Attitudes About Psychotherapy: A Qualitative Study of Introductory Psychology Students Who Have Never Been In Psychotherapy and the Influence of Attachment Style

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Abstract

**Design:** Interviews about attitudes about psychotherapy with 12 undergraduate students who had never been in psychotherapy were analysed using consensual qualitative research. **Results:** Participants believed that the client role is to disclose, be receptive, and be motivated; that the therapist role is to listen, support, and give advice; and that the therapeutic relationship should be close and personal. Participants had ideas about the benefits (a healing therapeutic relationship, personal and interpersonal changes) and the barriers (self-stigma and public stigma, difficulty revealing, need to solve problems on own, cost) associated with seeking therapy, and they disliked the idea of being diagnosed. In contrast with participants who were securely attached, those who were insecurely attached more often wanted a professional therapeutic relationship, wanted the therapist to ask questions, mentioned fewer benefits to therapy, and thought that they would have difficulty disclosing to a therapist. **Discussion:** Implications for changing attitudes about psychotherapy and improving training programs for practitioners are discussed.

Introduction

Despite research demonstrating the effectiveness of psychotherapy (Wampold, 2001), many individuals have negative perceptions of people who seek psychotherapy (Ben-Porath, 2002) and only seek psychotherapy after all other attempts (e.g. talking to family or friends) have failed (Hinson & Swanson, 1993). If we want to reach and help people who may be reluctant to seek mental health services, we need a deeper knowledge about attitudes concerning such services.

Attitudes toward seeking help

People with positive attitudes towards seeking help were more likely than people with negative attitudes to seek and perceive potential benefits from psychotherapy (Leech, 2007; Shaffer, Vogel, & Wei, 2006; Shechtman, Vogel, & Maman, 2010). In addition, attitudes towards therapy predicted openness to different aspects of therapy, such as expressing emotions (Vogel & Wester, 2003). Relatedly, stigma seems to be the most common barrier to seeking therapy (Corrigan, 2004). Both public stigma (i.e. the belief that anyone who seeks therapy is socially inferior or unacceptable; Deane & Chamberlain, 1994; Leaf, Bruce, & Tischler, 1986; Nelson & Barbaro, 1985) and self-stigma (internalized stigma; Vogel, Wade, & Haake, 2006) discourage people from seeking psychotherapy. Many individuals doubt the value of psychotherapy and question whether their problems are severe enough to merit psychotherapy (Snyder, Hill, & Derksen, 1972; Vogel & Wester, 2003; Vogel, Wester, Wei, & Boysen, 2005). Individuals also typically choose not to seek therapy when it was perceived as involving more risk or cost than benefits (Bayer & Peay, 1997; Tinsley, Brown, de St. Aubin, & Lucek, 1984; Vogel & Wester, 2003). Apprehension about interacting with a mental health professional, fears of potential judgment and coercion by a therapist, lack of awareness about what therapy entails, and negative attitudes about discussing painful emotions in therapy have also been cited as barriers (Deane & Todd, 1996; Komiya, Good, & Sherrod, 2000; Kushner & Sher, 1989).

In addition, attachment style has emerged as a moderator of attitudes, willingness, and intention to seek therapy (Diener & Monroe, 2011; Vogel & Wei, 2005). For example, Shaffer et al. (2006) found that individuals
who scored highly on attachment avoidance anticipated many risks and few benefits in seeking counselling, and thus had negative attitudes about and were less likely to seek help. Although individuals who scored highly on attachment anxiety similarly anticipated many risks, they also perceived many benefits from seeking therapy. The more benefits perceived by participants reporting an anxious attachment style, the more likely they were to have positive attitudes about therapy and intend to seek help.

Purpose of the present study
The first purpose of the present study was to explore attitudes towards therapy among undergraduate psychology students who had never been in therapy. We used this population because college is a time of great change, and students often benefit from talking with counsellors about these transitions. We thus explored beliefs about therapy, the sources of those beliefs, expectations and preferences about the role of clients and therapists in therapy, expectations and preferences about the ideal therapeutic relationship and managing conflict in therapy, perceived benefits of and barriers to seeking therapy, and the perceived effects of receiving a psychiatric diagnosis. The second purpose of the study was to examine how attitudes towards seeking therapy might vary based on attachment style. To gain a more complete understanding of this topic, we used consensual qualitative research (CQR; Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) because it provides a rigorous approach to collecting and analysing qualitative data.

