

Predictors of the Change in Self-Stigma Following a Single Session of Group Counseling

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One of the major obstacles to seeking psychological help is the stigma associated with counseling and therapy. Self-stigma, the fear of losing self-respect or self-esteem as a result of seeking help, is an important factor in the help-seeking process. In the present study, college students meeting a clinical cutoff for psychological symptoms participated in 1 session of group counseling that either contained therapist self-disclosure or did not. In general, participants reported significantly less self-stigma following the session. Working alliance—bond and session depth significantly predicted the change in self-stigma. Furthermore, self-stigma (as well as bond, depth, psychological symptoms, and being female) predicted the intention to seek help following the session. Self-stigma and session depth also predicted interest in continuing with counseling. The therapist self-disclosure condition, however, had no effect on the change in self-stigma, intentions to seek help, or interest in continuing with group counseling.

Keywords: self-stigma, stigma, help seeking, group counseling/therapy, self-disclosure

Stigma has been declared a major obstacle to Americans getting quality mental health care (The President's New Freedom Commission on Mental Health, 2002). The Surgeon General has stated that concerns about stigmatization interfere both with the decision to seek help and with the continuing use of services (U.S. Department of Health and Human Services, 1999). In fact, greater stigma has been linked with poorer follow-through with therapy (Sirey, Bruce, Alexopoulos, Perlick, Friedman, & Meyers, 2001) and with early termination of treatment (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001). It seems clients may continue to hold concerns about stigmatization even after they have made the initial decision to seek help. Accordingly, there is a clear need to better understand the role of stigma both before and after the decision to start counseling has been made.

Despite this need, researchers have rarely examined the occurrence of stigma in those already receiving counseling. The goal of this investigation was to explore stigma before and after an initial session of group counseling and to examine aspects of the counseling process (e.g., session quality, working alliance, counselor self-disclosure) that may predict changes in stigma. A better understanding of the factors related to the reduction of stigma following the inception of counseling could inform counselors of the pertinent issues associated with increasing treatment compliance and decreasing premature termination as a result of self-stigma for seeking help.

Self-Stigma of Seeking Psychological Help

One explanation for why stigma may be a major barrier to seeking counseling is based on modified labeling theory (MLT; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). MLT posits that negative external perceptions of those with mental illness can negatively affect a person's internal sense of self if the individual is labeled as having a psychological problem. These external perceptions have been called *public stigma*, or the general public's negative reactions to those with a mental illness that can lead to avoidance, discrimination, and/or stereotyping. In turn, a person's negative perceptions of him- or herself as a result of having a mental illness has been called *self-stigma* (Corrigan, 2004). Consistent with MLT, people have been found to internalize negative external perceptions of mental illness (Link, 1987; Link & Phelan, 2001) and to report lower self-esteem after being labeled as mentally ill (Link, Struening, Neese-Tood, Asmussen, & Phelan, 2001). Therefore, in an attempt to prevent public and self-stigma, people may try to avoid the label of mental illness by deciding not to seek counseling services (Corrigan, 2004).

Originally, MLT was developed in relation to perceptions of mental illness (Link et al., 1989). More recently, however, MLT has been applied to decisions to seek counseling (Vogel, Wade, & Hackler, 2007). Specifically, researchers have examined the relationships between the public stigma and self-stigma associated with seeking help for a psychological problem (e.g., Vogel, Wade, & Haake, 2006). To test the hypothesized relationships expressed by MLT between public and self-stigma, researchers recently tested models in which self-stigma for seeking help was found to fully mediate the relationship between public stigma and both attitudes toward and intentions to seek individual and group counseling (Ludwikowski, Vogel, & Armstrong, 2009; Vogel, Shechtman, & Wade, 2010; Vogel et al., 2007). Similarly, strong associations between self-stigma for seeking help and attitudes toward and intentions to seek counseling have been found for individual

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(Vogel, Wade, et al., 2006) and group counseling (Shechtman, Vogel, & Maman, 2010; Vogel et al., 2010).

The distinction between public stigma and self-stigma allows for an important assessment of how people feel about their own psychological concerns and their treatment. For example, although people might be aware of the public stigma associated with seeking help, they might have lower self-stigma for seeking help due to previous experiences with counseling or knowing someone who benefited from counseling (Vogel & Wade, 2009). Consequently, although a person might accurately perceive a general public stigma, he or she knows from personal experience that seeking help is beneficial, has less concern about it personally, and, therefore, experiences lower self-stigma for seeking help. As a result, it may be more beneficial for psychologists to develop interventions at an individual (i.e., self-stigma) level rather than the community (i.e., public stigma) level to help people reduce self-stigma for seeking help.

Interventions to Reduce Self-Stigma

Self-stigma is an important concept in understanding obstacles to help seeking and is a consistent predictor of help-seeking attitudes and intentions over and above other types of stigma (Vogel, Wade, et al., 2006). As a result, researchers are starting to discuss potential ways to reduce self-stigma, and a few methods have been empirically tested (e.g., providing information and fostering self-acceptance: Hayward & Bright, 1997; desensitization and reframing: Corrigan & Calabrese, 2005). For example, in one Internet-based intervention to reduce the personal stigma specifically associated with depression, clients who received information about depression reported significant reductions in personal stigma (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). However, even if interventions or larger scale educational campaigns that try to reach a broad audience actually increase the likelihood that a person in need will attend a first session of counseling, it is still unknown what impact that first session will have. Given the association between stigma and treatment adherence (Sirey, Bruce, Alexopoulos, Perlick, Friedman, & Meyers, 2001) and early termination (Sirey, Bruce, Alexopoulos, Perlick, Raue, et al., 2001), understanding ways that counseling itself relates to stigma may be important for increasing treatment adherence and avoiding early terminations.

Certainly, aspects of counseling itself might be useful for reducing self-stigma and helping people to decide to return to counseling. There is good reason to expect that being in counseling, even just a single session, would help reduce the stigma associated with going to counseling. For example, data show that people who have been in counseling in the past report lower self-stigma for seeking help than those who have not (Vogel, Wade, et al., 2006). However, this correlation could be a result of the tendency of people who initially have lower self-stigma for seeking help to be more willing to go to counseling, rather than counseling itself actually leading to a reduction in self-stigma. Still, it is reasonable to expect that having a positive experience in counseling would help to mitigate self-stigma for seeking help. If, then, being in counseling helps reduce self-stigma, what about the process is beneficial?

One possible factor that might help reduce stigma is the mere exposure to an unknown process or experience that is believed to

lead to negative outcomes. By actually experiencing counseling (even just an initial session), people might see that their beliefs or concerns are not justified and that the experience will help them rather than cause them to think less of themselves. This is particularly relevant to group counseling, in which people not only get exposed to the process of counseling but do so with peers. Group experts have often discussed the power of hearing another's story, pain, or struggle in normalizing mental health issues (e.g., Yalom, 2005). It can also be helpful when other members in the group talk about how beneficial group counseling has been for them.

