

THE EFFECT OF ATTITUDES AND STIGMA ON THE WILLINGNESS TO SEEK  
TREATMENT FOR MENTAL PROBLEMS

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THE EFFECT OF ATTITUDES AND STIGMA ON THE WILLINGNESS TO SEEK  
TREATMENT FOR MENTAL PROBLEMS

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Abstract:

This study examined the attitudes and stigma toward psychotherapy and medication. It was hypothesized that participants would endorse higher levels of stigma towards psychotherapy than medication. Approximately 200 students were surveyed at Texas State University, using an investigator-designed questionnaire intended to assess stigma towards mental health treatment. Paired t-tests were run to compare responses on survey questions that differed only in terms of a focus on medication or psychotherapy. A significantly more negative attitude towards psychotherapy was found in areas of parental use of treatment, and self-attitudes. Attitudes about friends' use of different treatment forms were found to be non-significant. When an analysis of variance was run for ethnic differences, there was a significant difference in medication-related attitudes between White and Hispanic participants.

## **Review of Literature**

### *Stigma*

There can be many different barriers to seeking treatment for a mental health issue. Cost, health insurance, access and knowledge of medical services, and time can all hinder successful adoption of treatment. Stigma is another such barrier. However, stigma, which in extreme cases can be the fear of social isolation due to the reaction of others, is a very powerful obstacle to overcome. Erving Goffman defined stigma as “the process by which the reaction of others spoils normal identity” (Goffman, 1963). This can also be put as the fear of being judged by others. Stigma is interesting to study in that it is not as easily “cured” as other barriers. For example, cost can be resolved by use of social services and low-income health care; however, stigma is a more deep-rooted problem.

“One of the most common reasons for people to not seek treatment is stigma” (Vogel & Wade, 2009, 20). This stigma does not just extend to those diagnosed with a mental illness, as those who seek public help in general can be stigmatized by society. Stigma can generally be categorized in one of two ways. There is the public stigma caused from the rejections of others. Such stigma often results when an individual violates social norms within a culture. A relatively new concept is self-stigma, which is the stigma felt by the individual in which the fear of potential rejection can prevent adoption of a specific treatment. Vogel & Wade (2009) believe that self-stigma is externally given, yet internally accepted. This can be especially crippling in the adoption of voluntary types of

treatment, such as non-court ordered psychotherapy and medications. Thus, public stigma can indirectly limit treatment seeking when individuals engage in self-stigma and avoid seeking help for their condition.

### *Stigma in Psychotherapy and Medication*

Slavet, Parker, Kitowicz, and MacDonald (2000) studied the stigma associated with seeking psychotherapy and found that those who seek psychotherapy and those diagnosed with a mental illness were seen as the same, regardless of whether those seeking psychotherapy could be classified as mentally ill. Both groups were seen as different from normal people.

Sirley, *et al.* (2001) found that stigma was a mediating factor in maintaining a treatment regimen. Lower perceived stigma was associated with better adherence to a prescribed medication. This study shows the importance of identifying and reducing stigma to improve treatment adherence and outcomes in those diagnosed with a mental illness. This study and the one conducted by Slavet, *et al.* (2000) both identify stigma within a single type of treatment. However, neither examines both psychotherapy and medication in the same sample or whether stigma is greater towards either of these treatment modalities.

Together, studies show that there is a generally negative or at least somewhat condescending attitude towards those seeking help for mental health problems (this probably needs a citation).

## *Race*

Racial differences in stigma are still relatively understudied, especially among those seeking treatment for mental health concerns. Conner, Koeske, and Brown (2009) examined differences in attitudes towards professional mental health services in elderly Whites and African-Americans. They found that African-Americans possessed more negative views regarding mental health treatment, and that this attitude then served as a barrier to treatment-seeking behaviors. These negative views were attributed to internalized stigma.

