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Reducing the Stigma Associated With Seeking Psychotherapy Through Self-Affirmation

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Psychotherapy may be underutilized because people experience self-stigma—the internalization of public stigma associated with seeking psychotherapy. The purpose of this study was to experimentally test whether the self-stigma associated with seeking psychotherapy could be reduced by a self-affirmation intervention wherein participants reflected on an important personal characteristic. Compared with a control group, we hypothesized that a self-affirmation writing task would attenuate self-stigma, and thereby evidence indirect effects on intentions and willingness to seek psychotherapy. Participants were 84 undergraduates experiencing psychological distress. After completing pretest measures of self-stigma, intentions, and willingness to seek psychotherapy, participants were randomly assigned to either a self-affirmation or a control writing task, and subsequently completed posttest measures of self-stigma, intentions, and willingness to seek psychotherapy. Consistent with hypotheses, participants who engaged in self-affirmation reported lower self-stigma at posttest. Moreover, the self-affirmation writing task resulted in a positive indirect effect on willingness to seek psychotherapy, though results failed to support an indirect effect on intentions to seek psychotherapy. Findings suggest that self-affirmation theory may provide a useful framework for designing interventions that seek to address the underutilization of psychological services through reductions in self-stigma.

Keywords: self-affirmation, stigma, intentions, willingness, psychotherapy

There is substantial evidence that psychotherapy is an effective means of addressing a broad range of mental health concerns for clients of different ages and cultural backgrounds (American Psychological Association, 2012). Despite psychotherapy's effectiveness, large-scale epidemiological studies have suggested that psychotherapy is underutilized. In fact, from 1998 to 2007, utilization rates of psychotherapy in the U.S. population actually decreased slightly from 3.4% in 1998 to 3.2% in 2007 (Olfson & Marcus, 2010). Although there may be numerous economic, demographic, and cultural factors influencing these low utilization rates (Karlin, Duffy, & Gleaves, 2008; Maramba & Nagayama Hall, 2002; Olfson, Marcus, Druss, & Pincus, 2002), one salient reason may be to avoid stigmatization (President's New Freedom Commission on Mental Health, 2003; U.S. Department of Health and Human Services, 1999). Previous studies have linked the fear of being stigmatized (Corrigan, 2004; MacKenzie, Gekoski, & Knox, 2006; Yap, Wright, & Jorm, 2011), and in particular concerns about self-stigmatization when considering seeking psychological help, to negative attitudes about psychotherapy and a decreased likelihood of seeking and receiving psychological services (C. Brown et al., 2010; Vogel, Wade, & Hackler, 2007). To address the underutilization of psychotherapy, it is important to develop means of reducing therapy-related self-stigma, particularly among those in psychological distress. Thus, in this article, we focus on stigma associated with seeking psychotherapy (Tucker, Hammer, Vogel, Bitman, & Wade, in press).

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Self-Stigma of Seeking Psychotherapy

One way to directly intervene on an individual level to reduce the negative impact of stigma on help-seeking may be to target self-stigma—the extent to which people internalize and apply the prejudice of public stigma to themselves (Corrigan, 2004; Corrigan, Larson, & Rüsch, 2009; Corrigan & Watson, 2002; Rüsch, Angermeyer, & Corrigan, 2005). According to this perspective, an individual's awareness of society's stigma associated with seeking psychotherapy may be less pertinent in predicting help-seeking behavior than is an individual's beliefs that this stigma applies to one's self. For example, a person might be aware of the public's stigma toward psychotherapy, but disagree with it due to positive, personal experiences with psychotherapy. As a result, self-stigma may be of particular importance in affecting decisions about whether or not to seek psychological help (C. Brown et al., 2010; Vogel & Wade, 2009; Vogel et al., 2007).

Work on developing interventions aimed at reducing self-stigma is still in its early stages, has mixed findings, and lacks a strong theoretical framework (Mittal, Sullivan, Chekuri, Allee, & Corrigan, 2012). One stigma reduction strategy that has been advocated entails increasing self-esteem (Corrigan et al., 2009), though these interventions have had limited effects in adult populations because self-esteem tends to be both highly stable (Trzesniewski, Donnellan, & Robins, 2003) and resistant to change (Torrey, Mueser, McHugo, & Drake, 2000). A more common intervention strategy has involved the provision of psychoeducation or cognitive re-

structuring through cognitive behavioral therapy or acceptance and commitment therapy (Luoma, Kohlenberg, Hayes, Bunting, & Rye, 2008; Masuda et al., 2007). Unfortunately, many of these direct attempts to dispute stigma via psychoeducation have also resulted in mixed success possibly due to a "rebound" effect, inducing greater activation and recall of negative stereotypes (Corrigan, 2004; Macrae, Bodenhausen, Milne, & Jetten, 1994). Interestingly, two cognitive restructuring interventions (Luoma et al., 2008; Masuda et al., 2007) may have been able to mitigate such rebound effects; however, in doing so, these interventions were time-intensive, requiring between 2 and 6 hr. This presents a quandary for those with high levels of self-stigma; in order to decrease their self-stigma, they need to engage in 2–6 hr of psychotherapy-related interventions, for which their self-stigma will likely prevent them from seeking in the first place. Thus, if self-stigma interventions ultimately aim to decrease barriers to seeking psychotherapy, shorter interventions that do not require individuals to engage in the stigmatized activity may be particularly useful. Accordingly, in the current research, we focused on the development and testing of a theory-based intervention that can attenuate self-stigma in a brief format.

Self-Affirmation Theory and the Reduction of Self-Stigma

Self-affirmation theory (Sherman & Cohen, 2002, 2006; Sherman & Hartson, 2011; Steele, 1988; Steele & Liu, 1983) holds promise not only for understanding the psychological processes associated with self-stigma but also for suggesting means by which self-stigma might be reduced. According to self-affirmation theory, individuals are motivated to maintain a global sense of self-worth by holding on to favorable self-conceptions and positive beliefs that one is a competent, adequate, and stable individual (Steele, 1988). This motivation affects how people respond to information that threatens their self-image. That is, information suggesting that one is incompetent, inadequate, or unstable serves to threaten a person's self-worth, thereby eliciting a response from the individual to address this threatening information in order to maintain a positive self-image.

