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Investigation of Views on Mental Health Treatment Seeking

Huy Tran

INVESTIGATION OF VIEWS ON MENTAL HEALTH TREATMENT SEEKING

by

HUY TRAN

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Sarah M. Sass, Ph.D., Committee Chair

College of Education and Psychology

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This is to certify that the Master's Thesis of

HUY TRAN

has been approved for the thesis requirement on
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for the Master of Arts in Counseling Psychology degree

Approvals:

Thesis Chair: Sarah M. Sass, Ph.D.

Member: Charles R. Barké, Ph.D.

Member: Rosemary E. Barké, Ph.D.

Chair, Department of Counseling and Psychology

Dean, College of Education and Psychology

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Abstract

INVESTIGATION OF VIEWS ON MENTAL HEALTH TREATMENT SEEKING

Huy Tran

Thesis Chair: Sarah M. Sass, Ph.D.

The University of Texas at Tyler
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Although research exists regarding barriers to mental health care for individuals with depression and anxiety disorders, few studies have compared characteristics of those who seek treatment versus those who do not seek treatment for psychological distress associated with these disorders. Such studies are needed in order to better understand factors involved in treatment seeking and treatment abstention. The present study addresses treatment seeking and treatment abstention in individuals with major depressive disorder (MDD) and generalized anxiety disorder (GAD), in order to understand barriers to treatment in this population. Results indicate that the groups did not significantly differ on their gender, finances, sexual orientation, ethnicity, and grade classification. Results also suggest that those who seek treatment associate less stigma with mental health than those who do not seek treatment. Finally, both groups prefer to handle their own problems and think that their problems would eventually resolve themselves. These results may be helpful in informing outreach and prevention efforts targeted to an MDD and GAD population.

Introduction

There exists a very large treatment gap in the area of mental health disorders within the United States. A treatment gap is defined as the number of people who need treatment but are not receiving it, even though effective treatment is available. Approximately 28% of Americans will suffer from an anxiety or depressive disorder (Kessler et al., 2005). The treatment gap is approximately 68% for GAD and 72% for MDD (Kohn et al, 2004). Indeed, a large percentage of people who need treatment are not receiving it with direct and indirect ramifications (Wang et al., 2005).

Due to depressive disorders alone, lost productivity in the workforce accounts for a $23 billion cost to the United States annually (Kohn et al., 2004). Wang, Simon, and Kessler (2003) reported that about 44% of those surveyed in the National Comorbidity Study (NCS) were absent for at least one day of work in the last three months due to complications regarding major depression. Additionally, compared to disorder-free individuals, they were 27 times more likely to experience work loss (Wang et al., 2003). For GAD, Wittchen (2002) states that it may lead to complete disability, diminished productivity at work, and is as much of a burden on society as depression. Moreover, individuals with comorbid GAD and MDD experience a higher level of disability (Wittchen, 2002). In addition to GAD and MDD being problematic disorders when not comorbid, their comorbidity exacerbates economic costs to society.

Untreated depressive and anxiety disorders also affect several aspects of an individual's life, including personal and social domains. Depressive disorders may affect

an individual's workplace functioning, interpersonal relationships, marriage, educational achievement, and employment (Collins, Westra, Dozois, & Burns, 2004). Children affected by anxiety disorders may have poor academic performance, a greater likelihood of being suspended, and run away from home (Collins et al., 2004). Adults with anxiety disorders face problems in interpersonal relationships, including family interactions (Collins et al., 2004). Despite efficacious treatment such as cognitive behavioral therapy and pharmacological options for anxiety and depressive disorders (Dobson, 1989), the treatment gap remains problematic.

Literature Review

A Closer Look at Treatment Barriers

There is currently a scarcity of data in the research literature pertaining specifically to individuals with MDD, GAD, and comorbid MDD/GAD and their respective barriers to treatment. Table 1 lists the most common barriers to treatment seeking for anxiety and depression (Collins et al., 2004). In order to narrow down the scope of this research project, only barriers on an individual level are examined. However, provider and systemic factors contribute to the overall treatment gap problem and will be considered further in the Discussion section.

In addition to the barriers to treatment noted by Collins et al. (2004), Vogel, Wester, and Larson (2007) identified several general reasons why individuals with anxiety and depression may avoid counseling, referred to as "avoidance factors." These barriers include social stigma, treatment fears, fear of emotion, anticipated utility and

risks, and self-disclosure. More specifically, treatment fears are described as the fear of how one may be treated and viewed by a mental health professional which may delay or disrupt treatment-seeking behaviors. Fear of emotion is described as the fear of discussing and experiencing painful emotions which may delay or disrupt treatment-seeking behaviors. Finally, anticipated utility and risks is described as the individual's perception of how useful treatment will be, and whether the risks outweigh the benefits. It is important to note that Vogel et al. (2007) describe barriers to counseling whereas Collins et al. (2004) describe barriers to medication in addition to counseling for mental health problems.

The present study examines barriers to both medication and counseling using a student sample. In a related study, Downs and Eisenberg (2012) examined treatment-seeking behaviors and perceptions in a college sample endorsing suicidal ideation. The researchers did not explicitly state whether their participants met criteria for MDD and/or GAD. Still, suicidality is a common symptom among those with MDD and/or GAD, and there is a possibility that those who express suicidality may meet criteria for MDD and/ or GAD. In fact, Downs and Eisenberg (2012) state that "9 out of 10 people who die by suicide in the United States have probable mental illnesses, and depressive symptoms have been associated with 95% of college students with reported suicidal ideation. " Another important statistic that was reported is that less than half of students screening positive for depression or anxiety disorders received any mental health services in the last 12 months. It is evident that the researchers believe that there is a treatment gap among

the average college population suffering from depression and anxiety disorders, and that this gap can lead to suicidal ideation.

In the Downs and Eisenberg (2012) study, participants were asked to rate their top barriers to treatment. The majority of participants stated that they did not seek treatment because they preferred to deal with their own problems, perceived their stress as being "normal," and questioned whether their problems warranted treatment. Preferring to solve one's own problems is a common trend in the treatment-seeking literature. This self-reliance is also reflected in a study completed by Meltzer et al. (2003). However, in addition to participants reporting that they prefer to handle their own problems, in this study they also questioned the efficacy of treatment, worried about social stigma, and thought that their problems would eventually improve without treatment. Overall, it appears that a lack of insight into the chronicity and severity of mental health issues can be a major barrier for treatment seeking (Meltzer et al., 2003). Furthermore, high personal stigma was correlated with a lower perceived need for help in an untreated population (Schomerus et al., 2012).

What other factors should be considered? In a study that involved approximately 347 adults living in Great Britain, Meltzer et al. (2003) found that socio-demographic and socioeconomic factors were not largely correlated with a reluctance to seek treatment. Instead, the researchers discovered that symptom severity played a more important role in seeking treatment. Counterintuitively, the more severe the symptoms, the more likely it was for participants to express reluctance. One important caveat of this study is that the

researchers only interviewed participants who "had not been to see a doctor when they or their family and friends thought they should" within the past year. Participants who did not seek treatment because they did not perceive a need were not interviewed. This is an important distinction because a lack of knowledge about disorders has been found to be a barrier to treatment seeking. Another caveat is that the researchers collapsed ethnicity into four distinct categories: White, Black (African, African-Caribbean, and 'Black Other'), South Asian (Indian, Pakistani, and Bangladeshi), and 'Other.' There could be differences within these groups that should be examined. Of those participants who did endorse a reluctance to seek treatment, two of the most common reasons given were "…not thinking anyone could help," and "…a problem one should be able to cope with." This study, despite the caveats mentioned, present another facet to the treatment gap problem. That is, the severity of an individual's mental health problems may contribute to their unwillingness to seek help despite needing it.

Phillips, Mayer, and Aday (2000) reported disparities in treatment barriers for different racial/ethnic groups in the United States in a separate study. The study states that minorities, especially Hispanics, reported barriers more frequently than non-Hispanic whites. Hispanics were most likely to endorse problems in obtaining care compared to other racial/ethnic groups. Asian Americans were most likely to report dissatisfaction with the quality of care received. The authors suggest that continuity of care may be a problem in this group. African Americans more frequently reported barriers than non-Hispanic whites, but less so than other racial/ethnic groups. Individuals with insurance,

across all racial/ethnic groups, reported fewer barriers to care but "insurance alone did not guarantee better access to care" (Phillips et al., 2000). In fact, about two-thirds of families who reported having barriers to care were insured. This study highlights the importance of examining cultural barriers that racial/ethnic populations may face when attempting to access care. Although having insurance and the ability to pay is important, being insured is not a guarantee for a high quality of treatment. Researchers and advocators must also look at stigma, language, cultural, and socioeconomic barriers—combined—in order to fully comprehend the needs of these populations.

In addition to investigating barriers to treatment, examining characteristics of individuals who display positive treatment-seeking behaviors (i.e., those who seek treatment) should be examined as well in order to develop a better understanding of what motivates treatment seeking. In the current literature, there is a paucity of data examining attitudes and beliefs of treatment seekers for MDD and/or GAD. However, Thomas, Caputi, and Wilson (2014) found several attitudinal factors that may predict positive treatment-seeking behavior in an undergraduate sample of psychology students who experienced distress. Their results indicate two attitudes that were endorsed by participants who intended to seek treatment for psychological distress: "If I believe that I was having a mental breakdown, my first thought would be to get professional attention," and, "A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help." As previously noted, two common barriers to treatment seeking include a lower perceived need for help and the desire to solve one's

own problems. The results from this study indicate that those who intended to seek treatment were more likely to do so if they perceived a need for help and believed that one is unlikely to resolve one's own mental health problems.

