

The Relationship Between Stigma and Helping-Seeking Behaviors Among Refugee, Asylum Seeker, Immigrant (RASI) Populations Specifically of Muslim Origin

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In order to understand the relationship between stigma and help-seeking behaviors in refugee, asylum seeker, and immigrant (RASI) populations in the United States, this review examines stigma and its various forms: public, perceived public, self, and stigma by association. Issues which RASI populations face when immigrating to the U.S. and the effects of integrating into a new culture on stigma are also discussed. An emphasis is placed on investigating these interactions in Muslim-specific populations in further detail due to increases in discrimination toward this group in the United States since 2016. The analysis concludes by examining ways that a counselor can actively change the course of stigma. Recommendations are proffered regarding being a culturally cognizant clinician in treating this population, which is currently seeing an increase in stigmatization in the United States.

Keywords

refugee • immigrant • immigrant • refugee • Muslim
• help-seeking • mental health • stigma

Introduction

In the United States, it is estimated that the rate of psychopathology in the adult population is approximately 18.57% – nearly 45 million people – with approximately 57% of those not actively seeking any form of support for their issues (Mental Health America, 2020; National

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Alliance of Mental Illness [NAMI], 2019, National Institute of Mental Health [NIMH], 2019). While many variables play a role, some are particularly magnified for multicultural populations. Contributing factors may include, though certainly are not limited to, “[limited] access to treatment, a culturally insensitive health care system, racism, bias or discrimination in treatment settings, language barriers, [diminished] quality of care, lowered rates of health insurances, and higher levels of stigma” (NAMI, 2019).

The present literature review investigates the relationships between help-seeking behaviors and stigma in the United States among refugees, asylum seekers, and immigrants (RASI), which have been assessed collectively due to a multitude of shared commonalities (da Silva Rebelo, Fernández, & Achotegui, 2018). This review provides a conceptualization of the manifestation of stigma at the individual and society level (Corrigan, Powell, & Rüschi, 2012), as well as its effects on help-seeking behavior among people with mental illness; the role of stigma on treatment adherence and factors that can moderate those effects are also discussed.

Stigma as it pertains to the general population is first reviewed in order to establish a backdrop for evaluating its effects on RASI populations specifically. Barriers to treatment for RASI populations are presented in order to further elucidate the difficulties that this underserved group faces. The analysis then narrows its scope to the Muslim RASI population – a focus that is offered in the context of prevailing socio-political conditions involving escalations in discrimination and prejudice that further marginalize this group and lead to an expanding gap between mental illness and seeking treatment. The diversity of cultural backgrounds of Muslim RASI are discussed, as well as the effects of acculturation on help-seeking behaviors in the United States. Treatment advice is offered for counselors serving RASI clients, with specifics for those from several Muslim backgrounds. The review concludes with suggestions for ways a therapist can become culturally competent and work to decrease stigmatization within their own therapeutic practice while providing local community advocacy.

Mental Illness and Stigma

Stigma is a form of discrimination, prejudice, and stereotype based on a perceived flaw in another (Corrigan et al., 2012; Vogel, Wade, & Haake, 2006). Stigma can be experienced across a wide variety of environments, is linked with the manifestation of mental health disorders, and has been found to be a negatively correlated with both seeking and receiving mental health treatment (Hayden & Mash, 2014). Researchers have postulated that stigma can be delineated into public stigma and self-stigma (Corrigan et al., 2012). Public stigma is a stable belief held by the community that leads to negative reactions due to societally held stereotypes. Self-stigma is the result of the internalization of public stigma by an individual who is a member of the stigmatized group due to perceived slights; it is particularly associated with those who have some form of mental illness (Corrigan et al., 2012). Corrigan, Rafacz, and Rüschi (2011) note that there are five stereotypes which make up self-stigma:

[A]lienation (the subjective experience of being less than a full member of society or having a ‘spoiled identity’), stereotype endorsement (the degree to which respondents agree with common stereotypes), discrimination experience (perception of the way respondents believe they are treated negatively by others), social withdrawal (the degree to which the respondent avoids others to escape rejection), and stigma resistance (the experience of resisting or being unaffected by stigma) p. 339.

Self-stigma can be represented as model with four parts that have the potential to reciprocally interact and produce detrimental effects (Corrigan, Bink, Schmidt, Jones, & Rüschi, 2016; Corrigan et al., 2012; Corrigan, Watson, & Barr, 2006). The first part, stereotype awareness, occurs when the individual becomes cognizant of society's stigmatizations. The second phase, stereotype agreement, occurs when stigmatized individuals come to endorse these publicly held stereotypes (Corrigan et al., 2006). The third component involves self-concurring, wherein individuals apply the stereotype to themselves; this typically culminates with the fourth stage of the model, which manifests as reduced self-esteem (Corrigan et al., 2012; Corrigan et al., 2006). The last two parts of self-stigma's progression may produce a 'why try' effect, a sense of hopelessness which results in self-esteem decrement where individuals feel as though they are helpless and undeserving, and which has been associated with attenuated recovery and a higher endorsement of public stigma overall. (Corrigan et al., 2016). Importantly, this relationship between self-concurrence and self-esteem decrement was found to be significant even when depression was removed from analyses. These researchers also found that the resulting harm from diminished self-esteem is likely to result in behavioral despondence, or an aversion to endeavor to alleviate one's mental illness. Vogel, Bitman, Hammer, and Wade (2013), investigating the association between public and self-stigma, discovered that public stigma served as an obstacle both to the formation of internal healthy and positive attitudes about one's self and capabilities, not just to seeking mental health services.

