The Effects of a Brief, Mass-Media Intervention on Attitude and Intention to Seek Professional Psychological Treatment

A dissertation presented to the faculty of the College of Arts and Sciences of Ohio University

In partial fulfillment of the requirements for the degree Doctor of Philosophy

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March 2009

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This dissertation titled

The Effects of a Brief, Mass-Media Intervention on Attitude and Intention to Seek
Professional Psychological Treatment

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ABSTRACT

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This study examined the effects of a mass-media, public service announcement (PSA) style video intervention that was developed for this study. Prior research findings on expectations, attitudes and intentions towards seeking mental health services were applied to the design of the intervention. A total of 228 participants were randomly assigned to one of two conditions: (1.) the media-exposed intervention group, who watched programming in which the video intervention was inserted, and (2.) a control group, who watched the same programming without the video intervention. Results indicated that the intervention was effective at increasing both positive attitudes towards therapy and intentions to seek therapy. The overall positive effect of the media intervention on intentions was primarily for seeking help for interpersonal problems (and not for academic or substance abuse problems). However, the media intervention was no different from the control group on measures of the belief-based factors that, in theory, should change prior to changes in attitudes and the actual intentions to seek. Implications of these findings for future research are discussed.

Approved: ______________________________________________________________

Timothy M. Anderson

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>3</td>
</tr>
<tr>
<td>List of Tables</td>
<td>6</td>
</tr>
<tr>
<td>List of Figures</td>
<td>7</td>
</tr>
<tr>
<td>Review of Literature</td>
<td>8</td>
</tr>
<tr>
<td>Factors That Affect Help-Seeking</td>
<td>11</td>
</tr>
<tr>
<td>Methods</td>
<td>16</td>
</tr>
<tr>
<td>Participants</td>
<td>16</td>
</tr>
<tr>
<td>Materials</td>
<td>16</td>
</tr>
<tr>
<td>Procedure</td>
<td>27</td>
</tr>
<tr>
<td>Results</td>
<td>28</td>
</tr>
<tr>
<td>Discussion</td>
<td>37</td>
</tr>
<tr>
<td>Belief-Based Barriers and Expectations</td>
<td>38</td>
</tr>
<tr>
<td>Treatment Context Variables</td>
<td>39</td>
</tr>
<tr>
<td>Limitations</td>
<td>44</td>
</tr>
<tr>
<td>Future Directions and Conclusions</td>
<td>46</td>
</tr>
<tr>
<td>References</td>
<td>49</td>
</tr>
<tr>
<td>Appendix A: Demographics Questionnaire</td>
<td>56</td>
</tr>
<tr>
<td>Appendix: B: Intentions to Seek Counseling Inventory</td>
<td>57</td>
</tr>
<tr>
<td>Appendix C: Attitudes towards seeking Professional Psychological Help</td>
<td>59</td>
</tr>
<tr>
<td>Appendix D: Stigma Scale for Receiving Psychological Help</td>
<td>61</td>
</tr>
<tr>
<td>Appendix E: Thoughts about Psychotherapy</td>
<td>62</td>
</tr>
</tbody>
</table>
Appendix F: Social Norm Items .................................................................64
Appendix G: Outcome Questionnaire ......................................................65
Appendix H: Media intervention script ....................................................67
Appendix I: Focus Group Outline ..............................................................69
Appendix J: Focus Group Methods .............................................................71
LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Intervention Content and Corresponding Barrier</td>
<td>24</td>
</tr>
<tr>
<td>Table 2</td>
<td>Means, and Standard Deviations for Factors affecting Help-Seeking for Media Exposed and Control Groups</td>
<td>29</td>
</tr>
<tr>
<td>Table 3</td>
<td>Interpersonal intention Means, and Standard Deviations for all Between Subjects Variables</td>
<td>32</td>
</tr>
<tr>
<td>Table 4</td>
<td>Multiple Regressions Predicting Attitude towards Treatment</td>
<td>34</td>
</tr>
<tr>
<td>Table 5</td>
<td>Multiple Regressions Predicting Intention to seek Treatment for Interpersonal Problems</td>
<td>34</td>
</tr>
<tr>
<td>Table 6</td>
<td>Multiple Regressions Predicting Intention to seek Treatment for Academic Problems</td>
<td>35</td>
</tr>
<tr>
<td>Table 7</td>
<td>Multiple Regressions Predicting Intention to seek Treatment for Drug and Alcohol related Problems</td>
<td>35</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Figure 1. Vogel and Colleagues’ (2005) resulting Structural Model</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Figure 2. Multiple Regression Model with Standardized Regression Coefficients</td>
<td>36</td>
<td></td>
</tr>
</tbody>
</table>
REVIEW OF LITERATURE

Many people who might benefit from psychotherapy do not seek it. Both the Epidemiological Catchment Area (ECA) and the National Comorbidity Survey (NCS) found that only about one in three of all respondents reported that they received the mental health care services that they were in need of (U.S. Department of Health & Human Services [DHHS], 2001). In terms of raw numbers, the 2004 Therapy in America Survey estimated that approximately 24 million U.S. adults experience significant psychological distress and yet are not receiving mental health care. Further, those who seek treatment often receive services solely through medical practitioners, who generally prescribe medication as the sole form of treatment approximately 73% of the time (The MaGPIe Research Group, 2006). Exacerbating this situation is the fact that most individuals know little about mental illness and its treatments and thus, will not likely seek services in the absence of information about mental health services (Gelso & McKenzie, 1973). For example, in a national survey of 1,005 American adults, 44% reported that they know “little” or “almost nothing at all” about mental disorders and related services (American Psychiatric Association, 2006).

Given this lack of public knowledge about psychological services, such as psychotherapy, attempts have been made to encourage individuals to consider the benefits that psychological services might bring to the treatment of psychological distress. For example, educational campaigns (i.e. workshops and seminars; Battaglia, Coverdale, & Bushong, 1990) printed information (i.e. paper pamphlets and the use of billboards; Faberman, 1997; Gonzalez, Tinsley, & Kreuder 2002), and videotaped interventions (Barker, Pistrang, Shapiro, Davies, & Shaw, 1993) have all been
successfully utilized to increase the public’s knowledge regarding mental health services. The ultimate goal of these interventions appears to be well founded, since exposure to information about mental health may promote more favorable attitudes towards seeking mental health treatment (Deanne & Todd, 1996; Vogel et al., 2005), and thus might positively affect any future decisions to seek mental health care services.

Initial mental health promotion efforts first explored the effects of exposure to psychoeducational interventions which relied on a demythologizing approach (Morrison, 1980; Morrison & Teta 1977, 1980). This approach presumes that the public holds inaccurate beliefs about mental illness and mental health care which serve as barriers to treatment. Content for initial mental health promotion interventions were based primarily on results which indicated that presenting individuals with information about “problems of living that [the public] can learn to resolve” serves to improve their attitudes about mental health and its related treatment (Morrison & Teta, 1977, p. 1128). For example, Morrison and Teta (1980) first demonstrated the effects of a 2-hour teaching intervention that presented accurate information countering some commonly held negative beliefs about mental illness. Results demonstrated significant improvement in the students’ attitudes towards mental illness directly after the 2-hour seminar and at a 2-week follow-up. Furthermore, a 2-day adventure camp (Stuhlmiller, 2003), a 4-hour seminar aimed at police officers (Pinfold, Huxley, Thornicroft, Farmer, Toulmin, & Graham, 2003) a theatre company intervention aimed at 13-14 year olds (Essler, Arthur, & Stickley, 2006) and a 270-minute long instruction intervention for high school students (Essler, Cooker, & Ittenbach, 1998) have all been utilized to promote positive attitudes towards mental
health. However, seminar-type instructional interventions, while effective, have proved costly, time consuming, and have the capacity to reach only a limited audience.

On the other hand, written interventions appear to address some of the limitations of seminar-type interventions. For example, Gonzalez, Tinsley, and Krueeder (2002) explored the effects of 2 written psychoeducational interventions meant to inform readers about psychotherapy and to normalize help-seeking. Individuals who received the written information reported significantly improved attitudes towards help-seeking directly following the intervention as well as at a 4-week follow-up. These results demonstrated written interventions as a viable option for improving the public’s attitudes and beliefs about help-seeking compared to no treatment control groups. Yet, when compared to other methods of disseminating information, they do not fare as well. Tinsley and colleagues (1988) reviewed studies that used written documents for altering therapy expectations and demonstrated that only 4 of 11 studies found that written documents were effective in producing changes in therapy expectations. In addition, Tinsley and colleagues (1988) note that written materials are a less feasible method for altering public expectations and attitudes since it is difficult to assure that written materials such as pamphlets would be read and understood by the public.

Although the review above reflects many different types of educational interventions, relatively few attempts have been made to develop mass media style interventions that might improve expectations and attitudes about psychotherapy to the general public on a larger scale. Faberman (1997), for example, reported on the development of the American Psychological Association’s mental health mass media promotion effort. In this effort, public relations firms used focus groups for developing
print advertisements (billboards). The effects of the advertisements were assessed by measuring the number of phone calls received by psychological referral services in the two states in which the campaign was launched (Connecticut and Colorado). In both states the number of calls significantly increased with calls in Connecticut doubling and calls to Colorado’s referral service quadrupling.

Another example of a mass media effort is Barker, Pistrang, Shapiro, Davies, & Shaw’s (1993) preventive mental health television series. This program aired in the United Kingdom, and consisted of 7, 10-minute television programs. Results indicated that those who viewed the programs demonstrated improved mental health awareness, but that the positive impact was primarily on respondents’ views of others’ problems rather than for their own. Overall, the fact that there are only a few existing mass media mental health prevention and treatment advertisements that have been developed and researched is likely due to their expense, since the previous efforts have been generally fruitful. Given limited resources, it would stand to reason that future interventions be framed around empirically developed models of help seeking in order to maximize the effectiveness of this outreach.

