# COLLABORATIVE CARE MANAGEMENT: THE INFLUENCE OF LOCATION OF CARE ON MENTAL HEALTH SELF-STIGMA

by

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Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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# Abstract

This study was designed to contribute to the literature on self-stigma as it relates to mental health. Specifically, it was designed to explore whether those who received a certain type of care in the primary care setting (i.e., Collaborative Care [CoCM]) experienced self-stigma differently than those who received mental health care in more traditional settings or no care at all. It was hypothesized that those who received CoCM would experience lower rates of self-stigma. Participants for the study were drawn from a purposive sample of adult primary care patients with depression from a large health system located in upstate South Carolina. A total of 58 individuals participated in the study. Differences in results were not statistically significant. The lack of any statistically significant difference in self-stigma scores between the two groups, despite participation in CoCM, supports that interventions focused only on care integration may not be sufficient to overcome the barrier of self-stigma.

*Keywords*: integrated care, collaborative care, stigma, mental health treatment, primary care

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# List of Abbreviations

Collaborative Care (CoCM)

Advancing Integrated Mental Health Solutions (AIMS)

Self-Stigma of Seeking Help Scale (SSOSH)

# Chapter One: Introduction

## Overview

This work involved examining how self-stigma affects people's attitudes toward seeking care for mental health symptoms, specifically whether the location of the care influences their attitudes. The study was a quantitative quasi-experimental static-group comparison design in which the researcher attempted to answer the following questions: Is there a difference in self-stigma toward seeking mental health care between primary care patients with depression receiving Collaborative Care (CoCM; as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM? Is there a difference in self-stigma toward seeking mental health care between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM? Is there a difference in self-stigma toward seeking mental health care between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM? Is there a difference in how the male and female groups are affected by the location of care? This chapter provides the background of the problem, how the study was designed to address the gap in the literature, the purpose of the study, the significance of the study, the research questions, and pertinent definitions related to the topic.

## Background

In an average year, one in five adults in the United States (i.e., approximately 50 million people) are living with a diagnosable mental illness (McBain et al., 2023). This number was significantly affected by the COVID-19 pandemic , resulting in an increase of individuals affected by mental illness (Amsalem et al., 2021). In 2019, suicide was the cause of 47,500 deaths in the United States(World Health Organization [WHO], 2021). However, despite their significant prevalence and associated high risks, mental health issues remain underdiagnosed and undertreated (Center for Health Care Strategies, 2019). Many researchers attribute self-stigma as a primary cause of this issue (Rössler, 2016).

## Historical Context

The idea of stigma has been studied since the late 1800s, with Emile Durkheim's research on social integration (Durkheim, 1893). Durkheim believed individuals are influenced by the societal norms of their time, which shape their behavior. He argued that societal values are collectively shaped by the people who live in that society, and that stigma serves a purpose in creating a sense of unity and community among the in-group by labeling certain groups as "other." In doing so, stigma functions as a preservation of a sense of social integration (Goldstein, 2002).

Around the middle of the 20th century, Erving Goffman's book, Stigma: Notes on the Management of Spoiled Identity introduced a more scientific understanding of mental health stigma. He introduced a cognitive perspective of stigma that complemented Durkheim's sociological approach to the concept. In the book, he determines stigma to be a socially constructed concept that arises from interactions between individuals and society. This is as opposed to an inherent attribute of an individual or group (Goffman, 1963).

A few years later, Thomas Scheff (1966) also made a significant contribution to the research on mental health stigma. He developed a labeling theory of mental illness. This was built on the foundation of the existing labeling theory. Labeling theory says that the labels that are assigned to individuals by society can strongly influence their behavior and perception of themselves. Scheff expanded upon this theory to specifically address stigma related to mental illness rather than general stigma related to specific traits (Scheff, 1966).

Edward Jones and colleagues were next in their contributions. They identified and defined different dimensions of stigma. The level of stigma that is associated with a specific characteristic or condition is believed to be related to these different dimensions, as described by Jones et al. (1984).

Gerhard Falk, a German sociologist and historian, also made significant contributions to the stigma literature by introducing two categories of stigma: existential stigma and achieved stigma. Existential stigma stems from a condition the stigmatized individual either did not cause or over which they lack control. Achieved stigma is stigma “earned by” people as a result of their behavior or choices. (Falk, 2001). Link and Phelan (2001) were also important figures in the conceptualization of stigma. They proposed that stigma exists under four specific conditions: individuals being distinguished based on differences and labeled accordingly, dominant societal beliefs associating labeled individuals with negative characteristics, labeled individuals being separated into groups to create a sense of “us” versus “them,” and labeled individuals experiencing a reduction in status and discrimination (Link & Phelan, 2001).

## Theoretical Context

The primary theory of public stigma toward individuals with mental illness is based on attribution theory, which was proposed by Fritz Heider in 1958. Attribution theory says that how people assign cause to a behavior influences how they treat people with that behavior. In other words, if a behavior is determined to be that person’s fault, then they will more likely be stigmatized (Heider, 1958). Kelley (1967) further developed this theory by introducing the covariation model of attribution, which emphasizes the presence or absence of factors when an individual engages in a particular behavior. If people believe individuals have control over their mental illness, it is called dispositional attribution. Making this attribution may cause people to avoid, not help, and discriminate against those with mental illness. It is thought that believing in a person's responsibility decreases compassion and increases anger and fear, leading to rejection. This is particularly true if people also believe those with mental illness are dangerous, which intensifies fear (Corrigan et al., 2003).

### Social Context

Mental illness is a prevalent issue worldwide, with an estimated global prevalence of 29.1% in 2020 (Nochaiwong et al., 2021). This has significant financial implications for society, with mental health disorders accounting for approximately five trillion dollars in disability related lost income (Arias, Saxena, & Verguet, 2022). The impact of mental health conditions is not limited to monetary costs, as over half of adults in permanent supportive housing have a mental or co-occurring substance use disorder (U.S. Department of Housing and Urban Development, 2016), and comorbidities with chronic physical illnesses are also prevalent, estimated at 68% in some studies (Daré et al., 2019).

Stigma is a major barrier to seeking care for individuals with mental illness, and the literature heavily focuses on this topic. Research has shown stigma is often perceived as a more significant barrier to care than are structural barriers such as cost and availability of providers, and overcoming stigma may help individuals to address other barriers to care (Andrade et al., 2014). In summary, stigma is an issue that significantly affects a large number of people and much research has been devoted to reducing the impact of stigma on receiving mental health care. Though this is the case, gaps in the literature remain.

## Problem Statement

Typically, individuals with mental health issues are initially identified in primary care facilities. According to one study, around 70% of primary care appointments involve some aspect of behavioral health (Collins, 2009). Primary care physicians prescribe almost 80% of antidepressant medications (Barkil-Oteo, 2013). Depression is particularly widespread. In fact, it is the most prevalent mental health diagnosis in the United States (Kessler et al., 2012), as approximately 21.0 million adults in the US had one or more major depressive episodes. In other words, 8.4% of all U.S. adults have experienced a depressive episode. In 2019, 18.5% of adults reported symptoms of depression in the past 2 weeks (Villarroel & Terlizzi, 2020).

However, despite their frequency in primary care settings, behavioral health conditions are often not properly recognized or treated, highlighting the need for support (Unützer et al., 2002). Primary care doctors report a deficiency in training and confidence about diagnosing and treating mental illness (McCaffrey et al., 2021). Choi et al. (2019) surveyed primary care clerkship directors for medical schools and asked them to estimate the percentage of students exposed to integrated behavioral health. Of those surveyed, 44% reported 0%–20% of their students had been exposed. Psychiatry is typically a 4-week rotation out of the 4 years of medical school (Jafari et al., 2012). The Society for the Teachers of Family Medicine reported that there is not consistency in training on behavioral health across residencies and identified behavioral health as a major gap in the education of resident physicians (Landoll et al., 2020).

To address this lack of training, integrated behavioral health settings have become more common (Curtis & Christian, 2012). Integrated behavioral health care refers to a primary care approach that addresses both physical health conditions and behavioral health concerns, considers biopsychosocial factors, and involves a treatment team (Reiter et al., 2018). The current literature on integrated behavioral health has centered on Collaborative Care, also known as CoCM. Integrating behavioral health into primary care is intended to reduce the stigma surrounding seeking services, according to P. J. Robinson and Strosahl (2009). The problem is this benefit is often mentioned in the literature without supporting evidence (American Psychiatric Association & Academy of Psychosomatic Medicine, 2016, p. 10; Bree Collaborative, 2017, p. 14; Linkins et al., 2013, p. 5; WHO, 2008, p. 21).

## Purpose Statement

Rowan et al. (2021) stressed the need for further investigation into the correlation between integrated primary care and mental health stigma. In their literature review on this topic, they found only seven articles that provided evidence of a connection. In addition to the scarcity of relevant articles, Rowan et al. found methodological flaws in some of the studies, highlighting the need for more rigorous research. As a result of the limited number of studies and methodological limitations, the authors concluded that any assertions about the effect of integrated care on stigma and help-seeking remain uncertain (Rowan et al., 2021).

Although there is a research gap concerning the relationship between integrated behavioral health and self-stigma, the gap is even wider with regard to CoCM and self-stigma. According to the University of Washington AIMS Center, which maintains a database of published articles on CoCM numbering approximately 65, none of them investigated the purported advantage of decreased self-stigma (University of Washington AIMS Center, 2021). Thus, the purpose of this quantitative quasi-experimental study was to determine to what extent the location of care received affects a person’s experience of self-stigma.

## Significance of the Study

The current study was designed to add to the literature on the understanding of self-stigma. As mentioned previously in this work, there is evidence to support that stigma is a larger barrier to people receiving care than are structural barriers (Andrade et al., 2014). As a result, any understanding of how to reduce stigma may be instrumental in increasing the number of people who can access and receive care for their mental health conditions. If a link is established between CoCM and reduced stigma, it could lead to the creation of more effective interventions to address the stigma associated with mental health disorders. This could be a significant step in increasing access to care and improving mental health outcomes for individuals who might otherwise avoid seeking mental health care due to the stigma surrounding mental illness.

## Research Questions

**RQ1:** Is there a difference in self-stigma toward seeking help between primary care patients with depression receiving Collaborative Care (CoCM; as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM?

**RQ2:** Is there a difference in self-stigma toward seeking help between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM?

**RQ3:** Is there a difference in self-stigma toward seeking help between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM?

**RQ4:** Is there a difference in how the male and female groups are affected by the location of care?

## Definitions

Collaborative Care (CoCM): a patient-centered, team-based approach to providing mental health care that involves a primary care provider, a behavioral health care manager, and a mental health specialist, usually a psychiatrist, working together to deliver integrated care (University of Washington AIMS Center, 2022).

Integrated behavioral health care: the coordinated and collaborative provision of physical and mental health care services within a primary care setting (American Psychiatric Association, 2014).

Public stigma: negative attitudes, beliefs, and behaviors held by society toward individuals with a stigmatized condition, such as mental illness (Link & Phelan, 2001).

Self-stigma: " characterized by the acceptance of negative attitudes and stereotypes held by society and the application of those stereotypes to oneself" (Corrigan et al., 2016, p. 3).

Stigma: a means of separating people based on a social construct that certain individuals or groups are different or other (Corrigan et al., 2003).

## Summary

This chapter served as an introduction to this study on how self-stigma affects people's attitudes toward seeking mental health help and whether the location of care influences these attitudes. The research involved the use of a quantitative quasi-experimental static-group comparison design to answer the following questions: Is there a difference in self-stigma toward seeking mental health care between primary care patients with depression receiving Collaborative Care (as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM? Is there a difference in self-stigma toward seeking mental health care between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM? Is there a difference in self-stigma toward seeking mental health care between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM? Is there a difference in how the male and female groups are affected by the location of care?

Chapter 2 provides a more in-depth background of the concepts discussed in this study as well as a review of the related literature.

# Chapter Two: Literature Review

## Overview

Behavioral health conditions are widespread and contribute significantly to the disease burden in the United States (Kamal et al., 2017). Mental illness can be described as a pandemic of the 21st century and most agree it is a significant global health challenge. Despite these facts, mental health issues remain underdiagnosed and undertreated (Center for Health Care Strategies, 2019). Many believe self-stigma is a primary driver of this problem (Rössler, 2016).

The current study was designed to contribute to the literature surrounding self-stigma. The specific focus was on how self-stigma relates to mental health treatment seeking among patients in a primary care setting. A better understanding of this issue will represent a significant step toward increasing the number of people who seek treatment for their mental health. Specifically, the study was designed to explore whether those with depression who receive a specific type of care in the primary care setting (i.e., CoCM) experience self-stigma differently than those with depression who receive mental health care in more traditional settings or no care at all. Chapter 2 is divided into the following sections: conceptual framework, related literature, and summary.

## Conceptual Framework

Stigma is a means of separating people based on a social construct that certain individuals or groups are different or other. Stereotypes, prejudice, and discrimination can all be rooted in stigma. Stigma has affected numerous areas of health but possibly the clearest means of impact in the literature is that of mental health stigma (Corrigan et al., 2003).

## Theory of Social Integration

A discussion of the societal construct of stigma around mental health must start with French sociologist Emile Durkheim's contribution to the field of study of society itself. It is not lightly that he is referred to as the father of sociology. His contribution to the literature is encompassed in his theory of social integration (Durkheim, 1893). In this theory, Durkheim (1893) suggested that morality is a construct of society. He described a process of phases or selves individuals go through: the primal self and the social self (Durkheim, 1893). The primal self is akin to Freud's id. It is impetuous, self-centered, and unbothered by societal expectations. The social self, in turn, describes a person who has transitioned out of egotism into someone who is conformed to society through social integration. Durkheim (1893)stressed social facts as the foundation of this transformation and as vital in understanding the behavior of any one person. Social facts are any method of acting with the ability to exert over the person an external constraint. These can also be described as cultural mores or societal norms. In short, Durkheim stated people are molded, and all of their behavior is affected by the societal norms of their time.

Out of this social integration process comes what Durkheim (1893) coined a collective unconscious, defined as a morality shared by a group of people. The more socially integrated a group of people is, the more similar their beliefs and expectations are likely to be around issues of morality. In Durkheim's view, people are shaped by their society's values and they, in turn, collectively shape these societal values (Durkheim, 1893). Using this conceptualization, many sociological phenomena can be explained by a society's level of social integration (Durkheim, 1893). This work led to the first documented exploration of stigma by Durkheim (1893). He described the purpose stigma serves within a society and explained that describing groups as "other" helps to create a feeling of unity and community for those in the in-group, thus preserving their sense of social integration (Goldstein, 2002).

**Erving Goffman's Theory of Stigma**

A more scientific conceptualization of mental health stigma began emerging midway through the 20th century in the book, *Stigma: Notes on the Management of Spoiled Identity* by Erving Goffman (Goffman, 1963). Goffman was a major sociological figure in the 20th century and his book served as the basis for research on the concept of stigma. In the book, Goffman made the argument that mental conditions are highly stigmatizing (Goffman, 1963). Of note, this text was written following Goffman immersing himself in a psychiatric hospital in Washington, DC (Plotz, 2019).

In Goffman's (1963) theory, stigma is a characteristic, behavior, or reputation that is socially disgracing. This characteristic or behavior then results in the person being cognitively classified by others based on a negative stereotype. According to Goffman (1963), people relate to stigma in one of three ways: they are the stigmatized, the normals, or the wise. He described how "normals" dehumanize those who are stigmatized and then discriminate against them in ways that hurt their ability to achieve success (Goffman, 1963). The category described as wise consists of "normals" who act more understanding of the stigmatized or are considered honorary members of the group. This may be a family member of a stigmatized individual who is not a part of that group but has intimate knowledge of the group (Goffman, 1963).

To avoid discrimination, Goffman (1963) described how people work to protect the parts of their identities that will alter others' impressions of them, primarily through concealment. It is clear to see that the fear of being identified as a member of the stigmatized for those dealing with mental health issues would influence treatment seeking. In short, a major contribution Goffman made was a cognitive conceptualization of stigma to add to Durkheim's sociological conceptualization of the construct.

### Labeling Theory

Another seminal contributor to the body of research is Thomas Scheff (1966). His contribution to the literature is described as a labeling theory of mental illness, building on the foundation of traditional labeling theory (Scheff, 1966). The traditional theory states people's behaviors and their perception of their identity are strongly influenced by the labels placed on them by society. The position is that the concept of deviance is based on the majority placing expectations on the minority or those who do not conform to cultural norms (Muncie, 2010).

Scheff's (1966) theory built on this but specifically in terms of the concept of mental illness. It starts with the messages we receive as children about people with mental illness. Simply through typical everyday interactions, we learn stereotypes about this group people of people exemplified in words like "crazy" or "nuts." These words are connected with "disturbed" behaviors and violent crimes, creating stigmatized beliefs (Scheff, 1966). Additionally, Scheff (1966) assumed all people will experience psychological symptoms at some point in life. For most people, these symptoms are explained away so they escape being labeled. However, if the norm violation is large enough, the deviant behavior is classified as mental illness (Scheff, 1966).

Then, when the behaviors of an individual are labeled as mental illness, this elicits these learned negative stereotypes, leading people to socially reject the individual. They are treated with distrust, hostility, and removed from opportunities for social engagement and employment. This social rejection results in changes in the identity of the stigmatized individual. The person then starts to take on the role of a "mentally ill person," internalizing that stigma. Similar to

Durkheim's point that stigmatizing serves to strengthen the in-group (Durkheim, 1893), chronic mental illness serves a social role in ensuring people fit into certain roles in society. This also results in them having a defined identity (Scheff, 1966).

### Six Dimensions of Stigma

Building from the foundational work of Goffman's conceptualization is Edward Jones and colleagues' six dimensions of stigma. They described stigma as comprising concealability, course, disruptiveness, peril, aesthetics, and origin (Jones at al., 1984). The idea is that the level of stigma attached to a particular characteristic or condition is correlated with these different dimensions (Jones et al., 1984).

The first is concealability, which refers to whether or not the stigmatized characteristic is something that can be hidden. Characteristics that are easily identified, such as race, are more stigmatized than are those that can remain secret (Jones et al., 1984). When examining research on mental health stigma specifically, this helps explain the heightened stigma toward a disorder like schizophrenia as compared to a disorder like major depressive disorder (Lundberg et al., 2007).

The next characteristic is course. In other words, how the stigmatized characteristic progresses or changes over time. Another way to phrase this concept or dimension is stability. How likely is it that the characteristic will go away or is it chronic in nature? Characteristics that are more chronic in nature are likely to carry higher stigma (Jones et al., 1984). Related to course is the concept of disruptiveness or how the condition affects day-to-day life and interactions in relationships (Jones et al., 1984). This also includes how it affects the potential for success in society, pointing back to Goffman's discussion of the impact of stigma on success as well as Scheff's description of what causes behaviors to be labeled (Goffman, 1963; Scheff, 1966). The more disruptive a characteristic is or the more it is perceived to reduce the chances of success in life, the more stigma that is attached (Jones et al., 1984).

