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Predictors of Perceived Anxiety Disorder Stigma in Adults with Anxiety Disorders

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Walden University
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Abstract

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MA, Western Michigan University, 2014

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Licensed professional counselors strive to eliminate systemic barriers to mental health treatment. Perceived anxiety disorder stigma may be a barrier to mental health treatment for those who are affected by this type of stigma. This quantitative correlational study examined whether factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults in the U.S. who had been diagnosed with anxiety disorders as measured by the Generalized Anxiety Stigma Scale (GASS). Goffman's theory of social stigma served as the theoretical framework for this study. An existing data set of 82 adults diagnosed with anxiety disorders was obtained from a midwestern U.S. anxiety treatment clinic. Data were analyzed using multiple regression analysis to predict factors that contribute to the dependent variable of perceived anxiety disorder stigma. The independent factors included age, gender, and level of education. The findings of this study suggested that age, gender, and level of education are significant predictors of perceived anxiety disorder stigma. Among all predictor variables, gender predicted the greatest amount of variance for the dependent variable of perceived anxiety disorder stigma. This study may help the counseling profession limit the impact of perceived anxiety disorders stigma as a barrier to mental health treatment for persons with anxiety disorders who are vulnerable to this type of stigma.

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Dedication

This study is dedicated to those impacted by anxiety disorders. Your courage to keep pressing on despite your triggers is heroic. It is my hope that this study helps the field of mental health continue to find better ways to assist people with anxiety disorders.

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Chapter 1: Introduction to the Study

Mental health disorders are classified as a broad range of mental states that can negatively affect a person's behavior, emotions, thinking, and ability to care for their daily needs (Dennin & Lee, 2018). Anxiety disorders are a subgroup of mental health conditions that share standard features such as unwarranted levels of fear and anxiety-related behavioral and emotional disturbances (American Psychiatric Association [APA], 2022). Individuals impacted by anxiety disorders may experience disrupting symptoms such as intrusive anxiety-provoking thoughts, sweating, racing heart, chills, hot flashes, and dizziness (Karthikeyan et al., 2020). For persons with anxiety disorders, the fear of experiencing anxiety symptoms could further deteriorate their ability to function (De Jonge et al., 2016).

Anxiety disorders cause more functional impairment for adults in the United States than other mental health conditions (Konnopka & König, 2020). The loss of productivity resulting from anxiety disorders could significantly impact persons diagnosed with this disorder (Canals et al., 2019). For example, people with anxiety disorders may be more likely to experience long-term sick leave than coworkers not affected by anxiety disorders (Muschalla, 2018). Additionally, quality of life may also be significantly affected by anxiety disorders. Persons impacted by anxiety disorders could potentially experience substantial impairment in self-esteem, social relationships, social roles, and physical health (Carmack et al., 2018). Anxiety disorders that are not addressed could result in significant personal costs, loss of productivity, and reductions in quality of life (Langley et al., 2018).

Despite potential functional impairments and loss of productivity experienced by persons with anxiety disorders, those who share this disorder may be going without therapy even though effective treatments are theoretically available (Weissman et al., 2017). It can take longer for people to seek help for anxiety disorders than affective disorders such as depression and bipolar (Clark et al., 2018). Wang et al. (2005) found that delays in help-seeking behaviors for anxiety disorders ranged from 9 to 20 years compared to 5-9 years for affective disorders such as depression and bipolar. Many factors may contribute to delays in help-seeking behaviors for adults with anxiety disorders (Gutierrez et al., 2020). Anxiety stigma could be one of these factors (Konnopka & König, 2020). Anxiety stigma can be defined as having unfavorable attitudes about anxiety based on prejudice and ignorance displayed in reaction to observing overt anxiety symptoms (Negroni et al., 2020).

A specific type of anxiety stigma called perceived anxiety disorder stigma may contribute to delays in help-seeking behaviors, premature treatment dropout and could act as a barrier to mental health treatment for persons with anxiety disorders (Nearchou et al., 2018; Ross et al., 2019; Sickel et al., 2019). When people believe that others have negative beliefs regarding anxiety disorders, this concept is known as perceived anxiety disorder stigma (Grant et al., 2016). People with anxiety disorders may rethink their potential relationships with anxiety therapy or refrain from sharing their anxiety symptoms if they believe others have negative attitudes about anxiety disorders (Nearchou et al., 2018). Systemically, perceived anxiety disorder stigma may function as a type of social injustice for specific demographics of persons with anxiety disorders

(Pompeo-Fargnoli, 2020). This type of anxiety stigma may create inequalities in access to mental health care for adults impacted by anxiety disorders (Hom et al., 2017).

Counselors are mental health professionals that aspire to remove systemic barriers or obstacles that inhibit client growth, such as perceived anxiety disorder stigma. Professional counselors seek to enhance the quality of life in society through the practice of counseling (Wood et al., 2021). Professional counselors can be defined as state-licensed mental health professionals who provide mental health therapy (Burns & Cruikshanks, 2017). Additionally, professional counselors may take leadership roles in their communities when addressing mental health topics (Peters & Vereen, 2020). When appropriate, the counseling profession advocates at the individual, group, institutional, or societal levels to address potential barriers that inhibit access to the mental healthcare system (American Counseling Association [ACA], 2014).

Adults in the United States with anxiety disorders who are vulnerable to perceived anxiety disorder stigma may be a group in need of advocacy (Calear et al., 2017). For these adults, perceived anxiety disorder stigma may culturally and systematically discourage them from associating with the mental healthcare system or prematurely dropout from mental health treatment (Calear et al., 2020; Clark et al., 2020). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (2016) also state, under Leadership and Advocacy, that counselors should develop competencies for advocating for clients at the institutional and individual levels. Failing to advocate for adults with anxiety disorders impacted by perceived anxiety

disorder stigma could lead to worse mental health outcomes for these adults (Alonso et al., 2008; Clark et al., 2018).

Studies have identified predictors of perceived anxiety disorder stigma in nonclinical populations of adults for the purposes of reducing anxiety stigma through targeted psychoeducation (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2017; DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011). Grant et al. (2016) found that perceived anxiety disorder stigma was high in a nonclinical population of adult males who live in rural environments. Similar studies highlighted that being male, living in rural areas, and an individual's level of contact with persons impacted by anxiety also appear to predict perceived anxiety disorder stigma in nonclinical populations of adults (Nearchou et al., 2018; Patten et al., 2016; Pedersen & Paves, 2014).

Despite the growth of research focused on predictors of perceived anxiety disorder stigma in nonclinical adult populations, little is known about what factors may predict perceived anxiety disorder stigma in clinical populations of adults diagnosed with anxiety disorders (Schofield & Ponzini, 2020). This distinction is significant because clinical populations of adults with anxiety disorders may be impacted more severely by perceived anxiety disorder stigma than nonclinical populations of adults without anxiety disorders (Batterham et al., 2013). Specifically, perceived anxiety disorder stigma could affect clinical populations of adults in a manner that causes them to experience more significant mental health difficulties and greater economic hardships than nonclinical populations of adults who are affected by perceived anxiety disorder stigma (Calear et al., 2017; Schofield & Ponzini, 2020). In this study, the independent variables of age, gender,

and level of education were explored and assessed to see if there were corollary relationships between these variables and the dependent variable of perceived anxiety disorder stigma in a population of adults with anxiety disorders.

Clinical supervisors are concerned with both the supervisee's development as a professional counselor and the welfare of clients treated by the supervisee (Rapp et al., 2018). Professional counselors can better advocate for clinical populations vulnerable to mental health stigma when they can predict at-risk demographics (Crumb et al., 2019). Clinical supervision may be one way the counseling profession of can advocate for vulnerable populations of adults with anxiety disorders impacted by perceived anxiety disorder stigma. There are various models of supervision that focus on developing a counselor's clinical competency and awareness of social injustices faced by clients (Tanhan, 2018).

Currently, supervisees are becoming more culturally aware of their client's diversity needs through classroom education and clinical supervision (Fickling et al., 2019). However, a client's diversity needs may also include how they are impacted by mental health stigma and who may be more vulnerable to certain types of mental health stigma (Avent-Harris et al., 2021). This study may help to improve how the counseling profession delivers supervision topics related to mental health stigma impact, clinical demographic vulnerability, and predictors of perceived anxiety disorder stigma. In addition, this study could allow supervisors to help supervisees develop competencies about specific populations of adults with anxiety disorders. Adults with anxiety disorders may be more vulnerable to this type of stigma so that supervisees can better advocate for

these populations and reduce the negative impact perceived anxiety disorder stigma has on help-seeking behavior and treatment compliance for anxiety disorders. Finally, this study could allow clinical supervisors to better help supervisee fulfill their professional roles as client advocates as set forth by the ACA (2014) and CACREP (2016).

This chapter introduces the phenomenon of perceived anxiety disorder stigma and its potential to adversely affect persons impacted by anxiety disorders. Moreover, a discussion about potential predictors of anxiety disorder stigma such as age, gender, and level of education is discussed. This chapter also explains the study and its significance to social change and its significance to the counseling profession. The following are sections included in this chapter: background of the study, the problem statement, the purpose of the study, hypothesis, research question, theoretical foundation, nature of the study, definitions, assumptions, delimitations, limitations, and significance of the study.

Background of the Study

Mental Health Stigma

Mental health stigma can be described as a condition whereby individuals hold negative beliefs about persons with mental health disorders or when individuals hold negative thoughts about mental health treatment (DeFreitas et al., 2018). The negative beliefs associated with mental health disorders and mental health treatment could influence individuals to classify mental disorders and mental health treatment in an undesirable, rejected stereotype rather than an acceptable normed stereotype (Nearchou et al., 2018). According to Coles and Coleman (2010), mental health stigma can cause additional hardships unrelated to mental health issues. For example, mental health stigma

can negatively affect a person's employment opportunities and social status if their mental health status were disclosed. Persons with a subclassification of mental health disorders called anxiety disorders may also experience mental health stigma in the form of anxiety disorder stigma (Goetter et al., 2020).

Anxiety Disorder Stigma

Anxiety disorder stigma occurs when unfavorable belief systems about people with anxiety disorders are formed based on observable nonnormative behavioral characteristics. (Michaels et al., 2017). Ociskova et al. (2015) found that high levels of anxiety disorder stigma were associated with more intense anxiety disorder symptoms, higher rates of dissociation and harm avoidance, higher levels of depression, and comorbid personality disorders. Negative public and professional attitudes toward anxiety disorders may lead to poor treatment outcomes for people with anxiety disorders (Davies, 2000). The perceived attitudes that others hold about anxiety disorders can act as a form of anxiety stigma called perceived anxiety disorder stigma (Patten et al., 2016).

Perceived Anxiety Disorder Stigma

When a person believes that others have damaging beliefs regarding anxiety disorders, this is known as perceived anxiety disorder stigma (Grant et al., 2016). A person with anxiety may rethink their relationship with anxiety therapy or sharing their anxiety symptoms if they believe others have negative attitudes regarding anxiety disorders (Nearchou et al., 2018). The stigma associated with anxiety appears to be a barrier to mental health treatment (Calear et al., 2017). Clement et al. (2014) observed perceived anxiety disorder stigma might restrict help-seeking activity in an adult

population and found the amount of reduction in help-seeking behavior in their study was significant. The study indicated adults seeking mental health therapy may be significantly impacted by perceived anxiety disorder stigma. Additionally, specific demographics of adults such as age, gender, and a person's level of education, and having an anxiety disorder could make them more vulnerable to perceived anxiety disorder stigma.

Perceived Anxiety Disorder Stigma and Gender

Grant et al. (2016) found that men have a higher perceived stigma toward anxiety than women. In a sample of collegiate athletes, the authors found that student-athletes were willing to seek mental treatment. However, men were less likely to seek treatment than women and experienced higher levels of perceived mental health stigma (Moreland et al., 2018). According to Baxter et al. (2016), men, more so than women, appear to experience significant shame about their mental health status. Furthermore, the study suggested men are more likely to perceive others may shamefully view them about their mental health condition. For men, shame about mental health status and the accompanying perceived stigma can reduce men's likelihood to seek help for mental health issues (Clark et al., 2020). Shame and perceived mental health stigma can also influence low engagement in therapy and premature treatment dropout (Seidler et al., 2018).

Perceived Anxiety Disorder Stigma and Age

Certain age demographics also appear to predict perceived mental health stigma. Sarkin et al. (2015) noted that stigma and stigma levels differ as a function of gender, diagnosis, and age. Nearchou et al. (2018) found that older adolescents are more

vulnerable to perceived mental health stigma than middle-aged adolescents. Older adolescents can be described as persons between the ages of 18 to 24; middle adolescents include persons between the ages of 15 to 17 (Maree, 2021). Nearchou et al. (2018) concluded that older adolescents with high levels of perceived mental health stigma were less likely to engage in help-seeking behaviors for anxiety and depression than middle-aged adolescents. Negative perceptions of peers toward mental health conditions were a common factor that discouraged older adolescents from seeking mental health assistance.

Persons aged 60 and up are considered older adults; individuals between the ages of 40 to 60 are considered middle-aged adults, and persons between the ages of 20 and 40 are classified as early adults (Jones et al., 2018). Older adults appear to be more vulnerable to perceived mental health stigma than early adults or middle-aged adults (Benjenk et al., 2019). As adults enter later life and old age, they can adopt negative attitudes about aging perpetuated by social stereotypes (Stewart et al., 2015). Studies have shown that older adults can be affected by a double stigma, the stigma of being old, and the stigma of having a mental health disorder (Sarkin et al., 2015). Older adults impacted by double stigma may perceive that society would view them negatively if there were to develop a mental health disorder (González-Domínguez et al., 2018).

Perceived Anxiety Disorder Stigma and Education

A person's level of education may or may not serve as a protective factor against perceived anxiety disorder stigma (Parcesepe & Cabassa, 2013). However, level of education has been identified as a potential protective factor against perceived depression stigma (Grant et al., 2016). The higher one's level of formal education, the less they are

affected by perceived depression stigma (Griffiths, 2011). Griffiths et al. (2008) found that adults with bachelor's degrees and master's degrees were more likely to have lower levels of perceived depression stigma than adults with only a high school education. Lower levels of perceived depression stigma may reduce delays in help-seeking behavior for adults with depression. However, unlike depression, level of education does not appear to be a protective factor for lower levels of perceived anxiety disorder stigma among men and women (Grant et al., 2016). Grant viewed level of education as a predictor of lower levels of perceived depression stigma. However, level of education did not predict low perceived anxiety disorder stigma.

A person's level of education may be associated with a willingness to seek mental health treatment. Parcesepe and Cabassa (2013) found that individuals with a college degree were more willing to engage in mental health treatment than adults without a college education. Currently, little research exists in the literature that addresses level of education as a protective factor specifically for perceived anxiety disorder stigma. Some authors' findings suggested that perceived anxiety disorder stigma levels were less influenced by protective factors such as higher levels of education compared with other mental health disorders such as depression (Grant et al., 2016; Griffiths et al., 2008).

Perceived Anxiety Disorder Stigma and Anxiety Disorders

People with anxiety disorders face significant challenges to treatment due to shame and worries about stigma, yet little stigma-based research has focused on people with anxiety disorders (Schofield & Ponzini, 2020). It is surprising that less is known about perceived, personal, and self-stigma in the context of anxiety disorders, given that

persons with anxiety disorders may be more sensitive and subject to unfavorable stereotypes in the social environment (Clement et al., 2014). Although some studies looked at the association between stigma and a variety of mental health disorders in the context of seeking care, there has not been a thorough overview of the literature on stigma and anxiety disorders (Calear et al., 2017).

Most studies on the nature and impact of stigma for psychological disorders are limited to a few conditions (Patten et al., 2016). Depression stigma and schizophrenia stigma have received significant attention in the literature (Corrigan et al., 2014). Anxiety disorders are under-represented in stigma research and treatment barriers (Goetter et al., 2020). According to a comprehensive analysis, anxiety disorders account for fewer than 3% of the studies in the review (Clement et al., 2014). Researchers argued for an expansion of stigma and mental health disorder studies due to this limited scope (Bos et al., 2013; Link & Hatzenbuehler, 2016). Given that most research on the association between stigma and anxiety disorders has just recently begun to emerge in volume over the previous 10 years, the time for a systematic literature review looks to be ideal. Predictors of anxiety disorder stigma in nonclinical populations and select clinical populations such as depression and schizophrenia are well known (Batterham et al., 2013). However, predictors of anxiety disorder stigma, including perceived anxiety disorder stigma for persons with anxiety disorders, are less known at the moment (Schofield & Ponzini, 2020).

Perceived Anxiety Disorder Stigma and Help-Seeking Behavior

Despite efforts to encourage proactive mental health help-seeking behavior, mental health stigma continues to be a source of worry for people with mental disorders and may contribute to delays in help-seeking behavior (Holder et al., 2019). According to Clement et al. (2014), stigma does contribute to delays in help-seeking behaviors. Perceptions of other's opinions about mental health may influence a person's desire to associate themselves with the mental health care system. Clark et al. (2020) assessed perceived attitudes on clinical and nonclinical vignettes depicting persons diagnosed with anxiety. Perceived stigma attitudes for clinical vignettes were likewise shown to be harsher than comments stigmatizing nonclinical vignettes. Perceived stigma was most often associated with the notion that a mental condition was caused by a personal flaw. Individuals who made negative stigmatizing remarks were also more likely to have unfavorable feelings about seeking mental health treatment (Clark et al., 2020).

Gap in Literature

In nonclinical groups of people, researchers have identified various predictors of anxiety disorder stigma (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2017; DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011). Grant et al. (2016) discovered that in a nonclinical group of adult males living in rural areas, perceived anxiety disorder stigma was significant. Being male and being a young adult or older adult may also predict perceived anxiety disorder stigma in nonclinical populations of adults (Nearchou et al., 2018; Patten et al., 2016; Pedersen & Paves, 2014). In nonclinical populations of young adults, higher levels of perceived anxiety disorder stigma are

associated with a non-English speaking background, living with one or no parents, having higher levels of depressive symptoms and lower levels of anxiety literacy (Batterham et al., 2013). Several studies suggested community and mental health interventions aimed at reducing the impact of perceived anxiety disorder stigma for non-clinical groups of males who have culturally diverse backgrounds and low levels of exposure to anxiety literacy content (Grant et al., 2016).

