

Attitudes Toward Seeking Professional Help for an Eating Disorder: The Role of Stigma and Anticipated Outcomes

Ashley H. Hackler, David L. Vogel, and Nathaniel G. Wade

This study examined the relationship between self-stigma, anticipated risks and benefits associated with seeking counseling, and attitudes toward seeking counseling among college students with disordered eating attitudes and behaviors. The results of hierarchical regression analyses demonstrated that self-stigma and the anticipated risks and benefits significantly predicted attitudes toward counseling for people with disordered eating. In addition, self-stigma had a stronger relationship with men's attitudes toward counseling than with women's, and anticipated benefits had a stronger relationship with women's attitudes toward counseling than with men's.

Although between 5% and 17% of college students have an eating disorder such as anorexia nervosa or bulimia nervosa (Becker, Franko, Nussbaum, & Herzog, 2004; Prouty, Protinsky, & Canady, 2002), little is known about the determinants of help-seeking decisions for people experiencing or at risk for an eating disorder. This is a significant omission in the literature because only a small percentage of people seek professional help for eating-related issues (Becker et al., 2004; Cachelin & Striegel-Moore, 2006; Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000). For example, researchers have reported that less than 45% of individuals with a diagnosed eating disorder ever receive treatment (Cachelin & Striegel-Moore, 2006; Striegel-Moore et al., 2000), and only 17% of those identified as at risk for an eating disorder report seeking help for the problem (Becker et al., 2004). The substantial number of individuals who do not receive treatment indicates a need to better understand the factors involved in the help-seeking decisions of those experiencing and at risk for an eating disorder. This need is also important because researchers have found that eating disorders often are associated with a severe and chronic course of illness, including numerous psychological (e.g., depression, anxiety, alcohol and substance abuse) and medical comorbidities (e.g., reproductive problems, osteoporosis, cardiovascular problems) (Fairburn & Brownell, 2002; Pike & Striegel-Moore, 1997). Not surprisingly, researchers have noted the need to explore specifically the barriers to seeking help among those at risk for disordered eating attitudes and behaviors to implement effective interventions for these barriers (Meyer, 2001). The current study examines the roles of self-stigma and the anticipated risks and benefits of counseling in predicting attitudes toward counseling among a sample of individuals currently at risk for an eating disorder. This study also explores the role of gender in moderating these effects.

Help Seeking Among Individuals At Risk for an Eating Disorder

In the last decade, researchers have started to examine the barriers to seeking help for individuals with unhealthy eating attitudes and behaviors. One of the barriers noted by researchers is the desire to keep the symptoms of the disorder a secret. For example, in a sample of high school students, Meyer (2001) found that the desire to keep eating issues private was an important reason for not seeking help. Similarly, college students who exhibit patterns of disordered eating tend to hide such problems from most of the people in their life and report that, initially, not seeking help is an attempt to hide their disorder (Oliver, Reed, Katz, & Haugh, 1999; Schwitzer, Rodriguez, Thomas, & Salimi, 2001).

One reason individuals may try to hide their symptoms is fear of being labeled as having a mental illness and the stigmatization resulting from this label (Corrigan, 2004). Stigmatization can lead to negative reactions from others and, what is even more insidious, to *self-stigmatization*: the internalization of the negative beliefs held by society that can lead to the individual viewing himself or herself in a negative manner (Corrigan, 2004). The self-stigma associated with being labeled as having a mental illness has been linked to decreased self-esteem (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001), and in the general help-seeking literature, self-stigma has been found to be negatively related to attitudes toward seeking counseling (Vogel, Wade, & Haake, 2006; Vogel, Wade, & Hackler, 2007). Although self-stigma has not yet been studied in relation to eating disorders, one study found that individuals experiencing symptoms of an eating disorder might have negative attitudes about seeking help because of a fear of being labeled (Cachelin & Striegel-Moore, 2006). Similarly, three studies have found that the shame associated with seeking counseling may be crucial in the formation of attitudes about seeking counseling for people with disordered

