Enabling Behaviors, Stigmatization, and Attitudes towards Substance Abuse and Bulimia

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Abstract

Enabling behaviors may impair the recovery of individuals with substance use and eating disorders. Participants read one of six vignettes portraying a character with either a substance use disorder or bulimia and were asked how they would react. The effects of several factors, such as gender, knowledge of disorder, disorder type, and enabling behaviors, on the likelihood of specific responses were examined for the most common responses. Some notable results included that females were more likely to intend to provide support. Participants who had higher enabling scores were less likely to tell a professional and were more likely to do nothing. Higher stigma scores were observed for those in the "other" category, which encompassed several less definitive responses. Responses did not vary by character gender, knowledge of disorder, or disorder type. The results point to the need for education and stigma reduction efforts for substance use and eating disorders.

Enabling Behaviors, Stigmatization, and Attitudes towards Substance Abuse and Bulimia

Persons with substance dependence can be impaired in their recovery if the actions of those around them do not support that recovery (Asher & Brissett, 1988; Ditrich & Trapold, 1984; Falkin & Strauss, 2003; Rotunda, West, & O'Farrell, 2004; Thomas, Yoshioka, & Ager, 1996) and if they experience the negative effects of social rejection (Cunningham, Sobell, Sobell, Agrawal, & Toneatto, 1993; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Research on enabling behaviors for substance abuse, the stigmatization of and other attitudes towards substance abuse, and their effects on help-seeking behaviors of those who engage in substance use will be reviewed. Next, similar issues will be considered in regard to eating disorders, specifically bulimia.

Enabling of a problematic behavior such as substance abuse can occur as a result of the actions of spouses, relatives, or friends, or due to an event or to various social, physical and environmental variables (Thomas et al., 1996). Thomas et al. (1996) identified two types of enabling; direct and indirect. Actions by others or other factors that directly affect substance use are described as direct enabling, whereas indirect enabling occurs when persons or other factors induce other behaviors that ultimately increase substance use.

Several researchers have provided varying conceptions of enabling behavior for substance abuse. For example, Asher and Brisset (1988) found that many women define enabling behaviors for alcoholism as care-taking behaviors, including babysitting, defending or making excuses for drinking behavior, denial of the problem, and lying to cover up the drinking behavior. Brown, Tracy, Jun, Park, and Min (2015) found that family members who lack knowledge of substance dependence may facilitate opportunities for the individual to use substances. Relatives who are using substances themselves can enable substance use behavior. If

the user manipulates their relatives into helping them with responsibilities, this can enable substance use. Being around other users while in treatment may encourage substance use (Brown et al., 2015). Other enabling behaviors for drug use may include using drugs with the user, giving the user drugs, giving the user money for drugs, and watching the user's children while he or she engages in drug use (Falkin & Strauss, 2003).

Thomas et al. (1996) conducted two case studies of enabling behavior in regard to alcoholism. One partner indicated that she did not believe that she enabled her husband, but she did report that she has participated in several examples of what would easily be construed as enabling behaviors, including buying alcohol for the home, drinking with her husband, and visiting establishments that sell alcohol. Other examples of enabling behavior reported by another partner include attending social events involving drinking, finding misplaced items for the intoxicated partner, and drinking with her partner.

Rotunda et al. (2004) assessed enabling behaviors using reports from clients engaging in alcohol abuse and their partners, and they found that all of the couples reported enabling behavior at some point during the relationship. The enabling behaviors that were most commonly endorsed by the partners of individuals abusing alcohol included making excuses for one's partner to family and friends, taking over chores or duties for one's partner, threatening to leave without following through, and altering plans due to drinking behaviors. Further examples of enabling behaviors included lying to family and friends to hide drinking behaviors and purchasing alcohol for the client engaging in alcohol abuse. For many of these behaviors, client reports corroborated those of the partners. Dittrich and Trapold (1984) described other enabling behaviors by partners including losing sleep while waiting for their partner to return home,

monitoring their partner's behavior at social events, and kissing their partner to examine alcohol use.

Factors Affecting Enabling Behavior

There are several factors that may impact enabling behavior. Internal beliefs and values of the partners of those who abuse substances have been found to be correlated with enabling behavior (Rotunda et al., 2004). These beliefs may include that it is the partner's duty to take on more family responsibilities in times of stress, acceptance of partners' substance use if they control its extent, minimizing or denying the seriousness of the problem, or thinking that the partner abusing substances cannot get along without the spouse. These beliefs were found to be associated with several enabling behaviors. Therefore, it is argued that these beliefs may predict several enabling behaviors, and in turn, could facilitate higher levels of substance abuse (Rotunda et al., 2004).

Effects of Enabling Behaviors

There are several risks associated with enabling behavior, as well as some benefits perceived by the enabler (Young & Timko, 2015). Engaging in a relationship with someone struggling with alcoholism can reinforce the enabler's self-concept. For example, enablers may perceive themselves as more loyal if they makes excuses for their partner or take care of their partners when they are sick due to their substance use. An individual may develop a social identity based on being in a relationship with a person who is dependent on substances due to social and cultural norms. For example, females engaging in care-taking behavior may fulfill the cultural norm of females being communal. Financial security may be a practical benefit of staying in a relationship with someone with alcoholism, and it may offer a sense of stability. Staying in a relationship with a person abusing alcohol may offer some sense of hope of recovery

for that individual, as well. Risks associated with staying in a relationship with a person abusing alcohol include the development of various psychological problems, relationship stress, financial stress, and legal issues (Young & Timko, 2015).

Enabling behavior has been found to interfere with individuals seeking treatment. Several of the enabling behaviors previously mentioned, including engaging in substance use with the person, financially supporting the substance use, watching the user's children for them, or making excuses and taking over responsibilities, will ultimately decrease the chances of them attempting to get treatment (Falkin & Strauss, 2003; Rotunda et al., 2004). Family members may lack knowledge on substance dependence and can thus be more easily manipulated by the user, which may also impede recovery (Brown et al., 2015).

Role of Stigmatization of Substance Use and Other Mental Disorders

People possess various negative attitudes towards mental illness and substance use that are stigmatizing. Luoma, O'Hair, Kohlenberg, Hayes, and Fletcher (2010) developed a measure of stigmatization: the Perceived Stigma of Addiction Scale (PSAS). This measure assessed the degree of social acceptance of someone being treated for substance use. Stigmatization may include the view that individuals with substance dependence are not trustworthy, should not be hired in a professional context, and should not be trusted to care for children. Link et al. (1999) assessed perceptions of risk of violence and preferred social distance with regard to an individual with alcohol dependence, major depressive disorder (MDD), schizophrenia, cocaine dependence, or a troubled person. The "troubled person" vignette portrayed an individual who exhibited some symptoms of a clinical condition, but did not meet diagnostic criteria. This allowed the researchers to examine the participant's ability to discriminate between a more mild condition and a clinically significant condition, as the other vignettes portrayed conditions that met

diagnostic criteria according to the Diagnostic and Statistical Manuel, Fourth Edition (DSM-IV). Link et al. (1999) defined social distance as a participant's willingness to accept an individual into their family though marriage, or being neighbors, making friends, or being coworkers with an individual. Results indicated that participants perceived cocaine users as likely to be the most violent, followed by alcohol dependence, schizophrenia, MDD, and a troubled person. Perception of the risk of violence correlated with preferred social distance as well. Respondents indicated that they would want the most social distance from someone with a cocaine addiction, followed by alcohol dependence, schizophrenia, MDD, and a troubled person. Overall, individuals with substance use were perceived as most likely to be violent and elicited the greatest preferred social distance (Link et al., 1999).

