

# **Stigma and Cybertherapy**

by

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## Abstract

The present study was designed to shed light on whether people stigmatize individuals seeking cybertherapy less than they stigmatize those who seek traditional therapy. Using Amazon's Mechanical Turk crowdsourcing service, 289 participants were recruited. Participants were presented with two vignettes in which "John" either sought therapy from a cybertherapy clinician or a traditional therapist. Participants then filled out two measures for each vignette intended to assess social distance and perceived discrimination. Two repeated measures ANOVAs showed that there were no significant differences between groups, indicating that this modality of therapy may be subject to the same stigmatization as traditional therapy. Future directions for research and implications for practice are discussed.

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## List of Abbreviations

PDD Perceived Devaluation Discrimination

SDS Social Distance Scale

## **Chapter I**

### **Introduction**

Stigma is a concept of interest to psychologists and sociologists, particularly stigma related to gender, race, disabilities, sexual orientation, and mental health. The word “stigma” originates from ancient Greece, a time when people physically branded those that were considered undesirable from the rest of the population (Foerschner, 2010; Goffman, 1963; Hinshaw & Stier, 2008). This was mostly done to indicate perceived moral status, and the stigma was typically signified by a physical cut or burn to indicate the person was a criminal, traitor, slave, or the like. It has been theorized that this response evolved as a way to perceive and react to a threat within the environment (Arboleda-Florez, 2005; Klin & Lemish, 2008). Alternatively, it has also been speculated that stigma may be the result of an attempt to identify others who may be carrying diseases (based on physical markers), are part of a group that could be exploited for personal or in-group advantages, or have qualities that would make social interaction undesirable (Major & O'brien, 2005). Regardless of the underlying purpose of stigma, it has become so central to human social structures that stigma and discriminatory policies can be found in every country in the world (Arboleda-Florez, 2005). Research in this area generally views stigma as a social phenomenon in which certain individuals or groups are “separated” from the larger society by attributing to members of the group negative characteristics which they are presumed to have in common. In turn, these negative characterizations have negative consequences for those stigmatized (Shelton, Alegre, & Son, 2010). For the purpose of this research, stigma is defined as “an attribute that is deeply discrediting” (Goffman, 1963, p.3), and the person who is stigmatized is “the bearer of a ‘mark’ that defines him or her as deviant, flawed, limited, spoiled, or generally undesirable” (Jones et al., 1984, p. 6).

### **Consequences of being stigmatized**

Stigma has been associated with a variety of negative consequences for those stigmatized, including an overall poorer quality of life (Gaebel, Zasko, & Baumann, 2006). For example, stigma can cause severe psychological stress for an individual, often resulting in depression and fear (Van Brakel, 2006). Additionally, society tends to provide those stigmatized with limited opportunities for sufficient housing, employment, friendships, and mental health treatment (Gaebel, Zasko, & Baumann, 2006; Hatzenbuehler, Phelan, & Link, 2013; Overton & Medina, 2008). A literature review of health-related stigma also showed that there are negative consequences affecting intimate relationships, education, recreational activities, and social and religious involvement as a result of stigma (Van Brakel, 2006).

Experiencing continued discrimination, loss of status, and lack of acceptance can lead to internalization of these constructs with accompanying negative effects on personal identities and self-integrity (Yang et al., 2007). Furthermore, the lack of support on both systemic and individual levels for stigmatized individuals can have a negative impact on self-efficacy and general ability to function within society (Overton & Medina, 2008). This may be in part due to depleted mental resources from having to cope with being stigmatized and devalued, which may affect overall ability to respond and adapt to changing situations in life (Hatzenbuehler, Phelan, & Link, 2013).

Even health professionals are not immune from stigmatizing their patients. In a review of 28 studies, Van Boekel and colleagues (2013) found that substance abuse patients had worse outcomes from treatment due to the stigma held by their healthcare professionals. Specifically, professionals were less involved with their substance-abusing patients, described their patients negatively (e.g., manipulative, violent, unmotivated), and had reduced empathy for their patients. Due to discrimination and prejudice against stigmatized populations, individuals seeking health services may be refused



access to resources within the community as well (Angermeyer & Matschinger, 2005; Coverdale & Roberts, 2010; Knifton, 2012).

### **Purpose of the Study**

Given the severe consequences for those stigmatized, the current study was designed to shed light on the differences in stigma toward traditional therapy and the new modalities of therapy offered over the internet. In particular, this study assessed how people perceive others who are thought to be using cybertherapy services, as compared with those who are assumed to be in traditional therapy.

## Chapter II

### Literature Review

#### Cybertherapy Overview

One of the more significant developments in technology use in applied psychology has been the capability to provide psychotherapy services online. These online services have been known by a myriad of names, such as online therapy, cybertherapy, teletherapy, internet therapy, e-therapy, and web counseling. Throughout this paper, these names will be used interchangeably. Although the names may all refer to online services, these services can be offered through various modalities: chatrooms, video calling, e-mail, instant messenger, phone texting, and intensive online modules. Because of limited legal regulation, online therapy is provided by essentially any licensed therapist that wishes to do so. To get some idea of the range of services currently being offered online, the author googled the term “e-therapy” and reviewed the first five pages of results (i.e., the first 50 websites from the results):

- Some sites charge therapists a subscription fee for using their scheduling services (such as an online calendar to schedule appointments as provided by <http://www.e-therapy.com.au>, but other therapists simply set up their own website and allow clients to contact them privately (e.g., <http://etherapyofct.com>, <https://audreyjung.com/E-Therapy.html>, <http://www.measures4successllc.com/index.html>, and <http://www.etherapylive.com>).
- Online therapy is available to individuals, couples, families, children and groups, although most sites require clients to be at least 18 years old and not suicidal, homicidal, or in crisis (<http://www.aprivatetalk.com>; <http://drjulieann.com/etherapy.htm>; <http://www.e-therapyhelper.com>).

- Prices seem to be similar to traditional fees, and most therapists charge the same amount for a 50 minute video conference as they do face-to-face counseling. E-mails are generally charged either by the amount of time it takes the therapist to respond (ex: \$35 for a 30 minute response as by <http://www.e-therapyhelper.com> and <http://www.aprivatetalk.com>) or by a defined price per email response (<http://etherapyofct.com>). More variety in pricing is found using text-based mediums – some therapists charge the same for a 50 minute chat/texting session (<http://www.talktala.com>; <http://www.psyshrink.com>), but others provide a discount for these services (<http://www.therapyave.com>).
- With few exceptions, the sites note that insurance companies are unlikely to cover the online therapy services provided.

