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COLLEGE STUDENTS' PERCEIVED AND PERSONAL MENTAL HEALTH  
STIGMA: THE INFLUENCE ON HELP-SEEKING ATTITUDES AND INTENTIONS

A DISSERTATION

Submitted to the Faculty of  
Montclair State University in partial fulfillment  
of the requirements  
for the degree of Doctor of Philosophy

by

ALYSON POMPEO

Montclair State University

Upper Montclair, NJ

2014

Dissertation Chair: Dana Heller Levitt, PhD

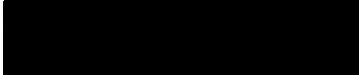
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MONTCLAIR STATE UNIVERSITY  
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DISSERTATION APPROVAL


We hereby approve the Dissertation  
COLLEGE STUDENTS' PERCEIVED AND PERSONAL  
MENTAL HEALTH STIGMA:  
THE INFLUENCE ON HELP-SEEKING ATTITUDES AND INTENTIONS  
of  
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Doctor of Philosophy

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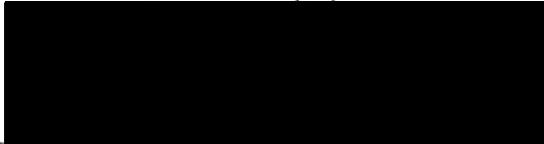
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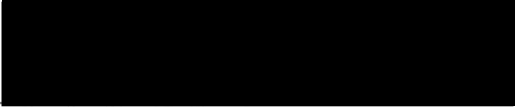
  
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## ABSTRACT

### COLLEGE STUDENTS' PERCEIVED AND PERSONAL MENTAL HEALTH STIGMA: THE INFLUENCE ON HELP-SEEKING ATTITUDES AND INTENTIONS

by Alyson M. Pompeo

Despite being vulnerable to mental health problems, college students are a population that is especially influenced by perceptions of peer mental health stigmatization (Quinn, Wilson, MacIntyre, & Tinklin, 2009), a known barrier to seeking mental health services (Corrigan, 2004a; Komiya, Good, & Sherrod, 2000; Vogel, Wade, & Haake, 2006), and the greatest barrier to college students (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010). This paper begins with a thorough discussion of the participant population—undergraduate college students, including well established theories of college student development, and developmental challenges and issues that are faced. Mental health stigma is also explored in detail, including specific types and its role as a barrier to help-seeking behaviors. There is a negative impact on mental health through perceived public stigma (Andrews, Issakidis, & Carter, 2001; Komiya, Good, & Sherrod, 2000), yet, the amount of public stigma may be overestimated through misperception, as estimates are considerably greater than one's own personal stigma (Eisenberg et al., 2009). Also, higher levels of perceived public stigma have been associated with lower levels of help-seeking (Eisenberg et al., 2009). This study gained a better understanding of the relationships and predictions between perceived and personal stigmas and help-seeking attitudes and intentions. Furthermore, this study accounted for the variable of social desirability in such relationships, as prior research has not. This paper presents

justifications and discusses the specific methods used for the current study, as well as the findings. Finally, implications for clinical and educational use are presented along with implications for future research.

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encouragement you showed me as I made the decision to enter this doctoral program. Thank you for all of your flexibility and help as you made working full-time and completing doctoral classes possible.

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Thank you to my family and friends for your support. Thank you to my husband and best friend, Anthony Fagnoli, the one I dedicate this work to. Last but not least,



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## DEDICATION

Commitment, effort, and dedication were fundamental elements for the completion of my doctoral dissertation, but even more so was the support of my family and friends. To my husband and best friend, Anthony, I dedicate this important professional achievement to you because without your patience, support, and love, I would have not achieved my goal. I love you.

We have been together through two doctoral program acceptances, our wedding, new jobs, our relocation from NJ to NC, and the literal building of a home together. We have had quite a ride already! I am looking forward to starting the next chapter of our lives together. I am so very excited and proud of you as you complete your own dissertation at The University of Pennsylvania. Here's to a house of "Dr. & Dr." as you finish yours in the next few months. I am so proud of you. While we may have joked at times about having a "race to the dissertation finish line," you were the best running partner.

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## **Chapter One**

### **College Students' Perceived and Personal Mental Health Stigma: The Influence on Help-Seeking Attitudes and Intentions**

#### **Introduction**

Since Princeton University started the first campus mental health center in 1910, there has been awareness in higher education about the mental health needs of students (Kadison & DiGeronimo, 2004). Recent years have seen an increase in college student mental health issues and the need for college counseling centers. For example, Gallagher (2011) found that 91% of college counseling center directors reported a continued increase in the number of students with severe psychological problems. This trend of college student and mental health concerns is not unique to the United States. The Schools Health Education Unit (2002), a nationally-recognized provider of reliable local survey data for schools and colleges in the U.K. ([www.sheu.org.uk](http://www.sheu.org.uk), 2012), found that 26% of college students suffered from severe emotional and psychological problems during the studied college term, and that 46% of the college students had experienced mental health problems in the past. Regardless of this increasing college student need for mental health services, the 2011 National Survey for Counseling Center Directors found that only 10.6% of college students received counseling at their campus counseling centers (Gallagher, 2011).

As college counseling centers watch an increase in the number of students presenting with what counseling staff assess as severe psychological problems, the need for attention in this area becomes evident. According to the 2011 National Survey for

Counseling Directors, counseling center directors reveal that 37% of their clients have severe psychological problems and of these, 5.9% have psychological problems of a severity that impedes them from remaining in college. In order to alter mood and behavior, 23% of college counseling center clients use psychotropic medications (Gallagher, 2011). In fact, college student use of psychotropic medication has risen from 9% in 1994 (Gallagher, 1994) to 20% in 2003 (Gallagher, 2003). In addition, 78% of counseling center directors have noted an increase in the amount of mental health crises that require an immediate response (Gallagher, 2011). Counseling directors' reports of an increase in mental health issues seen on campuses is also evident in student reports. The 2008 National College Health Assessment revealed that 54.2% of college students have felt hopeless, 69.5% have felt very sad, 37.2% have felt so depressed that it was difficult to function, and 8.4% have seriously considered attempting suicide (American College Health Association, 2008). The National Institute of Mental Health (NIMH) found that the college-aged student population has the highest prevalence of serious mental health illness (NIMH, 2008). During all four years of an NIMH study (NIMH, 2005, 2006, 2007, 2008), occurrence of depression was found to be higher in the college aged population than any other group. These findings and statistics further support the need to increase research in this arena, in hopes of paving the way for an intervention that will help this vulnerable and in-need group.

Watkins, Hunt, and Eisenberg (2011) examined changes in the demand and role of college counseling centers. Through interviews, the researchers found an increase in the severity of mental health issues that are being seen at college counseling centers. As

they note, "...findings suggest that the severity and complexity of mental disorders among current college student populations have led to an increase in the demand for mental health services on college campuses..." (p.325). These findings mirror Gallagher's (2011) survey that found that 92% of college counseling directors have seen an increase in the severity of students' mental health issues at the centers. Regardless of all of these factors, only 10% (Gallagher, 2011) of students are choosing to seek help at their campus counseling center and only 15% are seeking counseling services at any location, including an off-campus provider (American College Health Association, 2008). Many more students could benefit from counseling services.

It is possible that the findings from the 2011 National College Counseling Directors Survey (Gallagher, 2011) and the American College Health Association's (ACHA, 2008) findings may be similar to what is occurring at most colleges and universities. Other colleges and universities may also be seeing only 10-15% of their students seeking counseling services. The age group of 18-25 year olds are the least likely to utilize any type of mental health services (NIMH, 2008). As concerns of mental health stigma are the greatest deterrent for help-seeking (Evans et al., 2007; Hepworth & Paxton, 2007; Martin, 2010), perhaps the low college student utilization of services (ACHA, 2008; NIMH, 2008) is in part due to the high levels of mental health stigma concerns within the college-aged population (Quinn et al., 2009).

Corrigan (2004a) found that many people who are in need of mental health services do not seek help or remain in treatment. In fact, Andrews, Issakidis, and Carter (2001) reported that only 32% of people with a diagnosable mental health disorder will seek

treatment. In addition, only a mere 2% of the people who struggle with undiagnosable mental health problems will seek treatment (Andrews et al., 2001). One of the major reasons why people do not seek mental health care is because of perceptions of being stigmatized (Corrigan, 2004a; Komiya, et al., 2000; Vogel, Wade, & Haake, 2006). Therefore, simply this anticipation of resulting stigmatization is powerful enough to prevent much-needed treatment.

*Mental health stigma* has been described as the perception that a person who receives mental health services is not fully accepted by society (Vogel, Wade, & Haake, 2006). Even perceived stigma can often prevent help-seeking (Corrigan, 2004a; Komiya, Good, & Sherrod, 2000; Martin, 2010; Vogel, Wade, & Haake, 2006). This perceived mental health stigma is defined as an individual's perception of stigma (Corrigan, 2004a). Eisenberg et al. (2009) found that an increase in personal stigma can also reduce help-seeking. Personal stigma has been defined to include the stereotypes and prejudices that each person believes (Eisenberg et al., 2009).

Stigma influences help-seeking behavior in the general population and especially in the college student population (Corrigan, 2004b). Unfortunately, despite being vulnerable to mental health problems, studies have shown that college students are a population that is especially influenced by perceptions of peer mental health stigmatization (Quinn, Wilson, MacIntyre, & Tinklin, 2009). In fact, this perception of peer mental health stigmatization is not only a known barrier to seeking mental health services to the general population (Corrigan, 2004b; Komiya, Good, & Sherrod, 2000;

Vogel, et al., 2006), but also the greatest barrier to college student population seeking mental health services (Martin, 2010).

Levels of perceived public stigma are often greater than personal stigma levels (Eisenberg et al., 2009). Vogel, Wade, and Hackler (2007), as well as others, showed that perceived public stigma negatively affects help seeking attitudes and reduces willingness to seek counseling (Komiya, Good, & Sherrod, 2000). This is problematic because it shows that some people will deny themselves access to needed mental health services solely based on the belief, or perception, that the public would have stigma towards them. Therefore, regardless of the existence of any proven or experienced public stigma, simply the belief that it exists is powerful enough to prevent help-seeking. Revealing the levels of college student perceived and actual peer levels of stigma is important when exploring students' own help-seeking attitudes and intentions because by better understanding the influences of this stigma, ways to increase help-seeking and improve treatment may be possible.

Exacerbating the challenge of mental health stigma perceptions is that individuals with mental health issues who have higher perceptions of public stigma have significantly worse physical quality of life (Alonso et al., 2009). Furthermore, they have been shown to experience more job problems and more social adjustment issues than other individuals who deal with the same mental health problems but are free of perceptions of public stigma (Alonso et al., 2009). These findings suggest that those with mental health issues not only have the challenges of the mental illness itself, but are also negatively impacted by their perceptions of existing stigma towards the illness.

The perception of mental health stigma as the dominant reason why college students are not seeking services (Martin, 2012), and the fact that this population is seeking treatment less than any other age group (NIMH, 2008), makes them an important population to study. Survey data has shown that college student perceptions of mental health stigma among their peers is considerably greater than their own personal stigma (Eisenberg et al., 2009). Eisenberg et al. (2009) defined *personal stigma* as “each individual’s stereotypes and prejudices.” There is little understanding of the relationship between perceptions of mental health stigma and personal stigma, and help-seeking intentions. The relationship between college students’ perceptions of mental health stigma and their own personal stigma and intentions of help-seeking is not clearly understood.

### **Problem Statement**

To date, no studies have looked at the potential relationship between college students’ levels of perceived mental health stigma, personal mental health stigma, and attitudes and intentions of help-seeking. In addition, research has not studied the relationships among these variables and the role of social desirability in the process. Social desirability is a concept that has been described as responding in a manner that people feel will place them in a socially favorable light. Social desirability may contribute to conformity to social standards or ideals, while forgoing true personal beliefs or responses (Edwards, 1953). When studying levels of perceived and personal stigma, along with help-seeking attitudes and intentions, social desirability may be of significant influence and a necessary variable to control. Beginning to explore mental health stigma

and the perception of it can be important first steps to understanding the influences on college student attitudes and intentions around help-seeking. As college students' perceptions of campus mental health stigma and their own personal stigma are better understood, the misperception of stigma levels can begin to be addressed. It is hoped that the results of this study will begin the steps to identifying misperceptions of stigma, which may eventually pave the way to educating about the misperceptions, changing beliefs, and finally changing behavior.

### **Purpose of the Study**

The purpose of this study was to examine college students' perceptions of the campus mental health stigma (perceived public stigma), their own personal stigma and how these perceptions influence their own attitudes and intentions of help-seeking. A measure of the actual public stigma was found via a sum of all personal stigmas gathered.

### **Research Question**

The research questions that guided this study were as follows:

Do college students' perceptions of their peers' attitudes toward participation in campus counseling affect their own help-seeking attitudes and intentions?

### **Research Sub-questions**

1. Is there a significant difference between college students' perceived public stigma levels and their personal stigma levels (personal stigma levels combined will represent the actual stigma levels on campus)?
2. Do college students' levels of social desirability affect their self-reported levels of perceived public stigma?

3. Do college students' levels of social desirability affect their self-reported levels of personal stigma?

### **Research Hypotheses**

This study's research hypothesis was that negative perceptions of peer attitudes toward counseling (high perceived public stigma) will negatively affect their own help-seeking attitudes and intentions. It was also expected that as levels of perceived public stigma increase, help-seeking attitudes and intentions would decrease.

The sub-hypotheses included the expectation that perceived public stigma would be greater than personal stigma. Also, it was expected that there would be a positive correlation between perceived public stigma levels and personal stigma levels, such that as perceived public stigma increases, so would personal stigma, and vice versa.

Finally, it was expected that levels of social desirability would be related to levels of personal stigma and perceived public stigma. It was also expected that higher social desirability would be related to lower self-reported personal stigma and perceived public stigma.

### **Significance of the Study**

In a time when college aged students are showing greater prevalence of severe mental illness and depression than any other age population (NIMH, 2005, 2006, 2007, 2008), and presenting at campus counseling centers with more severe diagnoses (Gallagher, 2011; Gallagher, 2012), exploring this specific population is greatly warranted. College students are a group that appears to be at an increased risk for mental health issues, and therefore have an increased need for mental health services. This



increased need in mental health services can be illustrated by the finding that 78% of counseling center directors noted an increase in college student mental health crises that require an immediate response (Gallagher, 2011). Furthermore, the college-aged student population has the highest prevalence of serious mental health illness (NIMH, 2008) and from 2005-2008, depression was found to be higher in the college aged population than any other group (NIMH, 2005, 2006, 2007, 2008). The mental health services need for college students is apparent, yet perceptions of stigma are preventing much of this population from seeking help (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010).

There is a need to study the barriers of college student mental health help-seeking behavior, in hopes of reducing such barriers. For these reasons, the current study explored the greatest known barrier to college student mental health treatment seeking: stigma (Evans et al., 2007; Hepworth & Paxton, 2007; Martin, 2010). Perceived stigma, in particular, is the most salient contributing factor of not seeking help (Eisenberg et al., 2009; Martin, 2010). The impetus for this study was the hope that by learning more about stigma and its role in the attitudes and intentions of college student help seeking, that eventually we may learn strategies to reduce stigma, the perceptions of it, and increase help-seeking. If perceptions of stigma were reduced, the number of students who seek help would likely increase greatly because the need for such services is apparent. The American College Health Association (ACHA, 2012) found that 10.9% of college students report having been simply diagnosed or diagnosed and treated for only depression by a professional in any setting. Yet Gallagher (2011) found that only a total

of 10.6% of college students had sought campus counseling for *any* mental health problem. Because, within this 10.6%, many diagnoses exist in addition to depression, it appears that many students with depression are seeking treatment outside of the campus counseling center or are being diagnosed but not treated. This again supports that many students have mental health diagnosis but are not seeking out treatment.

If more than the current 10.6% (Gallagher, 2011) of college students would seek help at their campus counseling centers, it is possible that they would have a better overall college experience. When 12.4% of college students are describing that feelings of depression had negatively affected their academic performance (ACHA, 2012), there is clear support that colleges student mental health issues can have far-reaching life effects. Martin (2010) found that when college students utilize their campus counseling center, they described it as their main source of campus support and reason for their improved mental health. In addition, students in Martin's (2010) study who used the counseling center reported that it helped improve their academic performance, which had suffered prior to counseling.

Equipping college counseling centers with knowledge of and strategies to decrease actual and perceived levels of stigma on campus may be a major key to promoting student help-seeking. Knowing that perceived stigma is the greatest reason why college students do not seek counseling (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010) makes it plausible to assume that by learning more about this stigma, strategies to reduce it may be found and thus help-seeking behaviors increased.

Through this study, more has been learned about perceived stigma, personal stigma, and help-seeking, therefore, practicing counselors may be better equipped to understand their clients. As anticipated, a better understanding of the influences on student perceptions around mental health stigma was revealed. This knowledge may help counselors to be aware of addressing these issues, both during counseling outreach, as well as within the individual session, to best help their clients. Therefore, studying college student mental health stigma and its influence on help-seeking attitudes and intentions may pave the way for a reduction in stigma and an increase in utilization of services. Furthermore, such an increase in service utilization may contribute to increased college student feelings of support, emotional well-being, happiness, and academic performance.

### **Limitations**

When measuring stigma, participants may have been more likely to give socially acceptable answers. The possible motivation to answer in a more socially favorable light may have contributed to lower than actual perceived, and even more so, personal stigma. When studying college students' public and personal stigma levels, Eisenberg et al. (2009) also described such a limitation, "Respondents may have understated their true levels of personal stigma because they were unwilling to admit to others or perhaps even to themselves that they hold attitudes that may be considered socially undesirable" (p. 535). The present study measured each participant's level of social desirability in an attempt to limit its effect. Furthermore, the researcher was not present during the survey distribution, to also alleviate some of the social desirability bias.

Another limitation of this study is that while help-seeking attitudes and intentions were examined, the actual behaviors of help-seeking could only be inferred from attitudes and participant-noted intentions. For some individuals, the type of mental health issue, other events taking place in their lives at the time, and so forth may prevent help-seeking even if previous attitudes and intentions were favorable. Therefore, while this measured the relationship between perceived public stigma and personal stigma on help-seeking attitudes and intentions, the relationship between these stigmas and actual future help-seeking behavior is not known. Limitations more specific to the study will be discussed in chapter 5, following reporting of the results.

### **Conclusion**

This chapter has addressed current college counseling center statistics that show an increase in the severity of students exhibiting mental health concerns, as well as the growing need for college counseling centers. It has described mental health stigma, the most prevalent barrier to students seeking services. The need for a focus on perceived and personal stigmas and their influence on help-seeking intentions was noted. The concept of social desirability and its potential impact on these factors has also been introduced.

This dissertation includes four additional chapters. Chapter two includes a thorough literature review that addresses and elaborates on each concept introduced in chapter 1 and addresses the research and findings. The author addresses college student development, including psychosocial, intellectual, ethical, and moral development and key theories. Specific challenges to college student development are also described. The known relationship between stigma and help-seeking is explored, including a discussion

of public perceived stigma and personal stigma. Finally, social desirability is addressed along with its potential impact on reports of stigma. Chapter 3 involves a thorough description of the study's methodology in order to have studied perceived public and personal stigmas and their influence on help-seeking attitudes and intentions. This chapter includes specific details about the participants, who were undergraduate college students, and the settings of the two Universities of which the study took place. The instrumentation is also described, which included surveys to measure participant demographics, levels of perceived public and personal stigmas, social desirability, and help-seeking attitudes and intentions. The specific study procedure and data processing and analysis is described. Ethical considerations in carrying out this research are addressed along with a description of the factors that were in place to prevent harm. Chapter four focuses on the results of the study, which included statistical outcomes of the variables measured. The final chapter is a discussion of the study findings. In this chapter results are summarized, evaluated, and interpreted in relation to the original research question. Practical uses and next steps for the findings are also suggested, along with limitations of the study and proposed future research.

### **Definition of Terms**

*College Counselor.* This term was defined as a counselor who works at the on-campus college or university counseling center.

*College Students.* For the purpose of this paper, college students was defined as traditionally-aged, 18-22 years old, and are currently in attendance at a college or university; this included residential and commuter students.

*Help-seeking behavior.* This has been defined as a “problem focused, planned behavior, involving interpersonal interaction with a selected health-care professional” (Cornally & McCarthy, 2011, p.280).

*Mental health.* This term is defined as a person’s level of psychological well-being.

*Mental health stigma.* The perception that a person who receives mental health services is not fully accepted by society (Vogel et al., 2006).

*Stigma.* As a general term, stigma has been defined as “a feeling of being negatively differentiated owing to a particular condition, group membership, or state in life” (Arboleda-Florez & Stuart, 2012, p. 457). The definition has also included the power differential that accompanies stigma in that it is the powerful or dominant group that can elicit stigma through social inequities (Arboleda-Florez & Stuart, 2012). Types of stigma may include race, ethnicity, religion, age, and gender. This study will focus on mental health stigma.

*Perceived Public Stigma.* An individual’s perception of public stigma (Corrigan, 2004a).

*Personal Stigma.* This has been defined as “each individual’s stereotypes and prejudices” (Eisenberg et al., 2009, p. 523). When combining the personal stigmas of many, this may also be considered the *actual stigma* of the population, as the current study will refer to it as when discussing it in relation to *perceived stigma*.

*Public stigma.* When mental health stigma is occurring by the general public and includes “what a naïve public does to the stigmatized group when they endorse the prejudice about that group” (Corrigan, 2004a, p.616). Elaborations to the definition have also included: “the perception held by a group or society that an individual is socially unacceptable and

often leads to negative reactions toward them” (Vogel et al., 2006, p.325). For the current study, public stigma focused on its relation to mental health services. This has been defined as: “the perception that a person who seeks psychological treatment is undesirable or socially unacceptable” (Vogel et al., 2006, p.325). This is also referred to as *actual stigma*.

*Self-stigma*. When an individual places stereotypes and prejudices onto oneself and identifies with the stigmatized group (Eisenberg et al., 2009).

*Social desirability*. An individual’s desire to present him or herself in a socially positive light (Edwards, 1953).

## **Chapter Two**

### **Introduction**

Increased societal pressures during college, pre-existing psychological issues, and a change in the psychosocial presentation of college students have been noted as potential influencers of mental health issues (Watkins et al., 2011). The well-known influential National College Counseling Directors Survey (Gallagher, 2011) found that counseling center directors describe 37% of their clients to have severe psychological problems. College counseling center directors describe overall psychosocial differences in today's college student population (Watkins et al., 2011). Specifically, directors have commented on a connection between the new millennial generation of college students and new factors that they seem to bring with them to college such as higher levels of anxiety, Obsessive-Compulsive Disorder, perfectionism, and Attention Deficit Disorder, which contribute to the increase in panic attacks and panic disorders (Watkins et al., 2011). Directors described a believed connection between these overall psychosocial differences in current college students and the increased severity of mental health issues being seen at college counseling centers. While it appears that a new generation of Millennial students are bringing new mental health issues with them to college, it is also important to consider what this population is experiencing while at college that may affect their current mental health problems or aid in the creation of new ones.

The chapter begins by discussing college student development and the major theories in this area as well as the psychosocial challenges that may impede development. Next, a thorough discussion of mental health stigma, including perceived and personal



stigmas, is presented. The concept of social desirability is focused on in relation to college students and how they are affected by such. This section also includes the role of social norms on social desirability. Finally, help-seeking is explored in relation to mental health services. Combined, the roles of college student development, mental health stigma, and social desirability are discussed in relation to help-seeking. In addition to help-seeking as a behavior, the intentions of help-seeking are reviewed as this is a specific variable of the current study.

### **College Student Development**

College student development has been defined as more complex than simple change (Pascarella & Terenzini, 1995). While college students experience change through alterations over time in areas such as knowledge and skills, developmental growth has typically implied a greater movement towards maturity. Westefeld et al. (2006) describe,

Notable developmental changes are present at many life-stage transitions.

Traditional college age is a period of transition, where a late adolescent or young adult creates a degree of distance between his/her family or high school support group and establishes new avenues of support. The transition occurs on many levels including social, academic, psychological, and existential. (p. 932)

This section addresses well-established theories of college student development, including intellectual and ethical (Perry, 1970), psychosocial (Chickering, 1969; Erikson, 1968), and moral (Kohlberg, 1970). Based upon these theories, specific discussion of

college student development, specific transition stages, and potential challenges, are addressed.

### **College Student Intellectual and Ethical Development: Perry**

Perry (1970) has connected the complexity of developmental growth to a psychological, educational, or even moral completion. Certain factors may impede college student intellectual and ethical developmental process, and specific challenges may delay developmental milestones during the college years and may contribute to the increased need for college counseling.

Perry (1970) has proposed that college students journey through nine positions, which are grouped into four categories, during their intellectual and ethical development. These categories are as follows:

**Dualism.** A belief that there are only right and wrong answers and that those in positions of authority are the keepers of this knowledge. Within this stage there are two positions, the first being of a basic duality where the student believes that all problems are solvable and the task is to find solutions. The other position in this stage is referred to as a Full Dualism in which there is acceptance that some of the authorities may disagree, yet there is only one true answer and the student must find it.

