PUBLIC ATTITUDES TOWARD THERAPY FRAMED BY COMMON FACTORS AND SPECIFIC INGREDIENTS

By

LAWTON K. SWAN

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Psychotherapy scholars have devoted considerable attention to resolving the question of how psychotherapy works: do specific psychological interventions target distinct psychopathologies, or do the nonspecific factors common to all forms of therapy—such as a compassionate therapist and a cogent rationale for treatment—account for successful treatment outcomes? Despite decades of psychotherapy process and outcome research, a clear answer has yet to emerge from the empirical data. Among psychotherapy consumers, however, recent evidence suggests a marked preference for common factors relative to specific interventions (“ingredients”). The present studies tested the notion that the public preference for therapy framed by common factors stems in part from the belief that the alternative, therapy which focuses on treating pathology (specific ingredients), carries a relatively higher risk of social stigmatization. Participants recruited from Amazon’s Mechanical Turk™ service \(N = 98\); Study 1) and SocialSci.com \(N = 375\); Study 2) each rated their attitudes toward seeking two varieties of psychotherapy: one emphasizing nonspecific common factors, and one emphasizing specific evidence-based therapy ingredients. Consistent with prior research, analyses revealed an overall preference for therapy framed by common
factors. Differences in participants’ perceptions of stigmatization by others for seeking each type of therapy partially mediated this effect, supporting the specific ingredients stigma model articulated in Chapter 1. Exploratory analyses revealed that therapy preferences depended on whether participants considered treatment for themselves or for another person, and on the type of psychological problem participants anticipated experiencing. Implications for research and for campaigns attempting to improve public attitudes toward psychotherapy are discussed.
CHAPTER 1
INTRODUCTION

In their widely cited 2006 report on the nature and objectives of evidence-based practice in psychology, the American Psychological Association’s Presidential Task Force deliberately underscored the importance of attending to clients’ preferences when rendering therapeutic services. Although similar calls appeared in the psychological literature more than 40 years ago (e.g., Rosen, 1967), the empirical study of client preferences, defined as the behaviors or attributes of a therapist or therapy that clients desire (Glass, Arnkoff, & Shapiro, 2001), has burgeoned only recently. Consistent with early suspicions and the Task Force’s proposal, researchers have found that individuals assigned to psychotherapy congruent with their preferences—whether for a particular type of therapist, treatment modality, or the role clients are expected to play in session—show lower rates of attrition and greater post-treatment gains than their non-matched counterparts (Swift & Callahan, 2009; see also Swift, Callahan, & Volmer, 2011 for a comprehensive review). Preferences likely exert their influence on treatment outcomes in conjunction with expectations (e.g., Greers & Rose, 2011), a related but conceptually distinct construct (Tracey & Dundon, 1998) describing the features of a therapist or therapy that clients anticipate (Glass et al., 2001).

Recently, Swift and Callahan (2010) nominated a new and potentially important preference dimension for study: the relative emphases practitioners place on empirically-supported interventions versus nonspecific common factors in therapy. This dimension mirrors a theoretical divide among scholars concerning the role of theoretically-derived, specific techniques (e.g., systematically challenging the maladaptive thought patterns associated with depression) in effective psychotherapy.
(Wampold, 2001). Many regard these specific techniques as the active “ingredients” therapy requires to produce change. Therapy guided by this perspective, often deemed the “medical model” (Elkins, 2009; Wampold, Ahn, & Coleman, 2001), proceeds by first classifying a client’s problem (diagnosis), and subsequently delivering empirically-supported “psychological procedures targeted at the psychopathology at hand” (Barlow, 2004, p. 873; see also Baker, McFall, & Shoham, 2009; Chambless & Ollendick, 2001; Hunsley & Di Giulio, 2002). On the other hand, common factors theory (e.g., Frank & Frank, 1991; Hubble, Duncan, & Miller, 1999; Wampold, 2001) contends that the true source of psychotherapy’s successful outcomes are the salutary elements common to all efficacious approaches, such as a strong therapist-client alliance and a cogent rationale for treatment (Messer & Wampold, 2002). Both positions offer conflicting answers to the question of precisely how psychotherapy works (Elkins, 2009), both have attracted scores of loyal allies and vociferous opponents (Wampold, 2009), and both can ostensibly justify their views with the published psychotherapy process and outcome research (Lilienfeld & Arkowitz, 2012). Among scientists and scholars, a clear winner has yet to emerge. Among psychotherapy consumers, however, recent evidence suggests a marked preference for common factors.

Swift and Callahan (2010) provided the first preliminary evidence that psychotherapy clients may place more value on therapeutic common factors—such as a strong working relationship facilitated by a warm and experienced clinician—than on an

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1 A full treatment of the “Great Psychotherapy Debate” over the relative contributions of common factors and specific ingredients to treatment outcomes is beyond the scope of this dissertation, which will focus on consumer preference rather than therapy effectiveness. For reviews of the controversy surrounding therapy effectiveness, see Cuijpers et al. (2008); Imel and Wampold (2008); Hunsley and Di Giulio (2002); and Wampold (2009). Additionally, a slightly more thorough summary of the debate’s history begins Chapter 4.
individual treatment’s documented efficacy. Specifically, their sample of 57 adult clients of a university-based clinic was willing to sacrifice up to 49% of an intervention’s empirical support to ensure that the therapist delivering said intervention was relatable, empathetic, experienced, and likely to do more listening than talking in session. My own research suggests that this willingness to forfeit empirically-established efficacy extends to an overall preference for therapy framed by common factors, even among those who have never experienced psychotherapy. In a within-participant study of Amazon Mechanical Turk™ (20132; abbreviated as “MTurk™” hereafter) users (Swan & Heesacker, 2013), my coauthor and I asked 329 adults from across the United States (60.2% female, mean age= 35.92) to rate their attitudes toward seeking two varieties of psychotherapy: one emphasizing nonspecific common factors3, and one emphasizing specific evidence-based therapy ingredients4. Analyses revealed a pronounced (d = .50) preference for therapy framed by common factors among previous clients and non-clients alike, indicating that potential clients may seek help more readily from providers who accentuate the nonspecific aspects of therapy.

Research Aims and Hypotheses

Together, these two studies suggest that campaigns to increase the utilization of mental health services may do well to stress the importance and presence of nonspecific common factors, rather than the scientific credibility of individual

2 Amazon Mechanical Turk™ is a registered trademark of Amazon.com, Inc. or its affiliates in the United States and/or other countries.

3 The description highlighting common factors read: There are many different varieties of effective psychotherapy. Research has shown that they all work because of what they share in common: a space to freely talk about and work through your problems with a therapist you can trust.

4 The description highlighting specific ingredients read: Psychological treatments work just like taking medicine. After assigning a diagnosis, your clinician can choose the correct therapy to fix your particular problem. Receiving the right evidence-based treatment leads to the best outcomes.
interventions or techniques. However, such a broad recommendation seems unwarranted on the basis of one sample of active clients in a single clinic and one sample of MTurk™ users—replication with independent samples and variation in research methods would bolster confidence in the generalizability of this apparent public preference for therapy framed by common factors. This dissertation’s first research aim was to conduct such a replication. Hypothesis 1 predicted that, in two samples of adults from across the United States, participants would report more positive help-seeking attitudes toward a description of psychotherapy framed by common factors relative to a similar description framed instead by specific ingredients. To ensure that the effect is not limited to the particular wordings I used in my prior research (see footnotes one and two above), I constructed entirely new descriptions for the present studies to capture the essential features of each model (Chapter 2).

This dissertation’s second research aim sought to extend prior work by testing a theoretical explanation for this discrepancy in attitudes. Specifically, Hypothesis 2 predicted that participants would view involvement in therapy guided by common factors as less stigmatizing than involvement in therapy guided by specific ingredients. This expectation is grounded in a robust literature documenting a reliable correlation between expecting stigmatization for participating in mental health services on the one hand, and attitudes toward seeking professional psychological help on the other—as perceptions of mental health treatment stigma increase, help-seeking attitudes become more negative (see Vogel, Wade, & Hackler, 2007 for a review of this literature). Modified labeling theory (Link et al., 1989), which posits that awareness of societal devaluation–discrimination toward the mentally ill leads to negative consequences for
people’s self-esteem if they are labeled as having a mental illness, serves as this dissertation’s major theoretical framework. According to this model, the threat of being classified as mentally ill by one’s social network motivates avoidance of treatment, even when such treatment is likely to help alleviate suffering. Psychotherapy described primarily as the matching of specific techniques to particular diagnoses may therefore elicit higher levels of anticipated societal stigma for seeking treatment than a description highlighting nonspecific and non-pathology based elements. Hypothesis 3 combined Hypotheses 1 and 2 into a causal model, predicting that differences in perceptions of stigmatization for seeking each type of therapy (common factors versus specific ingredients) will mediate the relationship between psychotherapy framing and help-seeking attitudes. That is, Hypothesis 3 puts forward the notion that the public preference for therapy framed by common factors stems at least in part from the belief that therapy which focuses on treating pathology carries a relatively higher risk of incurring stigmatization (the specific ingredients stigma model).