Factors That Affect Help-Seeking

Empirical findings indicate that persons are more likely to seek psychological treatment based on select factors. Context variables make up one subgroup of factors. For example, gender (Deane & Chamberlain, 1994; Kelly & Achter, 1995; Leong & Zachar, 1999), race/ethnicity (Duncan & Johnson, 2007) and socioeconomic status (Duncan & Johnson, 2007) have all been prominently identified in the literature as contextual factors that affect help seeking. Other aspects of the help-seekers immediate
context have also been identified as associated with help-seeking behavior, including whether the help-seeker’s social support network encourages treatment (Sherbourne, 1988), prior treatment experience (Deane, Skogstad, & Williams, 1999; Vogel et al., 2005), and level of distress (e.g. Cepeda-Benito & Short, 1998; Cramer, 1999; Deane & Chamberlain, 1994; Kelly & Achter, 1995; Kushner & Sher, 1989). Contextual factors may be useful for tailoring interventions to select populations and may also contribute to understanding the conditions in which mass media interventions might be most effective, but are of limited use in identifying how best to encourage persons to seek treatment when needed.

Belief-based psychological factors account for another subcategory of factors associated with seeking psychological treatment. Belief-based factors have proven more malleable to experimental manipulation and thus useful in understanding how mental health promotion might be most effectively utilized. Ajzen and Fishbein’s (1980) theory of reasoned action provides an organizing framework for understanding how an individual decides to seek treatment. First, as applied to treatment seeking, the theory of reasoned action holds that a person must overcome belief-based barriers as a means of improving their expectations that treatment would lead to a beneficial outcome. Second, positive attitudes develop after expectations are improved about the behavior of seeking treatment. Third, positive attitudes influence one’s behavioral intentions of seeking help and ultimately their behavioral outcome. Despite the wide use of the theory of reasoned action, it is important to note that other reputable theories exist, which also attempt to predict behavior (i.e. the health belief model, protection motivation theory, social cognitive theory).
Some evidence has accumulated that supports the notion that the first step in the theory of reasoned action, expectations and belief-based barriers, may be influenced through intervention. For example, Essler, Arthur, and Stickley (2006) developed a school-based intervention designed to alter the belief-based barrier of stigma. Pre and post-test scores supported the effectiveness of their intervention with results indicating a positive change in the attitudes of students who participated in the study. Short-comings of the study include utilizing a non-controlled design, meaning that students who did not want to participate were not included. In addition, disclosure fears/desire to self-conceal (Kahn & Hessling, 2001; Kahn & Williams, 2003; Kelly & Achter, 2005; Vogel & Wester, 2003; Vogel et al., 2005), treatment fears (Deane & Todd, 1996; Vogel et al., 2005) poor expected outcome (Vogel et al., 2005; West, Kayser, Overton, & Saltmarsh, 1991), and social norm perceptions (Vogel et al., 2005) have all been prominently identified in the literature as belief-based factors that affect one’s decision to seek professional psychological services. However, findings on factors believed to affect help seeking also include numerous null findings. For example, Cepeda-Benito & Short, (1998) demonstrated that perceived social support predicts intention to seek help, whereas other investigations into similar university samples report that these factors do not predict help-seeking intention (Kelly & Archer, 1995; Vogel & Wester, 2003).

Vogel, Wester, Wei, and Boysen (2005) found a statistically good fit when organizing a diverse and comprehensive list of professional help-seeking variables into three sets based on the Theory of Reasoned Action (Ajzen and Fishbein, 1980) described above: belief-based, attitude, and intention variables.
This structural equation model included most of the existing help-seeking variables to be measures of the first Theory of Reasoned Action manifest variable, belief-based barriers: (1) stigma related to help-seeking behaviors (variance estimate = -.23), (2) treatment fears (variance estimate = .19), (3) poor expected outcome of therapeutic services (also referred to as the anticipated utility of psychological services) (variance estimate = .50), and (4) social norm perception (how common or rare help-seeking is perceived to be) (variance estimate = .20). The list of significant factors also included (5) previous help-seeking behavior (variance estimate = .15) and (6) social support (variance estimate = -.13). Figure 1 depicts Vogel and colleagues’ resulting structural model. Support for the theory of reasoned action was found because these belief-based variables combined to significantly predict attitudes towards seeking professional help. In turn, attitudes predicted intention to seek professional help. See Figure 1 for the results of Vogel and colleagues (2005) structural model. Vogel and colleagues’ (2005) study not only examined multiple factors previously demonstrated to serve as barriers to help-seeking, but it also directly explored the role of attitudes towards seeking professional psychological help, making it the lone investigation into the fit of the theory of reasoned action as it applies to help-seeking behavior.

The current investigation developed and empirically tested the effects of a brief, mass media mental health services promotion intervention. Unlike past studies of other mass media style interventions, the intervention for the present study was patterned after the aforementioned findings about the factors influencing seeking psychological treatment. In addition, the current study utilized focus groups to further tailor the intervention to university students (see appendix I and J for focus group outline and
The intervention was tested using a controlled design in which the effects of the intervention (media exposed) were compared to a control group. Specifically, it was hypothesized that the media-exposed group would endorse fewer belief-based barriers to seeking psychological treatment than the control group. It was also expected that the media-exposed group would have higher positive attitudes and intentions to seek psychological treatment than a no-intervention control group. While the primary focus of the investigation was on the media intervention, the contextual variables of gender, previous treatment, and level of distress were also included in order to explore if the media intervention significantly interacted with these contextual variables.
METHODS

Participants

The sample for this study was comprised of 228 psychology students who received course credit for their voluntary participation. Of the participants, 57.5% (n = 131) were women and 42.5% (n = 97) were men. Of those, 36% were freshman, 21% were sophomores, 23% were juniors, and 20% were seniors. The sample group had an age range of 18-55 with a mean age of 20.24. Participants predominately identified their race as Caucasian (83%; African American = 8.8%; Hispanic = 1.3%; Asian = 1.3%; Native American = 1.3%; other = 3.5%). One hundred fifty-two (66.7%) participants reported that they had never sought professional psychological assistance, whereas 72 (31.6%) participants reported that they had. Four participants (1.8%) did not respond to this item.

Materials

Intentions to seek counseling (ISCI; Cash, Begely, McCown & Weise, 1975). The ISCI is a 17-item, self-report questionnaire which asks respondents to rate how likely they would be to seek the services of a therapist if they were experiencing the problem listed. Participants are required to rate their likelihood of seeking mental health care services on a 7-point Likert-type scale ranging from 1 (very unlikely) to 6 (very likely). Responses are summed such that higher scores indicate a greater likelihood of seeking the services of a therapist.

The ISCI has shown adequate internal consistency ranging from .84 to .95 across studies (e.g. Lopez, Melendez, Sauer, Berger, Wyssman 1988; Vogel & Wester, 2003) and construct validity has been demonstrated in that it has been shown to be positively
associated with favorable attitudes towards therapy (Kelly & Archer, 1995). The ISCI consists of three subscales examining respondents’ likelihood of seeking the services of a therapist for problems related to (1) interpersonal concerns, (2) academic problems, and (3) drug and alcohol problems. The ISCI has demonstrated adequate internal consistency for the three subscales (.90 for interpersonal concerns, .71 for academic problems, and .86 for drug/alcohol problems). The current study’s internal consistency for the three subscales also reflected adequate reliability (.83 = interpersonal concerns, .76 = academic concerns, and .66 = drug and alcohol problems).

Attitudes towards Seeking Professional Psychological Help Scale: a shortened form (ATSPPH; Fisher & Farnian, 1995). The 10-item ATSPPH was used to assess respondents’ attitudes towards seeking help from professional mental health care providers. Respondents are asked to provide their opinions regarding their agreement and disagreement with statements pertaining to mental health. Items are self-reported on a 4-point Likert-type scale ranging from 0 (agree) to 3 (disagree). This scale is scored by adding item responses after reverse scoring 5 of the 10 items. Higher scores indicate more positive attitudes towards counseling services.

The ATSPPH shortened form was created from the original 29-item measure and intended for use in research. The 10-item scale has an internal consistency coefficient of .84 and strongly correlates with the original 29-item measure ($r = .87$) accounting for 76% of the shared variance (Fisher & Farnia, 1995). Chronbach’s alpha was equal to .85 for the present study.

The shortened form’s test-retest results indicated a one month correlation equal to .80 ($N = 32$) (Fisher and Farnia, 1995). The shortened form ATSPPH has also been
utilized in many related investigations (e.g. Morgan, Ness, & Robinson, 2003; Vogel et al., 2005) and was selected for use in the present study due to its excellent reputation as the standard for investigating attitudes regarding professional mental health help-seeking based on its ease of use and strong psychometric properties (Hayes, 2006).

*Stigma Scale for Receiving Psychological Help (SSRPH; Komiya et al., 2000).*

The 5-item SSRPH was used to assess the level of stigmatization held by respondents towards those who seek professional psychological services. The SSRPH is rated on a 4-point Likert-type scale from 0 (*strongly disagree*) to 3 (*strongly agree*) with higher scores indicating greater stigmatized help-seeking beliefs.

The coefficient alpha for the SSRPH has been found to be = .72, indicating an acceptable level of internal consistency (Komiya, Good, & Sherrod, 2000). The internal consistency for the current investigation was = .65. In addition to adequate inter-item reliability, this measure has good construct validity in that it was found to negatively correlate (*r* = -.40, *p* < .0001) with the ATSPPH, demonstrating that the less stigma endorsed by the respondent, the greater their attitudes towards seeking psychological services (Komiya, Good, & Sherrod, 2000). The current investigation also revealed a similar correlation value between the SSRPH and the ATSPPH (*r* = -.42, *p* < .0001). This measure was selected above others due to its use in similar investigations (Vogel et al., 2005).

*Thoughts about Psychotherapy Survey (TAPS; Kushner & Sher, 1989).* The TAPS was used in the current study to assess one’s level of fearfulness of mental health services, regardless of whether the respondent had sought the services of mental health care providers in the past. Those participants who had not seen a therapist are instructed
to image seeing a therapist for the first time (Kushner & Sher, 1989). Participants respond to this 19-item inventory on a five point Likert-type scale, ranging from 1 (I have not been concerned about this) to 5 (I am very concerned about this). A sample item reads: 

*Will everything I say in psychotherapy be kept confidential?*

Chronbach’s alpha for reliability have ranged between .87 and .92 (Deanne & Todd, 1996). The current study also reflected good internal consistency (.93) for the TAPS. This scale has been widely used when assessing the level of fearfulness that individuals may experience when seeking psychological services however no validity data have been reported (Deanne & Chamberlain, 1994). The TAPS was selected to assess fearfulness due to its satisfactory psychometrics as well as its inclusion in studies similar to the current investigation.