Ojeda and Bergstresser(2008) examined race, stigma-related attitudes and mistrust of the medical establishment. They found that non-Latino white males possessed the largest amount of stigma and medical treatment avoidance. One explanation for this was, “The admission of a stigmatized condition such as mental illness, or moving from ‘discreditable’ to ‘discredited’ status implies a greater risk of social loss for individuals already in positions of higher perceived status or for individuals within certain status groups” (Ojeda & Bergstresser, 2008, 329). This assumes that the non-Latino white males have more to lose by being stigmatized; therefore, they have greater treatment avoidance. The same study also concluded that use of mental health services is also highly stigmatized among minorities.

Saetermoe, Scattone, and Kim, (2000) researched ethnic differences in the stigma of those with disabilities. They found that “Asian-Americans were most likely to stigmatize

and less likely to differentiate between individuals with physical and mental illness”(Saetermoe, Scattone, & Kim, 2000, 699). They also found that people were willing to work with and befriend those with mental illness, but there was less acceptance overall of family members having mental illness.

It seems that racial differences exist in the area of stigma and mental illness, yet much still seems to be unknown. The high levels of stigma towards mental health treatment possessed by both non-Latino white males and minority individuals may illustrate that stigma is high across ethnicity; regardless, further research is needed to clarify the influence of ethnicity on stigma towards treatment.

#### *Family & Friends*

Vogel, Michaels and Gruss (2009) studied whether attitudes regarding therapy can be transmitted by parents to children. They hypothesized that attitudes regarding therapy for treatment of a mental disorder could be passed down from parent to child. In the end, parental attitudes toward seeking mental health services were a significant factor in children’s willingness to seek mental health services. Also, they found that the children’s attachment level to their parents played a role in their adoption of the parents’ attitudes. Higher levels of attachment led to greater adoption of the parents’ mindset. When attachment to parents was low, attitudes were unrelated. So, it was not only the attitude towards treatment of a parent, but the child’s particular attachment to that parent. These results may explain why some students have a reluctance to seek treatment, but it fails to explain the specific thoughts and feelings preventing them from seeking such treatment.



Family is an important factor in the outcome of treatment for mental disorders. Evans, Cowlshaw & Hopwood, (2009) found that family functioning could determine successful or unsuccessful change in veterans with post-traumatic stress disorder. They theorized that families who are more adaptive encourage positive change. Also veterans with poor family functioning may rely more on withdrawing from their environment (Evans, Cowlshaw, & Hopwood, 2009). While this study does provide evidence of the positive and negative impact family can have, it did not examine specific attitudes and how they affect outcomes of treatment.

#### *Difference in Psychotherapy and Medication*

Stecker and Alvidrez (2007) conducted a study to find if stigma-related attitudes affected initiation rates of psychotherapy within a sample of people diagnosed with depression. The participants generally had high scores on the attitudinal questionnaire, which asked participants if they thought psychotherapy was efficacious. Yet after 3-months, only six of the 29 participants initiated a session of psychotherapy. In observation of attitudes towards medication of the 29 participants, only 11 reported filling and taking a prescription medication; of these 11, only five continued treatment for more than 6-months. Although no significant correlations were found, this study indicates that some factors impede treatment-seeking in a sample in need of treatment. While attitudes towards the effectiveness of treatment were not a significant predictor of treatment initiation, the study did not examine stigma. Stigma differs from belief in the efficacy of treatment, and participants could have had high levels of each, ultimately impeding treatment-seeking.

Löwe, Schulz, Gräfe, & Wilke(2006) conducted interviews with depressed and non-depressed outpatients to find their attitudes about antidepressants, psychotherapy and self-management techniques for depression. It was found that psychotherapy was the most highly preferred treatment (29%) but not that much higher than no treatment at all (25%; Löwe, Schulz, Gräfe, & Wilke,2006). They also found that participants related improved well-being to psychotherapy, but not as often to antidepressants. “Other study results indicate that this preference might go back to the patients’ belief that emotional problems are most frequently caused by alterable factors, such as interpersonal problems, work-related problems, and health problems” (Löwe, Schulz, Gräfe, & Wilke, 2006). This study shows the possibility of misconceptions regarding treatment, specifically psychotherapy. It also demonstrates differences in preferences toward treatment for depression.