Ashley H. Hackler, David L. Vogel, and Nathaniel G. Wade, Department of Psychology, Iowa State University. Correspondence concerning this article should be addressed to Ashley H. Hackler, Department of Psychology, Iowa State University, W112 Lagomarcino Hall, Ames, IA 50011-3180 (e-mail: ahackler@iastate.edu).

eating (Cachelin & Striegel-Moore, 2006; Meyer, 2001; Pike & Striegel-Moore, 1997). Specifically, it has been suggested that individuals may experience shame and self-loathing and may be in therapy for prolonged periods before disclosing issues related to disordered eating (Pike & Striegel-Moore, 1997). Therefore, this study directly examines the role of self-stigma in determining the help-seeking attitudes of individuals who are at risk for an eating disorder.

A second factor that researchers have noted as a potential barrier to seeking help for individuals at risk for an eating disorder is the anticipated consequence of undergoing therapy. Consistent with the more extensive body of help-seeking research, it has been found that people's decision to seek counseling is linked to their perceptions of the anticipated risks and benefits of seeking counseling (Vogel & Wester, 2003). Researchers have defined *anticipated risks* as the perception of the potential threats associated with opening up to a counselor (Vogel & Wester, 2003). Consistent with this definition, in a study of group psychotherapy for eating issues, Wanlass, Moreno, and Thompson (2005) found that participants reported several concerns about therapy, such as difficulty trusting others and not feeling safe in the group. In addition, individuals with eating issues were found to fear treatment because it might lead to weight gain (Pike & Striegel-Moore, 1997). *Anticipated benefits* of seeking counseling have been defined as the perceived utility of discussing personal issues with a counselor (Vogel & Wester, 2003). Researchers have established the importance of these anticipated outcomes both in general samples (Shaffer, Vogel, & Wei, 2006; Vogel & Wester, 2003) and for individuals with symptoms of psychological distress (Vogel, Wester, Wei, & Boysen, 2005). Therefore, whereas few studies have examined the different anticipated outcomes that individuals at risk for an eating issue may perceive about counseling, the initial findings suggest that people with unhealthy eating attitudes and behaviors may anticipate a number of risks and few benefits associated with seeking counseling. The goal of this study is to expand these findings about anticipated risks and benefits of seeking counseling to individuals who are at risk for an eating disorder.

Gender and Help Seeking

Another omission in the extant research on the barriers to seeking counseling for eating-related issues is the focus on gender. Most studies have only focused on women. Although more women than men experience eating disorders (the lifetime prevalence rate of any eating disorder is as high as 17.9% for women and between 6.5% and 10% for men; Kjelsas, Bjornstrom, & Gotestam, 2003; Weltzin et al., 2005), the rate of the prevalence of eating issues for men is increasing (Harvey & Robinson, 2003). Therefore, teasing out the unique factors for women and men is important if counselors want to develop the most effective interventions to increase help-

seeking behaviors. Researchers have clearly shown that the help-seeking decisions of women and men are not the same. For example, women are more likely than men to seek help for emotional issues (Moller-Leimkuhler, 2002), and women consistently report more positive attitudes toward counseling than do men (Fischer & Farina, 1995). One reason for these differences may be that men perceive greater stigma associated with seeking counseling. Society considers counseling to be a last resort, something to use only after other sources of support have failed (Angermeyer, Matschinger, & Riedel-Heller, 1999). Such attitudes may be particularly salient for men, who are expected by society to be independent and in control and for whom seeking therapy may mean admitting to the inability to handle things on their own (Addis & Mahalik, 2003). Therefore, if a man believed that he needed counseling, he might experience a greater sense of failure (i.e., increased self-stigma and anticipated risk and decreased anticipated benefits), which would make the act of asking for help particularly difficult. Consistent with this is the fact that undergraduate men have reported higher levels of self-stigma than are reported by their female counterparts (Vogel et al., 2006). Nevertheless, researchers have not examined the potential moderating effects of gender on men's and women's help-seeking behavior for disordered eating. Therefore, the current study examined the interaction of gender, self-stigma, anticipated risk, and anticipated benefits on attitudes toward seeking counseling.