**Multiplicity.** This stage involves subjective knowledge. The first position within this category, Early Multiplicity, is that there are solutions to problems, and while some are known, some are still unknown. The task of the student is to find these answers. The second position, Late Multiplicity, involves a thinking that most problems do not have

definite solutions and therefore people are entitled to their own positions. There may also be acceptance that some problems do not have solutions.

**Relativism.** During this stage, it is accepted that ambiguity is a fact of life and that different situations have different answers (Perry, 1970). The positions during this stage include Contextual Relativism, which notes that students realize that some solutions are better than others depending on the situation and value is seen in evaluating each situation. The other position at this time is Pre-Commitment, where students understand the need to make choices and follow through with a solution.

**Commitment.** This stage involves constructed knowledge that the student has developed through life experiences. The first of the three positions in this stage is Commitment in which the student chooses to make a commitment to their solution. The second position is Challenges to Commitment, where the student experiences the possible consequences of making a commitment. Post-Commitment is realized when the student acknowledges that commitment is ongoing and that one can be at different stages in the process at once depending on each situation (Perry 1970).

Perry's (1970) model has been discussed as being a novel developmental concept of its time that describes the changes in college student thinking; a progression from dualistic thinking to one of multiple perspectives and options for use in a world with many grey areas (Magolda, 2006). Just as the favorable outcome of multiple perspectives is described here, so is the developmental stance of college students before reaching this. Perry (1970) and Magolda (1996) describe college students as believing in a simple right or wrong answer for all things during the early stages of their intellectual and

developmental journey. This type of dualistic thinking might be relevant to college students and mental health stigma. For instance, if college students have been told, whether by society, culture, or other outlets, that if help-seeking will be stigmatized, then students will likely find it difficult to question these beliefs in the early stages of their development. They may accept the perceived stigmatizing beliefs as truth, and perceptions of stigma prevent college students from help-seeking (Martin, 2010). College students in earlier stages of development may be prone to more dualistic thinking and hold a stronger belief in mental health stigma as truth than college students in later stages of development.

### **Psychosocial Development**

**Erikson.** A major developmental theorist whose work has application to the development of college students is Erik Erikson. Erikson (1968) has described 8 psychosocial stages throughout the lifetime. Each of these stages is described through the characteristic that will be gained after successfully completing the stage versus the characteristic that will result from a failure to complete. Stages also have approximate age time frames and are built upon one another, so as one stage is passed through, the next will come in sequence. Each of Erikson's stages are briefly described for context; because the stages of "Identity vs. Role Confusion" and "Intimacy vs. Isolation" have specific applicability to the college years, these two stages will also be described in greater detail later. Erikson's stages are:

***Trust vs. mistrust.*** From birth until approximately age 2, children will either learn to trust the world around them by receiving good care and having all needs met, or will learn to mistrust if needs are not met.

***Autonomy vs. shame and doubt.*** During this stage, from 2-4 years old, children will explore their independence. If they are supported and allowed to explore the world around them, they will develop a sense of autonomy. If they are scolded or restricted, they may develop feelings of shame and doubt.

***Initiative vs. guilt.*** Children (4-5 years old) will attempt to plan actions and test behaviors. They will realize that they can affect the world around them. If they are encouraged during this time they will develop a sense of initiative; if they are discouraged and dismissed guilt can result.

***Industry vs. inferiority.*** During this stage (5-12 years old) children begin gaining a sense of tasks that they can complete and are able to do well. Self-confidence may be gained during this stage if caregivers provide opportunities for such growth and support all efforts. Feelings of inferiority may develop if interests are discouraged.

***Identity vs. role confusion.*** This stage is considered the start of adulthood (13-19 years old) and the first of two important stages during the college years. This stage is especially relevant because it encompasses the age when the majority of students will enter college. This stage will be later returned to and described in greater detail and with a special focus on college students. During this stage individuals become more aware of and concerned with how they are perceived by the people around them. They also begin

to explore their place in society and their identity, including areas such as sexuality and future career. If a sense of personal identity is not met, role confusion may occur.

***Intimacy vs. isolation.*** This stage (during early adulthood) is also especially important when exploring college student development because it encompasses the majority of their time at college. During this stage there is a longing for connections with others, both romantically and through peers. There are also fears of rejection at this time if one is not accepted by peers or a romantic relationship is ended. To avoid isolation, intimate relationships must be developed along with a sense of willingness to compromise and care for others. As a result of the need for peer acceptance being great during this stage, college students may be much more aware and concerned of any behaviors that may elicit rejection from peers. As studies have shown, the perception of peer rejection resulting from mental health stigma is a strong belief of college students (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010). In addition, college students may also perceive that peer rejection could decrease opportunity for intimate and romantic relationships, thus possibly resulting in isolation.

***Generativity vs. stagnation.*** This stage illustrates a time when the focus is on leaving a lasting and meaningful impact on future generations. If a feeling of productivity and contribution to society is accomplished, rather than selfishness, then the stage has been successful.

***Integrity vs. despair.*** This stage occurs during the remainder of one's life. At this point there is an emphasis on feeling satisfied with one's life as a whole, rather than regret and sadness.

For the purpose of examining the psychosocial development of college students, Erikson's (1968) stages of *Identity vs. Role Confusion* and *Intimacy vs. Isolation* will be most applicable to discuss. Both of these stages overlap the age frame of the traditional college student (18-22 years old). This will be discussed in depth. Yet, first, attention is turned to another major college student developmental theorist: Author Chickering.

**Chickering.** Another major theorist in the area of college student development is Arthur Chickering. Garfield and David (1986) describe Chickering's (1969) theory as holding a main premise that the college environment is better than any other institution at promoting human development and potential.

Chickering's work views college development from a psychosocial stance, which notes the advancement of personal development by achievement of specific developmental tasks. These developmental tasks are often accomplished by resolving certain challenges at each stage (Pascarella & Terenzini, 2005). Chickering's (1969) college student development model includes 7 specific vectors of development during the college years that illustrate this developmental process. These vectors are: Competence, Managing Emotions, Autonomy, Identity, Healthy Interpersonal Relationships, Purpose, and Integrity.

**Competence.** This vector includes intellectual, physical, and interpersonal competencies. These include building skills in content and intellect, in manual and artistic endeavors, and social skills such as listening and communicating effectively.

**Managing emotions.** This includes when students gain awareness of their emotions and are able to deal with them in healthy and nondestructive ways. The purpose

here is not to eliminate these emotions, but rather to accept them and acknowledge them as signals. Through acceptance and not repression of emotions, students will gain better insight into themselves and their needs.

***Autonomy.*** This vector is recognized as moving towards interdependence. Students will experience separation from parents and other supports, and learn to rely on themselves. Overall, after experiencing this autonomy, old relationships are revisited and new ones are formed.

***Identity.*** This involves having successfully passed through the initial vectors and having now formed new pieces of one's self and a new acceptance and awareness of who one is. These pieces of identity include acceptance with one's physical body, sexual orientation, culture, life roles, and overall self-image.

***Healthy interpersonal relationships.*** This vector involves transcending beyond criticisms and stereotypes of others and towards acceptance. This also includes developing intimate relationships with honesty and trust and mutuality rather than dependence.

***Purpose.*** This involves students having intentional direction around career and life goals. It also includes combining one's values, interests, and talents towards a life path.

***Integrity.*** This is the final vector which includes feeling settled and confident in one's own values, beliefs, and convictions. In addition, a balance is found between holding one's own beliefs, while respecting those of others and society as a whole (Chickering, 1969).



Related to the present study, stigma seems in direct contrast to the final vector of Integrity. As this vector involves a full respect of others (Chickering, 1969), holding mental health stigma towards others would accomplish a lack of respect for others. Since the greatest reason why college students do not seek counseling is because of perceptions of mental health stigma towards them (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010), they appear to not be confident in their own values, beliefs, convictions, as is the case in the Integrity vector (Chickering, 1969). Attention will now be turned to simultaneously discuss both Erikson's (1968) and Chickering's (1969) theories in relation to college students and further detail of the specific stages or vectors that are more applicable.

### **Erikson and Chickering: Theory Application to College Students**

From the theories of Erikson (1968) and Chickering (1969), one can surmise that college can be a time of extreme personal growth and transition for students. For instance, Chickering and Reisser (1993) refer to this developmental period as one which includes learning to "own" the "house of one's self and be comfortable in all of its rooms" (p. 49). Studies have examined the personal development of college students and have found that students rate themselves to have positively grown in areas such as: developing values and ethical standards, understanding themselves (interests, personality, and abilities), understanding others, social communication, and personal health (Flowers, 2002; Kaufman & Creamer, 1991). It is ideal when students are able to move through this developmental time seamlessly and reach one's full potential. It is believed that the success of each subsequent developmental task or vector is dependent upon the resolution

of preceding tasks (Pascarella & Terenzini, 2005). Yet, conflict and struggles may interfere. College students may be more prone to experience specific challenges to their growth and development. Positively progressing through these stages includes having self-confidence and self-acceptance, rather than looking for approval from others and being overly concerned with what others think (Chickering & Reisser, 1993). Students may become especially concerned with how they are perceived by others when they face developmental challenges that impede this process. As a result, their perceptions of public stigma may be especially high and prevent them from help-seeking.

Many similarities can be seen between Erikson's theory and Chickering's (1969) theory which were developed during the same time period. Chickering's (1969) vectors of Identity and Healthy Interpersonal Relationships are very similar. All of these stages center around the individual's journey to find a personal identity and healthy peer and intimate relationships.

During these two major developmental stages, college students are experiencing much transition, which has the potential to increase the need for mental health services. Yet, while the need for such services may increase during this time, these specific developmental experiences may decrease students' willingness to seek services. Specifically through perceptions of peer stigma and perceived social rejection, college students often choose not to utilize services (Corrigan, 2004b; Martin, 2101). Erikson's Identity vs. Role Confusion stage and Chickering's (1969) Identity vector involve acceptance and awareness of who one is. During this time students are overly concerned about how others perceive them and their identities are shaky. Discovery of personal

identity also encompasses multiple facets of one's self, including physical body, sexual orientation, culture, life roles, and overall self-image. During this stage, concerns of being stigmatized by others may be exceptionally high. As a result, if stigmatization towards mental health services by one's peers and the general public is perceived, it would make sense that this might cause a fear of judgment strong enough to prevent use of services. This is in line with what studies have shown during this age range, as college students note fear of stigma as their greatest obstacle to seeking services (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010).

Erikson's (1968) psychosocial stage of Intimacy vs. Isolation and Chickering's (1969) vector of Healthy Interpersonal Relationships include transcending beyond criticisms and stereotypes of others and towards acceptance. In both theoretical developmental models, these relational stages come only after completing the prior stages that deal with personal identity. This is in line with the idea that one must fully know and accept him or herself before one can fully accept those around him or her (Chickering, 1969). These similar stages of Erikson and Chickering include developing intimate relationships. Chickering's vector of Healthy Interpersonal relationships involves a movement towards acceptance and away from criticisms and stereotypes. Instead, honesty, mutuality, and trust in relationships are worked towards.

Prior to completing this vector, criticisms and stereotypes likely exist and these may contribute to stigma since stereotypes and prejudices are at the root of stigmatization (Eisenberg et al., 2009). If students in this stage have yet to fully accept others, they may hold more stigma towards those around them, and thus may perceive that those around

them actually hold more stigma towards others as well. This is important to consider because feelings of perceived stigma have shown to be very influential in preventing help-seeking (Andrews et al., 2001). During these stages, help-seeking behaviors for mental health issues may also be influenced. At this point in development, students are seeking connections and intimacy with others, and are especially concerned about how they are perceived by others (Chickering, 1969; Erikson, 1968). If students perceive that others will negatively view them for seeking mental health services, they may be concerned that help-seeking behaviors may negatively influence chances of social connections and intimacy. Therefore, it is important to consider that these students may be less likely to seek mental health services for concerns of peer stigma and a potential reduction in social connections.

### **College Student Moral Development**

Higher education has been viewed as a significantly influential factor in moral development (Kohlberg, 1970; Mayhew, 2012). In a report from a meeting of national leaders in higher education, college student moral development was described as a purposeful intention of the college experience (Wingspread Group, 1993). The leaders discussed their hopes for student moral outcomes that “Students will graduate as individuals of character more sensitive to the needs of the community, more competent in their ability to contribute to society, and more civil in their habits of thoughts, speech, and action” (Wingspread Group, 1993, p.9). Overall, they suggest that “the moral

purpose of knowledge is at least as important as its utility” (Wingspread Group, 1993, p.7).

Kohlberg’s well-known work stated that moral reasoning develops over time through specific stages. The first stage of development has been referred to as the Preconventional Stage (Kohlberg, 1970). During this stage, moral decisions are based on what is culturally prescribed as good or bad, or right or wrong. Decisions are also based on the consequences of such behavior, such as reward or punishment. Within this first stage, there also exist 2 levels. The first of these involves a Punishment-Obedience orientation. Decisions are purely based on the avoidance of physical punishment as opposed to any personal values. Authority also goes unquestioned and there is little deviation from this or exceptions. The next level during this time is known as the Instrumental-Relativist orientation. This is characterized by a focus on what is best for the person and his/her values and preferences. At times, it may seem that there is a focus on the welfare of others or the society, but this is only with a true intention of an overall benefit to one’s self (Kohlberg, 1970).

After a progression through the Preconventional stage, the Conventional Stage (Kohlberg, 1970) may follow. During this stage much importance is placed on the expectations of family, peers, and society as a whole. Not only is conformity to these expectations a key aspect, but loyalty and maintenance of such social expectations is as well. Within this stage two levels are identified. The Interpersonal-Concordance level exhibits a belief that good behaviors are those that are approved by and pleases others. Kohlberg has even coined this level as “good boy-good girl.” The second level during

this time is known as the Law-and-Order orientation. Characteristics of this include pure adherence to law and authority. Its focus is on maintaining social order for only the good of the order itself.

If college students are operating from this “good boy-good girl” (Kohlberg, 1970) mentality, then they may find it difficult to deviate from any preconceived notions that one is not “good” if one attends counseling. Some college students believe that attending counseling can show personal weakness and may be viewed negatively by society (Martin, 2010), therefore, potentially hurting the “good boy-good girl” (Kohlberg, 1970) image. This may play a role in perceived public and personal stigmas as well as help-seeking. Furthermore, this stage’s preoccupation with concerns of peer acceptance may also increase concerns of peer stigma, especially as that has already been identified as the greatest barrier to college student help-seeking (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010).

The third and final stage of moral development is the Post-Conventional or Autonomous level (Kohlberg, 1970). This level has a focus on defining morals and values that are not simply prescribed by authority or personal preference. There are also 2 levels within this final stage. The first is the Social-Contract, Legalistic orientation. This involves a belief in standards that have been critically examined, focused on human rights, and agreed upon by society. Also, laws are no longer viewed as unquestionable and may be changed based on considerations of social welfare. The final level within this final orientation is Universal-Ethical-Principle. During this advanced level, the conscience and self-chosen ethical principles are guides. These principles are not black

and white. Rather, they allow for different decisions in different situations based on ethics and moral code (Kohlberg, 1970). Kohlberg has described these by noting that, “At heart, these are universal principles of justice, of the reciprocity and equality of human rights, and of respect for the dignity of human beings as individual persons” (Kohlberg & Hersh, 1977, p.55).

Even at similar ages, moral and ethical decision making development may vary greatly among individuals. When reviewing the literature about college students, some connections can begin to appear that may suggest moral stages that are more likely to be seen in this population. Since the perception of stigma is a great barrier to help-seeking behaviors (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010) and mental health stigma involves not being accepted by society (Vogel, Wade, & Haake, 2006), having perceptions of stigma that prevent help-seeking could illustrate the moral stage that many college students are in. Many college students care greatly about peer and societal acceptance and approval (Martin, 2010). This idea aligns with Kohlberg’s (1970) second (Conventional) stage. As described earlier, during the Conventional stage the person is focused on the importance of expectations of family, peers, and society. Therefore, it appears that many college students may be operating from this specific moral developmental stage when determining whether to seek help for mental health concerns. Perhaps if they believe disapproval by parents, peers, and society will result from seeking counseling, then this may cause them to decide that it is not a good choice. Understanding the moral decision-making process that many college students are

operating from can be very helpful in understanding what motivates their choices to seek help or to not.

### **College Women and Development**

A brief mention of the unique issues to college women's development is warranted within the discussion of college student development. College women represent a larger population than college men, as traditional age (18-24 years) college women make up 57% of the college population (Marklein, 2005). Estimates predict that this male to female ratio will only widen as women will become an even greater majority of college undergraduates (National Center for Education Statistics, 2005). As women have surpassed men in college attendance for the first time in history, it is realized that women value higher education and have career aspects that require a college education. Also, college women will experience different, and likely more numerous, developmental challenges than their male counterparts (Miller, 1976). Therefore, when discussing college student development, the unique challenges for college women is worthy of mention.

Part of college women's development includes skill building, which is in line with Chickering's (1969) college student development vector of Competence. Competence includes intellectual, physical, and interpersonal competencies. These include building skills in content and intellect, manual and artistic endeavors, and social skills—all of which are important to develop during college. Unfortunately, even when these areas of development are surpassed, college women will likely still have to contend with societal gender inequalities. This may cause them to question or hide their achieved skills.



Overall, this has the potential of being a challenge to their development both during and after college. Therefore, while they may develop their competence (Chickering, 1969) in skills society may discourage the use of such skills or encourage their existence to be ignored. For example, while women are often praised for having superior leadership skills and are shown to possess more qualities of leadership styles related to effective performance than men, significantly more people prefer a male boss over a female boss (Eagly, 2007).

Women are expected to display typical female traits such as warmth and gentleness (Eagly, 2007; Miller, 1976). Unfortunately, these traits go in contradiction to typical masculine traits, or what traits are expected in leadership roles. Therefore, it is nearly impossible for women to accomplish both roles. As Chickering (1969) notes, one major task of college student development is the formation of a personal identity. As women may experience a double bind between their feminine identity and traits and what society expects of them (Eagly, 2007), a great internal conflict may result. This double-bind of feminine identity may also bring challenge to their development through Erikson's (1968) fifth stage of Identity vs. Role Confusion. This stage of development, which typically occurs during the college years, involves a greater awareness and concern for how one is perceived by others. For college women, knowing that they are or may be treated unfairly by society may bring about increased self-consciousness of how they portray themselves and are preventing a full acceptance of their true identities. As Erikson (1968) also describes, this developmental stage includes exploring one's place in society and identity. Furthermore, if college women are not allowed to develop their own

identities, free of societal constraints, then proper development of a complete personal identity may suffer. Erikson (1968) stated that if a sense of personal identity is not attained during development role confusion may occur.

All of these potential challenges can also negatively contribute to a woman's developmental process. As Perry (1970) discussed that college students will experience developmental challenges that make counseling useful, these potential gender role challenges for college women may warrant such counseling. When considering the specific developmental journey of college women, it makes sense that gender bias concerns can affect development. Being aware of such challenges and having support in place at colleges may greatly help college women.

Much intellectual and ethical (Perry, 1970), psychosocial (Chickering, 1969; Erikson, 1968), and moral (Kohlberg, 1970) development takes place during the college years. Regardless of which developmental stage a student is in, he or she will likely be more prone to certain developmental challenges. During these times of development, certain challenges may become more concerning mental health issues. For instance, Westefeld et al. (2011) note, "Aspects of the college culture and the development of the college student may increase the risk of suicide....The combination of college-age developmental changes and specific suicide risk factors is what may ultimately lead to college students taking their own life" (p.932). Therefore, as Westefeld et al. (2011) and others (Gallagher, 2012; Pascarella & Terenzini, 1995; Perry, 1970) have suggested the developmental changes and challenges during the college years can put college students at an increased need for counseling services. While this population seems at an increased

need for services, they are also especially affected by perceptions of stigma (Quinn, Wilson, MacIntyre, & Tinklin, 2009), which has been shown to reduce help-seeking amongst college students (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010). The following section will discuss some of the major influential factors that may exacerbate mental health issues during college student development.

### **Influences on the Development of Mental Health Issues**

#### **Societal View of Psychiatric Medications**

It is difficult to turn on the television and not see an ad for some type of pharmaceutical medication, many of which are for mental health issues. Society may have even become used to medication as the treatment answer to all mental disorders. There is even a medication for depression that shows a cartoon “sad pill” that turns into a “happy pill” after taking this anti-depressant medication. More disorders are now able to be controlled by medications than just a few decades ago. As a result, more students are now able to come to college, even if struggling with a mental disorder. In the last decade there has been a significant increase in the use of prescription medications for psychiatric disorders by college students (Bates, 2010). In fact, college student use of prescription medications for depression, anxiety, and attention-deficit/hyperactivity disorder, has more than doubled, with student use at 11% in 1998 and 24% in 2009. This is perhaps one reason why college counseling centers are seeing more students who are entering college already on psychiatric medications (Gallagher, 2011).

Colleges may also be experiencing a trend in students with severe psychological problems and increased psychiatric medications (Gallagher, 2011) because society is

often told that if one feels depressed or anxious, or has trouble sleeping, medications are always the solution. Taking this into consideration, it makes sense that more college students are being seen at college counseling centers already on psychiatric medications and suffering from severe psychological problems (Gallagher, 2011; Guthman, 2010, as cited in Bates, 2010). Furthermore, there may be a societal opinion forming that if medication can easily “cure” all mental problems, then someone that seeks counseling must be “incurable” through medication, and a very severe case. In reality, being on such medications is not a cure. In fact, 13% of college suicides last year occurred while the students were on psychiatric medications. In many cases medications may just mask symptoms, and counseling is necessary to transcend beyond the symptoms.

College is a large transition for many students, academically, socially, and emotionally. Warwick et al. (2008) note that the transition of beginning college can be an especially stressful situation. College can bring about adjustment challenges (Enochs & Roland, 2006). Some of the students that are being increasingly seen entering college on medications for psychological disorders (Gallagher, 2011; Guthman, 2010) may have had a reduction in their symptoms and even stability in high school upon first entering college. However, the medications and dosages the student was prescribed in high school may not be able to maintain stability anymore. As a result of these new trends that college counseling centers are seeing, it is imperative that the students who require counseling do seek help.

For many residential (“dorming”) students, the move to campus life marks the first time they have lived away from home and parental comforts. This time can mark a

great period of personal adjustment. First-year college women have reported significantly lower “overall adjustment” to college than their male counterparts (Enochs & Roland, 2006). This means that even though the initial college year can be an exciting time and an opportunity for growth, it can also be a time of adjustment challenge, especially for young women who may need special consideration. During this potentially difficult time of transition, college counseling services can be of critical support.

### **Relationships and College Transition**

The importance of strong relationships is connected to an increased amount of social support, feelings of connectedness, and psychological health. For instance, both Erikson (1968) and Chickering (1969) have established specific and essential stages of adolescent development that revolve around formulating healthy relationships. In addition, social connectedness is identified as a main variable in the prevention of depression and low self-esteem (Williams & Galliher, 2006). In one study 46% of college student suicides were related to relational problems (Gallagher, 2011). Granello (2010a) includes the ending of a significant relationship as a risk factor of college student suicide assessment. In addition, college students who present at college counseling centers with issues of college adjustment and interpersonal problems are more psychologically distressed than students with substance abuse issues or any pre-existing conditions (Eyler et al., 2009).

The transition to college life weakens relational ties and some are lost completely. Some “long-distance” romantic relationships result in breakups; everyday contact with parents is reduced to semester break visits, and close childhood friends may become

“pen-pals” for the next few years. Unfortunately, these reductions in strength or losses of relationships occur when students are most vulnerable in times of difficulty and transition, such as going away to college. Thus, for the college student’s healthy development, it is important to form new relationships and make social adjustments in college (Chickering, 1969; Frey, Beesley, & Miller, 2006; Williams & Galliher, 2006). Just as social connectedness and healthy relationships breakdown can promote student suicide risk (Gallagher, 2011; Granello, 2010a; Williams & Galliher, 2006), promoting these same factors can be a strategy for working with suicidal risk. For instance, in her description of strategies for working with suicidal students, Granello (2010b) includes engaging in social support.

### **Relationships and Psychological Health**

Pascarella and Terenzini (2005) described the potential impact that college has on a student’s self-esteem. Their study controlled for multiple variables, including gender, academic ability, and family environment. Findings indicated that class level was positively related to self-esteem, more so than age, suggesting that self-esteem may be more related to the amount of college experienced than age maturation. Class year is important for college counseling centers to remember as first year students become clients, and also when determining target populations for outreach efforts, including anti-stigma. The shorter the amount of time is since the relationship separation, the greater the psychological distress of the student (Frey, 2004). In other words, the most intense distress might be expected to occur within the first year of college. When assessing for the level of psychological distress of college students presenting for appointments at

college counseling centers, the relationship between level of distress and year in school should be considered. College counselors should be aware that newer students are potentially at greater risk for high levels of psychological distress.

Being aware that many college students do not seek counseling because of perceptions of stigma (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010), this barrier to help-seeking may be especially detrimental to first-year students because they appear to be in the greatest need for such services (Pascarella & Terenzini, 2005). First year college students are more likely to be settled in dualistic thinking and their beliefs are less easily changed (Perry, 1970), including beliefs about stigma. Taking this developmental piece into consideration may also be a reason to give extra attention to first-year college students.