Stigma and Beliefs About Mental Health Affecting Help-Seeking Behavior

Public stigma and self-stigma can be further characterized by unique perceptions concerning psychopathology. Public stigma when applied to mental illness involves the communally held belief that those who seek mental health treatment are unacceptable by society's standards (Vogel, Wade, & Haake, 2006). According to Quinn, Williams, and Weisz (2015), mental illness stigma, a form of public stigma, carries with it the assumptions that those who are mentally ill are risky, erratic, defective, and/or inherently weak by allowing themselves to be mentally ill. Ben-Porath (2002) found that there is a greater degree of stigma associated with mental illness for those who pursue treatment as compared to those who do not. Vogel and colleagues' (2013) study supports research which has found that public stigma internalized as self-stigma over time may lead some to avoid seeking treatment to avoid discrimination that comes with labeling. Stigmatization may go on to affect an individual at every step of the help-seeking process from possible aversive thoughts about treatment to reduced adherence to early termination (Vogel et al., 2013; Vogel, Wade & Hackler, 2007). Self-stigma is associated with actively avoiding treatment because the internalization of public stigma leads to a perception that to pursue treatment equates to personal weakness; a person avoids treatment when the desire to maintain a positive internal self-image is stronger than the need to seek psychological services (Vogel et al., 2007).

Swan, Heesacker, and King (2016) found that a correlation existed between the expectation of stigma and the action of seeking mental health treatment. They discovered that as perceived stigma rises, the willingness to seek treatment for mental health ailments decreases since the attitudes surrounding finding treatment are also negative. Overall, the therapeutic alliance was found to be a protective factor when it comes to the potential stigma an individual with mental illness faces. Specifically, the research discovered that a positive working alliance has been found to be a factor to protect against stigmatization and, in fact, further predicts that a client's self-stigma will diminish as they continue in therapy (Swan, Heesacker, & King, 2016).

Particularly, stigma was lessened when the alliance purposely allocated time to decreasing these personal stigmatizations.

Stigma's Effects on Treatment Adherence

Kendra, Mohr, and Pollard (2014) investigated the effect which perceived public stigma and self-stigma had on depressive symptomology, engaging in the beginning phases of therapy, and the creation of a working alliance. Modifying existing measures, the researchers created a questionnaire to quantify perceived public stigma and self-stigma and examine both changes over time to make “the clinically meaningful distinction between factors that account for (a) session-to-session differences within a client and (b) differences between clients” (p. 564).

Overall, Kendra and colleagues (2014) found that if self-stigma increased from session to session reaching a level higher than the previously established norm, this would often decrease a client's preference to continue to engage in therapy. Over the course of treatment, self-stigma remained constant while perceived public stigma decreased over time. The researchers theorize that this occurred because the therapist did not act consistently with the perceived public stigma a client may have held, thus challenging the client's previously held societal beliefs. It was hypothesized that self-stigma may be linked to long-held personalized beliefs and therefore be more resistant to change. While a continued high self-stigma reflected diminished therapeutic engagement, high perceived public stigma resulted in greater engagement. It was theorized that clients who hold high perceived public stigma may want to try harder with a therapist once trust has been established because they want to eliminate the potential for outside stigma to re-occur.

Public stigma surrounding mental illness has also been found to result in judgment in educational, housing, and employment settings (Quinn, Williams, & Weisz, 2015). These societal perceptions then become ingrained in those stigmatized, thereby resulting in worries about discrimination and rejection across other life contexts. Quinn and colleagues (2015) found that even the expectation of societal discrimination contributes to the internalization of the stigma even if no actual discrimination is present. While earlier literature had not clearly delineated between anticipated discrimination and anticipated social stigma, Quinn and colleagues defined the former as consisting of concerns of intermittent, but severe, distinct actions, like being denied a loan or passed over for promotion and the latter as manifesting in concerns of being degraded and socially isolated on a daily basis, such as people cancelling social engagements or being slighted in public by strangers.

Quinn and colleagues (2015) investigated how experiencing discrimination may affect its future anticipation as well as whether expectation of stigma predicts increased internalization. They found that “experiences of discrimination over one's lifetime” likely affect not just people's amount of concern over future discrimination, “but also how much they internalize negative feelings about the self” (p. 103). It is therefore not merely experience of discrimination that leads to deleterious outcomes, but also the anticipatory trepidation that further stigmatization will happen in the future.