The Current Study

Researchers have stressed the crucial need to better understand the specific reasons for which individuals who are experiencing unhealthy eating attitudes and behaviors avoid seeking help (Meyer, 2001; Pike & Striegel-Moore, 1997). Such knowledge could lead to more effective outreach programs and interventions aimed at increasing the likelihood of seeking help for an eating disorder. The goal of the current study was to add to the current body of research by examining the roles of self-stigma and the anticipated risks and benefits of counseling in predicting attitudes toward counseling among a sample of individuals who are currently at risk for an eating disorder. We used hierarchical regression analyses to develop a model for predicting attitudes toward counseling on the basis of individuals' self-stigma and anticipated risks and benefits associated with counseling. We hypothesized that for people experiencing disordered eating attitudes and behaviors, self-stigma and anticipated risks and benefits would predict attitudes toward seeking counseling. Specifically, anticipated benefits would positively predict attitudes toward seeking counseling, whereas self-stigma and anticipated risks would negatively predict attitudes toward counseling. In addition, we hypothesized a significant interaction effect for gender. On the basis of women's general tendency to experience more positive attitudes toward counseling (Fischer & Farina, 1995)

and men's tendency to experience more stigma associated with seeking counseling (Vogel et al., 2006), we hypothesized that there would be a moderating effect of gender on the relationship between each of the variables (i.e., self-stigma, anticipated risks, and anticipated benefits) and attitudes toward seeking counseling such that these relationships would be stronger for men than for women.

Method

Participants

Students from undergraduate psychology courses at a large midwestern university who met the criteria for disordered eating (score of 20 or higher on the Eating Attitudes Test [EAT-26]; Garner, Olmstead, Bohr, & Garfinkel, 1982) constituted the sample. Of the 658 participants surveyed, 145 (22%) of the students met the cut-off score on the EAT-26 and were thus included in this analysis. A power analysis with power set at .8, seven predictor variables in the regression model, and the assumption of a medium effect indicated that the study should include at least 103 participants, which suggests that the sample of 145 was sufficient. The percentage of students who met the cut-off score on the EAT-26 in this sample is slightly higher than it was for previous research using the EAT-26 with college students (i.e., 17%; Prouty et al., 2002). The majority of the sample was female (85.5%) and European American (88.1%). Students identifying as African American (5.6%), multiracial American (2.8%), Asian American (1.4%), Native American (1.4%), and international (0.7%) constituted the rest of the sample. The proportion of students from various racial and ethnic backgrounds was representative of the undergraduate student population of the university where the study took place.

Measures

Eating attitudes. The EAT-26 (Garner et al., 1982) is a widely used self-report screening measure for the symptoms of anorexia nervosa and bulimia nervosa. The EAT-26 is a shortened version of the original 40-item EAT (Garner & Garfinkel, 1979). Garner et al. (1982) eliminated 14 items from the EAT after running factor analysis that determined the items to be redundant. The EAT-26 has three subscales measuring dieting, oral control, and bulimia and food preoccupation. In addition, a total score can be calculated, and a cut-off of 20 for this score is used to signify high disordered eating (Garner & Garfinkel, 1979; Nelson, Hughes, Katz, & Searight, 1999). The EAT-26 is scored on a 6-point Likert-type scale ranging from 0 (*always*) to 5 (*never*). Participants are asked to indicate how often each of the items in the questionnaire applies to them. Responses are then weighted from 0 to 3, with a response of *always* equaling 3 points, *usually* equaling 2 points, and *often* equaling 1 point. Responses of *sometimes*, *rarely*, or *never* equal zero points. Item 26 is reverse scored. The resulting total score can range from 0 to 75. The EAT-26

