

2020

Professional psychologists and mental health stigma: Exploring a complicated relationship

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Professional psychologists and mental health stigma:

Exploring a complicated relationship

by

Lily A. Mathison

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Psychology (Counseling Psychology)

Program of Study Committee:
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The student author, whose presentation of scholarship herein was approved by the program of study committee, is solely responsible for the content of this dissertation. The Graduate College will ensure this dissertation is globally accessible and will not permit alterations after a degree is conferred.

Iowa State University

Ames, Iowa

2020

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DEDICATION

I dedicate this dissertation to all the professional psychologists out there who straddle the divide between wounded and healer – who themselves have experienced mental illness or who have suffered adversity and who use those experiences to promote healing in their clients.

I see you; you are not alone.

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ACKNOWLEDGEMENTS

I would like to thank those who helped me find my way along the long, winding path of completing a dissertation. First, thank you to my major professor, Nathaniel Wade. Your guidance and patience were invaluable and your continued belief in me gave me the push I needed to finish. Also, I appreciate your willingness to engage in this neglected and controversial topic with me – I am hoping this project may start a conversation.

Likewise, thank you to Courtney Plante for being my sounding board and on-call statistics consultant throughout this process; I appreciate the many Sundays you took out of your schedule to help me.

Next, thank you to my committee members, Meifen Wei, Warren Phillips, Marcus Crede, and Kevin Blankenship for their insights and guidance. Thank you for believing in my project and showing me how push it even further.

Also, thank you to my friends and family who supported me through this process; I couldn't have done this without you.

Finally, thank you to all the licensed psychologists who completed my survey. I appreciate your openness and honesty in answering my survey – this dissertation would not have been possible without you.

ABSTRACT

This was the first study in 18 years to assess licensed psychologists in the United States for their own mental illness and mental health treatment history. It is the only known study linking U.S. psychologists' own mental health to stigmatizing attitudes toward people with mental illness. The primary hypothesis, based on Allport's contact hypothesis and Pettigrew's intergroup contact theory, that increased levels of contact with people with mental illness would predict lower levels of stigma, was not supported. Instead a complex relationship between psychologists' own mental illness, current psychological distress, and mental health stigma emerged.

Despite the past finding that psychologists with their own experiences of mental illness and adversity experience stigma from other psychologists, in the present study the majority of the 143 participants reported personal experience with mental illness. In fact, 73% reported experiencing a mental illness and 76% reported having sought treatment for a mental illness in their lifetimes – findings similar to past studies. In contrast, over 75% scored in the nonclinical range on current psychological distress. Despite past life experiences, when psychologists had higher levels of psychological distress their self-stigmas of seeking help and mental illness increased and they identified less with other psychologists. Furthermore, the less psychologists identified with people with mental illness the more they personally endorsed stigma against people with mental illness. I suggest that, instead of stigmatizing psychologists with past and current mental illness, we as psychologists instead strive for openness and support in order to encourage growth and resiliency among colleagues.

CHAPTER 1. GENERAL INTRODUCTION/OVERVIEW

Mental illness stigma is powerful; its effects pervasive and grievous. People with mental illness often face discrimination in employment, housing, health care, and social interaction (Bathje & Pryor, 2011; Corrigan, Roe, & Tsang, 2011). While it is estimated that about one in four adult Americans suffer with a diagnosable mental illness during the course of a year (Kessler, Chiu, Demler, & Walters, 2005), less than one third of those will seek treatment from a mental health professional (Bathje & Pryor, 2011). This is considering ample evidence that mental health treatments work (Wampold & Imel, 2015). While the reasons behind this paradox are varied, mental health stigma is one of the most critical factors (Bathje & Pryor, 2011; Henderson, Evans-Lacko, & Thornicroft, 2013).

Mental health related stigma research has grown over the past 20 years, growing out of a larger body of stigma research. It built off Goffman's (1963) seminal work on stigma describing it as the view non-stigmatized individuals, or "normals" as he calls them, have of those with a stigmatized identity as not quite human, and so these normals do not feel the need to treat them with the same respect and dignity as other humans. After Goffman, stigma research developed around a diverse set of issues, only one of which was mental illness. There was little agreement on a definition of stigma. Link and Phelan (2001) came in and provided a conceptualization of stigma that could be used across disciplinary fields. Researchers focusing on mental health related stigma defined mental illness stigma (i.e. Corrigan, 2004), developed distinctions between mental illness stigma and help-seeking stigma (i.e. Komiya, Good, & Sherrod, 2000; Tucker, Hammer, Vogel, Bitman, Wade, & Maier, 2013), and distinctions between public stigma and self-stigma (i.e. Ben-Porath, 2002; Corrigan, Kerr, & Knudsen, 2005; Vogel & Wade, 2009). Finally, personal stigma functions as the public stigma that a person believes him or herself,

rather than that a person reports what others believe (Schnyder, Panczak, Groth, & Schultze-Lutter, 2017; Eisenberg, Downs, Golberstein, & Zivin, 2009).

While the presence of mental health stigma has been well explored in the general population, equally rigorous studies exploring this stigma in mental health professionals have been far scarcer. What studies there have been indicate that mental health professionals have the same levels of mental illness stigma as the general population, if not more (Schulze, 2007). What is concerning about this is that, although the general population has no systematic opportunity to act on their stigma, mental health professionals have a direct impact on people with mental illness as a function of their profession. People who use mental health services have reported a variety of negative experiences with mental health professionals (Schulze, 2007; Knaak, Mantler, & Szeto, 2017).

In addition, mental health professionals who have their own mental illness have reported experiences of stigmatization from colleagues (Knaak et al., 2017; Zeruvabel & Wright, 2012; Cain, 2000). This is considering that studies have estimated 60-70 percent of psychologists have experienced some mental illness – in most cases mild to moderate depression – in their lifetime (Pope & Tabachnick, 1994; Gilroy, Murra, & Carroll, 2002; Tay, Alcock, & Scior, 2018). That said, far fewer psychologists (about 10 percent or less) reported having what might be categorized as severe mental illness, including severe depression, psychosis, bipolar disorder, more than passive suicidal ideation, or any mental illness that resulted in hospitalization (Pope & Tabachnick, 1994; Gilroy, Murra, & Carroll, 2002; Tay, Alcock, & Scior, 2018). As far as this author knows, this paradoxical relationship between psychologists' own mental illness and their stigmatizing attitudes toward others with mental illness has not been explained in the literature.

In any case, the level of mental health professionals' mental illness stigma is striking when considered through the lens of the contact hypothesis and intergroup contact theory, as mental health professionals have regular interaction with people with mental illness, which – under the right conditions – could reduce prejudice or stigma (Allport, 1954; Pettigrew, 1998, 2011). Conditions of the contact hypothesis include that the two groups have equal status in the contact situation, must be working for common goals, be cooperating with one another rather than competing, and have support from authority, law, or custom. Intergroup contact theory posits the process by which the contact hypothesis works. This includes four processes of change: learning about the outgroup, changing behavior, generating emotional ties like one sees in friendship, and proving insight about the ingroup as well as the outgroup.

In order to better understand the complicated relationship between mental health professionals (in this case psychologists) and their clients/patients, a study of their stigma levels, their own mental illness, and their amount of contact with clients and others with mental illness is needed.

The Present Study

In the present dissertation, I collected information on psychologists' own history of mental illness and experiences with mental health treatment and their level of mental health related stigma toward the general population and psychologists with mental illness. I applied that information to test Allport's contact hypothesis and Pettigrew's intergroup contact theory in this population. The sample included 143 licensed psychologists contacted through various American Psychological Association (APA) Division listservs and state psychological association listservs. Then I used bivariate correlations and a series of hierarchical regressions to test how different

levels of contact influence four kinds of stigma: personal stigma of mental illness, personal stigma of seeking help, self-stigma of mental illness, and self-stigma of seeking help.

CHAPTER 2. LITERATURE REVIEW

As recounted by Corrigan, Roe, and Tsang (2011), many aspects of mental health stigma have been around for millennia. Greeks of the classical era reflected stigma of mental illness through beliefs that mental illness came about through displeasure from the gods; ancient plays showed deities damning people with psychosis, bipolar, or depression. Relics from ancient Egypt show attempts to cure individuals of demon possession, of mental illness. Ancient Hebrews punished disturbed behavior by death; Mayans and Aztecs threw out demons by human sacrifice. In the religious fervor of the Middle Ages in Europe, symptoms of mental illness were seen as a result of the individual's wickedness, demon possession requiring exorcism, or even burning at the stake in order to erase wickedness from the community. Even as late as the 18th and 19th centuries the practice was to put people with mental illness into asylums: chaining people to walls, denying them basic needs such as food or clothing, and "treatments" that terrified patients. It was not until there were movements in several countries around the 1800's that "moral" treatments were advocated for, including treating the individual with respect and kindness and establishing asylums that were less like prisons and more like retreat centers. The advent of psychiatric medication in the 1950's allowed many who lived with chronic mental illness to have control over symptoms, allowing some to return to their communities instead of living in asylums.

This is not to say that mental health related stigma does not exist today, by any stretch of the imagination. Mass media, an immensely influential source of stigma, depicts people with mental illness as dangerous, unpredictable, or inept (Corrigan, Roe, & Tsang, 2011). One only has to look at the headlines regarding mental illness or recent films that depict mental illness. Mass shooting? More often not they are attributed to serious mental illness or "dangerous

people” rather than “dangerous weapons,” according to one study that looked at news stories from 1997-2012 (McGinty, Webster, Jarlenski, Barry, 2014; p.406). In a similar study of 400 news stories about mental illness from 1995-2014, the most common topic in relation to mental illness was violence (57%), with mentions of mass shootings being more common in the second decade than the first (McGinty, Kennedy-Hendricks, Chosky, & Barry, 2016). Notable films depicting people with mental illness as violent include *Psycho* (Hitchcock, 1960) about a violent, mentally unstable hotel owner; *Silence of the Lambs* (Demme, 1991) with the unforgettable Hannibal Lector, a former psychiatrist in a hospital for the criminally insane after being caught cannibalizing his victims; *Shutter Island* (Scorsese, 2010) with its depiction of dozens in a hospital for the criminally insane; and *Split* (Shyamalan, 2016) where a man with dissociative identity disorder kidnaps three girls (Morris, 2016; Kondo, 2008). Corrigan and colleagues noted that the stigma of mental illness has been worsening over the past 50 years (2011)¹.

The effects of media portrayals as well as other factors that influence mental health related stigma are far reaching and impact the daily lives of people with mental illness. The Behavioral Risk Factor Surveillance System (BRFSS) group surveyed adults in 37 U.S. states and territories about their attitudes toward mental illness. Based on their data a majority of adults agreed that treatment can help persons with mental illness lead normal lives, both individuals with psychological distress (78%) and without psychological distress (89%). Unfortunately, while 57 percent of the whole sample believed people are caring and sympathetic to people with mental illness, only 25 percent of adults who personally experienced psychological distress believed so (CDC, 2010). Furthermore, according to Mental Health America, 58 percent of

¹ For a more comprehensive list of negative portrayals of mental illness in the media, I suggest reading Corrigan and colleagues’ book, *Challenging the Stigma of Mental Illness*.

Americans do not want to have a person with mental illness in their workplace and 68 percent do not want one to marry into their family (2011). As previously mentioned, people with mental illnesses often face discrimination in health care, social interaction, housing, and employment (Bathje & Pryor, 2011). In addition, both the family and friends of a person with mental illness can experience stigma as well (Corrigan, Kerr, & Knudsen, 2005).

One would hope that mental health professionals would not hold such stigmatizing attitudes, however, what limited research has been done on the topic suggests that they have the same levels of stigma as the general population (Schulze, 2007). This is concerning as mental health professionals have far more direct contact with people with mental illness than the general population and have direct influence over their lives. People who use mental health services have reported a variety of negative experiences with mental health professionals including receiving threats of coercive treatment, being told they will not recover from their mental illness, receiving insufficient information about diagnosis and treatment options, being treated in a demeaning or paternalistic way, and being spoken to or about with derogatory or demeaning language (Knaak, Mantler, & Szeto, 2017).

What is more, mental health professionals stigmatize not only clients or patients, but colleagues with mental illness as well (Knaak, Mantler, & Szeto, 2017). Zeruvabel and Wright (2012) suggest that a false dichotomy is drawn in the world of psychological professionals that separates the wounded (client or patient) from the healer (psychologist). The authors posit that wounded healers, or individuals who identify as healing others through their history of mental illness, are a silenced and stigmatized minority among psychologists. However, these individuals could offer valuable insight into the relationships between mental health professionals and their

clients and facilitate a decrease in the stigma professionals hold against people with mental illness.

Now that we have some background on mental health related stigma, it is important to establish a theoretical understanding of the construct of stigma and how it works. But first, a note about terminology.

Stigma vs. Prejudice

The terms “stigma” and “prejudice” will both come up in this dissertation, and therefore a review of their evolving definitions is warranted. Definitions of the two were penned by the seminal authors Allport and Goffman. Allport’s definition of prejudice was centered around ethnic prejudice and was defined as, “an antipathy based upon a faulty and inflexible generalization. It may be felt or expressed. It may be directed toward a group as a whole, or toward an individual because he is a member of that group” (1954, p.9). Goffman’s definition of stigma, on the other hand, is when a person is denied full social acceptance and the stigmatized individual is “reduced in our minds from a whole and usual person to a tainted, discounted one” (Goffman, 1963, p. 3). From that point, two distinct literatures formed with little cross communication until the 1990’s.

Because it is not unheard of for two literatures to develop around basically identical concepts, Phelan, Link, and Dovidio (2008) reviewed 18 models of prejudice and stigma to determine whether the two concepts were, in fact, distinct. They concluded from their study that stigma and prejudice are essentially “the same animal” with most differences being a function of focus and emphasis (Phelan, Link, & Dovidio, 2008; p. 367). The most salient distinction between the two was that prejudice generally focuses on race, ethnicity, and religion while stigma is more general and focuses on disease and disabilities as well as deviant behavior and

identities. Following Dovidio, Major, and Crocker (2000), the authors suggested using “stigma” to refer to a broader process including a variety of identities and characteristics and “prejudice” to refer to the attitudinal pieces of this process. That said, Phelan, Link, and Dovidio saw enough overlap between stigma and prejudice that they encouraged researchers to reach across the conceptual line when looking for theory, methods, and research findings to support future projects. This paper follows this suggestion and so the terms stigma and prejudice will serve as proxies for one another.

Roots of the Study of Stigma

As alluded to above, a seminal work in the study of stigma was Erving Goffman’s *Stigma: Notes on the Management of Spoiled Identity* (1963). As a note, in the work he refers to the stigmatized individual as a person with a stigma and a non-stigmatized individual as a “normal.” Goffman (1963) offers several important implications of having a stigmatized quality or identity, or a stigma. He asserts that normals “believe the person with a stigma is not quite human” (p. 5). This is stigma in its essence; that because normals do not think of stigmatized individuals as entirely human they are not required to treat them with the respect and dignity owed human beings. Goffman posits that, “On this assumption [normals] exercise varieties of discrimination, through which [they] effectively, if often unthinkingly, reduce [the stigmatized individual’s] life chances” (p.5). Due to the negative implications of being stigmatized, a stigmatized individual will often attempt to conceal the stigmatized trait.

Goffman (1963) divides stigmatized individuals into two groups, those who are *discredited* or those for whom their stigmatized trait is readily apparent, and those who are *discreditable* or those for whom their stigmatized trait is not readily apparent. Some examples of people who are discredited include people in wheelchairs, people with dark skin, or people in

specific religious garb such as a turban or a hijab. Some examples of people who are discreditable include people with mental illness, queer individuals, or people with ambiguous skin color. Those who are discredited are immediately subject to prejudice and discrimination while those who are discreditable can hide the stigmatized trait to avoid prejudice and discrimination but must always be fearful of being discovered.

Furthermore, Goffman (1963) states that “the stigmatized individual tends to hold the same beliefs about identity” that normals do (p.7), meaning that even if he or she does succeed in hiding their stigmatized trait they may internalize the negative beliefs. This can lead to self-loathing because one does not see oneself as completely human.

Goffman’s conceptualization of stigma in general is readily applied to the stigma associated with having a mental illness. People with mental illness have a discreditable stigma in that most people with mental illness can hide that they have a mental illness. However, when the mental illness is discovered, they regularly face discrimination in employment, housing, healthcare, and social interaction (Bathje & Pryor, 2011). Furthermore, as described in more detail later, there is a process of internalizing stigma beliefs that further impacts the individual.

For the purposes of this dissertation, stigma is defined as “a mark of shame associated with a specific condition or characteristic” (Lannin, Vogel, Brenner, & Tucker, 2015; p. 65; Goffman, 1963). More recent research has delineated several important variations of mental illness stigma that play a role in the process of seeking mental health treatment.

Link and Phelan’s Conceptualization of Stigma

Almost 40 years after Goffman’s seminal work, Link and Phelan (2001) sought to conceptualize stigma. After Goffman’s essay there was an abundance of research on stigma in diverse areas, from mental illness to leprosy to exotic dancing. Researchers were not all

psychologists, either, as stigma research has been multidisciplinary through the years. Sociologists, anthropologists, political scientists, and social geographers have all been involved. As one might imagine, definitions of stigma varied, sometimes due to the type of stigma (e.g., mental illness vs. leprosy), sometimes as a result of differences in disciplinary field. But even within disciplines, there has been variation in stigma definitions. Link and Phelan (2001), both sociologists, sought to conceptualize stigma in a way that would synthesize the literature but still allow for some variation based on context and discipline.

Link and Phelan's conceptualization contained four components: labeling, stereotyping, separation, and status loss and discrimination (2001). The first component, labeling, is the process by which society takes aspects of human difference (sometimes alleged human difference), draws attention to certain aspects, and assigns salience to them. The idea behind this is that there are all sorts of human difference that are ignored, such as the color of one's car or the size of one's feet. The authors give an example of how in the late 19th century small foreheads and large faces were labeled as ape-like and thought to indicate that the people with these features had criminal natures. The word "label" as opposed to "attribute" or "condition" is important because, unlike the other terms, it does not imply that the designation has validity. This distinction is key. The term "label" highlights the fact that the human difference has been named and designated as inferior by certain groups in a way that is not inherent to the human difference itself.

The second component, stereotyping, involves the process by which labeled differences are linked to stereotypes. This aspect of stigma was emphasized by Goffman (1963) and is central to many definitions of stigma, especially in psychology. Link and Phelan give an example from a study completed by Link and colleagues (1987). The study consisted of vignettes which

were randomly assigned to participants. In half of the vignettes the characters were labeled as “former mental patients” and in the other half “former back-pain patients.” The study measured rejecting responses toward the vignette character and to what extent participants believed that mental patients were dangerous in general. The authors found that when the character was labeled as a former back-pain patient endorsement of the dangerousness of mental patients did not predict rejecting responses. In contrast, when the character was labeled as a former mental patient endorsement of the dangerousness of mental patients predicted rejecting responses. Participants only attached the negative stereotype to the character when he or she had been labeled (Link, Cullen, Frank, & Wozniak, 1987).

The third component of stigma in Link and Phelan’s conceptualization is separation, or when the label suggests a separation of “us” and “them” (2001). Linking labels to undesirable characteristics, then, is the reason behind believing that labeled people are fundamentally different from those who are not labeled. When labeled people are considered distinct, or “different than,” stereotyping is easily employed, because it doesn’t impact the person stereotyping to affix all types of bad characteristics to “them.” This is where Goffman asserts that normals (non-stigmatized people) “believe the person with a stigma is not quite human” (1963; p. 5). This component of stigma is revealed in the way people commonly talk about stigmatized people. For example, a person with schizophrenia is frequently called a “schizophrenic,” but less stigmatized conditions are not spoken about this way; people have the flu or cancer, they are not considered synonymous with their condition, for example, by being labeled an “influenzic” or a “cancerite” (Link & Phelan, 2001).

The fourth and final component of stigma includes both status loss and discrimination. Status loss has to do with one’s relative place in the status hierarchies that occur in everyday

situations, such as meetings, classes, or conversations. Some characteristics, like race and gender, impact status hierarchies even if the characteristic has nothing to do with the person's proficiency in the task at hand. For example, men and European Americans are more likely than women and African Americans to have higher status – they talk more often, their ideas are more likely to be accepted, and they are more likely to be chosen as leaders. This component often occurs outside awareness such that it can be difficult to specify exactly what caused the unequal outcome, but nonetheless unequal outcomes result (Link & Phelan, 2001).

