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# Investigation on How Access to Insurance and Different Mental Health Services Impact Stigmatized Beliefs on Mental Health

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# Investigation on How Access to Insurance and Different Mental Health Services Impact Stigmatized Beliefs on Mental Health

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Mental health-related stigma is a barrier to seeking help with mental health-related concerns. Stigma is a socially constructed term that implies disapproval with manifestations of shame and humiliation, leading to rejection, exclusion, and discrimination (Picco et al., 2016; VandenBos, 2015). Mental health-related stigma comes from how people are characterized, to what extent people take on the identity of their mental illness, and then how they are treated as a result. After their meta-analysis of 144 quantitative and qualitative studies, Clement et al. (2015) found that mental health-related stigma had a small to moderate negative effect on help-seeking, with specific population groups (e.g., some minority ethnic groups, males, young people, those in military and health occupations) disproportionately affected.

When appraising stigma, public stigma is what most people consider to be the definition. Public stigma expresses the prejudice and discrimination directed at specific groups by mainstream society (Corrigan & Rao, 2012). Comparing stigmatized attitudes with diagnostic labels has a cyclical impact on individuals with the mentally ill label, insomuch as different diagnoses carry unique and varying degrees of stigma that influence the cycle of perceived fear, self-blame, and shame. Afterward, they must develop psychological resilience depending on a hierarchy of stigma, their family and friends, and institutional stigma (Huggett et al., 2018), inasmuch as different diagnoses carry unique and varying degrees of stigma that influence the cycle of perceived fear, self-blame, and shame. When seeking help for mental illness, feelings of not mattering are related to perceived stigma by others (Shannon et al., 2020). Institutional stigma is stigma from institutions (e.g., hospitals, prisons, government) and the individuals working within them (Huggett et al., 2018). Public and self-stigma correlate with mental health problems, and they are apparent in the way the justice system and laws are structured, and how allocated resources are then dispersed (Corrigan & Watson, 2002).

When public stigma is internalized, it affects help-seeking behaviors. According to Social Identity

Theory developed by Tajfel and Turner in 1979, individuals form a social identity through self-categorization and social comparison (Stets & Burke, 2000). Therefore, internalized stigma, commonly referred to as self-stigma, is experienced when a person internalizes negative public attitudes, agrees with them, and then labels themselves negatively (Corrigan & Rao, 2012; Picco et al., 2016). Self-stigma toward help-seeking could be perceived as undesirability and unacceptability directed at the individual seeking professional treatment (Tucker et al., 2013; Vogel et al., 2006). The U.S. Surgeon General's report released in 2000 addressed mental illness for the first time and briefly detailed different barriers to help-seeking. Among those were availability to and access to care, as 44 million Americans are uninsured or lack adequate coverage. The report also discussed increased stigma, including individuals with mental illness being more visible and sensationalized by the media and myths surrounding mental illness (Henger, 2000).

**Insurance Coverage**

Barriers surrounding access to affordable insurance coverage and type of insurance delay help-seeking and make it more challenging to access some mental health services, such as inpatient or outpatient treatment. The label of mental illness already carries feelings of shame, but the addition of stigma related to access can implicitly and explicitly impact help-seeking behaviors (Knaak et al., 2017). Hamersma and Ye (2021) report some individuals struggle with the decreasing availability of affordable insurance coverage, affecting help-seeking and quality treatment for adults and children. Individuals with lower-income employment may not qualify for public insurance but may not have access to affordable private insurance options either, leaving families and individuals without insurance coverage entirely (Sohn et al., 2017).

Individuals with public insurance coverage (e.g., Medicare, Medicaid, other state-sponsored insurance) experience an increased difficulty accessing mental health services. Martinez-Hume and colleagues (2016) detail the range of experiences with stigma in the healthcare system navigated by participants, much related to insurance status. Difficulty accessing mental health services was correlated with negative help-seeking attitudes and mental health-related stigma. When asked about treatment from healthcare providers concerning public insurance coverage, most participants thought it was affected and said they had either personally experienced or observed others being treated differently. The stigma that accompanies public insurance was compounded by other stigma linked to race, socioeconomic status, gender, or one's status of illness.