The next dimension is peril or perceived degree of dangerousness. If a disorder or characteristic is observed as destructive to the person or other people, a high level of stigma comes along with that perception (Jones et al., 1984). This dimension, in particular, is considered to be a foundational aspect of the stigma literature and one that is cited frequently (Jones et al., 1984). Hand in hand with the peril dimension is aesthetics or how displeasing a characteristic is to others. Behaviors that are considered outside of societal norms cause people to feel uncomfortable and have higher levels of stigma toward the people doing those behaviors (Jones et al., 1984).

The last dimension is that of origin or controllability, another cornerstone of the stigma literature. If an undesired or abnormal behavior is considered to be under the control of a person, then the stigma attached to it is high (Jones et al., 1984). This idea is further reinforced through attribution theory, discussed later in this chapter.

Gerhard Falk, a German sociologist and historian, contributed to the stigma literature as well. He echoed those who came before him by grounding his theory in the idea that stigma will always exist because of the purpose it serves in society. Namely, it creates a sense of solidarity in groups that enables them to distinguish between outsiders and insiders (Falk, 2001).

Falk (2001) conceptualized two categories of stigma: existential stigma and achieved stigma. Existential stigma stems from a condition the stigmatized individual either did not cause or which they lack control. This would include stigma based on race, age, marital status, weight, or mental illness. Achieved stigma is stigma “earned by” people as a result of their behavior or choices (Falk, 2001). Examples would be the stigma that is attached to immigration, homelessness, prostitution, addiction, and criminal history. Falk went on to describe that existential and achieved stigma not only affect the stigmatized individual but those surrounding them as well (Falk, 2001). This includes friends, families, support networks, and others. This serves to continue to isolate those who are stigmatized (Falk, 2001). Falk’s points connect with those who came before in acknowledging that the perception of cause or fault affects the experience of stigma.

### Link and Phelan

Two other major figures in the conceptualization of stigma are Link and Phelan (2001). They proposed that stigma exists under four specific conditions: individuals distinguish between each other based on differences and label those differences, dominant societal beliefs associate labeled individuals with negative characteristics, those who are labeled are separated into groups with the purpose of creating a sense of separation between “us” and “them,” and labeled people experience a diminishment of status and resultant discrimination (Link & Phelan, 2001).

Link and Phelan (2001) started with the idea that there are countless differences between human beings, but stigma is not attached to every one of these differences. In fact, most of these differences are ignored. However, there are differences to which people attach meaning and these are primarily social in nature. The social nature of these meanings is demonstrated in multiple ways. First, these differences happen as a result of oversimplification in order to create groups (Link & Phelan, 2001). Examples include race or disability status. Both of these categories occur on a spectrum and there is variation in the subcategories, but society tends to treat them as a clear category. Second, the differences that are determined to be relevant differ significantly according to both time and place. Due to the socially constructed nature of these characteristics, Link and Phelan (2001) suggested the intentional use of the word label rather than attribute or characteristic.

The next condition Link and Phelan (2001) described is the association of certain labels with negative characteristics or stereotypes. This was an idea first brought forth by Goffman (1963) that Link and Phelan expanded upon. These stereotypes are often “automatic” for people who may believe them without even realizing they do. This is largely a function of the brain’s design for efficiency and compartmentalization (Link & Phelan, 2001).

The third condition described by Link and Phelan (2001) is the idea that those who are labeled are separated into groups with the purpose of creating a sense of separation between “us” and “them” (Link & Phelan, 2001). The construct of “us” versus “them” is well-documented throughout human history. The other components of stigma exist to rationalize this one. From society’s perspective, based on these negative characteristics, those with negative labels are fundamentally different from those who do not share the label. As a result, it makes sense to separate them and treat them differently. This is demonstrated in identity-based labels. An example is describing a person who has epilepsy as epileptic. We do not see such language used for people diagnosed with cancer or the flu. They are not “other” (Link & Phelan, 2001).

The last component of Link and Phelan’s (2001) research is a new addition to the literature that Link and Phelan (2001) argued is essential to any discussion of stigma. In order for stigma to truly exist, labeled people must experience a diminishment of status and resultant discrimination (Link & Phelan, 2001). When reading through the previous three conditions, it is clear to see how the last one exists. When people are placed into separate categories and associated with negative qualities, it stands to reason that they would be negatively affected (Link & Phelan, 2001). The research is consistent in indicating those who are stigmatized experience poorer outcomes financially, medically, socially, and mentally (Druss et al., 2000). This status loss is theorized to result from both individual and structural discrimination. Examples of individual discrimination include refusing to hire or refusing to rent housing to a person of a certain group. Structural discrimination refers to the discrimination that is built into the very system that exists. It is the collection of practices that work to the disadvantage of stigmatized persons (Link & Phelan, 2001). An example of structural discrimination would be the amount of public funding that goes into research surrounding a particular condition. If that condition is highly stigmatized, it will receive less funding and less research. Both forms of discrimination lead to an internalization by the stigmatized persons. They are not immune to the influences of society and often hold similar stigmatizing beliefs toward themselves (Link & Phelan, 2001).

### Stigma Allure

Matthew Hughey contributed some nuance to the conceptualization of stigma (Hughey, 2012). Prior to his work, the literature focused on responding to stigma by stigmatized individuals attempting to camouflage or hide, ostracizing the stigmatized, or stigmatized individuals sharing their stigmatized characteristic with only a select group of people. In contrast, Hughey proposed the idea of stigma allure, in which people embrace their label as either a mark of morality or authenticity. Some people, rather than trying to pass as “normal,” may purposefully embrace a stigmatized identity with the purpose of gaining a sense of control. His research mainly focused on stigma attached to identity as a White antiracist (Hughey, 2012).

Hughey’s (2012) contribution to the field of stigma can be summed up in four main points. First, he posited the expansion of the view of stigma past just the relation of the top of the hierarchy to the bottom of the hierarchy. Second, he stated stigma does not require deviation from societal expectations. Rather, cohesion in society can be created through the struggle against norms, not just the enforcement of norms. Third, stigma does not automatically trigger stereotypes. Last, managing stigma and reducing stigma should be viewed as separate constructs (Hughey, 2012).

### Communication of Stigma

This brings us to Rachel Smith's contribution to the literature focusing on the communication of stigma. She argued that communication plays a significant role in the creation, maintenance, and spread of stigmas. Her model indicates the communication of stigma messages is composed of specific constructs: marks/labels, responsibility, and peril. The purpose of the communication is to bring about emotional and cognitive responses and create the stigma (Smith, 2007).

The idea of marks encompasses a physical characteristic, a label, or even the use of pronouns that denote someone as different or part of a stigmatized group. When these marks and labels are communicated, stigma appears. Language around responsibility is another way to communicate stigma. This goes back to Jones et al.'s (1984) six dimensions of stigma. If a certain behavior or condition is chosen, then that choice is considered to result from a character flaw and stigma is deserved. Stigma messages also convey communication of peril or danger that a person with a condition or label may bring. Peril is communicated by signal words (danger or warning), hazard statements (specifying what quality holds danger), hazard avoidance statements (encouragement to avoid the stigmatized), and consequence statements (the results if the recommendation for avoidance is ignored). This can also be communicated nonverbally. For example, there could be ominous music playing on a television show portraying a character with mental illness or their costuming suggesting they are the villain in the story (Smith, 2007).

The next step in the model is the reactions to the message. Smith (2007) posited that people respond cognitively to messages conveying stigma by gaining access to associated social beliefs and stereotypes. Communication of stigma then has a great ability to persuade when the stigmatized label conjures more disgust and cannot be easily hidden, when those who are stigmatized are labeled as “other” or as less than human, and when the perception of danger is high. The emotional reactions that accompany these messages range from disgust to anger to fear. Typically, a higher emotional association results in a more entrenched belief. All of this elicits a continued sharing of the stigma message (Smith, 2007).

Last, Smith (2007) described the effects of the message. First, a stigma attitude is developed, both by the marked and by the unmarked. The marked have a higher chance of self-isolation, which results in significant mental distress, decreased self-esteem, and smaller support circles. The unmarked contribute to this by isolating the stigmatized in an attempt to self-protect against the perceived danger, whether physical or social. In a continued attempt toward this self-protection, the stigma message continues to be dispersed (Smith, 2007).

## Attribution Theory

The predominant theory of public stigma toward individuals with mental illness is based on attribution theory, proposed by Fritz Heider in 1958. Attribution theory lends to the understanding about how people relate to and make sense of society and the individuals in that society. Heider described people as “psychologists” who attempt to make sense of other people by creating cause and effect relationships. In short, attribution theory reflects how people explain the causes of others’ behaviors and events in life. The idea is that how a person attributes cause affects how they feel about and relate to others (Heider, 1958).

Heider posited there are two types of attribution: dispositional and situational. Dispositional attribution is when causality is assigned to some sort of internal factor. Internal factors are within the control of a person. People have a choice about how they behave. Examples would be attributing someone's behavior to their personality, beliefs, or motives. Situational attribution is when causality is assigned to an external factor. This is a factor outside of the control of the person. Whatever happened or was done was the result of something in the environment, rather than the choice of a person (Heider, 1958).

## Covariation Model of Attribution

Kelley (1967) expanded upon attribution theory with the addition of the covariation model of attribution. His model emphasizes the factors that are present when a person engages in a behavior and what factors are not present. He posited there are three attribution factors: consistency, distinctiveness, and consensus.

Consistency looks at how often a person engages in a specific behavior. In other words, does it happen more than once? If a behavior tends to happen consistently, a person is likely to make a dispositional attribution about that behavior. Distinctiveness has to do with whether or not a person's behavior is typically the same toward different stimuli. More distinction lends people toward a situational attribution. Consensus relates to whether others in general tend to behave in the same way. The theory indicates all three of these factors contribute to a person's conceptualization of attribution (Kelley, 1967).

When people believe that whether someone has a mental illness is under their control, they are making a dispositional attribution. Those who make a dispositional attribution of mental illness are more likely to avoid those people, are less likely to help them, and will endorse prejudicial and discriminatory behavior toward them. The theory is that the belief in that person’s responsibility decreases pity and increases anger and fear, which results in rejection. This is even more so the case if there is a belief that people with mental illness are dangerous, which also increases fear (Corrigan et al., 2003).

## Related Literature

### Prevalence and Significance of Mental Illness

The prevalence of mental illness is seen across the globe. In 2020, the worldwide prevalence of all mental illness was estimated at 29.1% (Nochaiwong et al., 2021). The estimated prevalence of depression was 28% and the prevalence of anxiety was 26.9% (Nochaiwong et al., 2021). These numbers, of course, vary from country to country. For depression, prevalence ranged from 14.5% in South Africa to 63.3% in the country of Brazil. For anxiety, prevalence ranged from 7.7% in Vietnam to 49.9% in Mexico. The global prevalence for suicidal ideation was 16.4% (Nochaiwong et al., 2021).

Around one in five American adults live with any mental illness (Substance Abuse and Mental Health Services Administration, 2021). In 2020, this number equaled 52.9 million people. In the same year, of those 52.9 million adults, 14.2 million experienced serious mental illness (SMI; Substance Abuse and Mental Health Services Administration, 2021). In other words, 5.6% of all American adults experienced SMI in 2020. SMI is defined as a mental, behavioral, or emotional disorder that results in considerable functional impairment with impact in one or more major activities of daily living (Substance Abuse and Mental Health Services Administration, 2021). Among adolescents aged 13–18 years, the number is even higher. In 2020, an estimated 49.5% of adolescents had any mental illness. Of those adolescents, 22.2% were seriously impaired by their symptoms (Merikangas et al., 2021).

Mental illness has significant financial effects on society. In 2019, spending to provide treatment for adults with mental disorders was a total of $106.5 billion (*Healthcare Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Population, 2019*, 2022). Over a lifetime, the estimated costs of perinatal depression and anxiety alone to both mother and infant are $112,299 and $51,622. Suicide and non-suicidal self-injury cost the United States over $1 trillion in 2019 (Rockett et al., 2023).

Much of this cost is due to loss in workplace productivity. Poor mental health is linked with decreased productivity, increased workplace absences, and an increased chance of unemployment. People diagnosed with a mental illness make up 30%–40% of disability benefit cases and the total expense of disability benefit funding related to mental health conditions is around 0.7% of the average gross domestic product (OECD, 2015).

However, the cost of mental health conditions is measured in more than just dollars. According to data collected from the Department of Housing and Urban Development, more than half of adults living in permanent supportive housing either have a mental disorder or co-occurring mental and substance use disorder (U.S. Department of Housing and Urban Development, 2016). People with mental health conditions use drugs that harm their health at higher rates than do people without mental health diagnoses (U.S. Department of Health and Human Services, 2018). Many children with emotional problems have difficulty in school. In fact, the suspension/expulsion rate for these children is 68% (Kang-Yi et al., 2018). Mental health conditions are often linked with one or more chronic physical illnesses. One study estimated the prevalence of these comorbidities at 68% (Daré et al., 2019).

## Barriers to Care

Despite the high worldwide prevalence of mental health conditions, most people who experience them do not get the care they need (“Mental Health America issues report,” 2021). As previously discussed, the cost, emotionally and financially, of mental illness is high. Part of the reason for this cost is because help-seeking is often deferred or totally eschewed (Schnyder et al., 2017). People who go without treatment have an increased rate of difficult interpersonal and family functioning as well as lower life expectancies (Bhatia & Bhatia, 2007; Kessler et al., 1995; Mezuk et al., 2008). By some estimates, only a third of people with mental illness seek professional help (Savage et al., 2016).

For those who do seek professional help, they often do so years after the beginning of their symptoms (Wang et al., 2005). The length of time varies depending on multiple factors, including the nature of the person’s symptoms, the severity, and characteristics of the person. For mood disorders such as major depressive disorder, the length of times ranges from 6 to 8 years. For anxiety disorders, the range is as wide as between 9 and 23 years (Wang et al., 2005). People with more severe problems are more likely to seek help sooner. Women are more likely to seek care than are men (Bebbington et al., 2000).

Not everyone who seeks treatment gets it, however. Bebbington, Brugha, Meltzer, Jenkins, et al. (2000) found that less than a third of people with mental health symptoms who requested help from their physicians were receiving treatment for their symptoms. As discussed previously, the cost of delayed treatment is high and much research has been devoted to understanding why this phenomenon occurs.

This research has resulted in numerous schools of thought as to why individuals never seek or delay seeking care for their mental health. One major contributor is the fact that mental health care providers remain in short supply. In the United States, 89.3 million individuals live in a mental health professional shortage area, according to the Health Resources and Services Administration (2015). In 2008, almost every county (96%) in the United States had a shortage of psychiatrists and 77% reported a shortage of any type of mental health worker (Thomas et al., 2009). In a survey of state mental health leadership conducted in the summer of 2020, 71% of respondents reported workforce shortages because of COVID-19, 73% reported that providers in their communities had reduced staff or services, and 20% reported closures of community providers (Lutterman, 2020). The need for providers is only continuing to grow. In fact, it is expected to grow 6% by 2025 (Health Resources and Services Administration, 2016).

The workforce that does exist is feeling the strain. In a survey of over 1,000 mental health professionals in England, 52% reported feeling they were too overworked to be able to provide the care they would like to and 44% did not feel their current workload was manageable. Two thirds reported there were gaps in the workforce and a little more than two thirds reported these gaps consistently existed (Mahase, 2020).

Other causal factors discussed within the literature include concern about the cost of services, a belief from the individual experiencing symptoms that they can handle the symptoms on their own, a lack of mental health literacy, concerns about confidentiality, and stigma (U.S. Department of Health and Human Services, 2018). Sareen et al. (2007) investigated why people do not seek care and found that people report the financial cost as a factor. In the study by Sareen et al., 47% of participants with a mood, anxiety, or substance use disorder reported cost or lack of health insurance as a reason why they did not receive care. There is reason to believe that the number of people who report this as a barrier is increasing, rather than decreasing (Mojtabai, 2005). People with mental illness are actually less likely to be insured than are those who do not have mental illness. In fact, 10.6% of U.S. adults with mental illness had no insurance coverage in 2021 (U.S. Department of Health and Human Services, 2021).

Even for those who are insured, the cost is high. People often pay high out-of-pocket expenses for medical care. Approximately 29% of mental health and substance abuse outpatient costs are paid out of pocket (Zuvekas & Meyerhoefer, 2009). Around 14% of adult patients with a mental illness incur out-of-pocket expenses that surpass 20% of their annual family income (Cunningham, 2009).

People's perceived need for treatment can also be a barrier. Some people simply do not believe they need mental health treatment. This tends to be highly correlated with the severity of the mental illness. Individuals with mild to moderate severity are more likely to have lower recognized need than are people with high severity problems (Andrade et al., 2014). In one study, people who did have a high perceived need but did not seek treatment or dropped out of treatment reported a desire to handle the problem on their own (Mojtabai et al., 2011).

Another construct that has emerged from the literature to explain why people are not receiving or seeking help for mental illness is mental health literacy. This includes whether people recognize their symptoms as mental health symptoms, their knowledge about where to seek treatment, and what kind of treatment to seek. The concept is made up of multiple components: a person's ability to recognize disorders or types of mental distress; their familiarity with and beliefs about mental illness factors and causes; knowledge, and beliefs about ways to help themselves; knowledge, and beliefs about what professional help is available to them; attitudes toward mental health; and knowledge of how to get more quality information about mental health (Jorm, 2000). Results from numerous research studies in countries across the globe repeatedly show that less than half of people recognize the signs of mental disorders (Dahlberg et al., 2008; Wang et al., 2007).

Concerns about confidentiality are another often reported barrier to seeking care. This is especially true for adolescents amid concerns about sharing information with parents or caregivers (James, 2007). Studies have revealed concerns and doubts about confidentiality as a major barrier to care (Arun et al., 2022). Results of one study of dental students indicated the students endorsed that they would only receive counseling if confidentiality was absolutely guaranteed. They reported it as integral in believing the service would be of benefit to them and they could be honest (Hassan et al., 2020).

Another theory posed to explain the problem of a lack of help seeking that has received increased attention in the literature is the separation of the mental health system and the larger medical system focused on physical health (Ratzliff et al., 2017). Mental health services and physical health services are provided by different professionals and distinct institutions, and are organized and financed differently (Center for Health Care Strategies, 2019). This is occurring despite the existence of a growing body of research that indicates outcomes for patients are improved when these two services are integrated. This contributes to people conceptualizing care of their mental health as a totally different thing than caring for their physical health (Ratzliff et al., 2017).