Method
Participants
Interviewees
Interviewees were 12 (9 female, 3 male; 5 African American, 4 European American, 3 Asian American; 4 first year, 6 second year, 2 third year; all between 18 to 20 years of age) undergraduate students at a large United States public university. None had ever been in psychotherapy. This sample was representative of the introductory psychology population at the university in terms of gender and age but was more racially/ethnically diverse. Participants received research credit for an undergraduate psychology course.

Research team
The primary team involved six (all female; 4 European American, 1 African American, 1 Hispanic) seniors majoring in psychology at the same public university. They ranged in age from 21 to 34 years, and all planned to pursue graduate training in the helping professions. These students served as interviewers as well as judges. In addition, a 62-year-old European American female professor at the same university served as the principal investigator, a judge, and an internal auditor; a 49-year-old European American female associate professor from another university served as the external auditor.

Reflexivity
In terms of motivation for participating in this study, the six undergraduate students had voluntarily enrolled in an upper level honours class led by the professor on consensual qualitative research. The class consensually decided upon the topic for the study. In terms of biases, two students had been in therapy, had positive experiences, and came from families who believed in therapy; two students had been in therapy and had positive experiences but reported that their families had negative attitudes toward therapy; two had never been in therapy, reported that their families had negative attitudes toward therapy, and reported that they had neutral to negative attitudes about therapy. Both the professor and associate professor had been in therapy, been therapists, conducted research on therapy, and believed in the value of therapy. All researchers expressed great interest in the topic, talked at length about their biases, and expressed an ability to approach the topic with openness and curiosity, and seemed able to bracket (i.e. set aside) their biases and expectations throughout the research process.
Measures
The interview protocol was semi-structured (it contained 15 questions to be asked of all interviewees as well as allowing for probes to elicit additional information relevant to the individual interviewee). Research team members developed the interview by generating questions and then selected the best questions by consensus. The interview was revised based on several pilot interviews. The final protocol included questions about general feelings and beliefs about therapy, client and therapist roles, ideal therapeutic relationship, dealing with conflict in therapy, benefits and barriers regarding therapy, attitudes about diagnoses, and reactions to the interview (see Appendix for interview protocol).

Attachment styles were assessed using the 36-item self-report Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998), a widely-used self-report measure of attachment. Factor analyses revealed two scales: Anxiety (assesses fears of rejection and preoccupation with abandonment) and Avoidance (assesses fears of intimacy and discomfort with getting close to others), both with good psychometric properties.

Procedures

Ethical considerations
The Institutional Review Board at the University of Maryland approved the study. No adverse consequences occurred.

Interviewer training
The research team read and discussed Hill (2012) and three CQR articles. They then practiced interviewing in class, with the professor giving constructive feedback. Each student also practiced the interview with two volunteers.

Interviews
Interviewees were recruited from introductory psychology classes (out of a possible 867 students in these classes during one semester) for a study entitled ‘Attitudes about Help-Seeking’ using an online sign-up system. Students were required to participate in research but had many options of studies in which to participate. To participate in this study, students had to be between 18 and 21 years of age and never have been a client in psychotherapy. When they arrived for the study, participants read and signed the informed consent and then completed the ECR. Interviewers then defined psychotherapy as ‘one individual seeking help for personal-emotional problems from another individual trained in providing help’ and identified the purpose of the interview as gathering information about participant’s attitudes about help-seeking. Next, interviewers asked each question on the interview protocol, restated (e.g. ‘It seems that you’re saying...’), and probed (e.g. ‘Tell me more about that’) to gain in-depth information. A total of 14 interviews were conducted, but two were not used because the interviewees had been in therapy. The interviews were about 60 minutes, and all were audiotaped. The professor monitored all interviews to ensure that interviewers established rapport, elicited in-depth information from the interviewees, and did not impose their biases and expectations on interviewees.

Data analyses
Interviewers transcribed interviews verbatim (except for minimal responses such as ‘mhmhm,’ ‘you know,’ and ‘like’), including nonverbal behaviours (e.g. sighs, laughter, pauses) to provide context. All names and locations were deleted to preserve anonymity. Once transcripts were completed, tapes were erased, and code numbers were used.