Despite the growing body of research on predictors of anxiety disorder stigma in nonclinical adult populations in the counseling profession, professional counselors know little about which factors may predict anxiety disorder stigma in clinical populations of adults diagnosed with anxiety disorders (Clement et al., 2014; Schofield & Ponzini, 2020). An exhaustive search of the literature has found no studies that specifically focus on predictors of anxiety disorder stigma in a population of adults with anxiety disorders. The purpose of this study addressed perceived anxiety disorder stigma as it may have a greater quality of life impact on clinical populations of adults with anxiety disorders than nonclinical populations of adults without anxiety disorders (Anderson et al., 2015). In contrast, clinical populations of adults may experience more substantial mental health issues and economic hardships resulting from perceived anxiety disorder stigma than nonclinical populations of adults affected by this type of stigma (Calear et al., 2017; DeFreitas et al., 2018).

Problem Statement

Counselors aspire to remove systemic barriers to mental health treatment (Wood et al., 2021). Perceived anxiety disorder stigma may be a barrier to mental health

treatment for persons impacted by this type of stigma (Clement et al., 2014; Schofield & Ponzini, 2020). Perceived anxiety disorder stigma happens when a person perceives that society views anxiety disorders negatively (Griffiths & Christensen, 2011). This perception can discourage persons with an anxiety disorder from seeking timely mental health treatment to avoid stigmatizing societal labels (Hom et al., 2017). The counseling profession commonly advocates for underserved populations by understanding demographics at risk of delaying or refusing mental health treatment (Crumb et al., 2019). The literature is robust with studies that identify predictors of perceived anxiety disorder stigma in nonclinical populations of adults (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2017; DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011). Although studies on predictors of perceived anxiety disorder stigma in nonclinical populations are helpful in combating negative attitudes about anxiety, nonclinical populations may not be in need of mental health treatment. Moreover, nonclinical populations of adults may experience less functional impairments caused by perceived anxiety disorder stigma than clinical population of adults impacted by this type of stigma (Schofield & Ponzini, 2020).

There is currently little data in the literature about predictors of perceived anxiety disorder stigma in clinical populations of adults with anxiety disorders (Batterham et al., 2013; Nearchou et al., 2018). This distinction is significant because clinical populations of adults with anxiety disorders who are impacted by perceived anxiety may be in greater need of mental health treatment than non-clinical populations of adults affected by perceived anxiety disorder stigma (Calear et al., 2017). Counselors may be unable to

effectively identify which subgroups of adults with anxiety disorders are most at risk of refusing treatment unless they understand the factors that predict anxiety disorder stigma in adults with anxiety disorders.

Anxiety disorders have the largest cost impact of any disease in workplace settings (Johnston et al., 2009; Williams et al., 2018). The productivity loss caused by anxiety disorders can severely affect those impacted by this illness (Konnopka & König, 2020). For example, individuals with anxiety disorders are more likely than nonimpacted colleagues to have long-term sick leave (Muschalla, 2018). Furthermore, anxiety disorders can also substantially influence a person's quality of life (Langley et al., 2018). For example, people with anxiety might have a severe deficiency in self-esteem, social connections, social roles, and physical health (Saris et al., 2017). Receiving timely mental health treatment for anxiety disorders can significantly impact how quickly a person recovers from an anxiety disorder (Bekhuis et al., 2018).

However, despite functionality and production impairments experienced by persons with anxiety disorders, there are many with this disorder who are going without treatment despite the potential availability of suitable therapies (Weissman et al., 2017). Adults struggling with anxiety disorders largely underutilize mental health treatment services (Wu et al., 2017).

The way a person seeks treatment for medical and mental health care can be described as help-seeking behaviors (Wasylkiw et al., 2018). Wang et al. (2005) found that delays in help-seeking behaviors for anxiety disorders ranged from 9 to 20 years compared to 5-9 years for affective disorders such as depression and bipolar disorders.

Approximately 75% of persons affected by anxiety do not seek mental health treatment (Goetter et al., 2020). There is evidence to suggest that anxiety disorder stigma and discrimination negatively influence help-seeking behaviors for adults with anxiety disorders.

Adults with anxiety disorders can hold stigmatized beliefs about anxiety that may influence delaying treatment for anxiety and or cause premature dropout from therapy (Jennings et al., 2016). Adults with anxiety disorders can develop feelings of shame and fear discrimination from others (Anderson et al., 2015). Feelings of shame and fear of discrimination could cause adults affected by anxiety disorders to develop negative perceptions about how society views anxiety disorders; this is also known as perceived anxiety disorder stigma (Calear et al., 2017). Perceived anxiety disorder stigma may be partially responsible since some adults living in the U.S. are going without treatment for anxiety (Clark et al., 2020).

Clinical supervision may be one way that professional counselor educators and supervisors can advocate for vulnerable populations of adults with anxiety disorders impacted by perceived anxiety disorder stigma. Various models of supervision focus on developing a counselor's clinical competency and awareness of social injustices faced by clients (Tanhan, 2018). Clinical supervisors are concerned with both the supervisee's development as a professional counselor and the welfare of future clients and current clients of the supervisee (Rapp et al., 2018). This study may help to improve how Counselor Education and Supervision graduates deliver supervision topics related to

mental health stigma impact, clinical demographic vulnerability, and predictors perceived anxiety disorder stigma.

Purpose of the Study

The purpose of this quantitative study is to examine if factors such as age, gender, level of education, and presence of a diagnosed anxiety disorder predict perceived anxiety disorder stigma in a population of adults in the United States as measured by the Generalized Anxiety Stigma Scale (GASS). To address this gap in the literature, data for this study came from an existing data sample at a anxiety treatment center in the Midwest. This anxiety treatment center was established in 2014. Its charter focuses on the evidence-based treatment of moderate to severe anxiety disorders and the empirical research of anxiety topics and anxiety disorders that serve to better inform anxiety treatment. The data set exists due to the center's charter and was not affiliated with this study.

Several normed stress, depression, anxiety, and stigma scales comprise a standard intake battery used at the anxiety treatment center that helps to inform treatment and provide data for anxiety research. The standard intake battery included, The Primary Mental Health Demographic Intake Questionnaire (PMHIQ), The Beck Anxiety Scale (BAS), The Beck Depression Inventory (BDS), The Outcome Questionnaire 45 (OQ45), and The Generalized Anxiety Stigma Scale (GASS). Prior to each intake assessment given, clients at the anxiety treatment center are provided with a consent form requesting permission to use their test data anonymously for future anxiety research purposes that serve to better inform anxiety treatment. For example, test data can help to inform

treatment by better understanding the severity of a client's anxiety, the extent that anxiety impacts functioning, depression that may co-occur with anxiety symptoms, and a clients anxiety stigma experience. New clients are given examples of how their test data may be used anonymously. Test data, for example, might be used to advise therapy, assist in the formulation of a diagnosis, or serve as a data collection for research purposes. Clients are also advised about where their anonymous data may appear if it is utilized for research reasons.

This study was designed to answer a research question by anonymously using the existing data sample after IRB approval was obtained. The independent variables were age, gender, and level of education. Data were analyzed using a Pearson product-moment correlation analysis and a multiple regression analysis to assess for correlations between and among perceived anxiety disorder stigma, age, gender, and level of education in a population of adults diagnosed with anxiety disorders as measured by the GASS.

Research Question and Hypothesis

This study used a quantitative research design that was organized around one research question and one hypothesis:

Research Question 1 (RQ1): Do factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS?

H_0: Factors such as age, gender, and level of education do not predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

H_1: Factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

Theoretical Framework

The theoretical framework used to support this dissertation topic was Goffman's theory of social stigma (Goffman, 1963). Goffman's theory postulated that as a society, categories and attributes are created that are considered normal for its members. During first impressions, societal members who have attributes differing from normative categories are more susceptible to having a stigmatized social identity placed upon them (Goffman, 1963). Once an individual has a stigmatized social identity, the individual is more likely to face additional difficulties as a member of society (Batterham et al., 2013). Predominant U.S. culture has historically labeled anxiety as a sign of weakness and inferiority (Pedersen & Paves, 2014). Therefore, people who have been diagnosed with mental health disorders may be heavily stigmatized in the U.S. (Coles & Coleman, 2010).

Adults with anxiety disorders have historically been segmented outside the predominant U.S. culture's normative categories; this may be due to adults with anxiety disorders displaying nonnormative traits and behaviors such as excessive fear, worry, and avoidance (McKnight et al., 2016). Observing these traits and behaviors tend to contribute to a stigmatized identity on adults with anxiety disorders (Anderson et al., 2015; Davies, 2000; Goffman, 1963). Moreover, adults with anxiety disorders who have a stigmatized social identity and who are outside of normative categories, according to Goffman's theory, are more likely to experience additional difficulties as members of

society (Goffman, 1963). Therefore, Goffman's theory of social stigma provides insight into how perceived anxiety disorder stigma may contribute to delays in help-seeking behaviors for adults diagnosed with anxiety disorders. Goffman's theory of social stigma is discussed further in Chapter 2.

Nature of the Study

For this study, a quantitative correlational design was used (see Creswell & Creswell, 2017). The purpose of this study is to better understand determinants of perceived anxiety disorder stigma in people who reside in the midwest region of the United States who have been diagnosed with anxiety disorders. For issues such as perceived anxiety disorder stigma, quantitative survey methodologies are helpful for evaluating attitudinal levels (Marcopulos et al., 2020). Mental health research has relied heavily on quantitative survey research and correlational study methodologies to investigate extraneous predictive variables and their effect on mental health concepts such as mental health stigma (Bebbington, 2016; Dillman, 2016). A correlational study design could aid in determining the extent to which the independent variables of age, gender, and level of education, are connected and predict the dependent variable of perceived anxiety disorder stigma in adults diagnosed with anxiety disorders.

The data for this study originated from an existing data set consisted of adults diagnosed with anxiety disorders who sought treatment at a Midwest anxiety treatment center. The data set exists as part of the anxiety treatment center’s normal intake process. Several normed stress, depression, anxiety, and stigma scales comprise a standard intake battery used at the anxiety treatment center that helps to inform treatment and provide

data for anxiety research. The standard intake battery has included The Primary Mental Health Demographic Intake Questionnaire (PMHIQ), The Beck Anxiety Scale (BAI), The Beck Depression Inventory (BDI), The Outcome Questionnaire 45 (OQ-45), and The Generalized Anxiety Stigma Scale (GASS). New clients at the anxiety treatment center are provided with consent forms that explain how their test data may be used anonymously in various scenarios. Test results, for example, might be used to guide therapy, assist in diagnosis, or serve as a data collection for future studies.

After receiving IRB approval, this study used de-identified data from the existing data collected by the anxiety treatment center for the purposes of answering RQ1. Data was analyzed using a Pearson product moment correlation coefficient and a multiple regression analysis to assess for correlations between the dependent variable and independent variables and predict factors leading to the dependent variable. The dependent variable is perceived anxiety disorder stigma. The independent variables are age, gender, and level of education.

Definitions

The following is a collection of terms that provide applicable definitions related to this dissertation. Additional definitions may exist; however, they may not be relevant to this study.

Anxiety: Refers to the anticipation of a future worry and is often accompanied by mental and or physical discomfort (Kais & Raudsepp, 2005).

Anxiety disorder: DSM-5-TR describes anxiety disorders as mental health conditions that share common features such as unwarranted levels of fear and anxiety-related behavioral and emotional disturbances (APA, 2022).

Anti-anxiety stigma campaign: This refers to the collective efforts of others to provide educational resources and to reduce negative attitudes about anxiety disorders and promote help-seeking behaviors for anxiety treatment (Thompson & Lefler, 2016).

Gender: Refers to characteristics that identify and differentiate between masculine and feminine (Ahmed et al., 2021).

Help-seeking: The willingness and ability of people to seek professional assistance (Wasylkiw et al., 2018).

Level of education: Level of education refers to the highest level of school an individual has completed in a traditional education system within the United States (Dzikiti et al., 2020).

Mental health: This can be described as characteristics of a person's mental functioning, which can include an individual's emotional, psychological, and social well-being (Satcher, 2000).

Older adolescents: may be described as persons between the ages of 18 and 24 (Nearchou et al., 2018)

Older adults: Older adults may be defined as persons age 65 and older (Jones et al., 2018).

Perceived anxiety disorder stigma: Describes a person's attitudes or perceptions about the beliefs others most likely have towards anxiety disorders (Griffiths et al., 2011).

Younger adolescents: Is defined as persons between the ages of 13 to 15 (Nearchou et al., 2018).

Assumptions

A study on anxiety stigma, mental health stigma, and social stigma requires multiple basic assumptions. One assumption was that individuals with mental health disorders, by default, are negatively influenced by mental health stigma (Brouwers, 2020). In addition, this study assumed that because anxiety disorders are the most prevalent U.S. mental health disorder, individuals with anxiety disorders were negatively affected by mental health stigma at higher rates than individuals who are affected by other mental health disorders outside of anxiety. Moreover, this study assumed that the distress from anxiety disorder stigma may be equal to anxiety disorder distress (Schofield & Ponzini, 2020).

A significant assumption in this study was that adults with anxiety disorders answered perceived anxiety disorder stigma questions truthfully. It was also assumed that men, on average, experience higher levels of perceived anxiety disorder stigma in the U.S. as compared to women. A final assumption was that adults with anxiety disorders were less likely to be affected by social desirability bias when answering survey questions about perceived anxiety disorder stigma.

Scope and Delimitations

This quantitative study was limited to U.S. adults who had been diagnosed with one or more anxiety disorders to align with existing research on mental health stigma and clinical populations of adults. Limiting the theoretical framework to Goffman's theory of

social stigma highlights the significant impact that social stigma may have on adults diagnosed with anxiety disorders. The scope of this research study was comprised of an existing dataset of participants from an anxiety treatment center in the Midwest who sought treatment for anxiety and were diagnosed with one or more anxiety disorders. The findings of this study may contribute to the generalizability of predictors of perceived anxiety disorders stigma in adults diagnosed with anxiety disorders. Understanding predictors of perceived anxiety disorder stigma in adults impacted by anxiety disorders may help the counseling profession better advocate for at risk populations of adults effected by stigma who may delay or avoid mental health therapy for anxiety.

Limitations

Although this study examined potential correlations between perceived disorder anxiety stigma, gender, age, level of education, and anxiety disorder, it did not assess for correlations within other vital demographics such as race, socioeconomic status, level of contact with anxiety disorders, religion, and introversion versus extroversion. The sample size for this study was geographically confined. The sample size and specific geographic location of participants in this study were not a representative distribution of the U.S. population.

This study assessed for predictors of perceived anxiety disorder stigma. However, it did not assess if high levels of perceived anxiety disorder stigma correlate with increased rates of treatment refusal or premature treatment dropout. The study did not address culture and its effects on perceived anxiety disorder stigma. Participant's cultural bias may unknowingly influence levels of perceived anxiety disorder stigma in a

population of U.S. adults diagnosed with anxiety disorders. For example, respondents within the existing data set may come from a cultural background where it is normal to have overtly negative attitudes about anxiety disorders. Confirmation bias from the author may have also created limitations in this study. Confirmation bias can occur when a researcher establishes a hypothesis or belief and uses the facts provided by respondents to corroborate that assumption (Talluri et al., 2018). Confirmation bias happens when data that does not support the author's hypotheses is dismissed. The following strategies can be used to address the limitations of confirmation bias. First the researcher should determine when and how they are likely to be biased. Next, the researcher can maintain awareness of their bias in pertinent circumstances, and even question if they guilty of it. Finally, the researcher should determine what type of negative consequences the bias may have for them (Moller & Skaaning, 2021).

Significance of the Study

Anxiety disorders are among the most prevalent mental health issues in the United States and are among the leading mental health issues globally (Baxter et al., 2013). Mental health stigma is thought to play a significant role in delayed help-seeking behaviors (Vankar et al., 2014). Evidence-based treatments such as cognitive behavioral therapy (CBT) are empirically supported as effective modalities for treating anxiety disorders (Caplan et al., 2017). Over 60% of clients who receive CBT treatment for anxiety disorders experience substantial improvement in anxiety disorder symptoms (Bandelow et al., 2017). However, individuals who do not seek treatment or prematurely drop out due to high perceived anxiety disorder stigma may not benefit from evidence-

based therapies, such as CBT (Corrigan et al., 2014). It is expressly noted that providing a treatment or other intervention is not the purpose of this study.

Little is known about how age, gender, level of education, and anxiety disorder predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2020; Calear et al., 2017; Griffiths et al., 2015). Perceived anxiety disorder stigma in nonclinical adults appears to be predicted by rurality, being male, and an individual's level of contact with persons impacted by anxiety disorders. (Grant et al., 2016). However, these predictors are less known in a clinical population of U.S. adults with anxiety disorders (Calear et al., 2017; Griffiths et al., 2015). More research on perceived anxiety disorders predictors in a population of U.S. adults impacted by anxiety disorders may help answer questions related to perceived anxiety disorder predictors in clinical populations.

Furthermore, social change implications for this study are multifaceted. Understanding predictors of perceived anxiety such as age, gender, level of education, and anxiety disorder in adults with anxiety disorders may help the counseling profession better understand subpopulations with anxiety disorders that are more susceptible to perceived anxiety disorder stigma. Perceived anxiety disorder stigma may function as a type of social injustice that creates obstacles to treatment for persons impacted by anxiety disorders (Calear et al., 2020; Clark et al., 2020). Identifying subsets of persons with anxiety disorders who are more susceptible to perceived anxiety disorders stigma may help the counseling profession advocate more effectively for persons with anxiety disorders.