### *Mental Illness*

Stigma can have a drastic effect on treatment-seeking attitudes and outcomes for those diagnosed with a mental illness. “Dysfunctional coping strategies, such as secrecy and withdrawal have potential to enhance the effects of perceived stigma by reducing the stigmatized person’s range of social contacts and constricting social networks, and thus may increase the rate of relapse and rehospitalization” (Kleim, Vauth, Adam, Stieglitz, Hayward, & Corrigan, 2008, 483). Results of this study indicated that among those diagnosed with schizophrenia, those that perceived stigma had less optimistic treatment outcomes.

One factor that may increase stigma and block treatment seeking may be media portrayal of the mentally ill. Stuart (2006) explains that despite research showing the effectiveness of treatment, there is still a general suspicion about treatment; this can be attributed, in part, to the media's treatment of those with mental illness. This shows that a negative stereotype does surround adoption of treatment in individuals with mental health problems. However, it is still necessary to find out if this effect changes depending on the type of treatment.

Previous studies have shown the existence of a stigma related to mental illness, and a stigma for those who seek treatment. This study attempts to connect previous research to find specifically whether stigma is different between psychotherapy and medication and if there are certain ethnic, familial and age considerations that magnify or decrease this stigma. Perceptions and acceptance of friends and family among those who seek help for mental problems is incredibly important, and if stigma exists on the part of any party involved, it needs to be clearly identified and dealt with for a more successful treatment outcome. Also, those with mental illnesses can be stereotyped in society adding to this problem. Clearer connections need to be made to more clearly identify this societal problem.

There are obvious inconsistencies in studying race in the issue of stigma. A particular limitation of the previous mentioned studies involving race is that they tend to focus on a single ethnicity. This study hopes to correct that problem by not restricting participation based on ethnicity. The literature also shows that family attitudes can play a role in an

individual's stigma; however, the impact of friends in this area is understudied. It is clear that there are many issues affecting stigma, and this study hopes to start to clarify more exact roles that family, friends, ethnicity, and mental health history can have on attitudes toward treatment.

The main aim of this study is to survey the effects of stigma on attitudes towards treatment. For this, the two most popular forms of treatment were chosen, psychotherapy and psychotropic medications. Gender differences will also be assessed. Previous findings in the literature such as those of the Ojeda and Bergstresser (2008) study found that males can have more treatment avoidance; the current study will examine if these attitudes exist in a more educated, college-aged, sample. Ethnic and age differences in attitudes toward treatment will also be studied. Comprehensive research on race and stigma is still lacking, and while the sample of Texas State University will likely be primarily white, a large subsample of Latino or Hispanic individuals is also expected.

This study will not answer every one of the many questions that exist on this topic; however, it will provide an overview of many under-researched areas. Identifying barriers to treatment would have significant impact in clinical practice. Identification of stigma could mean the difference of adherence and non-adherence in a patient seeking relief for mental problems. This may be especially important for those with more chronic mental illnesses such as schizophrenia.

## **Methods**

### *Participants*

Participants were recruited primarily through class announcements in undergraduate courses in the Department of Psychology. Participants were offered extra credit in their class for completion of a survey. The amount of extra credit was left to the discretion of the instructor of the course. The amount of extra credit offered was known by prospective participants prior to survey administration, allowing them to make a fully informed decision. Efforts were also made to recruit students from the Department of Music and other departments. This was intended to provide a more diverse and representative sample of the entire university. Participants were not screened for any specific characteristics. Approval for this study has been obtained by Texas State University's Institutional Review Board.