Private insurance coverage (e.g., Blue Cross Blue Shield, United Healthcare, other employment-based insurance) has its own struggles with access to services. Kail et al. (2016) reported on several studies, finding continuous access to private insurance coverage without lapses or complete loss of insurance, was associated with lower mortality, better physical health, better self-assessed health, and lower risk of the onset of new difficulties with mobility for retirement-age adults. Along with better health, private insurance coverage was linked to fewer depressive symptoms than public or no insurance coverage (Kail et al., 2016). For some, this may indicate less stigma associated with private insurance, but private insurance

coverage may still affect help-seeking behaviors for those struggling with mental health-related concerns.

**Inpatient vs. Outpatient Treatment**

Those with mental health-related concerns have higher public- and self-stigma when seeking professional help and are more likely to seek outpatient treatment. Children treated at outpatient sites experienced less self-stigma and reduced secrecy about receiving treatment (Kaushik et al., 2021). Individuals seeking outpatient treatment have increased public stigma of outpatient treatment; self-stigma specifically mediates this relationship, though the effect size was small (Mathison et al., 2021). Kaushik et al. (2021) found that stigma associated with mental health treatment in children was not related to the location of treatment: inpatient or outpatient but related to feelings of rejection, which was higher in inpatient than outpatient settings. Children treated at outpatient facilities reported less self-stigma after the follow-up process (Kaushik et al., 2021). Furthermore, those seeking professional help tend to prefer outpatient psychotherapy, and face-to-face counseling has shown to be a more favorable service method (Bird et al., 2020).

Individuals with higher public stigma and self-stigma are less likely to seek inpatient treatment for mental health care. Participants showed increased public stigma, self-stigma, and poorer attitudes toward inpatient treatment compared to outpatient treatment (Mathison et al., 2021). Another factor related to inpatient treatment is institutional stigma, which is more systemic and limiting for individuals with mental health concerns (Corrigan & Watson, 2002; Crowe et al., 2020; Huggett et al., 2018). The public stigma surrounding inpatient treatment may substantially affect inpatient help-seeking attitudes (Mathison et al., 2021). Inpatient treatment is more noticeable due to the extended time patients miss work, school, or other commitments (Mathison et al., 2021). In addition, individuals feel more rejected when their treatment provider is associated with mental illness-type services. They would prefer to seek out a clergy, then a psychologist, then a psychiatrist, and feel the most rejection associated with hospital care (Mathison et al., 2021).

**Current Research**

The current study aims to investigate how access to healthcare impacts mental health-related stigma and help-seeking attitudes. Our first hypothesis is that individuals without insurance coverage will have higher public and self-stigmatized beliefs and lower help-seeking attitudes. Additionally, we predict that individuals with public insurance coverage will have higher self-stigmatized beliefs and lower help-seeking attitudes than those with private insurance coverage. Lastly, we expect that those with higher self-stigmatized beliefs are more likely to have participated in outpatient treatment over inpatient psychiatric treatment.

## Method

**Participants**

The sample of 192 participants ranged in age from 18 to 89 years old ($M$ = 30.44, $SD$ = 13.73). Participants consisted of 145 women (76%), 40 men (21%), 5 non-binary (0.5%), 1 transgender woman (0.5%), and 1 gender/genderfluid (0.5%). The race and ethnicity of participants were identified as Caucasian/White (142, 74%); African American/Black (19, 10%);

Multiracial (16, 8%); Hispanic (7, 4%); Latino/Latina/Latinx (3, 2%); Cape Verdean, Portuguese, or Haitian (3, 2%); Native American/Indigenous American (1, 0.5%); and Asian/Asian American (1, 0.5%). About half ($n$ = 95) reported an annual income of less than $53,413, and almost a third ($n$ = 61) reported making less than $32,048.

