THE INSTITUTION FOR PSYCHOLOGY

Therapy Taboo in Sweden?

A study investigating perceived public stigma, self-stigma, and attitudes toward seeking professional therapy

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Abstract

This thesis examines which factors (gender, age, level of education, and prior experience of therapy) that impact attitudes towards seeking therapy in Sweden, and if any significant main effects and interaction effects are present. Further, the thesis also aims to examine which variable, perceived public stigma or self-stigma, is the best to predict attitudes toward seeking therapy. The study was conducted through surveys examining 193 participants (96 men and 97 women) aged 19 to 62, mainly recruited in Malmö. The results showed that participants that had studied at university, were women, and had prior experience of therapy, were more positive towards seeking therapy. Age was not a significant factor. Further, participants with higher self-stigma and perceived public stigma were less positive towards seeking therapy. Self-stigma was the best variable to predict attitudes toward seeking therapy and accounted for 28% of the total variance. Further, in terms of gender, men were found to experience a higher level of self-stigma than women. Surprisingly only half of the participants knew where to turn to seek therapy. This suggests that there is a gap between availability of mental health services and the public's knowledge, which needs to be filled.

Keywords: attitudes, seeking therapy, help seeking, perceived public stigma, self-stigma, social stigma scale, attitudes toward seeking professional psychological help scale (ATSPPHS).

Introduction

Even in the 21st century, mental health problems and psychological treatment are surrounded by prejudice and taboos. This is widely manifested and seen in newspapers, literature, film, art and in everyday conversations. There is often a distinct gap between peoples' attitudes towards somatic and mental health problems.

Mental disorders such as depression and anxiety, but also emotional distress, exhaustion, and interpersonal problems are widespread in society. The path for seeking help is complex and over the past couple of decades, several variables have been positioned to influence individuals to seek, avoid, or resist psychological services. These include availability and accessibility, affordability of services, socio-demographic factors, as well as more complex characteristics such as personality, personal preference and attitudes (Cepeda-Bento & Short, 1998; Dahlberg, 2008). But before a person actually engages in help-seeking behavior, a positive attitude and anticipated utility are prerequisites. So the question is what affects a person's attitudes towards seeking professional help in the form of therapy?

If mental illness and emotional issues are so widespread, think about the following scenario. Why does one (mostly) not dare to say out loud "I am busy this afternoon; I have an appointment to see my therapist/psychologist."? But on the contrary, you wouldn't feel any shame to say openly that you have an appointment with the physiotherapist or personal trainer, and no one would really react because this type of appointment is seen as socially acceptable.

We can ask for help when it comes to our muscles and body but getting help for our thoughts and feelings from a professional (psychological) therapist brings with it a stigma from the public. In turn, this also affects the individual's self-esteem, self-image, and their attitudes towards seeking therapy negatively, which may result in internally stigmatizing oneself (Corrigan, 1998, 2004; Holmes & River, 1998; Vogel, Wade, & Hackler, 2007).

There are Swedish articles mentioning that the sense of taboo, associated with seeking professional help/therapy, is present. For example, in a recent article in Aftonbladet (2015) it says that especially adolescents and young adults feels this sense of taboo, and they, just as other persons wanting or in need of professional (psychological) help/therapy hold concerns of being misunderstood, judged, or even ignored (Aftonbladet, 2015; Harris, Dersch, & Mital, 1999). But how do other age groups experience this sense of shame and taboo associated with seeking therapy? What role does stigma play in help-seeking attitudes across the general population?

Theory

The Components of Attitudes. Attitudes are very complex to study empirically. An attitude can be defined as “an evaluation of an object in a positive or negative fashion that includes the elements of affect, cognition, and behavior.” (Gilovich, Keltner, Chen, & Nisbet, 2013, pp 235). The “affect” component involves how much a person likes or dislikes an object, a therapist, themselves or similar which triggers some degree of positive or negative emotion. The “cognitions” component involves the thoughts that typically underpin a person’s feelings. Your attitude towards seeing a therapist, for example, includes knowledge or the lack of knowledge about how to do so, how appealing or how beneficial it would be. Finally, the “behavior” component can be described in a sense of behavioral tendency in the form of approach versus avoid. So for example, when specific positive attitudes toward seeking therapy are primed/brought to mind (even subconsciously), the person is more likely to act in a way consistent with the attitude (approach behavior). On the contrary, if specific negative attitudes toward seeking therapy are primed, such that the attitude and the behavior go in line with each other, the person is more likely to avoid seeking therapy (avoidance behavior) (Gilovich et al., 2013).

Why study attitudes and not behavior directly in order to find out if people seek therapy or not? That is because in order to predict a specific type of behavior as accurately as possible, one has to measure people’s attitudes toward that specific type of behavior. The attitude will have an impact on intention, which in turn will have an impact on the final behavior (Gilovich et al., 2013). However, there is a problem. It is not always that our attitudes are formed from oneself. Sometimes our attitudes about something can be based on secondhand information, such as from family members, friends and even the society, which shapes how we think and feel about something (Gilovich et al., 2013). This brings us to the subject of stigma.

Understanding our own attitudes – The Self-perception theory. How is it that a person can have either positive or negative attitudes towards seeking therapy if he/she never has done so? According to the self-perception theory an individual becomes insightful of their own attitudes by looking at their own behavior (Gilovich et al., 2013). This could suggest that the attitudes a person hold may actually come from close others, such as friends and family members, or even the public. For example, in cases when close others and the public views that seeking therapy as

shameful or even taboo, the individual is likely to convert his/her attitudes to fall in line. On the contrary, it could also suggest that a person who has sought therapy and has a positive experience would hold positive attitudes towards seeking therapy again in the future (and vice versa if they had a negative experience).

Balance theory & cognitive dissonance theory. The balance theory and the cognitive dissonance theory are very similar to one another, where the prior asserts that it is important for an individual to maintain a balance among one's beliefs, cognitions and sentiments (Heider, 1946), and the latter asserts that cognitive dissonance occurs when two attitudes or attitude and behavior conflict with each other (Festinger, 1957). Cognitive dissonance implies feelings of tension that arises when one is simultaneously aware of two inconsistent cognitions.

While Festinger (1957) argued that dissonance reduction is a phenomenon that occurs after a decision has been made and is irrevocable, Heider's concern is that the individual maintains balance among their beliefs, cognitions and sentiments throughout the whole process of decision-making. For example, an individual holds a positive attitude toward seeking therapy or have already been to a therapy session and then finds out that close friends or family members hold negative attitudes and discourage them from seeking therapy, imbalance occurs as well as a triggered dissonance within the individual. Due to the balance theory the individual then feels the urge to reduce this dissonance. The individual will then exert psychological energy needed in order to achieve or restore balance of this triad relationship (beliefs, cognitions and sentiments). And according to the cognitive dissonance theory, the individual has to choose if he/she should stick with his/her own original attitudes by finding arguments and continuing to seek therapy, or if they should mirror the attitudes of family members or close friends and withdraw from seeking therapy to eliminate the created internal dissonance. Another example of the balance theory is when you see one of your favorite celebrities in the media saying positive things about psychological services. This will put psychological pressure on you to like this type of service and hold the same attitude.

Defining Level of Stigma. The word stigma, when termed by Goffman in 1963, refers to a negative evaluation of an individual seen as flawed and unworthy, and who has a personal or physical characteristic that is viewed as socially unacceptable and thus the individual is therefore

at risk of social isolation (Blain, 2000; Goffman, 1963; O´Neil, 1981). The stigma associated with seeking therapy, has been divided into two types: public stigma and self-stigma (Corrigan, 2004).

***Public stigma*.** The public stigma associated with seeking therapy is the perception that the individual who seeks psychological support or treatment is undesirable and socially unacceptable (Vogel, Wade, & Haake, 2006). These perceptions, not only frequently lead to negative reactions toward the therapy-seeking individual, but can often be harmful to the individual because the perceptions lead to stereotyping, prejudice, and discrimination, and may be reasons why people hide psychological concerns and avoid treatment (Corrigan & Matthews, 2003; Corrigan, 2004). Corrigan calls this label avoidance, which is referred to as the tendency of denying mental health concerns and not wanting to seek psychological support or treatment because it can cause one to be negatively labeled.

Self-stigma. Self-stigma (when associated with seeking therapy) is the reduction of an individual's internalized self-concept, self-esteem, and self-efficacy if he/she were to seek therapy (Corrigan, 1998, 2004; Holmes & River, 1998). It is a sense of self-labeling oneself as socially unacceptable (Vogel et al., 2006). To preserve self-esteem and positive self-image, the individual may choose not to seek therapy, even when they are experiencing emotional pain, because of the belief that it would be a sign of weakness or an acknowledgment of failure (Ames, 1983; Fischer, Nadler, & Whitcher-Alagna, 1983; Miller, 1985; Nadler & Fischer, 1986). And by not seeking therapy, there is no risk that the individual may be negatively labeled by close others or by the public.