The other part of the fourth component, discrimination, occurs on multiple levels, individual and structural. On an individual level, discrimination occurs when an individual person acts against a person with a stigmatized trait, whether overtly or covertly. For example, overt discrimination occurs when a person rejects a job application from or refuses to rent an apartment to a person with a stigmatized trait whether that person makes their reasoning clear or not. On a structural level, discrimination can be more insidious and have a far-reaching impact. One example the authors gave was how schizophrenia is a particularly stigmatized mental illness. Treatment facilities for schizophrenia are either isolated from other people or in disadvantaged neighborhoods that do not have enough influence to keep away the treatment facility. Furthermore, the most successful mental health professionals treat people with less stigmatized and perhaps less serious mental illnesses in more affluent areas that people with schizophrenia cannot always access. Thus, whether or not an individual may overtly discriminate against a person with schizophrenia, the institution is set up in a discriminatory manner (Link & Phelan, 2001).

Link and Phelan (2001) emphasize that “it takes power to stigmatize” (p.375). It is easy to focus so much on the stigmatized trait that one is unaware of the power differential between

the stigmatized and the non-stigmatized. The authors offer an example of a patient in a program for people with severe mental illness. Even if the patient were to label a particular provider a “pill pusher” and engage in all of the stigmatizing components discussed above, the provider would not be stigmatized because the patient does not possess the power to enact any serious consequences on the provider. A person must control some sort of access to resources such as education, employment, housing, or health care to make it so that the distinctions they draw have a wider impact. Without power, some of the components of stigma might exist, but the whole beast would not be present (Link & Phelan, 2001).

Public vs. Self-Stigma of Mental Illness

Public stigma of mental illness. Whereas Link and Phelan (2001) conceptualized stigma as a whole, Corrigan (2004) conceptualized stigma as it relates to mental illness in particular. He notes the importance of four social-cognitive processes in relation to stigma: cues, stereotypes, prejudice, and discrimination. To begin, the general public may believe that a person has a mental illness based on cues, such as psychiatric symptoms, physical appearance, deficits in social skills, and the label of mental illness as given by a mental health professional or as inferred when a person walks out of a mental health professional’s office. Once the general public is cued in that a person has a mental illness, stereotypes are then brought to mind. Stereotypes allow people to quickly draw conclusions about social groups. In the case of mental illness, some common stereotypes include that people with mental illness are dangerous, incompetent, or to blame for their condition. People who are prejudiced against people with mental illness endorse the negative stereotypes and have negative emotional responses as a result. Finally, the prejudice (a cognitive and affective response) leads to discrimination (a

behavioral response). Discrimination includes negative actions against people with mental illness or, conversely, positive actions only for people without mental illness.

Public stigma of mental illness includes the negative stereotypes, prejudice, and discrimination of those known to have a mental illness (Corrigan, 2004; Corrigan, Kerr, & Knudsen, 2005). Examples of public stigma include not wanting to have a person with mental illness marry into one's family, being more negative and critical of a job applicant who identifies as having a mental illness, or not wanting a person with mental illness to serve in a position of authority (Corrigan, 2004; Link, 1987). They are, in essence, society's negative attitudes toward people with mental illness.

Self-stigma of mental illness. Prejudice and discrimination against those with a mental illness are heavy burdens to carry for many people with mental illness. However, the effects of stigma do not stop there, as stigma can be internalized. Self-stigma of mental illness occurs when an individual with mental illness internalizes public stigma, leading to lower self-esteem, self-efficacy, and hope for one's future (Corrigan, 2004; Vogel, Wade, & Haake, 2006). As suggested by Goffman "the stigmatized individual tends to hold the same beliefs about identity" as the general public, namely that stigmatized individuals are less than human (Goffman, 1963, p.7). Link (1987) provides an excellent example – patients who had been hospitalized and who endorsed stigmatizing beliefs about patients like themselves experienced worse outcomes, such as loss of income and unemployment, than those who did not. This can be because self-stigma may impact a person's pursuit of life goals such as obtaining employment and developing relationships via the "why try" effect (i.e., why should I try to have a relationship? Someone like me can't handle one; Corrigan, Roe, & Tsang, 2011). Self-stigma can also impact whether a person will be compliant with treatment, continue going to therapy, or even seek mental health

services to begin with (Tucker et al., 2013). This can seriously slow the process of recovery from mental illness and make worse an already troubling problem.

Thus, having a mental illness can carry both public and self-stigma. However, there is also stigma associated with seeking psychological help (e.g., psychotherapy). Help-seeking stigma has been found to be distinct from mental health stigma, explaining unique variance in attitudes toward and intentions to seek psychotherapy (Tucker et al., 2013).

Help-Seeking Stigma

Despite strong evidence that psychological treatments work (e.g. Wampold & Imel, 2015), treatment utilization rates are low, with estimated annual rates between 1% and 15% worldwide (Demyttenaere et al., 2004). This leads to unnecessary suffering in addition to aggravating the interpersonal costs of mental illness and economic burdens related to disability due to mental illness (Schnyder, Panczak, Groth, & Schultze-Lutter, 2017). Help-seeking stigma is a barrier in the help-seeking process (Vogel et al., 2017), the size of that effect on help-seeking is estimated to be small to moderate (Clement et al., 2015).

Four types of stigma influence help-seeking: perceived public stigma, personal stigma, self-stigma, and attitudes toward seeking psychological services (Schnyder et al., 2017). Perceived public stigma and personal stigma are both types of public stigma, and so are similar to the public stigma of mental illness as described above. Public stigma of help-seeking here is defined as “an external form of stigma that denotes the perception held by society that individuals are undesirable or socially unacceptable if they were to seek help” (Vogel et al., 2017; p. 3). Perceived public stigma, then, is an individual’s perception of society’s stigma of help seeking whereas personal stigma is the stigma that an individual holds him or herself toward others who seek help (Schnyder et al., 2017; Eisenberg, Downs, Golberstein, & Zivin, 2009).

Eisenberg and colleagues (2009) conducted a study to parse out the difference between perceived public stigma and personal stigma. They hypothesized that perceived public stigma and personal stigma would be independently associated with less help-seeking behavior. They surveyed 5,555 college students across 13 universities in various locations around the United States. They found that not only are perceived public stigma and personal stigma different, with only a moderate correlation, but that only personal stigma (not perceived public stigma) was associated with measures of help-seeking. Also, perceived public stigma was significantly higher than personal public stigma.

In contrast to public and personal stigma, the self-stigma of seeking help is defined as “the perception held by the individual that he or she is undesirable or socially unacceptable if they were to seek help” (Vogel et al., 2017; p. 3). Vogel, Bitman, Hammer, and Wade (2013) conducted a longitudinal study assessing for the relationship between public stigma and self-stigma of seeking help. They surveyed 448 college students at a large university in the Midwestern United States once (Time 1), then again at second point three months later (Time 2). They found that public stigma at Time 1 predicted self-stigma at Time 2, but that the converse was not true. This, they asserted, was evidence that public stigma was internalized as self-stigma.

Tucker and colleagues (2013) assessed for whether there is a clear distinction between the self-stigma of mental illness and the self-stigma of seeking psychological services. They surveyed 217 undergraduates at a large university in the Midwest with clinical distress in addition to 324 web-based community members who self-reported having one or more mental illnesses. The authors found that not only were the two self-stigmas distinct, they found that each self-stigma was strongly and independently related to their corresponding public stigma. In other words, the self-stigma of mental illness was strongly related to the public stigma of mental

illness, but not the public stigma of help-seeking and the self-stigma of help-seeking was strongly related to the public stigma of help-seeking, but not the public stigma of mental illness. Each stigma operated in its own pathway.

Attitudes toward seeking psychological services includes several aspects such as the perceived need for services, the tolerance of stigma related to getting services, and confidence that one will find relief with the services (Schnyder et al., 2017). Attitudes toward seeking services was found to be one of the most proximal predictors of intentions to seek counseling (Vogel & Wester, 2003). Vogel and Wester's (2003) article sought to understand the role that avoidance factors, most importantly the fear of self-disclosure, played in attitudes and intentions to seek counseling. Previous research had focused only on approach factors, such as need for social support, distress levels, and previous experience with counseling. Across two studies with, respectively, 209 and 268 college students the authors found that avoidance factors accounted for at least as much variance as approach factors and that avoidance factors predicted negative attitudes toward counseling which predicted negative intentions to seek counseling. In a follow up study with 354 college students, Vogel, Wester, Wei, and Boysen (2005) found that 11 psychological factors (such as social stigma, treatment fears, self-disclosure) and attitudes toward seeking counseling predicted more than 60% of the variance in intent to seek help for interpersonal problems and 18% of the variance for intent to seek help for drug problems. In addition, attitudes mediated most of the relationship between the psychological factors and intent to seek counseling.

Self-Stigma Model

Vogel, Wade, and Hackler (2007) brought together research on public stigma, self-stigma, attitudes toward seeking psychological services, and intentions to seek services into one

model. Using data from 676 college students, the authors employed structural equation modeling (SEM) and showed that the relationship between perceived public stigma and intentions to seek counseling was fully mediated by self-stigma and attitudes toward seeking counseling (i.e., public stigma → self-stigma → attitudes → intentions). In an effort to find if this model generalized to international populations, Vogel and colleagues (2017), tested the public stigma→self-stigma→attitudes relationship with a sample of 3,276 college students from 10 international sites (Australia, Brazil, Canada, Hong Kong, Portugal, Romania, Taiwan, Turkey, United Arab Emirates, and United States). Again, using SEM the authors found that the relationship between public stigma and attitudes was mediated by self-stigma at each site.

It should be noted that one limitation of the self-stigma research is that it has primarily been conducted with college students. It is important to expand the above findings to see if they apply to other populations, such as the population of interest in this paper, psychologists. As we shall see, psychologists experience their own mental health problems and experience the stigma of mental illness and help-seeking just as college students do. Furthermore, there are factors that complicate psychologists' decisions to seek help that do not apply to college students.

Psychologists' own Mental Illness

In 1994, Pope and Tabachnick published a study assessing psychologists' mental health and experiences with mental health treatment. Questionnaires were mailed to 800 randomly selected psychologists (400 men and 400 women) from the APA's Divisions 12 (Clinical Psychology), 17 (Counseling Psychology), 29 (Psychotherapy), and 42 (Psychologists in Independent Practice). Their sample included 476 respondents. In their study, 61% of participants reported at least one episode of clinical depression in their life, 15% had taken psychotropic medication as a part of their treatment, and 3.8% had had a psychiatric hospitalization. While specific diagnoses were not collected, it was clear that mental health

concerns among psychologists were not uncommon. In 2002, Gilroy, Murra, and Carroll performed a similar study, this time looking at counseling psychologists' personal experiences with depression and treatment. Questionnaires were mailed to 1000 randomly selected members of Division 17 (Counseling Psychology) of the American Psychological Association (APA) who were either full- or part-time licensed clinicians. There were 425 respondents. Out of the 425, 62% self-identified as depressed with the preponderance of those experiencing dysthymia (chronic mild depression) and adjustment disorder with depressed mood. Forty-two percent reported experiencing some form of suicidal ideation or behavior. Thirty-one percent reported that they had been prescribed psychotropic medication. Finally, 2% reported having been hospitalized for depression. Some level of depression, therefore, is common among psychologists.

Interestingly, the most commonly reported negative impact on the psychologists' collegial relationships was a sense of withdrawal and isolation from colleagues while being depressed. The experiences of psychologists with depression reflects a typical occurrence for those with depression; people with depression in general often deal with negative attitudes, rejection, and devaluation from others including psychotherapists (Gilroy, Murra, & Carroll, 2002).

In a recent study of clinical psychologists in the United Kingdom, Tay, Alcock, and Scior (2018) found similar figures to Gilroy and colleagues (2002). An invitation to complete the survey was emailed to the 3,600 qualified clinical psychologists who were on the mailing list of the British Psychological Society's Division of Clinical Psychology (DCP). Six hundred seventy-eight responded with usable data. Two-thirds of respondents had experienced some sort of mental health problems. Of those, 69.9% experienced mild to moderate depression, 42.1%

anxiety, 12.9% severe depression, 11.1% eating disorders, 4.2% addiction, 3.3% psychosis and 1.2% bipolar disorder (with some reporting comorbidities).

The negative collegial experiences of psychologists with depression have been documented elsewhere. In a qualitative study of psychotherapists with mental illness, Cain (2000) found that stigma was the primary reason participants in her study were hesitant to disclose their psychiatric histories to colleagues and supervisors. In fact, to varying degrees all participants reported that the stigma of mental illness was present in the mental health system.

Psychologists' Own Help-Seeking

Even though they did not ask about psychologists' experiences with help-seeking per say, Pope and Tabachnick (1994) asked their sample of 476 psychologists who were part of the APA about their experiences with psychotherapy. Most of the respondents ($n = 400$, 84%) reported having been a therapy client at some point in their lives, with 100 respondents (21%) reporting they were in therapy at the time they took the survey. Of the 300 therapists who had previously been in therapy but were not currently in it, 188 had considered resuming therapy. Only 15 percent had taken psychotropic medication as a part of their therapy and 4 percent had been hospitalized.

Gilroy and colleagues (2002) asked their sample of 425 Counseling Psychologists about their experiences with psychological treatment as well, while also collecting some information on help-seeking. Of their sample, 264 (62%) self-identified as depressed. Of the 264, 178 (67%) sought treatment for their depression symptoms. Thirty-one percent, or 58, of those who had sought treatment for depression reported having been prescribed psychiatric medication. Only 2% (3) reported being hospitalized for depression. Some of the reported reasons for not seeking treatment included that symptoms went away, alternative coping strategies were sought, there

was not an acceptable therapist nearby, that there was no therapist nearby the participant did not already know, concerns about confidentiality, concerns about censure, not wanting to invest the energy, financial concerns, significant other not willing, belief that therapy wouldn't work, and an unwillingness to admit the seriousness of the problem. It is important to note that some of the reasons for not seeking therapy, such as financial concerns and not wanting to invest the energy, could be said of any person with mental health concerns. However, there were some reasons that were specific to mental health professionals, such as that there were no therapists available that the participant didn't already know. Some of the noted stipulations for seeking a therapist were also specific to mental health professionals, such as finding a therapist with whom one had no professional conflicts of interest and feeling safe in terms of confidentiality. Confidentiality would be particularly a problem for mental health professionals as they may have extensive professional contacts within the therapist community from which they are seeking treatment. For example, it may be a problem for a psychologist wanting therapy to go to a practice or center where they know anyone on staff, as simply being seen in the waiting room could feel like confidentiality is being breached. It can also be tricky if the therapist of the psychologist seeking help is in a consulting group with someone that the psychologists knows, as one's confidentiality could feel at risk in that case as well.

In their recent study, Tay and colleagues (2018) found that of the 425 participants (psychologists in the United Kingdom) who had experienced a mental health problem in their sample, 357 (84%) had sought help. The majority, 53.2%, had sought help from a general practitioner and slightly less than a majority, 45.6%, had seen a private psychotherapist and another 11.3% reported seeing a psychotherapist through the National Health Service (NHS), the United Kingdom's free, state-sponsored health care system. Others had seen a private clinical

psychologist (13.2%), or a psychiatrist, privately (3.8%) or through the NHS (10.1%). Only 46 participants (16%) of those who reported a mental illness had sought help from no one. Of those 46, over two thirds reported that they feared being judged negatively and that there would be a negative impact on their career if they disclosed. Shame and worry about negative impact on their self-image were also reported as reasons for not disclosing. The authors reported that those who had disclosed to no one had significantly higher self-stigma than those who had sought professional help.

Intergroup Contact Theory

Mental health professionals and people with mental illness represent two groups to which intergroup contact theory can be applied. In this case, people with mental illness represent the more stigmatized and less powerful group, whereas mental health professionals the more powerful group. As mentioned above, mental health professionals exhibit stigma against people with mental illness just as people in the general population do. They keep social distance between themselves and people with mental illness, especially people with more severe mental illness such as schizophrenia and borderline personality disorder (Schulze, 2007). Another recent study compared the implicit and explicit attitudes toward people with mental illness of professionals (psychiatrists and psychotherapists, $n = 29$) and non-professionals (first-year medical students, $n = 28$) at the University of Warsaw in Poland. In this case, with regard to the explicit attitudes, the professionals reported significantly more willingness to approach people with mental illness than non-professionals, with no difference in the withdrawal or distancing emotions between the two groups. In contrast, on the Go/No Go Association Task (GNAT), an implicit measure of attitudes toward people with mental illness, the two groups did not differ in their implicit attitudes, with both showing a significant tendency to associate “mentally ill” with “unpleasant” rather than “pleasant” (Kopera et al., 2015). This suggests that even if professionals

explicitly express fewer negative attitudes toward those with mental illness than non-professionals, their implicit stigma is similar. Furthermore, mental health professionals with their own mental illness have reported that the mental health system perpetuates mental illness stigma (Knaak, Mantler, & Szeto, 2017). If there is to be change in the way mental health professionals view and treat people with mental illness, including other professionals with mental illness, then it is important to understand intergroup contact theory and how it can be applied to the situation.

Intergroup contact theory has its roots in Allport's contact hypothesis (Pettigrew, 1998). In his hypothesis, Allport (1954) explained that four conditions are necessary for the intergroup contact to have positive effects, such as lowering stigma. The groups must have equal status within the contact situation; the groups must be working toward common goals; the groups must be cooperating with one another and not competing; and the groups must have support from authorities, law, or custom. When one or more of these conditions are violated, then the contact is hypothesized to have fewer positive effects. This was initially supported by research with European Americans and African Americans during desegregation in the United States. That said, in research over the past 50 years most studies have found positive effects from contact even in situations that lack one or more of the four conditions (Pettigrew, 1998).

Pettigrew (1998) developed intergroup contact theory to build on Allport's contact hypothesis. He noted that a major weakness in the contact hypothesis was that it said nothing about the process by which contact produces change in behavior and attitudes. He provided four processes of change through intergroup contact: learning about the outgroup, changing behavior (because behavior change often precedes attitude change), generating emotional ties in the intergroup relationship like one sees in friendship, and providing insight about the ingroup as well as the outgroup. The essence of these processes is that a friendship-like relationship needs to

develop in order for contact to have positive effects. This theory provided a corrective to the contact hypothesis and previous research, which focused more on the cognitive process by which prejudice is reduced. This was problematic because prejudice has both cognitive and affective components, so to ignore the affective components is to miss half the problem. In addition, as the development of friendship requires repeated contact over multiple situations, intergroup contact theory posits that the intergroup contact must occur repeatedly over time and in multiple situations for prejudice to decrease and for the decrease to generalize to other people and situations.

Pettigrew and colleagues (2011) more recently wrote a review of intergroup contact theory that included meta-analytic findings. The meta-analysis included 515 studies, both published and unpublished, including more than 250,000 subjects. In this review, the authors report that Allport's original conditions for optimal contact facilitate the reduction of prejudice but are not essential. In fact, despite the fact that the studies represented a variety of contact conditions, 94% of the studies found that contact reduced prejudice (mean $r = -.21$). Multiple types of intergroup prejudice were studied and found to be lessened by contact including subtle and blatant prejudice assessed with implicit and explicit measures. The results were found to generalize across 38 nations and occur not only for ethnic groups but also for other groups such as the LGBTQ+ community, people with disabilities, and people with mental illness. As theorized, it was found that intergroup friendship is especially important in this process. The most impactful mediators of the effect are essentially affective: increased empathy and decreased anxiety. Negative results from contact can occur, especially when the contact was not voluntary and was threatening. Lastly, the authors noted that segregation such as that found between Arabs and Israelis in Israel and historically in the American South and apartheid South Africa have

historically failed and inhibited any group contact from occurring, which prevents the possible reduction of prejudice.

Intergroup Contact Theory in the Client-Therapist Relationship

The case of mental health professionals interacting with people with mental illness is an interesting application of intergroup contact theory in considering whether professional contact should reduce mental health professionals' prejudice toward people with mental illness. There are many conditions that should facilitate positive contact between professionals and people with mental illness in a professional relationship. For example, there are generally common goals being worked on in a cooperative manner in such a professional relationship. Typically, authority supports mental health services; there are many public service campaigns to promote utilization of mental health services. That said, the stigma of seeking mental health services is strong, which could hinder or limit contact, although this effect would be more pronounced for the person with mental illness than the professional. Reportedly, both implicit and explicit prejudice should decrease as a result of contact. Even if professionals started out with lower explicit stigma contact should theoretically decrease implicit stigma as well. Finally, in the professional relationship there tend to be many contacts and not just one or two.