has been used in studies both in the United States and abroad (e.g., Nelson et al., 1999). The EAT-26 Dieting subscale and the Bulimia and Food Preoccupation subscale were found to correlate with the difficulties identifying feelings ($r = .24$ and $r = .35$, respectively) and difficulties describing feelings ($r = .20$ and $r = .31$, respectively; Miller, Schmidt, Vaillancourt, McDougall, & Laliberte, 2006). Researchers estimate the internal consistency for the total EAT-26 to be .90 in college samples (Garner et al., 1982; Miller et al., 2006). Researchers have also found the EAT-26 to have acceptable reliability for men ($\alpha = .76$ to $.81$) and women ($\alpha = .79$ to $.89$; see Greenberg, Cwikel, & Mirsky, 2007; Koenig & Wasserman, 1995).

Self-stigma. Individuals' view of themselves if they were to seek counseling for an eating disorder was measured with the Self-Stigma of Seeking Help Scale (SSOSH; Vogel et al., 2006). The SSOSH is a 10-item scale, with items measured on a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The SSOSH has no subscales and Items 2, 4, 5, 7, and 9 are reverse scored. Vogel et al. (2006) reported internal consistency ($\alpha s = .86$ to $.90$) and 2-week test-retest reliability ($r = .72$). Vogel et al. (2006) also found the SSOSH to correlate with attitudes toward seeking counseling ($r s = -.53$ to $-.63$) and intentions to seek professional help ($r s = -.32$ to $-.38$). For the current sample, the coefficient alpha for the SSOSH was .91.

Attitudes toward seeking counseling. Attitudes toward seeking counseling were measured with the Attitudes Toward Seeking Professional Psychological Help—Short Form (ATSPPH-SF; Fischer & Farina, 1995). Scale instructions for this measure were modified to refer to seeking help for an eating disorder. Items are rated on a 4-point scale ranging from 1 (*disagree*) to 4 (*agree*). There are no subscales for the ATSPPH-SF, and Items 2, 4, 8, 9, and 10 are reverse scored. Fischer and Farina (1995) found that the ATSPPH-SF is correlated with the original version ($r = .87$); they also reported 1-month test-retest ($r = .80$) and internal consistency ($r = .84$) reliabilities. Fischer and Farina (1995) have used the ATSPPH-SF to distinguish individuals who have positive attitudes about seeking counseling for a psychological problem from those who do not. In addition, Vogel et al. (2005) found the ATSPPH-SF to correlate negatively with self-concealment tendencies ($r = -.19$) and positively with intentions to seek counseling for psychological concerns ($r = .56$; Vogel et al., 2005). For the current sample, the coefficient alpha for the ATSPPH-SF was .85.

Anticipated risks and anticipated benefits. We used the Disclosure Expectations Scale (DES; Vogel et al., 2005) to assess anticipated risks and anticipated benefits of talking to a counselor about a psychological problem. We modified scale instructions for this measure to refer to seeking help for an eating disorder. Instructions for the current study read, "Imagine you had an eating disorder that needed to be treated by a mental health professional." All eight items on the DES are rated on a 5-point Likert-type scale ranging from 1 (*not at*

all) to 5 (very). The eight items are divided into two subscales: Anticipated Risks and Anticipated Benefits. A sample item for the Anticipated Benefits subscale is "If you were dealing with an emotional problem, how beneficial for yourself would it be to self-disclose personal information about the problem to a counselor?" A sample item for the Anticipated Risks subscale is "How worried about what the other person is thinking would you be if you disclosed negative emotions to a counselor?" Responses for each subscale are totaled, with higher scores representing more anticipated risk and more anticipated benefits. The Anticipated Risks subscale correlates positively with self-concealment ($r = .26$) and negatively with self-disclosure ($r = -.17$). Vogel and Wester (2003) found the Anticipated Benefits subscale to correlate positively with self-disclosure ($r = .24$) and negatively with self-concealment ($r = .12$; Vogel & Wester, 2003). Vogel et al. (2005) found the internal consistency to be .81 for the Anticipated Benefits subscale and .80 for the Anticipated Risks subscale (Vogel et al., 2005). For the current sample, the coefficient alpha was .86 for the Anticipated Risks subscale and .82 for the Anticipated Benefits subscale.

