THE EFFECTS OF MENTAL HEALTH EDUCATION ON REDUCING STIGMA AND INCREASING POSITIVE ATTITUDES TOWARD SEEKING THERAPY

By

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A Thesis

Presented to

The Faculty of Humboldt State University

In Partial Fulfillment of the Requirements for the Degree

Masters of Arts

In Psychology: Counseling

May 2008
THE EFFECTS OF MENTAL HEALTH EDUCATION ON REDUCING STIGMA
AND INCREASING POSITIVE ATTITUDES TOWARD SEEKING THERAPY

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ABSTRACT

Stigma associated with mental health care is an important factor in people’s decision to seek out and engage in psychotherapy or counseling. Many previous studies have suggested that educating individuals about mental health can be an effective tool in reducing stigma towards seeking mental health services. This thesis attempted to measure the effects of mental health education on students’ endorsements of self stigma and social stigma, as well as attitudes towards counseling, and intentions to seek counseling. Social stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable. Self stigma is the internalization of social stigma or the belief that if one needs psychological treatment he or she is inferior.

Several surveys were used in this study to assess the relationship between social and self stigma to attitudes toward seeking psychological help and intentions to seek counseling. A Pearson Correlation revealed that there was a statistically significant positive relationship between ratings of self stigma and attitudes toward seeking psychological services and between self stigma and intentions to seek counseling. Additionally, analysis revealed a statistically significant positive relationship between social stigma and attitudes toward seeking psychological services and between social stigma and intentions to seek counseling. This study also found that the individuals in
the experimental group exposed to a brief session of Mental Health Education were more likely to seek counseling services than individuals in the control group.

This study did not find support for the hypothesis that individuals exposed to a brief session of Mental Health Education will have more positive attitudes toward seeking psychological services. Additionally, this study did not find support for the hypotheses that individuals exposed to Mental Health Education will have lower ratings of social stigma and self stigma. The findings here indicate that while there is a significant relationship between stigmas and attitudes toward seeking help that brief mental health education did not improve these attitudes.
ACKNOWLEDGEMENTS

I would first and foremost like to express my appreciation for my thesis committee: Dr. Emily Sommerman, Dr. Jim Dupree, and Dr. Lou Ann Wieand. Thank you from the bottom of my heart for all of your help and support over the last two years. I have truly enjoyed the time spent with each of you and I am very grateful for all the wonderful information you have shared with me. Thank you for guiding me through the many stages of this project and offering words of encouragement. Through working with each of you I have become a better student, counselor, and person. Thank you for giving me the opportunity to work with you all.

I would like to give special thanks to Diane Hunt and Richard Bruce. Thank you for all your help and support over my years at HSU.

I would also like to thank my wonderful cohort. I have learned many valuable lessons from each of you that I will never forget. Getting to know and love each of you has been a wonderful experience. Even though we are a small group, we have big energy and I have enjoyed being a part of that for the last two years.

Thank you to my family, especially, my mom and dad; both of you have always been sources of inspiration and I never would have made it this far without you. Thank you for all your guidance and love. Thank you for always believing in me, even when I didn’t believe in myself. I feel extremely lucky to have you both as parents and friends.

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I would also like to thank Annette, Gage, Amber, Chase, Cali, and Chris; you all have made Humboldt a home for me and we have shared many good times that have made my time here very special. I love all of you.

And last, but not least, I would like to thank my partner Trevor Vaughn Doom. You rock and I love you more than you know. You have always stood by my side and helped me through many bumps along the road and I thank you for that and so much more.
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Introduction to Mental Healthcare

The U.S Department of Health and Human Services defines mental health services as “Beneficial activities which aim to overcome issues involving emotional disturbance or maladaptive behavior adversely affecting socialization, learning, or development. Usually provided by public or private mental health agencies and includes both residential and non-residential activities” (Satcher, 1999, p. 210). Mental healthcare services work toward improving the understanding of the way thoughts, feelings, and behaviors affect every individual’s life. Mental health is an important part of our lives and affects how we see ourselves and relate to others.

A recent study conducted by the American Psychological Association (APA) concluded that 97% of Americans believe access to mental healthcare is important (Buetler, 2004, p. 2). Receiving mental healthcare for many mental health concerns often leads to a positive self-image and more satisfying relationships with friends and an individual’s community (Buetler, 2007, p. 14). Mental health services, including psychotherapy and other treatment interventions, can be received from a licensed professional such as a psychologist, psychiatrist, marriage and family therapist, or clinical social worker. In some situations, physicians may recommend the use of medication for
an individual with a mental health problem. Research has consistently shown that, when necessary, the use of medication for mental health problems works best in conjunction with some form of psychotherapy or counseling (Schniederman, 2007).

*Psychotherapy and Counseling Services*

Psychotherapy, referred to here as simply therapy, is an important part of mental health treatment offered by qualified professionals. Therapy is an interpersonal, relational intervention where a partnership is established between an individual and a professional who is trained to help people understand their feelings and assist them with modifying behaviors to function better in life (Buetler, 2007, p. 10). Therapy usually includes increasing an individuals’ sense of well being and reducing discomforting feelings. Therapy can be extremely beneficial for anyone regardless of age, gender, ethnicity, sexual orientation, or educational background. Therapy is available in many forms: individual, family, couples, and group counseling. Different types of therapy may be more appropriate for certain mental health concerns. For example, an individual with social anxiety may gain more from the process of group therapy than individual counseling. Many therapists, counselors, physicians, social workers, and teachers support the use of therapy for mental health concerns. Additionally, more and more research is supporting the use of therapy as an effective treatment method.
Research suggests that therapy effectively decreases clients’ unpleasant symptoms such as depression, anxiety, or relationship difficulties and has been found to have positive effects on the body’s immune system (Buetler, 2007, p. 16). Mental health is as important as physical health and the two are closely related. In fact, many studies have shown that when an individual experiences a mental health concern the risk of developing a physical health problem increases (Schniederman, 2007). Conversely, APA suggests that chronic and serious illness such as heart disease or cancer is often accompanied by depression (Buetler, 2004, p.16 ). Research increasingly supports the idea that “emotional and physical healths are closely linked and that therapy can improve a person’s overall health status” (Buetler, 2007, Conclusion section, para. 1). Mental health services have shown to be effective in helping individuals, couples, families, and children deal with emotional and behavioral disturbances and can be tremendously useful if people reach out for help when a mental health problem occurs (Corrigan, 2004). The heart of this issue is that while many people do reach out for physical health services, many do not seek mental health services when experiencing even severe mental health problems. Many researchers, mental health professionals, and community leaders have begun to look into the prevalence of mental health issues and, more importantly, the reasons so many people who need mental health services are not seeking help.
Barriers to Mental Healthcare

