence their decision to attend psychotherapy. Particularly diminished feelings of self-worth that existed within the concept of self-stigma may have been an important factor in participants' decision to seek help. For group therapy, greater self-stigma and less positive attitudes were endorsed as opposed to individual therapy. There was also less intention to attend group therapy as opposed to individual therapy. These trends are consistent with previous research that proved that group therapy was viewed more negatively than individual therapy (Shechtman et al., 2018)

Research by Topkaya (2014) evaluated these trends and also added a new variable into the equation: gender. Topkaya examined the impact of gender, self-stigma, and public stigma on one's decision to seek psychological help, as well as how that relationship would predict help-seeking attitudes. The correlational analysis found a significant moderate negative correlation between attitudes toward help-seeking and gender where males were more likely to have negative attitudes. This trend was also seen in the relationship between help-seeking attitudes and self-stigma. The results suggested that self-stigma and gender significantly predicted attitudes toward help-seeking.

Vogel et al. (2007) used structural equation modeling (SEM) to uncover the link between perceived public stigma and desire to attend counseling which was predicted to be affected by self-stigma and attitudes towards seeking help. Therefore, the existence of negative attitudes towards psychotherapy was evidence that a person had some level of self-stigma. The

researchers determined that self-stigma was negatively associated with attitudes held towards help-seeking. They also discovered that attitudes towards treatment predict help-seeking while attitudes also have a strong relationship with stigma. The model used in this research accounted for 57% of the variance, which supported the notion that self-stigma was indeed a powerful predictor of help-seeking attitudes and willingness to attend counseling.

In a more recent study, Vogel et al. (2017) sought to understand the association between public stigma, self-stigma, and views toward seeking psychological treatment. Like their other related study (Vogel et al., 2007) they used structural equation modeling to discover trends in their data. Analyses found an inverse relationship between stigma and help-seeking attitudes. Higher stigma levels were linked to increasingly negative attitudes in most of the evaluated countries.

These various studies have many areas that require further elucidation. The participant pool in Bathje and Pryor (2011), Topkaya (2014), and Vogel et al. (2007) consisted of only college students and the majority of the participants were European American. Similarly, Vogel et al.'s (2017) participants were mostly young women and were from a college setting. Shechtman et al. (2018) did not account for populations other than Israeli adolescents between ages 14 and 18. Pattyn et al. (2014), was limited to the Belgian population. Held and Owens (2013) only obtained data from military populations. Nam et al. (2013) only focused on nonclinical university students. Therefore the results from prior studies are not broadly generalizable. Prior studies also did not examine the impact of other factors such as various mental illnesses, age, gender, education, etc., that could affect stigma, and attitudes and willingness to seek treatment. Importantly, none of these studies examined self-stigma and attitudes toward seeking help in a population of those with mental illness.

Self-Stigma, Attitudes, Help-seeking, and People Diagnosed with Mental Illness

The impact of self-stigma on attitudes towards seeking treatment for mental illness is a topic with an adequate number of studies. However, the impact of this relationship amongst those with mental illness is where less research has been conducted. While research that delves into these relationships exists (see Clement et al., 2015; Conner, 2010; Komiti et al., 2006; Livingston & Boyd, 2010; Szczesniak et al., 2018), it does not clarify the extent to which self-stigma impacts the choice of services among people diagnosed with mental illness. Clement et al. (2015) examined the impact of stigma on help-seeking for those who have a mental illness. A meta-synthesis of quantitative and qualitative studies was conducted to identify research to include in the study. 56 studies demonstrated a negative association between self-stigma and help-seeking attitudes. A median effect size of -0.27 existed between these studies. Therefore these findings support that internalized stigma was associated with a reduction in help-seeking among people with mental illness.

One study (Conner, 2010) inspected the influence of public stigma and internalized stigma on multiple races in regards to attitudes and behaviors towards treatment-seeking amongst older adults diagnosed with depression. Random digit dialing was utilized to obtain participants. This study found partial support for the hypothesis that high levels of internalized stigma would be related to more negative attitudes for treatment-seeking. For older African American and White participants, less positive help-seeking attitudes were significantly related to higher levels of internalized stigma (Conner, 2010).

Komiti et al. (2006) used a self-report measure to determine if attitudinal characteristics (stigma, attitudes towards help-seeking, and views of helpfulness of general practitioners) predicted help-seeking. They discovered that exhibiting a more positive attitude towards seeking

psychological help was a significant predictor of having sought help from a General Practitioner. Therefore it can also be said that willingness to seek help is affected by an individual's attitude towards help-seeking.

Another systematic review of 127 articles and meta-analysis of 47 articles, regarding the empirical relationship between internalized stigma and sociodemographic, psychiatric and psychosocial variables was conducted by Livingston and Boyd (2010). Livingston and Boyd (2010) found a negative relationship between internalized stigma and treatment adherence. The effect size is as follows: higher levels of internalized stigma were related with hopelessness ($r = -.58$, $p < .001$), poorer self-esteem ($r = -.55$, $p < .001$), lowered empowerment/mastery ($r = -.52$, $p < .001$), reduced self-efficacy ($r = -.54$, $p < .001$), decreased quality of life ($r = -.47$, $p < .001$), and weakened social support/integration ($r = -.28$, $p < .05$) (Livingston & Boyd,2010).

At an international level, a study in Poland investigated levels of internalized stigma amongst those with severe mental illnesses (Szczesniak et al., 2018). It also studied the relationship of internalized stigma with demographic and clinical variables. This research used a two-phase cross-sectional study design. Patients who suffered from depression had higher scores on the Internalized Stigma of Mental Illness Scale (ISMI) than patients with psychotic disorders. As in the previous study (Livingston & Boyd, 2010), there was no significant difference between the level of internalized stigma and gender (Szczesniak et al., 2018).

Although previous studies make clear that internalized stigma is related to help-seeking, they do not elaborate on the extent to which it might impact the specific type of mental health services one might seek. Further limitations include the lack of diversity in the samples studied and the impact of other characteristics, such as gender.

Current Study

The current study aimed to fill a gap in the literature and understand the extent to which self-stigma impacts people's decision of whether to participate in psychotherapy or exclusively take medication; as well as who would be more likely to enroll in individual vs group therapy. It also attempted to uncover if self-stigma is related to attitudes towards help-seeking. By understanding the effect of these variables, it is hoped that practitioners can better identify what may be preventing people with mental illness from seeking and accepting certain types of services.

In order to examine factors that may have an effect on treatment choice amongst individuals with mental illness, a series of measures were administered. The *Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF)* and *Internalized Stigma of Mental Illness Scale-9 (ISMI-9)* were used to measure views towards mental health, mainly providing a means of estimating stigma. *The Mental Help Seeking Attitudes Scale (MHSAS)* and *Attitudes Toward Seeking Professional Psychological Help Short Form(ATSPPH-SF)* were used to categorize views towards seeking help.

Hypothesis 1: It was hypothesized that people who endorse greater stigma towards treatment would be more likely to take medication only, rather than attend psychotherapy

Hypothesis 1a: Men, regardless of ethnicity or age, would be more likely to take medication rather than psychotherapy

Hypothesis 1b: Women, regardless of age or ethnicity, would be more likely to attend psychotherapy rather than medication

Hypothesis 2: Self-stigma will be associated with a decreased likelihood of enrolling in psychotherapy.

Hypothesis 3: Men will be more likely to engage in individual therapy while women will be more likely to engage in group therapy.

Hypothesis 4: Self-stigma will be negatively associated with help-seeking attitudes.