*Distress Disclosure Index (DDI; Kahn & Hessling, 2001).* Comfort level with self-disclosure was measured by the DDI. The 12-item DDI was developed to assess the extent to which an individual is comfortable talking with others about personal and potentially distressing information. The DDI requires participants to rate their responses on a 5 point Likert-type scale that ranges from 1 (strongly disagree) to 5 (strongly agree).

The DDI has been demonstrated to have good test-retest reliability (.80 for a 3-month period). It has additionally been shown to have a single construct that reflects good internal consistency (.93) (Vogel et al., 2005). Internal consistency for the present sample was consistent (.93). Scoring the DDI requires summing the items after reverse scoring 6 of the 12 items. Higher scores reflect a greater willingness to self-disclose potentially distressing information.
Self-Concealment Scale (SCS; Larson & Chastain, 1990). The SCS was utilized in the current study to measure the extent to which an individual desires to conceal personal information. This 10-item measure requires participants to rate their level of agreement to items on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). The sum of responses determines the respondent’s level of self-concealment with higher scores indicating greater desire to conceal personal information.

The SCS has been shown to be a reliable measure of self-concealment with good internal consistency (.83) and test-retest reliability demonstrated over a 4-week period (.81) (Larson & Chastin, 1990). Good internal consistency for the current sample was also demonstrated with a Chronbach’s alpha of .88. Construct validity for the SCS is supported by its correlation (.43) with the Self-Disclosure Index (Miller, Berg & Archer, 1983).

Disclosure Expectations Scale (DES; Vogel & Wester, 2003). The DES was used to assess two factors, (1) anticipated utility and (2) anticipated risk of seeking professional psychological services. The 8-item measure requires respondents to disclose their perceived expectations about the utility and risk associated with disclosing a distressing issue to a mental health professional on a 5 point Likert-type scale. The scale ranged from 1 (not at all) to 5 (very). Two (anticipated utility, anticipated risk) subscales (4 items each) are identified and summed such that lower scores reflect less anticipated utility and less anticipated risk associated with self-disclosure.

The DES has demonstrated adequate validity in that it has been shown to correlate with measures of self-disclosure and self-concealment. However, it is important to note that the construct of self-disclosure has been demonstrated as empirically distinct from
self-concealment (Larson & Chastain, 1990). The DES furthermore has been shown to have adequate internal consistency on both subscales (anticipated utility = .81, anticipated risk = .80) (Vogel et al, 2005). The current study revealed a Cronbach’s alpha equal to .83 for the 4 utility items and .78 for the 4 risk items. The DES was selected to assess participants’ perceived utility and risk based on its psychometric properties and use in similar investigations.

*Social norm items.* The perceived social norms of participants were assessed by two individual self-report items. The first item required participants to provide the percentage of the US population whom they believed to seek out professional psychological help each year. The second item asked participants to rate the level of encouragement that important family members and friends would provide them if they sought the services of mental health care professionals. The first item required participants to list a percentage. The ratings were gauged on a Likert-type scale for the second item and ranged from 1 (*minimal encouragement*) to 5 (*high levels of encouragement*).

*Outcome Questionnaire (OQ-45; Lambert, Gregerson, & Burlingame, 2004).* In order to determine the effectiveness of the current investigations independent variable’s (mass media pro-psychotherapy intervention) ability to alter attitudes and intention to seek psychological services on varying levels of psychological functioning, the Outcome Questionnaire was administered to all participants. Standardized OQ-45 norms were used to identify those participants who scored in the clinically significant distress range.

The OQ-45 is a self-report measure which was developed for tracking and assessing client outcomes in a therapeutic setting. Clinical and normative data for this
measure have been analyzed to provide cutoff scores (Lambert & Ogles, 2004). The
cutoff on the OQ-45 for marking the point at which a person’s score is more likely to
originate from a dysfunctional population than a functional population has been estimated
at 64. Scores that sum to 63 or below are considered to be similar to non-clinical
functioning levels.

The OQ-45 is a self-response inventory consisting of 45 items on a 5-point scale
where 0 = never, 1 = rarely, 3 = sometimes, 3 = frequently, and 4 = almost always.
Therefore, the total score of the OQ-45 can range from 0–180 with higher scores
indicating higher distress. The OQ-45 was selected to determine level of psychological
distress as it is widely used, well-established outcome measure which has demonstrated
good internal consistency (.93) and adequate 3-week test-retest values ($r = .84$) (Lambert
& Ogles, 2004). In addition, the OQ-45’s concurrent validity has been demonstrated
through significant ($p \leq .01$) comparisons with the Symptoms Checklist-90 (SCL-90;
Derogatis, 1977), the Beck Depression Inventory (BDI: Beck, Steer, & Garbin, 1988),
and the State-Trait Anxiety Inventory (STAI: Spielberger, 1985).

**Brief Mass Media Video Intervention.** The 2-minute long, public service
announcement (PSA)-type narrative script was developed specifically for the current
study. Moreover, based on the recommendations of the focus groups, the message of the
script was designed to be somewhat humorous and “light” in order to appeal to a college-aged
audience (see appendix H for full script). The script selected reflects a problem for
which university students commonly seek professional psychological services; the time
management of coursework (Komiya, Good, & Sherrod, 2000). Below, statements from
the PSA-length intervention content will be reviewed. Its corresponding belief-based
factor will also be described when appropriate. See Table 1 for complete list of belief-based factors addressed in the PSA.

(1) “Meeting with a therapist can be a useful solution to life’s hurdles.”

This statement is intended to point out to the viewing audience that therapy can help them cope with difficulties in life. It presents therapy as a viable option for “life’s hurdles” which can be interpreted as needed by the viewer. “Life’s hurdles” can be seen as mild problems or concerns and it can also be perceived as larger, more debilitating psychopathology. In a sense this statement reflects that ability of therapy to serve problems of all size, big or small. It is important to address the appropriateness of problems for which one might seek professional psychological services as research
Table 1. 
*Intervention Content and Corresponding Barrier*

<table>
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<tr>
<th>Intervention content</th>
<th>Barriers addressed through content</th>
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<tr>
<td>Independent studies show that most people “get better” compared with those who try to “fix things on their own”</td>
<td>Poor outcome expectation</td>
</tr>
<tr>
<td>Therapy is confidential; that means what is said in therapy is just between you and your therapist. In addition, most people feel better after just making the appointment.</td>
<td>Fear of self-disclosure</td>
</tr>
<tr>
<td>Therapy is a common, effective way to address life’s concerns and setback, as well as increase your overall life satisfaction.</td>
<td>Stigma Social norm perception</td>
</tr>
<tr>
<td>You'd be surprised to see whose benefiting from it right now!</td>
<td>Stigma Social norm perception</td>
</tr>
</tbody>
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indicates that most individuals do not know when a problem is suitable to see a therapist (Faberman, 1997). In addition, 45% of respondents from a national survey (N = 1,005) said that they are not informed when it comes to identifying mental illness (American Psychiatric Association, 2006). This statement intends to inform as well as address stigmatized views of therapy as treatment that is only for “crazy” people.

(2) “Independent studies show that most people “get better” [when seeking therapy] compared with those who try to “fix things on their own”. In fact, most people feel better after just making the appointment.” Most individuals are not aware of the effectiveness of psychotherapy (American Psychiatric Association, 2006). Poor outcome expectations have been widely researched in the psychotherapy literature as a prominent barrier to help-seeking professional psychological services. This statement intends to
educate the public about the relatively high effectiveness rates of therapy. It intends to address the belief-based help-seeking barrier that therapy often results in poor outcomes and is therefore not worth pursuing.

(3) “Therapy is confidential; that means that what you say in therapy is just between you and your therapist. In addition, therapists follow other professional guidelines, like always working with your best interest in mind”. In addition to being fearful about divulging personal and distressing information to a relatively unknown individual (a therapist), a further concern addressed in the literature is about perceived therapist characteristics; in that they act unethically and are not trustworthy. Most therapists however abide by strict ethical codes of which the public is generally unaware. This statement intends to convey the commitment that the majority of therapists have for their clients and the ethical code, emphasizing the ethical responsibility to uphold confidentiality for things which are disclosed. This statement is intended to address the fear-based barrier rooted in self disclosure by emphasizing the ethical principles (i.e. confidentiality of records) and standards by which psychologists must abide.

(4) “And finding the right therapist for you is important.” This project was presented at a state wide psychotherapy conference where it received wide interest. The purpose of the presentation, given that it was presented at an early stage of research development, was to solicit feedback from other professionals who were knowledgeable in the field. The resulting feedback was for the intervention to address the notion of client-therapist match and the importance of finding a therapist suited for your personal needs. Statement #4 intends to convey the importance of taking time to carefully select a therapist and encourages potential clients to switch therapists if they don’t feel the
relationship is a fit for them, rather than conclude that they personally are not fit for therapy.

(5) “Therapy is a common, effective way to address life’s concerns and setbacks as well as increase your overall life satisfaction. You’d be surprised to see whose benefiting from it right now!” According to the theory of reasoned action, individuals’ attitudes about behaviors like help-seeking are often based on their perception of what is perceived normal or average. Studies have demonstrated support for the public’s common underestimation of those who utilize professional psychological services. This set of statements is intended to highlight the commonness of seeing a therapist for problems one might encounter in life. The larger goal is to lessen the stigma associated with help-seeking by depicting therapy as a commonly accepted, effective way to deal with distressing personal problems, even by those who are otherwise academically and socially successful. This is intended to address the stigma and inaccurate social norm belief-based barrier to help-seeking.

The script was developed through the cooperation of Ohio University’s telecommunications department. A thorough presentation was made by the first author to a telecommunication advanced script-writing course regarding the specific aims of the project. These students had agreed to develop scripts for this project over the subsequent weeks with the understanding that one student’s script would be selected for the project. The students received extra credit in their course if their scripts were selected. The script which best addressed the aims of the current investigation was selected and further revised by a telecommunication faculty member. See appendix H for full script.
Procedure

At the start of each session participants were reminded that their participation in the study was voluntary and anonymous. They were told that they would be asked questions which asked their opinion about the effects of music in advertising and they were told they would be watching video segments comprised of public service announcements and musical performances. After completing an informed consent sheet students were randomly broken into two groups.