Fear of getting labeled - The modified labeling theory. How much do we care about becoming a victim of negative labels and what society thinks of us? The modified labeling theory, an adopted version of the original label theory by Scheff (1966), asserts that there is a perceived discrimination and devaluation from the society towards mentally ill patients, which in turn affects the individual with consequences of lowered self-esteem, withdrawal from society, but also an attempt to educate others in a hope to ward off negative attitudes. The more patients believe that they will be devalued and discriminated, the more threatened they will feel to interact with others, and may choose to keep treatment a secret. Finally they may become vulnerable to new mental disorders or to repeat episodes of existing disorders (for example increased numbers of panic attacks in a day) due to the labeling and stigma induced on them (Link, Cullen, Struening, Shrout, 1989). Hence, applying this theory to the topic of the current study, it may

suggest that individuals hold fears turned into negative attitudes even when it comes to seeking therapy because they are afraid of getting diagnosed and then being labeled and stigmatized by society or people in their network.

Defining seeking therapy. To clarify the terminology used in this thesis, whenever the term "seeking therapy" is used, it is referred to as any form of professional psychological help or support in the form of therapy, whether it is traditional psychodynamic therapy, cognitive behavioral therapy, or alternative psychological therapy. Secondly, the cause for seeking therapy referred to in this thesis includes therapy for persons struggling with emotional pain and distress to moderate mental health problems such as depression or anxiety, but excluding therapy for persons with more severe mental illnesses such as schizophrenia or bipolar disease.

Previous studies

The Swedish government recently took on a greater responsibility in order to increase the awareness about mental ill health and to increase the availability of treatment. They have partially done so through allocating resources for increased competence within psychotherapy (Socialstyrelsen 2013a, 2013b) and through contributions to affect the attitude of the general public towards persons who have a mental illness. Resources have for example been allocated to the governmental authority called Handisam which in cooperation with the entity NSPH (Nationell Samverkan för Psykisk Hälsa) ran a national campaign called Hjärnkoll (Handisam 2009). The Hjärnkoll campaign started in 2009 and ran until 2014 with the aim and purpose to increase the knowledge about, and change attitudes towards persons with mental illness and psychological dysfunction. Three hundred "ambassadors", regular private individuals, were recruited and educated to provide information about mental illness. They then participated in media and seminars, visited schools, workplaces, and various public places, engaged in discussions to increase the awareness about mental illness. The tagline of their campaign was "equal rights for mentally ill". By the end of the campaign, results presented showed that attitudes, knowledge and behavior significantly changed between 2009 and 2013, with a 5 percent increase of positive attitudes towards persons with a mental illness and disorders (CEPI, 2013). However, when it comes to investigating peoples' attitudes toward seeking professional (psychological) help in the form of therapy, and factors that may influence it, no study in Sweden (to the author's knowledge) exist.

Instead, the extensive amount of empirical research that exists on attitudes toward seeking help for mental illness, mental disorders, emotional concerns and distress, interpersonal problems, or career-counseling has been undertaken internationally. It seems that the majority of existing studies in Sweden have focused on attitudes towards persons with mental illness. For example, Swedish University students' attitudes (Markström, 2009), mental health professionals' attitudes (Hansson, Jormfeldt, Svedberg, & Svensson, 2011), or a larger sample trying to portray the general public's attitudes towards mentally ill persons (Högberg, Magnusson, Exertzon, & Lutzen, 2008). Other Swedish studies have focused on perceived discrimination of persons in contact with mental health services in Sweden (Hansson, Stjernswärd, & Svensson, 2013), or differences in mental health literacy and attitudes among mental health persons and persons with symptoms of mental illness with and without treatment contact (Dahlberg, Waern, & Runeson, 2008), or factors associated with help-seeking for mental health problems such as people's opinions and expectations of mental health care (Dahlberg, 2008). Below are central factors that influence attitudes toward seeking therapy presented.

Stigma & Social Support. Society can influence some individuals to feel shameful about seeking help. In a study by Diala et al., (2000) it was found that individuals are three times less likely to seek help if they knew that friends would find out about it due to the embarrassment they would experience. But before actually consulting a therapist, the majority of individuals prefer to first talk to their close family members and friends. The family members and friends' attitudes and opinions have a great impact on the individual with distressing symptoms. If the family members and friends have positive attitudes towards therapy, approve of such help services, and encourage help-seeking behavior, the attitudes of the distressed individual toward seeking help greatly inclines (Angermeyer, Matschinger, & Riedel-heller, 2001; Bayer & Peay, 1997; Narikyo & Kameoka, 1992; Rickwood & Braithwaite, 1994; Saunders, 1996; Vogel, Wester, Wei, & Boysen, 2005).

On the contrary, if the help-seeking individual anticipates negative attitudes and upsetting response from friends or family members, the individual will not likely seek therapy (Leaf, Livingston, and Tischler, 1986). In a study by Leaf, Bruce, Tischler & Holzer (1987) it was found that about 25% of the participants perceived that their family would be upset if they entered this form of treatment.

Perceived Public Stigma & Self-Stigma. David L. Vogel is one of the researchers who has conducted a vast amount of studies on attitudes toward seeking therapy/counseling. He and colleagues have studied different demographic factors affecting seeking therapy, where stigma has also been accounted for. Examples of his articles include "The perceived public stigma and the willingness to seek counseling; the mediating roles of self-stigma and attitudes toward counseling" (Vogel et al., 2007), "Attitudes toward career counseling: the role of public and self-stigma" (Ludwikowski, Vogel, & Armstrong, 2009), "Measuring the self-stigma associated with seeking psychological help" (Vogel, Wade, & Haake, 2006) and "the role of outcome expectations and attitudes on decisions to seek professional help" (Vogel et al., 2005). To summarise his overall findings, perceptions of public stigma contributed to the experience of self-stigma, which in turn influenced attitudes toward seeking therapy. More specifically, Vogel and colleagues (2007) found that self-stigma is a mediating factor on the link between public stigma and attitudes (and willingness) to seek therapy (see figure 1). Self-stigma is a more proximal indicator than perceived public stigma, and accounted for 57% of the variance in help-seeking attitudes for psychological and interpersonal concerns.

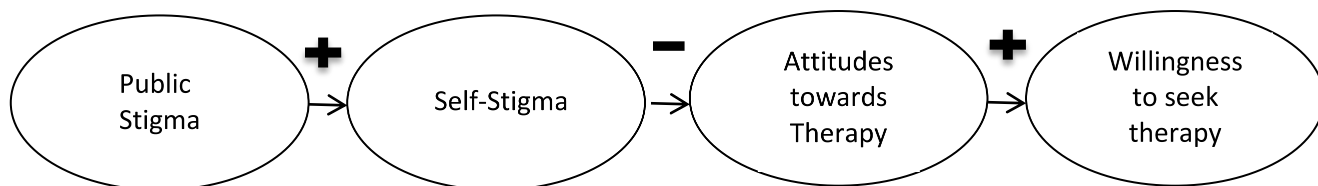

Figure 1. Mediated model (Vogel et al. 2007, p. 42). The figure displays that perceived public stigma is positively related to self-stigma, which in turn is negatively associated with the attitudes toward counseling/therapy, and that these attitudes are positively associated with willingness to seek help for psychological and interpersonal concerns

Age and Educational level. Age is an important factor to consider in help-seeking attitudes and intentions. Prior studies have found that young adults (those in their 20s) with a university degree have more favorable attitudes and intentions toward seeking therapy than elderly persons or persons without a university education (Vessey & Howard, 1993). A study by Veroff, Kulka and Douvan (1981) found that almost one quarter of individuals' with a university degree sought professional help; and out of these individuals, they were more than twice as likely to seek therapy than those individuals' without a degree.

Older adults (individuals over 65) have been found to have more negative attitudes toward seeking therapy (Allen, Walker, Shergill, D'ath, & Katona, 1998). And even though older adults

are particularly vulnerable to the effects of depression (Sirey, Bruce, & Alexopoulous, 2005), these elderly adults are less likely to be identified and treated (Conner et. al., 2010). It seems though that elderly adults doubt whether or not therapy will help, and may rather deal with the problems on their own (Conner et al., 2010) or by seeking help from a general medical doctor, which is consistent with the findings by Leaf et al. (1987). The qualitative study by Conner et al. (2010) who investigated barriers to treatment among depressed older adults, reported that some of their participants believed that they were "too old to be helped, and that mental health services should be reserved for younger individuals who might benefit more" (p. 977). Another participant expressed that if one could not handle one's own depression, you were weak and lacked personal strength (Conner et al., 2010). Lastly, another interesting finding suggested that terminology about depression mattered. Many participants perceived a reduced stigma attached to having a mental health problem when calling depression by another name, for example that one's nerves are bad (ibid).

