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Disentangling Mental Health and Help-Seeking Stigmas

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Abstract

This chapter provides an overview and delineation of the four major stigmas related to mental illness and seeking psychological help: public stigma of mental illness, public stigma of seeking help, self-stigma of mental illness, and self-stigma of seeking help. It begins with discussion of a theoretical model that distinguishes these four stigmas, outlines how they relate to each other, and asserts how they relate to mental health and help-seeking outcomes. We then discuss the evidence for the assertions of the model and the theoretical distinction of these forms of stigma. The chapter concludes with discussion of a possible new type of stigma, future directions, and cultural considerations.

Disentangling Mental Health and Help-Seeking Stigmas

Stigma is the adverse beliefs and discriminatory views against someone based on personal traits and behaviors that are considered undesirable (Blaine, 2000). Mental health stigma plays a meaningful, deleterious role for those experiencing mental health concerns, interfering with treatment seeking, compliance, and engagement, exacerbating depression, and lowering self-esteem (Fung et al., 2010; Conner et al., 2010; Lannin et al., 2015; Seidman, Wade et al., 2019). Having a mental illness is stigmatized, as is the act of seeking psychological help (Ben-Porath, 2002; Corrigan, 2004; Vogel et al., 2006). Historically, researchers have often lumped these forms of stigma together (Lannin et al., 2015). Researchers have also identified several forms of stigma related to mental illness as well as seeking psychological help at external (i.e., stigma held by members of the public; Corrigan, 2004; Komiya et al., 2000), and internal levels (i.e., stigma held by oneself; Corrigan et al., 2004; Vogel et al., 2006). This research raises an important question—are stigmas towards those with mental illness and stigmas towards seeking psychological help theoretically distinct? That is, there may be unique stigmas related to mental health based on who is stigmatizing (e.g., public, self) and what is being stigmatized (i.e., having a mental illness, seeking psychological help). Table 1 provides a graphic illustrating these conceptual differences by highlighting the source of stigma (the public or the self) and the target of stigma (mental illness or help-seeking). Disentangling these stigmas is essential to understanding the pathways through which they interfere with mental health and help seeking and, in turn, to developing effective, targeted interventions that increase help-seeking and improve mental health.

Recently, researchers have taken a more active role in defining the unique forms of stigma related to mental illness and seeking help (Corrigan, 2004; Lannin et al., 2015; Vogel et

al., 2006; Vogel et al., 2009), understanding how they uniquely relate to each other and relevant help-seeking and mental health outcomes (e.g., Lannin et al., 2015; Vogel et al., 2017), and examining evidence to test these theoretical distinctions (Brenner et al., 2019; Lannin et al., 2015; Tucker et al., 2013). This evolving research currently indicates that mental illness and help seeking stigmas operate with theoretical distinction and demonstrate meaningfully unique relationships to clinically relevant outcomes; however, this research continues to grow.

As such, this current chapter has two central aims: 1) outline these different forms of stigma, including how they relate to each other and mental health and help-seeking outcomes, and 2) report the current state of the science regarding the theoretical and applied distinctions between the help-seeking and mental illness stigmas. We provide an overview of the Internalized Stigma Model (ISM; Lannin et al., 2015), which provided the first framework for the theoretical delineation of the four major stigmas and their unique relationships with mental health and help-seeking outcomes. Then we discuss each form of stigma, the extant support for the relationships outlined by the ISM, explore new research findings that further test the delineation of these mental illness and help-seeking stigmas, and related future directions.

Internalized Stigma Model

Building upon prior work (e.g., Corrigan 2005, Corrigan & Watson, 2002; Link et al., 1989; Link & Phelan, 2001; Vogel et al., 2007), Lannin et al. (2015) proposed the *Internalized Stigma Model* (ISM; see Figure 1), which aimed to explain the development of internalized stigma as well as its impact on relevant mental health and help-seeking outcomes. This model provided the first simultaneous consideration of the four major stigmas at once: public stigma of seeking help, public stigma of mental illness, self-stigma of seeking help, and self-stigma of

mental illness. Although we will expand upon each of these stigmas in this chapter, we briefly provide definitions of each form of stigma now.

The ***public stigma of mental illness*** refers to the societal stigma towards those who have or are perceived to have mental illness (Corrigan, 2004; Corrigan & Watson, 2002). The ***self-stigma of mental illness*** is the reduction in self-worth one experiences for having a mental illness or anticipates experiencing if they were to have a mental illness (Corrigan, 2004; Corrigan & Watson, 2002). The ***public stigma of seeking help*** denotes the societal stigma towards individuals who seek psychological help (Vogel et al., 2006). The ***self-stigma of seeking help*** refers to the reduction in self-worth one experiences for seeking professional help or anticipates experiencing if they were to seek professional help for mental health concerns (Vogel et al., 2006). In other words, the public stigmas of mental illness and seeking help represent perceptions of societally held stigmas targeted towards having mental health concerns or for seeking help, respectively. Both of these public stigmas are internalized as their respective self-stigma of mental illness or self-stigma of seeking help, in which the individual acts as their own society, turning the perceived public stigma inwards towards themselves.