During the first of two sessions, each group watched 4, 10 minute video segments which consisted of public service announcements alternating like commercials around a musical performance. The music performance had been previously aired on the university’s music television program. The music performances were selected because they were of a similar quality to the media intervention. The control group’s video segments were identical to the media-exposed groups’ video segments with one exception: it did not include the 2-minute long pro-psychotherapy PSA-type intervention. In between the segments participants completed a brief task which asked about their opinions about the impact of music in advertising. A sample task item asked, “In what way do you feel televised advertisements are influenced by popular music?” Upon viewing the four segments and completing the three tasks between the segments, participants were reminded of the follow-up session to take place the same day and time the following week and were then dismissed.

The second session required participants to return to the rooms where they viewed the first 4 video segments. Informed consent was then reviewed and consent forms were once again distributed and completed by participants. Three additional video segments
were viewed with two alternating tasks inquiring about music in advertising. Finally, all participants completed the questionnaire packet (appendix A-G).

RESULTS

Plan of Analyses. In order to test the three hypotheses, a series of 2 X 2 X 2 X 2 between subjects designs were conducted with the dependent measures for barriers, attitudes, and intentions as the dependent measures. The intervention (media exposed or control group) served as the primary between subjects variable of interest. See Table 2 for means and standard deviations. Three contextual variables were also included in the analyses as between subject variables: clinically significant distress level (low or high), previous treatment (previous experience with counseling or no previous experience), and gender (male or female).
Table 2. 
*Means, and Standard Deviations for Factors affecting Help-Seeking for Media Exposed and Control Groups*

<table>
<thead>
<tr>
<th></th>
<th>Media Exposed group</th>
<th>Control group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Attitude*</td>
<td>18.61</td>
<td>5.65</td>
</tr>
<tr>
<td>Intention</td>
<td>55.21</td>
<td>17.59</td>
</tr>
<tr>
<td>Interpersonal*</td>
<td>3.27</td>
<td>1.17</td>
</tr>
<tr>
<td>Academic</td>
<td>2.68</td>
<td>1.11</td>
</tr>
<tr>
<td>Drug/Alcohol</td>
<td>3.55</td>
<td>.95</td>
</tr>
<tr>
<td>Social stigma</td>
<td>6.85</td>
<td>2.25</td>
</tr>
<tr>
<td>Disclosure distress</td>
<td>40.55</td>
<td>9.66</td>
</tr>
<tr>
<td>Desire to self-conceal</td>
<td>26.45</td>
<td>7.73</td>
</tr>
<tr>
<td>Treatment fears</td>
<td>55.16</td>
<td>16.78</td>
</tr>
<tr>
<td>Disclosure risk</td>
<td>11.87</td>
<td>3.59</td>
</tr>
<tr>
<td>Disclosure utility</td>
<td>13.97</td>
<td>3.42</td>
</tr>
<tr>
<td>Level of distress</td>
<td>55.81</td>
<td>20.91</td>
</tr>
<tr>
<td>Social norm perception</td>
<td>30.11</td>
<td>22.93</td>
</tr>
<tr>
<td>Level of encouragement</td>
<td>4.27</td>
<td>.89</td>
</tr>
</tbody>
</table>

*Hypothesis 1: Belief-Based Barriers.* To address the first hypothesis, a 2 X 2 X 2 MANOVA was conducted with the belief-based barriers towards treatment serving as the dependent variables (i.e., disclosure utility, stigma, disclosure risk, self concealment, treatment fears, disclosure distress, social norm perception and encouragement from others). There was no significant main effect for the media intervention among these belief-based factors, $F(8, 175) = .90, p = .53, \eta^2 = .04$. The
MANOVA, however, yielded a significant main effect for gender $F(8, 175) = 3.00, p = .001, \eta^2 = .14$, and clinically significant distress level, $F(8, 175) = 7.18, p = .000, \eta^2 = .24$. There was no significant main effect for previous treatment.

There was a significant interaction between clinically significant distress and previous treatment $F(8, 175) = 3.00, p = .003, \eta^2 = .07$, which was primarily due to interactions on two of the dependent variables: treatment fears $F(1, 182) = 16.10, p = .001, \eta^2 = .08$ and social norm perception $F(1, 182) = 4.74, p = .03, \eta^2 = .02$. Follow-up univariate analyses indicated that for those who had received prior treatment, there were significantly fewer treatment fears for those in the functional range of distress ($M = 44.11, SD = 15.96$) than compared to those with clinically significant distress ($M = 63.31, SD = 16.19$). Treatment fears were similarly high for participants who had not sought prior treatment in the past and did not significantly differ on clinically significant distress ($M = 57.97, SD = 15.52$).

Similarly, for participants with prior treatment, social norm perceptions were significantly lower for those participants who endorsed clinical levels of distress ($M = 23.37, SD = 21.93$) compared to those who fell in the functional range of distress ($M = 34.49, SD = 15.96$). There was no significant effect of distress level on social norm perceptions for those with no prior mental health care service experience.

Hypothesis 2: Attitude towards treatment. To address the second hypothesis, a 2 X 2 X 2 X 2 univariate ANOVA was conducted with attitude toward treatment serving as the dependent variable. Main effects emerged for each factor and there were no significant interactions. The media-exposed group demonstrated significantly more positive attitudes towards mental health care services compared to the control group, $F$
Those with clinically significant distress demonstrated more positive attitudes toward treatment when compared to those in the functional range, $F(1, 193) = 5.05, p = .026, \eta^2 = .03$. Furthermore, those participants who reported having seen a therapist in the past demonstrated more positive attitudes towards mental health care services compared to those who had not seen a therapist in the past, $F(1, 193) = 11.80, p = .001, \eta^2 = .06$. Lastly, female participants endorsed significantly more positive attitudes ($M = 19.14, SD = 5.63$) toward mental health care services compared to male participants ($M = 14.80, SD = 5.83$), $F(1, 193) = 17.61, p = .000, \eta^2 = .08$.

**Hypothesis 3: Intention to seek treatment.** Two statistical interactions emerged in the MANOVA testing the effects on intentions to seek treatment, one of which included the media intervention and prior treatment, $F(3, 191) = 3.06, p = .03, \eta^2 = .05$. This interaction was primarily from the intention to seek treatment for the interpersonal problems subscale, $F(3, 193) = 3.94, p = .05, \eta^2 = .02$ and not from the other two intention to seek treatment subscales (academic or substance-use problem subscales). Specifically, those who received the media intervention and who had prior treatment demonstrated significantly greater intentions to seek psychological treatment for their interpersonal problems ($M = 3.30, SD = 1.27$) than those who had the media intervention but who had never sought treatment ($M = 2.96, SD = 1.02$). Participants without the media intervention also had uniformly low intentions, regardless of whether they had prior treatment ($M = 2.83; SD = 1.16$) or not ($M = 2.93; SD = 1.03$).

In addition, a significant three-way interaction emerged among all three contextual variables of level of distress, prior treatment, and gender $F(3, 191) = 4.81, p =$
.003, $\eta^2 = .07$. Part of the three-way interaction can be understood by a significant two-way interaction between level of distress and prior treatment $F(3, 191) = 2.61, p = .05, \eta$

Table 3.
*Interpersonal Intentions Means and Standard Deviations for Between Subjects Factors*

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Level of distress</th>
<th>Prior tx</th>
<th>Gender</th>
<th>Mean</th>
<th>SD</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Exposure</td>
<td>Low</td>
<td>None</td>
<td>Female</td>
<td>3.13</td>
<td>.87</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>2.53</td>
<td>1.04</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>2.92</td>
<td>.97</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>None</td>
<td>Female</td>
<td>3.93</td>
<td>.97</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
<td>2.69</td>
<td>1.21</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>3.0</td>
<td>1.26</td>
<td>20</td>
</tr>
<tr>
<td>Low</td>
<td>Yes</td>
<td>Female</td>
<td>2.83</td>
<td>1.01</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>1.9</td>
<td>.86</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>2.54</td>
<td>1.04</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Yes</td>
<td>Female</td>
<td>3.11</td>
<td>1.33</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>3.66</td>
<td>1.06</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>3.26</td>
<td>1.24</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Exposure</td>
<td>Low</td>
<td>None</td>
<td>Female</td>
<td>2.88</td>
<td>1.06</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>2.76</td>
<td>1.01</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>2.81</td>
<td>1.02</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>None</td>
<td>Female</td>
<td>3.61</td>
<td>.92</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>3.17</td>
<td>1.01</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>3.39</td>
<td>.96</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Yes</td>
<td>Female</td>
<td>3.59</td>
<td>1.25</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>2.19</td>
<td>1.21</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>3.03</td>
<td>1.39</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Yes</td>
<td>Female</td>
<td>4.11</td>
<td>.78</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Male</td>
<td>4.67</td>
<td>1.16</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>4.18</td>
<td>.83</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>
Similarly, the clinically significant distress X prior treatment interaction was due largely to intentions to seek treatment for interpersonal problems, $F(3, 191) = 4.05, p = .05, \eta^2 = .02$, but not for academic nor drug related concerns. Specifically, intention to seek treatment for interpersonal problems was significantly greater for those who had reported prior treatment ($M = 3.80, SD = 1.07$) compared to those who had not ($M = 3.16, SD = 1.12$), but only for those who also endorsed a clinical level of distress. For those participants who were in the functional range of distress, there were no significant differences in intention to seek treatment between those participants who had prior treatment and those who had not. In regards to the role of the variable, gender, (in the three-way interaction between distress, prior treatment, and gender) intention to seek treatment was the greatest for males ($M = 4.67, SD = 1.16$) compared to females ($M = 4.10, SD = .78$) but only for those who reported a clinical level of distress, and who also reported previous treatment. See Table 3 for means and standard deviations by media exposure, level of distress, prior treatment, and gender.