Although these services are still relatively new in the field of counseling, they have quickly become so widespread that the American Psychological Association (APA) recently released “Guidelines for the Practice of Telepsychology” (APA, 2013). These guidelines provide a framework from which practicing psychologists can attempt to navigate this new evolution in the field. Given that this area is still so novel, the guidelines only make suggestions about how to help protect clients, rather than provide mandatory standards (APA, 2013). APA notes that there may be a large number of benefits to telepsychology, but also recognizes that there may be new risks and threats to client welfare when using a relatively untested modality in providing services. Glueckauf and colleagues (2003) identified four major advantages to cybertherapy over traditional therapy:

“a) the potential to deliver health information and services across geographical distance for underserved population; b) the potential to enhance the quality of health information and services in particular areas or for specific populations; c) the potential to ensure

continuous medical and psychological service overall for chronic disabilities reducing the cost of an extended traditional assistance; and d) the growing trend of patients' preferring to use home-based computer systems for psychotherapy" (Gaggioli & Riva, 2007, p. 2).

Additionally, Gaggioli and Riva (2007) found that online interaction promotes feelings of "togetherness and social presence," which may address some concerns that online therapy lacks important social components in the relationship.

Given the skepticism that online therapy could be effective (McClure, Livingston, & Livingston, 2005; Skinner & Latchford, 2006), some studies have examined whether online therapy has comparable outcomes to traditional therapy. Murphy and colleagues (2009) attempted to answer this question by comparing outcomes on the Global Assessment of Functioning (GAF) and Client Satisfaction Survey (CSS) for online counseling and traditional therapy. Their results showed no significant differences between either type of therapy for their sample of clients receiving therapy between 2006 and 2008. Online cognitive-behavioral therapy (CBT) being offered through modules (including interactive media, weekly online sessions with a therapist, and homework) has also been proven to be effective, and to have low cost (Cavanagh et al., 2009). Out of a sample of 219 patients with anxiety or depression concerns, 89% of participants reported finding the program to be helpful, and rated the program "about the same" or higher when compared to previous therapy experiences with depression or anxiety treatments. Chirita and colleagues (2006) also found low-cost virtual reality treatments to be effective, with participants improving faster and at least as much as those in the traditional CBT treatment group. Supporting these findings, De Las Cuevas (2005) demonstrated that

clients participating in 24 weeks of videoconferencing therapy showed significant improvement and decreased distress from when treatment began.

In addition to examining effectiveness of online therapy, the literature has tried to determine the demographics of online clients. However, results from this research on characteristics of cybertherapy clients have been more ambiguous than the effectiveness studies. People from Asian cultures that valued conformity were expected to gravitate more to an online mode of therapy, because it would be easier to hide the fact that the person was breaking social norms by seeking mental health services (Lee, 2009). However, Chang and Chang (2004) found that Asian American and Asian international students actually had less positive attitudes toward cybertherapy than traditional counseling. Interestingly, these attitudes were not influenced by degree of assimilation to American culture. In a study by Young (2005), e-therapy clients were shown to be mostly white males who had a four-year college degree. Contrary to these findings, though, Dubois (2004) reported that out of his own 217 online therapy clients, 85 percent were female.

### **Mental Health Stigma**

Throughout history, mental health stigma has taken on different connotations as the perspectives on what causes mental illness have changed. Records of treatment for mental illness date back to 5000 BCE, during which time people believed that evil spirits and demons were possessing those afflicted (Foerschner, 2010). Similarly, some believed that mental illness was the result of incurring the wrath of the Lord through immoral behavior and deeds. As a result, people with mental illness were stigmatized, resulting in others attempting to avoid and isolate them in judgment of whatever trespasses they must have committed against God. As time and scientific interest in the body progressed, physicians such as Hippocrates promoted the idea that all ailments have physical causes that can be

treated through medical aids, such as nutrition and other treatment (Moffat, 1788). Thus, attempts to treat mental illness began to include early formulations of medicine, rather than exorcisms and prayer. Therefore, those with mental illnesses were no longer necessarily viewed as immoral for being so afflicted; however, the tendency to isolate and shun mentally ill individuals continued to pervade cultures throughout these times.

In the 1800's, the medical field began to acknowledge the effect that stigma can have on patients. Esquirol (1845) noted “the difficulty catching the varied and fugitive forms of insanity, the savage rudeness of certain monomaniacs, the obstinate silence of some, the scorn and abuse of others, the threats and blows of maniacs, the disgusting filthiness of imbeciles, have discouraged those who wished to cultivate this branch of healing art.” (p. 72). Although Esquirol does advocate helping those suffering from mental illness, this quote also perfectly portrays the derogatory language often used to describe them. Such stigmatizing attitudes are clearly part of the reason that treatment for these individuals has been slow to advance. Thorough analysis of this construct, however, is still in its infancy. A search for “mental health stigma” in PsycInfo indicates that over 85% of the work on this topic has been published within the last decade. Additionally, in a meta-analysis examining the changes in attitudes over time, Schomerus and colleagues (2012) noted a greater acceptance of helping those with mental problems, but also observed public attitudes worsening towards those suffering from mental illness.

Several researchers have noted that the stigma can be as harmful, if not more harmful, than mental illness itself (Feldman & Crandall, 2007; Overton & Medina, 2008). Masuda and colleagues (2009) found that there is a positive correlation between mental health stigma and psychological distress. The public tends to perceive those with mental illness as being unpredictable, dangerous,

unintelligent, a poor employee, and not suited for marriage (Knifton, 2012). Unfortunately, these views are further exacerbated by the media's negative portrayal of the mentally ill, which promote fear and disdain for those suffering from mental disorders (Overton & Medina, 2008). In particular, there is an attitude that the mentally ill should not romantically partner with “healthy” individuals (Cechnicki & Bielanska, 2009).

