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Mental illness stigma and engagement in an implementation trial for Cognitive Processing Therapy at a diverse community health center: a qualitative investigation

Sarah E. Valentine^{a,b}, Louise Dixon^a, Christina P. C. Borba^{a,b}, Derri L. Shtasel^{a,b}, and Luana Marques^{a,b}

^aMassachusetts General Hospital, Boston, MA

^bHarvard Medical School, Boston, MA

Abstract

The present study aimed to describe associations between various types of mental health stigma and help-seeking behaviors among ethnically diverse clients with posttraumatic stress disorder (PTSD) served by an urban community health clinic. The present study draws qualitative data from a parent National Institute of Mental Health Study that aims to identify barriers and facilitators of implementing Cognitive Processing Therapy (CPT) for PTSD. A total of 24 participants from the initial phase of the trial were included in the present study. Mental health stigma emerged as one notable barrier to seeking mental health treatment, as participants described how experiences of environment-level stigma, internalized (self-)stigma and perceived (felt) stigma from their family, friends and previous healthcare providers influenced their decisions to seek care. Despite these barriers to help seeking, many clients also reported that positive interactions with informal and formal support systems, and encouragement from study therapists, helped to combat mental health stigma and facilitate decisions to participate in an implementation trial for CPT. Findings suggest that providers in community health settings may need to attend directly to stigma at the initiation of mental health treatment.

CONTACT Sarah E. Valentine sevalentine@mgh.harvard.edu.

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No potential conflict of interest was reported by the authors.

Notes on contributors

Sarah E. Valentine, PhD is a Research and Clinical Fellow at the Community Psychiatry Program for Research in Implementation and Dissemination of Evidence-Based Treatments, Department of Psychiatry, Massachusetts General Hospital, and Clinical fellow in Psychology at Harvard Medical School.

Louise Dixon is a clinical research coordinator at Community Psychiatry Program for Research in Implementation and Dissemination of Evidence-Based Treatments, Department of Psychiatry, Massachusetts General Hospital.

Christina P. C. Borba, PhD, MPH is Director of Research for The Chester M. Pierce, MD Division of Global Psychiatry at the Massachusetts General Hospital (MGH). She is an Assistant in Psychology (Psychiatry) at Harvard Medical School and an Assistant in Research at MGH.

Derri L. Shtasel, MD, MPH is the Director of the Division of Public and Community Psychiatry at Massachusetts General Hospital and the Executive Director of the Kraft Family National Center for Leadership and Training in Community Health.

Luana Marques, PhD is the Director of the Community Psychiatry Program for Research in Implementation and Dissemination of Evidence-Based Treatments. She is Assistant Professor in the Department of Psychiatry at Massachusetts General Hospital/Harvard Medical School.

Keywords

Stigma; mental health; literacy; trauma; community

Introduction

In recent years, mental health stigma has emerged as a consistent barrier to mental health treatment-seeking, and this barrier is even more pronounced among ethnic and racial minority groups (for a review, see Livingston & Boyd, 2010). Stigma can exist at both environment (i.e., community, cultural, societal) and individual (internalized/self-stigma) levels, and some researchers have further delineated individual-level stigma as *felt* versus *self*-stigma (Herek, Gillis, & Cogan, 2009). Herek et al. (2009) define *felt* stigma as the client's awareness of how others negatively perceive the condition the client has (e.g., mental illness) or group that the client belongs to (e.g., race, ethnicity, socioeconomic status), whereas *self*-stigma is the extent to which the client accepts or internalizes these negative beliefs about the client's condition or group membership. One robust finding from a recent meta-analysis (Livingston & Boyd, 2010) revealed that, across 127 studies, internalized mental health stigma was related to higher mental illness severity, lower adherence and higher dropout from mental health treatment.

