"This Is What's Going to Happen Next": Using Procedural Information to Increase Help-Seeking Behaviours and The Effect of Expectancy Violations

BSc. Thesis

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Contents

Abstract

Background. Lack of treatment constitutes a main driving factor in the increasing prevalence and costs of mental health conditions. Help-seeking barriers often prevent individuals suffering from mental health conditions from accessing the treatment they need. Lack of mental health literacy and lack of rapport between professional and client constitute major barriers, as they affect both treatment initiation and continuation.

Objective. The current study investigated the effect of procedural information on help-seeking behaviours and the influence of expectancy violations on this effect. It was hypothesized that providing clients with procedural information will increase rapport as well as the likelihood that they initiate treatment. Further, it was hypothesized that increased rapport will lead to increased treatment continuation. At last, it was expected that expectancy violations regarding the information will limit its effects.

Method. Using a between-subjects design, 99 participants were randomly allocated to one of three groups. The control group received irrelevant information. The other two groups received procedural information. Subsequently, participants took part in online intake interviews. In the control group and in one group that received procedural information, the healthcare professional acted in accordance with the information, while in the third group they did not act in accordance with the information. After the session, rapport, treatment initiation and treatment continuation were assessed.

Results. The findings of this study do not indicate any direct effect of providing clients with information, as well as violating expectations they may hold on treatment initiation, treatment continuation and rapport. It was found, however, that greater rapport is associated with increased help-seeking behaviour in clients.

Conclusion. Currently, it cannot be assumed that the provision of procedural information is an effective method for increasing help-seeking behaviours of individuals suffering from mental health conditions. Instead, healthcare professionals should aim for establishing rapport with their clients as much and as quickly as possible.

Introduction

The World Health Organisation (2004, p. 11) defines mental health as: "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". For many people, this state of well-being is disrupted. In fact, the number of individuals with mental health conditions is increasing worldwide (World Health Organisation, n.d.). The latest report on the global, regional, and national burden of mental health conditions reports a worldwide increase of more than 48 % from 1990 to 2019 (GBD 2019 Mental Disorders Collaborators, 2022). With a total of over 970 million people, more than 12 % of the world's population suffered from a mental health disorder in 2019 (GBD 2019 Mental Disorders Collaborators, 2022; United Nations et al., 2019). The contemporary COVID-19 pandemic further increased the urgency of the problem. According to a new analysis by Santomauro et al. (2021), the global number of cases of mental disorders rose dramatically in 2020 with an additional 52.2 million cases of major depressive disorders (+27.6%) and 76.2 million cases of anxiety (+25.6%). As mental health conditions have substantial effects on all areas of life, "such as school or work performance, relationships with family and friends and one's ability to participate in the community", the subsequent individual cost is undeniable (World Health Organisation, n.d., para. 2). Beyond the individual, poor mental health costs the global economy an estimated US$ 3.5 trillion a year, a figure that is expected to increase to US$ 6 trillion by 2030 (MBZ Netherlands, n.d.).

Treatment and prevention are the most effective resources for alleviating the increasing cost of mental illnesses (Saxena et al., 2006; Schnyder et al., 2017). However, help-seeking for mental health conditions is often largely delayed or fails completely, as so-called help-seeking "barriers" prevent people from seeking treatment (Gulliver et al., 2010; Heinig et al., 2021; Leach, 2005; Schnyder et al., 2017; Verhaeghe & Bracke, 2011; Wang et al., 2007). A lack of sufficient knowledge about mental health conditions, and

failure to establish a positive relationship with the therapist, are considered major help-seeking barriers, as the prior prevents individuals from initiating treatment, while the latter prevents patients from continuing treatment.

Contemporary interventions, for decreasing help-seeking barriers, are relatively costly in both time and resources, creating the need for more effective alternatives (Xu et al., 2018). Providing people with information on the therapy procedure, expectedly, constitutes such an alternative (Rosenthal, 2018). By increasing their knowledge about mental health conditions and facilitating the relationship with the healthcare professional, people will be more inclined to initiate and continue treatment. However, this effect might be reduced, or even reversed, if the therapy does not go as clients expect it to (Burgoon & Miller, 1985; Campo et al., 2004). By generating empirical insights into this topic, clinical practice as well as research can be informed on the potential effectiveness of procedural information for facilitating treatment seeking in individuals with mental health conditions in the future. Exploring the relationship between procedural information, and help-seeking behaviour and investigating how it is impacted by expectancy violations, consequently, comprises essential groundwork in this endeavour.

In the following paragraphs, the two main help-seeking barriers "*lack of mental health literacy*", and "*lack of rapport*", are introduced in greater detail. Then, it will be explained how procedural information is expected to reduce these barriers. At last, the Expectancy Violation Theory is used to describe how the effect of procedural information could be mitigated if a therapy session does not go as the client expects it to go.

Help-Seeking Barriers

As established, lack of treatment is caused by so-called help-seeking "barriers" (Miranda et al., 2015; Naifeh et al., 2016). These barriers impact a person's help-seeking behaviour and, subsequently, their likelihood to initiate and continue treatment (Cornally & McCarthy, 2011; Miranda et al., 2015; Naifeh et al., 2016).

Lack of Mental Health Literacy. One major barrier to treatment initiation is a lack of mental health literacy (Gulliver et al., 2010; Heinig et al., 2021; Schnyder et al., 2017; Xu et al., 2018). Mental health literacy refers to the "knowledge and beliefs about mental disorders" and is central to a person's "ability to recognize specific disorders; [...] knowledge of [...] professional help available; and attitudes that promote recognition and appropriate help-seeking." (Jorm et al., 1997, p. 1). Individuals that lack mental health literacy might not know that they suffer from a specific condition, do not know where and how they can seek for help, and/or simply think that no one would be able to help them (Gulliver et al., 2010; Jorm et al., 1997). As a result of this, they are much less likely to seek help (Gulliver et al., 2010; Jorm et al., 1997). To reduce this barrier, individuals need to acquire knowledge about mental disorders and the respective help available to them.

Lack of Rapport. Beyond initiating treatment, effective help-seeking also requires the treatment to be continued. As treatment is a process, continuation is just as important as initiation for treatment success. A major predictor of treatment continuation is the establishment of rapport with the respective healthcare professional (Leach, 2005; Verhaeghe & Bracke, 2011). The American Psychological Association (n.d., para. 1) describes rapport as: "a warm, relaxed relationship of mutual understanding, acceptance, and sympathetic compatibility between or among individuals". The establishment of rapport is a significant goal in facilitating the treatment process (American Psychological Association, n.d.). However, clients frequently find it difficult to establish such a beneficial relationship with their therapist, as they experience the therapeutic process to be a "mystery" (Fisher & Oransky, 2008; Turns et al., 2019). For most clients, therapy is a foreign environment filled with misinformation, stigma and fear (Turns et al., 2019). This impedes rapport-building by making it hard for them to engage with the therapist (Turns et al., 2019). Failure to establish rapport between healthcare professional and client accounts for large parts of treatment drop-outs (Heinig et al., 2021). Moreover, individuals that do not have an established relationship with healthcare professionals are less likely to

accept and follow up on their treatment in the future (Gulliver et al., 2010; Wisdom et al., 2006; Zifkin et al., 2021). Thus, lack of rapport represents a major barrier to help-seeking occurrence and recurrence, which could be reduced by facilitating rapport building.

Procedural Information & Reducing Help-Seeking Barriers

Having identified the major barriers to help-seeking, it is essential to investigate how they might be overcome. The provision of procedural information might play an important role in achieving this. In this context, provision of procedural information means informing individuals about the processes involved in screening, diagnosing, and treating mental health conditions. Prior research shows providing procedural information to be beneficial in increasing help-seeking for specific treatment settings (Zhuzha, 2018). In the following paragraph, it will, therefore, be laid out how providing procedural information is expected to increase the likelihood of treatment initiation and continuation, by reducing the previously mentioned help-seeking barriers.

As established, the help-seeking barrier of mental health illiteracy can be reduced by providing knowledge about the topic. Through offering procedural information to an individual, they are able to obtain knowledge about the treatment options available to them. Furthermore, individuals can use procedural information to learn about how a typical treatment option usually manifests. For example, they can read about the different steps of a therapy session, in turn, overcome their knowledge gap with factual information about the treatment process. By increasing their mental health literacy, recipients of procedural information are, thus, expected to be more inclined to actively seek help via initiating treatment.

