

Mental Health Stigma: Personal and Cultural Impacts on Attitudes

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The stigma attached to mental illness can serve as barrier for help-seeking among individuals who experience a mental health issue. In an effort to contribute to the professional understanding of mental illness stigma and barriers to help-seeking, the authors conducted a phenomenological study to explore the perceptions of 10 full-time university employees. Analysis of interview data from two focus groups (group one = six participants; group two = four participants) resulted in the identification of themes related to the meaning of mental illness stigma, negative cultural views in the United States about mental illness, and seeking assistance for mental illness. Implications for counselor education and practice are discussed.

Keywords: stigma, mental illness, help-seeking, counseling, attitudes, counselor education

In the United States (U.S.), approximately 1 in 5 adults experience mental illness in a given year (National Alliance on Mental Illness [NAMI], 2015a). *Mental illness* is defined as a medical condition that affects an individual's mood, thinking, decision making, abilities, and interactions with others (NAMI, 2015b). Although empirical evidence shows that treatment for mental illness is effective in decreasing symptoms and improving quality of life, 70% of individuals do not seek professional mental health

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services (Henderson, Evans-Lacko, & Thornicroft, 2013; Wang et al., 2007). Often referred to as the treatment gap, a disparity exists between those who need assistance, and those who actually seek it (Dua et al., 2011). Reasons for the existence of the treatment gap include a lack of knowledge about mental illness symptoms and/or available services, negative attitudes about mental illness, and expectations of discrimination once being diagnosed with a mental illness (Henderson et al., 2013).

The Stigma of Mental Illness

Stigma is defined as a mark that signals to others that an individual has an attribute that reduces her or him from being a “whole” person to a “tainted” one (Pescosolido, 2013). The concept of stigma is a combination of factors including stereotypes, prejudices, and discrimination (see Corrigan, 2004). *Stereotypes* are the beliefs about what it means to have a mental illness (e.g., someone with a mental illness is strange, weak, or dangerous), *prejudice* includes agreement with the stereotype which results in an emotional reaction of some kind (e.g., fear, disgust), and *discrimination* is the behavior that is associated with the emotional reaction (e.g., avoidance due to the belief that the person is strange, weak, or dangerous).

Stigma, as it relates to mental illness, can be conceptualized as including the following five domains: self-stigma, help-seeking stigma, associative stigma, public stigma, and anticipated stigma. *Self-stigma*, or the notion that the person stigmatizes him or herself because of internalized negative attitudes from others, results in lowered self-esteem and self-worth (Corrigan, 2004). *Help-seeking stigma* refers to the stigma one experiences from seeking help for a mental illness, resulting in many not seeking mental health treatment (Tucker et al., 2013). *Associative stigma* describes stigma that is felt by family or close friends of the person with the mental health concern (Mehta & Farina, 1988; Ostman & Kjellin, 2002). *Public or cultural stigma* is the reaction that the general public has about mental illness (Corrigan & Watson, 2002; Parcesepe & Cabassa, 2012; Pescosolido, 2013), and *anticipated stigma* is the belief that disclosing a mental illness will result in stigma, resulting in secrecy and nondisclosure to others (Quinn & Chaudoir, 2009). Some have even asserted that self-stigma can be further disassembled into self-stigma one feels about having a mental illness and the self-stigma one feels about help-seeking (Tucker et al., 2013).

Stigma is important to uncover, as it results in damaging consequences for the person experiencing it (Corrigan, Druss, & Perlick, 2014). In fact, researchers have long made the claim that the stigma associated with mental illness can be as damaging as any mental health symptom (Feldman & Crandall, 2007). Outcomes of stigma can include increased feelings of depression (Manos, Rüscher, Kanter, & Clifford, 2009), negative attitudes towards treatment (Conner et al., 2010), lower treatment compliance (Fung & Tsang, 2010), and less willingness to return for treatment (Wade, Post, Cornish, Vogel, & Tucker, 2011).

Mental Illness Stigma and Help-Seeking Among Persons with Mental Illness

Researchers (Crowe, Averett, & Glass, 2016; Henderson et al., 2013; Lally, O’Conghaile, Quigley, Bainbridge, & McDonald, 2013; Tucker et al., 2013) have examined how stigma impacts help-seeking behaviors and determined that mental illness stigma certainly plays a role in reluctance to seek mental health treatment. In an investigation of mental illness stigma and help-seeking in university students, Lally and colleagues (2013) assessed overall levels of self-stigma and perceived public stigma as they related to help-seeking intentions. Higher perceived public stigma levels were found when compared to self-stigma levels. Perceived public stigma was not significantly related to future non-help-seeking intentions, but self-stigma was significantly associated with a decreased likelihood of future help-seeking intentions. The authors also assessed demographic factors in order to explore how these impacted stigma and help-seeking. Those under the age of 25, those who had no personal experience with mental illness and seeking treatment for a mental illness, and no personal contact with someone with a mental illness were all associated with higher levels of self-stigma. Because of these results, the authors suggested that self-stigma, in particular, represents a significant barrier to mental health treatment. As well, the authors suggested that stigma might be especially present in young adults and those without experience with mental health concerns.

