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# Can Podcast Listening Influence Attitudes About Mental Illness?: An Exploratory Study

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Running head: IMPACT OF PODCAST LISTENING ON BEHAVIOR

Can Podcast Listening Influence Attitudes About Mental Illness?:  
An Exploratory Study

by

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DISSERTATION

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Keene, New Hampshire



Department of Clinical Psychology

**DISSERTATION COMMITTEE PAGE**

The undersigned have examined the dissertation entitled:

**CAN PODCAST LISTENING INFLUENCE ATTITUDES ABOUT MENTAL ILLNESS?: AN EXPLORATORY STUDY**

presented on April 24, 2018

by

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### Abstract

Mental illness (MI) is a major problem in the United States, with significant economic, emotional, and physical impacts on individuals with MI, their loved ones, and their employers. Many of those who could benefit from treatment do not seek it out, despite the researched benefits of mental health care. The self-stigma (SS) associated with MI is a well-documented obstacle to help-seeking behavior. Mental health professionals have tried, with mixed results, to combat SS and encourage help-seeking. Individuals with MI have found and supported one another, forming a community and successfully advocating for reforms to the mental health system. Contemporary peer support organizations, while continuing to advocate for change on a systemic level, additionally focus on encouraging health and help-seeking behavior for those living with MI. The Mental Illness Happy Hour (MIHH) podcast is a weekly audio interview, freely available via the internet, in which the host and a guest discuss firsthand experiences of living with MI, the legacies of trauma and substance abuse, and experiences in treatment. The aim of this study was to determine if any relationship could be identified between listening behavior and change in attitudes relative to the presence and treatment of MI. The Impact of Listening Behavior (ILB) scale, a brief self-report measure, was developed for the study. Results show that respondents feel their attitudes towards the presence and treatment of MI have improved relative to their listening behavior. Small but significant inverse correlations were found between the Duration of Listening (DL) and several ILB items, suggesting a relationship between listening and improved attitudes among a self-selecting sample of MIHH listeners.

*Keywords:* self-stigma, help-seeking behavior, peer-support, podcast

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## Can Podcast Listening Influence Attitudes About Mental Illness?: An Exploratory Study

### Literature Review

#### **Mental Illness Exacts a Staggering Toll on Individuals and Society**

Approximately 25% of the adult US population meets criteria for a psychiatric diagnosis in a given year, with a lifetime mental illness (MI) prevalence of nearly 50 percent (Taylor & Johnson, 2013). A 2008 Substance Abuse and Mental Health Services Administration (SAMHSA) survey found that 4.4% of adults experienced serious mental illness (SMI), those who meet diagnostic criteria with associated functional impairment in major life activities, in the past 12 months. Kessler et al. (2008) estimated the overall financial impact of MI in the United States at approximately \$300 billion annually. This cost estimate was largely based on workers with MI experiencing decreased productivity, as well as employer earnings lost due to employee absences (217 million days annually; Kessler et al., 2008).

#### **Mental Illness Can be Successfully Treated**

Ample evidence supports psychotherapy as the first-line treatment for a majority of mental health issues (e.g., Cuijpers, Van Straten, Hollon, & Andersson, 2010; Gaebel, Riesbeck, & Wobrock, 2011; Huhn et al., 2014; Hunsley, Elliott, & Therrien, 2014). In a review of meta-analyses, Hunsley et al. examined the efficacy of psychotherapy for anxiety, mood, and related disorders. Results indicated that all forms of psychotherapy (i.e., interpersonal therapy, short-term psychodynamic therapy, non-directive supportive therapy, and various types of cognitive behavioral therapy [CBT]) outperformed control groups for treatment of depression. CBT was found to reduce anxiety disorder symptoms in both self- and clinician-reports beyond the symptom reduction achieved by either treatment-as-usual or waitlist conditions. Psychotherapy was identified as a key component in preventing relapse for individuals with

bi-polar disorder (Hunsley et al., 2014). In sum, psychosocial treatments have a robust evidence base and are considered first-line treatment options for MI, leading the American Psychological Association (APA) and SAMHSA (<http://www.samhsa.gov/ebp-web-guide>) to maintain active and updated lists of standard treatments for specific mental illnesses.

Psychopharmacology also plays an important role in MI treatment. The primary intervention for schizophrenia is psychoactive medication with adjunctive psychosocial treatment supporting medication adherence and social functioning (Gaebel et al., 2011). Stimulant medication is the frontline treatment for ADHD (Faraone, Biederman, Spencer, & Aleari, 2006; Sonuga-Barke et al., 2013) with behavioral intervention indicated for treatment of the remaining psychosocial symptoms (Galanter, 2013). Pharmacological intervention is the primary treatment for all phases of bipolar disorder (Fountoulakis et al., 2012).

Meta-analytic results indicate that combined pharmacotherapy and psychotherapy produce the largest treatment effect sizes for most disorders (Huhn et al., 2014). For instance, psychotherapy and psychopharmacology had similar effect sizes on depression (Cuijpers, van Straten, van Oppen, & Andersson, 2008) with a small observed increase in effect size for conjoint use (Cuijpers et al., 2010). A combination of CBT and selective serotonin reuptake inhibitors (SSRIs) was found to be superior to CBT treatment alone for panic disorder (van Apeldoorn et al., 2008).

### **Many People Never Seek Help for Mental Illness**

As many as two thirds of MI sufferers fail to seek mental health treatment (Andrews, Issakidis, & Carter, 2001; Taylor & Johnson, 2013). A representative survey of the US population (National Comorbidity Survey Replication [NCS-R]; N = 9282; data collection from February 2001 to April 2003) found that attitudinal/evaluative factors (e.g., wanted to handle it

personally; perceived treatment ineffectiveness; stigma; thought it would get better; problem not severe) were the primary obstacles to help-seeking for individuals self-reporting the need for, but avoidance of, treatment in the previous 12 months (Mojtabai et al., 2011). At least one structural barrier (e.g., cost, availability, transportation, convenience) was cited by 22.4% of respondents. However, nearly all (97.4%) respondents endorsed at least one attitudinal/evaluative barrier (Mojtabai et al., 2011). These results suggest that the mental health treatment need-use gap is created and sustained by both internal and external pressures and highlight the importance of addressing the internal barriers to help-seeking.

### **What is Stigma?**

Link and Phelan (2001) conceptualize stigma as resulting from interrelated cognitive, affective, and social factors. These interrelationships hinge on differences (e.g., crazy vs. sane) that can be identified and manipulated within social, political, and economic spheres, and result in power differentials, with MI sufferers as a lower-status out-group as compared to their mentally healthy peers. Though only 9.1% of respondents specifically endorsed stigma as a help-seeking obstacle in the NCS-R (Mojtabai et al., 2011), modern theories propose (see Corrigan, 2004; Link & Phelan, 2001) and research supports (Clement et al., 2015; Farrelly et al., 2014) an understanding of MI stigma as a multi-faceted barrier to help-seeking behavior. MI stigma has been linked to discrimination, loss of self-esteem, and denial of opportunities (Farrelly et al., 2014) creating health, income, and quality of life differences for individuals with MI.