Further, higher reported mental health stigma among racial and ethnic minorities has been posited as one explanatory factor for higher symptom severity and lower completion rates among racial and ethnic minority clients (relative to non-Latino White clients) enrolled in clinical trials for evidence-based treatments (EBTs). This presumption comes from previous studies that have found that racial and ethnic minority clients are more likely to experience diagnosis-related stigma in healthcare settings (Roeloffs et al., 2003), and that stigma is associated with higher dropout rates (Pecoraro et al., 2013). Consistent with these findings, a clinical trial of Cognitive Processing Therapy (CPT) (CPT: Resick & Schnicke, 1992) for women with post-traumatic stress disorder (PTSD) found that Black women were significantly less likely than White women to complete the 12-week EBT (Lester, Artz, Resick, & Young-Xu, 2010). Further, Black women who completed this trial did not experience significant reductions in PTSD symptom severity (Lester et al., 2010). Ethnic or racial minority identity has also been established as a predictor of dropout among outpatient groups diagnosed with depression (Arnow et al., 2007). As such, reducing diagnosis-related stigma among minority clients may increase treatment adherence and retention in care, leading to positive health outcomes (Reece, 2003).

Racial and ethnic minority clients, low-income clients and clients with low educational attainment often endorse stigma associated with seeking professional help for mental health problems – termed, help-seeking stigma (Clement et al., 2015; Kovandžić et al., 2011). A recent meta-analysis (Clement et al., 2015) revealed that mental health stigma was the fourth highest barrier to help-seeking, with various studies demonstrating that racial and ethnic minority participants (i.e., Latinos, Asian-Americans, Black/African-Americans) endorse more negative attitudes toward seeking professional mental health services compared to non-Latino White participants (Hines-Martin, Usui, Kim, & Furr, 2004; Rao, Feinglass, &

Corrigan, 2007). Further, individuals from low-income backgrounds report higher levels of help-seeking stigma compared to individuals with a higher income. In particular, men from low-income households were most likely to report poor acceptability of professional treatment (e.g., ‘I preferred to self-manage’: Shlaunwhite, 2015). In addition, low-income clients or clients with lower educational attainment are more likely to endorse stigmatizing beliefs about mental illness and less likely to seek mental health treatment (Thoits, 2005). Together, these studies suggest that help-seeking stigma may be high in community health centers, where a majority of racial and ethnic minority and low-income clients receive their care.

Previous studies have highlighted how mental health stigma stems from stereotypical beliefs about mental health (Jorm, 2000). One large quantitative study ($N = 1,437$) examined relations between perceived non-recovery from mental illness, perceived level of social distance from people living with mental illness, and mental health stigma (Barczyk, 2014). Structural equation modeling of this large sample revealed that individuals who reported belief in recovery from mental illness were less likely to endorse stigmatizing beliefs. In finer detail, Barczyk (2014) found that men, ethnic and racial minorities, and individuals with less education were significantly less likely to report social contact with individuals with mental illness; these same groups were also more likely to report pessimistic attitudes toward recovery from mental illness.

Given the importance of this line of inquiry, further research is needed to better understand how attitudes toward mental illness, mental health stigma and mental health beliefs (i.e., beliefs about treatment, recovery process, etiology of mental illness) affect help-seeking behaviors within community health settings. Qualitative investigation is needed to provide an in-depth understanding of how these beliefs, perceived attitudes and experiences influence decisions about mental health treatment. Further, qualitative methods are able to capture the richness of the relations between constructs of interest as well as the importance of reporting on participant’s lived experiences in their own words. In the current study, we aim, first, to describe various types of mental health stigma (i.e., environment-versus individual-level) experienced by community mental health clients with PTSD diagnosis. Second, we aim to better understand how mental health stigma contributes to engagement in formal mental health treatment. A better understanding of relations between mental health stigma and clients’ decisions to engagement in mental health treatment (in general) and CPT (specifically) may help clinicians and implementation scientists to identify and mitigate barriers to treatment. As such, the present study focuses narrowly on the contribution of mental health stigma as one potential implementation barrier for community health clients enrolled in a parent study – an implementation trial for CPT for PTSD (Resick et al., 2008; Resick & Schnicke, 1992). Data are derived from semi-structured interviews on barriers and facilitators to the decision to engage in PTSD treatment (i.e., implementation trial for CPT).

