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Alicia E. Vasquez  
*Pacific University*

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## **Abstract**

Mental health literacy is defined as the ability to recognize and understand characteristics of mental disorders, including risks, causes, and when and how to obtain resources and services. Mental health literacy allows for accurate evaluation and communication, which becomes the foundation for increased awareness about mental and emotional health and towards promoting, maintaining, and improving well-being. Given that mental health issues are often diagnosed by age 24, college can be considered an important time to not only intervene but also to promote well-being. The current qualitative study ( $N = 32$ ) examined how college students conceptualize mental and emotional health in their lives. A modified grounded theory approach was used, resulting in four emergent themes. Students (a) struggled to define mental and emotional health and (b) believed it was secondary to other interests and pursuits. Students also (c) relied on information from a variety of sources that may or may not be accurate and (d) used dichotomies based on extremes to talk about mental illness versus wellness. Implications from the results are discussed.

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Alicia E. Vasquez

Pacific University

### Abstract

Mental health literacy is defined as the ability to recognize and understand characteristics of mental disorders, including risks, causes, and when and how to obtain resources and services. Mental health literacy allows for accurate evaluation and communication, which becomes the foundation for increased awareness about mental and emotional health and towards promoting, maintaining, and improving well-being. Given that mental health issues are often diagnosed by age 24, college can be considered an important time to not only intervene but also to promote well-being. The current qualitative study ( $N = 32$ ) examined how college students conceptualize mental and emotional health in their lives. A modified grounded theory approach was used, resulting in four emergent themes. Students (a) struggled to define mental and emotional health and (b) believed it was secondary to other interests and pursuits. Students also (c) relied on information from a variety of sources that may or may not be accurate and (d) used dichotomies based on extremes to talk about mental illness versus wellness. Implications from the results are discussed.

## Mental Health Literacy among College Students:

### Conceptualizations of Mental and Emotional Health

In 2001, Seligman critiqued psychology for its singular focus on psychopathology while at the same time ignoring aspects associated with the promotion of well-being. As a result, there is an overall difficulty in understanding the differences between illness and wellness (Keyes, 2005). Historically, mental illness has been defined as the presence or absence of a mental disorder, further emphasizing an importance on psychopathology over mental health and well-being (Manderscheid, Ryff, Freeman, Mcknight-Eily, Dhingra, & Strine, 2010). Ryff and Keyes (1995) define mental wellness as positive psychological functioning associated with a positive sense of self, a sense of purpose and growth over time, connections with others, and a sense of autonomy and agency. Individuals tend to not consider these definitions and instead think of illness and wellness as being positioned as opposite ends of the same spectrum, rather than their own separate concepts that occur at varying degrees. This leads to the conceptualization of wellness as simply the absence of psychopathology. However, previous research suggests that only a limited number of individuals without a mental illness could also be described as flourishing (Keyes, 2005). Flourishing is a large indicator of well-being and it coincides with high levels of emotional, psychological and, social well-being. This conflation of wellness with the absence of illness is likely a result of medical model within psychology almost exclusively highlighting aspects of psychopathology, such as treatment and diagnosis, over the attainment of overall well-being. Proper conceptualizations of mental illness and mental wellness are essential underpinnings to the attainment of mental health literacy, without more basic understandings of the differences between mental illness and wellness, mental health literacy becomes almost entirely unattainable.

Mental health literacy is defined as knowledge and beliefs about mental disorders which aid in an individual's recognition, management, and prevention of mental illness (Furnham, Cook, Martin, & Batey, 2011). Mental health literacy is a key component in many factors including: (a) the ability to recognize specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. Low mental health literacy can influence a decreased perception of need, and subsequent utilization rates (Gagnon, Gelinas, & Friesen, 2015). Delay and failure to seek proper treatment for mental disorders can have adverse effects and increase the likelihood of having more severe mental health outcomes later in life, while successful management will lead to a reduction in disabling symptoms (Eisenberg, Hunt, & Speer, 2012; Jorm, 2000). While mental health literacy interventions do exist, they tend to focus on treating mental illness instead of promoting psychological well-being as its own outcome.

