Attitudes Toward Professional Psychological Help Seeking in South Asian Students: Role of Stigma and Gender

Prerna G. Arora, Kristina Metz, and Cindy I. Carlson

This study examined (a) the roles of perceived and personal stigma on attitudes toward professional psychological help seeking and (b) the effects of these constructs across gender in South Asians. Personal stigma and being male was negatively associated with attitudes toward professional psychological help seeking; no difference in the association between personal and perceived stigma and attitudes across genders was found. These findings have implications for the engagement of South Asians in mental health services in the United States.

Keywords: South Asian, help seeking, mental health, stigma, gender

Este estudio examinó (a) los roles de estigmas percibidos y personales en las actitudes hacia la búsqueda de ayuda psicológica profesional y (b) los efectos de estos constructos en individuos sudasiáticos según su sexo. El estigma personal y la identidad masculina se asociaron negativamente con las actitudes hacia la búsqueda de ayuda psicológica profesional; no se halló diferencia en la asociación entre estigmas personales y percibidos y las actitudes de los distintos sexos. Estos hallazgos tienen implicaciones para la participación de los individuos sudasiáticos en los servicios de salud mental en Estados Unidos.

Palabras clave: sudasiático, búsqueda de ayuda, salud mental, estigma, sexo

Asian Americans represent the third largest and fastest growing racial group in the United States (Hoeffel, Rastogi, Kim, & Shahid, 2012). (Although the terminology used to discuss this population in previous literature varies, in this article, we use the terms South Asian and South Asian American to refer to individuals of South Asian origin. To use the most accurate classification of the sample, we also maintained the terminology of previous studies [e.g., if a cited study referred to its sample as Asian Americans, we used this descriptor].) Within the various Asian subgroups, South Asians, including those individuals who identify as Asian Indian, Bangladeshi, Pakistani, or Sri Lankan, comprise the third largest and fastest growing group, with more than 3.5 million individuals residing in the United States (Hoeffel et al., 2012). (This estimate includes individuals who identified as Asian Indian, Bangladeshi, Pakistani, or Sri Lankan and individuals who identified as a combination of two racial groups with at least one of them being Asian Indian, Bangladeshi,

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Pakistani, or Sri Lankan.) Studies have found that, like their other Asian counterparts, South Asians are at high risk for depression, self-injury, and suicide (Sen, 2004). Yet despite their population growth, the prevalence of mental health concerns, and the need for mental health services (Kearney, Draper, & Baron, 2005), South Asian individuals living in the United States hold negative attitudes toward professional psychological help seeking (V. Rao et al., 2011) and subsequently underuse mental health services (Eisenberg, Golberstein, & Gollust, 2007; U.S. Department of Health and Human Services, 2001).

The purpose of this study was to examine the degree to which certain culture-bound variables (e.g., stigma) that previous literature found to be associated with professional psychological help seeking among the Asian American population generalize to the subgroup of South Asians residing in the United States. The presence of South Asians in the majority of relevant studies have totaled a mere 2% to 11% of the sample (B. S. K. Kim & Omizo, 2003; Miville & Constantine, 2007; Ruzek, Nguyen & Herzog, 2011; Shea & Yeh, 2008; Zhang & Dixon, 2003). Thus, findings from broader Asian American populations have often been generalized to South Asian populations. This is of concern because it fails to account for distinctive aspects of the South Asian culture (Barreto & Segal, 2005; Bhattacharya & Schoppelrey, 2004), such as variations in patterns of acculturation, conceptualizations of mental illness, openness to mental health services (Farver, Narang, & Bhadha, 2002; D. Rao, 2006), and a particular focus on hierarchical family structure with a preference for attending to concerns within the family unit (Das & Kemp, 1997). Furthermore, this lack of understanding of cultural differences between Asian subpopulations may result in potential errors in diagnosis and difficulties engaging individuals in treatment (Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006). Thus, additional research focusing exclusively on South Asian populations, particularly with regard to professional psychological help seeking, is needed.

Therefore, in this study, we extended previous research on barriers to seeking mental health services by examining the role of several understudied variables on attitudes toward professional psychological help seeking in South Asian populations residing in the United States. In particular, we investigated the roles of perceived stigma by close others and personal stigma on attitudes toward professional psychological help seeking and examined the effects of these constructs across gender. Although a few studies have examined attitudes toward professional psychological help seeking in South Asian populations, and even fewer have examined the role of stigma, no studies, to our knowledge, have examined the potential moderating effect of gender on the impact of both perceived stigma by close others and personal stigma on attitudes toward professional psychological help seeking. Furthermore, the majority of studies on professional psychological help seeking in South Asian populations have included participants from populations outside the United States (e.g., Britain); although there are some global similarities in the cultural experiences of South Asians, several studies have pointed to the
unique experiences of South Asians in the United States, including experiences of immigration and racism (Finney & Simpson, 2009; Iceland, Mateos, & Sharp, 2011).