Methods

The present study examined data gathered through qualitative interviews with participants in a National Institute of Mental Health-funded study. We report on qualitative findings from

client pre-treatment interviews that were gathered during the pre-implementation phase of the parent trial. The hospital Institutional Review Board approved all study procedures.

Participants and procedures

Study participants were recruited from a community health center in an impoverished community where nearly two-thirds of residents identified as Latinos, primarily of Salvadoran, Puerto Rican or Honduran descent (US Census Bureau, 2010). Clients with a PTSD diagnosis (per medical record or clinician judgment) and a score above the clinical cutoff (> 35 ; Wilkins, Lang, & Norman, 2011) on a standard self-report measure of PTSD symptoms (PTSD Checklist-Specific Version: Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) were eligible to participate in the CPT implementation study (Resick et al., 2008). Potentially eligible clients were recruited by study site providers and referred to the bilingual (English and Spanish) clinical research coordinator to complete an informed consent. At the time of informed consent, the clinical research coordinator also asked clients if they were willing to participate in a brief audio-recorded interview prior to starting Session 1 of CPT. Of the 40 clients enrolled in this phase of the implementation trial, two clients declined the interview due to discomfort with audio-recording and 14 clients were unable to take part in the interview due to time constraints (i.e., to reduce participant burden, the informed consent and interview were often scheduled immediately prior to Session 1), yielding an analytic sample of 24. Participants were remunerated with \$85 for participation in the implementation trial, including the pre-treatment interview.

The research team consisted of the principal investigator, one postdoctoral fellow, one clinical research coordinator, and a team of four undergraduate research assistants. Four members of the research team were fluent in Spanish.

Interview guide development

The semi-structured interview guide was developed by research staff in consultation with leaders in the field of implementation science and a national trainer for CPT. Specifically, the development of interview questions was guided by: (1) the narrative inquiry approach to qualitative data collection (Chase, 2005) with the goal of understanding participant's lived experiences; and (2) qualitative procedures for implementation research described by Green and colleagues (2015), whereby interview questions are specifically designed to elicit responses that describe potential barriers, facilitators, and predictors of implementation. Implementation barriers relevant to this study include attitudes about: (1) mental health diagnosis and treatment, (2) seeking mental health treatment and (3) knowledge about mental health diagnoses. Study clinicians assisted in the development and refinement of questions. The final interview guide was approved by research staff, study clinicians and experts in implementation science and CPT. Interview questions broadly assessed for potential barriers and facilitators to engagement in mental health treatment (generally) and to participation in CPT for PTSD (specifically). The semi-structured interviews facilitated discussion of a wide variety of factors affecting client care experiences. Sample interview questions include: How do you define trauma/PTSD? What do you think are common beliefs that people hold about trauma/PTSD? How do your friends and family react when you talk about your trauma/PTSD? Is there something in your life that makes it difficult for

you to seek mental health treatment? Does your family know that you are receiving mental health treatment? What do they think about it? Although language used in the interview did not specifically use the term ‘mental health stigma’, references to stigma emerged in the participants’ responses to questions about clients’ views about mental health, their family and friends’ opinions about mental health and treatment and their knowledge of mental health disorders and treatment.