In addition to all the consequences of stigma mentioned above, social distance has been cited as one of the main consequences of mental illness stigma, partially due to the myth that mental illness is contagious (Overton & Medina, 2008). Supporting the claim that mental illness is associated with social distance, Feldman and Crandall (2007) found that 75% out of the 40 mental illness vignettes used in their study elicited negative attitudes. This study also found that there are three core characteristics that lead to social distance: personal responsibility (how much the individual is to blame for the disorder), dangerousness (whether that person is a threat), and rarity of the mental illness (often mistaken by lay people for severity of the illness) (Feldman & Crandall, 2007). Given that stigmatized individuals also tend to be devalued within society, people may be concerned that they have nothing to gain from an interaction with a stigmatized individual (Overton & Medina, 2008). As a result, they may avoid them entirely to ensure they will not be “cheated” in a social exchange. This is particularly unfortunate, given that contact with stigmatized individuals actually tends to reduce the stigma (Corrigan & Rao, 2012; Couture & Penn, 2003)

Stigma may even result in "self-stigma," which can occur when negative societal perceptions are internalized by the stigmatized individual (Livingston & Boyd, 2010). A meta-analysis of the correlates of stigma showed that internalized stigma significantly and negatively affected every psychosocial variable that was included in the study: quality of life, hope, self-esteem, self-efficacy,

empowerment, and social support (Corrigan, 2004; Livingston and Boyd, 2010). The association between stigma and low self-esteem seems to be particularly strong; Research shows that people who endorse feeling stigmatized are seven to nine times as likely to have low self-esteem compared with those who do not (Link et al., 2001). Self-stigma is also associated with self-isolation and overall poor health outcomes (Corrigan & Rao, 2012). This self-isolation can lead to further difficulty in accessing, accepting, and utilizing the limited work and independent housing opportunities afforded to stigmatized individuals (Rüsch, Angermeyer, & Corrigan, 2005). Unfortunately, self-stigma may be very difficult to treat, given that the few techniques and interventions to do so have limited research support in terms of validation and appropriate application (Corrigan & Rao, 2012). Additionally, stigmatized individuals are less likely to seek out treatment or stay in treatment, due to concerns about possible judgments from others and the desire for autonomous problem solving (Corrigan, 2004).

There has also been some research about how different cultural factors play a role in mental health stigma. For example, Latinos have been found to express more shame related to being mentally ill and also believed they would face more stigma in the community than non-Latino Whites (Jimenez et al., 2013). Many Asian cultures also view mental health as a reflection of the family, rather than just an individual, which is also associated with experiencing greater shame for having a mental illness (Jimenez et al., 2013; WonPat-Borja et al., 2012). Jimenez and colleagues (2013) found that a greater proportion of Asian Americans in their sample stated that they would have difficulty pursuing treatment if others knew, as compared with non-Latino Whites. These results are consistent with several Asian cultural norms that place great importance on “saving face,” and the idea of bringing honor to the family and avoiding bringing shame (WonPat-Borja et al., 2012). Interestingly, research also shows that members of minority groups are less likely to stigmatize those suffering from mental illness, because their experience of being judged by others due to being members of an outgroup (Corrigan et al., 2001).



Additionally, the literature shows that gender also plays a role. In particular, gender roles for men emphasize the suppression of emotion and the need for the individual to solve his own problems (Steinfeldt et al., 2009; Topkaya, 2014; Vogel et al., 2014). Given that therapy requires an openness to exploring emotional content and asking someone else to help with personal problems, psychological help-seeking behaviors are negatively correlated with belief in traditional gender roles for males (Topkaya, 2014). Steinfeldt and colleagues (2009) also found that this effect is stronger if males identify with an athlete role, because utilizing professional psychological services may be seen as a sign of weakness.

### **Stigma Related to Cybertherapy**

Because cybertherapy is a relatively new modality in delivering psychological services, there is a lack of research investigating stigma associated with receipt of this form of mental health services. Specifically, there appears to be no literature on stigma related to cybertherapy services or cybertherapy clients. However, there are several reasons that cybertherapy might be less stigmatized than traditional therapy. For example, it has become very commonplace to find solutions for everyday problems online, and it may seem more “normal” to some that others would use this new online modality to address mental health concerns. There may also be a perception that if someone had a very serious mental problem, they would need therapy in person. In other words, online therapy could be perceived as a service which only people who do not have a serious condition would pursue. A parallel here might be “if you are really sick, you go to the doctor; if you are a little bit sick, maybe you just call your doctor.” As a result, others may assume that a client seeking cybertherapy services has less severe concerns than clients in traditional therapy, theoretically reducing the associated stigma as well.

To support the idea that cybertherapy stigma may be different than traditional therapy stigma, the literature recognizes that certain situational variables evoke different kinds of stigma. Phillips (1963) demonstrated that a person's willingness to be socially close to someone with mental health concerns is largely dependent on the reported profession (e.g., clergymen, physicians, psychiatrists) of the person providing needed mental health services. Using a social distance scale as a measurement of rejection, Phillips (1963) found that people seeking treatment from psychiatrists faced the most rejection. Interestingly, results also showed that a person depicted without symptoms who used a mental hospital at one point elicited more rejecting attitudes than did individuals with current psychotic symptoms who were not seeking treatment (Phillips, 1963).

These findings are particularly significant when thinking about the increased use of online therapies in the psychological community. If the profession of the person delivering clinical services impacts the degree of social rejection, it is logical to ask whether delivery systems themselves (e.g., traditional therapy versus cybertherapy) have different levels of stigma associated with them. Within the past decade, a multitude of different options for providing therapy online have been developed. In general, technology is becoming more and more integrated into treatment, as evidenced by use of virtual reality software to study, assess, and treat psychological issues such as phobias (Bullinger et al., 2005; Klinger et al., 2003; Wiederhold et al., 2005), eating disorders (Ferrer-Garcia & Gutierrez Maldonado, 2005; Riva, 2005), stress (Villani, Preziosa, & Riva, 2006), pain management (Tse, 2003), memory restructuring (van den Steen et al., 2010), and more. Additionally, robot-assisted therapy (Lebin, 2003; Shibata et al., 2004), bio-sensors (Lisetti et al., 2009), and video game use (Fanning & Brighton, 2007; Gaggioli & Riva, 2007) during session are providing a stark contrast to the perception that the only accessories to counseling are chairs.