We acknowledge the heterogeneity that exists within cultural delineations even among an Asian subgroup; however, in the absence of the ability to study each person individually, the focus of this study is on the cultural similarities that exist within this subpopulation and the commonalities that may affect attitudes toward seeking mental health services. We first review existing research on attitudes toward professional psychological help seeking, stigma, and gender in this understudied group before elaborating on the current study.

attitudes toward professional psychological help seeking

Mental health models accounting for help-seeking behaviors consider the decision to seek help as the end result of a process heavily influenced by preexisting attitudinal beliefs about mental illness and its treatment. For example, the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) purports that an individual’s behavior can be predicted by his or her behavioral intention, which is influenced by the individual’s attitudes and beliefs toward the behavior (Ajzen & Fishbein, 1980). Previous research has supported this model, demonstrating that attitudes and beliefs toward professional psychological help seeking predict willingness to seek counseling (Vogel, Wade, & Hackler, 2007), even among Asian American samples (B. S. K. Kim & Omizo, 2003; P. Y. Kim & Park, 2009). Similarly, another frequently used model of help-seeking behavior (Pescosolido, 1992) describes psychological help seeking as the result of preexisting attitudes and beliefs about mental illness and mental health care. Research has also provided support for this model, as demonstrated by studies finding that positive attitudes toward professional psychological help seeking were associated with a 2.5-fold increase in both perceiving a need for mental health services and subsequently using such services (Eisenberg et al., 2007; Mojtabai, Olfson, & Mechanic, 2002). Thus, the use of attitudinal beliefs as a predictor of future behavior has been established in the literature (Kraus, 1995). Accordingly, many studies have used help-seeking attitudes as a predictive measure for an individual’s probability of seeking mental health services (P. Y. Kim & Park, 2009).

Help-seeking attitudes are thought to vary between groups, with cultural views regarding mental illness having an impact on these differences. In particular, culture is believed to play a role in the attitudes toward mental illness and mental health services (Eisenberg et al., 2007; Pescosolido, 1992). Traditional Asian cultural values, such as discomfort with self-disclosure outside the family, emotional restraint and self-control, and social conformity (Das & Kemp, 1997; Sue & Sue, 2008; Vogel, Wester, & Larson, 2007), may directly affect attitudes toward seeking
mental health services and may deter the individual from seeking mental health services. For example, many Asian individuals are taught to have self-control and to use restraint when experiencing potentially disruptive emotions (Kaneshige, 1973; Leong, 1992; Murakawa, 1986; Tinloy, 1978; Tung, 1985; Uba, 1994); therefore, a public display of emotional instability, including symptoms of mental illness, may be viewed as a poor reflection on the individual as well as on his or her family and/or community. Indeed, Asian Americans have been shown, with the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH; Fischer & Turner, 1970), to hold increasingly negative attitudes toward professional psychological help seeking compared with their Black and White counterparts (Atkinson, Morten, & Sue, 1998; Masuda et al., 2009), and stronger adherence to traditional Asian values has been linked to negative attitudes toward professional psychological help seeking, as assessed by the ATSPPH–Short Form (ATSPPH-SF; Fischer & Farina, 1995; B. S. K. Kim & Omizo, 2003).

South Asian cultures may have increasingly negative attitudes toward seeking mental health services. Specifically, in addition to placing importance on family honor and achievement (Bradby et al., 2007; Das & Kemp, 1997), South Asian cultures place an equally high value on marrying into an “honorable” family within their culture (Durvasula & Mylvaganam, 1994). Thus, displaying signs of emotional instability may not only bring shame and disgrace to oneself and one’s family but also decrease marriage prospects. However, because not much is known regarding attitudes toward professional psychological help seeking within this group, particularly within the United States, further exploration of this subgroup is needed.

stigma and attitudes toward professional psychological help-seeking behavior

The stigma of mental illness, which consists of the devaluing, disgracing, and disfavoring of individuals with mental illnesses (Abdullah & Brown, 2011), is one of the largest barriers to seeking help for mental health problems (Corrigan, 2004). Multiple, and often overlapping, definitions of the types of stigma have been applied. Nonetheless, some consensus about certain types of stigma and their relationships to attitudes toward professional psychological help seeking exist. Specifically, perceived (or public) stigma is the perception of societal discrimination or “that a person who seeks psychological treatment is undesirable or socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). Perceived stigma has been implicated as a key factor influencing the decision to seek mental health support (Corrigan, 2004; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Previous research
has shown that perceived stigma is negatively associated with help-seeking attitudes and behaviors (Barney, Griffiths, Jorm, & Christensen, 2006; Vogel, Wade, & Hackler, 2007). Moreover, data from the National Survey on Drug Use and Health found that approximately one third of individuals reported concerns about perceived or public stigma affecting their decisions to seek mental health treatment (Substance Abuse and Mental Health Services Administration, 2006).

