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Depression: The role of cultural factors and perception of treatment.

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DEPRESSION: THE ROLE OF CULTURAL FACTORS AND PERCEPTION OF
TREATMENT

A Thesis

Presented to

The Faculty of the Department of Psychology

San Jose State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

by

Cynthia Chacon

December 2009

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SAN JOSE STATE UNIVERSITY

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DEPRESSION: THE ROLE OF CULTURAL FACTORS AND PERCEPTION OF
TREATMENT

by
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ABSTRACT

DEPRESSION: THE ROLE OF CULTURAL FACTORS AND PERCEPTION OF TREATMENT

by Cynthia Chacon

Depression is a prevalent mental disorder. Various factors influence people's attitudes toward help seeking, perceptions, and beliefs about psychotherapy, including ethnicity (language), distress level, social support, treatment modality, and subpopulation. Cognitive behavioral therapy (CBT) and psychodynamic therapy (PT) have been used to treat depression. This study explored the relationship between the aforementioned variables. Participants (N = 264) were White and Mexican-American from a college and the community. Results indicated that ethnicity and subpopulation were not significantly related to seeking help; people who reported higher distress levels and higher social support expressed greater likelihood to seek help. All groups rated CBT higher than PT. Mexican-Americans rated therapy more positively than Whites regardless of modality. There was a positive relationship between ethnicity and treatment choice.

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Introduction

Major Depressive Disorder affects approximately 11% of the population, and this number is expected to increase (Goldney, Fisher, & Wilson, 2001). Clinical depression has been found to be one of the most common disorders people experience, affecting approximately 300 million people worldwide (McLoughlin, 2002). According to Apfel (2003), between the years 1990 and 1998 there was a 45.9 percent increase in the number of people being diagnosed with clinical depression. Additionally, it has been suggested that in the near future depression will be the “second leading cause of disability worldwide” (Goldney et al., p.615; McLoughlin). Depression is not only a problem for the White population, but it affects other ethnic groups including Mexican-Americans, African-Americans, and Asian-Americans (Iwata & Buka, 2002; Miranda et al., 2003).

Researchers have suggested that depression is prevalent in all ethnic groups; thus, it is important that these groups are included when examining interventions designed to alleviate depression (Iwata & Buka, 2002; Miranda et al., 2003). Moreover, Brown, Abe-Kim, and Barrio (2003) stated that the expression of psychological distress is influenced by culture and ethnicity. It has also been reported that those individuals who identify themselves with an ethnic minority that has been disadvantaged have poorer mental health and premature mortality when compared to those who identify with the dominant, White group (Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; Williams & Coffins as cited in Miranda et al.). Increasingly there has been a drive to consider cultural as well as linguistic factors with the goal to provide adequate psychological services for diverse populations (“Guidelines,” 1993).

Depression has been examined in various ethnic and cultural groups. Depressive symptoms that have been observed in these groups include sadness, lack of pleasure, lack of energy, inability to concentrate, and feelings of worthlessness (Tsai, Pole, Levenson, & Muñoz, 2003). While the clinical symptomatology of depression is consistent across populations, it is not clearly defined what type of interventions are effective and which are preferred by particular minority populations. According to Tsai et al., research in the area of depression is needed in order to better understand how this disorder may affect the emotional functioning in a particular population and which interventions would be effective. Research has suggested that certain individual characteristics contributed to higher degrees of depressive symptoms such as being older, female, and being of a racial and ethnic minority (Rosenthal & Schreiner, 2000). For Mexican-Americans, some of the factors that have shown to have contributed to higher risks for depressive symptoms included immigration status, employment, marital status, age, educational level, and income (Aranda, Castaneda, Lee, & Soble, 2001). Since minorities are at least as likely to experience and suffer from depression as Whites, depression is also a problem for these populations.

Latinos are expected to be the largest minority in the United States; it has been predicted that this population will reach about 53 million by 2010 (Aranda et al., 2001). More specifically Mexican-Americans comprise 62% of the Latino population (Chun, Organista & Marin, 2003). Ethnic minorities might be at a greater risk for depression as a result of having to experience social, economic, and cultural difficulties (Organista, Muñoz, & Gonzalez, 1994). In the Hispanic/Latino population, women more than men,

reported higher rates of depressive symptoms when compared to Whites (Amaro & Russo, 1987). Additionally, Mexican-Americans reported higher levels of depression when compared to other Latino subgroups such as Cubans and Puerto Ricans (Kouyoumdjian, Zamboanga, & Hansen, 2003). Research has also found that minorities are underserved and under identified (Amaro & Russo; Goldney et al., 2001; Muñoz, Le, & Ippen, 2000; Sue, 1988). This could be due to lack of financial resources (Sue, Zane, & Young, 1994), as it may be more difficult to detect depression in minorities because different populations talk about depression differently (Brown et al., 2003; Goldney et al.; Muñoz et al.), and minorities are less likely to report and seek help (Jorm et al., 2000).

Help-seeking Behavior

Help-seeking behavior has been widely studied and many researchers have attempted to explain and explore what factors might contribute to it. Calhoun and Selby (1974) examined the relationship between severity of symptoms and help-seeking behavior. Using an undergraduate sample of participants, Calhoun and Selby concluded that participants who had greater levels of perceived distress were less likely to seek help. Nonetheless, help-seeking is a process determined by various factors (Mojtabai, Olfson, & Mechanic, 2002). Mojtabai et al. argued that help-seeking behavior was not only influenced by psychopathology but also by whether people perceived the need to seek professional psychological help. They further suggested that a person's attitudes and sociodemographic variables were more likely to determine the need to obtain professional help.

In a meta-analysis, Bristow and Patten (2002) found that help seeking rates have increased over the years. The general findings were that although people might not have a formal diagnosis or meet criteria for one, they also seek help. The factors that influenced individuals' behavior of seeking help were age, ethnicity, social support, and clinical/psychiatric factors. More specifically, it was suggested that people who expressed lower rates of help-seeking behaviors were young adults, elderly, nonwhites, and those who had low levels of social support (Bristow & Patten). In a study that examined perceptions about psychotherapy and psychotherapists using an undergraduate sample, it was suggested that students had positive attitudes toward therapy and were fairly knowledgeable about what therapy would entail (Bram, 1997). With regards to the Latino population Peifer, Hu, and Vega (2000) suggested that people from Mexican origin demonstrated low rates of help-seeking even for those who met diagnostic criteria for a mental health illness. Mexican-Americans have been found to under utilize services more than other minority ethnic groups (Kouyoumdjian et al., 2003; Organista et al., 1994). Kouyoumdjian et al. suggested that this may be the result of not being able to provide culturally sensitive treatment, including providing services in their native language, and accessibility of treatment due to financial barriers, including transportation difficulties.