Recent separations from home relationships, relationship losses, and the stress of transition point to the importance of forming new relationships when beginning college. College women who report stronger levels of peer and community relationships show a decrease in psychological distress (Frey, Beesley, & Miller, 2006). Among college males, community relationships are a predictor of a decrease in psychological distress but peer relationships are not. Thus, both college men and women have a lower risk of psychological distress when they have strong community relationships. Interestingly, however, peer relationships are a factor in decreased psychological distress for women, but not for men (Frey et al., 2006). Perhaps one reason for this difference is the social pressure placed on males to be part of larger community connections such as sports or politics as opposed to smaller more intimate relationships expected of women.

Regardless of the reason for this difference, one thing seems clear: for both men and women social connections can lead to improved psychological functioning. These findings are consistent with other studies about student relationships (Chickering, 1969; Frey et al., 2006; Williams & Galliher, 2006) that have also shown the importance of healthy social connections during the college years.

The strength of these relationships is further evident in the finding that peer and community relationships can even have a greater effect on psychological health than parental attachment (Frey et al., 2006). While insecure parental attachments are predictors of increased psychological distress, secure peer and community relationships are significant enough to have a much greater impact on psychological health. It is interesting that a relationship as impactful as the parent-child relationship can be overshadowed by peer and community relationships (Frey et al., 2006). Perhaps one reason for this is that college dorming causes the amount of parental interaction to be diminished. In place of this parental relationship are now peer and community relationships. Having lived with and been influenced by parents daily, this parental relationship was once a core. Residential college students will now experience far less parental contact and instead experience new daily interactions with peers (roommates, floormates, classmates) and community (college sports teams, clubs, sororities) (Frey et al., 2006). For college counseling centers, it is critical to understand the magnitude of having—and lacking—these peer and community relationships and how this can affect the development of college students.



Commuter students have also been shown to face their own struggles. Stark (1965) noted that commuter students had significantly greater problems than residential students in the areas of finances, living conditions, employment, and home and family. Tinto (1993) built upon Stark's (1965) findings by discovering that commuter students often struggle with their obligations between college, work, and family. It is also interesting that commuter students value social and interactive campus activities more than residential students, perhaps because of a reduction in these natural social interactions by not living on campus (Lon, Teasley, Krumm, 2011). Supporting this are findings that commuter students have fewer interactions with faculty and other students than do residential students (Pascarella & Terenzini, 1991; Tinto, 1993). Stark (1965) also found that the willingness to seek campus counseling services was not significantly different between the commuter and residential students. Today, nearly 50 years since Stark's (1965) study, the area of college student struggles and seeking campus counseling is still a topic of importance.

Loss of relationships can have a psychological impact on the development and psychological health of college students (Jordan, 2001; Mellin, 2008). Therefore, college students may greatly benefit from counseling services during this potentially challenging developmental period. Better understanding the influences on the stigma that these college students perceive and believe, and their effect on help-seeking intentions, may be an important starting point to increasing the number of students that seek services.

### **Major College Student Mental Health Issues**

Having discussed the developmental challenges and issues that colleges students may face, it is also important to address some of the mental health issues that can result from or be exacerbated by these developmental challenges. The major mental health issues that will be discussed are student depression and suicide, societal pressures, eating disorders, and issues of gender inequality. It is important to note that the scope of this chapter does not allow for the depth of discussion of all college student mental health concerns and issues. The following will discuss some that appear to effect students more often and/or are of greater concern.

### **Depression**

The American College Health Association (2007) notes that depression is the second most common diagnosis and treatment at campus counseling centers. The Spring 2012 American College Health Association report (ACHA, 2012) revealed that 10.9% of college students self-reported having been diagnosed *or* treated for depression alone, by a professional. Yet, only a total of 10.6% of college students seek campus counseling for *any* mental health problem (Gallagher, 2012). Therefore, it seems possible that students may be diagnosed and treated for depression by family doctors and other physicians who are not offering counseling as a form of treatment. In many of these cases, treatment may come only in the form of medications for depression. These statistics support that a large majority of students are being diagnosed but are choosing not to seek services.

The ACHA (2012) also found that 12.4% of college students reported that their feelings of depression had negatively affected their academic performance. Students' awareness of the connection between depression and academics and seeking help are two

different things. Low academic performance can lead to financial problems (such as loss of a scholarship) and academic probation. College students may begin with a diagnosis of depression, but soon this root cause can cast a shadow on multiple areas of life. Choosing to seek help earlier may help offset some of these additional problems.

***Social media and depression.*** New methods for insight into depression disclosure are being uncovered through technological advances. For instance, one study revealed the role of the popular social networking site, *Facebook*, in undergraduate students' depression disclosures (Moreno et al., 2011). Results revealed that 25% of the student profiles described depressive symptoms and 2.5% met the clinical criteria for a Major Depressive Episode. This appears to hint towards a new mental health stigma phenomenon. It appears that students are more likely to share their mental health problems when through a social media outlet, indicating a potential reduction in perceptions or concerns of peer stigma. This statistic is surprising given that college students are a known population that is especially influenced by perceptions of peer mental health stigmatization (Quinn, Wilson, MacIntyre, & Tinklin, 2009). Therefore, when studying college students and depression, new technological advances such as online social networking may be a valuable tool. In addition, "Given the frequency of depression symptom displays on public profiles, social networking sites could be an innovative avenue for combating stigma surrounding mental health conditions or for identifying students at risk for depression" (Moreno et al., 2011, p. 447). While this study does reveal an interesting aspect of seemingly reduced mental health stigma within social media outlets, this form of depression declaration is much different than in person

declarations. Being “hidden” behind a computer screen may give the student a stronger sense of control over the declaration by having the possibility to just delete such comments. When revealing mental health issues in person, it is not easy to just retreat as one might by shutting off a computer.

*College Student Suicide.* College student depression is also an especially important topic because of its strong relationship to student suicide (Garlow et al., 2008). When discussing college student depression, the issue of suicidality must also be addressed. College student suicidal ideation has been prominently associated with symptoms of depression (Garlow et al., 2008). In fact, 11.1% of college students described current (within the past four weeks) suicidal ideation and 16.5% had attempted suicide or exhibited self-injurious behavior in their lifetime. Also, students with current suicidal ideation had significantly higher depression scores than those students without current suicidal ideation (Garlow et al., 2008).

Twenty four percent of college students have thought about attempting suicide (Westefeld et al., 2006). Figures as recent as 2012 showed that 7% of college students had attempted suicide (American College Health Association, 2012). It makes sense that more than 10.6%, the current percentage of college students that utilize campus counseling for all kinds of mental health concerns (Gallagher, 2012), could be in need of campus counseling. In 2008, only 15% of students with moderately severe to severe depression, and only 16% of students with current suicidal ideation, were receiving psychiatric services (Garlow et al., 2008). Knowing the dominant role that stigma plays in reducing help-seeking, tied with these statistics, helps to see just how many students

may need help but choose not to for concerns of stigma. These findings reveal the vulnerability of the college student population and the importance of mental health treatment and outreach to these students. The need for mental health services, yet the apparent comparatively low number of students actual seeking of services, shows the importance of studying this issue in hopes of eventual change.

College males are treated less often (6.9%) for depression than their female counterparts (12.9%; American College Health Association, 2012). In fact, depression among college males is a rising concern, as an increase was found from 2000-2007 of 6.2% to 10.9% in college males that met the clinical criteria for a depression diagnosis (American College Health Association, 2007). In addition, the reported rates of male depression are likely under-represented as males are less likely to self-report with depression (Olliffe et al., 2010). Although females typically report higher feelings of suicidality than males, the numbers are not that far off. In 2012, 6.7% of males reported having seriously considered suicide in the past 12 months; this is only slightly below the percentage of females (7.2%; American College Health Association, 2012). When the American College Health Association's (2012) recent survey asked college students if they had attempted suicide in the past year, 1.2% of females, and a close 1.1% of males answered positively. These statistics are consistent with other findings that reveal that college counseling directors report 77.2% of their completed student suicides last year were by male students (Gallagher, 2012). While college males are treated only approximately half as often for depression as college females, college males are still attempting suicide at nearly the same rate as females (American College Health

Association, 2012), and completing it more than three times as often as females (Gallagher, 2012).

### **Eating Disorders**

Another potential college student mental health issue is body dissatisfaction and eating disorders. College women are dieting at an alarming rate, with 83% indicating the use of dieting to lose weight (Malinauskas, Raedeke, Aeby, Smith, & Dallas, 2007). The transition of moving to college and searching for new relationships and connections may increase the desire to be accepted by peers, and as a result body dissatisfaction may become an issue. Dieting frequency has been linked to depression, low self-esteem, insecurity, and relationship issues (Ackard, Croll, & Kearney-Cook, 2002). As both a strong self-identity and healthy relationships are necessary pieces of positive student development (Chickering, 1969; Pascarella & Terenzini, 1995), lacking these factors can be detrimental to the student's personal development. Eisenberg, Nicklett, Roeder, and Kiz (2011) revealed that 13.5% of college women and 3.6% of college men met positive criteria for eating disorders. Of these students, only 20% had received mental health treatment in the past year for the disorder. Unfortunately, 80% of the students that met criteria for eating disorders had not sought mental health treatment. This study shows that while eating disorders are affecting college students, especially women, at an alarming rate, few are seeking treatment.

Only one in three students seek treatment after being recommended and given referral information for their eating disorder (Evans et al., 2007). The major barriers described by participants in this qualitative study were stigma and shame. As one

participant described, “the only barrier is my own shame...[the health professional] didn’t do anything to shame me, it was just how I was feeling” (Evans et al., 2007, p.279). These findings are powerful because they illustrate the personal stigma that some eating disorder clients place on themselves and how it can prevent them from seeking services. Other studies have described the connection between stigma and shame of eating disorders and barriers to help seeking (Hepworth & Paxton, 2007). In fact, of all barriers to help-seeking, Hepworth and Paxton (2007) found that a perception of stigma was the most prominent. Within their study, one participant described the perception of stigma around seeking treatment, “I thought that people would judge me. I thought that people would be disgusted with what I was doing and that they wouldn’t want to know me anymore” (p.498). Following a fear of stigma, shame was described as the next greatest barrier to seeking treatment, which may be associated with a kind of self-stigma towards one’s self. Perhaps stigmatizing oneself or feeling that suffering from such an eating disorder is a personal fault, which can result in feelings of shame. Hepworth and Paxton’s (2007) study support this association with overlapping themes of Fear of Stigma and Shame. They too describe a possible occurrence of self-stigma taking place by those with eating disorders having a tendency to internalize the stigmatizing beliefs held by society. Therefore, as it has been well-established that college students in general often do not seek help for concerns of perceived stigma (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010), students with eating disorders may hold even greater perceptions and concerns of peer stigma. Within these concerns of stigma may lie the idea that for students with eating disorders, seeking help may represent the first time they

are admitting their disorder to anyone, including, perhaps even themselves.

Unfortunately, at a time when colleges students may be in greatest need for mental health services for issues such as eating disorders (Ackard et al., 2002), they also hold great concerns of being stigmatized for such a disorder (Evans et al., 2007; Hepworth & Paxton, 2007).

While much of the research regarding eating disorders has been focused on women, since males have been generally considered to only encompass approximately 10% of those diagnosed (Garfinkel et al., 1995), a shift is taking place to recognize more males and eating disorders. Feltman and Ferraro (2011) propose that it is likely that males may make up a greater proportion of the disordered eating population than what has been generally accepted and shown in most research. Feltman and Ferraro (2011) note that more recent research has drawn focus on binge eating disorders, in which males have shown to account for approximately 40% of those diagnosed. Furthermore, they describe the lack in self report by males with eating disorders, and thus a potentially greater discrepancy in the previously accepted gender difference. Males who exhibit a higher occurrence of depression, anxiety, anger, impulsivity, and perfectionism are at a greater risk for an eating disorder (Feltman & Ferraro, 2011). Thus, with males accounting for 43% of the college student population (Marklein, 2005), it is important that the potential of an eating disorder to develop during their college student developmental years not be ignored.

### **Mental Health Stigma**



Stigma is the most damaging factor in the life of anyone who has a mental illness. It humiliates and embarrasses; it is painful; it generates stereotypes, fear, and rejection; it leads to terrible discrimination. Perhaps the greatest tragedy is that stigma keeps people from seeking help for fear of being labeled “mentally ill.”(Carter, 2010, p. 1)

The US Surgeon General described mental health stigma as the most daunting barrier to the progress of improving mental health (Clark et al., 2013). As a general term, *stigma* has been defined as “a feeling of being negatively differentiated owing to a particular condition, group membership, or state in life” (Arboleda-Florez & Stuart, 2012, p. 457). Furthermore, this broad definition goes on to describe the power differential that accompanies stigma in that it is the powerful or dominant group that can elicit stigma through social inequities (Arboleda-Florez & Stuart, 2012). When speaking of stigma in relation to race, ethnicity, religion, age, and gender, stigma can often mirror prejudice. In fact, Phelan, Link, and Dovidio (2008) have written about the "one animal" that stigma and prejudice often present as. In their best efforts to distinguish the two terms, they note that stigma often encompasses a focus on "deviant behavior and identities, and disease and disabilities" (p.358) whereas prejudice often encompasses the human characteristics such as race. Furthermore, they have developed a typology which includes three functions of stigma and prejudice. The functions of both stigma and prejudice are: exploitation and domination (which they describe as keeping the marginalized group down), norm enforcement (to keep people in those positions), and disease avoidance (or maintaining a distance; Phelan et al., 2008).

For the purpose of the current study, attention was focused on stigma, more specifically mental health stigma. Vogel et al. (2006) define *mental health stigma* as the perception that a person who receives mental health services is not fully accepted by society. Clark et al. (2013) have also described mental health stigma to include negative beliefs, prejudicial attitudes, and discrimination. All of these harmful attributes of mental health stigma can influence those with mental illness to avoid treatment and discontinue therapy early (Corrigan, 2004a).

### **Misperceptions: The Beliefs that Can Build Stigma**

Negative misperceptions about individuals with mental illness can result in feelings of stigma towards them (Carter, 2010). Misperceptions include the ideas that those with mental illnesses are incompetent, unreliable, have poor judgment, and are unable to make their own decisions. Some people believe that these individuals are dangerous, violent, and unable to get better (Carter, 2010). In reality, the majority of people with mental do not display the above traits.. Rather, many are productive in the world and able to recover. Many people with mental illness live alone and are a part of the workforce (Harrison et al., 2001). Unfortunately, many misperceptions and stereotypes about those with mental illness exist, and in some cases, these misperceptions may be related to a lack of education about those with mental illness. Corrigan et al. (2001) found that education is one of the strategies that exist for changing public stigma, and it is effective. When factual information about those suffering from mental illnesses were revealed, people's beliefs were corrected and levels of stigma were reduced. From this, it can be seen that as misperceptions about mental illness are corrected, personal

stigma beliefs can be reduced. In turn, it is possible that not only may personal attitudes of stigma be reduced, but perhaps also perceptions of others' levels of stigma.

Utilizing education to change misperceptions and beliefs has been effective in other areas as well. College students have shown a misperception between perceived and personal factors. For instance, when examining college students' alcohol drinking behaviors, LaBrie, Hummer, Grant, and Lac (2010) found that students perceive much higher consumption than actually exists amongst their college peers. In addition, when researchers or others reveal these misperceptions to students, or educate them, their perceptions are changed to reflect reality. Arbour-Nicitopoulos, Kwan, Lowe, Tamna, and Faulkner (2010) found university students to have misperceptions of their peer substance use, including alcohol, smoking, and marijuana use. Scribner et al. (2011) found correcting of misperceptions to have an effect on reducing student alcohol use, when looking at universities that had a lower amount of alcohol purchasing venues on campus. Therefore, results indicate that a correction in misperceptions can change student behavior. If student misperceptions are changed to reflect a more accurate and less extreme drinking behavior by their college peers, students may drink less (Scribner et al., 2011) by no longer having such misperceived social norms to follow. This same idea of correcting misperceptions to change attitudes and behavior may be considered when looking at mental health stigma. For example, misperceptions of mental health stigma have been shown to exist through greater perceived stigma than the actual existing stigma (Eisenberg et al., 2009). Given these findings, further research in this area may be warranted.

### **Effects of Mental Health Stigma**

Skinner, Berry, Griffith, and Byers (1995) found that a person who had previously been hospitalized for mental illness was considered more likely to experience social embarrassment and stigma than an ex-convict or an ex-drug addict. Feldman and Crandall (2007) note that mental illness is responsible for two types of harm. They describe the first harm as those directly from the mental disorder, including cognitive, behavioral, affective, and other problems that limit one's ability to function. They describe a second harm as "the social rejection, interpersonal disruption, and fractured identity that comes from the stigma of mental illness" (Feldman & Crandall, 2007, p.137).

Alonso et al. (2009) found that physical quality of life, job, and social problems are negatively affected by perceived stigma. This is especially detrimental to mental health improvement, because these life areas are likely also areas that are vital to help one recover from mental illness. Therefore, it may be possible that perceptions of stigma can also slow or even halt mental health recovery and treatment. This idea, compounded with the greater potential that those with perceived stigma beliefs are less likely to seek counseling (Eisenberg et al., 2009; Vogel, Wade, & Hackler, 2007; Komiya, Good, & Sherrod, 2000), may combine for a complex barrier to mental health recovery.

Feldman and Crandall (2007) note that mental illness stigma can be as harmful as the illness itself. Their study examined the aspects of mental disorders that are responsible for stigmatization and social rejection. The study involved 281 college students who were asked to read 40 brief vignettes, each describing a different mental

disorder diagnosis. Participants then rated each vignette's character in different areas, such as dangerousness, treatability, and social disruptiveness. Participants' ratings of social distance to each character were also assessed. Findings revealed that nearly 75% of the presented disorders resulted in "overall rejecting attitudes" by participants, or with a mean social distance score greater than the scale's midpoint. This is an alarming finding that may be related to college students' reluctance to seek help. If the majority of college students report rejecting attitudes towards those with mental disorder diagnoses (Feldman & Crandall, 2007), then there is credibility to the college student fear of being stigmatized for help-seeking (Martin, 2010). While help-seeking does not necessarily result in a mental disorder diagnosis (as the above study's vignettes portrayed), there may still be a perceived association between the two.

Seven characteristics of mental illness were found to lead to stigmatization: dangerousness, disruptiveness, lack of reality, untreatable with medication, personal responsibility, level of illness rarity, and degree of avoidability (Feldman & Crandall, 2007). Three of these listed characteristics were also found to be significant factors that contribute to social rejection: dangerousness, level of illness rarity, and personal responsibility. Dangerousness was described as the person being viewed as a threat. As a person's level of perceived dangerousness increases, so does the willingness to reject such a person. The authors mention that level of illness rarity may increase social distance because rarer conditions may be thought of as more severe. Finally, personal responsibility was described as the degree to which it is believed that the person is responsible for his or her disorder. The authors note a likely connection between this and

low sympathy for a person who is believed to be responsible for their illness and in turn, avoidance towards that person (Feldman & Crandall, 2007). Similar findings also support this idea, as people that are considered responsible for their mental illness are often more stigmatized and rejected by society. Furthermore, more societal anger, avoidance, and refusal to help can be elicited from such a perception (Weiner, Perry, & Magnusson, 1988). Colleagues agree that mental health stigmas can be a major roadblock to help-seeking as will be discussed in the next section (Corrigan, 2004a; Corrigan, 2004b; Eisenberg et al., 2009; Komiya, Good, & Sherrod, 2000, Martin, 2010; Vogel, Wade, & Hackler, 2007).

### **Public and Perceived Stigmas**

**Public Stigma.** Corrigan (2004a) described *public stigma* as “what a naïve public does to the stigmatized group when they endorse the prejudice about that group” (p.616). Vogel et al. (2006) built on Corrigan’s (2004a) definition of public stigma to include, “the perception held by a group or society that an individual is socially unacceptable and often leads to negative reactions toward them” (p.325). Vogel et al. (2006) further elaborated on this term in specific relation to mental health services by describing it as a perception that the person seeking mental health services is not accepted by society.

Reeder and Pryor (2008) studied the psychological processes which underlie public stigma, and propose that associative or rule-based processing occur. In relation to public stigma, they describe associative processing as a stigmatizing reaction that has an automatic reaction of negative feelings. It is also possible that the person with the stigmatizing feelings does not even fully realize or understand the feelings. Simply being

exposed to or associated with a socially stigmatized person can elicit these feelings of public stigma from others. Furthermore, these feelings may not be planned or even conscious. A person may have an automatic response of these stigmatizing feelings, yet their actual beliefs about the individual may not match the initial feeling response. Reeder and Pryor (2008) describe this phenomenon by noting that a person may initially react with fear to a mentally ill person, even though they do not consciously believe the individual to be dangerous. Wahl (1995) has addressed media images of mental illness that further stigmatize. One idea is that through saturation of media messages, showing the mentally ill as dangerous and in other stigmatizing ways, the general public has acquired an automatic psychological reaction of stigmatization.

In contrast to associative processing, rule-based processing of public stigma involves a conscious and planned reaction to the stigmatized person (Reeder & Pryor, 2008). In rule-based processing an automatic response is followed with conscious thinking about the situation and whether facts are known to prevent feelings of stigma towards the person, thus causing a self-regulatory process. Reeder and Pryor (2008) describe a potential thought process involving considering if the person is responsible for the stigmatized issue, and often if he or she is not, sympathy rather than public stigma may result. Studying the processing behind public stigma is important because while there may be an automatic stigmatizing response, ingrained from things such as media messages, there is also the opportunity for a subsequent rule-based processing which can diminish the original public stigma.

**Perceived public stigma.** Corrigan (2004a) described an individual's perception of public stigma as *perceived public stigma*. Perceived public stigma has been measured in relation to mental disorders. In one study, perceived public stigma to people suffering from depression was assessed through vignettes about people suffering from depression, followed by questionnaires (Peluso & Blay, 2009). Fifty-six percent of participants perceived society to consider those suffering from depression as dangerous. Forty-nine percent perceived society to have negative reactions to depression sufferers. Also, 41% perceived that discrimination from society would occur. Yet, when the participants themselves were asked to report their own emotional reactions to those suffering from depression, the reactions were mainly positive in nature. Given these student reports, which the researchers assume to be honest representations of their true feelings, this study strongly illustrates the disparity between perceived public stigma and personal stigma. While participants perceived strong public stigma to be focused on those with depression, the participants' own personal stigma was far less.

These findings are in line with Eisenberg and colleagues' (2009) conclusions that college students' levels of perceived stigma by their peers are greater than their levels of personal stigma. This shows that there is a misperception of stigma occurring. If multiple levels of personal stigmas combine to represent public stigma, then it is possible that perceived public stigma is actually an overestimate of what the levels of public stigma truly are. This over-estimating of public stigma is important because perceived public stigma can negatively influence a person's decision to seek mental health services. Studies support the great influence that perceived public stigma plays on an individual's



decision to choose mental health consultation and treatment (Andrews et al., 2001; Corrigan, 2004a). Furthermore, Corrigan and Wassel (2008) have found public stigma to be a barrier to personal aspirations and life goals. Through concerns of public stigma, judgment and non-acceptance, people are less willing to move forward with actions that may lead to their personal goals and aspirations. The concern of public judgment and disapproval appears to be greater than not only choosing to help-seek, but also of one's happiness.

**Personal stigma.** Eisenberg et al. (2009) defined *personal stigma* as “each individual's stereotypes and prejudices” (p.523). Eisenberg and colleagues found college students' perceived public stigma to be considerably higher than their own personal stigma. These findings are important because they identify the misperception that college students have about assumptions of their peers' personal stigma levels and the actual levels of stigma. Studies have shown the negative impact on mental health concerns through public stigma (Corrigan, 2004a, Skinner, Berry, Griffith, & Byers, 1995) and perceived public stigma (Andrews et al., 2001; Eisenberg, 2009; Komiya et al., 2000).

### **Stigma: A Barrier to Seeking Mental Health Services**

The action of help-seeking has been defined as a “problem focused, planned behavior, involving interpersonal interaction with a selected health-care professional” (Cornally & McCarthy, 2011, p.280). Andrews et al. (2001) revealed the great influence that perceived public stigma plays on a person's decision to choose mental health consultation and treatment. They found that factors that did *not* affect rates of mental health consultation were ones such as financial expenditures or responsiveness of mental

health care systems. The greatest contributing factors to a lack in seeking services were diagnostic type, attitudinal, and societal. Andrews et al. (2001) revealed that 1 out of 3 people with a mental disorder sought help. Ninety percent of those with schizophrenia sought help (but this was often due to external influences such as family because this mental disorder tended to be difficult to keep hidden), 60% of those with depression, and 15% of those suffering from substance abuse or personality disorders (Andrews et al., 2001). The majority of those with mental illness who chose not to seek help noted that they preferred to deal with the illness by themselves. These findings illustrate the influential role that perceived public stigma plays on seeking mental health treatment. These findings regarding the effect of perceived public stigma on help-seeking behaviors of those with mental disorders are similar to findings related to the college student population and help-seeking (Gallagher, 2011) and perceptions of public stigma is one of the greatest reasons that college students report for not seeking services (Evans et al., 2007; Hepworth & Paxton, 2007; Martin, 2010).