Research team members independently reviewed three transcripts to identify possible domains (i.e. topic areas). Although they kept the interview questions in mind, they approached the interview data with a fresh perspective to determine if new domains emerged. They then discussed and reached a domain list by
consensus. They read through another three transcripts and decided consensually on the domain for each segment of the transcript (a phrase or several paragraphs about the same topic). They revised the domain list throughout this process until a stable list emerged (i.e. no changes emerged when new transcripts were coded). The whole group assigned domains for eight transcripts; the remaining four transcripts were assigned domains by subgroups of two students.

The team constructed core ideas (i.e. summaries of what participants said in clearer and more concise terms) by summarizing ideas within domains within cases. Core ideas were constructed for the first case by the whole team to ensure that everyone approached this task similarly; core ideas were constructed for the remainder of the cases by rotating teams of two judges, with the professor auditing all cases. Consensus versions (i.e. core ideas within domains) of each case were sent to the external auditor for review and revised by consensus using her feedback.

All core ideas were amassed into a table. Team members independently read through the core ideas to identify themes and then met to consensually construct categories and subcategories for each domain. Meeting in small groups, they then coded each core idea into these categories and subcategories. These cross-analyses were reviewed by all members of the team, revised, sent to the external auditor, and revised based on her feedback.

Results

Based on recommendations for CQR (Hill, 2012), categories for the total sample of 12 participants were considered general if they applied to 11 or 12 cases, typical if they applied to 7–10 cases, and variant if they applied to 2–6 cases. Categories applying to only one case were excluded. 1 shows the general, typical, and variant results for the total sample, although only general and typical results are presented in the text. 1 also shows the results for a subsample of four participants who scored high in both anxiety and avoidant attachment (considered insecurely attached) and a subsample of four participants who scored low in both anxiety and avoidant attachment (considered securely attached).

Table 1. Table I. Domains/categories of attitudes about psychotherapy for the total sample and for subgroups based on attachment styles.

<table>
<thead>
<tr>
<th>Domain/category</th>
<th>Total sample</th>
<th>Insecure (n=4)</th>
<th>Secure (n=4)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beliefs and attitudes about seeking help</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circumstances when would seek therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosable problems</td>
<td>G (12)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Problems in living</td>
<td>T (10)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>V (6)</td>
<td>T (3)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Prevention</td>
<td>V (3)</td>
<td>– (1)</td>
<td>V (2)</td>
</tr>
<tr>
<td><strong>Value of therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive value</td>
<td>G (12)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Negative value/Ambivalent</td>
<td>V (5)</td>
<td>V (2)</td>
<td>V (2)</td>
</tr>
<tr>
<td><strong>Source of beliefs about therapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family, friends, culture</td>
<td>G (11)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Media</td>
<td>T (9)</td>
<td>T (3)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Personal experiences/interests</td>
<td>T (7)</td>
<td>– (1)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Classroom</td>
<td>V (5)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
<tr>
<td><strong>Beliefs about therapy process</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client role in therapy</td>
<td></td>
<td></td>
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<tr>
<td>Therapist role in therapy</td>
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<tr>
<td>---------------------------</td>
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</tr>
<tr>
<td>Be active</td>
<td>G (12)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Provide good relationship</td>
<td>G (11)</td>
<td>G (4)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Be helpful</td>
<td>T (9)</td>
<td>V (2)</td>
<td>T (3)</td>
</tr>
<tr>
<td>Listen</td>
<td>T (8)</td>
<td>V (2)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Ask questions</td>
<td>V (6)</td>
<td>T (3)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Know/understand client deeply</td>
<td>V (6)</td>
<td>– (1)</td>
<td>T (3)</td>
</tr>
<tr>
<td>Respect client boundaries/autonomy</td>
<td>V (4)</td>
<td>V (2)</td>
<td>– (0)</td>
</tr>
<tr>
<td>Give insight/new perspective</td>
<td>V (4)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Be self-aware/not let personal issues interfere</td>
<td>V (3)</td>
<td>– (0)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Self-disclose</td>
<td>V (2)</td>
<td>– (1)</td>
<td>– (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ideal therapeutic relationship</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Close relationship</td>
<td>T (10)</td>
<td>T (3)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Professional relationship</td>
<td>V (6)</td>
<td>T (3)</td>
<td>– (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dealing with conflict in therapy</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Discuss with therapist</td>
<td>T (8)</td>
<td>V (2)</td>
<td>T (3)</td>
</tr>
<tr>
<td>Terminate without trying to resolve</td>
<td>V (5)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Terminate after trying to resolve</td>
<td>V (4)</td>
<td>– (1)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Do not discuss with therapist</td>
<td>V (4)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits and barriers</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Benefits related to the process of therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone to talk to</td>
<td>T (8)</td>
<td>T (3)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Supportive, caring relationship</td>
<td>V (6)</td>
<td>– (1)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Advice or help with problems</td>
<td>V (5)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Help seeing things in a new way</td>
<td>V (3)</td>
<td>– (1)</td>
<td>– (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits related to the outcome of therapy</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel better about self</td>
<td>T (9)</td>
<td>V (2)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Improved functioning</td>
<td>T (7)</td>
<td>– (1)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Reduced symptomatology</td>
<td>V (4)</td>
<td>– (0)</td>
<td>T (3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Barriers to seeking therapy</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Public stigma/shame</td>
<td>T (9)</td>
<td>V (2)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Difficulty disclosing/trusting therapist</td>
<td>T (8)</td>
<td>G (4)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Cost</td>
<td>T (7)</td>
<td>V (2)</td>
<td>T (3)</td>
</tr>
<tr>
<td>Negative self-perception/self-stigma</td>
<td>T (7)</td>
<td>– (1)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Need to be strong/self-sufficient</td>
<td>T (7)</td>
<td>V (2)</td>
<td>V (2)</td>
</tr>
<tr>
<td>Difficulty admitting problems</td>
<td>V (6)</td>
<td>T (3)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Lack of access</td>
<td>V (3)</td>
<td>– (1)</td>
<td>– (1)</td>
</tr>
<tr>
<td>Racial/cultural deterrents</td>
<td>V (3)</td>
<td>– (1)</td>
<td>V (2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likely feelings if given a psychiatric diagnosis/label</th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Negative self-perception/self-stigma</td>
<td>G (11)</td>
<td>T (3)</td>
<td>G (4)</td>
</tr>
<tr>
<td>Work to overcome diagnosis</td>
<td>T (8)</td>
<td>V (2)</td>
<td>T (3)</td>
</tr>
<tr>
<td>Relieved to have an explanation</td>
<td>V (5)</td>
<td>V (2)</td>
<td>– (1)</td>
</tr>
</tbody>
</table>
Public stigma

