Brief Video Intervention to Increase Treatment-Seeking Intentions Among Young Adults With Psychiatric Symptoms:

A Randomized Controlled Trial

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Abstract

Objective: Brief social contact–based video interventions are effective in decreasing self-stigma and increasing treatment-seeking intentions. The present study is the first to target essential workers with self-reported anxiety, depression, and posttraumatic stress disorder (PTSD) symptoms during the COVID-19 pandemic. We hypothesized that viewers of the intervention would show greater increases in treatment-seeking intentions than nonviewers and that those without prior mental health diagnoses or care would have larger increases than those with past mental health care engagement. Additionally, participants who were more emotionally engaged with the intervention would experience greater treatment-seeking intention increases.

Methods: This randomized controlled trial recruited 1,309 essential workers via crowdsourcing who self-reported threshold levels of anxiety, depression, or PTSD symptoms to view either a brief social contact–based video intervention or a control video. Participants' treatment-seeking intentions were assessed using 3 items from the Attitudes Toward Seeking Professional Psychological Help–Short Form at baseline, immediately postintervention, and 30 days afterward.

Results: Generalized estimating equation (GEE) analyses revealed an immediate group-by-time effect of increased treatment-seeking intentions in the intervention group ($P = .006$, Cohen $d = 0.22$). Further GEE analyses revealed significant effects among individuals in the intervention group without prior psychiatric diagnoses ($P < .001$, Cohen $d = 0.41$), as compared to those with psychiatric diagnoses, and among those without prior treatment experience ($P < .001$, Cohen $d = 0.40$) compared to those who had. Participants who were more emotionally engaged experienced significantly greater increases in treatment-seeking intentions ($P < .001$).

Conclusion: All hypotheses were supported, indicating the efficacy of a brief video intervention in increasing treatment-seeking intentions among essential workers with clinical needs. These results highlight the ability of brief, easily disseminated interventions to reach those most in need of care and effectively increase treatment-seeking intentions.

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Self-stigma, or internalized negative beliefs about struggles with one's mental health, is a primary barrier to seeking mental health treatment,[1,2] with previous studies showing that self-stigma predicts low treatment-seeking intentions.[3,4] Furthermore, research has shown that reducing self-stigma increases treatment-seeking intentions.[2,5] Most of these studies, however, have been conducted in the general population, not among individuals who meet criteria for psychiatric diagnoses and may have greater need for clinical intervention.

One methodology used to target self-stigma is a *social contact–based intervention*, in which a presenter from a stigmatized group shares their story of coping with challenges and achieving goals.[6] These interventions decrease mental health–related stigma, including self-stigma, and increase treatment-seeking intentions.[6,7] This may be due to their emotional content over and above the pure information provision of psychoeducation-based interventions, thus inviting the viewer to identify with the protagonist by emotionally engaging with their narrative.[8] Many social contact–based interventions,

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Clinical Points

- Brief social contact-based video interventions may increase treatment-seeking intentions, but they have yet to be tested among young adults who meet clinical thresholds of self-reported psychiatric symptoms.
- This brief video intervention engendered greater increases in treatment-seeking intentions among individuals with self-reported psychiatric symptoms who were not previously engaged in the mental health care system and those who were more emotionally engaged with its content.

however, take place in vivo, via direct contact.[7] These face-to-face interventions can have limited reach and be difficult to replicate, whereas easily accessible and cost-effective video versions of social contact–based interventions have been developed and tested, with similar effectiveness.[9,10] Brief videos, rather than longer ones, have been found to be particularly effective, as they accommodate shorter attention spans and are easily disseminated via social media.[11]

Extant research has shown promising results when testing these brief social contact–based video interventions in various groups at high risk for clinical distress, including survivors of childhood maltreatment[12] and essential workers during the COVID-19 pandemic.[8,13,14] Yet, research specifically focusing on populations most in need of clinical help—individuals experiencing heightened clinical symptoms—is scarce. This is important, since most people with high levels of clinical symptoms do not receive formal provider-conferred diagnoses or seek treatment.[15–17]

Our earlier research targeted COVID-19 essential workers because of their elevated psychiatric risks amidst high levels of burnout, physical illness, and potential income loss while standing on the frontlines of a global catastrophe.[18–21] Despite their evident need for mental health care, treatment-seeking remained low given their barriers to care, including internalized stigma.[22] In addition, being a young adult was associated with disproportionately high levels of clinical distress and lower use of mental health services.[23–26] In these earlier studies, we found that brief social contact–based video interventions were effective in increasing help-seeking intentions among essential workers as a whole.[8,13,14] But we focused on the broader group at risk, all essential workers, rather than individuals with clinically significant psychiatric symptoms.