Further, procedural information can also be expected to increase the likelihood of a person continuing treatment by facilitating rapport-building. Previous work by Fisher and Oransky (2008) states that providing clients with information about the therapeutic process helps in demystifying the therapeutic process (Fisher & Oransky, 2008). More

specifically, when a person receives procedural information, they feel more informed about the therapeutic process. As misinformation, stigma, and fear are replaced with information and knowledge, the clients are less likely to perceive therapy as a mysterious, foreign environment (Turns et al., 2019). This then makes it easier for them to engage with, and establish rapport with, the therapist (Turns et al., 2019).

Moreover, Leach (2005) have found, that providing rationales for procedures is an important part of facilitating effective rapport building. By incorporating such rationale into procedural information, beneficial conditions for fostering the relationship between patient and professional could be established prior to the first interaction (Leach, 2005). Kick-starting the rapport building process in such a way seems to be especially advantageous when considering that it helps alleviate time constraints, which often limit rapport-building (Leach, 2005). Once rapport has been established, clients are then more likely to continue the previously initiated treatment (Gulliver et al., 2010; Wisdom et al., 2006; Zifkin et al., 2021).

Expectancy Violations

Providing procedural information evokes expectations about how treatment will take place. Although these expectations have the potential to effectively mitigate the aforementioned help-seeking barriers, it might not always be possible for real-life treatment to take place exactly as depicted in the provided information. Factors such as the nature of the problem, a therapist's preferences, and personalities frequently influence and re-shape the treatment process (Saxon & Barkham, 2012; Snippe et al., 2019; Wampold & Brown, 2005). Beyond this, practicalities such as time limitations also exert an impact on the therapeutic procedure (De Geest & Meganck, 2019). All of these factors have the potential to influence therapy to an extent where a person's expectation might not be met.

The Expectancy Violation Theory (EVT) by Burgoon and Hale (1988) refers to such an event as an *expectancy violation* (Burgoon & Hale, 1988). More specifically, the EVT

states that individuals have expectations about behaviours of others, and that violations of these expectations can be interpreted as positive or negative by the receiver (Burgoon & Hale, 1988). When a positive violation occurs (i.e., something is more favourable than expected), the message that created this expectation will be perceived more positively (Burgoon & Miller, 1985; Campo et al., 2004). When a negative violation occurs (i.e., something is less favourable than expected), the message that created this expectation is perceived either similarly or more negatively (Burgoon & Miller, 1985; Campo et al., 2004).

As individuals receive procedural information, they will expect the healthcare professional to behave in a specific way. If, for one of the various reasons (i.e., nature of the problem, therapist preferences, personalities, lack of time), the healthcare professional behaves differently from how the client expected them, a negative expectancy violation occurs. According to the EVT, such a negative violation would then either reverse the effect of procedural information on help-seeking, or decrease the likelihood of help-seeking to be lower than before providing information. This implies that procedural information might, inversely, have the potential to reduce help-seeking behaviour, if a healthcare professional acts differently than the information depicts. Investigating the influence of expectancy violations in this context will allow inferences on the impact that actions of health-care professionals have on the effect of procedural information.

Present Study

Synthesizing from the introduction, lack of treatment leads to an increasing burden of mental health conditions (Rehm & Shield, 2019). As lack of treatment is caused by help-seeking barriers, this research paper aims to investigate whether these can be overcome using procedural information. More specifically, it is expected that the provision of procedural information increases knowledge about conditions and available help, thus increasing the likelihood of treatment initiation. Furthermore, procedural information is expected to demystify the therapeutic process, as well as provide beneficial rationale for

the procedures, subsequently enhancing rapport-building between client and healthcare professional. Next, this increased rapport is expected to increase the likelihood of treatment continuation. Irrespective of the relationship, it is further expected that expectancy violations impact the effect of procedural information on rapport and treatment initiation. If an expectation acquired from receiving procedural information is violated, it is anticipated, that this negates the effect of procedural information.

The subsequent hypotheses of this study are, therefore, as follows:

H1: *When a client receives procedural information, they are more inclined to initiate psychological treatment than clients who do not receive procedural information.*

H2: *When a client receives procedural information, they are more inclined to continue treatment than clients who do not receive procedural information.*

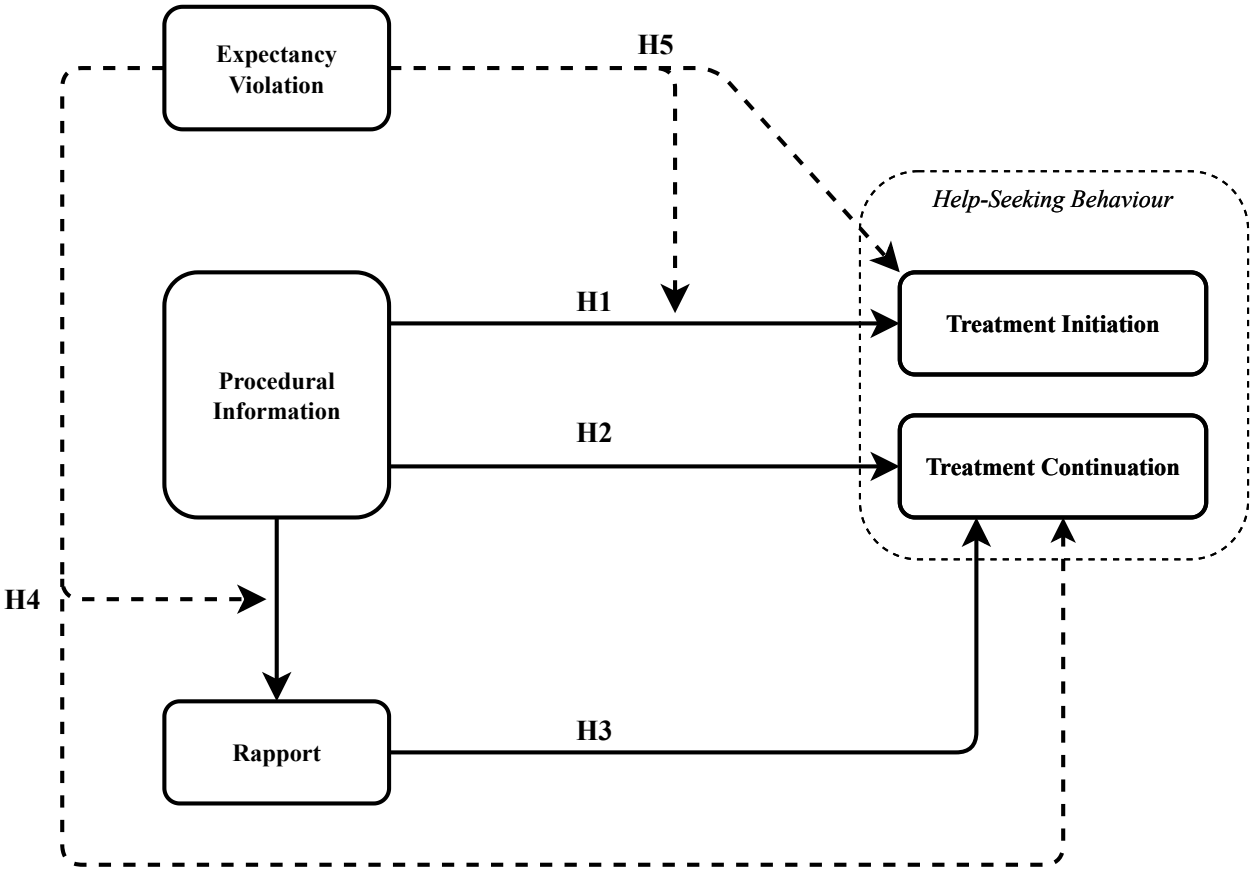
H3: *Rapport partially mediates the relationship between procedural information and treatment continuation.*

H4: *Expectancy violation moderates the relationship between procedural information and rapport, in that clients who experience expectancy violations are expected to have lower levels of rapport than clients who receive procedural information without expectancy violations.*

H5: *Expectancy violation moderates the relationship between procedural information and treatment initiation, in that clients who experience expectancy violations are expected to be less likely to initiate treatment than clients who receive procedural information without expectancy violations.*

Figure 1

Theoretical model of the present study.