Clinical supervision of treating clinicians in training may be one approach for Counselor Education and Supervision professionals to advocate for vulnerable groups of individuals with anxiety disorders impacted by perceived anxiety disorder stigma. Clinical supervisors are concerned with the supervisee's growth as a professional counselor and the welfare of the supervisee's clients (Rapp et al., 2018). Through classroom teaching and clinical supervision, supervisees are becoming more culturally sensitive to their clients' diversity needs (Fickling et al., 2019). A client's diverse reality, on the other hand, may include how mental health stigma affects them and who is more prone to various forms of mental health stigma.

This research may aid in improving how Counselor Education and Supervision provides supervision on subjects such as mental health stigma, clinical demographic vulnerability, and predictors of anxiety disorder stigma. Furthermore, this research may enable supervisors to assist supervisees in developing competencies about specific populations of adults with anxiety disorders who are more vulnerable to this type of stigma, allowing supervisees to better advocate for these populations and reduce the negative impact of perceived anxiety disorder stigma on help-seeking behavior and treatment compliance for anxiety disorders. Finally, the findings of this study may enable clinical supervisors to better assist supervisees in fulfilling their professional roles as client advocates, as defined by the ACA (2014) and CACREP (2016).

Summary and Transition

This study explored predictors of perceived anxiety disorder stigma in U.S. adults who have been diagnosed with anxiety disorders. Mental health stigma and

discrimination may negatively influence help-seeking behaviors for U.S. adults with anxiety disorders (Clark et al., 2018). Despite the growth of research focused on predictors of anxiety disorder stigma in nonclinical populations, little is known about predictors of mental health stigma for adults with anxiety disorders (Schofield & Ponzini, 2020). Adults with anxiety disorders can hold stigmatized beliefs about anxiety that may influence delaying treatment for anxiety and or cause premature dropout from therapy (Jennings et al., 2016). Gender, age, level of education, and anxiety disorder may also influence levels of susceptibility to perceived mental health stigma (Baxter et al., 2016; Grant et al., 2016; Nearchou et al., 2018). It is possible that educating counselors about anxiety stigma through clinical supervision may be one approach for the Counselor Education and Supervision profession to advocate for vulnerable groups of individuals with anxiety disorders impacted by perceived anxiety disorder stigma.

A discussion of literature relevant to this study takes place in Chapter 2. This discussion expounds on the phenomenon of perceived anxiety disorder stigma in U.S. adults with anxiety disorders. Existing gaps in the literature were explored and highlighted. Finally, Chapter 2 extensively covers social stigma theory and how it supports the phenomenon of perceived anxiety disorder stigma.

Chapter 2: Literature Review

The purpose of this quantitative study was to determine if variables such as age, gender, level of education, and the existence of a documented anxiety disorder predict perceived anxiety disorder stigma in an adult population in the United States, as measured by the GASS. The counseling profession aspires to remove systemic barriers to mental health treatment (Wood et al., 2021). Perceived anxiety disorder stigma may be a barrier to mental health treatment for those who are affected by this type of stigma (Clement et al., 2014; Schofield & Ponzini, 2020). Perceived anxiety disorder stigma occurs when a person believes that society views anxiety disorders negatively (Griffiths & Christensen, 2011). This perception may discourage people with anxiety disorders from seeking timely mental health treatment to avoid stigmatizing societal labels (Hom et al., 2017).

Adults in the United States who have been diagnosed with anxiety disorders may be susceptible to perceived anxiety disorder stigma and potentially warrant advocacy (DeFreitas et al., 2018). Perceived anxiety disorder stigma, whether experienced systematically or culturally, may prevent persons diagnosed with anxiety disorders from engaging with the mental healthcare system for treatment (Pompeo-Fargnoli, 2020). Perceived anxiety disorder stigma occurs when a person feels that others have unfavorable attitudes about anxiety disorders (Grant et al., 2016). For example, if a person with anxiety believes that others have unfavorable views about anxiety disorders, they may reconsider their connection with anxiety-focused treatment or disclosing personal symptoms (Nearchou et al., 2018).

Despite the functional impairments and loss of productivity experienced by those with anxiety disorders, many people choose not to seek treatment, even though effective therapies are theoretically accessible (Weissman et al., 2017). It also takes significantly longer for people to seek assistance for anxiety disorders than it does for those suffering from affective disorders such as depression (Wang et al., 2005). As a result, anxiety stigma may be associated with greater levels of delayed help-seeking behaviors and early treatment dropout than depression stigma (Konnopka & König, 2020). According to the literature, perceived anxiety disorder stigma may lead to delays in seeking assistance and premature treatment dropout, as well as being a barrier to mental health care for people with anxiety disorders (Nearchou et al., 2018; Ross et al., 2019; Sickel et al., 2019). Systemically, perceived anxiety disorder stigma may act as a type of social injustice for demographics of people with anxiety disorders (DeFreitas et al., 2018). As a result, perceived anxiety disorder stigma may generate disparities in access to mental health care for individuals affected by anxiety disorders.

Despite the growing body of research on predictors of anxiety disorder stigma in nonclinical adult populations, little is known about which factors may predict anxiety disorder stigma in clinical populations of adults diagnosed with anxiety disorders (Schofield & Ponzini, 2020). This distinction is important because perceived anxiety disorder stigma may have a greater impact on clinical populations of adults with anxiety disorders than nonclinical populations of adults without anxiety disorders. Clinical populations of adults who are impacted by perceived anxiety disorder stigma may face more substantial mental health challenges and financial troubles than nonclinical

populations of adults who are affected by perceived anxiety disorder stigma (Calear et al., 2017).

The literature review summarizes the literature search strategy and the primary theoretical orientation underpinning the study. Next, the review turns to a discussion that provides an exhaustive review of the current literature related to social stigma theory, mental health discrimination, perceived anxiety disorder stigma, and mental health help-seeking behaviors. Finally, the literature review concludes with a summary of major themes in the study of perceived anxiety disorder stigma, age, gender, and level of education and their relation to help-seeking behaviors for adults.

Literature Search Strategy

An exhaustive literature review began with a search within the Walden University library databases. Databases in the fields of psychology and sociology were primarily used for conducting research. A search engine within the Walden Library was used to locate relevant articles related to the concepts of anxiety stigma, anxiety disorders, social stigma, mental health stigma, perceived anxiety disorder stigma, mental health discrimination, and mental health help-seeking behavior. Walden library search engines were set to source articles from the years 2016 to 2022. For more exhaustive reviews of the literature, Walden library search engine parameters for year of article released were set between 1960 and 2022. The review used the EBSCO database connected to the Walden Library. Several popular databases were used during the literature review including Google Scholar, ProQuest, psycINFO, SAGE Full-Text, and psychARTICLES.

The search terms *perceived anxiety disorder stigma* in Google Scholar returned eight results between the years 1960 and 2021. The term *anxiety stigma* in Google Scholar returned 634 results, while the phrase *mental health stigma* produced over 11,000 results. A combination of keywords used included *anxiety stigma, mental health stigma, mental health discrimination, help-seeking, perceived anxiety disorder stigma*, and *personal anxiety stigma*. Various combinations of search phrases were used in multiple library databases.

Theoretical Foundation

The theoretical framework chosen to support this dissertation topic was Erving Goffman's theory of social stigma (Goffman, 1963). Goffman hypothesized that people create attributes and categories that are considered normative for societal members. During first impressions, societal members who possess traits or attributes that differ from normative categories are more susceptible to having a stigmatized social identity placed upon them (Goffman, 1963). When a person has a stigmatized social identity placed on them, they are more likely to face additional difficulties as society members (Batterham et al., 2013). Coleman (1986) continued advancing Goffman's theory of social stigma by adding that social stigma broadly mirrors current cultural trends. Non-normative stigmatizing labels are not absolute and tend to evolve based on changes in what a culture or society deems normal (Coleman, 1986). However, the act of being deemed nonnormative and having a stigmatizing label applied has historically correlated with a lower quality of life for the stigmatized individual compared to their non-stigmatized counterparts (Griffiths et al., 2016).

For instance, social stigma is commonly placed on individuals with some level of impairment in their physical functioning and or mental capabilities (Bos et al., 2013). In addition, social stigma is historically placed on individuals who differ in physical characteristics from a popular normative group (Benjenk et al., 2019). Mental health disorders are heavily stigmatized in the United States (Coles & Coleman, 2010). Predominant U.S. culture has generally labeled anxiety as a sign of weakness and inferiority (Pedersen & Paves, 2014). Adults with anxiety disorders traditionally have been placed outside of the normative categories created by the dominant U.S. culture; this results from adults with anxiety disorders displaying non-normative characteristics such as excessive worry, fear, and avoidance behaviors (McKnight et al., 2016). Observing non-normative characteristics and behaviors encourages society to adopt a stigmatized view of adults with anxiety disorders (Anderson et al., 2015; Davies, 2000; Goffman, 1963). According to Goffman (1963), adults with anxiety disorders who have a stigmatized social identity placed on them have increased odds of experiencing more difficulties as members of society. These include potential mental health discrimination and denied access to upward mobility opportunities. In Goffman's (1963) theory, social stigma was divided into three categories:

1. Scars, physical symptoms of anorexia nervosa, and physical limitations are examples of overt physical or bodily deformations.
2. Abnormal personality traits, such as mental disease, addictions, and criminal behavior.

3. Tribal stigmas refer to characteristics associated with specific ethnic groups, nations, or faiths that have been considered to be deviant and abnormal in comparison to the dominant, normative ethnicity, nationality, or religion (Goffman, 1963).

There is a distinction between discredited and discreditable varieties of stigmatization, according to Goffman. Discreditable stigma refers to stigma attached to features that are not easily obvious to the general population. In such instances, a person is potentially discreditable, as his or her differences have not yet been discovered and may be revealed either purposefully or unintentionally. Discredited stigma, on the other hand, refers to a stigma that has already been exposed to others. While discreditable stigma impacts a person's decision to hide or expose differences, it also affects the public's attitude to the stigmatized individual (Goffman, 1963).

Goffman's theory was also broadened by Crocker, (1999), who stressed that social stigma arises in certain social interactions and social circumstances. What is valued in one social contact or context may be discounted in a different social interaction or environment. As a result, the level of esteem and/or devaluation associated with certain features and characteristics is determined by the social environment, and the stigma associated with various attributes and characteristics is likely to vary between communities, cultures, and subcultures (Crocker, 1999).

Pryor and Reeder (2011) classified social stigma into four distinct levels based on Goffman's (1963) theory of social stigma:

1. The emotive, cognitive, and behavioral reactions of society to persons with stigmatized conditions or features are referred to as public stigma.
2. Individuals' internalized feelings of shame and inadequacy as a result of their stigmatized condition or attribute are referred to as self-stigma.
3. The individual's perception of others' attitudes is reflected in perceived stigma. People who have been stigmatized may internalize stereotypes and acquire unfavorable thoughts about themselves.
4. Stigma through association refers to stigmatizing attitudes against people who are linked to those who have stigmatized conditions or features.

The authors highlighted that the social and emotional consequences of stigma experience differ depending on the amount of stigma encountered (Pryor & Reeder, 2011).

Building on Goffman's (1963) underpinnings, researchers have explored the experience of stigma in relation to various aspects. For example, Clement et al. (2014) found that stigma associated with anxiety disorders may limit help-seeking behavior in adults, and that the reduction in help-seeking behavior was significant in this study. This study shows that anxiety disorder stigma may have a major impact on adults seeking mental health treatment. According to Grant et al. (2016), men are more stigmatized than women when it comes to anxiety. The authors discovered that student-athletes were willing to seek counseling in a sample of collegiate athletes. Men, on the other hand, were less likely than women to seek treatment and were more stigmatized about mental health disorders (Moreland et al., 2018).

In this study, Goffman's Theory of Social Stigma provides a theoretical foundation and understand that there may be demographics of adults with anxiety disorders who fear others' stigmatized perceptions towards their anxiety. As a result, adults with anxiety disorders who have high levels of perceived anxiety disorder stigma may refuse to associate with mental health treatment to avoid being placed outside of normative categories and avoid experiencing additional hardships influenced by mental health stigma, mental health discrimination, and social exclusion.

Literature Review

Stigma

Social stigma can be defined as an attitude of discrimination or disapproval towards a person due to social characteristics that differentiate someone from normative societal members (Baxter et al., 2016). Goffman published his theory of social stigma in 1963 (Goffman, 1963). Goffman's theory of social stigma helps us understand that social stigma can and often does lower a person's quality of life. Individuals who experience social stigma may find it harder to receive support from fellow societal members (Ramaci et al., 2020). In contrast, normative nonstigmatized persons can experience fewer societal hardships than nonnormative stigmatized persons (Koumaki et al., 2019). Further studies have explored the phenomenon of social stigma, its positive utility, and inherent adverse effects on individuals and culture (Gibbons & Birks, 2016).

Historical documentation of social stigma and its impact on a person's quality of life dates back to ancient Egypt and ancient Greece (Cooper & Mitra, 2018; Vázquez, 2016). Ancient Egyptians experienced high levels of social stigma within their social

hierarchy. Menstruation and marriage were significantly stigmatized in ancient Egypt. During the Pharaonic period in Egypt, menstruating women were stigmatized as tainted and unhealthy (Frandsen, 2007). A woman's blood was seen as a source of danger or pollution (Hieke, 2015). Menstruating women experienced isolation from family members and society to avoid contaminating others (Hieke, 2015). In extreme cases, these women were executed if they did not take adequate precautions to isolate themselves (Frandsen, 2007). Egyptian royalty experienced stigma related to incestual marriage. Royal Egyptians stigmatized commoners as having impure blood. Therefore, Egyptian pharaohs were expected to marry within the family bloodline (Koenig, 2019).

Ancient Greeks used distinct markings to identify low-ranking members within their society. Greeks burned or cut marks on traitors, slaves, and criminals (Lauer, 2017). The markings identified these individuals as immoral or tainted people. The insignia burned or cut into criminals, slaves, and traitors gave them an undesirable social identity that let others know they were to be avoided (Bos et al., 2013). Socially discredited and socially stigmatized Greeks experienced a lower quality of life similar to stigmatized persons in ancient Egypt (Cooper & Mitra, 2018; Vázquez, 2016).

The presence of social and cultural stigma appears to have been widespread among ancient cultures such as the Egyptians and Greeks. Social stigma was applied to those who deviated significantly from societal norms in both ancient Greece and ancient Egypt. Avoiding socially stigmatizing labels may have been an important goal for ancient Greeks and Egyptians, as it appears that individuals who were socially stigmatized in both ancient cultures experienced a lower quality of life.

Stigma Throughout United States History

The U.S. has a long history of stigmatized populations who have experienced discriminatory behavior due to being placed outside of normative categories (Thornicroft et al., 2016). Most notably is the social stigma towards Africans brought to the U.S. during the slave trade between the 16th and 19th centuries (Boxell, 2019). Enslaved Africans in the U.S. were stigmatized as being less than human and lower in intelligence (Pierce & Snyder, 2018). The stigma placed on enslaved Africans by a majority of white Americans justified their enslavement and poor treatment (Woods, 2019). Other notable stigmatized populations in the U.S.'s formative years include women, specific minorities, the poor, the mentally ill, criminals, and persons with gay or lesbian preferences (Berg et al., 2017; Srivastava & Singh, 2015). Such stigmatized populations endured socioeconomic hardships caused by social stigma.

Themes in the literature appear to support the notion that certain characteristics of a person, such as skin color, gender, proclivity for criminal behavior, mental status, and sexual orientation, may predispose an individual to being stigmatized in a way that diminishes their humanity. Although Africans were subjected to social stigma by their white counterparts during the early years of the United States, white women were also subjected to a socially discredited stereotype of inferior intelligence based on their gender.

In the early 20th century, U.S. women were not allowed to vote for elected government officials. Women endured the social stigma of being considered not being intelligent enough to vote (Unger, 2019). Consequently, women’s’ issues were not fairly

represented due to the social stigma imposed on them by white men who represented society's normative non-stigmatized population (Miller, 2015). In addition to white women, minority populations in the U.S. have experienced reductions in quality of life due to social stigma.

Specific minority populations in the U.S. have experienced significant social stigma impacting the quality of life for those belonging to these minority groups. The Mexican American experience is rife with examples of social stigma and discrimination. For example, normative groups in the U.S. placed Mexican Americans outside of normative categories by socially stigmatizing them as pests, criminals, and immoral (Rivera, 2015).

Not all people of Mexican descent came to the U.S. legally (Vidrio, 2019). For some Mexican immigrants who came to the U.S. illegally, taking low-paying jobs or committing crimes for money were the only methods of earning a living. (Chalfin & Deza, 2020). Mexicans in the U.S. often were not assessed and judged individually but rather viewed as a whole, despite citizenship status (Berry et al., 2020). Throughout the 20th century, the stigmatized identity placed on Mexican Americans helped justify the deportation of Mexicans who held U.S. citizenship. As a result, some legal U.S. Mexican citizens were stolen from their families and communities through deportation efforts (Callister et al., 2019).

Historically, Black Americans were denied benefits awarded to persons holding U.S. citizenship. Unfavorable socially stigmatized identities heavily influenced a denial of benefits for Black Americans (Paul et al., 2020). Expressly, Black Americans were

denied upward mobility opportunities such as better-paying jobs and homeownership (Driscoll, 2019). A socially discredited and stigmatized identity as being an inferior race not fit for integration was primarily responsible for the discrimination experienced by Black Americans in the 20th century (Bassey & Edor, 2020).

According to the literature, minority populations in the U.S. appear to be large. A socially discredited stereotype appears to have been justified for any person in the U.S. who is not part of the non-normative culture. Throughout the history of the U.S., White men have been the normative standard, and anything other than being male and White has been subject to social stigma. However, at its core, social stigma is concerned with socially discredited and non-normative aspects of groups and people. As a result, while White men are likely to be seen as normative, the presence of medical or mental health conditions in White men appears to subject them to the same level of social stigma as non-normative minority groups.