**Procedure and Materials**

Participants were recruited via Bridgewater State University Student Announcements and through the personal emails of people known to the researchers. The participants were screened to ensure a minimum age of 18 years or above and United States citizenship. A hyperlink for the survey first brought participants to an electronic informed consent form before allowing them to proceed to the survey questionnaire. The survey asked for demographics, followed by several self-created questions, and previously validated questionnaires using a Likert scale. For the purpose of our project, we evaluated five self-created questions and three different scales related to insurance coverage, mental health services, stigma, and help-seeking attitudes. This was part of a larger study that contained other measures not described in our paper. Following the survey, participants were debriefed. They were thanked, and no compensation was given. The study was pre-registered to the Open Science Framework (https://osf.io/dzaex) and approved by the Institutional Review Board of Bridgewater State University.

***Access to Insurance***

Two self-created questions asked participants which type of health insurance they were enrolled in (Medicare only, Medicare plus a secondary insurance, Medicaid, Private or commercial only, or none), and if mental health benefits were provided by their insurance. A majority ($n$ = 142) participants reported being enrolled in private or commercial only, followed by Medicaid ($n$ = 34), Medicare ($n$ = 8), Medicare plus a secondary insurance ($n$ = 3), and no insurance ($n$ = 4). A greater number reported having mental health benefits ($n$ = 127) compared to those that did not ($n$ = 7), or those that did not know ($n$ = 58).

***Mental Health Services***

Three self-created questions asked participants if they had ever received inpatient psychiatric treatment, outpatient mental health treatment, and/or diversionary services. Each definition was taken from the MassHealth website. Inpatient psychiatric treatment was defined as services provided in a 24-hour hospital setting that offered evaluation and treatment of acute mental health or substance use disorders (e.g., residential, state hospital). Most of the participants ($n$ = 163) reported they had not received inpatient services, followed by 26 who had, and 3 who preferred not to answer. Outpatient mental health services were defined as services that were provided in places like clinics; community health centers; hospital outpatient departments; and your home, school, or other places in the community (e.g., individual therapy, group therapy, family/couples therapy). Most of the participants recorded they had received outpatient services ($n$ = 128), followed by those who had not ($n$ = 64). Diversionary services were defined as mental health and substance use disorder services that provided intensive support upon returning to the community after being in a hospi-

tal and provided in a 24-hour facility or a non-24-hour setting such as partial hospitalization programs, community crisis stabilization, or residential rehabilitation services. Most of the participants ($n$ = 176) recorded they had not received diversionary services followed by 14 who had, and 2 who were unsure.

### *Self-Stigma*

The Self-Stigma of Mental Illness (SSOMI) Scale (Tucker et al., 2013) is a 10-item scale utilized in our study to measure the self-stigma of a mental illness diagnosis or label. Participants were asked to rate how they would react if they were to have a mental illness (e.g., "I would feel inadequate if I had a mental illness") on a five-point Likert scale, ranging from 1 (*strongly disagree)* to 5 (*strongly agree*); half being reverse-scored with the purpose of the higher score representing a greater self-stigma associated with the mental illness label. In this present study, we summed all items to create a total score for self-stigma (α = . 87).

### *Public Stigma*

The Public Stigma Scale (Pryor et al., 2012) is an 18-item scale utilized in our study to measure perceived public stigma toward people with a mental illness diagnosis or label. Participants were asked to rate how most people might act toward others with mental illness (e.g., "Most people would blame someone for having a severe mental illness") on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). In this present study, we summed all items to create a total score for public stigma (α = .80).