Method

Design

This correlational survey study examined the effect of mental health stigma on participants' preference of medication or psychotherapy as treatment, as well as their preference for individual or group psychotherapy. It also examined the relationship of self-stigma on help seeking attitudes. These relationships were studied amongst a sample of individuals with mental illness. This study attempted to determine if there was a significant relationship between stigma and variables of treatment. To assess the link between these variables surveys were administered to people who were diagnosed with a mental disorder.

Participants

128 persons who self-identified as having a mental illness participated in the study. Recruitment was conducted online where potential participants were given access to the study (see Appendix A for recruitment dialogue). Instructions were also given to participants before they accessed the survey (see Appendix B for instructions).

Inclusion Criteria:

1. Have a mental disorder diagnosed by a certified professional

2. Must be 18 years of age or older

Exclusion Criteria:

1. Have not been diagnosed with a mental disorder by a certified professional
2. Not 18 years of age or older

Participation was only open to those who lived in the United States. Participants were recruited from Amazon MTurk through Cloud Research. Eligible participants were prompted to check a yes or no box on an electronic consent form and given the survey link with the option of participating. Participation in the study was completely voluntary.

Procedures

Institutional Board Review (IRB) approval was received from the City University of New York (CUNY) to conduct this study. The survey was created in Qualtrics and reviewed multiple times to ensure it worked properly. The survey link was then posted to MTurk through Cloud research, a system from Amazon. Those who were recruited through MTurk were given immediate access to the survey link upon passing the screening questions and electronically checking the yes box on the consent form. The survey link was made available for a month where out of the 200 participant goal, 156 were obtained. The 200 participant goal stemmed from participant numbers in other research, therefore this number should have provided adequate statistical power. Participants who were at least 18 years old and had a mental disorder diagnosed by a certified professional (e.g., psychologist, psychiatrist) were eligible to participate in the study.

In order to determine if participants met the criteria to participate in this survey, they were asked a few screening questions. The first screening question determined if the participant

was diagnosed with a mental disorder, if they responded affirmatively, they were prompted to answer the next question. The second screening question asked participants if they were over the age of 18, if he/she responded positively the participant was given access to the informed consent (see Appendix C for informed consent). After participants selected the yes box on the informed consent they were able to begin the survey questions. The survey used in this study was created on Qualtrics (see Appendix D for questions). After participants completed the survey their results were recorded and they were awarded three dollars through amazon. Participants were also provided with a contact number and email in case of any concerns during or after the survey as a link to the National Institute on Mental Health website with information about mental health treatment. Participants were asked to report demographic variables such as age, gender, education, marital status, and race/ethnicity. Participants were asked about their history of mental health treatment and current mental health diagnoses. They were also asked questions about their experience with treatment.

After data was received from 156 participants, it was cleaned to allow for easier interpretation using SPSS. All cases under 180 seconds were removed from the data set with the exception of three cases which were those who were diagnosed with schizophrenia, in order to obtain more diversity these were kept. The 3 participants diagnosed with schizophrenia that were included all fully answered each item in the survey. Cases that were duplicated (multiple responses from one person) were also removed from the data set, such that a total of 28 cases were removed. The total number of participants at the end was 128 participants. It is possible, however, that a few duplicate cases were overlooked as the answers were different but around the same time range. The mental disorders that were listed were divided into two categories: primary and secondary diagnosis. Categories were created for those items that needed to be

reverse coded as well as those that needed a final score (such as the scales). The data was analyzed in SPSS for descriptives, crosstabs, correlations, and ANOVA.

Measures

Survey Questions

Questions related to demographic variables such as age, race/ethnicity, gender, marital status, income, and psychology-related education were asked. Note that type of psychology education was not specified in the survey. Open-ended questions include those that asked about diagnoses, length of illness, and treatment method/history. The survey had a total of 50 questions including the scales. The survey included specific questions to determine participants preferred treatment. Participants were asked directly if they would choose to take medication, undergo psychotherapy, or both. They were also questioned as to if they would participate in individual or group therapy. Participants were asked to rate their treatment experience on a scale from extremely positive to extremely negative (creating a +/- variable).

Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF) (see Appendix E for items)

The *Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF)* (Corrigan et al., 2006) is a 20 item measure that assesses attitudes that a person possesses towards mental illness. The statements on the scale are rated by respondents on a 9 point Likert scale (1 = *completely disagree* - 9 = *completely agree*). The scale includes four different subscales with five statements in each category. For the purposes of this study, only two of the subscales were used.

The first subscale represents awareness, the respondent is given the statement "I think the public believes…", followed by 5 other similar statements. The responses of the respondent exhibit the level of perceived public stigma. The second subscale reflects agreement: the

respondent answers the statement “I think most persons with mental illness...” with finishing phrases such as “ pose a threat”, therefore capturing self-endorsing stigma. Cronbach’s α for the SSMIS-SF was reported in a range from .72 to .92, exhibiting a high and stable internal consistency (Corrigan et al., 2012).

The recent study by Corrigan et al., (2012) evaluated the validity of the SSMIS-SF using data from three previous studies related to the SSMIS. It showed a 0.91 alpha level for public subscales and 0.88 alpha for self-subscales, therefore depicting a high internal consistency for the SSMIS-SF. In the current study, the alpha for the awareness subscale was 0.89 while the alpha for the agree subscale was 0.93.

Internalized Stigma of Mental Illness Scale-9 (ISMI-9)(see Appendix F for items)

The ISMI-9 is a unidimensional self-report measure that measures the intensity of a person's internalized stigma towards mental illness (Hammer, & Toland,2017). The ISMI-9 is made up of nine items, where items 2 and 9 must be reverse coded. The total score can be found by adding the total of all 9 items and dividing by the number of answered items. It is not recommended to keep data from those that answer less than 8 items. Because the ISMI-9 reflects a common variance source on the end score should be interpreted. The ISMI-9 is a numerical quantification to which respondents agree with the five concepts of internalized stigma: Stereotype Endorsement, Alienation, Social Withdrawal, Perceived Discrimination, and Stigma Resistance. Cronbach's α was 0.86 which demonstrated a reliable and stronger internal consistency than the ISMI-10.

The validity of the ISMI-9 overlaps with that of the ISMI-10 and both with the ISMI-29. The ISMI-10 has an adequate external validity which can therefore be said for the ISMI-9 (Boyd,

Otilingham, & DeForge, 2014). Further testing is needed to examine the convergent validity of the ISMI-9. The current study demonstrated an alpha of 0.80 for this scale.

The Mental Help Seeking Attitudes Scale (MHSAS) (see Appendix G for items)

The MHSAS is a 9-item unidimensional instrument intended to measure evaluations *(unfavorable* vs. *favorable*) of help-seeking from a mental health professional (Hammer, Parent, & Spiker,2018). The score determines whether a person has a positive or negative attitude towards help-seeking. The MHSAS uses a seven-point semantic differential scale which was labeled (3, 2, 1, 0, 1, 2, 3). Items on this scale were reverse coded to accurately calculate the mean score. The scale exhibited internal consistency where Cronbach's α was 0.92. This demonstrated that the items measured the same construct and were highly reliable.

Convergent evidence of validity was demonstrated when the MHSAS score supported the hypothesized relationships with the following variables: subjective norms, public stigma control, intention, self-stigma, anticipated risks, and benefits perceived behavioral. Validity was also demonstrated when the scale considered the ability to account for unique variance. Validity of known-group evidence was established when women and people who formerly tried mental health services were evidenced to report favorable attitudes. The scale proved to be significantly reliable as well valid to determine views of help-seeking. The MHSAS exhibited an alpha of 0.94 for this study.