Moderating Effects on the Level of Stigma

Heath, Brenner, Lannin, and Vogel (2018) found that not all those who are subjected to stigma and mental illness discrimination internalize these experiences. They point to self-compassion – the ability to view oneself through a lens of non-judgement and sympathy regardless of

perceived failure, suffering, or feelings of incompetence – as a mechanism by which this harmful process can be circumvented. Elevated self-compassion has been found to confer resiliency by providing a protective layer between anticipatory self-stigma and perceived public stigma and is associated with greater persistence in the pursuit of help-seeking efforts for mental illness (Heath et al. 2018).

Firmin and colleagues (2017) investigated methods of stigma resistance, a process whereby an individual opposes stereotypes concerning mental illness by separating them from their own identity and challenging them. At the individual level, researchers found that there were four strategies subjects utilized to resist stigma. The first was not believing in the stigma and the participants' belief that maintaining a positive self image could influence how others viewed them. The second strategy involved becoming educated about the harm of stigma and enhancing awareness of its presence to facilitate use of in-the-moment responses to mitigate self-stigma. The third was persistence in treatment, such that eventual success with the recovery process serving as disproof of existing stigma. The fourth strategy to personally resist stigma was differentiating the self from one's mental illness, which was associated with the development of a positive self-identity. Moving outside the individual, the research team found that helping others, which itself was tied to having received positive help previously, also helped mitigate self-stigma (Firmin et al., 2017). To lessen public stigma, the subjects shared that educating others, sharing personal experiences, and advocacy against the spread of stigma were all important processes. Resisting stigma was an ongoing process that required the continuation of strategies at both the personal and societal level.

Stigma by Association

Van der Sanden, Bos, Stutterheim, Pryor, and Kok (2013) found that stigma by association, stigma that family members of those with a mental illness may experience, was strongly associated with perceived public stigma. Individuals experiencing stigma by association tend to experience greater levels of psychological distress, and relatedly, often socially distance themselves from the relative they perceive as being stigmatized. The study found that one's role in a family is associated with how much stigma they may be experiencing. Specifically, parents are often blamed for children with mental illness and siblings are blamed for not helping their relatives stick to treatment plans, while children of parents with mental illness were found to fear "contamination." However, research indicates that feelings of stigma by association declines as the degree of closeness increases in the relationship (van der Sanden et al., 2013).

Van der Sanden and colleagues (2013) found that heredity was not related to stigma by association. Rather, it was related to forms of psychological distress, such as worries concerning the latency of mental illness and worries about one's personal health. They discovered that fear for oneself can occur when confronted with a family member's own mental illness. Van der Sanden, Bos, Stutterheim, Pryor, and Kok (2015) examined the impact of stigma by association on immediate family members and found a variety of experiences including negative treatment, being impugned, being held accountable for the illness, and an interrupted social life, all of which led to increased psychological distress and both social- and self-imposed exclusion. Family members reported feeling that they received no support from mental health professionals in handling the emotional struggles within their family (van der Sanden et al., 2015). The strain that this stigma by association places on family relationships can exacerbate the stigma that an individual with the mental illness already experiences, further contributing to a decreased likelihood to pursue, receive, and continue treatment (van der Sanden et al., 2015; Hayden & Mash, 2014).

The particular manner in which stigma by association is experienced may be influenced by factors such as specific type of family relationship, co-residency, and gender of the family member. As to the former, individuals occupying roles of 'parent' or 'spouse' had comparable experiences of stigma by association, reporting that, in the views of dominant American culture, parents are responsible for their child's upbringing and spouses are responsible for correcting their partner (van der Sanden et al, 2015). As children are typically not perceived to bear a care-taking responsibility for others, the role of 'child' was less associated with stigma by association. A notable exception to this can be seen in Muslim immigrants, however, wherein children do tend to assume a measure of responsibility for their elders' wellbeing, as will be discussed in further detail in a following section (Amri & Bemak, 2013; van der Sanden et al., 2015). Additionally, it was found that the effects of stigma by association increased with development, such that as youth reached adolescence, they experienced greater social rejection and exclusion (van der Sanden et al., 2015). A second factor, co-residing with a mentally ill person, was found to be an indicator of increased stigma by association, as individuals described that this shared living situation led to feelings of social exclusion, abandonment, and elevated psychological distress (van der Sanden et al., 2015). Lastly, researchers found that female participants experienced greater levels of stigma by association than their male counterparts, which was hypothesized as stemming from prevailing social attitudes about women's roles and responsibilities within the family (van der Sanden et al., 2015).