Rooted in Modified Labeling Theory (Link et al. 1989) and Social-Cognitive Models of Stigma (see Corrigan, 2004), the ISM makes several assertions that this chapter will explore. First, implied in the model framework, the ISM posits that the stigmas of seeking help and of mental illness are theoretically distinct from each other. Second, a central assertion is that each public stigma is internalized as its respective self-stigma. Third, the self-stigmas mediate the relationships between public stigmas and recovery variables such as self-esteem and intent to seek psychological help. That is, as illustrated in Figure 1, the model highlights two parallel paths, where public stigma of mental illness is linked to greater self-stigma of mental illness, and

public stigma of seeking help is linked to greater self-stigma of seeking help, and both self-stigmas are detrimentally linked to relevant help-seeking and mental health outcomes. The ISM also posits that self-stigma of seeking help mediates the public stigma of mental illness, and self-stigma of mental illness mediates public stigma of seeking help; nascent research findings support this claim (Lannin et al., 2015), and also suggest that the unique strengths of these relationships may be smaller than with their respective stigmas (Brenner et al., 2019; Lannin et al., 2015; Tucker et al., 2013).

Finally, based in previous research (e.g., Tucker et al., 2013), the ISM proposed a unique pattern of relationships with help-seeking outcomes. Because self-stigma operates by eliciting negative self-evaluations (Lannin et al., 2015), the ISM posits that both the self-stigma of mental illness and the self-stigma of seeking help are uniquely linked to lower self-esteem; however, only the self-stigma of seeking help is uniquely linked to intentions to seek help—the self-stigma of mental illness is not. The ISM reasons that because the self-stigma of seeking help directly devalues seeking psychological services, the self-stigma of seeking help will be more proximally related to intention to seek help than the self-stigma of mental illness. Thus, the self-stigma of seeking help should mediate the relationship between self-stigma of mental illness and intention to seek help, with the only self-stigma of seeking help uniquely linked to this intention.

Stigma of Mental Illness. According to Modified Labeling Theory (Link et al., 1989), mental illness carries devaluing, denigrating, and discriminatory labels, or stereotypes towards individuals “labeled” with mental illness. Indeed, those with mental illness face societal stereotypes (e.g., dangerous, incompetent), prejudices (e.g., endorsing these stereotypes, fearing those with mental illness, viewing people with mental illness as incompetent), and discrimination (e.g., not hiring someone with mental illness; Corrigan, 2004).

Ben-Porath (2002) conducted an experimental study in which 422 college students in the U.S. read one of four vignettes in which "Tom" was either depressed after a breakup or injured his back. These vignettes were identical except for manipulation of the disorder type (mental versus physical health) and mental health treatment. That is, "Tom" either had been (a) depressed after a breakup three months ago and sought mental health treatment (b) depressed after a breakup three months ago, (c) injured his back three months ago and sought treatment from the university health center, or (d) injured his back three months ago. All vignettes ended saying that Tom is doing better now. After reading the vignette, participants rated "Tom" on scales that captured dimensions: Warm, Emotional Instability, Interpersonally Interesting, Competence, and Confidence. Demonstrating the existence of stigma towards those with mental illness, participants who read the vignette in which "Tom" was depressed rated him as more emotionally unstable, less interpersonally interesting, less competent, and less confident compared to those rating the vignette in which "Tom" suffered from a physical injury.

Indeed, the existence of societal stigma towards those with mental illness is well-documented. A systematic review of stigma of mental illness in the United States indicates that there is a pervasive societal stigma toward individuals with mental health concerns; across studies and age groups, adults and children endorsed the beliefs that those with mental illnesses are violent, dangerous, and incompetent these beliefs are tied to the tendency to desire to keep social distance from such people (Parcesepe & & Cabassa, 2013). Moreover, individuals with mental illness experience disproportionate rates of homelessness, housing discrimination, and employment discrimination when compared to individuals without mental health concerns. For example, a study on job acquisition among individuals with severe mental health issues, only 56% of participants were able to find competitive employment (Corbiere et al. 2011). The level

of stigma varied between groups—for example, those with substance use disorder and other drug dependence as well as children with depression were among the most stigmatized; nonetheless, stigma toward those with mental illness appeared to be present to some degree for all mental health concerns (Parcesepe & Cabassa, 2013). This stigma may be on the rise. For example, in 2006 people with mental illness were 2.3 times more likely to be perceived as violent compared to perceptions in 1950, which indicates that over time people are increasingly perceiving individuals with mental illness as dangerous (Parcesepe & Cabassa, 2013; see Chapter 6 in this handbook for additional discussion of changes in stigma over time).

Public Stigma of Mental Illness. Unsurprisingly, people are aware of the stigma society holds towards those with mental illness. While some studies, such as those discussed above, assess the existence this societal stigma, awareness of it can also lend psychological and behavioral consequences (e.g., Link et al., 1989; Vogel et al., 2007). Thus, most researchers have assessed awareness of the *public stigma of mental illness* (i.e., societally held stigma towards those who have or appear to have mental illness). This includes awareness of the stereotypes (e.g., dangerous, incompetent), prejudices (e.g., endorsing these stereotypes, fearing those with mental illness, viewing people with mental illness as incompetent), and discrimination (e.g., not hiring someone with mental illness; Corrigan, 2004) mentioned above. Public stigma of mental illness is most often measured using the Devaluation-Discrimination (BDD; Link, 1987) scale.