Besides the mere exposure to therapy, there might be particular aspects of therapy that help to reduce self-stigma, such as seeing a therapist as a real person. This might reduce the unknown and help to ground the experience in a person who is professional, caring, and not like the media stereotypes. It might be more important in a first session of group counseling to feel connected to the group leader rather than the group members because, in the initial stage of group counseling, people often look to the leader for direction, help, and reassurance (Yalom, 2005). Therapists disclosing information about themselves, their past experiences, and their current feelings might help them appear more approachable and caring and less like the negative stereotypes that some people have about therapists. Seeing one's therapist as a caring professional who might be able to help with psychological problems could lead to a reduction in self-stigma for seeking help, so much so that a client will no longer feel his or her self-confidence and esteem are threatened by the counselor or the counseling process.

Therapist Self-Disclosure

Therapist self-disclosure in therapy has been an issue of considerable interest to researchers and clinicians since the beginning of psychotherapy. Freud (1912/1995) laid the initial guidelines for self-disclosure when he stated that "the doctor should be opaque to his patients, and like a mirror, should show them nothing but what is shown to him" (p. 361). However, even as early as the 1920s, this approach was challenged when Ferenczi and Burrow each experimented with mutual therapy, blurring the lines between patient and doctor (Cohen & Schermer, 2001). Jourard (1964) further challenged the blank screen when he claimed that therapist self-disclosure could provide a healthy interpersonal model for clients. Yalom (2005) also believed that therapist self-disclosure can be useful and, as a result, devoted a chapter in his classic text on group psychotherapy to discussing the benefits (and techniques) of therapist transparency.

In the past several decades, empirical research on self-disclosure has begun to catch up to the century-long debate. Several findings from this research are relevant to the current study. First, an estimated 90% of therapists do report using some form of self-disclosure (Henretty & Levitt, 2010). When they disclose, therapists share a range of experiences and emotions with their clients, such as fears and sadness and their values and beliefs along with more basic information such as their credentials (Berg-Cross, 1984). As such, self-disclosure may be a tool used by many therapists. Some of the main reasons therapists may choose to self-disclose are to make themselves more accessible to clients, to develop the working alliance, and to build greater trust in the therapeutic relationship. These factors are likely to reduce negative perceptions that clients might have of themselves for seeking help.

In other words, clients are likely to feel less self-stigma when working with a group counselor that they trust and view positively as, in such situations, the threat to one's self-esteem and confidence is less likely. In the group therapy research, some evidence suggests that therapists who self-disclose are viewed by group members as more friendly, disclosing, trusting, intimate, helpful, and facilitating (Dies, 1973). In addition, some evidence suggests that therapist self-disclosure has been shown to effect willingness to return to therapy and willingness to refer a friend to the therapist (see Henretty & Levitt, 2010). Returning to therapy and referring a friend may be indications of lower self-stigma for seeking help. Therefore, if therapist self-disclosure increases therapy retention and referring behaviors, it may also be reducing self-stigma for seeking help. Given these initial results in the group therapy research, it may be beneficial to explore these variables in greater detail.

Process Variables Potentially Related to the Reduction of Self-Stigma

Other process-oriented variables might also help to reduce self-stigma for seeking help. For example, the development of a strong working alliance with the group counselor(s) might help diminish the concern that counseling will lead to feeling worse or will reduce confidence and self-esteem. Through a working alliance with a counselor, clients are better able to trust the process of counseling, to believe that it will be useful and helpful for them, and ultimately to benefit more from counseling (Horvath & Symonds, 1991). Through this trust and belief in the counselor and the process of counseling, self-stigma for seeking help may be diminished as clients see the potential benefits to themselves. It might be particularly important in a first session of group counseling to feel connected to the group leader rather than the other group members because, early in group, members often look to the leader for direction, help, and reassurance (Yalom, 2005). There is some evidence that even later in group counseling, alliance with the therapist may be an important predictor of outcomes, such as a reduction in psychiatric symptoms (Marziali, Munroe-Blum, & McCleary, 1997), although this has not been found consistently (Crowe & Grenyer, 2008). Still, this suggests that alliance with the therapist might be an important part of the group counseling process and therefore may have an impact on self-stigma for seeking help.

The quality of the group session may also have a positive impact on self-stigma. If the session is of higher quality, it is more likely that clients will respond positively, that they will believe counseling will be helpful for them, and that self-stigma will be reduced. In past research, session quality has been related to more positive, helpful sessions that lead to greater self-understanding (Stiles et al., 1994). Session quality has also been related to a secure attachment with the therapist (Romano, Fitzpatrick, & Janzen, 2008) and with reduced psychological symptoms (Muran et al., 2009). These results indicate that greater session quality may be an important indicator of effective therapy. Thus, participants who perceive the session as having greater quality are likely to have more favorable opinions about the treatment and be less likely to see therapy as a threat to their self-worth. Therefore, they may be more likely to continue with therapy.

In addition, the more positive the group climate, specifically, how engaged the member perceives the group to be, the better the experience is likely to be and the greater reduction one would expect in self-stigma for seeking help. Some evidence indicates that greater group engagement is related to group counseling retention (Connelly, Piper, DeCarufel, & Debbane, 1986). Although Connelly et al. (1986) did not assess self-stigma, retention might be an outcome that would be related to self-stigma for seeking help. If this is the case, then greater engagement might reduce self-stigma, which might enhance treatment retention.

The Present Study

The present study was conducted to explore the effects of one session of group counseling on self-stigma for seeking help and the related variables of the intention to seek help and the desire to continue group counseling. In addition to the effects of actually attending a session of group counseling, we were also interested in the degree to which process variables might predict changes in self-stigma for seeking help. Specifically, we were interested in the effects of counselor self-disclosure on self-stigma, as well as the relationships between changes in self-stigma for seeking help and the working alliance, session quality, and group climate. We predicted that, in general, attending a session of group counseling would result in a decrease in self-stigma for seeking help. Furthermore, those who attended sessions in which the counselors disclosed information and feelings about themselves would have lower self-stigma than those who did not have a counselor self-disclose during the session. Finally, we hypothesized that greater perceptions of the working alliance, session quality, and group climate would be related to greater change in self-stigma for seeking help from presession to postsession. We included biological sex and psychological problems and functioning in each of the regression analyses primarily as control variables because, in previous research, being female and severity of psychological disturbance have been related to greater intentions to seek help and to less stigma for seeking help in individual (Vogel et al., 2007) and group counseling (Shechtman et al., 2010).

Method

Participants

Participants included 263 undergraduate students of Iowa State University (Ames, IA). The participants were predominantly European American ($n = 226$ [86%]; five African Americans [2%]; 12 Asian Americans [4.5%]; eight Latin Americans [3%]; 12 other/no response [4.5%]), matching the demographic make-up of the university student body. The sample was 55% female ($n = 144$) and 45% male ($n = 119$). The average age of the clients was 19.1 years ($SD = 1.56$, range = 18–31). A total of 17 participants had attended counseling prior to their participation in this study, with 13 people attending individual, three people attending group, and one person attending couples counseling. They had attended from one to 30 sessions ($M = 6.0$, $SD = 7.1$).