The Impact of Stigma on Help-Seeking Behaviors in Refugees, Asylum Seekers, and Immigrants (RASI)

Regardless of gender, age, race, or religion, it has been found that refugees, asylum seekers, and immigrants (RASI) are significantly affected by stigmatization related to help-seeking behaviors; such stigma may arise either from the culture of origin or due to the complex process of integrating into a new culture, specifically into the United States (Abu-Ras & Abu-Bader, 2009; da Silva Rebelo et al., 2018). Asylum seekers request refuge once on United States soil, whether it be in the United States mainland, at the airport, or at a border checkpoint; the refugee process occurs abroad, and they do not travel to the United States until they are approved (Connor & Krogstad, 2018). Both categories seek to gain entry due to maltreatment or fear thereof "on account of race, religion, nationality, membership in a particular social group, or political opinion" (Mossaad & Baugh, 2018, p.1).

Da Silva Rebelo and colleagues (2018) performed a meta-analysis of 12 studies conducted in Australia, the Netherlands, the United Kingdom, the United States, and Switzerland among RASI populations. These studies assessed the effects of restrictive health services on undocumented immigrants, government laws and policies on asylum seekers, and deportation threats. The team found that an overwhelming amount of racism, aggression, and distrust directed toward asylum seekers and refugees was cultivated by strict governmental policies and negative media portrayals and had a high potential of affecting health care professionals' feelings toward this population. The researchers further found that this may result in a reciprocal relationship; when health care workers would respond negatively toward a member of this population, that member would often respond in kind. These negative effects would then lead to an overall decline in psychological, physical, and societal wellbeing and an overall refusal to seek health care services. This was particularly the case for immigrants that did not have documentation and feared deportation. This systemic racism and hostility leads to an overall vulnerability in these populations.

Social stigmatization of mental health issues among RASI affects this population's health seeking attitudes. A member of the RASI population may not seek psychotherapeutic intervention due to inherent beliefs that mental illness (a) may be caused by a family member's past indiscretions and thus shame the family; (b) is heritable, and will lead to persecution of the family at large; (c) may lead to deportation if discovered; or (d) may become the subject of gossip in the community (Alhomaizi et al., 2018; Amri & Bemak, 2013). RASI community members often seek mental health services as a last resort after failed efforts to get help from family, a community healer, or traditional medicines.

Compounding the disconnect between psychological need and the pursuit of help, those RASI who come to the United States and seek psychological services encounter multiple barriers (Alhomaizi et al., 2018; Bemak & Chung, 2017). These include shortages of therapists appropriately trained in cultural responsiveness and bilingual-bicultural representatives. Due to the latter, RASI are treated and placed at whatever level of the mental health system is available to them, regardless of whether or not it is appropriate for their particular needs or level of distress. Additionally, barriers exist to accessing mental health services, such as limited public transportation options and a fundamental lack of awareness of the facilities that are available to provide help.

If treatment is actually started, more barriers to success arise, including the fact that the therapeutic intervention is typically provided in a Westernized format. This potentially ignores the RASI's particular ailment or culturally sensitive background that may inform the prognosis. For instance, depending on the country of origin of the RASI, they may present with more somatic and pragmatic complaints rather than emotional ones, and, therefore, are often more receptive to tangible tasks and instructive methods than treatments which focus on emotional issues (Bemak & Chung, 2017). The length of a normal Westernized treatment too, may be seen as a barrier, as the concept of a recurrent visit can be indicative of failure and cause early termination without proper explanation that counseling is an ongoing approach that cannot be solved within a single visit (Bemak & Chung, 2017). Cultural conceptualizations regarding the origins of psychological illness must also be explored (Sood, Mendez, & Kendall, 2014) as these influence treatment approach. Researchers have found that RASI clients often seek mental health services while also still seeing their own cultural healer; if a counselor disparages this practice, it may cause conflict in the therapeutic alliance (Amri & Bemak, 2013; Bemak & Chung, 2017). To this end, the role of medication must also be explicitly discussed in hopes of avoiding premature treatment termination; specifically, RASI who conceptualize their struggles to be of a spiritual nature might question a prescription whereas those who believe their ailment to be organic might question the absence of psychopharmacological intervention.

RASI from Muslim Cultural Backgrounds

RASI in the United States from Muslim communities currently face a further elevated risk of going untreated or receiving inadequate treatment. To unpack this issue, one must first examine the Muslim population in America. As of 2017, approximately 58% of the adult Muslim population – in contrast to only 18% of the general public – in the United States was born abroad (Pew Research Center, 2017). The number of refugees admitted into the United States had been increasing steadily since 2010, with refugees during this time coming mainly from the South and Near Eastern regions of Asia and accounting for 45% of the admissions during that period (Mossaad & Baugh, 2018). However, as of 2018, this trend has been moving in the opposite direction, most likely due to policies of the current administration such as the Executive

Order 13769, which forbade refugees and immigrants from seven Muslim-majority countries entry into the United States in 2017 (da Silva Rebelo et al., 2018). The number of Muslim refugees admitted to the United States in a six-month period from the end of 2017 to mid-2018 was 1,800 of approximately 10,500 refugees overall (Connor & Krogstad, 2018). As of 2020, the most recent presidential administration set a new all-time low cap on refugees, planning on only allowing in 18,000, which is 12,000 less than the cap in 2019 and the lowest since 1980 when the program for refugee resettlement was created (Krogstad, 2019). Additionally, the admittance of Muslims refugees is significantly fewer compared to Christian refugees over the years. Specifically, with Muslims and other religious groups accounting for only 21% of the refugees coming into the U.S. in the 2019 fiscal year (Krogstad, 2019).

