An experimental study on branding in Cognitive Behavioural Therapy

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Examination Number: B164819

Word Count: 8,225

THE UNIVERSITY *of* EDINBURGH

MASTER OF SCIENCE

PSYCHOLOGY OF MENTAL HEALTH (CONVERSION)

2020

Acknowledgements

This study would quite literally not have been possible without the support from my supervisor, David. Thank you for believing in this topic as much as I do, your encouragement and willingness to be creative is valued more than I can express. To all of the participants that took the time to partake in this study – thank you! I hope this study will get each of us closer to a more mentally friendly world. To my parents and family, your unwavering belief in me keeps me going irrespective of any self-doubt. Thank you for the much-needed calls, texts and chats over the last year. To Liam, who taught me the power of a purposefully designed experience, I am endlessly grateful. Your mentorship and kindness have shaped my thinking in ways I am forever thankful for. Last but not least, to my trusty sidekick and four-legged friend, Belle – thank you for listening to me ramble and rant about how important branding is to therapy.

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Abstract

Introduction

There is a compelling body of evidence suggesting there is a large gap in the numbers between those that require psychological help and those that seek out and partake in psychological therapy. In recent years, more studies are emerging on the role of branding in healthcare organisations and how it can be used as a means of managing patient perceptions. Carl Jung's theory of archetypes (Jung, 1968) has influenced a branding technique commonly used in the field of marketing, archetypal branding. Despite its common use, few studies have been conducted to support the efficacy of this approach.

Aims and Research Questions

The purpose of the present study was to explore the impact archetypal branding has on people's perceptions of Cognitive Behavioural Therapy (CBT). We predicted that higher levels of perceived trust, validity and efficacy would be associated with the group of participants exposed to the branded description of CBT.

Method

A between-individuals, quazi-randomized control trial design using an online format delivered to a non-clinical sample was employed for this study. Participants were randomly allocated to one of two groups in which they were exposed to either a branded or non-branded description of CBT.

Results

Results showed no significant differences in perceived levels of trust, validity or efficacy between those exposed to the branded and non-branded descriptions of CBT. Additionally, results suggest that we did not successfully manipulate the independent variable. This makes it difficult to ascertain with certainty whether or not archetypal branding does indeed impact people's perceptions of therapy.

Conclusion

Failure to manipulate the independent variable suggests further research is required to experiment with alternative ways in which CBT may be branded using archetypal branding. Future studies may benefit from including archetypal imagery presented in a manner that replicates a real-life advertisement. Additional research is also required to explore how best to measure both the manipulation of the independent variable and participant perception within a healthcare setting.

1. Introduction

The role of branding in healthcare is a relatively novel area of study, with a limited, yet growing body of research. The marriage of these two fields gained pace in the early 2000's and underlying this change was a shift in perception of the role of branding in healthcare, from being 'merely advertising', (Wagner et al., 1994) towards a means through which patient needs can be satisfied. Emotions are often an inherent part of a patient's experience in healthcare settings, and the role this plays in how patients make decisions about their health is receiving greater recognition. Branding is being turned to as a means of actively managing and enhancing this patient decision making process, with healthcare organizations using branding to, "…build trust…manage consumer perceptions and emotions regarding the healthcare organization", (Speak, 1996; Mangini, 2002).

Advertising often encourages consumers to attribute human features to brands in the knowledge that, if done correctly, it enables a relationship to be built with the brand and encourages loyalty (Aggarwal and McGill, 2007). As brands build 'personalities', whether explicitly or implicitly, consumers begin to develop expectations of what words, attitudes, behaviours and thoughts the brand will employ to communicate with them (Aaker and Fournier, 1995). Establishing consistency across each of these ensures brand trust can be built and maintained (Govers and Schoormans, 2005). This practice of personality building in branding has expanded and is now a common marketing technique used to enhance product and service perceptions (Erdogmus and Budeyri-Turan, 2012). Many frameworks for brand personality development have been created and are commonly utilized by marketing professionals. An example of such a framework is archetypal branding, derived from Carl Jung's theory of archetypes (Jung, 1968). Despite the common use of archetypes in the branding industry, there is limited research available to support their use in branding practices.

From a mental healthcare perspective, the ability of branding to build relationships and loyalty offers a unique opportunity to enhance the ongoing challenge faced by service providers of engagement and participation in care for patients with mental health difficulties (McHugh et al., 2013). There is a significant body of research supporting evidence-based psychological services and their ability to effectively reduce dysfunction and disability associated with mental illness (Gaudiano et al., 2016). Yet, despite the consistent interest in developing and testing psychological interventions, a disconnect remains between treatment availability and treatment seeking (Corrigan, 2014). This disconnect between availability of effective treatment and lack of care-seeking behaviour has been studied across populations and geographies, consistently highlighting the universality of the trend.

The present piece of research will firstly address the problem faced by mental health service providers whereby individuals that require mental health support, do not seek it out. Secondly, the emerging role of branding in healthcare will be explored, highlighting the specific ways in which it

can influence individual's perception of seeking out and partaking in psychological therapy. Finally, the method of branding utilised in this study, archetypal branding, and how it will be implemented into the present piece of research will be discussed.

1.1 Patient Perception of Therapy

Over 450 million people globally are impacted by mental disorders making it one of the largest contributors to ill-health across the world (Teh et al., 2014). Yet, despite the significant number of people impacted by mental illness, only 59.6% of people impacted in the United States in 2011 sought out and partook in relevant treatment (SAMHSA, 2012). Indeed, there is evidence to suggest that the numbers of individuals accessing psychotherapy are progressively decreasing (Olfson and Marcus, 2010). The literature cites a myriad of contributing factors to this gap in service use. Poor mental health literacy, a desire to remain self-reliant, expectations of therapy efficacy, fear of emotion and poor understanding of the qualifications and credentials of mental health professionals have all been reported as perceived barriers to accessing mental health services (Farberman et al., 1997; Gulliver, Griffiths & Christensen., 2010; Vogel & Wester, 2003; Komiya et al., 2000; Corrigan et al., 2014). Above all other factors, stigma associated with mental illness is one of the most studied contributors preventing people seeking out and partaking in therapy (Stuart, 2008; Corrigan and Penn, 1999). Stigma is an inherently complex construct, comprising of public and self-stigmatizing elements (Corrigan et al., 2014). To pinpoint any one of these factors as the main contributor to the help-seeking problem proves a difficult task and is beyond the scope of the current study. Research suggests however, that each of these factors cumulatively contributes towards a larger issue of the perception associated with seeking out and engaging with professional psychological help (Schomerus and Angermeyer, 2008).

The last decade has seen a significant effort placed on mental health awareness and education. This effort can be seen at a national level in the numerous public health campaigns run by governments across the world. In the UK for example, the ‘Time to Change’ programme ran between 2009-2014 and sought to focus on the destigmatization of individuals with mental health issues as measured by changes in knowledge, attitudes and behaviour (Sampogna et al., 2017). The campaign proved successful with those aware of the campaign being associated with more positive attitudes towards those suffering with mental health problems (Sampogna et al., 2017). However, the current study argues that efforts to shift perception of psychological therapy are needed at a systemic level, involving both government awareness campaigns and purposeful branding at the service provider level.