**Exploratory analysis.** To make comparisons between the current investigation and Vogel and colleagues’ study, a series of multiple stepwise regression analyses were conducted in order to develop a path model. The first analysis included the belief based factors (stigma, treatment fears, distress disclosure, self-concealment, disclosure utility, disclosure risk, social norm, and encouragement from others) as predictors, and attitude towards treatment as the dependent variable. See Table 4 for the results of this regression. Next, a multiple stepwise regression was conducted with the same belief based factors and also included attitude towards treatment as predictors. Intentions to seek counseling for interpersonal problems served as the dependent variable. Like Vogel
and colleagues (2005) model, the best predictor of attitude was the factor entitled, “disclosure utility” when compared to the other factors included in the model. See Table 5 for the results of this stepwise regression. This result highlights the importance of one’s belief about the effectiveness of mental health services on one’s attitude towards these services.

Table 4.  
*Multiple regressions predicting attitudes towards treatment*

<table>
<thead>
<tr>
<th>Model Statistics</th>
<th>Variable</th>
<th>Predictor statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$\beta$</td>
</tr>
<tr>
<td>$R^2_{Adj} = .44$</td>
<td>Disclosure utility</td>
<td>.52</td>
</tr>
<tr>
<td>$F (4, 195) = 39.44$</td>
<td>Stigma</td>
<td>-.33</td>
</tr>
<tr>
<td>$p &lt; .000$</td>
<td>Disclosure risk</td>
<td>-.19</td>
</tr>
<tr>
<td></td>
<td>Desire to self-conceal</td>
<td>.14</td>
</tr>
</tbody>
</table>

Table 5.  
*Multiple regressions predicting intention to seek treatment for interpersonal problems*

<table>
<thead>
<tr>
<th>Model Statistics</th>
<th>Variable</th>
<th>Predictor statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$\beta$</td>
</tr>
<tr>
<td>$R^2_{Adj} = .35$</td>
<td>Attitude towards tx</td>
<td>.44</td>
</tr>
<tr>
<td>$F (3, 195) = 36.36$</td>
<td>Tx fears</td>
<td>.19</td>
</tr>
<tr>
<td>$p &lt; .000$</td>
<td>Disclosure utility</td>
<td>.19</td>
</tr>
</tbody>
</table>
Table 6.  
*Multiple regressions predicting intention to seek treatment for academic problems*

<table>
<thead>
<tr>
<th>Model Statistics</th>
<th>Variable</th>
<th>Predictor statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2_{\text{Adj}} = .21$</td>
<td>Attitude towards tx</td>
<td>.41 6.40 .000</td>
</tr>
<tr>
<td>$F(3, 195) = 18.23$</td>
<td>Tx fears</td>
<td>.24 3.84 .000</td>
</tr>
<tr>
<td>$p &lt; .000$</td>
<td>Social norm</td>
<td>.14 2.15 .033</td>
</tr>
</tbody>
</table>

Table 7.  
*Multiple regressions predicting intention to seek treatment for drug-related problems*

<table>
<thead>
<tr>
<th>Model Statistics</th>
<th>Variable</th>
<th>Predictor statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>$R^2_{\text{Adj}} = .24$</td>
<td>Disclosure utility</td>
<td>.17 2.25 .026</td>
</tr>
<tr>
<td>$F(3, 195) = 21.50$</td>
<td>Tx fears</td>
<td>.26 4.09 .000</td>
</tr>
<tr>
<td>$p &lt; .000$</td>
<td>Attitude towards tx</td>
<td>.30 3.90 .000</td>
</tr>
</tbody>
</table>

A similar analysis was run for intention to seek counseling for academic concerns (see Table 6). An additional stepwise regression was conducted which again included the aforementioned belief based barriers and attitude towards treatment as predictors, and intention to seek treatment for drug related problems serving as the dependent variable (see Table 7). And, unlike the models for intention to seek treatment for interpersonal and academic concerns, attitude towards treatment did not emerge as the best predictor, rather disclosure utility best predicted intention to seek treatment for drug related problems $\beta = .38, t(195) = 5.78, p = .000$. In contrast, Vogel and colleagues’ model, treatment fears
(variance estimate = .36) was the best predictor of intention to seek treatment for drug-related problems, followed by attitude towards treatment (variance estimate = .24). The complete resulting path model based on the multiple stepwise regression analyses is presented in Figure 2.

Figure 2.
*Multiple Regression Model with Standardized Regression Coefficients*

Nonsignificant path structure are not shown.
* *p < .05. **p < .01. ***p < .001*
DISCUSSION

The findings of this investigation offer support for the brief media intervention (the exposure to a mass-media video intervention embedded within standard programming) to alter both attitudes and intentions to seek professional psychological treatment. However, the effects of the intervention were complex and not conclusive. While there was a main effect for the media intervention on treatment intentions, the media intervention X prior treatment interaction suggests that the effects of the media intervention significantly depends on prior treatment. Specifically, the media intervention was effective at increasing one’s intention to seek treatment for interpersonal problems compared to those in the control group, but only for those who had sought prior treatment. Perhaps the most straightforward interpretation of this finding is that the media intervention increases intentions to seek psychological treatment, but perhaps may not be effective for individuals who have not had significant previous exposure to treatment in the past.

Particularly encouraging about these findings, then, is that according to the theory of reasoned action (Azjen & Fishbein, 1980) both attitudes and intentions to seek help most immediately precede actual help-seeking behavior. Thus, the two components of the model that most immediately precede the behavior of seeking psychological services were significantly increased by the media intervention in this study. Interestingly, media exposure had no significant effect on belief-based factors thought to serve as barriers to help-seeking. This was unexpected because the help-seeking models that the media intervention was built around (Azjen & Fishbein, 1980; Vogel et al, 2005) suggest that belief-based factors precede both attitude change and actual intention to seek help. This
apparent lack of consistency between these findings and the model will be explored further below.

Belief-Based Barriers and Expectations

The finding that the intervention had no effect on the belief-based factors is problematic given that past empirical modeling of help-seeking suggests that barriers directly influence both attitudes and intentions to seek psychological help (Vogel et al., 2005). It’s important to note that prior treatment, distress, and gender were treated as independent variables in the present experiment even though Vogel et al. (2005) treated them similarly to the belief based factors. However, these variables are not easily thought of as beliefs or expectations (at least, as measured). The most parsimonious explanation would be that the media intervention positively influences intentions so long as the prospective client is not faced with lacking some prior exposure to actual treatment in some form. Persons who have actually been in treatment are less likely to have other barriers interfere with future help-seeking since they had previously demonstrated actual help-seeking behavior. The interaction of the media intervention with prior treatment found in this study could have implications for other media intervention studies. In fact, the two previous studies that tested a mass media intervention (Faberbman, 1997; Barker, et al., 1993) did not measure prior treatment.

The complexity of the large set of belief-based factors that precede attitudes and intentions may also help explain some of the apparent inconsistencies involving these psychological factors in the present study. For example, the psychological factors may have different levels of salience, potentially cancelling out their effects, yet still resulting in the expected change in participants’ attitude and intention to seek psychological
treatment. Vogel et al. (2005) underscored this complexity when considering the numerous, interwoven beliefs and expectations that might influence any individual person’s decision to seek treatment: “As in any situation in which there are both positive and negative expected consequences, certain factors will have to take prominence or become salient in a person’s decision.” This is an assertion that was first introduced by Ajzen and Fishbein (1980) and later supported by Vogel and colleagues (2005) in their investigation into the relationship between disclosure risk and utility. Their finding that that anticipated risks were more directly predictive of actual help-seeking behavior compared to anticipated utility (Vogel & colleagues, 2005) is a good example of how variables differentially affect one’s actual help seeking behavior.

Treatment Context Variables

Prior Treatment. In terms of the effect of prior treatment on other barriers, however, the present study found greater treatment barriers for those who had prior treatment and experienced high distress. Specifically, those with prior treatment and high distress had greater treatment fears and lower social norm perceptions (i.e., greater fear of treatment; the perception that fewer individuals actually seek treatment). This is somewhat consistent with studies that have found that psychological distress predicts help seeking intent (Cepeda-Benito, & Short, 1998; Cramer, 1999), whereas yet other studies have failed to support this connection (Kelly & Achter, 1995; Vogel & Wester, 2003; Vogel et al. 2005).

Past experience with professional psychological services has also been widely researched in the help-seeking literature and its effects were evident from the results of the current study. In the current study, those participants who reported that they had seen
a therapist in the past demonstrated significantly more positive attitudes towards
treatment compared to those who did not. This finding is consistent with previous
literature which indicates that individuals who have had past experience with mental
health care services tend to demonstrate more positive attitudes about the services
compared to those who have not utilized such services before (Vogel et al., 2005). This
is a promising finding given that one’s preconceptions of counseling strongly influence
whether or not one will seek help (Cepeda-Benito, & Short, 1998; Deanne & Todd, 1996;
Kelly & Achter, 1995; Pipes, Schwarz & Crouch, 1985). As a result, it seems plausible
to assume that those who had seen a therapist in the past, on the average, had satisfactory
experiences and therefore hold more positive (pre)conceptions than those who have had
no personal experience with mental health services. And, it serves to explain the
disparity in intention level between those with past treatment experience, and those with
no experience with mental health care services. It also offers support to Morrison’s
(1980) demythologizing theory which asserts that providing information will serve to
improve one’s attitude towards mental health and mental health care services. This is
based on the belief that those who have seen a therapist in the past would generally have
more information about mental health services through their first hand exposure to it.

Overall, it seems that once someone has experience in therapy, they tend to have
positive attitudes towards it and a greater future intention to seek it compared to those
individuals who have not. Again, this is consistent with previous studies. For example,
Deane & Todd’s (1996) results demonstrated that those participants who indicated they
had previous seen a therapist rated themselves as more likely to seek help than those with
no prior counseling. Furthermore, intention to seek treatment for interpersonal problems
was significantly greater for those who had reported previous treatment compared to those who did not report previous treatment, but only for individuals who endorsed clinical levels of distress. It seems that endorsing clinical levels of distress serves as prerequisite for the pro-psychotherapy intervention effectiveness. This makes sense given that those who are high functioning (low, nonclinical levels of distress) would have little need for mental health care services and therefore lower intentions to seek treatment, despite exposure to a pro-psychotherapy intervention, compared to those who reported clinical levels of distress.