Data collection, transcription and coding

All qualitative interviews ($N=24$) were digitally recorded and transcribed verbatim by members of the study staff. The software NVIVO 10 was used for data management (QSR International, 2014). Qualitative analysis was guided by the method of conventional content analysis outlined by Hsieh and Shannon (2005). Two undergraduate research assistants coded the data after sufficient training in qualitative coding procedures from senior study staff. The coding process was closely supervised by senior study staff (i.e., one doctoral-level behavioral scientist and two doctoral-level clinical psychologists) to assure adherence to coding procedures. Coders independently reviewed 10 client inter-views to generate initial codes and themes for the codebook. The research team met on a weekly basis to generate and organize emergent themes from the data. Codebook development proceeded in an iterative process until theoretical saturation was reached (i.e., after eight transcripts). After generating an initial codebook, coders reviewed a subset of transcripts and met weekly to address coding discrepancies through the process of consensus. In some cases, solutions to coding discrepancies led to minor changes in the codebook or to coding procedures. The codebook was then finalized, and all transcripts were re-coded in accordance with the final codebook. All data were double-coded, resulting in sufficient overall inter-coder reliability; 82% of codes pertaining to the aims of this study were agreed upon between coders.

Results

Full sample demographics are presented in Table 1. Our sample consisted of 24 participants, of whom 16 (66.7%) identified as Latino, 7 (29.1%) as non-Latino White and 1 (4.2%) as non-Latino bi-racial (Black/African American and White). The majority of participants reported their annual incomes below the state poverty line (i.e., < US\$11,670/per year for a family of 1: Federal Poverty Guidelines, 2014). The coding process revealed mental health stigma and references to help-seeking in 22 of the 24 transcripts, yielding 84 coded segments. Frequencies of each code (out of total coded segments) are noted in Tables 2 and 3.

Environment-level stigma

Participants described mental health attitudes and beliefs held by their informal support networks, as well as beliefs that were held by the participant’s larger community (see Table 2). Although not all participants identified as racial or ethnic minorities, all of the clients resided in the same low-income urban community. Most participants noted the prevalence of stigmatizing beliefs about individuals with mental illness (in general) endorsed by their community and families. Some participants further described community-level perceptions that people with mental illness are violent or that mental illness is an explanation for violent

behavior (i.e., a person who commits violent acts must have ‘something wrong’ with them). Clients also described exposure to social distancing attitudes towards people with mental illness or believing that individuals with mental illness are ‘lazy’ or to blame for their suffering. A general sentiment that emerged from the data reflected fears (individual, family, community) that disclosures made during mental health treatment would have negative consequences on the family. For example, clients described fears that disclosure of familial abuse, sub-stance use or criminal behaviors might result in Department of Children and Families involvement, deportation or involvement with the legal system.

Individual-level felt stigma

In addition, some participants provided specific examples of stigmatizing beliefs endorsed by both informal and formal supports regarding the participant’s own mental health (see Table 2). Interview responses reflect that the size and strength of informal support networks varied greatly across clients participating in this study. For example, some clients expressed that they had little to no emotional support from their immediate social networks. Clients discussed the presence of stigmatizing attitudes endorsed by family or friends that were directed at the client, for example, one woman described how her family blamed her for *causing* her depression. Other participants described their family’s dismissing attitude toward seriousness of the client’s mental health symptoms, with a family member stating that her mental health symptoms are ‘all in your [her] head.’ As for formal supports, clients recalled a variety of positive and negative experiences with mental health providers at both the current study site and at other locations. Participants described the importance of these past experiences in shaping their beliefs about the healthcare system, prognosis of mental health problems and appropriate treatment for mental health problems; clients also stated that these encounters with formal support networks were just as crucial as encounters with informal support systems when making decisions about seeking mental health treatment.

Individual-level self stigma

Participants described the influence of two kinds of mental health self-stigma (see Table 3). Some participants endorsed (general) mental health stigma beliefs that paralleled beliefs endorsed by the participants’ informal supports; in addition, participants reflected on their own PTSD-specific mental health beliefs. Participants noted how their own internalized mental health stigma contributed to initial help-seeking as well as decisions around disclosure about treatment to their families. For example, some participants described actual or anticipated negative reactions to the participant’s help-seeking behaviors as reasons for not disclosing mental health symptoms or treatment to informal supports. For other participants, internalized mental health stigma delayed help seeking. Participants who experienced particular challenges in engaging their informal support networks reported that engagement with formal support (therapy) was helpful – and even preferred – suggesting that patient-provider relationship may provide a type of social support that is not readily available in these clients’ current social networks. Overall, participants in this sample reported negative attitudes towards psychotropic medications, and a few participants reported mistrust of the healthcare system.