Generational effects on attitudes toward seeking therapy. Today's generation seem to have more positive attitudes toward seeking therapy than older generations. In a study by Rojas-Vilches, Negy and Reig-Ferrer (2011) attitudes toward seeking therapy among Puerto Rican and Cuban American young adults and one of their parents were studied. The study comprised a total of 256 individuals (132 Puerto Ricans and 124 Cuban Americans, both males and females) who completed one demographic survey and five other surveys including the Beliefs toward Mental Illness Scale, Stigma Scale for Receiving Psychological Help, Bidimensional Acculturation Scale for Hispanics, Multidimensional Scale for Perceived Social Support, and nine items of the Intrinsic subscale of the Religiosity Scale. Among parents, the results showed that the more they (the parents) believed there is a public stigma attached to those with psychological problems and who receive therapy, the less likely they would be to seek therapy themselves for emotional problems and distress. The results also indicated the more they (the parents) believed that mental illness is untreatable, the less likely they would be to seek therapy themselves.

In contrast, the results for the young adults showed the opposite. They were significantly less likely to perceive those with mental illness as dangerous, lacking social skills or being stigmatized, than their parents, and they were more open towards seeking therapy.

On the contrary, in a 40-year (from 1968 to 2008) cross temporal meta-analysis by Mackenzie, Erickson, Deane and Wright (2014) they investigated changes in attitudes toward

seeking mental health services in 22 studies that comprised participants of college students in the United States. These studies were not seen as clinical samples (meeting the criteria for mental disorder or at risk for mental disorder) nor were recent immigrants (acculturation did not have to be considered for). Lastly, the studies had used Fischer and Turner's (1970) attitudes toward seeking professional psychological help scale. Findings indicated that attitudes have become increasingly negative over time, which in other words is suggesting that generations of today hold more negative attitudes toward seeking help than older generations. The authors suggest that these increasingly negative attitudes may be "a result of the intended negative effects of efforts in recent decades to reduce stigma" (Mackenzie et al., 2014, pp 99) and market biological therapies (drug treatments, electroconvulsive therapy, and psychosurgery) by making mental health problems seen as a pathological medical condition and to also be treated as such (Mackenzie et al., 2014).

Gender differences on attitudes toward seeking help. Gender roles have been found to play a part in help-seeking behavior and attitudes. Various studies found that women have more positive attitudes towards counseling (Fischer and Farina, 1995) and are more likely to seek help for emotional issues and emotional distress (Moller-Leimkuhler, 2002; Vogel et al., 2007), while men are more likely to seek help for severe psychiatric diagnoses (Leaf and Bruce, 1987)

To understand why there are these differences in help-seeking behavior it is important to look at influences of traditional gender roles. The traditional male gender role emphasizes being independent and in control; asking for help leads to increased concerns about loss of self-esteem as well as admitting the inability to handle things on one's own, hence directly threatening the masculine identity (Addis & Mahalik, 2003; Angermeyer, Matschinger, Riedel-Heller, 1999; Vogel et al., 2006; & Williams, 2000). The female traditional gender role emphasizes more on expressing how one feels and asking for help (Danielsson, 2012) when needed, which may therefore make it more expected and accepted by the public to do so. As for men, asking for help seems to be a perceived threat to the masculine gender role. It has been suggested that this perceived threat is associated with men's perception that there is a greater stigma associated with seeking help. According to Angermeyer et al. (1999) and Vogel, Wester, and Larson (2007) society regards therapy as a last resort and therefore men feel a greater sense of failure if they ask for help. Consistent with these findings are Vogel et al., (2006) who showed that men experienced greater self-stigma than women regarding help-seeking in college settings and that gender was

found to be a moderator such that men internalized public stigma as self-stigma to a greater degree than what women did (Vogel, Wade & Ascheman, 2008). Hence, men's attitudes toward seeking therapy therefore seem to be more conservative and negative than women's and they are less inclined to seek help when they need it (Courtenay, 2003; Fischer & Turner, 1970; Good, Dell, & Mintz, 1989; Tudiver & Talbot, 1999).

Lastly, Levant, McMillan, Kelleher, and Sellers (2005) investigated the impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward seeking professional psychological help. They found that men who score higher on measures of gender role conflict and traditional masculinity ideology tend to have more negative attitudes toward seeking psychological help. Their findings are consistent with a meta-analysis by Yulish, Oleen-Junk, Raines, Sanchez, Wampold (2014) where they investigated the relationship between masculine ideology and attitudes toward seeking help in adult men across 38 studies in the years between 1987 and 2013. They found that on average, men with higher scores of masculine identity were significantly less willing to seek therapy.

Prior experience of therapy. Many studies have found that individuals with prior experience of psychosocial services have more positive attitudes towards seeking help. One of these studies is Vogel et al. (2005) who studied predictors of seeking psychological services. With a sample of 354 respondents, they found that five psychological factors (social support, self-disclosure, anticipated utility, social stigma, and social norm) as well as previous use of therapy significantly predicted attitudes towards seeking professional help. This is consistent with the findings of later studies (Anderson & Demyan, 2012; Turner & Heffer, 2007); participants who had seen a therapist in the past reported more positive attitudes toward mental health care services than those who had not seen one in the past.

Summary of Prior Studies

There exists a vast amount of research on the subject of help-seeking attitudes toward therapy, however, most have been made internationally and little or none exist in Sweden. Instead, prior studies that exist in Sweden have focused on investigating peoples' attitudes toward mental illness or the perceived public stigma toward the mentally ill; none (to the author's knowledge) have examined individuals' attitudes toward seeking therapy. In international studies, many different factors have been examined that impact attitudes toward seeking therapy, and

some of the central ones include perceived public stigma, self-stigma, social support, age, educational level, generational effects, gender differences, and prior experience of therapy. David L. Vogel has conducted a vast amount of studies on attitudes toward seeking therapy and has proposed various hypothesized models to examine the relationship between help-seeking and various factors, in which one of the models is being used in this thesis (Figure 1). With a population sample of (680 American college students), Vogel's findings show that perceived public stigma contributes to the experience of self-stigma, which in turn influences attitudes toward seeking therapy. Other prior studies present contradictory results amongst the impact of some of the other central factors. For example, while Rojas-Vilches et al. (2011) have found that today's generation holds more positive attitudes towards help-seeking than older generations, Mackenzie et al. (2014) report opposite findings. As for the remaining central factors mentioned, prior studies have found consistent results. Will a Swedish population sample be consistent with these results? If so, how will they differ?

Objective

The aim of this thesis is to investigate which factors (gender, age, level of education, and prior experience of therapy) impact attitudes towards seeking therapy in Sweden, and if there are any significant main effects and interactions effects. Further, the thesis also aims to look at perceived public stigma and self-stigma associated with seeking therapy and, to investigate which one of the latter two variables is the best to predict attitudes toward seeking therapy.

Research Questions:

1. What is the impact of the demographic variables (gender, age, educational level, and prior experience of therapy) on attitudes toward seeking therapy/professional (psychological) help?
2. Is there an interaction effect between the demographic variables (gender, age, educational level, and prior experience of therapy) that moderate attitudes of seeking therapy/professional (psychological) help?
3. Is there a correlation between attitudes toward seeking therapy and: a) perceived public stigma and b) self-stigma?
4. Which of the two variables, perceived public stigma or self-stigma, is the best to predict attitudes toward seeking therapy/professional (psychological) help?

Hypotheses:

1. Women have more positive attitudes towards seeking therapy than men.
2. Persons with a higher level of education have more positive attitudes towards seeking therapy.
3. Persons with greater perception of being publically stigmatized have less positive attitudes towards seeking therapy.
4. Persons who self-stigmatize more have less positive attitudes towards seeking therapy.

Method

Participants. The study participants were 193 adults who ranged in age from 19 to 62 years old (*M*=37.9, *SD*=12.45), and included both men and women (96 men and 97 women, see table 1). The recruitment of participants mainly took place in Malmo from various public places, various work related places, and Malmö University, and a few participants were recruited in Lund. The reason why most of the participants were recruited in Malmö was because Lund is widely an academic city and it can be assumed that majority of persons living there will have a higher level of education, which potentially could affect the results when investigating its impact on help-seeking attitudes. Further, as a population-sample to reflect the Swedish population as a whole was favored; the recruitment of participants took place not only in public places (square markets, shopping malls, the central train station) but also at a university and various work related places, to ensure an even wider spread.

Table 1. *Demographic data overview*

Characteristics	*n* (%)
Gender	
Women	97 (47.3)
Men	96 (46.8)
Missing data	12 (5.9)
Age	
19 -30 (young)	66 (32.2)
31-44 (mature)	66 (32.2)
45-62 (older)	60 (29.3)
Missing data	13 (6.3)
Educational Level	
High School	42 (20.5)
Post-High School	39 (19.0)
University <2 years	47 (22.9)
University ≥2 years	60 (29.3)
Missing data	17 (8.3)
Prior Experience Therapy	
No	133 (64.9)
Yes	58 (28.3)
Missing data	14 (6.8)

Instruments. Three instruments and one demographic questionnaire were collected into a single self-report survey of 34 items. The three instruments used a Likert type response. The first page of the survey (Appendix B) comprised of six questions about demographic information, one "yes" or "no" question about prior experience of therapy, and one "yes", "unsure"; and "no" question about knowledge of where to seek professional help; and one "yes" or "no" question about perceived social support.