Methods

Design

This study used a between-subjects design with procedural information, and expectancy violation as independent variables. The dependent variables were treatment initiation and treatment continuation, with rapport as a mediator. Participants were randomly allocated to one of three groups: *Control*, *Procedural Information (PI)*, or *Procedural Information & Expectancy Violation (PI&EV)*. As this research was a collaborative effort, additional dependent variables were explored beyond those relevant to this paper. These variables were trust, anxiety, and thoughts about psychotherapy.

Participants

The participants of this study were sampled by use of convenience, and snowball sampling methods. Further, the test subject pool of the Faculty of Behavioural Management Sciences (BMS) of the University of Twente was used to recruit participants. All participants gave their informed consent ahead of their participation. The BMS ethics committee of the University of Twente confirmed the research project's compliance with all ethical guidelines. In total, 110 people agreed to participate in the study. Of these, 4 had to be excluded as they prematurely ended their participation. Another 7 participants of the expectancy violations group were excluded from the analysis, as it was determined that they did not fully attend the study during the manipulation check. Subsequently, the sample consists of 99 participants, which were randomly distributed among the three groups. Of these, 34 (34.3%) participants were randomly assigned to the control group, 35 (35.4%) participants to the procedural information group, and 30 (30.3%) to the expectancy violation group. The participants' ages ranged from 19 to 58 (M=24.5, SD=7.1). Out of the 99 participants, 42 identified as male (42.4%), 53 (53.5%) identified as female, and 4 (4%) identified as non-binary/third gender. In terms of nationalities, 49 (49.5%) were German, 39 (39.4%) Dutch, and 11 (11.1%) of other nationalities. Most participants were students (n = 76, 76.8%) followed by working (n = 21, 21.2%). Another 2 (2%) participants had other occupations. When asked whether they had any prior experience with mental healthcare professionals, 54 (54.5%) participants said yes, 44 (44.4%) reported that they did not and 1 (1%) participant preferred not to answer.

Procedure

Before the Study. A flow chart of the procedure can be found in Appendix A1. Prior to signing up, participants were told that the study aims to investigate the difference between initial contact with one or two general practitioners. Although this was not the actual aim of the study, it was chosen to deceive participants, as they might otherwise be

biased in their interaction with the GP and subsequent survey answers. Upon signing up, participants were randomly allocated to one of three groups: *Control*, *Procedural Information (PI)*, and *Procedural Information & Expectancy Violation (PI&EV)*. These groups will be explained more thoroughly in the following paragraphs. Participants were sent an email containing a digital informed consent form, alongside with information and instructions regarding the study, 48 hours in advance of the treatment session. Next to the informed consent, all participants received a scenario that prepared them for a 5-minute treatment session and assures similarity, and subsequent comparability, between every participant (Appendix C). In this scenario, participants received elaborate information on problems they face, their emotional well-being, and the context of the session with their general practitioner (GP). As part of this, they were told that they lost their appetite, leading to an unintentional loss of 6 kg. Depending on their group, participants also received additional information. Individuals of the PI, and PI&EV groups received a leaflet containing information on the procedure of a typical appointment with a GP (Appendix C). Participants were told about the common steps of an intake session and what they could expect from it. Most importantly, they were informed that the GP will ask them about any unintentional changes to their body, such as weight loss. Further, they were also informed that in the case of weight loss without dieting, the GP will refer them to a psychologist and schedule a blood test. This information served as the procedural information manipulation, and was subsequently violated in the treatment of the PI&EV group to allow for the expectancy violation manipulation. Individuals of the control group did not receive any information. At last, participants of all groups received a link to the Qualtrics questionnaire and a link to the Zoom conference used for the treatment. They were instructed to first enter the questionnaire at their scheduled time, and join the Zoom conference once prompted to in the questionnaire.

Treatment Session. At the time of their appointment, participants entered the Qualtrics questionnaire. Here, they were given the informed consent once more. After this,

participants received a recap of all the symptoms they were asked to imagine experiencing for their role. Further, participants of the PI, and PI&EV groups were shown the procedural information leaflet once more (Appendix C). The control group was shown a leaflet about the best 5 movies of all time (Appendix C). After receiving the leaflets, participants of all groups took part in the treatment. This treatment consisted of a simulated first session with a GP. One of the researchers played the role of the GP, and the participants that of the client. The researchers followed a pre-defined script which differed, depending on the participants' group.

For the control, and procedural information group, a script mimicking an intake session at a GP that is in-line with a standard intake session as described in the procedural information text was used (Appendix C). The researcher began by introducing themselves as the GP, and asked the client several questions regarding the background of their visit. As laid out in the procedural information leaflet, the GP then asked the client whether they have noticed any weight loss during the last month without dieting. If the client has already mentioned that they lost weight unintentionally, the GP simply prompted the client to elaborate. To wrap up, the GP thanked the client for sharing all of this with them. They summed up everything the client said and informed them that, to rule out any physical explanations for their weight loss, they will schedule a blood test. The GP also added that the client will receive a referral to a psychologist who can help them in an intake session. The GP then asked whether everything is clear and repeated that they will schedule a blood test and refer the client to a psychologist, and wished them a nice day.

For the PI&EV group, this script was designed to be out of line with the procedural information that this group received earlier (Appendix C). While the script is mostly identical to that of the other groups, participants in the PI&EV were not asked about their unintentional weight loss. Further, no blood test was scheduled, and they were only referred to a psychologist. These actions were not in line with the information provided in the procedural information, as this script served as the expectancy violation manipulation.

Questionnaires & Debriefing. Following the treatment, several measurements were made. First, participants were given the Mental Help Seeking Attitudes Scale (MHSAS) (Appendix B1). This scale was used to measure participants' attitudes towards help-seeking as an indication of treatment initiation. Additionally, they were also asked to fill out a separate questionnaire on their motivation to continue treatment beyond the first session, the newly constructed Motivation To Continue Treatment Scale (MTCTS) (Appendix B2). Further, participants were provided with the Rapport Scale for Investigative Interviews and Interrogations (RS3i) (Appendix B3) to measure their rapport with the GP (Duke et al., 2018). As part of the manipulation check, it was then measured whether the control group would have liked to receive procedural information, whether the PI and PI&EV group found the information leaflet useful, and whether the expectancies of the PI&EV group were violated. Finally, after asking the participants to fill out a questionnaire on their demographics, they were fully debriefed about the study.

Measures

Mental Help Seeking Attitudes Scale (MHSAS). To better fit this study's scenario, the initial statement of the MHSAS (Appendix B1) was adjusted (Hammer et al., 2018). More specifically, "If I had a mental health concern, seeking help from a mental health professional would be.." was replaced with "Considering your current symptoms (e.g., inability to concentrate, weight loss, loneliness), seeking help from a psychologist would be..." (Hammer et al., 2018). Participants then rate their attitudes across 9 different items (e.g.: useless-useful, healing-hurting, important-unimportant, etc.) by use of a seven-point differential scale . We created a single mean score to describe their attitudes towards help-seeking in the mental health context . Higher scores indicate more positive attitudes towards mental help-seeking. The MHSAS was chosen for its valid and reliable measurements of help-seeking attitudes in prior research ($\alpha = .92$) (Hammer et al., 2018). In this study, the MHSAS also showed to be reliable ($\alpha = .89$) (Taber, 2018).

Motivation To Continue Treatment Scale (MTCTS). As research lacks an adequate scale, the *Motivation To Continue Treatment Scale (MTCTS)* (Appendix B2) was constructed for this study specifically. Made up of five response items, it uses a five-point Likert scale to measure participants' willingness to continue with future therapy sessions. Examples of items include "*Future therapy sessions would help me in dealing with my problems*", or "*Continuing therapy would do more harm than good*". To create a scale, we calculated the mean score of all items. A higher score indicates a greater motivation to continue treatment. In terms of psychometrics, the MTCTS has a fairly high reliability, with a Cronbach's alpha of $\alpha = .77$ (Taber, 2018).

Rapport Scales for Investigative Interviews and Interrogations (RS3i). The *Rapport Scales for Investigative Interviews and Interrogations (RS3i)* (Appendix B3) by Duke et al. (2018) was used as a foundation and adapted to fit the current study design (Duke et al., 2018). In order to match the scenario of this study, "*the interviewer*" was replaced with "*the GP*". Further, "*the interview*" was changed to "*the session with the GP*". Subsequently, the adapted RS3i used in this study employs a five-point Likert scale to assess the extent to which participants agree to 21 different items on their attitudes towards the GP (e.g., "*The GP respects my knowledge*", "*The GP was attentive to me*", "*I wanted to do a good job during the session with the GP*", etc.) (Duke et al., 2018). We created a scale by calculating the mean score of all items. Higher scores indicate greater rapport. The reliability of the RS3i in this study was shown to be strong ($\alpha = .92$) (Taber, 2018).