Measures

Self-stigma. The Self-Stigma of Seeking Help Scale (SSOSH; Vogel, Wade, & Haake, 2006) was used to measure

participants' self-stigma related to seeking professional psychological help. The SSOSH is a 10-item scale consisting of statements such as "It would make me feel inferior to ask a therapist for help," "I would feel worse about myself if I could not solve my own problems," and "My self-esteem would increase if I talked to a therapist" (reverse-scored; Vogel, Wade, & Haake, 2006, p. 328). Items are rated on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). Scale scores range from 10 to 50, with higher scores indicating greater self-stigma. The SSOSH has been found to have a unidimensional factor structure. Internal consistency estimates have ranged from .86 to .90, and the reported 2-week test-retest reliability is .72 in college student samples (Vogel, Wade, & Haake, 2006). Support for the validity of the SSOSH has been reported via relationships with attitudes toward seeking professional help ($r_s = -.53$ to $-.63$) and intention to seek counseling ($r_s = -.32$ to $-.38$; Vogel, Wade, & Haake, 2006). The SSOSH has also been shown to predict those who sought counseling from those who did not seek counseling across a 2-month period (Vogel, Wade, & Haake, 2006).

Intent to seek counseling. The Intentions to Seek Counseling Inventory (ISCI; Cepeda-Benito & Short, 1998) was used to measure participants' intentions to seek counseling. Using an original list of concerns developed by Cash, Begley, McCown, and Weise (1975), Cepeda-Benito and Short (1998) created a questionnaire with 17 concerns that commonly bring college students to counseling. Respondents are asked to assume they are experiencing each problem and then rate their likelihood of seeking counseling for that issue. For the current study, participants were asked to rate their likelihood on a 1 (*very unlikely*) to 4 (*very likely*) scale (range = 10–40), with higher scores indicating a greater intention to seek help. Cepeda-Benito and Short's factor analysis of the ISCI found three factors, labeled Psychological and Interpersonal Concerns (10 items; $\alpha = .90$), Academic Concerns (four items; $\alpha = .71$), and Drug Use Concerns (two items; $\alpha = .86$). The overall alpha was .89 (Cepeda-Benito & Short, 1998). Only the Psychological and Interpersonal Concerns subscale was used in this study. Items on the subscale include difficulty with friends, concerns about sexuality, and loneliness. The ISCI has been found to be related to the perceived significance of a current problem and to general attitudes toward seeking help ($r = .36$; Kelly & Achter, 1995).

Bond with counselor. The Bond subscale of the Working Alliance Inventory—Short Form (WAI-S; Tracey & Kokotovic, 1989) was used to measure participants' perceptions of the bond developed with the counselor. The WAI-S consists of 12 items measuring three unique aspects of the counselor–client working alliance (i.e., task, bond, and goal). The Task and Goal subscales were excluded from this study because, unlike the Bond subscale, both Task and Goal were not directly applicable to the study, in which participants attended only one session and may not have had any particular tasks or goals for the session. In contrast, the Bond subscale allowed for an assessment of how well the participants bonded with their group counselors. The Bond subscale has four items, including "I believe [the counselor] likes me" (Horvath & Greenberg, 1989). For this study, items were changed from the present tense to the past tense. Each item is ranked on a 7-point scale (1 = *strongly disagree*, 7 = *strongly agree*). Scores can range from 4 to 28, with higher scores indicating greater bond with the counselor. The Bond subscale has been reported to have high

internal consistency ($\alpha = .92$) among a sample of clients who received one individual counseling session (Tracey & Kokotovic, 1989). The short version of the Bond subscale was not tested for validity in the original publication, but the larger Bond subscale from which it was drawn showed adequate validity through correlations with counselor-rated bond ($r = .53$) and, in two samples, client-rated counselor empathy ($r_s = .83$ and $.76$), attractiveness ($r_s = .38$ and $.73$), and expertness ($r_s = .28$ and $.66$; Horvath & Greenberg, 1989).

Group engagement. The Group Climate Questionnaire—Short Form (MacKenzie, 1983) is a 12-item questionnaire that measures various interactional dimensions of a group session. Factor analysis has revealed three factors, labeled Engaged, Avoiding, and Conflict. Only the Engaged factor was used in this study. The Engaged subscale consists of five items (e.g., "The members felt what was happening was important and there was a sense of participation") that describe a positive working atmosphere (MacKenzie, 1983, p. 161). Items are rated on a 7-point scale (1 = *not at all*, 7 = *extremely*). Subscale scores can range from 5 to 35. The internal consistency of the Engaged subscale has been reported to be .92 (Kivlighan & Goldfine, 1991). The Engaged subscale has been found to moderately correlate with measures of group cohesion and member bonds (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005).

Session quality. The Depth and Smoothness factors of the Session Evaluation Questionnaire (SEQ; Stiles et al., 1994) were used to measure participants' evaluation of the group counseling session. Each item begins with the phrase "This session was . . ." and is followed by polarities separated by a 7-point scale. Five polarities each comprise the Depth (e.g., powerful–weak, full–empty) and Smoothness (e.g., smooth–rough, relaxed–tense) factors. Items on each factor are summed for factor scores ranging from 5 to 35, with higher scores indicating greater session depth or smoothness. The SEQ Depth factor was found to have moderate to strong positive correlations with clients' ratings of understanding, problem solving, and relationships with other group members. The SEQ Smoothness factor also had a moderate correlation with the relationship measure (Stiles et al., 1994). Coefficient alphas for the Depth and Smoothness factors are .90 and .92, respectively (Stiles et al., 1994).

Psychological problems and functioning. The Clinical Outcomes in Routine Evaluation outcome measure (CORE-OM; Evans et al., 2000) is a 34-item scale designed to assess the severity of clients' problems at treatment outset and to measure changes in severity over the course of treatment. The CORE-OM covers three dimensions: subjective well-being (four items), problems/symptoms (12 items), and life functioning (12 items). It also includes six items assessing for risk of harm to self or others. Only the Problems/Symptoms (e.g., "I have felt tense, anxious, or nervous") and Life Functioning (e.g., "I have felt terribly alone and isolated"; Evans et al., 2000, p. 251) subscales were used in this study. Participants rated on a 5-point scale (0 = *not at all*, 4 = *most or all of the time*) how often each item applied to them in the past week. Scores on each subscale were averaged, resulting in possible scores ranging from 0 to 4. Validity evidence is provided by the ability of the CORE-OM to discriminate between clinical and nonclinical populations. In addition, the CORE-OM has strong correlations with measures of psychological distress, including depression, anxiety, and interpersonal problems (Evans et al.,

2000). Coefficient alphas are high for both the Problems/Symptoms (.87–.91) and Life Functioning (.85–.88) subscales (Evans et al., 2000).

Interest in continued group counseling. A single item was used to assess participants' interest in continuing with group counseling. Participants responded *yes* or *no* to the question, "Would you be interested in continuing with a counseling group?" If participants responded positively, they provided their contact information and were given an opportunity to continue with group counseling after the study ended.

Procedures

Selection of participants. Participants were selected from approximately 3,500 undergraduate students enrolled in introductory psychology courses who completed a screening questionnaire offered during the first 3 weeks of classes during three successive semesters. The screening procedure is part of the psychology department's procedures each semester for assessing and screening potential research participants. Students receive partial course credit for completing the screenings and any subsequent research projects they complete. Participants do not have to complete research studies, as there are alternatives provided for them to receive the course credit. The screening questionnaire included two questionnaires for the current study, the SSOSH¹ and the CORE-OM. Because we were interested in a sample similar to a clinical population, we set the eligibility criteria so that participants needed a score at or above the clinical cutoff point on at least one of the two subscales—symptoms/problems (e.g., depression, anxiety) and functioning (e.g., close relationships, social relationships)—of the CORE-OM. Eligible students ($N = 1,044$) then received an e-mail inviting them to participate in a single session of group counseling.