Using measures such as the Perceived Devaluation-Discrimination Scale (Link, Cullen, James, & Wozniak, 1987) or the Stigma of Seeking Professional Psychological Help Scale (Komiya, Good, & Sherrod, 2000), researchers have, for the most part, measured perceived stigma as perceptions of the discrimination and stigma that individuals seeking mental health face from the broader community. Such scales assess beliefs about the general public’s perception of those seeking mental health treatment by asking broadly framed questions, such as “Most people would . . .” or “People will see . . .” (Komiya et al., 2000; Link et al., 1987). Some, however, have argued that individuals may face additional stigmatization from those in their more immediate community (i.e., people in their social network with whom they may more frequently interact), thus making mental health help seeking even less likely (Vogel, Wade, Wester, Larson, & Hackler, 2007). Thus, researchers have more recently developed measures that assess perceptions of mental health stigmatization by others in one’s social group or perceived stigma by close others, such as the Perceptions of Stigmatization by Others for Seeking Help Scale (PSOSH; Vogel, Wade, & Ascheman, 2009).

Personal stigma, or an individual’s stigmatizing views, is also believed to affect attitudes toward professional psychological help seeking (Cooper, Corrigan, & Watson, 2003; Penn et al., 2005). In a study examining the relative contributions of these types of stigma on attitudes toward professional psychological help seeking, personal, not perceived, stigma predicted subsequent attitudes in a large sample of German individuals (Schomerus, Matschinger, & Angermeyer, 2009). However, Calear, Griffiths, and Christensen (2011) and Eisenberg, Downs, Golberstein, and Zivin (2009) both reported higher levels of perceived stigma than personal stigma in college-age youth in the United States and Australia, respectively. Thus, some questions about the relative influences of both types of stigma continue to exist. Measures used to assess this construct, moreover, have ranged from modified versions of perceived stigma scales (e.g., changing “Most people think . . .” to “I think . . .”; Eisenberg et al., 2009) to disorder-specific scales such as the Depression Stigma Scale (Griffiths, Christensen, Jorm, Evans, & Groves, 2004) or the commonly used Social Distance Scale (SDS; Link et al., 1987), further contributing to this lack of clarity surrounding the role of personal stigma.

Stigma of mental illness has been found to vary across cultures (e.g., Abdullah & Brown, 2011; Anglin, Link, & Phelan, 2006; D. Rao, Feinglass, & Corrigan,
2007). In Asian populations, cultural beliefs, such as mental illness being a punishment from God (Fogel & Ford, 2005), the result of bad deeds in a previous life (Raguram, Raghu, Vounatsou, & Weiss, 2004), or indicative of “bad genes” (Chen, 2005), are thought to contribute to the stigmatization of mental illness. In part, because of these cultural beliefs, rates of stigmatization of mental illness have been found to be significantly higher in Asian populations than in White ones (Fogel & Ford, 2005). In fact, Constantine, Kindaichi, Okazaki, Gainor, and Baden (2005) found that Asian international college women viewed psychological treatment for mental health concerns as a last resort because of the stigma associated with mental instability. In addition, although both perceived and personal stigma have been found to be relevant for Asian populations, perceived stigma has been shown to be higher in this population (Eisenberg et al., 2009), a finding which has been explained by literature indicating that Asian populations are more likely than their peers to avoid deviating from social norms (Yang et al., 2007). Furthermore, although not always differentiating between types, stigma, particularly perceived stigma, has been linked to negative attitudes toward professional psychological help seeking in Asian American populations (Choi & Miller, 2014; Miville & Constantine, 2007; Shea & Yeh, 2008).

Although some research has been done examining the role of perceived and personal stigma on attitudes toward professional psychological help seeking in Asian populations, this area remains understudied in South Asians. Generally, stigma toward mental illness and mental health treatment has been endorsed as a significant concern in the South Asian community (Ng, 1997) and is believed to be a key impediment to the use of mental health services in this population (Bradby et al., 2007). In the only study—to our knowledge—on this subject, Loya, Reddy, and Hinshaw (2010) found that, unlike in broader Asian samples, South Asian students reported more personal stigma, but fewer perceived stigma, than their White counterparts. Furthermore, they found that only personal stigma had a significant effect on attitudes toward professional psychological help seeking in this population. It should be noted, however, that Loya et al. assessed perceived stigma as participants’ perceptions of the discrimination that individuals with mental illness face from the broader community using the Perceived Devaluation-Discrimination Scale (Link et al., 1987), described earlier, rather than the variable of perceived stigma by close others (Vogel et al., 2009), which may be particularly relevant for this subgroup (Das & Kemp, 1997; Loya et al., 2010). Their study highlighted that personal and perceived stigma by the broader community may function differently for South Asian populations than broader Asian populations because of unique cultural attributes within the South Asian culture. However, questions regarding the role of perceived stigma from members of one’s community (or stigma by close others; Vogel et al., 2009) on attitudes toward professional psychological help seeking in South Asian populations remain.
gender, stigma, and attitudes toward professional psychological help-seeking behavior