Self-stigma. The first ten items comprised the Self-stigma of Seeking Help Scale (SSOHS), designed by Vogel et al. (2006). The items were scored using a 5-point Likert type scale ranging from 1 (strongly disagree) to 5 (strongly agree). An example of a sample item is: "I would feel inadequate if I went to a therapist for psychological help." The SSOHS has been found to negatively correlate with attitudes toward seeking help. Total scores range from 0 to 50, where higher scores reflect greater perceptions of self-stigma. Estimates of the internal consistency (Cronbach's alpha) as estimated by Vogel et al. (2006), range from .86 to .90.

Perceived Social Stigma. After the self-stigma instrument, five items of the adapted version of the Stigma scale for receiving psychological help (SSRPH) followed. This instrument measures the respondent's perception of how stigmatizing it is to receive psychological help was followed. The items were scored using a 4-point Likert type scale ranging from zero (strongly agree) to 3 (strongly disagree). Higher scores reflect the respondent's view of there being social stigma attached to those persons (with mental illnesses and) who receive therapy. The scale was designed by Komiya, Good, and Sherrod (2000), and has been found to negatively correlate with attitudes toward seeking help. Total scores range from 0 to 15, with higher scores reflecting higher validation of the view of that there is social stigma attached to seeking professional (psychological) help/therapy. Internal consistency, as estimated by Komiya et al. (2000) was good with a Cronbach's alpha = .72

Attitudes towards seeking therapy. The last scale comprised the abbreviated version of the Attitude toward seeking professional psychological help scale (ATSPPHS – short form; Fischer and Farina; 1995). This instrument explores the relationship between attitudes toward seeking psychological help to other explanatory variables. It comprises 10 items chosen from Fischer and Turner's (1970) attitudes toward seeking professional psychological help scale. It uses a 4-point Likert type scale ranging 1 (agree) to 4 (disagree). Total scores ranged from 0 to 30, with higher scores reflecting positive attitudes toward seeking professional (psychological) help/therapy with personal or family problems. An example of one of the items included is: "If I believed I was having a mental breakdown, my first inclination would be to get professional help". Internal consistency, as estimated by Fischer and Farina; 1995, was good with a Cronbach's alpha = .84

Translation phase of Instruments. Back-to-back translation method was used. In the first stage of the translation phase, the three instruments were translated from English to Swedish by a person who writes and speaks Swedish and English fluently. In the second stage, the instruments were translated back to English by another person with the same language skills as the first translator. This is performed in order to guarantee a high quality of the translation (Beaton & Guillemin, 2000). In the third stage, the author of the study compared the original version of the scales with the translated version in order to discover flaws or any words not in consensus in the translation. Lastly, all the items that were translated into Swedish were critically reviewed by a PhD student in linguistics, as well as by three other persons. This was done in order to secure the linguistic correctness as well as to grasp the cultural meaning and maintain the content validity of

the scales at a conceptual level. Hence, there were some words that could not be translated directly, but instead the sentence as a whole provided the same meaning. As Beaton and Guillemin (2000) point out, cross-cultural adaptation must be considered during the process of conducting a survey for use in another setting (in this case in another country with different language than English).

Procedure. The study was conducted through survey self-report measures that were given out individually to each participant. There were two student assistants' who distributed the surveys, and when recruiting the participants, the participants' were first only informed that the study was about attitudes. More detailed information was given in a cover letter attached to the survey explaining the purpose of the study together with information about voluntary participation and anonymity. Respondents were asked to fill out self-answered questions. But before they were to do so, they were asked to fill out a demographic sheet asking about gender, age, occupation, education level, country of birth, parents country of birth, prior experience of therapy, knowledge about seeking professional help/therapy; and perceived social support respectively. The completed surveys were returned to a research assistant.

Ethical considerations. First, since the surveys were anonymous, all the data was non-identifiable already from the start of the collection. On the first page, an information letter to the recruited participants, it stated that no information would make it possible to trace their answers back to them (see Appendix A). Further, it also stated that it was voluntary to participate in the study, and that they could at any time discontinue their participation. Each participant also had to confirm that they had read the information in the cover letter and approved to participate in the study by checking a box for "yes" on a separate sheet of agreement. The ethical considerations concerning the questions on the survey, were regarded not to have a psychological post effect, and therefore seen as non-violating in any kind of way.

Data analysis. The statistical calculations were made using Statistical Package for Social Sciences (SPSS) version 22. When the data from the surveys was input, some missing data was noticed. Also, some participants fell outside of the required age span. Therefore, when conducting the testing on the total data, these missing values and participants above the target age were excluded from the data set, which was not found to be a problem since there was such a high

remaining number of study participants in the sample (N = 193; see table 1). After all the data was inserted to SPSS, some variables were coded. Gender was coded 0 for woman and 1 for man. Age which comprised 19 to 62 was divided into three categories proposed by SPSS Survival Manual Guide by Pallant (2013); 1 = 18-29 years (referred to as young adults), 2 = 30-44 years (referred to as mature adults), 3 = 45+yrs (referred to as older adults), with one minor modification. Instead of 1 = 18-29 years, 19-29 was used as this was the starting age for the current study, and 3 = 45-62 years was used as 62 years was the maximum age in the current study. Level of education was coded 1 for Years 1 to 9; primary and secondary school ("Grundskola"); 2 for High School; 3 for post-High School Education; 4 for University less than two years; and 5 for University equal to or more than two years. However, it was found that group 1 (Years 1 to 9) level of education only consisted of 2 participants, therefore these were excluded. Prior experience of therapy was coded 0 for "No", and 1 for "Yes". Country of birth for respondents and their parents respectively were intended to be coded 0 for individualistic cultural background and 1 for collectivistic cultural background. However, insufficient participants were found to belong to the collectivistic group. Therefore, these two variables were excluded completely from the data analysis. Further, the demographic questionnaire also included other items (occupation and perceived social support), but these were chosen to be excluded from the study completely, either due to time restrictions but mainly because insufficient participants were found in each of the levels to conduct testing and provide reliable statistical results.

For each of the three instruments (self-stigma scale, public stigma scale and attitudes towards seeking professional psychological help scale) a total sum of the scores were calculated for each participant and entered in a new column.

To describe the characteristics of the research group and to calculate the frequencies and missing values, descriptive statistics were used. One outlier was found and this participant was excluded from the data set. When looking at the impact of the demographic factors on attitudes toward seeking therapy (the first research question), t-test was used and ANOVA for the independent variables that had more than two levels (age and level of education). As it was found that Group 1 (years 1 to 9) of educational level only consisted of two participants, these two values were excluded from the data set, and the Group 1 was not used for data analysis. Effect size was calculated using Eta squared. Using Cohen's (1988, p. 284-7, referenced in Pallant, 2003) guidelines; 0.01 = small effect size; 0.06 = moderate effect size; and 0.14 = large effect size.

The correlation calculations were performed using Pearson Correlation (r) in order to determine the relationship between the variables measured. When the correlations were found to be significant, a multiple regression analysis was performed in order to calculate the predictors' variance accounted for of the dependent variable. Because normal distribution, linearity and homoscedasticity were found to be present and not violated, the correlations were done using Pearson Correlation. The interpretation of the strength of statistically significant correlation is determined using Cohen (1988, p. 79-81, referenced in Pallant, 2003) guidelines where a weak relationship is found if r = 0.10-0.30; a moderate relationship is found if r = 0.30-0.50; and a strong relationship is found if r = 0.50-1.0.

Results

The results are presented in the section below. Table 2 shows the frequencies of valid and missing data of the three measurements used in this study.

Table 2. *Frequency responses and missing data*

	Self-Stigma	Public Stigma	ATSPPH*
N valid data	182	190	178
Missing data	23	15	27

*ATSPPH (attitudes toward seeking professional psychological help)

The overall mean value for the participant in this study for the three scales were the following; self-stigma (SSOHS) 23.0 (*SD* 7.02), perceived public stigma (SSRPH) 15.0 (*SD* 3.76), and attitudes towards seeking therapy (ATSPPHS-SF) 27.94 (*SD* 6.17). Mean values for each age group (young, mature, older) are presented in table 3 below.

Table 3. *Minimum and maximum scores for each scale. Mean values within age categories.*

	Self-Stigma	Public Stigma	ATSPPH*
Min - Max scores	10 to 42	0 to 15	11 to 40
19-30yrs (young)	26.6 (*SD* 6.39)	7.2 (*SD* 3.82)	26.6 (*SD* 6.39)
31-44yrs (mature)	28.9 (*SD* 6.11)	6.8 (*SD* 3.96)	28.9 (*SD* 6.11)
45-62yrs (older)	27.9 (*SD* 6.02)	7.4 (*SD* 3.43)	28.2 (*SD* 6.02)

*ATSPPH (attitudes toward seeking professional psychological help)

Research question one: *What is the impact of the demographic variables (gender, age, educational level, and prior experience of therapy) on attitudes toward seeking therapy?*

Gender. An independent-samples t-test was conducted in order to compare attitudes towards seeking therapy for males and females. There was a significant difference in scores for males (M = 26.06, SD = 6.18) and females (M = 29.86, SD = 5.55; t (174) = 4.30, $p < 0.01$, two-tailed). The magnitude of the differences of the means was moderate (eta squared = 0.098).