Attitudes Toward Seeking Professional Psychological Help Short Form(ATSPPH-SF) (see Appendix H for items)

Attitudes of help-seeking for mental health issues are evaluated through the *ATSPPH-SF* scale (Fischer and Farina, 1995). This is a 10 item shortened form of the original 29 item scale

created by Fischer. The Items are rated on a 4-point Likert scale (0 = *Disagree*,3 = *Agree*). Items 2, 4, 8, 9, and 10 are reverse scored, higher final scores depict positive attitudes toward seeking professional help. The reliability and validity of the scale were tested through a population of student vs medical patients for this scale. Cronbach's α was 0.77 for the college student population and 0.78 for the patient population. This demonstrates that the *ATSPPH-SF* was as reliable as the original scale.

In terms of construct validity, a moderate negative correlation of − .41 ($P < 0.001$) was exhibited between the ATSPPHSF and Stigma Scale for Receiving Psychological Help (measures stigma towards help-seeking). Strong construct validity of the scale was demonstrated through a negative binomial regression. *Nagelkerke's R2 = 0.06,* which showed that for every point on the scale students were 22% more likely to visit doctors for treatment while patients were 16% more likely to seek treatment (Elhai, Schweinle, & Anderson,2008). This scale exhibited a reliable alpha at 0.76.

Results

Sample characteristics are reported in Table 1. The study sample consisted of 128 participants, 58 men (45.3%), 59 (53.9%) women, and 1 transgender person (0.8%). Participant ages ranged from 18 to 65, with a mean age of 26. The racial/ethnic breakdown was as follows: White (89, or 69.5%); Black or African American (27, or 21.1%); Asian or Asian American (3, or 2.3%); Native Hawaii or Pacific Islander (1, or 0.8%); and Other (8, or 6.3%). In this sample 79 were never married(%= 61.7), 38 were Married (%=29.7);6 were Divorced (%=4.7);3 were Widowed (2.3%) and 2 were Separated (1.6%). The largest group of participants had some college education (42; 32.8 %), followed by those with a 4 year degree (29; 22.7%); 2 year degree (22; 17.2%); professional degree (18; 14.1%); high school graduate (15; 11.7 %) and a

Doctorate (2; 1.6%). This sample had 57 participants (44.5%) with 1-2 years of psychology related knowledge (was not specified in the survey, it could be anything related to psychology such as reading books or attending classes); 27(21.1%) with 3-4 years; 26(20.3%) with less than 1 year and 18 (14.1%) with 5+ years. As a primary diagnosis, 36 (28.1%) people reported some type of depressive disorder, 17 (13.3%) had an unspecified anxiety-related disorder, others were diagnosed with disorders such as bipolar disorder, ADHD, schizophrenia, and various other disorders. Most did not list a secondary diagnosis (76 or %=59.4), after that about 19 (14.8%) suffered from some type of anxiety disorder, other disorders were listed as well.

Table 1

Demographic Sample Characteristics

		n=128	
		n	%
Gender	Female	69	53.9
	Male	58	45.3
	Transgender	1	.8
Age	18 - 24	24	18.8
	25 - 34	60	46.9
	35 - 44	24	18.8
	45 - 54	15	11.7
	55 - 65	5	3.9
Race/Eth	Asian	3	2.3

	Black or African American	27	21.1
	Native Hawaiian or Pacific Islander	1	.8
	Other	8	6.3
	White	89	69.5
Marital	Divorced	6	4.7
	Married	38	29.7
	Never married	79	61.7
	Separated	2	1.6
	Widowed	3	2.3
Education	High school graduate	15	11.7
	Some college	42	32.8
	2-year degree	22	17.2
	4-year degree	29	22.7
	Doctorate	2	1.6
	Professional degree	18	14.1
Psychology Knowledge	1-2 years	57	44.5
	3-4 years	27	21.1
	5+ years	18	14.1
	Less than 1 year	26	20.3
First Diagnosis	UNKNOWN	30	23.4
	ADHD	7	5.5

	ASD	2	1.6
	BED	1	.8
	Bipolar (1)	2	1.6
	Bipolar (2)	1	.8
	Depression	1	.8
	GAD	9	7.0
	MDD	8	6.3
	OCD	2	1.6
	PTSD	3	2.3
	Schizophrenia	3	2.3
	SPD	1	.8
	UAD	17	13.3
	UBD	5	3.9
	UDD	36	28.1
Second	UNKNOWN	76	59.4
Diagnosis	ADHD	1	.8
	AUD	1	.8
	BDD	1	.8
	Bipolar (1)	1	.8
	BPD	2	1.6
	GAD	2	1.6
	MDD	1	.8

OCD	2	1.6
PMDD	1	.8
PTSD	8	6.3
SAD	2	1.6
UAD	19	14.8
UBD	2	1.6
UDD	9	7.0

Note. ASD- Autism Spectrum Disorder; AUD-Alcohol Use Disorder; BDD- Body Dysmorphic Disorder; BED-Binge Eating Disorder; Bipolar(1)- Bipolar Disorder TYPE 1; Bipolar(2)-Bipolar Disorder TYPE 2; BPD- Borderline Personality Disorder; GAD- General Anxiety Disorder; MDD- Major Depressive Disorder; SAD-Social Anxiety Disorder; SPD-Schizoid Personality Disorder; UAD- Unspecified Anxiety Disorder; UBD-Unspecified Bipolar Disorder; UDD-Unspecified Depressive Disorder

Test for Hypothesis 1

Table 2 presents findings examining the relationship between the stigma scales and the variable treatment choice. As can be seen Table 2, the result of the One-way ANOVA revealed that there was not a statistically significant difference between the SSMISSF2 (agreement scale): F (33,93) = 1.179, p = .266; SSMISSF1 (awareness scale): F (38,88) = .877, p = .668; ISMI-9: F (21,106) = .693, p = .831 and the treatment choice variable, indicating that self-stigma was not related to choice of Psychotherapy vs. Medication.

Table 2

ANOVA of Treatment choice and Stigma scales

TREAT CHOICE	Sum of Square	*df*	Mean Square	*F*	*p*
SSMISSF2(Agree)	29.310	33	.888	1.179	.266
	70.044	93	.753		
	99.354	126			
SSMISSF(Aware)	27.296	38	.718	.877	.668
	72.058	88	.819		
	99.354	126			
ISMI-9	12.006	21	.572	.693	.831
	87.424	106	.825		
	99.430	127			

Note. Treatment Choice includes Psychotherapy, Medication, and both.

Table 3 reports on the relationship between gender and treatment choice. Out of 69 (53.9%) women, 23 chose to participate in psychotherapy,10 chose to take medication and 36 chose to do both of these methods conjointly. Out of 58 (45.3%) men, 14 chose psychotherapy, 9 chose medication, and 35 chose both. The one (0.8%) transgender person chose both forms of treatment. In total 37 decided on psychotherapy,19 took medication,72 (a little more than half the population) adopted both methods.

