

**Examining the Effectiveness of Providing Procedural Information and the Influence of
Expectancy Violations on Help-Seeking and Fear Towards Treatment**

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June 28, 2022

Abstract

Although people increasingly suffer from mental issues, many refrain from attending treatment in services due to lacking knowledge and motivation or fear. Using an experimental design, the current study examined whether providing procedural information about treatment and the first appointment with a general practitioner could cause positive changes in help-seeking and fear towards treatment; and whether the fear might explain the relationship between receiving procedural information and help-seeking. It also tried to assess whether experiencing a session wherein these expectations were not met negatively influences help-seeking and fear. People belonging to the general population ($N = 99$) were invited to engage in a mock interview with the GP. They did not know that they were divided into one control condition, one condition which received procedural information beforehand and one group in which the expectations triggered through the procedural information were violated during the interview. Compared to no information, receiving procedural information did not significantly affect help-seeking or fear towards treatment. Similarly, expectancy violations did not affect motivation to continue treatment or fear towards treatment significantly, when compared to expectancy confirmations. Fear levels also did not significantly explain the relationship between procedural information and motivation to continue treatment. This preliminary implies that in practice it is not effective to deliver information about treatment procedure to decrease fear towards treatment or increase treatment engagement. Yet, the study implies that future studies should investigate whether procedural information or expectancy violations influence help-seeking or fear towards treatment in a clinical sample.

Keywords: mental health, treatment initiation, motivation to continue treatment, fear towards treatment, procedural information, expectancy violations

Examining the Effectiveness of Providing Procedural Information and the Influence of Expectancy Violations on Help-seeking and Fear Towards Treatment

The occurrence of mental health issues increases constantly, rising by 13% between 2010 to 2017 alone (WHO, n.d.). The increase in occurrence was accelerated by the corona pandemic, which for instance also generally impacted on the mental health of 60% of the US population (Li et al., 2020; Single Care Team, 2022). Quarantining, bereavement or isolation are supposed to cause increases in loneliness, fears, anxieties and depression, to give some examples (Li et al., 2020; Kumar & Najar, 2021; Yao et al., 2020). The rising numbers are of concern as mental issues can impact society and the individual in all areas of life substantially, for instance including their social, physical, and work functioning (WHO, n.d.).

However, a “treatment gap” exists, namely a discrepancy between people suffering from mental issues and people accessing treatment services (Kohn et al., 2004, p.859). Eisenberg et al. (2011) found that across colleges merely 25% of students in need also accessed treatment. Furthermore, the majority of people who initiate a first appointment do not appear and 40% of clients terminate treatment early, according to therapists (Leong & Zachar, 1999; Swift & Greenberg, 2012). This is of special concern as many disorders can be successfully treated, whereas lack of treatment can cause worsening of current disorders, development of other mental disorders or suicide (Dell’Osso et al., 2013, as cited in Clement et al., 2015, p.11; Pompili et al., 2012).

The reasons for the underusage of mental health services are diverse. Common barriers towards help-seeking are accessibility, including costs and waiting lists, underestimation of symptoms, negative beliefs about mental health care services and stigma (Aguirre Valesco et al., 2020; Gulliver et al., 2010; Radez et al., 2020; Pepin et al., 2009). Stigma refers to either others’ or own internalised negative attitudes towards and from those seeking help, for instance being seen or perceiving oneself as weak, socially intolerable or “mentally impaired” (Nam et al., 2013, p. 43; Tuliao, 2021). Across literature, lack of knowledge and fear towards the treatment were repeatedly perceived as being major barriers as well (Eigenhuis et al, 2021; Gulliver et al., 2010, Pepin et al., 2009, Radez et al., 2020).

Concluding, taking the ongoing pandemic, rising incidence of mental issues and treatment gap together, the resulting negative consequences for society and the individual will similarly increase. Thus, it is important to increase service use by reducing help-seeking barriers, especially the most prevalent ones, as lack of knowledge and fear towards treatment.

In the following, first help-seeking barriers will be described, with special regards to lack of knowledge, uncertainty and fear towards treatment. Next, the impact of providing

procedural information and individuals' expectations on such barriers will be introduced in connection to these barriers. Lastly, the aim and current study outline will be given.

Help-Seeking and Help-Seeking Barriers

Help-seeking in the mental health context was defined as an “adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern” (Rickwood & Thomas, 2012, p. 180). A distinction is made between formal and informal help-seeking, which describes the support either obtained through mental health professionals or through family, friends and other lay people from one's social environment, respectively. As the current study tries to increase mental health service use, the term used throughout the paper refers to formal help-seeking. The inconsistency between the incidences of mental issues and help-seeking can be explained by factors, namely the “barriers”, which hinder individuals from seeking help.

Lack of Knowledge and Certainty

A barrier which was repeatedly revealed across literature as being one of the main predominant ones, is lack of knowledge and uncertainty about the service and treatment-provision (Eigenhuis et al., 2021; Gonzalez et al., 2005; Gulliver et al., 2010; Lambert, 2007; Radez et al., 2020). Literature outlines that people with and without mental health issues have little awareness of treatments, available services and missing or negative perceptions of how the services work (Dubow et al., 1990, as cited in Gonzalez et al., 2005, p. 624; Kantor et al., 2017; Seamark & Gabriel, 2018). Also, the limited knowledge people possess is often inaccurate, merely gained through prior experience, media, adoption of general opinions or interaction with others, for instance peers or teachers (Crisp et al, 2000; Wilson & Deane, 2001). The lack or inaccuracy of knowledge is concerning in two ways. Firstly, uncertainty and mistaken beliefs about therapy were not merely associated with negative attitudes towards, but also active avoidance of engagement with mental health professionals and the treatment (Hom et al., 2015; Kushner & Sher, 1991; Leite & Kuiper, 2008; Nock & Kazdin, 2001). Secondly, even more important, this lack of knowledge, misconception and ambiguity of treatment can cause negative or wrong expectations as well as fear towards psychotherapy and treatment, which both have been identified as major barrier towards help-seeking on their own (Kushner & Sher, 1991; Nock & Kazdin, 2001; Westra et al., 2010).

Fear Towards Treatment

This bridges to another predominant barrier, already mentioned above, the fear towards therapy and treatment. Fear towards treatment has been associated with avoidance and cessation of treatment across all age groups (Cepeda-Benito & Short, 1998; Pepin et al.,

2009; Wuthrich & Frei, 2015; Zartaloudi & Madianos, 2010). The fear towards treatment also appears to increase when motivation towards and in turn reality of using mental health services increases (Kushner & Sher, 1989). Generally, fear towards treatment was defined as “the subjective state of apprehension that arises from aversive expectations surrounding the seeking and consuming of mental health services” (Kushner & Sher, 1989, p. 251). In literature, individuals reported having general fear of how the perceived services may work, of treatment and of the professional (Gulliver et al., 2010; Seamark and Gabriel, 2018). The general fears also include more specific fears, such as fear of being hospitalised, stigmatised, exposed to feared or rigid treatment techniques or pressured to communicate about intimate issues by the health care professional (Kantor et al., 2015; Love & Morgan, 2021; Pepin et al., 2009; Wuthrich & Frei, 2015; Seamark and Gabriel, 2018). Hence, one can conclude that the fear towards treatment overall may affect both seeking and getting treatment due to the uncertainty about what will be experienced in treatment, thus the fear towards the service and procedure.

Procedural Information

Several authors suggested that interventions to increase help-seeking and reduce barriers as fear should reduce the uncertainty about formal help and provide an accurate description of where to seek and what can be expected, including the activities and strategies used in treatment sessions and “typical courses of care” (Hom et al., 2015, p.32; Radez et al., 2020; Vogel et al., 2007). The description could also counter help-seeking avoidance stemming from wrong beliefs (Hom et al., 2015). However, apart from the suggestions, current interventions and studies have to date merely focused on increasing help-literacy, thus knowledge about symptom severity and awareness, and about how to seek help, rather than on the knowledge about the services (Button et al., 2019; Xu et al., 2018). Thus, there is a gap in literature regarding the influence of providing procedural information (also referred to as PI) about the treatment.

Due to the likely relation between ambiguity, inaccurate expectations and fear towards treatment outlined above, one could suggest that providing information about treatment procedure might reduce the fear towards it that is prevalent in clients. The reduction in fears could, in turn, also positively influence for instance people with anxiety disorders, social anxiety or neurodiverse people seeking help. There is a gap in literature which assesses these suggestions, but support for effectiveness of providing PI to reduce fear can be found in a different context, the medical health domain. Bray et al. (2019) investigated that children unknowing of how the upcoming medical treatment will proceed reported higher fear levels,

and that providing pre-treatment information reduced patient's fear to engage in it, as well as induced more realistic expectations of the procedure. The influence of fear on help-seeking also in the mental health domain links to Cepeda-Benito and Short's (1998) examination that the disproval of the fears towards treatment can positively affect drop-out rates. Followingly, receiving information and having accurate expectations seems to be important, which raises the question how the individuals fear towards and further engagement in treatment might be affected if the experiences of treatment do not link to the expectations triggered through the provided information.