Research is beginning to emerge exploring in more detail the specifics of the advertisements we use to encourage those that require support to seek it out. Specifically, evaluations of the role language plays in patient's perceptions of psychotherapy have been the focus in studies over the last 5 years (Schofield, Ponzini and Becker, 2020). In three separate studies, campaigns were designed with varying levels of reference to 'expert language' used in their promotions (Brecht et al., 2017; Gallo et al., 2015; Ponzini and Schofield, 2019). The term 'evidence-based' was used to measure the impact including expert language has on individual's perception of therapy (Schofield et al., 2020). One campaign made no reference to the significant levels of research supporting the efficacy of psychotherapy (Gallo et al., 2015). The second campaign made a brief reference to this information with regards to psychotherapy, (Brecht et al., 2017), and the most recent promoting Cognitive Behavioural Therapy (CBT) focused predominantly on the evidence-based information available on the topic (Ponzini and Schofield, 2019). Schofield et al., (2020) report on these studies that despite the expectation that providing evidence of efficacy would result in positive perceptions of credibility and efficacy of treatment, there is evidence of the opposite. Qualitative evidence presented by the authors suggests that alongside a common misinterpretation of the term 'evidence-based', participants actually report a dislike for the term and the presumed rigidity it invokes upon learning its true meaning (Becker et al., 2016).

In opposition to this finding are the results of the study Schofield et al., (2020) proceeded to undertake, evaluating lay-knowledge on commonly used clinical terminology (i.e. evidence-based), and the impact this had on marketing efforts of therapy for anxiety disorders. The authors found a contradictory result to their review of prior studies, evidencing that when individuals received more information on the scientific evidence to support CBT, they reported more positive perceptions of treatment (Schofield et al., 2020). The authors conclude that the evidence supporting the inclusion or exclusion of expert language remains unclear, however this may suggest that the way in which the evidence is presented has an impact (Schofield et al., 2020).

This study argues that research such as that carried out by Schofield et al. (2020) amongst others, although in its infancy, will be crucial to helping mental health practitioners advertise their services in a manner that optimises resonance with those that require their help. The need for purposeful branding at the service provider level and the research surrounding healthcare branding will now be explored.

1.2 Branding in Healthcare

The body of evidence supporting the role branding can play in the management of healthcare organizations is growing. Kemp et al. (2014) explore the concept of branding in healthcare in research

based on the role affective branding specifically has on the consumer's relationship with healthcare organizations. The authors found that trust is a key ingredient in the process of developing an emotional connection with consumers. Importantly, the authors found the establishment of trust is dependent upon consumer's attitude towards the brand and their perception of the brand. The authors note an unexpected finding which highlights the knock-on impact of the cultivation of an affective relationship on what is described as 'a self-brand connection', (Kemp et al., 2014, p.133). The authors found that when a healthcare organization successfully builds an affective relationship with their consumer, the organization's brand becomes aligned with the consumer's self-concept, causing the individual to identify with the institution.

Indeed, this use of brands in the construction of self-identity is a well-studied phenomenon (Escalas and Bettman, 2003). Consumers are thought to use brands and products that are aligned with their own personality traits (Lin, 2010). Connections consumers make with brands have been shown to serve several purposes, notably, satisfying psychological needs, reinforcing a sense of self and enabling connections with others (Escalas, 2004; Escalas and Bettman, 2003; Wallendorf and Arnold, 1988). The knock-on effects of building a brand relationship with patients can be seen in patient behaviour. Snihurowych et al. (2009) conducted a study exploring the potential impact of branding on patient engagement with healthcare organizations. The authors found that branding improved retention rates and patient satisfaction. From a mental health perspective, the role branding can play in encouraging those that require help to seek out and partake in therapy provides a unique opportunity.

From both studies described, it becomes apparent that the role branding can play in healthcare organizations goes beyond the traditional view that such activities are not part of patient treatment. Indeed, the present study argues that branding impacts patient outcomes, both directly and indirectly, through the role it plays in patient perception of seeking out and partaking in therapy.

1.3 Archetypes and Archetypal Branding

The present study will utilize a specific form of branding, archetypal branding, to explore the impact this has on participant's perception of psychological therapy. Archetypal theory was first developed by Carl Jung (1875-1961) and describes archetypes as implicit or subconscious mental models of personality types, embodying specific behaviour patterns that are universally recognizable by all humans (Faber and Mayer, 2009). Jung attributes the universal recognition of archetypes to what he called the 'collective unconscious', a distinctly separate entity from the individual unconscious (Jung, 1968). From a clinical perspective, Jung's theory has been controversial from the beginning (Roesler, 2012), and to prove or disprove Jung's theory remains beyond the boundaries of the present study.

However, the ability to recognize archetypes and the impact they have on those perceiving them is central to the present piece of research. Table 1 displays a comprehensive list of the most commonly referenced Jungian archetypes and their descriptions (Faber and Mayer, 2009).

In 2009, Faber and Mayer conducted a comprehensive study analysing the responses of 100 participants to archetypal imagery found in media (i.e. books, movies, magazines etc.). The authors found that participants could reliably identify archetypes and that archetypes resonated differently with each participant. This study highlights the implicit nature of archetypes found in our various mediums of communication. The authors also found evidence that linked this difference in resonance to 'archetypal life themes', (Faber and Mayer, 2009, p.320), that display trends not only in media preferences but in social interactions and interests' individuals are drawn towards. The authors highlight the potential pertinence of such a finding for advertising and public health communications. This finding is in line with the results of a study conducted by Kemp et al. (2014), whereby participants developed a self-brand connection, aligning the organizations brand with their own self-concept. Indeed, Jung in his original work on archetypes posited that when we encounter archetypal imagery and or behaviour in our everyday lives, an emotional reaction is evoked, highlighting the powerful impact an understanding of archetypes can have. Maloney (1999) found evidence to support this notion that we respond to certain archetypes affectively, reporting a significant difference in patterned responses in a study he conducted amongst participants exposed to two distinct archetypes.

Table 1 Descriptions of Archetypes

Archetype	Description
Caregiver	A caring, compassionate figure, displaying generosity. Associated with protectiveness, devotion, sacrifice, nourishment and mother figures.
Creator	Often associated with innovators, inventors and artists. Seen as somewhat of a distant dreamer in search of novelty and beauty.
Everyman/Everywoman	Seen as the working-class underdog or neighbour. Thought to be candid, careful, realistic and wholesome.

Explorer	Seeks adventure and independence, driven by discovery and a curiosity of self and the world. Often seen as a wanderer, constantly moving.
Hero	Seen as a courageous figure, often represented by a warrior. A rescuer that seeks to prove themselves. Source of inspiration and represents human strength.
Innocent	Depicted as pure, childlike and naïve. Often associated with traditional values and simplicity.
Jester	Driven by mischief and fun, often depicted as comedian. Averse to responsibility.
Lover	Seeks love, passion and romance. A sensual figure that is often represented as erotic and seductive.
Magician	Driven by metamorphoses, a need to understand how things happen, a visionary. Often depicted as a performer or scientist.
Outlaw	Seen as a disruptive rule-breaker, often causing trouble. Rebellious figure that can be associated with anger.
Ruler	Highly influential figure, driven by power and control. Often represented as a dominant character.
Sage	Seeks to gain understanding, insight and knowledge. Seen as a wise scholar and expert, holding wisdom. Sometimes pretentious.
Shadow	Often lacks morality, represents humankind's downfalls. Sometimes seen as a savage and nemesis.

