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DEVELOPING THE LABEL AVOIDANCE MEASURE OF STIGMA: A PRELIMINARY PSYCHOMETRIC REVIEW

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Professional Paper

presented in partial fulfillment of the requirements
for the degree of

Master of Arts
in Clinical Psychology

The University of Montana
Missoula, MT

May 2021

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Developing the Label Avoidance Measure of Stigma: A Preliminary Psychometric Review

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Stigma acts as a barrier to treatment for mental health concerns. Label avoidance, one of several different aspects that compose the overarching concept of stigma, captures the stigma involved when individuals avoid social institutions that might confer a psychiatric diagnostic label and would mark them as an individual with a mental health problem. Label avoidance has been described as a key stigma construct in the literature but has been sparsely studied. Answering a call in the field for new, psychometrically sound stigma measures, we created a new measure of label avoidance and acquired initial validity and reliability evidence supporting its use among an adult population. Preliminary item development for the Label Avoidance Measure (LAM) was performed using a rational scale construction approach, allowing us to generate items based on our conceptual understanding of label avoidance and stigma theory. A sample ($n = 41$) of undergraduate students provided input during the item development phase. Data were then collected over two time periods utilizing participants from the crowdsourcing technique, Amazon Mechanical Turk (MTurk) (Time 1: $n = 232$; Time 2: $n = 95$). An exploratory components factor analysis of the LAM indicated a one-factor solution, rather than suggesting the LAM should comprise multiple subscales. Three items were eliminated because they did not meaningfully load onto the factor (criterion level < .4). Internal consistency analysis indicated that the items on the LAM are strongly related ($\alpha = .976$). Additionally, preliminary convergent and discriminant validity evidence was gathered to compare the LAM to existing measures. The LAM was significantly and strongly correlated with the Self-Stigma of Seeking Help Scale ($r = .744$, $p<.01$) and the Perceptions of Stigmatization by Others for Seeking Help Scale ($r = .619$, $p<.01$), suggesting that the LAM is related to other stigma measures. On the other hand, the LAM was significantly and weakly correlated with measures examining dissimilar constructs: The Adult Trait Hope Scale ($r = -.243$, $p<.01$) and the Marlow-Crowne Social Desirability Scale-Form XI ($r = -.309$, $p<.01$). Additionally, the LAM demonstrated good test-retest reliability ($r = .810$, $p<.01$). Though further research is needed, this preliminary evidence indicates that the LAM is internally consistent and demonstrates acceptable convergent and discriminant validity evidence. In addition, the measure appears to be temporally stable, with good reliability over a two week interval. This measure has good potential for use to identify individuals who may benefit from treatment for a mental health problem but are hesitant to receive help due to the possibility of being labeled as part of a stigmatized group. Limitations and clinical implications will be discussed.

Introduction

While stigma is a common barrier to receiving mental health care, there are aspects of stigma that have yet to be fully understood. Once such aspect is label avoidance, or the inclination to deny one's group status as having a mental illness, as well as the institutions that may confer a mental illness label on them (Corrigan, 2004). This study aimed to create and test preliminary measure of label avoidance in order to better understand our ability to quantify this aspect of stigma and, ultimately, better connect individuals to mental health care.

Approximately 44 million American adults experience a mental illness, and it is estimated that more than half of these adults do not receive treatment for their conditions (MHA, 2019). About 20% of adults with a mental illness report that they are unable to receive needed treatment due to barriers such as insufficient insurance or an understaffed mental health workforce (MHA, 2019). The remaining individuals who do not report these specific barriers still experience circumstances that prohibit them from receiving necessary mental health treatment. Thus, it is important to consider other factors that play a role in the treatment gap.

There are a number of potential barriers that can help explain the gap between those experiencing symptoms of mental illness and those receiving help. A commonly reported barrier is stigma, or fear that seeking treatment will lead one to be evaluated negatively by others (Vogel, Wester, & Larson, 2007). Stigma is a complex phenomenon at the social/clinical psychological interface that involves active discrimination of others, as well as a fear of being treated harshly and negatively evaluated by people in society (Owen et al., 2013). 'Public stigma' is a type of stigma that encompasses negative attitudes, stereotypes, prejudice, and discriminatory behavior towards individuals that have a mental health condition (Corrigan, 2004). This can lead to a fear of judgement that impedes mental health treatment, inhibiting

someone from finding help or from fully engaging in the treatment process (Link & Phelan, 2006; Owen et al., 2013). There are many different ways to conceptualize stigma, in addition to public stigma, so it becomes important to consider different behaviors and appraisals that may compose this concept.

Corrigan (2004) explains that 'self-stigma' arises when individuals internalize the negative messages perpetuated by their social network and start to feel negatively about themselves. In essence, self-stigma is the internal adoption of public stigma. While self-stigma and public stigma are separate concepts, they interact with each other in a reciprocal fashion (Corrigan, 2004). In addition to impacting treatment seeking and engagement, self-stigma can have negative implications for the individual, including reduced self-esteem, worsened psychiatric symptoms, and higher amounts of distress (Link & Phelan, 2010; Owen et al., 2013; Lucksted & Drapalski, 2015). Link and Phelan (2006) explain that there are power dynamics at play, where stigmatization occurs when a higher-power group translates their negative views into social consequences for the lower-power, stigmatized group. Internalization of the judgmental stereotypes put forth by higher-power groups can further solidify the powerlessness of the stigmatized group and result in lessened pursuit of life goals and reduced participation in society and social relationships (Lucksted & Drapalski, 2015). Because withdrawal can further worsen psychiatric symptoms, it is important to interrupt this cycle (Lucksted & Drapalski, 2015).

In a comprehensive review, Fox et al. (2018) compiled over 400 stigma measures and examined conceptualizations of stigma in the extant literature. They observed that researchers frequently use different terms to describe similar aspects of stigma, making it difficult to advance the field of stigma research. This observation led to the proposal of a new framework to guide subsequent researchers' operationalization of different aspects of stigma and streamline the terms

used to discuss it (Figure 1). This framework proposes that public stigma, as discussed above, is a precursor to internalized and anticipated stigma, previously defined as self-stigma (Fox et al., 2018). Fox and colleagues (2018) further proposed that both anticipated and internalized stigma lead to outcomes such as delayed treatment seeking and decreased treatment adherence. For the purposes of this project, self-stigma will be referred to as internalized stigma. Anticipated stigma refers to treatment avoidance due to one's anticipation of the public having a negative view of them. Thus, individuals must choose between receiving beneficial help and risking being stigmatized by the people with whom they interact in daily life (Corrigan, 2004). As such, it has been postulated that individuals may specifically avoid treatment—and, in turn, avoid receiving any potential psychiatric labels—in order to combat the expectation of being devalued and rejected by society (Link, 1987; Stolzenburg et al., 2017). This area of research is understudied, likely because the idea has been conceptualized a number of different ways, including "treatment stigma" and "anticipated stigma" (Clement et al., 2014). In order to clarify this issue and propel the field forward, it may be helpful to create a more definitive understanding surrounding the idea of avoiding institutions for fear of being stigmatized.

It is possible that the conceptual pathway depicting societal stigma leading into anticipated and internalized stigma, which leads to outcomes such as delayed treatment seeking, would benefit from an additional aspect of stigma between internalized and anticipated stigma and delayed treatment seeking (Fox et al., 2018). Potentially, a particular person's knowledge of public stigma may lead them to experience anticipated stigma, which in turn might influence label avoidance, hampering treatment seeking. Thus, label avoidance may be a concept missing from conceptual pathways linking anticipated stigma and delayed treatment seeking.

Label avoidance, a specific subset of internalized stigma that has garnered recent research attention, is the target of the proposed study. Consistent with his modified labeling theory, Link (1982) postulated that psychiatric labeling maintains behaviors that lead to negative consequences involving jobs, friendships, and family relations. Assignment of psychiatric labels, Link maintained, specifically places individuals with mental illnesses in a societally devalued 'other' category, separate from those without these conditions. Due to this, individuals may feel and think negatively about the possibility of receiving a label indicative of mental illness. Further, Corrigan (2004) defines label avoidance as an occasion when individuals "opt to avoid… stigma all together by denying their status and by not seeking the institutions that mark them (i.e., mental health care)" (p. 616). Corrigan's (2004) two components of label avoidance, denial of group status and avoidance of institutions, direct the focus of the scale development for this study. While stigma as a whole encompasses the idea of negative evaluation, label avoidance specifically addresses the avoidance of institutions that would confer a label and further perpetuate the stigma one might experience as a result of their mental illness. Essentially, internalized stigma resulting from negative public views of those with mental illness can lead to label avoidance and decrease the likelihood of treatment participation (Corrigan, 2004).

The denial of group status highlighted by Corrigan (2004) is conceptually similar to ideas proposed by others (Schomerus et al., 2012; Stolzenburg et al., 2017) who have studied a person's willingness to self-identify as having a mental illness. Stolzenburg and colleagues (2017) explain that the decision to avoid a label must begin on an intrapersonal level, when someone appraises their symptoms as a sign of a mental illness (Stolzenburg et al., 2017). Theoretically, an individual cannot choose to avoid an institution that may confer on them a mental illness label if they do not realize that they have symptoms indicative of a mental illness;

if an individual without mental illness symptoms did avoid an institution, it would not be a behavior considered under the umbrella of label avoidance. Schomerus and colleagues (2012) wrestled with this relation of label avoidance and personal labeling and created the "Mental Health Problem Appraisal Scale" (MPA). The MPA gauged how individuals thought about personal experiences that could denote the presence of mental health symptoms. Schomerus et al. (2012) found that depressed individuals with high levels of internalized stigma reported lower perceived need for professional help and were less likely to appraise depressive symptoms as indicative of a mental health problem. In other words, individuals who internalized more negative cultural messages about mental illnesses were less likely to think that they themselves might have a mental health condition.