In our previous study of MTurk™ users’ help-seeking attitudes (Swan & Heesacker, 2013), my coauthor and I selected ten individual difference constructs to explore as potential predictors of participants’ therapy preferences. Each seemed to hold some promise in answering the question of who is more likely to prefer the common factors or specific ingredients approaches to psychotherapy. For instance, we suspected that those with a high need for closure, external locus of control, and a tendency to submit to authority would desire structured interventions targeting clearly

5 These included participants’ global attitudes toward seeking professional psychological help, the tendency to submit to authority, need for closure, locus of control, comfort with emotions, current level of psychological distress, gender, and belief in the role of genetics in precipitating mental illness. A recent unpublished study also similarly failed to find a significant moderating effect of adult attachment style (King, Swan, & Heesacker, 2013).
defined problems (diagnoses). To the contrary, the vast majority of these variables failed to predict attitudes toward either type of therapy—only having previous experience with psychotherapy and feeling that science makes our way of life change too quickly emerged as significant participant-level predictors (both were positively associated with a preference for common factors). Rather than continuing to focus on internal (dispositional, attitudinal) participant factors that might predict therapy preferences, this dissertation’s third exploratory research aim was to investigate the influence of two external (social, situational) factors: (a) the possible discrepancy between what sort of psychotherapy one would seek for one’s self versus the sort one would recommend to another; and (b) the particular psychological problem that one anticipates experiencing (depression, anxiety, eating disorders, substance abuse, or thought disturbances). The theoretical rationales for exploring these factors are presented in the introductory section of Chapter 3.

**Implications**

In practice, clients may not face a dichotomous choice between therapies guided exclusively by specific or nonspecific factors. This dissertation aims only to test the notion that the relative emphases placed on each meta-theory when describing the gist of treatment to the public matters. Many potential clients have likely been exposed to the idea that therapists differ in their use of empirically-supported interventions, and to a debate amongst scholars of psychotherapy concerning the question of whether the only scientific approach to psychotherapy is one based on the medical model (e.g., Abbot, 2009; Palca, 2009). Consider for instance Newsweek contributor and science editor Sharon Begley’s 2009 editorial, “Ignoring the Evidence: Why Do Psychologists Reject Science?” Citing recent calls in scholarly journals for increased scientific rigor in the
training of clinical psychologists (Baker, McFall, & Shoham, 2009; Mischel, 2009), Begley bemoaned what she perceived as a tenuous relationship between psychotherapy and scientific research, contrasting the specific ingredients approach (e.g., utilizing cognitive-behavioral techniques for clients with panic disorders) with patently pseudoscientific modalities (e.g., facilitated communication or dolphin-assisted therapy).

Decades of research have clearly shown that far more people could benefit from psychotherapy than are availing themselves of it (Center for Mental Health Services, 2000; González et al., 2010). Efforts to improve this situation, such as the new psychotherapy awareness initiative launched recently by the American Psychological Association (2012), represent an active focus of outreach in professional psychology. However, the question of how focusing on common factors or specific ingredients in these campaigns might affect attitudes toward seeking mental and behavioral health care has yet to be investigated empirically. Moreover, the common factors approach, born of and supported by a vast body of empirical literature (see Wampold, 2009), has not been meaningfully included in the national conversation about the scientific status of psychotherapy. By investigating reactions to the terminology and processes associated with two science-based approaches that differ with regard to their emphasis on diagnosis and specific interventions, the findings of this study might suggest a viable pathway by which people who might benefit from therapy can be recruited to participate in it.
CHAPTER 2
STUDY 1

Overview

In Study 1, I attempted to replicate the findings of previous investigations of psychotherapy preferences, which have revealed a clear preference for common therapy variables (such as a compassionate provider) relative to specific scientifically-supported interventions (Swan & Heesacker, 2013; Swift & Callahan, 2010). Study 1 also constituted a preliminary test of the mediational model of psychotherapy framing, perceptions of stigmatization, and help-seeking attitudes (the specific ingredients stigma model) articulated in Chapter 1.

Method

Participants

Recruitment for Study 1 occurred through Amazon’s Mechanical Turk™ (MTurk) service. Registered MTurk™ users serve as an on-demand and scalable workforce for simple computer-based tasks that require human intelligence, such as categorizing digital photos or transcribing audio clips (Pontin, 2007). Recently, social scientists have begun to view MTurk™ as an untapped source of diverse research participants (Bohannon, 2011; Crump, McDonnell, & Gureckis, in press). Studies have shown that MTurk™ users better represent the U.S. population than convenience samples of undergraduates (Paolacci, Chandler, & Ipeirotis, 2010); produce high-quality survey data (e.g., adequate internal-consistency and test-retest reliability coefficients with evidence of criterion-related validity) even for remuneration as low as $0.02 (Buhrmester, Kwang, & Gosling, 2011; Shapiro, Chandler, & Mueller, in press); and report incidences of depression, general anxiety, and trauma exposure that mirror or
exceed the prevalence of these problems in the general population (Shapiro et al., in press).

An a priori power analysis (α = .05, power = .95) using G*Power 3.1.2 (Faul et al., 2009) found that 45 participants would be necessary to detect the medium-sized effects reported in prior research using a similar method and procedure (d = .50; Swan & Heesacker, 2013). To achieve this minimum sample size, I invited 100 U.S. MTurk™ users to participate in this study in return for $0.50 each on July 29, 2012. Data collection occurred between 2:27 PM and 3:40 PM PDT. After the removal of two participants who failed a fidelity check to ensure that they actually attended to the survey questions (see below), 98 cases remained for analysis. Table 2-1 presents a breakdown of participants’ demographic characteristics.

**Materials and Procedure**

An online questionnaire (hosted by Qualtrics Survey Software; Appendix B contains the full text of Study 1’s materials) introduced the study by providing a general description of psychotherapy (*the general process of addressing mental health concerns by talking with a psychologist or other mental health provider*), a statement concerning psychotherapy’s general demonstrated efficacy (*More than 20 years of scientific research have led to the conclusion that psychotherapy works quite well for those who use it*), and an introduction to the notion that different therapists may hold divergent views on the question of how psychotherapy produces its benefits. Participants then viewed two separate answers to the question of how psychotherapy produces its benefits.

1 Although evidence suggests that lower pay would not have adversely affected the quality of the data (Buhrmester et al., 2011), a higher financial incentive has been linked to both the speed of data collection and the rate of participant dropout (Crump et al., in press).
works, each purportedly written by a different practicing psychologist. I constructed these descriptions by systematically distilling and adapting the four (common factors or “contextual” model) and five (specific ingredients or “medical” model) components of each approach outlined by Wampold, Ahn, and Coleman (2001) and Wampold (2009).

The first, reflecting a common factors approach, read:

At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you’ll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.

The second, reflecting a specific ingredients approach, read:

Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.

All participants received both descriptions, which were counterbalanced randomly to prevent order effects. Several counseling psychology graduate students and PhD-level psychologists provided feedback on each description’s accuracy, fairness, and affective valence. I chose a within-subjects design under the assumption that simple descriptions of psychotherapy that differ in meta-theoretical emphasis would be unlikely to alter participants’ long-standing psychotherapy schemas when presented in isolation (see Shy & Waehler, 2008 for an example of the failure of simple terminology changes to affect help-seeking attitudes). Instead, confronting participants with two contrasting descriptions will likely trigger the use of conscious, controlled decision-making processes and override the activation of implicit stereotypes about and attitudes toward therapy in general.
Following each description, participants rated on a seven-point Likert-type scale (a) the likelihood that they would schedule an appointment with each therapist if they believed they were having a mental breakdown, and (b) whether they believed that psychotherapy of that sort would have value for a person like them. Adapted from Fischer and Farina’s (1995) 10-item, global Attitudes Toward Seeking Professional Psychological Help Short Form scale, these two criterion items reflect the full scale’s two established factors, Openness to Seeking Treatment for Emotional Problems, and Value and Need in Seeking Treatment (Elhai, Schweinle, & Anderson, 2008), respectively. Strong inter-item correlations supported the decision to combine these items into a single global attitude score: Cronbach’s $\alpha = .77$ ($r = .63, p < .001$) for the common factors description and $.80$ ($r = .68, p < .001$) for the specific ingredients description. Summing these two items produced overall attitude scores ranging between 2 and 14 for each psychotherapy description, with higher scores indicating more positive help-seeking attitudes.

Participants also completed Vogel, Wade, & Ascheman’s (2009) five-item Perceptions of Stigmatization by Others for Seeking Help scale twice, once for each description. Vogel and colleagues (2009) found this scale, designed to measure the amount of stigmatization people believe they will experience from those in their social network for seeking psychological help, to be a reliable and valid measure of stigma perceptions across five collegiate samples. Summing the five Likert-type items, which included adapted wording such as “If the people in your life (friends, family, co-workers) found out that you were enrolled in therapy like this description, to what degree do you believe that they would think bad things of you?”, produced a total score for each
participant ranging between 5 and 20, with higher scores indicating more expected stigmatization for seeking help ($\alpha = .91$ or the common factors description and .93 for the specific ingredients description).