Note. Adapted from "Resonance to archetypes in media: there's some accounting for taste", by Faber, M., and Mayer, J.D., 2009, *Journal of Research in Personality, 43*(3), 307-322.

There is limited research available on archetypal branding, and even fewer studies available on archetypal branding in healthcare. One study that has taken archetypal theory and applied it to branding in a healthcare setting was conducted by Woodside et al. (2018). The study focused on measuring the impact archetypally developed ads for pharmaceuticals had on physician engagement and behaviour, relative to the pharmaceutical product being sold. The study employed significant resources, investing in an external ad agency and the licensing of the agency's intellectual property (IP) specifically designed to aid in the development of archetypal personas for healthcare products. The study found that well executed archetypal focused ads performed significantly better than non-archetypal focused ads. Additionally, performance of non-archetypal ads was inconsistent, whereas archetypal ads consistently performed at a higher level. Performance was measured by physician engagement as defined by intention to act (i.e. intention to prescribe the product in question to patients and the likelihood of asking the sales representative about the product).

The studies described above present three key findings that lay the foundation for the present piece of research. Firstly, the ability to perceive archetypes in media displayed in Faber and Mayer's study highlights the implicit nature of such constructs in all forms of communication. Secondly, individuals not only perceive and accurately identify archetypal figures in different forms of communication but display subconscious preferences in the types of archetypal figures they are drawn towards in their lives. Finally, using archetypes in branding may enhance perceptions and ad performance regardless of personal preferences of archetypal life themes. Studies such as these are rare, and despite the common use of archetypes in the branding industry, there is limited research available to support their use in branding practices. The present study proposes that in describing and advertising for psychological therapies, service providers are implicitly branding therapy. In doing so, they may be unintentionally resonating with some groups of people over others depending on an individual's archetypal preferences.

The implications of this for individuals seeking out and partaking in therapy may be significant and the present study argues that branding, through the role it plays in patient perception of therapy, impacts patient outcomes, both directly and indirectly. To test the impact branding has on people's perceptions of therapy, two descriptions of CBT therapy will be presented. One is taken from the Health Sector Executive (HSE) website in Ireland and the second is an archetypally branded alternative. Although unbranded, the HSE description is believed to be implicitly branded as the 'Sage' archetype (Jung, 1968). To ensure both descriptions are as distant from each other as possible, the Everyman archetype was used to develop the branded CBT description as it was deemed to be the most distinct from the Sage archetype.

The Sage is described as representing knowledge, truth and understanding (Faber and Mayer, 2009). Often presented as an expert or counselor, the Sage plays the role of scholar and guide (Jung, 1968; Hall and Lindzey, 1978; Mark and Pearson, 2001). The Everyman archetype is described as being the common person, pragmatic, down to earth and relatable, driven by a core desire to belong and connect with others, and a belief that everyone is created equal (Mark and Pearson, 2001; Campbell, 2008; Hall and Lindzey, 1978).

1.4 Aims of the present study

The present study aims to explore the impact archetypal branding has on participant's perceived levels of trustworthiness, credibility and efficacy of CBT. The literature presented indicates that the language utilised in advertisements of psychological therapies does impact patient's perceptions of therapy, although exactly how and why is unclear (Schofield et al., 2020). Research also shows that the expectations patients build of a healthcare organisation impact their levels of brand trust in the organisation, and as a result, their engagement with their healthcare provider (Speak, 1996; Mancini, 2002). Such expectations are built through the words, attitudes, behaviours and thoughts the healthcare organisation's brand uses to communicate with them (Aaker, 1996). The aim of this study is to contribute to our understanding of how research from the field of branding can be utilised by mental health practitioners to encourage those that require psychological help, to seek out and partake in psychological therapy.

1.5 Hypothesis:

- Individuals exposed to archetypal branding will display significantly higher levels of perceived trustworthiness, credibility, and efficacy towards the description of CBT than those in the control condition

2. Methods

2.1 Design

A between-individuals, quazi-randomized control trial design using an online format delivered to a non-clinical sample was employed for this study. To test for the impact branding CBT descriptions

has on people's perception of CBT, participants were allocated to one of two experimental conditions, based on whether they had an odd or even numbered age. Those that had an odd numbered age were exposed to the non-branded, neutral description of CBT. Those with an even numbered age were exposed to the experimental, branded description, altered based upon the Jungian archetype of the 'Everyman'.

Two descriptions of CBT were included in this experiment: 1) A non-branded CBT description that was taken from the Health Service Executive (HSE) website in Ireland (Health Service Executive, 2020); 2) An altered version of the HSE description that deliberately introduced archetypal branding language cues based upon the Jungian 'Everyman' archetype. A specific focus was placed on the use of verbs and pronouns to integrate the Everyman archetype into the description. For example, where the HSE description used pronouns such as 'you', and 'your', the Everyman branded description replaced this with 'we', 'us', and 'our', to emphasize the Everyman's image as the 'common-person', (Faber and Mayer, 2009). Both descriptions were matched as much as possible for sentence structure, length, number of words and length of sentence using an online software tool (Readable, 2020).

Table 2 CBT Descriptions

	Non-Branded	**Branded**
CBT Descriptions	"Cognitive Behavioural Therapy (CBT) helps you manage your problems by thinking more positively. It frees you from unhelpful patterns of behaviour. CBT is based on the idea that the way you think about a situation affects how you act. Your actions then affect the way you think and feel. So, it is necessary to change both thinking	"Cognitive Behavioural Therapy (CBT) *teaches us* that *we* can *normalize* our thoughts through positive thinking. Using *practical* methods, it helps *us get back to our regular daily lives*. *Put simply*, CBT shows *us* that how *we* think affects how *we* act. How *we* act then affects how *we* think and feel. By working *alongside* our CBT therapist, *we* can change how *we* think and what *we* do, to get *us* feeling connected with the kind of person *we* most want to be again.

	and what you do at the same time. CBT has been shown to work for a variety of mental health problems, such as: depression, anxiety, panic disorders phobias, obsessive compulsive disorder, post-traumatic stress disorder, some eating disorders, especially bulimia”	CBT is often used to help *us* deal with the following mental health challenges: depression, anxiety panic disorders, phobias obsessive compulsive disorder post-traumatic stress disorder some eating disorders, especially bulimia”
Pronouns	You, Your	We, Our, Us
Verbs	Helps, Manage, Frees, Shown	Teaches, Normalize, Connect
Flesch-Kincaid Readability Scale	7.6	7
Word Count	97	113
Sentence Count	12	12

Descriptors (Used for measurement of IV manipulation)	respectable, wise, proud, knowledgeable, scientific, prestigious, informative, analytical, intellectual	relatable, empathetic, understanding, accepting, friendly, humble, inclusive, pragmatic, supportive

2.2 Procedure

Ethical approval was provided by the University of Edinburgh's School of Health in Social Science ethics committee. Once approval was received, the study was shared on social media networks by both the researcher and the supervisor to enable recruitment. The study was created online using Jisc Online Surveys which is also where the data was collected. There were no incentives provided for participation.