Self-Stigma of Mental Illness. Modified Labeling Theory (Link et al. 1989) and other theorists (Corrigan & Watson, 2002; Corrigan, 2004) also suggest that those labelled as mentally ill may turn the stereotypes and prejudice held by society inwards toward themselves and experience an internal degradation of self-worth. While the research on mental illness stigma existed for decades before (e.g., Link et al., 1989; Freeman, 1961), Corrigan and colleagues (e.g.,

Corrigan & Watson, 2002; Corrigan, 2004) formally delineated public stigma of mental illness from the self-stigma of mental illness. Self-stigma is the internalized shame associated with a specific condition or characteristic (Corrigan, 2004). The *self-stigma of mental illness* is the reduction in self-worth one experiences due to having a mental illness or anticipates experiencing if they were to have a mental illness (Corrigan, 2004; Link & Phelan, 2001). That is, in addition to the negative impacts of others' stigma towards those with mental illness (e.g., lost job opportunities, viewed as socially undesirable), people may apply these stereotypes and prejudices to themselves (Corrigan, 2004). Internalizing this external, public stigma, people may view themselves as incompetent and unworthy, or carry out those same forms of discrimination to themselves, believing they should not even pursue a job because of their incompetence (Corrigan, 2004). Self-stigma of mental illness is most-often measured using the Internalized Stigma of Mental Illness Scale (Ritsher et al., 2003) or the application subscale of the Self-Stigma of Mental Illness-Scale-Short Form (Corrigan et al., 2012).

Further, this process can result in decreased self-esteem (Link et al., 1987) and hinder one's interpersonal relationships (Farina et al., 1971). This may then lead to increased vulnerability for mental health issues in the future (Link et al., 29189). Hughes and colleagues (2020) examined the impact of the self-stigma of mental illness on intentions and behaviors to seek psychological help in a sample of people who previously received mental health care as well as a general community sample. For individuals who previously sought help for mental health concerns, endorsing high rates of self-stigma was linked with less intentions to seek psychological help for themselves. Further, the results indicated that stigma has the greatest influence on behavioral outcomes (e.g., making an appointment for therapy) when actions are psychologically proximal (e.g., seeking treatment in two days) compared to psychologically

distant (e.g., three months). That is, self-stigma impacted participant's treatment decisions more when the behavioral outcome was in the near future compared to several weeks away.

Stigma of Seeking Help. As the research examining the stigma of mental illness continued to flourish, a similar, parallel line of research began to gain momentum. Researchers applied Modified Labeling Theory (Link et al. 1989) to contend that a comparable but distinct process can occur for seeking psychological help. A person who seeks psychological help may be labeled or label themselves as a help seeker, and help seeking carries its own stigma (Vogel et al., 2006). That is, researchers began to distinguish between the stigma of seeking help and the stigma of having a mental illness. In the "Tom" vignette study mentioned earlier, Ben-Porath (2002) also examined help-seeking behavior. Participants rated "Tom" as more unstable and less confident when he sought help than when he didn't, regardless of whether it was for depression or physical injury (Ben-Porath, 2002). In other words, there is a stigma for seeking help that is different from the presence of a mental illness, specifically. Indeed, help seekers are associated with labels such as awkward, defensive, insecure, inadequate, inferior, not in control of one's emotions, weak, or disturbed (King, et al., 1973; Sibicky & Dovidio, 1986; Vogel et al., 2006; Vogel et al., 2009). Similar to mental illness stigma, the stigma of seeking help also entails its own unique set of stigmas, which we outline below.

Public Stigma of Seeking Help. Paralleling the public stigma of mental illness, the *public stigma of seeking help* refers to the societal stigma towards seeking psychological help. This stigma entails the view that those who seek help are socially unacceptable or undesirable (Vogel et al., 2006). Indeed, those who have sought psychological help in the past report higher perceived discrimination relative to those who have no sought psychological help (Jorm & Wright, 2008). Public stigma of seeking help is most-often measured as to the extent to which

people perceive or are aware of this societal stigma using such scales as the Stigma Scale for Receiving Psychological Help (Komiya et al., 2000). This public stigma has been found worldwide (see Vogel et al., 2017) such as in Australia (Mellor et al., 2013), Brazil (Sartorius & Schulze, 2005), Canada (Cook & Wang, 2010; Mackenzie et al., 2019), China (Lee et al., 2005), Hong Kong (Lam et al., 2015; Mak & Cheung, 2010), Israel (Shechtman et al., 2018), Portugal (Evans-Lacko et al., 2012; Gonçalves et al., 2013), Romania (Evans-Lacko et al., 2012), Taiwan (Mellor et al., 2013), Turkey (Güneri & Skovholt, 1999; Topkaya, 2011; Towle & Arslanoglu, 1998; Topyaka et al., 2017), the United Arab Emirates (Al-Krenawi, et al., 2004; Heath et al. 2016), and the U.S. (Brenner, Cornish et al., 2020; Komiya et al., 2000; Vogel et al., 2017).