## **Attitudes Related to Cybertherapy**

Even though research on stigma related to cybertherapy is still in its infancy, there has been some research focused on attitudes, perceptions, and expectations of cybertherapy. One of the largest differences between cybertherapy and traditional therapy is the added anonymity that an online relationship offers. Beattie and colleagues (2009) found that some participants were excited about this increased privacy, while others were more skeptical and noted that it may be difficult to tell if the therapist was empathetic through a text-based therapy. College students also voiced skepticism about the effectiveness of online therapy, expressing concerns about establishing a strong therapeutic relationship, confidentiality, and assessment (Finn, 2002). Overall, though, most participants in these studies had neutral attitudes towards online therapy (Beattie et al., 2009; Finn, 2002; Skinner & Latchford, 2006). Those that had already used internet support groups tended to have more positive expectations, stating that anonymity, convenience, and increased concentration during therapy sessions were factors in their judgments. Even participants who were skeptical at first tended to have positive reviews of their online counseling after experiencing it themselves (Beattie et al, 2009; Young, 2005) and were surprised that the therapeutic relationship was that strong (Beattie et al, 2009). This finding provides evidence that online therapy may be used more in the future, because even in a sample in which the majority of participants would prefer traditional therapy over online therapy, only 9.6% were unwilling to use online mental health services (Klein & Cook, 2010). Additionally, over half of the students in a college sample reported they would use online programs or online services if they were in distress (Ryan, Shochet, & Stallman, 2010).

Therapists have their own reservations about the use of this new technology. Therapists in the United States voiced a need for specific training regarding the use of these technologies, but were not

united on what this training might look like on a larger scale (Finn & Barak, 2010). Other countries, however, are already using online services much more extensively than is the United States. Finn and Barak (2010) found that online therapists in other countries have established ethical guidelines to follow, and that there is considerably more standardization than currently found in the United States. As of 2007, in Norway, almost half the therapists already used text-based communication with their clients, compared to the 10% of therapists in the United States using similar methodology (Wangberg, Gammon, & Spitznogle, 2007). Therapists in Texas, however, have contended that online therapy will actually have a negative effect on the profession as a whole, because it is not an effective mode of counseling (McClure, Livingston, & Livingston, 2005). Most of the individuals in this sample suggested that online therapy represents too much risk, which becomes even more problematic when considering the difficulty of maintaining updated ethical guidelines and security measures at the same pace as technology's rapid growth.

Attitudes regarding the integration of software into existing face-to-face therapy seems to garner more positive support. Segal and colleagues (2011) found that therapists perceived virtual realities (VR) as very helpful for treating phobias and some other presenting concerns, but also recognized that the high cost is a factor in widespread use. Virtual reality has also been found to be helpful in creating a social environment for narrative therapy or computerized doll therapy in the form of video games such as Sims (Belloni, Cantamesse & Galimberti, 2007; Fanning & Brighton, 2007). Additionally, military service members and their healthcare providers reported already using some online tools (Luxton et al., 2011). Wilson and colleagues (2008) found that, within their sample of soldiers who were unwilling to seek traditional therapy, one-third of soldiers would consider seeking mental health services delivered through technological mediums. Therefore, there is some evidence that online therapy can be useful to a certain segment of the population that would otherwise not receive

any treatment at all, even if e-therapy is not the preferred primary mode of therapy for everyone. If this mode of therapy continues to grow at the rapid rate it is currently, more research will be needed to better understand the ways in which cybertherapy impacts the welfare of a wide diversity of clients. One way in which the welfare of clients might be affected is the attitudes the public might hold toward those receiving cybertherapy.

With the integration of technology in psychological services occurring so rapidly, it is important to fill the large gaps in the literature related to cybertherapy clients. In particular, the fact that there is no research regarding the stigma related to obtaining services in this new modality is striking. The current study sought to better understand the use of cybertherapy by exploring stigma which may surround receiving such services.

### **Overview of Study**

Review of relevant literature suggests that the use of cybertherapy is increasing. One question to emerge from the literature is whether those who utilize cybertherapy are or are not stigmatized in the same way as are those that utilize traditional counseling services. Some data suggest that when individuals (observers) make judgments about clients seeking psychotherapy, the degree to which they stigmatize such clients may depend on the gender and ethnicity of the observer.

The current study used two 2 (gender of the observer) X 2 (ethnicity of the observer) X 2 (stigma measures) x (2) (type of therapy [cybertherapy vs traditional therapy]) repeated measures ANOVAs to investigate how these variables are related to stigma toward psychotherapy clients.

## **Chapter III**

### **Hypotheses**

1. Participants will rate the cybertherapy client as less likely to be stigmatized than the traditional therapy client. The likelihood of being stigmatized was measured by scores on the Perceived Devaluation-Discrimination Measure.
2. Participants will indicate less rejection towards the cybertherapy client than the traditional therapy client. Rejection of clients was measured by scores on the Social Distance Scale.
3. Participants from minority ethnic groups (i.e., non-Caucasian) will indicate less rejection and stigma towards the clients described in both versions of the vignette than will Caucasian participants.
4. Male participants will indicate more rejection and stigma towards clients described in both versions of the vignette than will female participants.

## Chapter IV

### Methodology

#### Overall Design

*Participants.* A total of 289 participants were recruited using Amazon’s Mechanical Turk crowdsourcing service to be part of a study entitled “Seeking Psychotherapy.” Mechanical Turk has been determined to be an effective way to access a large number of participants without diminishing the validity of the data (Bates & Lanza, 2013; Mason & Suri, 2012; Paolacci, Chandler, & Ipeirotis, 2010). Participants were told that the study would take approximately 30 minutes and that they would be paid \$0.70 for their time (participants using Mechanical Turk are typically paid \$1.40 per hour; Paolacci, Chandler, & Ipeirotis, 2010). A priori power analysis was run with GPower 3.1 (Faul et al., 2007), revealing that the MANOVAs (the analysis initially selected) would require 192 participants for the experiment, with an effect size of .10, alpha of .05, and power of .95, for the 16 groups (see Overview of Study in Chapter II), and 2 dependent variables. Subsequent to data collection and initial analysis, it was determined that rather than using MANOVAs, a better approach to data analysis was to use two mixed repeated measures ANOVAs to examine the data.<sup>1</sup> The decision to use separate ANOVAs was made because the initial analysis showed low correlations between the two measures and very low reliability for one of the measures (see Results).

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It is important to note that the number of participants required by a power analysis decreases with the use of two ANOVA's, instead of the originally planned MANOVA.