The survey was designed to assess the impact of branding on people's perception of the efficacy, credibility and trustworthiness of CBT. Several ethical considerations were made for this study. Although unlikely, it was possible that asking people to indicate if they had previously engaged in psychological therapy might be upsetting. To mitigate this, a detailed information sheet (appendix 1) was provided, that described the kinds of questions that would be asked, as well as giving links to sources of mental health support. The information sheet also described how data would be stored, processed and kept secure and confidential. Finally, the information sheet described clear procedures for the governance of the research, including withdrawal and complaints. All participants provided informed consent and no participant found the study upsetting.

2.3 Inclusion Criteria

To be included in the study, participants had to meet the following criteria: 1) Speak English as their first language; 2) be over the age of 16. People from all geographic locations were included in the study. A demographic questionnaire was included in the study to establish if people met this list of criteria.

2.4 Measures

2.4.1 Dependent Variables

This online experimental study was interested in measuring the impact the IV (i.e. branded therapy descriptions) had on participant perceptions of CBT. Literature focused on therapy perception typically measures perception relative to those that are currently partaking in therapy. Indeed, there is significant ambiguity in the literature of how we define patient perception, with the term often used interchangeably with 'patient participation', (Gallivan et al., 2012). This study was concerned with exploring patient perception of CBT, relative to the advertising description they were exposed to. Given the scarcity of research on individual's perception of CBT advertising material, research conducted on consumer branding more broadly was consulted to aid in constructing appropriate measures. Despite a vast amount of research being available on this topic, currently, there is no unitary, well-established theory or corresponding measurement tool developed for use in research on consumer brand perception (Gambetti et al., 2012).

The measures chosen for this study were designed to capture three broad elements that were both present across the literature and relevant to the limited scope of the present study. Trust has been highlighted as a major contributor to brand perception in healthcare due to the intangibility of the product (i.e. the knowledge and experience of the healthcare provider), and so was deemed an integral part of our measurement (Berry, 2000; Kim, Kim, Kim, Kim and Kang, 2008). Perceived credibility and how it can be enhanced is also a focus across healthcare branding literature which led to its inclusion in the present study (Keller and Aaker, 1998; Walker and Kent, 2012). Perceived credibility is often mentioned in tandem with Corporate Social Responsibility (CSR) highlighting the reputational element of this factor. Finally, perceived levels of efficacy in a healthcare setting are described as underpinning a consumer's perception of how well a healthcare organisation can execute on the task at hand (Donabedian, 1997; Dranove and White, 1998).

This study adapted each of the above factors to reflect their role in a healthcare setting, measuring perceived levels of; efficacy, validity/credibility and trust/safety, allowing us to capture the impact of branding on each variable and thus overall perception. Each of these elements was measured on a 10-point Likert scale ranging from 1 (highly unsafe, untrustworthy; highly invalid, not credible; likely to be ineffective) to 10 (highly safe, trustworthy; highly valid, credible; likely to be effective). See Table 3 below (See also Appendix 2).

Table 3 *Likert Measurements*

Q13. *This therapy seems …*

	1	2	3	4	5	6	7	8	9	10	
Highly Unsafe, Untrustworthy											High Safe, Trustworthy
Highly Invalid, not credible											Highly valid, credible
Likely to be ineffective											Likely to be effective

2.4.2 Fidelity Check

To assess how well the independent variable was manipulated (i.e., how well the description was branded), participants selected words that most described each therapy, from the words in Table 2 marked 'Descriptors' (See also Appendix 3). A total of 18 characteristics were included in this list, 9 for each description. There were no limitations to the number of characteristics participants could choose. Although there is limited research available on the efficacy of using archetypes to brand therapy, there are studies in other fields, such as higher education, interested in measuring the ability of individuals to perceive archetypes (i.e., Coetzee, 2012). The study conducted by Coetzee (2012) was also concerned with measuring perception of archetypal constructs and utilized the Pearson-Marr Archetype Indicator (Pearson and Marr, 2002). Initially, this study hoped to employ the same measure, however licensing costs prevented this and so the measure this study employs was created utilizing the researcher's knowledge of archetypes. The measure developed included 9 adjectives used to describe the Everyman archetype and 9 adjectives used to describe the Sage archetype. The words were displayed randomly to participants and not in the format seen in Table 2.

2.5 Analytic Plan

2.5.1 Power Analysis

An a priori power analysis, based on similar studies conducted by Rochelle et al. (2009), Chang (2008) and Hammer and Vogel (2008) found an average effect of Cohen's D = .48. Based on Cohen (1992) using a between groups T-Test with an α of .05, power of .8 and medium effect size of .48, power analysis indicated a total of 128 participants would be sufficient to detect a medium effect or larger. Each of these studies focused on measuring the impact of public health campaigns on participants perceptions of mental health.

2.5.2 Data Analysis

Data analysis was conducted using SPSS version 24 (IBM, 2016). Initial analysis involved removal of participants that did not meet inclusion criteria, checking for missing data, normality of distribution and identification of outliers.

Following this, a visual inspection of the data set was carried out. Incomplete questionnaires were deleted which included 4 cases of missing data for age and 6 cases of missing data on Likert scales. To ensure there was no other missing data remaining in the data set, a 'Missing Value Analysis' was carried out to confirm the remaining data set comprised of complete questionnaires. Following this, analysis on the complete data set commenced. Initial tests of normality using Shapiro-Wilk's test found the data to be significantly non-normally distributed. Given the large sample size and the sensitivity of the Shapiro-Wilk test (Ahad et al., 2011), normality plots were also referenced. The decision was made to use non-parametric analysis instead of transforming the data. Although non-parametric analysis is less powerful than parametric analysis (Field, 2009), the large sample size helps to negate this drawback. Initially, a Chi Square analysis was run to examine how effectively CBT was branded using the everyman archetype, examining the pattern of selecting yes or no for each word, as a function of group membership. If the branding was successful, people in the branding condition should be more likely to select everyman archetype descriptors, compared to the other words, and the non-branded group would be more likely to select words at random. Descriptive statistics were determined for demographic variables (i.e., age, gender, prior therapy experience), and for the three dependent variables (i.e., trust/safety, validity/credibility and efficacy).

3. Results

3.1 Participants

A total of 305 participants were recruited with individuals ages ranging from 17 to 69 (M=33.5, SD = 10.7). 14.1% of the participants were aged between 17 -25, 57.6% of the participants were aged between 26-35, 12.7% were aged between 36 – 45, and finally, 15.6% of the participants were aged 45years and over. Participants were recruited from online social media channels in June 2020. 61.6% of participants identified as female and 38.4% identified as male, with no participants identifying as non-binary. Half of the participants had previously been to therapy (50.4%), 25% had considered going to therapy and 24.6% had neither been to nor considered going to therapy. Table 4 displays an outline of this demographic information.

