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Psychological distress and attitudes toward seeking help for personal and career counseling: the contributions of public and self-stigma

Spurty Surapaneni
Iowa State University

Psychological distress and attitudes toward seeking help for personal and career counseling: The contributions of public and self-stigma

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Spurty Surapaneni

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Lisa M. Larson, Major Professor
David Vogel
Max Guyll

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ABSTRACT

The current study observed the relation between psychological distress, stigma (public and self) and help-seeking attitudes for career and personal concerns. In particular, the study examined the contribution of psychological distress and stigma (public and self) to help-seeking attitudes. A total of 510 (N = 202 for career and N =308 for personal) students at a large Midwestern university completed an online survey in fall 2014. Data was analyzed using hierarchical moderated multiple regression. First, neither career distress nor personal distress contributed significant variance to help-seeking attitudes. Second, stigma (public and self), for both career and personal concerns, contributed significant variance to help-seeking attitudes; the relations were negative. Third, neither the interactions of career distress and public stigma nor personal distress and public stigma contributed significant variance to help-seeking attitudes. Last, the interaction of career distress and self-stigma did not contribute significant variance to help-seeking attitudes, but the interaction of personal distress and self-stigma did contribute significant variance. Results were discussed based on the theory of planned behavior (TPB), modified labeling theory (MLT) and approach-avoidance models. Limitations, implications, and future studies were discussed.

CHAPTER 1. INTRODUCTION

The role of help-seeking on incoming and continuing college students has been of major interest in the current literature. Due to the increase in college opportunities and access, more young adults are attending college to pursue a Bachelor's degree. For many of them, this is their first time on their own, and they are learning to navigate the world without the support of parents. Due to this newfound independence, many individuals struggle with adjusting and coping with the difficulties of a new environment that may cause psychological distress. College counseling centers exist to help these students learn to cope with these difficulties. However, students do not utilize these services or a very low number do.

Literature has indicated a discrepancy between those who need help and those who receive it. Blanco et al. (2008) reported that 50% of college students had a diagnosable disorder but only 25% to 50% sought treatment. Benton, Robertson, Tseng, Newton, and Benton (2003) found that 17% to 22% of college students reported experiencing vocational problems, but only about 6% sought help for them (Fouad et al., 2006). Constantine, Wilton, and Caldwell (2003) emphasized that college students, especially African-American and Latino students, placed greater cultural value on informal sources (e.g., parents, friends, community) to resolve concerns than formal sources such as counseling. Other studies have provided similar explanations in ascribing the discrepancy to the preference of using informal sources to resolve problems over formal sources (e.g., Tinsley, de St. Aubin, & Brown, 1982; Utsey, Adams, & Bolden, 2000).

Corrigan (2004) indicated that mental illness was a "two-edged sword" (p. 403). On one side was psychological distress that debilitated a person from normal and optimal functioning. On the other side was stigma that hindered an individual from taking necessary action to alleviate psychological distress (Corrigan, 2004). Therefore, psychological distress and stigma

were both consequences of having a mental disorder. Kushner and Sher (1989) conceptualized, based on Miller (1944) approach-avoidance conflict, that seeking help was an intricate interaction of approach and avoidance factors. Kushner and Sher (1989) conceptualized treatment fears, analogous to stigma (Dean & Chamberlin, 1994), as avoidance factors, and psychological distress as an approach factor.

In reviewing the help-seeking literature, the author found that most studies examined help seeking attitudes, followed by some studies that examined help-seeking intentions, and very few studies that examined help-seeking behavior. Given the conceptual narrative provided by Corrigan (2004) and Kushner and Sher (1989), it seemed that studies examining the relations of stigma, psychological distress, and help-seeking attitudes would be prevalent. The results of a literature search indicated no relevant studies that examined the relations between all three variables. However, the relation between two of the three variables was studied in the literature. For example, there were studies looking at the relation between psychological distress and help-seeking attitudes and the relation between stigma (public and self) and help-seeking attitudes. There were fewer articles looking at the relation between psychological distress and stigma (public and self). In the literature review section both the conceptual articles and empirical articles were examined.

In reviewing studies that solely examined the relation of stigma (public and self) and help-seeking attitudes several limitations were evident. First, the role of psychological distress in these studies was problematic. Some studies only examined individuals with high psychological distress, which reduced variability. Other studies did not measure psychological distress, which reduced applicability of results to distressed populations. Second, the relation of stigma (public and self) and help-seeking attitudes was heavily focused on mental illness (e.g., schizophrenia)

with little focus on less severe personal concerns (e.g., adjustment difficulties) or career concerns (e.g. choosing a major). Third, the studies examining the relations between psychological distress and stigma (public and self) and psychological distress and help-seeking attitudes were scarce and provided contradictory relations. The literature review highlighted these flaws further and explained how the current study addressed them.

The purpose of the present study was threefold. First, the author sought to clarify the relation between psychological distress and stigma and psychological distress and help-seeking attitudes, especially due to the contradictory results. Second, the author sought to understand how all three variables related to each other, especially the contribution of stigma (public and self) on the relation between psychological distress and help-seeking attitudes. Finally, the relation between all three variables was investigated with respect to new areas of interest, namely personal concerns (e.g., adjustment difficulties, relationship difficulties) and career concerns (e.g., career indecision).

College students' level of psychological distress was rarely measured in the literature that studied psychological distress, stigma (public and self), and help-seeking attitudes. Yet researchers have ascertained that the majority of them have experienced psychological distress due to career or college major difficulties and adjustment difficulties (Fouad et al. 2006, Rosenthal & Schreiner, 2000). These difficulties may result in negative consequences such as reduced support from peers, poor academic performance, and higher risk of dropout (Cueso, 2005). If the researcher could understand how varying levels of psychological distress and stigma (public and self) impact help-seeking attitudes, the researcher could create targeted interventions to reduce psychological distress or stigma (public and self) and increase help-seeking attitudes for college students.

CHAPTER 2. LITERATURE REVIEW

The layout of the literature review is presented here as an easy guideline to follow and informs the logic and reasoning for having conducted the present study. A general overview of psychological distress, stigma (public and self), and help-seeking attitudes, intentions, and behavior will be presented. Following this, the theoretical models utilized to conceive the relations between the variables will be detailed. Finally, an extensive but selective review will be presented of the connections already established in the literature between the variables.

General Overview of Variables

Psychological distress

Psychological distress captures the subjective experience of an individual who feels incapable of normal psychological functioning in their daily lives (Abeloff et al., 2000). Abeloff et al. (2000) also reported psychological distress as maladaptive functioning in the face of stressful life events. These individuals may suffer from an inability to conduct their activities of daily living, ranging from minimal interference to severe disturbance. In the literature, psychological distress was defined and measured in many ways. Both the definitions and measures provided insight into how the construct was understood and utilized.

Restrictions. Psychological distress was assumed or not measured in many help-seeking attitudes studies. When it was assumed, the participant pool had been limited to those with clear signs of psychological distress (e.g., Tucker et al., 2013), thus reducing the variation in psychological distress levels. This included individuals with mental disorders (e.g., schizophrenia), psychological problems (e.g., depression) or career problems (career indecision). Tucker et al. (2013) indicated that their sample consisted only of "those reporting clinical levels of psychological distress and those with a self-reported history of mental illness" (p. 528).

Therefore, there was no variation of psychological distress levels in their study. While it was restricted in some studies to only capture high psychological distress, others studies did not measure this construct. Vogel, Wade, and Hackler (2007) indicated that their "sample was not chosen on the basis of psychological distress" (p. 48) and that it should be addressed in future studies. Similarly, Ludwikowski, Vogel, and Armstrong (2009) studied career counseling but did not measure the level of career distress of the sample. With these studies, there is a clear indication that psychological distress was not being examined as a continuum. Thus, the focus had been on only high psychological distress or not measuring it all. By limiting the range of the measure or not measuring it all, the variability is severely reduced. Therefore, it is unclear if varying levels of psychological distress relate differentially to stigma (public and self) and help-seeking attitudes. Intentionally measuring psychological distress could clarify the relations.

Measures. Psychological distress has been measured in a general way and in specific ways (e.g., anxiety or depression). The most prominent general measure was the Hopkins Checklist -21- Item Version (HSC-21; Green, Walkey, McCormick, & Taylor, 1988) that was a revision of the original 58-items Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974). This checklist was used to measure psychological and behavioral levels of psychological distress. This measure was utilized in studies that look at psychological distress with stigma (public and self), help-seeking attitudes, and treatment fearfulness for diverse samples (e.g., Komiya, Good, & Sherrod, 2000) as well as specific racial and ethnic minorities (REM; Gupta, Szymanski, & Leong, 2011). A similar general measure was the Brief Symptom Inventory (BSI; Derogatis & Melisaratos, 1983), which reported the degree to which individuals had experienced symptoms related to psychological distress. The BSI was utilized in studies that focused on psychological distress and help-seeking attitudes for diverse

samples (Nam et al., 2013) as well as specific REMs (Obsai & Leong, 2009). Another widely used measure was the Counseling Center Assessment of Psychological Symptoms- 62 (CCAPS-62; Locke et al., 2011) which assessed psychological distress by examining academic distress, depression, eating concerns, generalized anxiety, hostility, social anxiety, and substance abuse. Cheng, Kwan, and Sevig (2013) used this measure to examine the relation between psychological distress and stigma (public and self) for REM college students. One measure that was widely used in the larger literature was positive and negative affect schedule (PANAS; Watson, Clark, & Tellegen, 1988). PANAS was used and verified in multiple studies as a psychological distress measure (e.g., Crawford & Henry, 2004) and correlated highly with other psychological distress measures, such as the BSI and HSCL-21 (Watson et al., 1988). However, it was not used in the literature focusing on psychological distress and stigma (public and self) and psychological distress and help-seeking attitudes; the current study included the PANAS to measure psychological distress beyond symptom expression.

Another area of focus in assessing psychological distress has been on measures of specific types of distress such as stress, depression, and anxiety. The Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck & Steer, 1990), the Patient Health Questionnaire (PHQ; Spitzer, Kroenke, & Williams, 1999), and the Depression Anxiety Stress Scale (DASS; Lovibond and Lovibond, 1995) all measured depression and/or anxiety of the individual as an indicator of psychological distress. These measures of psychological distress were utilized to connect psychological distress to help-seeking attitudes and intentions for diverse populations and diverse ages (e.g., Chang, 2007; Golberstein, Eisenberg, & Gollust, 2008, Sheffield, Fiorenza, & Sofronoff, 2004).

While these measures capitalized on both the specific and the broad operationalizations of psychological distress, there was no consensus measure for psychological distress. Thus, it's relation to other variables may be flawed as a result of lack of cohesion in measurement. The bandwidth-fidelity principle states that specific constructs should be measured with specific measures whereas global constructs should be measured with global measures (Cronbach & Gleser, 1965). Therefore, if the focus is solely on depressed individuals (specific construct), a specific measure should be used (e.g., BDI-II). However, if the focus is on all psychologically distressed individuals (broad construct), a broad measure should be used (e.g., HSCL-21).

Limitations. In this general review of psychological distress, several flaws appeared. First, there was a lack of clarity on the population of interest and the measure used to capture the psychological distress of that population. Second, there were only a few studies that examined psychological distress caused by different sources. While the measures captured a wide array of sources, the focus had been primarily on people with mental illness. There was little to no focus on everyday personal problems and career problems. The present study addressed both of these areas and used measures of psychological distress that addressed those sources specifically.

Stigma

General stigma. Stigma research has been an influential and relevant topic, because stigma seems to permeate into many domains and hinder individuals from taking action. For example, individuals who are "fat" are ridiculed and teased. Individuals who suffer from physical ailments such as Down syndrome or autism are feared. Individuals with mental illnesses are considered dysfunctional (Bos, Pryor, Reeder, & Stutterheim, 2013). In this section, stigma will be presented as a broad, overall concept and its roots and development through time will be explored.

Stigma was first mentioned in historical record during Greek times when criminals and traitors were physically branded as a way of identifying tainted people that should be shunned by society (Goffman, 1963). While the Greek notion of stigma emphasized a physical mark, Goffman (1963) stated that stigma could be any mark, physical or attribution that led to social disapproval and social distancing. As research continued, scholars defined stigma as a social construction, one in which the public stigmatized an individual (Crocker, Major, & Steele, 1998). Further the stigmatization by society could be overt, such as avoidance or rejection of stigmatized individual or covert, such as negative nonverbal expression (e.g., no eye contact) towards stigmatized individual (Bos et al., 2013).

As scholarship continued, social psychology provided insight into the functional purpose of stigmatization (Phelan, Link & Dovido, 2008). The purposes included "keeping people down", "keeping people in" and "keeping people away" (Bos et al., 2013, p. 2). Therefore, society stigmatized in order to remain in control and be protected by creating an 'us' vs. 'them' mentality. As time passed, two lines of research emerged: the study of prejudice and the study of stigma. Prejudice research focused on understanding domination, especially how certain groups exploited others, while stigma research focused on understanding norm deviation and disease avoidance (Phelan et al., 2008). Stigma research has gone in many different avenues, but the interest of the current study is research pertaining to psychological concerns (e.g., mental illness). Rusch, Angermeyer, and Corrigan (2005) stated that stigmatizing beliefs led to exclusion from society and an inability to be independent. As mental illness stigma continued to be explored, scholars dissected the many different aspects of it. The next few sections will focus in on these specific and relevant aspects.

Public stigma. Public stigma, also known as social stigma or perceived stigma, represents how people respond socially and psychologically to a stigmatized individual (Bos et al., 2013). It comprises of cognitive, affective, and behavioral components that align with stereotypes, prejudice, and discrimination. Stereotypes capture the cognitions that stigmatized individuals are dangerous, defiant, and unpredictable (Bos et al., 2013). Prejudice captures the emotional connection with the beliefs and endorsement of these beliefs as true (Rusch et al., 2005). Discrimination captures the behavioral enactment of explicitly or implicitly rejecting individuals who fit the stereotype (Bos et al., 2013; Rusch et al., 2005). Thus, a person starts by knowing the stereotypes about the mentally ill, becomes prejudiced when s/he endorses the stereotype and fears the mentally ill and discriminates when s/he enacts behavior rejecting the mentally ill.

While the focus of public stigma was on how the public forms stigma, scholars focused on how public stigma impacted the stigmatized. Scholars concluded that stigmatized individuals needed help, but they avoided it due to public stigma. Thus, public stigma of seeking help seemed very relevant to address. Public stigma of seeking help can be defined as the public seeing an individual as socially unacceptable and leading to less favorable views of the individual (Corrigan, 2004; Sibickly & Dovido, 1986). Ben-Porath (2002) reported that in scenario-based research, individuals with a mental illness who were seeking help were seen more negatively than those individuals with only a mental illness. The process described above about how public stigma forms was applicable to public stigma of psychological help. People had stereotypes about those who sought help as being emotionally unstable, less confident, and less interesting (Ben-Porath, 2002). These stereotypes become endorsed leading to prejudice and finally discrimination. Thus, stigmatized individuals, who cannot avoid their mental illness, may avoid seeking help to reduce the public stigma and negative consequences that results from it.

Self-stigma. Self-stigma represents how an individual of a stigmatized group takes public stigma and focuses it inwards (Corrigan, 2004). Public stigma can impact the self in two crucial ways; felt stigma and internalized stigma. Felt stigma refers to the fear or anticipation of being stigmatized for being of a particular stigmatized group. Internalized stigma refers to internalization of public attitudes that lead to reduced self-worth and self-esteem (Bos et al., 2013). For the purposes of this review, the focus will be on internalized stigma and not felt stigma. Thus, self-stigma from here on is reflecting just internalized stigma.

Self-stigma has been conceptualized as having a cognitive, affective, and behavioral component that aligns with stereotypes, prejudice, and discrimination (Rusch et al., 2005). Stereotypes represent the negative beliefs about self as being incompetent and weak. Prejudice occurs when the beliefs are accepted and leads to lower self-esteem. Finally, discrimination occurs when the prejudice impedes action, such as help-seeking behavior (Rusch et al, 2005). Therefore, a stigmatized individual can hold negative stereotypes, believe those stereotypes are true, feel less self-esteem and engage in maladaptive behavior. Thus, self-stigma can lead a stigmatized individual to become worse and neglect resources that could help dissipate problems.

Because self-stigma in general may impede purposeful action, it may impede help-seeking behavior. Thus, the literature has examined self-stigma of help-seeking. Self-stigma of seeking help is defined as the internalization of public stigma of seeking help. Therefore, it is an individual's perception that s/he is unacceptable for seeking help. Corrigan and Rao (2012) provided a stage format of how public-stigma became internalized into self-stigma. First, the self is aware of negative public stereotypes that lead to agreement of these views by self. Once there is agreement, the self applies the stereotype to himself or herself. Finally, the self allows the

stereotype to take root and harm the self by reducing self-worth or neglect help-seeking behavior (Corrigan & Rao, 2012; Rusch et al., 2005).

Strengths and limitations. Public stigma and self-stigma literature has been extensively researched separately as well as together. Both concepts are theoretically background and associated with help-seeking attitudes. However, stigma research is still limited. First, a majority of stigma studies examine mental illness stigma with little focus on stigma associated with career concerns or less severe personal concerns (e.g. relationship difficulties). Tucker et al. (2013) reported that the stigma (public and self) of mental illness was fundamentally different from stigma (public and self) of seeking psychological help and should be examined as such. With this distinction, it was critical to examine how help-seeking stigma occurred for other problem areas. The present study expanded the role of public and self-stigma for less severe personal concerns and career concerns. An important note, less severe personal concerns reflected those problems that are considered not as urgent by the general public and even the discipline. It did not reflect the internal subjective experience of the individual with the concern. Therefore, less severe were not considered as less distressing to the individual.

Help-seeking

Help-seeking behaviors refer to a person seeking professional help for problems that are causing an inability to function properly. Individuals usually seek help when they want to reduce their psychological distress or perceive their problems to be greater than others (Goodman, Sewell, & Jampol, 1984; Mechanic, 1975). However, many factors impede help-seeking behavior. First, people rely on informal resources (e.g., parents, friends) to a greater extent than formal sources (Tinsley et al., 1982). Therefore, professional help is considered a last resort (Hinson & Swanson, 1993).

Help-seeking was examined in the literature in three ways; attitudes, intentions, and behavior (Gulliver, Griffiths, Christensen, & Bewer, 2012). The theory of planned behavior (TPB; Ajzen, 1985) defines all three components and explains their relation to each other. Attitudes are formed by the behavioral beliefs (beliefs about the outcome and evaluation of the outcome) people have about engaging in a particular behavior, in this case help-seeking. Behavioral beliefs can "produce an overall positive or negative attitude toward the behavior" (Ajzen, 2012, p.441). Intentions are formed from the combination of behavioral beliefs (attitudes), normative beliefs (subjective norms), and control beliefs (behavioral control). Subjective norms are defined as an individual's belief that others of importance (e.g., family, friends) have certain expectations or beliefs about the individual engaging in a particular behavior, in this case help-seeking. Control beliefs are defined as factors that harm or facilitate the performance of a behavior, in this case help-seeking by an individual. The facilitating factors include knowledge, skills, and abilities whereas the harmful factors include external obstacles. Behavior is enacted when an individual feels a sufficient amount of behavioral control (perceived behavioral control) and can carry out his or her intentions. Perceived behavioral control is defined as an individual's belief that he or she has control over performing a behavior, in this case help-seeking (Ajzen, 2012). Measures of help-seeking usually focus on one of these three areas. The predominant measure is the Attitudes towards Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Farina, 1995), which is a 10-item revision of the 29-item scale (Fischer & Turner, 1970). Following this scale, intentions to seek help has been measured by the Intentions to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975). Both of these measures have been widely used in many studies and have become the standard measures for assessing attitudes and intentions, respectively.