Procedure

Participants were contacted through their psychology classes and asked to participate in the study. We obtained the university's institutional review board approval prior to contacting participants. Participants read and signed an informed consent before completing the EAT-26, the SSOSH, the ATSPPH-SF, the DES, and demographic questions regarding gender, ethnicity/race, and year in school. After completing the survey, participants read a debriefing statement. Participation in this study was voluntary, and participants received 2 points of credit in their psychology class for their participation.

Results

Table 1 lists the zero-order correlations, means, and standard deviations for the five observed variables. To examine the role of anticipated risks, anticipated benefits, self-stigma, and gender in predicting attitudes toward seeking counseling among

people who met the cut-off for disordered eating (i.e., above 20 on the EAT-26; Garner et al., 1982), we conducted a hierarchical regression analysis to determine the unique and combined effects that each independent variable had on attitudes toward seeking counseling. Four predictor variables of help-seeking attitudes were included in Step 1 of the model: (a) anticipated risks (measured by the DES subscale); (b) anticipated benefits (measured by the DES subscale); (c) self-stigma (measured by the SSOSH), and (d) participants' gender (0 = male, 1 = female). The order in which the predictor variables were entered into the model was determined before data collection and analysis. In Step 1 of the regression, anticipated risks, anticipated benefits, self-stigma, and participants' gender were included. In Step 2, we added the interaction terms between gender and self-stigma, gender and anticipated risks, and gender and anticipated benefits of seeking counseling to the model to examine the possible moderating effects of gender. Before creating the interaction terms, the continuous variables (anticipated risks, anticipated benefits, and self-stigma) were standardized by calculating z scores to reduce multicollinearity among the predictor variables and their interaction terms (see Cohen, Cohen, West, & Aiken, 2003).

We hypothesized that anticipated risks, anticipated benefits, self-stigma, and gender would have a significant relationship with attitudes toward seeking counseling. Consistent with this, the overall hierarchical regression analysis (see Table 2) was significant, $F(4, 144) = 47.63, p < .05; R = .76, R^2 = .58, \text{adj. } R^2 = .57$. Furthermore, each of the predictor variables (anticipated risks, $\beta = -.12$, semipartial correlation = $-.11$); anticipated benefits, $\beta = .38$, semipartial correlation = $.34$; self-stigma, $\beta = -.44$, semipartial correlation = $-.39$) except gender had unique and significant effects on attitudes toward seeking counseling for people who met the cut-off for disordered eating. We also hypothesized that there would be an interaction between gender and self-stigma, gender and anticipated risks, and gender and anticipated benefits. Step 2 of the analysis, with the inclusion of the interaction terms was also significant, $F(7, 144) = 28.92, p < .05; R = .77, R^2 = .60, \text{adj. } R^2 = .58$. The hypothesized interaction of self-stigma and gender as well as anticipated benefits and gender had a unique relationship with attitudes toward seeking counseling, although the interaction between gender and anticipated risks was not significant (see Table 2). It is important that the significant interaction terms added meaningfully to the model over and above the variables in Step 1 ($\Delta R^2 = .02, p < .05$). Thus, gender alone did not have a unique association with attitudes but when added to the model as part of an interaction term, it had a significant moderating effect on self-stigma and anticipated benefits, but not on anticipated risks. We used the regression equation $\hat{y} = b_0 + b_1x_1 + b_2x_2 + b_3(x_1x_2)$ to calculate the predicted attitude scores resulting from the interaction between gender and self-stigma as well as the interaction between gender and anticipated benefits. Analysis of the first interaction indicated that there was a significant negative re-

TABLE 1

Zero-Order Correlations, Means, and Standard Deviations Among the Five Observed Variables