The National Alliance on Mentally Illness (NAMI) states that one in five people worldwide will have a mental or neurological disorder at some point in their lives, and that 450 million people currently suffer from such conditions. The World Health Organization reported that mental health concerns represent 10% of the global burden of disease and that depression will be one of the largest health concerns by 2020 (Herrman, 2001). Clearly, mental health problems are a vast concern and deserve proper treatment. Effective treatments exist for most mental disorders and psychological concerns not meeting the criteria for a formal diagnosis. However, many individuals who could benefit from mental health services never seek help. The underutilization of mental health services is especially troubling since the lifetime prevalence rate of mental illness has been estimated to be as high as 50% among the general population (Jorm, 2000). This suggests that almost everyone will develop, or have contact with someone with some form of mental health concern.

Although the quality and effectiveness of mental health treatments and services have greatly improved over the past 50 years, many barriers to adequate mental health care still exist today (Corrigan, 2004). A huge concern and frustration for mental health providers is that many individuals are hesitant to seek professional psychological help when they need it. The existing literature consistently finds that less than one third of those who experience psychological distress seek help from a mental health professional.
(Andrews, Issakidis, & Carter, 2001). The focus of much previous research has been to find out what factors contribute to the vast underutilization of mental health services.

Various factors keep people from seeking psychological services. Previous research has identified some of the factors contributing to individuals’ reluctance to seek psychological services. These factors include fear of emotional disclosure (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003), desire to avoid experiencing painful feelings (Komiya, Good, & Sherod, 2000), and perceived social support (Rickwood & Braithwait, 1994). Individuals with social support systems accepting of seeking psychological help are more likely to seek counseling than individuals with a social network that discourages help seeking (Friedson, 1961; Rickwood & Braithwait, 1994) and are more likely to seek help only when they perceive their psychological problems as more severe than the problems of others (Goodman, Sewell, & Jampol, 1984).

Other variables that have been associated with the decision to seek professional psychological help include availability, accessibility, and affordability of services (Kushner & Sher, 1991). Many individuals in rural areas or communities may not be able to access services when needed. Additional factors shown to inhibit individuals from seeking psychological services include demographic variables such as gender and socioeconomic status (SES) (Tessler & Schwarts, 1972). For example, women hold more favorable attitudes towards seeking and using mental health services than do men
(Fischer & Turner, 1970; Leaf, Bruce, Tischler, & Holzer, 1987). Furthermore, concern for monetary cost, education level (Leaf et al., 1987), ethnicity and age (Narikiyo & Kameoka, 1992) can all contribute to the decision of whether or not to seek mental health services. In general, individuals from Western backgrounds (i.e., European or Latin), who are older and of higher SES hold more positive attitudes towards seeking professional psychological help than those who are non-Western (i.e., Asian or African), younger, and of lower SES (Oliver, Reed, & Smith, 1998).

Stigma

*Stigma as a Barrier to Mental Healthcare*

Clearly, many relevant factors exist that play a role in a person’s decision to seek mental health services. However, the most frequently cited reason for why people do not seek counseling and other mental health services is the stigma associated with mental illness and seeking treatment (Corrigan, 2004). The “stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment is undesirable or socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). Stigma has consistently been cited as one of the main factors inhibiting individuals from seeking mental health care and there is a great deal of research suggestive of the strong stigma attached to mental illness and seeking psychological services (Brown & Bradley, 2002;
This stigma is characterized by fear, mistrust, dislike, and occasionally violence against the mentally ill (Gonzalez et al., 2002) and this stigmatization is pervasive and prevalent in individuals of all ages (Sadow et al., 2002). Stigma is directed toward individuals with mental health concerns and toward mental health services. The APA states that “20% of Americans chose not to seek help from a mental health professional because they feel there is a stigma associated with therapy” (Buetler, 2007, p. 18). Furthermore, the APA affirms that “30% of Americans say they would be concerned about other people knowing they saw a mental health professional” (Buetler, 2007, p. 18). These findings are consistent with the 1999 Surgeon General’s report on mental health (Satcher, 1999, p. 215), stating that the “fear of stigmatization deters individuals from (a) acknowledging their illness, (b) seeking help, and (c) remaining in treatment, thus creating unnecessary suffering” (p. 117). Numerous individuals who could benefit from utilizing some form of mental health service never reach out for help due to the overwhelming prevalence of stigma toward mental illness and mental healthcare. Understanding mental health care stigma and learning techniques to overcome this barrier is therefore an important priority for professionals and prospective clients alike.
Public/Social Stigma

According to Corrigan (2004), two types of stigma exist: public or social stigma and self stigma. Social stigma associated with seeking mental health services is the perception that a person who seeks psychological treatment or is diagnosed with a mental health concern, such as depression, is undesirable or socially unacceptable. Social stigma may be better described as “what a naïve public does to the stigmatized group when they endorse the prejudice about that group” (Corrigan, 1999). A statement demonstrating social stigma is “all people with mental illness are dangerous.” These perceptions can be harmful because they lead to stereotyping, prejudice, and discrimination of individuals who seek psychological help (Corrigan, 2003). Previous research has indicated that people tend to hide psychological concerns and avoid treatment to reduce the perceived detrimental consequences linked with public stigma (Corrigan & Matthews, 2003). Furthermore, the social stigma associated with mental health concerns has been associated with negative attitudes about seeking psychological help (Komiya et al., 2000; Vogel, Wester, Wei, & Boysen, 2005).

