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Help Seeking for Mental Health Problems in Mental Health Counselors: Prevalence, Barriers, and Predictors

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Abstract

This study surveyed a sample of 255 mental health counselors in the United States and used descriptive statistics, chi-square tests, one-way ANOVA, and logistic regression analysis to investigate the prevalence of mental health problems and help seeking, the perceived barriers to, and predictors of help seeking for mental health problems among mental health counselors. In this sample, 62.6% (n = 159) reported they had experienced a mental health problem during the time since licensure. Of those, 13.2% (n = 21) reported they had not received treatment. “Handling the problem on my own” was the most cited barrier to help seeking, followed by “not being able to afford the financial costs,” “difficulty taking time off, and “having had bad experiences with mental health care.” The study also found that increased help-seeking self-stigma predicted decreased intention to seek help from a mental health professional, while experience of role model disclosure of positive experiences with mental health treatment predicted increased intention to seek help. A limitation of this study was the use of availability sampling which resulted in a non-representative sample, skewed toward white, non-Hispanic, females. Important areas for future research include studies with larger more representative samples, studies of interventions to encourage help seeking in mental health counselors, studies of other potential predictors of help seeking, and studies to develop instruments for use specifically with mental health counselors. The study findings underscore the importance of more open dialogue about these issues within the counseling profession to support and encourage help seeking in mental health counselors and find ways to ensure that mental health counselors have the information and resources they need to access quality mental health care.

Keywords: stigma, mental illness, mental health stigma, help seeking, mental health treatment, treatment barriers, help-seeking barriers, help-seeking stigma

Dedication

This dissertation is dedicated to my fellow mental health counselors who have inspired me by their commitment to provide quality mental health care for their clients, while managing their own often stressful and challenging personal lives. It is my hope that this study will encourage more open dialogue and sharing about personal mental health problems and treatment within the counseling profession and help to foster a more wellness-based culture that normalizes, supports, and encourages help seeking for mental health problems in mental health counselors.

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Table of Contents

Chapter 1: The Research Problem

In 2018, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) reported the results of a national survey of US adults and estimated that 18.9% (*n* = 46.6 million) had experienced symptoms of mental health problems in the past year. Of those, the researchers estimated that only 42.8% (*n* = 19.8 million) received treatment for mental health problems (SAMHSA, 2018). Although this was a general population survey, there is evidence to suggest that unrealistic expectations of resilience and mental wellness within the mental health profession (Lawson, 2007; Lawson & Venart, 2005; Lawson et al., 2007; Young & Lambie, 2007), compassion fatigue (Skovholt & Trotter-Mathison, 2011; Smith & Moss, 2009; Stebnicki, 2007), and vicarious trauma (Saakvitne et al., 1996; Skovholt & Trotter-Mathison, 2011; Smith & Moss, 2009), may leave mental health professionals even more vulnerable to mental health problems and more likely to experience barriers to treatment than the general population.

Given the primacy of the therapeutic relationship in positive counseling outcomes (Beutler, 2000; Rogers, 1961; Wampold, 2015) and the importance of counselor mental health in maintaining an empathic therapeutic relationship (Rogers, 1961) and optimum job performance (Lawson et al., 2007), it is vital that counselors are encouraged and supported in seeking help for their mental health problems (Lawson, 2007; Lawson & Venart, 2005; Lawson et al., 2007). Research is needed to understand the prevalence of mental health problems as well as the perceived barriers to and predictors of help seeking for mental health problems in mental health counselors, both to raise awareness of these

issues within the counseling profession and to inform interventions to increase help seeking and counselor wellness.

Although a number of studies have explored the prevalence of mental health problems and perceived barriers to and predictors of mental health-related help seeking in the general population (Boerema et al., 2016; Clement, et al., 2015; Hantzi et al., 2019; Horsfield at al., 2019; Klik et al., 2019; Mojtabai et al., 2011; Pattyn et al., 2015; Schnyder, et al., 2017; Schomerus et al., 2019; Tomczyk et al., 2020), only a handful of studies have looked at help seeking for mental health problems in healthcare providers (Cohen, 2016; Dyrbye et al., 2015; Fischbein & Bonfine, 2019; Gold et al., 2016). Even fewer studies have looked at help seeking for mental health problems among mental health professionals in general (Edwards & Crisp, 2017; Mullen & Crowe, 2017; Tay et al., 2018), and no studies were found which investigated help seeking for mental health problems in mental health counselors. This is a serious gap in the literature which the current study attempted to address.

Many of the studies reviewed in this proposal use the term *mental illness* when referring to *mental health problems*. Within the mental health counseling profession, the term *mental health problem* is preferred to the term *mental illness*, as the latter implies a medical disease model of emotional distress which is not consistent with the wellness and strengths-based focus of the mental health counseling profession. This study used the term *mental health problem* in place of *mental illness* wherever possible. Similarly, although the term *mental illness stigma* has been widely used in the literature, the current study used the term *mental health-related stigma* when referring to this construct.

Statement of Research Problem

In addition to the US general population survey cited above (SAMHSA/CDC, 2018), a few studies have looked at the prevalence of mental health problems and help seeking in healthcare providers and mental health professionals. Gold et al. (2016) found that 49% (n = 1,033) of a sample of US female physicians had experienced a mental health problem they believed had impaired their work performance but had not sought treatment. Cohen et al. (2016) found that 60% (n = 1,149) of UK physicians reported having a mental health problem at some point in their professional career but only 41% (n = 478) reported seeking treatment. In a survey of Australian mental health professionals, 61.4% (n = 35) reported having a mental health problem for which they did not seek treatment (Edwards & Crisp, 2017). Tay et al. (2018) found that 62.7% (n = 425) of a sample of UK clinical psychologist reported having had a mental health problem during their lifetime, although 14.6% (n = 62) reported that they sought help from no one.

Most studies of help seeking for mental health problems have focused on the perceived barriers to help seeking. A smaller number of studies have also investigated predictors of help seeking attitudes, intentions, and/or behaviors (see Table 1 for a summary of studies reviewed for this proposal). Barriers to help seeking have been broadly categorized as either structural or attitudinal/evaluative barriers (Mojtabai, 2011). Structural barriers include things like *distance from treatment locations*, *ability to pay for services*, and other physical factors which limit access to helping resources, while attitudinal/evaluative barriers include beliefs about *treatment efficacy*, *need for treatment*, *fear of discrimination*, *embarrassment*, or other attitudes or beliefs which might limit help seeking.

In a US national survey of adults with mental health problems (*n* = 1,350), Mojtabai et al. (2011) found that *desire to handle the problem alone* and *perceived need for treatment* were the two most common barriers cited. In a systematic review of both quantitative and qualitative studies of stigma barriers to mental health treatment, Clement et al. (2015) found that *stigma* was only the fourth of the ten most commonly cited treatment barriers. Of the reported stigma barriers, the reviewers found that *concerns about disclosure* and *concerns about confidentiality* had the largest effect sizes, followed by *help-seeking stigma* and *mental health-related self-stigma* (shame/embarrassment). In another systematic review of the general population literature on stigma and help seeking for mental health problems, Schnyder et al. (2017) found that help-seeking stigma had the strongest negative association with help seeking for mental health problems, followed by personal mental health-related stigma.

A number of general population studies have also looked at predictors of help seeking for mental health problems and found that *help-seeking stigma*, *mental health-related self-stigma* (stigmatizing beliefs about one's own mental health problems), *personal mental health-related stigma* (stigmatizing beliefs about others with mental health problems) and *perceived mental health-related stigma* (beliefs about the stigmatizing beliefs held by others) were negatively associated with help seeking for mental health problems (see Table 1). Still other general population studies have found that *symptom severity*, *female gender*, *identification as a person with mental health problems*, *having close contact with people with mental health problems*, *perceived need for treatment*, and *belief in treatment efficacy* were positively associated with help seeking (see Table 1).

In a subgroup analysis of the studies reviewed, Clement et al. (2015) found that healthcare professionals reported concerns about *negative social judgment* and *disclosure* more frequently than other subgroups. More recent studies of healthcare providers have also found that *fears about disclosure*, *fear of employment discrimination*, and *perceived mental health-related stigma* were commonly reported as barriers to help seeking (Cohen et al., 2016; Dyrbye et al., 2015; Fischbein and Bonfine, 2019; Gold et al., 2016). Cohen et al. (2016) also found that *age* and *female gender* were positive predictors of help seeking in UK physicians.

Edwards and Crisp (2017) found that *wanting to solve the problem alone* was one of the most cited reasons for not seeking help for mental health problems in a survey of Australian mental health professionals. Both Tay et al. (2018) and Edwards and Crisp (2017) found that *fear of disclosure* and *fear of employment discrimination* were common reasons for not seeking help in samples of UK clinical psychologists in the UK and Australian mental health professionals, respectively. Tay et al. (2018) found that *help-seeking stigma* and *mental health-related self-stigma* were higher in a subgroup of UK clinical psychologists who had experienced mental health problems but had not sought help. Mullen & Crowe (2017) also found that *mental health-related self-stigma* was negatively associated with *help-seeking intentions* in US school counselors.

The studies reviewed for this study defined help seeking in several different ways, some looked at help-seeking attitudes, others looked at help-seeking intentions or actual help-seeking behaviors (see Table 1), some looked at help-seeking for current mental health problems, others for problems within the past 30 days, the past year, or even over the life span. In response to what has become a somewhat confusing array of operational

definitions of help seeking, Rickwood and Thomas (2012) proposed a conceptual framework of help seeking measurement to give guidance to researchers. This framework included four major components which Rickwood and Thomas (2012) recommended researchers consider when designing a study of help seeking for mental health problems, namely: (a) help-seeking process step of interest for the study (attitudes towards help seeking, help-seeking intentions, or help-seeking behaviors); (b) timeframe of help seeking of interest for the study; (c) source of help of interest for the study; and (d) type of mental health concern of interest for the study. Using this framework, the current study focused on help-seeking behavior for any mental health problem experienced since obtaining mental health counseling licensure and help-seeking intentions for any future mental health problems. In both cases, the current study defined the source of help as a professional healthcare provider (mental health professional, primary care physician, or other healthcare provider).

Purpose

The mental health of counselors is not only important for the well-being of each individual counselor, it is also critical for the safety and well-being of counseling clients. The ethical principles of the American Counseling Association (ACA) emphasize the importance of both beneficence and non-maleficence in dealings with clients which makes it imperative that the counseling profession do all that it can to ensure that counselors get the help and support they need to provide quality care (Lawson & Venart, 2005). The current study investigated the prevalence of mental health problems and help seeking among mental health counselors as well as the barriers to and predictors of help seeking for mental health problems in this population. The study addressed an important

gap in the literature that hopefully will help raise awareness of these issues and provide guidance to counselor educators and researchers to develop counseling curricula and other interventions to help foster a culture of support and encouragement for help seeking within the counseling profession.

Background

In 2003, the Governing Council of the American Counseling Association (ACA) was becoming aware of a growing number of counselors in the field who had mental health problems. In response the Governing Council established a Task Force on Impaired Counselors to develop resources and interventions to help struggling counselors (Lawson & Venart, 2005). The task force produced recommendations for self-care and self-monitoring to promote counselor wellness and resilience and attempted to raise awareness of the issue within the profession. The task force concluded that it was the ethical responsibility of individual counselors to follow these recommendations and to seek the help they needed for mental health problems (Lawson & Venart, 2005). In a follow-up Counselor Wellness survey of ACA members (N = 501), Lawler (2007) found evidence of mental health problems in a substantial minority of respondents, with 10.8% (n = 54) scoring high on a compassion fatigue/vicarious trauma measure, 5.2% (n = 26) scoring high on a burnout measure, and 14% (n = 70) scoring low on a compassion satisfaction measure, further underscoring the need for attention to this issue.

Unfortunately, since that time no studies have been conducted to explore help-seeking attitudes and behaviors among mental health counselors, although Mullen and Crowe (2017) did conduct a path analysis of a model of help seeking with a sample of school counselors. Studies with other healthcare providers and mental health

professionals have provided evidence that both these subgroups may be particularly vulnerable to burnout and other mental health problems but face barriers to the treatment they may need to provide patient care responsibly (Clement, et al., 2015; Cohen, 2016; Dyrbye et al., 2015; Edwards & Crisp, 2017; Fischbein & Bonfine, 2019; Gold et al., 2016; Lawson, 2007; Lawson & Venart, 2005; Lawson et al., 2007; Mullen & Crowe, 2017; Tay et al., 2018). The current study will hopefully help raise awareness of this problem within the mental health counseling profession and provide direction for future research to develop interventions to increase help seeking for mental health problems and support the mental health and well-being of mental health counselors.

Foundations

The current study was based on a model of help seeking for mental health problems first suggested by Rickwood and Thomas (2012) and based on Ajzen's (1991; 2002) theory of planned behavior. According to this model, the help-seeking process involves three basic steps: (a) orientation and attitudes to help seeking, (b) intentions to seek help, and (c) actual help-seeking behaviors. Building on these models, Schomerus et al. (2009; 2019) conceptualized the help-seeking process in four steps: (a) self-identification as someone with a mental health problem, (b) perceived need for treatment, (c) help-seeking intentions, and (d) help-seeking behaviors. Tomcyzk et al. (2020) expanded the process model to include *identification and selection of a healthcare provider* and *negotiating the structural and attitudinal barriers* involved in making contact and disclosing a problem to a healthcare provider, based on similar concepts found in models of help seeking for more general health concerns (Cornally & McCarthy, 2011).

Given the level of training about mental health and exposure to people with mental health problems which mental health counselors receive, these models of help seeking would predict that mental health counselors would experience fewer barriers to the *self-identification* and *perceived need* steps of the help-seeking process and would also be more aware of mental health resources than the general population. These models would, therefore, predict that mental health counselors would face more barriers in the *help-seeking intention* and *help-seeking behavior* steps of the help-seeking process when selection of a healthcare provider and decisions about making contact and disclosure to the provider are the primary decision-making tasks.

Potential barriers in the *help-seeking intention* and *help-seeking behavior* steps include structural barriers like *finances* and *accessibility* (time and distance) as well as attitudinal/evaluative barriers like *help-seeking stigma*, *fear of disclosure*, *fear of employment discrimination*, *mental health-related stigma*, and *beliefs about what it means to be a competent mental health counselor*. Based on this model, the current study explored both structural and attitudinal/evaluative barriers to *help seeking intentions* and *help-seeking behavior* and investigated *help-seeking stigma* and *mental health-related stigma* as potential predictors of *help-seeking intentions* in mental health counselors.

Link and Phelan (2001) conceptualize stigma as four interrelated components which must co-occur. The four components are: (a) people in the dominant culture identify and label human differences; (b) the dominant culture perpetuates beliefs which link these labeled differences to negative stereotypes; (c) the dominant culture separates themselves from the labeled persons, creating an “us” vs. “them” relationship; and (d) the stereotyped group experiences a loss of status and discrimination within the dominant

culture. Using this conceptualization of stigma, the current study investigated *negative stereotypes* about both people with mental health problems and help seeking for mental health problems and investigated *experiences of discrimination* related both to mental health problems and to help seeking as potential barriers to and predictors of help seeking for mental health problems.

Research Questions and Hypotheses

Based on the theoretical foundations and research described above, the current study addressed the following research questions: (a) Research Question 1: what is the prevalence of mental health problems and help seeking for mental health problems among mental health counselors?; (b) Research Question 2: what do mental health counselors perceive as barriers to help seeking for their own treatment for mental health problems?; (c) Research Question 3: in what ways do the attitudes about mental health problems and help seeking of mental health counselors who have experienced personal mental health problems and treatment differ from those of mental health counselors who have not experienced mental health problems or treatment?; (d) Research Question 4: what factors predict help-seeking intentions for mental health problems in mental health counselors?

Research Question 1 Hypotheses

Hypothesis 1: *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other health care provider and mental health professional samples*, based on findings in studies of healthcare providers (Cohen et al., 2016; Gold et al., 2016) and mental health professionals (Edwards & Crisp, 2017; Lawson, 2007; Tay et al., 2018).

Hypothesis 2: *mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates*, based on similar findings in studies of disclosure of mental health problems and help seeking in a sample of UK physicians (Cohen et al., 2016) and a sample of UK clinical psychologists (Tay et al., 2018).

Research Question 2 Hypotheses

Hypothesis 3: *fear of disclosure, fear of loss of status and discrimination, and desire to handle on one's own will be the most commonly cited barriers to help seeking among mental health counselors*, based on similar findings in studies of barriers to help seeking for mental health problems in a US general population sample (Mojtabai et al., 2011), in samples of healthcare providers (Cohen et al., 2016; Gold et al., 2016), in samples of mental health professionals (Edwards & Crisp, 2017; Tay et al., 2018), and in a systematic literature review (Clement et al., 2015).

Hypothesis 4: *attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors*, based on studies of barriers to help seeking for mental health problems in a US general population sample (Mojtabai et al., 2011), in samples of healthcare providers (Cohen et al., 2016; Gold et al., 2016), and in samples of mental health professionals (Edwards & Crisp, 2017; Tay et al., 2018).

Research Question 3 Hypotheses

Hypothesis 5: *mental health counselors who have disclosed mental health problems and treatment will have statistically significantly lower personal mental health-related stigma, perceived mental health-related stigma, and help-seeking self-stigma*

scores than mental health counselors who have never disclosed mental health problems or help seeking, based on similar findings in a study of UK clinical psychologists (Tay et al., 2018) and a systematic literature review (Clement et al., 2015).

Hypothesis 6: *mental health counselors who have disclosed mental health problems and help seeking will be more willing to refer clients to colleagues with mental health problems than mental health counselors who have not disclosed mental health problems and help seeking*, based on a similar hypothesis posited in a study of barriers to help seeking for mental health problems in a sample of Australian mental health professionals (Edwards & Crisp, 2016).

Research Question 4 Hypotheses

Hypothesis 7: *more positive help-seeking role models will predict increased help-seeking intentions for mental health problems in mental health counselors*, based on Bandura's social learning theory (1979) which predicts that when humans observe behaviors in others that result in positive outcomes, they are more likely to imitate those behaviors. This is particularly true when the person observed is valued by the observer as someone they would like to emulate, as would likely be the case with a professional mentor or other role model.

Hypothesis 8: *more help-seeking self-stigma, perceived mental health-related stigma, personal mental health-related stigma, and personal or observed experience of discrimination for mental health problems and/or help seeking will predict less help-seeking intentions for mental health problems in mental health counselors*, based on similar findings in studies of *help-seeking stigma* (Boerema et al., 2016; Clement et al., 2015; Hantzi et al., 2019; Schnyder et al., 2017; Tomczyk et al., 2020), *perceived mental*

health-related stigma (Clement et al., 2015; Schnyder et al., 2017), *personal mental health-related stigma* (Boerema et al., 2016; Clement et al., 2015; Horsfield et al.,2019; Pattyn et al., 2015; Schnyder et al., 2017; Schomerus et al., 2019), and *fear of employment discrimination* (Clement et al., 2015; Cohen et al., 2016; Edwards & Crisp, 2017; Gold et al., 2016; Tay et al., 2018) as predictors of help seeking for mental health problems.

Although several of the studies reviewed for this study looked at *mental illness self-stigma* as a potential predictor of help seeking, Tucker et al. (2013) presented strong evidence that *help-seeking self-stigma* ($r^2 = .10$) accounts for substantially more of the variance in *help-seeking intentions* than *mental illness self-stigma* ($r^2 = .0004$). Given this evidence, the current study did not include *mental illness self-stigma* as a potential predictor of *help-seeking intentions*.

Significance of the Problem

Given the primacy of the therapeutic relationship in positive counseling outcomes (Beutler, 2000; Rogers, 1961; Wampold, 2015) and the importance of counselor mental health in maintaining an empathic therapeutic relationship and optimum job performance (Lawson et al., 2007; Lee et al., 2007), it is vital that counselors practice self-care and are encouraged and supported in seeking help for their mental health problems (Lawson & Venart, 2005; Lawson, 2007). Research is needed to understand the prevalence and predictors of help seeking for mental health problems in mental health counselors to raise awareness of these issues and to inform research to develop interventions to increase help seeking for mental health problems and encourage and support a culture of wellness

within the counseling profession. This is a serious gap in the literature which the current study attempted to address.

Implications

As noted above, the current study has important implications for counselor education and the counseling profession. As the ACA Task Force on Impaired Counselors warned in 2005, counselors suffering from burnout and other mental health problems can pose a serious threat to their clients, and it is important to raise awareness of this problem within the profession and to provide resources and support for counselors experiencing mental health problems (Lawson & Venart, 2005). Research is needed to develop interventions for professional leaders and counselor educators to encourage and support self-care and wellness within the counseling community. Studies are also needed to provide counselor educators with the information they need to expand the counseling curriculum to include these same types of interventions and to begin a healthy dialogue with students about their own experiences of mental health issues and treatment. Whatever the perceived barriers to help seeking, research is needed to identify them and begin to address them at every level of the counseling profession.

Summary

Within the United States, it is estimated that 18.9% of the adult population has experienced mental health problems in the past year and that less than half of those individuals are receiving treatment (SAMHSA, 2018). There is reason to believe that these numbers are no better for mental health professionals and may be even worse due to the compassion fatigue (Skovholt & Trotter-Mathison, 2011; Smith & Moss, 2009; Stebnicki, 2007), vicarious trauma (Saakvitne et al., 1996; Skovholt & Trotter-Mathison,

2011; Smith & Moss, 2009), and unrealistic professional expectations of resilience and mental wellness (Lawson, 2007; Lawson & Venart, 2005; Lawson et al., 2007; Young & Lambie, 2007) unique to their work. It is well established that the therapeutic relationship between counselor and client is the key to positive counseling outcomes (Beutler, 2000; Rogers, 1961; Wampold, 2015), and it is vital that counselors are encouraged and supported in seeking help for their mental health problems (Lawson, 2007; Lawson & Venart., 2005; Lawson et al., 2007),

To date, very few studies have investigated the prevalence of mental health problems or the perceived barriers to and predictors of help seeking for mental health problems among mental health professionals in general, and no studies have explored these issues in mental health counselors in particular. Research is needed to understand the prevalence of mental health problems among mental health counselors as well as the barriers to and predictors of help seeking for those problems. The current study attempted to address these questions.

Chapter 2: Literature Review

Several general population studies have explored stigma and other personal and structural barriers to help seeking for mental health problems. Only a handful of studies have explored help seeking for mental health problems among healthcare providers and no studies have been conducted to explore help-seeking attitudes, intentions, and behaviors among mental health counselors experiencing mental health problems. Given the importance of the mental health of a counselor in maintaining a consistent and therapeutic relationship with their clients, it is important to understand the prevalence and predictors of help seeking for mental health problems in this population. This is a serious gap in the literature which the current study attempted to address.

Literature Search

A search of the counseling and mental health research literature was conducted using the keywords “stigma,” “mental illness,” “mental health stigma,” “help seeking,” “mental health treatment,” “treatment barriers,” “help-seeking barriers” and “help-seeking stigma,”. Only systematic reviews and quantitative studies of the prevalence, barriers to, and predictors of help seeking for mental illness in the general or health care provider population were included in this review. General population studies were further limited to studies conducted after the most recent systematic reviews of the literature on help seeking and stigma. Of studies found which met these criteria, seven were general population studies, one was an analysis of a US national survey, two were systematic literature reviews, and four were health care provider population studies, of which three were studies of mental health providers. No studies of mental health counselors were found in the literature search. Summaries of included studies are presented in the

following sections below: National Survey Review, Literature Reviews, General Population Studies, Health Care Provider Studies, and Mental Health Provider Studies (see Table 1 for a summary of studies included in this review).

National Survey Review

Mojtabai et al. (2011) used data from the National Comorbidity Survey Replication (NCS-R) to understand more about perceived barriers to mental illness treatment in the United States. The NCS-R was a nationally representative household survey of the US general population conducted between 2001 and 2003 through in-person interviews with 9,282 adults. Part 1 of the survey included a diagnostic assessment (Composite International Diagnostic Interview) and a questionnaire about mental health service use, including single-item questions about perceived need for treatment, structural barriers (availability, transportation, ease of access, and financial), and attitudinal/evaluative barriers (self-reliance, perceived treatment efficacy, stigma, and beliefs about symptom severity and outcomes). Part 2 of the survey was a more in-depth mental health assessment administered to respondents in Part 1 who met DSM-IV criteria or had a mental health history, as well as a probability sample of other respondents from Part 1.

Using data from the NCS-R Part 2 respondents (N = 5, 962), the researchers identified 2,201 respondents who met DMS-IV criteria for at least one common mental health disorder in the past 12 months. Using this sample (N = 2,201), the researchers designed a study to explore the relationship between perceived need for treatment, structural and attitudinal/evaluative treatment barriers and treatment seeking (including discontinuation of treatment). The researchers also investigated the relationship

between illness severity, various demographic variables, treatment barriers, and treatment seeking.

The researchers used descriptive statistics to conclude that attitudes about mental illness and treatment were much more commonly cited as barriers to treatment than structural barriers (97.4%, *n* = 763, versus 22.2%, *n* = 174). They found this to be the case for reasons cited for discontinuing treatment as well (81.9%, *n* = 64, versus 31.8%, *n* = 25). Although all participants in the study met the criteria for a DSM-IV diagnosis, 44.8% (*n* = 605) did not believe they needed treatment. This result varied with illness severity, however, with individuals with milder symptoms reporting lower perceived need for treatment (mild: 57.0%, *n* = 315; moderate: 39.3%, *n* = 218; severe: 25.9%, *n* = 63).

