Self-Stigma, Anticipated Stigma, and Help-Seeking Communication in People with Mental Illness

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According to the World Health Organization (WHO 2010), mental disorders are among the leading causes of ill-health and disability worldwide, affecting over 450 million people. Although treatments are available, large numbers of people with mental illness (PWMI) remain undiagnosed and are without adequate support (Andrews, Issakidis & Carter 2001). Undiagnosed or undertreated mental illness can have dire consequences, including suicide (WHO 2012). One key reason for PWMI avoiding diagnosis or treatment is the stigma associated with mental illness. The US Surgeon General's report on mental health has noted how stigma hinders PWMI from acknowledging their illness, seeking help, and disclosing to others (Satcher 2000).

There are various theories about the origins of mental illness stigma (Corrigan, Watson & Ottati 2003). On the one hand, critical psychology questions whether mental illness conceptualisation, labelling and treatment causes stigma in the first place; that is, any system of psychology itself could be a source of oppression (Parker 1999). On the other hand, it is also true that individuals often feel better when they have an explanation for their distress, and a biomedical diagnostic label may decrease the stigma by miminising blaming the individual as weak or sinful (Schreiber & Hartrick 2002). Regardless of the complexities surrounding how labelling could give rise to stigma, the fact remains that mental illness stigma exists in many societies across the globe. That stigma causes PWMI to be discriminated against when renting homes, applying for jobs, using health services or encountering police officers (Overton & Medina 2008; Corrigan *et al.* 2003).

Stigma also inhibits PWMIs from seeking help because people want to avoid being labelled as mental patients (Cooper *et al.* 2003). As proposed in the modified labeling theory (Link *et al.* 1989), this avoidance stems from fear of rejection that arises through psychosocial processes. Modified labelling theory states that socialisation leads individuals to develop beliefs about how most people treat mental illness. If a person believes that others will reject a PWMI and think of them as less competent or trustworthy, there will be fear of rejection should that person experience symptoms of mental illness (Link & Phelan 2001). Thus the PWMI might choose to keep their condition a secret or to withdraw from social contacts. Given this potential pathway for stigma to inhibit PWMIs seeking help, it is worthwhile to interrogate what constitutes mental illness stigma. One in five Australian adults experience a mental illness in any given year, yet only 35 percent of people with symptoms of mental health problems seek help (Australian Bureau of Statistics 2007). This scenario is complicated by cultural and linguistic backgrounds that generate diverse conceptualisations of mental illness (Jacobsson 2002), and thus diverse approaches by PWMIs in seeking treatment. For example, if an individual with mental distress has experienced discrimination due to their cultural background, such individuals may experience profound mental illness stigma.

Previous work has been done to determine the effect that different types of stigma have on help-seeking decisions (Barney *et al.* 2006; Vogel *et al.* 2006), but the focus of this paper will be on anticipated stigma versus self-stigma. In contrast to public stigma, which refers to discriminatory beliefs held by general society towards PWMI (Corrigan & Watson 2002), anticipated stigma and self-stigma are facets of personal stigma experienced by PWMI. Anticipated or expected stigma is the belief of PWMI that others would think of them as having negative attributes (Cechnicki *et al.* 2011; Chaudoir *et al.* 2013). The prevalence of such stigma can be linked to judgment errors about the representativeness of media portrayals (Kahneman & Tversky 1972) where people tend to mistakenly believe that PWMI with negative attributes are more common than in reality due to what they are told by media sources. These mistaken attributes, which are often persistent, include being dangerous (Corrigan *et al.* 2002) and incompetent (Dickerson *et al.* 2002). Self-stigma arises when PWMI internalise the negative stereotypes and prejudices associated with having mental health conditions, labelling themselves as socially unacceptable (Ben-Zeev *et al.* 2010; Rose & Thornicroft 2010).

Indeed, one study in Europe involving 1,229 participants with psychotic disorders from fourteen countries found that almost half of the participants reported moderate or high levels of self-stigma (Brohan *et al.* 2010).