*Clinically Significant Distress.* In the current investigation, one’s level of psychological distress significantly affected one’s attitude towards seeking mental health care services. Those endorsing clinical levels of distress reported significantly more positive attitudes towards treatment compared to those who scored in the nonclinical range of distress. It’s interesting that those who would be considered the most in need of mental health care services, based on their endorsement of clinical levels of distress, also appear to hold more positive attitudes about the services. Distress level has been an important variable in the help-seeking literature. It is believed that individuals are more likely to seek counseling when their distress level exceeds their ability to cope. Certainly, there is evidence that distress serves a major (and perhaps the most important) contextual factor that influences actual help seeking (Cepeda-Benito, and Short, 1998; Kelly & Achter, 1995). Research initially explored the impact of one’s level of distress on help seeking. But, as aforementioned, investigations into the impact of distress on one’s help seeking behavior have often resulted in contradictory findings. And, it has been proposed that it may not be one’s general level of distress that affects help seeking; rather it may be
the experience of an acute problematic situation that results in help seeking behavior (Norcross, Prochaska, & DiClemente 1986). In the present study, the media intervention had main effects and one interaction with clinically significant distress. Obviously, it would be useful to target mass media interventions toward those who experience distress (while remaining sensitive to not to send stigmatizing messages that might reinforce belief-based barriers).

*Gender.* Consistent with the previous help-seeking literature, women tended to report lower belief based barriers overall compared to men. Female participants also reported more positive attitudes towards treatment compared to male participants. As aforementioned, despite the fact that women generally endorse more positive attitudes towards treatment (Fisher & Farnia, 1995) and are more likely to seek treatment compared to men (Moller-Leimkuhler, 2002), the results demonstrated that men were more likely than females to seek treatment, but only for those participants who reported a clinical level of distress, and who also reported that they had seen a therapist before. The results seem to suggest that the effects of previous treatment paired with clinical levels of distress counter the usually robust finding that women are more prevalent help seekers compared to men (Kushner & Sher, 1991) and further supports the dynamic interplay of factors found to affect one’s decision to help seek (or not).

Perhaps the best illustration of the complexity of the importance of the treatment context in the present study was the 3-way interaction involving gender, clinically significant distress, and prior treatment. Those participants with the greatest intention to seek treatment for interpersonal problems were men who reported prior treatment as well as clinically significant distress. Yet, it has been suggested that men’s socialization
actually makes this group more resistant to help seeking (Fisher & Farnia, 1995). This result seems to indicate the presence of factors of unique importance to men’s decision-making process in relation to help seeking. Additionally, Pederson and Vogel’s recent study (2007) provides the first empirical support for the notion that men are deterred from seeking help due to socialized gender role conflict. In other words, men are dissuaded from seeking counseling because the activity of counseling (getting help from someone, admitting vulnerabilities [Fischer & Farnia, 1995]) is in violation of the socialized male gender role, leaving this group more susceptible to self stigma and a desire to conceal distressing information (Pederson & Vogel, 2007). Yet, the findings of the current investigation indicate that highly distressed men with previous counseling experience reported greater intention to seek treatment for interpersonal problems compared to their female counterparts. Given these results, it seems valuable to explore the characteristics of those men who have had prior experience with therapy in an effort to better understand the unique conditions which facilitate help-seeking and counter the effects of gender role conflict. And although it was not investigated in their study, Pederson and Vogel (2007) advise the future exploration of distress and suggest that greater psychological distress should lead to greater recognition of the need to use services.

*Modeling Treatment Preparation.* Although a model comparison with Vogel and colleagues’ results was not the primary intention of the current investigation, it is important to note the striking similarities between the two. Both anticipated disclosure utility and stigma emerged as significant predictors of one’s attitude towards mental health care services. Subsequently, attitude towards treatment predicted intention to seek treatment. The results of these models offer support to the theory of reasoned action
(Azjen & Fishbein, 1980) which serves to define the links between attitude, intention, and actual behavior. And, given that the bulk of the belief-based factors were associated with one’s attitude towards therapy, and one’s attitude towards treatment was associated with one’s intention to seek mental health care services, the results appear to fit the path predicted by the theory of reasoned action.

Inconsistent with the theory of reasoned action, is that both the present investigation and Vogel and colleague’s (2005) show a direct link between the belief based factor relating treatment fears to intention to seek treatment. Moreover, treatment fears were positively correlated with one’s intention to seek help. Initially, this seems an illogical result; however it is consistent with previous findings (Cepeda-Benito, & Short, 1998). Kushner and Sher (1991) speculated that treatment fearfulness actually increases as one’s intention to seek treatment increases. They propose that high intentions may activate fears because fears about treatment would be more likely to be activated as the individual increases his/her intention to seek psychological treatment.

Limitations

The findings of the current investigation must of course be interpreted within the context of the studies’ design limitations. Potential selection bias existed due to the fact that volunteer participants were taken from one university only. Moreover, the generalizability of the findings may be limited in that the study utilized a homogeneous sample with a controlled design. There may also be limitations due to the self-report methodology used. Future studies may want to include a social desirability scale to control for these effects. Deane & Todd (1996) also report this as a recommendation for future help-seeking investigations utilizing self-report.
Further limitations of the current investigation include the fact that the investigation looked at attitude and intention change, but not actual behavior. Future investigations should consider assessing actual help-seeking behavior given the potential for disparity between having high intentions to seek mental health care services and performing the actual help-seeking behavior (Azjen & Fishbein, 1980). Also, both individuals who have never sought mental health care services and previous help-seekers were included in the study. This is problematic due to the confounding influence of experience, attitudes, expectations and opinion. Future research may benefit from examining these groups separately. It may also benefit from gathering more information about participants’ past treatment experiences. For example, Deane & Todd (1996) asked participants to report the number of sessions they had with a therapist.

Additionally, it would be beneficial to look at rate at which participants endorse that they would refer friends to mental health care services as opposed to just looking at the impact of the intervention on help-seeking intentions for self. It is estimated that about half of those who seek treatment are self-referred, yet the remaining percentage stated that someone other than themselves suggested that they seek professional help (Therapy in America, 2004). This opens up the possibility of promoting therapy to a third party rather than directly to the end user. In other words, instead of interventions aimed at getting the viewer to seek treatment, it might be useful to have efforts which target the friends and family of those in need of therapy. This fits with the literature which identifies perceived social encouragement (to seek treatment) as a factor that affects help-seeking (Vogel et al., 2005). Furthermore, Barker and colleagues’ (1993) investigation into a pro-psychotherapy media intervention indicated that those who viewed their
informative mental health programs demonstrated improved mental health awareness, but that the positive impact was primarily on respondents’ views and understanding of others’ problems rather than for their own.

*Future Directions and Conclusions*

The results of this study provide more evidence for the continuation of mental health care promotion. Further tailoring of interventions to other subpopulations found to underutilize mental health services would be beneficial. For example, research consistently demonstrates that men are less likely than women to seek mental health services (Leong & Zachar, 1999). Brief media interventions targeted to the unique perspectives and needs of men would be a fruitful endeavor given that men report higher levels of mental health stigma and related reluctance to seek treatment (Galdas, Cheater, & Marshall, 2005). Select racial and ethnic identities (i.e. African American and Hispanic) also underutilize mental health services (Narrow, Regier, Norquist, Rae, Kennedy, & Arons, 2000) and given the promising results of the current investigation, media interventions tailored to select groups seem a sound next step to advance this area of research. Furthermore, Deane and Todd (1996) suggest that future empirical studies set out to identify specific predictors for different samples given the psychosocial and cultural variations that exist. This area of research could also be advanced by investigating the effects of a brief media intervention that is tailored not only to the target population, but also tailored to specific and common presenting problems (i.e. depression, anxiety).

The results of this study might support bypassing attempts to alter belief-based factors and aim more directly on enhancing positive attitudes and intentions to actually
seek treatment. In retrospect, the mass media intervention for this study was aimed at producing attitude change (e.g., a person having nightmare suddenly changes to a bright, cheerful scene (i.e., attitude) in which the main character is shown making a phone contact for therapy, and walking into the waiting room (i.e., target behavior). Attitude association with a simple idea meant to evoke an emotional response has been found to be effective in theory and research in the communication literature on mass media advertisements (Dillard & Peck, 2000; Dillard & Peck, 2001; Parrott, 2004; MacLachlan, 1984). However, it’s also important to consider the possibility that failing to address and alter belief-based barriers may have limited influence.

Similarly, attempts to alter belief-based factors may benefit from separate, more specific strategies. Recent research seems to be moving in the direction of altering specific and independently defined belief based factors. Two recent studies that emerged since this study was initiated provide evidence for interventions that are targeted toward more specific belief-based factors. Vogel, Wade and Haak (2006) manipulated the specific factor of help-seeking stigma by specifying help-seeking stigma components. In this effort, Vogel and colleagues further defined the psychological factor *stigma* by exploring the possible impact of self-stigma (as opposed to public stigma) on help seeking behavior. They demonstrated that self-stigma uniquely predicted attitudes towards and intention to seek counseling. Moreover, Shaffer, Vogel, & Wei (2006) also recently found that attachment perspective significantly contributed to one’s perceptions of the benefits and risks of counseling, which in turn contributed to one’s attitudes and intention toward seeking treatment. Thus, future development of interventions might benefit by focusing the intervention toward specific belief-based variables and to
consider how the media intervention would be most influential within specific
demographics and contexts (e.g., gender, prior treatment, level of distress, attachment
style).

Most pre-treatment preparation and mass advertisement research has not
examined the psychological mechanism that lead to the initiation of treatment.
Obviously, knowing the mechanisms of treatment initiation may facilitate in the
development of more effective and targeted pre-treatment interventions. Understanding
help seeking behavior is an imperative step in developing more effective interventions
meant to encourage those with untreated psychological distress to seek treatment. Even
though the media intervention was not intended to be a standalone solution, the results of
this investigation contribute to the literature by demonstrating that even limited exposure
to a brief intervention has the capacity to alter one’s attitudes towards seeking mental
health services.