Expectations And Expectancy Violations

In literature, expectation violation theory (EVT) suggests that individuals have specific expectations about what will happen in interaction with others, based on social norms and individual characteristics (Burgoon, 2015). If the expectations remain unfulfilled, they are referred to as violated. The violations can be evaluated as positive or negative by the individual, depending on its desirability. Negative evaluations could be perceived as discomforting and threatening. The greater the differences between expectation and actual interaction, the larger the effect on the individual's behaviour and the interaction (Burgoon, 2015). Regarding the mental health context, "process expectations" (Westra et al., 2010, p.436), which consist of procedure and role expectations, influence an individual's decision whether and whom to consult for help, as well as their engagement once the decision to enter treatment has already been made (Demyan & Anderson, 2012; Nock & Kazdin, 2001; Seamark & Gabriel, 2018; Tinsley et al., 1984). Clients who have beliefs coinciding with the experienced delivery of therapy are more likely to continue it (Nock & Kazdin, 2001). Unmet expectations and expectation violations (further referred to as EV), namely inconsistencies between what the client expects and actually experiences in treatment, have detrimental effects for seeking help and are reasons for discontinuation of treatment (Zartaloudi & Madianos, 2010). Importantly, already the first interaction between help perceiver and service provider affects the willingness to continue treatment (Rickwood et al., 2007). Too much discrepancy between what the client expected and what occurred in treatment was the most prominent reason for terminating treatment already after the intake interview (Tinsley et al., 1988). Thus, the actual discourse and EV have an influence on perception of the treatment and could trigger ambiguity about the procedure or even lead to fear, negative expectations or hesitation about seeking future treatment (Knox et al., 2011; Westra et al., 2010). However, differences between what the client expects and how the professional behaves, as well as unexpected surprises commonly occur in therapy (Button et al., 2019).

Taking all together, the need to induce realistic procedural expectations becomes obvious. Wilson and Deane (2001) highlight the necessity for interventions to induce realistic expectations about which help is provided by different sources. However, current interventions and studies mostly focused on the effect of outcome rather than procedural expectations. Concludingly, it leaves open the question whether providing procedural information might increase realistic expectations and whether experiencing violations will decrease its impact or might be worse than being uncertain about the procedure before, especially in regards to fear towards and motivation to continue treatment.

The Current Study

Therefore, this study set-up aims to unravel the effect of PI and EVs on engagement in and fear towards treatment for mental health issues. In line with the above-mentioned literature, it was firstly hypothesized that providing procedural information will positively influence help-seeking. It is expected that procedural information will reduce the fear towards therapy and consequently that fear towards treatment mediates the impact of the information provision on help-seeking. Lastly, expectancy violations are hypothesized to moderate the effect of providing procedural information on fear and help-seeking, meaning that the help-seeking of individuals experiencing inconsistency between the actual procedure and before triggered expectations will be negatively influenced.

Hence, the exact hypotheses to be investigated in this study are:

H1a: Participants receiving procedural information will be more inclined to seek help compared to those who do not receive any procedural information.

H1b: Participants subjected to procedural information will be more motivated to continue therapy or treatment than participants who do not receive procedural information.

H2: Participants who received information about the procedure will on average display lower fear levels regarding treatment sessions, compared to those who do not receive such information.

H3: The effect of providing procedural information on help-seeking motivation will be partially explained by fear towards treatment.

H4: Expectancy violations moderate the effect of providing procedural information on motivation to continue treatment, with participants with violated expectations being less motivated to continue treatment than clients where expectations were not violated.

H5: Expectancy violations moderate the effect of providing procedural information on fear towards treatment, in that the effect will be weaker for participants with violated expectations than for participants whose expectations were not violated.

Methods

Design

To meet the objectives of this study, an experimental set-up with a between-subjects design was performed with three groups (Control, Procedural Information, Procedural Information including Expectancy Violations). The dependent variables investigated were motivation to initiate treatment, motivation to continue treatment and fear towards treatment. The subjects read a case vignette about a person suffering from mental health issues starting to seek treatment, then engaged in a simulation interview of the first session with a GP and lastly filled out questionnaires. As this study was part of a larger study, participants completed six questionnaires not relevant for this study's aims: the "Thoughts About Psychotherapy Scale (TAPS)" (Kushner & Sher, 1989), the adjusted "Dyadic Trust Scale" (Peschken & Johnson, 1997), "Rapport Scale for Investigative Interviews and Interrogations" (RS3i; Duke et al., 2018), 'Intolerance of Uncertainty Scale' (IUS; Afifi & Burgoon, 2000), "Specific Uncertainty Scale" (Freeston et al., 1994) and a Neurodiversity Scale.

Participants

In total, 111 participants from the general population were recruited via convenience sampling, advertisement via social media, word of mouth and snowball-sampling. Students of the University of Twente were additionally sampled via "Sona", a platform of the University where students can upload their own research and participate in others' research. Eligibility criteria required being at least 18 years old and possessing sufficient English and reading skills. The study was ethically approved by the BMS Ethics Committee of the University, participation was voluntary and informed consent was given upon the start of the study. Students recruited through Sona received credits for participating. For the others, no concrete incentives were provided.

Five people were excluded as they did not finish the study. Analyses of the manipulation check for the expectancy violation revealed that seven participants gave incorrect answers. The participants either forgot whether they had been referred for a blood test ($n = 4$) or reported having been referred for a blood test although they were not ($n = 3$). As the recognition of not having been referred is crucial for realising that one's expectations were violated (see procedure section for explanation), these participants were excluded. Analysis of the manipulation for the procedural information revealed that 28 people ($n = 11$, 31%, in the PI condition; $n = 17$, 57%, in the EV condition), did not expect the in the leaflet mentioned referral for a blood test, which might indicate inaccurate processing of the information. However, inaccurate question formulation might have led participants to answer

based on initial rather than on the through the PI leaflet triggered expectations. The check was also not exhaustive, excluding for instance checks for expectations about the in the leaflet mentioned question regarding weight loss. Hence, the leaflet might have still somewhat influenced participants' expectations and therefore the participants were included in data analysis. A subsample analysis excluding these cases was performed (see Appendix A). The results of all main analyses remained not significant. Yet, the number of participants per individual conditions, especially the EV condition, was much reduced ($n = 13$), wherefore drawing conclusions remains questionable.

After exclusion, the sample consisted of 99 participants ($M_{age} = 24.52$, $SD = 7.06$), of whom 42 were male, 53 female and 4 were non-binary. The majority came from Germany (50%) and the Netherlands (40%), the rest from other countries ($n = 11$). Most participants were students ($n = 76$; others worked, $n = 21$; or indicated other, $n = 2$). Slightly more people had no prior experience with mental health practitioners (55%), whereas almost half did have prior experience (44%; $n = 1$ preferred not to say).

The random allocation and the exclusion led to an uneven distribution of participants across the conditions: 34 people were assigned to the control condition, 35 people to the PI condition and 30 participants were left in the EV condition. There were no significant differences in gender, occupation, nationality, or previous experience between conditions (see Table B1, Appendix B). The demographics regarding occupation, nationality, and prior experience per condition are displayed in Table B2 (see Appendix B).

Materials

To conduct the study, a computer was needed with a functioning microphone and camera. The platform Zoom was used to conduct and record the audios of the interview. Qualtrics was utilised for data collection, by providing the consent, material, questionnaires and debriefing.

Questionnaires

Help-Seeking

Treatment Initiation

Two questionnaires were used to determine the first dependent variable help-seeking. The first one, the "Mental Health Seeking Attitudes Scale" (MHSAS, Hammer et al., 2018), consists of 9 items and provides an insight about an individual's attitude towards consulting a mental health practitioner if they would suffer from a mental issue (Giroux & Geiss, 2019; see Appendix C). Answers were given on a 7-point semantic differential scale, with opposing adjectives on either end. The instructions were adjusted by replacing "mental health

practitioner” with “psychologist”. Items were adjusted so that all unfavourable adjectives were at the same side of the scale, to prevent later reverse coding, as well as possible confusion or misreading on sides of participants. An example item is “If I had a mental health concern, seeking help from a mental health professional would be... undesirable/desirable”. Higher mean scores represent more positive attitudes towards seeking help from a psychologist. The measurement is valid and internal reliability was high (Hammer et al., 2018: $\alpha = .93$; in this study: $\alpha = .89$; Taber, 2018).

Treatment Continuation

A self-constructed scale was used, to assess the individuals’ motivation to continue therapy (see Appendix D). It contained 5 items, such as “I would look forward to future therapy sessions”, answered on a 5-point Likert-scale (1 = *strongly disagree*, 5 = *strongly agree*). Items 3 and 4 must be reverse coded and mean scores were computed. A higher score indicates a higher motivation. The measurement demonstrated reliability ($\alpha = .77$; Taber, 2018).