Table 3

Crosstab of Gender and Treatment Choice

Gender	PSY		MED		BOTH		Total	
	n	%	n	%	n	%	n	%
Female	23	62.2%	10	52.6%	36	50.0%	69	53.9%
Male	14	37.8%	9	47.4%	35	48.6%	58	45.3%
Transgender	0	0.0%	0	0.0%	1	1.4%	1	0.8%
Total	37	100.0%	19	100.0%	72	100.0%	128	100.0%

χ^2 (4) = 2.10, p =.717

Note. PSY: Psychotherapy; MED: Medication

Table 2 revealed that no statistically significant difference existed for the means of TREAT CHOICE (psychotherapy, medication, or both) and the scales that estimated self-stigma. None of the p statistics were less than our set alpha level .05, therefore none were significant. Self-stigma was not impacted by treatment choice. There was no evidence to support the idea that those within a certain treatment type would endorse a certain amount or level of stigma as well as the opposite effect. As seen in Table 3, men and women both preferred to take medication and undergo psychotherapy conjointly, as opposed to one gender preferring a certain type over another. A combination of treatment types seemed to be the preferred method of treatment by those who have a mental illness. It also seemed like both genders were more likely to choose psychotherapy over medication. However, it was hard to gauge the transgender population since there was only one transgender participant.

No particular evidence in regards to treatment preference was found based on gender. In this study, self-stigma was not related to if an individual preferred psychotherapy, medication, or both. Regardless of gender, those with mental illness seemed to prefer to undergo treatment consisting of medicine consumption and psychotherapy.

Test for Hypothesis 2

Table 4 reports findings on differences in study scales by the attendance of psychotherapy (rather or not an individual has attended psychotherapy regardless of the number of sessions). As can be seen in Table 4 and illustrated in Figure 1, there was a statistically significant difference between the MHSAS scale final scores and attendance of psychotherapy, F *(*1,126) = 7.928, p = .006. A statistically significant difference also existed between the ATSPPHSF scale and attendance of psychotherapy, F *(*1,125) = 10.358, p = .002. This indicates that participants who preferred to attend psychotherapy tended to report more favorable attitudes toward help-seeking. Similar to findings reported in Table 2, there was no statistically significant difference between the ISMI-9 scale F *(*1,126) = 2.730, p = .101, the SSMISSF1 awareness subscale F *(*1,125) = 3.202, p = .076, the SSMISSF2 agreement subscale, F *(*1,125) = 1.531, p = .218 and the attendance of psychotherapy variable.

Table 4

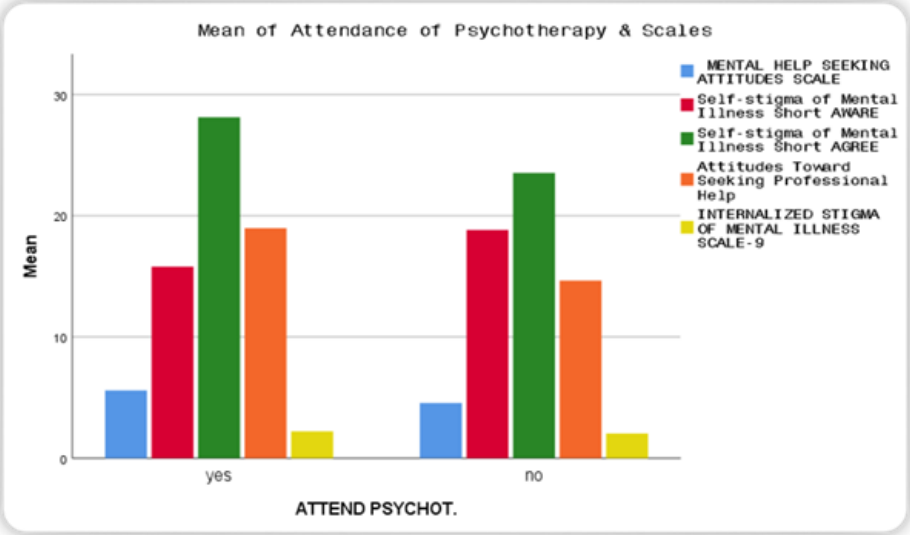
ANOVA of scales and attendance of Psychotherapy

Scales	Yes	No	Total		
	Mean (SD)	Mean (SD)	Mean (SD)	*F*	*p*
MHSAS	5.58(1.36)	4.62(1.19)	5.45(1.38)	7.92	.006
SSMISSF2	15.79(9.50)	18.82(8.78)	16.20(9.42)	1.53	.218
SSMISSF1	28.13(10.02)	23.53(8.68)	27.51(9.95)	3.20	.076
ATSPPHSF	18.97(5.29)	14.65(4.15)	18.39(5.35)	10.36	.002
ISMI-9	2.21(.55)	1.98(.56)	2.18(.56)	2.73	.101

*Note.*ATSPPHSF,SSMISSF2(Agreement) and SSMISSF1(awareness): Sum of scale items.ISMI-9 and MHSAS: average of scale items.

Figure 1

Mean of scales compared for Attendance of Psychotherapy variable



As noted, there was no difference of statistical significance between one's choice to attend psychotherapy and the scales that estimated self-stigma. However, there was a statistically

significant difference between the option to participate in psychotherapy and the two attitudes towards help seeking scales (MHSAS & ATSPPHSF). Those with higher scores on the MHSAS and ATSPPHSF were more likely to attend psychotherapy. Higher scores indicated that they had more favorable attitudes towards help-seeking which may have led to participants choosing to attend psychotherapy.

Test for Hypothesis 3

Table 5 reports findings on the relationship between gender and type of psychotherapy. As can be seen in Table 5, there was a similar balance in the choice of individual and group psychotherapy between the genders. However, the chi-square analysis indicated a statistically significant difference, suggesting that the apparent preference for men to be more likely to attend group therapy than women (52.9 % v. 41.2%) was not due to chance.

Table 5

Crosstab of Gender and Choice of Psychotherapy

Gender	IND		GRP		Total	
	n	%	n	%	n	%
Female	61	56.0%	7	41.2%	68	54.0%
Male	48	44.0%	9	52.9%	57	45.2%
Transgender	0	0.0%	1	5.9%	1	0.8%
Total	109	100.0%	17	100.0%	126	100.0%

χ^2 (2) = 7.27, p = .026

Note. IND: Individual Therapy. GRP: Group Therapy.

Test for Hypothesis 4

Table 6 reports on correlations between study scales. As can be seen in Table 6, the MHSAS and ATSPPHSF were moderately positively correlated $r(125) = .51$, $p < .01$. The MHSAS and the ISMI-9 were weakly negatively correlated $r(126) = -.32$, $p < .01$. The SSMISSF2 and ATSPPHSF were weakly negatively correlated $r(125) = -.35$, $p < .01$. The SSMISSF2 (Agreement subscale) and the ISMI-9 were weakly positively correlated $r(125) = .39$, $p < .01$. The ATSPPHSF and ISMI-9 were weakly negatively correlated $r(125) = -.39$, $p < .01$. Notably, these findings support that self-stigma (as measured by the ISMI-9), was weakly but significantly negatively correlated with the MHSAS and ATSPPHSF, such that those with greater self-stigma tending to have lower scores on the MHSAS and ATSPPHSF, meaning, less agreeable attitudes for seeking treatment. The ATSPPHSF and MHSAS displayed a weak but significant negative relationship with the SSMISSF2, the agree subscale, and also a measure of self-stigma.