*Vignettes (Appendix A)*. These vignettes were originally created by Link and colleagues (1999) to study perceptions of different mental illnesses. Their study used five vignettes, each featuring a different mental disorder. Given that the purpose of the current study was to focus on the treatment modality received, rather than the disorder being treated, only the “troubled person” vignette (for which symptoms do not meet any particular disorder) was used. The vignettes were altered to use present tense language and to include information about which treatment (either online therapy or face-to-face therapy) the person described is participating in. Additionally, to make the vignettes more believable, yet without introducing other variables of significance, they were altered to include geographical location and age of the person described, but ethnicity and educational level variables were removed in an effort to keep these variables from influencing the participant’s responses to the questionnaires.

## **Measures**

*Biographical Questionnaire (Appendix B)*. This questionnaire consists of basic demographic information.

*Perceived Devaluation-Discrimination Measure (Appendix C)*. This assessment consisted of twelve questions in a Likert format from 1 (strongly agree) to 6 (strongly disagree). The Perceived Devaluation-Discrimination measure (PDD) was first developed by Link (1987), and was originally written to assess how much an individual believes the public would devalue or discriminate against someone who was a psychiatric patient. To make the scale more applicable to this study, the wording was changed from “former mental patient” to the name of the person in the vignette (John). Ratings were summed and divided by twelve to produce a scaled score between 1 and 6, higher scores indicating greater perceived stigma. Link and colleagues (2001) found the reliability of this scale to be .88 at baseline, .86 at a six-month follow-up, and .88 at a 24-month follow-up. The measure has also



been found to have adequate internal consistency based on several studies, with alphas ranging from .78 to .84 (Boyd, 2003; Link, 1987; Vogel, Wade, & Hackler, 2007). The Cronbach Alpha was calculated to determine the internal consistency specific to the sample used in this study as well. Additionally, a confirmatory factor analysis showed that a 1-factor model provided the best fit for this measure, given the high interfactor correlation ( $r=0.9$ ) (Glass, Kristjansson, & Bucholz, 2013). Link and colleagues (2001) found this scale to have a strong relationship with the internal experience of demoralization and lower self-esteem, both at 6 months and 24 months later. Finally, this scale has also been correlated with self-stigma (Krajewski, Burazeri, & Brand, 2013).

*Social Distance Scale (Appendix D).* This questionnaire contains five 5-point items about whether participants want to keep social distance with the person described in the vignette. This scale was first created by Philips (1963), and the five responses are summed and divided by five to provide an overall score of rejection. This is the first scale to have applied the concept of social distance to mental illness (Link et al., 2004), and variations of it have been used in several studies since (Emul et al., 2011; Martin, 2000; Weinfurt & Maghaddan, 2001). Social distance scales rely largely on face validity and internal consistency measures (Link et al., 2004). Phillips' (1963) scale is unidimensional and has Cronbach Alpha coefficient of .97 (Philips, 1963). The Cronbach Alpha was calculated to determine the internal consistency specific to the sample used in this study as well, but it was surprisingly low (0.59). This is further discussed in the Discussion section.

*Additional Questions (Appendix E).* After answering questions about both vignettes, participants were also asked to answer the following questions: "How much do you use the internet per week?" "Have you been in therapy, either in person or online? Check all that apply," "Please rate the problem described in the vignette in terms of severity," and "Comments or reactions related to this study."

## **Procedure**

Participants first reviewed the informed consent form (Appendix F), and then were asked to read the two versions of the vignette. After each version, participants were asked to answer the questions in the Perceived Devaluation-Discrimination measure and the Social Distance Scale. The order in which the dependent variables and vignette versions were administered was randomized.

## Chapter V

### Results

*Introduction.* The following analyses of the data are divided into preliminary findings and primary findings. Preliminary findings refer to basic demographic information about the sample (results summarized in Appendix G). The primary findings include a description of the analyses used to test the major hypotheses for this study.

*Preliminary findings.* A total of 289 participants were recruited. The sample consisted of 123 females, 165 males, and one participant who identified as “other.” Because there was only one person that indicated “other” as gender, this person’s responses were not included in the analysis. Ages ranged between 19 and 71, with the mean age being 33-years old (median = 30). Additionally, 210 participants identified as White/Caucasian, 28 as Asian American, 18 as African American, 23 as Latino(a)/Hispanic, and 10 as “other.” These ethnic groupings were then categorized as either “White” or “Non-White” for the analysis, to highlight whether ethnic minority groups responded differently than Caucasian participants. Highest earned degree were distributed as follows: High School (87; 30%); Two-year college degree (51; 18%); Four-year college degree (127; 44%); Some graduate school (23; 8%); No degree (1; 0%). Previous research on Amazon’s Mechanical Turk crowdsourcing service found the population to be slightly more female (54-55%), slightly less diverse (about 86% Caucasian), with a similar age distribution (Bates & Lanza, 2013; Mason & Suri, 2012). Overall, the sample used for this study was demographically similar to other studies that have obtained reliable results from this population that are comparable to laboratory studies (see Appendix G).

As described above, at the end of the survey, participants were asked three questions related to their internet use, their therapy history and their perceptions of the severity of the portrayed client’s problem. Rather than providing participants with structured categories (units of time) from which to

choose, the question regarding internet usage asked participants to indicate how much they used the internet weekly. Many participants chose to describe their internet use narratively, without providing an exact number of hours. Because of this, no quantitative result can be given regarding the average time that participants spent on the internet on a weekly basis. However, it was clear that the large majority of participants use the internet daily, and most of the numerical responses given indicated use of 40 hours or more per week. A total of 126 (44%) of the participants had been in traditional therapy before, and 18 (6%) had received online therapy in the past. Finally, participants were also asked for their estimation of the severity of the problem described in the vignette. The mean severity rating given was 2.29 (median = 2) for the 6-point likert scale, indicating that participants did not perceive the problem as particularly severe.

*Primary findings.* The purpose of this study was to examine the stigma associated with online therapy clients as compared with those seeking traditional counseling services. The study hypothesized that participants would rate a cybertherapy client (described in a vignette) in a less stigmatizing way than they rated a client described as being in more traditional therapy. The likelihood of being stigmatized was measured by scores on the Perceived Devaluation-Discrimination (PDD) Measure. Secondly, participants were expected to indicate less rejection towards the cybertherapy client than the traditional therapy client. Rejection of clients was measured by scores on the Social Distance Scale (SDS). Finally, participants were also hypothesized to indicate less stigma and rejection for both types of therapy if they identified as an ethnic minority or female.

