EFFECTS OF VIDEO INTERVENTIONS ON PERCEPTIONS OF
MENTAL HEALTH STIGMA IN LATINO COLLEGE STUDENTS

A Thesis Presented to the Faculty
of
California State University, Stanislaus

In Partial Fulfillment
of the Requirements for the Degree
of Master of Science in Psychology

By
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August 2017
CERTIFICATION OF APPROVAL

EFFECTS OF VIDEO INTERVENTIONS ON PERCEPTIONS OF MENTAL HEALTH STIGMA IN LATINO COLLEGE STUDENTS

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Signed Certification of Approval page is on file with the University Library
DEDICATION

This thesis is dedicated to my parents, Rafael Ayala Villasenor and Mercedes Ayala Lopez, who have motivated and supported me during my entire academic career. I would like to also dedicate this to partner, Jose Alfredo Lugo Meza, who was there to push me and motivate me through this process. I love and appreciate you all very much.
ACKNOWLEDGEMENTS

I would like to acknowledge Dr. Kurt Baker, who has been there since the very beginning. His candor, experience, and humor made it easy to bounce ideas, thoughts and my randomness. Thank you for sticking by me and supporting me during this process. I would like to also thank my committee members Dr. Guichard and Dr. Luevano for your valuable time and feedback. I appreciate the dedication and expertise you bring to our department and university.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER I. Mental Health Stigma</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attribution Theory</td>
<td>4</td>
</tr>
<tr>
<td>Latino Issues</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER II. Stigma Interventions in General</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma Interventions Using Video</td>
<td>8</td>
</tr>
<tr>
<td>Video Interventions</td>
<td>10</td>
</tr>
<tr>
<td>Healthy Minds Public Service Announcement Intervention</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER III. Methods</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
<td>14</td>
</tr>
<tr>
<td>Materials</td>
<td>14</td>
</tr>
<tr>
<td>Procedure</td>
<td>16</td>
</tr>
<tr>
<td>Design</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHAPTER IV. Results</th>
<th>18</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CHAPTER V. Discussion</th>
<th>22</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>References</th>
<th>24</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Appendices</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Consent Form</td>
<td>31</td>
</tr>
<tr>
<td>B. Debriefing Form</td>
<td>32</td>
</tr>
<tr>
<td>C. Self-Stigma of Seeking Help (SSOSH)</td>
<td>33</td>
</tr>
</tbody>
</table>
D. Perception of Stigmatization by Others for Seeking Help (PSOSH) ........... 34
E. Modified Labeling Theory Approach of Mental Disorders ((MLTAMD).... 35
F. Demographic Form .......................................................................................... 36
<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Means and Standard Deviations for Scores of Measures</td>
<td>19</td>
</tr>
</tbody>
</table>
ABSTRACT

Mental health stigma affects a large number of people in the world today. However, video-based interventions have helped improve attitudes about those with mental illness. This study evaluated the effects of a one minute video and participants’ ethnicity on perceptions of mental health stigma. Contrary to what was hypothesized, the anti-stigma video had a negative influence on perceptions of mental health stigma for both Latino and Caucasian participants. A significant effect was found in the scores of measures for the experimental group versus the control group. We observed that people’s perceptions around mental health stigma and help seeking behavior were negatively influenced. Previous research has used 75 to 85 minute video interventions, further research is needed to see if the desired impact could be accomplished with videos longer than a minute, but shorter than 75 minutes. Limitations of this study for future anti-stigma interventions are also discussed.
CHAPTER I

MENTAL HEALTH STIGMA

Mental health stigma is a global phenomenon affecting many individuals today. Stigmatization carries strong assumptions about individuals, places and things. Although stigmatization is seen in cultures around the world, it can be observed openly directed toward individuals with mental illness. Determining how many people have mental illness can be difficult to gauge because an estimated one in four adults in the United States experience symptoms of mental illness in a given 12 month period (Federation of American Scientists, 2015). Stigmatization also impacts the family and other significant support persons of individuals’ with the mental illness due to stereotypes, prejudices, and discrimination. The effects of stigmatization are twofold for individuals with mental illness as a result of public stigma and self-stigma when the mental illness is perceived to be under the person’s control.

Interestingly, public stigma is demonstrated by individuals in the healthcare field and members of the general public, including those with mental illness and their family members. Public stigma occurs when a group of people perceives an individual as being socially unacceptable or unable to integrate well into society. Self-stigma occurs when an individual holds the perception that he or she is socially unacceptable, in this case, due to mental illness (Corrigan, 2004). Vogel concluded that public stigma is directly contributes to self-stigma (Vogel et al., 2007).