For some, the term *self-affirmation* may evoke Al Franken's satirical character Stewart Smalley, whose attempts at self-help involve reciting his "daily affirmation" in the mirror: "I'm good enough. I'm smart enough. And doggone it, people like me!" (Franken & Smalley, 1992). Stewart Smalley's daily affirmations evoke hilarity, in part, because they represent obviously forced, desperate, and exaggerated attempts to buttress an unfathomably fragile self-esteem. Furthermore, the audience perceives that Stuart's explicit attempts at "self-affirmation" are doomed to failure, an expectation that is, in fact, supported by research. Specifically, engaging in explicit self-affirming activity with the awareness that it is intended to directly counter a self-threat actually intensifies anxiety and the awareness of evidence of failure (Crocker & Park, 2004). In contrast, self-affirmation interventions are neither direct attempts to contradict threatened domains of self-worth nor attempts to bolster self-esteem or improve mood (Schmeichel & Martens, 2005; Schmeichel & Vohs, 2009; Sherman & Hartson, 2011). Instead, self-affirmation involves a form of compensation, wherein an individual affirms a specific area of self-worth that is not under threat and that one is likely to believe (see Allport, 1961; J. D. Brown & Smart, 1991; Sherman & Cohen, 2002, 2006). Thus, self-affirmation can be considered as a part of a larger psychological "immune system" that is activated when people experience threats to the self (Gilbert, Pinel, Wilson, Blumberg, & Wheatley, 1998; Sherman & Hartson, 2011). Accordingly, self-affirmation reduces self-protective, defensive cognitions by reminding the person of valued personal characteristics, thereby enhancing one's ability to effectively cope with threats in an unrelated domain.

The potential usefulness of self-affirmation interventions with respect to seeking psychotherapy is supported by research demonstrating self-affirmation's ability to reduce defensiveness when encountering threatening health-related information (Cohen, Aronson, & Steele, 2000; Harris, Mayle, Mabbott, & Napper, 2007; McQueen & Klein, 2006; Reed & Aspinwall, 1998; van Koningsbruggen, Das, & Roskos-Ewoldsen, 2009). Specifically, self-affirmation has exhibited positive effects in at-risk groups by increasing processing of health-risk information, increasing perceived personal relevance of health-risk information, increasing attention paid to health-risk messages, increasing intentions to change unhealthy behaviors, and reducing derogation of health-risk messages (see Harris & Epton, 2009, for a review). Even though this body of work suggests that self-affirmation would operate similarly with regard to self-threats associated with seeking psychotherapy by reducing defensiveness and self-stigma, to date no study has tested that hypothesis.

Self-Affirmation Theory and Possible Responses to Psychotherapy Information

Self-affirmation theory proposes three pathways by which an individual might satisfy his or her motivation to maintain a sense of self-worth when exposed to threatening information, such as information about psychotherapy that may activate self-evaluative concerns that one is incompetent, inadequate, unstable, or inconsistent. By way of illustrating these pathways, consider the example of a person who receives information from a friend or family member who he or she might need therapy in order to better deal with a current mental health concern. The first pathway corresponds to when a person accepts the threatening information as accurate (Sherman & Cohen, 2006) and accommodates it by changing his or her behavior to address the mental health concern and thereby reduce the threat. In this case, the person considering seeking psychotherapy may be fearful that seeking help from another would be a sign of weakness or failure. However, recognizing that he or she may need help to deal with the current concerns, this person may thus seek psychotherapy despite the associated fears. This first pathway, which we refer to as the *accommodation pathway*, represents a positive response as it corresponds to a person accommodating threatening information in an adaptive manner rather than rejecting, avoiding, or disparaging it. However, this pathway can often be difficult, particularly if the threatening information attacks a key aspect of one's identity, as participating in psychotherapy is often viewed to do (Fischer, Nadler, & Whitcher-Alagna, 1982).

If a person is not able to directly accept and accommodate the threatening self-information, then a second pathway to satisfy one's motivation to maintain a positive sense of self-worth is defensiveness. Defensiveness entails counteracting or neutralizing

the threatening information—such as by ignoring, denying, disputing, or contradicting the information—in order to repair or protect the self-conception that one is competent, adequate, and stable (Sherman & Cohen, 2002, 2006). For example, a person who perceives the need to seek psychotherapy as threatening might respond defensively by downplaying his or her need for it, and may evaluate psychotherapy with increased negativity (Fischer et al., 1982). This person may view seeking psychotherapy as appropriate only for severely disturbed, fundamentally incompetent, or exceptionally weak individuals. These stigmatizing perceptions may thus allow this person to temporarily hold onto a more positive self-view because, in comparison to himself or herself, a person who seeks psychotherapy is viewed as someone with more severe problems and flaws. In other words, this defensive stance allows a person to determine that he or she is fundamentally different from those who need psychotherapy, a conclusion that naturally discourages help seeking. This pathway, which we refer to as the *defensive pathway*, can provide some immediate self-protection by enabling one to conclude that help is not needed, but it does so at the cost of not accommodating potentially useful information.

In contrast, the third pathway, which we refer to as the *self-affirmation pathway*, corresponds to when individuals bolster their self-worth through self-affirmation, such as by reflecting on a positive and self-relevant personal characteristic in order to maintain the perception that they are competent, adequate, and stable (Sherman & Cohen, 2006). Thus, if self-affirmation occurs prior to the presentation of threatening information, the positive self-image is maintained by the preceding self-affirmation, thereby obviating the need to engage in defensiveness to protect the self. For example, if a person first reflects on a positive and self-relevant personal characteristic, such as that one is a generous person, and then considers the need for psychotherapy, that person might then be able to respond nondefensively to the threats associated with seeking psychotherapy. In other words, the person can retain high self-worth in a global sense by neutralizing the threatening information through positive self-evaluations in an unrelated domain that is not under threat (Sherman & Cohen, 2006). In the context of help seeking, bolstering a distressed person's self-worth in an unthreatened domain could, therefore, reduce the degree to which he or she perceives psychotherapy to be a threat to self-worth, and thus allow a person to more objectively evaluate the decision to seek psychotherapy for a mental health concern they are experiencing.

In sum, self-affirmation theory provides a useful theoretical framework for hypothesizing how seeking psychotherapy may be perceived as threatening, and how affirming the self may attenuate this threat and lead to beneficial outcomes. People may be resistant to information about psychotherapy because it elicits negative self-evaluations and makes salient therapy-related stigma (Vogel & Wade, 2009; Vogel, Wade, & Ascheman, 2009; Vogel, Wade, & Haake, 2006; Vogel et al., 2007). Insofar as psychotherapy is perceived as threatening, people in turn may exhibit defensive responses such as derogating and avoiding psychotherapy (Fischer et al., 1982), and believing that being in psychotherapy is inconsistent with being an adequate, competent person (Vogel et al., 2006). This type of response is emblematic of the defensive response pathway discussed above and provides a barrier to effectively addressing mental health concerns. However, if people are able to self-affirm prior to being exposed to psychotherapy information, they might be able to maintain their self-worth, be less defensive, and therefore be more open to evaluating the potential usefulness of seeking psychotherapy.