Muslims tend to immigrate to the United States to, among other reasons, obtain increased prospects economically or educationally, reunite with family, or escape from religious or ethnic persecution, civil war, or international conflict (Amri & Bemak, 2013; Pew Research Center, 2017). In 2017, of the countries from which refugees were migrating, the top three had a Muslim majority. As of 2018, of the top five countries from which refugees were being admitted, none had a Muslim majority (Connor & Krogstad, 2018). Because 67% of the United States' refugees in the previous ten years were from Muslim-majority countries (Connor & Krogstad, 2018), recent Muslim refugees to the United States have diversified the US Muslim population in terms of country of origin and cultural background.

While religious demographics of Muslims in the United States are consistent with the rest of the world, those for country of origin are inconsistent with that of the global Muslim distribution (Pew Research Center, 2017). According to a 2017 study conducted by Pew Research Center, there is not one single country that makes up more than 15% of the influx of Muslim immigrants coming to the United States. The Muslim population of the United States is also more diverse than that of Canada or Australia (Australian Government Department of Home Affairs, 2018; Statistics Canada, 2011). With such diversity among the Muslim immigrant population of the United States, discrimination can be experienced based on anything from initial country of origin, religious sect, and/or race. It has been further found that this experience can then result in negative mental and physical health outcomes. Abu-Ras and Abu-Bader (2009) note that mental health problems in Muslim refugees are more likely if they have fled from countries that are either politically volatile or highly culturally different compared to the country to which they are immigrating.

Abu-Ras and Abu-Bader (2009) looked at the extent that these negative experiences have had on Muslim men since the terrorist attacks of 9/11 and its subsequent effects by utilizing Carter's Race Based Traumatic Stress Injury Model, which was created after a comprehensive analysis of the extant research on racial discrimination and both general and posttraumatic stress. Their results found that those who are subject to either perceived or tangible racism may feel pain, either emotionally or physically, or experience the fear of being harmed as this perception may be expressed toward the individual with anger, mistrust, or outright hostility (Abu-Ras & Abu-Bader, 2009; da Silva Rebelo et al., 2018). Those subject to these ill effects may feel particularly isolated, thereby creating negative effects on their psychological and physical wellbeing the longer they spend in a Western country (da Silva Rebelo et al., 2018).

As of 2017, 48% of those identifying as Muslims in the United States shared that they experienced discrimination, an increase from 43% in 2011 and 40% in 2007 (Pew Research Center, 2017). While this is lower compared to other ethnic groups, these acts of discrimination have been found to increase to 64% when one's appearance can be identified as distinctively Muslim (Pew Research Center, 2016, 2017). In spite of this trend in the self-report data, Pew found that among Americans at large, the general population perceives Muslims

as facing more discrimination than other minorities. And, although the American public's acceptance of the Muslim population in the United States has improved since 2014, their perceptions were still less positive than those towards any other religion (Pew Research Center, 2017).

Anti-Muslim sentiment has been pervasive in the United States even before the events surrounding September 11th, 2001; this has been hypothesized to be due to possible perceptions of those who follow the Islamic religion as the adversaries of Christians (Abu-Ras & Abu-Bader, 2009). After 9/11, these sentiments were found to increase 17-fold (Abu-Ras & Abu-Bader 2009). Kira and colleagues (2010) found that post-9/11 there were specific discriminations that occurred against Muslims who were immigrants or from refugee populations. These discriminations included negative one-on-one interactions, negative portrayals in the media, negative oratory by political and social figures, as well as an increase in racial profiling and negative governmental policies specifically targeting these populations.

Micro- and macroaggressions can result in trauma-like symptoms such as depression, difficulty concentrating, memory loss, hyperactivity, and flashbacks or nightmares (Abu-Ras & Suarez, 2009). As noted by Carter's model, it is important to recognize that aggressions can come in various forms, including

racial harassment (e.g., physical and verbal assaults, also known as hate crimes, profiling), racial discrimination (e.g., barring access, exclusion; sabotage), or discriminatory harassment (e.g., denial of promotions, isolation at work; Abu-Ras & Suarez 2009, p. 49).

A study conducted by Kira, Ramaswamy, Lewandowski, Mohanesh, and Abdul-Khalek (2015) measuring the internalized stigma of mental illness in Arab, majority Muslim (84.9%) refugees found that mental health stigma could be alternatively labeled as type III trauma, as it is often a continuance without anticipatable end and has possible aggregated effects when amalgamated with other traumas. In another study conducted by Kira and colleagues (2014) exploring the traumatogenic effects of a variety of internalized mental illness stigmas in Muslim and Arab American refugees, researchers found that these stigmas were both positively and significantly associated with other type III identity traumas, such as discrimination and poverty, while negatively associated with non-identity traumas. Additionally, researchers found that internalized self-stigma would magnify the effects of these traumas on an individual's mental health, especially in minority groups.