Help-seeking literature has focused predominately on individuals who seek help for mental illness. Tinsley et al. (1982) found that only 36% and 26 % of individuals who had personal-social concerns and vocational concerns, respectively endorsed seeking help for personal-social concerns and vocational concerns. The present study examined help-seeking attitudes for less severe personal concerns and career concerns.

Theoretical Models

This portion focuses on explaining the underlying theoretical basis for the variables of interest; psychological distress, stigma, and help-seeking attitudes. These theories help explain the undergirding processes that occur for each variable. In addition, these theories provide support for studying the connections between the variables of interest, which is the purpose of the present study.

Approach-avoidance models

Literature on help-seeking attitudes identifies psychological factors that promote it and psychological factors that hinder it. Miller (1944) described the theory of approach-avoidance conflict as the conflict between motivational influences and inhibitory influences of differing strengths on some behavior or goal. The theory proposes that as motivational influences move an individual toward a goal, inhibitory influences became apparent and move an individual away from the goal. Kushner and Sher (1989) utilized approach-avoidance conflict to conceptualize how psychological factors resembled approach tendencies or avoidance tendencies. These researchers hypothesized that psychological distress was an approach factor whereas treatment fears were an avoidance factor. Kushner and Sher (1991) further examined in detail the underlying aspects of treatment fears, identifying six sources. Dean and Chamberlin (1994)

focused on one source, namely the fears of negative judgment, which they stated as being analogous to stigma and psychological distress in seeking professional psychological help.

Interestingly, this theory states that approach and avoidance factors interact to influence behavior (e.g., help-seeking). However, the literature has not yet examined their interactive effects. For example, Nam et al. (2013) looked at the direct effects of psychological distress and stigma on help-seeking attitudes. However, these researchers did not look at the interaction of psychological distress and stigma on help-seeking attitudes. Therefore, while the factors should be intertwined to explain behavior, they are explained separately. This is problematic because it does not allow for the approach and avoidance factors to influence each other in explaining behavior. The present study addressed this concern by testing the interaction between approach and avoidance factors on help-seeking attitudes.

Labeling models

Labeling theory. Scheff (1966) proposed a labeling approach that explained how being labeled resulted in prolonging mental illness and was due to negative public views. He indicated that there existed stereotypes about mentally ill individuals in society. If a person fit those stereotypes, s/he was labeled as mentally ill by society. These negative views impacted the person such that s/he molded his or her identity around being mentally ill. By doing so, the person continued to be mentally ill. Therefore, the labeling process made public views become self views and sustained a person's mental illness. If a person was not labeled, s/he did not receive the negative views and any deviant behavior was considered transitory. In this theory, labeling is considered to be root to the emergence and maintenance of mental illness.

Modified labeling theory. While Scheff's theory explains the power of labeling, its assertion that labeling causes mental illness has been criticized (Gove, 1982). Therefore, Link,

Cullen, Struening, Shrout, and Dohrenwend (1989) proposed the Modified Labeling Theory (MLT). These researchers focused on how labeling led to negative consequences that influence mental illness. Thus, the consequences of labeling are the focus of their theory. First, the theory proposes that stereotypes exist which are based on the devaluation and discrimination mentally ill people will face (Cumming & Cumming, 1965; Goffman, 1963). From these stereotypes, individuals with mental illness can be labeled, by themselves or others, and begin responding in maladaptive ways (e.g., secrecy, withdrawal) leading to negative consequences such as low self-esteem. An important aspect is that when labeled, by self or others, the individual has the power to accept the label or reject it. Therefore, the consequences only occur if the individual accepts the label, thus accepting that s/he will be devalued or discriminated.

This labeling process was utilized as a theoretical basis for studies that examined public and self-stigma (e.g., Vogel et al., 2007). The stereotypes in society and labeling by society were analogous to public stigma whereas the internalization of these stereotypes and labels was analogous to self-stigma. Modified Labeling Theory was utilized heavily in studies focusing on mental illness and was not utilized in studies focusing on less severe personal concerns and career concerns. However, the underlying process proposed by the theory could be applied to these areas. The present study used the theoretical basis of this theory to understand how public stigma and self-stigma impacted these less studied concerns.

Application to Career Concerns

A major focus of this study was to examine personal concerns and career concerns. The literature reviewed thus far provides ample support for studying psychological distress, stigma, and help-seeking attitudes for personal concerns. There is also a need for more attention concerning career concerns. This section will highlight the reasons to study career concerns and

provide evidence of literature that has studied psychological distress, stigma, and help-seeking attitudes in regards to career concerns.

Many studies have indicated that individuals who seek counseling for career concerns express heightened levels of psychological distress when compared to normal populations. Multon, Heppner, Gysbers, Zook, and Ellis-Kalton (2001) stated that 60% of college students seeking career services reported significant psychological distress compared to 13% of a normal population experienced psychological distress. Similarly, Benton et al. (2003) conducted a longitudinal study of 13 years examining the types of concerns seen at a college counseling center. The authors separated the 13 years into three five-year periods (1988-1992, 1992-1996, 1996-2001) and compared them via a chi-square analysis. The authors found a quadratic relationship between the three time periods. Their analyses indicated that vocational concerns dropped from the first five-year to the second five-year period. The prevalence of vocational problems dropped from 21.91% to 17.12%. From the second five-year period to their third five-year period, vocational concerns steadily increased from 17.12% to 21.74 %. The authors concluded that 1) vocational concerns were on the rise and 2) vocational concerns intertwined with personal concerns.

While literature establishes that career concerns are distressing, it also reports that those who seek help for it experience reduced psychological distress and alleviation of the concern. Utz (1983) highlighted that research looking at differences between those who seek help (seekers) and those who do not (nonseekers) has addressed only personal concerns. He expanded the literature by examining differences between seekers and nonseekers for vocational concerns. He tested the differences by looking at three distinct groups; a group who saw a career counselor, a group who took a career planning class, and a group that did nothing. Results indicated that

seekers had less vocational indecision than nonseekers, F (1, 102) = 13.56, $p < .001$. This indicated that those who sought help actually felt less distressed afterwards. Likewise, studies have found that counseling for career concerns and career interventions were effective in reducing or alleviating students' career distress levels and career concerns (Multon et al., 2001; Whiston & Rahardja, 2008).

With clear evidence that career concerns are distressing and that seeking help reduces these, there is still a discrepancy between those who need help and those who seek it. For example, Benton et al. (2003) indicated that 17% to 22% of college students report vocational problems, but Fouad et al. (2006) stated that only 6.3% use career services. It is not very clear in the literature the reason why individuals who have distressing career concerns do not seek help. Research examining personal counseling has stated that stigma (public and self) is a significant barrier to seeking help (Kahn, Wood, & Wiesen, 1999; Vogel et al. 2007). While stigma is a barrier in personal counseling, it is ambiguous and uncertain if stigma would also be a barrier in career counseling (Ludwikowski et al., 2009). This ambiguity and uncertainty may be due to the repeated and heated dispute between career counseling and personal counseling in the counseling literature.

In the 1990s, researchers debated how similar or different career counseling and personal counseling were to each other. Spokane (1992) defined career counseling or coaching as a rational, solution focused, short-term therapy that was viewed by clients as less threatening. On the other hand, Zeig and Munion (1990) defined personal counseling as an emotional, process focused, long-term therapy that was viewed by clients as more threatening. Bluestein and Spengler (1995) used these two different definitions to argue that career and personal counseling were clearly separate with some common factors (e.g., therapeutic alliance). Betz and Corning

(1993) highlighted that both the public and professionals adhere to this differentiation. For example, they indicated their bewilderment in situations where counseling graduate students stated their dislike for career counseling because it was too rational and boring. However, these researchers explained theoretically the similarities between the two types of counseling. They indicated that both career and personal counseling focused on 1) the person as a whole (holistic philosophy), 2) therapeutic alliance, and 3) client-oriented goals and interventions (Betz & Corning, 1993). Other theoretical studies have indicated this differentiation as a false dichotomy (Blustein & Spengler, 1995; Fouad et al. 2006; Hackett, 1993). Thus, the similarities between the two far outweighed the differences. Based on Wampold's (2001) *The Great Psychotherapy Debate*, the common factors matter far more than the specific details. Therefore, the larger common processes between career counseling and personal counseling make these two more similar than different. With the support from Betz and Corning (1993), and Wampold (2001), it seems that processes that impact personal counseling such as stigma should and could impact career counseling as well. Fouad et al. (2006) suggested in their discussion section that stigma could have played a potential role for their results that indicated a discrepancy between those who need help and those who actually get help for career concerns.

While theoretical reasoning provides support to see the two counseling types as similar, the empirical literature and actual counseling still sees them as different. Thus, there is a lot of research focusing on personal counseling and little on career counseling. For example, Anderson (1998) indicated that clinicians and counseling graduate students focus more on relationship problems and ignore career problems in therapy. Fouad et al. (2006) exposed the lack of exploration regarding help-seeking for career services and encouraged future research to examine "factors that may encourage (or discourage) students from actually seeking services" (p.

418). Overall, the ability to link processes that have been studied in personal counseling to career counseling is missing.

Many factors that promote or hinder help-seeking attitudes have been examined for personal counseling (e.g., Nam et al., 2013 Vogel et al., 2006; Vogel et al., 2007) Ludwikowski et al. (2009) was the only study found that examined how stigma may hinder (or promote) career counseling. Researchers examined the relation between public stigma, self-stigma, and attitudes toward career counseling. They hypothesized that self-stigma would mediate the relationship between public stigma and attitudes toward career counseling. Results indicated that self-stigma was negatively related to attitudes toward seeking help for career counseling and mediated the relationship between public stigma and attitudes toward career counseling. However, a limitation of this study was that it did not target a population of undergraduates who expressed varying levels of career distress and the participants in the study did not complete measures of career distress. However, the researchers justified that a randomly selected sample would be comparable to a distressed population when doing path model analyses (based on Vogel et al., 2007). Because it is unclear how stigma would have impacted individuals who actually endorsed differing levels of career distress, the external validity of the study was questionable.

The present study addressed the dearth of literature that focused on examining career distress, stigma, and help-seeking attitudes for career counseling. First, it targeted individuals who endorsed varying levels of career distress to see how that impacted help-seeking attitudes. Second, it focused on how career distress and stigma together affected help-seeking attitudes. Last, it tried to dissolve the gap between career counseling and personal counseling by using processes well established in personal counseling to inform career counseling. For example, more stigma hindered individuals from seeking personal counseling (Vogel et al., 2007) so it is

likely to hinder individuals from seeking career counseling. In a similar vein, more psychological distress promoted people to seek personal counseling (Sheffield et al., 2004) so it is likely to promote people to seek career counseling.

Relations between Variables

Public stigma and self-stigma

This section details studies that focused purely on the relation between public and self-stigma. Vogel, Bitman, Hammer, and Wade (2013) examined if public stigma was internalized as self-stigma over time. They measured public stigma and self-stigma at Time 1 (T1) and three months later at Time 2 (T2). Results indicated that at T1 and T2, public stigma was positively related to self-stigma ($r = .46$, $p < .001$; $r = .18$, $p < .001$, respectively). Also, public stigma at T1 was positively correlated with self-stigma at T2, as hypothesized.

Other studies have examined the relation of public stigma and self-stigma in relation to help-seeking attitudes, intentions, and behavior. Most of these studies have found a positive relation between self-stigma and public stigma (e.g., Vogel et al., 2007). Only one study found a null relation between self-stigma and public stigma ($r = .05$, $p > .05$; Loya, Reddy, & Hinshaw, 2010) Overall, there is more support that there is a positive relation amongst these two variables than a null or negative relation.

Stigma and help-seeking

This segment will focus on reviewing the empirical findings between public stigma, self-stigma and help-seeking (attitudes, intentions, and behavior). The empirical findings will highlight the contradictory results between these variables and highlight how to further explore these variables.

Public stigma and help-seeking. This section details those studies that focused on public stigma (social stigma, perceived stigma) and help-seeking (attitudes and intentions). In general, there seem to be conflicting results on the relation of these two variables.

Help-seeking attitudes. Many studies indicate a negative relation between public stigma and help-seeking attitudes. Nam et al. (2013) meta-analysis examined the relation between psychological factors and attitudes toward seeking help for college students. One of the psychological factors was public stigma, which was measured using the Stigma Scale for Receiving Psychological Help (SSRPH; Komiya et al., 2000) and the Perceived Devaluation-Discrimination Scale (PDD; Link et al., 1987;). The researchers found a significant negative relation between public stigma and attitudes towards help-seeking, measured using the ATSPPHS (r = -.24, p < .001, 95% CI [-.4, -.04]; K = 7; N = 2,286).

Other studies measuring public stigma and help-seeking attitudes found a null relation or meaningless relation. Evans-Lacko, Brohan, Mojtabai, and Thornicroft (2012) examined public stigma of mental illness and attitudes towards mental illness for seeking help from samples in 14 European countries. The authors measured attitudes by providing negative stereotypes and asking participants to indicate how much they agreed with those stereotypes. Therefore, higher scores indicated more negative attitudes. Results indicated a positive relation (r = .06, p = .01). However, the relation that higher levels of public stigma were related to more negative attitudes was meaningless because of the large sample size (N = 1835). The significant relation was more a result of a large sample size rather than there being a positive relation between the variables. Loya et al. (2010) examined the relation between public stigma and help-seeking attitudes for Caucasian and Asian college students. The study used the PDD to measure public stigma and the Inventory of Attitudes toward Seeking Mental Health services (IASMHS; Mackenzie, Knox,

Gekoski, & Macaulay, 2004), which is an adaption of the ATSPPHS. The results indicated there was a non-significant relation between the two variables ($r = .09$, $p > .05$). Similarly, Golberstein et al. (2008) utilized the same measure for public stigma and measured help-seeking attitudes as perceived need. They looked at how public stigma would impact the likelihood of attitudes towards seeking help. Findings indicated that public stigma did not predict the likelihood of attitudes towards seeking help (*OR*: .99, $p > .05$).

Help-seeking intentions. So far the focus has been on examining help-seeking as attitudes towards help-seeking, but help-seeking is examined in other ways, particularly intentions. Research examining public stigma and help-seeking intentions has also found contradictory results.

Barney, Griffiths, Jorm, and Christensen (2005) examined how public stigma would impact the likelihood of help-seeking intentions for a depressed Australian community. Public stigma was measured as individuals' perceptions that health professionals would view them as condescending (5 items), unbalanced (5 items) and devalued (5 items). The summation of the three areas reflected a person's public stigma score. Help-seeking intentions were measured using a standard one question of how likely they would be to see a professional. Results indicated that public stigma significantly predicted likelihood of help-seeking intentions (*OR*: 1.19; $p < .001$). More public stigma reduced the likelihood of help-seeking intentions. Likewise, Deane and Chamberlin (1994) tested how social stigma, also known as public stigma, would impact the likelihood of help-seeking intentions among college students in Great Britain. Social stigma was measured using the Stigma Concerns portion of the Thoughts about Psychotherapy Survey (TAPS; Kushner & Sher, 1989) and an additional 11 items targeting social stigma. Help-seeking intentions were measured with a standard one question asking about the likelihood of

seeing a professional. Researchers concluded that social stigma significantly predicted help-seeking intentions (β =-.198, $p < .05$). Greater social stigma resulted in less likelihood of intending to seek help.

While there seems to be a negative relation, a study by Lally, Conghaile, Quigley, Bainbridge, and McDonald (2013) found a null relation between public stigma of mental illness and help-seeking intentions for college students. Public stigma was measured using the PDD scale whereas help-seeking intentions were measured with a statement about if would seek or not seek help for mental health problems. Researchers reported a null relation (*OR*: .871, $p > .05$).

Qualitative studies. An area that has not been covered by the above articles is qualitative studies where themes are constructed based on people's responses. In qualitative research looking at help-seeking, public/perceived stigma emerged as an essential barrier (Gulliver et al., 2010; Hill et al., 2012). Hill et al. (2012) interviewed 12 undergraduate students and nine of those 12 reported public stigma as a significant barrier. Gulliver et al. (2010) examined 13 qualitative studies that looked at barriers. In 10 of those 13, public stigma or perceived stigma was indicated as important. Therefore, qualitative studies also provide support for the vital need to look at public stigma and help-seeking together.

Self-stigma and help-seeking. This section details those studies that focus on self-stigma (internalized stigma) and help-seeking (attitudes, intentions and behavior). Unlike public stigma and help-seeking, the relation between self-stigma and help-seeking is clearly negative.

Help-seeking attitudes. Nam et al. (2013) met-analysis examined psychological factors that predict help-seeking attitudes in college students and identified self-stigma as one these factors. Self-stigma was measured using the Self-Stigma of Seeking Help Scale (SSOSH: Vogel, Wade, & Haake, 2006) whereas attitudes toward help-seeking were measured with ATSPPHS.

The authors concluded that greater self-stigma was related to less positive attitudes toward help-seeking (r = -.63, p < .001, 95% CI [-.66, -.59]; K = 3; N = 1,357). Due to the much stronger relation and smaller confidence interval, self-stigma was considered the most significant predictor of attitudes toward help-seeking when compared to self-concealment, self-disclosure, anticipated benefits and risks, and social support.

Help-seeking intentions. Other studies not included in the meta-analysis found parallel findings. Barney et al. (2005) found a significant negative relation between self-stigma and likelihood of help-seeking intentions (*OR*: 1.87, p < .001) for a community of mostly depressed individuals.

Help-seeking behavior. Vogel et al. (2006; study 5) examined if the SSOSH would predict future help-seeking behavior in college students. They found a significant difference in self-stigma between those who sought help and those who did not, such that those with less-stigma sought help at a greater proportion than those with high-stigma [χ^2 (1, 654) = 5.05, p < .05]. However, the significant difference between the groups may be a result of large sample size (power) and the size of the effect may be small.

Qualitative studies. Qualitative studies have indicated a negative relation as well between self-stigma and help-seeking. Hill et al. (2012) indicated that seven of 12 participants stated self-stigma as being a barrier to seeking help. Gulliver et al. (2010) reported in the examination of 13 qualitative studies that looked at barriers, 10 of these studies reported self-stigma as a vital barrier.

Public stigma, self-stigma and help-seeking. Few studies have examined the relation between all three variables. However, theoretically it makes sense that public stigma and self-

stigma both uniquely contribute to help-seeking (attitudes and intentions). Studies have examined this assertion and found significant results.

Help-seeking attitudes. Bathje and Pryor (2011), expanding on Vogel et al. (2007), stated that public stigma was not only awareness of society's view but also an endorsement of it. Thus, they wanted to 1) examine how public stigma (awareness and endorsement) related to help-seeking attitudes and 2) see if self-stigma mediated the relation. The Sobel test (Preacher & Leonardelli, 2001), a test that supports the presence of mediation, was used. Results indicated that the relation between public stigma and help-seeking attitudes was fully mediated by self-stigma (Sobel test = - 5.165, $p < .001$).

While Bathje and Pryor (2011) focused on deepening understanding of public stigma, Ludwikowski et al. (2009) focused on help-seeking attitudes for career counseling. The study proposed that self-stigma would mediate the relation between public stigma and help-seeking attitudes for career counseling. Using SEM, the fully mediated model was the best fit for the data, χ^2 (31, $N = 509$) = 73.17, $p < .001$. The model showed that public stigma was positively related to self-stigma, which was negatively related to attitudes toward career counseling.

Help-seeking attitudes and intentions. Vogel et al. (2007) proposed that the relation between public stigma and intentions to seek counseling for college students would be fully mediated by self-stigma and attitudes toward counseling. Using structural equation modeling (SEM), the authors tested their fully mediated model and a partially mediated model to see which would be the best fitting model. In the fully mediated model, the direct link between public stigma and attitudes, and public stigma and intentions was eliminated. Results indicated a good fit to the data, χ^2 (51, $N = 676$) = 86.08, $p = .001$. In the partially mediated model, all direct and indirect paths were included resulting in a good fit as well, χ^2 (48, $N = 676$) = 82.86, $p = .001$.