Of those who did perceive a need for treatment, 72.6% (*n* = 568) cited a desire to handle the problem on their own as the reason they did not seek treatment. The next most commonly cited reasons for avoiding treatment were the belief that the problem was not severe enough to warrant treatment (16.9%, *n* = 132), perceived ineffectiveness of treatment (16.4%, *n* = 128), the belief the problem would resolve without treatment (11.5%, *n* = 90), and stigma (9.1%, *n* = 71). Among those who dropped out of treatment, 42.2% (*n* = 33) cited a desire to handle the problem on their own as their reason. Respondents with more severe illness more likely to cite structural barriers as reasons for not seeking treatment than were respondents with mild or moderate illness (severe-38.5%, *n* = 70; moderate-20.4%, *n* = 70; mild-13.5%, *n* = 35).

The researchers used multivariate logistic regression models to examine potential predictors of treatment seeking and found that age, gender, and illness

severity were predictive of perceived need for treatment in this sample, such that being a male, being over 65 years of age, and having mild symptoms predicted lower perceived need for treatment ($x^2 = 159.9$, $p < 0.001$). Being under 50 years of age and with more severe symptoms predicted more perceived structural barriers to treatment ($x^2 = 53.6$, $p < 0.001$). The researchers did not find any statistically significant predictors of attitudinal/evaluative barriers.

An obvious strength of this study was the large sample size and the use of data from a nationally representative survey of US households. One major weakness of the study was the use of single-item questions and checklists to assess perceived structural and attitudinal and evaluative barriers to help seeking with no available psychometric data on the validity or reliability of those measures. Another possible threat to validity was the recall bias introduced through reliance on self-reports of service use and reasons for not seeking treatment during a 12-month period. The small sample size for the discontinuation of treatment subgroup ($n = 78$) was another weakness of the study, making interpretation of those study results uncertain.

Literature Reviews

Clement et al. (2015) conducted a systematic review and meta-analysis of the literature from 1980 to 2011 to understand the role of stigma as a deterrent to help seeking for mental health problems in the general population as well as subgroups of the general population. The review included 144 quantitative and qualitative studies, representing 90,189 study participants. Only quantitative studies which explored treatment/help-seeking barriers or associations between help seeking and stigma were included. Similarly, only qualitative studies concerned with the processes underlying the

relationship between stigma and help seeking were included. The researchers categorized the studies as either associative studies (44 studies, N = 27,575) or barrier studies (56 studies, N = 60,036). Help seeking was broadly defined to include studies of help-seeking attitudes, intentions, or behaviors.

In order to include both quantitative and qualitative studies in their meta-analysis, the researchers used thematic analysis and narrative synthesis to quantify the qualitative study results. To synthesize the results for associative studies, the researchers extracted quantitative statistics to create standardized effect sizes (Cohen's d) for each study and calculated the median effect size across all association studies. To synthesize the barrier studies, the researchers assigned a standardized rank to each barrier referenced in the study and calculated a median rank for each barrier across all barrier studies.

From the meta-synthesis of the association studies, the reviewers concluded that stigma, particularly mental illness self-stigma and treatment or help-seeking stigma, was negatively associated with help seeking (d = -0.27, n = 27,572). In subgroup analyses of these association studies, the reviewers found a larger median negative association in Asian American (d = -1.20, n = 898) and Arabic (d = -1.21, n = 292) student samples and a small negative association in African American (d = -0.25, n = 570) and mixed samples (d = -0.23, n = 25,479), suggesting that other cultural variables were important moderators of the relationship between stigma and help seeking attitudes.

From an analysis of the barrier studies, the reviewers found that the highest ranked barrier to help seeking across all treatment barrier studies was concern about consequences of disclosure or breeches of treatment confidentiality (median = 32%; range: 4-68%; n = 19,212). Fear of employment discrimination was the second highest

median ranked help-seeking barrier (median = 23%; range: 9-71%; *n* =13,808), perceived stigma (fear of negative social judgement) was the third highest median ranked barrier (median = 22%; range: 4-73%; *n* = 13,208), and shame/embarrassment (self-stigma) was the fourth highest median ranked barrier (median = 21%; range: 8-59%; *n* = 12,608). The reviewers also performed subgroup analyses of the studies and found that health professionals reported concerns about negative social judgment (median = 46%; range: unreported; *n* = 1,304) and disclosure (median = 50%; range: 21-50%; *n* = 1,417) more frequently than other subgroups, although the rankings remained the same overall.

Schnyder et al. (2017) conducted a systematic review of the literature (27 studies, *N* = 31,677) to explore the impact that stigma has on help seeking for mental illness problems in the general population. The reviewers included only quantitative cross-sectional or longitudinal surveys of the general population which explored the relationship of stigma and help-seeking behavior. Stigma was defined as one of four types: (a) perceived public stigma: beliefs participant has about how others view people with mental illness; (b) personal stigma: stigma held about people with mental illness expressed by the participant; (c) self-stigma: stigmatizing attitudes held by the participant about the self; and (d) help-seeking stigma: attitudes toward help seeking.

After performing a systematic review of these studies, the reviewers calculated an odds ratio (OR) for stigma effect on help seeking for each type of stigma reviewed and calculated the I-squared statistic to evaluate heterogeneity and identify study subgroups. The researchers also performed stratification analyses to investigate statistically significant heterogeneity between studies. From this meta-analysis, the reviewers concluded that help-seeking stigma had the strongest negative association with help

seeking for mental health problems in the general population (*OR* = 0.80, *n* = 9,928), followed by personal stigma (*OR* = 0.82, *n* = 7.304). In the analysis, personal mental health-related stigma was defined as endorsement of stigmatizing attitudes about others and OR < 1 indicated a negative association between mental health-related stigma and help seeking. The researchers did not find a statistically significant relationship between mental health-related self-stigma, perceived public stigma, or general stigma and help seeking in their meta-analysis.

General Population Studies

The following general population studies were conducted after the last systematic review discussed above. These studies investigated the relationship between stigma and other hypothesized barriers to help seeking and help-seeking intentions and behaviors.

Klik et al. (2019) conducted two studies, one using the Amazon Mechanical Turk crowdsourcing website (*N* = 90) and the other using Facebook's "boost" feature (*N* = 131) to explore the relationship between social identification as a person with mental illness and help seeking. Based on Branscombe's (1999) rejection-identify model (RIM) and Tajfel and Turner's (1979) social identity perspective (SIP) theory, the first study tested the hypothesis that social identification and perceptions about group identity would be negatively associated with experiences of stigma and positively associated with the self-relevant step of help seeking. The purpose of the second study was to explore the relationship between social identification, group perceptions, and actual help-seeking behavior.

The researchers operationalized the constructs for these two studies using the following measures: (a) help-seeking behavior: single-item questions about service

utilization; (b) discrimination experiences: Discrimination Experiences subscale of the Internalized Stigma of Mental Illness (IMSI) scale; (c) social identification: six item 7-point Likert-type scale (α= 0.81; Quinn et al., 2014); (d) perceptions about the group: Private Regard subscale of the Multidimensional Inventory of Black Identity (MIBI; Sellers et al., 1997); (e) Self-relevant step of help seeking: four item 4-point Likert-type scale; (f) Symptom severity: one item 5-point Likert-type scale. Participants in both study 1 and study 2 completed all survey items.

In study 1, the researchers used descriptive statistics, multiple regression analysis, and path analysis to conclude that social identification was associated with the self-relevant step of help seeking (β = 0.49; B = 0.28; $SE\ B$ = 0.07; p = 0.00) and indirectly mediated the relationship between discrimination experiences and the self-relevant step of help seeking (β = 0.25; B = 0.28; $SE\ B$ = 0.09; p = 0.00). The researchers also found that perceptions about the group was a moderator of the relationship between social identification and the self-relevant step of help seeking (β = −.45; B = −0.08; $SE\ B$ = 0.03; p = .01).

Interestingly, the researchers found that the relationship between social identification and the self-relevant step of help seeking was strongest among those who reported a negative perception of the group (β = .34; B = 0.38; $SE\ B$ = 0.10; p = .00) when compared with those who reported a positive perception of the group (β = 0.17; B = 0.19; $SE\ B$ = 0.08; p = .02), although both were positively associated with the self-relevant step of help seeking. The researchers suggested one possible interpretation of these results would be that individuals who strongly identify as having a mental illness but have negative feelings about people with mental illness might see treatment as

relevant for them so they can be cured and distance themselves from that stigmatized group.

In study 2, the researchers tested the hypothesis that increased social identification as a person with mental illness, negative perceptions about that group, and the self-relevant step of help seeking would predict actual help seeking through service utilization. The researchers also hypothesized that perceptions of the group would be a moderator of the relationship between social identification and help seeking such that individuals with higher levels of social identification who had negative perceptions of the group would have higher levels of actual help seeking behavior than those with more positive perceptions of the group.

The researchers used multinomial regression analysis to conclude that both social identification ($B = 0.68$; $SE\ B = 0.19$; $p = 0.00$) and the self-relevant step of help seeking ($B = 1.46$; $SE\ B = 0.55$; $p = 0.01$) were positively associated with help-seeking behavior. They did not find evidence to support an association between perceptions of the group and actual help-seeking behavior or any moderating effects of perceptions of the group on the relationship between social identification and actual help-seeking behavior.

These findings were contrary to the researchers' expectations that the moderating effects of perceptions of the group on the relationship between social identification and the self-relevant step of help seeking found in study 1 would imply a similar moderating effect on the relationship between social identification and actual help-seeking behavior. The researchers suggested that this discrepancy might be due either to uncontrolled differences in the samples for the two studies or to other factors involved in the help seeking process which mediate the relationship between the self-relevant step of help

seeking and actual help-seeking behavior and require further investigation. A weakness of both studies was the lack of diversity of the samples which turned out to be largely white, female, and college educated. A major strength of these studies is that they are among the first to investigate social identity and stigma as predictors of help seeking for mental illness.

Boerema et al. (2016) conducted a study of 102 participants recruited through the Netherlands' Municipal Health Services to explore the relationship between help seeking for mental illness and stigma, duration of symptoms, and other personal factors. Participants who had completed the annual Netherland's Health Monitor general population survey in 2012 and received a high score on the Kessler-10 scale for psychological distress (Kessler et al., 2010), were invited for a screening interview. During the interview, researchers used the Composite International Diagnostic Interview (CIDI 2.1) to assess each participant's current level of depression. Participants who met the criteria for major depressive disorder or dysthymia were included in the study.

The researchers operationalized the study constructs as follows: (a) social structure: Loneliness scale (De Jong Gierveld, et al., 1985); (b) personality characteristics: Neuroticism subscale of the NEO-Five Factor Inventory (NEO-FFI); (c) stigma: Depression Stigma Scale (DSS) Personal and Perceived Stigma subscales; (d) psychological distress: Kessler-10 scale; (e) symptom duration: single item question; (f) physical illness: records of chronic illness; (g) help-seeking behaviors: questions about types of professional mental health care received in past six months.

The researchers used descriptive statistics along with univariate and multivariate logistic regression analyses to conclude that longer symptom duration was positively

associated with help seeking (*OR* = 2.60; *95 % CI* = 1.05 – 6.41; *p* = 0.03) and personal stigma was negatively associated with help seeking (*OR* = 0.89; *95 % CI* = 0.83 – 0.96; *p* = 0.005) in this sample. No statistically significant relationships were found with any other personal factors and help seeking. A weakness of the study was the high comorbidity of physical and mental illness in the sample which confounded study results.

Hantzi et al. (2019) conducted a study of 119 adults recruited from the Greek general population to test a model of professional help seeking for mental illness based on intergroup contact theory (Brown & Hewstone, 2005; Hewstone & Swart, 2011). The researchers proposed that direct and extended contact with mental illness would decrease intergroup anxiety and essentialist beliefs about mental illness which would in turn reduce negative beliefs about mental illness. They further postulated that a decrease in negative beliefs about mental illness would reduce both self-stigma and perceived public help-seeking stigma which would mediate an increase in positive attitudes about help seeking.

The researchers operationalized the study constructs as follows: (a) help-seeking attitudes: Attitudes Toward Seeking Professional Psychological Help scale (Fischer & Farina, 1995); (b) help-seeking self-stigma: Self-Stigma of Seeking Help (Vogel et al., 2006); (c) perceived public help-seeking stigma: Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya et al., 2000); (d) negative beliefs about mental illness: 21-item Beliefs Toward Mental Illness Scale (Hirai & Clum, 2000); (e) essentialist beliefs about mental illness: eight items from Essentialist Beliefs Scale (Haslam & Ernst, 2002); (f) intergroup anxiety: eight 7-point semantic differential scale items (Turner et al., 2007); (g) direct contact: two questions about number of friends with

mental health problems and frequency of contact; (h) extended contact: two questions about number of friends or relatives who had friends with mental health problems and their frequency of contact.

Using descriptive statistics and path analysis, the researchers found that direct, not extended, contact with mental illness led to less negative (B = -0.592; p < .001) and less essentialist beliefs (B = -0.269; p < .01) about mental illness and that this relationship was mediated by reduction of intergroup anxiety (B = -0.439; p < .001). They also found that negative beliefs about mental illness were associated with more negative attitudes about help seeking (B = -0.448; p < .001) and that this relationship was mediated by an increase in self-stigma for help seeking (B = 0.415; p < .001). The researchers did not find a statistically significant relationship between either perceived public stigma or extended contact and help seeking. One strength of this study was its innovative use of intergroup contact theory. Major weaknesses of the study were its small sample size and self-selection sampling bias.

Pattyn et al. (2015) conducted a study to explore the relationship between gender, stigma, and help seeking for mental illness using data from the 2009 Stigma In A Global Context- Mental Health Study (SGC-MHS). The SGC-MHS was a 16-country comparative study of the prevalence and predictors of stigma of persons with symptoms of major depression and schizophrenia which used representative samples of adults from each of the 16 study member countries. For their study, Pattyn et al. (2015) used data from the Belgian sample (N = 743).

In the SGC-MHS study, researchers conducted in-person interviews to assess participants' reactions to a vignette of a person with symptoms typical of someone with

major depressive disorder. The study assumed that a participant's attitudes about and treatment recommendations for the individual depicted in the treatment vignette would reflect the participant's attitudes about actual persons with mental illness. The researchers operationalized the study constructs as follows: (a) gender: binary (male/female); (b) recommending self-care only: open ended question about treatment suggestions; (c) treatment attitudes: single-item helpfulness question for different treatment types using a 7-point Likert-type scale; (d) stigmatizing attitudes: open-ended questions later categorized as "blame" or "shame" attributions; (e) familiarity with mental illness: single-item questions; (f) labeling: single question "how likely is it the person in the vignette has a mental illness?" (4-point Likert-type scale); (g) out-group/in-group status: vignette presented with Belgian versus Turkish ethnicity.

Using descriptive statistics along with linear and logistic regression models, the researchers found that female respondents were more likely to rate psychotherapy as helpful in a female vignette (B = -0.207; SE = 0.1; $p < .05$). Male respondents were less likely than female respondents to rate psychotherapy as helpful in either male (B = -0.341; SE = 0.104; $p < .01$) or female (B = -0.207; SE = 0.1; $p < .05$) vignettes, although they are more likely to rate tranquilizers (one of treatment types assessed in treatment attitudes measure) as helpful in male vignettes (B = 0.316; SE = 0.152; $p < .05$). Male respondents also attributed more blame to female vignettes (OR = -1.689; *95% CI* = 1.071-2.635; $p < .05$) and more shame to male vignettes (OR = -1.57; *95% CI* = 1.010-2.441; $p < .05$) than female respondents. The researchers also found that respondents who labeled the characters in the vignettes as having "mental illness" were less likely to recommend self-care (B = 0.746; *95% CI* = 0.595–0.937; $p < .05$) and were more likely

to agree that the vignette character should be "embarrassed" (*B* = 1.459; *95% CI* = 1.206–1.764; $p < .001$). Finally, the researchers found that both male and female respondents were less likely to recommend self-care for a vignette character from an out-group (*B* = 0.656; *95% CI* = 0.451–0.955; $p < .05$).

One major strength of this study was the use of a large representative general population sample. One weakness of the study was the failure to control for other variables, like socioeconomic class or type of mental illness depicted, in the vignette description which may have evoked implicit bias and confounded the study results. Another limitation of the study was the questionable assumption that responses to a vignette about a third party reflected the help-seeking attitudes and behaviors the respondents would choose for themselves if faced with a mental health problem.

Horsfield et al. (2019), Schomerus et al. (2019), and Tomczyk et al. (2020) conducted prospective studies of adults with untreated depression recruited from the German general population. These three studies used data collected from the same sample of German adults with untreated symptoms of depression who were recruited using newspaper advertisements and social media. After completing a telephone screening interview to confirm their untreated depression (using the Patient Health Questionnaire for Depression, PHQ-9), 255 individuals were invited for an in-person interview with researchers. The participants completed a self-administered questionnaire with items required for each of the three studies and met with a clinical psychologist who made a DSM-IV diagnosis, using the Mini-International Neuropsychiatric Interview. Based on these interviews, 205 participants were included in the study. Of those, 188

completed at least one follow-up interview. The results of each of the three studies were published separately and are described below.

Using data collected from the sample of untreated depressed German adults described above, Horsfield et al. (2019) designed a study to test the hypothesis that personal stigma would predict willingness to self-label as mentally ill and future help-seeking. The researchers operationalized the study constructs as follows: (a) symptom awareness: Patient Health Questionnaire for Depression (PHQ-9); (b) self-labeling: open ended question which researchers later defined as 3 level categorical variables, physical illness, mental illness, not at all ill; (c) perceived stigma: Aware subscale of Self-Stigma of Mental Illness (SSMI); (d) agreement with negative stereotypes: Agree subscale of SSMI; (e) agreement with blame stereotype: 4 items adapted from the Community Attitudes Toward the Mentally Ill (CAMI) scale (Corrigan et al., 2006); (f) support for discrimination: three item 5-point Likert-type scale; (g) personal stigmatizing attitudes: Social Distance Scale; (h) help-seeking behavior: open questions about actual help-seeking behavior.

Using descriptive statistics, hierarchical multiple linear regression, and logistic regression analysis, the researchers found that participants who self-labeled as mentally ill had lower levels of personal stigma than those who did not. The researchers also found that self-labeling as physically ill (OR = 4.00; $95\%\ CI$ = 1.05-15.28; $p < 0.043$) and age (OR = 1.04; $95\%\ CI$ = 1.01-1.06; $p < 0.002$) were associated with increased help seeking from a general practitioner. Only severity of depression symptoms was a significant predictor of help seeking from a mental health professional (OR = 1.11; $95\%\ CI$ = 1.02-1.22; $p < 0.014$). Researchers also found significant differences in self-labeling categories

based on age ($F(2, 191) = 8.61$; $p < 0.001$), symptom severity ($F(2, 189) = 9.57$; $p < 0.001$), and past treatment experience ($\chi 2(2) = 6.67$; $p = 0.036$), with older participants more likely to self-label as physically ill and participants with more severe symptoms or past treatment experience more likely to self-label as mentally ill.

One weakness of this study was its small sample size ($N = 188$) and potential selection bias introduced through the study invitation which recruited individuals who were aware that they had symptoms of depression, increasing the likelihood that they would be willing to self-label as mentally ill. Another weakness of the study was possible bias introduced through the categorization of self-labels by researchers from open-ended questions to participants and possible social desirability bias introduced through in-person interviews.

Using the data collected from the sample of untreated depressed German adults described above, Schomerus et al. (2019) designed a study to explore how stigma and mental health literacy might be related to the following steps in the help-seeking process: (a) self-identification as having a mental illness; (b) perceived need for treatment; (c) help-seeking intentions; and (d) help-seeking behavior. The researchers tested two models of help seeking: one for help seeking from general practitioners and one for help seeking from mental health professionals.

The researchers operationalized their study constructs as follows: (a) mental health status: Mini-International Neuropsychiatric Interview (M.I.N.I.); (b) self-identification as having a mental illness: Self-Identification as Having Mental Illness Scale (Schomerus, et al., 2012); (c) perceived need for treatment: single-item question using 7-point Likert-type scale; (d) help-seeking intentions: single-item questions to rate

likelihood of seeing different types of mental health professionals using a 7-point Likert-type scale; (e) help-seeking behavior: questions about treatment seeking since last interview; (f) prejudice: four items asking about agreement with stereotypes of blame from Corrigan et al. (2006); (g) support for Discrimination: 3 items asking about agreement with statements of discrimination against people with mental illness; (h) discrimination: Social Distance Scale; (i) mental health literacy: Depression Literacy Scale (Griffiths, et al., 2004); (j) previous treatment experience: single-item question.

Using descriptive statistics and path analysis (Mplus 8), the researchers found support for their study hypotheses that self-identification as a person with a mental illness was negatively associated with support for discrimination (B = -0.14; $p < 0.05$) and positively associated with knowledge about depression (B = 0.21; $p < 0.01$), previous treatment experience (B = 0.28; $p < 0.001$), and severity of depressive symptoms (B = 0.35; $p < 0.001$).The researchers also found that self-identification (B = 0.32; $p < 0.001$) and severity of depressive symptoms (B = 0.24; $p < 0.01$) both predicted greater perceived need for treatment, but blame was associated with lower perceived need (B = -0.16; $p < 0.05$). The researchers also found that perceived need was positively associated with help-seeking intention (GP: B = 0.45; $p < 0.001$; MHP: B = 0.38; $p < 0.001$) which predicted actual help seeking for mental help professionals (B = 0.31, $p < 0.01$) but was not a statistically significant predictor for general practitioners. The study models accounted for 37% of the variance (R^2 = 0.37; p = 0.00) in help seeking from a mental health professional and 33% of the variance (R^2 = 0.33; p = 0.00) in help seeking from a general practitioner in the sample.

From these results, the researchers concluded that self-identification as mentally ill is an important first step in treatment seeking for mental illness and may be inhibited by stigma and lack of mental health knowledge. One strength of this study is its prospective design and attempt to relate help-seeking intentions to actual help-seeking behaviors. A major weakness of the study was the small sample size and the sample attrition rate between baseline and follow-up. Another weakness of the study was the possibility that other barriers to help seeking which were not measured may have been confounded the results.

Tomczyk et al. (2020) designed a study to explore the relationships between structural treatment barriers (awareness of local services, perceived accessibility, temporal and spatial distance from treatment resources), attitudinal/evaluative barriers (mental health literacy, stigma, and beliefs about treatment efficacy), and help-seeking intentions and behaviors, also using data collected from the sample of untreated depressed German adults described above. Based on previous studies, the researchers hypothesized that both structural and attitudinal barriers would have a negative relationship to help-seeking intentions and behaviors.

The researchers operationalized the study constructs as follows: (a) mental health status: Patient Health Questionnaire for Depression (PHQ-9; baseline and follow-up); (b) mental health literacy: Depression Literacy Scale (Griffiths et al., 2004); (c) help-seeking: Self-stigma of Seeking Help Scale; (d) awareness of local resource: yes/no; (e) spatial distance: single-item question (time to physically travel to resource); (f) accessibility: single-item question (belief they would get an appointment); (g) temporal distance: single-item question (time to available appointment); (h) treatment efficacy

beliefs: single-item question (7-point Likert-type scale); (i) help-seeking intentions: rate likelihood of seeking help from 15 different sources (7-point Likert-type scale); (j) help-seeking behaviors: questions about actual help-seeking behaviors relative to each of 15 different resources at 3 months and 6 months from baseline survey.

Using hierarchical regression models (linear regression for help-seeking intentions and logistic regression for help-seeking behaviors), the researchers found that, although structural barriers like awareness of local services (psychiatrist/neurologist: B = 0.25; $p < 0.01$), spatial distance (psychiatrist/neurologist: B = -0.21; $p < 0.05$), and temporal distance (general practitioner: B = -0.19; $p < 0.05$) of mental health resources predicted help seeking in some cases, treatment efficacy beliefs were the strongest predictors of help-seeking intentions across all types of resources (psychiatrist/neurologists: B = 0.23; $p < 0.01$; psychologists and psychotherapists: B = 0.25; $p < 0.01$; general practitioners: B = 0.28; $p < 0.01$) but only predicted actual help seeking behaviors for psychologists and psychotherapists (B = 0.28; $p < 0.01$).

Surprisingly, the researchers found that treatment-related stigma was negatively associated with help-seeking intentions only in a subgroup of participants who identified as having access to a mental health care resources (general practitioner: B = -0.16; $p < 0.05$; psychologist/psychotherapist: B = -0.25; $p < 0.05$). Similarly, the researchers found that treatment-related stigma predicted decreased help seeking (psychologist/psychotherapist: *aOR* = 0.86; *95% CI* = 0.74-0.99; $p < 0.05$) only in this subgroup. The researchers suggested that this might indicate that concerns about stigma only become salient at later stages in the help-seeking process. Although depression severity was considered a covariate in this study, the researchers confirmed findings from

other studies that depression severity predicted both help-seeking intentions (psychiatrist/neurologist: $B = 0.27$; $p < 0.01$; psychologists/psychotherapists: $B = 0.26$; $p < 0.01$) and behaviors (psychiatrist/neurologist: *aOR* = 1.13; *95% CI* = 1.02-1.25; $p < 0.05$; psychologist/ psychotherapist: *aOR* = 1.38; *95% CI* = 1.55-1.66; $p < 0.01$). Contrary to common wisdom, the researchers found that mental health literacy was not a significant predicter of either health-seeking intentions or behaviors in this sample.

A strength of this study was its longitudinal design and attempt to control for demographic and experiential factors, although the relatively small sample size and attrition rate between baseline and follow-up were limitations. Another weakness of this study was the failure to measure other potential structural barriers and the possible confounding effect of perceived effectiveness of past treatment experiences which was not measured.

Health Care Provider Population Studies

Dyrbye et al. (2015) conducted a survey of 873 second and fourth-year medical students recruited from seven public and private medical schools in the United States to understand more about the experience of burnout, depression, and diminished quality of life and the relationship between perceived mental illness stigma, experiences of discrimination, and treatment seeking in medical students. The researchers also compared their results with data from the National Comorbidity Survey-Replication (NCS-R; Kessler & Merikangas, 2004) for age matched individuals from the US general population to provide more context for their study.