The MPA was later renamed the "Self-Identification as Having a Mental Illness-Scale" (SELF-I) and used to measure the degree to which individuals identify as someone who has or could develop a mental illness (Stolzenburg et al., 2017). As with the previous research (Schomerus et al., 2012), individuals with stronger stigma as measured by the SELF-I were less likely to identify as having a mental illness (Stolzenburg et al., 2017). Thus, Stolzenburg and colleagues (2017) operationalized high stigma as a low likelihood of identifying as potentially having a mental illness.

As noted above, this work surrounding an individual's willingness to appraise concerns as indicative of a mental illness addresses denial of group status, half of Corrigan's (2004) definition of label avoidance. Importantly, the SELF-I does not make any reference to the behavioral element of label avoidance, an element that entails avoidance of those institutions with potential to mark an individual with a mental illness label. Indeed, Corrigan's (2004) conception of label avoidance includes both self-appraisal *and* decisions about avoiding

institutions. As a result, a scale or measurement tool proposing to quantify label avoidance should include both concepts. It is possible that individuals may fit Corrigan's (2004) definition of label avoidance by avoiding institutions without having gone through a thorough self-appraisal process. In those cases, the SELF-I scale would fail to identify all individuals impacted by this aspect of stigma and scores on the measure would underestimate stigma. It could also be argued that engagement with institutions that confer a mental illness label would contribute to an individual's self-appraisal process, which similarly highlights the importance of measuring both of Corrigan's (2004) aspects of label avoidance. A failure to capture the full spectrum of label avoiders will result in difficulty identifying individuals who could benefit from treatment.

It would be interesting to consider if the relationship between stigmatizing thoughts and treatment attitudes changes when potential behaviors are considered as well. As it is, incomplete measurement, like that which composes the SELF-I, makes it difficult to fully target label avoidance as a treatment barrier, as Corrigan and colleagues (2004) suggest the field ought to do. The current study addressed this gap by creating a scale that fully aligns with Corrigan's proposed definition of label avoidance.

Presently, published research isolates the self-appraisal aspect of label avoidance, and we know of no published work that conceptualizes label avoidance according to the full definition Corrigan proposes. One of the first studies to explicitly study label avoidance asked primary care patients with probable major depression whether they would agree with a label of depression from their physician, but did not ask direct questions about institutional avoidance (Campbell et al., 2016). Individuals with depression who said they would not accept a label of depression for themselves (high label avoidance) reported significantly lower openness to care from mental health providers than individuals with low label avoidance. At a seven-month follow-up, high

label avoidance participants were more likely to avoid mental health professionals entirely (Campbell et al., 2016). While high and low stigma patients were equally likely to interact with the healthcare system, including visits to primary care physicians, patients high in stigma were less likely to explicitly address mental health concerns. Furthermore, high label avoidance patients were less likely to receive adequate depression care than low label avoidance patients (Campbell et al., 2016). Overall, this research suggests that the depression label itself may be important in patients' decision making, and that individuals who are more averse to it may be less likely to seek out and engage in appropriate and adequate treatment for their symptoms (Campbell et al., 2016). Because depression is the leading cause of disability worldwide (World Health Organization, 2018), it is an important first step to examine label avoidance in individuals who have symptoms of depression and inadequate connection to care. Between measuring agreement with a diagnosis and observing later avoidance, this research seems to encapsulate a portion of Corrigan's conception of label avoidance. At the same time, Campbell et al.'s (2016) single question is insufficiently broad to capture the nuanced spectrum of avoidance tendencies in persons who might benefit from care.

In an unpublished dissertation study, Meyer (2017) continued this work, using rational scale construction to expand Campbell and colleagues' (2016) single question of label avoidance into a five item scale. Meyer found that higher levels of label avoidance were associated with a lower likelihood of intention to seek mental health specialist care for depression, and a higher likelihood of intention to manage depression on one's own (Meyer, 2017). Meyer's measure proved to be a useful preliminary scale for measuring label avoidance, though item-level analysis indicated that the scale would reflect better internal consistency reliability if one of the five questions ("People with a diagnosis of depression are treated differently than others after being

diagnosed than before”) were removed (Meyer, 2017). The present study expanded Meyer’s scale even further, in hopes of increasing the internal consistency reliability of label avoidance measurement and better distinguishing label avoidance from self-labeling and other forms of stigma. Similar to Meyer’s work (2017), a rational scale construction approach was used, creating preliminary items for the scale based on the author’s conceptual understanding of label avoidance and stigma theory. Though Meyer’s (2017) and Campbell et al.’s (2016) label avoidance measures focused on the label of ‘depression’ specifically, the present scale inquired about ‘mental illness’ or ‘mental health diagnoses’ more generally, in an attempt to capture a broader range of symptom experiences.

Overall, previous research has found that there is a large need for decreasing the gap between those who need care for mental health concerns and those who get it. Stigma establishes and perpetuates this treatment gap; understanding different facets of stigma will likely inform future interventions to target these negative conceptualizations of individuals with mental illness. Therefore, it is important to have a standard way to measure and discuss different aspects of stigma, including the concept of label avoidance. The present study focused specifically on Corrigan’s (2004) conception of label avoidance to create and test a label avoidance scale that includes the cognitive appraisal and emotional consequences of receiving a mental health diagnosis, as well as the avoidance of institutions that may confer that label.

It was hypothesized that label avoidance would emerge as a construct that is distinct from public stigma, internalized and anticipated stigma, and self-identification through examination of the validity evidence. Establishing the new measure’s preliminary validity evidence and testing the scale’s reliability are necessary before we begin to examine what might make someone more likely to exhibit label avoidance. Additionally, it was hypothesized that this measure will be a

reliable tool, with emerging validity evidence for the measurement of label avoidance in an adult population.

To examine the new scale's validity evidence, we compared it to existing scales that propose to measure similar constructs such as the SELF-I. It was expected that if the scores on the new label avoidance scale and the SELF-I were very highly correlated, there would be no need for a new label avoidance scale, despite the apparent missing information from Corrigan's theory. If the scales were minimally or moderately correlated, it will be interesting to consider sociodemographic and illness-related differences between participants who are high in self-appraisal and high in label avoidance. Either way, this study aimed to examine if researchers should be focusing on Corrigan's definition, or if the newer understanding of self-appraisal accomplishes the same goals with regard to stigma measurement.

In addition to understanding the process of self-appraisal, it is useful to consider why association with certain institutions themselves may lead the public to automatically perpetuate stigmatizing views on people affiliated with those institutions. There is a well-documented concept in sociology and social psychology that individuals see themselves as belonging to ingroups, while tending to reject those who associate with outgroups (Fiske, 2000). Someone who does not have a mental illness would likely not consider themselves to have the same group membership as someone who does have that label; recognizing someone as affiliated with a mental health institution has potential to relegate that individual to the outgroup of persons with a mental illness. Individuals often erroneously view outgroups as homogenous and aligned with certain stereotypes (Fiske, 2000). Thus, the association of a person with the outgroup of anyone who has a mental illness may invoke a desire to stay apart from that group and an association of that individual with those who are the target of stigmatized views (Fiske, 2000; Corrigan, 2015).

Methods

Corrigan (2004) explains that label avoidance occurs when an individual denies their group status as someone with a mental health condition and ultimately avoids the institutions and professionals that would mark them as an individual member of that group. While Schomerus and colleagues (2018) developed a scale to measure the degree to which individuals appraise their symptoms as evidence of a mental illness, no scale exists to assess the second aspect of Corrigan's definition of label avoidance involving specific institutional avoidance. Indeed, Corrigan and colleagues (2018) themselves highlight the absence of a label avoidance measure as a hindrance to label avoidance intervention research.

Preliminary item development for the Label Avoidance Measure (LAM) was completed (see Appendix H). Refinement and testing of the measure proceeded in three stages. The first stage included undergraduate students from the University of Montana who were recruited from the Psychology Department subject pool. Data for the 2nd and 3rd stages were collected from research participants using the crowdsourcing technique Amazon Mechanical Turk (MTurk). MTurk is a participation recruitment resource that is commonly used in the social sciences. Previous reports suggested that data collected using MTurk workers is comparable to data collected using undergraduate students and provides researchers with a larger participant pool than an undergraduate university would (Difallah et al., 2018). As a number of scales used in this study were validated with an undergraduate population, we assumed that the scales can examined with data collected from MTurk workers as well. Institutional Review Board human subjects research approval was obtained prior to the beginning of the study. Though there is no consensus on how to determine a sample size for validating a new measurement scale, a review of new measure studies found that the median sample size was 207 (Anthoine et al., 2014). This study

aimed to have a similar number of participants. In order to contextualize this study, it is important to note that all data were collected during the COVID-19 pandemic.

Fox and colleagues (2018) caution against conflating the experiences of people who impose stigma on others (i.e., the stigmatizers) and people who feel it (i.e., the stigmatized). Indeed, research often focuses on a general sample of individuals who may fall into either or both of those categories. In order to address this concern and to align all participants with the “stigmatized” category, the LAM asked individuals to consider how they might answer the scale’s questions if they were experiencing symptoms of a mental illness. It is hard to know for certain if the scale examined the perspective of the stigmatizers or the stigmatized, as one’s imaginal experience is likely to differ from one’s lived experience. At the same time, it is difficult to assess treatment avoidance behavior in a stigmatized population, as label avoiders will be working to not associate with that group. To introduce as much clarity as possible and to allow for creation of subgroups during data analysis, participants answered ‘yes’ or ‘no’ to questions asking if they personally had been diagnosed with a mental illness and if they believed they have a mental illness.