Both forms of personal stigma have been shown to reduce willingness of PWMI to seek help and it is conceivable that they mutually reinforce each other. Bos *et al.* (2013), for example, combine both concepts together and refers to it as self-stigma. However, some researchers have attempted to isolate these two inter-related concepts because the subtle differences between them could be important for unlocking how stigma impacts help seeking by PWMI. For example, when Schomerus, Matschinger and Angermeyer (2009) used different instruments to measure anticipated stigma and self-stigma, they found that self-stigma was more of an obstacle to help seeking. Other research showed that it is anticipated stigma that fuels self-stigma, which then influences willingness to seek counselling (Vogel *et al.* 2007). This study frames the question of how different stigma types affect willingness to communicate for help. We propose the term help-seeking communication to refer to self-disclosure by individuals about their psychological distress to another party who can respond personally. Understanding how personal stigma inhibits communication for help is necessary to help PWMI fight the effects of stigma and communicate for help despite the inhibition they feel.

This communication focus arises from the apparent paucity of research focusing on the link between help-seeking communication and personal stigma in PWMI (Hinshaw 2004). In Goffman's (1963) seminal work on stigma, he argued that stigmatised persons would respond by limiting contact or passing off as an unstigmatised individual. Such responses necessarily involve communication choices by PWMI—that is, they limit communication with others or choose not to disclose about their psychological struggles—so it is important to explore the link between stigma and help- seeking communication. This study fills a gap in existing literature that primarily focuses on communication to PWMI, for example, communication of stigma (Meisenbach 2010) or communication to improve clinical outcomes (Patel & Sinclair 2008), instead of communication by PWMI.

This study attempts to shed light on the link between the two kinds of personal stigma and help-seeking communication. To counter stigma's influence on help-seeking communication effectively it is vital to know which type of stigma is at a higher level in

PWMI, how each type of stigma correlates to willingness to communicate for help and also which stigma type is more correlated with reduced help-seeking communication. We aimed, first, to measure the difference in levels of self-stigma (what I think of me) versus anticipated stigma (what I think others think of me) in PWMI. We hypothesised that PWMI would report different levels of these two aspects of personal stigma. Second, we wanted to determine the nature and strength of the correlation between willingness to communicate and anticipated and self-stigma. Establishing which type of stigma has stronger correlation to help-seeking communication could inform more effective anti-stigma interventions.

We used the grounded theory approach in this study, defined as follows:

> A grounded theory is one that is inductively derived from the study of the phenomenon it represents … Therefore, data collection, analysis and theory stand in reciprocal relationship with each other. One does not begin with a theory then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge. (Strauss & Corbin 1990: 23)

The methods section will elaborate on how this approach, usually used in qualitative studies, guided the development of this study's quantitative survey instrument. A new survey was needed because previous scales such as the anticipated discrimination when seeing a psychiatrist (ADSP; Schomerus *et al.* 2009) or the Self-Stigma of Seeking Help (SSOSH; Vogel *et al.* 2006) were too focused on seeking psychological help. This study aims to look at help-seeking communication in a broader sense, including disclosure to laypersons because such communication can improve societal attitudes (Price 2009), which can benefit PWMI.

Methods

Setting and sample

The study was conducted in Brisbane, Australia, between March and May 2011. At the time of the study, all participants had lived in Australia for at least one year over the previous five years. Recruitment occurred through email referrals and social networking platforms to disseminate the online survey link. Several mental health organisations helped to distribute the survey and posters were put up in community spaces such as libraries, shopping centres, pharmacies and primary care clinics. Ethical clearance was obtained from the first author's university. The survey was anonymous to maintain confidentiality of participants. More than half of the stigma items were phrased in the form of affirming statements.

Design

Potential participants were given a URL link to the survey. The first question enquired about the respondent's mental condition, ensuring that only those who had experienced mental illness were surveyed (if currently undiagnosed, they were asked to self-diagnose based on their symptoms). Hard copies of the survey (along with pre-paid envelopes) were distributed to those without Internet access. Participants who volunteered for the follow-up interviews provided their contact details. Interviews took place at a venue and time of the participant's choice.