Research Questions and Hypotheses

The present study's focus was to examine common barriers to treatment amongst a student sample meeting criteria for MDD and/or GAD by exploring differences between treatment seekers and non-treatment seekers. The goal of the study was to identify demographic, attitudinal, and other barriers in accessing care that could be targeted for change and could inform future outreach efforts.

Demographic Differences. Are there demographic differences between the treatment and non-treatment seeking groups? For example, are treatment seekers more likely to be female? How does age, grade classification, sexual orientation, ethnicity, and symptom severity factor in? Results might indicate that participants belonging to certain demographic groups are more or less likely to seek treatment than others. This information would help inform advocacy groups and also help as a starting point for outreach efforts.

Attitudinal Differences. Another purpose of this study was to find differences in attitudes between treatment and non-treatment seekers. Attitudes are defined as *a way of thinking about mental health and people who have mental health problems* for the purpose of this study. Negative attitudes about mental health, for example, includes thinking that seeking treatment makes an individual less likable or that a person who

seeks treatment is weak. A positive attitude includes thinking that seeking treatment is a sign of personal strength, or that one would be friends with someone with a mental health problem.

Other Barrier Differences. In addition to demographic and attitudinal barriers, other barriers will also be examined. One example of a barrier that could inhibit treatment seeking is holding a belief that one can handle one's own problems. In fact, a previous study found that non-treatment seekers prefer to handle problems on their own and are less likely to seek treatment (Downs & Eisenberg, 2012; Meltzer et al., 2003).

Results from this study may be helpful in changing perceptions of treatment and mental health in individuals experiencing mental health symptoms as well as in their friends and families. For instance, if results indicate that those with MDD and/or GAD are less likely to seek treatment if they perceive treatment in a negative light or that they can handle their own issues, then mental health advocates can target those specific perceptions through various outreach campaigns (e.g., TV public service announcements, university and community awareness and outreach days, local and national support groups). In conclusion, results from this study may contribute to increasing mental health literacy and educating the public about the effectiveness of treatment while lessening the associated stigma of treatment for mental health issues.

Method

Participants

A total of 549 undergraduate participants were screened via a Qualtrics online questionnaire (87 in Fall 2013, 133 in Spring 2014, 202 in Fall 2014, 127 in Spring 2015). Thirty-five participants met criteria based on meeting cut-off scores on two or more prescreening questionnaires (discussed further below) and were invited to complete a clinical interview using the Mini-International Neuropsychiatric Interview Plus 6.0 (Sheehan et al., 1998) in order to verify diagnostic status. These 35 participants were also asked to complete several questionnaire measures of treatment-seeking attitudes and behaviors. Participants ranged in age from 18 to 64. This study is IRB-approved and all participants must consent to participate before engaging in the study.

Procedure

Phase One. In the first phase, students were asked to complete multiple screening questionnaires assessing their current and past symptomatology. Based on these scores, students who met criteria were asked to participate in the second phase of the study which included a structured diagnostic interview. Specifically, two questionnaires were used to screen for worry symptoms in the initial phase of the study: the Penn State Worry Questionnaire (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990; Molina & Borkovec, 1994; Behar et al., 2003; Fresco et al., 2003) and the Generalized Anxiety Disorder seven-question assessment (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006). Two questionnaires were also used to screen for depression: an 8-item

subset of the Anhedonic Depression subscale of the Mood and Anxiety Symptom Questionnaire (MASQ; Watson, Clark, et al., 1995; Watson, Weber, et al., 1995; Nitschke, Heller, Imig, McDonald, & Miller, 2001) as well as the revised Center for Epidemiologic Studies-Depression Scale (CESD; Radloff, 1977; CESD-R; Eaton et al., 2004). The prescreening questionnaires took approximately 30 minutes to complete.

***Anxiety Measures*.**

*Penn State Worry Questionnaire***.** The PSWQ is a 16-item questionnaire designed to measure chronic worry. In a college sample, the PSWQ had high internal consistency (coefficient alphas = .92), and stability over time. Correlations for test-retest stability of the PSWQ ranged from r = .75 to r = .92 over several time intervals (2 weeks, 4 weeks, and 8-10 weeks – Behar et al., 2003). Most importantly, the questionnaire distinguishes anxious samples from non-anxious samples. Overall, the PSWQ is an effective measure for assessing "clinically significant, pathological worry" in a college population (Molina & Borkovec, 1994). The present study uses a cut-off score of 62, as suggested by Behar, Alcaine, Zuellig, and Borkovec (2003).

Generalized Anxiety Disorder-7-Questionnaire. Another measure that the present study uses for measuring anxiety is the GAD-7. The GAD-7, is a 7-item questionnaire measuring anxiety symptoms typical of GAD. In a study assessing symptoms in a population undergoing addictions treatment, Delgadillo et al. (2012) found that the GAD-7 demonstrated high internal consistency (Cronbach's alpha = 0.91). Additionally, a GAD-7 score of 9 or greater had a sensitivity of 80% and specificity of 86% for any

anxiety disorder. In other words, the questionnaire was sensitive enough to detect most participants who had an anxiety disorder, while being specific enough to target only those with GAD. In a separate study, of more than 2,500 people assessed, the GAD-7 was found to have high sensitivity and specificity with a cut-off score of 10 or greater, and was found to have good reliability and validity (Spitzer et al., 2006). Overall, the GAD-7 is an effective and valid tool for screening anxious symptoms that are characteristic of GAD (Spitzer et al., 2006; Delgadillo et al., 2012). The present study uses a cut-off score of 10, as suggested by Spitzer et al., 2006.

***Depression Measures*.**

Mood and Anxiety Symptom Questionnaire Anhedonia Subscale. The MASQ-AD 8 is an 8-item subset of the Anhedonic Depression subscale of the Mood and Anxiety Symptom Questionnaire. The scale is cited as having good convergent and discriminant validity in undergraduate samples (Bredemeier et al., 2010). Additionally, the scale reliably predicted whether participants met criteria for a current Major Depressive Episode. In the present study, the MASQ-AD 8 was used to screen for current and past MDE. The instructions were slightly altered so that participants would frame their answers either during the past week (for current) or prior to that period (for past). A cut-off score of 23 achieves a balance of sensitivity and specificity (Bredemeier et al., 2010) and was used as the cut-off score in the present study.

Center for Epidemiologic Studies-Depression Scale Revised. The CESD-R was also used to measure depression symptoms. The CESD-R is a revision of the original

CESD scale and has been shown to be as reliable and valid as the original scale. One advantage is that this revised scale is "more relevant to the current definitions of major depression" (Eaton et al., 2004). The researchers also attest to the CESD-R's excellent internal reliability and face and construct validity. Furthermore the test-retest reliability and criterion validity of the CESD-R are "expected to be very good" (Eaton et al., 2004). The lowest score for having a possibility of meeting depression criteria is 16. The present study uses a cut-off score of 16 or above.

These questionnaires were selected based on their strong psychometric properties as evidenced by the current research literature. Finally, the justification for using more than one measure per domain is to have greater confidence that participants will meet criteria based on a structured diagnostic interview. The structure diagnostic interview was used as another layer to understanding the participants' symptoms.

Phase Two. After the initial screening step, qualifying participants were invited to participate in the second phase of the study (i.e., the post-screening) by email or phone. Once the subject agreed to participate, they were asked if they would consent to being audio recorded for training and supervisory purposes. If they declined, the interview would continue without the audio recording. No participants declined being recorded. After completing the interview, participants completed a computerized self-assessment including demographic and opinion-based questions relating to mental health and treatment seeking. All participants were given an informational sheet advising them of

available mental health resources located in the local community at the conclusion of each phase two session.

Structured Diagnostic Interview (MINI Plus 6).

MINI Plus 6. Once a participant met criteria for either anxiety or depression domains, they were invited to an in-person one-on-one interview conducted by one of three trained graduate student researchers. Once the subject agreed to participate, they were asked to consent to being audio recorded for training and supervisory purposes. Each participant was administered the Mini-International Neuropsychiatric Interview Plus 6.0 brief structured diagnostic interview.

Developers of the MINI conducted validity and reliability studies comparing it to the Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition and the Composite International Diagnostic Interview (SCID-I/P; First, M., Spitzer, R., Gibbon, M., & Williams, J., 2002; CIDI; Robins, et al., 1988). Results from Sheehan et al. (1998) indicate that the MINI has validity and reliability properties that are similar to the SCID-I/P and CIDI. However, one advantage is that it can be administered in a shorter duration. This tool was chosen for its good psychometric properties and relatively short administration time.

All participants were asked to disclose information about their mental health care history, their family's mental health care history, and their attitudes and behaviors regarding treatment seeking in the post-screening survey. An example of a question assessing a treatment-seeking attitude: "How satisfied are you with the effectiveness of

the psychotherapy or counseling that you received, if any?" For the actual survey used, please refer to the post-screening questionnaire in Appendix B.