Based on the parsimonious principle, the authors selected the fully mediated model as the best model. The researchers stated that the model indicated that public stigma was positively related to self-stigma, which was negatively related to attitudes, which were positively related to intentions to seek help. This study provided an understanding that there was more occurring in-between public stigma and help-seeking attitudes, in this case self-stigma. It paved the way for researchers to continue looking at other mediating variables as well as expanding on the model.

Brown et al. (2010) proposed that the relation between public stigma and help-seeking attitudes and public stigma and help-seeking intentions for African Americans would be mediated by internalized stigma. Results indicated that the relations were fully mediated by internalized stigma (β = -.179, p < .001). When the authors tested for direct effects between public stigma and attitudes and public stigma and intentions, they found null results (β = - .027, p > .05). Therefore, their results supported a fully mediated model rather than a partially mediated model.

Stigma and psychological distress

This segment will focus on reviewing the empirical literature that explores the relation between psychological distress and stigma (public and self). The brevity of this portion reflects the scarcity of studies that focus on this relation. It is an indirect indication to concentrate on these variables and understand them further in future research.

Psychological distress and public stigma. This section details the two studies found in the literature search that consider the association between psychological distress and public stigma.

Komiya et al. (2000) did not directly hypothesize a relation between public stigma and psychological distress. They examined how both public stigma and psychological distress separately related to help-seeking attitudes. However, the authors looked at the correlations

between their predictor variables and found that public stigma and psychological distress did not significantly correlate ($r = .04$, $p > .05$).

Another study directly examined the correlation between psychological distress and perceived stigma for individuals with HIV/AIDS (Herek, Saha, & Burack, 2013). These authors tested if perceived stigma was related to anxiety and depression symptoms. Findings indicated that there was a medium positive relation between the variables ($r = .37$ for depression, $r = .37$ for anxiety).

From reviewing these articles, it is clear that there is not much clarity or evidence about the relation between the two variables. First, the population of interest in these articles is different. In the Komiya et al. (2000), the participants were college students. The HIV/AIDS patients in Herek et al. (2013) study probably experienced higher levels of psychological distress and it was more salient to them. Second, the measures varied in both studies. Komiya et al. (2000) used the SSRPH and HSC-21, whereas Herek et al. (2013) used the Perceived Stigma of HIV/AIDS: Public View Scale (Westbrook & Bauman, 1996) and anxiety/depression scale. Overall, there is not enough literature looking at only these two variables to make any confirmatory statement about the true nature of their relation.

Psychological distress and self-stigma. This section reviews the one study that looked at psychological distress and self-stigma.

Herek et al. (2013) studied the link between self-stigma and psychological distress. Utilizing the Perceived Stigma of HIV/AIDS: Public View Scale and anxiety/depression measures, they found a small positive relation ($r = .231$, $p < .001$ for depression, $r = .308$, $p < .001$ for anxiety). Due to the small effect found in Herek et al. (2013) and the lack of literature, it

is unclear if the relation between psychological distress and self-stigma is positive, negative or neither. More studies need to examine this relation, in order to get a better understanding.

Psychological distress, self-stigma, and public stigma. This section details the one study that looked at the relation between all three variables. It brings some clarity to the direct relation of psychological distress to self-stigma and public stigma. It also examines if mediation can explain the relation between the three variables more accurately.

Cheng et al. (2013) proposed that the relation between psychological distress and self-stigma was mediated by public stigma for REMs. Using SEM, they tested this hypothesis and found public stigma mediated the relation between psychological distress and self-stigma significantly for all REMs ($\beta = .14$, $p < .05$ for African Americans, $\beta = .11$, $p < .05$ for Asian Americans, and $\beta = .13$, $p < .05$ for Latino Americans). The authors also examined the direct paths between psychological distress and public stigma and psychological distress and self-stigma. All paths were significant at $p < .05$ and reflected a positive relation. Therefore, psychological distress was positively related to self-stigma and public stigma. Further, public stigma mediated the relation such that greater psychological distress indicated greater public stigma, which indicated greater self-stigma.

Psychological distress and help-seeking

This section focuses on those empirical studies that look at the direct relation between psychological distress and help-seeking (attitudes and intentions). It provides ample support that the results are contradictory and need to be examined further.

Help-seeking attitudes. Nam et al. (2013) meta-analysis inspected how psychological distress and help-seeking attitudes were related using eight studies. These studies used the ATSPPHS for help-seeking attitudes and the BSI and HSC-21 for psychological distress.

Findings indicated a null relation (r = .06, p > .05, 95% CI [-.1, .19]; K = 8; N = 2,482). Therefore, the authors concluded that psychological distress did not relate to help-seeking attitudes. However, this conclusion may be flawed and the null relation may reflect the contradictory results found in the studies. For example, some studies have found a positive relation between psychological distress and help-seeking attitudes (Komiti, Judd, & Jackson, 2006; Rickwood & Braithwaite, 1994). However, others have found a negative relation between psychological distress and help-seeking attitudes (Cepeda-Benito & Short, 1998; Cramer, 1999; Mikesell & Calhoun, 1971). Due to the negative and positive effect sizes, the overall effect size may have become insignificant. This also opens the possibility of moderation.

This section highlights those articles left out of the meta-analysis that provide support for a small to medium negative relation. Using the ATSPPHS, the measure used in the meta-analysis, researchers found negative correlations of a small to medium effect size (r = -.29, p < .05, β = -.13, p = .001, r = -.31, p = .01; Calhoun & Selby, 1974; Chang, 2007; Obasi & Leong, 2009, respectively). One limitation of these findings is that the population was college students, so the results can't be generalized to other populations such as older adults.

Help-seeking intentions. This section highlights the importance of examining help-seeking more broadly than just attitudes. Deane and Chamberlin (1994) examined the intentions to seek counseling by simply asking one question. They found that greater psychological distress resulted in greater intentions to seek help (β = .176, p < .01). In similar fashion, Constantine et al. (2003) asked a one-item question about intentions to seek help to African American and Latino American participants. Results indicated that greater psychological distress was linked to greater intentions to seek help for both African Americans college students [F (1, 94) = 20.73, p < .001] and Latino American college students [F (1, 60) = 35.40, p < .001]. Sheffield et al.

(2004) followed a similar protocol focusing on adolescents. Results indicated greater psychological distress was related to more intentions to seek help from formal sources ($\beta = 0.15$, $p < .05$).

Psychological distress, stigma, and help-seeking

In reviewing the literature, there were no studies that looked at the relation between all three variables. Plenty of studies examined the direct relation between two of the three variables, while others looked at all three variables separately. This is reflected in the multiple repetitions of same citations in different section throughout this review. For example, a study would examine both the direct relation of stigma and help-seeking attitudes and the direct relation of psychological distress and help-seeking attitudes (e.g., Nam et al., 2013). However, it would not look at the combined effect of stigma and psychological distress on help-seeking attitudes. While this was disheartening at first glance, it actually added depth to the current study. It indicated that all these variables were related to each other and mattered in the understanding of each other. Thus, these studies supported and guided the endeavor to find the relation between all three variables. This seemed the logical next step to take in furthering this literature.

The Present Study

Purpose

The main goal of this study was to address what was lacking in the literature regarding the variables of interest: psychological distress, stigma, and help-seeking attitudes. First, the idea that psychological distress occurred at differential levels for individuals was missing in the literature. Studies only examined individuals with high psychological distress or did not measure it all together. However, it seemed that understanding how varying levels of psychological distress impacted other behaviors (e.g., help-seeking) was crucial. If there was a difference

between those with high psychological distress and those with low psychological distress, then interventions that are more targeted could be created. Second the literature on psychological distress focused primarily on mental illness and other areas were not examined, such as personal and career concerns. Therefore, this study focused on investigating psychological distress related to career concerns and less severe personal concerns. It focused on finding participants that reflect variability in psychological distress.

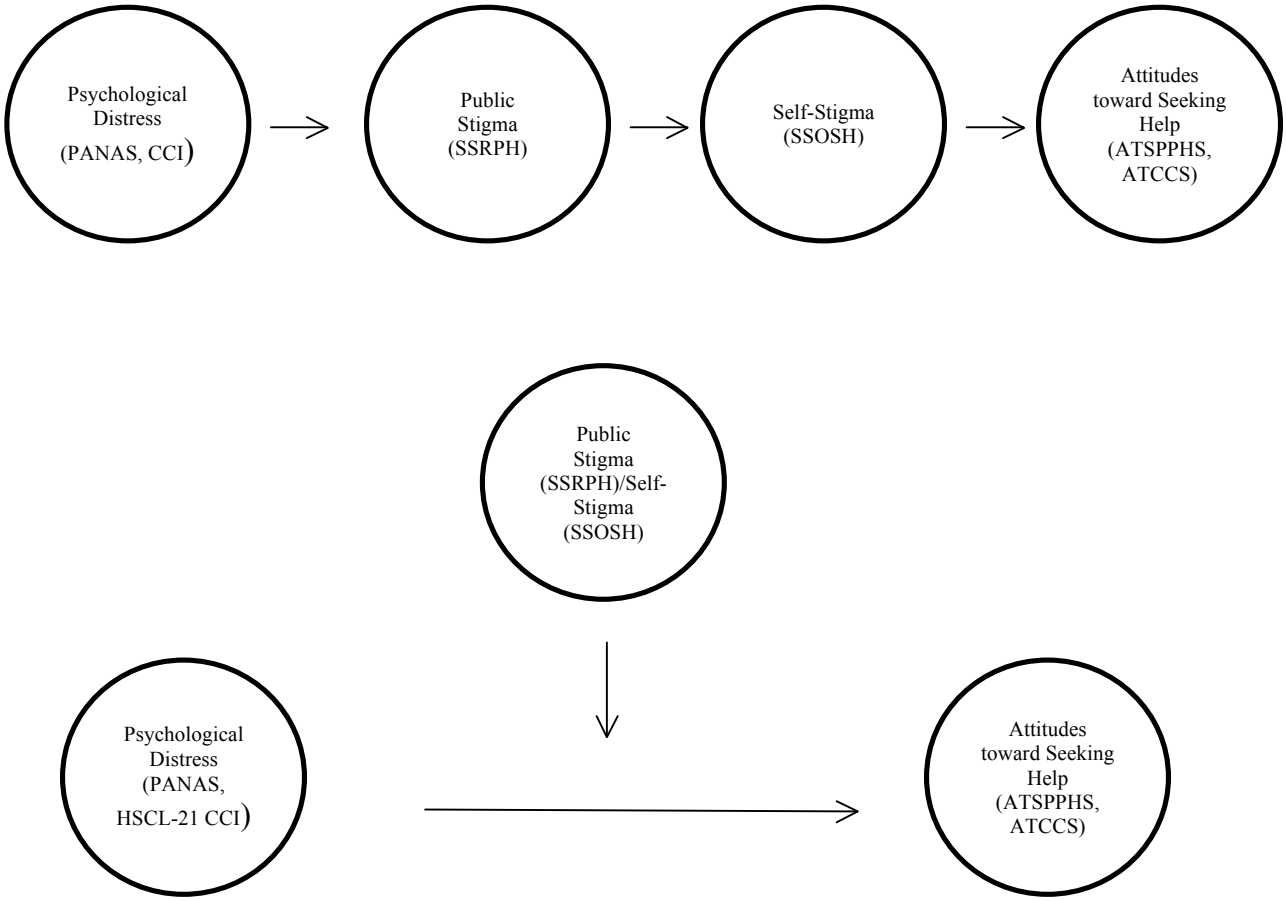
Multiple studies have examined the association between psychological distress and stigma, between stigma and help-seeking attitudes, and between psychological distress and help-seeking attitudes. The overall conclusion of these studies was inconclusive. Studies of psychological distress and public stigma were inconsistent, which was the same for psychological distress and help-seeking attitudes. Only, psychological distress and self-stigma had a consistent positive relation. The present study further examined these variables to clarify the confusion. In order to do this, the current study proposed examining the relations among all three variables. There were no studies found that looked at all three variables. First, psychological distress was considered the predictor variable and help-seeking attitudes was considered the criterion variable. Second, stigma was conceived as the contributing factor that would clarify the unclear relation between psychological distress and help-seeking attitudes. Both public and self-stigma were utilized. Since there were inconclusive results for psychological distress and public stigma, but positive results for self-stigma, this study utilized both. Last, the past literature on these variables was heavily focused on help-seeking attitudes for mental illness, so the current study explored help-seeking attitudes for less severe personal problems and career concerns.

Hypotheses

Modified Labeling Theory (MLT; Link et al., 1989) provides a theoretical basis for the connection between public stigma and self-stigma. It proposes that once an individual is labeled mentally ill, the public acts towards them in negative ways that get internalized. One assumption of this theory is that mental illnesses are clearly labeled by the public or self. Therefore, a person with schizophrenia or bipolar disorder is easily recognized as mentally ill and labeled. However, this perspective does not apply well for more discrete problems such as adjustment difficulties, relationship difficulties, or career indecision. These distressing events can be hidden from others relatively easily, but cause great discomfort to the individual.

Thus, the present author hypothesized that psychological distress was the motivating factor for labeling when it comes to less severe personal problems or career concerns. If an individual is feeling psychological distress, s/he will label him or herself as distressed and feel a need to get help. Studies examining psychological distress for personal counseling and career counseling have found that greater psychological distress was linked to greater need for help (Fouad et al., 2006; Golberstein et al., 2008). This need will fuel worries about what others think of the individual for seeking help (public stigma) and will get internalized within the self (self-stigma). Public and self-stigma may influence an individual to believe that seeking help for psychological distress has negative consequences or outcomes. Utilizing the theory of planned behavior (TPB; Ajzen, 1985), attitudes are formed from behavioral beliefs (beliefs about the outcome and expectations of the outcome) and if the behavioral beliefs are negative than the attitudes towards the behavior will be unfavorable (negative). The hypothesis was that public and self-stigma would contribute significantly to explaining the relation between psychological

distress and help-seeking attitudes for both career and personal counseling. As an important note, this was more exploratory as the literature on these variables has found inconclusive results.



Approach-Avoidance models (e.g., Kushner & Sher, 1989) indicate that certain factors propel individuals to carry out a behavior while other factors hinder individuals from doing so. It is the interaction of these two that explains behavior. Using this theoretical basis, the current study examined how psychological distress (an approach factor) and stigma (avoidance factor) interacted to effect help-seeking attitudes. The purpose was two-fold. First, the possibility of an interaction had yet to be studied in the literature. Second, this model had not been applied to personal or career counseling. Therefore, both those areas were explored.

Hypothesis 1. Public stigma (SSRPH) will contribute significant variance to attitudes toward help-seeking for career counseling (Attitudes Toward Career Counseling Scale [ATCCS]; Rochlen, Mohr, & Hargrove, 1999; ATSPPHS) after variance due to career distress (Coping with Career Indecision Scale [CCI]: Subjective Career Distress and Obstacles subscale; Larson, Toulouse, Ngumba, Fitzpatrick, & Heppner, 1994) has been accounted for.

Hypothesis 2. Self-stigma (SSOSH) will contribute significant variance to attitudes toward help-seeking for career counseling (ATCCS; ATSPPHS) after variance due to career distress (CCI: Subjective Career Distress and Obstacles subscale) and public stigma (SSRPH) has been accounted for.

Hypothesis 3. The interaction of career distress (CCI: Subjective Career Distress subscale) and public stigma (SSRPH) will contribute significant variance to help-seeking attitudes for career counseling (ATCCS; ATSPPHS) after variance due to self-stigma, public stigma, and career distress have been accounted for. Specifically, the relationship between career distress and help-seeking attitudes will tend to become algebraically smaller as stigma increases.

Hypothesis 4. The interaction of career distress (CCI: Subjective Career Distress subscale) and self-stigma (SSOSH) will contribute significant variance to help-seeking attitudes for career counseling (ATCCS; ATSPPHS) after variance due to self-stigma, public stigma, and career distress have been accounted for. Specifically, the relationship between career distress and help-seeking attitudes will tend to be algebraically smaller as stigma increases.

Hypothesis 5. Public stigma (SSRPH) will contribute significant variance to attitudes toward help-seeking for personal counseling (ATSPPHS) after variance due to personal distress (PANAS; Hopkins Symptom Checklist-21 [HSCL-21]; three subscales of HSCL-21) has been accounted for.

Hypothesis 6. Self-stigma (SSOSH) will contribute significant variance to attitudes toward help-seeking for personal counseling (ATSPPHS) after variance due to personal distress (PANAS; HSCL-21; three subscales of HSCL-21) and public stigma (SSRPH) has been accounted for.

Hypothesis 7. The interaction of personal distress (PANAS; HSCL-21; three subscales of HSCL-21) and public stigma (SSRPH) will contribute significant variance to help-seeking attitudes for personal counseling (ATSPPHS) after variance due to self-stigma, public stigma, and personal distress has been accounted for. Specifically, the relationship between personal distress and help-seeking attitudes will tend to become algebraically smaller as stigma increases.

Hypothesis 8. The interaction of personal distress (PANAS; HSCL-21; three subscales of HSCL-21) and self-stigma (SSOSH) will contribute significant variance to help-seeking attitudes for personal counseling (ATSPPHS) after variance due to self-stigma, public stigma, and personal distress have been accounted for. Specifically, the relationship between personal distress and help-seeking attitudes will tend to become algebraically smaller as stigma increases.

CHAPTER 3. METHOD

Design

The current study was a descriptive, correlational design that examined the relations amongst psychological distress, stigma, and help-seeking attitudes for personal and career concerns. The predictor variables were psychological distress, public stigma, and self-stigma in that order, whereas the criterion variable was help-seeking attitudes.

Participants

Participants were undergraduate students in introductory psychology classes at Iowa State University. Participants received one credit towards their psychology courses for every 30 minutes spent in the study, based on the Department of Psychology's research participation program. In order to attain a medium effect ($f^2 = .15$) at a power of .80 and $p < .05$, the sample size in a multiple regression with five independent variables, namely psychological distress, public stigma, self-stigma, and the interactions of public stigma and psychological distress and self-stigma and psychological distress, was a minimum of 91 participants (Cohen, 1992). The present study had two samples of interest (personal counseling and career counseling) so it required at minimum 91 participants per sample for an overall minimum total of 182 participants.

Mass testing sample 1. The first sample targeted individuals with varying levels of career distress. Participating students were provided with a measure of career distress (CCI: Subjective Career Distress and Obstacles subscale). In order to capture the full array of career distress, participants who endorsed high distress and low distress were deliberately invited to participate in the study. The criteria used to discern high and low distress was any student whose score was one standard deviation above or below the mean for the CCI: Subjective Career Distress and

Obstacles subscale. 383 students were invited to participate with 205 being below 1*SD* and 178 being above 1*SD*.

Mass testing sample 2. The second sample targeted individuals with varying levels of personal distress. Participating students were provided with a measure of personal distress (PANAS). In order to capture the full array of personal distress, participants who endorsed high distress and low distress were deliberately invited to participate in the study. The criteria used to discern high and low distress was any student whose score was one standard deviation above or below the mean for the PANAS. 401 students were invited to participate with 211 being below 1*SD* and 104 being above 1*SD*.

Career counseling. The sample was comprised of 202 participants, 123 women and 77 men. Two participants did not report gender. The average age was 19.22 years (*SD* = 1.47). Six participants did not indicate age. The sample consisted of 52% freshmen, 28% sophomores, 11% of juniors, 5% of seniors, and 1% of other. Six participants did not report year in school. Approximately 78.7% was Caucasian, 3.5% were African American, 5.4% were Asian American, 5% were Hispanic American, 0.5% were Native American and 6.9% identified as other. 34% of participants had sought prior counseling.