Fear Towards Treatment

To assess the second dependent variable, the overall fear towards treatment, I used the short version of the state anxiety subscale of the State-Trait-Anxiety Inventory, namely STAIS-5 (Zsido et al, 2020; see Appendix E). The STAIS-5 indicates an individual’s state anxiety at that moment. The instruction was adapted, focusing it on one’s current feelings explicitly regarding the following treatment process. The questionnaire includes 5 items, such as “I feel nervous” (Zsido et al., 2020). Answers were given on a 4-point Likert-scale (1 = *not at all* to 4 = *very much so*). Mean scores were computed, the higher the score, the greater the fear towards treatment. The short form strongly correlated with the original scale, and reliability and internal consistency are excellent ($\alpha = .90$; Zsido et al., 2020). The reliability of the scale ($\alpha = .67$) in this sample turned out as close to but lower than the critical threshold of .70 for being acceptable (Taber, 2018).

Manipulation Check

To check for the usefulness of the provided information, the control group was asked whether they wished for more information regarding treatment procedure, while both experimental groups indicated the usefulness from 1 = *not at all* to 5 = *very much* on a 5-point Likert-scale.

A question “Did you expect your GP to refer you for a blood test”, with the answer categories “yes” and “no”, assessed whether both experimental group participants’ processed the procedural information and expected the procedure to happen as prescribed.

To investigate whether the expectations were recognised as violated in the expectancy violation group, the question “Did your GP refer you for a blood test” was added, with the answers “yes”, “no” or “I do not remember”. The checks can be seen in Appendix F.

Demographics

A self-constructed demographics questionnaire assessed gender, age, nationality, main occupation and any preceding contact with mental health care professionals (see Appendix G).

Case Vignette

Individuals received an instruction to imagine suffering from mental issues, to give them a reason to and facilitate their imagination of needing and initiating treatment by consulting their GP (see Appendix H). The instruction included a detailed description of worsened feelings and symptoms, such as e.g., “unintentional weight loss”. Symptoms were again summed up in key points at the end of the description.

Procedural Information

Both intervention groups received the preparatory leaflet called “A guide to mental health treatment” (see Appendix I). It included a title page, table of contents and information about when it is necessary to see a GP, preparation for an appointment, procedural information about the appointment and following treatment procedure, as well as rationale for it. The focus was especially laid on unintentional weight loss and the following treatment.

The control group received a leaflet called “Top 5 Best Movies Of All Time” (see Appendix J). It consisted of a title page, introduction, and the description of five movies ordered from the fifth to the first place. One example was “Forest Gump”.

Interview Script

To reduce the possibility of differences in the data caused through variables other than the manipulations, the researchers created a structured interview script. The outline was chosen to resemble a first appointment with the GP, as this is the first real step into a help-receiving procedure (Rickwood et al., 2007). Open questions were chosen, concerning the feelings, symptoms, symptom duration and impact on the client’s life. Active listening was used to ensure standardised reaction to different answers while keeping the interview on a realistic level. However, the script differed slightly between the conditions, either resembling or being incompatible with the provided procedural information. For the control and PI condition, the script included the question “Have you/So you have lost weight unintentionally during the last month” and ended with the referral for a blood test and for a psychologist (see Appendix K). In the EV condition, merely a referral to a psychologist was given (see

Appendix L). The researchers decided for these manipulations, to try to ensure expectancy violations to occur due to inconsistency between the provided procedural information and actual interview procedure, rather than through other factors, such as negative behaviour of the GP.

Procedure

Participants were allocated in repeated, successive order to the “control”, “procedural information (PI)” or “expectancy violation (EV)” condition, directly after agreeing to take part, to strive for an equal number of participants per condition and as much randomisation as possible. Then, an appointment was scheduled. Participants recruited via Sona were allocated to their condition according to the day of their appointment. All participants initially received the cover story that the purpose of the study was to investigate the difference between facing one or two GPs in the initial appointment. To avoid confusion, all were told to be part of the “one practitioner condition”.

Figure 1 visualises the procedure. Participants received preparatory emails 24-48 hours before the appointment. All emails included the case vignette, informed consent and link to the zoom session. Each condition received a different link for the according survey in Qualtrics. The PI and EV group additionally received the leaflet “Getting help to for mental health issues”. Hence, depending on the condition, the preparation took either 6 or 10 minutes.

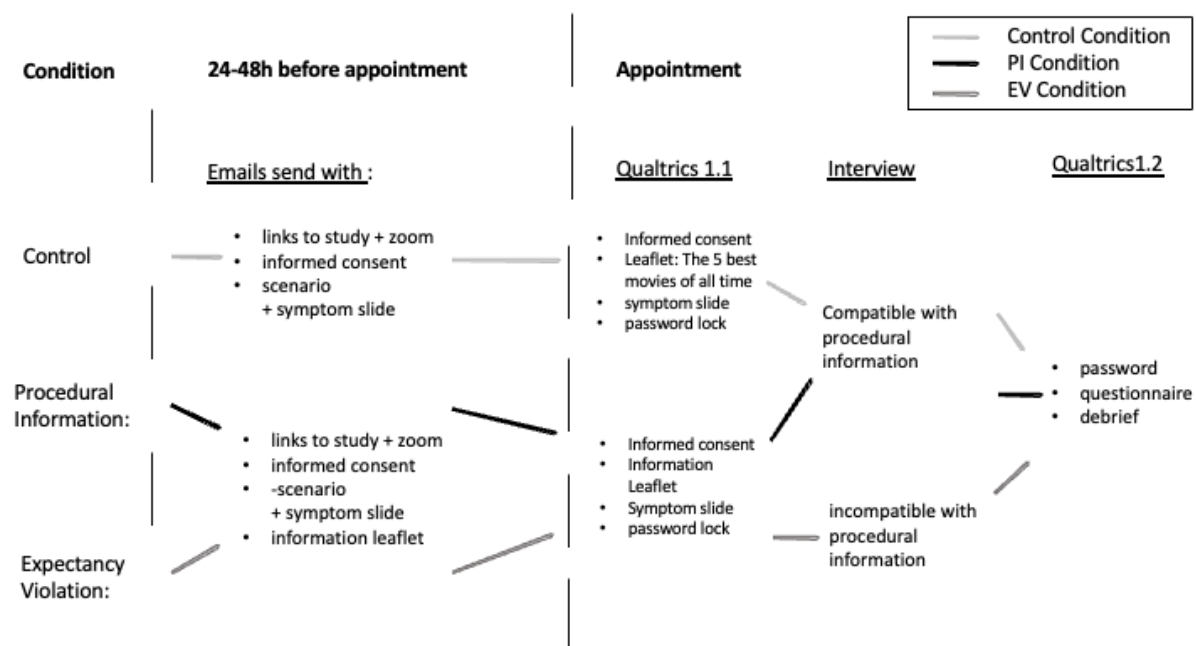
At the appointment, the participant had to click on the provided link to start the survey in Qualtrics. There, they gave informed consent and again faced the summary of their symptoms (see Appendix M). Under the instructions of “being in the waiting room”, the control participants clicked through the leaflet “The best 5 movies of all time”, while the PI and EV condition clicked through the PI leaflet. After reading, all individuals were instructed to enter the zoom session with the GP via the link in the preparation email. A password lock prevented survey continuation before having participated in the session.

The interview endured approximately 5 minutes, where the researcher represented the GP and directly started with the recording. The researcher adhered to the script in line with the procedural information provided before when facing control or PI participants. In the EV condition, the changed script was used, not asking about the weight loss and merely giving a referral to the psychologist. The researcher ended the session and recording by providing the password key to continue the survey in Qualtrics. In Qualtrics, the participants filled out the questionnaires in the following order: STAIS-5, MHSAS, Motivation to Continue Treatment Scale, Dyadic Trust Scale, RS3i, IUS, Special Uncertainty Scale, and information check, or,

in the experimental groups, the manipulation checks. Answers were forced to decrease the possibility of missing data later. In the end, participants got debriefed about the real purpose of the study, rationale for deception and the importance of their participation (see Appendix N). The overall duration of the study was 20 minutes.

Figure 1

Schematic Overview of the Study Procedure



Note. PI condition = Procedural Information condition. EV Condition = Expectancy violation condition. Qualtrics 1.1 = Material in Qualtrics until the password lock. Qualtrics 1.2 = The same Qualtrics, yet including the material from after having entered the password until the end.

Results

The data was analysed in SPSS (Version 27, with the addition of the MACRO process package from Hayes, 2018).

Manipulations

As mentioned in the participant section, several respondents in both experimental conditions gave incorrect answers to the manipulation checks for procedural information but were included in the study. The frequency tables for the answers to the check “Did you expect your GP to refer you for a blood test?” additionally revealed that most of the PI participants

expected to be referred ($n = 24, 68.6\%$), whereas the majority of participants in the EV condition did not expect to be referred ($n = 17, 56.7\%$). To test whether the difference in answers was significant, a one-way analysis of variance (ANOVA) was run with the independent variable condition and the dependent variable expectation (the question). The difference between the groups in reporting expectations towards being referred was significant, $F(1, 63) = 4.35, p = .041$. The regressions coefficient showed that the PI condition expected significantly more often to be referred ($b = 0.252, t(1,36) = 2.09, p = .041, 95\% \text{ CI } [0.01; 0.49]$). The results indicate firstly that the manipulation, which was expected to occur among all participants, did not properly work. Secondly, the significant difference between groups indicate that one must be cautious when comparing both groups and following interpretation of results is limited, as no proper conclusions can be drawn.