### *Procedure*

Participants were given an informed consent form explaining the study, its risks and benefits, alternatives to participation, and other salient details prior to participation. Prior to signing the form, all participants read the consent and study personnel explained the aims of the study, risks and benefits and the study procedures. Participants signed informed consent prior to any participation, and all forms were collected before surveys were handed out. Participants completed a 27-question survey, with questions designed to

find out attitudes relating to mental health problems and treatment types. The questions were also created to be blunt, as stigma is often very blunt and pointed.

For data analysis, survey questions were coded into one of three categories: therapy (T), medication (M), or mental health attitudes (A). They were also coded with a 1-7 number denoting either more (5-7) or less (1-3) stigma.

### *Measures*

The survey questions were designed specifically for this study. The questions were created with the objective of measuring stigma regarding psychotherapy, medication, and mental health issues in a general population. The researcher created questions, as a previously created survey that was appropriate for the study could not be found. General questions on race, gender, ethnicity, and mental health history were also included. Mental health history was divided into past diagnosis in the respondent and parent/friend history of mental health problems. For the questions regarding psychotherapy and medication, several questions assessing attitudes were created. Within these questions were items assessing the participant's attitudes as well as attitudes of parents and friends. These questions were cross-referenced to include both the participant's attitude towards a friend/parent receiving treatment and the perceived judgment the participant might feel from a parent/friend.

Three questions that are designed to measure attitude toward mental illness were taken from the Attitude Scale for Mental Illness (ASMI) designed by Ng and Chan (2000). The ASMI is a modified version of the Opinions about Mental Illness in Chinese Community

Scale, which was originally employed to test student attitudes about mental illness. The 33 items in the ASMI scale have a high internal consistency (Cronbach's  $\alpha = .87$ ; Ng, Chan, 2000).

The survey was originally put on surveymonkey.com as a pilot to examine potential problems. These online surveys were distributed by e-mail to students in undergraduate psychology courses, as well as on Facebook.com. A small sample (n=67) was gathered and descriptive analyses were performed on the data. A non-significant difference was found in stigma-related attitudes between genders indicating that significance may be found in a larger sample.

After the pilot data was collected, the survey questions were reassessed to identify potential problems. Question 18 originally stated, "People who see a psychiatrist are crazy" which received an almost unanimously negative response, so the word "crazy" was changed to "weak" to more properly measure negative attitudes based on social stereotypes. Question 9 stated, "When I get stressed out, I find it helps to talk it out with someone." The word "someone" was later replaced with "a therapist", which was more accurate as a measure of psychotherapy-related attitudes.

#### *Data analysis*

All data was analyzed using PASW statistical analysis software, version 18. To compare the attitudes of medication and therapy paired t-tests were conducted. To analyze differences in ethnicity, age, and mental health history, independent t-tests and analysis

of variance (ANOVA) were used. Finally, a logistic regression analysis was to predict group membership by attitude score.

### *Demographics*

Survey respondents were predominantly white (57%), female (68%), with no previous mental illness (83%). This reflects the general population of the university as indicated in the 2008-2009 Texas State University College Senior Survey (Higher Education Research Institute, University of California at Los Angeles, 2008-2009).

### *Hypotheses*

Hypothesis 1 (H1): Participants will endorse higher levels of stigma towards psychotherapy than medication.

H2: Higher levels of reported therapy and medication stigma will be seen in samples of Hispanic/Latino participants, when compared to White participants.

H3: Those with a history of mental health problems will report significantly less therapy and medication stigma overall.

H4: Those who have a parent or friend with a mental health problem will report significantly less therapy and medication stigma overall.



## Results

### *T-tests*

The main hypothesis of this study was that psychotherapy would have greater levels of stigma than medication, which may influence an individual's decision to seek treatment. Respondents did have more acceptance of medication in most situations, the main exception being with a friend who was seeking treatment.