Modified Labeling Theory (MLT) is often used to explain self-stigma according to Vogel, et al. (2013). MLT has been used to explain the impact of stigma
on individuals with mental illness. According to the theory, negative external perceptions, such as public stigmatization, can have a harmful impact on the individuals’ perception of themselves (Vogel et al., 2013). In other words, public stigma is internalized by the individual (Vogel et al., 2007).

Public stigma manifests as stereotypes, which are negative beliefs about a group or individual which include, but are not limited to perceived incompetence, character weakness, and dangerousness. Individuals may manifest their prejudice or beliefs they hold true through emotional expressions of anger or fear (Angermeyer & Matschinger, 2003). Stereotypes and prejudice can then lead to discrimination, which is behavior towards the individual or group which manifests as refusing to give them work or refusing to accept them as renters or roommates (Rüsch, Angermeyer, & Corrigan, 2005). Discrimination can also be seen in the way of social distancing, which manifests as excluding the mentally ill from social circles and other social activities like participation in sports and clubs (Rüsch, Angermeyer, & Corrigan, 2005).

It can be difficult for an individual with mental illness to be a productive citizen in society as a result of stereotypes, prejudices, and discrimination he or she may face. Individuals must not only manage their symptoms, but also cope with the stigma linked to mental illness. There are several ways in which individuals with mental illness may be discriminated against. However, a prominent result of social distancing is that these individuals have a difficult time obtaining and maintaining a
job (Pinto, 2006). Furthermore, these individuals lack social support, which would also be a support in seeking mental health services. Stigmatization can become a major barrier to seeking psychological services which could lead to recovery (Pinto, 2006). The present study explored a potentially effective and efficient way of influencing mental health stigma and perceptions related to seeking mental health services.

A meta-analysis of 19 studies, involving 7,397 university students by Nam and Choi (2013), sought to identify the relationship between attitudes toward seeking professional psychological help and relevant psychological variables. The study analyzed a variety of factors including public stigma, self-stigma, anticipated benefits, anticipated risks, depression, psychological distress, self-concealment, self-disclosure, and social support. Nam and Choi (2013) categorized their results in terms of positive and negative relationships in attitudes towards seeking professional help. Anticipated benefits, self-disclosure, and social support showed a positive relationship with help-seeking attitudes for individuals living with mental illness. On the other hand, self-stigma, anticipated risks, self-concealment, and depression have a negative relationship with help seeking attitudes (Nam & Choi). While these individuals may benefit from psychological treatment, due the development of self-stigma, they may refrain from seeking mental health services. Furthermore, when clients do seek mental health services they are given a diagnosis, which is then converted into a label. The label then brings preconceived notions about the individual with this diagnosis (Angermeyer & Matschinger, 2003).
Attribution Theory

Attribution theory predicts that uncontrollable behaviors are less likely to be stigmatized than controllable behaviors (Boysen & Vogel, 2008). Corrigan’s (2000) found that schizophrenia was more “acceptable” when the mental illness was perceived as being caused by uncontrollable situations like an accident, as compared to controlled factors, such as drug use. This research suggests that in order to reduce the stigma of mental illness, it should be depicted as uncontrollable.

Angermeyer and Matschinger (2003), conducted a survey study involving 5,025 adults. The participants were given a vignette containing an unlabeled psychiatric case history. They were then asked to label the problem described in the vignette. In addition, participants were also asked to identify perceived attributes of the person in the vignette and their emotions towards the person it was describing. Researchers found that participants who labeled the individual as mentally ill, also perceived the individual as being dangerous. The perception of dangerousness was also linked to feelings of fear and anger towards the mentally ill. In addition, fear positively correlated with social distance. Social distance is defined as the level of closeness an individual would have with someone with a mental illness. Angermeyer and Matschinger (2003) utilized a modified version of the Bogardus Social Distance Scale to measure social distancing towards individuals with mental illness. The items measured factors such as renting a room, sharing a place of work, living in the same neighborhood, accepting them as a member of the same social circle, personal job collaboration, and marriage into one’s family. Holding such perceptions of individuals
with mental illnesses can create social distancing, and therefore, increase public stigma and self-stigma. Hence, it is important to seek interventions that target public stigma in such a way as to reduce self-stigma and increase help seeking attitudes in individuals, particularly in marginalized communities like Latinos. Being able to reduce stigma by giving individuals, particularly minorities, the patient role explained by attribution theory will allow the individual to seek help.