Self Stigma

In contrast to public endorsements of stigma, self stigma is a reduction in an individual’s self-esteem or self-worth as a consequence of that individual’s self-identification as being someone in need of mental health services. Self stigma can be
thought of as “what members of a stigmatized group may do to themselves if they internalize public stigma” (Corrigan, 2004). A statement exhibiting self-stigma is “I have a mental health problem, therefore I am incompetent.” Research has shown that people do internalize negative perceptions when dealing with mental health concerns (Link, 1987, Link & Phelan, 2001) and that being labeled mentally ill or being identified as a person in therapy can lead to lower self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Help seeking is often viewed as a threat to one’s self-esteem because seeking help from another is often internalized by the individuals as being inadequate or inferior and may lead the person to decide not to seek help, even when experiencing psychological distress (Fisher, Nadler, & Whitcher-Alagna, 1983; Nadler & Fisher, 1986).

Fighting Stigma with Education

Existing bodies of research have comprehensively described why people might opt to avoid services because of stigma. The challenge now is for mental health professionals and the society to advocate for programs that combat stigma and increase intentions to seek mental health services. By educating the public about mental health, how to get help, and what to expect from treatments, such as therapy, more individuals may receive help for psychological distress and help to minimize the effects of mental health care stigma. Programs that work to decrease stigma will often help reduce attitudes and behaviors that might be barriers to seeking mental health services (Corrigan,
Several agencies have well established programs that work towards fighting the stigma associated with mental illness and increasing awareness about mental health services. The National Alliance on Mental Illness has developed a program called “Stigma Busters” that encourages advocates to fight inaccurate and hurtful depictions of individuals with mental illness in the media and to praise accurate ones (Nami.org, 2007). The “Stigma Busters” program has been effective in increasing awareness about the stigma towards individuals with mental illness and encouraging communities to overcome this harmful barrier to getting help (Nami.org, 2007).

Yet, the widespread use of educational programs that address the stigma associated with seeking out professional psychological help remains to be seen. Research on education related to mental health care stigma has suggested that participation in these kinds of programs has led to improved attitudes about persons with mental health concerns (Corrigan & Penn, 1999; Keane, 1990). Unfortunately, research also suggests that the effects of education may not endure over time (Corrigan et al., 2002). People with mental health concerns who self-stigmatize tend to report little personal empowerment in terms of treatment, and thus the participation in treatment is reduced. As a result, interventions that challenge self-stigma and facilitate empowerment are likely to increase intentions to seek counseling services (Speer, Jackson, & Peterson, 2001). By educating the public about what mental health is and what to expect from mental health services more individuals who could benefit from this kind of help could feel comfortable
about seeking out these services and know what to expect from mental health services like therapy. Education can foster empowerment and not only help combat social stigma, but self stigma as well (Sadow, Ryder, & Webster, 2002).

Applying an educational program to combat the stigma associated with mental health care and increase willingness to seek services could be extremely useful in many different settings and with many different groups of people. The underutilization of mental health services is a trend that appears in all age groups, especially among college students (Sharp, Hargrove, Johnson, & Deal, 2006). For example, less than half of college students in need of mental health services actually seek them out (Oliver, Reed, & Smith, 1998). “College represents a transition from adolescence to adulthood chronologically, socially, and developmentally; during these transitions many students face symptoms of substance abuse and psychological distress” (Sharp et al., p. 310, 2006). Educating college students about mental health services can help these young adults get professional psychological help before mental health concerns become severe and incapacitating.

The American Psychological Association (APA) is one organization that has been working to educate people about mental health care and increase positive attitudes towards seeking services (Buetler, 2007, p. 1). The APA has constructed several brochures, available online, informing the public about mental health and related services, like therapy. Educating potential clients about mental health concerns and mental health
services, as well as, normalizing and explaining common symptoms can be an effective way to decrease stigma and increase intentions to seek counseling or other related mental health services (Buetler, 2007, Conclusion section, para. 3). Through answering common questions like “What is mental health” and “What is therapy and why go?” the APA has provided an educational service to the public. For the purposes of this study the APA information has been adapted into a one page question and answer educational-informational tool.

Implications and Relevance

Stigma associated with mental health care is an important factor in people’s decision to seek out and engage in psychotherapy. Both social and self stigma associated with mental health services are consistently cited as the main reason why individuals in need of psychological help don’t seek out services. Educating the public about mental health services and empowering individuals to seek out help when experiencing psychological distress will help combat the adverse effects that accompany untreated mental health concerns. This study aims to measure the effects of mental health education on students’ endorsements of stigma, as well as willingness and intentions to seek counseling. More importantly, this study aspires to help more people in need of mental health services.
Hypotheses and Research Questions

1. Individuals with higher ratings of self stigma will have more negative attitudes toward seeking professional psychological help.

2. Individuals with higher ratings of self stigma will be less likely to seek counseling services when experiencing some form of psychological distress.

3. Individuals with higher ratings of social stigma will have more negative attitudes toward seeking professional psychological help.

4. Individuals with higher ratings of social stigma will be less likely to seek counseling when experiencing some form of psychological distress.

5. Individuals exposed to Mental Health Education will show more positive attitudes toward seeking professional psychological help.

6. Individuals exposed to Mental Health Education will be more likely to seek counseling services when experiencing psychological distress.

7. Individuals exposed to Mental Health Education will have lower scores on self stigma than the control group.

8. Individuals exposed to Mental Health Education will have lower scores on social stigma than the control group.
CHAPTER TWO: METHOD

Participants

Participation was entirely voluntary and the criterion for participation was that the subject be at least 18 years of age and a current HSU student. One hundred and ninety-six HSU students were surveyed. The participants in this study were comprised of 99 females and 97 males (n=196) ages 18 to 54, with a mean age of 24.55 years (SD = 5.95) (See Table 1). The distribution of genders between the control and experimental groups was slightly disproportionate. Out of the 99 participants in the control condition, 46 were females and 53 were males. In the experimental group consisting of 97 participants, 53 were females and 44 were males (See Table 2).

The sample was made up of 9.2% African American/Black, 4.1% Asian/Asian American, 57.7% Caucasian/White, Filipino/Pacific Islander 0%, 5.1% Hispanic, 6.6% Native American, 17.4% Other/Unknown. Whereas the university enrollment was reported as Asian 3.2%, Black 2.8%, Hispanic 7.8%, Native American 2.3 %, Pacific Islander 0.6%, White 60.6%, Other/Unknown 22.7%. The average age of students was reported to be 26 years old.