Demographics. For measuring the demographics of the participants, a questionnaire asking for their gender identification, age, and nationality as well as their prior therapy experience was employed.

Distribution. The study was conducted online by use of the survey tool *Qualtrics* for the survey and the video conferencing software *Zoom* for the treatment session, under the licence of the faculty of *Behavioural, Management and Social Sciences (BMS)* of the University of Twente.

Results

Scale Correlations and Reliabilities

Table 1 shows the means, standard deviations, reliabilities and inter-correlations between the study variables. All used scales have been found to be reliable. Regarding the correlations, it was expected that all scales correlate positively. Surprisingly, treatment initiation negatively correlates with both treatment continuation and rapport in this study.

Table 1

Mean, standard deviations, reliability, and inter-correlations among study variables.

Variables	*M*	*SD*	*a*	1	2	3
1. Treatment Initiation	5.62	0.83	.89	.18		
2. Treatment Continuation	3.88	0.66	.77	-.16	.49	
3. Rapport	3.79	0.58	.92	-.20*	.35*	.60

Note. $N = 99$, * $p<.05$.

Manipulation Check

Descriptive statistics were employed for performing the manipulation check. Table 2 shows how many participants of the PI and PI&EV groups expected to be referred for a blood test, as well as the frequency with which participants of the PI&EV group reported having been referred for a blood test. The findings shown in the first row indicate that the procedural information manipulation was more successful in the PI group than in the PI&EV group. The second row shows that most of the PI&EV group correctly recognized that the GP did not refer them for a blood test. Of the rest of the group, some either wrongfully stated the GP to have referred them for a blood test and some stated that they did not remember.

Based on this manipulation check, it was decided to exclude those individuals that either wrongfully thought they were referred for a blood test ($n = 3$) as well as those who

did not remember ($n = 4$) from further analyses of the PI&EV group as it could be reasonably assumed that they did not fully commit to the study and subsequently are not indicative of an expectancy violation effect. While it was also observed that only 45.9% ($n = 17$) participants of the PI&EV group expected to be referred for a blood test, it was not assessed whether they also had an expectancy towards being asked about their weight loss. Further, the possibility that they misunderstood the question and did not answer regarding their expectancy before the interview cannot be fully excluded either. Subsequently, it was decided to only exclude the aforementioned seven participants from further analyses.

Table 2

Group Information Attitude Frequencies.

Question	Condition	Response	Absolute Frequency	Relative Percent
Did you expect your GP to refer you for a blood test?	Procedural Information	Yes	24	68.6%
		No	11	31.4%
	Expectancy Violation	Yes	17	45.9%
		No	20	54.1%
Did your GP refer you for a blood test?	Expectancy Violation	Yes[a]	3	8.1%
		No	30	81.1%
		I do not remember[a]	4	10.8%

Note. [a]Excluded from further analyses.

Hypothesis Testing

Hypothesis 1. To test the first hypothesis that: "*When a client receives procedural information, they are more inclined to initiate psychological treatment than clients who do not receive procedural information*", an analysis of variance (ANOVA) with a planned comparison, or contrast analysis was used. Contrast analyses were chosen for these first two hypotheses as they allow for more accurate interpretations by also utilizing the information provided by the third group, in this case the PI&EV Group, which is not part of the actual analysis (van den Berg, 2018). The treatment initiation of the PI group

(i.e., MHSAS mean score), was contrasted with the treatment initiation of the control group, which did not receive any procedural information. To answer the hypothesis, relevant contrast estimates and 95% confidence intervals were examined.

Table 3 shows the mean scores and standard deviations for treatment initiation in both groups. The relationship between procedural information and treatment initiation was found to be not significant, with a contrast estimate of -0.02 ($SE = 0.2$) $F(1, 96) = 0.01$, $p = .928$. While the PI group scored slightly higher than the control group in treatment initiation, as expected, this difference between the groups was not found to be significant. Subsequently, the null-hypothesis, that there is no difference between the groups, cannot be rejected, and hypothesis 1 is rejected.

Hypothesis 2. To test the second hypothesis that: "*When a client receives procedural information, they are more inclined to continue psychological treatment than clients who do not receive procedural information*", again, an ANOVA with a contrast analysis was performed. Similarly, the PI group's motivation to continue treatment (i.e. MTCTS mean score), was contrasted with the motivation to continue treatment of the control group, that did not receive any procedural information. To answer the hypothesis, relevant contrast estimates and 95% confidence intervals were examined.

Table 3 presents the mean scores and standard deviations for treatment continuation in both groups. The relationship between procedural information and treatment continuation was also found to be not significant, with a contrast estimate of 0.13 ($SE = 0.16$) $F(1, 96) = 0.62$, $p = .432$. Surprisingly, the control group showed slightly higher scores in treatment continuation than the PI group. However, with no statistically significant difference between the groups, the null-hypothesis cannot be rejected and hypothesis 2 is, subsequently, rejected.

Table 3

Means and Standard Deviations for Scale Scores by Group.

	Condition					
	Control		Procedural Information		Expectancy Violation	
	(n = 34)		*(n = 35)*		*(n = 30)*	
Measurements	*M*	*SD*	*M*	*SD*	*M*	*SD*
Treatment Initiation[a]	5.69	0.61	5.71	1.18	5.73	0.54
Treatment Continuation[b]	4.01	0.51	3.88	0.82	3.74	0.61
Rapport[b]	3.92	0.47	3.80	0.68	3.63	0.55

Note. [a]Max Score = 7. [b]Max Score = 5

Hypothesis 3. To test the third hypothesis that: "*Rapport partially mediates the relationship between procedural information and treatment continuation*", a series of steps were undertaken. The analyses were conducted using model 4 of the PROCESS macro in SPSS, as it enables the estimation of the indirect effect size of procedural information on treatment continuation (Hayes, 2017). Bootstrapping was used in all analyses to account for the sample size. First, the effect size of procedural information on rapport was examined. The analyses were conducted using the categorical variable of procedural information as a predictor, and treatment continuation, as measured by the MTCTS, as the outcome while including rapport as a mediator.

The effect of procedural information on rapport was found to be not significant (B = -0.122, SE = 0.142, t = -0.858, p = .394, 95%CI [-0.405, 0.161]). Examining the effect of rapport on treatment continuation, a significant effect was found (B = 0.768, SE = 0.107, t = 7.175, p = <.001), 95%CI [0.554, 0.982]. The total effect of procedural information on treatment continuation was not significant (B = -0.126, SE = 0.165, t = -0.765, p = .447), 95%CI [-0.454, 0.202]. For answering the hypothesis, the indirect effect of procedural information on treatment continuation with its relevant parameter estimates and a 95%

confidence interval was observed. The indirect effect turned out to be not significant B = -0.093, SE = 0.111, 95%CI [-0.335, 0.103]. As no significant mediation effect was found, hypothesis 3 is rejected. Nevertheless, while this was not a hypothesis itself, the analysis confirms part of the hypothesis 3, in that a strongly significant positive relationship between rapport and treatment continuation was found.

Hypotheses 4 and 5. The fourth hypothesis that: "*Expectancy violation moderates the relationship between procedural information and rapport, in that clients who experience expectancy violations are expected to have lower levels of rapport than clients who receive procedural information without expectancy violations*", and the fifth hypothesis that: "*Expectancy violation moderates the relationship between procedural information and treatment initiation, in that clients who experience expectancy violations are expected to be less likely to initiate treatment than clients who receive procedural information without expectancy violations*", were both tested using similar analyses. More specifically, a one-way ANOVA was used, that tested whether there is a significant difference between at least two of the three groups in the population, regarding their average score in rapport and treatment initiation respectively. Relevant test statistics (F-value) and their p-values were examined. To get a more elaborate impression of the data in the sample, additional planned comparisons were performed that contrasted the average scores on rapport and treatment initiation of all three groups with each other. This way, it was estimated what size the differences between the groups had, and thus whether the findings were in line with the hypotheses.