It may be the case, for example, that a Latino person who is experiencing depression may find it stigmatizing to seek professional psychological help (Kouyoumdjian et al., 2003; Muñoz et al., 2000). This in turn may affect that person's choice to seek treatment or not. As a result, such minorities may be less likely to attend

therapy and more likely to visit a physician (Jackson-Triche et al., 2002). This in itself may be a problem because physicians may not be as knowledgeable and as experienced in identifying clinical depression as mental health providers (Muñoz et al.). Miranda and colleagues (2003) stated that, if ethnic minorities are able to obtain mental health services they are less likely than Whites to obtain treatments that are evidence based. One possible reason for this was that minorities may be skeptical about psychotherapy and might not see the value of obtaining it (Sue et al., 1994).

Social Support

Another argument that was posited related to depression and seeking professional help was that low levels of social support were strongly correlated with experiencing depression consequently. In general, people were at higher risks for depressive symptoms when they did not have an intimate relationship that was supportive (Aranda et al., 2001). Aranda and colleagues stated that particularly for the Mexican-American population, satisfaction level with social support was related to lower levels of distress for both genders. Furthermore, women who had low levels of social support from their spouse/partner also expressed higher levels of depressive symptoms. Within the Latino population, it is widely accepted that they hold a collectivist view; this may be considered a support network whereby this population is able to obtain support and not necessarily have the need or perceive the need to seek mental health services (Kouyoumdjian et al., 2003). In a study that used female college students (Castillo, Conoley, & Brossart, 2004), it was suggested that those who had high levels of social and financial support had

lower levels of perceived distress, which one might argue could prevent a person from experiencing depressive symptoms, and consequently be less likely to seek help.

Treatment Preference

Further, according to Cooper et al. (2003) and Miranda et al. (2003), various ethnic groups may have different treatment preferences, for example as broadly defined as desire for medication or psychotherapy. Treatment preferences have also been examined amongst therapeutic interventions for people experiencing symptoms of depression. The variables that have been examined in relation to depression include ethnicity, attitudes and perception toward treatment, attitudes toward seeking help, social support, distress level, treatment approaches/modalities, treatment preference, and language.

Cooper and colleagues (2003) examined treatment preferences among White, Hispanic, and African American patients in primary care settings. Overall, Hispanics and African Americans had more negative attitudes toward medication than psychotherapy and had more favorable attitudes toward psychotherapy when compared to Whites (Dwight-Johnson et al., 2000). A study that explored treatment preferences among primary care patients found that patients preferred active treatment to no treatment and they preferred counseling over medication, despite their symptom severity (Dwight-Johnson et al.). Additionally, there were no significant differences between preferences for group versus individual therapy (Dwight-Johnson et al.). In another study, college students rated treatments for depression; the results indicated that they viewed psychotherapy as more acceptable than pharmacotherapy (Apfel, 2003; Hall &

Robertson, 1998). Furnham and Wardley (1990) examined factors that contributed to participants' more negative beliefs and attitudes toward psychotherapy as well as being more skeptical; these variables included being older, more educated, and having more experience with psychotherapy.

Some criticisms of this literature include that not much attention has been focused on exploring whether different groups prefer certain types of treatment approaches such as psychodynamic or behavioral approaches (Furnham & Wardley, 1990). Additionally, the majority of the research has focused on the White population and on people who are connected with mental health services in primary care settings (Furnham & Wardley). With regards to the Mexican-American population the majority of studies have examined depressed individuals in primary care settings. Placing a focus on people who have access to mental health services/clinics may be a problem as people in the general community may not always have access to these services; as a result, the general community may not be identified and probably not able to obtain mental health treatment.

CBT and Psychodynamic Perspectives

The two treatment approaches examined in this study were cognitive behavioral therapy (CBT) and psychodynamic therapy (PT), as both have been utilized to treat depression (Bond, 2006). PT, as defined by Bond, "Generally involves developing a therapeutic alliance and addressing defense mechanisms and intrapsychic conflicts in an attempt to show the multiple conscious and unconscious factors which influence a patient's symptoms and behaviors, therapy can range in length and depth from psychoanalysis to short-term dynamic psychotherapy" (p. 40-41). Trijsburg, Semeniuk,

and Perry (2004) stated that “Cognitive behavioral therapists emphasized the cognitive control of negative affect through the use of intellect and rationality, combined with vigorous support, and reassurance on the part of the therapist” (p. 327).

Research in the area of depression and effective treatments for depression have included comparisons of both CBT and PT, as well as other types of therapeutic approaches. A study examined the effectiveness of CBT and the results suggested that it was viewed as an acceptable treatment for depression as rated by undergraduate university students, which the authors considered potential consumers (Hall & Robertson, 1998). In a study that explored the effectiveness of CBT for ethnic minority patients, CBT was effective in symptom reduction (Miranda, Azocar, Organista, Dwyer, & Areane, 2003); however, this improvement from pre- to post-intervention was not as large as previously seen in other outcome studies (Organista et al., 1994). In the aforementioned study, it was also concluded that those who had higher symptom severity before initiating therapy, had poorer outcome. It is noteworthy to restate that the majority of studies on the efficacy of the therapeutic approaches have been conducted with college students, patients at primary care settings, and the White population.

Some studies have suggested that CBT was more effective than PT (e.g., Perez, 1999). Both therapy approaches were effective in reducing depressive symptoms post-treatment; however, at one-year follow-up, CBT demonstrated to have greater improvement (Barkham, Shapiro, Hardy, & Rees, 1999; Perez). Studies also have suggested that both treatment approaches were equally effective (Leichsenring, Rabung, & Leibing, 2004). Other researchers have not been able to identify which type of

treatment approach was more effective (Bond, 2006; Comas-Diaz, 1990) for particular populations; thus, it is imperative to explore treatment preferences and people's perceptions regarding the effectiveness of treatments as this might shed some insight into which therapy is viewed as more effective. In a meta-analysis (Bond), it was concluded that there was no data that support that PT was more or less effective than other treatment approaches to treat mood disorders as well as other psychiatric disorders (Leichsenring et al.).

Iselin and Addis (2003) conducted a study in which various treatments for depression were rated as helpful or not helpful based on participants' perceptions of the cause of the depressive symptoms. It was concluded that when the symptoms (physical/medication versus psychological/psychotherapy) matched the treatment approach, the treatment was perceived as more helpful. Clarifying which treatment approach people from different ethnicities prefer might also impact attrition rates, as it has been stated that attrition rates were higher among ethnic minorities than among Whites and higher for those involved in psychotherapy than those being treated with medication (Iselin & Addis). Additionally, this might also provide evidence as to which treatment might better address a specific population's needs and thus allow clients to participate more actively in their treatment, which could result in a decrease in attrition rates.

Apfel (2003) argued "that no one treatment will work for everyone" (p.79). The author also argued that if people's preferences for specific treatments were considered, people would be allowed to choose the treatment they think would be more helpful and

this may result in a decrease in relapse rates. This notion was also supported by Wong (1994) who argued that people's beliefs about psychotherapy, such as the effectiveness of certain treatments may influence a person's choice to engage and participate in treatment.