Hopelessness about mental health treatment

Some clients described hopelessness associated with having mental health problems, and endorsed believing that their conditions could never improve. Some participants described internalized beliefs in non-recovery that mirrored beliefs endorsed by informal (and sometimes formal) supports. Other participants reported pessimism about recovery due to their own experiences with previous types of mental health treatment.

Non-disclosure of treatment

Confounding the perceived lack of social support endorsed by clients was the fact that many clients chose not to disclose that they were in treatment to their immediate informal support networks. Some clients endorsed fearing that engagement in therapy might damage relationships with family and friends, or that engaging in therapy would require unwanted disclosure of traumatic experiences. This may be particularly true for clients seeking treatment for PTSD symptoms related to interpersonal trauma, as engaging in this type of therapy may necessitate disclosure of abuse as well as perpetrators (who may be family members). One woman described her initial reluctance to seek treatment for depression due to mental health stigma endorsed by her informal support network – she reflected on differences in her mother’s ‘Central American’ beliefs versus her own ‘American’ beliefs about mental illness. This woman noted that internally accepting and reconciling generational differences in mental health beliefs, some of which were heavily influenced by acculturation, allowed her to finally reach out for formal support.

PTSD literacy

Overall, we observed that challenges in participants’ ability to organize their internal experiences and responses to trauma were limited by their lack of prior psychoeducation or exposure to PTSD as a mental health diagnosis, including an observed lack of awareness that PTSD is a common mental health problem that can result from exposure to community violence. Many participants were unable to describe symptoms associated with their index trauma, including diagnosis of PTSD. Several clients reported that they had not heard of PTSD prior to the informed consent interview despite having this diagnosis listed on their medical record and receiving a referral for PTSD treatment from their therapist. Some clients also endorsed the belief that only ‘weak-minded’ people develop PTSD, implying that mental illness was a sign of personal failure or weakness.

Discussion

We have presented findings from qualitative interviews of community health center clients ($N=24$) prior to engagement in CPT for PTSD. These interviews revealed the nuanced and pervasive experience of mental health stigma in participants’ beliefs about mental illness (diagnosis and treatment) and help-seeking behaviors. Participants reported on various types of mental health stigma, which presented at the environment and individual level. Consistent with previous quantitative studies, participants described global beliefs that exist in their larger community context, such as the belief that individuals with mental illness are ‘crazy’ and display bizarre and disruptive behavior, and beliefs in non-recovery from mental illness (e.g., Barczyk, 2014). This finding is also consistent with previous descriptions mental

health beliefs among Latinos by Organista (2006), who theorizes that these beliefs about mental illness may originate from the shortage of mental health services in their home countries, as these services were reserved for *personas locas* who required institutionalization.

Our findings also revealed a knowledge gap among community mental health clients regarding the prevalence and course of mental illness, especially in regard to PTSD. As such, it is important that clinicians provide early psychoeducation on mental health disorders as well as the treatment process. This approach is embedded in cognitive-behavioral EBTs, which focus initially on role preparation (Howard, Kopta, Krause, & Orlinsky, 1986). During role preparation, clients receive guidance on what to expect over the course of therapy, including the core features of the patient-provider relationship. Setting clear expectations and providing a road map for clients may be particularly relevant for clients who endorse stigmatizing beliefs about mental illness, including non-recovery or the belief that individuals living with mental illness are to blame for their struggles. Given the consistency between our findings and the previous studies, special attention to normalizing mental health disorders (e.g., depression, anxiety, PTSD) and conveying optimism about the effectiveness of EBTs for treating these disorders may enhance engagement in care, although this has yet to be tested empirically. This may instill hope in recovery by challenging preconceived notions about the prevalence and course of mental illness.