In addition to the positive conditions that the professional relationship provides for contact, there are also some negative conditions. There's certainly not equal status between a mental health professional and the client; there is a clear power differential between the two with the mental health professional having more power. We see this in the relationship itself, where the client is expected to divulge sensitive personal information while the professional is not. We also see this in the professionals' choice to take on a client for services or not, give homework outside of session, guide the session, diagnose the client, and even involuntarily hospitalize the

client in certain crisis situations. Furthermore, the professional relationship offers no possibility of friendship. This does not necessarily indicate that the professional could not experience a reduction in anxiety about interacting with people with mental illness nor that it couldn't increase empathy toward and knowledge of people with mental illness, however the professional relationship does not necessarily encourage their reassessment of their own group in relation to the other group, for example. Furthermore, ethical guidelines limit if not prohibit interaction between the client and psychologist outside of the therapy situation (APA, 2017), which could limit the generalizability of the contact's impact. In addition, depending on the professional's circumstances, the contact with people with mental illness could be perceived as nonvoluntary if the professional does not have control over which clients are assigned to them or if the professional finds the client threatening.

All of this, however, assumes that mental health professionals do not have mental illness. As discussed above, this is not a safe assumption. Researchers have found that about 60% of psychologists, one type of mental health professional, have experienced notable depression in their lifetime (Pope & Tabachnick, 1994; Gilroy, Carroll, & Murra, 2002; Tay, Alcock, & Scior, 2018). In this sense, many psychologists have occupied both the world of the professional and the world of the person with mental illness. With this statistic in mind, it is a surprising finding that mental health professionals should have the same or higher levels of stigma toward people with mental illness as the general population.

If one takes a closer look at the severity indicators in the three studies that have collected data on psychologists' mental illness and mental treatment, a more nuanced picture emerges (Pope & Tabachnick, 1994; Gilroy, Carroll, & Murra, 2002; Tay, Alcock, & Scior, 2018). Pope and Tabachnik found that although 61% of their sample had felt what the participant would

characterize as clinical depression, the number of participants who reported ever experiencing suicidal ideation was half that, and the number of participants who reported a psychiatric hospitalization or suicide attempt were only about 4% each. Gilroy and colleagues found that in their sample of counseling psychologists, of those who reported depressive symptoms about 69% reported that they were diagnosed with a mild depressive disorder such as dysthymia or adjustment disorder with depressed mood, while only 13% reported more than a mild depressive disorder. They found that 42% had had some sort of suicidal ideation with half that reporting more than passive suicidal ideation and less than 1% reporting a suicide attempt. Only 2% had reported experiencing psychiatric hospitalization. This indicates that a far smaller proportion of the two psychologist samples experienced what might be called a serious mental illness. Finally, in Tay and colleague's study in the United Kingdom, 69.9% of the participants who reported their own mental illness reported only mild to moderate depression, while only 12.9% reported severe depression, 3.3% reported psychosis, and 1.2% bipolar disorder. This might indicate more of a separation between client and psychologist than the numbers originally suggest.

The Current Study

In this dissertation, I gathered data about psychologists' own mental illness and mental health related stigma and related it to Allport's contact hypothesis (1954) and Pettigrew's (1998, 2011) intergroup contact theory. The data about psychologists' own mental illness included diagnosis, mental health treatment history, and a measure of current symptoms. This is to help clarify the current level of mental illness in psychologists to help tease out how the psychologists' own symptoms and experience of mental illness impact their stigma. Furthermore, this will provide updated figures of mental illness in psychologists in the United States, a population that has not been assessed for this since 2002.

The data about psychologists' own mental health related stigma included personal stigma of mental illness, personal stigma of help-seeking, self-stigma of mental illness, and self-stigma of mental illness. We collected data on the personal stigma of mental illness rather than the public stigma as items for the public stigma scales load on what attitudes participants believe others feel about people with mental illness, when in this study we are interested in their own beliefs about the same.

I tested the contact hypothesis by assessing for psychologists' ingroup identification with other psychologists, people with mental illness, and people who use mental health services as well as number of hours of contact (i.e. the number of hours per week the psychologist meets with clients); their familiarity with mental illness in any setting (e.g. a family member with a mental illness or have watched a film on mental illness); measuring egalitarianism in the therapy relationship (more information below), as well as the psychologists' own psychological distress.

Egalitarianism will act as a proxy for how clinical or professional versus friend-like the client-psychologist relationships are and how much the psychologist engages in power-sharing behaviors, which would allow for the client and psychologist to have more equal status in the relationship. The egalitarian relationship in therapy comes from Feminist Therapy. Brown (2010) stated that in the egalitarian relationship the therapist acknowledges that therapy involves an imbalance of power as a rule, but that he or she makes a systematic effort to make that imbalance as small as possible; the therapist engages in power-sharing behaviors that privilege the voice, knowing, and experiences of the client rather than the therapist.

Hypotheses and Proposed Analyses

In this dissertation, I tested several hypotheses regarding psychologists' own mental illness, psychologists' levels of mental illness stigma toward the general population,

psychologists' level of stigma against psychologists with mental illness, and the application of intergroup contact theory as follows:

- 1) I hypothesized that the more serious a psychologist's own psychological distress, the higher will be their group identification with people with mental illness and with people who use mental health services. I predicted that the relationship between mental health symptom severity and group identification will be both linear and quadratic. It would be linear because as symptoms increase, group identification will increase as the more severe the symptoms are the more likely they will feel that they see themselves as like others with mental illness or who use mental health services. I also predicted that it will be quadratic as I believed that the relationship between the severity of symptoms and group identification will be exponential. My rationale was that lower symptom severity allowed for denial of symptoms and less identification, but that greater symptom severity was harder to deny and resulted in much higher identification. Specifically, I believed that there were certain severe symptoms that would greatly increase identification, such as history of attempted suicide, realizing one has hallucinations or delusions, or that one is manic – symptoms so severe one may be hospitalized. I tested this hypothesis by running two regressions for each identification variable. In the first regression for both variables I regressed mental illness severity on group identification and expected to find a linear relationship. In the second regression I used an exponential expression and expected it to be stronger than the linear expression. I further predicted that group identification with others with mental illness and group identification with people who use mental health services would be significantly correlated, and qualitatively that the correlation would be positive and strong. I tested this with a bivariate correlation.

- 2) I hypothesized that the more therapy sessions psychologists had attended in the last five years, or since obtaining their psychology license if less than 5 years previous, the greater the degree to which they would identify with people who use mental health services. My rationale was that the experience of participating in therapy recently (within the past five years) would increase participants' identification with others who had had similar experiences, including clients. I tested this with bivariate correlations.
- 3) I hypothesized that there will be a negative relationship between the degree to which participants identified with licensed psychologists and the degree to which they identified with people who use mental health services such that the more participants identified with licensed psychologists the less they would identify with people who use mental health services. My rationale behind this hypothesis was that, in qualitative studies of psychologists with mental illness, those psychologists frequently felt rejected by other psychologists (Zerubabel & Wright, 2012), which would make them, the psychologists with mental illness, identify less with psychologists at large. I tested this using bivariate correlations.
- 4) Finally, the last hypotheses were a part of a series that I tested using four hierarchical regressions, one regression for each of four criterion variables: personal stigma of mental illness, personal stigma of help seeking, self-stigma of help-seeking, and the self-stigma of mental illness. In this series of four hierarchical regressions, I tested how various types of contact impacted mental-health-related stigma. As described in the literature review above, there were various types of stigma that individuals held about themselves or others rather than the stigma that the participants perceived others have, as we would see with

the public stigma of mental illness or of help-seeking. These four criterion variables therefore offered both breadth and specificity.

- a. In the first step of each regression, I hypothesized that simple contact (i.e., number of hours per week the psychologist sees clients for assessment and/or treatment) would predict the four criterion variables but that contact with important others in the life of the psychologist, such as a friend of the family, would predict more variance in the four criterion variables. My rationale for this hypothesis was that Allport's (1954) contact hypothesis stipulated that one of the four conditions for contact to reduce prejudice or stigma was that there should be equal status within the contact situation. In therapeutic or assessment settings, there is not equal status, whereas with personal contact, it is much more likely that there will be equal status. That said, I hypothesized that simply the number of contact hours would predict stigma as evidence has shown that even in situations where the four conditions were not met, contact still lowered prejudice (Pettigrew et al., 2011). I tested this by running two steps of a hierarchical regression. In the first step I tested simple contact. In the second step, I tested both simple contact and personal contact.
- b. Second, I hypothesized that egalitarianism in the client-psychologist relationship would significantly predict stigma such that the higher psychologists were in egalitarianism, the lower the four types of stigma would be. In addition, I hypothesized that egalitarianism would moderate the relationship between contact and stigma, such that for psychologists low in egalitarianism there would be no relationship between contact and the four stigma variables whereas those high in

egalitarianism would show a negative relationship between contact and the four stigma variables. My rationale behind this was that egalitarianism in the psychologist-client relationship represented an attitude that sought to equalize the power dynamics in the relationship, allowing for the two to have more equal status in the relationship. In this way, the fourth of Allport's four conditions for contact decreasing prejudice/stigma, equal status in the interaction (1954), would have been met. I tested this by running a third step in the above proposed four hierarchical regressions with egalitarianism as predictors of the four types of stigmas mentioned above, then a fourth step in which the interaction between egalitarianism and contact was added.

- c. Third, I hypothesized that additional variance would be explained by adding history of having a mental illness and group identification with people who have a mental illness. My rationale was that psychologists with a history of receiving psychological services and a high level of group identification with people who use mental health services had met the most stringent level of contact with people with mental illness – they themselves had mental illness and identified with people who use mental health services. I tested this by adding a fifth step in the hierarchical regressions, with history of seeing a psychotherapist and group identification added as predictors.

CHAPTER 3. METHODS

Participants

Participants were 143 individuals who were 18 years of age or older, licensed psychologists, fluent in English, residents of the United States of America, and provide services (psychotherapy, psychological testing, or medication management if applicable) to clients/patients two or more hours per week. The sample was 69.2% identified female ($n = 99$; with $n = 37$ males, $n = 2$ transgender; and $n = 5$ not specified). Racially/ethnically the sample was 71.3% European American/White ($n = 102$), 1.4% Latin American/Hispanic ($n = 2$), 15.4% Asian/Asian American ($n = 22$), 0.7% African American/Black ($n = 1$), 5.6% multiracial American ($n = 8$), 0.7% Native American ($n = 1$), and 4.9% not specified ($n = 7$). When asked if they have a disability, 81.1% reported they did not ($n = 116$); 9.1% reported they had physical disabilities ($n = 13$), 6.3% reported they had a serious mental illness ($n = 9$); 1.4% reported hearing loss ($n = 2$); and 1.4% reported they had a disability but did not specify it ($n = 2$). The mean age was 44.91 with a range of 29-73 ($SD = 11.98$).

The demographics of the sample were compared to the 2015 demographics of the health service psychologist population as reported by the American Psychological Association (APA; 2016). The sample included both APA members and nonmembers. Compared to the 2015 APA sample in terms of percentages, the present study had more women, fewer European American/White, fewer Latin American/Hispanic, more Asian/Asian American, fewer African American, more multiracial American, and more people with at least one disability. That said, it should be noted that there were differences in the methodology for collecting data so results should be compared cautiously. See Table 1.

Table 1*Demographics of licensed psychologists by survey*

Demographic	Present Study	2015 APA Survey
Female	69.2%	59.2%
Male	25.9%	40%
Transgender	1.4%	0.1%
European American/White	71.3%	87.8%
Latin American/Hispanic	1.4%	4.4%
Asian/Asian American	15.4%	2.5%
African American/Black	0.7%	2.6%
Native American	0.7%	<1%
Multiracial American	5.6%	1.7%
Disability (At least one)	18.8%	5.8%

Note. There were differences in the methodology so results should be compared cautiously.

The mean year they received their license was 2008 with a range of 1977-2019 ($SD = 10.59$) and the mean hours per week providing services was 21.92 with a range of 2-45 ($SD = 10.19$). Services provided included psychotherapy (85.3%; $n = 122$), assessment or psychological evaluation (67.1%; $n = 96$), medication management (2.8%; $n = 4$), and other (13.3%; $n = 19$). Examples of other services provided included rehabilitation, clinical supervision, being an expert witness, consultation, and case management. When asked, on average, what percentage of their clients/patients experience symptoms of severe psychopathology (e.g. hallucinations, delusions, mania, severe depression), the mean reported was 25.8 percent ($SD = 23.8$) with a range of 0-100.

Measures

Public (personal) stigma of mental illness. Day, Edgren, and Eshleman (2007)

developed Day's Mental Illness Stigma scale (DMIS) to measure personal stigma toward people

with mental illness, that is the stigma that that the participant himself or herself holds against people with mental illness. The full scale used 28 items to measure seven factors: interpersonal anxiety, relationship disruption, poor hygiene, visibility, treatability, professional efficacy, and recovery. The number of items per factor varied from two (professional efficacy and recovery) to seven (anxiety). Items are rated on a 7-point Likert scale from 1 (*completely disagree*) to 7 (*completely agree*). Participants' total score was used in this study. The original scale was written such that "mental illness" could be replaced by depression, bipolar, and schizophrenia as the developers were interested in the difference in stigma as it relates to specific conditions. For example, one statement was "I would find it difficult to trust someone with [a mental illness]." Because we were trying to keep the terminology consistent with the Level of Contact Report (see below) we inserted "severe mental illness" where "mental illness" is in the questions.

Due to concerns about survey length, we only used the 6-item relationship disruption factor. We considered using the anxiety and hygiene factors as well but realized that the anxiety and hygiene items would tap into licensed psychologists' professional experiences with clients/patients rather than their personal attitudes. For example, the anxiety item "I feel anxious and uncomfortable when I'm around someone with [a mental illness]" has a different meaning for a psychologist working with clients/patients on a weekly basis because they work with people with a mental illness regularly. Therefore, the anxiety factor is loading on actual experiences rather than attitudes. The same goes for the hygiene factor. An example item: "People with [mental illnesses] ignore their hygiene, such as bathing and using deodorant." Licensed psychologists are more likely to think about actual clients rather than relying on attitudes. In contrast, the relationship disruption items are written in a way that specifically ask about their personal attitudes toward people that would not be a client/patient. For example, "I think that a

personal relationship with someone with [a mental illness] would be too demanding.” The relationship disruption factor had good internal consistency in previous research ($\alpha = .84$; Day et al., 2007). The internal consistency in the present study is also good ($\alpha = .87$).

Self-stigma of mental illness. Tucker and colleagues (2013) developed the 10-item Self-Stigma of Mental Illness (SSOMI) scale to measure the self-stigma of being labeled as having a mental illness. This scale was developed as a parallel to the Self-Stigma of Seeking Help (SSOSH) Scale. Items are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and include statements such as “It would make me feel inferior to have a mental illness.” Participants’ total score was used in this study. Half the items are reverse scored such that higher scores represent greater self-stigma associated with having a mental illness. Evidence for convergent validity was demonstrated through a strong, positive correlation with the modified Self-Stigma of Depression (SSD) Scale ($r = .73, p < .001$). Discriminant validity for the SSOMI comes from its small, negative correlation with self-esteem ($r = -.25, p < .001$). It had excellent internal consistency in previous research ($\alpha = .91-.92$; Tucker et al., 2013). The internal consistency in the present study is also excellent ($\alpha = .92$).

Self-stigma of seeking help. The Self-Stigma of Seeking Help (SSOSH) scale is a 10-item questionnaire, has a unitary factor structure and measures the stigma one might feel toward themselves for seeking psychological help (Vogel & Wade, 2009). Items are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*) and include statements such as, “Seeking psychological help would make me feel less intelligent.” Participants’ total score was used in this study. The SSOSH demonstrates good construct validity through correlations with intentions to seek counseling, attitudes toward counseling, and the public stigma for seeking help (Vogel et al., 2006). It has been shown to distinguish between those who seek help and those

who do not. Finally, in previous research the SSOSH demonstrated discriminant validity through its zero-order, non-significant correlation with self-esteem ($r = .06$; Vogel et al., 2006), and demonstrated acceptable test-retest reliability over a period of 2 months ($\alpha = .72$) and had good internal consistency ($\alpha = .89$; Vogel, Wade, & Aschman, 2009). The internal consistency in the present study is excellent ($\alpha = .90$).

Degree of contact with people with mental illness. Holmes and colleagues (1999) developed the Level-of-Contact Report (LOCR), a 12-item measure, to get a more nuanced assessment of a person's level of contact with people with mental illness than a categorical question of, "Do you know someone with a mental illness?" (Holmes, Corrigan, Williams, Canar, & Kubiak, 1999; p. 449). The LOCR lists 12 situations in which a person could have contact with a person with mental illness, with the level of intimacy varying. Each situation has been rank ordered according to level of intimacy, from the least ("I have never observed a person that I was aware had a severe mental illness;" rank order = 1) to medium intimacy ("I have observed persons with a severe mental illness on a frequent basis;" rank order = 5) to high intimacy ("I live with a person who has a severe mental illness;" rank order = 11; and "I have a severe mental illness;" rank order = 12). The person is instructed "to check all situations on the list that they had experienced in their lifetime" (Holmes et al., 1999; p. 450). The participant's score is the number of the highest rank-order option she or he chose. For example, if they chose, "I live with a person who has a severe mental illness" as the option with the greatest level of intimacy, they would get a score of 11. Scores range from 1 to 12. The mean of rank order correlations summarizing interrater reliability was 0.83; which was validated with a subsequent sample of 100 college students (Holmes et al., 1999).

Psychological distress. The General Population – Clinical Outcomes in Routine Evaluation (GP-CORE) is a 14-item self-report measure of psychological distress for a nonclinical population (Sinclair, Barkham, Evans, Connell, & Audin, 2005). It was derived from the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Evans et al., 2000; 2002), a 34-item measure designed to monitor the psychological distress of psychotherapy clients including well-being, problems or symptoms, functioning, and risk. It was designed to measure changes in severity as well as to differentiate whether a client’s symptoms are more similar to a clinical or non-clinical population (Sinclair et al., 2005). Responses are rated on a 5-point Likert scale from 0 (*not at all*) to 4 (*most or all of the time*; Evans et al., 2000). Items include statements like, “I have felt anxious or nervous” and “I have felt optimistic about my future” (reversed scored). Participants’ mean score was used in this study.

In previous research, the GP-CORE demonstrated good internal consistency ($\alpha = .87$) and excellent test-retest reliability ($\alpha = .91$; Sinclair et al., 2005). The internal consistency in the present study was excellent ($\alpha = .90$). Evidence of the convergent validity of the scale comes from its strong correlations with other measures of psychological distress, such as the Beck Depression Inventory, 2nd edition (BDI-II; $r = .84$) and the Symptom Checklist-90-Revised (SLC-90-R; $r = .71$). Sinclair and colleagues (2005) found that there was a significant difference between the GP-CORE means for their clinical ($M = 2.11$, $SD = 0.67$) and their nonclinical ($M = 1.04$, $SD = 0.67$) samples. Cut-off scores of 1.49 for males and 1.63 for females were suggested.

Group identification. Group identification was measured using three adaptations of a 4-item scale developed by Doosje, Ellemers, and Spears (1995; Saleem et al., 2015): one adaptation for psychologists, one for people with mental illness, and one for people who use mental health services. Doosje and colleagues developed the measure to cover the cognitive,

evaluative, and affective aspects of identification with stems such as “I identify with other ____” and “I feel strong ties with ____.” Responses are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Participants’ total score was used in this study. Internal consistency reliability was excellent in previous research ($\alpha = .90$; Saleem et al., 2015). In the present study, internal consistency was questionable for the adaptation for people with mental illness ($\alpha = .60$), acceptable for the adaptation for people who use mental health services ($\alpha = .79$), and good for the adaptation for psychologists ($\alpha = .85$).

Egalitarianism. Robinson and Worrell (1991) developed the Therapy with Women Scale (TWS) to distinguish feminist therapy from other therapies but more specifically to measure power-sharing behaviors. The measure was developed from a review of the beliefs and principles of the feminist therapy literature (Worrell & Johnson, 2001; Rader & Gilbert, 2005). While the original scale included 40-items, for the purpose of this study we used two items that apply more broadly to power-sharing behaviors in therapy with all clients, not just women. Responses are rated on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). Internal reliability for the full 40-item scale was high ($\alpha = .91-.94$; Robinson and Worrell, 1991; Rader & Gilbert, 2005). Six additional items were generated by Lily Mathison and Nathaniel Wade based on Brown’s (2010) concept of the egalitarian relationship in therapy. Internal consistency for the developed scale in the present study was unacceptable ($\alpha = .37$). For this and other reasons described in the results chapter that follows, the Egalitarianism Scale was not used for the analyses.