In a recent study, Schomerus, Auer, Rhode, Luppá, Freyberger, and Schmidt (2012) studied the relationship between personal stigma and how those that suffered from depression viewed their illness. The study participants were untreated individuals who were experiencing symptoms of depression. The study controlled for severity of the depression and previous help-seeking history. The results indicated that higher levels of personal stigma of the participants were related to a lower belief that their depression was an important issue. Another important finding of this study was that higher levels of personal stigma were related to a lower perceived need for professional help. A lower

belief in the importance of their illness was directly linked to a reduction in perceived help need. Specific types of help-seeking that were reduced by personal stigma included counseling, use of needed mental health medication, and nonclinical sources of support. This study reveals the direct link between a high personal stigma and the dismissal of mental illness importance and need for help. From this it can be seen how holding a high personal stigma can be a barrier to help-seeking.

Other studies have revealed the strong role that societal influences play in mental health help-seeking. Corrigan (2004a) found that avoiding being negatively labeled by society was a motivator to hide one's mental health problems from others, avoid treatment, discontinue services, and not fully follow therapeutic treatment plans. Wade, Wester, Larson, and Hackler (2007) studied the societal influences of knowing others who have sought mental health services, and being recommended by someone to seek services. These factors were then examined in relation to expectations, attitudes, and behavior of help-seeking. The authors surveyed 780 college students and found that a student's social network significantly affects help-seeking attitudes and behaviors. Results revealed that both being recommended to seek help by people in one's social circle, and knowing someone who had sought help, both increased favorable attitudes toward mental health services. Furthermore, knowing someone who had sought services increased one's intentions to help seek themselves. Overall, the study found that of those participants who sought services, 75% of them were recommended to do so by someone, and 94% had known someone who had sought services (Wade et al., 2007).

While the Gallagher (2011) study does reveal some shocking statistics regarding increases in student mental health, it is important to remember that the students the directors were reporting on were already clients at the counseling centers. One must wonder to what extent and severity students outside the counseling center are experiencing mental health problems. Nearly 90% of college students are not seeking help at college counseling centers (Gallagher, 2011). While this is not to say that every college student needs to seek help, it is likely that more than 10.6% of students could benefit from the services.

Among the potential influences on attitudes toward seeking mental health services in college is the level of perceived stigma (Komiya et al., 2000). Komiya and colleagues (2000) assessed perceptions of stigma around receiving mental health treatment among college students. Findings indicated that higher perceptions of stigmatization were related to less favorable attitudes toward seeking mental health services. Studies have shown that many college students do not seek help from their college counseling centers because of a perception of stigma by their peers (Eisenberg et al., 2009; Vogel et al., 2007; Vogel et al., 2006). Stigmatization has been shown to be a great factor in why college students with mental health problems do not seek help from their college counseling centers. For example, one interview of a student included the quote, "Mental health problems are hugely stigmatized...the vast majority of people with mental health problems do not want people to know because people look at you differently" (Quinn, Wilson, MacIntyre, & Tinklin, 2009, p.410).

Quinn and colleagues (2009) conducted in-depth interviews with college students who were experiencing mental health issues in order to better understand this issue of college students and mental health stigma. Findings indicate that the existing stigma towards mental health problems was the cause for student hesitation to disclose personal mental health problems and to seek college counseling services for support. When students did seek help at college counseling centers, the majority noted having greatly benefited from the experience and considered the support to be of value. A common response from students was that they felt regret for not having sought counseling sooner (Quinn et al., 2009).

These findings were important to the current study because they supported the idea of the strong influence of stigma on seeking college counseling services. In addition, Quinn and colleagues' (2008) findings of students noting benefits from counseling showed support in the current supposition that correcting misperceptions of stigma can result in the use of counseling services and in improved life functioning. While this study supplied powerful in-depth information through student interviews, there was a need for additional information about the relationship between perceived and personal mental health stigma and how these factors influence attitudes and intentions of help-seeking.

College marks a major change in the academic arena accompanied by significant psychosocial change as well. It is critical for college counselors to consider these challenges when understanding the developmental path and needs of the college student population so that counselors can be cognizant of other factors that may be influencing client presenting issues as well as their progress. Furthermore, by better understanding

their clients—including their developmental challenges—counselors may be more likely to develop a better therapeutic relationship with clients. Having a good therapeutic relationship is critically important to the counseling process. It has been shown that college students' perceptions of a strong therapeutic relationship with their college counseling center counselor is directly related to positive outcomes in counseling (Eyler, Gaskins, & Chalk, 2009).

The majority of college students with mental health problems choose not to disclose their issues and, thus, do not receive help and support (Martin, 2010). Martin found that students' primary reason for not disclosing was the perception and fear of being stigmatized and discriminated against. Regardless, many students noted the extreme difficulty in trying to hide their mental illness and as a result, their academic obligations suffered. For the few that did choose to disclose to college staff, they received help with their mental illness and as a result their academic concerns improved as well. In fact, Martin (2010) also found that college counseling services were identified by students as a main source of support for their mental illness. For these college students that chose to disclose and overcome fears of stigmatization and seek help, the benefits were great. Yet, for the majority of college students that choose not to seek needed counseling services, stigma remains the major barrier.

### **Help-Seeking Perceptions**

Eisenberg and colleagues (2009) studied the perceived public stigma and personal stigma of college student mental health help-seeking. Their findings suggest that college students' perceptions of public stigma were considerably higher than their own personal

stigma; their perceptions of the public's stigma towards someone seeking help were greater than their own perceptions about such persons. In addition, findings also indicated that help seeking significantly decreases when there are higher levels of personal stigma. Therefore, people's own stigmatizing attitudes (personal stigma) can significantly reduce help-seeking behaviors.

Vogel and colleagues (2007) examined the relationship between college students' perceived public stigma and their willingness to seek counseling resources for psychological and interpersonal issues. They found that having perceptions of public stigma increased feelings of personal stigma. Further, they found that having these feelings of personal stigma negatively influenced students' willingness to seek counseling. As a result, their work demonstrates the connection between having perceptions of public stigma and the reduction in seeking counseling. A limitation to this study included the fact that, while the study did look at the relationship between perceived public stigma and personal stigma, it did so without taking into account the factor of social desirability. Social desirability is a powerful factor that can influence responses in an effort to choose socially desirable responses, especially regarding topics such as stigma (Henderson, Evans-Lacko, Flach, & Thornicroft, 2012). The current study examined levels of social desirability in relation to reported perceived and personal stigma to examine if social desirability influences participants to give more favorably desirable responses.

If college students are able to correct their misperceptions, their perceived public stigma beliefs, they may be more likely to seek out mental health services at college

counseling centers. It is hoped that this, in turn, will lead to improved mental health, including described outcomes of college counseling such as goal attainment, acquisition of coping skills, learning about oneself, and improved academic performance (Eyler et al., 2009). It is also important to better understand the influences on college students' perceived public stigma and personal stigma, to benefit students who are already currently receiving campus counseling. Counselors can become better equipped to address the issue of stigma within the counseling session. As clients open up about their mental illness and self-stigma in session and stigma is addressed in the session, misperceptions of levels of public stigma may be corrected, it is hoped that the counseling process will also become even more beneficial.

### **Gender and Help-Seeking**

When discussing stigma and help-seeking, it is also important to briefly mention the role that gender can play. Studies show that males hold even greater concerns of stigma than females and are less likely to help-seek because of the concern that help-seeking is not accepted by societal masculinity expectations (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). A strong link has also been found between masculine norms and self-stigma (Hammer et al, 2012). This study shows that the greater the personal conformity to masculine norms, the greater the self-stigma and unfavorable attitudes towards help-seeking. These findings have been found to be true of men across varying cultural backgrounds as well and with self-stigma being twice as strong in men from rural backgrounds than any other group (Hammer et al., 2012).



“Self-stigma is an important barrier to seeking professional mental health services for men across community size, education, and income lines. Addressing stigma as a primary mediator, and more proximal antecedent to help-seeking attitudes, appears worthwhile” (Hammer et al., 2012, p. 23). Oliffe et al. (2010) revealed that many college men have a great concern that anyone will realize any feelings of depression. This worry of others learning of one’s mental disorder echoes the problem of mental health stigma. Perhaps the societal expectation for males to be stronger and powerful instills more fear of mental health stigma as it may be associated with weakness. Yet, with 73% of college student suicides being by males, this is an important group to remember (Gallagher, 2011). Therefore, when exploring a connection between stigma and help-seeking, the additional variable of gender should be remembered.

### **Social Desirability**

Edwards (1953) has described social desirability as an individual’s desire to present him or herself in a socially positive light. Social desirability is an important variable to consider alongside stigma because study participants may report what they consider socially desirable responses on stigma, rather than their true beliefs (Edwards, 1953). When studying public mental health attitudes, Henderson et al. (2012) also considered social desirability as a potential variable to affect participant responses. The authors studied the influence of social desirability on face-to-face interviews compared to anonymous online surveys. “Being interviewed face-to-face by someone may be more likely than answering an online survey to elicit ideal responses” (Henderson et al., 2012, p.154). Using the Marlowe-Crowne Social Desirability Scale (Crowne-Marlowe, 1960),

the authors studied responses to stigma related mental health knowledge as well as intended behavior towards those with mental health illness, and the influence of data collection methods. In addition, they studied self-disclosure of mental health issues and data collection method influence.

Four items were found to significantly correlate with social desirability (Henderson et al., 2012). These items addressed: Currently or in the past having: lived with someone with a mental health problem, worked with someone with a mental health problem, had a neighbor with a mental health problem, had a close friend with a mental health problem ( $r=0.12$  to  $0.13$ ,  $P<0.05$ ). The current study took levels of social desirability into account when assessing participants' self-reports. By determining, and ultimately controlling for levels of social desirability, more pure levels of perceived public stigma and personal stigma are hoped to be attained.

Henderson et al.'s (2012) findings supported the hypothesis that social desirability affects face-to-face interview responses more than online anonymous responses. For instance, when participants were asked if they believed medication could be an effective treatment for people with mental health problems, 80.6% of face-to-face interviewees agreed, yet only 69.9% of online respondents agreed. When participants were asked if they would know how to help a friend with a mental health problem get professional care, 51.5% of face-to-face interviewees said they would, yet only 35.2% of online respondents agreed. It was also surprising that 48.5% of face-to-face interviewees viewed drug addiction as a mental illness, yet only 34.2% of online respondents considered it as such. Self-disclosure of mental health illness also appeared to be influenced by data

collection method (Henderson et al., 2012). Findings revealed that a lower percentage (57.1%) of participants of face-to-face interviews reported knowing anyone with a mental illness, as opposed to anonymous online participants that disclosed (70.9%). Furthermore, 12.2% of anonymous online participants reported having a mental illness, yet, only 4.6% of face-to-face interviewees disclosed this. The authors stipulate that this may be for concern of self-disclosure to interviewers and possibly embarrassment (Henderson et al., 2012).

Gender has also been found to effect rates of social desirability. Dalton and Ortegren (2011) noted that females respond with more ethical or socially desirable responses than males. These authors also used the Marlow-Crowne scale (Crowne & Marlow, 1960), to account for social desirability. Findings concluded that when accounting for social desirability, female responses were not more significantly ethical than male responses. Therefore, it appears that social desirability is a substantial factor in the relationship between gender and ethical response. It is well known that women experience more pressures as they develop a sense of self, based on societal gender role expectations (Eagly, 2007; Miller, 1976). Perhaps such societal expectations also induce pressure on women to respond in more socially desirable ways, thus the connection between gender and ethical responses.

Henderson et al.'s (2012) findings also supported that self-report of intended behavior towards those with mental health illness is affected by participant anonymity. For example, 43.9% of face-to-face interviewees said they would be willing to live with someone with a mental health problem, yet only 31.1% of online respondents reported

being willing to. Even when asking if participants would be willing to simply live near someone with a mental health problem, face-to-face interview respondents answered more favorably (63.8%), or socially desirable, than anonymous respondents (61.2%). The findings of this study do suggest that studies involving participants' stigma related mental health knowledge and self-described intended behavior towards those with mental illness, are affected by data collection methods (such as face-to-face versus anonymous online collection). For both participant groups, face-to-face and online, social desirability did influence mental health knowledge responses. Also, social desirability positively increased participant reported intended behavior towards those with mental illness.

### **Conclusion**

College students are in a time of great physical, intellectual, psychosocial, ethical, and moral development. These developmental tasks and stages have been explored in detail to help the reader better understand what the typical college student may be experiencing "under the surface." Furthermore, amongst these developmental processes, college students are also faced with challenges that may impede or halt healthy development. All of the above strive to paint a picture of the intense transition that takes place during the college years.

Based on these facts, the importance of the college campus counseling center becomes more evident. Unfortunately, the mere presence of such a support resource is only as helpful as students allow it to be, by utilization. Perceptions of mental health stigma are the greatest roadblock to students seeking help at their college counseling centers (Evans et al., 2007; Hepworth & Paxton, 2007; Martin, 2010). These perceptions

of stigma may be especially rooted and difficult to change, simply based on where students are in their developmental journeys, because of the characteristics of each stage of development.

Public stigma and perceptions of it on mental health have been explored along with personal stigma. While these concepts have been described, this study also explored how the levels of these types of stigma compare to one another. Also, an expanded awareness of the role of these forms of stigma on help-seeking attitudes and intentions of college students was studied. Social desirability has been described, and furthermore, this study utilized it as a variable, as it is a known impediment to honest self-report. The following chapter describes in detail how the current study addressed each of these areas. It will include specific research questions and the detailed methodology of the research.

## Chapter Three

### Introduction

This study examined college students' perceptions about their college peers' attitudes toward participation in campus counseling and how this perception influences their own help-seeking attitudes and intentions toward receiving campus counseling services. College student perceptions of peer mental health stigma, or the perceived public stigma, were assessed. *Perceived public stigma* has been referred to as an individual's perception of public stigma (Corrigan, 2004a). College students' own personal mental health stigma was also assessed. Personal stigma has been described as each individual's stereotypes and prejudices (Eisenberg et al., 2009). Reported personal stigma of students was then compared to perceived levels of stigma, with the purpose of determining any statistically significant difference between students' actual reported stigma and their perceptions of their peers. Finally, participant level of social desirability was assessed, which has been defined as an individual's desire to present him or herself in a socially positive light (Edwards, 1953). Social desirability was examined to determine if it is an influential factor on self-reported levels of perceived public stigma and/or self-reported levels of personal stigma.

This chapter discusses the methods that were used in conducting the study. The research design and research question is provided to identify the quantitative method and purpose of the study. The research context and participants are described to better understand the culture and demographic profile of the sample population. The procedures

used to collect data are detailed. And finally, a review of the measures of each of the variables and the data analysis is provided.

### *Research Design*

This study used a quantitative survey research design with the incorporation of bivariate correlations to measure the potential relationship among variables (Salkind, 2008) and regression analysis to assess the effect of college student levels of perceived stigma on help-seeking attitudes and intentions. Furthermore, correlations between participant levels of perceived stigma and personal stigma were investigated, along with comparisons between the means of the two variables. These findings assessed whether college student levels of perceived stigma affect their own help-seeking attitudes and intentions, and if their levels of perceived stigma differ from their own personal stigma. Levels of social desirability were also assessed to determine its influence on the variables. Survey research methodology was employed to collect self-report data on the above variables.

### *Research Question*

The primary research question in this study is as follows:

Do college students' perceptions of their peers' attitudes toward participation in counseling (perceived public stigma) affect their own help-seeking attitudes and intentions?

### *Research Sub-questions*

1. Is there a significant correlation between college students' perceived public stigma levels and their personal stigma levels (personal stigma levels combined will represent the actual stigma levels on campus)?
2. Do college students' levels of social desirability affect their self-reported levels of perceived public stigma?
3. Do college students' levels of social desirability affect their self-reported levels of personal stigma?

#### *Research Participants*

A sample of undergraduate college students at 2 public universities in the United States was utilized. A college student was defined as any student at the selected universities who was considered an undergraduate student by the university. This sample was comprised of undergraduates who were enrolled part-time or full-time at either of the two sampled universities, and who had been assigned a university based email account. One data collection site was Montclair State University. This is a public university in the North Eastern United States (New Jersey) and the undergraduate population is approximately 14,590. The other data collection site was Winthrop University, a public university in the South Eastern United States (South Carolina). This university has approximately 5,059 undergraduates registered. The aim was to sample a total of 150 students from Montclair State University and Winthrop University.

#### **Procedures**

##### *Data Collection Method*



Anonymous surveys were distributed electronically through an email invitation for volunteers. Studies have supported email and online surveys as a viable method of data collection amongst the college student population (Eisenberg, Gollust, Golberstein, & Hefner, 2007). Further support for this data collection method was to encourage more honest participant responses about stigma. In-person survey distribution might have otherwise influenced self-reporting because both the researcher and other participants would have been in the same room, possibly having contributed to less than honest participant responses. McCabe (2004) found that participants were more honest in admitting their lifetime cocaine use if a web-based survey was conducted as opposed to an in-person paper and pencil format. While the topic of cocaine use was different from the current study's topic of mental health, both topics have been shown to elicit respondent concerns of related stigmatization (McCabe, 2004; Quinn et al., 2009). Based on these findings, web-based distribution of the survey was the most viable method.

Data collection was carried out via an email blast to all undergraduate students at both Montclair State University and Winthrop University, encouraging voluntary anonymous participation through an online survey link. It was hoped that the electronic survey resulted in higher response rates than an in-person format would have. Web-based survey participation yielded higher response rates (63%) versus in-person administration (40%) in one study (McCabe, 2004). As an additional strategy to encourage participation, an incentive of winning one \$100 gift card was described in the email. The winner of this gift card was randomly selected from students that completed the survey. At the end of the anonymous online survey, participants were given the contact information (email

address) to submit their entry for the raffle drawing. They were asked to simply email a blank email with the subject line, "Please enter me in the gift card drawing." Entries were not tied to survey responses. The randomly selected raffle winner was notified via email.

Within the body of the email, students viewed the informed consent, which explained the purpose of the study, the benefits and possible cost of participation (see Appendix A). Participants were also informed that participation was anonymous and voluntary. Students who chose to participate clicked on the email link, which also served as their acknowledgement that they had read and agreed to the informed consent. The email link then routed them to the anonymous online survey through Survey Monkey. Within this company's privacy policy, Survey Monkey notes that they "treat your survey questions and responses as information that is private to you. We know that, in many cases, you want to keep your survey questions and responses (which we collectively refer to as "survey data") private. Unless you decide to share your survey questions and/or responses with the public, we do not use your survey data for our own purposes" (SurveyMonkey Inc, 2013). They also note that they do not sell survey data to any third parties. The site account is also password protected, of which will only be known by this study's primary investigator. *SurveyMonkey Inc.* (2013) also describes in their privacy policy that they "have a state-of-the-art security infrastructure to make sure the data we collect is safe" and that they use SSL (Secure Sockets Layer) encryption protocol and connections.

The survey consisted of (copy found in Appendix A):

1. A demographic questionnaire (Gender, age, race, ethnicity, class level, and past or present participation in counseling service)
2. A modified form (Eisenberg, Downs, Ezra, Golberstein, & Zivin, 2009) of the Perceived Devaluation-Discrimination scale (Link, 1987), to measure college students' perceptions of their peers' attitudes toward participation in counseling (perceived public stigma) (Eisenberg, Downs, Ezra, Golberstein, & Zivin, 2009).
3. The Personal Stigma Scale (Eisenberg, Downs, Ezra, Golberstein, & Zivin, 2009), which is a modified form of the Perceived Devaluation-Discrimination scale (Link, 1987), to measure college students' personal stigma toward participation in counseling.
4. The Self-Stigma of Seeking Help (SSOSH) Scale to assess help-seeking attitudes and intentions (Vogel, Wade, & Haake, 2006).
5. The full form of the Crown-Marlowe (1960) Social Desirability scale to measure participant levels of social desirability.

Each participant's completion was estimated at approx. 10-15 minutes. Upon completion of data collection, all surveys were segregated by date, numbered and then entered into SPSS software for statistical analysis.

### **Instrumentation**

The following section describes the measures used for data collection in the study. A self-report anonymous survey was used to collect demographic information and data on each of the variables studied. The primary variables studied were levels of perceived

stigma, levels of personal stigma, social desirability, help-seeking attitudes and intentions. Demographic variables such as gender, age, race and ethnicity, class level, and past or present participation in counseling services were also included in the survey. These were the primary components of the survey instrument. The instructions for completing the anonymous online survey were provided and it is estimated that it took participants an average of 10-15 minutes to complete the survey.

#### *Demographic Questionnaire*

Gender, age, race, ethnicity, class level, and past or present participation in counseling services were some of the demographic variables of the study. All of these variables, with the exception of age, were obtained from straightforward check list items. Age was determined by asking participants to write their age on the questionnaire. This allowed for exact ages and the ability to categorize age groups. The demographic questionnaire consisted of a total of 12 questions.

#### *PDD- Perceived-Devaluation-Discrimination Scale (adapted form)*

An adapted form of the PDD was used to measure college students' perceptions of their peers' attitudes toward participation in counseling (perceived public stigma). Eisenberg, Downs, Ezra, Golberstein, & Zivin's (2009) adapted form of the PDD was created to measure perceived public stigma towards those that have participated in counseling.

This adaptation of the PDD, by Eisenberg et al (2009) was created from the original PDD (Link, 1987), which was created to measure the perceived stigma towards those that have been hospitalized for mental illness. The most recent version of the

original PDD scale has a revised Cronbach's alpha of .80 (Link, 2013). Multiple studies have utilized Link's (1987) original PDD scale to measure levels of perceived stigma (Bjorkman, Svensson, & Lundberg, 2007; Glass, Kristjansson, & Bucholz, 2013; Lundberg, Hansson, Wentz, & Björkman, 2007). Bjorkman et al. (2007) recommend the use of the PDD scale for future studies regarding stigma among people with mental illness and have found the scale to have good reliability and validity

The original PDD (Link, 1987) consists of 12 items that are self-scored and rate perceived stigma. Examples of items are: "Most young people would be reluctant to date someone who has been hospitalized for a serious mental illness" and "Most employers will not hire a person who has been hospitalized for mental illness." The PDD's 12 inventory statements begin with "Most people would/believe..." and are then followed by a stereotype or negative attribute. The only exception to this are inventories that are followed by acceptance or neutrality towards the hospitalized person, yet this items are scored in reverse. Items are questioned in a 4-point scale: "strongly agree"= 3, "agree"=2, "disagree"= 1, "strongly disagree"= 0. In six of the items, the scoring of the item is reversed in creating a sum score. An example of a reversed item is "Most people would accept a person who has been in a mental hospital as a close friend." In his adaptation of Link's (1987) PDD, Eisenberg had changed the wording of the original scale. Eisenberg et al.'s adaptation (2009) will be used for the current study. The most recent revision of this adapted PDD (Eisenberg et al., 2009) scale and permissions were obtained for the purpose of this study. For the purpose of the current study, perceived public stigma towards anyone who has received mental health treatment was the focus,

rather than the original PDD scale items which focus on only those who have been in a mental hospital. Therefore, the same adaptation of the PDD scale developed by Eisenberg et al. (2009) was used for the current study. This adaptation involves just a word adjustment on each item, from “mental health patient” or “who has been hospitalized for mental illness,” with the adapted wording of, “a person who has received mental health treatment.” In this adjusted format, Eisenberg et al. (2009) found a high internal reliability (Cronbach’s alpha = .89) and high internal validity. Other studies have also adapted the PDD, such as to measure perceived alcohol stigma and have found it to have reliability and validity (Glass, Kristjansson, & Bucholz, 2013).

#### *Personal Stigma Scale*

Eisenberg et al. (2009) defined personal stigma as “people’s own stigmatizing attitudes about mental health treatment” (p.527). In an effort to measure this personal stigma, Eisenberg and colleagues (2009) created an adapted form of the *Perceived Devaluation-Discrimination (PDD) Scale* (Link, 1987). In this adapted stigma scale, named the *Personal Stigma Scale* (Eisenberg, et al, 2009), three items from the PDD were adjusted. While the PDD items began with “Most people,” the adjusted items began with “I.” The three items that were adjusted, which make up the total instrument, were related to a negative attitude (“I would think less of a person who received mental health treatment”), an accepting behavior, (“I would accept a person who has received mental health treatment as a close friend”), and an accepting attitude, (“I would think that someone who has received mental health treatment is just as trustworthy as the average citizen”). Eisenberg et al (2009) then used the same Likert scoring as the PDD and

assessed and index of personal stigma. The internal reliability of this was found to be relatively high at a Cronbach's alpha of .78. Permission from Link to use the modified version of his original scale was obtained. Permission from Eisenberg was gained to utilize his modified version of Link's scale.