The researchers operationalized and measured their study constructs as follows: (a) burnout: Maslach Burnout Inventory; (b) depression: 2-item Primary Care Evaluation

of Mental Disorders; (c) quality of life: Medical Outcomes Study Short Form (SF-8); (d) stigma: combination of items from available measures of public, perceived and self-stigma of mental illness and help seeking; (e) fear of disclosure resulting from observed discrimination: single-item questions; (f) help seeking behaviors: questions about treatment seeking in past 12 months; (g) help seeking attitudes: National Comorbidity Survey-Replication (NCS-R) items to assess attitudes toward seeking mental health treatment.

The researchers used descriptive statistics, chi-squared tests, and Wilcoxon–Mann–Whitney analysis to conclude that only 33.9% (*n* = 154) of medical students sought help for burnout in this sample, although 52.7% (*n* = 454) met criteria for burnout. Although the prevalence of burnout in the sample was similar to that found in the NCS-R survey, the help-seeking rate was significantly lower than reported in the NCS-R survey of the general population (44.3%, *n* = 4,112) and age-matched individuals (38.8%, *n* = 339). The researchers also found that, although only 10.3% (*n* = 90) of medical students believed seeking help for a mental illness was a sign of personal weakness, a majority of medical students cited perceived stigma (51%, *n* = 445), fear that disclosure would have negative consequences with supervisors (53.4%, *n* = 466), and actual experiences of observed discrimination (11.6%, *n* = 101) as potential barriers to help seeking. An even higher percentage of study participants (61.9%, *n* = 540) indicated that they would hide treatment from others. The researchers also noted that of the medical students who did seek treatment in this sample, more sought treatment for burnout symptoms of "emotional exhaustion" (40%, *n* = 140) than for burnout symptoms of

"depersonalization" (32%, *n* = 92), suggesting that failure to recognize some signs of burnout might also be a factor in help-seeking behavior.

Among the strengths of this study was the relatively large sample size across multiple medical schools and the comparison with an age-matched sample from the general population. One weakness of the study was its low response rate (35.6%, *n* = 873) and the limited number of potential help-seeking barriers and personal factors assessed.

Cohen et al. (2016) conducted a survey of 1,915 doctors and doctors in training from across the United Kingdom to understand more about both the prevalence of mental illness and predictors of self-disclosure about mental illness in this population. The researchers developed a short questionnaire containing both categorical and open-ended questions to gather the following information: (a) demographic information: age, gender, job role, job status, years in practice, ethnicity, mental health training; (b) personal experience of mental illness: single-item questions; (c) willingness to disclose: single-item questions; (d) actual disclosure: single-item questions; (e) reason to disclose or not disclose: open text responses.

Using descriptive analysis, the researchers found that 60% (*n* = 1,149) of those surveyed had experienced mental health symptoms. Of those who had experienced a mental illness and answered questions about disclosure, only 41% (*n* = 478) reported disclosing their symptoms. The most common reasons for disclosing were professional responsibility (52%, *n* = 248), for advice on how to manage work/studies along with mental ill health (41%, *n* = 196), for emotional support (38%, *n* = 182), and to obtain treatment (28%, *n* = 134). The researchers also asked these questions of those who had never experienced a mental health problem. Interestingly, 54% (*n* = 570) believed they

would be willing to disclose, with professional responsibility (85%, *n* = 484), advice on how to manage work/studies along with mental ill health (66%, *n* = 376), and emotional support (39%, *n* = 222) being the most common reasons. The researchers also found that 97% of those surveyed indicated that they would disclose first to someone outside the workplace.

When asked about reasons for not disclosing mental illness symptoms, not wanting to be labeled was the most frequently cited reason by both those who had and those who had not experienced mental illness. Interestingly, 19% (*n* = 217) of those who had experienced a mental illness cited letting colleagues down as their reason, compared to 38% (*n* = 291) of those who had not experienced mental illness. Of those who had had a mental illness, 25% (*n* = 287) wrote in reasons for not disclosing which included: mild symptoms, lack of insight, didn't see relevance, and able to deal with it alone.

Using logistic regression analysis, the researchers found that being female (*OR* = 1.3; *95% CI* = 1.04, 1.58; $p < .05$), older (*OR* = 7.5; *95% CI* = 2.07, 27.23; $p < .01$) and having to take sick leave (*OR* = 3.6; *95% CI* = 1.16, 12.24; $p < .05$) were all positively associated with willingness to disclose. Interestingly, not having experienced a mental health problem was also positively associated with willingness to disclose (*OR* = 5.3; *95% CI* = 4.22, 6.63; $p < .001$). One strength of the study was the large sample size and comparison of attitudes of doctors with mental health problems to those who had not had mental health problems. One weakness of the study was the use of convenience sampling which resulted in a gender ratio (66% female, *n* = 1263) that was not representative of the UK physician population (44% female, *n* ~= 191,500).

Fischbein and Bonfine (2019) conducted a study of 482 US pharmacy and medical students to investigate the prevalence of mental health problems (including substance abuse), mental health-related stigma, and attitudes about help seeking and treatment. The researchers used data collected in the 2015-2016 Healthy Minds Study, an annual internet-based survey of a random sample of 34,299 students from 23 colleges and universities in the United States, conducted by the University of Michigan Healthy Minds Network. From this data, the researchers extracted a sample of 482 students who were enrolled in a PharmD, Ph.D. in Pharmacy, or M.D. program. Of these, 159 were pharmacy students and 323 were medical students, representing 17 different US institutions.

The Healthy Minds Study constructs were operationalized as follows: (a) positive mental health: eight-item Flourishing Scale; (b) depression: Patient-Health-Questionnaire-9 (PHQ-9); (c) anxiety: Generalized Anxiety Disorder 7-Item (GAD-7); (d) substance abuse: single-item questions about alcohol and drug use; (e) medical treatment: single-item question about use of prescribed medication for psychiatric diagnosis; (f) knowledge of treatment access: single-item question; (g) perceptions of treatment helpfulness: single-item question; (h) help seeking: single-item questions about actual formal and informal help seeking as well as future help-seeking intentions; (i) perceived stigma: single-item question; (j) public stigma: single-item question.

Because the Healthy Minds study used sample weights to control for response bias, the researchers used statistical tests designed to handle weighted data to analyze their results, including calculation of sample-weighted means and percentages, the use of adjusted Wald tests to compare weighted means, and the use of Pearson design-based *F*

tests to replace chi-squared tests to compare weighted percentages. From these analyses, the researchers concluded that both US pharmacy and medical students in this sample experienced significant mental health needs (depression: 18%, *n* = 87; anxiety: 13.8%, *n* = 66), although a higher percentage of medical students (21%, *n* = 68) would be willing to seek help for mental health issues than pharmacy students (11%, *n* = 17). As one of only a few studies of help seeking among healthcare providers, this study made an important contribution to the literature. A weakness of the study is the potential for sampling error, both in the relatively small sample size of pharmacy (*n* = 159) versus medical students (*n* = 323) and in the small number of institutions surveyed (only 23 of 297 accredited US medical and pharmacy schools).

Gold et al. (2016) conducted a mixed methods survey of 2,109 female physicians across the United States to investigate attitudes and personal experiences of mental health issues, treatment, and reporting. The survey included twenty quantitative and four open-ended questions about mental health history and treatment, perceptions of stigma, opinions about state licensing questions on mental health, personal experiences with reporting, and perceived barriers to treatment. The researchers analyzed the quantitative data using descriptive statistics and chi-squared tests and the qualitative data using content analysis to identify themes and narratives. Only 357 physicians completed the qualitative questions.

The researchers concluded from their analyses that 49% (*n* = 1,033) of this sample of US female physicians believed they had had a diagnosable mental health condition at some point in their professional career but did not seek treatment. Among participants who did not seek treatment, the most common reasons given were the belief they did not

need help to manage the condition (68%, *n* = 707), insufficient time to attend counseling (52%, *n* = 541), the belief that a mental health diagnosis was embarrassing or shameful (45%, *n* = 468), fear of consequences if they were reported to a medical licensing board (44%, *n* = 458), fear of disclosure to colleagues or other professionals (39%, *n* = 406), and the belief that a diagnosis would make them appear less competent or able to work (36%, *n* = 374).

Of those who did seek treatment, only 6% (*n* = 62) disclosed their condition to the state medical board. The most common reasons cited for not disclosing treatment to the state medical board were that their condition did not pose any safety risk to patients (75%, *n* = 216), that their condition was not relevant to patient care (70%, *n* = 202), and that their condition was not the business of the state medical board (63%, *n* = 181).

An obvious strength of this study was the large sample size and the attempt made to survey physicians from all 50 states and the District of Columbia. Very few studies have been conducted to investigate mental illness and treatment-seeking among healthcare providers, and this study helps raise awareness of the help seeking challenges faced by this population. One weakness of the study was that the sample was drawn from a closed Facebook site for physicians who were also mothers, making it impossible to generalize the results beyond that group.

Mental Health Professional Population Studies

Edwards and Crisp (2017) conducted a study of 98 Australian mental health professionals (*n* = 67) and trainees (*n* = 31) recruited through snowball, purposive sampling to understand their perceptions of barriers to help seeking for their own mental health conditions. Of these, 69.2% (*n* = 68) were psychologists and the rest of the sample

included nurses, psychiatrists, and social workers. The researchers operationalized the study constructs as follows: (a) barriers to seeking help: Barriers to Access to Care Evaluation scale (BACE; Clement et al., 2012); and (b) help-seeking experiences and intentions: single-item questions about current and past experiences of mental illness and treatment, willingness to refer to someone with mental illness, and the role of the mandatory impairment reporting requirement in Australia in help seeking and willingness to disclose impairment.

The researchers used descriptive statistics and chi-squared tests to conclude that, although most Australian mental health providers indicated that they would seek help for mental health problems (88.8%, *n* = 87), they also admitted that they had not sought help at times (58.2%, *n* = 56). The most cited barrier to treatment was "wanting to solve the problem on my own" (92%, *n* = 90), with 27.6% (*n* = 27) citing this as a major barrier. The researchers also found that 40.8% (*n* = 40) reported having had a mental illness at least once and 59.4% (*n* = 57) reported seeking treatment.

Of those who had not sought help for problems in the past, 61.4% (*n* = 35) believed their condition impaired their work, and 43.9% (*n* = 25) of those respondents cited "financial concerns" as the primary reason for not seeking treatment, followed by "other reasons" (42.1%, *n* = 24), "fear of disclosure to colleagues" (29.8%, *n* = 17), "no suitable clinicians available" (26.3%, *n* = 15), and "belief they could treat themselves" (22.8%, *n* = 13). When asked about fear of negative consequences resulting from the Australian Health Practitioner Regulation Agency's mandatory reporting requirement, 64.3% (*n* = 63) indicated that the requirement would prevent them from disclosing impairment at work, and 57.1% (*n* = 56) said that it would be a barrier to future help

seeking. No results were reported for the question about willingness to refer to colleagues with mental health problems.

A major strength of this study is that it is one of only a handful of studies of barriers to mental health treatment in mental health professionals and provides important insights into help seeking for mental illness in this population. One weakness of this study is its small sample size and likely sampling bias introduced through snowball sampling methods. Another weakness is the use of single-item questions with no available psychometric data on validity or reliability to measure the help-seeking behaviors and attitudes construct.

Mullen and Crowe (2017) conducted a survey of US school counselors to better understand the relationship between counselor self-stigma, burnout, stress, life satisfaction, and help seeking. The researchers sent email invitations and survey instructions to a random sample of 5,000 school counselors listed in the American School Counselor Association (ASCA) online membership directory. Of the 5,000 school counselors invited to participate, 333 (7.5% useable response rate) completed the survey and were included in the study.

The researchers operationalized the study constructs as follows: (a) burnout: Burnout Measure, Short Version (BMS; Malach-Pines, 2005); (b) stress: Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983); (c) life satisfaction: Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985); (d) help-seeking intentions: General Help-Seeking Questionnaire (GHSQ; Wilson, Deane, Ciarrochi, & Rickwood, 2005); and (e) self-stigma of mental illness: Self-Stigma of Mental Illness Scale (SSOMI; Tucker et al., 2013).

The researchers used path analysis to test their hypotheses that mental health-related self-stigma would have a negative relationship with help-seeking behaviors, and help-seeking behaviors would have a negative relationship with school counselors' level of stress, burnout, and satisfaction with life. The study results supported these hypotheses, although the effect sizes were small. Specifically, the researchers found that mental health-related self-stigma had a negative relationship with help-seeking intentions (B = -0.21, p < .001), and help-seeking intentions had a negative relationship with stress (B = -0.25, p < .001) and burnout (B = -0.24, p < .001). The researchers also found that both burnout (B = -0.23, p < .001) and stress (B = -0.40, p < .001) were negatively associated with life satisfaction. One strength of this study was the use of established measures with strong evidence of validity and internal reliability. One weakness of the study was the low usable response rate of the survey (7.5%) which decreased the study's external validity.

Tay et al. (2018) conducted a survey of 678 clinical psychologists from the UK to understand more about the prevalence of mental health problems and help seeking and the role of mental health-related external, perceived, and self-stigma in disclosure and help seeking for mental health problems in this population. The researchers hypothesized that UK clinical psychologists would be more willing to disclose mental health problems to family and friends than to professional colleagues or employers, and less willing to disclose more stigmatized problems like psychosis or bipolar disorder. The researchers also hypothesized that UK clinical psychologists would have more mental health-related perceived stigma than public stigma and that higher perceived stigma, self-stigma, and fear of negative consequences for disclosure of help seeking would predict less

willingness to disclose. The researchers recruited study participants through an email invitation to the 3,600 members of the British Psychological Society's Division of Clinical Psychology. The resulting study sample was determined to be representative of the UK clinical psychologist population.

The researchers used the following measures to operationalize the study constructs: (a) external (public) stigma: Social Distance Scale (Link et al., 1987); (b) perceived stigma: Stig-9 Perceived Devaluation Discrimination Scale (Gierk, Murray, Kohlmann, & Löwe, 2013); (c) self-stigma: 10-item self-stigma subscale of the Military Stigma Scale (Skopp et al., 2012); (d) disclosure attitudes: Secrecy Scale (Link, Struening, Neese-todd, Asmussen, & Phelan, 2002); (e) disclosure experience: single-item questions; (f) help-seeking attitudes: Attitudes towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Fischer & Farina, 1995); and (g) lived experience: single-item questions about mental health problems and help seeking at any point in the respondent's lifetime.

The researchers used descriptive statistics, one-way ANOVA, and independent samples t-tests to conclude that 62.7% (n = 425) of the clinical psychologists surveyed had experienced a mental health problem, and 84% (n = 357) sought professional help, with 14.6% (n = 62) seeking help from no one. Among those who had experienced a mental health problem, depression (n = 352, 82.8%) and anxiety (n = 179, 42.1%) were the most reported. Of those who had experienced a mental health problem, only 44.5% (n = 189) disclosed their difficulties in their workplace, although more disclosed to family (68.2%, n = 290) or friends (65.2%, n = 277). Of the 10.8% (n = 46) who disclosed to no one, self-stigma, fear of negative effect on self-image, and shame were the most common

reasons cited. Those who had not sought professional help (*n* = 68, 16%) had statistically significantly higher help-seeking self-stigma and less positive attitudes about help-seeking than those who had sought help.

This study was the only one found which explored the prevalence of mental health problems and attitudes toward help seeking among clinical psychologists and as such makes an important contribution to the literature. Another obvious strength of the study was its large sample size and high usable response rate (81.9%, *n* = 678), although external validity was limited by the self-selection bias inherent in survey research.

Summary

Several general population studies have explored the role of stigma and other personal and structural barriers to help seeking for mental illness. Only a handful of studies have explored help seeking for mental health problems among healthcare providers and even fewer studies have explored mental health attitudes and help seeking in mental health professionals. No studies were found in this review which explored personal experiences of mental health problems or help-seeking attitudes, intentions, and behaviors among mental health counselors. Given the importance of the mental health of a counselor in maintaining a consistent and therapeutic relationship with their clients, it is important to understand the prevalence, barriers to, and predictors of help seeking for mental health problems in this population. This is a serious gap in the literature which the current study attempted to address.

Chapter 3: Methodology

The mental health of counselors is critical to providing competent care for counseling clients, and it is vital that counselors are encouraged and supported in seeking help for their mental health problems (Lawson, 2007; Lawson & Venart, 2005). To date, no studies have been conducted to investigate the prevalence of mental health problems and help seeking among mental health counselors or the perceived barriers to and predictors of help seeking for mental health problems in this population. This research is necessary both to raise awareness of these issues within the counseling profession and to inform interventions to increase help seeking for mental health problems and support mental health and wellness in mental health counselors. This is a serious gap in the literature which the current study attempted to address.

Research Design

The current study used a descriptive correlational design to investigate the following research questions: (a) Research Question 1: what is the prevalence of mental health problems and help seeking for mental health problems among mental health counselors?; (b) Research Question 2: what do mental health counselors perceive as barriers to help seeking for their own treatment for mental health problems?; (c) Research Question 3: in what ways do the attitudes about mental health problems and help seeking of mental health counselors who have experienced personal mental health problems and treatment differ from those of mental health counselors who have not experienced mental health problems or treatment?; and (d) Research Question 4: what factors predict help-seeking intentions for mental health problems in mental health counselors?

The hypotheses associated with Research Question 1 were as follows: (a)

Hypothesis 1: the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples; (b) Hypothesis 2: mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates.

The hypotheses associated with Research Question 2 were as follows: (a) Hypothesis 3: fear of disclosure, fear of loss of status and discrimination, and desire to handle on one's own will be the most commonly cited barriers to help seeking among mental health counselors; and (b) Hypothesis 4: attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors.

The hypotheses associated with Research Question 3 were as follows: (a) Hypothesis 5: mental health counselors who have disclosed mental health problems and treatment will have statistically significantly lower personal mental health-related stigma, perceived mental health-related stigma, and help-seeking self-stigma scores than mental health counselors who have never disclosed mental health problems or help seeking; and (b) Hypothesis 6: mental health counselors who have disclosed mental health problems and help seeking will be more willing to refer clients to colleagues with mental health problems than mental health counselors who have not disclosed mental health problems and help seeking.

The hypotheses associated with Research Question 4 were as follows: (a) Hypothesis 7: more positive help-seeking role models will predict increased help-seeking intentions for mental health problems in mental health counselors; and (b) Hypothesis 8:

more help-seeking self-stigma, perceived mental health-related stigma, personal mental health-related stigma, and personal or observed experience of discrimination for mental health problems and/or help seeking will predict less help-seeking intentions for mental health problems in mental health counselors.

Participants

Study participants included mental health counselors who were currently licensed (LPC, LMHC, LCPC, LPCC) and practicing counseling in the United States. Participants were recruited through postings on professional mental health counseling organization listservs (CESNET), forums (American Mental Health Counselor Association (AMHCA)), blogs (American Counseling Association (ACA)), Facebook groups, as well as through direct emails to colleagues.

The final sample included 255 mental health counselors. The demographic characteristics of this sample are summarized in Appendix A, Table 2. Of the 255 participants, 85.9% were female (*n* = 219), 12.9% male (*n* = 33), and 1.2% identified as gender queer (*n* = 3). Ages ranged from 26 to 74 (*M* = 47.54, *SD* = 12.83). Most participants identified as Caucasian (*n* = 217, 85.1%), followed by Latinx (*n* = 13, 5.2%), African American (*n* = 12, 4.7%), Asian (*n* = 6, 2.4%), Native American, Alaskan Native, or Native Hawaiian (*n* = 3, 1.2%), Other (mixed) (*n* = 3, 1.2%), and Other (n = 2, < 1.0%). Participants were from all 50 states and the District of Columbia. Missouri (*n* = 41, 16.1%), New York (*n* = 26, 10.2%), Texas (*n* = 18, 7.1%), and Florida (*n* = 16, 6.3 %) had the highest percentage representation. When viewed by region (as categorized by the U.S. Census), 33.7% (*n* = 86) of participants were from the south, 32.2% (*n* = 82) were from the Midwest, 21.2% (*n* =54) were from the northeast, 12.5% (*n* = 32) were

from the west, and < 1% (*n* = 1) were from the pacific region. Most participants were licensed professional counselors (LPCs, 56.1%) or licensed mental health counselors (LMHCs, 29.4%). The rest were either licensed clinical professional counselors (LCPCs, 8.2%), or professional clinical counselors (LPCCs, 6.3%). The number of years participants had been licensed to practice counseling ranged from 1 to 40 (*M* = 10.74, *SD* = 8.59). According to the US Census Bureau (2017), the US mental health counselor population has a median age of 41, is 77.6% female, 61.4% white, 20.7% African-American, 6.1% Asian-American, 4.7% Latinx, and less than 1% Native.

Participants were also asked about their personal experiences of mental health problems and treatment. These results are summarized in Appendix A, Table 3. Of the 255 participants in the final sample, 62.4% (*n* = 159) reported having had mental health problems during the time since they were licensed. When asked about the types of mental health problems they had experienced, 79.9% (*n* = 127) reported anxiety, 64% (*n* = 102) depression, 59.1% (*n* = 94) stress, 39% (*n* = 62) relationship issues, 24.5% (*n* = 39) trauma-related issues, 10.7% (*n* = 17) PTSD, 7.5% (*n* = 12) eating disorder, 5% (*n* = 8) other (grief), 3.1% (*n* = 5) bipolar disorder, 2.5% (*n* = 4) substance use issues, 1.9% (*n* = 3) borderline disorder, 1.9% (*n* = 3) other (adjustment), and 1.2% (*n* = 2) other.

Of those respondents who reported having experienced a personal mental health problem during the time since licensure, 86,8% (*n* = 138) reported seeking treatment for their mental health problem. When asked from which types of providers they had received mental health treatment, 63.8% (n = 88) reported receiving treatment from a mental health counselor, 27.5% (n = 38) from a medical doctor, 26.1% (n =36) from a

psychologist, 26.1% (n = 36) from a psychiatrist, 21% (n = 29) from a social worker, and 5.8% (n = 8) from other.

Measures

The proposed study used the questionnaires and scales described below to operationalize the study constructs. Copies of each scale and questionnaire, including scoring instructions, can be found in Appendices A-H. Since the psychometric properties of the scales proposed in this study had not previously been evaluated in samples of mental health counselors, Cronbach's alpha was calculated and reported for each scale to evaluate the internal consistency reliability of each scale with the current study sample.

Demographic and Personal Experience Questionnaire

The proposed study used a 34-item *Demographic and Personal Experience Questionnaire* (see Appendix B) which included the following: (a) three screening questions (*age*, *licensure*, *currently seeing clients*); (b) six questions about *gender*, *ethnicity*, *location of practice*, and *years counseling clients*; (c) nine questions about *personal experience of mental health problems and help seeking*; (d) four questions about *disclosure of mental health problems and treatment*; (e) a four-item 6-point Likert-type scale to assess *positive experience of role model disclosure* of mental health problems and treatment; (f) a two-item 6-point Likert-type scale to assess *personal experience of discrimination* resulting from disclosure of mental health problems and treatment; (g) a two-item 6-point Likert-type scale to assess *observed experience of discrimination* resulting from disclosure of mental health problems and treatment; and (h) a one-item 6-point Likert-type scale to assess *willingness to refer clients to a colleague with mental health problems*.

The *Demographic and Personal Experience Questionnaire* items which used the 6-point Likert-type scale, each had a mean score ranging from 1 to 6, with higher scores indicating more *positive experience of role model disclosure*, more *personal experience of discrimination*, more *observed experience of discrimination*, and more *willingness to refer clients to a colleague with mental health problems*, respectively. All other questions on the Demographic and Personal Experience Questionnaire used a checklist format (see Appendix B).

Separate subscale scores were calculated for *positive experience of role model disclosure of mental health problems* and *positive experience of role model disclosure of treatment*. A composite total *positive experience of role model disclosure* score was also calculated. The Cronbach's alpha coefficient was .72 for the *positive experience of role model disclosure of mental health problems* subscale, .63 for the *positive experience of role model disclosure of treatment* subscale, and .78 for the composite *positive experience of role model disclosure* scale, in the current sample.

Separate scores were also calculated for *personal experience of discrimination for disclosure of mental health problems*, *personal experience of discrimination for disclosure of mental health treatment*, *observed experience of discrimination for disclosure of mental health problems*, *observed experience of discrimination for disclosure of mental health treatment*, as well as composite total *personal experience of discrimination* and *observed experience of discrimination* scores. The Cronbach's alpha coefficient was .86 for the *personal experience of discrimination* subscale and .94 for the *observed experience of discrimination* subscale in the current sample.

Barriers to Access to Care Evaluation (BACE)

Clement et al. (2012) developed the *Barriers to Access Care Evaluation* scale (*BACE*) to provide a comprehensive measure of perceived barriers to mental health treatment. The developers provided strong evidence of construct and criterion validity and good test-retest reliability (*Cohen's kappa* > 0.4) for this measure. The scale includes 30 items, each measured using a 4-point Likert-type scale to assess the degree to which a given item is perceived as a barrier to help seeking. Scores for each item range from 0 (not at all) to 3 (a lot). The scale also includes a 12-item *stigma subscale* which can be used to assess mental health-related stigma. The *stigma subscale* is scored by taking the mean of the subscale item scores, ranging from zero to three, with higher scores indicating greater stigma concerns. The *stigma subscale* demonstrated strong evidence of good internal reliability with Cronbach's alpha of .89 (Clement et al., 2012). The Cronbach's alpha coefficient was .87 in the current sample.

The *BACE* was chosen for the current study because it provides the most comprehensive list of potential barriers available in a standardized instrument and can be used to assess both the relative importance (mean item score) of each individual perceived barrier and the frequency distribution of barriers within a sample. Unlike most scale measures, individual items on the *BACE* may be used in analyses to determine the prevalence or relationship of specific barriers to other study constructs (Clement et al., 2012). The current study used the *BACE* to operationalize *perceived barriers to help seeking* and the *BACE stigma subscale* to operationalize *perceived mental health-related stigma* (see Appendix C).