Tucker and colleagues (2013) explored the concepts of mental illness self-stigma and help-seeking self-stigma. In a sample of undergraduate college students who identified as having clinical levels of mental health distress ($n = 217$) and a second sample of those in the community who self-reported as having a history of mental illness ($n = 324$), the authors administered a series of self-report surveys on self-stigma, public stigma, stigma related to seeking help, help-seeking attitudes, and help-seeking intentions. Confirmatory factor analyses revealed strong evidence for independence between the two types of self-stigmas (self-stigma of having a mental illness and self-stigma associated with seeking help). Regression analyses revealed that the two types of self-stigmas predicted variations in stigma-related constructs (e.g., shame, blame) as well as help-seeking attitudes and intentions. The research suggests that self-stigma might in fact be two separate concepts, and confirmed the importance of self-stigma as it inhibits help-seeking in regards to both attitudes and intentions.

In a qualitative study by Crowe et al. (2016) that explored relationships between mental illness stigma, resilience, and help-seeking, many relationships were found between these three concepts including: stigma decreased resilience and stigma also decreased help-seeking behaviors. Conversely, the authors found that having more resilience can decrease the stigma associated with having a mental illness. In the same study, the authors found that help-seeking behaviors related to increased resilience and decreased stigma, suggesting that seeking help for a mental illness helps one cope as well as decreases negative attitudes associated with help-seeking for a mental health concern (Crowe et al., 2016).

Mental Illness Stigma and Help-Seeking Behaviors Among Helping Professionals

Stigma related to mental illness as it exists in the general U.S. population has been studied for quite some time, dating back to Goffman's seminal work on stigma (1963). In the last decade, an emerging body of literature (Crowe & Averett, 2015; Mullen & Crowe, 2016; Smith & Cashwell, 2010) has suggested that such stigma also exists in professionals who work in mental health settings. In the counseling literature, in particular, there have been recent efforts to explore the topic of mental illness stigma and its impact on help-seeking (Mullen & Crowe, 2016), as well as what impacts attitudes towards mental illness among mental health professionals (Crowe & Averett, 2015; Smith & Cashwell, 2010). Related to mental illness stigma and help-seeking, Mullen and Crowe (2016) surveyed 333 professional school counselors and found that self-stigma of mental health concerns contributed to a decrease in help-seeking behaviors, which contributed to stress and burnout. The authors suggested that there is still work to be done to normalize mental health issues, since even professionals who are trained to work within and promote mental health services might be reluctant to seek mental health support for themselves. In looking at attitudes towards mental illness among a variety of mental health professionals (e.g., counselors as compared to social workers, psychologists, and non-mental health professionals), Smith and Cashwell (2010) found no difference between counselors as compared to social workers and psychologists in attitudes toward mental illness. Taken together as a group, mental health trainees and professionals in all disciplines had more positive attitudes than those who were not in a mental health discipline. More so, mental health professionals who were receiving clinical supervision had more positive attitudes than those who were not in supervision, suggesting that supervision might play a role in decreasing negative attitudes towards mental illness.

Using qualitative measures to look more closely at what might impact attitudes towards mental illness in mental health professionals, Crowe and Averett (2015) asked counselors, social workers, and psychologists about professional experience as well as one's educational training program, and how these might have impacted attitudes. The product of this study included a continuum for each (education and professional experience) that displayed a range of attitudes among mental health professionals.

Researchers (Corrigan, 2004; Crowe et al., 2016) have substantiated that stigma associated with mental illness and treatment seeking is a primary reason that people, including some professionals who work in the mental health settings, as well as those in the general population, choose not to pursue counseling or other mental health services. While these studies (Corrigan, 2004; Crowe et al., 2015) provide an overview of the attitudes and beliefs held about mental illness and ways to reduce the stigma associated with it, they do not focus on the origin of these views. In fact, there is a paucity of qualitative studies that focus on the origins and influence of U. S. culture on stigma, help-seeking, and mental illness in the current literature. The following research study attempts to determine what larger U.S. cultural factors contribute to negative percep-

tions. It is critical that researchers comprehend this aspect of mental illness stigma so they can better understand how stigma affects help-seeking behaviors among individuals experiencing a mental health issue.

The Current Study

There is still more to learn regarding how those in the general population might perceive mental illness. The growing body of counseling research has focused on professionals' attitudes (Crowe & Averett, 2015; Mullen & Crowe, 2016; Smith & Cashwell, 2010) and what might influence attitudes towards mental illness. In order to expand this literature base, it is also critical to include the general populations' views on mental illness, and assess what factors might contribute to these. To better understand the general population's view on mental health stigma and how it inhibits many from seeking help, the current study explored perceptions of mental health stigma, as well as how these contribute to lack of seeking help through a qualitative investigation. This study may offer insight on the possible causes for mental health stigma and the impacts of stigma on help-seeking behaviors. Research questions include: What are common perceptions of the term "mental illness stigma?"; What are common negative views in the U.S. culture about mental illness that might cause stigma, according to our sample?; and How does stigma impede people from seeking assistance for a mental health concern?