Table 6

Correlation between scales

Scales	ISMI-9	SSMISSF2	SSMISSF1	ATSPPHSF	MHSAS
ISMI-9	_	.			
SSMISSF2	.393**	_			
SSMISSF1	.196*	.284**	_		
ATSPPHSF	-.391**	-.353**	-.026	_	
MHSAS	-.315**	-.182*	.088	.514**	_

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Note. ATSPPHSF: Attitudes Toward Seeking Professional Psychological Help Short Form. Self-Stigma of Mental Illness Scale - Short Form: SSMISSF2(Agreement) and SSMISSF1(awareness).ISMI-9:Internalized Stigma of Mental Illness Scale-9. MHSAS: The Mental Help Seeking Attitudes Scale

Test for Unexpected Data

Table 7 represents an examination of the relationship between the psychotherapy choice variable (individual or group) and the SSMISSF2 agree subscale. As can be seen in Table 7, the one-way ANOVA, $F(32,92) = 1.555$, $p = .054$, shows that there was a borderline significant difference between these two groups, such that those that chose group therapy were likely to score higher on all scales, indicated more self-stigma.

Table 7

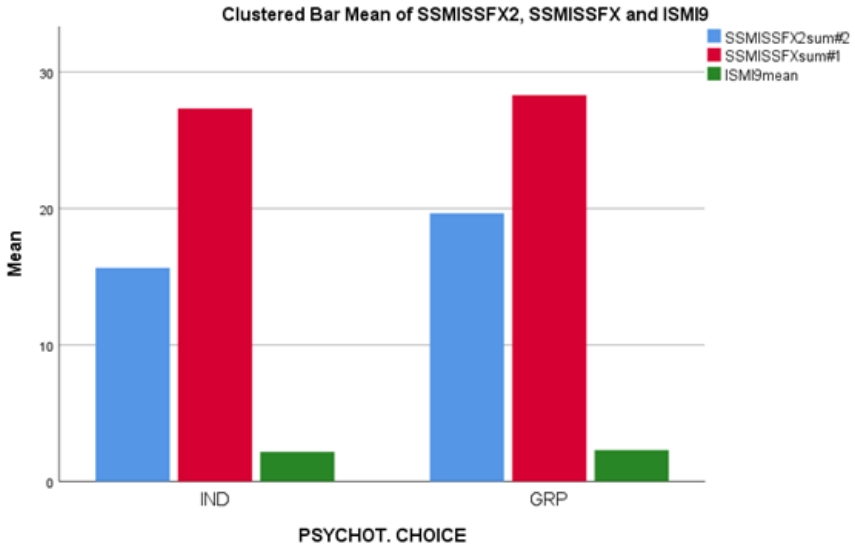
ANOVA of SSMISSF2 Agree subscale and Choice of Psychotherapy

PSYCHOT. CHOICE	Sum of Squares	*df*	Mean Square	*F*	*p*
SSMISSF2	5.155	32	.161	1.555	.054
	9.533	92	.104		
	14.688	124			

Note. PSYCHOT CHOICE: Psychotherapy Choice- Individual or Group Therapy.

Figure 2

Mean of stigma scales compared to PYCHOT. CHOICE variable



The clustered bar chart compares scale scores across psychotherapy choices.

Table 8 and Figure 3 present findings from analyses examining the relationship between the positive/negative treatment variable and study scales. ANOVA discovered that there was a statistically significant difference between the +/- treatment variable and the MHSAS scale F *(41*,86) = 1.544, *p* = .046 as well as the ISMI-9 scale F *(21*,106) = 2.301, *p* = .003. However, a statistically significant difference was not found amongst the +/- TREAT variable and the ATSPPHSF scale F *(22*,104) = 1.121, *p* = .338; the SSMISSF2 scale, F *(33*,93) = 1.121, *p* = .327 and the SSMISSF1 scale, F *(38*,88) = 0.962, *p* = .541. Findings supported that participants with more negative views towards personal treatment experience endorsed more self-stigma and less favorable views toward help-seeking.

Table 8

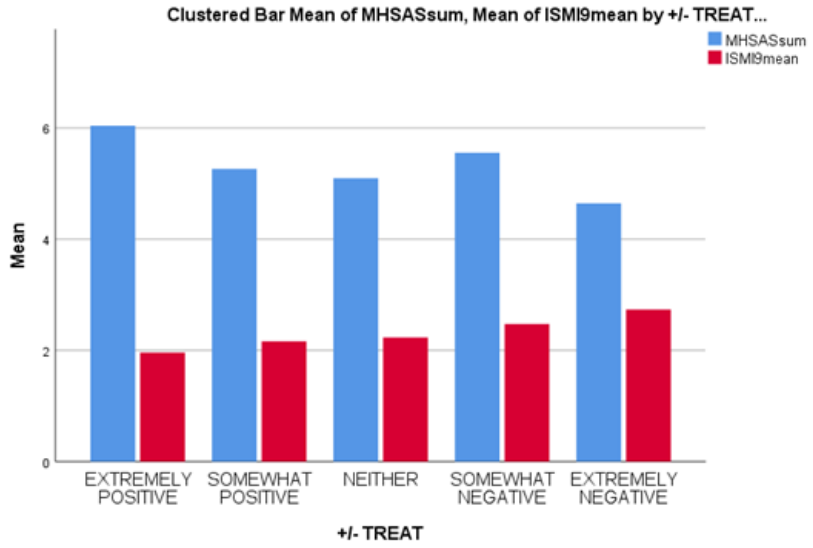
ANOVA of Scales and Positive or negative views of treatment

+/- TREAT	Sum of Squares	*df*	Mean Square	*F*	*p*
MHSAS	65.063	41	1.587	1.544	.046
	88.367	86	1.028		
	153.430	127			
SSMISSF2	43.652	33	1.323	1.121	.327
	109.703	93	1.180		
	153.354	126			
SSMISSF	45.013	38	1.185	.962	.541
	108.342	88	1.231		
	153.354	126			
ATSPPHSF	29.398	22	1.336	1.121	.338
	123.957	104	1.192		
	153.354	126			
ISMI-9	48.041	21	2.288	2.301	.003
	105.389	106	.994		
	153.430	127			

Note. +/- TREAT: scale of views from extremely positive to extremely negative.

Figure 3

Mean of MHSAS and ISMI-9 scales compared to views towards treatment variable



Discussion

This study aimed to understand how stigma affects an individual's choice to take medication or psychotherapy. It also focused on which gender would be more likely to participate in individual therapy vs group therapy. In addition, it examined the impact of self-stigma on help-seeking attitudes. The data collected in this study helped to answer these questions. There was no evidence to support the idea that people who exhibit greater stigma would be more likely to choose one treatment over the other or even both. From the data, it was clear that men and women preferred both psychotherapy and medicine conjointly, although there was some evidence that men were more likely to prefer group therapy than women. There was also no support for the hypothesis that self-stigma would be related to preference for therapy over medication. However, there was evidence to support that preference for medication over therapy is related to negative attitudes toward help-seeking and that an inverse relationship

existed between help-seeking attitudes and self-stigma. Also, there was evidence that having a negative attitude toward treatment (as expressed in categorical responses) was related to both self-stigma and help-seeking attitudes. Thus, this study showed some evidence that self-stigma was negatively associated with attitudes towards help-seeking. These findings are important because they suggest that stigma and negative attitudes toward help-seeking impact not only the decision to seek help in the first place but the type of treatment that is chosen.

This study did not provide evidence for a direct effect of stigma on treatment selection. This result was contrary to expectations that higher levels of self-stigma would lead to one choosing medication to treat their illness. It was anticipated that those with a significant amount of self-stigma would prefer medication in order to avoid interacting with others who may inflate one's negative view of oneself, or even judge them for having to seek treatment. However, the results did not support this notion as it depicted a nonsignificant relationship between these variables, and for a possible indirect relationship by way of the strong relationship between self-stigma and help-seeking attitudes.