Comparisons of questions 24 and 25 (see tables A1 & A2) relate to treatment avoiding behavior and barriers that may exist. A significant preference was found for medication ( $M = 5.37, SD = 1.57$ ) over psychotherapy ( $M = 4.58, SD = 1.96$ ),  $t(184) = 5.62, p < .001$ . Respondents indicated a significant preference for their parents (see tables B1 & B2) to be treated with medication ( $M = 5.27, SD = 1.53$ ) over psychotherapy ( $M = 3.35, SD = 1.30$ ),  $t(184) = -14.62, p < .001$ . The mean average rating for medication treatment fell under "slightly agree" that it was acceptable, while the mean acceptance of psychotherapy was in the range of "slightly disagree" that it was acceptable. This question evidenced the largest mean difference of those tested under hypothesis 1. The difference between parents acceptance of the respondents' choice of treatment was also significant (see tables C1 & C2). Respondents showed a significant preference for medication ( $M = 4.91, SD = 1.92$ ) over psychotherapy ( $M = 5.43, SD = 1.93$ ),  $t(184) = 2.92, p = .004$ . When questions 24 and 25 were paired (tables D1 & D2), results once

again showed significant preference for medication ( $M = 6.19, SD = 1.24$ ) over psychotherapy ( $M = 4.58, SD = 1.96$ ),  $t(184) = 12.03, p < .001$ .

Conversely, results showed no significant differences in treatment preference for friends (see tables E1 & E2). A non-significant preference was found for therapy, ( $M = 5.90, SD = 1.38$ ) over medication ( $M = 5.82, SD = 1.42$ ),  $t(184) = 12.03, p < .001$ . While the difference is slight, it is important to note that it is the only reported pair of questions that do not support hypothesis 1. The other area of perception of friends dealt with discussion of psychotherapy and medication (see tables F1 & F2). A significant preference was found for discussing medication with friends ( $M = 2.83, SD = 1.59$ ) over psychotherapy ( $M = 3.44, SD = 1.89$ ),  $t(184) = -4.30, p < .001$ .

Hypothesis 2 was that there would be ethnic differences in attitudes and medication; specifically, it was hypothesized that minorities would possess higher levels of stigma. Significant differences were found when comparing White and Hispanic/Latino in area of medication stigma (see tables G1 & G2). Hispanic/Latino individuals ( $M = 3.47, SD = 1.88$ ) possessed significantly higher stigma-related attitudes than White individuals ( $M = 4.51, SD = 1.79$ ),  $t(148) = 3.24, p = .001$ . There was not a significant difference concerning therapy.

### *Logistic Regression*

Logistic Regression was run to test hypotheses 3 and 4. No significance was found when history of mental illness (H3), or having a friend/parent with a mental illness was examined (H4).

For hypothesis 2 (table H1), Some race or ethnicity-based differences between White and Hispanic/Latino were found in attitudes toward medication ( $p=.014$ ), while therapy ( $p=.246$ ) showed no significance. When the interaction term was added, therapy ( $B=.152$ ,  $SE=.244$ ,  $p=.534$ ), medication ( $B=.28$ ,  $SE=.26$ ,  $p=.29$ ), or the interaction term ( $B=-.01$ ,  $SE=.05$ ,  $p=.872$ ) were all non-significant.

Without the inclusion of the interaction term between attitudes towards therapy and attitudes towards medication, no significance was found for gender in attitudes towards medication ( $p=.85$ ) or therapy ( $p=.79$ ; see table J1) Inclusion of the interaction term resulted in near-significant p-values for attitudes towards medication ( $B=.36$ ,  $SE=.21$ ,  $p=.09$ ), therapy ( $B=.37$ ,  $SE=.20$ ,  $p=.065$ ) and the interaction term ( $B=-.08$ ,  $SE=.04$ ,  $p=.055$ ).

## **Discussion**

Psychotherapy and medication are both widely accepted as successful treatments for mental problems. Despite this, barriers exist that prevent individuals from seeking treatment. One of these barriers is the perception of social stigma felt by the individual seeking treatment. Participants in this study, on average, were less willing to seek therapy for their mental distress, compared to medication. This was only not significant in the case of preferred treatment for friends.