Table 4 Demographic Variables

		N	Frequency (%)
Age (in yrs.)			
	17-25	39	14.1
	26-35	159	57.6
	36-45	35	12.7
	45+	43	15.6
Gender			
	Male	106	38.4
	Female	170	61.6
Experience of Therapy			
	Has been to therapy	139	50.4
	Has considered going to therapy	69	25
	Neither of the above	68	24.6
First Language is English			
	Yes	237	85.9
	No	39	14.1

3.2 Data Preparation

Firstly, an exploration into the impact of our control variables (i.e. age, gender, prior experience of therapy) were integrated into the analysis. Perceived levels of Trust, Validity and Efficacy were not significantly different for gender, previous experience of therapy, or age group. These were therefore not controlled for in the subsequent analysis. Secondly, a visual inspection of the data was carried out to assess the normality of distribution and from this it was determined the data was non-normally distributed. Q-Q plots and the Shapiro-Wilk test of normality were also used to assess normality. These indicated that all three dependent variables were significantly non-normally distributed. For Validity and Credibility, w (.837) = 237, p=.00, skewness (z = -1.226) and kurtosis (z= .780). Trust and Safety, w (.763) = 237, p=.00, skewness (z = -1.680) and kurtosis (z = 2.277). Finally, for Efficacy, w (.850) = 237, p=.00, skewness (z = -1.273) and kurtosis (z = 1.122). Given this was quite a large sample size, the decision was made to use non-parametric analysis instead of transforming the data.

The initial data analyses focused on ascertaining whether or not the independent variable had been successfully manipulated. Following this, a comparison was conducted on the results from the group exposed to the archetypal branded CBT description with those from the non-archetypal branded CBT description on each of the three dependent variables (i.e., trust/safety, validity/credibility and efficacy).

3.3 Manipulation of the Independent Variable

The first step in analysis involved ascertaining whether the manipulation of the independent variable had been successful. This was done using a Chi Square analysis. If the branding intervention were successful, people in the branding condition should be more likely to select the everyman archetype words, compared to the other words, and the non-branded group would be more likely to select words at random. This pattern of results was not observed. Participants in the branding condition and the non-branding condition did not differ in their selection of descriptors (Chi Square values between 0 and 3.3 (*df* = 1), all *p*>.05, *ns*). There were three of eighteen words that were exceptions to this pattern. The word ‘Respectable’ was selected by significantly fewer participants in the non-branding group than the branding group (Chi Square 11.0 (*df* = 1), *p* <.05, one tailed). As this was not one of the words considered to be closely related to the everyman archetype, this difference does not support the efficacy of the branding manipulation. A second word, ‘Accepting’ was associated with the Everyman archetype, and was selected by more branding group

participants than non-branding group participants, (Chi Square 3.3 (*df* = 1), *p* <.05, one tailed). Finally, the word 'Analytical' was predicted to be selected by fewer branding group participants than the non-branding group. This result was seen, though the pattern was not sufficiently strong to reach standard criteria for statistical significance (Chi Square 2.8 (*df* = 1), *p* =.06, *ns*). Overall, these results do not suggest that the experimental manipulation of branding was effective.

3.4 Trust/Safety

For the group exposed to the branded CBT description, the median total score on the Trust/Safety scale was 8.00 (N = 139, SD = 2.437). For the group exposed to the non-branded CBT description, the median total score was 9.00 (N = 98, SD = 2.315). Participants in the non-branded CBT group showed higher levels of perceived Trust/Safety than those in the branded group. To test the significance of this result, an independent samples Mann-Whitney U Test was performed. No significant difference was found between the branded and non-branded groups (U =6379.5, p = .39). Exploratory assessments were run to ascertain whether there were any significant associations between participant characteristics (i.e., age, gender and prior experience with therapy) and perceived levels of Trust/Safety. To explore if there were any relationships between the dependent variables and participant age, the age variable was grouped into 4 age categories (i.e., 17-25, 26- 35, 36-45 and 45+). No significant relationship was found between perceived levels of Trust/Safety and participant age. Results were as follows: 17-25 (U = 99, p = .788), 26-35 (U = 2221.5, p = -.9), 36-45 (U = 62.5, p = .054), 45+ (U = 171.5, p = .651). No significant relationship was found between participant gender and perceived levels of Trust/Safety. For females, (U = 2302.5, p = -.429), and for males (U = 1020.5, p = -.731). No significant relationships were found between participants prior experience with therapy and perceived levels of Trust/Safety. Results were as follows: Participants that have been to therapy previously (U = 1683.5, p = .934), participants that have considered going to therapy (U = 339.5, p = .875), and finally, participants that have neither been to or considered going to therapy (U = 379, p = .142).

3.5 Validity/Credibility

For the group exposed to the branded CBT description, the median total score on the Validity/Safety scale was 8.00 (SD = 2.592). For the group exposed to the non-branded CBT description, the mean total score was 8.00 (SD = 2.464). Participants in the branded group showed the same median levels of perceived Validity/Credibility as those in the non-branded group. An independent samples Mann-Whitney U Test found the difference in medians between the groups to be non-significant (U =

6417.5, p = .44). Running a Mann-Whitney U test again, there were no significant associations between participant age, gender or prior therapy experience and perceived Validity/Credibility. Results for age were as follows: 17-25 (U = 92, p = .562), 26-35 (U = 2019.5, p = .306), 36-45 (U = 76, p = .208), 45+ (U = 162.5, p = .481). No significant difference was found between participant gender and perceived levels of Validity/Credibility. For females, (U = 2428.5, p = -.797) and for males, (U = 933, p = .304). No significant relationship was found between participants prior experience with therapy and perceived levels of Validity/Credibility. Results were as follows: Participants that have been to therapy (U = 1496.5, p = .270), participants that have considered going to therapy (U = 338.5, p = .862) and finally, participants that have neither been to or considered going to therapy (U = 471.5, p = .897).

3.6 Efficacy

For the group exposed to the branded CBT description, the mean total score on the Efficacy scale was 8.00 (SD = 2.366). For the group exposed to the non-branded CBT description, the mean total score was 8.00 (SD = 2.254). Participants in the branded group displayed the same median levels of perceived Efficacy as those in the non-branded group. An independent samples Mann-Whitney U Test found the difference in means between the groups to be non-significant (U = 6337, p = .35). Running a Mann-Whitney U test again, no significant differences between participant age, gender or prior therapy experience and perceived Efficacy were found. Results for age were as follows: 17-25 (U = 76, p = .196), 26-35 (U = 2098.5, p = -.501), 36-45 (U = 182.5, p = .578), 45+ (U =169, p = .605). No significant difference was found between participant gender and perceived levels of Efficacy. For females, (U = 2145.5, p = .152), and for males, (U = 1014, p = -.693). There was no significant relationship found between participants prior experience with therapy and perceived levels of Efficacy. Results were as follows: Participants that have been to therapy (U = 1405.5, p =.111), participants that have considered going to therapy (U = 304.5, p = .423), and participants that have neither been to or considered going to therapy (U = 479, p = .983).

4. Discussion

In summary, our findings did not support the hypothesis that those exposed to an archetypally branded description of CBT displayed higher levels of perceived trust, credibility or efficacy of CBT than those in the control group. Additionally, our findings failed to show a successful manipulation of the independent variable, thus making it difficult to ascertain with any level of certainty whether or not branding CBT using archetypes can or does impact perceived levels of trust, credibility or efficacy.