Measures

Measure of mental health symptomatology: Mental health symptoms and well-being were assessed with the Symptoms and Assets Screening Scale (SASS). Presented in Appendix A, the SASS is a 34-item self-report measure that was designed to assess overall psychological distress in college-aged students (Downs et al., 2013). The SASS has subscales to assess depressive symptoms, anxiety symptoms, substance problems, eating problems, and well-being/assets. In initial analyses, each of the SASS subscales correlated strongly and significantly with existing instruments that measure similar constructs. Participants read each item and

indicate how well that item describes their experience over the past month (0 = *not true*; 3 = *certainly true*). Additionally, participants indicate if they have ever received a mental health diagnosis and if they have received professional help for a psychological problem. Each of the five subscales has acceptable internal consistency reliability, with coefficients ranging between .73 and .86.

Measure of public stigma: The Social Distance Scale (SDS; Appendix B) was one of the three measures to help assess the convergent validity of the newly-developed label avoidance scale (Link, 1987). The SDS is a seven-item scale that presents participants with a vignette about a person who has a mental illness, and then asks participants a series of questions about the person. A sample item asks "how would you feel about introducing this person to someone you are friendly with"; participants rate this on a four point scale, ranging from '1' (*definitely unwilling*) to '4' (*definitely willing*). The measure has evidenced good internal consistency reliability (e.g., $\alpha = .75$: Corrigan et al., 2001). This measure was used in Meyer's (2017) preliminary label avoidance scale research, and it was found to have an internal consistency reliability coefficient of .89 in a sample of undergraduate students.

Measure of internalized stigma: The internalized stigma one may feel as a result of seeking psychological help from a therapist was assessed using "The Self Stigma of Seeking Help Scale" (SSOSH; Appendix C) developed by Vogel and colleagues (2006). The SSOSH is considered to be a reliable measure of stigma ($\alpha =.79$). Corrigan (2004) has proposed that self-stigma, the internalization of negative public beliefs about mental illness, is related to label avoidance, so this scale will also be used to assess the new scale's convergent validity evidence. On the SSOSH participants are given 10 statements and asked to rate the degree to which they agree with each on a scale of '1' (*strongly disagree*) to '5' (*strongly agree)*. An example

statement is ‘I would feel inadequate if I went to a therapist for psychological help’. Responses are averaged together, with higher scores indicating higher levels of internalized stigma.

Measure of perception of stigma in personal social network: The Perceptions of Stigmatization by Others for Seeking Help Scale (PSoSH; Appendix D) asks participants to consider how people might interact with them if they, themselves, sought mental health services (Vogel et al., 2009). Vogel and colleagues (2009) explain that this is the first measure to assess the level of stigma within one’s personal social network, rather than in the general public. Though not explicitly stated, this may be an example of ‘anticipated stigma’ as outlined by Fox and colleagues (2018). This measure has evidence of good internal consistency reliability in a college sample, with an alpha value of .95 (Vogel et al., 2009). Participants are given 21 questions that relate to treatment seeking (e.g., “To what degree do you believe that the people you interact with would think of you in a less favorable way?”), and they rate how much they believe the situation outlined would occur. Answers range from ‘1’ (*not at all*) to ‘5’ (*a great deal).* Responses are summed, with higher scores indicating a higher perception of stigma from those with whom the respondent interacts. This scale was used to assess convergent validity with the label avoidance scale.

Measure of social desirability: Social desirability has been used in previous studies to assess discriminant validity in the development of new stigma scales (Vogel et al., 2006). Social desirability was measured using the Marlowe-Crowne Social Desirability Scale, Form XI (MCSDS-Form XI; Appendix E). Vogel et al. (2006) explains that this shortened version of the original MCSDS scale correlates substantially with the original version (.91). Participants will answer 10 items as either true or false; a sample item is “I always try to practice what I preach”

(Strahan & Gerbasi, 1972). False statements are scored as 0 and true statements are scored as 1; higher scores indicate a greater tendency to generate socially agreeable responses.

Measure of hope: We expected that hope would not be correlated with label avoidance, so a measure of hope was used to test discriminant validity. Hope, defined as a stable cognitive set that reflects goal-directed thinking, was measured with The Adult Trait Hope Scale (Snyder et al., 1991; Appendix F). Participants rated 12 statements on a scale from '1' (*definitely false*) to '8' (*definitely true*), with higher scores indicating higher hope; eight of these items contributed to the overall hope score and four of these items were filler items. A sample item is "I can think of many ways to get out of a jam."

Measures of label avoidance: Consistent with Corrigan's dual component conception of label avoidance, two separate measures assessed the construct. First, consistent with Corrigan's (2004) conception of denying group status, the "Self-Identification as Having a Mental Illness-Scale" (SELF-I; Appendix G) measures the degree to which someone identifies as having a mental health condition (Schomerus et al., 2012; Stolzenburg et al., 2017). This scale was developed with the concept of label avoidance in mind, as the authors argue that one must be aware of their own mental health as a first step to determine help-seeking behaviors; lack of recognition was proposed to reflect reluctance to accept a label. The SELF-I was used in order to compare differences or similarities between it and the LAM. Participants rated five statements on a scale of '1' (*do not agree at all)* to '5' *(agree completely),* with higher scores indicating higher self-identification and lower stigma. A sample item is "Current issues I am facing could be the first signs of a mental illness." This measure has evidence of good internal consistency reliability, with an alpha of .87 (Stolzenburg et al., 2017).

Second, the "Label Avoidance Measure" is the scale that was designed for the present study, using a rational test construction method (Appendix H). In early development work, this writer's research team brainstormed statements that align rationally with Corrigan's (2004) definition of label avoidance, working to highlight both denial of mental illness group status and avoidance of institutions that can confer a mental illness label. As a specific focus, questions were drafted to assess cognitive, affective, and behavioral avoidance of institutions that may mark an individual as having a mental illness. Additionally, some items from a pre-existing preliminary label avoidance scale were used as a starting point for the present scale construction, with the goal of increasing the internal consistency of the preliminary scale (Meyer, 2017). A sample item is "I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself", and participants are asked to respond on a scale of '1' (*strongly disagree*) to '6' (*strongly agree)*, with higher total scores indicating higher label avoidance.

Results

Refinement of Measure

Development sample: A total of 44 participants responded to the initial request to participate in the survey development process. Three respondents were excluded from the analysis due to a failure to accurately respond to validity check items. Thus, 41 undergraduate participants provided insight on the preliminary measure. As shown in Table 1, the 44 participants included in the analysis were mostly White (70%) cisgender women (93%) with an average age of 26.3 years (SD = 9.46).

Participants were first presented with a working definition of label avoidance. They were then asked to identify how much they agreed or disagreed that each statement on the preliminary measure fit with the definition of label avoidance provided. More than half of the participants strongly disagreed with five of the 42 statements as being indicative of label avoidance. However, we only eliminated the statement "I would seek treatment regardless of people's views of me concerning my mental health" because it was the only statement that had a mean below 2, indicating that participants did not agree that this statement was indicative of label avoidance (mean = 1.98; SD = 1.30; Table 2).

Participants also had the opportunity to suggest an original statement that they believed was indicative of label avoidance. We then compared these statements to Corrigan's definition of label avoidance, utilizing a rational scale construction approach, and decided to add five of the participant-generated statements to the preliminary Label Avoidance Measure (LAM) (see Appendix I)

Time one data collection: Once the preliminary scale items were finalized, data were collected in two phases. At time one, a total of 641 participants responded to the survey through the crowdsourcing technique Amazon Mechanical Turk (MTurk). Of these participants, 409 were excluded from the analysis for failing to accurately respond to one or more of the validity/attention items. Data analysis was performed on 232 participants who accurately responded to all attention checks. As shown in Table 1, the 232 participants included in the analysis were mostly White (76%) cisgender women (53%) with an average age of 43 (SD = 13.77). More than half of these participants (68%) had scores below the mental illness symptom cut-off on the SASS, indicating that they likely did not experience mental health concerns at the

time of data collection (Table 1). Thirty percent of participants reported that they had been diagnosed with a psychological problem or disorder at some point in their lifetimes.

In addition to assessing respondents' attention, percentage of missing data was examined in order to consider the validity of participants' responses. It was determined that an insignificant portion of data were missing, and that imputation of missing values would produce negligibly different results.

In order to address our primary aim of understanding the factor structure of the Label Avoidance Measure, an exploratory factor analysis of the LAM was completed. These analyses were conducted after necessary items were reverse-scored, such that higher scores always reflected higher label avoidance. It was observed that the Kaiser-Meyer-Olkin measure of sampling adequacy was .946, above the commonly recommended value of .6, and Bartlett's test of sphericity was significant (x^2 (1035) = 10503, p <.001). Additionally, the communalities were all above .3, further confirming that each item shared some common variance with other items. Given these indicators, it was deemed suitable to examine all 46 items in the factor analysis.

The factor analysis indicated a one-factor solution, accounting for 48% of the variance. Visual inspection of the scree plot supported this decision, as there was a clear leveling off of the slope after factor one (Figure 2). Additionally, the results indicated that three items could be eliminated because they did not meaningfully load onto the factor (criterion level < .4; Table 3). These items were: "I would call an anonymous crisis line to receive support for mental health concerns; I would not be concerned if I called an anonymous crisis line to receive support for mental health concerns; I would join a social media group (e.g. Facebook group) about a mental health concern."

Internal consistency analysis also supported eliminating these three items. The initial Cronbach's alpha for the LAM was .97 and it was indicated that the internal consistency would increase minimally if the same three items stated above were removed (Table 4). Further analyses were completed excluding these three items. Internal consistency analysis indicated that the items on the LAM were cohesive and strongly related (α = .98; Table 4).

Time two data collection: In order to measure test-retest reliability, the same MTurk participants were contacted two weeks later to complete the LAM a second time. A total of 114 participants responded to the survey; 19 participants were excluded from data analysis for failing to accurately respond to all attention checks. As shown in Table 1, the 95 participants included in the analysis were mostly White (79%) cisgender women (56%) with an average age of 44.1 years (SD = 13.79).