**Latino Issues**

According to the U.S. Census Bureau population estimates as of July 1, 2013, there were roughly 54 million Latinos living in the United States. Latinos make up approximately seventeen percent of the United States population, making them the nation’s largest race minority. It is estimated that by 2060, the Latino population will reach 128.8 million. It is important to take a closer look at this community, given its predicted population growth in the next few decades. In 2012, The California Department of Mental Health launched a statewide early intervention and preventive initiative for multiple groups of people, which included Latinos. The state funded initiative was implemented by the Center for Reducing Health Disparities (CRHD) at the University of California, Davis. According to the CRHD, individual-level barriers to seeking services include stigma associated with mental health problems, cultural barriers, masculinity, violence and trauma, and lack of knowledge and awareness about the mental health system (Aguilar-Gaxiola et al., 2012).

Racial and ethnic minorities like Latinos tend to underuse mental health services (Cheng, Sevig & Kwan, 2013). This is believed to be a result of compounded
factors, such as individuals’ relationships with their own ethnic group, with other
groups, and with society in general (Cheng, Sevig & Kwan, 2013). Looking at the
entire Latino population can be extremely complex and daunting. University students
are highly accessible for research and can be targeted conveniently to reduce stigma
and increase help-seeking attitudes. Additionally, Latino college students may be a
particularly important population is significant given that mental disorder
symptomatology typically starts to emerge between the ages of 15 to 24.

According to Cheng, Sevig and Kwan (2013), many college students underuse
professional psychological services for mental health difficulties, and stigma
associated with help seeking appears to be a major factor. Cheng et al. (2013)
included other minorities in their study, including African American and Asian
American college students. They found that the more racial and ethnic minority
students were concerned with stigmatization by others for seeking help, the more
likely they were to stigmatize themselves for seeking psychological help. This was
also true with racial and ethnic minorities’ perceived discrimination from others.
Higher ethnic identity predicted lower self-stigma associated with seeking
psychological help, but only for African American college students. This was not true
for Asian American and Latino American college students.
CHAPTER II

STIGMA INTERVENTIONS IN GENERAL

Various programs look at changing stigma on the basis of three processes: protest, education, and contact (Corrigan, 2004). Although there is additional research on a variety of interventions, we will not go into depth regarding these interventions to maintain clarity and focus in this study. However, we felt that these were important to highlight. Protest attempts to diminish negative attitudes about mental illness. The downside is that it usually does not promote positive attitudes towards those who are mental ill. Telling people what not to do, or “protest”, has shown to have a rebound effect, which means that people will react with negativity because they feel like they are being told what to do or think. The purpose of educational interventions is to provide information that will bring awareness to the public and help them make informed decisions regarding those with mental illness (Corrigan, 2004). According to Corrigan’s article, education has resulted in improved attitudes regarding individuals with mental illness. Corrigan’s claim is further validated by other studies that involved social interaction between the general public and individuals with mental illness.

Compeer is an example of a contact intervention to reduce mental health stigma (Bizup & Davidson, 2011). Compeer’s research has indicated that having personal contact with an individual with a mental illness can reduce mental health stigma in college students (Bizup & Davidson, 2011). Bizup and Davidson used this program as an adjunct intervention to therapy by facilitating the relationship between
one community member and individuals with a mental illness. In Bizup and Davidson’s research, the arrangement was made with college students (n = 5) who were instructed to spend time with a mentally ill individual out in the community for a minimum of 4 hours a month. The interaction proved to be effective in reducing mental health stigma and their concerns about people with mental illness. These stereotypes include dangerous, hopeless, unpredictable, and being constantly miserable. Other anti-stigma campaigns utilizing testimonials of mental health users have been shown to be effective in reducing stigma as well (Pinfold, 2005). Given the advancement of technology and the ways in which individuals communicate and share information online, it was important to explore the latest efforts in reducing stigma using these methods which include social media and video contact interventions.

**Stigma Interventions Using Video**

Yamaguchi et al. (2013) conducted a meta-analysis, which found that both social contact and video-based social contact interventions seemed to be the most effective at improving and reducing desire for social distance in college and university students. Yamaguchi and colleagues analyzed 35 studies which included 4,295 US and UK students. Studies included all types of brief interventions delivered in these colleges and universities which aimed to reduce mental health stigma. Brief interventions in this study were defined as three or fewer sessions. The study looked at five areas, or concepts, which included: knowledge about people with mental health problems; attitudes or contributions toward people with mental health
problems; social distance/behavioral intentions towards people with mental health problems; attitudes toward the use of services and help-seeking intentions; and actual behavior (discriminatory behavior and actual service use). The results were synthesized by intervention: social contact, video-based social contact, video-based education, an educational lecture, education-text, mainstream film, education-role play, and other interventions (Yamaguchi et al., 2013).