As described in the methodology, the original intent was to use a multivariate analysis of variance (MANOVA) to address these hypotheses. However, preliminary bivariate correlations between the two scales (SDS and PDD) showed that these scales are measuring different things ( $r = 1.67$ ,  $p=0.005$  for cybertherapy;  $r = .230$ ,  $p = .000$  for traditional therapy). Additionally, the SDS had poor

reliability in this sample (Chronbach Alpha = 0.59), but the PDD had very high reliability (Chronbach Alpha = 0.915). As a result, these scales were analyzed independently using two two-way (gender of participant [male/female], and ethnicity of participant [White/Non-White]) repeated measures univariate analyses of variance (ANOVAs).

No significant results were found for the PDD measure of stigma (see Appendix G). The main effect for therapy type ( $F=3.805$ ,  $p=.052$ ), therapy x gender interaction ( $F=.020$ ,  $p=.886$ ), therapy x ethnicity ( $F=.414$ ,  $p=.514$ ) and three-way therapy x gender x ethnicity interaction ( $F=.037$ ,  $p=.848$ ) did not show any significant differences between groups. This indicates that people did not have different stigmatizing attitudes towards traditional therapy clients than cybertherapy clients, regardless of their gender or ethnicity.

Analyses for the SDS revealed no significant results for therapy type ( $F=.695$ ,  $p=4.05$ ), revealing that participants are not more likely to reject a person seeking traditional therapy services than cybertherapy services (see Appendix G). There was no significant two-way interaction between therapy type and ethnicity ( $F=.466$ ,  $p=.495$ ), and no significant three-way interaction between therapy type, ethnicity and gender ( $F=.958$ ,  $p=.328$ ). However, there was a significant two-way interaction for therapy type and gender ( $F=6.927$ ,  $p=.009$ ). A post-hoc ANOVA looking at only therapy type and gender revealed a strong interaction ( $F=6.346$ ,  $p=.012$ ). T-tests were run to further compare genders at each level of therapy type on the SDS. First, the t-tests examining only traditional therapy ( $F=.334$ ,  $p=.180$ ) and then cybertherapy ( $F=4.043$ ,  $p=.485$ ) on both genders were not significant. Second, the data was split to compare therapy type scores for only males, which showed a significant result ( $t=2.247$ ,  $p=.026$ ;  $d = 0.17$ ). Therefore, males showed significantly more rejection (mean=3.110) against traditional therapy clients than against cybertherapy clients (mean=3.030), based on the SDS.

The same analysis was run for the female data split, but no significant results were found ( $t=1.399$ ,  $p=0.164$ ).

## Chapter VI

### Discussion

Findings from this study help contribute to our understanding of this newly emerging therapy modality. Because there has been limited research done related to the stigma attached to cybertherapy, little is known about the attitudes, behaviors, and perceptions of online therapy. Therefore, knowing that the results indicate no difference in stigma between online therapy and traditional therapy provides valuable insight. It should be noted that the two measures of stigma are intended to examine two different aspects. Specifically, the Perceived Devaluation-Discrimination Measure (PDD) examines the participants estimation of how much society devalues the person described in the vignette, whereas the Social Distance Scale (SDS) measures how much the participant socially rejects the person described.

*Hypothesis 1.* Participants will rate the cybertherapy client as less likely to be stigmatized than the traditional therapy client.

Given that it has become very commonplace to seek solutions online to resolve daily concerns, participants were expected to perceive online therapy as a treatment for less severe concerns than traditional therapy. However, results from this study showed no significant difference in stigma between the described cybertherapy client and the traditional therapy client, as measured by the Perceived Devaluation-Discrimination Measure (PDD). It's unfortunate that the results from this study indicate that online therapy clients will have to face the same stigma that traditional therapy clients do today, given the incredible impact that stigma can have on both seeking therapy and mental health during treatment. Past research has shown that stigmatized individuals tend to seek therapy less and are less likely to stay in treatment (Corrigan, 2004). Some researchers have gone so far as to say that the stigma is even worse than the mental illness itself (Feldman & Crandall, 2007; Overton & Medina, 2008).

*Hypothesis 2.* Participants will indicate less rejection towards the cybertherapy client than the traditional therapy client. Results from this study also did not show any difference in the amount of social rejection associated with the therapy modalities presented, as measured by the Social Desirability Scale (SDS). Social rejection is one of the key components in stigma, as it tends to ostracize individuals in society that are deemed undesirable. Based on this study, cybertherapy clients are likely to face the same kind of rejection that is associated with the stigma present for traditional therapy today. As such, it further lends support to the idea that online therapy clients are likely to face the same kinds of stigma that traditional therapy clients do already.

*Hypothesis 3.* Participants from minority ethnic groups will indicate less rejection and stigma towards the clients described in both versions of the vignette than will Caucasian participants. Because past research showed that people from minority ethnic groups tended to show less stigmatizing attitudes towards those suffering from mental health issues (Corrigan et al., 2001), participants were expected to show a similar trend in this study. Analyses using an ANOVA showed no such difference among the different ethnic groups. Therefore, results suggest that all participants, regardless of ethnic background, had similar responses to the vignettes describing the two therapy modalities.

*Hypothesis 4.* Male participants will indicate more rejection and stigma towards clients described in both versions of the vignette than will female participants. The traditional male gender role tends to emphasize the importance of suppressing emotion and solving one's own problems (Steinfeldt et al., 2009; Topkaya, 2014; Vogel et al., 2014), which would indicate that males would tend to be more stigmatizing of someone seeking outside help for mental concerns. In this study, no differences for gender were found for devaluation (measured by the Perceived Devaluation Discrimination scale). There were, however, significant results for gender on the Social Distance Scale (SDS). Specifically, males were more likely to desire social distance from someone in traditional therapy than females, but



were less likely to desire this social distance with cybertherapy clients. Social distance and rejection are components of stigma, meaning that males did have more negative reactions to traditional therapy clients, as expected. It's possible that cybertherapy is perceived as a more private tool to deal with problems than traditional therapy, making it more acceptable to men. Thus, men would be less likely to reject someone for being unable to solve their problems on their own, because they were accessing an online tool (i.e. cybertherapy) to solve it.