Personal experience with mental illness and mental health treatment and demographic questionnaire. Participants reported their age, gender, race/ethnicity, whether they have a disability, years since receiving psychology license, hours per week they spend providing direct

clinical services to people with mental illness, the type of services they provide, and the percentage of clients/patients seen experience symptoms of severe psychopathology (e.g. hallucinations, delusions, mania, severe depression). Participants then indicated if they have ever had a mental illness, if so, the most severe mental health diagnosis they have had, if they have ever been treated for mental illness, if so, from whom/where (select all that apply: psychotherapist, primary care medical provider, psychiatrist, emergency department, acute inpatient psychiatric unit, residential treatment, and other, please specify). Then they reported if they have received psychotherapy, how many sessions they have had in the last 5 years or since receiving their psychology license, and if they have ever been on psychoactive medication.

Attention Checks. Random responses from even 5% of participants can have a significant impact on observed correlations (Credé, 2010). It is highly recommended that researchers make every attempt to identify and eliminate such random responders (Osborne & Blanchard, 2011; Tucker, 2013). I attempted to identify random responding by requiring the participant to answer correctly an item prompting a specified response (e.g. “Please select *Strongly Disagree* for this item”).

Survey Procedures

First, the study was approved by Iowa State University’s Institutional Review Board (IRB). Originally, the procedure was to email the survey to a randomly selected sample of 4000 licensed psychologists who were members of the American Psychological Association (APA) using the APA Membership Directory. This was a similar procedure to that used by Gilroy and colleagues (2002) with their survey of psychologists back in the 1990’s. However, when we contacted APA to request permission to do so, we were informed this was not an approved use of the directory at this point in time. APA recommended a marketing company to contact for

licensed psychologists' contact information. Unfortunately, when we contacted that company, they informed us that they generally sold licensed psychologists' mailing addresses, and that they could not guarantee the quality of their lists of email addresses. Their email lists were also prohibitively expensive.

Stymied on multiple fronts, we nevertheless carried on. We decided we would recruit research participants from several APA Division Listservs. APA has 54 divisions; options to contact were decided based on appropriateness for inclusion including likelihood that a majority of subscribers would be licensed psychologists in practice. For example, Division 10 (Psychology of Aesthetics, Creativity, and the Arts) was not considered a good option to meet this criterion. Divisions contacted included Division 12 – Clinical Psychology, Division 17 – Counseling Psychology, Division 22 – Rehabilitation Psychology, Division 29 – Advancement of Psychotherapy, Division 36 – Religion and Spirituality, Division 40 – Clinical Neuropsychology (both the general ListServ and the Women of Neuropsychology ListServ), Division 49 – Group Psychology, Division 50 – Addiction Psychology, and Division 55 – Psychopharmacology. We also contacted three state psychological associations to request that they post our survey to their ListServ including the Iowa Psychological Association (IPA), the New Mexico Psychological Association (NMPA), and the Texas Psychological Association (TPA).

As requested by our IRB Committee, we first contacted the moderators of the ListServs to ask to post the request for participants. One Division (12) denied the request completely. Eight division ListServs and one state association (IPA) allowed us to post the request, usually with the requirement that a member be the one to post. One Division (40 – General) denied the request to post on the ListServ, but agreed to post the request for participants on the Division's Facebook

page. Finally, one Division (39) and two state associations (NMPA and TPA) were contacted without response from the moderator. Whenever possible, we posted to the Listservs on two occasions over the course of the fall of 2019.

For all Listserv and similar postings, an IRB approved description of the study as well as a link to the survey were emailed to psychologists inviting them to participate. The survey included the above described measures and questions. Finally, the participant was offered a chance to enter a drawing to win one of four \$50 Amazon gift cards.

Power Analyses

I conducted a power analysis to determine the necessary participants to find a significant effect on the t-test (two-tailed) associated with one predictor variable within the overall regression analyses should one exist. Through G*Power (Faul, Erdfelder, Lang, & Buchner, 2007), I explored the minimum number of participants needed to find a significant small and medium effect on a single predictor using the following criteria: alpha = .05, power = .80, and 7 predictor variables. To detect a medium effect, I would need to include 55 participants. To detect a small effect, I would need to include 395 participants.

CHAPTER 4. RESULTS

Psychologists' Own Mental Illness and Mental Health Treatment

Participants were asked about their own history of mental illness and mental health treatment. When asked if they had ever had a mental illness, 72.7% answered yes ($n = 104$), 23.1% answered no ($n = 33$), and 4.2% did not answer ($n = 6$). Most severe mental health diagnosis(es) specified included adjustment disorder (2.8%; $n = 4$); a depressive disorder (35.0%; $n = 50$) including Major Depressive Disorder and Dysthymia, bipolar disorder (2.8%; $n = 4$); an anxiety disorder (21.7%; $n = 31$) including Generalized Anxiety Disorder, Social Anxiety, and Panic Disorder; Obsessive Compulsive Disorder (2.8%; $n = 4$); Posttraumatic Stress Disorder (9.8%; $n = 14$); a substance use disorder (2.8%; $n = 4$) including Alcohol Use Disorder; an eating disorder (4.9%; $n = 7$) including Anorexia, Bulimia, and Binge Eating Disorder; Dissociative Identity Disorder (0.7%; $n = 1$); Attention Deficit Hyperactivity Disorder (0.7%; $n = 1$); four participants did not specify the disorder (2.8%). Of note, 10.5% ($n = 15$) specified more than one diagnosis. See Table 2.

Participants completed a measure of psychological symptoms for the general population, the General Population – Clinical Outcomes in Routine Evaluation (GP-CORE). Scores on the GP-CORE are calculated as the mean of the responses on 14 items and range from 0-4, 4 indicating the worst symptoms. The mean GP-CORE score for the sample was 1.04, ranging from 0.14 to 2.71 ($SD = .59$). As the cut-off scores for the GP-CORE differ based on gender (Sinclair et al., 2005; 1.49 for men, 1.63 for women), means for each gender were also calculated. For men the mean was 1.08 ($SD = .63$, $IQR = .61-1.43$) and for women 1.03 ($SD = .59$, $IQR = .57-1.50$). Even the 75th percentiles for the men (1.43) and women (1.50) in this study are lower than the clinical cut-offs.

Table 2*Mental Illnesses Reported by Licensed Psychologists (n = 104)*

Type of Mental Illness	n	%
Depressive Disorder	50	35.0
Anxiety Disorder	31	21.7
PTSD	14	9.8
Eating Disorder	7	4.9
Adjustment Disorder	4	2.8
Bipolar Disorder	4	2.8
OCD	4	2.8
Substance Use Disorder	4	2.8
DID	1	0.7
ADHD	1	0.7

Total % exceeds 100% owing to comorbidities. PTSD = Posttraumatic Stress Disorder, OCD = Obsessive Compulsive Disorder, DID = Dissociative Identity Disorder, ADHD = Attention Deficit Hyperactivity Disorder.

When asked if they had ever received treatment for a mental illness, 76.2% of participants answered yes ($n = 109$), 19.6% answered no ($n = 28$), and 4.2% did not answer ($n = 6$). Participants selected from whom they had received treatment including any psychotherapist (74.8%; $n = 107$), a master's level psychotherapist (41.3%; $n = 59$), a doctoral level psychotherapist (60.8%; $n = 87$), a primary care medical provider (32.2%; $n = 46$), a psychiatric specialist such as a psychiatrist or psychiatric nurse practitioner (36.4%; $n = 52$), an emergency department (2.1%; $n = 3$), an acute inpatient psychiatric unit (3.5%; $n = 5$), a residential facility (3.5%; $n = 5$), or other (2.1%; $n = 3$) including an acupuncturist, a partial hospitalization program, and electroconvulsive therapy. See Table 3. As a note, 56.6% of participants ($n = 81$) reported receiving treatment from more than one of the above sources. Participants reported the number of psychotherapy sessions they had received in the last five years or since receiving their

psychology license. The mean number was 25.5 ($SD = 52.7$) with a range of 0-250. When the participants were asked if they had ever been on psychoactive medication for a mental illness, 53.1% indicated yes ($n = 76$), 42.7% indicated no ($n = 61$), and 4.2% did not respond ($n = 6$).

Table 3

Treatment for Mental Illness Reported by Licensed Psychologists ($n = 143$)

Type of Treatment for Mental Illness	<i>n</i>	%
Any Treatment	109	76.2
Psychotherapy (Any)	107	74.8
Psychotherapy (Doctoral Level Clinician)	87	60.8
Psychotherapy (Master's Level Clinician)	59	41.3
Psychoactive Medication	76	53.1
Psychiatric Specialist	52	36.4
Primary Care Medical Provider	46	32.2
Acute Inpatient Psychiatric Unit	5	3.5
Residential Facility	5	3.5
Emergency Department	3	2.1
Other	3	2.1

Total % exceeds 100% owing to receiving treatment from multiple sources.

Development of Egalitarianism Scale

I planned to conduct an exploratory factor analysis (EFA) with principle axis factoring and a Direct Oblimin (oblique) rotation. As a first step, I used the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and found the value was .51. KMO values range from 0 to 1, with higher numbers indicating better sampling adequacy. Howard (2016) indicated the KMO should be above .60 before performing an EFA, as this indicates latent factors may be present and an EFA would be appropriate. Our scale did not meet this cut-off recommendation. In addition, the

internal consistency reliability of the items was found to be unacceptable (Cronbach's $\alpha = .37$). I conducted the same analyses on the two items taken from the Therapy with Women Scale (TWS) to see if it would be appropriate to use just those items in lieu of the eight-item scale given to participants. The KMO was also too low to perform an EFA at only .50 and the internal consistency was unacceptable ($\alpha = .49$). It was therefore decided that the Egalitarianism Scale would not be used in the analyses.

Missing Data

I searched my data for missing values for all of the variables that were included in the analyses to follow. For the most part, there were very few variables with missing data. In total, three variables had missing data: self-stigma of seeking help (SSOSH), self-stigma of mental illness (SSOMI), and number of hours per week seeing clients. For those variables, the percentage of missing data ranged from 0.7% ($n = 142$; SSOSH) to 3.5% ($n = 138$; Number of hours per week seeing clients). When data were missing, the cases were excluded listwise.

Preliminary Analyses

Previous literature has found that stigma can vary by gender (Vogel et al., 2006). As a result, I conducted independent samples *t*-test on DMIS, SSOSH, and SSOMI scores by gender. DMIS scores did not differ significantly between women ($M = 16.7$, $SD = 6.20$) and men ($M = 17.8$, $SD = 7.86$), $t(134) = .791$, $p = .430$. Neither did SSOSH scores differ between women ($M = 19.2$, $SD = 6.94$) and men ($M = 21.1$, $SD = 8.61$), $t(134) = 1.27$, $p = .208$, nor SSOMI scores between women ($M = 27.8$, $SD = 7.76$) and men ($M = 28.6$, $SD = 7.76$), $t(134) = .506$, $p = .615$. Means, standard deviations, possible scale ranges, and bivariate correlations for the main variables are presented in Table 4.

Table 4*Zero-Order Correlation Matrix, Means, Standard Deviations, and Ranges*

Variable	1	2	3	4	5	6	7	8	9	10
1. Personal Stigma	—									
2. Self-Stigma of Seeking Help	.13	—								
3. Self-Stigma of Mental Illness	.37***	.55**	—							
4. Group ID, Mental Illness	-.33***	.05	-.21**	—						
5. Group ID, Service Users	-.18*	-.35***	-.20*	.47***	—					
6. Group ID, Psychologists	-.06	-.25**	-.14	-.05	.13	—				
7. Psychological Distress	.13	.46***	.25**	.11	-.20*	-.50***	—			
8. Time Since Licensed	.39***	-.01	.09	-.33***	-.16	.24**	-.08	—		
9. Hours Providing Services	.03	.15	-.08	.10	-.04	-.03	.09	-.02	—	
10. Own Therapy Sessions	-.03	-.10	.09	.17*	.25**	.07	.05	-.10	.10	—
<i>M</i>	16.99	19.69	28.11	11.27	13.75	17.79	1.045	12.09	21.92	19.32
<i>SD</i>	6.77	7.38	7.84	2.75	3.17	2.66	.594	10.6	10.2	47.9
Sample Range	6-36	10-44	10-49	4-17	4-20	4-20	.14-2.71	1-43	2-45	0-250

Note. $N = 136-143$. * $p < .05$. ** $p < .01$. *** $p < .001$

Main Analyses

Hypothesis 1: Psychologists' own psychological distress and group identification. I hypothesized that the more serious a psychologist's own psychological distress, the higher would be their group identification with people with mental illness and with people who use mental health services. To examine the relationship between psychologists' own psychological distress and group identification with people with a mental illness (GIMI) and people who use mental health services (GIU), I conducted four regression analyses: two with each type of group identification as predictor variables. Because I predicted that the relationship between psychological distress and group identification would be more likely to be exponential than linear, for each type of group identification, I tested both a linear and an exponential regression model.

Before the regressions were conducted, the assumptions of normality and homoscedasticity were checked, and the plots were examined for outliers for each dependent variable. To check if the residuals of the regression followed a normal distribution, Predicted-Probability (P-P) plots were inspected. The P-P plots for both GIMI and GIU were normal. To check for homoscedasticity, scatterplots of the regression standardized predicted values and regression standardized residuals were inspected. The scatterplots indicated homoscedasticity for both GIMI and GIU. An examination of the data plots indicated no outliers.

The linear and exponential regressions were then conducted. First, I conducted the regressions with GIMI as the dependent variable and psychological distress as a predictor variable. Neither the linear regression model, $F(1,141) = 1.71, p = .193$, nor the exponential regression model, $F(1,141) = 2.70, p = .103$, with GIMI as the dependent variable were significant. Then, I conducted the regressions with GIU as the dependent variable and

psychological distress as a predictor variable. Both the linear regression, $F(1,141) = 5.60, p = .019$, and the exponential regression, $F(1,141) = 4.32, p = .039$, were significant. In both cases more severe psychological distress significantly predicted lower GIU; linear regression ($R^2 = .038, B = -1.04, SE = .441, \beta = -.195, p = .019$), exponential regression ($R^2 = .030, B = -.077, SE = .037, \beta = -.172, p = .039$). See Table 5. These results do not support my hypothesis. According to these findings, psychological distress are not related to therapists identifying with those who have mental illness. Furthermore, although psychological distress are related to therapists identifying with those who use mental health services, the relationship is in the opposite direction of what I hypothesized: those with greater psychological distress reported less identification with those who use psychological services.

Table 5

Linear and Exponential Regression Analyses of Psychological distress Predicting Group Identifications.

Dependent Variable	Model	<i>B</i>	<i>SE</i>	β	R^2	<i>F</i>	<i>p</i>
Group ID, Mental Illness	Linear	.508	.388	.110	.012	1.71	.193
	Exponential	.066	.040	.137	.019	2.70	.103
Group ID, Service Users	Linear	-1.04	.441	-.195	.038	5.60	.019
	Exponential	-.077	.037	-.172	.030	4.32	.039

Note. Predictor variable = psychological distress. *SE* = standard error of *B*.

A bivariate correlation was used to test if group identification with others with mental illness and group identification with people who use mental health services would be significantly correlated. The correlation was, indeed, significant ($r = .47, p < .001$). This indicates that the more participants identified with others with mental illness the more they identified with people who use mental health services.

Hypothesis 2: Group identification and psychologists' own psychotherapy. A

bivariate correlation was used to examine if the number of therapy sessions psychologists had attended in the last five years—or since obtaining their psychology license if less than 5 years previous—would be related to the degree to which they would identify with people who use mental health services. The correlation was, in fact, significant ($r = .25, p = .003$). This indicates that the more therapy sessions participants had attended, the more they tended to identify with people who use mental health services.

A hierarchical regression analysis was done to further explore this relationship, specifically to parcel out if the relationship with GIU was simply associated with receiving any treatment of mental illness or if it was specific to number of therapy sessions in the last five years or since obtaining their psychology license. In Step 1, whether or not the participant had ever received treatment for a mental illness was entered as the predictor variable with GIU as the dependent variable. Step 1 was not significant, $F(1,135) = 3.67, p = .058$. In Step 2, number of therapy sessions was added as a predictor variable. Step 2 was significant, $F(1,134) = 8.94, p = .003$, with more therapy sessions ($B = .016, SE = .005, \beta = .252, p = .003$) significantly predicting higher GIU, but not whether or not the participant had ever received treatment for a mental illness ($B = .871, SE = .650, \beta = .113, p = .183$). Therapy sessions accounted for 6.1% of the variance. See Table 6.

Hypothesis 3: Group identification with psychologists and people who use mental health services. A bivariate correlation was used to test if a negative relationship existed between the degree to which participants identified with being a licensed psychologist and the degree to which they identified with people who use mental health services, such that the more participants identified with being a licensed psychologist the less they would identify with

Table 6

Regression Analysis Predicting Group Identification with People Who Use Mental Health Services.

Predictor	<i>B</i>	<i>SE</i>	β	<i>p</i>	R^2	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.026	.026	3.67	.058
Own treatment	1.26	.656	.163	.058				
Step 2					.087	.061	8.94	.003
Own treatment	.871	.650	.113	.183				
Own therapy sessions	.016	.005	.252	.003				

Note. *SE* = standard error of *B*.

people who use mental health services. Contrary to my hypothesis, the correlation was not significant ($r = .13, p = .13$). In addition, there was not a significant correlation between group identification with people who have a mental illness and group identification with being a psychologist ($r = -.05, p = .52$). That said, there was a related finding that supports the idea behind the hypothesis. I found a significant, negative correlation between participants' psychological distress and their group identification with psychologists ($r = -.43, p < .001$). This indicates that as participants' psychological distress grew more severe, they identified less with other psychologists.

Hypothesis 4: Contact and various types of stigma. To examine the relationship between psychologists' contact with people with mental illness and their levels of mental health stigma, I conducted a series of hierarchical regressions. Initially, the intention had been to conduct four series of hierarchical regressions, one with each of four types of stigma as criterion variables: personal stigma of mental illness, personal stigma of help seeking, self-stigma of seeking help, and the self-stigma of mental illness. Unfortunately, one of the criterion variables, the personal stigma of seeking help, had to be dropped from analyses because the scale

estimating it, the Personal Stigma scale, was deemed to have poor psychometrics. As a result, I only conducted three hierarchical regressions. It had also been the intention to include both egalitarianism with clients and an interaction between egalitarianism and contact. Regretfully, the Egalitarianism Scale was also dropped from analyses due to concerns about poor psychometrics. As a result, the two steps testing egalitarianism were eliminated.

Before the hierarchical regressions were conducted, the assumptions of normality, homoscedasticity, and linearity were checked, and the plots were examined for outliers for each dependent variable. To check if the residuals of the regression followed a normal distribution Predicted-Probability (P-P) plots were inspected. The P-P plots for DMIS, SSOSH, and SSOMI were normal. To check for homoscedasticity scatterplots of the regression standardized predicted values and regression standardized residuals were inspected. The scatterplots indicated homoscedasticity for DMIS, SSOSH, and SSOMI. An examination of the data plots indicated no outliers. In addition, the variance inflation factor (VIF) and the condition indexes were examined. VIF for all of the analyses were between 1.00 and 1.24, meaning that the standard error for the coefficients were at its highest 1.24 times larger than if the two had been completely uncorrelated (O'Brien, 2007). This is below the typical cut-off value of five considered to be cause for concern (Menard, 1995). Additionally, no condition index was above 30, consistent with the data screening procedures recommended by Tabachnick and Fidell (2001). Regressions were considered appropriate in the present analysis and the significance of regression coefficients was considered interpretable.

Five-step hierarchical regressions were run for each of three separate dependent variables: personal stigma of mental illness, self-stigma of help seeking, and self-stigma of mental illness. Hours per week spent providing clinical services was entered at Step 1 of the

regressions to test participants' simple contact with people with mental illness. Participants' degree of contact, a measure designed to assess for different types of contact with people with mental illness, was entered at Step 2. Reported history of mental illness and reported number of therapy sessions over the last five years or since receiving license were added at Step 3. Group identification with people with mental illness was added at Step 4 to test for personal experience and identification with people with mental illness. Group identification with people who use mental health services was added at Step 5. Intercorrelations among the regression variables were reported in Table 4.