The literature shows historical correlations between socially stigmatized persons and a lower quality of life (Garbin et al., 2015). The stigmatization of persons with specific medical conditions may correlate with lower self-esteem and poorer life quality. Gredig and Bartelsen-Raemy (2017) explored stigma experiences among persons ages 16 to 96 with diabetes. The sample size included women (n = 1479) men (n = 1791) for a total of 3,270 participants. The respondents reported experiencing stigma and discrimination because of their diabetic conditions. The most frequently endorsed incident of stigma and discrimination was unequal treatment. Respondents reported being denied deductions for medical expenses, denied life insurance due to pre-existing

diabetes, and disqualified from military service. Moreover, participants also endorsed being the victims of multiple derogatory stereotypes for persons with diabetes. Among the most frequently received derogatory remarks was that people with diabetes who are obese and old are to blame for their condition (Gredig & Bartelsen-Raemy, 2017). The results of this study align with assumptions found in Goffman's (1963) theory of social stigma. Specifically, the assumption that individuals who are given a stigmatized personality are also socially discredited. Individuals in this study diagnosed with diabetes appeared to be socially discredited as deserving blame for their diabetic condition and obesity.

Hibbert et al. (2018) explored the stigma and discrimination experiences of persons diagnosed with the Human Immunodeficiency Virus (HIV). Participants were 18 and over and recruited through community organizations and HIV clinics and were administered the People Living with HIV Stigma Survey. Descriptive examinations of lived experiences in health care and social settings were conducted. A multivariate logistic regression analysis was used to recognize predictors of reporting being treated socially unfavorably compared to non-HIV individuals and having stigma-related difficulties when interacting with the health care system. In addition, this study looked at postponed or refused healthcare treatment in the past 12 months for persons living with HIV. High levels of experiences with stigma in social and family settings were reported by participants living with HIV. Transexual respondents living with HIV were more likely to worry about being excluded from family events and verbal harassment than non-transsexual participants living with HIV. Moreover, transexual respondents experience

higher levels of stigma and discrimination within the health care system; the experiences of stigma within a health care setting were correlated with harming health care outcomes for transexual persons living with HIV.

Hepatitis B appears to be another medical condition subjected to high levels of social stigma. Valizadeh et al. (2017) conducted a study designed to demonstrate the social stigma experienced by Hepatitis B patients. The social stigma associated with hepatitis includes social isolation, social rejection, embarrassment, and economic stigma. A central theme in this study was participants' desires to hide their Hepatitis B diagnosis. Participants in this study also endorsed experiencing complications with Hepatitis B treatment due to delayed help-seeking.

Social stigma can negatively affect the health outcomes of persons with highly stigmatized medical diagnoses (Geter et al., 2018). Individuals with highly stigmatized medical diagnoses may encounter discrimination from their social relationships and the healthcare system (Gredig & Bartelsen-Raemy, 2017; Hibbert et al., 2018). Moreover, social stigma appears to have similar adverse effects on mental health outcomes for persons with mental health disorders (Benjenk et al., 2019). Persons with mental health disorders impacted by social stigma may also experience discrimination from society which may negatively impact help-seeking behaviors for mental health treatment.

Persons with HIV, diabetes, and hepatitis B, appear to be categories of persons who are susceptible to social stigma in the U.S. Studies conducted by (Gredig & Bartelsen-Raemy, 2017; Hibbert et al., 2018; Valizadeh et al., 2017) highlight the social stigma and discrimination experiences of persons with stigmatized medical conditions.

From these studies, it is assumed that persons with HIV, diabetes, and hepatitis B may experience various types of social stigma. However, the aforementioned authors and studies did account for specific types of stigmas experienced such as personal stigma, perceived stigma, or public stigma. Moreover, predictors of specific types of stigmas we're not assessed.

Mental Health Stigma

The literature supports social stigma as one of many negative contributors to poor mental health outcomes. The U.S. has a long history of stigmatized populations who have experienced discriminatory behavior due to being placed outside normative categories (Thornicroft et al., 2016). Historically, normative populations have treated individuals with mental health disorders unfavorably (Maulik et al., 2017). Persons with mental health disorders can be perceived as being inferior due to impairments in their functioning caused by mental health disorders (Gronholm et al., 2017). In the U.S., 3 out of 4 people diagnosed with mental health disorders have reported experiencing stigma and discriminatory behavior related to their mental health (Batterham et al., 2013).

Mental health stigma happens when people hold negative beliefs about individuals with mental health disorders or when individuals have negative thoughts about mental health treatment (DeFreitas et al., 2018). The negative beliefs associated with mental health disorders and mental health treatment can cause individuals to classify mental disorders and mental health treatment in an undesirable, rejected stereotype rather than an acceptable normed stereotype (Nearchou et al., 2018). There is evidence to suggest that persons with undesirable rejected stereotypes experience greater difficulties

in receiving support from their community. The reduction in community support can often contribute to a lower quality of life for individuals who are targets of mental health stigma. For example, Haugen et al. (2017) studied the effects of mental health stigma on first responders. The findings suggested that fears about confidentiality and negative career impact were significant contributors to mental health treatment delay for first responders. This study supports themes within this literature review pertaining to social stigma and its potential impact on quality of life.

Maintaining an adequate quality of life appears to be an essential task (Muschalla, 2018). A significant barrier to sustaining an acceptable quality of life is the loss of employment or lack of upward mobility opportunities in one's career field. Mental health stigma can be a barrier to employment and upward mobility opportunities (Walker, 2018). In addition, perceptions are that mental health stigma can negatively impact a person's quality of life (Rasoolinajad et al., 2018). For example, persons with anxiety disorders may fear discrimination and its negative impact on quality of life if their anxiety diagnosis was disclosed.

Social media also appears to provide helpful insight into people's views on mental health. Robinson et al. (2019) conducted a qualitative thematic analysis of 6,500 social media tweets on Twitter. The Tweets or messages were related to five mental health conditions. Epilepsy, AIDS, cancer, diabetes, and asthma were among the medical problems. Autism, depression, eating disorders, obsessive-compulsive disorder, and schizophrenia were among the mental health issues studied. The findings concluded that mental health stigma is commonplace on social media. The authors also found that

mental health conditions were more stigmatized (12.9%) than physical conditions (8.1%). This study did not consider the reasons or motivations for why mental health conditions were stigmatized more than physical conditions. Pryor and Reeder (2011) offered one possible explanation, stating that stigmatized attitudes toward specific conditions may be influenced by perceptions of others. Individuals may perceive others as having more negative views of mental health ailments than physical health ailments and, as a result, adopt a negative attitude toward mental health themselves.

For example, a feature of mental health stigma is that stigmatized attitudes can be pervasive within culture. Sickel et al. (2019) assessed mental health stigma attitudes in a large population of adult students at a distance learning university and found that stigmatized attitudes about mental health, directly and indirectly, influence mental health treatment attitudes. The results of this study help to highlight the idea of stigma as being pervasive within a culture and also reflect a possible propensity for stigma to be perceived, internalized, and acted upon by a significant number of persons within a given culture.

Depression is a leading mental health issue in developed countries (Nahas et al., 2019). Public attitudes and social stigma may contribute to fundamental barriers to mental health treatment for persons with depression (Baxter et al., 2016). College students living with depression often underutilize mental health services. Wu et al. (2017) studied how social stigma can reduce mental health help-seeking behaviors in college students through exploration of stigma attitudes toward mental health services among a sample of (n = 8,285) college students across the United States. Groups of college

students endorsing high-stigma attitudes for mental health services were also less likely to engage in help-seeking behaviors for depression and anxiety (Wu et al., 2017).

Mental health stigma appears to be a causal factor for reduced help-seeking behaviors for mental health disorders (Nickerson et al., 2020). Low participation rates in the mental healthcare system further burden the cost of care for the health care system (Eekhout et al., 2016). Persons living with untreated mental health disorders may be more likely to experience impairments in life-sustaining behaviors such as maintaining employment and taking care of basic hygienic and nutritional needs that could lead to hospitalization (Hom & Stanley, 2021).

Treatment efficacy has increased for common mental health disorders, including depression and anxiety (Becker et al., 2018). The effectiveness of mental health treatments has also increased for childhood anxiety and depression (Das et al., 2016). Robinson et al. (2019) examined how mental health stigma impacted adolescents' help-seeking behavior. The themes explored in this study were social stigma, mental health stigma, self-stigma, and help-seeking. Robinson et al. found that mental health stigma in social media content discouraged adolescents from engaging in help-seeking behaviors with parents or guardians. In addition to mental health stigma, a more specific type of stigma called perceived mental health stigma may also contribute to poor mental health outcomes.

Perceived Mental Health Stigma

Perceived mental health stigma occurs when a person firmly believes that others hold stigmatizing beliefs about mental illness (Wood et al., 2014). Negative thoughts

about other's mental health perceptions can influence a person to refrain from associating with a mental illness. It may be possible that a central causal factor for developing perceived mental health stigma is the inability to refrain from internalizing cultural perceptions about mental health. Perceived mental health stigma can discourage individuals from seeking mental health treatment or cause a person to discontinue treatment prematurely (Bos et al., 2013). Individuals may avoid mental health treatment out of fear that a stigmatizing label will be placed on them by normative societal members (Grant et al., 2016).

Mental health professionals with psychological disorders can also be impacted by perceived mental health stigma. Tay et al. (2018) sought to explore perceived mental health stigma attitudes in clinical psychologists. The sample size (n = 678) included clinical psychologists who were given several anonymous web surveys. The surveys included the Attitudes towards Seeking Professional Psychological Help Scale-Short Form, Military Stigma Scale, Secrecy Scale, the Social Distance Scale, and the Stig-9. Three-fourths of respondents (n = 497) experienced prior mental health issues. Perceived mental health stigma was significantly higher compared to personal stigma and self-stigma. The study identified that respondents were more willing to disclose mental health issues in familiar social settings than in work environments. Participants endorsed apprehensions about adverse outcomes for themselves and their and careers. In addition, respondents endorsed that shame acted as a barrier to help-seeking.

Nearchou et al. (2018) studied perceived mental health stigma and help-seeking behaviors in a population of adolescents. The findings concluded that an adolescent's

attitudes about another person's stigma towards mental health disorders strongly predicted help-seeking intentions greater than the adolescent's own stigma beliefs. Another seminal study on perceived mental health stigma in an adolescent population included a study that examined relationships between perceived and personal mental health stigma in a population of college students (Pompeo-Fargnoli, 2020). The study included a sample of undergraduate college students (n = 352) attending two large U.S. universities. The results suggest that perceived mental health stigma was sizably greater than college student's personal mental health stigma.

Perceived mental health stigma may have adverse outcomes on the development of mental health disorders (Tay, 2018). A single episode of depression is a significant predictor of a person experiencing follow-up depression (Kuehner, 2017). According to Davey-Rothwell et al. (2018), perceived mental health stigma could be one of many causal factors that account for developing a single depressive episode. Griffiths (2015) found that persons with depression and stress were more likely to engage in acts of suicidal behavior when experiencing perceived mental health stigma compared to when stigma was not perceived. Compared to the general population, adult men in the U.S. appear to be at greater risk for suicide than adult U.S. women (Snowdon et al., 2017). Several factors are thought to play a role in men committing suicide. In addition, Kennedy et al. (2020) found that perceived mental health stigma is one factor that can significantly contribute to the development of suicidal thoughts and suicidal ideation in men. Suicidal literacy is the level of awareness one has on contributors to suicide, early warning signs for suicide, and resources available for persons at risk of suicide. Kennedy

et al. (2020) explored baseline suicide literacy levels in a rural population of men. Men who endorsed lower levels of suicide literacy also endorsed high levels of perceived mental health stigma.

Predictors of perceived mental health stigma for adults are well documented. However, little research exists in the literature that addresses predictors of perceived anxiety disorder stigma within a U.S. population of adults diagnosed with anxiety disorders. In addition, little existing research was found that measures levels of perceived stigma within a U.S. population of adults diagnosed with anxiety disorders (Grant et al., 2016). Finally, little existing research was found that measures perceived anxiety disorder stigma related to age, gender, and level of education within a U.S. population of adults diagnosed with anxiety disorders (Calear et al., 2017).

Anxiety Disorders and Stigma

Anxiety disorder stigma has the potential to cause more harm than an anxiety disorder itself (Calear et al., 2020). Persons with anxiety disorders can also experience anxiety disorder stigma. Anxiety disorder stigma happens when negative belief systems are formed about individuals with anxiety disorders based on observable non-normative behavioral traits (Michaels et al., 2017). The non-normative anxiety traits are classified as negative attributes by society and may lead to persons with anxiety disorders experiencing discrimination (Maulik et al., 2017). Brown and Bruce (2016) confirmed that career concern is a factor when deciding to disclose an anxiety disorder to a potential employer. In addition, seeking mental health treatment was seen as a threat to one's career should the employer discover that mental health treatment is being sought.

The DSM-5-TR describes anxiety disorders as mental health conditions that share common features such as unwarranted levels of fear and anxiety-related behavioral and emotional disturbances (APA, 2022). Excessive fear and anxiety can impair daily functioning resulting in reduced quality of life (McKnight et al., 2016). Overestimations of danger and avoidance behaviors are common in people diagnosed with anxiety disorders (Baxter et al., 2013). According to McKnight et al. (2016), chronic overestimations of danger can cause mental impairments such as loss of concentration and mental fatigue. Eustis et al. (2016) observed that people with anxiety disorders might frequently avoid anxiety triggers. Moreover, the authors found that frequent avoidance of anxiety-triggering situations can increase the intensity of a person's anxiety disorder. Finally, the authors found associations between avoidance behaviors and missed opportunities for upward mobility.

Anxiety disorders appear to affect people globally. Baxter et al. (2013) conducted a systematic meta-regression to assess global anxiety disorders' pervasiveness. In addition, the authors sought to identify factors that could influence prevalence rates. Approximations of current frequency rates for anxiety disorders were between (n = 0.9%) and (n = 28.3%) and past-year frequency between (n = 2.4%) and (n = 29.8%). Common factors contributing to a person’s anxiety disorder included culture, stigma, conflict, economic status, gender, age, and urbanicity.

Despite the global prevalence of anxiety disorders, persons with anxiety can still experience anxiety-stigma-related hardships. Individuals with anxiety disorders can be misdiagnosed and undermanaged within the healthcare system (Anderson, 2015).

Anxiety disorder stigma may be one of many factors contributing to the undermanagement of persons with anxiety disorders (Bandelow et al., 2017). Davies (2000) posited that negative public and professional perceptions of anxiety disorders could cause poor treatment outcomes for individuals with anxiety disorders.

Additionally, Ociskova et al. (2015) identified high levels of anxiety disorder stigma positively correlated with more intense anxiety disorder symptoms, higher rates of dissociation and harm avoidance, higher levels of depression, and comorbid personality disorders. A total of (n = 109) mental health patients with anxiety disorders and potential comorbid depressive or personality disorders participated in this study. Patients completed multiple psychodiagnostic assessments that assessed and explored experiences with anxiety disorder stigma and the effects of this stigma on their mental health, levels of anxiety distress, depression severity, and a brief personality inventory. The psychodiagnostic battery consisted of the Internalized Stigma of Mental Illness Scale, Temperament and Caracter Inventory-Revised Version, Adult Dispositional Hope Scale, Dissociative Experiences Scale, Beck Anxiety Inventory, Beck Depression Inventory-Second Edition, and the Clinical Global Impression Scale. Ociskova et al. (2015) rejected the notion that anxiety disorder stigma does not affect persons with anxiety disorders. Moreover, the authors posited that individuals with greater sensitivity to socially aversive stimuli and rejection might be prone to the development of stigmatizing themselves for having an anxiety disorder. Persons with anxiety disorders may also experience anxiety disorder stigma through their perceptions of how others view those impacted by anxiety; this type of stigma is called perceived anxiety disorder stigma.

Perceived Anxiety Disorder Stigma

Perceived anxiety disorder stigma occurs when a person perceives others hold harmful belief systems about anxiety disorders (Grant et al., 2016). The belief that others possess negative attitudes about anxiety disorders can make a person with anxiety reframe from associating with anxiety treatment or disclosing their anxiety symptoms (Nearchou et al., 2018). Perceived anxiety disorder stigma appears to be a barrier to mental health treatment (Calear et al., 2017). Clement et al. (2014) found perceived anxiety disorder stigma can reduce help-seeking behavior in a population of adults; the level of reduction in help-seeking behavior in this study was significant. In addition, people who experience high levels of perceived anxiety disorder stigma can have difficulties building effective rapport with a mental health therapist once they have decided to seek treatment (Jennings et al., 2016).

Carmack et al. (2018) suggested that college students were less likely to seek mental health treatment for anxiety if they endorsed high anxiety stigma levels. The study explored college student's attitudes about mental health and stigma related to anxiety and depression. The sample size included college students (n = 292) taking part in a large university communication course in the U.S. There were meaningful differences in willingness to seek treatment based on student's level of perceived anxiety disorder stigma. Students with high levels of perceived anxiety disorder stigma endorsed believing that a general public is likely to stigmatize mental health issues like anxiety or depression. Radez et al. (2020) also studied the effects of perceived mental health and anxiety stigma on a population of adolescents. A systematic review of qualitative and

quantitative studies reporting barriers to treatment for children and adolescents was conducted. Fifty-three eligible studies were identified. Twenty-two studies provided quantitative data; thirty studies provided qualitative data. Four main barriers to mental health treatment were identified. 96% of these studies reported limited mental health knowledge and help-seeking perceptions as barriers to mental health treatment. The second highest reported barrier, 92%, related to social stigma factors such as perceived mental health stigma and perceived anxiety disorder stigma. The third theme identified adolescent's negative perceptions of the therapeutic relationship 68%. The fourth theme related to structural barriers 58%, such as logistical barriers, availability of mental health services, and financial limitations. This study highlights a complex array of factors that contribute towards children and adolescents seeking mental health treatment. Moreover, the effects of mental health stigma, social stigma, and perceived stigma were significant.