Amri and Bemak (2013) found that there are a variety of issues Muslims may undergo when immigrating to the United States. Possession of non-transferable job skills or certifications can result in a loss of status, feelings of isolation, and internal strife. Confusion of government systems can cause stress during the immigration process. Another issue is the parentification of children, in which the younger generation takes on roles their parents normally would, often due to the ease they have with learning the language and culture. This parentification can create increased familial stigma by association for these children in the event that their parents have a mental illness; as previously noted from the research by van der Sanden and colleagues (2015), the presence of a sense of responsibility for a family member's adherence to a treatment protocol can result in increased stigma.

Many Muslim cultures are typically collectivistic, centering on family – both immediate and extended – as well as the community, such as neighbors and religious institutions. Individuals tend to look for support from this vast network first when needing help before seeking any form of outside treatment (Abu-Ras & Abu-Bader, 2009). In a study conducted by Al Ali, Dalky, Alqurneh and Al-Omari (2017) of psychiatric illness in the United Arab Emirates, which is

95% Muslim, it was found that individuals often prefer traditional healers as opposed to modern mental health treatment. Additionally, the researchers found that seeking help often occurred in a hierarchical format; first by asking for support from the family, then close friends, then a traditional healer, and only last, when all else has failed, would Arabs consult physicians. It was found that other factors that prevent individuals from seeking treatment include an internal lack of awareness of their mental health symptoms and their long-standing effects. Also influential is a lack of trained professionals and various institutional barriers.

For individuals from a Muslim population, stigma by association has been found to be an, “amplified,” “particularly impactful” hindrance to seeking mental health treatment (Alhomaizi et al., 2018 p. 39). Specifically, families may advise against treatment for the person with mental illness if it may reflect back negatively on them if the community were to find out (Alhomaizi et al., 2018; van der Sanden et al., 2013). In Muslim communities, a label of *majnoon* (crazy) can have an ill-effect on a family’s reputation; the stigma that comes with this label can be reason enough for the family to advise against treatment.

Individual attitudes about mental health treatment influence help-seeking behaviors, as Alhomaizi and colleagues (2018) found strong skepticism some Muslim communities. Specifically, for Arab-Muslim populations, this distrust centered on use of psychopharmacological intervention. This can be particularly confusing for counselors who have dealt with Muslim RASI from Asian cultures due to their preference for psychopharmacological treatments; therefore, a counselor should be cognizant of this differentiation and ask about preferences (Sood, Mendez & Kendall, 2014). Negative attitudes may also arise due to doubt surrounding the effectiveness of treatment. Additionally, with regard to non-Muslim counselors, clients were found to be concerned about the possibilities of discrimination and lack of understanding about their cultural background. It was found that this fear is pervasive within many minority communities and does not just solely reside within Muslim communities (Alhomaizi et al., 2018). Regarding not wanting to seek treatment from Muslim counselors, this was attributed to fear of being exposed within their community.

The study by Alhomaizi and colleagues (2018), along with others which they cite in their exploration, linked not seeking mental health services with a lack of confidence regarding the legitimacy of mental health treatment and found that clients from a Muslim community may attribute problems concerning mental health to mystic foundations. Those who do make these attributions prioritize seeking help in the community from those such as an imam (religious leader) or a *raki* (religious healer). The concept that a mental health concern is a test from God, either of patience or of strength and acceptance, is a belief among Muslims which can either hinder, for the former, or facilitate, for the latter, seeking treatment (Alhomaizi et al., 2018). There is heightened social stigma via community standards as the religion of Islam is perceived as a font of healing by its practitioners (Amri & Bemak, 2013). Some worry that by admitting mental health concerns they could be viewed as an apostate (Erickson & Al-Timimi, 2001; Amri & Bemak, 2013).

Erickson and Al-Timimi (2001) found that there was a lack of understanding and exposure to Westernized mental health practices within Muslim immigrant populations in the United States. In Arab-Muslim cultures, time is less structured. In some cases, this may contribute to Arab-Muslims arriving later than expected to their scheduled appointments which Westernized therapists may misinterpret as tardiness that is indicative of resistance to the counseling process. Therapy sessions where the client is asked to hypothesize about future consequences may be met with resistance because this future-oriented way of thinking is less common. Furthermore, these individuals are more apt to display their mental health issues psychosomatically, and overall are less psychologically minded. If an individual of Muslim culture is in counseling,

Erickson and Al-Timimi (2001) found that many expect explicit advice or instruction similar to what they might receive from a religious leader or community elder; they perceive this as being cared for, which is opposite to how Westernized mental health treatment is performed, leading to further misunderstanding and treatment difficulties.