Measuring stigma perception

Respondents were asked to what extent they agreed with two lists of twelve five-point Likert scale statements (1 = strongly disagree; 5 = strongly agree). The first list contained statements reflecting self-stigma and the second list the corresponding statements for anticipated stigma. Using the grounded theory approach, statements were generated from literature that reflected stigmatising beliefs about PWMI. Obviously the list cannot be exhaustive, but a selection of the more common beliefs was made; for example, as mentioned earlier, the view that PWMI are dangerous (Corrigan *et al.* 2002). A sample of a statement on the self-stigma list was 'I believe that having a mental health condition means that I may be a danger to myself/others.' The corresponding statement on the anticipated stigma list was 'I think if others knew about my mental health condition, they would think that I might be a danger to myself/others.'

Measuring willingness to communicate for help

Participants were asked to what extent they agreed with statements regarding willingness to talk about their psychological issues to counsellors, medical professionals, family members, non-kin close friends, and strangers in a self-help group (1 = strongly disagree; 5 = strongly agree). They were also asked if they had already spoken to these various help sources.

Statistical analysis

The ratings on the twelve items for self-stigma were combined into one scale by aggregating the scores (negatively worded items were reverse coded) and calculating a mean score. The same procedure was followed for computing the twelve-item scale for anticipated stigma and the five-item scale for willingness to communicate for help. Using SPSS 19, Cronbach's alphas were calculated for all three scales (0.74 self-stigma;

0.76 anticipated stigma; 0.80 willingness to communicate). A paired-samples t-test was used to determine if the means for the self-stigma ratings differed from the means of the anticipated-stigma ratings. This was done with the combined self- and anticipated stigma scales, as well as the individual stigma items. For correlation between willingness to communicate and stigma, Pearson's *r* was calculated for the participants when combined in a group and when they were split into two groups, Caucasian (generally those from more Western cultures) and non-Caucasian.

Supplementary interviews

Participants who were willing to participate in follow-up interviews gave their contact details in the survey. Face-to-face interviews, either in person or over Internet video chat, of participants were conducted a few weeks after the survey to obtain a deeper understanding of how stigma affects help-seeking communication. Interviewees were asked to elaborate on their stigma perception responses, for example, if they had answered strongly agree on the statement 'I believe that having a mental health condition means that I may be a danger to myself/others,' they would be asked why. They were also asked to describe their experiences with mental illness stigma and how it hindered help-seeking communication. The interviews were recorded with interviewee permission. Mean duration of interviews was approximately 30 minutes (the shortest went for 21.5 minutes while the longest was 43.5 minutes).

Results

Seventy-two participants (72 percent female) completed the survey. Participants had experienced a range of mental illness including depression, bipolar, anxiety and schizophrenia. Respondents between the ages of 25 and 34 comprised 38 percent of the sample, followed by those aged 35 and above (35 percent). The majority of the sample was Caucasians (61 percent), followed by Asians (32 percent). There were 26 participants who agreed to be interviewed but not all were available within the time frame of the study. Seventeen interviewees were chosen to represent as much diversity as possible in terms of the gender, age, culture and mental health characteristics of the respondents. This helped give the broadest picture possible about how personal stigma affects help-seeking communication. The rest of this section will present the findings in relation to the research questions. We will present the quantitative results from the survey, and to assist with explanations of these results we will supplement each finding

with quotes from the qualitative interviews. The quotes are not meant for deeper analysis, but are clear stand-alone exemplars of what participants said.

Attribute	Self-stigma M (SD)	Rank by self-stigma mean rating	Anticipated stigma M (SD)	Rank by anticipated stigma mean rating	t	p-value
Different due to illness	3.21 (1.29)	1	3.25 (1.22)	4	-.24	.81
Unpredictable	3.19 (1.26)	2	3.19 (1.22)	5	0.00	1.00
Untreatable	2.90 (1.19)	3	2.68 (1.12)	10	1.27	.21
Incompetent	2.81 (1.29)	4	3.35 (1.14)	1	-3.30**	.00
Dangerous	2.67 (1.31)	5	3.10 (1.25)	6	-3.02**	.00
Needy	2.67 (1.21)	6	3.00 (0.95)	8	-2.49*	.02
Unreliable	2.49 (1.23)	7	3.29 (1.16)	2	-4.99**	.00
Cannot live normally	2.32 (1.23)	8	2.69 (1.10)	9	-2.60*	.01
Lacks willpower	2.25 (1.25)	9	3.26 (1.18)	3	-5.94**	.00
Uses illness as excuse for failure	2.22 (1.11)	10	3.08 (1.14)	7	-4.83**	.00
Less able to contribute to society	1.64 (0.81)	11	2.64 (1.18)	11	-6.76**	.00
Needs to be treated as a child	1.56 (0.89)	12	2.07 (0.97)	12	-3.83**	.00
Combined scale	2.49 (0.61)		2.97 (0.60)		-6.24**	.00