Lack of mental health literacy becomes especially important among college students as 27% of college aged students suffer from a diagnosable mental disorder (Farrer, Leach, Griffiths, Christensen, & Jorm, 2008; Burns & Rapee, 2006), and 64% of individuals who dropped out of college did so because of a mental disorder (NAMI, 2012). Although 75% of lifetime disorders have their onset during college years, research suggests college students cannot effectively recognize their own mental illness or symptoms (Vanheusden, et al., 2008). Furnham, Cook, Martin & Batey (2011) reported that only eight of the 97 mental disorders listed could be recognized by a majority of participants. Farrer et al, (2008) also found that less than 50% of young adults could identify depression, and only about 25% could accurately identify psychosis.

Increased onset of mental illness alongside decreased mental health literacy among this group has the potential to increase the likelihood of failure in seeking treatment. Low rates of mental health literacy that result in decreased help-seeking among college-aged students can negatively impact academic success and educational attainment (Kessler, Foster, Saunders, & Stang, 1995; Eisenberg, Hunt, Speer, 2012), employment and productivity (Wang, et al., 2007; Eisenberg, Hunt, Speer, 2012), social relationships (Wang, et al., 2007; Eisenberg, Hunt, Speer, 2012), and substance use (Weitzman, 2004). Together, these results suggest that college is a critical time for intervention and promotion of well-being. An awareness and ability to conceptualize emotional and mental health is an important precursor towards developing skills that will operate to promote psychological well-being in college students.

Previous research has mostly focused on general patterns of mental health literacy among college students, while also placing an emphasis on recognizing illness rather than wellness. The current study relied on qualitative methods to examine college students' conceptualizations of mental and emotional health, focusing specifically on how these individuals think about and understand mental and emotional health in their own lives. Qualitative methods were better suited for this research as they allow for researchers to discover emergent themes based on participant responses, more personal interactions with participants, and they allow participants to have an active role in shaping the research based on their individual experiences.

## **Methods**

### **Participants**

Thirty-two students participated over the course of four focus groups. Participants were recruited both directly by research team members, and indirectly through professors who were

randomly selected to forward the recruitment email to their students. Participants were undergraduate students whose ages ranged from 18 to 24 ( $M= 19.41$ ,  $SD= 2.03$ ). All participants had to be full-time students, over the age of 18, and fluent in the English language. No participants dropped out of the study after the focus groups were initiated. As shown in Table 1, participants were predominantly White, followed by Asian, African American, Hispanic or Latino, and Native Hawaiian/Other Pacific Islander. Most participants were heterosexual, first year students, and living on campus. Roughly equal numbers of men and women were represented in the study.

## Measures

**Demographics and background factors.** Items assessed participant descriptives including age, gender, sexual orientation, race/ethnicity, class standing, and current living situation.

**Semi-structured focus group guide.** Focus group questions were adapted from previous qualitative studies with college students (Beauchemin, 2014; Gulliver, Griffiths, & Christensen, 2012; Koydemir, Erel, Yumurtaci, & Sahin, 2010; Li, Wong, Toth, 2013). Group discussions were centered on getting a more in depth understanding towards campus climate concerning seeking mental health services on campus, and understanding conceptualizations of mental health among college students. Example questions included: “How do you think college students define mental and emotional health?” and, “What do you think students need to know about mental health services on campus?”

Consistent with a modified grounded theory approach (Charmaz, 2000; Glaser & Strauss, 1967; Henwood & Pidgeon, 2003; Straus & Corbin, 1990), research questions were



more descriptive in nature, aiding the researcher in setting boundaries to the amount and types of data that were relevant to a specific line of investigation, and allowing for more detailed and complex coding and analysis.

### **Procedure**

The current study examined individuals' conceptualizations of mental and emotional health using focus group methodology. Recruitment for the focus groups took place within 6 months after IRB approval via convenience sampling. Participants were recruited through the use of various strategies, including involvement from another study, a simple random sample of professors on campus who were asked to forward the recruitment email to their students; tear-strip flyers posted around the campus; and various forms of social media.

Participants were contacted to verify that they met the inclusion criteria and were provided with a summary of the overall purpose, and scheduled at a convenient time. Two days prior to the focus group, participants received a reminder email providing the date, time, and location of the group discussion. Once the focus groups were scheduled and confirmed with participants via email, all emails and phone messages were deleted.