The belief in non-recovery reported by participants may also stem from an external locus of control, whereby the individual is powerless to make changes in their own life (De Jesus & Xiao, 2014; Kouyoudjian, Zamboanga, & Hansen, 2003; Organista, 2006). Belief in an external locus of control runs counter to EBTs, which provide clients with skills necessary to affect change in their lives (i.e., internal locus of control). Accordingly, it may be helpful for providers to discuss the complexity of personal power and control over mental health outcomes. For example, a provider would help a client determine exactly which behaviors or thoughts the client has control over, even in the context of limited control over life circumstances – that is, a client does not have the power to change a personal history of discrimination and violence, but the client does have the power to not use alcohol to cope with distress. Helping clients gain a complex understanding of power and control in their lives fosters a sense of agency and lends optimism to clients who endorse pervasive hopelessness about recovery. Future research is warranted to examine the effect of empowerment (i.e., internal locus of control, sense of agency) on engagement in mental health treatment.

Not surprisingly, familial beliefs were central to participants' organization of beliefs about mental illness as well as their decisions to seek (or remain in) mental health treatment. Clients unilaterally discussed the role of family as central to help-seeking. This observed familial orientation is consistent with previous research on traditional Latino values, where a collective or family orientation is preferred over the individualistic orientation, mainstream American values (Goldston et al., 2008; Organista, 2006; Uebelacker et al., 2012). Our data are consistent with previous studies that promote the importance of exploring the role of family in the treatment process when treating clients who endorse a familial orientation (Rossello, Bernal, & Rivera-Medina, 2012; Uebelacker et al., 2012).

Our findings are also consistent with previous literature that has highlighted the insidious role of mental health stigma in decisions to seek treatment for mental illness, including previous studies that have documented this phenomenon among racial and ethnic minority (Kouyoumdjian et al., 2003) or other socially disadvantaged groups (i.e., low-income groups: Kouyoumdjian et al., 2003). We have taken care in our analyses to highlight the various sources of mental health stigma experienced by the participants in this community health setting. Although clinicians are often limited by the reach of their intervention tools, there are several ways that clinicians can directly combat stigma. Previous researchers have highlighted the utility of protesting negative mental health representations, providing education and having direct contact with clients as important ways to address stigma-related barriers to treatment (Corrigan, Morris, Michaels, Rafacz, & Rüsçh, 2012; Wahl, 1997). Specifically, Corrigan and colleagues (2012) found that engaging in various means of contact with the stigmatized group reduced stigma within the general population, with individual conversations proving the most effective type of contact. Corrigan and colleagues also describe ways of addressing environment-level stigma through broad educational tools (e.g., movies, videos, podcasts).

In the present study, we faced challenges in assessing for PTSD-related stigma, as the majority of participants were unaware that they had a documented diagnosis of PTSD in their medical record. Previous research asserts that the first step in reducing stigma is to increase mental health literacy through the psychoeducation of clients and communities (Kouyoumdjian et al., 2003; Organista, 2006). Increased awareness and visibility of PTSD in community settings may facilitate treatment seeking. Previous researchers with these aims have utilized mobile applications, brief interventions and *novelas* (stories) to educate a broad audience (Bender, Martinez, & Kennedy, 2015; Gonzalez, 1997; Ramos & Alegria, 2014).

Conversations about diagnosis and course of treatment, led by providers, may facilitate direct conversations about what it *means* to the individual client to receive such a diagnosis. Allowing time in session to talk about the meaning behind diagnosis (i.e., diagnosis as validating versus diagnosis as pathologizing) may help address stigma-related concerns at the initiation of treatment (Abbey et al., 2011; Corrigan, 2004; Larson & Corrigan, 2008; Link, Struening, Rahav, Phelan, & Nuttbrock, 1997; Wahl, 1999). Addressing stigma at the onset of treatment may be particularly important as clients who express felt stigma and beliefs about non-recovery, may drop out of treatment before these conversations can be had. Given that mental health providers are unlikely to be first points of contact for most clients seen in community health centers, primary care providers and other first-line staff play a crucial role in facilitating engagement in mental health treatment. Frank conversations about mental illness, including diagnosis, prognosis and course of treatment, may reduce stigma and increase the likelihood that clients follow through with referrals for mental health treatment. The effect of such efforts should be tested in future studies.