<table>
<thead>
<tr>
<th></th>
<th>V (3)</th>
<th>− (0)</th>
<th>V (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry at therapist</td>
<td>V (2)</td>
<td>− (1)</td>
<td>− (1)</td>
</tr>
</tbody>
</table>

Note. N for total sample = 12, for subsamples = 4. G = general (11–12 of total, 4 of subsamples), T = typical (7–10 of total, 3 of subsamples), variant (2 of total, 2 of subsamples).

Total sample

Beliefs and attitudes about seeking help
Participants talked about circumstances that would lead them or others to seek therapy. They generally indicated that serious, diagnosable issues warrant therapy (e.g. ‘being depressed;’ ‘being anorexic;’ ‘If you think, you get angry often, or feel like, afraid to drive, or if you think you are addicted to something’). They also, however, typically thought that less serious problems in living also merited psychotherapy (e.g. ‘If someone has a problem not necessarily ... might not be serious, but it's an issue ... if you can't concentrate on for example studying if you have problems on just focusing you might seek therapy, but that's like not a mental disease but you can seek therapy for that.’). Regarding attitudes about therapy, participants generally said positive things (e.g. ‘I think it's mostly a good thing,’ ‘I think it's really helpful. I would go if I needed it.’).

Source of beliefs and attitudes about psychotherapy
Participants generally indicated that friends, family, and culture influenced their attitudes toward psychotherapy. Sometimes the influence was positive, for example:

One person who had gone through the therapy after she had been raped and I guess she kind of made me think differently about it because she was really, she didn't want to go because she, usually people say ‘I don't need therapy, I'm fine.’ She actually went to one session and she kept going back because she said it was a good release for her. So I guess that changed my belief about therapy.

Sometimes, however, the influence was negative. For example, one person said:

Growing up, I didn't have that guidance counsellor in my school. So to me, that idea of therapy was negative ... maybe that not having been exposed to it as much has also not made me that much warm and welcoming to it.

Participants also typically said that they were influenced by media. Again, some portrayals of psychotherapy were positive, for example:

But later on the media watching TV, my little guilty pleasure is the soap opera The Bold and the Beautiful, I don't know if you've heard of it. There's this psychologist there, she's a therapist, and I watched how sometimes she helps people. There was this woman who was going through a lot and she ended up having her child taken away and given to a foster home in that instance. So seeing that, my ideas changed somewhat. It's not that bad. Sometimes you do need to take that time away to get things back on track.