The time two internal consistency analysis again indicated that the items on the LAM are strongly related (α = .98; Table 4). Scores on the LAM from time one were correlated with scores from time two in order to investigate the stability of the scale over time. The LAM demonstrated good test-retest reliability ($r = .810$, $p<.01$).

Validity evidence for refined measure: Additionally, preliminary convergent and discriminant validity evidence was gathered to compare the LAM to existing measures of stigma and conceptually unrelated constructs, respectively. Internal consistency information for each measure is reported in Table 5. The LAM was significantly and strongly correlated with the Self-Stigma of Seeking Help Scale ($r = .744$, $p<.01$; Table 6) and the Perceptions of Stigmatization by Others for Seeking Help Scale ($r = .619$, $p<.01$; Table 6). These correlations support the hypotheses that label avoidance taps stigma as a general concept while it is concurrently somewhat independent of public stigma and internalized stigma, providing evidence against the

possibility of redundancy between the scales. On the other hand, the LAM was significantly and weakly correlated with measures examining dissimilar constructs: The Adult Trait Hope Scale ($r = -.243$, $p<.01$; Table 7) and the Marlow-Crowne Social Desirability Scale-Form XI ($r = -.309$, $p<.01$; Table 7). These correlations are higher than were hypothesized, suggesting some minimal relationship between the scales.

Contrary to our hypotheses, the LAM did not significantly correlate with the Social Distance Scale ($r = -.116$, $p <.01$) or the Self-Identification of Having a Mental Illness (SELF-I) scale ($r = -.043$, $p<.01$) (Table 6).

Discussion

The present study utilized Corrigan's (2004) conception of label avoidance to create and test a new label avoidance measure (LAM). While previous studies have attempted to ask questions about label avoidance, limitations have included insufficiently broad questions and a failure to fully capture all aspects of the construct, which necessitated further attention (Campbell et al., 2016; Meyer, 2017). The results of the present study add to the existing literature by creating a scale more closely aligned with the proposed definition of label avoidance when considering the possibility of receiving a mental illness label.

In approaching the current study's design, we took Fox et al.'s (2018) suggestions into consideration and recruited a sample of the target population to assist in creating and refining the preliminary label avoidance scale. Sample consultation, coupled with rational scale construction, supported creation of a preliminary measure that aligned with Corrigan's (2004) definition of label avoidance. This measure tapped an individual's desire to deny their status as having a mental illness and their expressed inclination to avoid institutions that may confer that label on

them. Participants rated the majority of statements as being indicative of label avoidance and prompted the removal of one item. Additionally, participants generated their own statements, five of which clearly mapped onto the working definition of label avoidance and were added to the LAM.

Exploratory factor analysis resulted in an unexpected finding concerning the structure of the Label Avoidance Measure. We hypothesized that we might see a two-factor solution that separated statements into appraisal and behavior, because we intended the LAM to target both affective considerations of being someone with a mental illness, as well as the possible behavioral responses to institutions. While there were 10 statements that potentially fit into a second factor, there were no conceptual relations in regard to mental appraisal or behavior between those statements and the remaining 33 statements. Additionally, the 10 statements that loaded on factor 2 also demonstrated substantial loadings on factor 1. Thus, it seemed reasonable to consider all 43 statements together in a one-factor solution.

A potential explanation for finding a one-factor solution is that, during item generation, we considered items that included both affective appraisal and behavioral intention in the same statement (e.g., I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself"). It was difficult to generate statements that exclusively considered appraisal because the denial of status in Corrigan's (2004) definition was difficult to parse from the behavioral act that may confer that label of status in the first place. For example, while the statement "I would feel ashamed to go to a clinic that would label me with a mental health concern" clearly involves affective appraisal, in considering the concept of shame, it is hard to definitively separate this appraisal from the possibility of behaviorally intending to avoid a clinic.

Additionally, a limitation of the Self-Identification of Having a Mental Illness Scale (SELF-I) noted previously was the failure to account for behavioral elements of label avoidance (Schomerus et al., 2012; Stolzenburg et al., 2017). The LAM clearly identified behavioral decisions as a way to rectify this limitation. It is possible that behavioral considerations of label avoidance are more significant in the conceptualization of the definition, as even deciding that one wants to deny their status of having a mental illness requires some behavior of doing so. If behavioral decisions are the driving force behind label avoidance, this provides additional conceptual support for the one-factor model of label avoidance.

We examined the LAM's reliability in two ways. As hypothesized, the LAM demonstrated strong internal consistency reliability, suggesting that the items measure a similar underlying construct. However, a high alpha value is only desirable up to a point, after which it becomes possible that the scale contains unnecessary, redundant items (Streiner, 2003). Streiner (2003) posits that any alpha over .90 indicates redundancy in the scale, as opposed to a desirable level of internal consistency. Given the LAM's alpha of .97, there is likely a high degree of redundancy among the items. As discussed above, some items in the LAM focused only on behavior, while other items contained both appraisal and behavior considerations. There were no notable differences between these items, especially as all items loaded meaningfully onto the same factor. So, it is possible that items only focused on behavior are redundant and can be eliminated—something future research should examine. Additionally, as hypothesized, the LAM demonstrated good test-retest reliability over an average of two weeks. This suggests that label avoidance is a relatively stable construct, at least over a short period of time. This observation is consistent with Corrigan's (2004) conception of label avoidance as a relatively stable construct.

The preliminary convergent validity evidence resulted in mixed findings. As hypothesized, the LAM correlated significantly with the Self-Stigma of Seeking Help scale and the Perceptions of Stigmatization by Others for Seeking Help Scale (Table 5). Scores on the LAM showing a positive association with scores on pre-existing stigma measures support the validity of this measure. These three measures all implicate help-seeking intentions, so the relationships between them support Corrigan's (2004) statement that label avoidance is potentially the most significant avenue through which stigma impedes care seeking.

It was also hypothesized that the LAM would moderately and significantly correlate with the Social Distance Scale and the Self-Identification as Having a Mental Illness, but neither of these scales was significantly correlated with the LAM (Table 5). Minimal correlation among the LAM and these two stigma scales suggests that social distance and self-identification of having a mental illness may be dissimilar, unrelated constructs. Social distance in stigma is often discussed in the context of perceiving the individual labeled with a mental illness as dangerous; it is possible that the LAM does not assess perceptions of danger associated with labels (Link et al., 1987). Previous research examining label avoidance observed a small correlation between social distance and label avoidance, where individuals with higher label avoidance also evidenced higher levels of social distance public stigma (Meyer, 2017). There are numerous possibilities to explain the differences found between these two studies, including the differences in sample and the different measurements of label avoidance. The present research utilized MTurk participants while Meyer's (2017) research participants were undergraduate students. Additionally, Meyer's (2017) research examined label avoidance with specific regards to depression, while the present study prompted participants to consider mental health concerns in general.

The finding that the LAM and the SELF-I did not correlate was unexpected, as both scales purport to measure label avoidance. As discussed above, it is possible that these two scales tap different aspects of label avoidance. At the same time, one would expect at least a minimal relationship between the scales if there was some overlap in the way both examine respondents' relationships with their own mental health symptoms. It is possible no correlation was found because appraising symptoms as potential signs of a mental illness may precede one's decision to avoid institutions that confer a label.

An explanation for the lack of correlation between the SELF-I and the LAM may involve the thought process about help-seeking. The LAM asks questions involving potential help-seeking behaviors and was significantly positively correlated with two other stigma measures that implicate help-seeking. The SELF-I, on the other hand, involves self-assessment of symptoms that may be indicative of mental illness. In our sample, the symptom-appraisal process did not appear to be correlated with the help-seeking process. This is understandable, because if someone does not believe their symptoms are indicative of a mental illness, they likely will not engage in thought about potential help-seeking. It may be helpful for future research to further explore the relationship between symptom appraisal and help seeking.

As Fiske (2000) explains, individuals who belong to a certain group tend to reject those who do not, so someone who does not have symptoms of a mental illness likely would not consider themselves to have the same group membership as someone who does.

To initiate investigation of this possibility, we subset our sample on the basis of SASS scores. The SASS proposes an "at risk" cut-off for participants who score in the top 5% of scores in the normative sample; this amounted to 17% of the time 1 participant sample. The relationship between the SELF-I and the LAM was examined specifically for participants who, according to

their SASS score, were likely experiencing mental health concerns at the time of data collection. We found that, for this subset of the population, the LAM and SELF-I had a significant negative correlation (r= -.473**, p<.01). Individuals who self-reported symptoms that could be consistent with a mental health concern, and who scored higher on the SELF-I, indicating that they appraise those symptoms as being indicative of mental illness, had lower label avoidance scores. The preliminary results of this exploratory aim suggest that stigma may be a barrier to symptom appraisal and once symptoms are appraised as being indicative of a mental health concern, avoidance of the mental illness label may not be as warranted. Future research is needed in order to more closely investigate if these scales perform differently for individuals who are experiencing mental health concerns compared to those who are not.

Examination of the discriminant validity evidence also resulted in interesting findings. We hypothesized that the LAM would be minimally and insignificantly correlated with the Adult Trait Hope Scale and the Marlow-Crowne Social Desirability Scale. Instead, the LAM was significantly negatively correlated with both of these scales (Table 6). These findings suggested that low hope and low social desirability were both associated with higher scores on our preliminary measure of label avoidance.

Snyder et al., (1991) define hope as goal-directed thinking, including agency and plans and pathways to meet goals. With this in mind, asking participants to consider how they may behave if they were experiencing symptoms of a mental health concern on the LAM may have resulted in participants considering potential goals and goal-directed behavior. This suggests that hope, as it relates to goal achievement, may be a separate but related construct to label avoidance, as measured by the LAM. Additionally, Corrigan et al. (2014) explain that recovery from mental illness is achieved when an individual replaces despair about their illness with hope

that achievement is possible. So, while hope may not have been closely correlated with other aspects of stigma, it is understandable that there may be some link between hope and label avoidance wherein high levels of label avoidance may be associated with low levels of hope. Corrigan (2004) discusses that individuals who avoid being labeled as having a mental illness escape negative public stigma statements that could lessen self-esteem. Hope and self-esteem have been found to be significantly and positively correlated. Thus, it appears that an individual who is low in trait hope may be more label avoidant as an attempt to protect their lower self-esteem from stigmatizing views (Snyder et al., 1991).