Self-Stigma of Seeking Help. In parallel to Corrigan and colleagues' public stigma and self-stigma of mental illness model (Corrigan, 2004; Corrigan & Watson, 2002) and Modified Labeling Theory (Link, 1989), help-seeking researchers propose that there is a self-stigma of seeking help. Whereas the self-stigma of mental illness denotes the reduction in self-worth one experiences if they have a mental illness (Link & Phelan, 2001), the *self-stigma of seeking help* is the reduction in self-worth one were to seek professional help for mental health concerns (Vogel et al., 2006). Self-stigma of seeking help is most-often measured as an anticipated reduction in self-worth (as this anticipation can be barrier to even considering seeking help) via the Self-Stigma of Seeking Help scale (SSOSH; Vogel et al., 2006), of which screener (SSOSH-3) and brief versions (SSOSH-7) have recently been published (Brenner, Colvin et al., 2020). The original SSOSH has received psychometric support across six countries (i.e., England, Greece, Israel, Taiwan, Turkey, and the US; Vogel, Armstrong et al., 2013), and the items retained in the SSOSH-3 were included in analyses supporting five of the SSOSH items across eight countries

(Australia, Brazil, Canada, Hong Kong, Portugal, Romania, Taiwan, Turkey, United Arab Emirates, and the US; Vogel et al., 2017).

Self-stigma of seeking help has become a major area of research focus due to its harmful relationship with help-seeking outcomes. It is consistently linked with worse attitudes towards seeking psychological help (e.g., Brenner, Colvin et al., 2020), lower intentions to seek psychological help (e.g., Brenner, Colvin et al., 2020; Brenner, Cornish et al., 2020), as well as greater perceived risk and lower anticipated benefit of self-disclosing to a therapist (e.g., Heath, Brenner et al., 2017; Seidman, Lannin et al., 2019; Vogel et al., 2006). Self-stigma of seeking help has been associated with help-seeking related behavior and can even interfere with learning about mental health and help-seeking. Among participants with relatively higher distress, studies have found that those with high self-stigma were less likely to seek information about counseling when given the option (Lannin et al., 2016), and they spent less time reading a brochure designed to decrease self-stigma (Cornish et al., 2019). Self-stigma of seeking help has predicted a lower likelihood of participants electing to receive their mental health score (Brenner et al., 2019). Although direct longitudinal examination of self-stigma to behavioral outcomes is limited, self-stigma of seeking help has been linked to attending fewer behavioral health care sessions over a two-year period among active-duty service members (Seidman, Wade et al., 2019), and lower likelihood of engaging in inpatient, outpatient, or medication treatment for mental health concerns over 1.5 years among post-9/11 veterans (Fox et al., 2018).

Disentangling Mental Illness and Help Seeking Stigmas

Thus far, we provided an overview of the four major types of mental illness and help seeking stigma. The first assertion of the ISM model is that the stigmas of seeking help and of

mental illness are theoretically distinct from each other. Next, we discuss the empirical evidence surrounding the theoretical distinction of these stigmas.

Disentangling Public Stigma. Evidence thus far has generally supported the distinction among the two types of public stigma: mental illness and help-seeking. For example, earlier we discussed Ben-Porath's (2002) findings. This study provided the first examination of this distinction. As a reminder, students read one of four vignettes in which "Tom" was depressed or injured, and either sought treatment or did not. If mental illness and help-seeking stigmas were the same, there would be similar results across the depression/no help-seeking and depression/help-seeking conditions. However, as mentioned earlier, participants rated Tom as more emotionally unstable, less interpersonally interesting, less competent, and less confident when he experienced depression compared to a physical injury, and more unstable and less confident when he sought help for depression or physical injury (Ben-Porath, 2002). This demonstrates a unique pattern of responses. Moreover, Ben-Porath found a significant interaction between disorder type and help-seeking behavior; participants rated Tom as more emotionally unstable when he was depressed and sought psychological help compared to when was depressed (with no mention of seeking help).

The Ben-Porath (2002) study examines existing stigmas that others hold rather than perceptions of societally held stigmas. If these stigmas operate uniquely among people who are part of society, it follows that others would perceive these stigmas as distinct and, in turn, public stigma of mental illness would function independently from public stigma of seeking help. Although the distinction of these external stigmas has received less attention than self-stigmas, there does appear to be support for this distinction. For example, an exploratory factor analysis of items from five stigma measures, including the public stigma of seeking help and public

stigma of mental illness, found that the public stigma of help seeking items loaded onto a separate factor from the public stigma of seeking mental illness items (Vogel et al., 2009). Similarly, in a direct test of the ISM using Structural Equation Modeling (SEM) the researchers found a good fit of the measurement model (i.e., testing whether the conceptualization of the model constructs demonstrated a good fit to the data), which included a distinction of these public stigmas (Lannin et al., 2015).