Clement et al. (2015) conducted a meta-synthesis of 144 studies of the impact of stigma representing 90,189 participants. Stigma was found to be inversely related to help-seeking with a median effect size of -0.27. The review also found that stigma most commonly interferes with

help-seeking due to shame/embarrassment, negative social judgment, and employment-related discrimination.

Corrigan (2004) posits stigma functionally as the product of “four social-cognitive processes: cues, stereotypes, prejudice, and discrimination” (p. 615). Summarizing Corrigan, MI stigma is defined for the purposes of this study as the thoughts, feelings, or attributions that make individuals with MI seem dangerous, unpredictable, or of weak character. Corrigan delineates between public and self-stigma, with public stigma comprising the prejudicial social consequences of MI labeling, and self-stigma (SS) being the harm to self-esteem and sense of self from the resulting internalization of stigmatizing ideas.

### **Understanding Self-Stigma as a Barrier to Help-seeking**

SS is damaging to individuals on a number of levels. SS has the capacity to isolate individuals from their supports and can be barrier to help-seeking (Corrigan, Druss, & Perlik, 2014). MI self-stigma can lead to beliefs that one is dangerous to other people, incompetent, or incapable of caring for oneself (Corrigan, 2004). A meta-analysis by Clement et al. (2015) found internalized stigma to have “small but consistent negative” association (p. 17) with help-seeking. The logical outcome of the belief of self-dangerousness is to protect others from oneself.

Bathje and Pryor (2011) surveyed 211 Midwestern college students examining relationships between public stigma (stereotypical beliefs about individuals with mental illness), self-stigma (evaluated by measuring perceived harm to self-esteem caused by the decision to seek counseling), and the participants’ attitudes and intentions toward help-seeking. They found that self-stigma was inversely related to help-seeking attitudes and fully mediated the relationship between public stigma and help-seeking attitudes. Sympathy emerged as a moderating factor, such that those who were more sympathetic to a peer engaging in

help-seeking behavior were less likely to anticipate negative self-assessments for engaging in help-seeking behavior themselves. Bathje and Pryor posit that self-sympathy disrupts the internalization of stigmatizing beliefs and subsequent harm to self-esteem. In this formulation, preserving self-image becomes dependent on a making a choice to sympathize about one's MI or to avoid MI self-identification.

### **Professional Efforts to Reduce Stigma Have Been Insufficient to Date**

Corrigan and Penn (1999) proposed three intervention strategies to combat stigma: (a) protest (directly challenging inaccurate or hostile portrayals of mental illness), (b) education (transmitting new and/or corrective information), and (c) direct contact (encouraging positive direct interactions with mentally ill individuals). These strategies primarily target public stigma (Corrigan, 2004) and the evidentiary support for broad anti-stigma efforts is limited.

Borschmann, Greenberg, Jones, & Henderson (2014) conducted a review of large-scale stigma reduction efforts across Europe. The programs in question generally operated within the Corrigan and Penn (1999) framework, attempting to correct negative beliefs of MI individuals (protest) and increase knowledge (education). The review found little evidence of a significant general stigma reduction effect. Positive effects did not follow any particular pattern, tending to vary by sub-population, specific attitude, or specific behavior (Borschmann et al., 2014).

Mittal, Sullivan, Chekuri, Allee, and Corrigan (2012) identified and reviewed 14 articles on self-stigma reduction interventions published from 2000–2011. Focused primarily on education and protest, eight of the 14 studies reported statistically significant decreases in self-stigma. Only four studies in this review had greater than 100 participants and several failed to use rigorous experimental designs (Mittal et al., 2012), attenuating the ability to make strong or causal conclusions based on this evidence.

Yanos, Lucksted, Drapalski, Roe, and Lysaker (2014) conducted a review of studies on six self-stigma specific intervention programs. The programs targeted negative views about the self related to diagnosis or treatment for “serious mental illness” (e.g., psychosis or schizophrenia). Program interventions were diverse in focus and message but generally engaged the strategies of protest and education. Programs largely couched anti-stigma efforts in a context of personal narratives and generally showed positive effect for participants. Reviewers considered these results to be “encouraging” (p. 177), while acknowledging that research on these programs is in the early stages (Yanos et al., 2014). It is important to note that interventions of this sort require prior identification of MI and assignment to a specific intervention effort, a degree of targeting that is resource intensive.

### **Consumers Aim to Support One Another**

The MI community, representing their disenfranchised and stigmatized identity, has a history of engaging in self-support and self-advocacy to fight against the impact of their othering and resulting exclusion and poor treatment (Adame & Leitner, 2008; Ostrow & Adams, 2012). The anti-psychiatry movement emerged in the mid-20th century as a strong voice against abusive, coercive, and oppressive methods of treatment (Rissmiller & Rissmiller, 2006). Deinstitutionalization in the 1960s and 1970s was followed by a wave of advocacy by former patients and their allies (Ostrow & Adams, 2012). They argued against a medical model that they felt had invalidated and ignored their experiences. Largely rejecting professional and governmental alliances for fear of being coopted, these groups remained isolated from the professional mental health community by choice for several decades (Ostrow & Adams, 2012).

Modern consumer movements, however, appear to have moved toward acceptance that there is more to be gained by working within the boundaries of the mental health system (Ostrow

& Adams, 2012). Adame and Leitner (2008) would seem to agree, stating that the “future of creating alternatives in the mental health system primarily lies in the hands of consumers and survivors” (p. 157). Goldstrom et al. (2006) conducted a survey to quantify the activities and reach of consumer run organizations (CRO)—groups run by and for individuals suffering from MI. They received responses from 7467 CROs serving roughly 1.5 million people in the United States in 2002. Groups reported providing direct support, recreational opportunities, education, and advocacy for their members and communities (Goldstrom et al., 2006). Ninety-four percent of CROs reported receiving referrals from formal helping systems. Explicitly acknowledging the limits of peer support and the importance of formal MI treatment, less than one percent believed that their efforts replaced professional help (Goldstrom et al., 2006). A hybrid system of utilizing formal resources for treatment while simultaneously accessing some form of peer support is potentially an effective means of maximizing the benefits of each.

### **Peer Support is Evolving**

Separate from CROs, professional mental health treatment providers have begun integrating peer support into their formal treatment models in order to supplement treatment as usual. The third annual Pillars of Peer Support Services Summit brought together leaders in the behavioral and physical health communities in order to determine best practices for integrating Peer Support Services (PSS; Daniels et al., 2012). The work resulted in a consensus statement that reads in part:

Peer Recovery Support Services are evidence based... and have been demonstrated to promote positive health outcomes and control the cost of healthcare. These services are offered by a trained individual with lived experience and recovery from a mental illness, substance use and/or chronic health conditions. Peer Recovery Support Services

minimally include... whole health and wellness promotion and engagement, relapse prevention, life skill coaching, and insurance and health systems navigation. (Daniels et al., 2012, p. 22).