Personal counseling. The sample was comprised of 308 participants, 159 women and 146 men. One participant identified as other, whereas two participants did not report gender. The average age was 19.3 years old (*SD* = 1.45). 10 participants did not report their age. The sample consisted of 51% freshmen, 30% sophomores, 10% of juniors, 8% of seniors, and 0.6% of other. One participant did not report year in school. Approximately 79.5% was Caucasian, 3.6% were African American, 5.8% were Asian American, 4.5% were Hispanic American, 1% were Native American, and 5.5% identified as other. 33% of participants had sought prior counseling.

Procedure

The first step was to receive Institutional Review Board (IRB) approval of the study, so that all guidelines met ethical practice. Second, this IRB approval ensured ethical and sound research practices were upheld as dictated by American Psychological Association (APA). Data was collected in fall semester of 2014 through an online survey composed using Qualtrics. The study was advertised on the SONA website as two separate studies; one for personal counseling and the other for career counseling.

This study had two parts. First, the career distress and personal distress measures were part of mass testing. Mass testing was a larger survey, conducted by the Department of Psychology that was comprised of multiple measures. These measures were used to identify undergraduates that would fit the population of interest for the many research studies being conducted. Because this current study wanted to find individuals that reflected variability (high and low) on personal and career distress, mass testing allowed for such identification. Individuals who displayed high levels of distress (1 standard deviation above the mean) and low levels of distress (1 standard deviation below the mean) were intentionally invited to complete the rest of the study; students in the moderate range may also have been participants in the study, but were not deliberately invited.

Second, the invited individuals were given a link to participate on an online survey created by Qualtrics. Individuals were presented with an informed consent that detailed the purpose of the study and their rights as participants (Refer to Appendix L). If individuals agreed to partake, they completed a demographic questionnaire that asked for age, sex, race and ethnicity, college year, and prior experience receiving counseling. Following that, participants completed the modified SSRPH, SSOSH, ATSPPHS, and the original ATCSS if in the sample

examining career counseling. If in the sample examining personal counseling, participants filled out the SSRPH, SSOSH, and ATSPPHS. Finally, participants were debriefed about the study, and thanked for participating. Participants were given the contact information of the primary investigator and study supervisor in case any concerns or questions arose.

Measures

Demographics. Participants completed a demographic questionnaire that requested age, ethnicity, gender, and year in school. Participants also identified if they had sought prior counseling. Please refer to Appendix A for the full questionnaire.

Career distress. The Coping with Career Indecision scale (CCI; Larson et al., 1994) has four subscales. For this study, the Subjective Career Distress and Obstacles subscale was used to measure career distress. This subscale has 21 items and is measured using a six-point Likert scale from one indicating "strongly agree" to six indicating "strongly disagree." An example item includes "I often feel a sense of helplessness in selecting a major and planning my career." Negative items are reverse keyed due to 6 indicating strongly disagree. The total score is attained by the summation of the 21 items with higher scores indicating greater career distress. The internal consistency of this measure was $\alpha = .90$ and two week test-retest reliability was $\alpha = .86$ (Larson et al., 1994). Subjective Career Distress and Obstacles subscale negatively correlated with Career Decision Scale(CDS) Certainty Score ($r = -.62$, $p < .0001$) and My Vocational Situation (MVS) Vocational Identity ($r = -.75$, $p < .0001$) to establish construct validity (Larson et al., 1994). Because those with high career distress should be less certain of their career choice and vocational identity, the negative correlations provided support that the Subjective Career Distress and Obstacles subscale was valid (Larson et al., 1994). Internal consistency for the present sample was $\alpha = .95$. Please refer to Appendix B for the complete measure.

Personal distress. Personal distress was measured using two scales, the Positive and the Negative Affect Schedule (PANAS) and the Hopkins Symptom Checklist-21 (HSCL-21). The Positive and the Negative Affect Schedule (PANAS; Watson et al. 1988) reflects a scale that captures two different concepts. The Positive Affect (PA) describes an individual's level of enthusiasm, alertness and activity. The Negative Affect (NA) indicates a person's level of subjective distress and negative moods. This scale has 10 PA items and 10 NA items that are measured on a five-point Likert scale from one meaning "very slightly or not at all" to five meaning "extremely." The items are one word descriptors of positive (e.g., excited) and negative (e.g., ashamed) feelings/emotions. The sum of all 10 PA items gives the overall PA score with higher scores indicating more positive affect. The sum of all 10 NA items gives the overall NA score with higher scores indicating more negative affect. In this study, individuals were instructed to indicate the extent to which they had experienced the PA items and the NA items in the past few weeks. Internal consistency of the measure was $\alpha = .88$ for PA and $\alpha = .87$ for NA whereas eight week test-retest reliability was $\alpha = .58$ for PA and $\alpha = .48$ for NA (Watson et al., 1988). PANAS was significantly correlated with the Hopkins Symptom Checklist (HSCL; $r = .74$ for NA; $r = -.19$ for PA) and the Beck Depression Inventory (BDI; $r = .56$ for NA; $r = -.35$ for PA), both measures of distress, to establish construct validity (Watson et al., 1988). The internal consistency for the current study was $\alpha = .88$ for PA, $\alpha = .84$ for NA, and $\alpha = .78$ for total (PA and NA). Please refer to Appendix C for the full measure.

The Hopkins Symptom Checklist-21 (HSCL-21; Green, Walkey, McCormick, & Taylor, 1988) is a measure of symptom distress that is composed of three subscales: General Feelings of Distress (GFD), Somatic Distress (SD), and Performance Difficulty (PD). The GFD subscale measures the emotions and thoughts associated with feeling distressed. An example item

includes “Feeling inferior to others.” The SD subscale measures how distress impacts the body and causes physical ailments. An example item includes “Pains in the lower part of your back” The PD subscale measures how distress affects ability to perform everyday tasks effectively. An example item includes “Trouble concentrating.” The checklist contains 21 items and is measured on a four-point Likert scale from one indicating “not at all” to four indicating “extremely.” The total score is obtained by the summation of all 21 items with higher scores indicating greater distress. In this study, individuals were instructed to indicate the extent to which they experienced these symptoms in the past week and the current day. The internal consistency of the overall scale, GFD subscale, SD subscale, and PD subscale was $\alpha = .90$, $\alpha = .86$, $\alpha = .75$, and $\alpha = .85$, respectively (Green et al., 1988). Deane, Leathem, and Spicer (1992) reported similar internal consistency for the overall scale ($\alpha = .89$), GFD subscale ($\alpha = .87$), SD subscale ($\alpha = .83$) and PD subscale ($\alpha = .80$). In addition, the researchers reported two-week test-retest reliability between .55 and .63. HSCL-21 correlated positively with the State Trait Anxiety Inventory Form Y (STAI-Y; $r = .63$ for State and $r = .71$ for Trait) and positively with the Brief Hopkins Psychiatric Rating Scale (BHPRS; $r = .36$) to establish construct validity (Deane et al., 1992). Internal consistency for the present sample was $\alpha = .87$ for GFD, $\alpha = .84$ for SD, $\alpha = .82$ for PD, and $\alpha = .92$ for total HSCL-21. Please refer to Appendix D for the complete measure.

Public stigma of career counseling. Ludwikowski et al. (2009) modified the Stigma Scale for Receiving Psychological Help (SSRPH, Komiya et al., 2000) to assess the perceived stigma an individual has about someone receiving career counseling. The scale was altered by replacing “professional psychological help” with “career counseling.” The five items are measured using a four-point Likert scale from one indicating “strongly disagree” to four indicating “strongly agree.” An example item includes “People tend to like less those who are receiving counseling

for a career issue." The total score is the summation of all five items with higher scores indicating greater public stigma. The internal consistency of the original measure was α = .72 (Komiya et al., 2000) and the adapted measure was α = .80 (Ludwikowski et al., 2009). The original SSRPH and ATSPPHS were negatively correlated (r = -.40, p < .001; Komiya et al., 2000) to establish construct validity. Higher levels of stigma related to less positive attitudes towards seeking help (Komiya et al., 2000). Internal consistency for the current study was α = .85. Please refer to Appendix E for the complete measure.

Public stigma of personal counseling. The Stigma Scale for Receiving Psychological Help (SSRPH; Komiya et al., 2000) assess the amount of perceived stigma an individual has about someone who receives counseling. This original scale has five items and is measured using a four-point Likert scale from zero indicating "strongly disagree" to three indicating "strongly agree." In order to keep consistent with other scales, the current study modified the four-point Likert scale to be from one indicating "strongly disagree" to four indicating "strongly agree." An example item includes "Seeing a psychologist for emotional or interpersonal problems carries social stigma." The SSRPH total score is the summation of the five items of the measure with higher scores indicating greater public stigma. The internal consistency was α = .72 (Komiya et al., 2000). Construct validity was established by finding a negative relation between the SSRPH and the ATSPPHS (r = -.40, p < .0001; Komiya et al., 2000) which aligned with the literature that more stigma related to less positive attitudes toward help-seeking. This measure has been widely used in the literature to assess public stigma (e.g., Nam et al., 2013; Vogel, Wester, Wei, & Boysen, 2005; Vogel et al. 2013). Internal consistency for the present study was α = .79. Please refer to Appendix F for the full measure.

Self-stigma of career counseling. Ludwikowski et al. (2009) adapted the Self-stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006) to assess the perception of stigma and individual has of himself or herself for seeking career counseling. The scale was modified by changing "therapist" and "psychologist" to "career counselor." The items are measured on a five-point Likert scale from one indicating "strongly disagree" to five indicating "strongly agree." An example item includes "If I went to a counselor for a career issue, I would be less satisfied with myself." The total score is the summation of the 10 items with higher scores indicating greater self-stigma. The internal consistency was $\alpha = .91$ for the original measure (Vogel et al., 2006) and $\alpha = .89$ for adapted measure (Ludwikowski et al., 2009). Two month test-retest reliability of the original, not adapted measure was $\alpha = .72$. The original SSOSH was positively correlated with SSRPH ($r = .48$, $p < .001$) and negatively correlated with ATSPPHS ($r = -.63$, $p < .001$) to establish construct validity (Vogel et al., 2006). The internal consistency for the present study was $\alpha = .84$. Please refer to Appendix G for the complete measure.

Self-stigma of personal counseling. The Self-stigma of Seeking Help scale (SSOSH; Vogel et al., 2006) measures the perception of stigma an individual has of himself or herself for receiving counseling. The scale has 10 items and is measured using a five-point Likert scale from one indicating "strongly disagree" to five indicating "strongly agree." An example item includes "It would make me feel inferior to ask a therapist for help." The SSOSH total score is the composite of all 10 items with higher scores indicating greater self-stigma. The internal consistency was $\alpha = .91$ and two month test-retest reliability was $\alpha = .72$ (Vogel et al., 2006). SSOSH was positively correlated with the SSRPH ($r = .48$, $p < .001$) and negatively correlated with ATSPPHS ($r = -.63$, $p < .001$) to establish construct validity (Vogel et al., 2006). This parallels the literature that indicates that self-stigma is positively related to public stigma and

negatively related to help-seeking attitudes. Many studies focusing on self-stigma have used this measure (e.g., Cheng et al., 2013; Nam et al., 2013; Vogel et al., 2007; Vogel et al. 2013). The internal consistency for the current sample was α = .90. Please refer to Appendix H for the full measure.

Help-seeking attitudes for career counseling. Two measures were used to assess this variable. First, the Attitudes toward Career Counseling Scale (ATCCS; Rochlen et al., 1999) has two subscales; the Stigma Related to Career Counseling (SRCC, 8 items) and the Value of Career Counseling (VCC, 8 items). For the purposes of this study, only the VCC was utilized. Ludwikowski et al. (2009) used only the VCC of the ATCCS stating that the SRCC could potentially confound with other stigma measures. The subscale is measured using a four-point Likert scale from one indicating "disagree" to four indicating "agree." An example item includes "I could easily imagine how career counseling could be beneficial for me." The ATCSS total score is the computed sum off all eight items with higher scores indicating more positive attitudes towards career counseling. Internal consistency was α = .86 and test-retest reliability was α = .88 (Rochlen et al., 1999). ATCCS was positively correlated with ATSPPHS (r = .34) and ISCI (r = .24) to establish convergent validity (Rochlen et al., 1999). Therefore, ATCCS items capture attitudes of those seeking career help. Ludwikowski et al. (2009) used the ATCCS which had an internal consistency of α = .89 in their study. Internal consistency for the present study was α =.92. Please refer to Appendix I for the complete measure.

Second, Ludwikowski et al. (2009) modified the ATSPPHS (Fischer & Farina, 1995) to measure attitudes toward seeking help for career concerns. The researchers decided to change the words to reflect career issues. The 10 items are measured on a four-point Likert scale from one indicating "disagree" to four indicating "agree." An example item includes "The idea of talking

about problems with a counselor strikes me as a poor way to get rid of career problems." The total score is a composite of all 10 items with higher scores reflecting more positive attitudes toward career counseling. The internal consistency of the original scale was α = .84 (Fischer & Farina, 1995) whereas the adapted scale was α = .81 (Ludwikowski et al., 2009). Test-retest reliability of the original scale was α = .80 (Fischer & Farina, 1995). The original ATSPPHS has been positively related with ISCI (r = .50, p < .001; Vogel et al. 2007) and indicated significant differences in attitudes between those who did and did not seek help via point-biserial correlations (r = .39, p < .0001; Fischer & Farina, 1995). This indicates that ATSPPHS is a valid measure and captures the attitudes of those who seek help. Internal consistency for the current study was α = .81. Please refer to Appendix J for the full measure.

Help-seeking attitudes for personal counseling. The Attitudes toward Seeking Professional Psychological Help Scale- Short Form (ATSPPHS-SF; Fischer & Farina, 1995) assess an individual's attitude towards seeking professional help for psychological problems. The original scale has 10 items and is measured using a four-point Likert scale from zero indicating "disagree" to three indicating "agree". To keep consistency across scales, the current study modified the Likert scale from one indicating "disagree" to four indicating "agree." An example item includes "A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help." The ATSPPHS total score is attained by summing up the 10 items with higher scores indicating more positive attitudes towards seeking counseling. Internal consistency was α = .84 and four week test-retest reliability was α = .80 (Fisher & Farina, 1995). ATSPPHS has been positively related with ISCI (r = .50, p < .001; Vogel et al. 2007). ATSPPHS indicated significant differences in attitudes between those who did and did not seek help via point-biserial correlations (r = .39, p < .0001; Fischer & Farina, 1995). Most

studies that examined attitudes toward help seeking have used this measure (e.g., Bathje & Pryor, 2011; Chang, 2007; Cheng et al., 2013; Nam et al., 2013, Tucker et al., 2013). Internal consistency for the present study was $\alpha = .77$. Please refer to Appendix K for the full measure.

CHAPTER 4. RESULTS

Career counseling

Preliminary analyses. The criterion variable was help-seeking attitudes, whereas the predictor variables were career distress, public stigma, and self-stigma. Means, standard deviations, and correlations are presented in Table 1 by sex for all variables under examination. Table 2 presents the means, standard deviations, and correlations for the whole sample. Independent samples *t*-tests were conducted to see if means of predictor and criterion variables for men were significantly different from means of predictor and criterion variables for women. Results indicated that there were no significant mean differences (*ps* > .05) between men and women on career distress, public stigma, self-stigma, and help-seeking attitudes. Moreover, using Fisher *r* to *z* transformation, *z* scores were calculated to determine if the Pearson product moment correlations by sex were significantly different using a Bonferonni correction of $p < .005$ given the number of comparisons. These analyses revealed no significant differences in the magnitude of the correlations by sex (*ps* > .005). Thus the total sample presented in Table 2 will be described.

Career distress was not significantly related to public stigma, self-stigma, or both measures of help-seeking attitudes (ATCCS and ATSPPHS) as seen in Table 2. Public stigma was significantly positively related to self-stigma ($r = .65$, $p < .01$) and significantly negatively related to both measures of help-seeking attitudes ($r = -.51$, $p < .01$ for ATCCS; $r = -.49$, $p < .01$ for ATSPPHS). Self-stigma was significantly negatively related to both measures of help-seeking attitudes ($r = -.67$, $p < .01$ for ATCCS; $r = -.64$, $p < .01$ for ATSPPHS). The two help-seeking attitudes measures (ATCCS and ATSPPHS) were significantly positively related to each other ($r = .69$, $p < .01$).

Mean comparisons. The means for all variables in this sample were analyzed to determine if they were significantly different from comparable samples' means. Five independent samples *t*-tests were conducted and Cohen's *d*s were computed to examine if any of the means were significantly different and can be seen in Table 1. Only the means of help-seeking attitudes, measured by ATCCS and ATSPPHS, were significantly different from comparable samples' means. The ATCCS mean in this sample ($M = 26.50$, $SD = 4.72$) was significantly higher than the Rochlen et al. (1999) ATCCS mean ($M = 25.37$, $SD = 4.78$) and resulted in $t = 2.83$, $p < .01$ with a Cohen's $d = .24$ (Cohen, 1969). The ATSPPHS mean in this sample ($M = 28.44$, $SD = 5.08$) was significantly higher than the Ludwikowski et al. (2009) ATSPPHS mean ($M = 23.68$, SD = 3.07) and resulted in $t = 11.80$, $p < .001$ with a Cohen's $d = 1.13$.

Main analyses. Using the Statistical Package for the Social Sciences 22 (SPSS), two hierarchical moderated multiple regressions were conducted to address the first two hypotheses that posited that career distress, public stigma, and self-stigma would contribute unique variance to help-seeking attitudes. Moreover, the hierarchical moderated multiple regression was also conducted to address the third and fourth hypotheses that the interactions of public stigma and career distress and self-stigma and career distress would contribute unique variance to help-seeking attitudes. The criterion variable was help-seeking attitudes (ATCCS and ATSPPHS). In the first step, career distress (CCI: Subjective Career Distress and Obstacles subscale) was entered into the model. In the second step, public stigma (SSRPH) was added to the model. In the third step, self-stigma (SSOSH) was added to the model. In the fourth step, the interactions of career distress and public stigma and career distress and self-stigma were added to the model. Predictor variables were standardized to reduce mulitcollinearity and increase efficiency in

plotting significant moderator effects (Cohen, Cohen, West, & Aiken, 2003; Fraizer, Tix, & Barron, 2004). The results of both regressions are presented in Tables 3 and 4.

Hierarchical moderated multiple regression 1. ATCCS was the criterion variable as can be seen by Table 3. In the first step, career distress did not explain a significant amount of variance (1.2%) in help-seeking attitudes [F (1, 200) = 2.45, $p > .05$]. In step two, public stigma contributed significant variance (24.3%) to help-seeking attitudes after accounting for the variance due to career distress as indicated by a significant increase [F(1, 199) = 64.96, $p <$ .001]. In step three, self-stigma contributed significant variance (20.5%) to help-seeking attitudes after accounting for the variance due to career distress and public stigma as indicated by a significant increase [F(1, 198) = 75.19, $p < .001$]. In step four, the interactions of career distress and public stigma and career distress and self-stigma did not contribute significant variance (0.5%) in help-seeking attitudes after accounting for the variance due to career distress, public stigma, and self-stigma [F(2, 196) = .909, $p > .05$]. The hierarchical moderated multiple regression provided support for the first hypothesis in that public stigma contributed significant variance to help-seeking attitudes after accounting for variance due to career distress. The hierarchical moderated multiple regression provided support for the second hypothesis in that self-stigma contributed significant variance to help-seeking attitudes after accounting for the variance due to career distress and public stigma. The hierarchical moderated multiple regression did not provide support for the third or fourth hypotheses in that the interaction of public stigma and career distress and the interaction of self-stigma and career distress did not contribute significant variance to help-seeking attitudes.