Brief media interventions offer the benefit of being an easily distributed vehicle to
educate the public about mental health care and its related services in that it requires only
a one-time creation and potentially limitless distribution. Furthermore, the current
intervention was an interdisciplinary, applied intervention. It was created based on
findings from clinical and social psychology research and took advantage of the
communication literature to create an effective media intervention. This unique,
integrative approach, which has not been previously utilized, makes sense given the
complexity of understanding and affecting individual behavior. It also provides support
for researching and developing future interdisciplinary interventions.
REFERENCES


Therapy in America (2004). Therapy in America: A National Survey. Retrieved on December 12th, 2005 from,


APPENDIX A: DEMOGRAPHICS QUESTIONNAIRE

Gender:  Male (2)  Female (1)
Circle one

Age  ___
please specify

Year in College:
Circle one  First Year (1)  Sophomore (2)  Junior (3)  Senior (4)

College Major  
please specify

Race:
Circle one  Caucasian (1)  African American (2)  Hispanic (3)  Asian (4)  Native American (5)  Other (6)  please specify

Marital Status:
Circle one  Single (1)  Married (2)  Separated (3)  Divorced (3)

Have you ever sought professional psychological help (presently or in the past)? Circle one  YES (1)  No (2)

If yes, for what type of problem did you seek services?

If yes, how helpful did you find your experience with professional psychological services?

Very unhelpful  unhelpful  somewhat helpful  helpful  very helpful

1  2  3  4  5

Would you recommend professional psychological services to others?

Very unlikely  unlikely  somewhat likely  likely  very likely

1  2  3  4  5
APPENDIX B: INTENTIONS OF SEEKING COUNSELING INVENTORY

Please rate the likeliness that you would see a therapist if you were experiencing one of the following problems.

<table>
<thead>
<tr>
<th></th>
<th>1 Very Unlikely</th>
<th>2 Unlikely</th>
<th>3 Somewhat Unlikely</th>
<th>4 Somewhat Likely</th>
<th>5 Likely</th>
<th>6 Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Weight control</td>
<td></td>
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<td></td>
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<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2.</td>
<td>Excessive alcohol use</td>
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<td></td>
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<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
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<tr>
<td>3.</td>
<td>Relationship difficulties</td>
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<tr>
<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>Concerns about sexuality</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>Depression</td>
<td></td>
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<tr>
<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>Conflicts with parents</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7.</td>
<td>Speech anxiety</td>
<td></td>
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<tr>
<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8.</td>
<td>Dating difficulties</td>
<td></td>
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<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9.</td>
<td>Choosing a major</td>
<td></td>
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<tr>
<td></td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10.</td>
<td>Difficulty in sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Drug problems

12. Inferiority feelings

13. Test anxiety

14. Difficulties with friends

15. Academic work procrastination

16. Self-understanding

17. Loneliness
APPENDIX C: ATTITUDES TOWARDS SEEKING PROFESSIONAL PSYCHOLOGICAL HELP
A shortened form

Please circle the number corresponding to your level of agreement with the following statements.

1. If I believed I was having a mental breakdown, my first inclination would be to get professional help.
   
   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3

2. The idea of talking about problems with a therapist strikes me as a poor way to get rid of emotional conflicts.

   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in therapy.

   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3

4. There is something admirable in the attitude of a person willing to cope with his or her conflicts and fears without resorting to therapy.

   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3

5. I would want to go to a therapist if I were worried or upset for a long period of time.

   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3

6. I might want to see a therapist in the future.

   Agree  Partly Agree  Partly Disagree  Disagree
   
   0           1    2          3
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve the problem with the help of a therapist.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

8. Considering the time and expense involved in therapy, it would have doubtful value for a person like me.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

9. A person should work out his or her own problems; seeing a therapist would be a last resort.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

10. Personal and emotional troubles, like many things, tend to work out by themselves.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Partly Agree</th>
<th>Partly Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
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<td>3</td>
</tr>
</tbody>
</table>
APPENDIX D: STIGMA SCALE FOR RECEIVING PSYCHOLOGICAL HELP

(SSIDPH)

1. Seeing a therapist for emotional or interpersonal problems carries social stigma.

   Strongly Disagree    Disagree    Agree    Strongly Agree
   0                    1           2        3

2. It is a sign of a personal weakness or inadequacy to see a therapist for emotional or interpersonal problems.

   Strongly Disagree    Disagree    Agree    Strongly Agree
   0                    1           2        3

3. People will see a person in a less favorable way if they come to know that he/she has seen a therapist.

   Strongly Disagree    Disagree    Agree    Strongly Agree
   0                    1           2        3

4. It is advisable for a person to hide from people that he/she is in therapy.

   Strongly Disagree    Disagree    Agree    Strongly Agree
   0                    1           2        3

5. People tend to like those who are in therapy.

   Strongly Disagree    Disagree    Agree    Strongly Agree
   0                    1           2        3
APPENDIX E: THOUGHTS ABOUT PSYCHOTHERAPY SURVEY

In filling out the following survey, we would like you to imagine that you have decided to see a therapist for a personal problem. Please answer the following questions using this scale:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>no concern</td>
<td>little concern</td>
<td>unsure</td>
<td>some concern</td>
<td>I am very concerned about this</td>
</tr>
</tbody>
</table>

1. Is psychotherapy what I need to help me with my problems?
   
   1 2 3 4 5

2. Will I be treated more as a case than as a person in psychotherapy?
   
   1 2 3 4 5

3. Will the therapist be honest with me?
   
   1 2 3 4 5

4. Will the therapist take my problems seriously?
   
   1 2 3 4 5

5. Will the therapist share my values?
   
   1 2 3 4 5

6. Will everything I say in psychotherapy be kept confidential?
   
   1 2 3 4 5

7. Will the therapist think I'm a bad person if I talk about everything I have been thinking and feeling?
   
   1 2 3 4 5

8. Will the therapist understand my problem?
   
   1 2 3 4 5
9: Will my friends think I'm abnormal or weird for coming?
   1  2  3  4  5

10. Will the therapist think I'm more disturbed than I am?
    1  2  3  4  5

11. Will the therapist find out things I don't want him/her to know about me and my life?
    1  2  3  4  5

12. Will I learn things about myself I don't really want to know?
    1  2  3  4  5

13. Will I lose control of my emotions while in psychotherapy?
    1  2  3  4  5

14. Will the therapist be competent to address my problem?
    1  2  3  4  5

15. Will I be pressured to do things in psychotherapy I don't want to do?
    1  2  3  4  5

16. Will I be pressured to make changes in my lifestyle that I feel unwilling or unable to make right now?
    1  2  3  4  5

17. Will I be pressured into talking about things that I don't want to?
    1  2  3  4  5

18. Will I end up changing the way I think or feel about things or the world in general?
    1  2  3  4  5

19. The thought of seeing a therapist would cause me to worry, experience nervousness or feel fearful in general.
    1  2  3  4  5
APPENDIX F: SOCIAL NORM ITEMS

1. Please rate what you believe to be the average percentage (between 1%-99%) of the U.S. adult population who suffers from a diagnosable psychological disorder in any given year. ________%

2. Please rate the level of encouragement that important family members and friends would provide you if you wanted to see a therapist for assistance with a problem.

   1  2  3  4  5
   Minimal encouragement   High levels of encouragement
APPENDIX G: OUTCOME QUESTIONNAIRE -HAI

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item and mark the category that best describes your current situation. If you are not employed, consider "housework" as "work".

Categories: (0) Never (1) Rarely (2) Sometimes (3) Frequently (4) Almost Always

1. I get along well with others.
2. I tire quickly.
3. I feel no interest in things.
4. I feel stressed at work
5. I blame myself for things.
6. I feel irritated
7. I feel unhappy in my marriage (if not married mark, “Never”)
8. I have thoughts of ending my life.
9. I feel weak.
10. I feel fearful.
11. After a heavy night of drinking I need a drink in the morning to keep going (if you do not drink mark, “Never”)
12. I find my job/school satisfying.
13. I am a happy person.
14. I find I work/study too much.
15. I feel worthless.
16. I am concerned about my family troubles.
17. I have an unfulfilling sex life.
18. I feel lonely.
19. I have frequent arguments.
20. I feel loved and wanted.
21. I enjoy my spare time.
22. I have difficulty concentrating.
23. I feel hopeless about the future.
24. I like myself.
25. I am not able to keep disturbing thoughts out of my mind.
26. I feel annoyed by people who criticize my drinking (or drug use).
   (If not applicable mark, “Never”)
27. I have an upset stomach.
28. I am not working/studying as well as I used to.
29. My heart pounds too much.
30. I have trouble getting along with friends and close acquaintances.
31. I am satisfied with my life.
32. I have trouble at work/school because of drinking or drug use.
   (If not applicable mark, “Never”)
33. I feel that something bad is going to happen.
34. I have sore muscles.
35. I feel afraid of open spaces, or of driving, or being on buses, subways.
36. I feel nervous.
37. I feel my love relationships are full and complete.
38. I feel that I am not doing well at work/school.
39. I feel something is wrong with my mind.
40. I have trouble falling asleep or staying asleep.
41. I feel blue.
42. I am satisfied with my relationships with others.
43. I feel angry enough at work/school to do something I might regret.
44. I have headaches.
APPENDIX H: TIME MANAGEMENT

FADE IN

INT. DORM ROOM - NIGHT

Samantha, 19, sits at a desk with a blank computer screen in front of her. Books piled up on the desk. A blank piece of paper in front of her, she holds a pen.

SAMANTHA
All right, no more excuses. I’ve gotta get his done.

Samantha brings the pen down to the paper when, all of a sudden, the paper ZIPS AWAY. Samantha, very confused...

EXT. ALLEY - NIGHT

Paper zips away down an alley. A MYSTERIOUS MAN grabs it, hops in a car and SPEEDS AWAY. Samantha jumps into her car and SPEEDS after him.

EXT. EDGE OF FOREST - NIGHT

Samantha’s car SCREECHES TO a stop, as Mysterious Man runs into a forest. Samantha follows him on foot.

EXT. FOREST CLEARING - NIGHT

Samantha loses the Mysterious Man but finds her piece of paper alone in a clearing. She is about to grab it, when... ALIENS emerge from the forest with RAY GUNS.