Challenges in Research

Sue (1988) has stated that previous research has not provided consistent and clear evidence that supports significant differences in treatment effectiveness for ethnic minorities and Whites. However, Sue argues that these differences might not have been identified as issues regarding ethnicity, as these differences have been misconceptualized. There have been insufficient studies to be able to draw clear conclusions as well as those studies that have been conducted and that have been published have methodological issues (Sue). Other demographic variables should be considered as ethnicity is just one of the factors that might determine treatment outcome (Sue). Sue argued that matching a client with a therapist that is of similar ethnicity is not enough as culture and language play an important role. Sue stated that degree of acculturation was a determining factor for the Mexican-American population in preferring to work with an ethnic similar therapist or not. Meaning that, for some Mexican-Americans who had closer connections with their culture, preferred to work with a Mexican-American counselor; however, those who had closer connections with the White culture, neither, or both were not as likely to choose to work with a ethnically similar counselor.

Language

Language was another variable that was included in the present study. It has been suggested as well as outlined in the guidelines for providers of mental health services that

services should be provided in the language that is understandable by the consumer as language impacts the delivery of appropriate mental health services (“Guidelines,” 1993; Comas-Diaz, 1990). Linguistic variables have been thought to be extremely important, as these have been shown to affect the process of therapy (Comas-Diaz).

Purpose of Present Study

The purpose of this study was to explore variables related to depression, including attitudes toward help-seeking, distress level, social support, and people’s perceptions of treatment approaches taking language and ethnicity into account and expand on what has already been reported in research. In addition, we used a more general sample as this has lacked in research. Previous research has not focused on the broader community samples and their attitudes toward seeking professional help; which this study sought to do. They have primarily focused on people involved with primary care settings, those who are college students, or those already involved with mental health services. Some have argued that utilizing non-clinical samples poses external validity issues, as these populations are not the actual recipients of mental health services (Iselin & Addis, 2003). However, it can be argued that examining the non-clinical population is the more appropriate sample to examine, as these populations (general population and Mexican-Americans) are not as likely to seek help, are underserved, and may not know how to access mental health services due to language and other sociodemographic factors.

Thus, this study explored various factors that have been examined in relation to depression and help-seeking attitudes including ethnicity, attitudes and perception toward treatment, social support, distress level, treatment approaches/modalities, treatment

preference, and language. More specifically, this study aimed to clarify, which of the two treatments either CBT or PT the Mexican-American college, the Mexican-American community, the White college, and the White community populations prefer. This can have important implications in terms of which treatment they would perceive as more effective and be more likely to participate in. Knowing and understanding what type of therapy Mexican-Americans choose compared to what Whites choose, can provide some direction as far as what interventions these particular populations prefer and view as effective, as well as the likelihood they would be to participate in treatment.

Methods

Participants

Participants ($N = 264$) were college students currently enrolled at San Jose State University ($n = 132$) and members of the general community population ($n = 132$). The researcher obtained IRB approval from SJSU. All participants were over the age of 18. College participants were recruited via a subject pool within the psychology department at San Jose State University. College participants received required experimental credit as stipulated by their psychology courses or volunteered with no compensation. Other student participants were recruited through the Mexican American Studies Department, where their participation was voluntary. Community participants were recruited via a local community agency, via a local fitness center, and a local church. Community participants volunteered with no compensation. This study focused on the Mexican-American and White population in both the college and community settings. Other ethnicities were not included in this study.

Descriptive Statistics

The descriptive statistics are summarized in Table 1.

Table 1. *Descriptive Statistics for the Variables in Percentages and Means (N = 264)*

<u>Variable</u>	<u>Group</u>			
	<u>White Col.</u> (n = 66)	<u>M-A Col.</u> (n = 68)	<u>White Comm.</u> (n = 65)	<u>M-A Comm.</u> (n = 65)
<u>Gender</u>				
Females	58%	68%	52%	71%
Males	42%	32%	48%	29%
<u>Age Range</u>	18-38	18-40	18-81	19-61
Mean	18.92	19.51	38.69	26.81
<u>Highest Education Level Completed</u>				
Elementary	0%	0%	0%	14%
Junior High	2%	0%	2%	12%
High School	94%	88%	14%	40%
College/University	5%	12%	73%	23%
Trade School	0%	0%	9%	9%
Other	0%	0%	2%	0%
None	0%	0%	0%	2%
<u>Marital Status</u>				
Single	95%	97%	32%	26%
Married	<1%	<1%	60%	69%
<u>Income Level</u>				
\$0-\$4,999	60%	47%	7%	8%
\$5,000-\$9,999	17%	25%	7%	8%
\$10,000-\$14,999	3%	10%	2%	8%
\$15,000-\$19,999	8%	2%	3%	8%
\$20,000-\$24,999	3%	6%	2%	13%
\$25,000-\$29,999	2%	3%	3%	11%
\$30,000-\$34,999	0%	2%	9%	11%
\$35,000-\$39,999	3%	2%	2%	8%
\$40,000-\$44,999	2%	0%	3%	3%
\$45,000-\$49,999	0%	0%	2%	8%
\$50,000-\$54,999	0%	3%	3%	5%
\$55,000-\$59,999	0%	0%	3%	0%
\$60,000-\$64,999	0%	0%	5%	5%
\$65,000-\$69,999	0%	0%	9%	0%
\$70,000-+	2%	0%	35%	2%
<u>Years lived in the U.S.</u>				
Range	1-26	5-25	13-81	1-61
Mean	18.27	18.45	41.30	14.70

Note. White Col. = White College, M-A Col. = Mexican-American College, White

Comm. = White Community, and M-A Comm. = Mexican-American Community. Some

percentages may not add to 100% due to rounding and lack of responses by participants to some questions.

One hundred percent of the White college and community participants as well as the Mexican-American college participants completed the study in English. Within the Mexican-American community group, 22% completed the study in English and 79% completed the study in Spanish.

Materials

Participants completed a demographics questionnaire, a total of three standardized psychological assessments, and two treatment rating forms. To obtain each individual's background information, a demographics questionnaire was utilized. The experimenter translated the demographics questionnaire into Spanish. The translated version was verified by two individuals (A Master's level Spanish student and a community college Spanish Instructor). One individual was female and the other male and both were bilingual in English and Spanish. The two individuals confirmed that the translated version of each item was accurate and clear. Once the individuals had the opportunity to verify the translated version, the researcher and the individuals compared the original English version to the Spanish version. Minor revisions were made to ensure that the original English version matched the verified Spanish version as accurately as possible taking the cultural context into account. The Brief Symptom Inventory (BSI) was utilized (Derogatis & Melisaratos, 1983) to measure participants' level of overall distress including possible psychopathology in the area of depression. A Spanish version of the BSI was available from the test publishers and was utilized for the Mexican-American

participants who preferred to complete the study in Spanish. Participants' attitudes toward seeking professional psychological help were measured by the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Turner 1970). The experimenter translated the ATSPPHS scale into Spanish, as a Spanish version was not found. As with the demographics questionnaire, the Spanish translated version of the ATSPPHS was verified by two independent Spanish-speaking translators (A Master's level Spanish student and a community college Spanish Instructor). The same procedure to verify translation accuracy was done with the ATSPPHS. To measure levels of social support, the Interpersonal Social Evaluation List (ISEL) was employed (Cohen, Mermelstein, Kamarck, & Hoberman, 1985). A Spanish translated version of the ISEL was found. However, the Spanish translated version of the ISEL was still verified by the two independent Spanish-speaking translators (A Master's level Spanish student and a community college Spanish Instructor) as the version found was translated in European Spanish. Treatment rating forms were used to measure participants' perceptions regarding the two therapeutic treatments being examined, CBT and PT. These were also translated by utilizing the same procedure as the other scales in this study.