Eisenberg, Downs, and Golberstein (2012) found that isolating specific components related to contact with individuals with a mental illness would prove significant given the findings of their study. The study found that contact with someone with mental illness was not sufficient to obtain a significant reduction in mental health stigma and, therefore, confirms their belief that stigma has not decreased significantly in recent years despite more people seeking mental health services. Pinto (2016) found that social contact with those with mental illness was instrumental for those with mental illness to seek psychological help. The interventions utilized collaboratively may be more effective in reducing stigma.

Given the previous results, further exploration of social contact interventions via video and live interventions is needed. In a related article, Clement et al. (2012) showed improvement in pro-social reactions to people with mental illness following social contact via film or one-on-one contact with an individual with mental illness. In this study, student nurses were randomly assigned to watch a 75 to 80 minute DVD of mental health service users and/or caretakers for those who are mentally ill talking about their experiences. Another group of nurses watched a similar live presentation
and the other groups attended a lecture. Several measures were administered to measure attitudes, emotional reactions, intended proximity and knowledge about mental illness. Researchers found that the use of filmed social contact interventions reduced stigma about mental illness (Clement, et al., 2012). Hence, observing direct contact with those with mental illness on social media seems to be an effective way to reduce stigma of mental illness and negative attitudes towards seeking help in college and university level students.

Adjusting to college for a first year (freshman) student can be difficult, even more so when dealing with a mental illness. Britt et al. (2008) found that stigma and barriers to care were moderately related to depression, whereas stress was strongly related to depression when observing freshmen college students. Those students with higher levels of stress were likely to perceive stigma and barriers to seeking psychological treatment. Accessing psychological treatment for students, especially those with suicidal thoughts, would increase if stigma would decrease (Downs & Eisenberg, 2012). Cheng, Kwan, and Sevig (2013) found that the more concerned racial and ethnic minority college students were with stigmatization by others for seeking psychological help, the more likely they may be to stigmatize themselves for seeking psychological help. Also, students who were more open toward other cultures and felt more connected with people from other groups held less negative views towards themselves if they sought professional help.
Video Interventions

Recent studies have shown that an internet platform that could be accessible by smart phones is an effective medium for distributing content regarding mental health stigma (Reichert, 2012). An internet platform would make sense given increasing use of this media by college students, personalization, social proliferation, inexpensiveness and efficiency (Morgan et al., 2011). It can be implied that this medium will support, reach, and influence college student behavior for seeking psychological treatment. This is consistent with related research related to media influence based on media portrayals of psychologists, those who seek therapy, and mental illness (Maier, Gentile, Vogel & Kaplan, 2013). Providing a specific population with more accurate and factual information about mental health may also influence perceptions in such a way as to decrease mental health stigma. Aguilar-Gaxiola et al. (2012) recommended that community and social media be used as an intervention to decrease stigma among the Latino community. The media should raise awareness of mental health illness with messages that reduce stigma and promote information and resources about early intervention.

Programs like the National Alliance for Mental Illness utilize video interventions in addition to one-on-one contact, education, and live presentations to reduce stigma and increase help seeking behaviors. However, video interventions in particular, have been shown to be efficient and effective in imparting this information. An example of a campaign utilizing video interventions is Healthy Minds Canada. Healthy Minds Canada (HMC) is a national charity that seeks to support mental
health research and raise awareness about mental health and addictions. HMC reaches thousands of people through the use of workshops, symposiums, print, and online resources. Furthermore, HMC reaches over five thousand people through its Facebook page specifically. I explored whether a one minute video that targets mental health stigma would have the same effect that a DVD that aims to reduce mental health stigma would have.

Healthy Minds Public Service Announcement Intervention

The goal of the present study was to add to the body of research showing that social contact interventions using can be effective at reducing mental health stigma. Given the impact of stigma on individuals with a mental health diagnosis, it is important to reduce stigma and welcome these individuals, particularly minorities like Latinos, into our communities. According to The National Institute of Mental Health (NIMH), the total associated costs of serious mental illness is in excess of $300 billion per year. There is a need for interventions to reduce mental stigma that are effective, practical, and cost efficient. Clement et al. (2012) found that filmed social contact interventions to reduce stigma are effective, practical, and cost efficient. The present study looked at replicating video interventions aimed at reducing mental health stigma in the college student population with a California Central Valley population. The video intervention was one minute long compared to a DVD with a longer duration, but may have the same effect. The video was used as an intervention in hopes that it would change attitudes about willingness to seek mental health services, particularly among Latino students.
Reichert (2012) reviewed a collection of demographic considerations in multiple studies and found that non-white individuals have significantly lower help seeking and detection rates than white non-Hispanic individuals. Racial and ethnic minority students who have high levels of psychological distress also had higher levels of perceived stigmatization by others and themselves related to seeking psychological help (Cheng, Kwan & Sevig, 2013).