A person's culture significantly influences their experience of stigma. For example, Choi and Miller (2014) found that Asians, Asian Americans, and Pacific Islanders experience higher rates of depression and anxiety than Caucasian Americans. However, this population is less likely to seek mental health care and many individuals reported this as having a cultural basis. Their cultural attitude discouraged them from seeking care for fear of stigma (Choi & Miller, 2014). This finding holds true across other cultures as well. Results of a study published by Wong et al. (2017) showed Latino participants described having high levels of self- stigma. These participants were more likely to hide a mental health issue from classmates or coworkers than were the White participants surveyed (Wong et al., 2017). Pederson et al. (2022) found that stigma was a significant barrier to Black adults receiving mental health care. Gender also influences stigma toward receiving mental health care. Bradbury (2020) found that females hold less stigmatized views than do males toward generalized anxiety disorder. This is particularly of note because females are more likely to access care than are males (Mental Health Foundation, 2016).

## Stigma as Barrier to Care

Though the barriers to care previously discussed certainly exist, a large part of the literature is focused on stigma as a barrier to care. In fact, the attitudinal barrier of stigma is reported to be an even greater barrier than the structural ones described in the previous sections. It is possible that if not for stigma, people would be more likely to attempt to overcome the other barriers (Andrade et al., 2014).

Stigma can be organized into two levels: public (stigma on the societal level) and self-stigma (loss of self-esteem and self-efficacy; Rössler, 2016). For example, people often report being deterred from seeking treatment for fear of how the public will perceive their symptoms and receipt of mental health services (public stigma). Additionally, people do not seek services for fear of how they would view themselves for receiving such treatment (self-stigma). Both of these facets of stigma contribute to a greater reliance on the self to cope with symptoms and a reluctance to seek services (Jennings et al., 2015).

### ***Public Stigma***

Public stigma is described as having three components: stereotypes, prejudice, and discrimination. Stereotypes are commonly held beliefs about members of particular groups that enable people to rapidly create conceptualizations of others. For those with mental illness, common examples include the idea that they are dangerous or are to blame for their illness. Prejudice is the belief in and affirmation of these stereotypes. Discrimination is a behavioral outpouring of prejudice. This can include coercion, segregation, physical harm, or avoidance (Corrigan et al., 2003).

Stereotypes are often created and maintained by the culture. Prejudice and discrimination are often born out of belief in stereotypes. Many of these stereotypes can be seen in popular culture. Research on media coverage of mental illness is likely to excessively center on things such as danger, criminality, and violence (Murphy et al., 2013; Rodrigues-Silva et al., 2017; Thornicroft et al., 2009). In Canada, a longitudinal study of almost 25,000 newspaper articles showed close to 50% of the articles connected danger, violence, and criminality to mental illness. Of those articles, only 15% had recovery or rehabilitation as a focus of the article and 20% actually involved quotes from people with mental illness (Whitley & Wang, 2017a). The same seems to hold true for television coverage of mental illness. In an examination of television news clips, results showed over 50% linked mental illness to violence and less than 10% had recovery as a focus (Whitley & Wang, 2017b).

Stereotypes are also seen in fictional works. Results of one study showed a little over three quarters of people receiving mental health services have come across hurtful or offensive portrayals of mental illness in the media. This same study also reported that 47% of these individuals encountered these portrayals regularly (Wahl, 1999). A study of American prime time television programs demonstrated that mentally ill characters in those shows had a higher chance of committing violent crime than both the real-life population of people with mental illness and other television show characters who did not have mental illness (Diefenbach & West, 2007).

Prejudice is another destructive component of public stigma. In a qualitative study asking school-aged children “What sorts of words or phrases might you use to describe someone who experiences mental health problems?”, a total of 250 words were generated and none were positive (Rose et al., 2007). Other articles have indicated people do tend to have negative implicit attitudes toward individuals with mental illness. These are often different from individual’s self-reported views (Kopera et al., 2014; Monteith & Pettit; 2011; Teachman et al., 2006).

There is a large body of evidence demonstrating the existence of public stigma in the form of discrimination toward those with mental illness in the United States. A survey of people from 27 different countries showed almost half of people with schizophrenia, for example, reported experiencing discrimination. Two thirds anticipated the possibility of experiencing discrimination (Thornicroft et al., 2009). Another study revealed even higher numbers, as over 91% of participants reported one or more experiences of discrimination in 2008 (Corker et al., 2013. Another study showed there is a strong relationship between mental health discrimination and stigma with the housing stability of those with mental illness (Mejia-Lancheros et al., 2021).

There is evidence that discrimination exists not just on a personal level but on a systemic level as well. For example, there is evidence of discrimination in funding for research. There is a smaller investment of health care resources earmarked to the care of people with mental illness compared to those with physical illnesses (Corrigan et al., 2004). Additionally, people with mental health diagnoses often receive unequal treatment for their co-occurring physical health conditions. This is theorized to be a contributing factor to an increase in morbidity and premature mortality in this population (Thornicroft, 2013).

Not only do studies demonstrate the existence of public stigma, there is also a large body of research that shows public stigma discourages people from seeking the care they need. Mojtabai et al. (2002) found that negative attitudes toward receiving help (including the expectation that they would feel embarrassed about receiving help) reduce the probability of perceiving a need for help and, as a result, using mental health care. It has also been found that between 24% and 29% of people with a perceived need for help reported being scared of what others might think about them as a reason to not seek care (Kessler et al., 2001).

### ***Self-Stigma***

Of the many studies examining self-stigma, the work of Patrick Corrigan provided the foundation. His works built on what came before in the work on public stigma. Stigma is perpetuated and enforced through stereotypes, which results in isolation and discrimination. People who experience stigmatization are susceptible to believing these stereotypes about themselves and self-discriminating by self-isolating (Corrigan & Rao, 2012).

Corrigan & Rao (2012) proposed a stage model of self-stigma and posited that self-stigma is separate from perceived stigma with the idea that perceived stigma is the first stage of this model. Specifically, the first stage is called awareness. In this stage, the person with the stigmatized condition becomes cognizant of public stigma. The second stage is agreement, in which the person agrees with the negative societal stereotypes. As a result, they progress to application and the person agrees that these stereotypes are not only true but apply to them. Significantly and unique from the literature, Corrigan’s model demonstrates that the malevolent effects of stigma on the individual do not occur until the person applies the stigma to themselves. This is where harm to self-esteem or self-efficacy is seen (Corrigan & Rao, 2012).

Related to this, Corrigan & Rao (2012) also contributed the concept of the “why try” effect. This describes how self-stigma affects the accomplishment of life goals. Stigma and self-stigma can be barriers to people’s goals. However, self-esteem and self-efficacy can be protective factors toward those effects. Without them, though, people buy into the “why try” effect. People feel powerless to fight the effects of stigma because the stigma has been internalized to the detriment of their belief in themselves to cope with the stigma (Corrigan & Rao, 2012).

Another contribution to the literature was made by Ritsher et al., (2003), who described a five-factor conceptualization of the stereotypes that make up self-stigma related to mental illness specifically. The first is the idea of being alienated or not being treated as a full member of society. This includes the idea that having a mental illness makes an individual feel out of place in the world, has ruined their life, that people without mental illness could not understand their experience, embarrassment, disappointment, and inferiority (Ritsher at al., 2003). The next is the level of endorsement of stereotypes or how much they agree with mental illness stereotypes. These stereotypes include beliefs related to violence, physical distinction caused by mental illness, whether or not someone with mental illness can lead a rewarding life, and if they should be allowed to be married. The third is the person’s experience of discrimination and whether or not people treat them differently in life because of their mental illness. The fourth is social withdrawal and whether their mental illness causes them to self-isolate, avoid getting close to people, or overall socialize less. The last is the person’s attitude toward resistance of stigma. It involves whether the individual feels comfortable being seen in the company of someone with mental illness, able to live life the way they want to, their belief in their ability to live meaningfully, their belief in the ability of those with mental illness to contribute to society, and what effect mental illness has had on their resiliency (Ritsher et al., 2003).

Self-stigma has been demonstrated to have an inverse relationship with help seeking. Livingston and Boyd (2010) conducted a meta-analysis of 127 internalized stigma-related studies. For individuals experiencing mental illness, they found a positive relationship between self-stigma and severity of psychiatric symptoms as well as emotional discomfort. There was a negative relationship, though, between stigma and adherence to treatment, empowerment, and hope. A systematic review of both quantitative and qualitative studies on the matter supported the idea that self-stigma and help seeking have a negative correlation (Clement et al., 2015). Interestingly, this relationship can be seen even in people in the counseling field. In a study of school counselors, this same negative correlation was seen, as those with higher levels of self-stigma were less likely to seek treatment (Mullen & Crowe, 2017).

### *Measuring Self-Stigma*

The concept of self-stigma has been extensively studied. So much so that a validated instrument was created to measure it. This measure is called the Self-Stigma of Seeking Help Scale (SSOSH). The scale contains 10 items to measure self-stigma. Specifically, it was designed to measure what impact in self-esteem a person believes they would experience if they were to seek mental health treatment. Participants respond to the ten times using a 5-point Likert scale. The options range from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). The higher the score on the scale, the higher levels of self-stigma someone exhibits (Vogel et al., 2006). The instrument has been used in numerous studies (Drury et al., 2023; Ibrahim et al., 2019; Kaya et al., 2015; Komlenac et al., 2022).

The data behind the scale is strong. In the first study of the scale, the Self-Stigma of Seeking Help Scale had a unidimensional factor structure. This was with a sample size of 583. It exhibited a reliability of .91 among respondents. The second study, with a sample size of 470 respondents, corroborated the factor structure. The second, third, and fourth studies demonstrated cross-validation of the reliability (.86 to .90; test–retest, .72). The scale also demonstrated validity (including construct validity, criterion validity, and predictive validity). The SSOSH predicted outlooks toward and intention to seek psychological help. Last, in the fifth study, with a sample size of 655, the SSOSH discerned those who received mental health services from those who did not (Vogel et al., 2006, p.1).

## Integrated Behavioral Health Care

People with mental health symptoms are usually first identified in the primary care setting (Collins, 2009). In a study by Collins (2009), around 75% of primary care visits have some basis in behavioral health as a focus. Almost 80% of antidepressant medicines are prescribed by primary care doctors (Barkil-Oteo, 2013). Despite how often they present in these settings, behavioral health conditions are often underrecognized and undertreated, demonstrating a need for support (Unützer et al., 2002). The Society for the Teachers of Family Medicine reported there is not consistency in training on behavioral health across residencies and identified this inconsistency as a major gap in the education of resident physicians (Landoll et al., 2020).

As a result, integrated behavioral health settings have been increasing (Curtis & Christian, 2012). Integrated behavioral health care is defined as a primary care approach to treating behavioral health concerns and physical health conditions with biopsychosocial factors through the means of a treatment team. The treatment team consists of the typical primary care team with the addition of a behavioral health clinician (Reiter et al., 2018).

There is evidence that integrated behavioral health reduces health care utilization, specifically office visits and emergency department visits (Thapa et al., 2021). Studies have also shown it may increase the use of mental health services when referred (Davis et al., 2016; McClellan et al., 2020). The results of another study by Hacker et al. (2014) designed to examine predictors of mental health referral from primary care yielded different results. When receiving a referral from their primary care offices to mental health services outside the clinic, only about half of the youth referred completed a follow-up appointment and only 18% had a visit within the 6 months following the referral (Hacker et al., 2014). Studies by Norfleet et al. (2016) and the Substance Abuse and Mental Health Services Administration (n.d.) have demonstrated integrated behavioral health care is associated with higher levels of patient satisfaction, better quality of care, and more cost-effective care (Norfleet et al., 2016; Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration Center for Integrated Health Solutions, n.d.).

Ther are numerous models of integrated care. One such model is the Screening, Brief Intervention, Referral to Treatment (SBIRT) model for alcohol and substance use disorders (Wamsley et al., 2018). SBIRT involves three steps. First, the clinician uses an empirically-validated screening instrument to screen all patients for the presence and severity of substance use. Second, they use a brief intervention directed by the results of the screening and clinical judgement. Last, the clinician leverages this conversation and intervention to provide a referral to treatment. In an integrated setting, this would involve a referral to an in-house behavioral health service, possibly introducing that clinician during the visit. This is often described as a warm handoff (Thoele et al., 2021).

Another model is consultation-liaison psychiatry, a subspecialty of psychiatry in which providers are trained to treat comorbid psychiatric and general medical conditions (Ostermeyer, 2017). This is where a psychiatrist serves as a consultant and liaison to a treatment team. They provide consultations on patients with mental health concerns and support and encourage communication among the treatment team. This typically occurs in an inpatient setting where the psychiatrist's treatment of the patient is usually acute rather than being a part of the entire treatment episode (Ferrari et al., 2020).

There is also the traditional integrated model in which a master's-level clinician is embedded in a primary care clinic, often referred to as IBH-PC. In this model, collaboration among providers is informal but services are offered in the same setting. For some period, there was no more formal definition. As a result, this could look many different ways in many different settings. This also made measuring outcomes difficult as care was not standard (Reiter et al., 2018).

## Collaborative Care (CoCM)

Currently, the literature around integrated behavioral health has focused on Collaborative Care (CoCM). This model was developed at the University of Washington during the 1990s in an attempt to meet the mental health care shortage previously discussed. It is a more specific and standardized model for providing integrated behavioral health services (University of Washington AIMS Center, 2021).

CoCM is a specific type of integrated care that involves a treatment team consisting of the patient, the primary care physician, a behavioral health consultant, and a psychiatric consultant. This treatment team discusses each patient, using a registry, with the behavioral health consultant providing short-term therapeutic interventions as the psychiatric consultant provides medication recommendations to the primary care physician. Consultation is formalized and regularly scheduled between the members of the treatment team (Gilbody et al., 2003).

The current model is based on five core principles: patient-centered team care, population-based care, measurement-based treatments to target, evidence-based care, and accountable care. Patient-centered care means care is provided in a way that is comfortable to patients and engages them in their treatment. Population-based care draws on principles from population health, examining trends in a patient population. In the model, all patients are tracked in a registry to ensure no one “falls through the cracks” or is forgotten. Treatment to target is exemplified by each patient’s treatment plan having specific goals and outcomes that are regularly measured by evidence-based tools. There is an emphasis on the use of interventions with research evidence of their efficacy. All providers on the treatment team are accountable and reimbursed for services based on quality of care and clinical outcomes, not just volume (University of Washington AIMS Center, 2021).

The first major study of the CoCM model was the IMPACT trial published in 2002 (Unützer et al., 2002). The IMPACT trial was a randomized controlled trial that went on for a little over 2 years examining the effectiveness of the model for late-life depression. Patients were assigned to either the IMPACT intervention or “usual care,” defined as any primary or specialty mental health services that were available to people. IMPACT intervention group participants had a depression care manager who used a brief psychotherapy called Problem Solving Treatment, a psychiatric consultant, and a primary care physician. The results of the study indicated the IMPACT model/CoCM was significantly more effective than usual care for treatment of late-life depression (Unützer et al., 2002).

Since the publication of that study, over 90 randomized control trials and meta-analyses (University of Washington AIMS Center, 2021) have demonstrated CoCM to be more effective than usual care for patients with depression; anxiety; posttraumatic stress disorder; comorbid mental health and physical conditions like cancer, diabetes, and HIV; and substance use disorders (Alford et al., 2011; Ma et al., 2019; Moise et al., 2018; Powers et al., 2020; Rombouts et al., 2020; Rossom et al., 2017). One study indicated not only that CoCM demonstrates more effectiveness but that the effectiveness can maintain more positive outcomes for up to 5 years (Gilbody et al., 2006).

The next wave of research focused on the financing and cost-effectiveness of CoCM programs. The majority of studies showed positive results in terms of reduced health care productivity loss, reduced health care utilization, and financial savings, and those workflows were able to be integrated into high-functioning clinics (Carlo et al., 2019; Carlo et al., 2020; Jacob et al., 2012; Katon et al., 2012; Lee et al., 2019). For example, one study showed the costs of implementing CoCM were likely to be counterbalanced by overall savings of 25% for the treatment of patients with opioid use disorder (Lee et al., 2019). Another showed individuals who received CoCM treatment had 114 reported depression-free days over a 2-year observation period and $594 saved in outpatient health care costs (Katon et al., 2012).

The next phase included a focus on issues related to using CoCM in different racial and ethnic groups, particularly minority groups, as well as under resourced communities. Research is still needed in this area (e.g., what elements of cultural adaptation are most helpful, issues around language, etc.) but the existing research seems to indicate CoCM is more effective for minority and underserved communities than is usual care (Areán et al., 2005; Hu et al., 2020; Powers et al., 2020; Watkins et al., 2017). Out of 12 studies examining CoCM in minority populations, eight demonstrated CoCM was effective (Hu et al., 2020). Another study showed CoCM recipients had significantly improved outcomes a year after treatment compared to those receiving usual care (Areán et al., 2005).

### CoCM and Self-Stigma

Integrated behavioral health care and CoCM, specifically, are growing in frequency quickly. One of the anticipated benefits of integrating behavioral health into primary care was a reduction in stigma attached to seeking services (P. J. Robinson & Strosahl, 2009). This anticipated benefit is seen frequently in the literature but often with no evidence to back it up (American Psychiatric Association & Academy of Psychosomatic Medicine, 2016, p. 10; Bree Collaborative, 2017, p. 14; Linkins et al., 2013, p. 5; WHO, 2008, p. 21).

There is a need for more literature examining the relationship between integrated primary care and mental health stigma (Rowan et al., 2021). A literature review by Rowan et al. (2021) on the topic yielded only seven articles demonstrating a link between the two. They conducted a search for articles published between 1995 and 2019 using the key words “primary care,” “integrated,” “collaborative,” “collocate,” “mental,” “behavioral,” and “psych.” They also examined the reference sections of the articles that were found. The articles found by Rowan et al. (2021) included those written by Miller-Matero et al. (2016, 2019), Lang (2005), Chen et al. (2006), Johnson and Possemato (2021), Gallo et al. (2004), and Hammer et al. (2019). The authors concluded that because the number of studies is so limited, any conclusions about the impact on integrated care on stigma on help-seeking are uncertain (Rowan et al., 2021).

The evidence that does exist, though, is promising, albeit mixed. For people who have received mental health services previously, the integrated care model has been to improve perceptions of seeking help—the same relationship was not found in those who had never sought help previously (Hammer et al., 2019). However, Royal Kenton et al. (2019) found stigma remained prevalent for those individuals receiving care in integrated behavioral health clinics. Johnson and Possemato (2021) found perceived stigma correlated with the utilization of services but not self-stigma. Chen et al. (2006) also found no significant difference between integrated services and usual care but did find that stigma was negatively associated with all types of mental health services.

However, when patients in an internal medicine clinic in a large urban hospital system were asked to report on their location preferences for seeing a psychologist, a majority (75%) expressed preference for the internal medicine clinic and 37.1% of respondents indicated they would only see a psychologist if they were in a primary care office (Miller-Matero et al., 2019). Of particular significance, those with higher levels of stigma related to mental health preferred receiving services in the primary care setting (Miller-Matero et al., 2019). Lang (2005) conducted a study in which they found participants were more willing to seek mental health therapy in a primary care setting.