Previous research has demonstrated that women tend to be more receptive than men to seeking psychological treatment for mental health concerns (Garland & Zigler, 1994; Kelly & Achter, 1995). Similar relationships have been found in Asian women (Barry & Grilo, 2002; Shea & Yeh, 2008; Yoo, Goh, & Yoon, 2005), as well as within a South Asian sample in Britain (Soorkia, Shelgar, & Swami, 2011). This gender difference may be influenced by gender ideals within the South Asian culture, such as pressures for South Asian men to appear strong and in control (Bhui, Chandran, & Sathyamoorthy, 2002) and beliefs that South Asian women are more susceptible to shame and instability (Guzder & Krishna, 1991). Such traditional beliefs may be more likely to be salient in South Asians who immigrated to the United States because immigration patterns have tended to favor families with conservative attitudes toward gender (Kurien, 2001). Thus, gender appears to be related to attitudes toward professional psychological help seeking, although the research is limited, particularly with regard to South Asian populations residing in the United States.

Women have been shown to espouse less stigmatizing beliefs toward mental illness and mental health treatment than men (Vogel, Wade, & Hackler, 2007). This finding also holds true in Asian populations, with perceived stigma being negatively associated with intentions to seek counseling in Asian women (Miville & Constantine, 2007). Although hypothesized to also be the case in South Asian populations (Inman, Ladany, Constantine, & Morano, 2001), little research in this area has been done. In a sample of foreign-born Asian Indians, adherence to cultural values (a proxy for perceived stigma) was not found to differ between genders (Soorkia et al., 2011). To clarify such conflicting findings as well as elucidate the role of stigma in South Asian female populations, additional research examining the “moderating role of gender on the indirect effects of stigma on ethnic differences in help-seeking attitudes” (Loya et al., 2010, p. 486) is needed.

Current study

To our knowledge, no studies have examined the role of perceived stigma by members of one’s community or close others on attitudes toward professional psychological help seeking or differences in gender on attitudes toward professional psychological help-seeking behavior and stigma across gender in South Asian populations in the United States. Thus, the current study sought to evaluate the relationships between perceived stigma by members in one’s community or close others, personal stigma, and gender on attitudes toward professional psychological help seeking in South Asian students. The
current study also sought to explore whether gender moderated personal or perceived stigma’s relation to attitudes toward professional psychological help seeking. We hypothesized that, in line with previous research (Loya et al., 2010), higher levels of personal stigma would be associated with more negative attitudes toward professional psychological help seeking. Because we assessed perceived stigma by close others (rather than by the broader community), we further hypothesized that perceived stigma would be associated with more negative attitudes toward professional psychological help seeking in this population. In line with previous literature, we further hypothesized that being male would be associated with more negative attitudes toward professional psychological help seeking (Soorkia et al., 2011). Furthermore, in line with existing literature (Inman et al., 2001; Vogel, Wade, & Hackler, 2007), we hypothesized that the relationship between the two types of stigma and attitudes toward help-seeking behaviors would differ based on gender. Finally, because previous literature has demonstrated the potential impact of generational status on attitudes toward professional psychological help seeking (Gloria, Castellanos, Park, & Kim, 2008), we controlled for generational status.

Method

Participants

The sample consisted of 160 students enrolled at a large university located in the southern United States. All participants were at least 18 years of age and older, were proficient in the English language, and self-identified as being of South Asian origin. The majority of the participants were ages 18 to 22 years (90.6%), were undergraduate students (95.6%), and identified as second generation (i.e., they were born in the United States but one of the parents was born in Asia or a country other than the United States; 62.5%). Table 1 presents the complete demographic information.

Measures

Stigmatization. We used two instruments to assess perceptions of stigma. We used the PSOSH (Vogel et al., 2009), a five-item scale, to measure perceived stigma by close others. All items began with the following prompt:

Imagine you had a problem that needed to be treated by a mental health professional. If you sought mental health services, to what degree do you believe that the people you interact with would _____ (e.g., react negatively to you)?

Items are measured on a 5-point Likert-type scale ranging from 1 (not at all) to 5 (a great deal), with a higher score indicating a greater level of perceived stigma. The measure has shown good test–retest reliability ($\alpha = .82$; Vogel et al., 2009). Concurrent validity has been supported through moderate associations with two different stigma measures (a measure of public stigma toward counseling, $r = .31$, and a measure of self-stigma, $r = .37$; Vogel et al., 2009).
Previous research has found that the PSOSH has good internal consistency (total sample, \( \alpha = .89 \); Caucasian, \( \alpha = .90 \); African American, \( \alpha = .90 \); Latino/a, \( \alpha = .90 \); Asian American, \( \alpha = .88 \); Native American, \( \alpha = .89 \); multiracial American, \( \alpha = .86 \); and international student, \( \alpha = .83 \); Vogel et al., 2009). Internal consistency for the current sample was good (\( \alpha = .88 \)).