Men and women preferred to take medication while participating in psychotherapy at the same time to treat their mental illness. This was an unexpected result as it seemed that men would be more likely to take medication since it seemed more plausible that they would prefer to hide their mental illness, while it was also expected that women would be more open to letting others know about their mental illness and would not mind interacting with others during the treatment process. While Albizu-Garcia et al. (2001) and Khalsa et al. (2011) determined that gender had no effect on treatment choice other researchers revealed a different finding. One study found that women were more likely than men to choose psychological treatment over pharmacological ones (McHugh et al., 2013). Pattyn et al. (2015) uncovered similar findings

where men were less likely to acknowledge the effects of psychotherapy as compared to women. Men also preferred to use tranquilizers and displayed more shame for their situation. Thus evidence has supported the idea that if there was a choice between medication and psychotherapy, men who associate shame with having to seek help will take medication in order to avoid confrontation and amplifying the shame they feel. While women would prefer psychotherapy since they believe it is more helpful and acknowledge the process. The data in this study has depicted a slightly different idea: that psychotherapy might be a preferred treatment method over medication for both men and women. This could be because medication despite its attempt to alleviate symptoms has various side effects on its users. Many people (personal and in articles) have complained about the way that medication makes them feel. Therefore, psychotherapy may be preferred as it has little to nonexistent side effects. Not much research has specifically evaluated the relationship of gender to treatment preference, therefore it is hard to know how reliable this trend is in the current study. The results however may point to the idea that mental health professionals who offer a combined treatment method might have better luck treating their patients. The preference of these patients could be attributed to the idea that the participants have had experiences taking both treatment methods conjointly as well as possibly separately. It might also be due to the recommendation of a mental health professional.

It was expected that those with higher levels of self-stigma would be less likely to enroll in psychotherapy since it would be more likely for those who have negative emotions towards their illness would be less likely to seek treatment as found in Clement et al. (2015). However, it occurred that attitudes towards help-seeking had a more significant relationship with enrolling in psychotherapy than self-stigma. This study found that those who attended psychotherapy had higher scores on the MHSAS and ATSPPHSSF, therefore had more positive attitudes towards

help-seeking. Those who chose not to attend had more negative attitudes. It seems that attitudes have a direct connection to psychotherapy. This could mean that attitudes are one of the main predictors of one's decision to attend psychotherapy. It may also point to the importance of attending psychotherapy as those who attended had more favorable views of help-seeking. It could also be possible that those who had more favorable attitudes towards help decided that they would attend psychotherapy. According to Dixon et al. (2016), those who attended treatment and built a strong alliance with their therapist were likely to continue treatment. Lower self-stigma was also associated with therapeutic alliance. In this study, we found that those who endorsed lower levels of self-stigma exhibited more favorable attitudes towards help-seeking. Based on this we can assume that a relationship may exist between therapeutic alliance and positive attitudes towards treatment. Therefore attending therapy may promote positive views towards seeking help. There exists evidence to support the notion the self-stigma has an impact on help-seeking. It may be possible that a certain scale or some other method was needed to accurately identify this relationship.

Prior studies **(**Bathje & Pryor, 2011; Clement et al., 2015; Komiti et al., 2006; Livingston & Boyd, 2010; Shechtman et al., 2018 and Vogel et al., 2007) provided support for the idea that self-stigma affects one's willingness to attend treatment contrary to what our data seems to say. Also, there is evidence in this data and others (Komiti et al., 2006; Vogel et al., 2007) that attitude impacts help-seeking. Positive attitudes are associated with treatment adherence. This study provided no evidence to support the hypothesis that self-stigma can influence an individual's decision to attend psychotherapy.

While there appeared to be a trend in the difference in group means between the SSMISSF2 agree subscale and the choice of therapy variable, the difference was not statistically

significant. Those who chose individual therapy were more likely to have lower scores on the SSMISSF2 as opposed to their counterparts who chose group therapy and were more likely to score higher on the scale. Those who preferred individual therapy seemed to have exhibited lower levels of self-stigma while those who chose group therapy had higher levels. A plausible explanation could be that those who had higher levels of stigma could have needed support and therefore may have chosen group therapy while the opposite could be said for those who enrolled in individual therapy.

Much evidence seems to support the positive relationship between views of therapy and attitudes (Komiti et al., 2006 and Vogel et al., 2007). According to Clement et al. (2015), internalized stigma led to negative views of therapy and therefore prevented help-seeking. Thus, our unexpected data seems to have substance as other studies have found the same. With the accurate measurement, it seems possible to understand the impact of positive/negative feelings towards treatment on self-stigma and help-seeking attitudes.

Findings suggested a small relationship between gender and preference for group vs. individual therapy choice. Some literature has claimed that women were more likely to have more positive views and less stigma. However, Shechtman et al. (2018), found that higher self-stigma levels led to choosing group therapy as well as the discovery that men were more likely to choose group therapy. Findings here provide some support for the view that men are more likely to choose group therapy than women, although the relationship was small.

In this study, the relationship was weaker, which may be attributed to the possibility that the men in this sample had lower self-stigma. This may imply that different populations may have different results as Shechtman et al. (2018) included Israeli youth between 14 and 18 while this sample included US adults over 18. It might be possible for results to differ based on the

country for various reasons such as beliefs, values, and various other things. It is plausible to say that results from one country are not generalizable to others. It is possible that women preferred individual therapy because of fear of being judged or further stigmatizing themselves due to the presence of other people. Further research is needed to establish the relationship between therapy and gender.

It was clear from the present study that, as expected, higher levels of self-stigma are associated with negative help-seeking attitudes. This was a trend that was expected even before reviewing other literature. Negative emotions towards a subject will clearly lead to bad attitudes towards that subject. So for those who had developed increasingly negative emotions towards mental illness, it would be most probable that they would view the treatment of their illness in the same way. It might also be that those who endorse greater self-stigma have seen how others are treated because of their illness and came to the conclusion that they would be treated the same way. Therefore this negativity is projected onto the treatment process as well. Previous studies have observed the same pattern (Bathje & Pryor, 2011; Conner, 2010; Nam et al., 2013; Pattyn et al., 2014; Shechtman, et al., 2018; Vogel et al., 2007; Vogel et al., 2017). They discovered that internalized stigma had an inverse relationship with attitudes towards help-seeking. Findings here also provided evidence which depicted that higher levels of stigma were associated with worse views of treatment while those who had more positive views had more favorable attitudes towards help-seeking. Therefore negative treatment views inevitably existed in those with more self-stigma and vice versa. The studies evaluated in the literature review do not use the same scales therefore it is hard to judge how accurate the positive correlations are between them. We discovered that self-stigma did have a negative relationship with help-seeking attitudes. The more self-stigma one had, the less positive their attitude toward seeking help for

their mental illness. It is possible and seen in other studies that a third or even fourth variable may have an impact on the relationship between self-stigma and attitudes. This may include other types of stigma, certain symptoms, or even specific feelings a person experiences. For example, in Livingston & Boyd (2010), there existed a relationship between internalized stigma and hopelessness. Other studies delved into the relationship between self-stigma, attitudes, and various other variables. There was a moderate relationship between the attitudes scales, which supported the idea that the scales were measuring the same concept. The same was true for the agree subscale and ISMI-9, self-stigma scales.