Some of the portrayals, however, were negative. For example:

The movies, maybe someone might see a schizophrenic person depicted as Dr. Jekyll and Mr. Hyde, like the complete other side of the spectrum, that's how they might see it, and then they associate that with therapy and like I'm not crazy I don't need to be there.

Finally, participants typically developed beliefs from personal experiences or interests in helping. One person said:
Maybe it's 'cause I like to help people. And even in high school, middle school, there's a little conflict between your friends, I'd be the one trying to fix it and stuff like that. So I guess it's something I enjoy and something I was good at maybe, and I just had an interest in it, so I wanted to pursue it.

Another said:

So many of my friends, guys and girls, would come to me, you know, and ask me, ‘What can I do, how can I fix this?’ And I would sit there for hours on end talking to them. And they would walk out, feel so much better, and be fine.

**Client’s role in psychotherapy**

First, participants generally indicated that the client should open up and disclose personal feelings and information (e.g. ‘I would think like just really talk...talk about their feelings;’ ‘The role of the client is to come in and be really open and really want to get help and really give every detail, because if they are not detailed then something could be missed that the counsellor might need to know so they can help you.’). Second, they typically thought that the client’s role is to work hard (i.e. be motivated, be positive, admit s/he has a problem). For example, one person said, ‘My belief is you got to work at it! ... you have to go with motivation and positivity;’ another said, ‘Someone else can’t just fix your life for you, you have to have some motivation or something to do it.’ Third, they typically stated that the client’s role is to be receptive (i.e. to follow the therapist's directions, be cooperative, and have an open mind). According to one participant, the client’s role ‘is kind of to be a sponge, taking everything that the doctor is saying,’ and another said, ‘Just like follow the advice.’

**Therapist's role in psychotherapy**

First, participants generally indicated that the therapists should be active (e.g. ‘maybe give advice;’ ‘They would analyse the problem to the patient...give options or alternatives...like give a clear picture of the situation so the patients know the options and alternatives and get a better picture of the situation itself;’ ‘The therapist is supposed to sort of guide the client through the process of the whole confrontation and like development of a strategy to overcome the issue.’). Second, participants generally believed that the therapist should provide a good relationship (i.e. be warm, supportive, empathic, genuine, caring, professional). According to one participant, ‘The therapist is supposed to be understanding and non-judgmental and just be able to facilitate someone to go onto the right track, and to be patient.’ Another said, ‘Be judge-free, you don’t want to make the client feel uncomfortable at all. So make it as comfortable as possible, and establish that trust with the client so the client has more faith in you and is willing to tell you all the information they can. I think you want to establish that comfortable relationship.’ Third, participants typically believed that the therapist’s role is to be helpful (e.g. ‘to help the client as much as possible;’ ‘trying to help them’). The fourth typical belief was that therapists should listen to their clients (e.g. ‘just sitting down and listening to what they have to say;’ ‘It's kind of just paying someone to be, like, to listen’).

**The ideal therapeutic relationship**

Participants typically wanted to feel close, comfortable disclosing personal information, and that therapists understood them, cared about them, and were empathic. One participant said, ‘I definitely think it's a close relationship, just because when you tell someone about yourself and you really open yourself up, you feel closer to someone knowing they're not saying nothing bad.’ Another said, ‘Someone I can be close with, I mean maybe not outside of the session, but when I get to the session I know this is someone I trust, this is someone that I know is looking for the best interests of me so I can be open and honest with them.’

**Dealing with conflict in psychotherapy**

Participants typically indicated that they would discuss any conflict with the therapist and try to understand the therapist's perspective. One person said, ‘I would just talk about it and try to understand what they're
therapist] is saying.’ Another said, ‘I’d like to know where she’s coming from, and like understand [the therapist].’

**Benefits of seeking psychotherapy**

Regarding the process of therapy, a typical perceived benefit was having someone to talk to about problems (e.g. ‘Having that someone to listen to you;’ ‘Just talking to someone and talking it out, you kind of feel relieved, it is off your chest.’). In terms of outcomes, participants typically identified feeling better about themselves (e.g. ‘It makes you feel better about yourself … feel better, be happy in life.’), and improved functioning in society (e.g. ‘[therapy] could improve your productivity at work or something. So not only are you feeling better about yourself, but now you’re doing a better job at your workplace’).