The increase in mental health stigma research builds on the findings related to effective and efficient anti-stigma interventions. The first hypothesis of this study was that participants shown the anti-stigma video would have more positive perceptions related to seeking help for mental illness, as compared to the perceptions of those in the control group. Participants shown the anti-stigma video would have more positive perceptions about individuals with mental illness, as compared to those in the control group when measured for stigmatization. The third hypothesis was that Latino participants shown the anti-stigma video would have more negative perceptions of stigmatization and help seeking for mental illness, as compared to Caucasian participants.
CHAPTER III

METHODS

Participants

A G*Power was used to conduct a power analysis. Data was collected from a total of 128 participants. Critical F = 3.91632, 128 participants is the power given when set at (.80). Only 106 participants remained when filtered by ethnicity, 85 Latinos and 21 Caucasians. Participants were undergraduate male and female students from California State University, Stanislaus. These participants were 18 years old and older. The ethnicities of special interest in this study are Caucasian and Latino due to previous research and demographic predictions on these two groups. Other ethnicities were included for observations around other minority groups, but their participation was not significant given the demographic of this sample. Participants were recruited through SONA, an online participant management system, and each received one experimental credit for their participation.

Materials

Three measures were utilized, the Self-Stigma of Seeking Help (SSOSH) scale (Vogel, Wade, & Haake, 2006), Perception of Stigmatization by Others for Seeking Help (Vogel, Wade, & Ascheman, 2009), and A Modified Labeling Theory Approach to Mental Disorders (MLT AMD) Empirical Assessment (Link et al., 1989). Self-Stigma of Seeking Help (see Appendix C) is a 10-item self-report scale that evaluates ones’ willingness to seek psychological help. The items are rated on a Likert-type scale, with 1 meaning strongly disagree and 5 meaning strongly agree. A
sample item is “I would feel inadequate if I went to a therapist for psychological help.” The purpose of the scale is to predict attitudes and willingness to seek counseling. The scale’s reliability is .86 to .90; test-retest, .72 and validity was tested among a college sample in the development of the scale (PSOSH; Vogel, Wade, & Ascheman, 2009).

Perceptions of Stigmatization by Others for Seeking Help (PSOSH) scale is a 5 item self-report measure (see Appendix D). The scale seeks to explore perceptions of the public around seeking counseling services. The items are rated on a Likert-type scale, 1 meaning strongly disagree and 5 meaning strongly agree. The following instructions are given to the participant: “Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would react negatively to you or think bad things of you?” Validity was supported by moderate associations between public stigma towards counseling, public stigma toward mental illness and self-stigma calculated (.78) and test-retest of (.82) among 5 samples. Items 1-5 were added to obtain a total score.

A Modified Labeling Theory Approach to Mental Disorders (MLTAMD) Empirical Assessment (see Appendix E) was modified for this study for the basis of measuring the participant’s beliefs about people with mental illness vs internalizing how they would feel if they had a mental illness. The modified measure has 12 items, with a Likert-type scale ranging from 1 strongly agree to 6 strongly disagree. Items 1 through 12 were summed, after reversing items 1, 3, 4, 6, 7, 9, 11, and 12 to obtain
the final score. Sample items include “I would willingly accept a former mental patient as a close friend” or “I believe that a person who has been in a mental hospital is just as intelligent as the average person.” This measure sought to capture devaluation and discrimination about those with mental illness (Link et al., 1989).

Participants were given a demographic questionnaire to assess age, sex, ethnic and/or racial group, the level of education, socioeconomic background, and gender identity (see Appendix F).

The one minute public service announcement titled “Healthy Minds Anti Stigma Video” was obtained from Healthy Minds, Canada. The public service announcement (PSA) video is part of a larger anti-stigma media campaign that was produced back in the late 1990’s when Healthy Minds Canada used to be the Canadian Psychiatric Research Foundation. The video shows a man dressed in business attire being hit by a car as he is crossing the street. People gather to observe the victim and verbalize the following: “He is okay.” “He’s not even bleeding,” “He is just being lazy,” and “He just wants attention.” The video concludes with a message saying “Imagine if we treated everyone like we treat the mentally ill.” This video had not been studied independently in changing perception about mental health stigma and seeking mental health services. The control group, on the other hand, viewed a one minute educational video on how to remove the stone from an avocado to maintain a level of consistency in the length of the video and educational piece.