Demographics Questionnaire

A demographics questionnaire was utilized to obtain participants' age, gender, and ethnicity, place of birth, number of years residing in the United States, educational level, marital status, primary and secondary language, and annual income. The experimenter developed the demographics questionnaire.

Brief Symptom Inventory

The BSI is a 53-item self-report measure developed as a brief form of the Symptom Checklist 90-Revised (SCL-90-R; Derogatis & Cleary, 1977). The BSI has been found to be reliable and valid; internal consistency coefficients have ranged from 0.71 to 0.85. The BSI has good construct, discriminant, and predictive validity. This measure was designed to reflect an individual's current psychological status in psychiatric and medical patients as well as non-patient populations. This inventory utilizes a 5-point rating scale of distress with scores ranging from 0-4, which include, "not at all," "a little bit," "moderately," "quite a bit," and "extremely". A sixth grade education level was needed to complete the BSI. The authors attempted to utilize the most basic language possible in order for people from diverse backgrounds to be able to understand and complete the BSI.

The BSI yields three global indices. For the purpose of this study only one of the three indices was used; the Global Severity Index (GSI). The GSI has been determined to be the best indicator of a person's overall current perceived distress if only a single measure is to be used. In order to obtain the overall distress level, the values for each of the items was added and then divided by the total number of items answered, which resulted in a raw score. Raw scores could range from 0 to 212. The raw score was then converted into a standardized T-score for interpretation purposes. The T-score for each of the participants was compared to the appropriate profile according to the norm group from which it was derived. For this study, the non-patient female and male norms were utilized. Separate norms were developed for females and males because according to the

authors, it has been well documented that females tend to report more psychological symptoms and greater levels of distress when compared to their male counterparts. A score was considered to meet criteria for “caseness” if the GSI score was greater than or equal to a T score of 63. A score of 63 represented a person experiencing considerable/clinically significant levels of distress.

Attitudes Toward Seeking Professional Psychological Help Scale

Participants’ attitudes toward seeking therapy were measured by the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner 1970). The ATSPPHS is a 29-item self-report measure. Four factors comprise the scale, which include (1) Recognition of personal need for psychotherapeutic help, (2) Stigma tolerance, (3) Interpersonal openness, and (4) Confidence in mental health practitioner. Respondents were asked to rate each of the statements using a scale of 0-3, from “strongly disagree,” “disagree,” “agree,” and “strongly agree”; thus scores could range from 0 to 87; higher scores reflected more positive attitudes toward seeking psychological help. To score the ATSPPHS, the items were summed. The ATSPPHS has been found to have good internal reliability, 0.86 (Fischer & Turner 1970). A copy of the ATSPPHS is included in Appendix A.

Twelve items in the ATSPPHS were modified by the experimenter. Items (2, 3, 4, 8, 11, 14, 18, 20, 25, 26, 27, and 28) on the ATSPPHS were modified to exclude words such as “psychiatrist, mental hospital, and mentally ill” and include words that focus on psychotherapeutic treatment, as this study is focusing primarily on the individuals’ perceptions and attitudes toward therapeutic treatment. Items 16 and 24 were not

significantly altered but the pronouns “she” and “her” were added to avoid gender biased language. A detailed list of the modified items is included in Appendix B.

Interpersonal Support Evaluation List

The Interpersonal Support Evaluation List (ISEL; Cohen et al., 1985) was employed to measure level of perceived social support. The General Population Form of the ISEL was used for this study, as it was more appropriate because the sample included people in the general community as well as students. Although a student version of the ISEL is available, comparisons between the scores of the two populations (community and college) would have created inconsistencies. The ISEL is a 40-item self-report measure, which focuses primarily on an individual’s perception of potential available social resources. Respondents were asked to rate each of the statements using a 4-point Likert scale of 0-3, ranging from “definitely false” to “definitely true.” The item responses were summed; high scores indicated higher levels of perceived social support. The reliability for the ISEL has been found to be adequate (Cohen et al.). Internal reliability for the ISEL has ranged from 0.88 to 0.90 and has been found to have adequate test-retest reliability and good discriminant validity (Cohen et al.). A copy of the ISEL can be found in Appendix C.

Clinical Vignettes and Treatment Descriptions

Three written descriptions were utilized for the second part of this study; a clinical vignette, a CBT description, and a PT description. The clinical vignette described a person who met criteria for clinical depression. The vignette was developed by this researcher. Ten Master’s Level (MFT) students were asked to verify the accuracy

of the vignette depicting a person who met criteria for depression. Additionally, a Clinical Psychologist/University Professor revised the vignette to confirm that the description accurately described symptoms for depression. A copy of the vignette is included in Appendix D.

The CBT treatment description illustrated how a therapist would address the individual's symptoms described in the vignette from a cognitive behavioral theoretical perspective. A copy of the CBT description is included in Appendix E. The PT treatment description illustrated how a therapist would address the individual's symptoms in the vignette from a psychodynamic theoretical perspective. A copy of the PT description is included in Appendix F. The two treatment descriptions were also developed by this researcher and were confirmed for accuracy by a Clinical Psychologist/University Professor.

The clinical vignette as well as the treatment descriptions depicted a female student and female therapists. It was necessary to assign a gender to the person portrayed in the vignette as well as to the therapists in the treatment descriptions because these were also used in Spanish for Mexican-American participants that preferred to complete the study in Spanish. In the Spanish language there is no term to keep gender neutral; thus, all three remained one consistent gender. Two independent Spanish-speaking translators verified the Spanish versions of the vignette and the two treatment descriptions. Additionally, all three descriptions were matched with the participant's ethnicity in order to control for possible confounds due to ethnicity mismatch. For the White population, the name for the person in the vignette (Melissa) and the last names for the two therapists

(Dr. Robertson and Dr. Sullivan) in the descriptions were of White origin. For the Mexican-American population, the name for the person in the vignette (Marisol) and the last names for the two therapists (Dr. Ramirez and Dr. Sanchez) in the descriptions were of Mexican-American origin.

Rating Forms for Treatments

Participants completed a rating form for each of the treatment descriptions to examine the differences in their perceptions of the two treatments. The ratings forms were partly developed by this researcher and some of the questions were adopted from the Treatment Credibility Scale used in this area of research (Rokke, Carter, Rehm, & Veltum, 1990). The rating forms included five questions and respondents were asked to rate each of the treatment descriptions using a scale of 1-7, 1 meaning “very” and 7 “not all” for the five questions. For example, “How reasonable does this therapy seem to you?,” “How effective do you think this therapy would be for most people?,” and “How likely would you be to go into this therapy if you were feeling depressed?” Participants were then asked to choose which one of the two treatments they thought was more effective in addressing the individual’s symptoms described in the vignette and which one of the two treatments was more effective personally if they were experiencing a similar situation and difficulties.