To address this knowledge gap, this study draws from a sample of young adults employed as essential workers during the COVID-19 pandemic, specifically those who met clinical self-report thresholds. Guided by our previous research indicating increased treatment-seeking intentions among essential workers following our brief social contact–based video intervention, we utilized a similar intervention in this sample but tailored its content to young adult participants. Previous findings indicated that young adults are an ideal audience for brief video interventions, likely because of their relatively higher levels of sensitivity to stigma and self-consciousness due to their developmental stage and their familiarity with brief videos, similar to those found on popular social media.[27–29] Specifically, in this randomized controlled trial, we recruited young adult essential workers (ages 18–35 years) who self-reported symptoms of anxiety, depression, or posttraumatic stress disorder (PTSD) that met clinical thresholds to examine the effects of a brief video intervention on treatment-seeking intentions. We hypothesized that (*a*) participants who viewed the intervention video would exhibit a greater increase in treatment-seeking intentions than those in the control group; (*b*) this effect would be stronger among those who had not previously received a formal diagnosis from a mental health professional; (*c*) this effect would also be stronger among those who had no prior treatment experience; and (*d*) the intervention video's immediate effect would be stronger among those emotionally engaged with the intervention.

METHODS

Recruitment and Participants

The procedures in this study followed the same approach as our previous studies testing brief social contact–based video interventions among essential workers.[8,13,14] The sample of young-adult essential workers was recruited during May 2023 via Prolific, an online crowdsourcing platform often utilized in psychiatric research.[30,31] Prolific maintains participant pool validity by regularly checking for bots and removing participants who obscure their location or endorse inconsistent demographic information. In addition to these built-in checks, we removed responses from participants who responded to the survey multiple times as well as those who failed attention checks (eg, "In the following question, please select the third response"). We also added a timer to discourage participants from skipping instructions or the video.

All participants were English-speaking US residents between the ages of 18–35 years. All participants were employed in an indispensable occupation during the COVID-19 pandemic (eg, nursing, medicine, construction, transportation, food industry, emergency services), attended work in-person during the pandemic, and met clinical thresholds for self-reported anxiety, depressive, or PTSD symptoms. As with our previous studies, we conducted power calculations using G*power to determine study sample size, powering our sample to detect a small-moderate main video group effect and

moderating effects of prior treatment, prior psychiatric diagnosis, and emotional engagement.[32] Participants were compensated $1.60 for completing the preintervention and postintervention assessments (Day 1) and $1.60 for completing the follow-up assessment (Day 30). The study was approved by the New York State Psychiatric Institute Institutional Review Board.

Procedure and Intervention

After consenting to the study procedures, participants completed the study via Qualtrics.com, a secure online data collection platform. All participants began by answering a preintervention survey that included demographic questions and a measure of treatment-seeking intentions. Participants were then randomly assigned using the Qualtrics randomization feature to the intervention group or the control group via a double-blind design, with an equivalent number of participants in each group to maximize statistical power. They viewed either an intervention video or the control video, corresponding to their group assignment. Immediately following the videos, participants were presented with the same measure of treatment-seeking intentions as at baseline, as well as a measure assessing emotional engagement with the videos. Participants were presented with the same treatment-seeking intentions measure 30 days afterward; due to previous findings of sustained follow-up effects, the intervention was not administered again at follow-up.[33] The study flow diagram (Figure 1) illustrates the full procedure.

The intervention videos depicted an essential worker in her mid-twenties describing the internal barriers she faced in seeking mental health care while experiencing COVID-19–related anxiety and depression, her experience overcoming these barriers, and the benefits she received from treatment. Appendix 1 includes the link to the videos, as well as further information regarding their contents and content validation. The control video featured the same actress narrating her daily routine, without mentioning mental health or clinical distress.

Instruments

Three measures were utilized to select participants who met thresholds for self-reported clinical symptoms: the Generalized Anxiety Disorder 7-Item (GAD-7), for self-reported anxiety symptoms[34]; the Patient Health Questionnaire-9 (PHQ-9), for self-reported depression symptoms[35]; and the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5), for self-reported PTSD symptoms.[36] A score of 5–9 on the GAD-7 indicates mild anxiety; 10–14, moderate anxiety; and 15 and above, severe anxiety.[34] On the PHQ-9, a score of 5–9 indicates mild depression; 10–14, moderate depression; 15–19, moderately severe depression; and 20 or more, severe depression.[35] The PC-PTSD includes a cutoff score of ≥3 as indicative of probable PTSD.[36] The study inclusion cutoff scores were ≥5 on the GAD-7 (mild anxiety[34]) and PHQ-9 (mild depression[35]) and ≥3 on the PC-PTSD (cutoff score[36]). Cronbach alphas in this sample were good-excellent (.87 for the GAD-7, .85 for the PHQ-9, and .63 for the PC-PTSD).