To assess personal stigma, we used the SDS (Link et al., 1987). This seven-item self-report questionnaire measures desire for social distance from individuals labeled as mentally ill. A sample item includes “How would you feel about having a person with a mental illness as a neighbor?” The measure is scored on a 4-point Likert-type scale ranging from 0 (definitely willing) to 3 (definitely unwilling). To determine a total score, responses are summed and divided by the number of questions, with a higher score indicating more personal stigma. Previous research has found that the SDS has good (\( \alpha = .86 \); Loya et al., 2010) to excellent (\( \alpha = .92 \); Link et al., 1987) internal consistency. Internal consistency for the current sample was acceptable (\( \alpha = .78 \)).

As described previously, both measures of stigma (i.e., perceived and personal) have been used in previous research to measure these constructs in Asian populations (Choi & Miller, 2014; Loya et al., 2010). These measures differ, with the perceived stigma measure being used to assess the perception of close others’ stigma toward the self if one chose to receive counseling and the personal stigma measure being used to examine stigma toward others with a mental illness.

**Attitudes toward professional psychological help seeking.** We used the ATSPPH-SF (Fischer & Farina, 1995), an abbreviation of ATSPPH (Fischer & Turner, 1970), to assess attitudes toward professional psychological help seeking. Although additional, more direct measures of help seeking exist (e.g., Willingness to See a Counselor measure; Gim, Atkinson, & Whiteley, 1990), we opted to use
this measure to capture participants’ views without limiting the reasons why they might seek professional psychological help from a psychologist, as well as to include participants regardless of whether they acknowledged having a mental health problem. The scale consists of 10 items. A sample item includes “If I believed I was having a mental breakdown, my first inclination would be to get professional attention.” Items are measured on a 4-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). To determine a total score, responses are summed and divided by the number of questions, with a higher score reflecting a more positive attitude toward seeking professional assistance. In previous research with South Asian populations, reliability was found to be good (α = .80; Kanukollu, 2010). Previous research has found adequate (α = .77; Elhai, Schweinle, & Anderson, 2008) to good (α = .84; Fischer & Farina, 1995) internal consistency. The internal consistency for the current sample was acceptable (α = .78).

Demographic information. We collected demographic information, including age, gender, educational level, generational status, and ethnicity, via self-report. We provided four age-range categories: 18–22 years, 23–27 years, 28–32 years, and 33 years and older. Gender was measured via self-report (0 = male, 1 = female). Students reported their educational level as undergraduate or graduate/professional student. Student generational status was queried and included options for first generation, second generation, third generation, and fourth or greater generation. Finally, ethnicity was queried as an open-ended question.

PROCEDURE

Participants were recruited through a university department participant pool. Inclusion criteria were being at least 18 years old and self-identifying as being of South Asian descent. After providing consent, enrolled participants completed an online survey. In addition, all participants provided an identification number, which allowed them to obtain course credit for their participation in the survey; to protect the identity of the individuals, researchers were unable to link participants’ numbers to their names. The university’s institutional review board approved all study procedures and consent forms.

results

The mean and standard deviation of the PSOSH for this sample (M = 9.34, SD = 4.09) were comparable with previous literature that found means ranging from 9.9 to 10.9 and standard deviations ranging from 3.7 to 4.5 (Vogel et al., 2009). The mean on the SDS for this sample (M = 2.56), however, was significantly higher than previous literature that found means ranging from 0.92 to 1.92 (Link et al., 1987; Loya et al. 2010). This indicates that study participants endorsed more personal stigma than other populations; however, the standard deviation (SD = 0.49) was comparable with other studies in which
the standard deviations ranged from 0.50 to 0.69 (Link et al., 1987; Loya et al. 2010). Finally, the mean and standard deviation for the ATSPPH-SF ($M = 2.53, SD = 0.44$) were comparable with previous literature that noted means ranging from 2.35 to 2.51 and standard deviations ranging from 0.53 to 0.63 (B. S. K. Kim & Omizo, 2003; Miller, Yang, Hui, Choi, & Lim, 2011).

We conducted hierarchical multiple regression analyses to examine the relationship between attitudes toward professional psychological help seeking and personal stigma, perceived stigma, and gender (see Table 2 for the bivariate correlation matrix). As noted earlier, because previous literature indicated the role of generational status on attitudes toward professional psychological help seeking (Gloria et al., 2008), we included this variable as a covariate. For purposes of the analyses, we categorized participants as either foreign born (i.e., first generation) or U.S. born (i.e., second and third generation). Although education and age have also been noted to be related to attitudes toward professional psychological help seeking (Pilkington, Msetfi, & Watson, 2011; Shea & Yeh, 2008), we opted to use generational status as the only covariate because there was little variability in educational level and age. Data were analyzed to detect multicollinearity among all independent variables in this study. Because the maximum correlation between predictor variables is very minimal, we excluded concerns about multicollinearity. Scatterplots and graphs showed no distinct outliers and normal distribution. An initial power analyses indicated that a regression analysis including six predictor variables would require a sample size of 92 participants to achieve a power of 0.80 with a medium effect size of 0.15 (Faul, Erdfelder, Lang, & Buchner, 2007).