Table 1. Mean ratings of stigma items (N = 72).
*$p < .05$. **$p < .01$

Difference in levels of self-stigma versus anticipated stigma

Table 1 (above) shows mean ratings of individual attributes in the two stigma scales as well as their ranks according to the mean ratings. All mean ratings above 3 indicate agreement with the stigma statement (with the highest possible score being 5). Table 1 also shows results of paired samples t-tests comparing ratings for individual stigma attributes and the two stigma scales. Significant differences between self-stigma and anticipated stigma ratings were found for 9 out of 12 attributes, five had anticipated stigma ratings above 3. The mean score for the anticipated stigma scale was significantly higher than that for the self-stigma scale, which means respondents believed that others viewed them more negatively than they viewed themselves.

An exemplar anecdote of anticipated stigma from participant #52 showed how a general practitioner (GP) clearly viewed her negatively for having depression:

> The GP told me, "You're a public servant, you've got nothing to complain about, you've got it easy. I work 50 hours a week, get over it." I walked out of his office bawling my eyes out. Most people believe it's in my head and the attitude is: "Snap out of it." It's the people who don't suffer depression who have that reaction. You tell them you're having a down day, they automatically think, "What's wrong?" They are looking for something specific but depression is not always triggered by an event. (#52, female, early 40s)

Nature and strength of correlation between stigma and willingness to communicate for help

Overall, self-stigma had a stronger negative correlation with willingness to seek help (r = -.15, p = .22) compared to anticipated stigma (r = -.01, p = .90) but both correlations were not significant at alpha level of .05. A typical example of how self-stigma plays a part in hindering help-seeking communication can be seen in the experience of participant #14. She first went through mental health services when she was caught self-harming at age 14 but suppressed the fact that she was hearing voices for over a year due to self-stigma. She said: "I felt like I was a freak and I was really scared how that would play out. It took me a long time to talk about it because to me that [hearing voices] was the stuff that made me really crazy" (#14, female, mid-20s).

A significant correlation was found between self-stigma and help-seeking communication among the Caucasian participants (see Table 2). One Caucasian respondent said that Western culture can give rise to high levels of stigma:

A lot of it [stigma] was coming from outside, because [mental illness] it's not spoken about and it's not something that's generally easily accessible – info about "oh actually this many people hear voices". Particularly in Western culture it's always voices that are portrayed [when] you're crazy or whatever. I think a lot of it came from outside. Specific things as well, my brother used to call me a freak, no real reason just a sibling thing but I think I internalised that and applied it to my own experience even though he didn't know what was going on. It kinda amplified everything in my head. (#14, female, mid-20s)

Stigma type	Correlation with willingness to communicate	*p*-value
Caucasians (*n* = 44)		
Self	-.36*	.02
Anticipated	-.16	.31
Non-Caucasians (*n* = 28)		
Self	.00	.99
Anticipated	-.04	.83

Table 2. Correlations between stigma and help-seeking
communication for Caucasians and Non-Caucasians
* *p* < .05

There were no significant correlations for the non-Caucasian group. However, the following exemplar quote from an Asian participant highlights the effect of stigma on help-seeking communication.