While a greater number of participants identified as African American/Black and a greater number of participants identified as Native American, the survey results are fairly representative of the population of the University from which it was taken. Additionally, 82 participants (41.8% of the sample) have received therapy before and 112 participants (57.1%) have never received therapy. Two participants (1.0%) declined to answer this question. The participants’ majors in this study were also somewhat representative of the student population at HSU; with 11.2% Art majors, 10.7% Biology, 9.2% Undeclared, 9.2% Psychology, 5.6% English, and less than 5% for all other majors.

Procedure

A true experimental, between-subjects design was used. Students for the sample were recruited by convenience sampling done by requesting volunteers to take surveys in central locations on campus at Humboldt State University. Participants were randomly assigned to either the experimental or control condition by random shuffling of the survey packets. Participation was completely voluntary and an informed consent (See Appendix A) was obtained for each participant before beginning the collection of data. Each participant was told that this is a study examining the effects of stigma on intentions to seek counseling.
Participants in both the control group and experimental group filled out a set of four short surveys measuring attitudes toward seeking professional psychological help, intentions to seek counseling, self stigma and social stigma. Participants in the experimental condition were given information in a question and answer form regarding mental health and mental health services adapted from the American Psychological Association (APA) Help Center (see Appendix C) and then asked to fill out the set of four short surveys. The control condition was asked to simply fill out the set of four surveys. At the end of the survey packet was a brief demographic form (See Appendix B) asking for the participants’ age, gender, major, ethnicity, and if he or she had received therapy previously. Participants took 10 - 20 minutes to complete the entire participation process and returned it to the principle investigator. The completed surveys were kept in a sealed folder until the time of data entry. After completing this study all informed consent forms were shredded to ensure the anonymity of participants. The data was collected during the fall semester of 2007 and the beginning of the spring semester of 2008. Approval was received from the Humboldt State University International Review Board on June 26, 2007, IRB approval #06-88.

The independent variable was the mental health educational information and the dependent variables measured in response to the educational intervention were social stigma, self-stigma, attitudes toward seeking professional psychological help, and intentions to seek counseling.
Instruments

All instruments used in the current study were obtained with permission of the original authors when needed. Four short surveys were combined to create the survey that was used for the current study. Participants completed an informed consent prior to beginning the survey and a short demographic section was filled out immediately following the survey. The four surveys used are outlined in the order of appearance on the survey used in the current study.

Attitudes toward Seeking Professional Psychological Help Scale

Attitudes toward Seeking Professional Psychological Help Scale: Short Form (ATSPPH-S; Fischer & Farina, 1995; Fischer & Turner, 1970) was originally developed in 1970 and revised in 1995. The updated version of the ATSPPH-S is a shortened 10 item revision of the original 29 item scale (Fischer & Farina, 1995). Items are rated on a Likert scale rating from 1 (disagree) to 4(agree), and five of the 10 items reverse scored so that higher scores reflect more positive attitudes towards seeking professional psychological help. Score ranging from 10 – 25 points are considered to reflect more positive attitudes whereas scores ranging from 26 – 40 reflect more negative attitudes. A sample item is “I would want to get psychological help if I were worried or upset for a long period of time.” Internal consistency and reliabilities have been found to be adequate (Vogel et al., 2004). (See Appendix D)
**Intentions to Seek Counseling Inventory**

Intentions to Seeking Counseling Inventory (ISCI) (Cash, Begley, McCown, & Weise, 1975) consist of 17-items that asks participates to rate how likely they would be to seek counseling if they were experiencing the problem listed, rating from 1 (very unlikely) to 4 (very likely). Some of these issues presented include relationship difficulties, depression, personal concerns, and drug-related problems. Total scores ranging from 17 – 42 indicate the participant is less likely to seek services whereas scores ranging from 43 – 68 indicate the participant is more likely to seek services. Three subscales exist within the ISCI that include Interpersonal Problems (10 items), Academic Problems (4 items), and Drug/Alcohol Problems (2 items). The ISCI has sufficient internal consistency estimates for the three subscales measuring .90 for Interpersonal Problems, .71 for Academic Problems, and .86 for Drug/Alcohol Problems. Scores can be totaled to reflect intentions to seek counseling for each of the three subscales or to gather an overall score on willingness to seek out services when needed (Cepeda-Benito & Short, 1998). (See Appendix E)

**Self Stigma of Seeking Help Scale**

One of the main ways previous researchers have attempted to understand social and self-stigma towards help seeking is through the development of scales measuring
these variables. To measure self stigma the Self Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) was developed. The original scale contained twenty-five statements rated on a Likert scale from 1 (strongly disagree) to 5 (strongly agree) measuring the self stigma associated with seeking psychological help such as psychotherapy or counseling. Scores ranging from 10 – 30 indicate the participant has less self stigma and scores ranging from 31 – 50 indicate the participant has more self stigma. The items within the SSOSH were constructed to evaluate concerns about the loss in self-esteem and overall sense of worth a person would feel if they decided to seek help from a psychologist or other mental health professional. A sample item is “I would feel inadequate if I went to a therapist for psychological help.” Higher scores on the SSOSH reflect higher endorsements of self stigma or more negative stigma toward seeking psychological help. (See Appendix F)

Social Stigma for Receiving Psychological Help Scale

The Social Stigma for Receiving Psychological Help scale (SSRPH; Komiya et al., 2000) was devised to evaluate individuals’ perceptions of how stigmatizing it is to receive professional psychological help. The SSRPH contains five questions each rated on a Likert scale from 1 (strongly disagree) to 4 (strongly agree); the higher scores ranging from 12 – 20 indicate greater perception of social stigma associated with receiving professional psychological help whereas the lower scores ranging from 4 – 11
indicate less social stigma. A sample item is “People tend to like less those who are receiving professional psychological help.” After preliminary analysis and examination of the scale by two doctoral level counseling psychologists, an acceptable level of internal consistency and construct validity were supported by the findings (Komiya et al., 2000). Support for the construct validity of the SSRPH also provided findings that the SSRPH correlated negatively with the Attitudes towards Seeking Professional Psychological Help Scale: Short form (ATSPPH-S); “this indicates that the less social stigma individuals perceived, the more positively they felt about seeking psychological help” (Komiya et al., 2000). (See Appendix G)
CHAPTER THREE: RESULTS

The purpose of this study was to measure the effects of mental health education on reducing stigma toward professional psychological services and increasing intentions to seek services. This study also attempted to demonstrate the relationship between social stigma and self stigma as it relates to attitudes toward seeking mental health services and intentions to seek psychological services when needed.