We measured treatment-seeking intentions with 3 items from the Attitudes Toward Seeking Professional Psychological Help scale–Short Form (ATSPPH-SF).[37] Participants rated each item on a Likert scale ranging from 1 ("disagree") to 4 ("agree"). Total scores ranged from 3 to 12; higher scores suggested greater treatment-seeking intentions. In this sample, this measure had a Cronbach alpha of .76.

Participants' levels of emotional engagement with the videos were assessed with the Emotional Engagement Scale (EES).[38] Participants rated each item on a Likert scale ranging from 1 ("strongly disagree") to 4 ("strongly agree"), and total scores ranged from 3 to 12. Higher scores suggested greater levels of emotional engagement. The EES had a Cronbach alpha of .87 in this study.

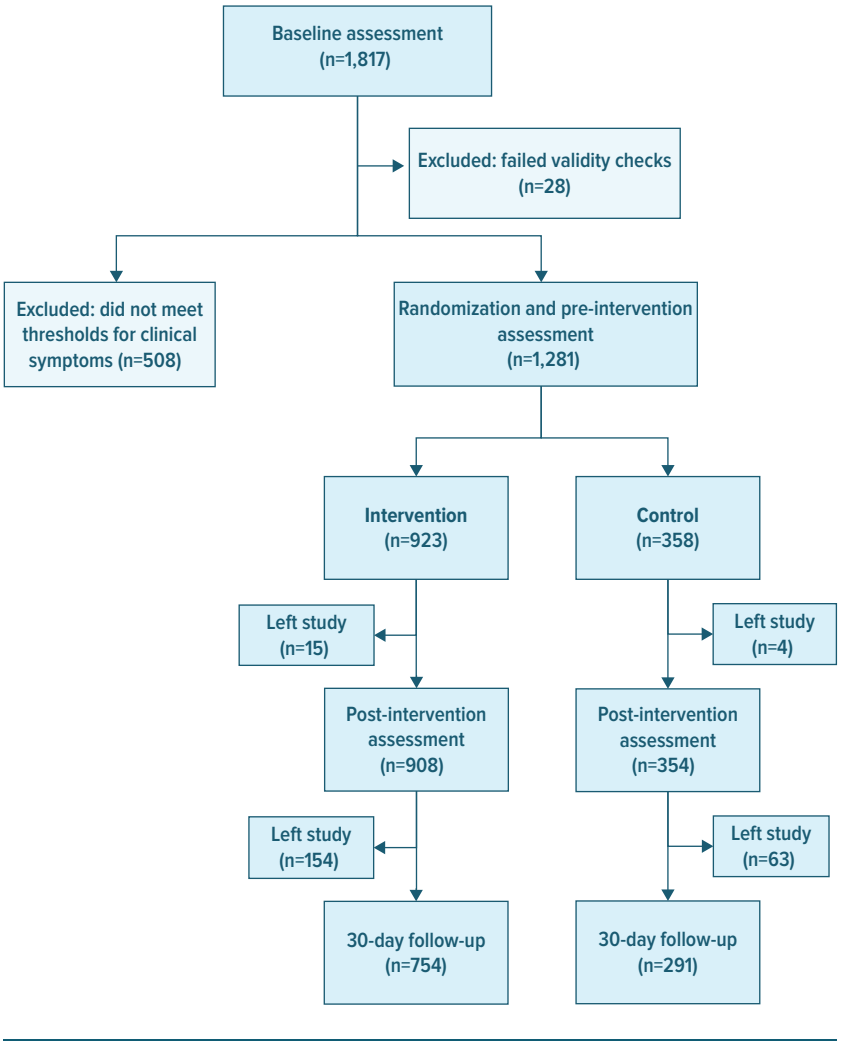
Data Analysis

We compared sociodemographic characteristics (age, gender, race/ethnicity, education, and occupation) between study groups using independent samples *t* tests and Pearson χ^2 to determine whether groups differed on baseline characteristics. We also compared baseline mean treatment-seeking scores between the two groups using independent *t* tests and between those with "mild" symptoms (those who did not exceed mild thresholds on either the PHQ-9 or the GAD-7; ie, scores of ≤9 on the PHQ-9 and the GAD-7) and those with "moderate or higher" symptoms (those who met or surpassed moderate thresholds on either of these instruments; ie, scores of >9 on either the PHQ-9 or the GAD-7).