Kessler Screening Scale for Psychological Distress (K6)

The *Kessler Screening Scale for Psychological Distress* (*K6*) was developed to provide researchers and clinicians a short and easily administered screening instrument to identify individuals with severe mental health problems (Kessler et al., 2002). Scores greater than or equal to 13 indicate the respondent has met criteria for a DSM-IV diagnosis (Kessler et al., 2003). More recently, in a general population study of California adults, Prochaska et al. (2012) found strong evidence that the *K6* was also a reliable and valid screening tool for more moderate psychological distress with scores from 5 to 12 indicating subclinical mental health problems. This six-item 5-point Likert-type scale asks the respondent to answer questions in the form "*during the last 30 days, about how often did you feel…<depressed, restless, anxious, worthless, effort, hopeless>*" to assess recent levels of psychological distress. Scores range from 0 to 24, with higher scores indicating greater psychological distress. The *K6* has strong evidence of both convergent and predictive validity, as well as excellent internal reliability with Cronbach's alpha of .89 (Kessler et al., 2002; Kessler et al., 2003). The current study used the *K6* to operationalize the *mental health status* construct (see Appendix D). The Cronbach's alpha coefficient was .84 in the current sample.

A modified version of the *K6* (see Appendix E) was included in the current study to help control for the potentially confounding effect of the recent coronavirus pandemic on the results obtained for the *mental health status* variable. In this modified version, the "during the past 30 days, about how often did you feel" prompt will be replaced by the prompt "in general, about how often do you feel." This "in general" prompt was chosen based on the "in general" prompt used in the State-Trait Anxiety Inventory (Spielberger

et al., 1983) to differentiate between recently occurring (state) and more enduring personality-based (trait) emotional experiences.

The mean and standard deviation for the *K6* (see Appendix D) and modified *K6* (see Appendix E) in the sample were 5.10 (*SD*=3.89) and 5.17 (*SD*=3.63), respectively. The Pearson correlation between the *K6* (see Appendix D) and modified *K6* (see Appendix E) scores in this sample was .86 ($p <. 01$), indicating a strong relationship, although a chi-square goodness of fit test determined that the frequency distribution of distress severity found on the *K6* (>13 = 5.1%, 5 to 12 = 38.4%, < 5 = 56.5%) and the frequency distribution of distress severity found on the modified *K6* (>13 = 3.9%, 5 to 12 = 43.5%, < 5 = 52.5%) were statistically significantly different, X^2 (1, N = 255) = 6.58, p = .01. The Cronbach's alpha coefficient for the modified *K6* was .83 in the current sample.

Mental Help-Seeking Intention Scale (MHSIS)

Hammer and Spiker (2018) developed the *MHSIS* to provide researchers with a short measure of psychological help-seeking intentions. This three-item 6-point Likert-type scale has scores which range from 3 to 18, with higher scores indicating stronger intention to seek psychological help from each of three different formal sources: (a) *a mental health professional*; (b) *a medical doctor*; and (c) *a phone helpline*. The *MHSIS* has strong evidence of construct and predictive validity as well as good internal consistency reliability with a Cronbach's alpha of .94 (Hammer & Spiker, 2018).

The current study used the *MHSIS* (see Appendix F) to operationalize the *help-seeking intentions* construct. This scale was chosen instead of the more widely used *General Help-Seeking Questionnaire* (*GHSQ*) because the *MHSIS* was developed using a

general population sample and has stronger evidence of predictive validity and internal consistency reliability than the *GHSQ* which was developed using a sample of high school students (Hammer & Spiker, 2018; Wilson et al., 2005). The Cronbach's alpha coefficient was .43 in the current sample.

Negative Stereotypes Subscale

SAMHSA researchers used exploratory and confirmatory analysis to develop a brief 10-item 5-point Likert-type scale to assess attitudes about people with mental health problems (SAMHSA/CDC, 2010). This scale consists of two subscales, the *negative stereotypes* (*NS*) subscale and the *recovery and outcomes* (*RO*) subscale. The researchers found strong evidence of concurrent validity with other attitude measures for both subscales as well as evidence of good internal consistency reliability with Cronbach's alpha of .70 for the *NS* subscale and .69 for the *RO* subscale in a diverse sample of U.S. citizens (SAMHSA/CDC, 2010).

The current study used only the *NS* subscale (see Appendix G) to operationalize the *personal mental health-related stigma* construct. This subscale presents five statements of negative stereotypes about people with mental health problems and asks respondents to rate their agreement or disagreement with each statement using a 5-point Likert-type scale. Possible scores range from 5 to 25, with higher scores indicating more *personal mental health-related stigma*. The Cronbach's alpha coefficient was .62 in the current sample.

Self-Stigma of Seeking Help Scale (SSOSH)

Vogel et al. (2006) developed the *Self-Stigma of Seeking Help Scale* (*SSOSH*) to measure the stigma people feel about seeking professional help for mental health

problems, as distinct from the stigma they may feel about having a mental health problem. The *SSOSH* (see Appendix H) is a 10-item 5-point Likert-type scale with scores ranging from 10 to 50 and higher scores indicating more self-stigma of seeking help. The researchers conducted both exploratory and confirmatory factor analyses which provided strong evidence of construct, criterion, and predictive validity for the *SSOSH* as a measure of the self-stigma of seeking help (Vogel et al., 2013; Vogel et al., 2006). These researchers also found strong evidence of internal consistency reliability (*Cronbach's alpha* = .90) and good test-retest reliability (r = .72). The current study used the *SSOSH* to operationalize the *help-seeking self-stigma* construct. The Cronbach's alpha coefficient was .80 in the current sample.

Procedures

Data for this study was collected using an online Qualtrics survey through which the measures described above were administered. The first screen of the survey included an informed consent statement which participants were required to read and acknowledge before proceeding. The *Demographic and Personal Experience Questionnaire* (see Appendix B) was then presented, and participants screened out of the study if they were younger than 21, did not have an active mental health counseling license (LPC, LCPC, LPCC, LMHC), or were not currently seeing clients in the United States. The remaining measures were presented in random order to participants.

The survey was set up in Qualtrics to prevent submission of more than one survey from the same IP address, to reduce the likelihood of false surveys. Participants were given 24 hours to complete the survey and could skip questions but could not return to earlier questions. This data collection procedure was reviewed and approved by the

UMSL institutional review board (IRB) to ensure that all the appropriate steps were taken to protect the rights and well-being of participants. After obtaining IRB approval, the Qualtrics survey was published and a link to the Qualtrics survey emailed and posted through social media to potential participants.

A total of 292 valid surveys (consent form signed, and inclusion criteria met) were downloaded from Qualtrics to SPSS v 25 for analysis. No pattern of missing data was detected. Because of skip logic in the survey, however, missing values on the *personal discrimination experience scale* were set to zero (this scale was not administered when respondent reported no experience of mental health problems). Missing values on the *BACE_SS* subscale were set to zero when skipped as "not applicable." Upon examination, 31 cases were found with too many of the main study variables missing to be useful in the analysis and were documented and deleted from the dataset. The dataset was then checked for univariate and multivariate outliers using methods and guidelines recommended by Tabachnick, Fidell, and Ullman (2019). Cases with responses greater than +/- 3.29 standard deviations from the mean on one or more scales were considered univariate outliers. Three cases were identified as univariate outliers, documented, and deleted from the dataset. A regression analysis using the main study variables was conducted to check for multivariate outliers. Cases with a MAH value greater than +/- 26.124 (chi-square table value for df=9 and p<.001) were considered multivariate outliers. Three cases were identified as multivariate outliers, documented, and deleted from the dataset. The resulting cleaned dataset contained 255 cases. Data was stored on secure servers during analysis and archived at UMSL, as required for IRB approved studies.

Data Analysis

Because the internal consistency reliability of the *Mental Help Seeking Intentions Scale* (see Appendix F) in the current study sample was unacceptably low, at only .43, and the study emphasis was on help seeking from a mental health professional, the decision was made to use the single-item, Likert-type *intentions to seek help from a mental health professional* subscale (see Appendix F) as the dependent variable in the analysis of help-seeking predictors, rather than the composite scale score. This change required the use of a logistic regression analysis rather than a linear regression analysis to test the help-seeking predictor hypotheses (Hypothesis 7 and Hypothesis 8). A power analysis using G*Power (Faul et al., 2007) determined that the achieved statistical power of the logistic regression analysis in this study was .61, with a sample size of 255, an effect size (odds ratio) of 1.42, $Pr(Y=1|X=1)H0 = 0.14$, and $p < 0.05$. A complete description of the data analysis is provided in Chapter 4.

Chapter 4: Results

The current study used descriptive statistics, Pearson correlations, chi-square goodness of fit tests, Kruskal-Wallis tests, one-way ANOVA, and logistic regression analysis to investigate the prevalence of personal mental health problems and help seeking, as well as the perceived barriers to and predictors of help seeking for personal mental health problems in mental health counselors. The preliminary and main data analysis processes and results are described below.

Preliminary Data Analysis

After cleaning the data (see Procedures section in Chapter 3), descriptive statistics (mean, median, mode, standard deviation, skewness, kurtosis, and frequency distributions) were calculated for the main study variables (see Appendix A, Table 4). A correlation table of the main study variables and covariates was also generated (see Appendix A, Table 5). Descriptive statistics (mean, median, mode, standard deviation, and frequency distributions, as appropriate for each variable data type) were also calculated for the personal experience variables (see Appendix A, Table 3) and demographic variables (see Appendix A, Table 2) gathered through the *Demographic and Personal Experience Questionnaire* (see Appendix B).

Analysis of Skewness and Kurtosis

The main study variables were examined for skewness and kurtosis (see Appendix A, Table 4) and found to be within the +/- 1 range recommended for normality (Wuensch, 2017), with the exception of the following variables: (a) *intentions to seek help from a mental health professional* subscale score **(**see *Mental Help-Seeking Intentions Scale - Mental Health Professional* subscale, Appendix F); (b) *perceived*

mental health-related stigma score (see *Barriers to Access to Care Evaluation Stigma Subscale,* Appendix C); (c) *discrimination experience* scores (see discussion of calculation of scores in Chapter 3: Measures: *Demographic and Personal Experience Questionnaire*); and (d) *positive role model experience* scores (see discussion of calculation of scores in Chapter 3: Measures: *Demographic and Personal Experience Questionnaire*). Each of these exceptions is discussed in detail below.

Intentions to Seek Help from a Mental Health Professional Score. The distribution of *intentions to seek help from a mental health professional* scores (see *Mental Help-Seeking Intentions Scale - Mental Health Professional* subscale, Appendix F) in this sample had skewness of -1.34 (*SE* = 0.15) and kurtosis of 2.74 (*SE* = 0.31), indicating a potentially non-normal distribution (Wuensch, 2017). The mode of the *intentions to seek help from a mental health professional* score (see *Mental Help-Seeking Intentions Scale - Mental Health Professional* subscale, Appendix F) was equal to the scale maximum of 6. A score of 6 on this scale indicates a response of "definitely true" to the statement "I would intend to seek help from a mental health professional (Hammer & Spiker, 2018). Examination of the distribution of scores in this sample found that 52.2% (*n* = 133) scored 6 ("definitely true"), and 85.3% (*n* = 215) scored 5 or 6 ("true" or "definitely true"), with a mean score of 5.36 and standard deviation of only 0.80.

Although normality is not a requirement of logistic regression analysis, because of the extreme ceiling effect in this sample, a decision was made to recode the ordinal subscale score as a categorical variable with "true" or "definitely true" coded as "1," and "definitely false," "false," "somewhat false," and "somewhat true" coded as "0." This

recoded categorical variable was used in the logistic regression analysis described in the Main Analysis section below.

Perceived Mental Health-Related Stigma Score. The *perceived mental health-related stigma* score (see *Barriers to Access to Care Evaluation Stigma Subscale*, Appendix C) distribution in this sample had skewness of 2.02 (*SE* = 0.16) and kurtosis of 5.54 (*SE* = 0.30) which were both outside the recommended range for normality (Wuensch, 2017). According to Clement et al. (2012), scores on the *Barriers to Access to Care Evaluation Stigma Subscale* (see Appendix C) range from 0.00 to 3.00, and represent the degree to which *perceived mental health-related stigma* has been a barrier to help seeking, with a score of 0.00 indicating "not at all," a score of 1.00 indicating "a little", a score of 2.00 indicating "a lot," and a score of 3.00 indicating "quite a lot".

Examination of the frequency distribution of *perceived mental health-related stigma* scores (see *Barriers to Access to Care Evaluation Stigma Subscale*, Appendix C) in this sample found that 34.5% (*n* = 88) of scores were 0.00 ("not at all") and 94.1% (*n* = 240) of the scores were less than 1.00 ("a little"), indicating a large floor effect in this sample. A square root transformation was performed on the *perceived mental health-related stigma* score (*Barriers to Access to Care Evaluation Stigma Subscale*, Appendix C) to reduce the skewness and kurtosis. The transformed variable had skewness of 0.48 (*SE* = 0.15) and kurtosis of -0.58 (*SE* = 0.30) which were within the recommended limits of normality (Wuensch, 2017). The transformed variable was used in all the one-way ANOVA tests to satisfy the normality requirement.

Discrimination Experience Scores. Several composite scores were calculated from responses to the *experience of discrimination and loss of status from disclosure of*

mental health problems and the *experience of discrimination and loss of status from disclosure of mental health treatment* questions on the *Demographic and Personal Experience Questionnaire,* Appendix B (see the Measures section in Chapter 3 for details of the calculation of these scores). When these composite scores were examined for skewness and kurtosis, the distribution of *personal experience of discrimination for disclosure of mental health problems* subtotal scores had skewness of 0.95 (*SE* = 0.15) and kurtosis of 3.22 (*SE* = 0.30), which was outside the recommended limits for normality (Wuensch, 2017). Similarly, the distribution of *personal experience of discrimination for disclosure of treatment* subtotal scores had skewness of 0.63 (*SE* = 0.15) and kurtosis of 4.57 (*SE* = 0.30), which was also outside the recommended limits for normality (Wuensch, 2017).

The distribution of composite *personal discrimination experience* total scores had acceptable skewness of 0.08 (*SE* = 0.15) and much lower kurtosis of 1.54 (*SE* = 0.30), as did the composite *observed discrimination experience* with skewness of -0.05 (*SE* = 0.30). Although normality is not a requirement for logistic regression analysis, a decision was made to use the composite *personal discrimination experience* and *observed discrimination experience* scores rather than the subscale scores to simplify the interpretation of the analysis.

Positive Role Model Experience Scores. Composite positive role model experience scores were calculated from responses to the *positive experience of role model disclosure of mental health problems* questions and the *positive experience of role model disclosure of mental health treatment* questions in the *Mental Help-Seeking Intentions Scale - Mental Health Professional* subscale (see Appendix F; see the Measures section

in Chapter 3 for details of the calculation of these composite scores). When these composite scores were examined for skewness and kurtosis, the distribution of the composite *positive experience of role model disclosure of mental health problems* scores had skewness of -1.29 (*SE* = 0.15) and kurtosis of 1.82 (0.30), with both skewness and kurtosis outside the recommended +/- 1 range for normality (Wuensch, 2017). The distribution of the composite *positive experience of role model disclosure of mental health treatment* scores had skewness of -0.83 (*SE* = 0.15) and kurtosis of 1.03 (*SE* = 0.31), with both skewness and kurtosis within the normal range recommended for normality.

Since logistic regression does not have an assumption of normality and positive experience of role model disclosure of both mental health problems and treatment were predictors in one of the main study hypotheses, the decision was made to include both the *positive experience* of *role model disclosure of mental health problems* score and the *positive experience* of *role model disclosure of mental health treatment* score in the logistic regression analysis.

Demographic and Personal Experience Covariates for Logistic Regression Analysis

To identify potential demographic and personal experience factors and covariates for the logistic regression analysis, Pearson correlations were calculated between the main study variables and the demographic and personal experience variables gathered in the *Demographic and Personal Experience Questionnaire* (see Appendix B). Upon examination of the correlation tables (see Appendix A, Table 5 and Appendix A, Table 6), no statistically significant correlations were found between the *intentions to seek help from a mental health professional* outcome variable (see Mental Help-Seeking Intentions

Scale, Appendix F) and any of the demographic or personal experience variables (see *Demographic and Personal Experience Questionnaire*, Appendix B). To reduce Type 1 error, a *p* value of .001 was used for significance. No additional covariates or factors were added to the logistic regression model.

Analysis of Assumptions of Logistic Regression Analysis

Before performing the main logistic regression analysis, the data were examined for violations of the assumptions of *linearity of independent variables and logits* (log odds), and *multicollinearity*, using methods and guidelines recommended by Wuensch (2020). The recoded categorical *intentions to seek help from a mental health professional* score (see *Mental Help-Seeking Intentions Scale - Mental Health Professional* subscale, Appendix F) was the dependent variable used in the logistic regression model. To test for the linearity assumption, a Box-Tidwell test was conducted by creating a logistic regression model which included the predictor variables as well as interaction variables for each of the predictor variables and its log (see method described in Wuensch, 2020). Only the *personal mental health-related stigma* log interaction variable was statistically significant. Because there was only a slight correlation between this variable and *intentions to seek help from a mental health professional* (Pearson's $r = -.13$, $p < .05$), making it unlikely to be a statistically significant predictor, a decision was made to exclude *personal mental health-related stigma* from the model to avoid any violations of the linearity assumption.

To test for multicollinearity, regression analyses were performed using the main variables and the outcome variable in the logistic regression model. Variable inflation factors (VIF) ranged from 1.051 to 1.357, well below the cutoff of 10 for

multicollinearity (Tabachnick, Fidell, & Ullman, 2019). Tolerance values ranged from .737 to .951, also well above the 0.1 cutoff, indicating no multicollinearity (Tabachnick, Fidell, & Ullman, 2019). Pearson correlations between predictor variables were also examined to confirm that none were greater than .70 (see Appendix A, Table 5). Based on these tests, the main variables were determined to have met the assumptions for logistic regression, except for *personal mental health-related stigma*, which was excluded from the model.

Main Data Analysis

The results of the data analysis for each of the study hypotheses are described below.

Analysis of Hypothesis 1

To test Hypothesis 1 that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples*, frequency distributions were generated for responses to the *personal experience of mental health problems* and *personal experience of mental health treatment* questions on the *Demographic and Personal Experience Questionnaire* (see Appendix B). A summary of these frequency results can be found in Appendix A, Table 3. Chi-square goodness of fit tests were then conducted to compare the prevalence frequencies found in the study sample of mental health counselors (observed frequencies) with the prevalence frequencies found in other study samples (expected frequencies). The Chi-square Goodness of Fit Calculator (Stangroom, 2018) was used in this analysis. The results of

the chi-square goodness of fit analyses are described in detail below and summarized in Appendix A, Table 7.

Prevalence of Mental Health Problems. To determine the prevalence of personal experience of mental health problems in this sample, a frequency distribution of responses to the "have you had any mental health problems since you were licensed as a mental health counselor?" question on the *Demographic and Personal Experience Questionnaire* (see Appendix B) was constructed (see Appendix A, Table 3). Examination of the frequency distribution found that 62.6% of participants (n = 159) reported experiencing a mental health problem during the time since they were licensed as a mental health counselor, and 37.4% (n = 95) had not. The "no mental health problem" group included 92 participants who responded "No" to this question and 3 participants who responded "I don't know" to this question for a total of 95 participants.

A chi-square goodness of fit test determined that there was no statistically significant difference between the prevalence of mental health problems (n = 159, 62.6%) found in the study sample of mental health counselors and the prevalence of mental health problems (62.7%, n = 425) found in a sample of UK clinical psychologists (Tay et al., 2018), X^2 (1, N = 255) = 0.00, p > .05. A chi-square goodness of fit test also determined that there was no statistically significant difference between the prevalence of mental health problems (n = 159, 62.6%) found in the study sample of mental health counselors and the prevalence of mental health problems (n = 1149, 60%) found in a sample of UK medical doctors (Cohen et al., 2016) , X^2 (1, N = 255) = 0.72, p > .05. These results supported the study hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar*

to that found in other healthcare provider and mental health professional samples (see Appendix A, Table 7).

Contrary to the study hypothesis, a chi-square goodness of fit test determined that the mental health problem prevalence (n = 159, 62.6%) found in the study sample of mental health counselors was statistically significantly higher than the prevalence (n = 1,033, 49%) found in a sample of US female physicians (Gold et al., 2016), X^2 (1, N = 255) = 18.19, $p < .001$. A chi-square goodness of fit test also determined that the mental health problem prevalence (n = 159, 62.6%) found in the study sample of mental health counselors was statistically significantly higher than the prevalence (n = 40, 40.8%) found in a sample of Australian psychologists, nurses, psychiatrists, and social workers (Edwards & Crisp, 2017), X^2 (1, N = 255) = 18.19, $p < .001$. These results did not support the study hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples* (see Appendix A, Table 7)..

Types of Mental Health Problems Experienced. To determine the types of mental health problems experienced in the study sample of mental health counselors, a frequency distribution of responses to the question "what types of mental health problems have you experienced?" on the *Demographic and Personal Experience Questionnaire* (see Appendix B) was constructed (see Appendix A, Table 3). An examination of the frequency distribution found the most cited mental health problems were anxiety (n = 127, 49.8%), depression (n = 102, 40.0%), and stress (n=94, 59.1%). A chi-square goodness of fit test determined that the prevalence of depression (n = 102, 40.0%) reported in the study sample of mental health counselors was statistically significantly

lower than the prevalence of depression (*n* = 352, 82.8%) reported in a sample of UK clinical psychologists (Tay et al, 2018), X^2 (1, N = 159) = 72.79, $p < .001$. A chi-square goodness of fit test determined that the prevalence of anxiety (*n* = 127, 49.8%) reported in the study sample of mental health counselors was statistically significantly higher than the prevalence of anxiety (*n* = 179, 42.1%) reported in a sample of UK clinical psychologists (Tay et al, 2018), X^2 (1, N = 159) = 43.78, $p < .001$. These results did not support the study hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples* (see Appendix A, Table 7).

Mental Health Treatment Prevalence Rates. To determine the prevalence of mental health treatment in the study sample of mental health counselors, a frequency distribution of the "have you received treatment for personal mental health problems since you were licensed?" question on the *Demographic and Personal Experience Questionnaire* (see Appendix B) was constructed (see Appendix A, Table 3). Of the 159 participants who indicated personal experience of a mental health problem, examination of the frequency distribution found that 138 (86.8%) reported they had received treatment. More participants reported seeing a mental health professional for supervision (*n* = 222, 87.7%) or for personal growth (*n*=192, 75.3%), than for help with a mental health problem (*n* = 138, 54.1%). Having reported seeing a mental health professional for personal growth was strongly correlated with having reported seeing a mental health professional for mental health problems, $r(163) = .78$, $p < .01$.

In support of the study hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples*, a chi-square goodness of fit test determined that there was no statistically significant difference between the prevalence of mental health treatment (n = 138, 86.8%) found in the study sample of mental health counselors and the prevalence of mental health treatment (n = 357, 84%) found in a sample of UK clinical psychologist (Tay et al., 2018), X^2 (1, N = 138) = 0.92, $p > .05$.

Contrary to the study hypothesis, a chi-square goodness of fit test determined that the prevalence of mental health treatment (n = 138, 86.8%) found in the study sample of mental health counselors was statistically significantly higher than the prevalence of mental health treatment (n = 478, 41%) found in a sample of UK medical doctors (Cohen et al., 2016), X^2 (1, N = 138) = 137.8, $p < .001$, statistically significantly higher than the prevalence of mental health treatment (n = 959, 45.9%) found in a sample of US female physicians (Gold et al., 2016), X^2 (1, N = 138) = 107.07, $p < .001$, and statistically significantly higher than the prevalence of mental health treatment (n = 57, 59.4%) found in a sample of Australian psychologists, nurses, psychiatrists, and social workers (Edwards & Crisp, 2017), X^2 (1, N = 255) = 49.47, $p < .001$. These results did not support the study hypothesis (see Appendix A, Table 7).

Treatment Provider Preferences. To determine the treatment provider preferences of mental health counselors in the study sample, a frequency distribution of responses to the statements “if I had a mental health concern, I would intend to seek help from a [mental health professional, medical doctor, phone line]” in the *Mental Help-*

Seeking Intentions Scale (see Appendix F) was constructed (see Appendix A, Table 3). Examination of the frequency distribution found that 84.4% (*n* = 215) of participants responded "true" or "definitely true" to the statement "if I had a mental health concern I would intend to seek help from a mental health professional," whereas only 29.1% (*n* = 74) responded "true" or "definitely true" to the statement "if I had a mental health concern I would intend to seek help from a medical doctor," and only 4.7% (*n* = 12) responded "true" or "definitely true" to the statement "if I had a mental health concern I would intend to seek help from a phone line."

A similar frequency distribution was constructed from responses to the "from which of the following have you received treatment for personal mental health problems?" question on the *Demographic and Personal Experience Questionnaire* (see Appendix B). An examination of this frequency distribution found the most cited treatment provider type was "mental health counselor" (*n* = 88, 63.7%), followed by "medical doctor" (*n* = 38, 27.5%). These results are summarized in Appendix A, Table 3. Comparable results were not available from other healthcare provider or mental health professional studies reviewed to test the study hypothesis.

Current Mental Health and Treatment Status. To determine the current mental health status of study participants, frequency distributions of responses to the "I am currently having mental health problems (yes/no)?" question and responses to the "I am currently receiving treatment for my mental health problem (yes/no)?" question on the *Demographic and Personal Experience Questionnaire* (see Appendix B) were constructed (see Appendix A, Table 3). Examination of these frequency distributions found that 31% (*n* = 79) of the respondents reported that they were currently experiencing

a mental health problem and 69.6% (*n* = 55) were currently receiving treatment from a mental health professional for that problem.