There are several limitations of the current study that should be noted. First, our results reflect the themes presented by clients in our sample, precluding broad generalization beyond this group. It is possible that findings would present differently in other samples, thus larger sample sizes are needed to further investigate these variables. In addition, we cannot speak to relations between stigma and retention in care – our data simply describe

perceptions of mental health diagnosis, course and treatment prior to trauma-focused therapy. It is also possible that mental health stigma may present differently across racial and ethnic minority groups, and across levels of acculturation for immigrant populations. Direct references to race and ethnicity-related stigma were notably lacking, thus it is possible that these experiences may be underreported in our study. This may be due to having an interviewer who was a non-Latino White, as previous research in this area supports the idea that racially or ethnically matched providers can serve to combat mistrust (Gonzalez, 1997; Sue & Zane, 2009). Future studies should seek to describe how mental health stigma differs across racial and ethnic minority groups, and how experiences of stigma related to racial and ethnic identity may be related to both mental health stigma and decisions to seek mental health treatment.

Further research is warranted to define stigma, and to quantify the effect of stigma on the treatment process. Doing so would move stigma from an ambiguous and amorphous construct to actionable treatment targets. While the extant literature often cites stigma as a barrier to care, especially for racial and ethnic minorities groups (Connor et al., 2010; Nadeem et al., 2007), few researchers have defined stigma in a way that can be directly addressed through current EBTs. That said, cognitive-behavioral experts on minority mental health would argue that basic tenets of their practice include validation of the client's experience and psychoeducation to reduce self-stigma (Ritsher & Phelan, 2004). Accordingly, providers attempting to implement EBTs may need to explicitly attend to the effect of stigma on engagement and adherence to treatment, and address stigma-related treatment-interfering behaviors (e.g., homework non-compliance, social withdrawal). Future research should also explore ways to involve client's informal supports, such as spouses or families, in the treatment process as this may serve to reduce felt stigma from the client's immediate social support network.

The majority of participants in this study reported longstanding relationships at least one provider at the clinic. Although some clients described initial hesitancy in seeking mental health treatment, they reported how encouragement from a trusted medical provider facilitated engagement in care. Given this feedback from clients, it may be possible that clients' global beliefs about 'the system' (i.e., medical institutions) are not unilaterally applied to all healthcare settings or providers. Several clients noted that their experience at the community health clinic was far 'warmer' than their experience of larger hospitals. These findings suggest that community health centers can leverage their accepted and trusted role in the community to reduce stigma and increase access to mental health care.

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Table 1

Client demographics (N = 24).

Age (years)	Range 18–63 N	M(SD) 40.57 (14.68) %
Language of interview		
English	18	75.0
Spanish	6	25.0
Gender		
Male	6	25.0
Female	18	75.0
Race/ethnicity		
Latino	16	66.7
Non-Latino, White	7	29.1
Non-Latino, bi-racial	1	4.2
If Latino, origin (N = 16)		
Cuban	2	8.3
Puerto Rican	5	20.8
South or Central American	9	37.5
Other	2	8.3
Marital status		
Single	7	29.2
Living with partner	4	16.7
Married	6	25.0
Divorced	4	16.7
Separated	2	8.3
Not given	1	4.2
Highest education level		
College graduate	3	12.5
Partial college	9	37.5
High school graduate	6	25.0
Partial high school	4	16.7
Junior high school	1	4.2
Not given	1	4.2
Annual income (US\$)		
0–4,999	6	25.0
5,000–9,999	6	25.0
10,000–14,999	0	0.0
15,000–24,999	1	4.2
25,000–34,999	1	4.2
35,000–49,999	4	16.7
50,000–74,999	2	8.3
Not given	4	16.7

Table 2

Themes and exemplar quotes related to environment-level and individual-level felt stigma.