In addition to custom-designed questions that assess barriers in accessing mental health care, the Barriers to Access to Care Evaluation scale (BACE; Clement et al., 2012) was included as part of the post-screening questionnaire. Participants were asked to rate how much a given factor might prevent them from seeking treatment. For example: "Concern that I might be seen as weak for having a mental health problem" would be rated by a participant from "not at all" to "a lot." Please refer to the Appendix B for a copy of the full BACE questionnaire used in phase two.

At the end of the post-screening, participants were thanked for their participation in the study. Each participant was given an informational sheet with a list of available resources in the community. Each participant was also compensated with a gift card in the amount of 15 dollars to 10 dollars, based on funds availability. The post-screening session was expected to last one to two hours per participant.

Data were analyzed using descriptive and inferential statistics on participants' responses to the questionnaires and measurements. Relationships between treatment seekers and non-treatment seekers were examined. Separate t-tests comparing treatment seekers and non-treatment seekers on symptoms, ratings of level of functioning, and questionnaire measures of perceptions of stigma and treatment efficacy were conducted. The two groups were compared via chi square tests on demographic factors in order to assess whether groups differed on demographic factors.

Results

Phase One Sample

Of the 549 participants screened for the study, 70% (n = 385) identified as White/Caucasian and 72% (n = 396) were female, both consistent with the race/gender of the undergraduate population majoring in psychology in the Psychology and Counseling department. Freshman students comprised 40.6% (n = 223) of the sample. Please refer to Tables 2 through 6 for more demographic details.

Phase Two Sample

Thirty-five participants were invited to the second phase of the study and successfully completed it. As mentioned above, these participants were administered the MINI Plus 6 diagnostic interview and then the treatment-seeking attitudes and behaviors questionnaire. Of those administered the diagnostic interview, 12 participants met criteria for a history of Major Depressive Disorder, 12 for Generalized Anxiety Disorder, and 22 for another disorder (e.g., bipolar disorder, panic disorder with agoraphobia, PTSD, etc.). Seven participants met no criteria for a disorder. Please refer to Table 11 for more information.

Regarding trends in the treatment-seeking questionnaire, of the 35 participants, 25 endorsed seeking medication, psychotherapy, or both (i.e., treatment seekers), and 10 denied seeking any type of treatment (i.e., non-treatment seekers). The treatment seekers sought services for problems with anxiety, depression, adjustment problems, and physiological problems such as insomnia.

Results of Demographic Differences. Regarding whether self-reported financial factors affected treatment seeking, there was no significant difference between the groups; $\chi^2(5, N = 35) = 6.83, p = .23$. This result suggests that financial barriers did not seem to influence non-treatment seekers' decision to not seek treatment. This result supports research in the literature concluding that a person's finances is not the sole determinant of whether or not they seek treatment and that other factors should be examined (Phillips, Mayer, & Aday, 2000). There were no gender differences between the two groups, $\chi^2(1, N = 35) = .08, p = .77$. Regarding ethnicity and grade classification, there was no significant difference between the groups; $\chi^2(4, N = 35) = 1.97, p = .74$ and $\chi^2(4, N = 35) = .89, p = .93$, respectively.

When examining whether there was a difference in treatment-seeking rates in those who had past and/or present MDD and those who did not, results suggest a difference. Those with MDD past and/or present ($N = 12$) were more likely to seek treatment than those without MDD past and/or present ($N = 23$); $\chi^2(1, N = 35) = 7.30, p = .007$. These results were not found in the sample who had GAD. For the GAD sample, there was no significant difference between those who were diagnosed with GAD and those who were not in terms of their treatment-seeking rates; $\chi^2(1, N = 35) = .11, p = .735$. A Chi-square test was conducted to test whether sexual orientation affected treatment seeking. Results indicate that, in this sample, participants' sexual orientation did not significantly affect treatment-seeking rates; $\chi^2(4, N = 35) = 6.94, p = .139$. Please

refer to Tables 12 – 16 for more information. Finally, to test whether symptom severity had an impact on treatment seeking behaviors, the present study assigned each phase two participant a Global Assessment of Functioning score (GAF). Results from an independent samples t-test analysis indicated no significant difference between the groups and their GAF scores; t (33) = 1.18, p = .246.

Results of Attitudinal Differences. Treatment seekers differed from non-treatment seekers on their self-report of the influence of stigma as measured by our six items stigma questionnaire (a list of these questions can be found in Appendix B, question 9.1). An independent samples t-test was conducted to compare how each group responded to stigma items. The results indicate that there was a significant difference in how much treatment seekers (M = 2.23, SD = .44) and non-treatment seekers (M = 2.62, SD = .37) attached stigma to mental health treatment; t (33) = 2.49, p = .02. This result indicates that non-treatment seekers attach slightly but reliably more stigma to mental health treatment than do treatment seekers in this sample. A subscale of the BACE was also used to tap into the stigma construct. An independent samples t-test was conducted on the means of participants' scores on a stigma subscale of the BACE. These questions gauged how much stigma acted as a barrier to treatment seeking. Results indicated that there was no significant difference in the way that treatment seekers (M = .87, SD = .64) and non-treatment seekers (M = .74, SD = .51) answered these questions; t(33) = .56, p = .58. This result suggests that this sample did not vary in their responses regarding whether stigma affects their treatment seeking rates.

In addition to stigma, participants were also assessed on their attitudes regarding the efficacy of medications, psychotherapy, and both medications and psychotherapy together, for people their age. An independent samples t-test conducted on the groups indicate that there that is no significant difference in how effective treatment seekers and non-treatment seekers perceived medication $t(33) = 1.05$, $p = .302$, psychotherapy $t(33) = .53$, $p = .597$, and both combined $t(33) = .51$, $p = .615$. Thus, when asked about the efficacy of each type of treatment for people their age, treatment seekers and non-treatment seekers did not significantly differ in their answers.

Results of Barrier Differences. There was no significant difference on the mean of all BACE questions for treatment seekers ($M = 89$, $SD = .46$) versus non-treatment seekers ($M = .92$, $SD = .37$); $t(33) = -.14$, $p = .89$. When looking at these results, one might conclude that, although non-treatment seekers attach more stigma to mental health than treatment seekers as measured by the six item stigma questionnaire, it is not a significant treatment barrier for them. However, the six item stigma questionnaire assessed the amount of stigma participants attached to mental health in general while the BACE stigma subscale measured whether stigma was a barrier to treatment seeking.

On the BACE scale, participants rated each barrier on a scale from 0 to 3 (with 0 being not at all concerned and 3 indicating "a lot" of concern). The top three barriers for treatment seekers were: Wanting to solve the problem on my own ($N = 25$, $M = 1.76$, $SD = 1.09$), thinking the problem would get better by itself (N = 25, M = 1.56, SD = .92), and concern about what my family might think, say, do or feel ($N = 25$, $M = 1.36$, $SD = 1.22$).

Of the non-treatment seeking participants, the top three barriers were: Wanting to solve the problem on my own (N = 10, M = 2.60, SD = .70), dislike of talking about my feelings, emotions or thoughts (N = 10, M = 1.60, SD = .97), and thinking the problem would get better by itself (N = 10, M = 1.40, SD = 1.17). Please note that both treatment seekers and non-treatment seekers reported "wanting to solve the problem on my own" and "thinking the problem would get better by itself" as two of their top three barriers, out of a list of 30 possible barriers.

Discussion

By understanding how individuals view treatment seeking, the mental health community may be better equipped to inform policy, increase mental health literacy, and diminish the treatment gap. Individuals who seek and receive adequate treatment experience an improvement in their quality of life. Remission rates in depression and GAD are low, and these disorders tend to be chronic in nature. In addition, future public tragedies could be prevented if more people affected by mental health problems sought treatment. One major aim of this research study was to provide an additional layer of understanding on the topic of treatment-seeking attitudes and behaviors.

The data collected thus far suggests many similarities and differences between treatment and non-treatment seekers. For example, both treatment and non-treatment seekers had similar ratings for the perceived helpfulness of medications, psychotherapy, and medication/psychotherapy combined. Both groups also agreed that psychotherapy is, in general, more helpful than medications for individuals of their age. Another similarity

exists in the participants' attitude towards stigma. There was a trend for both groups to have very low levels of personal stigma towards those who receive mental health treatment. However, many participants think that others do not think very highly of people with a mental health problem based on how participants rated the items on the 9.1 stigma questions. This discrepancy between personal and public stigma can help explain the treatment gap. Misperceptions about how the general public views those with a mental health problem can stifle treatment seeking behaviors. It is very interesting that individual perceptions about mental health may be shifting towards less stigmatization, yet individuals are worried the general public may not think highly of those who receive mental health treatment.

Another finding is that non-treatment seekers differed significantly from treatment seekers in the way that they responded to a set of questions measuring how much stigma they attached to mental health (i.e., the six item stigma questionnaire). Treatment seekers, on average, attached less stigma to mental health than did non-treatment seekers based on results from the six item stigma questionnaire. However, the groups did not differ significantly in their responses regarding stigma on a subset of questions in another measure (BACE). One possible explanation for this discrepancy is that the six item stigma questionnaire measured directly how much stigma participants attached to mental health. The other set of questions, the BACE stigma subscale, gauged how much stigma acted as a barrier for participants. This difference in how the questions are worded could explain why there is a discrepancy. Furthermore, participants might

attach stigma to mental health but this attachment alone does not act as a barrier to treatment seeking.