Stigmatization may also impact an individual's choice to seek treatment for substance use. Cunningham et al. (1993) found that perceived stigma about one's disorder is a significant deterrent from obtaining treatment.

Eating Disorders

Like substance abuse, certain factors can facilitate or hinder a person from obtaining treatment for other disorders, such as eating disorders. Just as family members and friends may enable someone to use substances, behaviors associated with eating disorders can be enabled as well. Also, there are many stigmatizing attitudes associated with mental illness in general, and this includes eating disorders. Enabling and stigmatization of eating disorders, such as bulimia, may prevent an individual with an eating disorder from obtaining treatment.

According to the American Psychiatric Association (2013), bulimia is an eating disorder that is characterized by recurring binge eating episodes. A binge eating episode entails eating significantly large portions of food within a period of time and the perception of a lack of control

over the eating episode. In addition, bulimia is characterized by compensatory behaviors to avoid weight gain, such as vomiting, fasting, use of laxatives, diuretics and medications, and excessive exercise. Diagnosis of bulimia further requires that the binge eating episodes and compensatory behaviors must occur at least once per week for three months. The individual's self-concept is based on the physical shape and weight of his or her body (American Psychiatric Association, 2013).

Perceptions of Treatment for Bulimia

Individuals may lack knowledge of bulimia or effective treatments for it, and this may have an impact on treatment seeking behavior and on how the individual is treated by others as well. Mond, Hay, Rodgers, and Owen (2008) examined perceptions of bulimia using a community sample of women with bulimia. A vignette was presented to a community sample of women with bulimia portraying a person who met the criteria for bulimia nervosa (BN). A Mental Health Literacy Survey was then provided inquiring about the nature of the problem and the prognosis for treatment for the problem. Results indicated that participants would most often go to a close friend (27.1%) with the given problem, followed by a doctor (20.6%), family member (12.3%), and a counselor (10.3%). Treatment preference differed by age. Forty-two percent of older participants, aged 30-42 years old, were more likely to rate hypnosis as being a helpful treatment option, as compared to 17.6% of younger participants, ages 18-29. Older and younger participants also differed in who they would go to first with this given problem. Older participants were more likely to go to a doctor first, whereas younger participants were more likely to go to a close friend first. Overall, this sample did not indicate a strong endorsement of using mental health service providers as a resource for treatment (Mond et al., 2008).

Mental health literacy regarding bulimia has also been assessed in samples who were not diagnosed with eating disorders. Mond et al. (2007) examined mental health literacy of adolescent girls concerning bulimia nervosa and it's prognosis and treatment. A vignette was presented to 522 female high school students portraying an adolescent who was diagnosed with bulimia. Results indicated that adolescent females regarded primary care doctors, mothers, female friends, and self-help strategies as more effective than mental health practitioners and antidepressant medication (Mond et al., 2007). Mond, Hay, Rodgers, Owen, and Beumont (2004a) examined perceptions of a community sample of women without bulimia, ages 18-45. Participants were presented with a vignette portraying a fictional person diagnosed with bulimia nervosa. Participants were then asked if they considered various treatments would be either helpful, harmful, or neither to the fictional character portrayed in the vignette through a face-to-face interview. Results indicated that participants perceived primary care physicians to be the most helpful individuals, and they would most likely approach this professional first. Overall, participants perceived primary care physicians as more helpful than a psychologist or psychiatrist. However, participants viewed counseling as the most helpful form of treatment. Many participants also perceived self-help strategies, including vitamins and minerals, as helpful, but very few participants viewed medications as helpful (Mond et al., 2004a). It is notable that participants diagnosed with bulimia had such markedly different perceptions of how helpful mental health service providers would be for this problem than participants without such a diagnosis.

Barriers to Treatment-Seeking Behavior for Bulimia

There are several barriers associated with treatment seeking behavior. Mond et al. (2009) conducted a prospective study examining differences between women with bulimic eating

disorders who did and did not get treatment. Respondents who met the criteria for having bulimia were asked to do a face-to face interview to gather more information about their eating disorder. The following variables were measured: psychopathology, impairment in daily functioning, symptoms of anxiety and depression, knowledge of bulimia, coping mechanisms, and treatment utilization. Results indicated that variables most strongly associated with treatment seeking behavior were impairment in daily functioning in relation to the eating disorder and the inability to repress negative emotions. Other variables associated with treatment seeking behavior include higher body mass index, greater psychopathology relating to the eating disorder, more symptoms of anxiety and depression, greater recognition of their problem, and also having prior treatment associated with weight issues (Mond et al., 2009). Therefore, the absence of any of these factors would reduce treatment-seeking. Other factors associated with help-seeking behavior may include the perception that bulimia is difficult to treat and believing relapse to be likely (Mond et al., 2007). Also, adolescent females who exhibit symptoms of an eating disorder have been found to be less likely to accurately identify an eating problem. Only 50% of those who were identified as exhibiting clinically significant symptoms of an eating disorder, based on the Eating Disorder Examination Questionnaire, stated that they may be experiencing a problem similar to the one portrayed in the vignette (Mond et al., 2007). Therefore, adolescent girls who may be at risk of an eating disorder may be less likely to identify it as a problem and thus potentially be less likely to seek appropriate forms of treatment (Mond et al., 2007).

Thompson and Park (2016) identified further barriers to treatment of eating disorder, specifically personality traits. For example, people diagnosed with bulimia are found to be more impulsive, while people diagnosed with anorexia are found to be less impulsive (Claes, Vandercycken, & Vertommen, 2002). Women who perceive their eating disorder as problematic

tend to be more likely to seek treatment (Akey, Rintamaki, & Kane, 2013). Race and ethnicity may affect the likelihood of seeking treatment. Caucasians were more likely to be referred to a health professional, after an eating disorder screening, than African-Americans, Asians, and Latinos (Becker, Arrindell, Perloe, Fay, & Striegel-Moore, 2010). There are financial barriers against obtaining treatment for an eating disorder. Inpatient treatment of an eating disorder costs about $500-$2,000 per day, and outpatient treatment costs about $30,000 for a month (South Carolina Department of Mental Health, n.d.). Ten states currently require private insurance companies to pay for treatment for anorexia and bulimia. However, most insurance companies will only insure treatment for anorexia, because they do not view bulimia and other eating disorders as having the same physical consequences as anorexia. The symptoms of eating disorders may go unnoticed or its full consequences may be underestimated in clinical settings (Becker et al., 2010).