Building on the Pillars of Support, Daniels et al. (2013) developed level-of-care guidelines in an attempt to establish insurance industry standards for PSS. These guidelines specify that a member qualifies for “peer bridger” services if they are living with a “severe and persistent behavioral health condition” as well as difficulty accessing or utilizing behavioral or medical care, or lacking family or social supports of helping the member manage their condition (p. 1191).

Llyod-Evans et al. (2014) conducted a meta-analysis of 16 studies covering 5597 participants in randomized controlled trials of peer support for people with SMI. Results were mixed, yielding little evidence of improvement in hospitalization, symptom relief, or outcome satisfaction over treatment as usual. However, two post-hoc analyses included the additional outcomes of hope and empowerment as being commonly reported and considered important by both researchers and service users (Llyod-Evans et al., 2014). Given that service utilization is identified as a major obstacle (Andrews et al., 2001), any resource that both encourages and facilitates MI service utilization is potentially valuable.

### **Free, Online, Peer Support Resources Have Unexplored Potential**

The internet contains free resources for nearly everything and mental illness is no exception. In recent years, technology has evolved so that nearly anyone can record and disseminate content via the internet. One notable example is the It Gets Better (IGB) campaign, an ongoing effort to provide outreach and support to LGBTQ+ youth over the internet ([itgetsbetter.org/about](http://itgetsbetter.org/about)). IGB founded in 2010 by activist Dan Savage and his partner Terry

Miller in response to a series of highly publicized suicides by LGBTQ+ youth. The campaign encourages LGBTQ+ individuals to share their stories of resilience and success on YouTube with the goal of providing remote emotional support to youths who might be struggling as a result of their identity (Asakura & Craig, 2014). As of their writing, Asakura and Craig noted over 30,000 entries with the IGB tag and 40 million views, providing strong anecdotal evidence for the popularity and potential reach of such outreach efforts.

The Mental Illness Happy Hour (MIHH) is a consumer produced podcast ([www.mentalpod.com](http://www.mentalpod.com)) that began in March, 2011. Operator and host Paul Gilmartin aims to provide a supportive, non-judgmental space for guests to talk freely about mental illness and the impact that it has on their lives. Mr. Gilmartin's decision to start the MIHH was based on his positive experiences with mental health support groups in which he felt connected with peers and less alone in his personal recovery. Though early episodes were largely conducted with Mr. Gilmartin's celebrity friends (Mr. Gilmartin has been a professional comedian for many years), he has since expanded interviewees to include those individuals who have a unique tale of illness and recovery to relate.

The purpose of the MIHH episodes is similar in many ways to the IGB videos. Guests share their experiences with Mr. Gilmartin and recordings of these are posted on the internet in a form that allows anonymous listeners to access at their leisure. Mr. Gilmartin views the MIHH as a place to explore, validate, and normalize guest experiences that otherwise might not be shared ([mentalpod.com](http://mentalpod.com)). His hope is that listeners might experience a connection with the stories being told, thus increasing their sympathy and hope for either themselves or others dealing with MI. Emphasizing his belief that the MIHH is not the solution to the struggles addressed within the episodes Mr. Gilmartin begins every podcast with the statement "it's not a doctor's office. It's

more like a waiting room that doesn't suck." He hopes that listeners will take heart and engage with their personal struggles (mentalpod.com).

### **What Impact, if Any, Does a Podcast Have on Listeners?**

The MIHH would seem to combat self-stigma as a barrier to help-seeking via mechanisms similar to those advocated by Corrigan and Penn (1999). MIHH listeners experience vicarious contact with MI sufferers in the context of a dialogue that both challenges inaccurate stereotypes of MI (protest) and provides corrective and new information about MI and treatment (education). The narrative structure of the interviews allows listeners to potentially connect with the lived experiences (contact), rather than having to identify with specific MI symptoms or diagnoses. Ideally this creates a space for listeners to reduce or bypass self-stigma and engage in help-seeking behavior. At this time we know little about the perceived impact on self-stigma and help-seeking behavior of MIHH or similar new media products.

### **This Study Explores the Impact of the MIHH on Listener Attitudes and Actions**

This study examined the extent to which listeners perceive that their engagement with the MIHH has decreased their self-stigma and impacted their attitudes towards MI and help-seeking behavior. This exploratory study, which contained no *a priori* hypotheses, had two primary research questions:

1. Do consumers of the MIHH podcast believe that listening has led to improved attitudes towards MI and treatment?
2. Is there a relationship between MIHH listening behavior and a) perceived changes in self-stigma and b) perceived changes in attitudes towards MI issues?

## Method

### Research Design

This study used a quantitative cross-sectional survey design. The independent variable was self-reported quantity of listening behavior. The dependent variables were perceived change in self-stigma and perceived change in help seeking attitude. Data were collected using an online survey hosted by Survey Monkey.

### Participants

Participants were recruited from listenership of the MIHH podcast. Mr. Gilmartin offered generous support for this project, promoting the study within two consecutive podcast episodes (9/8 and 9/15/17) and via the Twitter social media platform (9/11/17). To participate, listeners had to have listened to at least one episode of the MIHH podcast and be at least 18 years of age. Power analysis indicated that a correlational analysis required a minimum of 85 participants to have an 80% change of detecting a medium effect at a .05 level of probability (Cohen, 1992). The survey was live for 10 days (9/8-9/18/17) during which 559 responses were recorded by the Survey Monkey portal.

### Measures

**Demographic variables.** The survey asked participants to provide their age, sex, and race. Age was gathered as a continuous variable. Options provided for sex were Male, Female, Prefer not to say, and Not listed. Selecting Not listed offered respondents a space to self-define their preferred identity. Race was similarly presented as a multiple-choice item with a write-in option (See Table 1).

**Measures of listening behavior.** Respondents were asked to account for their listening behavior in two ways. They were asked to identify both their duration of listening (DL; i.e., how

long they had been listening) to the MIHH, as well as to estimate the number of episodes they had listened to in the past year (EPY). These data points functioned as the independent variables for analytic purposes.

**Perceived change in attitude towards treatment-seeking behavior.** The survey asked respondents if listening to the MIHH made them feel more positively about MI, as well as both talk therapy and medication management, for both themselves and others. These items used a five-point Likert-type response scale. The scale was designed to range from Strongly Agree (1), to Agree and Disagree Equally (3), to Strongly Disagree (5). Unfortunately, a typo resulted in “Strongly Disagree” being labeled “Disagree Equally” on the version of the survey that went live for data collection. Higher scores on these items indicate a lower perceived positive change in attitude to MI and treatment.