Age. Age was tested to see whether it had an impact on attitudes toward seeking therapy by conducting a one-way between-groups analysis of variance. The participants were divided into three groups. The result however, showed no statistically significant difference between any of the groups.

Educational level. To analyze if educational level had an impact on attitudes toward seeking therapy a one-way between-groups analysis of variance was conducted. Participants were divided into four groups (high school, post-high school education, university less than two years, and university equal to or more than two years). There was a statistically significant difference at the $p < 0.01$ levels in ATSPPHS-SF for two of the four educational groups: F (3, 169) = 6.6, $p < 0.01$. The differences in the mean scores between the groups ranged from 26.4 for High School to 30.5 for University equal to or more than two years. The effect size was calculated using eta squared with a moderate effect size (eta squared = 0.12). Post-hoc comparisons using the Tukey HSD test indicated that the mean score for group 4 (M = 30.49, SD = 5.61) was significantly different from group 1 (M = 26.44, SD = 5.94) and group 2 (M = 25.21, SD = 5.95). Group 3 (M = 28.11, SD = 6.29) did not differ significantly from either group 1, 2 or 4.

Prior experiences of therapy. An independent-samples t-test was conducted in order to investigate the impact of prior experiences of therapy on attitudes towards seeking therapy. There was a significant difference in scores for those who did not have prior experience of therapy (M = 26.31, SD = 5.89) and for those who did have prior experience of therapy (M = 31.71, SD = 5.26; t (172) = 5.81, $p < 0.01$, two-tailed). The magnitude of the differences of the means was large (eta squared = 0.164).

Research question two: *Is there an interaction effect between the demographic variables (gender, age, educational level, and prior experience of therapy) that moderate attitudes of seeking therapy?*

Gender and age. A two-way between group analysis of variance was conducted to explore the impact of gender and age on attitudes toward seeking help/therapy, as measured by the ATTSPH-SF. Results indicated that the interaction effect between gender and age group was not statistically significant, F (2, 167) = .34, p = 0.71. There was a statistically significant main effect for gender F (2, 167) = 20.87, $p < 0.01$; and the effect size was moderate (partial eta squared = 0.11). Females scored significantly higher than males in each of the three age groups (with a mean total value of 30 points verses males with a total mean score of 26 points where maximum was 40 points), meaning that females overall had more positive attitudes toward seeking therapy. There was also a statistically significant main effect for age F (2, 167) = 3.08, p = 0.048; and the effect size was small (partial eta squared = 0.04). However the post-hoc comparisons, using the Tukey HSD test, for the three age groups showed that there was no statistically significant result.

Gender and educational level. A two-way between group analysis of variance was conducted to investigate the impact of gender and educational level on attitudes toward seeking therapy, as measured by the ATSPPHS-SF. Results indicated that there was a statistically significant main effect for gender, F (1, 163) = 23.01, $p < 0.01$; with a moderate effect size (partial eta squared = 0.12). Overall, females had significantly more positive attitudes than males toward seeking therapy. There was also a statistically significant main effect for educational level F (3, 163) = 6.95, $p < 0.01$; with a moderate effect size (partial eta squared = 0.11). Those who had studied two years or more at university had the most positive attitudes toward seeking therapy. There was also a significant interaction between gender and educational level in respect to attitudes toward seeking therapy scores, F (3, 163) = 4.37, $p < 0.01$; with a moderate effect size (partial eta squared = 0.07). While females who had studied less than two years at university had the most positive attitudes, males who had studied two years or more at university had the most positive attitudes.

Gender and prior experience of therapy. To explore the impact of gender and prior experience of therapy on attitudes toward seeking help/therapy, as measured by the ATTSPH-SF

a two-way between group analysis of variance was conducted. Results indicated that the interaction effect between gender and prior experience of therapy was not statistically significant, F (1, 168) = 2.07, p = 0.15. There was a statistically significant main effect for gender F (1, 168) = 9.81, $p < 0.01$; however the effect size was small (partial eta squared = 0.06). There was also a statistically significant main effect for prior experience F (1, 168) = 29.78, $p < 0.01$; and the effect size was large (partial eta squared = 0.15).

Research question three: *Is there a correlation between attitudes toward seeking therapy and 1) perceived public stigma; and 2) self-stigma?*

The relationship between 1) perceived public stigma, as measured by the Stigma scale for receiving psychological help (SSRPH), and attitudes towards seeking help measured by ATSPPH-SF; and 2) self-stigma as measured by the Self-stigma of Seeking Help Scale (SSOHS), and attitude towards seeking help were investigated using Pearson product-moment correlation coefficient. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity and homoscedasticity. The results indicated that there was strong, negative correlation between perceived public stigma and attitudes towards seeking therapy; r = - 0.51, N = 174, $p < 0.01$, with high levels of perceived public-stigma associated with lower levels of attitudes of seeking therapy. In other words the higher the perceived public stigma the more negative attitudes toward seeking therapy. Secondly, the relationship between 2) self-stigma and attitudes towards seeking help showed that there was an even stronger, negative correlation between the two variables; r = - 0.72, N = 167, $p < 0.01$, with high levels of self-stigma associated with lower levels of attitudes of seeking help/therapy. In other words the higher the self-stigma the more negative attitudes toward seeking therapy.

Research question four: *Which variable (perceived public stigma or self-stigma) is the best to predict attitudes toward seeking therapy/professional (psychological) help?*

Standard multiple regression was used to answer this question. Preliminary analyses were performed to ensure no violation of the assumptions of normality, linearity, multicollinearity and homoscedasticity. Self-stigma, and perceived public-stigma, with attitudes towards seeking professional help were tested by a multivariate regression analysis, using the sum score of

attitudes toward seeking professional help scale (ATSPPHS-SF) as the dependent variable. Sum of scores of self-stigma and perceived public stigma was used as predictor variables. The total variance explained of the model as a whole was 54.3 %, $F (2, 160) = 66.83$, $p < 0.01$. Both variables were statistically significant, with self-stigma recording the highest impacting beta value; self-stigma ($\beta = - 0.64$), $p < 0.01$; perceived public stigma ($\beta = - 0.15$), $p < 0.05$. Self-stigma and perceived public stigma showed a relationship with attitudes toward seeking therapy; where self-stigma accounted for 28 %, and public stigma for 1.6 % of the total variance.

Additional analyses

Because stigma was found to have a significant impact on attitudes toward seeking therapy, it was decided to carry out additional analyses on these two variables.

Gender and self-stigma. An independent-samples t-test was conducted in order to compare self-stigma for males and females. There was a significant different in scores for males (M = 24.87, SD = 7.09) and females (M = 21.10, SD = 6.39; t (178) = -3.75, $p < 0.01$, two-tailed). The magnitude of the differences of the means was moderate (eta squared = 0.08).

Gender and public stigma. An independent-samples t-test was conducted in order to compare public stigma for males and females. The results were however not significant.

Prior experience of therapy. A frequency analysis was conducted to find out if (and how many) participants knew where to turn to if the need to seek therapy for oneself or a close other arose. Results indicated the following: “No” = 25 (valid 12.9 %); “Unsure” = 70 (valid 36.1%); “Yes” = 99 (valid 51.0%); and 11 missing values of participants who had left this question blank.

Discussion

The aim of the study was to investigate socio-demographic factors' impact on attitudes toward seeking therapy, and if there were any significant main and interaction effects. Secondly, the aim was also to investigate the relationship of public stigma and self-stigma on attitudes toward seeking therapy, and to investigate which of these two variables was the best to predict help-seeking attitudes.

Research question one

Gender. The results showed that females have more positive attitudes than men towards seeking therapy. This result not only supports the hypothesis but also is consistent with prior research (Courtenay, 2003; Fischer & Farina, 1995; Fischer & Turner, 1970; Good et al., 1989; Levant et al., 2005; and Tudiver & Talbot, 1999;). The reason for this outcome may have to do with how traditional gender roles and gender role expectations are represented, and associated to whether professional support in terms of therapy is sought. The female role, with an emphasis on nurture and emotional expressivity, may make it easier for women to disclose their problems and feelings to others, whereas the male role with an emphasis on achievement, success, emotional inexpressiveness, being independent and in control, makes it difficult for men to seek support when they are under stress (Belle, 1987; McMullen & Gross, 1983; Shumaker & Hill, 1991) or when dealing with emotional devastating life events or interpersonal problems. Women are "expected" to need help in times of stress, whether it is from people in their network or otherwise (Fischer et al., 1988). Therefore, women are less likely to feel ashamed to openly express their acceptance and positive attitudes towards seeking help (Dunkel-Schetter & Skokan, 1990).