In another study, a community sample of women, ages 18-45, were presented with a vignette portraying a fictional person diagnosed with bulimia nervosa (Mond, Hay, Rodgers, Owen, & Beumont, 2004b). Participants were then asked about their perceptions of the severity and prevalence of the disorder described in the vignette. The majority of participants perceived the problem as difficult to treat. More specifically, 44.2% of participants rated the problem as moderately difficult to treat and 38.5% of participants viewed the problem as very difficult to treat. The majority of participants (64.4%) believed it would not be so bad to have the problem portrayed in the vignette. When asked about the prevalence of the described problem, the majority of participants believed between 10%-30% of people in the general population may have this problem. Other factors were found to be associated with specific responses, and they could in turn impact treatment seeking behavior. Twelve (5.8%) of respondents believed they

may have a problem similar to the one described in the vignette and 40 respondents (20.4%) reported that they have experienced a similar problem in the past. These individuals were more likely to believe that it would not be that bad to have the given problem. These individuals were also more likely to perceive a greater prevalence of the problem (above 50% of the population). Thirteen (6.3%) of the participants met a clinically significant level of eating disorder symptoms. These individuals were more likely to have thought it would not be so bad to have the problem, and they also perceived a greater prevalence of the problem (30%-50% or over 90% of the general population). In conclusion, participants may be less likely to seek treatment due to perceiving the problem as difficult to treat. Also, participants who exhibit symptoms similar to the ones portrayed in the vignette may be less likely to seek treatment due to perceptions of greater prevalence in the general population, and the perception of it not being so bad to have this problem (Mond et al., 2004b).

Stigmatization towards eating disorders may also impact treatment-seeking behavior. Due to social stigma, many people may try to hide their eating disorders due to the shame and guilt associated with the disorder in the face of such stigmatization (Pettersen, Rosenvinge, & Ytterhus, 2008). Mclean et al. (2014) developed a scale to measure stigmatization towards eating disorders that assessed five categories of stigmatization, including the advantages of bulimia nervosa, minimization of the disorder, the belief that individuals with bulimia are unreliable, preferred social distance, and perceived personal responsibility of those with bulimia. The results suggested that the majority of participants saw bulimia as a serious disorder, but they did not express very high levels of stigmatization. The researchers acknowledged that social desirability biases may be evident here. However, several perceived the person as responsible for the disorder and preferred more social distance. Men, in particular, reported high stigmatization and

attributed more responsibility to the person with the eating disorder. These researchers argued that treatment-seeking for bulimia could be impaired due to this stigmatization, particularly if it is internalized (Mclean et al., 2014).

Enabling of Eating Disorders

The concept of enabling can also be applied to eating disorders. Family members and friends may act in ways that further contribute to a person's eating disorder. For example, family members or friends of an individual with an eating disorder may make excuses for their behaviors, lie to others, or purchase laxatives for the person with the eating disorder. These enabling behaviors may inhibit people who have eating disorders from seeking treatment, as well. To examine possible enabling behaviors for individuals with bulimia in comparison to substance abuse disorders, Dunham, Knapp, and Mattice (2014) presented college students with one of three versions of a vignette depicting either cocaine dependence, alcohol dependence, or bulimia. Participants then responded to measures of stigmatization, knowledge of the disorder, possible interventions, and enabling behaviors, among other measures. Some participants endorsed that it would not be so bad to have the disorders, particularly females responding to the vignette portraying bulimia. Stigma scores were found to be significantly lower for bulimia than for cocaine and alcohol dependence vignettes. All disorders were perceived as quite difficult to treat, but particularly cocaine dependence. Male characters were viewed as significantly more difficult to treat effectively, regardless of disorder. Significant differences were observed in specific enabling responses across disorder types. Buying the substance (or supplies needed for bulimic behaviors) was significantly more frequently endorsed for alcohol abuse than for bulimia; this question was not asked about the cocaine scenario due to ethical concerns. Doing the person's chores for them was significantly more endorsed for bulimia, then alcohol abuse,

then cocaine abuse. Using the substance (or using laxatives/diet pills for bulimia) with the character was significantly (and by a great extent) more likely for alcohol abuse than for bulimia (not asked for cocaine abuse). Telling the character it is okay to use the substance (or engage in bulimic symptoms) to prepare for a special event was significantly more endorsed for alcohol abuse, then cocaine abuse, then bulimia. Reassuring the character that their problem was not that serious was significantly more frequently endorsed for bulimia, then alcohol abuse and then cocaine abuse (both much lower). Coaxing the character to get up to go to school/work was significantly more likely for alcohol abuse and bulimia (equal) versus cocaine abuse (Dunham et al., 2014)

The present study will add to this previous research by analyzing the responses to an open-ended question asking how participants would respond to the character in the vignette. Open-ended questions were utilized due to concerns of social desirability biases if options of possible responses were presented for participants to choose from, which sounded particularly desirable or effective. The effects of the gender of the participant and of the vignette character, stigmatization, literacy on the disorder, and the type of disorder in the vignette on the nature of the response suggested in the open-ended question will be examined.

Some speculative hypotheses can be formulated based on previous research. These hypotheses, listed below, will be framed in terms of the effects of several variables on the likelihood of a more or less supportive response in the open-ended question asking how participants would respond to the character. More supportive responses would include references to providing emotional or practical support, attempts to build the character's confidence, and the most supportive response would be to encourage, or engage in, consultation with a professional or other responsible adult to intervene with the character in the vignette.

1) It is predicted that male participants will be less likely to report appropriate or supportive behaviors in response to the character, regardless of disorder type.

2) It is predicted that, regardless of disorder type, participants will be less likely to state intentions to provide a strongly supportive response to a male character.

3) It is predicted that increased stigma will be associated with less supportive responses to the character.

4) It is predicted that more accurate knowledge of the disorder will result in suggesting more supportive behaviors would be utilized.

5) It is predicted that the supportiveness of the intended response will be greater for the bulimia vignette than for the alcohol or cocaine abuse vignettes. And, given that more participants endorsed that it would "not be so bad" to have the problem depicted in the alcohol vignette, it is also predicted that there would be fewer intentions to provide support for that character as participants may view it as unwarranted.

6) It is predicted that participants will report intentions to engage in both enabling behaviors as well as attempts to be supportive in more general ways in the open-ended response.

Methods

Participants

A convenience sample of 264 college students (68 males, 195 females) was used. The mean age of the participants was 18.82 (*SD* = 1.30, range 18-26), and 76% of participants were Caucasian. Participants were randomly assigned to one of six versions of a survey, which were formed through various combinations of character gender and type of disorder.

Measures

Not all of the questions in the survey in the appendix are being discussed or analyzed for this study. Participants were presented with one of three versions of a hypothetical scenario depicting a college-aged peer who was exhibiting cocaine abuse, alcohol abuse, or bulimia. The scenarios depicted these disorders as defined by the DSM-IV-TR. The cocaine and alcohol scenarios were taken from Link et al. (1999) and the bulimia scenario was taken from Mond et al. (2008). The scenarios depicted either a male or female character. Participants were asked if they knew someone with a similar problem as the scenario they read.