Preliminary Analysis

To get an overview of the data, I computed descriptive statistics for the whole sample and per condition of the dependent variables motivation to initiate and to continue treatment and fear towards treatment. As depicted in Table 1, the sample on average scored moderate to above average scores on both help-seeking variables and on fear towards treatment. Pearson correlations were used to show the relationship between the three dependent variables. Motivation to initiate and to continue treatment were positively correlated, which suggests that participants who were more motivated to initiate treatment were also more motivated to continue treatment. Fear towards treatment did not significantly correlate with either motivation to initiate, nor to continue treatment, which might already suggest that it is unlikely to function as a mediator between providing procedural information and motivation to continue treatment.

Table 1

Means, Standard Deviations and Pearson Correlations between Motivation to Initiate and to Continue Treatment and Fear Towards Treatment

Variable	<i>M</i>	<i>SD</i>	1	2
1. Treatment initiation	5.71	0.83		
2. Motivation to continue	3.88	0.66	.49*	
3. Fear towards treatment	2.19	0.62	-.139	-0.154

Note. $N = 99$. Treatment initiation = Motivation to initiate treatment. Motivation to continue = Motivation to continue treatment.

^a Measured on a 7-point Likert-Scale. ^b Measured on a 5-point Likert-Scale. ^c Measured on a 4-point Likert-scale.

* $p < .01$

Hypothesis Testing

Upon examining the means in Table 2, it can be seen that the average scores for each condition on motivation to initiate and to continue treatment and fear are close to each other, which might already suggest that the effect of providing procedural information, or the possible influence of the provision on the outcome variables might be lower than initially expected in the study.

Table 2

Means and Standard Deviations for Participants Intention and Motivation to Continue Treatment and Fear per Condition

Variable	Condition					
	Control ($n = 34$)		Procedural Information ($n = 35$)		Expectancy violations ($n = 30$)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Treatment initiation	5.69	0.61	5.71	1.18	5.73	0.54
Motivation to continue	4.01	0.51	3.88	0.82	3.74	0.61
Fear	2.06	0.64	2.26	0.62	2.25	0.58

Note. Treatment Initiation = Motivation to initiate treatment. Motivation to continue = Motivation to continue treatment. Fear = Fear towards treatment.

^a Measured on a 7-point Likert-Scale. ^b Measured on a 5-point Likert-Scale. ^c Measured on a 4-point Likert-scale.

To test whether procedural information provision will result in higher motivation to initiate treatment (H1a), and to continue treatment (H1b), and less fear towards treatment (H2), I ran one-way ANOVA with condition as independent and treatment initiation, motivation to continue treatment and fear towards treatment, respectively, as dependent

variables. I included a contrast analysis between the means of the control and PI group each time, as my hypotheses were focused on the difference between these two groups (Van den Berg, 2019).

Hypothesis 1a

The one-way ANOVA demonstrated that there were no significant differences in mean treatment initiation between the three groups, $F(2, 96) = .02, p = .985$. The average motivation to initiate treatment was slightly higher in the PI than in the control group (see Table 2). Yet, the difference in means between the control and the PI condition was not significant, $C = .02, t(96) = 0.9, p = .928, 95\% \text{ CI } [-0.38, 0.42]$. The effect size was small ($d = 0.02, 95\% \text{ CI } [-0.45, 0.49]$). Hence, receiving procedural information does not seem to lead to a higher motivation to initiate treatment compared to not receiving such information. Hypothesis 1a was rejected.

Hypothesis 1b

The means of the three conditions on motivation to continue treatment did not differ significantly from each other, $F(2, 96) = 1.29, p = .028$. As can be seen in Table 2, the control group had a higher mean than the PI group on motivation to continue treatment. Contrast analysis supported the results of the one-way ANOVA, as the PI and the control condition did not show significant differences in means on of motivation to continue treatment, $C = -.13, t(96) = -0.79, p = .432, 95\% \text{ CI } [-0.44, 0.19]$. The effect size was small ($d = -0.19, 95\% \text{ CI } [-0.66, 0.28]$). Contrary to the hypothesis, people provided with procedural information did not seem to have a higher motivation to continue treatment. Hypothesis 1b was rejected.

Hypothesis 2

There was no significant difference between the means on fear towards treatment between all conditions, $F(2, 96) = 1.133, p = .326$. The average fear towards treatment was higher in the procedural information than in the control condition (see Table 2). The difference in means between the two conditions was not-significant, $C = 0.2, t(96) = 1.34, p = .185, 95\% \text{ CI } [-0.10, 0.49]$. A small effect size was found ($d = 0.32, 95\% \text{ CI } [-0.15, 0.80]$). The hypothesis was rejected, and the results indicate that providing procedural information did not positively impact an individual's fear towards treatment, compared to not having received such information.

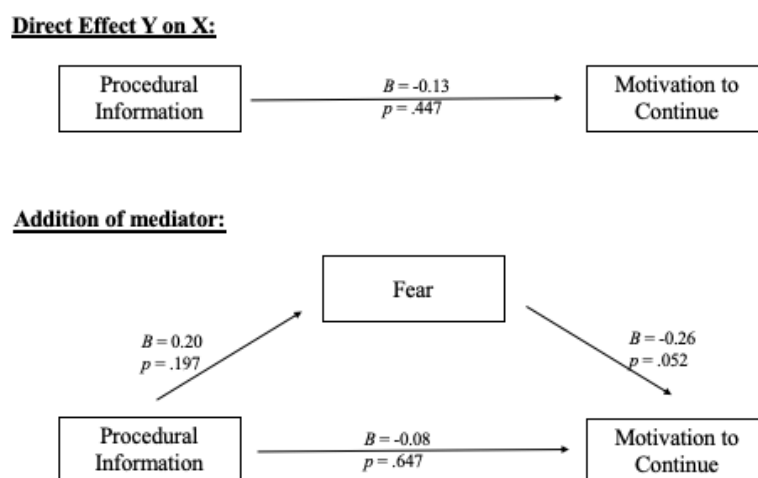
Hypothesis 3

To answer the third hypothesis that “The effect of providing procedural information on help-seeking motivation will be partially explained by fear towards treatment”, I selected the procedural and control condition and conducted a mediation analysis. The Process Macro

package version 4.1 from Hayes (2018) was used, with 5000 bootstrapping samples for determining 95% Confidence Intervals. The categorical variable condition was selected as independent variable, fear towards treatment as mediator and motivation to continue treatment as outcome variable, a simple mediation analysis was carried out. Figure 2 depicts the model to facilitate understanding of the results. First, the effect of providing procedural information on treatment continuation was not significant $B = -0.13$, $t(67) = -0.77$; $p = .447$, 95% CI [-0.45, 0.20]. Second, procedural information did not significantly predict fear towards treatment ($B = 0.20$; $t(67) = 1.30$, $p = .197$, 95% CI [-0.11, 0.50]). Moreover, the mediator fear towards treatment did not predict the participants motivation to continue treatment significantly while controlling for procedural information provision ($B = -0.26$; $t(66) = -1.98$, $p = .0516$, 95% CI [-0.51, 0.002]). Fourth, when controlling for fear, procedural information did not significantly predict motivation to continue treatment ($B = -0.08$; $t(66) = -0.46$, $p = .647$, 95% CI [-0.40, 0.25]). Hence, fear towards treatment did neither partially, nor fully mediate the relationship between providing procedural information and a person's motivation to continue treatment. The indirect effect was not significant ($B = -0.05$, 95% CI [-0.18; 0.03]). Hypothesis 3 was rejected.

Figure 2

Model of the Effect of Procedural Information on Motivation to Continue Treatment Mediated Through Fear Towards Treatment



Note. Motivation to Continue = Motivation to continue treatment. Fear = Fear towards treatment.

* $p < .05$

To test whether expectancy violations lead to less influence of procedural information on motivation to continue treatment (H4) and on fear towards treatment (H5), when compared to expectancy confirmations, I conducted one-way ANOVA with condition as predictor and motivation to continue treatment or fear towards treatment, respectively, as outcome variable. Thereby, I investigated whether significant differences in mean scores exist in at least two of the three groups in the population. If results were significant, I conducted a contrast analysis between the means of the PI and the EV condition on fear towards or motivation to continue treatment, respectively.

Hypothesis 4

No significant differences in group means on motivation to continue treatment were found between at least two of the three conditions, $F(2, 96) = 1.29, p = .281$. Although not significantly different, the average motivation to continue treatment was highest in the control condition, followed by the PI and lastly EV condition (see Table 2). This indicates that the effect of providing procedural information on motivation to continue treatment was not different, namely lower, when participants experienced a session procedure incompatible with the information. Hypothesis 4 was rejected.

Hypothesis 5

The PI condition had on average higher fear towards treatment than the EV condition, with the fear being lowest in the control condition (see Table 2). The differences in means between any of the three groups on fear levels was not significant, $F(2, 96) = 1.13, p = .326$. This indicates that experiencing expectancy violations does not result in higher fear towards treatment than experiencing expectancy confirmations and hypothesis 5 was rejected.