Overview

In the present study, we investigated whether the psychological mechanisms proposed by self-affirmation theory apply to help-seeking contexts among clinically distressed individuals. The study's first purpose was to empirically test whether self-affirmation influences self-stigma—that is, whether the process of self-affirming a positive, self-relevant personal characteristic reduces the degree to which distressed individuals perceive help seeking as a threatening self-stigmatizing behavior. As shown in Figure 1, the second purpose of this study was to examine whether self-affirmation would, by attenuating self-stigma, have a subsequent beneficial effect in increasing intentions and willingness to seek psychotherapy (Cohen, 1999; Gerrard, Gibbons, Houlihan, Stock, & Pomery, 2008; Godin & Kok, 1996; Hammer & Vogel, 2013; Lambert & Loiselle, 2007). Health behavior models have often considered *intention*—defined as a conscious plan to exert effort to perform a behavior—as the most important determinant of

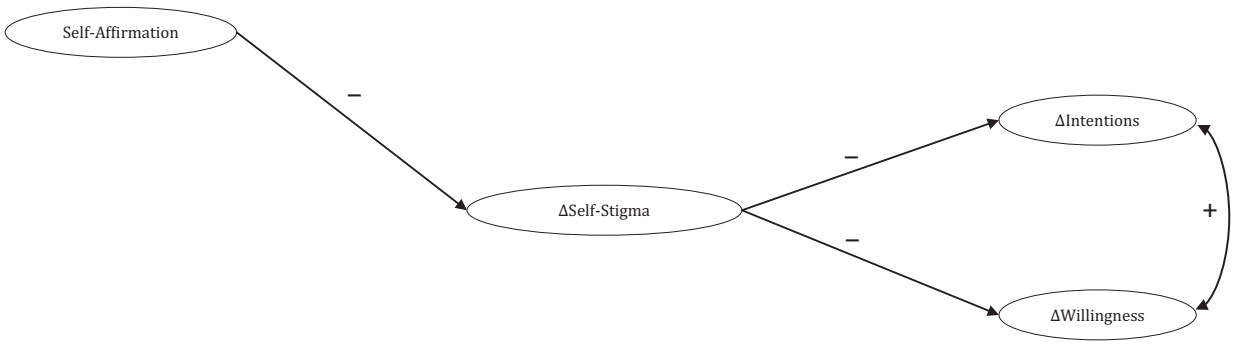

Figure 1. Hypothesized theoretical model. Self-Affirmation = experimental manipulation of self-affirmation, coded such that 0 = *control*, 1 = *self-affirmation*; ΔSelf-Stigma = latent residualized change from pretest to posttest in Self-Stigma of Seeking Psychotherapy; ΔIntentions = latent residualized change from pretest to posttest in Intentions to Seek Psychotherapy; ΔWillingness = latent residualized change from pretest to posttest in Willingness to Seek Psychotherapy. Direction of hypothesized relationships is denoted by + or −.

actual help-seeking behavior (Ajzen, 2011). However, in addition to intentions, spontaneous psychological processes may also predict help-seeking behaviors (Gibbons, Gerrard, Ouellette, & Burzette, 1998; Hammer & Vogel, 2013). Whereas intentions may account for reasoned and planned decision-making processes, *willingness*—defined as one's openness to perform a behavior given the opportunity—may account for more reactive, spontaneous decision making (Gibbons, Houlihan, & Gerrard, 2009). Consistent with this view, inclusion of both reasoned and reactionary processes tend to best account for behavior (e.g., Gerrard et al., 2008; Gibbons et al., 1998, 2009; Hammer & Vogel, 2013). Therefore, we addressed these two goals with an experiment in which we tested whether participants who self-affirmed via completing a self-affirmation writing task exhibited greater decreases in self-stigma of seeking psychotherapy than participants in a control condition who engaged in a nonself-affirming writing task. We also tested whether the self-affirmation writing task mediated the effect of self-stigma on participants' intentions and willingness to seek psychotherapy.

Furthermore, in addition to testing the hypothesized relationships detailed above, this investigation models and tests an alternative means whereby self-affirmation might reduce defensive self-stigma. Whereas self-affirmation theory proposes that self-affirmation works via positive compensating self-images, it has been suggested that self-affirmation may work via more general improvements in mood, which may in turn influence judgments (Clore & Huntsinger, 2007; Forgas, 1995). For example, positive mood has been found to facilitate individuals' ability to attend to and process potentially useful information that might otherwise be ignored due to being emotionally aversive (Raghunathan & Trope, 2002). Thus, it is conceivable that insofar as self-affirming activities improve mood that any effect of self-affirmation on self-stigma could be mediated by improvements in mood. Therefore, we tested an alternative model in which positive and negative mood were included as mediators of self-affirmation's effects on self-stigma, and were also modeled as direct predictors of intentions and willingness to seek psychotherapy. In this way, we were able to assess whether the conveyance of self-affirmation's effects on self-stigma might be better accounted for through improvements in mood, rather than directly as suggested by self-affirmation theory.

Method

Participants

Participants were 84 undergraduates at a large midwestern university who met a clinical cutoff point for psychological distress (female = 60%; mean age = 21.2, *SD* = 4.2, range = 19–46; year in school, first year = 56%, second year = 27%, third year = 12%, fourth year = 4%, graduate = 1%; European American = 71%, Asian American/Pacific Islander = 11%, Latino/a American = 6%, multiracial American = 5%, African American/Black = 4%, international = 2%, Native American = 1%).

Measures

Psychological distress. The *Clinical Outcomes in Routine Evaluation for the General Population* (CORE-GP; Sinclair, Barkham, Evans, Connell, & Audin, 2005) is a 14-item measure that was adapted for use with the general public from the widely used Clinical Outcomes in Routine Evaluation Outcome Measure (Evans et al., 2000). The measure was utilized to identify a recruitment pool of participants who were experiencing psychological distress or decreased functioning. The CORE-GP covers the domains of well-being, problems/symptoms, and functioning. Items are rated on a 5-point Likert scale where 0 = *not at all* and 4 = *most or all of the time*, and eight items are reverse scored. A clinical score is calculated as the mean of all completed items, providing a possible range from 0 to 4 (Barkham, Mellow-Clark, Connell, & Cahill, 2006; Leach et al., 2006). Previous research has provided support for the validity of the CORE-GP due to its ability to discriminate between clinical and nonclinical populations, as well as internal reliability with Cronbach's alpha values ranging from .82 to .90 (Sinclair et al., 2005). Internal reliability for the CORE-GP in the present study was assessed before laboratory procedures took place, with a Cronbach's alpha score equal to .86.

Self-stigma of seeking psychotherapy. The *Self-Stigma of Seeking Help* (SSOSH; Vogel et al., 2006) scale was used to measure participants' self-stigma related to seeking professional psychotherapy. The 10-item scale includes items such as "I would feel inadequate if I went to a therapist for psychological help," "Seeking psychological help would make me feel less intelligent," and "If I went to a therapist, I would be less satisfied with myself" (Vogel et al., 2006, p. 328). Five items are reversed scored. Items are rated on a 5-point Likert scale where 1 = *strongly disagree* and 5 = *strongly agree*, with higher scores corresponding to higher self-stigma related to seeking psychotherapy. Previous support for the validity of the SSOSH has indicated positive relationships with the public stigma of seeking psychological help and anticipated risks of disclosing in therapy, and negative relationships with attitudes toward seeking professional psychotherapy and intentions to seek counseling (Vogel et al., 2006). Previous Cronbach's alpha scores have ranged from .86 to .90 in undergraduate samples (test–retest, .72; Vogel et al., 2006). The Cronbach's alpha score in the present sample was .86.