Participants who endorsed more stigma were more likely to choose group therapy instead of individual therapy. Shechtman et al., (2018) supported the idea that those with greater self-stigma would choose group therapy, which was men. Women seemed to endorse less stigma, therefore, were likely to choose individual therapy. There seemed to be some evidence to support the notion that self-stigma may have an impact on an individual's selection of individual vs group therapy. Since there is an inverse relationship between stigma and attitudes, we can also conclude that those who choose group therapy will most likely have negative attitudes towards help-seeking.

Findings from the present study may be beneficial to assisting mental health professionals when choosing the best way to treat their patients. It may also provide a basis for professionals to research if group therapy may be contributing to higher levels of stigma or vice versa. It was clear that self-stigma is related to more negative views regarding treatment, which may lead to premature drop-out or other factors that could impact client outcomes. Of course, it is also plausible that higher levels of self-stigma and negative views may be a result of bad experiences with seeking help. Therefore, improving help-seeking quality may lead to more patients seeking

treatment and increase willingness to continue treatment. This suggests a need to provide clients with positive treatment experiences as early as possible, so as not to create a "negative feedback loop" in which clients expect treatment to go poorly and drop out early as a result.

Limitations

There were various limitations of this study. First, the population was not diverse enough. Most of the population was white which therefore did not account much for other races. While there were almost as many males as females there could have been more of other gender types. The main mental disorders in the study were some form of anxiety or depressive disorder. The small sample may be attributed to the fact that this study was conducted during the COVID-19 pandemic and therefore there was no in-person recruitment which may have allowed for a more diverse population. Second, had there been more time to collect data there might have been a larger participant pool. Third, data were not collected to understand the reasons why certain choices were made. The questions and scales were all self-report measures which may increase the possibility of bias and common method variance. For the sake of this study, only the first two subscales of the SSMISSF were used but perhaps the results would have been different if all four subscales were incorporated into the measures. There may have been stronger evidence to support the relationship between self-stigma and attitudes. We might have also been able to view how strongly the third and fourth subscales correlated with other scales. It is also important to note that some variables in this study have a relationship but do not necessarily have a direct effect on one another. Also, since the data collected in this study was self-reported rather than having participants complete symptom assessment scales, there may have been differences in symptom severity by diagnosis.

Future research

Future studies should further develop the idea behind this one which is to understand how stigma affects treatment choice. Researchers may want to consider looking into participants' past experience with treatment and evaluate how it may relate to stigma. Later studies can explore the relationship between other types of stigma and various other treatment options. It should also include a more diverse population in terms of gender, ethnicity, mental disorder, and other demographics. The study could also include residents of other countries as opposed to America only. Various other scales could also be used to test stigma. Future studies could determine if stigma levels are higher for certain types of illnesses. It should strive to uncover more variables that may lead to positive or negative views. Studies should further explore the effects of race on stigma and views towards treatment. This study included (n=27) Black or African American participants, the relationship between race/ethnicity and treatment-seeking could be further analyzed. Multiple regression analysis may be used in the future to understand the relationships between self-stigma, attitudes, and various other variables measured in this study. More qualitative research may be warranted to better understand what may impact people's views of treatment and the stigma associated with it.

Implication

This research demonstrates the need to understand how we can attempt to improve seeking help for mental health issues. The findings in this study support the research in other studies by providing a more supportive database and some more specific variables. Practitioners may increase the number of people who seek treatment by addressing the problem that prevents them from doing so. Professionals may also require extra training to effectively prepare for interventions. Formulating methods and strategies to reduce stigma may be imperative in the

attempt to increase treatment attendance. Internalized stigma programs such as those seen in Yanos et al. (2015), may require further steps (in terms of each treatment) to understand its participants and better apply the treatment programs. Understanding what leads to self-stigma may help practitioners address the issues before it develops. It may also aid them in improving mental health literacy. In the end, more research on what causes these problems and how to address them is imperative.

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Appendix A

Recruitment

This is a brief survey designed for people who have been diagnosed with mental illness exploring their attitudes toward mental health treatment.

Appendix B

Participant Survey Instructions

This study is for anyone who has been diagnosed with a mental illness (for example, depression, psychosis, anxiety, PTSD) by a professional (such as a psychologist, social worker, or psychiatrist). You can only complete this survey if you are eligible based on a two question screening. You will not be compensated for the screening questions.

Appendix C

THE CITY UNIVERSITY OF NEW YORK

John Jay College of Criminal Justice

Department of Psychology

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE OF STUDY

Stigma Towards Treatment Amongst People with Mental Illness

PRINCIPAL INVESTIGATOR

Haya Khan, Forensic Psychology BA

Haya.khan@jjay.cuny.edu

FACULTY ADVISOR

Dr.Philip Yanos, PhD

PURPOSE OF STUDY

You are being asked to take part in a research study because you are between the ages of 18-65 and have a diagnosed mental illness by a professional. Please ask the researcher if there is anything that is not clear or if you need more information. The purpose of this study is to understand how mental health stigma affects the decisions of those with mental illness when

choosing to take medication, undergo psychotherapy, or both; if psychotherapy is chosen do they prefer individual or group therapy is also of concern.

STUDY PROCEDURES

We aim to enroll 200 participants from Amazon MTurk. This study will be available completely online. You will first answer two screening questions that will determine if you are eligible to complete the study then, agree to a consent form. After you agree to the consent form, you will be given access to the survey which should take 10 to 15 minutes to complete. Questions include basic demographic information such as age, gender, education, etc. Other questions ask about your experience and feelings with different types of treatment. After completing the survey you will be given a unique code to enter in MTurk. MTurk will then allocate you $3 for your participation in the study.

RISKS

There is minimal estimated risk with this study. Some questions may cause emotional discomfort, if so, it may be skipped. You may choose to decline to answer any question and you may cancel your participation at any time if you choose to do so.

BENEFITS

This study does not provide a direct benefit to you however, it may benefit those with mental illness by helping researchers and doctors to identify ways to boost seeking treatment.

CONFIDENTIALITY

Your responses to this survey will be anonymous thus no identifying information will be required. Every effort will be made by the researcher to preserve your confidentiality.

Authorized CUNY staff/researchers, and government agencies that regulate this type of research may have access to research data and records to monitor the research. Research records provided to authorized individuals as well as publications and presentations will not contain identifiable information about you.

VOLUNTARY PARTICIPATION

Your participation in this study is **voluntary**. It is your choice to decide whether or not to take part in this study. If you choose not to participate there will be **NO** consequences or penalties. If you decide to take part in this study, you will be asked to agree to a consent form. After you do so, you are still free to withdraw at any time and without giving a reason. If you withdraw from the study before data collection is completed, your data will be destroyed.

CONTACT INFORMATION

If you have questions or concerns about this study, you may contact one of the following researchers:

Primary Researcher: Haya Khan, Haya.khan@jjay.cuny.edu

Faculty Advisor: Dr. Philip Yanos, pyanos@jjay.cuny.edu, 212.484.1320

If you have questions and concerns that you prefer to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918 or email HRPP@cuny.edu.

If you prefer you may write to:

CUNY Office of the Vice-Chancellor for Research

Attn: Research Compliance Administrator

205 East 42nd Street

New York, NY 10017

CONSENT

I have read, and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I voluntarily agree to take part in this study.

Yes, I consent to participate in this study

No, I do not consent to participate in this study

Appendix D

Survey Questions

Screening Question: Have you been diagnosed with a DSM disorder by a certified professional (e.g. psychologist, psychiatrist)? Are you 18 years of age or older?