**Procedure**
Participants were directed, from SONA to Qualtrics to complete the online study. Qualtrics is an online survey platform used to collect data for research. Participants were asked to read and electronically sign the informed consent. Qualtrics randomized the video presented to the participants -- some viewed the public service announcement titled “Healthy Minds Anti Stigma Video” with a duration of one minute and the other viewed an educational related video with the same duration. Following the video, the participants were asked to complete a mental health stigma perceptions measure, a help seeking attitude questionnaire, and a devaluation-discrimination questionnaire. Once the measures were completed, the participants were given a debriefing form with the researcher's contact information. Participants were thanked for their participation and received research credit through SONA.

**Design**

Measures were scored and entered in SPSS version 23. A factorial analysis of variance (ANOVA) was conducted for this study. A factorial ANOVA compares the mean differences between groups that have been split on two or more independent variables. We seek to understand the interaction between anti-stigma or educational video and ethnicity on perceptions of mental health stigma. Anti-stigma and nature videos and ethnicity were the independent variables and perceptions of mental health stigma were the dependent variables. Therefore, a 2 (type of video) by 2 (ethnicity) factorial ANOVA will be used to test hypothesis.
CHAPTER IV

RESULTS

This study evaluated the effects of a one minute video and ethnicity on perceptions of mental health stigma. Participants were given three measures, Perception of Stigmatization by Others for Seeking Help (PSOSH), Self-Stigma of Seeking Help (SSOSH), and Modified Labeling Theory Approach to Mental Disorders (MLTAMD). Table 1 presents means and standard deviations for these measures broken down by predictor variables. A factorial Analysis of Variance (ANOVA) was conducted to test significance between video type and ethnicity on perceptions of mental health stigma.
### Table 1

Means and Standard Deviations for Scores of Measures

<table>
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<tr>
<th>Video Type</th>
<th>Healthy Minds</th>
<th>Avocado</th>
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<tr>
<td><strong>SSOSH M(SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>2.69 (.635)</td>
<td>2.38 (.645)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2.66 (.750)</td>
<td>2.17 (.574)</td>
</tr>
<tr>
<td>Total</td>
<td>2.68 (.655)</td>
<td>2.34 (.634)</td>
</tr>
<tr>
<td><strong>PSOSH M(SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>2.0 (.865)</td>
<td>1.57 (.640)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>2.183 (.674)</td>
<td>1.51 (.708)</td>
</tr>
<tr>
<td>Total</td>
<td>2.045 (.823)</td>
<td>1.56 (.644)</td>
</tr>
<tr>
<td><strong>MLTAMD M(SD)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>3.03 (.569)</td>
<td>3.1 (.700)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>3.08 (.612)</td>
<td>2.94 (.629)</td>
</tr>
<tr>
<td>Total</td>
<td>3.04 (.573)</td>
<td>3.07 (.685)</td>
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Note: SOSH = Self-Stigma of Seeking Help; PSOSH = Perceptions of Stigmatization by Others for Seeking Help; MLTAMD = Modified Labeling Theory Approach to Mental Disorders
The analysis indicated there was no significant interaction between video type and ethnicity on scores on any of the measures, SSOSH $F(1, 105) = 0.318, p = 0.574$, PSOSH $F(1,106) = 0.419, p = 0.519$, and MLTAMD $F(1,105) = 0.187, p = 0.499$. However, there was a significant main effect for video type on scores for SSOSH $F(1,105) = 6.36, p = 0.013$ and PSOSH $F(1,106) = 9.21, p = 0.003)$. There was no significant effect for ethnicity on the scores of SSOSH $F(1,105) = 0.60, p = 0.44$ and PSOSH $F(1,106) = 0.11, p = 0.74$, and MLTAMD $F(1,105) = 0.12, p = 0.725$. The findings also indicated there was no significant difference between those who watched the healthy minds video and the avocado video on mental health perceptions of those with mental health disorders MLTAMD $F(1,105) = 0.050, p = 0.823$. These results suggest that participants reported higher levels of stigmatization of others for seeking help and perceptions of stigma after watching the healthy minds video compared to those who viewed the avocado video.
CHAPTER V
DISCUSSION

Contrary to what was hypothesized, the anti-stigma video did not positively influence perceptions of mental health stigma when observing Latino and Caucasian participants. However, the results show that the anti-stigma video affected responses on the measures when compared to the control video. Interestingly, we found that the participants who viewed the anti-stigma video reported higher levels of mental health stigma about themselves and others compared to the control group. Rather than reducing stigma, it appears the exposure to the video heightened their self-awareness of mental health stigma. It can be argued that rather than using this video as an intervention to reduce stigma it can be used to bring awareness about self-stigma and stigma about those with a mental illness.