Method

Research Design

The researchers utilized a phenomenological investigation in this study. According to Lester (1999), a phenomenological approach illuminates the specific, and identifies phenomena through how they are perceived by those involved in a situation. The process involves gathering deep information and perceptions through inductive, qualitative methods such as interviews, discussion and participant observation, and representing it from the perspective of the research participant(s).

As such, we chose to use focus groups as the primary method for gathering information on the meaning of mental illness stigma and barriers to help-seeking. Focus groups are often specifically recommended when there is little information known on a topic (Nassar-McMillan & Borders, 2002) and when taking an exploratory approach (Vaughn, Schumm, & Sinagub, 1996). Because this was the case for the current study, the use of focus groups was believed to be the best starting point for collecting data. Additionally, as a result of one of the research questions concerned with exploring views within the broader culture related to mental illness, it was also thought that using focus groups, which provide interaction among participants and assist in generating new information about a topic (Sagoe, 2012), was an appropriate method that aligned with the phenomenological approach.

The research team utilized several strategies of trustworthiness in order to promote

rigor of the research process as described by Lincoln and Guba (1985). These well-known and widely used strategies included peer debriefing, triangulation, research journaling, an audit trail, and a confirmability audit. Each strategy is described further in the Data Analysis section below.

Participants

Prior to participant recruitment and data collection, the Institutional Review Board of the authors' university approved the study. All participants were recruited via email from a university-wide staff listserv. Participation was voluntary and there were no incentives provided. To determine qualifications and obtain consent from participants, the authors conducted initial phone screenings to verify that all participants met the following inclusion criteria: at least 18 years old, comfortability discussing attitudes towards mental health in a focus group, and comfortability providing demographic information about personal mental health experiences. Those who met the inclusion criteria were invited to participate in this study.

The study included a total of 10 full-time employees at a large public university located in the southeastern United States. There were four men and six women ranging in age from 27 to 65 ($M = 49.6$, $SD = 11.03$). Nine of the participants identified as Caucasian and one identified as African American. Half of the participants ($n = 5$) reported being single, never married, and the other half ($n = 5$) reported being currently married. Half of the participants ($n = 5$) indicated that they had received a master's degree, with the remaining participants indicating that they had received either a four-year ($n = 2$) or a two-year ($n = 3$) college degree. Occupations included administrative assistant, archivist, lab compliance coordinator, library technician, student affairs administration, and maintenance technician, to name a few. The majority of participants indicated that they had previously sought treatment for a mental health concern ($n = 7$) and indicated the treatment they received was helpful. Reasons for seeking treatment included generalized anxiety disorder (GAD), bipolar disorder, past trauma experience, depression, family concerns, and relationship issues. The majority of the group also stated that they had a family member with a mental illness ($n = 7$). These family illnesses included alcoholism, depression, GAD, bipolar disorder, dementia, and schizophrenia. Additionally, the participants expressed that they would seek mental health treatment in the future should they begin to suffer from any symptoms ($n = 7$).

Data Collection

Participants provided a written consent as well as completed a demographic and mental health history questionnaire. Questions on the demographic questionnaire included participant's age, gender, ethnic background, current relationship status, highest level of education completed, as well as current occupation. Included on the mental health history questionnaire were questions related to whether each participant had sought previous mental health treatment; what the treatment was for; whether the treatment

was helpful; if a family member had sought treatment, and if so, what the diagnosis was; and whether or not the participants would seek mental health treatment in the future if they were experiencing mental health symptoms.

We conducted a total of two focus groups (one group consisting of six participants and one group consisting of four participants). Focus group membership was determined by participants' availability. The lead author led the first focus group meeting and a research team member led the second focus group. Focus groups lasted anywhere from 60 to 90 minutes and were directed by use of a pre-designed question script. Questions allowed participants to openly discuss their thoughts, feelings, and ideas concerning mental health stigma. All discussions were audio-recorded and later transcribed for ease of analysis. During each focus group, open-ended questions created by the researchers related to mental illness stigma and help-seeking were discussed (see Appendix).

Data Analysis

This research explored the content of open-ended questions using content analysis, which is a flexible data analysis method that can range from impressionistic interpretations to highly systematic analyses of text-based data (Hsieh & Shannon, 2005). It is considered a qualitative method for systematically and rigorously integrating, interpreting, and synthesizing qualitative findings that have been extracted from multiple qualitative or mixed-method research reports (Fingeld-Connett, 2014). This method attempts to identify core consistencies and meanings within the data (Patton, 2002).