There seems to be evidence that providers anticipate reduced stigma as being a benefit to integrated behavioral health. In a study of providers treating geriatric patients, 92.5% thought their patients experienced less stigma than a more usual type of referral (Gallo et al., 2004). In another study of an urban medicine clinic, 53% of providers indicated they thought patients preferred the integrated option because of reduced stigma (Miller-Matero et al., 2016).

With there being a gap in the research as it relates to integrated behavioral health and self-stigma, there is an even larger gap when it comes to CoCM and self-stigma. The University of Washington AIMS Center keeps a repository of published articles related to CoCM. None of the articles in their repository (approximately 65) studied whether or not the theorized benefit of reduced self-stigma actually exists (University of Washington AIMS Center, 2021).

## Summary

The United States is experiencing a mental health crisis (Sampson, Kubzansky, & Koenen, 2023) as there are not enough providers to meet the needs of the millions of people affected (Mongelli, Georgakopoulos, & Pato, 2020). Additionally, many real barriers exist to receiving care, not the least of which is self-stigma. Integrated behavioral health, specifically CoCM, holds real promise as a means of reducing this problem but the evidence does not yet exist to support this theory. Thus, the current study was designed to address this gap in the research by comparing levels of self-stigma among primary care patients with depression who were receiving CoCM versus those who were not.

This work was designed in an attempt to change the gap in the research by answering the question: Is there a difference in self-stigma between primary care patients with depression receiving Collaborative Care (as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM? By examining the differences in self-stigma between these two groups as well as differences by gender, this study was intended to shed light on the potential benefits of CoCM in reducing barriers to mental health treatment and improving overall mental health outcomes for patients. Ultimately, results of this research can be used to inform the development of more effective and accessible mental health interventions to address the ongoing crisis in the United States.

# Chapter Three: Methods

## Overview

This study was designed to contribute to the literature surrounding self-stigma as it relates to mental health in an effort to better understand the problem of self-stigma. Specifically, it was designed to explore whether those who received a certain type of care in the primary care setting (i.e., CoCM) experienced self-stigma differently than those who received mental health care in more traditional settings or no care at all and whether the difference was impacted by respondents' gender. Patients of a primary care practice were assessed through an online survey. Permission to contact these patients was obtained from the health system's internal review board, the health system of which the investigator was an employee.

Chapter 3 is divided into the following sections: design, research questions, participants and setting, instrumentation, procedures, and data analysis. The goal was to collect information that would answer the research questions, enable the investigator to make recommendations for future studies, and provide implications for counselors in future CoCM program development.

## Design

This study was a quantitative quasi-experimental static-group comparison design. This design is also sometimes referred to as a non-equivalent control group posttest-only design (Krishnan, 2019). The study involved comparing the results of a quantitative instrument, the Self-Stigma of Seeking Help Scale (SSOSH), between two groups of participants. Permission was obtained by the author to use this instrument. The investigator invited all patients age 18 years and older of a primary care practice (internal medicine or family medicine) to participate.

Quantitative research designs are largely categorized as either experimental or quasi-experimental. They differ from each other in the degree of control researchers have on the participants and variables of the study (Polit & Beck, 2017). A quasi-experiment is an experiment-like study, but participants are not randomly assigned to groups and the treatment (in this case CoCM) has already occurred (Polit & Beck, 2017). However, both types have the goal of demonstrating causality between an intervention and a dependent variable (Krishnan, 2019). The gold standard of investigating causal relationships is an experimental design (Heppner et al., 2016). However, this design was not used for the current study because of both time and financial limitations.

A quasi-experimental design was chosen in the hopes of being able to establish a causal relationship between the type of care received and the impact of stigma. The investigator had access to preexisting groups, making a quasi-experimental design achievable. As a result, there were obviously limitations to the data as compared to in an experimental design (Morgan et al., 2000). This type of design is chosen often in health care and social science research studies, when an experimental design is not feasible (Harris et al., 2006).

Types of quasi-experimental designs include those without a control group, those with a control group but no pretest, those with both a control group and pretest, and the interrupted time series design (Harris et al., 2006). The design in this study, the non-equivalent control group posttest-only design, involves an experimental group and a control group. The intervention is employed for the experimental group. Outcome measurements are taken from both groups and compared to each other (Polit & Beck 2017).

A static-group comparison design was chosen because of its advantages over other quasi-experimental designs. Collecting one post-intervention measurement from each group provides a measure of value as it relates to the internal validity of the design. It reduces the susceptibility to regression of the mean and reduces any temporal bias. This allows for reasonable assurance that changes to the dependent variable occurred after the independent variable, which is helpful when examining a possible causal relationship (Szafran, 2007).

Patients were asked to complete a survey in the waiting room of primary care offices across the system. Following IRB approval, the survey was given to those patients electronically through email and they were encouraged to complete the survey within a month of receiving the email. No formal controls were available to prevent participant collaboration in completing the survey.

## Research Questions

**RQ1:** Is there a difference in self-stigma toward seeking help between primary care patients with depression receiving Collaborative Care (as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM?

**RQ2:** Is there a difference in self-stigma toward seeking help between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM?

**RQ3:** Is there a difference in self-stigma toward seeking help between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM?

**RQ4:** Is there a difference in how the male and female groups are affected by the location of care?

## Hypotheses

**$H_a$1:** There will be a statistically significant difference between scores on the SSOSH. The experimental group will report lower scores for self-stigma toward seeking help as measured by the SSOSH compared to the control group.

**$H_b$2:** There will be a statistically significant difference in score on the SSOSH between female primary care patients who receive CoCM and those who do not.

**$H_b$3:** There will be a statistically significant difference in score on the SSOSH between male primary care patients who receive CoCM and those who do not.

**$H_b$4:** The statistically significant difference will be even stronger for male patients than for female patients or patients as a whole.

## Participants and Setting

Participants for the study were drawn from a purposive sample of adult primary care patients with depression from a large health system located in upstate South Carolina. The region’s population was 1,347,112 as of 2016 (U.S. Census Bureau, 2016). The health system comprises 47 primary care offices.

Purposive sampling, specifically stratified sampling, was used in this study. Options for purposive sampling include stratified, cell, quota, and theoretical sampling (Campbell et al., 2020). Stratified sampling was chosen because specific groups were desired for the study. Of interest was each patient’s diagnosis as that was the population eligible for inclusion in this study. This was just the reason given in the literature for choosing this sampling method—the idea that specific people need to be included in a study to accomplish the aims and objectives of the study (Mason, 2017; O. C. Robinson, 2014; Trost, 1986). This is especially true in studies with limited research resources (Palinkas et al., 2015).

## Instrumentation

### Initial Assessment Interview Form

Potential participants completed an assessment questionnaire designed to help ascertain that they met the inclusion criteria and did not meet the exclusion criteria. This questionnaire asked whether participants were over the age of 18 years, their gender, the name of their primary care office, whether they had been diagnosed with depression, and if they received mental health care in their primary care office (i.e., CoCM) or outside of their primary care office. Participants were also asked if they had been psychiatrically hospitalized in the past month, whether they had a substance use disorder, and whether they experienced psychosis.

Exclusion criteria for the study included children, any kind of unstable medical condition, any presence of a substance use disorder, history of psychosis, and inability to read English. Inclusion criteria were age (must be over 18 years), having a diagnosis of depression, receiving primary care from this particular health system, and the ability to read English.

### Self-Stigma Scale

The rest of the survey included the items from the Self-Stigma of Seeking Help Scale (SSOSH). The scale contains 10 items to measure self-stigma. Specifically, it was designed to measure what impact in self-esteem a person believes they would experience if they were to seek mental health treatment. Participants respond to the ten times using a 5-point Likert scale. The options range from 1 (Strongly Disagree) to 5 (Strongly Agree). The higher the score on the scale, the higher levels of self-stigma someone exhibits (Vogel et al., 2006). The instrument has been used in numerous studies (Drury et al., 2023; Ibraham et al., 2019; Kaya et al., 2015; Komlenac et al., 2022). It is free to use for research purposes and permission was obtained by email to use this scale in the current study.

The data behind the scale are strong. In Study 1 of the scale (*n* = 583), the SSOSH had a unidimensional factor structure and good reliability (.91) among participants. Study 2 (*n* = 470) corroborated the factor structure. Studies 2, 3 (*n* = 546), and 4 (*n* = 217) cross-validated the reliability (.86 to .90; test–retest, .72) and demonstrated evidence of validity (including construct, criterion, and predictive) across the study samples. The SSOSH uniquely predicted attitudes toward and intent to seek psychological help. Last, in Study 5 (*n* = 655), the SSOSH discerned those who sought psychological services from those who did not across a span of 2 months (Vogel et al., 2006).

## Procedures

The researcher worked with the IRB of the institution at which she was employed to first obtain approval as well as the IRB of the educational institution. Participants meeting the inclusion criteria were recruited from primary care clinics in the local area. The sample was limited to patients of one of the following types of outpatient primary care practices: internal medicine and family medicine. Excluded from the report were patients from the practice where the researcher was employed, to reduce a confounding variable.

Participants provided informed consent to participate in the study. Participants were emailed an online survey hosted by REDCap. REDCap was chosen because it is the survey of choice for the health system. This allowed for patients' comfortability, possibly having already used the platform previously. This survey included an initial assessment interview form asking if participants were over the age of 18 years, their gender, the name of their primary care office, whether they had been diagnosed with depression, and if they received mental health care in their primary care office (i.e., CoCM) or outside of their primary care office. Participants were also asked if they had been psychiatrically hospitalized in the past month, whether they had a substance use disorder, and whether they experienced psychosis. The rest of the survey were the items from the SSOSH. Data was then analyzed using appropriate statistical methods to compare self-stigma between the CoCM group and the non-CoCM group.

## Data Analysis

After the surveys were completed, the data collected was analyzed through the use of SPSS Statistics software. The survey was used to assess self-stigma toward seeking mental health care in patients of primary care practices and yielded discrete data. Descriptive statistics were generated, including the means, medians, modes, and standard deviations, to describe measures of central tendency. An independent group *t* test was also completed to compare the means between the two groups, as there were different subjects in each group. This was done after verifying that the variances were equal.

## Summary

Chapter 3 included a discussion of the design, research questions, participants and setting, instrumentation, procedures, and data analysis. This study was designed to examine whether those who received a specific type of care in the primary care setting (i.e., CoCM) experienced self-stigma differently than those who received mental health care in more traditional settings or no care at all. It involved a quantitative quasi-experimental static-group comparison design. The study’s research questions focused on determining the level of self-stigma and the difference in self-stigma between patients receiving CoCM and those not receiving this type of care. The study’s participants were adult primary care patients with depression located in upstate South Carolina.

This design was used to compare results of the SSOSH between a group of people with depression receiving CoCM from a major health system and a group of people with depression not receiving CoCM. The hypothesis was that those receiving CoCM would have lower levels of stigma and that this difference would be especially significant in men. The goal of this research was to contribute to the literature on self-stigma, provide recommendations for future research, and offer implications for counselors in future CoCM program development.

# Chapter Four: Findings

## Overview

This chapter presents the quantitative findings of this study on the stigma associated with seeking mental health care and the impact of the location of care. It includes descriptive statistics for the data collected, the steps of data analysis, and the results of each statistical test grouped by hypotheses.

## Descriptive Statistics

Data were collected between October 13, 2023, and December 31, 2023. A total of 58 individuals participated in the study. The sample population included only those who completed all measures in the survey (see Table 1). The participants received primary care from 21 different primary care offices across upstate South Carolina. The demographic questionnaire used in this study covered participants' gender and the name of their primary care office. Of the 58 participants, 50 identified as female, seven identified as male, and one identified as non-binary. Of the sample, 13 individuals were actively engaged in collaborative care and 45 were not receiving this specific intervention. The majority of the participants identified as female, with Center for Family Medicine-Oconee being the most common primary care office.

**Table 1**

*Participants' Demographic Characteristics*

| Characteristic | | *N* | % |
|---|---|---|---|
| Gender | Male | 7 | 12.1 |
| | Female | 50 | 86.2 |
| | Non-binary | 1 | 1.7 |
| Primary care office | Center for Family Medicine-Oconee | 13 | 22.4 |
| | BE Liberty Family Care | 1 | 1.7 |
| | Carolina Internal Medicine | 1 | 1.7 |
| | Center for Family Medicine-Greer | 1 | 1.7 |
| | Cypress IM-Greer | 1 | 1.7 |
| | Family and Internal Medicine-Five Forks | 1 | 1.7 |
| | Family Medicine - Walhalla | 5 | 8.6 |
| | Family Medicine-Mountain View | 1 | 1.7 |
| | Greenville Family Medicine | 2 | 3.4 |
| | Heritage Peds IM-Wren | 2 | 3.4 |
| | IM-Easley | 1 | 1.7 |
| | Internal Medicine Associates | 2 | 3.4 |
| | Internal Medicine Clinic | 1 | 1.7 |
| | Internal Medicine-Simpsonville | 2 | 3.4 |
| | Keystone Family Medicine | 1 | 1.7 |
| | Mountain Lakes Family Medicine | 3 | 5.2 |
| | Peds and IM-Patrick Square | 5 | 8.6 |
| | Seneca Medical Associates | 5 | 8.6 |
| | Simpsonville Family Medicine | 1 | 1.7 |
| | Travelers Rest Family Medicine | 4 | 6.9 |
| | Upstate Family Medicine | 5 | 8.6 |

*Note*. *N* = 58 participants.

All participants completed the SSOSH. Possible scores range from 10–50. Despite minor variations, the mean scores for the CoCM and non-CoCM groups were similar, indicating comparable levels of self-stigma across both groups. The mean score of the CoCM group was 25, the median was 23, the mode was 18, and the standard deviation was 6.54. The mean score of the not receiving CoCM group was 25.68, with a median of 26, mode of 20, and standard deviation of 6.86. For female participants receiving CoCM, the mean was 24.55, the median was 22, the mode was 18, and the standard deviation was 6.77. For female participants not receiving CoCM, the mean was 24.77, the median was 24, the mode was 20, and the standard deviation was 6.81. For male participants receiving CoCM, the mean was 27.5, the median was 27.5, the mode was not applicable (frequency too small), and the standard deviation was 6.36. For male participants not receiving CoCM, the mean was 31.67, the median was 32, the mode was 32, and the standard deviation was 3.50 (see Table 2).

**Table 2**

*Self-Stigma of Seeking Help Scale Scores*

| Group | *M* | Median | Mode | *SD* | *N* |
|---|---|---|---|---|---|
| Receiving CoCM | 25 | 23 | 18 | 6.54 | 13 |
| Not receiving CoCM | 25.68 | 26 | 20 | 6.86 | 45 |
| Females receiving CoCM | 24.55 | 22 | 18 | 6.77 | 11 |
| Females not receiving CoCM | 24.77 | 24 | 20 | 6.81 | 39 |
| Males receiving CoCM | 27.5 | 27.5 | n/a | 6.36 | 1 |
| Males not receiving CoCM | 31.67 | 32 | 32 | 3.5 | 6 |

*Note*. CoCM = collaborative care.

Though the data collected from the 58 participants provided some insights, the relatively small sample size introduced important limitations that must be considered (Sekaran & Bougie, 2016). With a larger sample, the results could be more confidently generalized to the broader population (Bryman, 2016). However, with a smaller sample, the findings may not accurately reflect the characteristics and experiences of the entire population (Sekaran & Bougie, 2016).

Additionally, smaller samples have lower statistical power, meaning there is a higher risk of failing to detect a true effect or mistaking random variations for significant differences (Hair et al., 2023).

Exploring the possibility of the presence of differences within subgroups based on gender may be unreliable because of the small sample size (Bryman, 2016). The small amount of points of data within each subgroup may not be enough to detect the presence of statistically significant variations (Sekaran & Bougie, 2016).

## Results

A Levene's test was conducted to determine whether the assumption of homogeneity of variances is met between the two groups: one receiving CoCM and the other not receiving CoCM. When the variances are unequal between groups, it can affect the accuracy and reliability of these tests and so it is vital to assess. The Levene's test resulted in a test statistic of 6.91 and a *p*-value of 0.00189. Because the *p*-value was less than 0.05, we rejected the null hypothesis of equal variances. Therefore, the assumption of equal variances was not met. Given this outcome, a Welch's *t* test was completed, which is robust to unequal variances, to compare the means of the two groups. Welch's *t* test provides reliable results even when the assumption of homogeneity of variances is not met. This is because it adjusts the degrees of freedom and the standard error of the mean, allowing for valid hypothesis testing in such situations (Welch, 1947).

## Hypotheses and Results

**$H_a$1:** There will be a statistically significant difference between scores on the SSOSH. The experimental group will report lower scores in self-stigma toward seeking help as measured by the SSOSH than the control group.

The Welch's *t* test revealed a test statistic of -0.3306 and a *p*-value of 0.7443. With the *p*-value being greater than the alpha level 0.05, we cannot reject the null hypothesis. The statistically insignificant result indicates there was not a significant difference in means between the two groups. The observed effect size *d* was small, at 0.1. This indicates the magnitude of the difference between the average and average was small.

**Hb2:** There will be a statistically significant difference in score on the SSOSH between female primary care patients who receive CoCM and those who do not.

**Hb3:** There will be a statistically significant difference in score on the SSOSH between male primary care patients who receive CoCM and those who do not.

**Hb4:** The statistically significant difference will be even stronger for male patients than for female patients or patients as a whole.

For male patients, the Welch's *t* test revealed a test statistic of -0.8825 and a *p*-value of 0.5181. With the *p*-value being greater than the alpha level 0.05, we cannot reject the null hypothesis. The statistically insignificant result indicates there was not a significant difference in means between the two groups. The observed effect size d was large, at 1.01. This indicates the magnitude of the difference between the average and average was large.

For female patients, the Welch's *t* test revealed a test statistic of -0.09666 and a *p*-value of 0.9242. With the *p*-value being greater than the alpha level 0.05, we cannot reject the null hypothesis. The statistically insignificant result indicates there was not a significant difference in means between the two groups. The observed effect size d was small, at 0.033. This indicates the magnitude of the difference between the average and average was small.

Overall, the findings from the Welch's *t* test (see Table 3) failed to support the hypotheses, indicating CoCM did not lead to significant differences in self-stigma scores between the experimental and control groups or within gender subgroups. Additionally, the small effect sizes indicate the observed differences in means, although non-significant, may still have practical implications that warrant exploration in future studies.