Disentangling Self-Stigmas. Several studies have also directly examined the theorized distinctions between the self-stigmas of mental illness and help seeking. As with public stigma, one avenue used to assess the theorized distinction was through testing competing measurement models using SEM. Tucker et al. (2013) developed the Self-Stigma of Mental Illness (SSOMI) scale by altering the wording of the Self-Stigma of Seeking Help (SSOSH; Vogel et al., 2006) scale items to refer to mental illness rather than to seeking help. They then used Confirmatory Factor Analysis (CFA) with a clinical undergraduate sample and a community sample with a reported history of mental illness to demonstrate that the self-stigma of mental illness (SSOMI items) and self-stigma of seeking help (SSOSH items) are best modeled as separate factors. Building on this study, Brenner et al. (2019) used a series of CFAs across two community and student samples to determine whether the high correlations observed between the SSOSH and SSOMI across multiple samples (Lannin et al., 2015; Tucker et al., 2013) indicated a general self-stigma factor (Reise, Moore, & Haviland, 2010), or simply represented method variance shared between the SSOSH and SSOMI that prior studies had not accounted for. They determined that an oblique (i.e., correlated) two-factor model with additional method factors best fit the data. This reinforced the conclusion offered by Tucker et al. (2013): that the self-stigma of

mental illness and the self-stigma of seeking help are independent constructs and should be treated as such in future theorizing and empirical research.

Unique relationships with self-report outcomes. Another avenue through which researchers can test the theoretical distinction between constructs is by examining distinct relationships with clinically-relevant outcomes. If the constructs are theoretically distinct, they should demonstrate unique patterns of relationships with other variables. Indeed, the ISM proposed unique patterns of relationships with mental health and help-seeking outcomes such that both self-stigmas directly contribute to mental health, whereas only self-stigma of seeking help would relate to help-seeking behavior. Using self-esteem and intent to seek help to represent the mental health and help seeking outcomes, respectively, Lannin et al. (2015) found initial support for this assertion. While both self-stigmas were inversely related to self-esteem, only self-stigma of seeking help was inversely related to intent to seek help. Tucker et al. (2013) also found that each self-stigma accounted for unique variance in help-seeking variables such as public stigma of seeking help and public stigma of mental illness, whereas in both samples only self-stigma of seeking help consistently accounted for unique variance in intentions to seek professional help. Using university and community samples, Brenner et al. (2019) likewise found that the self-stigma of seeking help was uniquely associated with lower intention to seek help and greater public help-seeking stigma, whereas the self-stigma of mental illness was uniquely associated with greater self-coldness, less self-compassion, and lower life satisfaction.

Essential to delineating these self-stigmas is demonstrating differences in predicting behavior. Accordingly, Brenner et al. (2019) determined that self-stigma of seeking help was associated with unwillingness to receive feedback on their current level of psychological distress

as measured by the K6 (Kessler et al., 2002), whereas the self-stigma of mental illness was (surprisingly) associated with willingness to receive this score.

Internalization of Public Stigma as Self-Stigma

Having now provided evidence for the first assertion of the ISM model (i.e., the stigmas of mental illness and help seeking at distinct), we will next review the evidence for the second assertion of the ISM model. The second assertion is that the two types of public stigma are internalized as their respective self-stigmas.

Mental Illness Stigma. The assertion of the ISM that the public stigma of mental illness is internalized as the self-stigma of mental illness has been supported in a number of cross-sectional studies. Public stigma of mental illness has been linked to greater self-stigma of mental illness, for example, among clinically distressed community adults (Tucker et al., 2013), clinically distressed college students (Tucker et al., 2013), and general samples of university students (Lannin et al., 2015; Brenner et al., 2019). However, one study examining a sample of 75 people in Chicago diagnosed with schizophrenia, schizoaffective disorder, bipolar disorder, or recurrent unipolar major depressive disorder demonstrated small but non-significant correlations between public stigma and self-stigma of mental illness (*r*s = .20, .19), measured by the Aware and Apply subscales of the Self-Stigma of Mental Illness Scale (SSMIS; Corrigan et al., 2006; Watson et al., 2007), respectively. Given the consistency of findings in other samples, there is need for researchers to rule out whether this finding reflects a true non-significant relationship rather than an artifact of a smaller sample size, or due to differences in measurement approaches.

In addition, longitudinal research is needed to fully realize the extent of internalization between public stigma of mental illness and self-stigma of mental illness, as a major limitation of the cross-sectional research is that correlation does not imply causation. To our knowledge, only

one study examined public stigma and self-stigma of mental illness stigma longitudinally (Corrigan et al., 2011). Yet, internalized stigma in this study was not examined as an outcome because the study aims focused on self-esteem and hopelessness leaving this question still open.