Perceived anxiety disorder stigma also appears to have a significant impact on adults seeking mental health treatment. Patten et al. (2016) found that anxiety stigma was perceived by 24% of adult respondents seeking mental health services. Canadian adults were surveyed using the Canadian Community Health Survey. The scales provided respondents the opportunity to describe perceived anxiety disorder stigma related to diagnosis. Respondents with higher levels of perceived anxiety disorder stigma experienced high levels of stress and worry when perceiving negative anxiety attitudes from others. Calear et al. (2017) identified perceived anxiety disorder stigma as a significant barrier to treatment in a population of adolescents. In this study, perceived anxiety disorder stigma was compared to personal anxiety disorder stigma. Peer

perceptions of others with anxiety disorders appeared to have a more significant impact on one's desires to associate themselves with anxiety compared to internalized perceptions of others with anxiety disorders.

Wood et al. (2014) examined public stigma attitudes toward schizophrenia, anxiety, and depression. Schizophrenia was associated with the most significant number of negative stereotypes. Respondents were not likely to blame persons with schizophrenia and depression for developing their condition. However, participants endorsed beliefs that persons with anxiety disorders were somewhat at fault for developing their anxiety disorder. Moreover, respondents shared that they believe others think similarly about anxiety disorders. Mitake et al. (2019) studied the effects of perceived mental health stigma on quality of life and workplace satisfaction. The study sought to understand the impact of mental health stigma and burnout within a population of nonprofessional mental health occupational staff. A cross-sectional study was conducted using (n = 282) participants who completed a mental health stigma and workplace satisfaction questionnaire. Depersonalization is a domain highly correlated to burnout. Negative perceptions of attitudes held by others contributed to decreased empathy felt toward persons with mental health disorders and increased depersonalization. The findings of this study suggest that high perceived mental health stigma and high perceived anxiety disorder stigma can have a significant impact on depersonalization and burnout.

(Grant et al., 2016) explored the extent to which perceived anxiety disorder stigma could be corrected in a population of adults. Perceived anxiety disorder stigma appears to be more persistent than personal anxiety disorder stigma and self-anxiety

disorder stigma. The study included (n = 350) university students and residents of the local community. An online survey assessing the level of contact and knowledge of anxiety and depression was administered to participants. Independent variables include age, gender, and current depression and anxiety symptoms. The dependent variable was personal, perceived, and self-stigma for both anxiety and depression. Personal contact and higher levels of knowledge about anxiety and depression predicted lower personal and self-stigma for both anxiety and depression. The role of contact and knowledge appear to be essential factors when reducing personal and self-stigma for anxiety and depression. However, contact and knowledge were not predictive factors for reducing perceived anxiety disorder stigma (Grant et al., 2016).

Perceived Anxiety Disorder Stigma and Gender

Baxter et al. (2016) explained men more than women, may have higher levels of shame about their mental health conditions. Moreover, men may perceive others' view their mental health conditions in a shameful manner more so than women. Reduced help-seeking behaviors have been found in men with high levels of shame and stigma about their mental health condition. In addition, men who seek treatment with high levels of shame and mental health stigma may be more likely to drop out of treatment prematurely than women with high levels of shame and mental health stigma (Seidler et al., 2018).

Batterham et al. (2013) assessed for predictors of anxiety disorder stigma in a population of adult men and women. The GASS was administered to adults (n = 617) and assessed attitudes related to personal and perceived anxiety disorder stigma. Moreover, the study included a depression stigma scale and an exposure to anxiety disorders survey.

A linear regression model indicated that women appeared to be less impacted by personal anxiety stigma and perceived anxiety disorder stigma than men. Having greater contact with individuals impacted by anxiety disorders also predicted lower levels of anxiety disorder stigma for both men and women.

Boysen and Logan (2017) noted that stereotypical feminine mental disorders elicited less mental health stigma than stereotypical masculine disorders. Anxiety disorders tend to affect men and women relatively equally (Jalnapurkar et al., 2018). However, anxiety is stereotypically associated with women more so than men (Maaravi & Heller, 2020). Stereotypically, feminine disorders such as social anxiety disorder will elicit more stigma if men display them. Decades of gender and stereotype research consistently document men's overall perceptions as assertive and strong and women as warm and sensitive. Men impacted by anxiety disorders appear to violate the socially constructed narrative of being strong and assertive and, thus, may experience a high level of mental health stigma (Boysen & Logan, 2017).

Perceived Anxiety Disorder Stigma and Age

Age appears to be predictive of mental health stigma, including perceived anxiety disorder stigma. Sarkin et al. (2015) posited that mental health stigma and stigma levels could differ based on gender, diagnosis, and age. Older adults appear to be vulnerable to mental health stigma (Benjenk et al., 2019). Older adults may be defined as women and men aged 65 and older (Jones et al., 2018). As adults enter into old age, they develop stigmatizing attitudes about aging perpetuated by social stereotypes (Stewart et al., 2015). The literature supports the existence of a phenomenon for older adults called double

stigma, the stigma of being old, and the stigma of declining mental health (Sarkin et al., 2015).

Nearchou et al. (2018) identified older adolescents ages 18 to 24 as being vulnerable to mental health stigma more so than younger adolescents ages 10 to 13. Both younger and older adolescents appear to be more affected by perceived mental health stigma than other forms of mental health stigma subtypes. Similar to findings in studies examining the impact of mental health stigma on help-seeking behaviors, older adolescents in this study were less likely to take part in help-seeking behavior for mental health services. However, younger adolescents were more likely to seek help for mental health disorders compared to older adolescents. Sarkin et al. (2015) explained that compared to younger adolescents, older adolescents might perceive higher mental health discrimination levels from peer groups more so than other age demographics. Cheng et al. (2018) also noted that older adolescents ages 18 to 19 appeared to be vulnerable to all mental health stigma subtypes, including perceived anxiety disorder stigma, bringing in the construct of education.

Perceived Anxiety Disorder Stigma and Level of Education

A person's level of education may not likely serve as a protective factor against perceived anxiety disorder stigma for adults and adolescents (Parcesepe & Cabassa, 2013). However, unlike perceived anxiety disorder stigma, education levels can consistently provide significant protection against perceived depression stigma for adolescents and adults (Grant, Bruce, & Batterham, 2016). Higher formal education levels appear to correlate to lower perceived depression stigma (Griffiths, 2011). Adults

with bachelor's degrees and master's degrees were less likely to have high levels of perceived depression stigma than adults with a high school education only (Griffiths et al., 2008). High levels of formal education and lower levels of perceived depression stigma also appear to correlate with an increase in help-seeking behaviors for depression disorders (Parcesepe & Cabassa, 2013).

Moreover, persons with a college education were more likely to seek treatment for depression compared to individuals without a college education. Grant, Bruce, and Batterham (2016) similarly found that level of education predicted a willingness to seek mental health treatment for depression. Few studies exist in the literature that examines level of education and its effects on perceived anxiety disorder stigma levels. Some authors' findings indicated that a person's formal education level has little impact on decreasing the amount of perceived anxiety disorder stigma experienced (Batterham et al., 2013).

Perceived Anxiety Disorder Stigma and Anxiety Disorders

In terms of psychological distress, mental health stigma is commonly cited as a roadblock to prompt mental health treatment (Clark et al., 2020). Fear of encountering these negative attitudes, concerns about the consequences of receiving a label of a negatively stereotyped identity, and discomfort pursuing a path that reinforces one's sense of shame all appear to diminish a person’s willingness to seek treatment for individuals with psychological disorders (Calear et al.,2020). Perceived anxiety disorder stigma deals with people's perceptions about how others view anxiety disorders. These perceptions are often unfavorable and assume that others think poorly of those with

anxiety disorders (Koumaki et al., 2019). Perceived anxiety disorder stigma has significant effects in terms of status loss and discrimination, as well as health inequalities (Nearchou et al., 2018). Persons impacted by perceived anxiety disorder stigma may avoid help-seeking activities such as mental health therapy if they perceive others may judge them negatively for associating with anxiety and mental health (Nickerson et al., 2020). As a result, perceived anxiety disorder stigma attitudes may directly account for a portion of the significant costs of untreated anxiety disorders (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2017; DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011).

Anxiety disorders are a subset of mental health disorders with shared characteristics such as excessive fear and anxiety-related behavioral and emotional disturbances (APA, 2022). These disorders may cause symptoms such as intrusive anxiety-provoking thoughts, sweating, racing heart, chills, hot flushes, and dizziness, among others (Karthikeyan et al., 2020). Anxiety disorders, such as generalized anxiety disorder, panic disorder with or without agoraphobia, specific phobias, separation anxiety disorder, and social anxiety disorder are the most common mental health disorders, with substantial healthcare expenditures and disease burden (Schofield & Ponzini, 2020). Despite their high comorbidity, anxiety disorders can be distinguished from one another by the items or circumstances that are feared, avoided, or cause anxiety (Bandelow et al., 2017). For example, social phobia is defined by dread or anxiety when social interactions are scrutinized by others. However, generalized anxiety disorder (GAD) is characterized

by excessive worry and anxiety across several categories that are not limited to a single event (Anderson et al., 2015)

In the U. S. anxiety disorders cause more functional impairment in adults than other mental health disorders (Konnopka & König, 2020). The loss of productivity caused by anxiety disorders can have a substantial influence on those who are diagnosed with it (Canals et al., 2019). People with anxiety disorders, for example, may be more prone than coworkers who are not afflicted by anxiety disorders to take long-term sick leave (Muschalla, 2018). Anxiety disorders can also have a negative impact on one's quality of life. Anxiety disorders can cause significant impairment in self-esteem, social connections, social roles, and physical health in people who suffer from them (Carmack et al., 2018). Untreated anxiety disorders can lead to severe personal costs, lost productivity, and a decline in quality of life. (Langley et al., 2018). Despite the fact that people with anxiety disorders may endure functional impairments and loss of productivity, those with this disorder may be going without treatment, even though effective therapies are theoretically accessible (Weissman et al., 2017). Anxiety disorders often take longer for people to seek care than affective disorders like depression and bipolar disorder (Clark et al., 2018). According to Wang et al. (2005), delays in getting care for anxiety disorders varied from 9 to 20 years, but delays in seeking help for affective disorders ranged from 5 to 9 years. Adults with anxiety disorders may have delays in getting care due to a variety of causes. One of these causes might be anxiety stigma, including perceived anxiety disorder stigma (Konnopka & König, 2020).

People with anxiety disorders face significant challenges to treatment due to shame and worries about stigma, yet little stigma research has focused on people with anxiety disorders (Schofield & Ponzini, 2020). Less is known about perceived, personal, and self-stigma in the context of anxiety disorders, given that persons with anxiety disorders are more sensitive and subject to unfavorable stereotypes in the social environment (Anderson et al., 2015). Although some studies have looked at the association between stigma and a variety of mental health disorders in the context of seeking care, there hasn't been a thorough overview of the literature on stigma and anxiety disorders (Clement et al., 2014).

The majority of studies on the nature and impact of stigma for psychological disorders are limited to a few conditions. Depression stigma and schizophrenia stigma have received significant attention in the literature (Corrigan et al., 2014). Anxiety disorders are under-represented in stigma research and treatment barriers (Goetter et al., 2020). Comprehensive analysis of anxiety disorders accounts for fewer than 3% of stigma research (Clement et al., 2014). Researchers argue for an expansion of the scope of stigma and mental health disorder studies as a result of this limited scope (Calear, 2017; Link & Hatzenbuehler, 2016). Given that most research on the association between stigma and anxiety disorders has just recently begun to emerge in volume over the previous ten years, the time of a systematic expansion of anxiety stigma research looks to be ideal. Predictors of anxiety disorder stigma in non-clinical populations and select clinical populations such as depression and schizophrenia are well known (DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011). However, predictors of anxiety

disorder stigma, including perceived anxiety disorder stigma for persons with anxiety disorders, are less known at the moment (Schofield & Ponzini, 2020).

Perceived Anxiety Disorder Stigma and Help-Seeking Behavior

Mental health treatment cannot be effective without a person actively seeking treatment (Clark et al., 2018). Kaiser et al. (2020) described help-seeking behavior as an action carried out by someone who believes they need mental health assistance or health care aid. Despite efforts to promote proactive mental health help-seeking behavior, mental health stigma is a persistent threat to the wellbeing of those with mental disorders and a burden to the health care system (Holder et al., 2019). Clement et al. (2014) studied the concept of mental health stigma and its effects on delayed help-seeking behaviors. A systematic review explored the impact of mental health-related stigma on help-seeking for problems related to mental health (Clement et al., 2014). Stigma ranked as the fourth-highest barrier to help-seeking. Employment-related discrimination ranked third highest, and shame/embarrassment ranked second highest. Disclosure of mental health symptoms was a primary concern contributing to a lack of help-seeking behaviors.

Sharac et al. (2010) examined the role of mental health stigma and delayed help-seeking behavior on the economy. A systematic review identified 30 papers within 27 studies related to mental health stigma and economic impact. Mental health stigma was found to negatively impact a person's abilities to care for themselves properly. Stigma and discrimination towards people with mental health disorders negatively impacted employment opportunities, income potential, and healthcare costs. Michaels et al. (2017) explained that public and perceived mental health stigma could adversely affect a

company’s willingness to employ and assist persons with mental disorders. Financial independence is necessary to support one's family, hobbies, and educational pursuits. A cross-sectional study by Michaels et al. (2017) posited that company attitudes demonstrated that persons with mental health disorders are less likely to be considered for a job. Denied employment opportunities related to mental health stigma and discrimination adversely affect a person's ability to maintain financial independence, engage in healthy hobbies, and support continued education endeavors (Michaels et al., 2017).

Multiple studies within the literature emphasize the importance of gender, age, and level of education, as they relate to persons vulnerable to anxiety disorders and anxiety disorder stigma (Grant et al., 2016; Nearchou et al., 2018; Seidler et al., 2018). Baxter et al. (2013) performed a global systematic meta-regression relevant to anxiety disorder prevalence. This meta-regression aimed to isolate variables that can influence global anxiety prevalence rates. Substantial vulnerability factors for developing an anxiety disorder included age and gender. Moreover, a person's education level did not serve as a protective factor for reducing global anxiety disorder prevalence rates.

Studies Related to Regression Analyses

O'Reilly et al. (2015) used survey methods and a multiple linear regression to assess mental health stigma attitudes and relationships between mental health knowledge and behaviors. The study included a random sample of (n = 1,000) pharmacists, all with active registrations to the Pharmacy Board of New South Wales. Participants were given a brief measure of mental health literacy to assess levels of mental health knowledge. In

addition, the 7-item Social Distance Scale was used as a measure to assess for stigma attitudes within diverse populations. The Social Distance Scale is a broadly used instrument aimed at measuring the behavioral intentions towards persons with mental health disorders. A multiple linear regression was used to assess the relationships between knowledge, behavior, and mental health stigma. The dependent variable for this study was behavioral intentions. The independent variables included social distance, age, personal experience of mental illness, area of practice, and age.

Breslin et al. (2019) sought to understand what demographic factors predicted mental health stigma in a population of athletes. The study included the use of The Mental Health Knowledge Schedule (MAKS). The MAKS assesses for general mental health attitudes and perceived mental health stigma. This questionnaire comprises two stigma subscales with the addition of a six-item mental health knowledge scale and a recognition and familiarity scale comprised of six items. Linear regression analysis was conducted to test for predictors of mental health stigma in athletes. Predictive factors in the multiple linear regression model included type of sport, gender, and normed attitudes about mental health. The results from the linear regression explained a large amount of variance in the intent to associate one's-self with persons impacted by mental health disorders.

Nakash et al. (2015) recruited participants from two large Israeli cities (Jun 2011-April 2012) and investigated the association between clinical factors and socio-demographic variables with stigma in the mental health care system and the impact of these factors on the quality of the client-therapist alliance. Demographic and stigma

measures were given to mental health clients and the treating therapist before counseling began. Measures collecting demographic information identified country of birth, self-defined level of religiosity, age, years of formal education, gender, and professional background. Measures assessing stigmatizing attitudes towards mental health treatment identified self-mental health stigma, perceived mental health stigma, and personal mental health stigma. A working alliance inventory was included to examine the strength of the therapeutic alliance during treatment. Using bond scale as a measure of outcome, the client's age, gender, years of education, mental health stigma attitudes, and religiosity were significant and predicted a variance of 13%.

Studies Related to Predictors of Perceived Anxiety Disorder Stigma

The concept of perceived anxiety disorder stigma and its impact on a person's mental health, help-seeking behaviors, and premature treatment dropout in diverse populations has been studied. For example, Batterham et al. (2013) assessed predictors of personal and perceived anxiety disorder stigma in a population of Australian adults. At the time of this study, the authors highlighted that few studies have systematically researched and explored the predictors of personal and perceived anxiety disorder stigma. This study was one of the first systematic examinations of personal and perceived anxiety disorders stigma and predictors of negative attitudes towards this disorder.

The study included a random sample of Australian adults (n = 617). This study’s independent variables included age, gender, rurality, exposure to anxiety disorders, and current stress, anxiety, and depression levels. Dependent variables included personal anxiety stigma, perceived anxiety disorder stigma, and depression stigma. Participants

were given two stigma scales to access anxiety disorder stigma and depression stigma. The GASS was given to assess for levels of perceived and personal anxiety disorder stigma. Respondents also completed the Depression Stigma Scale to assess negative and stigmatized attitudes towards depressive disorders. Linear regression models from this study suggest that women with more exposure to anxiety disorders and persons who reported a previous anxiety disorder diagnosis endorsed lower personal stigma levels towards anxiety disorders. Demographic factors such as rurality and higher exposure to anxiety disorders were significantly associated with participants having high levels of perceived anxiety disorder stigma (Batterham et al., 2013).