While mental health stigma alone does not explain the reason for the treatment gap in the present study, perhaps additional factors might provide more clarity. Gender, sexual orientation, ethnicity, grade classification, availability of funds, and symptom severity were examined to determine their impact on treatment seeking. Results from this study indicate that participants did not differ in each of these categories. It is interesting that there was no significant difference in gender composition in the treatment seeking vs. non-seeking groups. However, more female than male participants in both groups reflects the college sample that was surveyed (with more female than male psychology majors).

In addition to these demographic factors, we also examined if there was a significant difference in the amount of participants with MDD or GAD who sought treatment. Every participant with a diagnosis of MDD past and/or present in our sample reported being a treatment seeker. With GAD, there was no significant difference in the amount of treatment versus non-treatment seekers. This result suggests that those diagnosed with or meeting criteria for MDD are more likely to seek treatment than those meeting criteria for GAD. Perhaps it is the case that depression is more well-known than GAD; advertisements for depression medication far outnumber the ones for anxiety. Additionally, the symptoms of GAD might be erroneously attributed to personality traits rather than to a treatable disorder. Another interpretation, given the population of our college sample, is that high anxiety and worry are considered norms, and thus

participants preferred to resolve their anxiety problems on their own without seeking treatment.

This study is only a small piece of the puzzle and other important pieces include systemic- and provider-level barriers. For instance, if participants are not aware of available resources in their community, then it is logical that they will not successfully receive treatment for their mental health issues. Likewise, if a primary care physician does not refer them to appropriate resources, then the individual might not receive the services they need. A future direction of this study might aim to encapsulate additional levels of barriers, such as the systemic and provider levels.

One major limitation of the sample is lack of power associated with a relatively small sample size. While treatment seekers comprised 25 of the 35 participants in phase 2, non-treatment seekers comprised 10. Several efforts have been made to increase the amount of non-treatment seekers in the sample, but overall this group has been challenging to recruit. Another limitation of this study is that recruitment is confined to a university sample. However, the sample does have clinically significant anxiety and/or depression and the majority met DSM criteria for GAD and/or MDD, ensuring generalizability to the wider population of GAD and MDD. Another limitation lies in the nature of self-reported data. Data self-reported by participants on the questionnaires and in the interview was not independently verified for accuracy (e.g., against the participant's medical or mental health records) in the present study due to feasibility and privacy issues.

Findings from this study suggest that screening for mental health symptoms in the college population is important. Those with GAD, for example, might not know that they have a treatable condition. Screenings will provide insight into their symptoms. Then, those scoring highly on the screenings should be encouraged to seek treatment with the appropriate referrals. In addition to screenings, mental health professionals and other advocates can educate the public about mental health stigma to dispel the commonly held belief that seeking treatment means that one is weak or unable to handle one's own problems. After all, participants, as a whole, endorsed as a top barrier in the present study that they preferred to handle their own problems. For non-treatment seekers, they also endorsed that they did not like to discuss their emotions and feelings, and that they thought their problems would eventually get better with time. Screeners and outreach members can educate participants about the chronic course of untreated mental health disorders and about the beneficial effects of mental health treatment.

Despite the current limitations, results should contribute to the literature regarding how individuals meeting criteria on prescreening measures for MDD and GAD conceptualize treatment-seeking behaviors. This information can be used to inform mental health practitioners as well as individuals suffering from GAD and MDD regarding barriers and motivators for treatment. Ultimately, this work could also be incorporated into future research, outreach, and intervention efforts. An increase of treatment seekers could mean an increase in those who receive adequate treatment, leading to more people who are healthy and productive members of society.

References

Behar, E., Alcaine, O., Zuellig, A. R., & Borkovec, T. D. (2003). Screening for generalized anxiety disorder using the Penn State Worry Questionnaire: A receiver operating characteristic analysis. *Journal Of Behavior Therapy And Experimental Psychiatry*, *34*, 25-43. doi:10.1016/S0005-7916(03)00004-1

Bredemeier, K., Spielberg, J. M., Silton, R., Berenbaum, H., Heller, W., & Miller, G. A. (2010). Screening for depressive disorders using the Mood and Anxiety Symptoms Questionnaire Anhedonic Depression Scale: A receiver-operating characteristic analysis. *Psychological Assessment*, *22*, 702-710. doi:10.1037/a0019915

Clement, S., Brohan, E., Jeffery, D., Henderson, C., Hatch, S. L., & Thornicroft, G. (2012). Development and psychometric properties the Barriers to Access to Care Evaluation scale (BACE) related to people with mental ill health. *BMC Psychiatry*, 12. doi:10.1186/1471-244X-12-36

Collins, K. A., Westra, H. A., Dozois, D. J., & Burns, D. D. (2004). Gaps in Accessing Treatment for Anxiety and Depression: Challenges for the Delivery of Care. *Clinical Psychology Review*, *24*, 583-616.

Delgadillo, J., Payne, S., Gilbody, S., Godfrey, C., Gore, S., Jessop, D., & Dale, V. (2012). Brief case finding tools for anxiety disorders: Validation of GAD-7 and GAD-2 in addictions treatment. *Drug And Alcohol Dependence*, *125*, 37-42. doi:10.1016/j.drugalcdep.2012.03.011

Dobson, K. S. (1989). A Meta-Analysis of the Efficacy of Cognitive Therapy for Depression. *Journal of Counsulting and Clinical Psychology, 57,* 414-419.

Downs, M. F., & Eisenberg, D. (2012). Help seeking and treatment use among suicidal college students. *Journal Of American College Health*, *60,* 104-114. doi:10.1080/07448481.2011.619611

Eaton, W. W., Smith, C., Ybarra, M., Muntaner, C., & Tien, A. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In ME Maruish (Ed.). *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment* (3rd Ed.), Volume 3: Instruments for Adults, pp. 363-377. Mahwah, NJ: Lawrence Erlbaum.

First, M., Spitzer, R., Gibbon, M., & Williams, J. (2002). Structured Clinical Interview for DSM-IV-TR Axis I Disorders, Research Version, Patient Edition (SCID-I/P). In M. J. Hilsenroth, D. L. Segal (Eds.), *Comprehensive handbook of psychological assessment, Vol. 2: Personality assessment* (pp. 134-143). Hoboken, NJ: John Wiley & Sons Inc.

Fresco, D. M., Mennin, D. S., Heimberg, R. G., & Turk, C. L. (2003). Using the Penn State Worry Questionnaire to identify individuals with generalized anxiety disorder: A receiver operating characteristic analysis. *Journal Of Behavior Therapy And Experimental Psychiatry*, *34,* 283-291. doi:10.1016/j.jbtep.2003.09.001

Kessler, R. C., Chiu, W., Demler, O., & Walters, E. E. (2005). Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication. *Archives Of General Psychiatry, 62,* 617-627. doi:10.1001/archpsyc.62.6.617

Kohn, R., Shekhar, S., Levav, I., & Saraceno, B. (2004). The Treatment Gap in Mental Health Care. *Bulletin of the World Health Organization,82,* 858-866.

Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., & Lewis, G. (2003). The Reluctance to Seek Treatment for Neurotic Disorders. *International Review of Psychiatry, 15*, 123-128.

Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and Validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy, 28,* 487-495.

Molina, S., & Borkovec, T. D. (1994). The Penn State Worry Questionnaire: Psychometric properties and associated characteristics. In G. L. Davey, F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment and treatment* (pp. 265-283). Oxford: John Wiley & Sons.

Nitschke, J. B., Heller, W., Imig, J. C., McDonald, R. P., & Miller, G. A. (2001). Distinguishing dimensions of anxiety and depression. *Cognitive Therapy and Research, 25,* 1-22. doi:10.1023/A:1026485530405

Phillips, K., Mayer, M., & Aday, L. (2000). Barriers to care among racial/ethnic groups under managed care. *Health Affairs, 19,* 65-75.

Radloff, L. S. (1977). The CES-D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401. doi:10.1177/014662167700100306

Robins, L. N., Wing, J., Wittchen, H. U., Helzer, J. E., Babor, T. F., Burke, J., & ... Towle, L. H. (1988). The Composite International Diagnostic Interview: An epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. *Archives Of General Psychiatry, 45,* 1069-1077. doi:10.1001/archpsyc.1988.01800360017003

Sheehan, D. V., Lecrubier, Y., Sheehan, K., Amorim, P., Janavs, J., Weiller, E., & ... & Dunbar, G. C. (1998). The Mini-International Neuropsychiatric Interview (M.I.N.I): The development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry,* 59, 22-33.

Schomerus, G., Auer, C., Rhode, D., Luppa, M., Freyberger, H. J., & Schmidt, S. (2012). Personal stigma, problem appraisal and perceived need for professional help in currently untreated depressed persons. *Journal Of Affective Disorders, 139,* 94-97. doi:10.1016/j.jad.2012.02.022

Spitzer, R. L., Kroenke, K., Williams, J. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166,* 1092-1097. doi:10.1001/archinte.166.10.1092

Thomas, S. J., Caputi, P., & Wilson, C. J. (2014). Specific attitudes which predict psychology students' intentions to seek help for psychological distress. *Journal Of Clinical Psychology*, *70*, 273-282. doi:10.1002/jclp.22022

Vogel, D. L., Wester, S. R., & Larson, L. M. (2007). Avoidance of counseling: Psychological factors that inhibit seeking help. *Journal Of Counseling & Development*, *85*, 410-422. doi:10.1002/j.1556-6678.2007.tb00609.x

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629-640.