The construct of social desirability has been used to assess discriminant validity evidence in the previous development of new stigma scales (Vogel et al., 2006), so the insignificant correlation with the LAM suggests that the LAM may be assessing a different aspect of stigma than public and internalized stigma scales. A higher score on the social desirability scale indicates a higher tendency to report socially desirable statements. This would be expected to positively correlate to label avoidance, in accordance with the public stigma view that seeking mental health treatment is not socially desirable. It is unclear why the present study demonstrated that individuals with higher social desirability scores had lower label avoidance scores. Future research is warranted to examine the relationship between the avoidance of help-seeking and social desirability.

Limitations

There are a few important limitations to note. First, to orient participants to the LAM, we asked them to estimate what they might do in a future situation. Imaginal self-report methodology is fitting when trying to measure a lack of behavior (e.g., lack of engagement with healthcare), but it is important to remember that participants saying they might do something

does not necessarily mean they would definitely act in that certain way in the future. While our use of validity-check questions helps assess participant attentiveness, a large concern in self-report data, it is difficult to ascertain if participants were accurate in thinking about their potential behaviors. Further research is needed to investigate the predictive validity of the LAM.

Further, this investigation of a new label avoidance measure still only provides preliminary evidence that we are accurately capturing the construct of label avoidance. It is possible that there are other factors inhibiting an individual's interest in seeking mental health services, in addition to stigma. Corrigan (2004) notes that structural stigma, such as economic pressures, undermine care access. While the LAM asked participants to predict what they might do if they were experiencing symptoms of a mental illness, it is possible that in this hypothetical scenario participants factored access to care into their decisions.

Lastly, the nature of our sample also introduces some limitations. While we utilized MTurk to obtain a large sample of participants in the United States, these participants do not adequately represent the diversity of the US general population. The majority of participants were white, cisgender individuals, for example, and this does not reflect the demographic composition of the US at large. Future research should aim to assess patterns of label avoidance and the psychometric properties of the LAM in other samples of participants with broader representation of persons with minority identities. Additionally, it has been found that data collected from MTurk workers is comparable to data collected from undergraduate students (Difallah et al., 2018). It is also important to note that data were collected during the novel coronavirus pandemic. Replication of the present findings in an actual undergraduate sample is warranted, as is future research with participants who come from different socioeconomic strata.

Finally, it will be helpful to examine the preliminary psychometric characteristics of the LAM further, using data that are collected post-pandemic.

Conclusion

Ultimately, the findings of the current study provide preliminary support for the Label Avoidance Measure as a unitary scale to ascertain label avoidance in adults. Reliability analyses suggested that the LAM is a cohesive, stable measure. Additionally, some preliminary evidence suggested that label avoidance presents as a construct distinct from other types of stigma and social constructs such as hope. While future research and additional psychometric support are warranted, this study assisted in creating a more complex understanding of stigma as a treatment barrier and may help inform future interventions.

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Table 1

Self-reported characteristics of samples

	Measure Development (n = 41)	**Stage 1 (n = 232)**	**Stage 2 (n = 95)**
Age: m(SD)	26.3 (9.46)	43 (13.77)	44.1 (13.79)
Missing response	N = 0	N = 1	N = 0
Gender: n(%)			
Cis female	38 (93%)	124 (53%)	53 (56%)
Cis male	3 (7%)	104 (45%)	40 (42%)
Transgender/Agender	0 (0%)	3 (1%)	2 (2%)
Prefer not to disclose	0 (0%)	1 (.4%)	0 (0%)
Ethnicity: n(%)			
White/Caucasian	33 (80%)	176 (76%)	75 (79%)
Black/African American	0 (0%)	16 (7%)	4 (4%)
Other/prefer not to disclose	0 (0%)	15 (6%)	7 (7%)
Asian	0 (0%)	7 (3%)	3 (3%)
Biracial/Mixed	6 (15%)	7 (3%)	2 (2%)
Native American	0 (0%)	2 (1%)	2 (2%)
Hispanic	2 (5%)	2 (1%)	0 (0%)
Years of college completed: n(%)			
0	0 (0%)	25 (11%)	11 (11%)
1	7 (17%)	11 (5%)	6 (6%)
2	10 (24%)	33 (14%)	11 (11%)
3	8 (19%)	10 (4%)	6 (6%)
4	9 (22%)	108 (47%)	36 (38%)
5	7 (17%)	11 (5%)	4 (4%)
6+	0 (0%)	33 (14%)	21 (22%)
Missing response	0 (0%)	1 (.4%)	0 (0%)
SASS Scores: n(%)			
Below cut-off	-	150 (68%)	-
Above-average	-	32 (14%)	-
At-risk	-	38 (17%)	-

Table 2

Means for agreement/disagreement of statements indicative of label avoidance:

Statement	Mean (SD)
I would not want to be seen going into a mental health professional's office.	3.07 (1.14)
I would feel shame if I was seen going into a mental health professional's office.	2.86 (1.22)
I would think negatively about myself if I was seen going into a mental health professional's office.	2.83 (1.23)
I would avoid a mental health care support group.	2.67 (1.14)
I would avoid a mental health care support group in the fear that I would be seen as someone with a diagnosis of a mental health concern.	3.00 (1.31)
I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself.	2.88 (1.25)
I would approach a mental health information table in a public location.	3.14 (1.16)
I would feel confident approaching a mental health information table in the university center or other public area.	3.27 (1.13)
I would think highly of myself if I approached a mental health information table in the university center.	3.10 (1.12)
I would not want to be grouped together with people who have a diagnosis of a mental health concern.	2.79 (1.18)
I would be afraid to be seen as someone with a mental health diagnosis.	2.93 (1.22)
I would be think negatively about myself if I was grouped together with people who have a mental health diagnosis.	2.64 (1.27)
I would go to a healthcare professional to receive a diagnosis for a mental health concern.	2.77 (1.32)
I would go to a healthcare professional in the hopes of receiving a diagnosis for a mental health concern.	3.24 (1.10)
It would not hurt my self-image to go to a healthcare professional to receive a diagnosis for a mental health concern.	2.71 (1.37)
I would tell a healthcare professional about my mental health concern symptoms.	2.71 (1.35)
I am confident that I would tell my doctor about my mental health concern symptoms.	2.93 (1.31)
I would think poorly of myself if I told my doctor about my mental health concern.	2.79 (1.12)
I would avoid a clinic that would label me with a mental health concern.	3.08 (1.16)
I would feel ashamed to go to a clinic that would label me with a mental health concern.	3.10 (1.12)
I would have negative thoughts about myself if I went to a clinic that would label me with a mental health concern.	2.85 (1.22)
I would call an anonymous crisis line to receive support for mental health concerns.	2.43 (0.97)
I would not be concerned if I called an anonymous crisis line to receive support for mental health concerns.	2.86 (1.00)
I would hold myself in high regard if I called an anonymous crisis line to receive support for mental health concerns.	2.71 (1.09)

I would tell close friends that I have a diagnosis of a mental health concern.	2.88 (1.19)
I would not be scared to tell close friends that I have a diagnosis of a mental health concern.	2.95 (1.29)
I would not have negative thoughts about telling close friends I have a diagnosis of a mental health concern.	2.93 (1.20)
I would join a support group for people with mental health concerns	3.14 (1.03)
I would be comfortable joining a mental health support group.	3.14 (1.05)
I would think positively about myself if I joined a mental health support group.	3.07 (1.13)
I would not want a mental health concern diagnosis in my medical records.	3.14 (1.03)
I would be embarrassed to have a mental health concern diagnosis in my medical records.	3.10 (1.21)
I would think less of myself if I had a mental health diagnosis in my medical records.	2.90 (1.19)
I would seek treatment regardless of people's views of me concerning my mental health.	1.98 (1.30)
I would not seek treatment because other people's views of me would negatively change if I had a diagnosis of a mental health concern.	3.07 (1.26)
I would not seek treatment because other people would think I was weak if I had a diagnosis of a mental health concern.	3.05 (1.29)
I would not seek treatment because I do not want a mental health diagnosis.	2.93 (1.24)
I would not seek treatment because receiving a mental health diagnosis would make me think negatively about myself.	2.88 (1.25)
I would not seek treatment because I would feel embarrassed if I had a mental health diagnosis.	2.93 (1.28)
I would join a social media group (e.g. Facebook group) about a mental health concern.	3.14 (1.05)
I would be scared to post about myself in a social media group specific to a mental health concern.	2.95 (.94)
I would think badly of myself if I posted in a social media group specific to a mental health concern.	2.95 (1.09)

Table 3

Factor Analysis Component Matrix

	Component	
	1	2
1. I would not want to be seen going into a mental health professional's office.	.803	-.153
2. I would feel shame if I was seen going into a mental health professional's office.	.837	-.222
3. I would think negatively about myself if I was seen going into a mental health professional's office.	.843	-.206
4. I would avoid a mental health care support group.	.721	-.013
5. I would avoid a mental health care support group in the fear that I would be seen as someone with a diagnosis of a mental health concern.	.824	-.234
6. I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself.	.814	-.296
7. I would approach a mental health information table in a public location	.591	.562
8. I would feel confident approaching a mental health information table in a public location.	.603	.511
9. I would think highly of myself if I approached a mental health information table in a public location.	.527	.606
10. I would not want to be grouped together with people who have a diagnosis of a mental health concern.	.734	-.148
11. I would be afraid to be seen as someone with a mental health diagnosis.	.781	-.093
12. I would think negatively about myself if I was grouped together with people who have a mental health diagnosis.	.822	-.175
13. I would go to a healthcare professional to receive a diagnosis for a mental health concern.	.613	.361
14. I would go to a healthcare professional in the hopes of receiving a diagnosis for a mental health concern.	.573	.369
15. It would not hurt my self-image to go to a health care professional to receive a diagnosis for a mental health concern.	.686	.246
16. I would tell a healthcare professional about my mental health concern symptoms	.645	.297
17. I am confident that I would tell my healthcare professional about my mental health concern symptoms.	.637	.304
18. I would think poorly of myself if I told my healthcare professional about my mental health concern.	.723	-.409
19. I would avoid a clinic that would label me with a mental health concern.	.832	-.165
20. I would feel ashamed to go to a clinic that would label me with a mental health concern.	.862	-.251
21. I would have negative thoughts about myself if I went to a clinic that would label me with a mental health concern.	.842	-.223