*Self-Stigma of Seeking Help (SSOSH) Scale*

This scale was developed to assess help-seeking attitudes and intentions (Vogel, Wade, & Haake, 2006). As the authors note, "The SSOSH scale uniquely predicted attitude toward and intentions to seek psychological services" (p.334). This 10 item scale was used in the current study to measure participant help-seeking attitudes and intentions. This scale consists of a 5-point Likert scale, which includes items such as "My self-confidence would NOT be threatened if I sought professional help" and reverse items such as "Seeking psychological help would make me feel less intelligent." Responses range from 1 ("strongly disagree") to 5 ("strongly agree"), with a score of 3 representing agree and disagree equally. The scores of the scale can range from 10-50, with the higher scores representing greater levels of self-stigma help-seeking attitudes and intentions. Within their study, Vogel and colleagues (2006) conducted four phases of their study, with college student participants, to test the internal consistency, reliability, and validity of the SSOSH. Participant samples in each of these phases ranged from 217-583 participants. Over all four phases, a total of 1,816 participants were sampled. The scale's internal consistency ranged over the phases with a strong .88-.90. The scale was found to have good reliability (.86-.91). The authors also noted good construct, criterion, and predictive validity across all phases. Finally, a fifth phase was conducted over a 2 month

period to examine the scale's test-retest reliability, which was good at .72. Permission from Vogel was gained to utilize his SSOSH scale (See Appendix).

### *Social Desirability*

Bowman and Hill (2011) studied the biases in self-report of college students. In particular, it was found that college students do experience social desirability bias on self-report measures. As a result, the current study measured participant levels of social desirability in order to control for any affects. This was also an important measure, as the utilized stigma scales did not have built in controls for social desirability. The full form of the Crowne-Marlowe (1960) Social Desirability scale was used as a part of the current study's survey. Crowne and Marlowe (1960) showed the internal consistency of the 33 items to be .88, and the test-retest correlation was .89. Over 40 years later, Barger (2002) also found the Scale's internal consistency at .88 and test-retest at .89. Furthermore, over a period of one month, test-retest reliability was shown to be .86 (Crino, Svoboda, Rubinfeld, & White, 1983). When examining the reliability of the scale in relation to college students, Tanaka-Matsumi and Kameoka (1986) generated a reliability coefficient of .79. Other studies have also found support of the scale's validity (Johnson, Fendrich, Mackesy-Amiti, 2011). As a result, the Crowne-Marlowe (1960) Social Desirability Scale has largely been recognized as the most widely used scale of social desirability (Barger, 2002).

### **Ethical Considerations**

There were ethical considerations to be aware of to protect the study's research participants from harm. A concern of being stigmatized is the most common reason



why people do not seek mental health services (Corrigan, 2004a). This is also true for college students, as it was found that college students' main reason for not seeking mental health services on campus was because of perceptions of being stigmatized (Quinn et al., 2009). As a result, mental health stigma is a topic that should be studied carefully and with consideration. Researchers must be ethically responsible and consider additional factors when studying stigma. For instance, when assessing a student's levels of perceived and personal mental health stigma, we may not know if that person will be personally affected by the questions. Therefore, the researchers of the current study had a plan in place to attend to any adverse reactions that may have occurred.

Even if a participant did not suffer from mental illness or knew someone who has, there was still the possibility that this person could have been harmed from having realized his or her own levels of personal stigma towards others. For instance, if the person was answering questions about his or her level of stigma and realized that a personal stigma towards the mentally ill did exist, this could have resulted in feelings such as guilt and anxiety. Therefore, it was important that that the researcher of this study kept these possibilities in mind when studying stigma, and planned strategies to safeguard against any participant harm.

Prior to participation in the study, all participants were given an implied informed consent in the body of the email. At this point it was explained to them that participation in the study was voluntary. During the informed consent the potential harms resulting from participation was also explained to them. Had they choose to complete the survey, a

link was provided for them to click to enter the survey, which implied that they had read and agreed to the informed consent.

Following participation, all participants received a debriefing letter which described the focus of the study in greater detail, and how to contact the researcher if the participant had any questions or was interested in learning the results of the study. At this point, all participants were also given both immediate and longer-term resources for counseling, for if they had felt that the study negatively affected their mental health in any way.

### **Data Analysis**

The data analysis included an examination of the relationships and predictions regarding stigmas, help-seeking attitudes and intentions, and social desirability. The data analysis included a 3 three-step hierarchical regression analyses, each using help-seeking attitudes and intentions as the dependent variable. The purpose of this was to examine how help-seeking attitudes and intentions were associated with personal stigma and perceived stigma, while controlling for demographic variables and social desirability. The relationships between perceived stigma and personal stigma was examined, as well as comparisons of means between these two variables. Bivariate correlations were also used to study any relationships between demographic variables, levels of perceived stigma, levels of personal stigma, help-seeking attitudes and intentions, and levels of social desirability. Furthermore, levels of social desirability were controlled for in order to limit the effect of this variable on the other variables. Once the raw data was collected, it was loaded into SPSS generating descriptive, correlational, and regression analyses on the

predictor variable and the outcome variable. A standard regression analysis was run to screen the data for outliers, which were omitted from the data set.

## **Chapter Four**

### **Introduction**

The purpose of this study was to examine college students' perceptions of the campus mental health stigma (perceived public stigma), their own personal stigma and how these perceptions influence their own attitudes and intentions of help-seeking. This study surveyed college students at two public universities in the United States. One data collection site was Montclair State University, a public university in the Northeastern United States (New Jersey). The other data collection site was Winthrop University, a public university in the Southeastern United States (South Carolina). The aim was to sample a total of 150 students overall from Montclair State University and Winthrop University combined. Following data collection, the original sampling aim was more than doubled, with a total of 352 students sampled overall.

This chapter will describe the sample of college students, provide the data analysis of the aforementioned predictor variables, and finally present the results of the primary research question and subquestions.

### **Participants**

From the total of 352 surveys submitted, 49 were omitted prior to the data analysis due to incomplete responses in their surveys. It is possible that these participants either had technical computer issues when completing the survey, or chose to close out of the survey mid-way through it. Significant incomplete surveys were defined as leaving blank more than 25% of the items. After omitting these incomplete surveys, 303 usable surveys were included in the analysis.

### Demographics

This study targeted undergraduate college students. A majority of the students were from Montclair State University (80.9%). As stated earlier, Montclair State University is composed of an overall larger undergraduate student body (14,590) than Winthrop University (5,059). Participants ranged in age from 18 to 54 years ( $M=21.77$ ,  $SD=5.58$ ). The majority of participants were between ages 18-22 (80.9%), which is generally considered traditional college aged (Kimbrough & Weaver, 1999). Table 1 shows the breakdown of age levels. What has previously been defined as “traditional college aged” has been separated by each year, and “non-traditional” (ages 23+) has been combined into one group within the table.

Table 1

#### *Ages of Participants*

Age in years	<i>N</i>	%
18	33	10.9
19	56	18.5
20	55	18.2
21	74	24.4
22	27	8.9
23-54	58	19.1
Total	303	100.0

The majority of participants were women (84.8%). While the sampled population and responses collected had a male to female ratio that was higher than that national average, Marklein (2005) noted that females outweighed the number of males at college campuses (57% vs. 43%, respectively), and this ratio was only expected to continue to widen (National Center for Education Statistics, 2005). This male to female ratio is even wider at Montclair State University, where 60% of the students are men and 40% are women (Howard, 2013), and especially wide at Winthrop University, where 68% of the students are men and 32% are women (Sheehy, 2013). Residential students made up 53.8% ( $N = 163$ ) of the sample and commuter students completed the other 46.2% ( $N = 140$ ). In terms of race and ethnicity, the majority of participants were Caucasian (62.4%). Table 2 provides race and ethnicity representation of participants.

Table 2

*Participants by Race and Ethnicity*

Race/Ethnicity	<i>N</i>	%
Caucasian	189	62.4
Hispanic	40	13.2
African American/Black	29	9.6
Asian	26	8.6
Multiracial	18	5.9
American Indian	1	.3
Total	303	100.0

Grade point average (GPA) also varied across the sample. Table 3 provides GPA representation of participants.

Table 3

*Participants by Grade Point Average (GPA)*

GPA	<i>N</i>	%
4.00-3.50	138	45.5
3.49-3.00	110	36.3
2.99-2.50	40	13.2
2.00-2.49	11	3.6
Below 2.0	4	1.3
Total	303	100.0

Participants were also asked if they had utilized any form of counseling in the past. It was reported that 43.2% of students had used counseling in the past, while 56.8% had not. Furthermore, 14.9% of the participants had utilized counseling at their college campus counseling center. This is slightly higher than the national average, which shows that 10.6% of college students utilize their campus counseling centers (Gallagher, 2011). In the current study, only 1.7% of students that received campus counseling noted it as an unfavorable experience.

Studies have shown that students are more likely to share their mental health problems when through a social media outlet (Moreno, et al., 2012). Therefore, the current study decided to ask participants about their use of social media outlets (such as



Facebook). The majority of the participants noted daily use (79.5%). Another 11.6% noted weekly use, 4.3% monthly use, and only 4.6% described no use.

## **Data Analysis**

### **Data Screening**

During the data screening phase, the sum responses of each of the variables (Self-Stigma of Seeking Help [SSOSH], perceived stigma, personal stigma, social desirability) were examined. During this screening, one additional incomplete case was discovered. This one incomplete case only had missing data on the Crowne-Marlow scale (social desirability variable), and was complete on the other variables. Therefore, this case was included in all other analyses. Any test without the social desirability variable will have an *n* of 301. Any test with the social desirability variable will have an *n* of 300. All other cases were 100% complete in their responses.

Each variable was then tested for normality. The potential skewness and kurtosis of each was assessed. For this check, an alpha of .001 was utilized, as suggested by Field (2013). The SSOSH, perceived stigma, and social desirability variables all revealed a normal distribution. The personal stigma scale showed significant skewness, with a majority of the participants rating their personal stigma on the low side with positive skewness). Even after eliminating the outliers, this positive skewness on the personal stigma scale persisted. Chapter 5 will discuss in greater detail why a scale that measures a variable such as personal stigma may be more sensitive to positive skewness.

SPSS was utilized to locate any extreme values or outliers. As a result, two cases were identified as significant outliers. Running the data through a histogram, scatterplot,

boxplot, and normal probability plot also confirmed a visual representation of these extreme outliers. These two outliers were deleted from the final analysis. A total of 300 participants constitute the final sample size of this research study. Figure 1 shows the means and standard deviations of each of the main variables. Table 4 shows the normal curve distribution for the dependent variable (SSOSH) following removal of the 2 outliers.

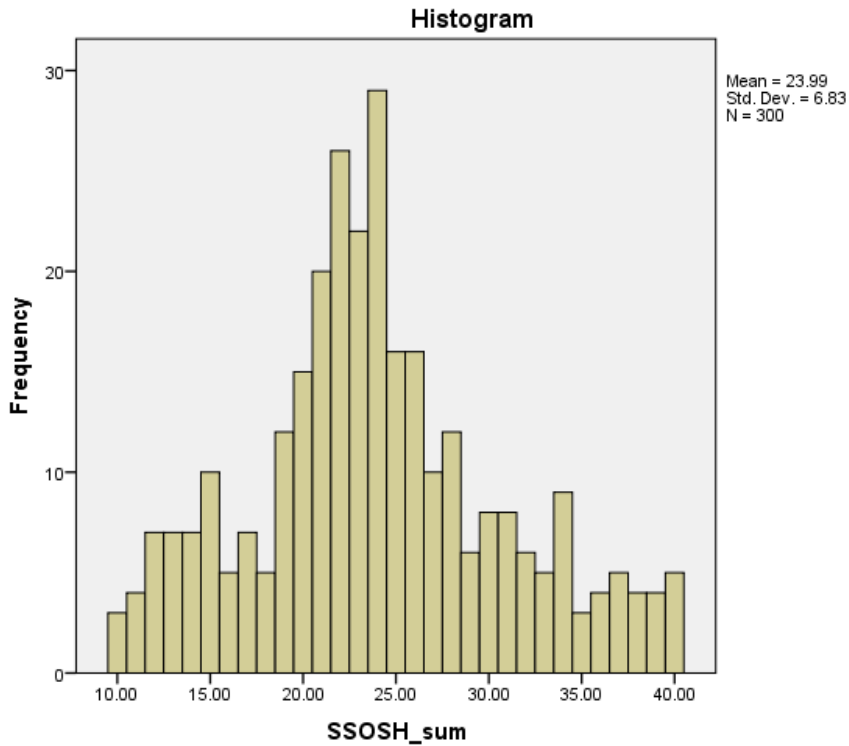
*Table 4*

*Means and Standard Deviations of Main Variables*

Variable	<i>M</i>	<i>SD</i>
SSOSH	23.99	6.83
Perceived Stigma	29.71	10.03
Personal Stigma	2.68	2.26
Social Desirability	16.28	5.49

Figure 2

*Normal Curve Distribution for Dependent Variable (SSOSH)*



### Comparisons between Demographic Variables

Analyses between demographic variables and history of counseling use were performed. When utilizing a t-test to examine age differences in those who did use counseling ( $M= 22.35$ ,  $SD= 6.05$ ) and those who did not ( $M=21.31$ ,  $SD= 4.30$ ), no statistically significant difference was found between the two groups,  $t(224.53) = -1.67$ ,  $p = ns$ .

A chi-squared test was used to examine difference in use of counseling services in the past between races. The demographic variable of race was dichotomized into only two categories to allow for a greater amount of participants in each group and more equal

data distribution. The two groups created from the race category were White (N=188) and Non-White (N=113). Significantly more White participants (50.5%) used counseling services in the past than did Non-White participants (31.9%),  $\chi^2 (1, N = 301) = 10.012, p < .05$ .

A chi-squared test was used to examine difference in use of counseling services in the past between gender, men (N=45) and women (N=256). There was no significant difference between the number of men (37.8%) and women (44.5%) that used counseling services in the past,  $\chi^2 (1, N = 301) = .710, p = ns$ .

#### **Demographic Differences: Personal Stigma, Perceived Stigma, and Help-Seeking**

To compare the differences between personal stigma, perceived stigma, and help-seeking by demographics, multiple independent samples t-tests were employed. The demographic groups of traditional aged (18-22 year old) and non-traditional aged (over 23) college students were compared across personal stigma, perceived stigma, and help-seeking. The Levene Test for Equality of Variances (Levene, 1960) showed that there was not a significant difference in variability between the two groups. Thus, the assumption of equal variances was met and a t-test was determined to be a proper test.

Results show that non-traditional aged college students hold significantly higher personal stigma (M=3.21, SD= 2.44) than traditional aged students (M=2.55, SD= 2.20),  $t (299) = -1.20, p=.047$ . Table 7 shows all of the results for this t-test, including those that were not significant.

When comparing men and women, men (M=3.42, SD=2.62) had higher personal stigma than women (M=2.55, SD= 2.17),  $t (55.05) = 2.12, p = .039$ . Also, Non-White

participants ( $M=3.27$ ,  $SD=2.40$ ) had higher personal stigma than Whites ( $M=2.32$ ,  $SD=2.10$ ),  $t(299) = -3.57$ ,  $p < .001$ . Finally, when comparing between the two sampled universities, Winthrop University students ( $M=32.62$ ,  $SD=9.04$ ) had higher perceived stigma than Montclair State University students ( $M=29.00$ ,  $SD=10.12$ ),  $t(299) = -2.50$ ,  $p < .05$ .

It is important to remember that the SSOSH (Self-Stigma of Seeking Help) scale, while it measures help-seeking attitudes and intentions, does so by giving a measurement for help seeking stigma. Thus, a higher score represents greater help-seeking stigma, and less favorable help-seeking attitudes and intentions (Vogel, Wade, & Haake, 2006).

Students who had not attended counseling in the past ( $M=25.00$ ,  $SD=6.81$ ) had higher help-seeking stigma (less favorable help-seeking attitudes and intentions) than students that have attended counseling ( $M=22.70$ ,  $SD=6.64$ ),  $t(299) = 2.93$ ,  $p < .05$ . Students who had not attended counseling ( $M=3.28$ ,  $SD=2.21$ ) had significantly higher personal stigma than students who had attended counseling ( $M=1.90$ ,  $SD=2.07$ ),  $t(299) = 5.55$ ,  $p < .001$ .

When examining social media usage, there was no significant difference between those that check social media sites daily and those that check less frequently in regards to their levels of stigmas or help-seeking.

Tables 5-10 show the t-tests for each of the demographic variables analyzed in relation to perceived stigma, personal stigma, and help-seeking. These tables include all results, including those that were not significant.

Table 5

*T-test Between Traditional and Non-traditional Aged Students*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>Traditional</i>	2.55	2.20	-2.00	.047
	<i>Non Traditional</i>	3.20*	2.44		
<i>Perceived Stigma</i>	<i>Traditional</i>	29.80	10.00	0.36	0.720
	<i>Non Traditional</i>	29.28	10.16		
<i>Help-Seeking</i>	<i>Traditional</i>	24.33	6.71	1.70	0.091
	<i>Non Traditional</i>	22.64	7.15		

Note: \* = Indicates the higher mean (significant at the 0.05 level).

Table 6

*T-test Between Gender (Males vs. Females)*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>Males</i>	3.42*	2.62	2.12	.039
	<i>Females</i>	2.55	2.17		
<i>Perceived Stigma</i>	<i>Males</i>	30.58	10.15	0.636	0.525
	<i>Females</i>	29.55	10.00		
<i>Help-Seeking</i>	<i>Males</i>	24.64	6.85	.687	0.493
	<i>Females</i>	23.89	6.82		

Note: \* = Indicates the higher mean (significant at the 0.05 level).

Table 7

*T-test Between Race (White vs. Non-white)*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>White</i>	2.32	2.10	2.12	.000
	<i>Non-white</i>	3.27*	2.39		
<i>Perceived Stigma</i>	<i>White</i>	29.10	10.08	0.636	0.173
	<i>Minority</i>	30.72	9.87		
<i>Help-Seeking</i>	<i>White</i>	23.94	7.03	.687	0.848
	<i>Non-white</i>	24.10	6.49		

Note: \* = Indicates the higher mean (significant at the 0.001 level).



Table 8

*T-test Between Universities (Montclair vs. Winthrop)*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>Montclair</i>	2.67	2.25	-1.74	.862
	<i>Winthrop</i>	2.72	2.31		
<i>Perceived Stigma</i>	<i>Montclair</i>	29.00	10.12	-2.50	0.13
	<i>Winthrop</i>	32.62*	9.04		
<i>Help-Seeking</i>	<i>Montclair</i>	23.70	6.72	-1.57	0.118
	<i>Winthrop</i>	25.26	7.15		

Note: \* = Indicates the higher mean (significant at the 0.05 level).

Table 9

*T-test Between Counseling use (History of use vs. non)*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>Past Counseling</i>	3.28**	2.21	5.56	.000
	<i>No Counseling</i>	1.90	2.07		
<i>Perceived Stigma</i>	<i>Past Counseling</i>	29.53	9.15	-.330	.742
	<i>No Counseling</i>	29.92	11.07		
<i>Help-Seeking</i>	<i>Past Counseling</i>	25.00*	6.81	2.93	.004
	<i>No Counseling</i>	22.70	6.64		

Note: Note: \* = Indicates the higher mean (significant at the 0.05 level).

\*\* = Indicates the higher mean (significant at the 0.001 level).

Table 10

*T-test Between Social Media Frequency (Non-daily vs. Daily Use)*

<i>Variable</i>	<i>Population</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>Sig.(2-tailed)</i>
<i>Personal Stigma</i>	<i>Daily</i>	2.98	2.31	1.19	.237
	<i>Non-daily</i>	2.60	2.24		
<i>Perceived Stigma</i>	<i>Daily</i>	29.43	9.86	-.240	.811
	<i>Non-daily</i>	29.77	10.07		
<i>Help-Seeking</i>	<i>Daily</i>	23.02	6.56	-1.26	.208
	<i>Non-daily</i>	24.25	6.88		

### **Social Desirability**

Correlations were run to gain a better understanding of social desirability. As described previously, social desirability was measured using the Crowne-Marlowe Social Desirability Scale (Crowne-Marlowe, 1960). A significant and strong negative correlation was found between social desirability and help-seeking (stigma of),  $r(298) = -.213, p < .001$ . This finding indicates that as levels of social desirability increase, levels of help-seeking (self-stigma of help-seeking) decrease. Or, as levels of social desirability increase, help-seeking attitudes and intentions become more favorable. It is also important to remember here that these levels are self-reported. So, as one has higher

levels of social desirability, they self-report more favorable help-seeking attitudes and intentions. Chapter 5 will discuss more in-depth possibilities for this association.

There was a significant negative correlation between social desirability and perceived stigma,  $r(298) = -.277, p < .001$ . Therefore, results indicate that students with higher levels of social desirability are likely to have lower levels of perceived stigma. The correlation between social desirability and personal stigma was not significant  $r(298) = -.064, p = ns$ . Chapter 5 will explore some possibilities of why this relationship may not exist, such as the extreme low scores (left-tailed skewness) that were reported for personal stigma.

Through results of a t-test, social desirability was found to be significantly higher in students with no past use of counseling ( $M = 16.99, SD = 5.34$ ) than those who had used counseling in the past ( $M = 15.36, SD = 5.57$ ),  $t(298) = 2.58, p < .05$ . Therefore, results indicate that students with higher levels of social desirability are less likely to utilize counseling services. Chapter 5 will discuss reasons why this phenomenon might exist. Table 11 shows the correlations between social desirability and help-seeking, perceived stigma, and personal stigma.

Finally, some analyses between social desirability and some demographic variables of interest were explored. A strong significant relationship was observed between race and social desirability. Non-White students ( $M = 17.93, SD = 5.02$ ) had higher levels of social desirability than White students ( $M = 15.28, SD = 5.54$ ),  $t(298) = -4.15, p < .001$ . No significant relationship was found between age and levels of social desirability,  $r(298) = .193, p = ns$

*Table 11**Correlations between Social Desirability*


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	Social Desirability	Help- Seeking	Personal Stigma	Perceived Stigma
Social Desirability	.	-.213**	-.064	-.277**

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Note: \*\* = Correlation significant at 0.01 level.

### **Personal and Perceived Stigmas**

#### **The Relationship between Personal and Perceived Stigma**

A correlation was employed to measure any relationship between perceived stigma and personal stigma. Perceived stigma and personal stigma were significantly and positively correlated,  $r(299) = .312, p < .001$ . Based on these findings, 9.7% of the variance in perceived stigma overlaps with personal stigma,  $r^2 = .097$ . This supported the initial hypothesis that as perceived stigma increased, so would personal stigma.

#### **Comparing Personal and Perceived Stigma**

A dependent samples t-test was conducted to compare personal and perceived stigma of the participants. The results of this analysis show that perceived stigma ( $M=2.477, SD=.837$ ) is much greater than their personal stigma ( $M=.897, SD=.753$ ). This

difference between personal and perceived stigma was found to be statistically significant at the .05 alpha level,  $t(300) = 29.399$ ,  $p < .001$ . These findings support the hypothesis, which stated that students' perceived stigma would be greater than their personal stigma.

The original hypothesis suggested that levels of perceived stigma would be greater than personal stigma, and personal stigma levels combined would represent the actual campus stigma, therefore making the perceived campus stigma an overestimate. This was tested by comparing the sums of only the items that were the same on both the personal and perceived stigma scales, except for how the question was worded per the scale "I would..." vs "Most people..." (as described in detail in Chapter 3). Findings indicate that students' perceptions of the level of campus stigma ( $M = 6.77$ ,  $SD = 2.99$ ) is significantly higher than the actual campus stigma ( $M = 2.67$ ,  $SD = 2.26$ ),  $t(300) = -22.52$ ,  $p < .001$ . Therefore, students perceived the campus stigma to be much greater than it is in reality.

### **The Interactions between Race and Counseling History**

A set of three 2x2 between subjects factorial Analysis of Variance (ANOVA) using race and counseling history was conducted based on personal stigma, perceived stigma, and help-seeking attitudes and intentions. Levene's Test of Equality of Error Variances (Levene, 1960) was again tested for at each phase.

#### **Personal Stigma**

When incorporating personal stigma as the dependent variable, the race X counseling history interaction was not significant, indicating that the effect of counseling history on personal stigma, did not significantly differ based on race,  $F(1, 297) = 3.33$ ,

$p=ns$ . When observing the main effect of race, a significant difference was found for personal stigma based on race,  $F(1, 297) = 5.01, p < .05$ . Non-Whites had higher total personal stigma ( $M=3.27, SD=2.39$ ) than White participants ( $M=2.32, SD= 2.10$ ). There was also a strong significant main effect of counseling history,  $F(1, 297) = 28.66, p < .001$ . Those that had not attended counseling in the past had significantly higher total personal stigma ( $M=3.28, SD=2.21$ ) than those that had attended counseling in the past ( $M=1.89, SD= 2.07$ ).

### **Perceived Stigma**

When incorporating perceived stigma as the dependent variable, the race X counseling history interaction was not significant, indicating that the effect of counseling history on perceived stigma, did not significantly differ based on race,  $F(1, 297) = .161, p= ns$ . The main effect of race was not significant,  $F(1, 297) = 1.73, p= ns$ , as Non-Whites did not have significantly higher total perceived stigma ( $M=30.72, SD=9.87$ ) than White participants ( $M=29.10, SD= 10.08$ ). There was not a significant main effect of counseling history,  $F(1, 297) = .194, p= ns$ . Those that had not attended counseling in the past did not have significantly higher total perceived stigma ( $M=29.56, SD=9.15$ ) than those who had attended counseling in the past ( $M=29.92, SD= 11.07$ ),  $F(1, 297) = .194, p= ns$ .