Procedures

Research was conducted in a research lab and in other classrooms on campus for college participants (San Jose State University). Data were collected in non-university classroom settings for community participants to avoid possible setting confounds.

Participants completed the study in groups and individually. During the study, participants were allowed to ask for clarification of the terms included in the materials if they were doubtful and were uncertain about the definition.

All material was read aloud by the researcher or one of the research assistants, as literacy levels varied. Reading aloud was done to all participants in English and Spanish depending on what language they completed the study in to prevent the introduction of a confounding variable. The experimenter(s) introduced themselves and informed the participants that they would be receiving either credit for a course or no compensation if they were participating voluntarily. Participants were asked if they preferred to complete the study in Spanish if they had signed-up for the Mexican-American group. All of the community participants in the Mexican-American population in this study completed the study in Spanish.

First, participants were given two copies of the consent form. One copy remained with the experimenter(s) and the other the participants kept if they chose to. The experimenter(s) read the consent form aloud; the participants were asked to sign the consent form if they agreed to participate. Next, participants were provided a summary of what their participation would entail; first they were informed that they would be completing several questionnaires and that the experimenter(s) would read three written descriptions two of which they would be asked to rate. At this point, participants were allowed to ask questions.

Once participants signed the consent forms, the experimenter(s) read the demographics questionnaire aloud, which participants completed as the experimenter

read every item. After participants completed the demographics questionnaire, the experimenter(s) read the instructions for the BSI as well as every item while participants completed it. Next, the experimenter(s) read the instructions for the ATSPPHS aloud as well as every item, which participants completed as the experimenter read these. Once participants finished the ATSPPHS, the experimenter(s) read the instructions for the ISEL as well as all the items aloud, which participants completed as the experimenter(s) read every item.

Participants were informed that this concluded the first part of the study and would be moving on to the second part. The experimenter(s) began by reading the clinical vignette aloud. The experimenter(s) informed the participants that the experimenter(s) would read aloud how a therapist would address this person's difficulties. Participants were presented with either "Treatment A" or "Treatment B." The treatment descriptions were counterbalanced in order of presentation to avoid possible order effects. "Treatment A" was always CBT and "Treatment B" was always PT. Following each treatment description, the participants rated each of the treatments using the rating forms, which were also read aloud. Once participants completed the second rating form, they were asked to turn their form face down and were asked two questions. At this point, they had been exposed to both of the treatments and they were asked to write down, which of the two treatments they thought was more effective for the person described in the vignette and which treatment they thought would be more effective personally if they were going through a similar situation and similar difficulties. Finally, participants were debriefed

and were informed of the purpose of the study. They were given the opportunity to ask questions.

Results

Experimental Design

A three-factor mixed design with two classification factors and one treatment factor was utilized. The two between-subjects classification factors were ethnicity (White versus Mexican-American) and subpopulation (college versus community). The within-subject treatment factor was treatment modality (CBT vs. PT). Correlational analyses were also conducted in order to explore the relationship between ethnicity, subpopulation, attitudes toward help seeking, distress level, and social support. Attitudes toward seeking help were measured by the ATSPPHS, where higher scores reflected more positive attitudes toward seeking psychological help and thus greater likelihood of help seeking. Distress level was measured by the BSI, designed to reflect an individual's current psychological status and perceived distress. Higher scores indicated higher degrees of distress. Social support was measured by the ISEL, where higher scores indicated higher levels of perceived social support.

Hypotheses

The present study investigated several hypotheses and explored the relationship between specific variables related to attitudes toward seeking professional psychological help. The primary hypothesis was that ethnicity, subpopulation, social support, and distress level would be related to people's attitudes toward seeking professional psychological help and treatment preference. It was predicted that the White population would demonstrate more positive attitudes toward seeking professional psychological help when compared with the Mexican-American population because ethnic minorities

have been less likely to seek professional help (Bristow & Patten, 2002; Calhoun & Selby, 1974; Peifer et al., 2000). Participants from community and college subpopulations would differ in their attitudes toward seeking help; college students would have more positive attitudes than non-students because it has been reported that college students are aware of what therapy would entail and have reported positive attitudes about therapy (Bram 1997). Participants' reported social support level and distress level would influence their likelihood to seek professional psychological treatment; higher levels of social support and lower levels of distress would result in a lower likelihood to seek professional psychological help, as participants may not need the support of a professional and may not be experiencing distress. Therefore, participants would not perceive the need to seek help (Aranda et al., 2001; Castillo et al., 2004). Based on previous research, (Miranda, Azocar, et al., 2003; Organista, et al., 1994; Perez, 1999) CBT would be viewed as more effective and reasonable than PT by all groups; the ethnicity and language used in the treatment descriptions matched those of the participants'. In addition to testing the present hypotheses, this study examined the relationship between participant ethnicity, treatment effectiveness as determined by scores on rating scales, and treatment choice.

A confidence level of 0.05 was used for all tests. It was predicted that White participants would demonstrate more positive attitudes toward seeking professional psychological help than the Mexican-American participants regardless of the subpopulation they belong to (college or community). The community and college subpopulations would differ in that college students would have more positive attitudes

than non-students. To test these hypotheses, a 2 x 2 ANOVA was employed; ethnicity (White and Mexican-American) and subpopulation (community and college) were the two factors each with two levels. Although the Mexican-American group ($M = 42.96$, $SD = 8.03$) had a slightly higher average score regarding attitudes toward seeking professional psychological help (dependent variable) than the White group ($M = 41.85$, $SD = 5.96$), this difference was not statistically significant [$F(1, 260) = 1.63$, $p = 0.20$, $\eta^2 = 0.01$]. College participants regardless of ethnicity had higher scores ($M = 43.16$, $SD = 5.77$) than the community participants ($M = 41.63$, $SD = 8.23$); however, this difference also was not statistically significant [$F(1, 260) = 3.07$, $p = 0.08$, $\eta^2 = 0.01$]. White college ($M = 42.91$, $SD = 6.18$) and community ($M = 40.77$, $SD = 5.58$) groups had lower mean scores on their attitudes toward seeking professional psychological help than the Mexican-American college ($M = 43.41$, $SD = 5.39$) and community ($M = 42.49$, $SD = 10.19$) groups. These results again were not significant [$F(1, 260) = 0.49$, $p = 0.48$, $\eta^2 = 0.00$]; the results did not support our second hypothesis and resulted in a non-significant interaction. The results are summarized in Table 2.

Table 2. *ANOVA for Attitudes-Toward-Seeking-Professional-Psychological-Help-Scale by Ethnicity and Subpopulation*

Source	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>p</i>
A (ethnicity)	81.71	1	81.71	1.63	.20
B (subpopulation)	154.38	1	154.38	3.07	.08
A x B	24.57	1	24.57	0.49	.48
Error	13069.71	260	50.27		
Total	13329.82	263			

An independent samples *t*-test was employed to determine whether significant distress level, as measured by the BSI, was related to participant attitudes toward seeking professional psychological help. The results indicated that, overall, participants who met criteria for “caseness” had higher mean scores ($M = 44.27$, $SD = 6.77$) than those who did not meet those criteria ($M = 40.76$, $SD = 7.04$). Therefore, those participants with significant levels of distress expressed positive attitudes toward seeking professional psychological help; this difference was statistically significant [$t(262) = 4.13$, $p < 0.001$, two-tailed].