Intentions to seek psychotherapy. The *Intentions to Seek Counseling Inventory* (ISCI) assesses participants' intentions to seek psychotherapy for a variety of specific problems (Cash, Begley, McCown, & Weise, 1975). The 17-item scale measures help-seeking intentions regarding problems such as choosing a major, weight control, relationship difficulties, low self-confidence, and depression. Participants are asked to rate how likely they would be to seek help from the university counseling center if they were experiencing each problem. For the present study, participants were asked to rate their likelihood on a 6-point Likert scale, wherein 1 = *very unlikely* and 6 = *very likely*, with higher scores indicating greater likelihood of seeking psychotherapy. Factor analysis of the ISCI has supported the existence of three subscales within the measure, labeled *Psychological and Interpersonal Concerns* (10 items; $\alpha = .90$), *Academic Concerns* (four items; $\alpha = .71$), and *Drug Use Concerns* (two items; $\alpha = .86$), with correlations among the subscales ranging from .18 to .50 (Cepeda-Benito & Short, 1998). In the present study, we used the Psychological and Interpersonal Concerns subscale, which taps intentions to seek psychotherapy for concerns such as loneliness, depression, and feelings of inferiority. Previous support for the validity of this subscale has indicated relationships with perceived significance of a current problem and general attitudes toward seeking psychotherapy (Kelly & Achter, 1995). The Cronbach's

alpha score for the Psychological and Interpersonal Concerns subscale in this sample was .86.

Willingness to seek psychotherapy. The *Willingness to Seek Help Scale* (WSHS) provided an indication of participants' willingness to seek psychotherapy given specific scenarios presented in four vignettes (Hammer & Vogel, 2013). For example, one such scenario was,

> Suppose you stop by the campus counseling center sometime in the next 3 months to get advice on how to help a friend of yours who is feeling really depressed about a recent breakup . . . How willing would you be to: (a) meet with the psychologist for a one-time session to speak about the issue you're dealing with and (b) return in subsequent weeks for additional sessions to continue speaking about the issue you're dealing with? (Hammer & Vogel, 2013, p. 96)

Participants rated items on a 7-point Likert scale, wherein 1 = *not at all willing* and 7 = *very willing*, with higher scores indicating greater willingness to seek psychotherapy. Support for validity of the WSHS has indicated positive relationships with attitudes toward seeking psychological help, intentions to seek psychotherapy, and help-seeking decisions. A Cronbach's alpha score of .90 has been reported in an undergraduate sample (Hammer & Vogel, 2013). The Cronbach's alpha score in the present sample was .86.

Mood. The *Positive and Negative Affect Schedule* (PANAS; Watson, Clark, & Tellegen, 1988) assessed mood during the experimental session. Participants completed items in response to the instruction "Indicate the extent to which you feel each emotion *right now*." The 20-item scale measures positive mood with emotional labels such as excited, proud, and strong, and negative mood with emotional labels such as distressed, upset, and scared (Watson et al., 1988, p. 1070). Items are rated on a 5-point Likert scale, wherein 1 = *very slightly or not at all* and 5 = *extremely*, with higher scores indicating greater experience of the corresponding mood. Previous support for the validity of the PANAS has indicated relationships with other prominent measures of positive and negative mood (Watson et al., 1988). Previous Cronbach's alpha scores in undergraduate samples for positive mood have ranged from .86 to .90, and for negative mood have ranged from .84 to .87 (Watson et al., 1988). In this sample, the Cronbach's alpha score for positive mood was .86, and for negative mood was .78.

Procedure

Participant recruitment and pretest measures. Participants were screened from a research pool of 1,428 students enrolled in introductory psychology and communication studies courses who completed questionnaires during the first 3 weeks of classes in the context of survey sessions in which many questionnaires were administered. These survey sessions are a routine aspect of the psychology department's procedures wherein participants receive class credit for completing a number of measures for a variety of research projects. Thus, participants subsequently recruited for a particular study based on their questionnaire responses are unable to connect that study with any particular measure completed during the survey session, which in this case took place at least 3 weeks prior to the experimental session. Survey session responses served two purposes. First, respondents completed the CORE-GP, which permitted identification of a recruitment pool of individuals who were experiencing psychological distress or decreased functioning, thereby approximating a clinical population. Specifically, male and female respondents whose CORE-GP scores exceeded 1.49 for males and 1.63 for females, respectively, were recruited to participate in the experimental portion of the study. Second, in addition to providing demographic information, respondents completed pretest measures of the outcome variables of this study, including the SSOSH, ISCI, and WSHS.

Of the 1,428 individuals who completed the survey sessions, 467 (33%) met the clinical cutoff point for psychological distress as assessed by the CORE-GP. These potential participants were sent an e-mail inviting them to participate in the experimental portion of the study. Of the 467 invited, 84 (18%) responded and fully completed the experimental portion of the study. Results of *t* tests comparing participants with those who were e-mailed but did not participate indicated that there were no significant differences with regard to CORE-GP, SSOSH, or ISCI scores at pretest (all $ps > .647$). However, those who chose to participate did score significantly higher on the WSHS at pretest ($M = 4.62$, $SD = 1.31$) than those who did not participate ($M = 4.09$, $SD = 1.45$), the mean difference corresponding to 0.52, 95% CI = [0.18, 0.86].

Experimental manipulation of self-affirmation. Individuals were scheduled to participate in individual sessions in what was described as a study of memory, and for which sessions lasted no more than 50 min. It was necessary to use this cover story because self-affirmation effects have been shown to be reduced when people are aware of the expected reduction in defensiveness caused by self-affirmation (Sherman et al., 2009), or when completion of the affirmation is externally imposed (Silverman, Logel, & Cohen, 2013). Upon arriving, participants provided informed consent, completed the PANAS, and were randomly assigned to either the self-affirmation writing task condition or the control writing task condition.

Participants in the self-affirmation writing task condition completed the adapted Sources of Validation Scale (Harber, 1995, as cited in Cohen et al., 2000), ranking 13 personal characteristics from 1 to 13 regarding the importance of the characteristic for themselves, where 1 = *most important* and 13 = *least important*. Cohen et al.'s (2000) version lists 11 personal characteristics: artistic skills/aesthetic appreciation, sense of humor, relations with friends/family, spontaneity/living life in the moment, social skills, athletics, musical ability/appreciation, physical attractiveness, creativity, business/managerial skills, and having romantic values. The version administered in the present study was adapted by the addition of two items—*religion* and a *blank line*—the latter of which enabled participants to provide an important personal characteristic not listed. Participants were then instructed to recall and write about several personal experiences in which their most highly ranked characteristic had been important to them and had made them feel good about themselves. A review of self-affirmation manipulations (McQueen & Klein, 2006) found that 21 of 69 studies had utilized a personal value or characteristic scale, and 19 of 69 had used an essay writing task. This self-affirmation writing task was intended to make salient and affirm a positive core characteristic that informed participants' self-worth. For example, participants who had rated sense of humor as most important were instructed to describe three to four experiences in which their sense of humor had been important to them and had made them feel good about themselves. Self-affirmation participants performed the self-affirmation writing task for 5 min.