Treating RASI Populations

Treating RASI in the United States requires clinicians to understand that members of this population often have increased internalized stigma, heightened public stigma, and increased rates of mental illness including, among others, posttraumatic stress disorder, psychosis, depression, anxiety, and dissociation (Bemak & Chung, 2017). While emigrating, there are multiple stressors that can compound these mental illnesses, such as threats of violence and sexual assault, economic strain, alienation, and loss of social status. These experiences can be so harrowing that they, alongside the subsequent forced acculturation, may engender trauma (Bemak & Chung, 2017).

RASI often need to learn a whole set of new skills and ways to communicate that may be vastly different from their own, as well as a new language. Adapting to a new, unique way of life can create tribulations that may hamper adjustment and integration. Possible absences of employment and educational opportunities, non-transferrable education, and upended cultural gender or familial roles, such as when women take on roles as wage earners, all can contribute to adaptation difficulties (Amri & Bemak, 2013; Bemak & Chung, 2017). When working with a RASI population, counselors should be cognizant of their own biases, whilst being aware of the socio-political climate surrounding their clients (Akinsulure-Smith, 2009).

In the fourth addition of Diagnostic and Statistical Manual, a semi-structured 16-question Cultural Formulation Interview (CFI) was added to assess cultural identity, conceptualizations of distress, psychosocial stressors, and more (APA, 2000). In the most recent fifth edition it was updated to include more information regarding the influence of culture, race, and ethnicity on the conceptualization of mental health difficulties (APA, 2013). La Roche, Fuentes, and Hinton (2015) note that the CFI in the DSM-5 is different than the approach to formulating a clinical diagnosis, leading to two separate approaches to assessment being utilized: one focusing on a biological foundation for a disorder without incorporating cultural context in the diagnosis, and another that highlights the importance of cultural context when understanding the manifestation of a patient's symptomology. The CFI's location in Section III of the DSM-5 after all the disorders have been described conveys inappropriately that cultural affiliation is not always important in a sound diagnosis – this is a grave error. On the contrary, it is absolutely crucial to recognize the immense diversity of experience of migrant populations, and the CFI can be utilized as a vital tool for gleaning critical cultural information to qualify appropriate diagnoses. Indeed, a clinician needs to be aware of the existence of the CFI so as to include the type of questions that lead to a culturally informed evaluation, thus avoiding “category errors” or incorrect assessments (La Roche et al., 2015).

In another approach to achieving culturally informed clinical practices, the Multiphase Model (MPM) of Psychotherapy, Counseling, Social Justice, and Human Rights has been found to be an efficacious therapeutic model of intervention when treating clients who are from RASI populations. The MPM has been found to be a “culturally responsive model of intervention specifically designed to address the unique circumstances and mental health needs of refugees, including trauma” (Bemak & Chung, 2017). To utilize this model, the counselor needs an active awareness of the client's experience; specifically, the relationship between trauma and politics and how these factors affect identity and ease in post-emigration. The model itself has

five phases to promote alleviation of stigmatization, decreased symptoms of mental illness, and a healthy integration between tradition and new ideals.

The first phase of the MPM involves mental health education. The therapeutic relationship, which is built on obtaining trust and providing a safe environment, is created here. To do this, the therapist will need to utilize empathy with a client while providing a place for acceptance and trust. The clinician will need to understand the cultural connotation of therapy for the specific client, the potential pitfalls that come from close community relations, and how these may affect perceptions of therapy, the therapeutic progress, and process. This phase involves balancing the client's potential internal and external stigmas and allowing them a space to feel safe while discussing these issues. This balancing can be done through working with the community and being open to alternative methods of therapy alongside Westernized techniques.

The second phase of the MPM is individual, group, and/or family psychotherapy. There is an emphasis herein on collectivistic principles, these featuring prominently in the cultures of the "top 10 countries of origin for refugees" (Bemak & Chung, 2017). Counselors must be aware of cultural traditions so they may intertwine cultural values with therapeutic practices. This phase may require self-disclosure and therapeutic intimacy to create a place of sensitivity, as the questions counselors often ask may trigger memories of traumatic experiences. Group counseling for refugees creates social ties that are vital to a productive recovery and alleviates feelings of alienation, while increasing a sense of belonging by providing a venue for shared information, interpersonal learning, and hope (Akinsulure-Smith, 2009). When counselors who work with refugee clients also work with the client's family, members of social services, and other mental health providers, more lasting and preventative care is given. Deep muscle relaxation activities and deep breathing exercises were more efficacious than Western-influenced therapeutic techniques, such as insight-oriented practices (Akinsulure-Smith, 2009).

The third phase of the MPM is cultural empowerment, teaching clients to effectively utilize their environment, overcome cultural barriers, and self-advocate (Bemak & Chung, 2017). This phase is more practical; the counselor takes on the role of a 'cultural systems information guide' who can provide clients with information to support their migration and mitigate any undue stress or harm from the acculturation process by helping the client with everyday frustrations (e.g., finding bilingual schools, workplaces, habitation, community support, governmental help as with taxes or public assistance, etc.) and providing support therein. The therapist needs to understand what problems arise when a refugee or immigrant migrates to a new country and must be apprised of socio-political events that may affect their clients.