Wang, P. S., Simon, G., & Kessler, R. C. (2003). The Economic Burden of Depression and the Cost-Effectiveness of Treatment. *International Journal of Methods in Psychiatric Research*, *12*, 22-33.

Watson, D., Weber, K., Assenheimer, J., Clark, L., Strauss, M. E., & McCormick, R. A. (1995). Testing a tripartite model: I. Evaluating the convergent and discriminant validity of anxiety and depression symptom scales. *Journal Of Abnormal Psychology*, *104*(1), 3-14. doi:10.1037/0021-843X.104.1.3

Watson, D., Clark, L., Weber, K., Assenheimer, J., Strauss, M. E., & McCormick, R. A. (1995). Testing a tripartite model: II. Exploring the symptom structure of anxiety and depression in student, adult, and patient samples. *Journal of Abnormal Psychology*, *104*, 15-25. doi:10.1037/0021-843X.104.1.15

Wittchen, H. (2002). Generalized anxiety disorder: Prevalence, burden, and cost to society. *Depression and Anxiety*, *16*, 162-171. doi:10.1002/da.10065

Table 1. *Barriers to Treatment for Anxiety and Depression*

Level	Barrier
Individual	Willingness to disclose problems
	Fear of stigma and embarrassment
	Lack of time for treatment
	Negative stereotypes of treatment
	Presence of comorbid medical problems
	Cultural factors
	Demographic factors (age, marital status)
	Geographic influences
	Desire to handle problems on one's own
	Lack of awareness of available treatment
	Minimizing severity of problems
	Degree of distress and disruption of symptoms
	Readiness for change
Provider	Underdetection within primary care sector
	Lack of knowledge of mental health problems
	Preoccupation with possible organic pathology
	Skill in assessing mental health difficulties
	Busyness and structure of practice
	Willingness to diagnose and treat mental health issues
	Stigma regarding discussing mental health issues
	Somatizing patient presentation style
Systemic	
	Level of distress in presentation
	Limited physician access to mental health services
	Lack of awareness of range of effective treatment options
	Primary care guidelines emphasizing pharmacotherapy
	Limited availability of specialty mental health providers
	Lack of integration of mental health services in primary care
	Low rates of provision of evidence-based care in mental health services
	Limited training in evidence-based care among mental health training programs
	Limited response rates to empirically supported treatments

Collins et al., 2004

Table 2. *Racial and Ethnic Distribution of Phase Sample*

	Frequency	Percent	Valid Percent
American Indian/ Alaska Native	7	1.3	1.3
Unknown or prefer not to report	18	3.3	3.3
Asian	36	6.6	6.6
Black or African American	49	8.9	8.9
Other or multiracial	54	9.8	9.8
White	385	70.1	70.1
Total	549	100.0	100.0

Table 3. *Age Distribution of Phase One Sample*

	Frequency	Percent	Valid Percent
13-17	3	.5	.5
55-64	3	.5	.5
35-54	18	3.3	3.3
26-34	27	4.9	4.9
18-25	498	90.7	90.7
Total	549	100.0	100.0

Table 4. *Gender Distribution of Phase One Sample*

	Frequency	Percent	Valid Percent
Prefer not to report	2	.4	.4
Male	151	27.5	27.5
Female	396	72.1	72.1
Total	549	100.0	100.0

Table 5. *Grade Classification of Phase One Sample*

	Frequency	Percent	Valid Percent
Graduate student	2	.4	.4
Other (e.g. non-degree student)	6	1.1	1.1
Senior	73	13.3	13.3
Junior	120	21.9	21.9
Sophomore	125	22.76867	22.76867
Freshman or first-year student	223	40.6	40.6
Total	549	100.0	100.0

Table 6. *Language Ability of Phase One Sample*

	Frequency	Percent	Valid Percent
Restricted ability (e.g., only reading or only speaking/listening)	1	.2	.2
Some familiarity (e.g., a year of instruction in school)	1	.2	.2
Limited but adequate competence in speaking, reading, and writing	3	.5	.5
Fully competent in speaking, listening, reading, and writing, but not native	85	15.5	15.5
Native (learned from birth)	459	83.6	83.6
Total	549	100.0	100.0

Table 7. *Descriptive Statistics of Test Scores of Phase One Sample*

	N	Minimum	Maximum	Mean	Std. Deviation
CESDRSum	549	.00	55.00	14.8452	12.61631
MASQPastSum	549	8.00	40.00	16.2550	6.27565
MASQRecentSum	549	8.00	39.00	15.1038	6.19322
GADSum	549	.00	21.00	6.8980	5.04800
PSWQSum*	537	17.00	80.00	49.9944	14.06826
Valid N (listwise)	537				

*A Qualtrics error at the onset of the study prevented some participants from taking the PSWQ.

Table 8. *Means of Some Scales Used*

	Did they seek treatment or not?	N	Mean	Std. Deviation	Std. Error Mean
BACE_ToTalMeanValue	Yes	25	.8933	.45612	.09122
	No	10	.9168	.37275	.11787
BACE_meanTreatstigma	Yes	25	.8700	.64284	.12857
	No	10	.7417	.50834	.16075
TreatmentStigmaRating	Yes	25	2.2267	.43536	.08707
	No	10	2.6170	.36898	.11668
PSWQSum	Yes	25	63.4000	10.17349	2.03470
	No	10	62.9000	7.65143	2.41960
GADSum	Yes	25	12.6400	3.32766	.66553
	No	10	12.4000	2.91357	.92135
MASQRecentSum	Yes	25	23.5200	7.17705	1.43541
	No	10	23.3000	3.52924	1.11604
MASQPastSum	Yes	25	22.3600	7.34212	1.46842
	No	10	22.6000	7.54542	2.38607
CESDRSum	Yes	25	30.8800	11.49029	2.29806
	No	10	29.3000	8.84496	2.79702

Table 9. *Independent Samples T-tests for the Total Mean of BACE and Stigma Items*

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
BACE_ToTalMeanValue	Equal variances assumed	.823	.371	-.144	33	.886	-.02346	.16275
	Equal variances not assumed			-.157	20.281	.876	-.02346	.14905
BACE_meanTreatstigma	Equal variances assumed	1.984	.168	.563	33	.577	.12833	.22791
	Equal variances not assumed			.623	20.978	.540	.12833	.20584
TreatmentStigmaRating	Equal variances assumed	.770	.387	-2.494	33	.018	-.39033	.15651
	Equal variances not assumed			-2.681	19.542	.015	-.39033	.14559

Table 10. *Independent Samples T-tests for Some Scales Used*

		Levene's Test for Equality of Variances		t-test for Equality of Means				
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference
PSWQSum	Equal variances assumed	.587	.449	.140	33	.890	.50000	3.57401
	Equal variances not assumed			.158	22.087	.876	.50000	3.16140
GADSum	Equal variances assumed	1.357	.252	.199	33	.843	.24000	1.20482
	Equal variances not assumed			.211	18.912	.835	.24000	1.13658
MASQRecentSum	Equal variances assumed	4.840	.035	.092	33	.927	.22000	2.39170
	Equal variances not assumed			.121	31.292	.904	.22000	1.81823
MASQPastSum	Equal variances assumed	.011	.918	-.087	33	.931	-.24000	2.76812
	Equal variances not assumed			-.086	16.235	.933	-.24000	2.80171
CESDRSum	Equal variances assumed	.801	.377	.390	33	.699	1.58000	4.05337
	Equal variances not assumed			.436	21.567	.667	1.58000	3.62000

Table 11. *Frequencies of Diagnoses Made by the MINI Plus 6*

Diagnosis of MDD, Past or Present

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	12	34.3	34.3	34.3
	no	23	65.7	65.7	100.0
	Total	35	100.0	100.0	

Diagnosis of GAD

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	12	34.3	34.3	34.3
	no	23	65.7	65.7	100.0
	Total	35	100.0	100.0	

Diagnosis of Other, Past or Present

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	22	62.9	62.9	62.9
	no	13	37.1	37.1	100.0
	Total	35	100.0	100.0	

Number Without a Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	7	20.0	20.0	20.0
	no	28	80.0	80.0	100.0
	Total	35	100.0	100.0	

Table 12. *Chi-Square Test Comparing Groups and Their Finances*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.825[a]	5	.234
Likelihood Ratio	7.471	5	.188
Linear-by-Linear Association	1.038	1	.308
N of Valid Cases	35		

a. 11 cells (91.7%) have expected count less than 5. The minimum expected count is .57.

