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Therapy with Mental Health Providers: A Study of Self-Stigma and Help Seeking Behaviors

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Abstract

We live in a society where stigma against people with mental illness exists. To make matters more complicated, our society devalues people who ask for help, labeling them as unstable or insecure. Those who do ask for help often face the most stigma related discrimination within the health care setting. In fact, some studies have shown that mental health providers frequently judge people chronic mental illness negatively. As a result, many people with mental illness chose to not seek help. For mental health providers, therapy is often seen as a desirable learning experience at the beginning of their careers, to work through personal issues that may interfere with doing work in the field and grow professionally. Yet, there is little research on providers seeking therapy at other stages in their careers. The idea that therapy is both valued by some as an educational experience and devalued by society raises questions about how mental health providers internalize these contradictory beliefs throughout their careers. This study asked mental health providers about their experiences with therapy and to complete the Self-Stigma of Seeking Help Scale created by Dr. David Vogel (2006) to further explore the relationship between self-stigma and therapy for mental health providers.

Introduction

If therapy is not mandated it is considered to be a desirable prerequisite for becoming professional in the field of mental health (Norcross, 2005). In this context, most therapists have undergone their own therapy (Norcross & Guy, 2005; Bike, Norcross, & Schatz, 2009; Orlinsky, Schofield, Schroder, & Kazantzis, 2011). These providers report that therapy was the largest influence for their own practice (Orlinsky & Rønnestad 2005). Career stage has been shown to be predictive of when people first enter treatment (Bike, Norcross, & Schatz, 2009). BSW students do not have particularly stigmatizing views towards those with mental illness or seeking their own mental health treatment, indicating they are open to the idea of participating in their own therapy (Zellmann, Madden, and Aguiniga, 2014).

Stigma has been related to poorer psychological outcomes, such as the devaluation of self, fear of rejection, demoralization, hopelessness, and lowered self-esteem and life satisfaction (Rosenfield, 1997; Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Mental health providers are just as likely to judge others stereotypically and with the same level of negativity as the general population (Ryan, Robinson, & Hausmann, 2001). Stigma leads to poorer employment outcomes and general social ostracism (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Rosenfield, 1997). Many mental health providers experience complications relating to their identity when they participate in therapy (Probst 2015; Vandenberghe & da Silveria, 2013; Fleischer & Wissler, 1985). At this time, there has been minimal research looking at stigma and mental health providers.

Research Questions

Is there a relationship between participation in therapy and self-stigma for mental health providers?

Is there a relationship between years of experience in the mental health field and self-stigma for mental health providers?

Methods

Selection and Recruitment

A purposeful and specific sample was chosen for this project. Potential participants were identified via snowball sampling. Inclusion criteria for participation in this study is self-identification as a mental health provider and being 18 years of age or older. All participants were informed that participation in this study was voluntary and no compensation would be provided.

Subject Protection

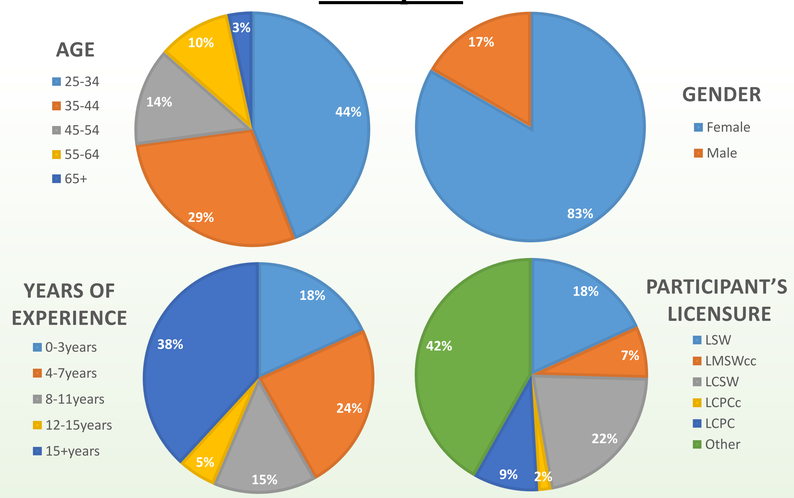
Approval for this study was obtained via the Internal Review Board at the University of Southern Maine. Every participant was informed of the goal of the research, the voluntariness of participation, that no compensation would be provided, and the anonymity of the study.

Instruments

Participants were asked about their personal experience in therapy and to complete a self-stigma questionnaire. All participants were asked to identify if they had participated in therapy or not. For those who had participate in their own therapy, they were asked where they received therapy, what type of provider did they see, and why they sought out therapy. Participants who had not participated in therapy were asked if they have ever considered going to therapy, why they were considering it, and what factors they felt led to their decision not to attend therapy. Participants were asked basic demographic information including age, gender, licensure, current job, and years of practice in the field of mental health.

All participants were asked to complete The Self-Stigma of Seeking Help Scale (SSOSH). The SSOSH is a 10-item self-report questionnaire that measures level of comfort or concern with regard to professional mental health treatment (Vogel, Wade, & Haake, 2006).

Descriptive



Results

The majority of participants (n=50, 83.3%) had received their own therapy. Of those who had been to therapy, most did so to process trauma (n=18, 36%). Participants also reported having gone to therapy for issues related to a mood disorder (n=16, 32%), relationship issues (n=7, 17%), to process grief (n=5, 10%), legal issues (n=1, 2%), insomnia (n=1, 2%), substance abuse (n=1, 2%), and self-reflection (n=1, 2%). Most participants reported they saw a therapist (n=44, 88%), and of those, 72% saw a therapist exclusively (n=32). 20% of participants saw a psychologist (n=10) and of those 30% saw a psychologist exclusively (n=3). 18% of participants saw a psychiatrist (n=9). All participants who saw a psychiatrist also reported seeing a therapist or a psychologist conjointly.