Hierarchical moderated multiple regression 2. ATSPPHS was the criterion variable as can be seen in Table 4. In the first step, career distress did not explain a significant amount of

variance (0.2%) in help-seeking attitudes [F (1, 200) = .477, p > .05]. In step two, public stigma contributed significant variance (23.4%) to help-seeking attitudes after accounting for variance due to career distress as indicated by a significant increase [F(1, 199) = 60.86, p < .001]. In step three, self-stigma contributed significant variance (18.9%) in help-seeking attitudes after accounting for variance due to career distress and public stigma as indicated by a significant increase [F(1, 198) = 65.00, p < .001]. In step four, the interactions of career distress and public stigma and career distress and self-stigma did not contribute significant variance (0.6%) to help-seeking attitudes after accounting for the variance due to career distress, public stigma, and self-stigma [F(2, 196) = .950, p > .05]. The hierarchical moderated multiple regression provided support for the first hypothesis in that public stigma contributed significant variance to help-seeking attitudes after accounting for variance due to career distress. The hierarchical moderated multiple regression provided support for the second hypothesis in that self-stigma contributed significant variance to help-seeking attitudes after accounting for the variance due to career distress and public stigma. The hierarchical moderated multiple regression did not provide support for the third or fourth hypotheses in that the interaction of public stigma and career distress and the interaction of self-stigma and career distress did not contribute significant variance to help-seeking attitudes.

Normality**.** Using the Statistical Package for the Social Sciences 22 (SPSS), post-hoc normality analyses were conducted to ascertain if the data was normal. In this study, normality was determined using the method described by Kim (2013). Kim (2013) stated that the Shapiro-Wilk statistic (W) should be utilized to determine normality of the data. However, the author also stated that the Shapiro-Wilk statistic was biased by a large sample size. If the Shapiro-Wilk

statistic (W) was significant ($p < .05$), skewness and kurtosis could be used to further examine normality of data (Kim, 2013).

First, the Shapiro-Wilk statistic (W) was examined for all the variables. All four variables, namely career distress ($W = .97$, $p < .001$), public stigma ($W = .94$, $p < .001$), self-stigma ($W = .97$, $p < .001$), and help-seeking attitudes ($W = .92$, $p < .001$ for ATCCS; $W =. 98$, $p < .001$ for ATSPPH) were non-normal. Second, the variables were further examined for normality by inspecting the skewness and kurtosis. Z scores were computed for skewness and kurtosis for each variable and compared to the standard z score for the skewness and kurtosis of a normal distribution ($z = 3. 29$, $p < .05$ for $50 < n < 300$; Kim, 2013). Skewness and kurtosis for career distress ($z = .50$, $z = 2.48$, respectively), public stigma ($z = 3.10$, $z = .05$, respectively), and self-stigma ($z = 3.06$, $z = .46$, respectively) were within the standard z score of 3.29. Help-seeking attitudes, measured using the ATCCS and ATSPPH, results for skewness and kurtosis differed based on the measure. The skewness and kurtosis for the ATSPHH ($z = 1.20$, $z = .27$, respectively) were within the standard z score of 3.29. However, only the kurtosis for the ATCCS ($z = .95$) was within the standard z score of 3.29. The skewness of the ATCCS ($z = 4.02$, skew = -.687) was above the standard z score of 3.29.

Table 1.
Summary of Means, Standard Deviations, and Correlations for All Variables under Examination by Sex

	1	2	3	4	5	*M*	*SD*
1. Career Distress	-	.08	-.03	-.12	-.01	3.06	1.11
2. Public Stigma	.20	-	.69**	-.60**	-.54**	1.82	.63
3. Self-Stigma	.23*	.54**	-	-.69**	-.65**	2.27	.77
4. Help-Seeking Attitudes (ATCCS)	-.13	-.34**	-.62**	-	.76**	3.35	.60
5. Help-Seeking Attitudes (ATSPPHS)	-.14	-.39**	-.61**	.59**	-	2.85	.51
M	2.78	1.77	2.27	3.24	2.82	-	-
SD	1.06	.54	.67	.57	.49	-	-

Note. $N = 200$ (123 women, 77 men). Two individuals were not included in the analysis due to not reporting sex. ATCCS = Attitudes toward Career Counseling Scale and ATSPPHS = Attitudes toward Seeking Professional Psychological Help Scale for career counseling. Bivariate correlations for women are presented above the diagonal and bivariate correlations for men are presented below the diagonal. There were no significant differences in the correlations between men and women ($p < .005$.) Means and standard deviations for women are presented in the vertical columns and the means and standard deviations for men are presented in the horizontal rows. Higher mean scores indicate more career distress, more public stigma, more self-stigma, and more positive attitudes towards seeking help. Career distress ranges from 1-6, public stigma ranges from 1-4, self-stigma ranges from 1-5 and attitudes towards seeking help (ATCCS and ATSPPHS) ranges from 1-4. * $p < .05$. ** $p < .01$.

Table 2.
Summary of Means, Standard Deviations, and Correlations for All Variables under Examination for Total Sample

	1	2	3	4	5
1. Career Distress	-				
2. Public Stigma	.13	-			
3. Self-Stigma	.06	.65**	-		
4. Help-Seeking Attitudes (ATCCS)	-.11	-.51**	-.67**	-	
5. Help-Seeking Attitudes (ATSPPHS)	-.05	-.49**	-.64**	.69**	-
M	2.95	1.79	2.26	3.31	2.84
SD	1.10	.60	.73	.59	.51

Note. $N = 202$. ATCCS = Attitudes toward Career Counseling Scale and ATSPPHS = Attitudes toward Seeking Professional Psychological Help Scale for career counseling. Higher mean scores indicate more career distress, more public stigma, more self-stigma and more positive attitudes towards seeking help. Career distress ranges from 1-6, public stigma ranges from 1-4, self-stigma ranges from 1-5 and attitudes towards seeking help (ATCCS and ATSPPHS) ranges from 1-4. * $p < .05$. ** $p < .01$.

Table 3.
Summary of Hierarchical Moderated Multiple Regression for Prediction of Help-seeking Attitudes (ATCCS) from Career Distress, Public Stigma, and Self-Stigma

Variable	R^2	ΔR^2	*b*	*SEb*	*β*
Step 1: Career Distress	.01	.01	-.52	.33	-.11
Step 2: Public Stigma	.25***	.24***			
Public Stigma			-2.34	.29	-.49***
Step 3: Self-Stigma	.46***	.21***			
Self-Stigma			-2.81	.33	-.59***
Step 4: Interactions	.47***	.01			
Career Distress x Public Stigma			.67	.58	.14
Career Distress x Self-Stigma			.61	1.06	.13

Note. $N = 202$. *** $p < .001$.

Table 4.
Summary of Hierarchical Moderated Multiple Regression for Prediction of Help-seeking Attitudes (ATSPPHS) from Career Distress, Public Stigma, and Self-Stigma

Variable	R^2	ΔR^2	*b*	*SEb*	*β*
Step 1: Career Distress	<. 01	< .01	-.25	.36	-.05
Step 2: Public Stigma	.24***	.23***			
Public Stigma			-2.47	.32	-.48***
Step 3: Self-Stigma	.43***	.19***			
Self-Stigma			-2.91	.36	-.57***
Step 4: Interactions	.43***	.01			
Career Distress x Public Stigma			.50	.64	.10
Career Distress x Self-Stigma			1.26	1.18	.25

Note. $N = 202$. *** $p < .001$.

Personal counseling

Preliminary analyses. The criterion variable was help-seeking attitudes, whereas the predictor variables were personal distress, public stigma, and self-stigma. A series of independent samples *t*-tests revealed that the means of predictor and criterion variables for men were comparable to means of predictor and criterion variables for women (*ps* > .05), except for personal distress, namely the GFD subscale, and help-seeking attitudes (ATSPPHS). Women reported significantly greater personal distress (GFD subscale) than men, $t = -2.01$, $p < .05$ with a Cohen's $d = .23$. Women also reported more positive attitudes towards seeking help than men, $t = -3.72$, $p < .001$ with a Cohen's $d = .43$. Means, standard deviations, and correlations are presented in Table 5 by sex for all examined variables. Table 6 presents the means, standard deviations, and correlations for the total sample. Using the Fisher *r* to *z* transformation, *z* scores were calculated to determine if the Pearson product moment correlations by sex were significantly different using a Bonferonni correction of $p < .005$ given the number of comparisons. These analyses revealed no significant differences in the magnitude of the correlations by sex (*ps* > .005). Thus only the total sample presented in Table 6 will be described.

Personal distress was measured by the PA scale and the NA scale of the PANAS. PA scale was not significantly related to public stigma ($r = -.09$, $p > .05$), self-stigma ($r = -.09$, $p > .05$), and help-seeking attitudes ($r = -.02$, $p > .05$) as seen in Table 6. The NA scale was significantly positively related to public stigma ($r = .27$, $p <. 01$), and self-stigma ($r = .13$, $p < .05$), but not related to help-seeking attitudes ($r = -.07$, $p > .05$). The PA scale was significantly negatively related to the NA scale ($r = -.13$, $p < .05$).

Personal distress, measured by the HSCL-21 total score, was not significantly related to help-seeking attitudes ($r = .03$, $p > .05$) as can be seen by Table 6. The HSCL-21 total score was

significantly positively related to public stigma ($r = .28$, $p < .01$), and self-stigma ($r = .11$, $p < .05$). Personal distress, measured by the three subscales (GFD, SD, and PD) of the HSCL-21, was not significantly related to help-seeking attitudes ($r = .03$, $p > .05$ for GFD; $r = -.03$, $p > .05$ for SD; $r = .06$, $p > .05$ for PD) as seen in Table 6. The GFD subscale was significantly positively related to public stigma ($r = .30$, $p < .01$) and self-stigma ($r = .20$, $p < .01$). The SD subscale was significantly positively related to public stigma ($r = .19$, $p < .01$) but not related to self-stigma ($r = .06$, $p > .05$). The PD subscale was significantly positively related to public stigma ($r = .23$, $p < .01$) but not related to self-stigma ($r = .02$, $p > .05$).

The relation between both measures of personal distress (PANAS; HSCL-21) was also examined as can be seen in Table 6. The PA scale was significantly negatively related to the HSCL-21 total score ($r = -.25$, $p < .01$). The PA scale was significantly negatively related to the GFD subscale ($r = -.33$, $p < .01$), the SD subscale ($r = -.13$, $p < .05$) and the PD subscale ($r = -.17$, $p < .01$). The NA scale was significantly positively related to the HSCL-21 total score ($r = .72$, $p < .01$). The NA scale was significantly positively related to the GFD subscale ($r = .69$, $p < .01$), SD subscale ($r = .58$, $p < .01$) and the PD ($r = .59$ $p < .01$).

The relations between public stigma and self-stigma, public stigma and help-seeking attitudes, and self-stigma and help-seeking attitudes were also examined as seen in Table 6. Public stigma and self-stigma significantly positively related to each other ($r = .46$, $p < .01$). Public stigma and self-stigma significantly negatively related to help-seeking attitudes ($r = -.25$, $p < .01$ for public stigma; $r = -.53$, $p < .01$ for self-stigma).

Mean comparisons. Means for all variables were compared with means from relevant studies. Nine independent samples *t*-tests were conducted and Cohen's *d*s were computed to examine if any of the means were significantly different and can be seen in Table 5. Only the

means of the NA scale, the HSCL-21 total score, the GFD subscale, and self-stigma were significantly different from the relevant studies' means. The NA scale mean (M = 22.53, SD = 6.89) was significantly higher than the Watson et al. (1988) NA scale mean (M =19.50, SD = 7.00) and resulted in t = 6.21, p < .001 with a Cohen's d = .44. The HSCL-21 total score mean (M = 39.48, SD = 11.05) was significantly lower than the Deane et al. (1992) HSCL-21 total score mean (M =45.42, SD = 11.74) and resulted in t = -4.18, p < .001 with a Cohen's d = .52. The GFD subscale mean (M = 13.50, SD = 4.63) was also significantly lower than the Deane et al. (1992) GFD subscale mean (M =17.15, SD = 5.06) and resulted in t = -5.99, p < .001 with a Cohen's d = .75. Self-stigma mean (M = 24.95, SD = 5.49) was significantly lower than the Vogel et al. (2007) mean (M = 28.50, SD = 7.40) and resulted in t = -8.39, p < .001 with a Cohen's d = .54. The participants in the current study compared to relevant samples reported more distress (NA scale), less distress (HSCL-21 total and one subscale, the GFD), and less self-stigma than those in the comparison studies examining these variables. Personal distress was operationally defined using the PA scale, the NA scale, and the HSCL-21. However, mean comparisons revealed a discrepancy in that the mean score of one measure, namely the NA scale was slightly higher than the comparison sample whereas the mean score of the other measure, namely the HSCL-21 total and the GFD subscale was slightly lower than the comparison sample. The discrepancy between the NA scale and the HSCl-21 and the GFD subscale may be reflective of the differential purpose of the measures. NA scale may be more sensitive to capturing the varying distress among normal samples whereas the HSCL may be less sensitive to this variability and more focused on identifying clinical samples (see Watson et al., 1988 and Green et al. 1988). Due to the present sample being composed of college students, who are more similar to normal samples than clinical samples, the NA may have been more sensitive to measuring

their distress and the HSCL may have been less sensitive to measuring distress. Differences also may be explained by time differences, such as the NA assessing distress for the past few weeks and the HSCL-21 assessing distress for the past week. Item content is also different in that the NA utilizes one word descriptors of affect (e.g. distressed), whereas the HSCL-21 utilizes phrases that capture affect, cognition, and somatic symptoms.

Main analyses. Using the Statistical Package for the Social Sciences 22 (SPSS), three hierarchical moderated multiple regressions were conducted to address the fifth and sixth hypotheses that posited that personal distress, public stigma, and self-stigma would contribute unique variance to help-seeking attitudes. Moreover, the hierarchical moderated multiple regression was also conducted to address the seventh and eight hypotheses that the interactions of public stigma and personal distress and self-stigma and personal distress would contribute unique variance to help-seeking attitudes. In the first step, personal distress (PA and NA; HSCL-21; 3 subscales of HSCL-21) was entered into the model. In the second step, public stigma (SSRPH) was added to the model. In the third step, self-stigma (SSOSH) was added to the model. In the fourth step, the interactions of personal distress and public stigma and personal distress and self-stigma were added to the model. Predictor variables were standardized to reduce mulitcollinearity and increase efficiency in plotting significant moderator effects (Cohen et al., 2003; Fraizer et al., 2004). The results of all three regressions are presented in Table 7, 8 and 9.

Hierarchical moderated multiple regression 1. Personal distress was measured using the PA scale and NA scale for this regression as can be seen in Table 7. In the first step, personal distress did not explain a significant amount of variance (0.6%) in help-seeking attitudes [F (2, 305) = .880, $p > .05$]. In step 2, public stigma contributed significant variance (5.8%) to help-seeking attitudes after accounting for variance due to personal distress as indicated by a

significant increase [$F(1, 304) = 18.76$, $p < .001$]. In step 3, self-stigma contributed significant variance (22.0%) to help-seeking attitudes after accounting for the variance due to personal distress and public stigma as indicated by a significant increase [$F(1, 303) = 92.99$, $p < .001$]. In step 4, the interactions of personal distress and public stigma and personal distress and self-stigma did not contribute significant variance (1.3%) to help-seeking attitudes after accounting for variance due to personal distress, public stigma, and self-stigma as indicated by an insignificant increase [$F(4, 299) = 1.40$, $p > .05$]. The hierarchical moderated multiple regression provided support for the fifth hypothesis in that public stigma contributed significant variance to help-seeking attitudes after accounting for variance due to personal distress as defined by PA and NA. The hierarchical moderated multiple regression provided support for the sixth hypothesis in that self-stigma contributed significant variance to help-seeking attitudes after accounting for the variance due to personal distress and public stigma. The hierarchical moderated multiple regression did not provide support for the seventh and eight hypotheses in that the interaction of public stigma and the PA and the NA scale and the interaction of self-stigma and the PA and the NA scale did not contribute significant variance to help-seeking attitudes.

Hierarchical moderated multiple regression 2. Personal distress was measured using the HSCL-21 total score for this regression as can be seen in Table 8. In the first step, personal distress did not explain a significant amount of variance (0.1%) in help-seeking attitudes [F (1, 306) = .188, $p > .05$]. In step two, public stigma contributed significantly variance (7.0%) to help-seeking attitudes after accounting for the variance due to personal distress as indicated by a significant increase [$F(1, 305) = 23.15$, $p < .001$]. In step three, self-stigma contributed significant variance (21.5%) in help-seeking attitudes after accounting for variance due to personal distress and public stigma as indicated by a significant increase [$F(1, 304) = 91.61$, $p <$

.001]. In step four, the interactions of personal distress and public stigma and personal distress and self-stigma did contribute significant variance (2.1%) to help-seeking attitudes after accounting for the variance due to personal distress, public stigma, and self-stigma as indicated by a significant increase $F(2, 302) = 4.56$, $p < .05$. Standardized regression coefficients (β) were examined for the fourth step in the regression to gain insight into the unique contribution of each interaction on help-seeking attitudes. The only significant interaction was that of self-stigma and personal distress ($\beta = 1.03$, $p < .05$). . This indicated that the relation between personal distress (HSCL-21 total score) and help-seeking attitudes was dependent on the level of self-stigma. Figure 1 graphically represents the interaction of personal distress and self-stigma on help-seeking attitudes. The plot was attained by substituting representative values of ±.50 standard deviation into the regression equation. This resulted in ascertaining the predicted values for each group when the standard deviations of the variables equal .50 (Cohen et al., 2003; Frazier et al., 2004). As can be seen by Figure 1, self-stigma altered the relation between personal distress and help-seeking attitudes at low levels of distress. This indicated that individuals had significantly more positive attitudes towards help-seeking at low levels of self-stigma and low levels of personal distress than at high levels of self-stigma and low levels of personal distress. Self-stigma did not alter the relation between personal distress and help-seeking attitudes at high levels of distress. This indicated that individuals at low levels of self-stigma and high levels of personal distress had similar attitudes towards help-seeking as individuals at high levels of self-stigma and high levels of personal distress. Therefore, high personal distress buffered the impact of self-stigma on the relation between personal distress and help-seeking attitudes.

In short, the hierarchical moderated multiple regression provided support for the fifth hypothesis in that public stigma contributed significant variance to help-seeking attitudes after

accounting for variance due to personal distress defined by the HSCL-21 total score. The hierarchical moderated multiple regression provided support for the sixth hypothesis in that self-stigma contributed significant variance to help-seeking attitudes after accounting for the variance due to personal distress and public stigma. The hierarchical moderated multiple regression did not provide support for the seventh hypothesis in that the interaction of public stigma and personal distress did not contribute significant variance to help-seeking attitudes. The hierarchical moderated multiple regression found that the interaction of self-stigma and personal distress, as measured by the HSCL-21, did contribute significant variance to help-seeking attitudes. However, the interaction did not provide support for the eight hypothesis, because rather than being negative, as predicted, the interaction was positive.