**Table 3**

*Welch's t Test Results*

| Hypothesis | Test statistic | *p* | Conclusion | Effect size (d) |
|---|---|---|---|---|
| $H_a1$ | -0.3306 | 0.7443 | Fail to reject null hypothesis | Small (0.1) |
| $H_b2$ (Male) | -0.8825 | 0.5181 | Fail to reject null hypothesis | Large (1.01) |
| $H_b2$ (Female) | -0.09666 | 0.9242 | Fail to reject null hypothesis | Small (0.033) |

## Summary

In this study, 58 participants from 21 different primary care offices in upstate South Carolina were examined, with 13 individuals receiving CoCM and 45 not receiving this intervention. The participants completed the SSOSH, with mean scores of 25 for the CoCM group and 25.68 for the non-CoCM group. Unfortunately, the study was limited by the small sample size, particularly within gender subgroups. The assumption tests revealed unequal variances, leading to the use of a Welch's *t* test for comparing means. Hypotheses testing on self-stigma scores showed statistically insignificant differences between groups, with small effect sizes. Subgroup analyses based on gender also yielded statistically insignificant results.

# Chapter Five: Conclusions

## Overview

This chapter expands on the results reported in Chapter 4. In this chapter, the author engages in a critical analysis of the results of the data collected from 58 participants across diverse primary care offices in upstate South Carolina. The discussion serves as a means for synthesizing the empirical evidence, drawing connections to the existing literature, and offering insights into the practical implications and potential avenues for future research in the area of mental health stigma and care interventions.

## Summary of Findings

The purpose of this study was to examine how self-stigma affects people's attitudes toward seeking help for mental health symptoms, and specifically whether the location of the care influences their attitudes. To investigate this issue, scores on the SSOSH were compared between patients who received CoCM and those who did not. This comparison was also made for the male subsample and the female subsample. The research questions are as follows:

**RQ1:** Is there a difference in self-stigma toward seeking help between primary care patients with depression receiving Collaborative Care (CoCM; as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM?

**RQ2:** Is there a difference in self-stigma toward seeking help between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM?

**RQ3:** Is there a difference in self-stigma toward seeking help between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM?

**RQ4:** Is there a difference in how the male and female groups are affected by the location of care?

Unfortunately, the research questions were difficult to answer because a statistically significant difference was not found in any of the three comparisons.

## Discussion

The global prevalence of mental illness, with rates varying by country, was estimated at 29.1% in 2020, including 28% for depression and 26.9% for anxiety (Nochaiwong et al., 2021). The literature has shown stigma to be a significant barrier to receiving mental health care, surpassing even structural obstacles (Andrade et al., 2014). Despite significant advancements in mental health awareness and advocacy, self-stigma remains a formidable barrier to individuals seeking professional support for their mental health concerns (Corrigan & Rao, 2012). This phenomenon operates within a broader sociocultural context in which societal attitudes, media portrayals, and interpersonal interactions contribute to the formation and perpetuation of stigma surrounding mental health issues (Pescosolido et al., 2010). As such, the experience of self-stigma can significantly affect an individual's self-concept, self-esteem, and willingness to seek help when needed (Livingston & Boyd, 2010).

### Self-Stigma and Location of Care

RQ1: Is there a difference in self-stigma toward seeking help between primary care patients with depression receiving Collaborative Care (as defined by the University of Washington AIMS model) and patients with a diagnosis of depression not receiving CoCM?

Thomas Scheff (1966), in his work on labeling theory, posits that individuals' behaviors and their perception of self are significantly shaped by the societal labels imposed upon them. The process of stigma begins with the messages absorbed during childhood regarding individuals with mental illness. Through routine interpersonal interactions, stereotypes about this demographic are internalized which are associated with "disturbed" behaviors and violent crimes, fostering stigmatized beliefs. Moreover, Scheff proposed that all individuals will encounter psychological symptoms at some juncture in their lives. While most individuals manage to rationalize away these symptoms, thereby evading labeling, significant norm violations may lead to the classification of deviant behavior as mental illness (Scheff, 1966).

Subsequently, when an individual's behaviors are labeled as indicative of mental illness, it triggers the activation of these learned negative stereotypes, resulting in social ostracism. They are met with suspicion, hostility, and exclusion from social and employment opportunities. This social exclusion induces alterations in the identity of the stigmatized individual, who begins to internalize the stigma of being "mentally ill."

Help-seeking behavior, which is crucial for addressing mental health concerns in a timely and effective manner, is heavily influenced by individuals' attitudes toward seeking help and the associated perceived stigma (Horsfield, 2020). A study by Livingston & Boyd demonstrated that people who have higher levels of self-stigma are less likely to disclose their mental health struggles, seek professional assistance, or adhere to treatment regimens (2010). This decreased likelihood to seek help can make mental health issues even worse, leading to an increase in suffering and an overall decrease in a person's quality of life (Clement et al., 2015).

Integrating behavioral health into primary care was expected to reduce the stigma associated with seeking services, a notion frequently mentioned in the literature but often lacking empirical support (American Psychiatric Association & Academy of Psychosomatic Medicine, 2016, p. 10; Bree Collaborative, 2017, p. 14; Linkins et al., 2013, p. 5; WHO, 2008, p. 21). However, Royal Kenton et al. (2019) found stigma persisted for individuals receiving care in integrated behavioral health clinics, whereas Chen et al. (2006) reported no significant difference in stigma between integrated services and usual care.

The current study produced similar results to those of Royal Kenton et al. (2019) and Chen et al. (2006), supporting the minimal existing data. Based on these studies, it appears self-stigma is not significantly influenced by the location in which a person receives care. Additionally, results of the current study support previous research and are in line with Scheff's (1966) labeling theory that indicated self-stigma continues to persist toward receiving mental health services (Royal Kenton et al., 2019). This finding raises questions about the effectiveness of collaborative care models in directly addressing the internalized stigma associated with seeking help for mental health issues. Though collaborative care models offer numerous benefits, including improved access to mental health services and enhanced communication between providers, they may not adequately target the underlying beliefs and attitudes that contribute to self-stigma (Unützer et al., 2002).

However, studies exist that demonstrated a difference, indicating some constructs may be missing. Hammer et al. (2019) found an integrated care model improved perceptions of seeking help for individuals with prior mental health service experience. This relationship did not exist among those who had never sought help before, indicating self-stigma appears to be a stubborn construct (Hammer et al., 2019). This is unsurprising given what is known about the theoretical foundations of the construct of stigma. Stigma was identified as a construct as early as the 19th century (Durkheim, 1893). Stigma serves as a means of helping people explain the unexplainable and providing a sense of control (Heider, 1958), resulting in the "stigma allure" (Hughey, 2012).

Though we can see the persistence of stigma in spite of change of setting, data do exist that give pause and indicate a missing link in the literature. For example, in a large urban hospital system, patients from an internal medicine clinic overwhelmingly favored receiving psychological services within their medical setting, with 75% expressing a preference for the internal medicine clinic (Miller-Matero et al., 2019). A noteworthy aspect is that 37.1% of the respondents specified a willingness to consult with a psychologist exclusively in a primary care office. Importantly, individuals exhibiting elevated levels of mental health-related stigma demonstrated a preference for accessing services within the primary care setting (Miller-Matero et al., 2019). Additionally, results of Lang's (2005) study revealed participants exhibited an increased willingness to pursue mental health therapy when it was integrated into primary care. A solid evidence base exists to show patients report a preference for receiving behavioral health services in primary care settings, though that does not necessarily affect their self-stigma, indicating the existence of some moderating factor.

Though collaborative care models represent a significant step toward integrating mental health services into primary care settings, they may not be sufficient in addressing the nuanced challenges of self-stigma. The non-significant findings in the current study indicate additional interventions targeting self-stigma are needed to promote positive help-seeking behaviors and improve mental health outcomes. Future research should be conducted to explore innovative approaches to reducing self-stigma, taking into account individual differences, cultural considerations, and systemic barriers to care. By addressing self-stigma at multiple levels, we can create environments that will empower people to seek help for their mental health concerns without judging themselves.

## Self-Stigma and Location of Care for Female Participants

RQ2: Is there a difference in self-stigma toward seeking help between female primary care patients with depression receiving CoCM and female primary care patients with depression not receiving CoCM?

There is research that suggests that women experience less self-stigma than men do. For example, Bradbury (2020) found that women exhibited less stigmatized attitudes toward generalized anxiety disorder compared to men, and Smith et al. (2019) found women exhibited lower levels of perceived stigma related to depression compared to men. These findings are significant considering women tend to seek mental health care more frequently than do men, likely because they have less self-stigma about it (Mental Health Foundation, 2016).

This difference in self-stigma between the two genders is attributed to social role theory. Social Role Theory states that society has certain expectations and assigned roles based on gender. These expectations and assigned roles in turn influence individuals' behaviors, beliefs, and opportunities. This is done through socialization as children and then continually reinforced throughout the lifespan through social institutions and everyday interactions. Through this process, these roles and expectations are internalized and gender stereotypes are reinforced. For example, traditional gender roles might associate men with qualities such as assertiveness and dominance, while women are expected to be nurturing and empathetic (Eagly & Wood, 2020). Emotional expression, seeking healthcare, and requesting assistance are often associated with femininity, while men are typically anticipated to demonstrate emotional stability and maintain a demeanor characterized by strength, independence, and self-reliance (Trompeter et al., 2023).

Though previous literature indicates women may experience lower levels of self-stigma compared to men, the lack of significant differences in the current study challenges that assumption. Though there is research to show women often experience less stigma surrounding mental health issues compared to men, this does not mean that women experience no self-stigma or that they are in any way immune to the self-stigma that many feel about receiving psychological help. Although the differences were not statistically significant, female participants tended to have lower scores on the SSOSH compared to male participants and the entire sample, consistent with previous research demonstrating women have lower levels of stigma.

The non-significant findings in the current study support the need for a deeper examination of the nuanced relationship between self-stigma and help-seeking behavior among women and to develop tailored interventions to address these barriers. In short, the relationship between self-stigma and help-seeking behavior remains complex and more information is needed to address the issue.

### Self-Stigma and Location of Care for Male Participants

RQ3: Is there a difference in self-stigma toward seeking help between male primary care patients with depression receiving CoCM and male primary care patients with depression not receiving CoCM?

RQ4: Is there a difference in how the male and female groups are affected by the location of care?

Research indicates men often experience higher levels of self-stigma related to mental health issues compared to women. This can result in a decreased willingness to seek help and access appropriate care. Vogel et al. (2006) found men tend to internalize negative societal attitudes surrounding mental health problems, leading to increased feelings of shame and reluctance to disclose or seek assistance for their concerns. Furthermore, in their research, Livingston and Boyd (2010) emphasized the role of traditional masculinity norms, which often discourage men from expressing vulnerability or seeking emotional support, exacerbating self-stigma and hindering help-seeking behaviors. This is further elaborated on in Social Role Theory (Eagly & Wood, 2012).

Research indicates self-stigma among men is associated with various negative outcomes, including decreased self-esteem and diminished quality of life. Corrigan and Watson (2002) demonstrated that self-stigma can act as a significant barrier to men's engagement with mental health care services, leading to delays in seeking treatment and exacerbating mental health disparities. Similarly, Clement et al. (2015) highlighted the detrimental impact of self-stigma on treatment adherence and recovery outcomes among men with mental health conditions. Though the sample size in the current study was too small to indicate any statistical significance, the results support previous research. The men who participated in the current study had higher scores on the SSOSH than their female counterparts and the sample as a whole.

Though the existing literature has shed light on the challenges men face regarding self-stigma and help-seeking behavior, results of the current study comparing scores on the SSOSH between men who received CoCM and those who did not yielded non-significant results. This finding prompts a closer examination of the effectiveness of CoCM interventions in addressing self-stigma among men. Collaborative care models aim to integrate mental health services into primary care settings to improve access and reduce stigma, but the lack of significant differences indicates these interventions may not be effectively targeting self-stigma among men.

## Implications

This study on the stigma associated with seeking mental health care and the impact of care location has several implications for both research and practical applications. First, the results of this study underscore the need for a nuanced understanding of self-stigma toward receiving mental health treatment. The lack of any statistically significant difference in self-stigma scores between the two groups, despite participation in CoCM, supports that interventions focused only on care integration may not be sufficient to overcome the barrier of self-stigma. This demonstrates the complexity of individual perceptions and the need for multifaceted interventions that go beyond the structural aspects of care. The researcher in the current study attempted to isolate a cause and effect relationship between the location of care and the stigma perceived at receiving that care. However, a statistically significant difference was not found,. This supports the idea that there must be other factors that contribute to self-stigma that may be too subtle and complex to be identified in a study design of this type. A qualitative study may better capture this relationship.

Second, the study highlights the importance of sample size in robust research. The relatively small sample size of 58 participants limited the ability to generalize the findings to the greater population. Larger sample sizes mitigate the risk of sampling bias and ensure the findings accurately reflect the broader population's characteristics and tendencies (Trochim & Donnelly, 2008). Additionally, and relevant to this study, a larger sample size enables researchers to conduct more robust subgroup analyses.

Finally, the study's implications extend to health care stakeholders and policymakers. The persistence of self-stigma, despite the location of care, highlights the need for a comprehensive and multifaceted approach to address the existence of self-stigma. Based on the insignificant results of this study, simply implementing CoCM may not be enough to reduce self-stigma. There is an evident need for a comprehensive approach in addressing self-stigma within health care settings.

## Christian Worldview

An integrated approach to mental health is one that acknowledges that mental health is multi-faceted, comprising spiritual, physical, emotional, and relational well-being. For a long time in the medical field, physical health and mental health were artificially separated. We are realizing now that divide was false and unhelpful. In the same way, spirituality plays a significant role in shaping individuals' experiences of mental health and healing and cannot be divorced from this idea(Rosmarin & Koenig, 2020).

From a Christian worldview, the sin that we experience in the world and put into the world affects every aspect of our existence. Paul writes in Romans 8:22, "For we know that the whole creation has been groaning together in the pains of childbirth until now" (English Standard Version). When Paul writes about this groaning, there's no reason to imagine that our hearts and minds would not also be included in the whole creation. When suffering and lament is seen in scripture, this should provide encouragement, comfort, and validation to those experiencing mental illness. It affirms not only their worth and dignity as beloved creations of God but the supremacy of God in the midst of this suffering (Rosmarin & Koenig, 2020).

Despite the examples of lament and suffering modeled in scripture, societal stigma toward mental illness can perpetuate feelings of shame and isolation, even in the church (Rosmarin & Koenig, 2020). This cannot and should not be the case. Galatians 6:2 (English Standard Version) encourages believers to "Bear one another's burdens, and so fulfill the law of Christ." This verse shows God's design of community and fellowship in navigating hardships in life, including mental health struggles. Within the Church, there is a shared responsibility to offer compassion, understanding, and practical assistance to those facing mental health difficulties (Rosmarin & Koenig, 2020). This is likely the most powerful antidote to both stigma and self-stigma that we could find.

### Limitations

The major limitation of this study was the small sample size. Response was low to the survey. This may have been because it was distributed electronically, people may have felt stigma about completing the survey though it was anonymous, and there was no immediate incentive for completion. The small sample size particularly became a problem when attempting to examine the data by gender. By further reducing the data into subsamples, the already weakened statistical power was even further decreased.

Other limitations to the study included being dependent on volunteers to complete the survey which introduces selection bias. Selection bias limits the extent to which findings can be extrapolated beyond the study sample and the information of those who declined to participate remains unknown (Trochim & Donnelly, 2008). Lastly, there exists the inherent limitations that affect any measures involving self-report.

Another major limitation was the choice to use a quasi-experimental study design. One of the primary limitations of quasi-experimental studies is the absence of true random assignment. Without randomization, it becomes challenging to establish a causal relationship between the independent variable and the observed outcomes (Shadish et al., 2002).

## Recommendations for Future Research

Future research is recommended with the use of larger sample sizes. A suggested possibility for a future study would be to replicate the method of the current study with in-person data collection. Unfortunately, the health system did not allow the researcher to physically go to clinics and invite participation. Expanding the study’s scope to include multiple health care systems and settings could provide a more comprehensive understanding of self-stigma dynamics across diverse populations. By incorporating a broader range of primary care clinics and mental health offices, researchers can capture variations in self-stigma experiences and help-seeking attitudes among different demographic groups and geographical regions in addition to simply increasing the sample size. Other suggested changes to this study’s methodology include conducting the study with a sample of primary care clinics and mental health offices, and taking the study outside of the institutional level and examining the relationship between location of care and stigma in the general adult population.

Other directions for future research could include conducting longitudinal studies to track changes in self-stigma over an extended period, as well as changes in individuals’ perceptions and behaviors. Longitudinal studies can elucidate the trajectory of self-stigma development, identify critical periods of intervention, and assess the effectiveness of interventions in mitigating self-stigma over time. Other suggestions include investigating how the quality of communication and the language used by health care providers may affect self-stigma, particularly in mental health contexts. Exploring self-stigma also lends itself to a qualitative study. Rather than focusing on an increased sample size, interviews could be conducted with participants who receive CoCM and those who do not to examine their relationship to self-stigma. Conducting interviews with participants who receive CoCM and those who do not can provide rich qualitative data, offering insights into the factors that shape self-stigma and the barriers to accessing mental health services (Lang, 2005). Such qualitative investigations can inform the development of tailored interventions that can address the unique needs and challenges faced by individuals with varying levels of self-stigma.

## Summary

The study was designed to explore the impact of self-stigma on attitudes toward seeking mental health care and whether the location of care influences these attitudes. Using the SSOSH, comparisons were made between primary care patients receiving CoCM and those who were not, as well as within gender subgroups. No statistically significant differences were found in self-stigma scores between the groups. The findings imply the need for a nuanced understanding of self-stigma and challenge the assumption that CoCM alone can effectively address the issue of self-stigma. The study had limitations, primarily the small sample size, low survey response, and dependence on self-report measures. In light of this, future research is recommended with larger sample sizes, in-person data collection, and an exploration of communication quality's impact on self-stigma.

# References

Alford, D. P., LaBelle, C. T., Kretsch, N., Bergeron, A., Winter, M., Botticelli, M., & Samet, J. H. (2011). Collaborative care of opioid-addicted patients in primary care using buprenorphine. *Archives of Internal Medicine, 171*(5), 425–431. https://doi.org/10.1001/archinternmed.2010.541

American Psychiatric Association. (2014). *What is integrated care?* https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/what-is-integrated-care

American Psychiatric Association & Academy of Psychosomatic Medicine. (2016, Spring). *Dissemination of integrated care within adult primary care settings: The Collaborative Care Model*. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf

Amsalem, D., Dixon, L. B., & Neria, Y. (2021). The coronavirus disease 2019 (COVID-19) outbreak and mental health: Current risks and recommended actions. *JAMA Psychiatry*, *78*(1), 9–10. https://doi.org/10.1001/jamapsychiatry.2020.1730

Andrade, L. H., Alonso, J., Mneimneh, Z., Wells, J. E., Al-Hamzawi, A., Borges, G., & Kessler, R. C. (2014). Barriers to mental health treatment: Results from the WHO World Mental Health surveys. *Psychological Medicine*, *44*(6), 1303–1317. https://doi.org/10.1017/S0033291713001943

Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *The Cochrane database of systematic reviews, 10*, CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

Areán, P. A., Ayalon, L., Hunkeler, E., Lin, E. H., Tang, L., Harpole, L., Hendrie, H., Williams, J. W., Jr., Unützer, J., & IMPACT Investigators. (2005). Improving depression care for older, minority patients in primary care. *Medical Care*, *43*(4), 381–390. https://doi.org/10.1097/01.mlr.0000156852.09920.b1

Arias, D., Saxena, S., & Verguet, S. (2022). Quantifying the global burden of mental disorders and their economic value. *EClinicalMedicine*, 54.