Exploratory Analyses

To gain insight about the objective opinion towards usefulness of procedural information in general, I created a frequency table for the answers of the control condition to the question whether they had wished for receiving more information about the appointment in advance. An equal number agreed ($n = 17; 50\%$) and disagreed ($n = 17; 50\%$). To assess the usefulness of the information specifically provided in this study, I investigated mean scores of the experimental conditions to the question how useful they found the procedural information. Usefulness was rated on average as 3.37 ($SD = 0.77$) in the PI condition, and

slightly lower in the EV condition, 3.13 ($SD = 0.86$). An independent samples t-test revealed that the difference in means between the PI and EV condition was not significant $t(63) = 1.18$, $p = .244$. Both mean scores mostly refer to “somewhat useful”.

Discussion

This study was the first to the author’s knowledge to investigate the effect of providing procedural information about and experiencing expectancy violations during the first appointment for treating mental issues, on help-seeking behaviour and fear towards treatment in an experimental setting. However, the study could not adequately prove that the provided information was processed and according expectations elicited in the sample, wherefore conclusions have to be treated with caution. In general, contrary to initial expectations and current findings in literature, the study has been unable to demonstrate that receiving procedural information has a positive effect on help-seeking or fear towards treatment when compared to not receiving any information. This finding influenced the interpretations of all hypotheses.

Help-seeking

Surprisingly, PI does not seem to positively influence an individual’s 1) motivation to initiate, nor 2) motivation to continue treatment, summarised as help-seeking behaviour. The findings generally contradict the studies initial predictions based on current literature, which firstly stress that lack of knowledge and misconceptions about treatment negatively influence the use of mental health services (Ghafoori, 2014; Hom et al., 2017; Kantor et al., 2017; Lambert, 2007). Secondly, based on such outcomes the studies suggest that providing PI about therapy and what should be expected in treatment are important facilitators of help-seeking (Koike & Ito, 2012; Lambert, 2007).

There are several possible explanations for the differences in findings between the current and previous studies. Firstly, most previous studies merely suggest, while the current study assessed the effect of providing procedural information. Furthermore, although procedural information was often included in effective interventions, it was seldom investigated while controlling for other effectful elements, which leaves unassessed whether procedural information is sufficiently effective on its own (Lindsey et al., 2014). Lastly, individuals are generally more likely to report intentions than to show actual behaviour (Demyan & Anderson, 2012). Regarding the current study’s findings, perhaps the influence of providing procedural information becomes merely relevant when having to execute the help-seeking behaviour instead of merely reporting the intention. As the act of help-seeking would become real, individuals could possibly feel an increased need to know what to expect and

providing procedural information might in turn increase their motivation to continue treatment. Future studies should investigate this possible influence by using a longitudinal design where participants receive procedural information about and attend several sessions.

Importantly, perhaps providing procedural information is generally effective, but the study yielded non-significant results due to lacking usefulness of the information arising from design choices. Firstly, the leaflet used in the current study introduced more information about preparation and the first session, than about follow-up treatment. Therefore, it might be less effectful for increasing motivation to continue treatment. Secondly, information must be targeted to the individuals' concerns, appealing, accurately processed and connected to existing knowledge by the participant to elicit changes (Deane & Chamberlain, 1994; Jorm et al., 2003). Contrarily, the designed leaflet merely addressed overall concerns, such as the GPs' professional handling and confidentiality of intimate disclosures made by the clients. Supporting the assumption of usefulness of procedural information but inappropriate design choices of the study, is the finding that half of the participants in the control condition reported having wished for more PI in advance and participants in both experimental groups still rated the information leaflet as "somewhat useful". Therefore, future research should design leaflets in a way that it includes more details about treatment also in longer term, as well as targets the information to the treatment concerns of the specific population that receives the material, to ultimately assess whether providing PI is effective.

Fear Towards Treatment

Preliminary, the study reveals that there is no effect of providing procedural information on a person's fear level compared to not receiving such information. Hence, it is not surprising that an individual's fear towards treatment did also not explain the relationship between receiving procedural information and being motivated to continue treatment, as initially proposed. This contradicts the finding that an individual's fears should be addressed through correcting wrong beliefs about treatment (Cepeda-Bonito & Short, 1998; Ghafouri et al., 2014). The hypothesised but not found explanatory value of fear towards treatment for the increase in help-seeking behaviour, is inconsistent with previous findings where fear was mentioned as barrier towards initiating and continuing treatment (Cepeda-Bonito & Short, 1998; Zartaloudi & Madianos, 2010). The non-significance of the results could be explained by the fact that fear towards treatment has been shown to include several components, which also differ in individuals (Deane & Chamberlain, 1994; Vogel et al., 2007). Individuals might have different fears, which implies that procedural information is only effective in reducing

the fear towards treatment in people if it targets and addresses their specific fears, which was also mentioned by Deane and Chamberlain (1994).

Another explanation which connects to the subjectivity of fear towards treatment regards the chosen measurement. By using a between-subjects design and post-measures in this study, possible changes in fear towards treatment within participants remained undetected. Besides, the post-measurement outcomes might have been distorted through the positive influence of having already participated and met the GP (Gulliver et al., 2010). Adding upon that, the reliability of the STAIS-5 used to measure fear towards treatment was questionable in this sample. Future studies should overcome these limitations by including a bigger sample size and a within-subjects, pre-post design to measure anxiety.

Next to that, Deane & Todd (1996, as cited in Vogel et al., 2007, p.411), suggest that fearfulness towards treatment is less predictive of help-seeking behaviour in individuals suffering from emotional or suicidal problems. The study might have been unable to detect a significant effect of procedural information as it instructed participants to imagine suffering from depression and symptoms as mood swings, feeling lonely and stressed. Therefore, it is crucial that future studies find out about the actual influence of providing PI on fear, by including different types of mentally ill people.

Expectancy Violations

In contrast with the initial predictions, in this sample there is no evidence that experiencing a session incompatible with one's expectations influences an individual's 1) fear towards treatment, nor 2) motivation to continue treatment when compared to experiencing a session compatible with expectations. One reason for non-significant results could be that factors such as interviewer style or trust in the GP or researcher might have been stronger than or countering the hypothesised negative effect of EV on fear and help-seeking (Greenberg, 1969). This could firstly explain the contradictions between findings of the current and previous studies, where inconsistency between one's expectations and the actual experience of a session significantly increased and triggered fear towards what will happen, as well as caused treatment cessation (Clemes & D'Andrea, 1965; Zartaloudi & Madianos, 2010). Secondly, the outcomes might give a hint that the strong effect reported in literature becomes less important when examining EV in isolation.

The design of the EV manipulation, namely PI and the inconsistent script, might account as further explanation for the contradiction and be a limitation of the current study. Missing out the question regarding weight loss and referral for the blood test might have been a too subtle violation to produce and assess effects. Presumably, most people of the general

population might generally expect to be referred to a psychologist when thinking about future treatment, instead of being referred for a blood test. Hence, experiencing the violations might have been more in line with and supported the participants' initial expectations. As this study assessed and designed the violations with the presumption that participants' expectations would be adjusted and according to the content of the PI, it might have been impossible to measure actual influences of expectancy violations on both outcome variables.

The finding that less people in the EV than in the PI group expected a referral for the test although receiving the same information also provide support for both above mentioned explanations. Besides, both explanations highlight the importance of future studies to use different and less subtle violations in such an experimental setting, to be able to detect the actual influence of EV in isolation.

General Limitations and Strength

The study suggests that there is no effect of 1) PI or 2) EV, on 1) help-seeking behaviour or 2) fear towards treatment. However, the study entails limitations which might have influenced all above-mentioned findings in a way leading to non-significant results and must be stressed before arriving at conclusions.

Firstly, there are three limitations in the used PI manipulation check and their outcomes. First, the checks could not prove that the information was processed and the expectations of the participants adjusted accordingly, which decreases the certainty with which conclusions can be drawn. The uncertainty increases through the second limitation, the construction of the checks, as it does not rule out the possibility that the manipulation partially worked and participants' expectancies adapted to at least some degree but remained undetected. Precisely, as already mentioned above, the checks contained ambiguous wording and were not exhaustive. Participants may have answered based on their general expectations independent of the study, and some expectations introduced through the PI leaflet, such as being asked about weight loss, were not included in the check, respectively. The third limitation regarding the checks used is that participants might have not processed the information thoroughly, or the manipulation leaflet used failed in general.

The failed expectancy violations could similarly be a result of 1) skipping through the procedural information, or 2) not being as attentive during the appointment. As significantly more people reported the expectations in the PI than the EV condition, it could be possible that individuals placed more trust in the GP than in the before provided information or that experiencing the procedure adapted the participants' previously triggered expectations.

Due to these limitations and inability of the manipulation checks to assess whether expectations were adapted, it stands to question whether the PI manipulation partly or fully failed. Although a subsample analysis merely including participants who correctly answered the checks yielded similar results, it was based on small, unevenly distributed sizes of the three conditions. Followingly, the overall effect of providing procedural information, or of experiencing expectancy violations, remains unclear and no clear conclusions can be drawn.