Variable	1	2	3	4	5	M	SD
1. DES1	—	-.24*	.31*	.34*	.03	13.03	4.10
2. DES2		—	-.42*	.61*	-.10	13.34	3.80
3. SSOSH			—	-.65*	.14	28.21	8.20
4. ATSPPH-SF				—	.00	26.00	6.37
5. EAT-26 Total					—	28.30	7.60

Note. $N = 145$. DES1 = Disclosure Expectations Scale, Anticipated Risks subscale; DES2 = Disclosure Expectations Scale, Anticipated

Benefits subscale; SSOSH = Self-Stigma of Seeking Help Scale; ATSPPH-SF = Attitudes Toward Seeking Professional Psychological Help—Short Form; EAT-26 = Eating Attitudes Test-26.

* $p < .05$.

TABLE 2

Summary of Hierarchical Regression Analysis for the Prediction of Attitudes Toward Seeking Counseling

Step	B	SE _b	β	SPC	t
Step 1					
Constant	24.55	0.94			
Anticipated risks	-0.77	0.38	-.12	-.11	2.03*
Anticipated benefits	2.44	0.40	.38	.34	6.17*
Self-stigma	-2.80	0.40	-.44	-.39	-7.03*
Participants' gender	1.00	1.02	.09	.09	1.00
Step 2					
Constant	24.11	1.05			
Anticipated risks	-0.93	0.88	-.15	-.06	-1.06
Anticipated benefits	0.38	1.11	.06	.02	0.34
Self-stigma	-5.03	1.00	-.79	-.27	-5.05*
Participants' gender	2.12	1.12	.12	.10	1.90
Gender $\times$ Anticipated Risks	0.07	0.97	.01	.01	0.07
Gender $\times$ Anticipated Benefits	2.33	1.19	.34	.17	1.97*
Gender $\times$ Self-Stigma	2.62	1.09	.38	.13	2.41*

Note. $N = 145$. Step 1: $F(4, 144) = 47.63, p < .05, R = .76, R^2 = .58$, adj. $R^2 = .57$. Step 2: $F(7, 144) = 28.92, p < .05, R = .77, R^2 = .60$, adj. $R^2 = .58, \Delta R^2 = .02$. SPC = semipartial correlation.

* $p < .05$.

relationship between self-stigma and attitudes toward seeking counseling for men but not for women (see Figure 1). Analysis of the second interaction showed that anticipated benefits were positively related to attitudes toward seeking counseling for women but not for men (see Figure 1).

Discussion

Researchers have argued for the need to better understand the specific reasons for which people avoid seeking help when experiencing symptoms associated with eating disorders (Meyer, 2001; Pike & Striegel-Moore, 1997). Greater understanding should lead to effective interventions that increase the likelihood of seeking help for an eating disorder. Meeting this need, the findings from this study demonstrate that both self-stigma

and anticipated outcomes of seeking counseling play a role in the attitudes toward seeking counseling for people who are experiencing unhealthy eating attitudes and behaviors. This is an important step in improving the understanding of this issue because prior to this research little was known about the determinants of help-seeking attitudes among this population. Without this knowledge and its possible implications, a large segment of college students who are at risk for eating disorders may go without assistance. This issue has been particularly problematic given that very few college students seek help for eating-related issues (Becker et al., 2004; Cachelin & Striegel-Moore, 2006; Striegel-Moore et al., 2000), and individuals with eating disorders often experience numerous psychological and medical comorbidities (Fairburn & Brownell, 2002; Pike & Striegel-Moore, 1997).