Participants assigned to the control writing task condition ranked jellybean flavors in order of tastiness from 1 to 12, using

each number once, where 1 = *most tasty jellybean flavor* and 12 = *least tasty jellybean flavor*. Next, control participants wrote a paragraph describing the flavor of the jellybean they ranked as the fourth tastiest. This task was chosen because it has previously been shown to be a content-unrelated task that would serve neither as a threat to nor as a self-affirmation of relevant personal characteristics (Critcher, Dunning, & Armor, 2010). Control participants performed the jellybean writing task for 5 min.

Presentation of potentially threatening information. After completing either the self-affirmation or control writing task, participants read an article that describes psychotherapy and its benefits. The article was adapted from materials developed by Levine, Stolz, and Lacks (1983) and included preparatory information appropriate for beginning psychotherapy clients. The purpose of the article was to activate participants' awareness of psychotherapy, thereby introducing a potential threat to self-worth. To ensure careful attention to the content of the article, participants were informed that a quiz would follow, on which they scored 97% on average, confirming that they did consciously process the information about psychotherapy.

Posttest measures. After participants read the article, they completed posttest measures that included the SSOSH, ISCI, WSHS, and the PANAS. Experimenters then probed participants for suspicion using a funnel debriefing procedure (Aronson & Carlsmith, 1968), revealing that none of the participants were either suspicious or aware of the true purpose of the study.

Results

Descriptive and Preliminary Analyses

Descriptive data and bivariate intercorrelations are displayed in Table 1 for pretest and posttest assessments of variables that are of primary interest in this study. Chi-square tests to assess for differences between conditions for the number of participants and gender were nonsignificant (both ps $> .21$), as was an independent samples t tests to assess differences between conditions regarding age ($p = .22$). Regarding pretest measures, independent samples t tests revealed no significant differences between conditions for the CORE-GP, SSOSH, ISCI, and WSHS (all ps $> .46$).

Analytic approach. To test for changes in the outcome variables from pretest to posttest, we used latent variable structural equation models composed of residualized change scores. In analyses of change, residualized change scores are preferred to difference scores because they not only adjust for baseline differences but also demonstrate better reliability (MacKinnon, 2008). Except for the self-affirmation manipulation, we modeled all variables as latent constructs in order to correct for biasing effects of measurement error that may be present in path analysis models (Coffman & MacCallum, 2005). Specifically, using the method of Russell, Kahn, Spoth, and Altmeier (1998), pretest responses to the SSOSH, ISCI, and positive and negative subscales of the PANAS were factor analyzed using the maximum likelihood method to identify three groups of items for each variable, each group of items being called a "parcel." The parcels determined from pretest responses were also used for posttest responses. Because the WSHS consists of distinct scenarios, three parcels were created on the basis of scenario items. For all variables, parcel scores at posttest were regressed on parcel scores at pretest to create residualized change scores, which then served as indicators of latent variables that reflect changes from pretest to posttest. The variable for the self-affirmation manipulation was dichotomously coded, such that values of 0 and 1 corresponded to the control and self-affirmation conditions, respectively.

We followed a two-step procedure recommended by Anderson and Gerbing (1988) by first testing the measurement model and then testing the hypothesized structural model. All models were evaluated using the maximum likelihood method in Mplus6, which

Table 1
Correlation Matrix of Pretest and Posttest Variables

Variable	1	2	3	4	5	6	7	8	9	10	11
Pretest assessments (Screening)											
1. Distress	—										
2. Stigma	.14	—									
3. Intentions	−.12	−.45***	—								
4. Willingness	.16	−.25*	.35**	—							
Pretest assessments (Laboratory)											
5. Positive Mood	−.21	.03	.03	.06	—						
6. Negative Mood	.22*	.13	−.12	.07	.10	—					
Posttest assessments (Laboratory)											
7. Stigma	.03	.70***	−.34**	−.23*	.04	.24*	—				
8. Intentions	−.11	−.33**	.49***	.38***	.10	−.02	−.26*	—			
9. Willingness	−.13	−.41***	.44***	.57***	.20	−.20	−.45***	.60***	—		
10. Positive Mood	−.13	.01	.04	.08	.84***	.14	−.06	.17	.25*	—	
11. Negative Mood	.29**	.04	−.08	.10	−.09	.75*	.21	−.03	−.18	.00	—
M (*SD*)	1.99 (0.38)	2.92 (0.61)	2.16 (0.57)	4.53 (1.34)	25.03 (6.62)	13.87 (3.72)	2.66 (0.69)	2.84 (1.00)	4.06 (1.12)	22.87 (6.97)	12.12 (2.97)

Note. Distress = Clincial Outomes in Routine Evaluation for the General Population; Stigma = Self-Stigma of Seeking Help; Intentions = Psychological and Interpersonal Concerns subscale of the Intentions to Seek Counseling Inventory; Willingness = Willingness to Seek Help Scale; Positive Mood = Positive Mood subscale of the Positive and Negative Affect Schedule (PANAS); Negative Mood = Negative Mood subscale of the PANAS.
* $p < .05$. ** $p < .01$. *** $p < .001$.

utilizes a mean-adjusted chi-square statistic that is robust to multivariate nonnormality (Muthén & Muthén, 2010; Satorra & Bentler, 2001). Four indices and their cutoff points were utilized to assess goodness of fit for all models: the comparative fit index (CFI; values of .95 or greater), the Tucker-Lewis Fit Index (TFI; values of .95 or greater), the root-mean-square error of approximation (RMSEA; values of .06 or less), and the standardized root-mean-square residual (SRMR; values of .08 or less). Tests of specific indirect effects were based on bias-corrected confidence intervals generated from 10,000 bootstrap draws of the data (Shrout & Bolger, 2002). Bootstrapping does not require multivariate normality of model effects and is more robust than alternative methods. However, in allowing for nonnormal distributions, the resulting nonsymmetric confidence intervals preclude the calculation of exact *p* values. Therefore, information regarding statistical significance of an indirect effect is conveyed by its 95% confidence interval.

Hypothesized Model

Measurement model. An initial test of the measurement model indicated a good fit to the data, Satorra-Bentler $\chi^2(30, N = 84) = 31.96$, $p = .369$; CFI = .990; TLI = .985; RMSEA = .028, 90% CI = [.000, .089]; SRMR = .063. Standardized factor loadings for all indicators on their respective latent variables ranged from .564 to .790 (all $ps < .001$), indicating that all latent variables were adequately measured by their respective indicators.