22. I would call an anonymous crisis line to receive support for mental health concerns.	.330	.412
~~23. I would not be concerned if I called an anonymous crisis line to receive support for mental health concerns.~~	.384	.290
24. I would hold myself in high regard if I called an anonymous crisis line to receive support for mental health concerns.	.494	.616
25. I would tell close friends that I have a diagnosis of a mental health concern.	.526	.460
26. I would not be scared to tell close friends that I have a diagnosis of a mental health concern.	.538	.427
27. I would not have negative thoughts about telling close friends I have a diagnosis of a mental health concern.	.532	.436
28. I would join a support group for people with mental health concerns.	.564	.624
29. I would be comfortable joining a mental health support group.	.599	.636
30. I would think positively about myself if I joined a mental health support group	.628	.568
31. I would not want a mental health concern diagnosis in my medical records.	.687	-.095
32. I would be embarrassed to have a mental health concern diagnosis in my medical records.	.756	-.208
33. I would think less of myself if I had a mental health diagnosis in my medical records.	.796	-.237
34. I would not seek treatment because other people's views of me would negatively change if I had a diagnosis of a mental health concern.	.759	-.328
35. I would not seek treatment because other people would think I was weak if I had a diagnosis of a mental health concern.	.729	-.374
36. I would not seek treatment because I do not want a mental health diagnosis.	.837	-.234
37. I would not seek treatment because receiving a mental health diagnosis would make me think negatively about myself.	.828	-.314
38. I would not seek treatment because I would feel embarrassed if I had a mental health diagnosis.	.814	-.332
39. I would join a social media group (e.g., Facebook group) about a mental health concern.	.290	.589
40. I would be scared to post about myself in a social media group specific to a mental health concern.	.593	.015
41. I would think badly of myself if I posted in a social media group specific to a mental health concern.	.681	-.138
42. I would not research my current mental health experiences.	.567	-.365
43. I would hide or understate how my mental health is affecting me when interacting with family or friends.	.728	-.093
44. I would not mention my family history with mental health concerns for fear of being associated with it.	.780	-.218
45. I would avoid getting mental health accommodations and work or school.	.758	.011

46. I would understate my mental health concerns when asked about them directly in a medical setting (such as in paperwork or a conversation with a health professional).	.678	-.289

Extraction Method: Principal Component Analysis.

a. 7 components extracted.

Note: While 7 components were extracted, only the first two included items with meaningful factor loading. Items that were considered for a second factor are highlighted.

Table 4

LAM alpha if item deleted

Item	Alpha	Item	Alpha
I would not want to be seen going into a mental health professional's office.	.973	I would hold myself in high regard if I called an anonymous crisis line to receive support for mental health concerns.	.974
I would feel shame if I was seen going into a mental health professional's office.	.973	I would tell close friends that I have a diagnosis of a mental health concern.	.974
I would think negatively about myself if I was seen going into a mental health professional's office.	.973	I would not be scared to tell close friends that I have a diagnosis of a mental health concern.	.974
I would avoid a mental health care support group.	.974	I would not have negative thoughts about telling close friends I have a diagnosis of a mental health concern.	.974
I would avoid a mental health care support group in the fear that I would be seen as someone with a diagnosis of a mental health concern.	.973	I would join a support group for people with mental health concerns.	.974
I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself.	.973	I would be comfortable joining a mental health support group.	.974
I would approach a mental health information table in a public location	.974	I would think positively about myself if I joined a mental health support group	.974
I would feel confident approaching a mental health information table in a public location.	.974	I would not want a mental health concern diagnosis in my medical records.	.974
I would think highly of myself if I approached a mental health information table in a public location.	.974	I would be embarrassed to have a mental health concern diagnosis in my medical records.	.973
I would not want to be grouped together with people who have a diagnosis of a mental health concern.	.974	I would think less of myself if I had a mental health diagnosis in my medical records.	.973

I would be afraid to be seen as someone with a mental health diagnosis.	.973	I would not seek treatment because other people's views of me would negatively change if I had a diagnosis of a mental health concern.	.973
I would think negatively about myself if I was grouped together with people who have a mental health diagnosis.	.973	I would not seek treatment because other people would think I was weak if I had a diagnosis of a mental health concern.	.974
I would go to a healthcare professional to receive a diagnosis for a mental health concern.	.974	I would not seek treatment because I do not want a mental health diagnosis.	.973
I would go to a healthcare professional in the hopes of receiving a diagnosis for a mental health concern.	.974	I would not seek treatment because receiving a mental health diagnosis would make me think negatively about myself.	.973
It would not hurt my self-image to go to a health care professional to receive a diagnosis for a mental health concern.	.974	I would not seek treatment because I would feel embarrassed if I had a mental health diagnosis.	.973
I would tell a healthcare professional about my mental health concern symptoms	.974	I would join a social media group (e.g. Facebook group) about a mental health concern.	.975
I am confident that I would tell my healthcare professional about my mental health concern symptoms.	.974	I would be scared to post about myself in a social media group specific to a mental health concern.	.974
I would think poorly of myself if I told my healthcare professional about my mental health concern.	.974	I would think badly of myself if I posted in a social media group specific to a mental health concern.	.974
I would avoid a clinic that would label me with a mental health concern.	.973	I would not research my current mental health experiences.	.974
I would feel ashamed to go to a clinic that would label me with a mental health concern.	.973	I would hide or understate how my mental health is affecting me when interacting with family or friends.	.974
I would have negative thoughts about myself if I went to a clinic that would label me with a mental health concern.	.973	I would not mention my family history with mental health concerns for fear of being associated with it.	.973

I would call an anonymous crisis line to receive support for mental health concerns.	.975	I would avoid getting mental health accommodations and work or school.	.973
I would not be concerned if I called an anonymous crisis line to receive support for mental health concerns.	.975	I would understate my mental health concerns when asked about them directly in a medical setting (such as in paperwork or a conversation with a health professional).	.974

Table 5

Internal Consistency

	Cronbach's Alpha
Social Distance Scale	0.896
Self Stigma of Seeking Help Scale	0.881
Perceptions of Stigma by Others Scale	0.987
Social Desirability Scale	0.764
Adult Trait Hope Scale	0.907
Self-Identification as Having a Mental Illness Scale	0.812
Label Avoidance Measure Time 1	0.976
Label Avoidance Measure Time 2	0.980
Symptoms and Assets Screening Scale	0.960

Table 6

Convergent validity: Correlations among stigma measures

	1	2	3	4
1. SDS	-			
2. SSoSH	-.119	-		
3. PoSoH	.034	.547**	-	
4. SELF-I	.262**	.090	.146**	-
5. LAM	-.116	.744**	.619**	-.043

**correlation is significant at the 0.01 level (2-tailed)

Note. SDS = Social Distance Scale; SSoSH = Self-Stigma of Seeking Help; PoSoH = Perceptions of Stigmatization by Others for Seeking Help; SELF-I = Self-Identification as Having a Mental Illness; LAM = Label Avoidance Measure

Table 7

Discriminant validity

	1	2
1. MCSDS-Form XI	-	
2. Adult Trait Hope	.289**	-
3. LAM	-.309**	-.243**

**correlation is significant at the 0.01 level (2-tailed)

Note. MCSDS = Marlow-Crowne Social Desirability Scale; LAM = Label Avoidance Measure