Assignment to groups and conditions. Group assignment operated on a first-come basis. Along with their invitation to participate, eligible students received a password that granted them access to the study on the psychology department's web-based research management system where participants signed up for a group time. Once all available seats were filled, the study was closed to the remaining eligible students. Because the study filled up at each wave of data collection, an exact assessment of the participation rate is impossible. However, the most conservative assessment would be a participation rate determined by the number of participants ($N = 263$) divided by the number of eligible participants ($N = 1,044$), which is 25.2%. However, because we were not able to accommodate every student who wanted to participate, the 25% rate of participation should be considered the lower bound.²

The 263 participants were randomly assigned to two different conditions across 41 separate small groups. One hundred fifty-five participants (59%) experienced the counselor-self-disclosure condition, and 108 (41%) received the no-counselor-self-disclosure condition. The 41 separate groups comprised between three and nine participants, with an average of 6.4 ($SD = 1.9$) participants per group ($Mode = 8$).

Group session procedures. Participants arrived 15 min prior to the start of the 90-min group session to complete consent forms and presession questionnaires. The counselor (for a description of the group counselors, see below) then led the participants in a

90-min group counseling session. The counselor went over group session guidelines (such as confidentiality) and then encouraged participants to talk about the experiences of coming to a group, their expectations, and their fears. They also were invited to talk about any concerns that they had in their personal or academic lives, but no one was required to share such information. The focus of the session was on connecting participants in the here and now, helping them to reflect on and share about the group process, and introducing them to the experience of being in a counseling group.

The counselor self-disclosure condition and the non-self-disclosure condition were identical in these regards. The difference between them was that counselors in the self-disclosure condition included relevant self-disclosures during the group session that were guided by the description of counselor self-disclosure provided by Knox and Hill (2003). Counselors were trained to disclose their thoughts and feelings about the here and now of the group session (disclosures of immediacy) but were also encouraged to disclose relevant past experiences, their training/qualifications, or other personal information such as disclosures of support, challenge, or insight (Knox & Hill, 2003). For example, in the beginning of all the group sessions, counselors asked participants to share their feelings and thoughts about coming to the group session. However, in the self-disclosure condition, counselors also shared their feelings, such as excitement, anxiety, hopefulness, and uncertainty. In the non-self-disclosure condition, counselors did not share this information.

Following the session, participants completed postsession questionnaires, received written debriefing, and were given referral information regarding group counseling. All participants received credit in their introductory psychology course.

Group counselors. The counselors ($n = 7$; four female and three male; one African American, one Asian American, and five European Americans) were graduate students (ages 25 to 30 years) enrolled in a doctoral program in counseling psychology. The counselors held a variety of theoretical orientations to individual counseling that informed their group work (i.e., interpersonal process, cognitive behavioral, feminist, and emotion-focused). However, all were trained in and adhered to an interpersonal process orientation in their group work. All had completed courses and practica in individual counseling, as well as a course in group counseling, and had or were currently taking a clinical practicum focused on group counseling. All counselors received additional training in regard to the specific group interventions to be used. The training consisted of information about counselor self-disclosure in therapy (with a focus on both the pros and the cons), clinical examples of positive and negative self-disclosure, and role-play practice. Counselors received weekly group supervision

¹ One wave of participants ($n = 86$) did not get the pretest SSOSH measure due to an oversight in the departmental data collection procedure. Therefore, there are no pretest SSOSH data for this wave of participants, and so, the sample size for the pre-post multilevel regression analyses is 177.

² To assess for self-selection bias based on self-stigma, we conducted an independent-samples *t* test to compare those who participated in the study with those who did not. There was no significant difference in self-stigma between those who participated in the study ($M = 29.1$, $SD = 7.6$) and those who did not ($M = 28.0$, $SD = 8.1$), $t(2015) = 1.59$, $p = .112$.

from Nathaniel G. Wade, a licensed counseling psychologist. Furthermore, although the facilitators were aware of the different treatments (self-disclosure vs. none), they were not aware of the study hypotheses. Each group counselor conducted between two and 13 separate groups and conducted at least one session of each intervention type.

Results

Preliminary Analyses

Descriptive data and correlations. Correlations, means, and standard deviations were calculated for all study variables. Correlations are provided in Table 1, and means and standard deviations by sex are provided in Table 2. In addition, we conducted two analyses of variance (ANOVAs) to determine whether group leader had an effect on self-stigma for seeking help and intentions to seek help. A 4 (group leader) $\times$ 2 (time) repeated measures ANOVA³ assessing self-stigma showed no significant effect of leader over time, $F(3, 168) = 0.53, p = .66$. A one-way ANOVA assessing intentions to seek help with group leader as the factor also showed that participants' intentions to seek help did not differ across leaders, $F(6, 255) = 0.86, p = .53$. We also conducted a chi-square analysis of group leaders crossed with those interested in continuing with group counseling or not. This analysis was also not significant, indicating that group leader was not related to whether people wanted to continue counseling or not, $\chi^2(6, N = 261) = 8.13, p = .23$. Given these results, the group leader factor was collapsed across groups and was not considered in the analyses below.

Manipulation check. To determine whether the group counselors implemented the self-disclosure condition according to verbal instructions and training, video recordings of the group sessions were coded for the number of therapist self-disclosures per group session. First, three undergraduate students were trained by Nathaniel G. Wade regarding counselor self-disclosure. The training included reading a journal article discussing the different forms of and purposes for self-disclosure (Knox & Hill, 2003) and practice identifying self-disclosure on video recordings. The three raters then independently rated each counselor speaking turn from the same two 90-min group sessions. Counselor speaking turns were defined as verbal expressions by the counselor that began when the counselor first started talking and ended when another group member spoke. Raters indicated whether the counselor self-disclosed (defined as in Knox & Hill, 2003) or not during each speaking turn. Multiple self-disclosures during one speaking turn were coded as one self-disclosure to simplify the coding.

After the raters independently rated the two separate group sessions, the three ratings were compared. For each speaking turn, a determination of agreement among the three raters was made. For the first group session, out of 167 speaking turns, the three raters agreed unanimously on 166 (99.4% agreement). For the second group, the raters unanimously agreed on 93 out of 97 speaking turns (95.9% agreement). Kappa statistics were also calculated on the ratings. Six total kappas were calculated, two for each of three pairs of raters. Kappas ranged from .48 to 1.00, all with significant values less than .001, for an average kappa of .73.

Given this high degree of agreement among the raters, each rater then completed approximately 13 more group sessions. These

ratings were then used to determine whether the group counselors provided more self-disclosures in the self-disclosure condition than in the no-self-disclosure condition. An independent-samples t test indicated that the group counselors provided more self-disclosures in the self-disclosure condition ($M = 7.3, SD = 3.5, Mode = 8$) than in the no-self-disclosure condition ($M = 2.1, SD = 2.7, Mode = 0$), $t(32) = 4.63, p < .001$.