Focus groups involved small group discussions on a predefined topic where participants were asked open-ended questions that were administered by a facilitator. These groups generated large amounts of information which were then subject to qualitative analysis. Each of the four focus groups was between 19 and 37 minutes in duration and was moderated by a member of the research team with the help of an assistant. Only the participants and the researchers were present during the focus groups. The discussion followed a semi-structured interview format based on previous literature that examined different aspects of mental health and help seeking on

college campuses, while also allowing for additional comments and topics to be discussed as they arose.

Upon arriving at the focus group, participants reviewed and signed a copy of the informed consent, and any questions or concerns of the study were addressed. Participants were then asked to fill out a short questionnaire to determine demographic and background characteristics of focus group participants. The questionnaires contained no identifying information other than the focus group date. Participants were asked to sign consent for audio recording, and a confidentiality agreement requesting that they not discuss the content of the discussions. The focus group mediator then went over basic information regarding the nature of the study, addressed proper etiquette for the discussion, and participants were reminded that they did not have to reveal anything that they are not comfortable. If the participants did not want to use their own name in the discussion group, they were informed that pseudonyms would be used in place of actual names.

Discussions began with the mediator reading a short introduction of the study, followed by the first question. The mediator guided the conversation with the focus group questions, but allowed for the conversation to flow between participants. Before moving on to each question, participants were given the opportunity to provide any additional comments. Upon completion of the focus groups participants were debriefed, provided with their incentive of \$10 for their participation, and given a campus resource handout including information about the campus counseling center. Finally, they were asked to sign a research incentive award form, and reminded to respect the confidentiality of the other participants in the group. Transcription of the focus groups were then made verbatim on NVivo9 software, without any identifying features.

Participants were not provided with final transcripts for comment or asked to provide feedback on the results.

### **Data Analysis**

Thematic analysis of focus group transcriptions was done through the use of modified grounded theory (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Analysis was conducted by all three researchers, and was then compared for interrater reliability. Participant statements were classified based on their relation to the conceptualization of mental and emotional health. The process began with open and line by line coding where member of the research team were able to uncover themes and develop concepts through the exploration of ideas, thoughts, and meanings within the data. This was followed by axial coding, which involved the process of relating broad themes and categories between and within focus groups to their subcategories. Selective coding was then used to ensure that subcategories and quotes were representative of the larger themes that they were embedded within. Throughout the entire coding process, constant comparative method was used to continuously make comparisons of quotes and stories across participants and groups, and memo-writing was used towards the creation of operational definitions.

### **Results**

College students' perceptions of mental and emotional health were categorized into four major themes. These themes included an overall difficulty in defining mental health, the idea that mental health and well-being was peripheral to other interests and pursuits, an understanding of mental health as being shaped through both factual and subjective information from outside sources, and lastly the conceptualization of mental and emotional health through a series of

dichotomous concepts and terms. Within each thematic section, major categories of each theme will be discussed.

### **Attributions of Mental and Emotional Health**

Throughout the focus groups, participants made a variety of attributions to mental and emotional health, indicating a lack of understanding. Some students directly noted that mental health is not really understood because there is no concrete, singular definition for it. For example, one student noted, “...it is hard to define because mental health and emotional health isn't always understood”. Another student stated, “...I think we all have different definitions”, indicating that definitions of mental and emotional health vary because each individual thinks about them in differing ways. Although it was evident throughout the focus groups that students had a difficult time defining mental and emotional health, when they did define it, it was often understood in relation to being balanced, academic life, and other general aspects such as affordability, a focus on psychopathology, reactivity, and levels of support.

In terms of an idea of balance, it was most often understood that mental health was directly related to one's ability to maintain balance within different aspects of their living, with a student noting, that mental health is “Always [doing] what you can to maintain balance”. This included, but was not limited to, an ability to prioritize different aspects of their lives, and an overall achievement of balance between physical and mental aspects of one's own body. This is exemplified in another student's quote saying, “...I personally define mental health as you're just able to prioritize what you need to get done and then it gets done”.