Participants were asked an open-ended question after reading the vignette as to how they would react, if at all, to the character if they knew him/her. Responses to this open-ended question were coded by two raters based on a coding scheme developed by Yap, Wright, and Jorm (2011). Responses were coded with a 'yes (1)' or 'no (0)' in each category, and multiple categories were possible. The categories included: listened/talked with person, provided general support, spent time/socialized with person, encouraged or facilitated socialization/activity, gave advice, encouraged or facilitated professional help seeking, cheered person up/ boosted person's confidence, encouraged person to tell someone/told someone or asked their advice, helped with responsibilities, gave or sought information, other (e.g., encouraged self-help; encouraged person to stop alcohol or drugs; did an intervention; assessed problem/risk of harm; confronted person; ask if they want help), don't know, and nothing. Inter-rater reliability was assessed by having a second rater code a random sample of 20% of the responses. There was 92.6% agreement between the two raters. Coding was performed by turning to the second page of the survey where the open-ended question was located, to restrict awareness of experimental condition, and

recording the codes in a computer spreadsheet. The second coder could not see the first coder's data during coding.

Participants were also given a modified version of the Behavior Enabling Scale (Rotunda et al., 2004). This 20-item scale was modified because it asked about actual enabling behaviors committed by respondents in the past; for the present study it asked about hypothetical use of enabling behaviors. Thus the response scale was designed to assess the participants' likelihood to use each behavior with the character in the vignette; it ranged from 1 (not at all likely) to 5 (very likely). Further modifications included the exclusion of two items that did not fit the scenario of a college peer in all versions, and exclusion of two further items in the cocaine version that referred to purchasing and using cocaine due to concerns about asking college students about illegal behaviors of that severity. For the original BES, Rotunda et al. reported an internal consistency coefficient of .91 for the BES in its original form.

Attitudes toward these disorders were also assessed using the Perceived Stigma of Addiction Scale (Luoma et al., 2010); its items were modified to depict cocaine abuse, alcohol abuse, and bulimia for each scenario type. This 8-item scale used a 7-point Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree). The wording of the questions was modified for each vignette version (cocaine, alcohol, and bulimia) from the original wording which stated "substance abuse" in each question. Luoma et al. reported an internal consistency coefficient of .73, and evidence of convergent and discriminant validity, for the original version.

Knowledge about each disorder was assessed, including difficulty of treatment, effective forms of help, and prognosis, using items taken from Mond et al. (2008). These questions asked about an array of aspects of knowledge of the disorder depicted in the vignette. Perceptions of how difficult the disorder would be to treat were assessed with a single item with a 5-point rating

scale (1 = not at all, 5 = extremely). Prognoses with and without treatment were assessed with a single item each, with a 6-point scale ranging from "get worse" to "full recovery with no further problems." The stress of the problem was rated on a single item with a 5-point scale ranging from "calming" to "very stressful." Participants were also asked if they ever thought it would "not be so bad" to have this problem, and rated this on a 5-point rating scale ranging from "never thought that" to "always thought that." The effectiveness of various sources of help were rated as helpful, harmful, or neither. The sources included medical help, psychological help, friends or family, and self-help. Demographic questions asked for participants' gender, age and ethnicity (see Appendix for three versions of full survey). The order of the measures was carefully planned to avoid the influence of certain measures on responses to other measures. Participants were instructed to not return to earlier pages once they were completed, and the researchers were present during data collection to monitor that.

Procedure

A convenience sample was drawn from introductory psychology classes. Participants first completed an informed consent form, and then completed the survey in groups. Participants were randomly assigned to one of three disorders depicted in a vignette, and each disorder was depicted with either a male or female character. This created six versions of the survey.

Data Analysis Plan

After coding is completed, the frequency of each of the coded behaviors in the open-ended responses will be summarized. As suggested by Yap et al. (2011), who developed this coding scheme, only those behaviors that are stated by more than 10% of participants will be further analyzed. The associations of other study variables with the presence or absence of each behavior code will be assessed. More specifically, chi-square tests will be used for associations

with categorical variables such as participant gender, character gender, and the type of disorder in the vignette, and independent t-tests will be used for associations with continuous variables such as stigma scores, literacy/knowledge ratings, and enabling scores.

Results

Participant responses were excluded when they referred to how they handled a real situation with someone with a similar problem to that presented in the vignette. A total of 15 responses to the open-ended question were excluded from further analysis on that basis. As summarized in Table 1, at least ten percent of the sample endorsed the following responses, "listened or talked with person," "provide general support (practical, emotional, or financial)," "encouraged professional help seeking," "tell someone (parent, teacher, etc.)," "other (intervention, confronted person, etc.)," and "nothing."

Chi-Square tests of association were performed to examine the relation between participant gender, character gender, and disorder type with each of six behaviors in the open-ended responses. The association between the response of "listened to/talked with" by participant gender was found to be significant. Among participants who stated they would "listen/talk" to the character, 84% were females, X^2 (1, N = 243) = 6.11, $p < .05$. The association between "tell someone (other than a professional)" by participant gender was found to be significant. Among participants who stated they would tell a parent, teacher, etc., 87% were females, X^2 (1, N = 243) = 4.60, $p < .05$. There were no significant associations between participant gender and the other four behaviors. There were no significant associations between character gender and the six behaviors. There were no significant associations between disorder type and the six behaviors.

Chi-Square tests of association were performed to examine the relation between participants' views of seven forms of possible intervention for the character by each of six

behaviors in the open-ended responses. None were found to be statistically significant. Ninety-seven percent of the sample rated professional help as helpful (as opposed to harmful or neither) and 89% rated medical help as helpful. This left little variability to detect associations with the behaviors in the open-ended responses.

Independent t-tests were performed to examine differences in the rating of a disorder as "not so bad to have" by each of the six behaviors. The 5-point rating that the disorder would be "not so bad to have" was scored such that a lower score indicated stronger endorsement of that view. Only one marginally significant difference was found for this rating. Those who viewed the disorder as "not so bad to have" were marginally significantly less likely to state that they would involve a professional, $t(233) = -1.96$, $p < .06$ (Tell professional: $M = 4.77$, $SD = .69$; did not suggest telling professional: $M = 4.51$, $SD = .89$).

To further examine the effects of literacy on and knowledge of the disorder on intended behaviors, independent t-tests on ratings of the stressful nature of the disorder (5-point rating), of perceptions of prognosis (6-point rating), and of perceived difficulty in treating the disorder (5-point rating) by each of the intended behaviors were conducted. No significant differences were found for any of the six behaviors for these ratings.

Independent t-tests were performed to examine differences in total enabling scores and total stigma scores by each of the six intended behaviors. Because of different numbers of items used in the enabling scale for each disorder condition (see Measures section), the total score was calculated separately for each disorder condition by dividing the sum of the ratings by 16 (for the cocaine condition) and by 18 (for the alcohol and bulimia conditions). Thus the enabling total scores could range from 1 to 5.