A Pearson Correlation was used to determine the relationship between variables for the hypotheses one through four (See Table 4). A two-tailed t test (ANOVA) was used to determine the relationship between variables for hypotheses four through eight (See Table 5).

Hypothesis #1: It was predicted that individuals with higher ratings of self stigma will have more negative attitudes toward seeking professional psychological help. That is the higher the self stigma score on the Self Stigma of Seeking Help (SSOSH) scale the more negative beliefs a person will hold regarding his or her self-worth if they did need psychological help. Individuals scoring high on the SSOSH scale may have agreed with statements like, “I would feel inadequate if I went to a therapist for psychological help,” or “I would feel worse about myself if I could not solve my own problems.” The more negative attitudes toward seeking professional psychological help are reflected by a low total score on the Attitudes toward Seeking Professional Psychological Help (ATSPPH)
Table 1

Means and Standard Deviations for Age for Entire Sample

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Table 2

Distribution of Genders between the Control and Experimental Conditions

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<th>n</th>
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<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Group</td>
<td>99</td>
<td>46</td>
<td>53</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>97</td>
<td>53</td>
<td>44</td>
</tr>
</tbody>
</table>
Table 3

Means and Standard Deviations for Gender Across Total Scores for Attitudes toward Seeking Professional Psychological Help (ATSPPH) Scale, Intentions to Seek Counseling Inventory (ISCI), Self Stigma of Seeking Help (SSOSH) Scale, and Social Stigma for Receiving Psychological Help (SSRPH) Scale

<table>
<thead>
<tr>
<th>Scale</th>
<th>Gender</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>*ATSPPH</td>
<td>Female</td>
<td>99</td>
<td>21.51</td>
<td>4.45</td>
</tr>
<tr>
<td>*ATSPPH</td>
<td>Male</td>
<td>97</td>
<td>23.69</td>
<td>4.76</td>
</tr>
<tr>
<td>ISCI</td>
<td>Female</td>
<td>99</td>
<td>42.32</td>
<td>8.06</td>
</tr>
<tr>
<td>ISCI</td>
<td>Male</td>
<td>97</td>
<td>37.23</td>
<td>9.64</td>
</tr>
<tr>
<td>*SSOSH</td>
<td>Female</td>
<td>99</td>
<td>23.18</td>
<td>6.60</td>
</tr>
<tr>
<td>*SSOSH</td>
<td>Male</td>
<td>97</td>
<td>26.05</td>
<td>6.78</td>
</tr>
<tr>
<td>SSRPH</td>
<td>Female</td>
<td>99</td>
<td>10.64</td>
<td>3.28</td>
</tr>
<tr>
<td>SSRPH</td>
<td>Male</td>
<td>97</td>
<td>12.18</td>
<td>3.39</td>
</tr>
</tbody>
</table>

*These scales contained reverse scores, signifying a higher the score as more negative.
Individuals scoring low on the ATSPPH scale may have agreed with statements like, “The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.” The scores on the SSOSH scale and the ATSPPH scale were compared for all 196 participants using a Pearson Correlation. This hypothesis was accepted ($r = .58$, $p < .01$) as the participants in the sample scoring high on self stigma also demonstrated more negative attitudes toward seeking professional psychological help with low scores on the ATSPPH scale (See Table 4). This supports the theory that individuals with higher self stigma or more negative beliefs about psychological services will have corresponding negative attitude toward seeking those services.

Hypothesis #2: It was stated that those individuals with higher self stigma will be less likely to seek counseling services when experiencing some form of psychological distress. This means the higher the self stigma score on the SSOSH scale or the more negative the self stigma the lower the score on the Intentions to Seek Counseling Inventory (ISCI) will be, indicating decreased likelihood of seeking counseling. Individuals scoring low on the ISCI may have said they would be unlikely to seek services when experiencing problems like depression, anxiety, drug problems, and relationship concerns. The scores on the SSOSH scale and the ISCI were compared for all 196 participants. This hypothesis was accepted ($r = -.50$, $p < .01$) showing that the
more negative self stigma the less likely a person will be to seek counseling services (See Table 4).

Hypothesis # 3: It was anticipated that individuals with higher ratings of social stigma will have more negative attitudes toward seeking professional psychological help. Scores were compared between the Social Stigma for Receiving Psychological Help (SSRPH) scale and the ATSPPH scale for all 196 participants. Higher scores on the SSRPH scale reflected more negative social stigma. Individuals with high scores on the SSRPH scale may have agreed with statements like, “It is a sign of personal weakness to see a psychologist,” or “It is advisable for a person to hide from others that he/she has seen a psychologist.” Low scores on the ATSPPH scale indicate more negative attitudes toward seeking psychological help. This hypothesis was also accepted ($r = .60$, $p < .01$) showing a significant relationship between high social stigma and negative attitudes toward seeking help (See Table 4).

Hypothesis # 4: It was expected that those individuals with higher social stigma will be less likely to seek counseling when experiencing some form of psychological distress. Scores were compared between the SSRPH scale and the ISCI for all 196 participants. The results were similar to the comparison of self stigma and intentions to seek counseling services. The hypothesis was accepted ($r = -.52$, $p < .01$) showing another significant relationship between high social stigma and low intentions to seek counseling services (See Table 4).
Hypothesis # 5: It was predicted that individuals exposed to Mental Health Education in the experimental condition will show more positive attitudes toward seeking professional psychological help. A two-tailed t test (ANOVA) was used to examine the experimental and control groups’ scores on the ATSPPH scale. This hypothesis was not accepted. Means on the ATSPPH scale for the experimental group \( (M = 21.75, SD = 4.50) \) were found to be significantly lower than the means for the control group \( (M = 23.41, SD = 4.78) \), \( t (194) = 2.503, p < .01 \) (See Table 5). This indicates that the Mental Health Education actually reduced positive attitudes toward seeking professional psychological help in the experimental condition.