Grant et al. (2016) similarly conducted a study on predictors of perceived anxiety disorder stigma that explored predictors of personal, perceived, and self-stigma towards anxiety and depression in a population of men and women with an age range between 17-63 years old. The sample (n = 350) included both male (n = 109) and female (n = 241) participants who were enrolled in a first-year psychology course at a major Australian University. Participants were given surveys presenting vignettes depicting and displaying typical behaviors of people diagnosed with anxiety disorders and depression. After completing the vignettes, respondents completed measures of perceived anxiety disorder stigma, personal anxiety stigma, self-anxiety stigma, and depression stigma in relation to each vignette. Perceived and personal anxiety stigma was measured using the GASS. Perceived and personal depression stigma were measured using the Depression Stigma Scale. Both scales in this study had high levels of internal consistency. Linear regression models were used to assess the effects of dependent factors on both stigma measures.

More significant contact and knowledge of mental disorders predicted lower personal stigma for depression and anxiety. However, perceived stigma was minimally affected by all dependent factors (Grant et al., 2016).

Calear et al. (2017) studied the phenomenon of perceived anxiety disorder stigma in a population of adolescents. The study sought to identify personal and perceived anxiety disorder stigma levels and predictors of stigma. The sample included (n = 1,840) adolescents between the ages of 12 and 18. The majority were female (64.6%). Respondents completed the Generalized Anxiety Disorder Stigma Scale in addition to the sociodemographic questionnaire. Like previous studies assessing for levels of perceived anxiety disorder stigma and predictors, respondents in this study reported considerably higher levels of perceived anxiety disorder stigma compared to personal stigma. Independent factors contributing to high levels of perceived anxiety disorder stigma included living with one parent, being male, having higher levels of anxiety literacy, and depressive symptoms.

Summary

In this chapter, a review of the literature was conducted exploring the concept of stigma, mental health stigma, anxiety stigma, and perceived anxiety disorder stigma. This review included important research discussing mental health stigma and the effects of perceived anxiety disorder stigma on help-seeking behaviors. Moreover, a discussion on perceived anxiety disorder stigma and its negative impacts on a person's beliefs about anxiety, its role in reducing help-seeking behavior, and how it can negatively impact function levels is included. Evidence of how the present study fills a gap in the literature

and extends knowledge in the discipline of counseling is also included. A summary and rationale are given for the use of social stigma theory and the independent and dependent variables used in this study. Finally, studies related to the research question, methodology, dependent variable, and independent variables were discussed.

The restricted breadth of stigma and anxiety disorder studies has led some researchers to call for an expansion of the field's study of stigma and its impact on persons with anxiety disorders (Calear, 2017; Link & Hatzenbuehler, 2016). Due to the shame experienced and concerns about stigma, people with anxiety disorders may encounter difficulties seeking treatment (Nearchou et al., 2020). However, little research has focused on stigma and anxiety disorders (Schofield & Ponzini, 2020). Given that people with anxiety disorders could be more vulnerable and susceptible to negative anxiety stereotypes, less is known about the impact of perceived anxiety disorder stigma, personal anxiety stigma, and self-anxiety-stigma on persons with anxiety disorders and factors that predict these types of stigmas (Goetter et al., 2020).

The majority of research on the nature and impact of stigma on mental health disorders focused on just a few conditions. The impact of stigma on depression and schizophrenia has garnered much attention in the literature (Corrigan et al., 2014). Mental health stigma and anxiety disorders account for less than 3% of the studies included in a thorough evaluation of mental health stigma research and mental health disorders (Schofield & Ponzini, 2020). Furthermore, predictors of perceived anxiety disorder stigma in a population of adults with anxiety disorders appears to be a subject in the

literature that has received little to no coverage (Clement et al., 2014). After a thorough study of the literature, no studies on this topic were found.

Clinical supervision might be one strategy for the Counselor Education and Supervision profession to advocate for vulnerable populations of people with anxiety disorders who are affected by perceived anxiety disorder stigma. Supervisees are becoming more culturally sensitive to the requirements of their diverse clients as a result of classroom instruction and clinical supervision (Fickling et al., 2019). A client's unique needs, on the other hand, may include how mental health stigma impacts them and who is more vulnerable to certain types of mental health stigma (Avent-Harris et al., 2021). This study might help improve how Counselor Education and Supervision supervisors provide supervision on topics such as mental health stigma, clinical demographic vulnerability, and predictors of anxiety disorder stigma. Finally, the study's findings may help clinical supervisors better support supervisees in performing their professional roles as client advocates, as described by the ACA (2014) and CACREP (2016).

This quantitative study could also help to address a gap in the stigma and anxiety disorder research literature. Specifically, this study may help address what is unknown about how factors such as age, gender, and level of education predict perceived anxiety disorder stigma in adults with anxiety disorders. A quantitative correlational design was used to better understand if factors like age, gender, level of education, and anxiety disorders predict perceived anxiety disorder stigma in adults (Creswell & Creswell, 2017). For concepts such as perceived anxiety disorder stigma, quantitative survey methodologies are helpful for evaluating attitudinal levels (Marcopulos et al., 2020).

Moreover, a correlational study design might aid in determining the extent to which the independent variables of age, gender, and level of education are connected and predict the dependent variable of perceived anxiety disorder stigma.

Chapter 3 will discuss this dissertation's design and methods, providing a discussion of the research design and justification for the measurements utilized in this dissertation. In addition, Chapter 3 will focus on the rationale for the study design, the sampling procedures, descriptions of populations used, data collection procedures, and data analysis methods. Chapter 3 will conclude with a summary of actions taken for the ethical protection of this dissertation's research participants.

Chapter 3: Research Method

The purpose of this study was to quantitatively assess for predictors between and among variables of perceived anxiety disorder stigma (as measured by the GASS), age, gender, and level of education in a population of adults in the United States who have been diagnosed with anxiety disorders. The independent variables were age, gender, and level of education. The outcome variable for this survey study was perceived anxiety disorder stigma. Data were analyzed using a Pearson product-moment correlation analysis and a multiple linear regression analysis to assess for correlations among the variables and predictions of the dependent variable perceived anxiety disorder stigma. The methodology for determining whether perceived anxiety disorder stigma levels differ by age, gender, level of education, and anxiety disorders is described in this chapter. This chapter also covered the study's research design and rationale, instrumentation and materials, population and sample size, data collection procedures, and implemented ethical protections provided to participants.

Research Question and Hypothesis

This study used a quantitative research design that was organized around one research question and associated hypothesis:

RQ1: Do factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS?

H_0: Factors such as age, gender, and level of education do not predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

H_1: Factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

Research Design and Rationale

The purpose of this study was to assess for predictors of perceived anxiety disorder stigma in a population of U.S. adults who have been diagnosed with anxiety disorders. The research design selected for this study was a non-experimental correlational approach implementing quantitative survey methods. The data for this study originated from an existing data set of U.S. adults diagnosed with anxiety disorders who sought treatment at an anxiety treatment center in the Midwest.

Several normed stress, depression, and anxiety scales are used in the anxiety treatment center's standard intake approach that help to inform treatment and provide data for anxiety research. Since 2015, the standard intake battery has included The Primary Mental Health Demographic Intake Questionnaire (PMHIQ), The Beck Anxiety Scale (BAS), The Beck Depression Inventory-II (BDI-II), The Outcome Questionnaire 45 (OQ45), and The Generalized Anxiety Stigma Scale (GASS). New clients at the anxiety treatment center are provided with consent forms that explain how their test data may be used anonymously in various scenarios. Test results, for example, might be used to guide therapy, assist in diagnosis, or serve as data for future anxiety disorder studies. After

receiving IRB approval, the existing data were used from the GASS to collect data about attitudes related to perceived anxiety disorders stigma in a population of adults with anxiety disorders.

This study examined if a significant correlation exists between the independent variables of age, gender, level of education, and anxiety disorder and the dependent variable perceived anxiety disorder stigma. Quantitative survey methods are appropriate for measuring attitudinal levels for concepts such as perceived anxiety disorder stigma (Marcopulos et al., 2020). Statistical and predictive existence can be effectively examined by using a quantitative correlational design (McCusker & Gunaydin, 2015). Mental health research has relied heavily on quantitative survey research and correlational research designs to understand extraneous predictor variables and their impact on mental health concepts, including mental health stigma (Bebbington, 2016; Dillman, 2016).

In this study, the correlational research design served as the line of inquiry and is aligned with the research question. For example, this study's research question examines the degree of variance explained in perceived anxiety disorder stigma through the following predictor variables: age, gender, and level of education. A correlational design using a linear regression analysis helped examine the degree of variance for the dependent variable, perceived anxiety disorder stigma. Moreover, a correlational design and linear regression analysis was helpful when testing the hypothesis of this study better than if the author attempted to use a descriptive research design which does not assess for relationships (see Creswell & Creswell, 2017).

Other research design choices were less suitable for this study for the following reasons: (a) an experimental design focuses on comparing group means (Ross, 2017), (b) the research question for this study was not intended for the researcher to examine group means, and (c) there was no experimental intervention required for this study. Therefore, dividing participants into test and control groups was not helpful for this study during the examination of predictors that may correlate with perceived anxiety disorder stigma (Khaldi, 2017). A solely descriptive analysis would have concluded with an incomplete analysis for testing relationships between and among variables (Holcomb, 2016).

Methodology

Population and Sampling Procedures

Data for this study was drawn from an existing data set of adults between the ages of 18 and 65 who live in the Midwest who sought specialized anxiety treatment for anxiety disorders. A G*Power 3 statistical analysis was used to derive a target sample size for this study (Faul et al., 2009). The sample input calculation included a fixed model with R^2 increased and a corrected level of statistical significance (Bonferroni, 1936) for the regression analysis with one criterion variable and the predictors. Alpha level was set to 0.05 and a medium power level with an effect size of .80 or greater (Faherty, 2007). This resulted in a sample size of 82.

Procedures for Recruitment, Participation, and Data Collection

The data for this study originated from an existing data set of U.S. adults who had been diagnosed with anxiety disorders and who subsequently sought treatment at a Midwest anxiety treatment center. The Midwest anxiety treatment center's charter

focuses on the evidence-based treatment of anxiety disorders and the empirical research of anxiety issues and anxiety disorders. Several normed stress, depression, anxiety, and stigma scales comprise a standard intake battery used at the Midwest anxiety treatment center that helps to inform treatment and provide data for anxiety research. Since 2015, The standard intake battery has included, The Primary Mental Health Demographic Intake Questionnaire (PMHIQ), The Beck Anxiety Scale (BAS), The Beck Depression Inventory (BDS), The Outcome Questionnaire 45 (OQ45), and The Generalized Anxiety Stigma Scale (GASS).

New clients at the Midwest anxiety treatment center are provided with consent forms attached to the top of the battery of assessments that explained how their test data may be used anonymously in various scenarios. The consent forms explained the following to all new clients at the Midwest anxiety treatment center: test results might be used to guide therapy, assist in diagnosis, or serve as anonymous data for anxiety studies. In addition, clients are informed about where their anonymous data may appear when used for research purposes. Examples of where test data may be used include journal articles, mental health workshops, mental health conferences, and community psychoeducation events.

The following precautions were taken to protect the identities of the participants in the existing data set. The proposal for this study was submitted for IRB review and approved. A managing member of the Midwest anxiety treatment removed identifying information before the existing data set was released to the author for analysis. All collected data from surveys was coded with a number only. Collected data was kept by

the researcher in a locked and secure file cabinet during this study. The researcher had sole access to the locked file cabinet containing the data for this study. The locked file cabinet was kept in a locked office inside a secure office suite with preserved anonymity.

Instrumentation

Data for this study originated from an existing data set collected as part of a standard intake procedure at a Midwest anxiety treatment center. Demographic data for this study was collected by accessing the PMHIQ survey data used in the standardized intake process. Data about perceived anxiety disorder stigma attitudes was captured by accessing the GASS survey data previously obtained from clients that was used in the standardized intake process. The instruments used are listed below.

Demographic Data Scale

The PMHIQ assesses basic demographic information. The PMHIQ is a generic mental health intake questionnaire that addresses demographic information from fifteen distinct categories: (a) identifying information such as name, age, and gender, (b) number of children, (c) persons residing in home, (d) nature of current problem, (e) mental health symptoms, (f) gender, (g) sexual orientation, (h) medication history, (i) medical history, (j) suicidal ideation, (k) family history, (l) social history, (m) education, (n) employment, and (o) substance abuse history. The PMHIQ addressed RQ1 by providing demographic information such as age, gender, and level of education. Only level of education, gender, and age were used in this study as independent variables and assessed to see whether these variables have a significant relationship with perceived anxiety disorder stigma.

Perceived Anxiety Disorder Stigma Subscale of the GASS

The GASS was designed to assess perceived anxiety disorder stigma in adults with anxiety disorders and addressed the dependent variable in this study for RQ1. The GASS is a scale developed by Griffiths et al. (2011). The GASS is used to assess the respondent's level of stigma attached to anxiety disorders. It is divided into two subscales that evaluate two forms of stigma: personal and perceived. The personal anxiety stigma subscale assesses respondent's attitudes toward anxiety disorders by asking them to rate how strongly they agree or disagree with ten statements regarding anxiety disorders. The perceived anxiety disorder stigma subscale assesses a respondent's view of other's attitudes toward anxiety disorders. Permission was obtained from the co-author of the GASS to include it and either subscale as part as part of this study's analysis (see appendix A). For this study, scores were only included for the perceived anxiety disorder stigma subscale to address RQ1. The scale for perceived anxiety disorder stigma consists of 10 Likert-type questions divided into distinct ordinal categories: (a) *strongly agree*, (b) *agree*, (c) *neither agree nor disagree*, (d) *disagree*, and (e) *strongly disagree*.

Scoring for the GASS includes summing up both subscales to create a total score between 0 and 80; for each subscale, the range is between 0 and 40. Higher scores reflect a higher level of anxiety disorder stigma in general. The perceived anxiety disorder stigma subscale is comprised of 10 questions: (a) Most people think that an anxiety disorder is not a real medical illness, (b) Most people think that an anxiety disorder is a sign of personal weakness, (c) Most people think that people with an anxiety disorder could snap out of it if they wanted to, (d) Most people think that people with an anxiety

disorder should be ashamed of themselves, (e) Most people think that people with an anxiety disorder do not make suitable employees, (f) Most people think that people with an anxiety disorder are unstable, (g) Most people think that people with an anxiety disorder are to blame for their problem, (h) Most people think that people with an anxiety disorder are just lazy, (i) Most people think that people with an anxiety disorder are a danger to others, (j) Most people think that people with an anxiety disorder are self-centred.

Validity and Reliability

Validity within assessments is thought of as the ability to accurately measure the target construct that the assessment was designed to measure (Yoshiyasu et al., 2019). Validity may vary based on the intent of accuracy assessed by a measure (Longest, 2019). Examples of this include construct validity, validity, criterion validity, and translational validity (Putra et al., 2019). According to Griffiths et al. (2011), the GASS is a promising short measure of stigma associated with anxiety disorders. The GASS, developed by Griffiths et al. (2011), is a measure of perceived and personal anxiety stigma. The psychometric properties for the GASS were derived from a population sample (n = 617) of Australian adults aged 18 to 65 who were randomly selected from one urban and one rural setting in NSW Australia, with (n = 212) in the follow-up sample (Griffiths et al., 2011). The GASS assessment for personal and perceived anxiety disorder stigma has demonstrated acceptable levels of validity and reliability which is discussed in greater detail in the next section (Griffiths et al., 2011). The GASS personal and perceived stigma scales are reported to have good divergent and convergent validity and moderate

test-retest reliability (Grant et al., 2010), high internal consistency (a = 0.86-0.90 and 0.91-0.94) separately.

Griffiths et al. (2017) examined factors such as age to determine if those factors influence a person's susceptibility to personal and perceived anxiety disorder stigma. The GASS was used as a valid measure to test both construct variables and their relation to age. An acceptable level of internal consistency was attained in this study using the GASS; Cronbach's alpha of 0.91 for GASS-personal anxiety stigma and 0.93 for GASS-perceived anxiety disorder stigma.

Griffiths et al. (2011) assessed psychometric properties of the GASS community sample of Australian adults. There were significant correlations between the GASS subscales and other popular measures that assess for stigma constructs. Other measures used for norming the GASS in this study included The Depression Stigma Scale (DSS), The Social Distance Scale (SDC), and the Devaluation Discrimination Scale. Significant correlations in construct validity were observed when comparing the GASS-personal stigma scale to the DDS ($p < 0.0001$) and the mental illness anxiety version of the Social Distance Scale ($p < 0.0001$). In addition, significant correlations were observed between the GASS-perceived subscale and the DSS-perceived depression subscale ($p < 0.0001$), with a significant correlation also observed when compared to the Devaluation Discrimination Scale ($p = 0.019$). The significant correlations between the GASS subscales and the SDC, DDS, and Devaluation Discrimination Scale demonstrated evidence of convergent validity.

In a similar psychometric property study by Griffiths et al. (2011), test-retest reliability of the GASS was examined. The average follow-up period for retest was 17.3 weeks (*SD* = 2.71). Test-retest reliability of the span of four months was 0.58 and 0.55 for perceived and personal stigma subscales respectively ($p < 0.0001$). In both personal and perceived anxiety disorder stigma subscales, significant differences were not observed in follow-up and baseline stigma scores; (GASS-perceived: difference = 0.39 $t_{208} = 0.94$, $p = 0.34$; GASS-personal: difference = -0.08 $t_{209} = 0.25$, $p = 0.80$).

Data Analysis Plan

The primary data analysis for this study consisted of a multiple linear regression among all predictor variables and the criterion variable since the objective of the research question is to assess for correlations between the independent variables and the dependent variable. Variables were evaluated at the interval level. The best predictive ranking of the three predictor variables of age, gender, and level of education were determined using a stepwise method. This method would better disclose any major controls that should be enforced. For all hypothesis checks, a judgment criterion of alpha ≤ 0.017 was set, which was calculated using a Bonferroni correction for three predictors ($0.05/3 \approx 0.017$). Using SPSS (v.28), descriptive statistics were implemented to describe the demographics of the study's population and the test variables.