As another assessment of the current mental health status of study participants, a frequency distribution of *Kessler Screening Scale for Psychological Distress* (*K6*; see Appendix D) scores, categorized by level of distress (see Kessler et al., 2003 and Prochaska et al., 2012), was also constructed (see Appendix A, Table 3). Examination of this frequency distribution found that 5.1% of respondents (*n* = 13) had scores indicating "severe distress (meet criteria for DSM-V diagnosis)," 38.4% (*n* = 98) had scores indicating "moderate distress (meet some criteria for DSM-V diagnosis)," and 56.5% (*n* = 144) had scores indicating "no distress." A chi-square goodness of fit test determined that the proportion of participants in the current study who reported that they were currently experiencing a mental health problem (*n* = 79, 31%) was statistically significantly lower than the proportion of respondents whose *K6* scores indicated "moderate distress," X^2 (1, N = 255) = 6.58, *p* = .01.

A chi-square goodness of fit test also determined that there was no statistically significant difference between the prevalence of severe distress (*n* = 13, 5.1%), as measured on the *Kessler Screening Scale for Psychological Distress* (Appendix D) in the current study sample of mental health counselors and the prevalence of high burnout (*n* = 26, 5.2%) as measured on the Professional Quality of Life Scale (Third Edition) in a sample of American Counseling Association counselors (Lawson, 2007), X^2 (1, N = 255) = 0.07, *p* = .797. These results supported the study hypothesis (see Appendix A, Table 7).

The 2018 United States Substance Abuse and Mental Health Services Administration (SAMHSA) health survey used the *Kessler Screening Scale for*

Psychological Distress (see Appendix D) as one of its measures of the prevalence of mental health problems meeting DSM-V criteria in the general population. A chi-squared test determined that the prevalence of mental health problems meeting DSM-V criteria (*n* = 13, 5.1%), as measured by the *Kessler Screening Scale for Psychological Distress* (*K6*; Appendix D) found in the current study sample of mental health counselors was statistically significantly lower than the prevalence of mental health problems meeting DSM-V criteria (*n* = 46.6 million, 18.9%) found in a US general population survey (SAMHSA, 2018), X^2 (1, N = 255) = 31.69, $p < .001$. This result did not support the study hypothesis.

Analysis of Hypothesis 2

To test Hypothesis 2 that *mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates*, frequency distributions of responses to the "have you disclosed personal mental health problems to anyone?" and "to whom have you disclosed personal mental health-related treatment?" questions (see *Demographic and Personal Experience Questionnaire*, Appendix B) were constructed (see Appendix A, Table 8). Examination of these frequency distributions found that, of those participants who reported having experienced a mental health problem during the time since licensure, 94.3% (*n* = 150) reported that they had disclosed that problem to someone. The most cited disclosures were to a family member (*n* = 143, 95.3%) or to a friend (*n* = 136, 90.7%). The next most cited disclosures were to a professional colleague (*n* = 92, 61.3%) or to a clinical supervisor (*n* = 44, 29.3%).

To explore disclosure of mental health-related treatment in this sample, frequency distributions of responses to the "have you disclosed personal mental health-related treatment to anyone?" and "to whom have you disclosed personal mental health-related treatment?" questions (see *Demographic and Personal Experience Questionnaire*, Appendix B) were constructed (see Appendix A, Table 8). An examination of these frequency distributions found that, of those respondents who reported having received treatment for a mental health problem during their professional career, 95.6% (n = 132) reported having disclosed their treatment to someone. The most cited disclosures were to family (n = 119, 90.2%) and friends (n = 119, 90.2%). The next most cited disclosures were to a professional colleague (n = 88, 66.7%) or clinical supervisor (n = 47, 35.6%).

An analysis was also conducted to explore the future disclosure intentions of respondents who reported not having experienced any mental health problems during the time since they were licensed (n = 92, 36.1%). To explore these future disclosure intentions, frequency distributions of responses to the "if you experienced a mental health problem in the future would you disclose that to anyone?" and "to whom have you disclosed personal mental health problems?" questions (see *Demographic and Personal Experience Questionnaire*, Appendix B) were constructed (see Appendix A, Table 8). Examination of these frequency distributions found that 90.2% (n = 83) of the respondents who reported never having had a mental health problem reported that they would disclose a future mental health problem to someone. The most cited disclosures were to a family member (n = 66, 79.5%) or a friend (n = 62, 74.7%). The next most cited disclosures were to a professional colleague (n = 45, 54.2%), and to a mentor (n = 22, 26.5%).

All these analyses found that the most cited disclosures (both actual past and intended future disclosures) were to a family member or a friend. These results supported the study hypothesis that *mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates*.

Analysis of Hypothesis 3

To test Hypothesis 3 that *fear of disclosure, fear of loss of status and discrimination, and desire to handle on one's own will be the most commonly cited barriers to help seeking among mental health counselors*, an analysis of the aggregate frequency distributions of the responses to individual items listed on the *Barriers to Access to Care Evaluation* (*BACE*; see Appendix C) was performed. Barriers were ranked by aggregating the frequencies of all or a subset of positive responses to the question "this barrier has stopped, delayed, or discouraged you from getting or continuing professional care for a mental health problem" for each item on the *BACE* scale.

Four different aggregate frequency distributions were constructed using different criteria for counting positive responses and selecting cases, namely: (a) all positive responses ("a little," "a lot," and "quite a lot") to each item across the entire sample (see Appendix A, Table 9); (b) only strongly positive responses ("a lot" and "quite a lot") to each item across the entire sample (see Appendix A, Table 10); (c) all positive responses ("a little," "a lot," and "quite a lot") to each item across the subgroup of respondents who reported experiencing a mental health problem for which they did not seek treatment (see Appendix A, Table 11); and (d) only strongly positive responses ("a lot" and "quite a

lot") to each item across the subgroup of respondents who reported experiencing a mental health problem for which they did not receive treatment (see Appendix A, Table 12).

In support of the study hypothesis, an examination of each of the four aggregate frequency distributions found that the most cited barrier to help seeking in all four was "wanting to solve the problem on my own." The next most cited barriers were also the same in each of the four aggregate frequency distributions examined, namely: "not being able to afford the financial costs involved;" "difficulty taking time off from work;" and "thinking the problem would get better by itself," although the specific rank order varied by aggregate grouping. In the aggregate ranking of strongly positive responses of participants who reported they had experienced a mental health problem for which they did not receive treatment, "having had a previous bad experience with mental health care" was the 4th highest ranked barrier. Contrary to the study hypothesis, the highest ranking of "concern that people I know might find out" (*fear of disclosure*) was 9th, and the highest ranking of "concern about what people at work might think, say, or do" (*fear of loss of status and discrimination*) was 13th in this sample of mental health counselors.

Analysis of Hypothesis 4

To test Hypothesis 4 that *attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors*, individual items on the *Barriers to Access to Care Evaluation* (see Appendix C) were categorized as structural or attitudinal barriers, using criteria defined in Clement et al. (2012). Of the 30 items on the *Barriers to Access to Care Evaluation* (see Appendix C), eight were categorized as structural, and 22 were categorized as attitudinal. Barriers were ranked by aggregating the frequencies of all or a subset of

positive responses to the question "this barrier has stopped, delayed, or discouraged you from getting or continuing professional care for a mental health problem" for each item on the *Barriers to Access to Care Evaluation* (see Appendix C) scale. Four different aggregate frequency distributions were constructed using different criteria for counting positive responses and selecting cases, namely: (a) all positive responses ("a little," "a lot," and "quite a lot") to each item across the entire sample (see Appendix A, Table 9); (b) only strongly positive responses ("a lot" and "quite a lot") to each item across the entire sample (see Appendix A, Table 10); (c) all positive responses ("a little," "a lot," and "quite a lot") to each item across the subgroup of respondents who reported experiencing a mental health problem for which they did not seek treatment (see Appendix A, Table 11); and (d) only strongly positive responses ("a lot" and "quite a lot") to each item across the subgroup of respondents who reported experiencing a mental health problem for which they did not receive treatment (see Appendix A, Table 12).

An examination of the four most cited barriers in each of the four aggregate frequency distributions found that each included at least two of the following structural barriers: "not being able to afford the financial costs involved;" "difficulty taking time off from work;" and "being unsure where to go to get professional care." These results challenged the study hypothesis that *attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors* and suggested that structural barriers to help seeking were as important as attitudinal barriers to help seeking in this sample.

Analysis of Hypothesis 5

To test Hypothesis 5 that *mental health counselors who have disclosed mental health problems and treatment will have statistically significantly lower personal and perceived mental health-related stigma and help-seeking self-stigma scores than mental health counselors who have never disclosed mental health problems or help seeking*, one-way ANOVA tests were conducted. Groups were assigned based on responses to the "have you disclosed mental health problems?" and "have you disclosed mental health treatment?" questions on the *Demographic and Personal Experience Questionnaire* (see Appendix B).

The analysis of variance found no statistically significant differences between the "disclosed a mental health problem" (n = 150) and "never disclosed a mental health problem" (n = 13) group mean scores for *personal mental health-related stigma* (*Negative Stereotypes Subscale,* Appendix G), $F(1,158) = 1.62$, $p = .205$, $\eta_p^2 = .010$, for *perceived mental health-related stigma* (*Barriers to Access to Care Evaluation Stigma Subscale,* Appendix C), $F(1,161) = 1.40$, $p = .239$, $\eta_p^2 = .009$, or for *help-seeking self-stigma* (*Self-Stigma of Seeking Help,* Appendix H), $F(1,159) = 0.37$, $p = .542$, $\eta_p^2 = .002$, in this sample.

Similarly, the analysis of variance found no statistically significant differences between the "disclosed mental health treatment" (n = 132) and "never disclosed mental health treatment" (n = 6) group mean scores for *personal mental health-related stigma* (*Negative Stereotypes Subscale,* Appendix G), $F(1,133) = .718$, $p = .398$, $\eta_p^2 = .005$, for *perceived mental health-related stigma* score (*Barriers to Access to Care Evaluation Stigma Subscale,* Appendix C), $F(1,136) = 1.55$, $p = .215$, $\eta_p^2 = .011$, or for *help-seeking*

self-stigma score (*Self-Stigma of Seeking Help,* Appendix H), $H(1) = 0.10$, $p = .754$, in this sample. Note: A Kurskal-Wallis one-way analysis of variance was used due to heteroscedasticity (significant Breusch-Pagan test) found in the one-way ANOVA for *help-seeking self-stigma* scores (see *Self-Stigma of Seeking Help,* Appendix H). These results did not support the study hypothesis.

A post hoc one-way ANOVA was also conducted with groups assigned based on responses to the "if you experienced a mental health problem in the future would you disclose that to anyone?" question on the *Demographic and Personal Experience Questionnaire* (see Appendix B). This analysis of variance determined that the group mean *personal mental health-related stigma* (see *Negative Stereotypes Subscale*, Appendix G) score in the "would disclose in the future" group ($n = 83$) was statistically significantly lower than that found in the "would not disclose in the future" group ($n = 9$), $F(1, 90) = 16.52$, $p = .000$, $\eta_p^2 = .16$, in this sample. The effect size of this result was large, based on Cohen's standards (1983).

No statistically significant group differences were found in the "would disclose in the future" and "would not disclose in the future" group mean scores for *perceived mental health-related stigma* (see *Barriers to Access to Care Evaluation Stigma Subscale,* Appendix C), $F(1,90 = 1.71$, $p = .194$, $\eta_p^2 = .019$, or for *help-seeking self-stigma* (see *Self-Stigma Of Seeking Help,* Appendix H), $H(1) = 2.93$, $p = .09$, in this sample. Note: A Kurskal-Wallis one-way analysis of variance was used due to heteroscedasticity (significant Breusch-Pagan test) found in the one-way ANOVA for *help-seeking self-stigma* (see *Self-Stigma Of Seeking Help,* Appendix H).

Analysis of Hypothesis 6

To test Hypothesis 6 that *mental health counselors who have disclosed mental health problems and help seeking will be more willing to refer clients to colleagues with mental health problems than mental health counselors who have not disclosed mental health problems and help seeking,* a one-way ANOVA was conducted. Groups were assigned based on responses to the "have you disclosed mental health problems?" and "have you disclosed mental health treatment?" questions on the *Demographic and Personal Experience Questionnaire* (see Appendix B). A mean *willingness to refer* score was calculated for each group based on the Likert-type scale response to the "I would refer clients to a mental health counselor I believed had a mental health problem" statement in the *Demographic and Personal Experience Questionnaire* (see Appendix B).

The analysis of variance found no statistically significant differences between the "disclosed a mental health problem" (n = 150) and "never disclosed a mental health problem" (n = 13) group mean scores for *willingness to refer* (see *Demographic and Personal Experience Questionnaire,* Appendix B)., $F(1,162) = 0.61$, $p = .812$, $\eta_p^2 = .00$, in this sample. Similarly, the analysis of variance found no statistically significant differences between the "disclosed mental health treatment" (n = 132) and "never disclosed mental health treatment" (n = 6) group mean scores for *willingness to refer* (see *Demographic and Personal Experience Questionnaire*, Appendix B), $F(1,137) = 2.61$, $p = .138$, $\eta_p^2 = .02$, in this sample. These results did not support the study hypothesis.

A post hoc one-way ANOVA was also conducted to determine if *willingness to refer* was affected by experience of mental health problems and treatment. To perform this analysis, groups were assigned based on responses to the "have you had any mental

health problems since you were licensed?" and " have you received treatment for personal mental health problems since you were licensed?" questions in the *Demographic and Personal Experience Questionnaire* (see Appendix B).

This post hoc analysis of variance determined that the group mean *willingness to refer* (see *Demographic and Personal Experience Questionnaire*, Appendix B) score was statistically significantly higher among those who reported experiencing a personal mental health problem (n = 159), than among those who reported they had not experienced a personal mental health problem (n = 94), $H(1) = 19.06$, $p < .001$. Note: A Kurskal-Wallis one-way analysis of variance was used due to heteroscedasticity found in the one-way ANOVA (positive Breusch-Pagan test).

Similarly, an analysis of variance determined that the group mean *willingness to refer* (see *Demographic and Personal Experience Questionnaire*, Appendix B) score was statistically significantly higher among those who reported that they had received treatment for a personal mental health problem (n = 137) than among those participants who reported that they had not received treatment for a mental health problem (n = 116), $F(1, 251) = 11.32$, $p = .001$, $\eta_p^2 = .04$, in this sample.

Logistic Regression Analysis (Hypothesis 7 and Hypothesis 8)

Because both Hypothesis 7 and Hypothesis 8 involved predictors of *intentions to seek help from a mental health professional*, the decision was made to conduct one binary logistic regression analysis to test both of these hypotheses, using the predictor variables from both hypotheses in a single logistic regression model. The results of this binary logistic regression analysis are described below and summarized in Appendix A, Table 13.

In this model, the dependent variable, *intentions to seek help from a mental health professional* (see *Mental Health Seeking Intentions Scale*, Appendix F) was recoded as a categorical variable with "1" indicating a response of "definitely true," or "true" to the statement "if I had a mental health concern, I would intend to see a mental health professional," and "0" indicating a response of "definitely false," "false," "somewhat false," and "somewhat true." The model predictor variables included *perceived mental health-related stigma* (see *Barriers to Access to Care Evaluation*, Appendix C), *help-seeking self-stigma* (see *Self-Stigma of Seeking Help* Scale, Appendix H), *personal discrimination experience*, *observed discrimination experience* (see *Demographic and Personal Experience Questionnaire*, Appendix B), *experience of positive role model disclosure of mental health problems* and e*xperience of positive role model disclosure of mental health treatment* (see *Demographic and Personal Experience Questionnaire*, Appendix B). *Personal mental health-related stigma* (see *Negative Stereotypes Subscale*, Appendix G) was excluded from the model due to violation of the linearity assumption of logistic regression (see Preliminary Analysis section).

The results of the Hosmer-Lemeshow goodness of fit test were not significant ($p = .129$), indicating that the model was a good fit to the data. There was also a statistically significant difference between the -2 Log likelihood of the baseline model and the study model ($\chi^2 = 31.28$, $df = 6$, $p < .001$), also indicating a good model fit. The Nagelkerke R^2 was .21, indicating that the model explained approximately 21% of the variation in the outcome. The model predicted 86.3% of the responses correctly; however, because the *intentions to seek help from a mental health professional* scores were so skewed toward positive responses in this sample ($n = 203/240$, 84.6%), the model only improved upon

chance by 1.7%. Both *help-seeking self-stigma* and *positive role model treatment experience* were statistically significant predictors in this model, but no other statistically significant predictors were found.

Analysis of Hypothesis 7. The results of this analysis supported Hypothesis 7 that *more positive help-seeking role models will predict increased help-seeking intentions for mental health problems in mental health counselors*. The odds ratio for e*xperience of positive role model disclosure of mental health treatment* was 1.42, with a 95% confidence interval of [1.07, 1.88], predicting a 42% increase in likelihood of *intention to seek help from a mental health professional* for every unit of increase in e*xperience of positive role model disclosure of mental health treatment* in this sample. Although this result was statistically significant, the relatively small sample size and small improvement in predictability of the model limited the interpretation of the result.

Analysis of Hypothesis 8. These results both supported and challenged study Hypothesis 8 that *more help-seeking self-stigma, perceived mental health-related stigma, personal mental health-related stigma, and personal or observed experience of discrimination for mental health problems and/or help seeking will predict less help-seeking intentions for mental health problems in mental health counselors*. The odds ratio for *help-seeking self-stigma* in this sample was 0.90 with a 95% confidence interval of [0.85, 0.96], predicting a 10% decrease in likelihood of *intention to seek help from a mental health professional* for every unit of increase in *help-seeking self-stigma* in this sample. Although this result supported one of the predictions of Hypothesis 8, the relatively small sample size and small improvement in predictability of the model limited

the interpretation of this result. Contrary to the study hypothesis, none of the other predictors proposed in Hypothesis 8 were statistically significant predictors in this model.

Summary

The results of the analysis of Hypothesis 1 both supported and challenged the hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other healthcare provider and mental health professional samples* (see Appendix A, Table 7). In support of the hypothesis, the analysis determined that there were no statistically significant differences between the prevalence of mental health problems and mental health treatment found in the study sample of mental health counselors and that found in a sample of UK clinical psychologists (Tay et al., 2018). The analysis also found no statistically significant difference between the prevalence of mental health problems found in the current study sample and that found in a sample of UK medical doctors (Cohen et al., 2016). Contrary to the study hypothesis, the analysis found that the prevalence of mental health problems and treatment found in the current study sample was statistically significantly higher than that found in a sample of US female physicians (Gold et al., 2016) and in a sample of Australian mental health professionals (Edwards & Crisp, 2017). The analysis also found that the prevalence of treatment found in the current study sample was statistically significantly higher than that found in a sample of UK physicians (Cohen et al., 2016).

An analysis of the current mental health status of the study participants, found that there was no statistically significant difference between the proportion of participants in the study sample of mental health counselors who met criteria for “severe distress,” as

measured on a screening instrument, and the proportion of participants who scored high on a burnout scale in a sample of counselors in an American Counseling Association national survey (Lawson, 2007) but was statistically significantly lower than the prevalence found in a US general population survey (SAMHSA, 2018). An analysis also determined that the proportion of mental health counselors in the study sample who identified as currently having a mental health problem was statistically significantly smaller than the proportion of respondents found to have "moderate distress," as measured by a screening instrument.

The results of the analysis of Hypothesis 2 supported the hypothesis that *mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates*. The most cited disclosures of mental health problems in the study sample of mental health counselors were to a family member (n = 143, 95.6%) or a friend (n = 136, 90.7%). Similarly, the most cited disclosures of mental health treatment in the study sample were to a family member (n = 125, 94.7%) or a friend (n = 119, 90.2%). An analysis of future disclosure intentions also found the most cited disclosures were to a family member (n = 66, 79.5%) or a friend (n = 62, 74.7%).

The results of the analysis of Hypothesis 3 both supported and challenged the hypothesis that *fear of disclosure, fear of loss of status and discrimination, and desire to handle on one's own will be the most commonly cited barriers to help seeking among mental health counselors*. In support of the study hypothesis, "wanting to solve the problem on my own" was the most cited barrier to help seeking in this sample. Contrary to the study hypothesis, the next most cited barriers to help seeking in this sample were

"not being able to afford the financial costs involved;" "difficulty taking time off from work;" and "thinking the problem would get better by itself." The highest ranking for "concern that people I know might find out" (*fear of disclosure*) was 9th, and the highest ranking for "concern about what people at work might say or do" (*fear of loss of status and discrimination*) was 13th among barriers to help seeking in this sample,

The results of the analysis of Hypothesis 4 did not support the study hypothesis that *attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors*. Of the top four most cited barriers to seeking help from a mental health professional in this sample, two were categorized as structural barriers and two were categorized as attitudinal barriers, indicating that structural and attitudinal barriers were equally important in this sample of mental health counselors.

The results of the analysis of Hypothesis 5 did not support the study hypothesis that *mental health counselors who have disclosed mental health problems and treatment will have statistically significantly lower personal and perceived mental health-related stigma and help-seeking self-stigma scores than mental health counselors who have never disclosed mental health problems or help seeking*, finding no statistically significant differences in mean scores between the two groups. A post hoc analysis did find that respondents who reported they had not experienced a mental health problem in the past but would disclose to someone if a mental health problem occurred in the future had statistically significantly lower mean *personal mental health-related stigma* scores than the "would not disclose to someone in the future" group.

The results of the analysis of Hypothesis 6 did not support the hypothesis that *mental health counselors who have disclosed mental health problems and help seeking will be more willing to refer clients to colleagues with mental health problems than mental health counselors who have not disclosed mental health problems and help seeking*, finding no statistically significant difference in the mean *willingness to refer* scores between the "disclosed" and "never disclosed" groups in this sample. A post hoc analysis did find that the group mean *willingness to refer* score of respondents who reported having experienced a mental health problem was statistically significantly higher than in the group of respondents who reported they had not experienced a mental health problem. The analysis also found that the group mean *willingness to refer* score of respondents who reported having received mental health treatment was statistically significantly higher than in the group of respondents who reported they had not received mental health treatment, in the current study sample.

The results of the analysis of Hypothesis 7 supported the hypothesis that *more positive help-seeking role models will predict increased help-seeking intentions for mental health problems in mental health* counselors, finding that an increase in e*xperience of positive role model disclosure of mental health treatment* was associated with an increase in the likelihood of *intention to seek help from a mental health professional* in this sample. Although this result was statistically significant, the relatively small sample size and small improvement in predictability of the model limited the interpretation of the result.

The results of the analysis of Hypothesis 8 supported one prediction of the study hypothesis that *more help-seeking self-stigma, perceived mental health-related stigma,*

personal mental health-related stigma, and personal or observed experience of discrimination for mental health problems and/or help seeking will predict less help-seeking intentions for mental health problems in mental health counselors, finding that an increase in *help-seeking self-stigma* scores was associated with a decrease in the likelihood of *intention to seek help from a mental health professional* in this sample of mental health counselors. Although this result was statistically significant, the relatively small sample size and small improvement in predictability of the model limited the interpretation of this result. Contrary to the study hypothesis, none of the other predictors proposed in the hypothesis were statistically significant predictors in this model.

Chapter 5: Discussion

In 2018, the United States Substance Abuse and Mental Health Services Administration (SAMHSA) reported the results of a national survey of US adults and estimated that 18.9% (*n* = 46.6 million) had experienced symptoms of mental health problems which met criteria for a DSM-V diagnosis in the past year. Of those, the researchers estimated that only 42.8% (*n* = 19.8 million) received treatment for mental health problems (SAMHSA, 2018). Although this was a general population survey, there is evidence to suggest that unrealistic expectations of resilience and mental wellness within the mental health profession (Lawson, 2007; Lawson & Venart, 2005; Lawson et al., 2007; Young & Lambie, 2007), compassion fatigue (Skovholt & Trotter-Mathison, 2011; Smith & Moss, 2009; Stebnicki, 2007), and vicarious trauma (Saakvitne et al., 1996; Skovholt & Trotter-Mathison, 2011; Smith & Moss, 2009) may leave mental health professionals even more vulnerable to mental health problems and more likely to experience barriers to treatment than the general population.

Given the primacy of the therapeutic relationship in positive counseling outcomes (Beutler, 2000; Rogers, 1961; Wampold, 2015) and the importance of counselor mental health in maintaining an empathic therapeutic relationship and optimum job performance (Lawson et al., 2007; Lee et al., 2007), it is important for the counseling profession to support and encourage mental health counselors to practice self-care and seek help for their own mental health problems (Lawson & Venart, 2005; Lawson, 2007). To this end, it is helpful to understand the prevalence of mental health problems among mental health counselors and to identify barriers they may experience in seeking help for those mental health problems, as well as positive factors that may encourage help seeking.

Although a number of studies have explored the prevalence of mental health problems and perceived barriers to and predictors of help seeking for mental health problems in the general population (Boerema et al., 2016; Clement, et al., 2015; Hantzi et al., 2019; Horsfield at al., 2019; Klik et al., 2019; Mojtabai et al., 2011; Pattyn et al., 2015; Schnyder, et al., 2017; Schomerus et al., 2019; Tomczyk et al., 2020), only a handful of studies have looked at help seeking for mental health problems in healthcare providers (Cohen, 2016; Gold et al., 2016). Even fewer studies have looked at help seeking for mental health problems among mental health professionals in general (Edwards & Crisp, 2017; Lawson, 2007; Tay et al., 2018). No studies were found which investigated help seeking for mental health problems in mental health counselors. This is a serious gap in the literature which the current study attempted to address.

Discussion of Findings

The current study explored the prevalence of personal mental health problems and help seeking, as well as the perceived barriers to and predictors of help seeking for personal mental health problems in mental health counselors. The following discussion of the study hypotheses and findings is organized around these three broad research topics, namely: (a) prevalence of mental health problems and help seeking in mental health counselors; (b) barriers to help seeking for mental health problems in mental health counselors; and (c) predictors of help seeking for mental health problems in mental health counselors..