Help-Seeking Stigma. The internalization of public stigma of seeking help as self-stigma of seeking help has been examined in both cross-sectional and longitudinal research. The extant literature reveals robust bivariate correlations between public stigma of seeking help and self-stigma of seeking help among clinical community and clinical university student samples (e.g., Tucker et al., 2013), general samples of college students (e.g., Brenner, Colvin et al., 2020; Brenner, Cornish et al., 2020; Heath et al., 2018), college student women and men (e.g., Lannin et al., 2015), community adults (e.g., Brenner, Colvin et al., 2020), and military personnel (e.g., Seidman, Wade et al., 2019; Wade et al., 2015). Cross-sectional studies examining these relationships within a larger theoretical model (i.e., controlling for covariates) and denote public stigma of seeking help as a predictor of self-stigma of seeking help have consistently found support for this relationship, including among a clinical sample of military personnel (Wade et al., 2015), college students in the US within the context of career counseling (Ludwikowski et al., 2009), as well as college students in the US (e.g., Brenner, Cornish et al., 2020; Heath et al., 2018; Lannin et al., 2015; Mathison et al., 2021), Turkey (Topkaya et al., 2017), Hong Kong, Australia, Brazil, Canada, Romania, Taiwan, and the United Arab Emirates (Vogel et al., 2017). One exception should be noted, this path was non-significant in Portugal (Vogel et al., 2017).

Although these robust cross-sectional studies provide initial support for this internalization, longitudinal testing is essential given the causal nature of this theorized relationship. In further support of this internalization, a cross-panel analysis from a longitudinal study indicated that public stigma is internalized as self-stigma over time (Vogel, Bitman et al.,

2013). Specifically, Vogel, Bitman et al. (2013) collected responses to measures of public stigma and self-stigma of seeking help at two time points (three months apart), from 448 undergraduate students. They compared four nested models, one of which included only autoregressive paths (i.e., T1 public stigma → T2 public stigma, T1 self-stigma → T2 self-stigma). The three other models included these autoregressive paths, as well as the proposed cross-lag, internalization path (i.e., T1 public stigma → T2 self-stigma), the addition of a T1 self-stigma → T2 public stigma path, or the addition of both of these paths. The cross-lag model that reflected the hypothesized internalization process (i.e., T1 public stigma → T2 self-stigma), demonstrated the best, most parsimonious fit to the data. Therefore, this study provided longitudinal support for the notion proposed by Link and colleagues (Link et al., 1989; Link & Phelan, 2001), Corrigan and colleagues (Corrigan, 2004; Corrigan & Watson, 2002), and the Internalized Stigma Model (Lannin et al., 2015) that public stigma is internalized as self-stigma over time.

Indirect Relationships of Public Stigma through Self-Stigma

Having provided evidence for the first two assertions of the ISM model, we will now review the evidence for the third assertion—that the different self-stigmas will mediate the relationships between their respective public stigmas and clinically relevant outcomes variables (e.g., self-esteem and intent to seek psychological help). This assertion is one of the most commonly examined among mental illness and help-seeking stigma theorists (e.g., Corrigan, 2004; Lannin et al., 2015; Link et al., 1989). This mediation framework has been tested cross-sectionally with stigma of mental illness, in which self-stigma of mental illness mediated the relationship between public stigma of mental illness and attitudes toward mental health treatment (Brown et al., 2010). In this study of 449 African American (n = 220) and white adults (n = 229), Brown et al. found that public stigma demonstrated an indirect effect on mental health treatment

attitudes through self-stigma. Lannin et al. (2015) also found support for indirect effects for both public stigmas and self-stigmas. Namely, in a college student sample, public stigma of mental illness was indirectly linked with self-esteem through self-stigma of mental illness. Public stigma of seeking help was indirectly linked with self-esteem and intentions to seek help through self-stigma of seeking help. However, as noted earlier, longitudinal research is needed to truly test the mediation and causal nature of these proposed relationships.

This mediation model has also received cross-sectional support internationally across at least ten countries, such as Israel (Shectman et al., 2018), Turkey (Topkaya et al., 2017; Vogel et al., 2017), Australia, Brazil, Canada, Hong Kong, Portugal, Romania, Taiwan, UAE, and the US (see Vogel et al., 2017). The majority of work in this area has focused on the stigma of help seeking in the US demonstrating an indirect effect of public stigma of seeking help on help-seeking outcomes (e.g., attitudes toward seeking help, intention to seek help) through self-stigma among college students (Brenner, Cornish et al., 2020; Lannin et al., 2015; Vogel et al., 2017) and Veterans (Wade et al., 2015), as well as with unique forms of psychological services such as career counseling (Ludwikowski et al., 2009) and group counseling (Shectman et al., 2018). However, these studies typically collected data cross-sectionally. Longitudinal research should be used test this model with appropriate rigor, and more research outside the US is needed.

Internalization Across Stigma Targets

In delineating the stigmas, the Internalized Stigma Model asserts that this cross-target internalization is weaker than same-target internalization. That is, public stigma of mental illness more strongly linked to self-stigma of mental illness than self-stigma of seeking help, and vice versa. When testing the Internalized Stigma Model, Lannin et al. (2015) found relationships between public stigma of mental illness and public stigma of seeking help demonstrated medium

to large effect sizes with self-stigma of mental illness and self-stigma of seeking help, respectively (i.e., $\beta \geq .42$) and small effect sizes with self-stigma of seeking help and self-stigma of mental illness, respectively (i.e., $\beta \leq .20$; Lannin et al., 2015). Statistical differences in the strengths of these relationships were not empirically examined. Interestingly, when examining all four major stigmas in the same model, Lannin et al., (2015) found that public stigma of mental illness demonstrated a small inverse relationship with self-stigma of seeking help (i.e., $\beta = -.12$, $p < .05$), which was significant among women ($\beta = -.14$, $p < .05$) but not men ($\beta = -.06$, $p > .05$). This finding contradicts previous research examining this relationship, (e.g., Tucker et al., 2013; Vogel et al., 2007), but this was the first study to test the four major forms of stigma at once and thus warrants further examination.