As a longitudinal randomized controlled trial, the effects of the intervention were analyzed using generalized estimating equations (GEEs).[39,40] This method is a correlated repeated-measures analysis, which allows us to account for missing data using estimated marginal means of any participant with response data for at least 1 study time point. We utilized an unstructured correlation matrix to account for within-subject dependencies in the models, and we used a full factorial model for all 3 study time points to analyze treatment-seeking intentions measured with the ATSPPH-SF. Post hoc analyses also utilized GEE models to decompose effects for baseline/postintervention and baseline/follow-up.

Separate GEE models were conducted to determine differences in intervention effect by time by prior formal psychiatric diagnosis, prior treatment engagement, and emotional engagement with the video. Utilizing an unstructured correlation matrix and a full factorial model for all 3 study time points, separate group-by-time GEE analyses were used to analyze treatment-seeking intentions over time among participants with and without

Figure 1.
Study Profile



prior formal psychiatric diagnoses. Similarly, separate group-by-time GEE analyses were used to analyze treatment-seeking intentions among participants with and without history of prior treatment engagement. Due to the exploratory nature of these aims, each of these analyses was performed via separate GEE models (ie, 4 separate models: participants with formal diagnoses, participants without formal diagnoses, participants with history of treatment engagement, and participants without history of treatment engagement).

To analyze immediate change effects alone (in contrast to the prior analyses, which examined both immediate and follow-up effects) of intervention vs. control by level of emotional engagement, a 2×2 ANOVA analysis was conducted. Emotional engagement level was operationalized as a binary variable, with participants with EES scores <9 designated as low emotional engagement, and those with EES scores ≥9 designated as high emotional engagement. As in previous studies, this cutoff was determined based on the median score of the sample.[8,32,41]

Effect sizes are reported where appropriate using Cohen *d*. All statistical analyses were conducted using IBM SPSS Statistics 29 for PC, and all tests were 2-sided with alpha levels of <.05.

RESULTS

Sample Characteristics

Of the 1,817 participants screened for the study, 1,309 (72%) were included after meeting clinical thresholds for self-reported symptoms of depression, anxiety, or PTSD. After removing 28 (2%) participants who failed validity checks, the remaining 1,281 participants were randomized and completed the baseline assessment. Ninety-six percent (n = 1,262) completed the postintervention assessment, and 1,045

Table 1.
Demographic Characteristics of Study Participants at Baseline

Characteristic	Intervention n = 923		Control n = 358		Total n = 1,281		Statistic	
	Mean	SD	Mean	SD	Mean	SD	t^a	*P*
Age, y (range 18–35 y)[a]	28.3	4.4	28.2	4.6	28.3	4.4	0.24	.81
	n	%	n	%	n	%	$X^{2,b}$	*P*
Gender							5.12	.40
Women	546	59	200	54	746	58		
Men	352	38	140	42	492	38		
Transgender or nonbinary	21	2	16	4	37	3		
Prefer not to answer	4	0	2	1	6	1		
Race and ethnicity							4.54	.81
Hispanic	145	16	59	17	204	16		
Non-Hispanic Black	104	11	34	9	138	11		
Non-Hispanic White	584	63	235	66	819	64		
Non-Hispanic Asian	55	6	21	6	76	6		
Non-Hispanic Native American	2	0	0	0	2	0		
Non-Hispanic Other[c]	24	3	7	2	31	2		
Prefer not to answer	9	1	2	1	11	1		
Education							5.67	.46
Never completed high school	5	1	3	1	8	1		
High school graduate	124	13	56	16	180	14		
Some college credit	230	25	85	24	315	25		
Bachelor's degree	397	43	138	39	535	42		
Master's degree	144	16	64	18	208	16		
Doctorate degree	16	2	11	3	27	2		
Prefer not to answer	2	0	1	0	3	0		
Occupation							13.64	.25
Construction	36	4	11	3	47	4		
Transportation	28	3	18	5	46	4		
Manufacturing	49	5	9	3	58	5		
Emergency services/police/military	22	2	7	2	29	2		
Food industry	32	4	11	3	43	3		
Education	174	19	74	21	248	20		
Hospitality	38	4	23	6	61	5		
Retail/sales	182	20	75	21	257	20		
Healthcare	140	15	50	14	190	15		
Civil services	42	5	16	5	58	5		
Other	180	20	64	18	244	19		

[a]Independent samples *t* test.
[b]Pearson χ^2.
[c]Non-Hispanic other: multiracial (n = 22), Middle Eastern (n = 4), unspecified (n = 5).