Reasons why men hold more negative attitudes towards seeking therapy seems to be because they experience a greater sense of stigma from the public and also internally stigmatizing themselves (self-stigma). This is what the results in the current study confirm regarding self-stigma (but not regarding public stigma) and is consistent with the findings from Vogel at al. (2006; 2008). It could be proposed that men (in Sweden similarly to those in the United States where the prior studies have been conducted) in comparison to women, self-stigmatize themselves more because they usually identify themselves with a traditional male gender role that emphasizes being independent and in control. Asking for help would then increase concerns about loss of self-esteem as well as admitting the inability to handle things on one's own, hence directly

threatening the man's masculine identity. This is consistent with prior research (Levant, 2005; and Yulish, 2014) regarding the relationship between traditional masculinity ideology and negative attitudes toward seeking psychological help.

Why women hold more positive attitudes toward therapy could be due the nature of their traditional gender role; to express how they feel and to ask for help (Danielsson, 2012) and also more expected and accepted by the public to do so. Secondly, women connect better with their emotional feelings than men, and may also have a less hard time sharing emotional feelings and thoughts than men (Fischer, 2000; Mirowsky, 1995) and therefore do not see the setting of a therapy session as intimidating as a man would do, nor would it be a threat to their traditional gender role as it would for men.

Age and Generation. Prior research has found conflicting results when it comes to age and attitudes toward seeking therapy. Some publications indicate that the younger adults of today's generation have more positive attitudes toward seeking therapy (Rojas-Vilches et al., 2011), while other studies have found the contrary (Mackenzie et al., 2014). In the current study, age was not a significant factor ($p = 0.13$) among the three age categories, meaning that neither young, mature nor older adults hold more or less positive/negative attitudes toward seeking therapy. However, even though there is no significant difference among the mean scores for the three groups, mature adults (Group 2) have the highest mean score (28.9 of 40) on the scale for attitudes toward seeking therapy. Older adults (Group 3) have nearly the same mean score (28.2) as mature adults, while young adults only have a slightly lower mean score of 26.6 (as seen in Table 3).

On the assumption, however, that these results are statistically significant, speculations about (or as to) why young adults have the least positive attitudes toward seeking therapy can be made. In comparison to mature adults and older adults, these individuals are in their 20s and may be more sensitive to identity – and self-esteem threats, social norms and labeling effects, since this age-frame is still a time of developing autonomy and enhancing one's sense of identity. Secondly, life crises are likely to be less in a person's 20s than in their 30s to 60s (Group 2 and Group 3). Usually, though not in all cases, the main concerns and stress factors for individuals in their 20s is university with assignments and exams to prepare for. Whereas individuals' in their 30s and early 40s often have a career, a marriage, and a family to manage, which sometimes can be an overload or an overwhelming amount to cope with. Therefore, seeking therapy may not

(yet) be a resource that comes to mind to be utilized. Instead, individuals in their 20s may (still) turn to their parents/families/friends for coping and/or emotional support, more than individuals in Group 2 and 3.

Educational level. The results concerning educational level support both the hypothesis and prior research. The current study shows that individuals higher levels of education (have studied at university) have more positive attitudes toward seeking therapy, which is consistent with Veroff (1981), and Vessey and Howard (1993). Individuals with higher levels of education may be less prone to perceived public stigma associated with mental and emotional ill health and thus feel less shame toward seeking therapy. Also, they may also self-stigmatize themselves less than individuals with lower levels of education who do not have university experience.

Prior experience. The results show that people who had prior experience of therapy hold more positive attitudes towards seeking therapy, which supports previous research. This confirms the hypothesis and is also consistent with prior research (Anderson & Demyan, 2012; Turner & Heffer, 2007; Vogel et al., 2005). Reasons why prior experience adds to positive attitudes towards seeking therapy could be because the experience brings knowledge, and knowledge diminishes prejudice, stereotypes, misconceptions and stigma, meaning that an individual who has already attended therapy before knows if it is beneficial and what it entails.

Research question two

Relationship between age and gender on attitudes toward seeking therapy. The results indicate that there is a main effect for both gender and age respectively, but no statistically significant interaction effects are found. However, when looking closer at the descriptive data analysis for post hoc, age is no longer statistically significant; there is only a tendency between young and mature adults. This tendency of young and mature adults holding more positive attitudes is contradictory to above results (in the "Age and Generation" section), where young adults were found to have the lowest mean scores on the scale for attitudes toward seeking therapy. However, those results did not come out as statistically significant.

Speculating why young and mature adults have a tendency to hold more positive attitudes than older adults toward seeking therapy could be that trends in society have changed over generations. That is to say that the older generation, such as those adults above 50, grew up in a

society where going to a therapist was more for the severely mentally ill and not for emotional issues such as distress, anxiety or interpersonal problems. Maybe our society today has become more influenced by other cultures, such as the U.S, where therapy is widely used as a common means of life support in any matter, which we are frequently exposed to in the media. Therefore adults aged 19-45 seem to perceive seeking therapy as more expected and more accepted. The results concerning gender have been discussed earlier.

Impact of gender and educational level on attitudes toward seeking therapy. Results indicate that there is a statistically significant main effect both for gender and educational level. Women overall have more positive attitudes than men toward seeking therapy, which is consistent with prior studies and supports the hypothesis in this thesis. Similar, individuals who have studied two years or more at university have the most positive attitudes toward seeking therapy, which also supports prior studies and the hypothesis. With a significant interaction effect between gender and educational level, the results show that women across all educational levels have, except for Group 4 (studied at university ≥ 2), higher mean scores of attitudes toward seeking therapy than men. It is interesting to note however, that women's mean score of attitudes slightly drop between having studied up to two years at university with those who have studied two years or more (i.e. those females who have studied up to two years have more positive attitudes). While men develop more positive attitudes with more years studied at university. Reasons for the women's results could possibly be because the fear of not coping is greater once getting close to finishing the university degree than if only having studied a few semesters. The inner pressure that this may create could therefore be linked to seeking therapy – as seeing a therapist would express a sense of failure or inability to cope. Men on the other hand become more positive the more years at university they have studied which may be because as they become more mature they are more accepting of the idea of receiving help as a means of support without perceiving it as a sign of failure.

Impact of between gender and prior experience of therapy on attitudes toward seeking therapy. Similar to previous reported results in this thesis, both gender and prior experience of therapy respectively show statistically significant main effects. However, no interaction effect of the two variables on attitudes toward seeking therapy is found. This would be interpreted as prior experience of having seen a therapist cannot be explained due to gender, i.e

not being gender specific. Furthermore, it is most likely that if the experience has been a positive one; attitudes towards therapy will also be more positive.

Research question three

Relationship between perceived public stigma and self-stigma on attitudes toward seeking therapy. The results indicate that both perceived public stigma and self-stigma correlates negatively with attitudes toward seeking help, which supports the hypotheses. However, prior research presented in this thesis has not found a significant correlation between public stigma and attitudes toward seeking therapy. Yet it is important to mention that the results from Vogel et al. (2007) used a mediated model (figure 1) where public stigma contributes to self-stigma (correlates positively) which in turn (self-stigma) correlates negatively with attitudes toward seeking therapy. This means that the higher the self-stigma one perceives, the more negative attitudes are held.

Further, the correlation between self-stigma and attitudes toward seeking therapy support the hypothesis as well as Vogel et al. (2007) findings (a strong negative correlation between self-stigma and attitudes toward therapy). Why an individual has a high internal self-stigma when it comes to one's attitudes toward seeking therapy could have many possible explanations. For instance, we adopt opinions from our friends and family, and if they think that seeking therapy is a sign of weakness (while we first did not) we will develop similar thoughts in order to avoid cognitive dissonance and restore internal balance (as suggested by the balance theory). However, our friends and family's negatively expressed thoughts and opinions contribute to a reduction of our self-esteem or self-worth, which in turn increases self-stigma and an increased negative attitude toward seeking therapy. Similarly, just the perception of being negatively labeled by others, be it from friends, family or society in general, also contributes to an increased self-stigma. For instance, getting labeled as "emotionally unstable" or "mentally ill" will most likely lower our self-esteem or self-worth leading to high self-stigma and negative attitudes toward seeking therapy.

Research question four

Best predictor - perceived public stigma or self-stigma? The result from the multiple regression show that both self-stigma and public-stigma significantly predict attitudes toward seeking therapy but that self-stigma accounts for more than one fourth of the total variance. Self-

stigma is the best variable of the two to predict attitudes toward seeking therapy. This can be interpreted as; though the stigma one perceives from the public does affect one's attitudes toward seeking therapy, one's tendency to self-stigmatize is a greater predictor of help-seeking attitudes. Besides supporting the modified labeling theory and the findings of Vogel et al. (2007), the results show that self-stigma plays a significant role in the formation of attitudes toward seeking therapy and most likely also the willingness to seek therapy services.

