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HIDE OR SEEK? THE EFFECT OF CAUSAL AND TREATABILITY INFORMATION ON STIGMA AND WILLINGNESS TO SEEK PSYCHOLOGICAL HELP

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Many individuals suffering from psychological disorders do not receive professional help, partly due to the highly stigmatizing nature of mental illness. The current research examined whether the informational model of mental illness, specifically perceived causal attributions and treatability, impacts stigma and willingness to seek professional help. The results indicate that biological attributions, regardless of the presence or absence of treatability information, can reduce stereotypes about the mentally ill, lower help-seeking stigma, and increase willingness to seek a psychiatrist, compared to psychosocial attributions. The decrease in help-seeking stigma accounts for the effect of attributions on willingness to seek help. Furthermore, an individual's mental health history interacts with the type of informational model to impact the likelihood of managing symptoms on one's own without professional help.

Keywords: mental illness, stigma, depression, help-seeking behavior, treatment

Sylvia Plath, an American poet and writer, once described depression as tantamount to a desolate and suffocating existence endured within the confines of a glass bell jar (Plath, 1971, p. 193). One month after her semi-autobiographical novel of the same name was published, she was dead. She had committed suicide after a decades-long battle with depression that involved only a few intermittent (and often involuntary) clinical encounters. Unfortunately, her story is not all that rare given that 10%

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of Americans suffer from depression and another 15% suffer from other types of mental illnesses (Center for Disease Control [CDC], 2010). Although many of these 80 million sufferers eventually receive treatment, the time from the onset of illness to treatment is about 10 years (Wang, Berglund, Olfson, & Kessler, 2004). For some, such as the 15% of depressed individuals who die by suicide (Suicide Awareness Voices of Education [SAVE], 2014), effective treatment comes too late (Kessler, Olfson, & Berglund, 1998).

One deterrent to seeking and receiving treatment is stigma, which Goffman (1963), defined as an "attribute that is deeply discrediting" such that the person becomes "reduced in our minds from a whole and usual person to a tainted, discounted one" (p. 3). Not only is there a stigma surrounding mental illness itself (i.e., the symptoms and stereotypes), but there is also one attached to the act of seeking professional help (Ben-Porath, 2002; Corrigan, Druss, & Perlick, 2014; Vogt, Fox, & Di Leone, 2014). Some researchers argue that the latter stigma is the more detrimental one. This is evident in the harsh stereotypical traits (e.g., insecure, awkward, extremely unstable) that are often used to describe those who seek help (Ben-Porath, 2002; Sibicky & Dovidio, 1986) and in its ability to permeate the recovery process at multiple points in time. Help-seeking stigma lowers not only one's likelihood of seeking treatment but also one's subsequent willingness to agree and adhere to it (Ben-Porath, 2002; Eisenberg, Downs, Golberstein, & Zivin, 2009; Verhaeghe & Bracke, 2011; Vogt, Di Leone et al., 2014). To make matters worse, there is widespread doubt in the efficacy of psychological treatment. Many people believe that it only has a 50% success rate and that a significant portion (at least one in four) of the mentally ill can recover on their own (Mojtabai, 2007).

There is preliminary evidence that help-seeking stigma is strongly associated with causal models of mental illness (Goldstein & Rosselli, 2003). Individuals who stigmatize seeking help for depression are more likely to believe in a psychological causal model (i.e., model in which maladaptive thoughts cause depression) than a biological one (i.e., model in which genetics and physiological factors cause mental illness; Goldstein & Rosselli, 2003). The association between perceived causality and stigma is

consistent with the doctrines of attribution theory (Heider, 1958). This theory states that our beliefs about the underlying causes of behavior determine our interpretations of the behavior and the individual who committed it. Attributions that minimize control and responsibility are typically associated with more favorable attitudes toward those with stigmatizing conditions (Crocker, Major, & Steele, 1998). For mental illness, such attributions typically emphasize the role of biological forces, as these tend to be perceived as uncontrollable (Deacon & Baird, 2009). Thus, biological models of mental illness may be the key to reducing stigma and improving outcomes.

To examine this possibility, Han, Chen, Hwang, and Wei (2006), had participants read one of the following: a description of the genetic and neurochemical basis of depression, a refutation of stereotypes of depressed individuals, a combination of both types of information, or no information at all. Those who read a biological explanation of depression were more willing to seek professional help compared to those in the control and destigmatizing conditions. Another study found that biological explanations decrease the stigma surrounding schizophrenia and borderline personality disorder, but only when they include treatability information (Lebowitz & Ahn, 2012).