**Measure of self-stigma.** In order to measure respondent SS, the survey included two items from the Self-Stigma of Seeking Help scale (SSOSH; Vogel, Wade, & Haake, 2006; Table 2). This scale was developed utilizing a rigorous scientific validation procedure in order to better assess MI treatment utilization relative to SS. The SSOSH scale was developed utilizing a sample of predominantly Caucasian college students in the Midwest. It is a 10-item measure with a five-point, partially anchored Likert-type scale ranging from 1 (Strongly Disagree) to 3 (Agree and Disagree Equally) to 5 (Strongly Agree). The researchers executed a series of five studies examining the validity and reliability of the scale. Vogel et al. (2006) found that the SSOSH had strong internal consistency reliability (Study 1  $\alpha = .91$ ,  $N = 583$ ; study 2  $\alpha = .89$ ,  $N = 470$ ) and test-retest reliability over a two-month period (Study 3 SSOSH total score correlation  $.72$ ,  $N=226$ ). Cross-cultural validity of the scale was supported in a second series of studies that found the single-factor construct of the scale held across six countries (Vogel, Armstrong et al.,

2013). Items were selected based on their applicability to this study and a consideration of the item-total correlations to the measure as a whole (.71 and .77, respectively).

### **Procedures**

The study was deemed exempt from oversight by the Antioch University Institutional Review Board due to its anonymous nature. The study was developed, conducted, and hosted on [www.surveymonkey.com](http://www.surveymonkey.com) (Survey Monkey), utilizing their software and hosting capacities to facilitate data collection. Anonymity was preserved by collecting limited personal data, as well as disabling IP address recording. Participants accessed links either in the “show notes” section of the podcast website or from Mr. Gilmartin’s tweets promoting the study. The first page of the survey was informed consent (Appendix A).

### **Data Analysis**

The file containing the responses to the online survey was downloaded from Survey Monkey and analyzed utilizing Apple’s Numbers software and R free statistical analysis software suite. Initial descriptive analyses focused on demographics and characterizing the respondents. Frequency distributions using counts and percentages were computed for demographic variables including gender, age, and number of MIHH episodes consumed. Descriptive statistics (frequencies, measures of central tendencies and variance) were used to explore the perceived impact of MIHH listening behavior. Finally, correlational analyses were conducted to determine if there was a relationship between MIHH listening behavior and (a) perceived changes in self-stigma and (b) perceived changes in attitudes towards MI and treatment-seeking behavior.

### **Results**

The survey was live for data collection on Survey Monkey from 9/8/17 to 9/18/17, during

which time 559 responses were recorded. The data was subject to a review in order to ensure the validity of the sample. Though the survey was designed to be brief, it would have been nearly impossible to provide informed/accurate responses in fewer than 60 seconds. Completion time data was available and allowed the exclusion of 36 surveys that failed to meet this minimum. A visual review of the remaining data revealed 39 incomplete responses that were also excluded from analysis.

Visual review also identified the presence of a set of aberrant set of responses on the question “Approximately how long ago did you start listening to the MIHH?” (Q4, Appendix B). Though this question predominantly generated responses containing a numeric value and a time frame (e.g., 18 months; 1.5 years), 64 respondents, however, provided only a two-digit numeric value with no time frame (e.g., 10; 20). Time stamps for this response set revealed that they were completed in bursts of three or four surveys consecutively, with each survey begun seconds after the prior had ended. This response pattern cast doubt on the likelihood that this response set was completed in good faith, and were thus excluded from the analysis. The remaining 420 responses appeared to represent valid responses and were subject to data analysis.

### **Descriptive Analyses**

**Demographics.** The average age of respondents was 36.4 years ( $SD = 10.1$ ,  $N = 420$ ) with a range from 18 to 70. Respondents were predominantly female (76.4%; Table 1). Eight respondents endorsed *not listed* and in the space provided, five identified some form of gender neutrality/fluidity, while three defined themselves by the direction of their personal gender transition. Respondents largely identified as White/White American (81.0%) with three respondents (0.7%) choosing not to self-identify (Table 1). Those who selected Other (10.7%) wrote in responses that they felt more accurately described their racial background, including

“White from [other country]” and a specified blended heritage. An additional 25 respondents (6.0%) selected other and identified themselves as White from another country.

**Study variables.** Respondents were asked to report how long they have been listening to the MIHH podcast. Answers were provided in a number-word format (e.g., 18 months; 1.5 years) that was converted to a numerical value (in years) for analysis. On average, respondents had been listening to the podcast for 2.5 years ( $SD = 1.8$ ) with a range of one week (brand new listeners) to 6.5 years (i.e. since the inception of the podcast). One hundred and twenty-eight (30.1%) respondents reported that they had been listening for a year or less.

Respondents were also asked about the frequency of listening in the past year. On average, respondents reported listening to 48.9 MIHH episodes in the past year ( $SD = 57.6$ ). This equates to roughly once a week (also the rate at which podcasts are released), with a range from zero to 348 (the total number of published episodes available during data collection), and a median of 34 episodes. Twenty-four (18.8%) of the 128 respondents listening for a year or less reported listening to two or more episodes a week (100+ EPY), while only 30 (10.5%) of the respondents listening for longer than one year reported similar high frequency listening habits.

Open-ended, anecdotal responses (e.g., *I googled “podcasts about depression”*; *[S]earched podcasts about mental health*) were provided by 417 respondents. Reviewing these responses revealed that about 80 respondents were actively seeking a podcast like the MIHH based on content, while approximately 60 reported hearing about the MIHH through a friend and another 30 through family. An additional 80 respondents indicated they had found the podcast either through Mr. Gilmartin having a particular guest on his show or being a guest on a different podcast. Three individuals indicated that they had been recommended the podcast by a mental

health provider, and a single respondent (a professor) stated that she learned about the podcast in a student's paper.

**Prior to listening.** One hundred percent of respondents indicated an awareness, prior to listening to the MIHH, that someone close to them was living with MI, and 79.1% of respondents reported awareness of someone close to them being in treatment (Table 2). Over four in five (81.9%) of respondents reported that they were aware of personally living with MI and approximately two out of three (62.1%) reported being in treatment for MI prior to listening to the MIHH. Over four in five (81.9%) of respondents reported feeling as though they needed help but didn't seek it at some point prior to listening to the MIHH.

**Impact of listening behavior (ILB).** Respondents were asked to rate their feelings on a five-point partially anchored Likert-style scale with an N/A option. Scale response options were labeled as Strongly Agree (1), Agree and Disagree Equally (3), and Disagree Equally (5). As seen in Table 3, respondents generally endorsed agreement with the statements provided. Average responses ranged from 1.44 (more positive feelings relative to personal pursuit of talk therapy; ILB3) to 1.98 (more positive feelings relative to personally using prescription medication; ILB6).

**Self-stigma.** An analysis was conducted for response integrity, attempting to roughly estimate the degree to which respondents attended to the reverse scoring of the two items. Survey design made it unlikely that individuals would provide the same non-neutral response to both items (both *Strongly Agree* or *Strongly Disagree*). It was therefore possible to determine the average degree of difference between the two items for each respondent. Subtracting responses to SSOSH2 from SSOSH1 created an average of -1.88 (SD = 1.77). Visual review of the data set indicated that only 22 responses (5.2%) endorsed both items at the same extreme (e.g., both

Strongly Agree or Strongly Disagree). The majority of respondents were attentive to the reverse scoring aspect of the SSOSH items, and thus the results are valid and interpretable in the context of this study. As seen in Table 4, average responses to SSOSH1 ( $M = 1.53$ ,  $SD = 0.92$ ) and SSOSH2 ( $M = 3.42$ ,  $SD = 1.28$ ) reflect endorsement of generally low to neutral feelings of SS among respondents.