Theme	Exemplar quotes <i>N (%)</i>
Environment-level	
People with mental illness are dangerous and should be avoided	5 (5.9%) Like if they hear something on the news about a guy doing – shooting someone. They don't think about, 'Oh, maybe he has a mental disorder or something like that.' You know, she's like, 'He's crazy.' That's the first thing they think, 'Oh he's crazy.' It has no – yeah, he needs to go to jail. There's no healing that person. There's no need to help him.... So there is a stigma.
People with mental illness are lazy or to blame for their own suffering	13 (15.5%) People use [depression] as an excuse or something like that. ...As far as treatment goes, oh people say you're depressed but you can just get over it.... That's what I was always hearing – basically I cause it [depression] for myself. If I'm depressed and I stay inside.
Fear that 'saying the wrong thing' to a mental health provider will have negative consequences for the family	6 (7.1%) Say the wrong thing to a person about your child and next thing you know you could lose them.
Individual-level felt stigma	
Informal supports	24 (28.6%) I don't speak to anybody and people don't understand my situation. They just think I'm just crazy and wild and nuts and they think it is fun and games and they don't understand that I'm having issues with that.
Formal supports	8 (9.5%) I've been getting treated here since I was a baby. It's comfortable. I don't like new places. ... Yeah, I'm familiar with [the system]; I know everybody here. I grew up here, so anywhere else would just be strange. I wanted to punch [the therapist] in his face. He was busy judging me instead of treating me.

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Table 3

Themes and exemplar quotes related to individual-level self stigma.

Theme	Exemplar quotes <i>N (%)</i>
Internalized mental health beliefs	
Hopelessness about mental health treatment.	6 (7.1%) Sometimes I just feel like, well not like giving up because I've been to therapy so much, but sometimes it doesn't help me I've just went and I felt like I tried and I just felt like they couldn't help me. Other people just kind of look at me like, you know, it's [therapy is] worthless. Like you're wasting your time, 'cause it's not going to help you.
Non-disclosure of treatment	10 (11.9%) I think the only thing [barrier to treatment] is my family. I think they'd feel offended if I came and got help like this. [My mother], even other people from her generation, they're like, 'Well that doesn't work. That's for the crazy people.' That's the first thing they will tell you – that's for the crazy people. So there is a lot of stigma, especially in Central America. They don't believe in it because they haven't grown up knowing about mental health.
Attitudes towards psychotropic medications	6 (7.1%) Too much treatment is how I feel. I feel like, um, sometimes doctors medicate people for no reason at all. You really honestly don't need it at all. People just feel like they have to live off that. I mean, there's always been comments saying like, you know, you don't need – people use that as an excuse or something like that. Like, or, you know, you don't need medication to....Like not to take meds because, I don't know, it makes you some type of way.
Formal supports can be less stigmatizing than informal supports	20 (23.8%) If I talk to my friends the way I do talk to my therapist, they would be like oh this bitch is crazy. You know like ... I don't want them to think I'm crazy, because I'm very kind, I'm very loyal, I'm very helpful, you know. They don't see that. They just see the person that is bad-ass. The person that is 100% there if they need me. Like if there was a fight, or if someone would get jumped or something, or they in trouble, I'm there 100%. Like, I won't hesitate to whoop ass, you know what I mean? And I don't want that. I want them to see the other side of me.
PTSD literacy	16 (19.0%) Well I think anyone can get [PTSD]. It just [depends on] ... how strong your mind is. I don't know a thing about [PTSD]. I have heard about it, but my mindset was that it only happened to soldiers. Not that I know of. I don't, again my own knowledge of [PTSD] is soldiers coming home with it. Um, I know that, uh, a war veteran can have PTSD due to the actions that happened in a war they were in or something.