The addition of treatability information to biological models may be vital to stigma reduction. Some research has found that biological attributions alone can inadvertently increase the endorsement of stereotypes (Kemp, Lickel, & Deacon, 2014; Read, 2007). For example, biological explanations of schizophrenia strengthen the belief that schizophrenics are violent (Read, 2007; Read, Haslam, Sayce, & Davies, 2006). By focusing on the inner causes of mental illness, these explanations may strengthen a set of beliefs, known as essentialism, that are the foundation of stereotyping and prejudice (for review, see Hamilton, 2007). A high degree of essentialism means that category members (e.g., mentally-ill individuals) are believed to possess a common, unalterable essence or core. Treatability information, however, may attenuate these beliefs by bolstering perceptions of membership alterability. Such information may also be necessary to increase prognostic optimism and, ultimately, the treatment outcome (Kichuk, Lebowitz, & Adams, 2015). Biological models alone have

been shown to produce pessimistic beliefs about the efficacy of psychotherapy (Deacon & Baird, 2009). Low treatment outcome expectancies may then result in low engagement with treatment and become a self-fulfilling prophecy.

The current research extended these limited experimental findings by examining the impact of different types of informational models on both mental illness stigma and help-seeking stigma as well as behavioral outcomes. In our study, participants read descriptions of depression that varied in terms of causal attribution (biological vs. psychosocial vs. no explanation) and treatability information (included vs. omitted). Our main hypothesis was that participants who read a biological explanation with treatability information would report (a) lower mental illness stigma, (b) lower help-seeking stigma, and (c) greater willingness to seek professional help, compared to those who read other types of explanations.

METHOD

PARTICIPANTS

Undergraduates from the University of Tampa ($N = 201$; 61 males and 140 females) volunteered to participate in exchange for extra credit in their General Psychology classes. Random assignment led to 44 participants in the Control condition, 39 in the Biological condition, 44 in the Biological + Treatability condition, 36 in the Psychosocial condition, and 38 in the Psychosocial + Treatability condition. The mean age of participants was 18.86 years ($SD = 1.79$). Most participants (85%) had never been diagnosed with depression. Of the 31 participants (15%) who had been diagnosed in the past, the majority had received psychotherapy (87%).

MEASURES

Mental Illness Stigma. The level of endorsement of negative stereotypes about the mentally ill was assessed using items from the Attitudes to and Stereotypes of Mental Health Measure. This measure has been shown to converge with a range of prejudicial

and discriminatory indices, such as the desire for social distance from the mentally-ill (Aromaa, Tolyanen, Tuulari, & Wahlbeck, 2011). Using a four-point scale from 1 (Strongly Disagree) to 4 (Strongly Agree), participants reported the extent to which they believe depressed individuals are unpredictable, weak, and sensitive ($\alpha = .72$).

Help-Seeking Stigma. Participants completed a four-item measure ($\alpha = .79$) that was adapted from the Self-Stigma of Seeking Help Scale—Therapy (SSOSH-T; Owen, Thomas, & Rodalfa, 2013). This measure is negatively associated with scores on other measures of help-seeking attitudes, such as the Attitudes Toward Seeking Professional Psychological Help Scale, and demonstrates high test-retest reliability and internal consistency (Owne, Thomas, & Rodalfa, 2013). Using a scale from 1 (Strongly Disagree) to 7 (Strongly Agree), participants reported their level of agreement with the following statements: Going to therapy is a sign of my personal weakness; By going to therapy, I would be admitting that my coping skills are inadequate; By seeking therapy, I am admitting that I am incompetent to solve my problems; and Depressed people can and should pull themselves together.

Willingness to Seek Help. Participants were asked to rate, on a 7-point scale from 1 (Not At All Likely) to 7 (Very Likely), how likely they were to manage symptoms on their own, seek help from a therapist, and seek help from a psychiatrist, respectively. These measures were derived from the Theory of Planned Behavior (TPB; Ajzen & Fishbein, 1969), which states that direct measures of intentions can be highly predictive of actual behavior. Prior research has measured intentions to seek help in a similar manner (Han, Chen, Hwang, & Wei, 2006).

Mental Health History. Participants were asked whether or not they had been diagnosed with depression and received treatment in the past.

PROCEDURE

To mask the true nature of the experiment, participants were told that the study explored one's ability to read, remember, and

interpret scientific information. After giving consent, they were randomly assigned to read one of five vignettes about depression. Although all vignettes described the symptoms of depression, they varied in terms of causality and treatability information. The vignettes were as follows: (a) Control condition: no additional information, (b) Biological condition: genetics and brain activity can increase risk, (c) Biological + Treatability condition: biological explanation with treatability information (i.e., medications and/or psychotherapy can effectively reduce symptoms), (d) Psychosocial condition: stressful life experiences can increase risk, and (e) Psychosocial + Treatability condition: psychosocial explanation with treatability information. Next, participants were asked to imagine that they were suffering from symptoms of depression while completing an online questionnaire (on SurveyMonkey) that containing the aforementioned measures. Finally, they were debriefed and thanked for their participation.