A single fidelity-check item assessed whether participants read and could recall the two psychotherapy descriptions (*Which of the following was not part of a psychologist’s answer on the previous page?*; the foil used to exclude participants read, *cognitive-behavioral therapy works best for treating depression and anxiety disorders, but not for eating disorders*). Two participants chose the foil, and were thus removed from the dataset. The final page of the survey contained demographic items (Table 2-1).

**Results**

All continuous variables appeared suitable for parametric analyses (i.e., absolute skewness and kurtosis coefficients less than 1.0). Unless otherwise noted, all analysis-specific assumptions were met. When comparing multiple means as part of a single analysis, I adjusted the alpha level using Bonferroni correction to control for family-wise error inflation. All participants in the final sample ($N = 98$) answered all help-seeking and stigma perception questions, and only one participant failed to answer one demographic item.

**Help-Seeking**

A repeated measures multivariate analysis of variance revealed a significant multivariate effect of meta-model framing on help-seeking attitudes and perceptions of stigmatization: Wilks’ $\lambda = .84$, $F(2, 96) = 9.42$, $p < .001$, $f = .44$. Consistent with Hypothesis 1, simple effects decomposition within each repeated measure revealed that participants reported significantly more positive attitudes toward the common factors description ($M = 9.91$, $SD = 2.68$) than the specific ingredients description ($M = 8.73$, $SD = 2.68$).
= 2.76), \( p = .001, \ d = .35^2 \). Of 98 final cases, 50.0% preferred the common factors description, 24.5% preferred the specific ingredients description, and 25.5% preferred neither.

**Stigma**

Consistent with Hypothesis 2, participants indicated expecting significantly less stigmatization by others for seeking therapy in the common factors condition (\( M = 8.56, \ SD = 3.71 \)) than in the specific ingredients condition (\( M = 9.60, \ SD = 4.21 \)), \( p < .001, \ d = .38 \). To test Hypothesis 3 (differences in perceptions of stigmatization for seeking each type of therapy will mediate the relationship between psychotherapy framing and help-seeking attitudes), I first calculated a preference score for each participant by subtracting their attitude score toward the specific ingredients description from their attitude score toward the common factors description (\( M = 1.17, \ SD = 3.34 \); a score of 0 indicates no preference, positive values indicate a common factors preference, and negative values indicate a specific ingredients preference). Second, I computed a perceived stigma main effect variable by summing participants’ perception of stigmatization scores across both conditions (\( M = 31.83, \ SD = 7.43 \)). Entering this variable into the regression model allowed the overall effect of perceived stigma to be controlled, and provided a test of moderation (see Judd, Kenny, & McClelland, 2001 for an overview of this repeated measures approach to mediation tests). Third, I calculated a stigma perception difference score for each participant by subtracting their stigma score toward the common factors description from their stigma score toward the specific

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\(^2\) I utilized Morris and DeShon’s (2002) equation for calculating \( d \) in repeated measures designs throughout this dissertation, dividing mean differences by average standard deviations, and correcting for the correlations between dependent observations.
ingredients description ($M = 1.04, SD = 2.79$). Finally, I regressed the difference in participants’ help-seeking attitudes onto both the stigma main effect (sum) and the stigma difference score. The overall model was significant, $F(2, 95) = 6.78, p < .01, R^2 = .13$. The main effect of stigma was not a significant predictor ($\beta = .01, p = .95$), indicating that perceived stigma did not moderate the effect of psychotherapy framing on help-seeking attitudes. However, consistent with Hypothesis 3, the difference in participants’ stigma scores significantly predicted differences in help-seeking attitudes ($\beta = .36, p < .001$), indicating that perceptions of stigmatization by others did mediate the effect of psychotherapy framing on help-seeking attitudes. A statistically significant model intercept ($B = 1.17, p < .001$) qualified this as a partial mediation.

**Discussion**

Prior research has documented a clear preference among both active therapy clients (Swift & Callahan, 2010) and the general population (Swan & Heesacker, 2013) for psychotherapy guided by common factors. Study 1’s successful replication of the latter finding is important for two reasons. First, reproducibility, especially in the case of novel or preliminary results, is crucial for the estimation true effect sizes (see the Open Science Collaboration, 2012). Discovering the same trend in multiple independent samples also reduces the likelihood of accepting spurious results and conclusions. Second, Study 1 addressed a methodological limitation of my prior work. Previously (Swan & Heesacker, 2013), my coauthor and I wrote and presented study participants with two descriptions of psychotherapy—one emphasizing common factors and one emphasizing specific evidence-based therapy ingredients—which ostensibly represented straightforward, non-technical distillations of each position (see footnotes one and two in Chapter 1 for the full text of these descriptions). Our aim was principally
to represent the essence of each model with the sort of simple verbiage an advocate might use to explain the process of psychotherapy to a novice. However, both characterizations left much room for disagreement from proponents of both models, and a gap between what has been described in the scholarly literature and what participants reacted to in the study. The present study’s descriptions bridged this gap, summarizing more faithfully and thoroughly each position as described by psychotherapy scholars (namely, Wampold, Ahn, & Coleman, 2001; and Wampold, 2009) using similar phrasing (e.g., *confiding relationship with a therapist; the benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients*) and ordering of various components. Thus, rather than relying on my own interpretations of each position, this study attempted to transport representative samples of the largely internal professional discourse on these two meta-theoretical positions into the public, non-professional arena. Although the effect sizes obtained in the present study were somewhat smaller than those obtained using the previous descriptions (e.g., $d = .35$ in this investigation versus $d = .50$ in Swan & Heescaker, in press), the overall result of a preference for the common factors approach was fully reproduced. This conceptual replication rules out the possibility that our previous results were due solely to word-choice. Study 1 therefore provided further scientific support for the claim that promoting psychotherapy by underscoring its nonspecific (or, humanistic; McKay et al., 2007)

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3 For instance, Wampold and colleagues (2001) listed the five components of the “medical model” as follows: “(a) the client presents with a disorder, problem, or complaint; (b) there exists a psychological explanation for the disorder, problem, or complaint; (c) theoretical conceptualization and knowledge are sufficient to posit a psychological mechanism of change; (d) the therapist administers a set of therapeutic ingredients that are logically derived from the psychological explanation and the mechanism of change; and (e) the benefits of psychotherapy are due, for the most part, to the specific ingredients” (p. 268).
features, rather than a model of diagnosis and treatment, will increase the likelihood of people seeking help when in need.

The finding that participants’ expectations of incurring stigmatization by others partially mediated this common factors preference reinforces this conclusion. The stigma associated with mental illness and psychological counseling is the most frequently cited reason for the decision to avoid seeking help (Corrigan, 2004), and recent research suggests that mental illness stigma remains a significant problem in the United States (e.g., Pescosolido, 2013; Pescosolido et al., 2010; Schwenk, Davis, & Wimsatt, 2010). Chapter 1 of this dissertation introduced a theoretically-grounded model to join these findings and the stigma literature with the common factors preference effect, positing that an awareness of mental illness stigma would lead individuals to feel less inclined to seek help from a provider who they believe will conceptualize their distress as an illness. Although caution is warranted when using mediational analyses to infer causality (Bullock, Green, & Ha, 2010), the results of Study 1 provide preliminary support for the specific ingredients stigma model. They also raise several important questions about the conditions under which the preference for psychotherapy framed by common factors will arise. Chapter 3 describes this dissertation’s second study, which, in addition to attempting to replicate the findings of Study 1, sought answers to two of these questions.
### Table 2-1. Study 1 sample characteristics (N = 98)

<table>
<thead>
<tr>
<th>Measure</th>
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<th>Measure</th>
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<td></td>
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<td>Neither</td>
<td>6.1</td>
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</tr>
</tbody>
</table>

<sup>a</sup>Participants were allowed to choose more than one racial identification category.

*Note.* Due to missing data on demographic items, some totals fail to reach 100% of the final sample size (N = 98).
CHAPTER 3
STUDY 2

Overview

Study 1 amassed strong support for the specific ingredients stigma model. However, it did so with a relatively small sample of participants ($N = 98$) drawn from the same volunteer pool (MTurk™ users) that I utilized in prior investigations of similar research questions. Study 2 re-tested hypotheses 1-3 in an independent sample of participants from a new source (SocialSci.com) with the aim of increasing confidence in the external validity of Study 1’s results. It also pursued this dissertation’s exploratory (third) research aim to investigate two likely moderators of participants’ psychotherapy preferences.

Personal Preference versus Recommendations for Others

The first of these likely moderators concerned a possible discrepancy between the type of psychotherapy one would seek for one’s self and the type one would recommend to another person. Studies have shown that people often internalize the public stigmatization of mental illness and treatment (Link & Phelan, 2001). Vogel and colleagues (2007) placed this notion of internalization at the center of a causal chain, having found in a large ($N = 680$) college student sample that the relationship between perceiving public stigma (a perception held by members of a society that an individual is socially unacceptable) and willingness to seek counseling was mediated fully by self-stigma (a perception held by the individual that he or she is socially unacceptable) and general attitudes toward obtaining professional psychological help (for one’s self). If concerns about stigmatization account for (part of) the public preference for common factors, as my specific ingredients stigma model suggests, thinking about
recommending help for someone else should attenuate the common factors preference effect. That is, imagining the public stigmatization of others may bypass the activation of internalized self-stigma and its negative impact on self-esteem, diminish the effect of perceived stigmatization in general, and increase the attractiveness of the specific ingredients model.