The current findings are consistent with previous research findings that people tend to avoid counseling because of several psychological factors, including self-stigma (Vogel et al., 2006) and the anticipated outcomes of seeking counseling (Vogel & Wester, 2003). Specifically, as in Vogel et al.'s (2006) study, self-stigma was found to be the strongest unique predictor of help-seeking attitudes (current study, $\beta = -.44$; in Vogel et al., 2006, $\beta = -.40$) such that participants who perceived greater self-stigma associated with seeking counseling had less positive attitudes toward seeking treatment. Similarly, an individual's anticipated benefits and anticipated risks showed effects similar to those found in previous research (Vogel & Wester, 2003). Participants who anticipated greater risks and fewer benefits associated with seeking counseling had less positive attitudes toward seeking counseling. The findings of the current study are also consistent with the limited research focusing on eating issues. For example, women at risk for an eating disorder may avoid seeking help because of concerns about feeling shame (i.e., self-stigma; Cachelin & Striegel-Moore, 2006) and fear of being labeled (i.e., desire to avoid stigma; Cachelin & Striegel-Moore,

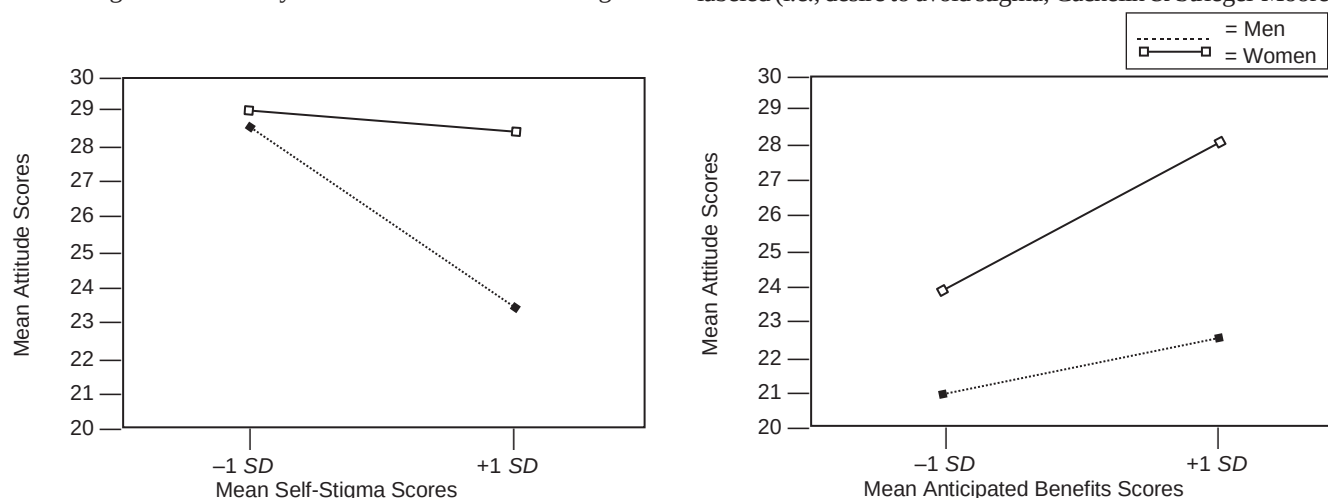


FIGURE 1

Interaction Between Gender and Self-Stigma and Gender and Anticipated Benefits on Attitudes Toward Seeking Counseling

2006). However, it is important to note that in the current study, the EAT-26 did not correlate significantly with any of the other measures. This is likely due to the restricted range of EAT-26 scores because participants were only included for analysis in this study if they met the cut-off score of 20.

The findings of the current study also add to the previous literature by empirically demonstrating the moderating role of gender on several factors associated with attitudes toward seeking counseling. Although it is possible that the low number of men in the sample could have limited detection of some differences (e.g., gender did not moderate the effect of anticipated risks), even with fewer men in the sample, the current results clearly showed that men's attitudes were more strongly linked with self-stigma than were women's attitudes. In other words, as self-stigma increased, positive attitudes decreased for women, but this effect was even more pronounced for men. In addition, women's attitudes toward seeking counseling were more positively related to the anticipated benefits than were men's attitudes toward seeking counseling. As anticipated benefits of seeking counseling increased, attitudes toward seeking counseling became more positive for women, but were less so for men. Previous research suggests that men tend to have negative attitudes toward seeking counseling (Tata & Leong, 1994) and perceive more self-stigma associated with seeking counseling (Vogel et al., 2007). Thus, the findings from this study provide empirical support for previous assertions by researchers that women and men may experience different social consequences related to the expression of psychological issues or symptoms. Given these results, researchers in future studies may want to expand on these findings by examining larger samples of both women and men.