(82%) completed the 30-day follow-up (Figure 1). More than half (58%) of the sample was female, and mean±SD respondent age was 28.3 ± 4.4. About two-thirds of the sample were non-Hispanic white (n = 819; 64%); 16% were Hispanic (n = 204), 11% non-Hispanic Black (n = 138), 6% non-Hispanic Asian (n = 76), 2% non-Hispanic other (n = 31), and <1% non-Hispanic Native American (n = 2). Independent *t* tests revealed no significant differences between study arms in baseline treatment-seeking scores (intervention: 9.3 ± 2.2 [mean±SD]; control 9.5 ± 2.0; $t = -1.4$, $P = .1$). Demographic characteristics did not differ significantly across study arms (Table 1).

Of the 1,281 study participants, 87% (n = 1,110) met clinical thresholds for self-reported anxiety symptoms (mild: n = 591, 33%; moderate: n = 322, 18%; severe: n = 197, 11%), 85% (n = 1,087) met clinical thresholds for depressive symptoms (mild: n = 502, 28%; moderate: n = 318, 18%; moderate-to-severe n = 191, 11%; severe n = 76, 4%), and 16% (n = 198) met the clinical threshold for PTSD symptoms. More than half (n = 963, 54%) of the sample met clinical thresholds for comorbid anxiety and depression symptoms. Participants with "mild" symptoms had significantly lower baseline treatment-seeking intentions than those with "moderate or higher" symptoms, with a mean score of 9.1 among the "mild" group (n = 222, 24%) and 9.5 in the "moderate or higher" group (n = 701, 76%; $t = 3.0$, Cohen $d = 0.20$, $P = .003$).

Intervention Effects

The GEE analysis of overall effects yielded significant differences in treatment-seeking intention outcomes

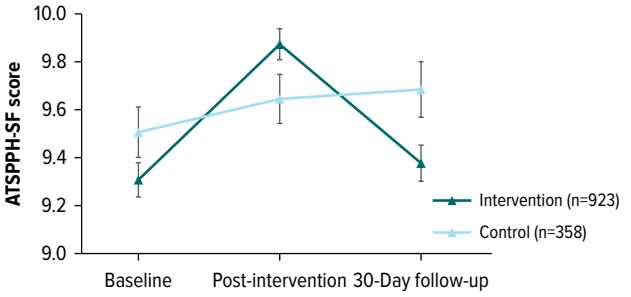
between study groups (Figure 2). The model revealed a significant group-by-time interaction effect ($\chi^2 = 36.9$, $df = 2$, $P < .001$). To decompose this effect, we compared treatment-seeking intentions scores between baseline and postintervention as well as between baseline and follow-up time points. These analyses revealed a significant immediate group-by-time effect ($\chi^2 = 7.5$, $df = 1$, $P = .006$, intervention group mean difference = 0.47, Cohen $d = 0.22$, CI = 0.28–0.67) for the baseline and postintervention time points. We did not observe a significant lasting effect at follow-up. Sensitivity analyses revealed that the intervention's immediate effects on treatment-seeking intentions were significantly stronger among participants in the "mild" group as compared to participants in the "moderate or higher" group on either of these instruments (n = 701, 76%; $t = -2.8$, Cohen $d = -0.23$, $P = .005$).

We performed separate GEE analyses to compare treatment-seeking intention outcomes over time among participants who did and did not report receiving a prior formal psychiatric diagnosis. This analysis revealed significant group-by-time interactions in both groups (no formal diagnosis: $\chi^2 = 14.7$, $df = 2$, $P < .001$; prior formal diagnosis: $\chi^2 = 6.3$, $df = 2$, $P = .043$; Figure 3A). However, a post hoc analysis revealed that an immediate effect was only observed in the group with no formal diagnosis ($\chi^2 = 18.3$, $df = 1$, $P < .001$, intervention group mean difference = 0.87, Cohen $d = 0.41$, CI = 0.67–1.06). No lasting effect was observed at follow-up for either group.