Another source of indirect support for this self-other discrepancy prediction may be found in the social psychological study of behavior attribution. Decades of empirical investigation have shown that when asked to infer the cause of someone else’s actions, people very often rely on highly predictable reasoning heuristics. Among the most well-documented of these is the correspondence bias (Jones, 1979), which describes the tendency for people to overattribute another’s actions to internal, dispositional factors at the expense of equally-likely external, situational explanations. The actor-observer effect (Jones & Nisbett, 1987) adds to this phenomenon the converse—when making attributions for their own behavior, people tend to overestimate situational factors and downplay the influence of stable traits and proclivities. Perhaps the most familiar illustration of these errors in action is the case of a law-breaking automobile driver. After observing another driver fail to observe a stop sign (or commit some other traffic infraction or discourtesy), people tend more often to attribute the offender’s actions to personality factors (e.g., “she’s so inconsiderate!”) rather than to the happenstance of the driver’s environment (e.g., “she must have been temporarily distracted”). When the previously offended driver later becomes an offender, breezing through a stop sign
himself, his attribution is likely to invert. There is no reason to suspect that people’s attributions for mental distress are immune to these same reasoning biases\(^1\).

Consider the same automobile driver, now struggling with a bout of major depression. To explain the etiology of his own depressive symptoms, he might conjecture that he has been under a great deal of stress (situational attribution), and thereby think relatively favorably of psychotherapy framed by the image of someone listening compassionately and helping him to bring about situational life changes (the common factors model). To explain the etiology of his neighbor’s symptoms, on the other hand, he may infer that something has gone seriously wrong with his neighbor’s psyche (internal attribution), and that his neighbor would therefore benefit most from a clearly defined and empirically-validated intervention (the specific ingredients model). Although neither of these two approaches to psychotherapy advocate explicitly for a particular cause of mental distress, the specific ingredients (“medical”) model does seem to imply an internal cause; a disorder within a person that can be ameliorated with the application of the correct treatment (Wampold, 2009), perhaps making it seem more appropriate for other people with psychological problems.

This is not to suggest that such lay conceptions—that the common factors model encourages external attributions while the specific ingredients model encourages internal ones—are correct. Indeed, a specific psychotherapeutic ingredient may be designed to teach a client new behaviors that will extinguish previously learned behaviors.

\(^1\) I discovered no research testing this hypothesis directly. However, a robust literature does exist on the implications of various attributions of others’ mental illness (e.g., controllability, responsibility) on prejudice and discrimination toward the mentally ill (see Corrigan et al., 2003 for an overview of the attribution model of public discrimination toward persons with mental illness). The question of whether attributing another’s mental distress to biological or otherwise uncontrollable (internal) factors increases or decreases stigma has yet to be resolved empirically (see Phelan, 2005 for an alternate “genetic essentialist” model).
environmental contingencies, such as the association of snakes with fear. However, applying and extending the principals of attribution theories to people’s attitudes toward these two approaches to psychotherapy suggests a possible perceptual discrepancy worthy of exploration.

**Different Types of Mental Distress**

The second likely moderator of participants’ psychotherapy preferences of interest in Study 2 concerns the type of psychological problem that participants anticipate experiencing. The measure recommended and used most frequently in the psychological literature (and indeed the measure used in this dissertation) to assess attitudes toward seeking professional psychological help—Fischer and Farina’s 1995 Attitudes Toward Seeking Professional Psychological Help Short Form scale—ignores this potentially rich source of situational variance. For instance, does thinking about persistent feelings of sadness trigger the same set of set of attitudes toward seeking help as thinking about a struggle with opiate addiction, binge eating, or auditory hallucinations? Items asking participants to consider a vague “mental breakdown” likely connote different problems for different people, obscuring the differential impact they may have on help-seeking attitudes. After first having participants consider psychological distress in the abstract, Study 2 asked them to also indicate their therapy preference (common factors, specific ingredients, no preference, or neither) for several different problems for which people often seek help from a psychologist.

**Method**

**Participants**

SocialSci (SocialSci.com), a web-based survey-hosting and participant pool service designed specifically for academic research (SocialSci, 2013), provided a
sample of participants for Study 2. Like Amazon’s MTurk\textsuperscript{TM} Service, SocialSci offers small monetary rewards (e.g., points redeemable for Amazon.com gift cards) to anyone\textsuperscript{2} who signs up for a free user account and elects to complete online surveys. SocialSci offers an additional layer of quality-assurance, beyond those offered by MTurk\textsuperscript{TM}, however, by permanently storing participants’ demographic characteristics and by checking for anomalies in response patterns\textsuperscript{3}.

Although an \textit{a priori} power analysis ($\alpha = .05$, power = .95) revealed that only 90 participants would be necessary to detect the smallest of the two effect sizes obtained in Study 1 ($d = .35$), any \textit{post hoc} between-participant explorations of subgroups (e.g., those who have never participated in psychotherapy) would require substantially more power to guarantee a large enough sample size in each cell. I therefore invited a total of 400 SocialSci users to participate in Study 2. After removing 25 who failed a fidelity check to ensure that they actually attended to the survey questions (see the \textit{Materials and Procedure} section below), 375 cases remained for analysis. Table 3-1 presents a breakdown of participants’ demographic characteristics.

\textbf{Materials and Procedure}

Study 2 replicated exactly the materials and procedure of Study 1—participants received identical instructions, the same psychotherapy descriptions, and the same items to assess help-seeking attitudes, perceptions of stigmatization by others, and task-attention (fidelity check). My two-item measure of help-seeking attitudes again

\textsuperscript{2} SocialSci recruits participants through a distributed advertising network of more than 40 websites, such as Facebook.com, as well as a variety of print media. Participants may also refer one another directly (SocialSci, 2013).

\textsuperscript{3} See https://research.socialsci.com/docs/contents/144-vetting for more information about this vetting system.
produced acceptable Cronbach’s α coefficients [.81 (r = .69, p < .001) and .76 (r = .61, p < .001) for the common factors and specific ingredients descriptions, respectively]. Vogel and colleagues’ (2009) five-item Perceptions of Stigmatization by Others for Seeking Help scale similarly proved internally consistent in both conditions (Cronbach’s α’s = .92 and .93, respectively).

Before presenting demographic questions, Study 2 included one additional page of questions to address the two exploratory aims outlined previously in this chapter (Appendix C contains the full text of this additional page). First, participants were re-presented with both (counterbalanced) psychotherapy descriptions and asked to again indicate their help-seeking attitudes toward each. This time, however, I instructed them to “think about other people in psychotherapy, rather than themselves.” The two help-seeking items’ wordings were also modified slightly to reflect the shift in perspective. A total of four help-seeking attitude scores could therefore be calculated for each participant in Study 2, all using the same metric: one pair for their own attitudes toward seeking help from the two types of therapy, and a second comparable pair for their attitudes toward others seeking help. The “help-seeking for others” items showed somewhat weaker internal reliability than their unmodified (help-seeking for self) counterparts: Cronbach’s α = .62 (r = .45, p < .01) for the common factors description and .67 (r = .51, p < .01) for the specific ingredients description. All analyses reported in the following sections of this chapter that included the help-seeking for others variable

---

4 From “How likely is it that you would schedule an appointment with this therapist if you believed you were having a mental breakdown” to “Other people should schedule an appointment with this therapist if they believed they were having a mental breakdown”; and from “Psychotherapy of this kind would not have value for a person like me” to “Psychotherapy of this kind would not have value for other people” (emphases in original; the second item in each set was reverse-coded).
therefore also subsequently examined each help-seeking for others item separately to search for discrepancies.

Next, using descriptions of five major categories of mental disorder (depression, anxiety, eating disorders, substance abuse, and thought disturbances) adapted from PubMed Health’s online resources for prospective help-seekers\(^5\), Study 2’s additional survey page also asked participants to indicate which of the two descriptions of therapy (common factors, specific ingredients, no preference, or neither) they would prefer if they experienced symptoms of each problem. Finally, Study 2 added two additional questions meant to measure potential confounds in the research design: \textit{Which of these two approaches to therapy do you think that they author of this survey favors?}; and, \textit{Before you started this survey, which of these two types of therapy would you have expected to receive if you sought help from a psychologist?} The former served as a manipulation check to ensure bias-free wording, while the latter served as a means of testing the assumption that preferences are not merely a result of pre-existing expectations about what occurs in therapy.

\textbf{Results}

All continuous variables appeared suitable for parametric analyses (i.e., absolute skewness coefficients less than 1.5\(^6\)). Unless otherwise noted, all analysis-specific assumptions were met. When comparing multiple means as part of a single analysis, I


\(^6\) The distribution of scores for the Perceptions of Stigmatization by Others for Seeking Help scale appeared somewhat negatively skewed (statistic = 1.42) and leptokurtic (statistic = 2.37) for the common factors description. Both coefficients seemed to reflect a large number of participants who perceived no stigmatization at all for this type of therapy \((n = 144; \text{approximately } 30\% \text{ of the overall sample})\). This was slightly less pronounced for the specific ingredients description \((n = 92, \text{approximately } 25\% \text{ of the overall sample}; \text{ kurtosis statistic } = 1.46)\). The general linear model equations I chose to analyze Study 2’s data are likely sufficiently robust to handle these small deviations of normality without any adverse effects.
adjusted the alpha level using Bonferroni correction to control for family-wise error inflation. All participants in the final sample \( N = 375 \) answered all survey items.