Hierarchical moderated multiple regression 3. Personal distress was measured using the three subscales (GFD, SD, PD) for this regression as can be seen by Table 9. In the first step, personal distress did not explain a significant amount of variance (1.0%) in help-seeking attitudes [F (3, 304) = 1.03, $p > .05$]. In step 2, public stigma contributed significant variance (7.4%) to help-seeking attitudes after accounting for the variance due to personal distress as indicated by a significant increase $F(1, 303) = [24.38, p < .001]$. In step 3, self-stigma contributed significant variance (22.1%) in help-seeking attitudes after accounting for the variance due to personal distress and public stigma as indicated by a significant increase [$F(1, 302) = 95.95, p < .001$]. In step 4, the interactions of personal distress and public stigma and personal distress and self-stigma did contribute significant variance (3.2%) to help-seeking attitudes after accounting for the variance due to personal distress, public stigma, and self-stigma as indicated by a significant increase [$F(6, 296) = 2.41, p < .05$]. Standardized regression coefficients (β) were examined for the fourth step in the regression to gain insight into the unique

contribution of each interaction on help-seeking attitudes. The only significant interaction was that of self-stigma and the GFD subscale ($\beta = 1.25$, $p < .05$). This indicates that the relation between personal distress (GFD subscale) and help-seeking attitudes is dependent on the level of self-stigma. Figure 2 graphically represents the interaction of personal distress and self-stigma on help-seeking attitudes. The plot was attained by substituting representative values of ±.50 standard deviation into the regression equation. This resulted in ascertaining the predicted values for each group when the standard deviations of the variables equal .50 (Cohen et al., 2003; Frazier et al., 2004). As can be seen by Figure 2, self-stigma strongly altered the relation between personal distress and help-seeking attitudes at low levels of distress. This indicated that individuals had significantly more positive attitudes towards help-seeking at low levels of self-stigma and low levels of personal distress than at high levels of self-stigma and low levels of personal distress. Self-stigma weakly altered the relation between personal distress and help-seeking attitudes at high levels of distress. This indicated that individuals at low levels of self-stigma and high levels of personal distress had similar attitudes towards help-seeking as individuals at high levels of self-stigma and high levels of personal distress. Therefore, high personal distress buffered the impact of self-stigma on the relation between personal distress and help-seeking attitudes.

In short, the hierarchical moderated multiple regression provided support for the fifth hypothesis in that public stigma contributed significant variance to help-seeking attitudes after accounting for variance due to personal distress as defined by the GFD subscale of the HSCL-21. The hierarchical moderated multiple regression provided support for the sixth hypothesis in that self-stigma contributed significant variance to help-seeking attitudes after accounting for the variance due to personal distress and public stigma. The hierarchical moderated multiple

regression did not provide support for the seventh hypothesis in that the interaction of public stigma and personal distress did not contribute significant variance to help-seeking attitudes. The hierarchical moderated multiple regression found that the interaction of self-stigma and personal distress, as measured by the GFD subscale of the HSCL-21, did contribute significant variance to help-seeking attitudes. However, the interaction did not provide support for the eight hypothesis, because rather than being negative, as predicted, the interaction was positive.

Normality**.** Using the Statistical Package for the Social Sciences 22 (SPSS), post-hoc normality analyses were conducted to ascertain if the data was normal. The same method used for career counseling, based on Kim (2013), was used for personal counseling.

First, the Shapiro-Wilk statistic (W) was examined for all the variables. The PA scale ($W = .99$, $p > .05$), self-stigma ($W = .99$, $p > .05$) and help-seeking attitudes ($W = .99$, $p > .05$) were normal. The NA scale ($W = .98$, $p < .001$), the HSCL scale ($W = .97$, $p < .001$), and public stigma ($W = .97$, $p < .001$) were non-normal. Second, the non-normal variables were further examined for normality by inspecting the skewness and kurtosis. Z scores were computed for skewness and kurtosis and compared to the standard z score for the skewness and kurtosis of a normal distribution ($z = 3.29$, $p < .05$ for $50 < n < 300$; Kim, 2013). Skewness and kurtosis for public stigma ($z = 1.70$, $z = 1.74$, respectively) was within the standard z score of 3.29. Personal distress, measured using the NA scale and HSCL scale, results for skewness and kurtosis differed based on the measure. The skewness and kurtosis for the NA scale ($z = 3.15$, $z = .43$, respectively) were within the standard z score of 3.29. However, only the kurtosis for the HSCL ($z = .01$) was within the standard z score of 3.29. The skewness of the HSCL scale ($z = 4.46$, skew = .620) was above the standard z score of 3.29.

Table 5.

Summary of means, standard deviations, and correlations for all variables under examination by sex

	1	2	3	4	5	6	7	8	9	*M*	*SD*
Distress											
1. PA Scale	-	-.17*	-.27**	-.39**	-.16*	-.15	-.02	-.05	-.07	3.26	.75
2. NA Scale	-.04	-	**.77****	.73**	.65**	.63**	.33**	.07	-.10	2.30	.72
3. HSCL-21 Total	-.17*	.64**	-	.84**	.86**	.89**	.35**	.05	-.05	1.91	.56
4. GFD Subscale	-.21*	.62**	.88**	-	.55**	.62**	.33**	.14	-.08	**1.99**	.68
5. SD Subscale	-.06	.48**	.80**	.53**	-	.70**	.29**	.02	-.04	1.70	.63
6.PD Subscale	-.16	.53**	.87**	.68**	.54**	-	.30**	-.04	-.01	2.04	.64
7. Public Stigma	-.15	.16	.15	.25**	.02	.08	-	.54**	-.35**	2.12	.63
8. Self-Stigma	-.12	.19*	.18*	.26**	.10	.07	.35**	-	-.50**	3.08	.66
9. Help-Seeking Attitudes	.02	-.05	.09	.10	-.03	.15	-.09	-.54**	-	**2.70**	.46
M	3.32	2.19	1.83	**1.84**	1.64	2.01	2.23	3.15	**2.49**	-	-
SD	.64	.64	.48	.63	.53	.54	.51	.71	.53	-	-

Note. $N = 305$ (159 women, 146 men). PA Scale = Positive Affect Scale, NA Scale = Negative Affect Scale, HSCL-21 Total = Hopkins Symptom Checklist-21 Total, GFD Subscale = General Feelings of Distress Subscale of HSCL-21, SD Subscale = Somatic Distress Subscale of HSCL-21, and PD Subscale = Performance Difficulty Subscale of the HSCL-21.Bivariate correlations for women are presented above the diagonal and bivariate correlations for men are presented below the diagonal. Means and standard deviations for women are presented in the vertical columns and the means and standard deviations for men are presented in the horizontal rows. Bolded means represent significant differences in the means between men and women. Higher mean scores indicate less personal distress (PA Scale), more personal distress (NA Scale, HSCL-21 Total, and GFD, SD, and PD subscales), more public stigma, more self-stigma and more positive attitudes towards seeking help. The PA and the NA Scale range from 1-5, the HSCL-21 ranges from 1-4, public stigma ranges from 1-4, self-stigma ranges from 1-5 and attitudes towards seeking help ranges from 1-4. * $p < .05$. ** $p < .01$.

Table 6.
Summary of means, standard deviations, and correlations for all variables under examination for total sample

	1	2	3	4	5	6	7	8	9
Distress									
1. PA Scale	-								
2. NA Scale	-.13*	-							
3. HSCL-21 Total	-.25**	.72**	-						
4. GFD Subscale	-.33**	.69**	.86**	-					
5. SD Subscale	-.13*	.58**	.83**	.54**	-				
6. PD Subscale	-.17**	.59**	.88**	.65**	.63**	-			
7. Public Stigma	-.09	.27**	.28**	.30**	.19**	.23**	-		
8. Self-Stigma	-.09	.13*	.11*	.20**	.06	.02	.46**	-	
9. Help-Seeking Attitudes	-.02	-.07	.03	.03	-.03	.06	-.25**	-.53**	-
M	3.28	2.25	1.87	1.93	1.67	2.03	2.18	3.11	2.59
SD	.70	.69	.52	.66	.58	.59	.58	.69	.50

Note. $N = 308$. PA Scale = Positive Affect Scale, NA Scale = Negative Affect Scale, HSCL-21 Total = Hopkins Symptom Checklist-21 Total, GFD Subscale = General Feelings of Distress Subscale of HSCL-21, SD Subscale = Somatic Distress Subscale of HSCL-21, and PD Subscale = Performance Difficulty Subscale of the HSCL-21. Higher mean scores indicate less personal distress (PA Scale), more personal distress (NA Scale, HSCL-21 Total, and GFD, SD, and PD subscales), more public stigma, more self-stigma and more positive attitudes towards seeking help. The PA and the NA Scale range from 1-5, the HSCL-21 ranges from 1-4, public stigma ranges from 1-4, self-stigma ranges from 1-5 and attitudes towards seeking help ranges from 1-4. * $p < .05$. ** $p < .01$.

Table 7.
Summary of Hierarchical Moderated Multiple Regression for Prediction of Help-seeking Attitudes from Personal Distress (PANAS), Public Stigma, and Self-Stigma

Variable	R^2	ΔR^2	*b*	*SEb*	*β*
Step 1: Personal Distress	.01	.01			
PA Scale			-.17	.29	-.03
NA Scale			-.37	.29	-.07
Step 2: Public Stigma	.06***	.06***			
Public Stigma			-1.26	.29	-.25***
Step 3: Self- Stigma	.28***	.22***			
Self-Stigma			-2.65	.28	-.53***
Step 4: Interactions	.29***	.01			
PA Scale x Public Stigma			-.71	1.63	-.14
NA Scale X Public Stigma			-2.01	-.40	-.26
PA Scale x Self-Stigma			-1.30	1.75	.13
NA Scale x Self-Stigma			2.85	1.59	.57

Note. $N = 308$. PA Scale = Positive Affect Schedule and NA Scale = Negative Affect Schedule. * $p < .05$. *** $p < .001$.

Table 8.
Summary of Hierarchical Moderated Multiple Regression for Prediction of Help-seeking Attitudes from Personal Distress (HSCL-21 Total), Public Stigma, and Self-Stigma

Variable	R^2	ΔR^2	*B*	*SEB*	*B*
Step 1: Personal Distress	<. 01	< .01			
HSCL-21 Total			.12	.29	.025
Step 2: Public Stigma	.07***	.07***			
Public Stigma			-1.39	.29	-.28***
Step 3: Self- Stigma	.29***	.22***			
Self-Stigma			-2.62	.27	-.52***
Step 4: Interactions	.31***	.02**			
HSCL-21 Total x Public Stigma			-2.18	1.40	-.43
HSCL-21 Total x Self-Stigma			5.17	1.71	1.03**

Note. N = 308. HSCL-21 Total = Hopkins Symptom Checklist-21 Total. ** $p < .01$. *** $p < .001$.

Table 9.
Summary of Hierarchical Moderated Multiple Regression for Prediction of Help-seeking Attitudes from Personal Distress (GFD, SD, PD), Public Stigma, and Self-Stigma

Variable	R^2	ΔR^2	*B*	*SEb*	β
Step 1: Personal Distress	.01	.01			
GFD Subscale			.03	.39	.01
SD Subscale			-.54	.38	-.11
PD Subscale			.62	.42	.12
Step 2: Public Stigma	.08***	.07***			
Public Stigma			-1.43	.29	-.29***
Step 3: Self- Stigma	.31***	.22***			
Self-Stigma			-2.71	.28	-.54***
Step 4: Interactions	.34***	.03*			
GFD Subscale x Public Stigma			-3.05	2.07	-.61
SD Subscale x Public Stigma			-2.03	1.78	-.40
PD Subscale x Public Stigma			2.17	2.34	.43
GFD Subscale x Self-Stigma			6.28	2.22	1.25**
SD Subscale x Self-Stigma			-.58	1.88	-.11
PD Subscale x Self-Stigma			.20	2.36	.04

Note. N = 308. GFD Subscale = General Feelings of Distress Subscale of HSCL-21, SD Subscale = Somatic Distress Subscale of HSCL-21, and PD Subscale = Performance Difficulty Subscale of HSCL-21. HSCL-21 = Hopkins Symptom Checklist-21. * $p < .05$. ** $p < .01$. *** $p < .001$.

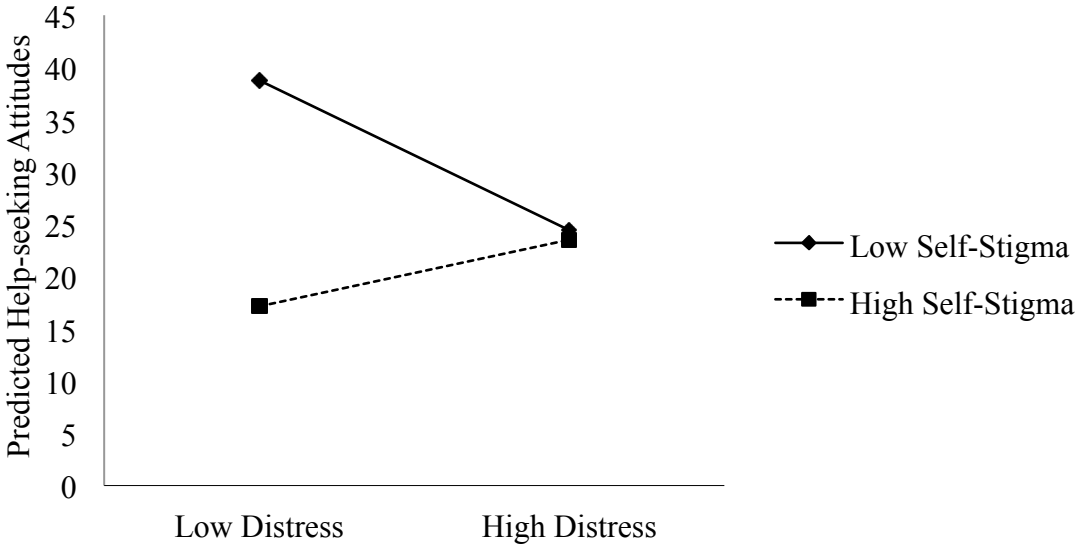


Figure 1. Depiction of the interaction of personal distress (HSCL-21 total score) and self-stigma on help-seeking attitudes.

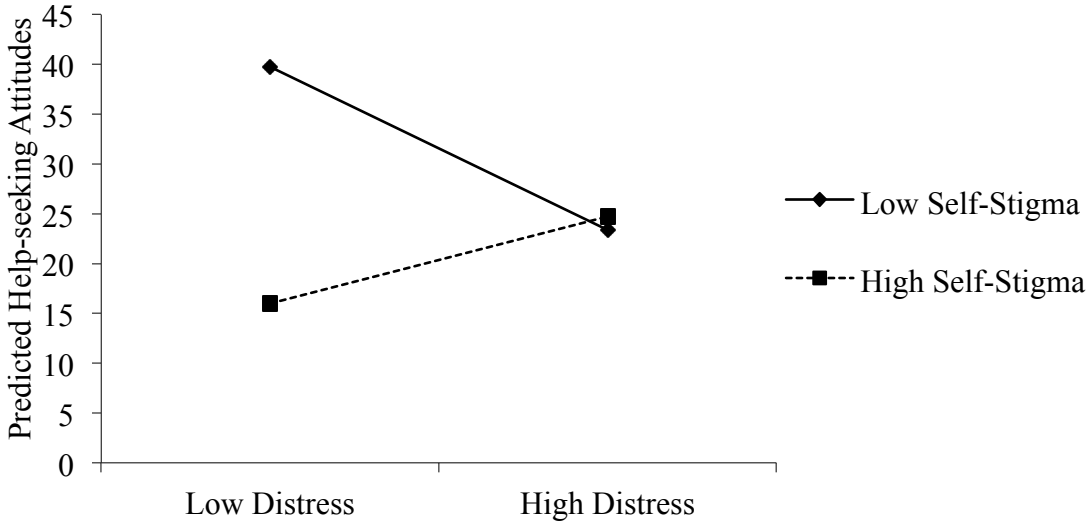


Figure 2. Depiction of the interaction of personal distress (GFD subscale) and self-stigma on help-seeking attitudes.

CHAPTER 5. DISCUSSION

This discussion highlights the contribution of public stigma and self-stigma on the relation between psychological distress (career and personal) and help-seeking attitudes. The results pertaining to career counseling are discussed first followed by the results pertaining to personal counseling. In each section, the results are explored in relation to supporting or refuting the proposed hypotheses. Empirical and theoretical support is provided for hypotheses that were supported and possible explanations are provided for hypotheses that were refuted. In addition, the limitations, implications and potential future studies are explored.

Career counseling

Career distress. Career distress did not contribute significant variance to help-seeking attitudes. This indicated that there was a null relation between career distress and help-seeking attitudes. In reviewing past studies, distress seemed to be related to the actual behavior of seeking help. Individuals who sought help for career concerns reported less distress than individuals who did not seek help (e.g., Multon et al., 2001; Utz, 1983). Therefore, the amount of career distress an individual feels may be related to if she or he actually engaged (did not engage) in seeking help and not be related to his or her attitudes towards seeking help.

An area not addressed by this study or past studies was the relation between career distress and intentions to seek help. Intentions are considered to be one step ahead of attitudes but one step behind actual behavior (Ajzen, 2012). Future studies could ascertain the role of career distress on an individual's intention to seek help by examining the relation of career distress and intentions to seek help. In addition, future studies could replicate this study to confirm or modify the results of this study. Due to the scarcity of articles examining these

variables, further studies would add clarity to the relation between career distress and help-seeking attitudes, intentions and behavior.

Public stigma. The author addressed the contribution of public stigma on help-seeking attitudes after accounting for the contribution of career distress. Public stigma did contribute significant variance to help-seeking attitudes after variance due to career distress was removed. Hypothesis one was supported. The relation between public stigma and help-seeking attitudes was negative, such that more public stigma correlated with less positive attitudes towards seeking help. This study supported Ludwikowski (2009) finding that public stigma for career concerns was significantly negatively related to help-seeking attitudes for career concerns. In addition, it was consistent with the theory of planned behavior (TPB; Ajzen, 1985) assertion that subjective norms, which are similar to public stigma, and attitudes towards a behavior relate to each other and influence behavior. It also supported modified labeling theory (MLT; Link et al., 1989) statement in that negative views by society, analogous to public stigma, resulted in negative consequences, analogous to less favorable attitudes towards help-seeking.

Self-stigma. The author addressed the contribution of self-stigma on help-seeking attitudes after accounting for the contribution of public stigma and career distress. Self-stigma did contribute significant variance to help-seeking attitudes after variance due to public stigma and career distress was removed. Hypothesis two was supported. The relation between self-stigma and help-seeking attitudes was negative, such that more self-stigma correlated with less positive attitudes towards seeking help. This study corroborated Ludwikowski (2009) finding that self-stigma for career concerns significantly negatively correlated with help-seeking attitudes for career concerns. It also supported modified labeling theory (MLT; Link et al., 1989) statement in that internalization of negative view of society by an individual, analogous to self-

stigma, resulted in negative consequences, analogous to less favorable attitudes towards help-seeking.

Interaction. The author addressed the contribution of the interactions of career distress and public stigma and career distress and self-stigma on help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and career distress. The interaction of career distress and public stigma did not contribute significant variance to help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and career distress. Also, the interaction of career distress and self-stigma did not contribute significant variance to help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and career distress. Hypotheses three and four were not supported. These results were inconsistent with Miller (1944) approach-avoidance conflict and Kushner and Sher (1989) approach-avoidance model. The presence of an approach factor, career distress did not seem to move an individual towards seeking help and enact an avoidance factor, stigma that moved the individual away from seeking help. Therefore, there was no approach-avoidance conflict and no differences in attitudes towards seeking help based on level of distress and level of stigma. A potential explanation for career distress not moving an individual towards seeking help may be that an individual has other resources to utilize. For example, each student has an academic advisor that can help him or her with major or career decisions. In addition, many college campuses have an organization geared towards career exploration such as a career exploration services center or a career center.

Personal counseling

Personal distress. Personal distress did not contribute significant variance to help-seeking attitudes. This indicated that there was a null relation between personal distress and help-seeking attitudes. This study supported Nam et al. (2013) meta-analyses that reported a null relation

between personal distress and help-seeking attitudes. An explanation for this result may be that personal distress influences help-seeking intentions and behavior rather than attitudes. Past studies examining personal distress and help-seeking intentions have reported a positive relation (e.g., Constantine et al., 2003; Sheffield et al., 2004). In addition, the theory of planned behavior (TPB, Ajzen 1985) states that intentions are a result of behavioral beliefs (attitudes) and subjective norms, similar to public stigma. It may be that psychological distress influences subjective norms rather than attitudes to influence intentions.