In the third hypothesis, it was predicted that participants reported social support level and distress level would be associated with their likelihood to seek professional psychological treatment, more specifically that people with lower levels of distress and with high levels of social support would be less likely to seek help. To test this hypothesis, a regression analysis was conducted with social support and distress as the independent variables and attitudes toward seeking professional psychological help as the

dependent variable. The regression model was significant [$F(2, 261) = 22.40, p < 0.001, r^2 = 0.15$]. Both predictors were significant and positively related to attitudes toward seeking help ($p < 0.001$). Results are summarized in Table 3.

Table 3. *Regression Analysis of Attitudes Toward Seeking Professional Psychological Help*

<u>Variable</u>	<u>B</u>	<u>S.E.</u>	<u>p</u>
Distress	0.15	0.04	<.001*
Social Support	0.29	0.05	<.001*
Y-intercept	15.34	4.07	<.001*

Note. Regression Equation- $y = 15.35 + 0.15(\text{Distress}) + 0.29(\text{Social Support})$.

* indicates the test met the criterion for statistical significance ($p < .05$).

It can be concluded that the two variables, social support and distress level, reliably predicted people's attitudes toward seeking professional psychological treatment. In the college population, 52% met criteria for caseness and, in the community population, 34% met criteria for caseness. In terms of ethnicity, 32% of the White population met criteria for caseness, and 50% of the Mexican-American community met criteria for caseness.

The fourth hypothesis stated that because ethnicity and language match those of the participants' CBT would be viewed as more effective and reasonable than PT by all groups; a 2 x 2 ANOVA was conducted with ethnicity (White and Mexican-American) as the between subjects factor and therapy/treatment type (CBT and PT) as the within subjects factor. It was possible for scores to range from 5-35; as mentioned previously, lower scores indicated more favorable perceptions. CBT ($M = 14.51, SD = 6.86$) was

rated more positively and was perceived as more effective and reasonable than PT ($M = 16.24$, $SD = 7.87$) by all groups regardless of ethnicity [$F(1, 262) = 9.52$, $p = 0.002$]. Regardless of treatment modality, there was a statistically significant difference in how Mexican-Americans and Whites perceived therapy. Mexican-Americans ($M = 13.40$) rated therapy treatment more favorably than did Whites ($M = 17.39$) [$F(1, 262) = 35.37$, $p < 0.001$]. Whites rated CBT ($M = 16.18$, $SD = 6.56$) and PT ($M = 18.59$, $SD = 7.57$) and the Mexican-American group rated CBT ($M = 12.86$, $SD = 6.78$) and PT ($M = 13.93$, $SD = 7.49$) [$F(1, 262) = 59.65$, $p = 0.23$]. A significant interaction was not found between ethnicity and treatment modality. Results are summarized in Table 4.

Table 4. *ANOVA for Treatment Preference by Ethnicity and Treatment Type*

Source	SS	df	MS	F	p
A (ethnicity)	2094.16	1	2094.16	9.52	.02*
B (treatment type)	399.60	1	399.60	35.37	<.001*
A x B	59.65	1	59.65	1.42	.23
Error	10995.07	262	41.97		
Total	13548.48	263			

Note. * indicates the test met the criterion for statistical significance ($p < .05$).

In order to further explore treatment preference, participants were asked to choose which of the two treatments they thought would be more effective for the person described in the vignette. A chi-square test for independence was employed with ethnicity and treatment as the two categorical variables. More specifically, participants were asked to choose which of the two treatments they thought would be more effective

for the person described in the vignette. Overall, White participants chose CBT (66%) over PT (34%), and Mexican-American participants chose CBT (52%) over PT (48%). The relationship between ethnicity and choice of treatment was statistically significant [$\chi^2(1, N = 264) = 5.11, p = 0.02, r^2 = 0.02$]. Not taking ethnicity into consideration, CBT (57%) was chosen over PT (39%).

Likewise, participants were asked to choose which of the two treatments they thought would be more effective personally if they were going through a situation similar to the person described in the vignette. A chi-square test for independence was conducted with ethnicity and treatment as the two categorical variables. White participants chose CBT (68%) over PT (33%), and Mexican-American participants chose CBT (53%) over PT (47%). The relationship between ethnicity and choice of treatment was statistically significant [$\chi^2(1, N = 264) = 5.47, p = 0.02, r^2 = 0.02$]. Not taking ethnicity into consideration, CBT (60%) was chosen over PT (40%).

Although gender was not a variable of interest, it may have influenced the results previously reported. An independent samples *t*-test was employed with attitudes toward seeking professional psychological help as the dependent variable and gender as the independent variable; there were more females ($n = 164$) than males ($n = 100$) in the general sample. The results indicated that females ($M = 42.36, SD = 7.57$) and males ($M = 42.49, SD = 6.35$) had similar scores in their likelihood of seeking professional psychological help, despite the higher number of female participants. The difference between the scores was not statistically significant [$t(262) = -0.144, p = 0.89$, two-tailed].

Discussion

Clinical depression is a condition that is prevalent and exists for people of different ethnic backgrounds. Thus, it is very important to consider linguistic and cultural factors when providing mental health services. In this study, Mexicans and Mexican-Americans were placed in one category as it was assumed that, although there may have been some cultural differences such as acculturation level, it could be argued that underlying similarities including history, values, traditions, and language are consistent and undeniable. All of the community participants in the Mexican-American group completed the study in Spanish; therefore, if language were not included, this target population would have been overlooked.

Inconsistent with previous research (Jorm, et al., 2000) that reported that minorities were less likely to seek help, this study concluded that the Mexican-American and White populations had similar scores in their attitudes toward seeking professional psychological help, which was surprising. One could argue that, although this difference was not statistically significant, this result could have been due to having included the participants' language and culture in this study. People from the Mexican-American group, especially within the community sample, were probably more likely to express more positive attitudes toward help seeking, as these two factors were taken into consideration and were an integral part of the present study. Additionally, it could have been that although people may find obtaining mental health services stigmatizing, they are more open to seeking help in the present time (Bristow & Patten, 2002), as evidenced by this study's results. This result may be explained by the fact that, with the Mexican-

American group, the researcher and research assistants were of Mexican descent, whereas with the White group, both Mexican and White research assistants gathered the data. This could have influenced the results.