Hypothesis # 6: It was expected that individuals exposed to Mental Health Education in the experimental condition will be more likely to seek counseling services when experiencing psychological distress than individuals in the control condition. A two-tailed t test (ANOVA) was used to examine scores on the ISCI between the experimental and control groups. This hypothesis was accepted. Means on the ISCI for the experimental group \( (M = 42.45, SD = 8.24) \) were found to be significantly higher than the means for the control group \( (M = 37.21, SD = 9.42) \), \( t (194) = -4.143, p < .001 \) (See Table 5). This indicates that being exposed to Mental Health Education increases one’s willingness to seeking counseling services when experiencing some type of psychological distress.
Hypothesis # 7: The seventh hypothesis proposed that individuals exposed to Mental Health Education in the experimental group will have lower scores on self stigma than the control group. A two-tailed t test (ANOVA) was used to examine scores on the SSOSH scale between the experimental and control groups. This hypothesis was not accepted. Means on the SSOSH scale for the experimental group ($M = 23.30, SD = 6.56$) were significantly lower than means for the control group ($M = 25.88, SD = 6.87$), $t (194) = 2.688$, $p < .008$ (See Table 5). This indicates that the Mental Health Education was not effective in improving self stigmatizing beliefs about seeking psychological help.

Hypothesis # 8: It was stated that individuals exposed to Mental Health Education in the experimental group will have lower scores on social stigma than the control group. A two-tailed t test (ANOVA) was used to examine scores on the SSRPH scale between the experimental and control groups. This hypothesis was not accepted. Means on the SSRPH scale for the experimental group ($M = 10.07, SD = 3.16$) were significantly lower than means for the control group ($M = 12.71, SD = 3.15$), $t (194) = 5.846$, $p < .001$ (See Table 5). This indicates that the Mental Health Education was not effective in improving social stigma toward receiving psychological services.
Table 4

Means and Standard Deviations for Correlations between Self Stigma (SSOSH) and Attitudes toward Seeking Professional Psychological Help (ATSPPH), Self Stigma and Intentions to Seek Help (ISCI), Social Stigma (SSRPH) and Attitudes toward Seeking Professional Psychological Help, and Social Stigma and Intentions to Seek Counseling

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSOSH</td>
<td>196</td>
<td>24.60</td>
<td>6.82</td>
</tr>
<tr>
<td>ATSPPH</td>
<td>196</td>
<td>22.59</td>
<td>4.71</td>
</tr>
<tr>
<td>ISCI</td>
<td>196</td>
<td>39.80</td>
<td>9.21</td>
</tr>
<tr>
<td>SSRPH</td>
<td>196</td>
<td>11.40</td>
<td>3.41</td>
</tr>
</tbody>
</table>
Table 5
Means and Standard Deviations for Attitudes toward Seeking Professional Psychological Help (ATSPPH) Scale, Intentions to Seek Counseling Inventory (ISCI), Self Stigma of Seeking Help (SSOSH) Scale, and Social Stigma for Receiving Psychological Help (SSRPH) Scale between Experimental and Control Groups

*Significance < .01; **Significance < .001

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ATSPPH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>99</td>
<td>23.41*</td>
<td>4.78</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>97</td>
<td>21.75</td>
<td>4.50</td>
</tr>
<tr>
<td><strong>ISCI</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>99</td>
<td>37.21</td>
<td>9.42</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>97</td>
<td>42.45**</td>
<td>8.24</td>
</tr>
<tr>
<td><strong>SSOSH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>99</td>
<td>25.88*</td>
<td>6.87</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>97</td>
<td>23.30</td>
<td>6.56</td>
</tr>
<tr>
<td><strong>SSRPH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>99</td>
<td>12.71**</td>
<td>3.15</td>
</tr>
<tr>
<td>Experimental Group</td>
<td>97</td>
<td>10.07</td>
<td>3.16</td>
</tr>
</tbody>
</table>
CHAPTER FOUR: DISCUSSION

Findings

The findings in this study are partially consistent with the expectations derived from reviewing the literature of past studies involving stigma and seeking counseling services. Previous studies have indicated that the self stigma associated with seeking psychological help may be an inhibiting factor in people's decisions and intentions to seek counseling services (Vogel et al, 2006). One of the primary predictors of help-seeking willingness is one's attitude toward seeking professional psychological help and one’s attitude toward the counseling process (Cepeda-Benito & Short, 1998; Kelly & Achter, 1995; Vogel & Wester, 2003, Vogel et al, 2006). Previous studies have indicated that the more negative attitudes an individual has toward seeking help the less willing they will be to do so (Vogel et al, 2006). These attitudes, in turn, are strongly associated with the degree of social and self stigma a person holds (Corrigan, 2004; Vogel et al, 2006). As shown by previous research, the more social and self-stigma an individual has the more negative the attitudes are toward counseling and the person is much less likely to seek out services (Komiya et al., 2000; Vogel, Wester, Wei, & Boysen, 2005).

In this sample, it was found that there was a significant relationship between stigma and attitudes toward counseling, as well as, between stigma and intentions to seek
counseling services. Participants with higher ratings of social and self stigma consistently showed more negative attitudes toward therapy and were much less likely to seek services compared to individuals with low ratings of stigma. A significant correlation was found between high social stigma and negative attitudes toward seeking counseling. This study also found a significant correlation between high social stigma and low intentions to seek counseling services. The results indicate that there is a strong negative correlation between social stigma and attitudes toward seeking professional psychological help and the willingness to seek services. A significant correlation was found between high self stigma and negative attitudes toward seeking counseling. Additionally, this study found a significant correlation between high self stigma and low intentions to seek services. The results also indicate there is a strong relationship between self stigma and attitudes toward therapy along with intentions to seek services.