The number of individuals endorsing high levels of SS that had participated in the study was of interest, prompting the development of metric to identify these respondents. An individual was determined to be endorsing high SS when rating SSOSH1 as 3-5 *and* SSOSH2 as 1-3, a pattern appropriately responsive to the reverse scoring of the items. Just 23 respondents (5.5%) responded in this fashion.

**Correlational analysis.** Pearson product-moment correlation coefficients were calculated to understand the relationship between ILB and SSOSH with reported Listening Duration (LD; the amount of years elapsed since listening to the MIHH for the first time) and the number of Episodes in the Past Year (EPY; Table 5). Listening duration showed small inverse correlations with more positive feelings about others with mental illness (ILB1;  $r = -.12$ ,  $p = 0.018$ ), others pursuing talk therapy for mental illness (ILB3;  $r = -.10$ ,  $p = 0.077$ ), and respondents personally using prescription medication to treat mental illness (ILB6,  $r = -.18$ ,  $p = 0.036$ ). Additionally, there was a small but significant correlation between LD and both self-stigma of seeking help items. Longer listening was correlated with stronger agreement with the statement *My self-confidence would NOT be threatened if I sought professional help* (SSOSH1;  $r = -.15$ ,  $p = 0.155$ ) and stronger disagreement with the statement *I would feel worse about myself if I could not solve my own problems* (SSOSH2;  $r = .12$ ,  $p = 0.0005$ ). EPY did not show a similar

relationship with the ILB or SSOSH items. The only statistically significant finding for EPY was a small inverse correlation with more positive feelings about others with mental illness (ILB1;  $r = -.12, p = 0.03$ ).

### **Discussion**

The primary purpose of this study was to gather information about how MIHH listeners perceive the impact of their listening behavior on attitudes related to mental illness and self-stigma. Descriptive results indicate that respondents broadly perceive the act of listening to the MIHH podcast as being responsible for positive attitude changes towards the presence and treatment of MI in both others and the self. Correlational analysis suggests that the overall length of time someone has been listening to the podcast has a significant relationship with these attitude changes. Of note when considering these relationships, each episode having a run time of 90–150 minutes means that listening to the average MIHH episode is a substantial investment in time for the listener.

Loyalty to the MIHH among respondents is notable given the identified relationship between LD and attitude change, and engenders curiosity about how listeners initially discovered the podcast. Nearly all respondents provided anecdotal data that helps to shed light on the answer. Answers cover a broad range of potential avenues of discovery: active search, friend/family recommendation, cross-promotion, or algorithmic suggestion by streaming or downloading service. A few individuals had even received a recommendation through their mental health professional. This data helps conceptualize the reach of the podcast, and could be useful when considering how to best target potential listeners in future studies of the MIHH or a similar product.

Nearly two thirds (62.1%) of listeners reported that they had personally sought out mental health treatment prior to listening to the MIHH, outpacing estimates for the general population that as many as two thirds of MI sufferers do *not* seek treatment (Andrews et al., 2001; Taylor & Johnson, 2013). Given the robust state of research on SS interfering with treatment use (Bathje & Pryor, 2011; Borschmann et al., 2014; Corrigan, 2004; Corrigan & Penn, 1999; Mittal et al., 2012; Mojtabai et al., 2011), the high frequency of treatment utilization among respondents is reflected in low SS, with just 23 respondents (5.5%) in the data set endorsing high levels of SS. It is difficult to say conclusively how and if the low SS and high treatment seeking activity among respondents are related because the data gathered is insufficient and study structure not suited for that sort of causal analysis. Individuals struggling with MI able to independently access a resource like the MIHH would likely also be capable of locating and accessing professional assistance because of their low feelings of stigma around their symptoms and/or diagnosis. Or it is possible that the low SS reflects the frequency of effective MI treatment access among respondents. Multiple scenarios are possible and none can be ruled in or out.

Furthermore, a pattern in the data appears to reflect the deeply ingrained nature of SS despite in spite of limited endorsement of SS among respondents. Relative to their listening behavior, respondents endorsed more positive change in attitudes about others with MI and other pursuit of talk therapy than for other utilization of prescription medication. The same pattern plays out for attitudes relative to the self: attitudes towards awareness of MI in the self are identified as improving more than attitudes towards personally seeking talk therapy, with both those showing more perceived positive change than the attitude towards personal utilization of medication management for MI. Thus, self-identified attitude change would appear to vary depending on both distance from the self (self < other) and intensity of the relationship to MI

(acknowledgement < talk therapy < medication management).

This data highlights the complicated relationship between self-stigma and help seeking. Prior to listening, 62.1% of respondents indicated that they had sought mental health treatment while at the same time 81.8% of respondents reported that at some point they failed to seek the mental health help they needed. This suggests that knowledge of MI does not equate directly to actionable behavior and highlights that many unidentified moderating factors that exist in the decision to seek treatment. Shame is one such potentially moderating factor, but the value of shame appears “built-in” to the concept of self-stigma to such an extent that operationalizing it as a separate concept for measurement would prove to be difficult. Many of the primary researchers on stigma and self-stigma (e.g., Corrigan, 2004; Link & Phelan, 2001) mention shame only in order to operationalize definitions of self-stigma. In fact, the word “shame” is not used a single time by Vogel et al., (2006) in their reporting on their development of the SSOSH scale.

Corrigan’s (2004) conceptualization is that SS represents the internalization of stigmatized views of individuals with MI (public stigma), the implication being that SS likely would not exist without public stigma. Both LD and EPY were correlated with more positive perceptions of others with mental illness. There were no other statistically significant correlations for EPY, while LD was also correlated with attitudes towards others receiving therapy and medication management for MI, as well as both attitudes towards personal therapy and medication management. This data would suggest attitude change in these areas is more of a long-term endeavor, and that perhaps it is length—and not intensity—of exposure that has a greater impact on attitudes.

Primetime television represents a vector by which individuals are exposed to ideas on a nightly basis. Diefenbach and West (2007) sampled 84 hours of primetime television in April

2003 to determine how individuals with MI were portrayed to the general public. They found that “mentally disordered” individuals were portrayed as violent offenders nine times more than real world statistics would suggest, and were approximately 10 times more likely to commit a violent crime than “the non-mentally disordered” characters within the shows. More recently, Parrott and Parrott (2015) analyzed 65 episodes of U.S. primetime crime drama television from 2010–2013 and found that mentally ill characters were more likely to commit a violent act (51%) than other characters (18%). Additionally, they noted that the mentally ill were more likely to be *victims* of a violent act (46%) than the general population (31%). In sum, they found that the “mentally ill were significantly more likely to be victims ( $z = 1.97, p < .01$ ) and perpetrators ( $z = 4.64, p < .001$ ) of violence” (Parrott & Parrott, 2015; p. 650).