ALIENS
Take us to your leader.

They ZAP Samantha with their ray guns.

INT. DARK ROOM

Samantha awakens beneath a spotlight shining down on her. A person dressed in a BROWN COW SUIT sits in the darkness, in an armchair, waving the paper.

SAMANTHA
How now, brown cow?

BLACK

Fade in Text: “Homework can be overwhelming at times. Therapy can help”
Voiceover: Meeting with a therapist can be a useful solution to life’s hurdles.

SAMANTHA, A 19-YEAR OLD, ATTRACTIVE ASIAN FEMALE THUMBS THROUGH PHONEBOOK OR UNIVERSITY DIRECTORY FOR THERAPISTS. A STRESSED SAMANTHA DIALS ON HER CELL PHONE AND FLIPS THROUGH HER PLANNER.

Voiceover: Studies show that people who see a licensed therapist generally report a better outcome compared with those who try to fix things on their own.

(Print across bottom of the screen: 80% of those who see a therapist report improvement compared with those who do not)

3. ALTHOUGH SAMANTHA CAN’T BE HEARD, SHE APPEARS AS IF SHE’S SCHEDULING AN APPOINTMENT. SHE HANGS UP AND APPEARS RELIEVED.

(Print from previous frame remains)

Voiceover: In fact, most people feel better after just making the appointment.

Voiceover: Therapy is confidential; that means what’s said in therapy is just between you and your therapist. In addition, therapists follow other professional guidelines, like always working with your best interest in mind.

6. SAMANTHA, LOOKING PLEASED, IS WALKED TO THE DOOR OF AN OFFICE BY HER THERAPIST. THEY SHAKE HANDS AND SMILE AS IF THEY JUST COMPLETED A BIG, SUCCESSFUL BUSINESS DEAL.

(Print across bottom of screen) 21% of children & adolescents, and 15% of the U.S. adult population use professional psychological services in any given year [USDHHS])

Voiceover: Therapy is a common, effective way to address life’s concerns and setbacks as well as increase your overall life satisfaction. You’d be surprised to see whose benefiting from it right now!

INT. DORM ROOM – NIGHT

Samantha tucks a page full of notes into one of her text books and hits PRINT on her computer. The SOUNDS OF A PRINTER can be heard as she picks up the phone.

SAMANTHA
You still want to do dinner? Sure. Anything but a burger.
APPENDIX I: FOCUS GROUP OUTLINE

Purpose: The purpose of conducting 3-4 focus groups is to investigate the participants’ opinions about seeking mental health services. Part of this investigation includes exploring what information participants have about mental health services, who they feel should seek treatment, and who they feel can benefit from therapy.

The ultimate goal is to create a pro-psychotherapy public service announcement (PSA) in order to encourage those individuals who are contemplating seeking mental health services to follow through and do so. The PSA would include information intended to make seeking the consultation of a mental health expert a less stressful and more positive experience.

Format of the focus group

1. To be presented to focus groups

1 minute – introduction to purpose of the study

*Opening questions* (Round Robin style) (5 minutes)

1. What do you think of when someone talks about seeing, or wanting to seek the services of a therapist?

*Introductory questions* (15 minutes)

1. What do you think it might be like to go see a therapist/counselor/clinical psychologist for the first time?

2. What kinds of problems might make you consider seeking consultation from a therapist?

*Transition questions* (15 minutes)

1. If you had a problem for which you might consider seeking consultation from a therapist, which might prevent you from doing so?

*Key Questions* (15 minutes)

1. Once barriers to treatment have been identified, the group will be presented the task of suggesting ways in which those barriers can be inoculated, specifically via the content of a public service announcement might address those barriers. Key questions will be based on responses to transition questions

*Ending questions* (10 minutes)

1. Group facilitator will summarize the group’s discussion regarding the potential barriers to seeking mental health services.
2. Group facilitator will summarize the group’s discussion regarding the potential information that, when presented to hesitant individuals who are contemplating treatment, will result in an increase in treatment seeking behaviors.

3. A summary of the group’s comments will be offered. Feedback will be solicited.

4. If given the task, how would you go about investigating why some people who are contemplating therapy do not seek treatment, as well as investigating the types of information (content) that might be influential in increasing the changes that a hesitant individual seek treatment. Are there certain questions you would ask? How would they be worded?

5. Group facilitator will ask: Are there any suggestions you might have to improve the effectiveness of this group, keeping in mind the intention is to develop a public service announcement that will inform, and therefore encourage, those who are contemplating seeking mental health services to do so.

6. At the conclusion of the group the participants will be given information on how to obtain the results of the study.
APPENDIX J: PRELIMINARY FOCUS GROUP METHODS

In addition to utilizing various areas of research literature to drive the content construction of a pro-psychotherapy public service announcement, focus groups were also run to further guide the current research endeavor. Five, 6-8 person focus groups (N = 29) were run to assess the accuracy and level of knowledge that college students have regarding mental health services. These groups also identified and attempted to address potential barriers to treatment for this population based on a standardized, yet informal, question format.

Focus group questions were structured according to guidelines outlined by Krueger (1994). According to Krueger (1994) several types of questions comprised the structure of the focus group. Examples of these questions include selecting an opening question that can be answered rather quickly in a round robin style. The opening question for this focus group was; (1) “What do you think of when someone talks about seeing, or wanting to seek the services of a therapist?” Next, introductory questions which introduce the general of the topic were used. The primary introductory question assessed participants’ expectations of a first time counseling session: (2) “What do you think it might be like to go see a therapist/counselor/clinical psychologist for the first time?” and (3) “What kinds of problems might make you consider seeking consultation from a therapist?” Key questions are those questions which drive the study. The key question of this focus group was; (4) “If you had a problem for which you might consider seeking consultation from a therapist, which might prevent you from doing so?” This study was approved by Ohio University Research Compliance Internal Review Board. Participants gave prior informed consent. They were also aware of the purpose of the focus group
prior to the commencement of the group. The age range for this group was 18-21 and had a mean equal to 19.2. Seventy-five percent of the participants were female and 25% male. The group was primarily Caucasian (89%) with 7% identifying as African American, and 4% identifying themselves as Asian. No participant identified themselves as Hispanic. Upon completion of a demographic questionnaire participants were then urged to participate in the group’s discussion via facilitative questioning and positive reinforcers from the group leader. Prominent themes emerged as the group was systematically questioned about their knowledge of professional psychological services. Prominent themes were independently identified by the principle researcher and the research assistant subsequent to listening to the audio recording of the groups. Any discrepancies between coders were discussed and resolved. Through this qualitative research design emerged themes which supported much of the preexisting quantitative research. It is important to note that the inclusion of qualitative focus group methodology was intended to serve as adjunct to the help-seeking literature therefore it was selected over more rigorous research methodologies. A preexisting coding process was not used; rather the focus group data was compared to the help-seeking literature in order to determine the extent to which focus group participants’ responses agreed with the findings of the help-seeking literature.

In accordance with the literature, a lack of information regarding professional psychological services was a primary hindrance to seeking services with this particular sample. Overall, the sample was generally unable to distinguish between psychologists and psychiatrists, nor were they aware of their training and licensing requirements. Additionally, the sample on the whole did not know when it might be appropriate to seek
professional psychological services. Very few participants reported having seen a therapist with a few rare exceptions. Any participant who did divulged that they had seen a therapist did so due to the divorce of their parents. It was also common for participants to divulge that they had a friend who saw a therapist when their parents divorced but beyond issues surrounding a divorce or blatant severe psychopathology (psychosis) participants were unable to identify problems for which professional psychological services could be helpful. Therefore, the group emphasized the importance of informing the public about the types of problems for which others in their age group might commonly seek professional psychological treatment. Furthermore, they thought it would be useful to depict an actual therapy setting so that they would have some idea of what to expect. This desire to know more about therapy prior to utilizing professional psychological services overlap with research demonstrating the effectiveness of preparatory educational programs for therapy clients. Reis and Brown (1999) demonstrated that clients who participated in preparatory educational programs prior to seeing a therapist reported a better understanding of the therapeutic process and the role of the client compared to non-prepared clients. Additionally, Tinsely and colleagues (1999) demonstrated that pre-intake clients’ expectations can have a significant impact on therapeutic outcomes and client compliance. Providing information to pre-intake and potential clients can be equated with turning on the light in a darkened room. One might avoid the darkened room to avoid the unknown, but once “illuminated” those fears often subside when one knows what to expect. In addition to expectations about the therapy process, focus group participants were unaware of the outcome effectiveness of professional psychological services. Most participants were surprised to hear that
professional psychological services had been empirically demonstrated as effective and that 80% of those who sought professional mental health care services were better off then those who did not receive such services (Smith, Glass and Miller, 1980). They felt it was important to emphasize the high rate of effectiveness of professional psychological services when developing a pro-psychotherapy PSA. They felt that if individuals knew that it was effective they would be more open to seeking professional psychological services.

Although participants did not have much accurate information about professional psychological services, most reported a favorable attitude towards those they knew who had. Participants frequently mentioned that they thought it was “normal” to see a therapist. Often individuals made statements which offered support and understanding to individuals they knew of who were seeking mental health services. Despite these supportive sediments, their comments were often followed with a statement that reflected the belief that although they would be supportive of others, therapy isn’t something they considered for themselves and that they would prefer to “fix things on their own” and talk with friends and family about psychological distress. This was interpreted as supporting the notion that stigma, specifically internalized self stigma, is still serving as a barrier to professional psychological services in this small sample of university students.

Fear of disclosure, (“Bringing up past feelings and problems is hard”) and concern about being pressured to take medication were also identified as barriers to professional psychological help-seeking. They wondered about others finding out about what was said in therapy and did not know that therapist followed strict ethical codes.
Lastly, a belief that therapy is a luxury for the wealthy also serve (albeit in a much more limited capacity) as a help-seeking deterrent for this group.

Suggestions from focus group participants to promote professional psychological services were also solicited. The group suggested to, “keep it light” and to possibly use humor when promoting professional psychological services. They recommended the slogan, “It’s just therapy”. Lastly, participants advocated the use of a spokes person, possibly a prominent figure on campus.