Consistent with the previous research of Calhoun & Selby, 1974; Kouyoumdjian et al., 2003, we found that social support and distress level were related to attitudes toward help seeking. Contrary to previous studies (Calhoun & Selby; Kouyoumdjian et al.) that reported that people who were more distressed and had higher levels of social support were less likely to seek help, it was concluded in this study that people who reported higher levels of distress and higher levels of social support generally were more likely to seek help. Therefore, this demonstrated that although people may be experiencing significant levels of distress, they still perceived the need to obtain help. Even when people had social support, they perceived the need to seek psychological help. It is noteworthy that participants in this study reported high rates of distress; thus, it is important to reach out to these populations, especially the Mexican-American population because, as mentioned previously, ethnic minorities might be at a greater risk for depression because of having to experience social, economic, and cultural difficulties (Organista, Muñoz, & Gonzalez, 1994). More specifically, 50% of the Mexican-American group met criteria for experiencing significant levels of distress in the clinical range compared to the 32% in the White group. This study supported the notion that help-seeking rates have increased over the years and that, even without a formal diagnosis, people seek help (Bristow & Patten, 2002).

The present study also focused on exploring treatment preference in terms of psychotherapy, as it had been found that Hispanics had more favorable attitudes toward therapy than medical treatment when compared to Whites, which may also explain the aforementioned results. This may have been influenced by sociodemographic variables, as well as an increase in people's help-seeking rates, as mentioned in previous research (Bristow & Patten, 2002). Our results were consistent with previous research (Dwight-Johnson et al., 2000) stating that minorities prefer counseling; the Mexican-American group had more positive attitudes toward therapy when compared to the White group. However, within each of the two ethnicities, there was no significant difference between a preference for CBT or PT based on the scores from the rating forms. Mexican-Americans preferred therapy more than Whites. White group participants reported higher educational levels when compared to Mexican-Americans; thus, this may have been a factor when the results suggested this population was less likely to seek help (Furnham & Wardley, 1990).

CBT was rated higher than the psychodynamic theory condition (Organista et al., 1994; Perez, 1999); thus, CBT was viewed to be more effective and reasonable. When given a choice to address another person's symptoms, Mexican-Americans and Whites chose CBT over PT. When participants were asked to choose between the two treatment modalities if they were personally struggling with depressive symptoms similar to the ones described in the vignette, Mexican-Americans and Whites chose CBT over PT. This was an interesting finding, as this connects back to the notion of the importance of allowing people to choose their treatment and be more actively involved.

Conclusions about Ethnicity

The Mexican-American population met criteria for experiencing clinically significant levels of distress at a higher percentage (50%) than the White population (32%). Mexican-Americans had slightly higher scores in the ATSPPSH, which measured their perceived likelihood of seeking professional psychological help. This might explain our result that distress level is related to people's attitudes toward seeking help, more specifically that people with higher levels of distress were more likely to seek help, as was the case with the Mexican-American group. Thus, Mexican-Americans were as likely to perceive the need to seek professional psychological help as Whites. Both Mexican-Americans and Whites rated CBT higher than PT. Additionally, Mexican-Americans rated therapy in general higher than Whites, showing a significant preference for therapy, regardless of the treatment type. Ethnicity and treatment type were significantly related; Mexican-Americans and Whites chose CBT over PT. Interestingly, looking at the percentages, there was a trend whereby Whites chose CBT (68%) over PT (33%) and Mexican-Americans chose CBT (53%) over PT (47%). Therefore, it was evident that there was a larger gap in preference percentages between CBT and PT for the White group than for the Mexican-American group. In conclusion, we emphasize the importance of reaching out to people in non-traditional settings, providing services in people's native language, allowing individuals to choose their treatment if possible, and helping people access mental health services.

Limitations and Strengths

One of the limitations of this study was that Mexican-Americans from different generations and acculturation levels were combined into one group, which may have influenced the results. Additionally, a gender bias might have affected our findings because we assigned a gender (female) in the vignette and the treatment descriptions and the researcher and research assistants were all females. Some of the strengths of this study were that we were able to reach out to the general community and compare it to more traditional samples. We were able to conduct the study in Spanish and English and give participants a choice. Important implications that surfaced for mental health services were that many people in this study reported having significant levels of distress, and as mentioned previously, the longer people wait to obtain adequate treatment, the worse their prognosis will be (Organista et al., 1994).

Future Research

It would be worthwhile to conduct studies on the differences between different generations and acculturation levels of the Mexican-American population and determine whether these factors should be taken into account. Participants in this study were given two treatment options; thus, treatment choice was context dependent. Utilizing non-traditional treatment choices may be important to include in future studies. Future research should focus on continuing to make efforts to include people of different ethnic backgrounds and in different community settings. It is also important to continue educating the general public in their language and in culturally appropriate ways regarding mental health conditions and treatments available.

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APPENDIX A

ATSPPHS

Directions: Please circle the number of the choice that best expresses your level of agreement with each statement. For example, if you strongly agree with the first statement, you would circle number 3.

1. Although there are clinics for people with mental troubles, I would not have much faith in them.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
2. If a good friend asked my advice about a mental problem I might recommend that he or she see a psychologist.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
3. I would feel uneasy going to a psychologist because of what some people would think.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
4. A person with a strong character can get over psychological conflicts by him- or her- self, and would have little need of a psychologist.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
5. There are times when I have felt completely lost, and would have welcomed professional advice for a personal or emotional problem.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.
0 1 2 3
Strongly Disagree Disagree Agree Strongly Agree

8. I would rather live with certain mental conflicts than to go through the ordeal of getting psychotherapy treatment.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
9. Emotional difficulties, like many things, tend to work out by themselves.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
10. There are certain problems which should not be discussed outside of one's immediate family.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
11. A person with a serious emotional disturbance would probably feel most secure in a good psychological treatment.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
14. Having been a therapy client is a blot on a person's life.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
16. A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree

17. I resent a person—professionally trained or not—who wants to know about my personal difficulties.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
18. I would want to get psychological attention if I was worried or upset for a long period of time.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional difficulties.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
20. Having been psychologically ill carries with it a burden of shame.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
21. There are experiences in my life I would not discuss with anyone.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
22. It is probably best not to know everything about oneself.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
24. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without reporting to professional help.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
25. At some future time I might want to have psychotherapy.
0	1	2	3
Strongly Disagree	Disagree	Agree	Strongly Agree
26. A person should work out his/her own problems; getting psychotherapy would be a last resort.
0	1	2	3

	Strongly Disagree	Disagree	Agree	Strongly Agree
27.	Had I received psychotherapy, I would not feel that it ought to be covered up.			
	0	1	2	3
	Strongly Disagree	Disagree	Agree	Strongly Agree
28.	If I thought I needed psychological help, I would get it no matter who knew about it.			
	0	1	2	3
	Strongly Disagree	Disagree	Agree	Strongly Agree
29.	It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.			
	0	1	2	3
	Strongly Disagree	Disagree	Agree	Strongly Agree

APPENDIX B

ATSPPHS-List of Modified Items

2. If a good friend asked my advice about a mental problem I might recommend that he or she see a psychologist.
3. I would feel uneasy going to a psychologist because of what some people would think.
4. A person with a strong character can get over psychological conflicts by him- or her- self, and would have little need of a psychologist.
8. I would rather live with certain mental conflicts than to go through the ordeal of getting psychotherapy treatment.
11. A person with a serious emotional disturbance would probably feel most secure in a good psychological treatment.
14. Having been a therapy client is a blot on a person's life.
16. A person with an emotional problem is not likely to solve it alone; he/she is likely to solve it with professional help.
18. I would want to get psychological attention if I was worried or upset for a long period of time.
20. Having been psychologically ill carries with it a burden of shame.
24. There is something admirable in the attitude of a person who is willing to cope with his/her conflicts and fears without reporting to professional help.
25. At some future time I might want to have psychotherapy.
26. A person should work out his/her own problems; getting psychotherapy would be a last resort.
27. Had I received psychotherapy, I would not feel that it ought to be covered up.
28. If I thought I needed psychological help, I would get it no matter who knew about it.