A marginally significant difference was found in the total enabling score between those who did and did not state that they would tell a professional, $t(242) = 1.85$, $p < .07$. Participants who indicated that they would tell a professional had marginally significantly lower total enabling scores ($M = 1.98$, $SD = .50$) than those who did not ($M = 2.14$, $SD = .58$).

A significant difference in total enabling scores was found between those who did and did not state that they would tell a parent, teacher, etc., $t(242) = 2.15$, $p < .05$. Participants who indicated that they would tell a parent, teacher, etc. had significantly lower total enabling scores ($M = 1.93$, $SD = .78$) than those who did not ($M = 2.14$, $SD = .51$).

A significant difference was found in total enabling scores between those who did and did not state that they would do nothing, $t(242) = -2.09$, $p < .05$. Participants who indicated that they would do nothing had higher total enabling scores ($M = 2.31$, $SD = .73$) than those who did not ($M = 2.08$, $SD = .54$). Total enabling scores did not differ significantly by the other three behaviors.

The total stigma scores could range from 8 to 56 (8 items each with 7-point rating scales). A significant difference in the total stigma score was found between those who did and did not state that they would use behaviors in the "other" category, $t(241) = -2.15$, $p < .05$. Participants who indicated that they would engage in behaviors within the "other" category had higher total stigma scores ($M = 36.61$, $SD = 9.19$) than those who did not ($M = 33.89$, $SD = 10.38$).

Exploratory logistic regressions were performed for those intended behaviors that showed significant associations with participant gender, total enabling scores, and/or total stigma scores, to check for possible interaction effects of these factors (gender, total enabling scores and/or total stigma scores) with disorder type in predicting the dichotomous outcome variables reflecting the presence or absence of each behavior in the open-ended responses. The specific intended

behaviors subjected to logistic regressions were “tell a parent, teacher, etc”, “tell a professional”, “other”, “nothing”, and “listened”. The model goodness of fit statistics were statistically significant for “tell a parent, teacher, etc” and for “tell a professional”, X^2s (7, N = 264) = 18.99 and 13.43, ps < .05, respectively. However, only one interaction was statistically significant in either model, which was the interaction of total enabling scores by disorder type in predicting “telling a professional”, X^2(2, N = 243) = 6.44, p < .05. This analysis was completed as an exploratory analysis. To explore the interaction, independent t-tests of total enabling scores by the presence/absence of telling a professional were conducted for each disorder condition separately. The difference was only significant for the alcohol vignette [t(76) = 2.77, p < .01] and again, lower total enabling scores were observed for those who said they would tell a professional (M = 1.87, SD = .37) than those who did not (M = 2.31, SD = .57). Thus the overall difference reported earlier was due largely to the difference in the alcohol condition.

Discussion

The effects of several factors, such as gender, knowledge of disorder, disorder type, and intended enabling behaviors, on the likelihood of intended supportive responses to a hypothetical character depicted as having either bulimia, cocaine dependence, or alcohol dependence were examined. It was predicted that male participants would be less likely to report appropriate or supportive behaviors in response to the character, regardless of disorder type. This hypothesis was supported in that females were found to be significantly more likely than males to “listen/talk with the person” and “tell someone (other than a professional).” McClean et al. (2014) found that male participants had higher levels of stigmatization towards individuals with bulimia than females, and males attributed the responsibility of the eating disorder to the individual, which could lead to fewer supportive responses. Yap et al. (2011) also found that

males were less likely to state that they would suggest professional help-seeking or provide general support regardless of the disorder in question. These findings are also consistent with general societal expectations and beliefs in regards to gender differences, in that females are generally perceived as more communal and supportive than males (Burleson, 2002).

The second hypothesis stated that, regardless of disorder type, participants would be less likely to state intentions to provide a strongly supportive response to a male character. However, no significant associations were found between character gender and any of the six behaviors. This may be due to the disorder overshadowing the character gender in the vignette. Dunham et al. (2014) found that male characters were viewed as more difficult to treat regardless of disorder type, but this apparently did not affect the intended behaviors consistently enough.

It was hypothesized that increased stigma would be associated with less supportive responses to the character. A significant association was found between higher total stigma scores and participants' endorsement of the "other" category. The "other" category captured multiple behaviors, including self-help, confrontation, direct intervention, and suggesting the person "get help," which could have multiple meanings. Providing a response in the "other" category does suggest a less definitive intent to involve a professional or family member, and perhaps those holding more stigmatized views of the disorders portrayed in this study are less certain of their views on effective forms of help. The effects of stigma on these intended responses to the characters could only be speculated upon due to a lack of relevant previous studies.

It was also predicted that more accurate knowledge of the disorder would result in greater intentions to engage in supportive behaviors. An interesting discrepancy was found between participants' intentions to involve a professional in their open-ended responses and their ratings

of helpfulness of professional help in the literacy questions. Although a large majority of participants rated psychological ad medical help as helpful for the disorders, only 24% indicated that they would involve a professional according to their open-ended responses. In coding open-ended responses, it was not always clear if they intended to involve a professional when the response was to "get the person help", for example, so the frequency of the intention to involve a professional from the open-ended responses may have been an underestimate of their true belief that this would be an appropriate response. No significant differences were found for knowledge ratings by any of the six behaviors. As reported by Dunham et al. (2014), participants viewed all disorders as relatively difficult to treat, but more so for cocaine dependence. So perhaps little variability in that rating was left to be accounted for by each of the six behaviors in those comparisons.

It was also hypothesized that the supportiveness of the intended response would be greater for the bulimia vignette than for the alcohol or cocaine abuse vignettes. And, given that more participants endorsed that it would "not be so bad" to have the problem in the alcohol vignette (Dunham et al. 2014), it was also predicted that there would be fewer intentions to provide support for that character as participants may have viewed it as unwarranted. Unexpectedly, no significant associations were found between disorder type and any behaviors. Unexplained variability in participants' responses and/or the nature of the coding scheme, in that the coding scheme may have not captured the finer aspects that differed by disorder type, may have clouded any potential effects of disorder type. Yap et al. (2011) utilized the same coding scheme and compared disorder types in vignettes with disorders like social phobia and depression, and they found significant differences. They attributed those differences to participants minimizing the seriousness of social phobia. Because no differences were found in

the behaviors according to disorder type in the current study, perhaps they are being treated with fairly equal seriousness and in need of similar types of interventions. When examining the perceived seriousness of the disorder, participants who indicated that the disorder would be "not so bad to have" were significantly less likely to state that they would involve a professional, but this did not vary be disorder type.