This study sought to explore the effectiveness of a short video intervention in influencing negative perceptions related to stigma and influencing perceptions around seeking psychological help. However, a one-minute video was not effective. Clement et al. (2012) utilized a 75 to 85 minute DVD that had two main parts which included personal narratives about mental health and stigma presented by those caring for a person with mental illness. In Clement’s 2012 study, participants who saw videoed social contact interventions reduced their ratings of stigma of mental illness. Yamaguchi’s (2013) meta-analysis found that social contact and video-based social contact interventions helped improve attitudes about those with mental health issues and reduced social distance. Social contact in this study was defined as any
interaction between people with mental health problems and participants. Video-based social contact was defined as media showing people (actors/actresses) with mental health problems talking about their own experiences of mental illness. Yamaguchi described that the effective ways in which video-based social contact reduced stigmatization were by describing a normal life which included successful life events despite their mental illness. This meta-analysis did not describe the length of the video but rather described the content of the videos. In the current study the Healthy Minds video asked participants to think about the way they treat those with mental illness, rather than describing the life events and success of those with a mental illness.

The results of this current study were influenced by several limitations. There were more Latino \( n = 85 \) participants than Caucasian participants \( n = 21 \). The number of participants proposed by the G*Power fell to 106 when we excluded participants that were African American, Asian Pacific Islanders and other ethnicities. The ratio of Latino to Caucasian participants is important when generalizing the results to any of the two ethnicities, especially with this sample size. When any particular group is not substantially represented, the interpretations can be skewed. Furthermore, the Healthy Minds public service announcement had not been used or tested as a single intervention in reducing mental health stigma. The Healthy Minds service announcement was part of a major campaign to reduce mental health stigma in Canada. This study assumed it could be utilized as an intervention by itself. The video was significant in influencing the scores in the measure but did not influence
what was hypothesized. In addition, those videos had substantial content related to the experience of those with mental health and those living with someone with mental illness. Further investigation can be made to see if a short video of more than one minute, but less than 75 minutes can have similar results as the 75 to 85 minute video when targeting college student populations.

This study sought to further research related to perceptions of mental health stigma with the use of a video intervention. Although the intervention did not prove to be successful in confirming our hypothesis, conclusions were made as a result. A one minute video, in this case, was not sufficient influencing perceptions of mental health stigma. However, it did make people more aware of mental health stigma. Student government and administrators must leverage how students will receive this information and how it is digested because not all students have exposure to this material outside a psychology course or personal experience with someone with mental illness. Based on the results of this study, it is important that the intervention utilized be tested before it is given to a larger population because this can be a risk; the risk being the increased awareness of mental health stigma in participants. Although longer videos with more substantial content humanizing the individuals with mental illness work, Healthy Minds was not able to portray that.
REFERENCES
REFERENCES


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APPENDICES
APPENDIX A

CONSENT FORM

This research study will examine factors that are related to perceptions of mental health stigma and help seeking behavior among college students. If you agree to participate, you will be asked to answer survey questions that ask about your perceptions about mental health and help seeking attitudes.

You are free to discontinue your participation at any time without penalty. You may also skip any survey questions that make you feel uncomfortable. Even if you withdraw from the study, you will receive any entitlements that have been promised to you in exchange for your participation, such as extra credit.

Participation in this research study does not guarantee any benefits to you. However, possible benefits include the fact that you may learn something about how research studies are conducted and you may learn something about this area of research (i.e., factors that are related to mental health stigma and help seeking behavior).

You will be given additional information about the study after your participation is complete.

If you agree to participate in the study, it will take about 10 minutes to complete the survey.

All data from this study will be kept from inappropriate disclosure and will be accessible only to the researcher and their faculty advisor. The researcher is not interested in anyone’s individual responses, only the average responses of everyone in the study.

The present research is designed to reduce the possibility of any negative experiences as a result of participation. Risks to participants are kept to a minimum. However, if your participation in this study causes you any concerns, anxiety, or distress, please contact the Student Counseling Center at (209) 667-3381 to make an appointment to discuss your concerns.

This research study is being conducted by Rafael Ayala Lopez. The faculty supervisor is Dr. Kurt Baker, Professor, Department of Psychology, California State University, Stanislaus.