### *Help-Seeking Attitudes*

The Inventory of Attitudes toward Seeking Mental Health Services (IASMHS, Mackenzie et al., 2004) is a 24-item scale with three subscales used in our study to evaluate certain aspects of mental health help-seeking attitudes. Participants were asked to indicate their agreement on a 5-point Likert scale from 1 (*strongly disagree*) to 5 (*strongly agree*). We summed all items per subscale to create a total score. The three subscales were: psychological openness (8 items, example item: "People should work out their own problems; getting professional help should be a last resort", α = .73); help-seeking propensity (8 items, example item: "It would be relatively easy for me to find the time to see a professional for psychological problems", α = .80); and help-seeking stigma (8 items, example item: "Having been mentally ill carries with it a burden of shame", α = .70).

## Results

### First Hypothesis

We predicted individuals without insurance coverage would have higher public and self-stigmatized beliefs and lower help-seeking attitudes compared to people with insurance coverage. Unfortunately, too few people reported not having insurance coverage ($n$ = 4), so we could not analyze the data.

### Second Hypothesis

We predicted that individuals with public insurance coverage would have higher self-stigmatized beliefs and lower help-seeking attitudes than those with private insurance coverage. We analyzed our hypothesis using a series of independent-samples $t$-Tests. In the first t-Test, individuals who reported having public

healthcare insurance were not significantly different in self-stigmatized beliefs compared to those with private insurance, $t(165) = 1.25$, $p = .21$, 95% CI [-1.11, 4.93], $d = .23$. Next, we looked at the three subscales of the IASMHS. The first subscale of psychological closedness was not significant, $t(150) = .03$, $p = .98$, 95% CI [-2.10, 2.17], $d = .01$. The second subscale of help-seeking propensity was also not significant, $t(149) = -.01$, $p = .99$, 95% CI [-2.22, 2.20], $d = -.002$. Finally, the third subscale of help-seeking stigma was again not significant, $t(149) = 1.27$, $p = .21$, 95% CI [-.73, 3.38], $d = .25$. Thus, we found that the data did not support our hypothesis.

**Third Hypothesis**

We predicted that those with higher self-stigmatized beliefs would be more likely to have participated in outpatient treatment than inpatient psychiatric treatment. We analyzed our hypothesis using a series of independent-samples *t*-Tests and found a trending association with inpatient self-stigma but no significance with outpatient self-stigma. There was a marginally significant trend toward individuals who reported they had received inpatient psychiatric treatment, showing more self-stigma ($M = 34.27$, $SD = 8.55$) compared to individuals who reported they had never received inpatient psychiatric treatment ($M = 31.04$, $SD = 8.05$), $t(166) = 1.74$, $p = .08$, 95% CI [-.43, 6.90], $d = .40$. However, there was no difference between individuals who reported that they had received outpatient treatment compared to those who had never received outpatient treatment, $t(169) = 1.15$, $p = .25$, 95% CI [-1.09, 4.11], $d = .19$. Unfortunately, too few people reported receiving diversionary services ($n = 14$), so we could not analyze the data.

**Discussion**

Overall, our data partially supported our hypotheses. Our first hypothesis, that individuals without insurance coverage would have higher public and self-stigmatized beliefs and lower help-seeking attitudes, was not able to be analyzed. Our second hypothesis, that individuals with public insurance coverage would have higher self-stigmatized beliefs and lower help-seeking attitudes than those with private insurance coverage, did not yield significantly different self-stigmatized beliefs or help-seeking attitudes. For our final hypothesis, that those with higher self-stigmatized beliefs would be more likely to have participated in outpatient treatment than inpatient psychiatric treatment, there was a marginally significant trend that indicated more self-stigma in individuals who received inpatient psychiatric treatment than those who had never received it, but no corresponding difference for outpatient treatment.