The second part of this study focused on using Mental Health Education to decrease stigmas, create more positive attitudes toward counseling, and increase willingness to seek psychological services. Previous research has suggested that participation in educational programs can lead to improved attitudes about persons with mental illness (Corrigan & Penn, 1999; Keane, 1990). Yet, previous research is lacking in the use of educational programs that address the stigma associated with seeking out professional psychological help. Some researchers have hypothesized that interventions that challenge self-stigma and facilitate empowerment are likely to increase intentions to
seek counseling services (Speer, Jackson, & Peterson, 2001). Unfortunately, research also suggests that the effects of education may not endure over time (Corrigan et al., 2002). The findings in this study indicate that the intervention used to assess Mental Health Education in this study was effective for increasing willingness to seek services, but not effective in decreasing stigmas or creating more positive attitudes toward counseling. This study found that participants exposed to Mental Health Education were more likely to seek counseling services than participants not exposed to such education. Means for total scores on the ISCI for the experimental group were significantly higher than the means for the control group. Mental Health Education may be an effective tool to increase willingness to seek out services when one is in need of psychological help. These findings support previous research.

This study did not find that using Mental Health Education is an effective means to decrease stigmas or create more positive attitudes toward psychological services. Means for total scores on the SSOSH scale for the experimental group were much lower than the means for the control group. This study also found that means for total scores on the SSRPH scale for the experimental group were lower than the means for the control group. This indicates that the Mental Health Education used in this study was not effective in improving self stigmatizing beliefs or social stigma toward psychological services. Additionally, the means for total scores on the ATSPPH scale for the experimental group were, again, lower than the means for the control group. This
indicates that the Mental Health Education did not increase positive attitudes toward seeking professional psychological help in the experimental condition.

Limitations of the Current Study

In conducting this study the hopes were to combine four preexisting surveys (ATSPPH, ISCI, SSOSH, and SSRPH) into one comprehensive survey in order to measure several related variables. It is important to note that while these variables (self stigma, social stigma, attitudes and willingness to seek counseling) are related to one another, that measuring all simultaneously may compromise the reliabilities and consistencies of the original scales from which this study was adapted. Previous research indicates high internal consistency, reliability, and validity within each of the four surveys used in this study (Cash, Begley, McCown, & Weise, 1975; Cepeda-Benito & Short, 1998, Fischer & Farina, 1995; Vogel et al, 2006). Results from previous research does indicate that perceptions of the social stigma associated with mental health concerns predicted the self-stigma associated with seeking counseling, which, in turn, predicted willingness to seek counseling services (Vogel, Wester, Wei, & Boysen, 2005; Vogel et al, 2006). This may indicate that when combined these surveys do measure each variable accordingly.
Another limit is that some sampling bias may exist due to the location of sampling and the way potential participants were approached. Participants were approached in front of the library and in the art quad at Humboldt State University. It may be important to consider that a bias in the location of sampling may have occurred so that more art students participated in the study. Participants were all approached in the same way with a request to voluntarily take a research survey for a master’s thesis. Participants may or may not have been approached in a biased manner depending on their demeanor. For example, participants on a cell phone were not always approached.

It is also important to consider that participants willing to help a graduate student may also be more willing to engage in help seeking behaviors such as counseling. The evidence from this study may corroborate this idea since 82 participants (41.8% of the sample) have received therapy before and 112 participants (57.1%) have never received therapy. The existing literature reports that less than half of college students in need of mental health services actually seek them out (Oliver, Reed, & Smith, 1998; Sharp, Hargrove, Johnson, & Deal, 2006) and that less than one third of those who experience psychological distress seek help from a mental health professional (Andrews, Issakidis, & Carter, 2001). With nearly half of the participants in this study reporting participation in therapy before, this seems high compared to other studies. This could have easily influenced the results of this study.
Yet, another limitation is that participants in the experimental condition may not have carefully read the Mental Health Education piece or may not have read it at all. This study did not factor in a way to insure that participants were reading the Mental Health Education and this may account for the results obtained in this study. Due to the busy nature of the student population from which this data was collected it is highly plausible that participants in the experimental group may not have read the Mental Health Education or could have just skimmed through this.

Lastly, it is important to discuss the Mental Health Education piece of this study. This educational information was adapted from APA’s website and abridged into one-page sheet of facts about mental health and counseling services. While informing individuals about mental health may be an effective tool in decrease stigma and increases willingness of services, it may also not be enough. Social stigma, self stigma, and attitudes toward counseling can be extremely difficult phenomena to change, requiring extensive education much more than a simple brochure or pamphlet can give. Simply reading a single page of information appears to not change someone’s ingrained beliefs or attitudes related to stigma and seeking counseling services and may tend to reinforce the stereotyped stigmas instead.
Suggestions for Further Research

One suggestion for future research would be to focus on using different types of mental health education as a mediator for stigma and help seeking behaviors. Using many different educational models and dispelling myths about professional psychology will help determine what works and what does not. Looking at what types of educational information is most helpful will be extremely beneficial for researcher and practitioners alike. Through utilizing psychoeducation, professional psychologists can reach out and help more people in need of mental health services. Using education in school settings, work environments, and within institutions with a wide range of different populations will also be important in determining what types of psychoeducation work best with certain groups. Using alternative forms of Mental Health Education like television programs or movies is one way to reach out to many different groups. Additionally, incorporating Mental Health Education into elementary and high school physical health classes may be a more effective means of changing people’s attitudes and level of stigma toward seeking psychological help.

Another consideration for future research is to consider using longitudinal studies that incorporate psychoeducation to reduce stigma and increase willingness to seek counseling services. This type of design can measure how effective an educational model is over time. This may be especially important since research also suggests that the
effects of education may not endure over time (Corrigan et al., 2002). Longitudinal research is rare, but can provide invaluable information regarding attitudes and help seeking behavior. Additionally, more experimental approaches can be useful in determining how changeable social stigma, self stigma, and attitudes toward professional psychology are and what can be used to maintain them.

A final suggestion for future research is to address demographic of groups used in the study more specifically. Individuals from different cultures, ethnic, and religious backgrounds will have different help seeking behaviors and different attitudes toward mental health services. Addressing this, as well as, age, gender, and if the individual has received therapy before are important factors in a person’s decision to seek services and the level of stigma one holds.
REFERENCES


APPENDIX A
Informed Consent

HUMBOLDT STATE UNIVERSITY
Study of HSU Students and the Effects of Stigma on Seeking Mental Health Services

CONSENT TO ACT AS A RESEARCH SUBJECT

I hereby agree to fill out the following surveys for experimental purposes and I understand that I must be at least 18 years of age to participate. I also understand that my participation is completely voluntary and that I may decline to enter this study or may withdraw from it at any time without jeopardy.