Personal stigma of mental illness. As noted in Table 7 below, for personal stigma of mental illness the hierarchical regression revealed that at Step 1, number of clinical hours per week did not contribute significantly to the regression model, $F(1,135) = .154, p = .696$. Likewise, introducing degree of contact at Step 2 did not contribute significantly to the model, $F(1,134) = .141, p = .708$, neither did adding reported history of mental illness or number of therapy sessions in the last five years at Step 3, $F(2,132) = 2.80, p = .065$. The addition of group identification with people with mental illness at Step 4, however, did contribute significantly, $F(1,131) = 10.4, p = .002$ ($B = -.721, SE = .223, \beta = -.296, p = .002$) and accounted for 7.0% of the variation in personal stigma of mental illness. The addition of group identification with people who use mental health services at Step 5, did not contribute significantly, $F(1,130) = .286, p = .594$. Together, the five independent variables accounted for 11.5% of the variance in personal stigma of mental illness. In short, it appears that those who identify more strongly with those who have a mental illness also hold less stigma toward that group.

Table 7*Hierarchical Regression Analysis Predicting Personal Stigma of Mental Illness*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.001	.001	.154	.70
Hours Providing Services	.02	.06	.034	.696				
Step 2					.002	.001	.141	.71
Hours Providing Services	.02	.06	.032	.708				
Degree of Contact	.14	.38	.032	.708				
Step 3					.043	.041	2.80	.065
Hours Providing Services	.03	.06	.038	.654				
Degree of Contact	.11	.38	.024	.778				
Own Mental Illness	-3.18	1.37	-.203	.021				
Own Therapy Sessions	.001	.012	.008	.929				
Step 4					.113	.070	10.41	.002
Hours Providing Services	.04	.06	.058	.487				
Degree of Contact	.18	.37	.041	.617				
Own Mental Illness	-1.28	1.45	-.082	.377				
Own Therapy Sessions	.005	.012	.033	.701				
Group ID, Mental Illness	-.721	.223	-.296	.002				
Step 5					.115	.002	.286	.59
Hours Providing Services	.034	.056	.052	.539				
Degree of Contact	.183	.37	.041	.617				
Own Mental Illness	-1.40	1.47	-.089	.342				
Own Therapy Sessions	.006	.012	.045	.613				
Group ID, Mental Illness	-.66	.25	-.272	.009				
Group ID, Service Users	-.111	.21	-.052	.594				

Note. *SE* = standard error of *B*.

Self-stigma of seeking help. As noted in Table 8, for self-stigma of seeking help the hierarchical regression revealed at Step 1 that the number of clinical hours per week did not contribute significantly to the regression model, $F(1,135) = 1.40, p = .239$. Similarly, introducing the degree of contact at Step 2 did not contribute significantly to the model, $F(1,134) = .361, p = .549$, neither did adding reported history of mental illness or number of therapy sessions in the last five years at Step 3, $F(2,132) = 1.69, p = .188$. In Step 4, the addition of group identification with people who have a mental illness also did not explain a significant amount of the variance in self-stigma of seeking help, $F(1,131) = .147, p = .702$.

The addition of group identification with people who use mental health services at Step 5, however, did contribute significantly, $F(1,130) = 22.46, p < .001$, and accounted for 14.2% of the variation in self-stigma of seeking help. In addition, even though group identification with people who have mental illness was not a significant predictor in Step 4 ($B = .099, SE = .257, \beta = .037, p = .702$), it was a significant predictor in Step 5 ($B = .665, SE = .266, \beta = .248, p = .014$) along with group identification with people who use mental health services ($B = -1.05, SE = .221, \beta = -.440, p < .001$). When entered into the model together, these two predictors act in opposite directions: group identification with those who have a mental illness is positively associated with the self-stigma of seeking help, whereas group identification with those who use mental health services is negatively associated with the self-stigma of seeking help. This indicates that those who identify more with those who have a mental illness, after controlling for those who identify with those who use services, report greater self-stigma of seeking help. In contrast, those who identify more with those who use services report less self-stigma of seeking help. Together, the six independent variables accounted for 18.0% of the variance in self-stigma of seeking help.

Table 8*Hierarchical Regression Analysis Predicting Self-Stigma of Seeking Help*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.010	.010	1.40	.24
Hours Providing Services	.074	.063	.101	.239				
Step 2					.013	.003	.361	.55
Hours Providing Services	.073	.063	.099	.251				
Degree of Contact	.252	.419	.052	.601				
Step 3					.038	.025	1.69	.19
Hours Providing Services	.080	.063	.109	.206				
Degree of Contact	.278	.417	.057	.506				
Own Mental Illness	2.01	1.51	.116	.187				
Own Therapy Sessions	-.020	.013	-.134	.129				
Step 4					.039	.001	.147	.70
Hours Providing Services	.078	.063	.107	.219				
Degree of Contact	.27	.42	.055	.525				
Own Mental Illness	1.75	1.66	.101	.295				
Own Therapy Sessions	-.021	.013	-.137	.123				
Group ID, Mental Illness	.099	.26	.037	.702				
Step 5					.180	.142	22.5	.000
Hours Providing Services	.040	.059	.055	.498				
Degree of Contact	.27	.39	.055	.490				
Own Mental Illness	.640	1.56	.037	.682				
Own Therapy Sessions	-.005	.013	-.035	.678				
Group ID, Mental Illness	.67	.27	.248	.014				
Group ID, Service Users	-1.05	.22	-.440	.000				

Note. *SE* = standard error of *B*.

Self-stigma of mental illness. As noted in Table 9, for self-stigma of mental illness, the hierarchical regression revealed that neither Step 1, number of clinical hours per week, nor Step 2, degree of contact contributed significantly to the regression model, $F(1,135) = .622, p = .432$; $F(1,134) = 3.73, p = .056$, respectively. Similarly, introducing reported history of mental illness and number of therapy session in the last five years at Step 3, $F(2,132) = 2.163, p = .119$, did not add significantly to the model. The addition of group identification with people with mental illness at Step 4 was significant, $F(1,131) = 4.32, p = .040$, and accounted for 3.0% of the variation in self-stigma of mental illness. When all five independent variables were included in Step 4 of the regression model, degree of contact (added in Step 2) became a significant predictor of self-stigma of mental illness ($B = .85, SE = .42, \beta = .169, p = .045$) along with group identification with people with mental illness ($B = -.54, SE = .26, \beta = -.193, p = .040$). It seems the more personal a psychologists' contact is with people with mental illness the more self-stigma of mental illness they have. The addition of group identification with people who use mental health services at Step 5, did not contributed significantly, $F(1,130) = 3.53, p = .063$. Oddly, group identification with people who use mental health services was not itself a significant predictor of self-stigma of mental illness in this step, neither was group identification with people who use mental health services, but degree of contact and number of therapy sessions in the last five years were significant. Together, the six independent variables accounted for 11.6% of the variance in self-stigma of mental illness.

Follow-up Analyses

Psychological distress and stigma. I was concerned that the variable used in the above hierarchical regressions to indicate whether or not a participant had a mental illness or not, a categorical variable, may not have encapsulated the concept of interest to an adequate degree.

Table 9*Hierarchical Regression Analysis Predicting Self-Stigma of Mental Illness*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.005	.005	.622	.432
Hours Providing Services	-.052	.065	-.068	.432				
Step 2					.032	.027	3.73	.056
Hours Providing Services	-.057	.065	-.074	.383				
Degree of Contact	.830	.430	.164	.056				
Step 3					.062	.031	2.16	.119
Hours Providing Services	-.063	.065	-.083	.330				
Degree of Contact	.80	.43	.158	.064				
Own Mental Illness	-2.68	1.55	-.070	.453				
Own Therapy Sessions	.023	.014	.146	.092				
Step 4					.092	.030	4.32	.040
Hours Providing Services	-.054	.064	-.070	.404				
Degree of Contact	.85	.42	.169	.045				
Own Mental Illness	-1.26	1.68	-.070	.453				
Own Therapy Sessions	.023	.014	.146	.092				
Group ID, Mental Illness	-.54	.26	-.193	.040				
Step 5					.116	.024	3.53	.063
Hours Providing Services	-.070	.064	-.092	.277				
Degree of Contact	.85	.42	.169	.043				
Own Mental Illness	-1.73	1.68	-.097	.304				
Own Therapy Sessions	.030	.014	.188	.035				
Group ID, Mental Illness	-.30	.29	-.106	.304				
Group ID, Service Users	-.446	.24	-.181	.063				

Note. *SE* = standard error of *B*.

This was underscored by the fact that psychologists' own mental illness did not significantly predict any of the stigma variables in the above analyses. In line with previous studies (Pope & Tabachnick, 1994; Gilroy, Carroll, & Murra, 2002; Tay, Alcock, & Scior, 2018), a large proportion of my sample reported experiencing a mental illness at some point in their lives. That said, I had hoped that I might be able to tease out whether or not participants had severe mental illness and determine whether that would impact their level of stigma. I had hoped that in gathering the participants' most severe diagnosis I would be able to create a variable that reflected whether or not participants had had a severe mental illness or not. Unfortunately, participants' responses did not contain enough detail. I considered whether there might be another way to estimate severity of mental illness. Even though it is not an estimate of severity of symptoms over a participant's lifetime, we did have a measure of severity of current psychological distress. I, therefore, decided to rerun the three hierarchical regressions using current psychological distress in lieu of the categorical self-reported mental illness variable in a post hoc analysis.

The substitution of psychological distress did not change the results for personal stigma of mental illness (see Table 10), but it did for self-stigma of seeking help (see Table 11) and self-stigma of mental illness (see Table 12). The addition of psychological distress at Step 3 contributed significantly to the model predicting self-stigma of seeking help, $F(2,133) = 18.18, p < .001$ ($B = .557, SE = .095, \beta = .450, p < .001$), and accounted for 21.2% of the variation in self-stigma of seeking help. Together, the six independent variables accounted for 29.9% of the variance in self-stigma of seeking help. Furthermore, the addition of psychological distress at Step 3 contributed significantly to the model predicting self-stigma of mental illness, $F(2,133) = 4.786, p = .01$ ($B = .304, SE = .107, \beta = .236, p = .005$), and accounted for 6.5% of the variation

Table 10*Hierarchical Regression Analysis Predicting Personal Stigma of Mental Illness.*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.001	.001	.089	.766
Hours Providing Services	.017	.056	.026	.766				
Step 2					.002	.001	.123	.726
Hours Providing Services	.016	.057	.024	.780				
Degree of Contact	.133	.380	.030	.726				
Step 3					.013	.012	.780	.461
Hours Providing Services	.013	.057	.019	.825				
Degree of Contact	.111	.380	.025	.772				
Psychological Distress	1.16	.973	.103	.236				
Own Therapy Sessions	-.005	.012	-.038	.665				
Step 4					.128	.115	17.4	.000
Hours Providing Services	.029	.054	.043	.599				
Degree of Contact	.168	.360	.038	.641				
Psychological Distress	1.60	.925	.143	.085				
Own Therapy Sessions	.003	.011	.019	.816				
Group ID, Mental Illness	-.847	.203	-.348	.000				
Step 5					.128	.000	.002	.968
Hours Providing Services	.029	.055	.044	.600				
Degree of Contact	.168	.362	.038	.643				
Psychological Distress	1.61	.968	.144	.098				
Own Therapy Sessions	.003	.012	.019	.829				
Group ID, Mental Illness	-.851	.231	-.350	.000				
Group ID, Service Users	.009	.211	.004	.968				

Note. SE = standard error of B.

Table 11*Hierarchical Regression Analysis Predicting Self-Stigma of Seeking Help.*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.010	.010	1.40	.232
Hours Providing Services	.007	.006	.102	.232				
Step 2					.013	.003	.363	.548
Hours Providing Services	.005	.006	.100	.245				
Degree of Contact	.025	.042	.052	.548				
Step 3					.225	.212	18.2	.000
Hours Providing Services	.005	.006	.075	.332				
Degree of Contact	.014	.037	.029	.705				
Psychological Distress	.557	.095	.450	.000				
Own Therapy Sessions	-.002	.001	-.130	.092				
Step 4					.226	.001	.102	.750
Hours Providing Services	.005	.006	.073	.946				
Degree of Contact	.014	.037	.028	.715				
Psychological Distress	.554	.096	.447	.000				
Own Therapy Sessions	-.002	.001	-.134	.088				
Group ID, Mental Illness	.007	.021	.025	.750				
Step 5					.299	.073	13.6	.000
Hours Providing Services	.003	.005	.046	.540				
Degree of Contact	.017	.036	.036	.626				
Psychological Distress	.453	.096	.336	.000				
Own Therapy Sessions	-.001	.001	-.065	.397				
Group ID, Mental Illness	.046	.023	.173	.045				
Group ID, Service Users	-.077	.021	-.326	.000				

Note. *SE* = standard error of *B*.

Table 12*Hierarchical Regression Analysis Predicting Self-Stigma of Mental Illness*

Predictor	<i>B</i>	<i>SE</i>	β	<i>P</i>	<i>R</i> ²	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.006	.006	.779	.379
Hours Providing Services	-.006	.006	-.075	.379				
Step 2					.032	.026	3.66	.058
Hours Providing Services	-.006	.006	-.083	.329				
Degree of Contact	.082	.043	.162	.058				
Step 3					.097	.065	4.79	.010
Hours Providing Services	-.008	.006	-.112	.182				
Degree of Contact	.076	.042	.150	.072				
Psychological Distress	.304	.107	.236	.005				
Own Therapy Sessions	.001	.001	.089	.285				
Step 4					.158	.061	9.93	.002
Hours Providing Services	-.007	.006	-.094	.246				
Degree of Contact	.081	.040	.160	.049				
Psychological Distress	.341	.104	.265	.001				
Own Therapy Sessions	.002	.001	.131	.111				
Group ID, Mental Illness	-.071	.023	-.255	.002				
Step 5					.164	.006	.885	.349
Hours Providing Services	-.008	.006	-.102	.213				
Degree of Contact	.082	.041	.162	.046				
Psychological Distress	.312	.109	.242	.005				
Own Therapy Sessions	.002	.001	.150	.077				
Group ID, Mental Illness	-.059	.026	-.214	.023				
Group ID, Service Users	-.022	.024	-.091	.349				

Note. *SE* = standard error of *B*.

in self-stigma of mental illness. Together, the six independent variables accounted for 16.4% of the variance in self-stigma of mental illness.

Psychological distress, group identification, and self-stigma of seeking help. So far, the results of my analyses related to psychological distress, group identification, and the self-stigma of seeking help have created a complicated picture. I found that as psychological distress increased group identification with people who use mental health services (GIU) decreased. I also found that as the self-stigma of seeking help increased, GIU decreased. Finally, a reference to the zero-order correlation matrix indicated that as psychological distress increased, so did GIU. I explored a possible mediating effect (post hoc) to further explore these results. I examined the possibility that greater psychological distress might make the stigma of seeking help more salient which in turn might encourage people to distance themselves from others who seek services. So, instead of causing people to identify more with those who use mental health services, greater psychological distress might make people more aware of the stigma that surrounds seeking help, which in turn might motivate them to avoid associations with seeking help, such as identifying with people who use mental health services.

Because the data were available, I tested a post hoc mediation model to see if the self-stigma of seeking help (SSOSH) accounted for the relationship between psychological distress (GP-CORE) and identification with people who use mental health services. The PROCESS macro for SPSS was used to test the mediation model (Hayes, 2013). A bootstrapping technique (5,000 resamples) generated 95% confidence interval estimates of the direct and indirect relationships, which were interpreted as significant if they did not include zero. As we know from the previous analyses, greater psychological distress predicted less group identification with users of mental health service ($B = -1.02, SE = .437, p = .021$). Psychological distress also

significantly predicted greater self-stigma of seeking help ($B = 5.65, SE = .931, p < .001$). Furthermore, greater self-stigma significantly predicted less group identification with users of mental health service ($B = -.140, SE = .0380, p < .001$). Finally, self-stigma significantly mediated the relationship between psychological distress and group identification ($B = -.232, SE = .471, p = .624$), as was indicated by the exclusion of zero in the 95% confidence interval of the indirect effect ($\beta = -.150, SE = .0583, 95\% \text{ CI: } [-.286, -.0571]$). These results provide some (albeit limited) support for the stigma salience idea: greater symptoms might make self-stigma more salient, which could then lead to less group identification. That said, it should be noted that this mediation model was conducted with correlational data and as such these findings should be considered with extreme caution.

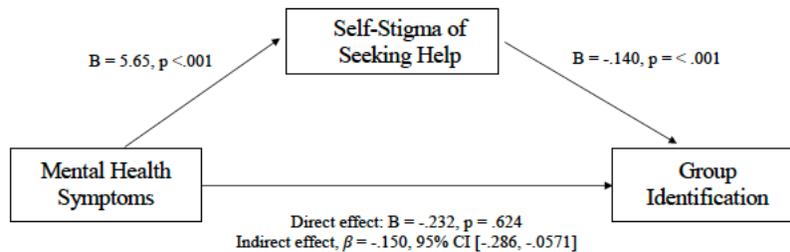


Figure 1 Mediation Model

Note. The relationship between psychological distress and group identification with people who use mental health services as mediated by self-stigma of seeking help.

CHAPTER 5. GENERAL CONCLUSION/DISCUSSION

The object of this study was to gather data about psychologists' own mental illness and mental health stigma and relate it to Allport's contact hypothesis (1954) and Pettigrew's (1998, 2011) intergroup contact theory. The data about psychologists' own mental illness included diagnosis, mental health treatment history, and a measure of current symptoms. This was to help clarify the participants' personal experience of mental illness to help tease out how their current symptoms and history of mental illness might be related to their stigma. Furthermore, this study provided updated figures of experiences with mental illness in psychologists in the United States, a population that has not been assessed for this since 2002. The data about psychologists' own mental health related stigma included personal stigma of mental illness, self-stigma of seeking help, and self-stigma of mental illness.

The contact hypothesis and intergroup contact theory were assessed through psychologists' group identification with other psychologists, people with mental illness, and people who use mental health services as well as number of hours of contact (i.e., the number of hours per week the psychologist meets with clients); their familiarity with mental illness in any setting; as well as the psychologists' own psychological distress. The respective influence of these variables was then tested using hierarchical regressions.

Psychologists' own Mental Illness

It is useful to compare the data regarding psychologists' own mental illness and mental health treatment from this study to similar studies conducted in the past. Differences in data collection practices make direct comparison difficult, but nevertheless intriguing. The two past studies conducted in the United States focused on depression specifically while the one study conducted in the United Kingdom focused on mental illness in general. Pope and Tabachnick (1994) did not report a breakdown of specific diagnoses but reported that 61% of their sample of

476 psychologists (both clinical and counseling) had experienced at least one episode of what the participants self-reported as clinical depression. Gilroy, Carroll, and Murra (2002) more specifically asked if the counseling psychologists in their study had experienced depressive symptoms while working as clinicians; the authors then obtained specific diagnoses. Despite the difference in methodology, Gilroy and colleagues (2002) obtained a number remarkably close to Pope and Tabachnick (1994) – 62% of their 425 participants. The authors did not make clear which of the listed diagnoses were included in this statistic, but it appears that adjustment disorders with depressed mood, bipolar disorder, and dysthymia were included along with major depressive disorders. If the present study were to define depressive symptoms similarly, 58 of the 143 participants or 41% would qualify. This is a lower number than either of the previous studies.

That said, in the present study when we asked participants if they had ever experienced a mental illness, 72.7% answered yes. In the United Kingdom study of clinical psychologists, Tay, Alcock, and Scior (2018) found that 62.7% of their 678 participants reported having mental health problems at some point in their lives. The percentage of participants reporting depressive symptoms were split into two groups, mild to moderate depression (44% of all participants) and severe depression (8% of all participants). Of note, the way Tay and colleagues reported their data, there could be overlap in the two groups. In this way, Tay and colleagues' findings are more similar to those in the present study rather than those in past studies.

Roughly comparing the above findings to established lifetime prevalence estimates of various disorders is eye opening. According to the National Comorbidity Survey Replication (NCS-R), observed lifetime prevalence of any disorder in the United States is 46.4% and for any mood disorder is 20.8% (Kessler et al., 2005). While it must be said that direct comparison is not

possible due to marked differences in methodology – the findings from these studies are not prevalence estimates – nevertheless, the three studies with psychologists are consistent in finding that participants’ self-report of lifetime mental illness are higher than general prevalence estimates by 15-25%. This means that it is likely that psychologists, overall, have experienced mental illness and in particular depression at rates higher than the general population.

Interestingly, the present study appears to be the first that included any measure of current psychological distress. This is notable; even though 72.7% of participants in our study answered that they had ever experienced a mental illness, participants’ mean score on the GP-CORE (the measure of psychological distress used) was comparable to a nonclinical sample for both men and women. Even the top 75th percentile for the GP-CORE mean for both men and women was below the cutoff for a clinical sample. These findings appear to be contradictory. While participants’ lifetime prevalence of any disorder is notably higher than epidemiological estimates, on average their current symptoms are nonclinical in nature. One explanation for this finding could be that psychologists may have higher rates of their own mental illness, but they also have higher rates of having sought mental health treatment – and the mental health treatment succeeded in returning psychologists to a healthy state. In order to explore this possibility, we look to our data on participants’ own mental health treatment.