Despite utilizing broad caricatures to facilitate dramatic storytelling there have been changes over time in the pop-culture portrayal of MI (Parrott & Parrott, 2015). It is somewhat encouraging that Parrott and Parrott also found MI characters appearance to be “more ambiguous” lacking “(t)he straitjackets, wild hair, and over-the-top mannerisms... used to denote mental illness in the past” (p. 652), and generally seeming more like the other characters on the shows in both physical appearance and behavior. The need for dramatic tension might always outweigh any efforts for completely equitable treatment of MI in these media, but the evidence suggests that shows are taking positive steps overall. This progress made towards more positive portrayal of mental illness in the popular culture will likely fall short of complete accuracy because of the need for dramatic tension.

I believe that the MIHH portrayal of MI is an earnest and valuable attempt to combat negative portrayals and stereotypes of MI. Mr. Gilmartin’s website states that “the biggest myth about mental illness is that you are alone and there is no help” ([www.mentalpod.com](http://www.mentalpod.com)). These

results suggest that listening to the MIHH may mitigate the negative portrayal of MI at the individual level. Indeed, efforts such as the It Gets Better campaign and the Mental Illness Happy Hour may serve a critical function in normalizing the lived experiences of these stigmatized identities. It is through these resources that individuals might find personalized representations that acknowledge struggles while still capturing their full humanity. These products aim to cut through self-stigma, reducing negative feelings and facilitating access to helpful professional resources. This study presents evidence that the MIHH has some perceived impact on these feelings among those who choose to listen.

### **Limitations**

The results from this exploratory study must be considered in light of several limitations emerging from both execution and design. The execution error occurred in the translation of the survey onto the Survey Monkey portal, in which the Likert-style scale on the online version of the ILB measure was mislabeled with the words *Disagree Equally* instead of *Strongly Disagree*. It is impossible to determine or assign value to the mislabeling in order to create an analytical correction; therefore, this limitation was taken into account when interpreting the data.

Additionally, participants in this study were listeners of the MIHH (a self-selecting group) who heard about and decided to participate in this project (a self-selecting group) through promotion from the host. It is probable that the people who chose to participate also are among the most engaged MIHH listeners; as such, the results may represent the more enthusiastic listeners of the podcast. The promotion of the study by Mr. Gilmartin may have unintentionally led to demand characteristics in which respondents wittingly or unwittingly felt pressure to endorse positive feelings towards the product. The skew of the sample compared to the general population is significant, with female and white/white American participants overrepresented

relative to the general population. Results are appropriately couched to reflect the sampling and generalizations outside this population are avoided.

No causal inferences are possible from this study. The correlational design is capable of identifying that listening to the podcast has a relationship to lower SS, but it is not reasonable to assert that listening causes that reduction. It could easily be that people with low SS choose to listen to the MIHH rather than that listening reduces SS. Finally, it should be noted that this project was conceived because I really enjoy listening to the podcast and wanted to explore whether it contained more than just entertainment value. Appropriate understanding of these limitations should not prevent future inquiries from being planned and designed based on the more general relationships between listening and attitude change found in this study.

### **Future Research**

This study was conceived as a launching off point for more rigorous experimental exploration of an understudied area. Future projects should make efforts to round out the understanding of the MIHH and similar new media products. It would be important to design a study that provides clearer insight into whether listeners perceive their listening behavior as an entertainment or information product in order to guide marketing and outreach efforts. Future studies would benefit from a structure that has subjects more clearly delineating their personal treatment and listening timelines, providing data about their reasoning for seeking treatment, and executing more rigorous experimental designs with a control or comparison group and with full measures of SS would all allow for more robust analysis and causal inferences. Researchers could ask non-listeners if they would be more interested in listening to a podcast like the MIHH depending on the source of the recommendation.

Additionally, researchers could explore the impact of listening to a single, targeted

episode in which the researchers match an individual to the content. This would seek to provide some answer as to whether the mechanism of attitude change lies in the direct identification with a particular diagnosis or symptoms presentation, or the normalization of MI more has a more generic impact. While these are just a few suggestions, media products straddling the intersection between information and entertainment like the MIHH might create a space for people to be more receptive to new, more positive portrayals of MI and should be more fully understood. Study in this area by professional psychology is potentially valuable, as resources such as the MIHH could help encourage or supplement treatments for large numbers of people with MI at little to no cost.

### **Conclusion**

This exploratory study was conducted in order to address the lack of research into the impact of new media products such as the MIHH and their potential value to the practice of professional psychology. It was conceived of as an exploration of personal interest, but was executed with an earnest attempt to reduce the impact of personal bias. Similarly, the MIHH is a passion project by the host, Mr. Gilmartin, with the goal of attempting to embody the lessons he has learned from his own treatment experiences. Respondents to this study were loyal listeners, willing to invest 90 minutes or more on a weekly conversation covering difficult topics. The results from this study would suggest that the MIHH is perceived as something of value by the listeners. The duration of listening to the MIHH podcast was found to be correlated with perceived positive change in attitudes, as well as reduction in feelings of SS relative to MI issues.

It is difficult to quantify the potential value of the MIHH or similar media products to professional psychology and society as a whole. Both cost and time constrains the amount of professional outreach possible to those with mental illness, and the culture at large perpetuates

many negative stereotypes that serve to generate self-stigma, which interferes with help-seeking behavior. Lay resources that successfully encourage help-seeking behavior and reduce the self-stigma around mental illness and other stigmatized identities should be explored further. This study hints at positive benefits to individuals who seek out and consume the MIHH on a regular basis, making this and similar products in the public arena appropriate for more rigorous scientific study.

## References

- Adame, A. L., & Leitner, L. M. (2008). Breaking Out of the Mainstream: The Evolution of Peer Support Alternatives to the Mental Health System. *Ethical Human Psychology and Psychiatry*, 10(3), 146–162.
- Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilisation. *The British Journal of Psychiatry*, 179(5), 417–425. <https://doi.org/10.1192/bjp.179.5.417>
- Asakura, K., & Craig, S. L. (2014). “It Gets Better” ... but How? Exploring Resilience Development in the Accounts of LGBTQ Adults. *Journal of Human Behavior in the Social Environment*, 24(3), 253–266. <https://doi.org/10.1080/10911359.2013.808971>
- Bathje, G. J., & Pryor, J. B. (2011). The relationships of public and self-stigma to seeking mental health services. *Journal of Mental Health Counseling*, 33(2), 161–177.
- Borschmann, R., Greenberg, N., Jones, N., & Henderson, R. C. (2014). Campaigns to reduce mental illness stigma in Europe: A scoping review. *Die Psychiatrie: Grundlagen & Perspektiven*, 11(1), 43–50.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, 45(1).
- Cohen, J. (1992). A Power Primer. *Psychological Bulletin*, 112(1), 155–159
- Corrigan, P. (2004). How Stigma Interferes With Mental Health Care. *American Psychologist*, 59(7), 614–625.
- Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, 15(2), 37–70. <https://doi.org/10.1177/1529100614531398>
- Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, 54(9), 765–776. <https://doi.org/10.1037/0003-066X.54.9.765>
- Cuijpers, P., van Straten, A., Hollon, S. D., & Andersson, G. (2010). The contribution of active medication to combined treatments of psychotherapy and pharmacotherapy for adult depression: A meta-analysis. *Acta Psychiatrica Scandinavica*, 121(6), 415–423. <https://doi.org/10.1111/j.1600-0447.2009.01513.x>
- Cuijpers, P., van Straten, A., van Oppen, P., & Andersson, G. (2008). Are psychological and pharmacologic interventions equally effective in the treatment of adult depressive