For testing hypothesis 4, the condition was used as a categorical predictor variable and rapport as an outcome variable. The mean scores and standard deviations for both groups can be seen in Table 3. Here, no statistically significant group difference was found regarding their average scores in rapport, $F(2, 96) = 2.06$, $p = .133$. The contrast estimate was 0.17 ($SE = 0.14$). While the PI&EV group showed a lower mean score in rapport than the PI group, as hypothesized, this difference was not statistically significant and the

null-hypothesis, that there is no difference between the groups, cannot be rejected.

In testing hypothesis 5, the condition was used as a categorical predictor variable and treatment initiation as an outcome variable. Table 3 shows the mean scores and standard deviations of both groups. Similarly, for hypothesis 5, no statistically significant differences were found for the groups' scores in treatment initiation, $F(2, 96) = 0.02$, $p = .985$. With a contrast estimate of -0.02 ($SE = 0.2$), the PI&EV group had a higher mean score in treatment initiation than the PI group, which is not in line with hypothesis 5. As there are no statistically significant findings, the null-hypotheses can not be rejected. As a result, hypotheses 4 and 5 are rejected.

Exploratory Analyses

The effect of Rapport. While investigating hypothesis 3, a strongly significant correlation between rapport and treatment continuation warranted further exploratory analyses. That is, we were interested to see whether rapport also influences treatment initiation. Performing another simple regression analysis with rapport as the predictor and treatment initiation as the outcome, another strongly significant relationship between rapport and treatment initiation was found ($B = 0.431$, $SE = 0.13$, t = 3.315, $p = .001$). This confirms a previously not hypothesized correlation between rapport and treatment initiation in the study's findings. Subsequently, this exploratory analysis, alongside with that of hypothesis 3, indicate that irrespective of the condition, higher levels of rapport predict higher levels in both treatment initiation and continuation.

Hypothesis 4 and 5 in a Sub-Sample. In the analyses of hypotheses 4 and 5, no significant effect was found. To explore to which extent this might be explained by participants not having any expectations towards the procedure in the first place, the analysis steps will be conducted once more with only those 17 participants of the PI&EV group that expected to be referred for a blood test.

Conducting an ANOVA with planned comparisons while using the condition as a

categorical predictor variable and rapport as outcome, in the sub-sample of individuals that expected to be referred for a blood test, no statistically significant group difference was found $F(2, 83) = 1.21$, $p = .304$. The contrast estimate was found to be 0.14 ($SE = 0.17$), with the PI group ($M = 3.80$, $SD = 0.68$) having a higher mean score in rapport than the PI&EV group ($M = 3.66$, $SD = 0.51$). Although statistically insignificant, this is both in line with the hypothesis and the main analysis of the full sample.

Performing another ANOVA with planned comparisons using condition as the categorical predictor and treatment initiation as the outcome, in the sub-sample of participants expecting to be referred for a blood test, again, no statistically significant difference between the groups was found $F(2, 83) = 0.02$, $p = .98$. The contrast estimate is -.03 ($SE = 0.26$), as the PI&EV group ($M = 5.75$, $SD = 0.57$) had a higher mean score than the PI group ($M = 5.71$, $SD = 1.18$). While this is in line with the main analysis, it was expected for the PI&EV group to score lower than the PI group.

Perceived Usefulness & Expectations. In an attempt to investigate possible explanations as for why no statistically significant effect of expectancy violations could be found, it is useful to investigate the effect that the perceived usefulness of the procedural information might have on the expectations of participants. In this end, a generalized linear model with a logistic regression analysis, with the perceived usefulness of procedural information as the predictor, and their expectations to be referred for a blood test as the outcome was employed. A significant relationship between the two variables was found $\chi^2(1, N = 65) = 4.27$, $p = .039$. This finding implies that the more useful participants found the procedural information, the higher the likelihood that they expected to be referred for a blood test.

Attitudes Towards Procedural Information. To get a more elaborate image of how the participants of this study perceived procedural information, we inquired them about their attitudes towards it in more detail. First, the control group was asked whether they would have wished for more information about the GP appointment regarding mental

health. Interestingly, half of the control group would have wished for more information (n = 17), while the other half would not have wished for more information (n = 17). This indicates that a non-negligible part of this group reportedly would not have even desired any procedural information.

Furthermore, the PI and PI&EV groups, that did receive procedural information, were asked to rate how useful they found this information. On average, the PI group rated the information to be only somewhat useful (M = 3.37, SD = 0.77). The PI&EV group also perceived the leaflet to be only somewhat useful, although slightly less than the PI group (M = 3.16, SD = 0.80). Performing an ANOVA with condition as the categorical predictor and perceived usefulness as the outcome, this difference in perceived usefulness between the two groups was found to be not significant SE = 0.20, t = -1.18, p = .244, 95%CI [-0.642, 0.166])

Discussion

This study aimed at investigating the impact of procedural information and expectancy violations on treatment initiation and rapport, and the resulting willingness of patients to initiate and continue mental health treatment.

In this research, no statistically significant effect of procedural information or expectancy violations on treatment initiation or continuation was observed, and all hypothesized effects had to be rejected. However, this research was able to establish a strongly significant effect of rapport on treatment continuation as part of hypothesis 3, and another strongly significant effect of rapport on treatment initiation outside the hypothesized effects. In the following paragraphs, all findings and their implications are discussed, divided by the hypothesized effect.

The Effect of Procedural Information

Based on contemporary research, it was expected that participants who receive procedural information would be more likely to initiate and continue treatment, as they

would possess greater mental health literacy (Gulliver et al., 2010; Jorm et al., 1997). Further, it was expected that by replacing misinformation, stigma and fear with information and knowledge, the clients are less likely to perceive therapy as a mysterious, foreign environment (Turns et al., 2019). This, in combination with the benefit that providing rationale about treatment procedures through procedural information offers for rapport building, lead to the expectation that clients who receive procedural information also show greater levels of rapport (Leach, 2005). Surprisingly, no effect of procedural information on treatment initiation, continuation, and rapport was found in this study. There are several possible implications of these findings.

First, it might be the case, that procedural information is entirely ineffective in increasing treatment initiation, continuation, and rapport. This would mean that it is not possible for procedural information to affect help-seeking through increasing mental health literacy and rapport. Especially when considering that half of the control group did not wish for more information about the GP appointment regarding mental health, it could be imagined that clients simply would not like to receive information, then do not attend to, or believe it, and are, subsequently, unaffected by it.

However, the fact that half of the control group would not have wished for more information is not necessarily an implication that procedural information is ineffective as a whole. Current research postulates that individuals often spontaneously consume information (Karreman et al., 2005). Therefore, it would arguably be possible for procedural information to affect individuals that were not interested in receiving the information before, once they are confronted with it. This, combined with the indications of previous research on procedural information, make it more likely that the procedural information manipulation failed as a result of this study's design rather than an ineffectiveness of procedural information as a whole. Bray et al. (2022) state that, for procedural information to be effective, it needs to be perceived as engaging, meaningful, and trusting. The findings of this study seem to be in line with Bray et al. (2022). It was

found that those participants, who perceived the information to be less useful, also had a lower likelihood of forming expectations. Further, participants of this study, on average, found the procedural information they received only somewhat useful. Subsequently, this likely impeded the effect of the information on treatment initiation and rapport as well. Integrating all of these findings, it appears most likely that the procedural information had no effect, as it was not perceived to be useful by the clients. Suggestions on how the procedural information can be designed to appear more useful are elaborated on in the procedural information limitations below.

The Effect of Rapport

It was expected that rapport will positively affect treatment continuation (Gulliver et al., 2010; Wisdom et al., 2006; Zifkin et al., 2021). This expected effect of rapport on treatment continuation, as part of hypothesis 3, was both confirmed and complemented by the finding that rapport also predicted the treatment initiation of clients in this study. More specifically, it was found that the greater the rapport, the greater the likelihood that participants in this study intended to both initiate and continue psychological treatment. Given that the results of this research are fully in-line with previous research, rapport seems to offer a promising potential mechanism for future interventions aiming to increase help-seeking behaviour in individuals suffering from mental health conditions.

Nevertheless, although strongly statistically significant relationships were found, the exact nature of the relationship was not explored and more research is needed to fully understand it. To assume any causality, an experimental design would be required. Thus, future research should aim to investigate the effect of rapport on help-seeking in greater detail, while also investigating how rapport could be increased and whether this is possible using procedural information. With a greater understanding of its effects, increasing rapport might turn out to be a promising mechanism of future interventions that strive to promote help-seeking behaviours.