	Very poor, could not afford health insurance	Enough to get by, but not enough for health insurance	Comfortable, could afford health insurance	Well to do, could afford health insurance	Prefer not to answer	I have never had emotional or mental health problems.
T. Seeker	3	5	10	5	2	0
Non-T. Seeker	1	1	5	1	0	2
Total	4	6	15	6	2	2

Table 13. *Chi-Square Test Comparing Groups and Their Gender*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.080[a]	1	.777		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.079	1	.779		
Fisher's Exact Test				1.000	.564
Linear-by-Linear Association	.078	1	.780		
N of Valid Cases	35				

a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 1.71.

b. Computed only for a 2x2 table

Count

		Gender		Total
		female	male	
Did they seek treatment or not?	Yes	21	4	25
	No	8	2	10
Total		29	6	35

Table 14. *Chi-Square Test Comparing Groups and MDD Past and/or Present*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7.304[a]	1	.007		
Continuity Correction[b]	5.329	1	.021		
Likelihood Ratio	10.387	1	.001		
Fisher's Exact Test				.007	.006
Linear-by-Linear Association	7.096	1	.008		
N of Valid Cases	35				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.43.

b. Computed only for a 2x2 table

Count

		MDDPastorPresent		Total
		yes	no	
Did they seek treatment or not?	Yes	12	13	25
	No	0	10	10
Total		12	23	35

Table 15. *Chi-Square Test Comparing Groups and GAD*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.114[a]	1	.735		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.116	1	.734		
Fisher's Exact Test				1.000	.530
Linear-by-Linear Association	.111	1	.739		
N of Valid Cases	35				

a. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3.43.

b. Computed only for a 2x2 table

Count

		GADPastorPresent		Total
		yes	no	
Did they seek treatment or not?	Yes	9	16	25
	No	3	7	10
Total		12	23	35

Table 16. *Chi-Square Test Comparing Groups and Sexual Orientation*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.939[a]	4	.139
Likelihood Ratio	7.733	4	.102
Linear-by-Linear Association	.014	1	.904
N of Valid Cases	35		

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .57.

Count

		What is your sexual orientation?					Total
		Heterosexual	Gay or Lesbian	Bisexual	Prefer not to answer	Other (please specify)	
Did they seek treatment or not?	Yes	19	0	2	1	3	25
	No	6	2	1	1	0	10
Total		25	2	3	2	3	35

Table 17. *Chi-Square Test Comparing Groups and Ethnicity*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.974[a]	4	.741
Likelihood Ratio	2.759	4	.599
N of Valid Cases	35		

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .29.

Crosstab

Count

		Ethnicity					Total
		asian	black or african american	other or multiracial	unknown or prefer not to report	white	
Did they seek treatment or not?	Yes	1	1	4	2	17	25
	No	0	1	1	0	8	10
Total		1	2	5	2	25	35

Table 18. *Chi-Square Test Comparing Groups and Grade Classification*

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.886[a]	4	.927
Likelihood Ratio	1.146	4	.887
N of Valid Cases	35		

a. 7 cells (70.0%) have expected count less than 5. The minimum expected count is .29.

Crosstab

Count

		Classification					Total
		freshman or first-year	junior	other (e.g., non-degree student)	senior	sophomore	
Did they seek treatment or not?	Yes	9	6	1	2	7	25
	No	3	2	0	1	4	10
Total		12	8	1	3	11	35

Table 19. *Chi-Square Test Comparing Groups and GAF Scores*

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
									Lower	Upper
GAFScore	Equal variances assumed	2.898	.098	-1.181	33	.246	-6.08000	5.15021	-16.55818	4.39818
	Equal variances not assumed			-1.283	20.062	.214	-6.08000	4.73802	-15.96137	3.80137

Group Statistics

	Did they seek treatment or not?	N	Mean	Std. Deviation	Std. Error Mean
GAFScore	Yes	25	74.1200	14.40289	2.88058
	No	10	80.2000	11.89584	3.76180

Appendix A. *Phase One Questionnaire*

Name: _____

Best contact email: _____

Best contact number

- ❍ Home phone _____
- ❍ Cell phone _____

1. How old are you?
- ❍ Under 13
- ❍ 13-17
- ❍ 18-25
- ❍ 26-34
- ❍ 35-54
- ❍ 55-64
- ❍ 65 or over

2. What is your gender?
- ❍ Male
- ❍ Female

3. What is your year in college?
- ❍ Freshman or first-year student
- ❍ Sophomore
- ❍ Junior
- ❍ Senior
- ❍ Graduate student
- ❍ Other (e.g. non-degree student)

4. Which of the following best describes you?
- ❍ Hispanic or Latino
- ❍ Not Hispanic or Latino
- ❍ Unknown or prefer not to report

5. What is your racial background?
- ❍ American Indian/ Alaska Native
- ❍ Asian
- ❍ Black or African American
- ❍ Native Hawaiian or Other Pacific Islander
- ❍ White
- ❍ Other or multiracial
- ❍ Unknown or prefer not to report

6. Please rate your overall ability in the English language:
- ❍ Native (learned from birth)

- ❍ Fully competent in speaking, listening, reading, and writing, but not native
- ❍ Limited but adequate competence in speaking, reading, and writing
- ❍ Restricted ability (e.g., only reading or only speaking/listening)
- ❍ Some familiarity (e.g., a year of instruction in school)

7. Over your lifetime, have you had any significant problems with work, school, or relationships due to a mental health problem?

- ❍ No
- ❍ Yes (please explain in 2 – 3 sentences):

- ❍ **Think back to a time when you struggled with mental health problems, if applicable. On a scale of 1 to 100, please rate your ability to handle day-to-day functions at that time in areas such as work, school, and relationships.** (Note: 1 means that you were persistently incapable of handling life's problems, and 100 means that you operated at a level of superior functioning, and life's problems never seemed to get out of hand).
- ❍ What is your rating? ___
- ❍ Not applicable

- ❍ **Have any physiological symptoms, like disturbed sleep and/or pains, ever kept you from functioning normally in areas such as work, school, or relationships?**No
- ❍ Yes (please explain in 2 – 3 sentences):

8. Pick a number from the scale below that best describes <u>how typical or characteristic</u> each of the items is of you. There is no right or wrong answers. Indicate your answer for each statement by writing your choice on the blank next to that statement.

1 2 3 4 5

Not at all typical Somewhat typical Very typical

_____ If I don't have enough time to do everything, I don't worry about it
_____ My worries overwhelm me.
_____ I don't tend to worry about things.
_____ Many situations make me worry.
_____ I know I shouldn't worry about things, but I just can't help it.
_____ When I am under pressure, I worry a lot.
_____ I am always worrying about something.
_____ I find it easy to dismiss worrisome thoughts.
_____ As soon as I finish one task, I start to worry about everything else I have to do.
_____ I never worry about anything.
_____ When there is nothing more I can do about a concern, I don't worry about it anymore.
_____ I've been a worrier all my life.
_____ I notice that I have been worrying about things.
_____ Once I start worrying, I can't stop.
_____ I worry all the time.
_____ I worry about projects until they are done.

9. Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? There are no right or wrong answers. Indicate your answer for each statement by writing your choice on the blank next to that statement.

0 1 2 3

Not at all | Several days | More than half the days | Nearly every day

_____ Feeling nervous, anxious, or on edge
_____ Not being able to stop or control worrying
_____ Worrying too much about different things
_____ Trouble relaxing
_____ Being so restless that it is hard to sit still
_____ Becoming easily annoyed or irritable
_____ Feeling afraid as if something awful might happen

10. Below is a list of the ways you might have felt or behaved. Indicate how often you have felt this way in the <u>past two weeks</u> by writing your choice on the blank next to that statement. There are no right or wrong answers.

0 1 2 3 _____ 4

Not at all or less than 1 day | 1 – 2 days | 3 – 4 days | 5 – 7 days | Nearly every day for 2 weeks

_____ My appetite was poor.
_____ I could not shake off the blues.
_____ I had trouble keeping my mind on what I was doing.
_____ I felt depressed.
_____ My sleep was restless.
_____ I felt sad.
_____ I could not get going.
_____ Nothing made me happy.
_____ I felt like a bad person.
_____ I lost interest in my usual activities.
_____ I slept much more than usual.
_____ I felt like I was moving too slowly.
_____ I felt fidgety.
_____ I wished I were dead.
_____ I wanted to hurt myself.
_____ I was tired all the time.
_____ I did not like myself.
_____ I lost a lot of weight without trying to.
_____ I had a lot of trouble getting to sleep.

_____ I could not focus on the important things.

11. Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Indicate your answer for each statement by writing your choice on the blank next to that statement. Use the choice that best describes how much you have felt or experienced things this way <u>during the past week, including today</u>.

1 2 3 4 5

Not at all A little bit Moderately Quite a bit Extremely

_____ Felt really slowed down
_____ Felt unattractive
_____ Felt withdrawn from other people
_____ Felt really bored
_____ Felt like it took extra effort to get started
_____ Felt like nothing was very enjoyable
_____ Felt like there wasn't anything interesting or fun to do
_____ Thought about death or suicide

12. Below is a list of feelings, sensations, problems, and experiences that people sometimes have. Indicate your answer for each statement by writing your choice on the blank next to that statement. Use the choice that best describes how much you have felt or experienced things this way <u>during your lifetime, not including the past week</u>.