Public stigma. The author addressed the contribution of public stigma on help-seeking attitudes after accounting for the contribution of personal distress. Public stigma contributed significant variance to help-seeking attitudes after variance due to personal distress was removed. Hypothesis five was supported. The relation between public stigma and help-seeking attitudes was negative, such that more public stigma correlated with less favorable attitudes towards help-seeking. This study was consistent with Nam et al. (2013) meta-analyses that public stigma and help-seeking attitudes were negatively related. It did not support studies conducted after the meta-analyses that found a null relation between public stigma and help-seeking attitudes (e.g., Evans-Lacko et al., 2012). In addition, it supported the theory of planned behavior (TPB; Ajzen, 2012) assertion that subjective norms, which are similar to public stigma, and attitudes toward a behavior relate to each other and influence behavior. It also supported modified labeling theory (MLT; Link et al., 1989) statement in that negative view of society by an individual, analogous to public stigma, resulted in negative consequences, analogous to less favorable attitudes towards help-seeking.

Self-stigma. The author addressed the contribution of self-stigma on help-seeking attitudes after accounting for the contribution of public stigma and the contribution of personal

distress. Self-stigma contributed significant variance to help-seeking attitudes after the variance due to public stigma and personal distress was removed. Hypothesis six was supported. The relation between self-stigma and help-seeking attitudes was negative, such that more self-stigma correlated with less favorable attitudes towards seeking help. This study reinforced Nam et al. (2013) finding that self-stigma significantly negatively correlated with help-seeking attitudes and was the strongest correlation compared to other constructs (e.g., public stigma and psychological distress). This study also supported Bathje and Pryor (2011) and Vogel et al. (2007) findings in that self-stigma for personal concerns significantly negatively correlated with help-seeking attitudes for personal concerns. In addition, it supported modified labeling theory (MLT; Link et al., 1989) statement in that internalization of negative view of society by an individual, analogous to self-stigma, resulted in negative consequences, analogous to less favorable attitudes towards help-seeking.

Interaction. The author addressed the contribution of the interaction of personal distress (PANAS and, HSCL-21) and public stigma and personal distress and self-stigma on help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and personal distress. The interaction of personal distress and public stigma did not contribute significant variance to help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and personal distress. Hypothesis seven was not supported. However, the interaction of personal distress and self-stigma did contribute significant variance to help-seeking attitudes after accounting for the contribution of self-stigma, public stigma and personal distress. Hypothesis eight was not supported, since the interaction was positive rather than the predicted negative. In examining the interaction, at low levels of personal distress, the level of self-stigma altered attitudes towards seeking help such that high levels of self-stigma resulted in significantly less

positive attitudes than low levels of self-stigma. However, at high levels of distress, the level of self-stigma did not alter attitudes toward seeking help.

The results did not align with and were contradictory of Miller (1994) approach-avoidance conflict and Kushner and Sher (1989) approach and avoidance factors. Based on Miller (1994) and Kushner and Sher (1989), the author predicted a negative interaction; however, the interaction was positive, Specifically, the relationship between psychological distress and help-seeking attitudes became algebraically larger rather than algebraically smaller as stigma increased. This positive interaction defies plausible interpretation based on research and theory examining psychological distress, stigma and help-seeking attitudes. One supposition is that distress may be both an approach and avoidance factor. Further research should be conducted to develop theory or plausible explanations for the positive interaction found in this study.

Limitations

Sample. The sample was a convenience sample of college students, so the generalizability of the results to other populations (e.g., community) may be limited. Nonetheless, college students experience varying levels of psychological distress (career and personal) throughout their collegiate years that require professional help. However, these students don't always seek help for these concerns (Blanco et al., 2008; Fouad et al., 2006). Therefore, understanding the contribution of stigma on the relation between psychological distress (career and personal) and help-seeking attitudes seems relevant to the college population.

A major purpose of this study was to capture a wide variability of distress. In order to achieve this purpose, individuals that had endorsed high and low levels of distress in mass testing were invited to partake in the study. While the students were invited, there was no obligation to

participate in the study. In addition, there was no procedure to identify, due to confidentiality concerns, if these individuals actually participated in the study. Therefore, the researcher was unable to derive how many individuals, who endorsed high or low distress, actually participated in the study. Another weakness was that mass testing occurred over four weeks, and an additional week was added in organizing the data and sending out the emails. Due to this, anywhere from one week to five weeks had passed from first assessment of distress (mass testing) to second assessment of distress (current study). It is feasible that over time individuals with high distress and low distress moved towards medium distress. Since there was no procedure to track individuals, the variability may have reduced simply due to time.

An additional weakness of the study was the lack of diversity in ethnicity in the population. The career counseling sample and personal counseling sample were predominately white, 78.7% and 79.5%, respectively. Due to this, the researcher could not examine if distress, stigma and help-seeking attitudes related differently based on ethnicity. Future studies could intentionally invite ethnically diverse students to partake in the study.

Size and power. There was a differential relation of career distress and stigma (public and self) and personal distress and stigma (public and self); personal distress and stigma were positively correlated whereas career distress and stigma were not correlated. In addition the contribution of the interaction of personal distress, when measured by the HSCL-21 and GFD subscale, and self-stigma to help-seeking attitudes was significant, whereas the contribution of the interaction of career distress and self-stigma to help seeking attitudes was not significant. An explanation for this difference may be that the career counseling sample ($N = 202$) had less power due to a smaller sample size whereas the personal counseling sample ($N = 308$) had more power due to a larger sample size. In order to provide support for this explanation, a post-hoc

power analysis was conducted to determine the power for each of the multiple regressions conducted (Faul, Erdfelder, Buchner, & Lang, 2009). In addition, the sample size required to ascertain a power of .80 was computed using the effect size of each multiple regression at a power of .80 and α =. 05 (Faul, Erdfelder, Buchner, & Lang, 2009).

Career counseling. For the regression using the ATCCS (see Table 3), the effect size was .02 and the sample size was 202 resulting in power of .39. In order to ascertain a power of .80 with an effect size of .02, the required sample size is 514. For the regression using the ATSPPH (see Table 4), the effect size was .01 and the sample size was 202 resulting in power of .20. In order to ascertain a power of .80, the required sample size is 1102. In order to determine if having an equivalent sample size to personal counseling (N = 308) would have yielded significant results, the power was computed using the effect size for ATCCS of .02 and ATSPPH of .01. The power was .57 and .29 for ATCCS and ATSPPH, respectively.

Personal counseling. For the regression using the PANAS (see Table 7), the effect size was .02 and the sample size was 308 resulting in power of .47. In order to ascertain power of .80 with an effect size of .02, the required sample is 605. For the regression using the HSCL total score (see Table 8), the effect size was .03 and the sample size was 308 resulting in power of .78. In order to ascertain power of .80 with an effect size of .03, the required sample is 321. For the regression using the GFD, SD and PD subscales (see Table 9), the effect size was .05 and the sample size was 308 resulting in power of .82. In order to ascertain power of .80 with an effect size of .05, the required sample is 289.

The goal of the current study was to ascertain a medium effect size so 182 participants were required (Cohen, 1992). However, in reviewing the results of the power analyses, the strength of the relationship among the predictor variables and criterion variable, be it for

personal or career counseling, was small. In addition, the detection of small sample sizes requires more participants based on Cohen (1992) and the conducted power analyses. For career counseling, an increase in sample size from 202 to 308 did not result in sufficient power to yield significant results. The current study had sufficient power and sample size to detect a medium effect size, but the effect size of the variables was small requiring a large sample size. While the small effect sizes were statistically significant, they may be irrelevant in clinical application due to the minute strength amongst the variables. Clinical researchers and therapists, in general, consider small effect sizes to be negligible in clinical application for career and personal counseling.

Intentions. A limitation of this study was that intentions towards a behavior, in this case help-seeking were not measured; instead attitudes towards seeking help were measured. Vogel et al. (2007) reported that intentions to seek help were a more proximal indicator of actual help-seeking behavior than attitudes towards seeking help. In addition, the theory of planned behavior (TPB; Ajzen, 1985) indicates that intentions are the result of attitudes (behavioral beliefs) and subjective norms, similar to public stigma. In this study, psychological distress was related to public stigma and may have been related to intentions to seek help, if measured. Therefore, it may be that psychological distress relates to intentions through subjective norms rather than through attitudes. Future studies could examine if personal distress contributes significant variance to intentions to seeking help and if public stigma contributes significant variance to intentions to seeking help after accounting for the contribution of personal distress.

Normality**.** Normality analyses were conducted, for both career and personal counseling, to test that the multivariate normality assumption of multiple regression was met. As a result of recruiting procedures, individuals with extreme levels (high or low) of distress were invited to

participate in the study which may have influenced the distribution of data and violated the normality assumption. In addition, a greater number of individuals who identified as low distress were invited in comparison to individuals who identified as high distress. This unequal representation may have skewed the data positively for the distress variables. Using the Statistical Package for the Social Sciences 22 (SPSS), post-hoc normality analyses were conducted to ascertain if the data was normal. The Shapiro-Wilk statistic (W), the skewness and the kurtosis were used to determine normality of the data for each variable. In the career counseling study, all variables were within the acceptable range of normal, except for ATCCS (skew = -.69, z = 4.02). This result aligned with the mean comparison between the mean ATCCS of the current sample and the mean ATCCS of the original sample by Rochlen et al. (1999); the current sample had more positive attitudes towards career counseling than Rochlen et al. (1999) sample. A potential explanation for this skewness may be that college students rely on other resources to relieve their distress, such as the career center or academic advisors, and therefore have mostly positive attitudes towards career counseling. In the personal counseling study, all variables were within the acceptable range of normal, except for personal distress, as measured by the HSCL scale (skew = .64, z = 4.46). This result aligned with the mean comparison between the mean HSCL of the current sample and the mean HSCL of the original sample by Green et al. (1988); the current sample had less personal distress than the Green et al. (1988) sample. A potential explanation for the skewness in the HSCL scale may be due to the non-clinical sample, whereas the HSCL was constructed to measure "neurotic symptoms" in "psychotherapeutic drug trials" (Green et al., 1988, p. 61). Therefore, college students, who represent a non-clinical sample, may report less personal distress. In addition, the positive skew may have resulted from intentionally inviting more low distress individuals than high distress individuals to participate in

the study. While the data was not perfectly normal, the skewness and kurtosis of most variables were within the acceptable range of normality, and for those outside the acceptable range, there was a plausible explanation for the deviation. In addition, the slight violation of multivariate normality should not have a meaningful impact on the data and conclusion, because multiple regression analysis is robust to violations of multivariate normality.

Implications

The major contribution of this study to the literature on help-seeking attitudes was the significant interaction of self-stigma and psychological distress, namely personal distress as defined by the expression of symptoms (HSCL-21), in explaining the variation in help-seeking attitudes. In this study, at low levels of personal distress, the level of self-stigma mattered and significantly altered help-seeking attitudes. However, at high levels of personal distress, the level of stigma was buffered by personal distress and did not significantly alter help-seeking attitudes. This is potentially helpful information given that most people will only seek help when experiencing considerable distress. These results are shown in Figures 1 and 2. Future studies need to replicate these findings. If these findings are substantiated, it appears that self-stigma may have differential negative effects on help-seeking attitudes depending on the level of the individual's distress.

Future Studies

First, future studies could continue to include other measures of psychological distress in order to understand the role of psychological distress and stigma on help-seeking attitudes. Second, future studies could focus on replicating the results of this study to verify that the findings are generalizable across different samples. Third, future studies could also focus on more specific types of psychological distress (e.g., depression), and examine if similar

interaction effects occur. Fourth, future studies could examine how psychological distress interacts with stigma to influence help-seeking intentions and behavior. As stated by Ajzen (2012) theory of planned behavior (TPB), intentions are a combination of behavioral beliefs (attitudes) and subjective norms, similar to public stigma. Therefore, psychological distress may interact with subjective norms to influence intentions and eventually behavior. Last, the current study examined the variables of interest, psychological distress, stigma (public and self), and help-seeking attitudes at one point in time rather than over time. Due to this, the study was able to ascertain only how current psychological distress and stigma (public and self) related to help-seeking attitudes. It would be informative to understand how change in psychological distress and change in stigma (public and self) over time relates to help-seeking attitudes. Future researchers could conduct a longitudinal study that tracks individuals' psychological distress levels, stigma (public and self) levels, and attitudes toward seeking help over time. A longitudinal study would be beneficial as it allows for tracking an individual over time and thus understanding how psychological distress and stigma (public and self) influence an individual's help-seeking attitudes over time. Therefore, longitudinal studies may aide in understanding and interpreting interaction effects more accurately, since the individuals in each level (e.g., high or low psychological distress) are the same. In addition, the longitudinal study could be broadened to include intentions toward seeking help.

Conclusion

Overall, this study found that psychological distress (career and personal) did not relate to help-seeking attitudes. In addition, this study reinforced past studies' findings that public stigma and self-stigma were negatively correlated with help-seeking attitudes. Last, it added to the field

by highlighting the importance of interactions effects on help-seeking attitudes, especially the interaction of personal distress and self-stigma.

APPENDIX A. DEMOGRAPHICS QUESTIONNAIRE

Age: _____

Gender:
- Male
- Female
- Other

Ethnicity:
- African American
- Asian American/Pacific Islander
- Caucasian/White
- Hispanic or Latino/a
- Native American
- Other: _____

Year in School:
- Freshman
- Sophomore
- Junior
- Senior
- Other: _____

Have you ever received counseling or seen a counselor?
- Yes
- No

APPENDIX B. COPING WITH CAREER INDECISION SCALE: SUBJECTIVE CAREER DISTRESS AND OBSTACLES SUBSCALE

(Larson et al., 1994)

1 = Strongly Agree, **2** = Moderately Agree, **3** = Slightly Agree, **4** = Slightly Disagree, **5** = Moderately Disagree, **6** = Strongly Disagree

1. I often feel down or depressed about selecting a major or career.
2. I often feel a sense of helplessness in selecting a major and planning my career.
3. I tend to procrastinate or avoid selecting a major and career, and just let time run its course.
4. I think I should make a career decision as soon as possible, but I can't and this makes me anxious.
5. I feel stress or pressure in selecting a satisfying major and career.
6. I frequently blame myself for something I did or did not do in selecting a major or career.
7. I tend to smooth over any career indecision and pretend that it doesn't exist.
8. I often feel that my life lacks much purpose.
9. I often hope that any problems I have or have had in selecting my major and career would just disappear.
10. I don't have the special talents to follow my first career choice.
11. An influential person doesn't approve of my career choice, which is hindering me from seeking that career.
12. I spend time every day thinking about selecting a major and career, and what I might do about it.
13. It seems like I receive a lot of contradictory or confusing information on academic majors that I've considered.
14. I get worried when I think about the intense competition in most careers.
15. I feel as if I have too many interests to settle on any one field.
16. I feel a lot of pressure from my parents to choose a certain major and/or career.
17. I find it difficult to make decisions in general, no matter what issue is involved.
18. If I could find the right career, many of my other personal problems would be solved.
19. At this point in time, almost any major would be better than no major.
20. Finances limit what career choice I make.
21. I know little about what kinds of people enter different occupations.

APPENDIX C. POSITIVE AND NEGATIVE AFFECT SCHEDULE

(Watson et al., 1988)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer. Indicate to what extent you have felt this way during the past few weeks. Use the following scale to record your answers.

1= Very slightly or not at all, **2** = A little, **3** = Moderately, **4** = Quite a bit, **5** = Extremely

_____ interested
_____ distressed
_____ excited
_____ upset
_____ strong
_____ guilty
_____ scared
_____ hostile
_____ enthusiastic
_____ proud
_____ irritable
_____ alert
_____ ashamed
_____ inspired
_____ nervous
_____ determined
_____ attentive
_____ jittery
_____ active
_____ afraid

APPENDIX D. HOPKINS SYMPTOM CHECKLIST-21

(Green et al., 1988)

How have you felt during the past week including today? Use the following scale to describe how distressing you have found these things over this time.

1 = Not at all, **2** = A little, **3** = Quite a bit, **4** = Extremely

1. Difficulty in speaking when you are excited
2. Trouble remembering things
3. Worried about sloppiness or carelessness
4. Blaming yourself for things
5. Pains in the lower part of your back
6. Feeling lonely
7. Feeling blue
8. Your feelings being easily hurt
9. Feeling others do not understand you or are sympathetic
10. Feeling people are unfriendly or dislike you
11. Having to do things very slowly in order to be sure you are doing them right
12. Feeling inferior to others
13. Soreness in your muscles
14. Having to check and double-check what you do
15. Hot or cold spells
16. Your mind going blank
17. Numbness or tingling in parts of your body
18. A lump in your throat
19. Trouble concentrating
20. Weakness in parts of your body
21. Heavy feelings in your arms and legs

APPENDIX E. STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL HELP FOR CAREER COUNSELING

(Adapted from Komiya et al., 2000; Ludwikowski et al., 2009)

1 = Strongly Disagree, **2** = Disagree, **3** = Agree, **4** = Strongly Agree

1. Seeing a counselor for career issues carries social stigma.
2. It is a sign of personal weakness or inadequacy to see a counselor for career issues.
3. People will see a person in less favorable way if they come to know he or she has seen a career counselor.
4. It is advisable for a person to hide from people that he/she has seen a career counselor
5. People tend to like less those who are receiving counseling for a career issue.

APPENDIX F. STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL HELP FOR PERSONAL COUNSELING

(Komiya et al., 2000)

1 = Strongly Disagree, **2** = Disagree, **3** = Agree, **4** = Strongly Agree

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

APPENDIX G. SELF-STIGMA OF SEEKING HELP SCALE FOR CAREER COUNSELING

(Adapted from Vogel et al., 2006; Ludwikowski et al., 2009)

1 = Strongly Disagree, **2** = Disagree, **3** = Agree and Disagree Equally, **4** = Agree, **5** = Strongly Disagree

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

APPENDIX H. SELF-STIGMA OF SEEKING HELP SCALE FOR PERSONAL COUNSELING

(Vogel et al., 2006)

1 = Strongly Disagree, **2** = Disagree, **3** = Agree and Disagree Equally, **4** = Agree, **5** = Strongly Disagree

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 help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

APPENDIX I. ATTITUDES TOWARD CAREER COUNSELING SCALE

(Rochlen et al., 1999)

Value of Career Counseling (Value; 8 items)

Instructions: Below are statements pertaining to career counseling. Read each statement carefully and indicate the degree to which you agree or disagree. Please express your honest opinion in rating the statements. There are no 'wrong' answers and the only right ones are the ones you honestly feel or believe. It is important that you answer every item.

1 = Disagree, **2** = Somewhat Disagree, **3** = Somewhat Agree, **4** = Agree

1. If a career related dilemma arose for me, I would be pleased to know that career counseling services are available.
2. Career counseling can be an effective way to learn what occupation is best suited for my interests.
3. Career counseling is a valuable resource in making a career choice.
4. If I was in a career transition, I would value the opportunity to see a career counselor.
5. If I were having trouble choosing a major, I would not hesitate to schedule an appointment with a career counselor.
6. I could easily imagine how career counseling could be beneficial for me.
7. Working with a trained career counselor might be a helpful way to feel more confident about career decisions.
8. With so many different ways to get help on career related decisions, I see career counseling as relatively important.

APPENDIX J. ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP- SHORT FORM FOR CAREER COUNSELING

(Adapted from Fisher & Farina, 1995; Ludwikowski et al., 2009)

Instructions: Below are statements pertaining to counseling. Read each statement thoroughly and state the degree to which you agree or disagree. Please indicate your honest view when rating the statements. It is crucial that you answer every item.