Classic content analysis, a specific approach utilized in this study, includes the process of coding, or transforming raw data into a standardized form, in order to easily study recorded human communications (Babbie, 2001). Content analysis is widely used and well known analysis method. Hsieh and Shannon (2005) stated that "conventional" content analysis is utilized when the existing theory or literature on a topic is limited and there are not pre-existing categories (p. 1279). In this analysis method, researchers approach the data with no preconceived notion of what they will find and categories are allowed to flow from the data. In the current research process, the researchers first read through the transcriptions several times to get an overall sense of the data and noted beginning possible themes. Then emerging common themes were noted and the data or text was sorted into the themes; this process is also known as coding. The data was then resorted and re-themed as needed in order to seek consistency among participant responses. Themes were determined to be prevalent if all three researchers had noted them as a theme and there were a larger number of coded responses associated with it. From the themes recorded, a common collection of responses emerged, which suggested continuity among participants ranging in cognition, affect, and behavior (Hsieh & Shannon, 2005). Each of the themes were interconnected, which was consistent with the definition of content analysis.

Six members of the research team were involved in the analysis of the data. This included the second author as well as the fifth through the eighth author. Initially, four

junior researchers (master's level students enrolled in a counseling program) independently coded the data. They then met on five occasions to discuss their findings, seek agreement, and negotiate differences in the findings. This process of triangulation is considered a way to enhance the "credibility" of qualitative research (Lincoln & Guba, 1985). Another member of the research team, more senior in experience, provided peer debriefing and consultation to the junior members throughout this process, which also added to the credibility of the methods (Lincoln & Guba, 1985). Finally, a fifth researcher also more senior in experience, engaged in an audit of the original analysis process, reviewing the notes and trail of the original three researchers. These techniques are known in qualitative circles as establishing confirmability (Lincoln & Guba, 1985). Each team member also kept a research journal, another hallmark of Lincoln and Guba's (1985) process. The research journal provides an audit trail of the data analysis procedures and considers individual reactions in the research process. Research journals can be used to describe the steps taken and provide additional records on the process, enhancing the confirmability of a study and thus aiding in establishing trustworthiness. As such, the use of triangulation, peer debriefing, an audit trail, research journals, and a confirmability audit increased the trustworthiness and dependability of the research (Lincoln & Guba, 1985).

Findings

Meaning of Mental Illness Stigma

Question One asked participants to define, in their own words, the term *mental illness stigma*. A total of 22 different themes were originally noted among the 28 responses made by participants, with the most prevalent themes then being grouped together based on similarities. The resulting final four themes included (a) Perceptions stemming from personal experience, (b) Perceptions of weakness in character, (c) Perceptions of stereotyped behaviors, and (d) Perceptions from being uninformed.

Perceptions from personal experience. Responses made by participants indicated that their understanding of the term "mental illness stigma" came from personal experiences they either had or did not have with having a mental illness or knowing a family member or friend with a mental illness. These responses included:

Well here again, personal experience. I have a family member who is severely mentally ill and if he doesn't take his meds he is a danger to himself and others and he has to be locked up.

I've never been told I was mentally ill, but all the characteristics that people are supposed to have are denied by mental illness.

The first time I remember ever hearing the concept of mental illness was an Indian spoke of it, who said, translated the phrase, as the af-

flicted of Allah, which is to say that this mental illness is God's blessing, therefore you don't have to do anything about it.

From these quotes it seems evident that the level of experience the participants had with mental illness impacted their perceptions. For one participant, it meant an individual with a mental illness was dangerous. For another participant, it was seen as a blessing.

Perceptions of weakness in character. For some participants, mental illness stigma meant that individuals had a flaw (specifically weakness) in their character. Example responses included:

You're not really depressed, you're just really down and you could have had better coping skills. You're more resilient and can deal with it, but that's the fact, it's viewed as an excuse or a lack of strength.

Not only do you have a character weakness, but you are unadaptable (sic).

...people think it's a weakness of character and that it's something that someone who had more strength of character could just pull themselves out of or control or make themselves not feel that way.

These responses indicate that some perceptions of mental illness stigma are related to it being a weakness, and more specifically a mental deficiency. Participants reflected on the notion that members of society believe a person should be able to control emotions, and that the inability to do so is related to a defect in their personality.

Perceptions of stereotyped behaviors. Another response among participants was that stigma is associated with automatic negative assumptions about persons with mental illness made by the general public. These negative assumptions were that individuals with a mental illness abuse the mental health system, are dangerous to both themselves and others, use their mental illness as an excuse rather than face their problems, and are burdens on society. Responses included:

I think there's an idea that it's sometimes used as an excuse. You can't cope so you're going to go see somebody.

...it was because someone else who had a store in the same mall space, her son had been diagnosed as being schizophrenic and they all thought he was going to attack people and that he was dangerous.

The billions of dollars that are spent in their country on mental health and my, it's going to sound bad, but abuse, I think it's abused.