To understand effects of prior treatment experience, we performed separate GEE analyses to compare treatment-seeking intention outcomes over time among participants with and without history of treatment engagement. This model revealed a significant group-by-time interaction in the group with no treatment history alone ($\chi^2 = 25.1$, $df = 2$, $P < .001$; Figure 3B). A post hoc analysis revealed a significant immediate effect among those without prior treatment experience ($\chi^2 = 18.8$, $df = 1$, $P < .001$, intervention group mean difference = 0.86, Cohen $d = 0.40$, CI = 0.70–1.01). There was no significant effect observed at follow-up.

The final analysis examined the intervention's effects on treatment-seeking intentions, moderated by level of emotional engagement with the video interventions (Figure 4). The overall GEE model revealed a significant group-by-time-by-emotional engagement interaction ($\chi^2 = 6.6$, $df = 2$, $P = .037$). Participants in the intervention group were significantly more emotionally engaged than those in the control group (high-EE intervention: n = 608, 67% vs high-EE control: n = 65, 18%; $\chi^2 = 241.7$, $df = 1$, $P < .001$). Those who were more emotionally engaged with the video intervention content exhibited an immediate change of 0.69 ± 0.06 (mean±SEM) points on the ATSPPH between baseline and postintervention, while those who were less engaged exhibited an immediate change of 0.29 ± 0.07 ($t = 4.2$; $P < .001$).

Figure 2.
Compared Effects of Intervention vs Control on Treatment-Seeking Intentions Over Time (N = 1,281)[a]



[a]Treatment-seeking intentions measured with the Attitudes Toward Seeking Professional Psychological Help Scale–Short Form (ATSPPH-SF); total scores range from 3 to 12; higher scores indicate greater treatment-seeking intentions.

DISCUSSION

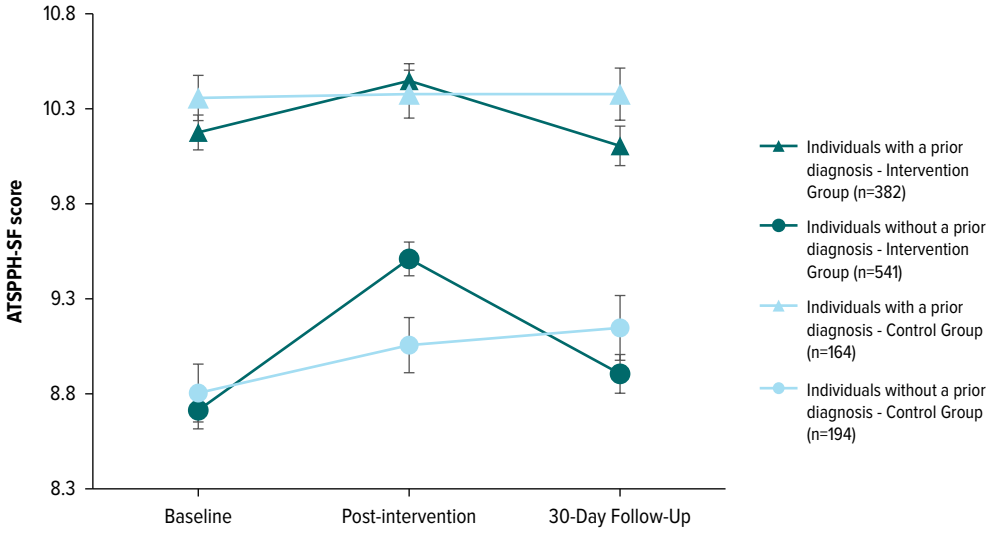
In this study, we replicated our earlier research on the efficacy of brief social contact–based video interventions to increase treatment-seeking intentions in a more focused population: individuals who met clinical thresholds for self-reported psychiatric symptomatology. Our results supported each of our 4 hypotheses: those who viewed the mental health–focused intervention video endorsed greater increases at postintervention in treatment-seeking intentions than those who viewed the nonmental health–focused control; the effect on treatment-seeking intentions was greater among those without a prior provider-conferred psychiatric diagnosis and those who had no previous treatment experience; and participants who showed greater emotional engagement with the intervention demonstrated greater increases in treatment-seeking intentions. We did not see sustained follow-up effects of the video on treatment-seeking intentions.