**Barriers to seeking psychotherapy**

First, participants typically mentioned feelings of shame (public stigma) for seeking psychotherapy (e.g. ‘I guess the social stigma, if people know you are seeking therapy … some people think you are crazy.’). Second, they typically described difficulty disclosing personal information to therapists and trusting therapists (e.g. ‘It would be awkward because I don’t know this person, and I am supposed to just start talking to them about my life to them, we haven't built up that rapport yet. I think it’s weird to go to someone and just like say, “Oh this goes on in my life”’). The third typical barrier was cost (e.g. ‘Financial might be a barrier because, like, therapists are expensive’). Fourth, negative perceptions of self (i.e. self-stigma) were also typically revealed (e.g. ‘If you to go to a therapist, you’re probably feeling almost inadequate, so that would make you go, that knowledge of yourself, that idea “I’m messed up” that’s a little disappointing, that disappointment with yourself, “I messed up so bad I have to go to a therapist”’). Finally, participants typically talked about a belief in the necessity of being strong and solving problems on their own (e.g. ‘We think we could fix it on our own, I can fix my life on my own. I don't need to go and spend money on someone else telling me what to do’).

Although racial/ethnic barriers were variant for the total sample (which was mixed in terms of race/ethnicity), we highlight the findings because they provide interesting hints about culture. One African American participant said, ‘Some people have a pride thing, like, I don't need therapy and I guess coming from a more … African-American typical thing I see we don't want to go to therapy like we think we could fix it on our own.’ Another African American said:

It's also the culture that I grew up in, just because I was born and raised in [country]. With us, it's usually, or maybe not all [people from this country], but for me I feel like if you have a problem, you go first to maybe your parents, if you're too shy about it maybe your friends, or someone you're really close to. If that doesn't work, maybe a second person you'd be close to. For me, it's almost like I grew up thinking therapy is almost, I mean now my opinion's changed but not too much. It's almost like you, and I don't want to use the word inadequate, but you can't do it anymore. You're so frustrated and you're sort of had enough, you're just on the verge of breaking down I feel. So that's when I go for therapy, when I feel like all hope is lost, and you need some sort of help.

An immigrant from an Asian country said that therapy was not available in his country-of-origin:

Most people don't ever go to therapists. Like, you look around there are no therapists. If something happens, usually you talk to your friends or family members. That's about it … You don't think there is any need for a therapist in our culture. It has to be really bad if you need a therapist. So, I guess it's more for serious stuff.

In contrast, a Jewish student talked about therapy being valued in her culture:
I've seen what family and friends, what they went through, and I've read about, different kinds of jobs in the psychology area ... It could be anybody, and anybody can have these problems, that people, can't, it's difficult, people can't always do it on their own really. Sometimes you need to give up and have the guidance ... I think it's normal to talk to anybody, to ask for guidance from anybody...unless you're asking your parents or something, and like helping you if you want a second opinion, that's fine too. But if a person is in a situation they can't get out of.

*Feelings about diagnoses*

Generally, participants indicated that if they were given a psychiatric diagnosis in psychotherapy, they would feel self-stigma (i.e. negative perceptions of themselves), in that they would feel hurt, shocked, upset, in denial, and an assault to their self-esteem. One participant stated, ‘I'd just be thinking “Oh I'm crazy, I'm a crazy person’”, whereas another said, ‘It'd definitely be crushing and disappointing,’ and yet another person said, ‘I could see myself denying it, saying “That's stupid, that's not what's going on with me”. I guess I could be angry at first, denial. Or if I did feel like it is true, not depression but kind of just like sadness I guess, I'd probably be upset.’ Participants also typically indicated, however, that receiving a psychiatric diagnosis would be motivating, because they would work to accept or overcome it. For example, one stated, ‘I would take the necessary steps to better myself,’ and another said, ‘You need to know that you have a problem, otherwise you won't fix it. If you know ... you have a disease or this is the way I'm feeling, it can be fixed. If you avoid that problem, you cannot fix it.’

*Comparison of subsamples*

We compared the results for the four participants who scored above the median reported by Shaffer et al. (2006) for an undergraduate sample on both Anxiety and Avoidance (insecurely attached) to the four who scored below the median on both scales (securely attached); the four who had less distinct patterns were dropped from this analysis. We present here only those findings that differed by at least two cases, given that Hill (2012) suggested at least a 30% difference.