The main hypothesis of this study was that therapy would have higher ratings of stigma than medication. This was supported in most aspects. When comparing “I would rather just deal with my problems by myself than see a psychotherapist” and “I would be ashamed of taking prescription medication for my mental health problems” respondents had a significant preference for medication. These questions address internalized stigma, not stigma based on friend or parental attitudes. When the same therapy question was compared to another question relating to medication, “I think it is a sign of weakness to take prescription drugs for a mental health problem” the results again showed a significant preference for medication over psychotherapy.

“My parents would not want me to take prescription drugs for a mental health problem” and “I would be afraid of what my parents would think if I started seeing a therapist” were compared and yielded significant results showing a preference for medication. Respondents perceived feeling less judgment from their parents if taking

medication over seeing a therapist. This could explain why therapy had stronger levels of stigma overall, as the study by Vogel, Michaels and Gruss (2009) showed that attitudes toward treatment could be generationally transmitted by parents. Therefore, perceived attitudes of the parent may reflect respondent attitudes overall.

A significant difference was also found for the respondent's preferred treatment type for their own parents. "You find out one of your parents started seeing a therapist for some mental health issues, you find this distressing" and "One of your parents starts taking prescribed medication for a diagnosed mental health problem; you are at ease with this situation" (reverse coded to match question 6) were compared. These paired questions indicated that respondents would rather their parents take medication than see a psychotherapist.

In the area of friends, respondents thought that it was more acceptable to discuss treatment with medication for a mental problem than to bring up that they were seeing a psychotherapist. This was not the case when respondents were asked for the preferred treatment of their friends. "A friend starts talking to you about the medication they were prescribed for some mental health problems, this makes you feel uncomfortable" and "A friend of yours started seeing a psychotherapist for some mental health problems they are facing; you are comfortable with this situation" (reverse coded) were compared. In this case, a slight, non-significant preference for therapy was observed. That was the only independentt-test that showed no difference between medication and psychotherapy.

When an independent t-test was run to compare the combined totals of medication and therapy stigma among ethnicities, significant results were found for medication. Hispanic individuals reported higher stigma-related attitudes toward medication, when compared to White individuals. This was not true however; in the case of psychotherapy, where there was no significant difference.

That the biographical (sex, age) data were not related to a difference in stigma replicates the results of a study by Snyder, Hill, and Derksen (1972) in which biographical data did not have any significant effect on whether a university student would utilize the school's counseling center.

### *Limitations*

One limitation of this study comes from the sample, which was a convenience sample of undergraduate students, composed mostly of psychology majors. However, the argument could be made that since the majority of students were being educated in psychology, that greater stigma could occur in the general population without a general knowledge of the discipline.

Another limitation is the possible influence of other barriers. While stigma may in fact be a barrier in seeking treatment, other factors could play a role as well. It cannot be determined how issues such as cost, health care, mistrust of the medical establishment, among others, could influence survey responses. Future research needs to investigate the magnitude of these other barriers.

Many things that may be limitations of this work simply go beyond the scope of the study at hand. While stigma may be a barrier in seeking treatment, other barriers such as cost, and time among others can be barriers as well and should be studied in the future.

### *Implications*

This study shows that stigma seems to be higher regarding psychotherapy, as compared to prescription medication. This finding needs to be studied further, to address why this phenomenon occurs and in what ways it can be reduced. This can have implications for clinical settings, as it could help reduce the impact of stigma as a possible barrier to seeking treatment.

The implication that medication is more acceptable to talk about in social situations raises some interesting factors. Further study might address what specific reasoning would cause this discrepancy in attitudes. If mentioning current psychotherapy treatment truly is less socially acceptable, then this needs to be addressed. Generally, the results of this study demonstrate the need for increased education about the benefits of psychotherapy.

Community-based involvement is one solution to educate individuals on the benefits of psychotherapy. Goldston et al. (2008) researched help-seeking in relation to suicide risk among different cultures and claims, “Efforts developed by and implemented by home communities have a greater likelihood of sustainability because of individual and community investment in the programs and because participants are able to experience first-hand the positive changes that occur as a result of interventions” (Goldston et al,

2008, 27). This could include involvement and education programs from local organizations, such as schools, churches and community centers.