The ability to draw conclusions from these study findings is limited in that these studies mostly gathered responses at once point in time, did not include all four stigmas, and/or did not statistically examine differences in relationship strengths. Future research should be conducted to test this to further strengthen (or challenge) the trending findings that public stigmas are more strongly related to their respective self-stigma, and also examine these relationships over time to truly support the assertion of this temporal development. A similar examination to Vogel, Bitman et al. (2013) that includes all four major stigmas could strengthen evidence for this mixed-target internalization process, including the assertion of the temporal development, as well as provide support for the delineation of these stigmas over time. For now, Lannin et al. (2015) appears to lend initial support for the theoretical distinction of these stigmas.

Future Directions

Taken together, this research supports a clear distinction between the self-stigma of seeking help and the self-stigma of mental illness. Veteran health administration agencies,

psychotherapy clinics, behavioral health units in hospitals, and university counseling centers hoping to increase help seeking might benefit from focusing their interventions on reducing the self-stigma of seeking help to increase help seeking, and to focus on the self-stigma of mental illness to improve mental health and well-being, and cultivate a willingness to learn about psychological functioning (Brenner et al., 2019). In this vein, identifying interventions that uniquely impact each form of self-stigma would be an important focus of future work. For example, the finding that self-stigma of mental illness but not self-stigma of seeking help was uniquely linked to life satisfaction and lower self-compassion (Brenner et al., 2019), may suggest that positive psychology interventions may be more effective in addressing mental illness stigma and may explain why findings have been mixed regarding the potential for self-compassion to reduce self-stigma of seeking help or buffer its internalization (Heath et al., 2018; Heath, Brenner et al., 2017; Hilliard et al., 2019). Perhaps these findings would be consistent if tested with self-stigma of mental illness (Brenner et al., 2019). Researchers could compare the effects self-compassion and related interventions, such as self-affirmation (e.g., Lannin et al., 2020; Seidman et al., 2018) or acceptance (Brenner, Cornish et al., 2020) on reducing both self-stigmas. Moreover, Brenner, Cornish et al. (2020) called for testing interventions that decrease the impact of self-stigma rather than reduce it. Thus, moderating each self-stigma's impact on behavior, the true outcome researchers are trying to shift, should be a point of focus as well.

As mentioned throughout the chapter, there is a strong need for longitudinal research. As experimental and longitudinal research is expanded, researchers might consider using briefer measures. Recently, researchers developed the SSOSH-3 (Brenner, Colvin et al., 2020), an ultra-brief, three-item version of the SSOSH (Vogel et al., 2006) to make longitudinal research more accessible, particularly to harder to reach populations. Because most clients seek initial help for

mental health from primary care physicians compared to mental health specialists (Druss et al., 2008), briefer measures can make it feasible to assess stigma during intake in applied medical settings and use tailored interventions that increase the likelihood that a person follows through on their physician's referral to psychological services (Brenner, Colvin et al., 2020). In addition, shorter outcome measures can provide a more valid assessment of intervention effects. Using briefer measures in these projects, and developing similarly brief measures for self-stigma of mental illness, could help researchers conduct such work on a larger scale more accessibly.

Marginalized Populations

As the field continues expand this work, it is imperative that researchers examine the unique ways these stigmas develop and relate to outcomes among those at greater need for services. Extant work predominantly focuses on white heterosexual samples; yet, people of color (see Maura & de Mamani, 2017), sexual minorities, transgender and gender non-conforming individuals (Borgogna et al., 2019), among other marginalized individuals, experience mental health disparities and are thus in greater need of such services. Researchers should also be inclusive when considering factors that contribute to the development of self-stigmas. This may include breaking the tendency to exclude women and TGNC individuals from research examining masculinity and self-stigma, especially given how masculine norms (e.g., self-reliance) overlap with other subcultures such as military norms (Heath, Seidman et al., 2017).