The findings of this study bear significant clinical weight, as the population of focus in this study uniformly displayed a need for clinical attention due to their self-expressed symptomatology. Despite this apparent need for mental health care, almost half (41%) of the sample had never sought treatment, which indicates an urgent need for interventions like these to increase treatment-seeking intentions. This is consistent with previous research, which has found that the majority of individuals who experience clinical symptomatology do not seek care.[17,42,43] This emphasizes the strength of the intervention tested in this study: stronger effects on

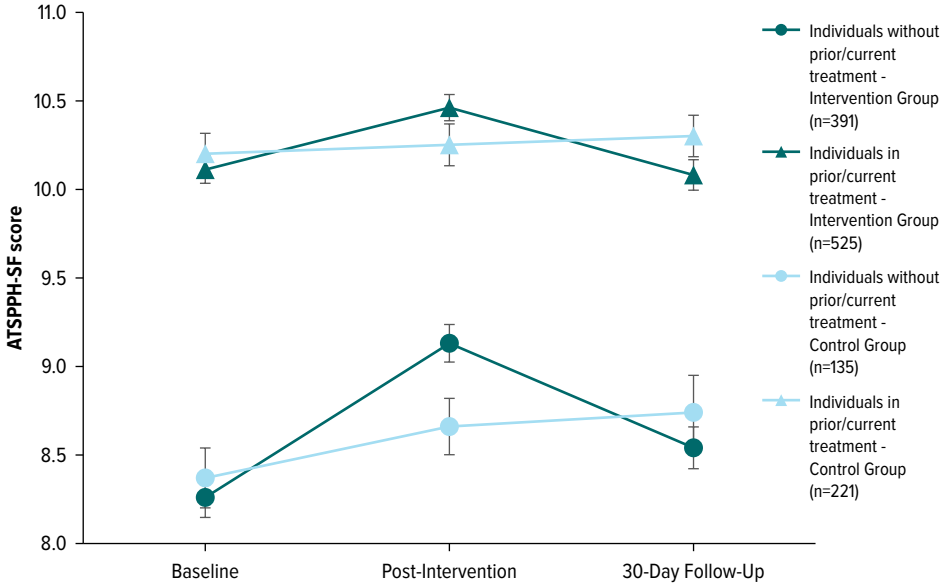
Figure 3.

Compared Effects of Intervention vs Control on Treatment-Seeking Intentions Over Time Across Subgroups (N = 1,281)[a]

A. Effects of Intervention and Control Compared by Prior Formal Psychiatric Diagnosis



B. Effects of Intervention and Control Compared by Prior Treatment Experience



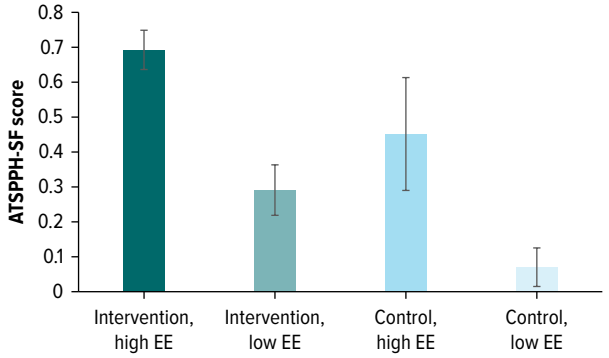
[a]Treatment-seeking measured with the Attitudes Toward Seeking Professional Psychological Help scale–Short Form (ATSPPH-SF); scores range from 3 to 12; higher scores indicate greater treatment-seeking intentions.

treatment-seeking intentions were found among those who did not have previous contact with the mental health care system, evidenced by the significant findings among those without mental health treatment history and those without history of provider-conferred psychiatric diagnoses. These findings reveal the efficacy of these brief video interventions in reaching groups who are both most in need—those with clinical symptoms—and not yet engaged with mental health care services.

The smaller group of participants who reported either mild anxiety or mild depression symptoms, but not higher, exhibited a significantly greater increase in treatment-seeking intentions following the intervention. This can likely be explained by the significant baseline difference between this group and those participants who met or exceeded moderate thresholds on at least 1 symptom measure. Because those with higher symptoms had higher treatment-seeking scores at

Figure 4.

Compared Effects of Intervention vs Control on Immediate Change in Treatment-Seeking Intentions by Level of Emotional Engagement with Videos (N = 1,281)[a]



[a]Treatment-seeking measured with the Attitudes Toward Seeking Professional Psychological Help scale–Short Form (ATSPPH-SF); scores range from 3 to 12; higher scores indicate greater treatment-seeking intentions. Emotional engagement (EE) was measured with the Emotional Engagement Scale; higher scores indicate greater engagement.

baseline, they likely experienced a ceiling effect, such that there was less room for improvement following the intervention.