Prevalence of Mental Health Problems and Help Seeking in Mental Health Counselors

The intent of the hypotheses described below was to explore the prevalence of mental health problems and help seeking in the current study sample of mental health

counselors. Discussion of hypotheses and findings related to disclosure of mental health problems and treatment is also included in this section. Findings for each of these hypotheses are discussed in detail below.

Comparison of Study Results with Other Population Samples. The current study found that 62.6% (*n* = 159) of participants had experienced a mental health problem during the time since they were licensed. Of those, 86.8% (*n* = 138) had received treatment. This is a much higher treatment rate than the treatment prevalence rate (*n* = 19.0M, 42.8%) found in the US general population (SAMSHA, 2018) which might be expected in a sample of mental health counselors who have been trained to recognize mental health problems and to seek appropriate treatment. Of more concern, however, were the 13.2% (*n* = 21) of study participants who reported that they had experienced a mental health problem during the time since licensure but had not received treatment for that mental health problem. Given what we know about the importance of counselor mental health in providing quality mental health care to clients (Lawson et al., 2007; Lee et al., 2007), this is not an inconsequential number of potentially impaired mental health counselors who did not receive mental health treatment. These findings underscore the importance of raising awareness of these issues within the counseling profession and developing effective interventions to encourage and support help seeking in mental health counselors.

When asked about current mental health status and treatment, 31% (*n* = 79) reported that they were currently experiencing a mental health problem. This is a somewhat surprising finding in that the prevalence of mental health problems in the US general population is only 18.9% (*n* = 46.6M, SAMSHA/CDC, 2018), although the US

general population survey defined mental health problems as meeting criteria for a DSM-V diagnosis, which was likely not the assumption of respondents in the current study sample. Nevertheless, for almost one-third of respondents to have reported that they were currently experiencing a mental health problem is somewhat alarming. One might be tempted to attribute this result to the general disruption caused by the pandemic in the US during the time the study survey was administered; however, a modified version of the *Kessler Screening Scale for Psychological Distress* (*K6,* Appendix E) which asked respondents about their symptoms "in general" (in contrast to the "in the last 30 days" prompt used in the original version) was also administered as part of the study survey. Analysis of the results of the original and modified versions of the screening instrument found that the proportion of respondents who demonstrated "moderate distress" when asked about symptoms in the past 30 days (n = 98, 38.4%) was actually statistically significantly smaller than the proportion who demonstrated "moderate distress" when asked about symptoms "in general" (n = 111, 43.5%). This finding suggested that the current mental health status reported in the study sample was not unusually high due to some current event like the pandemic and did not exceed perceived general levels of distress in this sample.

Of even more concern, however, was the finding that 30.4% (n = 24) of those respondents who reported that they were currently experiencing a mental health problem were not receiving treatment for their current mental health problem. This finding underscores once again the importance of raising awareness of these issues within the counseling profession and finding ways to encourage and support help seeking for mental health problems, particularly in this subgroup of mental health counselors.

Also of interest was the finding that, although 43.5% (*n* = 111) of respondents scored in the "moderate distress" or "severe distress" range on the *K6* (see Appendix D) in this sample, only 31% (*n* = 79) of respondents in this sample reported that they were currently experiencing a mental health problem. This finding raises the possibility that the prevalence of mental health problems might have been under-reported in this sample, possibly due to a failure to recognize symptoms, but more likely due to some type of social desirability bias or mental health-related or help-seeking self-stigma. Another sign of possible under-reporting of mental health problems in this sample was the finding that 75.3% (*n* = 192) of respondents reported that they had seen a mental health counselor for personal growth, but only 54.1% (*n* = 138) reported that they had received treatment for a mental health problem. It is possible that this difference was due to a subgroup of mental health counselors who actually did not have a mental health problem and did seek counseling purely for personal growth, but given the strong correlation, $r(163) = .78$, $p < .01$, found between respondents who had seen a mental health counselor for personal growth and respondents who had received treatment for a mental health problem, it is also possible that this difference was due to mental health-related stigma and a desire to avoid being marked as someone who had experienced a mental health problem. More research is needed to explore these relationships.

Considered more broadly, the results of the analysis of Hypothesis 1 both supported and challenged the hypothesis that *the prevalence of mental health problems and help seeking in the study sample of mental health counselors will be similar to that found in other health care provider and mental health professional samples*. It is interesting that both the prevalence of reported mental health problems and the

prevalence of reported treatment experience found in the current study sample were found to be statistically significantly the same or higher than the prevalence found in samples of other healthcare providers and mental health professionals. It is possible that this difference reflected an actual difference in the mental health of these samples, but it seems more likely that it reflected differences in the level of perceived mental health-related stigma or other attitudes about mental health problems and treatment within different healthcare and mental health professional samples (Clement et al., 2015; Cohen et al., 2016; Edwards & Crisp, 2017; Gold et al., 2016; Tay et al., 2018).

Although only speculation, it is possible that if there was greater willingness to identify as a person with a mental health problem and to seek help for that problem in the current study sample of mental health counselors than in samples of other healthcare professionals, this might be a consequence of the more wellness and strengths-based focus of the mental health counseling profession, in contrast with the medical disease model of emotional distress more common in other healthcare and mental healthcare professions. More research is needed to understand the differences found in the prevalence of mental health problems and treatment between different healthcare and mental health professional population samples.

Disclosure of Mental Health Problems and Treatment. The current study found that of those participants who reported having experienced a mental health problem during the time since licensure, 94.3% (n = 150) reported they had disclosed that problem to someone. The most cited disclosures were to a family member (n = 143, 95.3%) or to a friend (n = 136, 90.7%). Of those respondents who reported having been treated for a mental health problem during their professional career, 95.6% (n = 132) reported having

disclosed their treatment to someone. The most cited disclosures were to family (*n* = 125, 94.7%) and friends (*n* = 119, 90.2%). These results supported Hypothesis 2 that *mental health counselors will be more likely to have disclosed mental health problems and help seeking to friends and family than to professional associates*. These results were similar to those found in a sample of UK psychologists (Tay et al., 2018) and in a sample of UK medical doctors (Cohen et al., 2016). An analysis of future disclosure intentions in respondents who reported they had not experienced a mental health problem during the time since licensure also found the most cited disclosures were to a family member (*n* = 66, 79.5%) or a friend (*n* = 62. 74.7%). Similar future intended disclosure results were found in a sample of UK medical doctors (Cohen et al., 2016).

Disclosure of Mental Health Problems and Treatment and Stigma. The results of the analysis of Hypothesis 5 did not support the hypothesis that *mental health counselors who have disclosed mental health problems and treatment will have statistically significantly lower personal mental health-related stigma, perceived mental health-related stigma, and help-seeking self-stigma scores than mental health counselors who have never disclosed mental health problems or help seeking*, finding no statistically significant difference in the mean stigma scores of the "disclosed" and "never disclosed" groups.

Contrary to the current study finding, a study of UK clinical psychologists (Tay et al., 2018) found that participants who had disclosed mental health problems and treatment to no one had higher scores on mental health-related self-stigma measures. Similar findings were reported in a systematic review of the literature on help seeking and mental health-related stigma (Clement et al., 2015). It is possible that the current

study did not find statistically significant relationships between disclosure and stigma because the effect sizes of these relationships were small, and the current study did not have had sufficient power to detect these relationships due to very small "have not disclosed" group size in the current study sample relative to the UK study sample (Tay et al., 2018). The Tay et al. (2018) study and the studies analyzed in the systematic literature also used different instruments to measure the different types of mental health-related stigma, making meaningful comparison of results impossible. Future studies of mental health counselors might ask more questions about reasons participants decided not to disclose mental health problems and treatment and explore the relationship between help-seeking disclosure, help-seeking intentions, and actual help seeking to better understand the help-seeking decision making process. These findings also point to a need for future studies to use a more consistent set of measures to enable meaningful study comparisons.

A post hoc analysis did find that the group mean *personal mental health-related stigma* score of mental health counselors who reported that they had not experienced a mental health problem but would disclose mental health problems in the future was statistically significantly lower than the group mean score of those who reported that they would not disclose in the future in this sample. Although the sample size was small in the post hoc analysis, the effect size was large ($\eta_p^2 = .16$), suggesting another area for future research.

Willingness to Refer Clients to Colleagues with Mental Health Problems. The results of the analysis of Hypothesis 6 did not support the hypothesis that *mental health counselors who have disclosed mental health problems and help seeking will be more*

willing to refer clients to colleagues with mental health problems than mental health counselors who have not disclosed mental health problems and help seeking, finding no statistically significant differences in the mean *willingness to refer* scores of the "disclosed" and "never disclosed" groups. A post hoc analysis did find that the group mean *willingness to refer* scores of respondents who reported that they had experienced a mental health problem or received mental health treatment during the time since licensure were statistically significantly higher than the group mean scores in respondents who had not. Edwards and Crisp et al. (2017) included this question in their survey of Australian mental health professionals but did not report their results, so more research is needed to understand the relationships between *willingness to refer* and personal experience of mental health problems and treatment.

Barriers to Help Seeking for Mental Health Problems in Mental Health Counselors

The results of the analysis of Hypothesis 3 both supported and challenged the hypothesis that *fear of disclosure, fear of loss of status and discrimination, and desire to handle on one's own will be the most commonly cited barriers to help seeking among mental health counselors*. As predicted, "wanting to solve the problem on my own" was the most cited barrier to help seeking in this sample. This finding supported the study hypothesis and confirmed similar findings in a US general adult population sample (Mojtabai et al., 2011) and in a sample of Australian mental health professionals (Edwards & Crisp, 2017).

The next most cited barriers to help seeking in this sample were "not being able to afford the financial costs involved," "thinking the problem would get better by itself," and "taking time off work." These results did not support the study hypothesis but were

similar to those in a study of Australian mental health professionals which found that "thinking the problem would get better by itself," and "taking time off work," were the second and third most cited barriers (Edwards & Crisp, 2017). Among respondents who had experienced a mental health problem but did not receive treatment, "having had previous bad experiences with professional care for mental health" replaced "thinking the problem would get better by itself" in the ranking of most cited barriers in this study sample. In contrast, Tay et al. (2018) reported that "fear of being judged negatively," "fear of discrimination," and "negative impact on self-image" were the most important barriers to help seeking in a sample of UK clinical psychologists. Gold et al. (2016) reported that "didn't need help," "insufficient time," "shame," and "fear of disclosure" were the most important barriers in a sample of US female physicians. A systematic review of help seeking barrier studies found "fear of disclosure" and "fear of discrimination" as the most cited barriers (Clement et al., 2015).

It is difficult to know why the most cited barriers were different in many of the samples reviewed, but some of those differences might be due to the use of different barrier measures. The Edwards and Crisp (2017) study used the same *Barriers to Access to Care Evaluation* (see Appendix C) used in the current study and had the most similar results. The other studies mentioned above did not specify the questions they asked to measure barriers to help seeking in their studies, so it is possible they did not include the same barrier questions as the current study. The systematic literature review of help seeking barrier and predictor studies (Clement et al., 2015) included stigma as a required search term in their review selection criteria, possibly excluding some studies which looked at more structural barriers to help seeking.

Demographic and professional differences between the samples might also account for differences in perceived barriers to help seeking, although Mojtabai et al. (2011) found only age and illness severity were statistically significant predictors of perceived structural barriers to help seeking and did not find any statistically significant demographic predictors of perceived attitudinal barriers. Future research might explore perceived barriers to help seeking for mental health problems in different demographic and personal experience subgroups of mental health counselors to better understand barriers to help seeking in the mental health counselor population.

The results of the analysis of Hypothesis 4 did not support the study hypothesis that *attitudinal barriers will be more commonly cited than structural barriers as reasons not to seek help for mental health problems among mental health counselors*. In fact, results for both the entire study sample and for the subgroup of respondents who reported having experienced a mental health problem for which they did not seek treatment, found that of the top four most cited barriers to seeking help from a mental health professional, half were categorized as structural barriers and half were categorized as attitudinal barriers. In each of the other studies reviewed, attitudinal barriers were more commonly cited than structural (Edwards & Crisp, 2017; Gold et al., 2016; Mojtabai et al., 2011; Tay et al., 2018).

As discussed in the analysis of Hypothesis 3 above, it is difficult to know why the most cited barriers were different in many of the samples reviewed, but some of those differences might be due to the use of different barrier measures. It is also possible that demographic differences between the different study samples reflected differences in financial and other resources which made structural barriers less relevant for other study

samples. Tomcyzk et al. (2020) suggested that there is a natural progression from concern with structural barriers to concern with attitudinal barriers in the help seeking process, with attitudinal barriers becoming more salient as structural barriers have been overcome. It is also possible that socioeconomic and cultural differences like access to national healthcare in the UK or higher average incomes for US physicians might make structural barriers less relevant to respondents in some study samples than they might be for respondents in a sample of US mental health counselors who might have less access to affordable healthcare and lower average incomes (U.S. Census Bureau, 2017).

Future research with larger and more diverse samples of mental health counselors is needed to understand the relationship of personal and demographic factors to perceived barriers to help seeking in mental health counselors. This research is needed both to help identify counselors who might be most vulnerable to structural barriers and to find ways to remove those barriers. Unlike attitudinal barriers which can often be removed through education and encouragement, structural barriers require structural solutions, and research is needed to raise awareness of these problems and inform those solutions.

Predictors of Help Seeking for Mental Health Problems in Mental Health Counselors

The results of the analysis of Hypothesis 7 supported the hypothesis that *more positive help-seeking role models will predict increased help-seeking intentions for mental health problems in mental health* counselors. The current study found that more *positive experience of role model disclosure of treatment* was associated with increased likelihood of *intention to seek help from a mental health professional* in this sample. Hypothesis 7 was based on Bandura's social learning theory (1979) which predicts that when humans observe behaviors in others that result in positive outcomes, they are more

likely to imitate those behaviors. It follows logically from Bandura's theory that mental health counselors who have had role models who disclosed positive experiences of mental health treatment would be more likely to seek help from a mental health professional, as the study results suggest. However, the relatively small sample size and small improvement in predictability of the current study's logistic regression model signal the need for caution in interpreting these results. More research is needed with larger and more diverse samples of mental health counselors to confirm this relationship.

The results of the analysis of Hypothesis 8 both supported and challenged the hypothesis that *more help-seeking self-stigma, perceived mental health-related stigma, personal mental health-related stigma, and personal or observed experience of discrimination for mental health problems and/or help seeking will predict less help-seeking intentions for mental health problems in mental health counselors*. In support of the hypothesis, the analysis found that increased *help-seeking self-stigma* was associated with decreased likelihood of *intention to seek help from a mental health professional*. Contrary to the study hypothesis, none of the other predictors proposed in Hypothesis 8 were found to be statistically significant predictors in the logistic regression model.

Although the analysis of Hypothesis 8 did find that *help-seeking self-stigma* was a statistically significant negative predictor of *intentions to seek help from a mental health professional*, the relatively small sample size and small improvement in predictability of the model signal the need for caution in interpreting this result. The failure of the current study to find any other statistically significant predictors of *intentions to seek help from a mental health professional* in this sample might also be due to the relatively small sample size and modeling problems resulting from floor and ceiling effects in several of the

study measures. The effect sizes generally reported for these predictor relationships in other study samples were small and might have required more statistical power to detect than was available in the current study. More research is needed with larger and more diverse samples of mental health counselors to explore potential predictors of help seeking in mental health counselors.

Several of the other studies reviewed also found that *help-seeking self-stigma* was a negative predictor of *help-seeking intentions* for mental health problems, including two systematic literature reviews of studies of stigma and help seeking (Clement et al., 2015; Schnyder et al., 2017), a general population study of Greek adults (Hantzi et al., 2019), a study of a sample of UK clinical psychologists (Tay et al., 2018), and a study of a sample of untreated depressed German adults (Tomczyk et al., 2020).

Although the current study did not find a statistically significant relationship between either *personal mental health-related stigma* or *perceived mental health-related stigma* and *intentions to seek help from a mental health professional*, studies with other population samples did find these relationships. In their systematic literature review of studies of stigma and help seeking, Schnyder et al. (2017) found a statistically significant negative relationship between *personal mental health-related stigma* and *help seeking*, although they did not find a statistically significant relationship between *perceived mental health-related stigma* and *help seeking*,. A negative association between *personal mental health-related stigma* and *help seeking* was also found in a Dutch general adult population study (Boerema et al., 2016), in a German study of depressed adults (Schomerus et al., 2019), and in a Greek general adult population study (Hantzi et al., 2019). None of the studies reviewed looked specifically at *discrimination experience*,

although the current study found a small to moderate correlation (Pearson's $r = .23$, $p < .01$) between the items on the *discrimination experience* questions on the *Demographic and Personal Experience Questionnaires* and *perceived mental health-related stigma* scores (see *Barriers to Access to Care Evaluation Stigma Subscale*, see Appendix C), suggesting a possible relationship between these two constructs.

Each of the studies reviewed used different measures to operationalize its help-seeking and stigma constructs, making it difficult to compare the results. In fact, only Schomerus et al. (2019) operationalized the help-seeking construct as *help seeking intentions*, as in the current study. Hantzi, et al. (2019) and Tay et al. (2018) operationalized the help seeking construct as *help-seeking attitudes*, while Boerema et al. (2016) operationalized the construct as *help-seeking behaviors*, and Schnyder, at al. (2017) included only studies of *help-seeking behaviors* in their systematic literature review. Clement et al. (2015) included studies of *help-seeking attitudes*, *help-seeking intentions*, and *help-seeking behaviors* in their systematic literature review but did not include any analysis that differentiated study results by help-seeking definition. All these differences in study methods make study comparisons difficult and potentially misleading and point to the need for more studies to explore the relationship between help-seeking intentions, attitudes, and behaviors, using a more consistent set of study measures to enable meaningful study comparisons.

Summary of Study Findings

In exploring the prevalence of mental health problems and help seeking in the study sample of mental health counselors, the study found that 62.6% ($n = 159$) of participants had experienced a mental health problem during the time since they were

licensed. Of those, 13.2% (*n* = 21) reported that they had not received treatment for their mental health problem. Given what we know about the importance of counselor mental health in providing quality mental health care to clients (Lawson et al., 2007; Lee et al., 2007), this is not an inconsequential number of potentially impaired mental health counselors who did not receive mental health treatment and underscores the importance of raising awareness of these issues within the counseling profession and developing effective interventions to encourage and support help seeking in mental health counselors.

When asked about current mental health status and treatment, 31% (*n* = 79) reported that they were currently experiencing a mental health problem. This is a somewhat surprising finding in that the prevalence of mental health problems in the US general population is only 18.9% (*n* = 46.6M, SAMSHA/CDC, 2018). Of more concern, however, was the finding that 30.4% (*n* = 24) of those respondents reported that they were not receiving treatment for their current mental health problem. Also of interest was the finding that, although 43.5% (*n* = 111) of respondents in this sample scored in the "moderate distress" or "severe distress" range on the *Kessler Screening Scale for Psychological Distress* (see Appendix D), only 31% (*n* = 79) of respondents reported that they were currently experiencing a mental health problem. This finding raises the possibility that the prevalence of mental health problems might have been under-reported in this sample, possibly due to a failure to recognize symptoms, but more likely due to some type of social desirability bias or mental health-related or help-seeking self-stigma.

It is interesting that both the prevalence of reported mental health problems and the prevalence of reported treatment experience found in the current study sample were

found to be statistically significantly the same or higher than the prevalence found in samples of other healthcare providers and mental health professionals. It is possible that this difference reflected an actual difference in the mental health of these samples, but it seems more likely that it reflected differences in the level of perceived mental health-related stigma or other attitudes about mental health problems and treatment within different healthcare and mental health professional samples.

In exploring disclosure of mental health problems and help seeking in the current study sample of mental health counselors, study results supported the hypothesis that mental health counselors would be more likely to disclose mental health problems and treatment to family and friends than to professional associates. The study results did not support the hypothesis that *mental health counselors who had disclosed mental health problems and treatment would have statistically significantly lower perceived mental health-related stigma, personal mental health-related stigma, and help-seeking self-stigma that mental health counselors who had not disclosed mental health problems or treatment*. A post hoc analysis did find that respondents who had not had a mental health problem but reported they would disclose that problem if it occurred in the future had lower *personal mental health-related stigma* scores than those who did not intend to disclose future mental health problems.

In exploring perceived barriers to help seeking in this sample of mental health counselors, the study found that “wanting to solve the problem on my own,” “not being able to afford the financial costs involved,” “difficulty taking time off,” “thinking the problem would get better by itself,” and “having had bad experiences of mental health care” were the most cited barriers to help seeking from a mental health professional in

this sample. The importance of structural barriers to help seeking in the current study sample raises important questions for the counseling profession about how to ensure that all mental health counselors have the time and financial means to access quality mental health care for their own personal mental health problems. These findings did not support the study hypotheses.

In exploring predictors of intentions to seek help from a mental health counselor in this sample of mental health counselors, the study found that more *positive experience of role model disclosure of treatment* increased the likelihood of *intention to seek help from a mental health professional*, while more *help-seeking self-stigma* decreased the likelihood of *intention to seek help from a mental health professional.* Although *positive experience of role model disclosure of treatment* and *help-seeking self-stigma* were determined to be statistically significant predictors, the relatively small sample size and small improvement in predictability of the current study's logistic regression model signal the need for caution in interpreting these results

Limitations

One of the major limitations of this study was the use of availability sampling, which resulted in an unrepresentative sample of mental health counselors, skewed towards Caucasian mental health counselors (n = 217, 85.1%) with female sex (*n* = 222, 87.1%) from a non-representative sample of geographic regions, limiting the generalizability of the study findings (U.S. Census Bureau, 2017). Another important limitation of the study, inherent in all cross-sectional, correlational study designs, is that only associational, not causal, inferences can be made from the findings.

Another threat to the internal validity of the study findings was the use of a survey design which depended entirely on self-reports. Social desirability and other forms of respondent bias are established threats to the internal validity of all survey study results (Heppner, Wampold, & Kivlighan, 2015). This threat was compounded in this study because the very mental health-related and help-seeking stigmas under study were likely at play in the responses of participants to questions about their own biases, creating the paradoxical situation that the respondents with the most *personal mental health-related stigma*, *perceived mental health-related stigma*, and *help-seeking self-stigma* were likely the most vulnerable to social desirability bias.

Another limitation of the study was its relatively small sample size ($N = 255$) relative to the statistical power needed to detect the small effect sizes found in studies of help seeking in other healthcare provider and mental health professional samples, particularly when comparing subgroups of respondents who had experienced mental health problems and treatment and those respondents who had not. As in most social science research, there were also many potentially confounding demographic and personal experience variables not included in the study which threaten the internal validity of the study results.

One of the more serious limitations of the current study design was the lack of any instruments with strong evidence of validity and reliability which were developed specifically for use with mental health counselors. Most of the measures were developed with general population or undergraduate student samples, except for the *positive role model experience* and *discrimination experience* Likert-type scale questions which were developed informally for use with this study without any type of factor analysis with

other samples of mental health counselors. The lack of measures specifically designed for use with mental health counselors might also help to explain the floor effects found in the *perceived mental health-related stigma* (see *Barriers to Access of Care Evaluation,* Appendix C) scores in this sample, as well as the ceiling effects found in the *intentions to seek help from a mental health professional* (*Mental Health Seeking Intentions,* Appendix F) scores in this sample. Three of the study measures were also found to have very low internal consistency reliability in the current study sample, with Cronbach's alpha of .43 on the *Mental Health Seeking Intentions Scale* (Appendix F), Cronbach's alpha of .62 on the *Negative Stereotypes Subscale* (see Appendix G) and Cronbach's alpha of .63 on the *experience of positive role model disclosure of treatment* scale on the *Demographic and Personal Experience Questionnaire* (see Appendix B), further threatening the internal validity and reliability of the study findings.

Future Directions in Research

Despite the limitations of this study, it was the first to explore the prevalence of mental health problems, barriers to, and predictors of help seeking for mental health problems in a sample of mental health counselors and suggests several areas of inquiry for future research. Future studies of prevalence, barriers to, and predictors of help seeking for mental health problems with larger and more representative samples of mental health counselors are needed to provide more generalizable answers to these questions. Larger and more diverse study samples would also enable more study of the prevalence of mental health problems and help seeking, as well as the barriers to and predictors of help seeking and disclosure in subgroups of mental health counselors, based on race, ethnicity, socioeconomic status, geographic region, and personal and family

experience of mental health problems and treatment, and other personal experience and demographic variables. This is particularly important for future studies of discrimination experience and structural barriers to help seeking, which may be more salient factors in help-seeking decision making in more marginalized subgroups within the mental health counselor population. Future research might also look at the potential moderating effects of role model experience in this relationship.

Research into the effectiveness of different interventions to increase help seeking in mental health counselors is another important area for future study. More research is also needed to understand the help-seeking decision making process itself, beginning with the relationship between perceived barriers, help-seeking disclosure intentions, help-seeking intentions, and actual help-seeking behavior. Longitudinal studies to explore the relationship between predictors of help-seeking attitudes, help seeking intentions and actual help-seeking behavior are also needed. Another important area for future research would be the development of instruments for use specifically with mental health counselors. These instruments might include measures of perceived barriers to help seeking, measures of personal mental health-related stigma, measures of perceived mental health-related stigma, measures of help-seeking self-stigma, measures of role model experience, measures of discrimination experience, and measures of help-seeking intentions and attitudes and behaviors.