The Effect of Expectancy Violations

The EVT by (Burgoon & Hale, 1988) indicated, that when a healthcare professional acts differently than described in the procedural information, the effect of procedural information will be reduced or reversed. Contrary to the subsequent hypotheses, however, no effect of expectancy violations was found. This finding poses several possible implications. One possibility is that expectancy violations generally have no effect on the influence of procedural information.

However, as procedural information had no effect to begin with, it is more likely that this constituted an underlying factor in the missing effect of expectancy violations. In this study, it was found that a majority of participants of the PI&EV group did not form an expectation to be referred to a blood test, and that the likelihood that they did form an expectation increased with how useful they found the procedural information. As established, it was found that, for procedural information to be effective, it needs to be perceived as useful (Bray et al., 2022). Integrating these findings, it seems probable, that no effect of expectancy violations was observed because participants did not find the information useful, and thus did not form any expectations.

Nonetheless, the possibility that the violation would have failed irrespective of how useful the procedural information was perceived cannot be ruled out. It might, therefore, be the case that the chosen expectancy violation of this study specifically (i.e., not inquiring about weight loss and not referring the client for a blood test) was ineffective. The scenario depicted symptoms of depression, an illness that is often and easily recognized by lay people (Reavley & Jorm, 2011). Further, psychotherapy is a treatment most frequently recommended by lay people in cases of mental disorders, such as depression, while a blood test is not (Lauber et al., 2001). Thus, expecting to suffer from depression after reading the case vignette, participants could have already expected a referral for a psychologist to be appropriate and felt satisfied with it. As the GP's actions were in-line with what they expected, no expectancy violation occurred. Such an interpretation is also

in line with the exploratory finding that, even when participants reported expecting to be referred for a blood test, there was still no effect of expectancy violations.

To account for this, future studies may look into creating and violating expectations that do not compete with any potential pre-existent expectations and are thus more noticeable and easier to measure. For example, the procedural information may depict that someone with symptoms like that of the participant will be referred to further treatment options, while to violate the subsequent expectation, the GP would not perform such a referral.

Strengths, Limitations & Future Research

Looking back on this study, several strengths and limitations can be identified. In the following paragraphs, these will be laid out, alongside with recommendations for how future research can overcome these limitations to generate a deeper understanding of the topic.

Sample Limitations. The first limitation of this study was that the participants were not natively speaking English. As a result, it might have been more difficult for the participants to fully engage with the scenario and treatment session and answer the surveys. It could, for example, be imagined that participants find the information more useful if it is in their native language, as they would, arguably, have an inherently greater understanding of its content. Moreover, it was found that if the healthcare professional speaks to the client in their native language, rather than simply a language they share, treatment dropout is reduced and treatment outcome improved (Szoke et al., 2020). For these reasons, it seems likely that participants would have scored higher, in treatment initiation and continuation as well as rapport, if the study was carried out in their native languages.

Nevertheless, conducting the study in this way allowed for similarity and comparability between the participants, as all of them were not native speakers. As this influence of conducting the study in English evenly influenced the sample, it can be

accounted for. Further, the sample size was more than satisfactory and participants were equally distributed between Dutch and German as well as male and female, which is considered another strength of the study.

Future research, should aim to explore whether and how conducting the study in the participants' native language benefits the generation of statistically significant results.

Procedural Information Limitations. The second set of limitations relate to the procedural information used in this study. A great part of the participants did not form any expectations, which, as the results point out, most likely results from the fact that participants did not perceive the leaflet they received to be useful. What potentially adds to this is that the information leaflet was distributed digitally, which might be less intuitive for the client than a physical leaflet. While it was recognized that carrying out this research physically might have added to its realism, the contemporary COVID-19 pandemic as well as participant restraints did not allow for this. To compensate for this, the leaflets were designed to match what participants would expect from a traditional leaflet as closely as possible. At last, it was not assessed whether and to what extent participants engaged with the information. This could have an impact on the effectiveness of the procedural information and would have, therefore, offered useful information for informing future leaflet designs.

It would be insightful for future research to use the identified limitations as a base for their procedural information's design. More specifically, it needs to be investigated if procedural information can be made more useful to the client by using a physical leaflet and assessing the extent to which participants engage with the information. Engagement might best be measured by use of an electroencephalogram (Li, 2021). However, less resource consuming alternatives such as eye-tracking or observation may suffice (Li, 2021).

Treatment Session Limitations. Regarding the treatment sessions, the first limitation is that the treatment sessions were conducted online. Furthermore, the sessions took no more than five minutes. In an actual setting, patients would physically visit their

GP and likely talk to them for a longer duration (Pierse et al., 2019). Considering that time and communication are main factors in establishing relationships, these limitations might impede rapport building as clients lack the time and non-verbal cues needed to build a relationship with their GP (Leach, 2005). What adds to this, is that the participants did not actually suffer from a mental disorder and, thus, had to imagine a given scenario.

What should be noted, however, is that conducting the treatment session this way had several advantages. First, by conducting the study online and within a 5-minute timeframe as well as giving the participants a fixed scenario, it was made possible to sample more participants while also allowing comparability between them. Additionally, by performing the treatment session as a role-play, it was assured that no participant could be harmed through their participation. Further, the treatment session was integrated into an immersive story to maximize participant immersion. This way, these design choices can also be regarded as a strength, rather than a limitation.

For future research, it would be interesting to investigate the possibilities of conducting longer treatment sessions. A pilot study on the mean duration of GP sessions proposes a length in the realm of 14 minutes (Pierse et al., 2019). However, it is advised to stick to a fixed script. Further, when conducting a similar study design physically, rather than digitally, it would be insightful to investigate whether this aids in generating more significant results.

Conclusion

To explore how the ever-increasing prevalence and subsequent cost of mental health conditions may be reduced, this research looked into the effect of procedural information on help-seeking behaviours, as well as how this effect is influenced by expectancy violations (GBD 2019 Mental Disorders Collaborators, 2022). It was hypothesized that providing clients with information about the treatment procedure, increases their rapport with the healthcare professional, and their likelihood to initiate and continue treatment. Further, it

was hypothesized that these beneficial effects are reversed if the professional violates the clients' expectation by not acting in accordance with the procedural information.

The results of this study did not confirm these hypotheses. Nevertheless, rapport was found to be a promising predictor of help-seeking behaviour. These findings hold several academic and practical implications. First of all, it needs to be explored how procedural information can be designed in such a way that clients perceive it as useful and whether different expectancy violations may impact its effects. With rapport as an important predictor of help-seeking, researchers should further investigate whether and how rapport can be increased by use of procedural information. In this end, this study generated and validated several reliable scales to be used in measuring treatment initiation, continuation, and rapport in future studies. In terms of practical implications, this research has illustrated that providing clients with information about their treatment is a complicated process that may be influenced by all kinds of factors. Further, building rapport with the client is an important step in the treatment process that affects whether the client decides to initiate and continue their treatment.

To effectively combat the increasing prevalence of mental health conditions, it is essential for healthcare professionals to employ the most effective methods of increasing help-seeking behaviours. Currently, it cannot be assumed that the provision of procedural information is effective to this end. Instead, healthcare professionals should aim for establishing rapport with their clients as much and as quickly as possible.