**Replicating Study 1**

A repeated measures multivariate analysis of variance revealed a significant multivariate effect of meta-model framing on help-seeking attitudes and perceptions of stigmatization: Wilks’ \( \lambda = .87, F(2, 373) = 28.52, p < .001, f = .39 \). Consistent with Study 1 (Hypothesis 1), simple effects decomposition of each within-participant outcome revealed that participants reported significantly more positive attitudes toward the common factors description \((M = 10.31, SD = 2.75)\) than the specific ingredients description \((M = 9.48, SD = 2.79)\), \( p = .001, d = .29 \). Of 375 final cases, 45.9% preferred the common factors description, 23.2% preferred the specific ingredients description, and 30.9% preferred neither.

Again consistent with Study 1 (Hypothesis 2), participants indicated expecting significantly less stigmatization by others in the common factors condition \((M = 8.44, SD = 3.79)\) than in the specific ingredients condition \((M = 9.11, SD = 4.09)\), \( p < .001, d = .33 \). Regressing the difference in participants’ help-seeking attitudes onto both the stigma main effect (sum) and the stigma difference score revealed a significant omnibus effect, \( R^2 = .08, F(2, 372) = 15.57, p < .001 \). Inconsistent with Study 1, the main effect of stigma was a weak but significant predictor \((\beta = .14, p < .01)\), indicating that perceived stigma *moderated* the effect of psychotherapy framing on help-seeking attitudes. As perceived stigma for seeking help in general increased, the likelihood of a preference for common factors increased in concert. The difference in participants’ stigma scores also significantly predicted differences in help-seeking attitudes \((\beta = .27, p < .001)\), indicating that perceptions of stigmatization by others *mediated* the effect of
psychotherapy framing on help-seeking attitudes as well, supporting Hypothesis 3 and the specific ingredients stigma model. A statistically significant model intercept ($B = 1.15, p < .001$) again qualified this as a partial mediation.

**Exploratory Analyses**

**Personal preference versus recommendations for others**

To compare participants’ attitudes toward seeking help from the two types of therapy to their relative attitudes toward others seeking help, I conducted a second RMANOVA with two within-participant factors: psychotherapy framing (common factors versus specific ingredients) and help-seeking target (self versus other). A significant interaction term [Wilks’ $\lambda = .95$, $F(1, 374) = 18.55, p < .001$, $f = .22$] suggested that the effect of psychotherapy framing did indeed depend on the target (self or other). Simple effects decomposition revealed two interesting trends. First, participants’ attitudes toward seeking psychological help were significantly more favorable for other people than for themselves for both types of therapy ($p$’s < .001; $d’$s = .34 and .63 for the common factors and specific ingredients descriptions, respectively). Second, when considering others seeking help, participants on average expressed no preference between common factors ($M = 11.16, SD = 2.14$) and specific ingredients ($M = 10.94, SD = 2.22$), $p = .09$, $d = .09$. Figure 3-1 depicts these interaction effects graphically.

Given the marginally-acceptable Cronbach’s alpha coefficients produced by combining the help-seeking for others items, I subsequently re-ran the RMANOVA twice, each time entering one of the two individual help-seeking for others items instead of composite scores. No meaningful differences emerged.
Different types of mental distress

Figure 3-2 shows the percentages of participants who indicated that they would prefer psychotherapy framed by common factors, psychotherapy framed by specific ingredients, had no preference between the two, and preferred neither when considering seeking help for five different types of psychological distress (depression, anxiety, eating disorders, substance abuse, and thought disturbances). A series of continuity corrected McNemar $\chi^2$ tests revealed significant differences between the number of participants who preferred common factors and the number that preferred specific ingredients for depression [$\chi^2 = 64.70, p < 001$], eating disorders [$\chi^2 = 35.46, p < 001$], substance abuse [$\chi^2 = 30.88, p < 001$], and thought disturbances [$\chi^2 = 57.67, p < 001$], but not for anxiety [$\chi^2 = .38, p = 540$]. Combined with Figure 3-2, these results paint a clear picture: participants expressed a strong preference for common factors when the psychological problem involved depressive symptoms, but an equally strong preference for specific ingredients when they imagined experiencing symptoms of an eating disorder, substance abuse, or psychotic disturbance. A roughly equal number of participants preferred each when imagining symptoms of anxiety.

Previous psychotherapy exposure

This dissertation’s first research aim was to conduct a conceptual replication of my prior work (Swan & Heesacker, 2013) using independent samples and variation in research methods. Both of the present studies indeed found an overall preference for therapy framed by common factors. However, to support fully the claim that campaigns to increase the utilization of mental health services should stress the importance and presence of nonspecific common factors, rather than the scientific credibility of individual interventions or techniques, these data must show that even those who have
never experienced psychotherapy—the group arguably most in need of such targeted advertising—prefer the common factors approach. Indeed, when I added exposure to therapy (past or present versus no exposure) as a between-subjects factor to a new RMANOVA with psychotherapy framing as the within-participant factor and help-seeking attitudes as the criterion, simple effects decomposition showed that even non-clients exhibited a preference for common-factors guided therapy \((M = 9.59, SD = 2.72, n = 173)\) relative to the specific ingredients approach \((M = 8.79, SD = 2.78, n = 173)\), \(p < .001\), \(d = .31\).

**Expectations**

The specific ingredients stigma model relies on the notion that people’s preferences for therapy framed by common factors are not simply a result of pre-existing expectations about what occurs in therapy. Although psychotherapy preferences and expectations are likely to covary greatly, their correlation should not be perfect (e.g., Tracey & Dundon, 1998). A cross tabulation of categorical psychotherapy preferences [common factors \((n = 172)\), specific ingredients \((n = 87)\), or neither \((n = 116)\)]\(^7\) and expectations [common factors \((n = 239)\), specific ingredients \((n = 108)\), or neither \((n = 28)\)] confirmed the two variables’ strong but imperfect covariation \([\chi^2(4, N = 375) = 22.88, p < 001, \phi_c = .18]\). For instance, of 173 participants who preferred common factors, 29 expected to receive therapy consistent with the specific ingredients description, and 14 expected neither. That is, approximately 25% of those who preferred common factors did not expect to encounter it prior to beginning this study.

\(^7\) I created this categorical variable using participants’ continuous preference scores, which were calculated by subtracting attitude scores toward the specific ingredients description from attitude scores toward the common factors description \((M = -.83, SD = 2.85)\). A score of 0 indicates no preference, positive values indicate a common factors preference, and negative values indicate a specific ingredients preference.
Demand characteristics

Demand characteristics—subtle cues in a study’s materials or procedure that alert participants to the researchers’ hypotheses—often pose threats to the internal validity of studies in which participants are asked to disclose their attitudes. In these studies, participants might have deduced a particular allegiance to one of the two approaches to therapy on the part of the author, and thus responded in a socially desirable manner (i.e., as they believed the study’s author wanted them to respond). Indeed, many more participants surmised that my allegiance lay with the common factors approach \((n = 117)\) than the specific ingredients approach \((n = 81)\). However, most participants detected no author preference \((n = 177)\), and a cross tabulation of psychotherapy preferences and beliefs about the author’s allegiance showed only a small and statistically insignificant relationship \[\chi^2(4, N = 375) = 7.09, p = .13, \varphi_c = .10\].

The same was true when examining only those who did suspect an author allegiance (i.e., correcting for the influence of the large number of participants who did not on the chi-square statistic): \[\chi^2(2, N = 198) = 4.97, p = .08, \varphi_c = .16\].

Discussion

Study 2 replicated two important Study 1 effects. First, it confirmed that even those who have never experienced psychotherapy report more positive attitudes toward seeking help when therapy is guided by common factors. Second, it reproduced in an independent sample the mediating effect of perceived stigmatization on the relationship between psychotherapy framing (common factors versus specific ingredients) on help-seeking attitudes. Although the omnibus effect of perceived stigmatization for seeking mental health services emerged as a significant moderator of therapy preferences in Study 2 (but not in Study 1), its magnitude was small \((\beta = .14)\). In any case, common
factors prevailed on both counts: those who perceived more stigmatization for seeking help in general were more likely to prefer the common factors framing, and, independently, those who perceived relatively more stigmatization for seeking the specific ingredients therapy preferred common factors. A purposive test of moderated mediation may help to elucidate this discrepancy in future research. Neither demand characteristics nor prior expectations about psychotherapy could explain the common factors preference effect.