From the outset, this study sought to explore the impact archetypal branding has on people's perceived levels of trustworthiness, credibility and efficacy of CBT. It is well documented that a significant percentage of those that require professional psychological help, do not seek it out (Corrigan et al., 2014). Branding is a mechanism used in commercial organisations to manage consumer perceptions of an organization, product and service (Keller, 1993). This paper sought to merge practices from commercial branding into a mental health setting and explore the potential role it could play in improving patient perception of seeking out and partaking in therapy. Archetypes are a commonly used branding tool in the marketing and advertising sector, yet research supporting their efficacy is limited. Studies on the use of branding as a tool to solve problems faced by professionals in the mental health sector are also minimal. This study sought to explore this relatively ambiguous area of research by conducting an experiment on the impact archetypal branding has on individual's perceived levels of trustworthiness, credibility and efficacy of CBT.

4.1 Fidelity Check

The results of a chi square analysis conducted to ascertain how successfully the independent variable was manipulated suggest we were unsuccessful in our manipulation. The predicted pattern of participants in the branding condition being more likely to select everyman archetype descriptors compared to other descriptors was not observed. Out of the eighteen descriptions in the measure, only one supported our predictions, that is 'accepting', which as predicted was chosen by more participants in the branding condition than the non-branding condition (Chi Square 3.3 (df= 1), $p = .05$, one tailed). This, however, is not enough to support our predicted outcome. There are a number of potential reasons for seeing these results.

Firstly, the results may be accurate and reflect a failure to manipulate the independent variable and effectively brand CBT using archetypal branding. From the outset this study sought to limit the variations introduced in our experiment to ensure clear traceability of what variable was having an effect. Initially, the descriptions of CBT used were going to be presented in a structure that replicates that of regular advertisements which typically include both text and image. The image used would have been chosen to reflect the everyman archetype in the experimental condition and the sage archetype in the control condition. However, it would have been difficult to suggest with any degree of certainty in our results whether the image or text was having an effect if an effect was indeed observed. Thus, to ensure we isolated our independent variable in a manner that provided clarity to results, we chose to focus solely on manipulating the language used in a CBT description utilising archetypal branding.

However, there are drawbacks to this approach which may help explain the unsuccessful manipulation of the independent variable shown in the results. Prior studies showing significant results for the recognition of, and or impact of archetypes on advertising material used both imagery and language to bring the archetype to life (Woodside t al., 2018; Faber and Mayer, 2009; Maloney, 1999). For example, the study most similar in design to the present piece of research was that conducted by Woodside et al. (2018), in which the impact archetypal advertising has on physician engagement and behaviour was explored. The researchers in this study employed two external agencies to both assist in employing archetypal branding into their advertisements and in the actual creation of realistic advertisements that were subsequently embedded into a medical journal to be used in the experiment. The authors note that the creation of actual ads was chosen as prior studies indicated their superiority in providing the experiment with the best chance for success (Schlinger and Green, 1980; Woodside et al., 2018). By presenting plain text describing CBT in our study it allowed us to be certain of the chain of effects between variables, however it may have limited our ability to successfully manipulate the independent variable. Indeed, in both Maloney (1999) and Faber and Mayer's (2009) studies, the independent variable was successfully manipulated using only images. These results may provide support for the piece of Jung's theory that focuses on the interpretation of archetypes as 'primordial…mythological images', (Jung, 1963, p. 16). Indeed, other studies have shown that language alone may be enough to alter participants perceptions of therapy (Brecht et al., 2017; Gallo et al., 2015; Ponzini and Schofield, 2019). The results however are mixed, and it remains unclear as to how exactly language impacts perceptions of therapy (Ponzini and Schofield, 2020).

Secondly, the failure of the results to show a successful manipulation of the independent variable may have resulted from the measurement employed in the study. The lack of studies on the efficacy of archetypal branding has resulted in an equal lack in supply of measures tailored to this specific method of branding. Woodside et al. (2018) did include a bespoke measurement of archetypes in their study to ascertain the strength of the alignment of the ads in their experiment to the archetypes they were utilizing. However, the method employed in their study was carried out with the aid of an outsourced advertising agency and proved too complex to replicate in the present study. Alternative methods of measurement, namely the Pearson-Marr Archetype Indicator® were explored, however licensing barriers prevented their use in the present study. As a result, a bespoke measurement was created for use in this study utilising the researcher's knowledge of Jungian archetypes. There was a risk that this method would fail to capture the presence of a successful manipulation by oversimplifying the measurement. Thus, it is possible, although unlikely, that the independent variable was successfully manipulated but our measurement fails to capture this.

4.2 Perceived Levels of Trust/Safety, Validity/Credibility, Efficacy

Perceived levels of trustworthiness, validity and efficacy were measured as contributing factors to participants overall perceptions of seeking out and partaking in therapy. We hypothesized that the group exposed to the branded CBT description would display higher levels of perceived trustworthiness, validity and efficacy than those exposed to the non-branded CBT alternative. The results did not support this hypothesis and there was no significant difference found between groups on perceived levels of trustworthiness, validity or efficacy. It can be assumed with a reasonable amount of certainty that the results observed were seen as a direct impact of the failure to manipulate the independent variable Thus, it is difficult to say whether or not archetypal branding does indeed impact people's perceptions of therapy based on the present study alone. In addition to the failure to successfully manipulate the independent variable, there are a number of reasons as to why this result may have been observed.

Firstly, similar to our measurement utilised for our independent variable, there is a significant lack of well-established theory and corresponding measurement tools developed for use in research on consumer brand perception (Gambetti et al., 2012). Thus, the measurement employed to ascertain brand perception in this study was created based on three elements broadly present across the literature observed by the researcher. These elements were adapted to take into consideration their applicability to a healthcare setting and presented in the survey as perceived levels of; efficacy, validity/credibility and safety/trust to participants. However, it is possible that the measure created, although designed with perceptions of healthcare in mind, fails to capture with accuracy differences in participants perceptions of the therapy presented. Without a standardized measure it is difficult to say with certainty whether or not the results are due to the absence of an effect or a lack of ability to detect the presence of an effect with the current measure.

Similar studies that have adopted the same approach of creating bespoke measures of brand perception in healthcare settings have seen an effect present. For example, Kemp et al, (2014) found that the use of affective branding does lead to a significant positive increase in overall perception of healthcare organisations. However, the measurement employed by the authors encompassed a more complex range of ten different variables, including questions on participants perceptions of quality, brand prestige, customer-oriented behaviour, brand attitude amongst others. Indeed, the study conducted by Kemp et al, (2014) focused on measuring perceptions of a healthcare organisation participants were already affiliated with. This makes it difficult to deconstruct specifically what branding activities in particular are contributing to overall changes in perception. Branding behaviours are displayed at every level of the organisation through the words, attitudes, behaviours and thoughts those working within the organisation employ (Aaker, 1996). Without a clear understanding of what

actions and behaviours are encompassed in branding, it is difficult to ascertain with any level of certainty what is contributing to changes in consumer's perception of a healthcare organisation. From a research perspective, it makes it particularly difficult to compare effects observed in different studies and contribute to the industry as a whole when we are often not comparing like with like.