Those individuals who were low in both attachment anxiety and avoidance (i.e. had a secure attachment style) indicated that they would be willing to engage deeply with therapists and with the process of therapy. They wanted a close rather than a professional relationship, suggesting that they were not threatened by intimacy. They saw benefits of seeking therapy, and barriers were more often related to stigma (an external barrier) than to difficulties in disclosing (an internal barrier). They were comfortable with a therapist listening and not asking a lot of questions, and they recognized the importance of therapists being self-aware and not letting their own personal reactions interfere with the therapy. For example, an 18-year old African-American woman spoke of therapy as ‘getting help when you need it.’ She strongly felt that ‘you gotta work at it ... you have to go with motivation and positivity.’ She thought that the client's role is ‘to be a sponge, taking in everything the doctor is saying, have an open mind.’ The therapist, she thought, ‘is supposed to listen and be understanding and non-judgmental and just be able to facilitate someone to go onto the right track and to be patient ... the relationship should be close and comfortable.’ She saw the benefits of therapy as ‘having a better lifestyle ... feel good about myself...make new friends ... only positivity can come out of therapy.’ Barriers included thinking she did not ‘have a problem to get help to go get fixed ... or therapy is for crazy people.’

In contrast, participants who were high in both attachment anxiety and avoidance (i.e. insecure attachment style) wanted a close relationship with a therapist, but were also very concerned that it should be a professional relationship (i.e. trustworthy, ethical) and that the therapist should respect boundaries and provide clients with autonomy. They thought that therapists should ask questions, as would a medical doctor, rather than just listen. They perceived few benefits of therapy and thought that disclosing in therapy would be very difficult. For example, a 19-year-old male student of Asian Indian origin was extremely nervous in his interview. His answers
were brief, and he often asked the interviewer to repeat questions. He noted that therapy was not common in
his country of origin (‘Most people don't ever go to therapists ... usually you talk to friends or family
members ... it has to be really bad if you need a therapist’). He indicated that the client role is to ‘Tell them what
is the problem, then listen to what the therapist says, and if they feel it is right they should follow it.’ The
therapist ‘should have some ideas ... advise the person ... be able to look from different angles ... you should be
able to talk to him about anything you want to talk about ... they should ask questions more directly to get me to
open up ... ’. In terms of benefits, he said, ‘I have a low self-esteem, so I'd probably want to make myself feel
more good about myself.’ In terms of barriers, he said ‘If you feel something is really secret ... then they don't
want to go to a therapist ... if someone knows that you are going to a therapist, then others will think you have
some big problem ... I'm not comfortable talking to other people, so that would hold me back.’

Discussion
Although these undergraduate students (aged 18–20) had never been in psychotherapy, they generally valued
therapy and perceived potential benefits in having someone listen to them. They were also, however, aware of
barriers associated with seeking therapy, particularly related to public and self-stigma. The results of the present
study thus provide support for quantitative research findings that public stigma and self-stigma adversely affect
people's thoughts about seeking psychotherapy (e.g. Ben-Porath, 2002; Corrigan, 2004; Deane &
Chamberlain, 1994; Leaf et al., 1986; Nelson & Barbaro, 1985; Vogel et al., 2006). Similar to what Corrigan and
Larson (2008) described, our participants worried about feeling ‘crazy,’ and also feared that other people would
think them ‘crazy’ if they went to therapy.

Of note, as well, was the emergence of other attitudes and beliefs that have not been described in the extant
literature. For example, our participants generally considered it appropriate to seek therapy for both severe
diagnostic disorders (e.g. depression, anorexia, addiction) and everyday problems in living (e.g. study problems,
relationship problems, stress), suggesting their openness to the range of concerns for which therapy may
provide help for others. When asked about when they would consider seeking therapy themselves, however,
they asserted the importance of being strong, independent, and solving their own problems. Intriguingly, then, it
seemed more permissible for others to seek therapy than for them to do so. In addition, we found hints that
attitudes varied by culture. Some cultures (e.g. African American) seemed particularly opposed to
psychotherapy, whereas others (e.g. Jewish American) seemed to value and embrace therapy. Within each of
these cultures, of course, attitudes varied, based on personal experiences and beliefs (e.g. not all African
Americans in our sample were opposed to psychotherapy).