Additional analyses

An additional analysis on self-stigma was performed in order to investigate it in more detail. The results concerning gender and self-stigma show that men score higher on the self-stigma scale than women, indicating that men internally stigmatize themselves more than women do. This seems likely since above prior results in this study show that women hold more positive attitudes toward seeking therapy than men do, which is consistent with findings of prior studies (Vogel et al., 2006). One of the reasons could be due to their traditional masculine gender role where asking for help is perceived as a sign of weakness and failure. Consistent with this is that self-stigma is found to negatively correlate with attitudes toward seeking therapy, meaning the higher the self-stigma, the less positive the attitudes. It therefore seems likely that the higher the tendency for men to internally stigmatize themselves, the less positive the attitudes they have toward seeking therapy. A reason why men indicate a higher self-stigma than women, could potentially have to do with the way men incorporate perceived public stigma into internal stigma associated with seeking therapy, which is what Vogel et al., (2008) found; men internalized public stigma as self-stigma to a greater degree than women did.

Moreover, an analysis to examine people's awareness of where to turn to for professional help to seek therapy was also performed. The result is quite interesting as it shows that only around half of the total participants actually know where to turn to in order to seek help. It is somewhat worrying and surprising, since we live in a society with good resources and with available support from licensed psychologists, alternative therapists, and from the local health center (vårdcentral). Still so many are either unsure or do not know where to turn to if they themselves or someone in their network needs professional help in the form of therapy. This suggests that there is somehow a gap in the awareness and the communication to the public about therapy services that ought to be filled.

Strengths and Limitations

Internal validity. The three instruments used in this study are well-established scales, validated by prior researchers, and have a high Cronbach's alpha. The scales were however only found in English, and therefore they had to be translated into Swedish. The final markup of the translation emphasized on communicating the same semantic meaning in Swedish as in English; rather than word-by-word translation. The translations were first done by back-to-back translation. Then they were looked at by three persons (separately) who speak and write Swedish and English fluently. Lastly, a pilot testing of all the translated items was done to make sure that the respondent grasped the questions. This thorough process would make it fair to say that the end result of the translation holds a high internal validity.

The demographic questionnaire (part of the survey; Appendix B) consisted of a total of nine questions, but three of them were excluded from the data analysis. Question 5 and 6 which were about one's country of birth, and parents' country of birth respectively were initially thought to be an interesting variable to study, but during data analysis it was found that not enough participants responded in each separate group and therefore had to be excluded completely. Question 9 (about perceived social support from close others) was also excluded from the study due to time restrictions.

When recruiting the participants, two male assistants were given the same verbal instructions by the author of this thesis when distributing the surveys. However, because the author was not present during the recruitment, it is unknown if the assistants made small alterations respectively, and if that then had an effect on the individuals' willingness to participate in the study, or when filling out the survey.

Another important factor to keep in mind is the social desirability; meaning that participants may have answered the questions in the survey according to what they perceive is socially desirable and not how they truly feel. Also questionable is, if gender of the assistants' who carried out the recruitment had an effect on the participants' way of answering the survey questions. For example, participants' tendency to answer what is socially desirable may differ more or less if it were a male or a female distributing the surveys. However, because the overall final results are consistent with prior studies, it does not seem like the case. Therefore, would be it fair to say that there was a good internal consistency.

External validity. The current study shows similar results as with prior studies when it comes to gender, educational level, prior experience of therapy, and self-stigma. This would suggest a good external validity, that the sample population is somewhat representative for the Swedish population. However, the recruitment of participants for this thesis was done in Malmö which is the third largest city in Sweden, except for a select few that took place in Lund. No recruitments took place in rural areas or other various cities (large and small) around Sweden. Maybe the sense of taboo amongst people in rural areas when it comes to help-seeking attitudes is higher than those in larger cities. It can therefore be questionable if the results are representative for Sweden as a whole. Further, because the current study can only be compared to previous studies conducted in the United States, it is more difficult to know if the results are reasonable. However, due to the strong significant values and similarities to previous studies in the United States, which is also an individualistic culture, it would plausibly be fair to say that the results are valid and rather representative.

Future studies

First, the study consisted mostly of individuals from an individualistic cultural background. It would be interesting to conduct a future study where both individuals from individualistic and collectivistic culture backgrounds are included in order to investigate if the cultures would differ. For example, self-stigma may or may not play an important role in groups that are more collectivistic.

Second, the thesis analyses relationships, and predictors, but does not deal with mediation among the variables. A mediation model is needed to investigate how much of the experience of self-stigma is impacted by perceived public stigma, which in turn influences attitudes toward seeking therapy. It would be further interesting to add a fourth component (willingness to seek therapy) to the chain in order to investigate the link between perceived public stigma and willingness to seek therapy mediated by self-stigma and help-seeking attitudes (as presented in figure 1). Only then can results be compared to those published by Vogel et al. (2007). Additionally, it would be interesting to investigate other potential mediating factors of self-stigma, for example personality, in order to examine how personality predicts perceived public stigma and self-stigma that in turn influences attitudes towards seeking therapy.

Third, since the study did not include a questionnaire to identify the participants' mental health state, it is unknown how much self-stigma differs in a "healthy" person versus a

distressed/anxious person, or even worse; a depressed person or a person with a severe mental disorder like schizophrenia. It could therefore be interesting to conduct a future study that will identify these participants into groups of categories first, and then examine the extent of perceived public stigma and self-stigma within each group to see how their attitudes towards seeking help in the form of therapy may differ.

Fourth, because Sweden is such a multicultural country, it would be interesting to investigate differences among cultural background since prior research outside of Sweden has found a difference between individualistic and collectivistic cultures when it comes to attitudes and intentions toward seeking therapy.

Further, in order to understand the relationship between prior experience of therapy and attitudes toward seeking therapy, it would be interesting to investigate if participants who have prior experience of therapy had a positive or a negative experience. This would be interesting because it would disclose information about the quality of mental health services in Sweden; if improved measures need to be taken, and could more closely explain the outcomes of attitudes towards seeking therapy.

Moreover, it would be interesting to conduct a longitudinal study where the main aim was to inform the public that the target audience for therapy services is not only persons with mental disorder and illnesses, but also for any person with less severe problems such as emotional distress or interpersonal problems. The goal of the study would be to investigate to what extent perceived public stigma and self-stigma is reduced, and how one’s beliefs directly cause or inhibit help-seeking. In other words, could the overall taboo over therapy decrease if the public saw therapy as a means of support to any daily life struggle?

Finally, this study only used a few, but central, variables (gender, age, educational level, prior experience of therapy, public stigma and, self-stigma) to investigate attitudes toward seeking help. Because attitudes are such a complex phenomenon, future studies including more variables or a different combination of variables would be advisable to carry out, in order to understand help-seeking attitudes, and further, intentions and willingness to seek therapy, such as those made in the United States, but not yet conducted here in Sweden. In Sweden the focus is more on mental illness and people’s attitudes towards mentally ill persons.

Societal implications. This study indicates that there is a need in Sweden to find ways to reduce stigma if/when seeking therapy. Even though there have been means to change and reduce negative attitudes towards mental ill health, the aim has been to change and reduce attitudes towards persons with mental illness and disorders, such as the national campaign (Hjärnkoll) that took place between 2009 and 2014, but none or little awareness has been created around availability and utility of therapy. Therapy can support not only moderate to severe mental ill health, such as what we traditionally think of; depression, anxiety, bipolar disorder, schizophrenia and so forth, but everyday life issues (such as emotional pain, distress or and interpersonal problems) that most people experience at some point, so that therapy in general can be seen as just as normal and accepted as going to a physiotherapist or personal trainer. If a national campaign through mediums such as schools, media, newspaper, articles, took place to inform adolescents and the public about availability and utility of therapy, there could be a reduced perceived public stigma and self-stigma, and the sense of taboo over seeking therapy could be diminished. But more importantly, from a welfare and societal perspective, if availability and utility of therapy with the combination of reduced stigma and sense of taboo associated with therapy was diminished or decreased, maybe less stress, burnouts, depression, and sick-leave from work would be reported, since these individuals would, at an earlier stage, decide to seek therapy without the sense of shame or failure internally or from the public.

Conclusion

Some central factors have been examined that impact attitudes towards seeking therapy in Sweden. The overall results showed that those persons who had studied at university had more positive attitudes towards seeking therapy, especially women more than men. Those who had prior experience of therapy also had more positive attitudes towards seeking therapy. Age was not a significant factor; there was only a tendency for young and mature adults to have more positive attitudes towards seeking therapy. Men were found to experience a higher internal (self) stigma associated with seeking therapy than women. Furthermore, what might seem surprisingly was that only half of the participants actually knew where to turn to, to seek for professional help in terms of therapy, the remaining were either unsure or did not know at all. Lastly, stigma plays an important role in help-seeking attitudes. Perceived public stigma correlated negatively with attitudes toward seeking therapy, and so did self-stigma. Self-stigma was, however, the best

variable of the two to predict attitudes toward seeking therapy. Given the strong negative relationship between (self-) stigma and attitudes toward seeking therapy, this could suggest there is a therapy taboo in Sweden.