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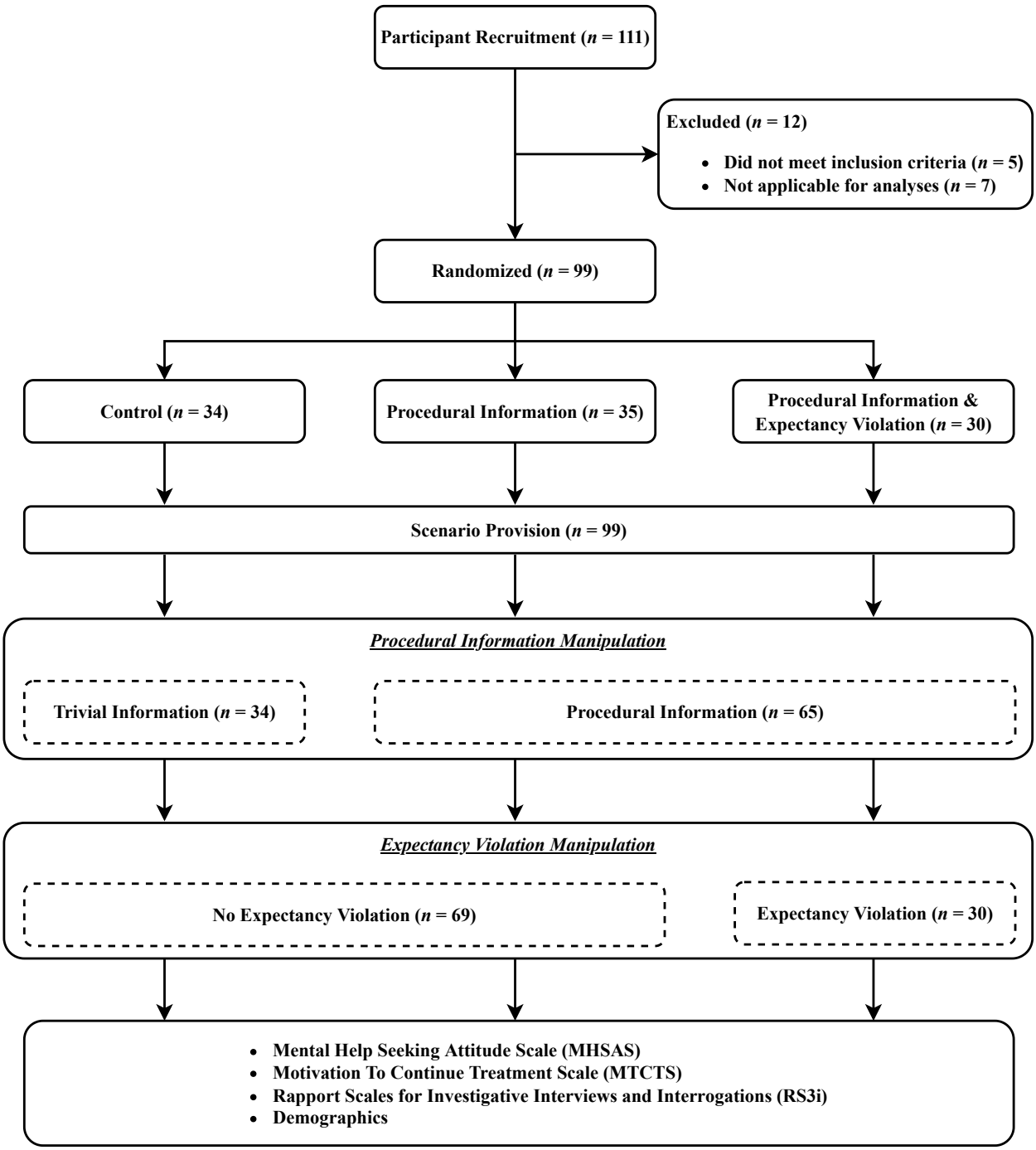
Appendix A

Figures

Figure A1

Flow Chart of the Procedure.



Appendix B

Measures

Table B1

Mental Help Seeking Attitudes Scale.

Considering your current symptoms (e.g., inability to concentrate, weight loss, loneliness), seeking help from a psychologist would be...								
	3	2	1	0	1	2	3	
Useless	○	○	○	○	○	○	○	Useful
Important	○	○	○	○	○	○	○	Unimportant
Unhealthy	○	○	○	○	○	○	○	Healthy
Ineffective	○	○	○	○	○	○	○	Effective
Good	○	○	○	○	○	○	○	Bad
Healing	○	○	○	○	○	○	○	Hurting
Disempowering	○	○	○	○	○	○	○	Empowering
Satisfying	○	○	○	○	○	○	○	Unsatisfying
Desirable	○	○	○	○	○	○	○	Undesirable

Table B2

Motivation To Continue Treatment Scale (MTCTS).

Motivation Questions	Response options				
	strongly agree	agree	neutral	disagree	strongly disagree
Q1. Future therapy sessions would help me in dealing with my problems.	○	○	○	○	○
Q2. I would look forward to future therapy sessions.	○	○	○	○	○
Q3. Continuing therapy would do more harm than good. (N)	○	○	○	○	○
Q4. I would not like to schedule any further therapy sessions. (N)	○	○	○	○	○
Q5. I intend to attend further therapy sessions.	○	○	○	○	○

Table B3

Rapport Scales for Investigative Interviews and Interrogations (RS3i)

Rapport Statements	Response options				
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Q1. I think the general practitioner is generally honest with me.	○	○	○	○	○
Q2. The general practitioner did his/her job with skill during the interview.	○	○	○	○	○
Q3. The general practitioner respects my knowledge.	○	○	○	○	○
Q4. The general practitioner and I have our culture in common.	○	○	○	○	○
Q5. The general practitioner performed expertly during the interview.	○	○	○	○	○
Q6. I think that the general practitioner can generally be trusted to keep his/her word.	○	○	○	○	○
Q7. The general practitioner and I probably share the same ethnicity.	○	○	○	○	○
Q8. The general practitioner really listened to what I had to say.	○	○	○	○	○
Q9. I was motivated to perform well during the session with the general practitioner.	○	○	○	○	○
Q10. I feel I can trust the general practitioner to keep his/her word to me.	○	○	○	○	○
Q11. The general practitioner made an effort to do a good job.	○	○	○	○	○
Q12. The general practitioner acted like a professional.	○	○	○	○	○
Q13. The general practitioner paid careful attention to my opinion.	○	○	○	○	○
Q14. The general practitioner and I got along well during the interview.	○	○	○	○	○
Q15. The general practitioner and I worked well together as a team.	○	○	○	○	○
Q16. The general practitioenr probably shares my culture.	○	○	○	○	○
Q17. I wanted to do a good job during the session with the general practitioner.	○	○	○	○	○
Q18. The general practitioner was attentive to me.	○	○	○	○	○
Q19. Communication went smoothly between the general practitioner and me.	○	○	○	○	○
Q20. The general practitioner was interested in my point of view.	○	○	○	○	○
Q21. I felt committed to accomplishing the goals of the session with the general practitioner.	○	○	○	○	○

Appendix C

Additional Materials

Treatment Scenario

Please imagine the following scenario: For a few months now, you feel like you do not have your life in order. Specifically, you feel like you are having **too many tasks to do**. At the same time, you have high expectations to complete all your tasks perfectly. You start to feel overwhelmed and cannot get yourself to start or complete the tasks ahead of you. You have already missed some important deadlines, at home, the dishes start piling up, and you cannot get yourself to do the laundry. You realise that your mental health has worsened extremely during the last month. You feel like every day is a burden and that there is nothing you can do about it. You are becoming more and more **stressed**. The stress is tearing you down and most of the day you feel extremely sad and exhausted. This has also affected your appetite. You realise that you **lost your appetite**, do not feel any desire to eat and leave out meals. This **unintentional** dieting also **reduced your weight** by 6 kg over the past month. You **don't seem to be able to concentrate** on the tasks you are carrying out anymore. Consequently, your performance has decreased dramatically. Even though you were generally sociable before, you started to **cancel meetings** with friends and stopped enjoying doing any sports.Things that brought you joy before, you don't seem to care about anymore. However, this increased time at home makes you feel even more **lonely**.You experience **mood swings** and can get frustrated over minor things.Your mood and worries also impact you during the night. You keep ruminating about all the activities you did not do, and expectations towards work you have yourself or feel like there will never be an opportunity to get better or to start enjoying life again. Hence, you have **trouble falling asleep**, needing more than an hour every night, even though you feel mentally and physically exhausted.During the night you only sleep 4-5 hours. These factors are making feel very fatigued throughout the day, to the point that your muscles ache.

You realised that you need help in dealing with your problems as you are unable to increase your circumstances yourself. Your friend urges you to make an appointment with a general practitioner, so you decide to **schedule a first appointment** with a general practitioner to find out how to proceed and get better.

Your symptoms

- Stress
- Loss of appetite
- Weight loss (unintentional)
- Lack of sleep
- Mood swings
- Inability to concentrate
- Loneliness

Procedural Information Leaflet

Do you need to see a GP?

Some of the most frequently experienced symptoms of poor mental wellbeing include:

- Loss of appetite.
- Feeling low or constantly anxious or worrying.
- Thinking negative thoughts about yourself.
- Irritability or moodiness.
- Finding it harder than usual to concentrate.
- Not enjoying life as much as you once did.
- Finding day-to-day life difficult (not feeling up to washing or eating, for example).
- Trouble sleeping or sleeping too much.