Also within this theme was the understanding that mental and emotional health was only a priority when it had an adverse impact on academic achievement and/or functioning. Many

students noted that they were just going to have bad mental health because they are in college, indicating that there is really no way to achieve positive mental and emotional health. We see this exemplified when a student stated,

*“...I have heard like the whole idea of college is stressful. That is like a staple. It’s not... something that might happen, it is something that will happen. You will be stressed... you are just going to accept that that is kind of a norm”.*

Of the differing definitions of mental and emotional health that were brought up in the focus groups, there were a large variety of factors described as being important to one’s psychological health. As these factors ranged from financial factors to, with students saying that mental health “...might be too expensive for a lot of people because it’s not cheap”. Other students defined mental health with an overwhelming focus on psychopathology. During one of the focus groups and individual stated, “*I think the term has kind of gotten a bad rap since it is really easy to think like, “Oh that’s just like depression and anxiety like when you could actually have like bad mental health, and just because of stress”*”, while another student answered that their definition of mental and emotional health was “*Anxiety or a panic attack*”. Individual reactivity was also a focus here, with participants stating that mental health was defined by, “*The way you react to certain situations*”. Factors external to the individual were also included in this category with one student stating that mental and emotional health is indicated by a “*Strong support system*”.

These results indicate that there are a large variety of ideas about what mental and emotional health is. Some students directly recognized that they had no clear definitions, and other students struggled to define mental health by relating it to balance, academics, and other very broad aspect that they felt contributed to mental and emotional health. Although definitions

were not clear, many students were confident about how they formed their ideas and opinions of mental and emotional health.

### **Influences on Individual Perceptions**

Another theme identified throughout the focus groups was an understanding of mental and emotional health based on an influence from outside sources. These sources were both factual and subjective, indicating that influences were not always accurate representations of mental and emotional health. Influential sources that were identified by participants ranged from family and peers' perceptions to media, environment, and global events. Also included were self-assessments, the website for the campus counseling center, and from other on-campus sources.

During focus groups, some participants included that they would take self-assessment to gauge their own mental and emotional health was doing, or what activities they were doing that would promote and/or hinder their mental and emotional health. One student noted,

*"I know there's online surveys....and it will ask you a series of questions and every time I have taken one, I have to stop in the middle, because it's like "have you eaten in the last five hours? Go eat!...and I always fail them".*

Also noted by participants was the understanding that peer perception and family perception were the top to influencers in shaping their own perceptions of mental and emotional health. Many of them noted that if their family or friends had a negative outlook on mental and emotional health, and its upkeep, then they likely would to. One student described reasons why an individual wouldn't be interested in taking care of their mental health in stating, *"...say they're in a relationship and their significant other doesn't want them to go, or maybe family isn't so keen on needing therapy or something like that".*

Students then began to discuss more distal sources of influence. Participants described on-campus resources to be one of the larger influencers of how they thought about mental and emotional health. Students discussed receiving information in a variety of formats (e.g., pamphlets, magnets, self-assessments) and from events, faculty and staff, clubs and organizations that all contributed to their understandings of mental and emotional health. One student said,

*“I think that there are lot of different resources where you can find the information they have, like magnets that sometimes have the information, and they do tabling in the UC, and they share their information, and they had the thing....where they gathered on the UC patio and talked”.*

These sources were seen to influence not only the way that individuals were thinking about and defining mental and emotional health, but also how their entire campus was perceiving mental health. Another common factor that was brought up while discussing sources of definitions of mental and emotional health was the idea that definitions were developed through many social sources such as media (i.e., television, social media), environment, or even global events. This is exemplified by the quote, *“I think a lot of the time [mental and emotional health] can get muddled mainly just because there’s, you know, what the media is telling us it is versus what it actually is...”*.

As noted above, there are a variety of sources that shape students’ definitions of mental, and emotional health. While some sources directly discuss mental health, others talk about it in a way that indicates that mental and emotional health is not as important, or shouldn’t be as much of a priority, and other aspects of life.

### **Secondary to Other Pursuits and Interests**

While students discussed that psychological health is discussed more in college than in high school, it is still perceived to be a lower priority when compared other interests and pursuits. Many participants noted that physical health and academic achievement were consciously placed in front of their mental health and well-being, but there were also a variety of other general interests and pursuits that they felt took precedence over attainment of mental health.

Mental and emotional health were considered to be of less importance than physical health by participants. It was seen as important to take care of physical aspects, but because mental health isn't emphasized as much as physical health, it becomes less important to individuals, and to society as a whole. One student directly noted this idea when they stated, *"I think in general it is not considered as important as physical health because people don't talk about mental health as much"*.