### **Help-Seeking Attitudes and Intentions**

When incorporating help-seeking attitudes and intentions as the dependent variable, the race X counseling history interaction was not significant, indicating that the effect of counseling history on help-seeking attitudes and intentions, did not significantly

differ based on race,  $F(1, 297) = .858, p = ns$ . When observing the main effect of race, no significant difference was found for help-seeking attitudes and intentions based on race,  $F(1, 297) = .014, p = ns$ . Non-Whites did not have significantly higher total help-seeking scale scores, ( $M=24.10, SD=6.50$ ), or more help-seeking stigma and less favorable help-seeking attitudes and intentions, than White participants ( $M=23.94, SD= 7.03$ ). There was a significant main effect of counseling history,  $F(1, 297) = 6.27, p < .05$ . Those that had not attended counseling in the past had higher total help-seeking scale scores ( $M=25.00, SD=6.81$ ), indicating more help-seeking stigma and less favorable help-seeking attitudes and intentions, than those that had attended counseling in the past ( $M=22.70, SD= 6.64$ ).

### **Personal Stigma, Perceived Stigma, and Help-Seeking**

To examine how help-seeking attitudes and intentions were associated with personal stigma and perceived stigma, while controlling for demographic variables and social desirability, 3 three-step hierarchical regression analyses were conducted, each using help-seeking attitudes and intentions as the dependent variable. All three of the hierarchical regression analyses were identical at their steps 1 and 2, with the IV's of demographics and social desirability, and the DV of help-seeking. Demographics consisted of four variables: gender, age, race, and use of counseling services in the past (the variable of race was separated into only two categories, "White" and "Non-white", as noted earlier). Yet, all three analyses differed at Step 3. During the first analysis, the influence that personal stigma has on help-seeking attitudes and intentions, after controlling for demographics and social desirability was examined at its third step.



During the second analysis, the influence that perceived stigma has on help-seeking attitudes and intentions, after controlling for demographics and social desirability was examined at its third step. Finally, the third analysis examined the influence that perceived AND personal stigmas combined have on help-seeking attitudes and intentions, after controlling for demographics and social desirability at its third step.

### **Personal Stigma and Help-Seeking Attitudes and Intentions**

The Durbin-Watson (Durbin & Watson, 1950) test was used to test the assumption of independence of error variance. The Durbin-Watson critical value (which should be between 1 and 3) was 1.858, indicating that the assumption was met. A scatterplot was also created to check the assumption of a linear relationship. The scatter plot created in SPSS indicated a good linear relationship, which allows us to conduct the hierarchical regression analysis.

At step 1, the variance in help-seeking attitudes and intentions accounted for by demographic control variables was 4.5%, which was significant at the .05 alpha level,  $R^2 = .045$ ,  $F(4, 295) = 3.481$ ,  $p < .05$ . The demographic variable most strongly related to help-seeking attitudes and intentions was use of counseling services in the past,  $\beta = -.154$ ,  $p < .05$ . During step 1, the variable of age was also related to help-seeking attitudes and intentions,  $\beta = -.128$ ,  $p < .05$ . Gender and age were not significant predictors, all  $\beta s < .040$ ,  $ps > .48$

In the second step, social desirability accounted for an additional 5.4% of the variance in help-seeking attitudes and intentions,  $\Delta R^2 = .054$ ,  $F(1, 294) = 17.705$ ,  $p < .001$ . Social desirability was strongly related to help-seeking attitudes and intentions,  $\beta = -$

.242,  $p < .001$ . This negative relationship indicated that an increase in social desirability is associated with a decrease in help seeking stigma (or an increase in favorable help-seeking attitudes and intentions). During this step, the demographic variables of age ( $\beta = -.113$ ,  $p < .05$ ) and use of counseling in the past ( $\beta = -.182$ ,  $p < .05$ ) remained significantly related to help-seeking attitudes and intentions.

In step 3, the variable of personal stigma accounts for an additional 10.8% of the variance in help-seeking attitudes and intentions,  $\Delta R^2 = .108$ ,  $F(1, 293) = 39.971$ ,  $p < .001$ . Personal stigma was strongly related to help-seeking attitudes and intentions,  $\beta = .358$ ,  $p < .001$ . The final model with all six predictors represent 20.7% of the variance in student help-seeking attitudes and intentions,  $R^2 = .207$ ,  $F(6, 293) = 12.781$ ,  $p < .001$ . The demographic variable of age ( $\beta = -.135$ ,  $p < .05$ ) remained significantly related to help-seeking attitudes and intentions, but use of counseling services did not. Social desirability also remained related to help-seeking attitudes and intentions, yet this relationship became slightly weaker than previously,  $\beta = -.189$ ,  $p < .05$ . As stated previously, this negative relationship indicated that an increase in social desirability is associated with a decrease in help seeking stigma (or an increase in favorable help-seeking attitudes and intentions).

### **Perceived Stigma and Help-Seeking Attitudes and Intentions**

The Durbin-Watson (Durbin & Watson, 1950) critical value (which should be between 1 and 3) was 1.899, indicating that the data met the assumption of independence of error variance. A scatterplot was also created to check the assumption of a linear

relationship. The scatter plot created in SPSS indicated a good linear relationship, which allows us to conduct the hierarchical regression analysis.

Steps 1 and 2 remained the same as previously described for personal stigma. Step 1 controlled for four demographic variables: gender, age, race, and use of counseling services in the past. However, in this analysis, Step 3 differed in that the variable of perceived stigma was used instead of personal stigma, and found to account for an additional 6.0% of the variance in help-seeking attitudes and intentions,  $\Delta R^2 = .060$ ,  $F(1, 293) = 20.742$ ,  $p < .001$ . Perceived stigma was strongly related to help-seeking attitudes and intentions,  $\beta = .309$ ,  $p < .001$ .

The final model with all six predictors represents 15.9% of the variance in student help-seeking attitudes and intentions,  $R^2 = .159$ ,  $F(6, 293) = 9.223$ ,  $p < .001$ . The demographic variables of whether one had used counseling in the past ( $\beta = -.186$ ,  $p < .05$ ) and social desirability ( $\beta = -.163$ ,  $p < .05$ ) remained significantly related to help-seeking attitudes and intentions.

### **Personal and Perceived Stigmas Combined and Help-Seeking Attitudes and Intentions**

The Durbin-Watson critical value (Durbin & Watson, 1950), which should be between 1 and 3, was 1.892, indicating that the data met the assumption of independence of error variance. A scatterplot was also created to check the assumption of a linear relationship. The scatter plot created in SPSS indicated a good linear relationship, which allows us to conduct the hierarchical regression analysis.

As in the previous regression analyses, Steps 1 and 2 remained the same. Step 1 controlled for four demographic variables: gender, age, race, and use of counseling services in the past. Once again, the variance in help-seeking attitudes and intentions accounted for by demographic control variables was 4.5%, with significance at the .05 alpha level,  $R^2 = .045$ ,  $F(4, 295) = 3.481$ ,  $p < .05$ . In the second step, the variable of social desirability accounted again for an additional 5.4% of the variance in help-seeking attitudes and intentions,  $\Delta R^2 = .054$ ,  $F(1, 294) = 17.705$ ,  $p < .001$ .

In this analysis, Step 3 differed in that personal and perceived stigmas were entered together (as opposed to separately as in previous analyses), and found to account for an additional 13.1% of the variance in help-seeking attitudes and intentions,  $\Delta R^2 = .131$ ,  $F(2, 292) = 24.844$ ,  $p < .001$ . Personal stigma was strongly related to help-seeking attitudes and intentions,  $\beta = .381$ ,  $p < .001$ . Perceived stigma was also strongly related to help-seeking attitudes and intentions,  $\beta = .309$ ,  $p < .001$ .

The final model with all seven predictors together represent 23.0% of the variance in student help-seeking attitudes and intentions,  $R^2 = .230$ ,  $F(7, 292) = 12.481$ ,  $p < .001$ . During this analysis's Step 3, the demographic variables of age ( $\beta = -.117$ ,  $p < .05$ ) and social desirability remained significantly related to help-seeking attitudes and intentions ( $\beta = -.145$ ,  $p < .05$ ).

## **Chapter 5**

### **Discussion**

As reported in Chapter 4, multiple results were found through this study. This chapter will focus on the most salient of these results as well as those that relate directly to the study's original hypothesis. This chapter will begin with a brief summary of the main results, followed by a more in-depth analysis, including possibilities for why such results may exist. Limitations of the current study will be discussed. Implications for counselors, college campus counseling centers, and counselor educators will then be explored. Finally, I will present ideas for future research lending from this study.

In relation to personal and perceived stigmas, main results include that levels of personal stigma were significantly less than levels of perceived stigma. Perceived stigma and personal stigma were also significantly and positively correlated, or as perceived stigma increased, so did personal stigma. Also, it was found that students do perceive the campus mental health stigma to be much greater than it is in reality. These findings regarding personal and perceived stigma levels support the original hypothesis of the study.

In relation to social desirability, a significant and strong negative correlation was found between social desirability and help-seeking (stigma of), or as levels of social desirability increased, help-seeking attitudes and intentions became more favorable. There was a significant negative correlation between social desirability and perceived stigma. Therefore, students with higher levels of social desirability had lower levels of perceived stigma. Social desirability was significantly higher in students with no past use

of counseling, than those who had used counseling in the past. Therefore, students with higher levels of social desirability have been less likely to have utilized counseling services in the past. It was also interesting that students who had not attended counseling in the past had higher help-seeking stigma (less favorable help-seeking attitudes and intentions) than students that have attended counseling. Finally, some interesting results were found regarding race, such that non-whites students hold significantly have significantly higher social desirability and personal stigma than White students. These above findings will be discussed in greater depth.

### **Perceived and Personal Stigmas**

A primary purpose of this study was to examine college students' perceptions of mental health stigma (perceived stigma) in relation to their own personal stigma. The original hypothesis was supported: levels of personal stigma were significantly less than levels of perceived stigma. Personal stigma, or the stereotypes and prejudices that each person believes (Eisenberg et al., 2009), was much lower than perceived stigma, or an individual's perception of public stigma (Corrigan, 2004a). In fact, while all variables had normal curve distributions, the variable of personal stigma was consistently scored so low by students that it maintained a skewed or right-tailed distribution. It is important to remember that scores were self-scored. In other words, students consistently scored themselves to have very low personal stigma.

One explanation of why such high levels of perceived stigma were found compared to levels low levels of personal stigma may be because of college student development. Perry (1970) and Magolda (1996) have described dualistic thinking in

college students, or believing in simple right or wrong answers during the early stages of their intellectual and developmental journey. If college students have been told, whether by society, culture, or other outlets, that help-seeking will be stigmatized, they will likely believe these messages and not question them in the early stages of their development. College students may be prone to believing mental health stigma as truth. Therefore, it makes sense that the findings of the current study illustrate that college students have higher levels of perceived stigma than personal stigma. These findings are consistent with Erikson's (1968) Identity vs. Role Confusion stage and Chickering's (1969) Identity vector which involve students being concerned with how they are perceived by others. During this time, concerns of being stigmatized by others may be exceptionally high. As a result, the perception of high mental health stigma by one's peers may exist.

The findings of the current study are consistent with other studies regarding personal and perceived stigmas. Eisenberg and colleagues (2009) also observed that perceived public stigma levels are often greater than personal stigma levels. Specifically comparable to the current study, other studies with college student self-survey data have shown that college student perceptions of stigma among their peers is considerably greater than their own personal stigma (e.g., Eisenberg et al., 2009). Peluso and Blay (2009) found that the majority of students perceived society to consider those suffering from depression as dangerous and holding other negative traits. Yet, when the student participants themselves were asked to report their own emotional reactions to those suffering from depression, the reactions were mainly positive in nature. While participants perceived strong public stigma towards those with depression, the

participants' own personal stigma was far less (Peluso & Blay, 2009), just as were the findings of the current study. Peluso and Blay's (2009) study supports the findings of the current study, as both found a disparity between perceived public stigma and personal stigma. These studies, as well as the current one, support that there is a misperception of stigma occurring. The current study expanded on prior research (Eisenberg et al., 2009; Peluso & Blay, 2009) by also looking at levels of college student perceived stigma in comparison to the actual mental health stigma on campus.

The original research hypothesis question stated that the combined personal stigma levels of participants would represent the actual mental health stigma on campus. Furthermore, this study's hypothesis stated that participant levels of perceived stigma would be greater than the actual mental health stigma on campus. The current study found that students perceived the campus stigma to be much greater than it is in reality. Quinn and colleagues (2009) also observed this high perception of college campus stigma through in-depth interviews with college students. Quinn and colleagues' (2009) findings indicate that the perception of the existing campus stigma towards mental health problems was very high and the cause for student hesitation to disclose personal mental health problems and to seek college counseling services for support. Quinn et al. (2009) did not study the actual mental health stigma on campus. Rather, their qualitative study discussed perceptions of campus stigma with participants. To build on the findings of Quinn et al. (2009), the current study was quantitative and has found specific measures of perceived and actual mental health stigma on campus.



Unlike most previous studies (Eisenberg et al., 2009; Peluso & Blay, 2009), the current study also examined the relationship between perceived and personal stigma. The current findings indicate that perceived stigma and personal stigma are significantly and positively correlated, or as perceived stigma increased, so did personal stigma. Other studies have also observed this positive correlation between personal and perceived stigmas. Vogel and colleagues (2007) examined the relationship between college students' perceived public stigma and their willingness to seek counseling resources for psychological and interpersonal issues. They found that perceptions of public stigma increased feelings of personal stigma. Further, they found that these feelings of personal stigma negatively influenced students' willingness to seek counseling. As a result, their work demonstrates the connection between perceptions of public stigma and the reduction in seeking counseling. While the findings of Vogel and colleagues (2007) support the findings of the current study, social desirability is an important variable that studies have not yet taken into account (Eisenberg et al., 2009; Peluso & Blay, 2009; Vogel et al., 2007). The current study builds upon other studies by also examining the variable of social desirability in relation to personal and perceived stigma. In the current study, social desirability was significantly higher in students with no past use of counseling, than those who had used counseling in the past. Therefore, students with higher levels of social desirability were less likely to have utilized counseling services in the past. This shows that levels of social desirability are important to examine when studying mental health help-seeking, as these levels seem to be related to help-seeking.

The current study's findings, with its novel use of social desirability as a variable in this area of research, warrants further focus in future studies.

### **Social Desirability**

A strong negative correlation was found between social desirability and help-seeking (stigma of). Therefore, as levels of social desirability increase, levels of help-seeking (self-stigma of help-seeking) decrease. In the current study, a higher help-seeking score actually represents greater help-seeking stigma, and less favorable help-seeking attitudes and intentions (Vogel, Wade, & Haake, 2006). In other words, findings show that as levels of social desirability increase, help-seeking attitudes and intentions become more favorable. It is also important to remember that these levels are self-reported. So, as students have higher levels of social desirability, they self-report more favorable help-seeking attitudes and intentions.

These findings are seemingly contradictory to what one might assume considering the nature of social desirability. Social desirability is a concept that has been described as responding in a manner that people feel will place them in a socially favorable light (Edwards, 1953). Therefore, a person with higher levels of social desirability would be more concerned with society viewing them positively. Conversely, the present study revealed that those with high social desirability have more favorable help-seeking attitudes and intentions. Yet, it would seem that those with high social desirability would have less favorable help-seeking because help-seeking is largely perceived to be stigmatized by society (Corrigan, 2004a; Komiya, Good, & Sherrod, 2000; Vogel, Wade,

& Haake, 2006), thus indicating that people with high social desirability would not want to be associated with help-seeking.

Therefore, it is important to remember that this study's results are based on self-scored surveys. Based on the nature of social desirability, it does make sense that those with high social desirability would want to appear accepting of help-seeking. In fact, Edwards (1953) has noted that social desirability may contribute to conformity of social standards or ideals, while forgoing true personal beliefs or responses. As a result, it seems plausible that those with high social desirability would intentionally rate themselves to have more favorable help-seeking attitudes and intentions, while they may not in reality. This idea is also relevant for the fact that those with high social desirability had lower levels of self-reported perceived stigma. Perhaps in this case also, it was seen as socially desirable to report lower perceptions of stigma. College student development theories also support this idea that college students may be more concerned about being perceived in a socially desirable light (Kohlberg, 1970). As Kohlberg's (1970) moral development Conventional Stage (Kohlberg, 1970) shows, much importance is placed on the expectations of family, peers, and society as a whole at this time. Not only is conformity to these expectations a key aspect, but loyalty and maintenance of such social expectations is as well.

College students are especially susceptible to concerns of being perceived negatively by others as a result of their current developmental stage (Chickering, 1969; Erikson, 1968). College students may be especially concerned with how they are perceived by others when progressing through their intellectual and psychosocial

development. As a result, their perceptions of public stigma may be especially high and prevent them from help-seeking. Positively progressing through these stages includes having self-confidence and self-acceptance, rather than looking for approval from others and being overly concerned with what others think (Chickering & Reisser, 1993). As a result, their perceptions of public stigma may be especially high and prevent them from help-seeking.

While high levels of social desirability appear to influence self-scored help-seeking attitudes and intentions and self-scored perceived stigma, the demographic variable of past use of counseling was less vulnerable to self-scoring bias. Students simply answered whether they have or have not attended counseling in the past, which was based on actual past behavior as opposed to personal beliefs, which are susceptible to untrue self-reports because of socially desirable objectives (Edwards, 1953). The current findings support this idea, as those with no past use of counseling had significantly higher social desirability scores. While those with high social desirability self-reported socially favorable beliefs, when their past counseling behavior was accessed, their actual previous actions differed from their self-reported beliefs. It is possible that one of the reasons why they did not use counseling in the past was for fears of stigmatization from others (Quinn, Wilson, MacIntyre, & Tinklin, 2009), especially considering that those with high social desirability are especially concerned with being perceived in a favorable light by others.

At first glance it may seem surprising that there is no significant relationship between levels of social desirability and personal stigma. It is plausible that those with high social desirability would want to appear with the socially desirable trait of low

personal stigma. The overall participant scores for personal stigma were so low that statistically there did not seem to be much variation to allow for the personal stigma scores to differ significantly. This is in line with Eisenberg et al.'s (2009) discussion of measuring personal stigma in college students, "Respondents may have understated their true levels of personal stigma because they were unwilling to admit to others or perhaps even to themselves that they hold attitudes that may be considered socially undesirable" (p. 535). While Eisenberg et al. (2009) offered the possibility of social desirability as a factor, his study did not measure social desirability, as the current study did. The current study found statistical support for social desirability as an important variable when assessing stigma and help-seeking attitudes and intentions.

### **Help-Seeking Attitudes and Intentions**

Results of the current study indicate that students who had not attended counseling in the past had higher total help-seeking scale scores, indicating more help-seeking stigma and less favorable help-seeking attitudes and intentions, than those who had attended counseling in the past. In other words, students that had not attended counseling in the past had less favorable help-seeking attitudes and intentions. Therefore, having a history of counseling attendance in the past does appear to influence help-seeking attitudes and intentions.

While associations between race and help-seeking attitudes and intentions were not included in the main hypothesis of the study, a mention of one interesting finding is worthy of a brief discussion. It was found that students who are not white have significantly higher personal stigma than White students. Given this study's overall

extreme low personal stigma scores already discussed, the fact that the personal stigma scores of students who are not white still showed as significantly higher, makes focusing attention to it even more important.

Other studies have supported this finding by showing that students who are black hold more stigma towards mental health than students who are white (Knifton, 2012). In support of non-white students holding more personal stigma is the finding of Silva DeCrane and Spielberger (1981), who found college students who are black held much more stigmatizing attitudes and less compassionate attitudes towards those with mental illness, than did white students. Hall and Tucker (1985) built on this idea and noted that students who are black also have a more negative opinion of and believe therapy to be less effective than do white students. These negative opinions about mental illness and reduced belief in the efficacy of therapy, makes individuals who are black less likely to seek mental health treatment.

The current study is consistent with others (e.g., Vogel et al., 2007) in finding a positive correlation between personal stigma and perceived stigma. Therefore, while the current study did not reveal non-white students to have significantly higher perceived stigma than students who are white, the literature seems to suggest that if the current study had enough participants who were black to compare them to participants who were white, their perceived stigma may have been higher. This is an area that may warrant future research.

### **Implications**

The findings of this study have important and far-reaching implications. The findings can be best used to help college students possibly participate more often in needed counseling, and have more beneficial counseling sessions. More broadly, these two potential end results can be attained through better knowledge about stigma for college counseling centers, college counselors, and counselor educators.

### **Implications for College Counseling Centers**

Equipping college counseling centers with knowledge of and strategies to decrease actual and perceived levels of stigma on campus can be a major key to promoting student help-seeking. Knowing that perceived stigma is the greatest reason why college students do not seek counseling (Evans, et al., 2007; Hepworth & Paxton, 2007; Martin, 2010) makes it plausible to assume that by learning more about this stigma, strategies to reduce it may be found and thus help-seeking behaviors increased. Furthermore, as the current study found, stigma is not as great as students perceive it to be. It is hoped that the results of this study may be a starting point to positively bring about change regarding stigma on college campuses by the findings that have revealed a misperception between perceived and personal levels of stigma. Two major implications could be for college counseling centers to consider beginning a social norms campaign for mental health stigma as well as an anti-stigma campaign on their campuses.

The role of college counseling centers appears to be shifting (Watkins et al., 2011). An increase in student outreach and education is now seen by college counseling directors as a necessary component. Watkins et al. (2011) interviewed college counseling center directors about their role in campus outreach. One respondent stated, “ ‘I think one

of the biggest changes I've seen since I've been here is being able to do more outreach or being able to interact with students and faculty outside of the [counseling] office more...and I think we're doing more outreach' ” (p.329). Such beneficial forms of this campus outreach may be through social norms and anti-stigma campaigns. It is hoped that the current study's findings will be an impetus for the creation of campus social norm and anti-stigma campaigns.

**Social norms campaigns.** The purpose of a social norms campaign is to correct misperceptions about societal norms, to bring about new knowledge, and then a change in behavior (Scribner, 2011). Through social norms campaigns, college student misperceptions and beliefs have been corrected in relation to peer substance abuse (Arbour-Nicitopoulos, Kwan, Lowe, Tamna, and Faulkner, 2010; LaBrie, Hummer, Grant, and Lac, 2010). These new beliefs also have the power to change student substance use behaviors (Scribner et al., 2011). These findings are at the base of the idea that changing college students' perceptions of peer mental health stigma may also have the power to change their help-seeking attitudes and possibly even their behaviors.

Social norms campaigns are typically implemented on college campuses in the area of substance use (LaBrie et al., 2010). In one study (LaBrie et al., 2010) findings indicated that a social norms campaigns can correct misperceptions of alcohol use. Scribner and colleagues (2011) took this social norms idea a step further and found that not only did such a campaign have the power to change misperceptions, but that it could also change behavior. This decrease in student alcohol consumption was attributed to the



correcting of alcohol use misperceptions, through the social norms campaigns. The current study found a misperception between levels of perceived stigma and the actual stigma on campus, which could be an important starting point for a campus social norms campaign based on mental health stigma.

*Social norms campaigns and mental health stigma.* While social norms campaigns have not been widely used in the area of mental health stigma, there is evidence that the public holds misperceptions about the mentally ill and furthermore, that these misperceptions can be corrected through the gaining of new and correct information (Carter, 2010). Carter (2010) found that people hold misperceptions about the mentally ill, such as that they are all dangerous, incompetent, and do not have jobs. When correct facts about those with mental illness were shared, people showed a correction in their previous misperceptions (Carter, 2010).

Social norms research has revealed a connection to the stigmatization of mental illness (Norman, Sorrentino, Widell, & Manchanda, 2008). Perceived social norms towards those with mental illness were found to contribute to levels of social distance. These perceived social norms were noted as, “beliefs concerning inappropriateness or disruptiveness of social behavior by those with mental illness and their potential dangerousness” (Norman et al., 2008, p.855). For both schizophrenia and depression, perceived social norms were found to be the most important predictor of the social distance kept from a person with these mental illnesses (Norman et al., 2008). For instance, in the case of schizophrenia, personal beliefs about the illness accounted for

29% of the variance in preferred social distance. Yet, when taking perceived social norms into account, this increased to 51%. Likewise, when examining depression, personal beliefs about the illness accounted for 13% of the variance in preferred social distance, and increased to 34% when taking perceived social norms into account. Norman and colleagues (2008) suggest that interventions designed to change perceived social norms, such as a mental health social norms campaign, may cause a reduction in stigmatization of those with mental illness. Therefore, as these findings and the findings of the current study show, perceptions of mental health stigma can have great consequences. A major implication of the current study is for college counseling centers to consider the adoption of a campus social norms campaign focused on reducing perceptions of mental health stigma. As the current study found a positive correlation between perceived and personal stigma levels, improving awareness about the actual level of stigma may result in reduced levels of perceived stigma and therefore reduced personal stigma as well. Overall, this may lead to an increase in college student positive attitudes towards, and utilization of, campus counseling services.