It should be noted, however, that the differences found for the SDS are very minor (see Appendix G). Therefore, it may have limited real world importance, even though this result was statistically significant. Additionally, the means found for both traditional and cybertherapy were quite high when compared to previous research in which SDS means were between 1.94-2.22, oftentimes assessed using vignettes for much more severe mental problems than the ones described in this study (Dabby, Tranulis, & Krimayer, 2015; Phillips, 1963; Reavely et al., 2014). However, these studies also showed much higher Cronbach alpha's than the one found for this sample. As such, it's possible that the large variance in this sample skewed the results disproportionately.

*Limitations.* This study was designed as a within-subjects research for several reasons. First, it affords greater power with fewer participants. Secondly, it gave participants a chance to review both vignettes in succession, which highlighted the therapy modality clearly for participants. This allowed participants to judge their ratings specific to the modality described, without giving undue focus to the overall condition of the person described in the vignette. By drawing the participant's attention to the modality, however, participants presumably were quite likely to be able to see through the underlying intent of the study. As a result, participants may have artificially rated the person described in the vignette similarly, so as to seem unbiased about the therapy modality described. This could have had a large impact on the results of this study.

Finally, the Cronbach alpha for the Social Distance Scale (SDS) was surprisingly low for this study (0.59), even though previous studies have found strong internal consistency (alpha = 0.97) for this scale. This low consistency scale may indicate rushing responses by participants, even though past research shows that results obtained with Mechanical Turk's sample are just as reliable as studies run using local samples (Bates & Lanza, 2013; Mason & Suri, 2012; Paolacci, Chandler, & Ipeirotis, 2010).

*Future research.* Obviously, the current study does not provide conclusive evidence that cybertherapy clients are subject to exactly the same stigma that traditional therapy clients experience. Thus, future research on the stigma related to cybertherapy could collect data using similar materials, but changing the design to a between-subjects one to mitigate some of the limitations above. It would also be helpful to add a manipulation check asking participants where the person described was seeking therapy (online or in-person). This would ensure that participants were thoroughly and thoughtfully reading the vignettes and were responding to the questions with the intended scenario in mind. In retrospect, the omission of some sort of manipulation check likely represents one of the more serious flaws in the overall design of the study. It is also rather obvious saying that using a more diverse and reliable set of outcome instruments would help make the results more conclusive.

Another aspect of studying stigma is understanding how much the behavior of a person is influenced by the stigma they experience (or the stigma they fear). Thus, a qualitative study in which clients are interviewed in depth about their fears of being stigmatized could help us better understand why people might be apt to choose cybertherapy over traditional therapy primarily to avoid stigma.

Future research may also focus on efforts to reduce mental health stigma related to cybertherapy, given the rise of this new modality. Considering that only 6% of the participants in this study had ever tried online therapy, it is possible that many of the participants were unaware of the availability of online mental health services. Cybertherapy provides an important opportunity to re-

frame what it means to seek mental health services in general. Research could illuminate some of the gaps in knowledge that the general population has, and how online therapy could best be represented to increase the likelihood of acceptance in the general population.

Finally, it may also be beneficial to specifically examine how cybertherapy stigma differs from traditional therapy stigma. Stigma related to traditional therapy has been extensively covered in the literature, yielding an impressive amount of different measures and definitions. As such, this study was only scratching the surface in uncovering how cybertherapy stigma may differ from traditional therapy stigma. With the rapid emergence of new mental health services being offered online, it is important for our understanding of the impact of these services to expand at a similar pace.

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## Appendix A

### Vignettes for the two Experimental Conditions

(Vignette for Traditional Therapy)

*Instructions: Please read the vignette below and try to get a general “feel” for the person described.*

*You will then be asked to answer some questions about the person described.*

John is a 35-year-old man who lives in a midsized town in the Midwest. Up until a year ago, life was pretty okay for John. While nothing much is going wrong in John's life, he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people, and, although John sometimes argues with his family, John is getting along pretty well with his family. John is seeking help at a nearby counseling center for the symptoms described above.

---

(Vignette for Cybertherapy)

*Instructions: Please read the vignette below and try to get a general “feel” for the person described.*

*You will then be asked to answer some questions about the person described.*

John is a 35-year-old man who lives in a midsized town in the Midwest. Up until a year ago, life was pretty okay for John. While nothing much is going wrong in John's life, he sometimes feels worried, a little sad, or has trouble sleeping at night. John feels that at times things bother him more than they bother other people and when things go wrong, he sometimes gets nervous or annoyed. Otherwise John is getting along pretty well. He enjoys being with other people, and, although John sometimes argues with his family, John is getting along pretty well with his family. John is seeking help through online therapy for the symptoms described above.

**Appendix B**  
**Biographical Questionnaire**

1. What is your gender?

- Female                       Male                       Other

2. What is your age?

\_\_\_\_\_

3. What is your ethnicity/race?

- White/  
Caucasian                       Asian  
American                       African  
American                       Latino(a)/  
Hispanic                       Other

4. What's the highest degree have you earned?

- High School  
Diploma or  
equivalent                       2-year  
College Degree                       4-year  
College Degree                       Graduate  
Work

## Appendix C

### Perceived Devaluation-Discrimination Measure

(Participants just saw “Questionnaire” as the title of this measure)

1. Most people would willingly accept John as a close friend.

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

2. Most people believe that John is just as intelligent as the average person.

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

3. Most people believe that John is just as trustworthy as the average citizen.

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

4. Most people would accept John as a teacher of young children in a public school.

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

5. Most people feel that John shows signs of personal failure. (R)

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

6. Most people would not hire John to take care of their children, even if he had felt better for some time. (R)

1                      2                      3                      4                      5                      6

Strongly Agree

Strongly Disagree

7. Most people think less of John, because he is in therapy. (R)

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

8. Most employers will hire John if he is qualified for the job.

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

9. Most employers will pass over John's application in favor of another applicant. (R)

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

10. Most people in my community would treat John just as they would treat anyone.

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

11. Most young women would be reluctant to date John. (R)

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

12. Once they know John, most people will take his opinions less seriously (R)

1                  2                  3                  4                  5                  6