APPENDIX C

ISEL

This scale is made up of a list of statements each of which may or may not be true about you. For each statement check “definitely true” if you are sure it is true about you and “probably true” if you think it is true but are not absolutely certain. Similarly, you should check “definitely false” if you are sure the statement is false and “probably false” if you think it is false but are not absolutely certain.

1. There are several people that I trust to help solve my problems.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
2. If I needed help fixing an appliance or repairing my car, there is someone who would help me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
3. Most of my friends are more interesting than I am.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
4. There is someone who takes pride in my accomplishments.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
5. When I feel lonely, there are several people I can talk to.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
6. There is no one that I feel comfortable to talking about intimate personal problems.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
7. I often meet or talk with family or friends.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
8. Most people I know think highly of me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)

9. If I needed a ride to the airport very early in the morning, I would have a hard time finding someone to take me.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

10. I feel like I'm not always included by my circle of friends.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

11. There really is no one who can give me an objective view of how I'm handling my problems.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

12. There are several different people I enjoy spending time with.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

13. I think that my friends feel that I'm not very good at helping them solve their problems.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

14. If I were sick and needed someone (friend, family member, or acquaintance) to take me to the doctor, I would have trouble finding someone.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

15. If I wanted to go on a trip for a day (e.g., to the mountains, beach, or country), I would have a hard time finding someone to go with me.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

16. If I needed a place to stay for a week because of an emergency (for example, water or electricity out in my apartment or house), I could easily find someone who would put me up.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

17. I feel that there is no one I can share my most private worries and fears with.

____ definitely true (3) ____ definitely false (0)

____ probably true (2) ____ probably false (1)

18. If I were sick, I could easily find someone to help me with my daily chores.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
19. There is someone I can turn to for advice about handling problems with my family.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
20. I am as good at doing things as most other people are.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
21. If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
22. When I need suggestions on how to deal with a personal problem, I know someone I can turn to.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
23. If I needed an emergency loan of \$100, there is someone (friend, relative, or acquaintance) I could get it from.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
24. In general, people do not have much confidence in me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
25. Most people I know do not enjoy the same things that I do.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
26. There is someone I could turn to for advice about making career plans or changing my job.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
27. I don't often get invited to do things with others.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)

28. Most of my friends are more successful at making changes in their lives than I am.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
29. If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
30. There really is no one I can trust to give me good financial advice.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
31. If I wanted to have lunch with someone, I could easily find someone to join me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
32. I am more satisfied with my life than most people are with theirs.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
33. If I was stranded 10 miles from home, there is someone I could call who would come and get me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
34. No one I know would throw a birthday party for me.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
35. It would be difficult to find someone who would lend me their car for a few hours.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
36. If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)
37. I am closer to my friends than most other people are to theirs.
____ definitely true (3) ____ definitely false (0)
____ probably true (2) ____ probably false (1)

38. There is at least one person I know whose advice I really trust.

_____ definitely true (3) _____ definitely false (0)

_____ probably true (2) _____ probably false (1)

39. If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.

_____ definitely true (3) _____ definitely false (0)

_____ probably true (2) _____ probably false (1)

40. I have a hard time keeping pace with my friends.

_____ definitely true (3) _____ definitely false (0)

_____ probably true (2) _____ probably false (1)

APPENDIX D

Vignette

Melissa is a 22-year old college student. She has decided to seek professional help because she has been feeling sad. She has been feeling sad for about 3 weeks, but because she thought the sadness would go away on its own, she did not seek the help of others. Currently, she thinks she cannot improve and perform to her own standards until she gets professional help. Melissa enjoyed playing soccer, horseback riding, bike riding, and painting, but now she does not practice any of these activities. Melissa has problems sleeping at night; sometimes she only gets 2 hours of sleep. She reports feeling tired to the point that she has missed classes at school for one week, which may lead to poor academic performance and threat of failing her classes. Melissa has called in sick to her part-time job at a restaurant various times, which could lead her to lose her job. Melissa also feels that she is worthless and that the world would be fine without her. Melissa does not drink or use drugs. Melissa has not lost anyone close to her and she cannot think of any major events that led her to her sadness, such as a death in her family.

APPENDIX E

CBT Description

Dr. Robertson begins by getting to know Melissa and inquires about why she has decided to come to therapy. Dr. Robertson tells Melissa that during therapy she will teach her strategies and new skills that will help her manage the difficult situations she is encountering. The therapist helps Melissa develop a schedule of activities that Melissa would like to participate in. She encourages Melissa to keep a diary of what happens throughout the day for at least 2 weeks, for example, upsetting events, feelings, thoughts, and behaviors. By maintaining a record of what she is doing as well as not doing, the therapist and Melissa will work together during therapy to help her have a better understanding of her difficulties and the events that are contributing to her symptoms and thus help her achieve her goals. As Melissa learns how to manage her symptoms, her feelings of sadness will diminish. The therapist asks Melissa about her job. The therapist encourages Melissa to keep her job and discusses with her the consequences of losing her job. Dr. Robertson wants to focus on Melissa's thoughts and her behaviors. Dr. Robertson wants Melissa to focus on her negative thoughts and help her replace them with positive and accurate thoughts. The therapist considers role-playing to practice her new skills, as this would give Melissa additional strategies to use when her symptoms arise. During role-playing, the therapist and Melissa will act out different roles and think of ways in which she can respond to difficult situations.

APPENDIX F

PT Description

Dr. Sullivan begins by getting to know Melissa and inquires about why she has decided to come to therapy. She explains to Melissa that we all have an unconscious mind that we are not always aware of what is making us experience certain feelings. The therapist then asks Melissa about her childhood experiences as these may inform her why her symptoms have come about. In particular, the therapist focuses on Melissa's relationships with her parents and how these relationships affect how she gets along with other people. The therapist is very interested in knowing about Melissa's previous life events. Dr. Sullivan suggests that her feelings of sadness and of unworthiness may have originated from events that occurred when she was only a little girl. Specifically, the therapist tells her that her current problems, for example having feelings of worthlessness and feelings of sadness, are due to her problems with her mother and father. She suggests that Melissa is keeping these feelings in her unconscious mind, which make them more painful because she is not aware of them. The therapist believes that since Melissa is trying to guard herself from these feelings because they are causing her emotional problems, Melissa needs help interpreting and understanding them. Once she has become aware of what is occurring in her mind she will be able to manage them and feel better.