Structural model. The hypothesized structural model provided a good fit to the data, Satorra-Bentler $\chi^2(32, N = 84) = 34.03$, $p = .370$; CFI = .990; TLI = .986; RMSEA = .027, 90% CI = [.000, .087]; SRMR = .068. As detailed in Figure 2, results supported the hypothesized direct effect of self-affirmation, in that engaging in self-affirmation decreased the self-stigma associated with seeking psychotherapy ($\beta = -0.61$, $SE = 0.22$, $p = .006$). In addition, whereas decreased self-stigma did not predict increased intentions to seek psychotherapy ($\beta = -0.05$, $SE = 0.13$, $p = .709$), it did predict increased willingness ($\beta = -0.37$, $SE = 0.12$, $p = .002$). With respect to the effects of the experimental manipulation on intentions and willingness to seek psychotherapy via decreases in self-stigma, engaging in self-affirmation did not evidence a significant indirect effect on intentions ($\beta = 0.03$, 95% CI = [−0.16, 0.22]), a result that is unsurprising given the nonsignificant direct effect of self-stigma on intentions reported above. However, self-affirmation activity did predict increased willingness to seek psychotherapy through reductions in self-stigma ($\beta = 0.23$, 95% CI = [0.00, 0.46]). Thus, results provided partial support to the hypothesis that self-affirmation would increase proximal predictors of help-seeking through reductions in self-stigma.

Alternative models. We further tested a partially mediated model to assess whether adding direct effects of self-affirmation to both intentions and willingness significantly improved on the hypothesized model (i.e., in which self-affirmation effects are fully

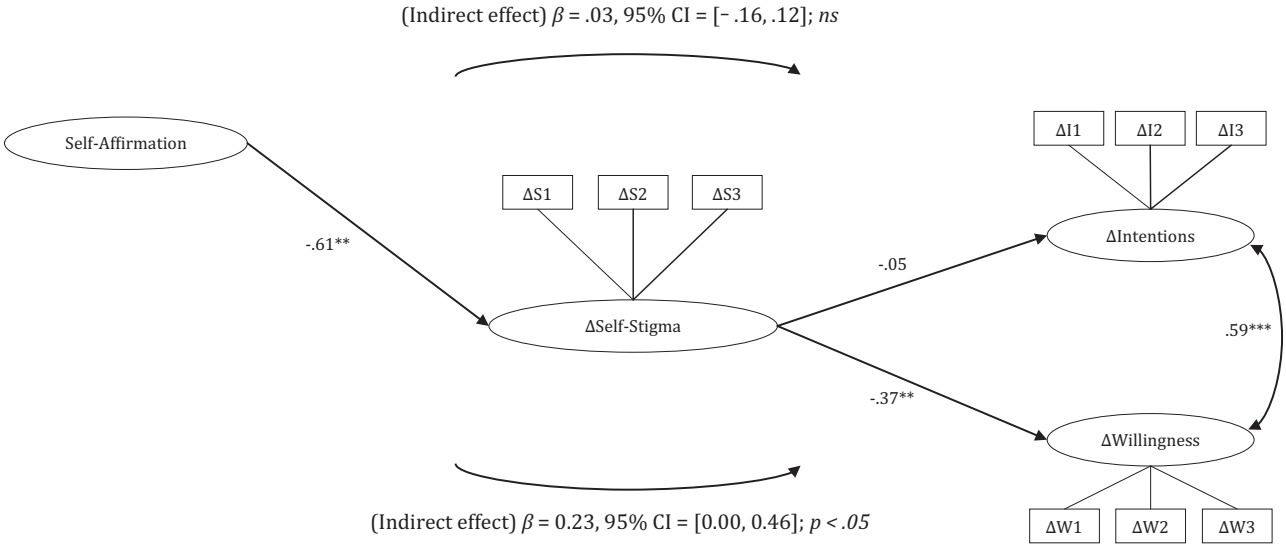

Figure 2. Hypothesized structural model of self-affirmation's effects on self-stigma, intentions, and willingness. Self-Affirmation = experimental manipulation of self-affirmation, coded such that 0 = *control*, 1 = *self-affirmation*; ΔSelf-Stigma = latent residualized change from pretest to posttest in Self-Stigma of Seeking Psychotherapy; ΔIntentions = latent residualized change from pretest to posttest in Intentions to Seek Psychotherapy; ΔWillingness = latent residualized change from pretest to posttest in Willingness to Seek Psychotherapy. The beta value from Self-Affirmation to ΔSelf-Stigma can be interpreted as the predicted amount of change in standard deviations of residualized change in self-stigma that occurs when completing the self-affirmation writing task as opposed to the control writing task. The beta values from ΔSelf-Stigma to ΔIntentions and ΔWillingness can be interpreted as equivalent to the change in standard deviations of the residualized change in the respective outcome variable that occurs when residualized change in self-stigma increases one standard deviation. CI = confidence interval; S = Self-Stigma; I = Intentions; W = Willingness. ** $p < .01$. *** $p < .001$.

mediated by self-stigma). The partially mediated model also fit the data well, Satorra-Bentler $\chi^2(30, N = 84) = 32.24$, $p = .357$; CFI = .989; TLI = .983; RMSEA = .030, 90% CI = [.000, .089]; SRMR = .063, though a scaled chi-square difference test revealed that inclusion of the additional direct effects did not improve model fit, $\chi^2(2) = 1.81$, $p = .405$, and that neither of the added direct effects were statistically significant ($ps > .178$).

To examine whether the direction of effects was in the hypothesized direction, we also assessed two other alternative models. The first was a model in which self-affirmation predicted willingness to seek psychotherapy, which in turn predicted both intentions to seek psychotherapy and self-stigma of seeking psychotherapy. This alternative model failed to meet the suggested fit index cutoff values for the TLI and SRMR, Satorra-Bentler $\chi^2(32, N = 84) = 39.62$, $p = .167$; RMSEA = .053, 90% CI = [.000, .102]; CFI = .961; TLI = .946; SRMR = .083, and was thus inferior to the hypothesized model. A further analysis evaluated a second model that included direct effects from self-affirmation to intentions, and from intentions to both self-stigma and willingness. This alternative model failed to meet the suggested fit index cutoff values for SRMR, Satorra-Bentler $\chi^2(32, N = 84) = 38.95$, $p = .185$; RMSEA = .051, 90% CI = [.000, .100]; CFI = .965; TLI = .950; SRMR = .082, a finding that is not surprising given the suggestion implied by this analysis that reasoned rational processes—as reflected by intentions—should be causally antecedent to spontaneous processes reflected by willingness.

Mood-mediated model. Finally, to consider the possibility that self-affirmation may work via more general improvements in mood, which may in turn influence judgments, we examined the possible mediating effects of positive and negative mood. This alternative model was identical to the original hypothesized model, except that latent residualized change score variables for positive mood and negative mood were included. In particular, direct effects of self-affirmation on both positive and negative mood were included, as were direct effects of the two mood variables on self-stigma, intentions and willingness, as depicted in Figure 3. Thus, this analysis tests whether positive and negative mood might provide a mediational pathway of self-affirmation's effects on the outcome variables. However, neither of the paths from the self-affirmation manipulation to the mood variables were significant ($ps > .151$). Furthermore, none of the indirect effects of the self-affirmation manipulation through either mood variable predicted changes in self-stigma, intentions, or willingness ($ps > .05$; all bootstrapped 95% CIs include zero).