Despite the variation in participant responses about stereotypical behaviors, a common thread among these responses was that judgments made by society as a whole have impacted their experiences with individuals who have a mental illness.

Perceptions from being uninformed. Certain responses from participants indicated that their lack of understanding and uncertainty about mental illness contributed to their perceptions of mental illness stigma. Example responses were as follows:

So I guess the stigma is some uncertainty and some doubt about whether or not things are really bad enough to be bad enough, or what is bad enough to be a mental health issue and what isn't.

There is also that we tend to want to rationalize things and illness is the irrationality of some of the behavior and we try to place those guidelines of 'I just can't understand why they wouldn't take their medicine,' I just don't, why wouldn't they take their medicine?]

...he was dangerous. That's just what everyone thought schizophrenia was, so that's what I thought it was when I was younger for a long time. Someone who hears voices and wants to attack people. Hears voices that tells them to attack people.

The respondents demonstrated that uncertainty and lack of familiarity and understanding of mental illness can result in stereotypical thoughts and behaviors. As seen in response three, the participant reiterated that because the people around her thought those diagnosed with schizophrenia were dangerous and wanted to attack people, she believed it too. Their misunderstanding about schizophrenia contributed to the participant's own misunderstandings as well.

Negative Cultural Views About Mental Illness

Question Two asked participants about the negative views the public and our culture in general has about mental illness that might cause stigma. Initially a total of 16 themes were noted among the 22 total responses made by the participants. The final four themes determined to be most prevalent include (a) Improvement of stigma associated with less serious mental illnesses, (b) Perceptions of stereotyped behaviors, (c) Shame and embarrassment, and (d) Perceptions that individuals with mental illnesses are a burden to society.

Improvement of stigma associated with less serious mental illness. Several responses made by the participants indicated that they felt there has been an overall improvement of stigma associated with some mental illnesses. According to the responses, it was suggested that stigma was less likely to be experienced when it came to certain mental health concerns, such as depression. For example, participants shared the following responses:

I don't think it's as prevalent as it used to be. I mean, it used to be a stigma really if you went to a therapist, but I think a lot of people realize that therapists can help you to work out your problems, that you don't have to be on medication, and really in many ways you come back feeling refreshed once you get to the core problem and you can figure out how to recognize the cycle when it gets started.

I think that going to a therapist has almost become kind of trendy like from TV and stuff. It's kind of, I want to get my nails done, see my therapist...but the hardcore mental health issues, maybe the stigma is still kind of there on that.

I think there has been a general improvement ...

...but, so when people say "well, I'm going to see a ...therapist," I say "good for you."

It seems evident that participants felt that there has been an improvement in stigma when it concerns seeking treatment for certain problems.

Perceptions of stereotyped behaviors. Similar to the stereotypical behaviors theme in Question One, this theme reflects participant views on stereotypes about mental illness that might cause stigma. A few of the stereotypical beliefs mentioned were that people with a mental illness cause fear, and that such persons are dangerous, unpredictable, and threatening. The stereotypes are reflected in the following responses:

Well yeah, there is a fear of how that person is behaving and discomfort.

How many times have you heard on the news about the halfway houses and things for the mentally ill that the local neighbors are like we don't want them here, now our children are in danger.

That I could be disabled but I'm not going to go out and kill people, whereas if you let him loose in the population he will hurt and kill people. There is a big difference there. So there is that unpredictability ...

I think all of these things really come down to a person who is a threat.

Shame and embarrassment. Another negative view that participants discussed as culturally derived, according to U.S. culture, was shame and embarrassment. The

following three responses are examples of this.

Going to the stigma, the job I was working on, I would say, 'Well I have to go with her, I have to take off for her,' and they would say, 'Where are you going?' and it was hard to say, 'I have to go to counseling with my wife, I have to take my wife to the doctor.'

Because if a person can't control the behavior, they can't be guilty or responsible for it, but they still feel that way.

But what I'm saying, all the others fit, but shame and guilt don't. If a person is not responsible, and we recognize that, if you are judged to be insane you can't be sentenced to jail. You can't be held responsible for a crime, so then there is treatment and all sorts of other things that are just as severe as jail, but it's not the same thing. I think that you can't really have a situation where somebody is out of control and yet responsible.

In the first quote mentioned above the participant noted shame and embarrassment associated with asking an employer for time off of work so that he could attend mental health treatment with his wife. The second and third quotes seem to describe the notion that shame and embarrassment should not be felt by those with mental illnesses although they frequently are.

Perceptions that those with mental illness are a burden to society. The last theme for Question Two is related to the negative view that individuals with a mental illness are a burden to society. Examples include:

I had to deal with *that* (a mentally ill family member) for 10 years.

I'm sure governments are concerned about it in sense that there are lots of people out there who aren't trying to make money, trying to get a better job, trying to make the economy grow faster, because they are all concerned with their own problems. And it cost a lot of money and everybody has to pay for it.