Given evidence that the influence of stigmatization on help-seeking attitudes may require internalization, and given several well-documented findings from the psychological science of behavior attribution (i.e., the tendency for people to attribute their own actions to external causes and others’ actions to their disposition), my specific ingredients stigma model can accommodate the self-other discrepancy findings of Study 2. An absence of stigma internalization may account for the finding that help-seeking attitudes for others were significantly more positive for others than for participants themselves—imagining the negative impact of stigmatization on others may not trigger the same negative associations (e.g., fears of social devaluation), therefore attenuating any preference participants held between the two. This represents only one possible interpretation of the self-other discrepancy, however. Future research should test these attribution hypotheses directly. It is important to note that the common factors preference effect did not reverse entirely when participants considered seeking help for others, which may have indicated a severe case of the actor-observer bias. Instead, the two approaches were rendered equally attractive (for others). More acceptable therapy options mean a greater likelihood of finding a provider and of recovery or improvement.
More research is needed to elucidate the preference trends related to psychotherapy framing and seeking help for different disorders. The emergent picture—which suggests that people may prefer common factors when imagining depressive symptoms but hold an equally strong preference for specific ingredients when they imagine experiencing symptoms of an eating disorder, substance abuse, or psychotic disturbance—should be interpreted with caution, and multiple explanations should be explored. For instance, it could be that PubMed’s descriptions of eating disorders, substance abuse, and thought disorders (i.e., the actual verbiage to which participants reacted in this study) imply uncontrollable, internal etiologies (e.g., “urges,” “compulsions,” and “hallucinations”; Appendix C). Lay theories about the etiology of each of these disorders likely influenced these preferences, and those lay theories likely differ between people. Nevertheless, these data suggest strongly that the help-seeking literature should attend to the variation in attitudes toward different disorders, rather than asking people to consider mental distress in aggregate without a theoretical rationale for doing so.

Although the effect sizes obtained in Study 1 and Study 2 ranged between small and medium by Cohen’s (1988) widely-recognized standards, the potential human impact of psychotherapy framing on help-seeking may be substantial. The evidence is clear that far fewer people seek professional psychological help than would benefit from it. A one-point increase on a 14-point scale could translate into hundreds or thousands more people receiving care, and improve, even if only slightly, the state of mental health in the United States. In Chapter 4, I attempt to place all of the aforementioned findings
into historical and contemporary contexts, and discuss recommendations for psychotherapy research and practice.
<table>
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<td>22</td>
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<td>25-34</td>
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<td>131</td>
<td>Less than $9,999</td>
<td>12.8</td>
<td>48</td>
</tr>
<tr>
<td>35-44</td>
<td>10.7</td>
<td>40</td>
<td>$10,000-$19,999</td>
<td>11.2</td>
<td>42</td>
</tr>
<tr>
<td>45-54</td>
<td>8.3</td>
<td>31</td>
<td>$20,000-$34,999</td>
<td>17.3</td>
<td>65</td>
</tr>
<tr>
<td>55-64</td>
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<td>9</td>
<td>$35,000-$49,999</td>
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<td>60</td>
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<td>65-74</td>
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<td>6</td>
<td>$50,000-$99,999</td>
<td>12.8</td>
<td>48</td>
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<tr>
<td>$100,000-$149,999</td>
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<td>6.1</td>
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<td>Region</td>
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<tr>
<td>College graduate</td>
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<td>Never married</td>
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<td>190</td>
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<tr>
<td>Postgraduate work/degree</td>
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<td>105</td>
<td>Living with partner</td>
<td>18.1</td>
<td>68</td>
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<td>Racial identification</td>
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<td></td>
<td>Divorced/separated</td>
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<td>14</td>
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<td>Asian</td>
<td>9.0</td>
<td>34</td>
<td>Widowed</td>
<td>0.3</td>
<td>1</td>
</tr>
<tr>
<td>Black/African American</td>
<td>2.1</td>
<td>8</td>
<td>Yes (past or present)</td>
<td>53.9</td>
<td>202</td>
</tr>
<tr>
<td>Native American/Alaska</td>
<td></td>
<td></td>
<td>Common factors</td>
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</tr>
<tr>
<td>Native</td>
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<td>5</td>
<td>Neither</td>
<td>4.3</td>
<td>16</td>
</tr>
<tr>
<td>Native Hawaiian/Pacific</td>
<td></td>
<td></td>
<td>Specific ingredients</td>
<td>14.9</td>
<td>56</td>
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<tr>
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<td>0</td>
<td>Neither</td>
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<td>16</td>
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<td>White</td>
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<td>321</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2.1</td>
<td>8</td>
<td></td>
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</tbody>
</table>

aParticipants were allowed to choose more than one racial identification category. Six participants identified solely as “multi-racial” without selecting any of the options listed above.

Note. Due to missing data on demographic items, some totals fail to reach 100% of the final sample size (N = 375).
Figure 3-1. Participants’ (N = 375) attitudes toward seeking two varieties of psychotherapy—one framed by common factors and framed one by specific ingredients—for themselves or for others. Scores ranged between 2 and 14, with higher scores indicating more positive help-seeking attitudes. Error bars represent 95% confidence intervals.
Figure 3-2. Percentage of participants ($N = 375$) who indicated that they would prefer psychotherapy framed by common factors, psychotherapy framed by specific ingredients, had no preference between the two, and preferred neither when considering seeking help for five different types of psychological distress.
CHAPTER 4
GENERAL DISCUSSION

A New Perspective

The search for psychotherapy’s active ingredients dates back at least to 1952, when the eminent psychologist Hans Eysenck published a nearly-fatal indictment against his own burgeoning field of clinical psychology. Undoubtedly influenced by the medical community’s contemporary endorsement of placebo-controlled clinical trials (Kaptchuk, 1998), Eysenck expressed in his now classic article great concern over the paucity of scientifically rigorous psychotherapy outcome evaluations. At the time, the best available evidence consisted of less than two dozen uncontrolled studies of psychodynamic and eclectic therapies, and even those, in Eysenck’s view, failed to prove that psychotherapy actually worked. It would later become clear that Eysenck’s discontent arose from his belief that the psychodynamic therapies of the 1950s were demonstrably inferior to therapies which focused exclusively on overt behavior (e.g., Eysenck, 1961; Wampold 2013). Thus began several decades of psychotherapy “brand wars,” in which proponents of various theoretical orientations (e.g., psychoanalytic, humanistic, interpersonal, experiential, cognitive-behavioral) proffered and defended competing explanations of and treatments for mental disorder (Wampold, 2009).

More than 60 years later, the question of overall efficacy has been unambiguously resolved: hundreds of studies and scores of meta-analyses have shown that psychotherapy is in fact extraordinarily effective, yielding an average standardized effect size estimate of .80 (e.g., Smith & Glass, 1977; see Wampold, 2001 for a review). Theoretical divides persist between schools of thought (e.g., between intrapsychic and behavioral explanations for psychological distress), but several decades of efficacy and
effectiveness research have failed to show conclusively that one “brand” of therapy produces better outcomes than its other mainstream (i.e., well-studied) competitors (e.g., Ahn & Wampold, 2001; Cuijpers et al., 2008; Ehlers et al., 2010; Robinson, Berman, & Neimeyer, 1990; Shapiro & Shapiro, 1982; Wampold, 2001; 2009; Wampold et al., 2002). Recent years have therefore seen the brand wars evolve into a more general debate about whether any theoretically-derived techniques contribute uniquely (i.e., above and beyond factors such as the therapists’ allegiance to a given theory or technique; Munder et al., 2012) to positive therapy outcomes. Approaches to psychotherapy built upon the empirical finding that nonspecific common factors account for the majority of variance in successful therapy outcomes across different types of therapy (see, for example, Wampold’s 2001 contextual model of psychotherapy) came to serve as science-based alternatives to models which maintained the superiority of specific ingredients (e.g., exposure therapy for post-traumatic stress disorder). As I noted in the opening pages of this dissertation, proponents of both positions can point to much research in support of their claims (Lilienfeld & Arkowitz, 2012).

This dissertation sought to advance a new perspective on the “great psychotherapy debate.” Namely, I proposed that the often polemical professional discourse concerning the contributions of common factors and specific ingredients to treatment outcomes has ignored the input of professional psychology’s most important constituency: its consumers. Psychotherapy scholars have acknowledged the importance of considering therapy clients’ preferences on both moral (APA Task Force, 2006) and scientific (e.g., Swift et al., 2011) grounds. The data I have presented here show clearly that preferences matter even before clients schedule their first
appointment—framing the psychotherapeutic process with either common factors or specific ingredients produced reliable differences in participants’ willingness to seek out help when in need. Given the large numbers of people who would likely benefit from therapy but fail to present for services, the finding (now obtained across four independent samples in total) that a majority of the public would prefer the common factors approach suggests a relatively simple tactic for increasing service use: when describing psychotherapy to non-professionals, practitioners of all theoretical persuasions should emphasize common factors, rather than their ability to diagnose and treat. The exploratory analyses presented in Chapter 3 also indicate that the opposite emphasis (specific ingredients over or in addition to common factors) will be most likely to encourage help-seeking when discussing eating disorders, substance abuse, or thought disturbances. Nevertheless, in general, when thinking about themselves in “talk therapy,” it seems that most people would prefer a practitioner who simply provides a safe atmosphere (a healing context) in which they can safely explore their troubles.