We used a hierarchical multiple regression analysis to test our hypotheses regarding the relationship between perceived stigma by close others, personal stigma, and gender with attitudes toward professional psychological help seeking (see Table 3 for regression analyses data). Generational status was entered at Step 1 of the regression as a control variable. Perceived stigma by close others, personal stigma, and gender were entered at Step 2. The results of the regression indicated that the overall model was statistically significant.

### TABLE 2

Bivariate Correlations of the Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>—</td>
<td>-.51**</td>
<td>-.19*</td>
<td>.09</td>
<td>.04</td>
<td>-.06</td>
</tr>
<tr>
<td>2. Education level</td>
<td>—</td>
<td>.28**</td>
<td>-.04</td>
<td>-.03</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>3. Generational status</td>
<td>—</td>
<td>.00</td>
<td>-.06</td>
<td>-.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Personal stigma</td>
<td>—</td>
<td>.09</td>
<td>.25**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. PSCO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.12</td>
<td></td>
</tr>
<tr>
<td>6. ATPPHS</td>
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</tbody>
</table>

*Note. Total ranges for the scales were as follows: personal stigma, 0–3; perceived stigma by close others (PSCO), 5–25; attitudes toward professional psychological help seeking (ATPPHS), 10–40. *p < .05. **p < .001.*
and the variables explained 10% of the variance in attitudes toward professional psychological help seeking, \( R^2 = .10, F(4, 159) = 4.18, p = .003 \). At Step 1, generational status did not significantly contribute to the regression model, \( R^2 = .00, F(1, 159) = 0.16, p = .689 \), and accounted for 0% of the variance in attitudes toward professional psychological help seeking. When gender was added, perceived stigma by close others and personal stigma explained an additional 10% of the variance in attitudes toward professional psychological help seeking; this change in \( R^2 \) was significant, \( \Delta R^2 = .10, \Delta F(3, 155) = 5.52, p = .001 \). Both personal stigma \((p < .001)\) and gender \((p < .05)\) were significantly related to attitudes toward professional psychological help seeking. Specifically, higher scores on the SDS, which reflect greater personal stigma toward others with mental health concerns, and being male were associated with lower scores on the ATSPPH-SF. However, perceived stigma by close others \((p = .156)\) was not significantly correlated to attitudes toward professional psychological help seeking.

To test the hypothesis that gender moderated the relationships between stigma and attitudes toward professional psychological help seeking, we added centered interaction terms to the regression equation. Specifically, in Step 3, we added the interaction terms between stigma and gender (i.e., Personal Stigma \(\times\) Gender and Perceived Stigma by Close Others \(\times\) Gender) to the regression model, which did not significantly add to the proportion of variance in attitudes toward professional psychological help seeking, \( \Delta R^2 = .02, \Delta F(2, 153) = 2.16, p = .119 \). Furthermore, the personal stigma interaction variable \((p = .235)\) and the perceived stigma by close others interaction variable \((p = .077)\) were not significant, indicating that there is no difference in the association between personal and perceived stigma and attitudes toward professional psychological help seeking across genders. Therefore, it was found that

**TABLE 3**

**Hierarchical Multiple Regression Analyses**

<table>
<thead>
<tr>
<th>Variable</th>
<th>( B )</th>
<th>( SE B )</th>
<th>( \beta )</th>
<th>( t )</th>
<th>( R^2 )</th>
<th>( \Delta R^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.00</td>
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<tr>
<td>Generational status</td>
<td>0.29</td>
<td>0.72</td>
<td>.03</td>
<td>0.40</td>
<td>.00</td>
<td>.10</td>
</tr>
<tr>
<td>Step 2</td>
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<td></td>
<td>.10**</td>
<td></td>
</tr>
<tr>
<td>Generational status</td>
<td>0.41</td>
<td>0.69</td>
<td>.05</td>
<td>0.60</td>
<td>.10**</td>
<td></td>
</tr>
<tr>
<td>PS</td>
<td>-1.13</td>
<td>0.34</td>
<td>-0.26</td>
<td>-3.35**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSCO</td>
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<td>-1.43</td>
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<tr>
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<td>0.68</td>
<td>.16</td>
<td>2.03*</td>
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<td>.12</td>
<td>.02</td>
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<td>PS (\times) Gender</td>
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<td>0.70</td>
<td>-0.23</td>
<td>-1.78</td>
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*Note. PS = personal stigma; PSCO = perceived stigma by close others.

*p < .05. **p < .001.
Neither personal nor perceived stigma’s effects on attitudes toward professional psychological help seeking were moderated by gender.