Furthermore, beliefs about therapy developed from hearing family members’ and friends’ experiences with
therapy, from the media, and from personal experiences helping others, suggesting multiple influences on
people’s views of therapy. Finally, most participants worried about possible negative self-perceptions if they
received psychiatric diagnoses from therapists, although a few participants noted that receiving a diagnosis
would empower them to overcome the diagnosis and get better.

Another finding new to this study was that participants indicated that the client role is to disclose, be receptive,
and be motivated for therapy to work, whereas the therapist role is to listen, provide support, and give advice.
In addition, participants thought that the therapeutic relationship should be close, similar to relationships with
friends, parents, and teachers, but with more objectivity and less personal investment on the part of the
therapist. Furthermore, participants expressed the importance of openly discussing with the therapist any
conflicts that may arise in therapy. Thus, these participants, despite never having been in therapy, had
expectations that fit closely with a humanistic, client-centred approach rather than a psychoanalytic or
cognitive-behavioural perspective.
In terms of their perceptions of the benefits of therapy, they held a relatively utilitarian perspective. Thus, they indicated that talking to someone about problems could be relieving and helpful, enable people to feel better, and improve their functioning in society. They did not mention that therapy could help with such things as personal growth, consciousness raising, or freedom from repression. They also perceived many barriers to seeking therapy, including public stigma (as described above), the difficulty in opening up to another person, and the cost of therapy.

The association between attachment style and attitudes
Attachment style did seem to be associated with attitudes about psychotherapy. Individuals who had secure attachment styles seemed less anxious about engaging with therapists, perceived more benefits and fewer barriers related to seeking therapy. These results provide support for the attachment theory proposition that securely attached individuals have the ability to use a therapist as a ‘secure base’ and collaborate with them in exploring, understanding, and solving their problems (Bowlby, 1988). Our findings also correspond to previous research indicating that individuals with a secure attachment style were better able to perceive and respond to their therapists as safe, available figures than were individuals with insecure attachment styles (Parish & Eagle, 2003).

In contrast, participants with an insecure attachment style seemed more anxious about getting close to a therapist, and perceived fewer benefits and more barriers to seeking and participating in psychotherapy. We speculate, based on attachment theory, that insecurely attached individuals were concerned about maintaining distance from therapists, and that the inherent intimacy of therapy was threatening to them. Similarly, Daly and Mallinckrodt (2009) found that when working with clients who had high attachment anxiety or avoidance, therapists tried to create an effective ‘therapeutic distance’ as a means of engaging clients with concerns related to closeness and dependency in relationships.

Taking together the results about culture, background experiences, and attachment style, these findings suggest that attitudes about psychotherapy vary widely. Thus, rather than just saying that people have a stigma about seeking psychotherapy, we need to think more complexly about personality, culture, and context when we think about attitudes toward psychotherapy.

Limitations and implications
Participants were college-aged students (18–20 years of age) from one large public US university; our results may not apply to people of other ages, education levels, and countries. Interviewers were upper-level undergraduates and thus may have been able to relate more to the participants than more experienced clinicians would have because of similarity in age; however, they may not have probed as much or as deeply as experienced clinicians would have. In addition, it may have been difficult for participants to identify and describe attitudes and beliefs, given that such attitudes and beliefs are often implicit.

We encourage researchers to follow up with larger samples of students from different cultures and different countries to learn more about cultural influences (see also Gonzalez, Alegría, & Prihoda, 2005). In addition, other variables, such as social class and education, should be investigated.

Given our findings, we also encourage mental health providers to develop and investigate interventions to combat stigma related to seeking psychotherapy. Furthermore, we suggest developing interventions that attend to attachment styles (e.g. to attract insecurely attached individuals, researchers might emphasise the professionalism of the therapists and highlight the benefits of psychotherapy). And, we could involve the media in an attempt to lessen public stigma attached to seeking psychotherapy (e.g. use celebrities to endorse psychotherapy, target specific cultural groups that have negative attitudes about therapy).
These results also have implications for therapy practitioners at university counselling centres. Specifically, practitioners need to be sensitive to concerns about stigma, and talk with clients about their feelings about seeking therapy and their attitudes toward themselves as a result of being in therapy. Practitioners might educate potential clients about the benefits of seeking therapy and work to reduce the barriers associated with seeking therapy (e.g. reduce the amount of time between contacting the counselling centre and the client's first session). Finally, training programs could be developed to teach therapists how to work with clients with different attachment styles.

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References