Arun, P., Ramamurthy, P., & Thilakan, P. (2022). Indian medical students with depression, anxiety, and suicidal behavior: Why do they not seek treatment? *Indian Journal of Psychological Medicine*, *44*(1), 10–16. https://doi.org/10.1177/0253717620982326

Barkil-Oteo, A. (2013). Collaborative care for depression in primary care: How psychiatry could "troubleshoot" current treatments and practices. *The Yale Journal of Biology and Medicine*, *86*(2), 139–146.

Bebbington, P., Brugha, T., Meltzer, H., Farrell, M., Ceresa, C., Jenkins, R., & Lewis, G. (2000). Psychiatric disorder and dysfunction in the UK National Survey of Psychiatric Morbidity. *Social Psychiatry and Psychiatric Epidemiology*, *35*(5), 191–197. https://doi.org/10.1007/s001270050227

Bebbington, P., Brugha, T. S., Meltzer, H., Jenkins, R., Ceresa, C., Farrell, M., & Lewis, G. (2000). Neurotic disorders and the receipt of psychiatric treatment. *Psychological Medicine, 30*(6), 1369–1376. https://doi.org/10.1017/S0033291799002974

Bebbington, P., Meltzer, H., Brugha, T. S., Farrell, M., Jenkins, R., Ceresa, C., & Lewis, G. (2000). Unequal access and unmet need: Neurotic disorders and the use of primary care services. *Psychological Medicine*, *30*(6), 1359–1367. https://doi.org/10.1017/S0033291799002950

Bhatia, S. K., & Bhatia, S. C. (2007). Childhood and adolescent depression. *American Family Physician*, *75*(1), 73–80. https://www.aafp.org/pubs/afp/issues/2007/0101/p73.pdf

Bradbury, A. (2020). Mental health stigma: The impact of age and gender on attitudes. *Community Mental Health Journal*, *56*(5), 933–938. https://doi.org/10.1007/s10597-020-00559-x

Bree Collaborative. (2017). *Behavioral health integration report and recommendations*. https://www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf

Bryman, A. (2016). *Social research methods*. Oxford University Press.

Campbell, S., Greenwood, M., Prior, S., Shearer, T., Walkem, K., Young, S., Bywaters, D., & Walker, K. (2020). Purposive sampling: Complex or simple? Research case examples. *Journal of Research in Nursing*, *25*(8), 652–661. https://doi.org/10.1177/1744987120927206

Carlo, A. D., Corage Baden, A., McCarty, R. L., & Ratzliff, A. (2019). Early health system experiences with collaborative care (CoCM) billing codes: A qualitative study of leadership and support staff. *Journal of General Internal Medicine*, *34*(10), 2150–2158. https://doi.org/10.1007/s11606-019-05195-0

Carlo, A. D., Drake, L., Ratzliff, A., Chang, D., & Unützer, J. (2020). Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system. *Psychiatric Services*, *71*(9), 972–974. https://doi.org/10.1176/appi.ps.201900581

Center for Health Care Strategies. (2019, August). *Integrating behavioral health into primary care: Advancing primary care innovation in Medicaid managed care*. https://www.chcs.org/media/PCI-Toolkit-BHI-Tool_090319.pdf

Chen, H., Coakley, E. H., Cheal, K., Maxwell, J., Constantino, J., Karhan, D., & Levkof, S. E. (2006). Satisfaction with mental health services in older primary care patients. *The American Journal of Geriatric Psychiatry*, *14*(4), 371–379. https://doi.org/10.1097/01.JGP.0000196632.65375.b9

Choi, N., & Miller, M. J. (2014). AAPI college students' willingness to seek counseling: The role of culture, stigma, and attitudes. *Journal of Counseling Psychology*, *61*(3), 340–351. https://doi.org/10.1037/cou0000027

Choi, R. J., Betancourt, R. M., DeMarco, M. P., & Bream, K. D. (2019). Medical student exposure to integrated behavioral health. *Academic Psychiatry, 43*, 191-195.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rüsch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45*(1), 11–27. https://doi.org/10.1017/S0033291714000129

Collins, C. (2009). Integrating behavioral and mental health services into the primary care setting. *North Carolina Medical Journal*, *70*(3), 248–252.

Corker, E., Hamilton, S., Henderson, C., Weeks, C., Pinfold, V., Rose, D., Williams, P., Flach, C., Gill, V., Lewis-Holmes, E., & Thornicroft, G. (2013). Experiences of discrimination among people using mental health services in England 2008-2011. *The British Journal of Psychiatry*, *202*(s55), s58–s63. https://doi.org/10.1192/bjp.bp.112.112912

Corrigan, P. W., Kosyluk, K. A., & Rusch, N. (2016). Stigma and self-stigma. In P. Corrigan (Ed.), *The stigma of disease and disability: Understanding causes and overcoming injustices* (pp. 3–27). American Psychological Association.

Corrigan, P. W., Markowitz, F. E., & Watson, A. C. (2004). Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin*, *30*(3), 481–491. https://doi.org/10.1093/oxfordjournals.schbul.a007096

Corrigan, P. W., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination toward persons with mental illness. *Journal of Health and Social Behavior*, *44*(2), 162–179. https://doi.org/10.2307/1519806

Corrigan, P. W., & Rao, D. (2012). *On the self-stigma of mental illness: Stages, disclosure, and strategies for change*. SAGE Publications. https://doi.org/10.1177/070674371205700804

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1*(1), 16–20.

Cunningham, P. J. (2009). *Chronic burdens: The persistently high out-of-pocket health care expenses faced by many Americans with chronic conditions* (Vol. 63). Commonwealth Fund.

Curtis, R., & Christian, E. (Eds.). (2012). *Integrated care: Applying theory to practice*. Routledge/Taylor & Francis Group.

Dahlberg, K. M., Waern, M., & Runeson, B. (2008). Mental health literacy and attitudes in a Swedish community sample–Investigating the role of personal experience of mental health care. *BMC Public Health, 8,* Article 8. https://doi.org/10.1186/1471-2458-8-8

Daré, L. O., Bruand, P., Gérard, D., Marin, B., Lameyre, V., Boumédiène, F., & Preux, P. (2019). Co-morbidities of mental disorders and chronic physical diseases in developing and emerging countries: A meta-analysis. *BMC Public Health*, *19*(1), Article 304. https://doi.org/10.1186/s12889-019-6623-6

Davis, M. J., Moore, K. M., Meyers, K., Mathews, J., & Zerth, E. O. (2016). Engagement in mental health treatment following primary care mental health integration contact. *Psychological Services*, *13*(4), 333–340. https://doi.org/10.1037/ser0000089

Diefenbach, D. L., & West, M. D. (2007). Television and attitudes toward mental health issues: Cultivation analysis and the third-person effect. *Journal of Community Psychology*, *35*(2), 181–195. https://doi.org/10.1002/jcop.20142

Drury, R. M., Taylor, N., & Porter, C. (2023). Medical students' perception of psychotherapy and predictors for self-utilization and prospective patient referrals. *Behavioral Sciences*, *13*(1), 17. https://doi.org/10.3390/bs13010017

Druss, B. G., Bradford, D. W., Rosenheck, R. A., Radford, M. J., & Krumholz, H. M. (2000). Mental disorders and use of cardiovascular procedures after myocardial infarction. *JAMA: The Journal of the American Medical Association*, *283*(4), 506–511. https://doi.org/10.1001/jama.283.4.506

Durkheim, E. (1893). *The division of labor in society*. Simon and Schuster.

Eagly, A. H., & Wood, W. (2012). Social role theory. *Handbook of theories of social psychology*, *2*, 458-476.

Falk, G. (2001). *Stigma: How we treat outsiders*. Prometheus Books.

Ferrari, S., Mattei, G., Marchi, M., Galeazzi, G. M., & Pingani, L. (2020). Is consultation-liaison psychiatry 'getting old'? How psychiatry referrals in the general hospital have changed over 20 years. *International Journal of Environmental Research and Public Health*, *17*(20), 7389. https://doi.org/10.3390/ijerph17207389

Gallo, J. J., Zubritsky, C., Maxwell, J., Nazar, M., Bogner, H. R., Quijano, L. M., Syropoulos, H. J., Cheal, K. L., Chen, H., Sanchez, H., Dodson, J., & Levkoff, S. E. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: Results from a multisite effectiveness trial (PRISM-E). *Annals of Family Medicine*, *2*(4), 305–309. https://doi.org/10.1370/afm.116

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: A cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine*, *166*(21), 2314–2321. https://doi.org/10.1001/archinte.166.21.2314

Gilbody, S., Whitty, P., Grimshaw, J., & Thomas, R. (2003). Educational and organizational interventions to improve the management of depression in primary care: A systematic review. *Journal of the American Medical Association*, *289*(23), 3145–3151. https://doi.org/10.1001/jama.289.23.3145

Goffman, E. (1963). *Stigma; Notes on the management of spoiled identity*. Prentice-Hall.

Goldstein, J. (2002). Stigma: How we treat outsiders. *Psychiatric Services*, *53*(12), 1643–1643. https://doi.org/10.1176/appi.ps.53.12.1643

Hacker, K., Arsenault, L., Franco, I., Shaligram, D., Sidor, M., Olfson, M., & Goldstein, J. (2014). Referral and follow-up after mental health screening in commercially insured adolescents. *Journal of Adolescent Health*, *55*(1), 17–23. https://doi.org/10.1016/j.jadohealth.2013.12.012

Hair, J. F., Black, W. C., Babin, B. J., & Anderson, R. E. (2023). *Multivariate data analysis*. Cengage Learning.

Hammer, J. H., Perrin, P. B., & Spiker, D. A. (2019). Impact of integrated care and co-location of care on mental help-seeking perceptions. *Journal of Mental Health*, *30*(4), 405–410. https://doi.org/10.1080/09638237.2019.1581334

Harris, A. D., McGregor, J. C., Perencevich, E. N., Furuno, J. P., Zhu, J., Peterson, D. E., & Finkelstein, J. (2006). The use and interpretation of quasi-experimental studies in medical informatics. *Journal of the American Medical Informatics Association*, *13*(1), 16–23. https://doi.org/10.1197/jamia.M1749

Hassan, A. U., Khan, S. A., Zaheer, R., Saqib, H., Shah, S. M. H., Rehman, I. U., & Tariq, A. (2020). Understanding the barriers for undergraduate dental students in seeking professional counselling. *Pakistan Journal of Science*, *72*(4), 344–347. https://doi.org/10.57041/pjs.v72i4.283

*Healthcare Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Population, 2019*. (2022, February). Retrieved February 27, 2024, from https://meps.ahrq.gov/data_files/publications/st539/stat539.pdf

Health Resources and Services Administration. (2015). *HPSA by state and county*. https://data.hrsa.gov /tools/shortage-area/hpsa-find

Health Resources and Services Administration. (2016). *National projections of supply and demand for behavioral health practitioners: 2013-2025*. Substance Abuse and Mental Health & Services Administration, Office of Policy, Planning, and Innovation. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf

Heider, F. (1958). *The psychology of interpersonal relations*. Wiley.

Heppner, P. P., Wampold, B. E., Owen, J., Thompson, M. N., & Wang, K. T. (2016). *Research design in counseling* (4th ed.). Cengage.

Horsfield, P., Stolzenburg, S., Hahm, S., Tomczyk, S., Muehlan, H., Schmidt, S., & Schomerus, G. (2020). Self-labeling as having a mental or physical illness: The effects of stigma and implications for help-seeking. *Social Psychiatry and Psychiatric Epidemiology*, *55*, 907-916.

Hu, J., Wu, T., Damodaran, S., Tabb, K. M., Bauer, A., & Huang, H. (2020). The effectiveness of collaborative care on depression outcomes for racial/ethnic minority populations in primary care: A systematic review. *Psychosomatics*, *61*(6), 632–644. https://doi.org/10.1016/j.psym.2020.03.007

Hughey, M. W. (2012). Stigma allure and White antiracist identity management. *Social Psychology Quarterly*, *75*(3), 219–241. https://doi.org/10.1177/0190272512446756

Ibrahim, N., Amit, N., Shahar, S., Wee, L-H., Ismail, R., Khairuddin, R., Ching, S. S., & Mohd Safien, A. (2019). Do depression literacy, mental illness beliefs and stigma influence mental health help-seeking attitude? A cross-sectional study of secondary school and university students from B40 households in Malaysia. *BMC Public Health*, *19*(Suppl 4), 544. https://doi.org/10.1186/s12889-019-6862-6

Jacob, V., Chattopadhay, S. K., & Sipe, T. A. (2012). Economics of collaborative care for management of depressive disorders: A community guide systematic review. *American Journal of Preventative Medicine*, *42*(1), 539–549. https://doi.org/10.1016/j.amepre.2012.01.011

Jafari, N., Loghmani, A., & Montazeri, A. (2012). Mental health of medical students in different levels of training. *International Journal of Preventive Medicine*, *3*(Suppl1), S107.

James, A. M. (2007). Principles of youth participation in mental health services. *Medical Journal of Australia*, *187*(S7), S57–S60. https://doi.org/10.5694/j.1326-5377.2007.tb01339.x

Jennings, K. S., Cheung, J. H., Britt, T. W., Goguen, K. N., Jeffirs, S. M., Peasley, A. L., & Lee, A. C. (2015). How are perceived stigma, self-stigma, and self-reliance related to treatment-seeking? A three-path model. *Psychiatric Rehabilitation Journal*, *38*(2), 109–116. https://doi.org/10.1037/prj0000138

Johnson, E. M., & Possemato, K. (2021). Problem recognition and treatment beliefs relate to mental health utilization among veteran primary care patients. *Psychological Services*, *18*(1), 11–22. https://doi.org/10.1037/ser0000341

Jones, E. E., Farina, A., Hastorf, A.H., Markus, H., Miller, D.T., Scott, R.A. (1984). *Social stigma: The psychology of marked relationships*. WH Freeman.

Jorm, A. F. (2000). Mental health literacy - Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, *177*(5), 396–401. https://doi.org/10.1192/bjp.177.5.396

Kamal, R., Cox, C., Rousseau, D., & Kaiser Family Foundation. (2017). Costs and outcomes of mental health and substance use disorders in the US. *Journal of the American Medical Association*, *318*(5), 415. https://doi.org/10.1001/jama.2017.8558

Kang-Yi, C. D., Wolk, C. B., Locke, J., Beidas, R. S., Lareef, I., Pisciella, A. E., Lim, S., Evans, A. C., & Mandell, D. S. (2018). Impact of school-based and out-of-school mental health services on reducing school absence and school suspension among children with psychiatric disorders. *Evaluation and Program Planning*, *67*, 105–112. https://doi.org/10.1016/j.evalprogplan.2017.12.006

Katon, W., Russo, J., Lin, E. H., Schmittdiel, J., Ciechanowski, P., Ludman, E., Peterson, D., Young, B., & Von Korff, M. (2012). Cost-effectiveness of a multicondition collaborative care intervention: A randomized controlled trial. *Archives of General Psychiatry*, *69*(5), 506–514. https://doi.org/10.1001/archgenpsychiatry.2011.1548

Kaya, C., Tansey, T., Chan, F., Bezyak, J., Melekoğlu, M. A., Çakıroğlu, O., & Köse, S. (2015). Dimensionality of the Turkish version of the Self-Stigma of Seeking Help Scale: Results from exploratory and confirmatory factor analyses. *International Journal for the Advancement of Counselling*, *37*(2), 105–116. https://doi.org/10.1007/s10447-014-9230-3

Kelley, H. H. (1967). Attribution theory in social psychology. *Nebraska Symposium on Motivation*, *15*, 192–238.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., Manderscheid, R. W., Rosenheck, R. A., Walters, E. E., & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health Services Research*, *36*(6 Pt 1), 987–1007.

Kessler, R. C., Foster, C. L., Saunders, W. B., & Stang, P. E. (1995). Social consequences of psychiatric disorders, I: Educational attainment. *American Journal of Psychiatry, 152*(7), 1026–1032.

Kessler, R. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H. U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. https://doi.org/10.1002/mpr.1359

Komlenac, N., Maresch, F., Lamp, E., & Hochleitner, M. (2022). Conformity to masculine norms and self-stigma of help-seeking are not unique barriers to formal help-seeking in men, but are also relevant for women. *European Psychiatry*, *65*(S1), S611–S612. https://doi.org/10.1192/j.eurpsy.2022.1566

Kopera, M., Suszek, H., Bonar, E., Myszka, M., Gmaj, B., Ilgen, M., & Marcin, M. (2014). Evaluating explicit and implicit stigma of mental illness in mental health professionals and medical students. *Community Mental Health Journal*, *51*, 628–634. https://doi.org/10.1007/s10597-014-9796-6

Krishnan, P. (2019). A review of the non-equivalent control group post-test-only design. *Nurse Researcher*, *26*(2), 37–40. https://doi.org/10.7748/nr.2018.e1582

Landoll, R., Cervero, R., Quinlan, J., & Maggio, L. (2020). Primary care behavioral health training in family medicine residencies: A qualitative study from a large health care system. *Family Medicine*, *52*(3), 174–181. https://doi.org/10.22454/FamMed.2020.681872

Lang, A. J. (2005). Mental health treatment preferences of primary care patients. *Journal of Behavioral Medicine*, *28*(6), 581–586. https://doi.org/10.1007/s10865-005-9019-2

Lee, C. M., Scheuter, C., Rochlin, D., Platchek, T., & Kaplan, R. M. (2019). A budget impact analysis of the Collaborative Care Model for treating opioid use disorder in primary care. *Journal of General Internal Medicine*, *34*(9), 1693–1694. https://doi.org/10.1007/s11606-019-04998-5

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, *27*(1), 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Linkins, K. W., Brya, J. J., Bess, G., Myers, J., Goldberg, S., & Dall, A. (2013). *Stigma and attitudes toward working in integrated care*. https://www.ibhpartners.org/wp-content/uploads/2015/12/Stigma-attitudes-of-workers-IBHP-brief.pdf

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, *71*(12), 2150–2161. https://doi.org/10.1016/j.socscimed.2010.09.030

Lundberg, B., Hansson, L., Wentz, E., & Björkman, T. (2007). Sociodemographic and clinical factors related to devaluation/discrimination and rejection experiences among users of mental health services. *Social Psychiatry and Psychiatric Epidemiology*, *42*, 295–300. https://doi.org/10.1007/s00127-007-0160-9

Lutterman, T. (2020). *Impact of COVID-19 on state mental health systems*. National Association of State Mental Health Program Directors Research Institute.