Discussion

The current study examined the relationship between personal stigma, perceived stigma, and gender on attitudes toward professional psychological help seeking in a sample of South Asian students; furthermore, the current study examined the potential moderating effect of gender on the relationships of both personal stigma and perceived stigma by close others with attitudes toward professional psychological help seeking. We hypothesized that higher levels of perceived stigma by close others, personal stigma, and being male would be associated with increasingly negative attitudes toward professional psychological help seeking, and that the relationship between the two types of stigma and attitudes toward help-seeking behaviors would differ based on gender. Our findings revealed that personal stigma, but not perceived stigma by close others, and gender affected attitudes toward professional psychological help seeking in South Asian populations. However, the findings did not indicate differences in the association between perceived and personal stigma and attitudes toward professional psychological help seeking across genders. This study extends previous research on attitudes toward professional psychological help seeking by shifting the current understanding of the relationship between the two forms of stigma and gender and clarifying the distinctiveness of the South Asian population.

In line with our hypotheses, higher levels of personal stigma were associated with increasingly negative attitudes toward professional psychological help seeking. This finding is consistent with previous research on Asian populations generally (Eisenberg et al., 2009), and on the South Asian population in particular (Loya et al., 2010), which found that personal stigma was related to attitudes toward professional psychological help seeking. The role of traditional Asian cultural beliefs, which underscore the importance of achievement and honoring the family, may explain this finding (Das & Kemp, 1997; Durvasula & Mylvaganam, 1994). Thus, it appears that, for South Asians, beliefs about the need to distance themselves from individuals with mental illness are negatively associated with attitudes toward professional psychological help seeking.

In addition, in line with our hypothesis, being male was associated with increasingly negative attitudes toward professional psychological help seeking. This finding is also consistent with previous literature on Asian populations generally (Barry & Grilo, 2002; Leong & Zachar, 1999; Shea & Yeh, 2008; Yoo et al., 2005) and on South Asian populations in Britain (Soorkia et al., 2011). This finding underscores the importance of considering gender when addressing attitudes toward professional psychological help seeking in South Asian populations. This finding may be explained by the role of traditional male gender expectations, which discourage expressions of emotion and
pain and encourage self-reliance (Connell, 2000), a finding that has been supported with South Asian men (Lalwani, Sharma, Rautji, & Millo 2004; Patel, Pereira, & Mann, 1998).

Because we used a measure of perceived stigma by close others or others in one’s community in this study, we hypothesized that perceived stigma by close others would be associated with attitudes toward professional psychological help seeking. However, this hypothesis was not supported. Although this finding is consistent with previous literature (Eisenberg et al., 2009; Loya et al., 2010), the previous research used measures of perceived stigma in the larger community. This finding may also be a manifestation of the manner in which we asked questions. Specifically, when asking about perceived stigma by close others, we focused the questions on how participants would expect other people to react to them if they were mentally ill (e.g., “To what degree do you believe that people you interact with would react negatively to you?”), whereas questions assessing personal stigma asked about how participants would feel about another person with a mental illness (e.g., “How would you feel about . . . having your children marry someone with a mental illness?”). Considering the stigma purported to exist around mental health within South Asian populations, respondents may have responded without bias when they were asked about another person having a mental illness versus themselves. Additional research is needed to clarify the role of perceived stigma by close others on attitudes toward professional psychological help seeking in South Asian populations.

This study, moreover, failed to find a difference in the association between perceived and personal stigma and attitudes toward professional psychological help seeking across genders. Although a power analysis determined that the sample size was sufficient to detect a moderate effect within the multiple regression equation, research has shown that the average effect size in moderation is only around .01 (Aguinis, Beaty, Boik, & Pierce, 2005). Thus, it is possible that, with increased power, a moderation effect would be detected. Further research must be undertaken to confirm this finding.

These results point to the importance of attending to personal stigma in South Asian populations to promote help seeking and the subsequent use of mental health services within South Asian populations. Destigmatizing efforts could be undertaken with South Asian populations that focus on improving the individual’s perceptions of mental illness and mental health treatment. For example, educational initiatives that include psychoeducation about mental illness and contact with others diagnosed with a mental illness have demonstrated success in reducing stigmatizing attitudes (Pinfold et al., 2003; Sartorius & Schulze, 2005) and thus could be used; however, additional research is needed to see whether such change leads to increased help-seeking behavior (Corrigan, 2004).

When already engaged in treatment, assessing and then addressing stigmatizing beliefs about mental illness held by members of the larger community may be important in encouraging continued use of mental health treatment.
by South Asian individuals, particularly because Asian Americans prematurely drop out of treatment at a higher rate than nonminority individuals (Leong & Lau, 2001). Furthermore, it may be important to discuss the process by which stigmatizing views of South Asians held by the community may become internalized and threaten the individual (Link et al., 1989). Thus, engaging South Asian clients in a discussion about their views of mental illness, while simultaneously remaining respectful of their cultural beliefs, may be beneficial in encouraging appropriate engagement in mental health services.