Initially I was quite willing to talk to my parents but at first they didn't want to accept it – that their girl is having depression. [Due to their] Asian upbringing – they felt there is no such thing as depression you are just being dramatic, over the top…. They said negative things like, 'Your life is good enough already, there are people who are worse off than you. Why do you feel like this?' It's mostly because of lack of knowledge about what depression is, lack of exposure to the sickness in the people from Asian culture. (#34, female, late 20s)

As the non-Caucasian group was made up of several cultural groups, it reflected a variety of mental illness conceptualisations, stigma responses and communication. For example, participant #35, a male of Middle Eastern descent who had been diagnosed with depression and anxiety, was convinced that Australian indigenous cultures allow for the possibility that those with mental illness are people with more evolved sensitivities. Owing to his belief that mental illness is 'not an illness,' he was open to communicating about his experiences. He had encountered mental illness stigma but was not affected by it. He said:

Perhaps one day we will realise that [mental illness] it's an increased awareness, perhaps an additional sense. Perhaps it's part of the human evolution…I see these phenomena as enhanced abilities…enhanced access to a consciousness or whatever. The fact that I can't see something that somebody else sees, does that mean that person is crazy or that I'm blind? Because my experiences particularly with indigenous cultures have brought about awareness that there are entities amongst us that we can't witness but some can. (#35, male, late-20s)

We also found two individual stigma attitudes that had significant negative correlations with communication willingness, both in the combined group as well as amongst the Caucasian participants (see Table 3). Correlations approaching marginal significance of $p < .05$ are listed in Table 3 as well.

Attribute (self- or anticipated stigma)	Correlation with willingness to communicate	p-value
Lacks willpower (self-stigma)		
Combined	-.35**	.00
Caucasian	-.47**	.00
Lacks willpower (anticipated stigma)		
Caucasian	-.29	.06
Less able to contribute to society (self-stigma)		
Caucasian	-.33*	.03
Unpredictable (self-stigma)		
Combined	-.23	.05
Non-Caucasian	-.36	.06
Needs to be treated as a child (anticipated stigma)		
Caucasian	-.28	.07
Incompetent (self-stigma)		
Caucasian	-.28	.06
Incompetent (anticipated stigma)		
Caucasian	-.27	.08
Excuse for failure (anticipated stigma)		
Combined	.24	.05

Table 3. Correlations between stigma attributes and help-seeking communication in Caucasians and Non-Caucasians.
*$p < .05$. **$p < .01$

The stigma perceptions that PWMI are weak-willed and less able to contribute to society come through experiences such as the following:

> Particularly within small organisations, people with mental illness are sometimes seen as weaker than others. Possibly moving the person back to a lesser role or not giving them an opportunity to step up would be more of an example rather than anything that is specifically said. (#47, Caucasian male, mid-20s)

Preferred help source

The vast majority of respondents had spoken to at least one of the 5 help sources (only 5

out of the 72 respondents said they had not spoken to any). Based on the help sources that participants said they had spoken to, it appears that the most preferred choice for self-disclosure (81 percent) is someone close but not related, as Table 4 shows.

Help source	Percent of respondents who have spoken to help source
1. Close friend (unrelated)	81
2. Family member	72
3. Counsellor	69
4. Medical professional	68
5. Self-help group member	26

Table 4. Preference of help source among PWMI. (N = 72)

Participants said they prefer to share their mental health struggles with friends because they want to spare family members, who may blame themselves for the problem. Another scenario is where family members are also struggling, as was the experience of participant #58, who suffered depression when her maternal grandmother died, followed by her father, in the same year. She felt she could not speak about her emotions with her mother, as her mother already had to cope with the two profound losses. She said:

> I always found it very hard to share my emotions but I used to be able to do it until just
> after my grandma died, I was taking my grandma's death very hard, and my dad said that
> I had to calm down and get over it because my mum was very upset as it was her mother
> … So I chose not to say what I was feeling anymore from that point on and then he died
> at the end of that year and that sort of made it worse. (#58, female, early 20s)

Discussion

This paper examined the interplay between the two kinds of personal stigma in PWMI and their willingness to communicate for help. Our first aim was to examine the difference between levels of anticipated and self-stigma. The fact that there was a significant difference in the stigma levels supports the previous research that have indicated that anticipated and self-stigma can be defined as separate constructs. Our finding that respondents felt higher levels of anticipated stigma than self-stigma is consistent with previous research. Vogel and colleagues (2007) noted that to alter anticipated stigma requires society-wide change. Overall, the results can be considered encouraging as a mean of 2.97 out of 5 for anticipated stigma indicates that participants were neutral about the stigma that they expected from others. The findings from this

study suggest that we are moving towards reducing stigma. However, continued work is still needed to reduce anticipated stigma or build resilience against it because Sirey *et al.* (2001) has shown that such stigma increases medical non-adherence.