Notably, the effects of our intervention were not sustained at follow-up, indicating a defined window for change. The acuity of the force of this intervention creates an opportunity for change that demands action from those who may capitalize on it—clinicians, researchers, and mental health policymakers. By finding ways to couple interventions such as these with concrete opportunities for behavioral change (eg, timely provision of contact information for mental health care providers), previous research supports the notion that mental health providers and policymakers can convert these immediate changes in treatment-seeking intentions to actual treatment-seeking behaviors.[44] Future research should focus on the extent to which these behaviors are impacted and the potential of these interventions to alleviate subjective psychological symptoms.

In considering these findings, it is important to note the limitations of this study. By recruiting participants through a crowdsourcing platform, we utilized a nonprobability sample, which may limit generalizability. Similarly, the ethno-racial breakdown of our sample differed slightly from the breakdown of the 2024 US census: the 2024 US census recorded a population breakdown that was 20% Hispanic (vs 16% in this study), 14% non-Hispanic Black (vs 11%), 75% non-Hispanic white (vs 64%), and 6% non-Hispanic Asian (vs 6%).[45] Additionally, we assessed clinical distress with self-report measures; these may be influenced by overreporting or underreporting which may limit the generalizability of the study findings.[46] Furthermore, the intervention did not exhibit sustained effects at follow-up, which may have been due to the lack of a "booster" readministration of the intervention video at follow-up.[47,48] Future studies should test whether the effect remains when those receiving the intervention have the opportunity to view it an additional time at follow-up. Finally, our sample was limited to young adults because of their particular familiarity with the brief video format and vulnerability to social stigma, but future studies should examine older adults to increase generalizability.

CONCLUSIONS

The findings of this study highlight a significant clinical opportunity to address a key barrier to treatment-seeking, potentially helping those most in need of care. While many individuals with a clinical need for treatment are hesitant to pursue it, this brief social contact–based video intervention has the potential to engage these individuals effectively. Its brevity and scalability make it suitable for widespread implementation, reaching diverse audiences. Such videos may be utilized in a range of settings, whether through employee wellness programs to specifically target essential workers like those in this study, in health system portals to engage individuals experiencing mental health concerns, or in recurring social media campaigns to target those yet to reach these resources. They may also be incorporated in mental health care referral systems to increase behavioral follow-through, capitalizing on the opportunity afforded by the video to boost immediate treatment-seeking intentions. As clinicians and mental health policymakers, there is an urgent need to adopt such interventions to foster greater engagement with mental health care and improve overall well-being.

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Supplementary Material

Article Title: Brief Video Intervention to Increase Treatment-Seeking Intentions Among Young Adults with Psychiatric Symptoms: A Randomized Controlled Trial

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LIST OF SUPPLEMENTARY MATERIAL FOR THE ARTICLE

1. **Appendix 1**

DISCLAIMER

This Supplementary Material has been provided by the authors as an enhancement to the published article. It has been approved by peer review; however, it has undergone neither editing nor formatting by in-house editorial staff. The material is presented in the manner supplied by the author.

Appendix 1

Video Interventions: https://www.youtube.com/watch?v=2Y9bicwlEuY

https://www.youtube.com/watch?v=XKMW9l4hJ0Y

Control: https://www.youtube.com/watch?v=PxEX5Aqe5sk

The video was shown to participants immediately following the preintervention assessment and immediately prior to the postintervention assessment, such that participants received one link at baseline to a survey with all three components presented in a sequential fashion (demographics and preintervention assessment, followed by intervention or control videos, followed by postintervention assessment). The intervention served to meet the principle of moderately disconfirming stereotypes through a balance of conveying the realities of struggles with mental health alongside a message of hope via pursuit of treatment.[1] This emphasis on themes of recovery has been shown to be impactful in decreasing stigma and increasing treatment-seeking intentions.[2] For this program of research with essential workers in particular, our earlier studies provided the basis for the content validation of the intervention in this study.[3–5]

In this study, the intervention included a narrative shared by an actress in which she explained the stressors she experienced as an essential worker during the COVID-19 pandemic, and the ways that she began to see them impacting her mental health ("I couldn't think properly, I couldn't sleep properly"). She then explained that a loved one reached out and recommended she seek treatment ("sometimes you have to put on your own oxygen mask before you help others"). Despite initial hesitations, she expressed that she decided to try it. From there, the video continues with a description of the ways that her mood and quality of life improved following beginning therapy. Although she is careful to note that things are not perfect, they are better than they were ("I still get anxious sometimes, but I am aware when it happens, and I can deal with it").

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