The purpose of this study is to determine the effectiveness of mental health education on decreasing stigma towards mental health services and increasing willingness to seek services.

Potential risks of this study are slight and may include minor emotional disturbance or questioning beliefs regarding mental health.

This information was explained to me by Heather Hobson.
I understand that she will answer any questions I may have concerning this investigation or the procedures at any time.

The surveys will not have a name or any other identifying feature attached to it. The surveys will be kept in a locked file cabinet while the research is conducted and after five years will be destroyed.

If I have any questions regarding the surveys and/or my participation I can contact Heather Hobson at (707) 822-5797 or heatherlouisehobson44@yahoo.com. The faculty advisor is also available, Dr. Emily Sommerman at (707) 826-3270 or es47@humboldt.edu.

Mental health services are available to all HSU students through Counseling and Psychological Services at the Student Health Center at (707) 826-3236

_________________________________
Subject’s signature

_________________________________
Date
Demographic Information

Please fill out the following information

Age ______________________

Gender____________________

Major____________________

Ethnicity__________________

Have you ever received counseling services or other psychological services before? (This may include: psychotherapy, counseling, receiving medication for a mental or emotional problem, family therapy, in and outpatient psychological services, and any other services provided by a licensed mental health worker)
(Check yes or no)

Yes______

No _______
PLEASE READ THE FOLLOWING INFORMATION ABOUT MENTAL HEALTH AND THEN COMPLETE THE SURVEYS ON THE FOLLOWING PAGES. THANK YOU

CHANGE YOUR MIND ABOUT MENTAL HEALTH

[Adapted from the APA Help Center, American Psychological Association (apa.org)]

Often people are afraid to talk about mental health or seek out services when experiencing a mental health concern because there are many misconceptions about mental health and related services. Here provided is some information from the American Psychological Association (APA) about mental health and mental health services.

**What is mental health?**
Mental health is the way your thoughts, feelings, and behaviors affect your life. Good mental health leads to positive self-image and satisfying relationships with friends and others. Mental health is as important as physical health and the two are closely related. Just as it is not someone’s fault for having a physical health problem like diabetes, it is not someone’s fault for having a mental health problem like depression. No one is to blame.

**What are mental health problems?**
Mental health problems are things like anxiety, depression, and relationship difficulties, to name a few. Some individuals experience mild mental health concerns and others more severe. Mental health problems are real and deserve to be treated. The consequences of not getting help for mental health problems can be serious. Untreated problems often continue and become worse, and new problems may occur. For example, someone with panic attacks might begin to drink too much alcohol with the mistaken hope that it will relieve his or her emotional pain.
How can people with mental health concerns get help?
Health professionals who specialize in helping people with mental health problems can help; these individuals include psychologists, psychiatrists, social workers, counselors, and psychiatric nurses. Psychotherapy, or just therapy, is often an important part of mental health treatment by qualified professionals. In some situations, physicians may recommend the use of medication for an individual with a mental health problem. Family members, friends, and the individual’s community can also be sources of support.

What is therapy and why go?
Therapy is an interpersonal, relational intervention used by licensed professionals such as psychologists or marriage and family therapists. Therapy is a partnership between an individual and a professional who is trained to help people understand their feelings and assist them with modifying behaviors to function better in life. Therapy usually includes increasing individual sense of well-being and reducing discomforting feelings. Many individuals find much success when using therapy for mental health concerns.

What does research show about the effectiveness of therapy?
Research suggests that therapy effectively decreases clients’ unpleasant symptoms – such as depression, anxiety, or relationship difficulties – and has been found to have positive effects on the body’s immune system. Research increasingly supports the idea that emotional and physical health are closely linked and that therapy can improve a person’s overall health status.
Attitudes toward Seeking Professional Psychological Help Scale

To what extent do you agree or disagree with the statements below:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree</th>
<th>Partly Disagree</th>
<th>Partly Agree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>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.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears <em>without</em> resorting to professional help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I would want to get psychological help if I were worried or upset for a long period of time.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I might want to have psychological counseling in the future.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. A person with an emotional problem is not likely to solve it alone; he or she <em>is</em> likely to solve it with professional help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. A person should work out his or her own problems; getting psychological counseling would be a last resort.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Personal and emotional troubles, like many things, tend to work out by themselves.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
APPENDIX E
**Intentions to Seek Counseling Inventory**

Below is a list of issues people commonly bring to counseling. How likely would you be to seek counseling if you were experiencing these problems? Please circle the corresponding answer.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Very unlikely</th>
<th>Unlikely</th>
<th>Likely</th>
<th>Very likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Weight control</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Excessive alcohol use</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Relationship differences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Concerns about sexuality</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Depression</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Conflict with parents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. Speech anxiety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. Difficulties dating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. Choosing a major</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. Difficulty in sleeping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. Drug problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. Inferiority feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. Test anxiety</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. Difficulty with friends</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. Academic work procrastination</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. Self-understanding</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17. Loneliness</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
**Self Stigma of Seeking Psychological Help Scale**

People at times find that they face problems for which they consider seeking help. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree   2 = Disagree   3 = Agree & Disagree Equally   4 = Agree   5 = Strongly Agree

Circle the number that corresponds to how you might react to each statement

1. I would feel inadequate if I went to a therapist for psychological help.  
2. My self-confidence would NOT be threatened if I sought professional help.  
3. Seeking psychological help would make me feel less intelligent.  
4. My self-esteem would increase if I talked to a therapist.  
5. My view of myself would not change just because I made the choice to see a therapist.  
6. It would make me feel inferior to ask a therapist for help.  
7. I would feel okay about myself if I made the choice to seek professional help.  
8. If I went to a therapist, I would be less satisfied with myself.  
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.  
10. I would feel worse about myself if I could not solve my own problems.
### Social Stigma for Receiving Psychological Help Scale

Please answer the following from (1) Strongly Disagree to (4) Strongly Agree

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Seeing a psychologist for emotional or interpersonal problems carries social stigma.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. It is a sign of personal weakness or inadequacy to see a psychologist for emotional or interpersonal problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. People will see a person in a less favorable way if they come to know that he/she has seen a psychologist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. It is advisable for a person to hide from people that he/she has seen a psychologist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. People tend to like less those who are receiving professional psychological help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>