And that society bears the burden of taking care of them which can cause them to be a stigmatized group.

These responses suggest that people who assist those with a mental illness might feel that doing so is a burden. These last two quotes also indicate that society in general might believe that those with a mental illness are unproductive and are a burden to others because it costs extra money to take care of them.

Seeking Assistance for Mental Illness

Question Three asked participants if they believe stigma prevents individuals from seeking assistance for a mental health concern, and then in a follow up, Question Four asked if so, how. After analyzing the 39 responses to these two questions, 12 initial themes emerged. These were then further collapsed and the final resulting four themes included (a) Perceptions based on personal experience, (b) Medication as a solution, (c) Stigma has decreased, and (d) Fear.

Perceptions based on personal experience. Several participants responded to the question with their own personal experiences with others seeking mental health treatment. Many of the participants felt that individuals do not seek mental health treatment because of their own experiences with treatment. For example, participants shared the following responses:

Just like you my brother spent 30 years in the army and he felt that way. That's the way he felt. Hey, I was in Vietnam and I didn't have to take no pills. Well, the last Gulf War, the last gun missile they shot fell on his warehouse. And he had just woke up. And his whole platoon was killed. And he was fine till he got home, and when he got here, he just couldn't sleep, he couldn't eat, he lost 100 pounds, I thought I was going to lose him.

I know from my brother's standpoint. I'm his healthcare power of attorney and he is in assisted living. And for years he would self-medicate with alcohol, heroin, cocaine, and marijuana. For a number of years when he was growing up he was also sort of a troublesome child, but back then they never diagnosed bipolar for children so he was just sort of the odd kid. Once mom passed away, then he went in to have a mitral valve replacement and when he came back out then all of the sudden he tells us he is bipolar. His twin is a clinical social worker who works with battered families and stuff like that so she had covered up for him for years.

These responses highlight that the participants felt that individuals do not seek treatment due to their personal experiences. Most of the participants felt negatively about treatment due to these experiences.

Medication as a solution. Several of the participants felt that individuals do not seek mental health treatment due to reliance on medication. The responses indicated that individuals allow medication to take the place of mental health counseling and therapy. The following responses indicated that medication is impeding individuals from seeking the care they require:

I do think there is stigma too that we manage to cure a lot of things medically. That you are going to go in and get this pill and walk out and going to be fine. Or you are going to get on this medicine and you are going to be fine. I appreciate what we've done a lot with medicines but the idea that there is a cure that you're going to walk in, and there is a cure for some things or some treatments for some things. That you're going to walk in and then walk out fine. I think that's a real problem.

And I think the expectations have grown for society on what the medical community, or health care providers, can do and there is almost a backlash of resentment if it, why isn't it working, are you taking your medicine, you were supposed to fix it, how come it's not getting fixed, as opposed to resigning itself, for lack of a better word, that is the way someone is going to be.

The responses suggest that individuals are relying on medication to “fix” mental health issues rather than a combination of medication and counseling, or counseling alone.

Stigma has decreased. The next theme noted was that the participants felt that overall there was a decrease in mental health stigma in the general public and culture. Participants noted that there may be a better understanding of individuals with mental health illness. Below are example participant responses:

So I think there has been more open discussion about it, not as much about schizophrenia, but people are getting a better idea of what it is. It doesn't mean they are psychotic it just means they have some issues with perception.

I know someone and she sought therapy and I think she saw it as being really a medical problem, which is how we tend to see it. But she had no concern about stigma.

I think it's less than it used to be. There are degrees of it (mental illnesses).

The responses indicate that the participant believed that there are “less serious” as well as better understood mental illnesses. For example, the participant in the first response stated that schizophrenia may be misunderstood, whereas better understood mental health diagnoses, or those deemed to be more common are discussed openly.

Fear. Participants felt that fear of the actual diagnosis, as well as reactions from others such as rejection, often hindered individuals from seeking mental health treatment. The following responses are examples:

I think that some people then, because mental health issues are so stigmatized, so not only is there something quote on quote wrong with you, but then also it's something that other people, it's not like you have cancer where people are going to support you, you might feel that it will make things worse for you if you are diagnosed with that.

So I think for a lot of people there is a fear of going, one because they don't want to find out there is something wrong, and then also because they are afraid that the diagnosis will lead them to being stigmatized this way. Even if they get treatment, then it is out there that they are crazy.

And she had a good response from people, but there is still that fear.

She was very brave talking about it. She was very fearful of rejection but she did not feel there was a stigma. I know that's a contradiction.

These responses emphasize the fear associated with seeking treatment, fear of the unknown, and the stigma associated with particular diagnoses.