A second limitation of the study is that it included a general rather than a clinical sample. All outcomes were dependent on the participants accurate imagination of suffering from mental issues and of having to enter treatment. Yet, participants might have not processed the leaflet thoroughly or forgotten what it included, as attending the session was actually irrelevant for them (Demyan & Anderson, 2012). Additionally, treatment fearfulness becomes greater when help-seeking becomes more real and actually suffering from mental disorders influences help-seeking behaviours (Demyan & Anderson, 2012; Kushner & Sher, 1989; Pepin et al., 2009). Somewhat in line with these findings, interventions to increase help-seeking have been more effective when targeting clinical populations, compared to those targeting the motivation of a non-clinical sample (Xu et al., 2018). Concluding, it is crucial that future studies use a clinical sample to investigate the actual effect of providing PI as well as experiencing EV on fear towards treatment and help-seeking behaviour.

Another limitation of the current study refers to the unrealistic set-up of the study. The individuals were aware of the fact that they are not attending a real GP session and had voluntarily participated in the study. Also, almost half of the sample reported having had prior experience with mental health services, which positively influences help-seeking as well as fear (Demyan & Anderson, 2012; Zartaloudi & Madianos, 2010). Besides, the session was short and carried out online, wherefore individuals could carry out the study in a familiar environment. In turn, participants probably perceived less ambiguity about what to expect. Concluding, the willingness to engage in help-seeking was already increased in the sample, which demands a stronger intervention to bring about and detect changes in fear towards and motivation to engage in future therapy (Cepeda-Bonito & Short, 1998).

However, in spite of these limitations, the study set-up also positively differentiates the study from previous studies. Importantly, this study was one of the first to test, rather than merely suggest the influence of providing PI. It has an advantage over previous studies as it required participants to actually engage in an online session. Thereby, this study circumvented relying on participants imagination to enter a session or on merely reporting of intentions. It was also one of the first to address the influence of EV on fear and help-seeking by directly

contrasting the effect of two sessions, compatible and incompatible with expectations triggered beforehand. Probably, the comparison led to a more appropriate assessment of EV than previous studies, which for instance provided participants with videos of sessions compatible or incompatible with expectations. Supposedly, the influence of such violations on the individual differs from actually experiencing such a violation. Many studies also interview therapists or clients, which however leaves open the question about the causal value of the violations.

Similar advantages of the set-up over previous studies apply to the investigation of the effect PI in this study. Most previous studies found providing PI to be effective by applying either a cross-sectional or pre-post design. By using an experimental setting including a control group, this study was one of the first to actually assess whether receiving information really causes the positive changes in help-seeking, which has been lacking in literature to date (Graham et al., 2017; Teng & Friedman, 2009). The comparison with a control group, or with the PI group when assessing the effect of EV, was chosen to try to account for influences of an individual's own characteristics or expectations, and external influences, as characteristics of the help-provider, to examining the mere effect of PI or EV on fear and help-seeking. Followingly, by including an experimental set-up including actual participation, the current study tried to increase its connection to reality, in turn striving to elicit more accurate results and generalisability.

This connects to another strength, namely that this study's intervention exclusively focused on providing procedural information. It thereby expands existing literature, as interventions assessing the influence of procedural information mostly included several other components, wherefore the question remained which element introduced positive changes (Lindsey, 2014; Mann et al., 2005).

Although the content of the PI leaflet needs adjustment, it has strength as well. The content addressed clients' general concerns, highlighting their control about how much information to disclose, and described the procedure of the GP appointment, which was suggested as being important (Vogel et al., 2007). Moreover, the content was focused on depressive people, which is crucial as information must be specifically targeted to particular groups, their disorders and expectations to increase help-seeking behaviours and decrease treatment fears (Deane & Chamberlain, 1996; Rith-Najarian et al., 2019). The fact that the provided information was rated as somewhat useful, even by participants in the experimental condition, supports this strength.

Conclusion

Preliminary, no effect of PI or EV on help-seeking or fear towards treatment was found, which indicates that it might be unnecessary for professionals to provide procedural information to the general population in practice. Yet, as conclusions cannot be drawn with certainty due to failed manipulations, especially also regarding EV, and the PI provision also did not cause negative effects on help-seeking or fear towards treatment, one could still suggest professionals to provide PI. The finding that half of the control group would have wished for more information and people in both experimental groups evaluated the information leaflet as somewhat useful, supports this suggestion and hints to the probability of some beneficial effect. Further investigation of the effect of PI and EV on help-seeking and fear towards treatment is hence crucial, especially when considering the implications this might have for reducing the service gap and its negative consequences for society. Taking the limitations and strength of the current study together, the study has several implications for such research. It could deal as a pilot, as future studies should use the same experimental set-up including control conditions to examine the causal effect of PI and EV on help-seeking and fear, yet among a clinical sample. This is crucial as procedural information provision, violation, help-seeking and fear towards treatment are actually instead of imaginatively important to such sample. Additionally, stronger, and more targeted interventions must be used for future studies to evaluate usefulness of PI and to be able to draw conclusions about the effect of EV.

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Appendix A

Results of the Subsample Analysis

Participants

The subsample consisted of 71 persons of the control condition ($n = 34$) and the experimental conditions excluding those who answered “no” to the question whether they expected a blood test (procedural information condition, $n = 24$; expectancy violation condition, $n = 13$). The sample consisted of 27 males, 41 females and 3 non-binary persons, ranging between 19 and 58 years of age ($M = 24.27$, $SD = 7.33$).

Regarding the individual conditions, 11 males and 22 females and 1 non-binary person participated in the control condition ($n = 34$; age, $M = 24.76$, $SD = 7.82$). The procedural information condition consisted of 24 individuals (18 males, 16 females, 1 non-binary person; age, $M = 24.88$, $SD = 8.35$). The expectancy violation condition included 13 participants (age, $M = 21.85$, $SD = 1.91$). This unequal division, as well as small sample size already hints to the fact that comparisons and findings must be treated with caution and interpretations cannot be regarded as certain. There were no significant differences in the demographics between all three conditions.

Results

Examining information usefulness, the procedural information condition on average rated it as 3.5 ($SD = 0.72$), which mostly refers to “somewhat useful”. The average score of the usefulness among the expectancy violations condition was slightly lower 3.38 ($SD = 0.51$), but still refers to “somewhat useful”.

The effect of providing procedural information remained not significant. There was no significant difference between mean scores of the control and the procedural information condition regarding treatment initiation, $C = 0.09$, $F(1, 68) = 0.15$, $p = .701$, 95% CI [-0.35, 0.55], motivation to continue treatment, $C = -0.10$, $F(1, 68) = 0.29$, $p = .594$, 95% CI [-0.46, 0.27]; or fear towards treatment, $C = 0.17$, $F(1, 68) = 0.96$, $p = .331$, 95% CI [-0.17, 0.51].

The mediation analysis to test whether the effect of reading procedural information on help-seeking will be partially mediated by fear towards therapy (H3) yielded similar results compared to outcomes of the main sample. The effect of the providing procedural information on help-seeking remained not significant ($B = -0.27$, $t(35) = -0.99$; $p = .33$, 95% CI [-0.85, 0.29]), as was the effect on the mediator fear ($B = 0.05$; $t(35) = 0.24$, $p = .813$, 95% CI [-0.39, 0.50]). Again, there was no significant effect of fear on help-seeking, when controlling for providing procedural information, $B = -0.26$; $t(34) = -1.19$, $p = .24$, 95% CI [-0.70, 0.18]. Last, the effect of providing procedural information on motivation to continue treatment while

controlling for fear towards treatment, remained not significant $B = -0.26$; $t(34) = -0.95$, $p = .350$, 95% CI $[-0.83, 0.30]$. Again, the indirect effect was not significant ($ab = -0.01$, 95% CI $[-0.21; 0.11]$). Hence, fear does not seem to partially explain the effect of providing procedural information on help-seeking.

Similar to the general sample, no significant differences were detected when examining the effect of expectancy violations in the subsample. There were no differences between mean scores of all groups on fear towards treatment, $F(2, 68) = 0.77$, $MSE = 0.41$, $p = 0.466$, nor motivation to continue treatment, $F(2, 68) = 1.42$, $MSE = 0.47$, $p = 0.249$, wherefore no planned comparisons between the procedural information and the expectancy violations group were further needed.

Appendix B**Table B1**

Pearson Chi-Square (Degrees of Freedom) and the According Significance Level for Differences Between the Conditions in Demographics

Variable	Differences between conditions	
	$\chi^2 (4, N = 99)^a$	<i>p</i>
Gender	3.49	0.480
Nationality	2.28	0.685
Occupation	2.77	0.598
Prev. Exp	2.39	0.664

Note. Prev. Exp. = Previous Experience with Mental Health Services.