Social Network Stigma of Seeking Help

Given the importance of close relationships within collectivists cultures (Cross, Gore, & Morris, 2003; Markus & Kitayama, 1991; Yeh, 2002), we want to bring attention to another form of help-seeking stigma that falls outside the scope of the delineation debate as outlined by the Internalized Stigma Model (Lannin et al., 2015). Vogel et al. (2009) introduced the notion that

perceptions of societally held stigma (i.e., public stigma) is not the only form of external stigma that should be measured. *Social network stigma of seeking help* involves the perceived stigma towards seeking psychological help held by those within one's direct social circle (Vogel et al., 2009). This stigma is most-often measured using the Perceptions of Stigmatization by Others for Seeking Help (PSOSH; Vogel et al., 2009). Social network stigma has been linked to greater public stigma, greater self-stigma, and worse attitudes toward seeking psychological help (Vogel et al., 2009; Ludwiskowi et al., 2009; Topkaya et al., 2017). Although moderately correlated with public stigma, there is evidence that social network stigma is unique from public stigma. For example, an exploratory factor analysis using items from measures including the PSOSH and a measure of public stigma of seeking help found that they loaded onto separate factors (Vogel et al., 2009). In addition, social network stigma has predicted self-stigma of seeking help over and above the public stigma of seeking help among U.S. clinical and general college student samples (Ludwikoswki et al., 2009; Vogel et al., 2009), and Turkish college students (Topkaya et al., 2017). Results from these preliminary studies suggest that social network stigma may demonstrate a smaller unique effect than public stigma; however, more studies are needed to further elucidate this, as well as determine any cross-cultural differences.

This has also received consideration within the realm of mental illness stigma. For example, Fox and colleagues (2018) inadvertently considered social network stigma of mental illness in a study mentioned earlier in the chapter. They found that a one-item measure, "If friends and family knew I had a mental health problem, they would think less of me" (p. 17, Fox et al., 2018), predicted an item that captures self-stigma of seeking help. Indeed, this was taken from the Concerns about Stigma from Loved Ones subscale of the Endorsed and Anticipated Stigma Inventory (EASI; Vogt et al., 2014). This social network stigma of mental illness has

been linked with a person's own beliefs towards those with mental health concerns, negative beliefs towards oneself seeking treatment, and negative beliefs towards mental health treatment itself (Vogt et al., 2014). As the debate regarding the theoretical distinction of these stigmas continues, researchers should also consider delineating these forms of social network stigma.

Given the importance of close relationships within collectivists cultures (Cross, Gore, & Morris, 2003; Markus & Kitayama, 1991; Yeh, 2002), researchers have suggested that social network stigma might be particularly relevant within these populations (Topkaya et al., 2017). We found one non-U.S. study examining social network stigma, with this research using a sample of college students in Turkey (Topkaya et al., 2017). Social network stigma demonstrated significant bivariate correlations with greater public stigma of seeking help, greater self-stigma of seeking help, and worse attitudes toward seeking counseling. Interestingly, although public stigma and social network stigma were moderately to strongly correlated with self-stigma of seeking help, in a structural model, social network stigma demonstrated a visibly smaller unique relationship with self-stigma (β =.17) than did public stigma (β =.57), and only public stigma demonstrated a unique relationship with intentions to seek counseling. This mirrors Ludwikowski et al.'s (2009) finding among U.S. college students (β's =.22, .63). This raises questions for future research regarding the cultural meaning of social network stigma. Turkey represents a hybrid of collectivist and individualistic values (İmamoğlu, 2003; Kağıtçıbaşı, 2012; Mocan- Aydin, 2000), therefore it is plausible that these unique relationships may differ if examined among more strongly collectivist cultures, such as those within China or Taiwan, or among older generations within Turkey, which may be less influenced by social media and intergenerational cultural shifts.

Researchers are starting to pay attention to these cross-cultural questions, which begins with examining the cross-cultural validity of the tools that may help answer them. A study examining the social network stigma measure used by Topkaya et al. (2017), the Personal Stigma of Seeking Help Scale (PSOSH; Vogel et al., 2009), across eleven countries found that the PSOSH items capture the same one-factor structure across countries and supported cross-country comparisons of the strengths of these relationships (Vogel et al., 2019). Although support for mean-difference comparisons were mixed based on the specific countries (Vogel et al., 2019), the bigger questions center less around comparing the extent to which social network stigma exists in these countries, but rather comparing the level of influence of social network stigma (i.e., the strengths of these relationships), which received cross-cultural support. Moreover, these findings raise the question of whether there are other forms of unmeasured stigma that may be more prominent in collectivist cultures. For example, is there a form of self-stigma in which a person experiences a reduction in self-worth for bringing shame to their family as a result of seeking help? Indeed, additional research is needed to more fully understand the impact and cultural variations of social network and other forms of help-seeking stigma, as well as delineate social network stigma of seeking help from social network stigma of mental illness.

Conclusion

This chapter aimed to serve two purposes: 1) provide distinct definitions of the four prominent forms of mental illness and help-seeking stigma and 2) discuss current state of the science regarding the delineation of these stigmas from each other and their relationships with clinically relevant constructs. Current evidence research lends support for the delineation of these stigmas with theoretically distinct relationships with clinically meaningful outcomes.

However, future research (e.g., examining help-seeking behavior longitudinally) is needed to replicate, extend, and strengthen these findings.

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Table 1

Different Types of Stigma Related to Having a Mental Illness and Seeking Help.

	Target of Stigma	
Source of Stigma	Mental Illness	Seeking Help
Public	Public Stigma of Mental Illness	Public Stigma of Seeking Help
Self	Self-Stigma of Mental Illness	Self-Stigma of Seeking Help

Figure 1. The Internalized Stigma Model (Lannin et al., 2015)