Part 1: Answer the following questions:

1. What gender do you identify as?
2. What is your age?
3. Please specify your race/ethnicity.
4. What is your marital status?
5. What is the highest level of education you have completed?
6. How many years of general psychology related knowledge do you have?
7. If you are comfortable, please list your current psychiatric diagnosis:
8. How long have you been living with your illness?
9. List the first 3 words that come to mind when you hear the word "therapy"?
10. Have you ever attended psychotherapy?
11. When seeking treatment would **you choose** to take medication, undergo psychotherapy aka talk therapy, or both?
12. If you had to choose between individual therapy (one on one with a therapist) or Group therapy (talking with a therapist and others who face similar worries as you) which would you choose?
13. Please describe your experience with treatment for your mental illness

    13b. As a follow up to the previous question: Were you left with a positive or negative impression.

14. Do you think your understanding about psychology affects your views of treatment?
15. In a theoretical situation if you did not have a mental illness but a friend of yours did, would you suggest that they seek treatment for their illness? Medication, psychotherapy, or both? If psychotherapy, individual or group therapy? Why?

Part 2: Fill in the following (retrieved from Corrigan et al., 2006)

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

I strongly Disagree — neither agree nor disagree — I strongly agree

1 2 3 4 5 6 7 8 9

Section 1:

I think the public believes…

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Section 2:
Now answer the next 5 items using the agreement scale.

I strongly Disagree — neither agree nor disagree — I strongly agree

1 2 3 4 5 6 7 8 9

I think…

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Part 3: Fill in the following (retrieved from Hammer, & Toland, 2017)

Internalized Stigma of Mental Illness Inventory – 9-item Version (ISMI-9) *

We are going to use the term "mental illness" in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it.

For each question, please mark whether you strongly disagree (1), disagree (2), agree (3), or strongly agree (4).

		Strongly disagree	Disagree	Agree	Strongly agree
1.	Stereotypes about the mentally ill apply to me.	1	2	3	4
2.	In general, I am able to live life the way I want to.	1	2	3	4
3.	Negative stereotypes about mental illness keep me isolated from the 'normal' world.	1	2	3	4
4.	I feel out of place in the world because I have a mental illness.	1	2	3	4
5.	Being around people who don't have a mental illness makes me feel out of place or inadequate.	1	2	3	4
6.	People without illness could not possible understand me.	1	2	3	4
7.	Nobody would be interested in getting close to me because I have a mental illness.	1	2	3	4
8.	I can't contribute anything to society because I have a mental illness.	1	2	3	4
9.	I can have a good, fulfilling life, despite my mental illness.	1	2	3	4

Part 4: Fill in the following (retrieved from Hammer, Parent & Spiker, 2018).

If I had a mental health concern, seeking help from a mental health professional would be...

	3	2	1	0	1	2	3	
Useless	○	○	○	○	○	○	○	Useful
Important	○	○	○	○	○	○	○	Unimportant
Unhealthy	○	○	○	○	○	○	○	Healthy
Ineffective	○	○	○	○	○	○	○	Effective
Good	○	○	○	○	○	○	○	Bad
Healing	○	○	○	○	○	○	○	Hurting
Disempowering	○	○	○	○	○	○	○	Empowering
Satisfying	○	○	○	○	○	○	○	Unsatisfying
Desirable	○	○	○	○	○	○	○	Undesirable

Part 5:Read each statement carefully and indicate your degree of agreement using the scale below. (retrieved from Fischer & Farina, 1995)

0 = Disagree 1 = Partly disagree 2 = Partly agree 3 = Agree

_____ 1. If I believed I was having a mental breakdown, my first inclination would be to get

professional attention.

_____ 2. The idea of talking about problems with a psychologist strikes me as a poor way to

get rid of emotional conflicts.

_____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be

confident that I could find relief in psychotherapy.

_____ 4. There is something admirable in the attitude of a person who is willing to cope with

his or her conflicts and fears without resorting to professional help.

_____ 5. I would want to get psychological help if I were worried or upset for a long period of

time.

_____ 6. I might want to have psychological counseling in the future.

_____ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely

to solve it with professional help.

_____ 8. Considering the time and expense involved in psychotherapy, it would have doubtful

value for a person like me.

_____ 9. A person should work out his or her own problems; getting psychological counseling

would be a last resort.

_____ 10. Personal and emotional troubles, like many things, tend to work out by themselves.

Appendix E

Self-Stigma of Mental Illness Scale - Short Form (SSMIS-SF)

The public has believed many different things about persons with serious mental illnesses over the years, including some things that could be considered offensive. We would like to know what you think most of the public as a whole, or most people in general, believe about persons with serious mental illnesses at the present time. Please answer the following items using the 9-point scale below.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

Section 1:

I think the public believes…

1. _____ most persons with mental illness are to blame for their problems.
2. _____ most persons with mental illness are unpredictable.
3. _____ most persons with mental illness will not recover or get better.
4. _____ most persons with mental illness are dangerous.
5. _____ most persons with mental illness are unable to take care of themselves.

Section 2:
Now answer the next 5 items using the agreement scale.

I strongly Disagree			neither agree nor disagree					I strongly agree
1	2	3	4	5	6	7	8	9

I think…

1. _____ most persons with mental illness are to blame for their problems.

2. _____ most persons with mental illness are unpredictable.

3. _____ most persons with mental illness will not recover or get better.

4. _____ most persons with mental illness are dangerous.

5. _____ most persons with mental illness are unable to take care of themselves.

Appendix F

Internalized Stigma of Mental Illness Inventory – 9-item Version (ISMI-9)

Internalized Stigma of Mental Illness Inventory – 9-item Version (ISMI-9) *

We are going to use the term "mental illness" in the rest of this questionnaire, but please think of it as whatever you feel is the best term for it.

For each question, please mark whether you strongly disagree (1), disagree (2), agree (3), or strongly agree (4).

	Strongly disagree	Disagree	Agree	Strongly agree
1. Stereotypes about the mentally ill apply to me.	1	2	3	4
2. In general, I am able to live life the way I want to.	1	2	3	4
3. Negative stereotypes about mental illness keep me isolated from the 'normal' world.	1	2	3	4
4. I feel out of place in the world because I have a mental illness.	1	2	3	4
5. Being around people who don't have a mental illness makes me feel out of place or inadequate.	1	2	3	4
6. People without illness could not possible understand me.	1	2	3	4
7. Nobody would be interested in getting close to me because I have a mental illness.	1	2	3	4
8. I can't contribute anything to society because I have a mental illness.	1	2	3	4
9. I can have a good, fulfilling life, despite my mental illness.	1	2	3	4

Appendix G

MHSAS Scale Items

If I had a mental health concern, seeking help from a mental health professional would be...

	3	2	1	0	1	2	3	
Useless	○	○	○	○	○	○	○	Useful
Important	○	○	○	○	○	○	○	Unimportant
Unhealthy	○	○	○	○	○	○	○	Healthy
Ineffective	○	○	○	○	○	○	○	Effective
Good	○	○	○	○	○	○	○	Bad
Healing	○	○	○	○	○	○	○	Hurting
Disempowering	○	○	○	○	○	○	○	Empowering
Satisfying	○	○	○	○	○	○	○	Unsatisfying
Desirable	○	○	○	○	○	○	○	Undesirable

Appendix H

Attitudes Toward Seeking Professional Help Scale items

_____ 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

_____ 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

_____ 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

_____ 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

_____ 5. I would want to get psychological help if I were worried or upset for a long period of time.

_____ 6. I might want to have psychological counseling in the future.

_____ 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

_____ 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

_____ 9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

_____ 10. Personal and emotional troubles, like many things, tend to work out by themselves