Given that enabling behaviors may be a misguided effort to help, it was predicted that participants would report intentions to engage in both enabling behaviors, as well attempts to be supportive in more general ways in the open-ended response. Differences were found in enabling scores by the intention to tell a professional *or* a family member, teacher, etc. Participants who indicated that they would tell either resource had lower total enabling scores. This finding reflects an overall stronger grasp of the need for intervention by a responsible party for these disorders. Differences were found in enabling scores for participants who did or did not indicate that they would do "nothing" in that participants whose responses fit the "nothing" category in the coding scheme had higher total enabling scores. This reflects an overall lack of recognition of the need or benefit of more serious interventions and should be targeted for educational efforts. The effect of the total enabling scores on the intention to tell a professional depended on disorder type and was strongest for the alcohol condition, where participants who indicated that they would tell a professional had significantly lower total enabling scores. The potential effects of enabling scores on intended responses to the character were only speculated on due to a lack of similar previous studies.

The present results must be considered in light of the strengths and weaknesses of the study. The current study possessed several strengths. Participants were randomly assigned to the six different vignettes, formed by varying character gender and disorder type. This increased the

internal validity of the study. The content of the vignettes were valid in that they utilized criteria from the Diagnostic Statistical Manual of Mental Disorders (4th edition, DSM-IV). The measures, including the coding scheme, were utilized and validated in previous studies. The open-ended question, which was coded in the current study, was asked at the beginning of the survey so that participant responses were not impacted by the other measures presented subsequently including the stigma questions which might have evoked a socially desirable response bias. Finally, the exclusion of the responses that referred to a real experience is a strength of this study because those incidents were not controlled in their nature as the hypothetical vignettes were. No inferences were made about how the participant may have responded to the vignette based on how they handled a similar real life situation.

Limitations of the current study include the use of a convenience sample of college students in introductory psychology classes. Therefore, the external validity of the study may be impacted due to a lack of generalizability to other populations. The use of a hypothetical vignette may also be considered a limitation. Participants may react much differently to a real person in a similar situation. Social desirability biases in responses are also possible due to the sensitive nature of the topic.

Further research could include inquiring about real-life experiences with people with bulimia and participants' actual responses to those individuals. The current study could be replicated with different samples to enhance generalizability. To further examine the effects of stigmatization, assessment of social reactions experienced by individuals with bulimia and their sense of stigmatizing attitudes of others towards their disorder could be pursued. Further research could also include examining the effects of perceptions of the seriousness of a disorder on a continuum by individuals without an eating disorder on their views of the need for treatment.

This research is important for the purposes of education of the public on these disorders and how to best support individuals struggling with substance use and eating disorders. As noted in the current study, as well as several previous studies, many factors, including gender, knowledge of disorders, and stigmatizing attitudes, may potentially have an influence on treatment-seeking behaviors. Understanding the impact of enabling behaviors, as well as perceptions of treatment options, is pertinent for the success of such individuals in coping with their disorder.

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Table 1
Frequency of Intended Responses to Character in Vignette

Behavior	%
Listened/talked with person	29.1
Provided general support	25.8
Spent time/socialized with person	3.3
Facilitated socialization/activity	.4
Gave advice	6.1
Encouraged professional help seeking	23.8
Cheered person up	3.3
Encouraged person to tell someone	16.4
Helped with responsibilities	0.0
Gave or sought information	7.0
Other (intervention, confronted person, etc.)	48.4
Don't Know	0.0
Nothing	11.5

Note. Each response could be coded in more than one category.

Appendix

GENERAL INSTRUCTIONS:

Please do not write your name on the survey (only put your name on the consent form).

Please do not go back to earlier pages and change your answers after you have moved on.

Please read the following paragraph and then answer the questions that follow about the person described in the paragraph you read.

John is a college student, and during the last month John has started to drink more than his usual amount of alcohol. In fact, he has noticed that he needs to drink twice as much as he used to in order to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down he became very agitated, sweaty, and he couldn't sleep, so he took another drink. His family has complained that he is often hung over, and has become unreliable—making plans one day, and canceling them the next.

1) Do you personally know someone like John? ___Yes ___No

If you do know someone like John, please answer the following questions concerning this person you knew. If you do <u>not</u> know someone like John, please skip to Question 2 on the next page now.

1a) Can you describe the nature of your relationship with this person who is like John (e.g., friend, family member, acquaintance, co-worker, etc)? Please do not name the person in your answers.

1b) How old were you when you encountered this person who is like John?

1c) Did you attend any education programs or counseling related to the situation with the person you knew before who is like John? If so, please describe these here.

2) Whether or not you knew someone like John before, how would you react, *if at all*, to this situation with John if you knew him? There are no right or wrong answers, and your responses are confidential, so please answer honestly.

2a) Please explain the reasoning for your response to the previous question about how you would respond, *if at all*, to the situation with John if you knew him.

Please answer the following questions about how you would react to this situation with John <u>if he was your close friend</u>. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

I would give John money to buy alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would purchase alcohol for John.

1	2	3	4	5
Not at all likely				Very likely

I would take over John's chores because he was drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would lie or make excuses to John's friends/family to hide his drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would drink alcohol with, or in front of, John.

1	2	3	4	5
Not at all likely				Very likely

I would tell John it was okay to drink alcohol to get ready for a special event.

1	2	3	4	5
Not at all likely				Very likely

I would give John money to pay his bills after he spent all of his money on alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would ask for help from professionals to get John out of trouble related to his drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would threaten John with ending our friendship because of his drinking alcohol, but later would not follow through with it.

1	2	3	4	5
Not at all likely				Very likely

I would pay John's medical, lawyer, or court bills/fees, or bail him out of jail, due to his alcohol-related offense/hospitalization.

1	2	3	4	5
Not at all likely				Very likely

I would help nurse John through a hangover after consuming alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would clean up John's vomit that resulted from his drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would ask or encourage family members or other friends to ignore, or be silent about, John's drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would help conceal John's drinking alcohol from others.

1	2	3	4	5
Not at all likely				Very likely

I would coax John up in the morning to go to work/school when he was hung over after consuming alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would make excuses to others for John's impaired behavior when he was drinking alcohol.

1	2	3	4	5
Not at all likely				Very likely

I would reassure John that his alcohol use was not that bad.

1	2	3	4	5
Not at all likely				Very likely

I would lie or tell a half-truth to a physician, counselor, or other professional about John's alcohol use.

1	2	3	4	5
Not at all likely				Very likely

Please answer the following questions about your thoughts about the best kinds of help for John with his situation. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

How difficult do you think John's problem would be to treat?

1	2	3	4	5
Not at all	A little	Moderately	Very	Extremely

What is John's likely prognosis (outcome) with psychological therapy?

__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement
__ Get worse

What is John's likely prognosis (outcome) with no psychological therapy?

__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement
__ Get worse

How stressful do you think it would be to have John's problem?

__ Very stressful
__ Somewhat Stressful
__ Neither stressful nor not stressful
__ Not stressful
__ Calming

Have you ever thought that it would not be so bad to have John's problem?

__ Always thought that
__ Often thought that
__ Occasionally thought that

__ Rarely thought that
__ Never thought that

Please indicate whether these sources of help would be Helpful, Harmful or Neither Helpful or Harmful for John's problem.