Considering the relatively greater acceptability of medical intervention and treatment by South Asian populations (Yeung et al., 2004), delivery of mental health care in more traditional medical settings (e.g., primary care) may be an appropriate setting for the identification and delivery of mental health care to South Asian populations, particularly men. Thus, medical professionals (e.g., primary care physicians) may need support in addressing stigma related to mental illness and mental health treatment with South Asian populations (Yeung et al., 2004), with an awareness that South Asian individuals may be more likely to display mental health symptomatology somatically (Lin & Cheung, 1999).

Efforts to improve attitudes toward professional psychological help seeking and thus promote mental health service usage among South Asian men should address potential perceived incompatibility between traditional South Asian male gender ideals of strength and control and the mental illness and mental health treatment. Educational initiatives, as outlined previously, may seek to incorporate a discussion of the impact of gender role expectations and beliefs about engaging in mental health treatment. Pilot studies of interventions to improve engagement in mental health treatment for men have demonstrated some success in reducing stigmatizing beliefs (O’Kearney, Gibson, Christensen, & Griffiths, 2006) and improving informal help seeking (Szydek, Addis, Green, Whorley, & Berger, 2014), although research linking such interventions to professional psychological help seeking, particularly in Asian men, is lacking.

Several notable limitations to this study exist. First, the generalizability to the larger South Asian population is a concern. Specifically, similar to other studies examining Asian and South Asian populations, we used a convenience sample. It is unclear the degree to which this sample of South Asian college students represents all South Asian college students, or, perhaps more important, the South Asian population at large. It is possible that the sample obtained in this study was discrepant from the larger South Asian population residing in the United States in terms of level of education, socioeconomic status, and, for those foreign born, time residing in the United States, among other variables. Future studies should attempt to pool from communities in which a larger sample of the South Asian population is represented. Sampling from economically underserved and vulnerable populations, including youth and older adults, is imperative because it will
allow for a better understanding of a heterogeneous population and improve the generalizability of the results.

In addition, certain measurement-related limitations exist. First, the study did not incorporate a measure of acculturation or enculturation (Berry, 1990, 1994). Specifically, although this study did control for generational status, we did not explicitly examine how these values affect both perceived and personal stigma, as well as attitudes toward professional psychological help seeking across genders in South Asian populations. Previous research has pointed to the link between acculturation and enculturation and attitudes toward professional psychological help seeking (B. S. K. Kim & Omizo, 2003; Liao, Rounds, & Klein, 2005). Furthermore, research has demonstrated the role of acculturation as a moderator in the relationship between stigma and mental health treatment (Atkinson & Gim, 1989; Zhang & Dixon, 2003). Although these findings have not yet been replicated in South Asian populations, some have suggested that research examining stigma should incorporate assessments of these variables (Loya et al., 2010). Thus, future studies should include assessments of these important variables to examine their relationship with attitudes toward help-seeking behavior, stigma, and gender. In addition, although we are interested in help-seeking behavior, this study did not directly assess this particular behavior; rather, we measured attitudes toward professional psychological help seeking. Although it is a limitation to extrapolate the former based on measurement of the latter, it can be stated that the measure assessing attitudes toward professional psychological help seeking (Fischer & Farina, 1995) has high criterion validity as demonstrated by its ability to significantly predict individuals’ usage of mental health services (Elhai & Simons, 2007). Future studies may seek to measure actual engagement in mental health service usage or help-seeking behavior.

Moreover, we did not analyze additional factors that may differentially affect the relationship between the variables examined. Despite having gathered data on self-identified ethnic backgrounds (e.g., Pakistani, Indian, Bengali), we did not analyze the data to examine their relationship to the variables of interest. Insufficient numbers of participants within each category prevented us from engaging in further analysis of these variables. Moreover, our process of using self-reports to determine participants’ ethnicity did not result in consistent definitions for each and, thus, lacked reliability across dimensions. Future studies might consider using consistent definitions of the various South Asian American subgroups to assess the relationship of these variables with each group as well as use continuous (instead of categorical, dummy-coded) variables as covariates.

Finally, an additional limitation is the correlational nature of the study. Specifically, the use of this methodology limits our ability to make conclusions regarding the directionality of the findings. Thus, it is not clear whether higher levels of personal stigma cause increasingly negative attitudes toward professional psychological help seeking or whether individuals with increasingly negative attitudes toward professional psychological help seeking are more likely to perceive and internalize negative views of mental illness. It
is important for future research to examine the bidirectional associations between these variables.

Despite these limitations, this study extends knowledge about addressing mental health treatment in South Asian populations. In addition, the study is novel in that it examines the relationship of both personal and perceived stigma by close others, as well as gender, to attitudes toward professional psychological help seeking in a U.S. sample of an understudied population. Findings from this study highlight unique aspects of the South Asian population and underscore the importance of considering this population as a subgroup distinct from the larger Asian group. Furthermore, the findings from this study also shift our current understanding of the relationship between the two forms of stigma and gender, highlighting the need to consider both distinctly in the context of Asian American mental health help-seeking behavior. Findings from this study also present additional research questions that warrant further consideration.

references