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Appendix A

Informationsbrev till deltagare

Hej!
Du tillfrågas härmed om du är villig att delta i en studie som ingår i en kandidatuppsats i psykologi vid Lunds Universitet. Syftet med studien är att undersöka om det finns skillnader i attityden av att söka professionell hjälp/terapi relaterat till ålder, kön, sysselsättning och bakgrund. Studien vänder sig till personer mellan 20-62 år i södra Sverige.

Deltagandet innebär att du fyller i fyra självskattningsformulär samt svarar på några bakgrundsfrågor. Detta tar cirka 10 minuter. När du besvarat alla frågor lämnar du tillbaka den till mig eller min assistent enligt den instruktion du får på plats.

Det är helt frivilligt att delta i studien och du kan avbryta din medverkan när du vill. Du är helt **anonym**, vilket innebär att du inte skriver ditt namn på enkäten. Ingen annan än forskaren kommer ta del av dina svar. Dina svar kommer inte att kunna spåras till dig. Resultatet av studien kommer att sammanställas statistiskt i avidentifierad form.

Tack för din medverkan!
Har du några frågor eller vill ta del av resultatet är du välkommen att kontakta mig:

Sujatha Kristensen
psykand@gmail.com

Handledare: Henrik Levinsson
Institutionen för Psykologi
Lunds Universitet

SAMTYCKE

Jag har tagit del av informationen ovan och ger mitt medgivande till att delta i studien (kryssa i rutan):

☐ JA

Appendix B

VÄNLIGEN BESVARA ALLA FRÅGOR

1. Hur gammal är du?________

2. Jag är: ☐ Man ☐ Kvinna ☐ Vill ej uppge

3. Nuvarande Sysselsättning:
(Kryssa endast ett alternativ)
☐ Studerande ☐ Fast arbete ☐ Tillfälligt arbete
☐ Egen företagare ☐ Söker arbete Annat:__________________

4. Markera din högsta utbildningsnivå:
☐ Grundskola ☐ Gymnasium ☐ Eftergymnasial utbildning
☐ Universitet <2 år ☐ Universitet >2år

5. I vilket land är du född?
☐ Sverige Annat land, vilket?___________________

6. I vilket land är dina föräldrar födda?
☐ Båda födda i Sverige ☐ En född i annat land, vilket?_______________________
☐ Båda födda i annat land, vilket/vilka?___________________ ____________________

7. Har du egen erfarenhet av att ha gått i terapi (såsom *livscoach, kurator, samtalsterapi, holistisk/alternativ, KBT*)? ☐ Ja ☐ Nej

8. Om du eller någon i din omgivning skulle behöva professionell hjälp i form av terapi, vet du då var du skulle vända dig? *(Kryssa för det svar som passar bäst)*
☐ Ja ☐ Osäker ☐ Nej

9. Jag upplever att jag har ett känslomässigt stöd från mina närstående när jag behöver det.
☐ Ja ☐ Nej

För varje fråga nedan vänligen markera om du (1) Instämmer inte alls, (2) Instämmer delvis inte, (3) Instämmer något, (4) Instämmer, (5) Instämmer helt

	Instämmer inte alls				Instämmer helt
10. Jag skulle känna mig otillräcklig om jag gick till en terapeut för psykologisk hjälp......................	[1	2	3	4	5]
11. Mitt självförtroende skulle inte hotas om jag uppsökte professionell hjälp........................	[1	2	3	4	5]
12. Att uppsöka terapi/psykologisk hjälp skulle få mig att känna mig mindre intelligent..................	[1	2	3	4	5]
13. Mitt självförtroende skulle öka om jag pratade med en terapeut...............................	[1	2	3	4	5]
14. Min självbild förändras inte bara för jag att jag bestämt mig för att träffa en terapeut.........	[1	2	3	4	5]
15. Det skulle få mig att känna mig underlägsen att be en terapeut om hjälp.................................	[1	2	3	4	5]
16. Det skulle kännas OK för mig om jag bestämde mig för att uppsöka professionell hjälp...............	[1	2	3	4	5]
17. Om jag träffade en terapeut skulle jag vara mindre nöjd med mig själv...	[1	2	3	4	5]
18. Mitt självförtroende skulle förbli detsamma om jag uppsökte professionell hjälp för ett problem jag inte kunde lösa.......................................	[1	2	3	4	5]
19. Jag skulle känna mig sämre om jag inte kunde lösa mina egna problem.......................................	[1	2	3	4	5]

För varje fråga nedan vänligen markera om du (0) Instämmer inte alls, (1) Instämmer delvis inte, (2) Instämmer, (3) Instämmer helt

	Instämmer inte alls			Instämmer helt
20. Att träffa en terapeut/psykolog för känslomässiga problem eller relationsproblem bär med sig ett socialt stigma*..	[0	1	2	3]
21. Det är ett tecken på personlig svaghet eller otillräcklighet att träffa en terapeut/psykolog för emotionella problem eller relationsproblem................................	[0	1	2	3]

***Stigma** är en typ av diskriminering som utgår från att man blir klassificerad och stämplad negativt (som sker på grund av fördomar och okunskap).

	Instämmer inte alls			Instämmer helt
22. Folk kommer uppfatta en person på ett mindre fördelaktigt sätt om de får reda på att han/hon har träffat en terapeut/psykolog………………………………	[0	1	2	3]
23. Det är klokt att en person döljer för andra människor om han/hon har träffat en terapeut/psykolog…………..	[0	1	2	3]
24. Människor tenderar att tycka mindre om de som får professionell psykologisk hjälp……………………………	[0	1	2	3]

För varje fråga nedan vänligen markera om du (1) Inte alls, (2) Lite, (3) Något, (4) Ganska (5) Mycket

	Inte alls				Mycket
25. Hur svårt skulle det vara för dig att dela med dig av personlig information till en terapeut? …………….	[1	2	3	4	5]
26. Hur sårbar skulle du känna dig om du berättade för en terapeut om något väldigt personligt som du aldrig tidigare hade berättat om för någon annan?…………………………………………	[1	2	3	4	5]
27. Om du hade ett känslomässigt problem, hur välgörande tror du att det skulle vara att öppna upp dig för en terapeut om dina personliga problem? ………………………………………	[1	2	3	4	5]
28. Hur riskfyllt skulle det kännas att öppna upp dig för en terapeut om dina dolda känslor? ……………………	[1	2	3	4	5]
29. Hur bekymrad skulle du vara om vad den andra personen tänker om du öppnade upp dig för en terapeut om dina negativa känslor?…………………	[1	2	3	4	5]
30. Hur hjälpsamt skulle det vara att öppna upp sig för en terapeut om ett personligt problem? ………….	[1	2	3	4	5]
31. Skulle det kännas bättre för dig om du öppnade upp dig för en terapeut om känslor av nedstämdhet eller ångest? ………………………………………………	[1	2	3	4	5]
32. Hur sannolikt vore det att få användbar respons om man öppnar upp sig för en terapeut om ett känslomässigt problem som man kämpar med?……………………………………	[1	2	3	4	5]

Vänligen vänd!

För varje fråga nedan vänligen markera om du (1) Instämmer inte alls, (2) Instämmer inte, (3) Instämmer delvis, (4) Instämmer helt

	Instämmer inte alls			Instämmer helt
33. Om jag höll på att få ett sammanbrott, skulle min första tanke vara att uppsöka professionell hjälp................	[1	2	3	4]
34. Tanken på att tala med en terapeut/psykolog om mina problem tycker jag är ett dåligt tillvägagångssätt för att bli av med känslomässiga konflikter...............	[1	2	3	4]
35. Om jag upplevde en allvarlig känslomässig kris i detta skede av mitt liv skulle jag vara säker på att jag fann lättnad genom terapi..	[1	2	3	4]
36. Det finns något beundransvärt i attityden hos personer som är villiga att ta itu med sina konflikter och rädslor utan att uppsöka hjälp.	[1	2	3	4]
37. Jag hade velat uppsöka psykologisk hjälp om jag kände mig orolig eller upprörd under en lång tidsperiod...........	[1	2	3	4]
38. Jag kommer kanske vilja erhålla terapi i framtiden.	[1	2	3	4]
39. En person med ett känslomässigt problem kan sannolikt inte lösa det själv, han eller hon har större sannolikhet att lösa det med professionell hjälp..	[1	2	3	4]
40. Med tanke på den tid och kostnad som terapi innefattar är jag osäker på vilket värde det skulle ha för en person som mig...	[1	2	3	4]
41. En person bör kunna reda ut sina egna problem, att uppsöka terapeut skulle vara den sista utvägen......................	[1	2	3	4]
42. Personliga och emotionella bekymmer, såsom många andra saker, brukar lösa sig av sig själva....................	[1	2	3	4]

Tack för din medverkan!