The identification of a discrepancy in attitudes between these two treatment types is very much a first step in this area. Further research should improve upon this study by identifying the specific mindset that fosters this stigmatic attitude. This will help identify the cognitive distortions and general logical fallacies that harbor stigmatic attitudes. Future study should also focus more on minorities; this study did not have a large enough sample of minorities to fully evaluate any racial or ethnic-based differences. A specific ethnic subgroup may be more at-risk than others, but it was not possible to identify with the sample obtained in this study.

The primary hypothesis of this study was that stigma regarding psychotherapy would be greater than stigma regarding medication. In most aspects, this hypothesis was generally supported by the research results. Further research can use this identification to determine the magnitude of this discrepancy in attitude and if it creates a general reluctance in seeking treatment.



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## Appendix

### *Tables*

Tables A1 and A2 refer to the following questions:

Question 24: I would rather just deal with my problems myself than see a psychotherapist.

Question 25: I would be ashamed of taking prescription medication for my mental health problem.

Table A1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair	25m1	5.37	185	1.569
	24t1	4.58	185	1.960

Table A2						
Paired Samples Test						
		Mean	Standard Deviation	T	df	Significance (2-tailed)
Pair	25m1	.789	1.909	5.622	184	.000
	- 24t1					

Tables B1 and B2 refer to the following questions:

Question 6: You find that one of your parents started seeing a therapist for some mental health issues, you find this distressing.

Question 20: One of your parents started taking prescribed medication for a diagnosed mental health problem; you are at ease with this situation. (reverse coded to match question 6)

Table B1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair 1	6t1	3.35	184	1.30
	20m1	5.27	184	1.53

Table B2						
Paired Samples Test						
		Mean	Standard Deviation	T	df	Significance (2- tailed)
Pair 1	6t1 – 20m1	-1.91	1.78	-14.62	184	.000

Tables C1 and C2 refer to the following questions:

Question 10: My parents would not want me to take prescription drugs for a mental health problem.

Question 22: I am afraid of what my parents would think if I started seeing a therapist.

Table C1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair 1	22t1	5.43	185	1.933
	10m1	4.91	185	1.915

Table C2						
Paired Samples Test						
		Mean	Standard Deviation	T	df	Significance (2- tailed)
Pair 1	22t1 - 10m1	.519	2.418	2.918	184	.004

Tables D1 and D2 refer to the following questions:

Question 24: I would rather just deal with my problems by myself than see a psychotherapist.

Question 27: I think it is a sign of weakness to take prescription drugs for a mental health problem.

Table D1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair	27m1	6.19	185	1.239
	24t1	4.58	185	1.960

Table D2						
Paired Samples Test						
		Mean	Standard Deviation	T	df	Significance (2-tailed)
Pair	27m1 –	1.611	1.821	12.033	184	.000
1	24t1					

Tables E1 and E2 refer to the following questions:

Question 12: A friend of yours started seeing a psychotherapist for some mental health problems they are facing; you are comfortable with this situation. (reverse coded to match question 17)

Question 17: A friend starts talking to you about the medication they were prescribed for some mental health problems, this makes you feel uncomfortable.

Table E1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair 1	17m1	5.82	185	1.42
	12t1	5.90	185	1.38

Table E2						
Paired Samples Test						
		Mean	Standard Deviation	t	df	Significance (2- tailed)
Pair 1	17m1	-.086	1.59	-.74	184	.459
	- 12t1					

Tables F1 and F2 refer to the following questions:

Question 19: It is okay to talk about taking medication prescribed for mental health problems with friends.

Question 24: It would be alright to bring up that I am seeing a therapist to my friends.