Of the 16.7% of participants who had not been in therapy, 60% had never considered the possibility of going to therapy. Most did not provide an explanation for why they never considered therapy, though one participant noted they are capable of managing their life stressors on their own and other noted that they never felt they had a reason to go to therapy as they are very happy with their life. Of the 40% who had considered therapy, one participant reported they decided not to go due to the cost, another noted that they had good natural supports, and one reported that they wondered if they the reason they identified for considering therapy was good enough.

The average SSOSH score for all participants was 20.62 (*min*=10, *max*=37, *sd*=5.99). SSOSH scores for participants who had participated in therapy (*m*=21.40) or had not participated in therapy (*m*=22.10) were not statistically significant (*t*(9)=.22, *p*=.83). SSOSH score for those who hadn't been in therapy but had considered it (*m*=21.00) or had not considered it (*m*=20.50) were not statistically significant *(t*(3)=.16, *p=.88).* In addition, there was no indication of a relationship between years of experience, age, or where people received therapy and SSOSH scores.

A paired-samples *t*-test was calculated to compare the mean SSOSH scores and gender. Male participants reported higher SSOSH scores (*m*=22.8, *sd*=5.85) compared to females (*m*=18.80, *sd*=4.39). However, this difference was not statically significant (*t*(9)= 1.88, *p*=.09).

A paired-samples *t*-test was calculated to compare the mean SSOSH scores of various licensure types. There was some indication of a relationship between licensure type and SSOSH scores, as LCPCs (*m*=23.6, *sd*=7.76) did have notably higher SSOSH scores compared to LCWs (*m*=15.8, *sd*=4.32). However, no statistical difference was found (*t*(4)= 1.59, *p*=.186). This result was not reflected when comparing SSOSH scores among other licensure types.

A paired-samples *t*-test was calculated to compare the mean SSOSH scores for participants who saw various mental health providers. The mean SSOSH score for participants who saw therapists was 18.22 (*sd*=4.12) and the mean SSOSH score for participants who saw psychiatrists was 24.33 (*sd*=6.67). A statistical difference was found (*t*(8)=3.12, *p*=.014).

A paired samples *t*-test was calculated to compare the mean SSOSH scores for participants who went to therapy for relationship issues and those who went to therapy to process grief. The mean score for those who went to therapy for relationship issues was 18.00 (*sd*=4.08) and the mean score for those who went to therapy to process grief was 24.33 (*sd*=6.67and A statistical difference was found (*t*(3)=3.66, *p*=.035).

Discussion

This study was designed to explore the possibility of there being a relationship between self stigma and having had participated in therapy and if there is a relationship between self stigma and years of work experience for mental health providers. It can be concluded that no evidence was found in this study to support a relationship on either account. There was also no evidence to support a relationship between self stigma and age, or where people got therapy.

While not significant, participants who had a LCPC license reported noticably higher self-stigma ratings than those who held LSW licensure. There were no differences between participants with LMSWcc, LCSW, or LCPC licenses nor were there any differences between participants with LSW, LMSWcc, LCSW licensures. A possible explanation for this finding is that there is a relationship between self-stigma and education, both in level and area of study. A LSW license only requires a bachelor's level degree, while all of the other licenses require a master's degree.

Men tended to report slightly higher self-stigma rates than women. While not statistically significant in this sample, this result indicates that gender may influence an individual's self-stigma. This is likely due to the way our society constructs gender and socializes individuals to believe that expressing and talking about emotions is inherently feminine, thus emasculating.

There was evidence that there is a relationship between self stigma and the type of provider seen. Participants who saw a psychiatrist were significantly more likely to have higher self-stigma ratings than participants who saw a therapist. This is likely due to the fact that typically psychiatrists approach treatment from a medical model, diagnosing and treating pathology. Whereas therapists typically approach treatment from a strengths-based model and normalize ones struggles on a spectrum of human experience.

Limitations

Some limitations should be considered when interpreting the results of this study. First, this study was based on a 100% online survey, thus excluding those without access to the internet or those who lack computer skills. This may have excluded mental health providers who are at the end of their careers and may not be as comfortable with using email or disclosing personal information on the internet as those at the beginning and middle of their careers.

Second, participants were encouraged to share the survey with peers who may be interested in participating in this study. Therefore, there is no way to assess the response rate of this survey. In addition, potential participants were recruited via snowball sampling, thus results of this study are not generalizable.

Third, the total sample size is relatively small (n=60) resulting in underrepresentation in various subcategories. For example, only one participant reported they had a LCPCc license. Therefore, there was not enough data to calculate a *t*-test for this licensure type. This limitation was also apparent when exploring the reasons why participants sought therapy.

Fourth, participants were not asked when in their lives or careers they had been in therapy. It is unknown if participants had participated in therapy prior to or when they were first starting their careers in mental health field versus having had worked in the field for several years and then gone to therapy. For that matter, it was not asked if participants had been to a single episode of mental health treatment or multiple episodes. These may be confounding variables.

Lastly, it may be that the lack of significant results can be explained by the fact individuals included to respond to a survey about their mental health treatment are inherently more likely to have lower self-stigma than those who chose not to participate.

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