Source of Help	**Helpful**	**Harmful**	**Neither Helpful or Harmful**
Medical help (e.g., doctor, nutritionist)			
Psychological Help (e.g., counselor, support groups)			
Female friend			
Male friend			
Female family member			
Male family member			
Self Help (e.g., reading books, searching web for information)			

Which of the above sources of help should John approach *first*? Please explain your answer.

Which of the above sources of help would be *most* helpful for John? Please explain your answer.

Please answer the following questions about what you believe most people would think or do about a person like John. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

Most people would willingly accept someone who has been treated for alcohol use as a close friend.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people believe that someone who has been treated for alcohol use is just as trustworthy as the average citizen.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would accept someone who has been treated for alcohol use as a teacher of young children in a public school.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would hire someone who has been treated for alcohol use to take care of their children.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people think less of a person who has been in treatment for alcohol use.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most employers will hire someone who has been treated for cocaine use if he or she is qualified for the job.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most employers will pass over the application of someone who has been treated for alcohol use in favor of another applicant.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would be willing to date someone who has been treated for alcohol use.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Please answer the following questions about yourself.

What is your age? _____

What is your gender? ____ M ____ F

What is your ethnicity? ____ Caucasian
____ African or African American
____ Asian or Asian American
____ Hispanic or Hispanic American
____ Other: _____

Thank you for your participation!

GENERAL INSTRUCTIONS:

Please do not write your name on the survey (only put your name on the consent form).

Please do not go back to earlier pages and change your answers after you have moved on.

Please read the following paragraph and then answer the questions that follow about the person described in the paragraph you read.

Kevin is an 18-year-old college student. Although mildly overweight when he was younger, Kevin's current weight is within the normal range for his height and build. However, he *thinks* he is overweight. Upon starting college, Kevin joined a fitness class at the gym and also started running regularly. Through these efforts, he gradually began to lose weight. Kevin then started to diet, avoiding all fatty foods, not eating between meals, and trying to eat set portions of healthy foods, mainly fruits and vegetables and bread or rice, each day. Kevin also continued with the exercise program, losing several more pounds. However, he has found it difficult to maintain the weight loss and for the past 18 months his weight has been continually fluctuating, sometimes by as much as 10 pounds within a few weeks. Kevin has also found it difficult to control his eating. While able to limit his food intake during the day, at night he is often unable to stop eating, bingeing on, for example, a loaf of bread and several pieces of fruit. To counteract the effects of this bingeing, Kevin takes laxative pills. On other occasions, he vomits after overeating. Because of his strict routines of eating and exercising, Kevin has lost contact with most of his friends.

1) Do you personally know someone like Kevin? ___Yes ___No

If you do know someone like Kevin, please answer the following questions concerning this person you knew. If you do <u>not</u> know someone like Kevin, please skip to Question 2 on the next page now.

1a) Can you describe the nature of your relationship with this person who is like Kevin (e.g., friend, family member, acquaintance, co-worker, etc)? Please do not name the person in your answers.

1b) How old were you when you encountered this person who is like Kevin?

1c) Did you attend any education programs or counseling related to the situation with the person you knew before who is like Kevin? If so, please describe these here.

2) Whether or not you knew someone like Kevin before, how would you react, *if at all*, to this situation with Kevin if you knew him? There are no right or wrong answers, and your responses are confidential, so please answer honestly.

2a) Please explain the reasoning for your response to the previous question about how you would respond, *if at all*, to the situation with Kevin if you knew him.

Please answer the following questions about how you would react to this situation with Kevin <u>if she was your close friend</u>. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

I would give Kevin money to buy laxatives, binge food, or diet pills.

1	2	3	4	5
Not at all likely				Very likely

I would purchase laxatives, binge food, or diet pills for Kevin.

1	2	3	4	5
Not at all likely				Very likely

I would take over Kevin's chores if he were not feeling well due to his bulimia.

1	2	3	4	5
Not at all likely				Very likely

I would lie or make excuses to Kevin's friends/family to hide his bulimia.

1	2	3	4	5

Not at all likely Very likely

I would use laxatives or diet pills with, or in front of, Kevin.

1 2 3 4 5
Not at all likely Very likely

I would tell Kevin it was okay to binge, purge, or use laxatives or diet pills to get ready for a special event.

1 2 3 4 5
Not at all likely Very likely

I would give Kevin money to pay his bills after he spent all of his money on laxatives, binge food, or diet pills.

1 2 3 4 5
Not at all likely Very likely

I would ask for help from professionals to help Kevin with problems due to his bulimia.

1 2 3 4 5
Not at all likely Very likely

I would threaten Kevin with ending our friendship because of his bulimia, but later would not follow through with it.

1 2 3 4 5
Not at all likely Very likely

I would pay Kevin's medical bills resulting from his bulimia.

1 2 3 4 5
Not at all likely Very likely

I would help nurse Kevin through feeling ill due to his bulimia.

1 2 3 4 5
Not at all likely Very likely

I would clean up Kevin's vomit that resulted from his bulimia.

1 2 3 4 5
Not at all likely Very likely

I would ask or encourage family members or other friends to ignore, or be silent about, Kevin's bulimia.

1 2 3 4 5
Not at all likely Very likely

I would help conceal Kevin's bulimia from others.

1	2	3	4	5
Not at all likely				Very likely

I would coax Kevin up in the morning to go to work/school when he was feeling ill due to his bulimia.

1	2	3	4	5
Not at all likely				Very likely

I would make excuses to others for Kevin's signs of not feeling well due to his bulimia.

1	2	3	4	5
Not at all likely				Very likely

I would reassure Kevin that his bulimia was not that bad.

1	2	3	4	5
Not at all likely				Very likely

I would lie or tell a half-truth to a physician, counselor, or other professional about Kevin's bulimia.

1	2	3	4	5
Not at all likely				Very likely

Please answer the following questions about your thoughts about the best kinds of help for Kevin with his situation. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

How difficult do you think Kevin's problem would be to treat?

1	2	3	4	5
Not at all	A little	Moderately	Very	Extremely

What is Kevin's likely prognosis (outcome) with psychological therapy?

__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement
__ Get worse

What is Kevin's likely prognosis (outcome) with no psychological therapy?

__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement

__ Get worse

How stressful do you think it would be to have Kevin's problem?
__ Very stressful
__ Somewhat Stressful
__ Neither stressful nor not stressful
__ Not stressful
__ Calming

Have you ever thought that it would not be so bad to have Kevin's problem?
__ Always thought that
__ Often thought that
__ Occasionally thought that
__ Rarely thought that
__ Never thought that

Please indicate whether these sources of help would be Helpful, Harmful or Neither Helpful or Harmful for Kevin's problem.

Source of Help	**Helpful**	**Harmful**	**Neither Helpful or Harmful**
Medical help (e.g., doctor, nutritionist)			
Psychological Help (e.g., counselor, support groups)			
Female friend			
Male friend			
Female family member			
Male family member			
Self Help (e.g., reading books, searching web for information)			

Which of the above sources of help should Kevin approach *first*? Please explain your answer.