The data was checked during the initial stage of analysis to see how the scores were distributed. During the initial stage, questionnaires were excluded from the data analysis if they are incomplete. Participants who did not meet the inclusion and exclusion criteria were not included in the final data analysis. Depending on the context and nature

of the data collection, outliers were dealt with in a variety of ways. To eliminate skewness in the data analysis, the record of a specific person/event were fully deleted from the dataset when significant outliers were identified.

It is unknown whether age, gender, and level of education predict perceived anxiety disorder stigma among U.S. adults with anxiety disorders, and if so, to what extent. The following research question and hypothesis were developed to answer this problem statement.

RQ1: Do factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS?

H_0: Factors such as age, gender, and level of education do not predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

H_1: Factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

The variables associated with RQ1 are V1: Perceived anxiety disorder stigma measured by the Perceived Stigma Subscale of the GASS. V2: age measured by the PMHIQ: gender measured by the PMHIQ: and level of education measured by the PMHIQ.

Assumptions

After the initial data was reviewed and cleaned, the data were then screened to ensure that the assumptions of a multiple regression were met. There are multiple data assumptions in a multiple linear regression analysis (Longest, 2019). The data assumptions are as follows:

1. Two or more predictor variables are measured either ordinal, interval, or ratio levels.
2. Independence of observation must be established (i.e., independence of residuals)
3. A linear relationship must be established between (a) the outcome/criterion and all the predictive variables and (b) the predictor and criterion variables together.
4. Homoscedasticity of residuals must be present.
5. No multicollinearity can be present.
6. There can be no high leverage points, significant outliers, or highly influential points.
7. There must be a normally distributed approximation of residuals (errors).

The first two assumptions are met because of the variable structure. The outcome/criterion variable perceived anxiety disorder stigma is interval, and all predictor variables meet the second assumption. While the study's nature ensures independence of observation, Assumption #3 can be checked by using the Durbin-Watson test. A scatterplot was used to evaluate the studentized residuals to assess linearity between the criterion and predictor variables collectively, and partial regression plot was used to

decide whether there is a linear relationship between the criterion and predictor variables individually.

The assumption that residuals are homoscedastic (Assumption #5) was tested visually by plotting studentized residuals against unstandardized predicted values. Multicollinearity (Assumption #6) was checked by looking at the correlation coefficients of the predictor variables to see if any of them had a correlation of more than 0.7 with other predictor variables. The Tolerance and VIF coefficients were also checked to see if they surpassed the limits of less than 0.1 for Tolerance and more than 10 for VIF. Casewise diagnostics were used to test assumption #7 (outliers) to see if any data points met and/or exceeded a standardized residual greater than ±3 standard deviations. Finally, a standard Q-Q plot of the studentized residuals was implemented to test Assumption #8 (normality). Normality of residuals was not violated for (Assumption #8. Following the completion of all screening procedures and the fulfillment of all needed assumptions for multiple/hierarchical regression, the data was analyzed using two hierarchical moderated regression analyses based on research question and hypothesis with a sample size of n = 82.

Threats to Validity

Threats to External Validity

The external validity of a research study refers to the extent to which its findings may be applied to a wider population (Brewer, 2000). Overgeneralization (population validity) of findings to all U.S. adults with anxiety disorders might pose a danger to external validity in this study. This threat to validity were reduced by using a bigger,

more representative sample (Frankfort-Nachmias & Nachmias, 2014). Furthermore, convenience sampling may have an impact on this study's external validity. To address this problem, a power analysis was utilized to determine the 82 suitable sample size, ensuring that the sample size is representative of the target population and appropriate to generalize. In addition, this study provided inclusion and exclusion criteria to improve the external validity and reliability of the research findings (Patino & Ferreira, 2018).

Threats to Internal Validity

Internal validity refers to the degree to which a study's findings are a function of the factors that were systematically controlled, measured, and observed throughout the research (Fraenkel & Wallen, 2003). To ensure the study's internal validity, a researcher should determine if changes in the dependent variable are caused by changes in the independent variable (Frankfort-Nachmias & Nachmias, 2014). Because cross-sectional research techniques lack control, the adoption of correlational research design may pose the greatest danger to internal validity in this study. This risk was addressed in this study by noting the study's limitations.

Selection interaction may pose a danger to internal validity in this study. Precautions were taken to reduce the risk of biased sampling procedures. For example, if participants are chosen based on desirable qualities like total perceived anxiety disorder stigma score the selection interaction might have an influence on the study, resulting in biased sampling. Biased sampling was mitigated by employing a random sampling approach to pick responders from a population in which everyone has an equal probability of being included (Frankfort-Nachmias & Nachmias, 2014).

Internal validity threats such as statistical regression might have an impact on the research findings. Statistical regression refers to the process of picking the participant with the highest or lowest score. This problem was handled by employing data screening procedures (Creswell & Creswell, 2017). Furthermore, the threat of instrumentation may have an impact on the validity of the current study's findings. When an independent and dependent variable are measured in distinct methods, this is known as instrumentation (Creswell & Creswell, 2017). This problem was addressed by collecting data from the sample using standardized techniques, conditions, and valid questionnaires.

Threats to Construct Validity

The extent to which measuring instruments are logically and empirically connected to the ideas and theoretical assumptions is referred to as construct validity (Frankfort-Nachmias & Nachmias, 2014). Lack of construct validity might lead to researchers assessing things they don't wish to measure. Valid, objective, and standardized scales such as the GASS and the PMHIQ were used to measure the independent variables (age, gender, and level of education), and dependent variable (perceived anxiety disorder stigma) in the current study to increase construct validity.

Furthermore, the alignment of the measurement instruments, the theoretical framework, and the constructs of interest in the study are discussed in this study. The theoretical framework of social stigma as presented in chapters 1, 2, and 3, assumes that people who have high levels of perceived anxiety disorder stigma may be less likely to associated themselves with mental health treatment to avoid being placed outside of normative categories and avoid experiencing additional hardships resulting from mental

health stigma, mental health discrimination, and social exclusion. To ensure that the theoretical framework, core construct, and measuring scales are adequately matched, all of the constructs employed in this study are operationally defined. Furthermore, the GASS measurement scales' statistical properties (e.g., validity, coefficient alpha) are specified in the current study to ensure that this scale measures the same construct that it claims to measure (Frankfort-Nachmias & Nachmias, 2014). Finally, generalizability may be a limitation due to a geographically confined sample (Creswell & Creswell, 2017).

Ethical Procedures

For this study, approval was sought and granted from the Institutional Research Review Board (IRRB) before conducting the study. The author also requested permission from all managing members of the Midwest treatment center to release the data set to the author for statistical analysis. Because the data set already exists, the author was not able to directly influence recruitment strategies, data collection, or provide informed research participation consent to respondents. However, to ensure that the participants within the random sample for this study are protected, the author reviewed the Midwest treatment centers consent for testing forms given to new clients to check for the following research consent factors:

1. The nature of the assessments was explained.
2. Consent was given about how test data may be used.
3. Specific consent was provided about test data being used anonymously for research purposes.

4. An option provided for test data to not be used anonymously for research purposes.
5. How test data will be stored.
6. Risks and benefits of taking assessment.
7. Where the results of research may appear that anonymously used the clients test data
8. How anonymity will be kept if test data is used for research purposes.

Surveys where the respondent did not answer all consent questions were removed from the sample.

Summary

This quantitative survey analysis examined if the dependent variables of age, gender, and level of education, predict perceived anxiety disorder stigma in a population of U.S. adults diagnosed with anxiety disorders as measured by the Perceived Anxiety Stigma subscale of the GASS. A correlational research design was used in this study. The correlational design was sufficient for answering RQ1 in this study. For example, the research question in this study explored the degree of variation explained in perceived anxiety disorder stigma by the predictor variables of age, gender, and educational level. A correlational design with multiple linear regression analysis can be used to investigate the degree of variance for reported anxiety disorder stigma. Furthermore, a correlational design and linear regression analysis was helpful in evaluating this study's hypothesis. The sample in this study consisted of adults between the ages of 18 and 65 who presented to a Midwest mental health practice for specialized anxiety care between 2015 and 2022.

Data from a Midwest mental health practice was used in this study. Within the existing data set, A PMHIQ was used to collect demographic data. In addition, the Perceived Stigma Subscale of the GASS was used to collect data on peoples' perceptions of anxiety stigma. Since the research question for this study examined if there are associations between independent variables and the dependent variable, the primary data analysis for this study was a multiple linear regression between all three predictor variables and the criterion variable. All variables were evaluated at the interval level for this study. The observations and conclusions from the statistical analysis performed are discussed in Chapter 4 of this dissertation.

Chapter 4: Results

The purpose of this study was to quantitatively assess for predictors between and among variables of perceived anxiety disorder stigma (as measured by the GASS), age, gender, and level of education in a population of U.S. adults diagnosed with anxiety disorders. Furthermore, the question of whether age, gender, and level of education predict perceived anxiety disorder stigma, as measured by the GASS, in adults with anxiety disorders was explored. Age, gender, and level of education were the independent variables. Perceived anxiety disorder stigma was the outcome variable for this study.

Data were analyzed using a Pearson product-moment correlation analysis and a multiple linear regression analysis to determine relationships between factors and predict the dependent variable perceived anxiety disorder stigma. Data collection strategies will be described in this chapter. This chapter will also cover the results of the Pearson product-moment correlation and multiple linear regression analysis.

Research Question and Hypothesis

This study used a quantitative research design that was organized around one research question and associated hypothesis:

RQ1: Do factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS?

H_0: Factors such as age, gender, and level of education do not predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

H_1: Factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evidenced by the Perceived Stigma Subscale of the GASS.

Data Collection

I gained Walden IRB approval on July 8, 2022 (IRB # 07-08-22-0576896). On July 11, 2022, an existing dataset of adults diagnosed with anxiety disorders who completed intake assessments at a Midwest anxiety treatment center was released to me by a managing member of the treatment center. Data were received in the form of anonymous completed assessment packets. The sample population (n = 82) included adults diagnosed with anxiety disorders between the ages of 18 to 65 with levels of education ranging from some high school through having obtained a doctorate degree. No problems were encountered during the data collection process that would create discrepancies in the data collection plan outlined in chapter 3.

The target population for this study consisted of adults of any gender or nonbinary gender between the ages of 18 to 65. Participants included those who had an education level between no high school and a doctorate degree who were also diagnosed with an anxiety disorder while receiving treatment at the anxiety treatment center. All respondents in this study's sample matched 100% of the criteria set forth for the target population. In this chapter, descriptive statistics are presented for the selected sample. Survey data were gathered, stored, and analyzed using Microsoft Excel and SPSS (v. 28). All data was gathered using the protocols outlined in Chapter 3.

Table 1 lists demographic characteristics, frequencies, and percentages. A large portion of the sample was comprised of females who represented 69.5% (*n* = 57) of the sample and males represented 30.5% (*n* = 25) of the total. The majority of respondents in this sample were adults between the ages of 35-44 (*n* = 31), which represented 37.8% of the sample. Ages 18-24 = 17.1% (*n* = 14); 25-34 = 20.7% (*n* = 17); and 45-55 = 24.4% (*n* = 20). In the sample, the most common degree held was a bachelor's degree with 43.9% (*n* = 36) holding this distinction. High school diploma = 7.3% (*n* = 6); some college = 17.1% (*n* = 14); trade or vocational = 4.9% (*n* = 4); associated degree = 12.2% (*n* = 10); and master's degree = 14.6% (*n* = 12).

Table 1

*Demographic Breakdown (*N=*82)*

Variable	Frequency	Percent
Gender		
Male	25	30.5%
Female	57	69.5%
Age		
18-24	14	17.1%
25-34	17	20.7%
35-44	31	37.8%
45-54	20	24.4
Level of Education		
High School Diploma	6	7.3%
Some College	14	17.1%
Trade or Vocational	4	4.9%
Associates Degree	10	12.2%
Bachelor's Degree	36	43.9%
Master's Degree	12	14.6%

Preliminary Analyses

Data Cleaning

The sample consisted of 82 participants. Screening procedures were conducted to identify and exclude intake packets with missing survey data. No intake packets in or

from the final sample had missing data from surveys. Outliers were determined using Tabachnick and Fidell's (2013) plus-minus range that asserts that scores should be greater than +3.29 and less than -3.29. Outliers that are not addressed can cause Type I and Type II errors. Because there were no outliers in this category, no participants were excluded. Descriptive statistics for this study's dependent and independent variables can be found in Table 2.

Table 2

Descriptive Statistics for Study Variables

Variable	*N*	Minimum	Maximum	*M*	*SD*
Perceived Anxiety Disorder Stigma	82	10	35	22.72	5.567
Age	82	1	4	2.70	1.027
Gender	82	0	1	.70	.463
Level of Education	82	2	7	5.12	1.559

Descriptive Statistics and Frequencies

Perceived anxiety disorder stigma = Perceived attitudes about how others view persons with anxiety disorder; scores closer to 0 = lower perceived anxiety disorder stigma, scores closer to 40 = higher perceived anxiety sigma. Age was code as follows; 1 = 18-24 years old; 2 = 25-34 years old; 3 = 35-44 years old; 4 = 45-54 years old; 5 = 55-64 years old; and 6 = 65-74 years old. Gender was coded as follows; 0 = male; 1 = female. Level of Education was coded as follows; 0 = no school; 1 = some high school; 2 = high school diploma; 3 = some college; 4 = trade or vocational school; 5 = associates

degree; 6 = bachelor's degree; 7 = master's degree; 8 = professional degree; and 9 = doctorate degree.

Assumption Testing

Prior to conducting the main analysis, the data was examined for linearity, normality, homoscedasticity, error independence, and a lack of multicollinearity (Tabachnick & Fidell, 2013). Normality of the dependent variable perceived anxiety disorder stigma was examined by observing the skew and kurtosis values. Normality is met when the skew is between $-2 < x < +2$ and the kurtosis is between $-4 < x < +4$ (Tabachnick & Fidell, 2013). The dependent variable perceived anxiety disorder stigma met the assumption of normality. Table 3 depicts the normality test.

Table 3

Assumptions of Normality

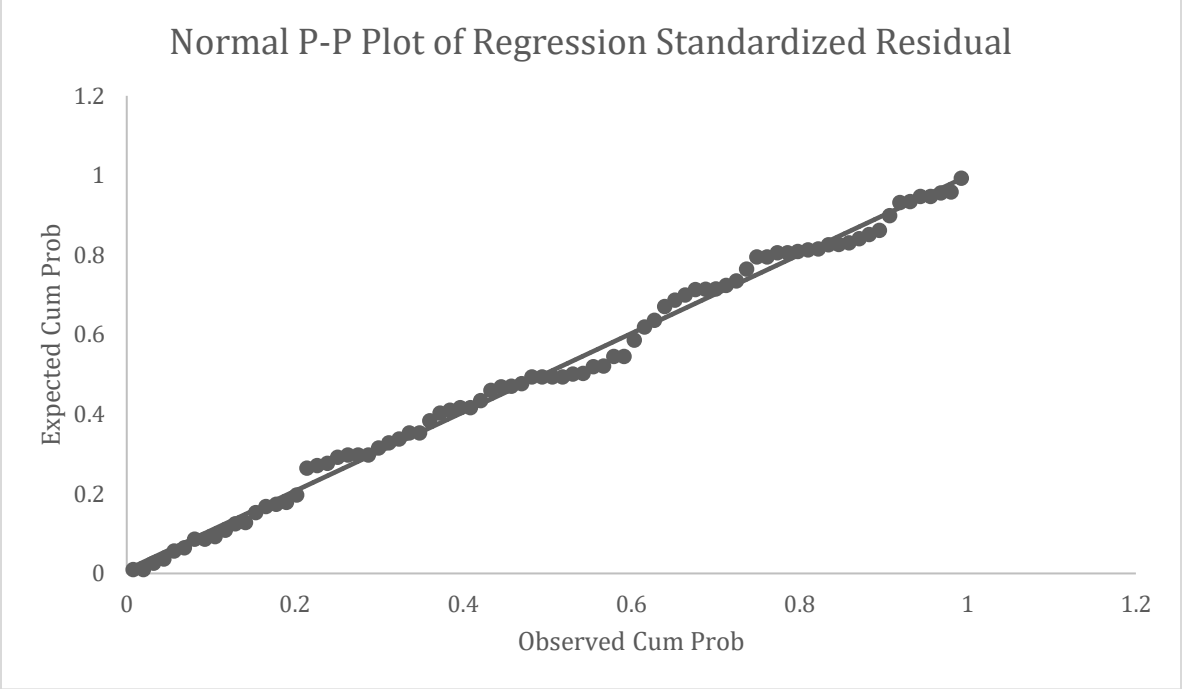
Instrument Scale	Skewness	Kurtosis
Perceived Anxiety Disorder Stigma	-.005	-.219

Linearity and homoscedasticity were also evaluated. A scatterplot was used to evaluate the residuals. The linearity assumption asserts that there is a straight-line relationship between the predictor variables of age, gender, level of education and the outcome variable of perceived anxiety disorder stigma. The assumption of homoscedasticity is that scores are regularly distributed around the regression line (Creswell & Creswell, 2017). The residuals scatterplot showed that the linearity and

homoscedasticity requirements were fulfilled. Figure 1 depicts the standard P-P plot for the outcome variable of perceived anxiety disorder stigma.

Figure 1

Normal P-P plot for perceived anxiety disorder stigma



Multicollinearity is used to assess for skewness. The lack of multicollinearity implies that the predictor variables in this study were not too closely connected (Faherty, 2007). Variance inflation factors (VIF) values were used to determine the absence of multicollinearity. Neither of the VIF values for the predictor variables or age, gender, and level of education were more than 2, suggesting that the assumption was satisfied. Table 4 shows the variance inflation components.