Main Analyses

Change in self-stigma following one session of group counseling. To examine the change in self-stigma for seeking help following one session of group counseling, we conducted a multilevel regression to account for the nested nature of the data. Because time points were nested within individuals and individuals were nested within groups, the design was a three-level model. We followed the recommendations of Tasca, Illing, Joyce, and Ogrodniczuk (2009) in conducting multilevel models for longitudinal group research. First, we conducted the base model, represented in the following equation:

$$\begin{aligned} \text{Level 1: } Y_{tij} &= \pi_{0ij} + e_{tij} \\ \text{Level 2: } \pi_{0ij} &= \beta_{00j} + r_{0ij}, \text{ and} \\ \text{Level 3: } \beta_{00j} &= \gamma_{000} + u_{00j}, \end{aligned} \quad (1)$$

in which Y_{tij} = self-stigma assessed at time t for individual i in group j , π_{0ij} = the mean in self-stigma across all time points for individual i in group j , and e_{tij} = the deviation of an individual i 's self-stigma measured at time t from his or her mean. Also, β_{00j} = average of self-stigma scores for individuals in group j , and r_{0ij} = the deviation in self-stigma score of individual i from the mean of group j . Finally, γ_{000} = the grand mean of self-stigma across all groups, and u_{00j} = the deviation in mean self-stigma of group j from the grand mean. This analysis provided an estimate of the total within-person variance ($\sigma_{\text{base}}^2 = 27.12$).

Next we conducted an unconditional model that specified time as a predictor and controlled for individual pretreatment self-stigma for seeking help (group mean centered) and group mean pretreatment self-stigma for seeking help (grand mean centered). The model was as follows:

$$\begin{aligned} \text{Level 1: } Y_{tij} &= \pi_{0ij} + \pi_{1ij}(\text{Time}) + e_{tij}; \\ \text{Level 2: } \pi_{0ij} &= \beta_{00j} + \beta_{01j}(\text{Individual Pretreatment Self-Stigma}) \\ &\quad + r_{0ij}, \\ \pi_{1ij} &= \beta_{10j} + \beta_{11j}(\text{Individual Pretreatment Self-Stigma}) \\ &\quad + r_{1ij}; \text{ and} \\ \text{Level 3: } \beta_{00j} &= \gamma_{000} + \gamma_{001}(\text{Group Pretreatment Self-Stigma}) \\ &\quad + u_{00j}, \end{aligned}$$

³ There were seven total therapists who participated in the study. However, because we had a data collection problem with the SSOSH (i.e., pretest SSOSH was not collected with one wave of participants), three of the group leaders were not included in these pre-post analyses.

Table 1
Correlations Among Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Self-stigma, pre-session	—										
2. Self-stigma, post-session	.65***	—									
3. Intentions to seek help	-.34***	-.40***	—								
4. Desire to continue treatment	-.08	-.21***	.33***	—							
5. Sex	.20**	.16**	-.27***	.12	—						
6. Working alliance—bond	-.19	-.29***	.24***	.20**	.01	—					
7. Session depth	-.16	-.28***	.21**	.34***	-.04	.43***	—				
8. Session smoothness	-.06	-.16	.04	.18**	.07	.32***	.36***	—			
9. Group climate—engagement	-.01	-.12	.08	.17**	.02	.34***	.51***	.29***	—		
10. Psychological problems	-.12	-.06	.27***	.15	-.12	.04	.05	-.06	.04	—	
11. Psychological functioning	-.02	.04	.16	.12	-.04	-.02	-.07	-.11	-.15	.70**	—

** $p < .01$. *** $p < .001$.

$$\beta_{01j} = \gamma_{010} + u_{01j}$$

$$\beta_{10j} = \gamma_{100} + \gamma_{101} (\text{Group Pretreatment Self-Stigma}) + u_{10j}, \text{ and}$$

$$\beta_{11j} = \gamma_{110} + u_{11j}. \quad (2)$$

This analysis provides information to calculate the intraclass correlation (ICC), which allows an assessment of the amount of dependency in the data as a result of the nested structure. For repeated measures designs, the ICC accounts for the effect of the nesting factor (in this case, group) on the change in self-stigma at the individual and group levels and is determined by

$$\text{ICC or } \rho = \tau_{10j} / \tau_{10j} + \tau_{11j}, \quad (3)$$

where τ_{10j} is the estimated variance associated with the group slope parameter (u_{10j}) and τ_{11j} is the estimated variance associated with the individual slope parameter (r_{11j}). Results indicated that there was substantial dependency of the data based on the nesting factor ($\rho = 3.56/3.56 + 3.43 = .51$). This indicates that the use of multilevel regression is necessary to control for inflation of Type I error that occurs from such dependency.

The unconditional model also provided an estimate of the total within-person variance accounting for time and pretreatment self-stigma ($\sigma_{\text{unconditional}}^2 = 6.10$). Comparing the within-person vari-

ances from the base model and unconditional model (termed pseudo- R^2 , or $\sim R^2$, which = $[\sigma_{\text{base}}^2 - \sigma_{\text{unconditional}}^2] / \sigma_{\text{base}}^2$) provides an estimate of the within-person variance accounted for by the time variable (Kreft & De Leeuw, 1998). In this case, $\sim R^2 = .78$, indicating that modeling the change in self-stigma for seeking help scores over time accounted for 78% of the within-person variance. The unconditional model also provides an estimate of the amount of change in self-stigma from pre- to posttreatment. Evaluation of the Level 3 coefficient, $\gamma_{100} = -3.83$, $SE = 0.47$, $t(27) = -8.20$, $p < .001$, indicates that the average change in self-stigma for seeking help following treatment is significant. This indicates that after accounting for pretreatment self-stigma, the average change following treatment was -3.83 , or a reduction of 3.83 points. Using the standard deviations from the means of pre- and posttreatment self-stigma for seeking help, we can calculate an estimated effect size ($d = .51$). This means that, on average, self-stigma for seeking help was reduced by half of a standard deviation after just one session of group counseling.

Predicting change in self-stigma. On the basis of these findings, we proceeded with building a multilevel model to predict change in self-stigma for seeking help following treatment. Guided by our hypotheses, we added several individual level (Level 2) predictors to our unconditional model, including sex (male = 0, female = 1), working alliance—bond, group climate, session evaluation (depth and smoothness), psychological problems, and psy-

Table 2
Means, Standard Deviations, and Internal Reliabilities of Continuous Variables

Variable	α	Women			Men			Total		
		n	M	SD	n	M	SD	n	M	SD
Self-stigma, pre-session	.88	90	27.4	7.2	85	30.5 ^a	8.2	175	28.9	7.8
Self-stigma, post-session	.87	144	24.2	6.9	118	26.6 ^a	7.6	262	25.3	7.3
Intentions to seek help	.86	144	24.6	5.8	118	21.2 ^a	6.6	262	23.0	6.4
Working alliance—bond	.86	144	22.2	3.9	118	22.1	3.6	262	22.1	3.8
Group climate—engagement	.79	144	21.2	4.7	118	21.4	4.6	262	21.3	4.7
Session depth	.87	144	25.3	5.5	117	24.8	5.3	261	25.1	5.4
Session smoothness	.83	144	26.2	5.1	117	26.8	4.8	261	26.5	5.0
Psychological problems	.87	144	1.55	.76	117	1.37	.71	261	1.47	.74
Psychological functioning	.83	144	1.29	.62	117	1.24	.62	261	1.27	.62