Psychologists’ own Mental Health Treatment

In the present study, 76.2% of participants, or 109 of 143, reported they had received treatment for mental illness in their lifetime with 74.8% or 107 reporting they had attended psychotherapy and 53.1% reporting they been on any psychoactive medications. Pope and Tabachnick (1994) found 84% of their 476 participants reported having been a client in therapy; they did not report if participants had been in other kinds of mental health treatment. Gilroy and

colleagues (2002) were much more targeted in their study; they asked participants to indicate if they had experienced depressive symptoms while working as clinicians and whether they had sought treatment for those symptoms in particular. Under these circumstances, 42% reported they had sought treatment with 14% indicating they had been prescribed psychotropic medication and 0.5% reporting they had been hospitalized. It is possible that, had Gilroy and colleagues asked about mental illness and treatment in a way that was more general, as was done in Pope and Tabachnick's study and the present one, that the findings would be more similar. As it stands, however, it is difficult to compare.

In the study by Tay and colleagues (2018), they only asked participants who had experienced mental health problems if they sought help. Of the 425 who reported mental health problems, 84% or 357 participants sought help. This represents 53% of their total sample. While Tay and colleagues did not report the number of participants who sought treatment from any psychotherapist, of the 425 who reported mental health problems 46% had seen a private psychotherapist, 13% had seen a private clinical psychologist, 12% had seen a clinical psychologist through the National Health Service (NHS) - the United Kingdom's free, state-sponsored health care system, and 11% had seen an NHS psychotherapist. It is also not clear how many participants had ever been on psychoactive medication, although of the 425 participants with mental health problems, 53% reported they had gone to a general practitioner, 10% to an NHS psychiatrist, and 4% to private psychiatrist. As a note, percentages total more than 100% because participants could choose more than one type of health professional. Similar to the difficulty in comparing Gilroy and colleagues' study to the present one, it is also difficult to compare Tay and colleagues' due to differences in methodology.

Overall, the differences in the way each study asked about mental illness and mental health treatment make it difficult to ascertain if the differences found are reflective of population differences or just divergence in methodology. Future studies would do well to either replicate the methods used in previous studies or find a way to standardize their methods.

Hypothesis 1: Group Identification and Psychologists' own Psychological distress

My hypothesis that the relationship between psychological distress and group identification with people with mental illness (GIMI) and people who use mental health services (GIU) would be more likely exponential than linear was not supported. Neither the linear nor exponential regressions for GIMI were significant. In contrast, both the linear and exponential regressions for GIU were significant, with the linear regression accounting for about the same amount of variance (3.8%) as the exponential regression (3.0%), contrary to my hypothesis. Both the linear and exponential models were consistent with the data and had small effects. Also, in both cases more severe psychological distress significantly predicted lower group identification with people who use mental health services; these negative relationships were the opposite of what I expected.

On the other hand, the correlation between GIMI and GIU was significant, as predicted. Psychologists who identified with others who have mental illness appeared to also identify with others who use mental health services. The correlation was not as strong as I expected, however. It was weak to moderate which indicates that, while the two concepts are related, they are nevertheless distinct.

It was surprising that GIU was significantly related to psychological distress but GIMI was not. As a measure of the symptoms that make up a mental illness, I would have predicted that psychological distress would be more directly related to identifying with other people with

mental illness rather than other people who use mental health services. Considering the significant (though weak to moderate) correlation between GIMI and GIU, I would have expected psychological distress to predict both types of group identification. It is possible that with more participants, either the exponential or linear regressions for GIMI would have been significant, but even still the standardized coefficients for GIMI and the amount of variance explained by GIMI were smaller than for GIU.

In any case, the regressions for GIU indicated that the more serious the psychological distress the lower the GIU for participants. It may be that psychological distress are in some way inhibiting participants' ability to relate to others who use mental health service. Or conversely, as people identify more with those who use services their psychological distress decrease. This could be explained by a third variable: actually receiving mental health services. Perhaps those who receive services may be more likely to identify with others who use services. In addition, those who receive services are more likely to have fewer symptoms.

Follow-Up Analysis: Psychological distress, Group Identification, and Self-Stigma of Seeking Help

With these surprising results, we looked for a third variable that might impact the relationship between psychological distress and group identification with people who use mental health services (GIU). I tested a model whereby SSOSH mediated the relationship between psychological distress and GIU. Results indicated that SSOSH fully mediated the relationship between psychological distress and GIU whereby higher psychological distress was related to higher self-stigma which was related to less group identification.

The fact that higher psychological distress predict higher SSOSH could be explained by the notion of salience. Bitman-Heinrichs (2017) suggested salience might explain an unexpected

finding in her study: that higher public stigma of seeking help predicted actual help seeking behavior in a sample of 125 clinically distressed adults. This finding was different than other studies in the literature that found that higher public stigma was associated with lower intentions to seek help (e.g. Vogel, Wade, & Hackler, 2007) with samples that were not clinically distressed. Bitman-Heinrichs (2017) suggested that in clinically distressed populations issues of stigma are more salient and more imminent; people with clinical distress are likely to be more aware of and perhaps more concerned about public stigma.

Even though the finding in the present study is regarding self-stigma, a similar process could be at play. If psychological distress is higher, then self-stigma of seeking help (SSOSH) could be more salient to the person. If SSOSH were higher, then a person would have endorsed more strongly items such as, “I would feel worse about myself if I could not solve my own problems.” If my psychological distress were at a point where I could solve my own problems, then it wouldn’t bother me as much to think about going to get help. I am not faced with the decision of whether or not I would need professional help. The question is hypothetical. But as soon as I am in clinical distress and I am faced with a situation where I cannot solve my problems on my own, it’s not hypothetical anymore. Because it’s not hypothetical, the shame of needing to get help (the self-stigma of seeking help) is activated in a way that wasn’t possible before.

This process could be underscored by the fact that this is a sample of health service psychologists. There is an expectation that, as a psychologist, they will need to seek help from a therapist at some point. Seeking therapy in graduate school is strongly encouraged in many programs. When seeking therapy is a hypothetical, it is not difficult to endorse self-stigma items in a way that is consistent with this value, producing lower total scores on the SSOSH. However,

if a psychologist is in clinical distress then seeking help is no longer hypothetical. Suddenly, the shame of seeking help is real whether or not it is consistent with my professional values; hence greater endorsement of SSOSH.

The next step in the mediation, that higher SSOSH is related to lower group identification with people who use mental health services (GIU), feels logical upon closer consideration of the types of items in each scale. Higher SSOSH scores indicate higher endorsement of items like “It would make me feel inferior to ask a therapist for help.” Lower GIU scores indicate lower endorsement of items like, “I am pleased to be a person who uses mental health services.” If a person feels inferior to ask a therapist for help would he or she be pleased to be a person who uses mental health services? Probably not. The data provide some evidence for this notion.

It is important to note two major limitations of this finding: this analysis was done post hoc and with cross-sectional data. Certainly, no interpretations about the direction of the effect or causality can be made at this time. The results from this mediation model are tentative and need considerable follow-up before any definitive statements can be made.

Hypothesis 2: Group Identification and Psychologists’ own Psychotherapy

My hypothesis that the more therapy sessions participants had attended in the last five years or since obtaining their license, the greater the degree to which they would identify with people who use mental health services was supported; the correlation between number of sessions and GIU was positive and significant. That said, the correlation was weak ($r = .25$). This is interesting, considering one might assume the number of therapy sessions would have a strong relationship with whether participants identified with others who use mental health services, but this was not the case. It would be interesting to explore what other factors may contribute to

GIU, such as self-stigma of mental illness as described above. It is possible that other types of mental health related stigma could also play a part.

Additionally, the hierarchical regression analysis suggested that number of therapy sessions and not simply whether participants had ever used mental health services was what predicted group identification with people who use mental health services. This is curious, as one might assume that whether participants had ever used mental health services – an umbrella variable that included whether participants had been to therapy – might be a more powerful predictor of group identification with people who use mental health services than number of therapy sessions. That said, number of therapy sessions is a variable with more depth than whether they had ever used mental health services, a categorical variable. Even if participants endorsed that they had used mental health services it does not indicate how often or how recently they had used mental health services. People who visited their primary care provider once 25 years ago are potentially lumped in with people who have attended psychotherapy weekly for most of their adult lives. In the former situation the participant is unlikely to identify with others who have used mental health services, while in the latter they are more likely.

Hypothesis 3: Group Identification with Psychologists and People Who Use Mental Health Services

Contrary to my hypothesis, the degree to which participants identified with being a licensed psychologist did not significantly correlate with the degree to which they identified with people who use mental health services. Neither did the degree to which participants identified with people with mental illness correlate with the degree to which participants identify with being a licensed psychologist. That said, as participants' psychological distress grew more severe their group identification with other psychologists decreased significantly. There is an important

distinction here; it is not group identification with service users or people with mental illness that relates to decreased group identification with being a psychologist, but rather the presence of psychological distress in and of itself. This suggests that the mechanism at play here may not be a matter of feeling conflicted about group identification, but rather there seems to be a more direct relationship between psychological distress and group identification with being a licensed psychologist.

Self-categorization theory (Turner & Reynolds, 2012; Turner, Hogg, Oakes, Reicher, & Wetherell, 1987; Hogg, Terry, & White, 1995), which is related to social identity theory (Tajfel & Turner, 1986), posits that people's social identities are defined by categorizing the self and others into distinct ingroups and outgroups according to prototypes. A prototype is a subjective representation of the key characteristics of a social category and is context specific; it can change over time or be based on immediate social situation. Because ingroups and outgroups are defined as distinct entities, prototypes and their related ingroups are strongly influenced by important outgroups (Hogg et al., 1995). In the case of psychologists, an important outgroup is their clients – people with mental illness and people who use mental health services. Prototypically, it may be that a major difference between a psychologist and their client is that a psychologist is supposed to have a healthy level of psychological distress in order to take care of clients. If a psychologist does not have a healthy level of psychological distress, they struggle to relate to the prototype of a psychologist. Future research could explore this possibility by assessing what specific characteristics make up the prototype of a psychologist.

Hypothesis 4: Contact and Various Types of Stigma

My hypothesis regarding the way various types of contact would impact three aspects of mental health related stigma, had little support overall. Three stepwise hierarchical regressions

were meant to test how increasing levels of contact would impact mental health related stigma in psychologists; each type of mental health related stigma was assessed with its own five step hierarchical regression. The three types of mental health related stigma were: personal stigma of mental illness, self-stigma of help-seeking, and self-stigma of mental illness. The five steps of each hierarchical regression were: 1) hours per week spent providing mental health services, which stands as a measure of simple contact, 2) degree of contact, a measure designed to assess for different types of contact with people with mental illness, 3) reported history of own mental illness and number of therapy sessions in the last five years or since receiving license, 4) group identification with people with mental illness, and 5) group identification with people who use mental health services.

Personal stigma of mental illness. Of all the variables tested, only group identification with people with mental illness (GIMI) significantly predicted personal stigma of mental illness. As GIMI increased personal stigma of mental illness decreased. This finding is notable because personal stigma of mental illness, as a measure of the participants' own attitudes toward those with mental illness, is likely the cleanest estimate of stigma or prejudice against another group in this study. Allport's contact hypothesis (1954) would have predicted the contact variable (hours per week spent providing services to people with mental illness) would predict less prejudice. If we remember, however, Allport's contact hypothesis has four conditions for intergroup contact to lower prejudice: the groups must have equal status within the contact situation; the groups must be working toward common goals; the groups must be cooperating with one another and not competing; and the groups must have support from authorities, law, or custom. Doubtless, at least one condition is not met for contact between psychologists and their clients: there is not equal status in the contact situation. That said, Pettigrew (1998) noted that research over the last

fifty years suggests contact should lower prejudice even absent one or more of the four conditions. And yet that is not reflected in these results.

This is where intergroup contact theory may help explain the results. Pettigrew's (1998) intergroup contact theory improves upon Allport's (1954) contact hypothesis by positing four processes by which contact decreases prejudice or stigma: learning about the outgroup, changing behavior (because behavior change often precedes attitude change), generating emotional ties in the intergroup relationship like one sees in friendship, and providing insight about the ingroup as well as the outgroup. The essence of these processes is that a friendship-like relationship needs to develop in order for contact to have positive effects (Pettigrew, 1998; 2011). Here again, we might expect some of the other variables in the series of regressions to predict lower stigma. For example, the degree of contact was meant to measure how personal participants' relationships with people with mental illness were. On the degree of contact measure, watching a documentary about a person with a mental illness has a lower score than living with a person with a mental illness. However, a pitfall of this particular measure is that it asks about the existence of certain experiences or relationships, but not their quality. If I live with a person with mental illness with whom I have a poor relationship, this is not likely to decrease my personal stigma. On the other hand, it also makes sense that identifying myself as a person with mental illness would lower personal stigma – as we found in this study. The items on the identification scale include being pleased one has a mental illness and feeling strong ties with others who have mental illness. Scoring high on the group identification with people with mental illness measure indicates the participant may have generated those emotional ties with others with mental illness.

Self-stigma of seeking help. The strongest predictor of self-stigma of seeking help (SSOSH) in terms of variance explained was not any of the predicted variables, but current

psychological distress, which explained 21.2% of the variance. The significant positive relationship between SSOSH and current psychological distress has been noted elsewhere in the literature including in a military sample (Heath, Seidman, Vogel, Cornish, & Wade, 2017), considering self-stigma and current depression symptoms (Kendra, Mohr, & Pollard, 2014), and self-stigma and psychological well-being (Owen, Thomas, & Rodolfa, 2013). It appears that the relationship between self-stigma and current psychological symptoms is an area that deserves more specific attention, especially considering the relationship found in the above described mediation analysis. I recommend that future studies explore this relationship in more detail.

Another interesting finding was that, after controlling for group identification with people who use mental health services, the more participants identified with other people with mental illness the higher their self-stigma of seeking help. This finding accounted for 14.2% of the variance in self-stigma of seeking help. Considering the previously found relationship with self-stigma of seeking help and reduced likelihood of seeking psychological help in other populations, especially college students (Vogel, Wade, & Hackler, 2007; Vogel et al., 2017), it would be instructive to see if a similar relationship is present with psychologists. In the event that it is, testing previously attempted interventions to buffer against self-stigma of seeking help with the new population of psychologists could produce fruit. For example, creating a public health campaign with electronic brochures could lower this self-stigma. Continuing education about the prevalence of mental illness among psychologists and steps to help those that are experiencing symptoms could possibly both alleviate stigma and help prevent a situation where a psychologists' mental health deteriorates to the point where they are impaired.

Self-stigma of mental illness. Only the degree of contact that participants had with those with mental illness and identification with those who have a mental illness predicted self-stigma

of mental illness. In contrast to the relationship found with self-stigma of seeking help, I found that as participants reported greater identification with those who have a mental illness, they had lower self-stigma of mental illness. Based on this relationship alone it would be tempting to say that greater identification with those with mental illness is related to lower self-stigma. Based on previous findings, however, there appears to be a more complex relationship going on. Future research would do well to clarify this relationship.

Measurement concerns. It should be noted that neither hours per week spent providing mental health services nor self-report of history of mental illness were significant predictors in any of the three hierarchical regressions. This could be due to any of several factors. It could simply be that there was no relationship to find between them and the stigma variables, but it could also be due to the low sample size or due to problems in measurement. The power analysis indicated that we would need usable data from almost 400 participants to detect a small effect with seven predictor variables and we only had 143. I suspect this might be what happened, for example, in Step 3 of the personal stigma of mental illness regression where own mental illness came up as a significant predictor, but the overall step was not significant.

That said, the scores could also have been poor representations of the concept of interest. Hours per week spent providing mental health services may not have been a good indicator of how much contact participants had had with people with mental illness and people who use mental health services, especially for clinicians who had been working as licensed psychologists for decades. For example, several participants who had been licensed since the 1970's or 1980's saw clients for 25 hours per week or less. It is possible that earlier in their career they may have seen more clients per week, but now they see fewer because they are in semi-retirement or have moved into administrative or teaching positions that involve less face-to-face client work. And

then it could be argued that cumulative hours spent with people with mental illness or people who use mental health services would be a better indicator of simple contact than hours per week spent with clients recently (See Appendix B).

Group Identification and Mental Health Related Stigma

Interestingly, as group identification with people who use mental health services increased self-stigma of seeking help and self-stigma of mental illness decreased. Similarly, as group identification with people with mental illness increased self-stigma of mental illness decreased. Considering people with greater self-stigma are more likely to report diminished self-esteem (Corrigan, Watson, & Barr, 2006; Corrigan, Rafacz, & Rüsçh, 2011), these findings are consistent with research that found disability pride protects self-esteem (Bogart, Lund, & Rottenstein, 2018) according to the rejection-identification model (RIM; Branscombe, Schmitt, & Harvey, 1999). The RIM stated that African-Americans' willingness to make attributions of prejudice across a variety of life situations was directly and negatively related to personal well-being (defined as higher personal self-esteem and lower experience of negative emotions), but that their attributions would be mediated by minority group identification, which would have a positive effect on well-being (Branscombe et al., 1999). Further development on the RIM suggested that the experience of stigma or discrimination is associated with reduced self-esteem but positive ingroup identification serves as a mediating variable that supports self-esteem and has been verified in a variety of stigmatized groups including ethnic minorities, international students, and even people with dwarfism (Bogart et al., 2018). Future research should explore the relationship between disability identity (specifically psychiatric disability identity) and stigma.

Limitations and Future Directions

There are limitations to the present study that need to be noted. First, it is important to note that the results presented are correlational and do not show causation. This is underscored by the cross-sectional nature of this data, which did not allow for us to establish temporality in the findings. In the future, longitudinal research would aid in establishing if, for example, psychological distress proceeds self-stigma of seeking help which proceeds group identification with people who use mental health services. Experimental designs would be ideal in future research, as this would allow for more direct testing of causal elements. Additionally, this study is limited by its small sample size. This is not to say that collecting data from licensed psychologists is an easy task – quite the contrary. However, it is possible that with a sample size of 143 we did not have the requisite power to find significance in some of these analyses.

Then, the method of data collection, namely soliciting responses from licensed psychologists by way of American Psychological Association (APA) and state association Listservs was not ideal. For one, it had been my intention to follow the data collection methods of previous studies (Pope & Tabachnick, 1994; Gilroy et al., 2002) by referring to the APA Membership Directory, randomly selecting members, and sending private invitations to complete the study. This would have allowed me to calculate response rates and have a better idea of what sort of psychologists were choosing to respond (gender, location, etc.) compared to those who were not. It would have likely been a more varied sample in some regards, as the APA Directory is national. However, using the APA Directory for research purposes is now against its acceptable use policy. After exploring other avenues for collecting data, it was determined that sending requests for participants using Listservs was the only feasible option.

This method of data collection, unfortunately, introduces self-selection bias. For example, it is possible that psychologists who have a history of mental illness were more likely to respond than those without such a history. Without knowing exactly to whom the invitation was sent it is not possible to estimate the degree to which self-selection bias may have been problematic. It is therefore recommended that future researchers attempt to collect data in a more comprehensive manner, such as by getting a nationally representative sample of psychologists. In addition, there were notable differences between my sample's demographics and those reported by the 2015 American Psychological Association (APA) survey of health service psychologists. In terms of percentages, compared to the 2015 APA sample, the present study had more women, fewer European American/White, fewer Latin American/Hispanic, more Asian/Asian American, fewer African American, more multiracial American, and more people with at least one disability. It is not known how these differences in demographics might have impacted the study, but future studies would do well to attempt to approximate the demographics of the U.S. population of health service psychologists.

Next, this study was limited by lack of previously validated measures of several of the variables of interest. For instance, after searching in vain for a measure of egalitarianism between therapist and client I was not able to find one. The attempt to create one for the purpose of this study was not successful; the psychometric properties were not adequate for use in analyses. As a result, I could not fully test Hypothesis 4: how types of contact impacted stigma. Relatedly, in the literature there is little standardization of measures or methodology used between researchers, making comparison between studies difficult. For example, in their studies of psychologists, Pope and Tabachnick (1994) and Gilroy, Carroll, and Murra (2002) collected data on participants' history of depression rather than on mental illness in general. In contrast, Tay,

Alcock, and Scior (2018) collected data on mental illness in general. This makes it more difficult to compare findings. Additionally, Tay and colleagues – the only one of the three studies to measure participants’ stigma – used different measures of stigma than I did, again making it difficult to compare findings. I suggest in the future attempting to standardize which measures are used, specifically with regard to stigma and psychological distress, so that comparisons between studies would be possible.