RESULTS

EFFECTS OF INFORMATIONAL MODEL ON STIGMA

We conducted 2 × 2 ANOVAs for causal attribution (biological vs. psychosocial) and provision of treatability information (provided vs. omitted) and found a main effect of causal attribution on both types of stigmas. Reading a biological explanation of depression led to less mental illness stigma (M = 1.95, SD = .62) compared to reading a psychosocial one (M = 2.22, SD = .58), F (1, 153) = 7.80, p = .01, η_p^2 = .05. In addition, reading a biological explanation led to decreased help-seeking stigma (M = 2.36, SD = 1.01) compared to reading a psychosocial one (M = 2.78, SD = 1.32), F (1, 153) = 5.06, p = .03, η_p^2 = .03. No other main effects or significant interactions were found (see Table 1 and Figure 1).

EFFECT OF INFORMATIONAL MODEL ON WILLINGNESS TO SEEK HELP

We also conducted 2 × 2 ANOVAs for causal attribution and treatability on willingness to seek help. There was a main effect of attribution on willingness to seek a psychiatrist, F (1, 153) =

TABLE 1. Means and Standard Deviations by Condition for Key Dependent Variables

Variable	Control	Biological Only	Biological + Treatability	Psychosocial Only	Psychosocial + Treatability
Mental Illness Stigma	1.97 (.61)	1.95 (.65)	1.95 (.61)	2.22 (.59)	2.22 (.58)
Help-Seeking Stigma	2.61 (1.32)	2.29 (1.06)	2.43 (.97)	2.68 (1.45)	2.88 (1.19)
Willingness to Seek Therapist	3.34 (2.00)	3.41 (1.77)	3.43 (1.73)	2.67 (1.94)	3.32 (1.68)
Willingness to Seek Psychiatrist	2.91 (1.72)	3.18 (1.54)	3.05 (1.79)	2.47 (1.83)	2.68 (1.60)
Likelihood of Managing Symptoms on Own	5.27 (1.66)	5.31 (1.66)	5.18 (1.67)	4.78 (1.91)	5.34 (1.58)

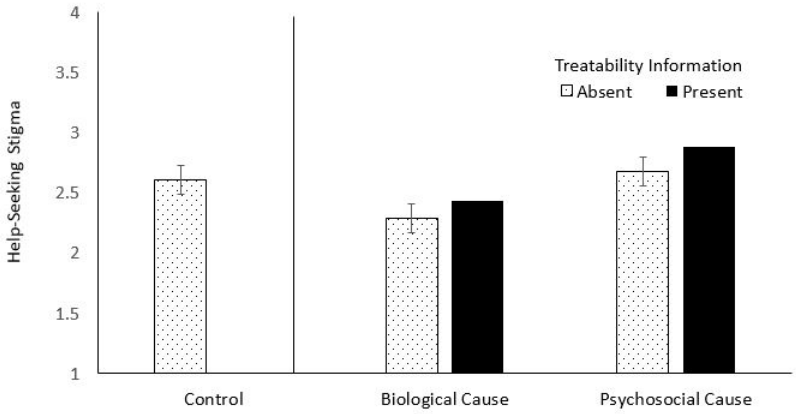

FIGURE 1. Mean scores for help-seeking stigma by causal attribution and treatability Information.

3.89, $p = .05$, $\eta_p^2 = .03$. A biological explanation led to greater likelihood of seeking a psychiatrist ($M = 3.11$, $SD = 1.67$) compared to a psychosocial one ($M = 2.58$, $SD = 1.70$). Once again, treatability information did not have an impact. No significant effects were found for likelihood of managing symptoms on one's own (without professional help), F (1, 153) = .46, $p = .5$, and for seeking a therapist, F (1, 153) = 2.28, $p = .13$ (see Table 1 and Figure 2).