Implications for Counseling

Although the current study found that 62.6% (n = 138) of mental health counselors in this sample had experienced a mental health problem during the time since licensure, and of those, 86.2% (n = 138) had received treatment, another 13.2% (n = 21)

did not receive treatment. This is not an inconsequential number and underscores the need to raise awareness of this issue within the counseling profession. The study also found that 43.5% (*n* = 111) of respondents scored in the "moderate distress" or "severe distress" range on the *Kessler Screening Scale for Psychological Distress* (see Appendix D), although only 31% (*n* = 79) of respondents reported that they were currently experiencing a mental health problem. This finding suggests that as many as 12.5% (*n* = 32) of respondents in this sample were unaware that they had a mental health problem or were uncomfortable identifying as someone with a mental health problem. Of even more concern was the finding that 30.4% (*n* = 24) of those respondents who did report that they were currently experiencing a mental health problem reported that they were not receiving treatment for their current mental health problems.

All these findings suggest that there may be a substantial minority of mental health counselors who are suffering from a mental health problem and experiencing barriers to help seeking for those mental health problems. Due to the importance of counselor mental health in maintaining an empathic therapeutic relationship and optimum job performance (Lawson et al., 2007; Lee et al., 2007), it is imperative that counselor educators and other leaders within the counseling profession encourage more open dialogue about these issues and promote research to inform more effective interventions to support and encourage mental health counselors to practice self-care and seek professional mental health care for their own mental health problems.

It is also important to note that two of the four most cited barriers to help seeking in this sample were structural, not attitudinal barriers, namely, "not being able to afford the financial costs involved," and "difficulty taking time off from work." Unlike

attitudinal barriers which can often be removed through education and encouragement, structural barriers to help seeking require structural solutions to ensure that mental health counselors are aware of, and have the time, and financial means to access quality mental health care.

The study also found that the fourth most cited barrier to help seeking from a mental health professional among respondents who had experienced a mental health problem but did not receive treatment was “having had a previous bad experience with professional mental health care.” This finding raises the issue of how mental health counselors can find mental health professionals with experience and competence in working with mental health counselors. In many ways this is also a structural issue, as not all mental health counselors live in areas where there are many other mental health professionals or even know where to find competent and well-trained mental health professionals to help them with their personal mental health problems. More research is needed to determine how best to support mental health counselor access to quality mental health care.

The study finding that more *positive experience of role model disclosure of treatment* increased the likelihood of *intention to seek help from a mental health professional* suggests that more open discussion about mental health stigma and more sharing of positive personal experiences of mental health problems and treatment by counselor educators, supervisors, and other role models might be important ways to foster a more wellness-based culture that supports and encourages help seeking for mental health problems in mental health counselors.

The study finding that more *help seeking self-stigma* decreased the likelihood of *intention to seek help from a mental health professional*, coupled with the finding that the most cited barrier to treatment in this sample was "wanting to solve the problem on my own," suggest there might be a perception among mental health counselors that seeking help from a mental health professional should be the exception rather than the rule within the counseling profession. This finding underscores the importance of raising awareness of these issues and normalizing the experience of mental health problems and treatment within the profession.

Summary

The current study explored the prevalence of mental health problems and help seeking, as well as the barriers to and predictors of help seeking for mental health problems in a sample of mental health counselors. In exploring the prevalence of mental health problems and help seeking in the study sample of mental health counselors, the study found that 62.6% (n = 159) of participants had experienced a mental health problem during the time since they were licensed, and of those, 13.2% (n = 21) reported that they had not received treatment for their mental health problem. When asked about current mental health status and treatment, 31% (n = 79) reported that they were currently experiencing a mental health problem and 30.4% (n = 24) reported that they were not receiving treatment for that problem. Of even more concern, however, was the finding that 43.5% (n = 111) of respondents in this sample scored in the "moderate distress" or "severe distress" range on the *Kessler Screening Scale for Psychological Distress* (see Appendix D), suggesting that as many as 12.5% (n = 32) of the study respondents were experiencing mental health symptoms which they either had not identified as a mental

health problem or were uncomfortable describing in that way. Given what we know about the importance of counselor mental health in providing quality mental health care to clients (Lawson et al., 2007; Lee et al., 2007), these findings are concerning and underscore the importance of raising awareness of these issues within the counseling profession and developing effective interventions to encourage and support help seeking in mental health counselors.

In exploring perceived barriers to help seeking in this sample of mental health counselors, the study found that "wanting to solve the problem on my own," "not being able to afford the financial costs involved," "difficulty taking time off," "thinking the problem would get better by itself," and "having had bad experiences of mental health care" were the most cited barriers to help seeking from a mental health professional in this sample. The importance of structural barriers to help seeking in the current study sample raises important questions for the counseling profession about how to ensure that all mental health counselors are aware of and have the time and financial means to access quality mental health care for their own personal mental health problems.

In exploring predictors of intentions to seek help from a mental health counselor in this sample, the study found that more *experience of positive role model disclosure of treatment* increased the likelihood of *intention to seek help from a mental health professional*, while more *help-seeking self-stigma* decreased the likelihood of *intention to seek help from a mental health professional.* However, the relatively small sample size and small improvement in predictability of the current study's logistic regression model signal the need for caution in interpreting these results

Several limitations were found with the study design and methods which threaten the internal and external validity and reliability of the study findings. The most central of these was the use of availability sampling and a relatively small sample size, which resulted in a non-representative sample of mental health counselors, skewed towards Caucasian mental health counselors, with female sex (n = 222, 87.1%) from a non-representative sample of geographic regions. The use of a cross-sectional correlational design limited conclusions to associations rather than causality, while use of a self-report survey introduced potentially confounding effects from social desirability and other forms of respondent bias. Another important threat to the internal validity of the study findings was the lack of instruments developed for use with mental health counselors. The instruments used in the study were all developed using general population or undergraduate student samples, which resulted in floor and ceiling effects in some measures and low internal consistency reliability in other measures.

Future research studies of the prevalence of mental health problems, barriers to, and predictors of help seeking for mental health problems with larger, more diverse, and more representative samples of mental health counselors are needed to provide more generalizable answers to these questions and to enable study of these questions in personal experience and demographic subgroups of mental health counselors. Studies are also needed to develop instruments designed specifically for use with mental health counselors, including: measures of help-seeking attitudes and intentions; measures of personal mental health-related stigma; measures of perceived mental health-related stigma; measures of help-seeking self-stigma; and other potential barriers to and predictors of help seeking. Longitudinal studies would also help to clarify the relationship

between help seeking attitudes, help-seeking intentions, and help-seeking behavior in mental health counselors. Research into possible interventions to increase help seeking for mental health problems in mental health counselors is another important area for future study.

The current study findings have several important implications for the counseling profession. The prevalence findings suggest that there may be a substantial minority of mental health counselors who are suffering from a mental health problem and experiencing barriers to help seeking. It is imperative that counselor educators and other leaders within the counseling profession encourage more open dialogue about these issues and promote research to inform more effective interventions to support and encourage mental health counselors to seek professional mental health care for their own mental health problems. It is also important to note that two of the four most cited barriers to help seeking in this sample were structural, not attitudinal barriers, namely, "not being able to afford the financial costs involved," and "difficulty taking time off from work." Unlike attitudinal barriers which education and encouragement can often remove, structural barriers to help seeking require structural solutions to ensure that mental health counselors are able to find competent mental health care in their location, and have the time, and financial means to access quality mental health care.

The study findings that *positive experience of role model disclosure of treatment* increased the likelihood of *intention to seek help from a mental health professional* suggests that encouraging more open dialogue and sharing of personal mental health problems and treatment by role models, like professors, supervisors, and respected colleagues, might be important ways to increase more help seeking for mental health

problems in mental health counselors. The study finding that *help-seeking self-stigma* decreased the likelihood of *intention to seek help from a mental health professional* suggests that there is still work to be done to promote a culture of wellness within the counseling profession that normalizes the experience of mental health problems and treatment and encourages mental health counselors to seek help from mental health professionals for their personal mental health problems.

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Appendix A

Table 1

Studies of Predictors of and Barriers to Help Seeking for Mental Health-Related Problems

Help-Seeking Barrier	**Predictive Studies**		**Barrier Studies**		
	GP	**HP/MHP**	**GP**	**HP**	**MHP**
Perceived Need (+)	Horsfield (B); Schomerus (B,I)		Mojtabai (B)	Cohen (B,I); Gold (B)	
Self-reliance (-)			Mojtabai (B)	Cohen (B,I); Gold (B);	Edwards (B,I)
Treatment efficacy (+)	Tomczyk (B)		Mojtabai (B)	Fischbein (B,I)*	
Symptom severity (+)	Boerema (B); Horsfield (B); Mojtabai (B); Schomerus (B,I); Tomczyk (B)		Mojtabai (B)		
Fears of disclosure (-)			Clement (A,B,I)	Clement (A,B,I); Cohen (B,I); Dyrbye (A,B)*; Gold (B);	Edwards (B,I); Tay (A,B,D)
Fears of employment discrimination (-)			Clement (A,B,I)	Dyrbye (A,B)*; Gold (B); Cohen (B,I)	Edwards (B,I); Tay (A,B,D)
Perceived mental health-related stigma (-)	Clement (A,B,I); Schnyder (B)		Mojtabai (B); Clement (A,B,I)	Dyrbye (A,B)*; Clement (A,B,I); Fischbein (B,I)*	Tay (A,B,D)
Mental health-related self-stigma (-)	Clement (A,B,I); Schnyder (B)	Mullen (I); Tay (A,B,D)	Clement (A,B,I)	Dyrbye (A,B)*; Gold (B)	Tay (A,B,D)
Help-seeking stigma (-)	Boerema (B); Clement (A,B,I); Hantzi (A); Schnyder (B); Tomczyk (B)	Tay (A,B,D)	Clement (A,B,I)	Clement (A,B,I); Dyrbye (A,B)*	
Personal mental health-related stigma (-)	Boerema (B); Clement (A,B,I); Horsfield (B); Pattyn (A); Schnyder (B); Schomerus (B,I);		Clement (A,B,I)	Clement (A,B,I); Dyrbye (A,B)*;Fischbein (B,I)*; Gold (B);	Tay (A,B,D)
Structural barriers (-)	Mojtabai (B); Tomczyk (B)		Mojtabai (B)	Fischbein (B,I)*; Gold (B)	Edwards (B,I)
Mental health literacy	Schomerus (B,I); Tomczyk (B)				
Contact (+)	Hantzi (A); Pattyn (A)				
Gender:male (-)	Mojtabai (B); Pattyn A);	Cohen (D)			
Age (+)	Horsfield (B); Mojtabai (B)	Cohen (D)			
Ethnicity (+/-)	Clement (A,B,I)				

Note: GP=general population; MHP=mental health professional; HP=healthcare provider; *Medical/pharmacy students; +/- = relationship; B=behavior; I=intentions; A=attitudes; D=disclosure

Note: Boerema et al., 2016 (Netherlands); Cohen et al., 2016 (All); Clement, et al., 2015 (UK); Dyrbye et al., 2015 (US); Edwards & Crisp, 2017 (Australia); Fischbein & Bonfine, 2019 (US); Gold et al., 2016 (US); Hantzi et al., 2019 (Greece); Horsfield at al., 2019 (Germany); Mojtabai et al., 2011 (US); Mullen & Crowe, 2017 (US); Pattyn et al., 2015 (Belgium); Schomerus et al., 2019 (Germany); Schnyder, et al., 2017 (All); Tay et al., 2018 (UK); Tomczyk et al., 2020 (Germany)

Table 2

Sample Demographic Characteristics: Descriptive Statistics and Frequency Distributions

	f	%
Gender		
Female	219	85.9
Male	33	12.9
Other	3	1.2
Sex		
Female	222	87.1
Male	33	12.9
Pronoun		
She	216	84.7
He	34	13.3
Other	5	2.0
Race/Ethnicity[a]		
Caucasian	219	85.9
Latinx	13	5.1
African American	12	4.7
Asian	6	2.4
Native Hawaiian, Alaskan, American	3	1.2
Other (mixed)	3	1.2
Other	2	< 1.0
License		
LPC	143	56.1
LMHC	75	29.4
LCPC	21	8.2
LPCC	16	6.3
States by Region[b]		
Northeast	54	21.2
South	86	33.7
Midwest	82	32.2
West	32	12.5
Pacific	1	0.40
	Mean	SD
Age	47.54	12.83
Years Licensed	10.74	8.59

Note: items above are from the *Demographic and Personal Experience Questionnaire* (Appendix B)

Note[a]: "Other" recoded: "white," and " White British" (+2) added to "Caucasian" count; "Hispanic," and "Mexican" (+2) added to "Latinx" count; "bi-racial," "Mixed," and "Multi" (3) reported as "Other (mixed)"

Note[b]: "State" summarized by region per U.S. Census regional designation

Table 3

Frequency Distribution of Personal Experience of Mental Health Problems and Treatment

	f	%
Experienced a mental health problem since licensed		
Yes	159	62.6
No	92	36.2
Don't know	3	1.2
Mental health problems experienced		
Anxiety	127	79.9
Depression	102	64.0
Stress	94	59.1
Relationship issues	62	39.0
Trauma-related issues	39	24.5
PTSD	17	10.7
Eating disorder	12	7.5
Other (grief) [a]	8	5.0
Bipolar disorder	5	3.1
Substance use issues	4	2.5
Borderline disorder	3	1.9
Other (adjustment) [a]	3	1.9
Other	2	1.2
Received treatment for a mental health problem since licensed		
Yes	138	86.8
No	21	13.2
Treatment Received		
Mental health counselor	88	63.8
Medical doctor	38	27.5
Psychologist	36	26.1
Psychiatrist	36	26.1
Social worker	29	21.0
Other	8	5.8
Have seen a mental health counselor for personal growth since licensure	192	75.3
Have seen anyone for clinical supervision or consultation since licensure	222	87.1
Currently having a mental health problem		
Yes	79	31.0
No	169	66.3
Don't know	2	0.8
Currently receiving treatment for my mental health problem		
Yes	55	69.6
No	24	30.4
Current mental health status (last 30 days)[b]		
None to mild symptoms	144	56.5
Moderate symptoms	98	38.4
Severe symptoms	13	5.1
Current mental health status (in general)[c]		
None (less than 5)	134	52.5
Moderate symptoms (5 to 12)	111	43.5
Severe symptoms (greater than or equal to 13)	10	3.9

Note: items above are from the *Demographic and Personal Experience Questionnaire* (Appendix B)

Note[a]:"Other" recoded as: "Grief," and "complicated bereavement" (8) reported as "Other (grief)"; "Adjustment disorder when diagnosed with breast cancer," "menopausal very occasional Dep. Mood and anxiety," and "Perinatal Depression and Anxiety" reported as "Other (adjustment)"

Note[b]: *Kessler Screening Scale for Psychological Distress* (Appendix E; Kessler et al. 2003; Prochaska et al., 2012)

Note[c]: *Modifed Kessler Screening Scale for Psychological Distress* (Appendix F; Kessler et al. 2003; Prochaska et al., 2012)

Table 4

Descriptive Statistics for Main Study Variables

Variable	*N*	*Mean*	*SD*	*Median*	*Mode*	*Skewness*	*Skewness Std Error*	*Kurtosis*	*Kurtosis Std Error*
Perceived mental health-related stigma [a]	255	0.29	0.38	0.17	0.00	0.85	0.15	0.13	0.31
Discrimination experience [b]	255	15.25	7.70	16.0	16.0	-0.06	0.15	0.21	0.30
Personal experience	255	6.82	3.22	8.00	8.00	0.08	0.15	1.54	0.30
Disclosure of mental health problem	255	3.65	1.84	4.00	4.00	0.95	0.15	3.22	0.30
Disclosure of treatment	255	3.42	1.41	4.00	4.00	0.63	0.15	4.57	0.30
Observed experience	255	9.34	4.80	8.00	8.00	0.69	0.15	-0.05	.030
Disclosure of mental health problem	255	4.83	2.43	4.00	4.00	0.78	0.15	-0.09	0.30
Disclosure of treatment	255	4.60	2.48	4.00	4.00	0.77	0.15	-0.80	0.30
Mental health status (last 30 days) [c]	249	5.10	3.89	4.00	2.00	0.94	0.15	0.20	0.31
Mental health status (in general) [d]	253	5.17	3.63	4.00	2.00	0.85	0.15	0.28	0.30
Help-seeking intentions [e]	255	11.38	2.49	11.00	11.00	0.25	0.15	0.20	0.30
Mental health professional	252	5.36	0.80	6.00	6.00	-1.34	0.15	2.74	0.31
Medical doctor	254	3.69	1.45	4.00	4.00	-0.22	0.15	-0.79	0.30
Phone helpline	253	2.36	1.23	2.00	2.00	0.75	0.15	-.01	0.30
Personal mental health-related stigma [f]	252	7.90	2.66	8.00	5.00	0.85	0.15	0.13	0.30
Positive role model experience [g]	250	19.29	3.65	20..00	20.00	-1.06	0.15	1.48	0.30
Disclosure of mental health problem	253	9.52	2.29	10.00	10.00	-1.29	0.15	1.82	.030
Disclosure of treatment	251	9.79	1.75	10.00	10.00	-0.83	0.15	1.03	0.31
Help-seeking self-stigma [h]	250	17.63	6.15	17.63	16.00	1.02	0.15	0.48	0.31

Note [a]*:* Perceived mental health-related stigma = *Barriers to Access to Care Evaluation Self-Stigma Scale* (Appendix C)
Note [b]*:* Discrimination experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)
Note [c]*:* Mental health status (last 30 days): *Kessler Screening Scale for Psychological Distress* (Appendix D)
Note[d]*:* Mental health status (in general): *Modified Kessler Screening Scale for Psychological Distress* (Appendix E)
Note [e]*:* Help-seeking intentions: *Mental Health Seeking Intentions Scale* (Appendix F)
Note [f]*:* Personal mental health-related stigma: *Negative Stereotypes Subscale* (Appendix G)
Note [g]*:* Positive role model experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)
Note [h]*:* Help-seeking self-stigma: *Self-Stigma of Seeking Help* (Appendix H)

Table 5

Correlations of Main Study Variables and Covariates

Variable	*n*	*M*	*SD*	1	2	3	4	5	6	7	8	9	10
1. Perceived mental health-related stigma [a]	255	0.29	0.38	1	.02	.25**	.31*	.15*	-.25**	-.12	.48**	-.12	-.00
2. Personal discrimination experience[b]	255	6.82	3.21	.02	1	.27**	-.04	-.03	-.03	-.01	.01	.25**	.24**
3. Observed discrimination experience [c]	255	9.34	4.80	.25**	.27**	1	.09	.09	-.09	-.09	.16**	.09	.10
4. Mental health status (last 30 days) [d]	249	5.10	3.89	.31**	-.04	.09	1	.02	-.11	-.08	.20**	-.44**	-.35**
5. Personal mental health-related stigma [e]	252	7.90	2.66	.15*	-.03	.09	.02	1	-.13*	-.01	.15*	.16**	.17**
6. Help-seeking intentions[f]	252	5.36	0.80	-.25**	-.03	-.09	-.10	-.13*	.1	.27**	-.39**	.08	-.19**
7. Positive role model treatment experience [g]	251	9.79	1.75	-.12	-.01	-.09	-.08	.01	.27**	1	-.22**	-.03	-.10
8. Help-seeking self-stigma[h]	250	17.63	6.15	.48**	.01	.16**	.20**	.15*	-.39**	-.22**	1	-.04	.10
9. Mental health problem experience[i]	254	1.37	0.48	-.12	.26**	.07	-.44**	.16**	.08	-.03	-.04	.1	.79**
10. Mental health treatment experience[j]	254	1.46	0.50	-.00	.24**	.10	.35**	.17**	-.19**	-.10	.10	79**	1

Note: $^{*}p < .05$. $^{**}p < .01$.

Note [a]: Perceived mental health-related stigma: *Barriers to Access to Care Evaluation Self-Stigma Scale* (Appendix C)

Note [b]: Personal discrimination experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)

Note[c]: Observed discrimination experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)

Note[d]: Mental health status (last 30 days): *Kessler Screening Scale for Psychological Distress* (Appendix D)

Note[e]: Personal mental health-related stigma: *Negative Stereotypes Subscale* (Appendix G)

Note[f]: Help-seeking intentions: *Mental Health Seeking Intentions Scale – Mental Health Professional Subscale* (Appendix F)

Note[g]: Positive role model treatment experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)

Note[h]: Help-seeking self-stigma: *Self-Stigma of Seeking Help* (Appendix H)

Note[i]: Mental health problem experience: item (0=yes/1=no) on *Demographic and Personal Experience Questionnaire* (Appendix B)

Note[j]: Mental health treatment experience: item (0=yes/1=no) *Demographic and Personal Experience Questionnaire* (Appendix B)

Table 6

Correlations of Demographic Variables with Main Study Variables and Covariates

Variable	*n*	Age	License	State	Gender	Sex	Pronoun	Race	Years
1. Perceived mental health-related stigma[a]	255	-.20**	.01	.01	-.07	.08	-.08	-.06	-.11
2. Discrimination experience[b]	255	-.01	-.00	.04	.05	-.04	.04	.01	-.00
3. Mental health status[c]	249	.34**	.09	,04	.06	.04	-.07	-.07	-.25**
4. Personal mental health-related stigma[d]	252	.00	-.04	-.11	-.06	.04	-.03	.14*	-.00
5. Help-seeking intentions[e]	252	.10	-.05	-.10	-.04	.04	-.04	.04	.10
6. Positive role model experience[f]	250	-.08	.03	-.01	-.10	.07	-.05	.03	.09
7. Help-seeking self-stigma[g]	250	-.16*	-.00	-.09	-.01	.00	.01	.01	-.08

Note: $^{*}p < .05$. $^{**}p < .01$.
Note[a]: Perceived mental health-related stigma: *Barriers to Access to Care Evaluation Self-Stigma Scale* (Appendix C)
Note[b]: Discrimination experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)
Note[c]: Mental health status (last 30 days): *Kessler Screening Scale for Psychological Distress* (Appendix D)
Note[d]: Personal mental health-related stigma: *Negative Stereotypes Subscale* (Appendix G)
Note[e]: Help-seeking intentions: *Mental Health Seeking Intentions Scale – Mental Health Professional Subscale* (Appendix F)
Note[f]: Positive role model experience: based on items from *Demographic and Personal Information Questionnaire* (Appendix B)
Note[g]: Help-seeking self-stigma: Self-Stigma of Seeking Help (Appendix H)

Table 7

Comparison of Prevalence of Mental Health Problems and Treatment During Professional Career with Other Samples

Prevalence Type/Sample Comparison	*F*	*%*	*Chi-Square Value*	*p*
Prevalence of mental health problems[a]				
UK medical doctors (Cohen et al., 2016)	1149	60.0	0.72	.38
Australian mental health providers (Edwards & Crisp, 2017)	40	40.8*	49.97	.00
US female physicians (Gold et al., 2016)	1009	48.3	20.80	.00
UK clinical psychologists (Tay et al., 2018)[c]	425	62.7	0.00	.97
Prevalence of mental health treatment[b]				
UK medical doctors (Cohen et al., 2016)	478	41.0	137.8	.00
Australian mental health providers (Edwards & Crisp, 2017)[c]	57	59.4	49.47	.00
US female physicians (Gold et al., 2016)	959	45.9	107.07	.00
UK clinical psychologists (Tay et al., 2018)[c]	357	84.0	0.92	.37
Prevalence of Depression[d]				
UK clinical psychologists (Tay et al., 2018)	352	82.8	72.79	.00
Prevalence of Anxiety[e]				
UK clinical psychologists (Tay et al., 2018)	179	42.1	43.78	.00
Prevalence of current mental health problems				
US general adult population (SAMSHA/CDC, 2018)[f]	46.6M	18.9	31.69	.00
US general adult population (SAMSHA/CDC, 2018)[g]	46.6M	18.9	316.43	.00
Prevalence of current mental health treatment[h]				
US general adult population (SAMSHA/CDC, 2018)	19.0M	42.8	46.95	.00
US sample of ACA counselors (Lawson, 2007)	26	5.2%	0.07	.80

Note[a]*: n* = 159, 62.6% (frequency of responses to item from *Demographic and Personal Experience Questionnaire* (Appendix B)
Note[b]*: n* = 138, 86.8% (frequency of responses to item from *Demographic and Personal Experience Questionnaire* (Appendix B)
Note[c]: prevalence across lifetime, not limited to professional career
Note[d]*: n* = 102, 64.0% (frequency of responses to item from *Demographic and Personal Experience Questionnaire* (Appendix B)
Note[e]*: n* = 127, 79.9% (frequency of responses to item from *Demographic and Personal Experience Questionnaire* (Appendix B)
Note[f]: *n* = 13, 5.1% (frequency of scores in severe distress (>=13) range: *Kessler Screening Scale for Psychological Distress* (Appendix D)
Note[g]: frequency of responses to *current mental health problem* (*n* = 79, 31%) on *Demographic and Personal Experience Questionnaire* (Appendix B)
Note[h]: frequency of responses to *current mental health treatment* (*n* = 55, 21.6%) on *Demographic and Personal Experience Questionnaire* (Appendix B)

Table 8

Frequency Distribution of Mental Health Problem and Treatment Disclosure Preferences

	N	%
Have you disclosed personal mental health problems?		
Yes	150	94.3
No	13	
To whom have you disclosed personal mental health problems? [a]		
Family	143	95.3
Friends	136	90.7
Professional colleague	92	61.3
Clinical supervisor	44	29.3
Employer	31	20.1
Mentor	28	18.7
Religious leader	21	14.0
Professional associate	16	10.7
Other (therapist/doctor)	15	10.0
Other	1	< 1.0
Have you disclosed personal mental health treatment?		
Yes	132	95.6
No	6	4.3
To whom have you disclosed personal mental health treatment? [b]		
Family	125	94.7
Friends	119	90.2
Professional colleague	88	66.7
Clinical supervisor	47	35.6
Employer	36	27.3
Mentor	24	18.2
Professional associate	21	15.9
Religious leader	19	14.4
Other (therapist/doctor)	3	2.3
Other	3	2.3
If you experienced a mental health problem in the future, would you disclose it to anyone?		
Yes	83	90.2
No	9	9.8
To whom would you disclose your mental health problem? [c]		
Family	66	79.5
Friends	62	74.7
Professional colleague	45	54.2
Mentor	22	26.5
Clinical supervisor	16	19.3
Other (therapist/doctor)	12	14.4
Religious leader	10	12.0
Employer	9	10.8
Professional associate	8	9.6