4.3 Limitations

The present study faced a number of limitations. Firstly, there is a significant amount of novelty involved in this study which created a number of challenges particularly in relation to measurement. Archetypal branding despite being used as a common marketing technique in the advertising industry, is not well researched. This posed a challenge in both how we used archetypes to alter the CBT description of the HSE website, and how we measured participants perceived differences in archetypal characteristics. Every effort was made to design a measure that could accurately trace differences in participants perception of therapy characteristics using Jungian theory of archetypes. However, without a measure well supported by research, it is difficult to say how effective this bespoke measure is in capturing such differences. Secondly, there is a significant amount of ambiguity present in the literature on how we measure brand perception, particularly brand perception in a healthcare setting. This again posed a measurement challenge in which input from the researcher was required to discern what variables were most important to measure overall perceptions of seeking out and partaking in therapy. Finally, branding as a marketing technique encompasses a range of different activities that typically work together to create an overall perception of a brand. The present study was limited by the range of branding activities it could undertake and how well it could measure which of these is having what kind of impact on overall participant perception. To ensure our results were clear on what variables had what impact, language was the only branding tool utilised to employ archetypal branding in this study. This restricted our ability to employ a full range of branding tools to create the image of an archetype. As a result, quality of branding was sacrificed to ensure the validity of the study and certainty of results were not impeded upon.

4.4 Future Studies

The failure of this study to manipulate the independent variable using solely language may suggest that archetypes are primarily a visual rather than linguistic phenomenon and thus best suited to imagery manipulation rather than solely linguistic manipulations. This may be an interesting line of enquiry for future studies exploring the role archetypal branding can play in people's perceptions of therapy. Building on the findings of the present study, future research could employ a similar design and introduce archetypal imagery alongside linguistic manipulations. This would enable researchers

to measure the impact including imagery has in comparison to focusing solely on linguistics the current study employed.

4.5 Conclusion

Research on the role branding can play in managing patient perception and experience in a healthcare setting is in its infancy. The present study, although failing to support our hypothesis, lays the foundation for future studies to be built upon its findings. Although studies are just beginning to emerge in this field, there is evidence that merits the role branding can play in improving both patient experience and perceptions in a healthcare setting. The merging of branding and mental healthcare could prove to be a successful avenue of research for encouraging those that need help, to seek out and partake in psychological therapy. Studies such as this highlight the need for practitioners to view all contact with patients, both direct and indirect, as key contributors to patient outcomes. How we present psychological therapy impacts how those that need help perceive it. By purposefully branding and tailoring our advertising materials, we can encourage those that need help to seek out and partake in psychological therapy.

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Appendices

Appendix 1

AN EXPERIMENTAL STUDY OF BRANDING IN COGNITIVE BEHAVIOURAL THERAPY PARTICIPANT INFORMATION SHEET
25.05.2020

You are being invited to take part in research on the topic of psychological therapy. X, Masters student in Clinical Psychology at the University of Edinburgh is leading this research, under the supervision of Dr David Gillanders, Head of Clinical Psychology. Before you decide to take part, it is important you understand what it will involve. Please take time to read the following information carefully.

DO I HAVE TO TAKE PART?

No – it is entirely up to you.

If you do decide to take part, please carefully read the information provided on this page and tick 'yes' on the boxes below to show that you consent. If you do decide to take part, you are still free to stop the study at any time, simply by shutting your browser. Data collected to that point will be deleted.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

You will firstly be asked to complete a short demographic questionnaire about age, gender and whether or not you have previously partaken in or considered partaking in psychological therapy. You will not be asked any details of this therapy, or reasons why you sought or considered therapy. You will not be asked about your mental health or psychological problems either currently or in the past. You will then be asked to read a short description of a psychological therapy. Following this, you will be asked to answer a very brief questionnaire about what you thought about the psychological therapy described. The entire process should take between 5 to 10 minutes to complete.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

By partaking in this research, you will be helping us to better understand how to communicate to people about psychological therapies. Our aim is to learn which kinds of communication lead to enhanced likelihood of uptake of psychological therapies, to make psychological therapies more accessible to people.

ARE THERE ANY RISKS ASSOCIATED WITH TAKING PART?

The questions we will ask and the description you will read will be quite general and will involve short answers only, all of which are check boxes. We will not ask for personal details or any particularly sensitive information. If you are experiencing any discomfort at any point you can stop answering the question, take a break, and/or stop participation entirely and withdraw from the study (with no negative repercussions).

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Agreeing to begin this study does not oblige you to complete it. If you decide to stop being in the study, simply close your browser. Data collected to that point will be deleted. As the data gathered is completely anonymized, once you have completed the study and submitted your responses, it will not be possible to withdraw your data from the study.

DATA PROTECTION AND CONFIDENTIALITY

No personally identifiable data will be collected about you. Even though the data will not be able to identify you, it will be processed in accordance with GDPR and UK data protection laws. Your data will only be viewed by the researcher/research team, though future studies may make use of the data and may involve new members of the research team at the University of Edinburgh, under the supervision of Dr David Gillanders. Your data will not be shared with other organisations. The online survey platform is secure and encrypted and compliant with UK and EU data processing and storage requirements. All electronic data will be stored on secure, encrypted cloud based storage, belonging to the University of Edinburgh, and accessed only through password-protected computer.

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

The results of this study will be summarised in the researchers' dissertation project. You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports). No individual can be identified in these reports. We will produce a summary of the results once the study has finished and make this available via the following link: https://www.wiki.ed.ac.uk/x/l_RlGg A summary of the results will be available on this site from 1st august 2020.

WHO CAN I CONTACT?

If you have any further questions about the study, please contact the lead investigator X at:

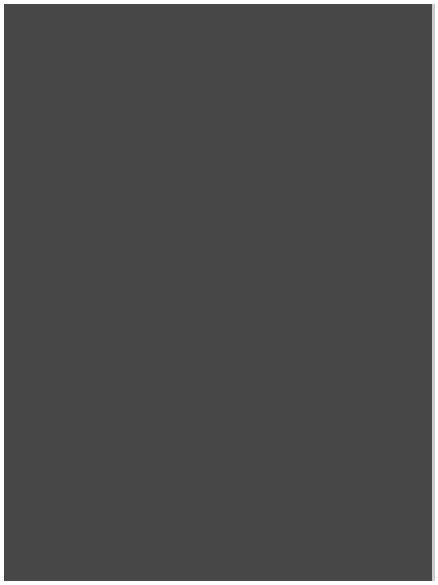
s1995303@ed.ac.uk

If you have any concerns following this study and/or would like to know more, please contact the project supervisor:

Dr. David Gillanders
Head of Clinical & Health Psychology University of Edinburgh
School of Health in Social Sciences Tel: +44 (0)131 651 3946
Email: David.gillanders@ed.ac.uk

If you have any concerns following this study and would like some advice from someone external to the project then please contact the Research Lead:

Dr Helen Sharpe
Department of Clinical and Health Psychology School of Health in Social Sciences
Tel: +44 (0)131 651 3949
Email: helen.sharpe@ed.ac.uk