Table 4

Variance Inflation Factor

Variables	VIF values
Age	1.277
Gender	1.023
Level of Education	1.285

Reliability

Perceived anxiety disorder stigma is a subscale of the GASS, this subscale was used in this study to measure perceived anxiety disorder stigma attitudes within this study's sample. The perceived anxiety disorder stigma scale of the GASS was found to be reliable by using Cronbach's alpha as an internal measure of consistency (Faherty, 2007). Scores that fall between $0.7 < a < 0.8$ are acceptable. The perceived anxiety disorder stigma scale yielded a Cronbach's alpha score of .787.

Main Analysis

RQ1 asked if factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evinced by the Perceived Stigma Subscale of the GASS. The predictive variables for this study were age, gender, and level of education. The hypothesis for this study stated that factors such as age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults diagnosed with anxiety disorders as evinced by the Perceived Stigma Subscale of the GASS.

A multiple linear regression was utilized to examine if the predictor variables of age, gender, and level of education predicted perceived anxiety disorder stigma attitudes in a sample of adults diagnosed with anxiety disorders. The results of the multiple linear regression analysis indicated that all predictor variables were significant predictors of perceived anxiety disorder stigma in a sample of adults diagnosed with anxiety disorders. These findings resulted in the rejection of the null hypothesis. Predictors of perceived anxiety disorder stigma in a sample of adults diagnosed with anxiety disorders is presented in Table 5.

Table 5

Predictors of Perceived Anxiety Disorder Stigma Coefficients[a]

Variable	*B*	*SE*	β	*t*	*p*
Age	1.394	.569	.257	2.449	.017
Gender	3.715	1.129	.309	3.290	.002
Level of Education	.911	.376	.255	2.421	.018

Summary

In summary, a multiple linear regression analysis was run to examine if the predictor variables of age, gender, and level of education, predicted perceived anxiety disorder stigma attitudes in a sample (n = 82) of adults diagnosed with anxiety disorders. The author of this study hypothesized that perceived anxiety disorder stigma could be predicted by age, gender, and level of education in a sample of adults diagnosed with anxiety disorders. The hypothesis of this study was supported by the results of the

multiple linear regression analysis that indicated all three predictor variables had a significant level of influence over the dependent variable of perceived anxiety disorder stigma.

Chapter 5 will address the significance of the multiple linear regression analysis results in this chapter. In addition, the findings will be interpreted in Chapter 5, as will the limitations to generalizability. Chapter 5 will also include recommendations for future study as well as implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this quantitative study was to determine whether factors including age, gender, and level of education, predicted perceived anxiety disorder stigma (as measured by the GASS) in a population of U.S. adults diagnosed with anxiety disorders. For this study, a quantitative correlational design was used, and a multiple linear regression analysis was conducted to assess for predictive relationships between the independent variables of age, gender, and level of education and the dependent variable of perceived anxiety disorder stigma. This type of study was necessary due to the impact that perceived anxiety disorder stigma can have on help seeking behaviors and premature treatment dropout along with limited data in the United States about demographics of adults with anxiety disorders who may be vulnerable to this type of stigma.

The hypothesis was demographic variables such as age, gender, and level of education would predict perceived anxiety disorder stigma, as evidenced by the Perceived Stigma Subscale of the GASS, in a population of U.S. adults diagnosed with anxiety disorders. The results of the multiple linear regression analysis validated this study's hypothesis, indicating that all three predictor variables had a significant level of influence over the dependent variable of perceived anxiety disorder stigma.

Interpretation of The Findings

The findings of this study suggested that age, gender, and level of education are significant predictors of perceived anxiety disorder stigma ($p < .001$). Among all predictor variables, gender predicted the greatest about of variance for the dependent variable of perceived anxiety disorder stigma $R^2 = .30$, $F(12,639) = 81$, $p = .002$; Age

generated the second highest amount of variance $R^2 = .26$, $F(12,639) = 81$, $p = .017$; and gender contributed to the third highest level of variance $R^2 = .25$, $F(12,639) = 81$, $p = .018$.

This study helps better understand factors that potentially impact perceived anxiety disorder stigma attitudes in U.S. adults diagnosed with anxiety disorders. A significant amount of research existed on predictors of anxiety disorder stigma and perceived anxiety disorder stigma in nonclinical populations of adults (Alonso et al., 2008; Batterham et al., 2013; Calear et al., 2017; DeFreitas et al., 2018; Grant et al., 2016; Griffiths et al., 2011). Within the literature, studies that focus on predictors of mental health stigma have heavily focused on predictors of depression and schizophrenia stigma in populations of adults who are not impacted by either condition (Gronholm et al., 2017; Nearchou et al., 2018; Sickel et al., 2019). Authors who have studied predictors of anxiety stigma have also heavily focused on predictors in populations not diagnosed with anxiety. Currently, no anxiety stigma studies could be found in the literature that examined predictors of perceived anxiety disorder stigma in adults who have been diagnosed with anxiety disorders. Moreover, no researcher has assessed predictive variables such as age, gender, and level of education associated with perceived anxiety disorder stigma in populations of adults diagnosed with anxiety disorders. The findings of this study help to extend what is already known about perceived anxiety disorder stigma in the literature and in the field of counseling.

The research question for this study addressed if factors including age, gender, and level of education predict perceived anxiety disorder stigma in a population of adults

diagnosed with anxiety disorders. The findings of this study suggested that within a population of adults diagnosed with anxiety disorders, age, gender, and level of education were significant predictors of perceived anxiety disorder stigma with gender being the most significant predictor.

The predictor variable of gender, accounting for the greatest variance among all predictor variables in this study, is consistent with perceived anxiety disorder stigma studies found in the literature. Perceived anxiety disorder stigma appears to significantly impact both men and women in different ways (Jalnapurkar et al., 2018). Stereotypically, females diagnosed with mental health disorders such as anxiety tend to negatively impact perceived anxiety disorder stigma attitudes of men. Men who struggle with anxiety disorders appear to contradict the culturally constructed narrative of being strong and confident, and as a result, may experience higher levels of perceived anxiety disorder stigma (Boysen & Logan, 2017). In addition, women who do not have outside contact with others who have anxiety disorders or contact with anxiety disorder psychoeducational materials also appear to have higher levels of perceived anxiety disorder stigma (Batterham et al., 2013).

People impacted by mental health disorders may be mocked, marginalized, and subjected to discrimination. This inequity can have negative social and emotional effects on those who are afflicted by such stigma (Pedersen & Paves, 2014). According to Goffman's theory of social stigma (Goffman, 1963), once an individual has a stigmatized social identity, the individual is more likely to face additional difficulties as a member of society. The results of this study support the underpinnings of Goffman's theory as it

relates to gender. For both men and women impacted by anxiety disorders, there appears to be concern about the perceptions others may have about persons who have been diagnosed with anxiety. These concerns may be related to a desire to avoid a stigmatized social identity. Based on the results of the regression model, age and level of education also predicted perceived anxiety disorder stigma, but to a lesser extent than gender.

Limitations of Study

There were multiple limitations in this study. The study's sample was geographically restricted to adults diagnosed with anxiety disorders in the Midwest. The geographic location of the study was limited and may not have adequately reflected the composition of adults in the U.S. diagnosed with anxiety disorders.

This study made no mention of how culture may affect perceived anxiety disorder stigma attitudes. Participants' cultural beliefs may have caused the respondent to answer perceived anxiety disorder stigma questions in a manner consistent with cultural norms. Cultural variables that may have influenced perceived anxiety disorder stigma attitudes for adults diagnosed with anxiety disorders were not included in the original data collection of this study, as they were not a part of the normal intake process at the Midwest anxiety treatment center.

Respondents in the existing data set were all clients of a Midwest anxiety treatment center who were diagnosed with one or multiple anxiety disorders after completing the intake appointment that included taking the GASS. Changes in diagnosis or misdiagnosis are a common phenomenon in mental health (Thombs et al., 2019). It is

possible that some respondents in this study's sample may not have had an anxiety disorder.

Recommendations

Additional research and follow-up studies may considerably improve the results of this study. This study is the first anxiety stigma study to assess anxiety stigma attitudes in a population of adults diagnosed with anxiety disorders. Much of the research on the nature and impact of stigma for psychological disorders is limited to a few conditions. Depression and schizophrenia stigma have received a great deal of attention in the literature (Corrigan et al., 2014). However, anxiety disorders are under-represented in stigma research and account for fewer than 3% of stigma research (Clement et al., 2014).

Since 2011, there has been a growing body of research that has examined predictors of anxiety stigma in teen and adult populations who are not clinically impacted by anxiety disorders. These studies have focused on reducing the stigma associated with anxiety disorders through targeted anti-anxiety stigma campaigns. In addition to studies seeking to understand predictors of anxiety stigma in non-clinical populations, future studies could also seek to better understand predictors of anxiety disorder stigma in clinical populations diagnosed with anxiety disorders. This distinction is important because clinical populations of people diagnosed with anxiety disorders who are impacted by anxiety stigma may require more mental health care than non-clinical populations who are impacted by anxiety disorder stigma (Calear et al., 2017).

Future studies on anxiety disorder stigma attitudes in populations diagnosed with anxiety disorders should also look at expanding this type of research in several significant

ways. First, researchers could look at a multitude of factors that may predict various types of anxiety stigma including but not limited to, race, sexual orientation, gender identity, level of income, and level of contact with anxiety disorders. Second, future studies could explore predictors of anxiety stigma in clinical populations of teenagers. Last, researchers may also benefit from assessing other types of anxiety disorder stigma in populations diagnosed with anxiety such as personal anxiety stigma, and self-anxiety stigma. Collecting cultural belief data as part of a future study may also enrich the understanding of predicted perceived anxiety stigma in a population of U.S. adults diagnosed with anxiety disorders.

Another recommendation would be to look at the topic of anxiety stigma attitudes in populations diagnosed with anxiety disorders from a mixed-method research design. For example, understanding anxiety stigma attitudes and predictors of various types of anxiety disorder stigma may provide significant insight to the literature. However, it would also be beneficial to understand the lived experiences of people diagnosed with anxiety disorders who are impacted by anxiety stigma. Understanding predictors of anxiety disorder stigma in addition to lived experiences such as length of delayed help-seeking behaviors and discrimination experiences could add to what is known about anxiety stigma and populations with anxiety disorders.

Implications for Social Change

The author of this study examined several variables as predictors of perceived anxiety disorder stigma in adults diagnosed with anxiety disorders. This study's findings could potentially have positive social change implications for adults diagnosed with

anxiety disorders who are also negatively impacted by perceived anxiety disorder stigma. From this study's findings, gender may be a significant predictor of persons with anxiety disorders being more susceptible to perceived anxiety disorder stigma. Previous studies have highlighted that both men and women can be negatively impacted by perceived anxiety disorder stigma due to unique challenges faced. For example, for men, these challenges might have the potential to result in others not viewing them in a masculine way (Jalnapurkar et al., 2018). In addition, women who are not connected to others with anxiety disorders or engaged in anxiety psychoeducational activities, may feel abnormal in their anxiety experience and thus have higher levels of perceived anxiety disorder stigma (Batterham et al., 2013).

Numerous studies have highlighted mental health stigma, including perceived anxiety disorder stigma, may discourage individuals from seeking mental health care (Clark et al., 2018; Holder et al., 2019; Kaiser et al., 2020). Perceived anxiety disorder stigma may also be a barrier to treatment or contribute to premature treatment dropout for men and women with anxiety disorders vulnerable to this type of stigma. Therefore, the results of this study may help shed light in the literature and in the mental healthcare field that gender may be a baseline predictor of perceived anxiety disorder stigma for persons diagnosed with anxiety disorders. Based on the results of this study, age and education level may also serve as predictors.

Moreover, this study's findings could help counselors better advocate for men and women with anxiety disorders who are in treatment or who have yet to begin therapy. Counselors, through the process of supervision, could help supervisees develop

competencies about how gender may impact the way that men and women with anxiety disorders who are influenced by perceived anxiety disorder stigma seek help. With this knowledge, counselors and supervisees could create educational anxiety stigma content to help clients with anxiety disorders stay in treatment. In addition, counselors and supervisees may also engage in community psychoeducation events that potentially target men and women with anxiety disorders who are impacted by perceived anxiety disorder stigma and may be delaying treatment for stigma-related reasons.

Moreover, the findings of this study could help decrease the time it takes to seek help for anxiety for persons with undiagnosed anxiety disorders who are impacted by perceived anxiety disorder stigma. Specifically, this study may help inform those with undiagnosed anxiety disorders about the concept of perceived anxiety disorder stigma, the role that age, gender, and level of education may have on creating unhealthy levels of perceived anxiety disorder stigma, and how this type of stigma could discourage timely help-seek behaviors for mental health treatment.

Conclusion

In conclusion, this study highlights possible predictors for anxiety disorder stigma in U.S. adults diagnosed with anxiety disorders. Mental health disorders have historically been associated with negative stigmatizing labels and identities (Nearchou et al., 2018). In the U.S., negative attitudes toward seeking mental health care remain a problem. In addition, negative stigmatized attitudes towards anxiety disorders appear to create longer delays in help-seeking behaviors compared to depression stigma and its impact on how fast help is sought (Wang et al., 2005).

Various studies have assessed predictors of depression stigma and anxiety stigma in non-clinical populations. However, to date, no study has assessed for predictors of anxiety stigma in a clinical population such as adults with anxiety disorders. The author of this study sought to fill a gap in the literature by exploring if age, gender, and level of education predicted perceived anxiety disorder stigma in adults diagnosed with anxiety disorders. The findings of this study indicated that age, gender, and level of education predict perceived anxiety disorder stigma with gender being the most significant predictor. This study confirms previous research findings of gender serving as a significant predictor of perceived anxiety disorder stigma. Age and education level were found to be secondary predictors. However, this study is the first to highlight gender as a significant predictor of perceived anxiety disorder stigma in adults diagnosed with anxiety disorders. The findings of this study may also help inform counselors as to the significant role gender, and to a lesser extent, age and level of education, play in seeking treatment for adults with anxiety disorders who are impacted by perceived anxiety disorder stigma.

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Appendix A: Permission to use the Generalized Anxiety Stigma Scale

[redacted] Jul 20, 2022, 11:17 PM [redacted]
to me

Hi Shawn,

Thanks for following up. Given the lack of response from Dr Griffiths and my co-authorship role in its development, I am happy to grant you permission to the use the measure. (Side note: I believe the copyright lies with the Institution where I am based and not solely with Dr Griffiths, so there should be no problem.)

Please let me know if you have any questions.

Best wishes,
Phil

Shawn Nabors <shawn.nabors@anxietykalamazoo.com> Thu, Jul 21, 11:18 PM [redacted]
[redacted]

Hi Dr. Batterham,

Thank you for granting me permission to use the GASS for my proposed dissertation. One last question, I only intend to use the perceived anxiety scale in the GASS. My reasoning is that I believe that my target population may be more impacted by perceived anxiety stigma than personal anxiety stigma. My committee has requested that I specifically ask for permission to use just the perceived anxiety scale in my study. If the GASS was not intended for this what might I be able to do to reduce any validity threats to the GASS?

[redacted] Jul 21, 2022, 11:26 PM [redacted]
to me

Hi Shawn,

That's fine, the perceived and personal scales were designed so that they could be used independently of each other, so I don't see a problem with only administering the perceived scale.

Cheers,
Phil

Appendix B: The Generalized Anxiety Stigma Scale

Perceived Anxiety Stigma Scale	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. Most people think that an anxiety disorder is not a real medical illness.	4	3	2	1	0
2. Most people think that an anxiety disorder is a sign of personal weakness.	4	3	2	1	0
3. Most people think that people with an anxiety disorder could snap out of it if they wanted to.	4	3	2	1	0
4. Most people think that people with an anxiety disorder should be ashamed of themselves.	4	3	2	1	0
5. Most people think that people with an anxiety disorder do not make suitable employees.	4	3	2	1	0
6. Most people think that people with anxiety disorders are unstable.	4	3	2	1	0
7. Most people think that people with anxiety disorders are to blame for their problem.	4	3	2	1	0
8. Most people think that people with anxiety disorders are just lazy.	4	3	2	1	0
9. Most people think that people with anxiety disorders are a danger to others.	4	3	2	1	0
10. Most people think that people with anxiety disorders are self-centered	4	3	2	1	0

Appendix C: Primary Mental Health Intake Questionnaire

Please answer the following demographic questions below. You make skip any question you do not feel comfortable answering.

1. Age: _____ years old
2. Gender: ☐female ☐male ☐non-binary
3. Ethnicity ☐Not Hispanic or Latino ☐Hispanic or Latino
4. Race:

   ☐White or Caucasian

   ☐Black or African American

   ☐Hispanic or Latino

   ☐American Indian or Alaska Native

   ☐Asian

   ☐Other
5. Marital Status?

   ☐Single

   ☐Married

   ☐Divorced

   ☐Separated

   ☐Partnered

   ☐Widowed

6. Sexual Orientation?

   ☐Heterosexual

   ☐Gay/Lesbian

   ☐Bisexual

   ☐Pansexual

7. Employment Status: ☐employed ☐unemployed ☐self-employed

8. Roughly, what is your annual gross take home pay for the previous year?

   _____

9. What is your highest level of education?

   ☐High School Diploma

   ☐Some College

   ☐Trade or Vocational

   ☐Associates Degree

   ☐Bachelor's Degree

   ☐Master's Degree

   ☐Professional Degree

   ☐Doctoral Degree

10. Do you have any medical conditions that you are aware of?

11. Are you currently taking any medication for physical or mental health?

12. Have you ever had problems with substance abuse? If yes, please explain.

13. Have you ever engaged in self-harm behavior? If yes, please explain.

14. Have you ever been diagnosed with a mental health disorder? If yes, please explain.

15. What problems with your mental health concern you the most?