In order to directly compare the mood mediated model with the hypothesized model, we first constrained all nine effects associated with positive and negative mood to zero, and then freed those nine effects and tested whether inclusion of the mood-related effects significantly improved model fit. A scaled chi-square difference test between the constrained model, Satorra-Bentler $\chi^2(101, N = 84) = 114.39$, $p = .171$; RMSEA = .040, 90% CI = [.000, .072]; CFI = .954; TLI = .945; SRMR = .093, and the unconstrained model, Satorra-Bentler $\chi^2(92, N = 84) = 102.42$, $p = .215$; RMSEA = .037, 90% CI = [.000, .071]; CFI = .964; TLI = .953; SRMR = .070, was not significant, $\chi^2(9) = 11.95$, $p = .216$. Thus, results did not support the addition of positive and negative mood

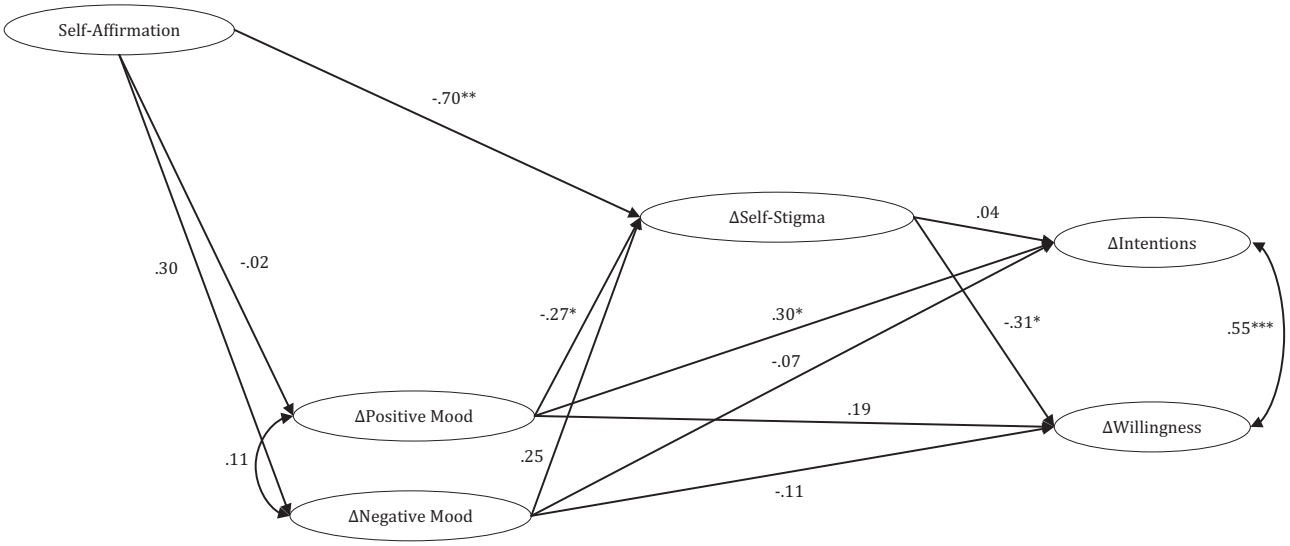

Figure 3. Mood-mediated model. Self-Affirmation = experimental manipulation of self-affirmation, coded such that 0 = *control*, 1 = *self-affirmation*; ΔPositive Mood = latent residualized change from pretest to posttest in Positive Mood; ΔNegative Mood = latent residualized change from pretest to posttest in Negative Mood; ΔSelf-Stigma = latent residualized change from pretest to posttest in Self-Stigma of Seeking Psychotherapy; ΔIntentions = latent residualized change from pretest to posttest in Intentions to Seek Psychotherapy; ΔWillingness = latent residualized change from pretest to posttest in Willingness to Seek Psychotherapy. The beta value from Self-Affirmation to ΔSelf-Stigma can be interpreted as the predicted amount of change in standard deviations of residualized change in self-stigma that occurs when completing the self-affirmation writing task as opposed to the control writing task. All other beta values can be interpreted as equivalent to the change in standard deviations of the residualized change in the respective outcome variable that occurs when residualized change in the predictor variable increases one standard deviation. $^{*}p < .05$. $^{**}p < .01$. $^{***}p < .001$.

effects to the originally hypothesized model. Furthermore, consistent with self-affirmation theory, mood did not mediate the effects of the self-affirmation intervention in the alternative model, and importantly, all paths retained from the original hypothesized model remained both similar in magnitude and unaltered with respect to the direction and significance of their effects.

Discussion

Self-affirmation theory posits that self-affirming activity bolsters self-worth, thereby reducing the need to protect one's positive self-image via defensiveness in response to a subsequent threat to the self (Steele, 1988). Accordingly, we hypothesized that self-affirming an important personal characteristic through a writing task would reduce self-stigma of seeking psychotherapy in clinically distressed individuals. Consistent with this prediction, self-affirmation did reduce self-stigma associated with seeking psychotherapy, and thus demonstrated an effect similar to that which has previously been shown on other variables related to defensiveness (for reviews, see McQueen & Klein, 2006; Sherman & Cohen, 2002, 2006; Sherman & Hartson, 2011). This result suggests a potential means of addressing the underutilization of psychotherapy services by first encouraging individuals to focus on positive, valued personal characteristics so that they are less likely to derogate help-seeking and more likely to view it as a viable option for themselves.

We further hypothesized that the self-affirmation writing task would—through its attenuation of self-stigma—have a beneficial effect on proximal predictors of help-seeking, including intentions and willingness to seek psychotherapy. Findings provided partial support for this hypothesis. Specifically, self-affirmation, by virtue of its effect on reducing self-stigma, increased the willingness to seek psychotherapy. Yet, there was no support for an indirect effect of self-affirmation on intentions to seek psychotherapy. Taken together, this pattern of results suggests that self-affirmation might primarily influence more spontaneous, reactive decision-making processes associated with the construct of willingness, and have comparatively weaker effects on the reasoned and rational decision-making processes connected with intentions. Whereas intentions reflect purposeful planning (Ajzen, 2011), willingness corresponds to an openness to engaging in a behavior should the opportunity arise (Gerrard et al., 2008). Therefore, self-affirmation may afford a method of indirectly influencing help-seeking not by facilitation of planned behavior, but by allowing for a greater openness to the prospect of seeking help, given the proper circumstances (Gibbons et al., 2009). This finding is especially relevant in light of recent research suggesting that spontaneous processes may be more influential than planned processes with respect to help-seeking behaviors (Hammer & Vogel, 2013).