^a Means between women and men are significantly different at $p < .01$.

chological functioning. These were added as predictors of change only (i.e., predicting the slope parameter of time, π_{1ij}). We also included one Level 3 predictor, the group condition (no disclosure = 0, therapist disclosure = 1), for both of the Level 2 intercepts (β_{00j} and β_{10j}), which represent the Level 1 intercept and slope, respectively. In this overall model, only working alliance–bond, $\gamma_{110} = -0.15$, $SE = 0.06$, $t(166) = -2.36$, $p = .02$, and depth of the session, $\gamma_{120} = -0.11$, $SE = 0.05$, $t(166) = -2.06$, $p = .04$, predicted change in self-stigma for seeking help. The results indicated that greater working alliance–bond was associated with greater negative slope on the time variable, which equates to greater reductions in self-stigma. Similarly, greater session depth was associated with greater reductions in self-stigma for seeking help over time.

Additional Analyses

In addition to exploring the effects of self-stigma for seeking help over time, we also were interested in the participants' intentions to seek help for a psychological or relational problem and their interest in continuing with group counseling. Both of these variables were measured to provide additional information that would approximate seeking psychological help and provide further validation of the self-stigma results.

Predictors of intentions to seek help following a session of group counseling. To examine the predictors of intentions to seek psychological help following a session of group counseling, we created another multilevel regression. Because intentions to seek help were only measured following the group session, there were only two levels to this multilevel regression, individuals (Level 1) nested within groups (Level 2). First, we ran the base model specified in the following equation:

$$\text{Level 1: } Y_{ij} = \beta_{0j} + r_{ij}, \text{ and}$$

$$\text{Level 2: } \beta_{0j} = \gamma_{00} + u_{0j}, \quad (4)$$

where Y_{ij} = intentions to seek help of individual i in group j , β_{0j} = average of intentions to seek help for individuals in group j , and r_{0ij} = the deviation in intentions score of individual i from the mean of group j . Also, γ_{00} = the grand mean of intentions across all groups, and u_{0j} = the deviation in mean intention score of group j from the grand mean. This analysis provided an estimate of the total within group variance ($\sigma_{\text{base}}^2 = 42.97$). We then calculated the ICC with the following equation:

$$\text{ICC or } \rho = \tau_{00}/\tau_{00} + \sigma^2, \quad (5)$$

where τ_{00} = the between-group variance in intentions and σ^2 = the within group variation in intentions. The ICC was .0002. Such a low ICC indicates that intentions to seek help were not dependent on the specific group that the participants attended, and therefore, multilevel regression is not necessary.

Thus, we conducted a hierarchical linear regression predicting intentions to seek help with sex (male = 0, female = 1), working alliance–bond, group climate, session depth, session smoothness, psychological problems, psychological functioning, and condition (no disclosure = 0, therapist disclosure = 1) in Step 1 and self-stigma (measured postgroup) at Step 2 (see Table 3). The overall model at Step 1 was significant, $R^2 = .19$, $F(8, 251) = 7.53$, $p < .001$. The variance in intentions was accounted for by

Table 3

Results of Hierarchical Linear Regression Predicting Intentions to Seek Help

Variable	Step 1			Step 2		
	<i>B</i>	<i>SE</i>	β	<i>B</i>	<i>SE</i>	β
Sex	2.95	.47	.23***	2.38	.71	.19**
Working alliance–bond	0.32	.11	.19**	0.21	.11	.12*
Group climate–engagement	−0.08	.09	−.06	−0.04	.09	−.03
Session depth	0.17	.09	.15*	0.10	.08	.08
Session smoothness	−0.03	.08	−.02	−0.05	.08	−.04
Psychological problems	1.97	.71	.23**	1.62	.68	.19*
Psychological functioning	−0.08	.86	−.01	0.34	.82	.03
Self-disclosure condition	0.22	.38	.04	0.30	.36	.05
Self-stigma, postsession	—	—	—	−.27	.05	−.31***

Note. R^2 at Steps 1 and 2 was .19 and .28, respectively. ΔR^2 from Step 1 to Step 2 was .08. All of these were significant at $p < .001$.

* $p < .05$. ** $p < .01$. *** $p < .001$.

four variables: sex ($B = 2.95$, $SE = .74$, $\beta = -.23$, $p < .001$), working alliance–bond ($B = 0.32$, $SE = .11$, $\beta = .19$, $p = .004$), session depth ($B = 0.17$, $SE = .09$, $\beta = .15$, $p = .047$), and psychological problems ($B = 1.97$, $SE = .71$, $\beta = .23$, $p = .006$). According to these results, women reported greater intentions to seek help than men, and those reporting greater session depth, working alliance–bond, and psychological problems reported greater intentions to seek help. The other variables did not predict intentions to seek help.

At Step 2, the overall model was significant, $R^2 = .28$, $F(9, 250) = 10.60$, $p < .001$, as was the change in R^2 , $\Delta R^2 = .08$, $F(1, 250) = 28.58$, $p < .001$. Self-stigma (postsession) was a significant predictor at the second step ($B = -0.27$, $SE = .05$, $\beta = -.31$, $p < .001$). With the addition of self-stigma to the overall model, depth of the session was no longer a predictor (all other significant variables remained significant; see Table 3). This finding, in connection with the finding above that session depth predicts change in self-stigma, suggests that the relationship session depth shares with intentions may be accounted for by the relationship between depth of the session and self-stigma. Thus, depth of the session may be more proximal to self-stigma for seeking help, and in turn, self-stigma may be more proximal to intentions to seek help.

Predictors of interest in continuing with group counseling. Following the group experience, participants indicated whether they would be interested in continuing with group counseling. Approximately 33% ($n = 86$) stated that they would be interested in continuing, whereas 65% ($n = 172$) would not be interested, and 2% ($n = 5$) did not answer. To examine the predictors of interest in continuing group counseling, we used a multilevel regression to predict the dichotomous variable of interest in continuing with group counseling (no = 0, yes = 1). Those who did not answer this question were excluded from the analyses. We used the Bernoulli approach in HLM 6.08, which estimates the coefficients and odds ratios for predictors of a dichotomous outcome variable. We included the same variables that were included in the equations above (i.e., sex, working alliance–bond, group climate, session depth, session smoothness, psychological problems, psychological functioning, self-disclosure condition, and self-stigma following

the group session). Two of these variables significantly predicted interest in continuing with group counseling, when controlling for the other variables: self-stigma for seeking help and session depth. The results indicated that for each unit increase in self-stigma (odds ratio = 0.95, $\beta = -.05$, $SE = .02$, $p = .047$), a client is .95 times more likely to indicate interest (that is, the client is 5% less likely to be interested in continuing with counseling). For context, the standard deviation for the SSOSH in this sample was 7.4. Thus, for a decrease in one standard deviation of self-stigma, a client would be approximately 37% ($7.4 \times 5\%$) more likely to be interested in continuing with counseling. Also, for a one-unit increase in session depth (odds ratio = 1.14, $\beta = .13$, $SE = .04$, $p = .001$), clients are 1.14 times more likely to have interest in continuing. Again for context, for a one- SD change in session depth ($SD = 5.4$), a client would be approximately 76% ($5.4 \times 14\%$) more likely to be interested in continuing with counseling.