The specific ingredients stigma model represents a viable explanation for this effect. According to this framework, which itself derives from the modified labeling theory of mental illness stigmatization, the common factors framing owes part of its relative attractiveness to its focus on situational attributions for psychological problems. That is, it deemphasizes the component of mental illness (namely, the “illness”) that begins the cascade of adverse effects that societal stigmatization has for people’s self-esteem. The necessity of employing diagnostic labels in specific ingredients approaches¹ carries many important benefits, including the ability for clinicians to

¹ After all, how can one apply the correct psychological procedure or intervention if one does not have a clearly defined problem? The current edition of the American Psychiatric Association’s Diagnostic and
communicate efficiently and the ability to operationalize critical research variables (e.g., measuring changes in a standard set of depressive symptoms; Lilienfeld et al., 2009). There is even evidence to suggest that diagnostic labels can increase the positivity of other people’s impressions of those struggling with mental disorder (e.g., in children with attention-deficit/hyperactivity disorders; Cornez-Ruiz & Hendricks, 1993). The notion that the expectation of a mental health diagnosis may impede help-seeking behavior, however, had not been previously investigated. Although this dissertation is certainly not the first attempt to show a relationship between clinical diagnosis and mental illness stigma (e.g., Rosenhan, 1973; Corrignan, 2007), the specific ingredients stigma model articulated here offers a new perspective on the costs such an approach may carry.

Limitations and Future Directions

These interpretations must be qualified by several limitations, which in turn suggest directions for future scholarship. Foremost, although more demographically diverse and representative than many convenience samples, workers in Amazon.com’s Mechanical Turk™ service and members of SocialSci.com’s opt-in pool do not perfectly represent the general population of U.S. adults. For instance, both of my samples underrepresented participants who identify as Hispanic. It is also worth noting in this context that Study 2’s (SocialSci) effect sizes were somewhat smaller than their Study 1 (MTurk™) counterparts (e.g., .29 versus .35 for help-seeking; .33 versus .38 for perceived stigmatization; and .27 versus .36 for the indirect effect of stigma on help-seeking). Each of these reductions fell within the effect sizes’ 95% confidence intervals.

Statistical Manual of Mental Disorders serves as the taxonomic system for the vast majority of specific ingredients approaches to psychotherapy.
However, they might also reflect slight differences in sample characteristics. Unlike Amazon.com’s MTurk™ service, SocialSci has not yet received widespread attention or endorsement from social scientists, and little is known about either the representativeness of its participants or the quality of the data they produce. In the present studies, SocialSci participants were somewhat more educated (e.g., 14.3% of participants in Study 1 held a postgraduate degree, compared to 28.0% in Study 2), slightly less diverse in their racial identifications (75.5% identified as White in Study 1, compared to 85.6% in Study 2) and had more personal experiences with psychotherapy (43.9% reported current or previous psychotherapy in Study 1, compared to 53.9% in Study 2). Whether these differences represent sampling error or systematic patterns in the respective demographics of each participant pool remains an open question. Future research should strive for the most nationally-representative sample possible to bolster confidence in the generalizability and external validity of these results.

A second important limitation concerns the wording of my specific ingredients and common factors descriptions. I did not construct these very brief representations to capture completely the breadth, depth, and heterogeneity within each meta-theoretical model. Certainly, proponents of both approaches might disagree with aspects of these characterizations. For instance, I do not mean to imply that proponents of the medical model ignore nonspecific therapy factors. Indeed, there is no reason to suspect that clinicians who focus on matching symptoms to empirically-supported interventions are less attentive to these elements, such as a strong therapeutic relationship, than advocates of common factors theory. Most of the theoretical work on the demarcation between the two meta-models, including the works I used to distill the descriptions used
in these studies, comes from Bruce Wampold, an outspoken advocate of common factors theory. However, no cogent outline of the medical model's components from a proponent’s point of view seems to exist in the published literature. One explanation for this lacuna is that advocates of specific ingredients approaches do not recognize the common factors model as scientific (Wampold, 2013). Moreover, clients may not face a dichotomous choice between therapies guided by specific or nonspecific factors in everyday life. I aimed only to test the notion that the relative emphases placed on each meta-theory when describing the gist of treatment matters. Insofar as they emphasize differences rather than similarities, I view this study as a preliminary step toward assessing the public’s perceptions of each position. Future studies should vary the wordings, isolate specific features, and include descriptions of therapy utilizing a combination of the two models.

Finally, I advise caution when interpreting the results of this study of help-seeking attitudes as a gauge of what people will actually do when they experience a need for professional psychological help. Although attitudes often predict behavior (and there is evidence that this is true for help-seeking attitudes; Ten Have et al., 2010), there are also likely to be conditions under which they do not (see Fazio, 1990 for a model). Moreover, this study focused exclusively on help-seeking attitudes, ignoring other potentially important factors such as treatment success or attendance patterns, which may be divergently affected (or altogether unaffected) by meta-model framing. For instance, Garland et al. (2012) found that among children with disruptive behavior problems in a community-based clinic, the intensity of evidence-based intervention delivery (the time spent on the practice element and the thoroughness with which it was
administered) was marginally ($p = .059$) related uniquely to the total number of treatment sessions children and their caregivers attended during the 16-month study period. Examining preferences among children and their caregivers may be especially important, especially given the evidence presented here concerning the discrepancy between what people prefer for themselves and for others (e.g., their children).

**Conclusion**

The goals of psychology’s new clinical science movement (promoting rigorous, objective, and empirically-based psychological treatments; e.g., Baker et al., 2009) are more than laudable—they are absolutely integral to the field’s success. To enjoy the status of a scientific discipline, clinical and counseling psychologists must continue to search for the most effective methods of helping those in emotional or psychological distress to improve the quality of their lives. They must do this as scientists, employing the most recent advances in research design and statistical analysis to sort the wheat from the chaff; to identify treatments that work, treatments appear to work but wither under the lights of controlled observation, and treatments that do measurable harm (Lilienfeld, 2007). But they must also accept a paradigm shift when the data suggest the time has come: the search for the “winning” theory of psychotherapy has now retuned enough disappointing data to warrant its sunset. The common factors approach to psychotherapy represents a remarkably viable science-based approach to providing help to those suffering or hoping to make life changes for the better. Unfortunately, the quest to improve psychology’s often distorted public image (Lilienfeld, 2011) by increasing the perception that psychotherapy is scientific, insofar as it entails describing our services as the successful treatment of psychiatric diagnoses, may inadvertently lead many individuals to avoid the endeavor altogether.
Please read this consent document carefully before you decide to participate in this study.

You must be 18 years of age or older to participate.

Purpose of the research study:
You have been invited to participate in a research study. The purpose of this study is to gather some of your opinions about psychotherapy. If you chose to participate in this study, you will be asked to complete an online survey by carefully reading all survey materials and providing honest responses to each question.

Time required:
About 5 minutes.

Risks, Benefits, and Compensation:
There are no known risks or benefits involved in this study. If you choose to participate, you will earn $0.50 for use on Amazon.com through the MTurk™ payment system.

Confidentiality:
All of your responses will be held in confidence, and you will never be identified as a participant. No identifying information will be collected. Your IP address (a numerical identification tied to your Internet service provider) will not be known to the researchers, and will not be collected with your answers.

There is a minimal risk that security of any online data may be breached, but since (1) no identifying information will be collected, (2) the online host (Qualtrics survey software) has SAS 70 Certification and meets the rigorous privacy standards imposed on health care records by the Health Insurance Portability and Accountability Act (HIPAA; see http://www.qualtrics.com/security-statement for Qualtrics’ data security statement), and (3) your data will be removed from the server soon after you complete the study, it is highly unlikely that a security breach of the online data will result in any adverse consequence for you.

Voluntary participation:
Your participation in this study is completely voluntary. You do not have to answer any questions that you do not wish to answer. You have the right to withdraw from the study at any time without consequence.

Whom to contact if you have questions about the study:
Ken Swan, PhD Candidate, Department of Psychology, University of Florida, lkswan@ufl.edu
Martin Heesacker, PhD: Department of Psychology, University of Florida, phone (352) 273-2137.

**Agreement:**
By choosing to respond to the questions in this survey, I am agreeing to the following statement: I have read the procedure described above, I voluntarily agree to participate in the procedure, I have received a copy of this description, and I am at least 18 years of age.
Study 2 (SocialSci)

*Purpose of the research study*:

You have been invited to participate in a research study. Our purpose is to gather some of your opinions about *psychotherapy*. If you chose to participate, you will be asked to complete an online survey by carefully reading all survey materials and providing honest responses to each question.

*Time required*:

About 10 minutes.

*Risks, Benefits, and Compensation*:

There are no known risks or benefits involved in this study. You will earn points for your SocialSci account for participating.

*Confidentiality*:

All of your responses will be held in confidence, and you will never be identified as a participant. No identifying information will be collected. Your IP address (a numerical identification tied to your internet service provider) will not be known to the researchers, and will not be collected with your answers. The final part of this survey asks you to provide some general demographic information about yourself. This information is only used to describe your general characteristics, not to identify you as a person. Analysis of answers will be in aggregate form and individual answers will not be published.