Discussion

The purpose of this study was to explore perceptions of mental illness stigma and barriers to help-seeking in a sample of 10 university employees. Through a phenomenological investigation, important themes emerged related to stigma, negative cultural views in the U.S. about mental illness, and seeking assistance for mental illness. Four themes related to the meaning of mental illness stigma included: (a) Perceptions stemming from personal experience, (b) Perceptions of weakness in character, (c) Perceptions of stereotyped behaviors, (d) Perceptions stemming from being uninformed. Four themes emerged about negative cultural views on mental illness to include: (a) Improvement of stigma associated with less serious mental illnesses, (b) Perceptions of stereotyped behaviors, (c) Shame and embarrassment, and (d) Perceptions that individuals with mental illnesses are a burden to society. And, finally, four themes related to seeking assistance for a mental illness emerged to include: (a) Perceptions based on personal experience, (b) Medication as a solution, (c) Stigma has decreased, and (d) Fear.

In Questions One and Three, personal experience related to mental illness was a common theme from participants in the study. This finding is consistent with literature in the mental health field that suggests that attitudes are improved when one is more familiar with mental illness in some way (Angermeyer & Matschinger, 1996; Angermeyer, Matschinger, & Corrigan, 2004; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Read & Law, 1999). This finding is also consistent with related literature on

attitudes towards lesbian, gay, bisexual, and transgender (LGBT) individuals and how attitudes are improved when individuals have a personal connection to a person who identifies as LGBT (Vonofakou, Hewstone, & Voci, 2007).

Questions Two and Three in the study evoked responses from participants about stereotyping and the encouraging trend of certain mental illnesses not holding as much negative stereotypes as they once did. In particular, those mental illnesses understood to be less serious or more common (e.g., depression) are now considered more acceptable and less stereotyped. Prior research (Sirey et al., 2001) had suggested that depression was still highly stigmatized, so this finding is promising in that it suggests that this trend might be changing. Clinicians might notice more stigma in those with more serious mental health concerns and less stigma in those with less severe mental health issues, or those that are more common in the U.S. While this finding is positive, the “other side of the coin” is that those with more serious concerns are still not seeking treatment and struggling with untreated symptoms. Future studies might investigate what might mitigate the stigma that still exists for more serious mental health concerns (e.g., schizophrenia, bipolar disorder) so that those who are struggling can get the help they need.

Another theme from the results that seems important to discuss is the role that medication plays in regard to stigma and help-seeking. For many, counseling and therapy have been replaced with medication, rather than medication being used to complement traditional talk therapy and counseling, or vice versa. Perhaps attitudes about mental illness have been impacted, for better or for worse, with the rise of media and marketing of mental health medicines for issues such as depression and anxiety (Frank, Conti, & Goldman, 2005). A final theme worth noting is the large amount of emotion that continues to be related to stigma and help-seeking. In our sample, fear, shame, and embarrassment were all mentioned as they relate to the study topics. This is very consistent with the notion that stigma includes beliefs that are most certainly tied to one’s feelings on a particular topic or concern (Corrigan, 2004). This theme is noteworthy as clinicians who are working with those who hold negative attitudes could consider exploring the emotions that are associated with self-stigmas, or negative beliefs about oneself. Normalizing help-seeking for someone who discloses feelings of embarrassment or shame seems particularly important if it will help increase the chances that someone will continue mental health treatment.

Implications for Counseling Practice and Counselor Education

Counselors and those in related mental health disciplines can certainly use results of the current study to inform their counseling practice. To begin, it seems clear that many in the U.S. feel reluctant to seek formal help for a mental health concern. Because of this, counselors can acknowledge the courage it might have taken for a person to seek help for the first time, or simply ask whether or not the person felt any type of stigma before, during, or after seeking help for a mental health concern. Engaging in conversation, normalizing the act of seeking help for a mental health concern, and advocating

for the client may all be tasks that professionals in mental health fields can engage in to assist with decreasing stigma related to mental health concerns.

Advocacy and public awareness efforts are other ways that mental health professionals might begin to decrease the stigma that is still associated with mental health concerns. Stereotyped behaviors and negative messages such as “those with mental illnesses have a weakness in character” can be combated with positive messages that more accurately reflect the prevalence of mental health disorders in the U.S. (e.g., 1 in 5 adults; NAMI, 2015). Perceptions from participants in our study appeared to be based on personal experience, so counselors and other mental health professionals can inquire about someone’s personal experience related to mental health concerns when they begin seeking services, in order to assess whether these experiences might have a positive or negative impact on the person. Anti-stigma efforts can also be tailored to those who might particularly benefit from them, such as those with less familiarity or personal experience with mental illness.

Previous research (e.g., Crowe & Averett, 2015; Smith & Cashwell, 2010) suggested that counseling students, as well as students in similar clinical programs, hold a variety of attitudes about mental health concerns, and that such attitudes are impacted by both education and experience in the field of mental health. Educators might include self-awareness activities or assignments related to attitudes about mental illness in courses such as Introduction to Clinical Mental Health Counseling, Multiculturalism, or Diagnosis, and discuss how personal views impact decisions about seeking treatment, and that mental illnesses in general are still stigmatized. Because students might hold some stigma themselves, or in the event that they see a client who feels stigmatized, these conversations will assist in preparing counseling students for working in mental health fields. Conversations about the variety of mental health concerns, ranging from those understood as less serious to very serious (e.g., mental illness verses serious mental illness) and associated attitudes could also lend itself to interesting classroom discussions.