Another limitation of this study is that, for Hypothesis 4 testing how various types of contact impact stigma, the same six independent variables were used to predict personal stigma of mental illness, self-stigma of seeking help, and self-stigma of mental illness. Considering the conceptual differences between these three types of stigma, it would have been better to make separate predictions for each type of stigma that were specific to each. In addition, it would be interesting to assess how the level of severity of clients seen by participants impacted their stigma, as contact with more severe clients could possibly lower stigma.

A limitation worth noting is that the measures used in this study were all face-valid measures – direct measures of stigma – which has its drawbacks. Micheals & Corrigan (2013) recommended testing for mental illness stigma in a way that reduces participants’ ability to answer in a socially desirable way. Micheals & Corrigan (2013) created a measure of mental illness stigma that would have reduced effects of social desirability, called the Knowledge Test of Mental Illness (KTMI). Basically, this measure purports to be a multiple-choice test of the participants’ knowledge about mental illness and the treatments associated with it. The truth, however, is that neither of the two options presented are accurate; rather the accurate choice is somewhere in between the two answers. For example, one question is, “The divorce rate among the general population is about 50%. What is the divorce rate among people who experience

mental illness?” The answer choices are “a) Greater than 70%,” and “b) Less than 50%.” The true answer is that the divorce rate among people with mental illness is the same as the general population – about 50%. This, however, is not an option. The selection of one answer over the other, therefore, indicates whether a person is higher or lower in stigma against people with mental illness. Because the measure pretends to be a quiz of knowledge it can measure stigma without asking about it directly.

Unfortunately, after much deliberation it was decided that the KTMI would not be an appropriate measure for professional psychologists. For one, professional psychologists may know the most accurate answer and realize that the KTMI didn’t offer that answer. This could allow them to realize that the KTMI wasn’t actually assessing knowledge, but something else – attitudes. Therefore, the KTMI wouldn’t function as a measure of stigma with reduced effects of social desirability, defeating the point of using it. Secondly, eight of the fourteen items refer to schizophrenia instead of general mental illness or even severe mental illness. Thus, a more appropriate name might have been the “Knowledge Test of Schizophrenia” rather than the “Knowledge Test of Mental Illness.” The focus of the present study was not schizophrenia but rather more general mental illness, which made the KTMI an inappropriate choice in this way as well.

Finally, it would be instructive to study the interplay between reported mental illness and psychological symptoms. Of the four studies collecting data on psychologists’ own mental illness in the last 26 years (Pope and Tabachnick, 1994; Gilroy et al., 2002; Tay et al., 2018), this is the only study to ask about both history of mental illness and to measure current psychological distress. Based on preliminary analyses, it appears that current psychological distress is a stronger predictor of the self-stigma of seeking help and mental illness than reported history of

mental illness. While history of mental illness did not significantly predict any of the three types of mental health stigma, psychological distress significantly predicted both types of self-stigma significantly. Psychological distress accounted for over 20% of the variance in self-stigma of seeking help – the most variance accounted for by any single predictor in this study. Which begs the question, what part does history of mental illness play in this 26-year-old story? Did the authors of all four studies – the present study and the three above cited studies – just follow a red herring by collecting information on psychologists' history of mental illness? Or is there some sort of relationship between history of mental illness and stigma that this study is overlooking?

Conclusion

This was the first study in 18 years to assess licensed psychologists in the United States for their own mental health and treatment history along and the only known study linking U.S. psychologists' own mental health to stigmatizing attitudes toward people with mental illness, including themselves. I had hypothesized that, based on Allport's (1954) contact hypothesis and Pettigrew's (1998, 2011) intergroup contact theory, increased levels of contact with people with mental illness would result in lower levels of stigma – especially personal contact. This hypothesis was not supported, at least as reflected in the way contact was measured in this study. Instead a complex relationship between psychologists' own mental illness, current psychological distress, and mental health stigma emerged.

According to the results of this study, Psychologists may have higher lifetime rates of mental illness than the general population, in particular depression. In contrast, the psychologists' current psychological distress was more similar to a nonclinical sample than a clinical one. At the same time, the levels of psychologists seeking mental health treatment was high in this study (76.2%). It was lower than one study's estimate of psychologists (Pope &

Tabachnick, 1994) but higher than others (Gilroy et al., 2002; Tay et al., 2018), although major differences in methodology make comparison difficult.

With regard to mental health stigma, the strongest relationship I found was between psychologists' psychological distress and their levels of self-stigma of seeking help. I ran a mediation model testing the mediating role of self-stigma of seeking help between current psychological distress and group identification with people who use mental health services; it was significant. This provided (limited) evidence of the notion that self-stigma of seeking help is activated by psychological distress. In other words, as psychological distress increased it made self-stigma of mental illness more salient, resulting in higher endorsement of the stigma. This in turn, made it less likely participants would endorse group identification with people who use mental health services.

Additionally, psychological distress predicted lower group identification with psychologists. This may provide evidence that clinical levels of psychological distress are contrary to the prototype, or the collective mental image, of what makes a psychologist according to self-categorization theory (Turner & Reynolds, 2012). According to a discourse going back to Carl Jung, Zeruvabel and Wright (2012) suggested that there is a common notion among therapists that there is a split between clients/patients as the wounded ones and psychotherapists as the healers. Applying this notion to the concept of the prototype of a licensed psychologist, it seems likely that a psychologist is expected to be the picture of good mental health in order to do their best work. This would indicate that the prototype of a psychologist doesn't include a history of mental illness, and certainly not current symptoms of mental illness. This would make sense of the repeated finding that many psychotherapists stigmatize colleagues who have a history of mental illness or are currently experiencing it (Knaak, Mantler, & Szeto,

2017; Zerubavel & Wright, 2012; Cain, 2000); perhaps psychotherapists are upholding the prototype of a licensed psychologists and are chastising those who do not fit it.

We see this stigmatization despite the fact that studies like this dissertation have repeatedly found that licensed psychologists have a higher than average history of experiencing mental illness (Pope & Tabachnick, 1994; Gilroy et al., 2002; Tay et al., 2018). This is problematic not only because it means the prototype is unrealistic but because it discourages psychologists from seeking professional help and social support from colleagues. Instead, it encourages psychologists to hide the mental illness. This is considering that a history of mental illness is a risk factor for developing a mental illness in the future (American Psychiatric Association, 2013), psychologists may be at increased risk for developing a mental illness at some point in their career or for experiencing a chronic mental illness. If they are less willing to get the help they need because of stigma, this makes psychologists more vulnerable to issues like countertransference, compassion fatigue, and in some cases professional impairment (Zerubavel & Wright, 2012).

We need not be ashamed of a history of mental illness or other personal struggles. Calling on the paradigm of the wounded healer – a paradigm that dates as far back as ancient Greece – Zerubavel and Wright (2012) note that psychotherapists can draw upon their woundedness to help heal both themselves and their clients. Also, many psychotherapists choose their profession specifically because they have been through their own journey of pain and suffering (Farber, Manevich, Metzger, & Saypol, 2005). Zerubavel and Wright (2012) stated that all therapists have some degree of woundedness in that we all have had painful experiences, have experienced physical or emotional suffering, or have overcome adversity. The findings from this study along

with studies in the past underscore this notion – the majority of licensed psychologists report having experienced some kind of mental illness in their past.

Instead of shaming psychologists into fear and silence for experiencing symptoms of mental illness, I believe we as a profession need to learn to support one another and embrace this all too common experience as an opportunity for growth both personally and professionally. It is time that we pull back the curtain and be vulnerable about our own experiences with mental illness as well as other areas where we have both been wounded and healed. It is time we support one another, helping each other get the interventions we need when actively struggling with a mental illness. It is time we see the woundedness and suffering in our own lives as a source of healing and resilience. Afterall, isn't that what we encourage our clients to do?

REFERENCES

- Allport, G.W. (1954). *The nature of prejudice*. Reading, MA: Addison-Wesley Publishing.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: 5th Ed.* Washington, DC: Author.
- American Psychological Association. (2016). *2015 survey of psychology health service providers*. Washington, DC: Author. Retrieved from <https://www.apa.org/workforce/publications/15-health-service-providers>.
- American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, Amended June 1, 2010 and January 1, 2017). Retrieved from <http://www.apa.org/ethics/code/index.aspx>.
- Barkham, M., Gilbert, N., Connell, J., Marshall, C., & Twigg, E. (2005). Suitability and utility of the CORE-OM and CORE-A for assessing severity of presenting problems in psychological therapy services based in primary and secondary care settings. *British Journal of Psychiatry*, *186*, 239-246.
- Bathje, G.J. & Pryor, J.B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, *33*(2), 161-177.
- Ben-Porath, D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behavior and the presence of depression. *Journal of Social and Clinical Psychology*, *21*, 400-413.
- Bitman-Heinrichs, R.L. (2017). *From attitude to intent to action: Predictors of psychological help-seeking behavior among clinically distressed adults* [Unpublished doctoral dissertation]. Iowa State University.
- Bogart, K.R., Lund, E.M., & Rottenstein, A. (2018). Disability pride protects self-esteem through the Rejection-Identification Model. *Rehabilitation Psychology*, *63*(1), 155-159.
- Branscombe, N.R., Schmitt, M.T., & Harvey, R.D. (1999). Perceiving pervasive discrimination among African Americans: Implications for group identification and well-being. *Journal of Personality and Social Psychology*, *77*(1), 135-149.
- Brown, L. (2010). *Feminist Therapy*. Washington, D.C.: American Psychological Association.
- Cain, N.R. (2000). Psychotherapists with personal histories of psychiatric hospitalization: Countertransference in wounded healers. *Psychiatric Rehabilitation Journal*, *24*, 22-28.
- Cash, T., Begley, P., McCown, D., & Weise, B. (1975). When counselors are heard but not seen: Initial impact of physical attractiveness. *Journal of Counseling Psychology*, *22*, 273-279.

- Centers for Disease Control and Prevention. (CDC, 2010). Attitudes Toward Mental Illness: 35 States, District of Columbia, and Puerto Rico. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5920a3.htm>.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S. Bezborodovs, N., ... Thonicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45, 11-27.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614-625.
- Corrigan, P., Edwards, A., Green, A., Diwan, S., & Penn, D. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, 27(2), 219-225.
- Corrigan, P., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventative Psychology*, 11, 179-190.
- Corrigan, P., Larson, J., Michaels, P., Buchholz, B., Del Rossi, R., Fontecchio, M.J., ... Rüsçh, N. (2015). Diminishing the self-stigma of mental illness by coming out proud. *Psychiatry Research*, 229 (1-2), 148-154.
- Corrigan, P., Rafacz, J., & Rüsçh, N. (2011). Examining a progressive model of self-stigma and its impact on people with serious mental illness. *Psychiatry Research*, 189(3), 339-343.
- Corrigan, P., Roe, D., & Tsang, H.W.H. (2011). *Challenging the stigma of mental illness: Lessons for therapists and advocates*. Oxford: Wiley-Blackwell.
- Corrigan, P., Watson, A., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25(9), 875-884.
- Crede, M. (2010). Random responding as a threat to the validity of effect size estimates in correlational research. *Educational and Psychological Measurement*, 70, 596-612.
- Day, E., Edgren, K., & Eshleman, A. (2007). Measuring stigma toward mental illness: Development and application of the Mental Illness Stigma Scale. *Journal of Applied Social Psychology*, 37(10), 2191-2219.
- Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I. Kovess, V., Lepine, J., ... Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys, *JAMA*, 291, 2581-2590.
- Doosje, B., Ellemers, N., & Spears, R. (1995). Perceived intragroup variability as a function of group status and identification. *Journal of Experimental Social Psychology*, 31, 410-436.

- Dovidio, J.F., Major, B., & Crocker, J. (2000). Stigma: Introduction and overview. In *The Social Psychology of Stigma* (Eds. Heatherton, T.F., Kleck, R.E., Hebl, M.R., & Hull, J.G.). New York: The Guildford Press.
- Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review*, 66, 522-541.
- Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J., & McGrath, G. (2000). CORE: Clinical Outcomes in Routine Evaluation. *Journal of Mental Health*, (9)3, 247-255.
- Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60.
- Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39, 175-191.
- Farber, B.A., Manevich, I., Metzger, J., Saypol, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology/In Session*, 61, 1009-1031.
- Fischer, E.H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, 36, 368-373.
- Fischer, E.H., & Turner, J. (1970). Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology*, 35, 79-90.
- Gelso, C., Kelley, F., Fuertes, J., Marmarosh, C., Holmes, S., Costa, C., & Hancock, G. (2005). Measuring the real relationship in psychotherapy: Initial validation of the therapist form. *Journal of Counseling Psychology*, 52(4), 640-649.
- Gilroy, P.J., Carroll, L., & Murra, J. (2002). A preliminary survey of counseling psychologists' personal experiences with depression and treatment. *Professional Psychology: Research and Practice*, 33(4), 402-407.
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York: Simon & Schuster, Inc.
- Hayes, A.F. (2013). *Introduction to mediation, moderation, and conditional process analysis: A regression-based approach*. New York, NY: Guildford Press.
- Heath, P.J., Seidman, A.J., Vogel, D.L., Cornish, M.A., & Wade, N.G. (2017). Help-seeking stigma among men in the military: The interaction of restrictive emotionality and distress. *Psychology of Men & Masculinity*, 18(3), 193-197.

- Henderson, C., Evans-Lacko, S., Flach, C., & Thornicroft, G. (2012). Responses to Mental Health Stigma Questions: The Importance of Social Desirability and Data Collection Method. *The Canadian Journal of Psychiatry*, 57(3): 152-160.
- Hitchcock, A. (Producer & Director). (1960). *Psycho* [Motion picture], United States: Paramount
- Hogg, M.A., Terry, D.J., & White, K.M. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly*, 58(4), 255-269.
- Holmes, E., Corrigan, P., Williams, P., Canar, J., & Kubiak, M. (1999). Changing attitudes about schizophrenia. *Schizophrenia Bulletin*, 25(3), 447-456.
- Howard, M.C. (2016). A review of exploratory factor analysis decisions and overview of current practices: What we are doing and how can we improve? *International Journal of Human-Computer Interaction*, 32(1), 51-62.
- Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology*, 42, 40-46.
- Kendra, M.S., Mohr, J.J., & Pollard, J.W. (2014). The stigma of having psychological problems: Relations with engagement, working alliance, and depression in psychotherapy. *Psychotherapy*, 51(4), 563-573.
- Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593-602.
- Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 62(2), 617-627.
- Knaak, S., Mantler, E., & Szeto, A. (2017). Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare Management Forum*, 30(2), 111-116.
- Komiya, N., Good, G., & Sherod, N. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology*, 47, 138-143.
- Kondo, N. (2008). Mental illness in film. *Psychiatric Rehabilitation Journal*, 31(3), 250-252.
- Kopera, M., Suszek, H., Bonar, E., Myszk, M., Gmaj, B., Ilgen, M., & Wojnar, M. (2015). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal*, 51, 628-634.

- Link, B.G. (1987). Understanding labeling effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review*, 52, 96-112.
- Link, B.G., Cullen, F.T., Frank, J., & Wozniak, J. (1987). The social rejection of former mental patients: Understanding why labels matter. *American Journal of Sociology*, 92, 1461-1500.
- Link, B.G. & Phelan, J.C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363-385.
- McGinty, E. E., Kennedy-Hendricks, A., Choksy, S., & Barry, C. L. (2016). Trends in news media coverage of mental illness in the United States: 1995-2014. *Health Affairs*, 35(6), 1121-1129.
- McGinty, E. E., Webster, D., Jarlenski, M., Barry, C. L. (2014). News media framing of serious mental illness and gun violence in the United States, 1997-2012. *American Journal of Public Health*, 104(3), 406-413.
- Menard, S. (1995). *Applied logistic regression analysis: Sage university series on quantitative applications in the social sciences*. Thousand Oaks, CA: Sage.
- Mental Health America of Eastern Missouri (2011). Articles: Mental health, treatment, and stigma statistics. Retrieved from http://mha-em.org/index.php?option=com_content&view=article&id=132:mental-health-treatment-and-stigma-statistics&catid=12:media.
- Michaels, P. & Corrigan, P. (2013). Measuring mental illness stigma with diminished social desirability effects. *Journal of Mental Health*, 22(3), 218-226.
- Morris, N. P. (2016, December 13). Mental illness on the silver screen. *Scientific American*, Retrieved from <https://blogs.scientificamerican.com/mind-guest-blog/mental-illness-on-the-silver-screen>.
- O'Brien, R. M. (2007). A caution regarding rules of thumb for variance inflation factors. *Quality & Quantity*, 4, 673-690.
- Owen, J., Thomas, L., Rodolfa, E. (2013). Stigma for seeking therapy: Self-stigma, social stigma, and therapeutic processes. *The Counseling Psychologist*, 41(6), 857-880.
- Penn, D., Guynan, K., Daily, T., Spaulding, W., Garbin, C., & Sullivan, M. (1994). Dispelling the stigma of schizophrenia: What sort of information is best? *Schizophrenia Bulletin*, 20(3), 567-578.
- Pettigrew, T.F. (1998). Intergroup contact theory. *Annual Review of Psychology*, 49, 65-85.

- Pettigrew, T.F., Tropp, L.R., Wagner, U., & Christ, O. (2011). Recent advances in intergroup contact theory. *International Journal of Intercultural Relations*, 35, 271-280.
- Phelan, J., Link, B., & Dovidio, J. (2008). Stigma and prejudice: One animal or two? *Social Science and Medicine*, 67, 358-367.
- Pope, K. N. & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. *Professional Psychology: Research and Practice*, 25(3), 247-58.
- Rader, J. & Gilbert, L.A. (2005). The egalitarian relationship in feminist therapy. *Psychology of Women Quarterly*, 29, 427-425.
- Robinson, D., & Worell, J. (1991). *The Therapy with Women Scale (TWS)*. Unpublished manuscript, University of Kentucky, Lexington.
- Saleem, M., Prot, S., Cikara, M., Lam, B., Anderson, C., & Jelic, M. (2015). Cutting Gordian knots: Reducing prejudice through attachment security. *Personality and Social Psychology Bulletin*, 41(11), 1560-1574.
- Schnyder, N., Panczak, R., Groth, N., & Schulze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *The British Journal of Psychiatry*, 210, 261-268.
- Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. *International Review of Psychiatry*, 19(2), 137-155.
- Sinclair, A., Barkham, M., Evans, C., Connell, J., & Audin, K. (2005). Rationale and development of a general population well-being measure: Psychometric status of the GP-CORE in a student sample. *British Journal of Guidance & Counselling*, 33(2), 153-173.
- Tabachnick, B., & Fidell, L. (2001). *Using multivariate statistics*. Boston, MA: Allyn & Bacon.
- Tajfel, H. & Turner, J.C. (1986). The social identity theory of inter-group behavior. In Worchel, S. & Austin, L.W. (Eds.) *The psychology of intergroup relations*. Chicago: Nelson-Hall.
- Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. *Journal of Clinical Psychology*, 74(9), 1545-1555.
- Tucker, J. R., Hammer, J. H., Vogel, D. L., Bitman, R. L., Wade, N. G., & Maier, E. J. (2013). Disentangling self-stigma: Are mental illness and help-seeking self-stigmas different? *Journal of Counseling Psychology*, 60, 520-531.
- Turner, J.C., Hogg, M.A., Oakes, P.J. Reicher, S.D., & Wetherell, M.S. (1987). *Rediscovering the Social Group: A Self-Categorization Theory*. Oxford: Blackwell.