Discussion

The present study has explored the predictors of self-stigma for seeking help, intentions to seek help, and interest in continuing group counseling following a session of group counseling. Results indicate that participants reported a significant decrease in self-stigma for seeking help following an initial session of group counseling. Greater change in self-stigma was associated with greater perceptions of working alliance–bond and session depth. Intentions to seek help following the session were associated with being female, having perceptions of greater working alliance–bond and session depth, more psychological problems, and lower self-stigma. Finally, the desire to continue with group counseling was associated with lower self-stigma and greater session depth.

Self-Stigma During Therapy

Self-stigma for seeking psychological help is a central variable in the help-seeking process (Vogel, Wester, Larson, & Wade, 2006). It has been implicated as an important variable for predicting attitudes about professional counseling and intentions to seek help (Vogel, Wade, & Haake, 2006). Self-stigma has been found to be a more proximal variable to help-seeking intentions than public stigma. In fact, it completely mediates the relationship between public stigma and intentions for individual and group counseling in U.S. populations (Vogel et al., 2007, 2010). Thus, self-stigma is an important variable in understanding who is likely to have better attitudes toward professional counseling and to have greater intentions to seek help. The present findings, therefore, make an important contribution to this literature by directly examining the degree of self-stigma for seeking help both before and after a group counseling session. One session of counseling is related to a reduction in self-stigma. Perhaps when people actually attend a counseling session, they can see for themselves that there is not much to be feared, that their self-worth is not likely to be challenged, and that they might actually feel better about themselves afterward, rather than worse.

In addition to this, the present study has identified two counseling processes that are related to the reduction in self-stigma for seeking help: greater perceptions of working alliance–bond and session depth. The former is not surprising as there is a host of evidence that points to the curative powers of the working alliance

(Horvath & Symonds, 1991; Wampold, 2001). When a strong working alliance is built between a counselor and client, hope is engendered, a trusting foundation for psychotherapeutic work is built, and many psychological symptoms dissipate. It may be that clients would also feel less self-stigma for seeking help when the working alliance is greater.

The relationship between the decrease in self-stigma and session depth may be less obvious. However, counseling sessions that are perceived to have greater depth tend to be rated by clients as more positive, more helpful, and leading to a greater understanding of themselves and their problems (Stiles et al., 1994). Perhaps the deeper a session is, the more meaningful it is and the more the client is likely to see it as a positive resource rather than something threatening that might damage his or her self-concept. Thus, session depth might lead to more positive outcome expectations about counseling. Instead of believing that counseling will result in negative outcomes (e.g., embarrassment about sharing one's problems), more positive outcomes are realized (e.g., feeling better after sharing). Therefore, the perception of a deeper session may contribute to a decrease in self-stigma for seeking help by showing clients that counseling can be generally positive and helpful and can lead to greater insight into themselves and their concerns. As a result, clients may come to see that counseling and help seeking will not have a negative effect on their self-confidence or self-esteem and that counseling may actually be quite helpful.

Alternatively, clients with greater self-stigma for seeking help may experience a form of cognitive dissonance following a positive counseling experience. The thoughts and beliefs that counseling will lead to diminished self-regard may come to odds with more positive thoughts about counseling that might emerge after deeper counseling sessions. This dissonance might be resolved in some clients by reducing self-stigma. However, the present study has not examined any of these specific pathways by which session depth is associated with the reduction in self-stigma. The mechanisms we suggest above might provide some useful directions for future research on the processes related to the reduction in self-stigma for seeking help.

Intentions to Seek Help and Desires to Continue Group Counseling

Because participants were not actively engaged in counseling but were instead volunteers for a single session of counseling, following the session they also completed measures assessing their intentions to seek help and their interest in continuing with group counseling. Similar to some prior research, intentions to seek help were related to being female (Mo & Mak, 2009) and to having lower self-stigma for seeking help (Vogel, Wade, & Haake, 2006). However, intentions to seek help were also related to perceptions of the working alliance–bond. Similar to the results for change in self-stigma, greater working alliance–bond may help participants to feel more positively about counseling and therefore to have greater intentions to seek help for psychological problems. Because intentions were only measured postsession, however, the correlations among these measures might be accounted for by various explanations, including that those who have greater intentions to seek help will look more favorably upon a counseling session and therefore perceive a greater bond.

Like intentions to seek help, the desire to continue with group counseling was related to lower self-stigma for seeking help and greater session depth, but not working alliance–bond. Here again is evidence of the usefulness and importance of self-stigma (as well as the depth of the session). Those with lower self-stigma for seeking help are more likely to express the desire to continue with group counseling as well as have intentions to seek help when they have a problem. Although these variables are not direct behaviors, they are strong predictors of behavior (Ajzen, & Fishbein, 1980). Therefore, it is reasonable to expect that those with lower self-stigma may be more likely to get the help that they need when struggling with a psychological or relationship problem and be more likely to continue with group counseling after they have started.

Likewise, those who experience counseling sessions as deeper are also more likely to continue. This is important information, as a considerable portion of university counseling center clients drop out early in counseling. For example, in two recent studies of clients presenting to university counseling centers, 18% dropped out after the first session (Reese, Norsworthy, & Rowlands, 2009), and 36% dropped out prior to the third session (Marmarosh et al., 2009). Determining the factors that keep clients interested enough in counseling to continue to receive the help that they need is important. The present results suggest that both self-stigma for seeking help and session depth may be important factors for researchers and clinicians to further consider.

Group Climate

So far, we have discussed these results in terms of counseling in general because the variables that emerged as significant predictors (e.g., working alliance–bond, session depth) are those that are more general in nature and may apply equally to both individual and group counseling (and potentially to other modalities, such as couples or family therapy). However, the research was conducted specifically in the context of group counseling, and as such, the results apply most directly to a single session of group counseling. What is intriguing about these results is that group climate–engagement was not a significant predictor of the change in self-stigma for seeking help, intentions to seek help, or the desire to continue with group counseling. Apparently, this was not just a result of multicollinearity with other predictors. The correlation table shows that group climate–engagement was not significantly related to any of the criterion variables except for the desire to continue with group counseling, and that was a small correlation ($r = .18$; see Table 1).

This result is curious for a construct that has been widely implicated as an important predictor of group counseling outcomes (e.g., Crowe & Grenyer, 2008; Kivlighan & Tarrant, 2001; Ogrodniczuk & Piper, 2003). Why was group climate–engagement not a more important predictor of self-stigma, intentions, or the desire to continue? One possible explanation for these results is that in one session of group counseling, an adequately stable group climate does not have the time to develop. Although researchers have found that early assessments of group climate do predict outcomes, these have been assessed later, such as after four sessions (Ogrodniczuk & Piper, 2003) or six sessions (Crowe & Grenyer, 2008), not after the first. It is reasonable to hypothesize that given more time for a stable group climate to develop, group climate–

engagement would be a more important predictor of changes in self-stigma, intentions, and desires to continue with group. This may be an important area for future research.