1 = disagree, **2** = Partly Disagree, **3** = Partly Agree, **4** = Agree

1. If I believed I was having career problems, my first inclination would be to get career counseling.
2. The idea of talking about problems with a counselor strikes me as poor way to get rid of career problems.
3. If I were experiencing a serious career problem at this point in my life, I would be confident that I could find relief in career counseling.
4. There is something admirable in the attitude of a person who is willing to cope with his or her career problems *without* resorting to help from a career counselor.
5. I would want to get help for career problems if I were worried or upset for a long period of time.
6. I might want to have career counseling in the future.
7. A person with a career problem is not likely to solve it alone; he or she *is* likely to solve it with help from a career counselor.
8. Considering the time and expense involved in career counseling, it would have doubtful value for a person like me.
9. A person should work out his or her own career problems; getting career counseling would be a last resort
10. Career troubles, like many things, tend to work out by themselves.

APPENDIX K. ATTITUDES TOWARD SEEKING PROFESSIONAL PSYCHOLOGICAL HELP- SHORT FORM FOR PERSONAL COUNSELING

(Fisher & Farina, 1995)

Instructions: Below are statements pertaining to counseling. Read each statement thoroughly and state the degree to which you agree or disagree. Please indicate your honest view when rating the statements. It is crucial that you answer every item.

1 = Disagree, **2** = Partly Disagree, **3** = Partly Agree, **4** = Agree

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as poor way to get rid of emotional conflicts.
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counseling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. A person should work out his or her own problems; getting psychological counseling would be a last resort
10. Personal and emotional troubles, like many things, tend to work out by themselves.

APPENDIX L. INFORMED CONSENT

Title of Study: **Role of Approach and Avoidant Factors in Seeking Help**
Investigators: Spurty Surapaneni, Principal Investigator
Lisa Larson, Ph.D., Supervisor

This is a research study. Please take your time reviewing the document before volunteering to participate. Please feel free to ask questions at any time.

INTRODUCTION
The purpose of this study is to better understand factors that help and/or hinder individuals from seeking professional help for personal and career concerns.

DESCRIPTION OF PROCEDURES
If you agree to participate, you will complete several surveys. First, you will be requested to answer some demographic information. Following that, you will be asked questions regarding factors that help and/or hinder professional help-seeking.

You may skip any question(s) that you wish not to answer or makes you feel uncomfortable, without any penalty. For the information to be beneficial to the study, please complete as many items as you can.

The overall survey will take no more than 50 minutes to complete. Please be informed that you *will not* be able to save your responses and finish at another time. If you plan to complete the survey you must do so within a few hours of opening the survey.

RISKS
The risks for participating in this survey are minimal and equivalent to risks one may encounter on a daily basis. However, if you should feel uncomfortable or have concerns regarding the survey, please contact the primary investigator, Spurty Surapaneni (email: ssura@iastate.edu) or the study supervisor, Lisa Larson, Ph.D. (email: lmlarson@iastate.edu).

BENEFITS
There are no direct benefits to you for participating in this study. However, it is hoped that the information gained in this study will contribute to the understanding of help-seeking attitudes and behaviors among college students.

COSTS AND COMPENSATION
There are no costs to participating in the study. You will receive two (2) research credits through SONA for participating. There are alternatives to completing this particular study if you wish to receive research credit such as participating in other studies, writing a research paper, etc. Please consult with your course instructor to learn about the different ways you can earn research credit.

PARTICIPANT RIGHTS

Your participation in this study is completely voluntary and you may refuse to participate or leave the study at any time. If you decide to not participate in the study or leave the study early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, 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 your records for quality assurance and data analysis. These records may contain private information.

To ensure confidentiality to the extent permitted by law, the following measures will be taken:

- Only the Principal Investigator and the research team will have access to the data.
- All data will be kept on a password-protected desktop computer within a locked room.
- If the results are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to contact the principal investigator with questions at any time during this survey.

- For further information about the study, contact Spurty Surapaneni (email: ssura@iastate.edu) or Lisa Larson, Ph.D. (email: lmlarson@iastate.edu).
- 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.

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PARTICIPANT CONSENT

By clicking on the "I understand this information" button below, you are indicating that you voluntarily agree to participate in this study, that the study has been explained to you, that you have been given the time to read the document, and that your questions have been satisfactorily answered.

- o I understand this information.

REFERENCES

Abeloff, M. D.; Lichter, A. S.; Niederhuber, J. E. et al.: Breast. Clinical Oncology. (Ed. Abeloff, M. D.; Armitage, J. O.; Lichter, A. S. and Niederhuber, J. E.) 2051-2159, Churchill Livingstone, New York (2000).

Ajzen, I. (1985). From intentions to actions: A theory of planned behavior. In J. Kuhl and J. Beckman (Eds.), *Action-control: From Cognition to Behavior* (pp. 11-39). Heidelberg: Springer.

Ajzen, I. (2012). The theory of planned behavior. In P. Van Lange, A. Kruglanski, and E. Higgins (Eds.), *Handbook of theories of social psychology (*Vol. 1., pp. 438-459) Sage Publications Ltd: Thousand Oaks, CA.

Anderson, D. C. (1998). A focus on career: Graduate training in counseling psychology. *Journal of Career Development, 25*(2), 101-110.

Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry, 40*(1), 51-54.

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.

Beck, A.T., & Steer, R.A. (1990). *Manual for the Beck Anxiety Inventory*. San Antonio, TX: Psychological Corporation.

Beck, A.T., Steer, R.A., & Brown, G.K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.

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(4), 400–413.

Benton, S. A., Robertson, J. M., Tseng, W., Newton, F. B., & Benton, S. L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice, 34*(1), 66-72.

Betz, N. E., & Corning, A. F. (1993). The inseparability of "career" and "personal" counseling. *The Career Development Quarterly, 42*(2), 137-142.

Blanco, C., Okuda, M., Wright, C., Hasin, D. S., Grant, B. F., Liu, S., & Olfson, M. (2008). Mental health of college students and their non-college-attending peers: Results from the national epidemiologic study on alcohol and related conditions. *Archives of General Psychiatry, 65*(12), 1429-1437.

Blustein, D. L., & Spengler, P. M. (1995). *Personal adjustment: Career counseling and psychotherapy.* Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Bos, A. E. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology, 35*(1), 1-9.

Brown, C., Conner, K. O., Copeland, V. C., Grote, N., Beach, S., Battista, D., & Reynolds, Charles F., I.,II. (2010). Depression stigma, race, and treatment seeking behavior and attitudes. *Journal of Community Psychology, 38*(3), 350-368.

Calhoun, L. G., & Selby, J. W. (1974). Help-seeking attitudes and severity of psychological distress. *Journal of Clinical Psychology, 30*(3), 247-248.

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*(4), 273–279.

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services,

and perceived likelihood of seeking professional help. *Journal of Counseling Psychology, 45*(1), 58-64.

Chang, H. (2007). Psychological distress and help-seeking among taiwanese college students: Role of gender and student status. *British Journal of Guidance & Counselling, 35*(3), 347-355.

Cheng, H., Kwan, K. K., & Sevig, T. (2013). Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates. *Journal of Counseling Psychology, 60*(1), 98-111.

Cohen, J. (1969). *Statistic power analysis in the behavioral sciences*. New York, NY: Academic Press.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112,* 155-159.

Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (2003). *Applied multiple regression/correlation analysis for the behavioral sciences* (3rd ed.). Mahwah, NJ: Erlbaum

Constantine, M. G., Wilton, L., & Caldwell, L. D. (2003). The role of social support in moderating the relationship between psychological distress and willingness to seek psychological help among black and latino college students. *Journal of College Counseling, 6*(2), 155-165.

Corrigan, P. (2004). How stigma interferes with health care. *American Psychologist, 59*(7), 614–625.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry / La Revue Canadienne De Psychiatrie, 57*(8), 464-469.

Corrigan, P.W. (2004). Don't call me nuts: An international perspective on the stigma of mental

illness. *Acta Psychiatrica Scandinavica, 109*(6), 403-404.

Cramer, K. M. (1999). Psychological antecedents to help-seeking behavior: A reanalysis using path modeling structures. *Journal of Counseling Psychology, 46(3)*, 381–387.

Crawford, J. R., & Henry, J. D. (2004). The Positive and Negative Affect Schedule (PANAS): Construct validity, measurement properties and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*,*43*(3), 245-265.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., Vol. 2, pp. 504–553). Boston, MA: McGraw-Hill.

Cronbach, L.J., & Gleser, G.C. (1965). *Psychological test and personnel decisions*. Urbana: University of Illinois Press.

Cuseo, J. (2005). Decided, undecided, and in transition: Implications for academic advisement, career counseling, and student retention. *Improving the first year of college: Research and practice*, 27-48.

Cumming, J., & Cumming E. (1965). On the Stigma of Mental Illness. *Community Mental Health Journal, 1,* 135-143.

Deane, F. P., & Chamberlain, K. (1994). Treatment fearfulness and distress as predictors of professional psychological help-seeking. *British Journal of Guidance & Counselling, 22*(2), 207-217.

Deane, F. P., Leathem, J., & Spicer, J. (1992). Clinical norms, reliability and validity for the hopkins symptom checklist-21. *Australian Journal of Psychology, 44*(1), 21-25.

Derogatis, L. R., & Melisaratos, N. (1983). The brief symptom inventory: An introductory report. *Psychological Medicine,13*(3), 595-605.

Derogatis, L. R., Lipman, R. S., Rickels, K., Uhlenhuth, E. H., & Covi, L. (1974). The hopkins symptom checklist (HSCL): A self-report symptom inventory. *Behavioral Science, 19*(1), 1-15.

Evans-Lacko, S., Brohan, E., Mojtabai, R., & Thornicroft, G. (2012). Association between public views of mental illness and self-stigma among individuals with mental illness in 14 european countries. *Psychological Medicine, 42*(8), 1741-1752.

Faul, F., Erdfelder, E., Buchner, A., & Lang, A.-G. (2009). Statistical power analyses using G*Power 3.1: Tests for correlation and regression analyses. *Behavior Research Methods*, *41*, 1149-1160. Retrieved from http://www.gpower.hhu.de/en.html

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*(4), 368-373.

Fischer, E. H., & Turner, J. L. (1970). Orientations to seeking professional help: Development and research utility of an attitude scale. *Journal of Consulting and Clinical Psychology, 35*(3), 79-90.

Fouad, N. A., Guillen, A., Harris-Hodge, E., Henry, C., Novakovic, A., Terry, S., & Kantamneni, N. (2006). Need, awareness, and use of career services for college students. *Journal of Career Assessment, 14*(4), 407– 420.

Frazier, P. A., Tix, A. P., & Barron, K. E. (2004). Testing moderator and mediator effects in counseling psychology research. *Journal of Counseling Psychology, 51*, 115-134.

Goffman, I. (1963). *Stigma: Notes on the management of spoiled identity.* Englewood Cliffs, NJ: Prentice-Hall.

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2008). Perceived stigma and mental health care

seeking. *Psychiatric Services,59*(4), 392-399.

Goodman, S. H., Sewell, D. R., & Jampol, R. C. (1984). On going to the counselor: Contributions of life stress and social supports to the decision to seek psychological counseling. *Journal of Counseling Psychology, 31*(3), 306–313.

Gove, W. R. (1982). Labelling theory's explanation of mental illness: An update of recent evidence. *Deviant Behavior, 3*(4), 307-327.

Green, D. E., Walkey, F H., McCormick, I. A., & Taylor, A. J. W. (1988). Development and evaluation of a 21-item version of the hopkins symptom checklist with New Zealand and United States respondents. *Australian Journal of Psychology, 40*(1), 61-70.

Gulliver, A., Griffiths, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *BMC Psychiatry, 10.*

Gulliver, A., Griffiths, K. M., Christensen, H., & Brewer, J. L. (2012). A systematic review of help-seeking interventions for depression, anxiety and general psychological distress. *BMC Psychiatry, 12.*

Gupta, A., Szymanski, D. M., & Leong, F. T. L. (2011). The "model minority myth": Internalized racialism of positive stereotypes as correlates of psychological distress, and attitudes toward help-seeking. *Asian American Journal of Psychology, 2*(2), 101-114.

Hackett, G. (1993). Career counseling and psychotherapy: False dichotomies and recommended remedies. *Journal of Career Assessment, 1*(2), 105-117.

Herek, G. M., Saha, S., & Burack, J. (2013). Stigma and psychological distress in people with HIV/AIDS. *Basic and Applied Social Psychology, 35*(1), 41-54.

Hill, C. E., Satterwhite, D. B., Larrimore, M. L., Mann, A. R., Johnson, V. C., Simon, R. E., . . .

Knox, S. (2012). Attitudes about psychotherapy: A qualitative study of introductory psychology students who have never been in psychotherapy and the influence of attachment style. *Counselling & Psychotherapy Research, 12*(1), 13-24.

Hinson, J. A., & Swanson, J. L. (1993). Willingness to seek help as a function of self-disclosure and problem severity. *Journal of Counseling & Development, 71*(4), 465-470.

Kahn, J. S., Wood, A., & Wiesen, F. E. (1999). Student perceptions of college counseling center services: Programming and marketing for a seamless learning environment. *Journal of College Student Psychotherapy, 14*(1), 69-80.

Kim, H.-Y. (2013). Statistical notes for clinical researchers: assessing normal distribution (2) using skewness and kurtosis. *Restorative Dentistry & Endodontics*, *38*(1), 52–54.

Komiti, A., Judd, F., & Jackson, H. (2006). The influence of stigma and attitudes on seeking help from a GP for mental health problems: A rural context. *Social Psychiatry and Psychiatric Epidemiology, 41*(9), 738-745.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*(1), 138-143.

Kushner, M. G., & Sher, K. J. (1989). Fear of psychological treatment and its relationship to mental health service avoidance. *Professional Psychology: Research and Practice, 20*(4), 251-257.

Kushner, M. G., & Sher, K. J. (1991). The relation of treatment fearfulness and psychological service utilization: An overview. *Professional Psychology: Research and Practice, 22*(3), 196-203.

Lally, J., O'Conghaile, A., Quigley, S., Bainbridge, E., & McDonald, C. (2013). Stigma of

mental illness and help-seeking intention in university students. *The Psychiatrist, 37*(8), 253-260.

Larson, L. M., Toulouse, A. L., Ngumba, W. E., Fitzpatrick, L. A., & Heppner, P. P. (1994). The development and validation of coping with career indecision. *Journal of Career Assessment,* 2(2), 91-110.

Link, B. G., Cullen, F., Struening, E., Shrout, P., & Dohrenwend, B. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review, 54*(3), 400–423.

Locke, B. D., Buzolitz, J. S., Lei, P., Boswell, J. F., McAleavey, A. A., Sevig, T. D., . . . Hayes, J. A. (2011). Development of the counseling center assessment of psychological symptoms-62 (CCAPS-62). *Journal of Counseling Psychology, 58*(1), 97-109.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy, 33*(3), 335-343.

Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental illness stigma as a mediator of differences in caucasian and south asian college students' attitudes toward psychological counseling. *Journal of Counseling Psychology, 57*(4), 484-490.

Ludwikowski, W. M. A., Vogel, D., & Armstrong, P. I. (2009). Attitudes toward career counseling: The role of public and self-stigma. *Journal of Counseling Psychology, 56*(3), 408-416.

Mackenzie, C. S., Knox, V. J., Gekoski, W. L., & Macaulay, H. L. (2004). An adaptation and extension of the attitudes toward seeking professional psychological help scale. *Journal of Applied Social Psychology, 34*(11), 2410–2435.

Mechanic, D. (1975). Sociocultural and social psychological factors affecting personal responses of psychological disorder. *Journal of Health and Social Behavior, 16*(4), 393–404.

Mikessel, R. H. and Calhoun, L. G. Attitudes toward seeking professional help as a function of causal attribution and severity of disturbance. Paper presented at the meeting of the South- eastern Psychological Association, Miami, April 1971.

Miller, N. E. (1944). Experimental studies of conflict. In J. McV. Hunt (Ed.), *Personality and the behavior disorders* (Vol. 1, pp. 431-465). New York: Roland Press.

Multon, K. D., Heppner, M. J., Gysbers, N. C., Zook, C., & Ellis-Kalton, C. (2001). Client psychological distress: An important factor in career counseling. *The Career Development Quarterly, 49*(4), 324-335.

Nam, S. K., Choi, S. I., Lee, J. H., Lee, M. K., Kim, A. R., & Lee, S. M. (2013). Psychological factors in college students' attitudes toward seeking professional psychological help: A meta-analysis. *Professional Psychology: Research and Practice, 44*(1), 37-45.

Obasi, E. M., & Leong, F. T. L. (2009). Psychological distress, acculturation, and mental health-seeking attitudes among people of african descent in the united states: A preliminary investigation. *Journal of Counseling Psychology, 56*(2), 227-238.

Phelan, J. C., Link, B. G., & Dovidio, J. F. (2008). Stigma and prejudice: One animal or two? *Social Science and Medicine, 67,* 358–367.

Preacher, K. J., & Leonardelli, G. J. (2003). *Calculation for the Sobel test: An interactive calculation tool for mediation tests*.

Rickwood, D. J., & Braithwaite, V. A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine, 39(4),* 563–572.

Rochlen, A. B., Mohr, J. J., & Hargrove, B. K. (1999). Development of the attitudes toward

career counseling scale. *Journal of Counseling Psychology, 46*(2), 196-206.

Rosenthal, B. S., & Schreiner, A. C. (2000). Prevalence of psychological symptoms among undergraduate students in an ethnically diverse urban public college. *Journal of American College Health, 49*(1), 12-18.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529-539.

Scheff, T. (1966). *Being mentally ill: A sociology theory.* Chicago: Aldine.

Sheffield, J. K., Fiorenza, E., & Sofronoff, K. (2004). Adolescents' willingness to seek psychological help: Promoting and preventing factors. *Journal of Youth and Adolescence, 33*(6), 495-507.

Sibicky, M., & Dovidio, J. F. (1986). Stigma of psychological therapy: Stereotypes, interpersonal reactions, and the self- fulfilling prophecy. *Journal of Counseling Psychology, 33(2),* 148-154.

Spitzer, R. L., Kroenke, K., & Williams, J. B. W. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *JAMA: Journal of the American Medical Association, 282*(18), 1737-1744.

Spokane, A. R. (1992). Personal constructs and careers: A reaction. *Journal of Career Development, 18*(3), 229-236.

Tinsley, H. E., de St. Aubin, T. M., & Brown, M. T. (1982). College students' help-seeking preferences. *Journal of Counseling Psychology, 29*(5), 523-533.

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*(4), 520-531.

Utsey, S. O., Bolden, M. A., Brown, C. F., & Chae, M. H. (2001). Assessing quality of life in the context of culture. In L. A. Suzuki, J.G. Ponterotto, & P. J. Meller (Eds.), *Handbook of multicultural assessment: Clinical, psychological, and educational applications* (2nd ed., pp. 191-212). San Francisco: Jossey-Bass.

Utz, P. W. (1983). A comparison of three groups of vocationally indecisive students. *Journal of Counseling Psychology, 30*(2), 262-266.

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*(2), 311-316.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (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*(1), 40-50.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*(3), 325-337.

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. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates Publishers.

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: the PANAS scales. *Journal of Personality and Social Psychology*, *54*(6), 1063-1070.

Westbrook, L. E., & Bauman, L. J. (1996). *The perceived stigma of HIV/AIDS: Personal View*

and Public View scales. Bronx, NY: Albert Einstein College of Medicine.

Whiston, S. C., & Rahardja, D. (2008). Vocational counseling process and outcome. *Handbook of counseling psychology (*4th ed., pp. 444-461). Hoboken, NJ: John Wiley & Sons Inc.

Zeig, J, K., & Munion, W. M. (Eds.) (1990). *What is psychotherapy?: Contemporary perspectives*. San Francisco: Jossey-Bass.