There is a minimal risk that security of any online data may be breached, but since (1) no identifying information will be collected, (2) the online host (SocialSci’s proprietary software) was designed such that it is not possible to link personal survey results with any individual (see https://research.socialsci.com/docs/contents/147-irb_compliance for SocialSci’s data security policies), and (3) your data will be removed from the server soon after you complete the study, it is highly unlikely that a security breach of the online data will result in any adverse consequence for you.

*Voluntary participation*:

Your participation in this study is completely voluntary. You do not have to answer any questions that you do not wish to answer. You have the right to withdraw from the study at any time without consequence.

*Whom to contact if you have questions about the study*:

Ken Swan, M.S., PhD Candidate, Department of Psychology, University of Florida, ta.kenswan@gmail.com
Martin Heesacker, PhD: Department of Psychology, University of Florida, phone (352) 273-2136.

*Whom to contact about your rights as a research participant in the study*:

This study has been approved by the Institutional Review Board at the University of Florida (IRB # 2012-U-1346): IRB02 Office, Box 112250, University of Florida, Gainesville, FL 32611-2250; phone 392-0433.

*Agreement*:

By choosing to respond to the questions in this survey, I am agreeing to the following statement: I have read the procedure described above, I voluntarily agree to participate in the procedure, I have received a copy of this description, and I am at least 18 years of age.
APPENDIX B
STUDY 1’S SURVEY MATERIALS

Welcome! We are truly thankful for your time. As you move through this short survey, please keep in mind that your responses will be strictly anonymous, having never been linked to your name or any other identifying information.

Our research endeavors to find out how people think and feel about psychotherapy: the general process of addressing mental health concerns by talking with a psychologist or other mental health provider. More than 20 years of scientific research have led to the conclusion that psychotherapy works quite well for those who use it. There is some debate among professionals, however, concerning how psychotherapy produces its benefits.

Now, we would like you to read two short answers to the question of how psychotherapy works, written for us by two different licensed mental health professionals (psychologists). After carefully reading and thinking about each answer (imagine what that therapy would look like), please respond to the two questions that follow.

Your deep reflection about these issues means a great deal to us and our research.

First answer:

[Randomized] At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you'll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.

How likely is it that you would schedule an appointment with this therapist if you believed you were having a mental breakdown?

- Very Likely
- Likely
- Somewhat Likely
- Undecided
- Somewhat Unlikely
- Unlikely
- Very Unlikely
Psychotherapy of this kind would not have value for a person like me.

- Strongly Agree
- Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Disagree
- Strongly Disagree

If the people in your life (friends, family, co-workers) found out that you were enrolled in therapy like this description, to what degree do you believe that they would ...

<table>
<thead>
<tr>
<th>...react negatively to you?</th>
<th>Not at all</th>
<th>A little</th>
<th>Some</th>
<th>A lot</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>...think bad things of you?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...see you as seriously disturbed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>...think of you in a less favorable way?</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>...think you posed a risk to others?</td>
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</table>

Second answer:

Randomized] Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.
How likely is it that you would schedule an appointment with this therapist if you believed you were having a mental breakdown?

- Very Likely
- Likely
- Somewhat Likely
- Undecided
- Somewhat Unlikely
- Unlikely
- Very Unlikely

Psychotherapy of this kind would not have value for a person like me.

- Strongly Agree
- Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Disagree
- Strongly Disagree

If the people in your life (friends, family, co-workers) found out that you were enrolled in therapy like this description, to what degree do you believe that they would ...

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
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<td>...think bad things of you?</td>
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<td>...see you as seriously disturbed?</td>
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<tr>
<td>...think of you in a less favorable way?</td>
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<tr>
<td>...think you posed a risk to others?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Please continue on to the next page.
Almost done!

But first, just a quick check to make sure you were paying attention: Which of the following was part of one of the descriptions of how therapy works we showed you in this survey?

- "Freudian therapy seems to work best for treating panic attacks”
- "a confiding relationship with a therapist, in which you can discuss your concerns with someone who will work in your best interest.”
- "cognitive-behavioral therapy works best for treating depression and anxiety disorders, but not for eating disorders."

Please continue on to the next page.
This last section of demographic information is only used to describe your general characteristics, not to identify you as a person.

Age: ____________________

Gender
☐ Male (1)
☐ Female (2)

Racial identification (please select all that apply)
☐ American Indian or Alaska Native (1)
☐ Asian (2)
☐ Black or African-American (3)
☐ Native Hawaiian or Other Pacific Islander (4)
☐ White (5)
☐ Some Other Race (6)

Which of the following best matches how you identify yourself?
☐ Hispanic or Latino/Latina (1)
☐ Not Hispanic or Latino/Latina (2)

Highest level of education completed
☐ 8th grade or less (1)
☐ 9th to 12th grade (2)
☐ High school graduate (3)
☐ Some college (4)
☐ Associate's degree (5)
☐ College graduate (6)
☐ Postgraduate work/degree (7)

Marital Status
☐ Married (1)
☐ Widowed (2)
☐ Divorced (3)
☐ Separated (4)
☐ Never married (5)
☐ Living with partner (6)
Household income
- Less than $9,999 (1)
- $10,000-$19,999 (2)
- $20,000-$34,999 (3)
- $35,000-$49,999 (4)
- $50,000-$99,999 (5)
- $100,000-$149,999 (6)
- $150,000+ (7)

Which geographic region best describes where you live in the US?
- Northeast (1)
- Midwest (2)
- South (3)
- West (4)

Have you ever in your life seen a psychiatrist, psychologist, or social worker for counseling or therapy? [Yes/No]

If you have ever in your life seen a psychiatrist, psychologist, or social worker for counseling or therapy, please indicate which of these two explanations of how therapy works best matches the kind of therapy you received (please choose all that apply):

- “At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you’ll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.”
- “Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.”
- Neither of these choices matches the kind of therapy I received.
Now, we’ll get a little bit more specific. Below are some problems for which people may seek help through psychotherapy. *Imagining that you were experiencing the problem listed below, which type of therapy would you prefer?*

**Therapy A**

[Randomized] At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you’ll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.

**Therapy B**

[Randomized] Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.

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<thead>
<tr>
<th>Feeling/Problem</th>
<th>Therapy A</th>
<th>Therapy B</th>
<th>No Preference</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of sadness, loss, guilt, or hopelessness that interfere with your everyday life for weeks or longer.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>The almost constant presence of worry or tension, even when there is little or no cause.</td>
<td>☐</td>
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</tr>
<tr>
<td>Serious disturbances to your everyday diet, such as a strong urge to eat extremely small amounts of food or severely overeat.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
The compulsive use of drugs or alcohol, despite its negative or dangerous effects on your daily life.

A loss of contact with reality, such as false beliefs about what is taking place or who one is (delusions), or seeing or hearing things that aren’t there (hallucinations).

Great! Now, things get a bit tricky. We ask that for the rest of the questions on this page, you think about other people in psychotherapy, rather than yourself:

Therapy A

[Randomized] At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you’ll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.

Other people should schedule an appointment with this therapist (Therapy A) if they believed they were having a mental breakdown. *

- [ ] Strongly agree
- [ ] Agree
- [ ] Somewhat Agree
- [ ] Neither Agree nor Disagree
- [ ] Somewhat Disagree
- [ ] Disagree
- [ ] Strongly disagree
Psychotherapy of this kind (Therapy A) would *NOT* have value for other people. *

- Strongly agree
- Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Agree
- Disagree
- Strongly Disagree

Therapy B

[Randomized] *Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.*

*Other people* should schedule an appointment with this therapist (Therapy B) if they believed they were having a mental breakdown. *

- Strongly agree
- Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Disagree
- Disagree
- Strongly disagree

Psychotherapy of this kind (Therapy B) would *NOT* have value for other people. *

- Strongly agree
- Agree
- Somewhat Agree
- Neither Agree nor Disagree
- Somewhat Agree
- Disagree
- Strongly Disagree
Which of these two approaches to therapy do you think that the author of this survey favors?

- “At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you'll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.”

- “Psychotherapy begins with the goal of an accurate diagnosis. This in turn points the way to an explanation for your symptoms, and the best course of treatment. Then, your therapist can administer a set of specific therapeutic interventions designed to target your particular problem. The benefits of psychotherapy are due to your participation in these scientifically-established therapy ingredients.”

- Neither of these choices

Before you started this survey, which of these types of therapy would you have expected to receive if you sought help from a psychologist?

- “At their core, all psychotherapies provide a confiding relationship with a therapist, in which you can safely discuss your problems with someone who will work in your best interest. As that relationship develops, you'll both attempt to better understand the reasons for your troubles. The final step requires active involvement from both you and your therapist as you work to bring about a change in your life.”

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- Neither of these choices
REFERENCES


BIOGRAPHICAL SKETCH

L. Ken Swan received his Ph.D. in psychology from the University of Florida in the summer of 2013. Subsequently, Ken obtained a faculty position in the University of Florida’s Department of Psychology, where he will serve as a full-time lecturer. Ken also plans to pursue licensure as a mental health counselor, and a new program of clinical research investigating the scientific and economic viability of providing supportive, common-factors-based psychotherapy to the socially marginalized and underprivileged on a large scale.