Counselor Self-Disclosure

Counselor self-disclosure did not have a detectable effect on the outcome variables. There are several possible explanations for this result. First, it may be that counselor disclosures early in group may not have any real impact on group members' self-stigma for seeking help, intentions to seek help, or desire to continue with group counseling. Alternatively, counselor self-disclosure may have an effect on these outcomes, but other factors of the group situation may have overwhelmed the disclosures made by the counselors. In addition to the variables tested in this study, these might be disclosures made by peers, connections felt to other members, or interventions offered by the counselor that do not include self-disclosure, such as facilitating here-and-now processing or connecting members with each other. In this explanation, the effect of self-disclosure may be real, but small.

Thus, we examined the study's power to detect a difference between the self-disclosure conditions. First, the ICC associated with self-stigma as the outcome was considerably higher than we had anticipated ($ICC = .51$). Therefore, the study was underpowered to find small or even medium effects in self-disclosure. For example, given this ICC and the number of participants and groups in the current sample, the mean difference effect size of self-disclosure on self-stigma over time would have to be nearly .70 (approaching a large effect). Another way to view it would be that given an ICC of .51, a medium effect size of .50, and six people per group, the study would need 77 total groups (for a total of 462 people) to reach a power level of .80. The numbers for reaching adequate power to detect a small effect would be much greater. In essence, the question of whether self-disclosure impacts self-stigma for seeking help, intentions to seek help, or interest in continuing with group counseling cannot be answered with the present data unless the self-disclosure effect is quite substantial.

Implications for Counseling

The results of this study have several implications for counseling. First, working alliance–bond predicted greater reduction in self-stigma for seeking help. Many counselors already concentrate on forming a positive working alliance with clients, and so, the reduction in self-stigma associated with working alliance–bond would be an added benefit. Group therapists, in particular, may want to focus on establishing a strong positive bond with clients in early sessions before group climate has time to develop. Group counselors who meet individually with clients for an orientation to group counseling might find this an opportune time to consciously attend to the bond.

A second counseling implication relates to the finding that session depth predicts greater reduction in self-stigma. This means that group counselors could potentially help lower clients' self-stigma by working to make a session deeper. Session depth can be fostered by encouraging clients to share at a deeper level than they would in their typical daily interactions. Also, the utilization of here-and-now interventions to help group members go beyond the sharing of there-and-then content and process group dynamics and

interpersonal patterns will likely add to the depth of a session. It is worth noting that although session depth was predictive of self-stigma, session smoothness was not significantly predictive. In other words, it may be more important for a client to feel that a session had depth, even if the depth includes conflict, than it is for the client to believe that a session went smoothly.

A third counseling implication relates to the finding that self-stigma predicted both intentions to seek help for personal problems and willingness to continue group counseling after an initial session. This finding suggests that self-stigma for seeking help may persist after treatment has begun. Research on stigma has primarily focused on pretherapy stigma, with an assumption that once a person seeks help, stigma is no longer a meaningful factor. However, the results of the current study suggest that self-stigma may be related to who continues with therapy after the first session. Perhaps self-stigma not only keeps psychologically distressed people from seeking help but may also hinder them from returning to therapy after they have begun. To the degree to which this is true, counselors may want to work to reduce stigma as therapy progresses. This could be done in a screening or first session in several ways, for example, by explicitly asking clients how they feel about their decision to enter counseling and affirming the strength required to seek help.

Limitations

One potential limitation of the present study is the use of participants who, although meeting the clinical cutoffs on a screening measure, were not truly seeking counseling. Those who attend a counseling group are likely more invested than those in our study, who participated primarily for research credits. Therefore, different forces might be at work for those who have experienced a significant problem, sought out a counselor, attended an intake session, and then enrolled in a counseling group. The present sample may not fit other populations as well, such as community mental health clinics, private practices with clients of various ages, or groups with greater ethnic or racial diversity. For example, it has been suggested that both public and self-stigma may have different roles in the help-seeking process depending on certain cultural factors (see Shechtman et al., 2009). Examining stigma across cultures with different orientations (i.e., individualistic vs. collectivistic orientations) is therefore an important future direction. Similarly, certain ethnic and racial minority groups tend to avoid traditional psychological help, possibly due to concerns about stigma (see Leong, Wagner, & Tata, 1995). In these cases, there might be other factors that have a greater influence on self-stigma, intentions, and the desire to continue with counseling after an initial session. Future research is needed to determine whether the results of the present study would apply in different settings.

On the other hand, our sample might be fairly similar to undergraduate students who are encouraged (by friends, family, or professors) to seek help at a university counseling center, might have less internal motivation for counseling, and might have greater stigma about seeking help. As group counseling is often an important part of counseling center services, many of these clients might be referred directly to group or to both group and individual counseling. The predictors of reduced self-stigma, intentions, and

who is likely to return to continue with counseling in this study are likely to fit this population.

Another important limitation to the present study is the lack of a no-treatment condition. Without a no-treatment condition, it is impossible to definitely determine whether the changes in self-stigma over time were a result of the group session or a general trend over time. The no-treatment group was not included because many of the predictor variables were dependent upon first attending a counseling group (e.g., working alliance—bond, group climate). In addition, past research has indicated that self-stigma is relatively stable with little or no intervention. For example, in a college student sample, the correlation between repeated measurements of self-stigma over 2 months was .72 (Vogel, Wade, & Haake, 2006). Furthermore, in a study of a video intervention designed to improve perceptions of seeking psychological help, college students' ratings of self-stigma did not change, despite significant changes in attitudes toward counseling and perceptions that counseling is a normative behavior for their peer group (Kaplan, Vogel, Gentile, & Wade, 2010).

Another limitation is that although an experimental design was employed, some aspects of the data analyses were not based on the experimental design and were essentially correlational, although longitudinal, in nature. For example, the relationships between the change in self-stigma for seeking help and working alliance—bond and session depth are correlational. The design of measuring self-stigma following the group session after the working alliance—bond was built and session depth experienced (and therefore after they were likely to have their effect) allows for some indication that bond and depth might be changing self-stigma. However, alternative possibilities cannot be ruled out. Further research is needed to explore these relationships, and different methods should be used to corroborate the present findings.

Finally, the data are limited to two time points without the benefit of a longer term follow-up. As a result, it is unknown whether the findings are temporally stable, lasting over the course of weeks or months, or whether the reduction in self-stigma for seeking help observed in the study was only temporary. Future research should be conducted to address this issue to determine the stability of the changes over time.

Conclusion

Self-stigma for seeking help is an important part of the help-seeking process. Understanding what predicts changes in self-stigma may help to guide intervention efforts for both those contemplating seeking help and those already in counseling. The results of the present study suggest that, of the numerous session variables considered, perceptions of session depth and the working alliance—bond are most strongly related to a reduction in self-stigma. Given the proximal role self-stigma plays in increasing one's intent to seek counseling and the mediating role it plays between public stigma and intentions to seek help, these findings are of special value to practitioners who wish to increase treatment adherence and decrease dropout rates through targeted measures.

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