Table F1				
Paired Samples Statistics				
		Mean	N	Standard Deviation
Pair 1	19m4	2.83	185	1.59
	23t4	3.44	185	1.89

Table F2						
Paired Samples Test						
		Mean	Standard Deviation	t	df	Significance (2- tailed)
Pair 1	19m4	-.61	1.91	-4.30	184	.000
	-23t4					



Tables G1 and G2 refer to the combined totals of all therapy and medication questions.

Table G1				
Group Statistics for Ethnicity				
	Race	N	Mean	Standard Deviation
Therapy	White	105	4.59	1.817
Stigma	Hispanic	44	4.57	1.848
Medication	White	105	4.51	1.787
Stigma	Hispanic	45	3.47	1.878

Table G2				
Compared Ethnic Differences				
	Mean Difference	F	df	Significance (2-tailed)
Therapy	.022	.00	147	.95
Medication	1.048	.01	148	.001

Table H1 refers to the combined totals of all therapy and medication questions.

Table H1			
Logistic Regression for Ethnicity			
	B	Standard Error	S
Therapy	.15	.244	.534
Medication	.28	.260	.286
Medication by Therapy	-.01	.05	.872

Table J1 refers to the combined totals of all therapy and medication questions.

Table J1			
Logistic Regression for Gender			
	B	Standard Error	Significance
Therapy	.37	.20	.065
Medication	.36	.21	.091
Medication by Therapy	-.08	.04	.055

*Surveys*

**Please answer all questions. Do not put your name! For questions using a scale,**

**1 = “Strongly Agree” 2 = “Agree” 3 = “Slightly Agree” 4 = “Neither Agree nor**

**Disagree”**

**5 = “Slightly Disagree” 6 = “Disagree” 7 = “Strongly Disagree”**

1.) Which ethnicity do you identify with? (Circle as many as apply to you)

White      African-American      Hispanic/Latino

Asian/Pacific Islander      American Indian      Other

2.) What is your gender? (Circle One)

Male      Female

3.) What is your age?(Write in) \_\_\_\_\_

4.) Have you ever been diagnosed with any type of mental problem? (Circle one)

Yes

No

5.) Have your parents or any of your close friends ever been diagnosed with a mental problem? Yes

No

6.) You find out that one of your parents started seeing a therapist for some mental health issues, you find this distressing.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

7.) Seeing a therapist is only for people with serious mental problems.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

8.) I would be afraid to start prescription medication for a mental health problem.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

9.) When I get stressed out, I think it would help to talk to a therapist.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

10.) My parents would not want me to take prescription drugs for a mental health problem.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

11.) After people with mental illness are treated, they are still more dangerous than normal people.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

12.) A friend of yours started seeing a psychotherapist for some mental health problems they are facing; you are comfortable with this situation.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

13.) It is better to keep my problems to myself than suffer the embarrassment of seeking outside help.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

14.) Prescription medication is only for people who cannot control their emotions.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

15.) Even after a person with mental illness is treated, I would still to be afraid around them.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

16.) If I started prescription drugs, I would be afraid of someone finding out.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly  
Disagree

17.) A friend starts talking to you about the medication they were prescribed for some mental health problems, this makes you feel uncomfortable.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

18.) People who see psychiatrists are weak.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

19.) It is okay to talk about taking medication prescribed for mental health problems with friends.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

20.) One of your parents starts taking prescribed medication for a diagnosed mental health problem; you are at ease with this situation.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

21.) People with mental illness have unpredictable behavior.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

22.) I am afraid of what my parents would think if I started seeing a therapist.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly

Disagree

23.) It would be alright to bring up that I am seeing a therapist to my friends.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly Disagree

24.) I would rather just deal with my problems by myself than see a psychotherapist.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly Disagree

25.) I would be ashamed of taking prescription medication for my mental health problems.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly Disagree

26.) If I was seeing a counselor I would be afraid of what my friends would say.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly Disagree

27.) I think it is a sign of weakness to take prescription drugs for a mental health problem.

Strongly Agree: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_ : Strongly Disagree

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