Participants also seemed to knowingly prioritized performing well as a student over taking care of their mental health. Grades and other forms of academic achievement were held to a higher value than maintaining mental and emotional health. One participant said, *"...I don't think it is really valued as much as it should be, cause I know I put school before my mental health all the time and that is not healthy, but that is the important thing to do, it is what you are supposed to do"*. Again, directly indicating that they knowingly place school in front of mental health because they feel that academic achievement is more valued by society.

Aside from physical health and academic achievements, many other responsibilities other pursuits (i.e., friends, family, work, etc.) were placed as a higher priority than mental health. One



student stated that because other things are more of a priority, there is a tendency to forget about mental and emotional health altogether. They stated, “...*You tend to forget about it as time goes by when it comes to dealing with school, uh work, hanging out with friends, or something else-so on so forth*”.

The current the exemplifies the ways that students either actively place mental and emotional health as secondary to other aspects of their lives, or they tend to forget about it as a whole. When students do think about mental and emotional health, they most often position it as opposite to mental and emotional illness through a variety of contrasts.

### **Reliant on Dichotomous Concepts and Terms**

A very distinct commonality throughout the focus groups was a reliance on dichotomous concepts and terms in order to differentiate mental illness from mental wellness. Participants identified dichotomies that included mental stability versus instability, extreme symptoms of mental health versus common symptoms, self-sufficiency in maintaining mental health versus help-seeking, and tragedy versus everyday stressors (e.g., drug addiction versus drug use). There was a prominent understanding among participants that if an individual is characterized at one end of the dichotomy, they could not also be characterized at the other end of it.

For many participants, mental and emotional health was often seen as being synonymous with mental stability, so much so that the absence of stability indicated the presence of instability. One participant noted, “*I also feel like some people think....either you are mentally stable, or just not, and there is no, like I guess, medium*”. Another participant indicated that having a diagnosable mental illness understood as being mentally unstable in saying that, “*I think people just perceive it as being crazy or not mentally stable*”. Similar to the understanding that

mental health equaled mental stability was the perception that the difference between mental and emotional health was the same as the difference between being good without depression, and being bad with depression. They noted that, “...*I guess when I think about it, it’s like are you are you good and not depressed, or are you depressed*”. Again, reiterating the idea that an individual can either be one or the other, but nowhere in between.

Circumstances of mental illness were also discussed in terms of dichotomies and contrasts. Participants believed that in order for an individual to be classified as mentally unhealthy they needed to be suffering from a form of tragedy. One student stated,

*“I never really thought about going [to seek help] either if you are just....kind of stressed....you just need someone to vent to I guess. In a way, if you have other problems you would only go to the counseling center if you are going through like a death in the family, or something like that”.*

If an individual was not explicitly suffering from some sort of tragedy, that their circumstances did not justify a status of being mentally ill. Similar to the idea of tragedy versus everyday stressors, there was the common perception among participants that for someone to be mentally or emotionally unhealthy, they needed to present with extreme symptoms. One student said that, “...*[students] have a perception that mental health is far and extreme cases, so they don’t think that they need it*”. Another student stated that they don’t need to worry about their mental and emotional health because their lack of extreme symptoms indicated the presence of mental health. They stated, “...*it’s like no I don’t drink alcohol all the time or I haven’t been abused, I don’t need this*”. This indicated that there is a perceived boundary between individual that qualify as mentally ill or mentally well, and to be one is to not be the other.

Also evident within focus groups was the understanding that mental and emotional health was defined by the difference between help-seeking and self-sufficiency. An individual who could take care of themselves would be seen as mentally healthy. In contrast, an individual seeking any form of professional help for their symptoms would be seen as mentally ill. This is exemplified in a student's response in the event that one of their close friends suggested getting therapy, they stated,

*“Oh do you think I am not normal and that I like need help?’, and that is kind of a negative, kind of, I guess, idea and it just makes them look like they are weak. Like most people think you are weak if you can't control your mental health and emotions on your own”.*

Overall, this theme exemplifies the perception that there are clear distinctions between mentally and emotionally healthy individuals, and those that are mentally and emotionally ill. This distinction is made through a variety of contrasting dichotomies and terms. These notions are made based on influences from outside sources that also give off the perception that mental and emotional health is not as important as other aspects of an individual's life. All of this resulting in the lack of a clear understanding of what mental and emotional health actually is.