Regardless of the relative importance of spontaneous and intentional processes, it seems likely that a combination of intervention strategies would be most effective in addressing the avoidance of psychotherapy. Whereas self-affirmation processes may be used to reduce defensiveness and diminish psychological barriers related to help-seeking, interventions derived from the theory of planned behavior could be utilized to encourage help-seeking behaviors more directly by fostering favorable attitudes about psychotherapy, presenting psychotherapy as normative, and providing individuals with the knowledge, skills, and means to seek help (Ajzen, 2011). In particular, self-affirmation interventions might be especially beneficial if they were delivered prior to using more explicit attempts to increase utilization of psychotherapy services. A self-affirmation intervention followed by psychoeducation or cognitive restructuring could evince synergistic effects, wherein self-affirmation first enables individuals to be less defensive, less self-stigmatizing, and more open when subsequently presented with information that encourages one to seek psychotherapy, thereby maximizing the likelihood of seeking help.

The present investigation also significantly adds to the larger social psychological literature on self-affirmation by directly addressing the possibility that self-affirmation operates via improvements in mood, and may not directly reduce defensive reactions, such as self-stigma (cf. McQueen & Klein, 2006). However, analyses provided no support for the idea that changes in mood mediated the effects of self-affirmation in this study. In fact, self-affirmation did not have any direct effects on mood, in that participants' levels of positive and negative mood were not significantly changed by the experimental manipulation. Consequently, results were consistent with self-affirmation theory, in that they supported the more parsimonious model that excluded mood effects and proposed only a direct effect of self-affirmation on self-stigma.

Results of the present study suggest that self-affirmation theory may provide a useful framework not only for understanding why individuals may avoid psychotherapy but also for informing the development of clinical interventions aimed at reducing barriers to seeking psychotherapy. However, it is important to consider several factors when contemplating the application of self-affirmation theory to help-seeking contexts. First, engaging in self-affirmation in the same domain in which the self is threatened may actually intensify defensiveness (Blanton, Cooper, Skurnik, & Aronson, 1997). In other words, a clinical self-affirmation intervention may not be effective if the self-affirmation activity reminds a person of characteristics too closely associated with therapy-related stigma. This psychological dynamic is in line with evidence that direct approaches to allay people's fears about mental illness tend to produce a "rebound" effect, resulting in greater activation and recall of negative mental illness stereotypes (Macrae et al., 1994).

Second, self-affirmation processes appear to work outside of awareness (Sherman & Cohen, 2006). Effects may be diminished when people are aware that the purpose of a self-affirmation activity is to maintain self-worth or improve one's openness to threatening information (Sherman et al., 2009). However, there is evidence that this effect of awareness may be moderated by providing individuals personal choice in whether or not they self-affirm (Silverman et al., 2013), thereby suggesting that self-affirmation could be beneficial as a deliberate coping strategy for some individuals under proper conditions.

Finally, the timing of self-affirmation is important, as self-affirmation has only been found to be effective when it occurs prior to the initiation of a defensive response to threat (Critcher et al., 2010). Therefore, interventions will be most effective to the degree that one can anticipate information that will be perceived as threatening so that self-affirmation may be encouraged beforehand. Accordingly, there are perhaps two readily apparent applications of self-affirmation interventions in clinical settings. First, as suggested above, self-affirmation may be used to decrease defensiveness and increase the likelihood of seeking psychotherapy, such as in outreach activities or initial contacts, wherein potential clients are first encouraged to assess and discuss their

strengths. Second, in the context of an ongoing therapy, self-affirmation activities across multiple domains of strength could be integrated into session activities, thereby building resilience against self-stigma associated with being in treatment and reducing risk of prematurely discontinuing therapy.

Limitations and Future Directions

In discussing the results of this study, it is important to consider several limitations. First, after the experimental manipulation but before assessment of the dependent variables at posttest, all participants read an article that described psychotherapy and its benefits, the purpose of which was to induce a threat to the self by having participants consciously process the prospect of receiving psychotherapy. The article presented psychotherapy in a positive light, which might raise the question as to whether or not the article actually induced a threat. To the degree that the article reduced threat, findings of this investigation would represent an underestimate of self-affirmation's full potential to reduce self-stigma. Nonetheless, in support of the present procedure, there is evidence that psychotherapy, even when framed positively, is still perceived as threatening due to stigma and the elicitation of negative self-evaluations that call into question one's competence, adequacy, stability, and consistency (Fischer et al., 1982; Vogel et al., 2006). Additionally, because long-term longitudinal data were not collected, it is unknown how long self-affirmation's salutary effects might last. Whereas the direct effects of self-affirmation might be short-lived (Crocker & Park, 2004), one important study revealed that a brief recurring self-affirmation interventions led to broad improvements in functioning for individuals in an at-risk population over the course of 2 years (Cohen, Garcia, Purdie-Vaughns, Apfel, & Brzustoski, 2009)—a finding that indicates the importance of conducting longitudinal research. Another limitation of the present study was that participants were relatively homogeneous with regard to ethnicity, indicating the importance of replicating these findings in more diverse samples in order to demonstrate generalizability of the effects. Nevertheless, it is worthwhile to note that the present sample was representative of the university undergraduate population from which it was drawn, and the participants did report symptoms of psychological distress consistent with a clinical sample for which counseling services would be appropriate. Related to the issue of generalizability are the specific means we used to encourage self-affirmation. Although the self-affirmation manipulation used in the present study is the most commonly used self-affirmation manipulation, there do exist a number of other self-affirmation techniques that would be expected to demonstrate similar effects (McQueen & Klein, 2006), such as self-imagery, positive feedback, completion of self-esteem scales, priming, and expecting that one will perform a positive behavior in the future. Replication of the present findings using a variety of such self-affirmation manipulations would increase confidence that the effects of the specific manipulation used in the present study truly reflect the operation of self-affirmation.

Despite these limitations, the present study provides initial evidence that self-affirmation processes are capable of reducing self-stigma of seeking psychotherapy and suggest several directions for additional research. First, future studies should test whether self-affirmation activity can reduce not only self-stigma but also public stigma as well. Public stigma can involve the derogation of persons with mental illness, or those who receive psychological treatment. Given that outgroup derogation can serve to protect a threatened self-image (Fein & Spencer, 1997), endorsement of public stigma may constitute a defensive process that can likewise be reduced by self-affirmation. Second, for developing practical interventions, future work should identify means by which clinicians might apply self-affirmation in therapeutic contexts. These methods might include enabling clients to succeed in personally relevant activities, utilizing structured icebreaker activities that remind clients of positive self-conceptions, or explicitly encouraging clients to recount previous successes in other domains. Third, future research should explore whether self-affirmation can affect other clinically relevant outcomes that might also stem from defensive processes, perhaps including negative interpersonal behaviors, avoidance of personal responsibility, and unwillingness to address issues that evoke aversive emotional experiences, such as guilt and shame.

Conclusion

Given that self-stigma has been identified as an important barrier to seeking psychotherapy, there is justification for research focused on attenuating self-stigma in clinical populations. The present study constitutes an initial step in understanding how psychological processes function to reduce the extent to which individuals internalize stigmatic beliefs regarding the receipt of psychological services. Bolstering self-worth via self-affirmation may be one such way to reduce self-stigma. If translated effectively in clinical applications, techniques based on self-affirmation theory could be used to reduce individuals' resistance to seeking psychotherapy, and thereby contribute to addressing the underutilization of mental health services.

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