The counseling literature also suggests that mental health professionals are reluctant to seek mental health services due to stigma towards mental illness, and this leads to counselor burnout and stress (Mullen & Crowe, 2016). Thus, although there is no research to date on what types of teaching strategies might effectively reduce mental illness stigma, counselor educators are encouraged to explore how to inform attitudes through various teaching methods in counseling students while in training programs. Assignments and classroom activities that encourage self-awareness and understanding might be particularly impactful so that counselors in training can begin to develop their own understanding of their personal attitudes. Typically, students in counseling programs are told that they must first make sure they are psychologically well in order to be a professional counselor, and that this should be present before working in the counseling field. Thus, it seems particularly important to normalize help-seeking so that when issues do arise, counselors-in-training feel comfortable receiving services.

Counselors might be mindful that clients who are also professional helpers might struggle with receiving help themselves. Asking about stigma and negative attitudes

might assist with this, as a way to promote sharing of these types of biases and assumptions in hopes to eliminate them. Counselors working with those impacted by mental illness might ask about personal experience during an initial meeting with a client, and invite a discussion about attitudes, stigma, and how it might or might not have impacted the client. Since Question One and Question Three from the current study evoked responses related to personal experience, this topic is of particular importance. Perhaps media effort can assist with debunking negative images and stereotypes related to mental illness, so that those in the general population feel as though it is not as farfetched, shameful, or worthy of stigma.

Limitations and Directions for Future Research

As with all research, this study is not without limitations that potentially impact internal validity. The topic of attitudes towards mental illness is a sensitive one, and social desirability may have affected responses. In addition, the focus group design lends itself to possible threats to internal validity, since discussing topics in a group format might differ from what one might discuss in a one-on-one interview (Sagoe, 2012). The participants in this study were predominately Caucasian who may have a different experience when compared to other racial and ethnic groups. As well, participants were employed at a university located in the southeastern United States. Thus their education level and exposure to mental health issues and treatment may have impacted their beliefs. The majority of participants indicated that they had previously sought treatment for a mental health concern ($n = 7$) and indicated the treatment they received was helpful. Therefore, our sample might be unique in that most had favorable opinions about mental health treatment and had struggled with a mental health concern themselves. Subjectivity should also be taken into consideration, as it is impossible for researchers to be completely objective. However, it is important to note that as discussed in the methods, many steps were taken to enhance the trustworthiness of the study (Lincoln & Guba, 1985).

Future directions for this line of inquiry might look at particular types of personal experience (e.g., one's own experience, of family members or acquaintances) and how these impact attitudes differently. In fact, given the variety of types of stigma (e.g., self-stigma, help-seeking stigma) research could examine how different types of familiarity impact the variety of types of stigmas. While this study explored personal and cultural impacts on attitudes qualitatively, a larger-scale, quantitative investigation on this topic would add to the counseling literature as well. Future research should aim to include a diverse sample so that generalizability can occur. Similar investigations might also explore what in particular has helped lessen the stigma associated with certain mental illnesses as well, so that these might be applied to more serious issues. Media efforts to destigmatize mental illness could be researched to determine the impact on attitudes and stigma. Perhaps stigma and negative attitudes can be decreased with this type of information, education, and exposure.

Conclusion

The current study sought to examine participants' views on mental illness stigma and barriers to help-seeking. Specifically, the current study investigated perceptions of the term, *mental illness stigma*; the common negative views in our culture about mental illness that might cause stigma; and the influence of stigma on seeking assistance for a mental health concern. Findings suggest that personal experience with mental illness plays an important role and impacts attitudes. As well, the findings suggest a decrease in negative attitudes towards mental illness deemed less serious and more frequent in society. The study contributes to the scholarly literature on mental illness stigma and offers a deeper understanding of views related to mental health stigma and how these relate to reluctance towards seeking mental health treatment.

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Appendix**Focus Group Questions**

The following questions were used in this study to explore participants' experience with mental illness:

1. We are studying negative attitudes that people hold toward mental illness and seeking help for mental health problems. Some researchers call this term mental illness stigma. Can you tell us in your own words, what you think the term mental illness stigma means?
 2. What are some of the negative views our culture, in general, has about mental illness that might cause stigma?
 3. Some researchers believe that stigma gets in the way of people seeking assistance for a mental health concern. Do you agree that this might prevent people from seeking help?
 4. How do you think mental illness stigma applies or doesn't apply to people you know, or people in general? In other words, have you known people who have feared seeking mental health treatment because of stigma? If yes, then what were the fears, hesitations, or possible negative consequences of seeking help for mental health treatment?
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