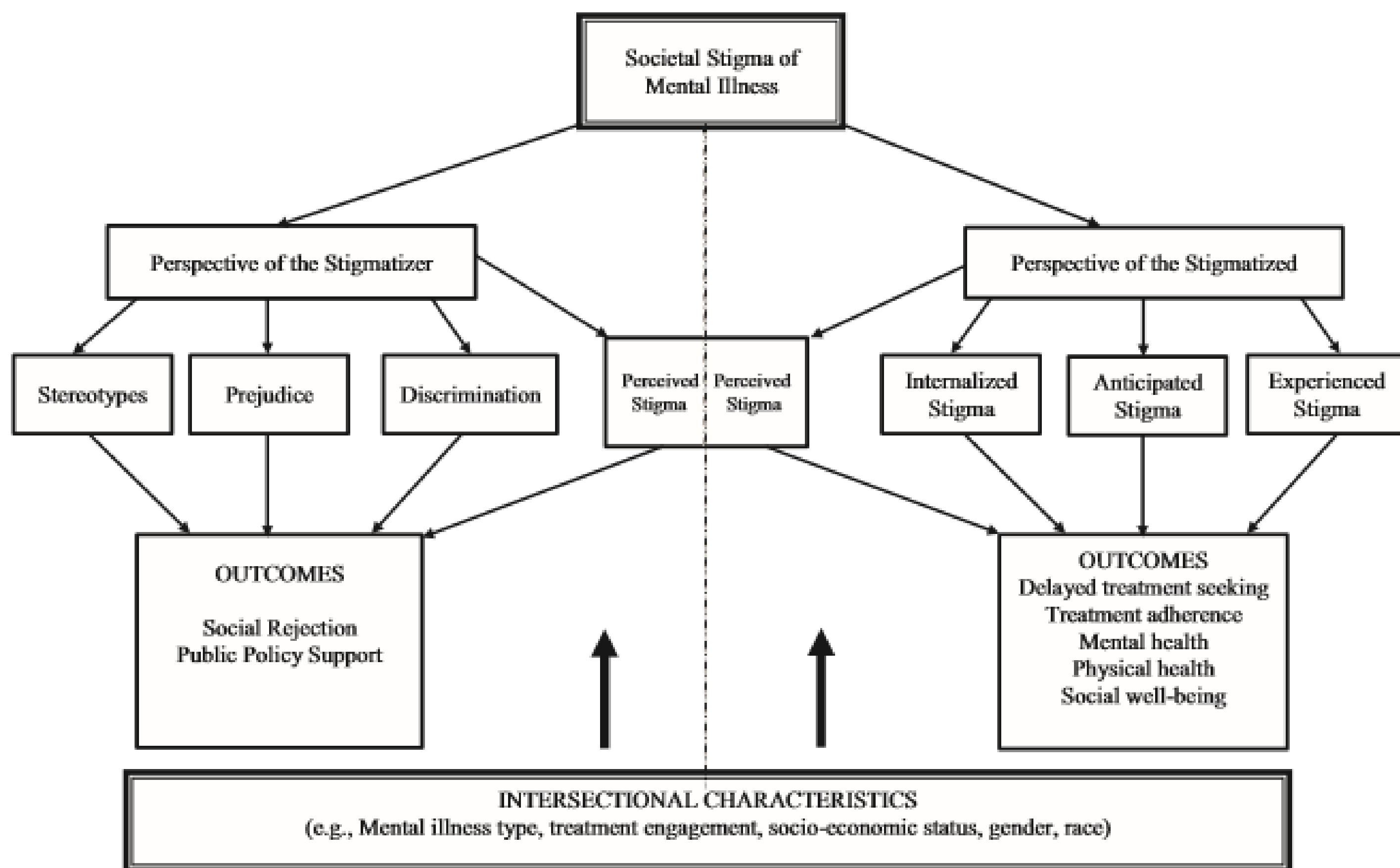

Figure 1. The mental illness stigma framework. (Reproduced with permission from Dr. Fox).

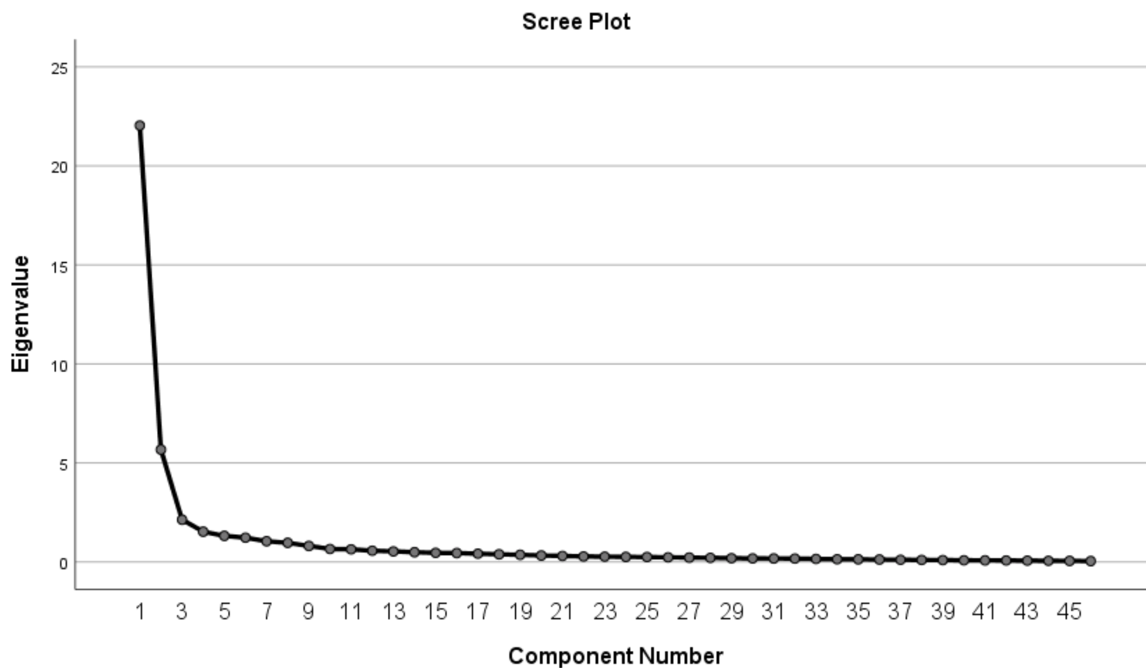

Figure 2. Label Avoidance Measure Scree Plot

Appendix A

Symptoms and Assets Screening Scale (SASS)

For each item please mark the box for Not True, A little True, Mostly True, or Certainly True based on how things have been for you **over the last month.** Please be as honest as possible and answer every question as best you can.

	Not True	A little True	Mostly True	Certainly True
I am often extremely tired or feel like I don't have enough energy				
I am very afraid of gaining weight or becoming fat				
I often feel happy				
I worry that I might panic when in new places or around new people				
I have difficulty limiting or cutting down on my use of alcohol or drugs				
I don't get any pleasure from most of the things I do throughout the day				
I skip meals or eat very little in order to lose weight or avoid gaining weigh				
I get so nervous that I sweat, can't breathe, shake, feel dizzy, or my heart beats fast				
I have one or more people in my life who I can always count on to be there for me				
I have done risky things when drinking or using drugs (e.g, drive, fight, unsafe sex)				
My appetite is disturbed (either increased or decreased compared to normal)				
My weight or shape has a very big influence on how I feel about myself				
I often feel worthless or guilty				
I often feel restless, tense, or on edge				
My drinking or drug use affects my attendance or performance in classes				
I feel confident and capable				
I am often unhappy, depressed, or tearful				
Sometimes I eat a lot more food than normal and can't seem to stop myself				
I often have difficulty falling or staying asleep				
My friends, family members, or I worry about my use of alcohol or drugs				
I often worry about things so much that I just can't seem to stop the worry				
I am optimistic and hopeful about the future				
If you read this question leave the answer blank				
I make myself vomit, use laxatives, or exercise a lot when I eat too much				
I feel hopeless				
I get scared easily or often feel afraid				
I sometimes hear voices or see things that aren't really there				
My drinking or drug use causes problems in my social or family relationships				
I often have difficulty concentrating or thinking clearly				
I feel good about myself				

Please turn over – there are a few more questions on the other side

Follow-up Questions

1) Overall, do you have problems with your emotions, behavior, thoughts, or relationships?

No, not at all Yes, a little Yes, a lot Yes, Extremely

If you answered "Yes," please answer questions 1a, 1b, 1c, and 1d:

1a) How long have you had the problems?

Less than 2 weeks 2 to 4 weeks 1 to 5 months 6 to 12 months Over a year

1b) Do the problems upset or distress you?

No, not at all Yes, a little Yes, a lot Yes, Extremely

1c) Do the problems upset or distress other people in your life (friends, family, etc.)?

No, not at all Yes, a little Yes, a lot Yes, Extremely

1d) Do the problems interfere with your everyday life in the following areas?	No, Not at all	Yes, A little	Yes, A lot	Yes, Extremely
Friendships	☐	☐	☐	☐
Family Relationships	☐	☐	☐	☐
Romantic Relationships	☐	☐	☐	☐
School or Work	☐	☐	☐	☐
Leisure Activities	☐	☐	☐	☐

2) Has there **ever** been a time in your life when you felt like you were 'on top of the world,' needed very little sleep (3 hours or less) for several days in a row, but you still felt energetic? **YES** or **NO** (Please circle)

3) Have you **ever** been diagnosed with a psychological problem or disorder? **YES** or **NO** (Please circle)

3a) If you answered "Yes," please indicate which specific disorders, when you were first diagnosed, and if you still have the disorder or problem.

Diagnosis ______________________ Age at diagnosis ____ Currently have diagnosis: **YES** or **NO**

Diagnosis ______________________ Age at diagnosis ____ Currently have diagnosis: **YES** or **NO**

Diagnosis ______________________ Age at diagnosis ____ Currently have diagnosis: **YES** or **NO**

4). Have you ever received professional help from a health care provider for a psychological disorder or problem? **YES** or **NO**

If you answered "Yes," please describe the nature of the help you received below.

4a) What kind of Health Care Provider helped you? (please circle all that apply):

Psychologist Social Worker Counselor Psychiatrist General Medical Doctor

Don’t remember

4b) What kind of help did you receive and how helpful was it? (Please place a check mark in front of the help you received & please circle how helpful it was to you).

_____ Medication (Med. Name: ________________________________):

Very helpful Somewhat helpful Not at all helpful

_____ Talk Therapy/Counseling:

Very helpful Somewhat helpful Not at all helpful

4c) Are you *currently* receiving professional help for a psychological disorder or problem? **YES** or **NO**

If you answered “Yes,” what kind of help are you currently receiving? (Please place a check mark in front of the help you currently receive)

_____ Medication

_____ Talk Therapy/Counseling

Appendix B

Social Distance Scale (SDS)

Here is a description of a 27-year-old man, let's call him Jim Johnson. About two years ago, he was hospitalized because of problems he was having related to severe depression. Now he appears to be doing pretty well. Jim works at a job in a local business. He earns enough money to make ends meet. He is well groomed and known for dressing neatly. At his job, he gets along well with his co-workers and is on friendly terms with them. He begins his days chatting briefly with the people he works with and then gets down to business. He takes coffee and lunch breaks during the day, just like everyone else, and returns to work when his co-workers do. While on the job, Jim checks his work carefully and doesn't pass

it along until it is correct. This might slow Jim down a little, but he is never criticized for the quality of the work he completes. Jim is interested in meeting someone to date in the community. He is considering joining a local church group to meet them. He is also looking for a job that gives him more responsibility and pays better than his current one.