- Turner, J.C. & Reynolds, K.J. (2012). Self-categorization theory. In Van Lange, P.A., Kruglanski, A.W., & Higgins, E.T. *The Handbook of Theories of Social Psychology: Volume 2*. London: Sage.
- Vogel, D. L., Bitman, R. L., Hammer, J. H., & Wade, N.G. (2013). Is stigma internalized? The longitudinal impact of public stigma on self-stigma. *Journal of Counseling Psychology, 60*, 311-316.
- Vogel, D. L., Strass, H. A., Heath, P. J., Al-Darmaki, F. R., Armstrong, P. I., Baptista, M. N., ... Zlati, A. (2017). Stigma of seeking psychological services: Examining college students across ten countries/regions. *The Counseling Psychologist, 45*(2), 170-192.
- Vogel, D. L., & Wade, N. G. (2009). Stigma and seeking help: It's not just about what others think. *The Psychologist, 22*, 20-23.
- Vogel, D. L., Wade, N. G., & Aschman, P. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology, 56*, 301-308.
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337.
- Vogel, D. L., Wade, N. G., & Hackler, A. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40-50.
- Vogel, D. L. & Wester, S. R. (2003). To seek help or not to seek help: The risks of self-disclosure. *Journal of Counseling Psychology, 50*(3), 351-361.
- Vogel, D. L., Wester, S. R., Wei, M., & Boysen, G. A. (2005). The role of outcome expectations and attitudes on decisions to seek professional help. *Journal of Counseling Psychology, 52*(4), 459-470.
- Wampold, B. E. & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work (2nd ed.)*. New York, NY: Routledge.
- Worrell, J. & Johnson, D. (2001). Therapy with women: Feminist frameworks. In R. K. Unger (Ed.), *Handbook of the Psychology of Women and Gender*. New York, NY: Wiley.
- Worthington, R.L. & Whittaker, T.A. (2006). Scale development research: A content analysis and recommendations for best practices. *The Counseling Psychologist, 34*(6), 806-838.
- Zerubavel, N. & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy, 49*(4), 482-91.

APPENDIX A: STUDY MATERIALS

INFORMED CONSENT FORM

Title of Study: Licensed Psychologists and Mental Illness

Investigators: Nathaniel Wade (Faculty Supervisor), Lily Mathison (Student Principle Investigator)

Invitation to be Part of a Research Study

You are invited to participate in a research study. This form has information to help you decide whether or not you wish to participate—please review it carefully. Research studies include only people who choose to take part—your participation is completely voluntary and you can stop at any time.

Please email or call the project staff any questions you have about the study or about this form before deciding to participate.

Purpose of the Study

The purpose of this study is to better understand health service psychologists' personal experiences with mental illness and their professional and personal attitudes toward mental illness.

Eligibility to Participate

You are eligible to participate in this study if you are 18 years of age or older, area licensed psychologist, are fluent in English, reside in the United States of America, and you provide mental health services (psychotherapy, psychological testing, or medication management, if applicable) to clients/patients two or more hours per week.

You should not participate if you are under 18 years of age, are not fluent in English, do not reside in the United States, or do not provide mental health services to clients/patients for two hours per week or more.

On the next screen, you will be asked if you meet these requirements. If not, you will be screened out of the study.

Description of Study Procedures

If you agree to participate, you will be asked to complete an online survey in which you will provide information about your own personal experiences with mental health and your personal history of mental health treatment (if any). We will also ask about your attitudes toward those with mental illness. You will also be asked to provide demographic information about yourself.

At the end of the survey, there will be a link to take you to a separate Qualtrics survey to enter your email address to be included in the drawing for one of four (4) \$50 Amazon gift cards.

Expected Duration of Participation

Your participation will last for about 10-15 minutes.

Risks or Discomforts

Some participants may become uncomfortable discussing mental illness or disclosing their personal or professional experience with mental illness. However, you may leave blank any questions you feel uncomfortable answering and/or may stop at any point without penalty.

If you are experiencing personal distress, or experiencing distress after completing these research materials, we encourage you to seek assistance from local mental health providers or to call the National Alliance on Mental Illness (NAMI) HelpLine at 1-800-950-NAMI (6264).

Benefits to you and to Others

It is hoped that the information gained in this study will benefit society by increasing understanding about psychologists' attitudes towards mental illness and about their own personal and professional experiences with mental illness.

If you decide to participate in this study there are no direct benefits to you.

If you would like, after all data have been collected and analyzed we can send a summary of findings to you by email. (At the end of the survey there will be an option to give your email address for this purpose.)

Costs and Compensation

Other than your time, there will be not costs associated with participating in this survey.

You will have the option to enter to win one of four (4) \$50 Amazon gift cards by clicking the link at the end of the survey, inputting your email address, selecting the option to enter. You will also have the option to receive a summary of the study's findings after all data have been collected and analyzed. As your participation is completely voluntary, you are not required to answer any survey questions in order to enter the drawing or receive a summary of the findings.

We will not use your email address for any other purpose than to notify you of winning the drawing and/or to email you a summary of the results.

Should you win the drawing for an Amazon gift card, you will need to complete a form to receive payment. Please know that payments may be subject to tax withholding requirements, which vary depending upon whether you are a legal resident of the U.S. or another country. If required, taxes will be withheld from the payment you receive.

This information allows the University to fulfill government reporting requirements. Confidentiality measures are in place to keep this information secure. Information regarding documentation required for participant compensation may be obtained from the Controller's Department: (515)294-2555 or <http://www.controller.iastate.edu>.

Your Rights as a Research Participant

Participating in this study is completely voluntary. You may choose not to take part in the study or to stop participating at any time, for any reason, without penalty or negative consequences. You can skip any questions that you do not wish to answer.

If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office for Responsible Research, Iowa State University, Ames, Iowa 50011.

Confidentiality

Research records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available without your permission. However, it is possible that other people and offices responsible for making sure research is done safely and responsibly will see your information. This includes federal government regulatory agencies, auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy study records for quality assurance and data analysis. These records may contain private information.

Your identity will not be associated with your responses on the questionnaire in any way. Your participation will be completely anonymous. Your email address, should you choose to enter it for the drawing and/or to receive the summary of research results, will be kept separate from your answers to the questionnaires so it cannot be linked to them.

To protect confidentiality of the study records and data the following measures will be taken:

- Data will be stored on a password protected and encrypted Qualtrics account or downloaded and kept on a password protected and encrypted computer or USB drive.
- Only researchers directly involved in the study will have access to the data.
- The email addresses will be deleted as soon as the winners for the drawing are selected and emails with the results are sent out.

To protect confidentiality when results of the study are reported, the following measures will be taken:

- Results of individual surveys will not be reported; results will only be reported in the aggregate.
- We will avoid reporting or tabling low cell size findings to protect the identity of individuals who have rare demographic characteristics.

Future Use of Your Information

Information about you will only be used by the research team for the project described in this document.

If you have Any Questions

You are encouraged to ask questions at any time during this study. For further information about the study, contact Lily Mathison by email at lily@iastate, or Dr. Nathaniel

Wade by phone at 515-294-1455, by mail at W112 Lagomarcino 901 Stange Road Ames, IA 50011, or by email at nwade@iastate.edu.

Your Consent

By clicking the arrow button on the lower right hand side of this page, you are certifying that you are 18 years of age or over and agree to participate in this research study.

Make sure you understand what the study involves before you agree. If you have questions about the study after you agree to participate, you can contact the research team using the information provided above.

You may print a copy of this form for your files.
(->)

Eligibility

I confirm that I am 18 years of age or older, a licensed health service psychologist, fluent in English, reside in the United States of America, and provide services to clients/patients (psychotherapy, psychological testing, or medication management if applicable) to clients two or more hours per week.

- I confirm
- I DO NOT confirm
Error Message: *I'm sorry, but it appears that you are not eligible for the study. Thank you for your willingness to complete it. Please exit out of this screen.*

Day's Mental Illness Stigma Scale

We are interested in your opinions about mental illness and people with mental illnesses in general.

1. I don't think that it is possible to have a normal relationship with someone with a severe mental illness.
2. I would find it difficult to trust someone with a severe mental illness.
3. It would be difficult to have a close meaningful relationship with someone with a severe mental illness.
4. A close relationship with someone with a severe mental illness would be like living on an emotional roller coaster.
5. I think that a personal relationship with someone with a severe mental illness would be too demanding.
6. Severe mental illnesses prevent people from having normal relationships with others.

Level of Contact Report

Please read each of the following statements carefully. After you have read all of the statements below, place a check by the statements that best depict your exposure to persons with a severe mental illness. **Please select all that apply.**

- 3 I have watched a movie or television show in which a character depicted a person with mental illness.
- 8 My job involves providing services/treatment for persons with severe mental illness.
- 2 I have observed, in passing, a person I believe may have had a severe mental illness.
- 5 I have observed persons with a severe mental illness on a frequent basis.
- 12 I have a severe mental illness.
- 6 I have worked with a person who had a severe mental illness at my place of employment.
- 1 I have never observed a person that I was aware had a severe mental illness.
- 7 My job includes providing services to persons with severe mental illness.
- 9 A friend of the family has a severe mental illness.
- 10 I have a relative who has a severe mental illness.
- 4 I have watched a documentary about severe mental illness.
- 11 I live with a person who has a severe mental illness.

Note: Rankings made by a panel of experts are included for each item; rankings not show to participants.

SSOSH

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

SSOMI

Directions: People at times find that they face mental health problems. This can bring up reactions about what mental illness would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react if you were to have a mental illness.

1. I would feel inadequate if I had a mental illness.
2. My self-confidence would NOT be threatened if I had a mental illness.
3. Having a mental illness would make me feel less intelligent.
4. My self-esteem would decrease if I had a mental illness.
5. My view of myself would not change just because I had a mental illness.
6. It would make me feel inferior to have a mental illness.
7. I would feel okay about myself if I had a mental illness.

8. If I had a mental illness, I would be less satisfied with myself.
9. My self-confidence would remain the same if I had a mental illness.
10. I would feel worse about myself if I had a mental illness.

GP-CORE

Directions: This form has statements about how you have been over the last week. Please read each statement and think how often you felt that way over the last week. Then click the circle closest to this.

1. I have felt tense, anxious, or nervous
2. I have felt I have someone to turn to when things go wrong*
3. I have felt OK about myself*
4. I have felt able to cope when things go wrong*
5. I have been troubled by aches, pains, or other physical problems
6. I have been happy with the things I have done*
7. I have had difficulty getting to sleep or staying asleep
8. I have felt warmth or affection for someone*
9. I have been able to do most things I needed to*
10. I have felt criticized by other people
11. I have felt unhappy
12. I have been irritable when with other people
13. I have felt optimistic about my future*
14. I have achieved the things I wanted to*

Group Identification – Mental Illness

I see myself as a person with a mental illness.
 I am pleased to be a person with a mental illness.
 I feel strong ties with fellow people with mental illness.
 I identify with other people with mental illness.

Group Identification – User of Mental Health Services

I see myself as a person who uses mental health services.
 I am pleased to be a person who uses mental health services.
 I feel strong ties with fellow people who use mental health services.
 I identify with other people who use mental health services.

Group Identification – Psychologist

I see myself as a psychologist.
 I am pleased to be a psychologist.
 I feel strong ties with fellow psychologists.
 I identify with other psychologists.

Egalitarianism Scale (ES) – Select Items from the Therapy with Women Scale and Created Items

For each of the following statements, decide to what degree it describes your approach to counseling and psychotherapy.

In my counseling and/or psychotherapy with clients...

1. I disclose my values to my clients.*
2. I disclose personal experiences relevant to my clients' issues.*
3. I sometimes cry with my clients.
4. I feel that if not for the therapeutic relationship, I would like to be friends with my clients.
5. I make a sharp distinction between me as the therapist and them as the clients.
6. I can see myself having the same experiences, reactions, and emotions as my clients do.
7. I take specific measures to equalize the power between us.
8. There is little difference between me and my clients, other than our assigned roles.

Demographic Questionnaire

Age (in years):

Gender:

Race/Ethnicity:

Do you identify as a person with a disability?

Yes, please specify

No

Please specify the year you received your psychology license.

In a typical week, how many hours do you spend providing direct clinical services for people with mental illness?

What sort of services do you provide? (Select all that apply):

Psychotherapy

Assessment

Medication Management (if Applicable)

Other: Please Specify

Although many psychologists see a varied caseload of clients, what percentage of your clients/patients fit the following description on average?

Percentage of my clients who experience symptoms of severe psychopathology (e.g., hallucinations, delusions, mania, severe depression).

Have you ever had a mental illness? Yes/no

If so, what was your most severe mental health diagnosis(es)?

Have you ever received treatment for a mental illness? Yes/no

If so, from whom? (Please select all that apply):

- Psychotherapist (master's level)
- Psychotherapist (doctoral level)
- Primary care medical provider
- Psychiatric specialist (Psychiatrist, psychiatric mental health nurse practitioner, etc.)
- Emergency department
- Acute inpatient psychiatric unit
- Residential treatment
- Other (Please specify):

If you received treatment from a psychotherapist, how many sessions have you had in the last 5 years or since receiving your psychology license (if less than 5 years ago)?

Have you ever been on any psychoactive medications for a mental disorder or concern? Yes/No

Debriefing Statement

Thank you for your participation. Please keep in mind that all of your responses are completely anonymous and cannot be connected back to you.

The aim of this study was to examine the relationship between licensed psychologists and the stigma of mental illness and psychological/psychiatric services as well as to estimate the current prevalence of mental disorders among licensed psychologists. Your responses to the survey may give us insight into psychologists' own experiences with mental illness as well as their attitudes toward mental illness.

If you are experiencing personal distress we encourage you to connect with local mental health providers or to call the National Alliance on Mental Illness (NAMI) HelpLine at 1-800-950-NAMI (6264).

This survey is a part of Lily Mathison's dissertation. You can reach her via email at lily@iastate.edu or by mail at Department of Psychology, Iowa State University, W112 Lagomarcino Hall, 901 Stange Road, Ames, IA 50011.

This research is supervised by Nathaniel Wade, a Professor in Counseling Psychology. You can reach him at 515-294-1455, via email at nwade@iastate.edu, or by mail to Department of Psychology, Iowa State University, W112 Lagomarcino Hall, 901 Stange Road, Ames, IA 50011.

We are very grateful for your help. Thank you again for participating.

If you would like to be entered into the drawing for one of four \$50 Amazon gift cards and/or you would like to receive a summary of the results after the study is completed, click the link below.

https://iastate.qualtrics.com/jfe/form/SV_4UbcfchzSUGjeex

As a reminder, email addresses will be collected separately from your survey answers and will not be connected with your data in any way.

Please enter your email address below and select from the following options.

- I would ONLY like to be entered in the raffle for the \$50 Amazon gift card and NOT receive a summary of the results when the study has been completed.
- I would like to be entered in the raffle for the \$50 Amazon gift card only AND ALSO receive a summary of the results when the study has been completed.
- I would NOT like to be entered in the raffle for the \$50 Amazon gift card and would ONLY like receive a summary of the results when the study has been completed.

Enter Email Address: _____

APPENDIX B: ALTERNATIVE ANALYSES

Regression analysis predicting personal stigma of mental illness

Predictor	<i>B</i>	<i>SE</i>	β	<i>p</i>	R^2	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.040	.040	5.79	.018
Own mental illness	-3.15	1.32	-.201	.018				
Step 2					.062	.021	3.06	.083
Own mental illness	-3.60	1.34	-.230	.008				
GP-CORE	1.67	.956	.149	.083				

Note. SE = standard error of B. Own Mental Illness: 1 = participant reports mental illness, 0 = participant does not report mental illness. GP-CORE: current psychological distress.

Regression analysis predicting self-stigma of seeking help

Predictor	<i>B</i>	<i>SE</i>	β	<i>p</i>	R^2	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.008	.008	1.07	.303
Own mental illness	1.53	1.48	.089	.303				
Step 2					.203	.195	17.09	.000
Own mental illness	.038	1.36	.002	.978				
GP-CORE	5.58	.973	.450	.000				

Note. SE = standard error of B. Own Mental Illness: 1 = participant reports mental illness, 0 = participant does not report mental illness. GP-CORE: current psychological distress.

Regression analysis predicting self-stigma of mental illness

Predictor	<i>B</i>	<i>SE</i>	β	<i>p</i>	R^2	ΔR^2	<i>F</i>	<i>p</i>
Step 1					.017	.017	2.34	.129
Own mental illness	-2.34	1.53	-.130	.129				
Step 2					.090	.073	10.82	.001
Own mental illness	-3.29	1.51	-.183	.031				
GP-CORE	3.55	1.08	.276	.001				

Note. SE = standard error of B. Own Mental Illness: 1 = participant reports mental illness, 0 = participant does not report mental illness. GP-CORE: current psychological distress.

Regression analysis predicting personal stigma of mental illness

Predictor	B	SE	β	p	R ²	F	p
Model Summary					.158	8.23	.000
Hours	.085	.084	.129	.313			
Contact_Total	.000	.000	-.210	.335			
Contact_40	.000	.000	.562	.005			

Note. SE = standard error of B. Hours = number of hours per week spent providing clinical services. Contact_Total = Years since receiving psychology license*Reported number of hours per week providing clinical services*50 weeks per year. Contact_40 = Years since receiving psychology license*40 hours per week*50 weeks per year.

Regression analysis predicting self-stigma of seeking help

Predictor	B	SE	β	p	R ²	F	p
Model Summary					.016	.709	.549
Hours	.071	.099	.098	.475			
Contact_Total	.000	.000	.057	.808			
Contact_40	.000	.000	-.050	.815			

Note. SE = standard error of B. Hours = number of hours per week spent providing clinical services. Contact_Total = Years since receiving psychology license*Reported number of hours per week providing clinical services*50 weeks per year. Contact_40 = Years since receiving psychology license*40 hours per week*50 weeks per year.

Regression analysis predicting self-stigma of mental illness

Predictor	B	SE	β	p	R ²	F	p
Model Summary					.013	.565	.639
Hours	-.075	.103	-.100	.468			
Contact_Total	.000	.000	.089	.707			
Contact_40	.000	.000	.015	.943			

Note. SE = standard error of B. Hours = number of hours per week spent providing clinical services. Contact_Total = Years since receiving psychology license*Reported number of hours per week providing clinical services*50 weeks per year. Contact_40 = Years since receiving psychology license*40 hours per week*50 weeks per year.

APPENDIX C: IRB APPROVAL MEMO

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
2420 Lincoln Way, Suite 202
Ames, Iowa 50014
515 294-4566

Date: 07/08/2019

To: Lily Mathison Nathaniel Wade

From: Office for Responsible Research

Title: Professional Psychologists and Mental Health-Related Stigma: Exploring a Complicated Relationship

IRB ID: 19-332

Submission Type: Initial Submission **Review Type:** Expedited

Approval Date: 07/08/2019 **Approval Expiration Date:** N/A

The project referenced above has received approval from the Institutional Review Board (IRB) at Iowa State University according to the dates shown above. Please refer to the IRB ID number shown above in all correspondence regarding this study.

To ensure compliance with federal regulations (45 CFR 46 & 21 CFR 56), please be sure to:

- **Use only the approved study materials** in your research, including the **recruitment materials and informed consent documents that have the IRB approval stamp.**
- [Retain signed informed consent documents](#) for 3 years after the close of the study, when documented consent is required.
- **Obtain IRB approval prior to implementing any changes** to the study or study materials.
- **Promptly inform the IRB of any addition of or change in federal funding for this study.** Approval of the protocol referenced above applies only to funding sources that are specifically identified in the corresponding IRB application.
- **Inform the IRB if the Principal Investigator and/or Supervising Investigator end their role or involvement with the project** with sufficient time to allow an alternate PI/Supervising Investigator to assume oversight responsibility. Projects must have an [eligible PI](#) to remain open.

- **Immediately inform the IRB of (1) all serious and/or unexpected [adverse experiences](#) involving risks to subjects or others; and (2) any other [unanticipated problems](#) involving risks to subjects or others.**
- IRB approval means that you have met the requirements of federal regulations and ISU policies governing human subjects research. **Approval from other entities may also be needed.** For example, access to data from private records (e.g., student, medical, or employment records, etc.) that are protected by FERPA, HIPAA, or other confidentiality policies requires permission from the holders of those records. Similarly, for research conducted in institutions other than ISU (e.g., schools, other colleges or universities, medical facilities, companies, etc.), investigators must obtain permission from the institution(s) as required by their policies. **IRB approval in no way implies or guarantees that permission from these other entities will be granted.**
- Your research study may be subject to [post-approval monitoring](#) by Iowa State University's Office for **Responsible Research**. In some cases, it may also be subject to formal audit or inspection by federal agencies and study sponsors.
- Upon completion of the project, transfer of IRB oversight to another IRB, or departure of the PI and/or Supervising Investigator, please initiate a Project Closure to officially close the project. For information on instances when a study may be closed, please refer to the [IRB Study Closure Policy](#).

If your study requires continuing review, indicated by a specific Approval Expiration Date above, you should:

- **Stop all human subjects research activity if IRB approval lapses**, unless continuation is necessary to prevent harm to research participants. Human subjects research activity can resume once IRB approval is re-established.
- **Submit an application for Continuing Review** at least three to four weeks prior to the **Approval Expiration Date** as noted above to provide sufficient time for the IRB to review and approve continuation of the study. We will send a courtesy reminder as this date approaches.

Please don't hesitate to contact us if you have questions or concerns at 515-294-4566 or IRB@iastate.edu.