Which of the above sources of help would be *most* helpful for Kevin? Please explain your answer.

Please answer the following questions about what you believe most people would think or do about a person like Kevin. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

Most people would willingly accept someone who has been treated for bulimia as a close friend.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people believe that someone who has been treated for bulimia is just as trustworthy as the average citizen.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would accept someone who has been treated for bulimia as a teacher of young children in a public school.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would hire someone who has been treated for bulimia to take care of their children.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people think less of a person who has been in treatment for bulimia.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most employers will hire someone who has been treated for bulimia if he or she is qualified for the job.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most employers will pass over the application of someone who has been treated for bulimia in favor of another applicant.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people would be willing to date someone who has been treated for bulimia.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Please answer the following questions about yourself.

What is your age? _____

What is your gender? ____ M ____ F

What is your ethnicity?

____ Caucasian
____ African or African American
____ Asian or Asian American
____ Hispanic or Hispanic American
____ Other: _____

Thank you for your participation!

GENERAL INSTRUCTIONS:

Please do not write your name on the survey (only put your name on the consent form).

Please do not go back to earlier pages and change your answers after you have moved on.

Please read the following paragraph and then answer the questions that follow about the person described in the paragraph you read.

Mike is a college student, and a year ago Mike sniffed cocaine for the first time with friends at a party. During the last few months he has been snorting it in binges that last several days at a time. He has lost weight and often experiences chills when bingeing. Mike has spent his savings to buy cocaine. When Mike's friends try to talk about the changes they see, he becomes angry and storms out. Friends and family have also noticed missing possessions and suspect Mike has stolen them. He has tried to stop snorting cocaine, but he can't. Each time he tries to stop he feels very tired and depressed and is unable to sleep. He lost his job a month ago after not showing up for work.

1) Do you personally know someone like Mike? ___Yes ___No

If you do know someone like Mike, please answer the following questions concerning this person you knew. If you do <u>not</u> know someone like Mike, please skip to Question 2 on the next page now.

1a) Can you describe the nature of your relationship with this person who is like Mike (e.g., friend, family member, acquaintance, co-worker, etc)? Please do not name the person in your answers.

1b) How old were you when you encountered this person who is like Mike?

1c) Did you attend any education programs or counseling related to the situation with the person you knew before who is like Mike? If so, please describe these here.

2) Whether or not you knew someone like Mike before, how would you react, *if at all*, to this situation with Mike if you knew him? There are no right or wrong answers, and your responses are confidential, so please answer honestly.

2a) Please explain the reasoning for your response to the previous question about how you would respond, *if at all*, to the situation with Mike if you knew him.

Please answer the following questions about how you would react to this situation with Mike <u>if he was your close friend</u>. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

I would give Mike money to buy cocaine.

1	2	3	4	5
Not at all likely				Very likely

I would take over Mike's chores because he was using cocaine.

1	2	3	4	5
Not at all likely				Very likely

I would lie or make excuses to Mike's friends/family to hide his cocaine use.

1	2	3	4	5
Not at all likely				Very likely

I would tell Mike it was okay to use cocaine to get ready for a special event.

1	2	3	4	5

Not at all likely Very likely

I would give Mike money to pay his bills after he spent all of his money on cocaine.

1 2 3 4 5

Not at all likely Very likely

I would ask for help from professionals to get Mike out of trouble related to his cocaine use.

1 2 3 4 5

Not at all likely Very likely

I would threaten Mike with ending our friendship because of his cocaine use, but later would not follow through with it.

1 2 3 4 5

Not at all likely Very likely

I would pay Mike's medical, lawyer, or court bills/fees, or bail him out of jail, due to his cocaine-related offense/hospitalization.

1 2 3 4 5

Not at all likely Very likely

I would help nurse Mike through the after-effects of consuming cocaine.

1 2 3 4 5

Not at all likely Very likely

I would clean up Mike's vomit that resulted from his cocaine use.

1 2 3 4 5

Not at all likely Very likely

I would ask or encourage family members or other friends to ignore, or be silent about, Mike's cocaine use.

1 2 3 4 5

Not at all likely Very likely

I would help conceal Mike's cocaine use from others.

1 2 3 4 5

Not at all likely Very likely

I would coax Mike up in the morning to go to work/school when he was not feeling well after using cocaine.

1 2 3 4 5

Not at all likely Very likely

I would make excuses to others for Mike's impaired behavior when he was using cocaine.

1 2 3 4 5

Not at all likely Very likely

I would reassure Mike that his cocaine use was not that bad.

1 2 3 4 5

Not at all likely Very likely

I would lie or tell a half-truth to a physician, counselor, or other professional about Mike's cocaine use.

1	2	3	4	5
Not at all likely				Very likely

Please answer the following questions about your thoughts about the best kinds of help for Mike with his situation. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

How difficult do you think Mike's problem would be to treat?

1	2	3	4	5
Not at all	A little	Moderately	Very	Extremely

What is Mike's likely prognosis (outcome) with psychological therapy?
__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement
__ Get worse

What is Mike's likely prognosis (outcome) with no psychological therapy?
__ Full recovery, with no further problems
__ Full recovery, but the problem will probably recur
__ Partial recovery
__ Partial recovery, but the problem will probably recur
__ No improvement
__ Get worse

How stressful do you think it would be to have Mike's problem?
__ Very stressful
__ Somewhat Stressful
__ Neither stressful nor not stressful
__ Not stressful
__ Calming

Have you ever thought that it would not be so bad to have Mike's problem?
__ Always thought that
__ Often thought that
__ Occasionally thought that
__ Rarely thought that
__ Never thought that

Please indicate whether these sources of help would be Helpful, Harmful or Neither Helpful or Harmful for Mike's problem.

Source of Help	**Helpful**	**Harmful**	**Neither Helpful or Harmful**
Medical help (e.g., doctor, nutritionist)			
Psychological Help (e.g., counselor, support groups)			
Female friend			
Male friend			
Female family member			
Male family member			
Self Help (e.g., reading books, searching web for information)			

Which of the above sources of help should Mike approach *first*? Please explain your answer.

Which of the above sources of help would be *most* helpful for Mike? Please explain your answer.

Please answer the following questions about what you believe most people would think or do about a person like Mike. There are no right or wrong answers, and your responses are confidential, so please answer honestly.

Most people would willingly accept someone who has been treated for cocaine use as a close friend.

1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most people believe that someone who has been treated for cocaine use is just as trustworthy as the average citizen.

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1 2 3 4 5 6 7
Strongly Disagree Strongly Agree

Most employers will pass over the application of someone who has been treated for cocaine use in favor of another applicant.

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

Most people would be willing to date someone who has been treated for cocaine use.

1	2	3	4	5	6	7
Strongly Disagree						Strongly Agree

Please answer the following questions about yourself.

What is your age? _____

What is your gender? ____ M ____ F

What is your ethnicity? ____ Caucasian
____ African or African American
____ Asian or Asian American
____ Hispanic or Hispanic American
____ Other: _____

Thank you for your participation!