Our findings on which attributes generated the highest stigma ratings (Table 1) can be useful to develop more targeted anti-stigma initiatives and increase help-seeking in specific contexts. For example, the attribute of incompetence that had the highest anticipated stigma rating could be a factor when employed PWMI consider whether to use company resources such as mental illness screening. They could be reluctant because they anticipate that their employers will get to know about their issues and see them as less capable in handling their work. Workplace campaigns to increase use of Employee Assistance Program resources for mental health (Ceniceros 2011) could benefit from addressing this particular facet of anticipated stigma pertaining to competence. Incompetence was one of the five attributes where anticipated stigma was significantly higher than self-stigma (the others were dangerous, unreliable, lacks willpower and uses mental illness as excuse for failure). Taken together, this set of attributes would make PWMI highly undesirable as an employee—which could explain why many do not disclose about their mental health problems to their employers (Henderson *et al.* 2012). By highlighting possible attributes salient to workplace stigma, our findings also add to previous research showing how such stigma is an important predictor of job acquisition for PWMI (Corbière *et al.* 2011).

With respect to self-stigma, two attributes had mean ratings above 3: respondents felt they were different and unpredictable due to their illness. Although the mean ratings were only 3.19 and 3.21, indicating a low level of agreement with the stigma statement, it is important to keep these aspects of self-stigma in mind. Many researchers have shown the numerous negative effects of self-stigma on psychological well-being (Corrigan *et al.* 2009; Ritsher & Phelan 2004). In addition, negative effects such as diminished self-esteem and self-efficacy have been known to persist even after someone recovers from psychiatric symptoms (Link *et al.*, 1997). Self-stigma also has a particularly strong inhibitory effect on help seeking (Barney *et al.* 2006; Schomerus *et al.* 2009).

In line with Schomerus et al. (2009), we found that self-stigma was more closely correlated with decreased willingness for disclosure. This finding supports previous

studies like that conducted by Rüsch *et al.* (2009: 552) which concluded that greater self-stigma could be related to reduced willingness to communicate for help, 'possibly leading to decreased coping resources and thus to psychiatric hospitalisation as a last resort.' This calls for initiatives aimed at challenging self-stigma, such as the training and empowerment of mental health consumers by health educators (Speer *et al.* 2001). Furthermore, clinicians could be trained to recognise signs of self-stigma in their patients so that they can take steps to address the stigma and prevent it from being a barrier to help-seeking communication. As the experience of Participant #14 showed, self-stigma can prevent full disclosure of a patient's mental health problems, which could result in less effective treatment.

The effect of cultural differences can be seen in the differing correlations between stigma and help-seeking communication in the two groups (Table 2 and Table 3). Previous researchers have also found cultural differences in mental illness stigma (Rao *et al.* 2007). The literature seems divided on the issue regarding whether some cultures are more stigmatising towards mental illness. Some researchers have found that less Westernised societies are less stigmatising towards PWMI, whereas other studies have shown that there is greater stigma in such societies (Jacobsson 2002). Jacobsson further observed that differences in mental illness stigma (that is, stereotypes, prejudices and resulting discrimination) could be linked to cultural perceptions of mental disorders. Kleinman and Benson (2006) highlight the importance of health professionals being aware of their own culture and using culturally appropriate terms when relating to patients. The authors wrote about a Chinese exchange student in the United States who declined treatment because her American health-care providers used the terms anxiety disorder and depressive disorder. She only resumed treatment when clinicians used the terms neurasthenia or a stress-related condition as this was what she was familiar with in China.