Every once in a while Jim becomes frustrated with all the demands at work and says he feels anxious about them. Once when he felt this way, he got red in the face, went to a back room, and began pacing and complaining to a co -worker in an angry tone of voice. Later, he talked to some of the people he works with about the pressures he is sometimes under.

1.How would you feel about renting a room in your home to someone like Jim Johnson?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

2.How about as a worker on the same job as someone like Jim Johnson?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

3.How would you feel having someone like Jim Johnson as a neighbor?

1	2	3	4
Definitely	Probably	Probably	Definitely

Unwilling	Unwilling	Willing	Willing

4.How about as the caretaker of your children for a couple of hours?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

5.How about having a child of yours date someone like Jim Johnson?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

6.How would you feel about introducing Jim Johnson to someone you are friendly with?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

7.How would you feel about recommending someone like Jim Johnson for a job working for a friend of yours?

1	2	3	4
Definitely Unwilling	Probably Unwilling	Probably Willing	Definitely Willing

Appendix C

The Self Stigma of Seeking Help Scale

People at times find that they face problems for which they consider seeking help. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

Circle the number that corresponds to how you might react to each statement

1.	I would feel inadequate if I went to a therapist for psychological help.	1	2	3	4	5
2.	My self-confidence would NOT be threatened if I sought professional help.	1	2	3	4	5
3.	Seeking psychological help would make me feel less intelligent.	1	2	3	4	5
4.	My self-esteem would increase if I talked to a therapist.	1	2	3	4	5
5.	My view of myself would not change just because I made the choice to see a therapist	1	2	3	4	5
6.	It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
7.	I would feel okay about myself if I made the choice to seek professional help.	1	2	3	4	5
8.	If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
9.	My self-confidence would remain the same if I sought professional help for a problem I could not solve.	1	2	3	4	5
10.	I would feel worse about myself if I could not solve my own problems.	1	2	3	4	5

(Vogel et al., 2006)

Appendix D

Perceptions of Stigmatization by Others of Seeking Help

Read the following statement below and then respond to each item with a 5 point scale ranging from 1 (not at all) to 5 (a great deal).

"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

	Not at all				A great deal
1. Think of you in a less favorable way	1	2	3	4	5
2. Think bad things of you	1	2	3	4	5
3. React negatively to you	1	2	3	4	5
4. See you as seriously disturbed	1	2	3	4	5
5. Think you posed a risk to others	1	2	3	4	5
6. Think you were crazy	1	2	3	4	5
7. Be scared of you	1	2	3	4	5
8. See you as weak	1	2	3	4	5
9. Like you less	1	2	3	4	5
10. Say something negative about you to others	1	2	3	4	5
11. Be ashamed of you	1	2	3	4	5
12. Treat you like a child	1	2	3	4	5
13. See you as less attractive	1	2	3	4	5
14. Believe you were unpredictable	1	2	3	4	5
15. Think it was your fault	1	2	3	4	5
16. Deny you access to a job	1	2	3	4	5
17. Believe you were more violent and dangerous	1	2	3	4	5
18. Be angry with you	1	2	3	4	5
19. Be uncomfortable around you	1	2	3	4	5
20. Treat you differently	1	2	3	4	5
21. Believe that you could not handle things on your own	1	2	3	4	5

would _____."

(Vogel, Wade, & Ascheman, 2009)

Appendix E

Marlowe-Crowne Social Desirability Scale Short Form (MC-1(10))

Read each item and decide whether it is true (T) or false (F) for you. Try to work rapidly and answer each question by clicking on the T or the F.

1. I'm always willing to admit it when I make a mistake	T	F
2. I always try to practice what I preach	T	F
3. I never resent being asked to return a favor	T	F
4. I have never been irked when people expressed ideas very different from my own	T	F
5. I have never deliberately said something that hurt someone's feelings	T	F
6. I like to gossip at times	T	F
7. There have been occasions when I took advantage of someone	T	F
8. I sometimes try to get even rather than forgive and forget	T	F
9. At times I have really insisted on having things my own way	T	F
10. There have been occasions when I felt like smashing things	T	F

Appendix F

Worksheet 3.4 The Adult Trait Hope Scale (Snyder et al., 1991)

Directions: Read each item carefully. Using the scale shown below, please circle the number next to each item that best describes YOU.

1	2	3	4	5	6	7	8
Definitely False	Mostly False	Somewhat False	Slightly False	Slightly True	Somewhat True	Mostly True	Definitely True

1 2 3 4 5 6 7 8 1. I can think of many ways to get out of a jam

1 2 3 4 5 6 7 8 2. I energetically pursue my goals

1 2 3 4 5 6 7 8 3. I feel tired most of the time

1 2 3 4 5 6 7 8 4. There are lots of ways around any problem

1 2 3 4 5 6 7 8 5. I am easily downed in an argument

1 2 3 4 5 6 7 8 6. I can think of many ways to get the things in life that are most important to me

1 2 3 4 5 6 7 8 7. I worry about my health

1 2 3 4 5 6 7 8 8. Even when others get discouraged, I know I can find a way to solve the problem

1 2 3 4 5 6 7 8 9. My past experiences have prepared me for my future

1 2 3 4 5 6 7 8 10. I've been pretty successful in life

1 2 3 4 5 6 7 8 11. I usually find myself worrying about something

1 2 3 4 5 6 7 8 12. I meet the goals that I set for myself

Appendix G

Self-Identification as Having a Mental Illness-Scale (SELF-I)

Read the following statement below and then respond to each item with a 5 point scale ranging from 1 (don't agree at all) to 5 (agree a great deal).

1. My present problems could be the first signs of a mental disorder
2. The thought of myself having a mental illness seems absurd to me
3. I am the type of person that could be prone to having a mental illness
4. I see myself as a person that is mentally healthy and emotionally stable
5. I am mentally stable; I do not have a mental illness

(Schomerus et al., 2012)

Appendix H

Label Avoidance Measure (LAM)

Think about how much you would agree or disagree with each statement below if you were experiencing symptoms of a mental health concern. Choose one number for each statement. (1 = completely disagree, 6 = completely agree).

1. I would not want to be seen going into a mental health professional's office.
2. I would feel shame if I was seen going into a mental health professional's office.
3. I would think negatively about myself if I was seen going into a mental health professional's office.
4. I would avoid a mental health care support group.
5. I would avoid a mental health care support group in the fear that I would be seen as someone with a diagnosis of a mental health concern.
6. I would avoid a mental health care support group because being seen as someone with a mental health concern would make me think badly about myself.
7. I would approach a mental health information table in a public location
8. I would feel confident approaching a mental health information table in a public location.
9. I would think highly of myself if I approached a mental health information table in a public location.
10. I would not want to be grouped together with people who have a diagnosis of a mental health concern.
11. I would be afraid to be seen as someone with a mental health diagnosis.
12. I would think negatively about myself if I was grouped together with people who have a mental health diagnosis.
13. I would go to a healthcare professional to receive a diagnosis for a mental health concern.
14. I would go to a healthcare professional in the hopes of receiving a diagnosis for a mental health concern.
15. It would not hurt my self-image to go to a health care professional to receive a diagnosis for a mental health concern.
16. I would tell a healthcare professional about my mental health concern symptoms
17. I am confident that I would tell my healthcare professional about my mental health concern symptoms.
18. I would think poorly of myself if I told my healthcare professional about my mental health concern.
19. I would avoid a clinic that would label me with a mental health concern.
20. I would feel ashamed to go to a clinic that would label me with a mental health concern.
21. I would have negative thoughts about myself if I went to a clinic that would label me with a mental health concern.
22. I would call an anonymous crisis line to receive support for mental health concerns.

23. I would not be concerned if I called an anonymous crisis line to receive support for mental health concerns.
24. I would hold myself in high regard if I called an anonymous crisis line to receive support for mental health concerns.
25. I would tell close friends that I have a diagnosis of a mental health concern.
26. I would not be scared to tell close friends that I have a diagnosis of a mental health concern.
27. I would not have negative thoughts about telling close friends I have a diagnosis of a mental health concern.
28. I would join a support group for people with mental health concerns.
29. I would be comfortable joining a mental health support group.
30. I would think positively about myself if I joined a mental health support group
31. I would not want a mental health concern diagnosis in my medical records.
32. I would be embarrassed to have a mental health concern diagnosis in my medical records.
33. I would think less of myself if I had a mental health diagnosis in my medical records.
34. I would not seek treatment because other people's views of me would negatively change if I had a diagnosis of a mental health concern.
35. I would not seek treatment because other people would think I was weak if I had a diagnosis of a mental health concern.
36. I would not seek treatment because I do not want a mental health diagnosis.
37. I would not seek treatment because receiving a mental health diagnosis would make me think negatively about myself.
38. I would not seek treatment because I would feel embarrassed if I had a mental health diagnosis.
39. I would join a social media group (e.g., Facebook group) about a mental health concern.
40. I would be scared to post about myself in a social media group specific to a mental health concern.
41. I would think badly of myself if I posted in a social media group specific to a mental health concern.
42. I would not research my current mental health experiences.
43. I would hide or understate how my mental health is affecting me when interacting with family or friends.
44. I would not mention my family history with mental health concerns for fear of being associated with it.
45. I would avoid getting mental health accommodations and work or school.
46. I would understate my mental health concerns when asked about them directly in a medical setting (such as in paperwork or a conversation with a health professional).

Appendix I

Additional LAM statements generated by participants

We added five statements suggested by the participants to the preliminary Label Avoidance Measure. These five additional statements were:

- I would not research my current mental health experiences
- I would hide or understate how my mental health is affecting me when interacting with family or friends
- I would not mention my family history with mental health concerns for fear of being associated with it
- I would avoid getting mental health accommodations at work or school
- I would understate my mental health concerns when asked about them directly in a medical setting (such as in paperwork or a conversation with a health professional).