Note: items above from the *Demographic and Personal Experience Questionnaire* (Appendix B)

Note[a]: "Other" recoded: "spouse, Significant other, "significant other/fiancé," partner" (+5) added to "Family" count; "doctor," "individual therapist," "my own therapist," "my therapist," "personal counselor," "personal therapist & psychiatrist," therapist," and "Therapist" (15) reported as "Other (therapist/doctor)"

Note[b]: "Other" recoded: "spouse, Significant other, significant other/fiancé, partners" (+6) added to "Family" count; "therapist," and "Therapist" (3) reported as "Other (therapist/doctor)"

Note[b]: "Other" included "counselor, doctor, Mental Health Counselor, Licensed therapist, MD, Medical doctor, Mental H(h)ealth counselor, My physician, my therapist (2), and Physician"

Table 9

Ranking of Barriers to Help Seeking by Total Positive Responses[a] – Entire Sample[b]

	f	%	Type
Wanting to solve the problem on my own (2)[c]	194	77.3%	Attitudinal
Thinking the problem would get better by itself (7)	159	63.1%	Attitudinal
Not being able to afford the financial costs involved (11)	146	57.9%	Structural
Difficulty taking time off from work (27)	126	50.2%	Structural
Being unsure where to go to get professional care (1)	112	44.6%	Structural
Having had bad experiences of mental health care (22)	103	41.2%	Attitudinal
Concern about the treatments available (20)	95	38.2%	Attitudinal
Feeling embarrassed or ashamed (9)	97	38.0%	Attitudinal
Dislike talking about feelings, emotions, or thoughts (18)	93	37.2%	Attitudinal
Preferring to get alternative forms of care (10)	89	35.6%	Attitudinal
Concern that I might be seen as weak (3)	86	33.7%	Attitudinal
Thinking I did not have a problem (25)	82	32.5%	Attitudinal
Not wanting mental health problem on medical records (21)	83	32.5%	Attitudinal
Thinking professional care probably would not help (13)	69	27.4%	Attitudinal
What people at work might think, say, or do (28)	68	26.7%	Attitudinal
People might not take me seriously if they found out (19)	67	26.3%	Attitudinal
Concern that people I know might find out (17)	66	25.9%	Attitudinal
Preferred to get help from family or friends (23)	63	25.2%	Attitudinal
Concern it might harm chances when applying for jobs (5)	57	22.4%	Attitudinal
Concern about what family might think, say, or do (8)	52	20.4%	Attitudinal
Concern I might be seen as "crazy" (12)	45	17.6%	Attitudinal
Having no one who could help me get professional care (30)	39	15.5%	Structural
Professionals of my ethnic/cultural group unavailable (15)	37	14.7%	Structural
Concern about what friends might think, say, or do (26)	34	13.3%	Attitudinal
Problems with transport or traveling to appointments (6)	33	13.2%	Structural
Being too unwell to ask for help (16)	30	12.0%	Structural
Concern that I might be seen as a bad parent (14)	30	11.8%	Attitudinal
Fear of being put in hospital against my will (4)	25	10.1%	Attitudinal
Problems with childcare during appointment (29)	21	9.3%	Structural
Concern I may lose access or custody of my children (24)	6	2.4%	Attitudinal

Note[a]: Any positive response ("a little," "a lot," or "quite a lot") to an item on the *Barriers to Access to Care Evaluation* (Appendix C) was included in the frequency count

Note[b]: All respondents in sample (N = 255)

Note[c]: Number in parentheses indicates item number on *Barriers to Access to Care Evaluation* (see Appendix C)

Table 10

Ranking of Barriers to Help Seeking by Total Positive Responses[a] - Did Not Seek Treatment[b]

	f	%	Type
Wanting to solve the problem on my own (2)[c]	22	91.7	Attitudinal
Not being able to afford the financial costs involved (11)	18	72.0	Structural
Thinking the problem would get better by itself (7)	18	70.8	Attitudinal
Difficulty taking time off from work (27)	15	60.0	Structural
Having had bad experiences of mental health care (22)	15	60.0	Attitudinal
Thinking professional care probably would not help (13)	15	58.3	Attitudinal
Concern that I might be seen as weak (3)	14	56.0	Attitudinal
Thinking I did not have a problem (25)	14	54.2	Attitudinal
Dislike talking about feelings, emotions, or thoughts (18)	13	54.2	Attitudinal
Feeling embarrassed or ashamed (9)	12	52.0	Attitudinal
Being unsure where to go to get professional care (1)	12	50.0	Structural
Preferring to get alternative forms of care (10)	12	50.0	Attitudinal
What people at work might think, say, or do (28)	12	48.0	Attitudinal
Concern that people I know might find out (17)	11	44.0	Attitudinal
Concern about the treatments available (20)	10	41.7	Attitudinal
Not wanting mental health problem on medical records (21)	10	40.0	Attitudinal
People might not take me seriously if they found out (19)	9	36.0	Attitudinal
Preferred to get help from family or friends (23)	8	34.8	Attitudinal
Having no one who could help me get professional care (30)	8	33.3	Structural
Concern it might harm chances when applying for jobs (5)	8	32.0	Attitudinal
Concern about what family might think, say, or do (8)	8	32.0	Attitudinal
Professionals of my ethnic/cultural group unavailable (15)	6	25.0	Structural
Concern I might be seen as "crazy" (12)	6	24.0	Attitudinal
Problems with transport or traveling to appointments (6)	5	20.8	Structural
Being too unwell to ask for help (16)	5	20.8	Structural
Concern about what friends might think, say, or do (26)	4	16.0	Attitudinal
Fear of being put in hospital against my will (4)	3	12.5	Attitudinal
Concern that I might be seen as a bad parent (14)	3	12.0	Attitudinal
Problems with childcare during appointment (29)	2	9.1	Structural
Concern I may lose access or custody of my children (24)	1	4.0	Attitudinal

Note[b]: Any positive response ("a little," "a lot," or "quite a lot") to an item on the *Barriers to Access to Care Evaluation* (Appendix C) was included in the frequency count

Note[a]: Frequency distribution is of respondents who reported experiencing a mental health problem during the time since licensure but did not seek treatment (n = 25, 15.3%).

Note[c]: Number in parentheses indicates item number on *Barriers to Access to Care Evaluation* (see Appendix C)

Table 11

Ranking of Barriers to Help Seeking by Total Strongly Positive Responses[a] – Entire Sample[b]

	f	%	Type
Wanting to solve the problem on my own (2)[b]	80	31.9%	Attitudinal
Not being able to afford the financial costs involved (11)	73	29.0%	Structural
Difficulty taking time off from work (27)	53	21.1%	Structural
Thinking the problem would get better by itself (7)	45	17.9%	Attitudinal
Having had bad experiences of mental health care (22)	41	16.4%	Attitudinal
Being unsure where to go to get professional care (1)	40	15.9%	Structural
Concern about the treatments available (20)	34	13.7%	Attitudinal
Preferring to get alternative forms of care (10)	28	11.2%	Attitudinal
Not wanting mental health problem on medical records (21)	28	11.0%	Attitudinal
Dislike talking about feelings, emotions, or thoughts (18)	26	10.4%	Attitudinal
Thinking professional care probably would not help (13)	21	8.3%	Attitudinal
Feeling embarrassed or ashamed (9)	21	8.2%	Attitudinal
Thinking I did not have a problem (25)	20	8.0%	Attitudinal
Concern that I might be seen as weak (3)	20	7.8%	Attitudinal
What people at work might think, say, or do (28)	13	5.1%	Attitudinal
People might not take me seriously if they found out (19)	13	5.1%	Attitudinal
Concern that people I know might find out (17)	13	5.1%	Attitudinal
Concern it might harm chances when applying for jobs (5)	13	5.1%	Attitudinal
Professionals of my ethnic/cultural group unavailable (15)	12	4.8%	Structural
Preferred to get help from family or friends (23)	12	4.8%	Attitudinal
Problems with transport or traveling to appointments (6)	10	4.0%	Structural
Concern I might be seen as "crazy" (12)	10	3.9%	Attitudinal
Fear of being put in hospital against my will (4)	9	3.6%	Attitudinal
Concern that I might be seen as a bad parent (14)	9	3.5%	Attitudinal
Being too unwell to ask for help (16)	8	3.2%	Structural
Problems with childcare during appointment (29)	6	2.7%	Structural
Having no one to help me get professional care (30)	5	2.0%	Structural
Concern about what friends might think, say, or do (26)	5	2.0%	Attitudinal
Concern about what family might think, say, or do (8)	4	1.6%	Attitudinal
Concern I may lose access or custody of my children (24)	2	0.8%	Attitudinal

Note[a]: Only a strongly positive response ("a lot," or "quite a lot") to an item on the *Barriers to Access to Care Evaluation* (see Appendix C) was included in the frequency count.

Note[b]: All respondents in sample (N = 255)

Note[c]: Number in parentheses indicates item number on *Barriers to Access to Care Evaluation* (see Appendix C)

Table 12

Ranking of Barriers to Help Seeking by Total Strongly Positive Responses[b] *- Did Not Seek Treatment*[b]

	f	*%*	Type
Wanting to solve the problem on my own (2)[c]	13	54.2	Attitudinal
Not being able to afford the financial costs involved (11)	11	44.0	Structural
Difficulty taking time off from work (27)	11	44.0	Structural
Having had bad experiences of mental health care (22)	9	36.0	Attitudinal
Thinking the problem would get better by itself (7)	8	33.3	Attitudinal
Thinking professional care probably would not help (13)	7	29.2	Attitudinal
Being unsure where to go to get professional care (1)	6	25.0	Structural
Preferring to get alternative forms of care (10)	6	25.0	Attitudinal
Concern that people I know might find out (17)	6	24.0	Attitudinal
Concern that I might be seen as weak (3)	6	24.0	Attitudinal
Not wanting mental health problem on medical records (21)	6	24.0	Attitudinal
Concern about the treatments available (20)	5	20.8	Attitudinal
Feeling embarrassed or ashamed (9)	5	20.0	Attitudinal
People might not take me seriously if they found out (19)	5	20.0	Attitudinal
Concern it might harm chances when applying for jobs (5)	4	16.0	Attitudinal
What people at work might think, say, or do (28)	4	16.0	Attitudinal
Thinking I did not have a problem (25)	3	12.5	Attitudinal
Dislike talking about feelings, emotions, or thoughts (18)	3	12.5	Attitudinal
Preferred to get help from family or friends (23)	3	13.0	Attitudinal
Having no one who could help me get professional care (30)	3	12.5	Structural
Professionals of my ethnic/cultural group unavailable (15)	3	12.5	Structural
Concern about what family might think, say, or do (8)	2	8.0	Attitudinal
Concern I might be seen as "crazy" (12)	2	8.0	Attitudinal
Problems with transport or traveling to appointments (6)	2	8.3	Structural
Concern about what friends might think, say, or do (26)	2	8.0	Attitudinal
Fear of being put in hospital against my will (4)	2	8.3	Attitudinal
Concern that I might be seen as a bad parent (14)	2	8.0	Attitudinal
Problems with childcare during appointment (29)	2	9.1	Structural
Being too unwell to ask for help (16)	0	0	Structural
Concern I may lose access or custody of my children (24)	0	0	Attitudinal

Note[a]: Frequency distribution is of respondents who reported experiencing a mental health problem during the time since licensure but did not seek treatment (n = 25, 15.3%).

Note[b]: Only strongly positive response ("a lot," or "quite a lot") to an item on the *Barriers to Access to Care Evaluation* (Appendix C) was included in the frequency count

Note[c]: Number in parentheses indicates item number on *Barriers to Access to Care Evaluation* (see Appendix C)

Table 13

Logistic Regression: Intentions to Seek Help from a Mental Health Professional as a Function of Stigma, Discrimination, and Role Model Experience

Variable	*Beta*	*Standard Error Beta*	*Wald* χ^2	*df*	*p*	*Odds Ratio*	*95% Confidence Interval*
Help-seeking self-stigma [a]	-0.10	0.03	9.48	1	.002	0.90	[0.85, 0.96]
Perceived mental health-related stigma [b]	-0.13	0.53	0.06	1	.811	0.88	[0.31, 2.48]
Personal discrimination experience [c]	-0.01	0.09	0.02	1	.887	0.99	[0.83, 1.18]
Observed discrimination experience[d]	0.02	0.05	0.16	1	.689	1.02	[0.92, 1.12]
Role model mental health problem disclosure[e]	0.04	0.10	0.14	1	.705	1.04	[0.86, 1.26]
Role model treatment disclosure[f]	0.35	0.14	5.85	1	.016	1.42	[1.07, 1.88]

Note: $N = 240$; $\chi^2 = 31.28$, $df = 6$, $p < .001$; Nagelkerke $r^2 = .21$; Hosmer & Lemeshow test: $p = .129$; Classification accuracy: 86.3%

Note: Dependent variable: Intentions to seek help from a mental health counselor (see *Mental Help-Seeking Intentions Scale – Mental Health Professional* subscale (Appendix F), recoded as a categorical variable, with "0" = "definitely false," "false," "somewhat false," "somewhat true," and "1" = "definitely true," and "true"

Note [a]: Help-seeking self-stigma: *Self-Stigma of Seeking Help* (Appendix H)

Note [b]: Perceived mental health-related stigma: *Barriers to Access to Care Evaluation Self-Stigma Scale* (Appendix C)

Note [c]: Personal discrimination experience: composite score based on "personal experience of discrimination and loss of status from disclosure of mental health problems and treatment" questions on the *Demographic and Personal Information Questionnaire* (see Appendix B)

Note[d]: Observed discrimination experience: composite score "observed experience of discrimination and loss of status from disclosure of mental health problems and treatment" questions on the *Demographic and Personal Information Questionnaire* (see Appendix B)

Note [e]: Positive role model mental health problem disclosure: composite score based on "positive experience of role model disclosure of mental health problems" questions on the *Demographic and Personal Information Questionnaire* (see Appendix B)

Note [f]: Positive role model mental health treatment disclosure: composite score based on "positive experience of role model disclosure of mental health treatment" questions from the *Demographic and Personal Information Questionnaire* (see Appendix B)

Appendix B

Demographic and Personal Experience Questionnaire

1. What is your age in years?
2. What type of mental health counseling license do you have? 1=Licensed Professional Counselor (LPC); 2=Licensed Clinical Professional Counselor (LCPC); 3=Professional Clinical Counselor (LPCC); 4=Licensed Mental Health Counselor (LMHC); 5=Other (please specify)
3. Are you currently counseling clients? 1=Yes; 2=No
4. In what state are you licensed to practice mental health counseling? If more than one state, please indicate the state in which you have the largest practice. Checklist of 50 States, District of Columbia, Puerto Rico, US Virgin Islands, Other (please specify).
5. What is your current gender identity? 1=Male; 2=Female; 3=Trans male/Trans man; 4=Trans female/Trans woman; 5=Genderqueer/Gender non-conforming; 6=Different identity (please state): _____
6. What sex were you assigned at birth, meaning on your original birth certificate? 1=Male; 2=Female
7. What is your preferred pronoun? 1=They; 2=She; 3=He; 4=Other (please specify)
8. With which racial or ethnic group(s) do you most identify? 1=African American; 2=Asian; 3=Caucasian (non-Hispanic); 4=Latino or Hispanic; 5=Native; 6=Other (please specify)
9. How many years have you been licensed to practice counseling?

10. Have you seen any mental health professional for your personal growth or preventive mental health care since you were licensed as a mental health counselor? 1=Yes; 2=No; 3=I choose not to answer
11. Have you seen anyone for clinical supervision or consultation since you were licensed as a mental health counselor? 1=Yes; 2=No; 3=I choose not to answer
12. Have you had any mental health problems since you were licensed as a mental health counselor? 1=Yes; 2=No; 3=I don't know
13. What types of mental health problems have you experienced? Please check all that apply. 1=Depression; 2=Anxiety; 3=Relationship issues; 4=Substance use issues; 5=Stress; 6=Trauma-related issues; 7=PTSD; 8=Bipolar disorder; 9=Psychosis; 11=Borderline disorder; 12=Eating disorder; 13=Other (please specify).
14. Have you received treatment for personal mental health problems since you were licensed? 1=Yes; 2=No
15. From which of the following have you received treatment for personal mental health problems? Please check all that apply. 1=Mental health counselor; 2=Psychologist; 3=Social worker; 4=Psychiatrist; 5=Medical doctor; 6=Other (please specify).
16. Have you disclosed personal mental health problems to anyone? 1=Yes; 2=No
17. To whom have you disclosed personal mental health problems? Please check all that apply. 1=Family member; 2=Friend; 3=Employer; 4=Mentor; 5=Clinical supervisor; 6=Professional colleague; 7=Professional associate; 8=Religious leader; 9=Other (please specify)

18. If you experienced a mental health problem in the future would you disclose that to anyone? 1=Yes; 2=No
19. To whom would you most likely disclose a personal mental health problem? Please check all that apply. 1=Family member; 2=Friend; 3=Employer; 4=Mentor; 5=Clinical supervisor; 6=Professional colleague; 7=Professional associate; 8=Religious leader; 9=Other (please specify)
20. Have you disclosed personal mental health-related treatment to anyone? 1=Yes; 2=No
21. To whom have you disclosed personal mental health-related treatment? Please check all that apply. 1=Family member; 2=Friend; 3=Employer; 4=Mentor; 5=Clinical supervisor; 6=Professional colleague; 7=Professional associate; 8=Religious leader; 9=Other (please specify)
22. I am currently having mental health problems. 0=No; 1=I don’t know; 2=Yes
23. I am currently receiving treatment for my mental health problems. 1=Yes; 2=No; 3=I choose not to answer

Using the scale below, please indicate the degree to which you personally agree or disagree with each statement: 1 = strongly disagree; 2 = disagree; 3 = somewhat disagree; 4 = somewhat agree; 5 = agree; 6 = strongly agree

24. I have experienced loss of status from employers, clinical supervisors, colleagues, or other professional associates after disclosure of personal mental health problems.
25. I have experienced other forms of discrimination from employers, clinical supervisors, colleagues, or other professional associates after disclosure of personal mental health-related treatment.
26. I have experienced loss of status from employers, clinical supervisors, colleagues, or other professional associates after disclosure of personal mental health problems.
27. I have experienced other forms of discrimination from employers, clinical supervisors, colleagues, or other professional associates after disclosure of personal mental health-related treatment.
28. Professional mentors, professors, clinical supervisors, and/or colleagues whom I respect have disclosed to me that they have had personal mental health problems.
29. Other people whom I respect have disclosed to me that they have had personal mental health problems.
30. Professional mentors, professors, supervisors, and/or colleagues whom I respect have disclosed to me that they have had positive personal experiences of mental health-related treatment.

31. Other people whom I respect have disclosed to me that they have had positive personal experiences of mental health-related treatment.
32. I have observed professional colleagues lose status from employers, clinical supervisors, colleagues, or other professional associates because of disclosure of mental health problems.
33. I have observed professional colleagues experience other forms of discrimination from employers, clinical supervisors, colleagues, or other professional associates because of disclosure of mental health problems.
34. I have observed professional colleagues lose status from employers, clinical supervisors, colleagues, or other professional associates because of disclosure of mental health-related treatment.
35. I have observed professional colleagues experience other forms of discrimination from employers, clinical supervisors, colleagues, or other professional associates because of disclosure of mental health-related treatment.
36. I would refer clients to a mental health counselor I believed had personal mental health problems.

Appendix C

Barriers to Access to Care Evaluation (BACE v3)

Below you can see a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care we mean care from such staff as a GP (family doctor), community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counsellor, psychologist or psychotherapist.

Have any of these issues <u>ever stopped, delayed or discouraged you</u> from getting, or continuing with, professional care for a mental health problem?

Please circle one number on <u>each</u> row to indicate the answer that best suits you.

For 'not applicable' e.g. if it is a question about children and you do not have children, please cross the Not applicable box.

	Issue	This has stopped, delayed or discouraged me **NOT AT ALL**	This has stopped, delayed or discouraged me **A LITTLE**	This has stopped, delayed or discouraged me **QUITE A LOT**	This has stopped, delayed or discouraged me **A LOT**
1.	Being unsure where to go to get professional care	0	1	2	3
2.	Wanting to solve the problem on my own	0	1	2	3
3.	Concern that I might be seen as weak for having a mental health problem	0	1	2	3
4.	Fear of being put in hospital against my will	0	1	2	3
5.	Concern that it might harm my chances when applying for jobs Not applicable □	0	1	2	3
6.	Problems with transport or travelling to appointments	0	1	2	3
7.	Thinking the problem would get better by itself	0	1	2	3
8.	Concern about what my family might think, say, do or feel	0	1	2	3

9.	Feeing embarrassed or ashamed	0	1	2	3
10.	Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies)	0	1	2	3
11.	Not being able to afford the financial costs involved	0	1	2	3
12.	Concern that I might be seen as 'crazy'	0	1	2	3
13.	Thinking that professional care probably would not help	0	1	2	3
14.	Concern that I might be seen as a bad parent Not applicable □	0	1	2	3
15.	Professionals from my own ethnic or cultural group not being available	0	1	2	3
16.	Being too unwell to ask for help	0	1	2	3
17.	Concern that people I know might find out	0	1	2	3
18.	Dislike of talking about my feelings, emotions or thoughts	0	1	2	3
19.	Concern that people might not take me seriously if they found out I was having professional care	0	1	2	3
20.	Concerns about the treatments available (e.g. medication side effects)	0	1	2	3
21	Not wanting a mental health problem to be on my medical records	0	1	2	3
22.	Having had previous bad experiences with professional care for mental health	0	1	2	3
23.	Preferring to get help from family or friends	0	1	2	3

24.	Concern that my children may be taken into care or that I may lose access or custody without my agreement Not applicable □	0	1	2	3
25.	Thinking I did not have a problem	0	1	2	3
26.	Concern about what my friends might think, say or do	0	1	2	3
27.	Difficulty taking time off work Not applicable □	0	1	2	3
28.	Concern about what people at work might think, say or do Not applicable □	0	1	2	3
29.	Having problems with childcare while I receive professional care Not applicable □	0	1	2	3
30.	Having no one who could help me get professional care	0	1	2	3

Note: Barriers to Care Evaluation (BACE) Scale (v3) Institute of Psychiatry, King's College London © 2011. For permission to use and a copy of the manual, please contact Dr Sarah Clement sarah.clement@kcl.ac.uk or Professor Graham Thornicroft, graham.thornicroft@kcl.ac.uk.

Note: BACE Stigma Subscale includes items: 3,5,8,9,12,14,17,19,21,24,26, and 28

Appendix D

Kessler Screening Scale for Psychological Distress (K6)

Answer each question using the scale below:

0 = none of the time; 1 = a little of the time; 2 = some of the time; 3 = most of the time; 4 = all of the time;

1. During the last 30 days, about how often did you feel so depressed that nothing could cheer you up?
2. During the last 30 days, about how often did you feel hopeless?
3. During the last 30 days, about how often did you feel restless or fidgety?
4. During the last 30 days, about how often did you feel that everything was an effort?
5. During the last 30 days, about how often did you feel worthless?
6. During the last 30 days, about how often did you feel nervous?

Note: 5<= K6 <= 12 indicates moderate (Prochaska et al., 2012); KS6 >=13 indicates likely meets DMS-IV diagnostic criteria (Kessler et al., 2003)

Appendix E

Kessler Screening Scale for Psychological Distress (K6) – Modified*

Answer each question using the scale below:

0 = none of the time; 1 = a little of the time; 2 = some of the time; 3 = most of the time;

4 = all of the time;

1. In general, about how often do you feel so depressed that nothing could cheer you up?
2. In general, about how often do you feel hopeless?
3. In general, about how often do you feel restless or fidgety?
4. In general, about how often do you feel that everything was an effort?
5. In general, about how often do you feel worthless?
6. In general, about how often do you feel nervous?

*Note: Modified scale to use "In general, about how often do you feel" prompt based on prompt from Spielberger state-trait anxiety inventory (Spielberger et al., 1983) instead of original K6 scale prompt "During the last 30 days, how often did you feel" (Kessler et al., 2003)

Appendix F

Mental Help-Seeking Intention Scale (MHSIS)

Please use the following scale to respond to each of the statements below.

1=definitely false; 2=false; 3=somewhat false; 4=somewhat true; 5=true;

6=definitely true

1. If I had a mental health concern, I would intend to seek help from a mental health professional.
2. If I had a mental health concern, I would intend to seek help from a medical doctor.
3. If I had a mental health concern, I would intend to seek help from a phone helpline.

Note: Hammer & Spiker (2018)

Appendix G

Negative Attitudes Subscale

For each statement listed, please indicate whether you personally agree or disagree with it, using the scale below:

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree;

5 = strongly agree

1. I believe a person with mental illness is a danger to others
2. I believe a person with mental illness is unpredictable
3. I believe a person with mental illness is hard to talk with
4. I believe a person with mental illness has only himself/herself to blame for his/her condition
5. I believe a person with mental illness could pull himself/herself together if he/she wanted

Note: SAMSHA/CDC (2010)

Appendix H

Self-Stigma of Seeking Help (SSOSH)

For each statement listed, please indicate whether you personally agree or disagree with it. If you don't understand a statement or it is not applicable to you, please leave that row blank. Indicate your level of agreement using the scale below:

1 = strongly disagree; 2 = disagree; 3 = neither agree nor disagree; 4 = agree;

5 = strongly agree

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.

Note: Scoring: even-numbered items must be reverse coded when added with odd-numbered items so that higher scores will indicate greater help-seeking self-stigma.

Note: Tucker et al., 2013; Vogel et al., 2006