Regarding knowledge of the role of self-stigma, anticipated risks, and anticipated benefits in determining attitudes toward seeking counseling for people with disordered eating, the results of this study extend previous findings by examining the specific role of several help-seeking correlates for people with disordered eating. In addition, the results of this study demonstrate the importance of continuing to investigate help-seeking behavior and attitude determinants for populations at risk for specific disorders or for clinical populations to ensure that the people who are in distress seek the help they need. Most studies of help seeking have focused on nonclinical populations. Extending those findings to populations in need, as we have done in the current study, will clarify which factors are most important to focus on for specific issues.

Future Research

The findings from the current study can be used to design future interventions aimed at improving attitudes toward seeking counseling for eating issues. Specifically, interventions may need to be tailored to reflect gender differences to effectively improve attitudes toward seeking counseling for eating issues. For instance, researchers may want to focus on ways to make interventions to address self-stigma more salient to men while making the anticipated benefits more

salient to women. Researchers may also want to assist in this process by examining what mediating factors (e.g., societal pressures, masculine and feminine gender norms) influence the relationship between women's and men's self-stigma and anticipated outcomes and attitudes toward seeking counseling. Thus, additional research will be necessary to gain a better sense of how to tailor interventions to address the differences between men's and women's attitudes toward seeking counseling for eating issues.

Study Limitations

An important strength of this study is that it used a sample of people currently experiencing unhealthy eating attitudes and behaviors to examine attitudes toward seeking counseling, thus extending previous research to a specific at-risk population. Future researchers should continue to focus on people currently experiencing unhealthy eating attitudes and behaviors as well as people experiencing other clinical symptoms to continue to extend the understanding of help-seeking factors for such populations. Despite this strength, the main limitation of this study is the difficulty in generalizing the findings to all individuals experiencing eating issues. Specifically, the current sample was characterized by lack of diversity in terms of ethnicity/race and age. Participants were from a large midwestern university in which the majority identified as European American. In addition, the majority of participants reported being either freshman or sophomores in college. Different groups may respond differently to the role of self-stigma, public stigma, anticipated risks, anticipated benefits, and attitudes toward seeking counseling. For instance, depending on their own ethnic/racial and cultural backgrounds, people may perceive more or less stigma and anticipated outcomes associated with seeking counseling. Thus, it is important to reach a diverse sample to gain a better understanding of the cultural and ethnic/racial differences related to help seeking. The current sample may also limit the ability to generalize to other areas of the United States or to other cultures. In addition, participants were recruited because of their enrollment in undergraduate psychology courses. Future researchers should try to reach a broader, more diverse sample on college campuses as well as in the community. One way to reach a diverse range of individuals would be to use the National Eating Disorders Screening Program (n.d.).

Conclusion

This study is the first to assess the relationship of self-stigma, anticipated risks, and anticipated benefits with attitudes toward seeking counseling for individuals currently experiencing unhealthy eating attitudes and behaviors. In addition, one of the main implications of this study is that it is important to further explore the effects of attitudes, stigma, anticipated risks, and anticipated benefits on help-seeking decisions by gender. Future interventions should accommodate these differences and either design separate interventions for men and women

or ensure that elements that correlate with change for both men and women are included in the treatment. In addition to their implications for future research, one practical implication of the current findings is not only that future studies should focus on reaching men and women, but that clinicians should be cognizant of gender differences regarding help seeking in clinical work with clients. These findings may lead counseling professionals to increased awareness of the gender differences in clients' views and feelings about counseling. Similarly, in participating in outreach activities in the community and making referrals, it is important to keep in mind that men and women may see counseling differently and may be affected differently by self-stigma, anticipated outcomes, and attitudes toward seeking counseling.

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