**Implications**

This study could not evaluate stigmatized beliefs nor help-seeking attitudes in the no insurance population, likely because most or all participants live in a state that requires insurance coverage and has done so for many years. Since we were not able to analyze these data, future studies could improve this with a different population. However, we found that those with public insurance compared to those with private insurance did not have higher stigmatized beliefs or lower help-seeking attitudes. This conveys that people could feel confident seeking mental health treatment, and

type of insurance was not a factor. It is possible that public insurance carries less stigma here than in other states, so a comparison study might be beneficial.

Additionally, this study found that self-stigmatized beliefs were marginally higher in individuals who had received past inpatient services than those who had not. This indicates that stigma-reducing interventions could benefit this specific population, but more research may be needed to further scrutinize which inpatient services, or if they may be distinguishable by diagnosis. Clinicians working with clients in an inpatient setting or similar environment should have higher self-awareness and sensitivity when working with this population. Also, those who had received past outpatient services did not have higher self-stigmatized beliefs than those who had not. This could imply decreases in stigma for this population or more stagnant stigma, which could be examined in future research studies. Our study was not able to compare inpatient services against outpatient services, but that could prove to be a valuable direction in future research as well.

Furthermore, these data increase awareness for the sensitivity of stigma and mental health services. Clinicians advocating in the community should be mindful when discussing therapy services, promoting therapy, and working in a professional environment, which could have an impact on mental health-related stigma and help-seeking behaviors. Clinicians can also use these data in situations with a new client or therapeutic environment, where stigma may have an impact on session intensity, engagement, and overall emotions towards therapy services. These data can apply to a clinical setting when approaching the types of interventions a therapist uses for stigma-related issues, such as a humanistic approach to encourage self-esteem.

**Limitation & Future Directions**

This study was limited by sample selection through convenience that may have restricted significant conclusions. There was a large number of Caucasian/White participants compared to other ethnicities that may have impacted stigmatized beliefs and help-seeking attitudes. Future studies might explore a more diverse population or compare views between different ethnicities. Further research could analyze a larger and more random population. Therefore, the data could be more generalized to the rest of the public.

Another limitation was that we were not able to compare inpatient to outpatient services due to our survey design, as we asked if participants had ever received either one. Therefore, an individual could have put yes to both past inpatient and outpatient treatments, so we could not compare the two against each other. This type of analysis could affect results in the sense that if someone had past inpatient services and outpatient services, they could feel more stigmatized than solely receiving outpatient treatment. Further research could ask participants to indicate whether they have had inpatient only, outpatient only, both inpatient and outpatient, or none and then compare the four groups against each other.

While the type of insurance held no significance in this study, 30 percent reported not knowing if they had mental health benefits. Future studies might evaluate how insurance literacy impacts help-seeking attitudes and behaviors as well as stigmatized beliefs. Having or not having benefits for mental health services could affect help-seeking attitudes and behaviors.

Other research could ask individuals about stigmatized beliefs based on the mental health benefits their insurance providers offer or explore mental health literacy. These data support the ongoing stigmatized beliefs of inpatient services and the impact of self-stigmatized beliefs on mental health services. Therapists and clinicians can use these data moving forward to be mindful when working with communities or populations that have differing insurance benefits and mental health services.

**Conclusion**

Previous research suggests stigma could impact individuals seeking mental health treatment or participating in different mental health services, and that insurance coverage may play a role (Clement et al., 2015; Corrigan & Watson, 2002, Hamersma & Ye, 2021; Kaushik et al., 2021). Data from this study can be used in a clinical setting when providing different mental health services to a variety of clients, and when advocating in communities to improve services and/or the mental health system. Additionally, these results can be used when approaching insurance coverage and benefits in relation to stigmatized beliefs and help-seeking behaviors. Furthermore, future research would benefit by expanding these ideas, especially regarding the area of insurance and mental health literacy and by using this study to inform the research design by restructuring the questionnaire. The benefit to pursuing this type of research is to gain a better understanding of the significance that stigma has on individuals seeking mental health treatment, and the different services they may need, as well as aid in the discernment of how access to insurance might be associated.

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