- disorders? A meta-analysis of comparative studies. *The Journal of Clinical Psychiatry*, 69(11), 1675-85-41.
- Daniels, A. S., Cate, R., Bergeson, S., Forquer, S., Niewenhous, G., & Epps, B. (2013). Best practices: Level-of-care criteria for peer support services: A best-practice guide. *Psychiatric Services*, 64(12), 1190-1192. <https://doi.org/10.1176/appi.ps.201300277>
- Daniels, A.S., Tunner, T.P., Ashenden, P., Bergeson, S., Fricks, L., & I. Powell. (2012). "Pillars of Peer Support – III: Whole Health Peer Support Services." Retrieved from <http://www.pillarsofpeersupport.org>
- Diefenbach, D. L., & West, M. D. (2007). Television and attitudes toward mental health issues: Cultivation analysis and the third-person effect. *Journal of Community Psychology*, 35(2), 181–195. <https://doi.org/10.1002/jcop.20142>
- Faraone, S. V., Biederman, J., Spencer, T. J., & Aleardi, M. (2006). Comparing the efficacy of medications for ADHD using meta-analysis. *MedGenMed : Medscape General Medicine*, 8(4), 4.
- Farrelly, S., Clement, S., Gabbidon, J., Jeffery, D., Dockery, L., Lassman, F., Thornicroft, G. (2014). Anticipated and experienced discrimination amongst people with schizophrenia, bipolar disorder and major depressive disorder: A cross sectional study. *BMC Psychiatry*, 14.
- Fountoulakis, K., Kasper, S., Andreassen, O., Blier, P., Okasha, A., Severus, E., Vieta, E. (2012). Efficacy of pharmacotherapy in bipolar disorder: A report by the WPA section on pharmacopsychiatry. *European Archives of Psychiatry & Clinical Neuroscience*, 262, 1–48. <https://doi.org/10.1007/s00406-012-0323-x>
- Gaebel, W., Riesbeck, M., & Wobrock, T. (2011). Schizophrenia guidelines across the world: A selective review and comparison. *International Review of Psychiatry*, 23(4), 379–387. <https://doi.org/10.3109/09540261.2011.606801>
- Galanter, C. A. (2013). Limited support for the efficacy of nonpharmacological treatments for the core symptoms of ADHD. *The American Journal of Psychiatry*, 170(3), 241–244.
- Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., & Manderscheid, R. W. (2006). National Estimates for Mental Health Mutual Support Groups, Self-Help Organizations, and Consumer-Operated Services. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(1), 92–103.
- Huhn, M., Tardy, M., Spineli, L. M., Kissling, W., Förstl, H., Pitschel-Walz, G., Leucht, S. (2014). Efficacy of pharmacotherapy and psychotherapy for adult psychiatric disorders: A systematic overview of meta-analyses. *JAMA Psychiatry*, 71(6), 706-715. <https://doi.org/10.1001/jamapsychiatry.2014.112>

- Hunsley, J., Elliott, K., & Therrien, Z. (2014). The efficacy and effectiveness of psychological treatments for mood, anxiety, and related disorders. *Canadian Psychology/Psychologie Canadienne*, 55(3), 161–176. <https://doi.org/10.1037/a0036933>
- Kessler, R. C., Heeringa, S., Lakoma, M. D., Petukhova, M., Rupp, A. E., Schoenbaum, M., Zaslavsky, A. M. (2008). Individual and societal effects of mental disorders on earnings in the United States: Results From the National Comorbidity Survey Replication. *The American Journal of Psychiatry*, 165(6), 703–711.
- Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology*, 27, 363–385.
- Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC Psychiatry*, 14. <https://doi.org/10.1186/1471-244X-14-39>
- Mittal, D., Sullivan, G., Chekuri, L., Allee, E., & Corrigan, P. W. (2012). Empirical studies of self-stigma reduction strategies: A critical review of the literature. *Psychiatric Services*, 63(10), 974–981. <https://doi.org/10.1176/appi.ps.201100459>
- Mojtabai R, Olfson M, Sampson NA, Jin R, Druss B, Wang PS, Kessler RC. (2011). Barriers to mental health treatment: results from the National Comorbidity Survey Replication. *Psychological Medicine*, 41(8), 1751–1761.
- Ostrow, L., & Adams, N. (2012). Recovery in the USA: From politics to peer support. *International Review of Psychiatry*, 24(1), 70-78. <https://doi.org/10.3109/09540261.2012.659659>
- Parrott, S., & Parrott, C. T. (2015). Law & disorder: The portrayal of mental illness in U.S. crime dramas. *Journal of Broadcasting & Electronic Media*, 59(4), 640–657. <https://doi.org/10.1080/08838151.2015.1093486>
- Rissmiller, D. J., & Rissmiller, J. H. (2006). Evolution of the antipsychiatry movement into mental health consumerism. *Psychiatric Services*, 57(6), 863–866. <https://doi.org/10.1176/appi.ps.57.6.863>
- Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.
- Sonuga-Barke, E. J. S., Brandeis, D., Cortese, S., Daley, D., Ferrin, M., Holtmann, M., Sergeant, J. (2013). Nonpharmacological interventions for ADHD: systematic review and meta-analyses of randomized controlled trials of dietary and psychological treatments. *The American Journal of Psychiatry*, 170(3), 275–289.

- Taylor, N. M., & Johnson, E. (2013). The cost of mental illness. In T. G. Plante (Ed.), *Abnormal psychology across the ages*, Vol. 1: History and conceptualizations, Vol. 2: Disorders and treatments, Vol. 3: Trends and future directions. (pp. 179–197). Santa Barbara, CA, US: Praeger/ABC-CLIO.
- van Apeldoorn, F. J., van Hout, W. J. P. J., Mersch, P. P. A., Huisman, M., Slaap, B. R., Hale, W. W., den Boer, J. A. (2008). Is a combined therapy more effective than either CBT or SSRI alone? Results of a multicenter trial on panic disorder with or without agoraphobia. *Acta Psychiatrica Scandinavica*, 117(4), 260–270.  
<https://doi.org/10.1111/j.1600-0447.2008.01157.x>
- Vogel, D. L., Armstrong, P. I., Pei-Chun Tsai, Wade, N. G., Hammer, J. H., Holtham, E., Topkaya. (2013). Cross-cultural validity of the Self-Stigma of Seeking Help (SSOSH) Scale: Examination across six nations. *Journal of Counseling Psychology*, 60(2).
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, 53(3), 325–337.  
<https://doi.org/10.1037/0022-0167.53.3.325>
- Yanos, P. T., Lucksted, A., Drapalski, A. L., Roe, D., & Lysaker, P. (2014). Interventions targeting mental health self-stigma: A review and comparison. *Psychiatric Rehabilitation Journal*. <https://doi.org/10.1037/prj0000100>