How to prepare for an appointment

Before the appointment it might be helpful to think about what you'd like to talk about to make sure that you don't forget anything. Take a few minutes before the appointment to maybe write up a list of things you might want to bring up:

- Think about any symptoms of how you're feeling and how your mood might be affecting your day-to-day life.
- Think about key personal information, including upsetting events in your past and any current major stressful events.

During your appointment

A typical GP appointment is around five minutes long, which many GPs and patients feel is not enough time to communicate everything they need.

During your appointment it is important to be as open and honest with the GP as possible.

They will **ask you questions** to gauge a full picture of your health, so be sure to share all the details about how you're **feeling** or how the **symptoms** are affecting you. Additionally, they will ask you **about any changes to your body** that happened **unintentionally** (such as **weight loss**).

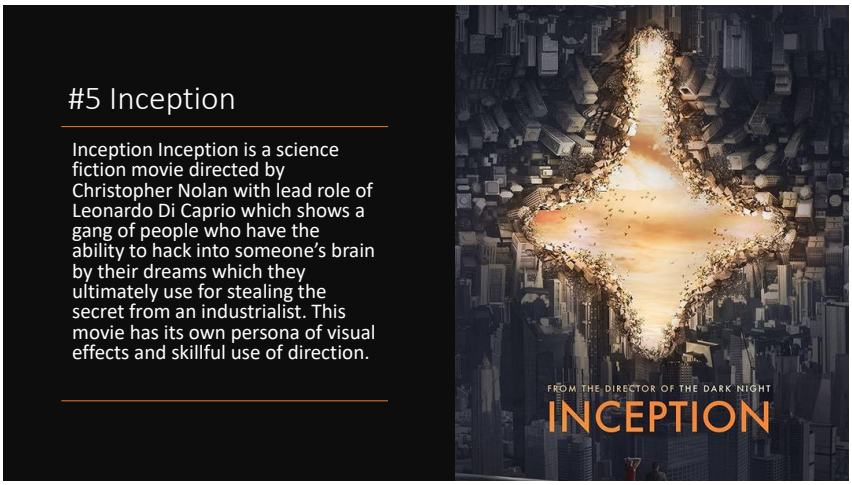
During your appointment

- Opening up about your feelings can be challenging, particularly to someone you don't know. However, GPs are trained to deal with sensitive issues in a professional and supportive way, so there is no need to be embarrassed. Everything you tell them is legally confidential, unless they are worried that you may be a danger to yourself or others.

<u>At the end of the appointment</u>:

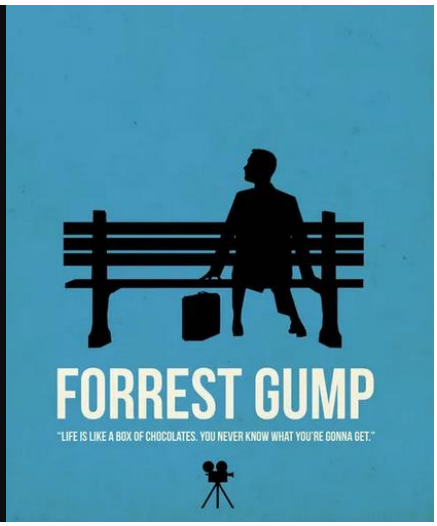
- **In the case of weight loss without dieting:** to determine that no illness is causing your symptoms, your GP will refer you for a **blood test.** He will **additionally** refer you to a **psychologist.**

Control Group Leaflet



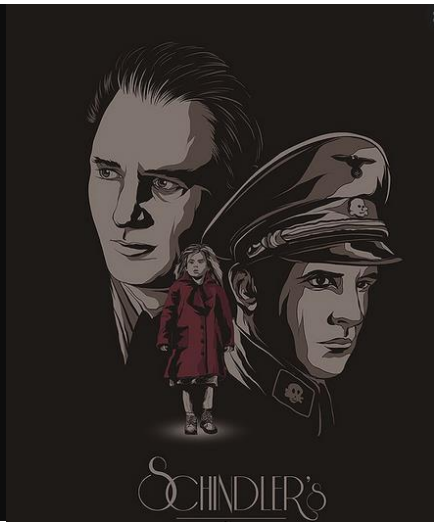
#4 Forrest Gump

Forrest Gump depicts a story of an American Army officer called Forrest Gump. This whole movie covers all the aspects of his life with a roller coaster ride of emotions. The best part of the movie is the central character which is played by Tom Hanks.



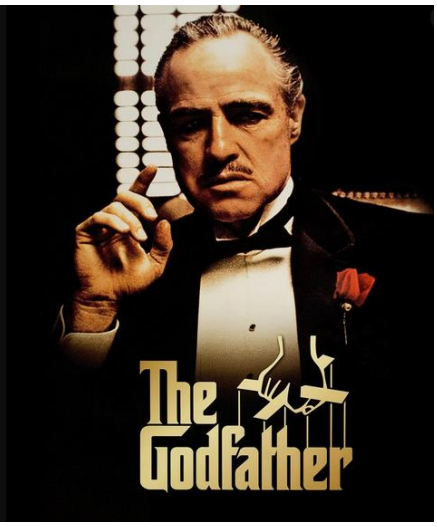
#3 Schindler's List

Schindler's List is a war time movie directed by Steven Spielberg. This movie shows the story of Poland which was occupied by the Germany during World War-2. Mr. Schindler a German Army officer is the central character of the movies who becomes very concerned about the Jewish people living in Poland. This movie will surely touch your emotional part with its ending.



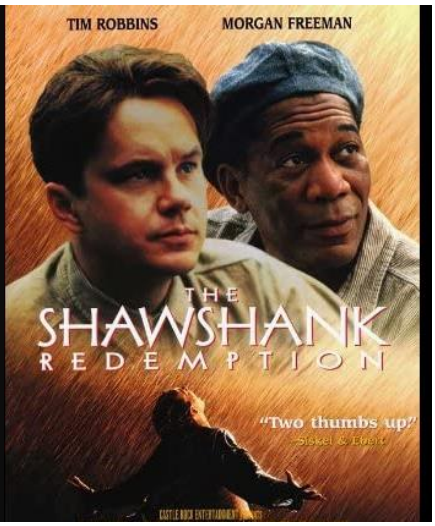
#2 Godfather

Godfather is one of the best movies of all time. This movie is based upon the story of an American mafia family whose head is Don Vito Corleone who decided to hand over his throne to his youngest son Michael. This movie shows a very efficient narrative of the mafia gangs of America with its equally effective story line up.



#1 Shawshank Redemption

Shawshank Redemption is the best movie of all time. It is a suspense thriller directed by Frank Darabont. This movie is based on the character of Andy Dufresne, a successful banker who got arrested for the murder of his wife and the story revolves around his life in the prison called Shawshank. This movie has a unique ability to mesmerize the audience in its flow.



Treatment Script - No Expectancy Violation

- Hello, I am Alex, your general practitioner. What can I help you with?
- How have you been feeling lately?
- What are your symptoms?
- For how long have you been noticing your symptoms?
- Have you unintentionally lost weight during the last month? (Or if they already mentioned it: So you have lost weight unintentionally during the last month?)
- Okay. Could you describe your symptoms in more detail to me? How are your symptoms impacting on your life?
- Okay, thank you for sharing this with me. I see that you have severe struggles with managing your life and that it impacts your mental health. As you said that you lost weight unintentionally, I would like to schedule a blood test to rule out any physical explanations for your weight loss. I will also refer you to a psychologist. They will diagnose you during the intake interview and if needed, you can get treatment there.
- Is that clear? Do you still want to mention anything you haven't said before?
- Okay, then I would say, we schedule a blood test and I will refer you to a psychologist, and then I wish you a nice day!

Treatment Script - Expectancy Violation

- Hello, I am Alex, your general practitioner. What can I help you with?
- How have you been feeling lately?
- What are your symptoms?
- For how long have you been noticing your symptoms?
- Okay. Could you describe your symptoms in more detail to me? How are your symptoms impacting on your life?
- Okay, thank you for sharing this with me. I see that you have severe struggles with managing your life and that it impacts your mental health. *(Only if they mentioned weightloss by themselves: As you said that you lost weight unintentionally,)*I will refer you to a psychologist. They will diagnose you during the intake interview and if needed, you can get treatment there.
- Is that clear? Do you still want to mention anything you haven't said before?
- Okay, then I would say, we schedule a blood test and I will refer you to a psychologist, and then I wish you a nice day!