^a degrees of freedom, sample size

Table B2*Nationality, Occupation and Previous Experience per Condition*

Condition	Variable								
	Nationality			Occupation			Previous Experience		
	<i>Dutch</i>	<i>Ger</i>	<i>Other</i>	<i>Stud</i>	<i>Work</i>	<i>Other</i>	<i>Yes</i>	<i>No</i>	<i>Not say</i>
Control ^a	14 (41%)	18 (53%)	2 (6%)	27 (79%)	6 (18%)	1 (3%)	14 (41%)	19 (56%)	1 (3%)
Procedure ^b	13 (37%)	16 (46%)	6 (17%)	24 (69%)	10 (28%)	1 (3%)	15 (43%)	20 (57%)	0
Expect. Violation ^c	12 (40%)	15 (50%)	3 (10%)	25 (83%)	5 (17%)	0	15 (50%)	15 (50%)	0

Note. Occupation = Current primary occupation; Previous Experience = Any previous experience with mental health practitioners; Ger = Germany; Stud = Student; Not say = Prefer not to say; Procedure = Procedural information condition; Expect. Violation = Expectancy violation condition.

^a $N = 34$. ^b $N = 35$. ^c $N = 30$.

Appendix D

Self-Constructed Scale to Assess Motivation to Continue Treatment

The following questions will be about whether, based on your first contact with the general practitioner, you would like to continue and seek help with a psychologist. Please rate to what extent you agree with the following statement on a scale from 1 = 'Strongly disagree' to 5 = 'Strongly agree'.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Future therapy sessions would help me in dealing with my problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would look forward to future therapy sessions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Continuing therapy would do more harm than good.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would not like to schedule further therapy sessions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I intend to attend further therapy sessions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix E

STAIS-5, Short Form of the State-Trait-Anxiety Inventory (Zsido et al., 2020) With Adjusted Instructions

After your conversation with your GP, we ask you to think about how you feel now. Thinking about the treatment of my current issues. . .

	Not at all	Somewhat	Moderately So	Very much so
I feel upset	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel frightened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am jittery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel confused	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Appendix F

Self-Constructed Manipulation Checks

Control Group

Would you have wished for more information about the GP appointment regarding mental health?

- Yes
- No

Procedural Information And Expectancy Violation Group

Please rate how useful you found the information leaflet for your appointment on a scale from 1 = 'not at all' to 5 = 'very much'.

	Not at all	Not really	Undecided	Somewhat	Very Much
I found the information leaflet useful.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did you expect your GP to refer you for a blood test?

- Yes
- No

Expectancy Violation

Did your GP refer you for a blood test?

- Yes
- No
- I do not remember

Appendix G

Demographics

You are almost done! At last, we would like you to answer a few questions about yourself.

What is your gender?

- Male
- Female
- Non-binary/third gender
- Prefer not to say

How old are you?

What is your nationality?

- Dutch
- German
- Other

What is your main occupation?

- Student
- Working
- Retired
- Other

Did you have any experience with mental healthcare professionals prior to this study?

- Yes
- No
- Prefer not to say

Appendix H


Case Vignette








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 6kg 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.

A quick overview of your main symptoms again:

Your symptoms



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

Appendix I

Procedural Information Leaflet

Title Page:



Page 1:



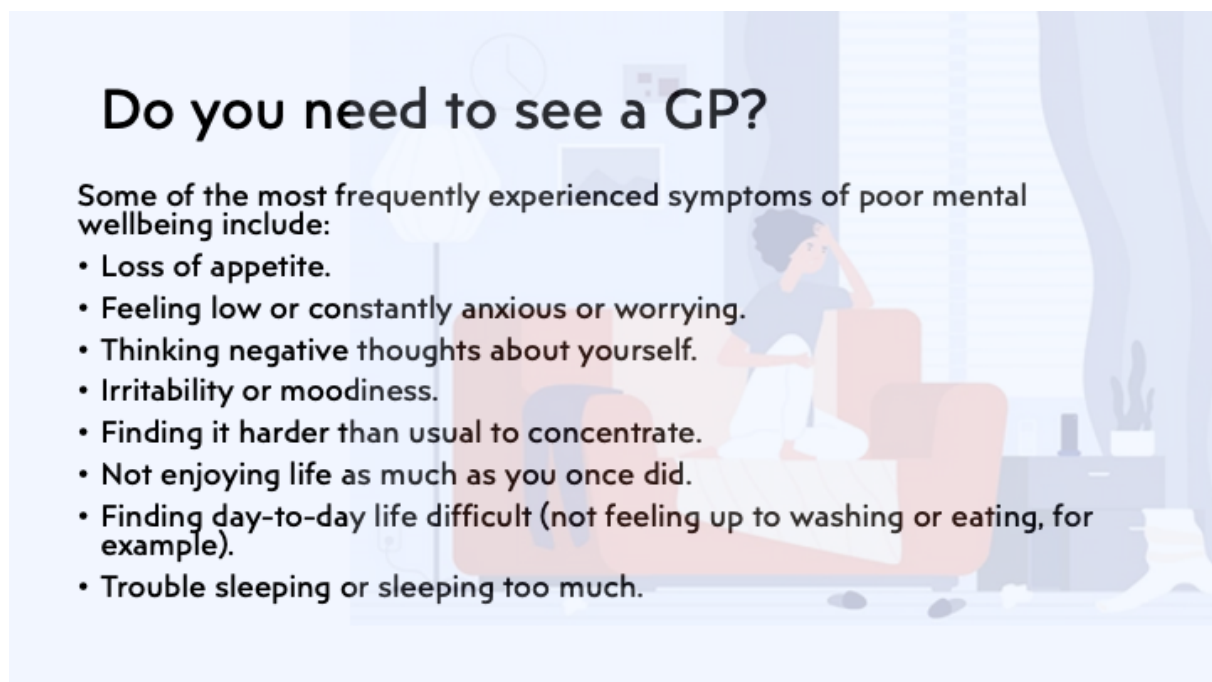
Page 2:



Do you need to see a GP?

If you've noticed changes in the way you are thinking or feeling over the past few weeks or months that concern you and cause you distress, you should consider going to see your GP.

Page 3:



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.

Page 4:

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.

An illustration showing a pair of hands writing on a white notepad with a yellow pencil. The notepad has several horizontal lines. The background is a solid green color.

Page 5:

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**).



Last Page:

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.



At the end of the appointment:

- **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**.

Appendix J

Control Leaflet

Title Page:



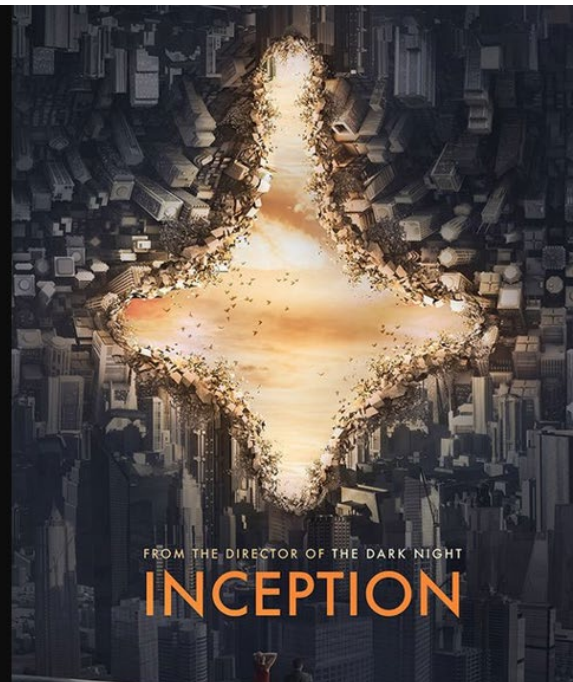
Page 1:



Page 2:

#5 Inception

Inception is a science fiction movie directed by Christopher Nolan with Leonardo Di Caprio as lead role. It is about a group of people who have the ability to hack into someone's brain through entering their dreams. This hacking is used to steal information from someone's brain. This movie makes use of impressive visual effects and of skillful perspective taking.



Page 3:

#4 Forrest Gump


Forrest Gump depicts a story of an American Army officer called 'Forrest Gump'. The movie covers all aspects of his life, including a rollercoaster ride of emotions. The best part of the movie is the central character, which is played by Tom Hanks.



Page 4:

#3 Schindler's List

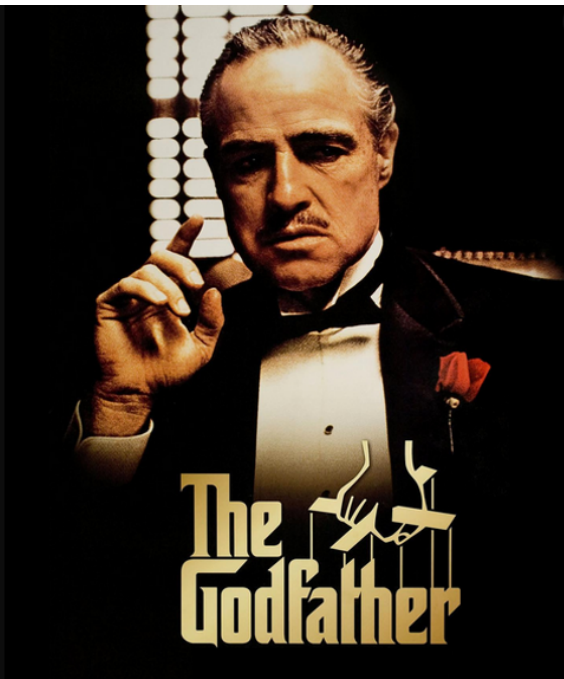
Schindler's List is a wartime movie directed by Steven Spielberg. This movie is about Poland, which was occupied by Germany during World War II. Mr. Schindler, an officer in the German army, is the central character of the movie. He becomes very concerned about the Jewish people living in Poland. This movie will surely elicit your emotional side with its grand ending.