### **Discussion**

Findings examined college students' conceptualizations of mental and emotional health. Four major themes emerged including, an overall difficulty in defining mental and emotional health, when it was defined they tended to focus on well-being within the context of maintaining balance, academic performance, and with an overall focus on psychopathology. Mental health was not considered to be secondary to other pursuits and interests, and perceptions of

psychological well-being were influenced by a variety of outside sources regardless of their accuracy. Lastly, many students relied on dichotomous concepts and terms in order to differentiate mental wellness from mental illness.

Results of this study indicate that mental health literacy is low among college students, and ideas of mental health and illness are largely influenced by personal experiences, anecdotes, and other potentially inaccurate sources of information (Jorm, 2000). These results expand beyond previous studies that have identified a lack of research and theory in determining and conceptualizing mental health from mental illness among college students. Previous studies only focus on patterns of mental health literacy, rather than qualitative discussions of how it is understood (Furnham, Cook, Martin & Batey, 2011; Farrer et al, 2008). Results from the current study suggest that concepts of mental and emotional health lack a standard definition, making it difficult for the general public to understand differentiate mental illness from mental wellness (Keys, 2005; Manderschied, et al., 2010). Jahoda (1985) focused on the importance of balance in maintaining an individual's psychological well-being, and this is seen in participant responses which highlight the importance of maintaining balance between different aspects of life as being a crucial component of mental and emotional health. However, other studies (Ryff, 1989) suggest that there are also more complex, and multi-dimensional models of psychological well-being that we do not see in the current study. Extending beyond the previous literature, results demonstrate that individuals willingly place other aspects of their lives in front of their mental well-being. Even knowing the importance of their psychological health, the conscious decision is made to make it less of a priority than other interests and responsibilities such as family, friends, school work, hanging out, etc. Also extending beyond previous research is the conceptualization of mental and emotional health in relation to academics. Students only perceived their mental

and emotional health as needing to be taken care of when it began to hinder their academic achievement. Until it began affecting their grades or GPA, being mentally unhealthy was simply seen as a common component of being in college. Overall, the findings suggest that thriving among college students is impeded by an inability to properly identify mental and emotional well-being. Without proper definitions of mental health, mental health literacy is unattainable, resulting in the continuation of emphasizing psychopathology over aspects of well-being.

### **Limitations and Future Research**

A primary limitation to the current research is that participants were recruited using convenience versus theoretical sampling. Another limitation was the unique environment of the study, with all participants being students at a small liberal arts school in the Pacific Northwest.

Future research might benefit from recruiting specific subgroups of students who may or may not have sought mental health services, has been involved in interventions aimed at increasing their mental health literacy and/or taken courses in positive psychology. This type of recruitment would elaborate on differences in mental health literacy and conceptualizations mental and emotional health between the general student population, and those who show interest in learning about aspects of mental illness and wellness. Future research would also benefit from studies that assess not only aspects related to illness and psychopathology, but also mental wellness and positive mental functioning (Butler & Kern, 2015).

### **Implications**

Results from the current study could be used to enhance the body of research regarding the way that college students make sense of mental and emotional health within their own lives. Results have implications for both clinical and educational settings. Within the context of clinical

settings, it may be of importance to not only assess mental illness, but also to determine how individuals perceive psychological health and wellness in an effort to develop a language more centered on the promotion of well-being, even in the absence of illness. Within educational settings, these findings suggest that activities and discussions regarding emotional and mental wellness should be included at multiple points throughout students' educational career in order to consistently promote positive psychological functioning (Seligman, Steen, Park, & Peterson, 2005). This is of specific importance among individuals who have direct contact with students (e.g., professors, counselors, coaches, advisors), as well as college administrators who influence the policies that would contribute to thriving and flourishing among college students.

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Table 1  
*Participant Characteristics*

Variable	<i>N</i>	%
Gender		
Male	15	46.88
Female	17	53.13
Class Standing		
First Year	14	43.75
Sophomore	10	31.25
Junior	5	15.63
Senior	3	9.38
Race <sup>a</sup>		
White, Non-Hispanic	20	62.50
Hispanic or Latino	4	12.50
African American	5	15.63
Native Hawaiian/Other Pacific Islander	3	6.25
Asian	7	21.87
Place of Residence		
On Campus Housing	24	68.75
Off Campus	8	21.88
Sexual Orientation		
Heterosexual	30	93.75
Sexual Minority	2	6.25

<sup>a</sup> Frequencies in this category are non-cumulative percentages.