Table 1

*Respondent Demographic Characteristics*

		N	%
Sex	Male	88	21.0
	Female	321	76.4
	Prefer not to say	3	0.7
	Other	8	1.9
Race	White/White American	340	81.0
	Black/African American	6	1.4
	Latino/Hispanic/Latinx	18	4.3
	Native Hawaiian/Pacific Islander	2	0.5
	Asian/Asian American	6	1.4
	Other	45	10.7
	No response provided	3	0.7

Table 2

<i>Respondent Relationship with MI and Treatment Prior to Listening to the MIHH</i>				
Prior to listening:		Yes	No	% Yes
PL1	...were you aware of anyone close to you (not yourself) living with MI?	420	0	100
PL2	...were you aware of anyone close to you (not yourself) receiving treatment for MI?	332	88	79
PL3	...were you aware that you personally were living with MI?	344	76	81.9
PL4	...were you personally in treatment for MI?	261	19	62.1
PL5	...did you ever feel as though you needed help but didn't seek it?	343	76	81.9

Table 3

*Average Response to the Impact of Listening Behavior (ILB) Items*

Do you feel/believe that listening to the MIHH has:		Average	SD	N/A
ILB1	...made you feel more positively about others with mental illnesses?	1.50	0.73	7
ILB2	...made you feel more positively about your own mental illness?	1.55	0.77	16
ILB3	...made you feel more positively about others pursuing talk therapy for mental illness	1.44	0.78	10
ILB4	...made you feel more positively about pursuing your own talk therapy for mental illness?	1.59	0.85	23
ILB5	...made you feel more positively about others use of prescription medication to treat mental illness?	1.78	0.93	10
ILB6	...made you feel more positively about personally using prescription medication to treat mental illness?	1.98	1.06	40

*Note.* Responses were based on a Likert-Style scale: Strongly Agree (1); Agree and Disagree Equally (3); Disagree Equally (5)

Table 4

*Average Response to the Self-Stigma of Seeking Help (SSOSH) Scale Items*

When thinking about your current feelings:		Average	SD
SSOSH1	My self-confidence would NOT be threatened if I sought professional help	1.53	0.92
SSOSH2	I would feel worse about myself if I could not solve my own problems*	3.42	1.28

*Note.* Responses were based on a Likert-Style scale: Strongly Agree (1); Agree and Disagree Equally (3); Strongly Disagree (5)

\*Item subject to reverse scoring

Table 5

*Correlational Analysis Between Listener Attitudes and two Measures of Listening Behavior*

	ILB1	ILB2	ILB3	ILB4	ILB5	ILB6	SSOSH1	SSOSH2
Listening Duration (LD)	-.12*	-.09	-.09	-.07	-.10*	-.18**	-.15**	.12*
Number of Episodes in the Past Year (EPY)	-.11*	-.02	-.09	-.06	-.08	-.02	.02	.04

*Note.* \* $p < .05$ ; \*\* $p < .005$

## Appendix A

**Informed Consent****The Impact of Podcast Listening Behavior on Treatment Seeking Attitudes and Behaviors: An Exploratory Study.****Introduction**

I am asking for you to take part in a research study. This is a study exploring the influence of the **Mental Illness Happy Hour (MIHH) podcast on listeners**. You were selected to take part in the study because you are a listener of the MIHH.

**What will I be asked to do?**

If you agree to participate in this study, you will fill out a **brief survey** that should take about 10-15 minutes to complete. All participants will begin with a few basic demographic questions, followed by **a series of questions** about their MIHH podcast listening behavior. All participation will be completed online from your personal smartphone, tablet, or computer.

**What are the risks involved if I participate in this study?**

The risks associated with this study are minimal. You might feel some discomfort when answering questions about mental illness.

**What are the possible benefits if I participate in this study?**

You will not benefit directly from the study. This study may benefit society in that it aims to identify resources that fall outside of the more traditional mental health service provision systems.

**Do I have to participate?**

No. Your participation is voluntary. You may decide not to participate and can stop at any time. You can continue to listen to the Mental Illness Happy Hour whether or not you participate.

**Will I be compensated?**

There is no individual compensation available for participation. You may enter into a drawing for one of two \$25 [amazon.com](https://www.amazon.com) gift cards.

**Who will know about my participation in this research study?**

This study is **confidential** and the records of this study will be kept private. The study is designed to be completely confidential. No data collected will allow anyone to connect you to your responses. Research records will be stored securely and only the researcher (Sam Nathan)

will have access to the records. Information for the gift card drawing (name and email address) will be collected separately from your survey responses by clicking a link to the entry at the conclusion of the survey. It will be a separate website and entry form, and there will be no way to connect that information to your survey responses.

**Whom do I contact with questions about the research?**

If you have questions about this study, you may contact Samuel Nathan by e-mail at XXXXXX or his dissertation adviser, Dr. James Fauth, at 603-283-2178 or by e-mail at [jfauth@antioch.edu](mailto:jfauth@antioch.edu).

**Whom do I contact about my rights as a research participant?**

The Institutional Review Board at Antioch University New England has reviewed this research study. If you have any questions about your rights as a research participant, you may contact Kevin Lyness, Chair of the Antioch University New England Institutional Review Board at [klyness@antioch.edu](mailto:klyness@antioch.edu) (603-283-2101) or Melinda Treadwell, Provost at [mtreadwell@antioch.edu](mailto:mtreadwell@antioch.edu) (603-283-2444).

**Agreement to Participate**

By checking the box below, you are consenting to participate in the study. **Please do not complete the survey if you do not wish to participate in this study.**

- I am 18 years or older. I consent and agree to participate
  
- I do not consent

## Appendix B

**Impact of Listening Behavior****Demographics**

1. Age: \_\_\_\_\_

2. Sex:

 Male Female Intersex Prefer Not to Say Not Listed: \_\_\_\_\_

3. Race:

 American Indian/Alaska Native Asian/Asian American Black/African-American Latino/Hispanic/Latinx Native Hawaiian/Pacific Islander White/White American Other (please specify): \_\_\_\_\_**Recall Questions**

For the purposes of this survey:

MIHH = Mental Illness Happy Hour Podcast

MI = Mental Illness

4. Approximately how long ago did you start listening to the MIHH?: \_\_\_\_\_

5. Briefly describe how you discovered the MIHH?: \_\_\_\_\_



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4	made you feel more positively about pursuing <b>your own</b> talk therapy for MI?	<input type="checkbox"/>					
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5	made you feel more positively about <b>others</b> use of prescription medication to treat MI?	<input type="checkbox"/>					
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6	made you feel more positively about <b>personally</b> using prescription medication to treat mental illness?	<input type="checkbox"/>					
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		Strongly agree		Agree and Disagree Equally		Strongly Disagree
		1	2	3	4	5

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1	My self-confidence would NOT be threatened if I sought professional help	<input type="checkbox"/>				
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2	I would feel worse about myself if I could not solve my own problems	<input type="checkbox"/>				
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