MEDIATING ROLE OF HELP-SEEKING STIGMA

Next, we examined whether help-seeking stigma could account for the effect of causal attribution on willingness to seek help from a psychiatrist. Multiple regression analyses were conducted to assess each component of the model. As shown in Figure 3, causal attribution (psychosocial vs. biological) was a significant predictor of help-seeking stigma, $B = -.42$, t (155) = −2.25, $p = .03$. Also, causal attribution, $B = .53$, t (155) = 1.96, $p = .05$, and help-seeking stigma, B = −.34, t (155) = −2.98, $p = .003$, were significant predictors of willingness to seek a psychiatrist, respectively. We then tested for mediation using the bootstrapping method with bias-corrected confidence intervals (Hayes, 2009). The 95% confidence interval for the indirect effect was obtained using 5,000

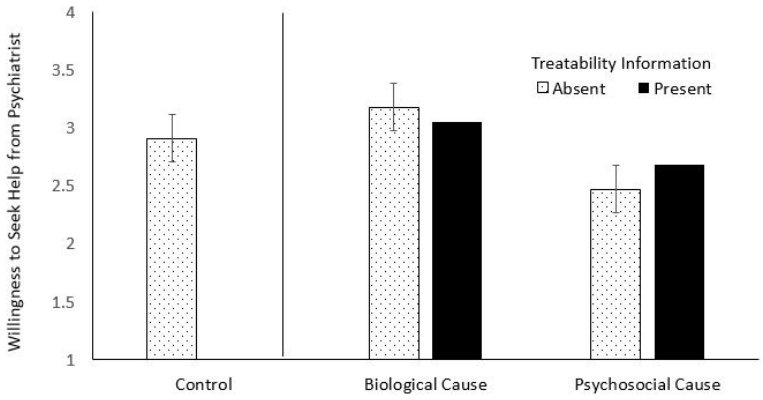

FIGURE 2. Mean scores for willingness to seek help from a psychiatrist by causal attribution and treatability information.

bootstrapped samples. The results revealed that help-seeking stigma did indeed mediate the relationship between causal attribution and willingness to seek help from a psychiatrist, $B = .14$, CI = .03 to .35. Furthermore, the direct effect of causal attribution on willingness to seek a psychiatrist became nonsignificant when controlling for stigma, $B = .39$, $p = .15$ (see Figure 3).

MODERATING ROLE OF MENTAL HEALTH HISTORY

We conducted a 2 (attribution) × 2 (treatability) × 2 (prior diagnosis of depression) ANOVA for all of the key measures. The analysis revealed that individuals with a prior diagnosis stigmatized mental illness significantly less ($M = 1.70$, $SD = .58$) than those who had not been diagnosed with depression (M = 2.15, $SD = .50$), F (1, 149) = 11.29, $p = .00$, $\eta_p^2 = .07$. No other significant main effects were found.

We also found a significant attribution × treatability × prior diagnosis interaction for likelihood of managing symptoms on one's own, F (1, 149) = 5.26, $p = .02$, $\eta_p^2 = .03$. Post-hoc analyses revealed that, for those previously diagnosed with depression, treatability information significantly impacted how a biological (but not psychosocial) attribution affected the likelihood of

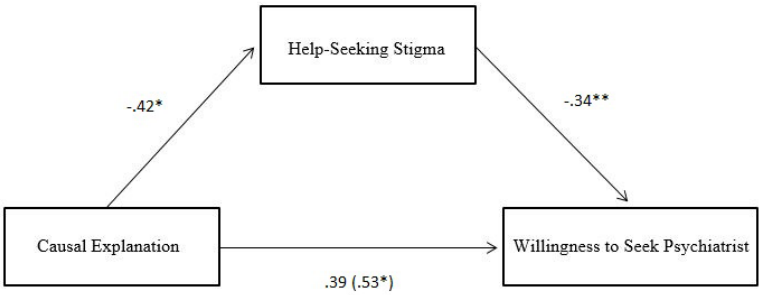

FIGURE 3. Indirect effect of causal attribution on willingness to seek help from a psychiatrist through help-seeking stigma.
Note. *$p \leq .05$; **$p \leq .01$, all two-tailed.

seeking help. Biological explanations with treatability information led to significantly greater likelihood of trying to manage the symptoms on one's own without help ($M = 6.20$, $SD = 2.30$) compared to biological explanations without such information ($M = 4.13$, $SD = .84$) t (11) = 9.54, $p = .04$. Treatability information seemed to dampen the effectiveness (in terms of motivating individuals to seek outside help) of biological explanations for those with a history of depression. For those without a prior diagnosis, treatability information did not impact the effectiveness of either of the causal explanations (see Table 2).