Strongly Agree

Strongly Disagree

## Appendix D

### Social Distance Scale

(Title which participants saw was “Questionnaire Continued”)

1. Would you discourage your children from marrying someone like this?

1                      2                      3                      4                      5

Strongly Agree

Strongly Disagree

2. If you had a room to rent in your home, would you be willing to rent it to someone like this?

1                      2                      3                      4                      5

Strongly Agree

Strongly Disagree

3. Would you be willing to work on a job with someone like this?

1                      2                      3                      4                      5

Strongly Agree

Strongly Disagree

4. Would you be willing to have someone like this join a favorite club or organization of yours?

1                      2                      3                      4                      5

Strongly Agree

Strongly Disagree

5. Would you object to having a person like this as a neighbor?

1                      2                      3                      4                      5

Strongly Agree

Strongly Disagree

## Appendix E Additional Questions

1. How much do you use the internet per week?
2. Have you been in therapy, either in person or online? Check all that apply.
  - In Person
  - Online

3. Please rate the problem described in the vignette in terms of severity:

1                      2                      3                      4                      5                      6

Very Mild

Very Severe

4. Comments or reactions related to this study:

## Appendix F

### Information Letter

Department of Special Education, Rehabilitation, and Counseling  
(NOTE: DO NOT SIGN THIS DOCUMENT UNLESS THE IRB APPROVAL  
INFORMATION HAS BEEN APPLIED TO THIS DOCUMENT.)

INFORMATION LETTER  
for a Research Study entitled  
"Seeking Psychotherapy"

**You are invited to participate in a research study** called "Seeking Psychotherapy". The study is being conducted by Natalie Reiner, doctoral candidate, under the direction of Dr. Randolph Pipes, professor, in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You were selected as a possible participant because you are age 19 or older.

**What will be involved if you participate?** If you decide to participate in this research study, you will be asked to provide some basic demographic information. You will then read two versions of a vignette and answer questions about each version. The intent of the study is to examine the factors involved in seeking psychotherapy services. Your total time commitment will be approximately thirty minutes.

**Are there any risks or discomforts?** There are no risks.

**Are there any benefits to yourself or others?** There are no benefits to you (but see "compensation" below).

**Will you receive compensation for participating?** To thank you for your time you will be offered \$0.70.

**Are there any costs?** There are no costs associated with participation in this study.

**If you change your mind about participating,** you can withdraw at any time during the study by closing your browser window. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Once you've submitted anonymous data, it cannot be withdrawn since it will be unidentifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with

Auburn University, the Department of Special Education, Rehabilitation, and Counseling, or the investigator.

**Your privacy will be protected.** Any data obtained in connection with this study will be anonymous and hence cannot be connected to you. Information obtained through your participation may be used to fulfill an educational requirement and may be published in a professional journal or presented at a professional meeting.

**If you have questions about this study,** contact Natalie Reiner at nzs0010@tigermail.auburn.edu.

**If you have questions about your rights as a research participant,** you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334) 844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW. YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

   
Investigator Date

The Auburn University Institutional Review Board has approved this document for use from 4/19/15 to 4/18/16. Protocol #15-171 EP 1504.

*Link to survey:*

[https://auburn.qualtrics.com/SE/?SID=SV\\_6s7vqquM1xYyKEt](https://auburn.qualtrics.com/SE/?SID=SV_6s7vqquM1xYyKEt)



## Appendix G

### Results Tables

Table 1

*Demographic Summary*

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Variables	Frequency	%
<b>Gender</b>		
Male	165	57
Female	123	43
<b>Age</b>		
19-35	198	69
36-71	91	31
<b>Ethnicity</b>		
Caucasian	210	73
Non-Caucasian	79	27
<b>Education</b>		
High School	87	30
Two-year College	51	18
Four-Year College	126	44
Some Graduate	24	8
<b>Previous Therapy</b>		
In-Person	126	43
Online	18	6

---

Table 2

*Descriptive Statistics and Reliability Information*

Dependent Variable	No. of Items	Mean	SD	Cronbach Alpha	Sample Item
Social Distance Scale	5	3.09	.60	0.59	“Would you be willing to work on a job with someone like this?”
Perceived Devaluation-Discrimination	12	2.56	.77	.915	“Most people would willingly accept John as a close friend.”

Table 3

*Descriptive Statistics by Condition*

Dependent Variable	Mean	SD
Social Distance Scale – Traditional Therapy	3.11	0.58
Social Distance Scale – Cybertherapy	3.07	0.61
Perceived Devaluation-Discrimination – Traditional Therapy	2.58	0.75
Perceived Devaluation-Discrimination - Cybertherapy	2.53	0.78

Table 4

*Social Distance Scale (SDS)*

Variables	<i>MS</i>	df	F	p	Effect Size
<b>Within-Subjects Effects</b>					
Therapy Type	.063	1	.696	.405	.002
Therapy Type *	.042	1	.466	.495	.002
Ethnicity					
Therapy Type *	.622	1	6.927	.009*	.024
Gender					
Therapy Type *	.090	1	.958	.328	.003
Ethnicity *					
Gender					
Error	.090	284			
<b>Between-Subjects Effects</b>					
Ethnicity	.049	1	.106	.745	.000
Gender	.060	1	.130	.719	.000
Ethnicity *	.003	1	.006	.938	.000
Gender					
Error	.460	284			

\*  $p < .05$ .

Table 5

*Social Distance Scale (SDS) – gender split*

Variables	<i>MS</i>	df	F	p	Effect Size
Therapy Type	.038	1	.423	.516	.000
Therapy Type *	.570	1	6.346	.012*	.022
Gender					
Error	.090	286			

\*  $p < .05$ .

Table 6

*Perceived Devaluation-Discrimination (PDD)*

Variables	<i>MS</i>	df	F	p	Effect Size
<b>Within-Subjects Effects</b>					
Therapy Type	.262	1	3.805	.052	.013
Therapy Type * Ethnicity	.029	1	.414	.521	.001
Therapy Type * Gender	.001	1	.020	.886	.000
Therapy Type * Ethnicity * Gender	.003	1	.037	.848	.000
Error	.069	284			
<b>Between-Subjects Effects</b>					
Ethnicity	1.49	1	1.37	.242	.005
Gender	0.35	1	.032	.859	.000
Ethnicity * Gender	.049	1	.045	.831	.000
Error	1.089	284			