1 2 3 4 5

Not at all A little bit Moderately Quite a bit Extremely

_____ Felt really slowed down
_____ Felt unattractive
_____ Felt withdrawn from other people
_____ Felt really bored
_____ Felt like it took extra effort to get started
_____ Felt like nothing was very enjoyable
_____ Felt like there wasn't anything interesting or fun to do
_____ Thought about death or suicide

Appendix B. *Phase Two Questionnaire*

Q2.1 **Please read each question carefully before selecting your answer.**

Q2.2 **Have you ever sought medications for emotional or mental health problems such as feeling sad, blue, anxious or nervous?**

- ❍ Yes (1)
- ❍ No (2)

Q2.3 **Have you ever sought psychotherapy or counseling for emotional or mental health problems such as feeling sad, blue, anxious or nervous?**

- ❍ Yes (1)
- ❍ No (2)

Q2.4 **What is your sexual orientation?**

- ❍ Heterosexual (1)
- ❍ Gay or Lesbian (2)
- ❍ Bisexual (3)
- ❍ Prefer not to answer (4)
- ❍ Other (please specify) (5) _____

Q2.5 **If you have had emotional or mental health problems, how would you best describe your financial situation at or around the time when you had those problems?**

- ❍ Very poor, could not afford health insurance (1)
- ❍ Enough to get by, but not enough for health insurance (2)
- ❍ Comfortable, could afford health insurance (3)
- ❍ Well to do, could afford health insurance (4)
- ❍ Prefer not to answer (5)
- ❍ I have never had emotional or mental health problems. (6)

Q3.1 **Which of the following professional service provider(s) did you seek? Check all that apply.**

- ❑ Psychologist (1)
- ❑ Psychiatrist (2)
- ❑ Licensed Professional Counselor (3)
- ❑ Licensed Clinical Social Worker (4)
- ❑ Psychiatric Nurse Practitioner (5)
- ❑ Physician/family doctor (6)
- ❑ Registered Nurse (7)
- ❑ Other (please specify) (8) _____

Q3.2 **How long ago was your most recent visit to a professional service provider for help? If you cannot remember or if you did not seek a professional service provider, check N/A.**

- ❍ In the last 6 months (1)
- ❍ Between 7 months to 1 year ago (2)
- ❍ 1 to 2 years ago (3)
- ❍ More than 2 years ago (4)
- ❍ N/A (5)

Q3.3 **Please indicate your primary reason(s) for seeking treatment. Check all that apply.**

- ❑ Anxiety (1)
- ❑ Depression (2)
- ❑ Problems adjusting to life problems (breakup, divorce, loss of loved one, etc.) (3)
- ❑ Physiological problems (fatigue, unusual sleep patterns, changes in appetite, bodily aches, etc.) (4)
- ❑ Prefer not to answer (5)
- ❑ Not sure (6)
- ❑ Other (please specific) (7) _____

Q3.4 **Please indicate your formal diagnosis by a professional service provider. Check all that apply.**

- ❑ Adult Deficit Hyperactivity Disorder (ADHD) (1)
- ❑ Bipolar Disorder (2)
- ❑ Depression NOS (3)
- ❑ Dysthymia (4)
- ❑ Generalized Anxiety Disorder (GAD) (5)
- ❑ Major Depressive Disorder (MDD) (6)
- ❑ Obsessive-Compulsive Disorder (OCD) (7)
- ❑ Post-Traumatic Stress Disorder (PTSD) (8)
- ❑ Specific Phobia (please specific which type) (9) _____
- ❑ Social Phobia/Social Anxiety Disorder (10)
- ❑ Prefer not to answer (11)
- ❑ Not sure (12)
- ❑ Other (please specify) (13) _____

Q3.5 **If you sought help from a source other than a professional service provider or you sought help in addition to a professional service provider for mental health problems, please indicate which ones below. Check all that apply.**

- ❑ Friends (1)
- ❑ Family (2)
- ❑ Romantic partner (e.g., boyfriend or girlfriend) (3)
- ❑ Pastor/minister (4)
- ❑ Co-workers (5)
- ❑ Acupuncture (6)
- ❑ Acupressure (7)
- ❑ Yoga (8)
- ❑ Alternative medicine (9)
- ❑ I only sought help from professional providers. (10)
- ❑ Other (please specify) (11) _____

Answer If If you sought help from a source other than a professiona... Family Is Selected

Q3.6 **Please indicate which family member(s) you sought for help. Check all that apply.**

- ❑ Grandfather (1)
- ❑ Grandmother (2)
- ❑ Father (3)
- ❑ Mother (4)
- ❑ Spouse (husband/wife) (5)
- ❑ Brother (6)
- ❑ Sister (7)
- ❑ Cousin (8)
- ❑ Other (please specify) (9) _____

Q3.7 **When was the last time you reached out to a non-professional source for help?**

- ❍ In the last 6 months (1)
- ❍ Between 7 months and 1 year ago (2)
- ❍ 1 to 2 years ago (3)
- ❍ More than 2 years ago (4)

Q3.8 **Directions: Please choose your answer on a scale from 1 to 5 with 1 being very dissatisfied and 5 being very satisfied. If you did not receive medications or psychotherapy/counseling, then check Not Applicable next to the appropriate box. If your answer is 1, please still click on that number or your answer will not be registered.**

_____ How satisfied are you with the effectiveness of the medications that you received, if any? (1)
_____ How satisfied are you with the effectiveness of the psychotherapy or counseling that you received, if any? (2)

Answer If Please choose your answer on a scale from 1 to 5 with 1 b... How satisfied are you with the effectiveness of the medications that you received, if any? Is Greater Than or Equal to 1

Q3.9 **Please explain, in a few sentences, why you gave the rating that you did for your satisfaction level with the effectiveness of the medications that you received. Click the next >> button when you are done.**

Answer If Please choose your answer on a scale from 1 to 5 with 1 b... How satisfied are you with the effectiveness of the psychotherapy or counseling that you received, if any? Is Greater Than or Equal to 1

Q3.10 **Please explain, in a few sentences, why you gave the rating that you did for your satisfaction level with the effectiveness of the psychotherapy/counseling that you received. Click the next >> button when you are done.**

Answer If Have you ever sought medications for emotional or mental ... No Is Selected

Q4.1 **Did you ever think that you would need mental health services, such as medications, for dealing with emotional or mental health problems such as feeling sad, blue, anxious, or nervous?**

- ❍ Yes (1)
- ❍ No (2)
- ❍ Not sure (3)

Answer If Have you ever sought psychotherapy or counseling for emot... No Is Selected

Q4.2 **Did you ever think that you would need mental health services, such as psychotherapy or counseling, for dealing with emotional or mental health problems such as feeling sad, blue, anxious, or nervous?**

- ❍ Yes (1)
- ❍ No (2)
- ❍ Not sure (3)

Q5.1 **Directions: Please choose your answer on a scale from 1 to 5 with 1 being not at all helpful and 5 being very helpful. If your answer is 1, please still click on that number or your answer will not be registered.**

_____ How helpful, on average, do you think medication is for people your age who have mental health problems? (1)
_____ How helpful, on average, do you think psychotherapy or counseling is for people your age who have mental health problems? (2)
_____ How helpful, on average, do you think both medications AND psychotherapy are for people your age who have mental health problems, when they are used together? (3)

Q5.2 **Please briefly explain your reasoning for giving the rating that you did when you rated the helpfulness of medications.**

Q5.3 **Please briefly explain your reasoning for giving the rating that you did when you rated the helpfulness of psychotherapy or counseling.**

Q5.4 **Please briefly explain your reasoning for giving the rating that you did when you rated the helpfulness of both medications and psychotherapy, when they are used together.**

Q6.1 **The following questions are about your closest friends and family members. Please answer them to the best of your knowledge. If you are not sure of any question, just click "Not sure."**

Q6.2 **How many of your closest friends and family members, excluding yourself, have been formally diagnosed with a mental health problem such as depression or anxiety?**

- ❍ 0 (1)
- ❍ 1 (2)
- ❍ 2 (3)
- ❍ 3+ (4)
- ❍ Not sure (5)

Q6.3 **How many of your closest friends and family members, excluding yourself, have had or currently have a mental health problem, such as depression or anxiety, but have not been formally diagnosed?**

- ❍ 0 (1)
- ❍ 1 (2)
- ❍ 2 (3)
- ❍ 3+ (4)
- ❍ Not sure (5)

Q7.1 **How many of your closest friends and family members, excluding yourself, have used only medications but not psychotherapy or counseling for their mental health problems?**

- ❍ 0 (1)
- ❍ 1 (2)
- ❍ 2 (3)
- ❍ 3+ (4)
- ❍ Not sure (5)

Answer If How many of your closest friends and family members, excl... 1 Is Selected Or How many of your closest friends and family members, excl... 2 Is Selected Or How many of your closest friends and family members, excl... 3+ Is Selected

Q7.2 **Directions: Please choose your answer on a scale from 1 to 5 with 1 being not at all helpful and 5 being very helpful. If your answer is 1, please still click on that number or your answer will not be registered.**

_____ In general, how helpful do you think the medications were in contributing to their wellbeing? (1)
_____ To the best of your knowledge, how helpful do they think the medications were in contributing to their wellbeing? (2)

Q7.3 **How many of your closest friends and family members, excluding yourself, have used only psychotherapy/counseling but not medications for their mental health problems?**

- ❍ 0 (1)
- ❍ 1 (2)
- ❍ 2 (3)
- ❍ 3+ (4)
- ❍ Not sure (5)