You may obtain information about the outcome of the study at the end of the academic year by contacting Dr. Baker at (209) 664-6681 or kbaker@csustan.edu.

If you have any questions about your rights as a research participant, you may contact the Chair of the Psychology Internal Review Board of California State University Stanislaus, Dr. Kelly Cotter, at kcotter@csustan.edu.

You will be provided with a blank, unsigned copy of this consent form at the beginning of the study.

By signing below, you attest that you are 18 years old or older.

By signing below, you are indicating that you have freely consented to participate in this research study.

PARTICIPANT’S SIGNATURE:        DATE:
APPENDIX B

DEBRIEFING FORM

Thank you for participating in this study! We are interested in understanding the relationship between anti-stigma video intervention and a cooking video on reducing mental health stigma and increase help seeking behaviors.

Prior research suggests that short video interventions are effective and efficient in reducing stigma more effectively over lecture and one-on-one contact. Furthermore, reduction in stigma may also increase help seeking attitudes for psychological services.

We expect to find similar results in our study. In addition, we want to investigate whether there is a relationship between mental health stigma and helping seeking behavior differences between Caucasian students and Latino Students. We predict that Latino students will have higher mental health stigma and fewer favorable attitudes towards help seeking for psychological disorders.

The data gathered in this study will be collected anonymously. The only identifying information provided will be the student ID through SONA to give them extra credit. The student ID will not be associated with their responses. We are not interested in anyone’s individual responses; rather, we want to look at the general patterns that emerge when all of the participants’ responses are put together. We ask that you do not discuss the nature of the study with others who may later participate in it, as this could affect the validity of our research conclusions.

If you have any questions about the study or would like to learn about the results of the study, you may contact me, Rafael Ayala Lopez at rayalalopez@csustan.edu or Dr. Kurt Baker at kbaker@csustan.edu or (209) 664-6681. If you have any questions about your rights as a research participant, you may contact the Chair of the Psychology Internal Review Board of California State University Stanislaus, Dr. Kelly Cotter, at kcotter@csustan.edu. If participation in the study caused you any concern, anxiety, or distress, you may contact the Student Counseling Center at (209) 667-3381.

If you would like to learn more about this research topic, we suggest the following references:


APPENDIX C

SELF-STIGMA OF SEEKING HELP (SSOSH)

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree     2 = Disagree     3 = Agree & Disagree Equally     4 = Agree
5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored
APPENDIX D

PERCEPTION OF STIGMATIZATION BY OTHERS FOR SEEKING HELP

(PSOSH)

INSTRUCTIONS: Imagine you had an emotional or personal issue that you could not solve on your own. If you sought counseling services for this issue, to what degree do you believe that the people you interact with would ______.

1 = Not at all   2 = A little   3 = Some   4 = A lot   5 = A great deal

1. React negatively to you
2. Think bad things of you
3. See you as seriously disturbed
4. Think of you in a less favorable way
5. Think you posed a risk to others

Scoring: add items 1-5.
APPENDIX E

A MODIFIED LABELING THEORY APPROACH OF MENTAL DISORDERS

(MLTAMD)

Agree= 1 to strongly disagree= 6

1. I would willingly accept a former mental patient as a close friend.
2. I believe that a person who has been in a mental hospital is just as intelligent as the average person.
3. I believe that a former mental patient is just as trustworthy as the average citizen.
4. I would accept a fully recovered former mental patient as a teacher of young children in a public school.
5. I think that entering a mental hospital is a sign of personal failure.
6. I would not hire a former mental patient to take care of my children, even if he or she had been well for some time.
7. I think less of a person who has been in a mental hospital.
8. I will hire a former mental patient if he or she is qualified for the job.
9. I will pass over the application of a former mental patient in favor of another applicant.
10. I think my community would treat a former mental patient just as they would treat anyone.
11. I think young women would be reluctant to date a man who has been hospitalized for a serious mental disorder.
12. I think that once a person has been in a mental hospital, most people will take his or her opinions less seriously.
APPENDIX F

DEMOGRAPHIC FORM

1. What is your age?
2. What is your sex?
   a. Male
   b. Female
3. What is your ethnicity?
   a. Caucasian
   b. Latino/Hispanic
   c. African American
   d. Asian/Pacific Islander
   e. Other
4. What is your year in school?
   a. Freshman
   b. Sophomore
   c. Junior
   d. Senior
   e. First Graduate Student
   f. Second Year Graduate Student
   g. Third Year Graduate Student
   h. Other
5. Have you ever been in psychotherapy?
   a. Yes
   b. No
6. Socioeconomic status
   a. Low
   b. Middle
   C. High