Ma, J., Rosas, L. G., Lv, N., Xiao, L., Snowden, M. B., Venditti, E. M., Lewis, M. A., Goldhaber-Fiebert, J. D., & Lavori, P. W. (2019). Effect of integrated behavioral weight loss treatment and problem-solving therapy on body mass index and depressive symptoms among patients with obesity and depression. *The Journal of the American Medical Association*, *321*(9), 869–879. https://doi.org/10.1001/jama.2019.0557

Mahase, E. (2020). Workforce crisis has left mental health staff at “breaking point” as demand rises. *British Medical Journal*, *368*. https://doi.org/10.1136/bmj.m88

Mason, J. (2017). *Qualitative researching*. Sage.

McBain, R. K., Cantor, J., Pera, M. F., Breslau, J., Bravata, D. M., & Whaley, C. M. (2023). Mental health service utilization rates among commercially insured adults in the US during the first year of the COVID-19 pandemic. *JAMA Health Forum*, *4*(1), e224936. https://doi.org/10.1001/jamahealthforum.2022.4936

McCaffrey, E., Chang, S., Farrelly, G., Rahman, A., Ritchie, B., Goldade, R., & Cawthorpe, D. (2021). The economic impact of providing evidence-based pediatric mental health literacy training to primary care physicians. *Psychiatry Investigation*, *18*(7), 695–700. https://doi.org/10.30773/pi.2021.0014

McClellan, C. C., Maclean, J. C., Saloner, B. B., McGinty, E. E., & Pesko, M. M. (2020). Integrated care models and behavioral healthcare utilization: Quasi-experimental evidence from Medicaid health homes. *Health Economics*, *29*(9), 1086–1097. https://doi.org/10.1002/hec.4027

McDaid, D., Park, A. L., & Wahlbeck, K. (2019). The economic case for the prevention of mental illness. *Annual Review of Public Health*, *40*, 373–389. https://doi.org/10.1146/annurev-publhealth-040617-013629

Mejia-Lancheros, C., Lachaud, J., Woodhall-Melnik, J., O'Campo, P., Hwang, S. W., & Stergiopoulos, V. (2021). Longitudinal interrelationships of mental health discrimination and stigma with housing and well-being outcomes in adults with mental illness and recent experience of homelessness. *Social Science & Medicine*, *268*, 113463. https://doi.org/10.1016/j.socscimed.2020.113463

Mental Health America issues report entitled 'State of mental health in America'. (2022). Targeted News Service. https://mhanational.org/issues/state-mental-health-america

Mental Health Foundation. (2016). *Women and mental health*. Retrieved April 4, 2023, from https://www.mentalhealth.org.uk/ato-z/w/women-and-mental-health

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2021). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *Journal of the American Academy of Child Adolescent Psychiatry*, *49*(10), 980–989. https://doi.org/10.1016/j.jaac.2010.05.017

Mezuk, B., Eaton, W. W., Albrecht, S., & Golden, S. H. (2008). Depression and type 2 diabetes over the lifespan: A meta-analysis. *Diabetes Care*, *31*(12), 2383–2390. https://doi.org/10.2337/dc08-0985

Miller-Matero, L. R., Dykuis, K. E., Albujoq, K., Martens, K., Fuller, B. S., Robinson, V., & Willens, D. E. (2016). Benefits of integrated behavioral health services: The physician perspective. *Families Systems & Health*, *34*(1), 51–55. https://doi.org/10.1037/fsh0000182

Miller-Matero, L. R., Khan, S., Thiem, R., DeHondt, T., Dubaybo, H., & Moore, D. (2019). Integrated primary care: Patient perceptions and the role of mental health stigma. *Primary Health Care Research & Development*, *20*, e48. https://doi.org/10.1017/S1463423618000403

Moise, N., Shah, R. N., Essock, S., Jones, A., Carruthers, J., Handley, M. A., Peccoralo, L., & Sederer, L. (2018). Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implementation Science*, *13*, 128. https://doi.org/10.1186/s13012-018-0818-6

Mojtabai, R. (2005). Trends in contacts with mental health professionals and cost barriers to mental health care among adults with significant psychological distress in the United States: 1997–2002. *American Journal of Public Health*, *95*(11), 2009–2014. https://doi.org/10.2105/AJPH.2003.037630

Mojtabai, R., Olfson, M., & Mechanic, D. (2002). Perceived need and help-seeking in adults with mood, anxiety, or substance use disorders. *Archives of General Psychiatry*, *59*(1), 77–84. https://doi.org/10.1001/archpsyc.59.1.77

Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., Wells, K. B., Pincus, H. A., & Kessler, R. C. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication. *Psychological Medicine, 41*(8), 1751–1761. https://doi.org/10.1017/S0033291710002291

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus, 18*(1), 16-24.

Monteith, L. L., & Pettit, J. W. (2011). Implicit and explicit stigmatizing attitudes and stereotypes about depression. *Journal of Social and Clinical Psychology, 30*(5), 484–505. https://doi.org/10.1521/jscp.2011.30.5.484

Morgan, G. A., Gliner, J. A., & Harmon, R. J. (2000). Quasi-experimental designs. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(6), 794–796. https://doi.org/10.1097/00004583-200006000-00020

Mullen, P. R., & Crowe, A. (2017). Self-stigma of mental illness and help seeking among school counselors. *Journal of Counseling & Development*, *95*(4), 401–411. https://doi.org/10.1002/jcad.12155

Muncie, J. (2010). Labelling, social reaction and social constructionism. In T. Newburn & E. McLaughlin (Eds.), *The Sage handbook of criminological theory* (pp. 139–152). Sage.

Murphy, N. A., Fatoye, F., & Wibberley, C. (2013). The changing face of newspaper representations of the mentally ill. *Journal of Mental Health, 22*(3), 271–282. https://doi.org/10.3109/09638237.2012.734660

Nochaiwong, S., Ruengorn, C., Thavorn, K., Hutton, B., Awiphan, R., Phosuya, C., & Wongpakaran, T. (2021). Global prevalence of mental health issues among the general population during the coronavirus disease-2019 pandemic: A systematic review and meta-analysis. *Scientific Reports*, *11*, 10173. https://doi.org/10.1038/s41598-021-89700-8

Norfleet, K. R., Ratzliff, A. D. H., Chan, Y.-F., Raney, L. E., & Unützer, J. (2016). The role of the integrated care psychiatrist in community settings: A survey of psychiatrists' perspectives. *Psychiatric Services*, *67*(3), 346–349. https://doi.org/10.1176/appi.ps.201400592

OECD. (2015). *Fit mind, fit job: From evidence to practice in mental health and work.* https://www.oecd.org/els/fit-mind-fit-job-9789264228283-en.htm

Ostermeyer, B. (2017). Overview of consultation-liaison psychiatry. *Psychiatric Annals*, *47*(4), 168–169. https://doi.org/10.3928/00485713-20170308-01

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, *42*, 533–544. https://doi.org/10.1007/s10488-013-0528-y

Pederson, A. B., Hawkins, D., & Conteh, N. (2022). Ethnic identity and mental health stigma among Black adults in the United States. *Ethics, Medicine, and Public Health*, *25*, 100774. https://doi.org/10.1016/j.jemep.2022.100774

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., & Link, B. G. (2010). "A disease like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *American journal of psychiatry*, *167*(11), 1321-1330.

Plotz, J. (2019). Having it both ways with Erving Goffman. *Victorian Literature and Culture*, *47*(2), 439–448. https://doi.org/10.1017/S1060150319000068

Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer Health.

Powers, D. M., Bowen, D. J., Arao, R. F., Vredevoogd, M., Russo, J., Grover, T., & Unützer, J. (2020). Rural clinics implementing collaborative care for low-income patients can achieve comparable or better depression outcomes. *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, *38*(3), 242–254. https://doi.org/10.1037/fsh0000522

Ratzliff, A., Phillips, K. E., Sugarman, J. R., Unützer, J., & Wagner, E. H. (2017). Practical approaches for achieving integrated behavioral health care in primary care settings. *American Journal of Medical Quality*, *32*(2), 117–121. https://doi.org/10.1177/1062860615618783

Reiter, J. T., Dobmeyer, A. C., & Hunter, C. L. (2018). The Primary Care Behavioral Health (PCBH) model: An overview and operational definition. *Journal of Clinical Psychology in Medical Settings*, *25*(2), 109–126. https://doi.org/10.1007/s10880-017-9531-x

Ritsher, J. B., Otilingam, P. G., & Grajales, M. (2003). Internalized stigma of mental illness: Psychometric properties of a new measure. *Psychiatry Research*, *121*(1), 31–49. https://doi.org/10.1016/j.psychres.2003.08.008

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology*, *11*(1), 25–41. https://doi.org/10.1080/14780887.2013.801543

Robinson, P. J., & Strosahl, K. D. (2009). Behavioral health consultation and primary care: Lessons learned. *Journal of Clinical Psychology in Medical Settings*, *16*(1), 58–71. https://doi.org/10.1007/s10880-009-9145-z

Rockett, I. R., Ali, B., Caine, E. D., Shepard, D. S., Banerjee, A., Nolte, K. B., & Miller, T. R. (2023). Escalating costs of self-injury mortality in the 21st century United States: an interstate observational study. *BMC public health*, *23*(1), 285.

Rodrigues-Silva, N., Falcão de Almeida, T., Araújo, F., Molodynski, A., Venâncio, A., & Bouça, J. (2017). Use of the word schizophrenia in Portuguese newspapers. *Journal of Mental Health*, *26*(5), 426–430. https://doi.org/10.1080/09638237.2016.1207231

Rombouts, S. A., Conigrave, J. H., Saitz, R., Louie, E., Haber, P., & Morley, K. C. (2020). Evidence based models of care for the treatment of alcohol use disorder in primary health care settings: A systematic review. *BMC Family Practice*, *21*, 260. https://doi.org/10.1186/s12875-020-01288-6

Rose, D., Thornicroft, G., Pinfold, V., & Kassam, A. (2007). 250 ways to label people with mental illness. *BMC Health Services Research 7*, 97. https://doi.org/10.1186/1472-6963-7-97

Rosmarin, D. H., & Koenig, H. G. (2020). *Handbook of spirituality, religion, and mental health*. Academic Press.

Rössler, W. (2016). The stigma of mental disorders: A millennia-long history of social exclusion and prejudices. *EMBO Reports*, *17*(9), 1250–1253. https://doi.org/10.15252/embr.201643041

Rossom, R. C., Solberg, L. I., Magnan, S., Crain, A. L., Beck, A., Coleman, K. J., Katzelnick, D., Williams, M. D., Neely, C., Ohnsorg, K., Whitebird, R., Brandenfels, E., Pollock, B., Ferguson, R., Williams, S., & Unützer, J. (2017). Impact of a national collaborative care initiative for patients with depression and diabetes or cardiovascular disease. *Journal of*

*General Hospital Psychiatry*, *44*(1), 77–85. https://doi.org/10.1016/j.genhosppsych.2016.05.006

Rowan, A. B., Grove, J., Solfelt, L., & Magnante, A. (2021). Reducing the impacts of mental health stigma through integrated primary care: An examination of the evidence. *Journal of Clinical Psychology in Medical Settings*, *28*(4), 679–693. https://doi.org/10.1007/s10880-020-09742-4

Royal Kenton, N., Broffman, L., Jones, K., Albrecht Mcmenamin, K., Weller, M., Brown, K., Currier, J., & Wright, B. (2019). Patient experiences in behavioral health integrated primary care settings: The role of stigma in shaping patient outcomes over time. *Psychology, Health & Medicine*, *24*(10), 1182–1197. https://doi.org/10.1080/13548506.2019.1595685

Sampson, L., Kubzansky, L. D., & Koenen, K. C. (2023). The Missing Piece: A Population Health Perspective to Address the US Mental Health Crisis. *Dædalus, 152*(4), 24-44.

Sareen, J., Jagdeo, A., Cox, B. J., Clara, I., ten Have, M., Belik, S. L., & Stein, M. B. (2007). Perceived barriers to mental health service utilization in the United States, Ontario, and the Netherlands. *Psychiatric Services*, *58*(3), 357–364.

Savage, H., Murray, J., Hatch, S. L., Hotopf, M., Evans-Lacko, S., & Brown, J. S. L. (2016). Exploring professional help-seeking for mental disorders. *Qualitative Health Research*, *26*(12), 1662–1673. https://doi.org/10.1177/1049732315591483

Scheff, T. J. (1966). *Being mentally ill: A sociological theory*. Aldine Publications.

Schnyder, N., Panczak, R., Groth, N., & Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: Systematic review and meta-analysis. *The*

*British Journal of Psychiatry*, *210*(4), 261–268. https://doi.org/10.1192/bjp.bp.116.189464

Sekaran, U., & Bougie, R. (2016). *Research methods for business: A skill-building approach*. John Wiley & Sons.

Shadish, W. R., Cook, T. D., & Campbell, D. T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Houghton Mifflin.

Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ open*, *9*(1), e024803.

Smith, R. A. (2007). Language of the lost: An explication of stigma communication. *Communication Theory*, *17*(4), 462-485.

Substance Abuse and Mental Health Services Administration. (2021). *2020 NSDUH annual national report*. https://www.samhsa.gov/data/report/2020-nsduh-annual-national-report

Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration Center for Integrated Health Solutions. (n.d.). *What is integrated care?* http://www.integration.samhsa.gov/about-us/what-is-integrated-care

Szafran, R. F. (2007). Assessing program outcomes when participation is voluntary: Getting more out of a static-group comparison. *Practical Assessment, Research, and Evaluation*, *12*, Article 8. https://doi.org/10.7275/9bw1-m645

Teachman, B., Wilson, J., & Komarovskaya, I. (2006). Implicit and explicit stigma of mental illness in diagnosed and healthy samples. *Journal of Social and Clinical Psychology*, *25*(1), 75–95. https://doi.org/10.1521/jscp.2006.25.1.75

Thapa, B. B., Laws, M. B., & Galárraga, O. (2021). Evaluating the impact of integrated behavioral health intervention: Evidence from Rhode Island. *Journal of Medicine*, *100*(34), e27066. https://doi.org/10.1097/MD.0000000000027066

Thoele, K., Moffat, L., Konicek, S., Lam-Chi, M., Newkirk, E., Fulton, J., & Newhouse, R. (2021). Strategies to promote the implementation of screening, brief intervention, and referral to treatment (SBIRT) in healthcare settings: A scoping review. *Substance Abuse Treatment, Prevention and Policy*, *16*(1), 42. https://doi.org/10.1186/s13011-021-00380-z

Thomas, K. C., Ellis, A. R., Konrad, T. R., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of mental health professional shortage in the United States. *Journal of Psychiatric Services*, *60*(10), 1323–1328. https://doi.org/10.1176/ps.2009.60.10.1323

Thornicroft, G. (2011). Physical health disparities and mental illness: The scandal of premature mortality. *The British Journal of Psychiatry*, *199*(6), 441–442. https://doi.org/10.1192/bjp.bp.111.092718

Thornicroft, G. (2013). Premature death among people with mental illness. *British Medical Journal*, *346*. https://doi.org/10.1136/bmj.f2969

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., & Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: A cross-sectional survey. *The Lancet*, *373*(9661), 408–415. https://doi.org/10.1016/S0140-6736(08)61817-6

Trochim, W. M., & Donnelly, J. P. (2008). *Research methods knowledge base*. Atomic Dog.

Trompeter, N., Rafferty, L., Dyball, D., McKenzie, A., Greenberg, N., Fear, N. T., & Stevelink, S. A. (2023). Gender differences in structural and attitudinal barriers to mental healthcare in UK Armed Forces personnel and veterans with self-reported mental health problems. *Social psychiatry and psychiatric epidemiology*, 1-11.

Trost, J. E. (1986). Statistically nonrepresentative stratified sampling: A sampling technique for qualitative studies. *Qualitative Sociology*, *9*(1), 54–57. https://doi.org/10.1007/BF00988249

University of Washington AIMS Center. (2021). *Evidence base for CoCM*. https://aims.uw.edu/evidence-base-for-cocm/

University of Washington AIMS Center. (n.d.). *About Collaborative Care*. https://aims.uw.edu/collaborative-care

Unützer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr., Hunkeler, E., Harpole, L., Hoffing, M., Della Penna, R. D., Noël, P. H., Lin, E. H., Areán, P. A., Hegel, M. T., Tang, L., Belin, T. R., Oishi, S., & Langston, C. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. *JAMA*, *288*(22), 2836–2845. https://doi.org/10.1001/jama.288.22.2836

U.S. Census Bureau. (2016). *Upstate SC Alliance*. https://www.upstatescalliance.com/wp-content/uploads/Fact-Sheet_2020_Upstate-SC-Region.pdf

U.S. Department of Health and Human Services. (2021). *Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

U.S. Department of Health and Human Services. (2018). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and*

*Health*. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

U.S. Department of Housing and Urban Development. (2016). *The 2015 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of homelessness in the United States*. https://huduser. gov/portal/sites/default/files/pdf/2015-AHAR-Part-2.pdf

Villarroel, M. A., & Terlizzi, E. P. (2020). *Symptoms of depression among adults: United States, 2019* (pp. 1-8). Hyattsville, MD, USA: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325

Wahl, O. F. (1999). Mental health consumers' experience of stigma. *Schizophrenia Bulletin*, *25*(3), 467–478. https://doi.org/10.1093/oxfordjournals.schbul.a033394

Wamsley, M., Satterfield, J. M., Curtis, A., Lundgren, L., & Satre, D. D. (2018). Alcohol and drug screening, brief intervention, and referral to treatment (SBIRT) training and implementation: Perspectives from 4 health professions. *Journal of Addiction Medicine*, *12*(4), 262–272. https://doi.org/10.1097/ADM.0000000000000410

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., Bruffaerts, R., de Girolamo, G., de Graaf, R., Gureje, O., Haro, J. M., Karam, E. G., Kessler, R. C., Kovess, V., Lane, M. C., Lee, S., Levinson, D., Ono, Y., Petukhova, M., & Wells, J. E. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO World Mental Health surveys. *The Lancet, 370*(9590), 841–850. https://doi.org/10.1016/S0140-6736(07)61414-7

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and delay in initial treatment contact after first onset of mental disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 603–613. https://doi.org/10.1001/archpsyc.62.6.603

Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Setodji, C., Osilla, K. C., Hunter, S. B., McCullough, C. M., Becker, K., Iyiewuare, P. O., Diamant, A., Heinzerling, K., & Pincus, H. A. (2017). Collaborative care for opioid and alcohol use disorders in primary care: The SUMMIT randomized clinical trial. *JAMA Internal Medicine*, *177*(10), 1480–1488. https://doi.org/10.1001/jamainternmed.2017.3947

Welch, B. L. (1947). The generalization of "student's" problem when several different population variances are involved. *Biometrika*, *34*(1/2), 28–35. https://doi.org/10.2307/2332510

Whitley, R., & Wang, J. (2017a). Good news? A longitudinal analysis of newspaper portrayals of mental illness in Canada 2005 to 2015. *The Canadian Journal of Psychiatry, 62*(4), 278–285. https://doi.org/10.1177/ 0706743716675856

Whitley, R., & Wang, J. (2017b). Television coverage of mental illness in Canada: 2013–2015. *Social Psychiatry and Psychiatric Epidemiology*, *52*(2), 241–244. https://doi.org/10.1007/s00127-016-1330-4

Wong, E. C., Collins, R. L., Cerully, J., Seelam, R., & Roth, B. (2017). Racial and ethnic differences in mental illness stigma and discrimination among Californians experiencing mental health challenges. *Rand Health Quarterly*, *6*(2), 6.