ANALYSES COMPARING EXPERIMENTAL AND CONTROL CONDITIONS

Additionally, we conducted a One-Way ANOVA comparing the four experimental conditions and the control condition on all measures. There were no significant effects for any of the key variables. However, when prior depression diagnosis was entered into the analyses, there was a significant interaction for managing symptoms on one's own, F (4, 191) = 2.77, $p = .03$, $\eta_p^2 = .06$. For those with a prior depression diagnosis, biological explanations (without treatability information) led to significantly

TABLE 2. Means and Standard Deviations by Condition and Prior Depression Diagnosis for Likelihood of Managing Symptoms on One's Own

	Control	Biological Only	Biological + Treatability	Psychosocial Only	Psychosocial + Treatability
Prior Depression Diagnosis	6.33 (1.03)	4.13 (2.30)	6.20 (.84)	4.80 (2.05)	4.71 (2.06)
No Prior Depression Diagnosis	5.11 (1.69)	5.61 (1.33)	5.05 (1.71)	4.78 (1.93)	5.48 (1.46)

lower likelihoods of managing symptoms on one's own (M = 4.13, SD = 2.30) compared to the control condition (M = 6.33, SD = 1.03), t (12) = 2.18, p = .05, and compared to the biological + treatability condition (M = 6.20, SD = .84), t (11) = 2.32, p = .04. For those who had never been diagnosed with depression, a psychosocial explanation led to significantly lower likelihoods of managing symptoms on one's own (M = 4.77, SD = 1.93) compared to biological explanations (M = 5.61, SD = 1.33), t (60) = 1.99, p = .05.

DISCUSSION

Many individuals who suffer from mental illness do not seek help in a timely manner despite the availability of evidence-based treatments. The current research provides evidence of the utility of biological causal models in changing this pattern for seeking medication treatments. Biological models (compared to psychosocial ones) can lower help-seeking stigma and, as a result, increase willingness to seek help from a psychiatrist.

The inclusion of treatability information in a model does not seem to have an impact on its effectiveness. This finding is unexpected given that Lebowitz and Ahn (2012) found that such information was necessary to reduce stigma. There are many possible reasons for this inconsistency. First of all, the two studies examined different types of mental illnesses, and perceptions of illnesses may vary greatly. Participants' level of interpersonal contact with those afflicted as well as their prior knowledge of the disorder may differ from illness to illness. Due to the greater prevalence of depression, it is quite possible that people have more frequent contact with individuals suffering from depression than they do with those suffering from schizophrenia or

borderline personality disorder. Also, some individuals may already believe that depression is treatable, so the addition of treatability information may not have made a difference. Overall, this suggests that the effectiveness of a model may depend on the specific mental illness at hand. Interventions should consider tailoring their attributional models and treatment rationales based on their target mental illness. Secondly, the inconsistency may have resulted from different operationalizations of stigma. Lebowitz and Ahn (2012) measured stigma as the level of undesirability of interpersonal contact with someone who suffers from mental illness (i.e., social distance). We measured stigma as the level of stereotyping associated with the illness. It may be the case that treatability information does not impact how we cognitively conceptualize a mental illness. Furthermore, we examined a stigma that was not looked at in prior research—the stigma attached to the act of seeking professional help.

We also explored how mental health history moderates the effectiveness of different types of informational models. For those with a prior diagnosis of depression, biological explanations with treatability information led to increased likelihood of reporting they would manage symptoms on their own (without help). Thus, it seems that treatability information may deter previously-diagnosed individuals from seeking more help. It is difficult to interpret this finding as good or bad. Given that the majority of these individuals reported past treatment, it is possible that a biological explanation with treatability information led them to feel confident in managing the symptoms on their own, given that they had already been taught useful coping techniques in the past. What is definitively clear though is that people who have had a mental illness process information about that illness differently than those who have not.

There were several limitations and weaknesses to the current study. First, the findings may be limited due to a lack of mundane realism that often comes with the use of vignettes. Our participants were asked to simply imagine that they were experiencing depressive symptoms. This may have been difficult for participants who were not currently experiencing these symptoms. Secondly, the vignettes conveyed a minimal amount of information about mental illness, thereby limiting the amount

of psychoeducation provided to the participants. The provision of thorough and detailed information about causality and treatability might affect the results.

In summary, the current research provides empirical evidence of the utility of biological explanations in lowering help-seeking stigma and increasing willingness to seek professional help from a psychiatrist. However, as there was no impact on willingness to seek help from a therapist, these biological models may increase willingness to seek psychiatric medications but not necessarily psychotherapy. Therefore, when providing treatability information with a biological attribution model to potential patients, it may be important to emphasize how psychosocial interventions can effect change on biologically-based conditions. The current research also suggests that an individual's mental health history must be considered, as it was shown to interact with the type of informational model on help-seeking behaviors. This research is among the first to examine the effects of informational models on help-seeking stigma and willingness to seek professional treatment. Future research should continue to explore ways to lower stigma associated with mental illness and help-seeking so that greater numbers of those with psychological disorders can receive effective treatments.

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