Answer If How many of your closest friends and family members, excl... 1 Is Selected Or How many of your closest friends and family members, excl... 2 Is Selected Or How many of your closest friends and family members, excl... 3+ Is Selected

Q7.4 **Directions: Please choose your answer on a scale from 1 to 5 with 1 being not at all helpful and 5 being very helpful. If your answer is 1, please still click on that number or your answer will not be registered.**

_____ In general, how helpful do you think the psychotherapy or counseling was in contributing to their wellbeing? (1)
_____ To the best of your knowledge, how helpful do they think the psychotherapy or counseling was in contributing to their wellbeing? (2)

Q7.5 **How many of your closest friends and family members, excluding yourself, have used BOTH psychotherapy AND medications for their mental health problems?**

- ❍ 0 (1)
- ❍ 1 (2)
- ❍ 2 (3)
- ❍ 3+ (4)
- ❍ Not sure (5)

Answer If How many of your closest friends and family members, excl... 1 Is Selected Or How many of your closest friends and family members, excl... 2 Is Selected Or How many of your closest friends and family members, excl... 3+ Is Selected

Q7.6 **Directions: Please choose your answer on a scale from 1 to 5 with 1 being not at all helpful and 5 being very helpful. If your answer is 1, please still click on that number or your answer will not be registered.**

_____ In general, how helpful do you think medications AND psychotherapy were (when used together) in contributing to their wellbeing? (1)
_____ To the best of your knowledge, how helpful do they think the medications AND psychotherapy were (when used together) in contributing to their wellbeing? (2)

Q8.1 **For the following questions, think of your closest friend or family member. If you cannot decide on just one, pick the person with whom you spend more time.**

Q8.2 **Who is your closest friend or family member who has used medications and/or psychotherapy?**

- ❍ Grandfather (1)
- ❍ Grandmother (2)
- ❍ Father (3)
- ❍ Mother (4)
- ❍ Spouse (5)
- ❍ Child (6)
- ❍ Brother (7)
- ❍ Sister (8)
- ❍ Cousin (9)
- ❍ Friend (10)
- ❍ Romantic partner (11)
- ❍ Other (please specify) (12) _____

Q8.3 **Which of the following professional service provider(s) did he or she seek? Check all that apply.**

- ❑ Psychologist (1)
- ❑ Psychiatrist (2)
- ❑ Licensed Professional Counselor (3)
- ❑ Licensed Clinical Social Worker (4)
- ❑ Psychiatric Nurse Practitioner (5)
- ❑ Physician/family doctor (6)
- ❑ Registered Nurse (7)
- ❑ Other (please specify) (8) _____

Q8.4 **How long ago was his or her most recent visit to a professional service provider for help? If you cannot remember, you don't know, or if he or she did not seek a professional service provider, check N/A.**

- ❍ In the last 6 months (1)
- ❍ Between 7 months to 1 year ago (2)
- ❍ 1 to 2 years ago (3)
- ❍ More than 2 years ago (4)
- ❍ N/A (5)

Q8.5 **Please indicate his or her primary reason(s) for seeking treatment. Check all that apply.**

- ❑ Anxiety (1)
- ❑ Depression (2)
- ❑ Problems adjusting to life problems (breakup, divorce, loss of loved one, etc.) (3)
- ❑ Physiological problems (fatigue, unusual sleep patterns, changes in appetite, bodily aches, etc.) (4)
- ❑ Prefer not to answer (5)
- ❑ Not sure (6)
- ❑ Other (please specific) (7) _____

Q8.6 **Please indicate his or her formal diagnosis by a professional service provider. Check all that apply.**

- ❑ Adult Deficit Hyperactivity Disorder (ADHD) (1)
- ❑ Bipolar Disorder (2)
- ❑ Depression NOS (3)
- ❑ Dysthymia (4)
- ❑ Generalized Anxiety Disorder (GAD) (5)
- ❑ Major Depressive Disorder (MDD) (6)
- ❑ Obsessive-Compulsive Disorder (OCD) (7)
- ❑ Post-Traumatic Stress Disorder (PTSD) (8)
- ❑ Specific Phobia (please specific which type) (9) _____
- ❑ Social Phobia/Social Anxiety Disorder (10)
- ❑ Prefer not to answer (11)
- ❑ Not sure (12)
- ❑ Other (please specify) (13) _____

Q8.7 **If he or she sought help from anything other than a professional service provider for mental health problems, please indicate which ones below. Check all that apply.**

- ❑ Friends (1)
- ❑ Family (2)
- ❑ Romantic partner (e.g., boyfriend or girlfriend) (3)
- ❑ Pastor/minister (4)
- ❑ Co-workers (5)
- ❑ Acupuncture (6)
- ❑ Acupressure (7)
- ❑ Yoga (8)
- ❑ Alternative medicine (9)
- ❑ He or she only sought help from professional providers. (10)
- ❑ Other (please specify) (11) _____

Answer If If he or she sought help from anything other than a profe... Family Is Selected

Q8.8 **Please indicate which family member(s) he or she sought for help. Check all that apply.**

- ❑ Grandfather (1)
- ❑ Grandmother (2)
- ❑ Father (3)
- ❑ Mother (4)
- ❑ Spouse (husband/wife) (5)
- ❑ Brother (6)
- ❑ Sister (7)
- ❑ Cousin (8)
- ❑ Not sure (9)
- ❑ Other (please specify) (10) _____

Answer If If he or she sought help from anything other than a profe... He or she only sought help from professional providers. Is Not Selected

Q8.9 **When was the last time he or she reached out to a non-professional source of help?**

- ❍ In the last 6 months (1)
- ❍ Between 7 months and 1 year ago (2)
- ❍ 1 to 2 years ago (3)
- ❍ More than 2 years ago (4)
- ❍ Not sure (5)
- ❍ N/A (6)

Q8.10 **Did this close friend or family member affect your decision to seek or not seek treatment in any way? Please state either Yes or No then explain in a few sentences.**

Q9.1 **For the following items, please circle an answer from 1 to 5, with 1 being strongly disagree and 5 being strongly agree.**

_____ I think less of a person who has received mental health treatment. (1)
_____ Most people would willingly accept someone who has received mental health treatment as a close friend. (2)
_____ Most people feel that receiving mental health treatment is a sign of personal failure. (3)
_____ I would willingly accept someone who has received mental health treatment as a close friend. (4)
_____ Most people think less of a person who has received mental health treatment. (5)
_____ I feel that receiving mental health treatment is a sign of personal failure. (6)

Q10.1 **Below is a list of things which can stop, delay or discourage people from getting professional care for a mental health problem, or continuing to get help. By professional care we mean care from such staff as a family doctor, community mental health team (e.g. care coordinator, mental health nurse or mental health social worker), psychiatrist, counselor, psychologist or psychotherapist. Have any of these issues ever stopped, delayed or discouraged you from getting, or continuing with, professional care for a mental health problem? Please select one number on each row to indicate the answer that best suits you. Note: Even if your answer is 0 please click on that number or your answer will be not registered. For 'not applicable' e.g. if it is a question about children and you do not have children, please click 0 and write N/A in the provided text box.**

_____ Being unsure where to go to get professional care (1)
_____ Wanting to solve the problem on my own (2)
_____ Concern that I might be seen as weak for having a mental health problem (3)
_____ Fear of being put in hospital against my will (4)
_____ Concern that it might harm my chances when applying for jobs. (please click 0 and type N/A if not applicable) (5)
_____ Problems with transportation or travelling to appointments (6)
_____ Thinking the problem would get better by itself (7)
_____ Concern about what my family might think, say, do or feel (8)
_____ Feeing embarrassed or ashamed (9)
_____ Preferring to get alternative forms of care (e.g. traditional / religious healing or alternative / complementary therapies) (10)
_____ Not being able to afford the financial costs involved (11)
_____ Concern that I might be seen as 'crazy' (12)
_____ Thinking that professional care probably would not help (13)
_____ Concern that I might be seen as a bad parent (please click 0 and type N/A if not applicable) (14)
_____ Professionals from my own ethnic or cultural group not being available (15)
_____ Being too unwell to ask for help (16)
_____ Concern that people I know might find out (17)
_____ Dislike of talking about my feelings, emotions or thoughts (18)
_____ Concern that people might not take me seriously if they found out I was having professional care (19)
_____ Concerns about the treatments available (e.g. medication side effects) (20)
_____ Not wanting a mental health problem to be on my medical records (21)
_____ Having had previous bad experiences with professional care for mental health (please click 0 and type N/A if not applicable) (22)
_____ Preferring to get help from family or friends (23)
_____ Concern that my children may be taken into care or that I may lose access or custody without my agreement (please click 0 and type N/A if not applicable) (24)
_____ Thinking I did not have a problem (25)
_____ Concern about what my friends might think, say or do (26)

_____ Difficulty taking time off work (please click 0 and type N/A if not applicable) (27)
_____ Concern about what people at work might think, say or do (please click 0 and type N/A if not applicable) (28)
_____ Having problems with childcare while I receive professional care (please click 0 and type N/A if not applicable) (29)
_____ Having no one who could help me get professional care (30)

Q10.2 **If you have any additional thoughts or comments about attitudes, beliefs, and behaviors toward treatment seeking, please provide them in the empty space below.**

Q10.3 **Thank you for your participation.**