While research has been conducted in the area of social norms campaigns and alcohol use (e.g., Arbour-Nicitopoulos, Kwan, Lowe, Tamna, & Faulkner, 2010; LaBrie, Hummer, Grant, & Lac, 2010), and on misperceptions of mental illness (Carter, 2010; Norman et al., 2008), there is limited research on mental health social norms campaigns. The findings of the current study could supply useful information to begin a mental health social norms campaign. Such a campaign might take place on a college campus in particular and be housed through the counseling center. National statistics about mental

health stigma and student perceptions of it would be showcased, with a focus on the misperceptions that exists between the two. Materials such as posters, flyers, and other distributed materials (pens, pencils, etc.) would incorporate these messages of misperception along with eye-catching illustrations of misperceptions (or optical illusions). For instance, as the current study found, one message might note the level of mental health stigma that students perceive to be on campus versus the actual levels of mental health stigma on campus. Such a message would help to educate students that perceptions are not always reality and that campus levels of mental health stigma are much lower than most students perceive them to be. In addition, some messages might be geared specifically towards men or women, as different messages might influence and affect each gender more powerfully. For instance, as a result of societal gender messages and expectations about men and masculinity, targeted social norms messages may be warranted to best reach each group. Finally, the delivery of such messages may also be employed through the voices of campus peer leaders. As discussed prior, college students are operating from developmental stages that place peer acceptance as a priority (Chickering, 1969; Erikson, 1968). Therefore, seeing college peer leaders in support of these social norms messages, might increase attention to and acceptance of such a campaign.

It is hoped that the findings from the current research study have supplied information that might begin a social norms campaign around mental health stigma. The future goal is that by supplying true facts about mental health illness stigma through social norms campaigns, that college students will correct their own misperceptions and

increase their help-seeking behaviors. The increased knowledge from the current study about college student mental health stigma and its influence on help-seeking attitudes and intentions may pave the way for a reduction in stigma and an increase in utilization of services. The process of increasing help-seeking of college students from the current 10% statistic (Gallagher, 2011) would be an overarching future goal born from the current study.

**Anti-stigma campaigns.** The current study demonstrated that college students exhibit stigma towards those with mental illness as well as some personal stigma. These findings are in line with college student developmental theories (Perry, 1970) that discuss college students exhibiting dualistic thinking, or believing in a simple right or wrong answer only. As Perry (1970) and Magolda (1996) describe, college students may not yet be at a point in their development where they will challenge their beliefs. This may help to explain why students may not challenge their preconceived ideas about mental health stigma. Therefore, in addition to the implementation of mental health social norms campaigns, college counseling centers may also consider anti-stigma campaigns to bring new knowledge about mental health to students. Some studies have begun to research anti-stigma campaigns and an increase in knowledge of mental health illness, and a change in attitudes and behaviors (Carter, 2010; Evans-Lacko, London, Little, Henderson, & Thornicroft, 2010; Vaughan & Hansen, 2004).

Studies have explored the question of whether anti-stigma campaigns are effective (Evans-Lacko et al., 2010). Results showed participants to have significant and time sustained positive increases in mental health knowledge. This research supports that anti-

stigma campaigns can be effective in increasing knowledge about mental illness. Anti-stigma campaigns have also shown success in increasing awareness and interest around mental health illness, as well as improving attitudes towards it. Vaughan and Hansen (2004) studied the effects of a campaign to reduce mental illness stigma and discrimination. Prior to the campaign, it was found that the general public had limited understanding and interest in mental illness. Following the campaign, there were positive changes in attitudes towards those with mental illness. There was also an increase in people noting that they would not feel ashamed if they had a mental illness, and an increase in acceptance of people with mental illness. Overall, 80% had reduced levels of mental health stigma and discrimination. These findings indicate that anti-stigma campaigns are capable of increasing awareness and interest in mental illness. These effects also appeared to be long lasting, as the results persisted months after the study. If such campaigns could be brought to college campuses, it is possible that both perceived and personal stigma levels of students could be reduced. The findings of the current study support the implementation of an anti-stigma campaign, as they indicate that student levels of perceived stigma are much greater than the actual stigma levels on campus. Therefore, students could learn that actual stigma is not as high as they believe it to be. In addition, the current study found that, while low, some mental health stigma does exist. Therefore, the findings support that an anti-stigma campaign would be warranted on college campuses.

While this study found that perceptions of stigma were greater than personal stigma, the overall message is that mental health stigma does exist on the college campus.

Many researchers have shown that mental health stigma has negative effects on college student mental health (Eisenberg et al., 2009; Quinn et al., 2009; Vogel et al., 2007; Vogel et al., 2006). Therefore, a main implication of this current study would be for college counseling centers to develop and promote anti-stigma campaigns on campuses.

### **Implications for College Counselors**

Through the current study's findings, more is known about the levels and relationships between perceived stigma, personal stigma, and help-seeking attitudes and intentions. Practicing college counselors will be better equipped to understand their clients. It is hoped that this newly attained knowledge about the levels and relationships of student perceptions around mental health stigma will be beneficial within the session.

This knowledge will help counselors to be aware of addressing stigma during the individual session, to best help their clients. College counselors can have better awareness of why students may not be coming to counseling (for concerns of perceived stigma). The current results indicate that clinicians may need to address client concerns about their personal stigma towards themselves in the counseling session. Changing society's perceptions of stigma and stigma of help seeking remains an important step and may be the ultimate goal. However, what takes place in the individual counseling session is extremely important as counselors can help clients to feel safe in the session and to manage and reduce their own personal stigma.

It is important to better understand college students' perceived public stigma and personal stigma, to benefit students who are already currently receiving campus counseling. Counselors can become better equipped to address the issue of stigma within

the counseling session. For instance, counselors may be better able to identify and address clients whose high levels of personal stigma have become internalized and present as self-stigma. Self-stigma occurs when an individual places stereotypes and prejudices onto oneself and identifies with the stigmatized group (Eisenberg et al., 2009). Identifying and correcting self-stigma is important because it has been shown that self-stigma negatively affects self-esteem and self-efficacy. In addition, “coming out” about one’s mental illness has been positively related to an improved quality of life (Corrigan et al., 2010). As counselors show genuine positive regard for their clients and facilitate a counseling environment free of judgment and stigma, clients may be more inclined to open up about their mental illness and self-stigma in session. As stigma is addressed in the session, misperceptions of levels of public stigma may be corrected, and it is hoped that the counseling process will also become even more beneficial.

When students do come in for counseling, the results of the current study suggest that it would be helpful for counselors to have increased awareness of how difficult it may have been for students to come in for counseling, because they may have had to overcome high perceived stigma. Even if the students were able to overcome the perceptions of stigma long enough to come in for counseling, it does not mean that the perceptions no longer exist. An internal conflict may exist for the client. One part of them may want to enter into the counseling relationship and know that it could be beneficial for them, but another part may feel hesitant because of concerns of perceived stigma. Being aware of this can be very helpful to the counselor. This knowledge can be a great catalyst for counselors to bring up the topic of perceived stigma in session. Rather than

both the counselor and client ignoring the topic of stigma, the counselor can broach the topic, thus normalizing the concerns about stigma that the student may have. Normalizing these feelings of perceived stigma may allow the client to feel more at ease and to be honest with the counselor about any internal conflicts, as noted prior, that he or she may be feeling. Having this candid discussion about feelings of stigma may help the client to process them in the session and feel more comfortable about partaking in counseling.

In addition, the counselor can use this as an educational moment to teach the student about the misperception between perceived and personal stigma. Hopefully, this will ease concerns that the student may have over his or her high perceptions of peer stigma. In turn, this may increase the likelihood that students will continue counseling sessions, rather than terminating over concerns of stigmatization. Ultimately, having this genuine conversation should help to build trust and comfort in the counseling relationship. Utilizing conversations such as this to build a strong basis for the counseling relationship can be helpful throughout the counseling experience.

### **Implications for Counselor Educators**

A primary focus of many counselor education programs typically revolves around what happens during the counseling session. While this is vital, it is also important to discuss why some clients never seek counseling. Concerns of mental health stigma is well known as the greatest barrier to seeking mental health services (Corrigan, 2004a; Komiya, Good, & Sherrod, 2000; Vogel, Wade, & Haake, 2006) and a significant result in the present study. Therefore, it makes sense that counselor educators should discuss this topic and its impact on clients and the profession with future counselors. This study



supports discussion about mental health stigma as a consideration for the curriculum for counselor education programs.

If future counselors are educated about how stigma can prevent people from seeking counseling, they may be more inclined to implement outreach strategies and similar methods to promote help-seeking. For instance, one of the key components of a successful social norms or anti-stigma campaign is the awareness that stigma exists and can impede help-seeking. If counselor education programs do not bring awareness to their students, these future counselors may never realize the impact that stigma can have, or that it even exists. Through multicultural classes and other sensitivity trainings, counselor education programs teach their students not to stigmatize or judge others, including mental illness. Mental illness may become normalized to students given its coverage in counselor education programs and as a result they may appear free of stigma by their own perceptions. Yet, it can be dangerous if these future counselors naively believe that just because they do not hold stigma towards the mentally ill, that no one else does.

As the current study shows, perceptions of stigma are much greater than personal stigma. Future counselors should be trained about this misperception and what this means for their future clients. Counselor education programs may teach their students that stigma is a topic that may be broached with clients. Future counselors should learn to feel comfortable discussing perceptions of stigma with their clients in order to best help them by assessing their clients' stigma levels and hopefully working through them. In the end,

a great disservice to our future counselors would be to “stigmatize” against the topic of stigma by never addressing it.

### **Limitations**

The study of stigma itself creates limitations. Participants may have been more inclined to give more socially acceptable responses, such as reporting less personal and perceived stigma. Eisenberg et al. (2009) also supported this by noting that participants may understate their true levels of personal stigma because they may not want to admit this socially undesirable stigma to others or even themselves. This limitation may better help explain why personal stigma scores were so low in the current study, making for a skewed distribution. This limitation may also be compounded by the fact that the responses were self-reported, thus making them more vulnerable to biased responses. While self-reporting may have been a limitation in the current study, it is difficult to measure stigma without self-reports. Attempting to measure stigma through behaviors would be a more elaborate study design with its own limitations. The current study did take measures to reduce these limitations as much as possible. For instance, not having the researcher present during data collection was intended to reduce dishonest responses. Also, by utilizing an online survey, and not having other participants present in the same room, dishonest responses by peer pressure may have been lessened.

Another limitation of this study was that the actual behavior of help-seeking was not measured, only help-seeking attitudes and intentions. We do not know if help-seeking attitudes and intentions are correlated with help-seeking behaviors. The actual behaviors of help-seeking can only be inferred from attitudes and participant-noted intentions. For

some individuals, the type of mental health issue, other events taking place in their lives at the time, and so forth may prevent help-seeking in the future even if previous attitudes and intentions were favorable. To have measured help-seeking behaviors would have meant a more elaborate and time-intensive longitudinal study, perhaps this would be an area for future study.

Another limitation of the study was the high ratio of female to male participants. Although national college statistics (National Center for Education Statistics, 2005; Marklein, 2005), Montclair State University (Forbes, 2012), and Winthrop University (UsNews, 2012) all have higher female student ratios, the current study still had a higher female ratio than average. Therefore, the participant pool did not include enough men. As a result, interpretations of the current study must use caution about generalizing them to all college students.

A final potential limitation to consider is that participants willing to participate in a research study about mental health may also be more willing to engage in help seeking behaviors such as counseling. The evidence from this study may corroborate this idea since 43.2% of participants have received counseling and 56.8% have never received counseling. The existing literature reports that less than one third of those who experience psychological distress seek mental health services (Andrews, Issakidis, & Carter, 2001) and only a total of 10.6% of college students seek campus counseling for any mental health problem (Gallagher, 2012). The over 43.2% of the participants in this study reporting past participation in counseling seems high compared to national statistics. This

high ratio of participants with a history of counseling use could have influenced the results of this study.

### **Directions for Future Research**

Future research with a larger and more diverse sample representative of the college population is warranted. In general, until more similar studies are conducted, it is difficult to weigh too heavily on the results of any one study. It is important to remember that the relationships found in this study are not causal. Studies with more extensive research designs would only contribute to the literature in this area.

A future study that incorporated a more culturally diverse sample is suggested. Individuals from different cultures, ethnic, and religious backgrounds may have different help seeking behaviors and different attitudes and intentions toward mental health services. Addressing this, as well as a more representative gender and past counseling history sample, may warrant a future study. Having a diverse sample is important, as the current study has revealed, since certain demographic factors can be related to levels of stigma and help-seeking attitudes and intentions. To accomplish this recruitment of a diverse sample, future studies may look to have an increased sample size, as well as to sample from many universities across the country and even the world.

In discussing a more varied gender sample for future research, the idea of conducting a similar study solely based on gender is warranted. As the findings of the current study revealed, men had higher personal stigma than women. Therefore, future studies might examine exclusively men and mental health stigma. As a result of influences such as societal gender messages and expectations, men may experience and

perceive mental health stigma very differently than women. Studies such as this might also supply new information for mental health social norms campaigns exclusively targeted at men.

Another suggestion for future research is a longitudinal study. A longitudinal study could allow insight into not only a relationship between stigma and help-seeking attitudes and intentions, but also actual help-seeking behaviors. By first assessing participant stigma levels and help-seeking attitudes and intentions, the same participants could be assessed at later intervals in their lives. Such a study could bring new insight into how well prior stigma levels and help-seeking attitudes and intentions actually predict counseling behaviors later in life. In such a longitudinal study, changes in participant stigma levels could also be observed throughout time, or different phases in life. In addition, such a study would allow for the study of stigma outside of the college years and college setting.

Psychoeducational and social norms campaigns can warrant future research. Results of other studies indicate that a correction in misperceptions can change student behavior, such as alcohol use (Scribner et al., 2011). Future studies devoted solely to measuring student levels of stigma and behavior changes as a result of mental health stigma campaigns are suggested. Such studies may also incorporate a longitudinal approach to even more effectively measure how any found behavior changes may increase or decrease over time. The implementation of social norms and anti-stigma campaigns regarding mental illness are limited, but will hopefully increase as a result of studies such as the current one. The efficacy of such campaigns, once implemented, will

help college counselors to know what methods are effective in reducing stigma and encouraging help-seeking among college students.

Future studies might also look at other potential impacts of personal and perceived stigma. While the current study has revealed a relationship between stigma and help-seeking attitudes and intentions, other associations may also exist. For instance, it would be interesting to research if levels of stigma are related to self-esteem, happiness, relationships, or even academics. Further exploration into stigma and its impacts would be helpful not just for better understanding and helping college students, but people in general.

Finally, an important next step is to conduct research to better understand how stigma occurs. Understanding the development of stigma and the thoughts that lead to it are important because they may pave the way towards best practices for guarding against it and reducing it. Few studies have actually examined the responses and thought process behind stigma. Reeder and Pryor (2008) did find that there may be an automatic stigmatizing response, ingrained from things such as media messages. Findings also suggest that there is the opportunity for a subsequent rule-based processing which can diminish the original stigma. Given their findings, Reeder and Pryor (2008) call for stigma reducing campaigns that address both automatic response and rule-based response public stigma. Efforts to reduce automatic stigma may include halting mainstream messages of mental health stigma, such as in the media. Efforts to increase rule-based processing may include efforts to increase individuals to think past and reconsider their automatic stigma. Reeder and Pryor (2008) describe this importance of understanding the

thought process behind public stigma, “In order to tear down the barriers that result from stigma, prevention efforts need to recognize the dual psychological processes—associative and rule-based—that underlie public stigma” (p.184). If more studies built upon this research, we may better understand how stigma develops and how to reduce current levels as well as prevent it in future generations.

### **Conclusion**

The results of the current study could have future applicability in many areas. The development of a mental health stigma social norms campaign, based on the current findings, could have far-reaching implications in educating people about mental illness through correcting misperceptions. The individual counseling session could benefit from the current findings as counselors could gain more information and strategies for working with future clients, especially those with high levels of personal and/or perceived stigma. Also, counselor education programs can consider such findings in their curricula so that the topic of mental health stigma is not forgotten, but rather discussed in depth to better prepare future counselors.

While the current study revealed some important findings regarding mental health stigma, it is just the beginning. Much more research is still needed in the field to fully understand mental health stigma, including how it develops, all that it influences, and the perceptions and/or misperceptions that are held around it. Only after mental health stigma is truly understood, can we work to reduce it, and perhaps even eliminate or prevent it. In 1910 Princeton University started the first campus mental health center (Kadison & DiGeronimo, 2004); universities have come a long way in just over 100 years. Yet, much

more is still to be done. Greater education about mental illness and mental health stigma—to counselors, counselor educators, students, and the general public— is vital. The results from studies such as the current one are the important first steps to this educational process.



## References

- Alonso, J., Buron, A., Rojas-Farreras, S., De Graff, R., Haro, J.M., De Girolamo, G., ... Vilagut, G. (2009). Perceived stigma among individuals with common mental disorders. *Journal of Affective Disorders, 118*, 180-186.
- American College Health Association. (2007). *National college health assessment: Reference group executive summary*. Available at <http://www.ncbi.nlm.nih.gov/pubmed/18400658> (Accessed 12 December 2012).
- American College Health Association. (2012). *National college health assessment: Reference group executive summary*. Available at: [http://www.acha-ncha.org/docs/ACHA-NCHA-II\\_ReferenceGroup\\_ExecutiveSummary\\_Spring2012.pdf](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2012.pdf) (Accessed 11 December 2012).
- Anderson, P. & Vandehey, M. (2006). *Career counseling and development in a global economy*. Boston, MA: Houghton Mifflin Company.
- Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilization. *British Journal of Psychiatry, 179*, 417-425.
- Arbour-Nicitopoulos, K.P., Kwan, Y.W., Lowe, D., Tamna, S., and Faulkner, G. E. (2010). Social norms of alcohol, smoking, and marijuana use within a Canadian university setting. *Journal of American College Health, 59*, 191-196.
- Arthur, N. & McMahon, M. (2005). Multicultural career counseling: Theoretical applications of the systems theory framework. *The Career Development Quarterly, 53*, 208-222.

Barger, S. D. (2002). The Marlowe-Crowne Affair: Short forms, psychometric structure, and social desirability. *Journal of Personality Assessment*, 79(2), 286-305.

Bates, B. (2010). *College campuses see more students with mental health issues*.

Retrieved from: <http://www.emaxhealth.com/1024/college-campuses-see-more-student-mental-health-issues>

Bjorkman, T. Svensson, B. & Lundberg, B. (2007). Experiences of stigma among people with severe mental illness. Reliability, acceptability and construct validity of the Swedish versions of two stigma scales measuring devaluation/discrimination and rejection experiences. *Nordic Journal of Psychiatry*, 61, 332-338.

Carlat, D.J., Camargo, C.A., & Herzog, D.B. (1997). Review of bulimia nervosa in males. *American Journal of Psychiatry*, 154, 1127-1132.

Carter, R. (2010). *Within our reach: Ending the mental health crisis*. New York, NY: Macmillian.

Catalyst. (2001). *Women in corporate leadership: Comparisons among the US, the UK, and Canada*. Retrieved December 20, 2012 from <http://www.catalyst.org/files/fact/US,%20UK,%20Canada%20WICL%20Comparisons.pdf>

Chickering, A.W. (1969) *Education and identity*. San Francisco, CA: Jossey-Bass.

Chickering, A. & Reisser, L. (1993). *Education and identity* (2<sup>nd</sup> ed.). San Francisco: Jossey-Bass.

Clark, W., Welch, S.N., Berry, S.H., Collentine, A.M., Collins, R., Lebron, D., & Shearer, A.L. (2013). California's Historic Effort to Reduce the Stigma of Mental Illness:

The Mental Health Services Act. *American Journal of Public Health*, 103, 786-794.

Cornally, N. & McCarthy, G. (2011). Help-seeking behavior: A concept analysis.

*International Journal of Nursing Practice*, 17, 280-288.

Corrigan, P.W. (2004a). How stigma interferes with mental health care. *American*

*Psychologist*, 59, 614-625.

Corrigan, P. W. (2004b). Target-specific stigma change: A strategy for impacting mental

illness stigma. *Psychiatric Rehabilitation Journal*, 28, 113-121.

Corrigan, P.W., River, L.P., Lundin, R.K., Penn, D.L., Uphoff-Wasowski, K., Campion,

J., et al. (2001). Three strategies for changing attributions about severe mental illness. *Schizophrenia Bulletin*, 27, 187-195.

Corrigan, P.W. & Wassel, A. (2008). Understanding and influencing the stigma of mental

illness. *Journal of Psychosocial Nursing and Mental Health Services*, 46, 42-28.

Crino, M. D., Svoboda, M., Rubinfeld, S., & White, M. C. (1983). Data on the Marlowe-

Crowne and Edwards social desirability scales. *Psychological Reports*, 53, 963-968.

Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D. &

Mitchell, J.E. (2009). Increased mortality in bulimia nervosa and other eating disorders. *American Journal of Psychiatry*, 166, 1342-1346.

Crowne, D. P. & Marlowe, D. (1960). A new scale of social desirability independent of

psychopathology. *Journal of Consulting Psychology*, 24, 349-354.

- Dalton, D. & Ortegren, M. (2011). Gender differences in ethics research: The importance of controlling for the social desirability response bias. *Journal of Business Ethics, 103*, 73-93.
- Downing-Matibag, T. M. & Geisinger, B. (2009). Hooking up and sexual risk taking among college students: A health belief model perspective. *Qualitative Health Research, 19* (9), 1196-1209.
- Duffey, T. & Somody, C. (2011). The role of Relational-Cultural Theory in mental health counseling. *Journal of Mental Health Counseling, 33*, 223-242.
- Durbin, J. & Watson, G. S. (1950). Testing for serial correlation in least squares. *Biometrika, 37*, 409-428.
- Eagly, A.H. (2007). Female leadership advantage and disadvantage: Resolving the contradictions. *Psychology of Women Quarterly, 31*, 1-12.
- Edwards, A. (1953). The relationship between the judged desirability of a trait and the probability that the trait will be endorsed. *Journal of Applied Psychology, 37*, 90-93.
- Eisenberg, D., Downs, M.F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66*, 522-541.
- Eisenberg, D., Gollust, S. E., Golberstein, E., & Hefner, J. L. (2007). Prevalence and correlates of depression, anxiety, and suicidality among university students. *American Journal of Orthopsychiatry, 77*, 534-542. doi:10.1037/0002-9432.77.4.534

- Eisenberg, D., Nicklett, E., Roeder, K., & Kirz, N. (2011). Eating disorder symptoms among college students: Prevalence, persistence, correlates, and treatment-seeking. *Journal of American College Health, 59*, 700-707.
- Enochs, W.K. & Roland, C.B. (2006). Social adjustment of college freshman: The importance of gender and living environment. *College Student Journal, 40*:1, 63-73.
- Erikson, E. H. (1968). *Identity: Youth and Crisis*. Norton, New York.
- Evans, E.J., Hay, P.J., Mond, J., Paxton, S.J., Quirk, F., Rodgers, B.,...Sawoniewska, M.A. (2011). Barriers to help-seeking in young women with eating disorders: A qualitative exploration in a longitudinal community survey. *Eating Disorders, 19*, 270-285.
- Evans-Lacko, S., London, J., Little, K., Henderson, C., & Thornicroft, G. (2010). Evaluation of a brief anti-stigma campaign in Cambridge: Do short-term campaigns work? *BMC Public Health, 10*, 339-344.
- Eyler, B.R., Gaskins, E.M., Chalk, H.M. (2009). Effects of presenting concern and therapeutic relationship on college counseling outcomes. *Psi Chi Journal of Research, 14*, 8-14.
- Feldman, D.B. & Crandall, C.S. (2007). Dimensions of mental illness stigma: What about mental illness causes social rejection? *Journal of Social and Clinical Psychology, 26*, 137-154.
- Feltman, K. & Ferraro, F. (2011). Preliminary data on risk factors and disordered eating in male college students. *Current Psychology, 30*, 194-202.

Field, A. (2013). *Discovering Statistics Using IBM SPSS Statistics* (4th ed.). UK: Sage.

Flowers, L. (2002). Developing purpose in college: Differences between freshman and seniors. *College Student Journal*, *36*, 478-484.

Frey, L. L., Beesely, D., & Miller, M. R. (2006). Relational health, attachment, and psychological distress in college women and men. *Psychology of Women Quarterly*, *30*, 303-311.

Frey, L.L., Tobin, J., & Beesley, D. (2004). Relational predictors of psychological distress in women and men presenting for university counseling center services. *Journal of College Counseling*, *7*, 129-139.

Gallagher, R.P. (1994). *National survey of counseling center director 1994*. Washington, D.C. International Association of Counseling Services. Available at <http://www.iacsinc.org/>

Gallagher, R.P. (2003). *National survey of counseling center director 2003*. Washington, D.C. International Association of Counseling Services. Available at <http://www.iacsinc.org/>

Gallagher, R.P. (2011). *National survey of counseling center director 2011*. Washington, D.C. International Association of Counseling Services. Available at <http://www.iacsinc.org/>

Garfield, N. & David, L. (1986). Author Chickering: Bridging theory and practice in student development. *Journal of Counseling and Development*, *64*, 483-491.