In this study, most of the significant or near-significant correlations in this study involved Caucasians. As this is an exploratory study, more data collection is needed before we can tease out why certain stigma attributes had significant correlations with willingness to communicate. The size of the non-Caucasian group was not large enough to make any conclusive findings. The fact that diverse cultural groups (such as Asian, Islander, Middle Eastern) were combined could have also masked how this group was

different from the Caucasians. Perhaps the conceptualisation of mental illness, which has long been established to be culture-dependent (Kleinman & Good 1985), plays a part in moderating the effect of stigma on help-seeking communication. This possibility can be seen in the earlier quote from participant #35, who felt that his condition was not an illness and therefore was open to share his experiences despite having encountered mental illness stigma.

This study also highlighted the importance of extending support for non-kin contacts that are the preferred help source. It lends weight to campaigns to enhance society's overall capability to support those facing mental health issues, e.g. the Mental Health First Aid programme. These are as important as initiatives that focus on equipping family members of PWMI, for example Family Survival psycho-education workshops (Pollio *et al.* 2006). On the other hand, our participants were reluctant to disclose to members of self-help groups. This may mean that such groups will have to make a greater effort to reach out. More research should also be done to see what role stigma plays in attitudes toward group counselling (Vogel *et al.* 2010).

Limitations

One limitation of the study is its reliance on self-reporting instead of objective measures to determine participants' actual mental health conditions. However, it is a valid method of uncovering perceptions, which have more to do with inner realities than external evaluations. The second limitation is the use of non-probability snowball sampling. Although this method is suited for dealing with stigmatised individuals (Kaplan *et al.* 1987), the pool of respondents may not be representative of the larger population of PWMI. Therefore generalisation of findings from this study needs to be drawn with caution. Third, there is difficulty in separating self-stigma from anticipated stigma as they are closely interrelated. Future research can propose and test models of causation, moderation or mediation between the two concepts of personal stigma. Fourth, the selection of stigma perceptions in this study is arbitrary, without considering whether the order of questions could potentially have carry-over effects or any other effects. Finally, the timeframe for this study did not allow for the survey instrument to go through a full validation process. A validated instrument called the Internalized Stigma of Mental Illness questionnaire was recently rated positively for its psychometric properties (Stevelink *et al.* 2012) so such instruments could be used in future research.

Conclusions

This study aimed to determine the strength of correlation between the two types of personal stigma in PWMI and their willingness to communicate for help. Anticipated stigma was more prevalent among respondents than self-stigma, but the latter is more closely linked with decreased willingness for communication about mental health issues. While there are campaigns aimed at changing negative public perceptions about mental illness, more effort should be directed towards helping individuals cope with self-stigma, thereby enhancing help-seeking communication.

Examples of internal interventions have included advocacy: a study of mental health consumers by Wahl (1999) found that the most common strategy for dealing with stigma was to speak out against the discrimination that they experienced. Narrative therapy has also been used to change negative personal narratives to reduce self-stigma via empowerment of the individual (Kondrat & Teater 2009). The underlying conceptualisations of identity and narrative are relevant to mental illness stigma, especially self-stigma, for the following reason: 'Self-stigma is not merely a matter of inaccurate beliefs but also infects the stories one tells about oneself. To accept, for instance, that one is dangerous would seem necessarily to have an enormous range of consequences for how one might tell or not tell one's life narrative' (Yanos *et al.* 2011: 578). A direction for future research that this study suggests is in examining how disease conceptualisations of PWMI affect their therapeutic relationships with their doctors, as these can be either empowering or disempowering.

In addition, Watson and Larson (2006) proposed to empower mentally ill individuals by encouraging engagement in various social identities related to their abilities. Social group memberships and other 'domains of self-worth' could provide both protection from the negative consequences of stigma and yield opportunities to build social support (Watson & Larson 2006: 242). Authors of the first self-stigma study in Iran, upon finding high levels of stigma (despite Islamic teachings and a well-developed mental health service), said that improving how mentally ill people cope with stigma is an 'interesting and promising route' (Ghanean *et al.* 2011: 16).

Future research into the effect of gender, age, culture, type of diagnosis/mental illness and time from disease onset on self-stigma can yield further insights on how to decrease self-stigma and increase help-seeking communication. More studies with statistically

representative samples can also yield strategies to encourage help-seeking communication. This correlation study is only a first step towards improving communication among PWMI. Increased communication can bring about a more varied discourse on psychological distress, which is preferable to unproductive suppression, as a problem shared is a problem halved.

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