World Health Organization. (2008). *Integrating mental health into primary care: A global perspective*. https://www.who.int/publications/i/item/9789241563680

World Health Organization. (2021). *Suicide worldwide in 2019: Global health estimates*. https://iris.who.int/handle/10665/341728

Zuvekas, S. H., & Meyerhoefer, C. D. (2009). State variations in the out-of-pocket spending burden for outpatient mental health treatment. *Health Affairs*, *28*(3), 713–722. https://doi.org/10.1377/hlthaff.28.3.713

# Appendix A: IRB Approval

[External] IRB-FY22-23-1315 - Initial: Initial - Exempt

do-not-reply@cayuse.com <[redacted]>
Fri 6/2/2023 12:44 PM
To:Boyd, Mollie Evans (Community Care and Counseling) [redacted]>;Tanner, Melicia Ivette [redacted]

[ EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content. ]

LIBERTY UNIVERSITY
INSTITUTIONAL REVIEW BOARD

June 2, 2023

Melicia Tanner
Mollie Boyd

Re: IRB Exemption - IRB-FY22-23-1315 Collaborative Care Management (CoCM): The Influence of Location of Care on Mental Health Self-Stigma

Dear Melicia Tanner, Mollie Boyd,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(i). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:
The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects;

**Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB.** Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at [redacted]

Sincerely,

## Appendix B: Demographic Survey

1. Are you older than 18 years of age?
2. What is your gender?
3. What is the name of your primary care office?
4. Have you ever received a diagnosis of depression?
5. Have you ever been psychiatrically hospitalized?
6. Have you ever been diagnosed with a substance use disorder?
7. Have you ever experienced psychosis?
8. Do you receive any kind of mental health care for your depression (counseling, medication, peer support, etc.)?
9. Do you receive that care outside of your primary care office or in it?

## Appendix C: Self-Stigma of Seeking Help Scale

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

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

1. I would feel inadequate if I went to a therapist for psychological help.

2. My self-confidence would NOT be threatened if I sought professional help.

3. Seeking psychological help would make me feel less intelligent.

4. My self-esteem would increase if I talked to a therapist.

5. My view of myself would not change just because I made the choice to see a therapist.

6. It would make me feel inferior to ask a therapist for help.

7. I would feel okay about myself if I made the choice to seek professional help.

8. If I went to a therapist, I would be less satisfied with myself.

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.

10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.

[External] Re: SSOSH Scale

Vogel, David L [PSYCH] <[redacted]

Mon 3/20/2023 10:51 AM

To:Tanner, Melicia Ivette [redacted]

4 attachments (587 KB)

SSOSH.doc; SSOSH Scale.pdf; Brenner et al 2021.pdf; Cross Cultural Stigma.pdf;

You don't often get email from dvogel@iastate.edu. Learn why this is important

[ EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content. ]

Feel free to use the scale in your research. Scale and some validity studies attached.

David

**From:** "Tanner, Melicia Ivette" [redacted]>
**Date:** Thursday, March 9, 2023 at 10:04 AM
**To:** "Vogel, David L [PSYCH]" <[redacted]
**Subject:** SSOSH Scale

Good morning,

I am emailing to request permission to use the Self-Stigma of Seeking Help Scale for my doctoral dissertation research.

**Melicia Tanner, MS LPC**

*"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."*

*— Maya Angelou*

# Appendix D: Informed Consent (Liberty University)

**Title of the Project:** Collaborative Care Management (CoCM): The Influence of Location of Care on Mental Health Self-Stigma
**Principal Investigator:** Melicia Tanner, Doctoral Candidate, School of Behavioral Sciences
Liberty University

## Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years of age or older, have a diagnosis of depression, receive primary care from Prisma Health, and be able to read English. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

## What is the study about and why is it being done?

The purpose of this study is to examine how self-stigma affects people's attitudes towards seeking help for mental health symptoms, specifically whether the location of the care impacts their attitudes.

## What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following:

1. Take an online survey through REDCap, sent to your email. The survey should take fifteen minutes to complete.

## How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include the enhancement of knowledge related to mental health care.

## What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life. The risks involved in this study include psychological stress from answering questions about your mental health. To reduce risk, I will provide referral information for counseling services.

## How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be anonymous.
- Data will be stored on an encrypted software called REDCap. After three years, all electronic records will be deleted.

## Is the researcher in a position of authority over participants, or does the researcher have a financial conflict of interest?

The researcher serves as a counselor at Prisma Health. To limit potential or perceived conflicts, data collection will be anonymous, so the researcher will not know who participated. This disclosure is made so that you can decide if this relationship will affect your willingness to participate in this study. No action will be taken against an individual based on his or her decision to participate or not participate in this study.

## Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or Prisma Health. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey without affecting those relationships.

## What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

## Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Melicia Tanner. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at [redacted]. You may also contact the researcher's faculty sponsor, Dr. Mollie Boyd, at [redacted].

## Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the IRB. Our physical address is [redacted]; our phone number is [redacted], and our email address is [redacted].

*Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers* *are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

## Your Consent

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of the document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.
*I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.*

Printed Subject Name

Printed LAR Name and Relationship to Subject

LAR Signature Date

## Appendix E: Informed Consent (Prisma Health)

### CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Collaborative Care Management (CoCM): The Influence of Location of Care on Mental Health Self-Stigma

**Study to be Conducted at:** Prisma Health
Greenville, SC 29605

**Principal Investigator:** Melicia Tanner, MS LPC, Candidate for Ed. D.
Work Number: [redacted]

**KEY INFORMATION**
You are being asked to participate in a research study. Participation in a research study is voluntary. The information in this consent form is meant to better inform you so you may decide whether or not to participate in this research study. Please ask the principal investigator to explain anything you do not understand.

This work examines how self-stigma affects people's attitudes towards seeking help for mental health symptoms, specifically whether the location of the care impacts their attitudes. There may be minimal risk involved in participating in this study. There are no direct benefits to for agreeing to be in this study. Please understand that although you may not benefit directly from participation in this study, you have the opportunity to enhance knowledge related to mental health care.

If you agree to participate, you will be asked to complete the attached questionnaire.

The Institutional Review Board of Prisma Health has reviewed this study for the protection of the rights of human participants in research studies, in accordance with federal and state regulations.

**PURPOSE**
You are being asked to participate in this study because you have a diagnosis of depression.

The purpose of this study is to examine how self-stigma affects people's attitudes towards seeking help for mental health symptoms, specifically whether the location of the care impacts their attitudes.

This research study is being done because there is minimal research on how the location of care impacts people's experience of stigma.

Your participation will last for completion of this survey.
The study is being conducted as part of the dissertation requirements of Liberty University.

**HOW THE STUDY WORKS**

Participants will be sent an online survey through REDCap, sent to their emails. This survey will include an initial assessment interview form asking if participants are over the age of 18, what their gender is, the name of their primary care office, whether they have been diagnosed with depression, and if they receive mental health care in their primary care office (collaborative care) or outside of their primary care office. Participants will also be asked is they have been psychiatrically hospitalized in the past month, whether they have a substance use disorder, and whether they experience psychosis. The rest of the survey will be the items from the Self-Stigma of Seeking Help Scale.

**POSSIBLE RISKS**

There are no known medical risks related to participation in this study. The greatest risk is the possible release of your personal health information. Your study records are considered confidential, but absolute confidentiality cannot be guaranteed. This study may result in presentations and publications, but steps will be taken to make sure you are not identified by name.

Some of the questions in the survey are personal and may be upsetting to some participants. The study staff will be available to discuss these questions should you have a concern or problem. You do not have to answer any questions that you do not want to answer.

If you are depressed or become depressed as a result of this study, steps will be taken to ensure that you are put into contact with someone who can help you. If you have any suicidal thoughts or tendencies, please contact the Suicide Hotline at 1-273-TALK (1-800-273-8255) or 1-800-SUICIDE (1-800-784-2433). If you feel in crisis, you can also call 911 or go to the nearest Emergency Room.

**POSSIBLE BENEFITS**

It is not possible to know whether or not you may benefit from participating in this study. The treatment or procedures you receive may even be harmful. The information gained from this study may be useful and may help others. Please understand that although you may not benefit directly from participation in this study, you have the opportunity to enhance knowledge related to mental health care.

**ALTERNATIVE (OTHER) TREATMENTS**

The decision to participate in this study is entirely up to you. The alternative to participating in this study is simply not to participate. If you decide not to participate in the study, you will not be penalized in any way.

**NEW INFORMATION**

Your doctor will tell you about new information that may affect your willingness to participate in this research study. Alternatives, or other choices, concerning your care will be discussed at that time.

There are no plans to share individual research results with you.

**COST TO YOU FOR PARTICIPATING IN THIS STUDY**

There are no anticipated costs to you for participating in the study.

**PAYMENT FOR PARTICIPATION**

*You will not be paid for participating in this study.*

**COMPENSATION FOR INJURY AS A RESULT OF STUDY PARTICIPATION**

Prisma Health will provide you the care needed to treat any injury, or illness, that directly results from taking part in this research study.

Injuries sometimes happen in research even when no one is at fault. The study sponsor, Prisma Health, or the investigators as part of this study have no plans to pay you or give you other compensation for an injury, should one occur. However, you are not giving up any of your legal rights by signing this form.

If you think you have been injured or have experienced a medical problem as a result of taking part in this research study, tell the person in charge of this study as soon as possible. The researcher's name and phone number are listed in the 'Contact for Questions' section of this consent.

**VOLUNTARY PARTICIPATION**

Participation in this research study is voluntary. You may refuse to participate or withdraw from the study at any time. If you refuse to participate or withdraw from the study, you will not be penalized or lose any benefits and your decision will not affect your relationship with your doctor or hospital.

However, if you decide to stop study participation, you are encouraged to talk with your doctor regarding safe removal from the study. Further treatment would be discussed at that time.

If your participation in this research study is stopped, your study doctor will discuss any tests or procedures that might be needed for your health and safety, but you may refuse any or all of these tests or procedures. Following this discussion with your study doctor, you still have the right to refuse any or all of these tests or procedures.

**AUTHORIZATION TO USE AND DISCLOSE (RELEASE) MEDICAL INFORMATION**

As part of this research study, the study doctor and his/her research team will keep records of your participation in this study. These study records may be kept on a computer and will include all information collected during the research study, and any health information in your medical records that is related to the research study. The study doctor and his/her research team will use and disclose (release) your health information to conduct this study. This study may result in scientific presentations and publications, but steps will be taken to make sure you are not identified.

Some of the organizations/entities that may receive your information are:

- The study sponsor and any company supporting the study (the sponsor's authorized representatives)
- The Institutional Review Board, which is a group of people who review research with the goal of protecting the people who take part in the study

- Liberty University

Under federal privacy laws, your study records cannot be used or released for research purposes unless you agree. If you sign this consent form, you are agreeing to the use and release of your health information. If you do not agree to this use, you will not be able to participate in this study. Once your health information has been released, federal privacy laws may no longer protect it from further release and use.

The right to use your health information for research purposes does not expire unless you withdraw your agreement. You have the right to withdraw your agreement at any time. You can do this by giving written notice to the study doctor. If you withdraw your agreement, you will not be allowed to continue participation in this research study. However, the information that has already been collected will still be used and released as described above. You have the right to review your health information that is created during your participation in this study. After the study is completed, you may request this information.

If you have any questions about the privacy of your health information, please ask the study doctor.

**CONTACT FOR QUESTIONS**

For more information concerning this study and research-related risks or injuries, or to give comments or express concerns or complaints, you may contact the principal investigator, whose information is included below.

You may also contact a representative of the Prisma Health Office of Human Research Protection for information regarding your rights as a participant involved in a research study or to give comments or express concerns, complaints or offer input. You may obtain the name and number of this person by calling [redacted].

Principal Investigator Name: Melicia Tanner, MS LPC

**CONSENT TO PARTICIPATE**

The study staff, Melicia Tanner, has explained the nature and purpose of this study to me. I have been given the time and place to read and review this consent form and I choose to participate in this study. I have been given the opportunity to ask questions about this study and my questions have been answered to my satisfaction. I have been given the opportunity to review my study doctor's Notice of Privacy Practices. I agree that my health information may be used and disclosed (released) as described in this consent form. After I sign this consent form, I will receive a copy of it for my own records. I do not give up any of my legal rights by signing this consent form.

________________________________________________

Printed Name of Participant

_________________________________________ ____________ ___________

Signature of Participant Date Time

________________________________________________

Printed Name of Investigator

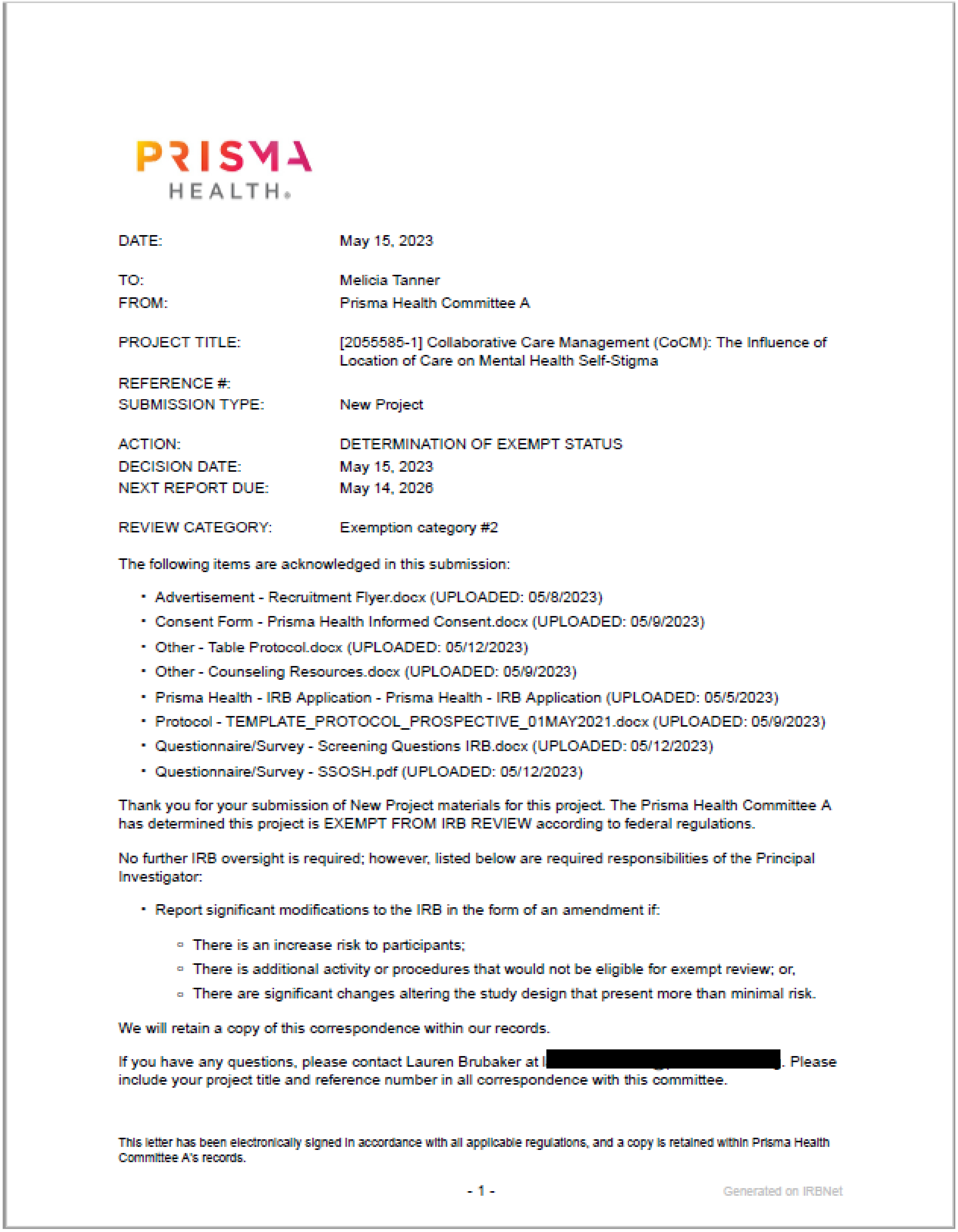
_________________________________________ ____________ ___________

Signature of Investigator Date Time

Principal Investigator: Phone:

Sub-investigators: Phone:

# Appendix F: Prisma Health IRB Exempt Letter



PRISMA
HEALTH

DATE: May 15, 2023

TO: Melicia Tanner
FROM: Prisma Health Committee A

PROJECT TITLE: [2055585-1] Collaborative Care Management (CoCM): The Influence of Location of Care on Mental Health Self-Stigma

REFERENCE #:
SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: May 15, 2023
NEXT REPORT DUE: May 14, 2026

REVIEW CATEGORY: Exemption category #2

The following items are acknowledged in this submission:

- Advertisement - Recruitment Flyer.docx (UPLOADED: 05/8/2023)
- Consent Form - Prisma Health Informed Consent.docx (UPLOADED: 05/9/2023)
- Other - Table Protocol.docx (UPLOADED: 05/12/2023)
- Other - Counseling Resources.docx (UPLOADED: 05/9/2023)
- Prisma Health - IRB Application - Prisma Health - IRB Application (UPLOADED: 05/5/2023)
- Protocol - TEMPLATE_PROTOCOL_PROSPECTIVE_01MAY2021.docx (UPLOADED: 05/9/2023)
- Questionnaire/Survey - Screening Questions IRB.docx (UPLOADED: 05/12/2023)
- Questionnaire/Survey - SSOSH.pdf (UPLOADED: 05/12/2023)

Thank you for your submission of New Project materials for this project. The Prisma Health Committee A has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

No further IRB oversight is required; however, listed below are required responsibilities of the Principal Investigator:

- Report significant modifications to the IRB in the form of an amendment if:
    - There is an increase risk to participants;
    - There is additional activity or procedures that would not be eligible for exempt review; or,
    - There are significant changes altering the study design that present more than minimal risk.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Lauren Brubaker at [redacted]. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Prisma Health Committee A's records.