A stylized, high-contrast illustration for the movie 'Schindler's List'. It features a large, detailed profile of a man's face (Oskar Schindler) on the left. In the center, a small figure of a young girl in a red coat stands. On the right, a German military officer in a cap with a skull and crossbones emblem is shown. The title 'SCHINDLER'S' is written in a decorative, serif font at the bottom.

Page 5:

#2 Godfather

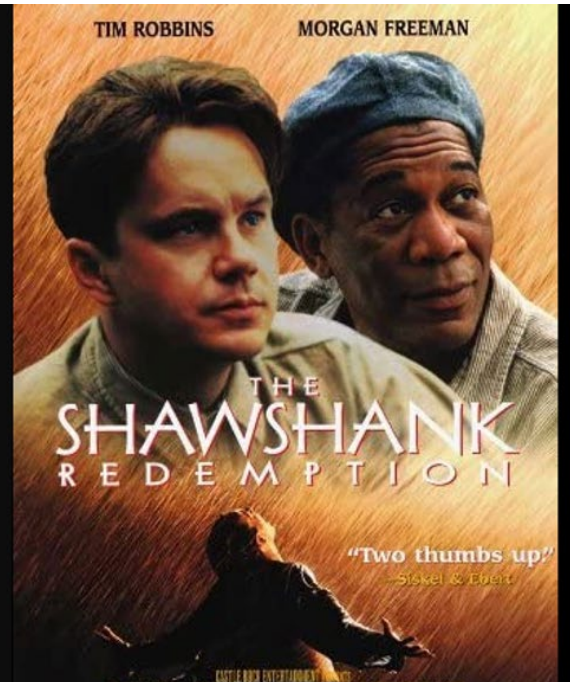
Godfather is one of the best movies of all time. This movie is based on a story of an American mafia family, whose head is Don Vito Corleone. Don decided to hand over his throne to his youngest son Michael. This movie displays a very realistic narrative of the mafia gangs of America with its equally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

A classic movie poster for 'The Godfather'. It features a close-up of Marlon Brando as Don Vito Corleone, wearing a tuxedo and a red boutonniere, with his hand raised in a gesture. The title 'The Godfather' is written in a large, stylized, gold-colored font at the bottom, with a graphic of a hand holding a gun above the word 'Godfather'.

Page 6:

#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 Andy Dufresne, a successful banker who got arrested for the murder of his wife. The story revolves around his life in a prison called 'Shawshank'. This movie has a unique ability to mesmerize its audience.



Appendix K

Script for Control and PI Condition

1. Hello, I am Alex, your general practitioner. What can I help you with?
2. How have you been feeling lately?
3. What are your symptoms?
4. For how long have you been noticing your symptoms?
5. 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?
6. Okay. Could you describe your symptoms in more detail to me? How are your symptoms impacting on your life?
7. 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.
8. Is that clear? Do you still want to mention anything you haven't said before?
9. 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!
➤ short break, then say:
10. You can now go back to the survey again that you have started before this interview. You will need to type in a password to continue. The password is 1234. Goodbye!

Appendix L

Script for EV Condition

1. Hello, I am Alex, your general practitioner. What can I help you with?
2. How have you been feeling lately?
3. What are your symptoms?
4. For how long have you been noticing your symptoms?
5. Okay. Could you describe your symptoms in more detail to me? How are your symptoms impacting on your life?
6. 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 will refer you to a psychologist. They will diagnose you during the intake interview and if needed, you can get treatment there.
7. Is that clear? Do you still want to mention anything you haven't said before?
8. Okay, then I would say, I will refer you to a psychologist and then I wish you a nice day!
 - *short break, then say:*
9. You can now go back to the survey again that you have started before this interview. You will need to type in a password to continue. The password is 1234. Goodbye!

Appendix M

Introduction And Informed Consent

Introduction

We are happy to see that you would like to take part in the study ‘Are two medical doctors better than one? - The impact of more than one practitioner on patients’ well-being!’

In the following study, you will be asked to read through a scenario, and you are asked to imagine that you are worried about your mental health. This scenario will give you an overview of your general state, activities, and feelings during the past few weeks. For this study, it is important that you read this information regarding your mental health thoroughly and really try to imagine being and feeling like that person. In the upcoming one or two days, you will then take part in a short dialogue (5 minutes) with a General Practitioner (GP, in everyday language, your medical doctor) where the audio will be recorded. Before, you will be shortly presented with a recap of your symptoms again (not the whole scenario), and it is important that you try to imagine being the person described in the scenario and take on their perspective for the whole duration of the study. After your conversation with the GP, you will be asked to answer some questions in a questionnaire. It is important that you answer these questionnaires as truthfully as possible. Your answers will be anonymous and are stored confidentially. Overall, the study will approximately take 15-20 minutes.

Purpose

The purpose of this research is to test the difference between initial contact with one or two GPs. You were randomly allocated to talk to one practitioner.

Risks or Discomforts

We do not expect any risks associated with this study. Discomfort might be experienced while reading through the scenario and imagining yourself suffering from poor mental health.

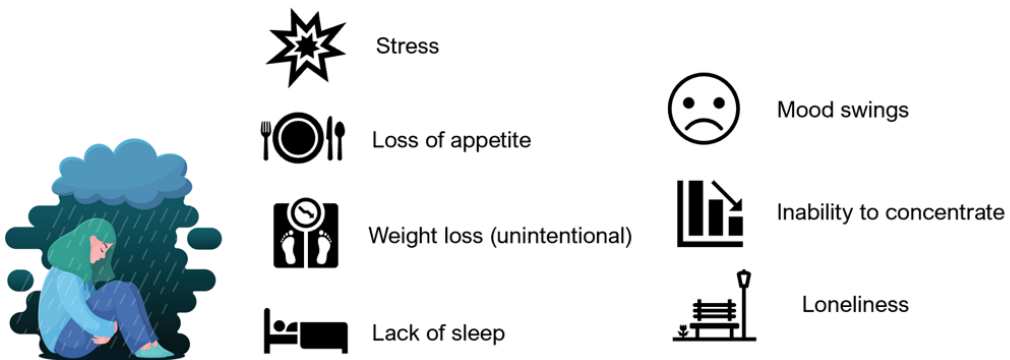
Participant Rights

Participating in this study is voluntary. You may withdraw from the study at any time, and no consequences will follow. If you wish to withdraw from the study at a later time, you can contact the research team via email. By participating in this study, you consent to have the audio of your session recorded. Any information that is collected will be anonymised and personally identifiable information will be removed. This data will be kept according to

security guidelines of the University of Twente for up to 10 years after the study to use in future research and publications. In case you would like to receive more information about your rights as a research participant or have questions regarding your participation, please contact the Secretary of the Ethics Committee ethicscommittee-bms@utwente.nl. This also applies if you wish to talk with someone else than the researchers about any concerns you might have about the study.

Symptom Summary

Your symptoms



Appendix N

Debrief

You made it to the end!

Thank you for your participation!

By pressing the next button, your responses will be submitted.

But before the end of the study, we would like to give you some more information on this study.

Study Objective

While you were previously informed that this study aims to investigate the effectiveness of treatment with different amounts of practitioners, this was not the actual aim of this study. However, this deception was necessary to allow for genuine responses regarding the actual aim of this study. The actual aim of this study was to investigate whether and how people might be more motivated to initiate and continue treatment as a result of receiving information about the therapy procedure. Further, we also wanted to investigate what happens when the actual therapy does not take place precisely as might be expected after reading this information.

How did it work?

As a participant in this study, you participated in an interview session with a student who played the role of a general practitioner. Prior to the session, you received procedural information. However, we manipulated the following factor: the procedural information that you were given (procedural information about the interview session vs. procedural information about movies). In this interview session, you had to answer several questions the therapist asked. The asked questions were either in line with your received procedural information or not. In the case where the questions were not in line with the procedural information, we altered what kind of questions were asked, and the order in which they were asked. This way, an expectancy violation could be initiated. Afterwards, you filled in several questionnaires in which you evaluated different aspects of the interview session.

Why is it important?

Lack of treatment for mental health conditions is a widespread problem, causing great individual suffering and increasingly large costs. Therefore, it is essential to investigate how

this lack of treatment can be reduced. With your participation in this study, you contributed to research on increasing effective utilisation of mental health services. By understanding how certain barriers to initiating and continuing treatment might be overcome, a solid foundation for future interventions can be established.

Please remember to click on the 'next' button below, so that your answers can be saved.