Garlow, S.J., Rosenberg, J., Moore, D. J., Haas, A. P., Koestner, B., Hendin, H., & Nemeroff, C. B. (2008). Depression, desperation, and suicidal ideation in college

students: Results from the American Foundation for Suicide Prevention college screening project at Emory University. *Depression and Anxiety*, 25, 482- 488.

Glass, J.E., Kristjansson, S.D., & Bucholz, K.K. (2013). Perceived alcohol stigma: Factor structure and construct validation. *Alcoholism: Clinical & Experimental Research*, 37, 237-246.

Granello, D. (2010a). The process of suicide risk assessment: Twelve core principles. *Journal of Counseling & Development*, 88(3), 363-371.

Granello, D. (2010b). A suicide crisis intervention model with 25 practical strategies for implementation. *Journal of Mental Health Counseling*, 32(3), 218-235.

Hall, L. & Tucker, C. (1985). Relationships between ethnicity, conceptions of mental illness, and attitudes associated with seeking psychological help. *Psychological Reports* 57: 907-916.

Hammer, J. H., Vogel, D., & Heimerdinger-Edwards, S. (2012). Men's help seeking: Examination of differences across community size, education, and income. *Psychology of Men and Masculinity*. Advance online publication. doi: 10.1037/a0026813.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., et al. (2001). Recovery from psychotic illness: A 15- and 25-year international follow-up study. *British Journal of Psychiatry*, 178, 506-517.

Henderson, C., Evans-Lacko, S., Flach, C., & Thornicroft, G. (2012). Responses to mental health stigma questions: The importance of social desirability and data collection method. *Canadian Journal of Psychiatry*, 57, 152-160.

- Hepworth, N. & Paxton, S.J. (2007). Pathways to help-seeking in bulimia nervosa and binge eating problems: A concept mapping approach. *International Journal of eating Disorders, 40*, 493-504.
- Howard, C. (2013). *America's Top Colleges 2013*. Retrieved from <http://www.forbes.com/sites/carolinehoward/2013/07/24/americas-top-colleges-2013/>
- Johnson, P. Fendrich, M. , Mackesy-Amiti, M. (2012). An evaluation of the validity of the Crowne-Marlowe need for approval scale. *Quality & Quantity Journal, 46*, 1883-1896.
- Jordan, J. V. (2001). A relational-cultural model: Healing through mutual empathy. *Bulletin of the Menninger Clinic, 65*: 1, 92-104.
- Kadison, R. & DiGeronimo, T.F. (2004). College of the overwhelmed: *The campus mental health crisis and what to do about it*. San Francisco, CA: Jossey- Bass.
- Kaufman, M., & Creamer, D. (1991). Influences of student goals for college on freshman-year quality of effort and growth. *Journal of College Student Development, 32*, 197-206.
- Kimbrough, D. R., & Weaver, G. C. (1999). Improving the background knowledge of non-traditional students. *Innovative Higher Education, 23*(3), 197-219.
- Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review, 21*(3), 287-298.



- Kohlberg, L. (1970). *Stages of moral development as a Basis for Moral Education*.  
University of Toronto Press: Toronto, Canada.
- Kohlberg, L. & Hersh, R.H. (1977). Moral development: A review of the theory. *Theory Into Practice, 16*, 53-59.
- Komiya, N., Good, G.E., & Sherrod, N.B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*, 138-144.
- LaBrie, J. Hummer, J. Grant, S. & Lac, A. (2010). Immediate reductions in misperceived social norms among high-risk college student groups. *Addictive Behaviors, 35*, 1094-1101.
- Levene, Howard (1960). *Contributions to probability and statistics: Essays in honor of Harold Hotelling*. Stanford University Press. pp. 278–292.
- Link, B. G. (1987). Understanding labeling Effects in the area of mental disorders: An assessment of the effects of expectations of rejection. *American Sociological Review, 52(1)*, 96-112.
- Lonn, S., Teasley, S. D., & Krumm, A. E. (2011). Who needs to do what where?: Using learning management systems on residential vs. commuter campuses. *Computers & Education, 56(3)*, 642-649. doi:10.1016/j.compedu.2010.10.006
- Lundberg, B., Hansson, L., Wentz, E., & Björkman, T. (2007). Sociodemographic and clinical factors related to devaluation/discrimination and rejection experiences among users of mental health services. *Social Psychiatry & Psychiatric Epidemiology, 42(4)*, 295-300. doi:10.1007/s00127-007-0160-9.

- Magolda, M. B. Baxter. (2006). Intellectual development in the college years. *Change*, 38, 50-54.
- Malinauskas, B.M., Raedeke, T.D., Aeby, V.G., Smith, J.L., & Dallas, M.B. (2006). Dieting practices, weight perceptions, and body composition: A comparison of normal weight, overweight, and obese females. *Nutrition Journal*, 5, 11-19.
- Marklein, M. B. (2005, October 19). *College gender gap widens: 57% are women* [Electronic version]. USA Today.
- Martin, J.M. (2010). Stigma and student mental health in higher education. *Higher Education Research & Development*, 29, 259-274.
- Mayhew, M. J. (2012). A multilevel examination of the influence of institutional type on the moral reasoning development of first-year students. *The Journal of Higher Education*, 83, 367-388.
- McCabe, S. E. (2004). Comparison of web and mail surveys in collecting illicit drug use data: A randomized experiment. *Journal of Drug Education*, 34, 61-72.
- Mellin, E.A. (2008). Rejection sensitivity and college student depression: Finding and implications for counseling. *Journal of College Counseling*, 11, 32-41.
- Merriam, S. B. (2010). *Qualitative research: A guide to design and implementation*. San Francisco: Jossey-Bass.
- Miller, J.B. (1976). *Toward a New Psychology of Women*. Boston: Beacon Press.
- Moreno, M. A., Jelenchick, L. A., Egan, K. G., Cox, E., Young, H., Gannon, K. E., & Becker, T. (2011). Feeling bad on Facebook: Depression disclosures by college students on a social networking site. *Depression and Anxiety*, 28, 447-455.

- Motulsky, S.L. (2010). Relational processes in career transition: Extending theory, research, and practice. *The Counseling Psychologist, 38*, 1078-1114.
- National Center for Education Statistics. (2005). *Projections of education statistics to 2014*. Washington, DC: U.S. Department of Education.
- National Institute of Mental Health (2008). *Prevalence of Serious Mental Illness Among U.S. Adults by Age, Sex, and Race*. Accessed on Jan. 23, 2013 from:  
[http://www.nimh.nih.gov/statistics/SMI\\_AASR.shtml](http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)
- The National Institute of Mental Health (2008). *Major Depressive Disorder Among Adults* Accessed on Jan. 23, 2013 from:  
[http://www.nimh.nih.gov/statistics/SMI\\_AASR.shtml](http://www.nimh.nih.gov/statistics/SMI_AASR.shtml)
- Negro, P. (2011). *Personal communication*, New Jersey Higher Education Consortium.
- New Jersey Department of Law and Public Safety (2012). *New Jersey Division of Highway Traffic Safety*. Accessed on April 14, 2012 from:  
<http://www.nj.gov/oag/hts/index.html>
- New Jersey Department of Law and Public Safety (2013). *Employment Discrimination*. Accessed on 1/5/2013 from: <http://www.state.nj.us/lps/>
- Norman, R., Sorrentino, R., Widell, D., & Manchanda, R. (2008). The role of perceived norms in the stigmatization of mental illness. *Social Psychiatry Epidemiology, 43*, 851-859.
- Oliffe, J.L., Kelly, M. T., Johnson, J. L., Bottorff, J. L., Gray, R. E., Ogrodniczuk, J. S., & Galdas, P. M. (2010). Masculinities and college men's depression: Recursive relationships. *Health Sociology Review, 19*, 465-477.

- Pascarella, E. T., and Terenzini, P. T. (1991). *How College Affects Students: Findings and Insights From Twenty-Years of Research* (1st ed.). San Francisco: Jossey-Bass Publishers.
- Pascarella, E. T., & Terenzini, P.T. (2005). *How college affects students: A third decade of research*. San Francisco: Jossey-Bass.
- Peluso, E.T. & Blay, S. L. (2009). Public stigma in relation to individuals with depression. *Journal of Affective Disorders, 115*, 201-206.
- Perry, W. (1970). *Forms of intellectual and ethical development in the college years: A scheme*. San Francisco: Jossey-Bass.
- Phelan, J.C., Link, B.G., Dovidio, J.F. (2008). Stigma and prejudice: One animal of two? *Social Science & Medicine, 67*, 358-367.
- Quinn, N., Wilson, A., MacIntyre, G., & Tinklin, T. (2009). 'People look at you differently': Students' experience of mental health support within higher education. *British Journal of Guidance & Counseling, 37*, 405-418.
- Reeder G.D. & Pryor J.B. (2008). Dual Psychological Processes Underlying Public Stigma and the Implications for Reducing Stigma. *Mens Sana Monographs, 6*, 175-186.
- Schomerus, G., Auer, C., Rhode, D., Lupp, M., Freyberger, H.J., & Schmidt, S. (2012). Personal stigma, problem appraisal and perceived need for professional help in currently untreated depressed persons. *Journal of Affective Disorders, 139*, 94-97.
- Schools Health Education Unit (2012). Accessed on Jan. 23, 2013 from:  
[www.sheu.org.uk](http://www.sheu.org.uk).

- Schwarzbaum, S. & Thomas, A. J. (2008). *Dimensions of multicultural counseling: A life story approach*. Thousand Oaks: Sage.
- Scribner, R.A., Theall, K.P., Mason, K., Simonsen, N., Schneider, S.K., Towvim, L.G., & DeJong, W. (2011). Alcohol prevention on college campuses: The moderating effect of the alcohol environment on the effectiveness of social norms marketing campaigns. *Journal of Studies on Alcohol and Drugs*, 72, 232-239.
- Sexual Harassment Law Firms.com (2013). *Learn About Sexual Harassment*. Retrieved on 1/5/13 from: [www.sexualharassmentlawfirms.com/Sexual-Harassment-statistics.cfm](http://www.sexualharassmentlawfirms.com/Sexual-Harassment-statistics.cfm)
- Sheehy, K. (2013). *Colleges: UsNews Rankings and Reviews: Regional*. Retrieved from: <http://colleges.usnews.rankingsandreviews.com/best-colleges/winthrop-university-3456?int=c6b9e3>
- Shouse, S.H. & Nilsson, J. (2011). Self-silencing, emotional awareness, and eating behaviors in college women. *Psychology of Women Quarterly*, 35, 451-457.
- Silva De Crane, R., & Spielberger, C. (1981). Attitudes of Hispanic, Black, and Caucasian university students toward mental illness. *Hispanic Journal of Behavioral Sciences*, 3, 241– 255.
- Skinner, L.J., Berry, K.K., Griffith, S.E., & Byers, B. (1995). Generalizability and specificity of the stigma associated with the mental illness label: A reconsideration twenty-five years later. *Journal of Community Psychology*, 23, 3-17.

- SurveyMonkey, Inc. (2013). Privacy Practices. Palo Alto, California, USA. Assessed from: [www.surveymonkey.com](http://www.surveymonkey.com)
- Tanaka-Matsumi, J., & Kameoka, V. A. (1986). Reliabilities and concurrent validities of popular self-report measures of depression, anxiety, and social desirability. *Journal of Consulting and Clinical Psychology, 54*, 328-333.
- Tinto, V. (1993). *Leaving College: Rethinking the Causes and Cures of Student Attrition*. (2nd ed.). Chicago: University of Chicago Press.
- Vaughan, G., & Hansen, C. (2004). 'Like minds, like mine': A New Zealand project to counter the stigma and discrimination associated with mental illness. *Australasian Psychiatry, 12*, 113-117.
- Vogel, D., Heimerdinger-Edwards, S., Hammer, J. H., & Hubbard, A. (2011). "Boys Don't Cry": Examination of the links between endorsement of masculine norms, self-stigma and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology, 58*, 368-382.
- Vogel, D.L., Wade, N.G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337.
- Vogel, D.L., Wade, N.G., & Hackler, A.H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology, 54*, 40-50.
- Vogel, D.L., Wade, N.G., Wester, S.R., Larson, L., & Hackler, A.H. (2007). Seeking help from a mental health professional: The influence of one's social network. *Journal of Clinical Psychology, 63* (3), 233-245.

- Wahl O.F., (1995), *Media madness: Public images of mental illness*. New Brunswick, NJ: Rutgers University Press.
- Warwick, I., Maxwell, C., Statham, J., Aggleton, P. and Simon, A. (2008) Supporting mental health and emotional well-being among younger students in further education. *Journal of Further and Higher Education*, 32, 1-13.
- Watkins, D., Hunt, J., & Eisenberg. (2011). Increased demand for mental health services on college campuses: Perspectives from administrators. *Qualitative Social Work*, 11, 319-337.
- Weiner, B., Perry, R.P, & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of Personality and Social Psychology*, 55, 738-748.
- West, C. K. (2005). The map of relational-cultural theory. *Women & Therapy*, 28, 93-110.
- Westefeld, J.S., Button, C., Haley, J. T., Kettmann, J.J., MacConnell, J., Sandil, R., & Tallman, B. (2006). College student suicide: A call to action. *Death Studies*, 30, 931-956.
- Williams, K.L., & Galliher, R.V. (2006). Predicting depression and self-esteem from social connectedness, support, and competence. *Journal of Social and Clinical Psychology*, 25, 855-874.
- Wingspread group. (1993). *An American imperative: Higher expectations for higher education*. report of the Wingspread group on Higher education. racine, WI: Johnson Foundation, Inc.

Young, R.A., Marshall, S.K., & Valach, L., 2007). Making career theories more culturally sensitive: Implications for counseling. *The Career Development Quarterly*, 56, 4-18.



Appendix A  
Instrument

**Survey on Mental Health Stigma**

**\*1. What is your current class level?**

Freshman      Sophomore      Junior      Senior      Graduate Student

**\*2. What is your age?**

**\*3. What is your gender?**

Male      Female

**\*4. Do you live on or off campus?**

On Campus (Residential)      Off Campus (Commuter)

**\*5. What race do you mainly identify with?**

African American/Black      Asian      American Indian      Hispanic or Mexican      Native Hawaiian, or other Pacific Islander      Multiracial      White

**6. Which State do you live in?**

NJ      SC      NC      NY

Other (please specify)

**\*7. Which University do you attend?**

Montclair State University      Winthrop University

**\*8. What is your current GPA?**

3.50-4.00      3.00-3.49      2.50-2.99      2.00-2.49      Below 2.0

**\*9. Have you attended any form of counseling in the past?**

Yes      No

**\*10. Was the counseling you attended at the campus counseling center?**

Yes      No      I have never attended counseling



**Survey on Mental Health Stigma**

**\* 19. I would feel okay about myself if I made the choice to seek professional help.**

Strongly Disagree      Disagree      Agree and Disagree Equally      Agree      Strongly Agree

**\* 20. If I went to a therapist, I would be less satisfied with myself.**

Strongly Disagree      Disagree      Agree and Disagree Equally      Agree      Strongly Agree

**\* 21. My self-confidence would remain the same if I sought professional help for a problem I could not solve.**

Strongly Disagree      Disagree      Agree and Disagree Equally      Agree      Strongly Agree

**\* 22. I would feel worse about myself if I could not solve my own problems.**

Strongly Disagree      Disagree      Agree and Disagree Equally      Agree      Strongly Agree

**Next set of Questions**

Please indicate whether you agree or disagree with the following statements.

1 = Strongly Agree 2 = Agree 3 = Somewhat Agree 4 = Somewhat Disagree 5 = Disagree 6= Strongly Disagree

**\*\*Please note that the scale has flipped since the previous page, as Strongly Agree is now on the Left side.\*\***

**\* 23. Most people would willingly accept someone who has received mental health treatment as a close friend.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**\* 24. Most people believe that a person who has received mental health treatment is just as intelligent as the average person.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**25. Most people believe that someone who has received mental health treatment is just as trustworthy as the average person.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**Survey on Mental Health Stigma**

**\*26. Most people would accept someone who has fully recovered from a mental illness as a teacher of young children in a public school.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*27. Most people feel that receiving mental health treatment is a sign of personal failure.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*28. Most people would not hire someone who has received mental health treatment to take care of their children, even if he or she had been well for some time.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*29. Most people think less of a person who has received mental health treatment.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*30. Most employers will hire someone who has received mental health treatment if he or she is qualified for the job.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*31. Most employers will pass over the application of someone who has received mental health treatment in favor of another applicant.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*32. Most people in my community would treat someone who has received mental health treatment just as they would treat anyone.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*33. Most young adults would be reluctant to date someone who has been hospitalized for a serious mental disorder.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**\*34. Once they know a person has received mental health treatment, most people will take that person's opinions less seriously.**

Strongly Agree    Agree    Somewhat Agree    Somewhat Disagree    Disagree    Strongly Disagree

**Survey on Mental Health Stigma**

Please indicate whether you agree or disagree with the following statements.

1 = Strongly Agree 2 = Agree 3 = Somewhat Agree 4 = Somewhat Disagree 5 = Disagree 6= Strongly Disagree

**\*35. I would willingly accept someone who has received mental health treatment as a close friend.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**\*36. I would think less of a person who has received mental health treatment.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**\*37. I believe that someone who has received mental health treatment is just as trustworthy as the average person.**

Strongly Agree      Agree      Somewhat Agree      Somewhat Disagree      Disagree      Strongly Disagree

**Final set of Questions**

Listed below are a number of statements concerning personal attitudes and traits. Read each item and click whether the statement is "True" or "False" for you.

**\*38. Before voting I thoroughly investigate the qualifications of all the candidates.**

True      False

**\*39. I never hesitate to go out of my way to help someone in trouble.**

True      False

**\*40. It is sometimes hard for me to go on with my work if I am not encouraged.**

True      False

**\*41. I have never intensely disliked anyone.**

True      False

**\*42. On occasion I have had doubts about my ability to succeed in life.**

True      False

**Survey on Mental Health Stigma**

**\*43. I sometimes feel resentful when I don't get my way.**

True

False

**\*44. I am always careful about my manner of dress.**

True

False

**\*45. My table manners at home are as good as when I eat out in a restaurant.**

True

False

**\*46. If I could get into a movie without paying and be sure I was not seen I would probably do it.**

True

False

**\*47. On a few occasions, I have given up doing something because I thought too little of my ability.**

True

False

**\*48. I like to gossip at times.**

True

False

**\*49. There have been times when I felt like rebelling against people in authority even though I knew they were right.**

True

False

**\*50. No matter who I'm talking to, I'm always a good listener.**

True

False

**Survey on Mental Health Stigma**

**\*51. I can remember “playing sick” to get out of something.**

True

False

**\*52. There have been occasions when I took advantage of someone.**

True

False

**\*53. I’m always willing to admit it when I make a mistake.**

True

False

**\*54. I always try to practice what I preach.**

True

False

**\*55. I don’t find it particularly difficult to get along with loud-mouthed, obnoxious people.**

True

False

**\*56. I sometimes try to get even rather than forgive and forget.**

True

False

**\*57. When I don’t know something I don’t at all mind admitting it.**

True

False

**Survey on Mental Health Stigma**

**\*58. I am always courteous, even to people who are disagreeable.**

True

False

**\*59. At times I have really insisted on having things my own way.**

True

False

**\*60. There have been occasions when I felt like smashing things.**

True

False

**\*61. I would never think of letting someone else be punished for my wrong-doings.**

True

False

**\*62. I never resent being asked to return a favor.**

True

False

**\*63. I have never been irked when people expressed ideas very different from my own.**

True

False

**\*64. I never make a long trip without checking the safety of my car.**

True

False

**\*65. There have times when I was quite jealous of the good fortune of others.**

True

False



**Survey on Mental Health Stigma**

**\*66. I have almost never felt the urge to tell someone off.**

True

False

**\*67. I am sometimes irritated by people who ask favors of me.**

True

False

**\*68. I have never felt that I was punished without cause.**

True

False

**\*69. I sometimes think when people have a misfortune they only got what they deserved.**

True

False

**\*70. I have never deliberately said something that hurt someone's feelings.**

True

False

**Thank you for completing the survey!**

If you feel any level of distress, having now completed this survey, please call your campus counseling services. The services are free to you as a student. The contact information for these resources is:  
Montclair State University students should call Counseling Services at 973-855-5211.  
Winthrop University students should call Counseling Services at 803-323-2206.

**GIFT CARD RAFFLE:**

If you would like to be entered into the \$100 gift card raffle, please email a blank email to: [pompeoa@winthrop.edu](mailto:pompeoa@winthrop.edu)  
Please note in the subject line: "Please enter me into the raffle."  
Thank you again for your time! If you are the winner of the raffle, you will receive an email letting you know.

## Appendix B

## Survey Email-Implied Consent

Hello!

You are invited to participate in an anonymous study about mental health stigma. The hope of the study is to learn ways to help more college students use campus counseling. Your honest answers are important and your participation will be greatly appreciated.

You were selected as a possible participant in this study because you are an undergraduate student at one of two participating universities. If you decide to participate, please complete the following survey. Your completion of this survey is your consent to participate in this research study. The survey is designed to help us understand more about mental health stigma. It will only take about 10 minutes.

To compensate you for time you spend in this study, you will be given a choice to enter a raffle. The winner of the raffle will win a \$100 gift card. This raffle will be available for those who complete the study survey.

Your responses will be used to help us better understand mental health stigma. This knowledge will hopefully help students to seek counseling if they need it in the future.

You will be asked additional questions such as demographic information, your current GPA, if you have participated in counseling before, and your feelings regarding mental health counseling. It is possible that some upsetting feelings could occur when answering questions about mental health stigma. You could have anxiety after answering questions about mental health stigma. If you realize your own stigma beliefs you may get upset. Please use counseling services if this happens. The services are free to you as a student. The contact information for these resources is:

Montclair State University students should call Counseling Services at 973-655-5211. Winthrop University students should call Counseling Services at 803-323-2206. We will give you these counseling numbers again at the end of the survey.

There are also possible benefits. Realizing one's stigmas can be a benefit. It can cause self-reflection and growth.

Data will be collected using the Internet. No guarantees can be made about the privacy of data sent through the Internet by any third party (i.e. your employer). Confidentiality will be kept to the degree permitted by the technology used.

Your decision whether or not to participate will not affect your future relationships with your University. If you decide to participate, you are free to stop at any time. You may also skip questions if you don't want to answer them or may decide not to submit the survey.

Please feel free to ask questions about this study. You may contact me or my Faculty Advisor if you have additional questions at:

Alyson Pompeo  
pompeoa1@mail.montclair.edu  
803-323-3290 ext. 6188  
Faculty Advisor:  
Dr. Dana Levitt  
Levittd@mail.montclair.edu  
973-655-2097

If you have any questions about your rights contact Dr. Katrina Bulkley, Chair of the Institutional Review Board at Montclair State University at [reviewboard@mail.montclair.edu](mailto:reviewboard@mail.montclair.edu) or 973-655-5189.

Thank you for your time.  
Sincerely,  
Alyson Pompeo  
Doctoral Candidate, Montclair State University  
Staff, Winthrop University

By clicking the link below, I confirm that I have read this form and decided that I will participate in the project described above. The purposes, the parts involved, and possible risks and inconveniences have been explained and I am satisfied. I understand that I can stop participation at any time. I give consent to the data from my responses to possibly be used in a future study. My consent also indicates that I am 18 years of age. [Please feel free to print a copy of this consent.]

If you agree to participate, please click the survey link (or paste into your browser):

<https://www.surveymonkey.com/s/msuwusurvey>

The study has been approved by the Montclair State University Institutional Review Board as study #001395 on September 10, 2013.

## Appendix C

## Institutional Review Board (IRB) Approval



Institutional Review Board  
College Hall, Room 248  
VOICE: 973-655-7583  
FAX: 973-655-3022

September 6, 2013

Ms. Alyson Pompeo  
459 Stalevicz Lane  
Rahway, NJ 07065

Re: IRB Number: **001395**

Project Title: **College Students' Perceived and Personal Mental Health Stigma: The Influence on Help-Seeking Attitudes and Intentions**

Dear Ms. Pompeo:

After an expedited 7 review, Montclair State University's Institutional Review Board (IRB) approved this protocol on **August 17, 2013**. The study is valid for one year and will expire on **August 17, 2014**.

Before requesting amendments, extensions, or project closure, please reference MSU's IRB website and download the current forms.

Should you wish to make changes to the IRB-approved procedures, prior to the expiration of your approval, submit your requests using the Amendment form.

For Continuing Review, it is advised that you submit your form 60 days before the month of the expiration date above. If you have not received MSU's IRB approval by your study's expiration date, ALL research activities must STOP, including data analysis. If your research continues without MSU's IRB approval, you will be in violation of Federal and other regulations.

After your study is completed, submit your Project Completion form.

If you have any questions regarding the IRB requirements, please contact me at 973-655-5189, [reviewboard@mail.montclair.edu](mailto:reviewboard@mail.montclair.edu), or the Institutional Review Board.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Katrina Bulkley".

Dr. Katrina Bulkley  
IRB Chair

cc:  Dr. Dana Heller Levitt, Faculty Sponsor