If you wish to make a complaint, please contact the Head of the School of Social Science:

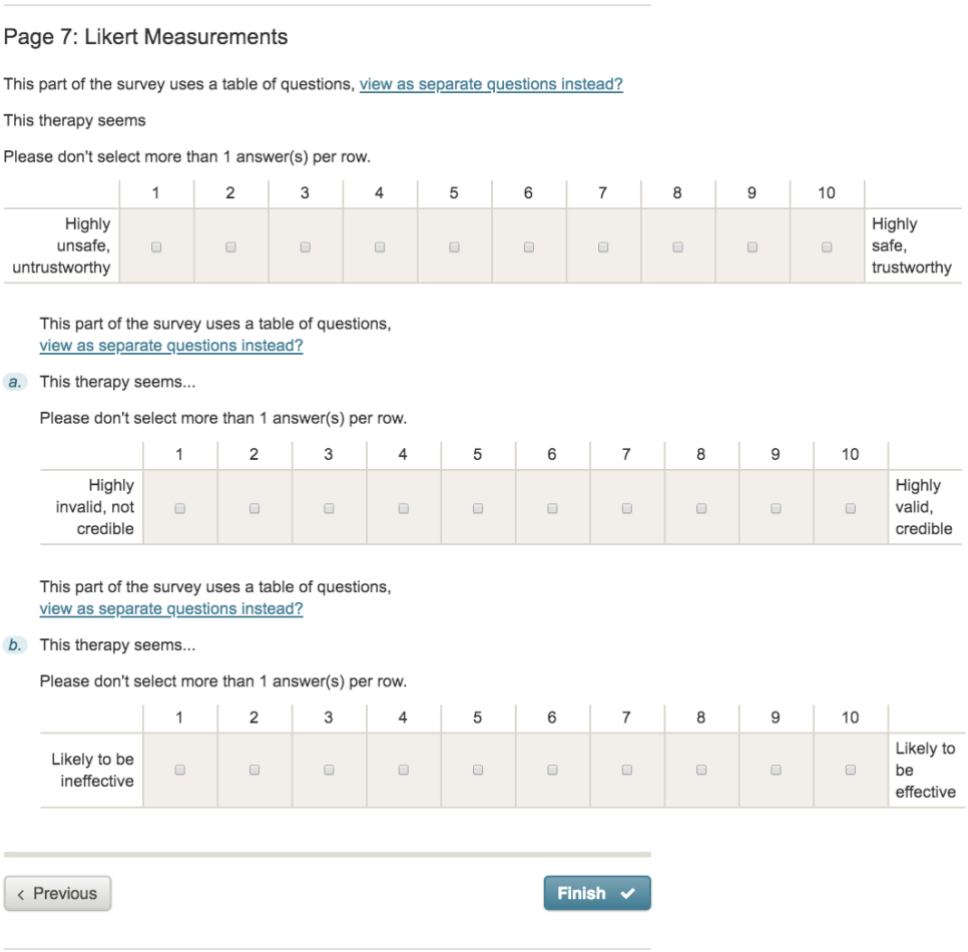
Professor Matthias Schwannauer Head of School of Social Science
Tel: +44 (0)131 651 3954
Email: headofschool.health@ed.ac.uk

Details of the University's complaint process and complaint form can be found here:

https://www.ed.ac.uk/students/academic-life/complaints

For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research

Appendix 2



Page 7: Likert Measurements

This part of the survey uses a table of questions, view as separate questions instead?

This therapy seems

Please don't select more than 1 answer(s) per row.

	1	2	3	4	5	6	7	8	9	10	
Highly unsafe, untrustworthy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Highly safe, trustworthy

This part of the survey uses a table of questions, view as separate questions instead?

a. This therapy seems...

Please don't select more than 1 answer(s) per row.

	1	2	3	4	5	6	7	8	9	10	
Highly invalid, not credible	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Highly valid, credible

This part of the survey uses a table of questions, view as separate questions instead?

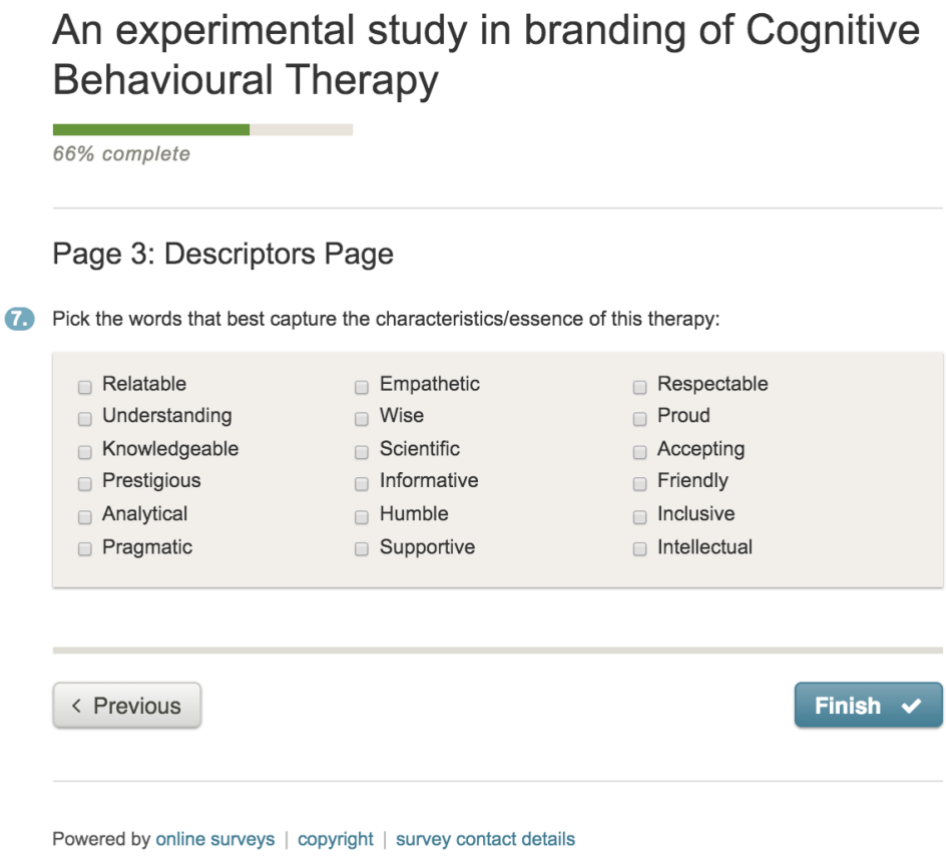
b. This therapy seems...

Please don't select more than 1 answer(s) per row.

	1	2	3	4	5	6	7	8	9	10	
Likely to be ineffective	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Likely to be effective

‹ Previous Finish ✔

Appendix 3



An experimental study in branding of Cognitive Behavioural Therapy

66% complete

Page 3: Descriptors Page

7. Pick the words that best capture the characteristics/essence of this therapy:

Relatable	Empathetic	Respectable
Understanding	Wise	Proud
Knowledgeable	Scientific	Accepting
Prestigious	Informative	Friendly
Analytical	Humble	Inclusive
Pragmatic	Supportive	Intellectual

< Previous

Finish

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