The fourth phase of the MPM, the 'indigenous healing' phase, combines traditional practices of non-Western origin with Westernized therapeutic ones, requiring an understanding of legitimate effective traditional practices via sustained research of the clients' source cultures (Bemak & Chung, 2017). Supporting evidence is key, as is corroborating one's own research via colleagues and other cultural professionals. This phase of the MPM also involves advocating for social justice and human rights. Counselors need to be proactive in this phase to continue improving the lives of their clients by taking steps to improve the conditions their clients face. This could include the counselor contacting their therapeutic boards, speaking at events, or getting involved with local government to advocate for proper resources and to attempt to change public policies or legislations which impact their clients. It could involve the counselor actively teaching their colleagues through continuing education lectures about the effects of the refugee and immigrant experience and helping mitigate a continuation of public stigmatization.

Treating Clients from the Arab-Muslim Community Specifically

When treating Arab and Muslim clients, similar to other RASI clients, a clinician should investigate and take note of a client's specific cultural or religious affiliations, the way they describe their reason for seeking treatment, and any other cultural factors that may intertwine with their environment and affect their disorder's presentation (Rassool, 2015). Some Muslims may only want to be seen by a practitioner of their own gender; every effort to accommodate should be made rather than associating this with any forms of client resistance. If this accommodation cannot be made, the clinician should make sure to come from a place of sensitivity and understanding when working with their client. Furthermore, they should understand that outside of the therapy session this may cause conflict within the home due to cultural stigmatization, the possibility of which should be addressed in-session.

A combination of Qur'anic healing alongside counseling is the most effective and preferred treatment for Muslim clients in the United States (Abu-Ras & Abu-Bader, 2009; Rassool, 2015). Therefore, a clinician should be aware that their patient may be seeking spiritual guidance from their imam; attempts to coordinate treatment may be beneficial for the client, so as to not create contradictions. A clinician can also thereby open communication with the community, which is highly held in the Muslim culture and demonstrates trust. However, the clinician should maintain discretion and uphold confidentiality when it comes to treatment of a specific client.

While working with clients from the Arab-Muslim community, it was found that providing positive feedback elicited favorable response on help-seeking behavior (Alhomaizi et al., 2018). Positive feedback can be defined as the encouragement a client may receive from members in the community or from their family regarding obtaining mental health treatment. This feedback was found to be highly motivating regarding treatment adherence and referrals to other community members. Community leaders, specifically imams, who provide positive feedback with respect to seeking treatment have been found to be particularly beneficial toward facilitation and adherence.

Conclusion

Stigma exists in a variety of forms and creates or exacerbates numerous barriers to successful mental health treatment. There are a number of ways in which a counselor can mitigate these effects. While stigma has the possibility to affect all persons with mental illness, RASI are at elevated risk because of their status as outsiders in the country to which they have immigrated. Recent data has shown that RASI from Muslim cultural backgrounds face unique circumstances in the United States due to the present sociopolitical climate.

Counselors working with a member of a RASI population need to make sure that they are cognizant of their client's cultural and psychosocial background and what implications, if any, these have on the manifestation and/or demonstration of their symptomology. To achieve this, it is suggested that they be aware of their client's country of origin, the socioeconomic and political climate therein, non-Western methods of treatment common to that region, the region's traditional gender norms and family structures, as well as the client's religion and the sect thereof, if applicable. Furthermore, it is suggested that the counselor utilize this information to engage in open communication with their client to understand the specific needs of their patient. Clinicians are equally ethically obligated to stay abreast of the social and political issues of the country in which they practice and the effects these have on their clients. Again, an ongoing dialogue should be utilized to keep the client feeling safe within the confines of therapy and to make sure the clinician understands what specifically affects their client.

The clinician ought to be cognizant of the acculturation process, the effects of coming to a new country, and how the differences between the client's country of origin and the new one can produce its own set of stigmas. Counselors should be open and willing to discuss these effects and provide empathy and respect, as well as creating a safe space for this to be discussed without any hint of intolerance or personal bias. The clinician can accomplish this by knowing ahead of time what factors make them uncomfortable and dealing with these before they begin treating a specific population. If they come to a factor while in treatment that may cause issue, then the clinician should be responsible to seek supervision or outside consultation to mitigate harm and divest themselves of any undue stigma that may make therapy difficult on their client. It is the clinician's responsibility to uphold a safe environment for their client and create a therapeutic relationship.

Particularly in the United States, as RASI populations are presently being highly stigmatized, it is important to understand how these outside stressors can further exacerbate the presentation of a mental health disorder or create aversion in the client toward the idea of utilizing Western therapy options. Clinicians practicing within minority communities are recommended to connect with the local community to facilitate accurate mental health education, disseminate information about treatment options, and foster trust, with the ultimate goal of being seen as a respectable and accepted method of providing help for community members (Alhomaizi et al., 2018; Moller, Burgess & Jogiyat, 2016).

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